

# The Challenges of Integrating Palliative Care into Cardiac Care

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# Key Issues in Heart Failure in Canada

- **Common** – affecting at least 2% of population
- **Dangerous** – high mortality and readmission rates
- **Disabling** – significantly impacts quality of life and readmission rates
- **Costly** – consumes at least 2-3% of health care budget

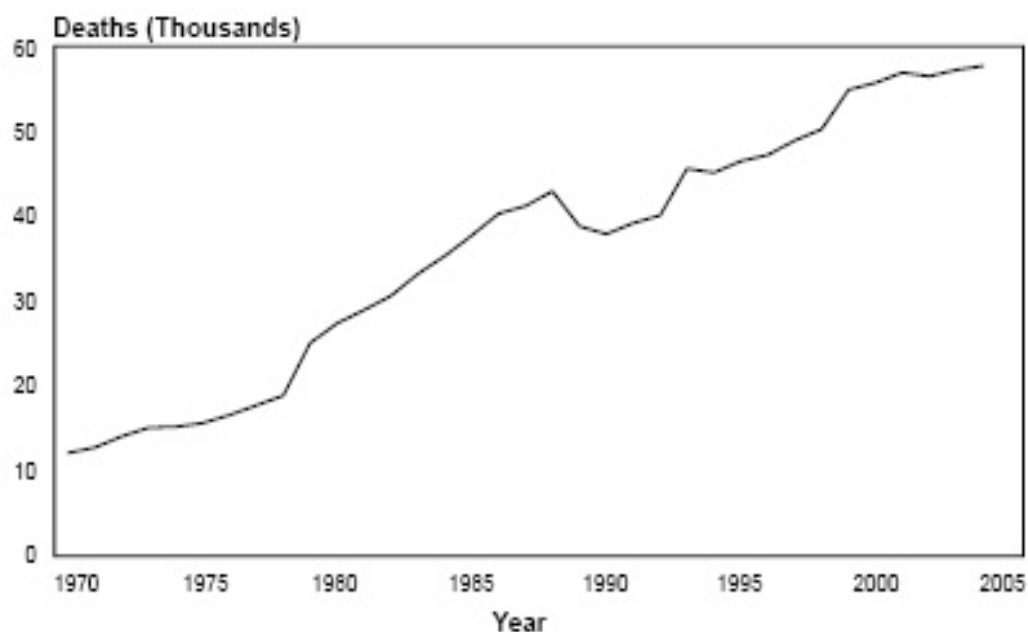
But today HF is **Treatable** – very successful treatment options now available

# St Mary's Heart Failure Patient Demographics

- Avg Age : 78 yr
- Sex : 52% ♂ 48% ♀
- Etiology: Coronary Artery Disease 57%
- LV Function: ~ 60 % LVEF < 40%  
~ 40% LVEF ≥ 45%
- Co-morbidities:
  - 40% have > 3 significant co-morbidities
  - > 1/3 have Calculated GFR's < 30 ml/min/1.73 m<sup>2</sup>
- 72 % patients taking > 6 medications
- Greater # of such patients admitted to Hospitalists as to Cardiologists.

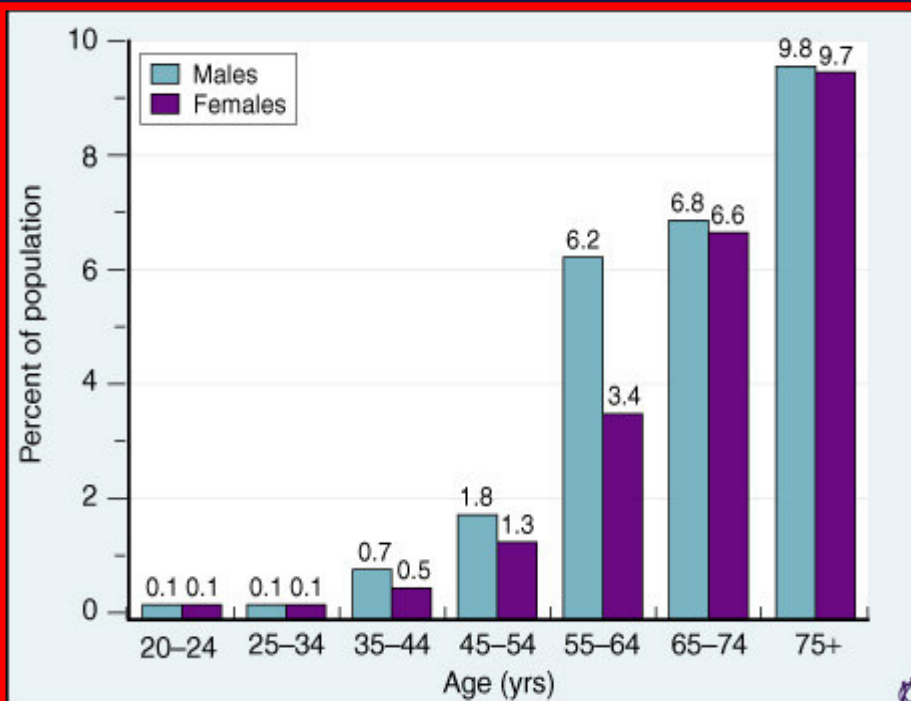
# Heart Failure – the Major Cause of CV Death

