PALLIATIVE CARE IN THE EMERGENCY DEPARTMENT

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Emergency Medicine

Learning Objectives:
- How do the fields of Emergency Medicine and Palliative and Hospice Care merge?
- Many patients who present to the Emergency Department have never had palliative or hospice care needs addressed or met.

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Palliative Care in the E.D.

Strange Bedfellows?
OR: A Marriage Made in Heaven?

I Submit to You:

IT’S BOTH!

Exactly how are E.R. Doctors Wired?
• We LOVE an adrenaline rush
• We LOVE to resuscitating and stabilizing
• We LOVE intubating, putting in chest tubes and central lines
• We LOVE procedures like L.P.s, reducing fractures and dislocations, and removing foreign bodies
• We LOVE being diagnostic sleuths
• We LOVE to SAVE LIVES

• We HATE missing a diagnosis
• We HATE unsuccessful resuscitations
• We HATE a full waiting room
• We HATE obstacles to doing our job
• We HATE being unable to “fix” a patient
• We HATE “giving up” and losing a patient – This patient is not going to die on my watch, on my shift!

• We reluctantly accept that we can’t fix stupid
• We reluctantly accept that we cannot mend society’s ills, such as domestic violence, lack of education, substance abuse, homelessness, lack of access to care, unemployment, and dysfunctional relationships. However, we take comfort in providing episodic care to many patients who fit the above description(s).
What does the average Emergency Physician in America know about Palliative/Hospice Care?

NOT A WHOLE HECK OF A LOT!

But then again...I am not your “average” E.R. Doc...
My (only) Hole-in-One!

We See Ourselves as Pilots of a Commercial Aircraft
So I ask myself:

Well, how did I get here?

How did I develop an interest and passion for Palliative and Hospice Care?
1. The face of Emergency Medicine has changed.

2. My beloved late mother, Sarona Molk.

The Face of Emergency Medicine has Changed:

• Patients have become sicker, disease processes more complex, we have an aging population, and multiple patients with numerous co-morbidities
• Too much being done for too many patients with poor quality of life for too long
• Result? Mere “prolongation of the inevitable” at enormous cost, with loss of human dignity and worsening of quality of life
• I began to realize that much of what we are doing is morally wrong, inhumane, unkind and not even good care

The Face of Emergency Medicine Has Changed:

• THE ED HAS BEEN IDENTIFIED AS A CRITICAL OPPORTUNITY/SITE OF PALLIATIVE AND HOSPICE CARE INTRODUCTION AND DELIVERY
My Beloved Mother, Sarona Molk

• Our journey with Alzheimer's Dementia.

I was identified by some of the leaders in Banner as someone who could champion the Palliative and Hospice initiative. I was sent to two educational conferences (EPEC and CAPC).

WHAT IT’S NOT:
“PULLING THE PLUG”

EUTHANASIA

DEATH PANELS
WHAT IT IS:

- Compassionate care for patients and families who are suffering
- Emphasis on symptom management
- Team approach
- Addressing goals of care
- Respecting patients’ wishes

It is that branch of medicine committed to relieving debilitating symptoms and improving quality of life for people facing serious illness.

It is independent of prognosis and can be delivered along with curative treatment. Goals are to relieve physical and emotional suffering.
What Can a Palliative Care Team Look Like?

- ED DOC(S)
- IN PATIENT PALLIATIVE CARE SPECIALIST
- TRANSITIONALIST
- HOSPITALIST REP
- NURSE MANAGER
- QI
- CMO AND CFO
- CASE MANAGERS/SOCIAL SERVICE REPS
- IT
- HOSPICE NURSE
- LEGAL
- FAMILY MEMBER WHO USED PALLIATIVE CARE/HOSPICE FOR A LOVE ONE
- SPIRITUAL CARE/CHAPLAIN
- OUTPATIENT PALLIATIVE CARE REPRESENTATIVE

Palliative care is about matching treatment to patient goals

Palliative Care Goals

- Specialized medical care for people with serious illness
- Provides relief from symptoms
  - pain, nausea, vomiting, anxiety, agitation, dyspnea, constipation
- Improves quality of life
- Provided by a team that works with the physician in charge to provide an extra layer of support
  - e.g. Doctors/nurses/social work/PharmD and other specialists
- Appropriate at any age and at any stage in serious illness
- Provided along with curative treatment
Hospice

- Paid Medicare benefit for patients with a prognosis of six months or less
- Indications for referral similar to those for palliative care
- Biggest compliant that hospice nurses have is that they wish the patient was referred sooner
- ALL IT TAKES IS A CALL TO HOSPICE – the social workers will do it for you! They are on board.

