THE UNIVERSITY OF ARIZONA
Arizona Center on Aging
www.aging.arizona.edu

June 2017

ELDER CARE

A Resource for Interprofessional Providers

Hospice Eligibility for Patients with COPD

Serena J. Scott, MD, Barry D. Weiss, MD, Ellyn Lee, MD, College of Medicine, University of Arizona

Chronic lung disease is the 4th most common cause of death among older adults in the United States. Each year, more than 140,000 older Americans die from direct complications of chronic lung disease, and another 70,000 (many of whom have chronic lung diseases) die from influenza and other lower respiratory tract infections. The vast majority of these individuals with chronic lung disease have chronic obstructive pulmonary disease (COPD). More than 3 million people worldwide died of COPD in 2015, representing 6% of all deaths that year. People dying from COPD frequently experience difficult and uncomfortable symptoms that lead to distress and panic. They commonly have disabling respiratory symptoms including severe breathlessness, limited tolerance for activity, and intractable coughing. They are also usually oxygen dependent, experience anorexia with weight loss and cachexia, and become dependent on others.

Despite the palliative care needs of individuals dying from end-stage COPD, only 30% of such individuals receive hospice care before death. Care in advanced disease is often suboptimal and inadequately coordinated, with patients suffering an average of 14 symptoms plus psychological and informational concerns prior to death. Furthermore, there is marked variation in the rate of hospice use across the US, with hospice enrollment in the highest-use states (Arizona, Colorado, and Florida) being more than triple the rate in lowest-use states (Alaska, Maine, South Dakota, Wyoming). Similarly in England, the hospital is the common place of death for patients with COPD, while deaths within hospice account for less than 1%. It is not clear why the rate of hospice use for patients with COPD is so low, but several explanations have been offered. The most important may be that few patients with severe COPD have discussed end-of-life planning with their clinician. Furthermore, many patients and clinicians do not view COPD as a terminal illness. Lack of awareness by clinicians that patients with chronic disorders, such as COPD, are eligible to receive hospice care may also contribute. Other reasons include lack of awareness that patients enrolled in hospice can continue to receive treatments for COPD, and the difficulty of establishing an accurate estimation of life expectancy in patients with COPD.

The fact is, however, that hospice, with its strong interdisciplinary approach, has been shown to improve quality of life for patients with end-stage respiratory disorders like COPD. Specific palliative treatments for the symptoms of late-stage COPD are discussed in another edition of Elder Care. In this issue, we discuss the need to consider involving hospice in the care of such patients, and the eligibility requirements established for receipt of such care under the Part A benefit of Medicare.

When to Consider Hospice Care for COPD

Determining prognosis is difficult in COPD. Clinicians often have 'prognostic paralysis' and may postpone end of life discussions with patients. While end-of-life-care is an appropriate topic to discuss with all patients, several factors have been suggested that should trigger this discussion with patients who have severe COPD. One factor is simply that a clinician would not be surprised if a patient with COPD were to die within the next 6-12 months. Another factor is if the patient's symptoms are no longer responding to current therapies. A clinician should consider hospice referral in a patient with COPD if they are experiencing any of the symptoms listed in Table 1.

Table 1. Clinical Symptoms That Should Prompt Hospice Referral for Patients with COPD
Persistent breathlessness despite optimal medical therapy
Inability to leave the house despite adequate rehabilitation
Increased frequency of hospital admissions
Limited improvement in symptoms after discharge
Unintentional weight loss
Increased fatigue and daytime somnolence

TIPS FOR DEALING WITH HOSPICE ELIGIBILITY FOR PATIENTS WITH COPD

- Don't forget that patients with advanced COPD are candidates for hospice care. Currently, hospice care is underused for COPD, with only about 30% of people who die from COPD receiving hospice care before death.
- Begin discussions about end-of-life care as soon as patient demonstrates findings of advanced COPD (Tables 1 & 2).
- Know the specific hospice eligibility criteria for patients with COPD (Table 3). Meeting these criteria makes a patient eligible for Medicare-funded hospice care, even if you are not certain the patient will die within 6 months.

Continued from front page

Other clinical characteristics warranting consideration of hospital care are found in Table 2. Note, however, that none of these factors are highly accurate for predicting length of survival. They are only reminders of the need to discuss end-of-life care.

Table 2. Clinical Characteristics That Should Prompt Discussion of End-of-Life Care for Patients with COPD*

Oxygen dependence	One or more hospitalizations for COPD in past year
FEV_1 < 30% predicted	Weight loss, cachexia, or decreased functional status
Age over 70	Comorbid conditions that might shorten life span

* Adapted from Curtis JR. Eur Resp J. 2008

Hospice Eligibility Criteria

If a Medicare enrollee meets certain eligibility criteria (Table 3), hospice care is a benefit covered by Part A of Medicare. There are both general hospice eligibility criteria and disease-specific supportive eligibility criteria.

