Increasing person-centered care in the emergency department for older adults through a pilot focused on advance care planning

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ED Vignette

• An 81-year-old female with a history of multiple strokes came to the ED for possible gangrene in one foot. The patient is nonverbal and dependent for all ADLs. She has three adult children; however, there is no identified health care agent/proxy. Notes from the nursing home include a letter from the daughter stating that the patient was clear about her wishes to “not be on machines.” The patient spent 24 hours in the ED undergoing various tests and consultations while awaiting a hospital bed. The sole focus of her ED care was medical stabilization of her underlying medical problems.

✓ Is this really what patients/families want from our health care system?
Definitions

• **Advance Care Planning**: education, information sharing, discussion of options and preferences between patient and doctor.
  – Preferences likely to change over time.
  – Dynamic Process

• **Advance Care Planning Discussion** (aka Advance Directive Discussion)
  – Needs to be accessible to providers and able to be easily updated.
  – If present, is usually buried in a progress note somewhere.
Advance Care Planning

- Decision Making Capacity
- Health Care Proxy
- Summary of wishes for care in case of serious illness
Definitions

- **POLST**: Physician Orders for Life Sustaining Treatment
- **MOLST**: Medical Orders for Life Sustaining Treatment
- **DC Comfort Care Orders**: DC’s version of above.
- Can be honored by EMTs and other providers.
- Don’t reflect the discussion of how these orders were derived.
Surprise Question

• Would you be surprised if this patient died within the next 6 months to a year?
Experience with Advance Care Planning in the VA Nursing Home

- 120 bed unit with 12 rehab beds, 20 hospice/palliative beds, 88 “long term care” for service connected Veterans who need nursing home care
- **100%** have advance care planning discussion documented in CPRS
- 50% set no limits to urgent care
- 13 years of experience
Focus on patients in GW Emergency Department

• Why?
  – Point of entry for a majority of GW admissions
  – Vulnerable transition point – evidence that outcomes can be improved
Can we put the data on the ED department into this slide?

- Data we looked at from ED department?
Existing Barriers

- Different EMR in ED, hospital, physician offices, nursing homes – no easy way to port information about ACP forms or discussions
- ED staff don’t have time or uncomfortable with ACP?
What is happening with ED and Palliative Care integration nationally?

- IPAL- EM
MAKING THE CASE FOR ED–PALLIATIVE CARE INTEGRATION

A Presentation of the IPAL-EM Project

Sponsored by the
Center to Advance Palliative Care and
The Olive Branch Fund
What Is Palliative Care Integration?

• The term “integration” is used to indicate the incorporation of palliative care principles\(^1\) into daily practice, with or without the involvement of a dedicated hospital palliative care team or inpatient palliative care unit.

1. Palliative Care Principles

• Palliative care is patient-centered care focused around patient-determined goals of care.
• The focus is on relief of suffering: physical, psychological, spiritual.
• Patient and family are the unit of care.
• Palliative care services are appropriate in all phases of a life-threatening or limited condition.
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
What Do Patients/Families Want?

• Assessment of the whole patient, not just the acute issue prompting the ED visit
• Prompt attention to pain and other distressing symptoms
• Excellent communication about the disease, prognosis and treatment options
• Coordination of care between care providers and across care sites
But what do patients and families actually experience in the ED?

- Unprepared for managing symptoms
- Uncertainty and anxiety
- Unclear communication
- Mixed experience with symptom management in ED
- Conflicting perspectives about palliative care in ED

ED Vignette

• Consider the same patient with gangrene as described earlier.
• The ED team meets with the patients family and outlines different approaches to care, including a shift to comfort care and hospice services.
• The family feels that hospice care is most consistent with the patient’s values. A hospice referral was made and the patient discharged back to the nursing home with a hospice plan of care.
What do ED providers say?

• ED providers say:
  – PC patients often visit ED because of family member distress over symptoms
  – Lack of communication between outpatient and ED providers leads to undesirable outcomes (eg. resuscitation attempts for patients not desiring it)
  – Conflict around withholding life-prolonging treatment is common
  – Training in pain management is inadequate

What do ED providers want?

