Caring Hearts: Supportive Medicine for Advanced Heart Failure

SANDRA REAGAN, APRN
UK PALLIATIVE CARE
ABIGAIL LATIMER, PHD, MSW, LCSW, APHSW-C
ASSISTANT PROFESSOR
COLLEGE OF NURSING

Disclosures

NONE

OBJECTIVES

- UNDERSTAND THE DIFFERENCES BETWEEN HOSPICE AND PRIMARY VS SPECIALTY PALLIATIVE
- DEFINE THE ROLE OF PALLIATIVE CARE IN ADVANCED HEART FAILURE
- DISCUSS THE BENEFITS OF PALLIATIVE CARE FOR PATIENTS WITH ADVANCED HEART FAILURE
- IDENTIFY OPPORTUNITIES TO PROVIDE PRIMARY PALLIATIVE CARE IN ADVANCED HEART FAILURE

DEFINING PALLIATIVE CARE

- PALLIATIVE CARE (PLC) IS SPECIALIZED MEDICAL CARE FOR PEOPLE LIVING WITH A SERIOUS ILLNESS (CAPC, 2023)
- FOCUSED ON PROVIDING RELIEF FROM SYMPTOMS AND STRESS OF ILLNESS
- GOAL IS TO IMPROVE THE QUALITY OF LIFE FOR BOTH THE PATIENT AND THE FAMILY
- DELIVERED ALONGSIDE LIFE-PROLONGING TREATMENTS

BARRIERS TO INTEGRATION

- MISPERCEPTION OF SPECIALIST PALLIATIVE CARE
- LACK OF CONSENSUS FOR INTEGRATION
- UNPREDICTABLE DISEASE TRAJECTORY
- VARIABLE ACCESSIBILITY TO SERVICES

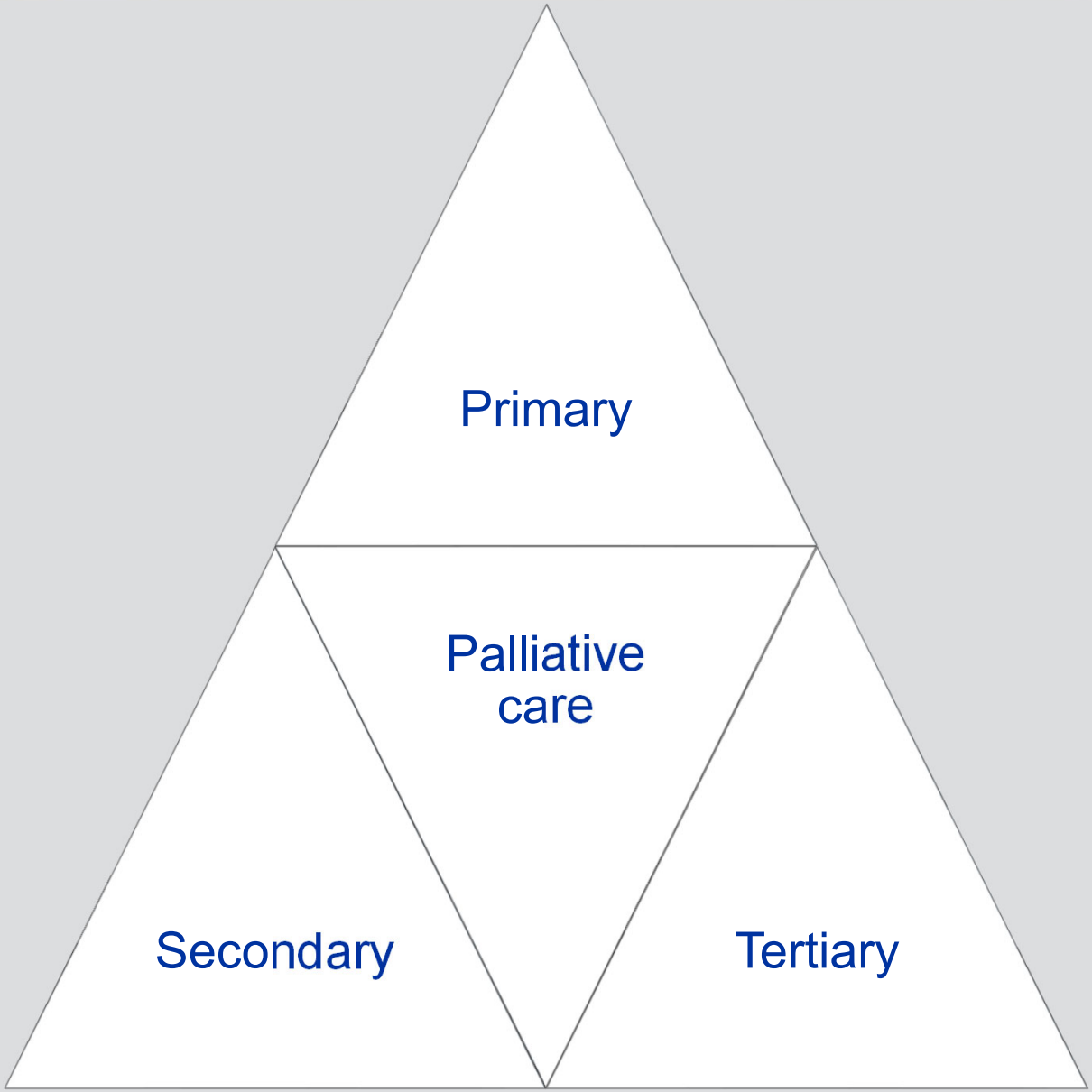
IS PALLIATIVE CARE HOSPICE?

