Hospice of the northwest

Guidelines

For Hospice Admission

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Hospice Basics

Hospice service is offered to patients and their families when a cure is no longer possible or no longer sought and prognosis is estimated to be less than six months.

When curative treatment is no longer available, hospice can be a tremendous source of emotional and physical support for patients and their families. Quality of life becomes the focus with symptom control, pain management and support for navigating social, emotional and spiritual transitions.

Hospice neither hastens nor prolongs the natural disease process. In fact, participation in hospice has been shown to lengthen life expectancy in some patients. Pain and symptom management, hospitalization rates and patient/family satisfaction improves when patients receive hospice interdisciplinary care.

The criteria within this booklet are to be used as guidelines and should not take the place of your clinical judgment. Informational visits are available and provided via phone. Contact our Referral Center or hospice physicians if you have any questions about patient eligibility: (360) 814-5550.

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Would you be surprised if your patient died within the next year?

Below are 10 questions to help you determine if your patient is eligible for hospice. Has your patient:

1. Been hospitalized or to the Emergency Room several times in the last six months?
2. Started needing help from others with any of the following?
    a. Getting out of bed
    b. Dressing
    c. Eating
    d. Walking
    e. Showering
    f. Toileting
3. Started feeling weaker or more tired/sleeping more?
4. Started spending most of the day in bed or a chair?
5. Fallen several times in the last six months?
6. Noticed shortness of breath with minimal activity or at rest?
7. Been making more frequent visits to the provider's office, or now arriving by wheelchair or with family help?
8. Started medication to lessen pain/shortness of breath?
9. Experienced any weight loss or worsening appetite?
10. Been told by you or another provider that life is limited?

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Dementia

1. Patient must have **ALL** of these signs and symptoms:
- ☐ Unable to walk without assistance
- ☐ Unable to dress themselves
- ☐ Need help for bathing and grooming
- ☐ Unable to consistently control bowel and bladder
- ☐ Might use some language, but unable to converse effectively

2. They may have also experienced at least **ONE** of the following in the last year:
- ☐ Serious lung or kidney infection (pneumonia; pyelonephritis)
- ☐ Sepsis
- ☐ Severe open pressure ulcers (stage 3-4 decubiti)
- ☐ Persistent fever, even after antibiotics
- ☐ Weight loss of >10% in last 6 months or serum albumin <3.0gm/dl
- ☐ Recent hospitalization
- ☐ Mitchell Mortality Risk Indicator score ≥9 **(See Appendix 4)**

In the absence of one or more of the above findings, rapid decline, co-morbidities, or Severe Frailty (see Appendix 5) may also support eligibility for hospice care.

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Amyotropic Lateral Sclerosis (ALS)

The patient meets at least one of the following (1 **or** 2):

1. Severely impaired breathing capacity with all of the following findings:
   - Dyspnea at rest
   - Vital capacity less than 30%
   - Requirement for supplemental oxygen at rest
   - The patient declines invasive ventilation (NIPPV is accepted)

2. Rapid disease progression is evident, plus, either **a** or **b** below:

   Rapid disease progression as evidenced by some of the following in the preceding twelve (12) months:
   - 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 caregiver in all ADLs

   PLUS

   a. Severe nutritional impairment demonstrated by all of the following in the preceding twelve (12) months:
      - Oral intake of nutrients and fluids insufficient to sustain life
      - Continuing weight loss
      - Dehydration or hypovolemia
      - Absence of artificial feeding methods

   OR

   b. Life-threatening complications demonstrated by one or more of the following in the preceding twelve (12) months:
      - Recurrent aspiration pneumonia (with or without tube feeding)
      - Upper urinary tract infection (pyelonephritis)
      - Sepsis
      - Recurrent fever after antibiotic therapy
      - Stage 3 or Stage 4 decubitus ulcer(s)

In the absence of one or more of the above findings, rapid decline or co-morbidities may also support eligibility for hospice care.

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Cancer

The patient has 1, 2 **and** 3:

1. Clinical findings of malignancy with widespread, aggressive or progressive disease as evidenced by increasing symptoms, worsening lab values and/or evidence of metastatic disease.

