

INTEGRATION OF PALLIATIVE CARE INTO EMERGENCY MEDICINE: THE IMPROVING PALLIATIVE CARE IN EMERGENCY MEDICINE (IPAL-EM) COLLABORATION

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□ Abstract—Background: Emergency department (ED) providers commonly care for seriously ill patients who suffer from advanced, chronic, life-limiting illnesses in addition to those that are acutely ill or injured. Both the chronically ill and those who present in extremis may benefit from application of palliative care principles. **Case Report:** We present a case highlighting the opportunities and need for better integration of emergency medicine and palliative care. **Discussion:** We offer practical guidelines to the ED faculty/administrators who seek to enhance the quality of patient care in their own unique ED setting by starting an initiative that better integrates palliative principles into daily practice. Specifically, we outline four things to do to jumpstart this collaborative effort. **Conclusion:** The Improving Palliative Care in Emergency Medicine project sponsored by the Center to Advance Palliative Care is a resource that assists ED health care providers with the pro-

cess and structure needed to integrate palliative care into the ED setting. © 2014 Elsevier Inc.

□ Keywords—emergency department; emergency medicine; palliative care; collaboration; integration

INTRODUCTION

The emergency department (ED) serves as a safety net for many patients who suffer from serious, life-limiting illnesses (1–5). ED providers not only manage the dying process in the ED for patients with *acute* injury-related terminal events, but also routinely care for those seriously ill from *chronic* underlying diseases. The number of such patients with chronic, serious, life-limiting illnesses who present to the ED for “crisis” events is expected to rise (1,2,6,7). Two themes have emerged in the literature to guide our treatment approach in such patients: 1) best practice-based clinical decision-making and 2) development of plans of care that consider patients’ values and

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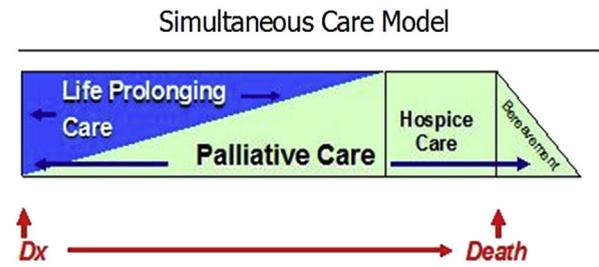


Figure 1. Simultaneous Care Model on diagnosis of a life-limiting illness.

goals because the ED often establishes (for better or worse) the in-hospital trajectory of care for patients who are seriously ill (2,5,8–13). Therefore, in the past 5 years, emergency medicine (EM) and emergency nursing have increasingly taken a central role in the early implementation of palliative care (2,3–5,8–13).

Although most recognize the importance of palliative care to the practice of EM, many barriers and competing priorities for both ED and palliative care providers jeopardize a more widespread integration of the disciplines (9–11,13). The term “integration” is used to indicate the incorporation of palliative care principles (outlined in Table 1) into daily ED practice with or without the involvement of a dedicated hospital palliative care team or inpatient palliative care unit (14,15). Palliative care is defined as patient care that is focused on relief of suffering (physical, spiritual, or psychological),

is based upon patient-determined goals, and is appropriate for *all phases* of a life-limiting condition (Figure 1) (9,10,14,15). This definition departs from the commonly held misconception that palliative care is appropriate only for dying patients. In fact, maximal patient benefit from palliative care is derived from early integration into care plans as opposed to considering palliative care as only a last resort measure when “no more can be done” for the patient (6–12,16–19). Both hospice and palliative medicine incorporate palliative care principles in the approach to care (Table 1); however, hospice services are based on prognosis and therefore can only be considered by ED clinical teams when patients have a predicted survival of 6 months or less (9,10,19,20).

The use of a simultaneous care model with early integration of palliative care into ED practice may provide substantial benefits to patients (16–19). Benefits include improved quality of life with optimal comfort measures and symptom control, but as recent literature suggests, sometimes even life prolongation (16–19,21,22).

