The Palliation of Emergency Medicine

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Research in emergency care

Window to population health

Research agenda to end disparities, & address the needs of society’s most vulnerable
Background

Increasing ED visits by older adults with serious illness

Most prefer to receive care at home and to minimize life-sustaining procedures

Palliative care improves quality of life and decreases health care use
Default Approach
Researcher as Builder and Architect
The foundation

Identify the palliative care needs of older adults in the ED

Explore attitudes and beliefs among emergency providers regarding palliative care

Identify hospital-level factors that affect the availability and delivery of palliative care in the ED
Methods

Cross-sectional, structured survey of palliative care needs in older adults and their caregivers

Focus groups with emergency providers

Semi-structured interviews with hospital leaders
Barriers and Opportunities

Emergency Providers: medico-legal, time, lack of skills, outside mission of emergency medicine

Key Informants: patient and family satisfaction, decrease utilization of ICU/monitored beds
Building the shell

RCT of ED-triggered palliative care in advanced cancer to test the impact on quality of life, healthcare utilization, and survival
Setting

Single, urban academic medical center

Mature palliative care service

High level of cooperation from EM, oncology, and palliative care
Intervention

Comprehensive palliative care consultation

• Symptom assessment
• Social needs
• Spiritual distress
• Goals of care
Results

134 patients enrolled and randomized 92% consultation rate in intervention group vs. 17% in controls
Quality of Life

9.2 point increase from baseline -> 6 wks in intervention group
2.7 in controls

= 6.5 point difference in change score
(Cohen’s d= 0.35, p<0.05)
Health Care Utilization

ICU admission in 10% of intervention patients vs. 8% of controls at 180 days

Hospice in 24% of intervention patients vs. 20% of controls at 180 days
Survival analysis

Median survival 280 days in intervention patients vs. 114 in controls
Textures, Finish, and Trim

Comparative effectiveness research comparing telephonic nurse-delivered palliative care to outpatient specialty care (EMPallIA)

Pragmatic trial of primary palliative care skills training for emergency providers (PRIM-ER)
Emergency Medicine Palliative Care Access (EMPallA)
Eligibility

50 years and older
Advanced Cancer OR End Stage Organ Failure
ED discharge or Observation
Intervention

Comprehensive palliative care assessment

• Symptom assessment
• Social needs
• Spiritual distress
• Goals of care

Intervention and referral
Interventions

Index ED Visit

1350 older adults with serious illness across nine EDs; 650 caregivers

Nurse-Led Telephonic Case Management

Facilitated Specialty, Outpatient Palliative Care

Quality of Life (FACT-G)

6 months
## Patient Outcomes

<table>
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<tr>
<th>Patient Outcomes</th>
<th>Measurement Tool</th>
<th>Data Collection Method</th>
<th>Timepoints</th>
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<tbody>
<tr>
<td>Patient Quality of Life</td>
<td>FACT-G&lt;sup&gt;53&lt;/sup&gt;</td>
<td>Patient interview</td>
<td>0, 12 weeks, 6 months*, 12 months</td>
</tr>
<tr>
<td>ED Revisit</td>
<td>Count</td>
<td>Administrative claims and self-report&lt;sup&gt;59&lt;/sup&gt;</td>
<td>Up to 12 months from enrollment</td>
</tr>
<tr>
<td>Inpatient Days</td>
<td>Count</td>
<td>Administrative claims and self-report&lt;sup&gt;59&lt;/sup&gt;</td>
<td>Up to 12 months from enrollment</td>
</tr>
<tr>
<td>Hospice Use</td>
<td>Yes/No</td>
<td>Administrative claims and self-report&lt;sup&gt;59&lt;/sup&gt;</td>
<td>Up to 12 months from enrollment</td>
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<tr>
<td>Loneliness</td>
<td>Revised UCLA 3-item Loneliness Scale (R-UCLA)&lt;sup&gt;57&lt;/sup&gt;</td>
<td>Patient interview</td>
<td>0, 12 weeks, 6 months*, 12 months</td>
</tr>
<tr>
<td>Symptom Burden</td>
<td>Edmonton Symptom Assessment Scale&lt;sup&gt;58&lt;/sup&gt;</td>
<td>Patient Interview</td>
<td>0, 12 weeks, 6 months*, 12 months</td>
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# Caregiver Outcomes

