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Center for Clinical Systems Improvement

Palliative Care:

BioMedical Assessment and Care Planning

Today's Presenter

Dr. Carol F. Robinson DNP, MS, BSN, RN, CHPN®

Dr. Robinson has had a varied nursing career in both clinical and administrative leadership positions. Her scholarly work has focused on communication skills for health professionals, including advance care planning (ACP) conversations.

OBJECTIVES

At the conclusion of this presentation, the participant will be able to:

- Review the differences of palliative care and hospice care
- Review legal components of the advance directive
- Describe a comprehensive assessment approach to include areas sensitive to serious illness (SI) end-stage conditions
- Describe care plan review, addressing the patient's values and goals while incorporating behavioral, medical, and social aspects impacting care
- Describe appropriate referral touchpoints to connect SI biomedical assessment and care planning with palliative or hospice care services

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Disclosure

MI-CCSI, or the presenter, does not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

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AGENDA

1	Begin with the End in Mind
2	Advance Care Planning Tools
3	Comprehensive Assessment
4	Person-Centered Care Plan Review
5	Referral Touchpoints

Begin with the End in Mind

Definitions of Palliative Care and Hospice Services

Being Mortal

Medicine and What Matters in the End

Gawande, A. (2015_Feb 10). Being Mortal. PBS Frontline. http://www.pbs.org/wgbh/frontline/film/being-mortal/

Being Mortal…

Atul Gawande MD, MPH

"What I came to understand is that it really is a question about, okay, you want to fight. *What do you want to fight for:* your best possible day today *or* to sacrifice your day today for the sake of possible time later while we treat you?"

Public Barriers:
Language "Triggers"

- **Palliative Care**
  - *Symptom management* of disease or treatments related to disease
- **Hospice**
  - Care focused on comfort *when cure is no longer possible*

"All hospice patients need palliative care,

but not all palliative care patients need hospice!"

Palliative/Serious Illness Care definition

- Specialized medical care for people with serious illness
- Care providing relief from pain and other symptoms, supports quality of life, and is focused on patients with serious illness and their families. (IOM, 2015; CAPC, CMMS)
- May begin early in the course or treatment for serious illness, across the continuum of health care settings (IOM, 2015; CMMS)
- Appropriate at any age and at any stage in serious illness (NCHPC 2018, p. iii)
- Can be provided along with curative treatment (NCHPC 2018, p. iii)
- Not time-limited
- Covered by insurance
- Can be delivered across the continuum of care (home, hospital, clinic, various living facilities)

Hospice Care definition

- Philosophy of care, versus a place.
- Focused on quality of life when cure is no longer possible.
- Treats the whole person, not just the disease.
- An interdisciplinary team that works with the person and family to design & implement a plan of care unique to each person's diagnosis.
- The person's wishes are always a priority.
- Hospice care continues, providing bereavement support up to 13 months post-death for the family and loved ones.

Hospice Services

- Manage a person's pain and symptoms
- Provide emotional support
- Provides needed medications, medical supplies and equipment associated with the terminal diagnosis
- Instructs and coaches loved ones on how to care for the person
- Delivers special services as needed (e.g., speech & physical therapy)
- Grief support to loved ones and friends (including 13 months post death)
- Short-term inpatient care if pain or symptoms can't be managed at home, or caregiver needs respite time

NHPCO:
Palliative Care or Hospice?

PALLIATIVE CARE OR HOSPICE?

The right service at the right time for seriously ill individuals

QUESTION	PALLIATIVE CARE	HOSPICE
What is the focus?	Palliative care is not hospice care: it does not replace the patient's primary treatment; palliative care works together with the primary treatment being received. It focuses on the pain, symptoms and stress of serious illness most often as an adjunct to curative care modalities. It is not time limited, allowing individuals who are 'upstream' of a 6-month or less terminal prognosis to receive services aligned with palliative care principles. Additionally, individuals who qualify for hospice service, and who are not emotionally ready to elect hospice care could benefit from these services.	Hospice care focuses on the pain, symptoms, and stress of serious illness during the terminal phase. The terminal phase is defined by Medicare as an individual with a life expectancy of 6-months or less if the disease runs its natural course. This care is provided by an interdisciplinary team who provides care encompassing the individual patient and their family's holistic needs.
Who can receive this type of care?	Any individual with a serious illness, regardless of life expectancy or prognosis.	Any individual with a serious illness measured in months not years. Hospice enrollment requires the individual has a terminal prognosis.
Can my patient continue to receive curative treatments?	Yes, individuals receiving palliative care are often still pursuing curative treatment modalities. Palliative care is not limited to the hospice benefit. However, there may be limitations based on their insurance provider.	The goal of hospice is to provide comfort through pain and symptom management, psychosocial and spiritual support because curative treatment modalities are no longer beneficial. Hospice should be considered at the point when the burden of any given curative treatment modalities outweighs the benefit coupled with prognosis. Other factors to consider and discuss, based on individual patient situations, are treatment modalities that no longer provide benefit due to a loss of efficacy.
What services are provided?	Pain and symptom management, in-person and telephonic visits, help navigating treatment options, advance care planning and referrals to community resources.	Pain and symptom management, 24-hour on-call service, in-person visits, medical equipment, related medications, inpatient care, continuous care in the home, respite care, volunteer services, spiritual care, bereavement and counseling services. There are four levels of care that can be provided to patients per CMS regulations (routine, inpatient, continuous, and respite care).
Where are services provided?	Palliative care may be provided in any care setting. ▮ Home ▮ Hospice facility ▮ Skilled Nursing Facility ▮ Long-term Care Facility ▮ Long Term Acute Care Facility ▮ Assisted Living Facility ▮ Hospital ▮ Group Home ▮ Clinics	Hospice care can be provided in most care settings. ▮ Home ▮ Hospice facility ▮ Skilled Nursing Facility ▮ Long-term Care Facility ▮ Assisted Living Facility ▮ Hospital (inpatient levels of care only) ▮ Group Home

(continued on reverse...)

National Hospice and Palliative Care Organization

NHPCO, 2019

Who provides these services?	Palliative care may be provided by an interdisciplinary team. However, most palliative services are provided by a physician, nurse practitioner or nurse with consultative support from social worker and chaplaincy services. These services are performed in collaboration with the primary care physician and specialists through consultative services or co-management of the patient's disease process.	Hospice care is provided by an interdisciplinary team that is led by a physician and includes nurses, social workers, chaplains, volunteers, hospice aides, therapy disciplines and others. These services are performed in collaboration with the attending physician.
What types of health care organizations may provide these services?	Palliative care is not dependent on care setting or type of medical practice. Services are performed in collaboration with the patient's primary care physician, other specialists, and health care settings they may be receiving services from. ▮ Palliative Care Practices ▮ Licensed Home Health Agencies ▮ Licensed Hospice Agencies ▮ Nursing Facilities ▮ Healthcare Clinics ▮ Hospitals	Hospice organizations ▮ State licensed and/or Medicare-certified Hospice providers ▮ Non-Medicare certified Hospice providers ▮ Veteran Affairs Hospice
How long can an individual receive services?	Palliative care is not time-limited. How long an individual can receive care will depend upon their care needs, and the coverage they have through Medicare, Medicaid, or private insurance. Most individuals receive palliative care on an intermittent basis that increased over time as their disease progresses.	As long as the individual patient meets Medicare, Medicaid, or their private insurer's criteria for hospice care. Again, this is measured in months, not years.
PAYMENT		
Does Medicare pay?	Palliative care is covered through Medicare Part B. Some treatments and medications may not be covered. May be subject to a co-pay according to the plan.	The Medicare Hospice Benefit pays all related costs associated with the care that is related to the terminal prognosis as directed by CMS. There may be some medications, services, and/or equipment that are not included in the Medicare Hospice Benefit.
Does Medicaid pay?	Palliative care is covered through Medicaid. Some treatments and medications may not be covered. May be subject to a co-pay according to the plan.	In most states Medicaid pays all related costs associated with the care related to the terminal prognosis as directed by CMS. There may be some medications, services and/or equipment that are not included in the Medicaid Hospice Benefit.
Does private insurance pay?	Most private insurers include palliative care as a covered service. Each payer is different, and their palliative services will be outlined through the insurer's member benefits. Some treatments and medications may not be covered. May be subject to a co-pay according to the plan.	Most private insurers have a hospice benefit that pays all related costs associated with the care related to the terminal prognosis. There may be some medications, services and/or equipment that are not included in the individual's policy. May be subject to a co-pay according to the plan.
When should I refer?	Patients with advanced chronic illness that have received maximum medical therapy and are at risk of using the hospital for decompensation.	If you would not be surprised if this patient died within the next 12 months, they are likely appropriate for hospice. Patients that have received maximum therapy and focus has shifted to symptom management and comfort care.

NHPCO, 2019

https://www.nhpco.org/patients-and-caregivers/about-palliative-care/palliative-care-faqs/

TAKEAWAY

- Palliative Care
  - *Advanced symptom management* of a disease or treatments related to disease
- Hospice
  - *Care* focused on comfort *when cure is no longer possible*

“All hospice patients need palliative care, but not all palliative care patients need hospice!”

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Advance Care Planning Tools

The “Who” and “How” of person-centered, values-based care

The PROCESS

Advance Care Planning (ACP)

Discuss

- Reflect on your values and beliefs

Decide

- Choose your Patient Advocate(s)
- Decide on your treatment preferences

Document

- Write your wishes in an Advance Directive (Durable Power of Attorney for Healthcare or DPOAH)
- Share your plan

The DIFFERENCE

Advance Directive versus Living Will

Advance Directive	Living Will
• Appoints your Patient Advocate (PA) • Gives the PA the right to participate in discussions about your care and ensures your wishes are followed • Required document by state of Michigan	• Gives your medical instruction (goals of care/treatment preferences) to your Patient Advocate • The GIFT you give your advocate! • it is not a required legal document in Michigan • It does not “stand alone” by state statute

Types of ACP forms

Advance Directive

Durable Power of Attorney for Healthcare
(Patient Advocate Designation)

Introduction

This document provides a way for you to create a Durable Power of Attorney for Healthcare (Patient Advocate Designation) and other documentation that will meet the basic requirements for this state. This Advance Directive (AD) allows you to appoint a person (and alternates) who shall take reasonable steps to follow the desires and instructions indicated within this document, or in other written or spoken treatment preferences.

