

## Fast Response is Key to Partnering with the Emergency Department

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**T**HE EMERGENCY DEPARTMENT (ED) is “absolutely the first place to get palliative care consultations done,” asserts Dr. Tammie Quest, Associate Professor of Emergency Medicine at Emory University Medical Center and director of the Palliative Care Oncology Program for the Grady Cancer Center for Excellence, both in Atlanta, Georgia. Quest, a principal investigator for Education in Palliative and End-of-Life Care—Emergency Medicine (EPEC-EM), a new curriculum for emergency medicine professionals, says EDs are likely to be receptive to working closely with palliative care programs that demonstrate their willingness to build responsive, collaborative relationships.

The palliative care service at Virginia Commonwealth University (VCU) Medical Center in Richmond, Virginia, has made purposeful outreach and inroads into the ED in its hospital. Nearly half of the referrals to VCU’s palliative care unit (described in *Notes from the Field* [*Journal of Palliative Medicine* 2006;6:1245]) come from direct admissions, either via the ED or from community physicians. Preliminary data suggest that palliative care in the ED can contribute to improved quality of care, patient and family satisfaction and cost management—with better patient outcomes and implications for the health system as a whole, says Dr. Laurie Lyckholm, palliative care physician at VCU.

The palliative care service does not offer 24-hour consultations but patients can be directly admitted to VCU’s 11-bed palliative care unit. “The way we made inroads into the emergency department was to be extremely user-friendly, offering solutions for our colleagues caring for ED patients,” explains Patrick

Coyne, VCU’s clinical director of palliative care services. “Really, there is no inappropriate consultation for palliative care.”

Expanded relationships with palliative care have the potential to improve quality of care, throughput and disposition of cases in the ED, reducing hospital length of stay and improving financial performance—thereby helping to advance palliative care’s overall goals within the hospital. But in order to build such relationships, palliative care must be willing to learn the culture and concerns of its new audience of ED colleagues. Critical to this relationship is the palliative care service’s ability to respond to ED needs in real time.

Will success require 24-hour availability, access to a dedicated palliative care unit, or admitting patients onto the palliative care service for primary medical management? Or can a palliative care consultation service without those features still have significant impact in the ED? Have some palliative care services shied away from a closer relationship with the ED out of a fear that they could be deluged with more referrals than they can handle? Answers to these questions could impact on the future growth of hospital-based palliative care.

### WHAT’S HAPPENING IN EMERGENCY MEDICINE?

In September 2006, the American Board of Emergency Medicine joined with nine other constituent boards of the American Board of Medical Specialties, becoming a cosponsor of hospice and palliative med-

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icine as a recognized medical subspecialty. The decision by ABEM was prompted by a petition from Quest and other leaders in emergency medicine who have an interest in palliative care, including a palliative medicine interest group formed within the Society for Academic Emergency Medicine.

EPEC-EM will be presented for the first time in a train-the-trainer format August 3–4, 2007, in Chicago, Illinois. Developed by leaders in emergency medicine and the EPEC team at Northwestern University, EPEC-EM is designed to teach emergency medicine professionals how to apply basic palliative care techniques in the emergency setting, as well as how to screen and refer for hospice, palliative care, or caregiver support. Advocates hope to establish a minimum level of pain and symptom management skills and communication competencies in the ED while creating access to palliative care consultations for more demanding cases.

Dr. Knox Todd, Professor of Emergency Medicine at Beth Israel Medical Center in New York City, also heads the Pain and Emergency Medicine Institute at Beth Israel, which received a grant from the Samuels Foundation for exploratory research on bringing palliative care principles and practices into the ED and facilitating faster discharge from the ED of palliative care-appropriate patients. This project will study the impact of a standardized palliative care screening tool and brief intervention from social workers assigned to the ED. Focused on the needs of chronically ill, elderly patients, it is being undertaken in collaboration with Beth Israel's Pain and Palliative Care Department.

Other emergency physicians are also taking leadership roles in bringing the two fields closer together. Dr. Robert Zalenski, a professor of emergency medicine, heads the Center to Advance Palliative-Care Excellence at Wayne State University, Detroit, Michigan. Dr. Susan Stone, emergency physician at University of Southern California-Los Angeles County Medical Center, obtained additional palliative care training and in August 2006 launched an inpatient palliative care consultation service at the medical center. This program, which is supported by the county health department, receives 60% to 70% percent of its referrals from the safety net medical center's emergency department.

### **WHY SHOULD PALLIATIVE CARE AND EMERGENCY MEDICINE SEEK CLOSER TIES?**

The largest benefit for palliative care from working closely with the ED is the opportunity to serve seri-

ously ill patients much earlier—on the first day of their hospital admission. This is in contrast to the passive, waiting-for-the-referral model whereby the patient is admitted to the hospital and exhausts conventional treatment approaches, which may or may not be beneficial or even desired, before being referred days or weeks later for a palliative care consultation and the first serious discussion of goals of care. The first hours in the ED are when determinative decisions are made about disposition and plan of care, and palliative care could be contributing to those decisions.

