An Overview of Hospice Care

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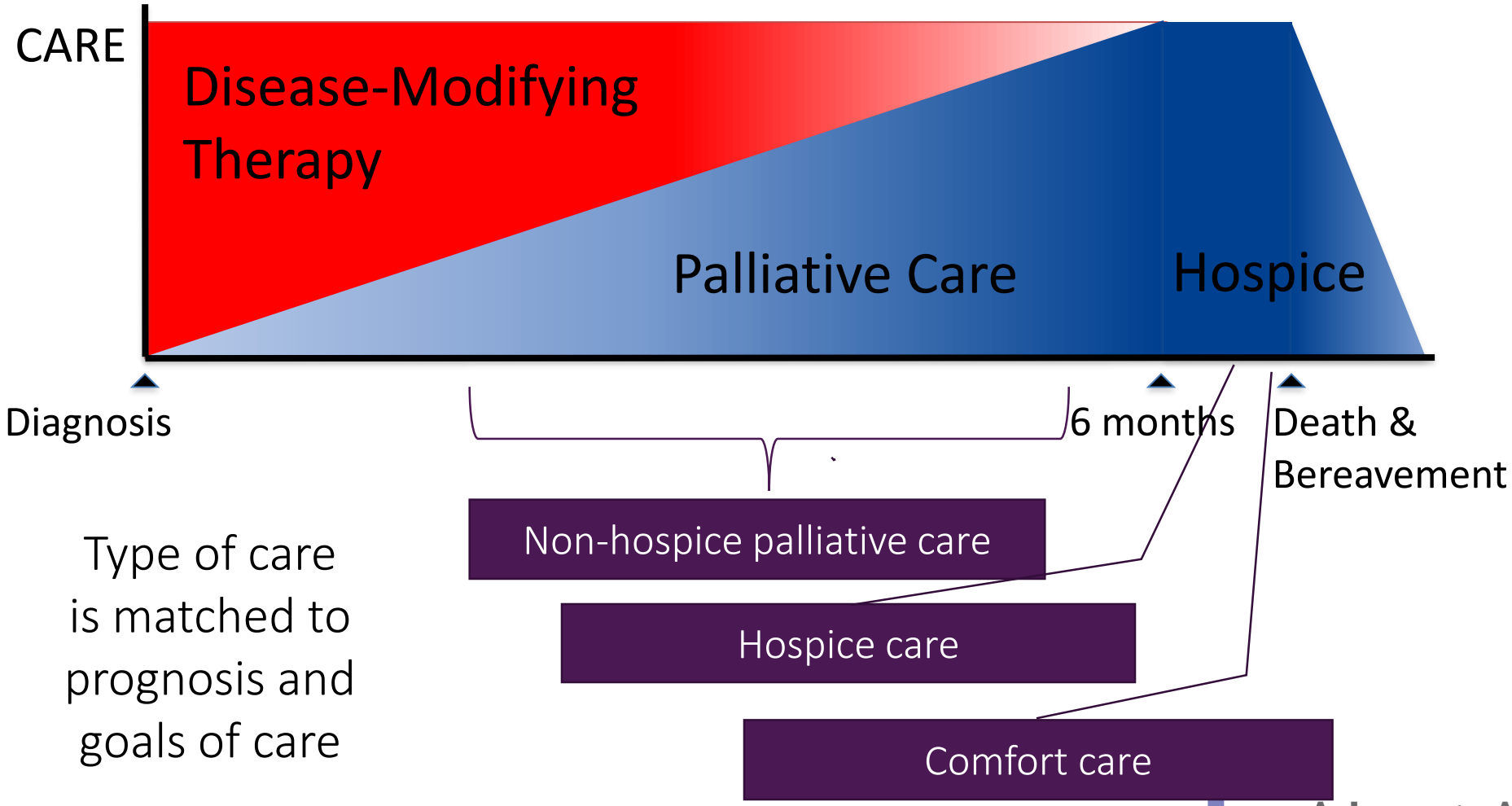
Types of Care Available to Patients with Serious Illness and Advance Disease

- Curative Care:
  - Focused on a cure to an illness and the prolonging your life
- Palliative Care:
  - Focused on comfort (treats symptoms related to the disease or resulting from the treatment)and quality of life (what's important to you)
  - Focus on ensuring patient understand their disease, their doctors, and treatment options
  - May be provided with treatments that seek to cure patient's disease or prolong the patient's life
- Hospice Care:
  - When a cure of the disease is not possible
  - When patient/family elects to forgo or discontinue curative treatment
  - Focused on comfort and quality of life

From Diagnosis to Death



Type of care is matched to prognosis and goals of care

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Hospice Eligibility

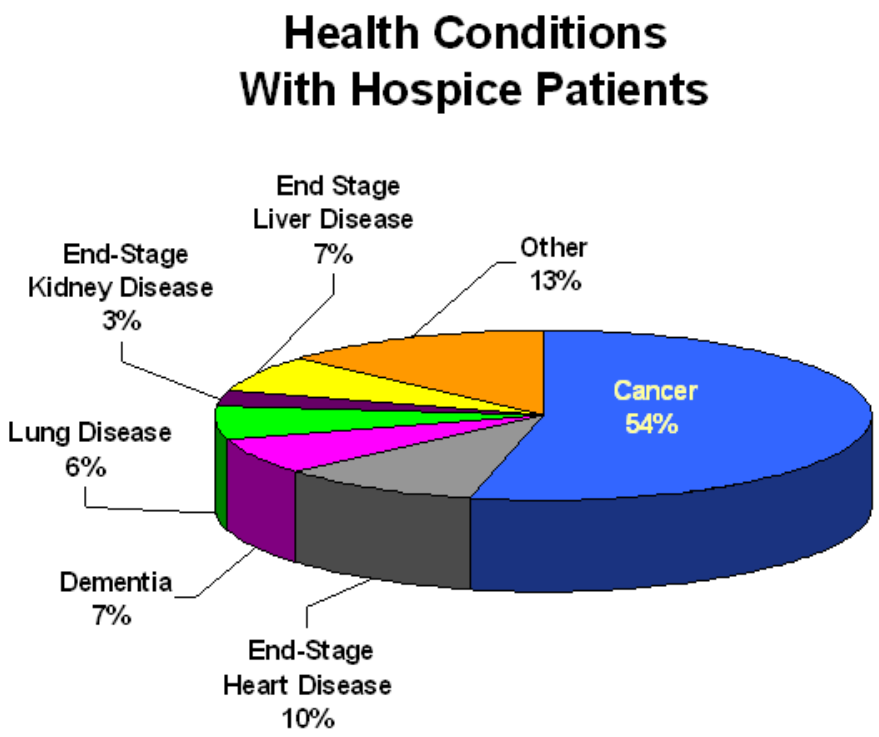
- *Per CMS guidelines, patients must qualify for Hospice Care*

- *Two physicians, the **attending physician** and the **hospice** medical director, must certify the patient*
  - Is a terminally ill or has a "life-limiting condition"
  - Prognosis of 6 months or less, assuming the disease process will run its usual course

- *Patient and/or payer surrogate must elect hospice care by signing Hospice consent forms*

