The Fundamentals of ED Palliative Care: Should We Need

Nursah Basol, MD
Assoc. Prof, Dept. of Emergency Medicine
Gaziosmanpasa University, Faculty of Medicine
Tokat, Turkey

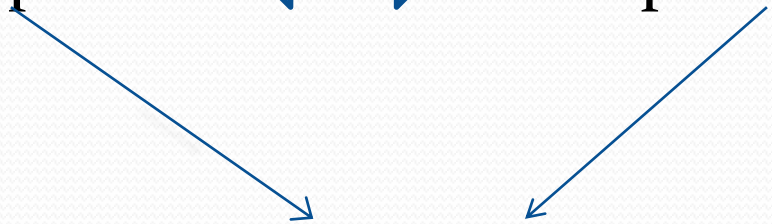
Contents

- Definition of PC
- The importance of ED
- Problems of integration
- Benefits of integration
- Screening Tools
- Getting Started

- Two billion older people by 2050
- Growth rate 2.6%

- *United Nations Department of Economic and Social Affairs. World population ageing. New York: United Nations, 2013.*

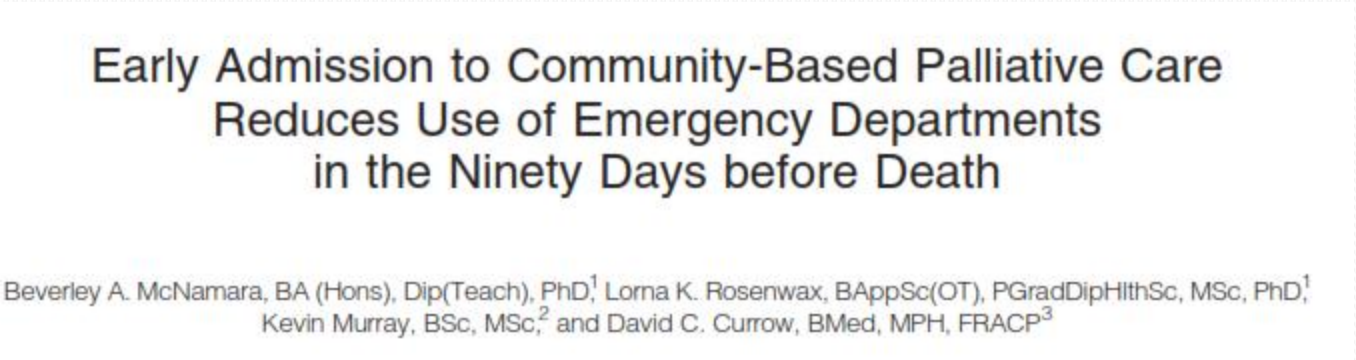
- Aging population ⟷ Development in medical care



- Growing number of people living with chronic life-limiting illnesses.

- Increased use of Emergency Department (ED) and hospitalization

- High rates of ED visits in the last weeks of life are accepted indicators of poor-quality end-of-life care.



Early Admission to Community-Based Palliative Care Reduces Use of Emergency Departments in the Ninety Days before Death

Beverley A. McNamara, BA (Hons), Dip(Teach), PhD,[1] Lorna K. Rosenwax, BAppSc(OT), PGradDipHlthSc, MSc, PhD,[1] Kevin Murray, BSc, MSc,[2] and David C. Currow, BMed, MPH, FRACP[3]

Definition of Palliative Care

- **W**ho? People with life-threatining illness and their families
- Formerly, PC was only conceived for terminal stage cancer patients.
- The spectrum of diseases is widened and anymore it includes heart, respiratory, metabolic, renal and neurological diseases as dementia.

Palliative Care

- **W**hy? Better quality of life

- to prevent and relieve suffering while supporting the best possible quality of life for patients and their families, regardless of the stage of the disease or the need for other therapies.

