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Palliative Care Concepts for the Rehabilitation Professional: Adapting to an Evolving Disease Process

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- Assistant Professor – Oakland University, Rochester Michigan
- Education Coordinator- Beaumont Health, Troy Michigan

Speaker Introduction

- Chris Wilson PT, DScPT, DPT, GCS
- Author of APTA Positions on Medical Necessity Position and Role of PT in HPC
- World Confederation for PT – Hospice and Palliative Care Coordinator
- APTA Hospice Palliative Care Special Interest Group Chair
- Graduate Certificate in Oncology Rehabilitation from Oakland University, Rochester MI
- Multiple publications and presentations in Palliative Care and Chronic Disease PT
Objectives

- The participant will be able to identify at least two components of their clinical physical therapy practice model for current and future regulatory and administrative changes related to palliative care.
- The participant will be able to describe at least three palliative care concepts within physical therapy practice to a patient across the spectrum of chronic disease and life-threatening illness.
- The participant will be able to identify at least two scenarios where administrative support structure is needed for rehab participation in palliative care and chronic disease management.
- The participant will be able to list at least three opportunities where physical therapy involvement can be expanded in the comprehensive management of the patient with chronic disease after exposure to examples.

Operational Definitions

- Palliative Care:
  - An approach that improves Quality of Life (QoL) for patients (pts) and families facing life-threatening illness
  - Applicable early in the course of illness
  - In conjunction with other therapies that are intended to prolong life
  - Prevention/relief of suffering (i.e. pain, physical, psychosocial, spiritual)

(World Health Organization, 2015)

- Palliative care is often perceived as a transition from active care to hospice care
  - Includes patients with life-threatening illness not imminently dying but in physical decline that need support services similar to hospice
“...end of life care...really is providing a de-escalation of active treatment and an increase in supportive care whether its pain relieving measures...it could be any type of palliative chemotherapy and radiation. Pain control is a big issue [and a disease process] can have a fairly long trajectory. I have clients that relapse and may continue to have fairly active lives for a year or two may be more.” - CA3
A System in Crisis\textsuperscript{20,21}

Financial Implications

- "10 percent—of the sickest Medicare beneficiaries accounted for about 57 percent of total program spending, which was more than $44,220 per capita per year"\textsuperscript{1}
- Palliative Care (PC) documented net per-patient savings of $2,659\textsuperscript{1}
“There is a lot of good evidence now that if you get physio soon and for a long time the outcome is better, so once you can show that, it’s pretty difficult for any system to deny services. I would really say the second one is advocacy, if you’re living in an area where people who strongly advocate for good palliative and hospice care and advocate for physio being involved it will generally happen.” -CAS

Palliative Care Team

- Referring Physicians
- Case Manager Nurse
- Social Worker
- Therapists
- Clergy
- Caregivers
- Family members and Patient
Care & TLC℠ Model
“Care and Treatment for Lifelong Conditions”

- One version of Palliative care program
- Is a specialty program within Homecare (like wound care or pediatrics programs)
- Designed for patients who are not yet ready or perhaps not yet eligible for hospice
- Homebound status applies
- Curative treatments can continue

What are Homebound Criteria?

The Medicare Coverage Criteria for home care patients indicate that:

- The patient must be homebound
- Leaving the home requires a considerable and taxing effort
- Absences from home for medical reasons are allowed and non-medical reasons are allowed if infrequent for short periods of time
- There is a normal inability to leave home without assistance
- Patient does not need to be confined to bed
Hospice vs. Palliative Care

Hospice
- Not covered under Home Care Benefit
- Covered under a separate Benefit
- Hospice receives $150 per day flat rate
- Pay nurses, drugs, therapy, equipment out of the same $150

Palliative Care
- Covered under traditional Medicare Part A or B
- Same OASIS rules apply
- Reimbursement based on OASIS scores
- Pt must be homebound
- Pt in Risk stratification level 4 or 5
- Sometime Risk Stratification Level 3

New in January 2016

Payment Reform For Hospice
- Two-tiered payment model
  - Hospices will be paid a higher rate for the first 60 days of hospice care and a lower rate for subsequent days in hospice care.

Service Intensity Add-On Payment
- Patients receiving visits conducted by an RN or social worker during the last week of life when patients and families typically have more intensive needs. (1)


CONTINUED™
Top 5 Medical Conditions Requiring Readmission

- Heart Failure
- Pneumonia
- COPD
- Psychoses
- Gastrointestinal Problems

Top 5 Surgical Conditions Requiring Readmission

- Cardiac Stent Placement
- Major Hip or Knee surgery
- Vascular Surgery
- Major Bowel Surgery
- Other Hip or Femur Surgery
Who is the Palliative Care Patient?

- Chronic disease state
- Multiple hospital re-admissions
- Multiple co-morbidities
- Declining function
- Life limiting incurable disease
- Needing end of life planning

Courses of Disease Processes\(^2\)

- Lynn and Adamson, 2003
- “Short period of evident decline”
  - Typical of cancer.
  - Longer term preservation of comfort and function until disease process becomes overwhelming to the systems, then a steady, rapid decline in function can occur.
- “Longer term limitations with intermittent exacerbations and sudden dying.”
  - Common with organ system failure pathologies such as COPD and CHF
- “Prolonged dwindling”
  - Typical of central nervous system failure
  - Generally slow decline where institutional long-term care facilities are beneficial
Figure Legend:
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From: Patterns of Functional Decline at the End of Life

Date of download: 3/3/2016
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Table 1. Operationalizing a Phenotype of Frailty

<table>
<thead>
<tr>
<th>A. Characteristics of Frailty</th>
<th>B. Cardiovascular Health Study Measure*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shrinking: Weight loss</td>
<td>Baseline: &gt;10 lbs lost unintentionally in prior year</td>
</tr>
<tr>
<td>(unintentional)</td>
<td></td>
</tr>
<tr>
<td>Sarcopenia (loss of muscle mass)</td>
<td></td>
</tr>
<tr>
<td>Weakness</td>
<td>Grip strength: lowest 20% (by gender, body mass index)</td>
</tr>
<tr>
<td>Poor endurance; exhaustion</td>
<td>“Exhaustion” (self-report)</td>
</tr>
<tr>
<td>Slowness</td>
<td>Walking time/15 feet: slowest 20% (by gender, height)</td>
</tr>
<tr>
<td>Low activity</td>
<td>Kcals/week: lowest 20%</td>
</tr>
<tr>
<td></td>
<td>males: &lt;338 Kcals/week</td>
</tr>
<tr>
<td></td>
<td>females: &lt;270 Kcals/week</td>
</tr>
</tbody>
</table>

C. Presence of Frailty

Positive for frailty phenotype: ≥3 criteria present
Intermediate or prefrail: 1 or 2 criteria present

*See Appendix.