As part of ongoing quality improvement efforts, many EDs are embracing the challenge of integrating palliative care principles into practice (2–5,18–20). Models of clinical integration of palliative care in the ED are evolving (23). Four clinical integration categories have recently been detailed and include: 1) *traditional consultation* model in which the ED clinician requests a palliative care expert consultation; 2) *basic integration*, in

Table 1. Principles and Elements of Palliative Care*

Patient and family-centered care	<ul style="list-style-type: none"> – Care plan is determined by goals and preferences of patient and family – Support system to help family cope during the patient’s illness and in their own bereavement
Timing	<ul style="list-style-type: none"> – Starts early in course of illness, in conjunction with other therapies that are intended to prolong life (such as chemotherapy) – Continues till cure or patient death with family bereavement support
Interdisciplinary team care	<ul style="list-style-type: none"> – A team approach is necessary to meet the multiple needs of patients and families (includes physicians, nurses, social workers, clergy, nursing assistants, pharmacists and volunteers)
Comprehensive care	<ul style="list-style-type: none"> – Multidimensional assessment to treat physical, psychological, social, and spiritual distress
Relief of suffering	<ul style="list-style-type: none"> – Prevent and relieve pain and other distressing symptoms
Skills in the care of the dying and bereaved	<ul style="list-style-type: none"> – Prognostication – Offers a support system to help patients live as actively as possible until death
Quality of life	<ul style="list-style-type: none"> – Enhance quality of life, and may also positively influence the course of illness – Affirms life and regards dying as a normal process
Continuity of care	<ul style="list-style-type: none"> – Ensure coordination, communication, and continuity of palliative care across institutional and homecare settings – Preventing crises and unnecessary transfers are important outcomes
†Quality assessment and performance improvement	<ul style="list-style-type: none"> – Incorporate attention at all times to safety and the systems of care that reduce error – Measure outcomes using validated instruments for data

* Patient population: patients of all ages experiencing a serious chronic or life-threatening illness or injury.

† Crucial metrics applicable to emergency department (ED) and hospital systems that may include seriously ill patients’ ED visits and length of stay, hospital and intensive care unit (ICU) length of stay, hospital readmissions, ICU admissions, and adequacy of pain control. Adapted from the National Consensus Project for Quality Palliative Care–Clinical Practice Guidelines for Quality Palliative Care and the World Health Organization palliative care definition (14,15).

which ED and palliative care programs work collectively on some goals/objectives; 3) *advanced integration*, in which ED and palliative care work together on processes and protocols, with the ED often taking the lead; and 4) *ED-focused advanced integration* programs, in which ED is highly engaged, may direct the integration and may be led by a dual EM-palliative care board-certified physician. Increasingly, ED providers consult and collaborate with an expert in palliative care to manage patients identified to have palliative care needs, for example, management of an imminently dying patient or a difficult-to-manage symptom, such as severe chronic malignant pain (23). Table 2 outlines some suggested clinical screening criteria where an early assessment may identify patient needs that could benefit from involvement of a palliative care expert (24).

The Improving Palliative Care in Emergency Medicine (IPAL-EM) project is a resource development and dissemination initiative to help accelerate the integration of palliative care services into ED settings. Started in 2010 by the Center to Advance Palliative Care (CAPC) with funding provided by the Olive Branch Foundation, it offers an on-line portal for sharing essential expertise, best evidence, tools, and practical resources to assist clinicians and administrators in the successful integration of palliative care and EM (25). The IPAL-EM Web site is continually updated, and new peer-reviewed tools representing best practices are being developed with the aid of an oversight board of nationally recognized interdisciplinary leaders in the field of emergency and palliative care (25).

In this article, we describe a case from two perspectives. In the first scenario, we present the actual clinical

course of the patient. In the second scenario, we describe an alternative possibility that incorporates palliative care principles into ED practice. We then offer practical advice to jumpstart the process to improve palliative care for patients and their families in the ED. Specifically, we describe four key steps to initiate a practice change: 1) identify your ED “champions”; 2) explore existing literature and educational resources; 3) identify local hospice and palliative care resources; and 4) develop a plan to complete a needs assessment (26).

