Hospice Eligibility

Healthcare Provider Guide

ST. JOSEPH
HOSPICE

Providing Peace, Comfort & Dignity

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INTRODUCTION

St. Joseph Hospice is committed to being a valuable and reliable source of information to our partners in the healthcare industry. We created this guide to help healthcare professionals identify and communicate with patients who meet hospice eligibility criteria, physicians and referral sources.

This guide provides general and diagnosis-specific criteria used to determine a patient's eligibility for hospice care, along with useful information to help you discuss hospice care with your patient.

WHY ST. JOSEPH HOSPICE?

St. Joseph Hospice has earned a solid reputation as an industry leader throughout the south, having served patients since 2002.

- Board Certified Palliative Care Physicians available for consult 24/7
- Staff specifically trained for **intensive hospice support**, and inpatient hospice facilities available.
- Locally-owned and operated
- Network of locations throughout Southeast Texas, Louisiana, Mississippi and South Alabama for relocations and/or emergency evacuations

HOSPICE ELIGBILITY GUIDELINES

HOSPICE ELIGIBILITY GUIDELINES

Hospice is designed to provide comfort and support to patients and families during the final stages of life. This service is available to persons who, according to their physician, have entered the last 6 months of life, if their disease progression runs its normal course. Having made the decision to forego further curative measures, the focus of care is on comfort *(palliative)* care, with a goal of *making every day a good day.* Hospice provides relief from pain and symptoms. Care is provided wherever the patient calls home *(including assisted living facilities, nursing homes or hospitals)*.

GENERAL GUIDELINES

Eligibility criteria in this guide are related to specific diagnoses provided by the Centers for Medicare and Medicaid *(CMS)* at ***CMS.gov***. Although limited to a select list of diagnoses for hospice benefit coverage, the list is not all-inclusive. Some patients may not meet all criteria in this guide, but may still be eligible for hospice. In addition, any disease process in the terminal stage is appropriate for hospice care. Hospice appropriate individuals may exhibit some or all of the following:

- Frequent hospitalizations
- Progressive weight loss
- Deteriorating mental abilities
- Recurrent infections
- Specific decline in conditions
- Decrease in functional ability

WHO SHOULD RECEIVE HOSPICE CARE?

- People with a life-limiting illness
- Patients and families who have chosen to focus on symptom management rather than curative treatment
- Patients and families who choose no extreme measures

THE ST. JOSEPH HOSPICE TEAM

The **St. Joseph Hospice** team works with physicians and medical professionals to formulate a plan of care tailored to each patient's needs. The plan may include medical and support care, social services, physician visits, education, psycho-social and bereavement counseling. The team includes:

- Board Certified Hospice & Palliative Care Physicians
- Hospice-Experienced Nurses
- Social Workers
- Chaplains
- Certified Nursing Assistants
- Bereavement Counselors, and
- Hospice-Trained Volunteers

We address the ***physical, emotional and spiritual needs*** of patients and their families.

DIAGNOSIS GUIDELINES

CANCER

Patients will be considered to be in the terminal stage of cancer if they meet the following criteria; factors 1 and 2 must be present, and either factor 3 OR 4 **must** be present. Consider all factors that impact the patient's prognosis.

1. Palliative Performance Scale ≤ 70% *See Appendix: Palliative Performance Scale (PPS)*
2. Dependence in 2 or more ADLs
3. Evidence of malignancy or metastases in pathology report.
4. Progression from earlier stage of disease to metastatic disease with either: ·

- Continued decline in spite of therapy; OR
- Patient declines further disease-directed therapy

NOTE: Certain cancers with poor prognoses may meet the guidelines without fulfilling other criteria in this section.

Comorbid or Secondary Conditions:

- COPD
- CHF
- Liver Disease
- Alcoholism
- Renal Failure
- Dementia
- Neurological Disease
- End-Stage HIV Disease

Patients who meet the criteria above are, by definition, eligible to receive hospice services. ***Some patients may not meet the criteria but may still be eligible for hospice care due to comorbidities or rapid functional decline***.

CARDIAC DISEASE

Patients will be considered to be in the terminal stage of cardiac disease if they meet the following criteria; factors 1 and 2 must be present, and factors from 3 lend supporting documentation, but are not required.

1. At the time of initial certification or recertification for hospice:

- Patient is already optimally treated with diuretics and vasodilators, which may include Angiotensin-converting enzyme *(ACE)* inhibitors or the combination of hydralazine and nitrates. If side effects, such as hypotension or hyperkalemia, prohibit the use of ACE inhibitors or the combination of hydralazine and nitrates, this must be documented in the medical records; **OR**
- Patients having angina pectoris, at rest, are resistant to standard nitrate therapy and are either not candidates or decline invasive procedures.

