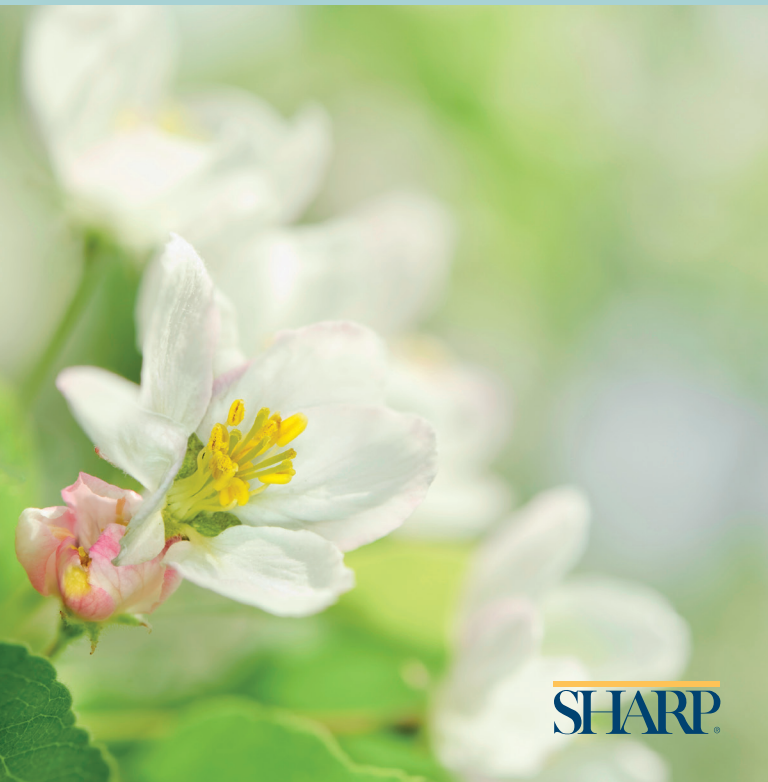
Transitions Program Guidelines: Chronic Illness Management

Revised 2020



SHARP

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Disclaimer: The information contained in this handbook is meant only to be a guide for determining whether a patient is eligible (with supporting criteria) for the Transitions Program.

Sharp HealthCare's Transitions Program is a pre-hospice service. It is the time when co-management of traditional treatment strategies and palliative strategies are both important for the patient. As the patient follows his or her natural disease course, palliative care becomes increasingly valuable.

Most patients want to live longer. However, as they age, medical evidence shows that comfort becomes more important than longevity. Models to deliver this level of care have not existed in the past. As health care evolves, Transitions has made it possible to parallel the life cycle while respecting patient choice, and providing best practice as the standard of care.

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Transitions Program Pillars

Sharp HealthCare Transitions Program follows four pillars:

1. **Evidence-based, in-home disease management** — Patient will receive care directly related to his or her medical diagnosis, including education about the disease.
2. **Evidence-based, medical prognostication** — Prognostication helps to understand the next and expected series of events for the patient's condition.
3. **Professional care for the caregiver** — Learning to support the caregiver, including emotionally, is essential because medical evidence shows that unsupported caregivers are at a higher risk for cancer, psychological damage and mortality.
4. **Advance care planning** — Family reconciliation before the inevitable consequences of natural progression of illness are discussed. This helps the family feel morally resolved that they are providing the most appropriate care for their loved one.

Patients and families should:

1. Be willing to attempt in-home disease management by the Transitions team instead of first going to the emergency room.
2. Be willing to participate in advance care planning.
3. Have Sharp Health Plan or Medicare Advantage Plans. Also, most Sharp HealthCare commercial managed care plans are covered.
4. A patient may also pay out of pocket if not covered under one of the above plans.

General Principles Regarding Admission

It can be difficult to tell the difference between an older adult getting older and an older adult facing the last couple of years of life. Also, medical evidence supports that, in general, the only demographic more overly optimistic when they prognosticate than health care providers are patients and families. Please feel comfortable referring patients for evaluation as early as possible; the Transitions Program will help screen for admission.

Also, please recognize that functional-decline patterns in late-stage vary tremendously. Therefore, the perspective of biological age and where the patient is in their life cycle must vary depending on diagnosis.