Hospice

- Certainly an important component of PC, but it is only one component.
- It is the one component that the lay public can identify.
- It is underused and moreover, most referrals are delayed until death is imminent.
- One component of PC we as EDP’S can promote and use more frequently with minimal infrastructure.

ALL IT TAKES IS............

TO CALL HOSPICE!!!!!!
At this early stage Hospice is truly the “low hanging fruit”
Examples of Conditions that could Benefit from Palliative/Hospice Care:

“No Brainers/Low-Lying Fruit”

- Advanced/Metastatic Cancer
- Advanced CHF
- Advanced COPD
- Advanced ESRD (on dialysis for years, with other co-morbidities)
- Advanced AIDS
- Advanced Dementia/Alzheimer’s/Failure to Thrive
- Advanced end stage liver disease
- Serious neurological disease (e.g. ALS/M.S.)

Challenges and Barriers to Embracing Palliative and Hospice Care:
We are at the crossroads of several initiatives and requirements, some of which are diametrically opposed to each other

Barriers

- Lack of familiarity
- No formal training during medical school/residency training
- LACK OF TIME
- We do not see it as “our job”
- Fear of litigation
• We are married to our “Loves” and “Hates” (see above)
• We need a culture change – change is hard!
• We need to educate and enlighten.
• We need buy-in from E.D. providers and many other specialists.
• We lose sight of the fact that life has a beginning, middle, and an end.

Patient/Family Barriers
• Expectations of medical miracles and cures
• Treating physicians give false hope and expectations
• INABILITY TO SAY GOODBYE
• Little/no knowledge of the existence or benefits of Palliative/Hospice care

SOMETIMES SAYING GOODBYE IS THE GREATEST ACT OF LOVE
Physician Barriers

• Most providers have little/no Palliative Care skills.
• We see death as the ultimate enemy and when a patient dies, we feel like failures.
• ED Providers: “This patient is not going to die on my shift, on my watch, under my care, in my area – if he/she is going to die, it will have to be in the ICU”

Physician Barriers Cont.

• Many specialists have a financial interest in keeping patients alive for as long as possible and too caught up in aggressive/often futile treatment
• Concerns that referring patients for Palliative/Hospice care can result in litigation- No evidence to substantiate this!
• P.S.: Nurses and social workers are NOT a problem here. They “get it.”

Physician Barriers Cont.

• We already have so much on our plate...To mention but a few:
Benchmarks, initiatives, core measures, metrics, and protocols:

- Door-to-doc
- LOS
- PERC Criteria for Ddimer or CT Angio
- Atraumatic headache initiative
- Pediatric order sets and metrics: Appendicitis, Bronchiolitis and Asthma
- High Risk Entities
- Chest Pain/STEMI Protocol
- Stroke Protocol
- Stroke/TIA: Document why tPA
- Pneumonia
- Restraint orders and documentation
- Severe sepsis/Sepsis Bundle
- Patient Satisfaction

Social workers and nurses are KEY

- MANY OF THE PRESENTATIONS AT CAPC WERE GIVEN BY SOCIAL WORKERS AND NURSES
- SOCIAL WORKERS IN PARTICULAR ALREADY HAVE TRAINING IN PC-MANY PC PROGRAMS ARE RUN BY THEM! THEY “GET IT”
- GETTING NURSES TO “BUY IN” SHOULD NOT BE A PROBLEM-HAVE ALREADY SPOKEN TO SEVERAL AND THEY ARE ALL FOR IT! WILL DO IN-SERVICES TO LET THEM KNOW WE ARE SERIOUS AND TEACH THE HOW TO IDENTIFY POTENTIAL PC PATIENTS

ACEP Recommendations:

“HOT OFF THE PRESSES!”
The ACEP board of directors approved the following 5 Choosing Wisely recommendations for patients seen in the emergency department:

For patients with minor head injury who are deemed to be at low risk for skull fractures or hemorrhage, based on validated decision rules, clinicians should avoid head computed tomography scans. The majority of minor head injuries do not result in brain hemorrhage.

