BC Heart Failure Network

Heart Failure End of Life Care

Cardiac Services BC
An agency of the Provincial Health Services Authority

BC's HEART FAILURE NETWORK
Quality care for quality life.

CANADIAN CARDIOVASCULAR CONGRESS
CONGRÈS CANADIEN SUR LA SANTÉ CARDIOVASCULAIRE

Disclosure Statement

Within the past two years:

☒ I **have not** had an affiliation (financial or otherwise) with a commercial organization that may have a direct or indirect connection to the content of my presentation.

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Does your presentation describe the off-label use of a device, product, or drug that is approved for another purpose?

☒ No ☐ Yes If you answered **YES**, you must disclose this to the audience within your presentation

Type of Relationship	Organization Name	
	Modest (less than $10K)	Significant (greater than $10K)
A. Consulting Fees/Honoraria		
B. Officer, Director, Or In Any Other Fiduciary Role		
C. Clinical Trials		
D. Ownership/Partnership/Principal		
E. Intellectual Property Rights		
F. Other Financial Benefit		

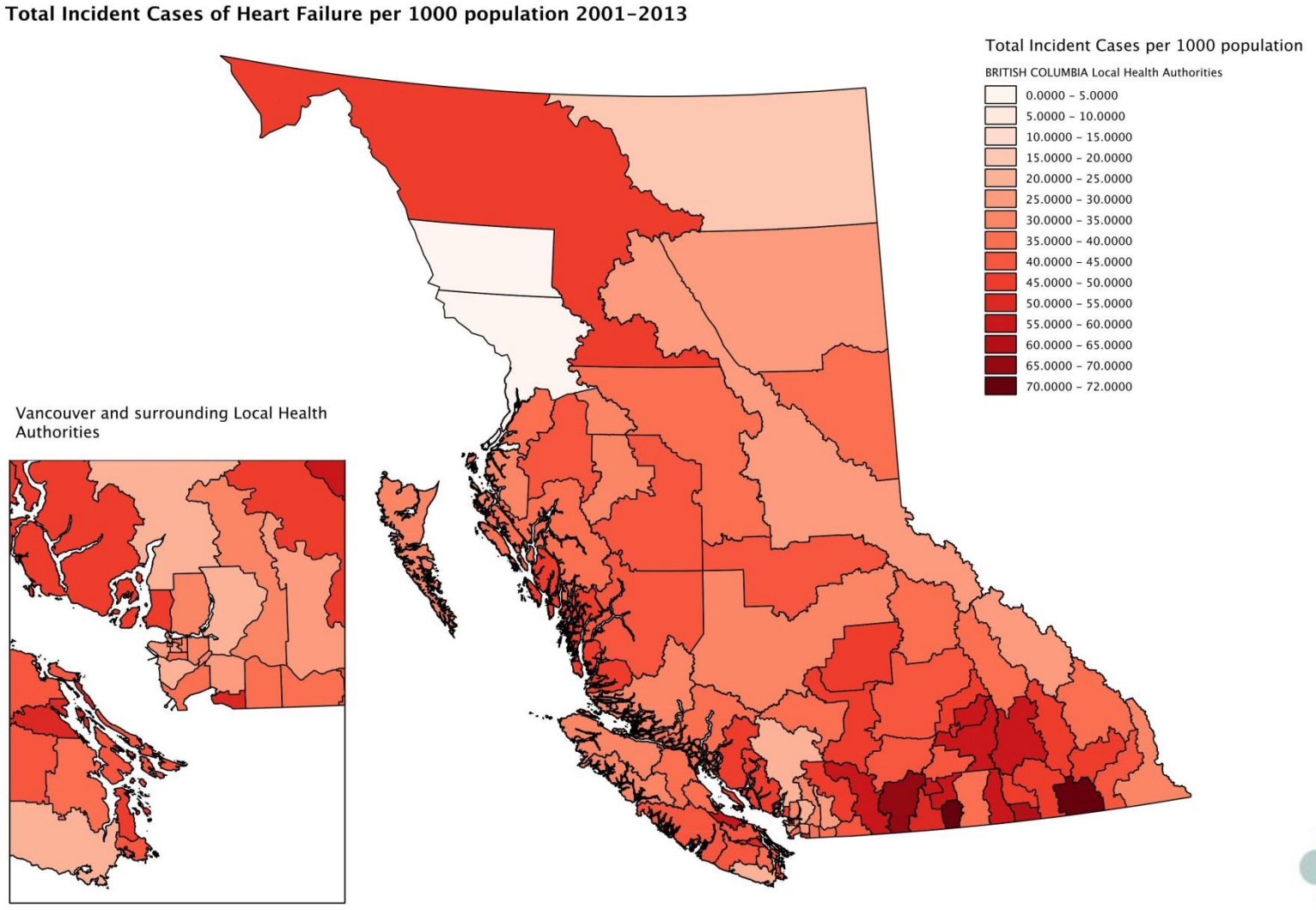
Outline

1. Discussion of BCs HF Strategy
2. Addition of HF EOL Stream
3. Current provincial HF EOL resources
4. Case presentations

Audience members?

