INTERDISCIPLINARY
PALLIATIVE CARE
CONSULTS IN THE ICU

NATIONAL KAISER
PERMANENTE GERIATRIC AND
PALLIATIVE MEDICINE
CONFERENCE 6/08

FACULTY

- Sharon Dahlinger, RN,CHPN Kaiser Permanente Denver, CO Sharon.Dahlinger@kp.org
- Kathleen McGrady, MD, FAAPM, MS, MA, Inpatient Palliative Care Kaiser Permanente Denver, CO Kathleen.McGrady@kp.org
- John Girten, MDIV, Manager Spiritual Care Exempla Good Samaritan Hospital Lafayette, CO Girtenj@exempla.org
- Lisa Sharpe, BSW Inpatient Palliative Care Exempla Saint Joseph Hospital Denver, Co Sharpel@exempla.org

Mrs C-What Might She Have Wanted?

- 82 F admitted urosepsis to ICU hx DM CHF old CVA mild dementia in assisted living
- Day 2 MI,CHF and then aspiration pneumonia
- Day 5 pneumothorax on vent
- Day 10 line sepsis
- Day 13 UGI bleed
- Day 17 renal failure
- Day 20 another MI while on dialysis
- Day 24 died in ICU What did she want?
- If Mrs. C was uncommon, we would be in another conference session
90% of adults prefer to be cared for in their own home if terminally ill.

Quality of Life at the End of Life: What Patients and Families Want

- Pain and symptom control
- To avoid inappropriate prolongation of the dying process
- To achieve a sense of control
- To relieve burden on family
- To strengthen relationships with loved ones

Singer et al, JAMA 1999

SUPPORT Study: How We Die

- 38% spent at least 10 days in the ICU
- Nearly 1/2 of patients received mechanical ventilation in the last 3 days before death
- Half of patients had moderate to severe pain 1/2 of the time prior to death
- 1/3 patients preferred no CPR, <1/2 of their MDs accurately reported preferences
- 31% families reported using all/most of savings

Distribution of Health Care Costs

>30 percent of Medicare payments cover the cost of care for people in the last year of life.

Baby Boomers: Coming of Age

- By 2010, America’s 77 million baby boomers will begin turning 65.
- America’s population over the age of 65 will double by the year 2020.

Stopping the Aging Process...
Why Palliative Care in the ICU?

- Over 4 million US patients are treated annually in the ICU
- 1 in 5 Americans die in an ICU
- Despite our best technology, many die in the ICU

Why PC in the ICU Cont’d

- More deaths in the ICU than anywhere else in the hospital
- Of the pts who die in the hospital, ½ spend 3 days in the ICU before death
- Of the pts who die in the hospital, 1/3 spend more than 10 days in the ICU before death

DEFINITION OF PALLIATIVE CARE

- Palliative care is INTERDISCIPLINARY care that aims to RELIEVE SUFFERING and IMPROVE QUALITY of life for PATIENTS with advanced illness and THEIR FAMILIES.

AND....
Definition of Palliative Care

- It is **IDEALLY** initiated at the time of diagnosis of any serious or life-threatening illness, independent of prognosis, and is **DELIVERED IN CONCERT** with curative or life-prolonging efforts, provided these latter therapies are **BENEFICIAL** to the patient.

Diane Meier "Geriatric Care" 2003

PC in the ICU

- Traditionally ICUs have been avoided by PC professionals—PC seen in the past as the opposite of ICU care.
- Times are changing. Now delivered in concert.
  - Multi-million grant RWJ study PC in ICU
  - KP CO seeing ICU since 4/03 now seeing several hundred pts per year.

Video of ICU consult
PC in the ICU

- Critical decisions in the ICU often have to do with advanced technology that is poorly understood by families.
- Pts are often incapable of communication or decision-making in the ICU.

Why Palliative Care in the ICU Cont’d

- Many pts have not provided guidance on their goals of care or what would be an acceptable quality of life.
- Since decisions must be made, families and physicians must define the goals of care together.
- Additional confusion: death unpredictable.

