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How you want to be treated.

Institute for HEART+LUNG Health
Strong beats. Clear breaths. Full lives.

Walking together: Palliative Care and heart failure.

St Paul's Hospital Heart Function Supportive Care Clinic

- Cindy Nordquist MN-NP(F)

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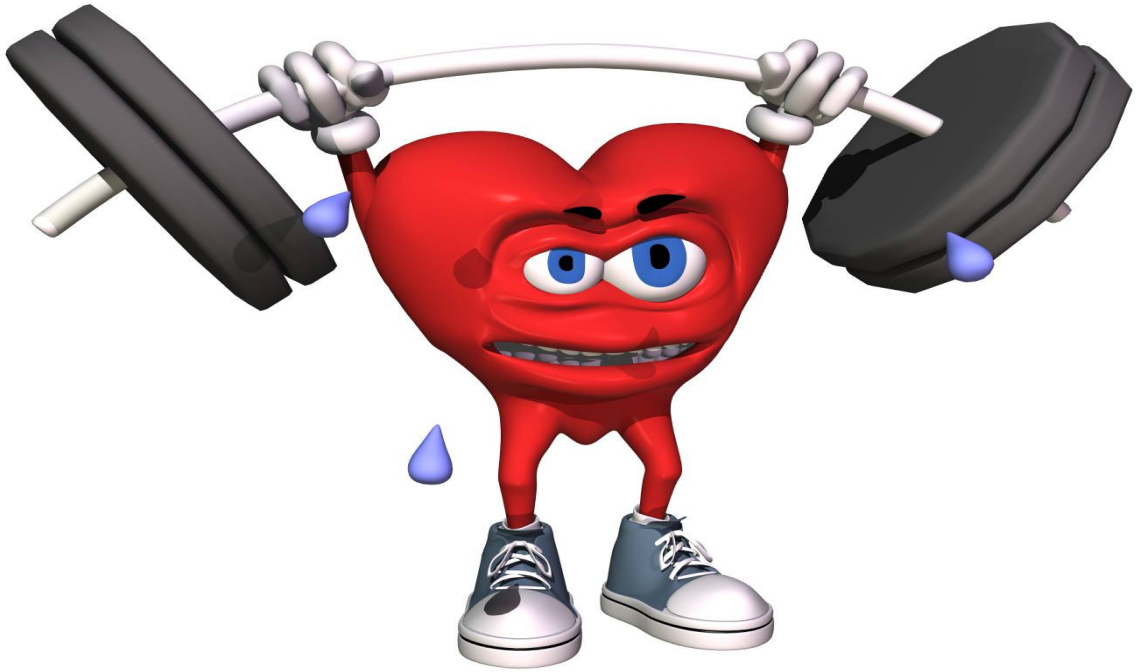
Objectives

- Review heart failure.
- Review palliative care/ palliative care approach.
- Barriers to implementing palliative care approach in heart failure.
- Benefits to involving palliative care/palliative care approach.
- When to involve palliative care/palliative care approach.
- St. Paul's Hospital Supportive Care Clinic

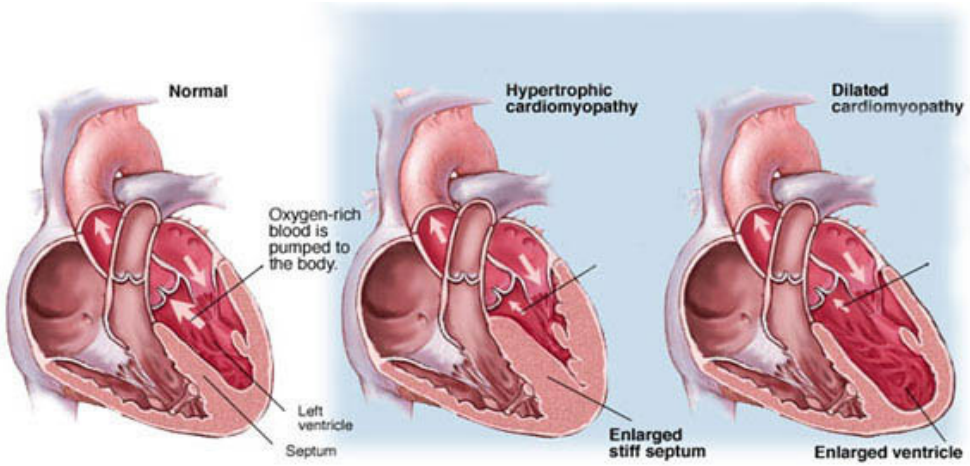
What is heart failure?

- Basically is the inability to meet the body's metabolic demands.



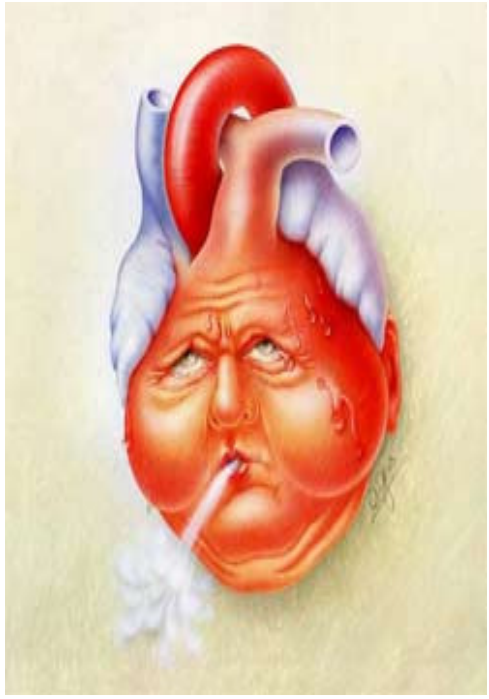
Types of heart failure:

- HF with reduced EF (HFrEF)- systolic HF.
- HF with preserved EF (HFpEF)- diastolic HF.



