Functional Decline in Hospice
Assessment, Intervention, & Documentation

Objectives
The learner will be able to:
- Assess functional decline utilizing appropriate evidence based tools
- Document functional indicators and their relationship to system decline
- Develop an interdisciplinary approach to ongoing assessment of functional decline
- Evaluate appropriateness of therapeutic intervention for symptom management
Patient Centered Care
It begins and ends with the goals.

Assessment
What is the patient's current status?
Can we measure it?
Self Management
Are they getting there?

Goal Setting
What does the patient need or want?

Plan of Care
How do we help them get there?
Self Management

“Self management by patients is not optional but inevitable because clinicians are present for only a fraction of the patient’s life, and nearly all outcomes are mediated by patient behavior.”

Glasgow, et.al., 2003

Self Management

Includes 3 different kinds of tasks:

- Care of the body and management of the condition
- Adapting everyday activities and roles to the condition
- Dealing with emotions arising from having the condition
Self Management Support

- Emphasize the patient's central role in caring for him/herself (empowerment, activation, autonomy)
- Assess patient knowledge, skills, behaviors, confidence and barriers
- Assure collaborative care planning and problem solving (empathy, respect, support, trust)
- Provide ongoing follow-up and support via peers and professionals.

Wagner, et.al, 2001

Documenting Patient Centered Hospice Care

- Documenting the assessment:
  - Establishes a baseline from which to measure
  - Establishes the patient's wishes/desires
  - Establishes the plan to achieve wishes/desires
- Documenting ongoing status:
  - Provides movement from the baseline
  - Proves we are achieving wishes/desires
  - Paints the needed picture for the payer
Diagnosis Guidance

- CMS expects that hospices not use ‘debility’ and ‘adult failure to thrive’ as the primary diagnosis on hospice claims effective immediately. In the April 30, 2013 edition of NAHC Report, we provided a summary of the FY2014 Hospice Wage Index proposal that included some detail of the portion of the proposed rule related to multiple diagnoses on hospice claims and specifically hospices’ use of ‘debility’, ‘adult failure to thrive’, and dementia as the principal diagnosis.
LCD Guidelines

- Part II. Non-disease specific baseline guidelines (both of these should be met)
  - Physiologic impairment of functional status as demonstrated by:
    - Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) <70%
      Note that two of the disease specific guidelines (HIV Disease, Stroke and Coma) establish a lower qualifying KPS or PPS.

LCD Guidelines

- Dependence on assistance for two or more activities of daily living (ADLs)
  - A. Feeding
  - B. Ambulation
  - C. Continence
  - D. Transfer
  - E. Bathing
  - F. Dressing

See appendix for disease specific guidelines to be used with these (Part II) baseline guidelines. The baseline guidelines do not independently qualify a patient for hospice coverage.
Evidence Based Intervention

- The Last 2 Years of Life: Functional Trajectories of Frail Older People
  - Conclusion: Patients with advanced frailty with or without cognitive impairment, have an end of life functional course marked by slowly progressive functional deterioration with only slight acceleration in the trajectory of functional loss as death approaches
  

Evidence Based Intervention

- Patterns of Functional Decline at the End of Life
  - Trajectories of functional decline at the end of life are quite variable. Differentiating among expected trajectories and related needs would help shape tailored strategies and better programs of care prior to death
  
  JAMA 2003
Functional Assessment & Documentation

- Gait Velocity
  - Gait Velocity (Speed) considered the 6th vital sign
  - *Normal Gait Speed in Healthy Elderly 1.2 m/s or 12 feet in less than 5 seconds*
  - Research Supports that declining gait speed is correlated with future morbidity and mortality

- Why Gait Velocity:
  - Gait is a complex process which requires multiple systems to function together harmoniously to produce the desired outcome
    - Vision
    - Hearing
    - Neuro response
    - Strength
    - Joint mobility
    - Cardiovascular integrity
Purpose - Assess clinical usefulness of gait velocity in predicting:

- Fall risk
- Hospitalization
- Need for a caregiver
- Fracture
- Nursing home placement
- Death
Functional Assessment & Documentation

- Montero-Odasso 2004 (cont.)
  - Participants
    - 140 Community Dwelling adults with the minimum age of 75
  - Data Collection
    - 10 Meter walk test was performed
      - Participants placed into 3 categories
        - Low gait velocity (<0.7 m/s)
        - Median gait velocity (0.7-1.0 m/s)
        - High gait velocity (>1.1 m/s)
    - Two year follow up to determine occurrence of adverse events

Results: percentage of at least one adverse event

- 73% in low gait velocity group
- 34% in median gait velocity group
- 20% in high gait velocity group

Conclusion:

- Gait Velocity alone is enough to predict risk for further adverse events in well functioning elders
Functional Assessment & Documentation

- Gait Velocity - Assessing and Documenting
  - Common walking distances
  - Symptoms during ambulation
  - Time of Ambulation
  - Amount of Assistance
  - Caregiver logs

Documentation Example:
- Patient ambulate from bed to Chair (4 meters) with a gait speed of .6 m/s This is a decline from ___(date) of .4 m/s

OR
- Patient ambulate from bed to chair (12 ft) in 9 seconds as compared to 6 seconds last week. Gait shuffling and patient required min assistance for balance
Functional Assessment & Documentation

- **Endurance**
  - Timed activities
  - Pulse Oximetry with activity
  - Tolerance for activities
    - Example: time of completion for a meal
    - Time out of bed
    - Time talking
  - Dyspnea Monitor- Borg Scale and Rate of Perceived Exertion

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Functional Assessment & Documentation

- **Modified Borg Scale**
  - How much difficulty is your breathing causing you right now?

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Nothing at all</td>
</tr>
<tr>
<td>0.5</td>
<td>Very, very slight (just noticeable)</td>
</tr>
<tr>
<td>1</td>
<td>Very slight</td>
</tr>
<tr>
<td>2</td>
<td>Slight</td>
</tr>
<tr>
<td>3</td>
<td>Moderate</td>
</tr>
<tr>
<td>4</td>
<td>Somewhat severe</td>
</tr>
<tr>
<td>5</td>
<td>Severe</td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Very severe</td>
</tr>
<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Very, very severe (almost maximal)</td>
</tr>
<tr>
<td>10</td>
<td>Maximal</td>
</tr>
</tbody>
</table>
Functional Assessment & Documentation

- Documentation Example:
  - Patient reports Modified Borg Score of 7/10 with transfer from supine to sit. Requires 2 minute rest to reduce Modified Borg Score to 2/10
  - Compare Modified Borg Score over time with same activity and return to balance time frame

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Functional Assessment & Documentation

- Rate of Perceived Exertion – RPE
  - Assess how difficult an activity is for an individual
  - Can use conversation ability to evaluate

### RPE Scale

<table>
<thead>
<tr>
<th>RPE</th>
<th>Rate of Perceived Exertion</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Maximum Effort</td>
</tr>
<tr>
<td>9</td>
<td>Very Hard</td>
</tr>
<tr>
<td>7-8</td>
<td>Exertion</td>
</tr>
<tr>
<td>4-6</td>
<td>Light</td>
</tr>
<tr>
<td>1</td>
<td>Very Light</td>
</tr>
</tbody>
</table>

- Rate of Perceived Exertion (RPE) is a subjective measure of how hard an activity feels to an individual. It can be used to assess the intensity of an activity and adjust interventions accordingly.
Functional Assessment & Documentation

- Documentation Example:
  - Patient reports RPE 4/10 with Transfer from bed to wheelchair with moderate assistance
  - Ambulation with wheeled walker decreases RPE to 2/10 as compared to 6/10 with cane; instructed patient to utilize wheeled walker to improve tolerance for activity

Functional Assessment & Documentation

Visual Analog Fatigue Scale

**Visual Analogue Fatigue Scale (VAFS)**
Please mark an “X” on the number line which describes your global fatigue with 0 being worst and 10 being normal.

