Supplementary Online Content


eMethods. Additional Details of Study Methods
eTable. Patient-Reported Outcomes at Baseline and in 6 month Survivors

This supplementary material has been provided by the authors to give readers additional information about their work.
eMethods. Additional Details of Study Methods

Risk Factors for Poor Prognosis

To be eligible for randomization, patients hospitalized with heart failure (HF) were required to have at least one risk factor for poor prognosis from the following list:

- hospitalization for HF management within a year prior to the index hospitalization
- age ≥80 years
- advanced chronic kidney disease (estimated glomerular filtration rate ≤ 45 mL/min/m²)
- systolic blood pressure ≤100 mm Hg
- serum sodium ≤ 130 meq/L, cardiogenic shock
- serious non-cardiovascular illness limiting 1-year life expectancy.

Assessment of Prognostic Expectations

To gather data regarding prognostic alignment, both providers and patients were queried separately at baseline about their expectations of patient prognosis. Physician expectations of prognosis were queried qualitatively using the ‘surprise’ question. The surprise question (SQ) been suggested as a simple test to identify patients who might benefit from palliative care interventions.[1] It asks clinicians to respond to the question, “Would you be surprised if this patient died within the next 12 months?”. Because this was a validated question that is widely promoted in palliative care frameworks for gauging physician estimates of prognosis, we employed this question for this purpose in SWAP-HF.

As we were unable to ask the same question of patients, patients were instead asked to estimate their life expectancy according to predefined categories (<=5 years, > 5 years, > 10 years) at baseline and again at the end of study follow up (6 months) to assess changes in prognostic awareness during the course of the study period.

Details of Social-Worker-Led Intervention

The social-worker led intervention began as a structured goals of care conversation with the patient that was initiated either during the index hospital stay, or at the first post-discharge follow up visit. The format of the initial conversation was based on the framework of the Serious Illness Conversation Guide [2], which directs the following stepwise approach: A standardized setup of the conversation to introduce the purpose of the conversation, prepare the patient for future decisions and solicit permission to proceed; an assessment of prognostic understanding and preferences regarding receipt of prognostic information; a discussion of prognosis and its implications for decisionmaking; an exploration of key topics including patient goals and priorities, fears and worries, sources of strength, perceived critical abilities, tradeoffs between length and quality of life, and family awareness of preferences and prognosis; and summary impressions and recommendations. This face to face conversation relied on narrative therapy techniques that emphasize scaffolding patient strengths as tied to their values. [3] Techniques such as virtual groups, normalization, case based references and direct discussion were utilized to move the conversation forward. Education was provided around the importance of advanced care planning, the role of health care proxy, and the need for other legal documents such as Power of Attorney. The results of this conversation were documented in the electronic health record and communicated verbally to treating clinicians to catalyze further direct discussions between patients and their providers.
Following this initial conversation, all patients were reviewed with a palliative care physician who provided guidance regarding strategies for facilitation of further discussions and directed specific interventions (formal palliative care physician consultation, Medical Orders for Life Sustaining Treatment, hospice referral, and the like) where indicated. The social worker then reached out by telephone or during subsequent scheduled clinic visits over the 6 month follow up period to further develop the conversation begun with the patient during the initial visit. These subsequent patient contacts were not scripted by protocol, but rather initiated at the discretion of the social worker, at the request of the supervising palliative care physician, or in follow up to requests for information or further discussion by patients or their treating clinicians. During the course of follow up, patients were regularly screened for symptoms of depression, anxiety, pain, and psychological distress, with unmet palliative care or symptom management needs relayed to the treating clinicians and ongoing psychosocial support provided by the palliative care social worker.

References


eTable. Patient-Reported Outcomes at Baseline and in 6 month Survivors

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>6 months</th>
<th>Change from Baseline in 6 month Survivors</th>
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<tbody>
<tr>
<td></td>
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<td>PHQ-8</td>
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<td>101±21.1</td>
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* Between-group difference in change from baseline, adjusted for baseline