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The Palliation of Emergency Medicine

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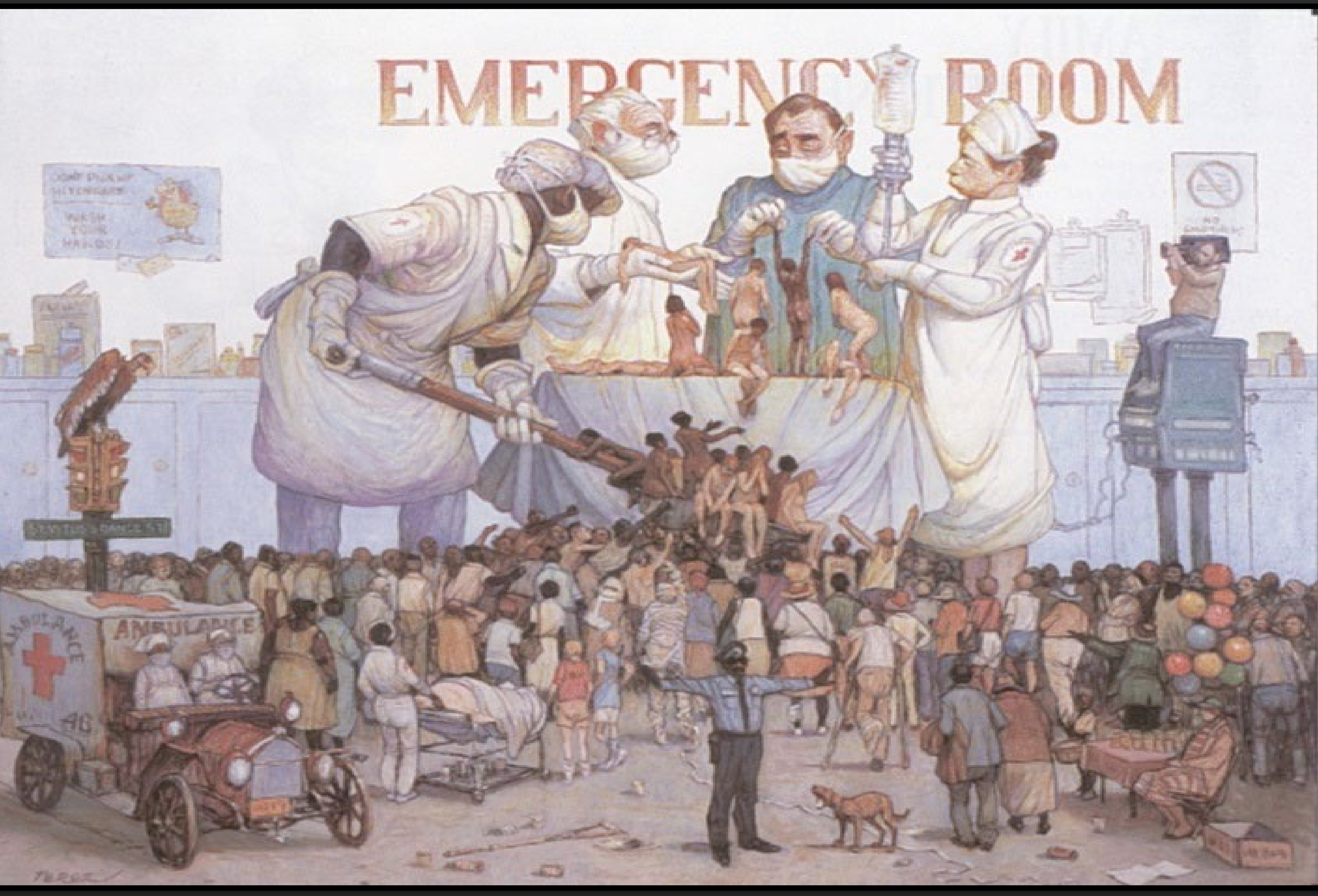


