

# The Effective and Efficient ED-Palliative Care Consult

Tammie E. Quest, MD

Director, Emory Palliative Care Center

Professor

Emory University School of Medicine

# Join us for upcoming CAPC events

## → Webinar:

- **Growth and Development Strategies in Pediatric Palliative Care with Justin Baker, MD:** Wednesday, February 15, 2017 | 2:00 - 3:00 pm ET

## → Virtual Office Hours:

- **Billing and RVUs in Hospital Palliative Care with Julie Pipke, CPC:** Wednesday, Feb. 8, 2017 | 11:00 am ET
- **Marketing to Increase Referrals with Lisa Morgan, MA and Andrew Esch, MD, MBA:** Wednesday, Feb. 8, 2017 | 2:00 pm ET
- **Role of the Social Worker on the IDT with Phil Higgins, PhD, LICSW:** Thursday, Feb. 9, 2017 | 12:00 pm ET
- **Business Plan for Community-Based Palliative Care with Lynn Hill Spragens, MBA:** Friday, Feb. 10, 2017 11:00 am ET
- **Ask Dr. Diane Meier: Open Topics:** Friday, Feb. 10, 2017 | 1:00 pm ET

Visit [www.capc.org/providers/webinars-and-virtual-office-hours/](http://www.capc.org/providers/webinars-and-virtual-office-hours/)

# The Effective and Efficient ED-Palliative Care Consult

Tammie E. Quest, MD

Director, Emory Palliative Care Center

Professor

Emory University School of Medicine

# Session Objectives

→ Palliative care providers may find the emergency department setting challenging to navigate and negotiate. This session will focus on elements of effective management of ED initiated palliative care consults.

## Objectives:

- 1. Discuss key elements of ED consultation intake and completion
- 2. Describe models of consultation management by the palliative care team of ED initiated consults
- 3. Identify 3 key pearls and pitfalls of consultation management to optimize palliative care team effectiveness

# Choosing Wisely Campaign

October 15<sup>th</sup>, 2013



**Don't delay engaging available palliative and hospice care services in the emergency department for patients likely to benefit.**

Palliative care is medical care that provides comfort and relief of symptoms for patients who have chronic and/or incurable diseases. Hospice care is palliative care for those patients in the final few months of life. Emergency physicians should engage patients who present to the emergency department with chronic or terminal illnesses, and their families, in conversations about palliative care and hospice services. Early referral from the emergency department to hospice and palliative care services can benefit select patients resulting in both improved quality and quantity of life.

<http://www.acep.org/Clinical---Practice-Management/ACEP-Announces-List-of-Tests-As-Part-of-Choosing-Wisely-Campaign/>

**capc** Center to Advance Palliative Care

# Primary Palliative Care Skills in EM

- Pain/non- symptom management
- Communication
  - Goals of Care
  - Breaking Bad News
  - Death Disclosure
- Family presence during resuscitation
- Ethical/Legal Aspects of Care
- Care in the last hours of living
- Caregiver Support
- Bereavement
- Caring for patients receiving hospice care
- Withdrawing/Withholding Life Sustaining Therapies
- **New Diagnosis of “Needs Palliative Care”**

\*Education in Palliative and End of Life Care-Emergency  
Medicine Curriculum (EPEC-EM)

# What is difficult about consults the ED?

# ED Challenges

## → ED Requestors

- Typically won't know or have a previous relationship with
- May not know what you can and cannot do
- Unclear what your availability and resources are
- Request help with disposition

## → ED Setting

- “Chaotic”
- Time pressured
- Crowded
- Non-private
- No seating
- Limited information
- Multiple interruptions



# Confusion Amongst Emergency Clinician About Palliative Care

- “What’s in a name? A qualitative exploration of what is understood by “palliative care” in the emergency department”
  - N=94 ED participants
    - Misunderstanding of the role of palliative care in the ED
    - Inconsistent engagement with palliative care

