

## Background

Heart failure (HF) is a chronic progressive disease with high symptom burden, frequent rehospitalizations, and high mortality.

- Dyspnea, anxiety, depression, pain are common symptoms
- Mortality within 5 years of diagnosis as high as 54%



\$23,077 on average per hospitalization

Palliative care (PC) can improve symptom burden, quality of life and lower cost

- Outpatient PC could address the needs of non-hospitalized HF patients, but is not well studied
  - Uncertainty of timing is one barrier to palliative referral
    - Use of a screening tool could help standardize the process of referral by providing data on patient symptoms
- Kansas City Cardiomyopathy Questionnaire*
- Reliability 0.94 (Cronbach's alpha)
  - Lower score indicates worsening disease status

## Clinical Question

In adult patients with a diagnosis of heart failure, does use of the KCCQ increase total referrals to outpatient palliative care by 25% over a 12-week timeframe?

**Palliative Care:** "specialized medical care focused on providing patients with relief from the symptoms and stress of a serious illness" (Meier & Bowman, 2017)



## Methods

- Outpatient clinic situated in near proximity to a large, suburban Atlanta hospital.
- Heart failure and palliative clinic share space
  - Palliative clinic open 2 days per week

### Recruitment and Consent

Convenience sample  
First-time or hospital f/u  
N = 21

### Participation

KCCQ-12  
Participation complete after self-administration

### Clinic Visit

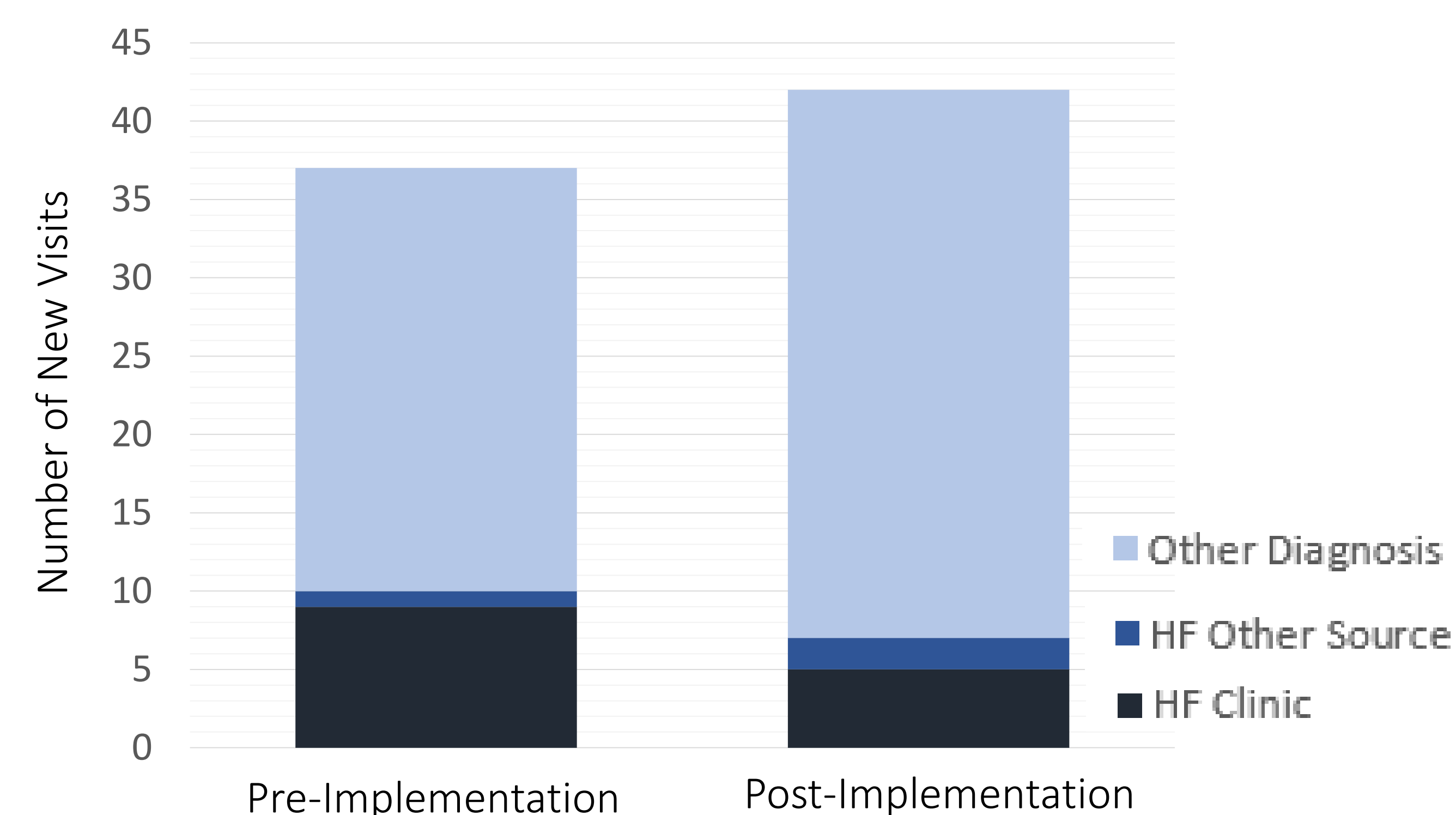
Followed protocol  
NPs and MDs excluded

### Data Collection and Analysis

Compared pre- and post-implementation  
Did not include KCCQ score

## Results

Palliative Clinic New Patient Visits



- Avg age = 60 years
- Range 35 – 85 years
- 13 men, 8 women
- No participant received a PC referral
- New patient visits reported because no-show referrals fell off clinic schedule

## Discussion

- Total referrals unknown due to no-shows
- 25% goal not achieved
- Increase in PC visits for other diagnoses – perhaps more referrals from other specialties or inpatient
- Uncertainty of timing remains a barrier

## LIMITATIONS

- Nature of HF clinic visit a barrier – patients see RN, SW, pharmacist, NP or MD
- Less time for discussion, patient-provider relationship not established
- Excluded cognitive impairment or dementia

## IMPLICATIONS

- Retrospective review of referral origin may provide more insight
- Examination of established patients including HF stage could highlight referral circumstances
- PC clinic design should consider both evidence and innovation
- Continued education and culture change necessary

## Selected References

Meier, D. E., & Bowman, B. (2017). The changing landscape of palliative care. *Journal of the American Society on Aging*, 41(1), 74–80.

Mizuno, A., Miyashita, M., Hayashi, A., Kawai, F., Niwa, K., Utsunomiya, T., ... Anzai, T. (2017). Potential palliative care quality indicators in heart disease patients: A review of the literature. *Journal of Cardiology*, 70, 335–341. doi: <https://doi.org/http://dx.doi.org/10.1016/j.jcc.2017.02.010>

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