

### 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:

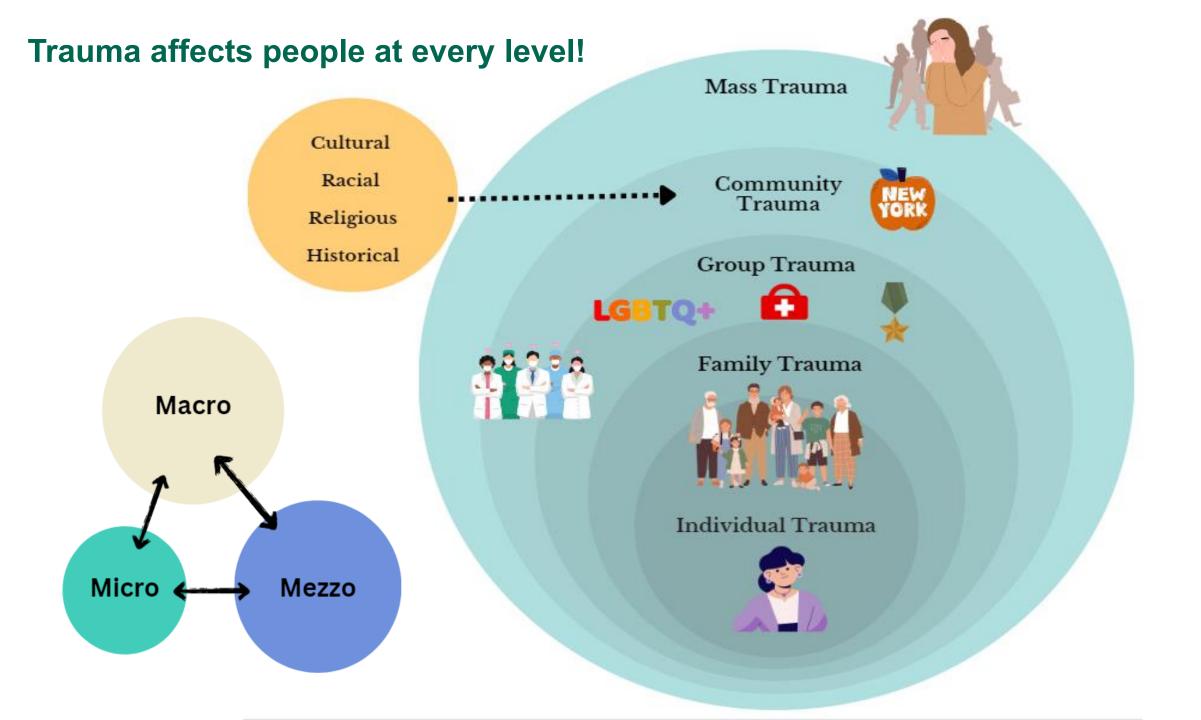
- Define trauma and identify trauma responses in our patients
- Demonstrate a trauma-informed approach to assessment, communication, and interaction with our patients
- Reflect on strategies to be a more trauma-informed provider