AND

2. Patient has significant symptoms of recurrent congestive heart failure *(CHF)* at rest, and is classified as a New York Heart Association *(NYHA)* Class IV.
See Appendix: New York Heart Association (NYHA)

- Unable to carry on any physical activity without symptoms;
- Symptoms are present even at rest;
- If any physical activity is undertaken, symptoms are increased.

CARDIAC DISEASE *(continued)*

3. Documentation of the following factors may provide additional support for determining prognosis in end-stage heart disease:

- Treatment-resistant symptomatic supraventricular or ventricular arrhythmias;
- History of cardiac arrest or resuscitation;
- History of unexplained syncope;
- Brain embolism of cardiac origin;
- Concomitant HIV disease;
- Documentation of ejection fraction of 20% or less *(only if available)*

Patients who meet the criteria above are, by definition, eligible to receive hospice services. ***Some patients may not meet the criteria but may still be eligible for hospice care due to comorbidities or rapid functional decline***.

PULMONARY DISEASE

Patients will be considered to be in the terminal stage of pulmonary disease if they meet the following criteria; factors 1 and 2 must be present, and factors 3, 4 AND/OR 5 provide supporting documentation.

1. Severe chronic lung disease as documented by both A and B:

A. Disabling dyspnea at rest, poor or no response to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough. *(Documentation of Forced Expiratory Volume in one second (FEV1), after bronchodilator, less than 30% of predicted is objective evidence for severe chronic lung disease, but is not necessary to obtain.)*

B. Progression of end-stage pulmonary disease, as evidenced by increasing visits to the emergency department or hospitalizations for pulmonary infections and/or respiratory failure. *(Documentation of serial decrease in FEV1 of greater than 40 ml/year is objective evidence for disease progression, but is not necessary to obtain.)*

2. Hypoxemia, as evidenced by:

- Oxygen saturation of 88% or less on room air.
- p02 ≤ 55mm Hg

(These values may be obtained from recent hospital records.)

Documentation of the following factors may provide additional support for end-stage pulmonary disease:

3. Cor pulmonale or right heart failure *(RHF)* secondary to pulmonary disease *(e.g., not secondary to left heart disease or valvulopathy)*.

4. Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.

5. Resting tachycardia >100/min.

Patients who meet the criteria above are, by definition, eligible to receive hospice services. ***Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline.***

DIAGNOSIS GUIDELINES

ALZHEIMER'S DISEASE & RELATED DISORDERS

Patients will be considered to be in the terminal stage of Alzheimer's Disease if they meet the following criteria. Factor 1 plus either 2 OR 3 must be present:

1. Stage 7 on the Functional Assessment Staging *(FAST)* Scale, A, B & C criteria are very important indicators of end-stage Alzheimer's Disease: Additional criteria lend additional support to terminal status:
See Appendix: Functional Assessment Staging (FAST) Scale

A. Ability to speak limited to approximately a half dozen intelligible different words or fewer, in the course of an average day or in the course of an intensive interview.

B. Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview *(the person may repeat the word over and over)*.

C. Ambulatory ability is lost *(cannot walk without personal assistance)*.
D. Cannot sit up without assistance.
E. Loss of ability to smile.
F. Loss of ability to hold head up independently.

2. Presence of comorbid disease distinct from the terminal illness will impact functional impairment. Combined effects of Alzheimer's and any comorbid condition should support a prognosis of 6 months or less.

- COPD
- Cancer
- Renal Failure
- CHF
- Liver Disease
- Neurological Disease

3. Patients should have had one of the following secondary conditions within the past 12 months:

- Delirium
- Recurrent or intractable infections, such as pneumonia or other URI
- Pyelonephritis or other urinary tract infection
- Septicemia
- Decubitus ulcers, multiple, stage 3-4
- Fever, recurrent after antibiotics
- Inability to maintain sufficient fluid and calorie intake demonstrated by either of the following:
  10% weight loss during the previous six months OR Serum albumin < 2.5 gm/dl
- Aspiration pneumonia

Patients who meet the criteria above are, by definition, eligible to receive hospice services. ***Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline.***

DIAGNOSIS GUIDELINES

STROKE OR COMA

STROKE

Patients are considered in the terminal stage of stroke or coma, if they meet the following criteria. Criteria 1 & 2 are important indicators of functional and nutritional status and support a terminal prognosis for patients with stroke diagnosis. #3 will lend support.