SCENARIO 1: ACTUAL CLINICAL COURSE

An 85-year-old woman with a history of multiple strokes, hypertension, diabetes, and peripheral vascular disease presents from a rehabilitation facility to the ED for evaluation of possible gangrene in her right foot. The patient is nonverbal, bed-bound, and dependent for all activities of daily living since her last major stroke. She receives artificial nutrition and hydration through a gastrostomy tube and has urine and fecal incontinence. She has three adult children. Documents from the transferring facility include a letter from one of her three daughters stating that the patient was clear about her wishes to “not be on any machines,” without further elaboration. She is frail, moans to painful stimuli, and her vital signs are: blood pressure 120/78 mm Hg, pulse 100 beats/min, temperature 37.8°C (100°F), oxygen saturation of 96% on room air, and finger-stick glucose of 400 mg/dL. The patient spent 16 h in the ED undergoing various blood- and imaging-related studies and had multiple consultations ranging from podiatry, vascular surgery, and orthopedic

Table 2. Screening Criteria for a Palliative Care Assessment at the Time of Admission (24)

A Potentially Life-limiting or Life-threatening Condition* AND...	
Primary criteria	
Global indicators that represent the minimum that hospitals should use to screen patients at risk for unmet palliative needs	
– The “surprise question”: Would you be surprised if the patient died within 12 months?	
– Frequent admissions (e.g., more than one admission for same condition within several months)	
– Admission prompted by difficult-to-control (moderate-severe) physical or psychological symptoms	
– Complex care requirements (e.g., functional dependency; complex home support for ventilator/feedings)	
– Decline in function, feeding intolerance, or failure to thrive	
Secondary criteria	
Specific indicators of a high likelihood of unmet palliative care needs	
– Admission from long-term care facility	
– Elderly patient, cognitively impaired, with acute hip fracture	
– Metastatic or locally advanced incurable cancer	
– Chronic home oxygen use	
– Out-of-hospital cardiac arrest	
– Current or past hospice program enrollee	
– Limited social support (e.g., family stress, chronic mental illness)	
– No history of completing an advance care planning discussion/document	

* Life-limiting or life-threatening condition is defined as any disease/disorder known to be life limiting (e.g., dementia, chronic obstructive pulmonary disease, metastatic cancer) or that has a high chance of leading to death (e.g., multi-organ failure, sepsis). Serious medical conditions for which recovery to baseline function is routine (e.g., community-acquired pneumonia in a healthy adult) are not included in the definition.

surgery while awaiting a hospital bed. The sole focus of her ED care was the diagnostic tests, coordination of consultants, and medical stabilization of her underlying medical problems.

Although a common scenario, this case raises questions about whether the care provided was patient and family-centered, and whether the clinicians missed an important opportunity to clarify the goals of care.

SCENARIO 2: EARLY INTEGRATION OF PALLIATIVE CARE PRINCIPLES IN THE ED

The ED provider calls the daughter (designated health care decision-maker) and listens to the daughter's understanding of her mother's condition and the mother's wishes for care. The ED provider then describes the clinical situation of the patient, the poor prognosis, and different approaches for care, including the option to shift to comfort care that may include hospice. This conversation bridges the clinical reality with the wishes of the mother and supports the daughter in honoring the patient's wishes. The daughter is asked to call her siblings and discuss treatment preferences for their mother and to consider the acute event in the context of the "big picture" and her mother's overall quality of life. The patient's children return the call and inform the ED provider that they feel a comfort care approach would be most appropriate, and that they want to proceed with next steps for hospice care based on their mother's previously stated values and goals of care. They also suggest the name of a local hospice that was familiar with their mother's condition due to preliminary conversations. The main family concern at the time is management of pain. The ED provider offers reassurance to the family that distressing symptoms will be addressed in a timely and efficient manner. The ED provider then contacts the primary physician, who agrees with the plan of care. The institution's social worker and the case manager from local hospice suggested by the family evaluate the patient and are able to arrange for an inpatient hospice bed. Recommendations for pain and wound management are made and the patient is discharged under hospice care. The ED length of stay is 6 h.

