hospice of the chesapeake

How to get the MOST help for your patients with Advanced Illness

hospicechesapeake.org
Referrals (877) 462.1103

Serving Anne Arundel, Charles and Prince George's Counties

Referral Number 877.462.1103

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General Indicators

- Physical decline
- Weight loss
- Multiple comorbidities
- Multiple emergency room visits or hospitalizations
- Increased physician visits related to the disease process
- Serum albumin <2.5 gm/dl
- Dependence on most activities of daily living (ADL's)
- Decline in Palliative Performance Scale (See page 16)

When Should You Consider Hospice Care for Cancer?

When curative treatment is no longer an option, hospice care can be beneficial for patients and a tremendous source of emotional and physical support for families. Hospice care includes a full-range of services including medical, pharmaceutical, social and spiritual support.

- Evidence of end-stage disease and/or distant metastases
- Continued decline in spite of therapy/patient declines further disease-directed therapy
- Potentially life-threatening complications or comorbidities

Ask yourself, "Would I be surprised if my patient were not alive six months from now?"

When Should You Consider Hospice Care for Alzheimer's and All Other Types of Dementia?

When curative treatment is no longer an option, hospice care can be beneficial for patients and a tremendous source of emotional and physical support for families. Hospice care includes a full range of services including medical, pharmaceutical, social and spiritual support.

- See General Indicators (See Page 4)
- FAST 7 or beyond (Criteria below)
  - o Unable to speak over 6 intelligible words during interview
  - o Can get out only 1 word during interview
  - o Unable to walk without assistance
  - o Unable to sit up without support
  - o Unable to smile
  - o Unable to hold your head up without support
- Inability to ambulate/dress without assistance
- Urinary and fecal incontinence, intermittent or constant
- No consistent meaningful/reality-based verbal communication
- Significant comorbidity
- Stage 3 to 4 or multiple decubitus ulcers

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When Should You Consider Hospice Care for Heart Disease – Congestive Heart Failure?

When curative treatment is no longer an option, hospice care can be beneficial for patients and a tremendous source of emotional and physical support for families. Hospice care includes a full range of services including medical, pharmaceutical, social and spiritual support.

- Angina at rest despite maximum medical therapy OR
- NYHA Class IV CHF
- Supporting evidence:
  - Treatment resistant symptomatic dysrhythmias
  - History of unexplained or cardiac related syncope
  - CVA secondary to cardiac embolism
  - History of cardiac arrest or resuscitation

Ask yourself, "Would I be surprised if my patient were not alive six months from now?"

When Should You Consider Hospice Care for Pulmonary Disease/COPD?

When curative treatment is no longer an option, hospice care can be beneficial for patients and a tremendous source of emotional and physical support for families. Hospice care includes a full range of services including medical, pharmaceutical, social and spiritual support.

- Documented disease progression
- Disabling dyspnea at rest
- Recurrent pulmonary infections

Plus any of the following:

- p02 <55mmHg by ABG, Sa02 <88%
- pC02 >50
- Loss of >10% of body weight in past 6 months
- Resting heart rate >100 per minute
- Cor pulmonale

Ask yourself, "Would I be surprised if my patient were not alive six months from now?"

When Should You Consider Hospice Care for Renal Disease?

When curative treatment is no longer an option, hospice care can be beneficial for patients and a tremendous source of emotional and physical support for families. Hospice care includes a full range of services including medical, pharmaceutical, social and spiritual support.

- Patient not seeking dialysis and
- Patient not a candidate for renal transplant

Plus any of the following:

  - o Creatinine clearance <10cc/min (<15 cc/min for diabetics)
  - o Serum creatinine >8.0mg/dl (>6 for diabetics)
  - o Signs and symptoms of renal failure

- Uremia
- Oliguria (e400 cc/d)
- Uremic pericarditis
- Hepatorenal syndrome

Ask yourself, "Would I be surprised if my patient were not alive six months from now?"

When Should You Consider Hospice Care for Liver Disease?

When curative treatment is no longer an option, hospice care can be beneficial for patients and a tremendous source of emotional and physical support for families. Hospice care includes a full range of services including medical, pharmaceutical, social and spiritual support.

- PTT more than 5 seconds over control or INR over 1.5
- Serum alvumin <2.5 g/dl
  - o And at least one of the following
- Spontaneous bacterial peritonitis
- Hepatorenal syndrome
- Refractory hepatic encephalopathy
- Refractory ascites
- Recurrent variceal bleeding, despite intensive therapy

Ask yourself, "Would I be surprised if my patient were not alive six months from now?"

