WELCOME to Palliative Care ECHO 4.0

Improving Care for those with Serious Illness

October 2024 – June 2025

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Trauma-Informed Approach to Serious Illness

Sarah E. Guarda, MSW, LICSW

Palliative Care Echo Session #1 October 1, 2024

Learning Objectives

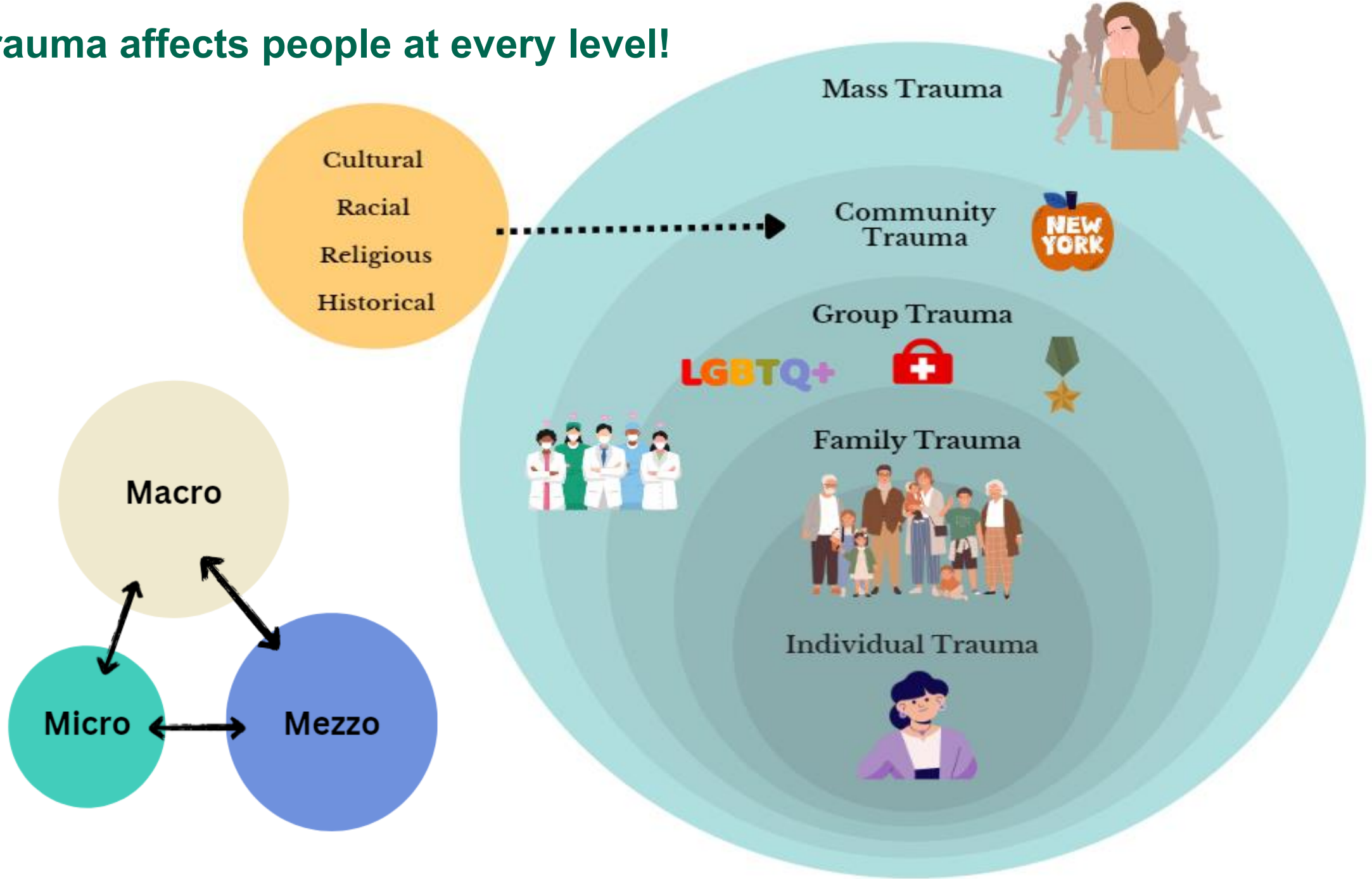
By the end of this session, ECHO participants will be able to:

- Define trauma and identify trauma responses in our patients
- Demonstrate a trauma-informed approach to assessment, communication, and interaction with our patients
- Reflect on strategies to be a more trauma-informed provider

The “3 E’s” of trauma: **event(s)** that someone **experiences** as harmful and have adverse **effects** on wellbeing.

EVENTS → EXPERIENCES → EFFECTS

Trauma affects people at every level!



TRAUMA CAUSES PHYSICAL AND MENTAL ILLNESS.

EMOTIONAL & INTERPERSONAL

- **Depression & anxiety**
- Difficulty trusting others
- Difficulty regulating emotions
- Withdrawal from family, friends, & community

BEHAVIORAL

- **Substance use & abuse**
- Self-destructive behaviors
- Impulsivity
- Avoidance of situations, people, & places

PHYSICAL

- **Hyperarousal (muscle tension and insomnia)**
- Headaches, high blood pressure, fatigue
- Increased risk of cardiovascular issues, diabetes, cancers

COGNITIVE

- **Decreased concentration**
- Changes in brain development
- Impaired speech & language
- Impaired memory
- Dissociation

SPIRITUAL

- **Feelings of abandonment, betrayal, & loss of faith**
- Existential distress
- Can also result in renewed faith or spirituality