DISCUSSION

Starting a Palliative Care Initiative in the Emergency Department

Each ED has its own unique characteristics. When starting a new initiative in the ED, it is important to begin with ED members that can "champion" the effort while incorporating lessons from other prior successes and failures so that the initiative is tailored to fit the setting

(26,27). The design of the initiative will ideally address preexisting hospital and community resources, availability of palliative care consultation services to the ED, and key deficiencies in ED palliative care (26,27). The initiative will also need to be sensitive to crucial metrics faced by the ED and hospital systems, including ED length of stay, hospital readmissions, and intensive care unit utilization metrics as common examples (18,26–28). We now further describe the four key steps that may help jump-start such an initiative (26).

Identify Your ED-Palliative Care "Champions"

An important initial step is to recruit members who are interested in and committed to the integration of palliative care in the ED by identifying those individuals who have previously expressed concern, frustration, or awareness of family and patient palliative needs in the ED (26). Because palliative care is based on a multidisciplinary collaboration, consider approaching providers from the varied professional disciplines based in the ED, as well as others throughout the institution who interact with the ED. In any event, the ED medical director and nurse manager(s) are key participants because their unique ED perspective allows them to design improvement efforts based on an understanding of baseline needs and resources, including staffing issues (26,27,29). They are also in the best position to engage support at both a broad institutional leadership level and among their ED colleagues. The integration of palliative care into ED practice and culture is likely to impact a number of hospital services and processes, so a range of administrative and clinical personnel should also be considered for inclusion. An example of such an initial work group and some key individuals to consider are listed in Table 3.

Explore the Existing Literature and Educational Resources

A list of key position statements and frequently updated research citations is available at the IPAL-EM Web site (25,30). Some of the consensus statements on the role of palliative care and ED are particularly worth noting, including policy statements from the American College of Emergency Physicians and Emergency Nurses Association on roles of the ED and ethical issues at the end of life (31–33). The Education in Palliative and End-of-Life Care for Emergency Medicine (EPEC-EM) curriculum is an educational resource for palliative care-related skills development for ED clinicians (34,35). Sponsoring some or all proposed "champions" at an upcoming EPEC-EM conference may yield an institutional pool of qualified candidates who could be targeted for future

Table 3. Potential “Champion” Members of ED Palliative Care Planning/Implementation Workgroup (26,27)

- ED medical director and emergency physician(s)
- ED nurse manager and ED nurse(s)
- Director or designee of palliative care program
- Nursing educator
- Social workers
- Chaplain
- Representatives of key admitting services (e.g., Medicine [hospitalist], ICU, Surgery, Oncology) that are most likely to be affected by improving palliative care services in the ED
- Hospital leadership: administration and finance
- Case manager
- Other individual(s) believed to be important to the success of a specific initiative (e.g., ethics consultant, mental health professional, Emergency Medical Services-EMS director, pharmacist)

ED = emergency department; ICU = intensive care unit.

career development. Many emergency physicians are seeking board certification in Hospice and Palliative Medicine after the American Board of EM became one of 10 cosponsors of the newly approved subspecialty. Although research on the optimal model of ED integration of palliative care is lacking, there are a growing number of examples in the literature of individual programs and specific strategies that have proven successful (2,4,5,23,36,37). Two recent articles also provide an introduction and overview of the role of palliative care in the ED (9,10).

