

Palliative Care for Heart Failure

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Objectives

1. Describe the admission history and pattern of patients with end stage heart disease in the last twelve months of life as identified by research results.
2. Identify an evidence based, quantifiable measure to determine the most appropriate time to refer to palliative care or hospice care.
3. Describe key palliative interventions for patients with end stage heart disease.

2

Industry Trends



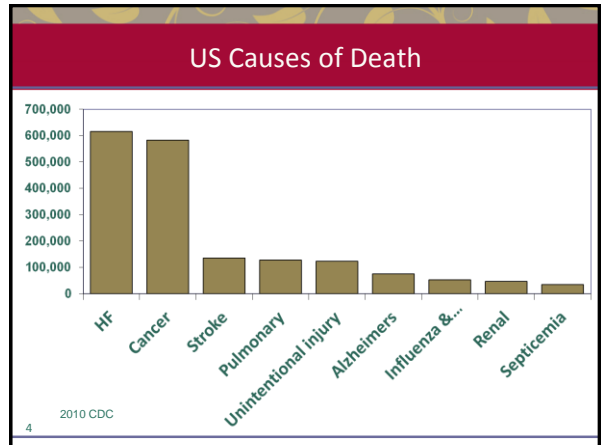
2,450,000
US Deaths

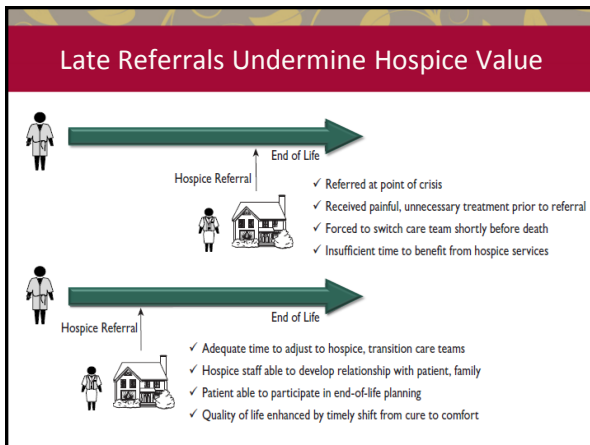
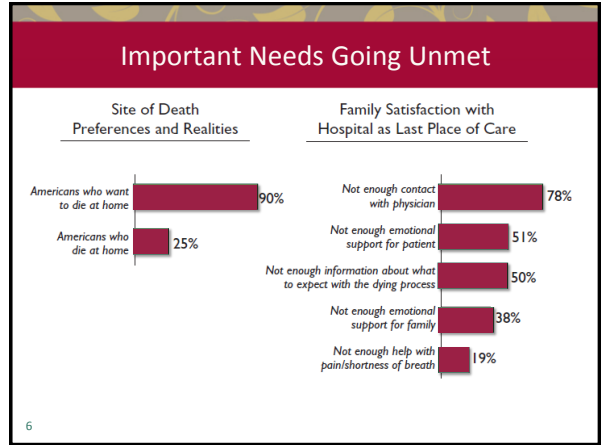
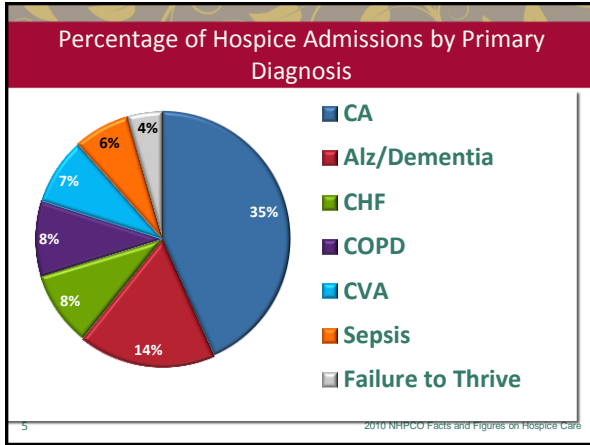
1,020,000
Hospice
Deaths
41.6%

- Number of deaths from chronic illness is approximately 70%
- NHPCO estimates nearly 41.6% of all deaths in the US were under the care of a hospice program *

*NHPCO Data 2009

3





The 2010 HF Society of America Comprehensive HF Practice Guidelines

End of Life care should be considered in patients who have advanced, persistent HF with symptoms at rest despite repeated attempts to optimize pharmacologic, cardiac device and other therapies, as evidenced by 1 or more of the following:

Heart Failure Hospitalization	Chronic poor quality of life with minimal or no ability to accomplish ADL's	Need for continuous intravenous inotropic therapy
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8

Challenges in Determining "End of Life"

Difficult to put a 6 Month time frame on patients with chronic diseases

- Most are fairly stable
- Accustomed to symptom exacerbation
- Develop new levels of normal


9

Challenges in determining "End of Life"

Would I be surprised if my patient died within the next twelve months?