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Survival curve estimates (unadjusted) over 72 months of follow-up by frailty status at baseline

<table>
<thead>
<tr>
<th>Group</th>
<th>n</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Frailty</td>
<td>2469</td>
<td>260</td>
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<tr>
<td>Intermediate</td>
<td>2480</td>
<td>474</td>
</tr>
<tr>
<td>Frail</td>
<td>368</td>
<td>130</td>
</tr>
</tbody>
</table>

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References:

Hospice and Palliative Care

- APTA HoD RC 17-11 – Unanimous and introduced by Michigan
- The APTA endorses the inclusion of the following concepts in hospice and palliative care:
  - Continuity of care and the active, compassionate role of PTs and PTAs
  - Rights of all individuals to have appropriate and adequate access to PT, regardless of medical prognosis or setting
  - An interdisciplinary approach, including timely and appropriate PT/PTA involvement, especially during transitions of care or during a physical or medical change in status
  - Education of PT/PTAs and students in the concepts related to treating an individual while in hospice and palliative care
  - Appropriate and comparable coverage and payment for physical therapy services
- Task force to develop a plan to achieve these goals
APTA HOD RC 8/9-15

Introduced by MI

- PRINCIPLE II. QUALITY OF PHYSICAL THERAPIST SERVICES
- A. MEDICALLY NECESSARY PHYSICAL THERAPIST SERVICES

Physical therapist services are considered medically necessary as determined by a licensed physical therapist, based on the results of a physical therapist evaluation, and when provided to improve or maintain the current level of function or to prevent, minimize, maintain, slow the decline of, or eliminate impairments, activity limitations, or participation restrictions.

Rehab in the context of regulatory changes of healthcare reform

\[
\text{Value} = \frac{\text{Quality}}{\text{Cost}}
\]

**Quality:**
- Improved client/family satisfaction and reduced stress
- Optimized clinical outcomes
- Improved safety of all parties

**Costs:**
- Reduced hospitalization
- Reduced need for more intensive or follow up services
- Reduce unwarranted variability in care
Palliative Care

- ↓ hospital costs
- ↓ emergency room visits
- ↓ hospitalizations

Chronic Diseases and Healthcare Reform

- Palliative care has potential to reduce readmissions
- Emphasis on continuum of care and continuity of services
- Ranganathan et al.
  - home palliative care patients had a reduced chance of 30 day readmission by ~10% as compared to standard care

Jimmo vs. Sebelius

- Longstanding practice whereby CMS, claims processors, and providers decide nursing care and therapy services are not available for beneficiaries whose condition is not “improving”

- Examples: “stable”, “chronic”, “plateaued”

http://www.aspe.hhs.gov/health/reports/2011/PACexpanded
Clinical Documentation

- Highly recommend clinical documentation justify why PT/OT was required to slow rate of decline, ensure safety, or maintenance required skill of a PT/OT
- Useful key phrases:
  - Without PT, the patient’s [body function/structure] would likely decline at a faster rate causing dysfunction to [Participation or Activity]...
  - Skilled therapy services are needed to ensure safety during [activity] due to the instability of the [health condition]
  - To optimize remaining quality of life, skilled PT is medically necessary to train the caregivers in X to avoid Y
  - Without preventative interventions by PT for [body function/structure], the risk of hospitalization is significantly heightened.

Definition of Cancer Survivorship

- The National Coalition for Cancer Survivorship (NCCS)\(^1\) pioneered the definition of survivor as:
  - From the time of diagnosis and for the balance of life, a person diagnosed with cancer is a survivor
  - This expansive definition of “survivor” includes people who are dying from untreatable cancer
  - NCCS later expanded the definition of survivor even further to include family, friends and voluntary caregivers who are affected by the diagnosis in any way
Association of Community Cancer Centers Guidelines

→ ACCC recommends comprehensive rehab services:

**SECTION 9**
**Rehabilitation Services**

**Guideline 1**
Comprehensive rehabilitation services are available to cancer patients and their families through the entire cancer care continuum from diagnosis through survivorship.

**Rationale**
Cancer is a chronic disease that may require adjustment in the physical, social, financial, and emotional aspects of life in order to maximize independence and quality of life within medical status. Professionals experienced in rehabilitation are best suited to meet these needs of cancer patients.