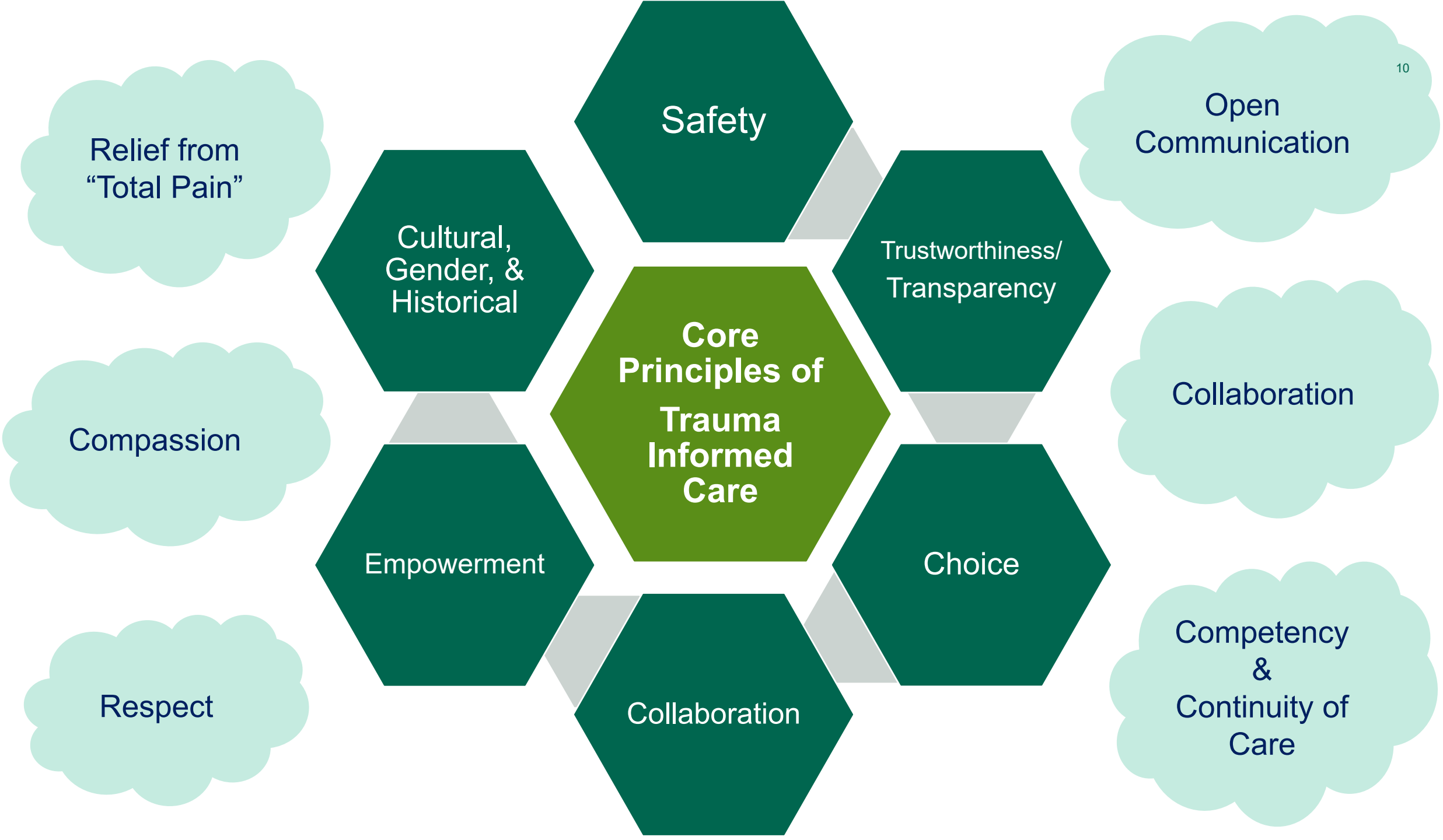
Trauma-informed approach is defined as:

"a strengths based service delivery approach that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes **physical, psychological, and emotional safety** for both providers and survivors to rebuild a sense of control and empowerment."

SAMHSA
Substance Abuse and Mental Health Services Administration

Trauma informed care **empowers** palliative providers to be their most effective.

- Trauma informed care is accessible
- Palliative philosophy aligns with trauma informed care
- Holistic and person-centered
- Improves positive patient and provider outcomes
- Fosters connection through individualized approach
- Prevents re-traumatization
- Supports pain management


Relief from "Total Pain"
Compassion
Respect
Safety
Cultural, Gender, & Historical
Trustworthiness/ Transparency
Core Principles of Trauma Informed Care
Empowerment
Choice
Collaboration
Open Communication
Collaboration
Competency & Continuity of Care

Ask questions to assess an individual's trauma history.

“What can our team do today to help you feel safe?”

Use **empathy**, **reassurance**, and **sensitivity** when responding to disclosures of trauma.

- “I appreciate the courage it took to share that with me.”
- “Thank you for trusting me enough to share these experiences today.”
- “I wish that you had not been harmed/betrayed/hurt.”
- “Please know that you deserve support.”
- “You deserve to be safe.”
- “I will keep these details private unless you tell me otherwise.”
- “What can we do to help you feel safe while receiving care?”
- “How would you like me to document this information?”

Establish **physical**, **psychological**, and **emotional safety** first.

- Share preferred name and pronouns
- Determine how individuals prefer to receive medical information
- Limit jargon and avoid the “righting reflex”
- Be curious, ask clarifying questions, ask for feedback
- Mirror affect and match your patient’s energy
- Respect boundaries and preferences, be mindful of known triggers
- Offer genuine validation and affirm patient experiences
- Be mindful of touch and personal space (don’t block the door!)
- Watch for discomfort or distress- have tissues handy!

Self-care is essential to being a resilient and empathic provider.

Closing Reflections:

What is **one** thing you will do differently to incorporate a **trauma-informed approach** while caring for people living with serious illness?

Please type your answers in the chat!

Dartmouth Health

Thank you!

References

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- Substance Abuse and Mental Health Services Administration. (2014). Trauma-Informed care in behavioral health services. In Treatment Improvement Protocol (TIP) Series 57.
- *Statement of Principles of Palliative Care*. (2019, September 1). ACS. https://www.facs.org/about-acs/statements/principles-of-palliative-care/
- Van Der Kolk, B. (2014). ***The body keeps the score: Brain, mind, and body in the healing of trauma***. New York: Viking.

Palliative Medicine
in the
Emergency Department

Phil Lawson MD

November, 2024

LITTLETON REGIONAL HEALTHCARE

Objectives

1. Recognize challenges of care in Emergency Departments (ED)

2. List ways to adjust and apply palliative interventions to the ED setting

3. Cite tools to assist ED providers in improving palliative care in the ED

Case:

- 84 yo comatose female brought to Critical Access Hospital GCS = 3
- AD's, POLST, P-DNR not with patient on arrival
- Intubated in ED with lines and tubes….
- Bilateral cerebral hemorrhage (brain bleed) -> call to neurosurgery -> helicopter on the way
- Friend arrives horrified stating she would never want this

GCS = Glascow Coma Scale; AD = Advance Directive; POLST = Portable Medical Order; DPOAH = Durable Power of Attorney for Healthcare

Best Practice Goals ED providers

Best Practice palliative care per ACEP includes:

1. Screening and assessing patients for palliative care needs
2. Managing patients with palliative care needs in the Emergency Department (ED)
3. Consulting palliative care specialists in/from the ED
4. Transitioning palliative care or hospice eligible patients from the ED

ACEP: American College of Emergency Physicians

Loffredo A et al. ***United States Best Practice Guidelines for Primary Palliative Care in the Emergency Department.*** Annals of Emergency Medicine Vol 78(5), Nov 2021, 658-669

Realities of the Venue

- Rapid Triage
- Variable wait times for care
- Focus is on the presenting complaint
  - Rule out what is life/limb threatening
  - Make a tentative diagnosis based on limited available information
  - Achieve disposition rapidly*

Realities of the Venue

- Loud, limited privacy, limited comfort
- Frequently interrupted patient/provider time
- Limited (sometimes no) available medical information
- Extensive testing (for the “rule out”)
- A culture of “If in doubt, intervene…”

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Conclusions from recent research

