

Hospital Administrators' Views on Barriers and Opportunities to Delivering Palliative Care in the Emergency Department

Corita R. Grudzen, MD, MSHS; Lynne D. Richardson, MD; Hannah Major-Monfried, BA; Brandon Kandarian, MS; Joanna M. Ortiz, BA; R. Sean Morrison, MD

Study objective: We identify hospital-level factors from the administrative perspective that affect the availability and delivery of palliative care services in the emergency department (ED).

Methods: Semistructured interviews were conducted with 14 key informants, including hospital executives, ED directors, and palliative care directors at a tertiary care center, a public hospital, and a community hospital. The discussions were digitally recorded and transcribed to conduct a thematic analysis using grounded theory. A coding scheme was iteratively developed to subsequently identify themes and subthemes that emerged from the interviews.

Results: Barriers to integrating palliative care and emergency medicine from the administrative perspective include the ED culture of aggressive care, limited knowledge, palliative care staffing, and medicolegal concerns. Incentives to the delivery of palliative care in the ED from these key informants' perspective include improved patient and family satisfaction, opportunities to provide meaningful care to patients, decreased costs of care for admitted patients, and avoidance of unnecessary admissions to more intensive hospital settings, such as the ICU, for patients who have little likelihood of benefit.

Conclusion: Though hospital administration at 3 urban hospitals on the East coast has great interest in integrating palliative care and emergency medicine to improve quality of care, patient and family satisfaction, and decrease length of stay for admitted patients, palliative care staffing, medicolegal concerns, and logistic issues need to be addressed. [Ann Emerg Med. 2013;61:654-660.]

Please see page 655 for the Editor's Capsule Summary of this article.

A **feedback** survey is available with each research article published on the Web at www.annemergmed.com.

A **podcast** for this article is available at www.annemergmed.com.

0196-0644/\$-see front matter

Copyright © 2012 by the American College of Emergency Physicians.

<http://dx.doi.org/10.1016/j.annemergmed.2012.06.008>

INTRODUCTION

Although patients with multiple, complex chronic conditions make up only 5% to 10% of Medicare beneficiaries, they account for more than half of costs,¹ a significant proportion of which are incurred in the last year of life.² Despite these high costs, patients and their families report untreated symptoms, unmet needs, high caregiver burden, and low satisfaction with care.³ Although palliative care consultation has been shown to reduce burdensome symptoms, increase patient and family member satisfaction, and decrease costs,⁴⁻⁶ consultation often occurs very late in the illness trajectory. Although approximately 85% of hospitals with more than 300 beds now have palliative care services and their availability continues to increase,⁷ hospital-based consultation typically occurs more than a week into a patient's hospital stay, rather than in the first critical days of admission when major decisions are made.

Moving palliative care consultation upstream to the emergency department (ED) as opposed to later during a hospital stay has the potential to decrease hospital length of stay and reduce costs per day for admitted patients. Inpatient

palliative care consultation has been shown to decrease costs for hospitals under the current prospective payment system.⁵ It follows that earlier consultation by emergency providers could further decrease length of stay and costs per day, making ED-based palliative care service delivery valuable to hospital administrators.

Although research demonstrates a high burden of unmet palliative care needs in ED patients with serious, life-limiting illness,⁸ a number of barriers exist among emergency providers to the delivery of palliative care services, including limited skills and knowledge of palliative care practices, fear of litigation, and lack of clear guidelines for consultation.^{9,10} Nonetheless, there is rapidly growing interest among emergency providers, and hospice and palliative medicine is now an official subspecialty of the American Board of Emergency Medicine. In response to the growing number of patients with advanced illness, several medical centers have recently initiated pilot programs to deliver ED-based palliative care consultation.¹¹⁻¹³

Editor's Capsule Summary*What is already known on this topic*

Barriers to the delivery of palliative care services exist among emergency providers.

What question this study addressed

Using semistructured interviews with a total of 14 administrators from a tertiary academic medical center, a public hospital, and a community hospital, this qualitative study addressed incentives and barriers to the use of palliative care in the emergency department (ED).

What this study adds to our knowledge

The participating hospital administrators were supportive of palliative care but identified staffing, logistic, and legal barriers that limit further use of these services.

How this is relevant to clinical practice

This study identifies several issues to be addressed among providers and hospital administrators that currently limit the use of palliative care in the ED.