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**Management & Administrative Structure of Palliative Care Rehab**

- Comprehensive palliative care rehab team members as well as service line experts
- Professional communications
- Access to services along continuum
- Protocol guidelines
- Advanced training of personnel
- Professional resources, settings, equipment
- Reimbursement, funding, costs to patients
- Research
Advanced Education Requirements

- Chronic Disease and Rehabilitation Disease Specific Pathology & Staging
- Diagnosis Specific Training on Treatments
- Evolution of side effects
- Timing of evaluations, education & interventions
- Prevention activities
- Intensity of interventions- education, manual therapy and exercise (flexibility, strengthening, aerobic)
- Current Research
- Rehab throughout the continuum of care

Education of Stakeholders

- Physicians
- Nurse Navigators
- Patients
- Caregivers
- Social workers, nutritionists, chaplains, OT, SLP, radiation therapists
- Insurers
- Universities & Residency Programs
- Research
Overview of “Historical” Rehab Services for Chronic Disease

- Patient complains of pain, dysfunction, disability
- Doctor identifies a need for physical therapy
- Patient is scheduled for physical therapy services
- Receives a bout of care and is commonly discharged without follow up by P.T./O.T.
- Very little to no communication between therapists or physicians as a patient transitions from setting to setting
- Physical/occupational therapists often outside “routine” or preventive management model

“Patient and family quality of life, I have always defined my interventions - safety first; second, comfort; and third, mobility. Safety for the patient and caregiver, then comfort issues - pain, edema, dyspnea, and third is mobility. How are they with driving, doing transfers, mobility? I have often felt safety has to be what drives what I do. The worst thing is having a patient fall and fracture a hip or be hospitalized and in more pain or family members injure themselves when caring for a loved one. It creates so much unneeded stress and discord at end of life.” - US2
Background

- Briggs proposed five patient management models beyond “traditional rehabilitation” for treating the patient with a life-threatening illness
  - A patient can go back and forth between the models or be receiving more than one at the same time
  - Can be used to establish care plans, justify appropriate physical therapy intervention, and educate patients, referral sources, and payers for these services

1. Rehabilitation Light
2. Rehabilitation in Reverse
3. Case Management
4. Skilled Maintenance
5. Supportive Care

(Briggs, 2000)
“[Educating the family/caregiver] further helps the family be prepared for the decline in the patient...it starts when they were doing sliding board transfers and then went to a Hoyer Lift then we went to bed positioning at all times, so through the whole decline I think it is so helpful. Having that relationship with the family where they trust you at a time when their emotional resources are limited I think is important.” - US3

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Care Philosophy for Palliative Care and Chronic Disease Management by Physical Therapy

- Need therapists who are dedicated to palliative care or patient-care discipline (i.e. COPD expert) as their primary practice area but don’t necessarily need to see every pt with this diagnosis
- Establish a personal relationship and trust with physicians, nurses, patients, multidisciplinary team
- Non-direct care time just as valued as direct treatment time
- Avoid unwarranted admissions
Vision: Coordination of Care and Longitudinal Management
Acute Care ➔ Post Acute Care

Common reasons hospital admission for pts in PC

- Initial diagnosis and workup
  - Variable receptiveness to P.T. but “plant the seed”
  - Screening or rounding
- Chemotherapy treatments
  - “well visit”
- Related sequelae
  - ex. UTI, sepsis, confusion, dehydration, nausea, diarrhea, vomiting, weakness, falls
- Unrelated medical issue
  - still placed on specific medical floor
- Decline in status or worsening of condition
  - re-evaluate patient needs or functional status
FYI: Physical Therapy Screening Acute/Inpatient

- Aggressive screening and early identification of palliative care and chronic disease patient during hospitalizations
- Essentially direct access for referral to PT/OT services
- Avoids traditional model of a patient not often getting a PT/OT treatment till day 3-4
- Direct communication between nurse and PT/OT for any possible patient needs with immediate assessment and treatment
- Therapist participates in daily huddles

"Before I was [in the IDT meetings], we used to have a lot of falls and nurses being injured. But now with me there and I do all this education on body mechanics and [in coordination with] whole new pharmacologic interventions. Have the PT come in and do the first transfers." - US2
Therapists’ Role in Palliative Care

- Common misunderstandings about therapists’ role in Palliative Care
- “Aggressive therapy” and “No therapy” are not the only options
- Focus to avoid interruption in rehabilitation care
- Strategic continuity and longitudinal management until end of life
- Even more sensitive to patient wishes/comfort

Shift focus to:
- Quality of life
- Anticipatory future disability and equipment needs
- “Bucket list” assistance
- Prevention of pressure ulcers, contractures, immobility pain
- Family/caregiver education and support/consultation

“The therapist needs to be ready for the patient’s condition to change and fluctuate over days and therapists may be ordering things that are inappropriate. A therapist got the family to put in a stair glide for a dying patient and the therapist didn’t realize the disease progression. The family used the glide once but the patient couldn’t get off it. The rehab therapist didn’t do the wrong thing. He had good intentions but the family was in a jumble. Education and communication are critical.” - US2
Differences between “Active” and “Palliative Care”

**Active Care**
1. Push patients closer to tolerance
2. More aggressive with treatment compliance
3. Focus on ADL function over temporary pain management
4. Generally have clarity with care goals
5. Little to no existential anxiety
6. More fact-based interactions
7. Procure DME with intent of improvement or long term stability

**Palliative Care**
1. Balance function and participation with comfort
2. More willing to accept a “refusal” or physical variability
3. Focus on pain control with modified ADLs
4. Anticipate unclear care goals
5. Patient and family distress
6. Emotion-based interactions
7. Procure DME for anticipatory decline or “bad days”

Overarching Themes of Palliative Care Rehabilitation

- Expect and anticipate frequent and dramatic fluctuations in:
  - Functional capacity
  - Strength
  - Pain
  - Ability to perform their activities of daily living
  - Motivation
  - Emotional states
    - Getting good or bad news
**Philosophy of Rehabilitation Services**

“Empower patients to maintain their own health and commitment to healing, through an individualized exercise and wellness program” = PRISM

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**Prevention and Wellness of the Palliative Patient**

- Primary prevention – Prevention of a disease in a potentially susceptible population
  - Impacting the health condition domain
- Secondary prevention – Decreasing the duration and severity through intervention
  - Impacting the body function/structure and activity domains
- Tertiary prevention – Decreasing the degree of disability in those with irreversible disorders
  - Often impacts activity and participation domains

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Transitions in Care

- Prior to HPC, patient may be undergoing OT or PT
- Once the decision for HPC is made, patient may be arbitrarily discharged or barriers to care encountered
  - Administrative structure
  - Reimbursement barriers
  - New, unfamiliar care team
  - Misunderstandings by family, patient, or caregivers
- Patient may still have the same physical needs and potential as when they were undergoing active treatment
- Should, by principle, have the same access to a PT/OT who provides these services