Deaths From Heart Failure, U.S., 1970–2004

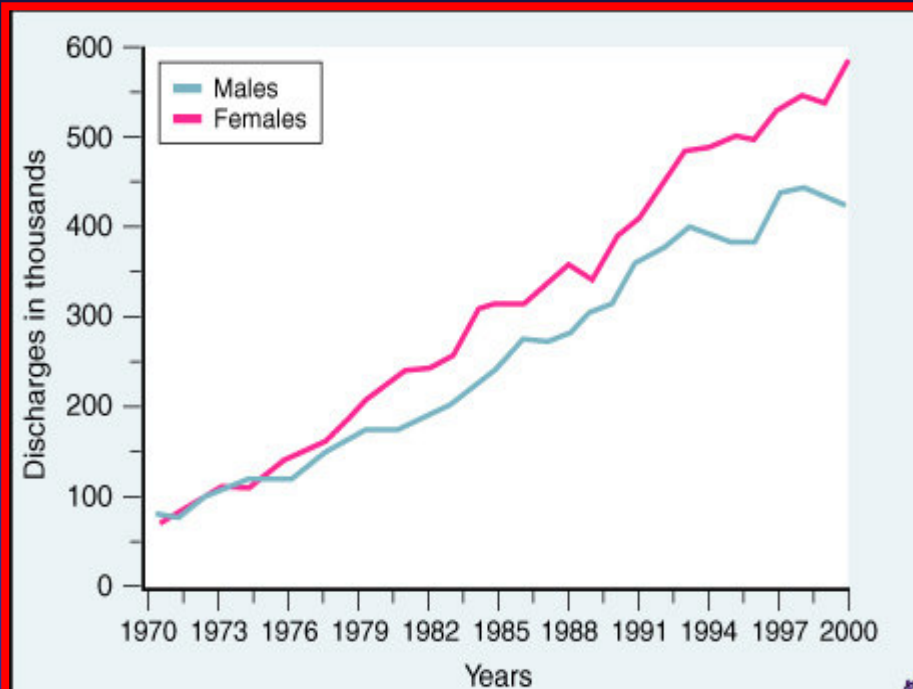


Note: The sharp drop occurring in 1989 is attributed to the revision of the death certificate.  
Source: Vital Statistics of the United States, NCHS.

# Epidemiology of Heart Failure in the USA ( AHA 2003 )



**Prevalence Rates of Heart Failure**



**Hospital Discharges for Heart Failure**

# Other Key Facts to Understand in Patients with Advanced HF

- $\leq 5\%$  of patients die during a index hospital admission but post discharge.....
- .....6 month discharge mortality was  $\sim 20\text{-}25\%$  ( usually due to pump failure)
- Patients usually respond relatively rapidly to therapy within 3-5 days.

# A Randomized Trial of the Efficacy of Multidisciplinary Care in Heart Failure Outpatients at High Risk of Hospital Readmission

E Kasper et al; JACC 39: 471 ( 2002)

## **Key Points from this Study:**

- Improvement in NYHA functional class
- Improvement in patient–assessed symptoms
- Significant increase in use of evidence based medications at least 50% of target doses
- Significant improvement in QOL scores.
- Very significant ↓ in hospital readmissions.
- No significant difference in costs or in survival.

