

United States Best Practice Guidelines for Primary Palliative Care in the Emergency Department



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The growing palliative care needs of emergency department (ED) patients in the United States have motivated the development of ED primary palliative care principles. An expert panel convened to develop best practice guidelines for ED primary palliative care to help guide frontline ED clinicians based on available evidence and consensus opinion of the panel. Results include recommendations for screening and assessment of palliative care needs, ED management of palliative care needs, goals of care conversations, ED palliative care and hospice consults, and transitions of care [Ann Emerg Med. 2021;78:658-669.]

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BACKGROUND

The recognition of US emergency departments (EDs) as an access point and a crossroads for an overwhelming volume of patients with serious or life-limiting conditions¹⁻³ led to the development of primary palliative care principles.^{4,5} Sixteen to 22% of hospice enrollees visit the ED,⁶ and 75% of Americans over the age of 65 years visit the ED in their last 6 months of life.⁷ The number of Americans aged >65 years is expected to double by the year 2050.⁸ The official recognition of hospice and palliative medicine as a subspecialty in 2006⁹ has led to a steady increase in the number of palliative care-certified emergency physicians since 2008,¹⁰ but it is not enough to address the palliative care needs of ED patients alone.^{11,12} Primary palliative care is defined as basic palliative care skills, including patient-centered communication, advance care planning, and refractory symptom management,⁵ that can be and are usually performed by emergency clinicians, including physicians, nurses, emergency medical services (EMS), physician assistants, nurse practitioners, and social workers. Emergency clinicians have gained expertise using national educational resources, such as the Palliative Care Network of Wisconsin Fast Facts,¹³ Education in Palliative and End-of-Life Care for Emergency Medicine,⁵ Integrating Palliative Care Practices in the Emergency Department,¹⁴ EM Talk,¹⁵ VitalTalk,¹⁶ and End-of-Life-Nursing Education Consortium,¹⁷ among others. While these resources appropriately provide hospice and palliative medicine and emergency medicine education and

potential care recommendations, the lack of standardized, evidence-based best practice ED primary palliative care clinical guidelines increases the potential for inconsistent care and harm.^{18,19}

IMPORTANCE

A significant body of literature in other disciplines demonstrates that palliative care can improve quality²⁰ and sometimes length^{21,22} of life while reducing utilization and costs in patients with life-threatening illnesses.²³⁻²⁹ The rate of publications on ED palliative care has more than doubled in the past 5 years, and authors of a recent systematic review concluded that based on heterogeneous studies of palliative care interventions in the ED largely delivered by palliative care specialists, ED palliative care is feasible, improves quality of life, and does not decrease survival; but more rigorous study is needed to make high-level conclusions regarding best practices.³⁰ Emerging research indicates that ED-initiated palliative care consults may reduce utilization and costs.^{31,32} Current ongoing research on ED primary palliative care is attempting to show the positive relationship with integration into emergency practice.³³⁻³⁷

Emergency clinicians must rapidly manage patients with palliative care needs 24/7, and they often do so without immediate (or any) access to hospice and palliative medicine specialists. Particularly when managing patients with serious illnesses or those at the end of life, the emergency clinician is responsible for implementing primary palliative care. Primary palliative care is performed

by all emergency clinicians, including those who work in limited-resource settings. Since emergency clinicians and emergency medicine residents have highlighted the value of the primary palliative care skill set in clinical practice and identified gaps that may exist in knowledge and skills,³⁸⁻⁴⁴ increasing efforts are being made to include primary palliative care in resident education.⁴⁵

While the ED poses specific challenges to optimal palliative care (eg, crowding^{46,47} and limited patient and family information⁴⁸), the brevity of the emergency clinician patient relationship arguably also places the emergency clinician in a unique position to objectively assess the patient's illness trajectory.⁴⁹ In light of multiple pilot projects nationwide and a recent systematic review showing that primary palliative care in various non-ED settings can improve quality of life without decreasing survival,⁵⁰ it is reasonable to expect that emergency clinicians informed by best practice guidelines can empathetically have goals-of-care discussions^{51,52} and address palliative care needs with significant benefits to patients, clinicians, and health care systems.⁵³⁻⁵⁸ Palliative care's focus on the whole patient and clinician could also advance the quadruple aim: improving the patient experience, population health, cost stewardship, and emotional betterment of health care clinicians and staff.⁵⁹