“The ED is a bottleneck and a staging area—a place of transition for many patients, whether from one health plan to another or from one stage of life to another,” Todd says. “It’s a place of crisis and opportunity—where changes in treatment philosophy are easier to implement.” Invasive technologies are often initiated in the emergency department, while troubling symptoms that are not addressed in the emergency department may go untreated for days after hospital admission.

Other areas in which palliative care could contribute include exploring the appropriateness of advance care planning, cardiopulmonary resuscitation or do-not-resuscitate options and choices; discussing organ and tissue donation; providing support and bereavement follow-up to family survivors; and encouraging the family's presence during complex decisions in the ED. For the palliative care service, a closer relationship with the ED may lead to increased referrals and an opportunity to demonstrate significant contributions to the hospital's most pressing needs, such as for efficient throughput, bed capacity, and availability of resources to those in greatest need.

Palliative care is able to improve pain and symptom management for patients while helping to assure communication about goals, and to facilitate decision making concordant with those goals. Palliative care can also help with disposition planning for complex discharges including a return home with pain or symptoms adequately managed, families prepared and confident in their ability to provide care, and adequate support from community resources, such as hospice, home health agencies, and others.

All of these reasons for a stronger palliative care-emergency department interface are intensified by increasing demands and overcrowding in the nation's emergency rooms, as well as evidence that the majority of patients with severe or chronic illness enter the hospital through the ED. In fact, the Institute of Medicine recently documented a brewing “national crisis in emergency medicine.”<sup>1</sup> Despite the lifesaving feats performed every day by emergency departments

and ambulance services, the nation's emergency medical system as a whole is overburdened, underfunded and highly fragmented, the Institute of Medicine notes. An estimated 379,000 deaths occurred in U.S. EDs in 2000.<sup>2</sup>

### GETTING IN THE DOOR

Palliative care advocates in emergency medicine say emergency physicians are hungry for the benefits palliative care can offer. "The hospice and palliative medicine community hasn't connected to colleagues in emergency medicine as well as it might, but once palliative care is explained, emergency medicine professionals see its concepts and principles as a no-brainer. The iron is hot right now for this connection," Quest says.

However, palliative care professionals need to learn and understand the processes and demands of the ED. That means speaking the language of the ED and being thoughtful about how to respond to its needs. It means providing support to deal with difficult cases and education and protocols or tools that can be used to prompt a palliative care referral—the more practical and straightforward the better. (An example of a screening tool for palliative care in the emergency department can be found in Figure 1.) Emergency physicians and nurses may instinctively recognize who needs palliative care, but they could benefit from direction on how to respond quickly and without hassle to those hunches under high-pressure conditions.

Having a palliative care unit to which appropriate patients can be referred and directly admitted from the ED, or a service that accepts primary medical responsibility for patients admitted to the hospital with palliative needs, may make the case for palliative care stronger and more obvious. Another helpful service is 24-hour availability—by telephone, if not in person—and the ability to respond in real time to referral requests or questions from the ED.

However, emergency medicine experts emphasize that these are not essential features for palliative care to make a meaningful contribution. Even if the palliative care service is only available from 9:00 to 5:00, if it is reliably available during the listed hours, that could still be a big help. If the palliative care service does not have a unit, it can still project a visible and responsive presence.

"Come down and meet with ED nursing and physician leadership," Zalenski suggests. Make presentations at departmental meetings. "Let them know that if they ever have patients with refractory symptoms

that they don't know how to handle, they can call palliative care. Tell them you're available to lend a hand." Focus on rapid response, prompt disposition, and the most urgent and serious medical needs.

"If you have a champion in the ED to advocate for palliative care, it's always better," says Stone. "But if you approach it that you want to help them get patients out of the ED, I can't think of any reason why they wouldn't want your help. Sometimes emergency physicians may seem abrupt, but we need to make quick decisions because we see a lot of patients in extremis. We never know who's going to come through the door next."


"You need to adhere to the general understanding that your hospital has set regarding the ED," advises Garrett Chan, professor of nursing at the University of California-San Francisco. "When the ED calls, usually it's 'STAT,' meaning that it takes high priority over whatever else is going on. You have to get back to them quickly, even if it's just to let them know they are next on your list. If you want to sell yourself to the ED, you need to offer a state of readiness." Of course, he adds, that doesn't mean rushing out of a scheduled palliative care family conference to answer a page from the ED, but accessibility and responsiveness is crucial. In addition to his expertise in emergency care, Chan sought and earned certification in advanced practice hospice and palliative nursing, along the way learning new tools with applicability in the ED.

