FREE WEBINAR
Hospice

Just Say YES!

Ensuring Eligible Patients Are Admitted to Hospice

with pioneering hospice physician
Marcia Levetown, MD, FAAHPM

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About the presenter

MARCIA LEVETOWN, MD, FAAHPM

Hospice physician

Objectives

- Be able to describe the critical difference between terminal prognosis and terminal diagnosis.
- Recognize the utility of specific measures to identify a terminal prognosis

.

- Be able to distinguish the patterns of illness and terminal path between different types of dementia.

Hospice Eligibility and Local Coverage Determinations (LCDs)

- The LCDs for the hospice's geographic area are used as guidelines to help a physician determine hospice eligibility. The LCDs are **not regulations and should not be used exclusively to determine or provide evidence of hospice eligibility**. **Certification or recertification is based upon a physician's clinical judgment, and is not an exact science**. Congress made this clear in Section 322 of the Benefits Improvement and Protection Act of 2000 (BIPA), which says that the hospice certification of terminal illness "shall be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness."

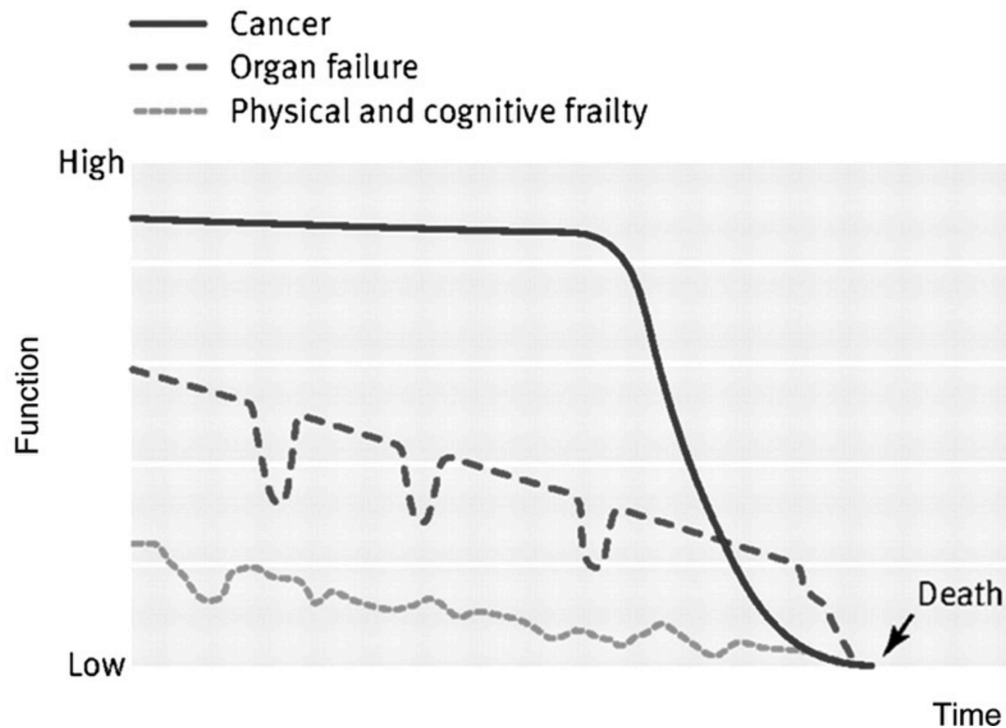
- **NHPCO website, accessed 6.24.17**

Terminal **Diagnosis** or Terminal **Prognosis**?

- Most people do not die of one thing.
- They may die before ever achieving the "end stage" of any diagnosis.
- While CMS requires a "primary diagnosis," what determines hospice eligibility is the aggregate picture of the patient's overall well-being and trajectory of illness.
- Be sure to list all complications of the primary diagnosis, as well as all complicating conditions that affect the patient's prognosis.
- Paint a picture of your assessment of prognosis — include general appearance.
- Look at the PERSON first, then figure out why he or she is dying!

Trajectories to Death

Murray and Sheikh, BMJ



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Tools to Recognize Terminal Prognosis

- The Surprise Question
- Medical History
- PPS
- Measures of Frailty, Flacker, and ADEPT Tools for LTC residents
- Differentiating Dementias Table

The Surprise Question

- Would you be surprised if this patient died in the next 6 months (1 year)?
- Applicable to numerous disease states
- Why?

Palliative Performance Scale

%	Ambulation	Activity/ Evidence of Disease	Self Care	Intake	Conscious Level
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 some evidence of disease	Full	Normal or reduced	Full
70	Reduced	Unable normal job/work some evidence of disease	Full	Normal or reduced	Full
60	Reduced	Unable hobby/house work significant disease	Occasional assistance necessary	Normal or reduced	Full or confusion

Palliative Performance Scale

%	Ambulation	Activity/ Evidence of Disease	Self Care	Intake	Conscious Level
50	Mainly sit/lie	Unable to do any work, extensive disease	Much assistance required	Normal or reduced	Full or confusion
40	Mainly in bed	Unable to do any work, extensive disease	Mainly assistance	Normal or reduced	Full or drowsy or confusion
30	Totally bed bound	Unable to do any work, extensive disease	Total care	Reduced	Full or drowsy or confusion
20	Totally bed bound	Unable to do any work, extensive disease	Total care	Minimal sips	Full or drowsy or confusion
10	Totally bed bound	Unable to do any work, extensive disease	Total care	Mouth care only	Drowsy or coma
0	Death				