GOALS OF THIS INVESTIGATION

The goal of this paper is to provide concise and user-friendly best practice guidelines for emergency clinicians to help establish a reasonable standard of primary palliative care in emergency medicine. This is based on current evidence and the consensus opinion of an interdisciplinary ED palliative care expert panel, including review of multiple publications on ED palliative care integration,^{5,31,36,42,48,51,60-69} the National Consensus Project for Quality Palliative Care,^{70,71} the National Quality Forum's Preferred Practices for Palliative and Hospice Care Quality,⁷² Trauma Quality Improvement Program,⁷³ Geriatric Emergency Department Guidelines,⁷⁴ and Oncology Clinical Practice Guidelines.⁷⁵ We are not aware of any best practice guidelines specifically for emergency clinicians delivering primary palliative care. In addition, these best practice guidelines can also be used by leaders to assist in the development of national benchmarks, policies, and research.

METHODS

An expert panel convened to develop best practice guidelines for ED primary palliative care based on a

review of evidence and expert consensus. Panelists included palliative care section leaders from the American College of Emergency Physicians (ACEP), Society of Academic Emergency Medicine, and American Academy of Emergency Medicine as well as members of American Academy of Hospice and Palliative Medicine emergency medicine section leadership and the Emergency Nurses Association. Diverse opinions were included from academic and community-based ED clinicians, palliative care- and nonpalliative care-trained emergency clinicians, and ED nurses. The panel included 4 academic faculty (SL, EI, RG, GC) and 5 community-based faculty (DW, KA, MR, AL, RP); 3 with dual board certifications in emergency medicine and hospice and palliative medicine (SL, DW, RG); 2 with hospice and palliative medicine fellowship training (DW, RG); and 6 with palliative care practice experience internal and external to the ED setting (GC, DW, RG, KA, MR, EI). A section grant from the ACEP funded staff support and resources for work group.

The panel first conducted a comprehensive literature review and found no best practice guidelines for ED primary palliative care. To establish a process for drafting these guidelines, the panel developed a framework through 2- to 3-hour-long phone conferences on a monthly basis over 3 years. The outline framed a patient's journey in the ED, from arrival through transition of care to the next setting. Next, the committee divided the relevant content and best practices for each of the 4 sections (Table 1) for drafting, with 2 to 3 panelists assigned to each section of the framework.

Each section was reviewed and then discussed on structured conference calls following a set timeline. The nominal group technique was used to achieve consensus. Voting occurred on conference calls, then comments and edits were submitted. Iterative revisions were continuously resubmitted for review, comments, and voting. Conflicts were resolved by group discussion for consensus. Draft key points were then also presented to ACEP palliative section members and attendees during the ACEP *Scientific Assembly* palliative medicine section meetings in 2017 and 2018 for additional comments and suggestions. Verbal and written comments were collected through roundtable discussions from the section members during the assemblies. These comments were implemented into the drafts and then peer reviewed by the panel for further edits.

Best efforts were made to comply with the Appraisal of Guidelines for Research and Evaluation Instrument

Table 1. Clinical best practice guidelines for ED primary palliative care: key points from ED arrival to transition of care.**Screening and Assessing ED Patients for Palliative Care Needs**

- Screening and assessment for palliative care needs should occur on a continuum: out-of-hospital to transition of care out of the ED.
- A tiered approach, starting with the “surprise question” to identify patients, is recommended:

Step 1: Ask, “Would you be surprised if the patient were to die within this hospitalization, or within 12 months?” If the answer is “no,” then:

Step 2: Perform needs assessment and provide primary palliative care by the interdisciplinary emergency clinician staff. Complex situations should be referred to the palliative care team.

- ED-based palliative care needs screening and assessment includes 5 key elements:
 1. Early identification of ED patients, families, and caregivers with palliative care needs.
 2. Gathering preexisting ACP documents, such as advance directives and prior code status orders (eg, POLST).
 3. Identifying the health care proxy and whoever may be essential for shared decisionmaking.
 4. Formulating and initiating a discussion of prognosis with the patient and/or the family.
 5. Initiating a culturally sensitive goals-of-care conversation with the patient and/or family.

Managing the ED Patient with Palliative Care Needs

Primary palliative care can and should occur in parallel with life-sustaining or disease-modifying care in all seriously ill patients.