Palliative Care

- **W**hen? After diagnosis of illness

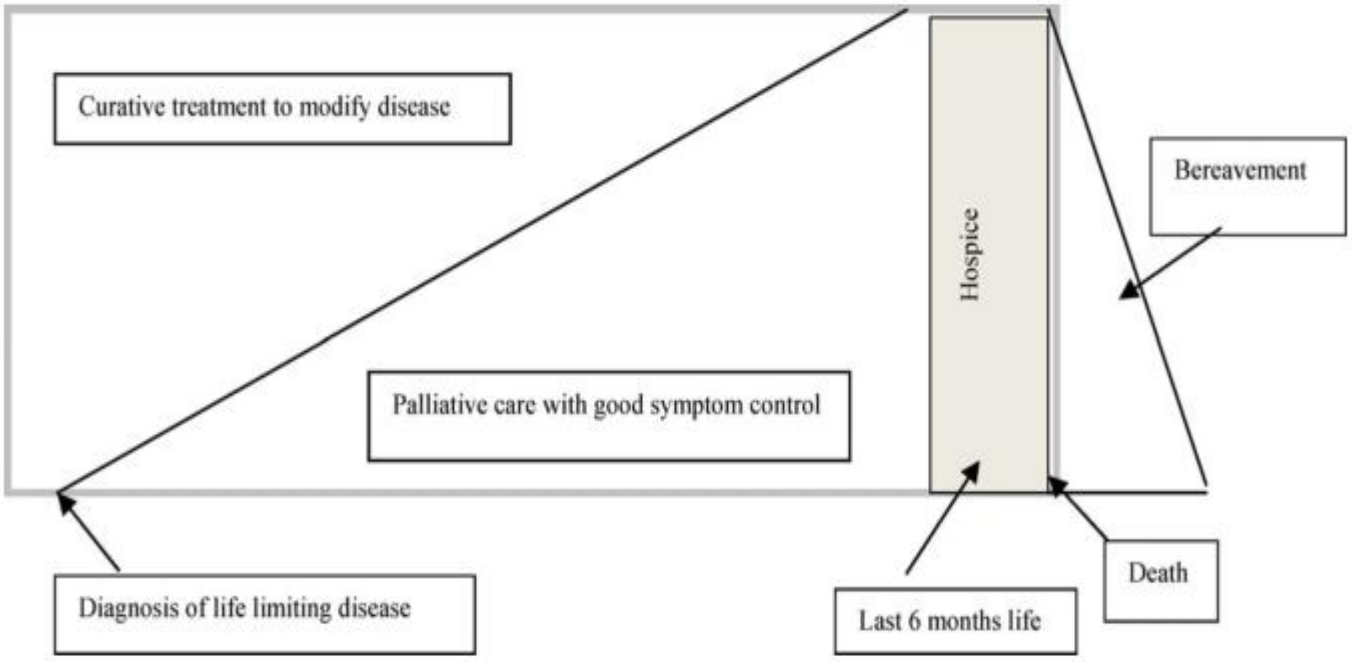


Figure 1. Optimal continuum of care on diagnosis of a life-limiting illness

Integrating Palliative Care in the Out-of-Hospital Setting: Four Things to Jump-Start an EMS-Palliative Care Initiative

Sangeeta Lamba, MD, Terri A. Schmidt, MD, MS, Garrett K. Chan, PhD, APRN, FAEN, FPCN, FNAP, FAAN, Knox H. Todd, MD, MPH, Corita R. Grudzen, MD, MSHS, David E. Weissman, MD, FACP, Tammie E. Quest, MD, IPAL-EM Board

Palliative Care

- **W**here? Firstly at home

- PC units
- PC services in hospitals
- PC consultants in hospitals
- PC home care teams
- Primary health care providers
- Hospices


Pilgrims
Hospices

Palliative Care

- **W**hat? Human Rights

- 19 million people who had palliative care needs in 1966,
- 56.5 million for the fiscal year 2016
- Just 14% receive PC in high income countries
- Centers for Medicare and Medicaid Services. CMS fast fact, June 2016. Available at: https://www.cms.gov/Research-Statistics-Dataand-Systems/Research-Statistics-Data-and-Systems.html.Accessed August 16, 2017.

Palliative Care

- **How?** Assessment and management of pain, other physical problems, psychosocial issues and spiritual needs
- Multidisciplinary approach
- Physicians/ Nurses/ Social Worker/ Nutritionist/ Psychologist/ Chaplain-imam/ …

Why ED?