EMERGENCY ROOM
AMBULANCE
AMBULANCE
46

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

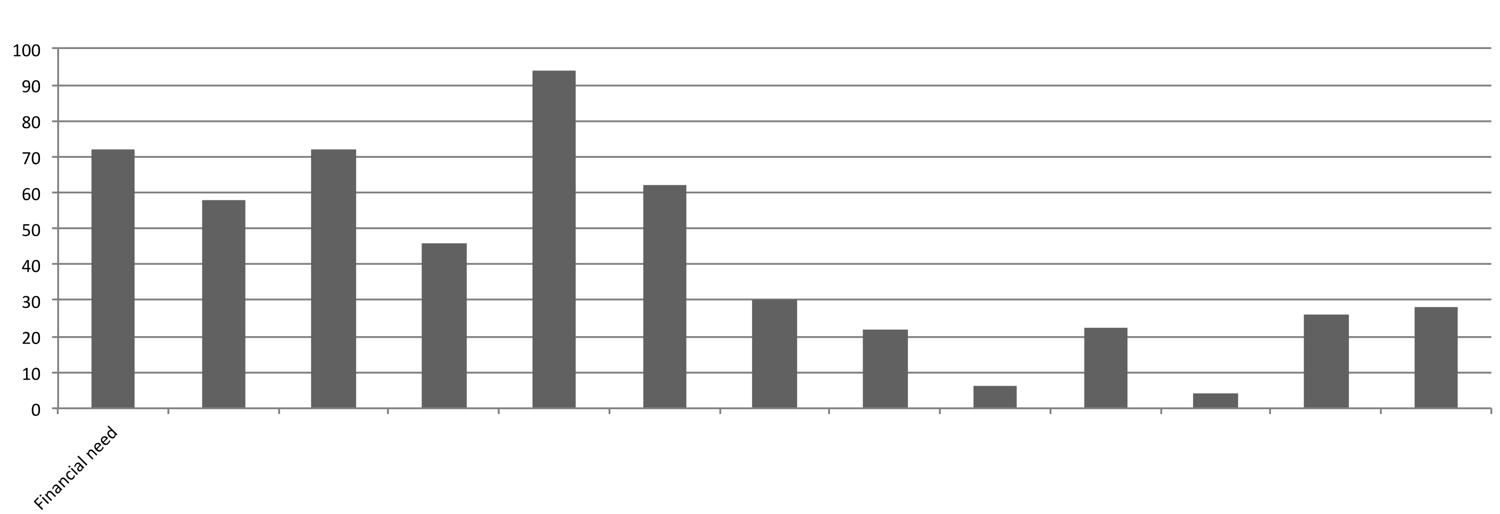
Identify hospital-level factors that affect the availability and delivery of palliative care in the ED

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



the *NEST-13*.

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, $p<0.05$)