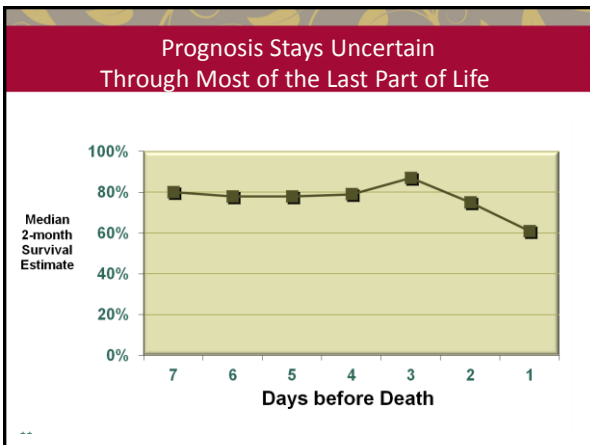
A study that looked at physician prognostic accuracy in terminally ill patients found

63% of physicians were overly optimistic in estimating survival	The closer the relationship to the patient, the longer the prognosis	Overall, physicians Overestimated survival by a factor of 5.3 Or 530%
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BMJ 2000; 320: 469-473

10



The Research

Can the admission history alone indicate when to refer to hospice or palliative care?

Retrospective review of charts	Adult patients who died at TriHealth hospitals from a chronic illness between April 2005 and October 2004	Review of 441 cases
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12

Key Outcome

Yes! The Admission history alone is a reliable tool to use to determine when to refer to hospice or palliative care.

Keep in Mind:

Recurring hospitalizations are often inconsistent with the patient's priorities, quality of life, and wishes	Hospice care reduces readmissions to the hospital	Recurring Hospitalizations are costly to the hospital
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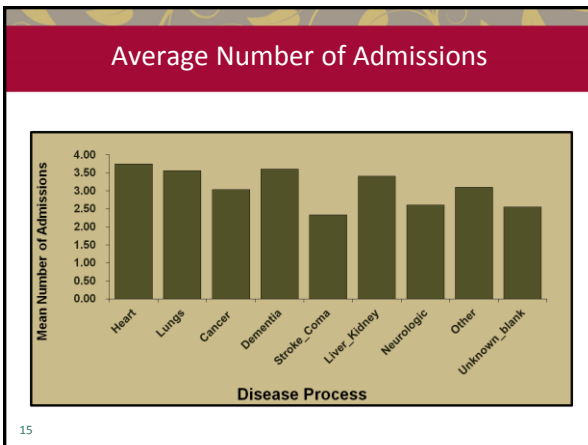
Financial Implications

441 patients in the study incurred a \$1,700,000 loss for TriHealth

Total cost less total payment

Takes into consideration the direct and indirect cost of providing care

14



Cost of Readmission within 30 Days

\$17.4 billion spent in 2004 in the US for unplanned Medicare re-hospitalizations

Approximately 28% of re-hospitalizations are avoidable

\$12 billion of this was for potentially preventable re-hospitalizations

16

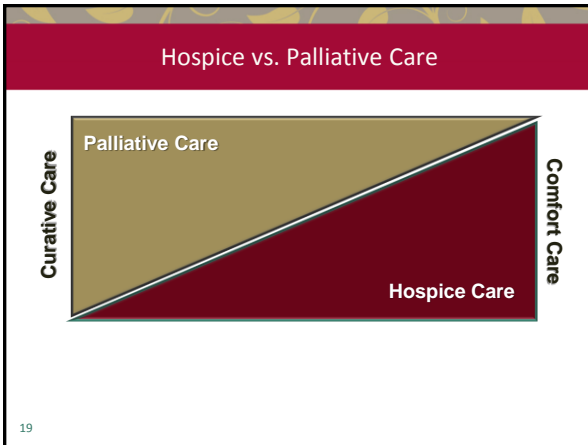
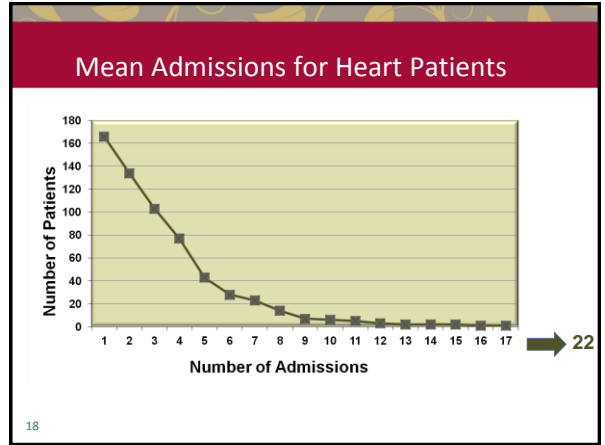
Healthcare Reform Act

