Sepsis
Care Transition from Prehospital Providers to ED

Lisa Schlemmer, RN, BSN, CFRN, EMT-P
Clinical Manager
UC Air Care & Mobile Care
EMS-Know Your Providers

- Level of care
  - BLS
  - ALS
  - CCT Interfacility
- Protocol-driven
  - Medical direction
    - EMS-trained/credentialed
    - Non-EMS trained
  - Varies by area
Critical Care Transport

• Air & Ground
• RN/MD, RN/APN, RN/RT, RN/EMT-P
• Protocols vary
• 3 & 6 hour bundle interventions
  – Antibiotics
  – Lactate & POC testing
Traditional Pre-Hospital EMS

- Assess and treat
- Recently viewed as resource/extension of hospital outcome
  - Trauma
  - STEMI
  - Stroke
Barriers to Pre-Hospital Care

- Conflicting research
- Screening tools not applicable in field
- Equipment not applicable
- Education
- Value
Removing Barriers

- EMS-specific research since 2010
- Field screening tools
  - Robson (Temp, HR, RR, AMS, Glu)
  - BAS 90-30-90 (SBP, RR, SpO2)
  - qSOFA (SBP, AMS, RR) Singer et al, 2016
Removing Barriers

• Equipment
  – Vital Signs
  – Thermometers
  – EtCO$_2$
  – Lactate
Prehospital Impact

- **Wang et al, 2010**
  - 1/3 ED patients with severe sepsis & septic shock received initial care from prehospital providers
  - 2/3 of sepsis deaths were transported by EMS

- **Seymour et al, 2012**
  - EMS transported more patients diagnosed with sepsis than STEMI's or stroke with a 19.7% mortality rate of admissions
Prehospital Impact

• Studnek et al, 2012
  – 51.4% transported by EMS
  – EMS patients had more organ failure
  – 41 minute reduction to Early Goal Directed Therapy (EGDT) (119 vs 160)
  – 35 minute reduction to administration of antibiotics (111 vs 146)
  – If EMS documented sepsis in report
    • 62 minute reduction to EGDT (69 vs 131)
    • 50 minute reduction to administration of antibiotics (70 vs 120)
Prehospital Impact

• Hunter et al, 2016
  – Initiation of prehospital sepsis alert decreased
    • Time to blood culture 27 vs 14
    • Time to antibiotics 56 vs 40
    • Time to fluids 34 vs 10
    • Length of Stay 13 vs 9
    • ICU Admission 53% vs 33%
    • Mortality 14% vs 7%
Prehospital Impact

Recognition is the key thing EMS can contribute to Sepsis care
Sepsis Alert

• EtCO$_2$
  – Non-invasive outcome predictor in suspected sepsis
    • Performs as well as serum lactate predicting mortality in septic patients
    • May provide a method for earlier identification and intervention in patients with suspected sepsis
Sepsis Alert

• EtCO$_2$
  – Early identification and resuscitation by prehospital providers may improve outcomes for patients with sepsis
    • Low EtCO$_2$ is correlated with an acidotic state
    • In the setting of suspected sepsis it serves as a similar outcome predictor to serum lactate levels
Sepsis Alert

The purpose of a Sepsis Alert is to provide pre-arrival Emergency Department notification in order to facilitate rapid assessment and treatment of a suspected severe sepsis patient. A Sepsis Alert will be instituted for patients meeting the following 3 criteria:

1. Suspected infection
2. Two or more of the following:
   - Temperature > 38°C (100.4°F) OR < 36°C (96.8°F)
   - Respiratory Rate > 20 breaths/min
   - Heart Rate > 90 beats/min
3. ETCO2 ≤ 25 mmHg

Hunter et al, 2016
Future?

• Sepsis Alert 2.0?
  – Sepsis 3.0 criteria
  – qSOFA
  – EtCO₂
  – Bedside lactate

• Treatment?
  – 30 ml/kg fluid resuscitation
  – Antibiotics
  – Steroids
Care Transition

• Listen to EMS report
  – Assessment of living situation
  – History from family at scene
  – Evolution of S/S and history
  – Trending of VS
  – Source of infection
  – Treatment
    • When fluids started
    • How much has been infused…1st liter or 3rd?
    • Change in VS after treatment
What Now?

