HHS Public Access

Author manuscript

Palliat Support Care. Author manuscript; available in PMC 2022 December 01.

Published in final edited form as:

Palliat Support Care. 2022 June ; 20(3): 363–368. doi:10.1017/S1478951521001012.

Palliative care in the emergency department: A qualitative study exploring barriers, facilitators, desired clinician qualities, and future directions

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Conflicts of interest. Author Christine Ritchie is a consultant for the American Academy of Hospice and Palliative Medicine as well as an editor for UpToDate.

Abstract

Objective.—To describe the perceived qualities of successful palliative care (PC) providers in the emergency department (ED), barriers and facilitators to ED–PC, and clinicians' perspectives on the future of ED–PC.

Method.—This qualitative study using semi-structured interviews was conducted in June-August 2020. Interviews were analyzed via a two-phase Rapid Analysis. The study's primary outcomes (innovations in ED–PC during COVID) are published elsewhere. In this secondary analysis, we examine interviewee responses to broader questions about ED–PC currently and in the future.

Results.—PC providers perceived as successful in their work in the ED were described as autonomous, competent, flexible, fast, and fluent in ED language and culture. Barriers to ED–PC integration included the ED environment, lack of access to PC providers at all times, the ED perception of PC, and the lack of a supporting financial model. Facilitators to ED–PC integration included proactive identification of patients who would benefit from PC, ED-focused PC education and tools, PC presence in the ED, and data supporting ED–PC. Increased primary PC education for ED staff, increased automation, and innovative ED–PC models were seen as areas for future growth.

Significance of results.—Our findings provide useful information for PC programs considering expanding their ED presence, particularly as this is the first study to our knowledge that examines traits of successful PC providers in the ED environment. Our findings also suggest that, despite growth in the arena of ED–PC, barriers and facilitators remain similar to those identified previously. Future research is needed to evaluate the impact that ED–PC initiatives may have on patient and system outcomes, to identify a financial model to maintain ED–PC integration, and to examine whether perceptions of successful providers align with objective measures of the same.

Keywords

Emergency department; Emergency medicine; Palliative care; Qualitative

Introduction

In recent years, there has been increasing recognition that the emergency department (ED) represents a valuable opportunity to ensure that seriously ill patients receive goal-concordant care, expert symptom management, and access to specialty-level palliative care (PC) when appropriate (Grudzen et al., 2011). Nevertheless, the implementation of proposed models has remained challenging (Cooper et al., 2018).

Previous studies have explored barriers to the provision of PC in the ED and identified key challenges including limited PC staffing, the ED culture of aggressive care, knowledge gaps, and medicolegal concerns (Grudzen et al., 2013; Lamba et al., 2013; Cooper et al., 2018). Similarly, studies have shown facilitators to increased integration and avenues for enhanced collaboration, including access to customized ED–PC education and increased availability of a PC team that understands the ED (Stone et al., 2011).

The COVID-19 pandemic catalyzed heightened interest in this area and resulted in the emergence of many new models of integrated ED–PC, with a spotlight on fully embedded PC providers in the ED (Fausto et al., 2020; Lai et al., 2020; Lee et al., 2020; Shalev et al., 2020; Stoltenberg et al., 2020). Since this time of increased implementation and interest, nothing to our knowledge has been published that examines whether our previous understandings still apply. Additionally, we know of no existing literature exploring the perceived qualities of successful PC clinicians in the ED.

In this moment of heightened appreciation for how the ED and PC can best come together, it is critical that we update the evidence base with an eye toward providing useful information for both ED and PC teams expanding into this space. As part of a larger study aimed at identifying the new models of care delivery that grew out of the COVID pandemic (Aaronson et al., 2020), we aimed to describe (1) the perceived qualities of successful PC providers in the ED; (2) barriers and facilitators to PC in the ED; and (3) clinicians' perspectives on the future of PC in the ED.