System Best Practices

- Designate a “lead” therapist for that diagnosis/service line who is familiar with the staff, procedures, and unique needs of this patient population
  - Doesn’t always have to see every PC patient but resource for coordination of care and complex cases
  - Enhances continuity of care through communication from Acute to Home to OP and across
  - Allows the clinicians to be familiar with the patient before they transition to palliative care philosophy
  - The therapist can be familiar with their goals, family situation, home environment, and physical needs
System Best Practices

- Palliative Care “Non-billable” time being just as valued as “billable” time
  - Lead therapist attends weekly rounds and huddles with interdisciplinary team members of service lines
    - Oncology
    - COPD
    - CVA/Neuro
  - Integral in further establishing our role in the HPC clients
- Including hospice nurses, pastoral care chaplains, dietary services, discharge planners, physicians, social workers and physical/occupational therapists
- Added benefit of contributing to our growth of our outpatient oncology and chronic disease management programs in therapy
  - Cancer survivorship and Wellness Program
  - COPD Transition Liaison Program

“[PTs] are not the most inexpensive clinician to employ and it takes a bite out of that [insurance payment] so we really try to create an idea of a return on investment to make sure that they are inside the plan of care and that each minute is spent with the patient is very, very impactful.” – US4
Points for Discussion

- Improved screening and access to patients in palliative care to identify needs early
- Reduce patient barriers to rehabilitation to assist with secondary and tertiary prevention of the sequelae of the patients condition or other conditions
- Once a patient receiving palliative consultative services, recommend a 3 step process to identify patient needs within OT/PT
  1. Screening through chart review of all patients on Palliative Service
  2. If chart review indicates possible needs, communicate with RN, NP, MD to determine needs
  3. If needs exist and pt is appropriate, initiate referral through protocol
     1. Or Direct Consultation through referral

Continuum of Care

- Important to connect Hospital Services with Home Care and Skilled Nursing Facilities and OP
- Goal: improves quality of life for patients with chronic, complex illnesses.
- Working with patients and families in the community setting, our interdisciplinary team provides the highest quality care through:
  - expert symptom management
  - advocacy
  - support for patients and families
  - achieving measurable improvements in clinical quality and patient satisfaction
Rehab Navigators between Acute and Home

- Focus on reducing preventable readmissions
- Palliative care really is chronic disease management
- Develop close relationship with Acute Care rehab team dedicated to develop and monitor a mobility ADL plan to be carried out at home with Home Care therapists
- Coordinate care with nursing and physicians
  - Ensure patients continue their function and mobility plan at home as designed by the acute Plan of Care and refined by the Home Care therapist.
- Home Care therapist and Acute Care OT therapist will monitor progress frequently to ensure patient’s success with functional and mobility activities

Coordinating Rehab Care Between Acute and Post Acute

- Acute care therapist and Home Care therapist would support each other through
  - Consultation
  - Collaboration
  - Advanced education
- The Acute Care / Home Care Rehabilitation team will proactively keep nursing and physicians abreast of barriers to functional success
- The Rehab plan of care will be evaluated on an ongoing basis
  - Evidence-based quality and outcome metrics with predetermined quality indicators
  - Recommendations for refinements to the intervention plan
Weekly Follow up
“Keystone Rounding”

<table>
<thead>
<tr>
<th>Keystone Rounding</th>
<th>Meeting Expections?</th>
<th>Plans/Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient progressing as expected from initial collaboration?</td>
<td></td>
<td></td>
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<tr>
<td>How much physical activity is the patient getting besides PT/OT?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any equipment needs identified?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vital sign responses to Rx?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barthel index as compared to baseline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation of clinical outcomes vs expected?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social barriers to activity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anything else the patient needs to be successful in the home?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barriers remaining to advance to next level of care? – OP PT/OT, Pulmonary Rehab</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hospital-Based Palliative Care
Multidisciplinary Rounds

- Rounds once twice a week to go over pts in the hospital with consult order for Palliative Care
- 1 hour meeting
  - 30 mins of discussing pts
  - 30 mins outstanding issues, barriers, journal club, evidence, new initiatives

- Members
  - Palliative care physician
  - Palliative care NP
  - Chief of PA services
  - OT/PT
  - Hospice RN
  - Hospice Chaplain
  - Home Care Nursing
  - Discharge Planning
Frequency of PT/OT orders in Patients with Palliative Care Consultations in Acute Care

n = 963

- Both PT/OT: 68%
- PT Only: 10%
- OT Only: 3%
- Neither PT/OT: 19%

Diagnosis Distribution 1 Year
Beaumont Hospital Troy Palliative Care

Frequency of Diagnoses

- Cardiac: 161
- Cancer: 324
- Neuro/CVA: 123
- Respiratory: 279
- Trauma: 14
- Other: 216

Diagnostic Categories

3 other dx
2 other dx
1 other dx
Only diagnosis
Frequency of PT/OT Orders for PC pts by Diagnostic Category

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Frequency of Consultation Orders</th>
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</thead>
<tbody>
<tr>
<td>Cardiac n=164</td>
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<tr>
<td>Cancer n=324</td>
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<tr>
<td>Neuro/CVA n=119</td>
<td></td>
</tr>
<tr>
<td>Respiratory n=279</td>
<td></td>
</tr>
<tr>
<td>Trauma n=14</td>
<td></td>
</tr>
<tr>
<td>Other n=216</td>
<td></td>
</tr>
</tbody>
</table>

Palliative Care vs Standard Care in Acute Care by DRG/ICD

- Average Cost per case of standard care: $13,650
- Cost Savings when Palliative Involved:
  - $2,076.00
  - N=157
- Beaumont Sample
Reporting Structure

- Palliative Care as a Consultant vs Attending
- Reporting structure of the therapist
- Dynamics and tension

Documenting progress and justifying future care

- An important part of therapy is using functional tools to document and validate progression or regression of care
- We use established, evidence-based, researched outcome measures called functional tools to document the patient's progress or current status
THE PALLIATIVE PERFORMANCE SCALE (PPS)
L. Scott Wilner, MD and Robert Arnold, MD

- The Palliative Performance Scale (PPS) uses five observer-rated domains correlated to the Karnofsky Performance Scale (100-0).
  - Reliable and valid tool
  - Correlates well with actual survival and median survival time for cancer patients.
- Found useful for purposes of identifying and tracking potential care needs of palliative care patients, particularly as these needs change with disease progression.
- Large validation studies are still needed, as is analysis of how the PPS does, or does not, correlate with other available prognostic tools and commonly used symptom scales.

