Painting the Picture:
Clinical Appropriateness for Hospice Care

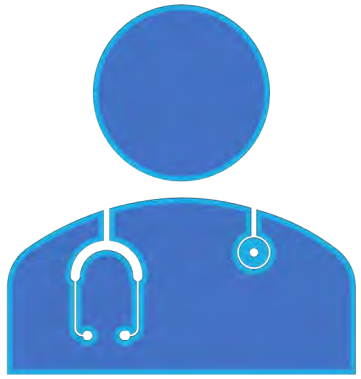
THE CONNECTICUT HOSPICE, INC.

Hospice Care: Making the Decision

A holistic approach to treatment that focuses on the patent and family

Addresses the physical, mental, emotional, and spiritual needs of the patient and family

Highly Personal decision that values patient choices and goals



What Does the Hospice Benefit Cover ?

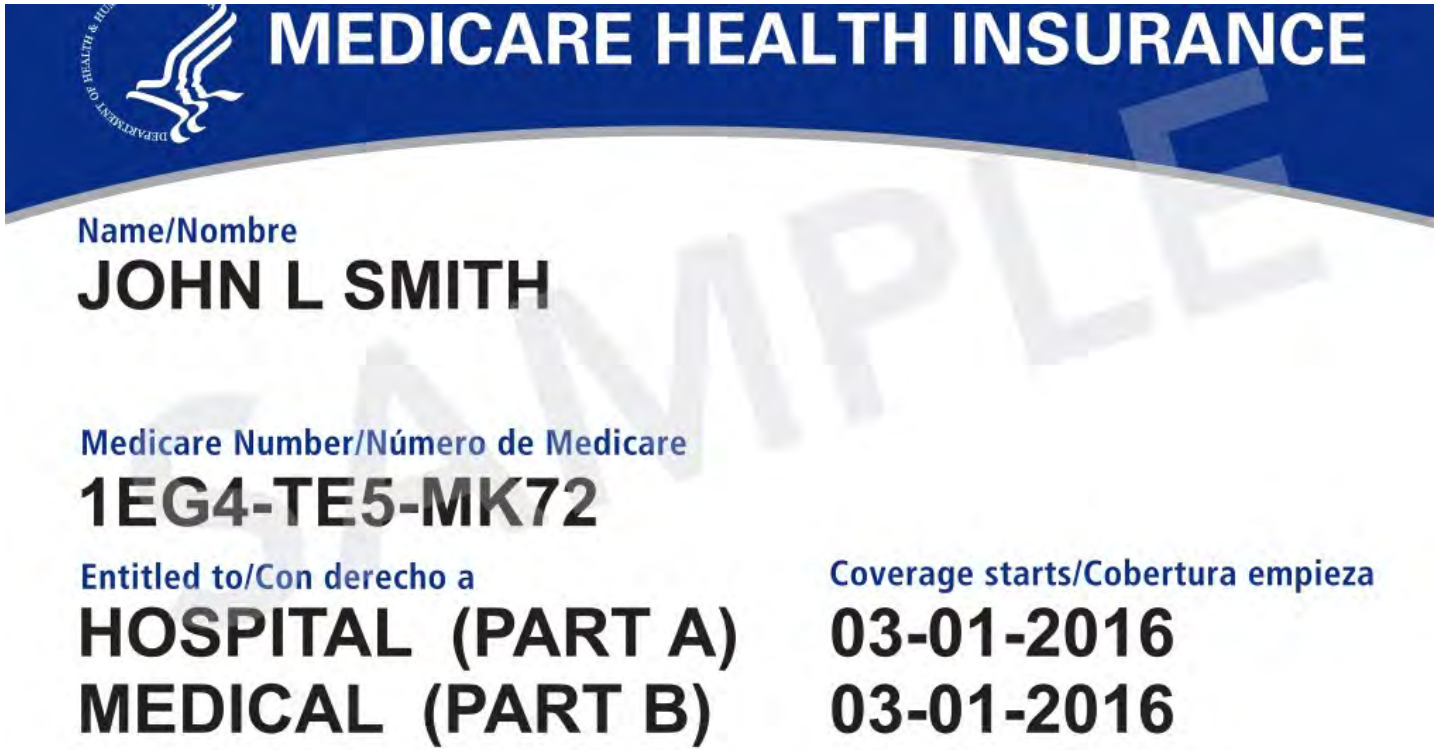
Medicare Hospice Benefit Eligibility

1. Medicare Part A

2. Physician certified six months or less prognosis if the terminal illness runs its natural course

3. The individual is willing to forgo curative therapy for the terminal illness, elect the hospice benefit, and waive all rights to Medicare payments for the terminal illness and related conditions