- Involve the interdisciplinary team to create a plan of care based on the palliative care assessment.
- Review and document preexisting ACP.
 - EHRs can have clinical decision support tools to remind emergency clinicians to review ACP documents and also can trigger palliative care consults if appropriate.
- Standardize orders with an ED-specific palliative care or comfort care order set.
- Control refractory symptoms (Figure 1).
- Effectively communicate with patient and family to align treatment decisions with the patient’s values and goals of care.
- Framing the discussion as “hoping for the best but preparing for the worst” can help build trust.
- Elicit the patient’s overall goals (eg, die at home) before discussing specific interventions (eg, intubation).
- Evaluate all interventions, including diagnostic tests, in the context of the patient’s goals of care (eg, a blood draw may be routine in early disease but burdensome in the imminently dying patient who desires comfort care only).
- Offer a time-limited trial of life-prolonging interventions along with initiating palliative care as a bridge when families are struggling with difficult decisions and/or prognoses.
- Recognize patient eligibility for hospice, start a discussion of hospice for appropriate patients, and communicate this to the palliative care team.
- When transitioning a patient to comfort measures or stopping nonbeneficial interventions (eg, mechanical ventilation), managing distressing symptoms (eg, dyspnea) should be done aggressively with staff physically present at the bedside so patient and family do not feel abandoned.

Consulting Palliative Care Specialists in the ED

ED consults to palliative care are encouraged since they can improve patient quality of life, ensure goal-concordant care, and decrease hospital length of stay and readmissions while having no negative impact on survival or disruption of life-prolonging treatments.

- ED and palliative care team leadership should collaborate to standardize consult guidelines.
- Timing: effectively communicate emergency versus urgent versus routine to determine the timing of consult.
- Who: Is there a specific palliative care team member best suited to address these needs, such as a pharmacist for symptom management, chaplain for bereavement support, etc?
- Question: Does the patient need anything specific in the ED from the palliative care team? Identify whether on-phone support will suffice or physical presence of consultant is needed, particularly during off hours.

Transitioning Care of Palliative Care- or Hospice-Eligible ED Patients

- Consider dispositions beyond the traditional paradigm of admission versus discharge, such as arranging a quiet room for the imminently dying patient, inpatient palliative care unit placement, referrals to hospice, and outpatient palliative care.
- Communicate and document effectively and clearly to the transitioning team to safeguard patient and family wishes and care plans negotiated in the ED.
- Engage with palliative care patients while they wait for transfer to the next setting to avoid the appearance of abandoning care.
- Know inpatient and community hospice resources and referral processes to ease transition of appropriate patients to hospice care.

ACP, advance care planning; EHR, electronic health record; POLST, Physician Orders for Life-Sustaining Treatment.

(AGREE II).¹⁸ Areas of noncompliance that need to be addressed in the next revision of these guidelines include: inclusion of other perspectives (eg, emergency clinicians from low-resource environments and those with minimal expertise in palliative care, the public, ED patients, and

additional emergency clinicians, such as EMS, social workers, and chaplains); external review by relevant professional groups, such as nursing, trauma, geriatrics, and oncology; and tools to assist guideline implementation.

RESULTS

Clinical best practice guidelines for ED palliative care are categorized into 4 phases of patient care (specific activities within each phase can be found in [Table 1](#)):

1. Screening and assessing the patient for palliative care needs
2. Managing the patient with palliative care needs in the ED
3. Consulting palliative care specialists from the ED
4. Transitioning palliative care- or hospice-eligible patients from the ED

Screening and Assessing Patients for Palliative Care Needs

Ideally, screening patients for palliative care needs would begin with EMS in the field or with the ED triage nurse and continue throughout the length of the ED stay, recognizing variables that can change over time, such as the patient's medical status, their decisionmaking capacity, and availability of advance care planning documents or surrogate decisionmakers.

Particularly for complex cases, the screening process will likely need to be tiered, or handed off to an interdisciplinary team to assess the full spectrum of palliative care needs in multiple dimensions, including:

- Physical: distressing symptoms such as pain, dyspnea, nausea, vomiting, constipation, etc.
- Emotional: sadness, anger, despair, etc.
- Social: family/caregiver burden and assistance with community resources
- Psychological: depression or anxiety
- Spiritual: religious or existential suffering
- Grief or bereavement

Screening. There are multiple screening tools that have been used or adapted for the ED setting.⁷⁶⁻⁷⁸ For example, the Palliative Care and Rapid Emergency Screening (P-CaRES) screening tool identifies emergency patients with serious, life-limiting illnesses who could benefit from palliative care services.^{77,79} The ED screening criteria often include a combination of factors and multiple steps, such as:⁷⁷⁻⁸¹

- 1) Identifying the presence of life-limiting conditions (eg, end-stage organ disease, advanced cancer, multiorgan system failure, or post cardiac arrest) combined with the presence of specific clinical indicators that identify seriousness of underlying disease (eg, more than 1 hospitalization in the last 6 months for cardiac or respiratory failure).
- 2) Considering functional decline, such as the ability to ambulate and take care of self (eg, Palliative Performance Scale⁶⁶).

