NWOOA Primary Care Update 2018 Kalahari Convention Center

November 9, 2018

Stein Hospice & Palliative Medicine
Sandusky, Ohio 44870

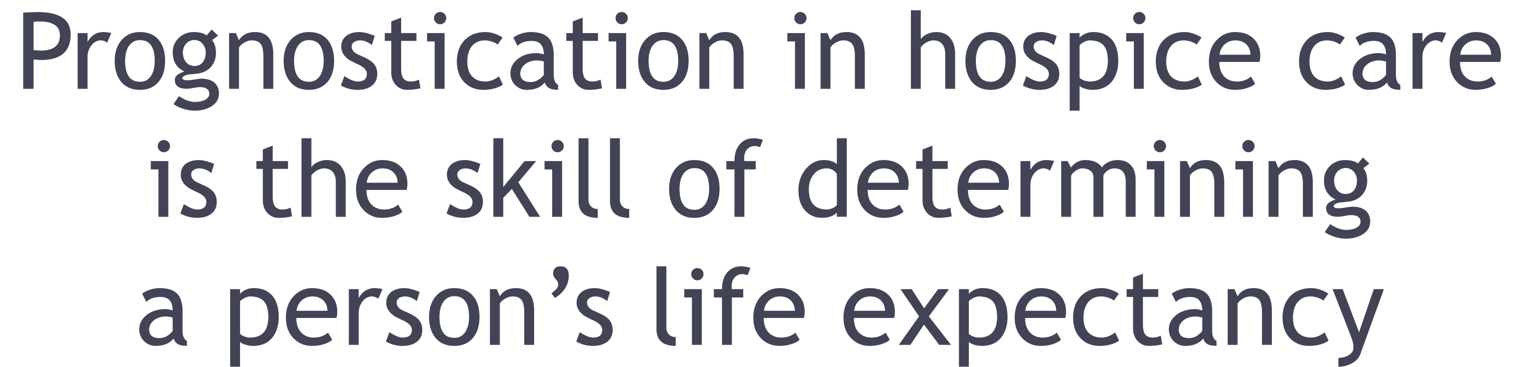
Doctor, Why are You Talking About Hospice Now?

Prognostication and
Hospice Eligibility
for Non-Cancer Diagnoses

Objectives

Attendee will be able to determine:

- Hospice eligibility for their non-cancer terminal patients.
- Recognize signs and symptoms of the non-cancer end of life patient.
- Know how to approach the topic of hospice care with their patients and who to contact for enrolling their hospice appropriate patients.



The Hospice Medical Director Manual
AAHPM 3rd Edition

Famous Quote:
“Talking to patients about end of life matters is messy and makes both the patient and me very uneasy!

