

Advanced Heart Failure Treatment

LifeVest/ ICD
Biventricular Pacing
LVAD
Advanced Care Planning

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Facts About Heart Failure in the United States

- About **6.5 million** adults in the United States have heart failure.¹
- Heart failure was a contributing cause of **1 in 8 deaths** in 2017.²
- 50% of heart failure patients will die within 5 years of diagnosis
- Heart failure costs the nation an estimated **\$30.7 billion** in 2012.³ This total includes the cost of health care services, medicines to treat heart failure, and missed days of work.

1. Benjamin EJ, Muntner P, Alonso A, Bittencourt MS, Callaway CW, Carson AP, et al. Heart disease and stroke statistics—2019 update: a report from the American Heart Association. *Circulation*. 2019;139(10):e56–528.
2. Centers for Disease Control and Prevention, National Center for Health Statistics. *Underlying Causes of Death, 1999–2017*. Accessed January 7, 2019.

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Advanced Heart Failure



- 10% of Heart Failure patients have advanced heart failure
- GDMT therapies and symptom management strategies are no longer working
- Stage D Heart Failure
 - SOB and other symptoms even at rest

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Table 23. ESC Definition of Advanced HF

1. Severe symptoms of HF with dyspnea and/or fatigue at rest or with minimal exertion (NYHA class III or IV)
2. Episodes of fluid retention (pulmonary and/or systemic congestion, peripheral edema) and/or reduced cardiac output at rest (peripheral hypoperfusion)
3. Objective evidence of severe cardiac dysfunction shown by at least 1 of the following:
 - a. LVEF <30%
 - b. Pseudonormal or restrictive mitral inflow pattern
 - c. Mean PCWP >16 mm Hg and/or RAP >12 mm Hg by PA catheterization
 - d. High BNP or NT-proBNP plasma levels in the absence of noncardiac causes
4. Severe impairment of functional capacity shown by 1 of the following:
 - a. Inability to exercise
 - b. 6-Minute walk distance <300 m
 - c. Peak V·O₂ <12 to 14 mL/kg/min
5. History of ≥1 HF hospitalization in past 6 mo
6. Presence of all the previous features despite “attempts to optimize” therapy, including diuretics and GDMT, unless these are poorly tolerated or contraindicated, and CRT when indicated

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2013 ACCF/AHA Guideline for the Management of Heart Failure

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Advanced Heart Failure Treatment Plan

- Need to be a shared decision-making plan
- Decisions
 - Do everything possible
 - Strive for comfort
 - “What if” conversations
- Family and/or friends should be included

Reference: American Heart Association <https://www.heart.org>

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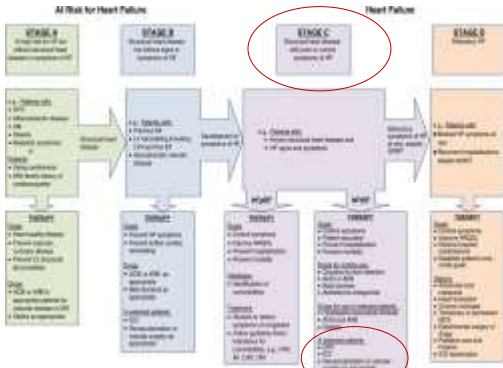
AHA Recommendations Guide for Shared Decision Making

- An annual heart failure review to discuss how well you are functioning, current treatment goals and your preferences for treating possible emergencies, such as kidney failure or sudden cardiac arrest.
- “Milestone” discussions to reassess treatment goals following a major event, such as a defibrillator shock, hospitalization or significant loss of function.
- Honest and thorough conversations about major side effects of treatment, quality of life, loss of independence, impact of worsening symptoms and increased commitment by caregivers and families.
- Considering palliative care, offered alongside medical treatment, to help manage symptoms and assist you and your family with tough decisions. Developing a care plan for the end of life that ensures your needs and wishes are met.

Reference: American Heart Association <https://www.heart.org>

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6



Clyde W. Yancy. Circulation. 2013 ACCF/AHA Guideline for the Management of Heart Failure. Volume: 128. Issue: 16. Pages: e240-e327. DOI: (10.1161/CIR.0b013e31829e8776)

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Sudden Cardiac Death (SCD)

High Risk Patients

- EF ≤ 35%
- Episodes of non-sustained or sustained ventricular tachycardia

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Wearable Cardioverter-Defibrillator

ICD	LVEF	Recommendations
Ia	B-NH	1. In patients with an ICD and a history of SCA or sustained VA in whom removal is reasonable for the prevention of SCD (1-4).
Ib	B-NH	2. In patients at an increased risk of SCD but who are not ineligible for an ICD, such as awaiting cardiac transplant, having an LVEF of 35% or less and are within 40 days from an MI, or have newly diagnosed NCM, revascularization within the past 90 days, myocarditis or secondary cardiomyopathy or a systemic infection, wearable cardioverter-defibrillator may be reasonable (1-5).