1. Poor functional status with a Palliative Performance Scale *(PPS)* of 40 or less. All criteria in number 1 should be met. *See Appendix: Palliative Performance Scale (PPS)*

- Mainly bed-bound
- Requires maximal assistance to perform self-care
- Either fully conscious or drowsy/confused
- Unable to work
- Food/fluid intake are normal/reduced

AND

2. Inability to maintain hydration and caloric intake with ONE of the following:

- Weight loss > 10% during previous 6 months
- Weight loss > 7.5% in previous 3 months
- Serum albumin < 2.5 gm/dl
- Current history of pulmonary aspiration without effective response to speech language pathology interventions to improve dysphagia and decrease aspiration events.
- Calorie counts showing inadequate caloric/fluid intake.
- Dysphagia severe enough to prevent the patient from receiving food/fluids necessary to sustain life in a patient not receiving artificial nutrition/hydration.

3. Documentation of medical complications within the previous 12 months, in the context of progressive clinical decline, will help support eligibility for hospice care.

- Recurrent or intractable infections such as pneumonia or other URI
- Urinary tract infection
- Sepsis
- Refractory stage 3-4 decubitus ulcers
- Fever recurrent after antibiotics

COMA

The medical criteria listed below would support a terminal prognosis for individuals with a diagnosis of coma *(any etiology)*. Comatose patients with any 3 of the following on day three of coma are considered terminal:

- Abnormal brain stem response
- Absent verbal response
- Absent withdrawal response to pain
- Serum creatinine > 1.5 mg/dl

Patients who meet the criteria above are, by definition, eligible to receive hospice services. ***Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline.***

DIAGNOSIS GUIDELINES

LIVER DISEASE

Patients will be considered to be in the terminal stage of liver disease if they meet the following criteria; factors 1 and 2 must be present, and factors from 3 will lend supporting documentation.

1. Patient has end-stage liver disease as evidenced by BOTH of the following:

- Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio *(INR)* > 1.5

AND

- Serum albumin < 2.5 gm/dl ***AND***

2. The patient shows at least ONE of the following:

- Ascites, refractory to treatment or patient non-compliant
- Spontaneous bacterial peritonitis
- Hepatorenal syndrome *(elevated creatinine and BUN with oliguria (<400ml/day) and urine sodium concentration <10 mEq/l)*
- Hepatic encephalopathy, refractory to treatment, or patient non-compliant
- Recurrent variceal bleeding, despite intensive therapy

3. Documentation of the following factors will support eligibility for hospice care:

- Progressive malnutrition
- Muscle wasting with reduced strength and endurance
- Continued active alcoholism *(> 80 gm ethanol/day)*
- HBsAg *(Hepatitis B)* positivity
- Hepatitis C refractory to interferon treatment
- Hepatocellular carcinomav

Patients awaiting a liver transplant, who otherwise fit the above criteria, may be certified for the Medicare hospice benefits, but if a donor organ is procured, the patient must be discharged from hospice.

Patients who meet the criteria above are, by definition, eligible to receive hospice services. ***Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline.***

RENAL DISEASE

Patients will be considered to be in the terminal stage of renal disease if they meet the following criteria. **Acute Renal Failure** *(1, 2 AND 3 must be present; factors from 4 will lend supporting documentation)*:

1. The patient is not seeking dialysis or renal transplant.

AND

2. Creatinine clearance < 10 cc/min *(< 15 cc/min for diabetes)*

AND

3. Serum creatinine > 8.0 mg/dl *(> 6.0 mg/dl for diabetes)*

RENAL DISEASE *(continued)*

4. Supporting documentation of comorbidities:

- Chronic lung disease
- Advanced cardiac disease
- Advanced liver disease
- Sepsis
- Immunosuppression/AIDS
- Albumin < 3.5 gm/d
- Cachexia
- Platelet count < 25,000
- Disseminated intravascular coagulation
- Gastrointestinal bleeding

Chronic Renal Failure *(1, 2, and 3 must be present; factors from 4 will lend supporting documentation)*:

1. The patient is not seeking dialysis or renal transplant

AND

2. Creatinine clearance < 10 cc/min *(< 15 cc/min for diabetes)*

AND

3. Serum creatinine > 8.0 mg/dl *(> 6.0 mg/dl for diabetes)*
4. Supporting documentation of comorbidities:

- Uremia
- Urine output < 400 cc/day
- Intractable hyperkalemia *(> 7.0)* not responsive to treatment
- Uremic pericarditis
- Hepatorenal syndrome
- Intractable fluid overload, not responsive to treatment

Patients who meet the criteria above are, by definition, eligible to receive hospice services. ***Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline.***

END-STAGE HIV DISEASE

Patients will be considered to be in the terminal stage of HIV disease if they meet the following criteria:

- Chronic persistent diarrhea for one year, regardless of etiology
- Persistent serum albumin <2.5 g/dl
- Concomitant substance abuse
- Decisions to forego antiretroviral, chemo therapeutic, and prophylactic drug therapy related specifically to HIV disease
- Congestive heart failure, symptomatic at rest
- CD4+ count below 25 cells/mcl
- Persistent HIV RNA (viral load) of >100,000 copies/ml
- Opportunistic diseases such as CNS lymphoma, progressive multifocal leukoencephalopathy, cryptosporidiosis, wasting, MAC bactermia, visceral Kasposi's sarcoma, renal failure, AIDS dementia complex, or toxoplasmosis

