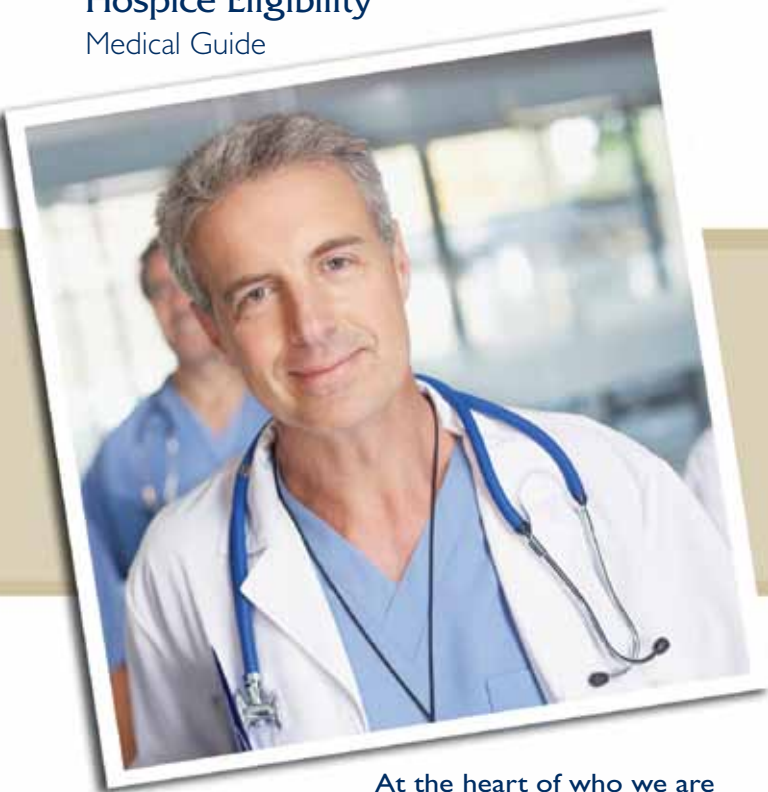




## Hospice Eligibility

Medical Guide



At the heart of who we are  
stands *compassion.*

# TABLE OF CONTENTS

## INTRODUCTION

## GENERAL GUIDELINES

## DIAGNOSIS GUIDELINES

- Cancer
- Cardiac Disease
- Pulmonary Disease
- Alzheimer's Disease and Related Disorders
- Adult Failure to Thrive
- Stroke or Coma
- Liver Disease
- Renal Disease
- Amyotrophic Lateral Sclerosis (ALS)

## SCALES

- New York Heart Association (NYHA) Functional Classification
- Palliative Performance Scale (PPS)
- Functional Assessment Staging (FAST) Scale
- Body Mass Index (BMI) Reference Chart
- FLACC Pain Scale

## USEFUL LANGUAGE FOR HOSPICE DISCUSSIONS



# INTRODUCTION

At Hospice Compassus we are committed to becoming an educational resource to our clients. To that end, the following Medical Guide has been designed to assist medical professionals in identifying and communicating with patients who meet hospice eligibility guidelines.

Within this guide are general and diagnosis-specific criteria used in determining a patient's eligibility for hospice care. Additionally, we have included useful language relating to the steps for an effective hospice discussion which will aid in the communication of the hospice benefit in a timely manner.

## THE HOSPICE COMPASSUS CARE DIFFERENCE:

Hospice Compassus advocates and respects the right of the patient and family to:

- Enjoy the best possible quality of life
- Have their values and wishes honored
- Experience dignity in their care
- Receive care in their environment of choice
- Know what to expect
- Receive continued support

Hospice Compassus is committed to clinical and professional excellence. Hospice locations are licensed by states and certified by Medicare and Medicaid. Our Hospice physicians and nursing staff are available 24/7 and around-the-clock care is implemented when necessary.