Centers for Medicare and Medicaid Services, 2021



Documentation of Decline

Patients are considered to have a life expectancy of six months or less if there is documented decline in clinical status

- Presumes assessment are done over time
- Baseline and follow up data must be reported
- Other clinical variables that may support this prognosis should also be included

What Does That Look Like?

PHYSICAL SIGNS

- Frequent or recurring infections
- Rapid decline in health despite aggressive medical treatment
- Frequent hospitalizations or emergency room visits
- Uncontrolled pain, nausea, or vomiting
- Increase in the amount of time sleeping
- Loss of urinary or bowel control
- Chest congestion and/or rapid breathing
- Decrease in food and fluid intake; weight loss
- Changes in body temperature (fever or feeling cool to the touch)
- Restlessness or repetitive motions
- Decreasing ability to perform daily tasks without assistance

MENTAL AND EMOTIONAL

- Withdrawal from family, friends, and loved ones
- Making statements or requests that seem out of character
- Giving away personal belongings
- Making funeral plans
- Experiencing visions or hallucinations
- Making apologies or saying goodbye
- Expressing a desire to no longer seek medical interventions, hospitalizations, treatment

What Does That Look Like

Recurrent or Intractable:

- Serious infections such as pneumonia, pyelonephritis, or sepsis

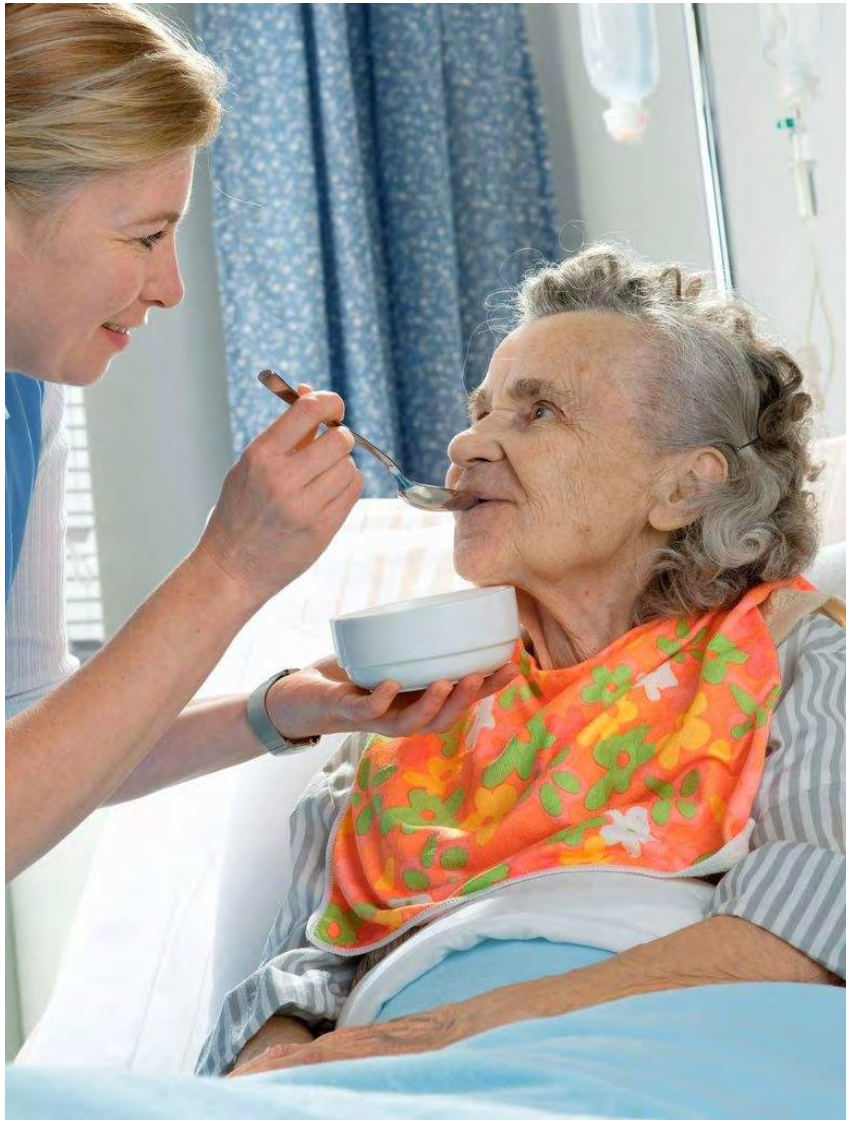
Nonresponsive to therapies:

- Pain requiring increasing doses of analgesics
- Persistent nausea despite multiple drug (Compazine, Phenergan, Zofran, Reglan)or non-pharmacological interventions (diet, aromatherapy)
- Dyspnea and persistent cough with increasing respiratory rate
- Diarrhea

What Does That Look Like

Progressive:

- Weight loss of at least 10% of body weight in the previous 6 month (not related to reversible causes; diuretic, depression)
- Decreasing anthroponomic measures (mid-arm circumference, abdominal girth)
- Observation of ill-fitting clothes , decrease skin turgor, increasing skin folds
- Other observation to demonstrate loss of weight in a patient that can not be weighted on a scale



What Does That Look Like?

Dysphagia

- Coughing or choking when eating or drinking, persistent drooling of saliva, pocketing of food; being unable to chew food properly, a gurgly, wet-sounding voice when eating or drinking.
- Leading to recurrent aspiration and/or inadequate oral intake
- Documented decrease in food portion consumption

Decline in Clinical Status

- Decline in systolic BP to < 90 or progressive postural hypotension
- Ascites
- Venous, arterial, lymphatic obstruction due to metastatic disease
- Edema
- Pleural or Pericardial effusion
- Weakness
- Change in level of consciousness

Decline In Clinical Status

Laboratory Values * *when available but not required to establish eligibility*

- Increasing or Decreasing pCO_2
- Decreasing SaO_2
- Increasing calcium, creatinine, or liver function test
- Increasing tumor markers
- Progressively decreasing or increasing serum potassium, or sodium

Decline in Clinical Status Guidelines

- Decrease in Karnofsky and Palliative performance Score due to disease progression
- Progressive decline in Functional Assessment Staging Test (FAST) for dementia to 7A or greater
- Progression to dependence on assistance with ADLs
- Progressive stage 3-4 pressure ulcers despite optima care
- Increasing ER visits, hospitalizations, or physician visits related to the terminal illness before election of the hospice benefit.

Non-Disease Specific Baseline Guidelines

Karnofsy Performance Status (KPS) and/or Palliative Performance Score (PPS) below 70%*

HIV Disease, Stroke, and Coma require a lower score to qualify

PALLIATIVE PERFORMANCE SCALE (PPS)

%	Ambulation	Activity level Evidence of disease	Self-care	Intake	Level of consciousness	Estimated median survival in days (a)	(b)	(c)
100	Full	Normal *No disease*	Full	Normal	Full	NA	NA	108
90	Full	Normal *Some disease*	Full	Normal	Full			
80	Full	Normal with effort *Some disease*	Full	Normal or reduced	Full			
70	Reduced	Can't do normal job or work *Some disease*	Full	As above	Full	145		
60	Reduced	Can't do hobbies or housework *Significant disease*	Occasional assistance needed	As above	Full or confusion	29	4	
50	Mainly sit/lie	Can't do any work *Extensive disease*	Considerable assistance needed	As above	Full or confusion	30	11	41
40	Mainly in bed	As above	Mainly assistance	As above	Full or drowsy or confusion	18	8	
30	Bed bound	As above	Total care	Reduced	As above	8	5	
20	Bed bound	As above	As above	Minimal	As above	4	2	6
10	Bed bound	As above	As above	Mouth care only	Drowsy or coma	1	1	
0	Death							