General Hospice Eligibility Requirements

There are two general hospice eligibility requirements with which most clinicians are familiar. One is that a physician must attest that the patient's life expectancy is 6 months or less if the terminal illness runs its normal course. The other is that there should be specific clinical findings and other documentation supporting that prognosis.

Disease-Specific Hospice Eligibility Requirements

The problem in COPD is that there are no hard-and-fast criteria that predict life expectancy with a high degree of certainty. Nonetheless, there is general agreement that the criteria listed in Table 3 are reasonable predictors that a patient with COPD is in the terminal stages of the disease.

To meet these Medicare-accepted eligibility requirements, criteria 1, 2, and 3 must be present. The presence of criteria 4 and/or 5 provide supporting documentation. In some circumstances, patients may still be eligible for hospice care even if they don't meet these criteria. Such patients usually are experiencing a rapid decline in functional status, or have comorbidities that are consistent with a life expectancy of less than 6 months.

Table 3. Disease-Specific Hospice Eligibility Criteria for Patients with COPD

Required Criteria (1-3 must be present)	
1	Severe chronic lung disease as documented by both A and B
	A. Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity (e.g., as bed to chair existence, fatigue, and cough). Documentation of FEV_1, after bronchodilator < 30% of predicted, is objective evidence for disabling dyspnea, but measurement of FEV_1 is not a requirement
	B. Progression of end-stage pulmonary disease, evidenced by increasing visits to the emergency department or hospitalizations for pulmonary infections and/or respiratory failure or increasing physician home visits. Documentation of serial decrease of FEV_1 > 40 mL/yr is objective evidence for disease progression, demonstration of declining FEV_1 is not a requirement
2	Hypoxemia at rest on room air, evidenced by $PO_2 \leq 55$ mmHg or oxygen saturation ≤ 88% on supplemental oxygen determined either by arterial blood gas levels or oxygen saturation monitors, or hypercapnia, as evidenced by $PCO_2 \geq 50$ mmHg
3	Right heart failure due to pulmonary disease (cor pulmonale), and not due to left heart disease or valvulopathy
Supportive Criteria	
4	Unintentional progressive weight loss of >10% of body weight over the preceding 6 mo
5	Resting tachycardia > 100 beats/min

References and Resources

Connor SR, Elwert F, Spence C, Christakis NA. Geographic variation in hospice use in the United States in 2002. *Journal of Pain and Symptom Management*. 2007; 34:277-285.

Curtis JR. Palliative and end-of-life care for patients with severe COPD. *European Respiratory Journal*. 2008; 32:796-803.

Curtis JR, Engelberg RA, Nielsen EL, Au DH, Patrick DL. Patient–physician communication about end-of-life care for patients with severe COPD. *European Respiratory Journal* 2004;24:200–205.

Dean MM. End-of-life-care for COPD patients. *Primary Care Respiratory Journal*. 2008; 17:46-50.

Gold Standards Framework for End of Life Care. http://www.goldstandardsframework.nhs.uk

Higginson et al. Which patients with advanced respiratory disease die in hospital? A 14-year population-based study of trends and associated factors. BMC Medicine (2017) 15:19

Janssen DJ, Spruit MA, Alsemgeest TP, et al. A patient-centred interdisciplinary palliative care programme for end-stage chronic respiratory diseases. Int J Palliat Nurs. 2010;16:189-94.

World Health Organization. Chronic obstructive pulmonary disease (COPD). Geneva: WHO; 2015. http://www.who.int/mediacentre/factsheets/fs315/en/.

Interprofessional care improves the outcomes of older adults with complex health problems.

Editors: Mindy Fain, MD; Jane Mohler, NP-c, MPH, PhD; and Barry D. Weiss, MD

Interprofessional Associate Editors: Tracy Carroll, PT, CHT, MPH; David Coon, PhD; Marilyn Gilbert, MS, CHES; Jeannie Lee, PharmD, BCPS; Linnea Nagel, PA-C, MPAS, Marisa Menchola, PhD; Francisco Moreno, MD; Lisa O'Neill, DBH, MPH; Floribella Redondo; Laura Vitkus, BA

The University of Arizona, PO Box 245069, Tucson, AZ 85724-5069 | (520) 626-5800 | http://aging.arizona.edu

Supported by: Donald W. Reynolds Foundation, Arizona Geriatrics Workforce Enhancement Program and the University of Arizona Center on Aging

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U1QHP28721, Arizona Geriatrics Workforce Enhancement Program. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.