

Palliative Care and the CHF Patient

Tennessee Hospice Organization

Nov 18th, 2016

2:50-3:40

Disclosures

- ***Regrettably*** :
- I do NOT receive any honorarium, buyouts or bribes from any pharmaceutical manufacturers or medical devices
- I am no one's paid consultant
- I am not being paid to plug expensive variations of old stand by drugs.

Heart Disease the leading cause of hospital admission > 65
It is the second most common non-cancer hospice diagnosis



“On the upside, you’re only one heart attack away from reaching our platinum V.I.P. status.”

True Story

I was talking with a cardiologist friend who shares an interest in ethics with me. I asked him 'when do you tell your patient's with **heart failure** that they have a potentially life ending illness with a roughly 50% 5 year mortality.'

He responded "Oh I think that is the Family Doctor's job"

I responded: "Well I *are* a family doctor." (this is East Tennessee) " I would argue that you as the content expert, would be the "authority" and should be the one to tell the patient."

He took a long sip on his coffee and just said "Nope, not gonna happen."

**WE HAVE MET
THE ENEMY
AND HE IS US.**



Setting the Stage

A Few Facts

Fully one quarter of physicians in the US are OVER 65!

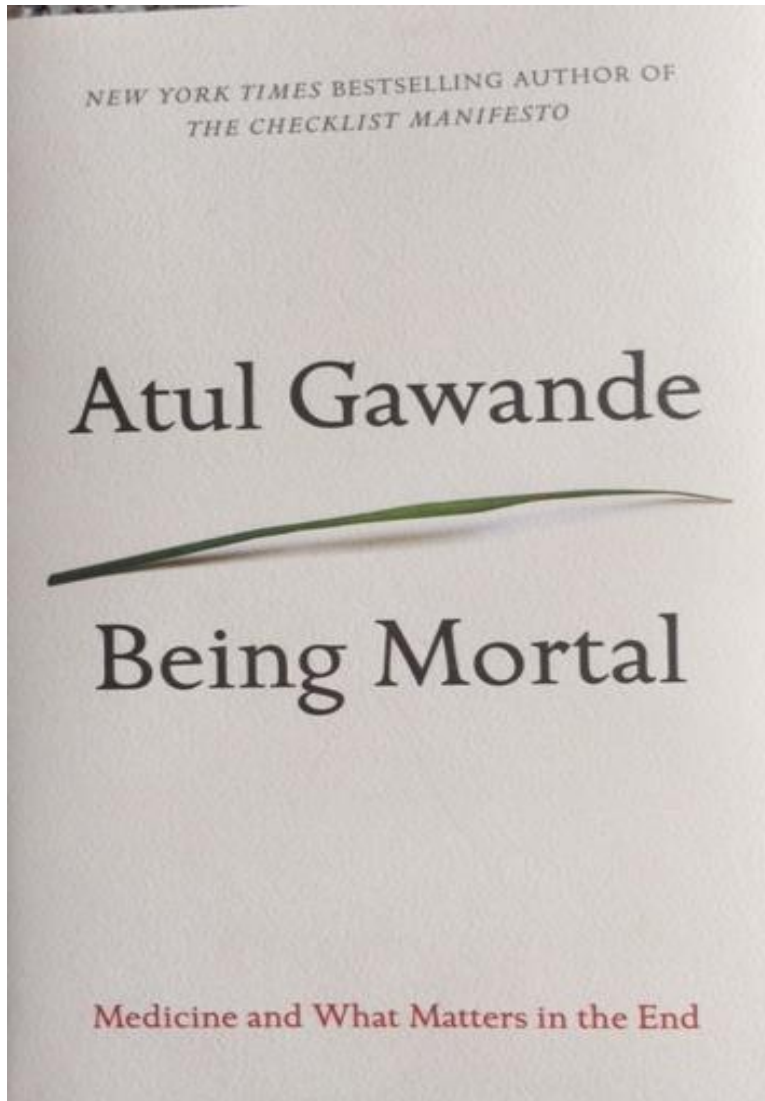
Average Age of physicians is in their mid fifties. And the single biggest block of physicians is 50-60

Hospice became a Medicare benefit 1982/3

Medical schools started training about palliative care and end of life care
Only in the late 2000's

Take home message—Current physician workforce is ill trained and ill prepared to discuss end of life care.

Getting to What Matters



“I learned a lot of things in medical school but mortality wasn’t one of them...our textbooks had almost nothing on aging or frailty or dying.

