A Hospital Pastoral Care Program to Improve Advance Care Planning Discussion in Patients with Heart Failure

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SIGNIFICANCE/BACKGROUND

- Heart failure (HF) is a chronic disease associated with poor quality of life (QoL), high rates of readmission and high inpatient cost.[1]
- Advance care planning (ACP) improves quality of life, and reduces readmission and its associated cost.[2]
- The uncertain trajectory of HF makes it difficult to find the 'right time' to initiate ACP communication, hindering patients, caregivers and health care providers to plan and prepare for the future care.[4]
- Hospitalization experience makes HF patients and caregivers more receptive and desire to discuss end of life care. Therefor, hospitalization may provide a timely opportunity to initiate ACP discussion and palliative care before discharge.[2]
- The goal of this project is to assess the completion rates of ACP discussion and documentation among hospitalized HF patients and identify barriers to initiate ACP communication.

PROJECT/METHODS

- This is a single center retrospective study using the data obtained from the Get with the Guidelines®-Heart Failure (GWTG-HF) registry.
- This study was unique in that we were able to take the data from a large teaching facility and form a process for both inpatient and outpatient improvement.
- The GWTG-HF program is a national registry that enrolls patients admitted to the hospital with worsening HF, and patients who develop HF symptoms during a hospitalization for which HF is the primary diagnosis at discharge.[3]
- We included patients who were hospitalized and discharged alive in the GWATG-HF registry.
- The primary outcomes of interest were ACP discussion and documentation rates at discharge.
- Secondary outcomes included demographic and other clinical variables.
- All analysis was performed using SPSS software version 26.
- Multidisciplinary team was created for this project. The team included cardiologists, heart failure nurses, nursing researchers, pastoral care providers, hospital administrators, health information specialist, and healthcare data analyst.

RESULTS

- There were 2757 HF patients discharged alive between December 29,2017 and June 25, 2020 from Augusta University Medical Center (AUMC).
- Descriptive analysis shows HF patients discharged from AUMC are more likely to be male (66.1%), black (56.9%) with a mean age of 62.4 (14.1%) years, the mean length of stay was 7.11 (7.90) days. The average BMI was 30.43 (9.34). The average BNP at discharge was 1201. The average EF was 26.7% (11.9).
- Of the study cohort, 79.6% were discharged home while less than 2% were discharged to hospice/palliative care program.
- Compared to other hospitals nationwide, HF patients discharged from AUMC were younger (62.4 vs. 69.9 years), male (66.1% vs 54.5%), black (56.9% vs. 29.3%), have worse or unchanged symptoms at discharge, higher in-hospital mortality during coronavirus pandemic (6.1% vs. 2.9%), and higher overall in-hospital risk adjusted mortality (1.6% vs 0.8%).
- Compared to other similar hospitals nationwide, HF patients discharged from AUMC had a lower ACP discussion (1.5% vs. 71.3%), and a lower ACP documentation (0.4% vs. 27%).
- Despite patient and caregiver preferences for ACP communication with their providers during hospital stay, evidence suggests such communication occurs infrequently due to:

ACP discussion	ACP skill	ACP Financial impact
• Lengthy • Interactive • Time for documentation • Large patient loads with high acuity/complexity	• Specialized skills and trainings needed • Discomfort in breaking bad news, inefficient skills in effectively delivering ACP discussions • Trained to make treatment plans and be life savers not death talkers	• Lack of financial incentives to support in-depth discussions about ACP

VALUE PROPOSITION

The finding showed that ACP discussion was rarely initiated at our hospital. It highlights significant area for potential improvement in the quality of end-of-life care received by patients with HF. With the new healthcare system that provides value based care, lack of reimbursement for the time spent in ACP discussions is not a barrier to conducting them. However, other (e.g., competing demands) and professional barriers (e.g., lack of training) remain. These persistent barriers suggest consideration of non-physicians for such discussions. Board-certified hospital chaplains have training and experience in discussing ACP with patients and families. We propose a quality improvement project to determine whether ACP discussion conducted by board-certified chaplain (BCC) would be feasible, effective, and acceptable to all stakeholders, improve QoL, and reduce readmission in HF patients.

CONCLUSION

- To improve QoL and reduce readmission, the ACCF/AHA Guideline for the Management of HF recommends ACP discussion to be initiated in hospitalized HF patients.
- Due to multiple barriers for clinician to initiate ACP communication, BCC and multi-disciplinary team should play a vital role in the care of patients with advanced HF by effectively discussing patients' values, preferences and planning for future care.

- The next steps:
  - Create a place in the EMR for Advanced directives
  - Virtual access to pastoral care
  - Incorporate pastoral care in HF clinic appointments
  - Provide pastoral care with a daily list of in-patients with HF
  - Addition of ACP information in HF patient packets

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DISCLOSURES

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