



Emergency Department Palliative Care *Information Paper*

*Developed by Members of the
Emergency Medicine Practice Committee*

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Emergency Department Palliative Care *an Information Paper*

The purpose of this paper is to start the discussion of integrating the subspecialty of hospice and palliative medicine into everyday emergency medicine practice. The subspecialty of palliative care concentrates on life threatening illnesses whether they are curable or not with palliative medicine representing the physician component of this interdisciplinary practice.¹ The Centers for Medicare and Medicaid Services (CMS) defines palliative care as “patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.”² Whereas the World Health Organization (WHO) defines palliative care as “care which improves the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end-of-life and bereavement.”³

The focus of palliative care is broad and includes several aspects of emergency practice already in place including symptom management, pain management, and discussion of critical decisions with families and loved ones. This paper provides an initial direction for the College in the area of palliative care and initiates a repository of palliative medicine resources.

Making a Case for ED Palliative Care

According to bioethicist Leon R. Kass “even the ordinary methods of treating disease and prolonging life have changed the context in which men die. Fewer and fewer people die in the familiar surroundings of home or in the company of family and friends. At the time of life when there is perhaps the greatest need for human warmth and comfort, the dying patient is kept company by cardiac pacemakers and defibrillators, respirators, aspirators, oxygenators, catheters and his intravenous drip. Ties to the community of men are replaced by attachments to an assemblage of machines.”⁴

Patients with advanced and end-stage disease in need of symptom management and pain relief often present to the emergency department (ED).^{5,6,7,8} Research focusing on patients who were at the end-of-life found that these patients often did not receive the care they anticipated.⁹ Once in the acute care setting the patient’s objectives and goals may be in direct contrast to the ED strategies of life-prolonging treatment.¹⁰ The need for palliative care and end-of-life care in the ED becomes apparent when considering that these medically complex patients present to EDs every day. Providers of emergency care have a unique opportunity to support palliative care interventions early in a patient’s disease trajectory, promoting quality of life as well as reducing cost associated with treatments.^{5,11,12,13} The ED offers a solution to the large gap in outpatient services for these patients by providing access to multidisciplinary teams for assessment, planning and needed interventions 24 hours a day, seven days a week.¹⁰ Recent literature suggests that palliative intervention in the ED provides numerous benefits to include timely provision of care,^{13,14} improved outcomes,^{14,15} direct referrals to hospice,¹³ reduced hospital length of stay,^{13,15,14} improved patient and family satisfaction,¹⁴ less utilization of intensive care,^{12,16} and cost savings.^{12,13,14,15,16}

Potential Barriers

Aside from the structural barriers inherent in the ED such as overcrowding, chaotic environments, and long wait times,^{13,17} there are additional barriers to consider. Physician attitudes and perceptions influence the delivery of palliative care and include personal perspectives of their ED roles, knowledge of palliative care, awareness of available hospital resources, understanding of relevant medical legal issues and concerns regarding the response of in-house palliative care teams and their hours of availability.^{5,17} Time itself can be a potential barrier in terms of discovering which patients may be appropriate for palliative care interventions/referral, the presence or absence of advance directives and the support of the patient and family in decision-making. Financial barriers include reimbursement issues for palliative care services in the ED. Billing codes do not address time spent with family discussing end-of-life issues.^{17,18}

Palliative care can be provided along with treatment that is meant to be curative or life-prolonging and can be very valuable to help relieve pain and suffering in patients dealing with illnesses that are chronic, life-threatening or potentially curable.

And finally, terminology may represent potential barriers to palliative care initiatives in the ED. Palliative care is not the same as end-of-life care.^{19,20} The two terms are used interchangeably in everyday language perpetuating the confusion. Further research is needed to better define these terms in the emergency setting.

Different Types of Programs

To provide optimal palliative care, individual EDs need to identify and utilize existing resources both internal and external to the hospital. These may include individuals within the hospital system as well as community agencies, such as hospice and palliative care providers, that are proficient in the care of the chronically ill.⁵ There are many ED palliative care delivery systems as providers have drawn on their experiences to design programs to meet the needs of diverse stakeholders. These delivery systems typically fall into one of three recurring models of palliative medicine/care: ED palliative care partnerships, ED palliative care champions, and ED hospice partnerships.¹⁰

An example of an ED palliative care partnership is the Life Sustaining Management and Alternatives (LSMA) program in Patterson, New Jersey at St. Joseph's Regional Medical Center (SJRMC). The primary goal of the LSMA is to identify those patients who might benefit from palliative care interventions upon entry into the health care system, and provide them with real-time palliative consults in the ED. The LSMA program identifies and supports patients' and families' wishes, which are then carried out throughout the plan of care.

A pilot program at Scripps Mercy Hospital in San Diego, California is an example of a palliative care champion in the ED.¹⁰ The program was initiated to increase ED-based palliative care consults; championed by an ED physician also trained in palliative medicine.

ED Focused Care²¹ at Shands-Jacksonville is an example of an ED hospice partnership. The program is a collaboration of Community Hospice and ED personnel working to identify patients who may benefit from hospice care. For all emergency physicians, the National Hospice and Palliative Care Organization searchable database at www.nhpco.org and the Hospice Foundation of America (www.hospicefoundation.org) provide resources for hospice collaboration.

Palliative Care and the Chronically Ill Older Adult in the ED

Older adults with chronic illnesses represent a complex, vulnerable population. Recent literature suggests identifying chronically ill older adults who may benefit from palliative intervention.^{5, 22} The typical response of emergency physicians offering life-prolonging interventions may not be in alignment with goals of this particular aging cohort, and may not provide a satisfactory response to the presenting complaint.⁵ Research and clinical protocols²⁴ noted in this paper may be instrumental in providing palliative medicine in response to the presenting complaints of many chronically ill elderly patients presenting to the ED.