- 3) Using clinician judgment, such as considering the “surprise question” (“Would I be surprised if the patient died within the next year?”).

Among the multiple screening tools studied,^{76,78} the “surprise” question—“Would I be surprised if the patient died within the next year?”—is an easily implemented emergency medicine predictor of palliative care needs for both acutely ill and stable patients.^{37,82-85} This question can also be tailored depending on needs of the ED and is valuable since it is available to all emergency clinicians, including those in low-resource settings. For example, putting a shorter time period on the question, such as “3 months” or “during this admission,” may increase the specificity of the tool. The sensitivity may be increased by increasing the duration of time, thereby identifying more patients earlier in their disease trajectories.

Use of electronic health record (EHR) clinical decision support tools is recommended to automatically remind emergency clinicians to access preexisting advance care planning documents, may help identify patients appropriate for palliative care, can automatically place referrals to palliative care^{77,78,81,86} or assist with meeting clinical guidelines.^{77,78,81,86,87} For example, the Emergency Department Supportive Care Clinical Decision Support tool, modeled after P-CaRES, fires alerts for 3 scenarios: when there is an advance care planning document present (informational and trigger for goals-of-care conversation); when a patient was previously discharged to hospice (informational and triggers social work/case management); and when serious life-limiting illness is present with no advance care planning documented (relies on history/encounter data points such as “surprise question,” prior do-not-resuscitate orders, transfer from long-term care facility, etc, to trigger palliative care consult and goals-of-care conversations). Regardless of the screening method or clinical decision support tool used, tailoring and adapting the elements to address a specific ED's workflow needs, populations, and available resources is recommended.

Assessment. While palliative care is expected to help many patients who are not near the end of life (eg, patients with refractory symptoms), an emergency clinician understanding of trajectories of illnesses, conditions that typically herald limited life expectancy, and preexisting functional capacity may help identify patients with palliative care needs early to facilitate compassionate ED risk-benefit discussions regarding medical interventions.

Additionally, when screening for palliative needs, prognosis can be difficult to predict for patients with organ system failure (eg, congestive heart failure) or frailty (eg, dementia), while advanced cancer patients tend to follow a more predictable trajectory. While oncologists'

determination of advanced or terminal cancer is an important consideration, conditions that typically portend life expectancy of 6 months or less include multiple brain metastases, hypercalcemia, malignant effusions, and bowel obstruction.⁵ Also, decreased functional capacity can be easily assessed and is a strong predictor of worse outcomes.⁸⁷ Cancer patients who are confined to a chair or bed 50% or more of their waking hours typically have a median life expectancy of 3 months (performance status with Eastern Cooperative Oncologic Group score of 3 or Karnofsky score of 50).^{66,88,89} Main categories of ED patient primary palliative care needs include clarification of code status, symptom management, early introduction to palliative care, and caring for a current or prior hospice patient.

Patient Management and Palliative Care Interventions

Symptom management. Tips for ED management of refractory symptom management are summarized in Table 2.⁵¹

ED goals-of-care discussions. These 4 components are integral to an effective goals-of-care discussion in the ED:

- *Assess* patient and family understanding of underlying illnesses and acute change in today’s presentation
- *Understand* how this illness has changed the patient’s quality of life
- *Ask* for patient’s and family’s greatest worry at this moment and what is most important to them
- *Provide* a clinical recommendation triangulating the patient/family priorities, underlying disease prognosis,

and probable clinical trajectories from today’s presentation

Assess: Comprehensive assessment of the patient’s and family’s understanding of the situation and goals of care begins with review of any existing advance care planning documents.⁹⁰⁻⁹² Consider questions such as “Is the patient able to make health care decisions?” “Who are the decision makers?” and “Is there a durable power of attorney?” However, ED visits are frequently prompted by unexpected illness, and patients may not have had these conversations or codified their wishes into legal documents. Secondly, take a few moments to gauge the patient’s and family’s understanding of the patient’s health prior to arrival and their impression of what precipitated the ED visit. Using open-ended questions allows family to reveal their baseline medical literacy, understanding of prognosis, and expectations (Table 3).