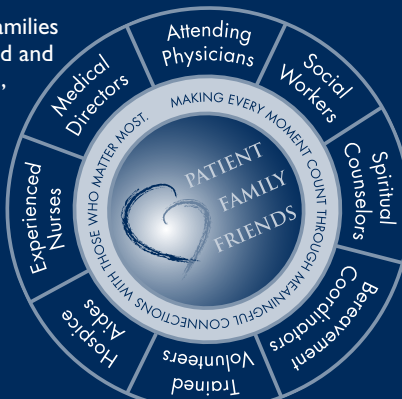
# THE HOSPICE COMPASSUS TEAM OF CARE:

Hospice Compassus provides a compassionate network of highly trained professionals and volunteers who work together as a team to assess and meet our patients' and their families' needs. Our team goes to great lengths to explore and evaluate treatment options in the context of each patient's symptoms, values and wishes.

A comprehensive plan of care is directed by the patient and managed by our experienced team which may include, but is not limited to:

- Your Physician
- The Hospice Physician
- Nurses
- Social Workers and Therapists
- Hospice Aides
- Chaplains and Bereavement Counselors
- Trained Volunteers

When our patients and families receive the care they need and the support they deserve, they often find that life takes on new meaning. They are able to live a more fulfilled life.



# HOSPICE ELIGIBILITY GUIDELINES

Hospice is a special kind of care designed to provide comfort and support for patients and their families during the final stages of life. To be eligible for hospice care, the patient's doctor and the hospice medical director must certify that the patient has a life expectancy of six months or less, if the disease progression were to run its normal course. Additionally, when a patient elects the hospice benefit they have accepted a goal of treatment focused on palliative care, comfort and relief from pain and symptoms.

## GENERAL GUIDELINES

The eligibility criteria contained within this guide are related to specific diagnoses that the Centers for Medicare and Medicaid Services (CMS) has provided. Although these guidelines are limited to a select list of diagnoses for hospice benefit coverage it is not to be considered an all-inclusive list. In fact, any disease process in the terminal stage is appropriate for hospice care. Hospice appropriate individuals may exhibit some or all of the following:

- Frequent hospitalizations
- Progressive weight loss
- Deteriorating mental abilities
- Recurrent infections
- Overall decline in condition

# WHO SHOULD RECEIVE HOSPICE CARE?

- Individuals with an illness causing a limited life expectancy of 6 months or less, if the disease runs its normal course.
- Individuals who have chosen palliative care that focuses on symptom management rather than curative treatment.
- Individuals who choose no extreme measures to sustain life.

For determination of hospice care eligibility please contact your local Hospice Compassus team to request an assessment.

# HOW TO REFER TO HOSPICE

Referrals to Hospice Compassus can be made 24 hours a day, 7 days a week using a 3 step process.

- 1. Place the call to Hospice Compassus.*
- 2. Our Admissions Coordinator contacts all responsible parties to coordinate the physician order, a family consultation and/or a patient assessment.*
- 3. Our Admission Team consults, evaluates and initiates care.*

(See back cover for contact information.)

# CANCER

Patients will be considered to be in the terminal stage of cancer if they meet the following criteria: 1 and 2 **MUST** be present; and either factor 3 or 4 **MUST** be present. Consider all factors that impact the patient's prognosis.

**1. Palliative Performance Scale  $\leq$  70%**

*(see Appendix: Palliative Performance Scale (PPS) )*

**2. Dependence on 2 or more ADL's**

**3. Pathology report reveals evidence of malignancy or metastases.**

**4. Progression from earlier stage of disease to metastatic disease with either:**

- Continued decline in spite of therapy; or
- Patient declines further disease directed therapy

*NOTE: Certain cancers with poor prognoses may be hospice eligible without fulfilling other criteria in this section.*

## **Co-morbid or Secondary Conditions**

- COPD
- CHF
- Liver Disease
- Alcoholism
- Renal Failure
- Dementia
- Neurological Disease

*If a patient meets the medical criteria above, they are by definition eligible to receive hospice services. Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline. Contact your Hospice Compassus Consultant for further information.*

## CARDIAC DISEASE

Patients will be considered to be in the terminal stage of cardiac disease if they meet the following criteria: 1 and 2 MUST be present; factors from 3 lend supporting documentation, but are not required.