Although previous qualitative research has explored the needs, attitudes, and beliefs of ED patients and providers about palliative care,^{8-10,14,15} little attention has been paid to understanding and describing the hospital-level factors that affect the availability and delivery of palliative care services in the ED. We chose to interview administrators from 3 hospital types to delineate what incentives and barriers exist from their perspectives to the more widespread use of palliative care in the ED. We interviewed ED directors because they have the broadest view of practice patterns, use of consultation services for ED patients, issues raised by patients and families, and problems that arise between emergency and inpatient providers. Directors of palliative care services have the most detailed knowledge of how palliative care is perceived by consulting physicians of different specialties. Hospital leadership has the interests of the entire patient population and medical staff in mind and thus provides an important and unique perspective on the relationship between services, the financial health of the hospital, and regulatory and medicolegal issues. Because little is known about attitudes toward palliative care delivery among ED, palliative care, and hospital executives, we chose to use qualitative methods to explore a range of topics and form hypotheses for future studies.

MATERIALS AND METHODS**Study Design**

Hospital, ED, and palliative care service administrators were recruited to participate in individual semistructured

Semistructured Interview Guide*

1. Can you describe the palliative care services that exist at your hospital?
 - a. How well used are palliative care services?
2. How is palliative care viewed by different physician groups within the hospital?
 - a. Explain the relationship between palliative care and different physician groups, such as intensivists, oncology, emergency physicians, or primary care physicians not employed by the hospital.
3. How are palliative care services received by patients and families?
 - a. Are patients and families receptive to having a palliative care consultation?
4. What barriers do you see to the more widespread use of palliative care services?
 - a. Why do you believe some patients who need palliative care are not receiving it?
5. How does palliative care fit into the hospital's mission?
6. How does palliative care fit into the priorities of the ED (ie, throughput)?

*Interviews followed the lead of participants, and thus questions provided only a basis for discussion and were adapted throughout.

Figure. Semistructured interview guide.

interviews about barriers and facilitators to delivering palliative care from 3 hospitals: a tertiary academic medical center, a public hospital, and a community hospital. Participants had to hold one of the following titles at the 3 participating hospitals: ED director, ED nurse manager, palliative care service director, or other hospital executive administrator (including chief executive officer, president, chief operating officer, chief nursing officer, chief medical officer, and executive director). Purposive sampling was used to obtain a range of participants by hospital and administrator type. The Mount Sinai School of Medicine Institutional Review Board approved all study procedures.

Data Collection and Processing

Interviews with key informants took place either at the hospital of interest in a private office or other location, or by telephone. All interviews were conducted by the principal investigator, a female emergency physician with master's-level research training and experience conducting qualitative research, in addition to content expertise in palliative medicine. She had no previously established relationship with the participants, except the ED, nursing, and palliative care director at her own institution. A research assistant was present for in-person, off-site interviews and took field notes. Participants provided informed consent and understood the role of the principal investigator and the general purpose of the study. Interviews continued until all topics were covered and the participant had no further comments, and lasted from approximately 30 minutes to just over an hour. Interviews were digitally recorded and transcribed verbatim. An interview guide was prepared ahead of time (Figure). The discussion was unstructured and followed the lead of the participants.

Table 1. Characteristics of key informants.

Characteristic	No. (%) [*]
Female	6 (43)
Time at institution, y	
0–5	1 (7)
6–10	2 (14)
>10	11 (79)
Hospital type	
Tertiary care	5 (36)
Public	4 (29)
Community	5 (36)
Job type	
ED administrator	5 (36)
Palliative care administrator	3 (21)
Hospital administrator	6 (43)

^{*}May not add to 100% because of rounding.

Table 2. Hospital, ED, and palliative care service characteristics.

Characteristic	Tertiary Care	Public	Community
Hospital beds	1,100	575	235
ED visits, yearly	90,000	135,000	50,000
Palliative care consultations, yearly	1,300	400	500

Primary Data Analysis

Data analysis followed the principles of grounded theory, a systematic methodology in the social sciences that involves the discovery of theory through the analysis of data.¹⁶ To analyze the data, the principal investigator and 2 research assistants read through all the transcripts to identify major themes and subthemes that emerged from the text. The process of identifying themes was considered complete when no new concepts were identified. The transcriptions were reviewed a second time and all themes and subthemes applied by the research assistants. All interview transcripts were coded line by line to identify conceptual themes and subthemes. Consequently, similar themes were grouped together across interviews to develop core concepts. The developing coding scheme was then validated and modified through multiple independent interview-by-interview coding sessions to ensure that the coding scheme fully captured the data.

