Adult Failure to Thrive & Debility as Terminal Diagnoses

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Objectives

• Describe how “debility, unspecified” became an acceptable hospice diagnosis
• Describe the evolution of “adult failure to thrive” syndrome
• Discuss how “adult failure to thrive” and debility, unspecified” are currently being utilized in hospice
Debility, Unspecified: History


1995-96: NHPCO guidelines for determining prognosis in selected non-cancer diagnoses developed and published.

Debility, Unspecified: History

Elderly patients who appear to be dying:
- Weight loss
- Declining functional status
- Frequent hospitalizations
- Multiple medical problems with impending failure of several organ systems
- No specific terminal diagnosis is evident
- Workup not successful or not desired
- Irreversibility recognized by patient/family/physician
Debility, Unspecified: History

Challenge:
- What ICD-9 diagnosis code should be used to describe these patients?
  - Multisystem failure
    - does not exist
  - “(Adult) Failure to Thrive”
    - makes sense
    - Pediatric only in ICD-9 code book
    - Adult failure to thrive syndrome only beginning to be described in geriatric literature and not well accepted

Debility, Unspecified: History

ICD-9 Code Book 1995
- Section 16: Symptoms, Signs, and Ill-defined conditions (780-799)
- Sub-section: “Ill-defined and unknown causes of morbidity and mortality (797-799)
- Debility, unspecified (799.3)
Debility, Unspecified: 1996 Study

Table 1. Debility, unspecified: General characteristics
(53 patient charts reviewed)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Overall population</th>
<th>Study population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients</td>
<td>238</td>
<td>53</td>
</tr>
<tr>
<td>Average age</td>
<td>86</td>
<td>86</td>
</tr>
<tr>
<td>Sex: Male/female</td>
<td>74/164</td>
<td>20/33</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>56 days</td>
<td>63 days</td>
</tr>
<tr>
<td>Median length of stay</td>
<td>&lt;20 days</td>
<td>&lt;20 days</td>
</tr>
</tbody>
</table>


Debility, Unspecified: 1996 Study

Table 2. Debility, unspecified: Record review

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of records reviewed</td>
<td>53</td>
</tr>
<tr>
<td>Number with alternative diagnosis</td>
<td>3</td>
</tr>
<tr>
<td>Number with confirmed dx of Debility</td>
<td>50</td>
</tr>
<tr>
<td>ADL Score (max. 17)</td>
<td>18.3</td>
</tr>
<tr>
<td>System impairment</td>
<td>7 (%)</td>
</tr>
<tr>
<td>Central Nervous System</td>
<td>48 (96)</td>
</tr>
<tr>
<td>Cardiopulmonary</td>
<td>36 (70)</td>
</tr>
<tr>
<td>Skin (Dermatitis)</td>
<td>21 (42)</td>
</tr>
<tr>
<td>Immune (Sepsis)</td>
<td>15 (30)</td>
</tr>
<tr>
<td>Other</td>
<td>24 (48)</td>
</tr>
</tbody>
</table>

Debility, Unspecified: 1996 Study

Decision Tree
Diagnosis: Debility, unspecified (799.3)

Figure 3. Decision tree for assigning the diagnosis of "debility, unspecified" (ICD-9 code 799.3). The tree permits the physician to eliminate other defined diseases of specific organ systems as the cause of terminality. If an anatomic disease is sufficient to warrant a terminal diagnosis, and if cumulative consequences exist, then the diagnosis of debility, unspecified is warranted.

Prognosis: ≤ 6 months; Severe AAI, Deliric; CNS Disease

1. Does patient meet criteria for terminal dementia, based on FAST 7C or higher classification?

   No
   
   Yes
   
   Specific terminal diagnosis such as:
   
   290.8 Alzheimer's disease
   
   290.9 Central degeneration other than Alzheimer's disease
   
   437.9 End-stage cerebrovascular disease

Adult Failure to Thrive

Institute of Medicine 1991

The Institute of Medicine defined failure to thrive late in life as a syndrome manifested by weight loss greater than 5 percent of baseline, decreased appetite, poor nutrition, and inactivity, often accompanied by dehydration, depressive symptoms, impaired immune function, and low cholesterol levels.

