THE HOSPICE

INDICATORS

Nightingale Hospice
What is Hospice?

Hospice is a lot of things, but hospice isn’t all about dying, a place to go to die or always depressing.

Hospice is about the journey, a place of sharing, an opportunity to help those in need and a safe environment for patients and families – not to mention the industry leading, specialized care received by patients.

Hospice is a special way of caring for patients, caregivers and family members that is available to people living with a terminal illness. However, that does not mean that patients must be in the last few days of life to qualify for hospice care.

Medicare has established industry guidelines to help doctors and hospice staff determine if a patient qualifies for hospice.

We are happy to answer any question you may have.

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HOSPICE INDICATORS

Congestive Heart Failure:
- Class IV functional status (NYHA)
- Ejection fracture of < 20%
- Optimal diuretic and vasodilator therapy
- Recurrent symptoms of CHF at rest

COPD:
- Disabling dyspnea at rest
- Oxygen dependent
- O2 saturation less than 88%
- Recurrent infections
- Poor response to bronchodilators

Dementia or Alzheimer’s:
- Stage 7 or higher on FAST
  - Unable to ambulate alone
  - Unable to dress, bathe or feed self
  - Incontinent of bowel and bladder
  - Unable to speak or communicate meaningfully
- Presence of or history of at least 1 comorbid condition in the past year
- Ex: Weight loss, UTI, aspiration pneumonia, decubitus ulcers, etc.

Neurological (CVA, Coma, Parkinson’s, etc.):
- State 7 or higher on FAST
  - Unable to ambulate alone
  - Unable to dress, bathe or feed self
  - Incontinent of bowel and bladder
  - Speech limited
- Karnofsky < 40%
- Poor nutritional status, dysphasia, and/or > 10% wt loss

Liver Disease:
- Documentation of specific liver disease
- Jaundice
- Abnormal liver enzymes
- Bleeding diathesis and elevated PTT

Renal Disease:
- Elevated BUN and Creatinine
- Urine output < 400 ml/24 hours
- Patient/Family choose to stop dialysis
- Hepatorenal syndrome

NIGHTINGALE HOSPICE IMPROVES THE QUALITY OF LIFE FOR PATIENTS WITH:
- Cancer
- Cardiovascular Disease
- Congestive Heart Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Dementia or Alzheimer’s Disease
- Neurological Disease (Parkinson’s, ALS, etc.)
- Renal Disease
- Liver Disease
- Acquired Immune Deficiency Syndrome (AIDS)
NEUROLOGICAL DISEASES
INDICATORS

• Stroke (CVA)
  • Physician diagnosis of CVA with confirmation of non-recovery is necessary.
  • Must have ONE of the following (#1, #2, or #3)
    * Post Stroke Dementia with:
      * Stage 7 on FAST scale
      * Cannot dress, bathe or ambulate self
      * Incontinent of bowel and bladder, intermittent or constant
      * No meaningful verbal communication, stereotypical phrases only, or the ability to speak is limited to six or fewer intelligible words
    * Poor functional status with Karnofsky score of < 40%
    * Poor nutritional status with inability to maintain sufficient fluid
      * Calorie intake with > 10% weight loss during previous 6 months or serum albumin < 2.5 gm/dl

• Coma
  • Physician diagnosis of Coma with confirmation of non-recovery is necessary.
  • Comatose patients with any 3 of the following on day 3 of coma:
    * Abnormal brain stem response
    * Absent verbal response
    * Absent withdrawal response to pain
    * Serum creatinine > 1.5 mg/dl

• Medical Complications for both CVA and Coma
  • Must have had ONE of these in the past 12 months:
    * Aspiration pneumonia
    * Upper urinary tract infection (pyelonephritis)
    * Sepsis
    * Stage 3-4 decubitus ulcers
    * Fever recurrent after antibiotics

HOW NIGHTINGALE HELPS

• Management of Symptoms
• Personalized management of ADLs
  * Individualized POC to meet patient’s needs
  * Speech therapy to assist in meeting communication needs
  * Safety measures
  * Occupational therapy to modify ADLs
• Support for patients and families
  * Psychosocial support
  * Spiritual support
  * Community resource
• Help with end of life planning
  * Prepare advance directives, funeral arrangements, obtain DNR order
• Provide medications, supplies and equipment related to terminal diagnosis
• Educate regarding nutrition and hydration issues
• Offer standardized wound protocol
• Reduce unnecessary ER visits and hospitalizations
• Attend and pronounce deaths
• Provide bereavement care
PATIENTS WITH CANCER

