Increasing Access to Primary Palliative Patient Care and Education in the Emergency Department

Alexandra Donnelly DO, Samita Heslin MD, Grace LaTorre MD

BACKGROUND

- The Emergency Department (ED) is a significant entryway for patients into the hospital and the Stony Brook medical community. It has been reported that nationally, over 75% of adults visit the ED in their final six months of life, and 51% have at least one visit in their last month of life (1). This time frame is a significant financial burden to both the patient and the health care system. More than 24% of Medicare dollars are spent in the last year of life with 50% in the last month (2). As the population ages, more older patients with serious illness are seeking care in the ED. Over the past decade there has been growing recognition of the necessity of palliative care services within the ED. With early recognition of a patient's palliative needs, there has been reported significantly decreased hospital LOS for patients with palliative care consultation in the ED (3). Given that ED providers are often needing to focus on life-saving, intensive interventions, it is a difficult timeframe to address patient wishes. Not all ED providers are familiar and comfortable with initiating Goals of Care (GOC) discussions and palliative care consults (4).

OBJECTIVES

- Determine the most significant barriers to palliative care in Stony Brook ED.
- Determine target areas of intervention to increase access to palliative care.
- Produce education material to assist residents with palliative care in the ED including:
  - GOC Conversations
  - Code Status Conversations
  - Comfort Care in the ED.
  - Advanced Directives/MOLST forms
- Assess changes in resident confidence regarding palliative care interventions in the ED.

METHODS

I. Needs assessment survey sent to ED residents, fellow, NP/PAs, and Attendings (7/31/23).

A. Questions included provider comfort with GOC conversations, code status conversations, previous palliative education, MOLST form knowledge, and demographic information.

II. Interventions created through the year:

A. July course palliative care introduction session for PGY1 residents (7/26/23).

B. Goals of Care Morning Report (10/18/23).

C. Department Palliative Care Grand Rounds with guest lecturer Dr. Stephanie Tsang (11/2/23).

D. Palliative Care Consult Screening Tool to create a targeted early consult screen for patients in the ED that meet specific criteria for earlier intervention. (See top right of poster).

E. Small Case Discussions during Academic Conference (5/16/24) regarding code status, death of a loved one, comfort care, health care proxy and MOLST forms with the 21 residents present.

III. Data Analysis from Small Case Discussions (5/16/24):

1. Likert scale questioning used in both pre- and post-intervention small case discussion surveys.
   A. Range of 1-5. 1:Strongly Disagree, 2: Somewhat Disagree, 3: Neutral, 4: Somewhat Agree, 5:Strongly Agree
2. Pre-and post-intervention survey results were compared using Fisher's Exact test. Both surveys were completed the day of the session.

RESULTS

The Needs Assessment identified residents as having the broadest of answers regarding comfort level with GOC conversations, code status conversations, and basic knowledge regarding palliative care at Stony Brook. Interventions became directed toward resident education.

Figure 1: Residents' 1st, 2nd, and 3rd Priorities Summarized from 7/31/23 Needs Assessment for Improving Palliative Care in our ED.

