What we will discuss today

- Review of the Medicare regulations related to eligibility
- Use of the Local Coverage Determinations (LCDs)
- Eligibility assessment principles
- Employ the correct use of assessment tools
  - Palliative Performance Scale (PPS)
  - New York Heart Classification (NYHC)
  - Functional Assessment Staging (FAST)
  - Body Mass Index (BMI)
  - Other objective data supporting eligibility

The Legal Standard

42 CFR 418.20 Eligibility Requirements
- 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

42 CFR 418.2 Definitions
- Terminally ill means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course

Hospice Eligibility Clarification

"The certification regarding terminal illness of an individual shall be based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness."

CMS Program Memorandum
Transmittal AB-03-040 (CR 2570)
March 28, 2003

Over the years CMS has stated in different venues and at different times that the physician does not need to know if the specific individual will die in 6 months, but rather that individuals who present in the same way generally die in 6 months.
Hospice Eligibility

• Based on **prognosis**
  • Which is why it **must** be done by physicians
  • Very unlike other types of physician certifications
    • Those are based on “Medical Necessity”
  • MHB is **not** based on medical necessity
  • MHB is based on **proximity to end of life**
    • Based on reasonable & necessary for the palliation or management of the terminal illness and related conditions (42 CFR 418.20)

So Who Is a Candidate for Hospice?

• Limited prognosis
  • < 6-months if disease runs its normal course
  • “More likely than not”
  • Don’t HAVE to be dead in 6 months
  • No penalties unless knowingly fraudulent

Question:

“Would you be surprised to read your patient’s obituary in the next 6 months?”

Why?

Disease Trajectory

Prognosis vs. Eligibility

• Assessing for eligibility is something anyone can do
  • Comparing a potential patient's characteristics to a listing in a book, guideline, LCD, etc.

• Prognostication is the practice of medicine
  • Based on experience, knowledge of research, clinical intuition, the art of medicine
  • Excluded from other scopes of practice
  • No one is very good at it
Prognosis & Physician’s Clinical Judgment

Clinical Assessment

Experience

Evidence Based Knowledge

Effects on Prognosis

• Primary diagnosis
  • Sometimes is automatically terminal; e.g. Stage IV lung cancer no longer seeking treatment

• Secondary conditions
  • Directly related to the terminal illness
  • Examples
    • Dementia
    • aspiration pneumonia, pressure ulcers, delirium, sepsis
    • Neuromuscular diseases
    • contractures, pressure ulcers

• Co-morbid conditions – distinct from the primary or related to the primary

Effects on Prognosis

• Function
  • Seriousness of disease (primary, secondary and co-morbid) is reflected by the degree of lost function
  • Decreased function is related to increased mortality

• Nutrition
  • Extremes of nutritional status are associated with increased mortality

Effects on Prognosis

• Cognition
  • Delirium
    • Highest risk of mortality
  • Dementia
    • Alzheimer’s and others
    • At end-stage is terminal in its own right
    • Moderate-Severe: increased mortality as a co-morbid
<table>
<thead>
<tr>
<th>Effects on Prognosis</th>
<th>Rapid Clinical Decline</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Younger</td>
<td>• Progressive deterioration while receiving appropriate care</td>
</tr>
<tr>
<td>• Need more things “wrong” (i.e. co-morbid diagnoses)</td>
<td>• Home health care or SNF rehab services</td>
</tr>
<tr>
<td>• Older</td>
<td>• Hospital Utilization</td>
</tr>
<tr>
<td>• Usually already have more things “wrong”</td>
<td>• Multiple recent hospitalizations, emergency room visits or utilization of other health care services which may have prevented a hospitalization</td>
</tr>
<tr>
<td>• Centenarians</td>
<td>• Serial Lab Assessments</td>
</tr>
<tr>
<td>• Almost automatically eligible, based on statistics</td>
<td>• Labs, x-rays, echo, etc. showing progressive illness</td>
</tr>
<tr>
<td>• However they still need to have a terminal illness &amp; prognosis of 6 months or less</td>
<td>• Nutritional Decline</td>
</tr>
<tr>
<td></td>
<td>• Functional Decline</td>
</tr>
<tr>
<td></td>
<td>• ADLs</td>
</tr>
<tr>
<td></td>
<td>• PPS decline by 20 points in past 2 - 3 months</td>
</tr>
</tbody>
</table>

Tools provide a data point or points that, used in context with the whole person, help to make a determination of eligibility.