Future Needs – Opportunities

There is a growing body of literature focusing on palliative care in the ED and numerous champions of this subspecialty emerging in hospitals of all sizes. Future research and collaboration within the ED community needs to be a priority to set the standards and policies in support of these vulnerable patients.^{5,6,7,18} Areas for focus are outlined below.

- Medical Education
 - Palliative care curriculum in medical school
 - EM core curriculum which includes end-of-life care
 - Pain management

- EM core competencies for residents with respect to older adults and palliative care
- Specific modules to align patient end-of-life preferences with treatment modalities
- Chronic illness trajectory including end-of-life
- Include all providers of emergency care from pre-hospital/EMS through disposition
- Competency assessments across disciplines
- Communication mechanism with outpatient providers to include advance directives
- Set Priorities for Research
 - Focus on end-of-life period
 - Refer to findings of the Palliative Care Workgroup 2009 for definitive approach to research focusing on palliative and end-of-life care in the ED5
- Clinical Protocol Development
 - Identify ED patients that may benefit from palliative interventions
 - Pain management
 - Non-pain symptom management (ie, nausea; constipation; pruritis)
 - Comfort care
 - Coordination of in-house palliative care team
- Evaluate the Ethical and Legal Framework Concerning End-of-life Care and Individual Wishes

Two web sites that provide noteworthy resources include: “Improving Palliative Care in Emergency Medicine”²³ and “Education in Palliative and End-of-Life Care for Emergency Medicine.”²⁴

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References

1. Quest T, Marco C, Derse A. Hospice and palliative medicine: New subspecialty, new opportunities. *Ann Emerg Med.* 2009;54:94-101.
2. U.S. Department of Health and Human Services. Medicare and Medicaid Programs: Hospice conditions of participation; final rule 2008;73(109):32088-32220. Accessed August 20, 2011; <http://edocket.access.gpo.gov/2008/pdf/08-1305.pdf>.
3. World Health Organization. Definition of Palliative Care. Accessed August 15, 2011; <http://www.who.int/cancer/palliative/definition/en/>
4. Kass LR. Toward a more natural science: biology of human affairs. The Free Press. New York: New York; 1985, p. 32.
5. Quest T, Asplin B, Cairns C, et al. Research priorities for palliative and end-of-life care in the emergency setting. *Acad Emerg Med.* 2011;18, e70-e76.
6. Grudzen C, Richardson L, Morrison M, et al. Palliative care needs of seriously ill, older adults presenting to the emergency department. *Acad Emerg Med.* 2010;17:1253-1257.
7. Smith A, Fisher J, Schnoberg M, et al. Am I doing the right thing? Provider perspectives on improving palliative care in the emergency department. *Ann Emerg Med.* 2009;54:86-94.
8. Ausband S, March J, Brown L. National prevalence of palliative care protocols in emergency medical services. *Prehosp Emerg Care.* 2002;6:36-40.
9. The SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients: The study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT). *JAMA.* 1995; 274(20):1591-98.
10. Grudzen CR, Stone S, Morrison S. The palliative care model for emergency department patients with advanced illness. *J Palliat Med.* 2011;14:945-950.
11. Lamba S. Early goal-directed palliative therapy in the emergency department: A step to move palliative care upstream. *J Palliat Med.* 2009;12:767.

12. Penrod J, Deb P, Dellenbaugh C, et al. Hospital-based palliative care consultation: Effects on hospital cost. *J Palliat Med.* 2010;13:973-977.
13. Stone S. Emergency department research in palliative care: Challenges in recruitment. *J Palliat Med.* 2009;12:867-868.
14. Meier D, Beresford L. Fast response is key to partnering with the emergency department. *J Palliat Med.* 2007;10:641-645.
15. Beemath A, Zalenski R. Palliative emergency medicine: Resuscitating comfort care? *Ann Emerg Med.* 2009; 54:103-104.
16. Penrod J, Deb P, Luhrs C, et al. Cost and utilization outcomes of patients receiving hospital-based palliative care consultation. *J Palliat Med.* 2006;9:855-860.
17. Grudzen C, Richardson L, Hopper S, et al. Does palliative care have a future in the emergency department? Discussions with attending emergency physicians. *J Pain Symp Manage.* 2012;43:1-9.
18. Kenen J. Palliative care in the emergency department. *Ann Emerg Med.* 2010;56:17A-19A.
19. Chan G, Malone R. End-of-life and palliative care in the emergency department: A call for research, education, policy and improved practice in this frontier area. *J Emerg Nurs.* 2006;32:101-103.
20. Reid C. Palliative care is not the same as end of life care. *BMJ.* 2011;342:1.
21. Community Hospice Emergency Department Focused Care at Shands Jacksonville. Accessed March 22, 2012; <http://ipal-live.capc.stackop.com/downloads/integrating-hospice-and-palliative-care-services-in-the-ed-saem.pdf>.
22. O'Mahony S, Blank A, Simpson J, et al. Preliminary report of a palliative care and case management project in an emergency department for chronically ill elderly patients. *J Urban Health.* 2008;85:443-451.
23. Improving Palliative Care in Emergency Medicine. Accessed March 11, 2012; <http://www.capc.org/ipal/ipal-em>.
24. Education in Palliative and End-of-Life Care for Emergency Medicine. Accessed May 2, 2012; <http://www.epec.net/epec.em.php>.