Also see- Letting Go What Medicine Should Do When it Can’t Save Your life
Atul Gawande MD-
New Yorker Aug 10th 2010

12% !!??

12% of physicians and NP's at the Mayo Clinic had the AHA recommended regular, annual discussion with CHF patient's about End of Life Care choices.

52 % were hesitant to mention end of life

21% felt patient's were ready.

11% were uncomfortable bringing up the topic

9% were concerned about destroying hope

8% said they didn't have the time.

30% had low or very low confidence in themselves as to initiating EOL discussions.

Dunlay SM, Foxen J, Cole T et al. Clinician Attitudes and Self Reported Practices Regarding End of Life Care in Heart Failure. Quality of Care and Outcomes Research conference- Baltimore MD. Reported on NPR June 4, 2014

Not Just in the US

clinicians seemed **reluctant to discuss** a palliative care approach without clear irreversible deterioration of the patient. However, patients welcomed, and some initiated, conversations about the change in focus of care. After such discussion, patients, carers, and clinicians found this approach beneficial, even with subsequent periods of stability or improvement. Other barriers included lack of recognition of symptoms by clinicians and difficulties in delivering proactive care

Amy Gadoud, Una Macleod, Eleanor Kane, Pat Ansell, Miriam Johnson
A palliative care approach for people with advanced heart failure: recognition of need, transitions in care, and effect on patients, family care givers, and clinicians.
The Lancet 26 Feb 2014

Communication

One of Six Core Competencies

- 70% of serious adverse outcomes from poor communication (Joint Commission)
- Two of three patients are discharged from the hospital without knowing their diagnosis
- 60% of patients misunderstood their instructions
- Physicians wait an average of 18 seconds before interrupting a patient
- Doctor's only introduced themselves ¼ times
- *Doctor, Shut up and Listen*, NYT 1/4/2015 Nirmal Joshi

Prognosis: The Chance to Plan (We Stink)

- Medical Literature Dx 37%, Tx 33%, Px 4%*
- Prognosis--The opportunity to look stupid.
- Unofficial Physician Norms-
 - Don't make a prognosis
 - If you have a prognosis, keep it to yourself unless asked
 - Don't be specific,
 - Don't be extreme
 - Be optimistic
- Doctors Err 2-5x duration to the optimistic side

***Death Foretold** by Nicholas Christakis MD 1999

In a 2000 study of 343 physicians by Christakis to provide survival estimates for 468 terminally ill patients at the time of hospice referral. Only 20% of predictions were accurate (as defined as within 33% of actual survival).

Overall, doctors overestimated by a factor of 5.3!

Christakis NA, Lamont EB. Extent and Determinants of Error in Doctor's Prognoses in Terminally Ill Patients: Prospective Cohort Study. *BMJ*. 2000; 320:469-472

1998 Nobel Prize for Economics

- Amartya Sen-
- Studied welfare recipients discovering people will do what they are financially incented to do

Amartya Sen - Facts



Amartya Sen

Born: 3 November 1933,
Santiniketan, India

Affiliation at the time of the award: Trinity College,
Cambridge, United Kingdom

Prize motivation: "for his
contributions to welfare
economics"

Field: welfare economics

Contribution: Research on
fundamental problems in welfare
economics. Studies of social
choice, welfare measurement, and
poverty.

Prize share: 1/1

Follow the Money!

- [Hospitals] are currently are not directly reimbursed for services having to do with communication, care planning and many aspects of palliative care, but rather for treating a patients specific diseases and symptoms....there are powerful financial incentives for hospitals to define care in terms of reimbursable treatment interventions and diagnostic testing, to prioritize quantity over quality of care and to set a lower value on patient services that are not income generating
- Hastings Center Manual on Ethics at End of Life (2nd ed)
- Health care is the second largest lobbying effort in Washington. The single biggest health lobby in Washington is the Pharmaceutical Research and Manufacturers of America (PhRMA*)
- Opensecrets.org
- *Full disclosure-the AMA is 9th, AHA 12th

Contemporary Commentary on the US Health Care System by the AMA

-the current “care system’ provides disjointed specialty services, ignores the challenges of living with disabilities, tolerates routine errors in medications and transitions, disdains individual preferences and provides little support for paid or volunteer care givers. This maladapted service delivery system now generates about half the life time costs for health care services, yet patients and families are left fearful and disoriented, with pain discomfort and distress.
- Lynn J., *Reliable and Sustainable Comprehensive Care for Frail Elderly People*. JAMA Nov 13th 2013 1935-6

Heart Failure

#1 Cause of Hospital Admission and Readmission

- Beginning 2011, hospitals began to be penalized in escalating scale for “inappropriate readmission rates.”
- Hospital trends 1993-2006-
- **The Good:** LOS down from 8.8 to 6.3 days, Mortality down from 8.5 to 4.3%. 30 day mortality down from 1.8 to 10.7%

Eric Widera. Have we Improved Outcomes for Elderly Patients Admitted with Heart Failure. (JAMA article review) GeriPal June 1, 2010.



