

ADVANCED CARE PLANNING & PATIENTS WITH HEART FAILURE

*The Full Spectrum of Heart Failure Therapy:
Optimizing Outcomes*

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DISCLOSURE

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No relevant financial relationship reported.



UW FULL SPECTRUM OF
HEART FAILURE THERAPY:
Optimizing Outcomes

OBJECTIVES

- Define advance care planning for heart failure patients
- Advance care planning for advanced HF therapies
- Psychosocial considerations in ACP.
- Benefits of multidisciplinary collaboration.
- Overview of resources.

WHAT IS ADVANCE CARE PLANNING?

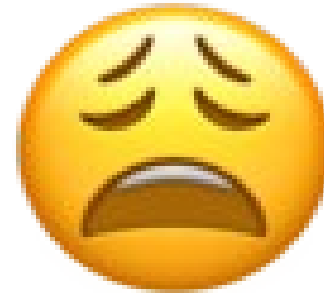
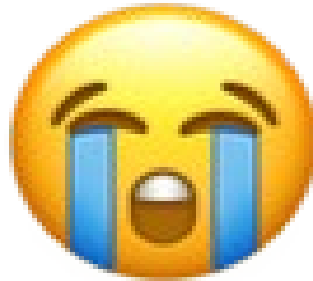
“A process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care.”

Sudore RL, Lum HD, You JJ, et al. Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. J Pain Symptom Manage 2017; 53:821.

WHAT'S THE POINT?

“To help ensure that people receive medical care that is consistent with their values, goals, and preferences.”

Sudore RL, Lum HD, You JJ, et al. Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. J Pain Symptom Manage 2017; 53:821.



ELEMENTS OF ACP

“Advanced care planning is a process, not a point.”

Advance Directive

- Living Will
- Health care Proxy
- POLST
- Five Wishes



Shared Decision Making: A good place to start.

“Shared decision making is the process through which clinicians and patients share information with each other and work toward decisions about treatment chosen from medically reasonable options that are aligned with the patients' values, goals, and preferences.”

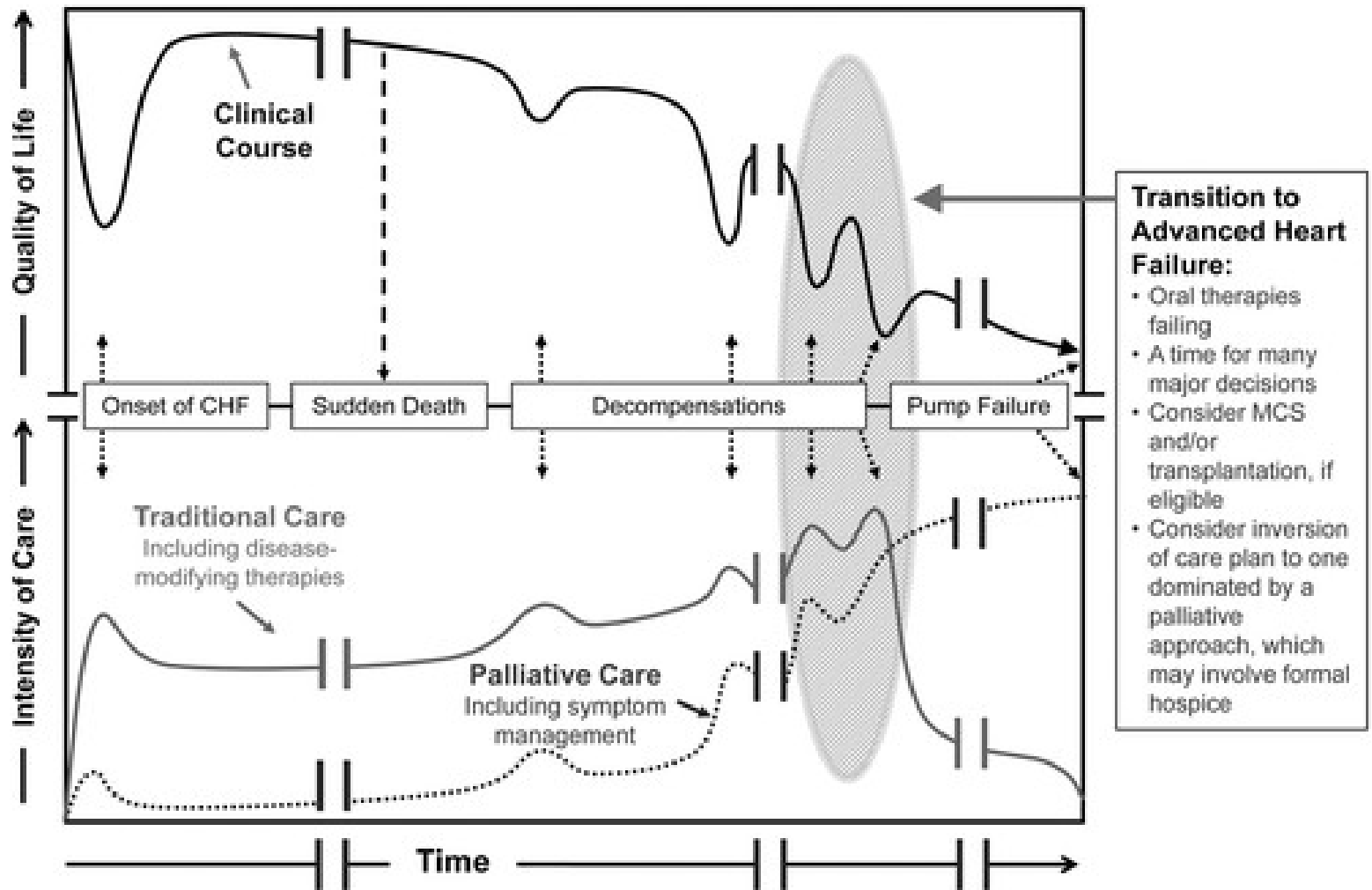
Difficult discussions now will simplify difficult decisions in the future.

