Early Palliative Care in Advanced Heart Failure

Karen Lock, Wendy Cheung, Susan Woollard, Dr. Daphna Grossman, Dr. Nina Horvath, Dr. Dorothy Sullivan, Dr. Karen Weisz, Dr. Richard James, Collene Traille-Brown, Karen Jingwei Yu, Archna Patel, Shana Haberman, Janet Coldwell, Dr. Daryl Roitman, Dr. Warren Lewin

NORTH YORK GENERAL
Making a World of Difference

BACKGROUND

- Heart failure (HF) is a chronic, life-limiting illness which progressively impacts overall health status, functional ability and quality of life.
- HF affects more than 600,000 Canadians and is the number one reason for hospitalization in Canada (Heart & Stroke Foundation, 2016).
- Prolonged survival is often correlated with increased symptom burden, compromised quality of life and increased care needs.
- Most patients do not receive comprehensive palliative care until the last few days to weeks of life. It is believed that only 16-30% of Canadians who could benefit from palliative care actually receive it (Lysyk, 2014) .
- It is important to start goals of care and advance care planning conversations early due to the unpredictable disease trajectory and varied progression of HF.

PROGRAM DESCRIPTION

- North York General Hospital believes "***patients come first in everything we do".***
- In July 2014, the Departments of Cardiology and Palliative Care collaboratively established the **Supportive Cardiology Program**, an inter-professional model to address the palliative care needs of patients with advanced HF.
- The team serves HF patients in the clinic and on the inpatient units.
- The program started as a 1-year pilot project funded by the Ministry of Health and Long-Term Care in Ontario, Canada.
- The program has evolved over the past year to include patients with other chronic progressive diseases and has been renamed the **Supportive Care Program** .

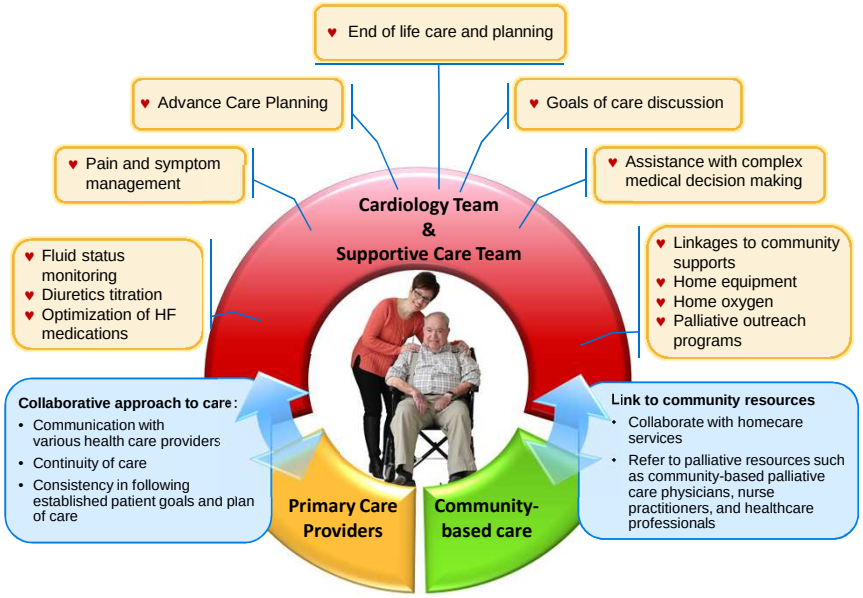
Program Objectives

- Identify patient's goals of care
- Facilitate advance care planning
- Optimize symptom management
- Connect patient/family to community resources, including home-based palliative care
- Provide quality end-of-life care

Program Goals

- Increase advance care planning and identification of goals of care
- Decrease Emergency Department visits
- Reduce recurrent hospitalization
- Increase staff, patient, and family satisfaction

New Model of Care: An Integrated Approach to Palliative Care for Patients with Advanced Heart Failure