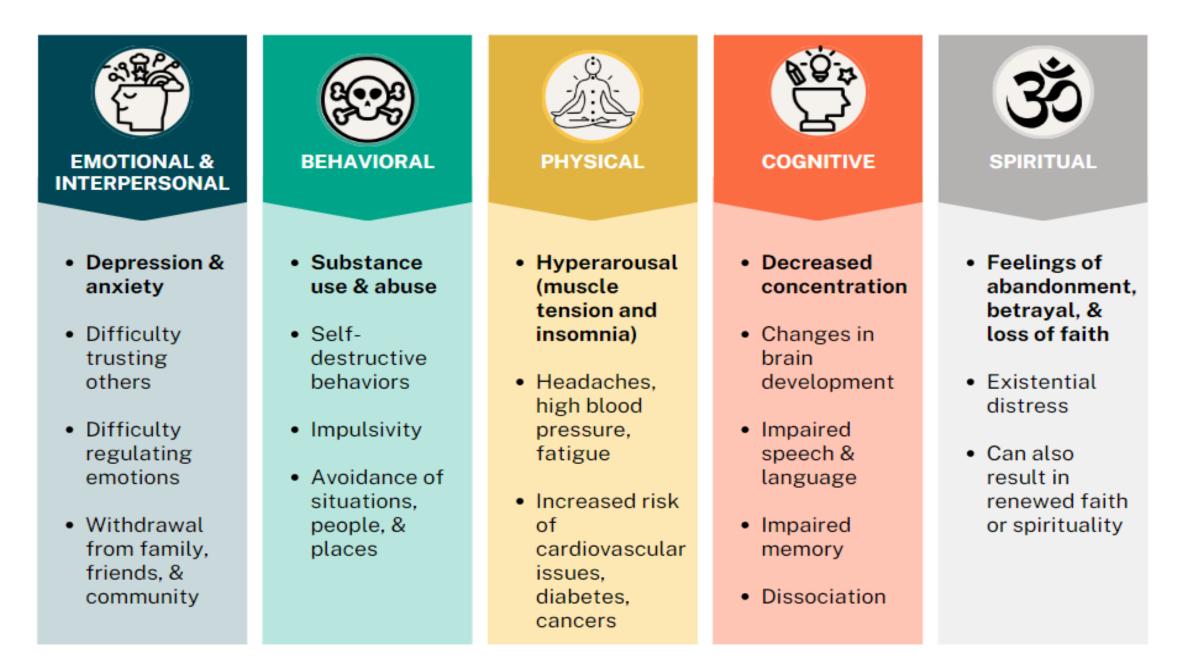
### The "3 E's" of trauma: **event(s)** that someone **experiences** as harmful and have adverse **effects** on wellbeing.



### $EVENTS \rightarrow EXPERIENCES \rightarrow EFFECTS$



#### TRAUMA CAUSES PHYSICAL AND MENTAL ILLNESS.



## 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."







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





#### 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 **traumainformed approach** while caring for people living with serious illness?

Please type your answers in the chat!



### Thank you!





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### Palliative Medicine in the Emergency Department

### Phil Lawson MD November, 2024





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





- 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..."





### **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; <u>https://doi.org/10.3390/cancers16162835</u>



### **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

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How to think about, talk about and plan for serious illness	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).		
or injuries which may keep you from making your own healthcare decisions.	(if you choose more than one person, they will become your agent in the order written, unless you indicate otherwise.)		
	A. Choosing Your Agent:		
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New Hampshire Advance Directives: Durable Power of Attorney for Health Care (DPDAH) Living Will	Alternate Agent: If the person above is not able, willing, or available, I appoint		
	B		
	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. Rease 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.		
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	HIPAA PERMITS DISCLOSURE OF POLST ORDERS TO HEALTH CARE PROVIDERS AS NECESSARY FOR TREATMENT SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED. ATTACH PINIC PONR FORM IF PATIENT HAS ONE. 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 ( <u>www.polst.org/guidance-appropriate-patients-pdf</u> ).						
Pati	ient Information.		Having a POLST	form is alw	ays voluntary.	
Thi	s is a medical or	rder,	Patient First Name:			
not	not an advance directive. Middle Name/Initial Preferred name					ne
For	information ab	oout	Last Name:			Suffix (Jr, Sr, etc):
PO	LST and to unde	erstand	STREET, COLORADO			
this	s document, visi	it:	DOB (mm/dd/yyyy)://	State wi	here form was cor	npleted:
WW	w.polst.org/for	rm	Gender: M F X Social	Security Num	ber's last 4 digits (	(optional) xxx xx
A. C	ardiopulmonary Re	esuscitation	Orders. Follow these orders if	patient has i	no pulse and is r	not breathing.
Pick 1	A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.           Image: Second Secon				Not Attempt Resuscitation. e any option in Section B) a DNR order and no separate DNR	
B. Ir	nitial Treatment Or	ders. Follo	w these orders if patient has a p	ulse and/or	is breathing.	
			th patient or patient representative r based on goals and specific outcome		sure treatments a	re meeting patient's care goals.
Pick 1	Selective Treatments. <u>Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion).</u> 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. <u>Goal: Maximize comfort through symptom management; allow natural death</u> , 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.]						
DA	Applically Assisted N	Nutrition (C	Offer food by mouth if desired by	nationt safe	and tolerated)	
			or existing surgically-placed tubes			tion desired
Pick 1			ition but no surgically-placed tubes			
E.S	The second s		Representative (eSigned docum			
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.						
-	er than patient,			Authority:		OLST form supersedes all
print	full name:					reviously completed POLST forms.
F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature. Thave 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/yy /	yy): Required Pl	hone#:
Print	ed Full Name:				Li	cense/Cert. #:
Supe	rvising physician dure:	N/A			Li	cense #:
A cop	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



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 ONI

#### **New Hampshire Forms**

Page 13

#### Advance Care **Planning Guide**

How to think about, talk about and plan for serious illness or injuries which may keep you from making your own healthcare decisions.