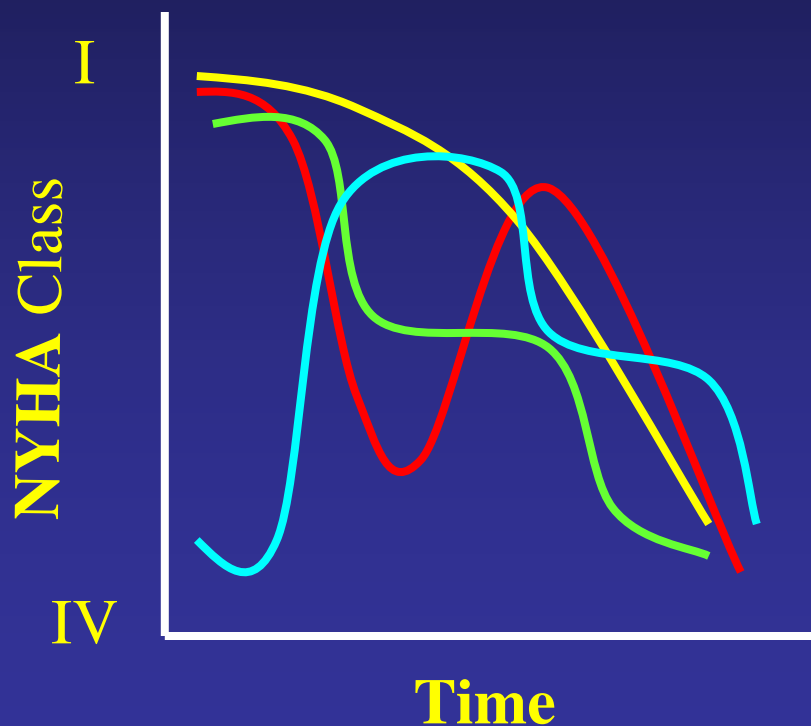
# “Interventional” Heart Failure Management

- BIPAP or ventilation
- Inotropic /vasodilator therapy
- Ultrafiltration therapy
- IABP's
- [ Left Ventricular Assist Device ] ???

# Managing Heart Failure

## Difficulties in Predicting Clinical Course

### “Real Life” HF

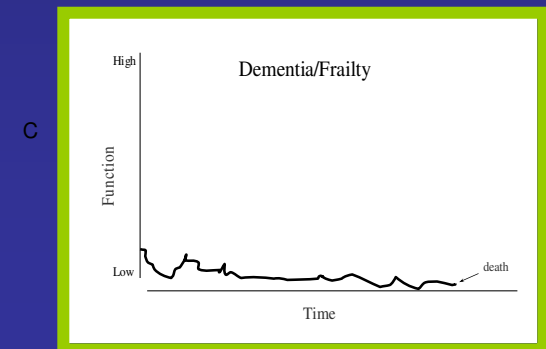
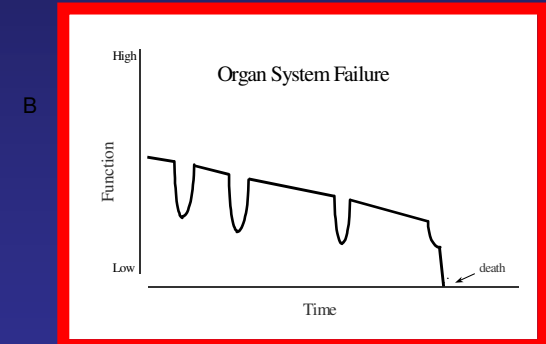
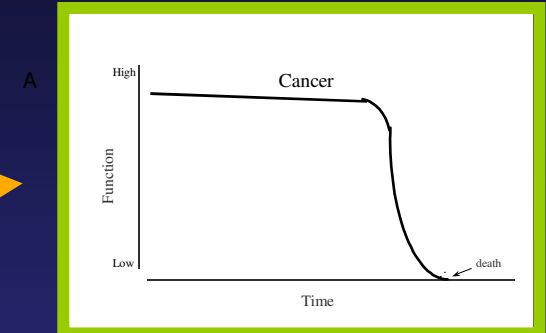
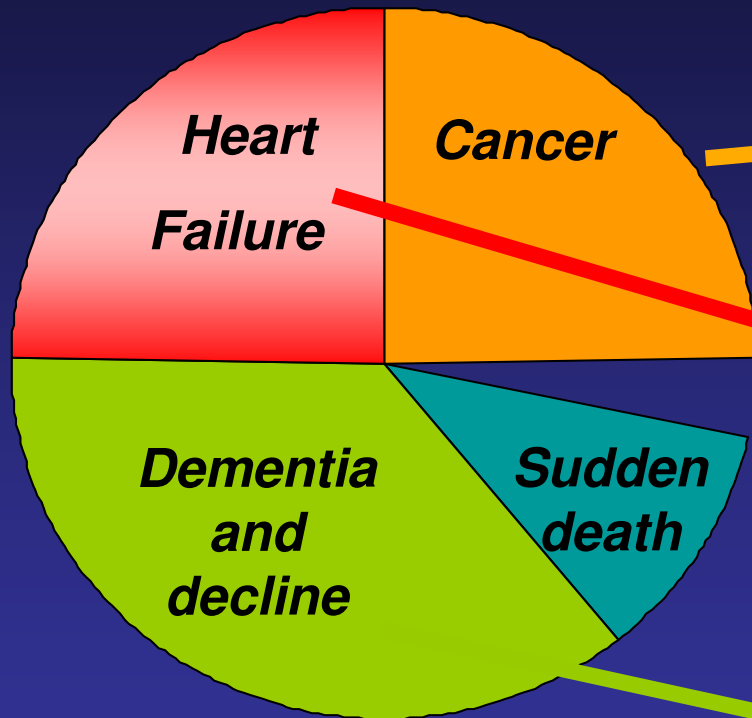