<table>
<thead>
<tr>
<th>%</th>
<th>Amb</th>
<th>Activity Level</th>
<th>Extent of Disease</th>
<th>Self Care</th>
<th>Intake</th>
<th>LOC</th>
<th>Est Median Survival (days)</th>
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<tbody>
<tr>
<td>100</td>
<td>Full</td>
<td>Normal</td>
<td>No Disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
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<td>90</td>
<td>Full</td>
<td>Normal</td>
<td>Some Disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
<td>N/A N/A 108</td>
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<td>80</td>
<td>Full</td>
<td>Some effort</td>
<td>Some Disease</td>
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<td>Normal or Reduced</td>
<td>Full</td>
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<td>70</td>
<td>Reduced</td>
<td>Can’t do normal job or work</td>
<td>Some Disease</td>
<td>Full</td>
<td>As above</td>
<td>Full</td>
<td>145 N/A 108</td>
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<td>60</td>
<td>Reduced</td>
<td>Can’t do hobbies or housework</td>
<td>Significant Disease</td>
<td>Occasional Assist Needed</td>
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<td>50</td>
<td>Mainly sit/lie</td>
<td>Can’t do any work</td>
<td>Extensive disease</td>
<td>Considerable Assist Needed</td>
<td>As above</td>
<td>Full or Confusion</td>
<td>30 11 41</td>
</tr>
<tr>
<td>40</td>
<td>Mainly in bed</td>
<td>As above</td>
<td>As above</td>
<td>Mainly Assistance</td>
<td>As above</td>
<td>Full or Drowsy or Confusion</td>
<td>18 8 41</td>
</tr>
<tr>
<td>30</td>
<td>Bed bound</td>
<td>As above</td>
<td>As above</td>
<td>Total Care</td>
<td>Reduced</td>
<td>As above</td>
<td>8 5 41</td>
</tr>
<tr>
<td>20</td>
<td>Bed bound</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
<td>Minimal</td>
<td>As above</td>
<td>4 2 6</td>
</tr>
<tr>
<td>10</td>
<td>Bed bound</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
<td>Mouth Care Only</td>
<td>Drowsy or coma</td>
<td>1 1 6</td>
</tr>
<tr>
<td>0</td>
<td>Death</td>
<td>-</td>
<td>-</td>
<td>72</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
Edmonton Functional Assessment Tool
(EGFT-2)

- Specially designed to measure physical impairment and functional performance of patients with advanced cancer / in palliative care.
- Documents the degrees of functional performance of patients throughout the terminal phase.
- Also useful in evaluation of rehabilitation.
- Typically administered by the PTs and OTs.
- Quick, simple, and do not require significant training.

Slides originally developed by Luiza Iervolino, SPT, Program in Physical Therapy, Oakland University, Rochester, MI. Reproduced with permission.

<table>
<thead>
<tr>
<th>Table 1: Edmonton Functional Assessment Tool (EFAT-2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication</strong></td>
</tr>
<tr>
<td>Independent</td>
</tr>
<tr>
<td>Effective &gt;50% but &lt; 100% of time</td>
</tr>
<tr>
<td>Effective &lt;50% of time</td>
</tr>
<tr>
<td>Unable to communicate</td>
</tr>
<tr>
<td><strong>Mental status</strong> (six tasks on memory and orientation)</td>
</tr>
<tr>
<td>Orientated and memory intact</td>
</tr>
<tr>
<td>Two–six tasks impaired, but follows simple commands</td>
</tr>
<tr>
<td>Three–four tasks impaired or responds inconsistently</td>
</tr>
<tr>
<td>Five–six tasks impaired or unresponsive to verbal commands</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
</tr>
<tr>
<td>No impact on function</td>
</tr>
<tr>
<td>Inhibits function minimally</td>
</tr>
<tr>
<td>Inhibits function moderately</td>
</tr>
<tr>
<td>Unable to do any activity due to pain</td>
</tr>
<tr>
<td><strong>Dyspnoea</strong></td>
</tr>
<tr>
<td>No SOB</td>
</tr>
<tr>
<td>Urgency with counting or SOB on exertion or intermittent use of O₂</td>
</tr>
<tr>
<td>One extra breath with counting or O₂ at 1–3 litres</td>
</tr>
<tr>
<td>At least two breaths with counting or O₂ at ≥ 4 litres</td>
</tr>
<tr>
<td><strong>Balance</strong> (sitting or standing)</td>
</tr>
<tr>
<td>Independent</td>
</tr>
<tr>
<td>Requires equipment or one person: minimal safety risk</td>
</tr>
<tr>
<td>Require moderate assistance, one or more persons: unsafe on own</td>
</tr>
<tr>
<td>Require maximal assistance, one or two persons or unable to evaluate</td>
</tr>
<tr>
<td><strong>Mobility</strong> (bed mobility and transfers)</td>
</tr>
<tr>
<td>Independent and safe</td>
</tr>
<tr>
<td>Requires one assistant to move safely</td>
</tr>
<tr>
<td>Requires two assistants to transfer safely</td>
</tr>
<tr>
<td>Unable to assist with position change. Requires mechanical lift</td>
</tr>
<tr>
<td><strong>Locomotion</strong> (walking or wheelchair)</td>
</tr>
<tr>
<td>Independent</td>
</tr>
<tr>
<td>Requires walking aid or one person to walk or supervision with wheelchair</td>
</tr>
<tr>
<td>Requires two persons to walk or assistance with wheelchair</td>
</tr>
<tr>
<td>Unable to walk. Dependent wheelchair management</td>
</tr>
<tr>
<td><strong>Fatigue</strong></td>
</tr>
<tr>
<td>Rarely needs to rest</td>
</tr>
<tr>
<td>Rest &lt;50% of day</td>
</tr>
<tr>
<td>Rest &gt;50% of day</td>
</tr>
<tr>
<td>Bedridden due to fatigue</td>
</tr>
<tr>
<td><strong>Motivation</strong></td>
</tr>
<tr>
<td>Participates in all activity</td>
</tr>
<tr>
<td>Participates &gt;50% of time</td>
</tr>
<tr>
<td>Participates &lt;50% of time</td>
</tr>
<tr>
<td>No desire to participate</td>
</tr>
<tr>
<td><strong>ADL</strong></td>
</tr>
<tr>
<td>Independent</td>
</tr>
<tr>
<td>Independent using equipment</td>
</tr>
<tr>
<td>Requires some assistance</td>
</tr>
<tr>
<td>Totally dependent</td>
</tr>
<tr>
<td><strong>Performance status</strong> (room/unit)</td>
</tr>
<tr>
<td>Independent</td>
</tr>
<tr>
<td>Independent with minimal assistance</td>
</tr>
<tr>
<td>Requires moderate assistance</td>
</tr>
<tr>
<td>Requires maximal assistance</td>
</tr>
</tbody>
</table>

