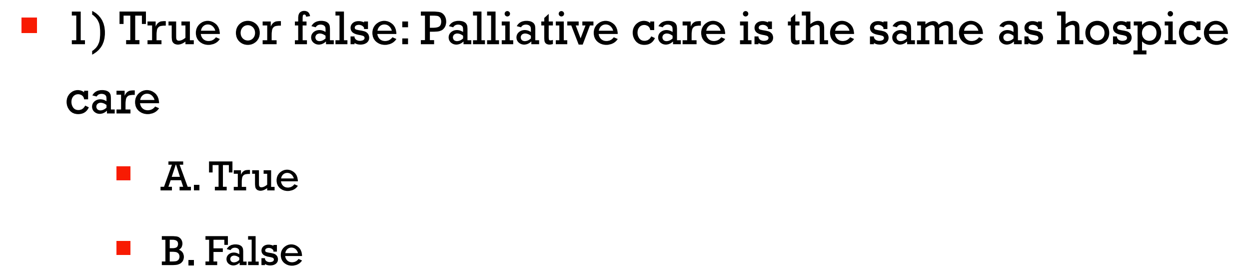
Palliative Care in the ICU: When less is more.

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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A. True
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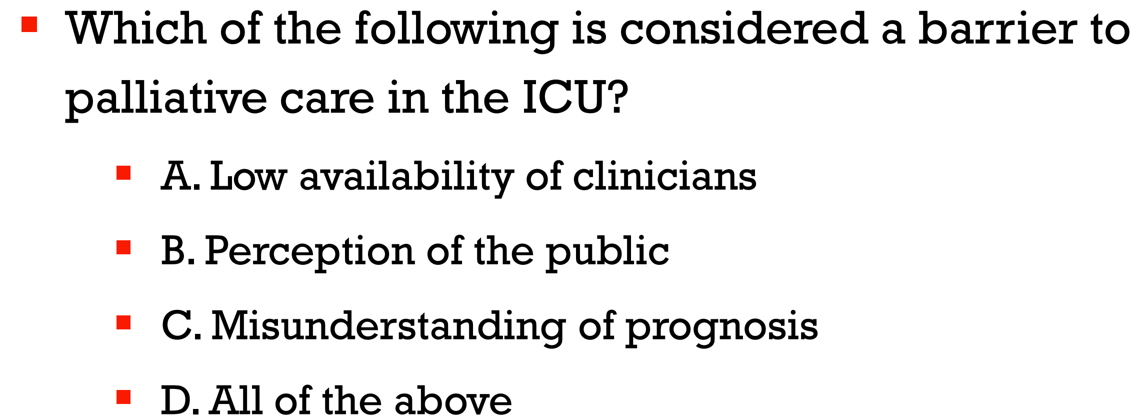

Which of the following is considered a barrier to palliative care in the ICU?
A. Low availability of clinicians
B. Perception of the public
C. Misunderstanding of prognosis
D. All of the above