For stable patients who can urinate on their own, clinicians should avoid placing indwelling urinary catheters for either urine output monitoring or patient or staff convenience.

For patients with uncomplicated skin and soft tissue abscesses successfully treated with incision and drainage, clinicians should provide adequate medical follow-up but avoid antibiotics and wound cultures.

For children with mild to moderate, uncomplicated dehydration, clinicians should avoid giving intravenous fluids before a trial of oral rehydration therapy.

For patients likely to benefit from palliative and hospice care services, clinicians should not delay in engaging such services when available. Early referral from the emergency department can improve quality, as well as quantity, of life.

How have I been trying to accomplish this?

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Summer Geriatrics Interprofessional Conference - - Palliative Care: State of the Art & Art of the State
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- By presentations at new provider orientation
- By email
- By example
- By reinforcement
- By frequent reminders
- By educating nurses and social workers in the E.D.
- By inviting experts to give talks to our providers
- By inviting myself to other departmental/subspecialty meetings and informing them of our E.D. objectives
- By meeting with and rounding with the Palliative Care Team

By teaching my colleagues about “Having the Conversation” about the birds and the bees of Palliative and Hospice Care.

Helpful Catchphrases/Conversation Starters
- It seems to me that you/your dad/your mom are having a really difficult time/ are suffering.
- Do you have a good understanding of your/his/her current condition?
- Would you like to talk about it?
- What are his/her/your wishes?
- If you had your choice, would you prefer to go home rather than say in the hospital?
- Would you like more help to relieve all your symptoms?
Helpful Catchphrases/Conversation Starters

• Your mom/dad/family member is not doing well and is in serious/critical condition. I cannot predict how things will turn out. If you/he/she prefer, we can continue to treat aggressively for 48 to 72 hours and then reassess the situation.
• Do you and your family need more support?
• Would you like to know what I would do if it were myself or my family? [BE SELECTIVE ON THIS ONE, BUT OK TO BRING UP IF PT/FAMILY IS LOOKING FOR GUIDANCE]

Data Proven Benefits of Palliative/Hospice Care

• Quality Improvement
• Symptoms
• Quality of life
• Length of life
• Family satisfaction
• Family bereavement outcomes
• Care matched to patient centered goals
• Costs Avoidance
• Hospital costs decrease
• Need for hospitalization/ICU decreases
• Maintenance of dignity
• Dignified death

FACT AND CHALLENGE

• FACT: WE ALREADY DELIVER EXCELLENT SHORT TERM PALLIATIVE CARE IN THE ED!
• CHALLENGE: TO IDENTIFY THOSE PATIENTS IN NEED OF LONG TERM PALLIATIVE CARE AND GET THEM ENROLLED IN A PROGRAM.
• Astonishing and disproportionate amount of health care dollars spent in the last 3-6 months of end-stage illnesses for life sustaining, yet futile care.
• In a very high percentage of these patients, the quality of life is poor and they are suffering

CULTURE CHANGE

* In 2005, over 200,000 people died in the emergency department.
* Many more patients present in the last days, weeks, or months of life. 90% of the respondents to a Gallup survey in 1996 desire to die at home, yet overall nearly 80% currently die in hospitals and institutions.

Changing the culture requires:

• Educational/enlightenment component
• Willingness to accept and embrace Palliative Care
• Understanding that Palliative Care can be excellent, caring compassionate and humane care
Challenges of the Culture Change

• Culture change may be most challenging as it would include ourselves, our colleagues and co-workers, patients, families and yes SOCIETY itself.....
• Accepting that offering a patient and family Palliative Care does NOT imply we are “giving up” on the care of the patient

WE ARE PART OF THE PROBLEM

• WE LOSE SIGHT OF THE FACT THAT LIFE HAS A BEGINNING, A MIDDLE AND AN END
• WE SEE LOSING A PATIENT AS A PERSONAL FAILURE-DEATH IS THE ULTIMATE ENEMY
• THE CONCEPT OF A “DIGNIFIED DEATH” IS FOREIGN TO MANY OF US
• SOME OF OUR COLLEAGUES ARE RELUCTANT TO REFER PT’S FOR PC AS THIS IS LOSS OF $$$ FOR THEM........
• WE HAVE A DOUBLE STANDARD ABOUT OUR END OF LIFE ISSUES VERSUS THAT OF OUR PATIENTS

