Palliative Management of Heart Failure

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NMAFP | August 2023

Acknowledgment:

Slides with  symbol have been drawn from the Serious Illness Care Program

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The learner will be able to...

1. Differentiate palliative care vs. hospice care in the patient with advanced heart failure.
2. Counsel patients and families regarding the benefits of palliative care, including early referral and participation.
3. Facilitate patient and family discussions to identify goals of care in the advanced stage of heart failure.
4. Provide initial palliative care for patients with common advanced heart failure signs and symptoms that can be implemented prior to referral to a palliative care specialist.
5. Develop collaborative management strategies with palliative subspecialists when routine symptom control becomes ineffective.

Underutilization

- Only a fraction of HF patients who are at high risk for morbidity and mortality receive palliative care services
  Kavalieratos J Am Heart Assoc 2014
- UK Survey: 47% of palliative care providers receive <10 referrals for heart failure annually
  Cheang Open Heart 2015
- PCPs and cardiologists often do not know the difference between palliative care and hospice, including eligibility for services
  Greener J Palliat Med 2014

Challenges

- Lack of evidence-based indications for palliative care
- Poor patient and provider understanding about appropriate patient referrals
- Little knowledge of services/benefits of palliative care
- Prognosis uncertainty
- Limited provider education/training on how to discuss and implement palliative care

Poll Question #1

How confident are you in managing and directing palliative care for your patients with heart failure?

A. Extremely confident
B. Very confident
C. Somewhat confident
D. Not very confident
E. Not at all confident

Palliative Care vs. Hospice

Palliative care is an interdisciplinary approach that focuses on improving quality of life for patients and families facing serious illness; appropriate across all stages of heart failure

Hospice is a specific model of specialty palliative care that is offered to patients with a terminal disease who are at the end of life when curative or life-prolonging therapy is no longer the focus of treatment

Annual Review

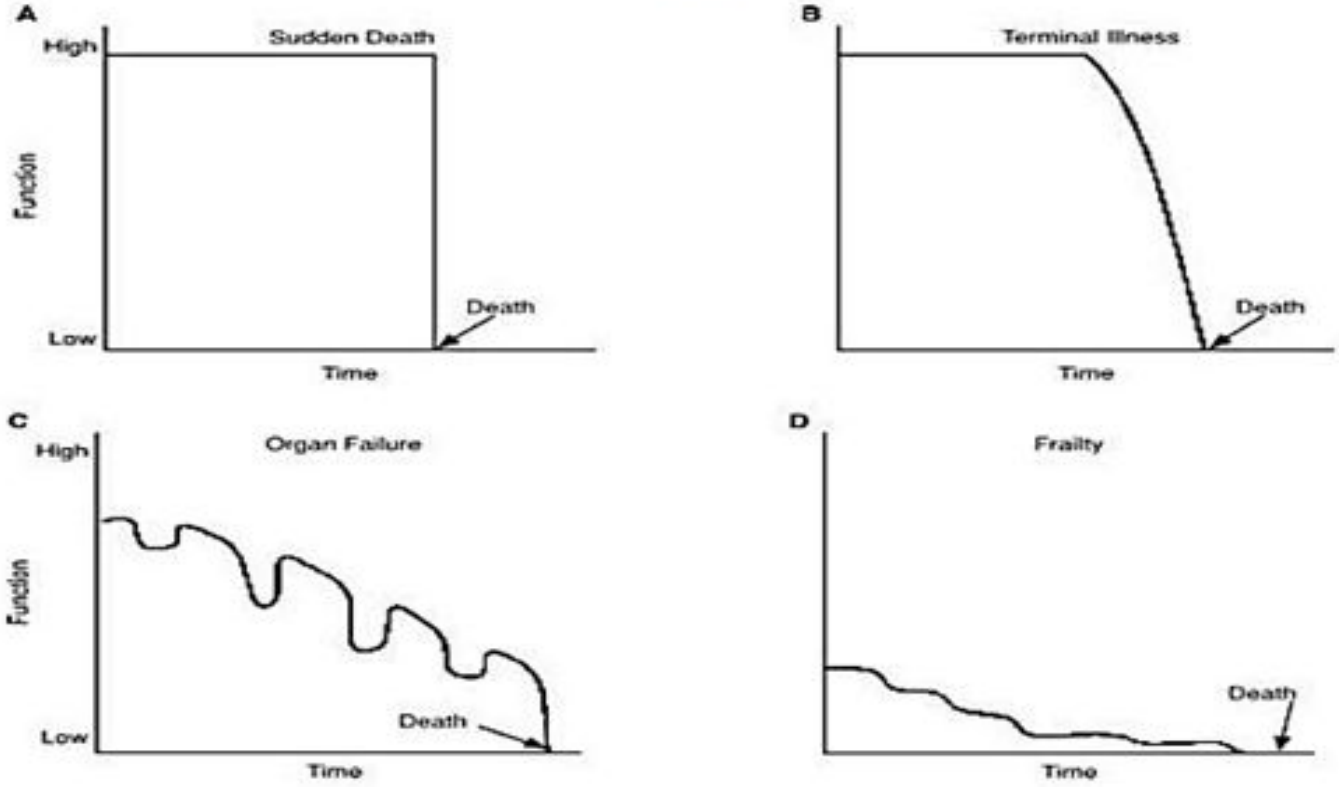
1. Assess clinical status
2. Estimate prognosis
3. Solicit patient values and beliefs
4. Review treatments
5. Consider options
6. Look ahead and plan