Last Years of Life: Death is not Predictable

(slide courtesy of Joanne Lynn, MD, Rand Corp.)
PC in the ICU

- PC is very appropriate for seriously ill pts while pursuing cure, life-prolonging treatments and recovery
- PC integrates palliative measures for some illness with treatments that can be curative or life prolonging
- No conflict with aggressive ICU care & PC
- Palliative Care does not mean no care

PC in the ICU Cont’d

- To make goals of care, the pts personhood needs to be understood
- Requires a good knowledge of the pt/family psycho-social-spiritual hx
- Requires attention to pt/family’s values, preferences and needs
- This is what PC does

PC in the ICU Cont’d

- Aggressively manages pain and sx
- Helps pt/family achieve a sense of control
- Helps relieve family burdens
- Supports hope
Why PC in the ICU Cont’d

- Skillfully addresses pt/family suffering
- Provides dignity/comfort to pt/family
- PC supports the family to avoid inappropriate prolongation of the dying process

PC in the ICU

- Provides communication between family members, staff/family, new medical providers entering the case and staff/family and more
- Helps to communicate changes in goals of care in a changing environment

Palliative Care Addresses “G-A-P-S” in End-of-Life Care

- G = Goals of care: establishing goals around comfort, function, length of life
- A = Advance care planning: starting the conversation to signing documents
- P = Psychosocial and spiritual support
- S = Symptom management

LOTS OF THIS IN THE ICU

James A Avery MD, NHPCO Audio Web Seminar, April 2006.
APPROPRIATE ICU PTS FOR PC

- Any pt with a life threatening or serious illness
- Pt/family confused/conflicted over goals of care
- Any pt who you would not be surprised if they died within a year
- Pts with uncontrolled pain/sx
- Pts with significant psycho-social-spiritual issues (case)
- Pts being removed from life support whose family/staff have need for ongoing support
APPROPRIATE ICU PTS FOR PC

- Pts with recurrent admissions to ICU
- Pts/family who do not wish to be in the ICU
- Pts with long ICU stays that are not improving
- Pts that wish to change/review goals of care and need info on PC

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APPROPRIATE ICU PTS FOR PC

- All medical services have appropriate PC care pts in the ICU-NS,surg,onc
- Pts/family that request PC
- Ethics committee requests PC (case)
- Pts/family whose wishes conflict with their goals of care

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PC Unlikely to Help ICU pts who:

- Recent OD without life limiting or serious illness
- Pts that are non-decisional without surrogate
- Failed resuscitation pts in the last moments of life
PC Unlikely to Help ICU pts who:

- Pt/family that decline consult
- Trauma pts with good prognosis
- Pts that are actively dying without family/staff concerns
- Pts/family that are comfortable with direct admit to hospice

Marketing to the ICU

- PC still new sub-specialty
- Are you hospice?
- If you aren’t hospice, just what do you do?
- Oh, I do that for all my pts everyday

Marketing

- Clear succinct message who you are and how to reach you throughout the entire hospital not just ICU
- Posters on boards, handouts, bagels, pencils, presentations to ICU staff
- Attend ICU rounds
- Be professionally visible (fish bowl)
Marketing
- Lunch with ICU docs, staff, administrators, everyone
- E-mails
- Presentations to SW, case management, administration, spiritual care, medical staff, nurses
- Present to the Ethics Committee

Marketing
- Remember ICU environment is different then the floor: Show you honor it and those that work there
- Thank those that referred the consult
- Seek feedback post consult
- Do not appear to be “shopping”
- Have individual conversations

Marketing-The ICU Perspective
- What can you do for me?
- Don’t create more work/don’t take my time
- Don’t anger pt/family, staff, or consulting docs
- Don’t look like you have time on your hands
Marketing - ICU Perspective

- Don’t crowd my space
- Honor our work
- Show me you are ethical
- Deliver/performance
- Document and then document more
- Make them feel: “When I see you, I know my day will be better.”
- “Don’t page me all the time”