PALLIATIVE CARE/PATIENT SATISFACTION ANALOGY

WHEN PT SATISFACTION CONCEPT FIRST CAME OUT-WE WERE RESISTANT AND SKEPTICAL UNTIL WE REALIZED THAT THE IDEA WAS IMPORTANT AND UNAVOIDABLE.....OUR CONTRACT WAS AND IS CONTINGENT ON IT......SAME WILL ULTIMATELY APPLY TO PALLIATIVE AND HOSPICE CARE.
WHAT DO PATIENTS/FAMILIES/ THE PUBLIC KNOW ABOUT PALLIATIVE CARE?

- ESSENTIALLY NOTHING! UNLESS THEY HAVE BEEN DIRECTLY EXPOSED TO PC, SURVEYS SHOW THAT ONLY ABOUT 20% OF PEOPLE KNOW ANYTHING ABOUT IT
- HUGE OPPORTUNITY IN THE ED TO INTRODUCE PT’S/FAMILIES TO PC
- MANY OF THEM HAVE HEARD ABOUT “DEATH SQUADS” IN THE NEWS-HAVE TO APPROACH THEM TACTFULLY/APPROPRIATELY

KEY TAKE-HOME POINT

- EVEN IF THEY DECLINE PC AT THE INITIAL INTERACTION, YOU HAVE PLANTED THE SEED
- VERY POSSIBLE/LIKELY THAT AT A FUTURE INTERACTION/VISIT/ENCOUNTER/ADMISSION THEY MAY BE RECEPTIVE
- FUTURE BENEFITS AND COST SAVINGS WOULD BE HUGE
- IF YOU FEEL UNCOMFORTABLE AND THAT ‘WE ARE DOING THIS JUST TO SAVE $”THAT’S OK-SEE PC AS GOOD MEDICAL CARE WITH COST SAVINGS BEING A “BY-PRODUCT”

SPEAKING OF COST SAVINGS.....

- ALREADY STATS OUT THERE THAT VALIDATE THE HUGE COST SAVINGS BENEFIT OF PC
- MORE DATA/LITERATURE COMING WILL CONTINUE TO SHOW THIS
- JUST AS THE “TEMPO” FOR MANAGEMENT OF A PARTICULAR PATIENT IS SET IN THE ED, SO WILL THE TEMPO BE SET FOR PALLIATIVE CARE IN THE ED
- WE CAN NO LONGER SAY “IT’S NOT OUR PROBLEM”
I’ve got news for you:
Legislators are committed to “reducing waste”

Real Life Cases in an Acute Care Area at Banner Good Samaritan and Banner Estrella ED’s:

Speaking of Low Lying Fruit...
8 Real Life Cases in an Acute Care Area at Banner Good Samaritan/Estrella ED’s in just 3 Days:
Case #1:

• 89 Year old female wheeled in from a car in the parking lot cyanotic, near-apneic, and barely responsive.
• She appears markedly cachectic and very frail. Her O2 Sats are 82% and she’s hot to the touch.
• Family unable to obtain any information from patient and family are parking the car, will be in room in three minutes.
• What to do?

Case #1

a) Do nothing. She’s obviously “on her way out.”

b) One of the nurses yells, “When are you going to intubate her?” Ask for the ET tube and laryngoscope and intubate stat.

c) Place her on oxygen, start an IV, make her comfortable, and ask the family what her/their wishes are.

Case #2

• 54 year old male ESLD from Hep C, drug abuse, and ETOH abuse – still drinks.
• Attends the liver clinic
• Recurrent E.D. visits and hospitalizations for ascites, encephalopathy, and upper G.I. bleeds
• Presents again with massive ascites, requests paracentesis
• Daughter feels he is “slipping away”
• WHAT TO DO?
Case #2

a) Just admit him to the hospital and keep the revolving door moving – can’t cure him in the E.D.
b) Call his liver doctor and come up with a better plan.
c) Arrange for paracentesis to make him comfortable.

