Palliative Care and End-Of-Life Decision Making

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NHLBI
Gilead
PCORI
Pfizer
Baxter
Glaxo Smith Kline
Life is pleasant. Death is peaceful. It’s the transition that’s troublesome.

Isaac Asimov

Or As Grandma Says…. Everyone wants to go to Heaven But No One Wants to Die to Get There!
Cardiovascular Disease

- Not a disease of our 50’s
- Begins at birth with the genetics we are born with
- Complicated by influences of our environment
- Cardiovascular therapy is not curative
Spectrum of Cardiovascular Disease
Opportunities for Care Discussions

Prevention

Birth 10 20 30 40 50 60 70 80 90 Death

Hypercholesterolemia

ACS

Heart Failure

Handberg. 2006. Prog Card Nsg
Pallative CARE

• Palliative care is patient- and family-centered care that optimizes QOL by anticipating, preventing, and treating suffering in multiple domains
Goals of Care

• Care at the end of life is focused on the prevention and management of distressing symptoms, with a focus on pain, dyspnea, and anxiety.

• The goal of care is to support a peaceful death for the patient and to provide support for the family.
# Survey of Providers in Minnesota

| Table 1. Characteristics of clinicians completing the survey. |
|-------------|----------------|----------------|
| Site of care | Tertiary care cardiology (n=41) | Community cardiology (n=25) | Primary care (n=29) |
| Clinician type | | | |
| Physician | 19 (46.3) | 18 (72.0) | 13 (44.8) |
| NP or PA | 22 (53.7) | 7 (28.0) | 16 (55.2) |
| Years of clinical experience | | | |
| 0–5 | 9 (22.0) | 4 (16.0) | 4 (13.8) |
| 6–10 | 4 (9.8) | 5 (20.0) | 7 (24.1) |
| 11–15 | 9 (22.0) | 7 (28.0) | 4 (13.8) |
| 15–20 | 6 (14.6) | 5 (20.0) | 2 (6.9) |
| >20 | 13 (31.7) | 4 (16.0) | 12 (41.4) |

NP: nurse practitioner; PA: physician assistant.
Timing of Discussion of Prognosis with HF Patients By Provider and Practice Type
Specific EOL Preference Discussions
By Provider Type and Site of Care
Clinician Confidence in Discussing/Providing EOL Care
Clinician Confidence in Discussing and Providing End-Of-Life Care
ICD Recipients

• Nationwide survey (n = 3,067) of Swedish ICD and Pacemaker Registry who completed a questionnaire about knowledge in relation to the ICD and end-of-life.

Findings:
• Insufficient knowledge is common
• Associated with attitudes and decisions that may result in a stressful and potentially painful end-of-life situation

Anna Stromberg, PACE 2014;37:834–842)
2012 Device Based Therapy of Cardiac Rhythm Abnormalities Recommends that:

• Implanting clinicians and/or those involved in device education need to provide more comprehensive information with regard to end-of-life issues.

• Clinicians should encourage pts undergoing device implantation to complete advanced directives and specifically address the matter of device management and deactivation if the patient is terminally ill.
# Recommendations for Hospital Discharge

<table>
<thead>
<tr>
<th>Recommendations or Indications</th>
<th>COR</th>
<th>LOE</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance improvement systems in the hospital and early postdischarge outpatient setting to identify HF for GDMT</td>
<td>I</td>
<td>B</td>
<td>82, 365, 706, 792–796</td>
</tr>
<tr>
<td>Before hospital discharge, at the first postdischarge visit, and in subsequent follow-up visits, the following should be addressed:</td>
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<tr>
<td>a. initiation of GDMT if not done or contraindicated;</td>
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<td>b. causes of HF, barriers to care, and limitations in support;</td>
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<td>c. assessment of volume status and blood pressure with adjustment of HF therapy;</td>
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<td>d. optimization of chronic oral HF therapy;</td>
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<td>e. renal function and electrolytes;</td>
<td></td>
<td></td>
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<tr>
<td>f. management of comorbid conditions;</td>
<td></td>
<td></td>
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<tr>
<td>g. HF education, self-care, emergency plans, and adherence; and</td>
<td>I</td>
<td>B</td>
<td>204, 795, 797–799</td>
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<tr>
<td>h. palliative or hospice care</td>
<td></td>
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<tr>
<td>Multidisciplinary HF disease-management programs for patients at high risk for hospital readmission are recommended</td>
<td>I</td>
<td>B</td>
<td>82, 800–802</td>
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<tr>
<td>A follow-up visit within 7 to 14 d and/or a telephone follow-up within 3 d of hospital discharge are reasonable</td>
<td>Ila</td>
<td>B</td>
<td>101, 803</td>
</tr>
<tr>
<td>Use of clinical risk-prediction tools and/or biomarkers to identify higher-risk patients are reasonable</td>
<td>Ila</td>
<td>B</td>
<td>215</td>
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</table>

