The Palliative Care Model for Emergency Department Patients with Advanced Illness

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Abstract

Background: Large gaps in the delivery of palliative care services exist in the outpatient setting, where there is a failure to address goals of care and to plan for and treat predictable crises. While not originally considered an ideal environment to deliver palliative care services, the emergency department presents a key decision point at which providers set the course for a patient's subsequent trajectory and goals of care. Many patients with serious and life-threatening illness present to emergency departments because symptoms, such as pain or nausea and vomiting, cannot be controlled at home, in an assisted living facility, or in a provider's office. Even for patients in whom goals of care are clear, families often need support for their loved one's physical as well as mental distress. The emergency department is often the only place that can provide needed interventions (e.g., intravenous fluids or pain medications) as well as immediate access to advanced diagnostic tests (e.g. computed tomography or magnetic resonance imaging).

Discussion: Palliative care services provide relief of burdensome symptoms, attention to spiritual and social concerns, goal setting, and patient-provider communication that are often not addressed in the acute care setting. While emergency providers could provide some of these services, there is a knowledge gap regarding palliative care in the emergency department setting. Emergency department-based palliative care programs are currently consultations for symptoms and/or goals of care, and have been initiated both by both the palliative care team and palliative care champions in the emergency department. Some programs have focused on the provision of hospice services through partnerships with hospice providers, which can potentially help emergency department providers with disposition.

Conclusion: Although some data on pilot programs are available, optimal models of delivery of emergency department-based palliative care have not been rigorously studied. Research is needed to determine how these services are best organized, what affect they will have on patients and caregivers, and whether they can decrease symptom burden and health care utilization.

Palliative Care and Emergency Medicine: Unmet Need

PATIENTS COME TO EMERGENCY DEPARTMENTS seeking relief from pain and other burdensome symptoms. Increasingly, these patients are older and more medically complex, necessitating greater skill in the delivery of palliative care services. Patients with cancer may fail outpatient management of pain or vomiting, residents of skilled nursing facilities need evaluation of fever and respiratory distress, and older adults with multiple chronic diseases have acute decompensations. Some problems are solved by a simple titration of opiates or review of an advance directive, while others require

more complex palliative care skills, such as a lengthy goals of care discussion when the patient and family members are in disagreement or denial.

Emergency medicine developed as a specialty to provide life-sustaining and disease-directed treatments to patients with acute illness. For some emergency patients with advanced and end-stage disease, traditional life-prolonging treatments offered by emergency providers may not be concordant with patients' goals, or address the symptoms for which they sought emergency care. Chronic diseases are now the leading causes of death, and there is a high prevalence of physical, psychosocial, spiritual, and financial suffering

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associated with serious and complex illness across many systems of care, including emergency departments.¹

Palliative care, as distinct from hospice, is not limited to end-of-life care and is offered simultaneously with life-prolonging therapies to persons living with serious, chronic illness. It utilizes an interdisciplinary, collaborative team-based approach to decrease pain and suffering. The goal is to achieve the best possible quality of life, including physical, psychological, social, and spiritual aspects, for patients and families through specific knowledge and skills.² These include the assessment and treatment of pain and other burdensome symptoms, aid with complex medical decision-making, mobilization of practical, spiritual, and psychosocial support, care coordination (especially during transitions of care), and bereavement services.²⁻⁵

Large gaps in the delivery of palliative care services exist in the outpatient setting, where there is a failure to address goals of care and to plan for and treat predictable crises.¹ In addition, outpatient clinics and physicians' offices are not well suited to treat pain crises or other symptoms, such as intractable vomiting or dyspnea, as most lack the capacity to provide urgent or emergent care, and if they do it is only during normal business hours. The emergency department is often the only place that can provide needed interventions (e.g., intravenous fluids or pain medications) as well as immediate access to advanced diagnostic tests (e.g., computed tomography or magnetic resonance imaging) 24 hours a day, 7 days a week. For this reason, both emergency providers and the palliative care community have increasingly acknowledged the need to deliver palliative care services in the emergency department.⁶ In 2008, American Board of Emergency Medicine became an official sponsor of Hospice and Palliative Medicine as a subspecialty.