Methods

Setting and study population

As previously described, we conducted a national qualitative study of 52 sites between June 30, 2020 and August 18, 2020 (Aaronson et al., 2020). Participants were recruited using a homogeneous purposive sampling technique (Coyne, 1997; "Qualitative Sampling Methods,") aimed at identifying sites with increased PC–ED integration and the individuals at those sites with the most knowledge of the PC integration efforts in the ED. This article adheres to the Standards for Reporting Qualitative Research (O'Brien et al., 2014). This study was approved by the Partners Healthcare Institutional Review Board.

Data collection

An interview guide was iteratively developed with the study team, which included stakeholders from both PC and Emergency Medicine (EM). The study lead, EA, had previous experience leading qualitative studies and received specific Rapid Analysis training from a PhD qualitative researcher, LT. Semi-structured interviews were conducted over Zoom and were recorded and facilitated by members of the study team. Team members involved in data collection received focused training in both Rapid Analysis and qualitative interviewing techniques.

Our interviews included questions about the programmatic elements of new models that emerged during COVID, which was our primary outcome and has been published elsewhere (Aaronson et al., 2020). In this secondary analysis, we examined interviewee reflections on ED–PC integration beyond just the pandemic. As launch points for this section of the interview, interviewees were asked questions including, specifically, "What qualities in a clinician providing palliative care in the ED do you think make them most successful in the ED?" "Are there any barriers that you think exist for the provision of PC in the ED more generally?" and "What do you think would make it easier to ensure PC concepts are

integrated into the ED visit?" Lastly, participants were asked to reflect on what they thought the future of PC in the ED held.

Data analysis

We performed a two-step rapid analysis (Gale et al., 2019) which included a non-facilitator member of the study team watching the interview and transposing the information into a structured template followed by the facilitator reviewing the summary and consolidating the information into a matrix. This matrix was then reviewed by the non-facilitator interview attendee. Disagreements were resolved by consensus. Interviews were conducted until content saturation (Guest et al., 2006; Trotter, 2012; Cleary et al., 2014; Morse, 2016) was reached.

Results

We conducted a total of 27 interviews with 31 individuals (Table 1), with one to three participants per interview (Aaronson et al., 2020). The interviewees represented a total of 52 institutions (some interviewees were involved with ED–PC integration at more than one institution). We included representatives of large academic centers, community hospitals, safety net hospitals, and one rural hospital. Using rapid analysis, we uncovered five vital qualities for PC providers working in the ED, as well as four principal barriers and four principal facilitators to ED–PC.

Perceived qualities of successful PC providers in the ED

Rapid analysis revealed five key qualities for PC providers working in the ED who were perceived as "successful": autonomous; competent; flexible; fast; and fluent in ED language and culture.

Subjects reported that successful PC providers in the ED are autonomous: proactive and able to work independently. They are confident in their role, the value that they bring, and their expertise. Subjects also reflected on the importance of competency, i.e., clinical excellence in areas including communication and rapport building. In addition to clinical competence, interviewees highlighted the need for systems competence, such as facility with the electronic medical record and with the logistics of the institution. As one interviewee put it, this allows PC providers to "hack the system for the family."

Given the pace and nature of ED work, two other qualities frequently identified as critical were being flexible and fast. It was noted that PC providers need to be comfortable working amidst the chaos with incomplete information, and they need to perform their assessments and provide recommendations rapidly. To this end, interviewees felt that providers are most effective when they focus on specific consult questions and give clear, timely answers.

The final quality was related to fluency in ED language and culture, which interviewees felt created solidarity. Interviewees reflected on the importance of PC providers being in the trenches alongside ED teams and cognizant of the specific demands on ED providers. As one EM-trained interviewee said, "If the palliative care provider can reassure me that they understand what my needs are… and that they're going to help work with those needs, then

that helps break down some barriers." Often facilitated by pre-existing ED experience or relationships, this intimate knowledge of ED customs, terminology, and pressures was felt to be a key attribute.

Barriers to ED–PC integration

Four barriers to ED–PC integration emerged: the ED environment; lack of access to PC providers at all times; the ED perception of PC; and the lack of a supporting financial model.