Table 1. A Geriatric Functional Continuum

<table>
<thead>
<tr>
<th>Stage for Potential Intervention</th>
<th>Clinical Correlate</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Independence</td>
<td>–</td>
</tr>
<tr>
<td></td>
<td>Coping</td>
<td>–</td>
</tr>
<tr>
<td>Intermediate</td>
<td>Independence with difficulty</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>The &quot;dwindles&quot;</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Functional decline</td>
<td>12, 18, 19</td>
</tr>
<tr>
<td>Secondary</td>
<td>Frailty</td>
<td>2, 3, 5–7, 9, 11, 13–15</td>
</tr>
<tr>
<td></td>
<td>Failure to thrive</td>
<td>20–25</td>
</tr>
<tr>
<td></td>
<td>Disability</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Failure to cope</td>
<td>27</td>
</tr>
<tr>
<td>Tertiary</td>
<td>Dependence</td>
<td>18,19</td>
</tr>
<tr>
<td></td>
<td>Taking to bed</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>Cachexia</td>
<td>29–33</td>
</tr>
<tr>
<td></td>
<td>Pro-death</td>
<td>34</td>
</tr>
</tbody>
</table>

Adult Failure to Thrive

Four major symptom domains are prevalent and predictive of adverse outcomes in persons who may have adult failure to thrive:

- Impaired physical functioning
- Malnutrition
- Depression
- Cognitive impairment


Adult Failure to Thrive

TABLE 1
Evaluating Elderly Patients for Failure to Thrive

<table>
<thead>
<tr>
<th>Test</th>
<th>Target Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood culture</td>
<td>Infection</td>
</tr>
<tr>
<td>Chest radiography</td>
<td>Infection, malignancy</td>
</tr>
<tr>
<td>Complete blood count</td>
<td>Anemia, infection</td>
</tr>
<tr>
<td>Computed tomography, MRI</td>
<td>Malnutrition, sepsis</td>
</tr>
<tr>
<td>ESR, C-reactive protein levels</td>
<td>Inflammation</td>
</tr>
<tr>
<td>Growth hormone, testosterone (men)</td>
<td>Endocrine deficiency</td>
</tr>
<tr>
<td>HIV, HEPatitis B</td>
<td>Infection</td>
</tr>
<tr>
<td>PPD</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Serum albumin and cholesterol levels</td>
<td>Malnutrition</td>
</tr>
<tr>
<td>Serum BUN and creatinine levels</td>
<td>Dehydration, renal failure</td>
</tr>
<tr>
<td>Serum electrolyte levels</td>
<td>Electrolyte imbalance</td>
</tr>
<tr>
<td>Serum glucose level</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Thyroid-stimulating hormone levels</td>
<td>Thyroid disease</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>Infection, renal failure, dehydration</td>
</tr>
</tbody>
</table>

MRI = magnetic resonance imaging; ESR = erythrocyte sedimentation rate; HIV = human immunodeficiency virus; PPD = purified protein derivative; BUN = blood urea nitrogen.


Adult Failure to Thrive

TABLE 2
Common Medical Conditions Associated with Failure to Thrive in Elderly Patients

<table>
<thead>
<tr>
<th>Medical condition</th>
<th>Cause of failure to thrive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>Metastases, malnutrition, cancer cachexia</td>
</tr>
<tr>
<td>Chronic lung disease</td>
<td>Respiratory failure</td>
</tr>
<tr>
<td>Chronic renal insufficiency</td>
<td>Renal failure</td>
</tr>
<tr>
<td>Chronic steroid use</td>
<td>Steroid nephropathy, diabetes, vasculopathy, vision loss</td>
</tr>
<tr>
<td>Chronic history of hepatitis</td>
<td>Hepatic failure</td>
</tr>
<tr>
<td>Depression, other psychiatric disorders</td>
<td>Major depression, psychosis, poor functional status, cognitive loss</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Malabsorption, poor glucose homeostasis, end-organ damage</td>
</tr>
<tr>
<td>Hip or other large-bone fracture</td>
<td>Malabsorption, malnutrition</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
<td>Malabsorption, malnutrition</td>
</tr>
<tr>
<td>Myocardial infarction, congestive heart failure</td>
<td>Malabsorption, malnutrition</td>
</tr>
<tr>
<td>Previous gastrointestinal surgery</td>
<td>Malabsorption, malnutrition</td>
</tr>
<tr>
<td>Renal cancer or sarcopenia</td>
<td>Malabsorption, malnutrition</td>
</tr>
<tr>
<td>Rheumatoid arthritis (eg, temporal arteritis)</td>
<td>Malabsorption, malnutrition</td>
</tr>
<tr>
<td>Tuberculosis, other systemic infection</td>
<td>Malabsorption, malnutrition</td>
</tr>
</tbody>
</table>