The person you appoint is called your **Patient Advocate**. This document gives your consent to allow your Patient Advocate to make decisions *only when two physicians, or a physician and a licensed psychologist, have determined you are unable to make your own decisions.* Every resident age 18 and over should appoint a Patient Advocate, as accidents can happen to anyone, at any time.

Note: This AD does *not* give your Patient Advocate permission to make your *financial* or other *business* decisions.

Before completing this document, take time to read it carefully. **It also is very important that you discuss your views, your values, and this document with your Patient Advocate(s).**
If you do not closely involve your Patient Advocate(s), and you do not make a clear plan together, your views and values may not be fully followed because they will not be understood.

This document was developed to meet the legal requirements of Michigan. It is not designed to replace the counsel of your attorney.

This is an Advance Directive for *(print legibly)*:

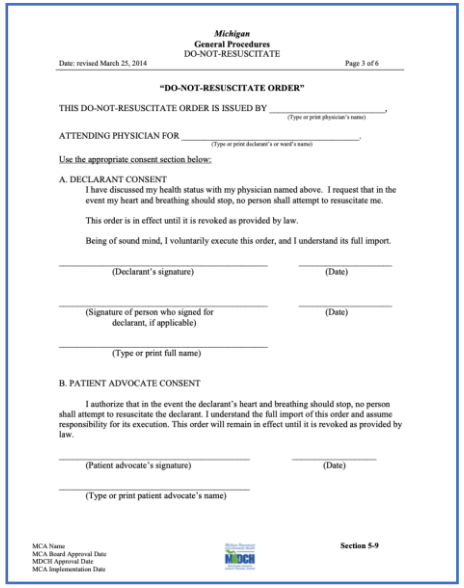
Name: _____ Date of Birth: _____ Last 4 digits of SSN: _____

Telephone: Primary (Cell ☐) _____ Secondary (Cell ☐) _____

Address: _____

City/State/Zip: _____

Where I would like to receive hospital care (whenever possible): _____



Michigan
General Procedures
DO-NOT-RESUSCITATE

Date: revised March 25, 2014 Page 3 of 6

"DO-NOT-RESUSCITATE ORDER"

THIS DO-NOT-RESUSCITATE ORDER IS ISSUED BY _____,
(Type or print physician's name)

ATTENDING PHYSICIAN FOR _____.
(Type or print declarant's or ward's name)

Use the appropriate consent section below:

A. DECLARANT CONSENT

I have discussed my health status with my physician named above. I request that in the event my heart and breathing should stop, no person shall attempt to resuscitate me.

This order is in effect until it is revoked as provided by law.

Being of sound mind, I voluntarily execute this order, and I understand its full import.

_____ _____
(Declarant's signature) (Date)

_____ _____
(Signature of person who signed for declarant, if applicable) (Date)

_____
(Type or print full name)

B. PATIENT ADVOCATE CONSENT

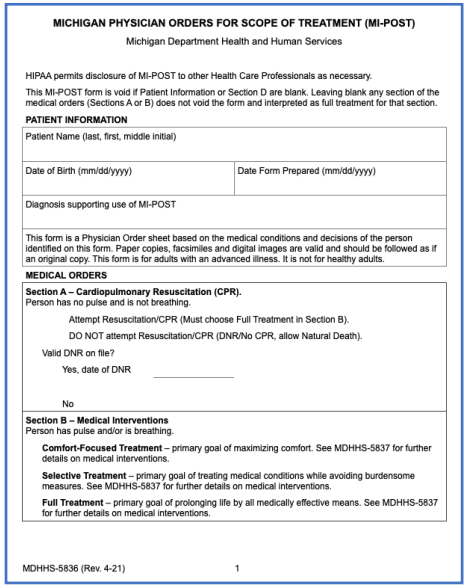
I authorize that in the event the declarant's heart and breathing should stop, no person shall attempt to resuscitate the declarant. I understand the full import of this order and assume responsibility for its execution. This order will remain in effect until it is revoked as provided by law.

_____ _____
(Patient advocate's signature) (Date)

_____
(Type or print patient advocate's name)

MCA Name
MCA Board Approval Date
MDCH Approval Date
MCA Implementation Date

Section 5-9



MICHIGAN PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (MI-POST)
Michigan Department Health and Human Services

HIPAA permits disclosure of MI-POST to other Health Care Professionals as necessary.

This MI-POST form is void if Patient Information or Section D are blank. Leaving blank any section of the medical orders (Sections A or B) does not void the form and interpreted as full treatment for that section.

PATIENT INFORMATION

Patient Name (last, first, middle initial)	
Date of Birth (mm/dd/yyyy)	Date Form Prepared (mm/dd/yyyy)
Diagnosis supporting use of MI-POST	

This form is a Physician Order sheet based on the medical conditions and decisions of the person identified on this form. Paper copies, facsimiles and digital images are valid and should be followed as if an original copy. This form is for adults with an advanced illness. It is not for healthy adults.

MEDICAL ORDERS

Section A – Cardiopulmonary Resuscitation (CPR).
Person has no pulse and is not breathing.

Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).

DO NOT attempt Resuscitation/CPR (DNR/No CPR, allow Natural Death).

Valid DNR on file?

Yes, date of DNR _____

No

Section B – Medical Interventions
Person has pulse and/or is breathing.

Comfort-Focused Treatment – primary goal of maximizing comfort. See MDHHS-5837 for further details on medical interventions.

Selective Treatment – primary goal of treating medical conditions while avoiding burdensome measures. See MDHHS-5837 for further details on medical interventions.

Full Treatment – primary goal of prolonging life by all medically effective means. See MDHHS-5837 for further details on medical interventions.

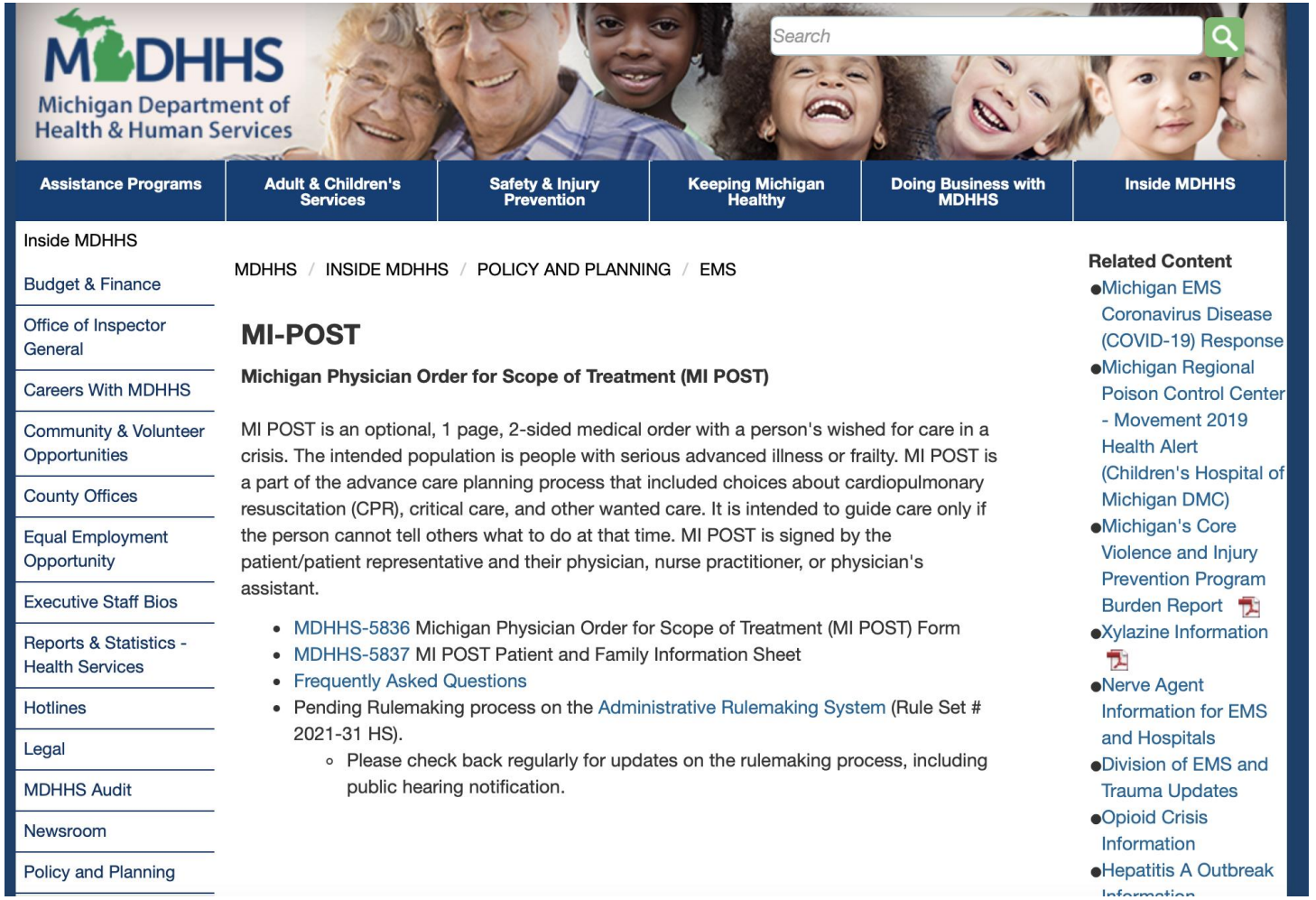
MDHHS-5836 (Rev. 4-21) 1

- **Legal**
  - Durable Power of Attorney for Healthcare (DPOAH)
  - ***"Who will speak for you if there is a time when you cannot speak for yourself?"***
- **Medical Order**
  - MI-POST: **Mi**chigan **P**hysician **O**rder for **S**cope of **T**reatment
  - DNR: Do Not Resuscitate

Document the Person-Centric Plan

Michigan Physician Order for Scope of Treatment (MI-POST)

Prevents or manages crisis intervention



https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5093_28508_76849-488836--,00.html

MICHIGAN PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (MI-POST)
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PATIENT INFORMATION

Patient Name (last, first, middle initial)	
Date of Birth (mm/dd/yyyy)	Date Form Prepared (mm/dd/yyyy)
Diagnosis supporting use of MI-POST	

This form is a Physician Order sheet based on the medical conditions and decisions of the person identified on this form. Paper copies, facsimiles and digital images are valid and should be followed as if an original copy. This form is for adults with an advanced illness. It is not for healthy adults.