### Points to Ponder

- When is HF “end stage” ?
- “End Stage HF “ can only be determined after reasonable attempts at controlling symptoms has failed .
- While we commonly consider inotropes/vasodilators and CRT devices as aggressive, they can provide significant symptom improvement .
- Most patients labelled as “end stage” are better labelled as having “Advanced Heart Failure”

# The Challenges of Integrating Palliative Care

## Differing Clinical Courses



# CHEST<sup>®</sup>

Official publication of the American College of Chest Physicians

## Prognostic Judgments and Triage Decisions for Patients With Acute Congestive Heart Failure\*

Wally R. Smith, Roy M. Poses, Donna K. McClish, Elizabeth C. Huber, F. Lynne W. Clemo, Donna Alexander and Brian P. Schmitt

Chest 2002;121:1810-1817  
DOI 10.1378/chest.121.5.1810

### Key Points:

- Critical care physicians substantially over-estimated the probability that HF patients would die or have severe complications that would require more aggressive care
- Physicians had only a modest ability to predict who would die vs who would not .
- British Study: Physicians correctly predicted the 1 year outcome ( death or still alive) of patients with a hx of "advanced heart failure" presenting to the ER only 24% of the time. !



Although approximately 40% of patients hospitalized with severe HF in the SUPPORT Study had previously stated their preference not to be resuscitated, 40% of these patients changed their minds within 2 months of discharge.

# The Challenges of Integrating Palliative Care into Heart Failure Care

## Summary

- ◆ The clinical course of HF is NOT the same as cancer  
..... similarities but not the same.
- ◆ HF is a syndrome where patients can oscillate between poor health status (often near death) and a reasonable or good functional status and QOL.
- ◆ It is important to differentiate between the patient who suffers from severe HF causing functional impairment at the NYHA FC III –IV level but who yet may still respond to aggressive treatment from the patient who has reached the stage of intractable HF.

# The Challenges of Integrating Palliative Care into Heart Failure Care

## Summary

- The ability to accurately prognosticate “outcome” over the next 6 -12 months is very difficult ..... even for those who specialize in dealing with this group of patients.
- Physicians (including Cardiologists) have limited abilities to accurately predict short term mortality , complications or need for more aggressive care. If anything they tend to “over-estimate” their ability to prognosticate.
- Physicians and nursing staff have a tendency to treat this group of patients “like end stage cancer patients” with respect to level of care issues , ongoing treatments, etc.



Modernisation Agency

Coronary Heart Disease Collaborative  
Supportive and palliative care  
for advanced heart failure



■ Do HF patient's really need "Palliative Care" ?

■ Is "Palliative Care" the best model ?

# Barriers to Integrating Palliative Care into Advanced Heart Failure Management

## From Cardiology

- Perception that palliative care only for dying
- Concentration on “Active Care” only
- Lack of experience in working in supportive, team environment
- Lack of communication skill re: palliative care
- Concern about inappropriate medication changes/ stops and lack of cardiac skills
- Tying up cardiac beds
- Patients will be upset about concept of “palliative care”

## From Palliative Care

- Concerns that “flood gates” will open and swamp them more
- Concern about tying up beds with chronic illness rather than palliative patients
- Concern that they don't have the skills to look after these patients
- Patients will be upset about concept of “palliative care”

## The Challenges of Integrating Palliative Care Into Heart Failure Care

# Many Questions ....

- Can very ill patients make informed decisions between treatments ( eg inotropic drugs , IV diuretics) that may improve symptoms but ↑ the risk of sudden cardiac death ?
- When does “supportive care” become “active care” ?  
( eg IV diuretics, IV inotropes, cardiac resynchronization )
- At what point does “prolonged life” become “prolonged dying ?”
- How best can we support the care givers of patients with advanced HF ?
- What drugs can we use safely to alleviate symptoms vs drugs that can be discontinued ?