EARLY ADVANCED CARE PLANNING CONVERSATIONS IN HEART FAILURE PATIENTS

PROBLEM

Heart Failure Readmissions are Problematic for Patients Because it Affects Quality of Life and increases Healthcare Costs

Heart Failure is the Most Common Hospital Discharge Diagnosis with an Excess Annual Spending of $23 Billion Annually

QUESTION

Does Early Identification of Advanced Heart Failure Patients increase Primary Care Conversations about Palliative Care?

PARTICIPANT & SETTING

17 Advanced Practice Providers (APPs) in At-Home Primary Care Program

A 30-day readmissions risk analysis found palliative care referrals beneficial in reducing HF readmissions. Early advanced care planning (ACP) conversations are vital in addressing end-of-life in HF patients due to risk of sudden death and need for resuscitative measures.

INTERVENTION

Structured Document Template in EHR Called the ACP Guide

The ACP guide helps the APPs to identify patients apropriate for ACP conversations and provides a guide to prompt early conversations.

OUTCOMES

1. **52.4% (33/63) Post-Intervention ACP Conversation Rate vs. 52% (153/294) Pre-Intervention Rate**
2. **Palliative and Hospice Referral Rate of 8.3% (5/53)**
3. **Post-Intervention Useability Score of 80 vs. Pre-Intervention Score of 76**