PALLIATIVE CARE BEGINS IN THE EMERGENCY DEPARTMENT

NOT “WHY?”, BUT “HOW?”

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DISCLOSURES

- None
AGENDA [50 MIN]

- Navigating palliative consults in the ED
- Designing ED-palliative initiatives for success
  - **Key Learnings** from admission-trigger protocols
- Actionable primary palliative care in the ED
NAVIGATING ED CONSULTS
EMERGENCY DEPARTMENTS CAPTURE EARLIER PALLIATIVE ENGAGEMENT

Old
- Life-prolonging care
- Medicare hospice benefit
- Death

New
- Life-prolonging care
- Palliative care
- Hospice care
- Bereavement

ED Visit #1
ED Visit #2
ED Visit #3
IN THE ED, TIME DETERMINES SUSTAINABILITY

% AAEM Physicians Reporting as Significant Barrier (n=450)

- Lack of time on shift to implement palliative care: 46%
- Poor or lack of collaboration with palliative consult service: 24%
- Not confident in my palliative care skills: 12%
- Limited interest in palliative care issues: 6%
EM AND PALLIATIVE ALIGN IN VISION BUT DIFFER IN PRIORITIES

**Emergency Department Priorities**

- Time in minutes
- Easy, quick dispositions
- ED Length of Stay
- Medicolegal risk
- Press-Ganey scores

*Shared Goal: Delivering the *right* care for patients*

**Palliative Consult Priorities**

- Time in hours
- Due diligence with family and providers
- Thoughtful dispositions
THE ED CONSULT: MANAGE EXPECTATIONS

ED: “They need palliative care.”
ED: “Sorry, who are you?”

Will you come see this patient in the ED?

PC: “I’m headed into a family meeting.”
PC: “Who is the primary team?”
THE ED CONSULT: SOLICIT A CLEAR “ASK”

Patient Safety
- Code status clarification / reversals
- “Permission to do less” or “distressed by futility”
- Hospice/goals adherence
- High opioid needs

Quality of care
- Refractory symptom control
- Patient and caregiver support
- Continuity of care

Be clear on how your requested input will change disposition.
DESIGNING ED-PALLIATIVE INITIATIVES FOR SUCCESS
ED-PALLIATIVE INITIATIVES: THE MANY FACES OF “UPSTREAM”

Increase PC services utilization
- Screening/triggers
- Pipeline to consults, clinics, units, community-based

ED primary palliative skills
- Communication/GoC
- Protocols / short-stay beds
- ED-Hospice discharges
DESIGN ED INITIATIVE **IMPACT** TO MEET CONSULT SERVICE **GOALS**

What will success look like?

<table>
<thead>
<tr>
<th></th>
<th>LAUNCH</th>
<th>GROWTH</th>
<th>MATURITY</th>
<th>DIVERSIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
<td>Accept all-comers</td>
<td>Build relationships Acquire resources to match demand</td>
<td>Refine brand Decline “primary palliative” consults</td>
<td>Redistribute resources from consult service to alternative settings</td>
</tr>
<tr>
<td><strong>Value metrics</strong></td>
<td># Consults</td>
<td># Consults / FTE Penetration</td>
<td>Defined separately from census</td>
<td>ACO / transitions Cost avoidance</td>
</tr>
</tbody>
</table>
Single academic ED, annual volume 80k, 2014-2015

➢ **Any ED healthcare team member** assesses patient by validated IPAL-EM criteria

➢ Patient given informational handout

➢ **Opt-in** process by interested patients after reading

➢ **Just-in-time training** sessions with MDs, advance practice providers, nurses, social workers, and case managers
Living with your serious illness requires coping daily with challenging symptoms. Both **palliative** and **curative** approaches are crucial in treating your illness. They go hand-in-hand. Palliative Care focuses on relieving suffering from your symptoms:

- Pain
- Nausea
- Difficulty breathing
- Loss of appetite

Today, what matters in your care? As things change, what will matter in the future?

My health goals for today: | My health goals for the future:
---|---

- Early Palliative Care interventions improve quality of life, length of life, and communication between doctors and families.
- Have you considered allowing Palliative Care specialists to work alongside your other doctors to provide compassionate, coordinated care tailored to you and your family's goals?

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**Palliative Care**

- Relieve symptoms
- Understand complex treatment options
- Support family, social, and spiritual needs

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**Discharge Orders**

- Consult to Palliative Care

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**Facility List Search**

- PALLIATIVE

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No medications for this admission.

