Congestive Heart Success (Not Failure): A Collaborative Consultation Triggers Project

Wellstar Kennestone Palliative Medicine Department, Marietta, GA
Vaidehi Ambai, DO., Anjali Grandhige, MD.

Introduction

Congestive heart failure (CHF) patients experience high symptom burden throughout their lives. Recurrent exacerbations and associated admissions often herald advancing disease, but because treatment of CHF is so effective, heart failure teams often do not consider palliative medicine involvement early in the course. Not just reserved for end of life care, palliative medicine focuses on mitigating symptoms, educating regarding disease trajectory, and improving overall quality of life. The burdens of CHF are not just physical, but the cost of recurrent admissions, both financially, at almost one third of Medicare expenditures, and emotionally weigh heavily on patients and caregivers. Palliative medicine consults can help empower patients to dictate their goals of care and seek alternative pathways outside of hospitalization.

Palliative care consultation impacts various inpatient quality metrics including length of stay, readmission rate, and inpatient mortality. With inpatient palliative medicine programs, timing of palliative medicine consultation varies and is largely provider specific without a consistent timeframe, often prompted when patients are imminently nearing end of life. This quality improvement project was developed in collaboration with heart failure specialist physicians and clinical nurse specialists and aims to have proactive nurse driven palliative care consult prompt on multidisciplinary rounds based on agreed upon disease specific criteria with a goal of initiating a palliative care consult within 48 hours of admission for patients meeting that consult criteria.

Objectives

- Identify Appropriate Triggers to Palliative Medicine Consult
- Standardize timing of Palliative consult from time of admission
- Observe trends in readmission rates and inpatient mortality rates

Methodology

Using electronic health record data via EPIC, this project prospectively evaluates the impact of congestive heart failure specific palliative care consult triggers on 90-day readmission rates. Additional metrics included inpatient mortality, honoring of code status, and advance directive completion. This study is a single center prospective study in a community based acute inpatient setting on one heart failure unit. Patients admitted with EF< 30% with one or more hospitalizations in the past 6 months were prompted for an inpatient palliative medicine consult within 48 hours of admission. This is an ongoing project and has been an interdisciplinary team effort, initiated by nursing staff and discussed during team-based rounds with social work and physician team members