**1. At the time of initial certification or recertification for hospice:**

- Patient is already optimally treated with diuretics and vasodilators, which may include Angiotensin-converting enzyme (ACE) inhibitors or the combination of hydralazine and nitrates. If side effects, such as hypotension or hyperkalemia, prohibit the use of ACE inhibitors or the combination of hydralazine and nitrates, this must be documented in the medical records; OR
- Patients having angina pectoris, at rest, resistant to standard nitrate therapy and are either not candidates or decline invasive procedures.

**AND**

**2. The patient has significant symptoms of recurrent congestive heart failure (CHF) at rest, and is classified as a New York Heart Association (NYHA) Class IV.**

*(see Appendix: New York Heart Association (NYHA) )*

- Unable to carry on any physical activity without symptoms;
- Symptoms are present even at rest;
- If any physical activity is undertaken, symptoms are increased.

3. Documentation of the following factors may provide additional support for determining prognosis in end stage heart disease:

- Treatment resistant symptomatic supraventricular or ventricular arrhythmias;
- History of cardiac arrest or resuscitation;
- History of unexplained syncope;
- Brain embolism of cardiac origin;
- Concomitant HIV disease;
- Documentation of ejection fraction of 20% or less (only if available)

*If a patient meets the medical criteria above, they are by definition eligible to receive hospice services. Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline. Contact your Hospice Compassus Consultant for further information.*

## PULMONARY DISEASE

Patients will be considered to be in the terminal stage of pulmonary disease if they meet the following criteria: 1 and 2 MUST be present; factors 3, 4 and/or 5 provide supporting documentation.

**1. Severe chronic lung disease as documented by both a and b:**

- a. Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough (documentation of Forced Expiratory Volume in one second (FEV1), after bronchodilator, less than 30% of predicted is objective evidence for severe chronic lung disease, but is not necessary to obtain).
- b. Progression of end stage pulmonary disease, as evidenced by increasing visits to the emergency department or hospitalizations for pulmonary infections and/or respiratory failure (documentation of serial decrease in FEV1 of greater than 40 ml/year is objective evidence for disease progression, but is not necessary to obtain).

**2. Hypoxemia, as evidenced by:**

- Oxygen saturation of 88% or less on room air.
- $O_2 \leq 55\text{mm Hg}$

(These values may be obtained from recent hospital records.)

Documentation of the following factors may provide additional support for end stage pulmonary disease:

3. Cor pulmonale or right heart failure (RHF) secondary to pulmonary disease (e.g., not secondary to left heart disease or valvulopathy).
4. Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.
5. Resting tachycardia > 100/min.

*If a patient meets the medical criteria above, they are by definition eligible to receive hospice services. Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline. Contact your Hospice Compassus Consultant for further information.*

## ALZHEIMER'S DISEASE AND RELATED DISORDERS

Patients will be considered to be in the terminal stage of Alzheimer's Disease if they meet the following criteria: 1 plus either 2 or 3 MUST be present:

- 1. Stage 7 on the Functional Assessment Staging (FAST) Scale, A, B & C criteria are very important indicators of end stage Alzheimer's Disease: Additional criteria lend additional support to terminal status:**

*(see Appendix: Functional Assessment Staging (FAST) Scale)*

- Incontinence
  - Inability to communicate meaningfully (1 to 5 words a day)
  - Non-ambulatory (unable to ambulate and bear weight)
  - All intelligible vocabulary lost
  - Unable to sit up independently
  - Unable to smile
  - Unable to hold head up
- 2. Presence of co-morbid disease distinct from the terminal illness will impact functional impairment. The combined effects of the Alzheimer's and any co-morbid condition should support a prognosis of 6 months or less.**
- COPD
  - CHF
  - Cancer
  - Liver Disease
  - Renal Failure
  - Neurological Disease