CPR on cancer patients in the ED

- Advance Directives (AD's) associated with:
  - Quicker adjustment to DNR status
  - Shorter ICU stay
  - Shorter hospital stay
  - No difference in mortality

Wechsler AH et al. Prior Advanced Care Planning and Outcomes of CPR in the ED of a Comprehensive Cancer Center. *Cancers* **2024**, *16*(16), 2835; https://doi.org/10.3390/cancers16162835

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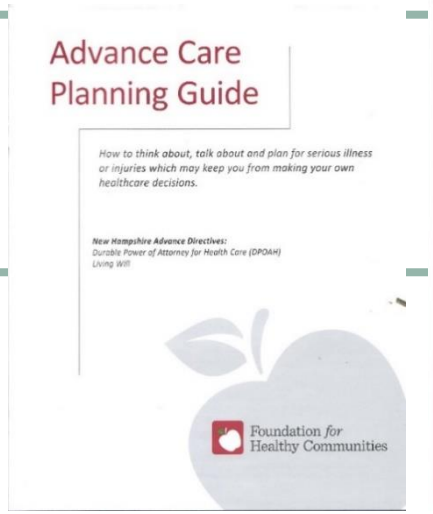
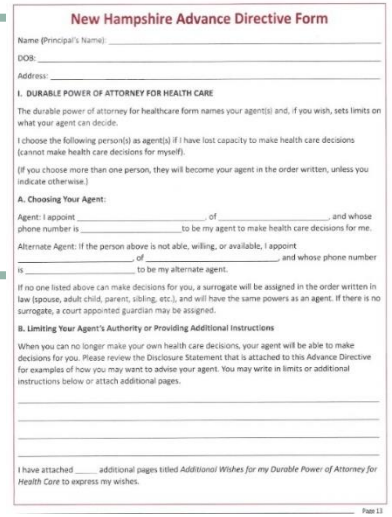
Recent Research



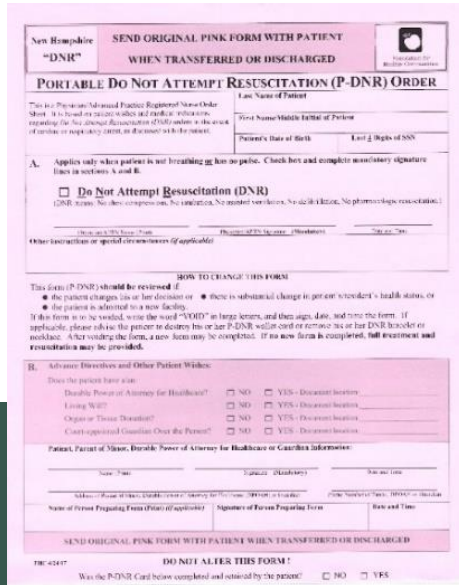


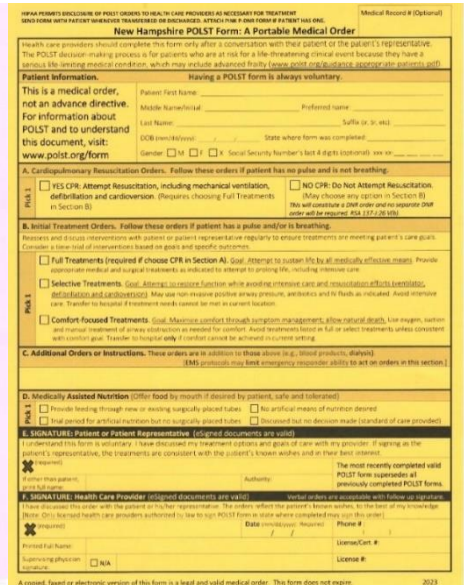
Advance Directives (AD's) are not available

- 20-25% reported having AD's; 7% available
- High variance amongst ED's: 1 - 48% had any form of AD's available

Patients and providers don't talk about AD's/goals of care in the ED

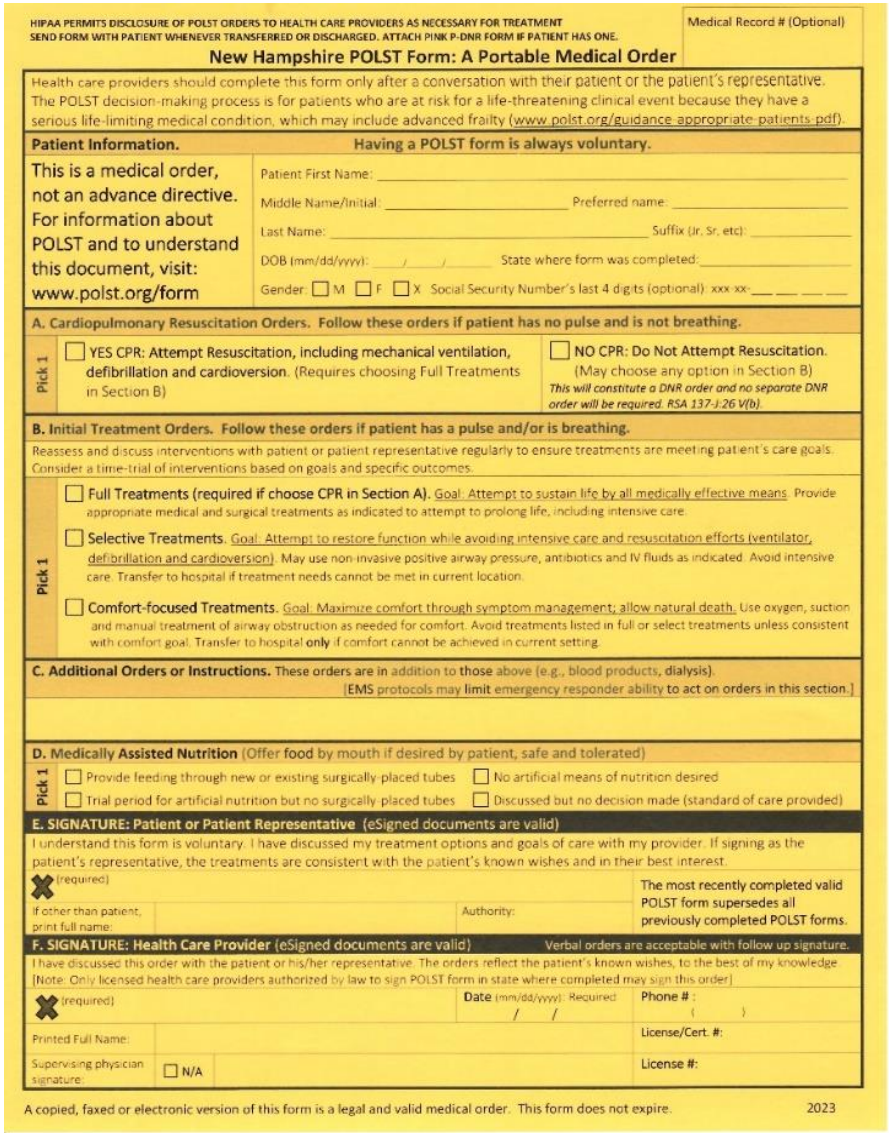
- @10% of elderly ill patients in ED are asked about AD's
- @80% thought ED providers should be aware
- <40% expressed desire to discuss goals of care





*References in chat

What PC Providers can offer the ED



HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. ATTACH PINK P-DNR FORM IF PATIENT HAS ONE.