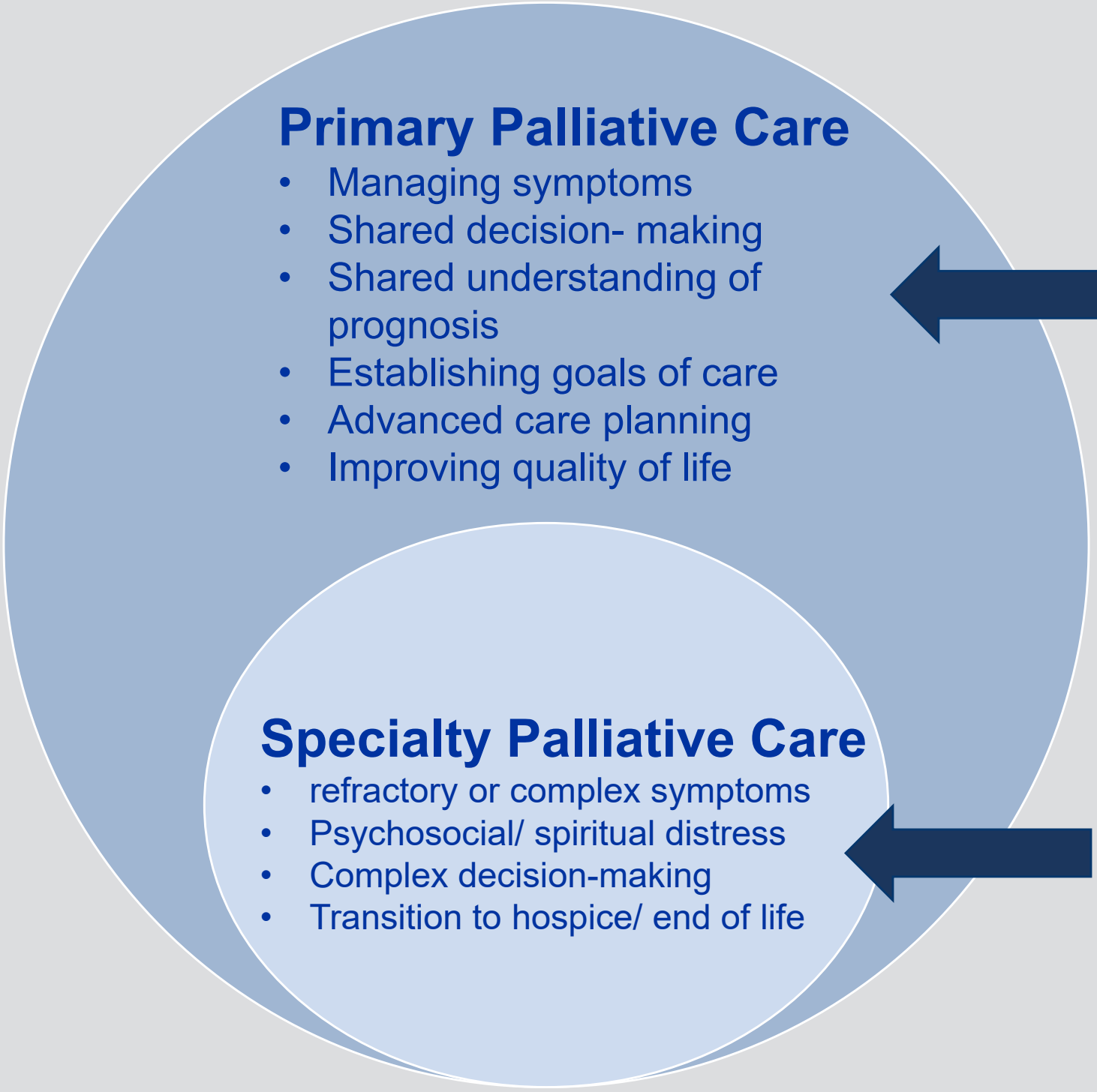
CLINICAL GUIDELINES RECOMMENDING PALLIATIVE CARE INTEGRATION

- AMERICAN COLLEGE OF CARDIOLOGY
- AMERICAN HEART ASSOCIATION
- INTERNATIONAL SOCIETY FOR HEART AND LUNG TRANSPLANTATION
- HEART RHYTHM SOCIETY
- HEART FAILURE SOCIETY OF AMERICA
- JOINT COMMISSION (DT LVAD)
- CENTERS FOR MEDICARE AND MEDICAID (DT LVAD)

J AM COLL CARDIOL. 2017 OCT 10;70(15):1919-1930.