© 2017 American Heart Association (AHA)/American College of Cardiology (ACC)/Heart Rhythm Society (HRS) Guideline for Management of Patients With Ventricular Arrhythmias and the Prevention of Sudden Cardiac Death (SCD)

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LifeVest

- The LifeVest is worn outside the body rather than implanted in the chest.
- This device continuously monitors the patient's heart with dry, non-adhesive sensing electrodes to detect life-threatening abnormal heart rhythms.
- If a life-threatening rhythm is detected, the device alerts the patient prior to delivering a treatment shock, and thus allows a conscious patient to delay the treatment shock.
- If the patient becomes unconscious, the device releases a Blue™ gel over the therapy electrodes and delivers an electrical shock to restore normal rhythm.

Source: <http://lifevest.zoll.com>

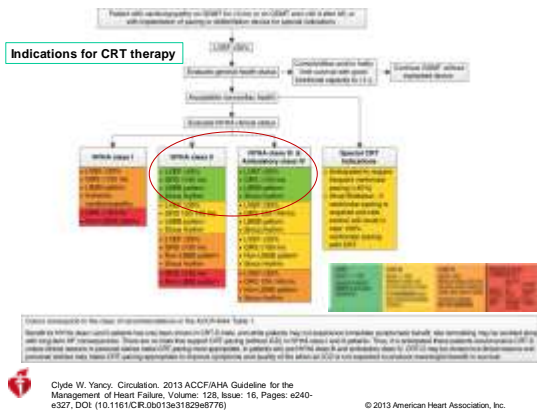
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CRT Cardiac Resynchronization Therapy Biventricular Pacing

- Atrial lead in right atrial appendage (same as conventional pacing)
- Right-ventricular lead at the RV apex or RV outflow tract
- Left-ventricular lead is passed through the coronary sinus and into one of the vessels on the outside of the heart

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Biventricular Pacing CRT

- Programmed to pace 100% of the time
- AV interval needs to be timed correctly for each patient
- Only see two spikes (atrial and ventricular)
- Look for changes in paced QRS morphology to determine lead problems

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ICD Internal Cardiac Defibrillator

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Tiered therapy & ICD's

- One of the most important concepts of current ICD's is *tiered therapy*
- Treatment alternatives are programmed into the ICD to specifically meet the needs of the patient.
 - Antitachycardia Pacing
 - Low Energy Cardioversion
 - Backup Pacing


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Antitachycardia Pacing (ATP)

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LVAD ~ Left Ventricular Assist Device


- The basic parts of a LVAD
 - Cannula in left ventricle and cannula in aorta
 - Drive line to pump (controller)
 - Power source - batteries or console



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Indications for Use

- Bridge to Transplant (BTT)
 - Non-reversible left heart failure
 - Imminent risk of death
 - Candidate for cardiac transplantation
- Destination Therapy (DT)
 - NYHA Class III/IV heart failure
 - Optimal medical therapy 45 of last 60 days
 - Not candidate for heart transplantation
- Bridge to Recovery (BTR)
 - Reversible cardiac insults (AMI, PP cardiomyopathy, myocarditis)
- Bridge to Candidacy (BTC)
 - Not currently listed for transplant
 - No absolute or permanent contraindication to transplant



Reference: Stewart, Givertz. Mechanical Circulatory Support for AHF. *Circulation*. 2012;125:3304-3315

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Assist Device History

- 1953 Era of Cardiac Surgery begins. 1st CBP
- 1963 First Report of artificial ventricle by Liotta
- 1966 DeBakey 1st successful LVAD post cardiomy shock wean and BTR
- 1969 Cooley 1st TAH as BTT post cardiomy shock
- 1982 Jarvik -7 TAH for permanent support
- 1984 1st successful LVAD for chronic heart failure
- 1992 – 1998: FDA approves several devices for bridge to transplant
- 2003 FDA approves Thoratec HeartMate XVE (pulsatile flow) for Destination therapy
- 2006 Interagency Registry of Mechanically Assisted Circulatory Support (INTERMACS) establishd
- 2010 FDA approves HeartMate II (continuous flow)
- 2010 Heart Ware (continuous flow) preliminary results BTT