INDICATORS

• Treatments not curing disease
• Failed multiple treatments
• Increasing pain and/or symptoms
• Multiple trips to hospital for symptom management
• Metastasis and/or Stage 3 or 4
• Toxicity outweighs benefits
• Poor performance status
  * ECOG of 3-4
  * Karnofsky < 50
• Terminal prognosis with only a few treatments left
• Exhausted patient and family/caregivers
• Treatment is having negative impact on patient’s quality of life
• Patient/family wants to stop curative treatment

HOW NIGHTINGALE HELPS - SUPPORTIVE CARE

• Consultations available 24 hours a day 7 days a week
• Expertise in pain and symptom management
• Pain evaluated on every visit and call
• Daily contact
• Psychosocial and spiritual counseling services
• End of life planning and life review
• 4 levels of care
• Radiation and/or chemotherapy treatments on an individualized basis
• Use of non-pharmacological therapy
• 24 hour availability of professional staff including RN, psychosocial, and physician
• Medications, equipment and supplies related to symptom management of the terminal diagnosis
• Communication and patient updates as determined by the referral source
• 13 months of bereavement services
DEBILITY UNSPECIFIED

INDICATORS

• Multiple diagnosis without 1 being prevalent
• Functional decline with a change in condition over the past 3-6 months
• At least 1 co-morbidity in the past 12 months. Examples include:
  * Urinary tract infection
  * Upper respiratory infection
  * Decubitus ulcer
  * Sepsis
  * Recurrent fever, after antibiotics
• Weight loss
• Hospitalizations or emergency room trips
• Change in cognitive level in the past 3-6 months
• Desire for palliative care

CASE STUDY

Mr. Smith is an 89 year old male who presents with dx of CAD, CHF, CVA, prostate cancer, diabetes, and anemia.

He has SOB on extreme exertion, tachycardia and had a UTI 3 months ago. He has minimal conversation. He was able to ambulate with assistance until he experienced a fall and subsequent emergency room trip 6 months ago. Currently he is wheelchair bound. Mr. Smith has a DNR status and requests no further hospitalizations.

During the past 6 months he has had a 7% weight loss. His current weight is 130 and height is 5 ft. 10 in. He used to consume 80% of meals. He used to eat with others but now chooses to stay in his room. He has a Stage 2 decubitus ulcer.

This patient would be eligible for hospice services based on:

• Co-morbidities including recent UTI, decubitus ulcer, tachycardia
• Changes in ADLs and socialization
• Falls, emergency room visits
• Weight loss, decreased appetite, hand fed
• DNR status, desiring palliative care
RENNAL DISEASE

INDICATORS

• The patient is not seeking dialysis or renal transplant
• Creatinine clearance < 10 cc/min (< 15 for diabetes)
• Serum creatinine > 8.0 mg/dl (> 6.0 mg/dl for diabetes)

Supplemental:
Presence of co-morbid conditions in acute renal failure is helpful
  * Examples may include advanced cardiac disease, chronic lung disease, cachexia, Albumin < 3.5 gm/dl, etc.

Presence of signs and symptoms in chronic renal failure is helpful
  * Examples include uremia, oliguria (<400cc/day), hyperkalemia (> 7.0) not responsive to treatment, hepatorenal syndrome, etc.

CASE STUDY

Mr. Hernandez, a 56 year old male, with a history of Type 2 diabetes, hypertension and peripheral vascular disease, has been having a hemodialysis 3 times a week for 4 years. He has been unable to work for the past 2 years. Prior to going on dialysis his creatinine was 6.5 and he had labile blood sugars.

Lately he feels “wiped out” after the treatments and complains of pruritis, nausea and sleep disturbances. He has expressed to the dialysis nurse that he is considering stopping dialysis.

He does not have a DNR order or an advance directive. He is married with 2 teenage children and his wife is disabled.

The team members assist him by discussing treatment options and advance directives and provide both psychosocial support to both him and his family.

His symptoms are controlled and his quality of life improved. He dies peacefully at home 2 weeks later.
CONTINUOUS CARE

INDICATORS

• Uncontrolled Symptoms:
  * Pain
  * Agitation
  * Delirium
  * Nausea/vomiting
  * Shortness of breath
  * Respiratory distress
  * Intractable diarrhea
  * Acute depression
  * Acute anxiety/terminal restlessness
  * Imminent death

• Conditions:
  * Fractures
  * Open lesions requiring frequent care
  * Complex wound care
  * Uncontrolled symptoms causing caregiver breakdown
  * Fear of dying requiring intensive interventions
  * Collapse of caregiver support requiring skilled care
  * Caregiver education for complex medications or treatment regimen

*Other circumstances may arise where the interdisciplinary team determines the patient’s condition requires a higher level of care

Continuous Care is short-term and used to maintain a patient in the patient’s residence during periods of crisis.

BENEFITS OF NIGHTINGALE’S CONTINUOUS CARE

Continuous Care is provided to patients where they reside... in the comfort of their homes, long-term care settings and assisted living communities. This level of care helps patients and families during times of crisis.