It is important to assess the data points over time.
Some Tools and Measurements

Tools
- LCDs: Local Coverage Determinations
- PPS: Palliative Performance Scale
- FAST: Functional Assessment Staging
- NYHA Functional Classifications

Measurements
- Weight Loss / BMI / MAC
- ADLs
- Cognitive function
- Pain
- Diagnostic studies
- Crystal Ball

Common Problems

- Using wrong tool(s) for patient or diagnosis or not using it at all
- Inconsistencies among clinicians
  - Scoring
  - Usage – some do, some don’t
  - Documentation placement (especially with EMRs)
- Not identifying scores that don’t make sense or are in conflict with others

Effective Use of Tools Requires

Definition of
- standard tools to be used
- how it works in your documentation system
- how tools connect to care and care planning
- Staff education and reeducation
- Monitoring to test results

LCDs

- Developed by the MACs
- Provide medical criteria for determining prognosis
  - But not consistent predictors of prognosis
- Use as guidelines for documenting terminal illness
- If a patient meets certain criteria, they are deemed eligible
- If a patient doesn’t meet the LCD,
  - May still be eligible for the MHB,
  - But must document why (best done by a physician)
- Not the legal standard for hospice eligibility
  - However, are followed by reviewers when reviewing an ADR

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THE SIGNIFICANCE OF FUNCTIONAL STATUS

Using Functional Measurement Tools

The PPS & FAST

- Excellent tools for monitoring, quantifying and documenting the functional performance and decline in hospice patients
- Documents a dementia patient's current cognitive abilities
  - How they manifest in the patient's functional abilities
  - Predict and document disease progression

Palliative Performance Scale (PPS)

- Designed to measure functional performance and progressive decline in palliative care patients
  - Ambulation
  - Activity
  - Evidence of disease
  - Self care
  - Intake
  - Level of consciousness
- Designed to measure what a person is capable of doing, not what they choose to do

Chance of Death at 6 months

<table>
<thead>
<tr>
<th>PPS Level</th>
<th>Chance of Death at 6 months* Cancer</th>
<th>Chance of Death at 6 months* Non-cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>84%</td>
<td>75%</td>
</tr>
<tr>
<td>40</td>
<td>95%</td>
<td>85%</td>
</tr>
<tr>
<td>30</td>
<td>95%</td>
<td>85%</td>
</tr>
<tr>
<td>20</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td>10</td>
<td>100%</td>
<td>96%</td>
</tr>
</tbody>
</table>

* Applies only to patients who have been to a hospice program

From Harrold J, Rickerson E, et al
Is the PPS a Useful Predictor of Mortality in a Heterogeneous Hospice Population
Journal of Palliative Medicare Volume 8, No. 3, 2005
Using the PPS

- Scores are determined by reading horizontally at each level to find a best fit
- Begin at the left hand column and read downward until the patient’s appropriate ambulation level is reached
- Move to the self care column and determine that score
- Ambulation and self care are more easily discernable so begin with those two

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### PPS: Example 1

77 year old man with COPD leads a bed to chair existence secondary to dyspnea. Tries to manage ADLs himself but actually needs a lot of help. Can do most of his personal care once in the bathroom. Inake is good. He is alert and oriented.

<table>
<thead>
<tr>
<th>%</th>
<th>Ability to Ambulate</th>
<th>Activity and Evidence of Disease</th>
<th>Self-Care</th>
<th>Intake</th>
<th>Level of Consciousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Full</td>
<td>Normal activity, no evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>90</td>
<td>Full</td>
<td>Normal activity, some evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>80</td>
<td>Full</td>
<td>Normal activity w/ effort, some evidence of disease</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
<tr>
<td>70</td>
<td>Reduced</td>
<td>Unable to do normal task, some evidence of disease</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
<tr>
<td>60</td>
<td>Reduced</td>
<td>Unable to do daily activities, moderate evidence of disease</td>
<td>Occasional assistance needed</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
<tr>
<td>50</td>
<td>Mainly in bed</td>
<td>Unable to do any task, minimal evidence of disease</td>
<td>Mainly assistance</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
<tr>
<td>40</td>
<td>Totally bed bound</td>
<td>Unable to do any task, extensive evidence of disease</td>
<td>Total care</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
<tr>
<td>30</td>
<td>Totally bed bound</td>
<td>Unable to do any task, extensive evidence of disease</td>
<td>Total care</td>
<td>Mouth care only</td>
<td>Drowsy or coma</td>
</tr>
<tr>
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<td>Totally bed bound</td>
<td>Unable to do any task, extensive evidence of disease</td>
<td>Total care</td>
<td>Minimal care</td>
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<tr>
<td>0</td>
<td>Death</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PPS = 50%

