



CENTER FOR IMPROVING
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Palliative Care Best Practices

A GUIDE FOR LONG-TERM CARE AND HOSPICE



Palliative Care Best Practices: A Guide for Long-Term Care and Hospice



CENTER FOR IMPROVING
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Palliative Care Time Line and Associated Practices

Palliative Care Time Line	Practices
Admission	<p>Advance care planning</p> <p>Advance directive documentation: Living Will, MDPOA, CPR Directive, <i>Five Wishes</i>, MOST</p> <p>Funeral planning</p> <p>Assessment of current medical and functional status</p> <p>Administration of MDS at admission and calculation of Flacker Mortality Score</p> <p>Life review and legacy planning</p>
Quarterly	<p>Readministration of MDS and recalculation of Flacker Mortality Score until results identify a prognosis of 12 months or less</p> <p>Review advance care plan— is it still current and appropriate?</p>
12-Month Prognosis	<p>Discussion with resident and family of current prognosis and goals of care</p> <p>Palliative care consultation</p>
6-Month Prognosis	<p>Explanation of hospice care, hospice services, and resident and family choice of services</p> <p>Re-evaluation of resident/family’s understanding of the disease process, expectations, goals, and values</p> <p>Review advance directives (clarify preferences: hospitalization, antibiotics, IV fluids, nutrition, etc.)</p> <p>Development of coordinated Plan of Care</p> <p>Aggressive management of symptoms, pain, and suffering</p>
Death Practices	<p>Informing residents of impending deaths and allowing them to say goodbye</p> <p>Creation of consistent practice to commemorate death</p> <p>Ideas and examples for death practices and memorials</p>

Palliative Care Time Line	Practices
<p>Bereavement</p>	<p>Resident family Resident community Long-term care staff</p>
<p>Appendixes</p>	<p>Appendix A: Advance Directives and Medical Orders for Scope of Treatment for Colorado Appendix B: Resources for Understanding and Accommodating Religious, Cultural, and Ethnic Variations Appendix C: Resources for Conducting Difficult Conversations Appendix D: Resources for Life Review Appendix E: Resources for Palliative Care and Hospice in the Long-Term Care Setting Appendix F: Palliative Care and Hospice Resources Appendix G: Commentary and Position Statement: Deactivation of Cardiac Pacing Devices in Hospice Appendix H: How to Identify and Deactivate an ICD or AICD Appendix I: Prognostic Tools Appendix J: Eden Alternative® Language for Hospice Appendix K: Charting Guidelines: General Inpatient (GI) Appendix L: Pain and Symptom Management Protocols Appendix M: References for Symptom Management Guidelines Appendix N: Face-to-Face Visits Appendix O: Resources for Death and Dying, Grief and Loss Activities Appendix P: Licensed Hospice Providers in Colorado</p>

Associated Regulations and Additional Resources

Regulations	Resources
Relevant Federal and State Regulations	<p>F309 (especially revised guidance regarding pain), 310, 311, 312, 314, 315, 317, 318, 319, 320, 325, 327, 329 regarding §483.25 Quality of Care, <i>State Operations Manual</i> (Centers for Medicare & Medicaid Services [CMS], 2011)</p> <p>F279 regarding §483.20(k) Coordinated and Comprehensive Care Plans, <i>State Operations Manual</i> (CMS, 2011)</p> <p>F241 and 242 regarding §483.15 Quality of Life, <i>State Operations Manual</i> (CMS, 2011)</p> <p>See also State Regulations, Chapter V, Long Term Care Facilities, Parts 5, 7, 8, 9, 12, 16 (CDPHE, 2011)</p>
Relevant American Health Care Association (AHCA) Standards of Care	AHCA Publications at: www.AHCAnet.org/facility_operations/clinical_practice
Relevant National Hospice & Palliative Care Organization (NHPCO) Standards of Care	<i>Standards of Practice for Hospice Programs</i> (Appendix II): Nursing Facility Hospice Care (NHPCO, 2010), www.NHPCO.org
Relevant Requirements of the Joint Commission on Accreditation of Healthcare Organizations	Provision of Care, Treatment and Services, PC-1-PC-50, <i>2010 Standards for Home Health, Personal Care and Support Services, and Hospice</i> (Joint Commission on the Accreditation of Healthcare Organizations, 2010), www.JointCommission.org
Additional Resources	See Appendixes for further references/resources