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0 1 2 3 4 5 6 7 8 9 10
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Functional Assessment & Documentation

- Documentation Example:
  - Patient reported a 7/10 on VAFS after being OOB for 20 minutes. On ____(date) patient tolerated OOB for 20 minutes with a report of 4/10 on VAFS.

Functional Assessment & Documentation

Activities of Balance
Confidence Scale
Functional Assessment & Documentation

- Documentation Example:
  - Patient reported that he has a ABC of 50% with walking across the room without an assistive device when given a cane his ABC increases to 80%. Instructed patient to utilize cane to reduce fall risk

- Communication and Swallowing
  - Prior to the evaluation you must determine
    - Pre-morbid level of function
    - Current medical status
    - Current nutrition and hydration status
    - Pain management regime
    - Patient’s wishes
    - Family’s wishes when appropriate
Functional Assessment & Documentation

- Communication status including the ability to follow commands and the ability to communicate basic needs
- Cognitive status including ability to make decisions
- Patient’s ability/desire to participate in his/her own care

Functional Assessment & Documentation

- What medical conditions are present that may influence oral intake tolerance?
- Can the patient be positioned for optimal oral intake?
- What is the patient’s preference for oral vs. non-oral intake?
Functional Assessment & Documentation

- Instrumental examination of swallowing or not?
  - Diagnostic assessment of swallowing could be by videofluoroscopy or FEES
  - Instrumental exam is not indicated when
    - Patient is medically unstable
    - Patient unable to cooperate in the examination
    - The instrumental examination would not change the clinical management of the patient

Functional Assessment & Documentation

- Bedside Swallowing Assessments
  - Are there current symptoms of dysphagia?
  - What is the current diet including any non-oral intake?
  - When is the patient most alert?
  - Does alertness vary throughout the day?
  - Can the patient communicate requests for oral intake?
Functional Assessment & Documentation

- Documentation Example
  - Patient can only maintain an alert state for five minutes today. This is a significant decline from twenty minutes on the prior session on 10/25/13.
  - Patient unable to be positioned for safe oral feedings today. She is refusing to sit up due to back pain she rates as “10”, an increase from pain ratings of “2” on previous visit.

Functional Assessment & Documentation

- Communication
  - What does the patient need/want to say?
    - Pain/discomfort
    - Emotions
    - Symptoms
    - Dialogue with family
    - Physical needs
    - Environmental needs
**Functional Assessment & Documentation**

- Focus on function
  - What is the best way for the patient to communicate wants, needs, and feelings to the family and other caregivers?
  - Yes/no responses, head nod, gestures?
  - Short written responses?
  - Pictures?
  - Augmentative devices?

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**Family reports that as of yesterday, 10/31/13, patient’s speech became slurred and unintelligible. Patient is no longer able to make his wishes known verbally. Patient is able to respond to “Yes/No” questions with an appropriate head shake. Family and other caregivers instructed to use “yes/no” questions to allow patient to participate in his care.**
Functional Assessment & Documentation

- Tools for Cognition/Memory Assessment
  - Montreal Cognitive Assessment
  - Burns Inventories
  - St. Louis University Mental Status Exam
- General Language
  - Cookie Thief Picture
- Visual Spatial Perception

Functional Assessment & Documentation

Barthel Index of Activities of Daily Living (ADL)
Documentation Example:

- Patient transfers now require ‘major help’, a score of 1 down from 2 in 45 days
- Family reports toilet use ‘needs some help’, a score of 1 down from 2; and
- Patient is dependent in dressing, a score of 0 down from 1 in 45 days

Activities of Daily Living (ADLs) include basic self-care activities (e.g., bathing, grooming, dressing, etc.).