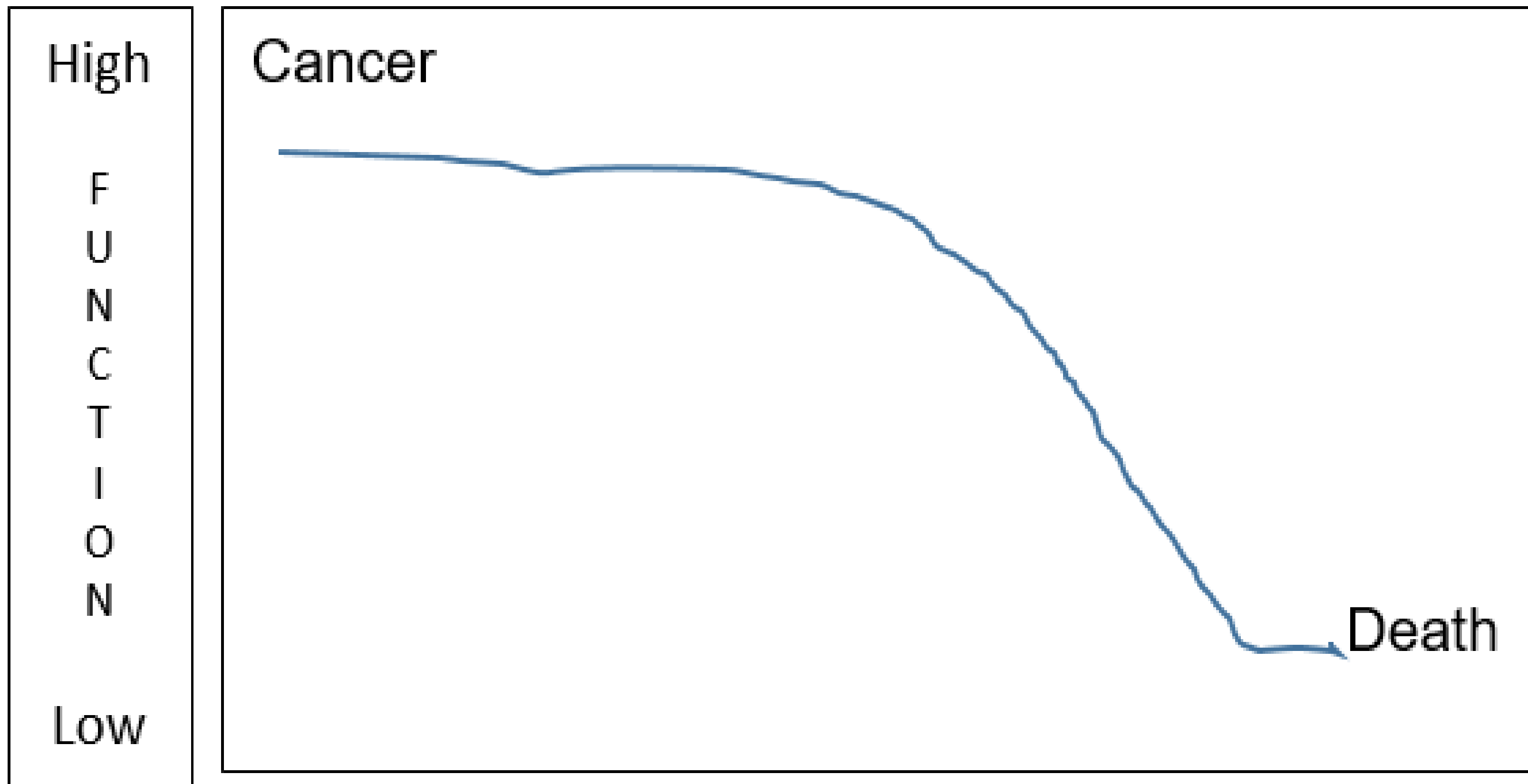
James Preston, D.O.

So… Why talk with my patients about end of life care?

1. 100% of patients will die.
   100% mortality = need to know
2. PCP and family are the patient's advocates at the hospital during EOL crisis
3. A lack of advance directives positively forces ED / Hospitalist to choose "Full Code" even when that choice is illogical.

