WebEx Quick Reference

- Welcome to today’s session!
- Please use Chat to “All Participants” for questions
- For technology issues only, please Chat to “Host”
- WebEx Technical Support: 866-569-3239
- Dial-in Info: Communicate / Join Teleconference (in menu)

When Chatting…

Please send your message to All Participants …NOT All Attendees
Overall Program Aim

The aim of this Expedition, Managing Advanced Disease and Palliative Care, is to help health professionals empower patients and families to make more informed choices about the use of specific life-sustaining treatments when coping with a serious illness.

Objectives of Expedition

- **Describe** the positive outcomes for all parties — patients with advanced illness, their families, health care providers, and institutions — that arise from outstanding informed consent, education, and advance care planning
- **Assess** their current system for conducting and documenting the informed consent conversation process at critical junctures in advanced illness: initiating tube feeding, kidney dialysis, or antibiotics
- **Identify** process steps and test improvements in the informed consent, documentation, and education processes for patients and families
- **Develop** a quality monitoring process for ongoing assessment of compliance with informed consent standards

Introducing faculty

Tammie E. Quest, MD

- Associate Professor, Emory University School of Medicine, Department of Emergency Medicine and Division of Geriatric Medicine
- Interim Director, Emory Palliative Care Center
- Director, Education in Palliative and End of Life Care – Emergency Medicine
- Chief, Section of Palliative Medicine, Atlanta VA Medical Center
Common Scenario

- 75 y/o man sent to ED from nursing facility with fever of 102°F and cough
- History of dementia, bed bound with minimal speech at baseline
- Patient has power of attorney for health care
- CXR shows lobar pneumonia
- Antibiotics begun in ED; patient admitted to ward; POA contacted with update

Questions?

- What is duty of the ED physician to contact the POA prior to starting antibiotics?
- What constitutes informed consent in the ED?
- What alternatives exist to antibiotics?
- How should the discussion be conducted?

Acute Infection in the setting of a terminal illness

- An acute infection represents an opportunity to establish patient-centered goals of care.
- Goals can only be truly made in the setting of true informed consent.
  - Description of the procedure
  - Risks/benefits
  - Alternatives
  - A recommendation
Two Broad Options

1. Start antibiotics with goal of life prolongation

2. Withhold antibiotics with goal of comfort, death a likely, but not assured, outcome

In the ideal world …

• Emergency Clinician:
  1. Contacts the legally authorized decision maker
  2. Clinical facts are revealed
  3. Goals of care are assessed
  4. Intercurrent illness is contextualized with an explanation within the framework of frailty/debility trajectory
  5. Check for understanding of surrogate
  6. Recommendation is made

In the real world …

• Assumption is made:
  — that antibiotics would be desired if infection present
  — No consent needed; antibiotics are a part of treating an emergency
  — Antibiotics are not “heroic” or extraordinary
  — Easily stopped by the “next physician
• Delay to antibiotics is considered a negative quality measure
• Antibiotics typically initiated without consultation of patient/family
• Surrogate often not available
In the real world...

- ED operations are driven by:
  - Quality Measures/outcomes
    - Joint commission
  - Key Performance/efficiency measures
    - ED Average length of stay
    - ED waiting times
    - ED “Left without being seen”
    - Relative Value Units (clinician performance)
  - Mantra: Evaluate and disposition
    - Admit, transfer, discharge without delay

Drivers: Antibiotics in the ED

- ED Culture
  - Antibiotics are a low risk intervention with potential harm (death) avoided
    - Not in the same class as: CPR, invasive airway management, central venous access
  - Emergency clinicians are “doers”

- Core ED Function
  - Avoidance/prolongation of death

Drivers: Antibiotics in the ED

- Joint Commission Core Measure
  - Pneumonia
    - “delivery of first antibiotic dose would be expected within 6 – 8 h of presentation whenever the admission diagnosis is likely CAP”
    - Cases may be expected from the core measure if there is proper documentation of comfort/palliative approach
Who with infection is excluded from infection focused Joint Commission Core Measures?

Excluded from Joint Commission Measure:

- Patients with *Comfort Measures Only* documented on *day of or day after arrival*
- Patients who expired on day of or day after arrival

…Drivers: Antibiotics in the ED

- Diagnosis of urine/respiratory infection it an ‘easy’ admissions
- Patient/Billing/Reimbursement
  - Relative Value units (RVUs)
  - Multiple phone calls decrease efficiency overall
  - However, discussion with surrogates can be used for critical care billing
- Medico-legal risk
  - Failure to treat; failure to diagnose
- Family satisfaction
  - We are doing something even if we can’t change the overall disease

Models of EDs doing this well

- Integrated ED Palliative Care/Hospice services
  - On call to the ED
  - Hospice in the ED
- Social work/case management/UR proactive with identification of surrogates
- Electronic Medical Records system with palliative care focused templates
Improving Systems of Care

- Clinician Education
  - Triggers, communication skills, medical evidence, documentation
- Electronic database/repository for advance care plans
- Electronic or paper record templates
- Policies that support attempts to reach surrogates before initiating treatment
- Family/Caregiver materials available

Improving the system of Care

- Basic Measures to improve care in the ED:
  - Policies
  - Standards
  - Standard forms
  - Patient identification triggers
  - Family education materials

Your Turn

- Right now...
  - Determine a project Aim; for example:
    ➢ Increase the number of patients admitted where there is documentation of an informed consent discussion in the ED by 20% over the next 6 months
- Write your Aim in the Chat Box
Your Turn

—Determine ONE intervention that you’d like to test and then implement in the next few months: for example:
  ➢ Standard template for ED documentation
  ➢ Policy development re: required steps of antibiotic decision process: who to involve, what education material to provide, etc.
  ➢ Utilize standard Patient/Family education material
  ➢ Communication training for selected clinicians involved in antibiotic decisions
—Write in Chat Box

Your Turn

• Make a list of 3-6 key individuals (by name) to bring together as an ED-Antibiotic workgroup, for example:
  • ED nursing director and physician
  • ED social worker
  • Palliative Care
  • Quality improvement

• Keep the list, don’t put in the Chat Box

Barriers

• Name the biggest barrier you anticipate to accomplishing your Aim

• Write in the chat box
**Homework**

- In the next two weeks ..
  - Contact individuals you identified in the prior slide
  - Arrange a meeting date, ideally before the next session
    - Share information learned in this project; If not in person, then via e-mail
  - Invite them to join you two weeks from now
  - Think more about what you’d like to accomplish re: antibiotics in the ED

**Next Session (#7) :**
**July 7 at 1-2p ET**

- Review what you have done
- Continue planning for improving discussions and decision making for antibiotics
- Prep for Session #8 on July 21 1-2p ET (this is the final session)

**References**

- Specification Manual for Joint Commission Quality Core Measures, Data Element Version 2010A1