



## PALLIATIVE CARE CASE OF THE MONTH

### “Discharging Terminal Patients from Hospice: A Perspective on this Conundrum”

by

Keith Lagnese, MD, FACP, HMDC

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**Case:** EB is an 89-year-old white female with a seven-year history of dementia and osteoarthritis who was admitted to an assisted living facility (ALF) two years ago after her husband died. At that time, she was talkative (non-sensical), ambulatory with an unsteady gait and weighed 118 lbs. She had trouble with “sun downing” after her evening meal, wandering and falls. After one year at the ALF, EB had deteriorated dramatically; her weight was down to 103lbs, her speech was limited, she required full assistance with ADL’s and she could no longer safely ambulate. She had troubles swallowing and had to be hand fed.

When the facility recommended a higher level of care, EB’s daughter asked about hospice services. The hospice nurse admitted her the next day and estimated her FAST score<sup>1</sup> to be 7c and her Palliative Performance Scale (PPS)<sup>2</sup> to be 40%. The nurse did twice-a-week nursing visits; and a home-health aide provided three days a week of personal care/bathing. A volunteer visited weekly to read to her and provide pet therapy. After three months of hospice services, the patient was more awake, less agitated and had gained 2 lbs. She was re-certified for her second 90-day benefit period, but after another two months she continued to do well with no UTI’s, or decline in her function, so the hospice team notified the daughter and the facility that the patient was going to be discharged from hospice. Considering the patient still had end-stage dementia, this created confusion amongst the patient’s daughter, the ALF staff and the attending physician.

**Discussion:** The Medicare Hospice Benefit (MHB), enacted by Congress in 1983, has not had significant reform in regards to clinical eligibility requirements despite a dramatic shift in the patients who enroll for hospice services. The 6 month terminal prognosis was built around expected survival in advanced cancer models, but now the majority of patients enrolled in hospice do not have cancer.

According to recent 2014 figures from the National Hospice and Palliative Care Organization (NHPCO), nearly 2/3 (63.4%) of hospice admission diagnoses were for “non-cancer.”<sup>3</sup> The top four non-cancer diagnoses in descending order are: dementia; heart disease; lung disease and stroke/coma. These diseases are much more challenging to prognosticate and, therefore, have a much longer length of stay in hospice. The average length of stay (ALOS) is 76.1 days for non-cancer patients and 44.8 days for cancer patients.<sup>4</sup>

Although there is no limit on the number of hospice benefit periods a patient may utilize, they must continue to meet eligibility for having a six-month terminal prognosis. Due to uncertainties in prognosticating survival, Medicare does provide general and disease-specific eligibility guidelines to help physicians.

In addition, after a patient has a hospice length of stay of 6 months, each additional 60-day re-certification period now requires a face-to-face visit by a hospice nurse practitioner or physician.

For dementia, this model is more challenging because these eligibility guidelines have not kept up with the evidence-based prognostication models. For example, in Alzheimer’s disease, a Functional Assessment Staging Scale (FAST) score of 7A or worse and a 10% wt. loss in the preceding six months continue to be the hallmarks of hospice eligibility. This is despite the fact that several prognostication tools have been found to be more accurate: Salpeter<sup>5</sup> for all non-cancer presentations and Mitchell<sup>6</sup> who developed the Mortality Risk Index (MRI) score for predicting mortality in institutionalized dementia patients.

Further complicating the biomedical models in hospice eligibility are the increasing federal regulations which have resulted in Medicare interpreting these rules in a more conservative manner. Longer lengths of stay in hospice have now become an area of concern for fraud and abuse. This has created a climate in which hospices are nervous about keeping patients who may not meet eligibility guidelines due to increased regulatory oversight.

**Back to the Case:** EB’s daughter feels abandoned and is frustrated by this turn of events and files an appeal, but the decision to discharge EB from hospice is upheld by Medicare. Approximately one month later, EB developed urosepsis and was sent emergently to the hospital by the facility where she passed three days later without any support from the hospice team.

**Conclusions of Case:** This clinical vignette presents an all too familiar story to hospice providers about providing a balance of quality hospice services in the setting of increased regulatory scrutiny. As a result, live discharges from hospice due to no longer being terminally ill are becoming more common. Recent national data from FY 2015 show that 15.9% of patients were discharged for this reason.<sup>7</sup> The onus remains on the industry to bridge the bi-modal distribution of long length of stay for non-cancer patients and the too often short length of stay for cancer patients (national median LOS remains low at 17.4 days in 2014).

This particular case also illustrates the importance of the patient’s attending staying involved with the hospice team’s plan of care in order to help support the patient’s continued eligibility. Although, unless significant reform to the six-month prognosis within the MHB occurs, terminal non-cancer patients like EB will continue to miss out on quality hospice care in the final days of life.

*Personal details in the case published have been altered to protect patient privacy.*

For palliative care consultations please contact the Supportive and Palliative Care programs at PUH/MUH, 647-7243, pager # 8511, Shadyside, 647-7243, pager # 8513, Perioperative/Trauma Pain, 647-7243, pager # 7246, UPCI Cancer Pain Service, pager 644-1724, Interventional Pain 784-4000, Magee Women’s Hospital, pager 412-647-7243 pager # 8510, VA Palliative Care Program, 688-6178, pager # 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children’s pager 958-3844.

With comments about “Case of the Month” call Dr. Robert Arnold at (412) 692-4834.



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