**3. Patients should have had one of the following secondary conditions within the past 12 months:**

- Delirium
- Recurrent or intractable infections, such as pneumonia or other URI
- Pyelonephritis or other urinary tract infection
- Septicemia
- Decubitus ulcers, multiple, stage 3-4
- Fever, recurrent after antibiotics
- Inability to maintain sufficient fluid and calorie intake demonstrated by either of the following: 10% weight loss during the previous six months OR Serum albumin < 2.5 gm/dl
- Aspiration pneumonia

*If a patient meets the medical criteria above, they are by definition eligible to receive hospice services. Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline. Contact your Hospice Compassus Consultant for further information.*

## ADULT FAILURE TO THRIVE

The adult failure to thrive syndrome is characterized by unexplained weight loss, malnutrition and disability. The syndrome has been associated with multiple primary conditions (e.g., infections and malignancies), but always includes two defining clinical elements, namely nutritional impairment and disability. The nutritional impairment and disability associated with the adult failure to thrive syndrome may be severe enough to impact a patient's short-term survival.

The adult failure to thrive syndrome may manifest as an irreversible progression in the patient's nutritional impairment/disability despite a trial of therapy (i.e., treatment intended to affect the primary condition responsible for the patient's clinical presentation.) The presence of comorbid conditions may hasten the patient's clinical progression and as such should be identified and addressed. The medical criteria below supports the terminal prognosis for patients with adult failure to thrive syndrome. Criteria 1 and 2 **MUST** be met; factor 3 will lend support to terminal status. The patient would meet criteria if **ALL** of the following are met:

### **1. Irreversible nutritional impairment, as evidence by both of the following:**

- Body Mass Index will be less than  $22\text{kg/m}^2$  ( $\text{BMI} (\text{kg/m}^2) = 703 \times (\text{weight in pounds}) / (\text{height in inches})^2$ )

*(see Appendix: Body Mass Index (BMI) Reference Chart)*

(At the time of recertification, recumbent mid-arm muscle area in  $\text{cm}^2$  may be substituted for weight or BMI with documentation as to why a BMI or weight could not be obtained.)

- Declines enteral/parenteral nutritional support OR has not responded to such support, despite an adequate caloric intake

**AND**

**2. Significant Disability as evidenced by the Palliative Performance Scale equal to or less than 40%.**

*(See Appendix: Palliative Performance Scale (PPS) )*

**3. Other variables lending support to terminal diagnosis include the following:**

- Recurrent or intractable infections, such as pneumonia or other URI, sepsis, or UTI
- Decreasing serum albumin or cholesterol
- Dysphagia leading to recurrent aspiration and inadequate oral intake documented by the decreasing food portion consumption
- Nausea/vomiting poorly responsive to treatment
- Diarrhea, intractable
- Generalized pain
- Decline in systolic blood pressure to below 90 or progressive postural hypotension
- Edema
- Change in level of consciousness
- Abnormal electrolyte levels
- Progressive 3-4 stage pressure ulcers

*If a patient meets the medical criteria above, they are by definition eligible to receive hospice services. Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline. Contact your Hospice Compassus Consultant for further information.*

# STROKE OR COMA

## STROKE

Patients will be considered to be in the terminal stage of stroke or coma if they meet the following criteria. Criteria 1 & 2 are important indicators of functional and nutritional status and will support a terminal prognosis for patients with diagnosis of stroke. Number 3 will lend support.

**1. Poor functional status with a Palliative Performance Scale (PPS) of 40 or less. All criteria in number 1 should be met.**

*(See appendix: Palliative Performance Scale (PPS) )*

- Mainly bed-bound
- Unable to work
- Requires maximal assistance to perform self-care
- Food/fluid intake are normal/reduced
- Either fully conscious or drowsy/confused

### AND

**2. Inability to maintain hydration and caloric intake with ONE of the following:**

- Weight loss > 10% during previous 6 months
- Weight loss > 7.5% in previous 3 months
- Serum albumin < 2.5 gm/dl
- Current history of pulmonary aspiration without effective response to speech language pathology interventions to improve dysphagia and decrease aspiration events.
- Calorie counts documenting inadequate caloric/fluid intake.
- Dysphagia severe enough to prevent the patient from receiving food/fluids that is necessary to sustain life in a patient who does not receive artificial nutrition/hydration.

