THE ICU JOURNEY FOR PATIENTS WITH SERIOUS ILLNESS: HOW DID WE GET HERE?

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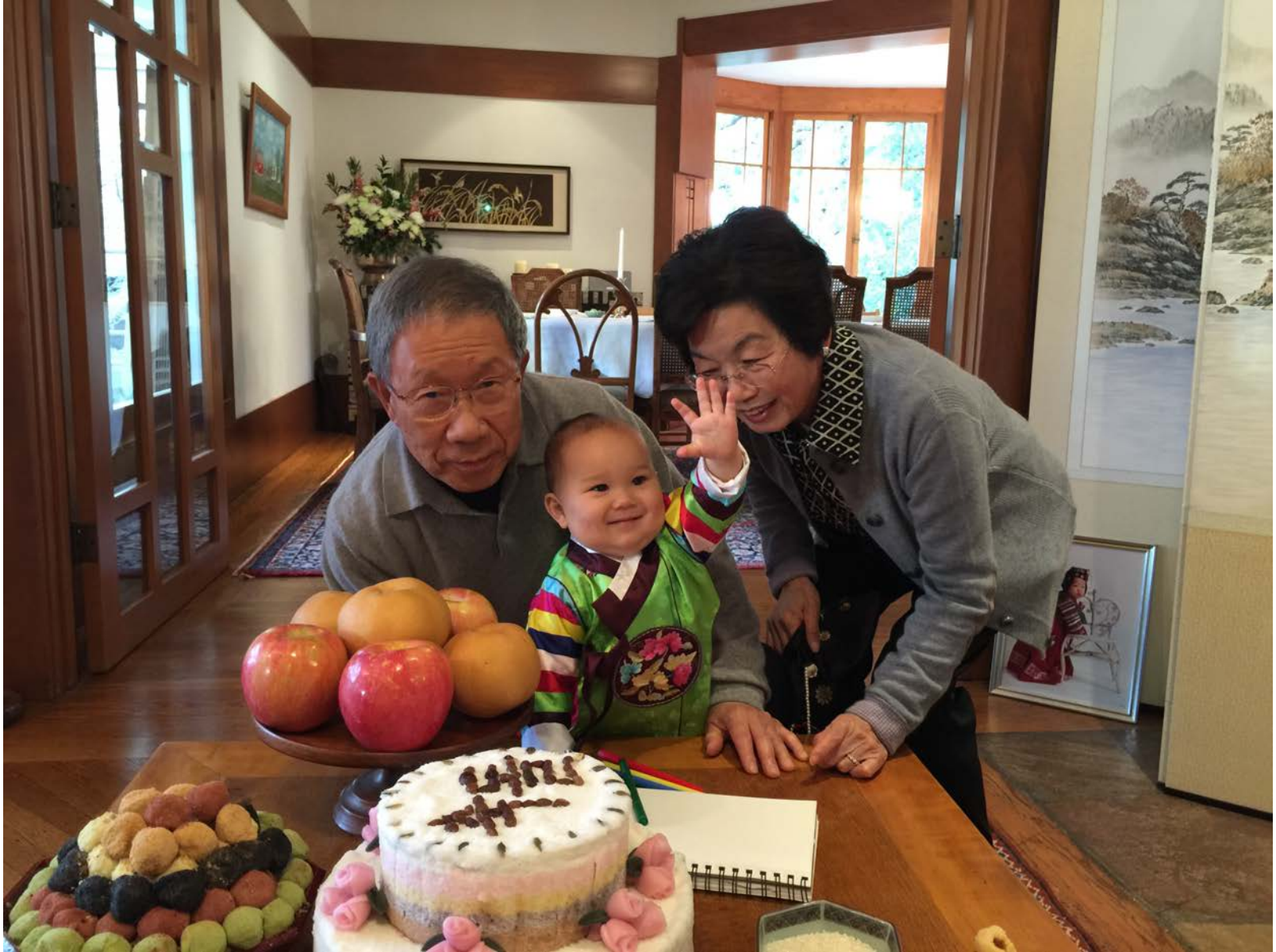
Goals for the next 45 minutes

Review the landscape for ICU outcomes for patients with serious illness;

Discuss our experience at Stanford;

Learn strategies for discussing ICU admissions in the midst of serious illness.