Adult Failure to Thrive

TABLE 3
Medications Commonly Associated with Failure to Thrive in Elderly Patients

<table>
<thead>
<tr>
<th>Medication Class</th>
<th>Possible Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticholinergic drugs</td>
<td>Cognition changes, dysgeusia, dry mouth</td>
</tr>
<tr>
<td>Antipsychotic drugs</td>
<td>Cognition changes, anorexia</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Anorexia, depression, cognition changes</td>
</tr>
<tr>
<td>Beta blockers</td>
<td>Cognition changes, depression</td>
</tr>
<tr>
<td>Central alpha antagonists</td>
<td>Cognition changes, anorexia, depression</td>
</tr>
<tr>
<td>Diabetics (high-potency combinations)</td>
<td>Dehydration, electrolyte abnormalities</td>
</tr>
<tr>
<td>Glucocorticoids</td>
<td>Steroid myopathy, diabetes, osteoporosis</td>
</tr>
<tr>
<td>More than four prescription medications</td>
<td>Drug interactions, adverse effects</td>
</tr>
<tr>
<td>Neuroleptics</td>
<td>Anorexia, parkinsonism</td>
</tr>
<tr>
<td>Opioids</td>
<td>Anorexia, cognition changes</td>
</tr>
<tr>
<td>SSRls</td>
<td>Anorexia</td>
</tr>
<tr>
<td>Triyclic antidepressants</td>
<td>Dysgeusia, dry mouth, cognition changes</td>
</tr>
</tbody>
</table>

SSRI = selective serotonin reuptake inhibitors.


Adult Failure to Thrive

Failure to Thrive in Elderly Patients

Indicators:
- Depression
- Malnutrition
- Cognitive impairment
- Functional impairment (decreased mobility)

Limited laboratory tests and radiologic survey
- MMSE, ADL, and FAQ scales
- “Up and Go Test”

Geriatric Depression Scale
- Nutritional assessment
- Medication review
- Chronic disease evaluation
- Environmental assessment

Adult Failure to Thrive

**Depression:**
- Psychotherapy
- Antidepressants
- Modify environment.

**Malnutrition:**
- Speech therapy evaluation
- Treat oral pathology
- Review dietary restrictions
- Increase frequency of feedings
- Nutritional supplements

**Cognitive Impairment:**
- Optimize living conditions
- Treat depression
- Treat medication
- Treat infection
- Administer dementia-delaying medications

**Functional Impairment:**
- Physical therapy
- Occupational therapy
- Modify environment

If response is positive, continue to treat.

If no or minimal response, conduct conference with patient, patient's family, and caregivers.

Repeat evaluations, if appropriate.

Consider discussion of end-of-life and hospice options.

