



Prognostication

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Objectives

- Overall goal – to improve prognostication skills
- Review the trajectory of illnesses as they relate to deteriorating function and diminished prognosis
 - Identify the common aspects of decline which are universal despite diagnosis
 - Review how to best “paint the picture” to support estimates of limited prognosis
 - Discuss available tools and measures that help support “painting the picture”
 - Discuss the environment of regulatory scrutiny and audits and the importance of prognostication and documentation

Prognosis



prog-no-sis (prg-nss) *n. pl. prog-no-ses (-sz)* 1.

- **a.** A prediction of the probable course and outcome of a disease.
- **b.** The likelihood of recovery from a disease.

“a most excellent thing for the physician to cultivate Prognosis; for by foreseeing and foretelling ... the present, the past, and the future, and explaining the omissions which patients have been guilty of, he will be the more readily believed to be acquainted with the circumstances of the sick, so that men will have confidence to entrust themselves to such a physician.”

Hippocrates as cited by Roy Porter (medical historian) in *The Greatest Benefit to Mankind*



“As a result of a failure to prognosticate, let alone prognosticate accurately, patients may die deaths they deplore in locations they despise. They may seek noxious chemotherapy rather than good palliative care, enroll in clinical trials of experimental therapy that offer more benefit to researchers than to themselves, or reassure loved ones that it is not yet time to pay a visit – only to lapse into a coma before having a chance to say good-bye.”

Nicholas Christakis MD PhD



Discussing Prognosis

Provides

- a framework to make informed decisions about care
- a time-frame that helps in setting priorities
- an opportunity for life & care planning
 - spiritual
 - financial
 - psychosocial – relationships/forgiveness
 - opportunity to say goodbye
 - life closure and legacy giving

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Prognosis → Overestimate

- 326 patients with cancer in 5 Chicago hospices
- 20% accuracy in predicting prognosis
- 63% overestimate, 17% underestimate
- Only 37% would give frank disclosure, even when patient requested survival estimate
- Average survival time was 26 days; average communicated survival time was 90 days
- Closer the relationship – more likely to err

Christakis, Annals of Int Med, 2001

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Prognostication – Hospital PC teams

- 4 Categories
 - <3 days
 - < 1 month
 - 1-6 months
 - > 6 months
- Correct category - 58% accurate
- 85% accurate if prognosis 0-3 days
- 27% overestimate, 16% underestimate
- 48% cancer N = 429 patients

Fromme et al, JPM Dec 2010

How COD and Life Expectancy have changed

1900	2006
1. Pneumonia	1. Heart Disease
2. Tuberculosis	2. Cancer
3. Diarrhea and Enteritis	3. Stroke
Life expectancy: 47 years Disability: Days to Weeks	78 years Weeks to Years

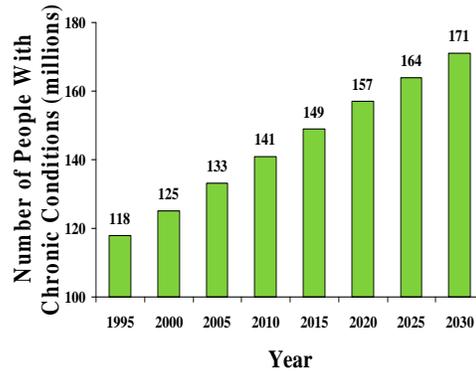
Growth in Chronic Disease

- Nearly **1 in 2** Americans has a chronic disease
- Projected to increase – 157 million Americans by 2020; **171 million by 2030**
- Americans are living longer –from 2010 to 2030 > 65 years old increase 13.2% to 20%
- 90% seniors have at least one chronic disease, 77% have 2
- 24% of those with chronic illness have disability

Chronic Conditions: Making the case for ongoing care. RWJ – 9/2004 update

The Number of People With Chronic Conditions Is Rapidly Increasing

- In 2005, 133 million Americans had one or more chronic conditions.
- This number is projected to increase by more than one percent each year through 2030.
- Between 2000 and 2030, the number of Americans with chronic conditions will increase by 37 percent, an increase of 46 million people.



Johns Hopkins University, Partnership for Solutions

Source: Wu, Shin-Yi and Green, Anthony. *Projection of Chronic Illness Prevalence and Cost Inflation*. RAND Corporation, October 2000.