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

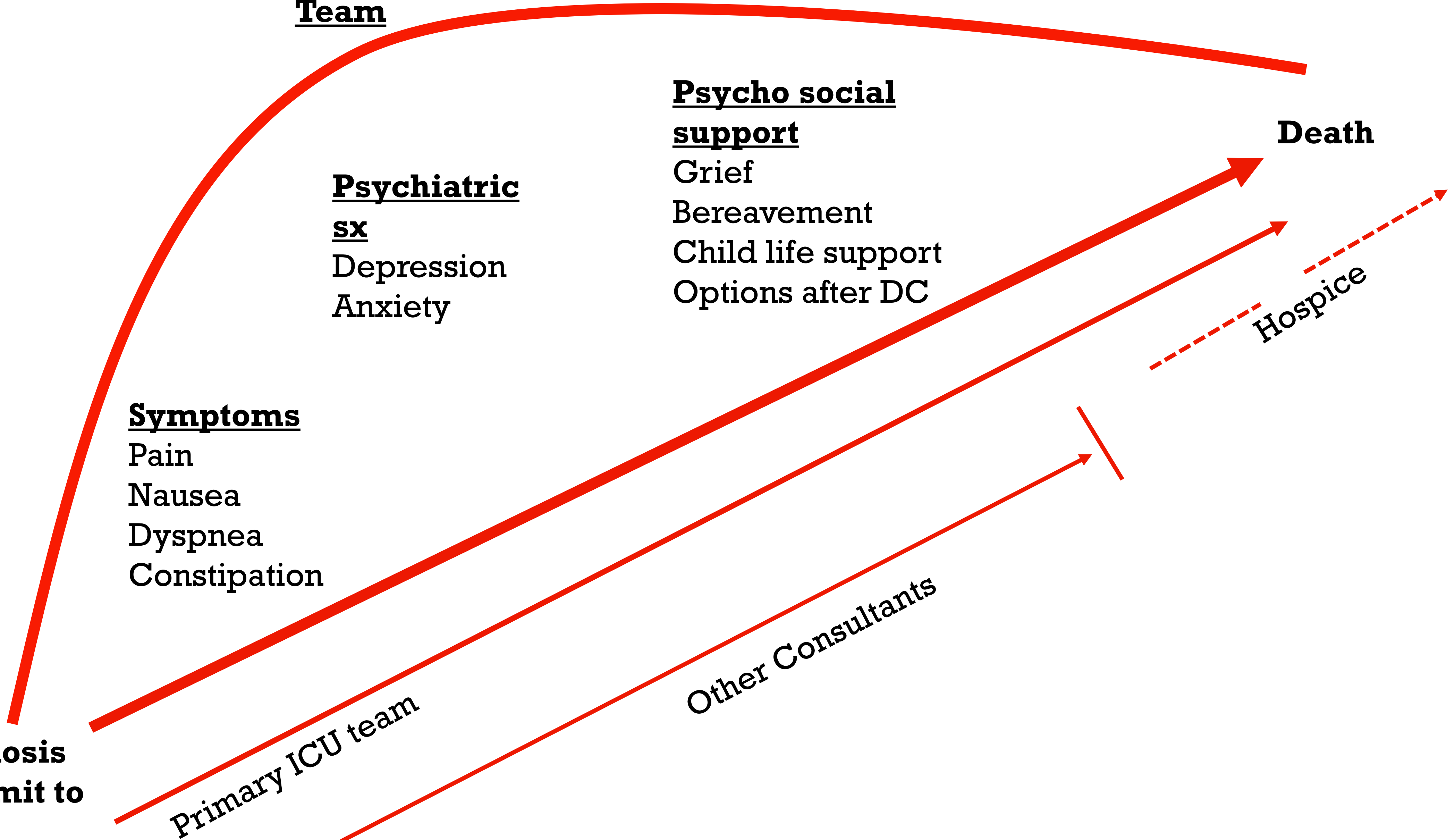
Morbidity and mortality in ICU

- 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


Palliative Consult Team
Psycho social support
Grief
Bereavement
Child life support
Options after DC
Death
Psychiatric sx
Depression
Anxiety
Hospice
Symptoms
Pain
Nausea
Dyspnea
Constipation
Other Consultants
Primary ICU team
Diagnosis or Admit to ICU

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

- Khandelwal N Kross E. Estimating the effect of Palliative care Intervention and advance care Planning on ICU Utilization A systematic review. Crit Care Med; 2015; 43(5) 1102-1111
  - 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

- Carson S Cox C et al. Effect of Palliative Care Led Meeting for Families of Patients with Chronic Critical Illness. JAMA 2016;316(1) 51-62.
  - 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…

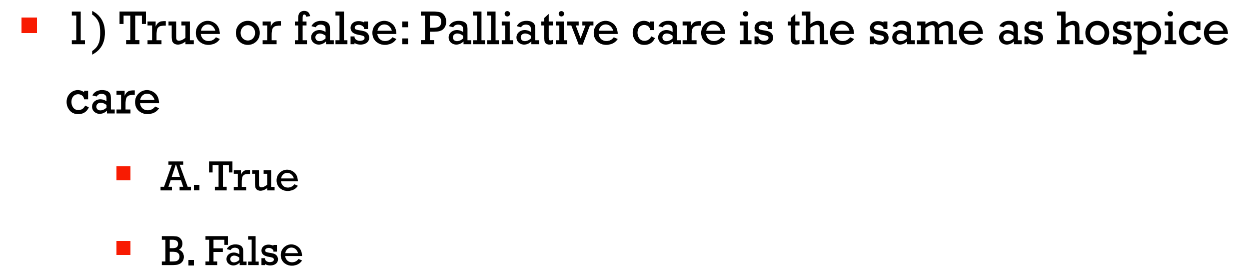
NYT: The Illness is Bad Enough. The Hospital May be Even Worse

