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Brief Report

IDENTIFYING ADVANCED ILLNESS PATIENTS IN THE EMERGENCY DEPARTMENT AND HAVING GOALS-OF-CARE DISCUSSIONS TO ASSIST WITH EARLY HOSPICE REFERRAL

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Abstract—Background: The emergency department (ED) is often where patients with advanced illness (AI) present when faced with an acute deterioration in their disease. **Objectives:** To investigate the effectiveness of our AI Management program in the ED on key outcomes. **Methods:** We conducted a pre-post study with a retrospective chart review with ED patients at an academic, tertiary care hospital in the New York metropolitan area. We assessed changes from baseline to intervention period on percent of patients identified in the ED with AI, percent who received an ED-led goals-of-care (GOC) discussion, and percent referred to hospice from the ED. We used the Fisher's exact test or the Mann-Whitney test to compare groups, as appropriate. **Results:** Our sample consisted of 82 patients (21 baseline and 61 intervention). Patients in the baseline period had a median age of 75 years, with 61.9% being female, whereas those in the intervention period had a median age of 83 years, with 67.2% being female. Patients in the intervention, compared with baseline, were significantly more likely to be identified as having AI in the ED (90.2% vs. 0.0%; $p < 0.0001$), to receive an ED-led GOC conversation (83.6% vs. 0.0%; $p < 0.0001$), and to be discharged to home hospice (39.3% vs. 0.0%; $p < 0.0001$). **Conclusions:** The ED provides a critical opportunity to identify AI patients, have ED-led GOC discussions, and refer appropriate patients to hospice. © 2017 Elsevier Inc. All rights reserved.

Keywords—advanced illness; goals-of-care discussions; early hospice referral

INTRODUCTION

Background

The emergency department (ED) is often the first place where advanced illness (AI) patients near the end of life present when faced with an acute deterioration in health. AI patients enter the ED seeking relief from incapacitating symptoms that cannot be appropriately controlled at home, in an assisted-living facility, or in their primary care physician's office. In the ED, AI patients are likely to receive aggressive, life-prolonging therapies, which may be in direct conflict with their wishes (1). Although the ED is not the optimal setting for relieving pain and suffering at the end of life, for many AI patients, this is the place where they die (2).

Palliative care medicine is an emerging specialty that aligns patient goals of care (GOC) with management focusing on quality of life at all stages of the disease process. Providing palliative care in the ED has become an area of growing research interest given that as many as half of patients over the age of 65 years are seen in

the ED in their last month of life (2). As the population continues to age, and new and more advanced life-sustaining therapies for illnesses are being developed, EDs will face even larger proportions of patients at the end of life. An opportunity exists in this setting to approach patients and families with GOC discussions and refer appropriate AI patients to hospice care directly from the ED. These practices have the potential to improve the quality of life for terminally ill patients and decrease the risk that they receive burdensome, often futile and increasingly expensive treatments.

Unfortunately, for many palliative care-eligible patients admitted through the ED, a palliative care consult (PCC) is not initiated by the ED provider and occurs days after admission (3). Thus, hospitals are beginning to start programs to provide PCC early in the ED, rather than later in the hospitalization. Research shows that early PCC in the ED improves outcomes, patient and family satisfaction, and decreases inpatient length of stay (LOS), costs, and hospital utilization (4–9). A 2016 systematic review found that only five studies investigated the relationship between ED-based palliative care interventions and patient outcomes (10). The authors noted the urgent need to conduct more AI research in the ED setting.

Goals of this Investigation

The principal objective of this study was to investigate the effectiveness of our AI Management program in the ED on the primary outcomes. Specifically, we sought to assess whether: 1) the percent of patients identified with AI in the ED increased from the baseline period to intervention period; 2) the percent of patients who had GOC conversations in the ED increased from the baseline period to intervention period; and 3) the percent of patients who were referred to home hospice from the ED increased from the baseline period to intervention period.

MATERIALS AND METHODS

Study Design

We used a pre-post design with a retrospective chart review to investigate the impact of our AI Management in the ED program. Our Institution Review Board provided approval under expedited status (IRB #: 15-027). Our sample consisted of ED patients at a large academic tertiary care hospital in the New York metropolitan area. Baseline period was from November 2013 to December 2014, and the intervention period was from January 2015 to February 2016. A well-trained project manager experienced in chart review methodology abstracted data from charts. Patients were identified

by ED case management when they met AI criteria. The project manager was provided with explicit criteria for case selection and definitions of important variables. The project manager reviewed charts for demographic and clinical information such as age, presenting symptoms, diagnosis, do-not-resuscitate (DNR) status, LOS if admitted, and number of hospital visits in the last 6 months.

Outcomes

Our primary outcome variables were: 1) percent of patients identified in the ED as having AI; 2) percent of patients who received an ED-led GOC discussion; and 3) percent of patients referred to hospice from the ED.

Interventions

The goals of the program were to screen ED patients for AI, provide ED health care providers with training to have GOC discussions, conduct ED-led GOC promptly, and develop a safe discharge to hospice for appropriate patients. An interdisciplinary team consisting of nurses, emergency and palliative care physicians, social workers, case management, quality, and administration was formed and met bi-weekly during the study period. The team utilized the ED electronic medical record (EMR) re-admission trigger tool, which is a simple procedure created to facilitate hospice directly from the ED. ED staff, led primarily by a physician, conducted GOC discussions that lasted, on average, 10 min. The interdisciplinary team documented the GOC discussions in the EMR. Case management/social work was available 12 h per day, and palliative care faculty was available to the ED providers for support. We displayed posters prominently throughout the ED for contact information. [Figure 1](#) presents the hospice referral algorithm. We defined AI as one or more medical conditions, which become severe to the extent that health and functioning worsen, and treatments begin to lose their impact. Specifically, patients were not expected to survive more than 6 months, or any AI with organ failure, advanced or metastatic cancer, more than one readmission in 3 months, weight loss of > 10% or albumin < 2.5, rapid decline in activities of daily living or other AI such as dementia or chronic obstructive pulmonary disease with survival < 6 months.

Analysis

We calculated descriptive statistics separately for each group (median, 25th and 75th percentiles for continuous variables; frequencies and percentages for categorical variables). We used the Fisher's exact test to compare

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