Symptoms of heart failure:

- Fatigue
- Dyspnea
- Pain
- Dry mouth
- Constipation
- Nausea
- Depression/anxiety
- Symptoms from other comorbid illnesses
- Average of 6.7 symptoms/patient in last 6 months of life.
- Nordgren & Sorensen Eur. J Cardiovascular Nursing 2003



Symptom Prevalence

- Fatigue 69%
- Nausea 48%
- Depression 9-36%
- SOB 60-88%
- Insomnia 36-48%
- Anxiety 48%
- Confusion 18-32%
- Constipation 38-42%
- Edema 44%
- Dizziness 21%
- Pain 41-77%

JP Solano 2006

Reality of heart failure

- Symptoms can appear at anytime during the trajectory.
- Symptoms affect every aspect of a patient's life.
- Many are living with multiple co-morbidities that can increase their symptom burden.
- High health care costs-approx 2 billion/year in Canada.
- In BC there are approx 90, 000 people living with heart failure and is expected to double by 2030.

Mortality

- Absolute mortality rates remain ~ 50% within 5 years of diagnosis.
- Survival rate for HF approx = to malignancy.
- Survival time decreases with repeated hospitalization
- NYHA Functional Class: Mortality 1 yr

  - Class I –Without symptoms 5-10%
  - Class II – Symptoms ordinary activity 15-30%
  - Class III – Symptoms < ordinary activity 15-30%
  - Class IV – Symptoms at rest 50-60%

Congestive Heart Failure

Repeated hospitalizations predict mortality in the community population with heart failure

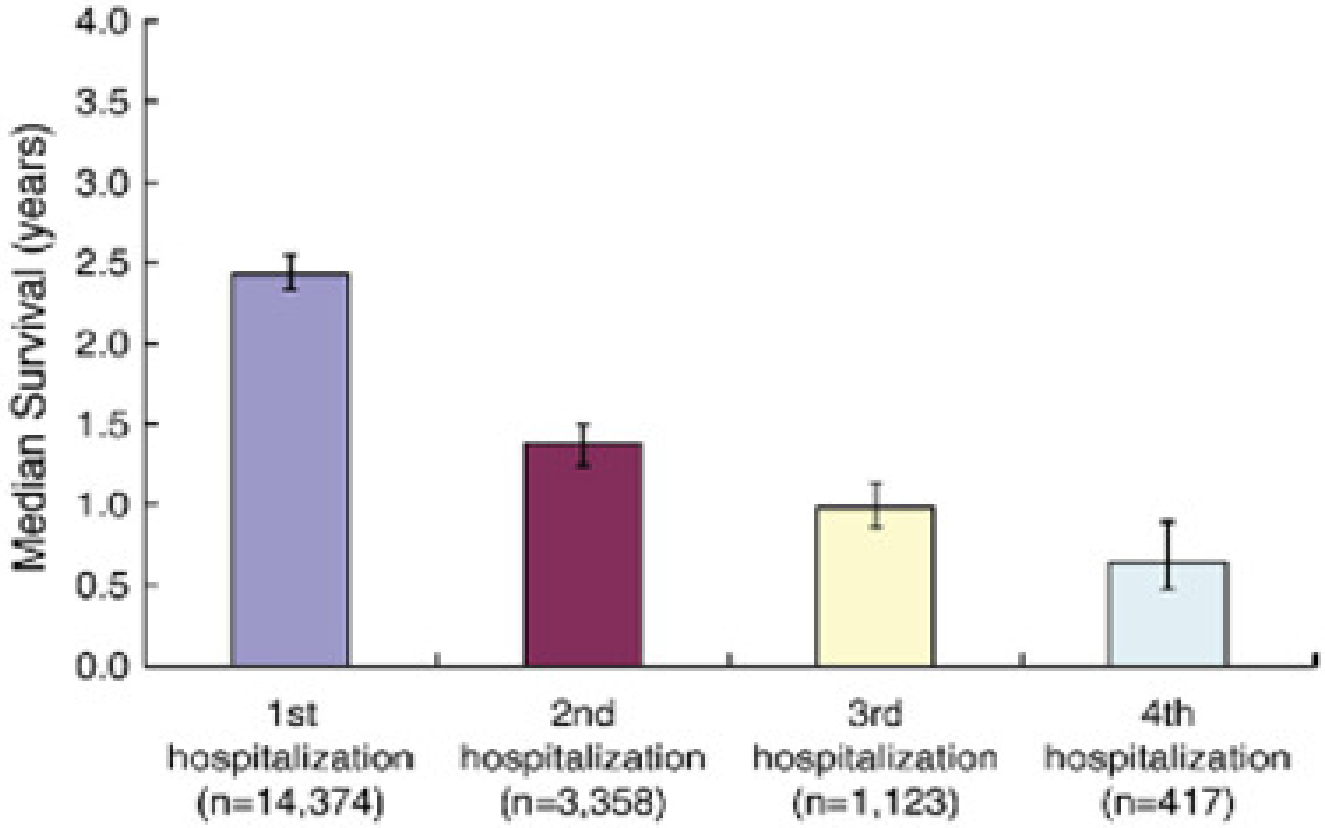
Soko Setoguchi, MD, DrPH,[a] Lynne Warner Stevenson, MD,[b] and Sebastian Schneeweiss, MD, ScD[a] *Boston, MA*

- Characterize survival on HF admissions
- BC cohort >14,000 patients
- Survival time measured after first and each hospitalization

