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Session: B95 Critical Care: New Clinical Trials
Monday, May 16, 2016, 3:45 p.m.–4 p.m.
Location: 3006/3008 (West Building, Level 3), MOSCONE CENTER

Meetings with Palliative Care Do Not Improve Anxiety and Depression Symptoms in Family Caregivers of Chronic Critically Ill Patients

ATS 2016, SAN FRANCISCO – Additional support by palliative care specialists failed to improve anxiety and depression symptoms in caregivers of patients with chronic critical illness, according to new research presented at the ATS 2016 International Conference. Patients also saw little benefit as the additional support did not lead to reduced time on a breathing machine or in the hospital.

“Family members indicated that they were satisfied with the information and support provided by the ICU physicians, and this may explain why the additional support from palliative care specialists did not improve family or patient outcomes,” said Shannon Carson, MD, of the University of North Carolina at Chapel Hill in Chapel Hill, North Carolina.

The study enrolled 256 adult patients and their caregivers from medical ICUS at three tertiary care centers and one community hospital. To be eligible, patients had to require at least seven days of mechanical ventilation. Patients were randomized to either usual care or two meetings with a palliative care physician and nurse practitioner.

Given that palliative care specialists, who are trained to provide emotional support and share difficult information, are routinely consulted to provide family support and facilitate goals of care discussions for chronically critically ill patients, the authors wanted to determine if these specialists would help to reduce psychological stress for families.

“Findings of our study indicate that routine referral of these patients for palliative care consultation does not improve psychological distress for families as compared to effective communication by ICU physicians,” said Dr. Carson. “ICU physicians should continue to make communication and support for family decision-makers an important part of their practice in the ICU. They should meet with families early and provide additional support as needed. Support for this physician effort by insurers is a good use of resources."

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Abstract 7026

A Multicenter Randomized Controlled Trial of Palliative Care-Led Informational/Emotional Support Meetings for Family Decision Makers of Patients with Chronic Critical Illness

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Abstract Body

Rationale: Family caregivers of patients with chronic critical illness (CCI) suffer psychological distress, which is intensified by limited information during shared decision making about intensive care. We hypothesized that family informational/emotional support meetings led by palliative care clinicians would therefore improve family- as well as patient-centered outcomes.

Methods: In this randomized controlled trial, we enrolled adult patients requiring at least 7 days of mechanical ventilation and their family decision maker(s) from medical ICUs at 3 tertiary care centers and 1 community hospital. Family members were randomized to intervention (at least 2 protocol-driven meetings with a palliative care physician and nurse practitioner) or control (usual care and communication provided by the primary critical care team). Primary outcomes were family members' symptoms of depression and anxiety, as measured by the Hospital Anxiety and Depression Scale (HADS), and symptoms of post-traumatic stress disorder [PTSD], as measured by the Impact of Event Scale Revised (IES-R), at 3 months after randomization. Patient outcomes included ventilator days, hospital length of stay, and discussion of preferences for care. Primary outcome variables were adjusted for baseline values (for HADS) and multiple respondent characteristics using multivariable regression models.

Results: Of 366 eligible patients, 256 were enrolled, mostly through surrogate consent, and randomized to the control or treatment arm along with 366 surrogate decision makers. Patients in the control and intervention groups were similar in age (57 years vs 58 years) and predicted 1-year mortality (55% vs 59%), respectively. 90-day survival (55% vs. 58%, p=.69) and median ventilator days after randomization (12 vs 10, p=.42) were not different between control and intervention, and median hospital length of stay after randomization was also similar (23 days vs

19 days, p=.51). Follow-up rate for family members was 85% at 3 months. For the primary family-centered outcomes, symptoms of anxiety and depression (HADS) did not differ between groups, but symptoms of PTSD (IES-R scores) were slightly higher in the intervention group (Table 1). Family perceptions of quality of communication, patient- and family-centered care, and family satisfaction were rated highly in both groups and were not significantly different. (Table 1)

Conclusions: Structured informational/emotional support meetings triggered for patients with prolonged mechanical ventilation and led by palliative care clinicians do not improve family decision maker anxiety, depression, or PTSD symptoms in settings where usual care and communication are rated highly by family decision makers of patients with CCI.

Table 1. Family-centered outcomes measured at 3 months

Outcome	**Control n=149**	**Intervention n=163**	**P value**
HADS Total, (0-42 scale), mean ± se	11.4±.63	12.2± .60	.34
Anxiety Subscale (0-21)	6.4± .35	7.2 ± .33	.09
Depression Subscale (0-21)	5.0± .33	7.3 ± .39	.11
IES-R Total, (0-88 scale), mean ± se	21.3±1.7	25.9 ±1.6	.0495
Avoidance subscale (0-32)	7.1± .61	8.8 ± .57	.048
Hyperarousal subscale (0-24)	4.4± .49	5.9 ± .46	.03
Intrusion subscale (0-32)	9.7± .73	11.1± .68	.17
Discussion of Care Preferences,* n (%)			.23
Discussed medical treatments	131 (94)	144 (95)	
Discussed whether care was consistent with patient wishes	133 (96)	136 (90)	
Discussed whether medical treatments were consistent with wishes	128 (92)	135 (89)	
All preference measures were discussed	114 (82)	112 (74)	.11
Overall rating for patient-focused, family-centered care,*[§] (0-10 scale)	8.99±.14	8.80± .13	.33
Overall family satisfaction,[†§] (0-100 scale)	84.3±1.5	81.1 ±1.4	.13
*From the After Death Bereavement Interview [†]From the Family Satisfaction in the ICU Survey (24) [§] Adjusted for multiple respondents and center, mean ± se			