Common Hospice Diagnoses

- Cardiac – Cardiomyopathy, Heart Failure, MI, CAD, PVD, Hypertensive heart disease, intractable arrhythmia
- Pulmonary – COPD, Pulm HTN, Pulm Fibrosis, Acute pneumonia with respiratory failure, COVID-19 pneumonia
- Neurologic – Advanced stage: MS, ALS, Alzheimer's & Parkinson's diseases, Lewy body dementias, intracranial hemorrhage, CVA (acute or late effect), cerebrovascular disease (for unspecified dementia if CT/MRI consistent)
- Renal: Chronic kidney disease (w/Heart failure); ESRD discontinuing dialysis
- Liver: End-stage cirrhosis, hepatorenal failure, liver failure
- Cancer – metastatic, end-stage unresponsive to treatment or patient electing to stop treatment
- Autoimmune – HIV, Advanced stage Lupus & Sarcoidosis; COVID-19 infection



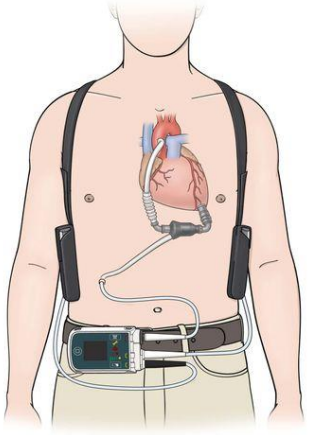
Traditional Hospice Services

- Manages the patient's pain and other symptoms
- Assists the patient and family members with the emotional, psychosocial, and spiritual aspects of dying
- Provides medications and medical equipment
- Instructs the family on how to care for the patient
- Makes short-term inpatient care available when pain and symptoms become too difficult to manage at home, or the caregiver needs respite time
- Provides grief support and counseling to surviving family and friends

Modern Hospice Care

Selected Non-curative Treatments including:

- IV Fluids/TPN
- SC Fluids
- BIPAP/Trilogy
- IV Antibiotics
- Limited Palliative Radiation Therapy
- Selective Dialysis (if not related to terminal diagnosis)
- Milrinone/Dobutamine infusions
- LVADs
- ICD/Pacemakers
- Extubation outside of the hospital (home, nursing facility, Zelber)
- Aromatherapy



Hospice Response to COVID-19

- **In-home COVID-19 testing & education by APN for:**
  - Persons Under Investigation:
    - Due to exposure e.g. positive family member in the home
    - Transferring from Nursing Facility or Rehab to home
    - Acute change in symptoms, consistent with COVID-19 (for patient education/planning, family and staff safety)
  - Pre-procedure
  - Prior to transfer from home to a nursing facility for Respite or Placement
- **Virtual Visit (via secured Zoom)**
  - For hospice presentation
  - For routine scheduled RN visits in home or facilities not allowing entry
  - Physician visit for symptom management or family conference
  - Chaplain and Social Worker routine scheduled visits
  - COVID-19 exposed staff who are asymptomatic or awaiting test results

Hospice Services

Hospice Physician	Attending	Nursing	Social Work
Chaplain	Home Health Aide	Volunteer	Complimentary Therapies
Medications	Medical Supplies	Medical Equipment	Bereavement

"Hospice"

- Hospice is **NOT** a place, it is a philosophy of care

- Hospice will be provided wherever the patient calls HOME: home, ALF, LTC
- Hospice is paid for by Medicare, Medicaid, some Insurances
- If activating Medicare hospice benefit and a patient is being discharged to a nursing facility with hospice, room & board will either be private pay or covered by Medicaid
  - Just like hospice does NOT pay the mortgage, hospice does NOT cover room and board.

Caregiver

- Hospice care in the home requires a caregiver in the home (preferred)
- Hospice is NOT the caregiver
- Typically, a family member serves as the primary caregiver, but can be a friend or hired caregiver
- Hospice team makes visits to assess the patient and work with the family/caregiver
  - Education on disease trajectory, daily care, and end-of-life care
- Hospice is on-call 24/7 (available by phone, staff visit if needed)

Levels of Hospice Care

Because a patient's symptom needs may change during the course of their disease process, hospice offers 4 different levels of care.

1. **Routine Home Care**
   - Hospice care in patient's place of residence (home)
2. **General Inpatient Care**
   - Hospice care in the hospital or hospice facility
3. **Continuous Care/Crisis Care**
   - Hospice care in the patient's place of residence (hom
4. **Respite Care**
   - Hospice care in a nursing facility or hospice facility

Rational

- **Routine Home Care**
  - Provides hospice care and support to patient and family in the location the patient calls home (house, apartment, assisted living, nursing home, homeless, group home)
- **General Inpatient Hospice Care**
  - When patient's symptoms/needs cannot be managed at home, the patient can be transferred to the hospital or hospice unit for higher level of care with 24 hour nurse availability until the symptoms are controlled/need is met and patient can return home.
- **Continuous Hospice Care (Crisis Care)**
  - Hospice care provided continuously for between 8 and 24 hours a day to manage any uncontrollable symptoms
  - CC is intended to maintain the patient's comfort at home during a pain or symptom **crisis**
- **Respite Care**
  - If/When the primary caregivers need to take a break (vacation/rest) the patient can be transferred to a inpatient hospice facility or nursing facility for custodial level care for a short time (usually 5 days)

Aurora Zilber Family Hospice Inpatient Facility

Video (2:58):
https://www.youtube.com/watch?v=wOE4h01fh_A

Aurora Zilber Family Hospice

Facility Purpose and Licensure

- *Inpatient Hospice Facility, CHAP accreditation**
- *18 beds – 3 units (6 beds/unit)*
- *2019: 834 patients/687 total deaths*
- *Two staff stations*
- *LOC (GIP, Respite, Routine)*
- *Interdisciplinary Care, Bereavement for 13 months*
- *Meeting rooms*
- *Administrative Offices*
  - *Also base for hospice home program*

Interdisciplinary Team

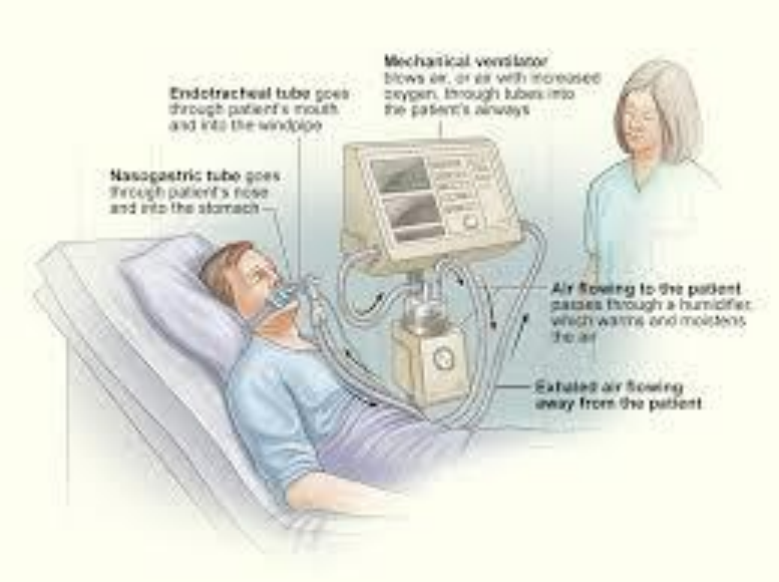
Image Source: NHPCO Facts and Figures on Hospice Care, 2015