- Number of CHF hospitalization = strong predictor of mortality

Setoguchi AHJ 2007

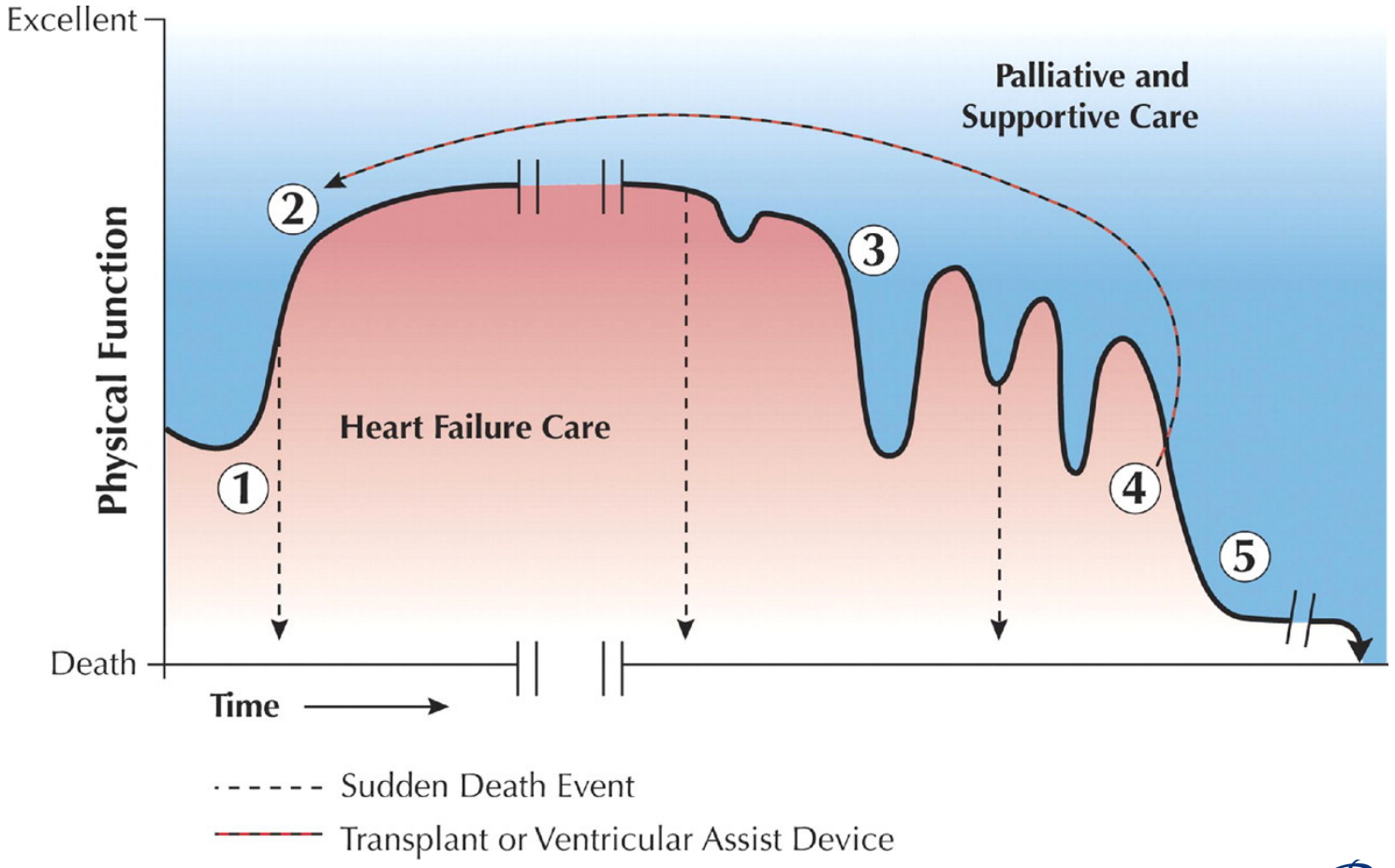
Survival Decreases with Repeated Hospitalizations



Median survival (50% mortality) and 95% confidence limits in patients with HF after each HF hospitalization.