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**Provider List**

- Providers
- Palliative
- Standard

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**Order Entry**

- Order Sets
- Prescriptions
- Order Number

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**Summary**

- Summary
- Orders
Some consults were cancelled next morning
- Housestaff hand-offs
- No buy-in from hospitalists
- Some of these re-consulted later in admission

Outpatient referrals lagged
- Education and awareness of clinics < consult service

Criteria became cumbersome...however culture changed
UCSF: EMR–EMBEDDED TRIGGERS

Single academic ED, annual volume 50k, 2015-2016

- Embedded best-practice alert for all admissions
- Validated Palliative Care and Rapid Emergency Screening (PCARES) criteria
- Consult optional, not mandatory
- Matched to PCQN data

EMR TRIGGER ALERTED FOR EVERY ADMISSION
EMR TRIGGERED AWARENESS BUT **NOT MANDATORY** CONSULT

Best Practice - Positive for unmet palliative care needs

**Your patient screens positive for unmet palliative care needs.**

- Notify the admit team of the patient's needs
- Consider placing a palliative care consult now (Place an Apex consult AND page the Palliative Care Team M-F 8-5pm to discuss the case)
- Address current palliative needs for the patient
- Consider orders for:
  - Pain medication
  - Anxiolytics
  - Social work or spiritual care

Acknowledge reason:
SURPRISINGLY, LOS (DAYS) UNTIL PC CONSULT DID NOT REDUCE
Majority academic center admissions are palliative-eligible

INITIATIVE NOT TAILORED TO PC CONSULT SERVICE’S NEEDS

Primary palliative care

Specialist palliative care

Urgency
SCRIPPS: MATURE PROGRAM WITH DEFINED GROWTH GOALS

![Bar chart showing patient data comparison]

<table>
<thead>
<tr>
<th>Location</th>
<th>Mean Days Until Consult</th>
<th>Median Days Until Consult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mercy SD</td>
<td>8.1</td>
<td>4.4</td>
</tr>
<tr>
<td>Encinitas</td>
<td>4.8</td>
<td>2.5</td>
</tr>
<tr>
<td>Chula Vista</td>
<td>4.9</td>
<td>3.0</td>
</tr>
<tr>
<td>La Jolla</td>
<td>6.9</td>
<td>4.0</td>
</tr>
<tr>
<td>Green</td>
<td>5.2</td>
<td>2.8</td>
</tr>
</tbody>
</table>

2017-2018 PCQN Database
Objective

For the sickest patients with likely poor outcomes, how can Palliative Care be integrated earlier into the inpatient course as standard of care?

Interdisciplinary ED or admitting team identification:

- A) Terminal diagnosis (metastatic cancer, end-stage organ failure, end-stage dementia)
- B) Mainly functionally limited to chair or bed
- C) You would not be surprised if patient dies this hospitalization

Palliative Care sees patient within 24 hours of admission
ED-PALLIATIVE PILOT RESULTS: EXECUTIVE SUMMARY

166% ↑ ED-initiated consults

Captured usual PC patients earlier in their admission

More likely to discharge with palliative services

Avoided admissions
PILOT CAPTURED MANY USUAL PC CONSULTS EARLIER IN ADMISSION

45% all consults are from acute settings
No ICU cannibalization

166% increase

Eleven avoided admissions

Patient Location at PC Consult

2017
- All Other Locations: 224
- ED-Initiated: 24
- ICU: 85

2018
- All Other Locations: 190
- ED-Initiated: 64
- ICU: 91
ED CONSULT DEMOGRAPHICS ARE COMPARABLE TO NON-ED CONSULTS

<table>
<thead>
<tr>
<th></th>
<th>ED-Initiated</th>
<th>Non-ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total N</td>
<td>64</td>
<td>276</td>
</tr>
<tr>
<td>Age</td>
<td>73</td>
<td>69</td>
</tr>
<tr>
<td>Male</td>
<td>52%</td>
<td>55%</td>
</tr>
<tr>
<td>Female</td>
<td>48%</td>
<td>45%</td>
</tr>
<tr>
<td>Palliative Performance Score</td>
<td>31%</td>
<td>35%</td>
</tr>
<tr>
<td>Median LOS prior to consult</td>
<td>0.0 days</td>
<td>5.0 days</td>
</tr>
</tbody>
</table>

ED is accurately identifying palliative patients using these admission trigger criteria
EARLIER CONSULTATION SIGNIFICANTLY INCREASES DISCHARGES WITH PALLIATIVE SERVICES

Outpatient Services for Pts Surviving to Discharge

- Hospice:
  - All Other Locations: 42%
  - ED-initiated: 58%
  - p = 0.047*

- Any Palliative Services:
  - All Other Locations: 48%
  - ED-initiated: 64%
  - p = 0.046*

*Statistically significant
# ED-initiated consults seen per week

Total: 64 consults in 185 days
HOSPITALISTS INITIATE 21% OF ED-PALLIATIVE CONSULTS