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Introduction

In 2006, the American Board of Medical Specialties granted official subspecialty status to the growing field of palliative care. Palliative care is an interdisciplinary practice aimed at improving the quality of life of residents and their families with advanced illness or life-threatening injury. Palliative care prevents and relieves suffering through early identification, thorough assessment, and expert treatment of pain and discomfort as well as other challenges: physical, psychosocial, and spiritual. Following are the defining features of quality palliative care:

- Affirmation of life and regard for dying as a normal process
- Intent to neither hasten nor postpone death
- Care throughout the continuum of illness that can be provided in conjunction with curative therapies
- Availability of interventions early in the course of illness to assist with symptom management or advance care planning
- Use of an interdisciplinary team approach to address the comprehensive needs of residents and families
 - Assessment and management of resident's pain and other distressing symptoms
 - Integration of the psychological and spiritual aspects of resident and family care
 - Offering a support system to help residents live as fully as possible
 - Offering a support system to help the family cope during the resident's illness and in their bereavement

Note the difference between the terms *palliative care* and *hospice care*. Palliative care can be offered throughout the course of a resident's illness and in conjunction with curative therapy. Palliative care can be initiated by appropriate nursing facility staff. Hospice care is an approach along the continuum of palliative care and is typically provided closer to the end of life. The defining feature of hospice care is the provision of comfort care when a resident discontinues curative treatments and his or her prognosis becomes terminal. Hospice care requires the services of a licensed, certified hospice agency.

Figure 1 illustrates the traditional care model for serious illness: life-prolonging or cure-directed therapy is pursued right up to the terminal stage, at which point there is a shift to comfort care.

Figure 1. Traditional Care Model



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In Figure 2, the integrated care model, palliative care is administered at the same time as curative or life-prolonging care. In many serious illnesses, especially in the elderly, as the disease progresses the focus of care shifts gradually to primarily palliative approaches so that at the terminal stage, the shift to hospice is not abrupt, surprising, or disconcerting. In this diagram, the stepped transition to palliative care suggests changes in condition, which provide opportunities for planning care and discussing alternatives all along the line.

Figure 2. Integrated Care Model



Source: ©1999, The EPEC Project, The Robert Wood Johnson Foundation. Adapted and reproduced with permission. Step variation attributed to Daniel Johnson, MD, Clinical Lead for Palliative Care, Care Management Institute, Kaiser Permanente; Physician Lead, Palliative Care Innovations and Development, KP-Colorado; Director, Life Quality Institute.

Palliative care is particularly well suited to the long-term care setting. Individuals entering a nursing facility—whether for respite, rehabilitation, or long-term residence—are admitted because they have somehow limited, lost, or perhaps never had “some degree of functional capacity” (Kane & Kane, 1987). If this loss is due to injury or chronic illness, it is likely that the person is experiencing some number and degree of distressing symptoms or discomfort (including mental/emotional/spiritual).

Nursing facilities and staff are dedicated to providing the best care and comfort for their residents; an intentional, best practice implementation of the palliative care approach can be readily adopted in the long-term care setting with superior results for residents, their families, and the staff.

This document provides a road map to implementing palliative care best practices from admission to death. The time line on page iii assists in planning care and identifying changes and milestones that suggest appropriate practices to put into action. It also provides guidance for managing the transition to hospice and the collaboration with the hospice team to ensure continuity of quality care.

Acknowledgments

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Admission to the Long-Term Care Facility

Advance Care Planning for Long-Term Care

The goal of advance care planning is for an individual to identify his or her care preferences in the event of a potentially life-threatening event or illness. Planning care in advance allows for calm, informed decision making in which the individual's preferences are known, rather than hasty, emotional reactions to crisis.