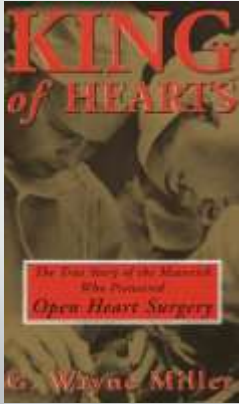
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1982



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Recommended Reading of Cardiac Surgery History



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Fig. 4- Patient with an implanted ENCORS VAD device.

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HeartMate IP



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Ventricular Assist Devices



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Innovative Pump Designs

- Improved clinical outcomes
- Altered the profile of mechanical circulation support
- Changed the structure of advanced heart failure programs
- With these new advances, new challenges and opportunities



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Dick Cheney



- 21 months LVAD bridge to transplant

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Table 6. Triggers for Referral for VAD Evaluation

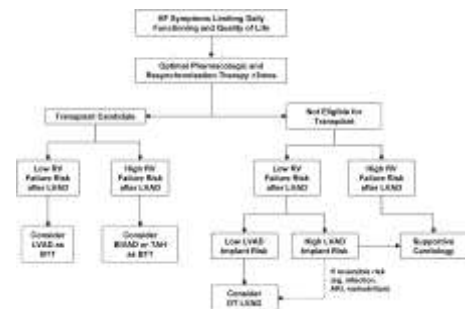
- Inability to wean inotropes or frequent inotropic use
- Peak $\dot{V}O_2 < 15-16$ mL · kg⁻¹ · min⁻¹ or <80% predicted
- Two or more HF admissions in 12 mo
- Worsening right heart failure and secondary pulmonary hypertension
- Dynamic infarct/loss associated with worsening vent function
- Circulatory-resist limitation to ACE inhibition
- Hypertension limiting β -blocker therapy
- NYctal case 1/ symptoms of rest on most days
- Seattle HF model score with anticipated mortality >15% at 1 y
- Six-minute walk distance <300 m
- Persistent hypotension (systolic sodium <134 mEq/L)
- Recurrent, refractory ventricular tachycardia
- Cardiac cachexia

ACE indicates angiotensin-converting enzyme; HF, heart failure; NYctal, New York Heart Association; and $\dot{V}O_2$, oxygen consumption.

Reference: Stewart, Givertz. Mechanical Circulatory Support for AHF. *Circulation*. 2012;125:1304-1315

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Decision tree for elective mechanical circulatory support in advanced heart failure.



Stewart G C , and Givertz M M *Circulation*. 2012;125:1304-1315



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Advanced Heart Failure Epidemic in USA

- Estimate to include 100,000 – 250,000 patients with refractory New York Heart Association (NYHA) class IIIB or IV symptoms
- **Less than 2300 hearts are available**
- Hearts reserved for younger patients with fewer morbidities
- Average weight time for Status I patient for a heart is > 6 months
 - Exposed to risks of infections, blood clots, pressure ulcers and exhaustion family members

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- Age is the most common reason for ineligibility for Heart transplant
 - 75% of HF patients are over 65 y/o
 - Average age of hospitalized HF patients with low EF is 75 y/o
- Thus, elderly are a evolving population for DT-LVAD (DT = Destination Therapy)

Reference: Mebra, etc. Listing criteria for heart transplantation. J Heart Lung Transplant, 2006;25:1024-1042

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LVAD considerations

- Allow patients to return home to improved quality of life while waiting for transplant
- Waiting for end-organ failure or more subtle signs of debilitation is no longer acceptable
- Should be considered an elective procedure in a medically stable patient not a "bailout" for the patient in refractory low cardiac output heart failure

Reference: Stewart, Givertz. Mechanical Circulatory Support for AHF. Circulation. 2012;125:3304-3315

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UNOS (United Network Organ System) Status Classification Heart Transplant Waiting List

- **Status 1A or urgent need:** Requires intensive care hospitalization, life-support measures, certain cardiac supporting intravenous medications with a Swan-Ganz catheter, or mechanical-assist device(s).
- **Status 1B:** Dependent on intravenous medications or a mechanical-assist device – in the hospital or at home.
- **Status 2:** Stable on oral medications and able to wait at home.
- **Status 7 or inactive list:** Inactive due to a change in condition – patients do not lose time they have already accrued.

