Objectives

At the end of this session, participants will be able to:
1. Describe the role of scales and trajectories in supporting ongoing hospice eligibility;
2. Explain requirements related to recertification of terminal illness; and,
3. Identify ways to minimize the risk of non-compliance and non-payment.

LCD For Determining Terminal Status (L13653)

- “...documentation certifying terminal status must contain enough information to support terminal status.”
- “If other clinical indicators of decline not listed in this policy such as psychological and spiritual factors form the basis for certifying terminal status, they should be documented as well.”
• “Patients will be considered to have a life expectancy of six months or less if he/she meets the non-disease specific decline in clinical status guidelines described in Part I”.
• “Alternatively, the baseline non-disease specific guidelines described in Part II plus the applicable disease specific guidelines listed in the appendix will establish the necessary expectancy.”

Clinical Discernment

• What is the pt’s burden of illness?
• What pattern of decline is evident and is this expected of and supported by, or different from, the terminal diagnosis?
• Discern “active” disease trajectory, based on described pattern of decline.

Discernment, cont’d.

• Does patient meet LCD guidelines?
• If not, what other data supports hospice admission?
• What factors are impacting patient’s “normal course”?
“…If The Illness Runs Its Normal Course…”

• Prognostication is not an exact science.
• Variables influencing “normal course”:
  – Multiple diagnoses;
  – Interrelated secondary and co-morbid conditions;
  – Age;
  – Degree of frailty;
  – Environment of care; and,
  – Access to other healthcare providers.

Complications

• **Secondary Conditions**: Complications directly related to primary hospice diagnosis.
• **Co-morbid Conditions**: Different from primary hospice diagnosis, but may contribute to patient’s limited life expectancy.

Complications, cont’d.

• Ultimately, *the combined effects* of the terminal condition, *and* any clinically significant co-morbid / secondary conditions, should be such that most patients would have a prognosis of 6 months or less.
Challenges

• Ensuring that the clinical record contains sufficient documentation to support hospice appropriateness and eligibility based on LCD guidelines at:
  – Admission; and,
  – Recertification.

<table>
<thead>
<tr>
<th>LCD Determinations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IDG DECISION</strong></td>
</tr>
<tr>
<td>Patient fully and completely meets LCD guidelines.</td>
</tr>
<tr>
<td>Patient partially meets LCD guidelines with conditions.</td>
</tr>
<tr>
<td>Patient partially meets LCD guidelines without conditions.</td>
</tr>
<tr>
<td>Patient does not meet LCD guidelines.</td>
</tr>
</tbody>
</table>

Understanding End Stage Disease Trajectories & Hospice Assessment Scales
21st CENTURY HOSPICE PATIENTS – COMPLEX COMBINATIONS

RAPID DECLINE
- Cancer

SAW-TOOTHED DECLINE
- Organ system failures (COPD, etc.)

SLOW INSIDIOUS DECLINE
- Neurodegenerative disorders
- Dementia

HOSPICE ASSESSMENT SCALES

Why Use Scales?

• Assessment scales are used for:
  - Prognostication;
  - Monitoring disease progression (eligibility);
  - Care planning;
  - Decisions regarding resource allocation;
  - Teaching (patient/caregiver and clinical teaching);
  - Research; and,
  - Communication among healthcare providers for quickly describing a patient’s current functional status.
HOSPICE ASSESSMENT TOOLS

<table>
<thead>
<tr>
<th>KPS / PPS</th>
<th>FAST</th>
<th>NYHA</th>
<th>ECOG</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>Alzheimer’s and Related Disorders</td>
<td>Cardio-Pulmonary</td>
<td>Lung Cancer</td>
</tr>
</tbody>
</table>

Palliative Performance Scale (PPS)

- A modification of the KPS.
- 11-point scale designed to measure patients’ performance status in 10% decrements from 100% (healthy) to 0% (death).
- Measures functional status based on 5 observable parameters: ambulation, ability to do activities, self-care, food/fluid intake, and consciousness level.

<table>
<thead>
<tr>
<th>PPS Level</th>
<th>Ambulation</th>
<th>Activity &amp; Evidence of Disease</th>
<th>Self Care</th>
<th>Intake</th>
<th>Conscious Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% Full</td>
<td>Full</td>
<td>Normal activity &amp; work. No evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>90% Full</td>
<td>Full</td>
<td>Normal activity &amp; work. Some evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>80% Full</td>
<td>Full</td>
<td>Normal activity with Effort. Some evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>70% Full</td>
<td>Full</td>
<td>Normal activity with Effort. Some evidence of disease</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
</tbody>
</table>
### PPS, cont’d.