# Fundamental Understanding of the ED

# Emergency Departments and Clinical Practice

## Challenges

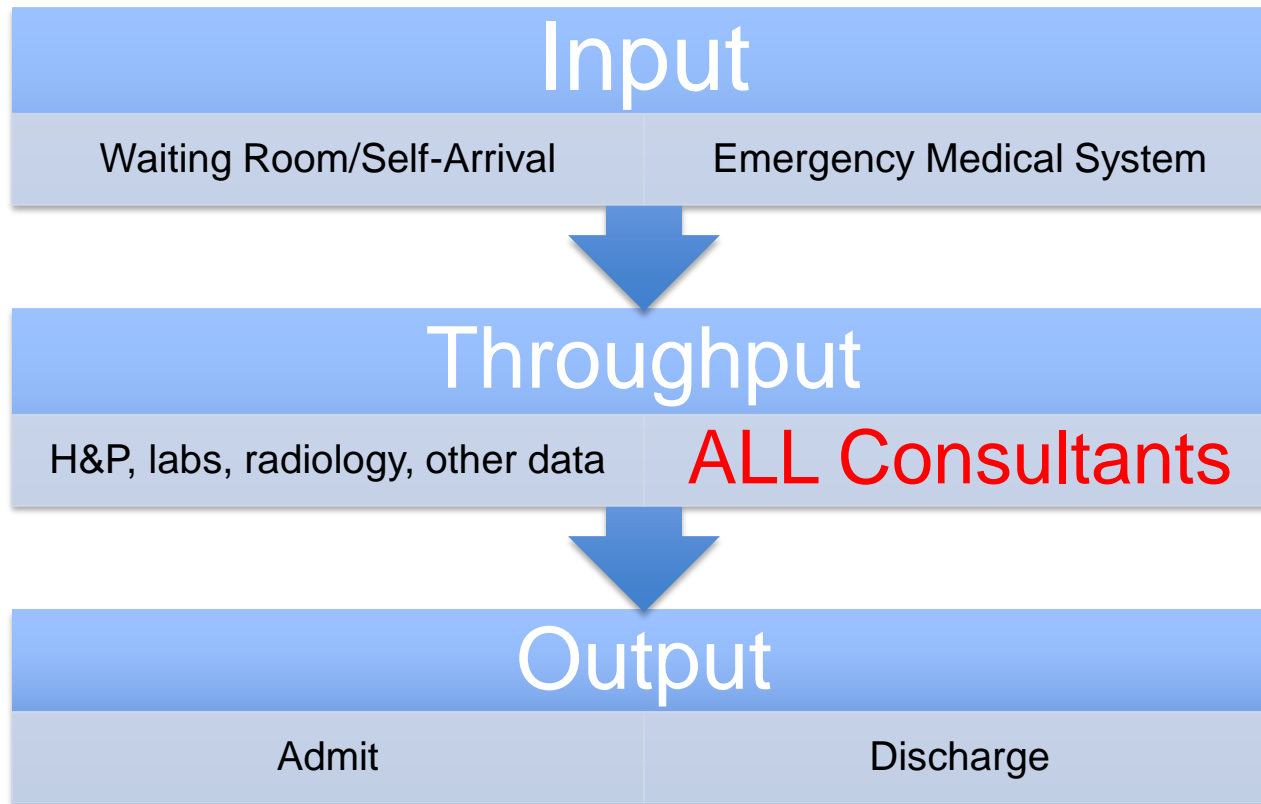
- Practice is high distraction
  - interruption q 3-6 mins for 8-12 hrs
- High medico-legal risk
- Currency is speed
  - Slow doc = ineffective
- National pressures on the ED around quality “core measures”

## Opportunities

- Receptive to new ideas
  - Domestic violence, smoking cessation
- Proud
  - Safety net for all
- Problem Solvers
  - will try to “handle it”, not bother others

# Understanding Patient Flow in the Emergency Department

## *Input-Throughput-Output*



# 3 Sources of Gridlock in the ED

- Tests/Radiographs
- **Calling a consult that requires physical presence**
- Admission to anyplace other than a floor bed
  - e.g. ICU or ‘stepdown/intermediate bed’ request