• Include EMS in your Sepsis planning
  – Identify all EMS key stakeholders in your area
  – Get them to the table
    • May mean MANY agencies
    • EMS Medical Directors
    • EMS Directors
  – Assist protocol development specific to your facility’s goals
References


Sepsis Transitions
ED Handoffs to Hospitalists
FISHER-TITUS MEDICAL CENTER
NORWALK, OH
OHA Sepsis Collaborative

- Goal: Identify and Mitigate Sepsis
  - 30% reduction in sepsis incidence
  - 30% reduction in sepsis mortality
- Fisher-Titus Medical Center to –
  - Submit Baseline data & Monthly data
  - Monthly Conference calls
  - Performance Improvement Projects
Sepsis Team

- Hospitalist Medical Director
- ICU Medical Director
- Medical & Surgical Nursing Director
- Emergency Department Medical Director
- Emergency Department Nursing Director
- Pharmacy Director
- Infection Control Director
- Nurse Clinical Analysts
St John Sepsis Rescue Agent Implementation

- House-wide including all areas of patient access.
- Alerts are sent to Primary Nurse based on Sepsis and SIRS Criteria.
- Nurse informs Attending Physician for further action.
- Weekly reports provided by Ressa Christman on the Alerts fired through the St John Sepsis Rescue agent.
- Feedback provided and Action taken based on the above report to Clinical staff.
Sepsis/Septic Shock Order Sets

- Evidence-Based Order-Set (includes 3hr and 6hr bundles) built into CERNER.
- Used by Emergency Physicians and Hospitalists.
- Usage of Sepsis Order Set is tracked and is part of Year-end incentive measures for the Hospitalists.
- Includes orders for – Blood Culture, Lactic Acid, Broad-Spectrum Antibiotics, IV NS or Lactated Ringer @ 30ml/kg, Repeat Lactic Acid, IV Vasopressors
Sepsis Measures
NQF #0500

- A. measure lactate level
- B. obtain blood cultures prior to antibiotics
- C. administer broad spectrum antibiotics
- D. administer 30 ml/kg crystalloid for hypotension or lactate >=4 mmol/L
- E. apply vasopressors (for hypotension that does not respond to initial fluid resuscitation to maintain a mean arterial pressure >= 65)
- F. In the event of persistent arterial hypotension despite volume resuscitation (septic shock) or initial lactate >=4 mmol/L (36 mg/dl) measure central venous pressure and central venous oxygen saturation
- G. re-measure lactate if initial lactate is elevated
# Sepsis Order Set

**Laboratory**

- **FT- Blood Culture**
  - Planned Pen...: 0 components selected
  - Obtain as indicated:
    - UA With Cult Reflex (Urinalysis with Culture Reflex): Urine, Stat collect, T;N
    - Sputum Culture: Stat collect, T;N

**Assess for End Organ Damage:**

- Lactic Acid: Blood, Stat collect, T;N
- Lactic Acid: Blood, Timed Study collect, ;,, Once
- Comprehensive Metabolic Panel (CMP): Blood, Stat collect, T;N
- PT & PTT: Blood, Stat collect, T;N
- CBC w/ Auto Diff: Blood, Stat collect, T;N
- Blood Gas Art: Blood-BG, Stat collect, T;N

**IMPORTANT NOTE to ordering clinician:**

- Review above lab results when available.
- If lab results DO indicate end organ damage, place orders in "SepsisBundle SevereSepsis/SepticShock" orderset.
- If lab results DO NOT indicate end organ damage, place orders in "SepsisBundle Step 2 Antibiotics".

