Interdisciplinary Palliative Care for Heart Transplant: A Collaborative Model

Institution Name: Atrium Health **| Location:** Charlotte, NC **| Contact Information:** Terri Long, NP

Presenters: Terri Long, NP; Boris Krivitsky, DO; Dulce Mange, LCSW; Carolyn Collins, RN; Nicole Rogers, LPN

Project Description:

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Objective: Standardizing collaboration between cardiac transplant and palliative care teams to provide early access to specialist palliative care to improve care for patients and families undergoing cardiac transplant.

Background: It is currently estimated that 5.7 million Americans live with heart failure (Heart failure fact sheet). Approximately 3,800 patients are awaiting cardiac transplantation in the United States according to the Organ Procurement and Transplant Network (OPTN). Transplant patients frequently experience significant emotional and physical symptoms that are not always addressed or recognized. Our collaboration with the heart failure team began in 2013, and in 2015, palliative care was integrated and embedded within the heart failure/heart transplant center. As we received an increased number of post-transplant referrals for complex physical and emotional symptoms (including adjustment disorder, anxiety, insomnia, and opioid weaning), the heart failure and heart transplant teams recognized the value of early palliative interventions and screening. We now provide an integrated palliative care model for all patients undergoing heart transplant evaluation and/or being considered for mechanical circulatory support.

Intervention Methods:

- All patients considered for total artificial heart (TAH), left ventricular assist device (LVAD) implantation and cardiac transplant are referred to our interdisciplinary palliative care team embedded within the heart failure transplant clinic.
- A Licensed Clinical Social Worker (LCSW) performs an assessment and evaluation for emotional and psychological coping/adjustment, and screening patients for psychotherapy needs both pre- and post-surgery.
- Caregiver fatigue assessment, support and self-care counseling.
- Nurses provide advance care planning education and completion of advance directives. In addition, they provide telephonic support and serve as liaisons/navigators for the inpatient and outpatient settings.
- A palliative care physician and nurse practitioner perform assessment needs for spiritual support and complex symptom management. They also care discussions regarding quality of life determinants, education on associated risks and benefits of surgery.
- Coordinating the transition of care between inpatient and outpatient palliative care teams.
- Close collaboration and communication with all members of the transplant team including monthly rounding.
- Longitudinal care is provided for continued assessment of physical and emotional symptoms pre- and post-transplant.

Summary:

Patients benefit from an interdisciplinary palliative care referral as part of their transplant evaluation process. This collaborative model normalizes palliative care involvement in patients with advanced cardiac illness and places greater focus on improved quality of life. It also allows for mental health screening as well as psychotherapy provided by a palliative LCSW, which leads to improved coping and adjustment pre- and post-surgical intervention.

Heart Failure Fact Sheet|Data & Statistics|DHDSP|CDC. (n. d.). Retrieved from https://www. cdc. gov/dhdsp/data_statistics/fact_sheets/fs_heart_failure. Htm

Organ Procurement and Transplantation Network. (n. d.). Retrieved from https://optn. transplant. hrsa. gov/data/view-data-reports/national-data/#