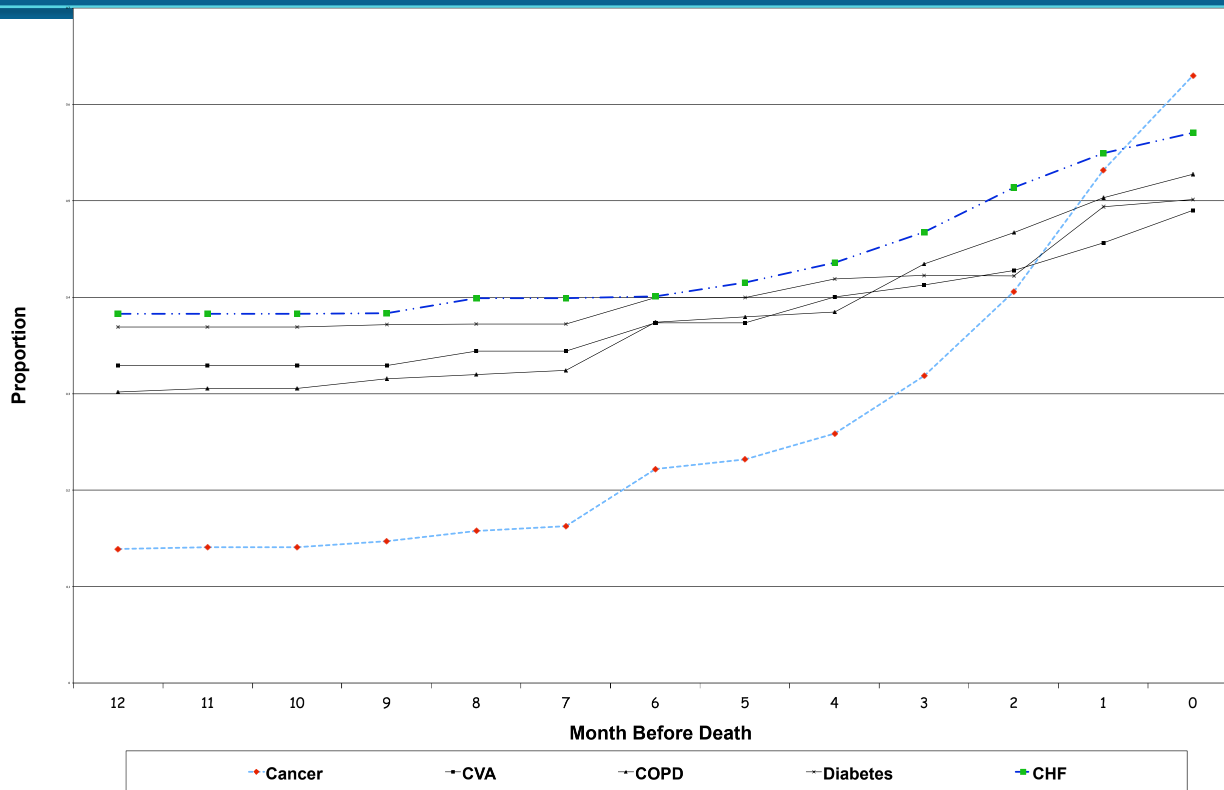
Frailty: Final Common Pathway?

- Weakness and unsteadiness
  - Falls
  - Slow ambulation
  - Poor hand grip
- Loss of IADLs, ADLs
- Loss of appetite and weight, >10% in 6 months
- Loss of energy and "excess" sleep hours
- Dyspneic at rest
- Pallor

Changes in Functional Status & Poor Px

- Cancer Patients
  - PPS $\leq$ 50 or ECOG $\geq$ 3
  - PPS $\leq$ 60 or ECOG $\geq$ 2 with symptoms
  - Decline in PPS of at least 20 units in 2-3months
- All Patients
  - Dependence in at least 3/6 Activities of Daily Living
  - PPS $\leq$ 50

Adjusted Proportion of People with Trouble Getting In and Out of Bed or Chair



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Medical History: Clues to End Stage Illness

- Frequent (2-3) readmissions for the same problem in the last 6 months
  - >60% chance of death
- ICU stay > 7 days
- CPR

CHF as an Exemplar of (not so) Difficult Prognostication

AF, 83 yo woman at SNF

- SNF post-hospzn for pneumonia + CHF exacerbation, prominent dyspnea
- Initially bedbound from hospitalization, improved w/ 20 days PT/OT
- Function
  - Walks w/ quad cane; difficulty getting around, slow gait, PPS 40-50%
  - Independent ADL prior to hospitalization, now needs 4-5/6 ADL assist due to fatigue, weakness
- Nutrition
  - Appetite fair, eats about 50% of food (100% 6 months ago)
  - Weight ↓ from 120 to 105 in 6 mo
- Cognition normal
- PMH
  - Hypertension x 40 years
  - Old CVA with residual left sided weakness
  - Arthritis
  - Hard of hearing

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Case of AF, continued…

- Medications
  - Amlodipine 10mg daily
  - Furosemide 20mg daily
  - Lisinopril 40mg daily
  - Toprol XL 50mg daily
  - Citalopram 20mg daily
  - APAP 500 mg every 6 hours as needed for pain
  - MVI
- Echo: EF 45% with concentric LVH
- Lived in an assisted living facility p/t hospitalization

Is AF **Terminally Ill** and **Hospice Eligible**?

