Palliative Care, Hospice, and Heart Failure Readmissions

Seasons Hospice & Palliative Care
Presented by:
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Objectives

Describe the difference between palliative and hospice care in the treatment of advanced heart failure.

Describe the goals for care for each phase of the heart failure disease trajectory.

Describe the role of palliative care and hospice in reducing HF readmissions
Heart Failure Statistics

5.7 million people have heart failure

280,000 deaths (1 in 9) in 2008.

About 50% of people who have heart failure die within 5 years of diagnosis.

Costs the nation $34.4 billion / year

Cost of hospitalization was higher when heart failure was the secondary diagnosis rather than the primary diagnosis ($25,325 versus $17,654).

National 30 day readmission rates: 24.7%


Go A S et al. Circulation 2013;127:e6-e245

American Heart Association
Learn and Live
Paradigm for Heart Failure End of Life

**Heart Failure End of Life Care**
- Symptom Management
- Improved Functional Ability
- Improved Quality of Life
- Decrease Hospitalizations

**Optimize Medical Management**
- ACE/ARB
- Diuretic
- B-Blocker
- Digoxin
- Aldosterone Antagonist

**Surgical – Research Options**
- Transplant
- VAD
- PM/CRT/CRT-D
- Implantable monitoring devices
- Stem Cell

**Home Health / Hospice for HF EOL Management**
- Aggressive Symptom Management / Continuing Heart Failure Medications
- Medical Power of Attorney / Living Will / In home DNR
- Continuous Intravenous Inotropic & Vasodialatory Agents
  - Milrinone
  - Dobutamine
  - Dopamine
  - IV Diuretics
PALLIATIVE CARE

- Aflirs life
- Promotes quality of life
- Treats the person
- Supports the family

HOSPICE
**Palliative Care: What is IT??**

*Active Process* involving patients / family whose disease is not responsive to curative treatment, including:

- Heart failure education
- Aggressive symptom management
- Comorbiditiy management
- Spiritual assessment
- Social and financial assessment and referrals
- Psychological assessment and treatment

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Goodlin, S.J. et al (2004), Consensus Statement: Palliative and Supportive Care in Advanced Heart Failure. *J. Card. Failure. 3* (10), 204
When does Palliative Care begin in Heart Failure?

a. NYHA Class III-IV / ACC AHA Stage C/D
b. Upon initial diagnosis and evaluation
c. Palliative care has no place in HF management
d. At end of life right before hospice referral
Prognosis and the Heart Failure Disease Trajectory

**Cancer**

**Predictable Course**
- Longer functional abilities before downward slide
- Average lifespan of 6 months after begin to decline
- Where referrals to Hospice usually occur

**Heart Failure**

**Less Predictable**
- Loss of functional abilities at onset of diagnosis
- Slower decline with repeated hospitalizations
- Pump failure vs sudden death
Hospice Care

What is It??

**Passive Process** that provides comfort and support to patients/families when a life-limiting illness no longer responds to curative treatments, including:

- Improving quality of last days
- Patient/family bereavement spirit counseling for family
- Symptom management with emphasis on pain and discomfort
- Deals with emotional social spiritual impact of disease
Phases and Goals for Care

Chronic disease care

Supportive and palliative care

Terminal care / Hospice
Advanced Symptom Management

Fatigue: Anemia
     Sleep disordered breathing
Dyspnea
Edema
Cardiac pain
Anorexia/ cachexia
Anxiety / Agitation / Confusion
Depression
Palliative Care Trajectory

Chronic Disease Management

Begins at HF diagnosis
NYHA Class I-III

GOALS:
Extend life
Symptom recognition
Symptom management
Promote self management
Supportive and Palliative Care Phase

GOALS:

- Alleviation of physical discomfort
- Assess emotional and spiritual support systems and support with available resources
- Ensure quality of life
Terminal Care Phase  HOSPICE

Class III B/IV  
Stage D  

GOALS:
Symptom management including IV diuretics and inotropes
Assess goals for care to ensure for quality of life
Assess emotional, spiritual, and social support system and intervene.
Terminal Care Phase  HOSPICE

GOALS of CARE Discussion

Is the patient / family finished with repeat hospitalizations??
Life support?
ICD / LVAD/ Transplant?
Discontinuation of medications
Prevent ethical dilemmas
Re-hospitalization may be the most powerful example of the cost of fragmented, provider-centered care....a successful campaign to reduce re-hospitalization will also make care more patient-centered”

Stephen Jencks, MD
Heart Failure Readmission
A Significant Issue

- Costs
- CMS penalties
- Preventable
- Operational issues
- Healthcare system variation
CMS Readmissions Performance

Hospitals are facing stiff penalties if readmissions for
- heart attack AMI
- heart failure
- pneumonia

Performance measures: two domains (2013)
- clinical process of care
- patient experiences of care
National Hospice Organization (NHO) Heart Failure Criteria

Terminal stage: life expectancy <6 mos
Guideline medication optimization
Not a candidate for
MCS (Mechanical Circulatory Support) Heart Transplant
NYHA Class IV Stage D
EF of ≤20%, but is not required
  Systolic vs Diastolic
Treatment resistant arrhythmias
H/O: cardiac arrest
  unexplained syncope
  brain embolism
HIV disease
Barriers to Hospice Care for Advanced Heart Failure