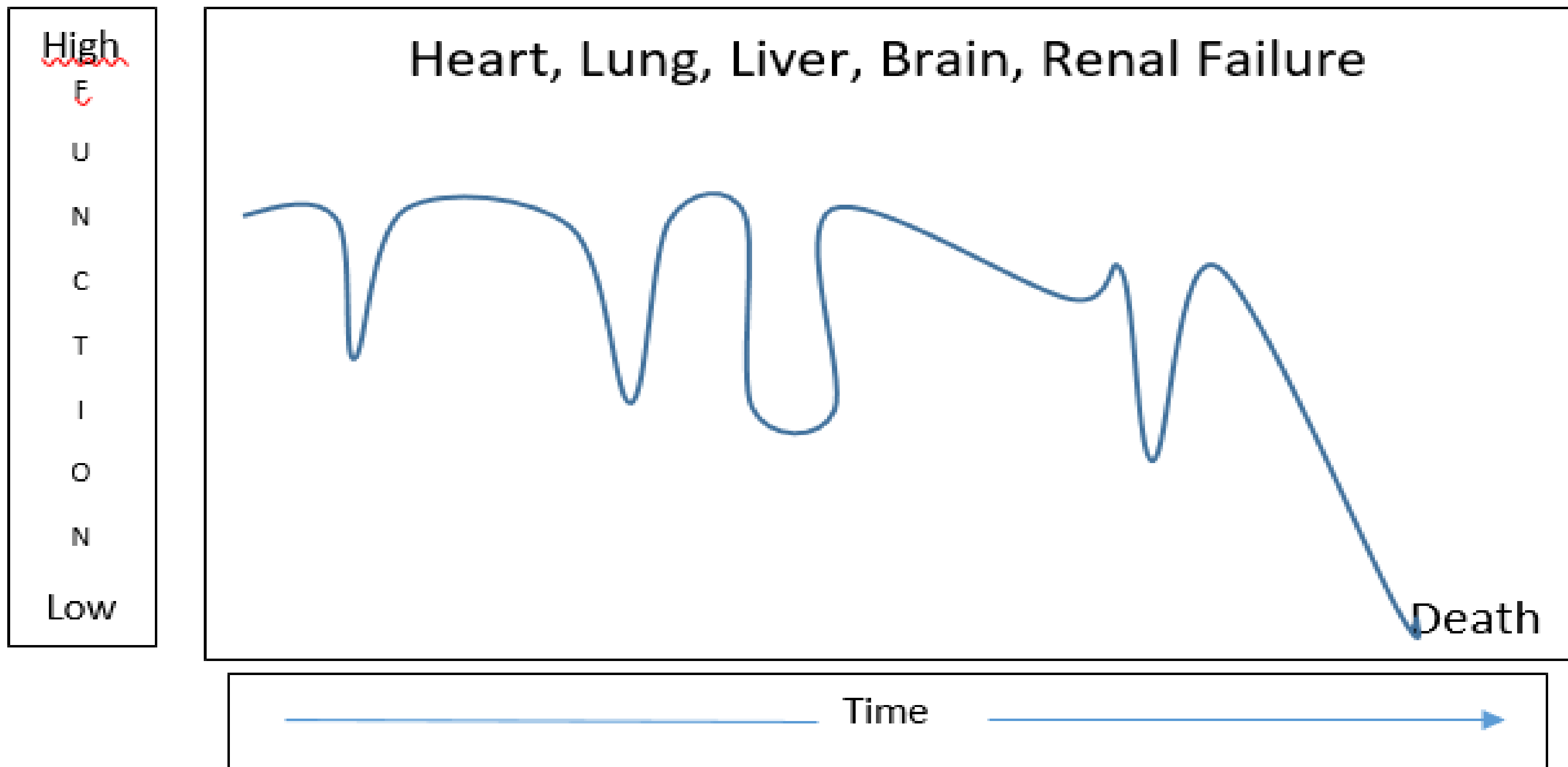
"Most terminally ill patients in the hospital die alone and in pain due to poor communication about end of life care." Support Study 1995

The inherent challenge of the Non Cancer disease prognostication



The Rand Corp 2006

The inherent challenge of the Non Cancer disease prognostication



The Rand Corp 2006

The Ugly Side of Prognostication

1. Main objection PCP's have in referring their patients for hospice care is the certification of a six month prognosis.

The Hospice Medical Directors Manual
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The Ugly Side of Prognostication

2. Physicians are ill prepared to prognosticate - this “dark art” mystifies most physicians.

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The Ugly Side of Prognostication

3. Physicians typically are terribly inaccurate and are overly optimistic by 3-5x factor.

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The Prognostication Forest and Trees for Non Cancer Hospice Diagnoses

1. Cardiovascular
   - CHF
   - CAD
   - Atherosclerotic Heart Disease / Valvular Disease
   - PVD
   - Congenital

The Prognostication Forest and Trees for Non Cancer Hospice Diagnoses

2. Pulmonary
   - COPD
   - Pulmonary Fibrosis / Interstitial Disease
   - Pulmonary Embolism
   - Pneumonia / Infectious
   - Congenital