NYHA Class and 1-year Mortality

NYHA Class	**Description** (fatigue, palpitations, or dyspnea)	Mortality 1-year
I	Symptoms only with more than ordinary activity	---
II	Symptoms with ordinary activity	7%
III	Symptoms with minimal activity	13%
IV	Symptoms at rest	20-52%

Compared NYHA 1, NYHA 4 5Xs increased risk hospital and 20Xs death

Eichorn, EJ. Prognosis determination in heart failure. *Am J Med* 2001

CHF Mortality with Optimal Medical Management

Study	Description	Patient Characteristics	Enrollment Period	1-year mortality	Median Survival
REMATCH	RCT LVAD VS OMM	NYHA III plus inotrope or NYHA IV	1998-2001	75%	5 months
COSI	Prospective study outpatients on inotropes	Stage D outpatients on chronic inotropes	1993-2002	94%	3.4 months
COMPANION	RCT of CRT vs OMM	NYHA III or IV with EF<35%	2000-2002	25%	Not available

Burden Heart Failure- Symptoms

Outcome	Heart Failure EF< or = 30%	Heart Failure >30%	Advanced Cancer
Number of physical symptoms	9.4 (1.1)	8.7 (1.2)	8.7 (1.5)
Depression Score	3.6 (0.6)	4.3 (0.6)	3.2 (0.8)
Spiritual Well Being	35.2 (1.8)	36.3 (1.9)	39.1 (2.3)

No significant difference between any of the groups.

Heart Failure Most Common Symptoms (>50%)

- Lack of energy
- Pain
- Feeling drowsy
- Dry mouth
- Shortness of breath
- Depression

Bekelman DB, et al. J Gen Intern Med 2009

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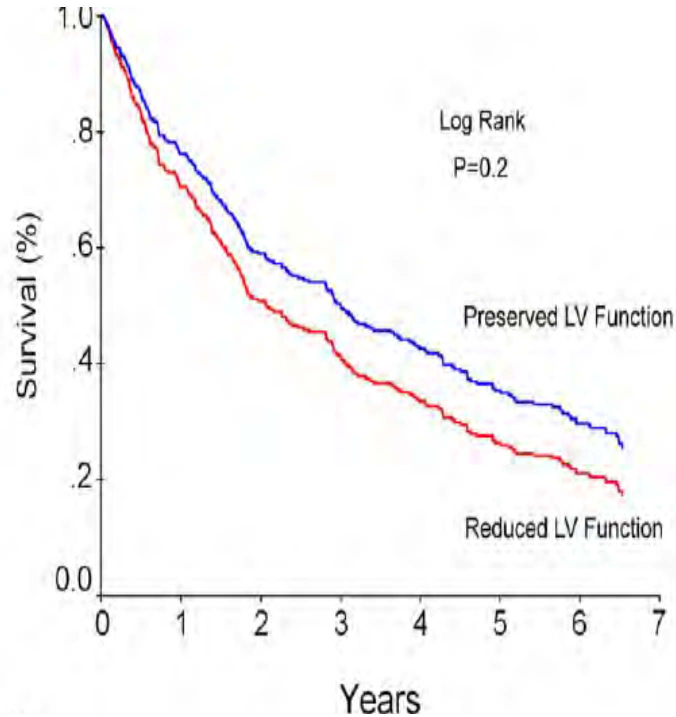
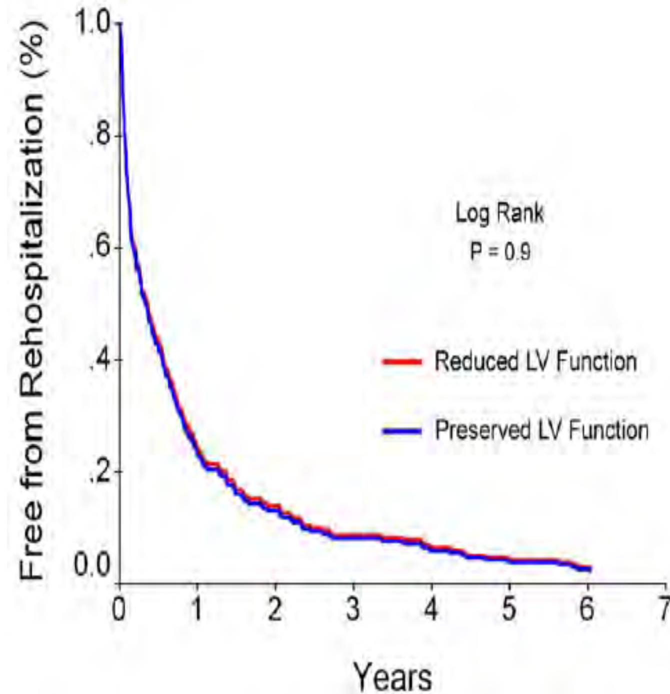
CHF Outcomes by Type





Gotsman I et al. Plos One 2012

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Cachexia and Mortality

- Cachexia = 7.5% weight loss over 6 mo period
- Mortality rates, independent of other factors
  - 18% at 3 months
  - 29% at 6 months
  - 39% at 12 months
  - 50% at 18 months

Anker SD. Wasting as an independent risk factor for mortality in chronic heart failure. Lancet 1997

