

**Implementing ICU Screening Criteria for Unmet Palliative Care Needs:
A Guide for ICU and Palliative Care Staff
A Technical Assistance Monograph from the IPAL-ICU Project**

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Introduction. Many ICUs are developing screening criteria to help identify patients with a high likelihood of unmet palliative care needs. The impetus for these projects typically arises out of the recognition of both the need to improve care delivery (e.g., improve communication with the patient/family) and address institutional priorities (e.g., reduce ICU length of stay to improve patient flow through the emergency department). Although it would seem a simple task to develop screening criteria and make them operational, in fact, the process is complex and has many pitfalls.

Notes:

- *Developing screening criteria may or may not be the right approach to improving care at your institution. However, if you have considered the pros and cons and wish to proceed, this guide will assist you in the implementation process.*
- *This guide makes no assumptions about the integration of palliative care specialty services into ICU practice; some ICUs will develop screening criteria and processes that utilize palliative care specialists, others will not.*

This guide was developed as a road map to help ICU and palliative care staff. The guide is a series of worksheets/process steps, organized into four sections:

- ✓ Part 1 Needs Assessment
- ✓ Part 2 Screening Criteria Selection
- ✓ Part 3 Implementation Planning
- ✓ Part 4 Evaluation

The guide is designed to be used collaboratively by the ICU and palliative care clinical staff. A key first step is to form a multidisciplinary planning committee with representatives from both services. Once organized, the committee can proceed through the worksheets sequentially. It is vital for planning committee members to realize that there are no “best” screening criteria; nor is there a “one-size-fits-all” implementation process. ICUs that successfully adopt a screening pathway share the following characteristics. They:

- Develop screening criteria through local consensus building among key stakeholders;
- Pay strict attention to details of pathway implementation that mesh with ICU structure and current workflow features;
- Build in evaluation stopping points to assess and revise screening criteria and the implementation process;
- Recognize and attend to the common barriers to program implementation.

We welcome your feedback on this guide and suggestions for improvement.

The IPAL-ICU Advisory Board

WORKSHEET 1. NEEDS ASSESSMENT

1. What is the impetus for developing a screening tool in your ICU (e.g., long ICU LOS; frequent conflicts over goals of care/requests for futile care)?

2. What resources are available to help integrate palliative care services into ICU care (e.g., new palliative care APN with ICU experience; ICU physician certified in Hospice and Palliative Medicine; hospital support for an initiative to reduce ICU LOS)?

3. What barriers exist to integrating palliative care services into ICU care (e.g., palliative care team is already at clinical capacity; frequent tension between ICU and palliative care staff)?

4. Assessment of team functioning: On a scale from 0 to 10, indicate the degree of “culture clash” between the ICU clinical team and the palliative care team.

0 = the teams rarely work together due to major differences in patient care philosophy

10 = the teams work exceedingly well together to meet patient and institutional needs

Your rating: _____

If you believe there is room for improvement in how the two teams work together, start a dialogue between them. List potential methods to improve the relationship (e.g., monthly joint case conference; individual self-assessment of attitudes toward care of seriously ill patients; group discussion of clinician attitudes/values that impact care decisions).

1.

2.

3.

4.

WORKSHEET 2. SCREENING CRITERIA SELECTION

There are neither “best” nor “validated” ICU screening criteria. The optimal criteria for your setting are those that meet the needs of patients and families while aligning with institutional priorities. Below is a table including criteria that have been reported in the literature and/or used by others. Complete this table either as a joint exercise with representatives of both the ICU and palliative care program, or have each program complete the table separately and then come together, share your thoughts, and work toward consensus. You may wish to include other stakeholders, such as ethics committee staff, hospitalists, or a hospital patient ombudsman. Space is provided to enter other criteria besides those listed below.