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112,804 waiting for transplant – all organs

- 3730 waiting for heart transplant as of January 9, 2020
- 3,269 Heart Transplants in 2019
- 4093 waiting for heart transplant as of October 7, 2016
- 2382 Heart Transplants in 2016 as of October 7, 2016

<https://optn.transplant.hrsa.gov/data/view-data-reports/national-data/#>

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Downstate Transplant Center Peoria, IL

- April 27, 1987 First Heart Transplant
 - April 2012 : 25 year survivor -- turned 80 y/o
- September 2016: 49 y/o heart transplant survivor celebrates 20 years of life with new heart
 - BiVAD: Bridge to Transplant for 4 months

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Survival with LVAD

- Survival with HF listed as status II is similar to 2nd generation LVAD continuous flow pumps
- In 2009, only 14% of transplants occurred in status II patients
- LVAD may improved functional capacity and quality of life compared to optimal medical therapy

Reference: Stewart, Givertz. Mechanical Circulatory Support for AHF. *Circulation*: 2012;125:3304-3315

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Infection – I can handle that!



“What’s an LVAD?”



“What do I do with it?”

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LVAD Care in a Nutshell



- Is the patient talking to you?
 - This is GOOD!
- Did their caregiver come with them?
 - Use as a resource
- Call the LVAD center 800 number for advice
- Patient usually brings patient education manual with them – use it!

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Caregivers and Patient

- Intensive Education
- Must master
 - Battery Changes
 - Driveline care
 - Device alarm troubleshooting

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Caregiver

- The patient and caregiver will know more than we do as they live with this every day.
- It's okay for them to continue the care of the LVAD
- They take a “rescue bag” with them everywhere
 - Use this to get the implant center and MDs phone numbers

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Patient Assessment



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Assessment

- LVAD technology is advanced
- However, assessment techniques require a return to low-technology methods
- Assessments require basic nursing skills

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Electrical System of the Heart



- Normally produces a mechanical response from the myocytes which causes contraction
- With LVAD electrical system less significant
 - Forward flow is maintained by pump not by mechanical response related to electrical activity
 - Pump operates irrespective of the electrical impulses
 - Arrhythmias that are typically lethal, may cause few or no symptoms in LVAD patient

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Mechanical System



- Normally mechanical function of the heart produces forward flow of blood
 - This is measured as blood pressure and felt as a pulse
- When a patient has a dysfunctional ventricle, cardiac output is low and unable to sustain metabolic functions
- LVAD to failing heart restores forward flow
- LVAD either augments or takes over the function of the failing LV

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Pulseless?

- LVAD is a continuous flow pump
- Blood moves in a constant flow pattern
- Constant flow does not produce a pulse
- Partial support may produce a diminished pulse
- Monitoring blood pressure and SpO₂ is difficult

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Assessment "Back to the Basics"

- Good peripheral circulation
 - Warm and pink legs and fingers
- Brisk capillary refill (< 5 seconds)
- Appropriate mentation
 - Follows commands
 - Able to talk to you and carry on normal conversation
 - Does not fall asleep
- Adequate urine output

Adequate
Support/Circulation
=
all these present
and absence of
alarms from LVAD

Reference: Christensen, D. Physiology of Continuous-Flow Pumps. AACN Adv CC 2012;23:1,4,6-54

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Blood Pressure

- LVAD produces blood flow during all phases of cardiac cycle
- No Systolic or Diastolic BP – it is a MAP
- Use doppler to get BP
- Target BP 70 – 90 mmHg

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Pulse Oximetry

- May or may not be accurate due to little or no pulse
- Okay to monitor but in low saturation measurements, verify accuracy with ABGs

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Vital Signs

- **B/P** Take manually with doppler.
 - The pressure you hear is the MAP
 - MAP should be 70 - 80
 - MAP > 90, call
 - With automatic BP you may get a systolic & diastolic pressure with a very narrow pulse pressure
- **Pulse** - - you may feel one radially, but it's not accurate. Need to Dopple.
- **Telemetry** – LVAD does not affect rhythm
- **Pulse ox** – likely accurate

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Arrhythmias

- Use urgency to evaluate the cause of the arrhythmia
- If hemodynamically stable
 - Assess and treat arrhythmia in less urgent manner
- If hemodynamically unstable
 - Assess and treat arrhythmia immediately

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Patient Pump Assessment

- Auscultate left upper quadrant over pump pocket as part of every assessment:
 - It should sound like a boat motor
 - If it sounds like a soda can with gravel in it, it's likely starting to clot.
 - What's the PT/INR?