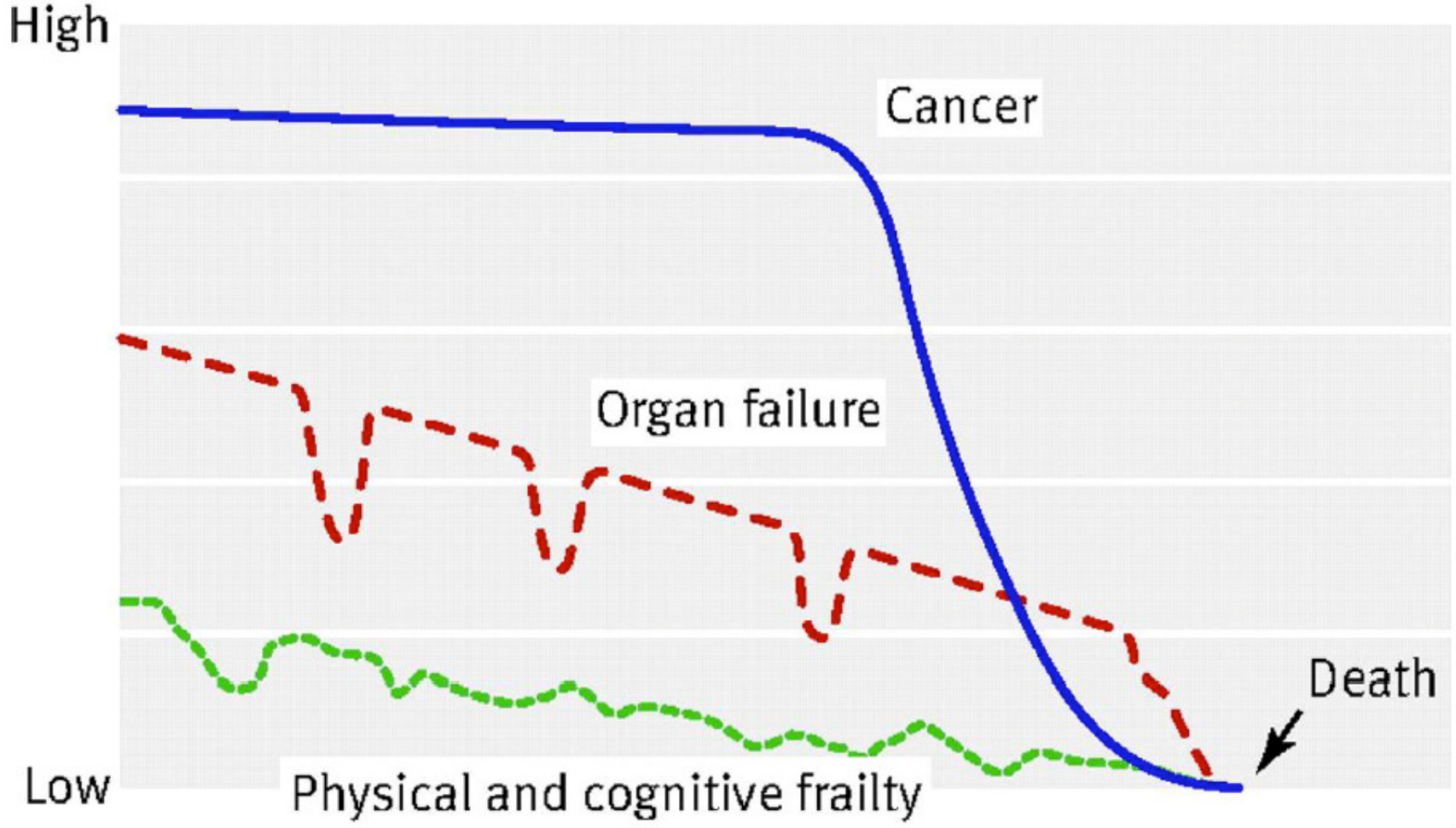
Setoguchi AHJ 2007

Phases of HF



Goodlin, S. J. *J.A.C.C.* 2009;54:386-396

Trajectories at End-of-Life



Jaarsma presentation; British Medical Journal 2008

Palliative Care

- Is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illnesses, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (WHO).
- The provision of palliative care services should systematically include every individual with any life-threatening disease and whose quality of life is being compromised by the symptoms associated with that disease (as cited by Mahtani-Chugani et al).

CCS guidelines

Ethical and end-of-life issues

Recommendations:

Patients with heart failure should be approached early in the heart failure disease process regarding their prognosis, advanced medical directives and wishes for resuscitative care. These decisions should be reviewed regularly and specifically after any change in the patient's condition (level I, grade C).

