Beyond Code Status: Palliative Care Begins in the Emergency Department

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PALLIATIVE CARE IS INCREASINGLY RELEVANT TO THE SCOPE OF EMERGENCY MEDICINE

The aging US population is increasingly dying from chronic rather than acute illnesses. By 2030, 1 of every 5 Americans will be older than 65 years.[1] Advances in management of acute illnesses have helped more patients now live long enough to develop end-stage organ disease, cancer, and dementia. With increasingly complex medical needs, these patients present to their emergency department (ED) with challenging complaints such as functional loss, bounce-back visits for uncontrolled symptoms, and caregiver fatigue.[2] Moreover, these visits point to a gradual decline that is often missed as a result of the usual focus on diagnosis and disposition. Patients may present their needs through subtle commentary (Table 1) that may be readily overlooked as subacute or social issues. However, although these concerns do not appear immediately actionable, early palliative intervention directly affects patients' quality of life and downstream use of the health care system. Emergency physicians encounter but may not recognize palliative care–eligible patients far earlier than their terminal admission.

PALLIATIVE CARE STARTS WELL BEFORE THE END OF LIFE

Despite increasing interest, there remains significant heterogeneity in emergency provider understanding of what is meant by the phrase "palliative care."[3] Similarly, 90% of Americans have little to no knowledge of palliative care, but when read a simple definition, they would want early palliative care for themselves and their loved ones.[4] Palliative care comprises an interdisciplinary team to provide relief to patients and their families from the symptoms and stress of incurable illnesses throughout the entire disease course. Although hospice and comfort care are subcomponents, palliative care adds significant value well before the final days of life. The best results are enjoyed when palliative care begins serving patients at their initial diagnosis of life-limiting illness (Figure 1), continuing along with their treatments from other specialists and taking on a greater role as their disease progresses. Palliative care teams preemptively address advanced care planning, caregiver needs (eg, housing, resources), streamlined communication between disparate provider teams, psychosocial support, and introducing hospice at the earliest opportunity to benefit. Through these channels, they provide an extra layer of support to ensure that the continuum of care is congruent with the patient's life goals.[5] Effective palliative care is a parallel process, not a handoff.

PALLIATIVE CARE IS A WIN FOR EMERGENCY MEDICINE AT A SYSTEMS LEVEL

With the Patient Protection and Affordable Care Act, health care systems are searching for innovation to curb spending without compromising quality of care. Recognizing the stewarding role that emergency medicine plays in health care use, in 2013 the American College of Emergency Physicians (ACEP) prioritized earlier access to palliative care as one of its top 5 measures in the Choosing Wisely campaign to reduce undesired and unnecessary medical treatments.[6]

Early palliative care is a win-win for patients and health care systems. EDs are an opportune entry point into the palliative care continuum. During the last 5 years, a large body of research has shown that early integration into palliative care reduces ED visits and hospitalizations by up to 50%.[7-10] This has been corroborated across community, academic, and county practice settings, as well as in diverse disease populations. Even for admitted patients, initiating a palliative care consultation directly from the ED (versus later as an inpatient) shortens length of stay by an average of 4 days, resulting in fewer inhospital deaths[11] while significantly increasing quality of life without reducing overall survival.[12] A 2014 meta-analysis estimated that palliative care consultation reduced hospital inpatient costs by 10% to 30%.[13]

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Table 1. How palliative care needs may present in the ED.

Palliative Care Domains	How Patients May Voice Their Needs	Benefit to Early Identification
Goals of care	"Mom never mentioned her wishes…. We want everything done."	Early patient engagement to create a care plan that honors their goals and values before presenting to the ED in extremis
Symptom control (eg, pain, nausea, dyspnea, delirium)	"I'm afraid to eat because of the constipation."	Achieving adequate outpatient symptom control to obviate ED revisits and admissions
Functional status	"You said this is not life threatening, but I can't live like this at home."	Early preparation and resource mobilization to anticipate transitions to higher levels of care (eg, caregivers, facilities)
Psychosocial support (eg, caregiver fatigue, faith crises)	"I've been spending all day with Dad, trying to manage my job and the kids."	Providing longitudinal support to patient, family, and caregivers through emotional, spiritual, and cultural channels
Hospice	"No way. We're not giving up yet."	Demystifying and destigmatizing hospice; early use not necessarily incompatible with some treatment plans