LEVELS OF PALLIATIVE CARE





HF Cardiologist
Social Worker
Nurse
Chaplain
Cardiac Surgeon

Palliative Team

Image adapted from Blume et al., 2023

KEY ELEMENTS OF PALLIATIVE INTEGRATION

SINGH ET AL (2023) SCOPING REVIEW

PATIENT CENTERED CARE

- Shared-decision making
- Future care planning
- Addressing physical/ psychological symptoms

TIMING AND SPECIALIST REFERRAL

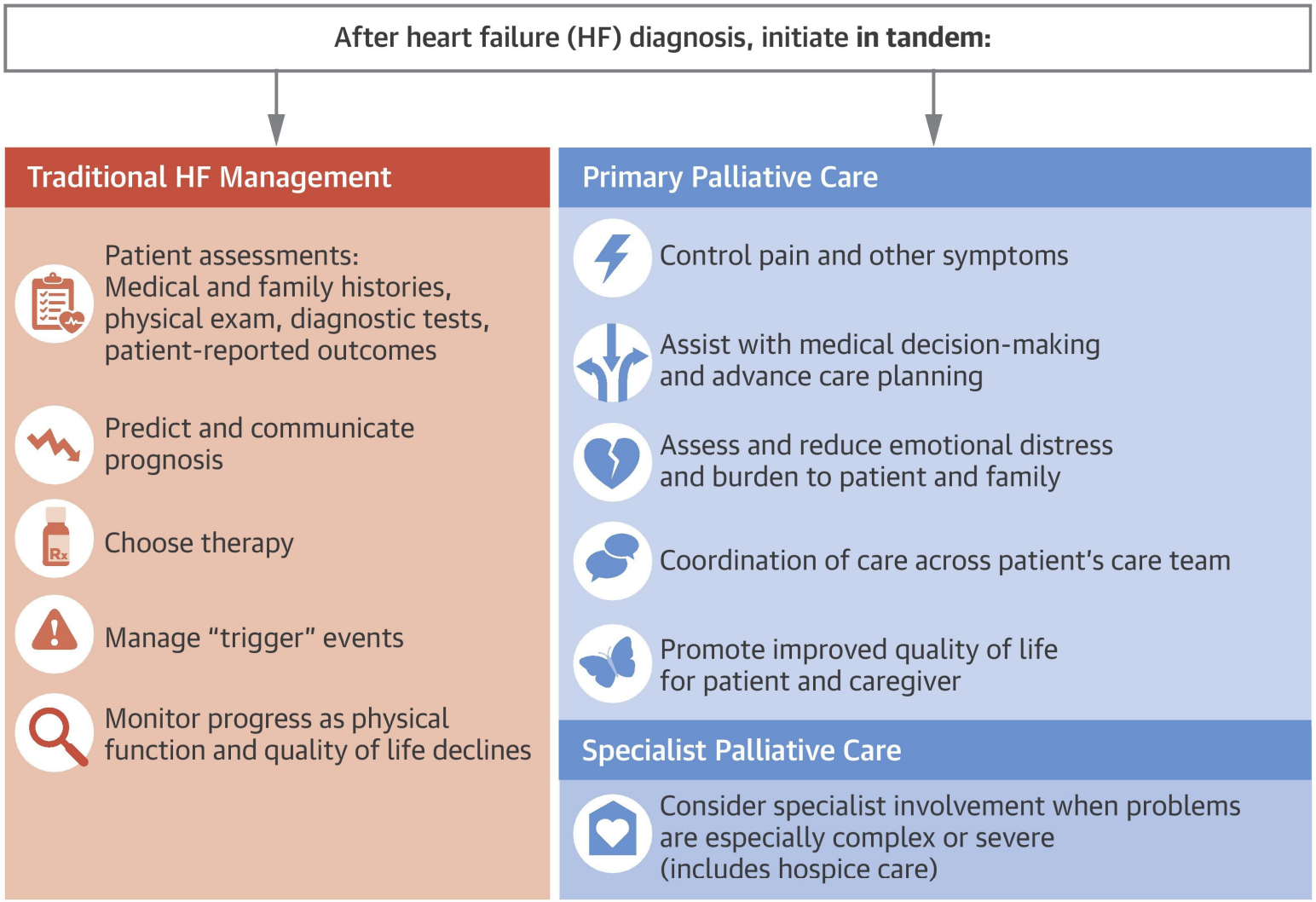
- Points of integration (at diagnosis, throughout, triggers)
- Precision palliative care