DIAGNOSIS GUIDELINES

AMYOTROPHIC LATERAL SCLEROSIS *(ALS)*

Patients will be considered to be in the terminal stage of ALS if they meet the following criteria *(must fulfill I, 2, or 3)*:

1. The patient must demonstrate critically impaired breathing capacity with ALL of the following characteristics in the past 12 months preceding initial hospice certification:

- Vital capacity *(VC)* <30% of normal
- Significant dyspnea at rest
- Requiring supplemental 02 at rest
- Patient declines artificial ventilation

OR

2. Patient must demonstrate BOTH:

A. Rapid progression of ALS as demonstrated by ALL of the following within the 12 months preceding initial hospice certification

AND

- Progression from independent ambulation to wheelchair or bed-bound status
- Progression from normal to barely intelligible or unintelligible speech
- Progression from normal to pureed diet
- Progression from independence in most or all activities of daily living *(ADLs)* to needing major assistance by caretaker in all ADLs.

B. Critical nutritional impairment as demonstrated by ALL of the following within 12 months preceding initial hospice certification:

- Oral intake of nutrients and fluids insufficient to sustain life
- Continuing weight loss
- Dehydration or hypovolemia
- Absence of artificial feeding methods

OR

3. Patient must demonstrate BOTH:

A. Rapid progression of ALS *(2.A. above)*

AND

B. Life-threatening complications as demonstrated by ONE of the following within the last 12 months preceding initial hospice certification:

- Recurrent aspiration pneumonia *(with or without tube feedings)*
- Upper UTI, e.g., pyelonephritis
- Sepsis
- Recurrent fever after antibiotic therapy
- Decubitus ulcers, multiple, Stage 3-4

In end-stage ALS, two factors are critical in determining prognosis: ability to breathe and, to a lesser extent, ability to swallow. *Patients who meet the criteria above are, by definition, eligible to receive hospice services.* ***Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline.***

SCALES

NEW YORK HEART ASSOCIATION FUNCTIONAL CLASSIFICATION

9th Edition (Cardiac Patients)

	Functional Capacity by Class	Objective Assmt*
I	No limitation in physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.	No evidence of cardiovascular disease
II	Slight limitation of physical activity, but comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.	Objective evidence of minimal cardiovascular disease
III	Comfortable at rest. Less than ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.	Objective evidence of moderately severe cardiovascular disease
IV	Unable to carry on physical activity without discomfort. S/S of heart failure or anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.	Objective evidence of severe cardiovascular disease

**Measures such as EKG, stress test, x-ray, echocardiogram and/or radiologic images.*

PALLIATIVE PERFORMANCE SCALE *(PPS)*

%	Ambulation	Activity & Evidence of Disease	Self-care	Intake	Level of Conscious
100	Full	Normal activity, no evidence of disease	Full	Normal	Full
90	Full	Normal activity with effort, 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, some evidence of disease	Full	Normal or Reduced	Full
60	Reduced	Unable to do hobbies or some housework, significant disease	Occasional assistance	Normal or Reduced	Full or confused
50	Mainly sit or lie	Unable to do any work, extensive disease	Considerable assistance	Normal or Reduced	Full or confused
40	Mainly in bed	Unable to do any work, extensive disease	Mainly assis-tance	Normal or Reduced	Any
30	Totally Bed Bound	Unable to do any work,	Total Care	Reduced	Any
20	Totally Bed Bound	Unable to do any work, extensive disease	Total Care	Minimal Signs	Any
10	Totally Bed Bound	Unable to do any work, extensive disease	Total Care	Mouth Care Only	Drowsy or Coma
0	Death	--	--	--	

SCALES

BODY MASS INDEX (BMI)