SUPPORTIVE CARDIOLOGY REFERRAL CRITERIA

- ☑ I would not be surprised if my patient died from their HF within the next year
- ☑ Patient or family has requested palliative care / supportive cardiology
- ☑ End-stage HF characterized by **1+2+3,** and at least one of either a or b:

1. Greater than 1 hospital admission for HF in prior 6 months
2. 1+ emergency department visit within prior 6 months
3. NYHA Class III/IV HF symptoms

AND

a) Co-morbidity – CRF, DM, Cancer, HIV, CVA, IPF, O2 dependent COPD

or

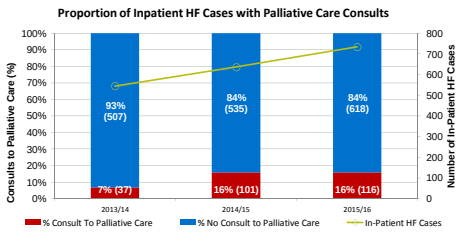
b) Previous ICU admission or CPR within past year

FEEDBACK

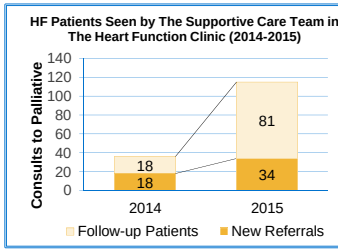
"I quickly learned that the Supportive Cardiology Team was going to be my family's partner in navigating the health supports available to help mitigate readmission and more importantly, maintain quality of life." – B.A. (Family Member)

"As our patients age and develop multiple morbidities, we realize that cardiologists alone cannot deal with end-of-life and symptom management. Our Supportive Cardiology Clinic team has become invaluable in managing these patients and reassuring their families. It's my belief that they are an essential limb of any Heart Function Clinic."—Dr. J. (Cardiologist)

IMPACT OF SUPPORTIVE CARDIOLOGY

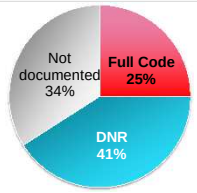


Since the launch of the Supportive Cardiology Program, the number of inpatient palliative care consults for all admitted HF patients has increased by 130%.

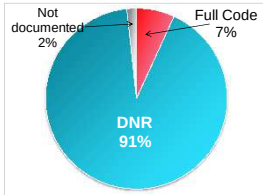


The number of out-patients from the Heart Function Clinic seen by the Supportive Cardiology Team has increased 3-folds from 2014 to 2015.

Code Status Documentation Pre and Post Supportive Cardiology Consultation for Patients with Advanced Heart Failure



Code Status Prior to Consult



Code Status After Consult

- Documented DNR status increased from 41% to 91% after Supportive Cardiology consult
- Request for Full Code decreased from 25% to 7%.
- Undocumented Code Status decreased from 34% to 2%.

Sample Size: 59 consecutive patients referred for Supportive Cardiology consult between July 2014 to February 2015.

SUMMARY

The integration of a collaborative model of care between Cardiology and Palliative Care in the management of patients with advanced heart failure has resulted in many positive outcomes. There has been an increased number of goals of care and advance care planning discussions. There has been positive feedback from patients and their families as well as from the cardiology team.

Since the inception of the program, there has been an almost 130% increase in Supportive Cardiology referrals between 2013 and 2015. Review of current data confirms that the increase of referrals have been sustained. This may demonstrate a better understanding of Supportive Cardiology which has facilitated a culture change regarding the role of palliative care in the management of heart failure.

Due to the success of Supportive Cardiology, the organization is in the process of adopting this model of care for patients with other chronic progressive diseases such as Chronic Obstructive Pulmonary Disease (COPD) and dementia. Consequently the Supportive Cardiology Program has now been renamed the Supportive Care Program.

Future Direction

- To measure impact of Supportive Care Program on emergency department visits and hospitalizations
- To measure cost saving as a result of the integration of Supportive Care
- To assess the impact of Supportive Care on patients with chronic progressive lung diseases such as COPD
- To integrate Supportive Care with Geriatrics to support the very frail elderly patients and patients with advanced dementia.

REFERENCES

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