Disease Related Prognostic Factors in CHF

- **Hospitalization and ED visits (utilization)**
- Inotrope use
- Inability to tolerate ACE or β -Blocker
- No longer responsive to increasing doses of diuretics
- ICD firing despite optimal medical management
- BUN > 30, (OR 5.8), Cr >1.4
- Serum sodium < 135, (OR 2.3)
- SPB< 120 mmHg on multiple occasions (OR 4.8)
- PAD, (OR 3.1)
- **Ongoing symptoms despite treatment**
- Difficult to control or new onset atrial fibrillation (Normal EF)

2013 ACCF/AHA Guideline for the Management of Heart Failure: Executive Summary and Huynh BC et al, JAGS, 2008 or OR of death in 6 mo

Returning to AF, 83 yo woman at SNF

- SNF post hospzn for pneumonia + CHF exacerbation, prominent dyspnea
- Initially bedbound from hospitalization, improved w/ 20 days PT/OT
- Function
  - Walks w/ quad cane; difficulty getting around, slow gait, PPS 40-50%
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  - Appetite fair, eats about 50% of food (100% 6 months ago)
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- PMH
  - Hypertension x 40 years
  - Old CVA with residual left sided weakness
  - Arthritis
  - Hard of hearing

AF, Hospice Admission?

- What would you list as the hospice diagnosis?
  - Primary
  - Supporting S/Sx
  - Comorbidities

AF, Hospice Admission Certification

- Primary
  - CHF preserved ejection fraction
- Supportive S/Sx
  - ADL dependence
  - Decreased food intake, > 10% Weight loss
  - Dyspnea
  - Fatigue/Weakness
  - Hypertension
  - Weight loss
- Comorbidity- DJD, HOH, remote CVA, Depression

Statement of Prognosis

AF is terminally ill w/ a PX of <6 mo if the illnesses runs its usual course. Her primary hospice diagnosis is CHF with preserved ejection fraction.

AF has NYHA CHF stage III to IV, w/ prominent dyspnea, weakness and a recent rapid functional decline:

- PPS ↓ from 70% to 40-50% over 6 mos
- Needs assist w/ 5/6 ADLs due to fatigue and weakness
- Cachexia; 12.5% wt loss (120➔105, 6 mo) w/ a fair appetite (eats ~ 50% of meal, down from 100% 6 mo ago)

S/SX supporting Px of <6 mo include recent hospitalization, rapid functional decline, weight loss, and ongoing symptoms of heart failure despite optimal treatment. Additional supportive features include depression and hypertension.

Evaluating Dementia Patients for Hospice

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Hospice Use Among NH Patients

Unroe K, Sachs G JAMDA 2013

- Data from 11 yrs: 33,387 pts > 65, CMS claims, MDS data
- 32% LTC, 11% had hospice, 30% of hospice pts had overlapping LTC stay= 1452 subjects
- 71% had non-CA dx
  - CA 60% of pts in 1998 →24% in 2009
  - Dementia 22%; CHF, COPD, Dementia, FTT all ↑ over time
- Mean LOS 114 days, median 36 days
- 92% of NH Hospice pts had 3 or more co-morbid diseases

Hospice Use Among NH Patients

Unroe K, Sachs G JAMDA 2013

LOS Statistics: Mean LOS 46d (1999),↑ to 93d (2006)

- 23% had LOS <7 days
- 48% had LOS < 30 days
- 19.7% had LOS > 180 days
- Predictors of longer LOS:
  - LOS in LTC
  - Lack of hospitalization in year prior to hospice enrollment
  - Hospice disenrollment (18%)- associated w/ non-white race (40% minority sample)
    - 16% died w/in 7 d; 27% w/in 30d; 53% by 1 yr

JG, an 88 yo with Dementia

- 88 y/o woman w/ “Alzheimer’s disease” x 5 yrs
- Recent accelerated functional decline
  - Walking to bedbound in 3 months, no falls
  - 5/6 ADL dependence
  - Last couple weeks difficulty swallowing developed
  - Ongoing restlessness and agitation
  - FAST 6E with fecal incontinence, PPS=30-40%
- Able to respond appropriately to simple questions
- Weight loss due to poor appetite, 10% 6 months, BMI 19
- PMH
  - Poorly controlled HTN
  - Hypothyroid
  - Arthritis and chronic low back pain
  - s/p CVA with LUE weakness

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Case of JG continued...

- Medications
  - Amlodipine 5mg bid
  - Hydralazine 50mg bid
  - Lisinopril 40mg daily
  - Metoprolol 50mg twice daily
  - Ativan 0.5mg as needed
- SH - lives with husband provides 24 hour care

Hospice Eligible?

- What would you list as the hospice diagnosis?
  - Primary
  - Secondary
  - Comorbidity

Dementia Diagnosis:
Most often a combination (50-75%)

Dementia Types

- Alzheimer disease 35-55%
- Vascular 20-40%
- Lewy Body 0-30%
- Frontotemporal dementia 5%
- Parkinson related
- Previous head trauma
- Alcohol
- B12 deficiency

Contributory Medical Conditions

- Delirium
- Liver disease
- Renal failure
- Depression
- Sleep apnea

Approach to Delineate Dementia Diagnosis

- Difficult to delineate underlying dementia diagnosis once progression to moderate stage or greater
- History, history, history!
  - Health care decision maker and other family
  - Health care provider
  - Medical records
    - Physician notes
    - Hospital records
    - Neuropsychological testing
    - Neuroimaging