“Geez Louise—I left the price tag on.”

Hospital Trends

1993-2006

The Bad: Nursing facilities admits up from 13 to 17%. 30 day readmits jumped from 17 to 20%. Post discharge mortality jumped from 4.3 to 6.3%. AT 6 months ½ of CHF patients were re-admitted.

Mortality- hospital admission triples mortality

30 days- 10%

6 months-25%

1 year- 33%

Eric Widera. Have we Improved Outcomes for Elderly Patients Admitted with Heart Failure. (JAMA article review) GeriPal June 1, 2010.

Three Phases of CHF Re-admission

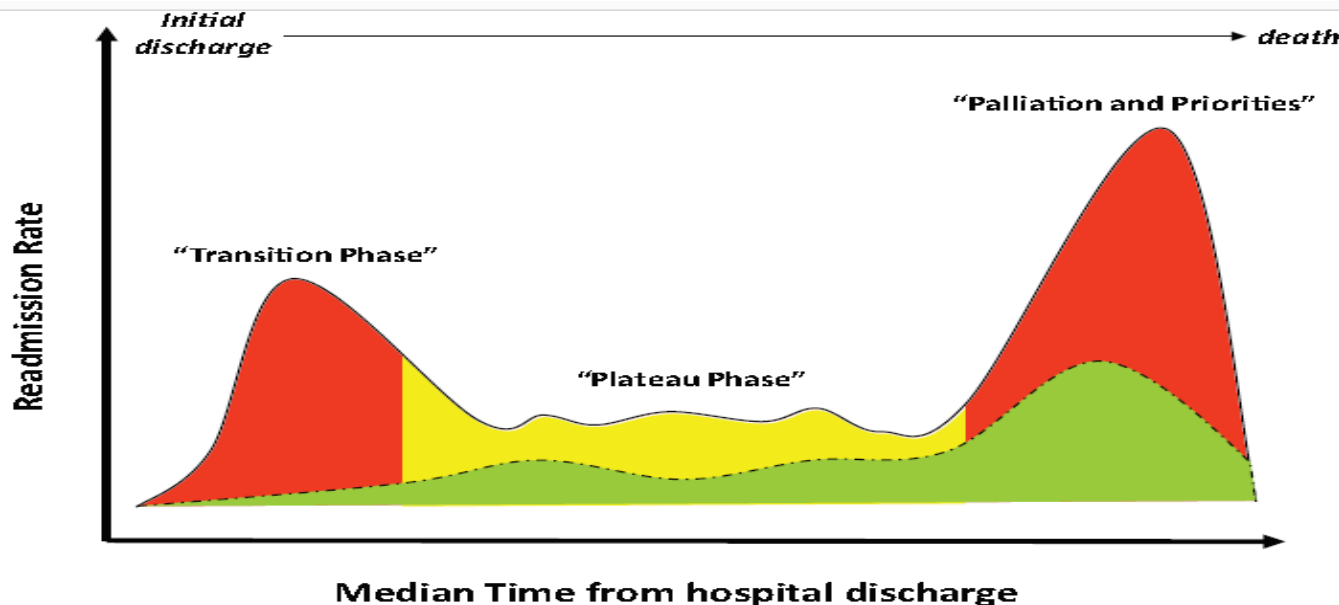


Figure 1. Three-phase terrain of lifetime readmission risk after heart failure hospitalization. Figure drawn to schematically depict data from Chun et al.⁷ and Russo et al.¹⁹ The shaded red areas depict periods of highest risk for readmission immediately following discharge and just before death; the shaded yellow area reflects the lower risk plateau phase; and the shaded green reflects the assumed baseline of unavoidable readmissions.

Affordable Care Act

Bundled Payment for Care Improvement

Bundles all costs and sites of care for an “episode of care”
Including hospital and post hospital care into one package
Hospitals and other Accountable Care Organizations
are now looking for ‘preferred care partners’ to help with
better managing these patient. CHF is second most
popular bundle for hospitals.

