PALS HF PROGRAM

PALLIATIVE CARE FOR THE PATIENT WITH CHRONIC HEART FAILURE

National Association for Home Care & Hospice Annual Meeting
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Washington, DC
Presented by: Helen Smith RN MS
Ric Baxter, MD FAAHPM

OBJECTIVES:

- Identify patients who meet the criteria for the PALS HF program
- Explain the referral process to the PALS HF program.
- Define VNA SL team approach
- Discuss appropriate initiation of palliative care conversations
Background

Heart Failure is a complex chronic syndrome with devastating effects:

- It challenges health care professionals due to the complexity of managing this disease through its progression.
- It drains health care systems—estimated cost of caring for this population will soar to 44.6 billion by 2015.
- It causes frequent admissions and readmissions—a million admissions each year with close to 1 in 4 or 25% readmissions.
- Devastating statistics call on our society to look for alternative ways to care for these patients.

Patients with chronic heart failure suffer with poor quality of life and this elicits significant symptom burden:

- Struggle with isolation and depression,
- Shortness of breath,
- Pain,
- Fatigue, and
- Anxiety.

These symptoms limit patients functional capacity and contribute to failed attempts to self-manage once they are home.
CHRONIC HEART FAILURE
PATIENT PROFILE AND IDENTIFICATION

- Older
- Multiple co-morbidities
- Physical frailty
- Failure to improve even with advanced medical interventions,
- **Persistent** symptoms even with optimal therapy
- Slowing of progression of disease but not reversal
- **Repeated hospitalizations**

HOW DO PATIENTS COPE WITH CHRONIC HF?

*Patients often seek the only solace they believe is there for them - the hospital*
GAPS IN TRANSITIONS OF CARE THAT CAUSE POOR OUTCOMES

- Inadequate discharge planning
- Poor communication
- Lack of follow-up care
- Unreal expectations of patients, families, caregivers and HCPs

Without a plan for management of symptoms this patient population continues to suffer and return to the hospital.

WHAT IS THE PALS HF PROGRAM?

- This is a interdisciplinary team program that can be started along with usual care
- Appropriate at all phases of the HF trajectory...not just the last 6 months of life
- Promote patient-centered care
- Relationship based
- Focus on symptom management to decrease the burden of this disease and promotion of improved quality of life
PALS HF TEAM

- Formed in April 2012
- Interdisciplinary
  - Dr. Ric Baxter Palliative Care physician
  - Judy Wlostowski RN MSN Director of VNA SL
  - Helen Smith RN BSN Heart Failure Care Coordinator
  - Jan Broniec RN BSN Heart Failure Care Coordinator
  - Adele Bon-Shannon MSW VNA SL
  - Deb Crush RN MSN CNS VNA SL
  - Sue Rodriguez BSN RN VNA SL
  - Carrie Chavarria CRNP SLCA
  - Sarah Baxter PA-C SLCA
  - OT and PT VNA SL

REFERRAL PROCESS

Inpatient:
- Consult Case Management
- Write order for PALS HF program or Palliative Care HF Program
- Case Management will then make a referral to VNA SL for HF Palliative Care Program (PALS HF Program)

Outpatient:
- Call HF Care Coordinator (Helen/Jan)
THE ROLE OF THE HEART FAILURE NURSE PRACTITIONER AND PHYSICIAN ASSISTANT

- Identify patients
  - Symptoms
  - Stage of Heart failure

Facilitate transition into palliative care program
  - Discussion with the patient about their health, health care goals, quality of life.
  - Discussion with family and support team about the patient’s wishes.
  - Collaborate with primary Cardiologist and facilitate enrollment into the PALS program.

ACC/AHA HF STAGE VS. NYHA FUNCTIONAL CLASS

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<tr>
<th>ACC/AHA HF Stage</th>
<th>NYHA Functional Class</th>
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<tr>
<td>A At high risk for HF, But without structural heart disease or symptoms (HTN, CAD, DM)</td>
<td>NONE</td>
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<tr>
<td>B Structural Heart Disease but without symptoms of HF</td>
<td>I Asymptomatic</td>
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<tr>
<td>C Structural heart disease with prior or current symptoms of HF</td>
<td>II Symptomatic with moderate exertion</td>
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<tr>
<td></td>
<td>III Symptomatic with minimal exertion</td>
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<td>D Refractory HF requiring Specialized interventions</td>
<td>IV Symptomatic at rest</td>
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Case Study

- Mr. Z is an 87 y/o male with PMH of ischemic cardiomyopathy EF 45%, chronic systolic/diastolic HF, CAD s/p CABG, severe AS s/p AVR, atrial flutter s/p PPM, CKD stage III, HTN, HLD, COPD/ILD.
- 2D echo LVEF for 45 to 50%, diastolic dysfunction, dilated RV, moderate MR, bioprosthetic AVR with reduced motion and severe AI, severe TR, severe HTN PA pressure 77mmHg.
- Lives alone, son lives nearby.
- Developed progressive dyspnea with minimal exertion, profound weakness, difficulty walking several steps due to dyspnea, + orthopnea, + PND, occasional chest pressure.