<table>
<thead>
<tr>
<th>Caregiver Strain</th>
<th>Modified Caregiver Strain Index(^{53})</th>
<th>Caregiver interview</th>
<th>0, 12 weeks, 6 months*, 12 months</th>
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<tr>
<td>Caregiver Quality of Life</td>
<td>CarerQol(^{53})</td>
<td>Caregiver interview</td>
<td>0, 12 weeks, 6 months*, 12 months</td>
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<tr>
<td>Bereavement</td>
<td>Inventory of Complicated Grief(^{69})</td>
<td>Caregiver interview</td>
<td>0, 12 weeks, 6 months*, 12 months</td>
</tr>
</tbody>
</table>
Primary Palliative Care for Emergency Medicine
UG3/UH3 funded by NCCIH and NIA
Goal of PRIM-ER: provider and system change

Theory of planned behaviour

- Attitude
- Subjective Norm
- Perceived Behavioral Control
- Intention
- Behavior
PRIM-ER Intervention Components

1. Evidence-based, multidisciplinary primary palliative care education (EPEC-EM, ELNEC);
2. Simulation-based workshops on communication in serious illness (EM Talk);
3. Clinical decision support; and
4. Provider audit and feedback.
18 Health Systems

Clinical Sites
- Allegheny Singer Research Institute
- Bayside Medical Center
- William Beaumont Hospital
- Brigham and Women's Hospital
- Christiana Care Health Service, Inc.
- Henry Ford Health System
- Icahn School of Medicine at Mount Sinai
- Mayo Clinic
- NYU School of Medicine
- Ochsner Clinic Foundation
- Rutgers University
- Ohio State University
- University of California, San Francisco
- University of Florida College of Medicine
- Trustees of the University of Pennsylvania
- University of Texas MD Anderson Cancer Center
- University of Utah
- Yale University
Cluster Randomized, Stepped Wedge Trial @ 35 EDs
Facility Extraction
All ED visitors 66+ years to any participating ED

Identify High-Risk Patients
Calculate Gagne Index to identify patients at high risk of short-term mortality (score >6) based on review of 12 months of prior inpatient, outpatient and carrier claims

Examine if transferred from SNF

First ED visit to participating ED when Gagne >6

Outcomes
Disposition at index ED visit, healthcare utilization and survival at 6 months

12 months prior → Index ED visit → 6 months post
Function 1. Identify seriously ill patients with advance care planning documents
Function 2. Identify patients on hospice.

![Active Hospice]

This patient has previously been referred to or enrolled with hospice services. Evaluate for social needs and notify hospice services, if appropriate.

[Blank Line]

Acknowledged

[Accept] [Dismiss]
Function 3. Refer patients to interdisciplinary services.

BestPractice Advisory - Supportive Care, TestThree

Active Hospice

This patient has previously been referred to or enrolled with hospice services. Consult Social Work and consider Palliative Care consultation.

Order  
Do Not Order

IP CONSULT TO SOCIAL WORK

Order  
Do Not Order

IP CONSULT TO PALLIATIVE CARE

Acknowledge Reason

SW and Palliative Care Consults Ordered  No Order at this time

Accept  Dismiss
Function 4. Initiate goals of care conversation.

**Goals of Care Discussion Trigger (No eMOLST on file)**

This patient **does not** have an eMOLST on file but does possibly have a serious life-limiting illness based on criteria met (see criteria in **blue** below).

Start a goals of care conversation.

Do you think this patient may die during this hospitalization?  
OR

Do they have any one of the following?  
- Worsening in functional status?  
- Uncontrolled symptoms due to a life-limiting illness?  
- Unclear goals of care?

If yes, then order a Social Work and Palliative Care Consult.  
If no, then dismiss BPA.

**Criteria met:**

ECOG=4, Poor functional status
Audit and Feedback Dashboard @ NYU Langone

ED Supportive Care Dashboard

Palliative Care

- # Palliative Care Orders
  - January 2017: 10
  - July 2017: 25
  - January 2018: 15

- # Pall care consults in ED
  - January 2017: 5
  - July 2017: 10
  - January 2018: 12

Care Management

- # Care Manager Notes
  - January 2017: 50
  - July 2017: 75
  - January 2018: 100

- # CM notes in ED
  - January 2017: 20
  - July 2017: 40
  - January 2018: 60

Social Work

- # SW Orders
  - January 2017: 300
  - July 2017: 400
  - January 2018: 500

- # SW consults in ED
  - January 2017: 5
  - July 2017: 10
  - January 2018: 12

ED disposition of inpatient hospice

- # of ED -> inpt hospice
  - January 2017: 2
  - July 2017: 4
  - January 2018: 8
What about COVID?
Next Steps
African Proverb

If you want to go fast, go alone.
If you want to go far, go together.
THANK YOU

NYU Langone Health