When is it time for hospice?

Definitions, Eligibility, Prognostication (and a few words about morphine)

Elizabeth Case, MD, FACP, HMDC

Hospice Medical Director, Middlesex Health

Middletown, CT

Disclaimer

I have no conflicts with any Commercial Interests.

All clinical recommendations are based on evidence that is accepted within the profession of medicine and all scientific research referred to, reported, or used in support of our justification of patient care recommendations conforms to the generally accepted standards of experimental design, data collection and analysis.

Objectives

At the end of this activity the participant will be able to:

1. Differentiate palliative care and hospice concepts and management.

1. Learn the hospice eligibility criteria for end stages of specific chronic disease states.

1. Understand and implement the Palliative Performance Scale.

Palliative Care

- What is Palliative Care?

Patient- and family-centered care that optimizes **quality of life** by **anticipating, preventing, and treating suffering.** Palliative care throughout the continuum of illness involves **addressing physical, intellectual, emotional, social, and spiritual** needs and to facilitate **patient autonomy, access to information, and choice.**

Hospice Care

- What is Hospice Care?

  A collaborative approach to providing care to people with terminal illnesses or injuries. Hospice optimizes quality of life to the extent possible, regardless of how much time the person has

  - Supports the patient through the dying process and the surviving family through the dying and bereavement processes
  - Provides comprehensive medical and supportive services across a variety of settings such as the home, nursing homes, assisted living facilities, hospitals, and other settings (e.g., prisons)
  - Is based on the idea that dying is a part of the normal life cycle

When to Consider a Palliative Approach

- **Multiple hospital admissions**, especially for exacerbation of symptoms of chronic disease
- **Progression of illness** or new diagnosis at an advanced stage of illness
- **Difficult to control symptoms of chronic disease**
- **Why are we doing this?** Are we improving a patient's quality of life? Or are we prolonging their death?
- **Advance directives** are not in place, but it feels like they should be

Palliative Care vs Hospice

Palliative Care	**Hospice**
Aggressive symptom and quality of life management	Aggressive symptom and quality of life management
Care philosophy centers on a team approach that includes the patient and family	Care philosophy centers on a team approach that includes the patient and family
Serious, chronic, life - limiting diagnosis	**Terminal diagnosis, 6 months or less**
Patient is seeking **curative treatments and may agree to return to the hospital for surgery, IV antibiotics, hydration, etc.**	Patient is **not seeking curative treatments or return to the hospital** (or curative treatments are no longer available to them)
Medicare Part B - same copay as other MD visits	Medicare Part A

Hospice

- Medicare Benefit Election
- When cure is no longer possible or desired
- Terminal illness < 6 months-determined by 2 physicians
- Interdisciplinary team approach to maintain quality of life through death
- Recognizes that death is integral part of life cycle
- Preparation of pt/family for the dying process and ensure comfort at the end of life.

Covered Services

- Nursing, Social Work, Therapy, Nutrition, Home Health Aide, Pastoral Care, Bereavement Care, Volunteers
- Medical supplies, durable medical equipment
- Medications for symptom management and those related to the terminal prognosis
- Any other service specified in the plan of care that is reasonable and necessary for the palliation and management of the patient’s terminal illness.

Four Levels of Hospice Care

Medicare pays a per diem rate based upon one of the four levels of care:

- **Routine Hospice is most common, takes place at home, in skilled nursing facility or assisted living, includes regular RN, social work, chaplain and volunteer visits. Some home health aide hours can be provided.**

- **Respite Care is reserved for primary caregiver relief for 5 consecutive nights, can be provided once per benefit period.**

- **Continuous Care is expanded, skilled care for medical crisis intervention, minimum of 8 consecutive hours before midnight and 50% of care must be provided by an RN.**

- **General Inpatient Care (GIP) is direct hospital admission (or other acute care hospice setting) for symptom management that cannot be provided in another setting. NOT for custodial care issues, NOT intended to address unsafe living conditions and NOT automatic when death is imminent.**

End Stage Chronic Disease Guidelines

Alzheimer's disease and Related Conditions

[**Vascular dementia** and **failure to thrive** are **not** acceptable hospice diagnoses per CMS rules, however **Cerebral atherosclerosis with advanced dementia, Lewy Body dementia and Pick's Disease** are allowed, with criteria as defined below]

FAST Score 7A (6 or fewer words) or greater - AND - at least ONE of the following criteria = prognosis of 6 months or less:

>= 10% total body weight loss over approximately 6 months
Worsening dysphagia or pocketing/not swallowing
Non-healing pressure injuries with obvious muscle wasting
Worsening agitation/behavioral disturbance

Dysphagia - specify oropharyngeal, esophageal or both

Recurrent aspiration - OR - inadequate po intake for sustenance due to progressive dysphagia
AND progressive weight loss - OR - functional decline with Palliative Performance Score 40% or less

Severe Protein Calorie Malnutrition

At least TWO of the following:

Obvious muscle wasting, or body fat loss, or significantly decreased grip strength
Total body weight loss >2%/one week; 5%/one month; 7.5%/3 months; >10%/6 months; >20%/12 months
Nutritional intake < 50% recommended for >= 2 weeks
Bedridden - OR - Palliative Performance Score 40% or less

End Stage Chronic Disease Guidelines

inson's Disease Stage 4-5
le to live alone and chairfast or bedridden)
BMI< 18 or 10% total body weight loss/6 months and tube feed not desired, OR
Frequent infections and/or pressure wounds, fractures from falls in the prior year, OR
Motor symptoms that are poorly responsive to medications, or side effects unacceptable, OR
Rapid progression of motor symptoms (gait and balance), OR
Severe non-motor symptoms, i.e., dysphagia, advanced dementia, unintelligible speech

otrophic Lateral Sclerosis
red breathing over the preceding 12 months:
VC < 30% if known, dyspnea at rest and declines mechanical ventilation, OR

progression of disease with malnutrition over the preceding 12 months:
No longer ambulatory, barely intelligible speech, modified diet and/or total care needed, OR
Malnutrition with inadequate intake for sustenance and declines artificial nutrition, weight loss, OR

progression with infections and/or Stage 3-4 decubitus ulcer

End Stage Chronic Disease Guidelines

COPD & Severe chronic lung disease

Hypoxia or hypercapnia at rest AND at least ONE of the following:

- FEV1 <= 30% if known
- Severe activity intolerance due to dyspnea
- Poor response to bronchodilators with functional decline, mostly chair fast
- Frequent exacerbations or infections
- Worsening fatigue and confusion

Supported by cor pulmonale, 10% total body weight loss over 6 months and/or resting tachycardia

Congestive Heart Failure

Short of breath at rest or severely activity intolerant despite optimal therapy AND one of the following:

- Frequent exacerbations with decreasing efficacy of diuretics and/or worsening renal function
- Frequent chest pain and/or wheezing

End Stage Chronic Disease Guidelines

Liver disease

[Usually cirrhosis; can include sclerosing cholangitis or other non-cancer causes]

Persistent ascites and INR >1.5

Hepatic encephalopathy despite lactulose

Hepatorenal syndrome

Esophageal varices with bleeding

Episode of bacterial peritonitis

Renal disease

Creatinine >8.0 or creatinine clearance <=15 ml/min

Uremic symptoms (persistent nausea, myoclonus, confusion, itching)

Anuria or stopping dialysis

End Stage Chronic Disease Guidelines

st Acute Sequelae of COVID 19 infection (PASC) and Post-COVID 19 Conditions (PCC)

C definition: Signs, symptoms and conditions that continue or develop after initial COVID-19 infection, present for 4 weeks or more, may be multisystemic, and may present with relapsing - remitting pattern progression.
O definition: Continuation or development of new symptoms 3 months after the original SARS-CoV-2 ction, lasting for at least 2 months with no other explanation.

primary hospice diagnosis must be the **clinical sequelae** of PASC or PCC and cannot be a symptom ne. After recovering from Covid, chronically ill patients may transition from serious illness to advanced ss, most commonly lung disease, dementia, cancer and CHF. Fatigue is a sign of Post Exertional aise (PEM) and a common thread linking post COVID and progression of chronic illness to an anced state and hospice eligibility.

Palliative Performance Scale (PPS score):

PPS scores are determined by reading horizontally at each level to find the best fit for the patient.

“Stronger” performance indicators are located on the left, and “softer” ones on the right. In determining the patient’s PPS score, we would first find the percentile that fits with the patient’s ambulation level. From there we work to the right across the scale, keeping in mind that the leftward indicators have more value than those on the right. We cannot choose between levels (e.g. 45%). Simply make your best assessment to determine the PPS score.

Only 10% of patients with PPS score <= 50% would be expected to survive > six months.

Palliative Performance Scale (PPv2) version

PPS	Ambulation	Activity/Evidence of Disease	Self Care	Oral Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	**Mainly Sit/Lie**	**Unable to do any work Extensive disease**	**Considerable assistance required**	**Normal or reduced**	**Full or Confusion**
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Palliative Performance Scale examples:

1. A patient who is primarily sitting or lying down due to fatigue from advanced disease, who requires considerable assistance to walk short distances and is otherwise fully conscious with full PO intake would be scored at PPS 50%

1. A patient who has become bed bound due to chronic disease requiring total care for activities of daily living, and is otherwise fully conscious with full PO intake would be scored at PPS 30%

1. If the patient in example 2 was bed bound and able to do some self care such as eat unassisted, the PPS score would be 40% or higher

PPS may be used as a communication tool to describe a patient's functional level, and has prognostic value in chronic disease.

Introduction to Opioids: Basic Principles

IMPORTANT NOTE

- Symptom management in hospice care is different than treatment of chronic pain. Opioids are frequently used in hospice for the side effect of suppressing respiratory drive, and thus treating dyspnea.
- Opioids are generally not recommended for chronic non-malignant pain.
- Even in patients with terminal illness, providers should consider maximizing non-opioid agents/interventions while titrating opioids.