One Way to do PC Consults in the ICU: The KP CO Experience

Two hospitals

Two full-time palliative care teams – RN, MD, SW, Chaplain

~ 1300 pt/year, several hundred in ICU/YR

1/3 are referred to hospice at the time of consultation

Our model is based on a Randomized Controlled Study: Gade et al JPM 2008:11(8)

ICU Consults Are Different

- More complex medical illness
- More complex family/social/spiritual
- More time intensive
- Rapidly changing environment
- Frequent change in providers
- Nursing staff very involved “hungry for PC help”
ICU Consults Are Different

- Docs also more involved (case)
- Much opportunity to do good; much opportunity to have a problem
- Little hx available on personhood-intense medical focus
- Large fish bowl
- Enormous communication needed

ICU Consults Are Different

- More providers involved, more likely to work with challenging doc/staff-case
- More ethical questions, challenges
- Suffering in ICU cases seems greater
- Consults can be very delayed (case)

ICU Consults Are Different

- Here is where an interdisciplinary team SHINES.
- What are the pts values?
- What is meaningful to the pt?
- Pt’s illness is a threat to their personhood
- Pt as a whole person-psycho-social-spiritual-suffering
- How does their physical condition fit with their stated goals?
Why the Whole Team

- Amount of information needed to support the whole pt is significant and specialty driven
- Coordination of specialty information critical
- Takes all specialties to facilitate a complex care plan from the ICU
- Pt/family and providers may see dramatic "snap shot" less chance to see the whole picture

PC Consultation: Basic Steps

Consult Request
Screening: Whole Patient Assessment
Pre-Consult Team Meeting
Team Meeting with Patient/Family
Post-Consult Team Debriefing
Action Plan and Follow Up

Components of PC Consult

- Assess pt’s/family’s knowledge & perception of disease, Rx & prognosis
- Discussion of medical issues
- Assist in identifying personal goals including EOL care
- Assess and manage physical sx
- Assess and manage psych, spiritual & practical needs
- Communication of care plan across the care continuum
Prior to ICU Consult

- MD seeks info on referral (complex)
- SW schedules family meeting
- Screening of whole patient: (complex)
  - PC RN intake evaluation (complex)
  - Team members confer with hospital colleagues (complex)
  - Pre-consult team meeting (complex)
  - Share information & identify known concerns and goals for patient/family

Family Meeting Cont'd

- Meeting consists of:
  - Pt/ family's perception dx, Rx and prognosis, often very fragmented in the ICU
  - Assistance in identifying personal goals for EOL, pt often more worried about next test or procedure
  - Pain/sx as well as psychological, social, spiritual needs, all often greater in ICU.

Post Consult Team Meeting Critical

- Leave room together
- Summary/next steps
- Follow-up arranged
- Assign tasks
- Opportunity to receive/give feedback
POST TEAM CONT’D
- Safe/honest: intent to improve consult & team work
- Debriefing-sharing of thoughts, feelings decreasing secondary trauma
- Make list for future discussions/exploration
- Share “PEARLS” with each other

POST ICU CONSULT WORK
- Frequently on-going, intense for all team members- usually go together
- On going relationship building as illness changes
- PC team can serve as communication hub
- Stabilizer for pt/family with change of providers/staff (case)

Post ICU Consult Work
- Untiring advocacy and support for pt/family
- Frequent review of goals of care as medical condition changes or new therapies/procedures offered
- Ensuring palliative measures in concert with life saving or prolonging treatments
Cohesive Team a Must

- Each completes their parts and f/u
- Separates real from “made up”
- Honest
- Honors the team and its work
- Family meeting as a team dialog
- Self care and team caring
- Avoids worsening secondary trauma
- Ongoing self learning and environment

Conclusion

- Palliative Care ICU consults often are complex and difficult, but very doable
- Likely will be the standard of care in the future
- Marketing needed
- Interdisciplinary team very helpful