Medical Record # (Optional)

New Hampshire POLST Form: A Portable Medical Order

Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients.pdf).

Patient Information. **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form

Patient First Name:
Middle Name/Initial: Preferred name:
Last Name: Suffix (Jr, Sr, etc):
DOB (mm/dd/yyyy): / / State where form was completed:
Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion. (Requires choosing Full Treatments in Section B)

☐ NO CPR: Do Not Attempt Resuscitation. (May choose any option in Section B)
This will constitute a DNR order and no separate DNR order will be required. RSA 137-J:26 V(b).

B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes ☐ No artificial means of nutrition desired
☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ Discussed but no decision made (standard of care provided)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (required)

If other than patient, print full name: Authority:

The most recently completed valid POLST form supersedes all previously completed POLST forms.

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. (Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order)

✖ (required) Date (mm/dd/yyyy): Required / / Phone # : ( )

Printed Full Name: License/Cert. #:

Supervising physician signature: ☐ N/A License #:

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2023

- Out of hospital arrest
- Goal concordant vs goal discordant care
- POLST as a starting place in the ED

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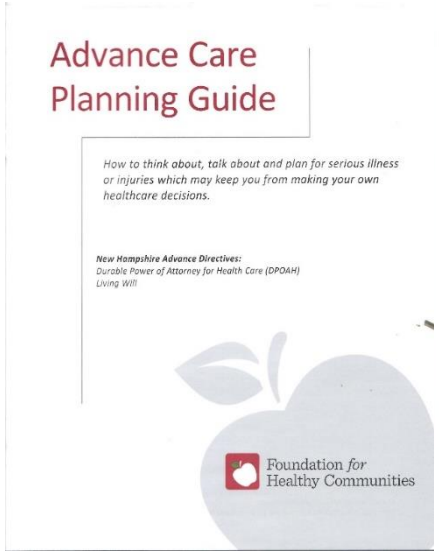
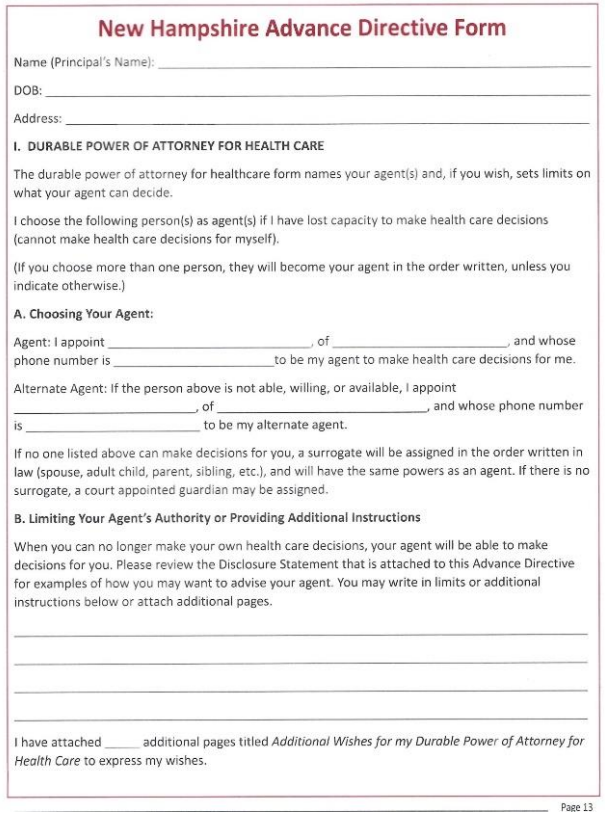
What PC Providers can offer the ED

New Hampshire Forms





New Hampshire Advance Directive Form

Name (Principal's Name): _____

DOB: _____

Address: _____

I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

The durable power of attorney for healthcare form names your agent(s) and, if you wish, sets limits on what your agent can decide.

I choose the following person(s) as agent(s) if I have lost capacity to make health care decisions (cannot make health care decisions for myself).

(If you choose more than one person, they will become your agent in the order written, unless you indicate otherwise.)

A. Choosing Your Agent:

Agent: I appoint _____, of _____, and whose phone number is _____to be my agent to make health care decisions for me.

Alternate Agent: If the person above is not able, willing, or available, I appoint _____, of _____, and whose phone number is _____ to be my alternate agent.

If no one listed above can make decisions for you, a surrogate will be assigned in the order written in law (spouse, adult child, parent, sibling, etc.), and will have the same powers as an agent. If there is no surrogate, a court appointed guardian may be assigned.

B. Limiting Your Agent's Authority or Providing Additional Instructions

When you can no longer make your own health care decisions, your agent will be able to make decisions for you. Please review the Disclosure Statement that is attached to this Advance Directive for examples of how you may want to advise your agent. You may write in limits or additional instructions below or attach additional pages.

_____

_____

_____

_____

I have attached _____ additional pages titled *Additional Wishes for my Durable Power of Attorney for Health Care* to express my wishes.

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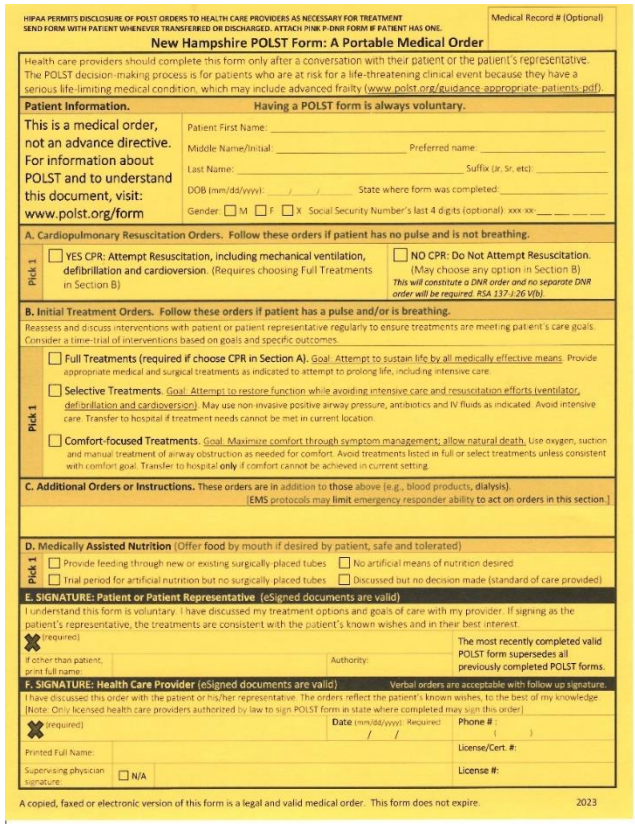