1. Current professions?
2. Current practice area?
3. Province of practice?

Heart Failure in BC



Background for the Provincial HF Strategy

- In April 2009, CSBC in collaboration with the Provincial Advisory Panel on Cardiac Health (PAPCH) held a planning day with clinicians, administrators and policy makers across the province

- A provincial plan for HF care was developed based upon the outcome of the planning day identifying provincial planning objectives and strategies to improved HF management

- Heart Failure Steering Committee was then established in winter of 2009 with clinical and administrative leadership from all Health Authorities
  - 3-year implementation plan by HA submitted March 2009
  - Resulted in $3 M allocated to regions in 2010/11
  - Projected to increase to $11 M by 2013/14

BC's HF Strategy/Network

Established in early 2010

Collaboration between CSBC and 5 Health Authorities

Funded by CSBC

Established to address the burden of HF by:

- Creating standardized HF resources for health care professional patients and families
- Improving patients and heath care professionals access to evidence based HF resources
- Standardizing HF care across the province
- Facilitate patients' HF self management
- Improving access to heart failure diagnostics and HF specialist care
- Facilitating shared care across the health care continuum

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New focus for the Provincial Strategy: HF End of Life Care

- End of Life Forum May 2012
- 70 health care professionals from across the province and patient representatives
- Identification of challenges to provision of supportive care

Identified Challenges to Quality HF End of Life Care

- Heart failure causes significant symptoms which affect QOL
- Very little use of supportive care for heart failure (15%)
- Quality care is impaired by lack of understanding of palliative approaches,
  - lack of knowledge and comfort in having difficult discussions
- Pts with active implantable cardioverter-defibrillator (ICD) devices are at risk of unwanted shocks at end of life

BCs HF EOL Priorities

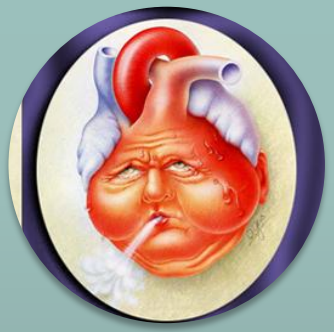
- Creating a provincially coordinated approach to HF EOL care
- Creating a standardized process and coordination of ICD deactivation in BC
- Creating tools and resources to guide HCP with symptom management of HF EOL
- Creating tools to guide HCP in how to appropriately prescribe medication to HF EOL patients
- Defining roles and responsibilities of specialists and HFC and how they over lap or collaborate with primary care- community care –patients preferences

Framework Development Guiding Principles

- Aim for comfortable and peaceful EOL Trajectory.
  - Family must be supported.
- The framework must to reflect the needs and wishes of individuals with heart failure and their family members/caregivers.
- Working on framework that reflects general palliative care approaches.
- Using evidence-based approaches that are currently in use and adapting and/or adopting wherever possible.
- We have a broad professional representation on our working groups including patients.

Heart Failure End of Life Framework

Primary & Specialty Patient Centred Shared-Care



Advanced Symptom Management

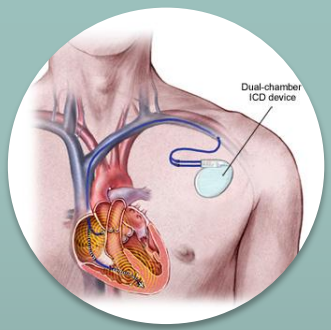
Assessment

Symptom Guidelines

Deprescribing Approaches

Health Care Provider & Health Care Team Roles

Specialist/Specialty Team Roles/Toolkit



Managing Technology

ICDs & End of Life Care

Advance Care Planning * End of Life Transitions * Psychological/Spiritual Care

GPSC Practice Support Program End of Life

BC Renal Agency Framework for End of Life

Draft V1.1

Working Group Membership

Advanced Symptom Management Group	• Carol Galte, Gil Kimel, Bonnie Catlin, Christine Jones, Romayne Gallagher, Douglas McGregor, Ella Garland, Sheila Domino, Mike Banwell, Barb Hennessy, Colleen Hennessy, Bruce Hobson, Annie Leong, Nola Wurtele
Specialist/Specialty Team Roles & Toolkit	• Carol Galte, Gil Kimel, Bonnie Catlin, Barb Hennessy, Colleen Hennessy, Mustafa Toma, Susan Germain, Sandy Juneja, Krista Greenberg, Madelene Daniel, Barb Field, Lin Lin Yu, Suzanne Nixon
ICD Management & End of Life Care	• Carol Galte, Gil Kimel, Bonnie Catlin, Barb Hennessy, Colleen Hennessy, Charlie Kerr, Pamela Luehr, Marie Hawkins, Jenn Kealy, Shelley Briggs, Laurel Landrey, Ingrid See, Matthew Bennett, Raymond Dong, Madelene Daniel

Leadership Team

Carol Galte, Bonnie Catlin, Gil Kimel

Patient Voices Network Representatives:

Sonny Kish, Peggy Davenport, Sue MacDonald

Patient Advisory Group

Three experts :