Reference Chart

	Normal						Overweight					Obese										Extreme Obesity									
BMI	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**	**39**	**40**	**41**	**42**	**43**	**44**	**45**	**46**	**47**	**48**	**49**
Height (inches)																**Body Weight (pounds)**															
58	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167	172	177	181	186	191	196	201	205	210	215	220	224	229	234
59	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173	178	183	188	193	198	203	208	212	217	222	227	232	237	242
60	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179	184	189	194	199	204	209	215	220	225	230	235	240	245	250
61	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185	190	195	201	206	211	217	222	227	232	238	243	248	254	259
62	104	109	115	120	126	131	136	142	147	153	158	164	169	175	180	186	191	196	202	207	213	218	224	229	235	240	246	251	256	262	267
63	107	113	118	124	130	135	141	146	152	158	163	169	175	180	186	191	197	203	208	214	220	225	231	237	242	248	254	259	265	270	278
64	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204	209	215	221	227	232	238	244	250	256	262	267	273	279	285
65	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210	216	222	228	234	240	246	252	258	264	270	276	282	288	294
66	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216	223	229	235	241	247	253	260	266	272	278	284	291	297	303
67	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223	230	236	242	249	255	261	268	274	280	287	293	299	306	312
68	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230	236	243	249	256	262	269	276	282	289	295	302	308	315	322
69	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236	243	250	257	263	270	277	284	291	297	304	311	318	324	331
70	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	243	250	257	264	271	278	285	292	299	306	313	320	327	334	341
71	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250	257	265	272	279	286	293	301	308	315	322	329	338	343	351
72	140	147	154	162	169	177	184	191	199	206	213	221	228	235	242	250	258	265	272	279	287	294	302	309	316	324	331	338	346	353	361
73	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265	272	280	288	295	302	310	318	325	333	340	348	355	363	371
74	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272	280	287	295	303	311	319	326	334	342	350	358	365	373	381
75	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279	287	295	303	311	319	327	335	343	351	359	367	375	383	391
76	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287	295	304	312	320	328	336	344	353	361	369	377	385	394	402

FUNCTIONAL ASSESSMENT STAGING *(FAST)* SCALE

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 locations. Decreased organizational capacity.*

4. Decreased ability to perform complex tasks, e.g., planning dinner for guests, handling personal finances *(such as forgetting to pay bills)*, difficulty marketing, etc.

5. Requires assistance in choosing proper clothing for the day, season, or occasion, e.g., patient may wear the same clothing repeatedly, unless supervised.*

FAST SCALE *(continued)*

6. A) Improperly putting on clothes without assistance or prompting *(e.g., may put street clothes on over night clothes, or put shoes on wrong feet, or have difficulty buttoning clothing)* occasionally or more frequently over the past weeks.*
   B) Unable to bathe properly *(e.g., difficulty adjusting bath-water temp.)* occasionally or more frequently over the past weeks.*
   C) Inability to handle mechanics of toileting *(e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue)* occasionally or more frequently over the past weeks.*
   D) Urinary incontinence *(occasionally or more frequently over the past weeks.)**
   E) Fecal incontinence *(occasionally or more frequently over the past weeks.)**

7. A) Ability to speak limited to approximately a half dozen intelligible different words or fewer, in the course of an average day or in the course of an intensive interview.
   B) Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview *(the person may repeat the word over and over)*.
   C) Ambulatory ability is lost *(can't walk without personal assistance)*.
   D) Cannot sit up without assistance.
   E) Loss of ability to smile.
   F) Loss of ability to hold head up independently.

**Scored primarily on the basis of information obtained from knowledgeable informant.*

FLACC SCALE
(Face, Legs, Activity, Cry, Consolability)

Instructions Rate patient in each of the five measurement categories. Add together to determine total pain score.

	0	1	2
FACE	No particular expression or smile, eye contact and interest in surroundings	Occasional grimace or frown, withdrawn, disinterested, worried look to face, eyebrows lowered, eyes partially closed, cheeks raised, mouth pursed	Frequent to constant frown, clenched jaw, quivering chin, deep furrows on forehead, eyes closed, mouth opened, deep lines around nose/lips
LEGS	Normal position or relaxed	Uneasy, restless, tense, increased tone, rigidity, intermittent flexion/extension of limbs	Kicking or legs drawn up, hypertonicity, exaggerated flexion/extension of limbs, tremors
ACTIVITY	Lying quietly, normal position, moves easily and freely	Squirming, shifting back and forth, tense, hesitant to move, guarding, pressure on body part	Arched, rigid or jerking, fixed position, rocking, side-to-side head movement, rubbing part of the body
CRY	No cry or moan (awake or asleep)	Moans or whimpers occasional cries, sighs, occasional complaint	Crying steadily, screams, sobs, moans, grunts, frequent complaints
CONSOLABILITY	Calm, content, relaxed, does not require consoling	Reassured by occasional touching, hugging or talking to distractible	Difficult to console or comfort

USEFUL LANGUAGE FOR HOSPICE DISCUSSION

Identify the Decision Makers
"Is there anyone you rely on to help you make important decisions?"
"Who in the family should be with us when we discuss the results?"

Assess Understanding of Prognosis
"What have your other doctors told you about your condition?"
"Have they tried to talk to you about what this latest problem might mean for you?"
"From what you know, do you think that over the next month your cancer will get better, worse or stay the same?"

Define the Patient's Goals for Care
"What do you hope for most in the next few months?"
"Is there anything that you're afraid of?"