*CHAP – Community Health Accreditation Partners

Aurora Zilber Family Hospice

Specialized Care in a Serene Setting

- All ages
- IV/SQ pain and symptom management
- Terminal Sedation (Propofol, or Lorazepam/Propofol)
- Milrinone
- Wound Care
- Trach Care
- Drains
- Ventilator Withdrawals (terminal extubation)
- LVAD and Bi-Pap Discontinuation
- Aromatherapy (Lavender Nites or diffuser)
- Reiki, Guided Imagery, Massage therapy, music & art therapy, pet therapy, comforting companions
- Comfort Café
- Open access 24/7 for family/friends, private space avail for family, kitchen, visits by 4-legged family members * modified visitor policy in place secondary to COVID-19



Honoring Special Life Events at AZFH

- *Weddings*
- *Baptisms*
- *Couples room – sculptor donated a hand casting*
- *Milwaukee Brewers Racing Sausages*
- *MyLegacy – audio*
- *We Honor Vets*
- *Milwaukee Ballet*
- *Bucket List - Major motion picture shown to patient prior to release*

Palliative Care vs Hospice

- **Focus**: Comfort and quality of life
- **Team**: APN/MD, *+/- CNA, SW, Chap*
- **Prognosis:** curable, chronic, life-threating or terminal disease
- **Expected Outcome**: relief from distressing symptoms, ease pain and enhance quality of life
- **Timing**: *no time restrictions*, at any age, any time and any stage of illness whether terminal or not; should begin early in the disease process to identify goals of care
- **Treatment:** comfort at any stage, no expectation that life-prolonging or aggressive therapies will be avoided; concurrent with treatment of primary disease
- **Location:** Hospital, outpatient, home, *rehab/SNF*, ECF/NH
- **Payment**: Medicaid/Medicare/Private Insurance

- **Focus**: Comfort and quality at end-of-life
- **Team**: MD/APN, RN, CAN, SW, Chap, Vol
- **Prognosis:** life-limiting, terminal, incurable
  - adults- life expectancy of 6 months or less,
- **Expected Outcome**: relief from distressing symptoms, ease pain and enhance quality of life *at end-of-life*
- **Timing:** end-of-life, *considered terminal*, with prognosis of 6 months or less
- **Treatment**: typically elect to *forego extensive life-prolonging treatment* for terminal diagnosis,
  - non-curative treatment focused on symptom relief for terminal illness
  - may receive curative treatment for acute illnesses
- **Location**: Hospital, outpatient, home, ECF/NH, *Hospice Facility*
- **Payment**: Medicaid/Medicare/Private Insurance

Questions???

Thank you!!

Hospice Indicators

Aurora at Home Hospice

Aurora at Home

We are AdvocateAuroraHealth

Admission Indicators

Admission criteria include:

- Patient has a life-limiting illness with a prognosis of 6 months or less
- Clinical progression of the terminal disease
- Two physicians confirm terminal condition
- Patient and family desire comfort-focused care

Admission indicators include a combination of the following:

- Life expectancy of 6 months or less if disease runs its normal course
- Recent decline in functional status as determined by:
  - Karnofsky Performance status less than 50% (see scale on page 2)
  - ECOG Performance Scale status of 3 or 4 (see scale on page 3)
  - Palliative Performance status less than 50% (see scale on page 4)
  - FAST Scale (see page 10)
  - Dependence in at least 3 of 6 ADLs (ie., personal hygiene, dressing, eating, maintaining continence, transferring and ambulation)

(continued on the next page)

Admission Indicators *(Continued)*

- Impaired nutritional status evidenced by either:
  - Weight loss of at least 10% over the past 6 months
  - Serum albumin less than 2.5 gm/dl
- Repeated hospitalizations or emergency room visits
- Recurring infections, such as UTI, URI, sepsis
- Presence of decubitus ulcers

Karnofsky Performance Scale

General Category	Index	Specific Criteria
Unable to care for self, requires institutional or hospital care or equivalent, disease may be rapidly progressing	50	Requires considerable assistance from others and frequent medical care
	40	Disabled, requires special care and assistance
	30	Severely disabled, hospitalization indicated, death not imminent
	20	Very sick, hospitalization necessary, active supportive treatment necessary
	10	Moribund, actively dying

Eastern Cooperative Oncology Group (ECOG) Performance Status

These criteria are used by doctors and researchers to assess how a patient's disease is progressing, assess how the disease affects the daily living abilities of the patient, and determine appropriate treatment and prognosis.

ECOG Performance Status*

Grade	ECOG
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours
3	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
5	Dead

* As published in Am. J. Clin. Oncol.:

Oken, M.M., Creech, R.H., Tormey, D.C., Horton, J., Davis, T.E., McFadden, E.T., Carbone, P.P.: Toxicity And Response Criteria Of The Eastern Cooperative Oncology Group. Am J Clin Oncol 5:649-555, 1982.

Palliative Performance Scale*

%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Consciousness Level
100	Full	Normal Activity No Evidence of Disease	Full	Normal	Full
90	Full	Normal Activity Some Evidence of Disease	Full	Normal	Full
80	Full	Normal Activity with Effort Some Evidence of Disease	Full	Normal or Reduced	Full
70	Reduced	Unable to do Normal Work Some Evidence of Disease	Full	Normal or Reduced	Full
60	Reduced	Unable to do 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 Any Work Extensive Disease	Mainly Assistance	Normal or Reduced	Full or Drowsy or Confusion
30	Totally Bed-Bound	Unable to do Any Work Extensive Disease	Total Care	Reduced	Full or Drowsy or Confusion
20	Totally Bed-Bound	Unable to do Any Work Extensive Disease	Total Care	Minimal Sips	Full or Drowsy or Confusion
10	Totally Bed-Bound	Unable to do Any Work Extensive Disease	Total Care	Mouth Care Only	Drowsy or Coma
0	Death	–	–	–	–

*This scale is a modification of the Karnofsky Performance Scale. It takes into account ambulation, activity, self-care, intake and consciousness level.

Hospice Indicators for Cancer

- Metastasis at presentation or progression
- Curative treatments are no longer effective
- Treatment is having negative impact on patient's quality of life
  - Increasing pain and/or symptoms
  - Multiple trips to hospital for symptom management
  - Toxicity outweighs benefits
- Poor performance status
  - ECOG of 3 – 4 (see scale on page 3)
  - Karnofsky or Palliative Performance Scale less than 50% (see scales on page 2 and page 4)
- Exhausted patient and family/caregivers
- Patient/Family/Caregivers wants to stop curative or palliative radiation and/or chemotherapy**

** Patients enrolled in hospice may qualify for palliative radiation and/or continuation chemotherapy treatment on an individualized basis for cancer symptom management.

Did you know?