The challenging nature of the ED environment was noted to be a significant obstacle for the provision of PC. Interviewees reflected that the chaotic atmosphere of the clinical setting compounded by limited private space made it difficult to facilitate sensitive conversations. Additionally, the transient nature of patients and often incomplete information were noted as major obstacles to both relationship-building as well as prognostication. Finally, the rapid pace and quick patient turn-over were both identified as hardships for the delivery of PC.

Lack of access to PC providers at all times was also noted to pose a significant barrier. Several subjects shared that PC was present during typical business hours but that the ED's peak volumes occur in the late afternoon and evening. As one interviewee shared, "Having a consult service that's 8 to 5 is not really useful to a department that gets busy at 3 pm."

Participants identified the ED's perception of PC as a limitation. Interviewees reflected that ED teams often neither recognize nor prioritize PC needs. ED providers do not always consider PC to be within their scope, and the ED's focus on flow and disposition may limit in-depth goal-based discussions while leading providers to default to more aggressive care.

Finally, interviewees reflected on the lack of a supporting financial model, noting that, within the modern American medical paradigm, ED–PC does not yet have a clear return-on-investment. They stated that their institutions did not have a business justification for focusing PC resources on the ED, which becomes particularly relevant when, as was true during the initial COVID-19 surge, PC resources are often stretched thin. From the ED's perspective, interviewees expressed a concern that increased ED–PC may slow patient dispositions in the ED to the department's financial detriment.

Facilitators of ED–PC integration

When asked about facilitators of ED–PC integration, interviewees identified four key facilitators of PC in the ED. These included proactive identification of patients who would benefit from PC, ED-focused PC education and tools, PC presence in the ED, and micro- and macro-level data supporting ED–PC.

Interviewees felt proactive patient selection helps remove the onus of identifying unmet PC needs from the ED provider. They suggested that this could happen in a variety of way, including case identification by PC clinicians and/or automated triggers. As one interviewee explained, these approaches "lower the activation energy" traditionally required to involve the PC team or engage in primary PC.

Similarly, recognizing the inherent challenges and unique nature of the ED, interviewees reflected on the utility of providing ED-specific PC education. Rather than trying to impart the entire PC skill set, several interviewees reflected on a pragmatic approach focused on concrete primary PC phrases, EMR integration, and shared decision-making tools tailored to the needs of the ED.

Another frequently cited facilitator was simply increased PC presence in the ED. Having a “boots on the ground” champion and increased PC visibility was noted to be critical. Different forms were suggested, including an embedded in-person provider or on-call expert support by someone known to the department.

Lastly, interviewees noted the importance of data to show ED teams the benefit of PC: on a micro-level, through exposure to the impact of PC on individual patients and, on a macro-level, through data on how ED–PC can improve patient-centered outcomes. Several interviewees discussed the importance of a larger body of research demonstrating the impact of PC on hospital operational metrics such as length of stay and utilization. One interviewee pointed to the opportunity to align this research with existing value-based health care quality initiatives and incentives.

Future of ED–PC

Rapid analysis uncovered three major areas for future ED–PC growth: increased primary PC education for ED staff; increased automation; and innovative ED–PC models.

When asked about what the future of ED–PC held, several interviewees hoped for and anticipated continued ED-specific PC education, which would not only help ED providers strengthen their own primary PC skillset but also identify which patients require specialty-level PC. Additionally, interviewees looked to expanded technologic support to augment provider expertise, including automated triggers to identify potential patients and needs; pathways to aid in symptom management as well as referrals to outpatient PC or hospice; and electronic medical record support for common ED–PC issues.

Interviewees also reflected a vision of ED–PC that expands beyond just the traditional consult. Several imagined a future with embedded PC providers in the form of social workers, advanced practice providers, or physicians. Others considered learning from ED addiction and trauma models that leverage social work and care coordinators to provide more wrap-around services. One interviewee also discussed the need to center equity moving forward, noting, “The thing that I’ve learned the most that was helpful… is the connection between health equity work and palliative care… and how important it is to make sure that your palliative care services and your ER… are thinking about that and keeping that in the front of their mind as they develop these services and offerings.”