Planning should begin upon admission and should be revisited with each change of health condition, new problem or loss of function, or change in the resident's circle of support (for instance, death of a spouse or the responsible adult child moving away). If there are no significant changes in the resident's condition, a review of the care plan every 3 to 6 months is still recommended.

Advance medical directives are specific legal documents detailing medical decisions and decision makers. The completion of these documents, an important part of advance care planning, allows an individual to communicate his or her choices and preferences with loved ones and care providers. The intent of decision making for the end of life is to determine the individual's preference for aggressive life-sustaining treatment (curative care) or for aggressive pain and symptom management (palliative care). As noted in the introduction, these approaches are not mutually exclusive. Many individuals can and should receive palliative care while also pursuing curative treatment. At some point, however, the balance may shift away from curative treatment, perhaps when cure is no longer possible or when the burdens of such treatments become too great, and palliative care becomes the primary focus. For each individual, identifying that point of transition is a key part of advance care planning.

Steps to Initiating Advance Care Planning

Effective advance care planning begins at admission to the long-term care facility. A thorough history and assessment of the resident's current condition should be made (see Assessment of Current Status). If a chronic, serious, or terminal illness is already present, the particular details of that illness as well as the person's condition and prognosis will direct the care-planning conversation.

The plan and documentation should be revisited at each quarterly care conference (at a minimum) and upon each significant change in the resident's health status, such as the onset of a serious illness or worsening of an existing condition.

A resident's religious, cultural, and ethnic background may have a strong influence on his or her approach and reaction to advance care planning discussions. In some cultures, discussion of serious illness or the likelihood of death must be avoided at all costs; in others, certain family members such as eldest sons are the designated decision makers regardless of the elder's competence. Some treatment options are considered obligatory in some faith traditions, whereas others are strictly forbidden. It is best not to make assumptions about your resident's beliefs or attitudes based on their apparent cultural heritage or religious affiliation; instead, at the outset of such discussions, ask if it is all right with the resident and family members to talk about care decisions and inquire if they have any strong beliefs or commitments

that they would like to have accommodated. There are multiple articles and monographs in the nursing and healthcare literature on navigating multicultural concerns. Some are referenced in Appendix B.

Here are some questions to keep in mind for all such conversations:

- Whom would you like to speak for you and make decisions on your behalf when you can no longer speak for yourself?
- How do you (the resident) define “quality of life”?
- What are your goals?
- (If the resident is experiencing pain) How much pain medication do you want? Enough to completely handle the pain, even if this means you might be sleepy some of the time? Or would you prefer to put up with some pain in order to be more aware and awake?
- What activities or abilities are most important to you?
- Are there abilities for which, if you lost them, you would refuse further treatment or care?
- What treatments or care would you refuse? What treatments or care would you like us to continue? (These questions can be made more specific depending on the resident’s condition and prognosis using the advance directive documents as a guide.)
- Is the person you’d like to speak for you (when you can’t) aware of your preferences and choices?

Note: If the resident has an implanted defibrillator, it is important to discuss the process by which the defibrillator may be deactivated prior to the active dying process. This is strongly advised and represents best practices to avoid any distressing “firing” of the device at the point of natural death. Defibrillators may be part of a dual implanted device with pacemaker and defibrillator capacity. A patient or the person who holds the patient’s medical durable power of attorney may opt to continue the pacemaker device—often seen as palliative in nature—while deactivating the defibrillator. Ongoing conversations regarding these decisions must be directed by the patient’s goals of care. For guidance on this topic, please see the COCHPC’s position statement, Deactivation of Cardiac Pacing Devices in Hospice Patients, in Appendix G.

If appropriate, the responses to these questions can be documented in advance directive documents.