# Why an ED Provider Calls for Consultation

- **Disposition**
  - Admission, Hospice, “Home” with follow-up needed
- **Advice that changes management**
  - Will make the difference between admit and discharge
- **Reduce medico legal risk**
  - Failure to diagnose/Failure to treat most common cause of tort cases in EM
  - “I don’t feel comfortable....”
  - Need help with “sanctioned permission to do less” by someone who understands more
    - Need help with code status, surrogate, limits of the advance care plan

# Disposition

- One of the MOST important factors in the ED
  - All patients must leave the ED
  - The emergency clinician needs to find a “DISPO” for EVERY patient in the ED
  - You are either “helping dispo” or “blocking dispo”

# Helping “Disposition”

→ *You (or your team)* is actively doing something that helps safely move a patient from the ED to somewhere else

– Examples:

- Direct admit to hospice unit, home hospice or PC unit
- Provide next day follow-up to allow a treatment plan initiated from the ED to work
- You come talk the patient and family and as a result patient can go to regular floor versus ICU



# Advice that Changes Management

## → Symptom management

- “Try X, Y and Z and if it works, you can send them home; if not, you should admit them”
- “I would just admit now because we can’t get it under control in the span of the ED”
- “The pain medication discharge regimen should be X, Y and Z and they should be safe for follow-up”

# Unhelpful ED Consults

- Create more work for the ED than they started with
  - You see the patient and leave a new “list” of things to do
- Don't offer anything that will help move the patient
- Person consulting is generally unpleasant and doesn't help you with anything that helps you get to the next step

# Case

- 62 yo male with Stage IV NSCLC presents to the ED with uncontrolled back pain. Work up shows no cord compression. The ED calls you for pain control. Patient is currently on Oxycodone 10mg po q4hrs prn pain and is using 6 doses in a 24 hour period and has been doing this for the last 8 days.
- Now that cord compression is ruled out, they are trying to get pain under control. He has a new lesion at T4 without neurological deficits
- He has been given hydromorphone 2mg IV once with good relief but pain is returning

# Key Aspects of the Approach

- Think: Will anything I suggest change if the patient goes home or not? If not, say so immediately
- Your recommendation and conversation should acknowledge that disposition is the issue

# Phone Conversation

## → Consultation (You):

- Sounds like you have done quite a bit. I want to help figure out your next step in “dispo”. If you got pain under control or had a plan, would you send him home?
- Does it seem like he has a caregiver to help him with a home plan?

# Phone Conversation

## → Consultation (You):

- Sounds like you have done quite a bit. I want to help figure out your next step in “dispo”. If you got pain under control or had a plan, would you send him home?
  - ED Answer: Yes, I would send him home
- Does it seem like he has a caregiver to help him with a home plan?
  - ED Answer: Yes, his wife is here with him and I think they could go home if we had a plan

# Give clear recommendation

- I would give one more dose of hydromorphone 2mg IV and if he is comfortable move to our discharge plan.
  - Can you call me back in about 30 minutes to let me know how he is doing?

# Give a clear recommendation

- I would send him home on:
  - Oxycontin 40mg po q12hrs for long acting with hydromorphone 8mg orally q4hrs prn pain
  - Naprosyn 500mg po q12hs
  - Senna 2 tabs po qhs for bowel prophylaxis
  - Give him a 5 day supply and we will call the patient tomorrow to see how he is doing
  - Our service will contact the oncologist and help arrange for visit and possible palliative radiation



# What the ED writes in the chart

- Spoke to palliative care service. Recommended Oxycontin and hydromorphone, Naprosyn and bowel regimen then they will follow-up tomorrow with their service.

