

## Clinical Practice Statement

### ***Palliative Care in the Emergency Department: Recognizing and Meeting the Needs of Seriously Ill Patients (9/16/2021)***

Chairs: Michael Abraham, MD FAAEM  
Grzegorz Waligora, MD FAAEM

Authors: Sharon Swencki, MD FAAEM  
Masha Rand Rosenthal, MD FAAEM  
Lisa A. Moreno, MD MS MSCR FAAEM FIFEM

Reviewers: Michael Abraham, MD FAAEM  
Steven Rosenbaum, MD FAAEM

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#### **What is Palliative Care?**

The Center to Advance Palliative Care has provided the following definition:

Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by a specially-trained team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support. Palliative care is based on the needs of the patient, not on the patient's prognosis. It is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment. (1)

Early involvement is associated with greater benefits, including improved quality and reduced cost of care. An increasing number of professional society guidelines recommend early palliative involvement, eg., American College of Emergency Physicians 2013 Choosing Wisely Campaign, American Society of Clinical Oncology 2018 Guideline Updates, National Comprehensive Cancer Network 2009, American Thoracic Society 2008 Clinical Policy Statement. (2, 3, 4, 5).

10 member boards of the American Board of Medical Specialties are co-sponsors of the Hospice and Palliative Medicine (HPM) specialty certification: American Board of Anesthesiology, American Board of Emergency Medicine (ABEM), American Board of Family Medicine, American Board of Pediatrics, American Board of Physical Medicine and Rehabilitation, American Board of Psychiatry and Neurology, and the American Board of Surgery. Currently, approximately 140 ABEM diplomates are double-boarded in HPM. (6)

**When and how often do seriously ill patients seek care in the Emergency Department?** Emergency physicians (EP) routinely take care of chronically ill and dying patients. Emergency Department (ED) utilization is common for seriously ill patients and is associated with high cost, goal-discordant care and significant patient and family burden. One large, longitudinal study found that

51% of US adults ages 65 and older have at least one ED visit in the last month of life and 75% in the last 6 months of life. Of those coming to the ED in the last month of life, 77% were admitted and 68% died in the hospital (7). Another study, spanning 3 years and looking at over 90,000 cancer patients revealed that 84% visited the ED in the last 6 months of life (with over 50% of these having more than one ED visit), and 34% had an ED visit in the last two weeks of life. (8) ED visits in the end of life are a widely accepted indicator of poor-quality end-of-life (EOL) care; this is one of the benchmarks used by National Quality Forum to assess quality of EOL care. (9)

### **Does palliative care have a role in the Emergency Department?**

There is mounting evidence that ED-based Palliative Care (PC) interventions are effective in improving outcomes and reducing costs. As a result, there is growing interest in education and initiatives to increase awareness of and access to PC for ED patients. MD Anderson piloted a project screening for PC needs and initiating PC in the ED using a dedicated ED PC team. They found a 23% reduction in in-hospital death, 1.5 day decrease in hospital length-of-stay, 19.4% decrease in ICU admit, 54.8% increase in DNR orders, and 23% higher hospice disposition rates. (10) A 2013 study found decreased length of stay for patients who had a PC consult initiated in the ED (11).

More recently, a 2019 systematic review found that PC interventions initiated in the ED improved patient quality of life, decreased length of stay, increased hospice utilization, and did not negatively affect patient survival (12).

### **What is the current state of palliative care education for emergency physicians?**

PC skills are broadly acknowledged to be important to the practice of Emergency Medicine (EM). (13) Education in PC and EOL communication is a much needed and often neglected part of residency training and medical education. New York City EM residents polled, expressed knowledge of the importance of PC education as well as the lack of training in this area. (14) Residents generally feel uncomfortable with EOL situations and often have goals of care discussions unsupervised. (15) Both simulation-based and classroom-based educational programs have been shown to increase resident comfort and confidence in these critical skills. (15,16) In 2018, an expert panel developed HPM-EM content topic list and milestones, using the Accreditation Council for Graduate Medical Education EM milestone framework, to guide development of residency curricula. (17)

For practicing EPs, continuing education in PC skills and interventions, including hospice, is necessary. Numerous groups are working on addressing this need. A feasibility pilot in a large urban ED found that after a brief educational session, EPs were able to accurately identify hospice eligible patients. Additionally, they noted a marked increase in hospice referrals.(18) Grudzen et al are undertaking an ambitious project, providing palliative education for EM health care professionals with a plan to evaluate the impact on outcomes including ED utilization, disposition and survival in older seriously ill ED patients.(19) Furthermore, formal education programs exist such as Education in Palliative and End of Life Care - Emergency Medicine (EPEC-EM), a train-the-trainer format, intensive course adapted specifically for EM health care professionals.(20) CAPC offers a series of online clinical courses on basic PC topics such as Communication Skills, Pain Management, Basic Advance Care Planning Skills to member institutions.(21)

### **What is the future of Palliative Care in the Emergency Department?**

The practice of EM has historically been open to change and fluid in its practice. Thus, it is not surprising that the role of palliative care in the practice of EM is rapidly gaining acceptance and recognition. With this

in mind, the ultimate goal is to see PC integrated into the care received by ED patients. There are two ways in which this can be achieved.

1. Education and Integration of PC into EM Practice

As we have discussed, in order for EM practice to adapt to the increasingly recognized PC needs of our patients, EPs should receive training in palliative skills and competencies starting from residency. At the same time, palliative health care professionals would benefit from education in the specific needs of the ED and its patients. For those of us who are already practicing, there are resources for increasing our PC skills. Continuing education in HPM is available for practicing EPs as noted.

Screening tools specifically designed for the ED setting can be powerful aids in identifying patients who would benefit from palliative interventions. Several hospitals have successfully adopted such screening tools. Screening tools can help EPs rapidly and accurately identify patients who may benefit from further PC intervention.

Identifying appropriate referrals and Initiating goals of care discussions with our patients in the ED can lay the groundwork for subsequent HPM specialty consult and prevent unwanted or burdensome care.

2. Partnership and Collaboration

Partnering with HPM health care professionals in other departments and in the community is another important means of expanding awareness and access. First and foremost, building relationships with inpatient palliative consult services can be very helpful in expanding PC access to ED. Involving ED case managers or social workers in early discussion with patients and their families can help expedite PC interventions and increase community and outpatient resource utilization.

**Conclusion**

Great strides have been made since ABEM had the vision to join nine other sponsoring boards in recognizing HPM as a subspecialty in 2006. However, much work remains to be done to quantify the impact of PC in the emergency setting, and to identify and create optimal implementation strategies. This evolution in our specialty stands to benefit all involved: patients, health care professionals, and health systems.