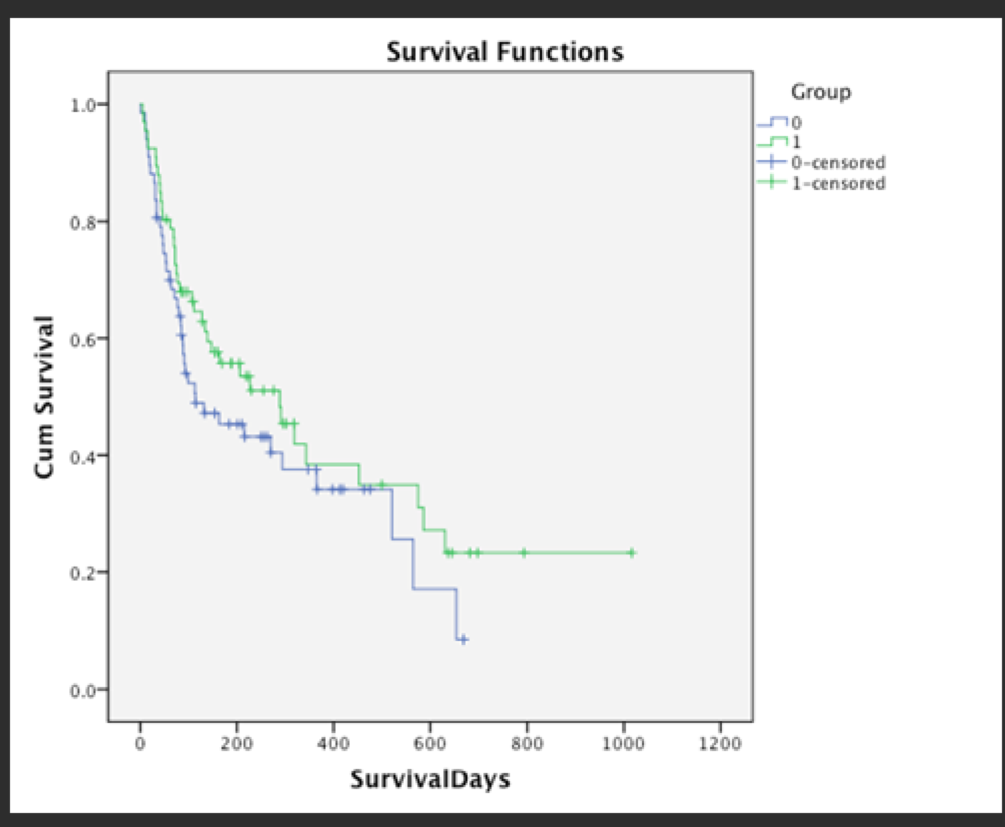
Health Care Utilization

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 (EMPallA)

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

Patient Quality of Life	FACT-G[53]	Patient interview	0, 12 weeks, 6 months*, 12 months
ED Revisit	Count	Administrative claims and self-report[59]	Up to 12 months from enrollment
Inpatient Days	Count	Administrative claims and self-report[59]	Up to 12 months from enrollment
Hospice Use	Yes/No	Administrative claims and self-report[59]	Up to 12 months from enrollment
Loneliness	Revised UCLA 3-item Loneliness Scale (R-UCLA)[57]	Patient interview	0, 12 weeks, 6 months*, 12 months
Symptom Burden	Edmonton Symptom Assessment Scale[58]	Patient Interview	0, 12 weeks, 6 months*, 12 months

Caregiver Outcomes