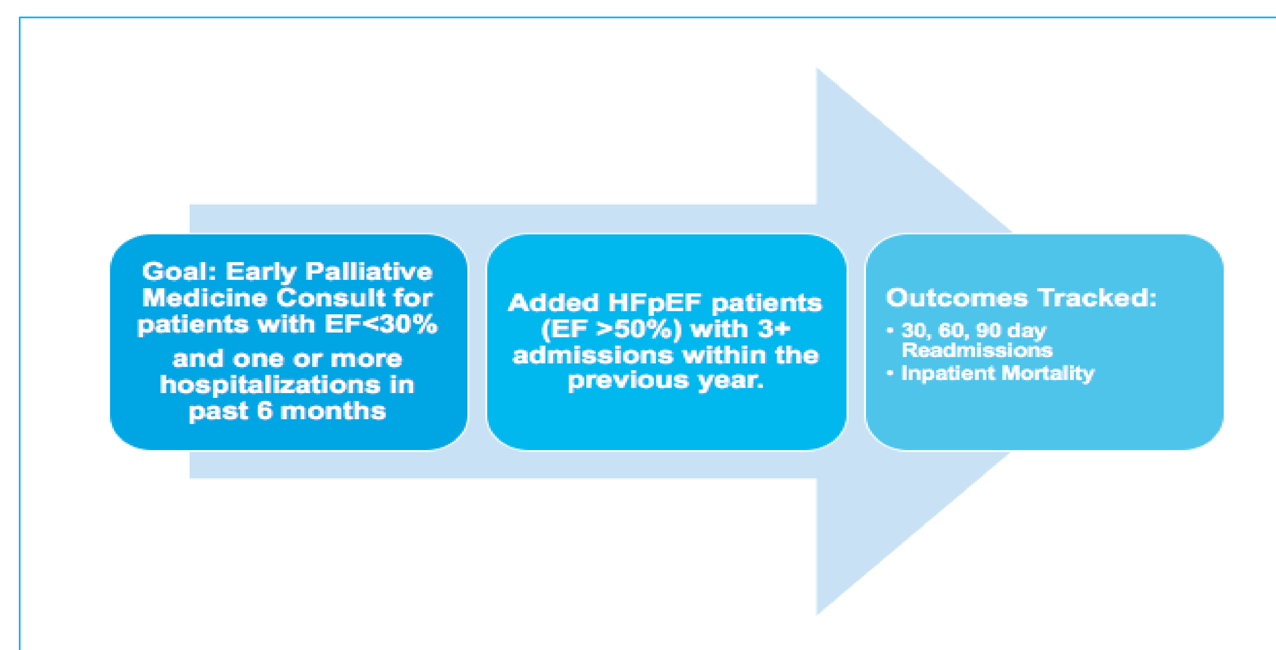

Figure 1

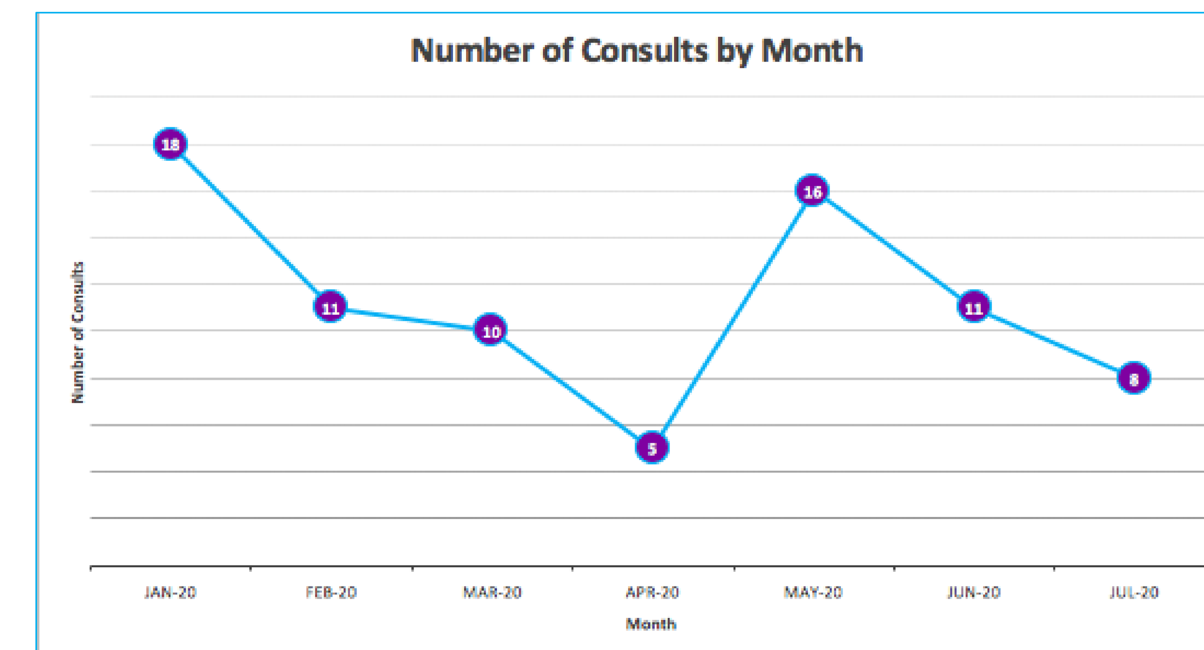

Figure 2

Results

There was a total of 79 unique patients Analysis of the data suggests that out of 79 patients since January 2020, 39% have died. Of these 31 deaths, only 16% died in hospital; 38% of these patients enrolled in hospice; 10 are still alive on hospice as of most recent analysis (9/20/2020). Readmission rates for 30, 60, 90 days after the consult were tracked and then compared to the readmissions in the year prior. This showed that there was a significant decrease ($p = 0.00023$, significant at $p<0.5$) of the sum of these admits over 90 days in comparison to the sum of readmissions in the year prior.