Re-frame Goals
"I wish we could guarantee that we could keep you alive until your daughter's graduation, but unfortunately, we can't. Perhaps we can work together on a letter for her to read on that day so that she will know you are there in spirit in case you cannot be there."

Identify Needs for Care
"It can be very difficult to care for a family member at home, and no one can do it alone. Have you thought about what kind of help you might need?"
"Would it help if we could help you find ways to access available community services?"
"Would it reassure you if we could send a nurse out to your home to check on you?"

Summarize and Link Goals With Care Needs
"So I think I understand that your main goal is to stay at home and spend time with your family. To do that, we will help you in several ways, for instance, by sending a nurse out to your home to help control symptoms and an aide to assist with bathing and ambulation. Is that right?"

Introduce Hospice
"One of the best ways to give you the help that you will need to stay at home with your family is a program called hospice. Have you heard of hospice?"
"Hospice is able to provide more services and support at home than most other care programs."
"The hospice care team has a lot of experience caring for seriously ill patients at home."

Respond to Emotions Elicited, Provide Closure and Acknowledge Responses
"You seem surprised to learn how sick you are."
"I can see it's not easy for you to talk about hospice."

Empathize
"I can imagine how hard it is for both of you; you care about each other so much."

Explore concerns
"Tell me what's upsetting you the most."

Explain hospice goals
"Hospice doesn't help people die sooner. Hospice helps people die naturally, in their own home."
"Hospice helps people live as well as they can for as long as they can."

Reassure
"Hospice's goal is to improve your quality of life as much as possible for whatever time you have left."
"Hospice can help you and your family make the most of the time you have left."

Reinforce commitment to care
"Let's think this over for a day or two; you know I will continue to care for you whatever decision you make."

Recommend hospice
"I think that hospice would be your best choice right now, but of course the final decision is yours."
"Hospice could be very helpful to you in the ways that we've talked about, but I realize it's a big decision. I'd like to arrange for a hospice nurse to visit you so you can decide for yourself whether hospice is right for you."

DISCUSSIONS

HOSPICE MYTHS

Hospice means that the patient will soon die.
Receiving hospice care does not mean giving up hope or that death is imminent. The earlier an individual receives hospice care, the more opportunity there is to regain the spirit of life, help manage symptoms and pain, address other needs and insure a better quality of life for the patient and family.

Hospice is only for cancer patients.
A large number of hospice patients have congestive heart failure, Alzheimer's disease or dementia, chronic lung disease, or other conditions.

How does Hospice manage pain?
Hospice physicians and nurses are experts at pain/symptom control. They are continually developing new protocols for keeping patients comfortable, alert and as independent as possible. Nurses trained specifically in palliative care know which medications and combinations provide the best results for each patient.

Hospice patients can't receive care from their PCP.
Hospice reinforces the patient-PCP relationship by advocating either office or home visits, according to the physician preference. Hospice agencies work closely with PCPs and consider the continuation of the patient-physician relationship to be of the highest priority.

Patients can only receive hospice for a limited time.
The Medicare benefit, and most private insurance, pays for hospice care as long as the patient continues to meet the criteria necessary.

GENERAL INPATIENT *(GIP)*

4 LEVELS OF HOSPICE CARE REIMBURSED BY MEDICARE

- **Routine Home Care** - Patient is at home under the care of St. Joseph Hospice and not receiving any other category of care.

- **Continuous Home Care** - Patient is at home and in a period of crisis requiring a high level of care to maintain them in the home setting.

- **Inpatient Respite Care** - Patient is in an approved inpatient facility and receiving respite care (caregiver relief).

- **General Inpatient Care** - Patient is inpatient at a hospice facility, hospital, or skilled nursing facility. In this highest level of hospice care, the intent is for short-term intervention to treat uncontrolled symptoms which cannot be managed in the home setting

INDICATIONS FOR GIP

- Pain Crisis
- Complicated technical delivery of medication
- Intractable N/V
- Dyspnea/Respiratory distress
- Uncontrolled seizures
- Unmanageable hemorrhage
- Complex wound care or frequent skilled dressing changes
- Acute agitation, delirium, anxiety, depression, or suicidal ideations requiring intensive intervention that is not manageable in home setting.

GIP CONSIDERATIONS

- The IDG determines what symptoms cannot be managed in a residential setting.
- Must continually assess need and be working toward a return to a lower level of care.
- While at GIP level, IDG must coordinate care, provide caregiver education, and discharge plan.
- Narrative comments are critical in supporting GIP care as individualized documentation is required.
- Do not document resolution of crisis without firm explanation of why GIP continues.

CHARTING REQUIREMENTS

- Start of Care note must include precipitating event information explaining why GIP is required and what interventions were tried and failed to manage symptoms.