- Sonny Kish
- Sue MacDonald
- Peggy Davenport

Review, edit and guide the work of all the working groups

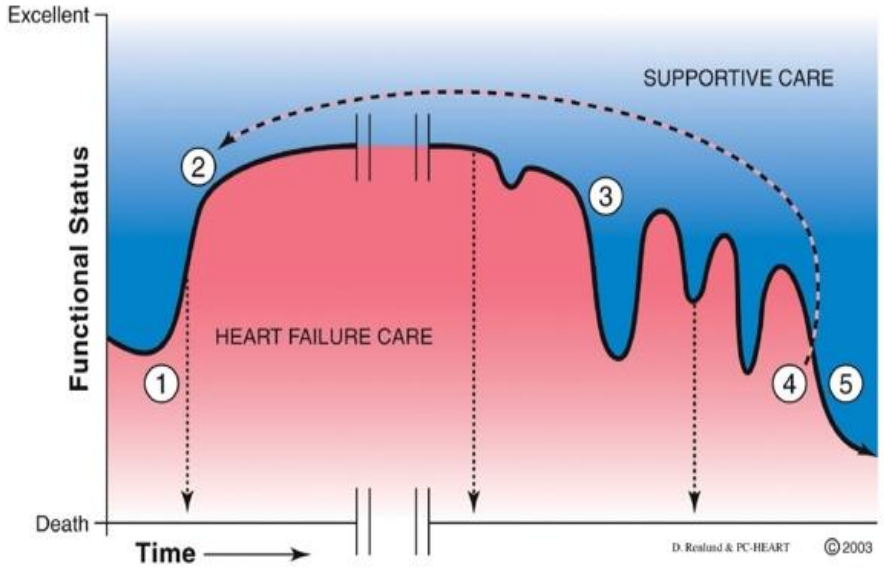
Building on previous work

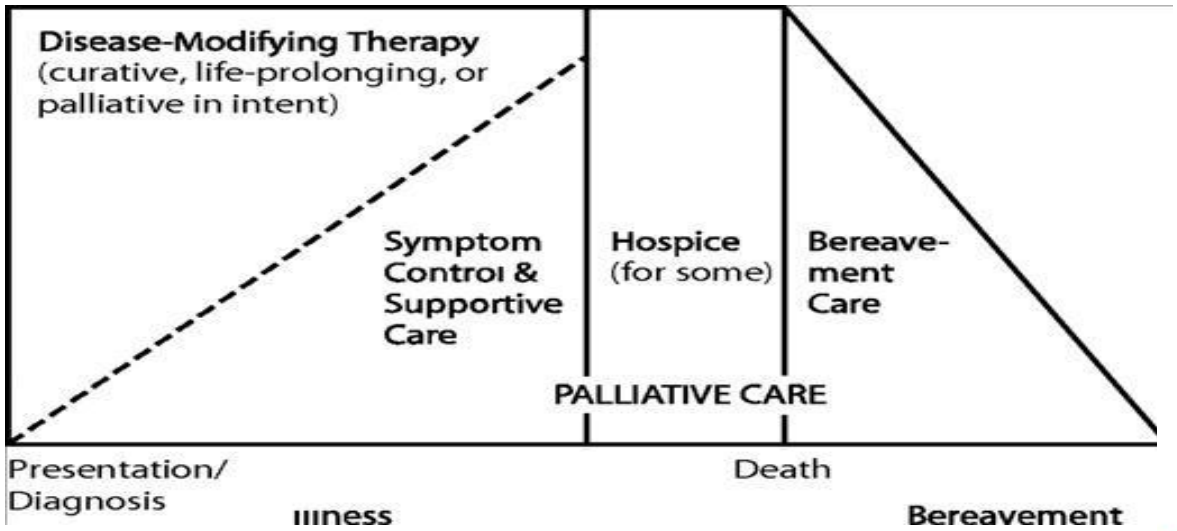
Consultant hired to create an inventory of current work related to:

- Other chronic disease end of life care – BC
- Other HF disease end of life care – National +/- International.

Inventory created and contacts developed to allow for adoption and adaptation when appropriate.

Applying Palliative Approach





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World Health Organization

- "Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."

Advance Care Planning

- Early in disease state – Surprise question?
- Recurrent conversations
- Ask "what matters to me"?
- Specialist Services Committee
  - Advance care planning incentive billing code
  - Advance care planning template
- Provincial Resources
  - My voice workbook

Transitions

(Gold Standards Framework, 2008)

Trigger Questions:

Surprise Question – In the next 6 months, would I surprised if your patient died?

Clinical indicators (at least 2 of):

- NYHA III or IV.
- The patient is in the last year of life
- Recurrent HF hospitalizations
- Difficult physical or psychological symptoms despite optimal therapy.

End of Life Transitions

Stable Chronic Disease
Transition 1 – Would you be surprised if this person died this year?
Transition 2 – Prognosis felt to be less than 6 months, spending >50% of day resting or in bed.
Transition 3/4 – Increasing symptoms and dependency. Concern about ability to support client at home. Increased care needs.
Transition 4 – Decline and terminal phase.
Transition 5 – Bereavement.

End of Life Transitions as a Framework for HF Care

Stable Chronic Disease	Transition 1	Transition 2	Transition 3/4	Transition 4
Acceptable functional status Guideline based care Symptom Management Advance Care Planning Action Plans/Self-Management Patient/Family Focused considerations Health care provider considerations Resource links	Would I Be surprised if patient died THIS year? Patient/Family Focused considerations Health care provider considerations Resource links	•Prognosis 6 months; Patient spending more than 50% of day resting/in bed. Patient/Family Focused considerations Health care provider considerations Resource links	Dependency/Symptom Increase •Concern about ability to support client at home. •Increased care needs Patient/Family Focused considerations Health care provider considerations Resource links	Decline & Terminal Phase •Declining, last days Focus on supporting the patient/family during final days and hours of life.