MEDICAL ORDERS

Section A – Cardiopulmonary Resuscitation (CPR).
Person has no pulse and is not breathing.
☐ Attempt Resuscitation/CPR (Must choose Full Treatment in Section B).
☐ DO NOT attempt Resuscitation/CPR (DNR/No CPR, allow Natural Death).
Valid DNR on file?
☐ Yes, date of DNR _____
☐ No

Section B – Medical Interventions
Person has pulse and/or is breathing.
☐ **Comfort-Focused Treatment** – primary goal of maximizing comfort. See MDHHS-5837 for further details on medical interventions.
☐ **Selective Treatment** – primary goal of treating medical conditions while avoiding burdensome measures. See MDHHS-5837 for further details on medical interventions.
☐ **Full Treatment** – primary goal of prolonging life by all medically effective means. See MDHHS-5837 for further details on medical interventions.

Section C – Additional Orders (optional)
Medical orders for whether or when to start, withhold, or stop a specific treatment. Treatments may include but are not limited to dialysis, medically assisted provisions of nutrition, long-term life-support, medications, and blood products.

Section D – Signature of Attending Health Professional
My signature below indicated that these orders are medically appropriate given the patient's current medical condition, reflect to the best of my knowledge the patient's goals for care, and that the patient (or the patient representative) has received the information sheet.

Print Name	Date
Signature	Phone Number

Send form with patient whenever transferred or discharged.

MDHHS-5836 (Rev. 4-21) 1

Patient Last Name	Patient First Name

Print Name of Collaborating Physician	Phone Number

Section E – Signature of Patient or Patient Representative
My signature indicates I have discussed, understand and voluntarily consent to the medical orders on this MI-POST form. I acknowledge that if I am signing as the patient's representative, these decisions are consistent with the patient's wishes to the best of my knowledge.
☐ Patient ☐ Patient Advocate/Durable Power of Attorney of Health Care (DPOAHC)
☐ Court-Appointed Guardian

Print Name	
Signature	Date

Information of Legally Authorized Representative
Complete this section if this MI-POST form was signed by a Patient Advocate/DPOAH or Court-Appointed Guardian.

Address	Phone Number	Alternate Phone Number

Section F – Individual Assisting with Completion of MI-POST Form

Print Preparer's Name	Title	Date
Preparer's Signature	Organization	Phone Number

Section G – To Reaffirm or Revoke This Form
This MI-POST form can be reaffirmed or revoked at any time, verbally or in writing.
See MDHHS-5837 for further details on reaffirmation or revocation. **If a new form is not completed, full treatment and resuscitation will be provided.**

Reaffirmation 1

Healthcare Provider Name/Collaborative Physician (if applicable)		
Patient/Representative Name		
Healthcare Provider Signature	Patient/Representative Signature	Reaffirmation Date

Send form with Patient whenever transferred or discharged.
HIPAA permits disclosure of MI-POST to other Health Care Professionals as necessary.

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

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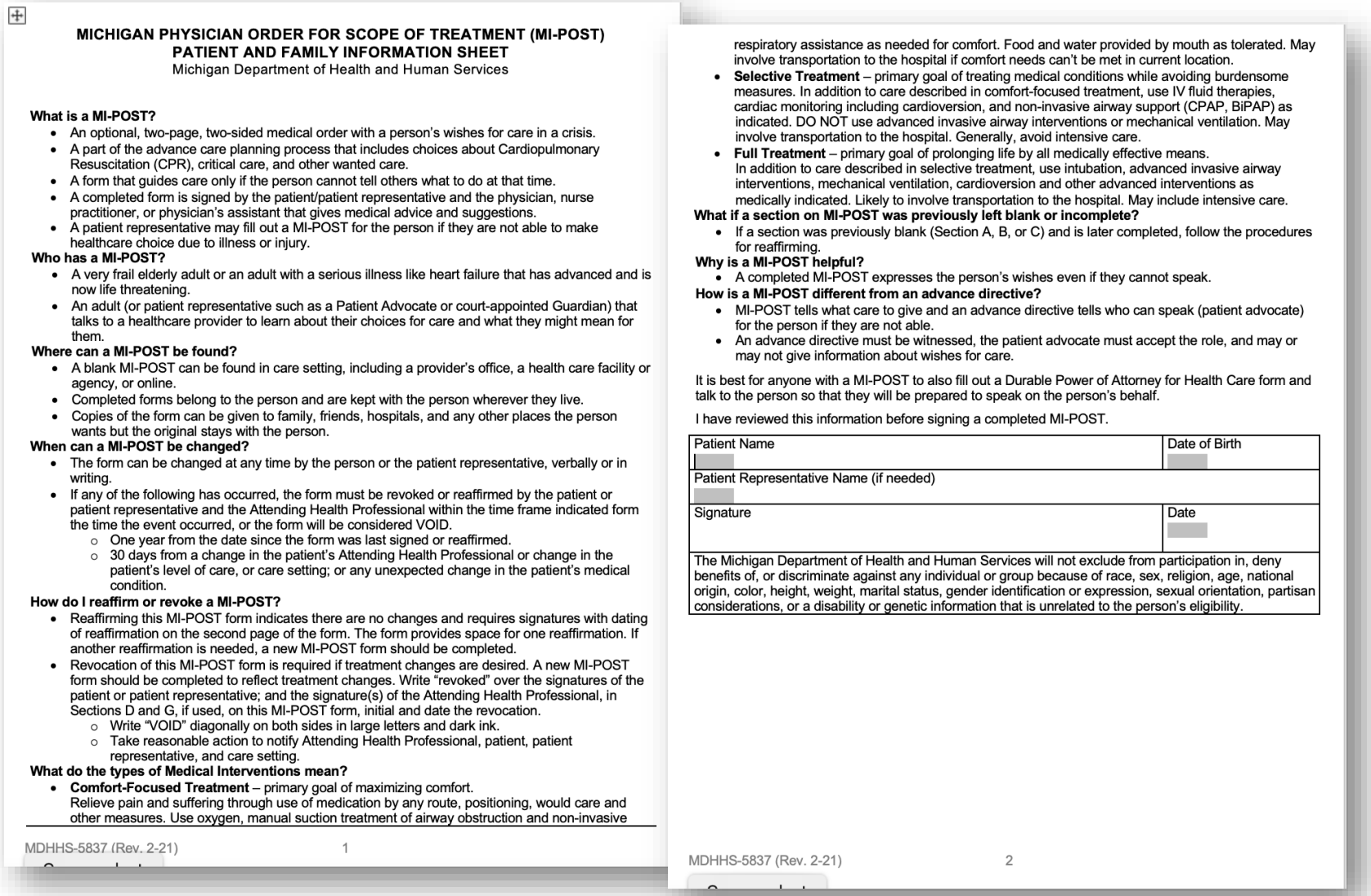
MI-POST Form

MI-POST

Patient & Family Information Sheet

This form *must be filled out* and *attached* to the MI-POST form!

See the MI-POST FAQ sheet for complete information



MICHIGAN PHYSICIAN ORDER FOR SCOPE OF TREATMENT (MI-POST)
PATIENT AND FAMILY INFORMATION SHEET
Michigan Department of Health and Human Services

What is a MI-POST?
- An optional, two-page, two-sided medical order with a person's wishes for care in a crisis.
- A part of the advance care planning process that includes choices about Cardiopulmonary Resuscitation (CPR), critical care, and other wanted care.
- A form that guides care only if the person cannot tell others what to do at that time.
- A completed form is signed by the patient/patient representative and the physician, nurse practitioner, or physician's assistant that gives medical advice and suggestions.
- A patient representative may fill out a MI-POST for the person if they are not able to make healthcare choice due to illness or injury.

Who has a MI-POST?
- A very frail elderly adult or an adult with a serious illness like heart failure that has advanced and is now life threatening.
- An adult (or patient representative such as a Patient Advocate or court-appointed Guardian) that talks to a healthcare provider to learn about their choices for care and what they might mean for them.

Where can a MI-POST be found?
- A blank MI-POST can be found in care setting, including a provider's office, a health care facility or agency, or online.
- Completed forms belong to the person and are kept with the person wherever they live.
- Copies of the form can be given to family, friends, hospitals, and any other places the person wants but the original stays with the person.

When can a MI-POST be changed?
- The form can be changed at any time by the person or the patient representative, verbally or in writing.
- If any of the following has occurred, the form must be revoked or reaffirmed by the patient or patient representative and the Attending Health Professional within the time frame indicated form the time the event occurred, or the form will be considered VOID.
  - One year from the date since the form was last signed or reaffirmed.
  - 30 days from a change in the patient's Attending Health Professional or change in the patient's level of care, or care setting; or any unexpected change in the patient's medical condition.

How do I reaffirm or revoke a MI-POST?
- Reaffirming this MI-POST form indicates there are no changes and requires signatures with dating of reaffirmation on the second page of the form. The form provides space for one reaffirmation. If another reaffirmation is needed, a new MI-POST form should be completed.
- Revocation of this MI-POST form is required if treatment changes are desired. A new MI-POST form should be completed to reflect treatment changes. Write "revoked" over the signatures of the patient or patient representative; and the signature(s) of the Attending Health Professional, in Sections D and G, if used, on this MI-POST form, initial and date the revocation.
  - Write "VOID" diagonally on both sides in large letters and dark ink.
  - Take reasonable action to notify Attending Health Professional, patient, patient representative, and care setting.