Assess clinical status

- ✓ functional ability
- ✓ symptom burden
- ✓ mental status
- ✓ quality of life
- ✓ recent disease trajectory

{Remember to ask patient + caregivers!}

Illness Trajectories



Lunney JR, Lynn J, Hogan C Profiles of older Medicare decedents. J Am Geriatr Soc 2002;50:1108-1112. CrossRefMedlineWeb of Science

Estimate prognosis

- ✓ Consider using objective modeling data
  - Seattle Heart Failure Model
  - Heart Failure Risk Calculator
- ✓ Recognize uncertainty

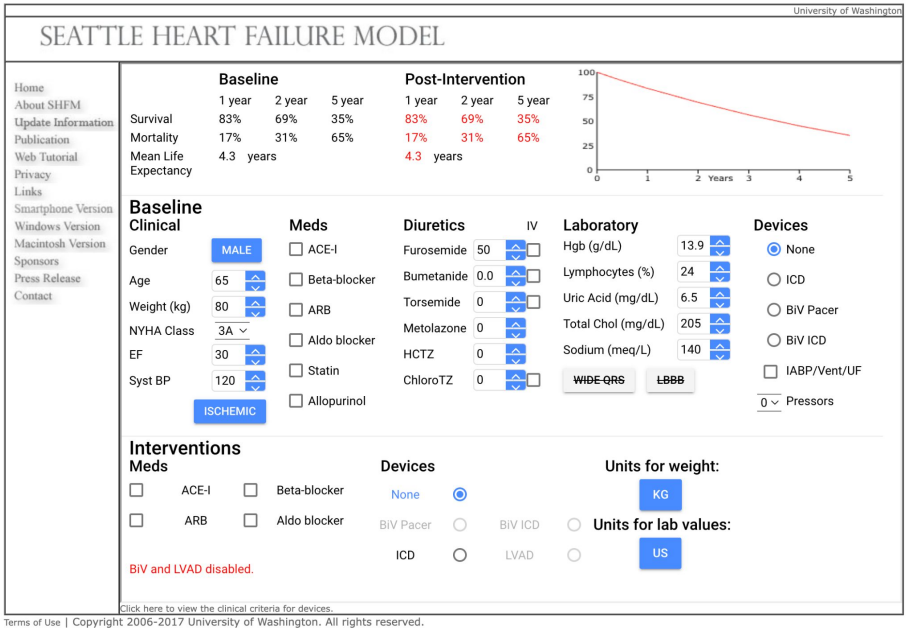
Seattle Heart Failure Model

Required Information:

- ✓ Clinical Data
- ✓ Ischemic v. Nonischemic HF
- ✓ Medications + Diuretics
- ✓ Lab Data (more complex)
- ✓ Devices

Calculates both 1-year and 5-year anticipated survival percentages.