What is hospice? Hospice is a program designed specifically for people who have chosen to change the plan of care for a life-limiting illness from aggressive medical treatment, focused on curing an illness, to care that manages pain and symptoms so patients can make the most of every day.

Hospice Indicators for Cardiopulmonary Disease

Identification of specific structural/functional impairments, along with relevant activity limitations such as:

- Disabling dyspnea at rest, poor response to bronchodilators
- Persistent symptoms of recurrent CHF at rest
- Optimally treated with diuretics and vasodilators (ACE inhibitors) or unable to tolerate
- New York Heart Class IV and/or American Heart Association (AHA) Stage D
- May have an impaired ejection fraction
- History of unexplained syncope
- History of cardiac arrest or MI
- Brain embolism of cardiac origin
- Increasing visits to the ER or hospitalizations for respiratory infections and/or respiratory failure
  - pO_2 less than or equal to 55 mmHg
  - Oxygen saturation less than or equal to 88%
- Resting tachycardia greater than 100/minute
- Presence of cor pulmonale or right heart failure (RHF)
- Identification of functional limitation, such as:
  - Decline in functional status

Examples of secondary conditions: Delirium, pneumonia, stasis ulcers, pressure ulcers, failure to thrive and debility

Example of co-morbid condition: End-stage renal disease (ESRD)

New York Heart Association (NYHA) Functional Clasification of Heart Failure:

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.
American College Cardiology/American Heart Association Stages of Heart Failure:	
Stage	**Patient Symptoms**
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. Comfort at rest.
C	Objective evidence of moderately severe cardiovasular 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.

Hospice Indicators for Dementia

Includes diagnoses such as Alzheimer's Disease, Parkinson's Disease, Lewy Body Dementia, frontal lobe dementia and *vascular dementia

***Note:** *Medicare does not accept vascular dementia or advanced dementia as a primary hospice diagnoses. However, they may be used as secondary diagnoses.*

1. Stage 7 on FAST Scale (loss of speech, locomotion and consciousness)

- 7a: Ability to speak is limited (1 to 5 words a day)
- 7b: Speech is unintelligible
- 7c: Non-ambulatory
- 7d: Unable to sit up independently
- 7e: Unable to smile
- 7f: Unable to hold head up

Co-morbidity, such as:

- CHD (Coronary Heart Disease)
- COPD

2. Should have one of the following in the past six months:

Secondary Conditions, such as:

- Decubitus ulcers, multiple Stage III-IV
- Inability to maintain sufficient fluid and calorie intake with 10% weight loss during previous six months or serum albumin less than 2.5 gm/dl
- Aspiration pneumonia
- Septiciemia
- Pyelonephritis
- Fever, recurrent after antibiotics

Functional Assessment STaging (FAST)

Grade	FAST
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, 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

*Scored primarily on information obtained from knowledgeable informant. Psychopharmacology bulletin, 1988 24:653-659.

Hospice Indicators for HIV Disease

1 and 2 must be present; factors from 3 will add supporting documentation:

1. CD4 + count less than 25 cells/mcL or persistent viral load greater than 100,000 copies/ml, plus ONE of the following:
   a. CNS Lymphoma
   b. Untreated, or not responsive to treatment, wasting (loss of 33% lean body mass)
   c. Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused
   d. Progressive multifocal leukoencephalopathy
   e. Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy
   f. Visceral Kaposi's Sarcoma unresponsive to therapy
   g. Renal failure in the absence of dialysis
   h. Cryptosporidium infection
   i. Toxoplasmosis, unresponsive to therapy
2. Decreased performance status, as measured by the Karnofsky Performance (KPS) Scale of less than or equal to 50
3. Documentation of the following factors support eligibility for hospice care:
   a. Chronic persistent diarrhea for one year
   b. Persistent serum albumin less than 2.5
   c. Concomitant, active substance abuse
   d. Age greater than 50 years

Eligibility factors continued on reverse

Hospice Indicators for HIV Disease (cont.)

e. Absence of antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease
f. Advanced AIDS dementia complex
g. Toxoplasmosis
h. Congestive heart failure, symptomatic at rest
i. Advanced liver disease

Did you know?

Hospice is not a place. Rather, it is a comprehensive service that is provided in the home 90 percent of the time. Sometimes, patients are temporarily moved to a hospital if a patient's pain or symptoms require skilled monitoring and plan of care changes.

The hospice team can also provide respite care so that caregivers can have a little time away from the day-to-day requirements of caring for a loved one in hospice care. The patient can be placed in a nursing home for a predetermined number of days while continuing to receive care from the hospice team.

Hospice Indicators for Liver Disease

Criteria in 1 and 2 should be present; factors from 3 will lend supporting documentation:

1. INR greater than 1.5 (or Prothrombin time prolonged more than 5 seconds over control); Serum Albumin less than 2.5 gm/dl
2. Documentation of end-stage liver disease, and patient shows at least one of the following:
   - Ascites, refractory to treatment, or patient non-compliant
   - Spontaneous bacterial peritonitis
   - Hepatorenal Syndrome (elevated creatinine and BUN with oliguria [less than 400 ml/day] and urine sodium concentration less than 10 mEq/l)
   - Hepatic encephalopathy, refractory to treatment, or patient non-compliant
   - Recurrent variceal bleeding despite intensive therapy
3. The following support eligibility:
   - Progressive malnutrition
   - Muscle wasting with reduced strength and endurance
   - Continued active alcoholism (greater than 80 gm ethanol/day)
   - Hepatocellular carcinoma
   - HBsAg (Hepatitis B) positivity
   - Hepatitis C refractory to interferon treatment

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

Did you know?

A multi-disciplinary team cares for hospice patients. The team includes: patient/caregivers; patient's physician; hospice physician; registered nurse; certified home health aide; social worker; chaplain; grief counselor; and volunteers.

Hospice Indicators for Other Neurological Conditions

Includes diagnoses such as CVA, Parkinson's Disease, ALS and MS

- Neurological conditions are associated with impairments, activity limitations and disability
- Identification of impaired function with increasing debility impacting quality of life/functional impairments
- Palliative Performance Scale less than or equal to 50
- Recurrent hospitalizations

Secondary Conditions such as:

- Dysphagia/Aspiration
- Aspiration pneumonia
- Pressure ulcers
- Anorexia/Decreased appetite/ Failure to thrive
- Mental status decline and confusion
- Generalized weakness and frequent falls
- Recurrent urinary tract infections
- Weight loss of greater than 10% in the past 6 months or 7.5% in the past 3 months
- Serum albumin less than 2.5 gm/dl
- Serum creatine greater than 1.5 mg/dl
- Pyelonephritis

-morbid conditions, such as COPD, heart failure or dementia.

Did you know?

Hospice is affordable. Medicare and Medicaid provide coverage at 100% for those hospice services and medications which are used to manage the life-limiting illness.