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Last Name: _____ Suffix (Jr, Sr, etc): _____
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✖ (required) Date (mm/dd/yyyy): Required: ___/___/_____ Phone #: (___) _____
Printed Full Name: License/Cert. #:
Supervising physician signature: ☐ N/A License #:

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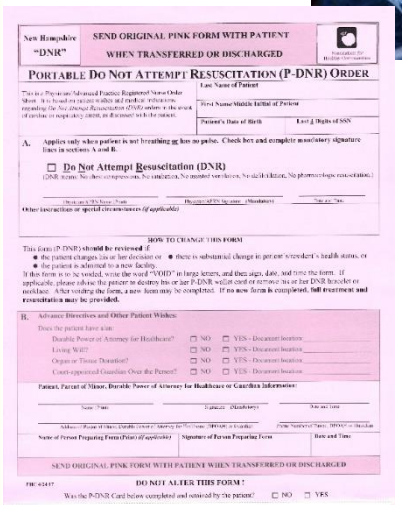

New Hampshire "DNR" — SEND ORIGINAL PINK FORM WITH PATIENT WHEN TRANSFERRED OR DISCHARGED

PORTABLE DO NOT ATTEMPT RESUSCITATION (P-DNR) ORDER

Last Name of Patient
First Name Middle Initial of Patient
Patient's Date of Birth
Last 4 Digits of SSN

A. Applies only when patient is not breathing or has no pulse. Check box and complete mandatory signature lines in sections A and B.

☐ **Do Not Attempt Resuscitation (DNR)**
(DNR means: No chest compressions, No intubation, No manual ventilation, No shock (defibrillation), No pharmacologic resuscitation.)

Physician's/APN Name (Print) — Physician/APN Signature (Mandatory) — Date of Order
Other instructions or special circumstances (if applicable)

HOW TO CHANGE THIS FORM

This form (P-DNR) should be reviewed if:
- the patient changes his or her decision or
- there is substantial change in patient's health status, or
- the patient is admitted to a new facility.

If this form is to be voided, write the word "VOID" in large letters, and then sign, date, and time the form. If applicable, please advise the patient to destroy his or her P-DNR wallet card or remove his or her DNR bracelet or necklace. After voiding the form, a new form may be completed. If no new form is completed, **full treatment and resuscitation may be provided.**

B. Advance Directives and Other Patient Wishes:
Does the patient have a/an:
Durable Power of Attorney for Healthcare? ☐ NO ☐ YES – Document location: _____
Living Will? ☐ NO ☐ YES – Document location: _____
Organ or Tissue Donation? ☐ NO ☐ YES – Document location: _____
Court-appointed Guardian Over the Person? ☐ NO ☐ YES – Document location: _____

Patient, Parent of Minor, Durable Power of Attorney for Healthcare or Guardian Information:
Name (Print) — Relation (Mandatory) — Date and Time
Address — Phone # — Durable Power of Attorney for Healthcare (DPOAH) or Guardian — Other Numbers (Cell, Work, etc.)
Name of Person Preparing Form (Print) (if applicable) — Signature of Person Preparing Form — Date and Time

SEND ORIGINAL PINK FORM WITH PATIENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM !
Was the P-DNR Card below completed and retrieved by the patient? ☐ NO ☐ YES

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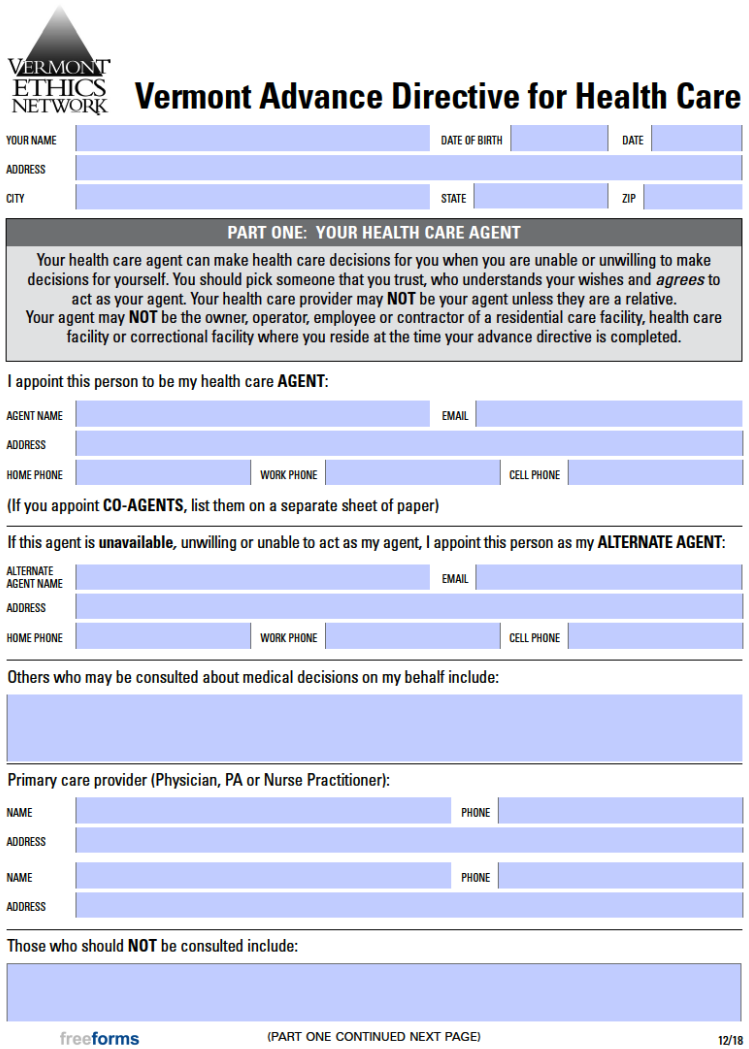
What PC Providers can offer the ED

Vermont Forms

- Short Form
- Long Form
- Registry
- COLST



VERMONT ETHICS NETWORK

Vermont Advance Directive for Health Care

YOUR NAME | DATE OF BIRTH | DATE

ADDRESS

CITY | STATE | ZIP

PART ONE: YOUR HEALTH CARE AGENT

Your health care agent can make health care decisions for you when you are unable or unwilling to make decisions for yourself. You should pick someone that you trust, who understands your wishes and *agrees* to act as your agent. Your health care provider may **NOT** be your agent unless they are a relative. Your agent may **NOT** be the owner, operator, employee or contractor of a residential care facility, health care facility or correctional facility where you reside at the time your advance directive is completed.

