

Advance Directives Among Hospitalized Patients With Heart Failure



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JACC: HEART FAILURE CME

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CME Objective for This Article: After reading this article, the reader should understand: 1) the frequency of documented advance directives among

patients hospitalized for heart failure at a large academic institution; and 2) factors independently associated with documentation of advance directives at a large academic institution.

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ABSTRACT

OBJECTIVES The purpose of this study was to assess the frequency and correlates of documented advance directives (ADs) among patients hospitalized for heart failure (HF).

BACKGROUND Discussing ADs with patients with HF is critical for identifying treatment goals consistent with patients' values and preferences and for facilitating health care team communication.

METHODS We retrospectively identified electronic medical records of adult patients admitted to 2 large tertiary care hospitals with either the primary or secondary discharge diagnosis of HF from September 2008 to August 2013 to assess the presence of ADs in electronic medical records. We performed analyses including HF as either the primary or secondary admission diagnosis and HF as the primary admission diagnosis only. Multivariable models were constructed to investigate independent predictors of documented ADs.

RESULTS Data included 44,768 admissions from 24,291 individual patients over 5 years. Mean age of patients at admission was 64.8 ± 15.9 years; 47.9% of these patients were female, 51.8% were black. The median length of stay for all admissions was 5 (3 to 10) days; 12.7% of patients had documented ADs. Older age, female sex, white race, higher socioeconomic status, higher risk for adverse in-hospital outcomes, length of stay ≥ 5 days, hospice discharge, palliative care consultation, and a do-not-resuscitate order were all associated with a significantly higher chance of having documented ADs. A significant increase in ADs over time was noted, but more than 80% of patients did not have ADs in medical records at the end of the study period.

CONCLUSIONS In a diverse population of hospitalized patients with HF, most did not have a documented AD in the medical records. Although several factors were associated with a higher probability, major opportunities exist for all subgroups of patients with HF to improve documentation of ADs. (J Am Coll Cardiol HF 2015;3:112-21) © 2015 by the American College of Cardiology Foundation.

Patients with heart failure (HF) suffer high morbidity and mortality risk and poor patient-centered outcomes (1,2). Almost 50% of patients with HF die within 5 years of diagnosis, including many who suffer sudden cardiac death (1). There are more than a million hospitalizations in the United States annually with HF as the primary discharge diagnosis and an additional 2 million hospitalizations with HF as a contributory diagnosis. One-year mortality post HF hospitalization remains higher than 30% (3-6). Costs of care for HF exceeds \$40 billion annually, with more than 50% consumed during the last 6 months of life (7).

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Considering the poor prognosis and the inability to predict the terminal phase of the disease accurately (8), discussing advance directives (ADs) early in the disease process is critical to optimize management, identify treatment goals consistent with patient

preference, and facilitate health care team communication and advance care planning (9,10). HF management guidelines recommend integration of palliative care and discussion of ADs (11). The federal Patient Self-Determination Act encourages patients to decide about the type and extent of care they want to accept or refuse if they become unable to make those decisions, and it mandates AD discussion with all hospitalized adults (12). The purposes of the Patient Self-Determination Act are to inform patients of their rights regarding decisions toward their medical care and to ensure that the health care providers communicate these rights. The 2 types of ADs are as follows: a living will, in which patients indicate the kind of care, especially life-sustaining care, they would or would not like to receive, and a medical power of attorney, in which a patient names another person to make decisions about the patient's medical care, if the patient is temporarily or permanently unable to communicate or make these decisions. ADs

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