Advance Directive Documentation

There are a number of options available for documenting advance care planning decisions. Residents may complete a Living Will, a Medical Durable Power of Attorney (MDPOA), a cardiopulmonary resuscitation (CPR) directive, or some combination of the three (see Appendix A for versions of these forms you can use for your residents). It is highly recommended that all residents complete a Medical Durable Power of Attorney. If the resident prefers to use the *Five Wishes*, this document is all-inclusive and, when signed and witnessed, nullifies any previously completed advance directives. In addition to advance directives, completion of a Medical Orders for Scope of Treatment (MOST) is strongly recommended for any nursing facility resident. As will be discussed shortly, the MOST summarizes key advance directives and provides additional guidance to healthcare providers in the form of portable medical orders.

Living Will

In Colorado, the Living Will is called the “Declaration as to Medical or Surgical Treatment.” This document instructs doctors and care providers in the use or removal of artificial life support measures if the signer (“declarant”) lacks decisional capacity and has an injury, disease, or illness that is not curable or reversible and is terminal or is considered to be in a persistent vegetative state (PVS). A person lacks decisional capacity when they are no longer able to make or communicate decisions about their care.

The Colorado Living Will was significantly revised in 2010, adding new features and wider applicability (see Appendix A). Living Wills completed before 2010 are still valid and do not have to be updated, although a review of any pre-2010 Living Wills at the resident’s next care conference would be appropriate.

The Living Will does not go into effect until 48 hours after two doctors agree in writing that the declarant lacks decisional capacity and has a terminal condition or is in PVS. In these circumstances, the Living Will instructs the declarant’s doctors to continue or discontinue life-sustaining procedures, artificial nutrition, and artificial hydration.

The Living Will does not require a physician’s signature, but the declarant must sign (and be competent to sign) and two adult witnesses are also needed.

Important: These witnesses cannot be any doctor or employee of the declarant’s doctor, any employee of the facility or agency providing care to the declarant, creditors, or anyone who may inherit property or money from the declarant. However, other residents of the long-term care facility who are competent to sign may now be witnesses to a Living Will. A notary’s signature is a good idea but not required.

For more information, and to obtain the Colorado “Declaration” document, visit the Colorado Hospital Association website, www.CHA.com, or the Colorado Advance Directives Consortium (CADDC) website, www.ColoradoAdvanceDirectives.com (click on Links and Resources).

Medical Durable Power of Attorney

In Colorado, no one is automatically authorized to make healthcare decisions for another adult. To authorize another person to make medical decisions, an individual (or “principal”) must complete a Medical Durable Power of Attorney (MDPOA), also called the Power of Attorney for Health Care (see Appendix A).

The person named as the surrogate decision maker is called the principal’s “agent for healthcare.” The agent must be at least 18 years old, mentally competent, and willing to serve, but otherwise there are no restrictions. If a principal’s spouse is named as an agent and the couple divorces, legally separates, or annuls their marriage, the spouse is automatically removed as an agent unless expressly stated otherwise in the MDPOA document.

Note: If no one is officially named as a surrogate decision maker, either through an MDPOA or by verbal designation recorded in the principal’s chart, when the principal can no longer speak for himself or herself, a surrogate must be chosen by consensus through the proxy process or through the courts by appointment of a guardian (see Appendix A). Both of these processes are complicated and time consuming, so it is a good idea to encourage residents to complete an MDPOA.

The agent makes decisions for the principal only when he or she is unable to do so. This may be temporary, while the principal is recovering from an accident or injury, or long term, if the principal is permanently incapacitated. If there is any question as to the principal's capacity, a formal cognitive assessment should be arranged.

The agent is authorized to obtain copies of the principal's medical records, consult with his or her doctors and other healthcare providers, and make all decisions necessary for care.

The agent is obligated to act according to the principal's wishes and values. This is why a conversation about the decisions is vital to provide the agent a clear understanding of what the principal would want under various circumstances. Specific instructions can be added to the MDPOA document as well.

An MDPOA is not the same as a general power of attorney (POA). The MDPOA agent is only authorized to make healthcare decisions, including organ donation. A general POA covers legal and financial affairs. Both types expire at the death of the principal.