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Insertion Site

- The insertion site needs to be kept dressed at all times.
- After healed, sterile dressing changes are generally every other day – do what patient has been instructed
- Most of the time, family member will want to do the dressing change. You can watch, but it's fine for them to continue to do it.
- Assess site during dressing change. Notify MD if any concerns or signs of infection



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Prevent infection

- Do everything you can to prevent infection!
- If the drive line gets infected, the patient will usually struggle with infection the rest of the time the LVAD is in.

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Pump Assessment



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Mechanics of LVAD

- LVAD is a machine
- Has no intuitive capabilities
- Programmed to run at certain speed
- Preload dependent
 - If inadequate blood is available for the pump to propel, the output of the pump decreases
 - When preload low (hypovolemia/dehydration), a negative pressure develops and lead to suction events in the ventricle

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Power Source Patient's Lifeline



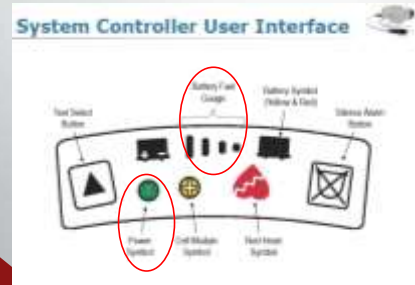
**Power Module
Use at Night**



14 Volt Lithium Ion Batteries

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This is what the controls look like up close and personal:



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Device Parameters Monitor every shift

- Document on flowsheet in patient's room.
- Device parameters
 - Speed
 - The speed of the rotor
 - Power
 - Flow
 - Flow range 3 – 10 liters/minute
 - Pulsatility Index (PI)
 - Measurement of the flow pulse through the pump

**Observe for changes
Call LVAD center for
patient specific
parameters.**



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Used for
HeartMate II.
HeartWare has
different
parameters

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Device Assessment

- Pump function
 - Auscultate left upper quadrant over pump pocket as part of every assessment:
 - It should sound like a boat motor
- Pump Parameters
- System controller settings, alarm status
- Review system controller event recorder log file
- Driveline connection to system controller and locked in place
- Exit site status, immobilization of driveline
- Backup system controller available & programmed

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System Controller Self Test Perform Daily



- Pump operation is not affected
- Checks lamps and audio tones only
- To Perform:
 - Press and hold Test Select button
 - After 3 seconds, verify all lamps illuminate and unbroken audio tone
 - Release the button. Tone and lamps will remain for at least 5 seconds

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Advisory & Hazard Alarms

- **Advisory Alarms**
 - Power Cable Disconnected
 - SC Battery Module Low
 - Replace System Controller
 - Low Speed Operation
 - Low Voltage
- **Hazard Alarms**
 - Low Voltage
 - Percutaneous Lead Disconnected
 - Low Flow
 - Loss of Power

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At Night

- Connect to power module
- Power module should be plugged into generator outlet in case electricity goes out
- There is 30 minute battery backup on power module and it will alarm loudly
- Power module cable is 20 feet long
- If bathroom not close enough, get commode

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Other tips

- When changing from power module to batteries or vice versa, only disconnect one cable at a time. Disconnecting both at the same time, the LVAD will stop
- Never disconnect the DRIVE line from the pump
- Be care with the DRIVE line and other cables that they don't get tangled or catch on anything especially when ambulating
- Patients can only shower if okay with implant surgeon and then they have a special protective bag.

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Specific LVAD Patient Care

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Complications

- Stroke
 - Embolic more common than hemorrhagic
 - Optimum level of antiplatelet and anticoagulation therapy is unknown
 - INR 1.5 – 2.0
- Infection
 - Percutaneous driveline
 - Pump pocket
- Bleeding
 - Acquired von Willebrand syndrome from high shear stress on blood
 - Chronic anticoagulation induced bleeding
 - GI bleeding
 - Hemorrhagic strokes
- Mechanical failure

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Hypovolemia

- LVAD is preload (volume) dependent
- If patient becomes dehydrated it causes the cannulas to suck up the walls of the LV
- This can cause arrhythmias
- Thus, keep patient euvolumic



Remember
Sepsis/Infection
Patients need
lots of fluid!