Palliative care should play a huge
role in this but is often not even at the table

Hospice care not included in BPCI at present

What not to do?

NOV

4

Teaching Physicians to Do LESS for Patients at End of Life

"I have often thought it would be important to instruct physicians how to behave in cases of incurable disease: not so much to tell them what to do; rather what not to do."

- Letter from Johann Stieglitz to Karl F.H. Marx (15 December 1826).



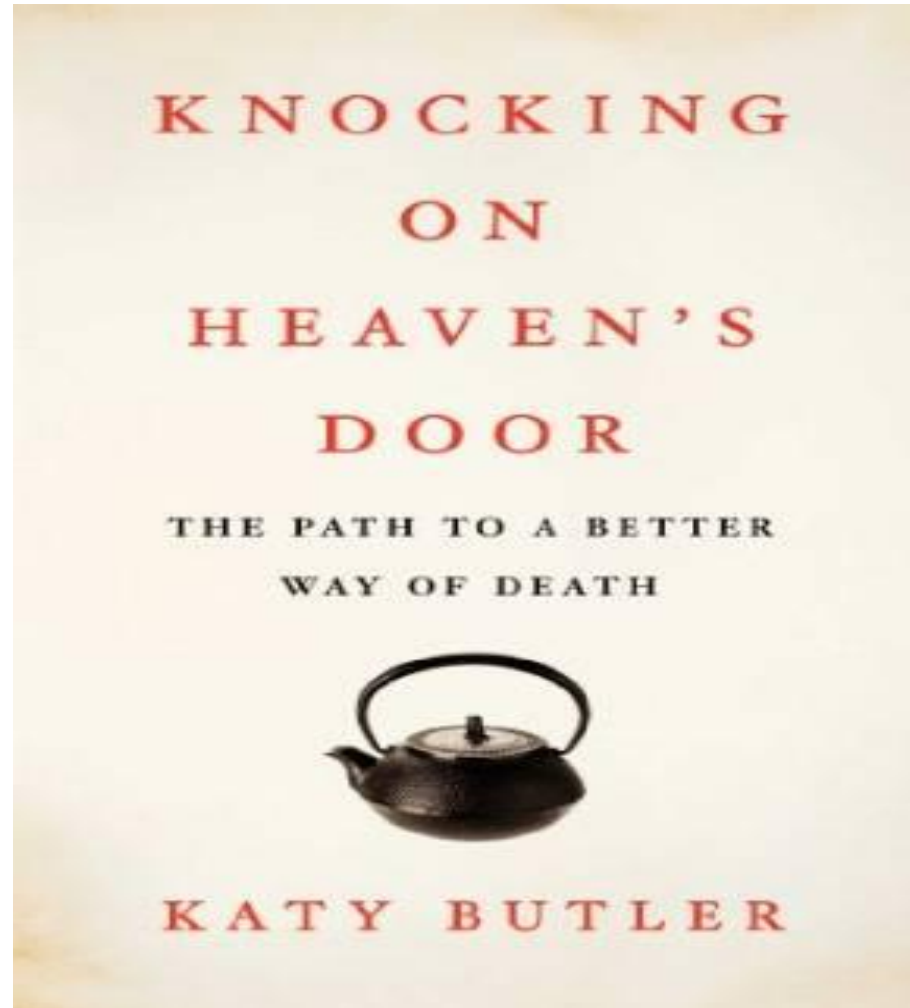
What is It ALL About?

Have the Conversation!

We are perfectly un-prepared
for

Something that is totally
predictable

Katy Butler's dad was dying of Alzheimer's. She wanted to turn off his pacemaker



Atul Gawande MD

Overkill-New Yorker May 11th 2015, p 42-53

- “..unnecessary care often crowds out necessary care, particularly when the necessary care is less remunerative.”
- “In just a single year,...25-42% of Medicare patients received at least one of twenty six useless tests and treatments.”
- “Millions of people are receiving drugs that aren’t helping them, operations that aren’t going to make them better and scans and tests that do nothing beneficial.”

Diseases with ~ 50% Five year mortality

Cancer

Heart Failure

COPD

ES Renal Failure

Prevalence of Symptoms and Suffering in Heart Failure

Pain (78%),
Dyspnea (61%),
Depression (59%),
Insomnia (45%),
Anorexia, (43%),
Anxiety (30%),
Constipation (37%),
Nausea/vomiting (32%),
Fatigue,
Difficulty ambulating,
Edema.