*—A positive response is defined as achievement of set pre-treatment goals, as determined by the patient, the patient's family, and participating caregivers.*


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Debility/Failure to Thrive

**PGBA LCD**
- Developed in 2000 and revised on several occasions - last revised 8/29/07
- Appropriate for the following diagnosis codes:
  - 783.41 Failure to Thrive
  - 783.7 Adult Failure to Thrive
  - 799.3 Debility Unspecified
  - 799.89 Other ill-defined conditions
  - 799.9 Other unknown and unspecified cause of morbidity or mortality
PGBA: Adult Failure to Thrive LCD

Characterized by:
- Unexplained weight loss
- Malnutrition
- Disability
- Criteria 1: Severe Nutritional Impairment
  - BMI < 22kg/m²
- Criteria 2: Significantly disabled
  - PPS (KPS) ≤ 40%

http://www.tha.com/tho/resources/2007/Aug%202007%20PGBA.ppt

PGBA: Adult Failure to Thrive LCD

- BMI and level of disability (PPS) should be determined using measurements/observations made within 6 months (180 days) of the most recent certification/recertification date
- If enteral nutrition has been instituted prior to hospice and will be continued, the BMI and level of disability should be determined at the time of initial recertification and at each subsequent recertification.
PGBA: Adult Failure to Thrive LCD

- At the time of recertification recumbent measurements (anthropometry) such as mid-arm muscle area in cm² may be substituted for BMI with documentation as to why BMI could not be measured. This information will be subject to a case by case review.

CAHABA: Adult Failure to Thrive LCD

CAHABA and UGS
- LCD for Hospice-Determining Terminal Status
- No specific criteria for Adult Failure to Thrive
- Criteria: “A patient will be considered to have a life expectancy of six months or less if he/she meets the non-specific decline in clinical status guidelines…(or) the baseline non-disease specific guidelines…plus the applicable disease specific guidelines….”
CAHABA: Adult Failure to Thrive LCD

Decline in Clinical Status Guidelines

- Progression of disease documented by worsening clinical status, symptoms, signs, and laboratory results
  - Clinical status: infection, weight loss, dysphagia with associated aspiration or inadequate oral intake
  - Symptoms: dyspnea/tachypnea, intractable cough, intractable GI symptoms, pain requiring increasing doses of analgesics
  - Signs: decreased BP, ascites, vascular/lymphatic obstruction due to cancer, edema, pleural/pericardial effusion, weakness, change in LOC
  - Lab (when available): Ca, LFTs, ABGs, tumor markers, renal dysfunction, electrolyte imbalance

Decline in Clinical Status Guidelines

- Decline in KPS/PPS from < 70% due to disease progression
- Increasing use of health care services due to hospice primary diagnosis
- Progressive decline in FAST for dementia (at least 7A)
- Progression to dependence of additional ADLs from baseline
- Progressive stage 3-4 pressure ulcers despite optimal care
CAHABA: Adult Failure to Thrive LCD

Non-disease specific baseline guidelines
- Physiologic impairment of functional status of KPS/PPS < 70%
  (HIV and Stroke and coma lower)
- Dependence on assistance for two or more ADLs
- Need to be combined with disease specific guidelines

Co-morbidities:
- Diseases outside the hospice primary diagnosis that are severe enough to contribute to prognosis of less than 6 months
- CHF, COPD, Ischemic heart disease, DM, Neurodegenerative diseases, renal failure, liver disease, cancer, AIDS, dementia

Debility/Adult Failure to Thrive

Table A
Top 10 Diagnostic Codes in Descending Order

<table>
<thead>
<tr>
<th>Year</th>
<th>Lung/Brnch Cancer</th>
<th>Lung/Brnch Cancer</th>
<th>Lung/Brnch Cancer</th>
<th>Lung/Brnch Cancer</th>
<th>Lung/Brnch Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>CHF</td>
<td>CHF</td>
<td>CHF</td>
<td>CHF</td>
<td>CHF</td>
</tr>
<tr>
<td>2009</td>
<td>CAO</td>
<td>CAO</td>
<td>CAO</td>
<td>CAO</td>
<td>CAO</td>
</tr>
<tr>
<td>2010</td>
<td>Prostate CA</td>
<td>CVA</td>
<td>Highway NOS</td>
<td>CAO</td>
<td>CAO</td>
</tr>
<tr>
<td>2011</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
</tr>
<tr>
<td>2012</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
</tr>
<tr>
<td>2013</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
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<tr>
<td>2014</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
</tr>
<tr>
<td>2015</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
<td>CVA</td>
</tr>
</tbody>
</table>