COR indicates Class of Recommendation; GDMT, guideline-directed medical therapy; HF, heart failure; and LOE, Level of Evidence.

An approach to dying pts who request pacemaker, ICD, or CRT deactivation should include:

- A dying patient (or, if the patient lacks decision-making capacity, the patient's surrogate decision maker) who requests device deactivation should be fully informed of consequences, alternatives to device deactivation be recorded in the MR.
- An order for device deactivation should be accompanied by a do-not-resuscitate (DNR) order; recorded in the patient's MR.
- Psychiatric consultation should be sought in any situation in which a dying patient who requests device deactivation is thought to have impaired decision-making capacity.
• Ethics consultation should be sought when clinicians disagree, based on their clinical judgment, with a request for device deactivation.
• If the clinician asked to deactivate a device has personal beliefs that prohibit him or her from carrying out device deactivation (conscientious objection), then the patient should be referred to another clinician.
• If the patient is remote from the implanting medical center, the clinician who is responsible for the patient's care at the local site should document this in the MR, and someone capable of programming the device to “inactive” status” should be recruited to reprogram the device under the direction of the local physician.
Requirements for Hospice

• For a beneficiary to elect hospice care, 2 physicians (the attending physician and a hospice physician) must certify that the beneficiary meets this criterion.

• Beneficiaries must “elect” the Medicare Hospice Benefit and agree to forgo Medicare coverage for curative treatment for their terminal illness.

• Under current policy, the first hospice benefit period is 90 days. If after 90 days the patient continues to remain eligible for hospice care (having a life expectancy of ≤ 6 months), the patient can be recertified for another 90 days and then recertified for an unlimited number of 60-day periods so long as he or she remains eligible for the benefit.
The Future of Geriatric Cardiology

- Typical Older Patients
  - Multimorbidity
  - Polypharmacy
  - Frailty
  - Cognitive

- Multiple Providers
  - Primary Care
  - Geriatricians
  - Cardiologists
  - Other Specialists
  - Hospitalists
  - Surgical Specialties
  - Physical Therapy
  - Nurses
  - Advanced Practice Providers
  - Pharmacists
  - Nutritionists

- Why Should Cardiologists Care For Older Patients?
  - Basic predisposition to cardiac disease in old age leads many patients to rely on their cardiologists for primary management

- Skills These Cardiologists Need:
  - Risk Assessment (cardiac, age, and comorbid perspectives in combination)
  - Cardiac management tailored to age including medications, procedures, and transitions
  - Rehabilitation and function integrated as fundamental components of CV care

- Distinct Skillsets Necessary For
  - Outpatient, Acute, and Long-term Care

- Goals of Care (Short and Long-term) Can Shift
  - Mortality but also Function, Independence, Pain, as many patients’ priorities

- Additional Care Considerations
  - Care Coordination
  - Shared Decision-making
  - End-of-Life Choices
  - Combined Payments
  - Readmission from Non-cardiac Disease
  - Caregiver Burden
  - Patient Education

Bell et al. JACC. 2015. 66(11) 1286-99.
Secular Trends in Hospice Enrollment, Palliative Care Consultations, and Hospitalizations at End-Of-Life

![Graph showing trends in hospice enrollment, palliative care consultations, and hospitalizations at end-of-life.](Image)