Characteristics of Common Dementias

Diagnosis	Characteristics	Trajectory
Alzheimer Disease	Memory loss, language, and visuospatial compromise	4-6 yrs, slowly progressive
Vascular Dementia	Heterogeneous (macrovascular, microvascular, subcortical)	Variable Previously described as stepwise
Lewy Body Dementia	Parkinsonian rigidity, Visual hallucinations, and fluctuations	4-10 yrs, slowly progressive
Frontotemporal	Personality changes, emotional lability, loss of insight, perseveration	Early onset, 8-11 years, some rapidly progressive

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Alzheimer Prognosis: FAST Score

- FAST is accurate ONLY for Alzheimer disease.
  - Do NOT report FAST score for other dementias.
  - Progression of illness in Alzheimer disease follows a strict pattern, though not timeline.
  - FAST 7c/d portends <= 6 month life expectancy, but is not exact.
  - Pneumonia is the means by which the patient dies in 54% of cases.
    - Urosepsis, sepsis constitute the vast majority of the remaining final complications.
    - Patients may also die of cardiac, pulmonary, cancer related problems and other causes.
  - Report pneumonia as proximal cause of death, as appropriate, but be sure to list Alzheimer disease as the underlying or primary diagnosis.
    - Research dollars are allocated based on death certificates.

Vascular Dementia

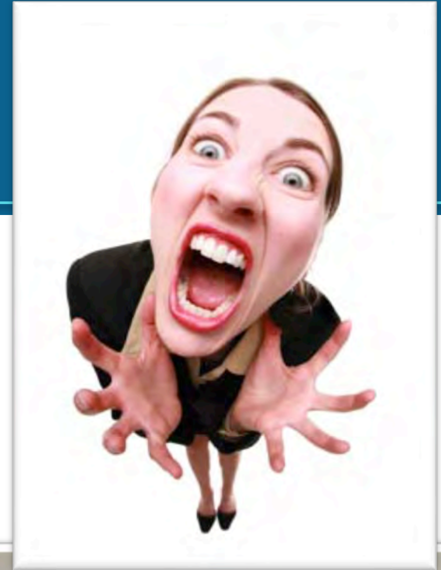
- "Stair-step progression," but often mixed with Alzheimer disease.
- May plateau for many, many years.
  - While difficult on caregivers, we are constrained to only take patients with a short life expectancy.
- Poor swallowing coordination with choking and aspiration is a reliable marker of the terminal phase of illness.
- FAST does NOT apply. Patients may lose the ability to talk and not be terminally ill.

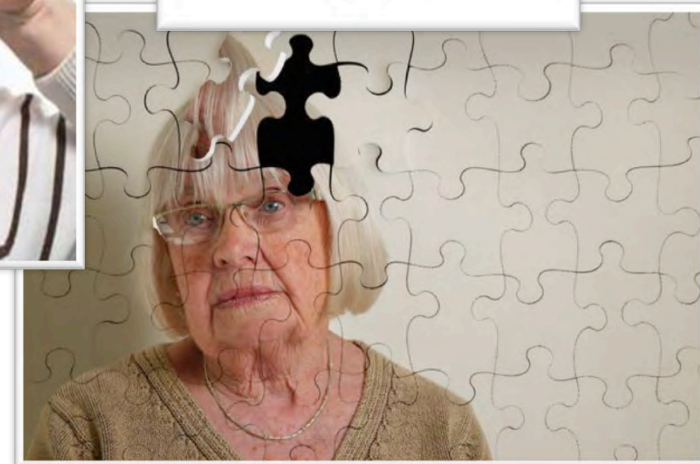
Vascular Dementia:
Subcortical, strength, coordination

Frontotemporal Dementia (FTD)

- Affects younger patients
- Often familial
- Male predominance
- Social dysfunction early in the course of illness
- Swallowing dysfunction also portends terminal prognosis

Frontotemporal Dementia
(FTD/ Pick's Disease, PPA)





Dx to Death 2-5 (FTD)
& 10-20 (PPA) Years

Diffuse Lewy Body Disease & Parkinson's Dementia

- Hallucinations early in the history of illness LBD

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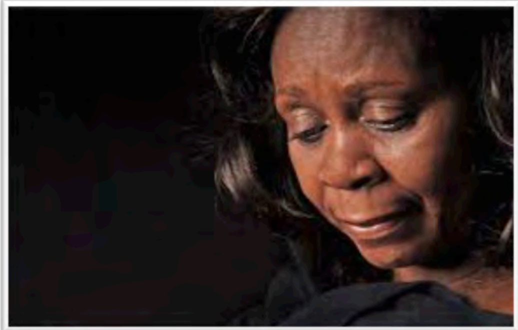
Parkinson disease-related dementia

- Very late complication of illness
- Patient has a long history of movement disorder
- Swallowing dysfunction (choking, coughing while eating, pneumonia) portends terminal phase of illness

Autonomic Symptoms, PD

Patients are all too aware of their loss of function & future.



Depression is very common in Parkinson's Dementia & Diffuse Lewy Body Disease.

Hospice Guide to Common Dementias

Hospice dementia cases appear similar, but two major clues will reveal the correct diagnosis – the duration of brain disease and the original symptoms.

Years since the first symptoms of the dementia appeared?