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Suction events

- Caused by low preload (hypovolemia/dehydration)
- Negative pressure sucks part of the ventricular wall and covers cannula
- Can cause an arrhythmia
- Pump will alarm and automatically decrease the speed to release the suction
- Treatment = fluids!

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Unresponsive?

- If LVAD running? If so, treat as any other unresponsive patient
 - Hypoglycemia
 - Stroke
 - Sepsis

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Pump stops running

- Don't panic!
- Call implant center immediately
- Most patients have some heart function (EF) without the LVAD

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Emergency Management

- Have the implant center phone numbers readily available
 - Place at Bedside
- Call them!
- Hand off these numbers to next shift

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UnityPoint Clinic – Methodist Cardiology Patient

Emergency Contact numbers include:
 - Dr. Adler or Billie G. Cardiology on call
 - Debra Myler

Other Resources:
 - University of Chicago VAD Coordinator 773-753-1000 ext 4422
 - After hours 773-753-0300 ext 4422 or call the VAD coordinator on call
 - VAD coordinator if the patient is a University of Chicago or Northwestern patient.
 - Cheryl Hernandez is a great resource for questions.
 - Call 308-478-4000
 - Home: 308-385-1882

Tips:

- Avoid chest compressions, unless absolutely necessary as they displace cannulae in the heart.
- Do NOT place defibrillation paddles over the pump.
- Defibrillate at the nipple line or above.
- Patient will not have a pulse in the groin. You will need to use a Doppler.

For more info: www.unmc.edu

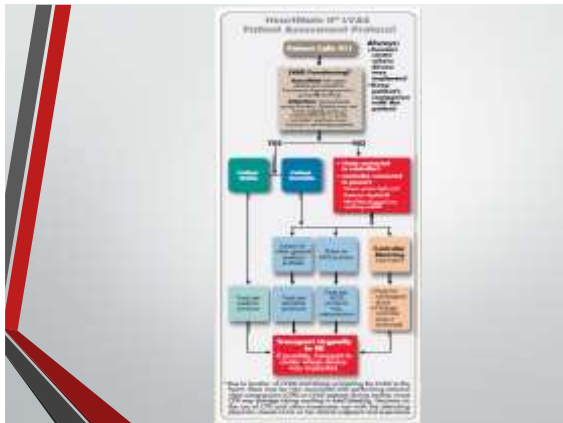
<http://www.unmc.edu/unitypoint/2014/05/>

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Emergency Management

- Arrhythmias are major cause of emergencies
 - If LVAD is running, blood is still circulating
 - OK to defibrillate or cardiovert or external pace
 - Do not stop the pump!
 - Do not place pads over implanted pump
- Do NOT do chest compressions.
 - Compressions will displace cannulas
 - Call implant center before doing compressions
 - If LVAD is running, blood is still circulating
- Dehydration can cause lethal arrhythmias.
 - Need immediate bolus

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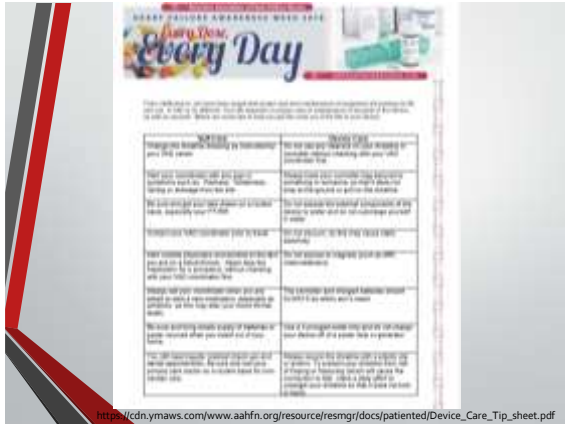
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Most Important!!

- No single parameter is a substitute for monitoring patient's clinical status!!
 - Note baseline values
 - Trends
 - Abrupt changes

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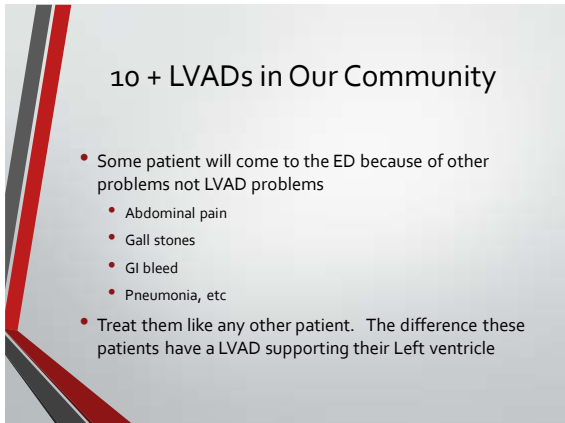


https://cdn.ymaws.com/www.aahfn.org/resource/resmgr/docs/patiented/Device_Care_Tip_sheet.pdf