- Serious, unrelieved symptoms
- Need for simple procedures
- Anxiety
- Family distress
- Somatic indications
- Feeling safer
- Access to multidisciplinary teams

Are emergency admissions in palliative cancer care always necessary? Results from a descriptive study

Marianne Jensen Hjermstad,[1,2] Jan Kolflaath,[3] Aud O Løkken,[3] Sjur B Hanssen,[1] Are P Normann,[4] Nina Aass[1,5]

24/7 service

Emergency Department Visits at the End of Life of Patients With Terminal Cancer: Pattern, Causes, and Avoidability

American Journal of Hospice & Palliative Medicine®
1-5

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Samy A. Alsirafy, MBBCh, MSc, MD, DipPallMed[1,2],
Ahmad A. Raheem, MBBCh, MSc, MD[1,3],
Abdullah S. Al-Zahrani, MD, ABIM, FRCPC[1],
Amrallah A. Mohammed, MBBCh, MSc, MD[1,3],
Mohamed A. Sherisher, MBBCh, MSc, MD[1,4],
Amr T. El-Kashif, MBBCh, MSc, MD[1,5],
and Hafez M. Ghanem, MBBCh, MSc, MD[1]

- Symptoms

Chief complaint	No.	%
Pain	141	45.6
Abdomen	92	29.8
No specific site	15	4.9
Back	10	3.2
Chest	10	3.2
Headache	6	1.9
Mouth	5	1.6
Lower limb	4	1.3
Neck	4	1.3
Pelvis	3	1
Upper limb	1	0.3
Dyspnea	41	13.3
Vomiting	38	12.3
Fatigue/weakness	34	11
Altered consciousness	32	10.3

Evaluation of Terminal-Stage Cancer Patients Needing Palliative Care in the Emergency Department

Nurşah Başol[1], Nagehan Çeltek[2], Tufan Alatlı[1], İlyas Koç[1], Mustafa Süren[3]

JAEM 2015; 14: 12-5

Table 1. Evaluation of multiple admissions in terms of complaints and gender

	Male			Female				
Number of admissions	**>5**	**3-5**	**1-3**	**>5**	**3-5**	**1-3**	**Total**	**p**
Nausea-vomiting	9	7	5	4	2	0	27	0.01
Pain	15	8	0	2	2	1	16	0.01
Loss of appetite	4	2	3	1	0	0	10	0.05
Dyspnea	3	1	1	1	1	1	8	0.01
Total	31	18	9	8	5	2	73	

Why ED?

- Need for simple procedures
- Anxiety
- Family distress
- Somatic indications
- Feeling safer
- Access to multidisciplinary teams
- Requiring diagnostic interventions

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24/7 service

Emergency Medicine

- Symptom oriented approach
- Find the problem
- Solve it as soon as possible

Palliative Medicine

- Patient centered care
- Not necessary to draw immediate medical actions
- Less invasiveness in critical situations
- Dying is an expected outcome

Crises in palliative care—a comprehensive approach

Friedmann Nauck, Bernd Alt-Epping

- Aggressive resuscitation might be inappropriate for every clinical situation in ED such PC patients.
- Death is an expected outcome for most PC patients.

Thoughts of Emergency Physicians about Palliative Care: Evaluation of Awareness

Nurşah Başol[1], Yıldıray Çelenk[2], İsmail Okan[3]