**Adult SIRS/Sepsis Orders, Sepsis Bundle Step 1, FT- Blood Culture (Planned Pending)**

**Communication**
# Septic Shock Order Set

<table>
<thead>
<tr>
<th>Adult SIRS/Sepsis Orders, Sepsis Bundle Severe Sepsis/Septic Shock (Planned Pending)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care</strong></td>
</tr>
<tr>
<td>☐ These orders are to be placed after the &quot;SepsisBundle Step 1&quot; phase if there is evidence of severe sepsis/septic shock with lab results consistent with end organ damage.</td>
</tr>
<tr>
<td>☐ Central Venous Line Insertion</td>
</tr>
<tr>
<td>☐ Central Venous Pressure</td>
</tr>
<tr>
<td>☐ Intake and Output</td>
</tr>
</tbody>
</table>

| **IV Solutions**                        |
|========================================|
| ☐ **Sodium Chloride 0.9% intravenous solution (NS 1000 ml Bolus)** |
|   1000 mL, IV, 30 mL/kg, 150 ml/hr or higher; STAT |
|   If SBP < 90 OR Mean Arterial Pressure < 65 mmHg OR Lactate level > 4 mmol/L after fluid bolus |
| ☐ **Lactated Ringers Injection (Lactated Ringers Bolus)** |
|   30 mL/kg, IV, Once; STAT; RATE: 150 ml/hr or higher |
|   If SBP < 90 OR Mean Arterial Pressure < 65 mmHg OR Lactate level > 4 mmol/L after fluid bolus |

| ☐ If hypotension persists after fluid administration within 6 hours of presentation of septic shock, start Vasopressors |
| ☐ **DOPamine 400mg/500mL - D5W Drip** |
|   500 mL, IV, 1 mL/hr, Routine, Maintain SBP > 90 |
|   Concentration 800 microgram/ml. Starting dose: 0.5 microgram/kg/min. Titrated 0.5 microgram/kg/min to maintain |
| ☐ **Levophed 8mg/250mL - D5W Drip** |
|   242 mL, IV, 3.75 mL/hr, Routine, titrate at 3.75 mL/hr (2 mcg/min) to Maintain SBP > 90 |
|   Concentration: 32 microgram/ml. Starting dose: 2 microgram/min. Suggested Maximum Dose: 30 microgram/min |
| ☐ **Epinphrine 1mg/250mL NS Drip** |
|   250 mL, IV, 15 mL/hr, Routine, Starting Dose: 15 mL/hr, titrate 15 mL/hr (1 mcg/min) to heart rate of 60 and, M |
|   Concentration: 4 mcg/ml. Starting dose: 1 microgram/min. Suggested Maximum Dose: 6 mcg/min (60 mL/hr) |
| ☐ **Neo Sympnephrine 50mg/150mL NeCl Drip** |
|   250 mL, IV, 3 mL/hr, Starting Dose: 3 mL/hr, titrate to keep, Maintain SBP > 90 |
|   Concentration 200 mcg/ml. Starting dose: 10 microgram/min. Suggested Maximum Dose: 200 mcg/min (60 mL/hr) |

| **Medications**                          |
|========================================|
| ☐ **Initiate SepsisBundle Step 2 Antibiotics** |
St John Sepsis Agent Criteria

Trigger counts for Criteria

Most Triggered Criteria

- Temperature < 36 or > 38.3 C
- Heart Rate > 95/min
- Respiratory Rate > 21/min
- Glucose > 140 mg/dl and < 200 mg/dl
- WBC > 12K OR < 4K or Bands > 10%
- Systolic BP < 90 mmHg or MAP < 65 mmHg
- Bilirubin 2.0 – 10.0 mg/dl
- Creatinine increase > 0.5 mg/dl over 72 hrs
- Lactate > 2.0 mmol/L
Sepsis Alert
## Sepsis Nursing Documentation

### Sepsis

- [ ] Continue Monitoring
- [ ] Will Call RRT Alert
- [ ] Will Call Sepsis Alert
- [ ] Will Initiate Sepsis Treatment
- [ ] Sepsis Treatment Not Indicated

### Reason Sepsis Treatment Not Indicated

- [ ] Considering Alternate Diagnosis
- [ ] Patient/Family Request
- [ ] Comfort care only
2 Year OHA Sepsis Initiative

- Process Improvements made by Team
- St John Sepsis Rescue Agent fires alert
- Sepsis Confirmed & Documented by clinician
- Re-assessment at 3 and 6 hours by Clinician
- Order-Set initiated by Clinician
- Process & Outcomes data reviewed by Team