## Table B
### Debility/Adult Failure to Thrive
### Patient Receiving Hospice Services (CY 1998 – 2006*)
### Top 10 Diagnostic Codes

<table>
<thead>
<tr>
<th></th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s</td>
<td>12,596</td>
<td>16,008</td>
<td>20,633</td>
<td>25,270</td>
<td>30,717</td>
<td>36,715</td>
<td>42,741</td>
<td>48,641</td>
<td>49,715</td>
</tr>
<tr>
<td>Senile Dementia</td>
<td>5,520+</td>
<td>8,108+</td>
<td>11,164+</td>
<td>14,172+</td>
<td>17,862</td>
<td>22,000</td>
<td>25,358</td>
<td>28,697</td>
<td>30,227</td>
</tr>
<tr>
<td>Debility NOS**</td>
<td>8,533</td>
<td>14,826</td>
<td>21,808</td>
<td>26,897</td>
<td>39,440</td>
<td>47,406</td>
<td>55,458</td>
<td>66,055</td>
<td>70,404</td>
</tr>
<tr>
<td>Adult Failure to Thrive</td>
<td>......</td>
<td>......</td>
<td>1,610+</td>
<td>10,719+</td>
<td>20,369</td>
<td>28,010</td>
<td>35,419</td>
<td>43,421</td>
<td>47,067</td>
</tr>
</tbody>
</table>

Total – All diagnoses: 420,701 474,189 534,213 594,384 691,533 729,044 797,117 871,249 850,304

## Table C
### Debility/Adult Failure to Thrive
### Average Days/Patient – Hospice
### Top 10 Diagnostic Codes

<table>
<thead>
<tr>
<th></th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s</td>
<td>67</td>
<td>65</td>
<td>66</td>
<td>73</td>
<td>84</td>
<td>93</td>
<td>95</td>
<td>99</td>
<td>108</td>
</tr>
<tr>
<td>Senile Dementia</td>
<td>56+</td>
<td>54+</td>
<td>57+</td>
<td>64+</td>
<td>69</td>
<td>78</td>
<td>84</td>
<td>85</td>
<td>87</td>
</tr>
<tr>
<td>Debility NOS**</td>
<td>51</td>
<td>50</td>
<td>51</td>
<td>56</td>
<td>59</td>
<td>65</td>
<td>70</td>
<td>73</td>
<td>76</td>
</tr>
<tr>
<td>Adult Failure to Thrive</td>
<td>......</td>
<td>......</td>
<td>32+</td>
<td>50+</td>
<td>63</td>
<td>70</td>
<td>76</td>
<td>78</td>
<td>80</td>
</tr>
</tbody>
</table>

Total – All diagnoses: 48 48 48 51 57 63 65 67 72
Debility/Adult Failure to Thrive

Table 6. Percentage of Hospice Admissions by Primary Diagnosis

<table>
<thead>
<tr>
<th>Primary Diagnosis</th>
<th>2008</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td>38.3%</td>
<td>41.3%</td>
</tr>
<tr>
<td>Non-Cancer Diagnoses</td>
<td>61.7%</td>
<td>58.7%</td>
</tr>
<tr>
<td>Debility Unspecified</td>
<td>15.3%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Heart Disease</td>
<td>11.7%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Dementia</td>
<td>11.3%</td>
<td>10.1%</td>
</tr>
<tr>
<td>Lung Disease</td>
<td>7.9%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Other</td>
<td>4.4%</td>
<td>6.5%</td>
</tr>
<tr>
<td>Stroke or Coma</td>
<td>4.0%</td>
<td>3.8%</td>
</tr>
<tr>
<td>Kidney Disease (ESRD)</td>
<td>2.8%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Non-ALS Motor Neuron</td>
<td>2.1%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>1.5%</td>
<td>2.0%</td>
</tr>
<tr>
<td>HIV / AIDS</td>
<td>0.5%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Amyotrophic Lateral Sclerosis (ALS)</td>
<td>0.4%</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

Issues

• Growth in use of Diagnoses
  – Proper utilization of the diagnoses

• Documentation:
  – Eligibility
  – Recertification
  – Related vs. Unrelated Hospitalizations
  – Pharmacy Management

Proper Utilization of Debility/Adult Failure to Thrive

“In our view, the label "failure to thrive" promotes an intellectual laziness—accompanied by a certain resignation, passivity, or fatalism—that needs to be balanced by a considered and thoughtful deconstructionist approach, wherein the areas of impairment would be carefully identified, quantified, and, most importantly, scrutinized for potential interactions.”