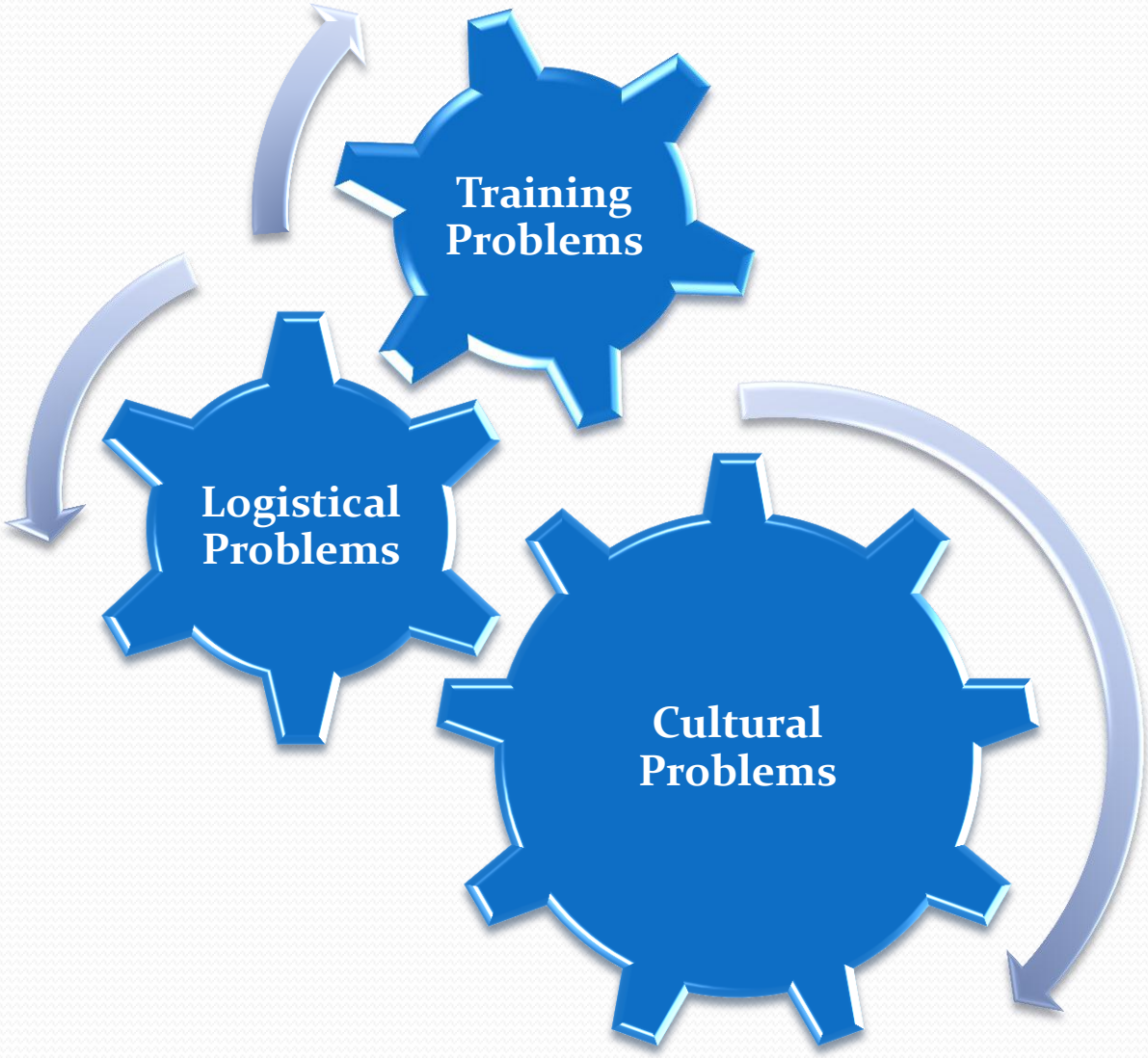
Table 2. Evaluation of problems about palliative care patients

Possible Problems of PC patients	**Count (%)**
They stay for a long time in ED	90 (94.7)
They come frequently to ED	82 (86.3)
Other departments do not want to admit them	73 (76.8)
Patient relatives often have unrealistic hopes or expectations	58 (61.6)
It is not provided to require enough physiological support to patients	30 (31.6)
Often, there are a lot of unnecessary tests on palliative care patients	16 (16.8)
Pain management is difficult	11 (11.6)

PC: palliative care; ED: emergency department

What's Wrong with the Current System of Care?

- Excessive focus on the acute illness rather than the whole patient
  - Inappropriate/overuse use of health care resources
- Fragmented health care delivery system
  - Between specialists and primary care clinicians
  - Across different sites of care
  - ED is often the inappropriate site of "primary care" for seriously ill patients
- Poor clinician-patient-family communication
  - Disease prognosis
  - Patient-centered goals of care
  - End-of-life needs/wishes
- Limited support for caregivers
  - Late referrals for hospice and palliative care services


Training Problems
Logistical Problems
Cultural Problems

Emergency Department

- One of the predictors of high caregiver burden is Emergency Department visits for caregivers.