2. Impaired performance status with a Palliative Performance Score (PPS) <70%. **(See Appendix 2)**

3. Patient is uninterested in further curative therapy or continues to decline despite definitive therapy. Decline is evidenced by one of the following:
    - Hypercalcemia ≥12
    - Cachexia or weight loss of 5% in the preceding three months
    - Recurrent disease after surgery/radiation/chemotherapy
    - No present goals to pursue curative or prolonging cancer treatment
    - Signs and symptoms of advanced disease (e.g. nausea, anemia, malignant ascites, pleural effusion, etc.)

In the absence of one or more of the above findings, rapid decline or co-morbidities may also support eligibility for hospice care.

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Cerebral Vascular Accident/Stroke or Coma

The patient has both 1 **and** 2:

1. Poor functional status with Palliative Performance Scale of <40% (unable to care for self) **(See Appendix 2)**

2. Poor nutritional status with inability to maintain sufficient caloric intake with one of the following:
    - >10% weight loss over the previous six (6) months - or -
    - >7.5% weight loss over the previous three (3) months
    - Serum albumin <3.0 gm/dl
    - Current history of pulmonary aspiration without effective response to speech therapy to improve dysphagia and decrease aspiration events

Supporting evidence for hospice eligibility
Coma (any etiology) with three (3) of the following on the third (3rd) day of coma:

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

In the absence of one or more of these findings, rapid decline or co-morbidities may also support eligibility for hospice care.

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Heart Disease/CHF

Basic requirements:

1. **New York Heart Association Class IV CHF**: Symptoms at rest such as dyspnea, orthopnea, PND, edema, syncope, profound weakness or chest pain. **(See Appendix 1)**

   OR

   Severe Aortic Stenosis with orthostatic hypotension, falls and functional loss

   OR

   Class III CHF (comfortable only at rest/marked limitation of any activity) **AND** any two (2) of the following:

   - ☐ Hospitalization for CHF in the last year
   - ☐ Stage 3 CKD with GFR <45
   - ☐ Systolic BP <100 or resting HR >100
   - ☐ Anemia with Hgb <12
   - ☐ Hyponatremia with sodium <132
   - ☐ Limited functional ability (PPS 40% or less) **(See Appendix 2)**
   - ☐ Pleural effusion or ascites requiring diuretics
   - ☐ History of cardiac arrest or resuscitation
   - ☐ Cardiac cachexia (weight loss 5% in the last 6 months)
   - ☐ Treatment-resistant dysrhythmias

AND

2. Maximally medically managed or unable to tolerate further medication management

AND

3. No plans for surgical or other cardiac interventions

Supporting evidence for hospice eligibility:

- Echo demonstrating an ejection fraction of 20% or less
- History of unexplained or cardiac related syncope
- CVA secondary to cardiac embolism

In the absence of one or more of these findings, rapid decline or comorbidities may also support eligibility for hospice care.

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Liver Disease

The patient has both 1 **and** 2

1. Liver failure as demonstrated by a **or** b :
   a. International Normalized Ratio (INR) >1.5 (not on warfarin)
   b. Serum albumin <2.5gm/dl

AND

2. End-stage liver disease is present and the patient has one or more of the following conditions:
   - Ascites, refractory to treatment or patient declines or is non-compliant
   - History of spontaneous bacterial peritonitis
   - Hepatorenal syndrome (elevated creatinine with oliguria [<400 ml/day])
   - Hepatic encephalopathy, refractory to treatment or patient non-compliant
   - History of esophageal varices

Supporting evidence for hospice eligibility:

- Progressive malnutrition
- Muscle wasting with reduced strength
- Ongoing alcoholism (>80 gm ethanol/day)
- Hepatocellular carcinoma
- Hepatitis B surface antigen positive
- Hepatitis C, refractory to treatment

In the absence of one or more of these findings, rapid decline or comorbidities may also support eligibility for hospice care.