Attention to the clinical trajectory is required to calibrate expectations and guide timely decisions, but prognostic uncertainty is inevitable and should be included in discussions with patients and caregivers.

Larry A. Allen. Circulation. Decision Making in Advanced Heart Failure, Volume: 125, Issue: 15, Pages: 1928-1952, DOI: (10.1161/CIR.0b013e31824f2173)

- Discussions should include outcomes beyond survival, including major adverse events, symptom burden, functional limitations, loss of independence, quality of life, and obligations for caregivers.
- As the end of life is anticipated, clinicians should take responsibility for initiating the development of a comprehensive plan for end-of-life care consistent with patient values, preferences, and goals.
- Assessing and integrating emotional readiness of the patient and family is vital to effective communication.
- Changes in organizational and reimbursement structures are essential to promote high-quality decision making and delivery of patient-centered health care.

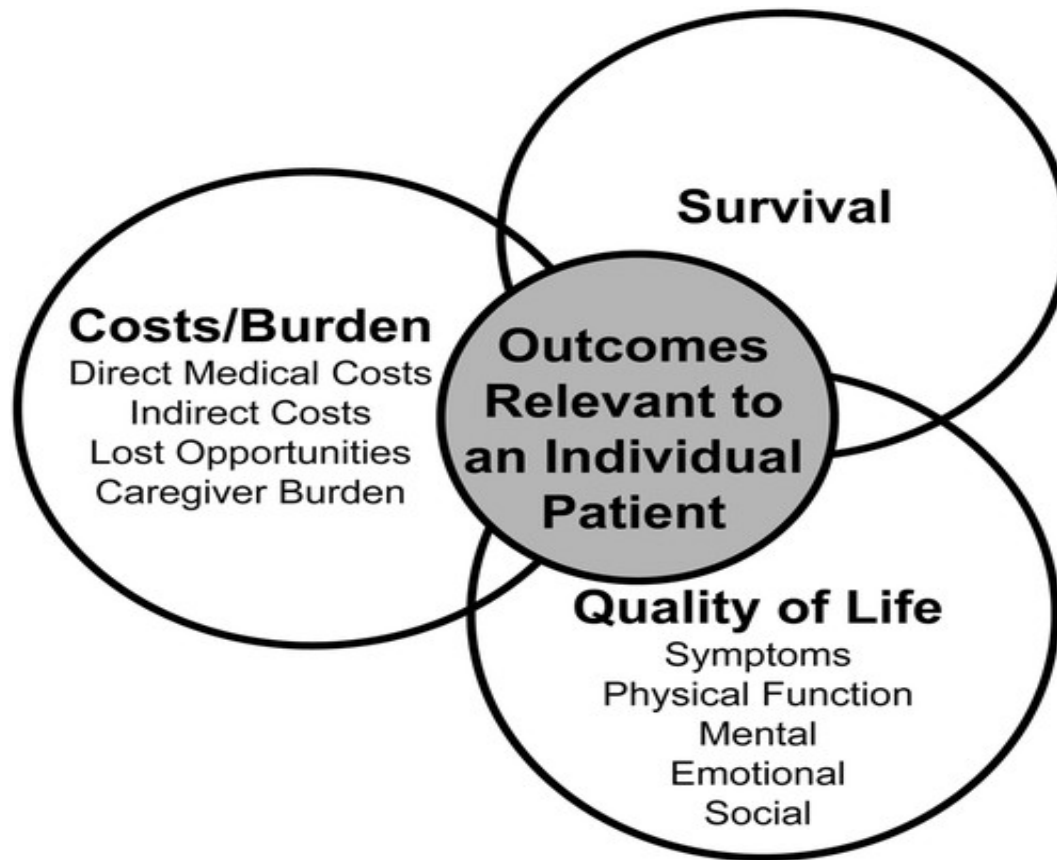
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FOR WHOM?