Health and Social Care in the Community (2016) **24**(4), 428–438 doi: 10.1111/hsc.12219

Predictors of caregiver burden across the home-based palliative care trajectory in Ontario, Canada

Denise Guerriere PhD[1], Amna Husain MD[2], Brandon Zagorski MSc[1], Denise Marshall MD[3], Hsien Seow PhD[4], Kevin Brazil PhD[5], Julia Kennedy MHSc[1], Sheri Burns BA[6], Heather Brooks BScH Student[7] and Peter C. Coyte PhD[1]

Core Competencies about PC

- Assessing illness trajectory
- Formulating prognosis
- Difficult communication with patients and families
- Pain and symptom management

Hospice and Palliative Medicine: New Subspecialty, New Opportunities

Tammie E. Quest, MD
Catherine A. Marco, MD
Arthur R. Derse, MD, JD

From Emory University, Atlanta, GA (Quest); the University of Toledo, Toledo, OH (Marco); and the Department of Population Health-Bioethics and Department of Emergency Medicine, Medical College of Wisconsin, Milwaukee, WI (Derse).

Core Competencies about PC

- Withdrawing or withholding non-beneficial treatments
- Planning advanced care
- Palliative care systems referrals
- An understanding of ethical and legal issues

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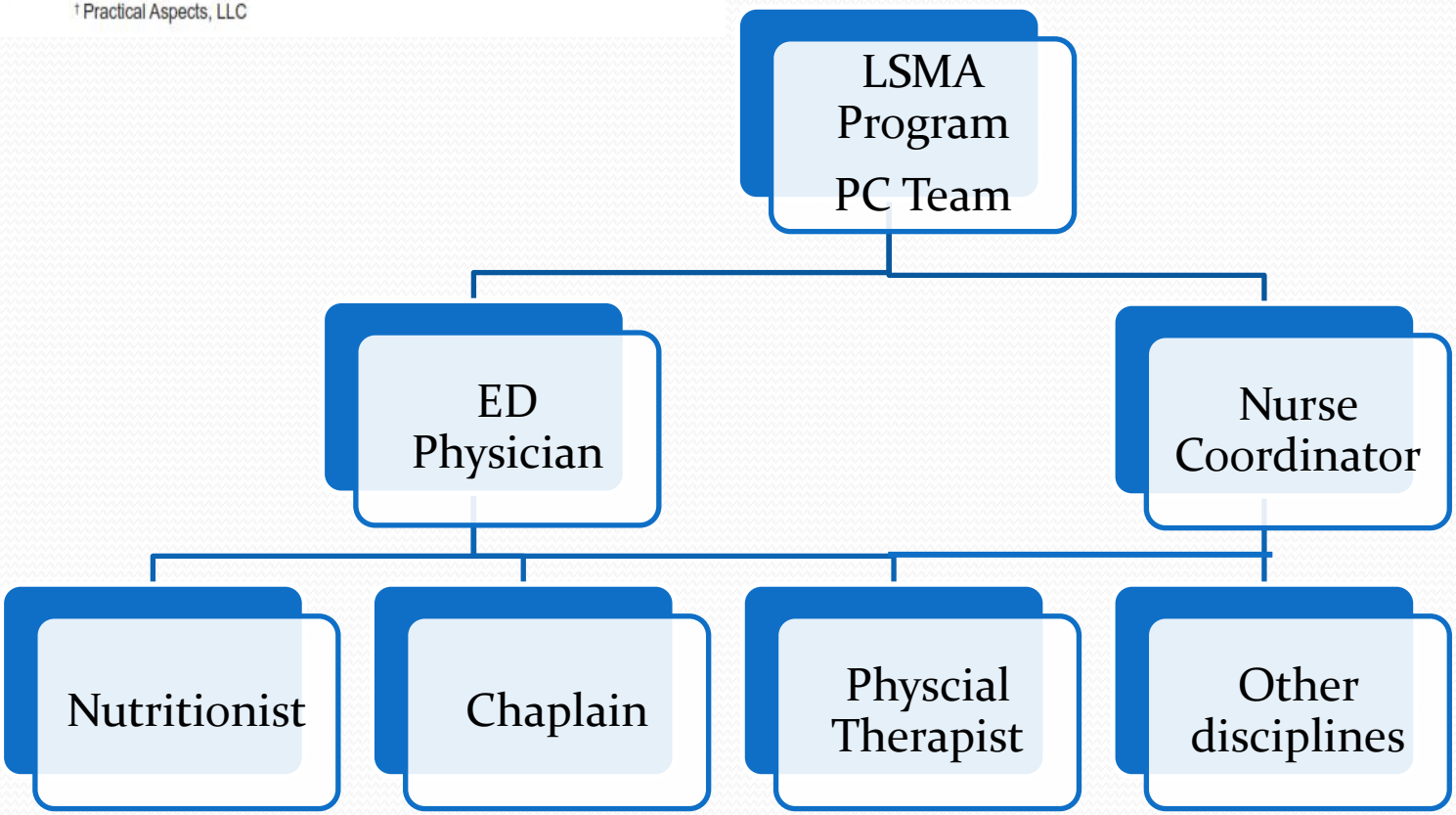
Integrated Model of Palliative Care in the Emergency Department