Why do we care about ICU admissions

- Benefit
- Informed consent
- Cost
- Moral injury

and…

Davydow DS et al. *Crit Care Med*. 2012;40:2506-2507
Needham, DM et al. *Crit Care Med*. 2012 Feb;40(2):502-9

Post-Intensive Care Syndrome (PICS)

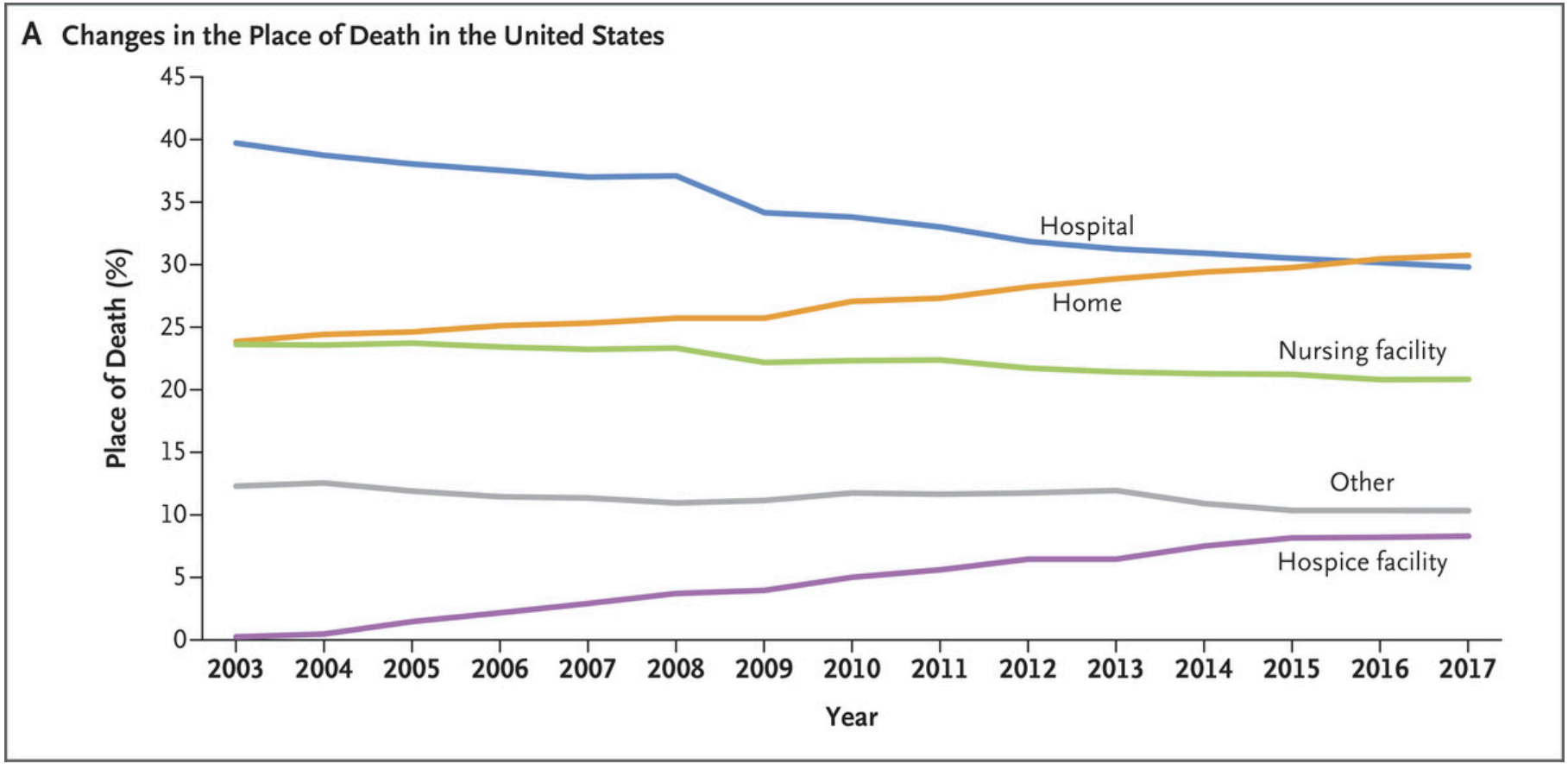
- Cognitive
- Psychiatric
- ICU-acquired weakness and other physical symptoms

...and PICS-Family

- Anxiety, depression, PTSD
  - Death in the ICU is a risk factor

Davydow DS et al. *Crit Care Med*. 2012;40:2506-2507
Needham, DM et al. *Crit Care Med*. 2012 Feb;40(2):502-9

Changes in the Place of Death in the United States



SH Cross, HJ Warraich. N Engl J Med 2019;381:2369-2370.

Who goes to the ICU before they die?

46%

of CA Medicare patients who died had at least one ICU stay in their last 6 months

https://www.dartmouthatlas.org/interactive-apps/end-of-life-care/#state

Why is this happening?

What are the potential causes of inappropriate ICU admissions?