The Prognostication Forest and Trees for Non Cancer Hospice Diagnoses

3. CNS
   - ALS / MS / Neuro-degenerative disease
   - Parkinson's Disease
   - Alzheimer's / Various Dementias
   - Infectious
   - Anoxic Brain Injury
     - CVA
     - Trauma
     - Drug Overdoses
   - Congenital

The Prognostication Forest and Trees for Non Cancer Hospice Diagnoses

4. Liver Failure / Cirrhosis
   - Alcoholic
   - Non Alcoholic
   - Infectious

The Prognostication Forest and Trees for Non Cancer Hospice Diagnoses

5. Miscellaneous Causes
   - Renal Failure
   - AIDS
   - Mesenteric Artery Ischemia / Thrombus

Time for PCP Super Hero!

Tools Fit For a Super Hero

“Give me a lever long enough
and a fulcrum on which to place it
AND I SHALL MOVE THE
WORLD.

Archimedes
Greek Family Physician 287BC

Hospice Tool Kit

1. Palliative Performance Scale
2. NYHA Functional Classification
3. Reisberg FAST Scale
4. The Local Coverage Determination Guidelines – LCD's

The Basic Premise = A six month prognosis

"If the patient's illness / disease runs its normal / usual course, would you be surprised if they died within six months?

The job of prognostication may very well take several tools plus the clinical record to arrive at a satisfactory answer. “Prognosis casting” is complicated.

Tool # 1 – The Palliative Performance Scale

- Originated in Canada in 1999, has been updated several times since
- Uses observer rated domains of;
  - Ambulation
  - Activity
  - Self Care
  - Intake
  - Conscious Level
- Left side of table takes dominance over right side of table

PPS Scale

PPS Level	Ambulation	Activity	Self Care	Intake	Conscious Level
100%	Full	Normal Activity	Full	Normal	Full
70%	Reduced	Unable to do normal job / work	Full	Normal or reduced	Full
60%	Reduced	Unable to do hobby or house work	Occassional assist	Normal or reduced	Full
50%	Mainly Sit / Lie	Unable to do any work	Considerable assistance needed	Normal or mainly sit / lie	Full or confusion
40%	Mainly in bed	Unable to do most activity	Mainly assistance	Normal or reduced	Full or drowsy +/- Confusion
30%	Totall Bed Bound	Unable to do any activity	Total Care	Normal or reduced	Full or drowsy +/- Confusion
20%	Totall Bed Bound	Unable to do any activity	Total Care	Minimal to sips	Full or drowsy +/- Confusion
10%	Totall Bed Bound	Unable to do any activity	total care	Mouth care only	Drowsy or =/- coma
0%	Death				

Broad Brush – 50-40% or worse is hospice appropriate if six month prognosis reflected by the exam and clinical record.

Tool # 2 – New York Heart Association (NYHA) Functional Classification

- Class I – Patients with cardiac disease, but without resulting limitation of physical activity. No limits, no symptoms.

- Class II – Patients with cardiac disease resulting in slight limitation of physical activity. Comfortable at rest.

Tool # 2 – New York Heart Association (NYHA) Functional Classification

- Class III – Patients with cardiac disease with limitations of physical activity. Comfortable at rest but less than ordinary activity causes fatigue, dyspnea, or angina.

Tool # 2 – New York Heart Association (NYHA) Functional Classification

- Class IV – Patients with cardiac disease resulting in an inability to carry on ANY physical activity without discomfort. May have symptoms at rest. Activity increases symptoms.

Broad Brush – Class IV is hospice appropriate if six months prognosis is reflected by the exam and clinical record.

An additional tool for Heart Disease is the APACHE scale.

Tool # 3 – Reisberg FAST Scale
(Functional Assessment Staging Test for Dementia)

Progression must be sequential.

1. No difficulties.
2. Forgets location of objects, difficulties in word finding.
3. Decreased job function; gets lost traveling.
4. Decreased ability to perform complex tasks.
5. Needs help choosing weather appropriate clothes.