PALLIATIVE CHAMPION

MULTIDISCIPLINARY TEAM- BASED APPROACH

ACROSS SETTINGS

CENTRAL ILLUSTRATION: Integrating Palliative Care Across the HF Experience

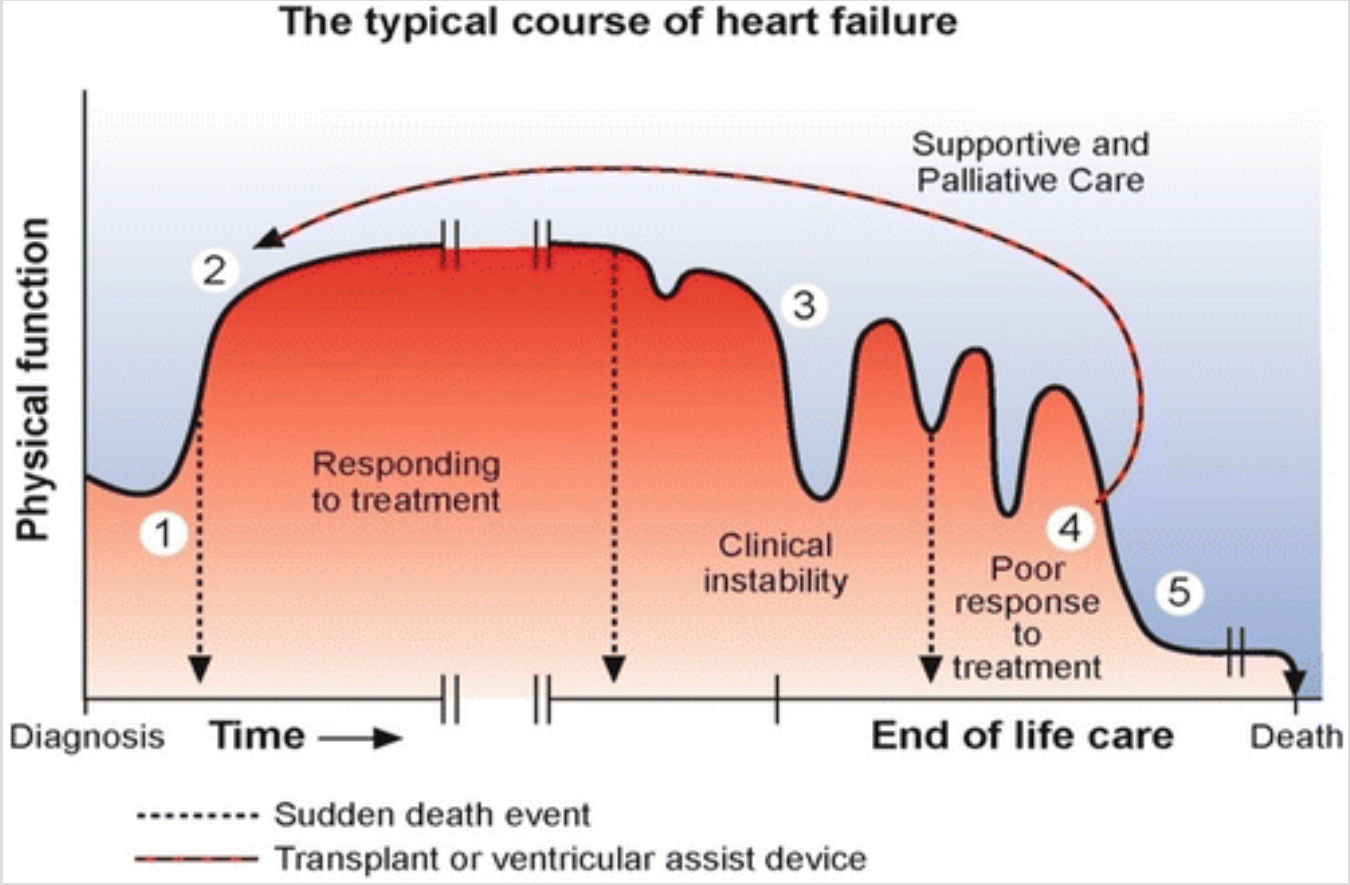


Kavalieratos, D. et al. J Am Coll Cardiol. 2017;70(15):1919-30.