# Medico Legal Risk



# Reduction Medico legal Risk

- Failure to diagnose/failure to treat
- Failure to secure follow-up
- Poor communication

# Failure to Diagnose/Failure to Treat

- Limitations in life sustaining treatments could be seen *after the fact* to be “failure to treat”
  - Intubation/Airway management
  - Resuscitation
  - Antibiotics/Fluids
- **Considered “High Stakes” by ED**

# Failure to Diagnose/Failure to Treat

- ED clinician may be seeking reassurance and support that they can withhold life sustaining therapy
  - Example ED Documentation:
    - “Case d/w palliative care service, confirmed patient has valid advance care plan that patient would not want CPR at EOL. I have confirmed the goals of care to be comfort care, will proceed with hospice and recommended by palliative care service”

# Help the ED Feel Comfortable

- Emergency clinicians WANT to do the right thing
- Trained to avoid death and when death is approaching it can be emotionally and professional difficult to handle
- Support the difficult nature

# ED Consult Model



# ED Consult Model

## → Phone

- The ED expects to be given advice over the phone so they can make a decision on the care
- Expect you to help with follow-up plan
  - Need outpatient appointment or referral

## → In Person

- Expects that your exam or discussion with the patient will be required to reach a conclusion
- Expect that you will help with dispo



# Consult after the Admission Decision

- Still have the ability to change disposition (most often different level bed)
- Due to **long ED boarding times**, patients may stay in the ED for hours or days waiting for bed

# PC Consultation Initiated from the ED

## Emergency Department-Initiated Palliative Care in Advanced Cancer: A Randomized Clinical Trial

Grudzen, C. R. Richardson, L. D., Johnson, P. N., Hu, M., Wang, B et. al

N= 136; half randomized to **ED Palliative care consultation vs usual care**

**-QOL higher (P<0.03)**

-Trend in longer survival longer (P=.2)

-No difference in: ICU, hospice (underpowered) or depression; trend toward longer hospitalizations in intervention group

**Note:** research staff identified the patients and called PC team; PC consult occurred same or following day; consult = symptoms, GOC, ACP and transition planning

# Palliative Care Resource in the ED Can Make A Difference

**A dedicated palliative care nurse improves access to palliative care and hospice services in an urban ED**

McIntosh M, Monticalvo D, Quest T, Adkins B, Bell S, Osian SR

Full time palliative care nurse M-F, 8am – 5pm placed in the Emergency Department. **Direct contact with 1139 patients** with a focus on **identification of surrogate**, advance care planning and identification of patients appropriate for **palliative care consultation**.

2016 Dec;34(12):2440-2441

# After the Consult is Complete



# Send follow-up communication to the ED provider

- Follow-up plan executed
  - Pt got to clinic; patient admitted to home based service
- Symptoms controlled
- Patient died and how family doing

# Summary Pearls

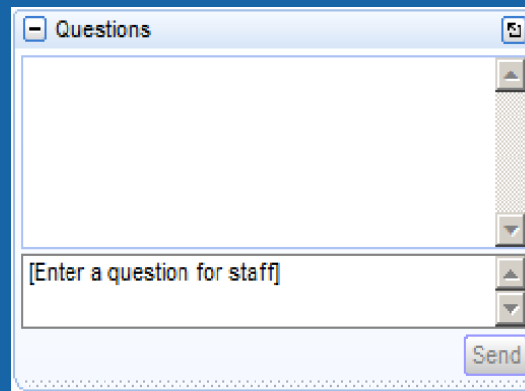
## The Effective and Efficient Consult

- Recognize the pressures and needs of the ED
- Focuses on disposition modifying recommendations
- Create “special” options for the ED
  - Next day appointments if you have an outpatient referral; hospice referrals from the ED; direct admit to PC unit
- Send follow-up note to the ED Provider



# Questions and Comments?

Please type your question into the questions pane on your webinar control panel.



A screenshot of a web-based interface titled "Questions". The interface consists of a large empty text area at the top, a smaller text input field at the bottom containing the placeholder text "[Enter a question for staff]", and a "Send" button located at the bottom right of the input field. The entire interface is enclosed in a light blue border with a small icon in the top right corner.