Treatment Thoughts

The best palliative treatment of heart failure is good medical treatment of heart failure

Dyspnea- Assess patient before making decisions. Many CHF patient also have COPD, effusions, hypotension or anemia. Positioning can help as can fans

Morphine is our friend!

Pain- Avoid NSAIDs-They antagonize ACE inhibitors and kidney function Think Vioxx

Morphine is our friend! Opioids are appropriate acutely and chronically for HF

NYHA II-IV

Depression: SSRI's are drug of choice, but in some cases psychostimulants work a lot faster

Little data on side effects in heart disease. Use w caution and start small

Usually only raises pulse and BP by a few points.

Diuretics: Lasix doses are usually doubled till effective. (Threshold effect)

Maximum dose of Lasix (furosimide) is 4000 mg daily! Can be ototoxic!

IV or sub Q drips 3-200 mg/h usually 10-20 can be more effective. Adding

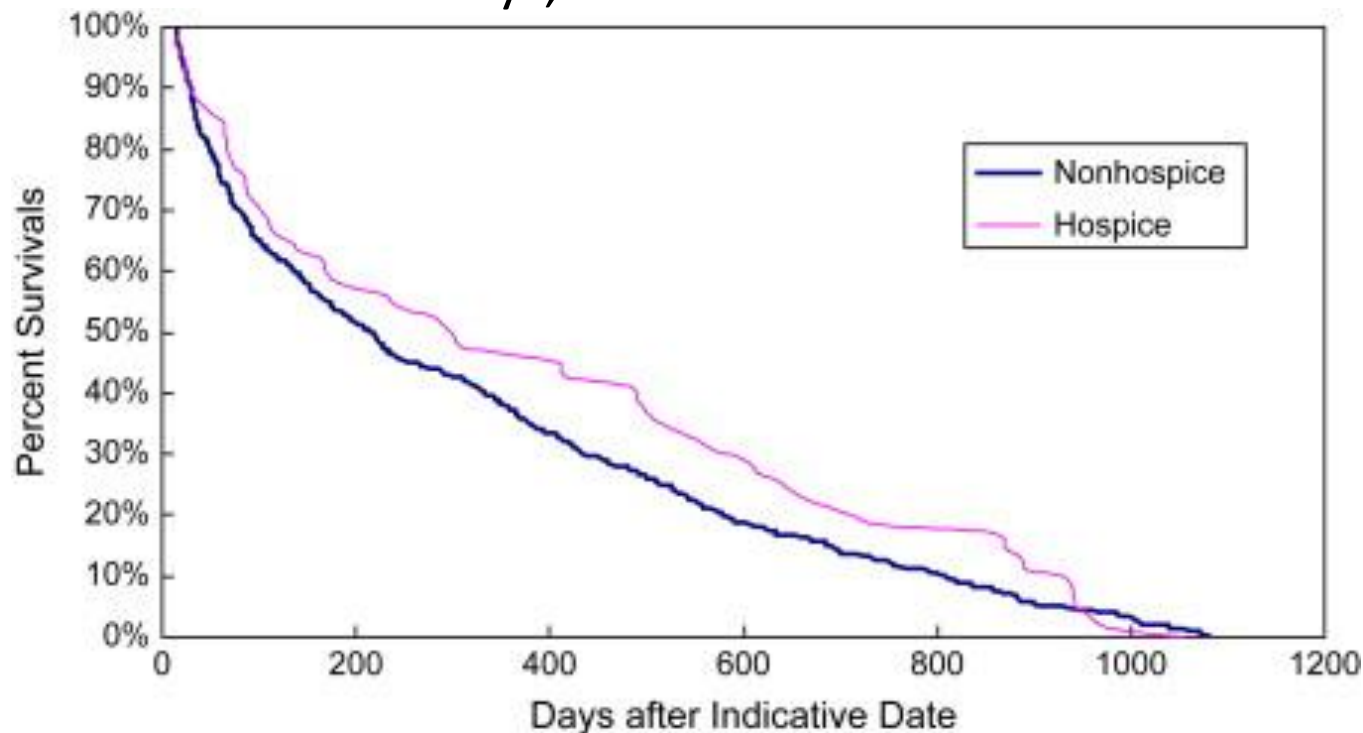
Metolazone 5-20 or HCTZ 25-100 can often act as a 'booster' for loop diuretics.