General Criteria

The following are general criteria when deciding on whether a patient qualifies for the Transitions Program:

1. Any patient who is likely to or who has started to use the hospital as a means to manage their late-stage disease qualifies for the Transitions Program. This refers to unplanned "decompensation," not elective procedures.
2. If a patient is currently on dialysis and considering the Transitions Program, they have to discontinue dialysis or not start dialysis.
3. Patients should be evaluated in their best compensated state.
4. Patients should have received maximum medical therapy *(see Appendix A for Medicare's definition)*.
5. Life expectancy of about two to three years or less (mean and median about 12 to 18 months).
6. Provide appropriate documentation that supports that the patient is late-stage.

Cancer

1. Any stage 4 cancer. *(However, a small number of people with stage 4 cancers are known to live for many years. These subgroups will receive initial advance care planning only. Follow-up nursing, social work and chaplain visits will occur at a later time.)*
2. Karnofsky Performance Scale (KPS) < or equal to 70 *(see Appendix B)*.
3. Diminished albumin, decreased hemoglobin, elevated CRP, elevated calcium or elevated cancer serologic markers provide prognostic information. Severely elevated calcium is a particularly poor prognostic marker.
4. > 12 hours in bed.

Cirrhosis

1. Albumin < 3.0
2. INR > 1.3
3. Plus one of the following:
   a. Ascites
   b. Subacute bacterial peritonitis
   c. Hepatic encephalopathy
   d. Hepatorenal syndrome
   e. Recurrent esophageal bleeds

   or
4. Model for End-Stage Liver Disease (MELD) score > 19

Scoring	6-Month Survival	12-Month Survival
0-9	98%	93%
10-19	92%	86%
20-29	78%	71%
30-39	40%	37%

To calculate MELD Score, visit mayoclinic.org/meld.

Congestive Heart Failure

1. Any patient who is hospitalized due to congestive heart failure as the primary diagnosis; no further invasive interventions planned

   or
2. Late-stage NYHA III

(continued)

3. Supportive criteria:
   a. EF < 30% for systolic failure
   b. Significant comorbidities (e.g., renal disease, diabetes, dementia, poor biomarkers)

Please note that rising BNP, pro-BNP, hsCRP and BUN/Creatinine provide highly prognostic information if collected when the patient is in their best compensated state.

Dementia

1. FAST 5 at high-risk of using the hospital to manage their disease — must document the reason it is felt that the patient is high-risk *(see Appendix C)*

   or

2. FAST 6 to 7C

   or

3. Any demented patient who has been institutionalized or has needed the hospital primarily due to their dementia plus has had an appropriate metabolic workup (CMP, Thyroid Function Tests, B-12) and neuro-imaging (or documented refusal)

Please note hemoglobin, fasting total cholesterol, albumin, CRP and a BMP to provide evidence-based prognostic information in this group.

Geriatric Frailty Syndrome

Physiological syndrome, characterized by decreased reserve, and diminished resistance to stressors — resulting from cumulative decline across multiple physiologic systems — and causing vulnerability to adverse outcomes.

Prognostic lab results include:

- Low albumin < 3.5
- Low total fasting cholesterol < 160 (off statin medications for at least one month)
- Low hemoglobin
- Elevated CRP, hyponatremia, elevated BUN/Creatinine

LABS SHOULD BE IN PATIENT'S BEST COMPENSATED STATE.

Diagnosing Frailty

1. Unintentional weight loss
2. Unsteady gait or slowed gait
3. Deteriorating muscle strength
4. Increased sleeping/decreased activities
5. Easily fatigued

(continued)

Qualifying Criteria

- Patient demonstrates all five criteria above plus low albumin OR low cholesterol (off statin medications for at least one month)
- Patient demonstrates four of the criteria plus two biomarkers (low albumin, low cholesterol or low hemoglobin)

Motor Neuron Disease (e.g., ALS)

Referral should occur after pulmonary, PT, OT and speech therapy are initiated. Earlier referral is appropriate.

Multiple Sclerosis

Variability exists in decline rates and may require the guidance from the patient's neurologist.

1. KPS of 50 or less
2. Frequent UTIs, pneumonia or pressure ulcers
3. Any hospitalization, swallowing difficulty or significant functional decline may represent an appropriate time for referral

Muscular Dystrophies

Please consult with patient's neurologist. Patient should be referred when it would not be surprising if they did not survive two years and are at risk of using the hospital to manage their decline.

Parkinson's and Parkinson's Plus Syndromes

Patients should have developed an inability to tolerate dopamine therapy; be unsuitable for surgery; and have advanced comorbidity. This should include:

1. Decreased mobility: falls, use of a wheelchair or need for transfer assist
2. Pressure ulcers of stage 2 or greater
3. Dysphagia: coughing with oral intake or increased salivation
4. Cognitive change: dementia, hallucinations or behavioral changes

Pulmonary Disease

All patients must have or be able to obtain a nebulizer, an E-kit, plus:

a. FEV1 < 35
b. Oxygen dependent at rest or while sleeping

Criteria are flexible based on diagnosis.