What do the types of Medical Interventions mean?
- **Comfort-Focused Treatment** – primary goal of maximizing comfort.
  Relieve pain and suffering through use of medication by any route, positioning, would care and other measures. Use oxygen, manual suction treatment of airway obstruction and non-invasive

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respiratory assistance as needed for comfort. Food and water provided by mouth as tolerated. May involve transportation to the hospital if comfort needs can't be met in current location.
- **Selective Treatment** – primary goal of treating medical conditions while avoiding burdensome measures. In addition to care described in comfort-focused treatment, use IV fluid therapies, cardiac monitoring including cardioversion, and non-invasive airway support (CPAP, BiPAP) as indicated. DO NOT use advanced invasive airway interventions or mechanical ventilation. May involve transportation to the hospital. Generally, avoid intensive care.
- **Full Treatment** – primary goal of prolonging life by all medically effective means.
  In addition to care described in selective treatment, use intubation, advanced invasive airway interventions, mechanical ventilation, cardioversion and other advanced interventions as medically indicated. Likely to involve transportation to the hospital. May include intensive care.

What if a section on MI-POST was previously left blank or incomplete?
- If a section was previously blank (Section A, B, or C) and is later completed, follow the procedures for reaffirming.

Why is a MI-POST helpful?
- A completed MI-POST expresses the person's wishes even if they cannot speak.

How is a MI-POST different from an advance directive?
- MI-POST tells what care to give and an advance directive tells who can speak (patient advocate) for the person if they are not able.
- An advance directive must be witnessed, the patient advocate must accept the role, and may or may not give information about wishes for care.

It is best for anyone with a MI-POST to also fill out a Durable Power of Attorney for Health Care form and talk to the person so that they will be prepared to speak on the person's behalf.

I have reviewed this information before signing a completed MI-POST.

Patient Name	Date of Birth
Patient Representative Name (if needed)	
Signature	Date

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

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Comprehensive Assessment

Comprehensive Assessment

> ***"To get to my body, my doctor has to get to my character. He has to go through my soul…I'd like my doctor to scan me, to grope for my spirit as well as my prostate. Without such recognition, I am nothing but my illness."***
>
> - Anatole Broyard

- Maximize listening skills
- Minimize quick judgments
- How would patient like to be addressed? Mr. Smith? John?
- Who is with the person? What are their names?
- Who is legally authorized to speak for the person if they cannot speak for themself (Patient Advocate/Durable Power of Attorney for Healthcare)?

Domains of Palliative Care

An interdisciplinary approach to holistic care

1. **Structure & Practice of Care**
   - Comprehensive IDT assessment; identified & expressed need of person & family
   - Emotional impact of the work on the Team Members
2. **Physical**
   - Pain & other symptoms
   - Treatment alternatives for person/family to make informed choices
3. **Psychologic and Psychiatric**
   - Pharmacologic, non-pharmacologic, Complementary and Alternative Medicine (CAM) as appropriate
   - Grief & Bereavement programming available to person & family

National Consensus Project for Quality Palliative Care (2018)

Domains of Palliative Care

An interdisciplinary approach to holistic care

4. **Social**
   - Family structure, relationships, medical decision-making, sexuality, caregiver availability, access to meds/equipment
   - Individualized comprehensive care plan to lessen caregiver burden and promote well-being
5. **Spiritual, Religious, Existential**
   - Assess and address spiritual concerns
   - Recognize and respect religious beliefs - provide spiritual support
   - Connect with community and spiritual groups or individuals important to person &/or family
6. **Cultural**
   - Assess and aim to meet cultural-specific needs of person and family
   - Respect and accommodate range of language, dietary, habitual and religious practices of person and family

National Consensus Project for Quality Palliative Care (2018)

Domains of Palliative Care

An interdisciplinary approach to holistic care

7. Imminently Dying Person

- IDT recognizes imminent death; provides appropriate care to the person and family, including planning for after-death care
- Introduce hospice referral as person declines
- Educate family on signs/symptoms of approaching death in developmentally, age and culturally appropriate manner; including, but not limited to, pain, dyspnea, nausea, agitation, delirium, and terminal secretions

8. Ethics & Law

- Family structure, relationships, medical decision-making, sexuality, caregiver availability, access to meds/equipment
- Individualized comprehensive care plan to lessen caregiver burden and promote well-being

National Consensus Project for Quality Palliative Care (2018)

The Interdisciplinary Team

- The Person's Attending Physician
  MD, DO, NP, PA and is identified by the person, at the time they elect to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

- Hospice Physician (if on service)
- Nurses
- Home Health Aides
- Social Workers
- Trained volunteers (if on service)
- Physical &/or Occupational Therapists
- Chaplain (if on service)
- Bereavement Counselors (if on service)

20.1 timing and Content of Certification, Rev. 246, Issued 09-14-18

The Interdisciplinary Team

Includes family or friends, or others, either paid or unpaid




NCPQPC, 2018

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Assessment

Needs & Concerns of Person

- Comprehensive assessment using open-ended questions
- Recognize common sources of suffering for people living with serious illness
- Define palliative care and how it could benefit the person
- Assess need for adaptive equipment

Ms. V welcomes her ninth great-grandchild, 4 days before her death

Comprehensive IDT Assessment

Open-ended questions using SPIKES Protocol

S etting:	Getting started
P erception:	What does the person know?
I nvitation:	How much does the person want to know?
K nowledge:	Share information.
E motion:	Respond to the person's feelings.
S ubsequent:	Planning and follow-up.

Buckman, R.(1992). How to break bad news: A guide for health care professionals. Baltimore, MD: The Johns Hopkins University Press.

Comprehensive Assessment
Stated and observed needs & concerns

Person's knowledge of disease

- What can you tell me about your illness/disease?
- How does your illness affect your daily activities?
- What symptoms bother you the most?
- What concerns you the most?
- How much of your day do you spend resting? Is it more or less than 50%? Has it changed recently?
- Has anyone talked with you about what to expect?
- How have your religious or spiritual beliefs been affected by your illness?
- Many people wonder about the meaning of all this - do you?
- Do you have a sense of how much time is left? Is this something you would like to talk about?

Medical College of Wisconsin (n.d.). Communication phrases in palliative care.

Managing Pain & Symptoms

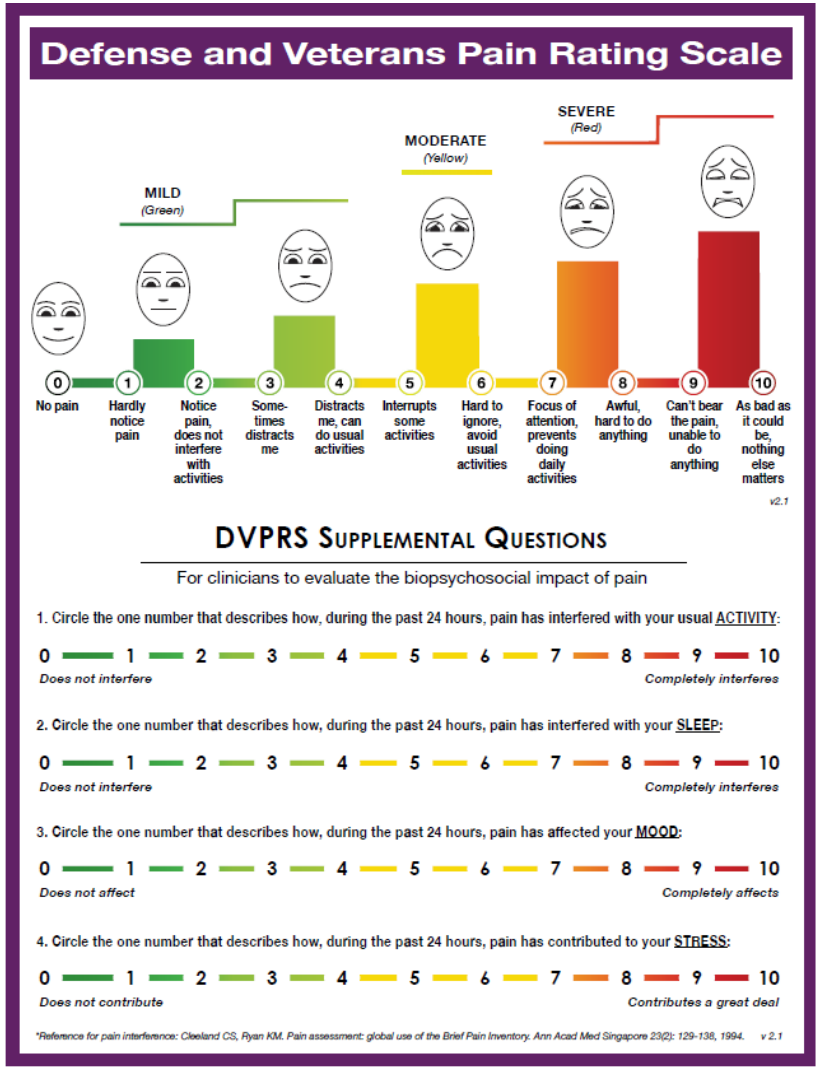
Identifying Serious Illness/Hospice Care Needs

- For ongoing patients, conduct regular symptom assessment and success in controlling troubling symptoms
- Initiate steps for symptom management when person is in distress

1. Pain
2. Breathing: shortness of breath/dyspnea/air hunger/respiratory distress
3. Nausea/vomiting
4. Bowel management
5. Appetite
6. Fatigue
7. Sleep
8. Emotional/Psychosocial Distress
9. Spiritual Distress

US Defense Health Agency

See Handout in the Palliative Care Packet



Defense and Veterans Pain Rating Scale

DVPRS Supplemental Questions

For clinicians to evaluate the biopsychosocial impact of pain

1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual ACTIVITY:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere … *Completely interferes*

2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your SLEEP:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere … *Completely interferes*