Case #3

• A 32 year old male is rushed from the parking lot to a treatment room and the nurse yells, “You need to get in here immediately!”
• Patient is extremely emaciated and looks like a concentration camp victim from WWII.
• His BP is 60/30, pulse is 140 and thready, respirations agonal, and his extremities are cool. O2 sats are in the 50’s. He is unresponsive. IV was already established by the nurse and his lactic acid was > 30.

Case #3

• His sister is at the bedside very distraught and tearful. She informs me that he has AIDS.
• I asked about what his wishes are.
• She claims she is his power of attorney, but does not know what his wishes are.
• What to do?
Case #3

a) Begin aggressive therapy for sepsis and hypotension.
b) Start a "slow code"
c) Explain to the sister that the dying process has set in, make patient comfortable and comfort the distraught sister and offer grief support.

Case #4

• 74 year old female with known metastatic ovarian CA
• Recent resection of invasive colon CA with colostomy
• Currently not on chemo or radiation RX
• Just discharged from hospital with acute urinary retention, Foley catheter placed, feels better. WBC elevated, but unchanged.

• What to do?

Case #4

a) Admit and do sepsis workup, her WBC is elevated.

b) Call urology stat – she can’t pee

c) Ask the patient and daughter what they would like.
Case #5

- 65 year old female on hemodialysis for 7 years
- Has had diarrhea for a “long time”
- Doesn’t want to eat
- Significant weight loss
- Missed her dialysis the day before because she felt “too weak to go”
- She appears depressed
- What to do?

Case #5

- a) Call nephrologist stat to arrange for immediate hemodialysis
- b) Call the transplant team
- c) Get a stat psych consult
- d) Talk to the patient/family and ask more questions

Case #6

- 71 year old frail-appearing female
- Recent diagnosis of pancreatic mass and liver mets
- Significant recent weight loss and in pain
- Sent in by an oncologist for inpatient management
- Recent DVT on Xaralto
- She is anxious and tearful
- What to do?
Case #6

a) Call surgery stat for urgent Whipple procedure
b) Get stat chest CT – She might have a P.E.
c) Talk to patient and family about prognosis and goals of care

Case #7

- 88 year old female
- Just discharged 2 days earlier with end-stage CHF
- Now returns to ED with dyspnea
- CXR unchanged
- She is cachetic and fatigued
- She’s accompanied by her daughter
- What to do?

Case #7

a) Call respiratory stat to start her on BiPAP
b) Admit to ICU as her CXR shows CHF
c) Talk to patient and daughter about their wishes/preferences
**Case #8**

- 86 Year old with advanced dementia presents with abd pain, vomiting, and O2 sats of 88%
- ED workup, including CT, nonspecific
- After anti-emetics and O2, she is smiling, looking and feeling better
- Home caregiver and daughter note that they contacted Hospice one year ago, but she was turned down
- **What to do?**

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**Case #8**

a) Get stat surgical consult

b) Get stat GI consult

c) Ask family if they would like us to call Hospice again

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- **There are not enough Palliative Care Specialists to meet our needs**
- Hospitalists, Intensivists, Generalists, ED Providers, and house staff all need to learn some basic Palliative Care skills
What’s Coming Down the Pike:

Development of multifaceted Provider education program to facilitate Primary Palliative Care (current)
- Hospitalist meetings
- Grand Rounds
- Web based education
- Case Management/SW quarterly
- Collaboration Compassionate Care
- ED Providers to be included

There is a plan/vision to create Cross-Continuum Palliative Care Models

• Development of Palliative Care Bundle/Alert/Triggers for EMR (Fall 2014)

• THIS IS GOING TO MAKE OUR JOB A WHOLE LOT EASIER IN THE EMR!!! WOOOHOOO!
Ongoing Educational Challenges

• Getting comfortable in “having the conversation,” i.e. developing primary Palliative Care skills
• **RECOGNIZING THE LAST MINUTES/HOURS OF LIVING**
• **FACILITATING A GOOD AND DIGNIFIED DEATH**
• Conflict Management

Take-Home Points

• Look for the “low-lying fruit”
• Ask patients and families questions like:
  Would they prefer to be hospitalized, or go home?
• OK to tell patients and their families what you would do under the circumstances if given an “opening” – an opportunity to educate and enlighten

Don’t just offer Palliative/Hospice Care because of the cost savings benefit..........................
Offer it because of

THE HUMAN ARGUMENT

THANK YOU FOR YOUR TIME!

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