Expedited Referral to Inpatient Hospice Unit Through the Jefferson Methodist Hospital Emergency Department

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Background

Palliative care is the branch of healthcare that aims to provide symptomatic relief for patients with chronic or incurable medical conditions. Hospice is a subcategory of palliative care in which the focus is placed on comfort to the exclusion of further curative efforts, generally reserved for patients with a life expectancy of six months or less.

The American College of Emergency Physicians (ACEP) Choosing Wisely guidelines recommend that emergency physicians refer appropriate patients to hospice and palliative services. Preventing hospital admission in favor of transfer to an inpatient hospice unit "can benefit select patients resulting in both improved quality and quantity of life." [1]

Additionally, from an operational perspective, especially in a system that deals with constant inpatient boarding in the ED, referral to hospice services can prevent acute admissions, opening beds both upstairs and in the ED to other patients. Similarly, CMS penalizes hospitals for return admissions within 30 days for such conditions as COPD/CHF. [2]

The population of South Philadelphia is a diverse group with a large burden of chronic illness. Increasing access to hospice services could allow both greater patient autonomy over their care as well as potentially bending the curve on hospital overcrowding and reducing readmissions.

By December 2018, we aim to institute a system of expedited inpatient hospice referral for patients presenting to our emergency department. Our goal was to increase the utilization of hospice services compared to prior years. Here we examine the initial effectiveness of this system in terms of utilization numbers on a rolling month to month basis.

Methods

The process to improve access began with a multidisciplinary discussion between hospital administration, inpatient hospitalists, the VITAS hospice unit nurses, medical director and administrators as well as the ED nursing supervisor and medical director.

Review of cases within the past 12 months who were referred to hospice within 24 hours of admission from the ED revealed a large potential base of patients who may be appropriate for direct ED admission.

A PDSA cycle was envisioned, where a combination of didactics, provided at faculty meetings, resident conference and direct clinical brief educational sessions were combined with an expedited process for admission. These educational sessions spoke to appropriate patient attributes, ways to approach the topic and available services.

A single phone number, made available 16 hours per day, was staffed with a hospice nurse who was tasked to arrive to the ED within 60 minutes of initial contact, to provide counselling to patients and family on choices of palliative care/hospice services as well as direct discharge and referral to an inpatient hospice unit on the grounds of the hospital.

Our primary outcome was the gross number of patients directly referred to the inpatient hospice unit on a month to month basis. This data was accrued directly from the hospice unit admission census and analyzed on a month to month basis. The control was rate of referral in the preceding years prior to the onset of the intervention.

Results

In the first four months of 2019, 19 patients were referred to inpatient hospice from the emergency department (4.75 referrals/month). In the previous four years (2015-2018), prior to the implementation of the expedited referral system, a total of 24 patients had been referred (mean = 6 referrals/year; range = 4-8), for an average of 0.5 referrals/month. This represents a 9.5-fold increase in monthly referrals after implementation of the expedited referral system **Figure 1** shows annual and monthly referral data.

The 19 patients referred to hospice in the first four months of 2019 had a median age of 79 years (range 50-99 years). Eight were male and 11 were female.

The most common chief complaint at the ED visit prompting hospice referral was shortness of breath (six patients). Of these, three patients had a history of malignancy of the lung and one had a head and neck malignancy. **Figure 2** breaks down the patients by chief complaint.

Nine patients had a history of cancer, either active or past. All had multiple significant, chronic medical issues as shown in **Figure 3**.

The diagnoses from the ED were heterogenous, with a plurality of infectious diagnoses, including two pneumonia diagnoses (both in patients with malignancy of the lung), one complicated urinary tract infection, and one with sepsis due to acute cholecystitis. Three patients' diagnoses included fractures related to recent falls.

Critical care time was documented by the ED attending on four of the 19 patients.

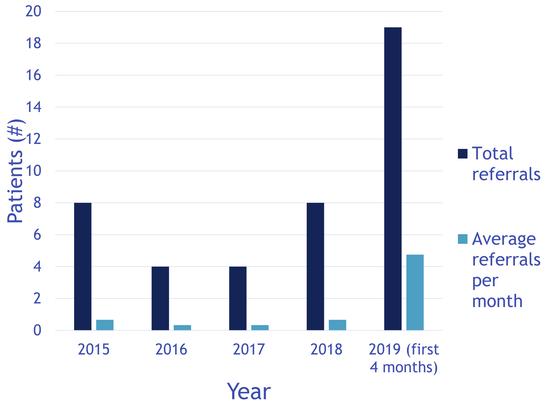

Figure 1: Patients referred to the inpatient hospice unit from the emergency department

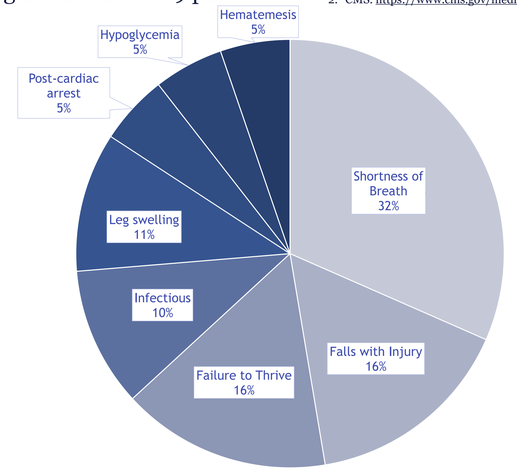

Figure 2: ED Chief complaint of patients referred to inpatient hospice from the ED

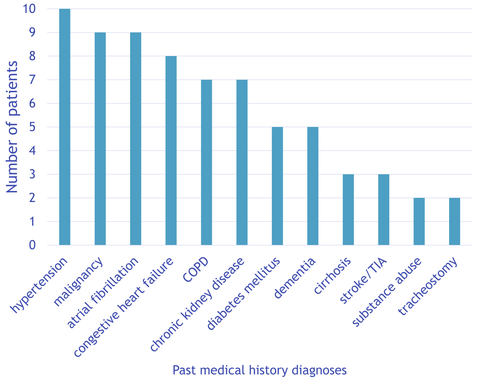

Figure 3: Frequency of underlying conditions among patients referred to hospice from the ED

Conclusions

A system of education and expedited referral from the emergency department to an inpatient hospice unit resulted in a dramatic increase in utilization of hospice services. Concerns about timeliness of referral and provider inexperience and hesitance appear to have been overstated.

The patients represented a diverse group in terms of their primary pathology, ethnicity and gender. Hospice services are valuable for all members of society and should be offered to everyone who is otherwise eligible.

Further study with more patients over a longer period of time is warranted to further elucidate the trend demonstrated here.

Additional areas of exploration include the effects of hospice referral from the emergency department on rates of ED boarding as well as reduction of 30 day readmissions.

Finally, additional interventions may be beneficial, such as a customized EHR clinical decision support tool, may increase provider recognition and rates of referral.

References

1. ACEP Choosing Wisely campaign. http://www.choosingwisely.org/clinician-lists/american-college-emergency-physicians-delaying-palliative-and-hospice-care-services-in-emergency-department/
2. CMS. https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html