Proper Utilization of Debility/Adult Failure to Thrive

**Intellectual laziness** in the hospice context

- Is it easier to use debility/adult failure to thrive diagnosis than it is to collect sufficiently detailed clinical information to provide a more specific terminal diagnosis?

Proper Utilization of Debility/Adult Failure to Thrive

• Diagnosis of Exclusion
  – General criteria: functional decline and weight loss
  – Multiple co-morbid conditions and/or intercurrent illnesses
  – Co-morbid conditions do not meet diagnosis specific criteria
  – Patient refusing further medical evaluation

• Collect pertinent clinical information on co-morbid conditions and inter-current illnesses
  – Information may not always be available at time of admission or initial assessment
  – May have to be done after patient admission resulting in change in diagnosis

Proper Utilization of Debility/Adult Failure to Thrive

• If there is a single diagnosis that appears primarily responsible for the patient’s terminal status, and eligibility criteria are not met:
  – Document why you believe this should be the patient’s terminal diagnosis
  – State all pertinent factors that lead you to your conclusion, including data that are NOT part of the eligibility criteria
  – State which criteria are not present and why, despite their absence, the patient, in your judgment has a terminal prognosis due to the specific diagnosis chosen
  – If diagnosis is being changed from debility, explain why the change is being made
Debility: Documentation of Eligibility

Describe in 3-4 sentences why, based on the clinical presentation of the patient, you believe that s/he is likely to die within the next 6 months.

Debility: Documentation of Eligibility

- Functional Decline
- Weight loss
- Chronic medical conditions
- Intercurrent Illnesses
- Patient goals and decisions regarding care
Palliative Performance Scale (PPS)

<table>
<thead>
<tr>
<th>PPS rating</th>
<th>Ambulation</th>
<th>Self-Care</th>
<th>Intake</th>
<th>LOC</th>
<th>Activity</th>
<th>Evidence of disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Full</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
<td>Normal</td>
<td>No evidence of disease</td>
</tr>
<tr>
<td>90</td>
<td>Full</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
<td>Normal</td>
<td>Some evidence of disease</td>
</tr>
<tr>
<td>80</td>
<td>Full</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
<td>Normal with effort</td>
<td>Some evidence of disease</td>
</tr>
<tr>
<td>70</td>
<td>Reduced</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
<td>Unable to do normal work</td>
<td>Significant disease</td>
</tr>
<tr>
<td>60</td>
<td>Reduced</td>
<td>Occasional Assistance</td>
<td>Normal or reduced</td>
<td>Full or confusion</td>
<td>Unable to do household work</td>
<td>Extensive disease</td>
</tr>
<tr>
<td>50</td>
<td>Mainly Sit/Lie</td>
<td>Considerable Assistance</td>
<td>Normal or reduced</td>
<td>Full or confusion</td>
<td>Unable to do any work</td>
<td>Extensive disease</td>
</tr>
<tr>
<td>40</td>
<td>Mainly in Bed</td>
<td>Complete Assistance</td>
<td>Normal or reduced</td>
<td>Full, drowsy, or confusion</td>
<td>Unable to do any work</td>
<td>Extensive disease</td>
</tr>
<tr>
<td>30</td>
<td>Bed Confined</td>
<td>Total Care</td>
<td>Reduced</td>
<td>Full, drowsy, or confusion</td>
<td>Unable to do any work</td>
<td>Extensive disease</td>
</tr>
<tr>
<td>20</td>
<td>Bed Confined</td>
<td>Total Care</td>
<td>Minimal sips</td>
<td>Full, drowsy, or confusion</td>
<td>Unable to do any work</td>
<td>Extensive disease</td>
</tr>
<tr>
<td>10</td>
<td>Bed Confined</td>
<td>Total Care</td>
<td>Mouth care only</td>
<td>Drowsy or coma</td>
<td>Unable to do any work</td>
<td>Extensive disease</td>
</tr>
<tr>
<td>0</td>
<td>Death</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Debility: Documentation of Eligibility