Defining inappropriate ICU treatment and admissions

"ICU interventions should generally be considered inappropriate when there is no reasonable expectation that the patient will improve sufficiently to survive outside the acute care setting, or when there is no reasonable expectation that the patient's neurologic function will improve sufficiently to allow the patient to perceive the benefits of treatment" – SCCM Ethics Committee, 2016

Little consensus on defining an inappropriate ICU admission

Kon, AA et al. Crit Care Med. 2016 Sep;44(9):1769-74

Literature findings

Estimates of the extent of the problem vary (10% or more)

Why are patients inappropriately admitted?

- Clinical doubt
- Limited decision time
- Assessment error

Cardona-Morell, M et al. *Int J Qual Health Care.* 2016 Sep;28(4):456-69
Giannini A, Consonni, D. Br J Anaesth. 2006; 96(1):57-62

Methods

- Academic level 1 trauma center
- Stratified purposive sampling resulting in 25 semi-structured interviews with range of experience and specialties
- Team-based coding and thematic analysis

Unpublished, submission in process

Participant Characteristics

Participant Characteristic	Number
Gender	Male (n=18) Female (n=7)
Role	Intensivist (n=15) Emergency medicine or hospital medicine (n=10)
Years of experience	Fellow (n=3) Attending 1-10 years (n=9) 11-20 years (n=6) 20+ years (n=7)

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Theme 1 – Perception of inappropriate admissions at study institution

"…for 1/3 of all patients…we probably shouldn't be doing what we're doing for this patient, that …their benefit from our therapy is so minimal that we should stop what we're doing or should have never started it."

- *Estimates of prevalence varied widely*

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Theme 2 – Clinical prognostication of patient outcome is challenging

"It's hard to meet [patients] for the first time and say confidently they're dying."

"Often, we are convinced that we can turn things around, and often we're convinced that we can't, and we're not always right."

- *Time pressure contributes to the challenge*
- *Past clinical experience can bias clinical decision making*

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Theme 3 – Fellows are more likely to accept patients inappropriately to the ICU

"Another thing that's endemic in the ICU and problematic is the fellows are used to people with multi-organ system failure that clearly requires intensive care treatment, and many of those people have very poor prognoses."

One intensivist said that because fellows are "just dealing with the issues in front of them," they "haven't stepped back and taken the bigger picture view of saying, is this someone we can really help?"

- *Fellows are encouraged to err on the side of caution*

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Theme 4 – Lack of upstream goals of care

"You might be surprised how many of those [dying] patients come in without any kind of goals of care…"

"it would be unreasonable and unacceptable for an oncologist to have a conversation with their patient [about their poor prognosis] because that patient would view that as abandoning the patient."

- *As a result, families can have misconceptions or no conception about the potential benefit of ICU-level interventions.*

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Discussion

- Key findings
  - Fellows are primary decision makers for ICU admissions and may be limited in their ability to make good admissions decisions.
  - Clinical uncertainty is a major limitation to developing absolute contraindications to ICU admission.
- Further investigation

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Limitations

- Single medical center
- Sample size, n=25 respondents
- Single interviewer

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Conclusions

Causes for inappropriate ICU admissions:

- Difficult prognostication
- Fellows as primary triage decision-maker
- Lack of upstream goals of care conversations

Further investigation: fellow training and development of relative contraindications