Hospice Indicators for Protein Calorie Malnutrition

Protein Calorie Malnutrition (Mild, Moderate or Severe)

- BMI less than or equal to 19
  - Mild protein calorie malnutrition defined as BMI 17.00 – 18.49
  - Moderate protein calorie malnutrition defined as BMI 16.00 – 16.99
  - Severe protein calorie malnutrition defined as BMI less than 16.00
- PPS less than 40% mostly in bed (marked reduction in physical activity)
- Dependent on greater than 2 ADLs
- Serum albumin less than 2.5 g/dL
- Weight loss greater than 10% in 6 months; greater than 5% in 3 months; visual fat loss, muscle wasting
  - Unable to maintain/not responding to any nutritional support
  - Unable to maintain sufficient calories or fluids
  - Patient/Family/Durable Power of Attorney does not want/refusing enteral or parenteral nutrition
- Stage 3 or 4 pressure ulcers
- Increase ER visits/multiple hospitalizations

Did you know?

After a patient dies, Aurora at Home Hospice offers family and loved ones a 13-month bereavement program. Grief support can be provided in different ways: Bereavement newsletter; individual grief support; grief support groups; workshops; and education.

Hospice Indicators for Renal Disease

The patient is not a candidate for dialysis or renal transplant or wishes to discontinue dialysis

- Serum creatinine greater than 8.0 mg/dl (greater than 6.0 mg/dl for diabetics)
- Creatinine clearance less than 10 cc/min (less than 15 cc/min for diabetics); or less than 15 cc/min (less than 20 cc/min for diabetics) with comorbidity of congestive heart failure
- Estimated glomerular filtration rate (GFR) less than 10 ml/min

Supplemental

Presence of co-morbid conditions in acute renal failure is helpful

- Coronary heart disease (CHD)
- Peripheral vascular disease (PVD)
- Vascular dementia
- Heart failure
- Advanced liver disease

Secondary conditions, directly related to the primary condition:

- Secondary hyperparathyroidism
- Calciphylaxis
- Electrolyte abnormalities
- Anorexia
- Fluid overload

Presence of signs and symptoms in chronic renal failure is helpful:

- Examples include uremia, oliguria (less than 400 cc/24 hours), intractable hyperkalemia (greater than 7.0) not responsive to treatment, hepatorenal syndrome, uremic pericarditis, Hepatorenal Syndrome, intractable fluid overload not responsive to treatment

How Aurora at Home Hospice Helps Patients and Families

- Enhances quality of life
- Consultations available 24 hours a day, 7 days a week by professional staff (ie., RN, MSW and physician)
- Pain evaluated on every visit
- Expertise in pain and symptom management
- Provides 4 Levels of Care (Routine, Respite, Crisis Care in an inpatient setting or Continuous Care at the patient's place of residence)
- Treats infections and wounds to promote patient comfort
- Provides medications, supplies and equipment related to symptom management of the terminal illness, anxiety and depression
- Educates regarding nutrition and hydration issues, with a focus on patient comfort and goals; evaluation for swallowing concerns can be ordered if needed
- Provides a personalized plan of care
- Reduces physician office calls, 911 calls, ER visits and hospitalizations

(continued on page 21)

How Aurora at Home Hospice Helps Patients and Families

- Helps with end-of-life planning
- Assists with documenting advance directives, such as Health Care POA
- Assists with funeral planning arrangements
- Anticipates needs of patient and family; may refer to available community resources
- Uses non-pharmacological therapy
- Visits provided by psychosocial and spiritual staff with ongoing follow-up for patients, families and staff
- Communicates with families regarding patient's condition
- Provides communication and patient updates as determined by the referral source
- Attends and confirms deaths
- Provides 13 months of bereavement services 

To learn more about Aurora at Home Hospice
or to make a referral, call:

1.833.268.1268

Aurora at Home

We are AdvocateAuroraHealth

GAS 3/19 MC 1623

Inpatient to ADVOCATE Hospice in the Hospital Steps

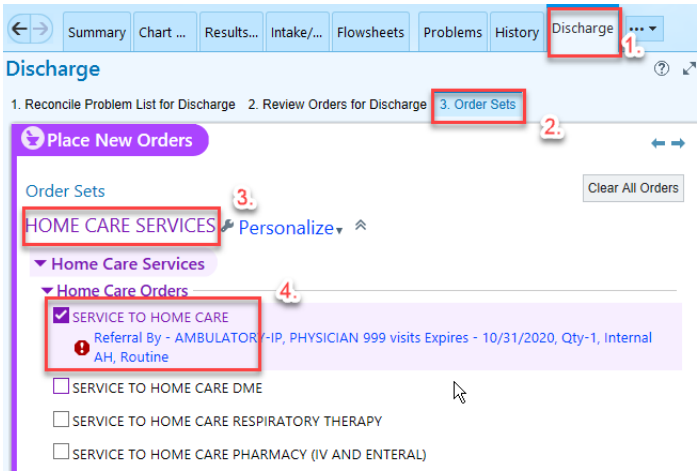
End Users Affected: Inpatient Nurses, Hospice Nurses, Care Managers, Patient Access/Registration, Unit Clerks, and Physicians

The following outlines the steps necessary to flip a patient to ADVOCATE Hospice in Epic from beginning to end.

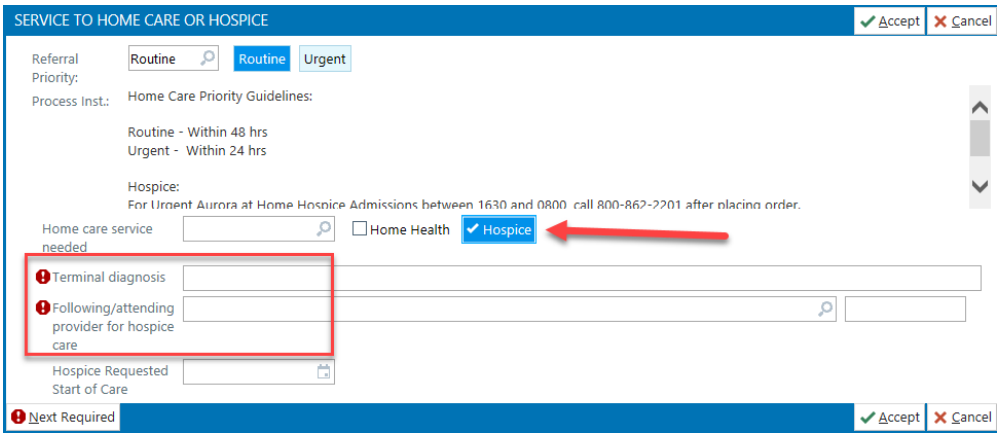
Entering Service to Hospice Order

I. Initial clinician steps [to be completed by a physician or anyone with order entry access, including nurses in the event that the physician is not available]

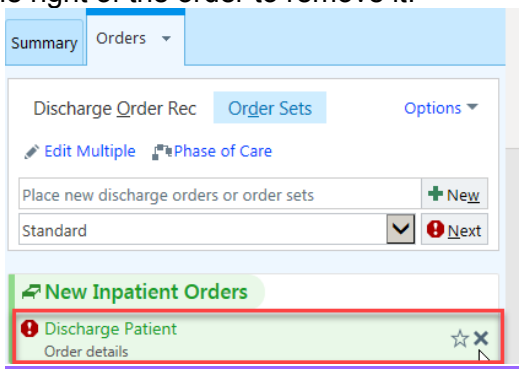
A. Navigate to the Discharge Navigator to open the **Home Care Services Order Set**



B. Click the Service to Home Care Option and then click on the blue hyperlink to open the order composer
   - Select Hospice for the Home care service needed
   - Fill in required fields: “Terminal Diagnosis” and “Following/Attending provider for Hospice Care”



C. Once the physician completes this order, click Accept.
   - You will see a Discharge order automatically queued up in the sidebar on the right hand side of screen. **Remove this order at this point, as you do not know if the patient will be accepted.**
     - Click "X" to the right of the order to remove it.



