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CREATING A PALLIATIVE CARE REFERRAL TO IMPROVE QUALITY OF LIFE IN HEART FAILURE PATIENTS

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Introduction

Although some patients with heart failure with reduced ejection fraction (HFrEF) respond well to medical management, others find themselves succumbing to their illness' debilitating symptoms. According to the American Heart Association (AHA) when conventional therapies and treatments no longer work in improving the symptoms associated with heart failure (HF), the patient's condition is considered advanced.[1] These patients are at the terminal end of their disease process and would benefit a great deal from palliative care (PC) or hospice care services.

Patients at a southern San Diego suburban hospital with HFrEF and numerous hospital readmissions did not qualify for transitional care, therefore greatly affecting their quality of life (QOL). Furthermore, there was no definitive structured PC or hospice referral process for this patient population. A referral process was created and implemented to improve QOL in patients living with HFrEF. Patients were presented with a cardiac version of Ferrans and Power's QOL questionnaire during their inpatient stay and repeated the follow-up questionnaire at their 30-day discharge date.

Background

A community-based care transitional program (CCTP) was utilized at a southern San Diego hospital to guide patients dealing with HF from an inpatient to an outpatient setting to decrease hospital readmissions. Although, very successful with a quarterly readmission average of nine percent, patients that are considered end-stage HF categorized when they have an ejection fraction less than 30% and having more than one visit in a thirty day period did not qualify for transitional care. Patients who did not meet CCTP inclusion criteria had a readmission rate of 50%. Patients found to be terminally ill were not receiving transitional care leading to twice the readmission rates when compared to the national average. About 25% of the patients admitted and discharged for HF return within 30 days.[2] The literature shows that patients who will not significantly improve within six months would benefit from PC or hospice care, thus a PC referral process was created to better capture patients that fell into CCTP exclusion criteria, but possibly qualified for PC or hospice care.[3] As few as ten percent of patients with heart failure are referred or receive PC.[4] Bridging the gap between various departments that play an instrumental role in meeting the transitional care needs of patients living with HFrEF by creating a concrete palliative care referral process patients will be placed on the most appropriate clinical care pathway. Evidence indicates that palliative care supports the best possible QOL in patients and families dealing with chronic and terminal illness.[5]

Objective

The purpose of this evidence-based process improvement project was to create and implement a palliative or hospice care referral process for end-stage heart patients. This project established a systematic referral process for end-stage HF patients meeting PC or hospice criteria. Lastly, the ultimate goal of this project was to bridge a gap between CCTP and PC in hopes of improving overall QOL in patients dealing with end-stage heart failure.

Project Data Collection and Methodology

Using the Iowa Model (2015), a problem-focused trigger was utilized to explore the literature and to guide the clinical practice change of creating a new palliative care referral process for end-stage heart failure patients to improve patient's QOL. Ferrans and Powers cardiac version QOL questionnaire was the tool utilized to measure the effectiveness of this process improvement project. A systematic literature review concluded that Ferrans model appeared to have the greatest potential to guide HRQOL research and practice change.[6] Departmental leaders from CCTP, PC, Advanced Illness Management (AIM), Education Department, and case management convened to create a refined CCTP ineligible patient palliative referral process. Patients not meeting transition criteria were not receiving a PC or hospice care consult. Therefore, patients that did not meet CCTP criteria were referred to PC and case management services for case review and possible PC or hospice eligibility. If the patient met palliative care, then the patient and family received discharge planning along with advanced HF resources. If the patient met hospice criteria, then hospice institution availability was identified and placement was attempted at a facility prior to discharge.

This process improvement project was implemented August 2016 at a southern California suburban hospital that admits, slightly, under 15,000 patients annually.[8] Patients that were utilized for this brief report were gathered from direct referrals forwarded to the Doctor of Nursing Practice (DNP) candidate by a palliative care nurse using a medical record number. Between September 2016 and January 2017 twelve patients were referred to the DNP candidate. Through the use of the hospital’s electronic medical record (EMR) system, these patient’s charts were screened for project inclusion criteria. All twelve patients selected had a discharge plan created by palliative care, a primary or secondary discharge diagnosis of HF, and an echo indicating a left ventricular ejection fraction (LVEF) less than 30%. Patients that met project criteria were contacted and presented with the initial Ferrans and Powers cardiac quality of life index (QOLI) questionnaire during their hospitalization or within five days of their discharge date. Ten of the twelve were contacted between day thirty and thirty-two of their post-discharge date. Those ten patients were presented with a follow-up QOLI questionnaire via telephone.