Emergency visits provide a unique opportunity to relieve especially burdensome symptoms and provide goal-directed care early in a patient's hospital course. During a crisis, families often coalesce and the reality of serious illness and life or death decisions cannot be postponed or ignored. Difficult conversations occur, including those that involve whether or not to initiate potentially life-sustaining therapies. Even if patients have expressed prior preferences for treatment, these can change over time, and with changes in clinical status.⁷⁻⁹ Patients often visit the emergency department because of new or worsening symptoms, and thus it is especially vital that pain and other symptoms get addressed. It may also be appropriate to readdress their goals of care at that time.

Current Models for Palliative Care Delivery in the Emergency Department

Optimal models for the delivery of emergency department-based palliative care services have not been studied. Current emergency department-based programs are reflective of the palliative care services available at each particular hospital, and range from consultation by a palliative care social worker, to physician consultation with potential for admission to a dedicated palliative care unit. Because palliative care is a relatively new specialty, many palliative care teams cannot yet accommodate emergency department-based consultations in real time. Despite these limitations, it is important to develop theoretical models of care delivery that are based on patient needs, as opposed to just allowing delivery to grow organically based on what services are available.

In response to the growing numbers of patients with advanced illness cared for in the emergency department, several medical centers have recently initiated pilot programs to deliver emergency department-based palliative care consultation. These programs are described in detail below and are of three types: emergency department-based consultation programs initiated by the hospital palliative care team, services initiated by palliative care champions in the emergency department, and emergency department partnerships with hospice providers.

Palliative care service initiated programs

A select number of well-established palliative care programs have reached out to the emergency department to encourage consultations, including Virginia Commonwealth University, Montefiore Medical Center, and the Mount Carmel Health System. Although significant staff and resources are often needed to begin such programs, preliminary data show that emergency department-palliative care partnerships can help identify patients with palliative care needs, and provide needed services. Billing and administrative data from Virginia Commonwealth University Medical Center showed that emergency department-based consultation decreased hospital length of stay and costs for those who are admitted to and die in the hospital.¹⁰ In addition, the emergency department is now the source for a significant proportion of their palliative care unit's admissions. The palliative care service at Montefiore Medical Center was able to identify chronically ill older adults in need of palliative care, homecare, and hospice services and to link such patients with these services.¹¹ At three hospitals within the Mount Carmel Health System in Columbus, Ohio, the palliative care team developed training and screening tools specific to the emergency department, participated in emergency department staff meetings, and made regular emergency department visits, resulting in a highly successful partnership in which 9.2% of all admissions and 66.7% of all direct admissions to the palliative care unit come from the emergency department.¹²

Palliative care champions in the emergency department

Now that palliative care is a subspecialty of emergency medicine, an increasing number of emergency physicians will be boarded in both disciplines, and can serve as champions in the emergency department. At Scripps Mercy Hospital in San Diego, California, an emergency physician trained in palliative medicine began a pilot program to increase emergency department-based palliative care consultations. Of the 78 emergency department patients who were seen during the first 4 months, 29 were admitted to hospice agencies, suggesting that transfer to hospice care is feasible for emergency patients.¹³ Not all palliative care-emergency department partnerships have been started at hospitals with well-established palliative care consultation services. At Los Angeles County-University of Southern California medical center, a physician boarded in both emergency medicine and palliative care began the first palliative care consult team at this large, urban county hospital. With funding from the Archstone Foundation, a prospective, randomized trial of an emergency department-based palliative care intervention called *ED-HELP* showed the challenges in recruiting patients with

TABLE 1. BARRIERS AND POTENTIAL SOLUTIONS TO ADDRESSING PALLIATIVE CARE NEEDS IN THE EMERGENCY DEPARTMENT

<i>Barrier</i>	<i>Solution</i>
Logistical Limited availability	Increase hours and response time Dedicate palliative care staff to emergency department
Environmental Crowding Lack of privacy	Dedicated private space Sound proof curtains or door, chairs for family
Culture Fast-paced Interventional/procedural	Observation units Physician champions/Key opinion leaders
Knowledge Emergency providers Patients and families	Education in Palliative and End of Life Care (EPEC-EM)

advanced illness in the emergency department for research studies.¹⁴ Even with bilingual research staff, many patients could not participate because of cognitive deficits and/or high symptom burden.

