A Practical Approach to Palliative Care in the ICU
Michelle M. Milic, MD, FCCP
Associate Clinical Professor of Medicine
Division of Pulmonary and Critical Care Medicine

Disclosures
• No relevant financial relationships to disclose.

Objectives
• Describe the role and benefits of Palliative Care in the ICU
• Identify specific models of Palliative Care in the ICU
• Outline a practical approach to incorporate Palliative Care in the ICU

What is Palliative Care?
specialized medical care for people with serious illnesses
relief from the symptoms, pain, and stress whatever the diagnosis
improve quality of life both the patient and family
any stage of illness provided by a team
extra layer of support together with curative or life prolonging treatments

Center to Advance Palliative Care
http://www.capc.org/
Why is Palliative Care important in ICU?

- **High risk population**
  - 20% of deaths occur in or around the time of ICU
  - 58% of patients who die in the acute care setting will be admitted to an ICU

- **Prevalence of advanced chronic illness after ICU discharge**
  - Functional disability, sleep disorders, PTSD, long term cognitive effects
  - Higher mortality

  
  Angus, CCM 2004
  Nelson, CCM 2010
  Pandharipande, NEJM 2013

- **High symptom burden**
  - 40-80% of patients report uncontrolled symptoms

- **Prevalent conflict, misunderstandings**
  - 70% of providers, 40% of family members

- **Psychosocial and spiritual distress**
  - 1/3 families anxiety, PTSD, complicated grief

- **High risk workplace**
  - providers report moral distress, burnout, PTSD

  
  Puntillo, CCM 2010; Myhren, CC 2010
  Azoulay, AJRCCM 2009
  Abbott, CCM 2011
  Anderson, J Gen int Med 2008
  Mealer, AJRCCM 2007; Merlani , AJRCCM 2011

**Outcomes of Palliative Care in ICU**

- Reduce ICU LOS
- Decrease use of nonbeneficial treatments
- Increase family satisfaction
- Decrease family anxiety/depression, PTSD
- Decreased conflict over goals of care
- Improve symptom assessment and patient comfort

  
  Campbell 2003
  Azoulay, AJRCCM 2009
  Ederk In J Qual Health Care 2004
  Curtis, AJRCCM 2008
  Campbell, Chest 2009
  Laurette, NEJM 2007
  Aslackson, J PM 2014

**Challenges**

- Each ICU has an intrinsic “culture”
  - Created by history, structure and policies
  - There are inherent challenges and barriers to each individual ICU

- Physician prognostication may be inaccurate

- Optimal end-of-life care may not be prioritized

- Education and experience in PC is variable

- Competing demands for clinicians time

- How to prioritize limited services for patients?

  
  Begg, J Crit Care. 2007
  Nelson, CCM 2006
Clinical case: Mr. S.

- 60 yo with AML s/p stem cell transplant in 2010 now with relapse admitted for re-induction chemotherapy complicated by neutropenic fever, septic shock and respiratory failure, ICU day 3.
- Patient: intubated and sedated
- Nurses: concerned about pain and dyspnea
- Doctors: worried about new renal failure
- Family: “He’s a fighter.”
- Would you call a PC consult?

What are families hoping for?

- **Clinical care of the patient**
  - Maintain comfort, dignity, personhood, privacy
- **Communication by clinicians**
  - Timely, ongoing, clear, complete, compassionate
  - Address condition, prognosis, and treatment

What are families hoping for?

- **Patient-focused medical decision-making**
  -Aligned with patient values, care goals, treatment preferences
- **Care of the family: Providing access, proximity, and support**
  - Allow liberal, flexible visiting
  - Value family input about patient needs and care
  - Offer practical, emotional, spiritual support to family
  - Offer bereavement support

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Domains of ICU Palliative Care

- Symptom Mgt Comfort
- Communication Team, Patient & Family
- Patient/Family Centered Decision Making
- Emotional Support
- Spiritual Support
- Continuity of Care
- Emotional and Organizational Support for Clinicians

Clarke, Crit Care Med 2003;31:2255–62

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Nelson, Crit Care Med 2010;38:808–18
Models of Palliative Care in the ICU

- **Consultative Model**
  - Increase involvement of PC consultants, especially high risk patients
  - Secondary PC
    - Specialist clinicians that provide consultation and specialty care

- **Integrative Model**
  - Embed PC principles and interventions into daily practice by the ICU team
  - Primary PC
    - Basic skills and competencies required of all health care professionals

Nelson, CCM 2010

Consultative Model: Primary Triggers for PC

- ICU admission after hospital stay > 10d
- Age >80 with 2 or more life threatening co-morbidities
- Active Stage IV malignancy
- Status post cardiac arrest
- Intracerebral hemorrhage requiring mechanical ventilation

Norton, CCM 2007

Estimates for Need of PC Consultation

- 385K admissions to 179 ICUs
- Unusual level of consistency across ICUs
- **13.8% of admissions met one or more primary triggers for PC consultations**
  - Upper estimate of 19.7% of admissions
- Did not vary greatly across settings
  - Type of ICU, type of hospital and hospital location

Hua, AJRCCM 2014

Efficient Model of PC Triggers

- Combined several additional trigger models
- Same triggers as listed with one exception
  - Multisystem organ failure > 3 systems
- **Captured 85% of all admissions meeting triggers with prevalence of 16.8%**

- Differences in rates of limitations of treatment
  - Med vs. Surgical (26% vs. 13.1%; P<0.001)
  - Gov and rural locations had highest rates
    - 23.8% and 24.2%
  - Authors suggest less variation in patients and more result of practice patterns

Hua, AJRCCM 2014
Estimates for Need of PC Consultation

• This could translate into 1.1 million patients who may require PC consultations by the trigger model
  • Hua, AJRCCM 2014

• How should PC be operationalized in the ICU?