Mark Rosenberg, DO, MBA*
Lynne Rosenberg, PhD†

*Department of Emergency Medicine, St. Joseph's Health Care System, Paterson, New Jersey
†Practical Aspects, LLC



Integrated Model of Palliative Care in the Emergency Department

Mark Rosenberg, DO, MBA*
Lynne Rosenberg, PhD†

*Department of Emergency Medicine, St. Joseph's Health Care System, Paterson, New Jersey
†Practical Aspects, LLC

- Increased patient and family satisfaction
- Reduction on costs
- Decreased LOS
- Reduction on the intensity of care
- Reduction in resuscitation rates

Benefits

- Patient-Centered
  - Improved control of physical symptoms
  - Reduced family anxiety, depression and post-traumatic stress disorder
  - Timely implementation of care plans that are realistic, appropriate and consistent with patients' preferences
  - Fewer conflicts about use of life-sustaining treatments
  - Earlier transition to appropriate community resources (e.g., hospice)

Benefits

- System-Focused
  - Improved ED/Hospital Metrics
    - Less ED crowding
    - Less use of nonbeneficial treatments
    - Reduced hospital length of stay
    - Fewer readmissions
    - Fewer inpatient and ICU deaths
  - Improved Patient Safety
    - Smoother transitions across care sites

Benefits

- Better Resource Utilization
  - Integration of palliative care into hospitals has been shown to improve care and reduce cost.
  - Cost avoidance occurs as a direct result of better matching of patient/family-centered goals of care with use of life-sustaining treatments.
  - In practice, this means fewer ICU days and less use of high-cost, minimal-impact life-sustaining treatments.

- Screening Tools

"It's our new method for determining who we should treat first. We take people in order of how loud they scream."

Content Validation of a Novel Screening Tool to Identify Emergency Department Patients With Significant Palliative Care Needs

Naomi George, MD, Nina Barrett, NP, Laura McPeake, MD, Rebecca Goett, MD, Kelsey Anderson, and Janette Baird, PhD

ACADEMIC EMERGENCY MEDICINE • July 2015, Vol. 22, No. 7

1. Does the Patient Have A Life-Limiting Illness? (Check All Items that Apply)	
■	**Advanced Dementia or CNS Disease** (e.g. history of Stroke, ALS, Parkinson's): Assistance needed for most self-care (e.g. ambulation, toileting) and/or Minimally verbal.
■	**Advanced Cancer**: Metastatic or locally aggressive disease.
■	**End Stage Renal Disease**: On dialysis or Creatinine > 6.
■	**Advanced COPD**: Continuous home O2 or chronic dyspnea at rest.
■	**Advanced Heart Failure**: Chronic dyspnea, chest pain or fatigue with minimal activity or rest.
■	**End Stage Liver Disease**: History of recurrent ascites, GI bleeding, or hepatic encephalopathy.
■	**Septic Shock (i.e. signs of organ failure due to infection)**: Requires ICU admission and has significant pre-existing comorbid illness.
■	**Provider Discretion - High chance of Accelerated Death**: *Examples:* Hip fracture > age 80; Major trauma in the elderly (multiple rib fractures, intracranial bleed), Advanced AIDS, etc
No Checked Items? STOP! Screening is Complete	**ONE** or More Checked Items? CONTINUE screening!