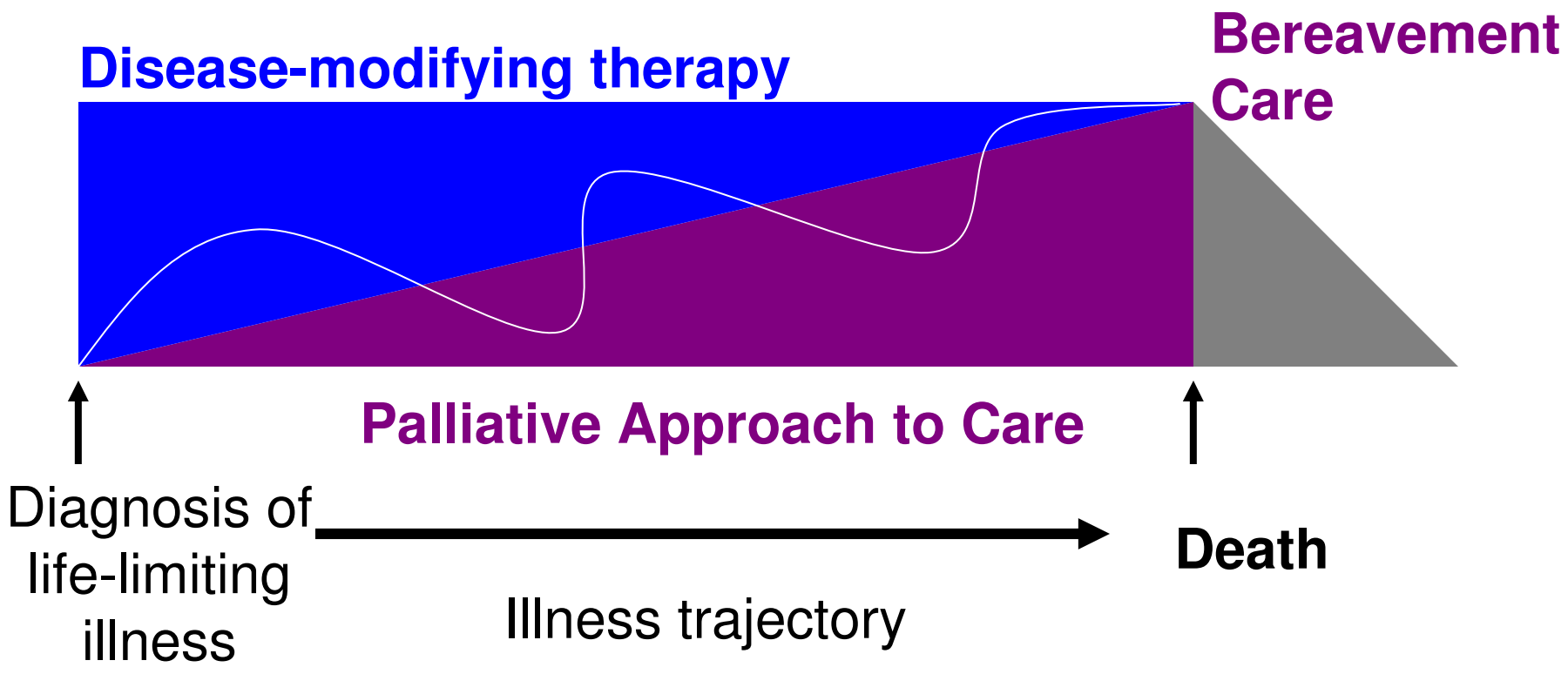
Palliative Approach

Guided by **person centered goals of care:**

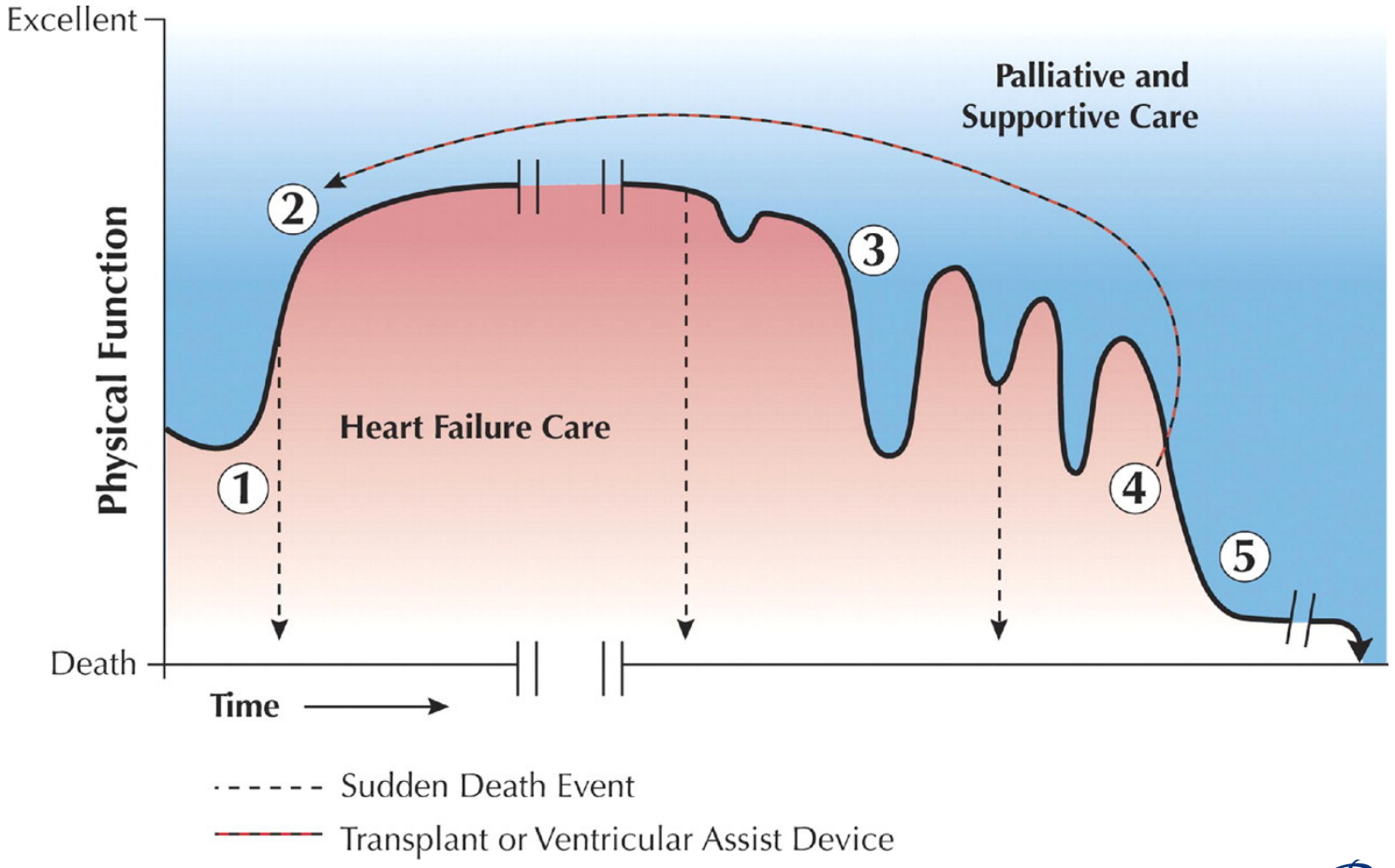
1. Pain and symptom management.
2. Psychosocial care for person.
3. Psychosocial care for family.
4. Spiritual care.
5. Disease management.
6. Preparing for and managing dying.
7. Bereavement.

(Canadian Hospice Palliative Care Association: Norms, 2002)

Canadian Hospice Palliative Care Association: Model of care (2002) www.chpca.net



Phases of HF



Goodlin, S. J. *J.A.C.C.* 2009;54:386-396

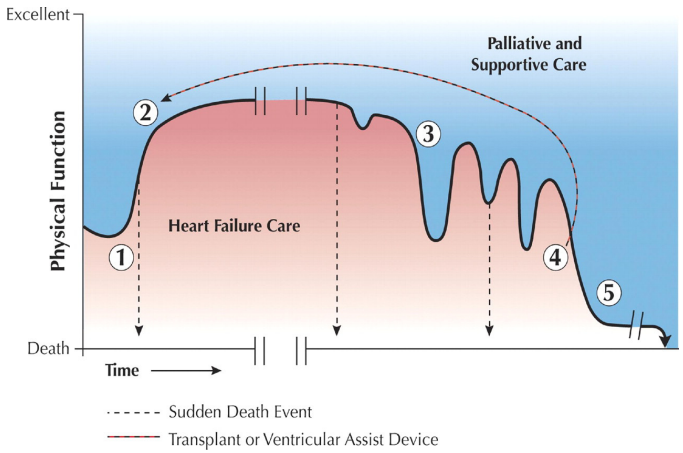
Heart Failure – Palliative Care

- Only ~ 10-15% of pts with HF receive palliative care
- Evidence for Palliative Care in HF far behind that for Cancer
- **CHF differs from Cancer:**
  - Prognostication more difficult
  - Thought to be more benign
  - Pt feels unwell told “doing well”
  - Feel better on treatment

Murray BMJ 2002; O’Brien BMJ 1998, Goldstein 2012

Barriers to Implementing Palliative Care:

- Lack of clarity about prognosis.
- Curative approach.
- Lack of shared understanding of goals of care.
- Lack of training in palliative care-"trained for curing".
- Linking of the word palliative care with death.
- Fear of destroying patients hope.
- Fluctuating trajectory.