Tool # 3 – Reisberg FAST Scale
(Functional Assessment Staging Test for Dementia)

6a Needs assistance to dress.
b Needs assistance to bathe.
c Needs assistance for toileting.
d Urinary incontinent.
e Fecal incontinent.

Tool # 3 – Reisberg FAST Scale
(Functional Assessment Staging Test for Dementia)

7a Ability to speak is limited to 6 words or less a day.

b Uses only one word a day.

c non ambulatory.

d unable to sit.

e unable to smile.

f Unable to hold head up.

Broad Brush – 7A or worse is hospice appropriate if six month prognosis is reflected by the exam and clinical record.

Additional Tool – ADEPT Score

The LCD's
Local Coverage Determinations

- Developed by National Hospice and Palliative Care Organization (NHPCO) in 1996 for Medicare.
- Consensus document, not evidence based.
- Had to start with something!

LCD’s

Were Adopted by and modified by the three Medicare Administrative Contractors (MAC’s) to use during audits of hospice care for appropriateness. “Guidelines, not mandates, so clinical judgement should be used…”

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Reminder of our Basic Premise:

A clinical judgement by both the referring physician and the hospice medical director that if the disease / illness runs its usual / normal course, it would not be surprising if the patient died within 6 months."

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LCD's

- Cardiac
  - PPS ≤ 40%
  - Max medical treatment including diuretic & vasodilator / ACE inhibitor.
  - NYHA CHF Class IV

LCD's

- Cardiac

OR

- Angina at rest, resistant to nitrates
- CHF symptoms at rest
- NYHA CHF Class IV

LCD'S

- Pulmonary
  - PPS $\leq$ 40%
  - Dyspnea at rest, decreased function.
  - O_2 sat. $<$ 88% on O_2
  - Increased hospital stays, ER visits
  - Weight loss
  - Decreased FEV_1 on serial tests.

LCD'S

- Dementia – usually Alzheimer's type
  - FAST 7a or worse
  - PPS ≤ 40%
- Plus one of the following;
  - Aspiration pneumonia
  - Septicemia
  - Pressure Ulcers
  - Delirium

LCD's

- Degenerative Neurologic Diseases
    - PPS ≤ 40%
    - Complications of disease projects a six month prognosis

LCD's

- Liver Failure
  - Prothrombin time > 5 sec over control or INR > 1.5 second.
  - Serum albumin < 2.5mg/dl
  - PPS ≤ 40%

Both must be present

LCD's

Liver Failure (continued)

- Plus one of the following:
  - Ascites
  - Spontaneous bacterial peritonitis
  - Recurrent variceal bleed
  - Hepatic Encephalopathy
  - Hepatorenal syndrome

LCD's

- Renal Failure
  - PPS $\leq$ 40%
  - Creatinine clearance < 10cc/min
  - If DM/CHF, creatinine clearance < 15

    <u>AND</u>

- Not seeking transplant or HD.

LCD's

- AIDS
  - Anti-retrovirals have all but eliminated AIDS as a hospice diagnosis.
  - CD4 $<$ 25
  - Viral Load $>$ 100,000 copies/ml
  - PPS $\leq$ 50%
  - Weight loss
  - Opportunistic infections

Bringing It On Home

The referring physician AND the hospice medical director agree on a six month prognosis.

The referring physician can ask for the hospice medical director's reasoning for the six month prognosis.

September 2000 GAO Report to Donna Shalala, Secretary of HHS:

According to Medicare program guidance to all hospices, the fact that a hospice patient lives beyond six months does not, by itself, constitute grounds for a determination that the patient was never eligible for hospice care or that Medicare does not cover services provided to the patient.

Ultimately, our failings in adequately caring for patients at the end of life come from the difficulties we have, both as patients and physicians, in confronting mortality."

Ashish K. Jha, M.D., MPH
JAMA, August 21, 2018
Volume 320, Number 7

? Questions ?