Leading Causes of Mortality (2007)

1. Cardiac disease
2. Cancer
3. Stroke
4. Respiratory Disease
5. Accidents
6. Dementia
7. Diabetes
8. Influenza and Pneumonia
9. Renal disease
10. Septicemia

Leading causes of death (2009)

- Heart disease: 599,413
- Cancer: 567,628
- Chronic lower respiratory diseases: 137,353
- Stroke (cerebrovascular diseases): 128,842
- Accidents (unintentional injuries): 118,021
- Alzheimer's disease: 79,003
- Diabetes: 68,705
- Influenza and Pneumonia: 53,692
- Nephritis, nephrotic syndrome, and nephrosis: 48,935
- Intentional self-harm (suicide): 36,909

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NHPCO & Diagnosis Codes for patients served (2008)

- Cancer – 38.3%
- Non Cancer – 68.7%
 - Dementia – 11.1%
 - Debility – 15.3%
 - **Cardiovascular – 11.7%**
 - **Respiratory – 7.9 %**
 - Stroke or Coma – 4%
 - Renal – 2.8%
 - Liver – 1.5%
 - Non-ALS – 2.1%
 - ALS – .4%
 - HIV- .5 %
 - Other 4.4%

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Prognostication

‘Would you be surprised if your patient died within the next year?’

Lynn, 2005

Prognosis Important factors to consider

- ✓ Primary disease and expected trajectory
- ✓ Co-morbid illnesses
- ✓ Rate of decline
- ✓ Nutritional status
- ✓ Functional status
- ✓ Cognitive status
- ✓ Age and gender
- ✓ Number of hospitalizations in past year
- ✓ Will to live
- ✓ Other (psychosocial, emotional and spiritual)



Depression and Social Isolation

- Depression and social isolation are independent risk factors
- Overall higher mortality rates from all diseases
- Increased rates of hospitalization
- Increased mortality post MI
- Increased mortality from cancer
- Lower immune functions

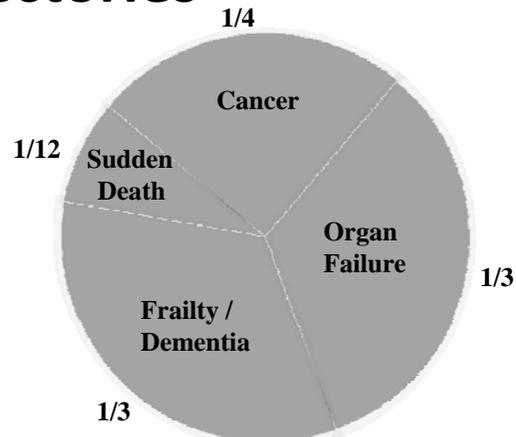


Spiritual Beliefs and Prognosis

- Major source of coping
 - 85% hospitalized pts
 - 40% most important factor
- Multiple studies in chronic diseases demonstrate these as a source of coping
- Suggested role in improving depression
- Literature demonstrates beneficial effects on health outcomes
- May inform decision-making around treatment options which could then impact prognosis

Disease Trajectories

- Sudden death
- Cancer
- Organ Failure
- Frailty



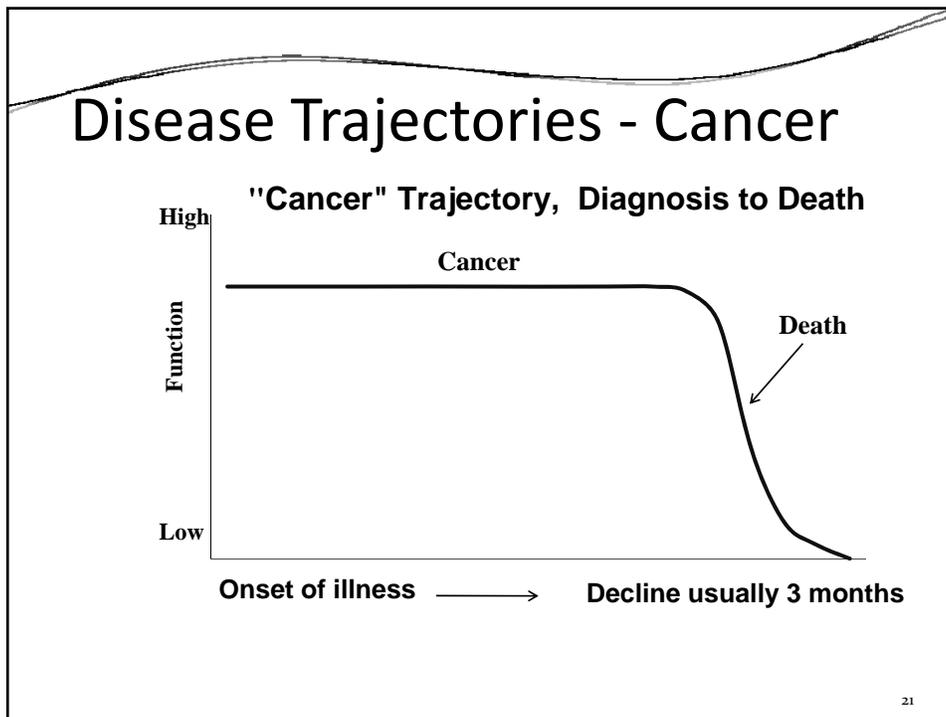
Prognostic Indicator Paper, Gold Standards Framework, England 2005

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Cancer

- Accounts for 30 % of all deaths
- Highly functional early on with slow steady decline 3 months prior to death
- Functional Dependence:
 - 1 year prior to death - .77 ADL
 - 3 months prior to death - 4.09 ADL

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Prognosis & Cancer

In general, a patient with any **metastatic** solid cancer (e.g. lung, kidney, melanoma, esophagus), acute leukemia or high-grade lymphoma, who will **not be receiving systemic chemotherapy** (for whatever reason), has a prognosis of less than 6 months.

