



Is there a role for palliative care in reducing emergency department use by older adults?

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Keywords: emergency department • geriatric • older adults • palliative care

We are living in an aging world. Look at any report coming from Canada, the USA, the UK or the EU and they all predict the same trend; that over the coming decades the proportion of the population aged 80 years and over is expected to increase exponentially. Although these numbers seem daunting, it is the story embedded in those numbers however, that needs to give us sober thought. First is the simple fact that in the western world, the median age of death is 78 years, and the majority of deaths occur after the age of 65 years [1]. Implicit in this is that the older adult population comprises a significant proportion of those who will require end-of-life care, many of whom have very different needs than those dying at a younger age. Second, although many individuals over the age of 65 years report relatively good health, it is a fact of life that most will eventually develop one or more chronic illnesses, which have a prolonged period of gradual decline, disability and eventual death [2]. Over three-quarters of the deaths in the USA are due to chronic progressive medical illnesses such as cardiovascular, pulmonary and neurological conditions; diseases that are typically characterized as unpredictable in their trajectories, with frequent exacerbations and the need for close medical monitoring [3]. These medical conditions do not occur in isolation; elderly patients often report the coexistence of four or more chronic conditions [4]. The number of older adults with multiple chronic conditions is projected to increase by more than a

third between 2000 and 2030 [5]. The final issue that confronts an aging world is the rise of those diagnosed and living with dementia. The impact of dementia to our global aging population represents one of the most significant challenges to health and social care. The impact of multiple comorbidities on older adults, including cognitive impairment, is that many report high symptom burden, physical and psychological symptom distress, progressive functional dependence and frailty, lower quality of life, problems with polypharmacy, strains on family caregivers, and high healthcare resource use, including the use of emergency departments (EDs) [3,6].

Emergency department use by older adults

Older adults represent an ever-growing population that utilizes ED services. Several studies indicate that older adults use EDs more often and for more urgent issues than any other age group with 12–21% of all visits being made by older adults [7]. The pattern of ED use differs for older adults as compared with younger patients; while medical complaints account for nearly 80% of all visits by older adults, these are relatively rare in younger patients who typically visit an ED for surgical complaints and accidents [7]. When presenting to the ED, older adults have a higher level of emergency and more serious medical illness than younger patients. Older adults present to the ED most often with complaints of chest pain, congestive



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heart failure, abdominal pain, delirium, pneumonia and syncope [8]. Falls and problems with self-care are also noted as significant problems that bring older adults into the ED [9] as are problems with complex psychosocial needs [10]. In many instances, the reason older adults seek out care in the ED are often the result of slowly evolving problems that culminate in the need for emergency care [9].

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Frequently, older adults present with atypical signs and symptoms and multiple comorbidities that make diagnosis and treatment more complex and place them at higher risk of hospitalization, a need for a return ED visit, and adverse events after ED use including death [9,11]. In a recent study by Beynon and colleagues, 56.8% of older adults who presented to an ED, had palliative care needs in the three months prior to admission to the ED and evidence was that this group had symptoms and/or complex social needs during this time [10]. In their systematic review, Gruneir *et al.* indicate that the evidence supports that older adults do have a greater need for care in the ED than other age groups, that their use of ED services is appropriate as noted by the seriousness of their presenting illness on arrival to the ED, and that often, older adults tried to contact their primary care provider or other regular source of medical care prior to arriving at the ED [9]. Therefore, in many instances, older adults had no other choice but to use the ED to help them manage their medical complaint. In essence, there was no proactive care system in place that prevented the need for ED care from developing in the first place for many older adults.

EDs are not particularly well suited to deal with the complexity of care required by older adults with multiple comorbidities. Designed to diagnose and treat acute or traumatic events, the ED and its practitioners are well suited to provide life-sustaining and disease-directed treatments to patients with acute illness [12]. When surveyed, ED clinicians report feeling ill-equipped to provide care to older adults [13]. Too often the ED system is set up to provide care that is directed at the ‘one-complaint per visit’ mantra; an orientation that fails to address the complexity of multiple morbidities and the root cause of the presenting issues. Often, the life-prolonging treatments offered may not be in keeping with the patients’ goals, prefer-

ences for care, or address the larger social or systemic implications that brought the person to the ED such as lack of social support or caregiver distress. As such, the care received in the ED may actually contribute to the overall suffering and distress experienced by older adults, and fails to adequately meet their needs.