Functional Decline
- Current PPS score
- Prior PPS scores if known
- Description of functional decline
  - Prior vs. current levels of ambulation and activity
  - Changes in performance of specific ADL’s
    - Dressing, Bathing, Feeding, Toileting, Continence, Transferring
Debility: Documentation of Eligibility

Weight Loss
- Current and prior weights, if available
  - Change should be significant
- Anthropomorphic measures
  - Triceps skin fold thickness
  - Mid-arm muscle area
- Descriptors that support negative weight change:
  - Interosseous and temporal muscle wasting
  - Drooping or sagging skin
  - Looser fitting clothing and rings
  - Loose fitting dentures

Debility: Documentation of Eligibility

Chronic Medical Conditions
- Heart Disease
- Lung Disease
- Cerebrovascular Disease
- Dementia
- Parkinson’s or other neurodegenerative disorders
- Hypertension
- Diabetes
- Renal Insufficiency
- Neoplastic diseases
Debility: Documentation of Eligibility

Intercurrent Illnesses

- Aspiration pneumonia
- Infections
  - Urosepsis
  - Pneumonia
- Decubitus ulcers
- Dehydration
- Impaired nutritional status

Debility: Documentation of Eligibility

Chronic Medical Conditions and Intercurrent Illnesses

- Include description of severity of each condition
- Describe how each condition contributes to the patient’s “debility”
Debility: Documentation of Eligibility

Patient goals and decisions regarding care
- Advance directive instructions
- DNR
- Artificial nutritional support and hydration
- Hospitalization

Debility: Documentation of Eligibility

Describe in 3-4 sentences why, based on the clinical presentation of the patient, you believe that s/he is likely to die within the next 6 months.
Debility: Documentation of Recertification

Functional Decline
- Change in PPS from admission or beginning of prior benefit period
- Changes in activity level or further dependence in ADLs
- If decline already at maximum, this should be stated as well

Weight loss
- Changes in weight, anthropomorphic measures, or other signs from admission or beginning of benefit period.
  - Weight changes should be significant (not 1 or 2 pounds)
  - Weight changes should not be due to reduced edema

Debility: Documentation of Recertification

Chronic diseases and intercurrent illnesses
- Document changes in chronic diseases and intercurrent illnesses that are impacting the patient’s “debility”

Patient’s goals and decisions regarding care
- Document changes, if any, in the patient’s goals and decisions regarding care and how that may impact prognosis
Debility: Documentation of Recertification

What if patient’s conditions is “stable” or “improved”?
• Document negatively but honestly
• If current patient’s condition is directly due to hospice interventions, make sure that is clearly documented in the record
• If it is believed that the patient remains terminally ill, the recertifying physician should document why, even though the patient’s condition has “plateaued” or has “somewhat improved”, s/he remains terminally ill.

Debility: Related vs. Related Hospitalizations

• Is the condition for which the patient requires hospitalization contributing to the patient’s “debility”?
• What are the patient’s goals of care regarding hospitalization for the particular problem?
• Examples:
  – Fractured hip
  – Infection
  – Heart attack
  – Uncontrolled diabetes
Debility: Related vs. Related Hospitalizations

Recommendation:
• Hospice medical director and attending physician discuss the situation
• Both physicians should write a note documenting why they believe the hospitalization or hospice general inpatient stay is or is not related to the patient’s terminal illness

Debility: Pharmacy Management

• What medications should be covered by the hospice when the patient has an admitted diagnosis of “debility”?  
  – Medications related to symptom management
  – Medications to treat chronic diseases and intercurrent illnesses that contribute to the “debility”
  – All medications
Debility: Pharmacy Management

**Recommendation:**

- For medications that are not being covered by the hospice, one should document why the hospice believes that the medication in question should not be covered due to the fact that condition being treated is not a contributing factor to the patient’s “debility”