3. Documentation of medical complications within the previous 12 months, in the context of progressive clinical decline, will help support eligibility for hospice care.
- Recurrent or intractable infections such as pneumonia or other URI
  - Urinary tract infection
  - Sepsis
  - Refractory stage 3-4 decubitus ulcers
  - Fever recurrent after antibiotics

## COMA

The medical criteria listed below would support a terminal prognosis for individuals with a diagnosis of coma (any etiology). Comatose patients with any 3 of the following on day three of coma are considered terminal:

- abnormal brain stem response
- absent verbal response
- absent withdrawal response to pain
- serum creatinine >1.5 mg/dl

*If a patient meets the medical criteria above, they are by definition eligible to receive hospice services. Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline. Contact your Hospice Compassus Consultant for further information.*

## LIVER DISEASE

Patients will be considered to be in the terminal stage of liver disease if they meet the following criteria: 1 and 2 **MUST** be present; factors from 3 will lend supporting documentation.

**1. The patient has end stage liver disease as evidenced by BOTH of the following:**

- Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio (INR) > 1.5 **AND**
- Serum albumin < 2.5 gm/dl

**AND**

**2. The 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 (<400ml/day) and urine sodium concentration <10 mEq/l)
- Hepatic encephalopathy, refractory to treatment, or patient non-compliant
- Recurrent variceal bleeding, despite intensive therapy

**3. Documentation of the following factors will support eligibility for hospice care:**

- Progressive malnutrition
- Muscle wasting with reduced strength and endurance
- Continued active alcoholism (>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.

*If a patient meets the medical criteria above, they are by definition eligible to receive hospice services. Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline. Contact your Hospice Compassus Consultant for further information.*

## RENAL DISEASE

Patients will be considered to be in the terminal stage of renal disease if they meet the following criteria:

**Acute renal failure** (1, 2 AND 3 must be present; factors from 4 will lend supporting documentation):

1. The patient is not seeking dialysis or renal transplant.

AND

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

AND

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

4. Supporting documentation of comorbidities:

- History of mechanical ventilation
- Malignancy (other organ system)
- Chronic lung disease
- Advanced cardiac disease
- Advanced liver disease
- Sepsis
- Immunosuppression/AIDS
- Albumin <3.5 gm/d
- Cachexia
- Platelet count <25,000
- Disseminated intravascular coagulation
- Gastrointestinal bleeding

**Chronic Renal Failure** (1, 2, and 3 must be present; factors from 4 will lend supporting documentation):

1. The patient is not seeking dialysis or renal transplant

AND

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

AND

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

#### 4. Supporting documentation of comorbidities:

- Uremia
- Urine output < 400 cc/day
- Intractable hyperkalemia (> 7.0) not responsive to treatment
- Uremic pericarditis
- Hepatorenal syndrome
- Intractable fluid overload, not responsive to treatment

*If a patient meets the medical criteria above, they are by definition eligible to receive hospice services. Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline. Contact your Hospice Compassus Consultant for further information.*

## AMYOTROPHIC LATERAL SCLEROSIS (ALS)

Patients will be considered to be in the terminal stage of ALS if they meet the following criteria (must fulfill 1, 2, or 3):

**1. The patient must demonstrate critically impaired breathing capacity with ALL of the following characteristics in the past 12 months preceding initial hospice certification:**

- Vital capacity (VC) <30% of normal
- Significant dyspnea at rest
- Requiring supplemental O<sub>2</sub> at rest
- Patient declines artificial ventilation

**OR**

**2. Patient must demonstrate BOTH:**

**A. Rapid progression of ALS as demonstrated by ALL of the following within the 12 months preceding initial hospice certification:**

- Progression from independent ambulation to wheelchair or bed-bound status
- Progression from normal to barely intelligible or unintelligible speech
- Progression from normal to pureed diet
- Progression from independence in most or all activities of daily living (ADLs) to needing major assistance by caretaker in all ADLs.