Discussion

In this qualitative study, we used rapid analysis to describe the perceived qualities of successful PC providers in the ED, the barriers and facilitators to ED–PC integration, and the possible future of ED–PC.

Perceived qualities of ED–PC providers

To our knowledge, there is limited literature examining qualities of providers who might be best suited for PC work in the ED. We found that providers felt to be most successful were autonomous, competent, flexible, fast, and fluent in ED language and culture. These findings, though perhaps not surprising, have important implications for both PC education and hiring.

From the educational perspective, while there is reference to recognizing PC emergencies in the Hospice and Palliative Medicine (HPM) Core Competencies, there is no standardized approach to helping trainees gain comfort in chaos, and there is no mandatory exposure to PC in the ED setting for HPM fellowships. While some skills honed in other arenas are likely transferable, speed and comfort in the ED may require more specific training. As the field of palliative medicine increasingly looks toward expanding its ED footprint, it will be important to examine not only what additional education might benefit ED providers but also what additional education might benefit PC providers.

For PC programs considering more robust ED support, knowing these potentially helpful qualities may aid in hiring and staffing decisions. Certainly, there are many qualified PC providers who, despite their expertise, may not be well suited to the particular demands of practicing in the ED. Conversely, there may be other PC providers whose background, temperament, and/or training may make them ideal candidates for this type of work. For providers interested in this arena but lacking in the specific skill set required, it is worth considering adding specific education or mentorship.

ED–PC barriers and facilitators

Previous research into ED–PC integration has identified similar barriers to those we found (including ED environment, lack of training, and limited PC team availability) as well as similar recommendations for possible facilitators (including EM-specific training, automation to identify potential patients, and increased PC visibility in the ED) (Smith et al., 2009; Stone et al., 2011; Grudzen et al., 2012; Cooper et al., 2018; Wright et al., 2018). While that work mostly represented the viewpoints of EM clinicians, we found similar responses in our more diverse sample, which included both EM and PC providers. Furthermore, whereas prior research often consisted of stand-alone interviews or surveys considering these issues in the abstract, our study occurred in the context of interviews about real-world ED–PC collaboration accelerated by the clinical demands of COVID-19. The similarity between our findings and those previously documented in the literature underscores the idea that these widely perceived barriers and facilitators are not merely theoretical but rather are grounded in the lived experiences and observations of both PC and ED team members.

That said, our study also adds to a growing body of literature showing that, while there are significant obstacles, there are also ample opportunities for ED–PC expansion. In particular, given the current interest in value-based care, there is a clear opening to align both ED and PC priorities via early identification of patients whose goals may align with less aggressive treatment trajectories. While there is already some data demonstrating how delivering PC in

the ED improves patient and systems metrics (Wu et al., 2013; Grudzen et al., 2015, 2016), robust evidence for this approach could facilitate not only heightened acceptance on the part of ED providers but also incentivize funding for models of care best suited to this particular nexus (for example, such a model could include staffing an ED-specific or ED-focused PC provider at peak ED hours rather than during business hours).

The future of ED–PC

Our work showed that interviewees anticipate a future with increased attention to PC education for ED providers, an area in which there has already been significant investment and which is the focus of ongoing research (Gisondi et al., 2010; Lamba et al., 2014; Shoenberger et al., 2018; Grudzen et al., 2019). Additionally, they hope that automation, including in patient identification, could lift the onus of responsibility off of ED providers, which has also been a topic of recent studies (Bowman et al., 2016; Tan et al., 2020).

Beyond this, there is an expectation of greater innovation in ED–PC models. The COVID-19 pandemic reshaped how many EDs and PC teams collaborated, and the organic diversity of care provision that grew out of this time seems to have led to increased interest in what might exist beyond the traditional paths of improved ED primary PC and early ED involvement of specialty-level PC (Aaronson et al., 2020). While it is beyond the scope of this paper to examine the exact models that interviewees had experienced and were envisioning, it is certainly relevant that some of the interviewees had recently erected embedded ED–PC programs or other similarly novel approaches during the initial surge. It appears that these events may have prompted an expanded vision of what could be possible in the future.