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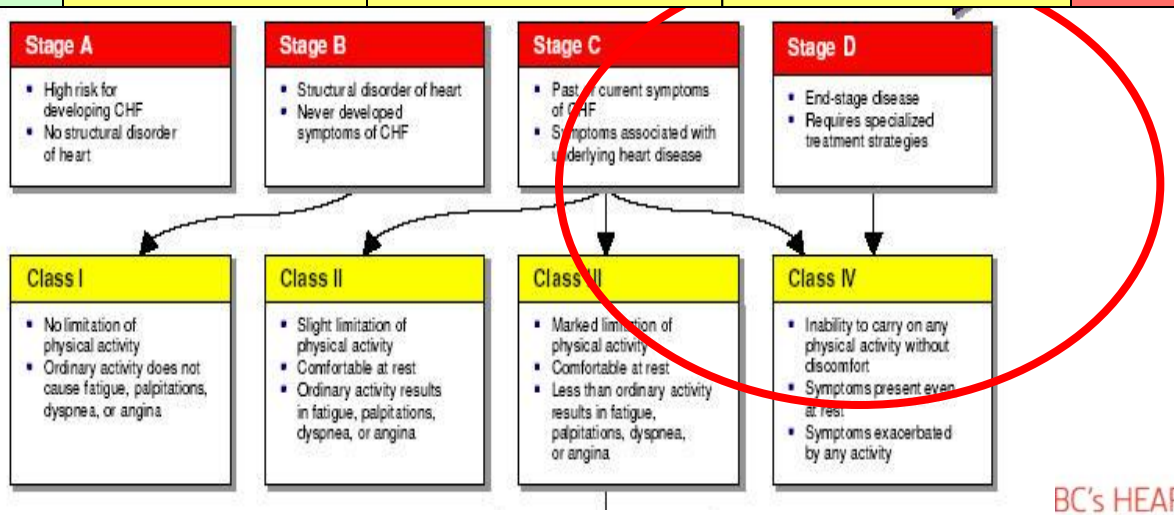
EOL Transitions for/HF Stages

Stable Chronic Disease	Transition 1	Transition 2	Transition 3/4	Transition 4
Acceptable functional status Guideline based care Symptom Management Advance Care Planning Action Plans/Self-Management Patient/Family Focused considerations Health care provider considerations Resource links	Would I Be surprised if patient died THIS year? Patient/Family Focused considerations Health care provider considerations Resource links	•Prognosis 6 months; Patient spending more than 50% of day resting/in bed. Patient/Family Focused considerations Health care provider considerations Resource links	Dependency/Symptom Increase •Concern about ability to support client at home. •Increased care needs Patient/Family Focused considerations Health care provider considerations Resource links	Decline & Terminal Phase •Declining, last days Focus on supporting the patient/family during final days and hours of life.



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Why did we decide to do this workshop – key messages

- Early referral to palliative care
- Quality symptom management
- Appropriate prescribing for HF EOL patients
- Managing technology at EOL and aligning it with goals of care
- Opportunities to share strategies and learn from each other
- Opportunity to launch the resources that have been developed by our provincial working groups

Expert Panel

Moderator: Carol Galte

Sonny Kish

Madelene Daniel

Annie Leong

Dr Matt Bennett

Dr Susan Germain

Dr Colleen Hennessy

Dr Bruce Hobson

Dr Gil Kimel

Dr Mustafa Toma

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Pre-questions

How many are comfortable caring for HF patients at EOL?

Case

- 78 male presenting into office/program with SOB
- PmHX: CHF – NYHA III, DM, Gout, A Fib, 25 PY smoker
- 3 yrs ago… large anterior wall MI
- Post MI Echo – LVEF 20% → ICD implanted
- ICD upgraded to CRT one year ago, initially some improvement

In last 2 years:

- 6 admissions to CCU decompensated HF
- Rec'd IV Lasix and Dobutamine
- Poorly compliant with diet, fluid and exercise
- No close family

Case Cont'd

In last 3 months:

- 2 appropriate ICD shocks for fast VT
- Device is reaching end of life

Pre-question

How many of you regularly talk about deactivation of ICD at the time of implant?

Managing Technology (ICD)and Heart Failure End of Life Transitions

A Consensus Framework BC Heart Failure Network End of Life Working Group

Discussions/Actions – Implant of ICD
Stable Disease

Patient/client is a suitable candidate based on ICD guidelines.
Consider clinical, physical and psychological conditions which might influence benefit of ICD implant.

Patient and Family focused considerations
Initiate advance care planning discussion as part of decision-making discussion for ICD implant.
- Find out "what is important" to the patient/client as an individual.
- Allow adequate time for discussion and prepare for "giving bad news" about potential for sudden cardiac death.

Health care provider considerations
Document/Communication with Providers
- Advance care plan documentation
- Patient/client informed decision
- Clarify roles around device management

Resource links:
- *ICD Information pamphlet for health care providers*
- *ICD information for patients/families (TBA)*
- Additional materials related to implant and care of device.
- *Provincial Advance care planning resources*

Discussions/Actions – Transitions 1-3
Progressive Disease & Dependency

Patient/family able to identify the role of ICD in their plan of care
Patient/family have opportunity for timely deactivation of ICD at the site of their usual device care
Device specialists are consulted regarding options around device deactivation

Patient and Family focused considerations
- Continue/initiate advance care planning discussion as part of determining when ICD therapy no longer meets goals of care.
- Discussion about options for deactivation and options for timing of device deactivation

Health care provider considerations
- Communicate patients decision about timing/location of deactivation.
- Provide contact information for consultation regarding deactivation.
- Initiate ICD deactivation protocol/pre-printed order.
- Advance care plan documentation including end of life device management plan.