Linkage to hospice services

A subset of emergency patients may benefit from active partnerships between emergency departments and hospice providers, especially those patients at the end of life with clear goals of care and a high burden of symptoms. The emergency department at Stands Hospital in Jacksonville, Florida, works closely with a community hospice to identify patients with end-stage illness whose pain and symptoms can be managed in the outpatient setting. The hospice provides two full-time nurses from 7:00 AM to 11:00 PM to assist the emergency department in identifying eligible patients and reviewing hospice benefits. While data are preliminary, the program is considered highly successful by hospital administrators and emergency department staff, and an increasing number of patients are discharged with hospice services.¹⁵

Potential Barriers to Expansion of Programs

While pilot programs to deliver palliative care to emergency department patients have demonstrated some early successes, real barriers exist to expanding such programs. Examples that are covered in detail below include emergency providers who may not view it as their role to provide palliative care, the primary team (i.e., primary care provider, hospitalist, or specialist), and limited staffing of palliative care teams (Table 1).

Attitudinal barriers among emergency providers

While emergency medicine developed as a specialty to treat and stabilize patients with acute illness or injury for definitive care, providers are increasingly providing care for acute exacerbations of chronic illness. While not at odds with palliative care, whose mission is to relieve pain and other burdensome symptoms, emergency medicine has traditionally been viewed as a rescue-oriented, procedural specialty. Emergency providers, as compared to primary care providers, are at some obvious disadvantages when trying to deliver goal-directed care that is consistent with patient preferences.

In addition to meeting patients and families for the first time, they may not be able to access patients' medical records or advance care planning documents. Patients are often brought to the closest appropriate facility during an emergency, which may or may not be their chosen site of care, or medical home. Depending on the time of day, the emergency provider may or may not be able to speak with the patient's primary provider, and a covering provider may not know the patient or have access to his or her medical records. Patients may present in extremis making it difficult or impossible to identify family or the primary provider before beginning potentially life-saving therapies. In addition, emergency providers may also feel it is not their role to discuss goals of care, and that primary care providers should address these predictable crises in advance. Initial exploratory research in this area endorses these themes.¹⁶

Nursing staff are typically supportive of palliative care and may be an important source of support. Depending on the site, staffing, and emergency department leadership, nurses could initiate palliative care consults themselves, or contact social work or chaplaincy services for patients and families. At some institutions, social workers can consult one another, and an emergency department social worker could engage the palliative care social worker who might have access to special resources specific to palliative care.

The primary care provider

Barriers to palliative care consultation exist not only among emergency providers, but also among the primary team caring for the patient, which could be the primary care provider, a hospitalist, or any of a number of specialists, such as oncology. When planning any emergency department-palliative care partnership, it is important to plan ahead and identify these particular barriers in advance. While primary providers could provide background on the patients' goals of care, prognosis, and trajectory of illness, they may not be reachable during a crisis, and thus the emergency physician may need to consult palliative care without the primary provider's assent, as the emergency physician would for any emergent consultation. If palliative care consultation is treated as a vital service for emergency department patients and families, similar to surgical consultation, then it should be standard practice to initiate consultation for certain patients.

Staffing

In an ideal world, an interdisciplinary palliative care team would be available for immediate consultation 24 hours a day, 365 days a year. In reality, emergency departments will need to make plans to provide some palliative care services themselves or arrange for delayed consultation. In situations where the team is not immediately available, emergency department observation units may be a useful way to clear the more acute beds and deliver symptomatic care and/or hold the patient until the palliative care team can get to the bedside. Patients can then be reevaluated for potential discharge the following day. This could also allow time for social work or other staff to help arrange hospice, visiting nurse or home care services before discharge. Palliative care patients who have severe symptoms or complex needs may, however, be too ill for discharge within 24 hours.