- ED providers’ highest improvement priority:
  - Improved **COMMUNICATION** and **DOCUMENTATION** from outpatient providers

The ED: A Critical Site of Care Delivery

- The Emergency Department is the safety net for the acutely and chronically seriously ill.
  - 116 M visits per year
    - 14 M admitted to the hospital
    - 1.1 M admitted from the nursing home
    - 1.6 M admitted to ICU
    - 139,000 died in the ED
- As the population ages, ED visits for crisis events in the setting of serious, chronic illness are likely to increase.
The ED: A Critical Site of Care Delivery

• Initial care trajectories are started in the ED:
  – Communication with patient/caregivers about illness/treatment options
  – Degree of medical intervention (e.g., ventilation, vasopressors, antibiotics)
  – Site of care determined (e.g., ICU, ward, home)

Yet we know that palliative care services are poorly integrated into ED culture/practice.
Current Status of Palliative Care Services in the ED

• Research has demonstrated that patients with serious illness who come to the ED can expect:

  – Poorly treated pain and other symptoms
  – Poor support for the needs of family members
  – Poor communication about disease prognosis/goals
  – Inefficient resource utilization
Palliative Care Needs in the ED

• Palliative care needs are prevalent.

  – In a survey of 50 functionally impaired adults 65 years or older with coexisting cancer, CHF, ESLD, ESRD, ESCOPD or dementia, the prevalence of symptoms was as follows:
    • physical symptoms (94%)
    • financial concerns (72%)
    • mental health issues (62%)
    • access to care issues (58%)

Support for Improving the Quality of ED Palliative Care

• National Quality Forum
  – No more than one emergency visit in the last 30 days of life.

• American College of Emergency Physicians

• Emergency Nurses Association
Terminology

• The preceding policy statements refer to improving “end-of-life care” (EOL). Palliative care is a broader construct than EOL.

  Palliative care is . . . the medical specialty focused on improving the quality of life of people facing serious illness. Emphasis is placed on pain and symptom management, communication and care coordination. Palliative care is appropriate from the time of diagnosis and can be provided along with curative treatment. (CAPC)

• The focus of this presentation is to improve palliative care services for patients who meet the broader definition of palliative care, not only those who are at the end of life.
From Policy to Practice:
Creating a Better System
Processes of Care

What do ED staff members care about?

• Providing excellent patient care
• Triage and disposition
• Optimizing and efficiently using ED resources
• Reducing ED length of stay
• Increasing ED throughput
• Decreasing ED boarding of admitted patients
• Increasing patient/family satisfaction
• Effective risk management/compliance
• Meeting core hospital measures (Joint Commission)
What Might Better ED–Palliative Care Integration Yield?

• Globally
  – Right care, right place, in a timely manner
  – Patient/family-centered care predicated on informed consent and choice
  – ED providers who are competent in core palliative care skills
  – Consistent, reliable access to expert-level palliative care clinicians
What Might Better ED–Palliative Care Integration Yield?

• 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)
What Might Better ED–Palliative Care Integration Yield?

• 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
What Might Better ED–Palliative Care Integration Yield?

• 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.
What Are the Data on the Benefits of Integrating Palliative Care into the ED?

• This is an emerging field with evolving evidence
  – Assessment of needs/attitudes/knowledge
  – Intervention studies emerging

• Data on palliative care integration into the general hospital environment and the ICU are now very solid, demonstrating a range of benefits that should be transferable to the ED.
Proactive Palliative Care in the ED

• Following implementation of palliative care “triggers” in ED, patients were better linked to community palliative care resources.
  – 291 patients enrolled
    • 30% enrolled in hospice care
    • 23% died outside the medical center
    • Only 7.7% in-hospital deaths

Bottom line: ↓ hospitalizations, ↓ in-hospital deaths, ↑ use of hospice care

Mahony SO et al., *Journal of Urban Health*. 2008 May;85(3):443–51
ED Consultant Physically in the ED

- Scripps Mercy Hospital (San Diego)
  - Emergency/palliative care expert in the ED full-time (4 months)
  - Direct consult from ED clinicians
    - 78 new palliative care consults performed (zero prior to the intervention)
    - 29/78 directly admitted to hospice care from the ED

Research Agenda

• 2009 (AHRQ) & American College of Emergency Physicians (ACEP) conference:

“Improving the Quality and Efficiency of Emergency Care Across the Continuum: A Systems Approach”

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 with 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?

4) What are the educational priorities for emergency clinical providers in the domain of palliative care?
Proposed intervention

- 3D – Discussion, documentation, dissemination

- For patients meeting a trigger (which one?),
  - have a goals of care conversation or call palliative care consult
  - Document in ED record
  - Transfer info to next site of care
Resources needed

• Education for ED staff
• Capacity to provide PC consults as requested (one of PC physicians is EM boarded)
• “fix” to allow transfer of information between medical records
Interesting possibility

- U Mass using Luminate
Need advice and input on pilot

• Is it realistic to create a “fix” for EMR problem in short time frame?
• Capacity for PC consults?
• Metrics to measure success?
Summary

• The ED is a key venue for providing and improving palliative care.

• Persistent deficiencies in palliative care cause distress for patients, families and clinicians and inefficient utilization of resources.

• An ED–palliative care initiative can achieve a broad range of clinical benefits and possibly cost savings.