<table>
<thead>
<tr>
<th>PPS Level</th>
<th>Ambulation</th>
<th>Activity &amp; Evidence of Disease</th>
<th>Self Care</th>
<th>Intake</th>
<th>Conscious Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>70%</td>
<td>Reduced</td>
<td>Unable Normal Job/Work</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
<tr>
<td>60%</td>
<td>Reduced</td>
<td>Unable to do light housework</td>
<td>Occasional assistance necessary</td>
<td>Normal or reduced</td>
<td>Full or Confusion</td>
</tr>
<tr>
<td>50%</td>
<td>Mainly Bed &amp; Bowel</td>
<td>Unable to do any work</td>
<td>Considerable assistance required</td>
<td>Normal or reduced</td>
<td>Full or Confusion</td>
</tr>
<tr>
<td>40%</td>
<td>Mainly in Bed</td>
<td>Unable to do most activity Extensive disease</td>
<td>Mildly assistance</td>
<td>Normal or reduced</td>
<td>Full or Drowsy +/- Confusion</td>
</tr>
<tr>
<td>30%</td>
<td>Totally Bed Bound</td>
<td>Unable to do any activity Extensive disease</td>
<td>Total Care</td>
<td>Normal or reduced</td>
<td>Full or Drowsy +/- Confusion</td>
</tr>
<tr>
<td>20%</td>
<td>Totally Bed Bound</td>
<td>Unable to do any activity Extensive disease</td>
<td>Total Care</td>
<td>Minimal to nil assistance</td>
<td>Full or Drowsy +/- Confusion</td>
</tr>
<tr>
<td>10%</td>
<td>Totally Bed Bound</td>
<td>Unable to do any activity Extensive disease</td>
<td>Total Care</td>
<td>Mouth care only</td>
<td>Drowsy or Coma +/- Confusion</td>
</tr>
<tr>
<td>0%</td>
<td>Death</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

### PPS Scoring

- Scores are determined by reading horizontally at each level to find a “best fit” for the patient.
- Scores are in 10% increments only.
- Choosing a “half-fit” value (e.g., 45%) is not correct.
- [http://web.his.uvic.ca/Research/NET/tools/PrognosticTools/PalliativePerformanceScale/PPSQuestionsAndAnswers.php](http://web.his.uvic.ca/Research/NET/tools/PrognosticTools/PalliativePerformanceScale/PPSQuestionsAndAnswers.php)
Scoring, cont’d.

- Begin at the left column and read downwards until the appropriate ambulation level is reached.
- Then read across to the next column and downwards again until the activity/evidence of disease is located.
- Repeated these steps until all 5 columns are covered before assigning the patient’s score.
- “Leftward” columns (columns to the left of any specific column) are “stronger” determinants and generally take precedence over others.

Examples

- Pt spends the majority of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances but who is otherwise fully conscious with good intake: PPS 50%.

Examples, cont’d.

- Pt paralyzed and quadriplegic requiring total care: PPS 30%  
  - Although this pt may be placed in a wheelchair (and perhaps seem initially to be at 50%), the score is 30% because s/he would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care including lift/transfer; pt may have normal intake and full conscious level; and,  
  - However, if the patient was paraplegic and bed bound but still able to do some self-care (e.g., eating independently), the PPS would be higher since s/he is not “total care” (40 or 50%).
Karnofsky Performance Scale

- Created by Dr. David Karnofsky and Dr. Joseph Burchenal in the 1940s.
- Attempted to evaluate the health of patients, post treatment, based upon their quality of life.
- Relates purely to physical ability and covers 11 points, from normal health to death, each scored as a percentage.
- The lower the score, the worse the survival rate.