When Should You Consider Hospice Care for Stroke, Parkinson's or Other Neurological Conditions?

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- See General Indicators (See Page 4)
- Difficulty with nutrition and hydration
- Pulmonary aspiration and infection
- Weight loss >10% in last six months
- Recurrent aspiration pneumonia

Ask yourself, "Would I be surprised if my patient were not alive six months from now?"

When Should You Consider Hospice Care for Amyotrophic Lateral Sclerosis (ALS)?

When curative treatment is no longer an option, hospice care can be beneficial for patients and a tremendous source of emotional and physical support for families. Hospice care includes a full range of services including medical, pharmaceutical, social and spiritual support.

- Critically impaired ventilatory capacity
- Rapid progression of ALS (most of disability developed in past 12 months)
- Fever recurrent after antibiotics
- Sepsis
- Pyelonephritis
- Stage 3-4 decubitus ulcers
- FVC of 60% predicted or a decline of > 20% over 2 to 3 months
- Rapid progressive paralysis in 2 body regions over 2 to 3 months

Ask yourself, "Would I be surprised if my patient were not alive six months from now?"

When Should You Consider Hospice Care for HIV/AIDS?

When curative treatment is no longer an option, hospice care can be beneficial for patients and a tremendous source of emotional and physical support for families. Hospice care includes a full range of services including medical, pharmaceutical, social and spiritual support.

- CD4 <25 cells/m^3 or persistent viral load >100,000 copies/ml, and
- PPS <50 and Antiretroviral therapy no longer effective or desired

Plus any of the following:

- CNS lymphoma
- Wasting syndrome (loss of 33% lean body mass)
- PML (progressive multifocal leukoencephalopathy)
- Cryptosporidium infection
- MAC (mycobacterium avium complex), unresponsive to treatment

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When Should You Consider Hospice Care for Coma?

When curative treatment is no longer an option, hospice care can be beneficial for patients and a tremendous source of emotional and physical support for families. Hospice care includes a full range of services including medical, pharmaceutical, social and spiritual support.

Comatose patient with any 3 of the following on day three of coma

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

Ask yourself, "Would I be surprised if my patient were not alive six months from now?"

Medicare Criteria for Hospice Inpatient Level of Care

- Admission decisions are made on a case-by-case basis after evaluation by the Hospice of the Chesapeake interdisciplinary team and in consultation with the patient's attending physician
- Patients will be considered appropriate for general inpatient care if one or more of the following conditions cannot be managed in an outpatient setting:
  - Pain
  - Severe shortness of breath or respiratory distress
  - Intractable nausea or vomiting
  - Open lesions requiring frequent professional care
  - Medication adjustment that must be monitored 24/7
  - Need for continued close monitoring of unstable recurring medical conditions
  - Other presenting problems will be identified and evaluated on an individual basis

Palliative Performance Scale

Intake	Level of consciousness	Estimated median survival in days (a)	(b)	(c)
Normal	Full	N/A	N/A	108
Normal	Full			
Normal or reduced	Full			
As above	Full	145		
As above	Full or confusion	29	4	
As Above	Full or confusion	30	11	41
As above	Full or drowsy or confusion	18	8	
Reduced	As above	8	5	
Minimal	As above	4	2	6
Mouth Care Only	Drowsy or coma	1	1	

(a) Survival post-admission to an inpatient palliative unit, all diagnoses (Virik 2002)

(b) Days until inpatient death following admission to an acute hospice unit, diagnoses not specified (Anderson 1996)

(c) Survival post admission to an inpatient palliative unit, cancer patients only (Morita 1999)

%	Ambulation	Activity level Evidence of disease	Self-care
100	Full	Normal No disease	Full
90	Full	Normal Some disease	Full
80	Full	Normal with effort Some disease	Full
70	Reduced	Can't do normal job or work Some disease	Full
60	Reduced	Can't do hobbies or housework Significant disease	Occasional assistance needed
50	Mainly sit/lie	Can't do any work Extensive disease	Considerable assistance needed
40	Mainly in bed	As above	Mainly assistance
30	Bed bound	As above	Total care
20	Bed bound	As above	As Above
10	Bed bound	As above	As Above
0	Death		

* Between 50% and 60% - Consider Hospice Referral
* Between 70% and 80% - Patient May Be Eligible for Hospice

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