First symptom of the brain disease?	10-15yrs	Anytime	5-8yrs	10yrs	10-20yrs	2-5yrs
Repeating themselves, forgetfulness	Alzheimers					
Sudden stepwise worsening		Vascular				
Visual hallucinations or gait disturbance with dementia			DLB			
Dementia beginning years after Parkinsons disease				Parkinsons		
Steady loss of language skills then speech					FTD	
Bizarre or psychotic behavior						FTD (Pick's)
Coding Guide						
ICD 9	331	290.4-	331.82	331.82	331.19	331.11
ICD 10	G30.-	F01.5-	G31.83	G31.83	G31.09	G31.01

Typical cases

Alzheimers	Began asking the same question and repeating the same stories over and over 12 years ago.
Vascular dementia	Suffered a stroke 10 years ago and and had memory problems but remained capable until two months ago when she suffered a second stroke.
Dementia with Lewy Bodies	Started having visual hallucinations 8 years ago soon followed by difficulty walking
Parkinsons	Began having tremor and balance difficulty 7 years ago
Frontotemporal dementia	Started having trouble finding her words and naming things 18 years ago
FTD (Pick's)	Developed severe paranoia and irritability 3 years ago

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Function

- Palliative Performance Scale
  - Current and 6 month ago
- FAST (Alzheimer disease ONLY)
- Hours asleep in a 24 hour period
- Contractures
- Activity Daily Living
  - Bathing, dressing, ambulation, continence, and eating

Cognition

- Follows commands
- Recognizes family/caregiver
- Recognizes the environment
- Interacts with environment

Disease-related Complications

- Pneumonia
- Pyelonephritis/UTI
- Sepsis
- Febrile episode
- **Eating problem**
- Pressure sores
- Hip fracture
- Feeding tube decision
- **Poor nutritional status**

Nutrition

- Body Mass Index- now and 3-6 months ago
- Mid-arm muscle area (non-dominant arm)
- Choking on and/or pocketing food
- Poor nutritional intake
  - Meals per day (consider size of meal)
  - Proportion consumed
- Time it takes to feed

Natural History of Dementia

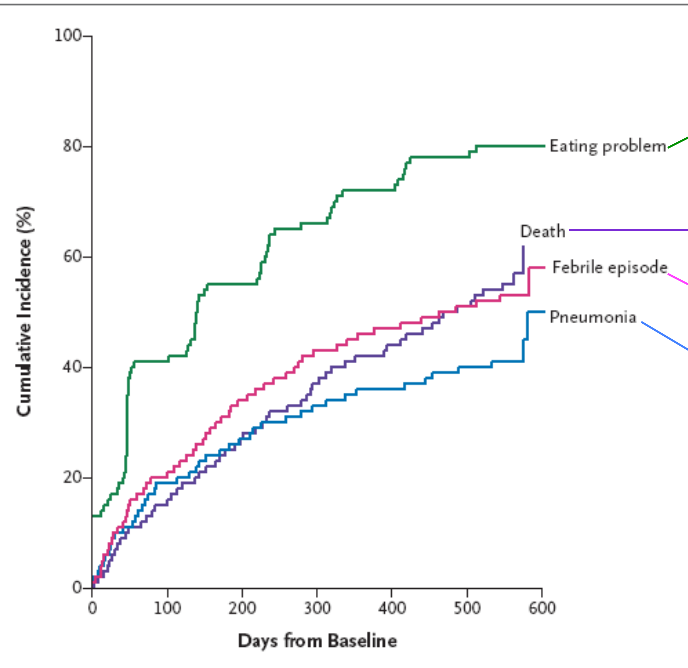

Figure 1. Overall Mortality and the Cumulative Incidences of Pneumonia, Febrile Episodes, and Eating Problems among Nursing Home Residents with Advanced Dementia.

Overall mortality for the nursing home residents during the 18-month course of the study is shown. The residents' median age was 86 years, and the median duration of dementia was 6 years; 85.4% of residents were women.

6 month mortality 38.6%

- Median survival was 478 days, 24.7% within 6 months
- 54.8% died, 93.8% in NH

6 month mortality 44.5%

6 month mortality 46.7%

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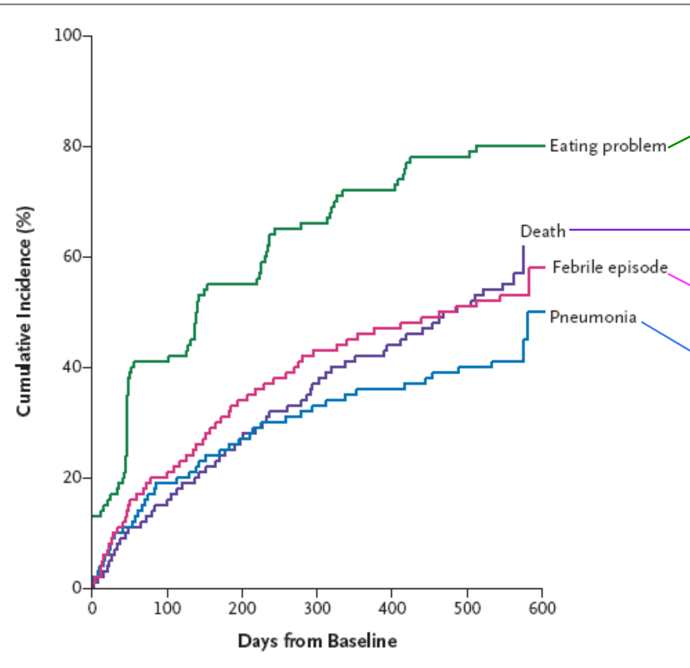
Natural History of Dementia



