BACKGROUND
Post-intensive care unit syndrome (PICS) refers to the long-term psychological, cognitive, and physical sequelae of critical illness. Because more intensive care unit (ICU) patients are surviving, more patients and families are at risk for PICS. The optimal approach to prevent and treat the psychological component of PICS is unknown. Currently there is evidence supporting inpatient psychiatrically-based behavioral health intervention teams. Traditionally, when psychiatry is consulted in our medical ICU (MICU), their evaluation and treatment is performed separately from the work of the medical team. To better support the interdependence of patient-family biopsychosocial health, we integrated a behavioral health clinician (BHC) into our MICU as a multidisciplinary quality improvement project.

AIM
To describe an ICU patient and family cohort when a behavioral health clinician is embedded into a medical ICU.

PROJECT DESIGN

1. Weekday Flow:
   - MICU attending physicians screened patients and families on morning rounds: cardiac arrest, critical neurological disorders*, respiratory failure, septic shock, severe electrolyte disorder, sepsis, liver failure, delirium, severe post-traumatic stress, critical neurological disorders*, post-intensive care unit syndrome (PICS), noncompliance, mood disorders, and medical complications.
   - BHC saw patients/families, recorded notes, verbally communicated urgent issues to MICU bedside nurses
   - MICU attending physicians screened patients and families on morning rounds: cardiac arrest, critical neurological disorders*, respiratory failure, septic shock, severe electrolyte disorder, sepsis, liver failure, delirium, severe post-traumatic stress, critical neurological disorders*, post-intensive care unit syndrome (PICS), noncompliance, mood disorders, and medical complications.

2. Interventions:
   - The BHC performed interventions and resolved concerns based on the patient and family needs. They conducted behavioral health interventions, talked to staff about the patient’s psychological status, and determined the need for additional services.

3. Data Collection:
   - All BHC interventions were documented in the MICU crisis care binder.
   - Behavioral health intervention data was collected and analyzed.

April 2016: Paper submitted
May 2016: Paper accepted
July 2016: 0.5 FTE BHC (an Advanced Practice Psychiatric RN with ICU and hospice experience) dedicated to MICU for Quality Improvement Project
August 11, 2017: Paper presented at 12th Annual Critical Care Learning and Research Conference
September, 2017: IRB Approval
July 25, 2017: Project Implementation
November, 2017: 1.0 FTE Psychologist to be embedded into MICU

WHAT WE LEARNED
1. Integrating a behavioral health clinician into an ICU is feasible and beneficial.
2. Critical components to integration:
   - Careful BHC selection: temperament and fit (e.g., individuals with flexibility and professional dexterity) is more important than specific credentials
   - Multiple, brief contacts over time between staff, patients, and families to build relationships
3. Approximately half of our cohort did not require palliative, psychiatric, or addiction medicine collaboration, suggesting an unmet behavioral health need.
4. Because the BHC discovered new patient/family information, we could deliver more compassionate, patient- and family-centered care.
5. ICU staff felt the BHC not only had a positive effect on patient and family behavioral health, but also made their workload less stressful.

FUTURE DIRECTION
Further research is needed to determine:
- if ICU behavioral health interventions impact clinical outcomes and healthcare costs
- if the presence of an ICU BHC has an impact on staff satisfaction and/or burnout
An impactful PICS patient and family peer support group
A PICS Clinic

REFERENCES
1. Harvey M, and Davidson JE: Post-intensive Care Syndrome: Right Care, Right Now...and Later. Critical Care Medicine 2016; 44: 381-5

DISCLOSURES: There are no financial conflicts for any of the authors.

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