<table>
<thead>
<tr>
<th>KPS</th>
<th>100%</th>
<th>90%</th>
<th>80%</th>
<th>70%</th>
<th>60%</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Normal no complaints; no evidence of disease.</td>
<td>Able to carry on normal activity; minor signs or symptoms of disease.</td>
<td>Normal activity with effort; some signs or symptoms of disease.</td>
<td>Cares for self; unable to carry on normal activity or to do active work.</td>
<td>Requires occasional assistance, but is able to care for most of his personal needs.</td>
<td>Requires considerable assistance and frequent medical care.</td>
</tr>
</tbody>
</table>

Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.
### KPS, cont’d.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>40%</td>
<td>Disabled; requires special care and assistance.</td>
</tr>
<tr>
<td>30%</td>
<td>Severely disabled; hospital admission is indicated although death not imminent.</td>
</tr>
<tr>
<td>20%</td>
<td>Very sick; hospital admission necessary; active supportive treatment necessary.</td>
</tr>
<tr>
<td>10%</td>
<td>Moribund; fatal processes progressing rapidly.</td>
</tr>
<tr>
<td>0%</td>
<td>Dead.</td>
</tr>
</tbody>
</table>

### Eastern Cooperative Oncology Group (ECOG)

<table>
<thead>
<tr>
<th>ECOG</th>
<th>FULLY ACTIVE</th>
<th>RESTRICED</th>
<th>AMBULATORY</th>
<th>CAPABLE</th>
<th>BEDRIDDEN</th>
<th>DEAD</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Fully active, able to carry on all pre-disease performance without restriction.</td>
<td>Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work.</td>
<td>Ambulatory and capable of all self care but unable to carry out any work activities. Up and about more than 50% of waking hours.</td>
<td>Capable of only limited self care, confined to bed or chair more than 50% of waking hours.</td>
<td>Completely disabled. Cannot carry on any self care. Totally confined to bed or chair.</td>
<td>Dead.</td>
</tr>
</tbody>
</table>

### Performance Status Scale Equivalences

<table>
<thead>
<tr>
<th>ECOG</th>
<th>KPS</th>
<th>DEFINITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100</td>
<td>Asymptomatic.</td>
</tr>
<tr>
<td>1</td>
<td>80-90</td>
<td>Symptomatic, fully ambulatory.</td>
</tr>
<tr>
<td>2</td>
<td>60-70</td>
<td>Symptomatic, in bed less than 50% of day.</td>
</tr>
<tr>
<td>3</td>
<td>40-50</td>
<td>Symptomatic, in bed more than 50% of the day, but not bedridden.</td>
</tr>
<tr>
<td>4</td>
<td>20-30</td>
<td>Bedridden.</td>
</tr>
<tr>
<td>5</td>
<td>0-10</td>
<td>Imminently dying / dead.</td>
</tr>
</tbody>
</table>
**Functional Assessment Staging (FAST) Classification**

- Created by Dr. Barry Reisberg in 1986.
- 16-item assessment tool, based on the patient's level of practical functioning, used to aid in the diagnosis and staging of Alzheimer's disease.
- Reliable and valid assessment technique for evaluating functional deterioration throughout the entire course of the illness.
- Illuminates the characteristic pattern of progressive, ordinal, and functional decline.

**FAST, cont’d.**

1. No difficulties, either subjectively or objectively.
2. Complains of forgetting location of objects. Subjective word finding difficulties.
3. Decreased job functioning evident to co-workers; difficulty in traveling to new locations. Decreased organizational capacity.
4. Decreased ability to perform complex tasks (e.g., planning dinner for guests), handling personal finances (forgetting to pay bills), difficulty marketing, etc.
5. Requires assistance in choosing proper clothing to wear for the day, season, or occasion.

**FAST, cont’d.**

6a. Difficulty putting clothing on properly without assistance.
6b. Unable to bathe properly; e.g., difficulty adjusting bath water temperature) occasionally or more frequently over the past weeks.
6c. Inability to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.
6d. Urinary incontinence, occasional or more frequent.
6e. Fecal incontinence, occasional or more frequently over the past week.
FAST, cont’d.

| 7a  | Ability to speak limited to about half a dozen words in an average day. |
| 7b  | Intelligible vocabulary limited to a single word in an average day. |
| 7c  | Non-ambulatory (unable to walk without assistance). |
| 7d  | Unable to sit up independently. |
| 7e  | Unable to smile. |
| 7f  | Unable to hold head up. |

The Stages Of Careiving

<table>
<thead>
<tr>
<th>FAST</th>
<th>STAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>The <strong>Assisting and Supervising</strong> Stage of Care</td>
</tr>
<tr>
<td>5-6</td>
<td>The <strong>Taking-Charge</strong> Stage of Care</td>
</tr>
<tr>
<td>7</td>
<td>The <strong>In-Charge</strong> Stage of Care</td>
</tr>
</tbody>
</table>

