Palliative Care in the ICU: When less is more.

Mathe’
Objectives

- Characterize patient and healthcare provider experiences around the end-of-life
- List potential solutions to local challenges related to end-of-life care
1) True or false: Palliative care is the same as hospice care
- A. True
- B. False
Which of the following is considered a barrier to palliative care in the ICU?

- A. Low availability of clinicians
- B. Perception of the public
- C. Misunderstanding of prognosis
- D. All of the above
Video – Grandma with hip fracture
Making the case for Palliative care in the ICU

- How can PC help in the case of Grandma? (and other ICU patients?)
  - Early in the ICU admit
  - Mid way through
  - Later in admit
Morbidity and mortality in ICU

- 20% of Americans die in or after ICU care  
  500,000 people per year
- 100,000 “survivors” continue with critical illness on a chronic basis

CAPC: IPAL-ICU
What is Palliative Care (PC)?

- Works along with primary service and other consulting services supporting care of patients mainly in hospital.
- Some areas have clinic based or home based PC teams
- A team based specialty – Clinician (physician, NP, PA), social work, chaplain, bedside RN, child life specialist

Palliative care is not:
- Equivalent to death
- Pushing patient to hospice
- Giving up on the patient
- A discharge coordinator
Diagnosis or Admit to ICU

Symptoms
- Pain
- Nausea
- Dyspnea
- Constipation

Psychiatric sx
- Depression
- Anxiety

Psycho social support
- Grief
- Bereavement
- Child life support
- Options after DC

Palliative Consult Team

Options after DC
- Palliative Consult Team
- Other Consultants

Primary ICU team

Death

Hospice
Barriers to Palliative Care in the ICU

- Patient / Family –
  - Misunderstanding of prognosis / not believing prognosis
  - Equating palliative care with death, hospice, or giving up

- Clinicians –
  - Equating Palliative Care with death / giving up / failure
    - “vultures of the hospital”
    - “red hot poker up the surgeon’s A**”
    - “don’t rush death”
    - “I don’t need help”

- Other barriers
  - Availability of Palliative Care clinicians
Back to Grandma with a hip fracture – Early - days 1-3

- Family meeting:
  - Coordinated with ICU team
  - Determine surrogate decision maker
  - Seek understanding of current situation
  - Clarify misconceptions if possible
  - Address resuscitation status
  - Establish plan for ongoing follow up
Is there evidence to support PC in the ICU?

- Aslakson R Cheng J. Evidence Based Palliative Care in the ICU: A systematic Review. J Pall Med 2014; 17(2) 219-235
  - 37 heterogeneous studies
  - Most showed decreased hospital and ICU length of stay without effect on mortality
  - Most showed family satisfaction not affected
Evidence to support PC in ICU

  - 22 studies 9 RCT 13 non RCT
  - The consensus suggests that advance care planning and Palliative Care consult reduce number of ICU admissions for patients at high risk of death
  - Also reduced ICU length of stay.
Other Evidence to Support PC in General

- Temel JS Greer J et al. Early Palliative Care for Patients with Metastatic Non Small Lung Cancer. NEJM 2010; 363: 733-742
  - 151 patients randomized to PC vs usual care
  - Patients with NSCLC had improved QOL and mood
  - Also less aggressive care at EOL but longer survival (11.9 months vs 8.9 months p = .02)
Other evidence...

- Gade G Venohr I. Impact of inpatient palliative care consults: a randomized controlled trial. J Pall Med 2008 11(2) 180-190
  - 517 patients randomized to PC vs Usual care in 3 hospitals
  - PC consult patients:
    - Greater satisfaction with care experience and provider communication
    - Fewer ICU admissions on a subsequent readmission
    - Lower total healthcare cost following hospital discharge
Back to grandma mid way through ICU stay - days 3-5

- State concerns of clinical team
- Address prognosis
- Align goals with that of patient and patient’s views of quality of life
- Address other needs if any
  - Child life specialist? Social issues?
- Establish plan for further discussion
- Resuscitation status
- Trach / PEG?
Expected benefits of integrating PC into ICU

- Increased family satisfaction
- Increased symptom assessment and patient comfort
- Decreased family anxiety / depression, post ICU post traumatic stress
- Decreased conflict over goals of care
- Decreased time from poor prognosis to comfort focus goals
  - Decreased ICU and hospital length of stay (without increase in mortality)
  - Decreased use of non beneficial treatments

From multiple sources available at Center for Advancement of Palliative Care (CAPC) IPAL-ICU
Consult Palliative Care on which patients?