Results

Patients provided with palliative care services had an increase of 19.25% in their overall QOL. Advanced HF patients ranked their family as having the highest level of importance during their hospitalization (22.3). However, family importance was the only category to decrease with a percentage change of -8.15% following their 30-day discharge period. Health and function scored the lowest on level of importance for patients initially (8.42), but was the highest increase with a 53.96% change, following palliative care services. Evaluation of pre/post project implementation data using Paired T-Tests: The PC referral process and phone follow-up QOLInitiative Project significantly improved Quality of Life, Health Function and Socioeconomic status of each HRrEF patient and was statistically significant at $p < .05$. Spiritual care and family involvement did not improve and family involvement decreased over the 30-day period.

Discussion

Some patients living with HF will respond to conventional medical therapy, while others are far too advanced that symptom management and proper outpatient guidance is more beneficial. Patients with HFrEF may feel frightened, hopelessness, vulnerable, isolated, burdensome to their family members, isolated and uncertainty regarding their course.[8,9]

In this brief report, the DNP student shows that patients who are hospitalized and treated for heart failure rank family involvement highest on their quality of life scale while ranking their perception of their health and function the lowest prior to PC intervention. Both categories were scored inversely thirty days after receiving PC guidance. Palliative care, advanced care planning, and resource guidance can provide patients dealing with HFrEF the structure, support, and most appropriate clinical care pathway which may lead to symptom alleviation ultimately improving their overall quality of life.

During the coarse of this process improvement project, some limitations were identified and should be addressed in the event that this project is continued in the future. The first and most significant limitation was the assessment of the patient's mental status prior to performing the QOLI questionnaire. Initially four patients were enrolled into the project, but were unable to complete the questionnaire. Those patients were removed from the project. Another limitation was the patient's respiratory status. Upon several patient encounters the patient was either on a vent, on a non-invasive breathing device, or was in respiratory distress. Moving forward with this project, the DNP student could perhaps set the previously mentioned as limiters to the search criteria when enrolling patients into their study.

Implications

The information gathered from this project can be utilized by physicians and advanced care clinicians practicing at an inpatient hospital setting to help assess a patient's needs, illness management, and QOL related to heart failure. Utilizing this referral process has potential to influence patient’s self-management, improve social support, improve family support structure, and ultimately improve overall QOL in HFrEF patients.

Reference

1. Advanced Heart Failure. Advanced Heart Association Web site. http://www.heart.org/HEARTORG/Conditions/HeartFailure/Advanced-Heart-Failure_UCM_441925_Article.jsp#.WOQSUY5JmAw. Published April 6, 2015. Updated February 9, 2017. Accessed February 13, 2017.
2. Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med 2009; 360:1418.
3. Local Coverage Determination (LCD): Hospice - Determining Terminal Status (L33393) http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33393&ver=2. (Accessed on December 23, 2016).
4. Daniel TG, Timothy Q, Offer A, Jill S, Robert EG. Palliative care referral among patients hospitalized with advanced heart failure. *J Palliat Med.* 2014; 17: 1115-1120.
5. World Health Organization (WHO) definition of palliative care, available online at http://www.who.int/cancer/palliative/definition/en. (Accessed on January 07, 2011).
6. Tamilyn B, Susan MM, Janet SC. Systematic review of health-related quality of life models. *Health Qual Life Outcomes.* 2012; 10:134.
7. Sharp Chula Vista Medical Center. U.S. News & World Report Web site. http://health.usnews.com/best-hospitals/area/ca/sharp-chula-vista-medical-center-6930405. Published 2017. Updated 2017. Accessed January 15, 2017.
8. Murray SA, Kendall M, Boyd K, et al. Exploring the spiritual needs of people dying of lung cancer or heart failure: a prospective qualitative interview study of patients and their careers. *Palliat Med.* 2004; 18:39.