RESULTS

Fourteen interviews were completed with key informants from the 3 hospitals. The ED and palliative care directors from all 3 hospitals chose to participate. Though all central hospital administrators were invited and agreed to participate, hospital leadership suggested one or more specific administrators because of scheduling conflicts. See Table 1 for the characteristics of key informants. Table 2 describes the hospital, ED, and palliative care service characteristics; emergency providers at all 3 hospitals are salaried or work for an hourly wage. Qualitative analysis using grounded theory methodology yielded 7 major themes.

Table 3 displays each theme with its associated subthemes and exemplar quotes.

Hospital administrators described wide-ranging perceptions of palliative care among hospital staff, patients, and families.

Many practitioners eschew palliative care because they equate it with giving up on the patient. A palliative care administrator said she often hears, “Oh, you’re involved? They’re not ready for palliative care.” Another palliative care administrator agreed, stating, “There’s often a nurse on the floor that feels we could help but the answer sometimes is, ‘Not yet.’”

Some associate palliative care only with end-of-life care. An ED director explained, “Palliative care has a bad rap because people think of it as death care.” A community hospital administrator similarly noted, “Palliative care is identified as the people who arrive with the skull and crossbones on their sleeve, as the guys who say, ‘Let’s get the [do not resuscitate] signed so the patient can die.’”

Few providers are able to distinguish between 2 separate domains of palliative care practice: relief of burdensome symptoms and goals of care discussions. A community hospital administrator explained, “The first part is equally important, if not more so, and has gotten lost in the background; treating pain, nausea and vomiting, and other nasty, disabling symptoms, are an area where they have tremendous skill, but this tends not to be their identity.”

An initial source of positive feedback described by administrators is from families of palliative care patients. A public hospital administrator explained, “Once physicians realize the immense value of palliative care to patients’ families, they start to embrace it.” She went on, “The transformation, or the epiphany, is hearing and seeing the response from patients’ families.”

A community hospital administrator described, “The most rewarding letters are ones we receive from families of patients who have passed away that had access to the palliative care program.” She went on, “They [the letters] bring tears to my eyes because we’re able to provide comfort and closure around what are very, very difficult issues.”

In addition to positive family reactions, initial support from a select group of physicians can spur more widespread acceptance of palliative care. An ED nursing director described support coming from “informal leaders,” who will “make it okay for everybody else.” Similarly, a community hospital administrator described how they started with “physicians that we knew would be more sympathetic.” She went on, “Ninety-five percent of physicians here really embrace palliative care now and find it to be helpful to them in terms of dealing with the patient and family.” A palliative care director described, “Yearly since we began, as most palliative care teams have found, we get more and more patients; we’re slowly converting the physicians.”

Administrators from all 3 hospitals recognized the need for open, honest communication with patients and their families

Table 3. Emergency, palliative care, and hospital administrators' views on the barriers and opportunities to delivering palliative care in the ED.

Theme		Representative Quotes
Perception/identity of palliative care		
Barrier	Palliative care as end-of-life care	People think palliative care equals DNR/DNI [do not resuscitate/do not intubate] and you're done.
Opportunity	Exposure to palliative care results in acceptance	The palliative care program had become wildly successful; the hospital community has become a big supporter of it.
The conversation/communication		
Barrier	Competing demands	Emergency physicians have a limited ability to focus on anything other than the 300 patients they're going to see today.
Barrier	Environmental barriers	There's no privacy.
Opportunity	Meaningful care	We need care that's valuable to the family.
Family expectations		
Barrier	False hope	There's this belief that if you're strong enough you can beat whatever terminal disease you have.
Opportunity	Creating and sustaining realistic expectations	Palliative care is about connecting the chronically ill to physicians that can help manage their quality of life with reasonable expectations around what's achievable.
Financial incentives		
Barrier	Limited palliative care workforce	Since we're a consult service, as our numbers go up, we're very short staffed and everybody becomes completely overwhelmed.
Opportunity	Alignment of patients' need with resources	Putting patients in the ED environment who won't benefit is wasteful. It's bad business and bad care.
Opportunity	ED throughput	Palliative care helps us keep beds open and available for people who belong in those beds.
Guidelines: criteria and quality		
Barrier	Lack of clinical standards	There are 25 physicians in the ED, each doing what they think is right, which doesn't necessarily mean they're all doing the same thing.
Opportunity	Development of algorithms	We should automatically put certain patients on a pathway.
Physician attitudes, knowledge and beliefs		
Barrier	Patient ownership	Our palliative care physician got beaten up on a regular basis, and a lot of it had to do with the physicians, not so much the family and patients.
Barrier	Culture of intervention/aggressive care	They are so gung-ho for invasive procedures, and don't realize it's because that's how we get paid.
Opportunity	Recognized need for education	In emergency medicine we haven't been exposed to starting palliative care in the ED.
Medicolegal		
Barrier	Defensive medicine	Just do the most so we won't get sued.
Barrier	Time constraints	This is a decision that I need to make in 3–5 minutes.

