Transitions Guidelines: Chronic Illness Management

Revised 2025

SHARP

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.

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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 their medical diagnoses, 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 a Sharp Rees-Stealy or Sharp Community Medical Group Medicare Advantage Plan.

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.

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 2 years or less (mean and median about 12 to 18 months)

6. Appropriate documentation is available to support 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.

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
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, 10 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 1 month)
- Low hemoglobin
- Elevated CRP, hyponatremia, elevated BUN/Creatinine

LABS SHOULD BE COMPLETED WHILE PATIENT IS IN THEIR 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

Qualifying Criteria

- Patient demonstrates all 5 criteria above plus low albumin OR low cholesterol (off statin medications for at least 1 month)
- Patient demonstrates 4 of the criteria plus 2 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 2 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

- **Hospitals use CarePort**

- **Sharp Epic users:**
  - Select: Ambulatory Referral to Sharp Hospital Transitions [REF254]
  - Ref to Department: SHC TRANSITIONS
  - Referral Reason: Specialty Services Required
  - Referral Priority: Routine
  - Class: Internal Referral (for Sharp HealthCare only)
  - Dept Specialty: Home Health Services
  - Comments: Please complete the information requested:
    - Patient/family aware of referral
    - Physician to provide patient's care
    - Referring provider callback phone number
    - Special instructions

- **Non-Epic Referrals**
  - By phone: 619-667-1940
  - By fax: 619-740-8584 (with signed physician order)
    - Referral form: sharp.com/hospice

For additional information about our programs, please visit **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) v2

PPS Level	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal Activity and Work, No Evidence of Disease	Full	Normal	Full
90%	Full	Normal Activity and Work, 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 to Do Normal Work, Significant Disease	Full	Normal or Reduced	Full
60%	Reduced	Unable to Do Hobby/Housework, Significant Disease	Occasional Assistance Necessary	Normal or Reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to Do Any Work, Extensive Disease	Considerable Assistance Required	Normal or Reduced	Full or Confusion
40%	Mainly in Bed	Unable to Do Most Activity, Extensive Disease	Mainly Assistance	Normal or Reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to Do Any Activity, Extensive Disease	Total Care	Normal or Reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to Do Any Activity, Extensive Disease	Total Care	Minimal to Sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to Do Any Activity, Extensive Disease	Total Care	Mouth Care Only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Instructions for Use of PPS (see also Definition of Terms for PPS)

1. PPS scores are determined by reading horizontally at each level to find a "best fit" for the patient, which is then assigned as the PPS % score.

2. Begin at the left column and read downward until the appropriate ambulation level is reached, then read across to the next column and downward again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, "leftward" columns (columns to the left of any specific column) are "stronger" determinants and generally take precedence over others.
   - **Example 1:** A patient who spends most of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances, but who is otherwise fully conscious with good intake, would be scored at PPS 50%.
   - **Example 2:** A patient who has become paralyzed and quadriplegic requiring total care would be PPS 30%. Although this patient may be placed in a wheelchair (and perhaps seem initially to be at 50%), the score is 30% because they would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care, including lift/transfer. The patient may have normal intake and full conscious level.
   - **Example 3:** However, if the patient in example 2 was paraplegic and bed bound but still able to do some self-care, such as feeding themself, then the PPS would be higher at 40% or 50% because they are not "total care."

3. PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two that seem better at a higher or lower level. One then needs to make a "best fit" decision. Choosing a "half-fit" value of PPS 45%, for example, is not correct. The combination of clinical judgment and "leftward precedence" is used to determine whether 40% or 50% is the more accurate score for that patient.

4. PPS may be used for several purposes. First, it is an excellent communication tool for quickly describing a patient's current functional level. Second, it may have value in criteria for workload assessment or other measurements and comparisons. Finally, it appears to have prognostic value.

Definition of Terms for PPS

As noted below, some of the terms have similar meanings with the differences being more readily apparent as one reads horizontally across each row to find an overall "best fit" using all five columns.

1. Ambulation

The items "**mainly sit/lie**," "**mainly in bed**" and "**totally bed bound**" are clearly similar. The subtle differences are related to items in the self-care column. For example, "totally bed bound" at PPS 30% is due to either profound weakness or paralysis such that the patient not only can't get out of bed but is also unable to do any self-care. The difference between "sit/lie" and "bed" is proportionate to the amount of time the patient is able to sit up vs. need to lie down.

"**Reduced ambulation**" is located at the PPS 70% and PPS 60% level. By using the adjacent column, the reduction of ambulation is tied to inability to carry out their normal job, work occupation, or some hobbies or housework activities. The person is still able to walk and transfer on their own but at PPS 60% needs occasional assistance.

2. Activity and Extent of Disease

"**Some**," "**significant**" and "**extensive**" disease refer to physical and investigative evidence that shows degrees of progression. For example, in breast cancer, a local recurrence would imply "some" disease; one or two metastases in the lung or bone would imply "significant" disease; and multiple metastases in lung, bone, liver, brain, hypercalcemia or other major complications would be "extensive" disease. The extent may also refer to progression of disease despite active treatments. Using PPS in AIDS, "some" may mean the shift from HIV to AIDS, and "significant" implies progression in physical decline, new or difficult symptoms, and laboratory findings with low counts. "Extensive" refers to one or more serious complications with or without continuation of active antiretrovirals, antibiotics, etc.

The above extent of disease is also judged in context with the ability to maintain one's work and hobbies or activities. Decline in activity may mean the person still plays golf but reduces from playing 18 holes to 9 holes, or just a par 3 course, or to backyard putting. People who enjoy walking will gradually reduce the distance covered, although they may continue trying, sometimes even close to death (e.g., trying to walk the halls).

3. Self-Care

"**Occasional assistance**" means that most of the time patients are able to transfer out of bed, walk, wash, toilet and eat by their own means, but that on occasion (perhaps once daily or a few times weekly) they require minor assistance.

"**Considerable assistance**" means that every day the patient regularly needs help, usually by one person, to do some of the activities noted above. For example, the person needs help to get to the bathroom but is then able to brush their teeth or wash at least their hands and face. Food will often need to be cut into edible sizes, but the patient is then able to eat on their own.

"**Mainly assistance**" is a further extension of "considerable." Using the above example, the patient now needs help getting up but also needs assistance washing their face or shaving, but "**total care**" means that the patient is completely unable to eat without help, toilet or do any self-care. Depending on the clinical situation, the patient may or may not be able to chew and swallow food once prepared and fed to them.

4. Intake

Changes in intake are quite obvious, with "**normal intake**" referring to the person's usual eating habits while healthy.

"**Reduced**" means any reduction from that and is highly variable according to the unique individual circumstances.

"**Minimal**" refers to very small amounts, usually pureed or liquid, which are well below nutritional sustenance.

5. Conscious Level

"**Full consciousness**" implies full alertness and orientation with good cognitive abilities in various domains of thinking, memory, etc. "**Confusion**" is used to denote presence of either delirium or dementia and is a reduced level of consciousness. It may be mild, moderate or severe with multiple possible etiologies. "**Drowsiness**" implies either fatigue, drug side effects, delirium or closeness to death, and is sometimes included in the term stupor. "**Coma**" in this context is the absence of response to verbal or physical stimuli; some reflexes may or may not remain. The depth of coma may fluctuate throughout a 24-hour period.

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 6 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

Notes

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