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<tbody>
<tr>
<td>Palliative Medicine consult (%)</td>
<td>10.8</td>
<td>22.5</td>
<td>43.6</td>
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<tr>
<td>Hospice (%)</td>
<td>28.6</td>
<td>34.2</td>
<td>42.2</td>
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<tr>
<td>Hospitalized in last month (%)</td>
<td>57.1</td>
<td>56.7</td>
<td>46.4</td>
</tr>
<tr>
<td>In-hospital death (%)</td>
<td>32.8</td>
<td>30.6</td>
<td>22.4</td>
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Dunlay et al. 2015. Circ Heart Fail. 8:489-96
CMS Funding for Palliative Care Planning

- Physicians and other health professionals will be reimbursed for advance care planning discussions beginning January 1, 2016.
AHA/ASA Guiding Principles for Palliative Care

• Palliative Care and Cardiovascular Disease and Stroke: A Policy Statement From the American Heart Association/American Stroke Association

Circulation. 2016;134:00–00.
Guiding Principals for Palliative Care

• Provides patients with access to continuous, coordinated, comprehensive, high-quality palliative care provided simultaneously with specialist-level cardiovascular and stroke care

• Customizes care to reflect patient and family preferences and the unique situation of each individual

• Develops and supports a skilled, compassionate, and responsive healthcare workforce

• Embeds and actualizes continual structure and performance assessment against these principles.
End of Life Scenarios in CV Disease

- Pediatric Cardiology
  - Hypoplastic left heart syndrome
  - Congenital heart disease
  - Sudden death in young athletes
- Electrophysiology
  - ICD patients
- Heart Failure
  - With or without devices
  - LVAD
  - Transplant
- ACS
  - Elderly
Honey.... We’re Going to see the Dr.

<table>
<thead>
<tr>
<th>Patient Characteristics*</th>
<th>Incidence Rate Ratio (95% CI)</th>
<th>P Value</th>
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<tbody>
<tr>
<td>Age at death (per 1 y increase)</td>
<td>0.96 (0.94–0.98)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Male</td>
<td>1.21 (0.81–1.82)</td>
<td>0.35</td>
</tr>
<tr>
<td>Preserved ejection fraction (≥50%)</td>
<td>0.83 (0.57–1.22)</td>
<td>0.34</td>
</tr>
<tr>
<td>Dementia</td>
<td>0.22 (0.09–0.54)</td>
<td>0.001</td>
</tr>
<tr>
<td>Married/living with a partner</td>
<td>2.43 (1.64–3.61)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Resided in skilled nursing facility last year of life</td>
<td>0.39 (0.26–0.57)</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Dunlay et al. 2015. Circ Heart Fail. 8:489-96
Palliative Care Conversations

• When do they begin?
• Who is the best person to have these conversations?
• Who in the family do you have them with?
• Does your institution have palliative care resources?
An Implementation Plan

**Stage 1**
- **Timing:** Unplanned hospital admission, insertion of ICD, significant deterioration in health/performance status
- **Identifying Patients:**
  - Any heart disease etiology with a poor prognosis
  - Advanced multimorbidity
  - Elderly (>75 years)
  - Multiple unscheduled hospital admissions
  - Prognostic indicators (chronic kidney disease, low weight, anaemia)
- **Advance Care Planning:**
  - Nominate a Power of Attorney
  - Shared decision-making with family participation
  - Any preferences or views about future treatments/care
  - Consider family carer support needs
  - Discussion about ICD/ cardiopulmonary resuscitation options

**Stage 2**
- **Timing:** Any time if patient wishes (expected to live >1 year)
- **Anticipatory Care Planning:**
  - Holistic assessment - physical, psychological, social and spiritual
  - Family carer support
  - Discuss plans for deactivation of cardiac devices
  - Update any existing Anticipatory Care Plan
  - Discuss personal goals and wishes
  - Preferred place of care/any reasons for admission
  - Discuss cardiopulmonary resuscitation (poor outcome)

**Stage 3**
- **Timing:** Last days of life
- **Individualised end-of-life care planning:**
  - Communication about poor prognosis and what to expect
  - Holistic end-of-life care for patient and family
  - ICD deactivation
  - Focus on a 'good death'
  - CPR is contraindicated as it will not work

*Figure 2* Staged implementation of advance care planning, anticipatory care planning and integrated end-of-life care planning.
Questions