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Pulmonary Disease

REQUIRED:

Dyspnea with minimal exertion

Decreased functional capacity with evidence of one of the following:

- ☐ Spends most of the day in a chair or bed, often arrives in wheelchair to office visits
- ☐ Fatigue with minimal exertion — need to rest during or after showering/bathing
- ☐ Exhausted from cough
- ☐ Evidence of pursed lip breathing with conversation
- ☐ Tripod positioning, evidence of pressure sores on elbows
- ☐ Increasing somnolence
- ☐ Difficulty completing a meal due to dyspnea

NOT REQUIRED but supporting:

- ☐ FEV1 <30% if COPD; DLCO < 40 if Pulmonary Fibrosis
- ☐ Poor response to bronchodilators or use is frequent (≥QID use)
- ☐ Steroid and oxygen dependent:
- ☐ Requires frequent oral steroid doses (monthly)
- ☐ Develops exacerbation with attempts to wean steroids

- ☐ Hypoxia at rest (PO2 <55mmHG/sat 88%) or Hypercapnia pCO2 >50mm HG in last 3 months

- ☐ Have co-morbid disease that makes dyspnea worse and episodic (CHF, ESRD, anemia, CAD, morbid obesity, OSA, restrictive disease)
- ☐ Progressive dementia:
  - Changing goals of care by family
  - Now unable to use MDIs
- ☐ Frequent clinic, ED or hospital visits for respiratory infections; respiratory failure in the last 12 months
- ☐ Evidence of Cor pulmonale
- ☐ Unintentional weight loss of >5% in past six (6) months
- ☐ Resting tachycardia
- ☐ Increasing anxiety/fearfulness/air hunger and hopes to avoid more hospital care
- ☐ Still smoking

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Multiple Sclerosis

The patient must meet at least one of the following criteria (1 **or** 2):

1. Severely impaired breathing capacity with all of the following findings:
- Dyspnea at rest
- Vital capacity less than 30%
- The requirement of supplemental oxygen at rest
- The patient declines artificial ventilation

OR

2. Rapid disease progression and either **a** or **b** below

Rapid disease progression as evidenced by all of the following in the preceding twelve (12) months:
- 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 (ADL) to needing major assistance by caretaker in all ADLs

AND

a. Severe nutritional impairment demonstrated by all of the following in the preceding twelve (12) months:
- Oral intake of nutrients and fluids insufficient to sustain life
- Continuing weight loss
- Dehydration or hypovolemia
- Absence of artificial feeding

OR

b. Life-threatening complications demonstrated by one or more of the following in the preceding twelve (12) months:
- Recurrent aspiration pneumonia (with or without tube feedings)
- Upper urinary tract infections (e.g. pyelonephritis)
- Sepsis
- Recurrent fever after antibiotic therapy
- Stage 3 or 4 decubitus ulcer(s)

In the absence of one or more of these findings, rapid decline or comorbidities may also support eligibility for hospice care.

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Parkinson's Disease

The patient must meet at least one of the following criteria (1 **or** 2):

1. Severely impaired breathing capacity with all of the following findings:
- Dyspnea at rest
- Vital capacity less than 30%
- The requirement of supplemental oxygen at rest
- The patient declines artificial ventilation

OR

2. Rapid disease progression and either **a** or **b** below:
- 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 (ADL) to needing major assistance by caretaker in all ADLs
- Progression of Dementia (often Lewy-Body type), now FAST score 7A **(See Appendix 3)**

AND

a. Severe nutritional impairment demonstrated by all of the following in the preceding twelve (12) months:
- Oral intake of nutrients and fluids insufficient to sustain life
- Continuing weight loss
- Dehydration or hypovolemia
- Absence of artificial feeing

OR

b. Life-threatening complications demonstrated by one or more of the following in the preceding twelve (12) months:
- Recurrent aspiration pneumonia (with or without tube feedings)
- Upper urinary tract infection (e.g. pyelonephritis)
- Sepsis
- Recurrent fever after antibiotic therapy
- Stage 3 or 4 decubitus ulcer(s)

In the absence of one or more of these findings, rapid decline or comorbidities may also support eligibility for hospice care.

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Renal Failure

The patient has 1 **and** either 2 **or** 3.