Services requesting ED-initiated Palliative consult

- 74% by Other
- 21% by Hospitalist
- 5% by Emergency Physician

02/27/2018-08/31/2018

Centricity
Eleven Planned Admissions Were Avoided

Eleven Avoided Admissions

- 4 directly from ED to home with hospice
- 3 already on hospice clarified goals
- 4 ED comfort care transitions and deaths

“We can do that in the ED!?”
ACTIONABLE PRIMARY PALLIATIVE CARE IN THE ED
FOCUS YOUR IN-SERVICE ON HIGH-YIELD TOPICS

Increase PC services utilization
- Screening/triggers
- Pipeline to consults, clinics, units, community-based

ED primary palliative skills
- Communication/GoC
- Protocols / short-stay beds
- ED-Hospice discharges
Table 3. Approaching 5-minute ED goals-of-care conversations systematically as a procedure.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minutes 1–2</td>
<td>Elicit patient understanding of underlying illness and today’s acute change If available, build on previous advance directives or documented conversations Acquire sense of patient’s values and character (to help frame prognosis and priorities for intervention) Name and validate observed goals, hopes, fears, and expectations</td>
</tr>
<tr>
<td>Minutes 3–4</td>
<td>Discuss treatment options, using reflected language Continually center on patient’s (not family’s) wishes and values Recommend a course of action, avoiding impartiality when prognosis is dire</td>
</tr>
<tr>
<td>Minute 5</td>
<td>Summarize and discuss next steps Introduce ancillary ED resources (eg, hospice/observation unit, social work, chaplain)</td>
</tr>
</tbody>
</table>

Table 1. Word choice matters in goals of care conversations [adapted from Wang]¹

<table>
<thead>
<tr>
<th>Avoid these phrases</th>
<th>Use these phrases</th>
</tr>
</thead>
<tbody>
<tr>
<td>We need to discuss code status. I wouldn’t want this for my own mother.</td>
<td>Tell me about your mother. What was she like before she became ill? How has this illness affected her quality of life?</td>
</tr>
<tr>
<td>I don’t believe resuscitation would be successful. It is highly unlikely that she would ever get off these life support machines.</td>
<td>It seems like this illness has already taken many of her joys away from her. From what I see today, I do not think she would be able to return to that quality of life that is meaningful to her, not even to her current state. This is the natural course of her disease, and she is now dying.</td>
</tr>
<tr>
<td>Do you want us to do everything? Would she want heroic measures? Do you want us to push on her chest or put in a breathing tube?</td>
<td>Based on what you have told me about your mother, do you think she would want to die a natural death?</td>
</tr>
<tr>
<td>There is nothing more we can do.</td>
<td>I wish things were different. I suggest that we shift our focus now to keeping her comfortable, and aggressively use medications to reduce any distress she may feel.</td>
</tr>
</tbody>
</table>

IN CODE STATUS DISCUSSIONS, WHAT DO PATIENTS CARE ABOUT?

Patients care about **treatments**

Doctors care about treatments. Because that determines what we’re going to do. Patients care about outcomes because that determines how they’re going to live.
ACP DOCUMENTS REMAIN (UNDERSTANDABLY) CONFUSING

Define actionable difference between POLST and ADs

Teach how to assess validity of documents

Clarify hospital policy around valid POLST and dissenting surrogates

Remind about futility

RESIDENTS WILL BE AMBASSADORS

Palliative Care Education in Emergency Medicine Residency Training: A Survey of Program Directors, Associate Program Directors, and Assistant Program Directors.

Kraus CK¹, Greenberg MR², Ray DE³, Dy SM⁴.

Development of Hospice and Palliative Medicine Knowledge and Skills for Emergency Medicine Residents: Using the Accreditation Council for Graduate Medical Education Milestone Framework

Jan Shoenberger MD, Sangeeta Lamba MD, MSHPEd, Rebecca Goett MD, Paul DeSandre DO,
AUTOMATING CULTURE

**EMR order sets:**
- Comfort care symptom management and ancillary services
- Compassionate extubation

**Observation rooms:**
- Comfort care / await family
- Bridge to hospice discharge
ED-HOSPICE DISCHARGES ARE NUANCED

- **Challenges:**
  - ED Length of Stay
  - Not stably housed
  - Unreliable caregiver network
  - Uncontrolled symptoms

- **Solutions**
  - Near 24/7 Case Management
  - Hospice priority partnerships
  - Short-stay observation units
  - Alignment with administrative leadership
ANTICIPATE RESISTANCE, IDENTIFY CHAMPIONS

Raise up an **ED champion:**
- EM Talk (Vital Talk)
- EPEC-EM
- National organizations (e.g. ACEP, ENA) for mentorship and resources

Be prepared to answer:
- “Why is this my problem?”
- “How can I do this quickly?”