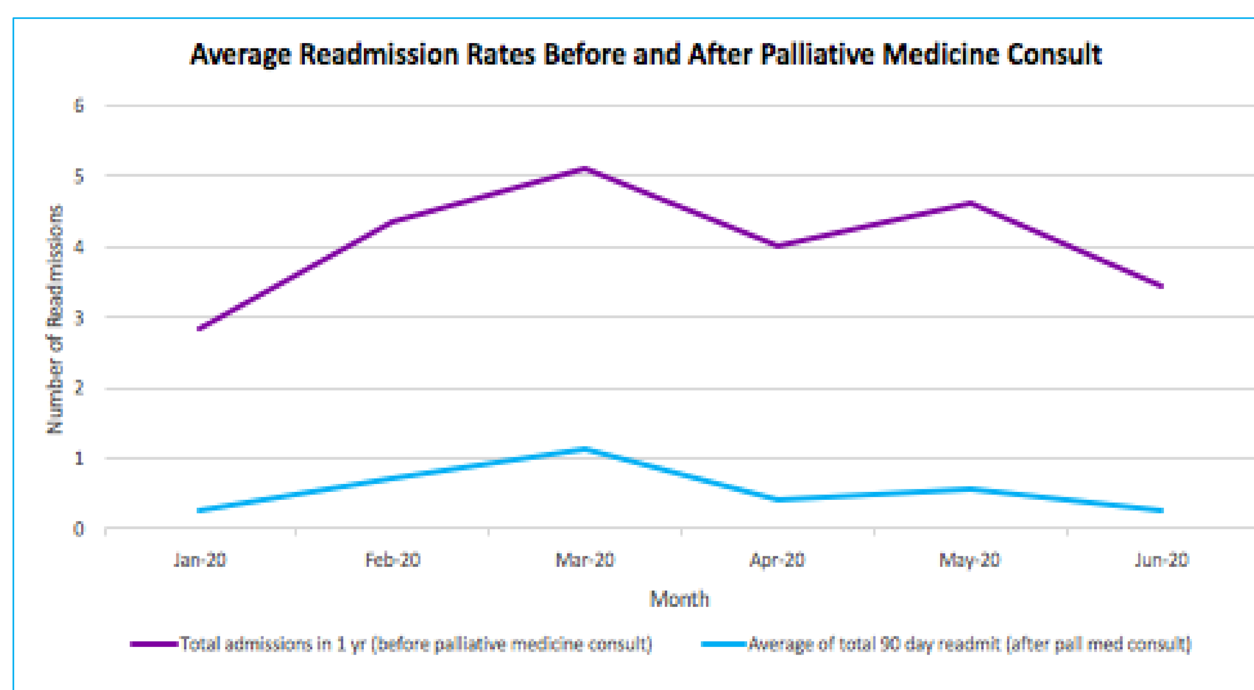

Figure 3

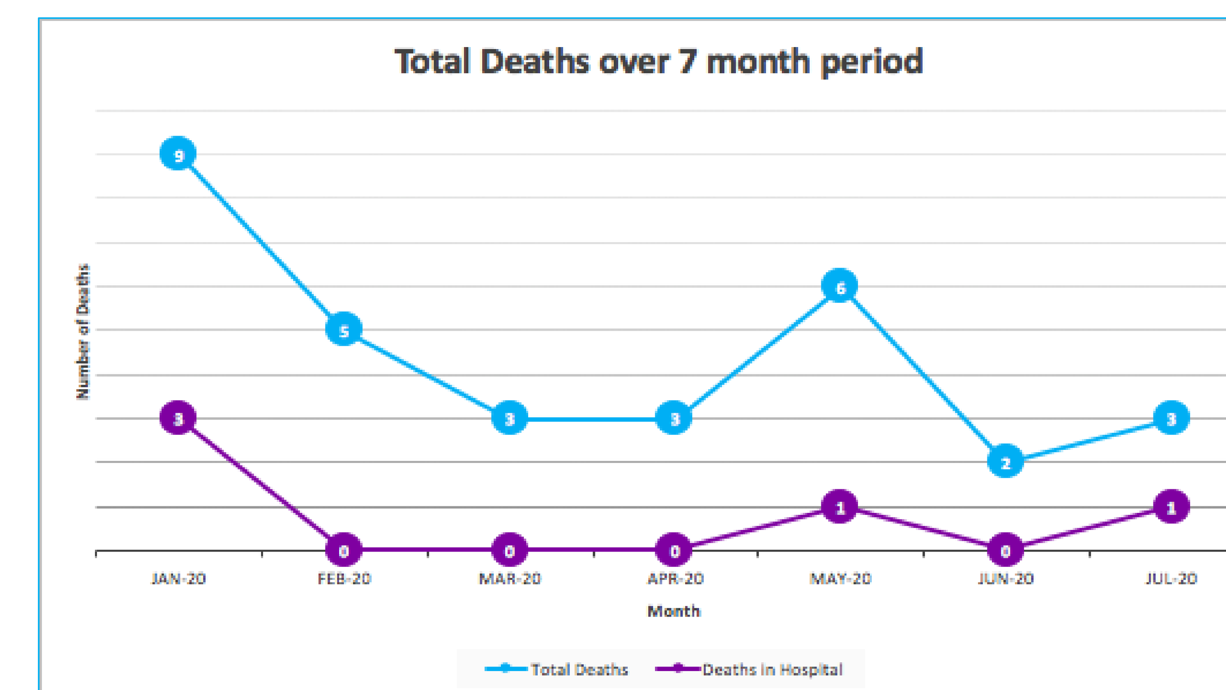

Figure 4

Discussion

The results of this project demonstrated that early palliative medicine consults can help facilitate conversations about goals of care so that patient treatment preferences are honored. This resulted in earlier hospice utilization, diminished burden of 90-day readmissions and reduced inpatient mortality.

As most patients prefer to experience end of life at home, having these conversations earlier in the disease course helped to ensure these wishes were honored.

Furthermore, by collaborating with a multidisciplinary team of nurses, CHF specialists and palliative care specialists, we demonstrated the value of integrating palliative care with standard heart failure management, consistent with specialty guidelines.

References

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