1. The patient is not seeking dialysis or transplant

AND

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

*Creatinine Clearance Calculation for men

$$CrCl = \frac{(140\text{-age, in years}) \times (\text{weight, in Kg})}{72 \times (\text{serum creatine in mg/dl})}$$

*Creatinine Clearance Calculation for men

$$CrCl = \frac{(140\text{-age, in years}) \times (\text{weight, in Kg}) \times 0.85}{72 \times (\text{serum creatine in mg/dl})}$$

OR

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

Supporting evidence for hospice eligibility:

- Uremia
- Oliguria (urine output is less than 400cc in 24 hours)
- Intractable hyperkalemia (greater than 7.0), not responsive to treatment
- Uremic pericarditis
- Hepatorenal syndrome
- Immunosuppression/AIDS
- Intractable fluid overload, not responsive to treatment

In the absence of one or more of these findings, rapid decline or comorbidities may also support eligibility for hospice care.

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APPENDIX 1

NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASSIFICATION
(Class & Description)

I Patients with cardiac disease, but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea, palpitations or anginal pain.

II Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, dyspnea, palpitations or anginal pain.

III Patients with marked limitations of physical activity. They are comfortable at rest. Less than ordinary physical activity causes fatigue, palpitations, dyspnea or angina pain.

IV Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or of the angina syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

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APPENDIX 2

Palliative Performance Scale (PPS)

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & 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 normal job/work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work 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	Mouth care only	Full or Drowsy +/- Confusion
0%	Death				

Determine ambulation first and then assess activity, self-care, intake and conscious level sequentially.

Patients with a Palliative Performance Scale of 40% and chronic or serious illness are generally hospice eligible.

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APPENDIX 3

Functional Assessment Staging (FAST) for Dementia
Assess highest consecutive level of disability

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 shopping, etc.).
5	Requires assistance in choosing proper clothing to wear for the day, season or occasion (e.g. patient may wear the same clothing repeatedly unless supervised).
6A	Improperly putting on clothes without assistance or cueing (e.g. may put on street clothes on overnight clothes, or put shoes on the wrong feet, or have difficulty buttoning clothing).
6B	Unable to bathe properly (e.g. difficulty adjusting the bath-water temperature).
6C	Inability to handle mechanisms of toileting (e.g. forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue).
6D	Urinary incontinence (worsening).
6E	Fecal incontinence (worsening).
7A	Ability to speak is limited to six (6) different intelligible words or fewer in the course of an average day or in the course of an intensive interview.
7B	Speech ability is limited to the use of a single intelligible word in an average day or in of an intensive interview (the person may repeat the word over and over).
7C	Ambulatory ability is lost (cannot walk without personal assistance).
7D	Cannot sit up without assistance (e.g. the individual will fall over if there are not lateral rests (arms) on the chair).
7E	Loss of ability to smile.
7F	Loss of ability to hold head up independently.

**Scored primarily on the basis of information obtained from knowledgeable source. Reisberg, B. Functional Assessment Staging (FAST). Psychopharmacology Bulletin 1988; 24:-653-659*

Patients with a FAST score of 7A are generally hospice eligible.

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APPENDIX 4

Dementia Mortality Risk Scoring:

Mortality Risk Index Score (Mitchell) for Dementia Patients	
Points	Risk Factor
1.9	Complete dependence with ADLs
1.9	Male gender
1.7	Cancer
1.6	Congestive heart failure
1.6	O_2 therapy needed w/in 14 day
1.5	Shortness of breath
1.5	<25% of food eaten at most meals
1.5	Unstable medical condition
1.5	Bowel incontinence
1.5	Bedfast
1.4	Age > 83 y
1.4	Not awake most of the day
Risk estimate of death within six (6) months	
Score	Risk %
0	8.9
1-2	10.8
3-5	23.2
6-8	40.4
9-11	57.0
= 12	70.0

Patients with a Mitchell Mortality Score of >9 are generally hospice eligible.