Process & Outcomes data reviewed by Team → St John Sepsis Rescue Agent fires alert → Sepsis Confirmed & Documented by clinician → Re-assessment at 3 and 6 hours by Clinician → Order-Set initiated by Clinician → Process Improvements made by Team
Emergency Department Handoff

- ED Physician phone call to Hospitalist
- Hospitalist sees patient
- Sepsis Order Set initiated
- ED Nurse phone call to Medical/Surgical Unit Nurse
- Sepsis protocol reviewed by Rounding team
**Emergency Department Handoff**

**IMCP Severe Sepsis/Septic Shock Bundle Handoff/Checklist - 2014**

<table>
<thead>
<tr>
<th>Patient Name: ___________________________</th>
<th>ECN: ___________</th>
<th>DOA <em><strong>/</strong></em>/___</th>
</tr>
</thead>
</table>

**Time Zero** (ED admits = time of arrival. -- Floor admits = time of admission to ICU or IMC)

| Enter "Time Zero" + 3 hours for ED patients or + 1 hour for other inpatient unit arrivals
|------------------------------------------|

**Severe Sepsis Resuscitation Bundle**

**Goal:** to be done within a max. of 3 hours from "Time Zero" above or for non-ED patients within 1 hour from "Time Zero" above

- Measure serum lactate. (If ≥ 2, see #7 below)
- Obtain blood cultures prior to antibiotic administration
- Broad-spectrum antibiotic administration*: (see below) **Time started:** ____:____
- Fluid bolus of 30 ml/kg of crystalloid IV over 1 hour PRN MBP < 65 and/or Lactate ≥ 4 mmol/L
## Emergency Department Handoff

### Septic Shock Bundle

<table>
<thead>
<tr>
<th>Time Zero</th>
<th>Compliant?</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 or 1 hour</td>
<td>5. Administer Vasopressors (norepinephrine is preferred if not contraindicated)</td>
</tr>
<tr>
<td>from Time Zero</td>
<td>6. Place central monitoring line and measure CVP and ScvO2 or use NICOM for further fluid resuscitation with goal of:</td>
</tr>
<tr>
<td></td>
<td>Central line: CVP &gt; 8 mmHg and ScvO2 ≥ 70% OR NICOM: ≤ 10% increase in SVI with PLR and CI ≥ 2.5 L/minute</td>
</tr>
<tr>
<td></td>
<td>7. If initial serum lactate is ≥ 2 repeat lactate within 6 hours (may be done before 6 hr.).</td>
</tr>
</tbody>
</table>

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**Emergency Department Handoff**

- If low BP responds to fluid bolus permanently, continue to monitor and mark steps 5-6 "NA".
- If persistent hypotension after fluid bolus proceed to steps 5-7.
- If MBP is > 65 but initial lactate is > 4, mark step 5 "NA" and proceed to steps 6-7.

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**FISHER TITUS MEDICAL CENTER**
Emergency Department Handoff

Maintenance Bundle

Compliance Met within 24 hours
Compliant?

8. Stress-dose Steroids if on high dose or multiple vasopressors**
   (Hydrocortisone 50 mg q6 hours or 200 mg as continuous 24 hour infusion)
   (**High dose includes norepinephrine ≥ 0.3 mcg/kg/min or use of 2 or more vasopressors simultaneously)

9. Mean glucose of 80-180 mg/dl by 24 hours checking glucose at least Q4 hours.
   (Exceptions for compliance will be given if initial glucose is < 400 mg)

10. If mechanical ventilated, target Vt at 6 mL/kg PBW (range 4-7 mL/kg PBW)

ENTER INTO EACH BLANK WHITE BOX ABOVE: "Y" = compliant, "N" = not compliant, or "NA" = not applicable

* Antibiotic Suggestions: (Use of antibiotic suggestions is not required to meet compliance criteria)
   CAP: Ceftriaxone + azithromycin (preferred) or levofloxacin alone.
   HCAP: Zosyn (high dose) + levofloxacin + Vancomycin if MRSA risk
   Urosepsis: Ceftriaxone or if Pseudomonads suspected Zosyn or Cefapime
   Surg. Site: Cefazolin or Vancomycin in MRSA suspected
   Intra-abdominal: Levofloxacin + Flagyl or Zosyn or Ceftriaxone + Flagyl