These financial implications are affecting downstream incentives for emergency physicians. In a shifting reimbursement landscape, hospitals are keen to minimize 30-day readmissions because these become unreimbursed care in the transition to bundled payment models. Many hospital budgets operate within a 2% to 4% profitability margin,[14] and Medicare readmission penalties may reduce revenues by 3%.[15] Given this slim buffer, there will be increasing scrutiny and effort on diverting readmissions. By proactively connecting eligible patients with early palliative care and thereby reducing ED revisits and hospital readmissions, emergency physicians continue to project their value in the health care system while enabling patients to receive treatment congruent with their goals of care.

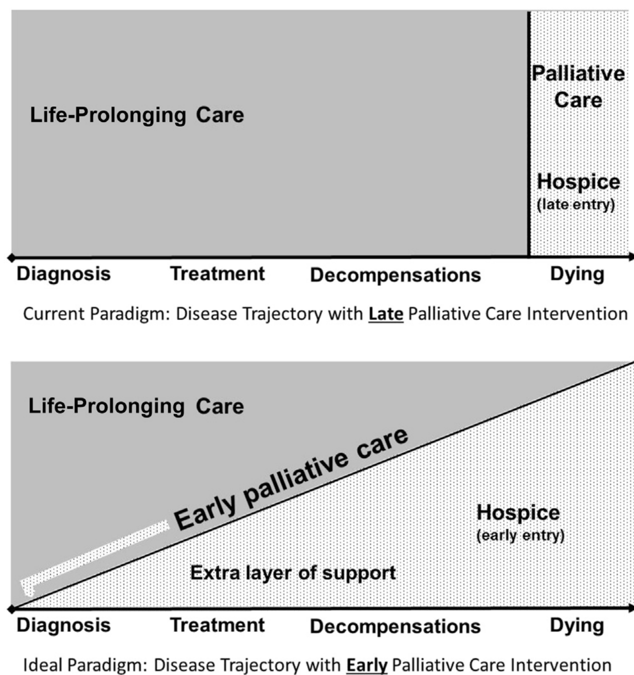

Figure 1. Reconceptualizing palliative care as a continuum of support.

PALLIATIVE CARE EDUCATION IS NEEDED FOR ALL EMERGENCY PHYSICIANS REGARDLESS OF EXPERIENCE

The anticipated gap between the need for and supply of palliative care providers is rapidly widening. There may never be a sufficient volume of fellowship-trained palliative physicians to deliver palliative care to all comers.[16] Fortunately, most patients do not necessarily require skilled "secondary palliative care" around complex ethical issues and symptom management. As highlighted in the 2015 Institute of Medicine report, most patients' palliative needs can and must be addressed by medicine's frontline providers.[17] Emergency physicians must now develop "primary palliative care" expertise unique to their practice climate.

Whenever a new domain of practice such as palliative care is introduced into emergency medicine, there are no preexisting content experts. Therefore, increasing years of clinical experience do not necessarily translate into advanced knowledge and skills. Even in teaching institutions, the traditional model of knowledge transmission from attending physician to resident may be insufficient because both are learning groundbreaking developments in tandem. A recent academic center survey demonstrated that a significant majority of attending physicians and residents believe palliative care to be an essential core competence for their practice and desire additional training. However, attending physicians do not report any greater ability or comfort with managing palliative care patients in the ED than senior residents.[18] Although a majority of emergency medicine training programs teach and identify palliative care as a core competency, they also report that the absence of experienced faculty is the most significant educational barrier.[19]

Both emergency providers and out-of-hospital personnel would also benefit from greater education on interpreting the myriad of advance directives, including state-specific Physician/Medical Orders for Life Sustaining Treatment

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