Notable exceptions to this are patients with breast or prostate cancer with **good performance status**, as these cancers, even when metastatic, may be quite indolent.

Weissman

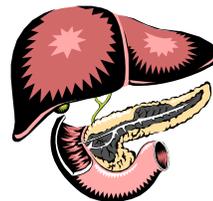
Prognostication in Cancer Patients

- Performance or functional status
 - Karnofsky Score < 50%
 - ECOG Score > 2
- Solid tumor, KS \leq 50% - average 3-month prognosis
- Signs and symptoms
 - anorexia
 - confusion or delirium
 - dysphagia
 - dyspnea
- Biomarkers – Ca-125, Ca 19-9, Ca 27.29, Ca 15-3

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Prognostication in Cancer

- Hypercalcemia (except newly dx Breast CA and Myeloma)
- Leptomeningeal Carcinomatosis
- Malignant pleural effusion
- Pericardial effusion
- Liver metastasis
- Brain metastasis
- Cord compression



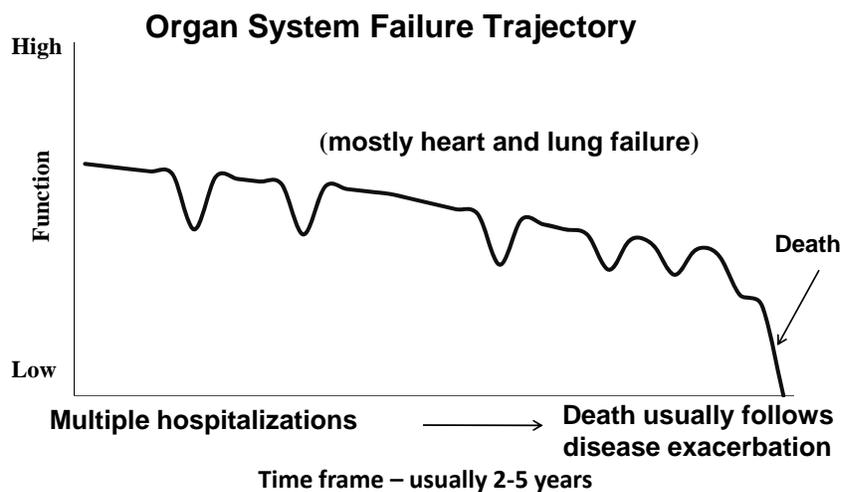
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Organ Systems Failure

- Account for 40% of all deaths
- Multiple exacerbations, often frequent hospitalizations
- Generally die during exacerbations
- Renal, liver, cardiac, pulmonary
- Functional status fluctuates with overall slow decline
 - 1 year prior to death – 2.1 ADL
 - 3 months prior to death – 3.66 ADL

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Disease Trajectories – OSF



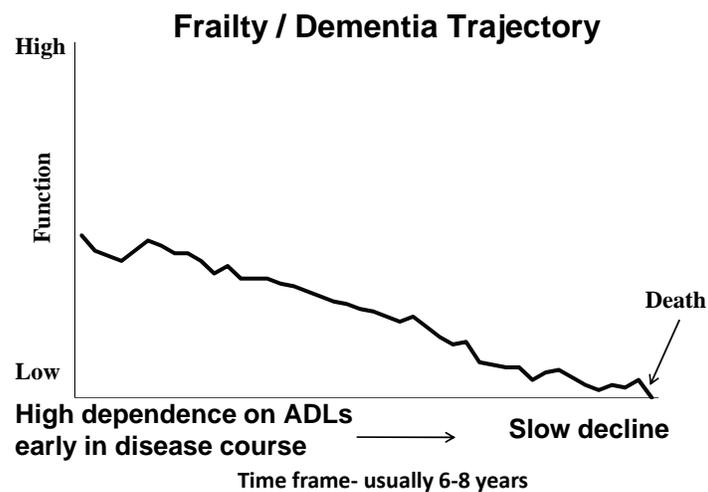
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Frailty

- Accounts for 20-30% of all deaths
- Elderly women with multiple co-morbidities
- Dementia often present
- Very slow rate of decline, with early functional decline
 - 1 year prior to death – 2.92 ADL
 - 1 month prior to death – 5.84 ADL

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Disease Trajectories



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Frailty

780.7 Malaise and fatigue

780.72 Functional quadriplegia

Complete immobility due to severe physical disability or frailty

Excludes:

hysterical paralysis (300.11)

immobility syndrome (728.3)

neurologic quadriplegia (344.00-344.09)

quadriplegia NOS (344.00)

Documenting Prognosis



- **Primary diagnosis** – what you think will likely be the cause of death
- **Secondary conditions** – conditions directly related and often a result of the primary diagnosis
 - Dementia patient – delirium, dysphagia, pressure ulcers...
 - Cardiac patient – arrhythmias, edema, hypoxemia...
- **Co-morbidities** – associated conditions not related to the primary illness whose presence adds to the burden of illness and prognosis
 - Dementia patient – cardiac disease, pulmonary disease, anemia...
- **Psychosocial Spiritual and Environmental** features
- **Data from available prognostic tools**

Paint the picture!!!