Understand: Prior to transitioning into giving medical updates or asking for decisions, it is important to qualitatively explore how the illness has affected the patient’s quality of life. For instance, learning how a patient with dementia is no longer able to enjoy their former hobbies or how a patient with cancer thinks about becoming bedbound sets up a pattern of decline that helps frame any potential further loss in quality of life from interventions.

Ask: After providing a brief medical update (nonjargon and short sentences), ask the family about their greatest worry and what is most important to them in this new situation. If the patient is dying from what would be an expected complication of their underlying illness, consider sharing that this is the natural course of their disease.

Table 2. Palliating refractory symptoms in the emergency department.⁵¹

Symptom	Therapy to Consider	Dose (May Reduce Doses for Comorbidities—eg, Renal Disease)	Comments
Pain—opioid tolerant	Morphine	10%–20% of current total daily dose for breakthrough pain	Titrate after first dose: for moderate pain, increase 50%; for severe pain, may increase 100% every 15 min for subcutaneous or intravenous doses, every hour for oral dose
Nausea and vomiting	Haloperidol	0.5–2 mg intravenously, subcutaneously, or by mouth	Prolongs QT, check ECG. Add diphenhydramine for dystonia
Dyspnea	Morphine	1–4 mg intravenously/subcutaneously every 15 min or 10 mg by mouth every hour	No respiratory depression at low doses Second line, may worsen delirium
	Lorazepam	0.5–1 mg intravenously, subcutaneously, or by mouth	
Delirium	Haloperidol	0.5–2 mg intravenously, subcutaneously, or by mouth	Search for underlying cause
Terminal Secretions	Atropine	0.5 mg intravenously or 2 gtt by mouth	Drops are same as ophthalmic suspension
	Glycopyrolate	0.1 mg intravenously or 0.2 mg by mouth	
Constipation	Senna (Stimulant)	8.6 mg tablet, 2 tabs by mouth daily	May increase to 12 tablets daily
	Lactulose (Osmotic)	15 mL by mouth daily	Maximum 60 mL daily
Opioid Induced	Methyl- naltrexone	450 mg by mouth or 12 mg subcutaneously daily	Limit to one dose daily

Table 3. Rapid goals-of-care conversations in the ED.⁹³

Step	Suggested Language
Assess understanding (patient and/or family)	"Can you tell me what happened today?"
Break serious news	
Ask permission:	"I have some serious news, is it ok to share?"
Headline (concise summary)	"I wish things were different, but he (she) is critically ill from (insert issues) and his (her) organs are failing."
+ meaning:	"I am worried that he (she) might die."
Acknowledge emotion:	"I can only imagine how difficult this must be."
Collaborate on a plan for care	"We need to work together quickly to decide on the best plan of care for him (her)." ... "If it is ok with you, can I ask a few questions?"
Discuss advance care Plan:	If prior documents (eg, POLST) were reviewed: eg, "During the last admissions, it appears that he (she) had indicated that he (she) would not want to be intubated, even if he (she) would die without it. Do you think he (she) would say the same thing now?" If there are no prior ACP documents: "Have you ever had any discussions about how he (she) should be cared for if he (she) were to be seriously ill?"
Determine baseline function:	"Before he (she) was ill, what kinds of activities could he (she) do throughout the day?"
Elicit core values:	"If time is short, what would be most important to him (her)?" "If he (she) could talk, what do you think would be his (her) greatest fear or concern?"
Summarize:	eg, "What I heard is that is important to him (her) and that treatments that would result in would be (un)acceptable to him (her). <i>Did I get that right?</i> "
Recommend:	"Based on our discussion, I would like to make a recommendation. Would that be ok?" "Based on our discussion, I recommend that we ___ ["focus 100% on his (her) comfort"] -or- [aggressive curative treatments.]

Families may surprise you and report that "not suffering anymore" is paramount at this point in time. Hearing these priorities early helps guide downstream discussions of code status, procedures, or ICU-level care.

