Outpatient Palliative Care for Heart Failure Patients

Brette Svensson, DNP, AGPCNP-BC; Kimberly Hires, PhD, RN; Katherine Evans, DNP, FNP-C, GNP-BC, ACHPN, FAANP

Georgia State University | Byrdine F. Lewis College of Nursing and Health Professions

Background

Heart failure (HF) is a chronic progressive disease with high symptom burden, frequent rehospitalizations, and high mortality.

- Dyspnea, anxiety, depression, pain are common symptoms
- Mortality within 5 years of diagnosis as high as 54%

$23,077 on average per hospitalization

Palliative care (PC) can improve symptom burden, quality of life and lower cost

- Outpatient PC could address the needs of non-hospitalized HF patients, but is not well studied
- Uncertainty of timing is one barrier to palliative referral
  - Use of a screening tool could help standardize the process of referral by providing data on patient symptoms

Kansas City Cardiomyopathy Questionnaire

- Reliability 0.94 (Cronbach's alpha)
- Lower score indicates worsening disease status

Clinical Question

In adult patients with a diagnosis of heart failure, does use of the KCCQ increase total referrals to outpatient palliative care by 25% over a 12-week timeframe?

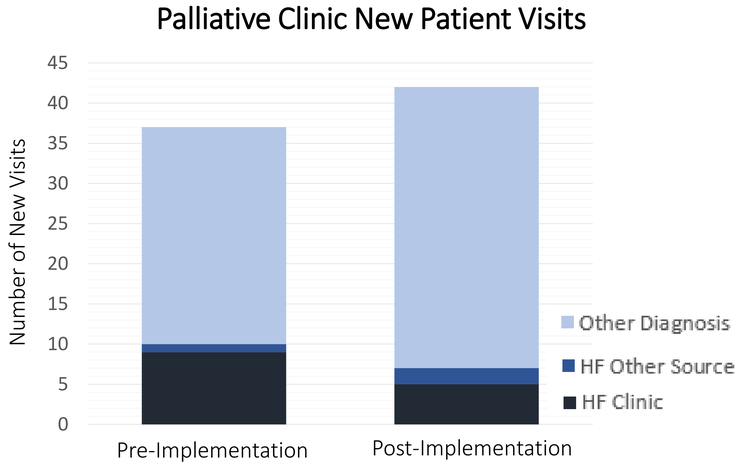
Palliative Care: "specialized medical care focused on providing patients with relief from the symptoms and stress of a serious illness" (Meier & Bowman, 2017)

Methods

- Outpatient clinic situated in near proximity to a large, suburban Atlanta hospital.
- Heart failure and palliative clinic share space
  - Palliative clinic open 2 days per week

Recruitment and Consent	Convenience sample First-time or hospital f/u N = 21
Participation	KCCQ-12 Participation complete after self-administration
Clinic Visit	Followed protocol NPs and MDs excluded
Data Collection and Analysis	Compared pre- and post-implementation Did not include KCCQ score

Results



- Avg age = 60 years
- Range 35 – 85 years
- 13 men, 8 women
- No participant received a PC referral
- *New patient visits reported because no-show referrals fell off clinic schedule*

Discussion

- *Total referrals unknown due to no-shows*
- 25% goal not achieved
- Increase in PC visits for other diagnoses – perhaps more referrals from other specialties or inpatient
- Uncertainty of timing remains a barrier

LIMITATIONS

- Nature of HF clinic visit a barrier – patients see RN, SW, pharmacist, NP or MD
- Less time for discussion, patient-provider relationship not established
- Excluded cognitive impairment or dementia

IMPLICATIONS

- Retrospective review of referral origin may provide more insight
- Examination of established patients including HF stage could highlight referral circumstances
- PC clinic design should consider both evidence and innovation
- Continued education and culture change necessary

Selected References

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Full references available upon request at brette.winston@gmail.com

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