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Hospice Medical Memo

A quarterly newsletter for physicians

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Hospice and the patient with heart failure by Garry Snipes, MD

Jack is an 84-year-old man with ischemic cardiomyopathy and an ejection fraction of 18%. Major comorbidities currently include longstanding Type II diabetes mellitus, chronic kidney disease Stage 3, hypertension and dyslipidemia. Jack underwent a 3 vessel CABG after an acute STEMI 10 years and after development of his first episode of pulmonary edema 4 years ago, cardiac catheterization demonstrated graft occlusion, no potential for revascularization. EF at that time was 32%.

Subsequently, despite excellent medical management, Jack's exercise tolerance has declined progressively to the point that he is dyspneic with minimal exertion. He uses nocturnal CPAP for sleep apnea, and nasal oxygen intermittently throughout the day to relieve dyspnea. Jack lives with his wife of 55 years, who is frail herself, but assists him with his basic activities of daily living. Jack spends the majority of his day in bed, although as recently as 3 months ago he was still able to work outside in his garden for short periods. His primary

care physician has evaluated him carefully for correctible causes of chronic decompensation and is managing him with diuretics, nitrates, hydralazine and beta blockers. He is not felt by his cardiologist to be a candidate for other invasive therapies.

Although the incidence of heart disease is decreasing overall, heart failure is becoming one of the more common causes of serious comorbidity, hospitalization and mortality in the United States. Ironically, advances in the care of hypertension, atherosclerotic heart disease, less severe heart failure and other precursor conditions have contributed to this changing epidemiology by forestalling early complications permitting survival to the development of late stage disease. With the array of new medical and device technologies available there are always other interventions that can be employed leading to complex decision making. What is the role of hospice for patients with this common end-of-life condition?

Hospice Care Guidelines

Guidelines for Hospice Care is generally underutilized in heart failure patients primarily because of the difficulty in determining prognosis. The National Hospice and Palliative Care Organization Guidelines promulgated in 1996¹ have not been validated to predict 6-month mortality although they are still utilized by fiscal intermediaries for eligibility purposes. In truth, determination of prognosis in heart failure is extremely difficult due to the high incidence of sudden death.

Hauptman and Havranek² have recently suggested a modification of these guidelines as follows. Patients with systolic heart failure who could be considered for hospice care include the following:

1. Severity of illness demonstrated through documentation of severe LV dysfunction (EF <20%) and Class IV symptoms despite optimal treatment.
2. Recent clinical progression as in frequent ED



admissions or hospitalizations, increasing dependency in ADLs and significant comorbidities (renal, hepatic, CNS dysfunction).

3. Unsuitability for advanced therapeutic options (CRT, ICD, LVAD or heart transplant) either because of contraindications or patient preference.
4. Preference for comfort care over life-sustaining treatment.

Hospice Care Benefits

Hospice care benefits the patient with advanced heart failure. Perhaps in no other illness is the line between disease modifying care and palliative care more indistinct. The most effective palliative management of heart failure is optimal

Who to call at Hospice of the Carolina Foothills

- Jean Eckert
Executive Director
- Garry Snipes, MD
Medical Director
- Sharon Maddox, RN, MPH
Director of Patient Care Services
- Doug Brooks, RN,
Admissions Coordinator

- Shannon Slater, LPC
Bereavement Care Coordinator
- Maureen Murphy
Program Liaison

To reach any of us, please call our Hospice Administration & Program Center in Columbus, NC at 828-894-7000 or 800-617-7132.



Patient with Heart Failure, continued

medical therapy. The standard therapy of heart failure has evolved to include a number of classes of medications such as diuretics, ACE inhibitors, ARBs, beta blockers, all of which must be monitored closely as far as physiologic (weight, BP) and laboratory (electrolytes, renal function) parameters. The availability of the hospice team to assist in this monitoring process and provide feedback to the treating clinician serves to allow the best possible symptom relief and function for the patient.

Other valuable features of hospice care for this group of patients include implementation of symptom management measures, family education and support, assistance with the ongoing decision making required and accessing community resources to facilitate home care.

More patients with heart failure are discharged from hospice care than with any other diagnosis. But remember that although the criteria for hospice care is a life expectancy of 6 months or less, patients can continue to receive hospice care as long as their prognosis is consistent with this criteria.

What happened to Jack? He was admitted to home hospice. Evaluation by the Interdisciplinary Team revealed significant underlying signs and symptoms of depression in Jack, and when this was reported to Jack's attending, she initiated treatment with an SSRI antidepressant. The social worker and chaplain addressed Jack's major concern which was a long-standing rift with his oldest son. With the facilitation of the hospice staff, the son visited his father and they reached an accommodation. Jack improved subsequently and recovered enough exercise tolerance to be able to spend short periods of time enjoying the outdoors and be up for meals with his wife in the dining room. His improved quality of life was evident in his mood and he survived in hospice for 9 months prior to his sudden death.

1. Stuart B, Alexander C, et al. *Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases*, 2nd edition. Standards and Accreditation Committee, Arlington VA: National Hospice Organization, 1996.
2. Hauptman PJ, Havranek EP. *Integrating Palliative Care Into Heart Failure Care*. Arch Intern Med 2005; 165: 374-378.

Dates to remember:

May 24th--11 a.m.
Groundbreaking for Hospice House at the Fairwinds Road site in Landrum.

June 5th--3:00-4:30 p.m.
Advance Care Planning Workshop at Hospice Center on St. Luke's Campus.

June 10th--3:00 p.m.
Remembrance Gathering at Landrum United Methodist Church to honor patients who passed away between May, 2006 and April 2007.

For more information, please call Maureen Murphy, Program Liaison, at 828-894-7000.