https://depts.washington.edu/shfm/



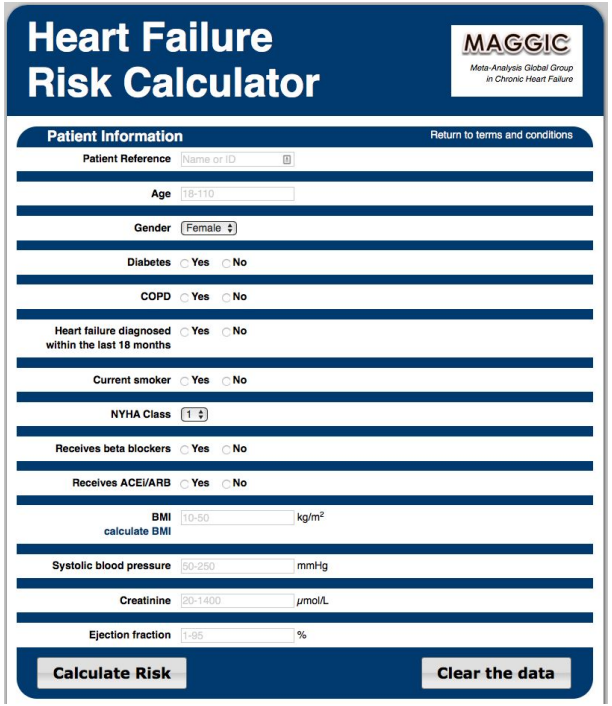
Heart Failure Risk Calculator

Required Information:

- ✓ Clinical Data
- ✓ Disease comorbidity
- ✓ HF DX Date
- ✓ Meds: beta-blocker, ACE/ARB
- ✓ Lab: creatinine only

Calculates 1-year and 3-year risk of dying + overall decile of risk.

http://www.heartfailurerisk.org



Solicit patient values and beliefs

Important to understand
what patients currently *get* …

… so we can make a change in
treatment to what patients *want*.

Poll Question #2

What percentage of patients report a desire to spend their final days at home?

A. 18%

B. 32%

C. 54%

D. 69%

E. 86%

What patients *want*...

Patients with serious illness have priorities besides living longer.

- Symptom management and quality of life
- Sense of control and completion
- Strengthening relationships

Singer JAMA 1999; Steinhauser JAMA 2000; Heyland Palliative Medicine 2015

What patients *want*...

Most people want to be at home and prefer comfort-focused care at the end of life, but that is often not the reality.

- 86% Medicare beneficiaries want to spend final days at home
  Barnato 2007
- 25-39% die in an acute care hospital
  Teno JAMA 2013; Silveira NEJM 2010
- 70% are hospitalized in the last 90 days
  Teno JM JAMA 2013
- 29% receive intensive care in the last 30 days
  Teno JM JAMA 2013
- Many experience care transitions and short hospice stays
  Teno JM JAMA 2013

What patients *get*...

Aggressive care for patients with advanced illness is often harmful!

- ✓ For patients:
  - Lower quality of life
  - Greater physical and psychological distress

    Wright, AA JAMA 2008; Mack JCO 2010
- ✓ For caregivers:
  - More major depression
  - Lower satisfaction

    Wright, AA JAMA 2008; Teno JM JAMA 2004

Review treatments

- Which heart failure medications and devices are appropriate?
- Review therapies for comorbidities, potential interactions, and side effects.
- Determine which preventive care is appropriate.

Treating HF: Medical Decisions

- ✓ Cardiac surgery, percutaneous catheter intervention, or cardiac resynchronization therapy: may reduce heart failure symptoms over time but involve short-term risk of morbidity and mortality.
- ✓ Implantable cardioverter-defibrillator therapy: reduces the risk of sudden death but does not improve heart failure symptoms.
- ✓ Supportive therapies (eg, IV inotropic therapy, hemodialysis): may be initiated during an acute decompensation but may continue to be required for an unanticipated duration of time.
- ✓ Aggressive treatment (eg, heart transplantation or LVAD): exchange one disease for another and markedly change life trajectory.

Consider options

- ✓ Anticipate major treatment choices on the horizon.
- ✓ Prepare for changes to existing treatment regimens to meet current patient goals.
- ✓ Refer or “phone a friend” if palliative care resources are needed beyond your scope.

Poll Question #3

What is the most common symptom of heart failure?