Provide: Lastly, provide a recommendation based on which clinical option best meets the patient's and family's priorities. Respect patients and/or families who may not be ready to discuss the end of life, but do not be impartial, as this can place an unfair burden on

those with limited medical literacy. Continuously recenter on the patient's wishes if family members are absorbed in their own feelings. If introducing comfort care, reassure family by shifting the conversation away from "what you won't do" (resuscitation, interventions, etc) toward "what you will do" (aggressive symptom management) and ultimately allowing a natural death. Seek further assistance from social work and chaplaincy, if desired and available, to support family throughout their ED stay.

Various conversation maps for ED goals-of-care conversations have been developed,^{5,13,15} quality metrics are in the early stages of development,⁵² and a standardized way to hold ED code status conversations for older patients in respiratory distress has been proposed.⁹³ Each framework essentially offers a stepwise approach that can be applied to either acute emergencies or subacute situations, though the order of steps may vary (Table 3). Time-constrained emergency clinicians have also identified rapid goals of care or code status conversations as a priority primary palliative care skill^{38,42,43} and might find the following bottom-line question helpful: "Are the burden and the expected outcome of the intervention (eg, intubation) acceptable to the patient, to the surrogate, and, ideally, to the family?"

It is important to acknowledge that even under ideal circumstances with immediate hospice and palliative medicine specialist assistance, not all goals-of-care conversations in the ED may be actionable. Sometimes, patients and surrogates need more time to resolve complex interpersonal dynamics, process weighty emotions, and other intangibles. Many of these can be perceived as conversations where the parties "just don't get it," but evidence suggests that this is not solely due to knowledge or communication gaps.⁹⁴ Repetition or paternalistic simplification of medical facts or outcomes are unlikely to be effective and may even harm families and their trust in later clinical teams. Best practice recommendations include: emergency clinicians should not offer ineffective interventions,^{91,95,96} should continue to offer support (eg, "We will be with you every step of the way"), and may invite further discussions with other clinicians, including hospice and palliative medicine, if available.

Time-limited trials. Often, definitive decisions are difficult to make in the setting of acute and evolving clinical status, especially when the decline was sudden and unanticipated. One recommended approach is to consider a time-limited trial of life-prolonging care in conjunction with ongoing goals-of-care conversations by the admitting team.⁹⁷ You may introduce the idea of considering a period

Figure 1. Time sensitivity of ED palliative care consults.

- Emergent: Critically ill patients for whom immediate assistance is needed with symptom management or goals of care (eg, obtunded terminal cancer patient in severe respiratory distress with family disagreement about intubation).
- Urgent: requires assistance within 24 hours (eg, terminal patient with chronic obstructive pulmonary disease admitted on time-limited trial of intubation, may need compassionate extubation).
- Routine: patient who can be seen a day or more later (eg, dementia patient admitted to ward with urinary tract infection. Surrogate needs assistance with goals of care).

of time to allow the family's hopes to unfold (eg, 24 to 72 hours). It is helpful to focus hopes on explicit milestones of improvement, how progress will be defined, and alternate considerations in case the desired outcome is not achieved.

Palliative Care Consultations in the ED

ED-initiated palliative care consults have been shown to improve quality of life, reduce readmissions, and lower costs and inpatient length of stay while having no effect on survival.^{30-32,57} A collaborative relationship with a palliative care team can improve understanding of available resources and allow palliative care team members with specific expertise to address individual patient needs.^{54,64,98-101} For example, a palliative care-trained pharmacist may assist with pain control; case managers and social workers may assist with home health or hospice. The ED and the palliative care team should also understand respective workflows, agree on time sensitivity (Figure 1), and agree on whether in-person support is required (eg, bereavement support) or phone-only is sufficient (eg, symptom management advice) for particular consults.^{102,103}

For the busy emergency clinician, real-time support for critically ill patients is most useful.⁵⁴ While palliative care consultations are beneficial at the time of diagnosis of any life-limiting illness,⁷⁶ this may not be practical in the ED due to time constraints. A streamlined workflow to refer dispositioned patients to palliative care for nonemergency needs can benefit both patients and health systems and decrease subsequent ED visits.

Hospice Consultations in ED

Initial hospice referrals may be considered from the ED for patients who have a life expectancy of 6 months or less and desire focusing on symptom management and quality of life rather than disease-directed treatments.^{104,105} A prior relationship with a hospice agency helps streamline the process, which requires patients to sign over their Medicare or insurance benefits to the hospice agency. Patients with unmanageable symptoms may require inpatient hospice

Figure 2. Common questions and answers regarding hospice.

Who pays?