3. Circle the one number that describes how, during the past 24 hours, pain has affected your MOOD:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not affect … *Completely affects*

4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your STRESS:

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not contribute … *Contributes a great deal*

*Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore 23(2): 129-138, 1994. v 2.1

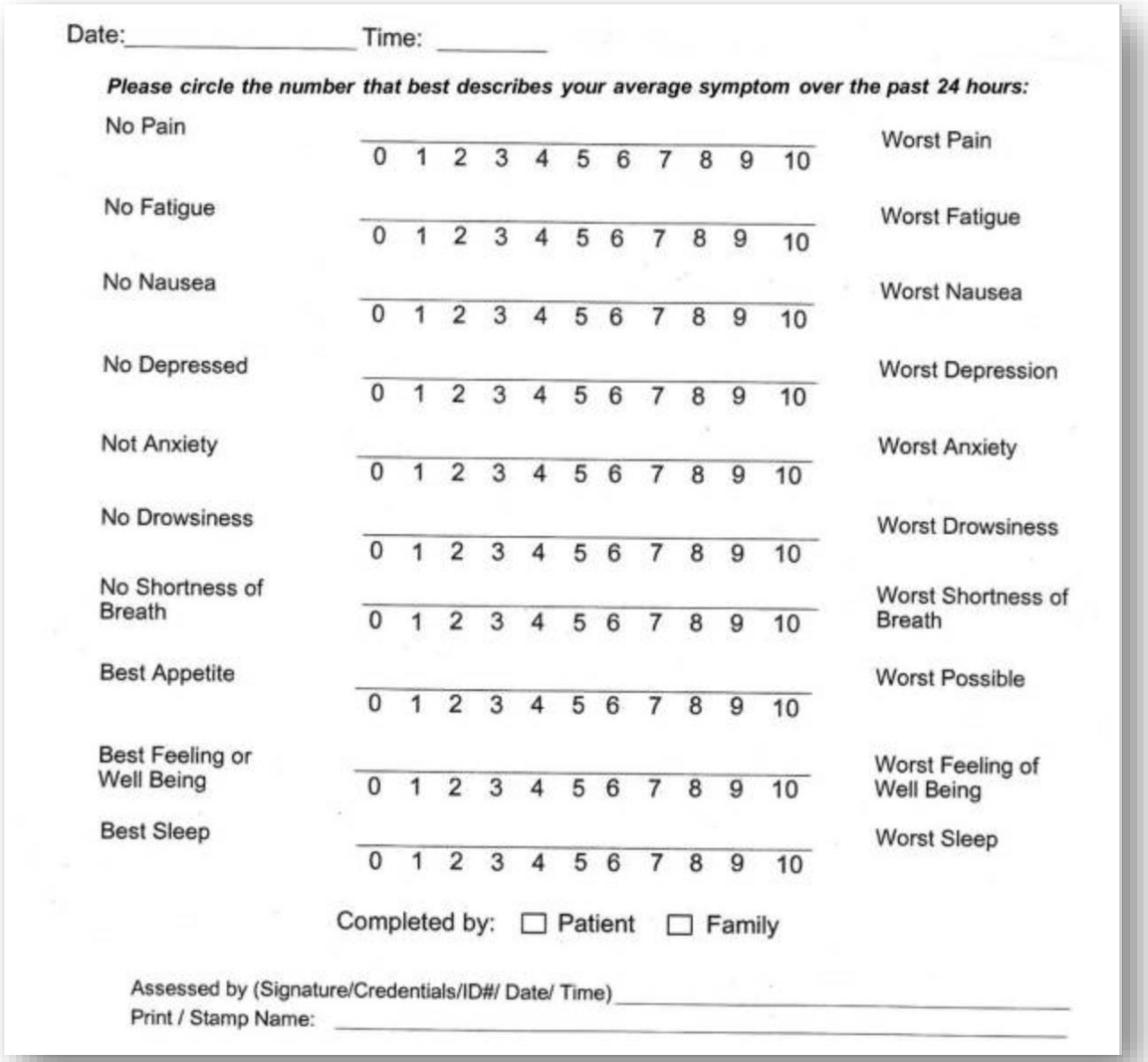
Pain & Symptom Management

Decision aids for referral to Specialty Palliative Care

- Karnofsky Performance Status Scale http://www.npcrc.org/files/news/karnofsky_performance_scale.pdf
- Palliative Performance Scale https://eprognosis.ucsf.edu/pps.php
- Edmonton Symptom Assessment Scale https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5337174/
- Respiratory Distress Observation Scale© https://www.floridahospices.org/archives/Press%20Releases/Forum%20links/Meg%20Campbell%20Article.pdf
- Heart Failure: Partnering in Your Treatment (American Heart Assn, 2019) https://www.heart.org/en/health-topics/heart-failure/what-is-heart-failure/classes-of-heart-failure
- End-Stage Renal Disease (ESRD). https://www.kidney.org/kidneydisease/siemens_hcp_quickreference
- FICA Spiritual Assessment Tool© https://smhs.gwu.edu/spirituality-health/sites/spirituality-health/files/FICA-Tool-PDF-ADA.pdf

Symptom Assessment

Edmonton Symptom Assessment Scale



Date:_____ Time: _____

Please circle the number that best describes your average symptom over the past 24 hours:

No Pain	0 1 2 3 4 5 6 7 8 9 10	Worst Pain
No Fatigue	0 1 2 3 4 5 6 7 8 9 10	Worst Fatigue
No Nausea	0 1 2 3 4 5 6 7 8 9 10	Worst Nausea
No Depressed	0 1 2 3 4 5 6 7 8 9 10	Worst Depression
Not Anxiety	0 1 2 3 4 5 6 7 8 9 10	Worst Anxiety
No Drowsiness	0 1 2 3 4 5 6 7 8 9 10	Worst Drowsiness
No Shortness of Breath	0 1 2 3 4 5 6 7 8 9 10	Worst Shortness of Breath
Best Appetite	0 1 2 3 4 5 6 7 8 9 10	Worst Possible
Best Feeling or Well Being	0 1 2 3 4 5 6 7 8 9 10	Worst Feeling of Well Being
Best Sleep	0 1 2 3 4 5 6 7 8 9 10	Worst Sleep

Completed by: ☐ Patient ☐ Family

Assessed by (Signature/Credentials/ID#/ Date/ Time) _____

Print / Stamp Name: _____

Edmonton Symptom Assessment Scale https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5337174/ Hui & Bruera (2017)

Symptom Assessment

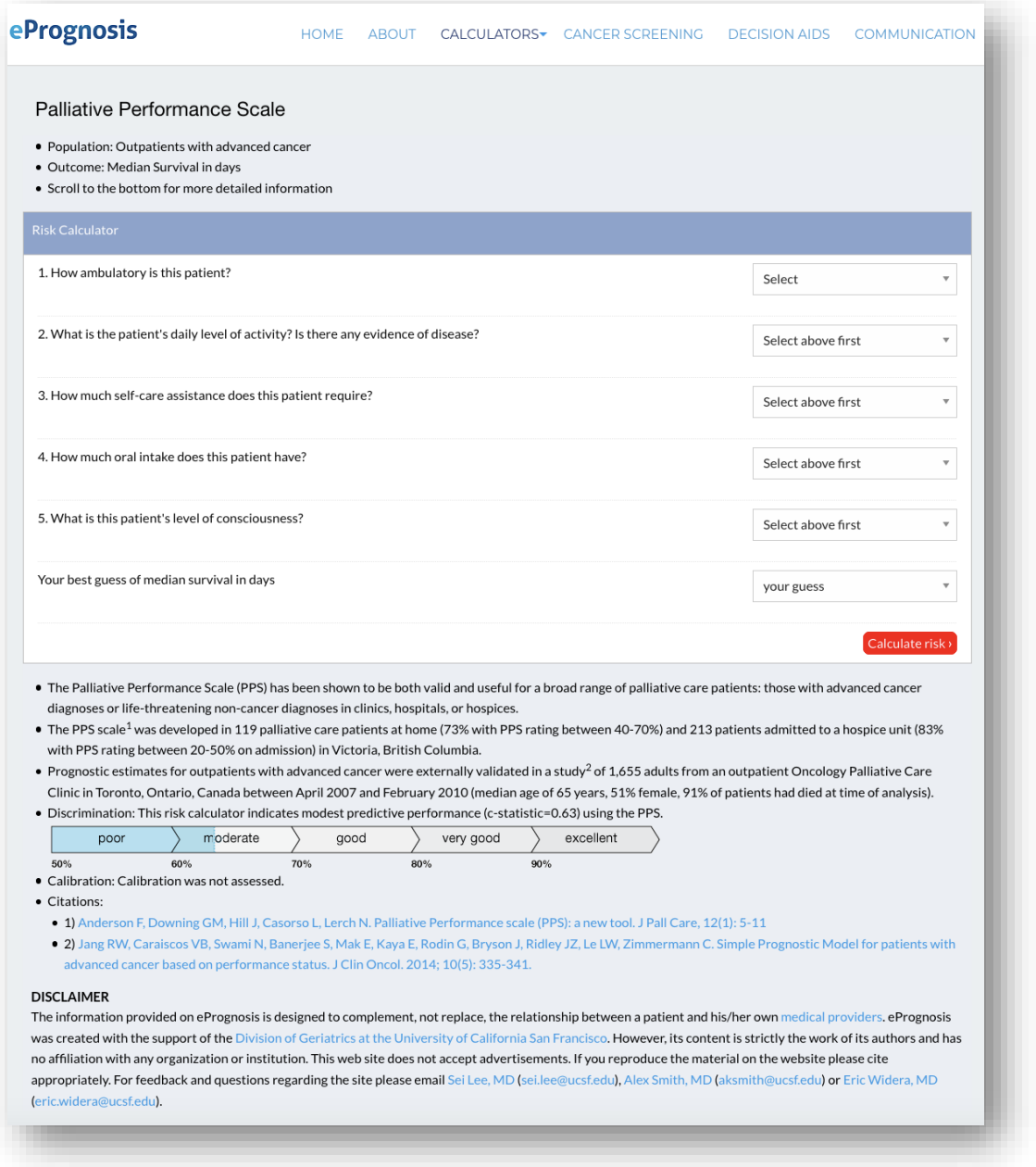
Karnofsky Performance Status Scale

KARNOFSKY PERFORMANCE STATUS SCALE DEFINITIONS	RATING (%)	CRITERIA
Able to carry on normal activity and to work; no special care needed.	100	Normal no complaints; no evidence of disease.
	90	Able to carry on normal activity; minor signs or symptoms of disease.
	80	Normal activity with effort; some signs or symptoms of disease.
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	70	Cares for self; unable to carry on normal activity or to do active work.
	60	Requires occasional assistance, but is able to care for most of his personal needs.
	50	Requires considerable assistance and frequent medical care.
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.	40	Disabled; requires special care and assistance.
	30	Severely disabled; hospital admission is indicated although death not imminent.
	20	Very sick; hospital admission necessary; active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly.
	0	Dead

Karnofsky Performance Scale http://www.npcrc.org/files/news/karnofsky_performance_scale.pdf Karnofsky & Burchenal (1949).