ACC/AHA / HFSA Guidelines for EOL management including:
- IV inotropes
- IV diuretics
- ICD / LVAD Deactivation
- Continuing Guideline Based Medical Therapy

Financial barriers / low reimbursement rate

Lack of staff knowledge and expertise

Cardio-renal syndrome requiring dialysis

HOSPICE PROGS: Paint the Picture

Old Age
Hypotension
Hemoglobin <10g/dl
Serum Sodium <136 mEq/L
Serum Creatinine >2.0/ elevated BUN
History of unexplained syncope
Repeated (≥2) hospitalizations or ED visits
History of cardiac arrest or resuscitation
Weight loss (e.g., cardiac cachexia)
Intolerance to HF guideline medications

Adapted from Russell et al. Congest Heart Fail. 2008;14:316-21.
Brain embolism of cardiac origin
Frequent persistent systolic blood pressure <90 mm Hg
Persistent dyspnea with dressing or bathing
Inability to walk 1 block on the level ground
Recent need to escalate diuretics to maintain volume status
Progressive decline in serum sodium, usually to <133 mEq/L
Frequent ICD shocks

Adapted from Russell et al. Congest Heart Fail. 2008;14:316-21.
HOSPICE READMISSION REDUCTION STRATEGIES

MEDICATIONS
- Delivered to the Home
- Medication Reconciliation Reviewed
- Medication Education & Down Titration
- GBMT IV Inotropes IV Diuretics

SYMPTOMS
- Oxygen for ALL
- Cardiac Emergency Kit
- IV Lasix
- Emergency Management Protocol Prevent 911 Calls
- Daily Weights with Immediate Intervention

POOR FOLLOW-UP
- RN visit up to 7 Days/week
- 24 HR Symptom Management
- NP/MD Home Visits
- Cardiologist Can Remain Attending

PSYCHOSOCIAL
- End of Life Planning
- DNR Status/ICD Termination
- Address Social Isolation
- Spiritual & Religious Concerns
WHERE DOES THE APN/RN FIT IN?
HF Transitions: CHRONIC DISEASE
OP Palliative Care APN / RN

1. Heart Failure physical assessment including hemodynamic, rhythm, and perfusion status
2. Symptom management including PO diuretic combinations, IV diuretics, guideline medication titration, inotropes
3. Review and evaluate effectiveness of current medication regimen with goals of care
4. Verification of referrals to MD, HH
5. Make referrals to hospice in collaboration with MD
6. Patient / family communication and support regarding prognosis and disease process
7. Patient and family spiritual and social evaluation and support
HF Transitions: END OF LIFE
HF Hospice APN / RN

1. Heart Failure physical assessment including hemodynamic, rhythm, and perfusion status
2. Symptom management including PO diuretic combinations, IV diuretics, guideline medication titration, inotropes.
3. ICD deactivation and support to patient and family
3. Review and evaluate effectiveness of current medication regimen with goals of care
4. Patient and family communication and support regarding prognosis, end of life symptom management
5. Patient / family spiritual and social evaluation and support
6. Communication with referring MD / Card / PCP
HOSPICE

- Timing
- Legalities
- Consult

Logistics
Ethics
Pain
Case Study

DC 86 yo WF ICMP (dx 2004), EF <20% CRTD 2009, afib, chronic angina, HTN, T2DM, rheumatoid arthritis, chronic pain, hyperlipidemia, hypothyroidism, poor functional capacity seen in clinic for shortness of breath at rest and chest discomfort

Goals of care:

1. To breathe better and feel better
2. To have better communication with her health care providers.
Case Study

DC 87 YO WF referred to PC NP for house calls. Home health and PC NP co-manage

- VS: 150/84; 71; 24; SaO₂ 96% (2L NC); 189lbs
- Chronically ill looking, lying in bed in living room
Case Study

- Neck: +JVD to mid neck
- Cardiac: irregular RR, soft sys.apical murmur
- Lungs: Diminished BS in bases bilaterally
- Abdomen: Large, soft, +HJR
- Extremities: Limited ROM, 2+ pitting edema mid calf bilaterally
Case Study
A/P
1. ESAS symptom assessment
2. ICMP Class IV Stage D volume overload
3. Pain
4. Anxiety
5. Constipation
6. Depression
7. Communication / Emotional / Spiritual
8. Refer to hospice
Case Study
87 YO WF Class IV Stage D HF end of life with multiple comorbidities

- Hospice CM communicates with patient/family about CRT-D deactivation
- Hospice CM facilitates CRT-D deactivation in home
- DC passes away at home with family
Recommendations for Future HF Palliative Care / Hospice Research

Bridging heart failure outpatient palliative care to hospice and home health services

Interdisciplinary supportive care for family caregiver

Communication between healthcare provider and patient /family
  - advanced care planning
  - honest communication about prognosis

Goodlin, S.J. et al. Consensus Statement: Palliative and Supportive Care in Advanced Heart Failure. J. Card. Failure. 3 (10), 204
THANK YOU!

HOME
Aggressive Symptom Management
Palliative and Hospice Care

HOSPITAL
Readmissions

End of Life
Heart Failure Patient