ON THE TRAJECTORY: POINTS OF INTEGRATION

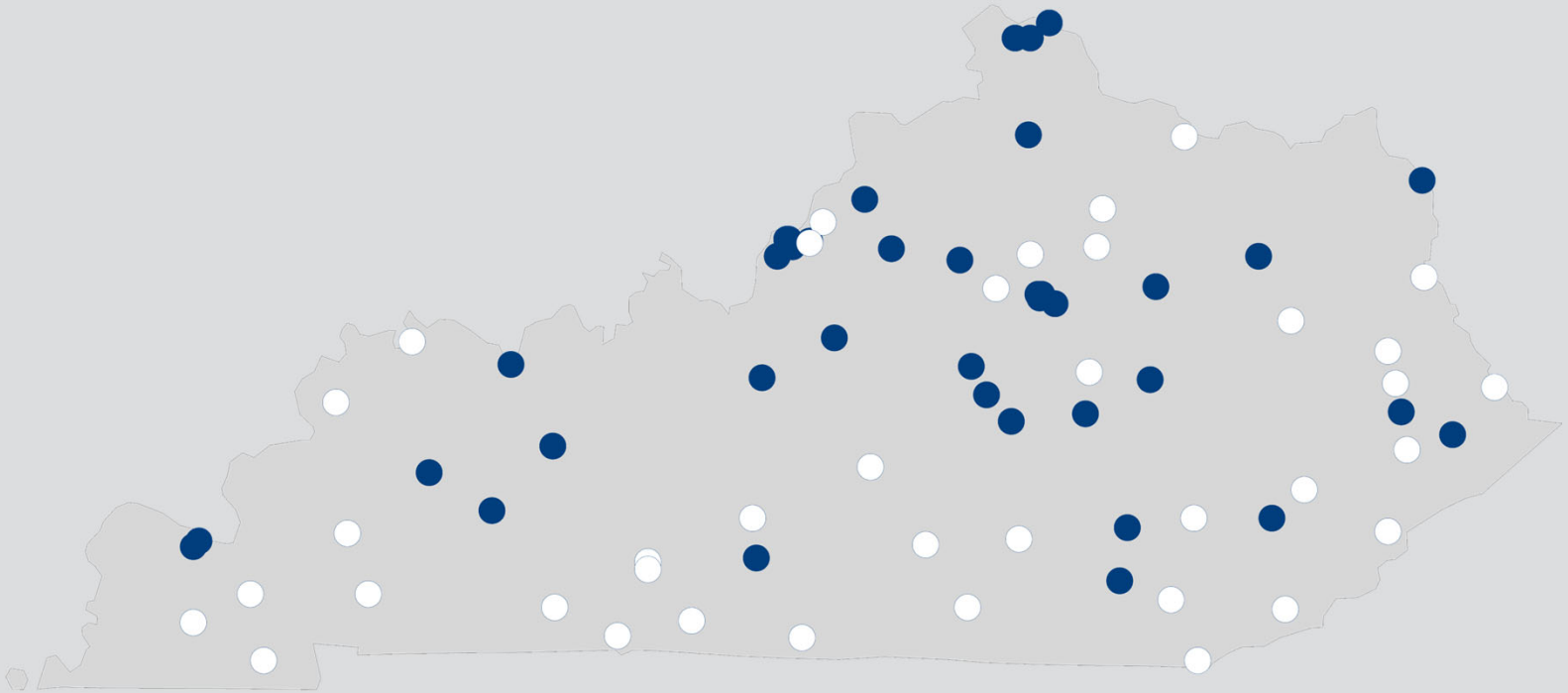
- INOTROPES
- ICD AND CARDIAC RESYNCHRONIZATION THERAPIES
- VENTRICULAR ASSIST DEVICES
- TRANSPLANT
- FREQUENT HOSPITALIZATIONS

PALLIATIVE CARE AND HEART FAILURE TRAJECTORY



Goodlin S, et al. *J Am Col Cardiol*. 2009 Jul, 54(5):386-396

HOSPITAL BASED PALLIATIVE CARE IN KY



Location	2019 Grade*	By Hospital Size			
		< 50 beds	50-150 beds	151-299 beds	300+ beds
State	57.1% C	41.4% (12/29)	30.4% (7/23)	85.7% (12/14)	75.0% (9/12)
Region	48.2% C	31.3% (40/128)	23.6% (21/89)	52.0% (26/50)	86.5% (45/52)
National	71.5% B	36.3% (557/1535)	51.1% (474/928)	75.6% (578/765)	93.7% (671/716)

PRIMARY PALLIATIVE PEARLS

Dyspnea

- DYSPNEA LOOP DIURETICS
- SELF-MANAGEMENT STRATEGIES
  - education about monitoring
  - identifying early signs of fluid overload
- OPIOIDS ARE OFTEN USED FOR REFRACTORY DYSPNEA, DESPITE OPTIMAL DIURETIC USE- TITRATION EVIDENCE IS INCONCLUSIVE

Pain

- OPIODS
- BONE PAIN: BISPHOSPHONATES
- ANGINAL PAIN: NITRATES, B-BLOCKERS, CALCIUM CHANNEL BLOCKERS, RANOLAZINE, CORONARY REVASCULARIZATION
- CHRONIC PAIN: ACUPUNCTURE, EXERCISE TRAINING, MUSIC THERAPY, NSAIDS

