



END-STAGE HEART DISEASE AND PALLIATIVE CARE

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Typically, the outcome of heart disease, end-stage or terminal heart disease is CHF. Congestive Heart Failure is a common diagnosis seen in hospice agencies and is an approved hospice diagnosis when the criteria set forth by CMS (Centers for Medicare and Medicaid Services) is met.

When a patient exhibits end-stage heart disease or congestive heart failure, signs and symptoms may include cardiomegaly, a cardiac index < 3 , an ejection fraction $< 30\%$, age > 55 , a thinning of the ventricular wall, atrial fibrillation, ventricular tachycardia, dyspnea at rest and/or increased dyspnea with minimal activities. This may include shortness of breath with meals, conversation and orthopnea. The patient may also exhibit left-ventricular end-diastolic pressure > 20 mmHg, increased weakness, significant fatigue, pitting and non-pitting edema and poor response to cardiovascular medication regimens. Many patients are presented with unintentional weight loss, impaired sleep patterns and depression. 50% of patients with Congestive Heart Failure can be expected to die within five years. Comorbidity factors increase the mortality rate and the patient's life span is significantly shortened.

Due to the shortage of organ donors, many heart disease patients die while waiting on a transplant list. The fact that a patient is waiting for a heart transplant does not

exclude a patient's eligibility for hospice care. CMS acknowledges that a patient can elect hospice care while waiting for a suitable donor, but will be required to revoke from hospice services when, and if, a compatible donor heart becomes available. Unfortunately, many patients die without the opportunity to receive transplantation. Denying these patients the opportunity to receive hospice services is reprehensible.

The Framingham study showed that out of 219 patients diagnosed with Congestive Heart Failure, hypertension was the most common precursor and was present in 75% of those patients; CAD was present in 59%; and approximately 29% were presented with both coronary disease and hypertension. Therefore patients with CHF, and specifically those with CHF, a comorbid of hypertension and CAD that are declining, may warrant a hospice evaluation to determine if a prognosis of six months or less is indicated. The study also concluded that after four years, the mortality associated with treated left-ventricular failure was 52% in men and 34% in women. This

References:

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2. <http://gateway.nlm.nih.gov> - An analysis of cost saving of the Medicare Hospice Benefit
3. Texas Heart Institute Journal-1987; 14:346-350
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increased significantly at five years, in which mortality rate increased to 62% and 42% respectively. Alarming, statistics showed that at eight years, 70% of the men and 65% of the women had died. The study also concluded that even in those patients treated aggressively, with various types of medications, 50% with chronic CHF died within five years, and the mortality rate was much higher in those patients with coronary disease. An ejection fraction of 20% is associated with a high two-year mortality rate. With an ejection fraction of 10%, the survival rate is only one year.

Many healthcare providers fail to recognize when patients with a diagnosis of heart disease could benefit from hospice care and those who do, tend to refer the patient much too late. The benefits of referring to hospice early include reports from patients as an increase in their quality of life due to the focus on symptom control in place of curative measures. The family is able to deal with the progression of the illness with newly taught coping skills. Anticipatory grief issues are addressed from the moment that the patient is admitted to hospice services. Although no one is ever "ready" to lose a loved one, the ongoing education on disease progression provided by the hospice team

assists the family in recognizing changes in the patient's condition as "normal", which reduces unnecessary hospital admissions and trips to the emergency department.

Medical costs skyrocket at the end of life. The financial strains associated with a debilitating disease can, and have, bankrupt many patients and their families. The financial benefits of hospice typically are not known or recognized by the medical community. Hospice has been recognized as a cost-saving measure. NLM Gateway, a service of the U.S. National Institutes of Health, has determined that patients who utilize hospice were less costly to Medicare than non-hospice users. Lewin-VHI, a Washington-based health care consulting firm, conducted a cost analysis of hospice care versus conventional care of Medicare beneficiaries with cancer and found that for every dollar Medicare spent on hospice patients, it saved \$1.52 in Medicare Part A and Part B expenditures.

Recognizing hospice as a course of treatment, rather than viewing it as a failure, can only improve a patient's life cycle.



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