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- 54.8% died, 93.8% in NH

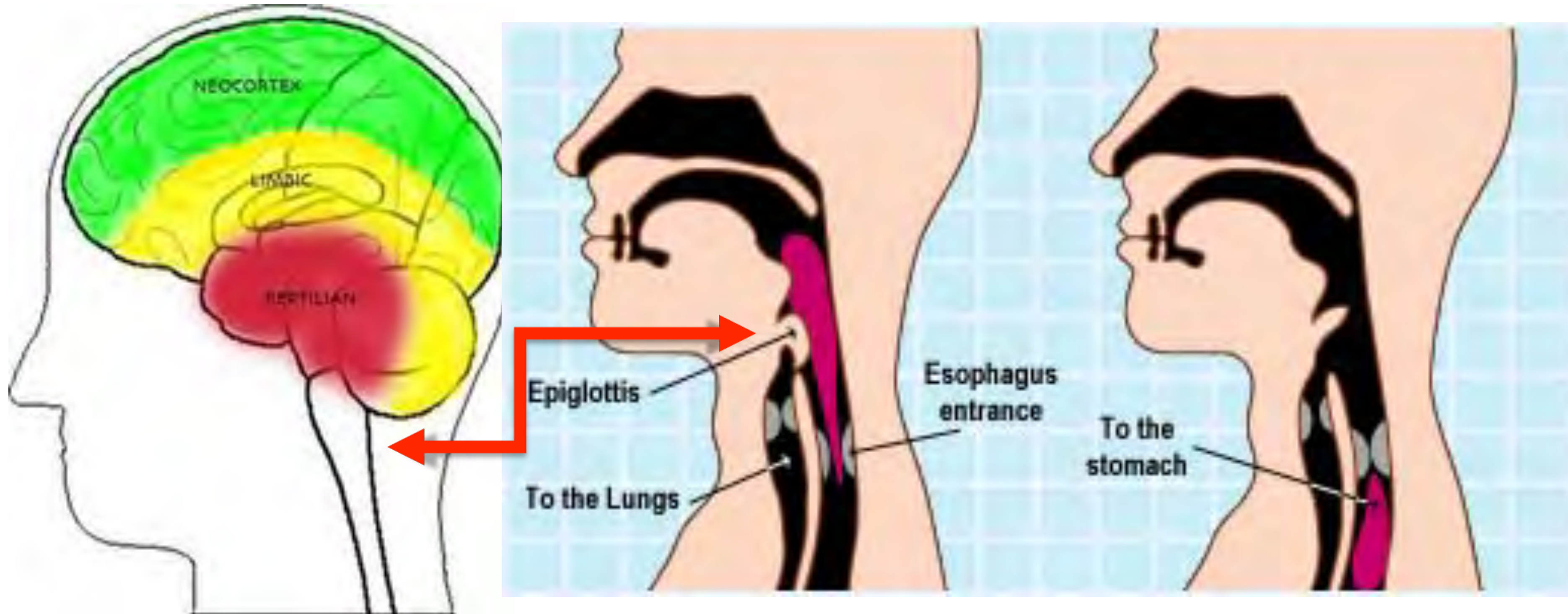
6 month mortality 44.5%

6 month mortality 46.7%

Sentinel events (42) rarely caused death:

- Seizures (14)
- GI bleeding (11)
- Hip / bone fracture (7)
- Stroke (3)
- PE (1)
- MI (1)
- Other (5)

Pneumonia: Inevitable



Secondary Supportive Conditions

- **Agitation and/or restlessness (usually, delirium)**
- Falls
- **Rapid functional decline**
- **Day/Night Reversal**
- Parkinsonian movements

JG, the woman with dementia

- 89 y/o woman w/"Alzheimer's disease" x 5 yrs
- Recent accelerated functional decline
  - Walking to bedbound in 3 months, no falls
  - 5/6 ADL dependence
  - Last couple weeks difficulty swallowing developed
  - Ongoing restlessness and agitation
  - FAST 6E with fecal incontinence, PPS=30-40%
- Able to respond appropriately to simple questions
- Weight loss due to poor appetite, 10% 6 months, BMI 19
- PMH
  - Poorly controlled HTN
  - Hypothyroid
  - Arthritis and chronic low back pain
  - s/p CVA with LUE weakness

JG, Neuroimaging

- CT scan of the head obtained as part of recent hospital admission for agitation
  - Extensive small vessel disease
  - Old large left cortical infarct
  - Multiple subcortical infarcts
  - No new ischemic or hemorrhagic area identified

Hospice Eligible?

- What would you list as the hospice diagnosis?
  - Primary
  - Secondary
  - Comorbidity

JG, Hospice Admission Certification

- Primary
  - Alzheimer Disease with Multi-infarct dementia r/t htn, s/p CVA
- Secondary symptom complex
  - Agitation
  - Sleep-wake disturbance
  - Weight loss
- Comorbidity- DJD, HOH, hypothyroid, Low back pain

JG, Statement of Prognosis

- JG is terminally ill with a PX of < 6 mos if the illnesses runs its usual course. She is eligible for hospice services, based on mixed Alzheimer and multi-infarct dementia.
- JG has experienced rapid fxnl decline, going from ambulatory to bedbound over 3 mos. She has a PPS of 30 to 40%, is dependent in 5/6 ADL except feeding. She is awake ~ 7 hrs / d down from 12 hrs /d 3 months ago. She eats only 30-50% of 2 small meals/ day, down from 100% of 3 meals/day.
- Disease related complications supporting a Px of< 6 mo include recent development of difficulty swallowing and 10% weight loss over the last 6 mos. Additional supportive features of a poor PX include agitation, and day/night reversal.