For more information, and to obtain the Colorado Medical Durable Power of Attorney document, visit the CADC website: www.ColoradoAdvanceDirectives.com. The CADC website also contains information for agents, including what is involved in being an agent and how to serve most effectively.

CPR Directive

A CPR directive states that the principal does not want to receive CPR (cardiopulmonary resuscitation) if he or she experiences cardiac or respiratory arrest or malfunction. CPR directives are almost always used by people who are severely or terminally ill or elderly. In these situations, the trauma involved in CPR is likely to do more harm than good, and the likelihood of survival is less than 5 percent for elderly, frail residents. However, emergency personnel are required to perform CPR unless a CPR directive tells them not to.

A CPR directive is not the same as a Do Not Resuscitate (DNR) order. A DNR order is a doctor's order made for severely or terminally ill patients in healthcare facilities, including skilled nursing facilities. A DNR does not require the patient's consent, and it does not remain in effect if the patient is discharged from the facility.

A CPR directive must be signed by the principal (or the principal's MDPOA agent) and his or her physician. CPR directives must also be immediately available to emergency personnel. A wallet card or special CPR directive bracelet or necklace can be obtained.

The CPR directive does not have to be made on a particular form, or on a particular kind of paper. The familiar Colorado Directive "blue form" is being phased out in favor of a template CPR directive form. This form can be used as is or modified for your facility, and it is available from the Colorado Department of Public Health and Environment website: www.CDHPE.state.co.us/em/Operations/CPRDirectives/template.pdf. It is also provided in Appendix A.

The CPR directive form does not have to be an original form—photocopies, faxes, scans, and electronic forms are just as valid.

The CPR directive statute states that a physician—and not an advanced practice nurse or physician's assistant—must sign the form. However, the newly revised CPR directive regulations encourage health-

care providers and first responders to honor clear directives refusing CPR even if a physician's signature is not on the form. Best practice, however, is to ensure that a resident's CPR directive is signed by a physician.

Healthcare agents may sign and revoke a CPR directive on behalf of the principal, but agents may not revoke CPR directives made by the principal for him- or herself.

The revised regulations can be downloaded from the Colorado Department of Public Health and Environment website: <http://www.CDPHE.state.co.us/regulations/ems/index.html>. For more information on CPR directives, visit the CADC website, www.ColoradoAdvanceDirectives.com, or the Colorado Department of Public Health and Environment website, www.CDPHE.state.co.us/em/Operations.

Five Wishes

The *Five Wishes* document is an increasingly popular form that serves as an all-purpose advance medical directive. Developed by Aging With Dignity, the form fulfills the purposes of the Living Will and the MDPOA and, in addition, provides extensive instruction on matters of general personal and medical care at the end of life.

Many people like this form because it provides a number of options and addresses care beyond the purely physical—such as whether clergy should be asked to visit or whether the person wants visitors. It also provides a space for funeral instructions.

The document is legal in Colorado, and copies can be downloaded at www.AgingWithDignity.org.

Note: While the form is considered very helpful in guiding an advance care planning conversation, it can be less helpful in guiding care. First responders, in particular, tend to consider it too long and complicated to be helpful in an emergent situation.

Medical Orders for Scope of Treatment

The Medical Orders for Scope of Treatment (MOST), established by law in Colorado in 2010, is not an advance directive. It is, however, a way to summarize or identify key advance care planning choices on a single form (see Appendix A). The MOST addresses CPR, general scope of treatment, artificial nutrition/hydration, and antibiotics. Other treatment choices can be addressed in additional orders sections. Choices range from no treatment to full treatment in each section.

The form is completed in conversation between a resident or resident's agent for healthcare and a healthcare provider who is qualified to explain the choices and their implications in the context of the resident's medical condition. This should not be a quick "check-the-box" exercise but a thorough discussion of options, possible outcomes, and goals. The provider should be sure to request and review any existing advance directives to make sure choices are consistent between the MOST and other documents.