PSYCHOLOGICAL DISTRESS

DEPRESSION, ANXIETY, CAREGIVER BURDEN, LONELINESS

ASSESSMENT

- PHQ-9 OR CES-D OR BECK DEPRESSION INVENTORY
- HOSPITAL ANXIETY/ DEPRESSION SCALE
- CAREGIVER BURDEN INVENTORY OR ZARIT BURDEN INVENTORY
- SOCIAL ISOLATION SHORT FORM
- CONTROL ATTITUDES SCALE- REVISED

INTERVENTIONS

- PSYCHOTHERAPY (CBT)
- PHARMACOTHERAPY (ANTIDEPRESSANTS)
- FINANCIAL NAVIGATION AND SUPPORT
- SOCIAL NETWORKING

COMMUNICATION AND FUTURE CARE PLANNING

- ASSESS VALUES AND PREFERENCES
  - What are your hopes?
  - What do you worry about?
  - What are your benchmarks for quality of life?
  - Tolerance for treatment burden
- ADVANCE CARE PLANNING
  - Who, other than your medical team, have you shared with about your thoughts/ feelings regarding future care/ treatments?
- IDENTIFYING SURROGATE DECISION MAKER
  - Decision makers are not always NOK

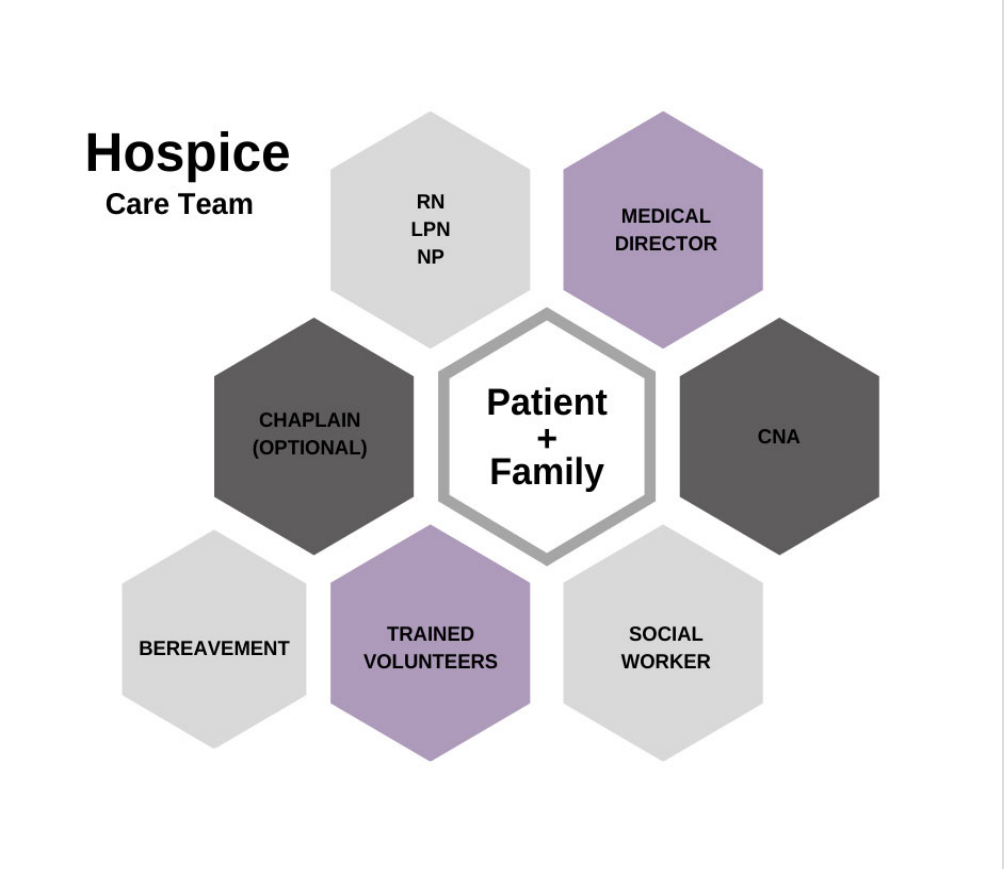
End of Life

Timing of Hospice

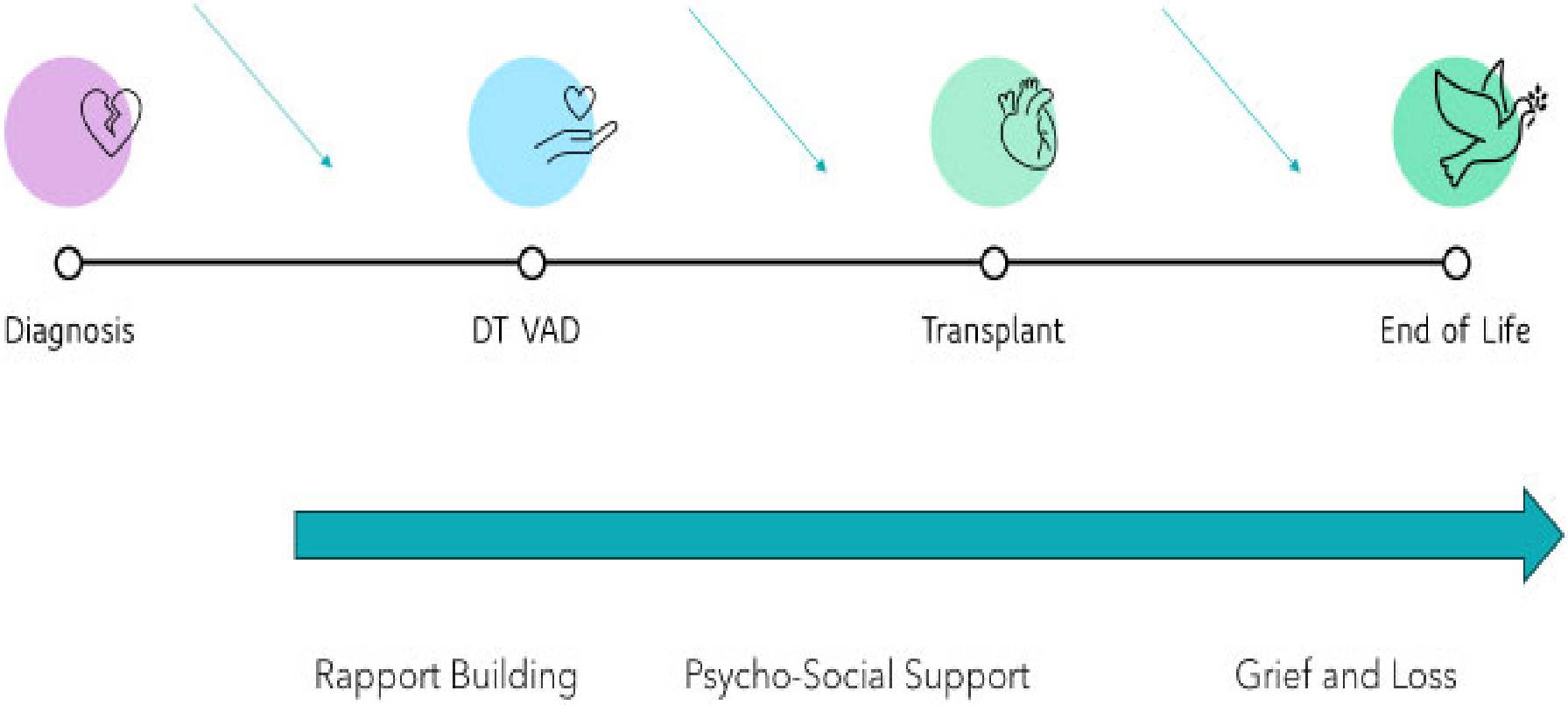
- PROGRESSIVE SYMPTOMS DESPITE MAXIMAL MEDICAL THERAPIES
- DECLINES/NOT ELIGIBLE FOR ADVANCED THERAPIES
- FREQUENT ADMISSIONS TO ED/HOSPITAL
- READY TO STAY HOME & NOT RETURN TO HOSPITAL

Hospice Philosophy of Care

- INSURANCE BENEFIT
- ESTIMATED PROGNOSIS OF 6 MONTHS OR LESS
- FOCUS ON COMFORT CARE
- PRESCRIBE & PROVIDE ALL MEDICAL EQUIPMENT AND PRESCRIPTIONS R/T DIAGNOSIS



MIDDLE AGED MAN ADMITTED IN ACUTE HF



SUMMARY

- PALLIATIVE CARE CAN BE UTILIZED AT ANY POINT ALONG THE DISEASE TRAJECTORY
- PRIMARY PALLIATIVE CARE SKILLS
- USE COMMON REFERRAL CRITERIA TO REFER TO SPECIALTY PALLIATIVE CARE
- PARTNERSHIP BETWEEN PRIMARY TEAM, PALLIATIVE AND THE PATIENT AND THEIR FAMILY