Prognostication Tools

- LCDs
- Disease Specific Tools (FAST, MELD, NYHA, Albumin, Cr cl, BNP, CO2)
- BMI/weight
- ADLs
- MMSE/clock drawing
- PPS/Karnofsky

Supportive info to add to =

- Primary Dx
- Rate of decline
- Co-morbidities
- Secondary conditions



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The LCD's...

The prognostic indicators used by the MACs to determine eligibility are based on:

1. Recommendations by the ABMS
2. Literature search
3. Guidelines from NHPCCO
4. Recommendations from subspecialty groups
5. A separate taskforce set up by CMS

NHPCO Guidelines

- Created in 1996 as a guide for physicians in determining hospice eligibility to be used in conjunction with clinical judgment – initially part of a research study.
- Never intended by NHPCO to be used as public policy
- Developed during Operation Restore Trust
- Intended to increase access, but has actually limited access to eligible patients
- Never validated
- Ineffective at predicting prognosis

Fox et al, JAMA 1999;282:1638-1645
Schonwetter, AmJHPM, 2003

General Prognostic Tools in Advanced Disease

- **ePrognosis.org** JAMA 2012
- Prognostat – age, gender, diagnosis, PPS
<http://web.his.uvic.ca/Research/NET/tools/PrognosticTools/PalliativePerformanceScale/Prognostat/ToEstimateSurvivalOfYourPatient/index.php>
- Palliative Prognostic Score (PaP) – FF #124
 - KS, WBC, lymphocytes, clinical, anorexia, dyspnea
- Palliative Prognostic Index (PPI) (time frame of weeks)
 - PPS, edema, oral intake, dyspnea, delirium in cancer patients



Time to Think!

62 yo M with Class IV heart disease, COPD, DM, and CRF admitted to ICU with asymptomatic ventricular arrhythmias. EF = 40%, FEV1 = 40%, Cr-1.5 Would you admit this patient to hospice?

1. Yes, cardiac disease
2. Yes, COPD
3. Yes, diabetes
4. Yes, debility
5. No

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Cardiovascular Disease - LCD

- NHPCO guidelines
 - NYHA Stage IV – symptoms at rest maximally treated with meds
 - EF < 20% (helpful, not required)
 - supported by treatment resistant arrhythmias, history of cardiac arrest, unexplained syncope, cardiogenic brain embolism, HIV

Less than 50% accuracy at predicting mortality

Cardiovascular disease (CHF) - unpredictable disease trajectory with high risk of sudden death

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Providing accurate prognostic data for 6-12 month mortality in HF has been nearly impossible.

Framingham Heart Study (1990-1999) showed a 5-year mortality rate of 50% for newly identified cases, BUT...

- 1) an unpredictable disease trajectory with high incidence (25-50%) of sudden death;
- 2) disparities in the application of evidence-based treatment guidelines;
- 3) inter-observer differences in New York Heart Association (NYHA) classification; and
- 4) heterogeneous study populations in the HF literature.

Fast Facts #143

Predictors of poor outcome in chronic heart failure

- High NYHA functional class
- Reduced left ventricular ejection fraction
- Low peak oxygen consumption with maximal exercise (% predicted value)
- Third heart sound
- Increased pulmonary artery capillary wedge pressure
- Reduced cardiac index
- Diabetes mellitus
- Reduced sodium concentration
- Raised plasma catecholamine and natriuretic peptide concentrations

General Predictors of Shorter Prognosis in HF

- Recent cardiac hospitalization (triples 1-year mortality).
- Elevated BUN (defined by upper limit of normal) and/or creatinine ≥ 1.4 mg/dl ($120 \mu\text{mol/l}$).
- Systolic blood pressure < 100 mm Hg and/or pulse > 100 bpm (each doubles 1-year mortality).
- Decreased left ventricular ejection fraction (linearly correlated with survival at LVEF $\leq 45\%$).
- Ventricular dysrhythmias, treatment resistant.
- Anemia (each 1 g/dl reduction in hemoglobin is associated with a 16% increase in mortality).
- Hyponatremia (serum sodium ≤ 135 - 137 mEq/l).
- Cachexia.
- Reduced functional capacity.
- Co-morbidities: diabetes, depression, COPD, cirrhosis, cerebrovascular disease, cancer, and HIV-associated cardiomyopathy.