The form must be signed by a physician, advanced practice nurse, or physician's assistant after reviewing the orders. The form must also be signed by the resident or the resident's agent for healthcare.

When signed by a physician, advanced practice nurse, or physician's assistant, the form becomes a medical order set. These orders are portable and must be honored in any healthcare facility or setting

across the state (with some particular exceptions detailed in the MOST instruction booklet, available on the CADC website: www.ColoradoAdvanceDirectives.com; click on MOST in Colorado).

The form belongs to and stays with the patient in order to communicate choices for care in transitions from setting to setting. If a resident requires emergency assistance or transport to the hospital, the original form should be given to the responding EMS and taken by them to the hospital and presented to the receiving healthcare providers. A copy of the form may be kept in the facility chart.

As noted, the MOST is strongly recommended for any nursing facility resident and should be completed as soon as possible following admission. The form is not required by law, however, and residents may refuse to complete the form, which is their right.

The form should be reviewed and updated regularly at least quarterly for nursing facility residents and upon any change in condition.

The MOST is part of the national Physician's Orders for Life-Sustaining Treatment (POLST) paradigm, versions of which have been adopted in all or part of 14 states and are in development in 25 more (as of January 2012). All POLST-like forms are accepted and should be honored in Colorado, and the Colorado MOST will likely be honored in any other POLST state.

In states where the MOST or POLST has been adopted, the completion of advance directives and the rate of adherence to those directives are much higher. They have also been demonstrated to reduce unnecessary hospitalizations and improve end-of-life care planning. For more information on the national program and to see a map of states with POLST/MOST programs, visit www.POLST.org.

To download a MOST template form and the complete healthcare providers instruction booklet, *Getting the MOST Out of the Medical Orders for Scope of Treatment Process and Form: Guidance for Healthcare Professionals*, visit www.ColoradoAdvanceDirectives.com and click on MOST in Colorado.

Life Quality Institute is the statewide coordinator of education and training on the MOST program. To request a training, e-mail Contact@LifeQualityInstitute.org or call 303-398-6326.

Assessment of Current Status

An important key to the optimal introduction of palliative care for a long-term care resident is regular assessment of current status, with specific attention to indicators of shortening lifespan. One tool to facilitate estimation of prognosis is the Flacker Mortality Score Form (Flacker & Kiely, 1998; see Appendix I), which uses data gleaned from a functional and clinical assessment to predict likely mortality. Following are suggestions for conducting assessments to measure cognitive status:

- Complete the Flacker Mortality Score Form (see Appendix I) on admission and at any significant change of condition.
- A Flacker Mortality Score of 7 or higher suggests that the resident is at high risk of dying within the next 12 months and indicates it might be time to introduce palliative care and a subsequent discussion about a transition to hospice care in the future.
- The Mini-Cog (see Appendix I) is a free tool that is as effective as the Mini Mental Status Exam

- (MMSE) to assess cognitive impairment.
- Asking the resident to draw a clock (an exercise included in the MMSE) is also a good indicator of cognitive changes.
 - The ADEPT Score (see Appendix I) can also be used to assess nursing home residents with advanced dementia who are at high risk of death within the next 6 months.

Life Review and Legacy Preparation

Life review and legacy planning are reflective processes intended to facilitate personal peace with the end of life. Life review refers to methods for eliciting autobiographical stories as a way of helping residents make sense of their lives, events, and relationships by putting memories into stories. Legacy planning involves recording life lessons; beliefs and values; moral or spiritual positions; and statements of love, honor, forgiveness, and repentance. Sometimes in the form of a letter or short essay, these legacies are also called “ethical wills” or “spiritual testaments.” In this context, legacy does not refer to financial or property dispositions—that is the responsibility of the resident and his or her family and advisors.

- Life review and legacy planning might precede completion of advance directives, as the process of reflection helps clarify goals and preferences.
- If writing is difficult for residents, audio or video tapes can be recorded and later played back or transcribed.
- There are a number of tools available to assist in this process (see Appendix D). Family members can be encouraged to participate.