References

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Extra slides

Benefits of Palliative

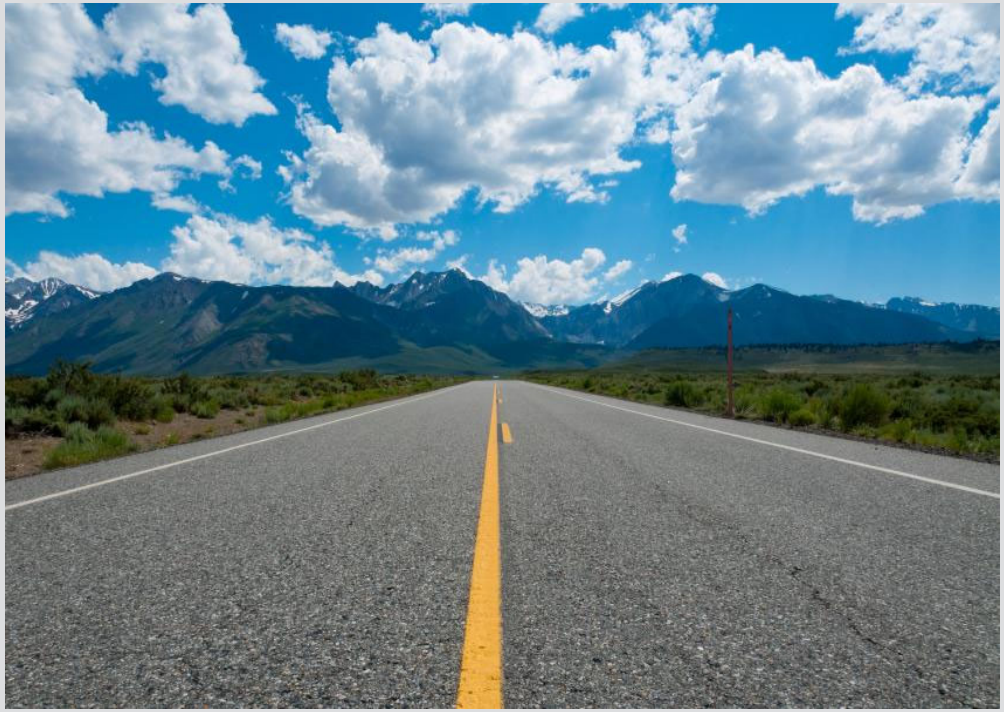
Palliative Care Is the Umbrella, Not the Rain—A Metaphor to Guide Conversations in Advanced Cancer

A Late palliative care referral

B Early palliative care referral

JAMA Oncol. Published online March 17, 2022. doi:10.1001/jamaoncol.2021.8210

The Journey



- ~6.7 MILLION AMERICANS 20 & OLDER HAD HF (NHANES 2017-2020)
- 3,817 HEART TRANSPLANTS IN 2021 (MOST EVER)
- THE AVERAGE COST IN US $407.3 BILLION IN 2018 TO 2019. (DIRECT & INDIRECT)
- ESTIMATED 5YR MORTALITY 52.6% OVERALL; 24.4% FOR THOSE 60 YEARS OF AGE; AND 54.4% FOR THOSE 80 YEARS OF AGE

Heart Disease and Stroke Statistics—2023 Update: A Report From the American Heart Association

Secondary Palliative Care: Specialists

- PALLIATIVE CARE SPECIALISTS WORK ALONGSIDE PROVIDERS TO PROVIDE EXTRA SUPPORT IN THE FOLLOWING WAYS:

  - LEARNING/COMMUNICATING ABOUT WHAT'S IMPORTANT
  - HELP WITH COMPLICATED HEALTHCARE DECISIONS
  - MANAGING SYMPTOMS
  - PSYCHO-SOCIAL SUPPORT
  - COORDINATING CARE ACROSS SETTINGS

CRITERIA FOR REFERRAL

CENTRAL ILLUSTRATION: Consensus Criteria for Specialist Palliative Care Referral for Patients With Advanced Heart Failure

Chang YK, et al. J Am Coll Cardiol. 2022;80(4):332-344.

Integration of Palliative

WHAT: Functional Knowledge of Palliative Care	• Misperception that all palliative care is hospice (i.e., prognosis-dependent, and requires suspension of life-prolonging therapy)* • Misperception that palliative care is not a tangible clinical entity, but rather a philosophy of care* • Poor knowledge of how to locally access specialist palliative care
WHEN: Appropriate Timing of Palliative Care	• Palliative care referral conceptualized based on trigger events • Unpredictable trajectory of heart failure poses a barrier to palliative care referral* • No clear referral point in HF due to insistence on life-prolonging therapies*
WHY: Perceptions of Palliative Care	• Palliative care inherently valuable due to its focus on quality of life • Sociocultural perceptions and incorrect assumptions about palliative care as "terminal care" may act as referral barriers • Traditional HF therapy is essentially palliative care due to the incurable nature of HF
WHO: Interprovider Relationships	• Knowledge transfer from palliative care discipline necessary to ensure proper messaging of what palliative care is versus hospice • Trust and rapport are key building blocks to interspecialty collaboration
WHERE: Origin of Referral	• Due to prior patient-provider relationships, primary care and cardiology providers should initiate palliative care referrals
HOW: Strategies for Improving Palliative Care Integration	• Provider education needed regarding what palliative care is, when it is appropriate, how it can benefit HF patients, and how to access it • Palliative care "basics" or "essentials" should be disseminated to non-palliative care specialists • Decision support tools (e.g., best practice alerts) needed to encourage earlier HF palliative care referral