about end of life issues, but acknowledged that these conversations are difficult in the ED.

Administrators believed that emergency physicians generally lack time to have such conversations because of competing demands. One ED director acknowledged the priority is “preservation of life at all costs,” instead of “the preservation of dignity,” though this may be appropriate for critically ill patients. Although emergency physicians recognize that these “conversations” should be held with the family, a community hospital administrator admitted, “They don't have the time or interest to do it themselves.” But whatever the cause, administrators agreed that the net result of the lack of communication in the ED is, in the words of one ED director, a “lack of frankness and openness about options.”

The ED, often described as “disruptive and chaotic,” poses obvious barriers to sensitive discussion between the medical team, family, and patient. A nurse administrator stated, “I can see in the eyes of the families how much more relaxed they are in a private room.”

Despite the barriers, administrators understood the importance of having these conversations in the ED. A tertiary care hospital administrator said, “If you listen carefully to patients and families, they're actually asking for palliative care; they're asking to be cared for in a way that preserves their dignity and the quality of their life.” An ED nursing director included these conversations in what she termed “valuable” or “meaningful care” and contrasted that care with “clinical care.” She described, “An emergency provider can think, ‘I took great care of that patient,’ but if the patient is at the end of life and no discussion took place they haven't provided meaningful care.”

Administrators from all 3 hospitals described how patients and their families can enter the ED with unrealistic beliefs about prognosis and suggested that palliative care can play a central role in creating and sustaining more realistic expectations.

Hospital administrators described 3 roots of false hope among family members of the seriously ill: a belief that the

patient is “strong enough to fight off the sickness,” an expectation that “the power of medicine can overcome any illness,” and a family’s “reluctance to accept a poor prognosis.”

As a tertiary care hospital administrator explained, “There is a growing disconnect between expectations and reality about what they should be getting, about their rights as patients, what we’re able to provide, and how we could even meet those expectations.” Finally, staff often foster, or fail to correct, the unrealistic expectations of patients and family. An ED director explained, “There’s a lot of false hope given to patients.”

Administrators believed palliative care could help foster realistic expectations about patients’ health. A community hospital administrator echoed these sentiments and discussed the importance of “setting expectations right from the beginning, instead of people believing a miracle will happen.” She acknowledged the “difficulty in initiating the conversation about where the person is at realistically” but concluded, “If you have this conversation right at the portal of entry and the person does get stabilized, how wonderful; or if the disease takes its natural progression, it’ll be expected instead of the family thinking something was done wrong.”

Hospital administrators from each type of hospital discussed the financial effect of palliative care on the hospital in general and the ED specifically. Many administrators thought that palliative care would be beneficial for patients and hospitals, whereas others focused on the staffing and educational challenges of integrating palliative care into the ED.

Palliative care administrators identified staffing as an important obstacle to bringing palliative care to the ED. Most hospitals maintain a small palliative care team, and one of the hospitals did not have a palliative care physician for almost a year. This leads to overworked team members, limited around-the-clock availability, and high staff burnout. One palliative care director explained, “The biggest struggle is trying to maintain numbers and staffing.”

A palliative care physician described the conflict between the continual needs of the ED and a limited palliative care workforce. She described how emergency physicians “wish palliative care could be available 24/7, but it’s not feasible to have someone who can be there in minutes.” She concluded, “We have to figure out how to give them the availability they need without killing ourselves.”