---

### PPS Example

79 year old woman with Alzheimer’s. NF staff lift her out of bed into a reclining chair occasionally. She requires significant assistance with ADLS and self care. She feeds herself and usually eats everything on her plate. She is very confused.

<table>
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<td></td>
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<td></td>
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PPS = 40%
FAST

- The FAST Scale is a 16-item scale designed to parallel the progressive activity limitations associated with Alzheimer’s Disease
- A 7-step staging system, to determine hospice eligibility which identifies progressive steps and sub-steps of functional decline
- Designed for Alzheimer’s Disease
  - Little information on other dementias
  - Problems of “non-ordinate” patients
- Stage 7 identifies the threshold of activity limitation that would support a six-month prognosis
  - To qualify under Alzheimer’s Disease the patient should have a FAST of 7 along with secondary conditions

Keys to Scoring

- The scoring must be done sequentially
  - It’s not the lowest score for which the patient qualifies, it’s the lowest uninterrupted score
- Unable to ambulate without assistance
  - This means personal assistance, someone holding them up so they can walk
  - It is not: walker, cane, standby assist
- Verbal communication
  - Ability to speak limited to approximately a half a dozen intelligible different words or fewer, in the course of an average day or in the course of an intensive interview
- Deficits are a result of the dementing process
  - Walking limitation can not be from osteoarthritis or other non related disease processes

Case Study

- Patient with Alzheimer’s living at home who requires significant assistance with all ADLs
  - She is incontinent of bowel and bladder
  - She has no memory and says over and over again “Why are you doing this to me?”
  - Her PPS is 40%
  - She is unable to ambulate at all
  - What’s her FAST?

Score

- ✔ 6a Needs assistance putting on clothes
- ✔ 6b Unable to bathe properly
- ✔ 6c Inability to handle the mechanics of toileting occasionally or more frequently recently
- ✔ 6d Occasional or more frequent urinary incontinence
- ✔ 6e Occasional or more frequent fecal incontinence
- ✔ 7a Speech limited to approximately 6 intelligible words in a day or interview
- ✔ 7b Speech limited to approximately 1 intelligible word in a day or interview
- ✔ 7c Ambulatory ability is lost (without personal assistance)
**Case Study**

Patient with Alzheimer's living in a SNF
- Unable to ambulate safely without assistance, but tries and falls frequently
- Cannot hold his balance on the edge of the bed
- No longer smiles.
- Frequently tells staff things like "don't touch that", "leave me alone", "this isn't my house", "I want ice cream"
- Is incontinent of bowel and bladder
- Needs assistance to dress, bathe and toilet
- What's the FAST?

**Score**

- 6a Needs assistance putting on clothes
- 6b Unable to bathe properly
- 6c Inability to handle the mechanics of toileting occasionally or more frequently recently
- 6d Occasional or more frequent urinary incontinence
- 6e Occasional or more frequent fecal incontinence
- 7a Speech limited to approximately 6 intelligible words in a day or interview
- 7b Speech limited to approximately 1 intelligible word in a day or interview
- 7c Ambulatory ability is lost (without personal assistance)

**Activities of Daily Living**

- ADL deficits are the most important predictor of 6-month mortality
- Ambulation, Continence, Transfers, Feeding, Bathing, Dressing
- Stronger than diagnosis, mental status, or ICU admission

**Activities of Daily Living Measurement**

- ADLS
  - Ambulation
  - Continence
  - Transfers
  - Feeding
  - Bathing
  - Dressing
- Amount of assistance required-describe
  - Independent
  - Uses device
  - Personal assistance-how much
  - Completely dependent
- Document the level of assistance needed for each ADL
- Be descriptive
Which Is More Descriptive?