Caregiver Strain	Modified Caregiver Strain Index[63]	Caregiver interview	0, 12 weeks, 6 months*, 12 months
Caregiver Quality of Life	CarerQol[65]	Caregiver interview	0, 12 weeks, 6 months*, 12 months
Bereavement	Inventory of Complicated Grief[66]	Caregiver interview	0, 12 weeks, 6 months*, 12 months

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

UNITED STATES

Clinical Sites

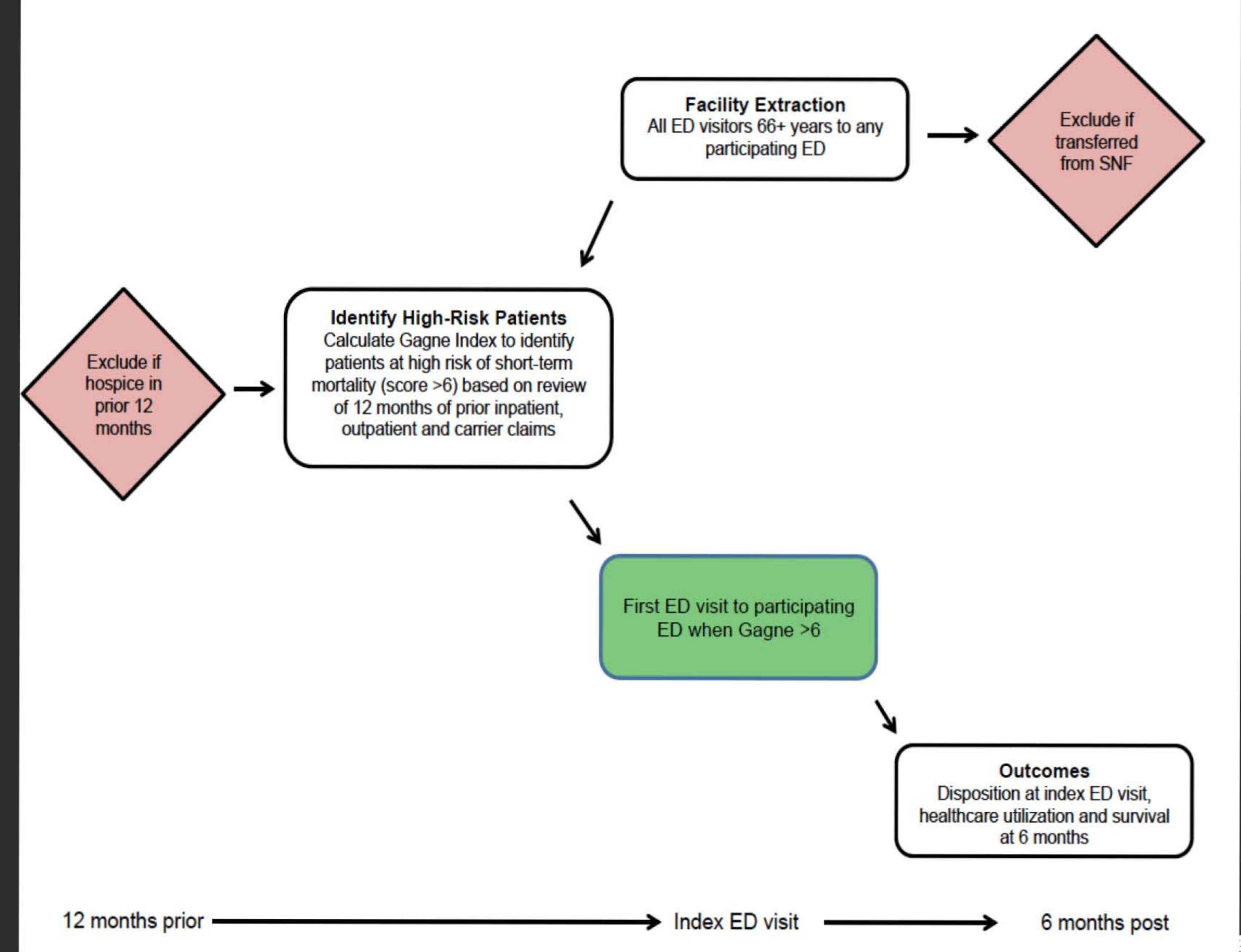
- Allegheny Singer Research Institute
- Baystate Medical Center
- William Beaumont Hospital
- Brigham and Women's Hospital
- Christiana Care Health Service, Inc.
- Henry Ford Health System
- Icahn School of Medicine at Mount Sinai
- Mayo Clinic
- NYU School of Medicine
- Ochsner Clinic Foundation
- Rutgers 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
- YaleUniversity