Identify Local Hospice and Palliative Care Resources

Most EDs have access to institutional palliative resources, for example, a chaplain, social worker, or bereavement counselor to assist families at the time of a patient’s death. Social workers and case managers are essential partners when navigating disposition issues and maximizing community resource utilization. However, these resources may not be easily identifiable by ED staff at the time of need (38). Some initial steps to direct ED providers to services in real time may include: 1) identifying these various hospital and community resources (Table 4); 2) cataloguing their roles and contact numbers; 3) publishing/posting pertinent call schedules in a visible area of the ED for ease of access; and 4) identifying clearly the hours of availability, whether in person or by phone. Social work and case managers are essential partners when navigating disposition issues and maximizing community resource utilization. Increasing numbers of institutions now offer access to specialty-level palliative care teams. Many palliative care teams are available 24/7 with in-person assistance during regular working hours and telephone support during off hours and weekends. Inclusion of such members in early discussions may be

Table 4. Potential Institutional and Community Resources (26)

- In-house palliative care team/unit availability and call schedules
- Outpatient clinic availability and practice hours
- Community hospice providers: home hospice and residential hospice
- 24/7 Chaplaincy support
- 24/7 Social service support
- Bereavement support
- Ethics consultant
- Child life specialist support availability (for pediatric patients/siblings, or children of adult patients)

helpful in creating “clinical screening (trigger) criteria” for ED providers to use in identifying patients with palliative needs (Table 2), and also help to create collaborative guidelines to determine what will constitute a nonurgent or urgent/emergent level of consultation (2,23,24,36).

Referrals to hospice from the ED are not only feasible, but also have the potential to facilitate early dispositions based on patient-determined goals of care, and thereby increase patient and family satisfaction with care (20). Providing a list of local hospice contacts and fostering relationships with those agencies help ED clinicians to initiate hospice referrals directly from the ED and assist in management of hospice patients who arrive with a crisis event (18,20,33,39). The ED may even be able to identify and have the palliative care team proactively reach out to long-term care facilities that frequently send patients to the ED for palliative care to promote management of unmet palliative/hospice needs and avoid “crisis” ED visits.

Complete a Needs Assessment

An institutional ED needs assessment can identify barriers to the integration of palliative care, institutional strengths and weaknesses, and opportunities for improvement, as well as target areas where easy interventions can lead to early success. The needs assessment can identify gaps between ideal and current practice to determine where initial resources might be assigned (40).

Clinical practice guidelines for quality palliative care in the ED are available on the IPAL-EM Web site (41). These ED-specific guidelines were created to supplement and build upon the core guidelines outlined by the National Consensus Project for Quality Palliative Care (NCP) for eight palliative care domains, for example, physical aspects of care and social aspects of care (14,41). The NCP guidelines represent goals and ideal practices that enable programs to define their palliative program organization, resource requirements, and performance measures. The ED-specific practice guidelines have also been translated into a “needs

assessment tool” that programs may use to identify areas for improvement (40).

Although the intersection of ED and palliative care is receiving more research attention, it is important to note that there are limited actual data regarding ED palliative care patient outcomes or the burdens palliative care efforts might impart on ED personnel and resources (23). The Agency for Healthcare Research and Quality/American College of Emergency Physicians conference, “Improving the Quality and Efficiency of Emergency Care Across the Continuum: A Systems Approach,” identified four key research questions: 1) Which patients are in greatest need of palliative care services in the ED?; 2) What is the optimal role of emergency clinicians in caring for patients along a chronic trajectory of illness?; 3) How does the integration and initiation of palliative care training and services in the ED setting affect health care utilization?; and 4) What are the educational priorities for emergency clinical providers in the domain of palliative care? The evidence in these domains would be strengthened using six categories of inquiry: descriptive, attitudinal, screening, outcomes, resource allocation, and education of clinicians (42).

CONCLUSION

ED care for patients who suffer from serious chronic life-limiting illnesses, and those who are imminently dying, can be optimized by incorporation of palliative care principles and services. The IPAL-EM initiative by CAPC is a resource development and dissemination initiative to help spur the integration of palliative care services into EM settings. Tools and resources reported in this article provide assistance to EDs seeking to further this integration.

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