Patients who are receiving hospice care may be appropriate for short-term Continuous Care for symptom management and conditions requiring skilled intervention.

Patients may also be discharged from the hospital to Continuous Care for intensive teaching, symptom management and/or frequent adjustment of medications.

FEATURES OF CONTINUOUS CARE

• One on one care provided until pain and/or symptoms are managed
• Emotional support provided to caregiver during crisis
• Daily RN assessment of symptom management and/or specific needs
• Caregiver education regarding treatment and medication regimens, safety and symptoms of dying
• Patient remains in his or her residence
FAILURE TO THRIVE

INDICATORS

• Unexplained weight loss
• Malnutrition or nutritional impairment
  * BMI < 22 kg/m² (BMI (kg/m²) = 703 x (wt in lbs)/(ht in inches)²)
  * Below mid-arm circumference averages based on age and gender
• Disability
  * Karnofsky < or = 40%

POSSIBLE PRESENTING SYMPTOMS:

• Weight loss
• Anorexia
• Weakness
• Dizziness related to:
  * Hypotension (Systolic <90 mmHg)
  * Electrolyte imbalance
  * Anemia
• Memory Loss
• Depression
• Change in ability to perform ADLs

CASE STUDY

Mrs. Jones is an 86 year old female who has dx of anemia and weight loss. According to staff she is “wasting away”, “withdrawn” and “has given up”. She sleeps 15 hours a day.

She has had weight loss of >13% in the past 6 months and currently weighs 91 lbs. She pushes food away and the time required to feed her has increased to 30 minutes per meal. She was able to feed herself 6 months ago. Mrs. Jones’ family requests neither feeding tube nor hospitalizations.

She requires assistance with all ADLs. She is contracted and no one is certain of her height. Her mid-arm circumference is 23 cm. She was hospitalized with a URI 5 months ago.

This patient would be eligible for hospice services based on:

  * >10% weight loss
  * Mid-arm circumference
  * Refusal of aggressive tx
  * Unable to feed herself
  * Pushing food away
  * Dependence in all ADLs
  * History of URI
  * Fat affect
CARDIO PULMONARY DISEASE
INDICATORS

- Persistent symptoms of recurrent CHF at rest
- Optimally treated with diuretics and vasodilators (ACE inhibitors)
- New York Heart Class IV
- Ejection Fraction of 20% or less
- Increased Physician visits
- Multiple hospitalizations or ER visits
- Supraventricular arrhythmias that are resistant to arrhythmia therapy
- History of unexplained syncope
- History of Cardiac Arrest or MI
- Hypoxia at rest on room air
  - \( pO_2 \leq 55 \text{mm Hg} \)
  - Oxygen saturation \( < or = to 88\% \)
- Severe, chronic lung disease as evidenced by:
  - Disabling dyspnea at rest, poorly or unresponsive to bronchodilators
  - Increasing visits to the ER or hospitalizations for respiratory infections and/or respiratory failure

Supplemental:
- Hypercapnia
- \( pCO_2 = to or > 50 \text{mmHG} \)
- Unintentional progressive weight loss
- > 10% of body weight over the preceding 6 months
- Resting tachycardia > 100/minute
- Presence of cor pulmonale or right heart failure (RHF)

Co-conditions:
- Pulmonary Disease
- Renal Disease

Symptoms:
- Inability to carry on any physical activity without pain or SOB
- Pain and/or SOB increase with physical activity
- Increased fatigue
- Orthopnea
- Paroxysmal Nocturnal Dyspnea
- JVD
- Cachexia or Weigh Gain

CASE STUDY

Mr. Taylor is a 68 year old male who has a history of CABG, MI, and co-morbidity of emphysema. He is non-compliant with multiple cardiac medications, is a full code and gets SOB while talking. He makes frequent calls to the physician, has acute respiratory exacerbations and recently was hospitalized for pneumonia.

Physician referred patient to Nightingale and the following occurs:
* Medications related to symptom management of terminal illness paid for by Nightingale
* Nurse assessment and education leading to increased compliance and increased patient comfort
* Decreased SOB, pain and anxiety
* Social Worker counsels patient/family regarding advance directive
* Psychosocial and spiritual support for Mr. Taylor and family
* Daily contact
* Higher level of care provided during crisis
* Decreased phone calls from patient/family to physician office
* Nightingale staff present at death
* 13 months of bereavement
ABOUT NIGHTINGALE

At Nightingale, we don’t believe patients and family members should have to make multiple phone calls to find out what services are available. Nightingale offers a truly different healthcare experience, offering most all healthcare services a patient may need in one convenient location – your home.

Nightingale is rated among the top home healthcare providers in the nation. We stand firm behind our commitment that “All Patients Come First.”