Physiology of CHF

- **Systolic** – 2/3 CAD, 1/3 valvular disease, DM, hypertension, thyroid disease, alcoholism and myocarditis
- **Diastolic** – CAD and Hypertension
 - 50% CHF in ≥ 70 y = stiff ventricles
- Symptoms – fatigue and dyspnea
- Maladaptive neuro-hormonal response
- TNF and IL-6 cause proteolysis and wasting, similar to cancer patients

Arrhythmias

Although arrhythmias are common in patients with heart failure and are indicators of disease severity, they are not powerful independent predictors of prognosis



Biomarkers in Heart Disease

- Troponin – myocardial cell damage
- BNP – LV dysfunction
- Cystatin C – renal function
- C-Reactive Protein – inflammation

Increased risk of death when all four elevated

Zethelius NEJM – 5/2008

- Others - TNF, IL-6, IL-1, Fas (APO-1), endothelin-1, NE, troponin-1, Na

Braunwald NEJM 2008;358

CHF – Prediction Models

- CVM-HF PREDICTOR
 - *Am J Cardiol* 2006;98:1076-1082
 - <http://www.ccort.ca/Research/CHFRiskModel.aspx>
 - Predicts death at 30 days and one year
- SEATTLE HEART FAILURE MODEL
 - *Circulation* 2006;113:1424-33. Levy et al. *The Seattle Heart Failure Model: Prediction of Survival in Heart Failure*
 - <http://depts.washington.edu/shfm/press.php>
 - Predicts 1, 2, 3 year survival with and w/o meds

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Seattle Heart Model

	Baseline			Intervention		
	1 Year	2 Year	5 Year	1 Year	2 Year	5 Year
Survival	80%	64%	32%	94%	88%	73%
Mortality	20%	36%	68%	6%	12%	27%
Mean life expectancy	4.0 years			9.3 years		

Clinical
 Age: 65
 Gender: Male
 NYHA Class: 3A
 Weight (kg): 80
 EF: 30
 Syst BP: 120
 Ischemic

Medications
 ACE-I
 Beta-blocker
 ARB
 Statin
 Allopurinol
 Aldosterone blocker

Diuretics
 Furosemide: 80
 Bumetanide: 0
 Torsemide: 0
 Metolazone: 0
 HCTZ: 0

Lab Data
 Hgb (g/dL): 14
 Lymphocyte %: 24
 Uric Acid (mg/dL): 8
 Total Chol (mg/dL): 190
 Sodium: 137
 QRS > 120 msec

Devices
 None
 BIV Pacer
 ICD
 BIV ICD

Interventions
 ACE-I
 ARB
 Beta-blocker
 Statin
 Aldosterone blocker

Devices
 None
 BIV Pacer
 BIV ICD
 ICD
 LVAD

Note: Some devices may be disabled if CMS clinical criteria are not met.

Copyright 2004–2007 Wayne Levy and David Linker

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Quiz Time!

62 yo with COPD, 2 episodes of pneumonia over the past year, 10 lb weight loss, who is referred to hospice because of increasing dyspnea. FEV1 is 30% and O2 sat on room air is 86%. Would you admit to hospice?

1. Yes
2. No

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Prognosis in COPD - NHPCO

- FEV1 <30% after bronchodilators
- pO2 <55, pCO2 >55 O2 sat ≤ 88% RA
- Cor Pulmonale from pulmonary hypertension

Additional Supporting Factors

- Weight loss > 10% (or BMI <21)
- Resting tachycardia > 100/minute
- Active smoker



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COPD Prognosis

- Dyspnea < 50 feet
- Depression
- Single
- One or more hospitalizations in last year
- Comorbid Illness
- FEV₁ <30%
- Functional decline
- Advanced age (>70)



Hansen-Flaschen COPD, the last year of life. Resp Care
2004;49(1): 90-97

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Hospitalized with COPD

- COPD patient **ventilated** – 25% mortality
- Co-morbidities
 - low albumin
 - low hgb
 - previous ventilation
 - severity of illness
 - **intubation > 3 days**

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Hospitalized with COPD

Patients with COPD admitted to an ICU for an acute exacerbation:

- Hospital mortality (24%).
- For patients aged 65 years or older, 1 year mortality doubles 30% to 59%.
- **If $p\text{CO}_2 > 50$ – 1 year mortality 50%**

COPD – Prognosis tools

BODE – point system

- Body Mass Index (BMI < 21)
- Obstruction – FEV1
- Dyspnea scale (MMRC)
- Exercise capacity – 6 min distance walked



Better predictor than FEV1 alone, but still not predictive of 6-month prognosis

<http://copd.about.com/od/copdbasics/a/BODEIndex.htm>

NEJM, 2004 150 (10) 1005-1012

...COPD - Prognosis

- **BODE** – no studies evaluated whether BODE matched observed mortality in different populations
- **ADO** = Age, dyspnea, obstruction
- Better predictive value when both used