Resource links:
- *ICD Deactivation pamphlet for HCP (TBA)*
- *ICD deactivation planned protocol*
- *Provincial advance care planning resources*

Discussion/Actions - Transition 4
End of Life and early Bereavement

Patient/family are aware of all options for deactivation of device (programming, magnet)
Deactivation decision reflects patients values and goals for care.
Providers are qualified to provide emergency device management/application of magnet (as appropriate).

Patient and Family focused considerations
- If patient wishes DNR, ensure understanding of context of ICD
- Explore patients wishes both to have device deactivated and to keep device active. Ensure decision is informed and accept patients wishes.

Health care provider considerations
- Advance care plan to include end of life device management plan.
- Ensure providers have contact information for questions/concerns that may arise.

Resource links:
- *ICD Deactivation Pamphlet (TBA)*
- *Unplanned ICD deactivation algorithm*
- *Provincial advance care planning resources.*

Trigger Questions (Gold Standards Framework, 2008) – consider transition to Stage D refractory heart failure

1) Surprise Question (In the next 6 months, would you be surprised to hear this individual had died?)
2) Choice/Need – Pt with advanced disease makes choice for comfort measures or is in special need of supportive palliative care (e.g. non a transplant candidate, VAD at end of life)
3) Clinical indicators (at least 2 of): a) NYHA III or IV; b) Thought to be in last year of life; c) Repeated HF hospitalizations; 4) Difficult physical or psychological symptoms despite optimal therapy.

References:
HRS Expert Consensus Statement on the Management of Cardiovascular Implantable Electronic Devices (CIEDs) in patients nearing end of life or requesting withdrawal of therapy (2010)
Gold Standards Framework (2008), National Health System, UK
GPSC Practice Support Program End of Life Modules/Tools

Managing Technology (ICD)and Heart Failure End of Life Transitions

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Resources:

- *ICD Information pamphlet for health care providers*
- *ICD information for patients/families* ***(www.hrsonline.org)***
- *Additional materials related to implant and care of device.*
- *Provincial Advance care planning resources – My voice workbook*

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Managing Technology (ICD)and Heart Failure End of Life Transitions

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Resources:

- *ICD planned deactivation guideline.*
  - *Referral form*
  - *Consent form*
  - *Sample pre printed orders*
- *ICD deactivation guideline urgent deactivation guideline*
- *EOL PSP Online Resource Guide for Caregivers (http://gpscbc.ca/psp-learning/tools-resources)*

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Managing Technology (ICD)and Heart Failure End of Life Transitions

Discussion/Actions - Transition 4

End of Life and early Bereavement

Patient/family are aware of all options for deactivation of device (programming, magnet)

Deactivation decision reflects patients values and goals for care.

Providers are qualified to provide emergency device management/application of magnet (as appropriate).

Patient and Family focused considerations

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Resources:

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- *Unplanned ICD deactivation algorithm*
- *Provincial advance care planning resources. My voice booklet*

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Case

History:

- Symptoms: SOB at rest (NYHA IV)
  - Exercise tolerance – 5 feet; + orthopnea/PND; no CP; poor sleep ; ESAS >65
- Medication: ASA, ACEi, BB, Statin, Lasix, Aldactone, Warfarin, Insulin, Allopurinol

Exam:

- BP 84/60, HR 88, O_2 92% (6 L HF), T 36.9
  - Elevated JVP, Crackles, peripheral edema, ascites, cool extremities

How would you manage this patient?

- Assessment
- Treatment
- Communication

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Pre-question

How many have referred a patient for or prescribed opioids for symptom management?

Heart Failure Symptom Management

-A Consensus Framework BC Heart Failure Network End of Life Working Group

Discussions/Actions
Stable Disease

Guideline based care
Exacerbation Symptom Management
Advance Care Planning
Action Plans/Self-Management

Patient and Family focused considerations

- Initiate advance care planning discussion
- Find out "what is important" to the patient/client as an individual.
- Allow adequate time for discussion and prepare for "giving bad news" about life limiting nature of disease
- Symptom management support as part of action plan/self-management support

Health care provider considerations

- Advance care plan documentation
- Patient/client informed decision
- Clarify roles around shared care

Resource links:
Symptom management guideline for providers: Dyspnea, Edema
Provincial Advance care planning resources- My voice booklet

Discussions/Actions – Transitions 1-3
Progressive Disease & Dependency

Improve quality of life in alignment with patient/family wishes and values.

Patient and Family focused considerations

- Continue/initiate advance care planning discussion
- Review current treatment and ensure alignment with goals of care
- Develop a plan for consistent and intermittent symptom management.
- Who to contact for refractory symptoms

Health care provider considerations

- Review options for treatment and ensure decisions aligned with patients goals of care; update advance care plan
- Ensure team decision/communication re: transition to Stage D heart failure
- Consider appropriate prescribing approaches to reduce treatment burden
- Provide guidance and contact information for symptom management support (cardiology & palliative specialty)
- Development of a collaborative team-based care plan

Resource links:
Symptom management guidelines for care providers Fatigue, N/V, Pain, Cachexia, appropriate prescribing
Advanced HF Personal Action Plan
Guideline for Appropriate prescribing
Provincial advance care planning resources

Discussion/Actions - Transition 4
End of Life and early Bereavement

Patient/family are aware of all options for symptom management
Patient and caregiver are supported to experience death in place of choice.