I appoint this person to be my health care **AGENT**:

AGENT NAME | EMAIL

ADDRESS

HOME PHONE | WORK PHONE | CELL PHONE

(If you appoint **CO-AGENTS**, list them on a separate sheet of paper)

If this agent is **unavailable**, unwilling or unable to act as my agent, I appoint this person as my **ALTERNATE AGENT**:

ALTERNATE AGENT NAME | EMAIL

ADDRESS

HOME PHONE | WORK PHONE | CELL PHONE

Others who may be consulted about medical decisions on my behalf include:

Primary care provider (Physician, PA or Nurse Practitioner):

NAME | PHONE

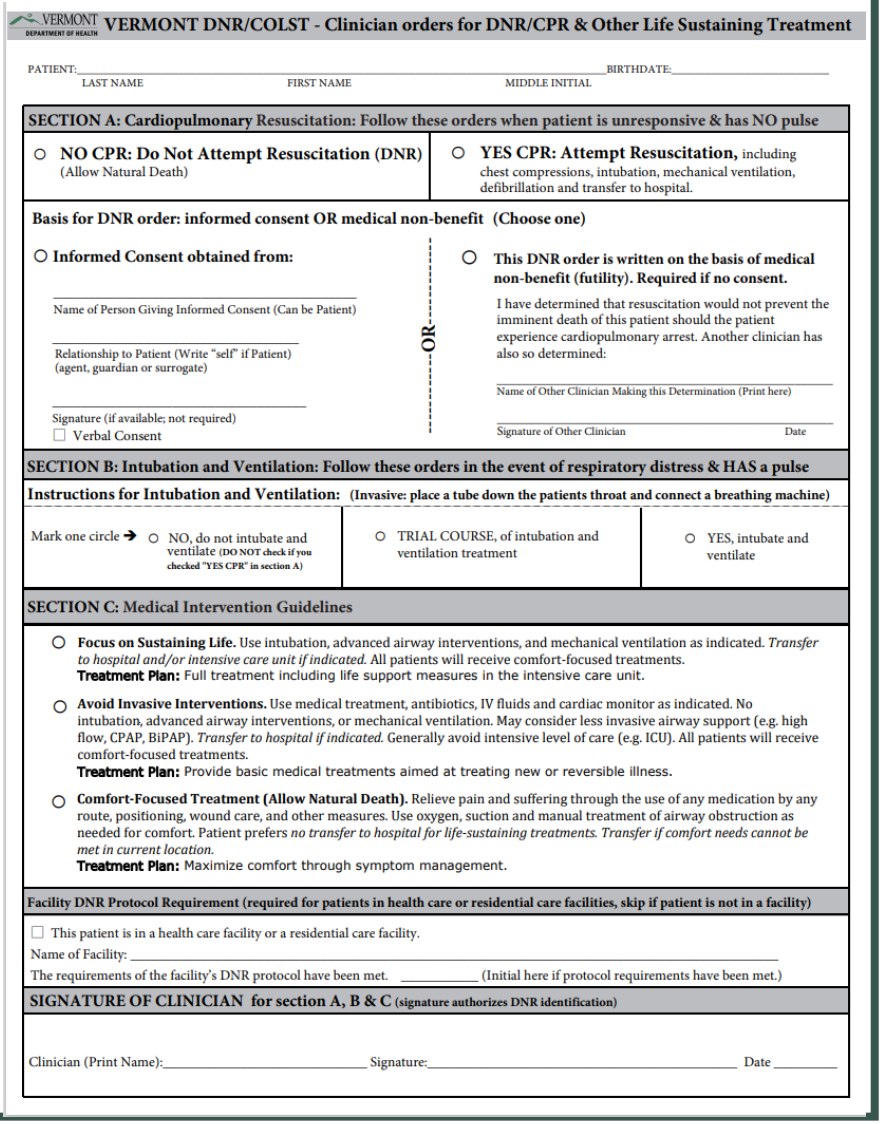
ADDRESS

NAME | PHONE

ADDRESS

Those who should **NOT** be consulted include:

freeforms (PART ONE CONTINUED NEXT PAGE) 12/18



VERMONT DEPARTMENT OF HEALTH

VERMONT DNR/COLST - Clinician orders for DNR/CPR & Other Life Sustaining Treatment

PATIENT: _____ BIRTHDATE: _____
LAST NAME FIRST NAME MIDDLE INITIAL

SECTION A: Cardiopulmonary Resuscitation: Follow these orders when patient is unresponsive & has NO pulse

- ○ **NO CPR: Do Not Attempt Resuscitation (DNR)** (Allow Natural Death)
- ○ **YES CPR: Attempt Resuscitation,** including chest compressions, intubation, mechanical ventilation, defibrillation and transfer to hospital.

Basis for DNR order: informed consent OR medical non-benefit (Choose one)

○ **Informed Consent obtained from:**

Name of Person Giving Informed Consent (Can be Patient)

Relationship to Patient (Write "self" if Patient) (agent, guardian or surrogate)

Signature (if available; not required)

☐ Verbal Consent

OR

○ **This DNR order is written on the basis of medical non-benefit (futility). Required if no consent.**

I have determined that resuscitation would not prevent the imminent death of this patient should the patient experience cardiopulmonary arrest. Another clinician has also so determined:

Name of Other Clinician Making this Determination (Print here)

Signature of Other Clinician Date

SECTION B: Intubation and Ventilation: Follow these orders in the event of respiratory distress & HAS a pulse

Instructions for Intubation and Ventilation: (Invasive: place a tube down the patients throat and connect a breathing machine)

Mark one circle ➔ ○ NO, do not intubate and ventilate (DO NOT check if you checked "YES CPR" in section A) | ○ TRIAL COURSE, of intubation and ventilation treatment | ○ YES, intubate and ventilate

SECTION C: Medical Intervention Guidelines

- ○ **Focus on Sustaining Life.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. *Transfer to hospital and/or intensive care unit if indicated.* All patients will receive comfort-focused treatments.
  Treatment Plan: Full treatment including life support measures in the intensive care unit.
- ○ **Avoid Invasive Interventions.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. high flow, CPAP, BiPAP). *Transfer to hospital if indicated.* Generally avoid intensive level of care (e.g. ICU). All patients will receive comfort-focused treatments.
  Treatment Plan: Provide basic medical treatments aimed at treating new or reversible illness.
- ○ **Comfort-Focused Treatment (Allow Natural Death).** Relieve pain and suffering through the use of any medication by any route, positioning, wound care, and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers *no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
  Treatment Plan: Maximize comfort through symptom management.

Facility DNR Protocol Requirement (required for patients in health care or residential care facilities, skip if patient is not in a facility)

☐ This patient is in a health care facility or a residential care facility.

Name of Facility: _____

The requirements of the facility's DNR protocol have been met. _____ (Initial here if protocol requirements have been met.)