- On a daily basis charting must provide supportive data that the crisis is ongoing along with the patient's response to interventions. Everything must be aimed at continually justifying the need for GIP.

- Quantitative data which includes weight, vital signs, meal % eaten, intake/output, pain rating.

CHARTING REQUIREMENTS *(continued)*

- Daily family/caregiver education is a requirement. The goal is to get the patient back to a lower level of care from the start of their stay so our efforts should be aimed at providing educational needs to the family that they may safely care for the patient.

- Discharge planning begins on admission. The staff should communicate the short term nature of GIP and establish a plan for discharge providing with options if the patient cannot return to their home.

- The Plan of Care must include all services necessary for the palliation and management of the patient's disease, symptoms, and related conditions. This is a reflection of the comprehensive assessment performed by the nurse. The IDG must review and revise the individualized plan as frequently as the patient's condition warrants.

EXAMPLES OF PHRASES

Below are examples of phrases we can tag onto the end of our shift summary statement that are helpful in necessitating GIP:

- "RN administering IVP meds for breakthrough pain."
- "Patient has required multiple medication titrations since admit."
- "Recently added medication must be monitored for effectiveness and adjusted accordingly."
- "GIP appropriate for close observation and potential titration of medications."
- "GIP for ongoing aggressive symptom management."

EXAMPLES OF DC PLAN PHRASING

- "Should patient's sx resolve, DC plan is for patient to return home with sitters. At this time patient remains GIP appropriate with continued daily re-evaluation from IDG."

- "Once patient's symptoms are managed, family plans to care for patient at home with SJH. Patient's wife and 2 adult children are the primary caregivers and will require education on how to monitor for nonverbal signs of pain, bed mobility and repositioning techniques, as well as how to provide wound care to patient's stage 2 sacral wound."

- "Family is adamant that once optimal symptom control is reached they do not want patient discharged to a nursing home. They are aware they will require education on how to properly care for patient with recently declined functional status, and are willing to learn."

- "Recently titrated MS Contin and Lorazepam are effectively managing sx of pain and SOB. Patient's daughter understands that patient needs a caregiver at all times and feels that a nursing home is the best option for the patient. Will enlist MSW in coordination of nursing home placement per family's request now."

- "Patient has transitioned to actively dying as evidenced by periods of apnea and some mottling to BLE. Patient is unresponsive and without sx of acute distress, however family is unable to cope with patient's recent decline and will not be able to provide care. Patient's death looks to be imminent and patient will likely remain at TCH through end of life."

EXAMPLES OF DC PLAN PHRASING *(continued)*

- "MD has asserted that patient is too frail for transfer out of facility and that such a move would likely hasten patient's passing. MD/IDG asserts that patient should remain GIP through end of life."
- "Patient's nausea and vomiting have resolved. MD increased MS Contin from 30mg to 45 mg yesterday. Will monitor patient's response to recently adjusted medication and likely discharge back to home with SJH if pain is controlled."
- "MSW pursuing NH placement when DC is appropriate."

IV FLUSH PROTOCOL

IV Flush & Dressing Change Protocol	Adult	Frequency	Dressing Changes
Peripheral	3mL 0.9% NS	Flush DAILY when not in use; after each use; and PRN	Every 3 days and PRN
Hickman	10mL 0.9%NS 5 mL Heparin 100 unit/mL	Flush DAILY when not in use; use SASH when in use; and PRN	Every week if transparent; Every 48 hours if occlusive; and PRN
Midline	5 mL 0.9%NS 3 mL Heparin 100 unit/mL	Flush DAILY when not in use; use SASH when in use; and PRN	Every week if transparent; Every 48 hours if occlusive; and PRN
Mediport	10 mL 0.9%NS 5 mL Heparin 100 unit/mL	Flush DAILY when not in use; use SASH when in use; and PRN	Every week with re-access when in use; and PRN
PICC	5 mL 0.9%NS 5 mL Heparin 100 unit/mL	Flush DAILY when not in use; use SASH when in use; and PRN	Every week if transparent; Every 48 hours if occlusive; and PRN
Groshong	10 mL 0.9%NS	Flush DAILY when not in use; and PRN	Every week if transparent; Every 48 hours if occlusive; and PRN
Central Line (IJ or SC)	10 mL 0.9%NS 5 mL Heparin 100 unit/mL	Flush DAILY when not in use; use SASH when in use; and PRN	Every week if transparent; Every 48 hours if occlusive; and PRN

SASH = SALINE – ADMINISTRATION – SALINE – HEPARIN

Change injection cap every week and PRN

NO GAUZE UNDER DRESSING! Dressings must be changes every 48 hours, if gauze under dressing.