Patient and Family focused considerations

Advance care plan clearly documented at home and on client record.
Plan for dying in place of choice
Patient and caregiver have action plan to manage symptoms during dying phase.

Health care provider considerations

Expected death at home documentation if home death planned.
Plan for admission to hospice if appropriate
Etc.

Resource links:
Sample palliative sedation protocol (TBA)
Action plan for acute symptoms (TBA)
Dying at home handout.
Symptom management guidelines for care providers- Fatigue, N/V, Pain, Cachexia, appropriate prescribing

Trigger Questions (Gold Standards Framework, 2008) – consider transition to Stage D refractory heart failure

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References: Cruz-Jentoft, Boland and Rexadr (2012)
Beattie & Goodlin (2008); Goodlin, (2009), Holmes (2006), FH Hospice Palliative Care (2009), PHC iPal Heart Failure

Heart Failure Symptom Management

Discussions/Actions
Stable Disease

Guideline based care

Exacerbation Symptom Management

Advance Care Planning

Action Plans/Self-Management

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Resources

Symptom management guidelines for care providers

- *Dyspnea*
- *Edema*
- *Provincial Advance care planning resources- My voice booklet*

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Heart Failure Symptom Management

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Resources:

Symptom management guidelines for providers:

- *Fatigue*
- *Nausea and vomiting*
- *Pain*
- *Cachexia*

Advanced Heart Failure Personal Action Plan
Guideline for Appropriate prescribing
Provincial advance care planning resources

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Heart Failure Symptom Management

Discussion/Actions - Transition 4
End of Life and early Bereavement

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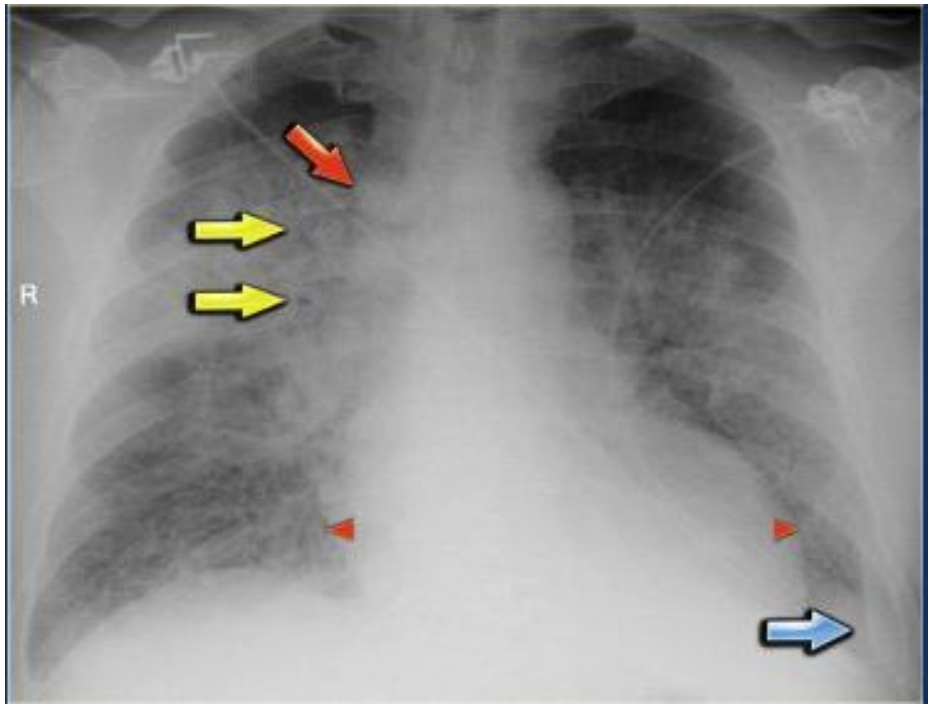
Case

Laboratory Studies:

- Hgb 104; WBC 7.0; Plts 118
- Na 128, K 4.1
- Cr: 260 (eGFR: 22)
- Trop I: 0.6
- BNP: 1076 pg/ml
- EKG: A. Fib



http://www.radiologyassistant.nl

Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	(5)	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	(8)	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	(8)	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	(7)	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	(7)	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	(9)	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	(9)	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	(9)	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	(9)	10	Worst Possible Wellbeing
No _____ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Patient's Name John Doe

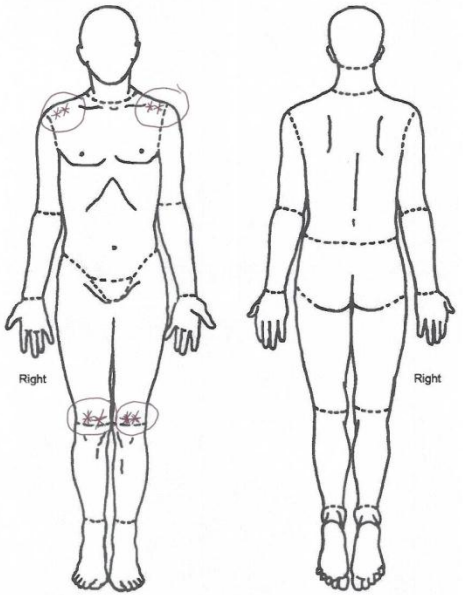
Date _____ Time _____

Completed by (check one):
- ☑ Patient
- ☐ Family caregiver
- ☐ Health care professional caregiver
- ☐ Caregiver-assisted