Palliative care for older adults

With its focus on the relief of suffering and achieving the best quality of life, palliative care can be understood as any care aimed at relieving the burden of physical, emotional, spiritual, social and existential distress that often accompanies chronic illness. It is a patient- and family-oriented philosophy of care that focuses on the ‘person’ through a holistic, interdisciplinary team approach. There is growing acceptance of the value of early involvement of palliative care in parallel to life-prolonging and supportive therapies across a range of disease states. In older adults, we need to broaden this conceptualization even further, moving beyond the focus of a single disease state to explore the needs of the individual suffering with multiple distinct pathologies and the needs that develop based on the combined effect and impact of multiple comorbidities [14]. It is also important to understand that palliative care is much more than end-of-life and/or hospice care; understanding it only as such fails to capitalize on the benefits espoused by the broader palliative approach and may result in missed opportunities and unmet needs in older adults. In their model of palliative care in the elderly, Jerant and colleagues identify that in order for palliative care within this population to be effective, a ‘TLC’ approach is needed [15]; care needs to be timely and team-oriented; longitudinal; and collaborative and comprehensive.

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For the older adult, the need to provide palliative care that is integrated, proactive and team-based is essential in order to meet their complex needs and to potentially reduce the need for costly ED services. There is some evidence that palliative care programs or services have been associated with a reduction in the number of ED visits by those enrolled in their programs [16–19]. The challenge remains, however, that too often, those enrolled in specialist community-based palliative care programs are those with cancer diagnoses with 6 months or less to live; not older adults with multiple comorbidities [20,21]. Despite efforts to broaden their mandate to a more inclu-

sive model, those with nonmalignant disease continue to be much less likely to receive specialist palliative care [10]. As a result, a new way of thinking about palliative care for older adults needs to be adopted, one predicated on a health-promoting and population-based model.

Geriatric palliative care & emergency care: importance of collaboration

To achieve optimal palliative care for older adults and to reduce their need to rely on ED services, the adoption of a health-promoting, population-based approach that recognizes not all older adults need or want the same level and access to specialized palliative care services is warranted. A model of care that is flexible, integrated through formal partnerships with different services and providers, incorporates generalist and specialist health professionals, and is responsive to patient and family need is integral to excellent palliative care provision, especially for older adults [22,23]. The acuity and complexity of the patient and family need defines the level of palliative care services delivered within this model. In this manner, older adults may move between different levels of care throughout their chronic illness trajectory [24]. The vast majority of older adults will have their needs most easily and best met by primary healthcare providers, including community nurses, family physicians and medical specialists, such as geriatricians. Those who experience sporadic or occasional exacerbation of physical, psychosocial or spiritual/existential distress will require expert consultation from specialist palliative care providers, with ongoing care being provided by their primary care provider. A subset of these patients may require more intense, ongoing collaboration and shared care arrangements between primary care and palliative care providers. A small subgroup of older adults will have complex care needs requiring direct ongoing involvement from specialist palliative care services either in the community or in designated palliative/hospice beds. Although some preliminary evidence exists, suggesting that such an integrated, interdisciplinary model of care delivery can reduce potentially unnecessary visits to

the ED [18], further research is sorely needed examining optimal models of services delivery for older adults that might reduce or eliminate reliance on the ED for chronic illness management.

Within this integrated model of collaborative care, the need to explore the role of ED care is vital. There will always be a group of older adults for whom ED services are needed, despite impeccable attention to meeting their palliative care needs proactively. Increasing palliative care knowledge among ED providers, the development of triggers for palliative care consultation among emergency patients, the use of volunteers, and creating private spaces within the ED for palliative care patients and their families are among some of the solutions proposed to addressing palliative care needs in the ED [25–27]. There is also a need for improved communication among and between different providers, and the development of information sharing systems that would promote coordinated care between primary care providers, medical specialists and the ED [28].

In order to begin to meet the needs of an aging population and to reduce their reliance on the ED as a primary place of care, adopting a health-promoting, population-based approach that recognizes and respects the relationship between primary care providers, older adults and their families is essential. In essence the goal of such a system is to ensure that older adults receive care in the setting best suited to meet their needs, is timely and responsive, and is delivered by health care providers skilled in ameliorating suffering, distress, and preserving dignity.

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References

- Murphy SL, Xu JQ, Kochanek KD. *Deaths: Final Data for 2010. National Statistics Reports. Vol 61, Issue 4.* National Center for Health Statistics, MD, USA (2013).
- Morrison RS. Research priorities in geriatric palliative care: an introduction to a new series. *J. Palliat. Med.* 16(7), 726–729 (2013).
- Kapo J, Morrison LJ, Liao S. Palliative care for the older adult. *J. Palliat. Med.* 10(1), 185–209 (2007).
- Combs S, Kluger BM, Kutner JS. Research priorities in geriatric palliative care: nonpain symptoms. *J. Palliat. Med.* 16(9), 1001–1007 (2013).
- Ritchie CS, Zulman DM. Research priorities in geriatric palliative care: multimorbidity. *J. Palliat. Med.* 16(8), 843–847 (2013).
- Geriatric Palliative Care.* Morrison RS, Meier DE (Eds). Oxford University Press, NY, USA (2003).
- Aminzadeh F, Dalziel WB. Older adults in the emergency department: a systematic review of patterns of use, adverse outcomes, and effectiveness of interventions. *Ann. Emerg. Med.* 39(3), 238–247 (2002).
- Samaras N, Chevalley T, Samaras D, Gold G. Older patients in the emergency department: a review. *Ann. Emerg. Med.* 56(3), 261–269 (2010).