Hospice is paid for completely by Medicare, Medicaid, and most private insurers.

Where is hospice delivered?

Hospice is often delivered at home. If hospice is delivered at a facility, a separate facility cost may be covered by insurance or be out of pocket.

What care is covered?

Hospice provides a team of nurses, social workers, chaplains, and caregivers to bring care to patients in their places of living. Most patients receive about 3 visits per week. If symptoms are severe, they can temporarily receive care around the clock. This includes medications, equipment, etc. Hospice does not provide 24/7 caregiving, although in most hospices, there is a clinician available 24/7 by phone for troubleshooting for patients and caregivers (ie, to call them instead of 911 if something changes).

What procedures are covered?

Hospice sometimes continues to pay for palliative procedures (ie, thoracentesis, paracentesis, transfusions, radiation) if they meaningfully add to quality of life.

What are other considerations regarding hospice?

Discussion with the primary outpatient physician is essential in making a hospice referral as that physician will often continue the plan of care. Patients on hospice are not required to have Do Not Attempt Resuscitation orders. Code status discussions may continue to be addressed. Patients may unenroll to pursue curative treatments at any time and reenroll in hospice without penalty.

when available. In some cases, the process of hospice enrollment is best managed by the inpatient team on an observation unit. For patients discharged home on hospice, case managers or social workers should be engaged early for key tasks such as documenting the name and phone number of the hospice agency in the EHR and obtaining necessary equipment for the home (eg, hospital bed). Some hospice-eligible patients may only be ready to accept an informational visit during their hospital admission or in their home from a hospice representative. This is a low-stakes negotiation that completes a critical first step of the process. Answers to common questions about hospice are listed in Figure 2.

Transitions of Care

Regardless of ultimate disposition, palliative care-eligible ED patients require thoughtful transitions to safeguard their goals of care. In contrast to traditional ED dispositions (admit versus discharge), these vulnerable patients have a potential myriad of options to best serve their needs.¹⁰³

Admitted patients awaiting inpatient palliative care consultation. It is essential to communicate the intent for palliative care consultation with the patient, family, and admitting teams and nursing. When the reasoning is not

clearly communicated, consultations may be canceled. Intentionally delineating the reason for palliative care consultation in the initial admission discussion creates professional courtesy and increases the likelihood of completion. Patients should be informed that you have invited an extra layer of supportive care specialists to augment their care.

Admitting patients to an inpatient unit for optimal symptom control. Palliative care-eligible patients often present with refractory symptoms (eg, pain, dyspnea), which require expertise beyond the scope of the ED. If the patient is already enrolled in hospice, the patient can usually be admitted to an inpatient service for symptom control without being required to unenroll from hospice. This is considered General Inpatient hospice care. If the patient is not enrolled in hospice, hospital admission with palliative care consultation or admission to the palliative care unit may be needed.

ED referrals to outpatient palliative care clinics. If there is a palliative care clinic available, introducing patients early into the palliative care continuum has the potential to significantly improve their quality of life and decrease inappropriate care.³¹ Eligible patients are those who are beginning to experience functional decline from their incurable illness. Close outpatient palliative care comanagement with their other specialists enables better symptom control, potentially decreases ED visits and hospitalizations, and facilitates advance care planning.

Transitioning to comfort care for actively dying patients. Standardized transitions to comfort care are important to ensure optimal symptom control and mitigate interprovider variation in best practices. Comfort order sets in EHRs help ensure that opioid and benzodiazepine boluses are prioritized (infusions may take hours to reach therapeutic levels), unnecessary vital sign monitoring is discontinued, and code status changes are transparent to all.

To prevent a sense of abandonment, emergency clinicians need to communicate the fact that the focus is now on aggressive comfort care or clearly state that the team is doing everything to ensure the patient goals of comfort and avoidance of harm are met. Similarly, it may be helpful to remind staff that “Do Not Attempt Resuscitation” should not be conflated with “Do Not Treat” and that these patients are critically ill and aggressive symptom management for them will often be very labor intensive.

