Standardized Proactive Palliative Care in the Medical Intensive Care Unit.

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Major Focus and Area of impact:

Integration of Palliative Care Services in the Intensive care unit.

Additional areas of impact: (2) Palliative care education. (3) Health system strategies. (4) Ensuring quality in advance care planning (5) Quality improvement

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PROJECT:

Introduction: Our national health care system and its providers continue to strive to look for avenues to improve the care offered to patients while providing efficient transitions of care, with cost-effective care and tailored medical procedures and interventions to the distinct choices of individuals. One of the areas where this can be accomplished is by providing appropriate Palliative care in the intensive care unit. Consultative and integrated models of palliative care in the MICU exist.

Methods. The targeted population consisted of older adults > age 60 and vulnerable older adults of the community. This group was identified to have chronic medical problems that were treatable but not curable and hence at increased risk for medical complications, prolonged hospital courses or death. The goal of this project was to bring early proactive involvement of the palliative care team (PCT) for those patients who would be determined to be appropriate for this layer of extra support. The consult would be triggered by a standardized list of major and minor criteria for referral.

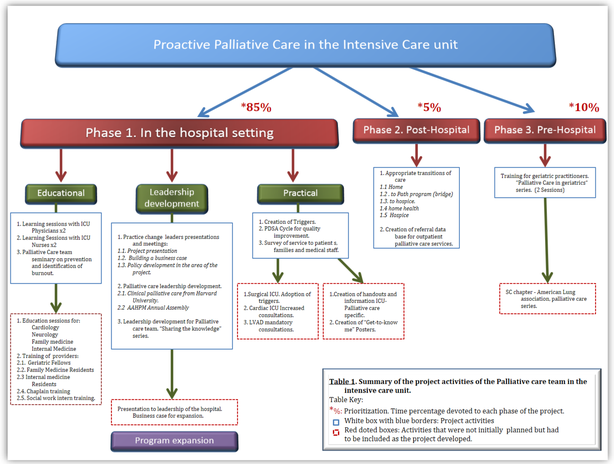
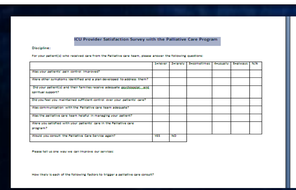
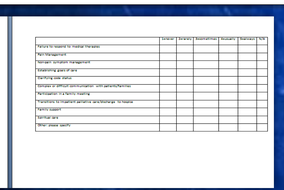
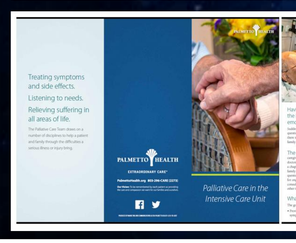


Figure 1. Summary of project with inpatient and outpatient components.







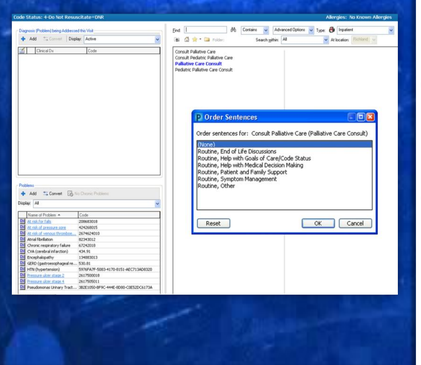
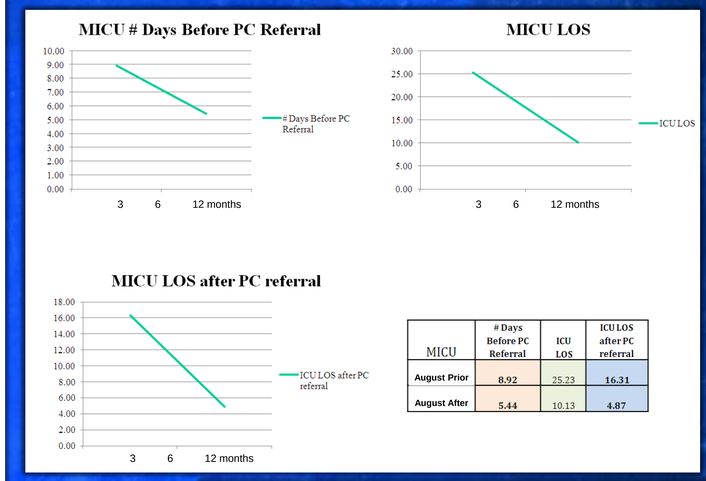


Figure 2. Tools utilized for the project. Left to right: (1) Standardized triggers for referral. (2) Survey for providers. (3) Educational handouts for patients and families. (4) Facilitated consultation orders in Electronic medical record.



MICU	# Days Before PC Referral	ICU LOS	ICU LOS after PC referral
August Prior	8.92	25.23	16.31
August After	5.44	10.13	4.87

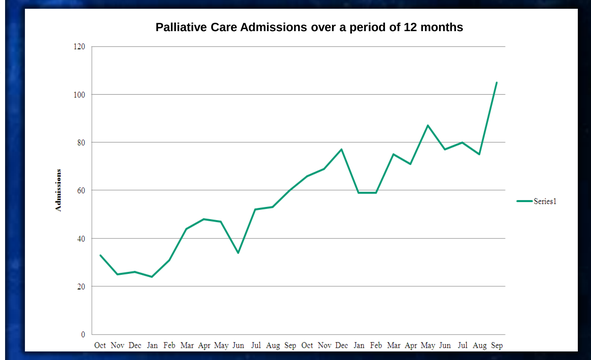


Figure 3. Changes in time to referral, length of stay and utilization of Palliative Care services.

Results. We noticed a decrease in the time required for the Palliative care team to be involved from 8.92 days to 5.44 days on average. Length of stay was reduced from 25.23 to 10.13 days. The number of consults increased from 20 to approximately 60 monthly. The number of patients who elected to transition to comfort care remained overall between 33 and 36%. Surveys about the perception of care received in the medical ICU reported improvement ratings from very good to excellent consistently. Interactions and the level of communication among Palliative care team members and ICU members improved and remained cordial and mutually respectful. Thanks to this proactive approach to care, geriatric fellows, internal and family medicine residents, nurse students, social work interns and chaplain residents initiated their training with the palliative care team during this period of time and participated actively in rotations in the intensive care unit with our team.

Conclusions. The introduction of a proactive approach to the care of patients in the medical intensive care unit with standardized triggers created an objective approach to determining patients who were at risk for complications or who required additional medical, psycho-social and spiritual support. Providing that additional support translated into appropriate and efficient transitions of care inside the hospital and into other services in the community including Home-Health, Path (bridge program), hospice, rehabilitation facility, long-term acute care hospital or nursing home among others. Length of stay decreased in the MICU. Patients and families reported improved satisfaction with care. Additional support served not only families and patients, but also to staff that felt unburdened. Educational opportunities to reach new trainees increased in the academic setting.