Sensation: deleted from original ETAT. *Reworded to increase objectivity. **Activity and wheelchair mobility collapsed. New items added. ADL: Activities of daily living; SOB: shortage of breath.
Edmonton Functional Assessment Tool (EFAT-2)

- Comparing admission of three groups of patients: (a) deceased on the unit, (b) transferred to a continuing care palliative unit, (c) discharged home.
- The ANOVA was significant (F[2,267] 29.063, p < 0.001).
- Internal Consistency: Cronbach’s alpha was 0.86.
- The results suggest that the EFAT-2 measures one construct. They also suggest that the EFAT-2 is able to discriminate between palliative care patients based on discharge location.
- Quick and easy tool to use as part of the patients routine assessment.
- Sensitive enough to pick up changes in symptoms such as pain, fatigue, and motivation, which impact greatly on functional performance.

Risk Stratification System

1. Patient has No Chronic Illness
   - Chronic Illness is Not Focus of Care or Expected to Impact Care

2. Patient Lives with Chronic Illness

3. More Fragile Health
   - Increasing Complications, Symptom Control Issues, Hospitalizations

4. Palliative Care
   - Complex Cases- Likely to Remain in Fragile Health and Risk for Serious Complications

5. Hospice
   - Serious Progressive Conditions that Could Lead to Death within a Year

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Risk Stratification Level 3

Moderate to High Risk
- 2-3 hospitalizations last 12 months
- Falls last 3-6 months
- Multiple co-morbidities
- Likely to live 2 or more years with condition
- May consult with palliative care team or physical therapist for early intervention and symptom management

Risk Stratification Level 4

Likely to Remain in Fragile Health and Risk for Serious Complications
- 2-3 hospitalizations in last 6 months
- Escalating or uncontrolled pain
- Disease Complications (ex: aspiration, pneumonia, septicemia)
- Limited Rehab potential (but we are needed for caregiver edu and more)
- Likely to live with disease 12 to 18 months
- Wants to reduce re-hospitalizations
Risk Stratification Level 5

Hospice Appropriate
► Likely will die from disease within six months/year
► Comfort care
► Some hospice appropriate patients are still in home care
► Still want aggressive treatment (radiation/chemo)
► Afraid of or against going to Hospice
► TLC RNCM and MSW excellent at guiding these transitions
► We must know how to speak of the benefits of Hospice

We have been treating these patients all along...
► To alleviate fear that this is some brand new thing, let me assure you, it is not
► The difference is a shift in philosophy
► These patients can be in any care setting,
► Outpatient, Skilled Nursing, IPR, Acute Care, HC, etc.
Home Health Care Therapy Medicare Guidelines

Services provided by patient, OT and SLP are specific, safe and an effective treatment for your condition. The amount, frequency and time period of the services needs to be reasonable, and they need to be complex or only qualified therapists can do them safely and effectively.

1) your condition must be expected to improve in a reasonable and generally-predictable period of time -OR-
2) you need a skilled therapist to safely and effectively make a maintenance program for your condition -OR-
3) you need a skilled therapist to safely and effectively do maintenance therapy for your condition.

Richard Briggs Discusses 4 Models of patient Care in Hospice and Palliative Care

- Palliative care model
- Oncology rehab model
- Neurodegenerative disease model
- Hypothesis-Oriented Algorithm for Clinicians II
Palliative Care Model

1. Rehab “light”
2. Case Management
3. Rehab in Reverse
4. Skilled Maintenance
5. Supportive care

Palliative Care Model

1. Rehab “Light”

- Patients experience ups and downs while in Chronic disease progression
- A patient may experience a set-back, followed by an improvement with the desire to regain small amount of strength, even with the knowledge that their illness may not be cured
- Limited and targeted exercise can be prescribed
- 1 visit per week for short bout modifying to more if tolerated
- Communication with the Nurse Case Manager essential
Rehab Light Case Example

- Recent exacerbation/hospitalization for lung cancer with mets
- Prior to Hospitalization pt amb with 2ww in home
- Home with hospice
- Bed bound for 2 weeks
- At two weeks pt becomes more alert and begins to request to get out of bed
- PT consult ordered