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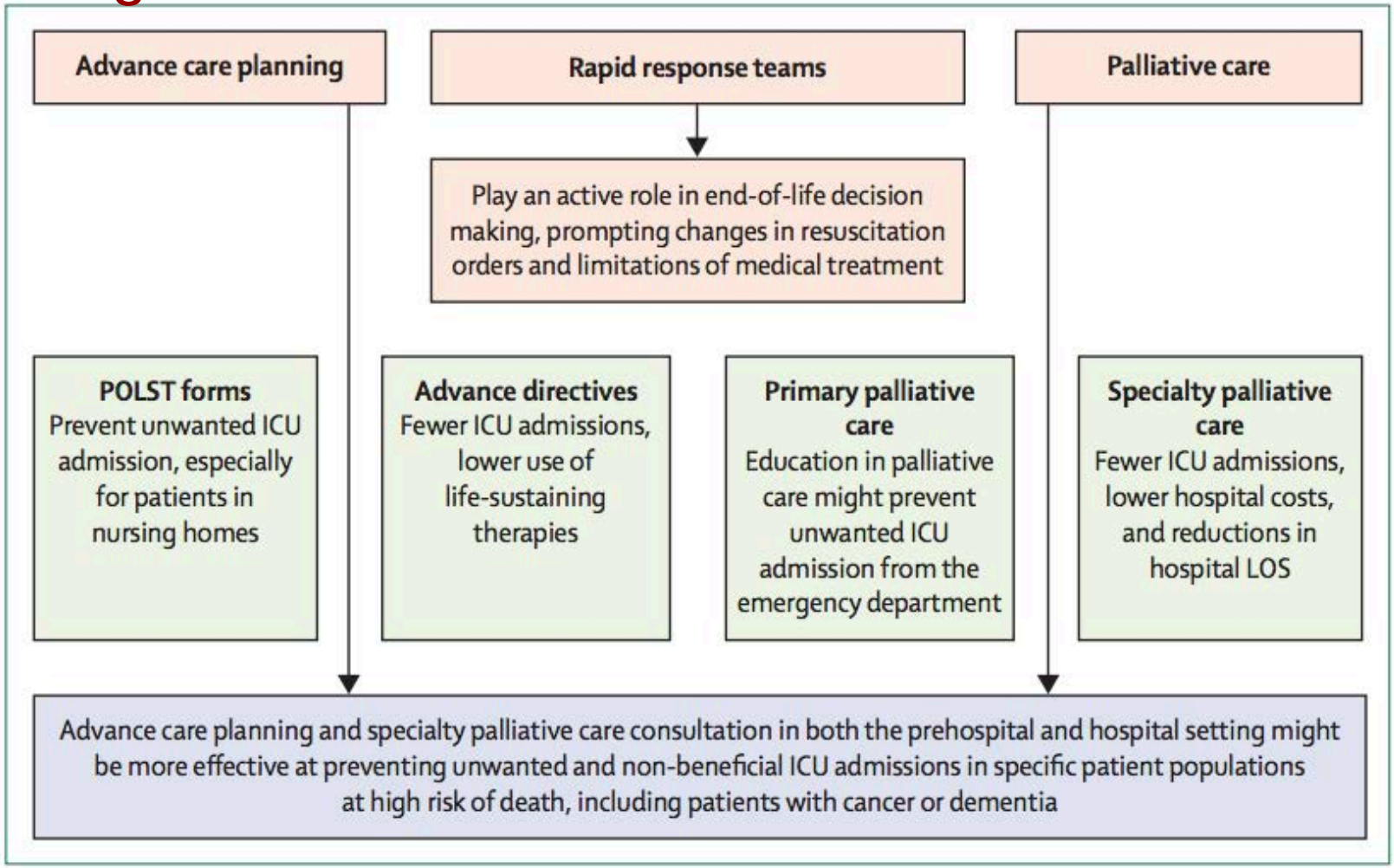
Strategies to avoid non-beneficial ICU admission



Khandelwal, N et al. *Lancet Resp Med 2019*;7:613-625

Key Take-Aways

Pre-hospital interventions: advance care planning and palliative care consultation

POLST forms, especially in SNFs!

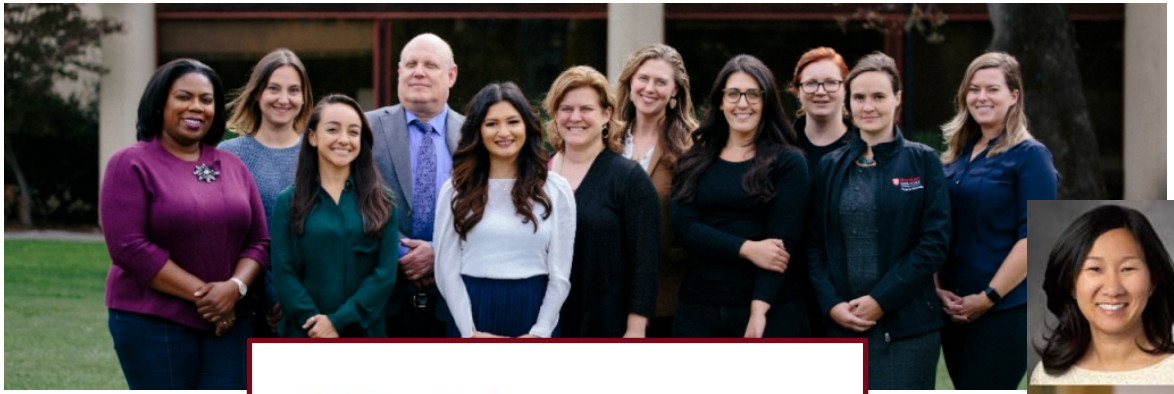
Engagement and education for the frontline who care for people with serious illness

Summary

ICU admissions impact the quality of life of our patients and their families

Systems and clinician factors contribute to inappropriate ICU admissions

Communication strategies, both upstream and in-hospital, can reduce non-beneficial ICU admissions



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Thank you!

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