KARNOFSKY PERFORMANCE STATUS SCALE DEFINITIONS RATING (%) CRITERIA

Able to carry on normal activity and to work; no special care needed.	100	Normal no complaints; no evidence of disease.
	90	Able to carry on normal activity; minor signs or symptoms of disease.
	80	Normal activity with effort; some signs or symptoms of disease.
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	70	Cares for self; unable to carry on normal activity or to do active work.
	60	Requires occasional assistance, but is able to care for most of his personal needs.
	50	Requires considerable assistance and frequent medical care.
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.	40	Disable; requires special care and assistance.
	30	Severely disabled; hospital admission is indicated although death not imminent.
	20	Very sick; hospital admission necessary; active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly.
	0	Dead

Non-Disease-Specific Guidelines

Dependence on assistance for two or more of the following ADLS

- Ambulation
- Continence
- Transfer
- Dressing
- Feeding
- Bathing

Comorbidities

- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Ischemic Heart Disease
- Diabetes Mellitus (DM)
- Neurologic Disease (Parkinson, ALS, MS, CVA)
- Renal Failure
- Liver disease
- Neoplasia
- AIDS/HIV
- Dementia
- Refractory Autoimmune disease (Lupus or Rheumatoid Arthritis)


Painting The Picture

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Weight Loss:

The patient is unable to be weighed on scales due to bed-bound status. MAC is 18cm to the right upper arm. During the interview with the daughter, who has been caring for the patient over the past year, she said that her mother has lost weight in the past 3 months but unable to state how much. The daughter states that she has been wearing clothing in a size 16 women's but now she had to get mother new clothing gradually over the past few months due to her clothing "falling off of her". The patient is now able to wear size 10 women's clothing.

Appetite:

The patient has been eating 4-6 child-size meals per day but has only eaten about 25% of each meal. This consists of 2 slices of bacon, 3 bits of grits for breakfast. She had a 1/3 of an Ensure supplement, then for lunch she had a few bites of homemade soup and a popsicle

Painting the Picture

Decline in Functional Status

The patient requires assistance of one for bathing at the sink, dressing his lower body and now uses a walker for all ambulation inside and outside of his room. The patient was completely independent with all ADL's and driving and working every day until 3 months ago when he was diagnosed.

Sleeping

The Nurses Aide describes the patient is sleeping 8-10 hours at night and then takes a 3-4 hour nap during the day. When the patient is up in the chair for more than an hour, she is frequently dosing off. This is a change from just 2 months ago when the patient was not even sleeping during the night and was having agitation in the evening and sleeping a few hours during the day only

Mrs. A is an 89 y/o female and LTC Resident for the last 2 years at your facility. After an ER visit this week and diagnosis of her 3rd UTI this year, her daughter has asked tht she no longer be sent to the ER and instead be “made comfortable” and “let nature takes it’s course.

A review of her LTC chart by the facility RN shows that in addition to 3 ER visits, Mrs. A has had the following documented evidence of clinical decline since January 2021: In January, Mrs. A could participate in dressing herself and transfer w/assist of one to the wheelchair. As of today, she is a full assist with bathing and dressing and can not participate. She can be lowered into the wheelchair and positioned in an upright position with pillows but otherwise bed bound. She went from feeding herself 50% of adult size meals 3x a day to requiring full feed assistance for all meals. She eats 25% of adult size meals, with change in diet to soft foods to prevent aspiration. Her last weight in March was 125lbs, a 2 lbs loss from February. The CNA reports that her clothing is loose-fitting.

She has a significant history for end-stage renal disease and hypertension. She has had increasing difficulty swallowing her medications and has not received her Lisinopril 10mg daily for the last 3 days. She is on an oral antibiotic for the UTI which was also held due to inability to swallow capsule. She has showed increasing agitation at bedtime which has not been effectively managed on increased Seroquel 25mg dose.

What services and interventions could be added to the care the Mrs. A receives that would be beneficial to her and to help her and her daughter achieve their goals?

Putting it All Together!