A joint Cardiology and Palliative care clinic for end stage cardiac patients with a novel approach for improving quality of care across the primary and secondary care interface

Jane Clarke  RN, MN  
ACNM Cardiology  
Hutt Valley DHB

Heart failure

- Heart failure (HF) patients experience high rates of hospitalisation and mortality, 20% at 6 months, 30% at 12 months, a prognosis worse than some cancers \(^{(1)}\) \(^{(2)}\)
- Studies show that between 80 – 87% of HF patients with a predicted survival of less than 1 and 2 years were unaware HF was a terminal illness \(^{(3)}\)
- National and international HF guidelines recommend the introduction of palliative care at the start of the illness trajectory \(^{(4)}\) \(^{(5)}\)
- 30-day readmission rates used as a benchmarking measure between hospitals in NZ and worldwide for cost analysis of HF admissions and quality of care
- HF Audit, Hutt 2015 – 62% of HF patients readmitted within 30 days were dead within 6 months
- **Only 12% of these patients received palliative care**
Diagnosing the ‘end-stage’ of Heart Failure is difficult

When to suspect end stage Heart Failure?

- Recurrent admissions
- HF increasingly resistant to medications
- Development of other medical problems due to HF or its treatment (e.g. renal impairment)
- Cardiac cachexia
Standard team based approach to cardiac patients

A collaborative model of care

The aim of this new initiative was to develop a collaborative model of care for cardiac patients supported by cardiology, palliative care and primary care.

To deal with the palliative care needs of end-stage cardiac patients.

To have discussions early enough so that patients are well enough to be able to engage in decision making about their care.

Patient centered – the patient’s agenda is more important than ours.
Which patients?

End-stage cardiac condition
- NYHA III/IV
- Recurrent readmissions
- Increasing resistance to medications

Complex symptom management

Patients who are struggling to come to terms with their illness

Cardiology collaborative care clinic

Held once a month in Cardiology department

Complete ACP and HF Minnesota living with HF questionnaire prior to clinic

GP contacted prior to appointment – advised that they can access ‘Palliative care innovative funding’
Clinic goals

- Help patients and family understand their condition and prognosis
- Discuss current active management
- Discuss options for symptom management
- Address fears
- Clarify and clearly document resuscitation status
- Discuss end of life options

Follow up

- Comprehensive clinic letter
- Pre-arranged appointment with the GP
- Repeat Minnesota Heart Failure questionnaire after 1 month
- Post clinic survey
- Ongoing support from HF nurses
Potential benefits

- Addressing some of the unmet palliative needs of HF patients
- Improving the communication between primary care, palliative care and cardiology teams and their patients
- Demystifying the dying process for patients and reducing fear of the unknown
- Empowering patients to decide on important issues at a time when they are well enough to do so
- Potential for reduced rehospitalisation
- If successful the concept potentially transferrable to other medical specialties

Next steps

At 12 months

Expand the service
Acknowledgements

• Dr Russell Anscombe, Consultant Cardiologist, HVDHB
• Dr Tom Middlemiss, Palliative Care Consultant, HVDHB/ Te Omanga Hospice
• Sonia Hawke, Specialty Nurse, HVDHB, Co author Readmission audit

References