- ✧ Healthy people
- ✧ Mild – moderate chronic illness (NYHA classes II – III; INTERMACS 6 - 4)
- ✧ Advanced life threatening illness (NYHA class IV; INTERMACS 3-1)



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Advance care planning for persons with mild-moderate, chronic heart failure:

- Increasing care burdens for patients and caregiver.
- Consideration of advanced heart failure therapies

Goals for LVAD patients:

- Maximize quality and quantity of life
- Enable patients to achieve their identified goals

Risks

- Our patients face adverse events such as bleeding, pump thrombosis, infection, RHF, device complications, neurological events etc
- Older patients have more chronic illnesses resulting in more comorbidities
- Some patients receive LVADs under medically urgent conditions and are less stable at time of implant (crash and burn scenario). Consent may be obtained under emergent situations.

Case Example 1

“Healthy” 26 year old male

Works full time as a fisherman

No known familial cardiac history

Admitted to ICU in cardiogenic shock

ECLS initiated

Urgent heart transplant/MCS evaluation

Total Artificial Heart as bridge to heart transplant.

Supportive family

Psychosocial issues

Case Example 2

67 y.o. male diagnosed dilated NICM in 1994.

Transplant referral in 2002.

LVAD 2015

OHT 2016

Married x 40 yrs

Good adherence to care

Motivated

Attended transplant support group

Minimal hospital readmissions

Spouse highly engaged with care

HEALTHCARE DOMAINS

Three Category Perspective

- **Physical:** Chronic medical conditions
- **Psychological:** Mood and anxiety disorders, psychotic disorders, substance use disorders.
- **Social:** Homelessness, poverty, abuse, neglect, immigrants & refugees

Who are the vulnerable? In: *At Risk in America: The Health and Health Care Needs of Vulnerable Populations in the United States*. 2nd ed. San Francisco, Calif: Jossey-Bass; 1991:1-15.



PSYCHOSOCIAL EVALUATION

Family background & supportive relationships

- Parental information
- Sibling information
- Children (biological, adoptive, foster, other)
- Marital status
- Effects of illness on relationships
- Availability of caregivers
- Advance Directives

PSYCHOSOCIAL EVALUATION

Social Background

- Physical living situation
- Educational attainment
- Employment history
- Retired/disabled
- Financial status
- Veteran's benefits
- Insurance status
- Medication coverage
- Home environment (ambulation & transportation)
- Hobbies/interests
- Functional ability

PSYCHOSOCIAL EVALUATION

- Understanding of Medical Situation

Treatment compliance/adherence

Knowledge about disease process

Willingness/desire for treatment

Health literacy

- Mental Health

Cognitive functioning

Psychologic history

Screening tools (GAD, PHQ, Coping, MoCA)

PSYCHOSOCIAL EVALUATION

Substance Use History

- Specific substances
- Assessment tools (AUDIT, CAGE)
- Treatment history
- Legal issues

TAKEAWAYS

- Ongoing discussions of current and potential therapies for both anticipated and unanticipated events.
- Shared decision making is an iterative process that evolves over time as a patient's disease and quality of life change
- Engage in discussion about patient's goals and values
- Should ideally address in the outpatient setting in a period of clinical stability



*The Full Spectrum of Heart Failure Therapy: Managing
The Trajectory*

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