Mahtani-Chugani (2010)

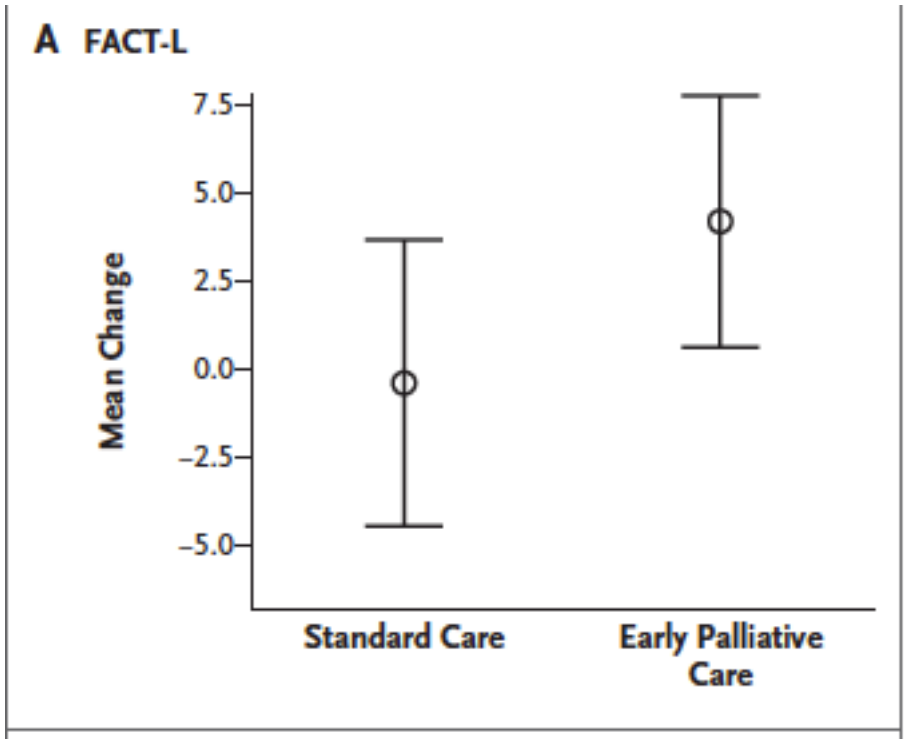
The NEW ENGLAND JOURNAL of MEDICINE

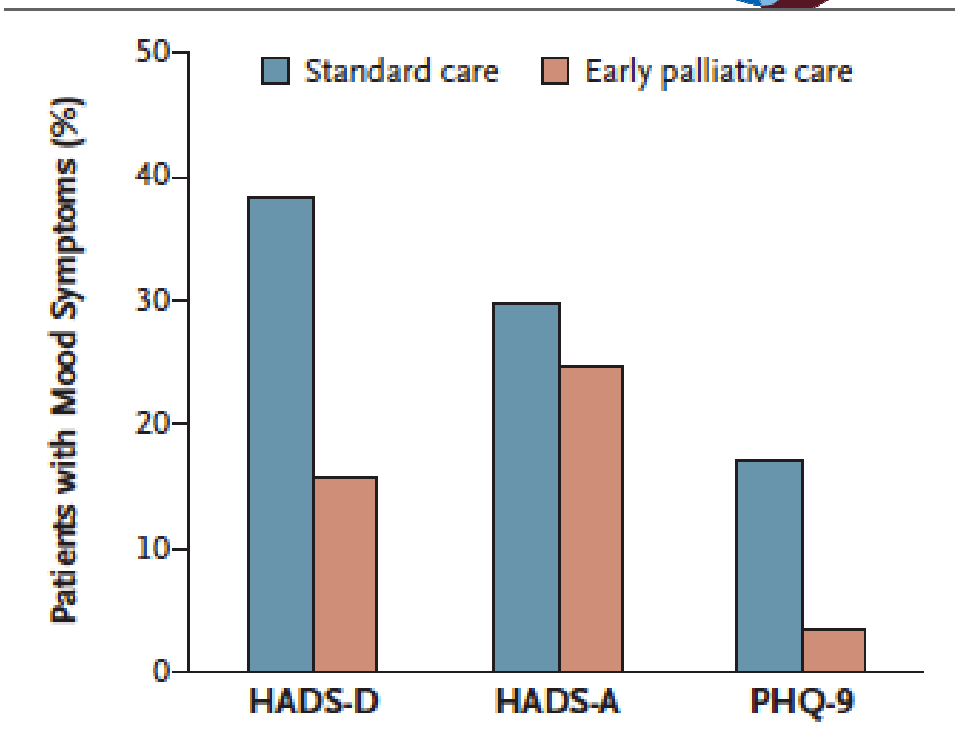
ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

- Newly diagnosed metastatic NSCLC (n =151)
  - **Randomized to:**
    - Early palliative care & standard oncology care
    - Standard oncology care
- **Primary outcome: QoL and Mood at 12 weeks**
  - QoL measured by FACT – L
  - Mood measured by Hospital Anxiety and Depression Scale