NEW YORK HEART ASSOCIATION (NYHA) CLASSIFICATION

| I. No limitation in physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain. | A. No evidence of cardio-vascular disease. |
| II. Slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain. | B. Objective evidence of *minimal* cardio-vascular disease. |
**NYHA, cont’d.**

<table>
<thead>
<tr>
<th>III. Marked limitation of physical activity. They are comfortable at rest. Less than ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.</th>
<th>C. Objective evidence of moderately severe cardiovascular disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV. Unable to carry on physical activity without discomfort. Symptoms of heart failure or anginal syndrome <strong>may</strong> be present even at rest. If any physical activity is undertaken, discomfort is increased.</td>
<td>D. Objective evidence of severe cardiovascular disease</td>
</tr>
</tbody>
</table>

**Rating Scale Concerns**

- Subjective; findings cannot be proven.
- Tendency to over-rate (choose higher scores).
- Inter-observer variability reduces reliability.
- Not created for hospice population.
- Categories do not align well with patient experiences and/or treatment options.
- Incorrect and/or infrequent use skews scoring.
- If scales seem meaningless to staff they may become rote (older scores are recopied).
TRAJECTORY OF ILLNESS: RAPID DECLINE

- Illnesses such as cancer have a progression that ends in a steady inexorable decline in function until death.
- The MHB was predicated on this pattern of decline and death.


LCD Specifics For Cancer Diagnoses

- Disease with distant metastases at presentation; or,
- Progression from an earlier stage of disease to metastatic disease with either:
  - continued decline in spite of therapy; or,
  - patient declines further disease directed therapy.

Admission Note

- S – Pt reports, "I can’t believe this is happening. I get knocked in the head and the next thing I hear is that I’m dying from a tumor I didn’t even know was there. How’s my wife going to cope with three kids by herself? My head’s throbbing, I can’t focus my eyes, and I want to throw up all the time. God, what am I going to do? My pain’s a 10 right now”.
- O – Pt in darkened room, holding head in both hands and grimacing at slightest noise.
Admitted 4/18/09 w/Glioblastoma. Fully and completely meets Medicare eligibility test AEB:
- Terminal diagnosis;
- Life expectancy of six months or less if the disease runs its normal course (as certified by the pt’s attending MD and the hospice MD); and,
- Opting for a palliative rather than curative approach to end-of-life care (per hospice election and advance directives).

Measurable Data Points

Pt: Mr. Jones  DX: Glioblastoma  SOC: 4/18/09

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>PTA</th>
<th>4/18/09</th>
<th>1ST Recert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight / BMI</td>
<td>-</td>
<td>235 / 27%</td>
<td>210/22%</td>
</tr>
<tr>
<td>KPS</td>
<td>-</td>
<td>70%</td>
<td>60%</td>
</tr>
<tr>
<td>FAST</td>
<td>-</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>ADLs</td>
<td>Independent</td>
<td>Independent</td>
<td>Dependent for ambulation</td>
</tr>
<tr>
<td>Skin</td>
<td>Intact</td>
<td>Intact</td>
<td>Intact</td>
</tr>
<tr>
<td>Infection</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

TRAJECTORY OF ILLNESS: “SAW-TOOTHED”

A slow incremental decline punctuated by multiple episodes of acute exacerbations (organ system failure; degenerative, infectious, inflammatory, metabolic, neurological diseases).

Decline: never get back to previous baseline
Referral Information

Mr. Doe:
- DX: COPD
- Age: 76
- Residence: Home
- PCG: Wife
- PTA: 56-year smoking history; declines cessation Rx; 5’9”; 120#; BMI=17.7% (underweight)
- Secondary: Cachexia
- Co-morbid: None

Admission Note

- S – Pt reports, “I can’t even do anything anymore and I’m totally exhausted.”
- O – Using accessory muscles & pursed-lipped breathing; push of speech noted; dyspnea @ rest; amb X 50 feet w/o rest 2 mos ago; now rests 5-10 min after only 10 feet; uses W/C with PCG assist to maneuver in house (too weak to self-propel); O2 @ 3L via NC; sat = 88% RA.

Note, cont’d.

- Admitted 4/18/09 w/COPD. Fully and completely meets disease specific LCD guidelines AEB:
  - Part II:
    - KPS 50%.
    - Dependent on PCG for 4 of 6 ADLs.
    - Co-morbid conditions: None (not required).
Note, cont’d.

