Healthcare Innovations
How practice has changed

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HepatoCare model of multi-disciplinary supportive and palliative care in advanced cirrhosis: A study of post-pilot real world performance

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Background

Patients with advanced cirrhosis have frequent unplanned admissions, high in-hospital death rates, low advance care planning and rationalisation of medications. To combat this, "*HepatoCare,*" a multidisciplinary clinic with hepatology nursing, palliative care physician and clinical pharmacist has been standard of care in our Unit since 2019. We aimed to evaluate whether *HepatoCare* continued to improve outcomes for patients with advanced cirrhosis in a real-world cohort (RWC).

Methods

We retrospectively compared outcomes in two cohorts of 30 consecutive *HepatoCare* patients: Pilot cohort (2017-18) vs. RWC (2019-20). All had been referred to *HepatoCare* by their treating Hepatologist with advanced cirrhosis, based on a modified set of SPICT™ criteria (Table 1). The primary outcome of interest was verifying a similar unplanned admission LOS in the RWC.

Cirrhosis-specific indicators
Palliative-intent HCC diagnosis (palliative systemic therapy or best supportive care)
Diuretic-resistant ascites > 6 months
Chronic hepatic encephalopathy > 6 months
Second episode of SBP within 12 months
Second episode of variceal bleeding within 12 months
Chronic, irreversible renal dysfunction (Cr > 130 mmol/L)*
Liver transplant indicated but not suitable/feasible
General indicators
Irreversible condition with poor performance status
Persistent symptoms despite optimal Hepatology care
Patient's priorities change focus to primarily palliative care

Table 1. "Referral criteria" used to identify patients with advanced cirrhosis who may benefit from Palliative Care referral (modifed from the SPICT™ tool).

Results

The RWC and Pilot cohorts had similarly advanced liver disease (mean Child-Pugh scores 8.5 vs 8.7 P=0.79). The RWC had statistically similar but higher 1-year mortality (57% vs. 33%; P=0.12) and similar avoidance of in-hospital death (53% vs. 54%; P=0.33). Unplanned admission LOS over 18months was lower in the RWC and approached significance (293 vs. 437 days; P=0.052). ACP was formally addressed in all patients in both cohorts. For the RWC, polypharmacy (5-9 medications per patient) was similarly high (87% vs 93%; P=0.67), and these patients experienced high rates of safe deprescription of ≥ 1 medication (80% vs 63%; P=0.25) and initiation of symptom-directed medication/s (90% vs 77%; P=0.30).

Conclusion

Pilot studies can over-estimate effectiveness of new interventions, but we have demonstrated a similar if not improved reduction in unplanned admission LOS in a RWC of patients with advanced cirrhosis referred to the *HepatoCare* clinic. Rates of rationalised therapy, ACP and avoidance of in-hospital death remained high.