Geriatric Emergency Medicine Symposium 2026
Conversations about The State of Palliative Care in Emergency Medicine
Dan Gingold, MD, MPH
Stephen Schenkel, MD, MPP

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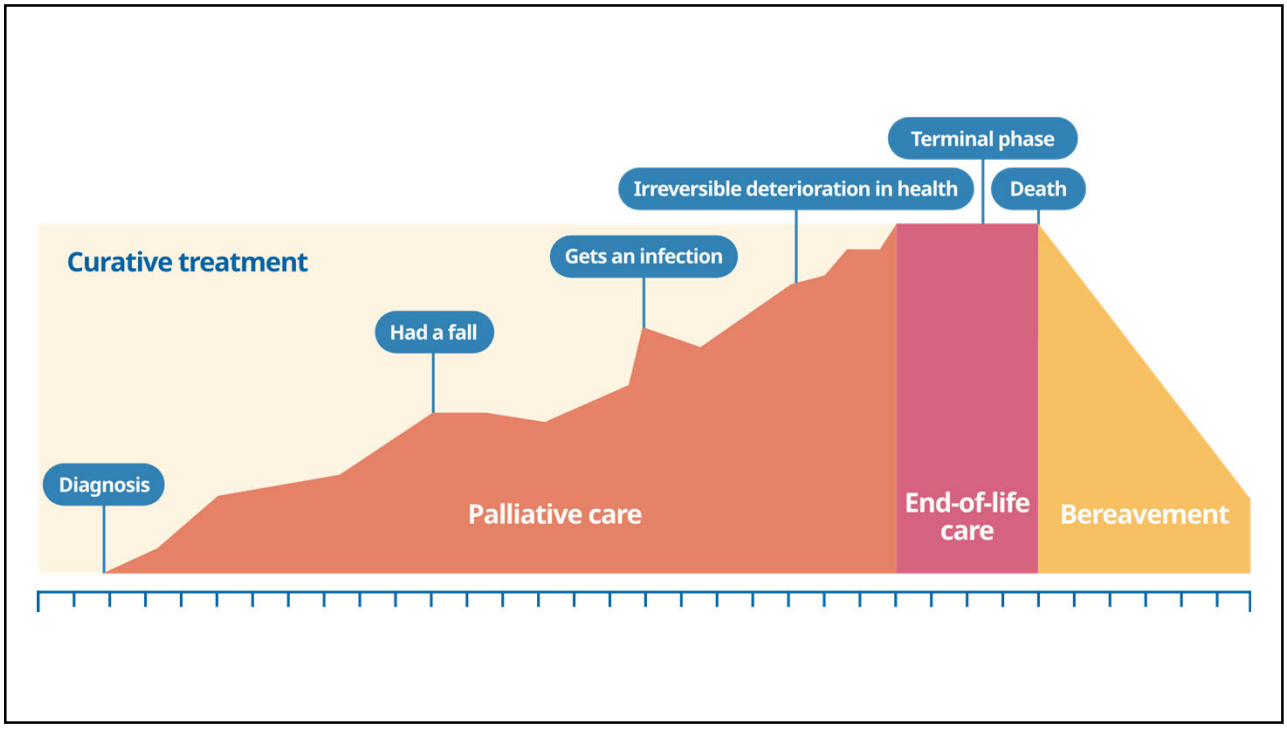

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Research

JAMA | Original Investigation

Palliative Care Initiated in the Emergency Department
A Cluster Randomized Clinical Trial

Corita R. Grudzen, MD, MSHS; Nina Siman, MA, MSEd; Allison M. Cuthel, MPH; Oluwaseun Adeyemi, MBBS, PhD; Rebecca Liddicoat Yamarik, MD; Keith S. Goldfeld, DrPH, MS, MPA; and the PRIM-ER Investigators

IMPORTANCE The emergency department (ED) offers an opportunity to initiate palliative care for older adults with serious, life-limiting illness.

OBJECTIVE To assess the effect of a multicomponent intervention to initiate palliative care in the ED on hospital admission, subsequent health care use, and survival in older adults with serious, life-limiting illness.

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Supplemental content

CME Quiz at jamacmelookup.com

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Table 1. Description of Intervention Components

Intervention component	Education in Palliative and End-of-Life Emergency Medicine	Emergency Medicine Talk	End-of-Life Nursing Education Consortium Critical Care	Clinical decision support tool	Audit and feedback
Actors	All full-time emergency physicians, physician assistants, and nurse practitioners	All full-time emergency physicians, physician assistants, and nurse practitioners	All full-time emergency medicine nurses	All emergency physicians, physician assistants, nurse practitioners, residents, and social workers	All emergency physicians, physician assistants, and nurse practitioners
Goal	Primary palliative care knowledge and skills in needs assessment and referral	Simulation workshop on end-of-life communication	Primary palliative care knowledge and skills in needs assessment and referral	Best practice alerts or banners and new workflow for referral to palliative care, home care, and hospice services[a]	Individual- or departmental-level reports for No. of referrals to palliative care, home care, and hospice services
Timing	Once during the 3-wk intervention	In-person or online[b] during the 3-wk intervention	Once during the 3-wk intervention	Went live during the 3-wk intervention	First report delivered during the 3-wk intervention and then frequency was tailored accordingly
Dose	1-h Online didactic course	4-h In-person or online simulation workshop with trained facilitators and actors	1-h Didactic course	Continued use throughout study period and beyond	Report 1 time (at a minimum) during the 3-wk intervention and incorporated into ED-specific continuous quality improvement practices
Incentive	1 CME credit	4 CME credits and a $67 gift card	1 Credit for nursing continuing education and a $50 gift card	Integrated into standard-of-care best practices	Integrated into continuous quality improvement best practices

Abbreviations: CME, continuing medical education; ED, emergency department.