Lancet 2009;374:667-668 704-711

Stroke Prognosis

- Acute Ischemic Stroke
- Intracranial Hemorrhage
- Interventricular Hemorrhage

Acute Ischemic Stroke – 85% CVA's

- Thrombotic or embolic
- 5% hospital mortality
- 17-21% 90 day mortality
- Medical complications in the hospital double mortality
- **NIHSS** and age – strongest predictors

<http://www.strokecenter.org/professionals/stroke-diagnosis/stroke-assessment-scales/>

JAMA. 2004;292

JAMA. 2005;294

Hemorrhagic Stroke – 15% CVA

- 52% 30 day mortality
- 90% 30 day mortality if brain stem
- Volume of bleed matters
 - <30ml 20% mortality
 - 30-60 ml (100% Rankin score>4 – unable to walk or any ADL's without assistance)
 - >60 ml 90+% mortality

Mitka. JAMA 2007;297 Hemorrhagic stroke guidelines issued

Traumatic Brain Injury

- Poor predictors for 6 month survival
 - Age
 - Pupillary reflex
 - Hypoxia
 - Hypotension
 - CT results: InterV, SDH or EDH
 - Motor Score
 - Lab – glucose and Hgb

Steyerberg PLoS Med 2008

Amyotrophic Lateral Sclerosis

- Prospective study – 180 patients
 - Median survival from onset of sx – 32 mo
 - Median survival from diagnosis – 19 mo
- Factors with worse outcome
 - Older age
 - Female Sex
 - Bulbar features
 - Short time from symptoms to diagnosis
 - Single

del Aguila. Prognosis in ALS; a population based study, Neurology 2003;60:813-819

Amyotrophic Lateral Sclerosis

Consensus panel: RWJ Promoting Excellence.

- Recommendations:
 - Early grief and psychosocial support for patients & caregivers
 - Measure quality of life
 - Assess Suicide risk
 - Maintain patient autonomy and self-direction when meaningful

Clinical issues:

- Severe psychological or spiritual distress
- Pain requiring high doses of analgesics
- Dysphagia requiring feeding tubes
- Respiratory failure
- Loss of function in 2 body regions

Completing the Continuum of ALS Care – A Consensus Document, 2004

Liver Disease – NHPCO guidelines

- PT > 5 or INR >1.5
- Serum albumin < 2.5 gm/dl

And at least one of these

- Ascites
 - refractory to treatment
 - spontaneous bacterial peritonitis (1 yr surv – 30%)
 - hepatorenal syndrome
 - hepatic encephalopathy
 - recurrent variceal bleeding

Liver Disease

- Calculate MELD score (Model ES Liver Dz)
 - INR
 - Bilirubin
 - Creatinine
 - Also the MELD-Na

<http://www.mayoclinic.org/meld/mayomodel6.html>

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Liver – MELD Scores

3 Month Mortality (Hospitalized)

<u>MELD Score</u>	<u>Death Rate</u>
≤ 9	4
10-19	27
20-29	76
30-39	83
≥ 40	100

MELD–Na is better predictor of those with
Hepatocellular Carcinoma (over MELD)

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Quiz Time Again!

92 yo with frailty, weight loss (90 lbs), recent history of pneumonia, mild dementia, DM, PVD and CRF. Albumin – 2.0, Cr – 1.9, Hgb – 10.5. Patient resides in NH; hospice consult requested. Would you admit?

1. Yes, renal disease
2. Yes, dementia
3. Yes, FTT
4. Yes, debility
5. No



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Chronic Renal Failure

	<u>Stages</u>	<u>GFR</u>
1	slight	> 90ml/min
2	mild	60-89
3	moderate	30-59
4	severe	15-29
5	end stage	<15 diabetics <10 non diabetics

Hemodialysis withdrawal the median survival is approximately 9.6 days, 32% > 2 weeks

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Renal Disease

- Not seeking dialysis or renal transplant
- Cr cl < 10 cc/min (15 cc/min with DM) or Cr > 8 mg/dl
- Albumin < 3
- Co-morbid conditions
 - PVD, especially amputation
 - CHF
 - DM
- Malnutrition
- Age > 80 years old



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Patients on Hemodialysis

- Predictive Model
 - Age
 - Dementia
 - Peripheral Vascular Disease
 - Albumin
 - SQ – “Would you be surprised if this patient died within 6 months?”

Clin J Am Soc Nephrol 2010 Jan 5; 72-9 Cohen
“Predicting Six-Month Mortality for Patients Who Are on Maintenance Hemodialysis”



Quiz Time!

86 yo WF with Fast Stage 6 dementia who falls at the NH and fractures a hip. Post op she is stable, eating about 20%. A hospice consult is requested. Would you admit this woman to hospice and under what diagnosis?