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2. Does the Patient Have TWO or More Unmet Palliative Care Needs? (Check All the Apply)	
■	**Frequent Visits:** 2 or more ED visits or hospital admissions in the past 6 months.
■	**Uncontrolled Symptoms:** Visit prompted by uncontrol symptom: e.g. pain, dyspnea, depression, fatigue, etc.
■	**Functional Decline:** e.g. loss of mobility, frequent falls, decrease PO, skin breakdown, etc.
■	**Uncertainty about Goals-of-Care and/or Caregiver Distress** Caregiver cannot meet long-term needs; Uncertainty/distress about goals-of-care.
■	**Surprise Question:** You would not be surprised if this patient died within 12 months.
Less than TWO checked Items? STOP! Screening is Negative	**TWO or more checked Items?** PC Referral Recommended!

Palliative Care ED Screening Tool
A Technical Assistance Resource from the IPAL-EM Project

Tammie E. Quest, MD,[1] Eric N. Bryant, MD,[2]
Denise Waugh, MD,[3] Corita Grudzen, MD, MSHS,[4] David E. Weissman, MD, FACP,[5]
for the IPAL-EM (Improving Palliative Care in Emergency Medicine) Project*

I. Patients with a Serious, Life-Threatening Illness** and One or More of the Following[1]:

- ❒ **NOT SURPRISED**
  - You would not be surprised if the patient died in the next 12 months, or if pediatric patient, will not survive to adulthood[2,3]
- ❒ **BOUNCE-BACKS**
  - More than one ED visit or hospital admission for the same condition within several months[4]
- ❒ **UNCONTROLLED SYMPTOMS**
  - ED visit prompted by difficult-to-control physical or psychological symptoms[3]
- ❒ **FUNCTIONAL DECLINE**
  - Decline in function, feeding intolerance, unintentional weight loss or caregiver distress[4]
- ❒ **INCREASINGLY COMPLICATED**
  - Complex long-term care needs requiring more support[1]

II. Previous Palliative Care/Hospice Intervention?[4,5]

❒ **YES**
Contact provider to assist with ED management (goals, symptoms) and disposition; may need palliative care assessment/consult if provider unavailable or there are changes in goals

❒ **NO**
Contact new palliative care assessment, consultation or referral

III. Timing of Intervention/Urgency

❒ • Routine: printed information, inpatient/outpatient referral

❒ • Urgent: follow-up within 72 hours of an ED visit

❒ • Emergent: rapid ED assessment or ED-based palliative care/hospice consult

Getting Started

1. Develop a collaborative work group of ED and palliative care staff (if available).
   - Identify key project goals.
   - Complete a SWOT analysis.
2. Complete a needs assessment to define targets for improvement:
   - pain and symptom management
   - care of the imminently dying patient
   - patient-centered goals of care matched to treatments
   - caregiver stress/distress
   - ED clinician palliative care attitudes/knowledge/skills

IPAL-EM

Improving Palliative Care in Emergency Medicine

Getting Started

3. Create an ED–Palliative Care Dashboard.
   - Metrics/outcomes that drive quality care
4. Develop a process of patient screening to identify unmet palliative care needs.
5. Develop a system to utilize specialty-level palliative care service providers when required.
6. Develop a system to fully utilize common palliative care disposition resources (e.g., home or residential hospice, inpatient palliative care).

IPAL-EM

Improving Palliative Care in Emergency Medicine

The Integration of Palliative Care into the Emergency Department

Nursah BASOL

Table 3. The list of solution proposals for providing better PC in the ED

Solution proposals
Arrangements that include facilities to provide PC can be made in the existing health care system.
Training programs that include core competencies of PC can be added to ED residency programs.
The management guidelines that include PC emergencies can be prepared for ED staff.
Educational materials and courses from the ED perspective can be added ongoing medical education.
Arrangements intended to remove logistical barriers should be made in ED.
The special palliative care teams can be formed in the ED.
Arrangements that include provide legality of advance directives and DNR orders can be done in existing health care system.

Turk J Emerg Med 2015;15(2):100–107

Create Your Own Way

- Institution-specific needs
- Availability of local resources
- Ability of an existing PC program or hospice
- Local ED clinician culture

In our ED

- Our emergency residency program includes PC skills
- Training program was done for our nurses
- We added a screening tool and symptom scales in our patient evaluation form
- We have PC training for medical and nursing students
- We have a PC team in our hospital
- We have a PC outpatient unit in our hospital

‘You matter because you are you. You matter to the last moment of your life, and we will do all we can , not only to help you die peacefully, but also to live until you die.’

Cicely Saunders (1918-2005) ‘The founder of modern hospice movement’

nursahbsl@gmail.com