This Form Is Not a Part of the Permanent Medical Record
FTMC Sepsis Incidence

- Sepsis Incidence

<table>
<thead>
<tr>
<th>Year</th>
<th>Incidence</th>
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<tbody>
<tr>
<td>2010</td>
<td>1.34%</td>
</tr>
<tr>
<td>2011</td>
<td>1.91%</td>
</tr>
<tr>
<td>2012</td>
<td>2.28%</td>
</tr>
<tr>
<td>2013</td>
<td>6.93%</td>
</tr>
<tr>
<td>2014</td>
<td>10.53%</td>
</tr>
<tr>
<td>2015</td>
<td>8.90%</td>
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</table>

St John Agent April 2015
Length Of Stay

- Length Of Stay (Days)

<table>
<thead>
<tr>
<th>Year</th>
<th>Length Of Stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>6.33</td>
</tr>
<tr>
<td>2011</td>
<td>5.8</td>
</tr>
<tr>
<td>2012</td>
<td>4.86</td>
</tr>
<tr>
<td>2013</td>
<td>5.35</td>
</tr>
<tr>
<td>2014</td>
<td>5.22</td>
</tr>
<tr>
<td>2015</td>
<td>4.74</td>
</tr>
</tbody>
</table>

St John Agent April 2015
FTMC Sepsis Mortality Rates

St John Agent
April 2015
Questions?
OhioHealth
Skilled Nursing Facility
Continuing Care Network:
Partnership between our Hospitals and Skilled Nursing Facilities
Why Did OhioHealth form a Skilled Nursing Facility Continuing Care Network (SNF CCN) ?

• Significant readmissions coming from SNFs
• Concern about quality
• Changes in healthcare environment
  – ACOs
  – Bundled payments
  – Value-Based Purchasing
• High utilization of SNFs
Objective of the Skilled Nursing Facility Continuing Care Network

• To create a network of quality-oriented SNF providers that adhere to identified service standards and reporting criteria as established by OhioHealth.

Goals

• To provide value: high-quality and efficient care
• Enhance patient experience
• Timely access from acute care setting
• Improved coordination of care throughout the post-acute continuum
Guiding Principles

• Focus on quality:
  – Oversight provided by the **Quality of Care Committee** which reports to OhioHealth’s Board of Directors.

• Create a narrow network

• Honor patient choice

• Not based on a business relationship with OhioHealth

• Create an organizational structure
SNF CCN Clinical Advisory Team (CAT)

• Clinical Advisory Team assisted in survey assessment and development of critical selection criteria

<table>
<thead>
<tr>
<th>Clinical Advisory Team Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>President, OhioHealth Home Care</td>
</tr>
<tr>
<td>VP Clinical Excellence, OPG</td>
</tr>
<tr>
<td>SNF CCN Program Coordinator</td>
</tr>
<tr>
<td>SNF CCN Physician Lead</td>
</tr>
<tr>
<td>System VP, Quality &amp; Safety</td>
</tr>
<tr>
<td>System VP, Clinical Effectiveness</td>
</tr>
<tr>
<td>System Director, Clinical Effectiveness</td>
</tr>
<tr>
<td>Senior Director, Care Coordination</td>
</tr>
<tr>
<td>Director, Care Coordination</td>
</tr>
<tr>
<td>Assistant General Council</td>
</tr>
</tbody>
</table>
OhioHealth Skilled Nursing Facility Continuing Care Network

AS OF MARCH 1, 2014

1. Altercare of Hilliard Post-Acute Center
   4660 Truman Boulevard
   Hilliard, Ohio 43026
   Phone: (614) 771.4400 | Fax: (614) 771.4474

2. Arbors West
   375 West Main Street
   West Jefferson, Ohio 43162
   Phone: (614) 879.7661 | Fax: (614) 879.7604

3. Arlington Court Skilled Nursing and Rehab
   1605 NW Professional Plaza
   Upper Arlington, Ohio 43220
   Phone: (614) 451.5677 | Fax: (614) 451.8096

4. Columbus Healthcare Center
   4301 Clume Road N
   Columbus, Ohio 43228
   Phone: (614) 276.4400 | Fax: (614) 278.7645