Renal Disease

All patients should have refused dialysis.

1. Any patient with an eGFR of 15 or less
2. Any patient with an eGFR of 25 or less with comorbidities, e.g., poor biomarkers, infections, weight loss or pressure ulcers

Referral Process

For referrals, please send:

- Physician order
- Demographics
- Transitions diagnosis

You can provide the information in one of the following ways:

1. By **phone**: 619-667-1900
2. By **fax**: 619-740-8584 or 619-667-1904
3. SRS providers can send a referral via Touchworks: Start a New Note. Go to "Visit Type" and select "Hospice and Transitions Referral Form." Fill out the form, save, sign and finalize the note. The note will be automatically faxed to the Sharp Hospice Department.
4. From hospitals via **Enso** under "Sharp HealthCare/ HospiceCare" in the provider database

You have the option of sending patients to the Transitions Program with a dual order for hospice, allowing them to be evaluated for the most appropriate program at that time. You will be notified of the outcome.

For referral forms or additional information about our program, please visit our Professionals section on **sharp.com/transitions**.

Appendix A

Medicare's definition of maximum medical therapy is any of the following:

1. No further reasonable traditional therapy is available
2. Patient is intolerant to further therapy
3. Patient declines further therapy
4. Patient repeatedly decompensates due to severe noncompliance

Appendix B
Palliative Performance Scale (PPS)
Adapted Karnofsky (KPS)

%	Ambulation (1)	Activity and Evidence of Disease (2)	Self-Care (3)	Intake (4)	Conscious Level (5)
100	Full	Normal Activity, No Evidence of Disease	Full	Normal	Full
90	Full	Normal Activity, Some Evidence of Disease	Full	Normal	Full
80	Full	Normal Activity With Effort, Evidence of Disease	Full	Normal or Reduced	Full
70	Reduced	Unable to Do Normal Work	Full	Normal or Reduced	Full
60	Reduced	Unable to Do Most Activities, Significant Disease	Occasional Assistance	Normal or Reduced	Full
50	Mainly Chair	Minimal Activity, Extensive Disease	Considerable Assistance	Normal or Reduced	Full ± Confusion
40	Mainly Bed	As Above	Mainly Assisted	Normal or Reduced	Full or Drowsy ± Confusion
30	Bed Bound	As Above	Total Care	Reduced	Full or Drowsy ± Confusion
20	Moribund	As Above	Total Care	Sips	Full or Drowsy ± Confusion
10	Moribund	As Above	Total Care	Mouth Care Only	Drowsy or Coma
0	Death	0	0	0	0
Rate					

To calculate score:

1. Determine value for each of the five categories.
2. Add all values together.
3. Divide the total value by five.

* **Average score must be less than 50.**

Example:

(1) = 50 (2) = 40 (3) = 40 (4) = 20 (5) = 50

Total: $\frac{200}{5}$ **= 40**

Appendix C
Functional Assessment Staging Tool (FAST)

Score	Description
1	No difficulty either subjectively or objectively
2	• Complains of forgetting location of objects • Subjective work difficulties
3	• Decreased job functioning evident to co-workers • Difficulty in traveling to new location • Decreased organization capacity
4	Decreased ability to perform complex tasks such as: • Planning dinner for guests • Handling personal finances (e.g., forgetting to pay bills) • Difficulty shopping, etc.
5	• Requires assistance in choosing proper clothing to wear for the day, season or occasion • Repeatedly observed wearing the same clothing, unless supervised

Score	Description
6	A. Improperly putting on clothes without assistance or cueing (e.g., shoes on wrong feet, day clothes over night clothes, difficulty buttoning) B. Unable to bathe properly (e.g., difficulty adjusting bath water temperature) C. Unable to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) D. Urinary incontinence — intermittent or constant E. Fecal incontinence — intermittent or constant
7	A. Limited ability to speak six or more intelligible words in an average day or interview B. Speech ability is limited to the use of a single intelligible word in a normal interaction — demonstrates repetitive actions C. Ambulatory ability is lost (cannot walk without personal assistance) D. Cannot sit up without assistance, or falls over if no lateral arm rests on chair E. Loss of ability to smile F. Loss of ability to hold up head independently

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