**AND**

**B. Critical nutritional impairment as demonstrated by ALL of the following within 12 months preceding initial hospice certification:**

- Oral intake of nutrients and fluids insufficient to sustain life
- Continuing weight loss

- Dehydration or hypovolemia
- Absence of artificial feeding methods

**OR**

**3. BOTH of the following:**

A. Rapid progression of ALS (2.A. above)

**AND**

- B. Life-threatening complications as demonstrated by ONE of the following within the last 12 months preceding initial hospice certification:
- Recurrent aspiration pneumonia (with or without tube feedings)
  - Upper UTI, e.g. , pyelonephritis
  - Sepsis
  - Recurrent fever after antibiotic therapy
  - Decubitus ulcers, multiple, Stage 3-4

**In end-stage ALS, two factors are critical in determining prognosis: ability to breathe, and to a lesser extent, ability to swallow.**

*If a patient meets the medical criteria above, they are by definition eligible to receive hospice services. Some patients may not meet the criteria, but may still be eligible for hospice care due to comorbidities or rapid functional decline. Contact your Hospice Compassus Consultant for further information.*

# Scales

---

- New York Heart Association (NYHA) Functional Classification
- Palliative Performance Scale (PPS)
- Functional Assessment Staging (FAST) Scale
- Body Mass Index (BMI) Reference Chart
- FLACC Pain Scale

# New York Heart Association 9th Edition (Cardiac Patients)

	Functional Capacity by Class	Objective Assmt*
<b>I</b>	No limitation in physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.	No evidence of cardiovascular disease
<b>II</b>	Slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.	Objective evidence of <i>minimal</i> cardiovascular disease
<b>III</b>	Comfortable at rest. Less than ordinary physical activity results in fatigue, palpitation, dyspnea or anginal pain.	Objective evidence of <i>moderately severe</i> cardiovascular disease
<b>IV</b>	Unable to carry on physical activity without discomfort. S/S of heart failure or anginal syndrome may be present <i>even at rest</i> . If any physical activity is undertaken, discomfort is increased.	Objective evidence of <i>severe</i> cardiovascular disease

\*Measures such as EKG, stress test, x-ray, echocardiogram and/or radiologic images.

## Palliative Performance Scale (PPS)

%	Ambulation	Activity & Evidence of Disease	Self-care	Intake	Level of Conscious
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 hobbies or some housework, significant disease	Occasional assistance	Normal or Reduced	Full or confusion
50	Mainly sit/lie	Unable to do any work, extensive disease	Considerable assistance	Normal or Reduced	Full or confusion
40	Mainly in bed	Unable to do any work, extensive disease	Mainly assistance	Normal or Reduced	Any
30	Totally Bed Bound	Unable to do any work, extensive disease	Total Care	Reduced	Any
20	Totally Bed Bound	Unable to do any work, extensive disease	Total Care	Minimal Sips	Any
10	Totally Bed Bound	Unable to do any work, extensive disease	Total Care	Mouth Care Only	Drowsy or Coma
0	Death	—	—	—	—

## FUNCTIONAL ASSESSMENT STAGING (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), difficulty marketing, etc.
5. Requires assistance in choosing proper clothing to wear for the day, season, or occasion, e.g. patient may wear the same clothing repeatedly, unless supervised.\*
6. A) Improperly putting on clothes without assistance or prompting (e.g. may put street clothes on over night clothes, or put shoes on wrong feet, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks.\*  
B) Unable to bathe properly (e.g., difficulty adjusting bath-water temp.) occasionally or more frequently over the past weeks.\*  
C) Inability to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.\*  
D) Urinary incontinence (occasionally or more frequently over the past weeks.)\*  
E) Fecal incontinence (occasionally or more frequently over the past weeks.)\*
7. A) Ability to speak limited to approximately a half dozen intelligible different words or fewer; 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 (the person may repeat the word over and over).  
C) Ambulatory ability is lost (cannot walk without personal assistance).  
D) Cannot sit up without assistance.  
E) Loss of ability to smile.  
F) Loss of ability to hold head up independently.

\*Scored primarily on the basis of information obtained from knowledgeable informant.