– Section II-F (Pulmonary Disease):
  • Dyspnea @ rest.
  • Bed-to-chair existence.
  • Extreme fatigue.
  • Productive cough.
  • Poor response to medication.
  • Oxygen-dependent.

Note, cont’d.

– Prior to hospice admit:
  • Increasing MD & ER visits w/ hospitalization for infections.
  • Respiratory failure (1/28/09).

Note, cont’d.

– Additional support:
  • Unintentional progressive weight loss of > 10% of total body weight over last 6 months.
  • Resting tachycardia > 100/min.
Measurable Data Points

Pt: Mr. Doe  DX: COPD  SOC: 4/18/09

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>PTA</th>
<th>4/18/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight / BMI</td>
<td>-</td>
<td>120 / 17.7%</td>
</tr>
<tr>
<td>KPS</td>
<td>-</td>
<td>50%</td>
</tr>
<tr>
<td>FAST</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>ADLs</td>
<td>-</td>
<td>Amb, transfer, dressing and bathing</td>
</tr>
<tr>
<td>Skin</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Infection</td>
<td>Pneumonia</td>
<td>-</td>
</tr>
<tr>
<td>Oxygen</td>
<td>2L PRN / 92% RA</td>
<td>3L cont / 88% RA</td>
</tr>
</tbody>
</table>

TRAJECTORY OF ILLNESS: PROLONGED INSIDIOUS PROGRESSION

• Steady progressive disability leading to death.
• Typical course of AFTT, dementia, disabling stroke and coma.

Referral Information

Mrs. Smith:
• DX: Dementia
• Age: 96
• Residence: SNF
• PCG: Facility staff; granddaughter
• PTA: 20-year dementia history; aspiration pneumonia; refusing food; 5’9”; 89#; BMI=13% (underweight)
• Secondary: Cachexia & 2 Stage III Decubitus Ulcers
• Co-morbid: Cardiac & NIDDM

Admission Note

• S – PCG reports, “She’s not talking or looking at me very much these days and I don’t know why or if something’s wrong.”
• O – Pt makes minimal eye contact during visit; occasionally turns head when name is called; can verbalize but speech is limited to < 6 words (usually unintelligible / non-meaningful).

Note, cont’d.

• Admitted 4/18/09 w/Dementia. Fully and completely meets disease specific LCD guidelines AEB:
  – Part II:
    • KPS 40%.
    • Dependent on PCG for 3 of 6 ADLs.
    • Co-morbid conditions: Cardiac Disease & Diabetes.

Note, cont’d.

  – Section IIB:
    • FAST 7a (speech limited to < 6 words).
    • Unable to dress, bathe and ambulate without assistance.
    • Stage III Decub (R) heel and (R) hip.
Measurable Data Points

Pt: Mrs. Smith  DX: Dementia  SOC: 4/18/09

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>PTA</th>
<th>4/18/09</th>
<th>1st Recert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight / BMI</td>
<td>-</td>
<td>89 / 13%</td>
<td>80/12%</td>
</tr>
<tr>
<td>KPS</td>
<td>-</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>FAST</td>
<td>-</td>
<td>7a</td>
<td>7b</td>
</tr>
<tr>
<td>ADLs</td>
<td>Amb, transfer w/1, incontinent of B&amp;B</td>
<td>Amb, transfer w/1, incontinent of B&amp;B</td>
<td>Amb, transfer w/2, incontinent of B&amp;B, feeding</td>
</tr>
<tr>
<td>Skin</td>
<td>Stage I (R) heel &amp; hip</td>
<td>Stage II (R) heel &amp; hip</td>
<td>Stage II (R) heel &amp; hip</td>
</tr>
<tr>
<td>Infection</td>
<td>Aspiration pneumonia</td>
<td>-</td>
<td>Aspiration precautions</td>
</tr>
</tbody>
</table>

Types Of Dementia

• Alzheimer’s Disease (prognosis ~8 years).
• Lewy Body (prognosis ~7 years).
• Vascular (prognosis ~3 years).
• Frontal Lobe Dementia.
• Traumatic Dementia.
• Dementia secondary to other diseases, such as:
  – Parkinson’s;
  – Alcoholism;
  – HIV-related; and,
  – Viral (CJD / Mad Cow Disease).

Alzheimer’s And Co-Morbids

• The FAST scale does not address the impact of co-morbid and secondary conditions.
• These 2 variables (FAST & co-morbid conditions) are considered separately by the LCD.
Alzheimer’s And Co-Morbids, cont’d.