Step 1. Place a check mark next to the criteria that you believe have a high percentage of patients with unmet palliative care needs in your setting. These needs generally fall into one or more of the following domains:

- ❖ Complex symptom management (e.g., pain, nausea)
- ❖ Family support (e.g., family overwhelmed with decision making)
- ❖ Complex decision making (e.g., prognostic uncertainty)
- ❖ Conflicts over care goals (e.g., use of life-sustaining treatments or CPR)
- ❖ Complex disposition planning (e.g., limited social support)

Disease Criteria	ICU Team Perspective	Palliative Care Team Perspective
Advanced cancer		
Prolonged multi-organ failure		
Major acute neurologic insult: e.g., CNS trauma, post-CPR encephalopathy, malignant stroke		
Chronic severe cognitive dysfunction: e.g., PVS, minimally conscious state		
Advanced dementia or other severe cognitive impairment		
ALS		
Chronic liver disease		
Chronic renal disease +/- chronic dialysis		
AIDS		
Advanced COPD		
Severe CHF		

Utilization Criteria	ICU Team Perspective	Palliative Care Team Perspective
ICU length of stay > 7 days		
ICU length of stay > 14 days		
ICU length of stay > __ days		
Frequent hospital or ICU admissions		
> 1 ICU admission during same hospital stay		
Admission from nursing home		
Consideration of PEG tube placement		
Consideration of tracheostomy placement		
Consideration for ethics consultation		
Consideration to start renal replacement therapy during ICU stay		
Other Criteria	ICU Team Perspective	Palliative Care Team Perspective
Conflicts re: goals, DNR, treatment decisions		
Lack of social support (e.g., homelessness, chronic mental illness)		
“Yes” answer to “surprise question” ¹		
Anticipated discharge to LTAC facility		
Difficult-to-control symptoms		
Homebound due to chronic illness		

¹Surprise question: “Would you be surprised if this patient died in the next 12 months?”

Step 2. Review the above list and discuss; select 4–8 criteria that you believe are most important to meeting patient care needs and priorities at your institution. Refine/adapt the criteria as written above to meet these needs and list them below.

1.	5.
2.	6.
3.	7.
4.	8.

Step 3. Review your list of criteria with key stakeholders; at a minimum this should include the ICU leadership team, all ICU staff (physicians, nurses, and case management, others) and palliative care team members. For now focus solely on whether you believe this list will identify patients most in need of palliative care services to improve patient care and meet institutional priorities. *Do not address implementation issues yet.* Following the review, rewrite the final agreed-upon screening criteria (you may decide to have fewer than or more than 8).

1.	5.
2.	6.
3.	7.
4.	8.

Step 4.

A. Gather data on patient volume to answer the following question: Approximately how many patients will the screening criteria identify over a brief period (1–2 weeks)? (See “Sample Worksheet for Collection of Palliative Care Integration Project Data” p.13) Review all patients in the ICU each day, both new admits and existing patients. Characterize the types of needs identified for each patient:

- Complex symptom management
- Family support
- Complex decision making
- Conflicts over care goals
- Complex disposition planning

B. Once the data are collected, return to the planning committee, review the data, and consider these questions:

i. What percentage of these needs could be managed by improving daily care processes within the ICU (e.g., improved documentation of care goals; routine family meetings)?
 ___%

ii. What percentage of the identified needs would likely best be served by a palliative care specialty consultation?
 ___%

▶ Assess the potential new workload for the palliative care team. Given current palliative care staffing, what percentage of the new ICU consults could team members realistically see?
 ___%

iii. Decide whether or not the criteria are too broad/too stringent to meet the goals of the screening project within available resources. Revise the screening criteria as necessary.

Revised Screening Criteria

1.	5.
2.	6.
3.	7.
4.	8.

WORKSHEET 3. IMPLEMENTATION PLANNING

Step 1. Once you have revised the screening criteria, now it is time to work on the details of implementation. Here are some key questions you will need to answer:

- Who will use the screening criteria to evaluate patients on a daily basis: (e.g., ICU case manager)? _____
- What happens next if a patient meets the screening criteria? Be very specific (e.g., the patient's case is discussed on ICU rounds within 24 hours for the potential of a palliative care consult; there is an automatic palliative care consult generated; or other). Fill in steps below, or draw a diagram of the process steps.