[a] Three template alerts or banners were provided to each site.

[b] Adaptation for COVID-19 pandemic.

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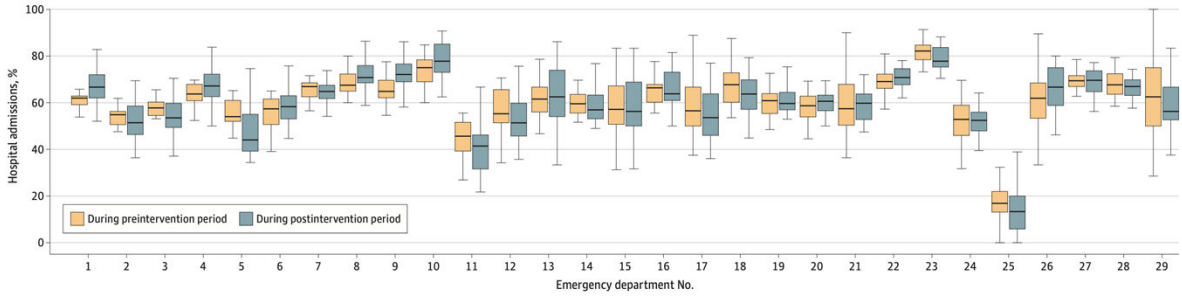
Figure 2. Hospital Admission Rates by Emergency Department Site and Intervention Period (Preintervention vs Postintervention)



Preintervention period																												
No. of patients	957	598	1980	517	1325	782	2827	1313	1917	1030	579	782	768	3258	820	3364	577	985	2397	2124	1053	4418	3868	1909	1153	1009	4280	4588	433
No. of hospital admissions	581	324	1115	335	730	437	1842	890	1251	769	255	442	470	1937	466	2184	335	658	1431	1249	619	3059	3161	993	197	605	2974	3099	266
Hospital admissions, %	60.7	54.2	56.3	64.8	55.1	55.9	65.2	67.8	65.3	74.7	44	56.5	61.2	59.5	56.8	64.9	58.1	66.8	59.7	58.8	58.8	69.2	81.7	52	17.1	60	69.5	67.6	61.4
Postintervention period																												
No. of patients	2882	1859	1663	1304	3233	1698	5819	2485	2903	1493	787	1173	848	3256	563	2280	419	625	1617	1276	638	1776	1522	867	258	318	1576	1989	184
No. of hospital admissions	1923	969	848	893	1486	983	3714	1769	2094	1166	321	615	533	1884	340	1508	231	394	990	773	375	1259	1197	458	44	205	1086	1327	109
Hospital admissions, %	66.7	52.1	51	68.5	46	57.9	63.8	71.2	72.1	78.1	40.8	52.4	62.9	57.9	60.4	66.1	55.1	63	61.2	60.6	58.8	70.9	78.7	52.8	17	64.5	68.9	66.7	59.2

Hospital admission is based on Medicare definitions. This category does not include patients assigned to observation status. The emergency department sites are ordered by intervention start date. The first site received the 3-week intervention in May 2019 with subsequent intervention rollouts planned every 3 weeks. The intervention rollouts were paused for 6 months because of the pandemic. The boxes are based on monthly hospital admission rates during each phase of the trial. Within the boxes, the line represents the median monthly hospital admission rates and the remainder of the box represents the first and third quartiles. The whiskers extend to upper and lower boundaries (1.5 × IQR). The lower hospitalization rate observed at emergency department site No. 25 may partly reflect underidentification of inpatient claims because visits at this site were identified using physician ID information due to the facility ID being shared across multiple emergency departments. The eFigure in Supplement 3 illustrates the hospital admission rates by month.

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Opinion

EDITORIAL

Expanding Palliative Care Access—Bridging Gaps in Diverse Clinical Settings

Hermioni L. Amonoo, MD, MPP, MPH; Preeti N. Malani, MD, MSJ; Stephen M. Schenkel, MD, MPP

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GENERAL MEDICINE/CONCEPTS

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

Anthony J. Loffredo, MD, MHDS*; Garrett K. Chan, PhD, APRN; David H. Wang, MD; Rebecca Goett, MD; Eric D. Isaacs, MD; Rachel Pearl, MD; Mark Rosenberg, DO, MBA; Kate Aberger, MS, MD; Sangeeta Lamba, MD, MS-HPEd

*Corresponding Author. *E-mail:* anthony.loffredo@cshs.org.

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.]

Continuing Medical Education exam for this article is available at http://www.acep.org/ACEPeCME/.

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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.

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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
	Lorazepam	0.5–1 mg intravenously, subcutaneously, or by mouth	Second line, may worsen delirium
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

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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). *Did I get that right?*"
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.]

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SYSTEMATIC REVIEW

Palliative care interventions for adults in the emergency department: A review of components, delivery models, and outcomes

Jonathan Bayuo RN, PhD[1] | Anita Eseenam Agbeko MD, PhD[2] | Emmanuel Kwasi Acheampong RN, MPhil[3] | Hammoda Abu-Odah RN, PhD[1] | Jephtah Davids RD, MPhil[4]

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CONCLUSION

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