Symptom Assessment

Palliative Performance Scale



ePrognosis HOME ABOUT CALCULATORS CANCER SCREENING DECISION AIDS COMMUNICATION

Palliative Performance Scale

- Population: Outpatients with advanced cancer
- Outcome: Median Survival in days
- Scroll to the bottom for more detailed information

Risk Calculator

1. How ambulatory is this patient? — Select
2. What is the patient's daily level of activity? Is there any evidence of disease? — Select above first
3. How much self-care assistance does this patient require? — Select above first
4. How much oral intake does this patient have? — Select above first
5. What is this patient's level of consciousness? — Select above first

Your best guess of median survival in days — your guess

Calculate risk ›

- The Palliative Performance Scale (PPS) has been shown to be both valid and useful for a broad range of palliative care patients: those with advanced cancer diagnoses or life-threatening non-cancer diagnoses in clinics, hospitals, or hospices.
- The PPS scale[1] was developed in 119 palliative care patients at home (73% with PPS rating between 40-70%) and 213 patients admitted to a hospice unit (83% with PPS rating between 20-50% on admission) in Victoria, British Columbia.
- Prognostic estimates for outpatients with advanced cancer were externally validated in a study[2] of 1,655 adults from an outpatient Oncology Palliative Care Clinic in Toronto, Ontario, Canada between April 2007 and February 2010 (median age of 65 years, 51% female, 91% of patients had died at time of analysis).
- Discrimination: This risk calculator indicates modest predictive performance (c-statistic=0.63) using the PPS.

- Calibration: Calibration was not assessed.
- Citations:
  - 1) Anderson F, Downing GM, Hill J, Casorso L, Lerch N. Palliative Performance scale (PPS): a new tool. J Pall Care, 12(1): 5-11
  - 2) Jang RW, Caraiscos VB, Swami N, Banerjee S, Mak E, Kaya E, Rodin G, Bryson J, Ridley JZ, Le LW, Zimmermann C. Simple Prognostic Model for patients with advanced cancer based on performance status. J Clin Oncol. 2014; 10(5): 335-341.

DISCLAIMER

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Palliative Performance Scale https://eprognosis.ucsf.edu/pps.php Lee, Smith, & Widera (nd)

Symptom Assessment

Heart Failure Classification

Class	Patient Symptoms
I	No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea (shortness of breath).
II	Slight limitation of physical activity. Comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea (shortness of breath).
III	Marked limitation of physical activity. Comfortable at rest. Less than ordinary activity causes fatigue, palpitation, or dyspnea.
IV	Unable to carry on any physical activity without discomfort. Symptoms of heart failure at rest. If any physical activity is undertaken, discomfort increases.

Class	Objective Assessment
A	No objective evidence of cardiovascular disease. No symptoms and no limitation in ordinary physical activity.
B	Objective evidence of minimal cardiovascular disease. Mild symptoms and slight limitation during ordinary activity. Comfortable at rest.
C	Objective evidence of moderately severe cardiovascular disease. Marked limitation in activity due to symptoms, even during less-than-ordinary activity. Comfortable only at rest.
D	Objective evidence of severe cardiovascular disease. Severe limitations. Experiences symptoms even while at rest.

For Example:

- A patient with minimal or no symptoms but a large pressure gradient across the aortic valve or severe obstruction of the left main coronary artery is classified:
  - **Function Capacity I, Objective Assessment D**
- A patient with severe anginal syndrome but angiographically normal coronary arteries is classified:
  - **Functional Capacity IV, Objective Assessment A**

Dolgin M. & New York Heart Association. (1994). *Nomenclature and criteria for diagnosis of diseases of the heart and great vessels* (9th ed.). Little Brown.

Person-Centered Care Plan Review

Addressing the person's values and goals while incorporating behavioral, medica
and social aspects impacting care

Incorporating Goals of Care
#WhatMattersMost

What is important for you to live life well, until the end? Have you told your Patient Advocate?

- Who, or what, is your source of hope and strength?
- How are decisions about quality of life made in your family?
- Who would be important to include in discussions about your care?

What are you expecting as your illness progresses? If your current condition worsens, what are your goals?

- What are your fears?
- Are there any tradeoffs you are willing to make?
- LATER: What would a good day look like?

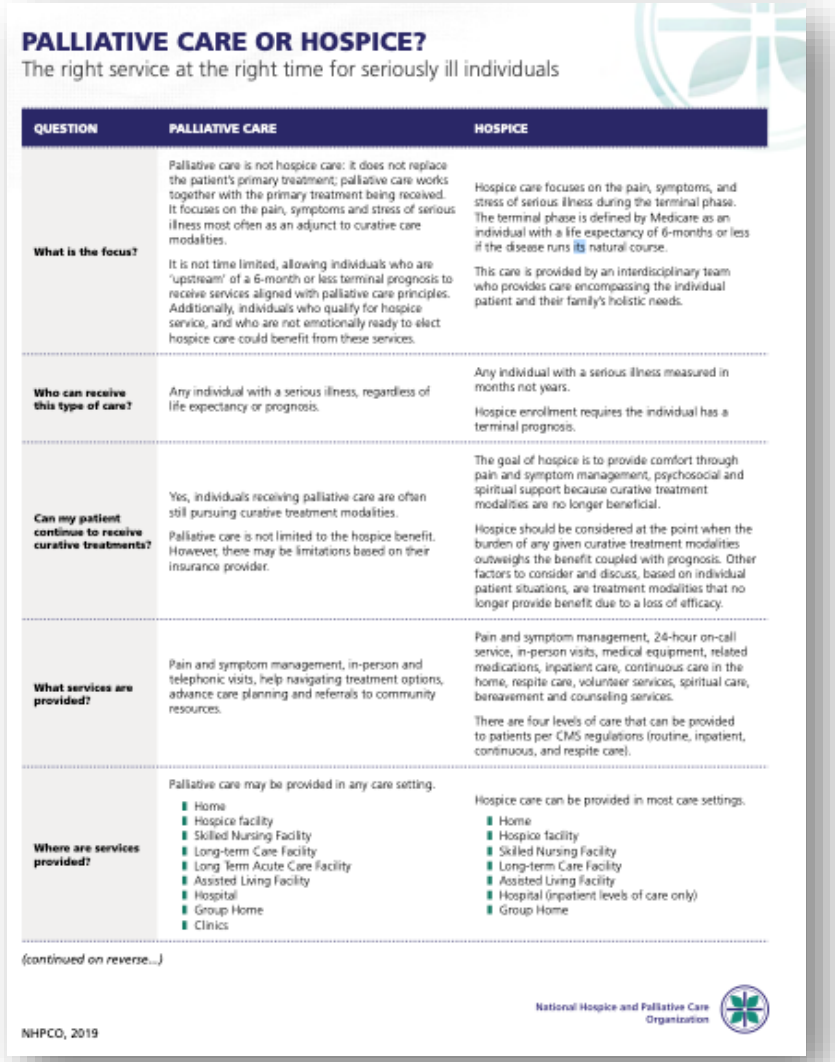
Ultimate Goal: Align the person's care to their values and preferences!

Block, S in Gawande (2014)

Referral Touchpoints

Palliative & Hospice Care

NHPCO: Palliative Care or Hospice?



PALLIATIVE CARE OR HOSPICE?

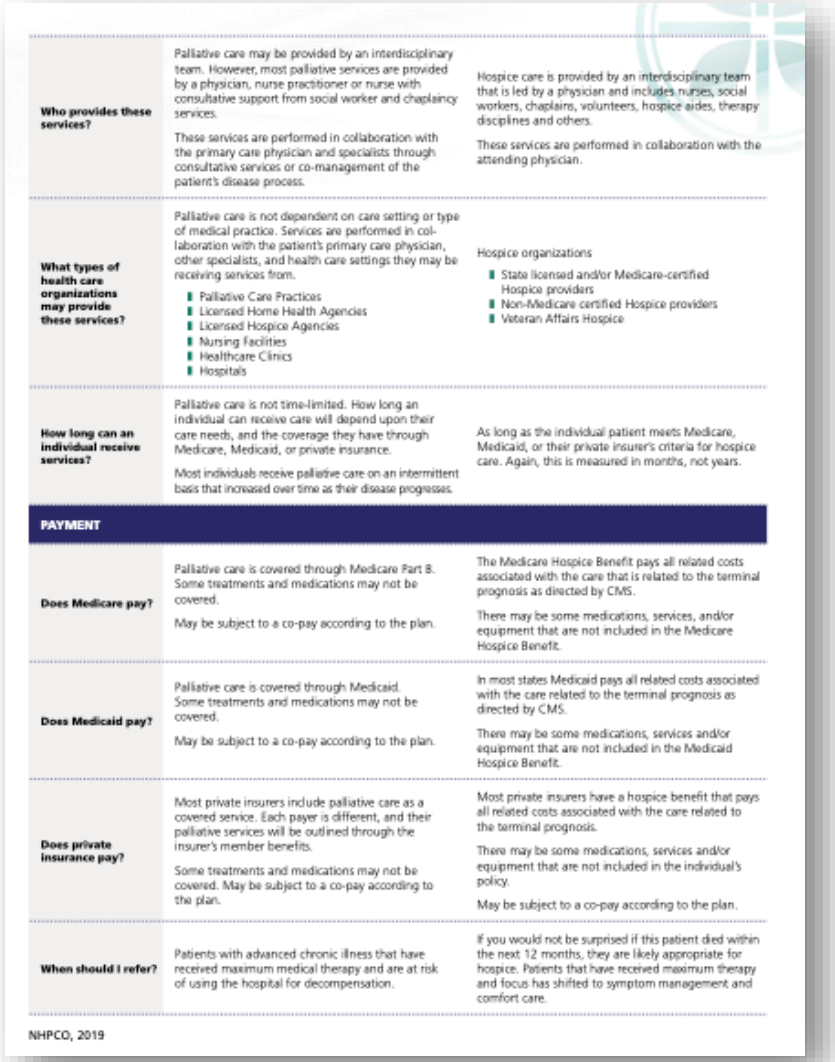
The right service at the right time for seriously ill individuals