Patient Protection and Affordable Care Act includes Value Based Purchasing (VBP) implemented March 2010

VBP is a Medicare system that considers quality of care in determining payment to individual providers

Hospitals will be penalized financially if their readmissions for heart failure, AMI, and pneumonia exceed national benchmarks

17



Why Focus on End Stage Heart Disease?

A 2008 Medpac report made recommendations to change the payment rate to hospitals with high re-admissions

Patients admitted with heart failure have shorter hospital LOS, but higher rates of re-admissions within 30 days (Jama, June 2, 2010)

20

Trend of the HF patient

Orientation

- Status quo
- Symptom exacerbation
- In and out of acute care
- With every admission may hit 'new normal' but maintaining at a new low
- Disease is the focus

Disorientation

- Bad news-chaos
- No language
- Unfamiliar territory
- Too difficult, too hard, too scary, too visceral

New Orientation

- New normal
- Most are not ready for "newness"
- Creating moments of joy; healing happens and may be seen as a gift and a surprise
- Promote openness and understanding
- Disease is in the background

21

Comparing Hospice and Nonhospice Patient Survival

Hospice care resulted in an average increase of life by 29 days.

Condition	Hospice (Days)	Nonhospice (Days)
CHF	81	~52
Lung Cancer	39	~25
Pancreatic Cancer	21	~18

Retrospective statistical analysis of 4493 patients from 5% of Medicare patients from 1998-2002
Connor SR et al. JPSM 2007;33:238-46

22

What does 81 days mean to your patients?

23

End of Life Conversations Alone Have Positive Impact

Advance cancer patients who had EOL discussions showed 35.7% in lower costs than those with no EOL discussions

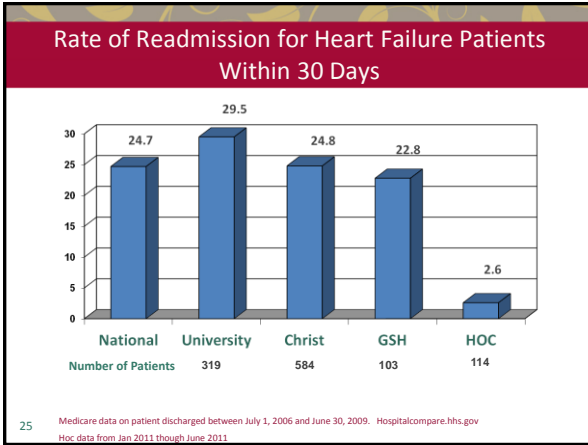
- Those who discussed EOL showed:
 - ¹ Higher tendency to want to know life expectancy
 - ² Acknowledgement of terminal illness
 - ³ Less likely to favor futile care over comfort
 - ⁴ Preference to avoid dying in the ICU
 - ⁵ Higher likelihood to receive outpatient hospice care and earlier referral

Aggregate Cost of Care

Discussion Type	Aggregate Cost of Care
EOL Discussion	\$1,876
No EOL Discussion	\$2,917

Source: Health Care Costs in the Last Week of Life: Associations with EOL Conversations, Arch Intern Med 2009

24



Pathways for End Stage Heart Disease

Effectively manage symptoms and avoid hospital re-admissions

- ❖ Nursing visits
- ❖ Cardiac medications
- ❖ Focus on patient **and** caregivers
- ❖ 24/7 Support Team
- ❖ Meet all levels of care

Implement a plan of care to create a positive and meaningful end of life experience

26

Nursing Visits

- Tailored to meet needs of patient
- Aggressive symptom management
- Educate about disease process
- Create an effective plan of care