## BODY MASS INDEX REFERENCE CHART

Underweight (< 18.5)    Ideal (19-24)    Overweight (25 - 29)    Obese (>30)

Height	Inches	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35
4' 10"	58"	91	96	100	105	110	115	119	124	129	134	138	143	148	153	158	162	167
4' 11"	59"	94	99	104	109	114	119	124	128	133	138	143	148	153	158	163	168	173
5' 0"	60"	97	102	107	112	118	123	128	133	138	143	148	153	158	163	168	174	179
5' 1"	61"	100	106	111	116	122	127	132	137	143	148	153	158	164	169	174	180	185
5' 2"	62"	104	109	115	120	126	131	136	142	147	153	158	163	169	175	180	186	191
5' 3"	63"	107	113	118	124	130	135	141	146	152	158	164	169	175	180	186	191	197
5' 4"	64"	110	116	122	128	134	140	145	151	157	163	169	174	180	186	192	197	204
5' 5"	65"	114	120	126	132	138	144	150	156	162	168	174	180	186	192	198	204	210
5' 6"	66"	118	124	130	136	142	148	155	161	167	173	179	186	192	198	204	210	216
5' 7"	67"	121	127	134	140	146	153	159	166	172	178	185	191	198	204	211	217	223
5' 8"	68"	125	131	138	144	151	158	164	171	177	184	190	197	203	210	216	223	230
5' 9"	69"	128	135	142	149	155	162	169	176	182	189	196	203	209	216	223	230	236
5' 10"	70"	132	139	146	153	160	167	174	181	188	195	202	209	216	222	229	236	242
5' 11"	71"	136	143	150	157	165	172	179	186	193	200	208	215	222	229	236	243	250
6' 0"	72"	140	147	154	162	169	177	184	191	199	206	213	221	228	236	242	250	258
6' 1"	73"	144	151	159	166	174	182	189	197	204	212	219	227	235	242	250	257	265
6' 2"	74"	148	155	163	171	179	186	194	202	210	218	225	233	241	249	256	264	272
6' 3"	75"	152	160	168	176	184	192	200	208	216	224	232	240	248	256	264	272	279
6' 4"	76"	156	164	172	180	189	197	205	213	221	230	238	246	254	263	271	279	287

# FLACC SCALE – (Face, Legs, Activity, Cry, Consolability)

Instructions: Rate patient in each of the five measurement categories.  
Add together to determine total pain score

	0	1	2
FACE	No particular expression or smile, <b>eye contact and interest in surroundings</b>	Occasional grimace or frown, withdrawn, disinterested, <b>worried look to face, eyebrows lowered, eyes partially closed, cheeks raised, mouth pursed</b>	Frequent to constant frown, clenched jaw, quivering chin, <b>deep furrows on forehead, eyes closed, mouth opened, deep lines around nose/lips</b>
LEGS	Normal position or relaxed	Uneasy, restless, tense, <b>increased tone, rigidity, intermittent flexion/extension of limbs</b>	Kicking or legs drawn up, <b>hypertonicity, exaggerated flexion/extension of limbs, tremors</b>
ACTIVITY	Lying quietly, normal position, moves easily <b>and freely</b>	Squirming, shifting back and forth, tense, <b>hesitant to move, guarding, pressure on body part</b>	Arched, rigid, or jerking, <b>fixed position, rocking, side to side head movement, rubbing of body part</b>
CRY	No cry or <b>moan</b> (awake or asleep)	Moans or whimpers, <b>occasional cries, sighs, occasional complaint</b>	Crying steadily, screams, sobs, moans, <b>grunts, frequent complaints</b>
CONSOLABILITY	<b>Calm</b> , content, relaxed, does not require consoling	Reassured by occasional touching, hugging, or talking to, <b>distraicable</b>	Difficult to console or comfort

# USEFUL LANGUAGE FOR HOSPICE DISCUSSIONS

## Identify other decision makers

“Is there anyone you rely on to help you make important decisions?”

“Who in the family should be there with us when we discuss the results?”

## Assess understanding of prognosis

“What have your other doctors told you about your condition?”