- Most patients with critical illness
  - Various "triggers"
    - Severe sepsis
    - Out of hospital cardiac arrest
    - Intracerebral hemorrhage and other severe brain injury
    - Multiple chronic conditions prior to admission
    - Severe organ failure
    - Advanced cancer
    - Help with symptom management
    - Help from child life specialist
    - Help from palliative trained Social Worker
Evidence against PC conducting family meetings in ICU

  - Intervention – structured PC led family mtgs after 7 days on vent then another mtg after 10 days on vent and a brochure about chronic critical illness.
  - Control – usual ICU team care including mtgs and the chronic critical illness brochure.
  - Primary outcome - 90 day post hospitalization interview with surrogate decision maker
    - HADS – Hospital Anxiety and Depression Scale
  - Secondary outcome – 90 days – PTSD symptoms of surrogate decision maker
    - IES-R Impact of Event Scale – Revised
Evidence against PC conducting family mtgs in ICU – outcomes

- HADS - no difference
- PTSD (IES-R) – worse in intervention group
- Length of stay – no difference (however LOS decreased 4 days $p=.51$)
Evidence against PC family mtgs in ICU how to explain unexpected outcome?

- Possibly too many mtgs – ICU team and PC team had mtgs separately – 1.4 mtg per patient by PC and 1.9 per patient by ICU team
- Not powered to show LOS difference although 4 days seems like a lot (p=.51)
- Not a full PC consult – just family mtgs
- So...
  - PC team should work with ICU team cooperatively – use PC SW and Chaplain
  - Full PC consult so PC team can get to know family better
  - Don't push families too hard to make decisions – work with what we have.
Sometimes best efforts are not helpful

Kentish-Barnes Chevret S. Effect of condolence letter on grief symptoms among relatives of patients who died in the ICU: a randomized controlled trial. Intensive Care Med 2017;43(4) 473-484.

- 22 hospitals in France
- Randomized to standard care vs condolence letter from ICU physician
- Primary outcomes surveys of grief, depression, PTSD by phone interview of family member one month and 6 months post death of patient.
- One month both groups similar
- At six months higher grief and depression scores in intervention group
- How to explain - ?
  - Phone call is better?
  - RN correspondence better?
  - Letter and survey serve as reminder of bad event?
Back to grandma later in ICU stay, after day 5

- Re address goals of care
- Clarify misunderstandings
- Re address trach / PEG – a fork in road for many -
  - Trach / PEG vs comfort vs trial extubation understanding
    no re intubation
- If decision is comfort care - prepare for shift in goals
  and educate family on process
- Address post ICU care / plans
Post hospital syndrome and homeostenosis

- Life is a long and ever narrowing road…
- Old age is standing on a precipice…
Stressors of hospitalization on the patient

- Original term “Post hospital syndrome” from Krumholz NEJM 368(2) 100-102
- While in hospital - Interrupted sleep, weight loss, delirium, deconditioning leaves the elderly in vulnerable state after discharge.
- 18% of Medicare patients re admitted within 30 days often for different problems
- Prevention of post hospital syndrome?
  - Early ambulation, patient's own clothes
  - Avoid long NPO periods, and family can bring in food
  - Avoid delirium
  - Avoid frequent interruptions of sleep

NYT: The Illness is Bad Enough. The Hospital May be Even Worse

NY Times Sept 30, 2018
Post ICU stress in families

  - Relatives of severe sepsis patients, survivors and non survivors questioned after 90 days
  - Helplessness
  - Feelings of being over burdened
  - Anxiety
  - Depression
  - Symptoms did not differ between survivors vs non survivors
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Non beneficial care in ICU patient’s nearing end of life.

- Offer time limited trials
- Seek second opinion
- Consider ethics consult
Palliative Care 2050

1980 2000 2030 2050

FIELD FOCUS: CRITICAL CARE
SURVIVAL

FIELD FOCUS: PALLIATIVE CARE
Hospice / End-of-Life Care
Palliative Care
Integrated Primary/Specialist Palliative Care from onset to recovery

GOAL OF ICU TREATMENTS
Physiologic stability
Acceptable cognition/function

PROCESS
Hierarchical Multiprofessional Teams
Interprofessional & Interdisciplinary Teamwork

COMMUNICATION
Clinical condition/Prognosis
Patient values/Family emotions
Mutual exchange of information

DECISION-MAKING
Paternalistic
Shared between patient/family & interprofessional/interdisciplinary team

PROGNOSTICATION
Striving for certainty
Acknowledging uncertainty

Mathews K, Nelson J. Intensive Care Medicine 2017. 43(12) 1850-1852