Potential Opportunities for Expansion of Programs

Despite the barriers, multiple opportunities exist to expand palliative care services in the emergency department. Examples include: increasing knowledge among emergency providers; development of triggers for palliative care consultations among emergency patients; and continually monitoring the benefits of moving palliative care consultation upstream for hospital administrators (Table 1).

Training of emergency providers

One way to ensure uniform access to palliative care services in the emergency department is to train emergency providers in palliative care delivery. The Education in Palliative and End-of-life Care for Emergency Medicine (EPEC-EM) curriculum, for instance, educates emergency clinicians on the essentials of emergency palliative care, including rapid assessment of palliative care needs and appropriate referral to hospice (www.epec.net/EPEC/Webpages/epecem.cfm). All health care providers should be expected to provide a minimal level of palliative care¹⁷; for emergency providers this would likely include treating pain, nausea, and vomiting up front and addressing goals of care before initiating aggressive interventions for patients with advanced illness who are unlikely to benefit. Emergency medicine providers should also understand the vital role they play as the first port of call for patients requiring palliative care, as the trajectory of an inpatient hospitalization is often set in the emergency department.

Triggered consultation

Triggers for palliative care consultation based on preset criteria are one way to overcome lack of knowledge attitudinal barriers to palliative care consultation.¹⁸ Patient-specific triggers have been developed for the surgical and medical intensive care units, and can help providers recognize appropriate patients for referral.^{19–21} These criteria could be built into the electronic medical record and could generate a recommendation to the provider to refer to palliative care. The emergency provider could “opt-out,” or decline consultation, while the patient/surrogate could decline services once the consult arrives. Defining criteria for consultation should involve key stakeholders, including emergency and palliative care providers, hospital administration, and other inpatient hospital providers who commonly care for such patients, such as internists and oncologists.

The business case

Palliative care has been shown to significantly improve patient and family member quality of life,^{22–27} while at the same time improving patient and caregiver satisfaction^{23,25,27–33} and reducing distressing symptoms,³⁴ such as pain or dyspnea,^{35,36} improving quality of care, reducing hospital length-of-stay^{19,33,37–41} and cost per day,^{37,40–42} and reducing health care costs^{19,23,26,33,36–42} in general, thereby reducing overall health care expenditures. Most interestingly, early palliative care consultation for patients with metastatic cancer has also been shown to reduce mortality.⁴³ Due to its demonstrated effectiveness, hospital-based palliative care has grown quickly and now more than half of hospitals with 50 or more beds have a palliative care service.^{44–47}

Although over 70% of hospitals with more than 250 beds now have palliative care services and their availability continues to increase,^{44,45,48,49} hospital-based consultation typically occurs over a week into a patient’s hospital stay,^{50,51} rather than in the first critical days of admission when major decisions are made. Preliminary data suggest that moving palliative care consultation upstream, to the emergency department as opposed to later during a hospital stay, can decrease hospital length of stay and reduce costs per day. A retrospective chart review of patients admitted to a community hospital in Detroit, Michigan, showed that patients who had palliative care consultation in the emergency department, as opposed to after hospital admission, was associated with shorter mean hospital length of stay (6.5 days versus 11.5 days, $p = 0.005$).⁵² A review of billing and administrative data from Virginia Commonwealth University showed that a partnership between the emergency department and palliative care can help identify emergency department patients for admission to a dedicated palliative care unit, which is associated with decreased costs per day and reduced ICU days.⁵³

Conclusion

In their report, the Institute of Medicine delineated many of the barriers to improving care at the end of life, including the historical separation of palliative or hospice care from potentially life-prolonging therapies.⁵⁴ Bringing palliative care into the emergency department, a place designed more to intervene than to comfort, is one important place to begin to break down these barriers. In fact, the integration of palliative care into emergency medicine is already occurring, with palliative care now an official subspecialty of emergency medicine. The number of emergency department-based pilot programs in the United States continues to rise, and preliminary data show associated reductions in hospital length of stay and costs per day. From a quality and cost-benefit perspective, offering palliative care services in the emergency department, at the beginning of the hospital course, might provide even greater benefit to patients, families and hospitals than inpatient consultation, which often occurs late in a patient’s hospital course.

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