- A patient with Alzheimer’s Disease and **clinically significant** CHD or COPD would have specific impairments of cardio-respiratory function (e.g., dyspnea, orthopnea, wheezing, chest pain), which may or may not respond to or be amenable to treatment.

Alzheimer’s And Co-Morbids, cont’d.

- The identified impairments in cardio-respiratory function would be associated with both specific structural impairments of the coronary arteries or bronchial tree and may be associated with activity limitations (e.g., mobility, self-care).

Alzheimer’s And Secondary Conditions

- Alzheimer’s Disease may be complicated by **secondary conditions** such as mental and movement-related functioning, delirium, and pressure ulcers.
**IDT VISIT DOCUMENTATION**

Documentation Opportunities

- Admission.
- IDT Visit Notes – all disciplines.
- IDT Review.
- Recertification.

**IDT Documentation**

- All narrative notes should:
  - Support terminal diagnosis, based on LCD guidelines;
  - *Paint the picture* of “active” disease trajectory (in words and for someone who doesn’t know the pt); and,
  - Explain “improvements” or “stability”.

---
Measurable Data Points

<table>
<thead>
<tr>
<th></th>
<th>PTA</th>
<th>SOC</th>
<th>1ST RECERT</th>
<th>2ND RECERT</th>
</tr>
</thead>
<tbody>
<tr>
<td>KPS / PPS</td>
<td>70%</td>
<td>58%</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td>FAST</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>NYHA</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>ADLs</td>
<td>Independent</td>
<td>Independent</td>
<td>1:6</td>
<td>2:6</td>
</tr>
<tr>
<td>Skin</td>
<td>intact</td>
<td>intact</td>
<td>1 Stage 1</td>
<td>2 Stage 1</td>
</tr>
<tr>
<td>Wt</td>
<td>235</td>
<td>229</td>
<td>225</td>
<td></td>
</tr>
<tr>
<td>BMI</td>
<td>30.2%</td>
<td>29.4%</td>
<td>28.9%</td>
<td></td>
</tr>
<tr>
<td>Infections</td>
<td>N/A</td>
<td>LRI</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>GI</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>2L PRN</td>
</tr>
</tbody>
</table>

Interdisciplinary Documentation

- IDT documentation:
  - Provides detailed evidence of the team’s commitment to high quality care;
  - Establishes and supports eligibility;
  - Affects reimbursement;
  - Impacts treatment and related decisions;
  - Confirms that care was provided;
  - Clearly outlines important task and process information; and,
  - Guides decisions downstream (e.g., on-call staff).

Ongoing Documentation: Establish Relevance To Diagnosis

- Discipline-specific visit notes should address:
  - Physical status;
  - Emotional health;
  - Spiritual health;
  - Disease severity and/or progression;
  - Physician assessment and orders; and,
  - Impact of secondary & comorbid conditions.
Relevance, cont’d.

• IDT visit notes must:
  – Continuously and consistently support the terminal prognosis;
  – Contain vital signs, weights, body mass measurements, meal percentages, lab values, etc. (nursing visits);
  – Contain other objective data (non-nursing disciplines);
  – “Tell the story” rather than reflect a stagnant snapshot in time;
  – Not contain inappropriate corrections (write-overs, cross outs and/or date changes); and,
  – Contain only agency-approved abbreviations.

Consider Using S.O.A.P.I.E.R. Documentation Format

<table>
<thead>
<tr>
<th>SUBJECTIVE</th>
<th>What do others tell you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>OBJECTIVE</td>
<td>What do you see, hear, read, observe?</td>
</tr>
<tr>
<td>ASSESSMENT</td>
<td>What do you make of it all? What actual and/or potential problems do you identify?</td>
</tr>
<tr>
<td>PLAN</td>
<td>Who is going to do what, where &amp; when? What are the goals of patient, of the IDG?</td>
</tr>
<tr>
<td>INTERVENTION</td>
<td>Take discipline-specific action that supports IDG problem oriented approach.</td>
</tr>
<tr>
<td>EVALUATE</td>
<td>Was outcome as expected? If not, why?</td>
</tr>
<tr>
<td>REASSESS</td>
<td>What happens next?</td>
</tr>
</tbody>
</table>

IDG REVIEW DOCUMENTATION
IDT Review

- Focus POC reviews by stating:
  1. The results of my pt/fam assessment are…
  2. The pt/fam outcomes we’re focusing on are…
  3. The priority for my next visit is…
  4. My anticipated visit frequency is…

Hospice PIGs

- Problems – Based on comprehensive assessment of patient / family needs.
- Interventions – Related to terminal diagnosis, palliative in nature.
- Goals – Designed to eliminate futile / unwarranted treatment, keep patient at home, assure comfort and pain / symptom management.