How Do We Determine PX in LTC? Flacker Mortality Score, <12 M

- Age > 88 years DOB-MDS Section AO 900 or face sheet, score +1.48.
- Male MDS Section AO 800, Score + 1.76.
- Functional Ability Score (FAS), MDS Section G0110, FAS > 4, score +2.50
  - (See next slide to calculate FAS.)
- Congestive Heart Failure MDS Section IO 600, score + 1.57.
- Shortness of Breath MDS Section J400, score +2.08.
- Swallowing Problems MDS Section K01004, score +1.81.
- Wt Loss > 5lbs in 30 d / 10 lbs in 180d MDS Sec K0300, score +2.26.
- Body Mass Index <22 kg/m2, MDS Section K0200, score + 1.75
    - Total Score:

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Functional Ability Score for the Flacker Mortality Score

Use MDS Section G1 data for the following seven items. Each item is scored from **0** (no impairment) to **4** (high impairment). Summary scale scores range from **0–28.**

- Bed mobility ________
- Transferring ________
- Eating ________
- Toileting ________
- Hygiene ________
- Locomotion on unit ________
- Total ________

Source: Flacker, J. M., & Kiely, D. K. (1998).

Flacker Mortality Score (continued)

Total score = probability of dying within 12 months

- 0–2 = 7%, no intervention
- 3–6 = 19%, no intervention
- 7–10 = 50%, Begin palliative care best practice and consider hospice discussion
- 11+ = 86% Begin palliative care best practice and consider hospice discussion

Flacker JM JAGS 1998, 2003
Also see https://eprognosis.ucsf.edu/flackernew.php

Advanced Dementia Prognostic Tool (ADEPT)

Mitchell, S. L., Miller, S. C., Teno, J. M., 2010

- Age, Male
- NH LOS
- Dyspnea
- Pressure ulcer >=2
- ADL Score = 28
- Bedfast most of the day
- Poor po intake, wt loss, BMI <18.5
- Bowel incontinence
- CHF

Summary

- Look at the **patient**, not the diagnosis list.
  Is he or she dying?
- **Then** figure out the reason the patient is dying.
- **Then** document everything that is evidence of or contributing to the patient's dying process.

You are now **ready**

to go out each day and
bring the benefits of hospice
care to **all** who are eligible,
regardless of disease process!

Thank you!

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Appendix

- Hospice Guide to Common Dementias
- Flacker Mortality Score worksheet

Hospice Guide to Common Dementias

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	Years since the first symptoms of the dementia appeared?					
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Sudden stepwise worsening		Vascular				
Visual hallucinations or gait disturbance with dementia			DLB			
Dementia beginning years after Parkinsons disease				Parkinsons		
Steady loss of language skills then speech					FTD	
Bizarre or psychotic behavior						FTD (Pick's)

Coding Guide

ICD 9	331	290.4-	331.82	331.82	331.19	331.11
ICD 10	G30.-	F01.5-	G31.83	G31.83	G31.09	G31.01

Typical cases

Alzheimers	Began asking the same question and repeating the same stories over and over 12 years ago.
Vascular dementia	Suffered a stroke 10 years ago and and had memory problems but remained capable until two months ago when she suffered a second stroke.
Dementia with Lewy Bodies	Started having visual hallucinations 8 years ago soon followed by difficulty walking
Parkinsons	Began having tremor and balance difficulty 7 years ago
Frontotemporal dementia	Started having trouble finding her words and naming things 18 years ago
FTD (Pick's)	Developed severe paranoia and irritability 3 years ago

Flacker Mortality Score

Using the Flacker Mortality Score* and the Resident Assessment Instrument to Identify Resident at High Risk for Dying Within One Year

Resident: ___________________________________ **Date:** _________________________

Resident Characteristic	Information Location	Scoring Chart	Score
Functional Ability Score	MDS Section **G1**.See Chart Below	If Summary functional ability score is greater than 4, Score **2.50**.	
Weight Loss	Weight sheet	If lost 5 or more pounds in last 30 days or 10 or more pounds in last 180 days, score **2.26**.	
Shortness of Breath	MDS Section **J1l**	If has shortness of breath, score **2.08**.	
Swallowing Problems	MDS Section **K1b**, **K5c**, also see diet order for special texture	If has swallowing problems, score **1.81**.	
Male Sex	MDS Section **AA2**	If Male, Score **1.76**.	
Body Mass Index	MDS Section **K2** – Use BMI Chart	If BMI is less than 22 kg/m2, score **1.75**.	
Congestive Heart Failure	MDS Section **l1f**	If has CHF, score **1.57**.	
Age > 88 Years	DOB – MDS Section **AA3** or face sheet	If age greater than 88, score **1.48**.	

If Total Score Is	Probability of dying within 1 year is approximately:
0 - 2	7%
3 - 6	19%
7 - 10	50%
11 +	86%

Flacker Mortality Score

Functional Ability Score: To derive functional ability score, use MDS Section **G1** data for the following 7 items: Each item is scored on a scale of 0 (no impairment) to 4 (high impairment), for a summary scale score ranging from 0-28.

a) Bed Mobility ______
b) Transferring ______
c) Eating ______
d) Toileting ______
e) Hygiene ______
f) Locomotion on unit ______
g) Dressing ______
h) Total ______

*Derived from: Flacker, J.M. & Kiely, D.K. (1998). A practical approach to identifying mortality-related factors in established long-term care residents. *Journal of the American Geriatrics Society*, 46, 1012-1015.