Transfer of the imminently dying to an observation unit. Some ED patients are expected to die within the next 24 hours. These may include patients with septic shock, neurologic insult with expected respiratory arrest, pulmonary insults, or palliative or compassionate

extubations awaiting family arrival. When considering palliative extubation, emergency clinicians should assess whether the patient triggers breaths, respiratory effort in correlation to amount of ventilator support, and if the patient has a cough or gag reflex. These factors do not preclude the option for palliative extubation but help clinicians understand how to best manage patients during the extubation.¹⁰⁶

EDs or short-stay observation units may have private rooms that can be flexed into comfort care suites. These are quiet spaces that can operate under protocols requiring minimal nursing resources. Transferring a dying patient to such a setting provides for privacy and dignity, improves family experience of a stressful event, improves ED throughput, and circumvents admission and handoffs. However, institutional policies may vary about allowing for natural death in such short-term care units.

Performance Improvement Initiatives and Quality of Care

Just as emergency clinicians strive to provide evidence-based and data-driven quality care across the spectrum of ED complaints, it is important to identify data points and outcomes related to patients with serious life-threatening illness to better serve their needs and goals. Individual EDs differ by location, patient population, resources available, and institutional mission. The type of ED care initiatives chosen will depend greatly on a department’s individual goals and resources, and the associated metrics for program success will similarly vary depending on departmental differences. Highest priority for implementation is best given to initiatives with the highest potential impact and the least difficulty or resources required.

Chosen metrics to evaluate quality of care could similarly be oriented to the 4 phases of care as described above: 1) screening and assessing palliative care needs, 2) managing symptoms, 3) specialty level consultations, and 4) transitioning palliative care- and hospice-eligible patients from the ED.

LIMITATIONS

This first edition of US ED best practice guidelines for primary palliative care is based on a small but growing body of evidence specific to ED palliative care practice. The expert consensus panel includes physicians and a nurse but does not include patients, EMS, non-ED clinicians, or the entirety of the traditional interprofessional practice of palliative medicine, which includes social workers, chaplains, and pharmacists. While the panelists represent both academic and community practice, they are palliative

care champions, practicing mostly in urban hospitals with significant resources and palliative medicine presence. These near-ideal circumstances are not present in the majority of EDs in the US and abroad.

DISCUSSION

US EDs provide care for those seriously ill and suffering with high symptom burden from advanced or catastrophic illnesses, from the patient with terminal cancer to the patient dying from an acute intracranial bleed. Emergency clinicians primarily focus on providing life-saving stabilization and resuscitation; however, the National Institute of Health, the Agency for Healthcare Research and Quality, and ACEP's Choosing Wisely campaign have all recommended the integration of palliative care into emergency medicine.¹⁰⁷⁻¹⁰⁹ With the increasing number of patients with advanced chronic illness, ED primary palliative care is essential to ensure that resuscitation efforts are appropriate, communication is empathetic and effective, and refractory symptoms are managed. While ongoing emergency clinician education is critical to the development and maintenance of necessary skills, the effective provision of primary palliative care on a national scale requires standardized processes and guidelines to support emergency clinicians.

Overarching best practice of ED palliative care involves engaging an interdisciplinary team to optimize the timely utilization of a broad range of services. While the overall goal is not cost savings, the improved alignment of care with patient goals afforded by quality palliative care has been shown to reduce ICU stays, readmissions, and costs and thus be beneficial to overburdened EDs and health care systems.^{23-25,31,32,51,56,58,110} Effective communication with patients, family, and caregivers remains a cornerstone for ED primary palliative care. Communicating current illness in context with prognosis while interpreting with a level of uncertainty within the ED is common, so improving skillful communication is essential. Establishing trust while expressing compassion to members of the patient's support system with thoughtful consideration of the patient's psychosocial aspects of care is part of a "holistic" approach in ED primary palliative care. All these elements may help to create a welcoming environment and improve patient satisfaction with ED care for seriously ill patients.

CONCLUSION

ED staff focus on delivering the right care, in the right place, at the right time to their patients. Emergency clinicians bear a significant responsibility for setting the

initial trajectory of care for patients during the ED visit and subsequent hospitalization. The ED remains an important site for the initiation and continuation of palliative care for seriously ill patients. US ED primary palliative care best practice guidelines provide a framework to deliver high-quality, patient-centered care through the 4 phases of emergency care for these patients. Readiness to implement ED palliative initiatives will vary across institutions and locales. Tailored integration and/or expansion of available palliative care resources must reflect institutional priorities and ED-specific culture and protocols. Successful implementation requires both emergency physician and nursing champions. Formal education and training of all members of the ED team, including emergency medicine residents,⁴⁵ will need to accompany any palliative care initiatives. Improving the ED care of seriously ill patients and their families can enhance the well-being of staff, as they know they are focusing on the individual patient's goals for care.

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