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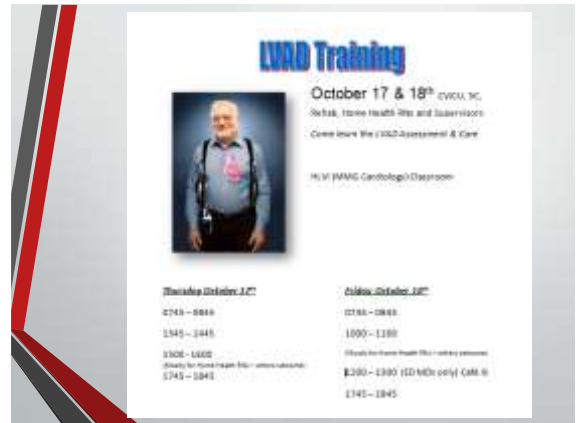
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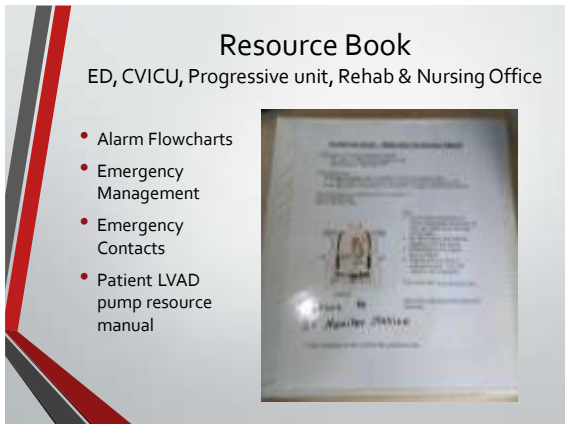
10 + LVADs in Our Community

- Some patient will come to the ED because of other problems not LVAD problems
 - Abdominal pain
 - Gall stones
 - GI bleed
 - Pneumonia, etc
- Treat them like any other patient. The difference these patients have a LVAD supporting their Left ventricle

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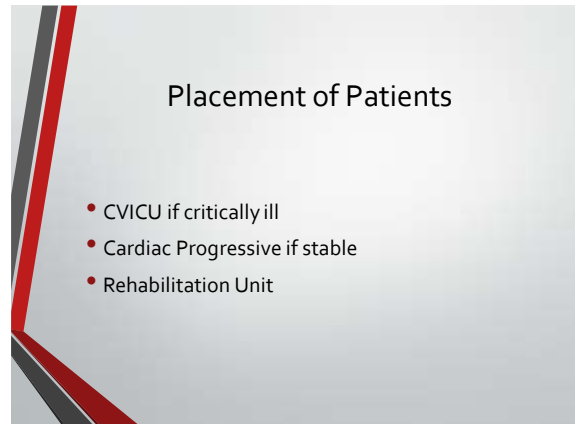
Resource Book

ED, CVICU, Progressive unit, Rehab & Nursing Office

- Alarm Flowcharts
- Emergency Management
- Emergency Contacts
- Patient LVAD pump resource manual



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Placement of Patients

- CVICU if critically ill
- Cardiac Progressive if stable
- Rehabilitation Unit

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Other Resources

- www.thoratec.com
- <http://www.thoratec.com/videos/mp-mcs.aspx>
- Hospital specific online LVAD learning module with quiz
- Also did education for EMS system

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Destination Therapy Left Ventricular Assist Device (DT_LVAD)

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LVAD
VVI pacer

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One year later DT-LVAD

- Doing well
- EF 20%

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Worldwide Clinical Experience*

More than 15,000 patients worldwide have now been implanted with the HeartMate II® LVAS.

Over 6,000 patients on ongoing support

- Patients supported ≥ 1 year: **3,838**
- Patients supported ≥ 2 years: **2,141**
- Patients supported ≥ 5 years: **294**

• 1 patient has even been supported for **over 8 years**

As of July 2013
*Based on clinical trial and device tracking data.