A. Fatigue

B. Dyspnea

C. Chest Pain

D. Nausea

E. Depression

Symptom Management: Dyspnea

1. Hemodynamic interventions (diuretics, afterload reduction, inotropes)
2. Opioids (low dose morphine, oxycodone if renal impairment)
   Johnson Eur J Heart Fail 2002
3. Benzodiazepines (only if anxiety also present)
4. Supplemental oxygen (only if hypoxia present)
5. Exercise (NYHA functional class II and III)
6. Other (breathing training, cool air by fan, anxiety management)
   Gysels Palliat Support Care 2009

Symptom Management: Fatigue

Determine underlying etiology and treat:

- decreased cardiac output
- elevated neurohormones
- deconditioning
- sleep impairment
- depression and/or anxiety

For chronic HF, selective thigh muscle strengthening improves fatigue.
Quittan Am J Phys Med Rehabil 2001

Symptom Management: Pain

Prevalence is 40-75% in patients with advanced HF (legs, back, major joints, chest).

Goodlin J Card Fail 2012

1. Opioids (added benefit of ↓ dyspnea)
2. Local treatment (cold/heat)
3. Physical therapy

NOT NSAIDS!

Symptom Management: Nausea

Almost 50% of patients with advanced HF report nausea in the last 6 months of life. Anorexia, weight loss and protein malnutrition are common.

Nordgren Eur J Cardiovasc Nurs 2003

Common causes: intestinal edema, hepatic congestion, acid-peptic disease, liver or kidney dysfunction, and medications.

Treatment:

1. Optimize HF medical management
2. Antiemetics for vomiting
   (Lorazepam does not prolong QT interval)

Symptom Management: Mood

The Data:

- ✓ High risk; prevalence is 20-40%
- ✓ Diagnosis of depression associated with worse clinical outcomes
  Faris Eur J Heart Fail 2002; Sullivan J Card Fail 2004
- ✓ Limited evidence to guide therapy

Treatment Options:

1. Cognitive behavioral therapy (helps depression not self care)
   Freedland JAMA 2015
2. SSRIs (hyponatremia)
3. Psychostimulants
4. TCAs (QT prolongation, consider Nortriptyline)

Look ahead and plan

1. Have conversations!
2. Document:
    - advance care directives
    - resuscitation preferences
    - preferences for and location of end-of-life care
    - surrogate decision makers

Timing for ACP Conversations

60-70% of people affirm that speaking with their doctor and/or family about their wishes is important.

Only 15-20% actually do!

- ✓ Waiting for the provider to bring it up
- ✓ Don’t want to talk about it too early

Conversations are KEY

Earlier conversations about patient goals and priorities for living with serious illness are associated with:

- ✓ Enhanced goal-concordant care
  Mack JCO 2010
- ✓ Improved quality of life
- ✓ Reduced suffering
- ✓ Better patient and family coping
- ✓ Higher patient satisfaction
  Detering BMJ 2010
- ✓ Less non-beneficial care and costs
  Wright 2008, Zhang 2009

Serious Illness Conversation Guide

CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
1. *Set up the conversation* Introduce the idea and benefits Ask permission	SET UP: "I'm hoping we can talk about where things are with your illness and where they might be going — **is this okay?**"
2. *Assess illness understanding and information preferences*	ASSESS: "What is your **understanding** now of where you are with your illness?" "How much **information** about what is likely to be ahead with your illness would you like from me?"
3. *Share prognosis* Tailor information to patient preference Allow silence, explore emotion	SHARE: **Prognosis:** "I'm worried that time may be short." *or* "This may be as strong as you feel."
4. *Explore key topics* Goals Fears and worries Sources of strength Critical abilities Tradeoffs Family	EXPLORE: "What are your most important **goals** if your health situation worsens?" "What are your biggest **fears and worries** about the future with your health?" "What gives you **strength** as you think about the future with your illness?" "What **abilities** are so critical to your life that you can't imagine living without them?" "If you become sicker, **how much are you willing to go through** for the possibility of gaining more time?" "How much does your **family** know about your priorities and wishes?"
5. *Close the conversation* Summarize what you've heard Make a recommendation Affirm your commitment to the patient	CLOSE: "**It sounds like** _____ is very important to you." "Given your goals and priorities and what we know about your illness at this stage, **I recommend...**" "**We're in this together.**"
6. *Document your conversation*	

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Reimbursement for ACP

- Main points of conversation must be documented in the visit note
- Time spent for the conversation must be documented in the chart
- CPT Codes:
  - 99497 (16-30 minute conversation)
  - 99498 (each add'l 30 minutes of conversation)

How do I get started?

- ✓ Build a framework for annual review of HF patients into your workflow.
- ✓ Make a connection with palliative care in your community or region.
- ✓ Role play a serious illness conversation with a colleague to gain comfort.

Questions?