Emergency physicians increasingly are playing roles in system-wide quality improvement within their hospitals, and that can provide another opportunity for interfacing with palliative care, Todd notes. If hospital administrators are persuaded of the potential benefits of a closer working relationship, they can serve as intermediaries.

One final suggestion, Todd says, is to be open to the possibility of quicker, shorter initial interventions with patients in the ED—a kind of triage of palliative care issues, with the full-bore palliative care assessment and team held off until the following day. In other cases, the ED may want palliative care to conduct a family meeting and help clarify goals of care while the patient is still in the emergency department, especially if there is an observation area for holding patients.

### AN EXAMPLE OF COLLABORATION

At the Mount Carmel Health System in Columbus, Ohio, the palliative care service in 2004 utilized *Six Sigma* quality-improvement processes to study and en-

 <p><b>MOUNT CARMEL</b>  <b>Mount Carmel Health System Palliative Care Service</b></p> <p><b>Indicators:</b></p> <p><b>Consideration for Direct Admission to Acute Palliative Care Unit</b></p> <p><b>Or</b></p> <p><b>Palliative Consultation initiated from ED</b></p>	
<i>ED Patient to be admitted to hospital presents with at least one of following:</i>	
Patient transferring from SNF	
DNR status established or requested	
Patient actively dying	
Patient in pain or discomfort	
Patient currently enrolled in a community hospice	
Previously discharged from Acute Palliative Care Unit	
Multiple admissions to the hospital (2 or more within 6 months) for the same problem	
Patient with advanced disease with frequent infections	
Nutritional complications with an albumin of less than 2.5mg/dl	
Primarily bed bound	
Advanced disease with enteral feeding in place	
Sudden acute event such as CVA	
Patient with advanced disease being admitted for PEG tube/trach placement	
Disease Triggers: Malignant neoplasm especially lung cancer; aspiration pneumonia, COPD, CHF, ESLD, septicemia, bone metastases, renal failure, hemorrhagic stroke	

**FIG. 1.** Indicators for palliative care in the emergency department. ED, emergency department; SNF, skilled nursing facility; DNR, do not resuscitate; CVA, cerebrovascular accident; PEG, percutaneous endoscopic gastrostomy; COPD, chronic obstructive pulmonary disease; CHF, congestive heart failure; ESLD, end-stage liver disease. *Source:* Sharol Herr, Mount Carmel Acute Palliative Care Service, Columbus, Ohio.

hance awareness and involvement in the EDs at three Mount Carmel hospitals, with important benefits for the system as a whole. “We developed extensive education and training, established tools and made them available to the ED,” reports palliative care physician Dr. Philip Santa-Emma. Palliative care staff attended emergency physician and nursing staff meetings and met with social workers, case managers and chaplains, following up with regular e-mail communications and

visits to ED. “We trained ourselves to be more responsive to their concerns.”

“One of the surprises for us was that we didn’t have to do a big sales pitch,” adds palliative care nurse clinician Sharol Herr. “Part of that is being articulate about what the interface will or won’t involve, and viewing the emergency department as an important customer.” Palliative care should be well grounded in what it is and what it does before it goes down to the ED, Herr

says. It is also important to respect emergency professionals for the work they do and the time-pressured conditions under which they must operate.

Recent statistics from Mount Carmel indicate that EDs were the source of 9.2 percent of all admissions to the palliative care units, and of 66.7 percent of all direct admissions. Length of stay in the palliative care units was approximately the same for these direct admits as for patients referred to the palliative care unit later in their hospital stays. "Clearly there is a subset of patients in the ED that is very appropriate for palliative care, and this relationship allows us to be more effective with them sooner," Santa-Emma says.

Dr. Loren Leidheiser, director of the ED at Mount Carmel St. Ann's Hospital, says his department is busy with 73,000 patient visits per year, many of them elderly and a quarter of them resulting in admissions to the hospital. "Part of our issue in the ED is that we're busy all the time, with no ability to control who comes in our doors. Yet we're responsible for ensuring that we're using the scarce resources of the hospital to their most appropriate capacity." The relationship with palliative care is built on education, on how to meet patients' needs better, and offer a broader range of options.

The key, Leidheiser adds, is availability. "If I'm in the emergency department tomorrow afternoon, I can call a palliative care physician and trust that

they'll answer my page and any questions I have. If it takes hours to respond, that would kill me. My whole world is to work quickly. If I have to say to a patient or family in the ED that I'm still waiting for my page to be answered, already they will lose confidence in me."

"In palliative care we pride ourselves on getting involved early," concludes USC's Stone, who maintains a practice in both fields of palliative and emergency medicine. Collaborating with the ED "is palliative care's big chance to do that and show that making an impact earlier not only markedly improves care quality, but also contributes to the hospital's overall efficiency. This is an opportunity to share and show what a valuable asset palliative care really is."

## REFERENCES

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