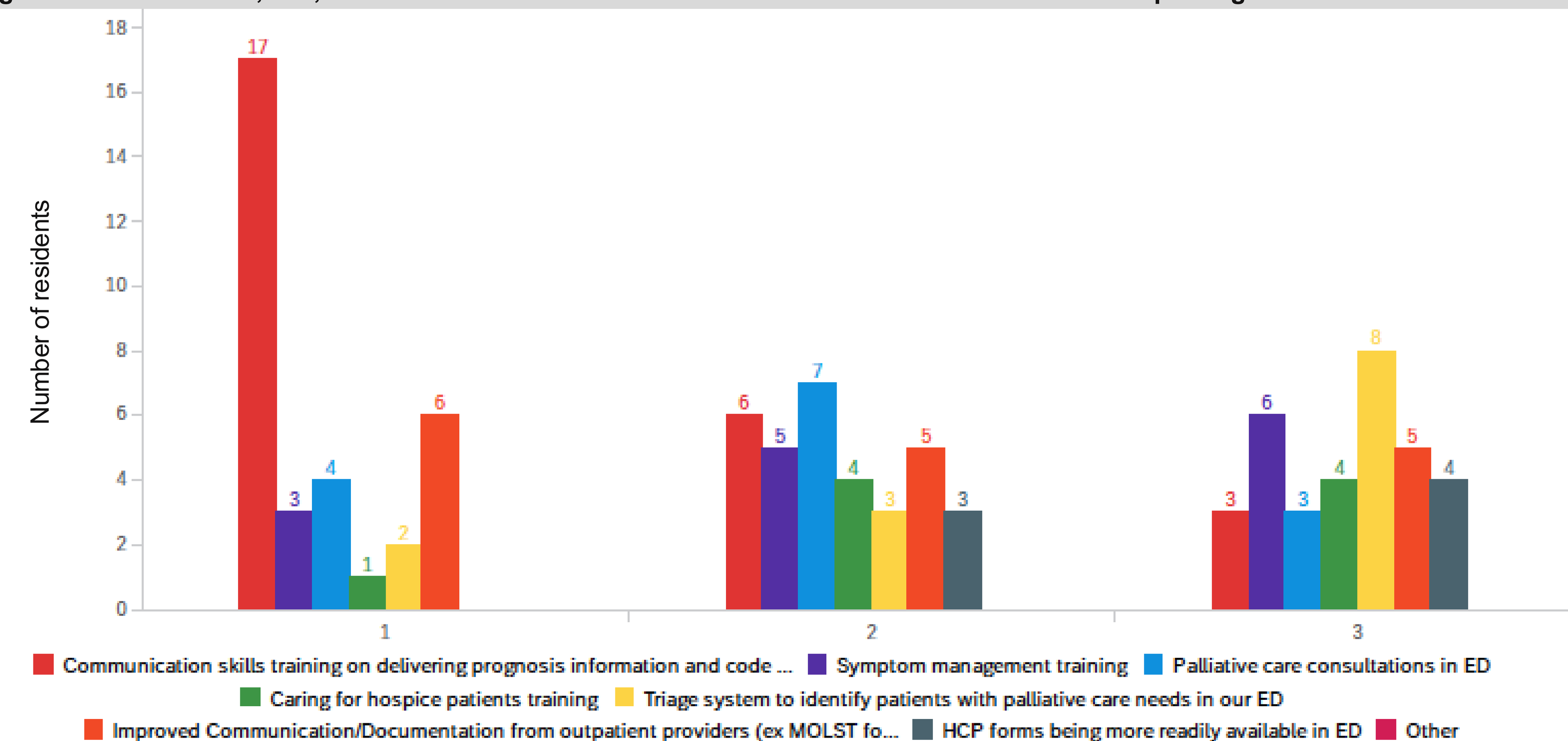
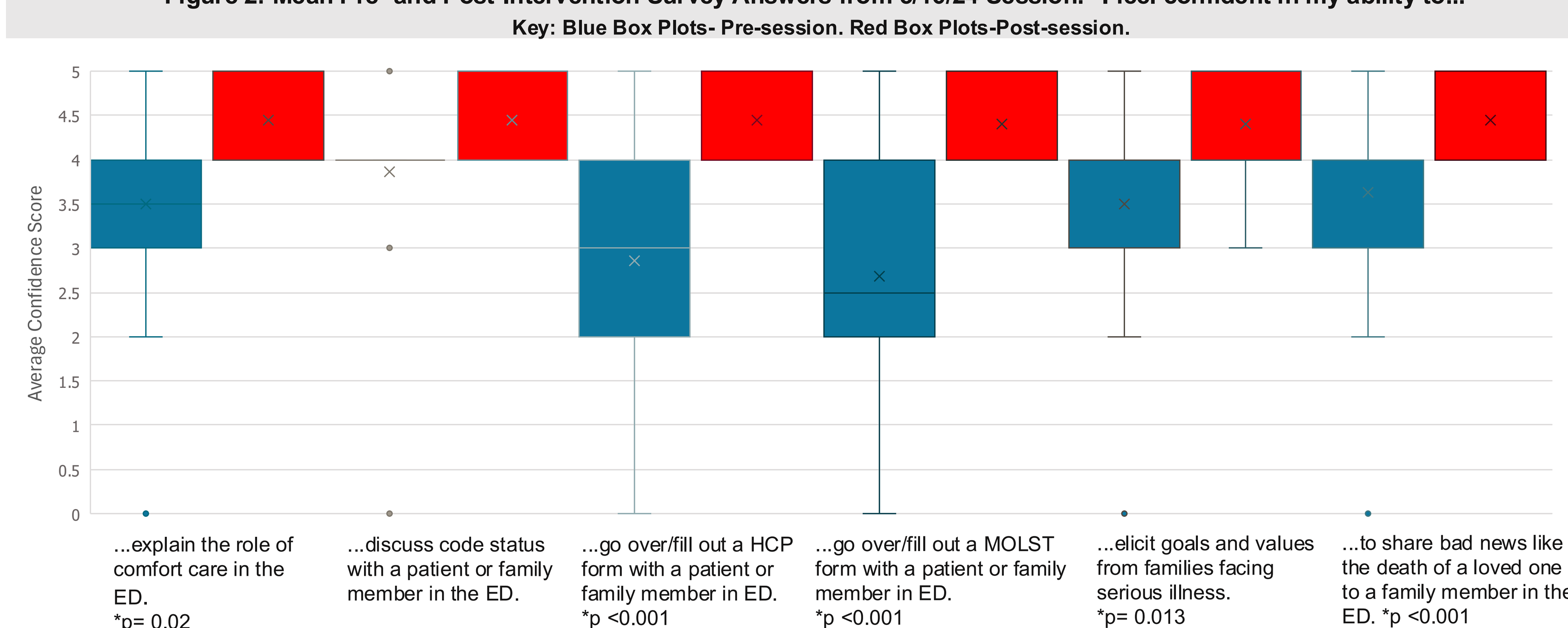