D. Select Sign. Associate a diagnosis if prompted.

After the patient has been evaluated by an Advocate at Home Nurse Liaison and has accepted and consented to "Hospice in the Hospital" they will contact the attending physician to collaborate on the entering of Hospice admission orders. Skip to Step III for details on that process.

NOTE: For referrals during off hours, weekends, holidays, and those that are emergent, call Advocate at Home directly after placing the order @ **630-963-6800.**

Advocate Hospice Admission Nurse

II. Advocate Hospice Admission Nurse

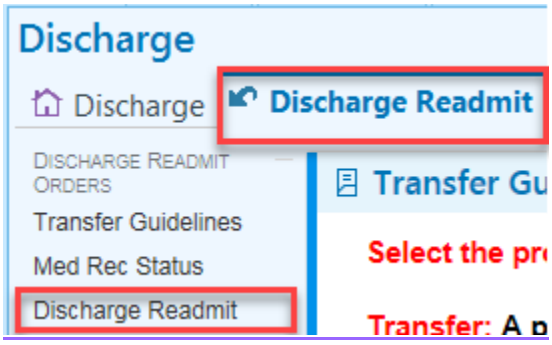
A. Completes election visit per normal
B. Contacts hospice medical director to inform them that the patient has consented to hospice.

C. Contacts the physician covering the patient in the hospital to inform them that the patient has consented to hospice.
    i. Collaborate with inpatient physician to complete the Discharge/Readmit Process and entering of Hospice orders (See Step III for details).
D. Call Admitting/Patient Access Dept. and let them know to set up a pre admission on the patient (See Step IV for details).
    - Remind them to add hospice as payer source and do not remove any payer sources.
    - They will still need to enter information such as patient name, room, diagnosis, MD following etc.
    - Request they call you back when done.
E. Call the unit clerk and ask them to move patient up into room from the bottom of their screen via Unit Manager (See Step V for details).
F. Call the patient's RN and let them know that once the Unit Clerk does the step above, they can release hospice orders from their Orders activity tab, Signed & Held tab (See step VI for details).

"Discharge/Readmit" Steps

III. **Discharge/Readmit Steps –** to be completed by the physician or Hospice RN if physician not available

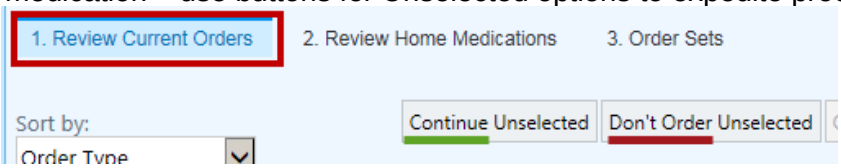
A. **PHYSICIAN STEPS:**
    i. **Go to Discharge Tab**
    ii. Click on second tab called **DISCHARGE READMIT navigator**, click Discharge readmit on the left side



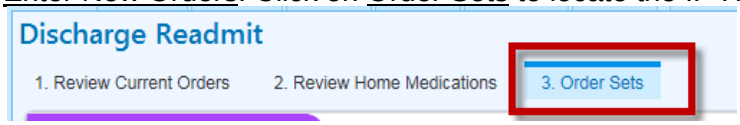
    iii. **Reconcile Medications**

These new medication orders will be signed and held! They will not be active on the MAR until the nurse releases the med orders after the patient has been readmitted as a Hospice Patient!

✓ Review Current Orders: Decide which orders to continue or don't order. Address each medication – use buttons for Unselected options to expedite process.

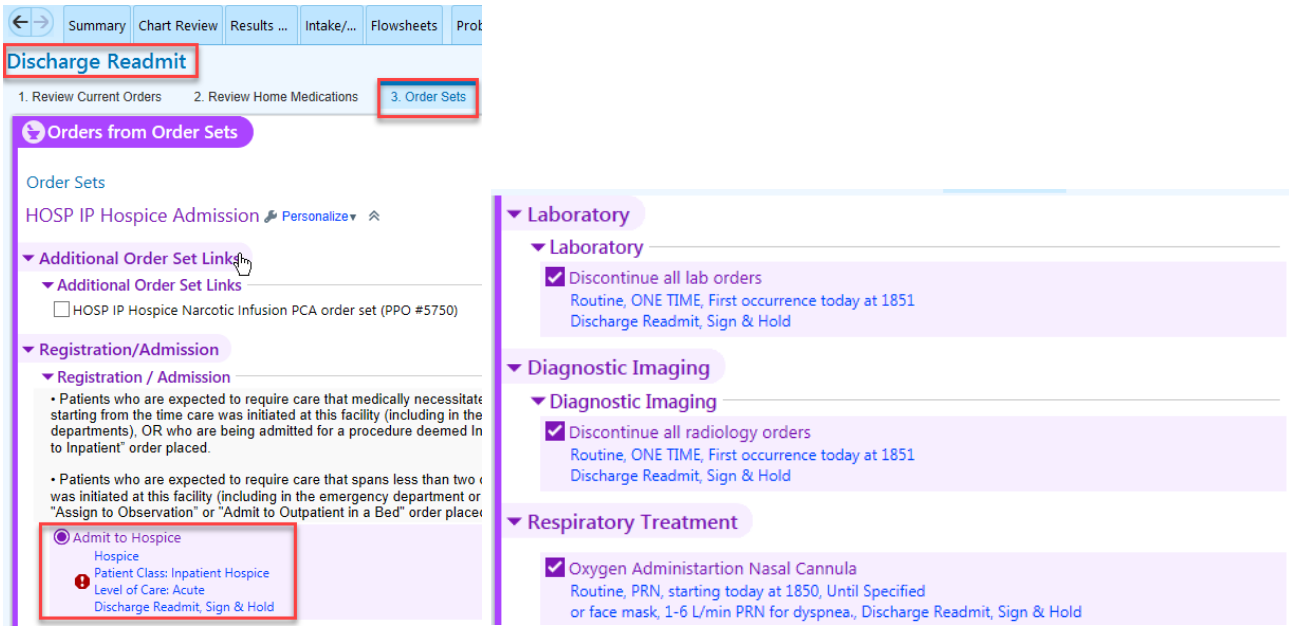


✓ Enter New Orders: Click on Order Sets to locate the IP Hospice Admission Order Set



iv. Click ORDER SETS tab.

- Search "IP Hospice" in Order Set search field in the sidebar to locate IP Hospice Admission Order Set
- Open the HOSP IP Hospice Admission Order Set (**right click to make a favorite**)
- Click on Admit to Hospice order – enter admitting dx
- Continue to enter appropriate orders for Hospice care. (Common orders are selected as default checked - Click on blue hyperlinks to make changes to order details as needed.)