Doc # 104249C

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 - Candidate for cardiac transplantation
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 - NYHA Class III/IV heart failure
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 - Not candidate for heart transplantation
- Bridge to Recovery (BTR)
 - Reversible cardiac insults (AMI, PP cardiomyopathy, myocarditis)
- Bridge to Candidacy (BTC)
 - Not currently listed for transplant
 - No absolute or permanent contraindication to transplant

Reference: Stewart, Givertz. Mechanical Circulatory Support for AHF. Circulation. 2012;125:1304-1325

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And the Rest of the Story

- Case Study #1 (NSTEMI)
 - BTT LVAD
 - One year later on Heart transplant list as Status 1A
 - Heart transplant performed and LVAD explanted
 - Doing well with transplant July 2014
- Case Study #2 & 4 (nonischemic cardiomyopathy/anemia)
 - DT LVAD since Oct 2014
 - ? BTC
- Case Study #3 (fx tibia)
 - Cardiomyopathy – chemo induced
 - DT LVAD since February 2014

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- Many patients as recent as 10 years ago would have died without the support of LVADs and are living relatively normal lives
- **More patient will come to the community hospitals because of other problems not LVAD problems**
 - Abdominal pain
 - Gall stones
 - GI bleed
 - Pneumonia, etc

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Destination to “Nowhere”

- Situations in which the device offers little or no improvement in quality of life
 - Ie – patient has stroke

Palliative Care

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Discussion Topics

1. What to do if the LVAD fails and the patient requires an emergent operation
2. What to do if multiorgan failure develops and the LVAD does not seem to be helping a “futile” situation
3. What to do if the LVAD device becomes infected
4. What to do if the patient has a postop stroke
5. What to do if a patient has a traumatic injury or a terminal malignant tumor and the LVAD is functioning properly

Source: O’Neill, B. Destination to Nowhere. CCN 34:2,52

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Advanced Care Planning

Never too early to have the conversations!

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The benefits of having an advance care plan.

- A important part of managing a chronic disease treatment options.
- A plan provides information to your health care team.
- Most persons at end of life can not speak for themselves.
- A plan relieves the family member from wondering if they made the right decision.
- A plan promotes family peace.



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The legal forms and the family conversation
you can't have one without the other!



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Long Distant Family – Include them!

If not, may complicate
communication &
increase stress



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POLST



- A & B need to be filled out
- Must be signed by Physician & Witness
- Carry with you
- Give copies to your loved ones
- Have readily available to give if call 911 or go to hospital
- Many medical centers have electronic records that POLST/Living Will, HCPOA can be scanned into

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What is a Successful Consultation?

- Getting the DNR?
- Managing narcotics?
- Communicating the physicians' understanding of the disease process
- Understanding the patient/family's goals
- Assisting with quality of life / health care goals

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Palliative Care

- A specialized medical care for people with serious illnesses. This type of care is **focused on providing patients with relief from the symptoms, pain and stress of a serious illness - whatever the diagnosis.**
- Is provided by a team of doctors, nurses and other specialists who work with a patient's other doctors to provide an extra layer of support.
- Is appropriate at any age and at any stage in a serious illness, and can be provided **together with curative treatment.**

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Hospice Care



- The focus is on caring, not curing. Hospice utilizes an interdisciplinary team of healthcare professionals and trained volunteers that address symptom control, pain management, and emotional and spiritual support expressly tailored to the patient's needs and wishes.
- Hospice is not "giving up," nor is it a form of euthanasia or physician assisted suicide
- The Medicare Hospice Benefit requires that a terminally-ill patient have a *prognosis* of six months or less: There is not a six-month limit to hospice care services.

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What is the difference between Hospice and Palliative Care?

	HOSPICE	PALLIATIVE CARE
DISEASE	Terminal; less than 6 months "if the disease runs its expected course"	Usually chronic progressive illness; may be any serious illness
PLACE	Home, hospital, nursing home, hospice unit/facility	Mostly hospital. Some efforts beginning in SNF, outpatient
PAYMENT	Medicare benefit, many insurances	No specific current structure
FOCUS	Family, symptoms	Family, symptoms
TREATMENT	Comfort	Comfort and possibly aggressive/curative

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Review Forms as Life Stages Change



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Statistics about death

One out of One Dies

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What would you do if
Six months to live?

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LIVE EACH DAY AS IF IT WERE
YOUR LAST

- Seize The Day
- Love Them
- Forgive Them
- Serve the Lord
- Leave a Legacy
- Priorities

carpe diem

carpe diem

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