Rehab Light Case Example

- Examination:
  - Pt able to tolerate supine to sit and sit to stand
  - Requires min assist
  - Able to stand 2 bouts of 40 seconds
  - Able to tolerate transfer training with wife from bed to commode
  - Able to tolerate sitting in wheelchair for 5 minutes.
  - Vitals monitored closely through all transitions
  - Some fluctuation in O2 saturation into low 90%
  - But recover with rest and deep breathing in 1 minute
Rehab Light Case Example

- **Recommendation:**
  - Family taught how to stand at edge of bed for 40 second bouts, working up to longer periods as patient tolerates
  - Energy efficient transfers educated to all caregivers including adjusting bed height, use of gait belt and proper techniques and body mechanics
  - Sitting and supine exercises prescribed to increase activity tolerance and strength
  - Low duration, higher frequency
  - Follow up scheduled for 1 weeks

---

Rehab Light Case Example

- 1 week follow up
- Pt now able to ambulate with walker for first time
- 10 feet first bout and 20 feet second bout
- Pt expresses desire to sit at table to eat at least one meal per day
- He also expresses a desire to exit the home
- Edu of family on home exit with w/c, ramp recommendations
Dosing exercise for the Seriously ill

- Don’t always give exercises (gas in the tank)
- Watch for discomfort/distress
- Monitor vitals
- Are you going to call 911?
  - Anticipate and educate on patient management of crisis moments
- Vital sign parameters and communication with the Dr./team

Some outcome measures for the Debilitated patient

- Barthel ADL Index
  - assesses function including transfers, dressing, stairs, toilet use, etc.
- PSFS
  - 3 meaningful activities
Palliative Care Model
2. Case Management

- Purpose to monitor for changing needs of patient
- Monthly or bi-monthly or “as needed” assessment and updated instruction
- May follow rehab “light” intervention
- May be initial intervention
- Communicate with others on Team

Case Management and Rehab Potential

- Patients transitioning between palliative care and hospice sometimes need determination if they are rehab appropriate.
- Some people end up in hospice, but have some recovery and want more therapy.
- Therapy is very limited in hospice
- I am consulted to see if pt is appropriate to transition back to home care for some therapy.
- Function in Sitting Test (FIST) (4)
Hospice Stats 2011

- 80% are covered by Medicare
- An estimated 1.651 million patients received services from hospice. This estimate includes:
  - 1,059,0001 patients died under hospice care
  - 313,0001 remained on the hospice census at the end of 2011 (known as "carryovers")
  - 278,0001 patients were discharged alive for reasons including:
    - extended prognosis
    - desire for curative treatment
    - other reasons (known as "live discharges").

Palliative Care Model
3. Rehab in Reverse

- In general patient patients are progressed from w/c to walker to cane to independent
- For the declining patient, need for assistive technologies change often in the reverse direction.
- We are the experts on assessing for need and appropriateness of the devices
- We are the experts in training the use of these devices.
Palliative Care Model

- Patients with chronic disease may become “frequent flyers” over the remaining 1-2 years of life
- Many predictors and signs that point to decline
- Identifying needs before falls occur
- Going from cane to walker
- Walker to w/c
- And use of Hoyer, commode, bedpan
- Helping to determine when pt is no longer safe to get out of bed
- Helping with the team facilitation of end of life planning and transition to hospice

Successful Outcomes

- Safely stay at home
- Caregivers with good understanding on use of equipment
- Reduce risk of falls
- Palliative care outcome measures at BHC are focused on pain reduction, reducing re-hospitalizations and dyspnea
- Opportunity in pain management
  - Example: pain with joint protection techniques vs more pain meds
Palliative Care Model
4. Skilled Maintenance

► Recognized by Medicare Home Health Guidelines
► When too complex or unsafe for caregivers to perform task of maintenance care
► Requires skilled handling abilities of therapist
► Must have documentation to back it up
► Intermittent visits can be made by agreement with the care team, as the issues of both support and of letting go during the natural dying process must be considered and addressed.

Skilled Maintenance

► Neurological disorders
► FIST (function in sitting test)\(^{30}\)
► Slowing debility
► Where muscle facilitations or inhibitions will make the difference for the patient
► Too technical for the family member
► Spread out visits over time
► Spread your visits out from other disciplines so you can be another set of eyes on the case
Documentation of Skill

From Medicare Handbook\textsuperscript{25}

“In the case of \textit{maintenance therapy}, the skills of a therapist are necessary to maintain, prevent, or slow further deterioration of the patient’s functional status, and the services cannot be safely and effectively carried out by the beneficiary personally, or with the assistance of non-therapists, including unskilled caregivers.”

Home Health Medicare

- “There is a requirement under Home Health Part A benefit for a functional reassessment of the patient by the 14\textsuperscript{th} and 20\textsuperscript{th} therapy visit or at least every 30 days”
- This is separate and apart from the functional limitation reporting requirement under Medicare Outpatient Therapy Part B
- There is a G-code under Home Health Part A that you should use on the Medicare Claim to show that the services were established and are being carried out for skilled maintenance.
- G0159 – Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes

APTA.org FAQ: Skilled Maintenance: Coding and Billing
Palliative Care Model 5. Supportive Care

- Gentle PROM
- Edema management with manual lymphatic drainage and compression wrapping
- Education to family provides meaningful way to comfort loved one in Hospice
- Ease discomfort of inactivity
- Rocking for vestibular stimulation
- Reduce contractures
- Trans disciplinary support

Supportive Care

- Primarily focuses on symptom management/relief
- Focus often shifts to the caregivers when pt is severely debilitated or impaired cognitively
- Education on body mechanics, positioning for the most energy efficiency
TEST YOUR KNOWLEDGE

- Based on the information provided in each case, choose the most appropriate treatment approach based on Briggs’ models for palliative care physical therapy.
- More than one answer may be appropriate in certain cases depending on the extent of the disease and patient context.
- Disclaimer: Examples may not all be applicable to homebound criteria.