- Once you have the orders selected from the order set, look at your sidebar.

Click on the "Sign-Will be Released on New Admission." The Discharge Patient order is now active, but all other orders are signed and held for the nurse to release after the following step below.

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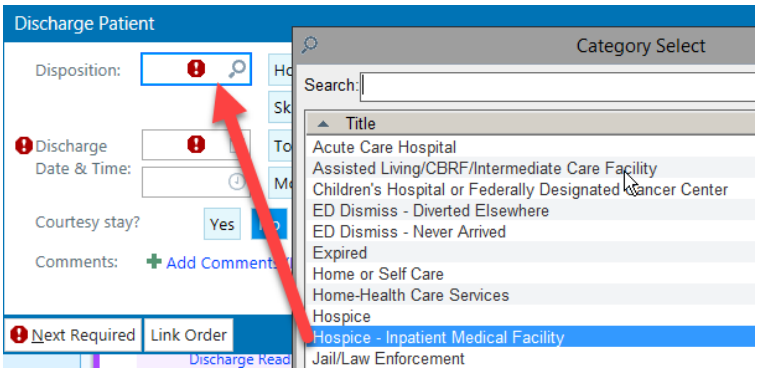
v. **Fill out the Discharge Patient Order details.**

In the Disposition field, enter "Hospice – Inpatient Medical Facility." Find this using the magnifying glass.



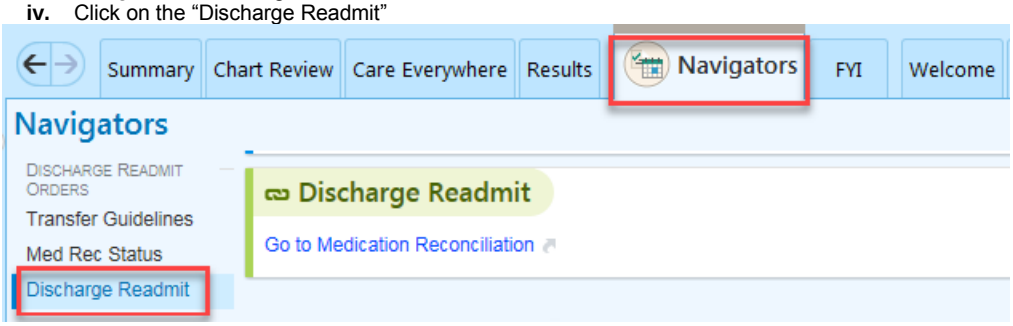
B. **HOSPICE RN STEPS:**

i. **Log in to Hyperspace in a "HOSPICE ADVOCATE…"** department (If you use Hospice Scheduling department or an Inpatient Hospital department, you will not get the correct tools!!!)

ii. **Navigate to the Patient List activity to open the patient's hospital chart.** Double click on the patient to open their chart. (If you access the patient's chart via any other method, you will not have the correct tools to perform the discharge/readmit process)

iii. Navigate to the "Navigators" tab.

iv. Click on the "Discharge Readmit"



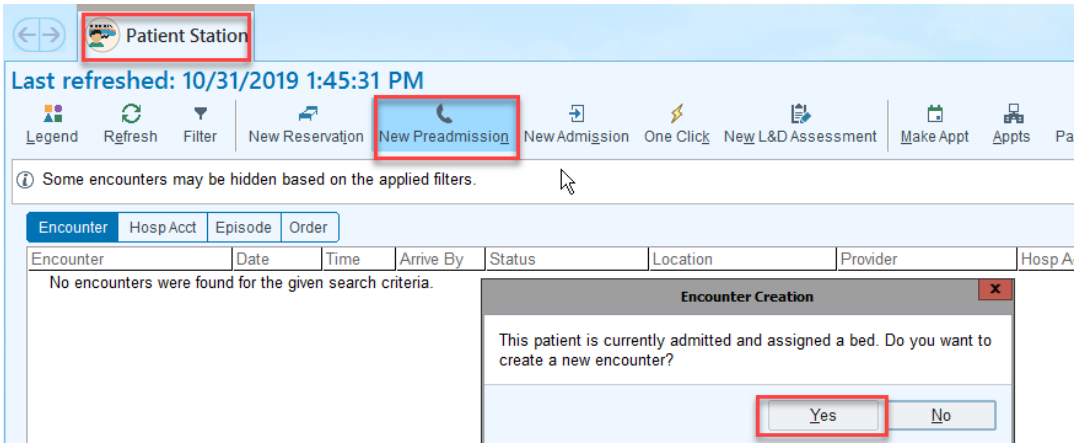
v. **From here the process mimics the physician steps starting at step iv above**

Patient Access: Creating New Pre-Admission

IV. Create New Pre-Admission

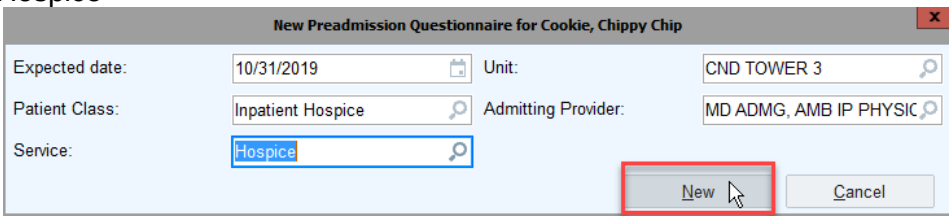
A. Navigate to the patient's Patient Station and click "New Preadmission".

B. Select Yes on the Encounter Creation warning that will populate.



C. In the New Admission Questionnaire complete the following fields:

- Expected Date: enter the expected date that the admission will occur
- Unit: select the appropriate unit
- Patient Class: Inpatient Hospice
- Admitting Provider: enter the appropriate provider
- Service: Hospice



D. Complete and Patient level registration that is needed if applicable

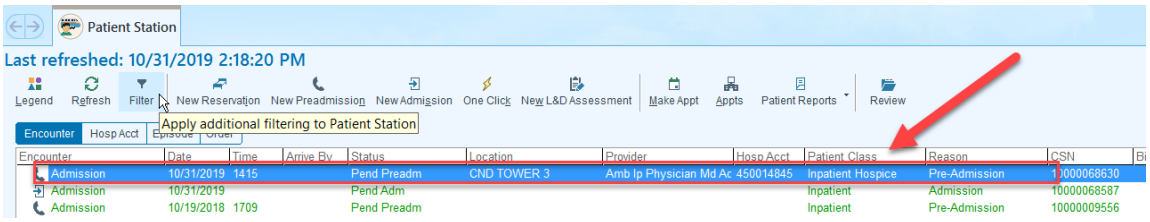
E. Enter the necessary information in the **Admission Info** folder

F. Move to the **Hospital Accounts** folder on the Form Navigator

G. Click the **Create New Account** Button

H. Click **PreAdmission** button at the bottom of the screen

I. Patient Station will open and the pending admission is listed as a current encounter – Look for Patient Class to say Inpatient Hospice.

