Palliative Care in the ICU: Business Planning and Assessing Models of Care

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The Coleman Palliative Medicine TRAINING PROGRAM

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Disclosure of Conflict of Interest

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Why focus on the ICU?

- In IL in 2012, 16.3% of terminal admissions were associated with a stay in the ICU (overall, 22.2% of deaths occurred in an acute care hospital)*
- High acuity = high levels of stress/distress for both staff and patients/families
- Most bang for your buck in terms of cost savings for the hospital

- *Dartmouth Atlas of Healthcare(Medicare pts age 67-99 w/at least one chronic illness)

Impact of ICU Palliative Interventions

- Early Referrals to Palliative Care in the ICU are not associated with earlier death but are associated with improved quality of care

-O'Mahony S *Palliative Medicine. 24(2): 154-165. March 2010*

- A multicenter randomized controlled trial at multiple medical centers demonstrated reductions in the prevalence of depressive and anxious symptoms measured with the Hospital Anxiety and Depression Scale and lower levels of post traumatic stress disorder for the family members of dying patients who had participated in proactive conferences and who received informational brochures when compared with controls

-. Lautrette A *N Eng J Med* 2007; 356(5): 469-478.

Palliative Care in the Rush MICU

Pre Proactive Consultation Service	Post Proactive Consultation Service
• Physician referral	• Proactive rounding by nurse practitioner specializing in palliative care twice per week • Palliative care consult “triggers” • Physician referral

Financial impact of this program

1. Mean direct hospital costs for decedents who spent at least one day in the MICU were $3,886 lower in the 6 months following the implementation of proactive rounding by a palliative care NP, use of referral triggers, focused education (N=118) vs. the 6 months prior to implementation (N=104).

   annualized this represents a savings of approximately $800,000 in one unit.*

*Direct Hospital Costs For Decedents Pre- and Post- Introduction of Proactive Rounding in the MICU by a Palliative Care NP : Source Shawn Amer Masters in Policy Presentation 3/4/11. Decision Support Team RUMC

Average Non Room and Board Charges for 61 patients who died in the Weiler ICU 2/2007 through 8/2007-- Single Site Case Control Study

	N	Average Daily Pre Charges	Average Daily Post Charges	Total Average Charges
Controls (Usual Care)	39	$6,639.76	$9,017.21	**$125, 713.30**
Cases (Palliative Care)	23	$9,490.60	$7,475.10	**$90, 979.96**

Mean time from admission to consultation is 2.81 days (Moses 15.5 days p<.0001)

Mean time from consultation to death is 4.69 days (Moses 5.02 days, p=.65)

Mean hospital charges for palliative care consultation group were lower (t=6.17, p<.0001)

Focus of consultations and reimbursement

- Disproportionate numbers of these consultations will include long patient and family face-to-face time as the subject of the consultations is likely to revolve around goals of care discussion. e.g. the reimbursement rate for 99356 E and M visit would be ~$170 under Medicare versus $70-$100 for 99233 (for typical visit involving pain and symptom management)

Implementing and Measuring the Success of ICU interventions

- Involve as many of the ICU team as possible if developing screens
- Identify and work with the appropriate ICU administrator, Quality Management, Decision Support, Nurse Educator, Chaplain, Social Worker
- Remember that different tools work in different ICUs
- Collect data to document change in clinical metrics, patient/family satisfaction, and utilization

Process Implementation for screening

- Pay attention to the details of the referral process, response time, responsible parties for implementation and documentation of the screening criteria on the EMR
- Collect data from the start, evaluate data at a pre-specified time point, adjust criteria if needed and adjust the intervention accordingly based on attitudes of the stakeholders and reports of barriers.
- Meet biweekly to monthly with the stakeholders to discuss and learn from successes and problematic cases.

Palliative Care and the ICU

- Select your team carefully
- APNs or MDs who have a background in critical care are an ideal fit for the ICU as they have a better understanding of and are comfortable with the technology, know the culture, and understand the workflow of the unit
- Meet the stakeholders, solicit their opinions and needs, and focus on those areas

Understand their expectations

- ICU teams are accustomed to fast turn around and response from other teams. They may not work with you if your response time exceeds 12 to 24 hours
- It may mean restructuring your work schedule to include more evening hours and probably some weekend availability.
- That said the focus on goals of care and family support may mean less frequent follow up than you may require for pain and symptom management consultations

Unit Culture

- Different units have different cultures and rounding structures.
- Take time to understand these cultures and rounding systems and develop strategies to negotiate them
- What should the palliative care team's boundaries be in discussing goals of care?
- There may be initial unrealistic expectations that palliative care can achieve a quick reset to family opinions and dynamics
- Educate that you are not the death squad

Role of the palliative team in ICU

- Helping patients and family members live with ambiguity. Often will move toward assistance with medical decision-making.
- Helping staff manage moral distress and uncertainty
- Being present—may not always be actively doing something: often easier for APNs because of nursing training
- Supporting staff debriefings

Meet and manage expectations

- You will be respected if you are consistently present—but be patient, this will take time.
- Try to proactively attend their interdisciplinary rounds two to three times per week.
- Provision of preemptive bereavement support and psychosocial counseling may warrant inclusion of a social worker/ bereavement counsellor on your team

Team building strategies

- Participate in and promote unit-based palliative medicine committees
- Provide debriefing and team support
- Maintain relationships with families throughout the stay, not just when there are active issues to be addressed
- Assist the ICU team with families who reject medical advice

Consultation Screening tool for critical care units

Standardization of referrals to palliative care team by the implementation of a palliative medicine screen in the ICU

- Hospital stay>30 days
- Cardiac Arrest (modified from in-hospital cardiac arrest
- Family request
- Family disagreement with team/ advance directive/each other (modified from >3 days)
- Multisystems organ failure (3 systems or more)
- Active stage IV malingnancy (same) or refractory hematological malignancy (new)
- Poor neurological prognosis and inability to wean from ventilator
- Untransplantable hepatic failure

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Clinical vignette

- 19 year old woman in NSICU has had brain stem hemorrhage complicated by locked in syndrome
- Family decided on withdrawal from ventilator based on prior expressed wishes, values and goals of the patient
- 6 visits by MD and APN over 3 days, including three one-hour family meetings
- Support the family in process of withdrawal
- Support to the team in the discussion of prognosis
- We are asked to divulge the plan to extubate to the 16 year old sister of the patient and ensure she knows that her sister's death is imminent
- Patient dies 12 hours after disconnection from the ventilator
- ICU team identified that palliative care should provide emotional support, pre-bereavement, and bereavement counseling to this family
- What psychosocial support, training and resources should a palliative medicine team have?

Considerations

- What do you do when you don't agree with management of the patient?
- How do you promote greater transparency and more uniform provision of information to family? e.g. standardization of routine family meetings rather than meeting in response to the latest change in a patients condition
- Meetings should be planned as with any other medical procedure; if multiple teams participating should pre-meet
- Make sure that the captain of the ship is there-the person in charge OR the provider most trusted by the family
- Don't assume consistency of opinion within the ICU team or between ICU team and other specialists

Considerations, continued

- Despite the seemingly large numbers of people involved in the patient's care documentation often lags rapidly changing events by many hours
- Don't assume that teams are articulating or communicating important differences of opinion amongst each other
- Always err on the side of paging/ calling the lead intensivist involved and important other parties: surgical attending, primary cardiologist, medical oncologist, etc.

Wrap-up and Thank You