Priorities for Evaluating Palliative Care Outcomes in Intensive Care Units

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KEYWORDS

• Outcome measures • Evaluation • Intensive care unit • Palliative care
• Performance measures

KEY POINTS

- Palliative care delivery in the intensive care unit (ICU) is growing and is increasingly accepted as an essential component of comprehensive care for the wide array of critically ill patients cared for in ICUs.
- Typical ICU outcome measures have often focused on reducing mortality and length of stay; these are less often considered traditional targets of palliative care.
- Multiple perspectives and domains must be taken into account when measuring ICU outcomes.
- Most ICU palliative care outcomes research has focused on communication.
- Future measurement of ICU outcomes should expand beyond length of stay and costs and focus to a greater extent on patient-centered and family-centered outcomes.

INTRODUCTION

Since the landmark SUPPORT (Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatments) study,[1] significant intensive care unit (ICU) quality-of-care issues (eg, inadequate physician communication, care not matched to patients' goals and preferences, pain, patient and family distress) have been

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Crit Care Nurs Clin N Am 27 (2015) 395–411
http://dx.doi.org/10.1016/j.cnc.2015.05.001 **ccnursing.theclinics.com**
0899-5885/15/$ – see front matter

documented. In 1997[2] and 2014,[3] the Institute of Medicine issued reports further highlighting these concerns, suggesting that although some progress has been made, issues surrounding advance care planning, communication, and lack of incentives to provide high quality end of life care persist, especially for patients who die in ICUs. In addition, an under-recognized consequence of poor quality of care in patients dying in ICUs is the moral distress experienced by the nurses, physicians, and other members of the care team who care for these patients.[4,5]

One widely suggested solution to the many care quality challenges in seriously ill ICU patients has been the integration of palliative care.[6] Via a variety of different models, palliative care is growing and is increasingly accepted as an essential component of comprehensive care for critically ill patients, regardless of diagnosis or prognosis.[7] Models of integrating palliative care services, such as initiating consults by palliative care specialists via triggers[8] or improving the palliative care skills of ICU clinicians,[9] or a combination, have been recommended.[10] Triggers for palliative care in a surgical ICU (SICU) identified by a clinician Delphi study included: family request; futility declared by the medical team; family disagreement with the medical team, the patient's advance directive, or each other lasting greater than 7 days; death expected during the same SICU stay; and SICU stay greater than 1 month.[11] With such triggers, some suggest that up to 1 in 7 ICU patients should be seen by palliative care.[12]

Several benefits from palliative care integration have already been noted. For example, early evidence shows reductions in hospital and ICU lengths of stay without an increase in mortality.[13] Reduced ICU use and length of stay has also resulted in reduced charges per patient, typically because of fewer invasive interventions[14,15] and reduced ICU admission from the general hospital floor.[16] Beneficial family outcomes, including reduced anxiety, depression, and posttraumatic stress disorder, have also been noted.[17,18]

However, unlike organized efforts to evaluate ICU care quality generally, evaluation of the impact of palliative care on outcomes is still in the early stages, although recent advances, such as organized quality improvement initiatives[19,20] and a potential framework on which to comprehensively evaluate ICU palliative care outcomes (**Fig. 1**),[21] are notable. This article discusses the context of ICU palliative outcomes, current methods of assessing palliative care quality outcomes, prospective trials that have attempted to measure selected palliative care outcomes in ICUs, and future directions.

THE CONTEXT OF MEASURING INTENSIVE CARE UNIT PALLIATIVE CARE OUTCOMES

Examination of palliative care outcomes in the ICU begins with understanding the context of the measurement environment; that is, the patients and settings to be studied. More patients are receiving care in a variety of medical, surgical, and subspecialty ICUs than ever before as therapies for chronic and acute illness are increasing.[22] The increasing number of ICU admissions has driven the call for increasing integration of palliative care, especially for patients with end-of-life and symptom management concerns. In particular, Teno and colleagues[23] found that although more Medicare beneficiaries aged 65 yeas and older are dying at home rather than in a hospital, ICU stays in the last month of life are increasing; decedents experiencing an ICU stay in the last months of life increased from 24.3% in 2000 to 29.2% in 2009. Reports from the Dartmouth Atlas of Health Care reinforce these trends. In chronically ill Medicare patients[24,25] from 2003 to 2007 there was an increase in the number of ICU days in the last 6 months of life. In addition, although there was a decrease nationally in the percentage of patients with cancer[24] dying in hospital between 2003 and 2007, there was an increase in those with an ICU stay during the last month of life.[26]