New Hampshire Advance Directives Durable Power of Attorney for Health Care (DPOAH) Living Will

> Foundation for **Healthy Communities**

DOB:		
2005.		
Address:		
I. DURABLE POWER OF ATTORN	IEY FOR HEALTH CARE	
The durable power of attorney fe what your agent can decide.	or healthcare form names your age	ent(s) and, if you wish, sets limits or
I choose the following person(s) (cannot make health care decision	as agent(s) if I have lost capacity to ons for myself).	make health care decisions
(If you choose more than one pe indicate otherwise.)	rson, they will become your agent	in the order written, unless you
A. Choosing Your Agent:		
Agent: Lappoint	, of	, and whose
phone number is	to be my agent to ma	ake health care decisions for me.
Alternate Agent: If the person at	oove is not able, willing, or availabl	e, l'appoint
	, of	
is	to be my alternate agent.	
	decisions for you, a surrogate will b sibling, etc.), and will have the sam ardian may be assigned.	
B. Limiting Your Agent's Author	ity or Providing Additional Instruc	tions
When you can no longer make y	our own health care decisions, you the Disclosure Statement that is at	

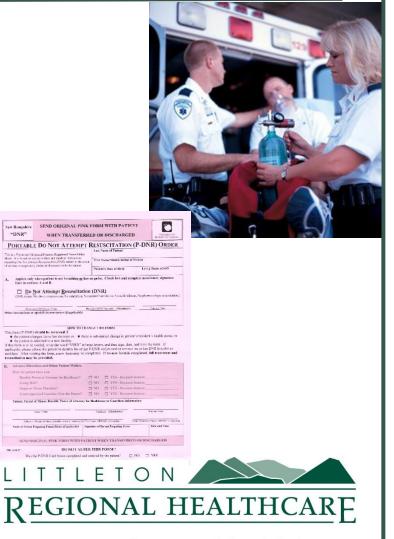
New Hampshire Advance Directive Form

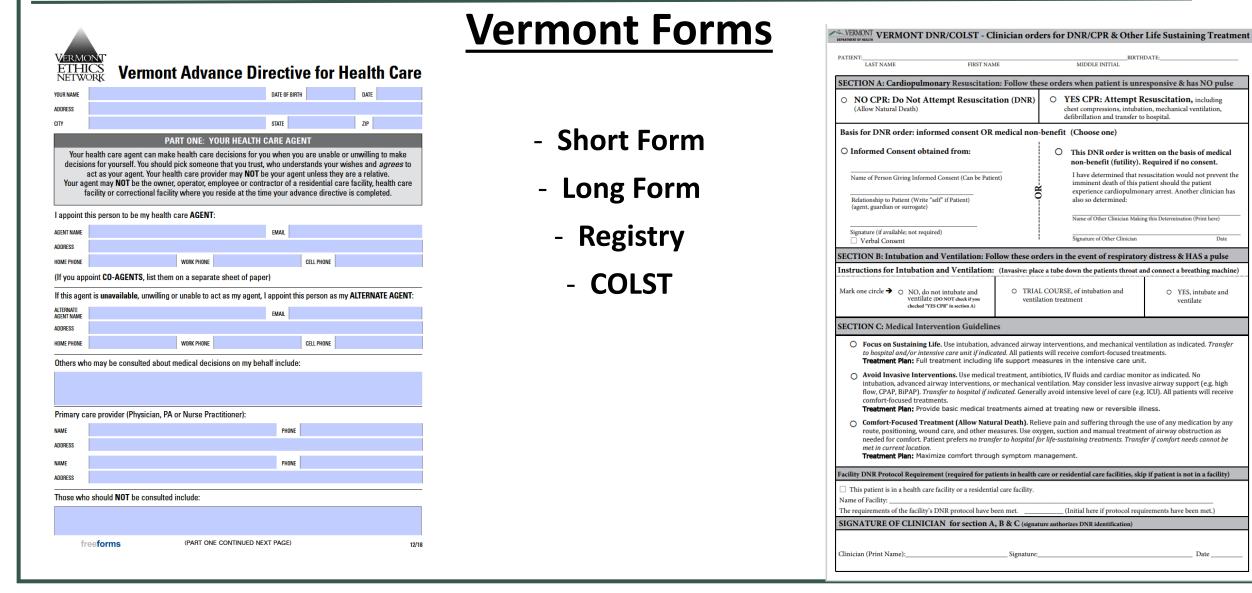
I have attached \_\_\_\_\_\_ additional pages titled Additional Wishes for my Durable Power of Attorney for Health Care to express my wishes.