Dressing Change
- Hand antisepsis and gloves
- Removed soiled or old dressings
- Inspect catheter and injection site for signs of catheter-related infection or complications: phlebitis, occlusion infiltration, extravasation, redness, tenderness, or purulent drainage
- Follow Dressing Change Protocols above

THE CARPENTER HOUSE

INPATIENT HOSPICE CARE AT THE CARPENTER HOUSE

The Carpenter House of St. Joseph Hospice serves as a place of peace for hospice patients with symptoms not managed well at home. Our staff works under the direction of a Board Certified Hospice and Palliative Care Physician.

The Carpenter House allows patients to transition directly from the hospital into a *home-like atmosphere* and helps patients in need of intense symptom management as they plan for long-term arrangements at their residence. During their stay, patients and their family members can meet and get to know the hospice staff that will provide care in the patient's home.

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Useful Language for Hospice Discussions
David J. Casarett, MD, MA, and Timothy E. Quill, MD
Annals of Internal Medicine, March 2007, Volume 146, Issue 6, p.443-449

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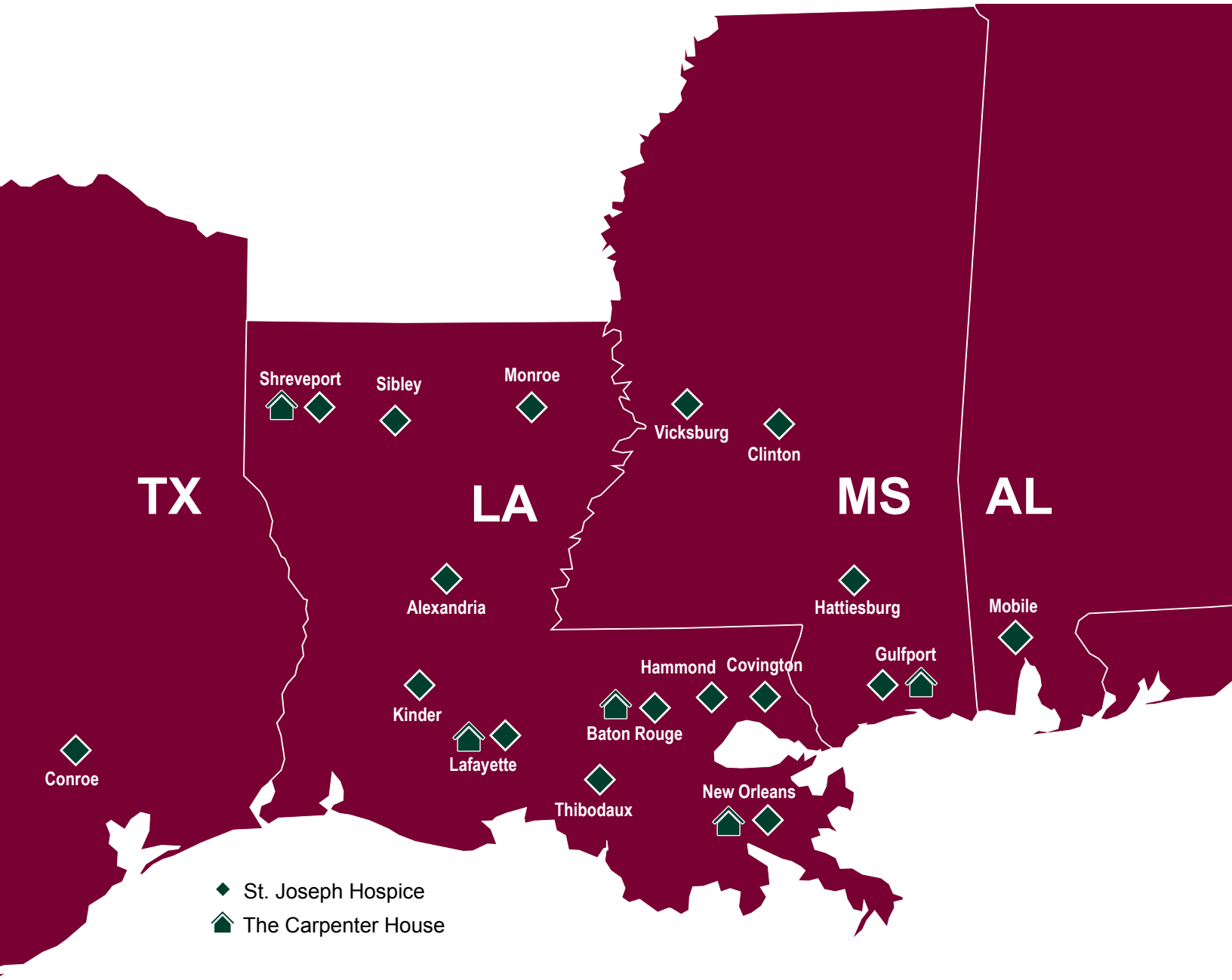

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