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The Primary Care Unit

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Advance care planning can improve quality of life in heart failure patients

Advance care planning (ACP) can improve the quality of life of people with heart failure. But only the minority of heart failure patients in the UK have the opportunity to engage with ACP, mainly because clinicians find it difficult.

This research alert summarises the case for interventions to engage clinicians in advance care planning with heart failure patients and sets out the latest findings from our research into what interventions work.

Links to sections

Key points

- Heart failure is the most common cause of hospital admissions in people over 65. As the population ages these figures are predicted to rise. Patients with end-stage heart failure merit optimal palliative care.
- Advance care planning can improve the quality of life of patients with heart failure. But only the minority get the opportunity to receive advance care planning mainly because clinicians find ACP difficult. As a result patient care is affected.
- Interventions targeting clinicians can be effective in improving clinical practice and patient care.
- Complex interventions, using patient-mediated components, shared decision-making tools, reminder systems, and training in communication skills, are needed to support clinicians and patients to improve quality of life and respect patient choice in heart failure.

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ACP is a shared conversation between patients, their friends and family and clinicians to clarify personal values and goals of future care, in order to ensure that patients receive treatment consistent with their preferences in case they become seriously ill.

Context: palliative care in heart failure is suboptimal

Regardless of therapeutic advances, heart failure remains unpredictable, progressive and ultimately fatal.[1 2] The prognosis associated with a diagnosis of heart failure is worse than for many cancers. 38% of patients die within one year of diagnosis; 60% die within five years.[3]

Heart failure is the most common cause of hospital admissions in people over 65 and affects around 900,000 people in the UK.[4] An ageing population, rising prevalence and new life-prolonging treatment approaches mean that over 5% of patients suffering from heart failure have developed symptoms that are resistant to treatment(5).

Patients with end-stage heart failure merit optimal palliative care. Advance care planning (ACP) is widely advocated to facilitate better care. But only the minority of patients get the opportunity to engage with ACP, mainly because clinicians find it difficult. As a result, patient care is affected and remains suboptimal.

Only 37% of patients with end-stage heart failure were aware of a poor prognosis.

36% of patients with end-stage heart failure died alone[5]

What we know already: advance care planning can improve quality of life in heart failure

Advance care planning (ACP) is a process that helps patients to understand and share their personal values and goals of future care, so that they may receive treatment consistent with their preferences if they become seriously ill.[6]

ACP can improve patients' quality of life, potentially lower hospital admissions and re-admissions leading to lower healthcare costs, and lower rates of depression in surviving relatives in heart failure.[7]

Heart failure patients in particular often experience periods of sudden and unexpected deterioration in their health status, so that clear guidance on their treatment preferences may be urgently needed. But despite national and international recommendations to engage with ACP, clinicians rarely undertake ACP conversations.[8]

In the UK, less than 8% of all eligible heart failure patients are likely to have an advance care plan.[9]

New messages from our research: clinician-targeted interventions can improve practice

The best ways of supporting clinicians to initiate appropriate discussions about end-of-life care are not well understood.[10] Past reviews had not looked at interventions directed at clinicians and had not provided much detail on different approaches used.

Our research aimed to identify which methods carry the best potential to engage clinicians with advance care planning for their heart failure patients, by carrying out a review and meta-analysis of published literature on this topic.[11]

We found that the most effective interventions for engaging clinicians in advance care planning with heart failure patients were:

Patient-mediated interventions. This is where patients were randomised to prompt their physician to talk about end-of-life care, and this increased the odds of clinician engagement five-fold.

Reminder systems – electronic or paper – more than tripled the odds of clinician engagement.

Educational meetings about advance care planning doubled the odds of clinician engagement.

Methods that simultaneously helped clinicians and patients talk about advance care planning were found to have the greatest potential.

Interventions to improve clinicians' behaviour are more likely to be effective when combined with a variety of techniques rather than using a stand-alone tool.

Future interventions

There is a lack of evidence about the optimal conditions under which to implement such a complex intervention. We need an evidence-based rationale for intervention choice and mechanism of action in heart failure with reference to patients and carers as well as clinicians.

As a possible approach, feasibility trials to further investigate this complex behavioural intervention should demonstrate the acceptability of the intervention to clinicians and patients. The intervention components need careful evaluation for timing, frequency, intensity and context, focusing on their capacity to improve clinical outcomes.

Priorities for health action: patient-mediated tools are key

Our findings are endorsed by the National Institute for Health Research (NIHR)[12] who recommend that every service which sees patients with heart failure should:

- Provide patient-mediated tools like a question prompt list for patients with heart failure, with appropriate support and explanation
- Use 'Choices of Care' tables or advance care plans for patients with heart failure
- Consider how to remind clinicians to ensure this is routinely done and reviewed
- Facilitate educational meetings for clinicians, to support their engagement of these interventions

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About the Primary Care Unit

The Primary Care Unit sits in the Department of Public Health and Primary Care at the University of Cambridge. We carry out research to identify and target the behaviours that lead to chronic disease, improve early detection of disease and improve the quality of health services; and we deliver first class teaching to medical students, clinicians, researchers and educators.

This research alert is published by the Primary Care Unit, University of Cambridge, for clinicians and health commissioners.
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Key references and resources

Health resources for the public

- Pumping marvellous: *https://pumpingmarvellous.org/*
- Healthtalkonline: *http://www.healthtalk.org/peoples-experiences/heart-disease/heart-failure/impact-diagnosis-heart-failure*
- British Heart Foundation: *https://www.bhf.org.uk/*
- Heart Failure Matters: *https://www.heartfailurematters.org/en_GB*
- Advance care planning: *https://www.dyingmatters.org/page/planning-your-future-care*

Datasets and reports

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