IDT Review, cont’d.

- Keep IDG meeting focused on pt/fam & POC (PIGs).
- Do not allow IDG to ramble or meeting to go on too long.
- Accomplish care planning versus reporting.
IDT Review, cont’d

- Identify new PIGs.
- Document problem resolution.
- Specify & follow *individualized* visit frequencies.
- Document recertification discussions and measurable clinical data points to support eligibility.

---

IDT Review, cont’d.

- Ensure POC:
  - **Drives** all care and services;
  - Reflects problems based on initial, comprehensive, and updated assessments; and,
  - Reflects care in accordance.

---

Sample POC – Mr. Jones

<table>
<thead>
<tr>
<th>PROBLEMS</th>
<th>INTERVENTIONS</th>
<th>GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pain</td>
<td>1. Verbal/non-verbal pain scales; meds A/O; stimulation (dark room, quiet, soft music PRN); ice pack to forehead; sunglasses; massage therapy…</td>
<td>1. Maintain SIT score of 3 or below.</td>
</tr>
<tr>
<td>2. Impaired judgment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Aphasia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Imminent death</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Spiritual distress</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Sample POC – Mr. Doe

<table>
<thead>
<tr>
<th>PROBLEMS</th>
<th>INTERVENTIONS</th>
<th>GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Impaired breathing</td>
<td>1. O2@3L via NC cont; conserve energy (freq rest periods, break tasks into multiple short steps); ask yes/no questions; soft foods; clear liquids, meds A/O; teach relaxation…</td>
<td>1. Maintain O2 sat above 90% to feel feelings of air hunger</td>
</tr>
<tr>
<td>2. Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Weight loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Depression</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Sample POC – Mrs. Green

<table>
<thead>
<tr>
<th>PROBLEMS</th>
<th>INTERVENTIONS</th>
<th>GOALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Altered skin integrity</td>
<td>1. Assess skin q visit; Rx A/O; measure wound q wk; photo per policy; pain meds PRN A/O; HA to √ temp q visit; room deodorizer…</td>
<td>1. Maintain comfort; prevent worsening &amp; infection; eliminate odor; and resurface.</td>
</tr>
<tr>
<td>2. Safety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Weight loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Impaired swallowing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Potential for infection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### RECERT DOCUMENTATION
**Disease Trajectories**

- **Rapid Decline**
  - Cancer

- **Saw-Toothed Decline**
  - Organ system failures (COPD, etc.)

- **Slow Insidious Decline**
  - Neurodegenerative disorders
  - Dementia

Recertification: Supporting Prognosis

- Use LCD guidelines.
- Tell story / paint picture *in words*.
- Write for someone who does not know pt.
- Support ongoing hospice eligibility and limited prognosis.
- Documentation must stand alone.
- Compare to baseline data (decline over time).
- Visit notes / assessments support eligibility.
- Describe the "normal" course of illness for the *individual patient*.

Recert Documentation

- All certification (admission) and recertification documentation *must* contain enough information to support the patient’s terminal status upon review.
- All clinical indicators of decline that form the basis for certifying / recertifying the patient *must* be documented:
  - By the IDG; and,
  - At every visit.
Recert, cont’d.

• Recertification for hospice care requires the same clinical standards be met as for initial certification.
• Documentation should “paint a picture” of why / how the patient is appropriate for hospice as well as the level of care being provided.
• Documentation should include observations and measurable data, not merely conclusions.

Recert, cont’d.

• There are patients for whom a particular LCD guideline does not match; and/or
• An LCD may be inadequate to predict the terminal prognosis of an individual patient who meets the guideline at the SOC and continues to do so over a prolonged period (> than 6 months).
• In such cases, it is important to document all factors that support the terminal prognosis.

Recert, cont’d.

• Document:
  – MD & IDG discussions and decisions, especially with regard to hospice eligibility;
  – “Related” and “unrelated” conditions; and,
  – Progress toward outcomes.
Recert, cont’d.