Salary for palliative care physicians was also cited as a factor affecting retention. Palliative care administrators described, “We are in a primary care area, so everybody comes in at a low salary despite the fact that they have fellowship training or a subspecialty.”

A hospital administrator described palliative care as “the perfect alignment between good care and good business.” He went on to say, “The catalyst for real change with palliative care is going to be economic reality of where our health care system finds itself.” A community hospital administrator expressed a similar view: “It would be so helpful to initiate a goals-of-care discussion in the ED instead of utilizing the full services

available and having a patient wait 23 hours in the ED for a critical care bed they don’t need.”

A palliative care administrator recognized palliative care’s role in “offloading the ED.” She concluded, “Anything that can move people up and out is great.” She also described, “The incentive for the ED to use palliative care is throughput.” A public hospital administrator in a hospital with inpatient hospice beds explained, “We’ve eliminated a number of 1-day stays because palliative care picks patients up straight from the [ED] so they get admitted right to hospice.”

Administrators from all 3 hospitals expressed the desire for a set of clear guidelines or criteria for how and when palliative care should be used in the ED to reduce unexplained variation in care.

Many hospitals lack criteria for deciding when to consult a palliative care needs assessment or address goals of care in the ED. Individual physicians are frequently left to make this difficult decision without any clear guidance. An ED director expressed, “There are 25 physicians in the ED, each doing what they think is right, which doesn’t necessarily mean they’re all doing the same thing.” He continued, “If somebody came in and was clearly end-stage and the family didn’t want them intubated, 99% of the time we wouldn’t intubate them, but there was not necessarily a standard or a legal document to fall back on. It was just doing what we thought was the right thing to do.”

Administrators suggested that hospitals adopt an algorithm or set of criteria to reduce variation in who receives palliative care interventions. An ED nursing director recommended creating “a system that sets a pathway for patients who present under a certain set of circumstances” so that a patient’s experience is not “random and variable.”

Hospital administrators from all 3 hospitals reported physician attitudes toward palliative care that ranged from hostile to indifferent to accepting. Knowledge about palliative care was generally reported to be limited.

Administrators describe emergency medicine culture as promoting aggressive medical care. A hospital administrator explained, “The environment is created for the aggressive management of illness, and spending money and throwing drugs and tests at patients is the culture.” An ED director worried, “We’re creating a generation of gunner proceduralists that think they’re compassionate, but they’re not.”

Many physicians transition into “treatment mode” when working in the ED. A palliative care director described a patient who was “still being given fluids when the patient was edematous and weeping; they are in the treatment mode and can’t see the big picture.” An ED nursing director characterized this as “task-oriented” care. He said, “Clinicians often think the care they’ve given is really good, but it’s only connected to finding out what’s wrong clinically, and may not be meaningful care for the patient or family.” Some described this as an emotional defense. An ED director explained, “If you allow yourself to break down that emotional barrier, it’s very difficult

to get through the shift. We're human. It's easier to put the central line in and follow the checklist."

Administrators acknowledged that emergency physicians required greater exposure to palliative care to successfully integrate in into their practice. An ED director suggested, "Some talks about what palliative care can do would be very informative for most emergency physicians."

A public hospital administrator suggested that exposure to palliative care start earlier, saying, "Emergency medicine doesn't focus enough in residency on palliative care, so the new doctors aren't getting the training." A community hospital administrator suggested, "Palliative care should be better presented in the medical curriculum so that younger people coming out are more familiar and comfortable with it."

Administrators from the public hospital expressed medicolegal concerns about integrating palliative care. A hospital administrator explained that when palliative care recommends forgoing an intervention, "the answer from risk management is always just no; the answer is, 'Just intubate.'" The fear of legal action can even trump financial considerations. He went on to explain, "Risk management is not going to say, 'Oh, it's going to cost \$10,000 a day to put this patient in the ICU'; they will just ask, 'What did the family say? What are the legal ramifications? Are we going to get sued?'"

Legal concerns place additional burdens on the decisionmaking process in the ED. An ED administrator described, "These are decisions that have to be made in a few minutes, not in a few hours or a few days. The lawyers will always say, 'You need to do this and you need to do that'; they don't understand this is a decision that I need to make in 3 to 5 minutes." A palliative care administrator emphasized the additional burden of documentation, noting, "We're required to do quite a bit of documentation to either withhold or withdraw care [interventions]."