77 y.o. M with metastatic prostate CA - lesion of R tibia

- Orthopedic oncologist notes 5% PWB R LE with gait.
- Patient goal is to not use BSC or bedpan.
- Patient has unsafe movement patterns when ambulating with assistive device but knows the basic concepts of standard walker use.
- Based on the amount of guarding and feedback the patient needs, the patient should not ambulate without a PT/PTA to ensure safety.
- There is not an anticipation of improvement in gait or function due to pts medical status.

- Rehab Light
- Rehab in Reverse
- Skilled Maintenance
- Case Management
- Supportive Care
- Risk Stratification Level?
  - 1, 2, 3, 4, 5
67 y.o. M with end stage renal disease and advanced metabolic encephalopathy

- Patient is max x2 assist with bed mobility and turning
- Non-ambulatory and A+Ox0
- Very high risk of developing sacral pressure ulcers and poor nutrition
- Pain and stiffness in thighs and legs that is alleviated with PROM
- Family needs education on a turning schedule and positioning for prevention
- Not open to hospice at this time due to family beliefs but would be a candidate for hospice

Rehab Light
Rehab in Reverse
Skilled Maintenance
Case Management
Supportive Care
Risk Stratification Level?
1, 2, 3, 4, 5

56 y.o. F with stage 2 COPD (moderately severe)

- Not significantly affecting her quality of life
- On 2 long acting inhalers
- Limitation of airflow begins to worsen and is easy to see on a spirometry test.
- Coughing and sputum production beginning to increase
- Good balance, coordination and able to ambulate 6 minute walk test in 380 meters without assistive device
- Wants to have a PT prescribe an exercise program and have periodic advancements or updates

Rehab Light
Rehab in Reverse
Skilled Maintenance
Case Management
Supportive Care
Risk Stratification Level?
1, 2, 3, 4, 5
51 y.o. M dx with spinal metastatic lesion and T12 cord compression from lung CA

- 3 weeks ago was ambulating without an assistive device
- Now using a cane and getting more unsteady and legs buckling more (mod assist x 2 for safety)
- Wearing a TLSO to protect the area
- Spinal lesion not responsive to radiation and palliative chemotherapy (continues to grow)
- Patient goal is to stay home and be mobile around the house without injuring his family or falling and injuring himself

- Rehab Light
- Rehab in Reverse
- Skilled Maintenance
- Case Management
- Supportive Care
- Risk Stratification Level?
  - 1, 2, 3, 4, 5

97 y.o. F with end stage congestive heart failure

- Ambulating with a 4 wheeled walker ~ 20' with fair+ balance
- Goal is to get back to church 1x per week
- Motivated to continue rehabilitation
- Borderline to achieve hospice admission but not open to it as she has a lot of living to do!
- Ejection fraction is 20% (normal is 55-60%)
- Borg RPE is 14/20 upon gait
- Wants to do as much therapy as she can but gets fatigued with being pushed too hard

- Rehab Light
- Rehab in Reverse
- Skilled Maintenance
- Case Management
- Supportive Care
- Risk Stratification Level?
  - 1, 2, 3, 4, 5

continued
CMS Hospital Readmission Reduction Program

- Incentivizes or penalizes hospitals to stabilize certain diagnoses to prevent readmission
- Certain diagnoses targeted first:
  - Acute myocardial infarction, heart failure, pneumonia, COPD, TKA, THA – possible stroke in future
  - Future conditions to follow as determined by CMS
  - Most importantly to palliative care - CHF and COPD

CMS Hospital Readmission Reduction Program

- Meant to reduce 30-day readmissions for commonly readmitted conditions
- By 2015, up to 3% of a hospital’s base DRG payment
- HOSPITALS LOOKING TO PARTNER
- Prompts healthcare team to encourage long term stability of chronic disease patients
Avoidable/ Unnecessary Readmission

- Prevent conditions from becoming severe through early identification and assessment of changes in resident condition
- Allows management of some conditions without transfer
- Improves advance care planning and palliative care
- *The goal is to improve care not to prevent all hospital transfers.*

Avoidable/ Unnecessary Readmission

- An 86 year old...
- Hospitalized for a lower respiratory infection with normal vital signs and oxygen saturation
- Developed delirium in the hospital, fell, resulted in fractured hip and developed a pressure ulcer
- AVOIDABLE??
- Manage some conditions without transfer
Avoidable/ Unnecessary Readmission

- A 94 year old...
- Hospitalized for UTI and dehydration
- Discharged back to home after days
- Re-hospitalized 6 days later for dehydration and recurrent UTI
- AVOIDABLE??
- Prevent conditions from becoming severe through early detection and evaluation.

Avoidable/ Unnecessary Readmission

- A 98 year old...
- Hospitalized for the 4th time in 2 months for aspiration pneumonia r/t end-stage Alzheimer’s
- Transferred to hospice on the day of admission
- AVOIDABLE??
- Improve advance care planning and use of palliative care
Palliative Care Programs Reduces Readmissions

- Reduces 911 calls
- Palliative care contact must be available 24/7
- Need excellent coordination between team members
- Need good communication of goals from different team members perspective
- Tailor a plan very specific to patient

PT (and other therapies!) Have a Role to Play!

- What outcomes are we looking for when the patient is declining?
- Better understanding of positioning of pt to reduce harm to self and to patient.
- Caregivers have a better technique which conserves energy to assist patient from bed to commode.
- Another set of ears and eyes!
- As people are puzzling with their transition into hospice, we are there to support and educate and make that recommendation when ready
Summary/wrap up

- Times are changing and we have a skill that can help contain the cost of readmissions
- We can facilitate the goal to stabilize the patient with chronic illness to keep them in the community as able
- We are the experts in positioning, ADLs, and predicting future disability

Summary/wrap up

- These are patients that we already see in our practice
- The philosophy is different, more holistic and comprehensive.
- We have to offer our expertise in facilitating function even in the face of decline or plateau of an illness
Questions?

Acknowledgements

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- Thank you to Tammy Demeere PT, DPT for collaboration on development of content
References


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