“Have they talked to you about what this latest problem might mean for you?”

“From what you know, do you think that over the next month your cancer will get better, worse, or stay the same?”

## Define the patient’s goals for care

“What do you hope for most in the next few months?”

“Is there anything that you’re afraid of?”

## Reframe goals

“I wish we could guarantee that we could keep you alive until your daughter’s graduation, but unfortunately we can’t. Perhaps we can work together on a letter for her to read on that day, so she will know you are there in spirit in case you cannot be there.”

## Identify needs for care

“It can be very difficult to care for a family member at home, and no one can do it alone. Have you thought about what kinds of help you might need?”

“Would it help if we could find a way to deliver your medications to you?”

“Would it reassure you if we could send a nurse out to your home to check on you?”

## Summarize and link goals with care needs

“So I think I understand that your main goal is to stay at home and spend time with your family. To do that, we will need to help you in several ways, for instance, by sending a nurse out to your home and giving you both some help around the house. Is that right?”

## **Introduce hospice**

“One of the best ways to give you the help that you will need to stay at home with your family is a program called hospice. Have you heard of hospice?”

“Hospice is able to provide more services and support at home than most other care programs.”

“The hospice team has a lot of experience caring for seriously ill patients at home.”

## **Respond to emotions elicited and provide closure**

### **Acknowledge Response:**

“You seem surprised to learn how sick you are.”

“I can see it’s not easy for you to talk about hospice.”

### **Legitimize Reaction:**

“Many people are understandably upset when they learn how ill their loved one is and that hospice is a possibility.”

### **Empathize:**

“I can imagine how hard it is for both of you; you care about each other so much.”

### **Explore concerns: “Tell me what’s upsetting you the most.”**

### **Explain hospice goals:**

“Hospice doesn’t help people die sooner. Hospice helps people die naturally, in their own time.”

“Hospice helps people live as well as they can for as long as they can.”

### **Reassure:**

“Hospice’s goal is to improve your quality of life as much as possible for whatever time you have left.”

“Hospice can help you and your family make the most of the time you have left.”

### **Reinforce commitment to care**

“Let’s think this over for a day or two; you know I will continue to care for you whatever decision you make.”

### **Recommend hospice**

“I think that hospice would be your best choice right now, but of course the final decision is yours.”

“Hospice could be very helpful to you in the ways that we’ve talked about, but I realize it’s a big decision. I’d like to arrange for a hospice nurse to visit you so you can decide for yourself whether hospice is right for you.”

# REFERENCES

## **General Hospice Guidelines**

National Hospice and Palliative Care Organization  
Copyright 1996 Medical Guidelines for Determining  
Prognosis in Selected Non-Cancer Diseases - 2nd Edition  
Centers for Medicare and Medicaid Services (CMS)  
Intermediary 2007 Local Coverage  
Determinations (LCD's)

## **NYHA Functional Classification**

The Criteria Committee of the New York Heart Association.  
Nomenclature and Criteria for Diagnosis of Diseases of the  
Heart and Great Vessels. 9th ed. Boston, Mass: Little, Brown  
& Co; 1994:253-256.

## **Palliative Performance Scale (PPS)**

Anderson, Fern et al. (1996) Palliative  
Performance Scale (PPS) A New Tool,  
Journal of Palliative Care 12(1), 5-11

## **Functional Assessment Staging (FAST) Scale**

National Hospice and Palliative Care Organization  
Copyright 1996 Medical Guidelines for Determining  
Prognosis in Selected Non-Cancer Diseases - 2nd Edition

## **Body Mass Index Reference Chart**

<http://nutritionnewsfocus.com/bmi.html>

## **FLACC Pain Scale**

A behavior pain assessment scale by S. Merkel and others,  
1997, Pediatric Nurse 23(3), p.293-297

## **Useful Language for Hospice Discussions**

David J. Casarett, MD, MA, and Timothy E. Quill, MD  
Annals of Internal Medicine, March 2007, Volume 146,  
Issue 6, p.443-449



[www.hospicecompassus.com](http://www.hospicecompassus.com)