LIMITATIONS

Despite its importance, our study does have limitations. Although we included 3 hospital types, our focus on 1 urban area likely limits the generalizability of our findings. It is well known that health care use, including access to palliative care services, varies by geographic region¹⁷; therefore, a more robust geographic sample may have provided other insights. In addition, the interviewer's interest in palliative care integration may have encouraged participants to respond to the topic more favorably. Though we attempted to triangulate our findings with multiple administrators from each hospital, we were limited by administrators' small number and limited availability, and their ability to report realistically for their staff. Next steps will include a national survey of hospital administrators to test some of the hypotheses generated in this study in a larger, more diverse sample.

DISCUSSION

We describe the views of hospital, ED, and palliative care service administrators on the barriers and opportunities to the

delivery of palliative care in the ED. Although it is unclear how often the administrative perspective matches the views or actions of clinicians in the ED, administrators have a unique and important vantage point on the relationship between services, the financial health of the hospital, and regulatory and medicolegal issues. In addition, they often make important decisions about staffing, draft policies and clinical guidelines, and have access to their division's finances. For these reasons, it is important to consider their perspective when designing ED palliative care interventions and partnerships, and enlist their support early for such projects.

Barriers specific to ED leadership include poor communication with patients and families, medicolegal concerns, and a lack of clear guidelines for forgoing care interventions or aggressive symptom management. Clear guidelines would help patients reach destinations, whether inpatient or outpatient, that are matched to their needs. This might also assuage medicolegal concerns if there are guidelines and processes for forgoing aggressive interventions for patients who are unlikely to benefit. Palliative care administrators felt challenged by physicians' fixed knowledge, attitudes, and beliefs and the perception and identity of the specialty as "end-of-life care." Administrators emphasized that palliative care focuses on symptom management and can be delivered simultaneously with curative therapies, unlike hospice. Barriers at all levels include the lack of adequate staffing to provide palliative care and the unrealistic expectations of family members.

Although some of these themes have emerged from provider and patient interviews in our previous qualitative work and that of others,^{9,10,18} much of what we are reporting here is novel. To our knowledge, this is the first study that describes barriers and opportunities to palliative care from the viewpoint of hospital executives and administrators. Previous studies have shown that impediments to palliative care delivery in the ED include poor communication, lack of clear clinical guidelines, and prioritization of the acutely ill over those with exacerbations of chronic, life-limiting disease. The potential benefits of delivering palliative care early in a patient's hospital stay, such as in the ED, have also been described, including increased staff, patient, and family member satisfaction with care. Our research, however, is among the first to describe the views of hospital administration, as well as the hospital-level factors, that impede the usability and accessibility of palliative care to emergency providers. Although our work helps elucidate the administrative perspective, it is not clear how accurately administrators' views reflect how EDs and the palliative care service function. For example, we know of no published studies that describe how often emergency providers choose to forgo aggressive interventions, conduct goals-of-care discussions with patients and families, or practice defensive medicine.

Multiple parallels can be drawn between our findings and those of previous research in other service areas, especially with regard to communication failures and medicolegal concerns. For example, failures to discuss goals of care and manage family

expectations have been well documented.¹⁹ Successful educational interventions to improve such communication skills among providers already exist and can be borrowed from other disciplines and adapted for emergency providers.²⁰ Medicolegal concerns are also well documented and are especially pronounced among emergency providers.²¹ These results suggest that there is both opportunity and support for solutions to these issues from multiple levels of hospital administration and staff. Specifically, the development of palliative care guidelines for EDs and physicians would help address some of these concerns. Specific guidelines, such as triggers for a palliative care needs assessment, have already been developed for hospitalized patients and can serve as a starting point for initiating an assessment in the ED.²² The Center to Advance Palliative Care's recent initiative to integrate palliative care in the ED, IPAL EM, also provides a central portal for improvement tools, evidence, and best practices (<http://www.capc.org/ipal/ipal-em>).

Supervising editor: Rita K. Cydulka, MD, MS

Author affiliations: From the Department of Emergency Medicine (Grudzen, Richardson, Major-Monfried, Ortiz) and the Brookdale Department of Geriatrics and Palliative Medicine (Grudzen, Kandarian, Morrison), Mount Sinai School of Medicine, New York, NY.