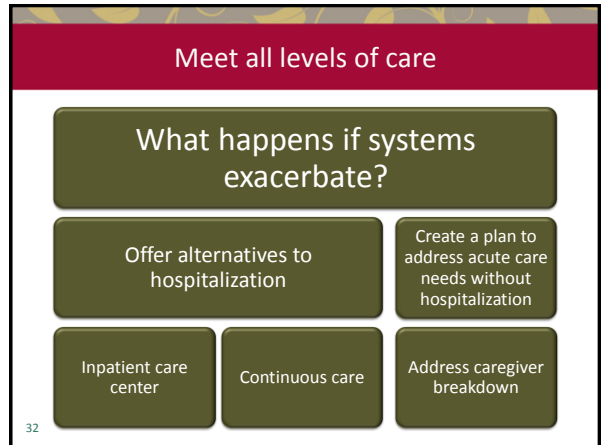
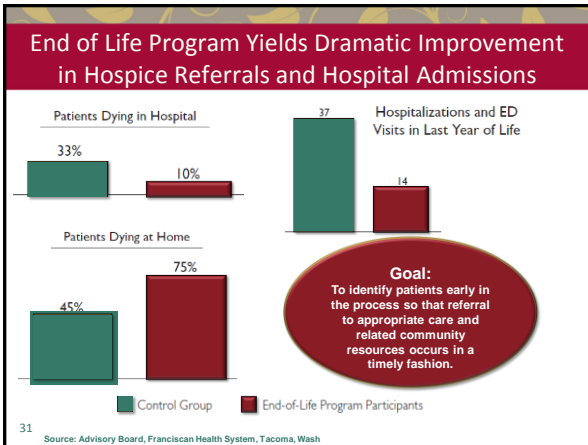
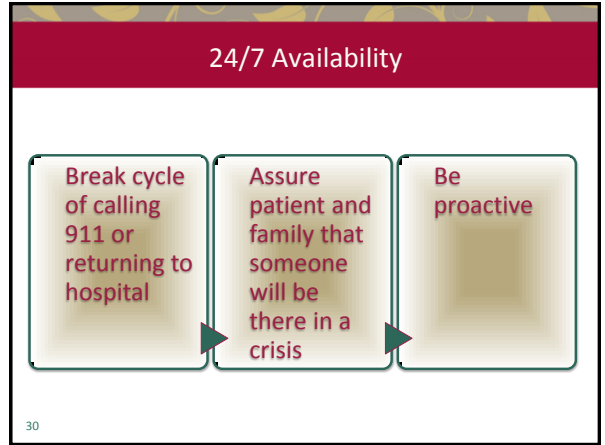
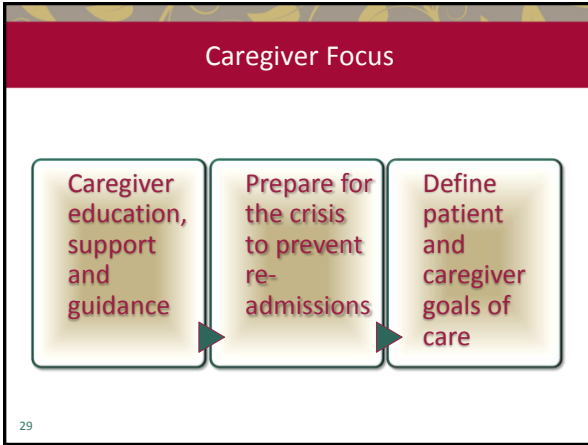
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Medications

Continue to utilize cardiac medications that are beneficial for symptom management

- Cardiac comfort pak (Lasix, nitroglycerin, ASA, morphine)

28



Palliative Care Saves Money and Improves End of Life Experience

Patients assigned to in-home Palliative Care were more satisfied with care

93% were very satisfied after 90 days	20% were more likely to die at home than the patients receiving usual care	13% were less likely to go to the ER or be admitted to the hospital than usual care patients	33% lower costs than patients with standard care
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33 ¹ Increasing Satisfaction with Care and Lower Costs: Results of a Randomized Trial of In-Home Palliative Care JAGS, The American Geriatrics Society, 2007

Help patients understand their options

Physicians have a lot of power in influencing the elderly population

Most patients don't have all the facts about hospice and palliative care

They count on their doctors to tell them

It is important that physicians take ownership in discussing end of life options

34

Create a plan for your patients

Have EOL conversations with your patients or partner with someone who can help you have these conversations

Advanced care planning
(Living Will, HCPOA, DNR)

Learn to Identify patients who meet EOL criteria

Utilize programs that can work with you to meet the needs of your patients

35

Thank You

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