- 9 Gruneir A, Silver MJ, Rochon PA. Emergency department use by older adults: a literature review on trends, appropriateness, and consequences of unmet health care needs. *Med. Care Res. Rev.* 68(2), 131–155 (2011).
- 10 Beynon T, Gomes B, Murtagh FE *et al.* How common are palliative care needs among older people who die in the emergency department? *Emerg. Med. J.* 28(6), 491–495 (2011).
- 11 McCusker J, Tousignant P, Borges Da Silva R *et al.* Factors predicting patient use of the emergency department: a retrospective cohort study. *CMAJ* 184(6), e307–e316 (2012).
- 12 Grudzen CR, Hwang U, Cohen JA, Fischman M, Morrison RS. Characteristics of emergency department patients who receive a palliative care consultation. *J. Palliat. Med.* 15(4), 396–399 (2012).
- 13 Schumacher JG. Emergency medicine and older adults: continuing challenges and opportunities. *Am. J. Emerg. Med.* 23(4), 556–560 (2005).
- 14 O'Brien T. The impact of an aging population on palliative care. *J. Pain Palliat. Care Pharmacother.* 27(4), 389–391 (2013).
- 15 Jerant AF, Azari RS, Nesbitt TS, Meyers FJ. The TLC model of palliative care in the elderly: preliminary application in the assisted living setting. *Ann. Fam. Med.* 2(1), 54–60 (2004).
- 16 Brumley RD, Enguidanos S, Cherin DA. Effectiveness of a home-based palliative care program for end-of-life. *J. Palliat. Med.* 6(5), 715–724 (2003).
- 17 Burge FI, Lawson BJ, Johnston GM, Grunfeld E. A population-based study of age inequalities in access to palliative care among cancer patients. *Med. Care* 46(12), 1203–1211 (2008).
- 18 Lawson BJ, Burge FI, McIntyre P, Field S, Maxwell D. Can the introduction of an integrated service model to an existing comprehensive palliative care service impact emergency department visits among enrolled patients? *J. Palliat. Med.* 12(3), 245–252 (2009).
- 19 McNamara BA, Rosenwax LK, Murray K, Currow DC. Early admission to community-based palliative care reduces use of emergency departments in the ninety days before death. *J. Palliat. Med.* 16(7), 774–779 (2013).
- 20 Ahmed N, Bestall JC, Ahmedzai SH, Payne SA, Clark D, Noble B. Systematic review of the problems and issues of accessing specialist palliative care by patients, carers and health and social care professionals. *Palliat. Med.* 18(6), 525–542 (2004).
- 21 Grande GE, McKerral A, Addington-Hall JM, Todd CJ. Place of death and use of health services in the last year of life. *J. Palliat. Care* 19(4), 263–270 (2003).
- 22 McKinlay E, McBain L. Evaluation of the palliative care partnership: a New Zealand solution to the provision of integrated palliative care. *NZ Med. J.* 120(1263), 2745–2757 (2007).
- 23 Travis S, Hunt P. Supportive and palliative care networks: a new model for integrated care. *Int. J. Palliat. Nurs.* 7(10), 501–504 (2001).
- 24 Palliative Care Australia. *A Guide to Palliative Care Service Development: a Population Based Approach*. Palliative Care Australia, Deakin, Australia (2005).
- 25 Lamba S, Desandre PL, Todd KH *et al.* Integration of palliative care into emergency medicine: the improving palliative care in emergency medicine (IPAL-EM) collaboration. *J. Emerg. Med.* 46(2), 264–270 (2014).
- 26 Sanon M, Baumlin KM, Kaplan SS, Grudzen CR. Care and respect for elders in emergencies program: a preliminary report of a volunteer approach to enhance care in the emergency department. *J. Am. Geriatr. Soc.* 62(2), 365–370 (2014).
- 27 Grudzen CR, Stone SC, Morrison RS. The palliative care model for emergency department patients with advanced illness. *J. Palliat. Med.* 14(8), 945–950 (2011).
- 28 Mahony SO, Blank A, Simpson J *et al.* Preliminary report of a palliative care and case management project in an emergency department for chronically ill elderly patients. *J. Urban Health* 85(3), 443–451 (2008).