SIGNATURE OF CLINICIAN for section A, B & C (signature authorizes DNR identification)

Clinician (Print Name): _____ Signature: _____ Date _____

What ED Providers need

- Respond immediately to requests for help
- Focus response with information that is:
  - “Need to know”
  - “Immediately actionable”
- Give very specific, focused recommendations
- Assure appropriate follow up

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Tools and Scripts

- **Opioid Equivalence Tools**
- **Early Hospice Referral**
  - Tools to address hospice qualifiers: LCD's
- **Transferable Medical Orders**
  - POLST: NH form
  - P-DNR form (Pink Portable) + card
- **Communication Skills Training**
  - Serious Illness Conversation Trainings, VITALtalk
- **System based and Quality Tools**
  - Center for Advancement of Palliative Care
  - American College of Emergency Physicians Toolkit

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Scripts: Our "surgical" Skills

What not to say	What might be more appropriate
"Do you want everything done?"	"This is a medical procedure that has risks and benefits. Let me briefly go through them with you"
"Do you want me to try to keep you alive?"	Review best possible, worst possible and expected outcomes
"You are not getting enough oxygen; do you want me to put a tube down to help you breath?"	"We are considering putting you on a breathing machine, but I am worried about what might happen to you if we do; and we have options to help your breathing…"
"Do you want us to try to revive you if your heart stops?"	"I want to make sure we treat you the way you want to be treated if your condition gets worse. CPR is an option that has risks for you….."

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Communication Tools

Best Possible

- “Alive hooked up to machines for at least a few days, and then a long rehabilitation likely in a nursing home; best possible outcome being a condition not as good as you have recently been”

Worst Possible

- “A prolonged dying process with suffering on machines”

Expected Outcomes

- “I think there is a chance you might survive, but I am worried that if you do, you will have to spend the rest of your life receiving extensive care from others, maybe in a nursing home”

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What PC Providers can offer the ED

Approaches to talk about CPR, intubation and life-sustaining care

- *"Miracles*… can occur no matter what type of medical care you choose"
- *Wish/ Worry/ Wonder*
  - "I wish we could get you *…. back home and independent*"
  - "I worry this could lead to … *a prolonged time of suffering on machines until your death*"
  - "I wonder if you might prefer… *a focus on comfort; allowing your natural death when it occurs?*"
- *Time Limited Trials*
  - If we choose to intervene what will success look like?
  - When should we reassess to see if we have reached that goal?

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Reasonable CPR outcome data

Location and Original setting/function	Survival to Discharge from Hospital	Survival with 'good' neurologic outcome
Hospital Monitored, High Functional Status	50-60% (1 in 2)	30-50% (1 in 2-3)
Hospital overall	15-25% (1 in 4-5)	10-15% (1 in 10-15)
Outpatient/ In hospital with cancer	10-15% (1 in 7-10)	5-8% (1 in 15-20)
Nursing Home	2-4% (1 in 25-50)	1-2% (1 in 50-100)
Frailty	1-4% (1 in 25-100)	< 1-2% (< 1 in 50-100)

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What PC Providers can offer the ED

Scripts to assist in demystifying hospice

- “Focused on bringing the care to your home and avoiding the ED”
- “Reduce the burdens of medical management for family”
- “Covered at 100% under Medicare” (for those without supplemental insurance)
- *“Would you like to meet with the someone from the hospice team to discuss what it would mean for your care?”*

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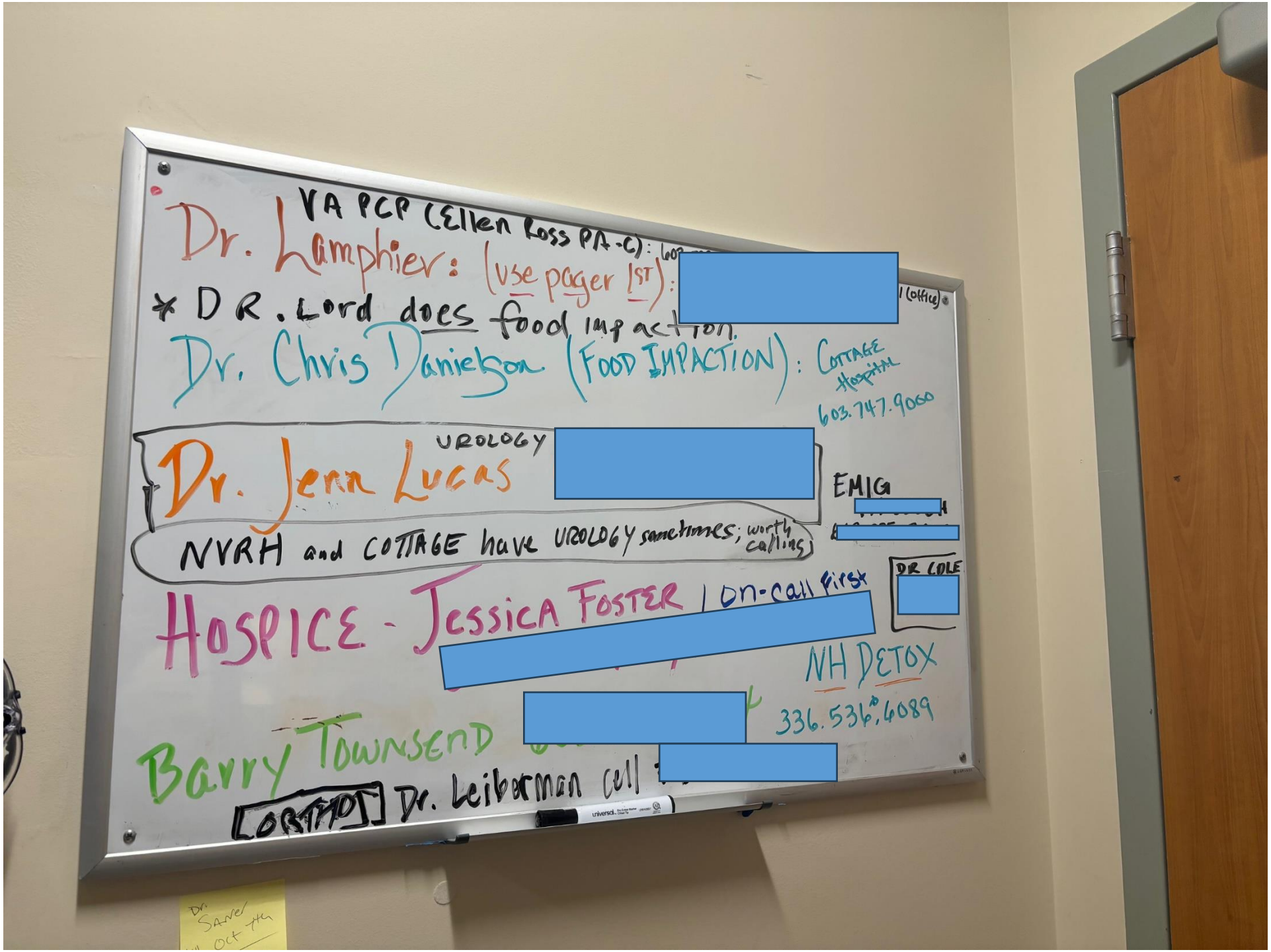
VA PCP (Ellen Ross PA-C):
Dr. Lamphier: (use pager 1ST):
* DR. Lord does food impaction
Dr. Chris Danielson (FOOD IMPACTION): COTTAGE Hospital
603.747.9000
UROLOGY
Dr. Jenn Lucas
EMIG
NVRH and COTTAGE have UROLOGY sometimes; worth calling
DR COLE
HOSPICE - Jessica Foster | on-call first
NH DETOX
336.536.4089
Barry Townsend
ORTHO
Dr. Leiberman cell