1. Yes, dementia
2. Yes, debility
3. No

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Prognosis in Dementia - NHPCO

- FAST 7c
 - 39.5 % mortality in 6 mo (poor selectivity)
 - 22.2% who died had FAST 7c (poor sensitivity)

Excluded a substantial portion of patients who died in 6 months – 77.8%

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Mortality Risk Index

- Retrospective study based on MDS
- Better outcome predictor than FAST scale 7c
- Assesses 12 risk factors and assign points
- Use in nursing home population

Mitchell, JAMA 2004;291:2734-2740

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Mortality Risk Index - Dementia

Complete dependence with ADLs	1.9
Male Gender	1.9
Cancer	1.7
CHF	1.6
Oxygen therapy past 14 days	1.6
SOB	1.5
<25% po intake	1.5
Unstable medical condition	1.5
Bowel incontinence	1.5
Bedfast	1.5
Age > 83 yo	1.4
Sleeps most of the day	1.4



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Mortality Risk Index

Risk of estimate of death in 6 months

- 0 pts 8.9 %
- 1-2 10.8 %
- 3-5 22.2 %
- 6-8 40.4 %
- 9-11 57.0 %
- >_12 70.0 %

Mitchell, SL, JAMA 2004, vol 291, 2734-2740

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Prognosis in Dementia

- Hospitalized with pneumonia
 - 53% 6-month mortality vs. 13% cognitively intact
- Hospitalized with hip fracture
 - 55% 6-month mortality vs. 12% cognitively intact



Morrison RS JAMA 2000;264:47-52

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Prognosis - Dementia

- Document Fast Scale
- MRI – supportive if score ≥ 9
- Co-morbidities – cardiac, pulmonary
- Secondary conditions
 - weight loss
 - dysphagia
 - urosepsis
 - pressure ulcers

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Eligible? What Diagnosis?

88 yo with mild CHF, mild dementia, who is referred to hospice for weight loss, poor nutrition, general decline, and multiple hospitalizations for infections

- Admit?
- What diagnosis?

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~~Debility (Ill Defined Condition)~~

- Primary contributing illness
- Progressive malnutrition
- Dysphagia
- KPS < 70%
- Dependence of < 2 ADL's
- Increase in ER visits/hospitalizations
- Co-morbidities

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~~Failure to Thrive~~

- BMI < 22 and declining nutritional state
- KPS or PPS \leq 40 %
- Anthropometric measurements support dx

Nutritional impairment and disability are the hallmark features

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Debility and FTT

- **Cannot use** anymore as of Summer 2013
- Whenever possible = try to identify primary organ failure and use that ICD-9 code
- Many of these patients have late effects of cardiovascular disease with dysphagia



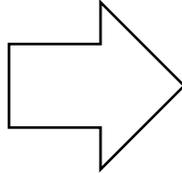
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Previous Triggers for Audits

- Non Cancer Length of Stay (NCLOS) > 210 days
- Providers over Cap
- General inpatient > 7days
- Diagnosis code 425.4 (cardiomyopathies) and 414.00 (CAD) with LOS greater than 6 months
- Ill defined diagnosis – Debility and FTT
- Continuous Care

Documentation – Paint the Picture

- Primary illness - maximally treated
- Co-morbidities
- Secondary conditions
- Nutritional
- Functional
- Cognitive
- ADLs
- Infections
- Signs and symptoms/supporting labs



Rate of decline



Recertifications

- **It's a team process!**
- **Process begins upon admission – capture data!**
Compare data points (weight, PPS, MAC, time to eat, time spent asleep...)
- **To recertify or not should be consistent with all prior documentation**
- **Recertification note – use biomarkers when they support decline**
- **Flow charts helpful**