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APPENDIX 5

Dementia Criteria/Frailty Screen

HNW Frailty Screen

1. Sex	Female = 0, Male = 5 points	_____
2. Age		
	a. 65-70 = 2 points	
	b. 71-80 = 4 points	
	c. 81-90 = 7 points	
	d. 91-100 = 9 points	
	e. >100 = 11 points	_____
3. Weight loss in last 3 months>5%	= 5 points	_____
4. GFR less than 30	= 6 points	_____
5. CHF	= 4 points	_____
6. Poor appetite	= 4 points	_____
7. Shortness of breath at rest	= 8 points	_____
8. Living in AL/AFH/SNF	= 8 points	_____
9. Cognitive loss in past 3 months	= 8 points	_____
10. ADLs dependence	= 1 point for each of 6	_____
11. Goals: prefers no Abx	= 4 points	_____
12. Falls in the past 3 months	= 1 point for first 5	_____
13. Agitation in the past 3 months	= 4 points	_____
	TOTAL	_____

Score 16-25 = Mild frailty

Score 26-35 = Moderate frailty

Score 36+ = Severe frailty = Eligible for hospice care

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APPENDIX 6

Basic ADLs

Basic ADLs consist of self-care tasks, including:

- Personal hygiene and grooming
- Dressing and undressing
- Feeding oneself
- Functional transfers, e.g. getting out of bed
- Voluntarily controlling urinary and stool elimination
- Ambulation (walking or using a wheelchair)

Instrumental ADLs

Instrumental activities of daily living (IADLs) are not necessary for fundamental functioning, but they let an individual live independently in a community:

- Housework
- Meal preparation and clean-up
- Tracking medications
- Managing money
- Shopping for groceries or clothing
- Telephone use
- Using technology (as applicable)
- Care of others (including selecting and supervising caregivers)
- Care of pets
- Child rearing
- Use of communication devices
- Community mobility
- Financial management
- Health management and maintenance
- Safety procedures and emergency responses

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APPENDIX 7

Hospice comfort medications:

Morphine sulfate 20mg/ml liquid; 5 mg (0.25cc) po/sl every 1 hour as needed for pain or shortness of breath. (Start with 2.5 mg (0.125cc) dose in opiate naïve patients.)

Lorazepam 2mg/ml liquid; 0.5 mg (0.25cc) po/sl every 2 hours as needed for anxiety.

Haloperidol 2mg/ml liquid; 0.5mg (0.25cc) po/sl every 2 hours as needed for nausea or agitation. (Yes! It works well for nausea at end of life)

Atropine ophthalmic drops; 2 drops sublingually every 2 hours as needed for hyper secretions.

Opioid Equivalency Pearls:

Hydrocodone is equivalent to oral morphine in opiate strength
ie. Hydrocodone 5mg = oral morphine sulfate 5 mg

Oxycodone is 50% stronger than oral morphine
ie. Oxycodone 5mg = oral morphine sulfate 7.5mg

Oral hydromorphone is five time stronger than oral morphine
ie. oral hydromorphone 2 mg = oral morphine sulfate 10 mg

IV morphine is 2-3 times stronger than oral morphine
ie. IV Morphine 2 mg = oral morphine 5 mg

IV Hydromorphone is 20 times stronger than oral morphine
ie. IV hydromorphone 1mg = oral morphine 20 mg

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RESOURCES

DPOA: Printable DPOA form available from Washington State Medical Association. Hospice of the Northwest keeps these forms on-site, available to anyone in the community.

https://wsma.org/advance-directives

POLST: Information about Portable Orders for Life-Sustaining Treatment. Hospice of the Northwest keeps these forms on-site, available to anyone in the community.

https://wsma.org/polst

The Conversation Project: Information on starting conversations about goals and end-of-life care.

http://theconversationproject.org/

Five Wishes: Information on easy to use legal document that includes advanced directive information and DPOA forms. (NOTE: Not all hospitals view this as a legal document.)

http://www.agingwithdignity.org/

PC Now: Website from the College of Wisconsin that provides information and resources for End-of-life and Palliative Care.

http://www.mypcnow.org/

Hospice of the Northwest: Website with information on hospice services, events (such as grief support groups), education, and how to refer.

https://www.HospiceNW.org/

IMPORTANT NOTES

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