Funeral Planning

Planning for the disposition of the body after death and the funeral or memorial service is an important part of advance care planning. Many people find the subject difficult to bring up or talk about, but often elderly persons, especially if they are ill, are open to or even eager for the discussion. The topic can be included along with the other advance care planning conversations.

If there is some resistance or awkwardness, a social worker or chaplain might be able to bring it up separately. If the resident has an affiliation with a particular faith community, a representative of the community can be involved in the conversation. Funeral directors are skilled at preplanning conversations and can be a helpful resource.

At the minimum, a choice for cremation or burial and a designation of a mortuary should be encouraged. More and more, funerals and memorial services are highly individualized, sometimes looking more like celebrations than occasions of sorrow and loss. People may have very specific ideas about what they want to happen at their death, and documentation of these ideas in advance can be of enormous help to the bereaved family members.

Important: Funeral plans and treatment of the body after death can be strongly influenced by the religious, cultural, and ethnic background of the resident. If the resident makes plans or requests that seem strange or difficult to accommodate, do what you can to oblige, within the regulations governing your facility and state law (see Appendix B).

A Special Note About Veterans at the End of Life

In 2000, World War II veterans comprised 4.2 percent of the nation's population; in 2005, veterans comprised nearly 11 percent of Colorado's population. Nationally, more than 500,000 veterans die each month, accounting for nearly a third of all deaths. The Vietnam era accounts for the largest number of veterans in our history: about 8.4 million in 2000.* Veterans at the end of life can face a number of special issues:

- Disease processes complicated by combat injuries
- Post-traumatic stress disorder
- Shame and guilt
- Fear of after-death consequences for their actions
- Substance abuse
- Homelessness, and more

Life review for veterans can involve a painful upheaval of long-hidden memories and experiences, or it can be a source of great pride and accomplishment. For more information on how to address veterans' special issues and challenges, as well as how to connect them with helpful Veterans Administration benefits, visit the Hospice-Veteran Partnership page of the NHPCO website: <http://www.NHPCO.org/i4a/pages/index.cfm?pageid=4269>

*Source: U.S. Census Bureau, 2000, "Go Figure," *Denver Post*, Nov. 11, 2006, p. 5B.

Quarterly Review

On a quarterly basis, readminister the MDS and calculation of the Flacker Score components (see the Assessment of Current Status section and Appendix I). Additionally, re-evaluate the resident's advance care plan and advance directive documents, including the MOST. This should be a component of the required quarterly care conference process and discussed with the resident and his or her family. Questions to consider include:

- Has the resident's physical or mental status changed since the last review? How?
- Are accommodations needed to address those changes? (e.g., if there is a new diagnosis, what is the likely progression of illness? What functions have or will likely be lost?)
- Have there been multiple hospital admissions heralding a progression in the underlying disease process over the past quarter?
- Have the resident's goals and preferences changed? (e.g., has life-prolonging treatment become burdensome, or, conversely, does the resident now want to aggressively "fight" the disease?)
- Have there been important changes in the resident's support circle? (e.g., has a spouse died or become ill or incapacitated?)
- Do advance directive documents or a MOST need to be prepared/updated to reflect changes?
- Is the MDPOA agent still available and willing to serve? Does he or she have a clear picture of the resident's preferences and goals?

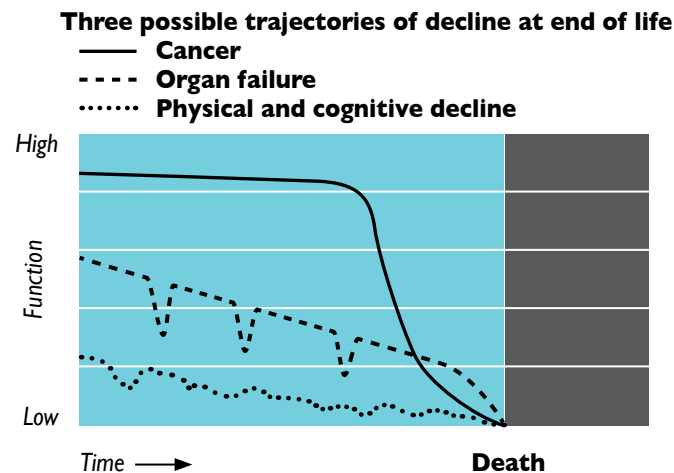
- If a CPR directive has not yet been completed, would this be an appropriate time? (The first section of the MOST can function as a CPR directive.)
- If funeral arrangements have not been made, would this be an appropriate time?