OPIOID PHARMACOKINETICS

- Onset of action
  - PO ~30 minutes
  - IV 5-10 minutes
- Time to peak
  - PO ~1 hour
  - IV ~20 minutes
- Half-Life
  - PO IR 3-4 hours
  - IV 1.5-2 hours

How soon would you give another dose if pain or dyspnea remains uncontrolled

After oral administration?

After IV administration?

Which route of administration is preferred?

Starting and Titrating opioids

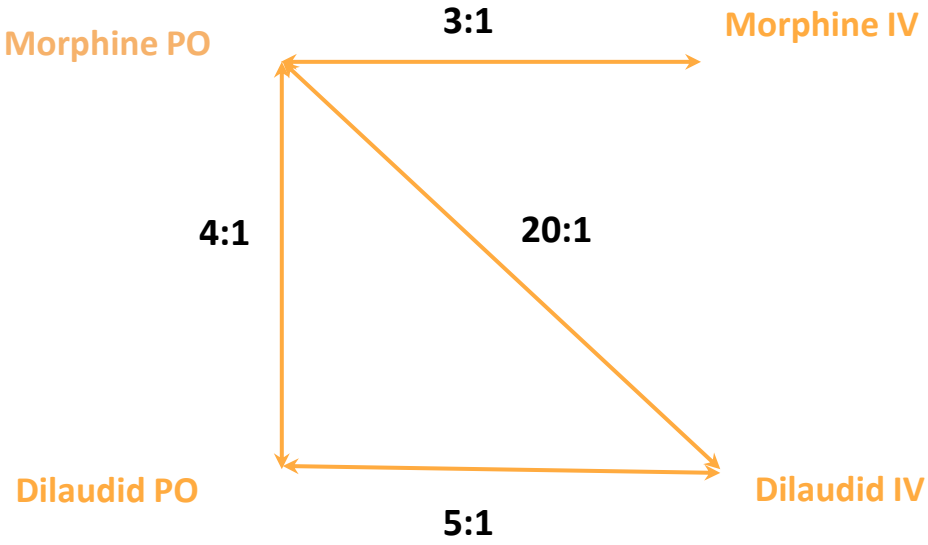
- Choosing an opioid:
  - Fentanyl, Oxycodone and Methadone are better tolerated than morphine and dilaudid in patients with severe renal impairment
  - Start with short-acting as needed regimen
  - Start long-acting when patient is requiring 4 or 5 prn doses per day
  - Bolus dose should be about 10-20% of total daily dose
  - Availability should be based on half-life of medicine (3-4h for PO, 1-2h for IV)

- Titrating

  Moderate pain (4-7 out of 10) → increase dose by 25-50%

  Severe pain (8-10 out of 10) → increase dose by 50-100%

OPIOID CONVERSIONS



*Methadone is never converted and should only be prescribed by an experienced practitioner

OPIOID CONVERSIONS

Morphine PO	30 mg
Morphine IV	10 mg
Dilaudid PO	7.5 mg
Dilaudid IV	1.5 mg
Oxycodone PO	~ 20 mg
Hydrocodone PO	30 mg

Converting from oral morphine to fentanyl patch Divide oral morphine equivalent (total daily dose) by 3

This gives you dose of fentanyl patch in mcg/hr q72h

SIX STEP APPROACH TO OPIOID CONVERSION

1. Assess the patient and their pain.
2. Determine the Total Daily Dose (TDD) of the current opioid and Calculate this in terms of oral morphine equivalent (OME).
3. Consider reducing total by 25-50% for cross reactivity. *
4. Calculate long-acting medicine dose and frequency.
5. Calculate prn medicine dose and frequency.
6. Follow-up and Reassess

* especially in hospice patients who may not have normal metabolism or if moving from one opioid to another

OPIOID SIDE EFFECTS

- Common Opioid Side Effects
  - Nausea
  - Constipation
  - Sedation
  - Itching
  - Urinary Retention

What to counsel patients?

- Important for patient to be aware when starting
- Most side effects get better over a few days as the body adjusts to the drug but constipation and itching do not.

OPIOID INDUCED CONSTIPATION

- Goal is to have one soft bowel movement every 24-72 hours
- Patients taking 3-5 doses of prn opioid medication should take senna daily to prevent opioid-induced constipation
- All patients taking opioids routinely should be on a stimulant laxative unless there is a clear reason why not (i.e., C.diff infection)
  - “the hand that writes the opioid rx should also write the bowel regimen”
  - Senna 1-2 tabs daily or BID
- If still constipated, continue senna and add osmotic laxative (if po fluid intake is adequate)
  - Polyethylene glycol (Miralax)
  - Lactulose
- If still constipated, continue senna and osmotic laxative, then consider suppository/enema
- If refractory, consider newer agent such as methylnaltrexone injection
- Avoid using Docusate as it has no proven efficacy

QUESTIONS???

Let the shenanigans begin!