5. Convalarium of Dublin
   6430 Post Road
   Dublin, Ohio 43016
   Phone: (614) 761.1188 | Fax: (614) 761.0410

6. Darby Glenn Nursing and Rehab
   4787 Tremont Club Drive
   Hilliard, Ohio 43026
   Phone: (614) 777.6001 | Fax: (614) 777.6008

7. Heartland of Uptown Westerville
   140 Old County Line Road
   Westerville, Ohio 43081
   Phone: (614) 882.1511 | Fax: (614) 890.6566

8. The Laurels of Norworth
   6830 North High Street
   Worthington, Ohio 43085
   Phone: (614) 888.4553 | Fax: (614) 847.0009

9. Mayfair Village Nursing Care Center
   3000 Bethel Road
   Columbus, Ohio 43220
   Phone: (614) 889.6320 | Fax: (614) 791.4972

10. Mill Run Gardens & Care Center
    3399 Mill Run Drive
    Hilliard, Ohio 43026
    Phone: (614) 527.3000 | Fax: (614) 345.0528

11. National Church Residences First Community Village
    1801 Riverside Drive
    Columbus, Ohio 43212
    Phone: (614) 486.9511 | Fax: (614) 324.2114

12. Scioto Community
    433 Obetz Road
    Columbus, Ohio 43207
    Phone: (614) 491.2000 | Fax: (614) 295.1414

13. Wesley Glen
    5155 North High Street
    Columbus, Ohio 43214
    Phone: (614) 842.8131 | Fax: (614) 842.8321

14. Westminster Thurber Community
    717 Neil Avenue
    Columbus, Ohio 43215
    Phone: (614) 228.8888 | Fax: (614) 629.5761

15. Wexner Heritage Village Rehabilitation and Long Term Care
    1151 College Avenue
    Columbus, Ohio 43209
    Phone: (614) 231.4900 | Fax: (614) 231.1974

16. Whetstone Gardens & Care Center
    3700 Olentangy River Road
    Columbus, Ohio 43214
    Phone: (614) 457.1100 | Fax: (614) 345.0530

A FAITH-BASED, NOT-FOR-PROFIT HEALTHCARE SYSTEM

OhioHealth
BELIEVE IN WE™
Transitions of Care Committee

• Patient X:
  – Hemoglobin actively trending down while at one of our acute care facilities
  – At 7.0 upon discharge.
  – Physician advised that SNF will transfuse if hemoglobin drops any lower, unable to transfuse at facility.
  – Hospitalist felt patient was stable enough to transfer
  – Next day patient dropped to 6.2, sent to ED for transfusion.
  – Readmit occurred due to anemia.
Transitions of Care Committee

• Patient Z:
  – Admitted with chest pain.
  – Cardiac work up and stent placed. On Dialysis with a broken right foot.
  – Nothing about dialysis or foot mentioned in orders or report. No details provided on current dialysis chair. She is NWB with a boot. Nothing mentioned.
  – Med Rec sent makes no sense.
  – Patient is upset because it does not match her current home medications.
Transitions of Care Committee

• Patient Y:
  – Scheduled surgery.
  – Due to ambulance transport issues in the market, patient not transferred to facility until 11 p.m.
  – Report not called
  – Scripts not sent
  – No COC or discharge instructions went with the patient
Transitions of Care Committee

- Improved Communication is vital with sepsis population
  - Why is patient on the antibiotic
  - Start and stop dates
  - Clear point of origin
  - These patients can crash quickly so critical to have as much detailed information as possible
Transitions of Care Committee

- Purpose: collaborative effort to improve the patient’s transition across the health care continuum
- Warm Hand-offs
- Access to EMR
- OBS Units
- Transfer Center
- Infusion Centers
- Ambulance Provider
Transitions of Care

PATIENT TRANSPORT PACKET

Date of Transport: ________________ Time of Pickup: ________________
Patient Name: ________________ Room #: ________________
Transferring Facility: ________________ Unit: ________________ Phone#: ________________
Receiving Facility: ________________ Phone#: ________________

TRANSPORT PAPERWORK

Ohio Health Nurse

- Face Sheet
- Ambulance Authorization Form (PCS)
- State DNR Form (if applicable)
- Discharge/Transfer Instructions
- RN COC
- Required Scripts
- Glasses/Dentures/Hearing Aids