QUESTION	PALLIATIVE CARE	HOSPICE
What is the focus?	Palliative care is not hospice care: it does not replace the patient's primary treatment; palliative care works together with the primary treatment being received. It focuses on the pain, symptoms and stress of serious illness most often as an adjunct to curative care modalities. It is not time limited, allowing individuals who are 'upstream' of a 6-month or less terminal prognosis to receive services aligned with palliative care principles. Additionally, individuals who qualify for hospice service, and who are not emotionally ready to elect hospice care could benefit from these services.	Hospice care focuses on the pain, symptoms, and stress of serious illness during the terminal phase. The terminal phase is defined by Medicare as an individual with a life expectancy of 6-months or less if the disease runs its natural course. This care is provided by an interdisciplinary team who provides care encompassing the individual patient and their family's holistic needs.
Who can receive this type of care?	Any individual with a serious illness, regardless of life expectancy or prognosis.	Any individual with a serious illness measured in months not years. Hospice enrollment requires the individual has a terminal prognosis.
Can my patient continue to receive curative treatments?	Yes, individuals receiving palliative care are often still pursuing curative treatment modalities. Palliative care is not limited to the hospice benefit. However, there may be limitations based on their insurance provider.	The goal of hospice is to provide comfort through pain and symptom management, psychosocial and spiritual support because curative treatment modalities are no longer beneficial. Hospice should be considered at the point when the burden of any given curative treatment modalities outweighs the benefit coupled with prognosis. Other factors to consider and discuss, based on individual patient situations, are treatment modalities that no longer provide benefit due to a loss of efficacy.
What services are provided?	Pain and symptom management, in-person and telephonic visits, help navigating treatment options, advance care planning and referrals to community resources.	Pain and symptom management, 24-hour on-call service, in-person visits, medical equipment, related medications, inpatient care, continuous care in the home, respite care, volunteer services, spiritual care, bereavement and counseling services. There are four levels of care that can be provided to patients per CMS regulations (routine, inpatient, continuous, and respite care).
Where are services provided?	Palliative care may be provided in any care setting. ▮ Home ▮ Hospice facility ▮ Skilled Nursing Facility ▮ Long-term Care Facility ▮ Long Term Acute Care Facility ▮ Assisted Living Facility ▮ Hospital ▮ Group Home ▮ Clinics	Hospice care can be provided in most care settings. ▮ Home ▮ Hospice facility ▮ Skilled Nursing Facility ▮ Long-term Care Facility ▮ Assisted Living Facility ▮ Hospital (inpatient levels of care only) ▮ Group Home

(continued on reverse...)

National Hospice and Palliative Care Organization

NHPCO, 2019



Who provides these services?	Palliative care may be provided by an interdisciplinary team. However, most palliative services are provided by a physician, nurse practitioner or nurse with consultative support from social worker and chaplaincy services. These services are performed in collaboration with the primary care physician and specialists through consultative services or co-management of the patient's disease process.	Hospice care is provided by an interdisciplinary team that is led by a physician and includes nurses, social workers, chaplains, volunteers, hospice aides, therapy disciplines and others. These services are performed in collaboration with the attending physician.
What types of health care organizations may provide these services?	Palliative care is not dependent on care setting or type of medical practice. Services are performed in collaboration with the patient's primary care physician, other specialists, and health care settings they may be receiving services from. ▮ Palliative Care Practices ▮ Licensed Home Health Agencies ▮ Licensed Hospice Agencies ▮ Nursing Facilities ▮ Healthcare Clinics ▮ Hospitals	Hospice organizations ▮ State licensed and/or Medicare-certified Hospice providers ▮ Non-Medicare certified Hospice providers ▮ Veteran Affairs Hospice
How long can an individual receive services?	Palliative care is not time-limited. How long an individual can receive care will depend upon their care needs, and the coverage they have through Medicare, Medicaid, or private insurance. Most individuals receive palliative care on an intermittent basis that increased over time as their disease progresses.	As long as the individual patient meets Medicare, Medicaid, or their private insurer's criteria for hospice care. Again, this is measured in months, not years.
PAYMENT		
Does Medicare pay?	Palliative care is covered through Medicare Part B. Some treatments and medications may not be covered. May be subject to a co-pay according to the plan.	The Medicare Hospice Benefit pays all related costs associated with the care that is related to the terminal prognosis as directed by CMS. There may be some medications, services, and/or equipment that are not included in the Medicare Hospice Benefit.
Does Medicaid pay?	Palliative care is covered through Medicaid. Some treatments and medications may not be covered. May be subject to a co-pay according to the plan.	In most states Medicaid pays all related costs associated with the care related to the terminal prognosis as directed by CMS. There may be some medications, services and/or equipment that are not included in the Medicaid Hospice Benefit.
Does private insurance pay?	Most private insurers include palliative care as a covered service. Each payer is different, and their palliative services will be outlined through the insurer's member benefits. Some treatments and medications may not be covered. May be subject to a co-pay according to the plan.	Most private insurers have a hospice benefit that pays all related costs associated with the care related to the terminal prognosis. There may be some medications, services and/or equipment that are not included in the individual's policy. May be subject to a co-pay according to the plan.
When should I refer?	Patients with advanced chronic illness that have received maximum medical therapy and are at risk of using the hospital for decompensation.	If you would not be surprised if this patient died within the next 12 months, they are likely appropriate for hospice. Patients that have received maximum therapy and focus has shifted to symptom management and comfort care.

NHPCO, 2019

https://www.nhpco.org/patients-and-caregivers/about-palliative-care/palliative-care-faqs/

Hospice Criteria

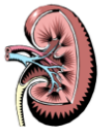
Hospice Criteria Card

NEUROLOGIC DISEASE

(Criteria are very similar for chronic degenerative conditions such as ALS, Parkinson's, Muscular Dystrophy, Myasthenia Gravis or Multiple Sclerosis)
The patient must meet at least one of the following criteria (1 or 2A or 2B):

1. Critically impaired breathing capacity, with all:
Dyspnea at rest, Vital capacity < 30%, Need O_2 at rest, patient refuses artificial ventilation
OR
2. Rapid disease progression with either A or B below:
Progression from :
independent ambulation to wheelchair or bed-bound status
normal to barely intelligible or unintelligible speech
normal to pureed diet
independence in most ADLs to needing major assistance in all ADLs
AND
A. Critical nutritional impairment demonstrated by all of the following in the preceding 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 in the past 12 months as demonstrated by ≥1:
Recurrent aspiration pneumonia, Pyelonephritis, Sepsis, Recurrent fever, Stage 3 or 4 pressure ulcer(s)

RENAL FAILURE



The patient has 1, 2, and 3.

1. The pt is not seeking dialysis or renal transplant
AND
2. Creatinine clearance* is < 10 cc/min (<15 for diabetics)
AND
3. Serum creatinine > 8.0 mg/dl (> 6.0 mg/dl for diabetics)

Supporting documentation for chronic renal failure includes:
Uremia, Oliguria (urine output < 400 cc in 24 hours), Intractable hyperkalemia (> 7.0), Uremic pericarditis, Hepatorenal syndrome, Intractable fluid overload.

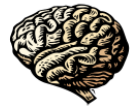
Supporting documentation for acute renal failure includes:
Mechanical ventilation, Malignancy (other organ system)
Chronic lung disease, Advanced cardiac disease, Advanced

STROKE OR COMA

The patient has both 1 and 2.
1. Poor functional status PPS* ≤ 40%
AND
2. Poor nutritional status with inability to maintain sufficient fluid and calorie intake with ≥1 of the following:
≥ 10% weight loss in past 6 months
≥7.5% weight loss in past 3 months
Serum albumin <2.5 gm/dl

Current history of pulmonary aspiration without effective response to speech therapy interventions to improve dysphagia and decrease aspiration events

Supporting documentation includes:
Coma (any etiology) with 3 of the following on the 3rd day of coma:
Abnormal brain stem response
Absent verbal responses
Absent withdrawal response to pain
Serum creatinine > 1.5 gm/dl



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1.Centers for Medicare & Medicaid services, HHS § 418.22 Certification of terminal illness. https://www.gpo.gov/fdsys/pkg/CFR-2011-title42-vol3/pdf/CFR-2011-title42-vol3-sec418-22.pdf Accessed 4/12/18
2. Medicare Program; FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements https://www.federalregister.gov/documents/2017/08/04/2017-16294/medicare-program-fy-2018-hospice-wage-index-and-payment-rate-update-and-hospice-quality-reporting Accessed 4/12/2018
3.Anderson F, Downing GM, Hill J. Palliative Performance Scale (PPS): a new tool. J Palliat Care. 1996; 12(1): 5-11.
4.Morita T, Tsunoda J, Inoue S, et al. Validity of the Palliative Performance Scale from a survival perspective. J Pain Symp Manage. 1999; 18(1):2-3.
5. Virik K, Glare P. Validation of the Palliative Performance Scale for inpatients admitted to a palliative care unit in Sydney, Australia. *J Pain Symp Manage.* 2002; 23(6):455-7.
6. Myers J, Kim A, Flanagan J. Palliative performance scale and survival among outpatients with advanced cancer. Supportive Care in Cancer 2015; 23.4: 913-918.