Temel, NEJM, 2010





Quality of Life

Mood

Temel, NEJM, 2010

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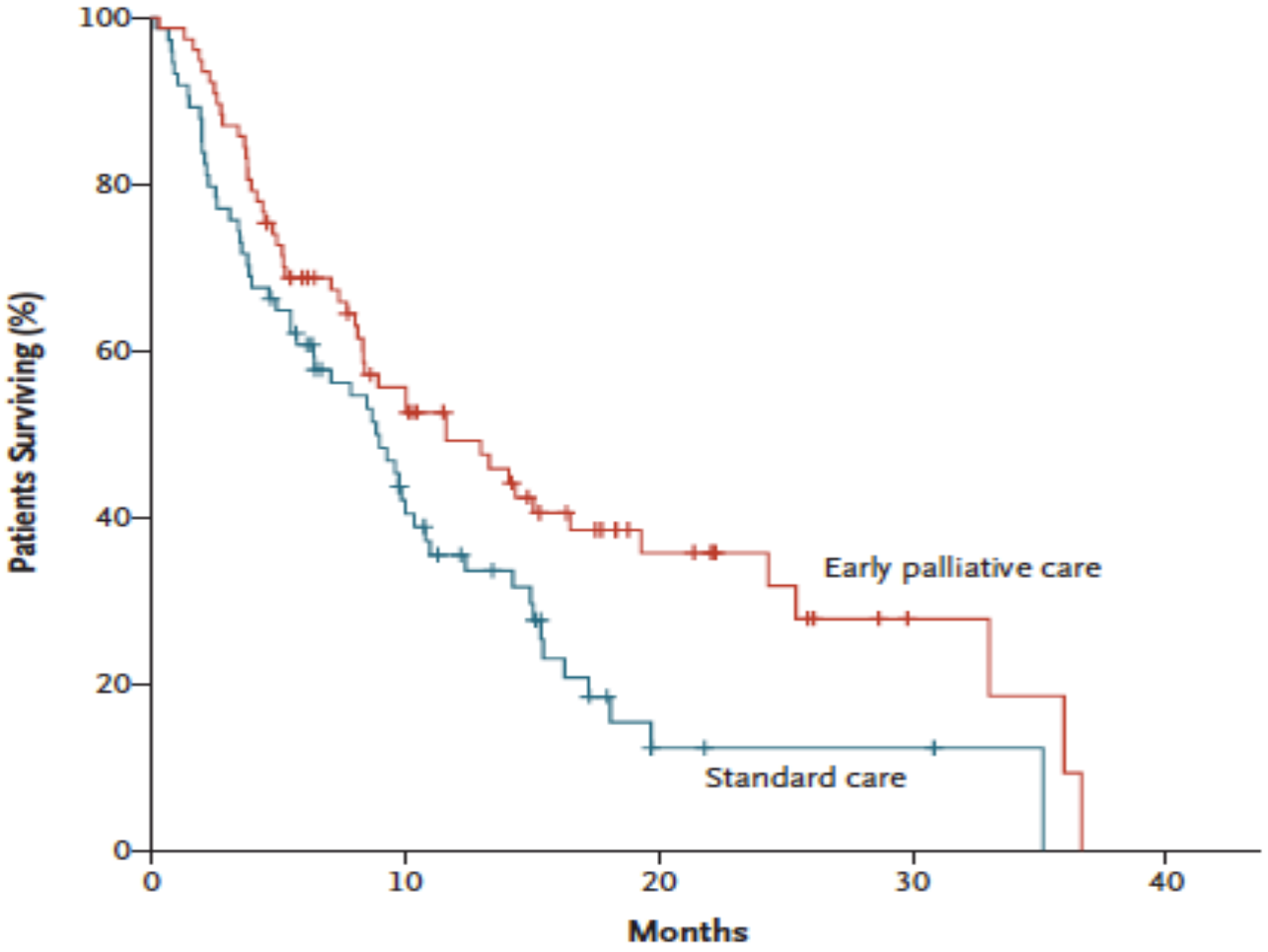

Figure 3. Kaplan–Meier Estimates of Survival According to Study Group.

Temel, NEJM, 2010

iPall – Heart Failure

Palliative Care Assessment Tool

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BC's HEART FAILURE NETWORK
Quality care for quality life.

Identify who would benefit from a palliative care assessment

1) ASK yourself

- Would I be surprised if this patient died in the next 6-12 months? **YES** or **NO**

2) LOOK for one or more general clinical indicators

- Performance status poor (limited self care; in bed or chair over 50% **of the day)** or deteriorating
- Multiple hospitalizations in the past 6 months
- Patient needs more care at home or is in a residential care facility.
- Patient has multiple co-morbidites causing symptoms/functional decline

3) LOOK closer for two or more disease related indicators

- NYHA class III / IV heart failure due to valve disease, or coronary artery disease not amenable to surgery/angioplasty
- Persistent symptoms (breathlessness or chest pain) despite optimal tolerated therapy
- Renal impairment (eGFR <30 ml/min)
- Cardiac cachexia: progressive loss of lean body mass, reduced muscle strength, anorexia, fatigue and abnormal biochemistry (see below)
- Markers of chronic inflammation/cachexia –
  Anemia: hemoglobin ≤ 115, Uric acid ≥ 565, albumen < 32
- Two or more acute episodes needing intravenous (furosemide and /or inotropes) therapy in last 6 months

If WOULD NOT be surprised AND patient meets criteria from LOOK categories – patient benefits from palliative care assessment

Boyd K, and Murray S. British Medical Journal 2010,
Weissman D, Meier D. Journal of Palliative Medicine 2011,
Lainscak M, von Haeling S, Anker S. Int. J of Cardiology,
Freeman L. Curr Opin Support Pallat Care 2009

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ST. Pauls Hospital Heart Failure Supportive Care Clinic, Vancouver BC.

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Supportive Care Clinic

- Was established in January 2011.
- Multi-disciplinary clinic:
  - All patients are co-seen by the NP and Palliative Care Physician.
  - Access to dietician, SW, pharmacist while in the clinic if needed.
  - Community referrals to PT, OT, home care nursing or other services as needed.

Goals of SCC:

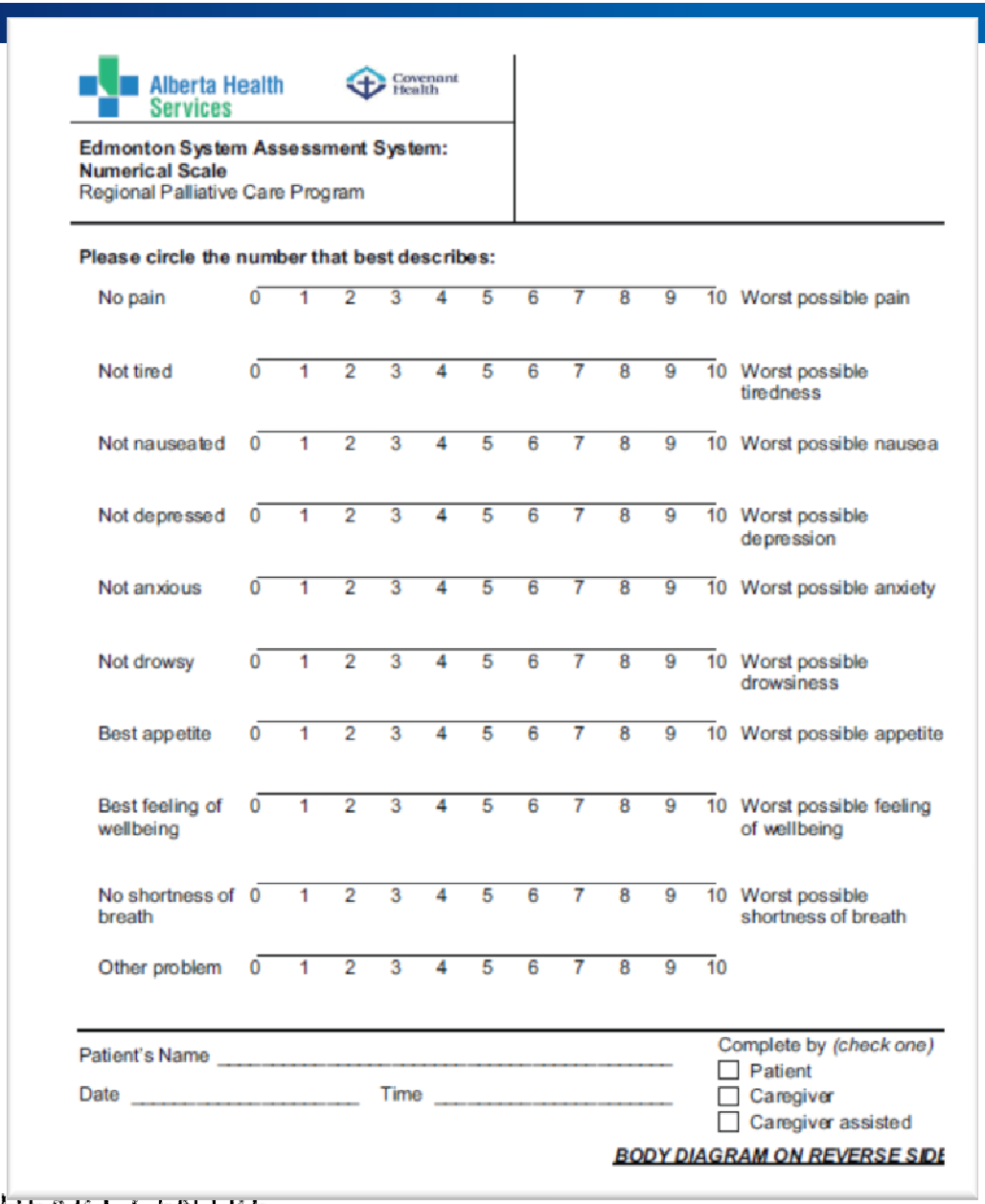
- Help patient to understand disease trajectory.
- Decrease hospital admissions.
- Assess and develop care plans around symptom management.
- Improve quality of life.
- End of life discussion.
- Advanced care planning.
- ICD deactivation.
- Referrals to appropriate community resources.
- Palliative Care Benefits and home DNR.

Supportive Care Clinic

- Outpatients.
- All patients have complex medical conditions.
- NYHA III/IV.
- Patients are referred by our clinic cardiologists or NP. Our nurses can also help to identify patients that may benefit from symptom management.
- Patients must be a part of our heart function clinic. We currently are not accepting outside referrals.

Care plans

- Directed by the prognosis and stage of illness and the patient/family centered goals of care translated into concrete, specific plans
  - May mean reduction in aggressive tests, procedures, medications. Not doing ‘too much’ or ‘too little.
  - Focus on quality of life and life completion.
  - Collaborative.
  - Supportive.
  - Dictated letters are sent to their primary care provider and other specialists after each visit.



Alberta Health Services

Covenant Health

Edmonton System Assessment System: Numerical Scale
Regional Palliative Care Program

Please circle the number that best describes:

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible pain
Not tired	0	1	2	3	4	5	6	7	8	9	10	Worst possible tiredness
Not nauseated	0	1	2	3	4	5	6	7	8	9	10	Worst possible nausea
Not depressed	0	1	2	3	4	5	6	7	8	9	10	Worst possible depression
Not anxious	0	1	2	3	4	5	6	7	8	9	10	Worst possible anxiety
Not drowsy	0	1	2	3	4	5	6	7	8	9	10	Worst possible drowsiness
Best appetite	0	1	2	3	4	5	6	7	8	9	10	Worst possible appetite
Best feeling of wellbeing	0	1	2	3	4	5	6	7	8	9	10	Worst possible feeling of wellbeing
No shortness of breath	0	1	2	3	4	5	6	7	8	9	10	Worst possible shortness of breath
Other problem	0	1	2	3	4	5	6	7	8	9	10	

Patient's Name _____

Date _____ Time _____

Complete by *(check one)*
- ☐ Patient
- ☐ Caregiver
- ☐ Caregiver assisted

BODY DIAGRAM ON REVERSE SIDE

ESAS:

Edmonton Symptom Assessment Scale

Preliminary Data

- 2012-May 2014:
  - 26 patients.
  - 12 deceased.
  - 74-90 years, mean age 79 years.
  - 21 were male, 5 female.
- 67% had improved total ESAS scores.
- 50% had improved on overall well-being.
- 31% had stable overall well-being scores.

SCC Preliminary Data

- Hospitalizations:
  - 41 hospitalizations, 16/41 for CHF.
  - 7/26 patients hospitalized with CHF.
  - 25% of SCC patients have not required hospitalization for CHF.
  - Other reasons for hospitalizations:
  - COPD (5), NSTEMI (2), GI bleed (2),pneuomina (2), RF(1), constipation(3), failure to thrive/cope(2), hypotension(2).

SCC Preliminary Data

Other reasons for hospitalizations:

- COPD (5), NSTEMI (2), GI bleed (2),pneuomina (2), RF(1), constipation(3), failure to thrive/cope(2), hypotension(2), C diff (1), hernia repair (1), cellulitis (1), urinary retention (1), MVA (1), fracture hip (1), vomiting (1).

SCC Preliminary Data

- Treatment usually included:
  - Discontinuation of less essential cardiac medications/titrating down medications.
  - Counseling on fluid and salt management, energy preservation.
  - Commencement of opioids.

Conclusion

- Heart failure impacts every aspect of a patients life.
- Patients often have a large symptom burden.
- Palliative care approach should be utilized early on in disease trajectory to improve quality of life and reduce hospitalizations.
- Frequent discussion of patients goals of care.
- Advanced care planning early.

Aknowledgments

- Nursing team: Catherine, Margaret, Deb, Annmarie, Ella.
- Dr. Kimel.
- Dr. Ignaszewski.