• Assist in 5 of 6 ADLs at admission and at recert
  Or
• Admission: Standby assistance with ambulation with walker; occasional incontinence; minimal assistance with transfers; independent in feeding, moderate assistance with bathing and dressing

• Recertification: Personal assistance with ambulation with walker; incontinent bowel and bladder; maximum assistance with transfers; independent in feeding, moderate assistance with bathing and dressing

NUTRITIONAL MEASUREMENT

Nutritional Measurement

• Extremes of nutritional status are associated with increased mortality
• >10% weight loss in elderly, over 6 months associated with high mortality
• BMI < 22 kg/m² in the elderly associated with increased mortality
• Decline in ability to take nourishment
  • Decline in # or % of meals consumed
  • Loss of ability to take solid food precedes loss of ability to take fluids

Weights

• Weights
  • Admission
    • Accurate actual weight (not reported)
    • For NF patients, if weights fluctuate find out why and then get an accurate admission weight
    • Obtain weight from 6 months ago (if available)
    • Obtain MAC for baseline future need
  • Ongoing
    • Accurate actual weight (not reported)
    • For NF patients, don’t accept wide discrepancies
    • Fluid retention
BMI

- Accurate actual weight (not what is reported)
- Maximum adult height (reported)
- Half arm-span
  - Multiply the half arm span measurement by 2

BMI App

- IPhone: [http://apps.usa.gov/bmi-app.shtml](http://apps.usa.gov/bmi-app.shtml)

Nutritional Assessment-MAC

- Provides an indication of skeletal muscle mass, bone and subcutaneous fat
- Used for patients who cannot be weighed
- Key point is consistency in measurement
  - Standard method
  - Centimeters
- Obtain a MAC on every patient at admission

Nutritional Assessments-Descriptions

- A visual assessment of the patient's general appearance can provide a relatively accurate assessment of his general nutrition status
  - Emaciated
  - Thin
  - Normal
  - Overweight
  - Obese
- Emaciation-weight loss is extreme and is accompanied by skeletal muscle wasting
  - As a consequence, the affected individual's cheeks are sunken and bony landmarks of his maxilla, major joints, ribs, scapulae, and pelvis are unusually prominent

NEW YORK HEART ASSOCIATION (NYHA) FUNCTIONAL CLASSIFICATION
NYHA Functional Classification

- Provides a simple way of classifying the extent of heart failure
- Places patients in 1 of 4 categories based on
  - How much they are limited during physical activity
  - Limitations / symptoms are in regards to normal breathing
  - Varying degrees in shortness of breath and / or angina pain

End Stage Heart Disease - Prognostication

<table>
<thead>
<tr>
<th>NYHA Class</th>
<th>1 Year Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>5-10%</td>
</tr>
<tr>
<td>II-III</td>
<td>15-30%</td>
</tr>
<tr>
<td>IV</td>
<td>50-60%</td>
</tr>
</tbody>
</table>

New York Heart Association Functional Classification

- **Class I** (Mild) No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, or dyspnea (shortness of breath)
- **Class II** (Mild) Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, or dyspnea
- **Class III** (Moderate) Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, or dyspnea
- **Class IV** (Severe) Unable to carry out any physical activity without discomfort. Symptoms of cardiac insufficiency at rest. If any physical activity is undertaken, discomfort is increased

Diagnostic studies

- On admission gather any previous recent diagnostic studies
- At recert, use sparingly and only as a last resort if not sure if patient remains eligible
DOCUMENTING ELIGIBILITY

Documentation is...

- The final chapter of the life story of a person
- Subjective description of objective reality
- How we communicate about the patients' and families' needs, goals and care
- Accurate & detailed documentation reflects their most pressing needs, which in turn should foster good care
- Provides a mechanism for understanding what is working and what still needs to be managed effectively

Documentation - Who is the Audience?

- IDG
- Quality reviews
- Surveyors (state, Medicare, accrediting bodies)
- Medicare (MACs, RACs, ZPICs, MICs)
- OIG
- Attorneys

And what are they looking for?