Incorporate ICF language

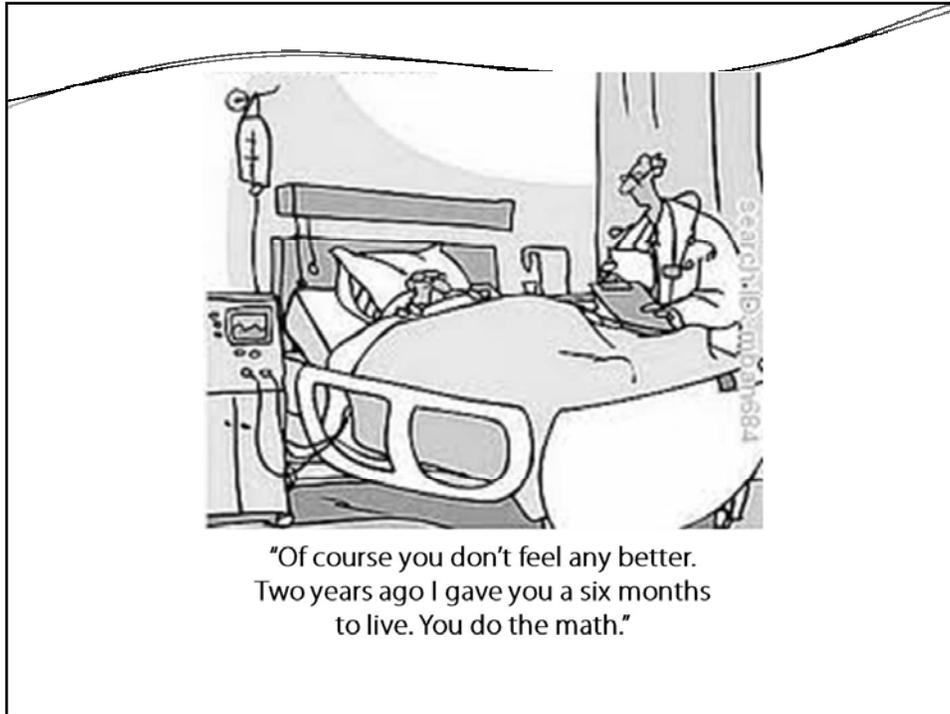
- Palmetto GBA – incorporated ICF into its medical review process
 - cardiopulmonary
 - neurological
- Document
 - Impairments
 - Activity limitations
 - Disability
 - The impact of environment

Checklist to cover:

- Primary disease process
- Functional status*
- Nutritional status*
- Cognitive status*
- Co-morbidities
- Secondary conditions
- Psychosocial Spiritual
- Clinical judgment

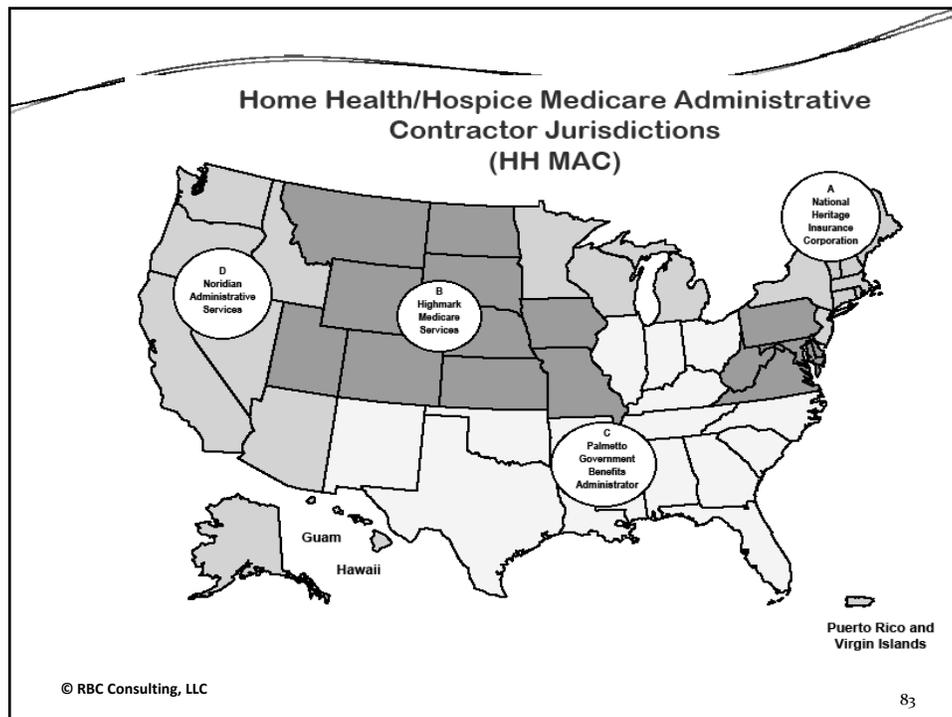


* Rate or cadence of decline described as months, weeks or days



Medicare Administrative Contractors

- Consolidation of Fiscal intermediaries into MACs
- MACs will administer and pay claims – for both Medicare Part A and B
- The LCDs (Prognostic Indicators) regarding hospice eligibility are based on the NHPCO guidelines with some additional restrictions
- LCDs - regulatory barrier that limits access to hospice care



Hospice Eligibility Criteria

2000 Benefits Improvement and Protection Act

- Section 322 – provision that clarifies the physician or medical director certification is based on their clinical judgment.

Certification:

- Initial certification – attending + medical director
- Recertification – hospice medical director
- Recertification \geq 3rd benefit – requires F2F

Prognostication

- Not an easy task but important to do
- Gives patients/families a framework to help them prioritize decisions
- Painting the clinical picture is critical – supporting the estimate with clinical information.
- Interdisciplinary input is critically important in determining eligibility for hospice.
- Understand your MAC and create partnerships!



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Special Recognition

- Thank you to Dr. Martha Twaddle, National Medical Advisor for AseraCare Hospice and Palliative Medicine for the development of this excellent educational resource.

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