serious life-limiting medical co	ndition, which may include advanced frailty (www	w polst.org/gu	
Patient Information.	Having a POLST form is al	ways volunta	ıry.
This is a medical order,	Patient First Name:		
not an advance directive		Preferred	name
For information about	Last Name:		Suffix (Jr, Sr, etc):
POLST and to understan	d		
this document, visit:	DOB (mm/dd/yyyy):/State v		
www.polst.org/form	Gender: M F X Social Security Nur	nber's last 4 dig	its (optional) xxx xx
A. Cardiopulmonary Resuscita	tion Orders. Follow these orders if patient has	no pulse and	is not breathing.
YES CPR: Attempt Res	uscitation, including mechanical ventilation,	NO CPR:	Do Not Attempt Resuscitation.
defibrillation and card in Section B)	ioversion. (Requires choosing Full Treatments	This will constit	oose any option in Section B) ute a DNR order and no separate DNR quired. RSA 137-J:26 V(b).
B. Initial Treatment Orders, F	ollow these orders if patient has a pulse and/o		
	s with patient or patient representative regularly to e		
Consider a time-trial of intervention	ons based on goals and specific outcomes.		
	Goal: Attempt to restore function while avoiding inte version). May use non-invasive positive airway pressure if treatment needs cannot be met in current location.		
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Medical Record # (Optional)

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



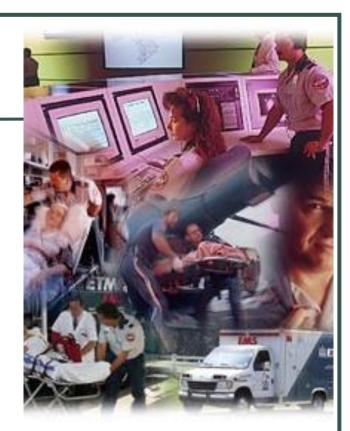


Date

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





### **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



### 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"
	LITTLETON

**REGIONAL HEALTHCARE** 

### **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"

Where good health begins.

REGIONAL HEALTHCAR

#### 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?



### **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)



## 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?"



Dr. Marce (Ellien Loss PA-C): 60 \* DR. Lord does food impaction. Dr. Chvis Daniebon (FOOD IMPACTION) I (office) a Corracte Hospith 603.747.9000 UROLOGY EMIG NVRH and COTTAGE have UROLDGY same homes; with and COTTAGE have UROLDGY same homes; with adding the HOSPICE - Jessica Foster 1 Dn-call first DR LOLE NH DETOX Evry Townsend Logaring Dr. Leiberman (ul) 336.536,4089

# 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

## 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. <u>Volume 39, Issue 1</u>; <u>https://doi.org/10.1177/08258597221149402</u> 2024



## 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



# 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.





### **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



### 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. <u>Set Quality Improvement goals for ED Palliative presence</u>
  - Start with active patients





### End of talk





### 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.

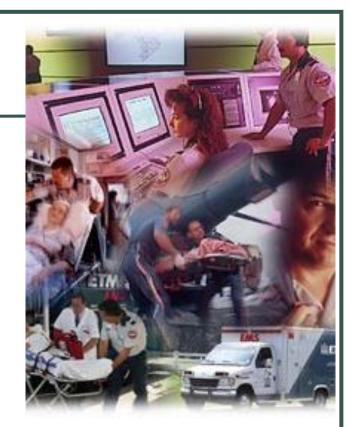
•Protect the privacy of patients and families near the end of life.

•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





### **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



Where good health begins.

Advance Care

**Planning Guide** 

healthcare decisions

New Hampshire Advance Directives: Durable Power of Attorney for Health Care (DPOA

How to think about, talk about and plan for serious illness or injuries which may keep you from making your own