What PC Providers can offer the ED

ED care of hospice patients:

1. Call hospice team immediately
2. Explore what triggered the decision to attend the ED/ call 911
3. Treat distressing symptoms
4. Avoid diagnostic interventions until coordinating with hospice or goals of care discussion
5. Urgent Palliative Care assistance @ any life-sustaining interventions
    - rapid goals of care discussion (ie hospice team or in-hospital palliative medicine assistance)

Adapted from Fast Fact #246. PCNOW. Palliative Care Network of Wisconsin

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Models of Palliative Care in the ED

ED Nurse driven Goals of Care (GOC) discussions

- 50% (who did not have one) completed a POLST
- 95% rated 4-5/5 satisfaction after; and 100% at 6 months
- No change in hospitalization, length of stay, or ICU stay

- Bigelow S et al. Difficult conversation: Outcomes of Emergency Department Nurse-Directed Goals of Care Discussions. Journal of Palliative Care. Volume 39, Issue 1; https://doi.org/10.1177/08258597221149402 2024

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Models of Palliative Care in the ED

Quality Improvement strategies for early hospice referral

- Multi-pronged quality improvement training in ED
- Prior MOLST was associated with much higher rates of hospice referral (OR 5.02)
- Pre: 22.6% Hospice referral < 96 hr vs Post: 54.1%

Baugh C et al. A hospice transitions program for Patients in the Emergency Department. JAMA. *JAMA Netw Open.* 2024;7(7):e2420695. doi:10.1001/jamanetworkopen.2024.20695

- Brigham and Womens, Boston

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Models of Palliative Care in the ED

Embed Palliative Care Provider Services in ED

- 10X increase in ED palliative consultation
- 49% changed code status in ED
- 11% admitted to lower level of care than planned
- 17% immediate hospice referral
- No change in ED length of stay
- Compared to inpatient consults: 8.1 day shorter length of stay (3.0 vs 11.1 days)
- 6.7X ROI ($)

Wang D and Heidt R. Emergency Department Embedded Palliative Care Service Creates Value for Health Systems. J Palliat Med 2023; May 26(5): 646-652. doi: 10.1089/jpm.2022.0245. Epub 2022 Nov 11.

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Consultation in the ED

1. What is the question? What is needed?
2. What is the urgency?
3. Who (of the team) can best address this need rapidly?
4. Get background data rapidly (chart review, corollary history, AD/POLST….)
5. Do consult and/or give specific, brief recommendations
   - Honor the reality of the ED environment
6. Offer effective tools
   - Opioid equivalence resource, Fast Facts, specific scripts/ communication skills
7. Assure follow up

Adapted from Fast Facts #298. PCNOW, Palliative Care Network of Wisconsin, June 11, 2024

Wang D et al. Top Ten Tips Palliative Care Clinicians should know about caring for Patients in the Emergency Department. 2019 Dec;22(12):1597-1602. doi: 10.1089/jpm.2019.0251. Epub 2019Jul 29

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Recommendations

1. Make Directives/ Orders available to ED staff (POLST, P-DNR, AD…)
   - Train ED staff to see them and use them
   - “Fix” the Electronic Medical Record barrier!
2. Build, Model and Distribute Tools for ED staff to assist in:
   - Scripts for rapid goals of care conversations at the bedside
   - Prognostic tools (ie PPS/ Karnovsky/ frailty indices….)
   - Prescribing tables/ tools (opioid equivalence, symptom mgt algorithms)
   - Rapid access to palliative and hospice specialty support
   - Assistance and support with debriefing strategies
3. Set Quality Improvement goals for ED Palliative presence
   - Start with active patients

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EMS

End of talk

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EMS

What ED Providers need

The American College of Emergency Physicians believes that:

- Emergency physicians play an important role in providing care at the end of life (EOL).
- Helping patients and their families achieve greater control over the dying process will improve EOL care.
- Advance care planning can help patients formulate and express individual wishes for EOL care and communicate those wishes to their health care providers by means of advance directives (including state approved advance directives, DNAR orders, living wills and durable powers of attorney for health care).

To enhance EOL care in the ED, the American College of Emergency Physicians believes that emergency physicians should:

- Respect the dying patient's needs for care, comfort, and compassion.
- Communicate promptly and appropriately with patients and their families about EOL care choices, avoiding medical jargon.
- Elicit the patient's goals for care before initiating treatment, recognizing that EOL care includes a broad range of therapeutic and palliative options.
- Respect the wishes of dying patients including those expressed in advance directives. Assist surrogates to make EOL care choices for patients who lack decision making capacity, based on the patient's own preferences, values, and goals.
- Encourage the presence of family and friends at the patient's bedside near the end of life, if desired by the patient.
- Protect the privacy of patients and families near the end of life.
- Promote liaisons with individuals and organizations in order to help patients and families honor EOL cultural and religious traditions.
- Develop skill at communicating sensitive information, including poor prognoses and the death of a loved one.
- Comply with institutional policies regarding recovery of organs for transplantation.
- Obtain informed consent from surrogates for postmortem procedures

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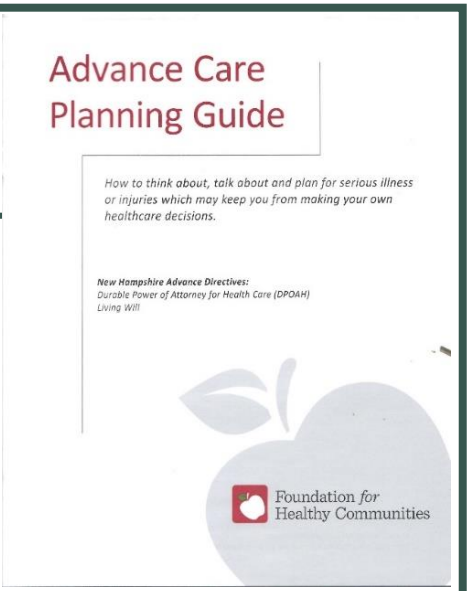
Conclusions from research



Evidence to support Advance Directives

- Sean Morrison's take: "Decades of research demonstrate advance care planning doesn't work. We need a new paradigm." Sean Morrison MD

Morrison, S.R., Meier, D.E., Arnold, R.M. (2021). What's wrong with advance care planning? *Journal of the American Medical Association* (326)16: 1575-1576. doi: 10.1001/jama.2021.16430

Jimenez G et al. Overview of systematic reviews of Advance Care Planning: Summary of Evidence and Global Lession. J Pain Sym Mgt. 56(3): 436-459 , 2018

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