• Tools, technical assistance and other resources to support such an initiative are available through the IPAL-EM Project (see www.capc.org).
References

Policy/Compendium Statements

• National Quality Forum

• American College of Emergency Physicians

• Emergency Nurses Association
References (cont. ’d)


References (cont. ’d)


References (cont. ’d)

Policy Statement: American College of Emergency Physicians (ACEP)

• The American College of Emergency Physicians believes that:
  – Emergency physicians play an important role in providing care at the end of life (EOL).
  – Helping patients and their families achieve greater control over the dying process will improve EOL care.
  – Advance care planning can help patients formulate and express individual wishes for EOL care and communicate those wishes to their health care providers by means of advance directives (including state-approved advance directives, DNAR orders, living wills and durable powers of attorney for health care).
To enhance EOL care in the emergency department, the American College of Emergency Physicians believes that emergency physicians should:

- **Respect the dying patient’s needs** for care, comfort and compassion.
- **Communicate promptly** and appropriately with patients and their families about EOL care choices, avoiding medical jargon.
- **Elicit the patient’s goals** for care before initiating treatment, recognizing that EOL care includes a broad range of therapeutic and palliative options.
To enhance EOL care in the emergency department, the American College of Emergency Physicians believes that emergency physicians should:

- **Respect the wishes** of dying patients, including those expressed in advance directives. Assist surrogates to make EOL care choices for patients who lack decision-making capacity, based on the patient’s own preferences, values and goals.

- **Encourage the presence of family and friends** at the patient’s bedside near the end of life, if desired by the patient.

- Protect the privacy of patients and families near the end of life.
Policy Statement: American College of Emergency Physicians (ACEP) – cont.’d

• To enhance EOL care in the emergency department, the American College of Emergency Physicians believes that emergency physicians should:
  – Promote liaisons with individuals and organizations in order to help patients and families honor EOL cultural and religious traditions.
  – Develop skill at communicating sensitive information, including poor prognoses and the death of a loved one.
  – Comply with institutional policies regarding recovery of organs for transplantation.
  – Obtain informed consent from surrogates for postmortem procedures.
It is the position of the Emergency Nurses Association that:

1. **Patients at the end of life and their families deserve care that respects their dignity and honors their right to refuse treatment.** Emergency care providers should use culturally appropriate measures that are consistent with patient preferences to relieve pain, dyspnea and other symptoms during the patient’s end of life. In accordance with the Family Presence Position Statement, emergency care providers should consider the option for family presence during resuscitation and invasive procedures.

2. **Emergency nurses must give assistance to families of dying patients** so that they may make informed and compassionate choices. Emergency nurses must use clear, appropriate, sensitive and open-ended questions to draw out the wishes and hopes of the patient and family regarding end-of-life care.
Emergency Nurses Association (cont.’d)

3. **Emergency care providers should respect** the physician’s professional responsibility to discontinue treatment when appropriate, with consideration of patient and family.

4. Because there are many ways of providing end-of-life care and significant potential for ethical dilemmas to arise from end-of-life issues, **an interdisciplinary team approach is recommended for decision making** and care delivery for the dying patient and family in the emergency department.

5. To address end-of-life issues in the emergency department, **emergency nurses should work with their institutions to develop policies and protocols** concerning: a) the identification of patients for whom cardiopulmonary resuscitation (CPR) is not indicated, b) the care of the dying patient and family, c) bioethics committee functions, and d) advance directives.
6. **Emergency nurses should establish close working relationships with organ and tissue procurement organizations** to develop timely donation interventions.

7. **Emergency nurses should work with their institutions to develop programs that are specially designed to meet the needs of dying patients** and their families in the emergency department. In addition, emergency nurses should participate in the development of palliative care units or services so that they may transfer dying patients to appropriate care settings such as hospital-based palliative care/hospice units or home hospice.

8. **Emergency nurses should work collaboratively with coroner and medical examiner offices** to allow visitation of family members postmortem.
9. In the fast-paced and high-anxiety environment of the emergency department, difficult end-of-life clinical and ethical decision making can become more complicated. Emergency nurses should use ethical principles to assist them in navigating through ethically difficult situations.

10. Emergency department management should make available Critical Incident Stress Debriefing (CISD) as needed to help emergency nurses and other providers who care for dying patients cope with potentially high-stress situations.

11. Nursing curricula and continuing education programs must address issues related to end-of-life care, bereavement care and symptom management.

12. Emergency nurses should be involved in research to gain a better understanding of end-of-life issues and to develop interventions for end-of-life care in the emergency department.
National Quality Forum — 2008

National Priorities Partnerships

- Minimum goal for ED visits at the end of life:

  No more than one emergency department visit in the last month of life