On this topic, it is worth noting not only what interviewees did say but also what they did not. Many of the COVID-era models depended upon a single PC provider who was, in the majority of cases, a physician. While several interviewees did discuss the role that non-physician disciplines may play going forward, few reflected on the implications of physician-centered independent PC practice. This relative silence may simply be a limitation of our study design, but the issue is significant nonetheless, particularly in light of the emphasis that interviewees placed on PC provider autonomy.

As highlighted in the Clinical Practice Guidelines for Quality Palliative Care, the interdisciplinary team is a core component of palliative medicine (Ferrell et al., 2018). Though solo approaches may offer a level of flexibility and speed that is desirable in the ED setting, it will be important for future interventions and studies to consider not only what might be gained but also what might be lost with such methods. This, too, is an opportunity for imagination. Is there, for example, a world in which the interdisciplinary nature is preserved albeit in a more asynchronous manner (such as a PC physician embedded alone in the ED who arranges inpatient or outpatient PC social work or chaplaincy as needed)? While the exact solution is unclear, as work in this arena proceeds, it is worth remembering exactly what makes PC so valuable in the first place to ensure that our adaptations do not accidentally erode our foundational beliefs.

Limitations

While interviews took place in the setting of COVID and were designed to learn about COVID-specific ED–PC innovations, we found that, in these topic areas, interviewees provided insight into the broader ED–PC landscape rather than focusing on pandemic-specific issues. That said, these findings are certainly colored by that context, and more work is needed to understand how they may apply to a post-COVID world.

Furthermore, while our interviewees did represent diverse settings, our study was not intended as a comprehensive survey representing all potential stakeholders. We may not have picked up on nuances that are specific to certain settings. We also may not have identified barriers that were so significant that they led to completely failed attempts at ED–PC integration.

Methodologically, we attempted to interview one or two people at a given institution with the most knowledge about ED–PC integration efforts. This resulted in a sample of largely physician voices, and a more interdisciplinary group may have yielded different perspectives on these issues.

Additionally, this is a qualitative study. As such, our findings represent the subjective perceptions of our interviewees, which may not align with objective measurements of these same topics. As one example, our interviewees were free to define “successful” however they saw fit, and the qualities they described as successful are what they have identified based on their experiences.

Conclusions

There is ongoing curiosity about ED–PC collaboration. In this study, we identified potential qualities of successful PC providers in the ED that have not previously been demonstrated in the literature and that have important implications for future PC education and hiring. We also built on previous work identifying both barriers and facilitators to ED–PC integration and suggest leveraging existing interest in value-based care. We found that, despite how drastically COVID-19 has reshaped our healthcare landscape and, in particular, exploded out the conception of ED–PC integration, barriers and facilitators to ED–PC have remained similar over the past decade. Finally, we examined what the future may look like for ED–PC.

Our findings provide useful additional information for PC programs considering expanding their ED presence. Future research is needed to evaluate the impact that such expansion may have on both patient-centered and system-level outcomes, to elucidate a financial model to sustainably maintain ED–PC integration, and to examine whether perceptions of successful providers align with objective measures of the same.

Funding.

This research received no specific grant from any funding agency, commercial, or not-for-profit sectors.

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Table 1.

Characteristics of interview participants and represented institutions

Characteristic	No (% or SD)
Clinical practice	
Palliative care only	12 (39%)
Emergency medicine only	7 (23%)
Palliative care and emergency medicine	12 (39%)
Clinical role	
Physician	29 (94%)
Nurse practitioner	1 (3%)
Social worker	1 (3%)
Interviewee (SD) number of years in practice	11 (8)
Mean (SD) ED annual visit volume	81,391 (50,875)
Geographic location	
Northeast	27
South	14
Midwest	4
West	7