



Featured
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Webinar for Healthcare Professionals When Decision-Making Is Imperative: Advance Care Planning in the ED

GOAL: Complex, chronically ill patients in the emergency department (ED) present an opportunity to discuss and implement hospice and palliative care. Many elderly patients who present to the ED are hospice-eligible because of functional decline and multi-morbidity. Key tools can quickly facilitate goals-of-care (GOC) conversations, advance care planning, and hospice referrals amid the ED's time constraints and high-acuity challenges.

Key Takeaways:

1. Introducing hospice is both a challenge and unique opportunity in the ED. Addressing patient concerns and offering comfort-focused care as an option require empathy and targeted conversations.
2. An ED patient's goals for care can change quickly, based on illness course, response to treatment, functional decline, and symptoms. Addressing GOC and advance care planning honors patients' values, addresses symptoms quickly and effectively, and supports patient/family control and comfort.
3. Two key screening tools are 1) **identification of an ED patient's prognosis** and 2) the **"surprise question."** Both can quickly elicit a patient's and family's goals of care, meet their needs for compassionate communication, and help them make better treatment decisions.
4. A rapid palliative care assessment uncovers relevant, illness-related needs. **"ABCD"** (advance care planning, feel better, consider caregivers, decision-making capacity) covers the physical and psychosocial domains of care for unstable patients. **"NEST"** (social needs, existential needs, symptoms, therapeutic goals) can be used when the patient stabilizes. Other tools include the **SPIKES** protocol and a **5-minute GOC** conversation.
5. Studies show that hospice utilization reduces hospitalizations/readmissions, ED and ICU use, and in-hospital death. Patients can be transitioned from the ED to hospice in their preferred setting, where they report higher levels of satisfaction.

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