BODY DIAGRAM ON REVERSE SIDE

ESAS-r
Revised: November 2010

Please mark on these pictures where it is that you hurt:



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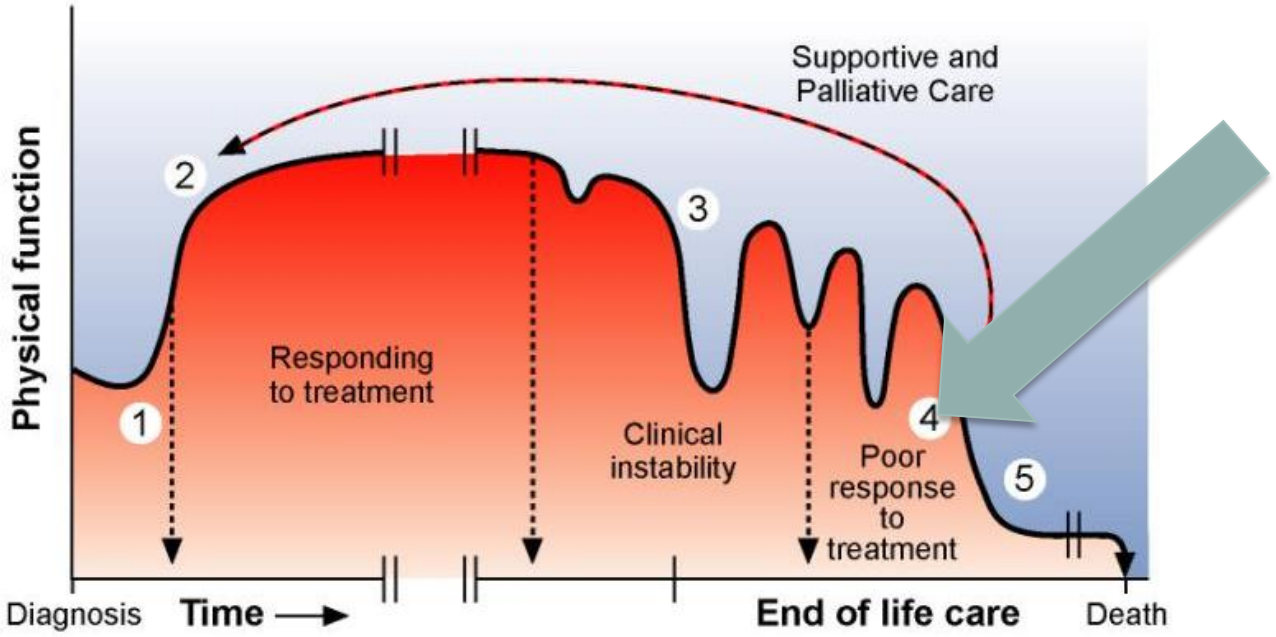
Back to Case

- 78 Male, NYHA IV, Post MI, CRT-D, Recurrent admissions, worsening CHF despite maximal medical therapy and RF
- Where is he on the trajectory?



Question

How many have referred a heart failure patient to palliative care in the last year?

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Specialist/Specialist Team Roles and Care Coordination - A Consensus Framework

BC Heart Failure Network End of Life Working Group

Specialist/Team Roles/Care Coordination Stable Disease

Specialist/Consultant

•Identify/diagnose, prognostication, investigations.
•Introduce/hold advance care planning conversations (Billing code: G78720).

Specialist Team

•Communicate/collaborate with GP/NP to create HF care plan that incorporates GP perspective and patients' goals.
•Identification of advanced illness based on anticipated trajectory.
•Connect with family, assess families ability to cope at each visit.
•Provide supportive care and/or wound care if needed.
•May introduce/hold advance care planning conversations. Collaborate with GP/NP.
•Provide client and family with information on relevant community resources.

Resources:

•Advance care planning, frequently asked questions.
•My Voice Workbook.
•EOL PSP PHC Advance care planning conversation guide.
•SSC BCMA Advance Care planning Care Plan. http://sscbc.ca/sites/default/files/ACP_Template.pdf

Specialist/Team Roles/Care Coordination Transitions 1-3 Progressive Disease & Dependency

Specialist/Consultant

•Negotiate shared care with GP, re-evaluate plan of care and interventions based on burden on client.
•Provide guidance related to medication management.
Initiate and/or review advanced care plan (Billing code: G78720) .

Specialist Team

•Initiate referral to Community Nursing team.
•Communicate with GP to establish shared care plan.
•Continue to provide psychological support in accordance with client's wishes.
•Collaborate with patient/family to initiate the Advanced Heart Failure Personal Action Plan

Resources:

•Edmonton Symptom Assessment System (ESAS).
•Palliative Care Benefits Forms (Plan P).
•Community NO CPR Form.
•Advanced HF Personal Action Plan.
•Symptom management guidelines.
•Appropriately prescribing guideline.
•ICD planned deactivation guideline.
•ICD urgent deactivation guideline (draft).
•EOL PSP Online Resource Guide for Caregivers.

Roles/Care Coordination Transition 3/4 End of Life and early Bereavement

Client, caregiver and family members will be supported to experience a peaceful death and bereavement..
There will be a clear plan of care for management of ICD at end of life

Specialist/Consultant:

•Assess level of input needed, demitting point, re-evaluate intervention.
•Facilitate deactivation of ICD (if in place).
•Provide urgent access as needed.