Case Study

- Hospitalized twice within a week for decompensated heart failure.
- Increased diuretics did not improve symptoms of dyspnea and weakness.
- Mr. Z’s goals were to remain home and feel comfortable. Did not want rehospitalization.
- Referral made to PALS HF Team.
- Mr. Z was started on morphine 2mg p.o. t.i.d. Dyspnea and chest pressure improved, able to ambulate farther, and improved quality of life.
- Eventual transition to hospice. In accordance with Mr. Z’s wishes, he was not rehospitalized before he passed away.
VNA ROLE WITH PALS HF

- VNA core services for heart failure patients
  - Nursing
  - Social Work
  - Physical and/or Occupational Therapy
  - Available as needed – Speech Therapy and Home Health Aide

NURSING SERVICES

- Physical assessment
- Teach self-management
- Facilitate med simplification
- Coaching and Motivational interviewing
- Respect patient’s goals of care
- Telehealth monitoring as appropriate
MEDICAL SOCIAL WORK

- Guide discussion of treatment options, benefits and burdens
- Establish goals based on patient’s values
- Counseling related to anxiety, depression, anticipatory grief
- Facilitate advanced directives, out-of-hospital DNR and POLST
- Reconcile family dynamics
- Info and referral to community services

HOW DOES THE PALS HF PROGRAM DIFFER FROM TRADITIONAL HOME HEALTH SERVICES?

- Dedicated staff trained in heart failure
- Emphasis on palliative care and symptom management
- Focus on patient and family goals with emphasis on quality of life
- Network approach to care
How does the PALS HF program differ from traditional home health services?

(Cont’d)

○ Care continues regardless of insurance coverage
  • When patient no longer qualifies under their insurance, cost of care shifted to network
  • As condition changes, insurance coverage can be readdressed
  • Allow continued home monitoring till death or transfer to Hospice
  • Anticipated cost for ongoing VNA services - $600/month

Affirms life
Promotes quality of life
Treats the person
Supports the family
Hospice Care vs. Palliative Care

- Hospice – The focus is on **care**, not cure, and on the **quality and value of life**, not the duration. Hospice emphasizes the use of palliative care.

- Palliative Care – The goal is to **prevent and relieve suffering** and to support the best possible **quality of life** for patients and their families, regardless of the stage of the disease or the need for other therapies.

Palliative Care’s Place in the Course of Illness

- Palliative care is both a philosophy of care and an organized system for delivering care.
- Palliative care services are indicated across the entire trajectory of a patient’s illness and its provision should not be restricted to the end-of-life phase.
Mission of Palliative Care Services

- To provide excellent, coordinated and comprehensive services to patients with advanced chronic, debilitating, or life-threatening medical illnesses.
- The goal is to relieve physical, emotional and spiritual suffering through the expert treatment of symptoms and the provision of emotional and spiritual support.
- Palliative care may be complementary to other therapies that are available and appropriate to the identified goals of care.

Palliative Care Improves Quality

- Relief of pain, symptoms and emotional suffering for patients and families.
- Enhanced patient-physician communication and decision-making.
- Improved coordination of care across multiple healthcare settings.
Palliative Care Reduces Costs

- Fewer admissions to the intensive care unit in the last six months of life.
- Significant reductions in pharmacy, laboratory and intensive care costs.
- Efficiently coordinated care.

Implications for Medicare and Medicaid

The patient population driving medical spending is the target population for palliative care.

- The seriously ill constitute only 5-10% of patients, but account for over half of the nation’s total healthcare cost.
- The 10% of Medicare beneficiaries with 5 or more co-morbid illnesses account for two-thirds of total Medicare.
- The 4% of the sickest Medicaid beneficiaries account for fully 48% of total program spending; 76% of the nation’s budget goes to acute hospital services, the most expensive setting of care.
Palliative Care & Heart Disease

- 2002 Medicare claims showed that 65% of cancer patients were enrolled in hospice compared to 12% of heart failure patients.
- In 2002, cancer caused 22.8% of all US deaths, while diseases of the heart accounted for 28.5%.

Palliative Care

Among non-cancer diagnoses, cardiac failure has been suggested as especially suited to palliative care for three reasons:
- Usually symptoms to control
- Prevalence of heart failure is high and increasing
- Poor prognosis
Better palliative care should be available to patients with heart disease.
A Case for Palliative Care

- Patients with advanced cardiac failure will be faced with frequent admissions to the hospital.
- Symptomatic management of advanced heart failure includes: breathlessness, muscle wasting, fatigue, lightheadedness, nausea/abnormal taste/anorexia, edema.
- A quarter to a third of these patients obtain little or no relief of symptoms.

Continuum of Care

- Heart failure is changing from an acute to a chronic illness.
- Patients live longer, but with higher co-morbidities.
- Pump failure deaths are often preceded by hyponatremia, azotemia, right heart failure, liver dysfunction, and reduced drug bioavailability.

Ideally, palliative care and hospice should be integrated into the continuum of care.
Hospice Referral Guidelines for Non-Cancer Diagnoses:

*End-Stage Heart Disease*

Functional Class III & IV NYHA Assessment
- Symptomatic despite maximum medical management with diuretics and vasodilators
- Arrhythmia resistance to treatment
- Ejection fraction < 20%
- History of cardiac arrest
- Cardiogenic embolic disease (e.g. CVA)
- Persistent resting tachycardia

Two or more items marked yes should generate a hospice consultation. For patients with non-cancer diagnoses, some may not meet criteria for hospice, yet still be hospice appropriate because of other co-morbidities and rapid decline.

Challenges to Cardiac Services
- Difficulty in predicting prognosis.
- Most older patients experience co-morbid conditions which affect the course of their illness.
- Extraordinary progress of technology and the development of effective therapies; shifting from care to cure.
- Reduction in cardiovascular mortality and increased prevalence of advanced heart failure.
The Reality of the Last Years of Life: Death Is Not Predictable
(slide courtesy of Joanne Lynn, MD, Rand Corp.)
Covinsky et al. JAGS 2003;
Lynn & Adamson RAND 2003;

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SEATTLE HEART FAILURE MODEL

http://depts.washington.edu/shfm
Comprehensive Care

- Palliative care may be combined with curative care, life-prolonging care, or it may be the main focus of care.
- The earlier the referral in the course of the disease, the better.

To cure sometimes, to relieve often, to comfort always