If long term treatment may wish to check electrolytes

(from Fast Facts 144)

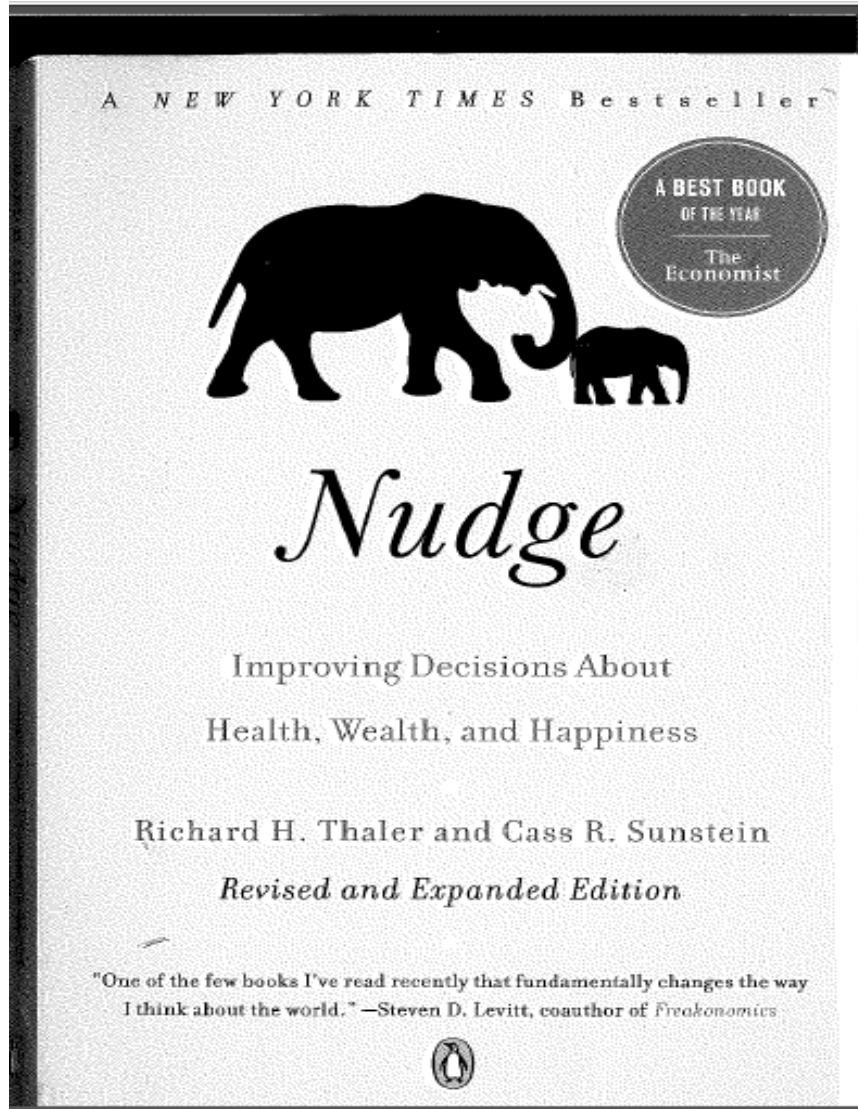
Hospice for Heart Failure Prolongs Survival

Using 5% Medicare file – 83 Hospice patients and 457 non-hospice patients - 402 vs. 321 days, $P = 0.05$



Connor SR et al. J Pain Symptom Manage. 2007;33(3):238-46.

The Nudge: Libertarian Paternalism



- Choice architecture
- Design a system where all options remain but the best choice is most obvious-
- CPOE- Example
- 1st- CHF admit gets education
- 2nd- Home Health to Follow and case manage
- 3rd admit-Palliative Care consult
- 4th admit- automatic Hospice Consult

CPR and AND/DNAR/DNR

- “The low rate of success of CPR may be an example of how a medical myth is perpetuated by the media because it is more appealing than the truth” -Robert Schmerling
- Success rate for CPR on TV was 65-100% the show to die on is Rescue 911*
- Diem, SJ., Lantos J.D., Tulskey, JA. Cardiopulmonary Resuscitation on Television NEJM 33:1578-82

Actual CPR

- Success* in the hospital, rates 13-20% average about 15%
- Out of hospitals rates 10% or less.
- Success in CPR is less age dependent than illness dependent.
- Overall 15%
- Frail elderly % 5%
- Advanced Chronic illness metastatic Ca, multi organ failure in bed more that ½ waking hours 0-3%
- A Review of ACLS Medications at **theNNT.com** found “**No Benefit**” to ACLS medications although defibrillation was helpful.