Author contributions: CRG, LDR, and RSM conceived and designed the study. CRG and JMO contributed to the acquisition of data. CRG, HMM, BK, and JMO helped analyze and interpret the data and drafted the article. All authors helped revise the manuscript for critical content and granted final approval of the version to be published.

Funding and support: By *Annals* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see www.icmje.org). The authors have stated that no such relationships exist. Dr. Grudzen was supported by both a Brookdale Leadership in Aging Fellowship and a Mentored Research Science Grant from the American Cancer Society. Dr. Morrison was supported by a K24 from the National Institute on Aging. Mr. Kandarian was supported by a Medical Student Training in Aging Research (MSTAR) Scholarship from the American Federation for Aging Research.

Publication dates: Received for publication April 18, 2012. Revisions received May 26, 2012, and May 30, 2012. Accepted for publication June 6, 2012. Available online July 7, 2012.

Address for correspondence: Corita R. Grudzen, MD, MSHS, E-mail: corita.grudzen@mssm.edu.

REFERENCES

1. Congressional Budget Office. *High-Cost Medicare beneficiaries*. Washington, DC: Congressional Budget Office; 2005.
2. Riley GF, Lubitz JD. Long-term trends in Medicare payments in the last year of life. *Health Serv Res*. 2010;45:565-576.
3. Teno JM, Clarridge BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. *JAMA*. 2004;291:88-93.
4. Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med*. 2010;363:733-742.
5. Morrison RS, Penrod JD, Cassel JB, et al. Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med*. 2008;168:1783-1790.
6. Gelfman LP, Meier DE, Morrison RS. Does palliative care improve quality? a survey of bereaved family members. *J Pain Symptom Manage*. 2008;36:22-28.
7. Morrison RS, Augustin R, Souvanna P, et al. America's care of serious illness: a state-by-state report card on access to palliative care in our nation's hospitals. *J Palliat Med*. 2011;14:1094-1096.
8. Grudzen CR, Richardson LD, Morrison M, et al. Palliative care needs of seriously ill, older adults presenting to the emergency department. *Acad Emerg Med*. 2010;17:1253-1257.
9. Grudzen CR, Richardson LD, Hopper SS, et al. Does palliative care have a future in the emergency department? discussions with attending emergency physicians. *J Pain Symptom Manage*. 2012;43:1-9.
10. Smith AK, Fisher J, Schonberg MA, et al. Am I doing the right thing? provider perspectives on improving palliative care in the emergency department. *Ann Emerg Med*. 2009;54:86-93.e1.
11. Waugh DG. Palliative care project in the emergency department. *J Palliat Med*. 2010;13:936.
12. 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*. 2008;85:443-451.
13. Glajchen M, Lawson R, Homel P, et al. A rapid two-stage screening protocol for palliative care in the emergency department: a quality improvement initiative. *J Pain Symptom Manage*. 2011;42:657-662.
14. Grudzen CR, Stone SC, Mohanty SA, et al. "I want to be taking my own last breath": patients' reflections on illness when presenting to the emergency department at the end of life. *J Palliat Med*. 2011;14:293-296.
15. Smith AK, Schonberg MA, Fisher J, et al. Emergency department experiences of acutely symptomatic patients with terminal illness and their family caregivers. *J Pain Symptom Manage*. 2010;39:972-981.
16. Bryant A, Charmaz K. *The Sage Handbook of Grounded Theory*. London, England: SAGE Publications; 2007.
17. Goldsmith B, Dietrich J, Du Q, et al. Variability in access to hospital palliative care in the United States. *J Palliat Med*. 2008;11:1094-1102.
18. Bailey C, Murphy R, Porock D. Trajectories of end-of-life care in the emergency department. *Ann Emerg Med*. 2011;57:362-369.
19. SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients. The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT). *JAMA*. 1995;274:1591-1598.
20. Back AL, Arnold RM, Baile WF, et al. Efficacy of communication skills training for giving bad news and discussing transitions to palliative care. *Arch Intern Med*. 2007;167:453-460.
21. Studdert DM, Mello MM, Sage WM, et al. Defensive medicine among high-risk specialist physicians in a volatile malpractice environment. *JAMA*. 2005;293:2609-2617.
22. Weissman DE, Meier DE. Identifying patients in need of a palliative care assessment in the hospital setting: a consensus report from the Center to Advance Palliative Care. *J Palliat Med*. 2011;14:17-23.