Cluster Randomized, Stepped Wedge Trial @ 35 EDs

35
30
25
20
15
10
5

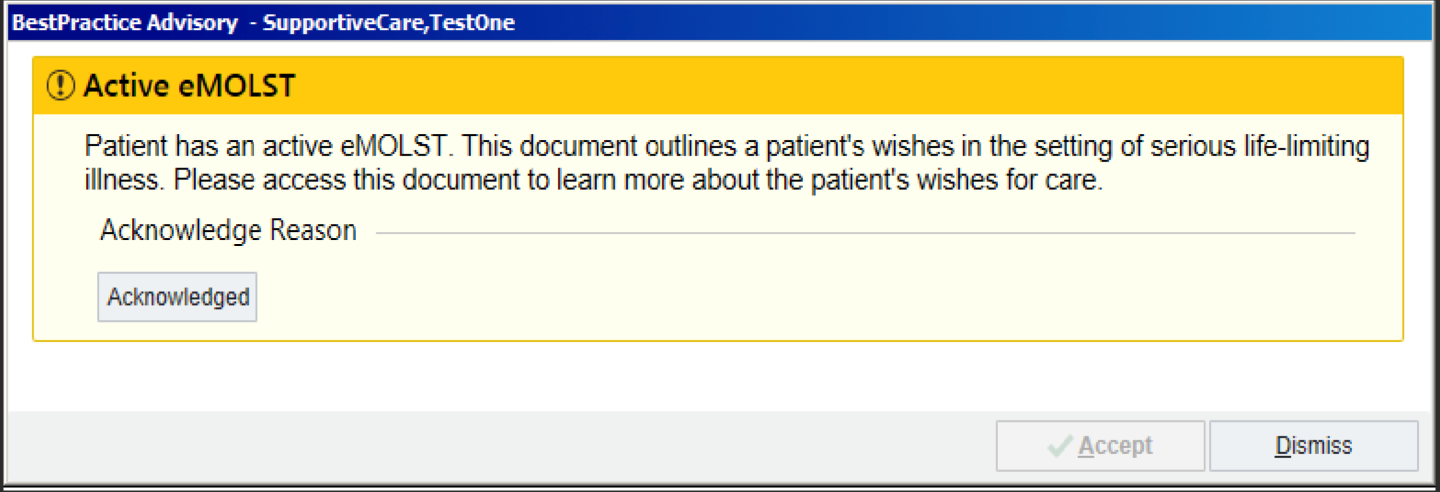
Year 1
Year 2
Year 3

Pre-Intervention
Pilot Test PRIM-ER
Post-Intervention
PRIM-ER Implementation

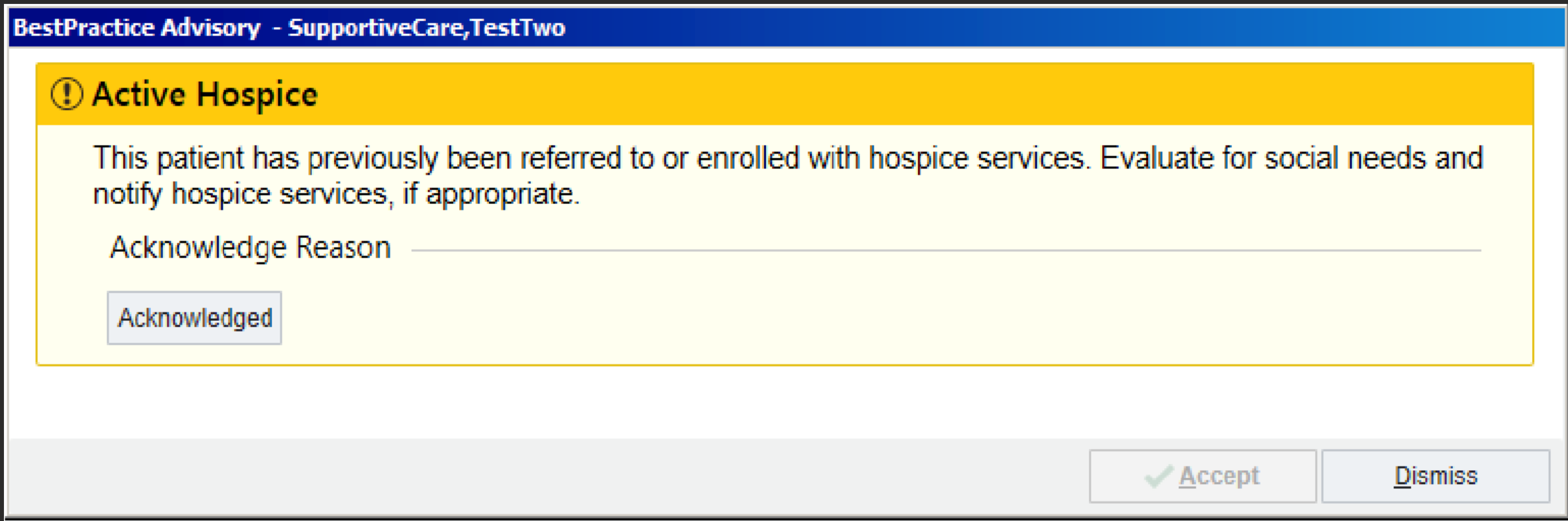

Facility Extraction
All ED visitors 66+ years to any participating ED
Exclude if transferred from SNF
Exclude if hospice in prior 12 months
Identify High-Risk Patients
Calculate Gagne Index to identify patients at high risk of short-term mortality (score >6) based on review of 12 months of prior inpatient, outpatient and carrier claims
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

Clinical Decision Support @ NYU Langone

Function 1. Identify seriously ill patients with advance care planning documents



Function 2. Identify patients on hospice.



Function 3. Refer patients to interdisciplinary services.

BestPractice Advisory - SupportiveCare,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.

BestPractice Advisory - SupportiveCare,TestSixteen

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

Last updated: 7/5/2018 4:10:16 PM

Instructions

January 2017 – June 2018

ED (All)

ED Supportive Care Dashboard

Palliative Care

Palliative Care Orders

Pall consults in ED+Obs

Pall consults in ED

Pall consults in Obs

January 2017 July 2017 January 2018

Care Management

Care Manager Notes

CM notes in ED+Obs

CM notes in ED

CM notes in Obs

January 2017 July 2017 January 2018

Social Work

SW Orders

SW consults in ED+Obs

SW consults in ED

SW consults in Obs

January 2017 July 2017 January 2018

ED disposition of inpatient hospice

of ED -> inpt hospice

January 2017 July 2017 January 2018

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