*Success often defined as surviving to discharge
Compassionandsupport.org

CPR injuries

- CPR injuries- rib fractures >30%
- Brain injury- of the 18-20% who survived in one study* 58% were still alive one year later however, 52% had moderate to severe neurologic injury and 60% went to a nursing home.
- Additional injuries: pneumothorax perforation of organs and or lacerations to internal organs.

Number Needed to Treat-NNT

- Osteoporosis/Alendronate-Primary prevention vertebral fracture NNT=50, Secondary NNT 16*
- Cholesterol/statins: NNT primary prevention of non-fatal MI= 60 (Taken x 5 years) 98% saw no benefit, 0% were helped by being saved from death, 1.6% were helped by preventing a heart attack, 0.4% were helped by preventing a stroke. 2% were harmed by developing diabetes, 10% were harmed by muscle damage**
- Stroke/warfarin: NNT 25 to prevent stroke**

Predictors of Shorter Prognosis

Recent cardiac hospitalization (triples 1-year mortality).

Elevated BUN (defined by upper limit of normal) and/or creatinine ≥ 1.4 mg/dl (120 $\mu\text{mol/l}$).

Systolic blood pressure < 100 mm Hg and/or pulse > 100 bpm (each doubles 1-year mortality).

Decreased left ventricular ejection fraction (linearly correlated with survival at LVEF $\leq 45\%$).

Ventricular dysrhythmias, treatment resistant.

Anemia (each 1 g/dl reduction in hemoglobin is associated with a 16% increase in mortality).

Hyponatremia (serum sodium ≤ 135 -137 mEq/l).

Cachexia or Reduced functional capacity.

Co-morbidities: diabetes, depression, COPD, cirrhosis, cerebrovascular disease, cancer, and HIV-associated cardiomyopathy.

Re-hospitalization as Marker for Mortality

- British Columbia Cohort of 4,374 patients hospitalized for HF
- Mortality significantly increased after each HF hospitalization. Number of HF hospitalizations was a strong predictor of all-cause death.
- Median survival after the first, second, third, and fourth hospitalization was 2.4, 1.4, 1.0, and 0.6 years.

Am Heart J. 2007 Aug;154(2):260-6.

One Common Prognostic Tool

SEATTLE HEART FAILURE MODEL	
Home About SHFM Update Information Publication Web Tutorial Privacy Links iPhone Version Windows Version Macintosh Version Sponsors Press Release Contact	<p>The Seattle Heart Failure Model (SHFM) is a calculator of projected survival at baseline and after interventions for patients with heart failure. SHFM is designed for use by health care providers knowledgeable in cardiac medicine. Patients should only use SHFM when their healthcare providers are present, such as at a doctor's office. Please click the option below that applies to you:</p> <p><input checked="" type="radio"/> I am a healthcare provider. <input type="radio"/> I am not a healthcare provider. <input type="button" value="Enter"/></p> <p>NOTE: In addition to the Seattle Heart Failure Model calculator for the web, there are free, downloadable versions for the Mac OS X®, Windows® platforms, as well as an online version for the iPhone®. Click on the appropriate choice to the left for more information.</p>

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NYHA Functional Classification of Heart Failure

- I. Patient without limitation of physical activity
- II. Patients have slight limitation of physical activity, in which ordinary physical activity leads to fatigue, palpitations, dyspnea or angina pain. They are comfortable at rest.
- III. Patients with marked limitation of physical activity, in which less than normal activity results in fatigue, palpitations, dyspnea or angina pain
They are comfortable at rest.
- IV Patients who are not only not able to carry on any physical activity without discomfort but who also have symptoms of heart failure or angina syndrome even at rest; the patient's discomfort increases if any activity is undertaken

Patient's often lie about comfort at rest or dyspnea even as they gasp!

Hospice Eligibility Guidelines

The National Hospice and Palliative Care Organization's 1996 guidelines for heart disease admission criteria include: a) symptoms of recurrent HF at rest (NYHA class IV) and b) optimal treatment with ACE inhibitors, diuretics, and vasodilators (contemporary optimal treatment now includes β -blockers, aldosterone antagonists, and device therapies). The NHPCO guide indicates that an ejection fraction $< 20\%$ is "helpful supplemental objective evidence," but not required. The NHPCO guidelines also assert that each of the following further decreases survival: treatment resistant ventricular or supra-ventricular arrhythmias, history of cardiac arrest in any setting, history of unexplained syncope, cardiogenic brain embolism, and concomitant HIV disease.