• Per LCD guidelines:
  – Patients with...long term survival in hospice, or apparent stability, can still be eligible for hospice benefits;
  – If this is the case, sufficient justification for a less than 6-month prognosis should appear in the record; and,
  – Inconsistent documentation should be specifically addressed and explained, including findings suggestive of a > 6-month prognosis.

Recert, cont’d.

• All patients, especially those with non-cancer diagnoses, should be assessed for:
  – Hospitalization risk;
  – Recertification potential; and,
  – Possible discharge.
• A patient does not become ineligible overnight.
• Discharge is a process not an event.
• A period of stability must be assessed in light of its potential to continue.

Documentation Basics

• Your documentation must be:
  – Timely;
  – Complete;
  – Accurate;
  – Legible;
  – Individualized;
  – Interdisciplinary; and,
  – Supportive of terminal diagnosis and prognosis.
WOULD YOU RECERTIFY?
CASE EXAMPLE # 1

Dx: Alzheimer’s Dementia.
Recert: 2nd benefit period recert due in 2 wks.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>Current</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>117</td>
<td>103</td>
<td>-11.96%</td>
</tr>
<tr>
<td>KPS</td>
<td>50%</td>
<td>30%</td>
<td>-20%</td>
</tr>
<tr>
<td>ADLs</td>
<td>2 assist transfer</td>
<td>Hoyer lift required</td>
<td>Total dependence</td>
</tr>
</tbody>
</table>

WOULD YOU RECERTIFY?
CASE EXAMPLE # 2

Dx: Alzheimer’s Dementia.
Recert: 6th benefit period recert due in 2 wks.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Admit</th>
<th>5th</th>
<th>Current</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td>-</td>
<td>143</td>
<td>140</td>
<td>-3 lbs in 90 days</td>
</tr>
<tr>
<td>KPS</td>
<td>50%</td>
<td>40%</td>
<td>50%</td>
<td>At baseline</td>
</tr>
<tr>
<td>FAST</td>
<td>7A</td>
<td>7A</td>
<td>7A</td>
<td>No change</td>
</tr>
<tr>
<td>Other</td>
<td>Recent UTI</td>
<td>none</td>
<td>Stage II on heels</td>
<td>Skin changes</td>
</tr>
</tbody>
</table>

DOCUMENTATION CHALLENGES
### Challenges, cont’d.

- Documentation must provide both qualitative and quantitative information.
- Avoid vague statements like:
  - “Patient is stable”;
  - “No change”;
  - “Doing well”;
  - “Eating well”;
  - “Slow, progressive decline”; and,
  - “Appears to be losing weight”.

### Challenges, cont’d.

- **DO NOT** confuse decline with prognosis.
- **DO NOT** mistake a prognosis of days for a prognosis of 6 months.
- **DO NOT** think improvement in symptoms means improvement in prognosis.
- **DO NOT** discharge because “we aren’t doing anything” for the patient.

### Challenges, cont’d.

- **DO** write notes relevant to diagnosis and prognosis (every IDG member).
- **DO** explain improvements in relation to:
  - Assistance / Support / Socialization;
  - Medication / Nutrition / Referrals; and,
  - Monitoring / DME / Quality of life.
- **DO** compare to “well” not “actively dying” patients (accentuate the negative).
- **DO** choose language meaningful to hospice population & relative to diagnosis.
Challenges, cont’d.

• Revise scheduling and tickler systems to reflect new 48-hour, 5-day and 15-day requirements.
• Audit to ensure 100% compliance.

Whose Patient Is It Anyway?

• Hospice, by regulation, is responsible for everything it deems necessary for palliation of the patient's terminal disease and related conditions including:
  – IDG visits;
  – Other consultations as needed (therapies, counseling, etc.);
  – Medications;
  – Treatments;
  – Durable Medical Equipment (DME); and,
  – Levels of Care.

Better Questions To Ask

• What is the goal of care and who's goal is it?
  – What does the patient want for his/her end-of-life?
  – Are the family and facility in agreement?
  – Does the attending and/or consulting physician concur?
  – Is the hospice IDT — including the medical director — in alignment?
Value-Added

• How is the “value-added” nature of hospice care evidenced?
  – Supporting, not supplanting, the facility in providing care to hospice patients;
  – Providing care in addition to what is required by the facility’s POC;
  – Meeting or exceeding the goals of care; and,
  – Monitoring, measuring, and improving patient outcomes.

Questions

Thank You!

WEATHERBEE RESOURCES, INC
HOSPICE EDUCATION NETWORK, INC
Hyannis, MA
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