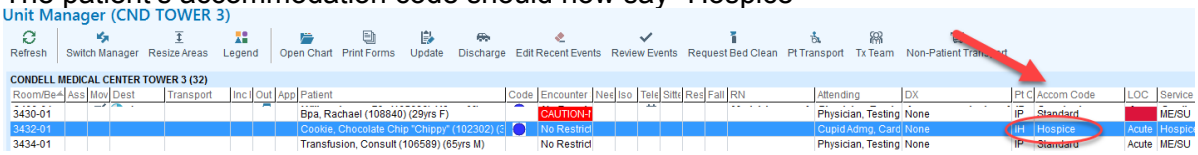


J. Call the Hospice Nurse and let them know that the preadmission has been created.

Unit Clerk/Inpatient RN: Discharge Readmit Steps

V. Discharging patient and readmit with new Preadmission

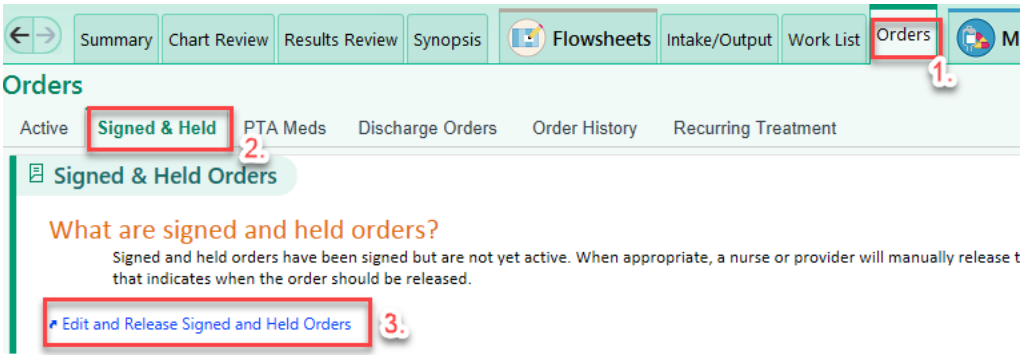
1. From Unit Manager select the patient and click Discharge
2. From Admissions on bottom left, drag the patient and drop in the room they were just discharged from.
3. The patient's accommodation code should now say "Hospice"



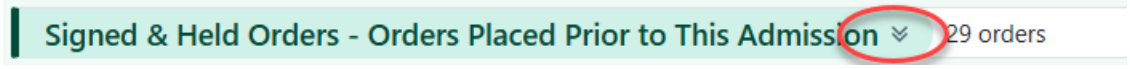
Inpatient Nurse: Releasing Orders

VI. Releasing Orders

1. Navigate to **Orders** activity tab
2. Select **Sign & Held**
3. Click the blue hyperlink **Edit and Release Signed and Held Orders**

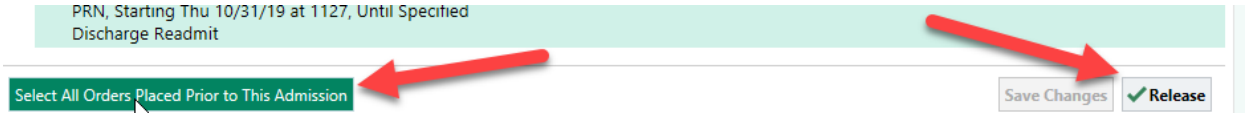


4. Click on the symbol if you don't see orders – they may be collapsed



5. Scroll down to the bottom and click **Select All Orders Placed Prior to This Admission** and then click **Release**

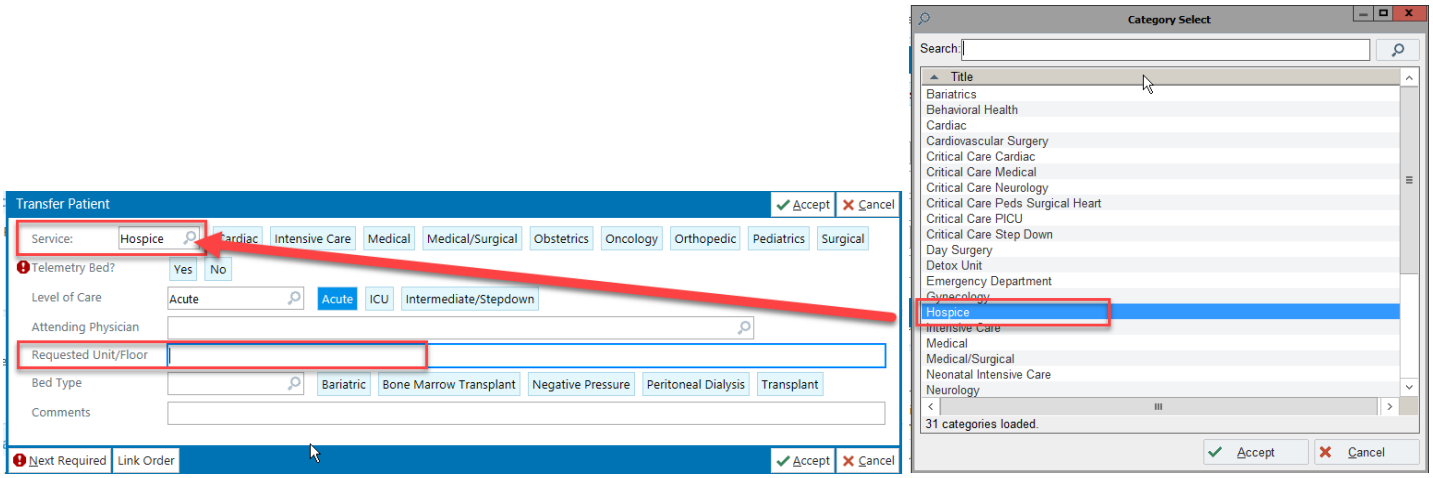
Inpatient Hospice



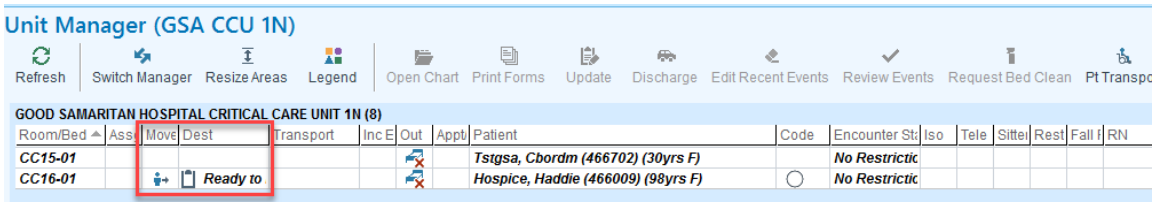
6. Complete all usual admission documentation

VII. Inpatient RN: Moving the patient to Another Unit or Bed

1. If the patient needs to be moved to another unit or bed, navigate to the Orders tab and search “Transfer (ADT7)”Order
2. Fill in all required fields as well as which Unit/Floor the patient is transferring to.



3. In the Unit Manager, the patient will now appear with an Icon and “Ready to Plan” column.



4. Follow regular transfer patient workflows from here.