Specialist Team

•Support referrals to home health, palliative care program and/or hospice if not already done.
•Provide psychological support in accordance with clients wishes.
•When required, support initial bereavement period.

Resources:

•Dying at home handout.
•End of Life Personal Action Plan.
•Symptom management guidelines.
•ICD planned deactivation guideline.
•ICD urgent deactivation guideline (draft).

Trigger Questions (Gold Standards Framework, 2008) –consider transition to Stage D – refractory HF

1) Surprise Question (In the next 6 months, would you be surprised to hear this individual had died?)
2) Choice/Need – Pt with advanced disease makes choice for comfort measures or is in special need of supportive palliative care
3) Clinical indicators (at least 2 of): a) NYHA III or IV; b) Thought to be in last year of life; c) Repeated CHF hospitalizations; 4) Difficult physical or psychological symptoms despite optimal therapy.

Specialist/Team Roles/Care Coordination

Specialist/Team Roles/Care Coordination
Stable Disease

Specialist/Consultant

•Identify/diagnose, prognostication, investigations.

•Introduce/hold advance care planning conversations (Billing code: G78720).

Specialist Team

•Communicate/collaborate with GP/NP to create HF care plan that incorporates GP perspective and patients' goals.

•Identification of advanced illness based on anticipated trajectory.

•Connect with family, assess families ability to cope at each visit.

•Provide supportive care and/or wound care if needed.

•May introduce/hold advance care planning conversations.

•Collaborate with GP/NP.

•Provide client and family with information on relevant community resources .

Resources:

- Introduction to advance care planning (http://www.seniorsbc.ca/news/advancedirective.html)
- My Voice Workbook.
- EOL PSP PHC Advance care planning conversation guide (http://gpscbc.ca/psp-learning/tools-resources)
- SSC BCMA Advance Care planning Care Plan. (http://sscbc.ca/sites/default/files/ACP_Template.pdf)

BC's HEART FAILURE NETWORK
Quality care for quality life.

Specialist/Team Roles/Care Coordination

Transitions 1-3
Progressive Disease & Dependency

Specialist/Consultant

- Negotiate shared care with GP, re-evaluate plan of care and interventions based on burden on client.
- Provide guidance related to medication management.
- Initiate and/or review advanced care plan (Billing code: G78720).

Specialist Team

- Initiate referral to Community Nursing team.
- Communicate with GP to establish shared care plan.
- Continue to provide psychological support in accordance with client's wishes.
- Collaborate with patient/family to initiate the Advanced Heart Failure Personal Action Plan

Resources:
Edmonton Symptom Assessment System (ESAS). (http://gpscbc.ca/psp-learning/tools-resources)
Palliative Care Benefits Forms (Plan P). (http://gpscbc.ca/psp-learning/tools-resources)
Community NO CPR Form. (http://gpscbc.ca/psp-learning/tools-resources)
Advanced Heart Failure Personal Action Plan.
Symptom management guidelines.
Appropriately prescribing guideline.
ICD planned deactivation guideline.
ICD urgent deactivation guideline (draft).
EOL PSP Online Resource Guide for Caregivers. (http://gpscbc.ca/psp-learning/tools-resources)

Specialist/Team Roles/Care Coordination

Transition 4 and 5
End of Life and Bereavement

Specialist/Consultant:

- Assess level of input needed, demitting point, re-evaluate intervention.
- Facilitate deactivation of ICD
- Provide urgent access as needed.

Specialist Team:

- Support referrals to home health, palliative care program and/or hospice if not already done.
- Provide psychological support in accordance with clients wishes.
- When required, support initial bereavement period.

Resources:

Dying at home handout

(http://www.gpscbc.ca/system/files/60_EOL_PSP_handout_dyingathome-1.pdf)

Symptom management guidelines

ICD planned deactivation guideline

ICD urgent deactivation guideline (draft)

Advance Heart Failure Personal Action Plan

BC's HEART FAILURE NETWORK
Quality care for quality life.

Case Wrap up

- Determination patient in transition stage 3- 4
- Proceed with deactivation of ICD
- Reviewed the medications and initiated appropriate prescribing
- Optimize symptom management
- Referral to palliative care team/community care providers

Post-Questions

- How many of you would refer a patient with heart failure to palliative services?
- How many of you would access community health services for heart failure patients?

Post-Questions

- How many now feel they have been using palliative approaches to care for heart failure patients?

Post-Questions

How many think they will prescribe opioid therapy for symptom management?

BC's Heart Failure Website

www.bcheartfailure.ca

BC's HEART FAILURE NETWORK
Quality care for quality life.

Share your HF EOL projects- resources ?

BC's HEART FAILURE NETWORK

Quality care for quality life.

Leading Cardiovascular Excellence

In BC, we take collaboration to heart.

Institute for HEART+LUNG Health

Cardiac Services BC

Provincial Health Services Authority
Province-wide solutions. Better health.

BCIAP

Centre for Heart, Lung & Vascular Health

CHÉOS

CHILD & FAMILY RESEARCH INSTITUTE

cins

Community Health Solutions

HEART & STROKE FOUNDATION

Interior Health

island health

LifeSciences British Columbia

northern health

PROOF

Providence

RACE

SFU

Faculty of Medicine

University of Victoria

Vancouver CoastalHealth

Vancouver CoastalHealth Research Institute

WOMEN'S HEALTH

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