Integrative Model: How do we make this happen?

Symptom Management
Communication
Patient & Family Support

Primary PC in ICU

• ICU clinicians assess
  • Symptom management
  • Communication
  • Patient and Family Support
• Needs Discussed/Addressed Regularly
• Consult Palliative Care if needs cannot be met by ICU interdisciplinary team

How Do We Prepare for Primary PC?

• High level of commitment of the ICU staff
• Identify champions
• Engage hospital leadership
• Knowledge and Skills
• Systems of Care
Integrative Model: Symptom Management

- Focus on symptom assessment and mgt
  - Are there distressing physical or psychological symptoms?
  - Are we able to maintain comfort and dignity?
- High prevalence, frequency and intensity of distressing common symptoms
  - Pain, dyspnea and thirst
  - Project workgroup, define problem, ?resources, action plan, target education, feedback

Puntillo, ICM 2014

Clinical Case: Mr. S.

- Nurses address pain and dyspnea
  - ICU creates a plan for pain management
  - Measures improve patient synchrony with vent

- Day 9, clinically worsening, now on 3 pressors
- Renal failure on CRRT, DIC and GI bleed
  - Nurses: worried about CPR
  - Doctors: would like to address DNR
  - Family: “We need to stay positive.”

Integrative Model: Communication

- Understanding of illness/prognosis and treatment options
  - Does the patient/family/surrogate understand the current illness, prognostic trajectory, and treatment options?
- Identification of patient-centered goals of care
  - What are the goals?
  - Are treatment options matched to the goals?

Communication Skills

- Value and appreciate what the families say
- Acknowledge families’ emotions
- Listen
- Understand who the patient is as a person
- Elicit questions

“Ask – Tell - Ask”
- Be patient, this is a process

Lautrette et al NEJM 2007
Empathy: NURSE Statement

- **Family:** “It’s just so hard to see him like this.”
- **Name** “It sounds like…”
- **Understand** “I’m hearing you say…” or “I cannot imagine what…”
- **Respect** “I am impressed that…”
- **Support** “I’ll be available for you…”
- **Explore** “It would help me to know more about…”

Pollak, K et al., J Clin Onc, 2007

Communication Toolkit

- [www.capc.org/ipal](http://www.capc.org/ipal)
- Family goal-setting conference
- Guide for conducting an ICU family meeting
- Communication phrases in PC
- Templates for family conference progress notes
- Intensive Talk developed by UPMC

UCSF Experience: IMPACT-ICU Project

- 2 ICUs in each of 5 University of California Medical Centers
- 8 hour communication workshop for ICU bedside nurses
- Skill to facilitate palliative communication among families & clinicians
- Support beside nurses in identifying and addressing patients’ palliative care needs
- Self care practices

Integrative Model: Patient and Family Support

- Social and Spiritual Assessment
  - Are there significant social or spiritual concerns affecting daily life?
- Care of the family:
  - Open access and proximity to patients
  - Interdisciplinary support in the ICU
  - Bereavement care for families
Clinical Case: Mr. S.

- ICU day 13, blasts still present on repeat BM
- Remains intubated with multisystem organ failure
  - Wife: hoping that he would survive to daughter’s wedding next year
  - Team: Informational and emotional support provided for family
- In the next 2 days, transitioned to comfort measures and died peacefully

UCSF Experience: Patient and Family Support

- Get To Know Me poster
  - Add personal information & photos
- ICU diary recounts patient’s stay in the ICU
  - Co-created by clinicians and family
- Bereavement Program
  - Condolences, family information, follow up phone calls and notes
- Patient and Family Rounds
  - Improve patient and family partnership through communication, support and resources
- Patient and Family Advisory Council
  - Under development

Care and Communication Bundle

- Identify health care proxy or surrogate
  - Determine if patient has an advance directive
- Clarify resuscitation status
  - Distribution of family information leaflet
- Manage pain optimally
  - Assess pain regularly using an appropriate scale
- Offer social work support
  - Offer spiritual support
- Conduct an interdisciplinary team meeting with the family

The IPAL Project

- Center to Advance Palliative Care
- http://www.capc.org/ipal/
- Resources including
  - Templates/forms/note
  - Quality monitoring tools
  - Policies and protocols
  - Patient and family resources
Take Home Points

• Virtually all ICU patients and their families have some PC need
• As ICU providers, you can provide primary PC
  – Symptom management
  – Communication
  – Patient and family support
• Build program changes based on the needs, resources and support at your own institution

Choosing Wisely...

• Don’t delay palliative care for a patient with serious illness who has physical, psychological, social or spiritual distress because they are pursuing disease-directed treatment.

References

• Hua M, Estimates of the need for palliative care consultation across United States intensive care units using a trigger-based model. Am J Respir Crit Care Med 2014;189:428–436