Figure 2: Mean Pre- and Post-Intervention Survey Answers from 5/16/24 Session. "I feel confident in my ability to..."
Key: Blue Box Plots- Pre-session. Red Box Plots-Post-session.



DISCUSSION

- Dedicated time for palliative care focused initiatives in the ED is vital for improved patient care and provider comfort with palliative care conversations, especially for residents in training.
- The 5/16/24 session reflected that with dedicated time for breaking down a multitude of difficult conversations, residents feel more comfortable to perform these tasks on shift. These conversations include comfort care, HCP forms, MOLST forms, goals and values in the face of serious illness, and the death of a loved one.
- There was no statistical significance in the discussion of code status conversations, as this may reflect a task residents perform more often on shift.
- The pre- and post- interval survey results while positive in nature, are limited, given less of half of the residency program was able to attend in given the conference time.
- Commentary from residents from the 5/16 session:
  - "Very useful session, there is a lot of room to include palliative care principles and skills in the ED that we do not often receive formal education on."
  - "Filling out MOLST forms feels less scary after this."
  - "Very helpful on creating a framework for these difficult conversations."

Stony Brook ED Palliative Care Consult Screening Tool

STEP 1: Determine if your patient has at least 1 life-limiting illness:	
Advanced Dementia or **CNS Disease** (ex CVA, ALS, Parkinson's)	**Advanced COPD** (continuous home O2, chronic dyspnea at rest)
Advanced Cancer	**End Stage Renal Disease**
Advanced Heart Failure	**End Stage Liver Disease**
Septic Shock (requires ICU admission and has significant pre-existing comorbid illness)	High Chance of **Accelerated Death** at **Provider Discretion** (ex: major trauma in elderly, advanced AIDs, failure to thrive)

STEP 2: Does your patient have at least 1 of the following:	
"Surprise" Thought	You would not be surprised if the patient died in **this** hospital admission.
No Advance Directives	Reviewed patient's EMR: Advanced Directives tab and/or presenting transfer paperwork with no documentation of treatment preferences or formal advance directives (MOLST, living will, out of hospital DNR, HCP) in the setting of progressive serious/life-threatening illness.
Known to Palliative Care Service	Patient has had a previous palliative care evaluation per EMR. Patient has previously been followed by the palliative care team while hospitalized or in the outpatient setting.
Progressive Functional decline	Ex: Loss of mobility, frequent falls, decreased oral intake, skin breakdown, decreased mental status.

STEP 3: Describe the clinical context/need for the palliative care consult.	
Example:	Description:
Frequent Visits	2 or more ED visits or hospitalizations in the past 3 months.
Uncontrolled Symptoms	Visit prompted by uncontrolled symptoms related to the patient's serious/life-threatening illness (Ex: agitation, pain, respiratory distress, agonal breathing, depression, fatigue)
Challenging GOC discussion	Despite initiation of goals of care (GOC) discussion, a plan of care cannot be formulated in line with patients goals or wishes, or concern for no clear goals/preferences

FUTURE PLANS

- Data collection of Palliative Care Consults in the ED and patient outcomes over 6 month blocks pre- and post-consult screening tool intervention in April 2024.
- Creation of a SIM-guided Emergency Medicine focused Palliative Care communication training session for residents.

REFERENCES

- (1) Smith AK, McCarthy E, Weber E, et al. Half of older Americans seen in emergency department in last month of life; most admitted to hospital, and many die there. *Health Aff (Millwood)*2012; **31**: 1277– 85.
- (2) Aldridge MD, Bradley EH. Epidemiology and patterns of care at the end of life: rising complexity, shifts in care patterns and sites of death. Health Aff. (Millwood) 2017; 36: 1175– 83.
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- (4) George, Naomi, et al. Past, present, and future of palliative care in emergency medicine in the USA. Acute Medicine and Surgery 2020; 7.