- 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

NY Times Sept 30, 2018

Post ICU stress in families

- Matt B Schwarzkopf D. Relatives perception of stressors and psychological outcomes. Jrnl Crit Care 2017 vol 39. 172-177.
  - 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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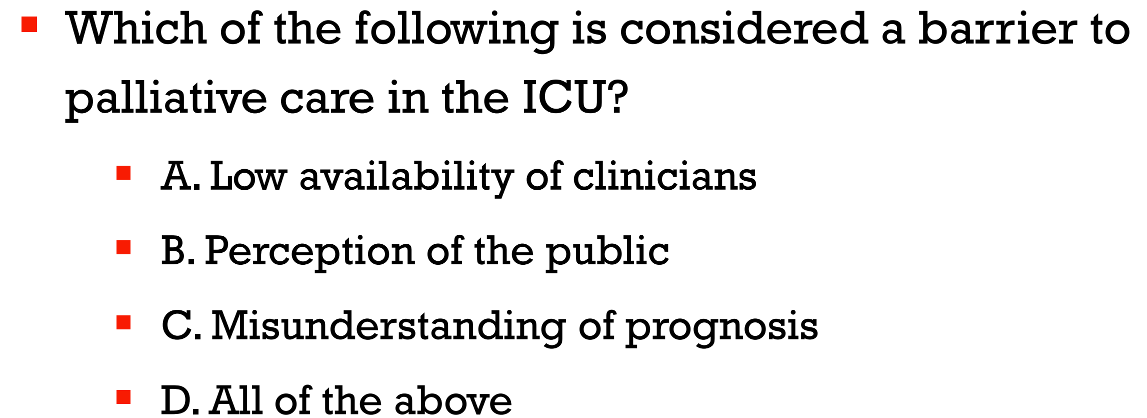
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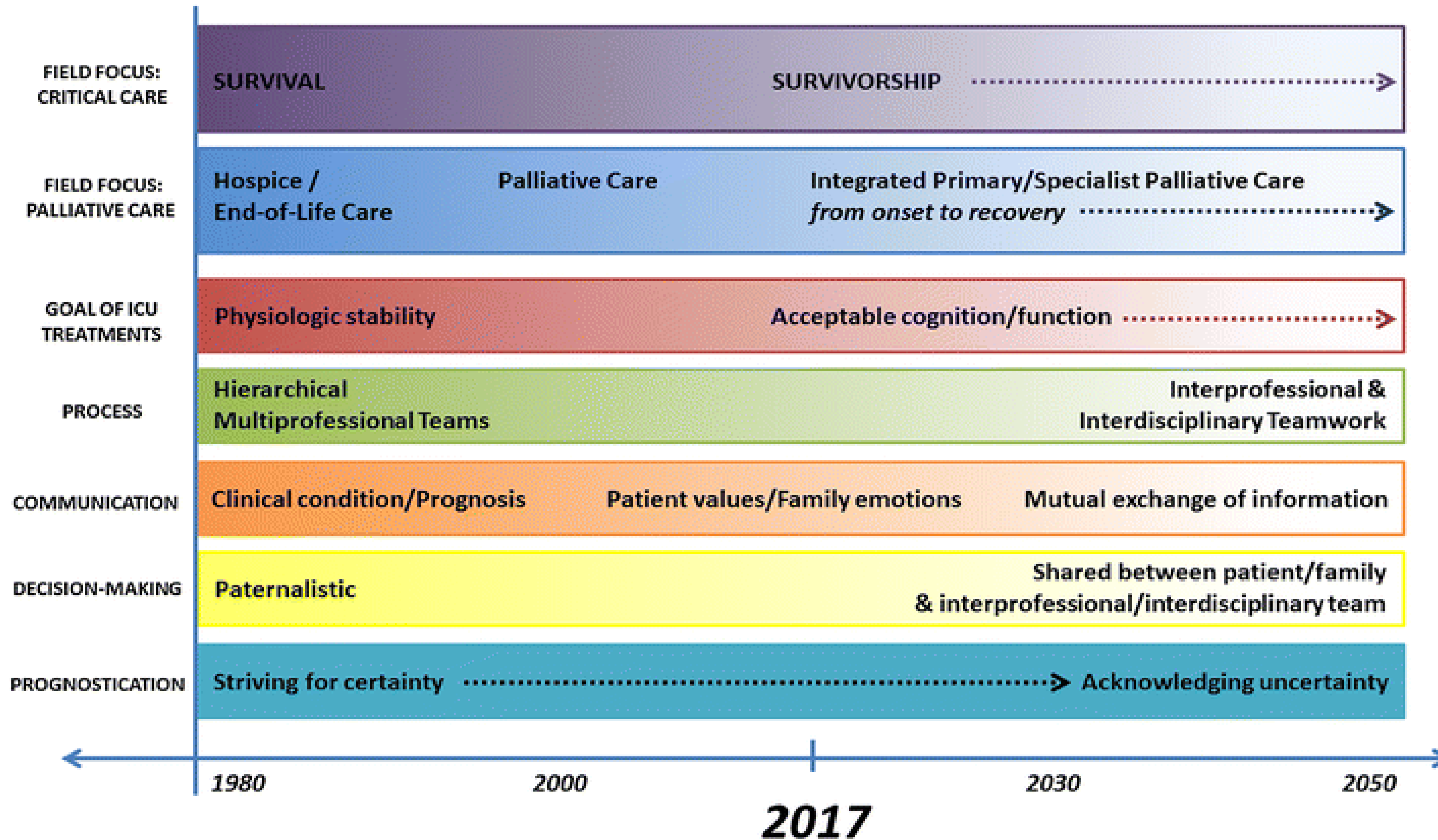
Non beneficial care in ICU patient’s nearing end of life.

- Offer time limited trials
- Seek second opinion
- Consider ethics consult

Palliative Care 2050



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