J.S. Ross MD, S. Sanchez-Reilly MD, J. Healy DO, 2018 STVHCS/ UTHSCSA

Hospice is a program designed to care for the dying & their special needs. All hospice programs should include:
(a) **Control of pain and other symptoms** through medication, environmental adjustment and education.
(b) **Psychosocial support** for both the patient and family, including all phases from diagnosis through bereavement.
(c) **Medical services** commensurate with patient needs.
(d) **Interdisciplinary Team (IDT)** approach to patient care, patient/ and family support, and education.
(e) Integration into existing facilities where possible.
(f) Specially trained personnel with expertise in care of the dying and their families.

Hospice Eligibility Criteria
In order to be eligible to elect hospice care under Medicare, an individual must be— (a) Entitled to Part A of Medicare; and (b) Certified as being terminally ill in accordance with § 418.22.

Duration of hospice care coverage—Election periods:
(1) An initial 90-day period;
(2) A subsequent 90-day period; or
(3) An unlimited number of subsequent 60-day periods.*

Hospice Face-To-Face (FTF) encounter Must include documentation that a hospice physician or a hospice nurse practitioner had a FTF encounter with the patient. This encounter is used to gather clinical findings to determine continued eligibility for hospice care. The FTF must occur within 30 days calendar prior to the start of the *3rd benefit period and every subsequent recertification period.

Hospice Levels of Care
Routine Home Care (RHC): Core services of hospice interdisciplinary team provided at patient's home (place of residence)
Continuous Home Care (CHC): intended to support patient and their caregivers through brief periods of crisis. CHC provides care for 8-24 hours a day. ≥50% of care must be primarily provided by an LPN or RN. Home health aid or homemaker services can be used to cover the needs.
Inpatient Respite Care (IRC): short term care to provide relief to family/ primary caregiver. Limited to 5 consecutive days
General Inpatient Care (GIP): care provided in acute hospital or other setting with intensive nursing & other support outside of the home. For management of uncontrolled distressing physical symptoms (e.g. uncontrolled pain, respiratory distress, etc.) or psychosocial problems (e.g. unsafe home or imminent death when family can't cope at home)

Hospice Principal Diagnosis
Identify the condition that is the main contributor to the person's terminal prognosis. Non-specific diagnoses such as Debility or Adult Failure to Thrive (AFTT) may no longer be listed as a principal terminal diagnosis. Debility and AFTT can and should be listed as secondary (related) conditions to support prognosis if indicated.

Ross, Sanchez-Reilly & Healy (2018), Page 1 https://cdn.ymaws.com/www.nmnpc.org/resource/resmgr/2018_annual_conf-_presentations-handouts/6_johnson/Hospice_Card__JSR_SSR_JMH_20.pdf

MI-CCSI
Center for Clinical Systems Improvement

Hospice Criteria

Palliative Performance Scale (PPS)

%	Ambulation	Activity Level Evidence of Disease	Self-Care	Intake	Level of Consciousness	Estimated Median Survival in Days A	B	C
100	Full	Normal /*No Disease*	Full	Normal	Full	N/A	N/A	108
90	Full	Normal /*Some Disease*	Full	Normal	Full			
80	Full	Normal with Effort/ *Some Disease*	Full	Normal or Reduced	Full			
70	Reduced	Can't do normal job/work/ *Some Disease*	Full	Normal or Reduced	Full	145		
60	Reduced	Can't do hobbies/ housework /*Significant Disease*	Occasional Assistance Needed	Normal or Reduced	Full or Confusion	29	4	
50	Mainly sit/lie	Can't do any work /*Extensive Disease*	Considerable Assistance Needed	Normal or Reduced	Full or Confusion	30	11	41
40	Mainly in Bed	Can't do any work /*Extensive Disease*	Mainly Assistance	Normal or Reduced	Full /Drowsy/ Confusion	18	8	
30	Bed Bound	Can't do any work *Extensive Disease*	Total Care	Reduced	As above	8	5	
20	Bed Bound	Can't do any work / *Extensive Disease*	Total Care	Minimal sips	As above	4	2	6
10	Bed Bound	Can't do any work /*Extensive Disease*	Total Care	Mouth care only	Drowsy or Coma	1	1	
0	Death	-	-	-	--	--	--	--

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).

Terminal Illness: GENERAL (non-specific)

Terminal condition not attributed to a single specific illness.

AND

Rapid decline over past 3-6 months as evidenced by:
Progression of disease evidenced by sx, signs & test results
Decline in PPS to ≤ 50%
Involuntary weight loss >10% and/or Albumin <2.5 (helpful)

CANCER

Patient meets ALL of the following:

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.Palliative performance Scale (PPS) ≤ 70%
3.Refuses further life-prolonging therapy OR continues to decline in spite of definitive therapy

Supporting documentation includes:
Hypercalcemia > 12
Cachexia or weight loss of 5% in past 3 months
Recurrent disease after surgery/radiation/chemotherapy
Signs and sx of advanced disease (e.g. nausea, requirement for transfusions, malignant ascites or pleural effusion, etc.)

Functional Assessment Scale (FAST) for Alzheimer's Type Dementia

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 task, (e.g., planning dinner for guests, handling personal finances e.g. forgetting to pay bills, etc.)
5	Requires assistance in choosing proper clothing to wear for the day, season or occasion, (e.g. pt may wear the same clothing repeatedly, unless supervised.*
6	Occasionally or more frequently over the past weeks. * for the following **A)** Improperly putting on clothes without assistance or cueing . **B)** Unable to bathe properly (not able to choose proper water temp) **C)** Inability to handle mechanics of toileting (e.g., forget to flush the toilet, does not wipe properly or properly dispose of toilet tissue) **D)** Urinary incontinence **E)** Fecal incontinence
7	**A)** Ability to speak limited to approximately ≤ 6 intelligible different words 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 **C)** Ambulatory ability is lost (cannot walk without personal assistance.) **D)** Cannot sit up without assistance (e.g., the individual will fall over if there are not lateral rests [arms] on the chair.) **E)** Loss of ability to smile. **F)** Loss of ability to hold up head independently.

*Scored primarily on information obtained from a knowledgeable informant.

DEMENTIA

The patient has both 1 and 2:
1. Stage 7C or beyond according to the FAST Scale
AND
2. One or more of the following conditions in the 12 months:
Aspiration pneumonia
Pyelonephritis
Septicemia
Multiple pressure ulcers (stage 3-4)
Recurrent Fever
Other significant condition that suggests a limited prognosis
Inability to maintain sufficient fluid and calorie intake in the past 6 months (10% weight loss or albumin < 2.5 gm/dl)

HEART DISEASE

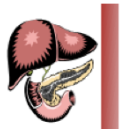
The patient has 1 and either 2 or 3.
1. CHF with **NYHA Class IV* symptoms & both:**
Significant symptoms at rest
Inability to carry out even minimal physical activity without dyspnea or angina
2. Patient is optimally treated
(ie diuretics, vasodilators, ACEI, or hydralazine and nitrates)
3. The patient has angina pectoris at rest, resistant to standard nitrate therapy, and is either not a candidate for/or has declined invasive procedures.

Supporting documentation includes:
EF ≤ 20%, Treatment resistant symptomatic dysrythmias
h/o cardiac related syncope, CVA 2/2 cardiac embolism
H/o cardiac resuscitation, concomitant HIV disease

HIV/AIDS

The patient has either 1A or 1B and 2 and 3.
1A. CD4+ < 25 cells/mcL **OR** 1B. Viral load > 100,000
AND
2. At least one (1) : CNS lymphoma, untreated or refractory wasting (loss of > 33% lean body mass), (MAC) bacteremia, Progressive multifocal leukoencephalopathy
Systemic lymphoma , visceral KS, Renal failure no HD, Cryptosporidium infection, Refractory toxoplasmosis
AND
3. PPS* of < 50%

LIVER DISEASE



The patient has both 1 and 2.
1. End stage liver disease as demonstrated by
A or B, & C:
A. PT> 5 sec
OR
B. INR > 1.5
AND
C. Serum albumin <2.5 gm / dl
AND
2. One or more of the following conditions:
Refractory Ascites, h/o spontaneous bacterial peritonitis, Hepatorenal syndrome , refractory hepatic encephalopathy, h/o recurrent variceal bleeding

Supporting Documents includes:
Progressive malnutrition, Muscle wasting with decreased strength. Ongoing alcoholism (> 80 gm ethanol/day), Hepato-cellular CA HBsAg positive, Hep. C refractory to treatment

PULMONARY DISEASE

Severe chronic lung disease as documented by 1, 2, and 3.
1. The patient has all of the following:
Disabling dyspnea at rest
Little of no response to bronchodilators
Decreased functional capacity (e.g. bed to chair existence, fatigue and cough)
AND
2. Progression of disease as evidenced by a recent h/o increasing office, home, or ED visits and/or hospitalizations for pulmonary infection and/or respiratory failure.
AND
3. Documentation within the past 3 months ≥1:
Hypoxemia at rest on room air (p02 < 55 mmHg by ABG) or oxygen saturation < 88%
Hypercapnia evidenced by pC02 > 50 mmHg

Supporting documentation includes:
Cor Pulmonale and right heart failure.
Unintentional progressive weight loss

Ross, Sanchez-Reilly & Healy (2018), Page 2 https://cdn.ymaws.com/www.nmnpc.org/resource/resmgr/2018_annual_conf-_presentations-handouts/6_johnson/Hospice_Card__JSR_SSR_JMH_20.pdf

Practical Application

MI-CCSI
Center for Clinical Systems Improvement

Questions?

Thank You