- Guidelines were written in 95/96 before diastolic heart failure was widely recognized entity.
- Were expert opinion not experimentally derived.
- Subsequent data shows most CHF patient's out live current guidelines at 6 months.

Four Paths to Eligibility

1. Meets **ALL** the Local Coverage Determination (LCD) criteria
2. Meets most of the LCD criteria AND has documented **rapid clinical decline** supporting a limited prognosis
3. Meets most of the LCD criteria AND has **significant comorbidities** that contribute to a limited prognosis
4. **Physician's clinical judgment** is that the patient has a limited prognosis

All four paths lead to the same destination: identification and support of a six-month prognosis

Heart Failure isn't just Pump Failure

Regardless of etiology, Heart Failure is characterized by alterations in the renin-angiotensin-aldosterone, sympathetic and other hormone systems resulting in a catabolic state.

Pro-inflammatory cytokines are activated in HF leading to insulin resistance, cachexia and anorexia.....

...results in respiratory and skeletal muscle atrophy, weakness, ...fatigue, dyspnea and limited exercise capacity.

Sarah Goodlin. Palliative Care in Congestive Heart Failure. Journal of the American College of Cardiology. # 5 2009.

Sleep Disorders

Sleep disordered breathing appears in ½ of heart failure patients....Oxygen de-saturation causes marked elevations in norepinephrine ... contributing to anxiety and depression and cognitive impairment.

Sarah Goodlin. Palliative Care in Congestive Heart Failure. Journal of the American College of Cardiology. # 5 2009.

Heart Failure Society of America

Module 9

Advance Care Planning

The Heart Failure Society of America (HFSA) is a non-profit organization of health care professionals and researchers who are dedicated to enhancing quality and duration of life for patients with heart failure and preventing the condition in those at risk. These educational modules have been developed to help patients, their families, and individuals at risk for heart failure understand and cope with the disease. For more information about the Society please visit our web site www.hfsa.org.



www.hfsa.org

Heart Failure Society
of America

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How Heart Failure Patients Die

About one half die of progressive pump failure.

One half is sudden arrest

Most CHF patients “substantially over estimate their life expectancy.”

Allen, LA, Yaer, JE, Funk, MJ et al
Discordance Between Patient-Predicted Life
Expectancy among Ambulatory Patients
With Heart Failure. JAMA;299 (21) 2009

“The course of death in patient’s should not be characterized by severe dyspnea or volume overload. Rather, most patients managed by HF specialists experience metabolic Derangement and coma or sudden death, not congestion and dyspnea.”

Sarah Goodlin. Palliative Care in Congestive Heart Failure. Journal of the American College of Cardiology. # 5 2009.

Voice your Choice!

Hoping for the best, While preparing for the worst

Utilize -Ask/Tell/ Ask format

Define medical terms in lay language/avoid jargon

Avoid Euphemisms

Simplify statistics to “one in ten” etc.

Normalize uncertainty “We can never be sure but...

Give prognosis in broad ranges –weeks to months, months to years.

Don't abandon! Partner and Plan

Empathize!-identify emotions and sympathize

Summarize the plan and set follow up.

“I'm just living this long to “piss off” Dr. Phelps

Two new CPT advanced care planning codes (99497 and 99498) are used to report the face-to-face service between a physician or other qualified healthcare professional (QHP) and a patient, family member or surrogate in counseling and discussing advance directives, with or without completing relevant legal forms. The use of these codes requires a face-to-face visit, however, the patient may not be present.

99497

First 30 min of the conversation (must be at least 16 minutes)

wRVU 1.50-Proposed reimbursement \$80.16

In addition to problem visit with modifier 25

In addition to wellness visit with modifier 33

99498

Additional 30 min

wRVU 1.40-Proposed reimbursement \$75.11

In addition to problem visit with modifier 25

In addition to wellness visit with modifier 33

Minimum documentation requirements for advance care planning discussions should include all of the following:

- Time in and time out
- The person designated to make decisions for the patient if the patient cannot speak for him or herself (HCR)
- Who participated in conversation (HCR, patient, family)
- What was discussed (preferences for treatment)
- What documentation was or was not completed.

“Medicine has forgotten how vital such matters are to people as they approach life’s end. People want to share memories, pass on wisdoms and keepsakes, connect with loved ones, and to make some last contributions to the world. These moments are among life’s most important, for both the dying and those left behind. And the way we in medicine deny people these moments, out of obtuseness and neglect, should be cause for our unending shame.”

The Best Possible Day
By **ATUL GAWANDE**

Thank you



I'm sorry, we did everything we could!