- If a palliative care consult is initiated, who will make contact with the PC team to discuss the consultation question? _____
- What are the expectations of the ICU from the palliative care consultant?
 - Time to complete consultation: _____

- Communication process to convey information to ICU team:

- Follow-up care after initial assessment (e.g. daily follow up and verbal discussion with (ICU team):

- Other: _____

- If a palliative care consult is not initiated, what steps will occur to ensure that unmet palliative care needs are addressed, and who will be the person responsible (e.g., daily reassessment for consultation needs during ICU rounds)?

Process Step	Person Responsible
1.	
2.	
3.	
4.	
5.	

Step 2. Stop and Walk Through the Process. The process steps for implementing the criteria presented above should be evaluated by going to the ICU, finding a patient who meets the screening criteria, and discussing how the implementation steps would apply to this actual case. The planning committee should critically discuss each step in the process and decide if said step is feasible and sustainable. Make changes to the process steps as needed.

Step 3. Documentation

What documentation tools will you need?

- Screening criteria checklist
- Palliative care patient assessment template to document potential unmet palliative care needs (e.g., symptoms, communication, family coping, discharge planning)
- Other: _____

How will these tools be integrated in the medical record? Do you need to design templates for the electronic medical record (EMR)?

Use the space below to describe any other features of the process steps to implement your screening plan.

A large, empty rounded rectangular box with a thin black border, intended for the user to describe other features of the process steps to implement their screening plan.

WORKSHEET 4. EVALUATION

Step 1. Building an evaluation schema of the new screening process from the outset is important in providing a structured opportunity to gather and review data on project impact. The planning committee should review the questions below and map out a strategy to gather and review data early after project launch (within 1–2 months).

1. Is the screening process working to identify the patients with the greatest needs?

- Do the screening criteria need to be revised?

2. How is the screening process working for the ICU team: physicians, bedside nurses, case manager/social worker?

- Does the ICU staff believe the new system is helping/hurting their ability to provide excellent ICU care?
- Are there concerns about workflow, team communication, clinician autonomy?

3. How is the screening process working for the palliative care team?

- Are team members able to manage the patient volume with existing resources?
- Are the consultation questions truly at a specialist level?
- Are there common issues that could be managed by the ICU team without palliative care involvement?
- How is the communication flow with the ICU team?

4. Refer back to self-assessment of team culture clash (Worksheet 1, “Needs Assessment”). Are things better or worse than they were at the start of this project?

Yes No Comments: _____

Step 2. Longer-term evaluation beyond 1–2 months will be necessary to assess project impact in terms of patient care and institutional priorities. Decide at the start of the project what data need to be collected proactively to best document project impact.

Data (e.g., ICU LOS)	Where are the data located?	Who will collect the data?	Who will analyze/report the data?	To whom will the data be reported?

References/Resources

References

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Resources

- IPAL-ICU: Tools and Technical Assistance for Palliative Care–ICU Integration. <http://www.capc.org/ipal/ipal-icu>.
- Sirkin HL, Keenan P, Jackson A. The hard side of change management. *Harv Bus Rev.* 2005 Oct;83(10):108–18, 158.
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Sample Worksheet for Collection of Palliative Care Integration Project Data

Unmet Palliative Care Needs

1. Complex symptom management (e.g., pain, nausea)
2. Family support (e.g., family overwhelmed with decision making)
3. Complex decision making (e.g., prognostic uncertainty)
4. Conflicts over care goals (e.g., DNR orders, use of life-sustaining treatments)
5. Complex disposition planning (e.g., limited social support)

Patient Name	John Smith
Age	75
Screening criteria	Advanced dementia
ICU admission dx	Sepsis

	PC Needs					Comments
	1	2	3	4	5	
Admit 2/2/2013	x					Delirium, dyspnea
2/3/13						Symptoms controlled
2/4/13		x	x	x		DNR conflict; feeding tube?
2/5/13		x	x	x		Continued conflict
2/6/13		x	x	x	x	Continued conflict
2/7/13		x	x	x	x	Continued conflict; family meeting, no resolution of conflict
Discharge 2/8/13		x			x	Discharge to ward, unresolved care goals