Receiving Nurse

- Nurse to Nurse Report given by: ________________
- To: ________________
A FAITH-BASED, NOT-FOR-PROFIT HEALTHCARE SYSTEM

RIVERSIDE METHODIST HOSPITAL + GRANT MEDICAL CENTER + DOCTORS HOSPITAL
GRADY MEMORIAL HOSPITAL + DUBLIN METHODIST HOSPITAL + HARDIN MEMORIAL HOSPITAL
MARION GENERAL HOSPITAL + REHABILITATION HOSPITAL + O’BLENNESS HOSPITAL + MANSFIELD HOSPITAL
SHELBY HOSPITAL + WESTERVILLE MEDICAL CAMPUS + HEALTH AND SURGERY CENTERS
PRIMARY AND SPECIALTY CARE + URGENT CARE + WELLNESS + HOSPICE
HOME CARE + 28,000 PHYSICIANS, ASSOCIATES & VOLUNTEERS
Palliative care and the ICU

June 15, 2016

Charles F von Gunten, MD, PhD
VP Medical Affairs, Hospice & Palliative Care
Presentation

Anti-disease Therapy

6m Death

Bereavement Care

Hospice Care
OhioHealth 2013

Presentation

Anti-disease Therapy

6m Death

Bereavement Care

Palliative Care
Palliative Care

• Interdisciplinary care focused on relieving suffering and improving quality of life.

• May be combined with therapies aimed at reducing or curing the illness, or it may be the total focus of care.

• Grew out of, and includes, hospice care
Therapies to relieve suffering and/or improve quality of life

OhioHealth 2014 → 2023

Anti-disease Therapy

Medicare Hospice Benefit = Enhanced Palliative Care

Palliative Care

Presentation

Therapies to relieve suffering and/or improve quality of life

6m

Death

Bereavement Care
Hope for the Best; Prepare for the worst
Palliative Care and the ICU

• Sickest patients at high risk of dying
  – High symptom burden, family, staff stress
  – Needs in multiple dimensions

• Culture of the ICU
  – Proud of the care they give
  – Open versus Closed
  – Surgical and Medical Patients
  – ‘Rescue’ (either ICU care OR Palliative Care)

What ICU Patients / Families say

- Patient / Family centered decision-making
- Community
- Continuity of Care
- Emotional and Practical support
- Symptom management
- Spiritual support
- Emotional support for ICU staff

Palliative Care/Palliative Medicine

- A best practice for all who work in the ICU during routine medical management
- An interdisciplinary, comprehensive practice approach at a specialist-level of care for patients and families in need
"There's no easy way I can tell you this, so I'm sending you to someone who can."
Palliative Care Team

- Specialist Physician
- Nurse Practitioner
- Social Worker
- Chaplain
- Pharmacist
Consultation Etiquette

• Call after the request made to the attending physician (may be multiple physicians)
• Gather information from other ICU disciplines
  – Nursing
  – Social Work
• See the patient and family
• Call after the encounter but BEFORE initiating anything
• Address only what has been asked
• Communicate in person, not through the chart
Effect of a Palliative Care Team

Riverside ICU’s

Q2 FY2016

UPDATE

RMH - 12 Month Rolling Average of Monthly Cases

- Patients with mechanical ventilation <96h (DRGs 871, 872, 208)
  - +75%*

- Patients with mechanical ventilation >96h (DRGs 870, 207)
  - +3%*

- Patients with mechanical ventilation getting a trach (DRGs 003, 004)
  - -35%*

*CY10 to CY15

Safety  Partnership  Efficiency
When to ask for Palliative Care in ICU?

- Difficult symptoms
- Challenging / Complex Family
- Goals of Care conversations
- Frequent ICU admissions

- ‘Trigger’ after 48 hours in the ICU

Conclusions

• Consultation Etiquette
  – Respect for the ICU as colleague and customer

• Both / And strategy

• Nothing wrong with asking Palliative Care Team to”
  – Conduct the family meeting
  – Have ‘the talk’
  – Do the management, including writing the orders for opioids, other medications