Medicare Coverage Requirements

- Medicare wants to know what they are paying for
- Eligibility-documentation that supports the patient has a prognosis of 6 months or less
- GIP and CHC-documentation that supports the higher level of care
- Certification/recertifications
  - F2F
  - Narrative
- Plan of care-established before care provided and care provided according to POC
Eligibility Documentation Principles - Paint the Picture

Why hospice?
Why now? What is the trigger for referral?
• Acuity or trajectory supports 6 month prognosis
• Hospitalization
• Change in condition
• Decline
• Symptom exacerbation
• Additional care needs
• Compare to Local Coverage Determinations (LCDs)
• Documentation should support the physicians' certification of terminal illness

Documentation - Admission

• Have benefit of 60-90 days of documentation
• Still compare to LCDs
• Decline over the benefit period and over the past 4 – 6 months
• Disease progression
• Comparison
• Hospice care is managing what symptoms

Clinical Decline

• Functional status and any changes
• Nutritional status and any changes
• Changes in vitals signs
• Hypotension
• Tachycardia
• Decubitus Ulcers
• Inpatient utilization
• Emergency department visits
• Other factors
Disease Progression

- Worsening of terminal condition – Signs & Symptoms
- Worsening and impact of secondary & co-morbid conditions
- Test Results
  - O2 saturations
  - Albumin
  - Others as appropriate or needed

Remember, When a Patient Appears to Have “Stabilized”

- Get back to the diagnosis—why was this person admitted to hospice?
- Have you been managing the symptoms or the disease?
- What do you expect the disease process to look like?
- What are you monitoring for?
- What secondary conditions are present?
- What co-morbidities are present?
- How does this person look compared to a well person of the same age?
- What interventions are in place that is contributing to this plateau?

Painting the Picture

- Comparison charting
- Subjective writing
- Use of comment boxes
- Clear and detailed descriptions
- Avoiding “stable, uncooperative, appears weak, slow decline, etc.” phrases
- Specific discipline’s documentation
- Illustrate why beneficiary is considered terminally ill
**Documentation**

- Use LCD (or LCDs) that best fits the patient
- Clarify all secondary and co-morbid conditions for consistent documentation and their impact on prognosis
- Use standard assessment tools and measurements for the right diagnosis
  - PPS, FAST, BMI, NYHA, MAC
- Care Planning

**Plans of Care**

- Should change with decline
- Support eligibility
- Services provided according to plan of care
- Examples
  - Hospice aide from 3 times per week as wife can no longer manage the increased physical requirements
  - Example: Hospice aide assignment changed to bed bath and too difficult to transfer patient into shower
  - Example: Oxygen order for 3 liters continuous from PRN

**The Documentation Should**

- Be specific to that individual patient
- Document what distinguishes the patient as terminal and not chronic
- Have narrative notes to explain information noted on a checklist - use comment sections
- Distinguish between exacerbation with stabilization and exacerbation with deterioration
- Compare current to previous
- Exacerbation and resulting decline/deterioration
- Purpose and need for aggressive palliative treatments

**“As Evidenced By…”**

When you use descriptors like: cachectic, anorexic, non-ambulatory, dyspnea (at rest or on exertion), weight loss, poor appetite, fragile, failing, weaker…

Always follow up with “as evidenced by..” to fully describe what you see
Common Documentation Problems

- Admission documentation does not contain description of why hospice/why now and what patient "looked" like 3 to 6 months ago
- Inconsistent
  - FAST 7C but chaplain states patient told him about his Navy days
  - PPS 30% but documentation describes patient ambulating with a walker
  - Weights 121 pounds one month and 142 pounds the next
- Imprecise
  - “Assist with all ADLs”
  - “Weight loss” or “estimated weight”

Common Documentation Challenges

- Using words like … stable, unchanged, deteriorating
  - Document abnormal findings consistently
  - Need to have the associated contextual description
- Failure to regularly weigh or measure
  - Obtain baseline measurements
- No consideration of intensity of care
  - Plan of care
  - Patient has had no skin breakdown due to the 24 hour RTC attention provided by daughters turning every 2 hours
- Failure to report injuries or falls, episodes of confusion or abnormal behaviors
  - Document them all in the record

Summary

Consider and document

- Patient’s terminal illness
- All important comorbid & related secondary conditions & impact on the terminal illness
- Any relevant laboratory and other test values
- Performance status, amount of assistance required for ADLs
- Nutritional status
- Any changes in status / condition over time

Charlene Ross, MSN, MBA, RN
602-740-0783
charlene@RCHealthcareSolutions.com

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