Instrumental Activities of Daily Living (IADLs) include activities associated with independent living necessary to support the ADLs (e.g., housekeeping, laundry, shopping, etc.).

IADLs usually require some degree of both cognitive and physical ability.

IADL items typically include management of medications and health-care related equipment.
Functional Assessment & Documentation

- Assessing ADLs and IADLs
  - Must refer back to patient centered goals and relevance of reporting
  - Must not be assessed in isolation
  - Activities are embedded in patient routines
- Use of the BORG RPE, VAF, duration of routine, or even O₂ sats to measure before during or after a sequence of needed activities is compelling to the patient’s performance

Functional Assessment & Documentation

- Brown’s End of Life Assessment Tool
  - Weighs premorbid level of function against current medical status
  - Helps the team to determine if the patient will benefit from therapeutic intervention
  - Examples:
    - High premorbid function, medically stable=good prognosis and would likely benefit
    - Low premorbid function, medically unstable=may not benefit, may be nearing end of life
    - Compromised premorbid functional status=benefit unclear, trial treatment period is suggested
It Takes a Team
The Role of Therapy in Hospice

10 Rules for 21st Century Healthcare

1. Care based on continuous healing relationships.
2. Customization based on patient needs and values.
3. The patient as the source of control.
4. Shared knowledge and the free flow of information.
5. Evidence-based decision making.
6. Safety as a system property.
7. The need for transparency.
8. Anticipation of needs.
10. Cooperation among clinicians.

(IOM, 2001)
Benefits of Physical Therapy

- Improve quality of life and ability to achieve end of life goals
- Maintain functional status
- Reduction of Pain – potential reduction of pain medication
- Reduce fall risk
- Reduce injury to caregivers and other staff members

Role of the Physical Therapist

- Pain Management
  - Edema/lymphedema control
  - Gentle ROM and mobilizations
  - Deep Breathing exercise
  - Modalities
  - Position and equipment recommendations
Role of the Physical Therapist

- Skilled Functional Mobility Maintenance
  - Home program for mobility
    - Within appropriate vital sign response
  - Patient and family education for safety and functional activities
  - Falls prevention
  - Adaptive equipment for mobility

Benefits of Occupational Therapy

- Support engagement in daily life occupations clients find meaningful and purposeful and contributes to the sustainment of self-worth
- Engagement in meaningful and purposeful occupation facilitates individuals making choices that give them a sense of control, identity, and competence.
Role of Occupational Therapist

- Help clients find relief from pain and suffering
- Identify daily life occupations clients find meaningful and purposeful
- Consider environmental and contextual factors (caregiver training, accessibility of objects or places in the environment, social contacts available to prevent isolation); and
- Personal factors (decreased endurance, increased anxiety)

Role of Occupational Therapist

- Symptom management
  - Biofeedback
  - Postural adjustments for better breathing
  - Positioning, equipment management
  - Retrograde massage, edema control
  - ROM for pain control
- ADL/IADL management
  - Energy conservation techniques
  - Family education for reduced fall risk
  - Home safety education, modification
Benefits of Speech Language Therapy
- Improved quality of life
- Improved nutrition and hydration
- Maintenance of ability to communicate with family and caregivers

Role of the Speech Language Pathologist
- Serve as a resource for patients, their families and the care team regarding:
  - Communication
  - Cognition
  - Swallowing
- Deliver therapy services when indicated focusing on:
  - Communication for decision making
  - Social interaction
  - Achievement of end of life goals
Role of the Speech Language Pathologist

- Facilitate management of dysphagia symptoms
- Develop strategies to maintain nutrition and hydration
- Educate care team members on appropriate means of communication including the use of any alternative or augmentative systems

Bringing it all together:
Assessment
Documentation
Intervention
Summary

- End of Life Care needs to be patient and family directed
- Functional assessment can facilitate best practices for quality of life interventions
- Evidence based functional assessments facilitate improved documentation and supports necessary interventions
- Therapy services need to play a vital role in hospice care

Discussion and Questions