12-Month Prognosis

When the care provider's best judgment and/or available tools indicate that the resident's prognosis is 12 months or less, it is appropriate to consider a palliative care consultation. Initiate discussions with the resident and his or her family members about care goals, preferences for treatment, sources of discomfort, and methods of palliation. Other prognostic indicators may include functional decline measured by the Karnofsky Performance Scale (Schag, Heinrich, & Ganz, 1984) or the Palliative Performance Scale (Anderson, Downing, Hill, Carsoso, & Lerch, 1999), and multiple hospital admissions.

Figure 3 indicates the typical trajectories for some chronic illnesses that lead to death.

Figure 3. Trajectories of Eventually Fatal Chronic Illnesses



Source: Reproduced from Murray Kendall Boyd, & Sheikh (2005). Illness trajectories and palliative care. British Medical Journal, 330, 1007-1011, with permission from BMJ Publishing Group Ltd. Image borrowed with permission from HealthTeamWorks, Palliative Care Guideline, ©2011.

Cancer. With most cancers, residents can maintain fairly high levels of function through supportive therapies. As the disease progresses and does not respond to treatment, decline can be fairly swift. Palliative care consultation should begin at the time of diagnosis, disease progression, or recurrence.

Organ Failure. In organ failure (heart, lung, kidney, etc.), the pattern involves periods of reasonable but declining function punctuated by sudden worsening of the disease, crisis, or hospitalization. Sometimes these exacerbations are followed by a degree of “recovery,” but any one of them can result in death. Even with “recovery,” residents’ overall function is likely to be decreased. Frequent review of care options and palliative consultation can ensure clarity of treatment goals and comfort.

Physical and Cognitive Frailty. Frailty and dementia pose special challenges, as decline can be slow, subtle, and lengthy. At diagnosis or at clear onset of dementia, advance care planning and palliative consultation can put in place necessary surrogate decision makers and clear instructions for future treatments.

Palliative Care Consultation

Palliative care consultation is intended to assess the resident's current health status, articulate appropriate and desired goals of care, and identify specific clinical and supportive interventions to help achieve those goals.

The resident's physician must order a consultation. Ideally the consultation is carried out by a specially trained consultative team consisting of a palliative care physician, nurse practitioner, and licensed clinical social worker (LCSW). A chaplain may also participate, if needed. At minimum, the consultation should be performed by a qualified palliative care physician, physician's assistant, or nurse practitioner.

The consultation takes into account physical, social, psychological, and spiritual conditions and needs. Palliative care specifically focuses on comfort—relief of pain and physical discomfort, as well as psychosocial stresses and concerns. Typically, a palliative care consultation will include discussion of an appropriate transition from curative approaches to comfort-only approaches (refer to Figure 2).

Some palliative care services provide ongoing implementation of the care plan or periodic supervision and education to the long-term care staff, resident, and family while other programs will continue to provide ongoing visits at intervals to be directed by the plan of care. Others may only provide initial consultation. These services are reimbursed under Medicare Part B. Palliative care can be provided in tandem with Medicare Part A skilled admission.

A palliative care consultation can facilitate and clarify the resident and family's perceptions, expectations, and goals for the end of life. These discussions can often be difficult given the dynamics that evolve over time as residents, family, and the staff face many significant end-of-life issues; however, additional difficulties are likely to arise if no conversation or planning has taken place.

A palliative care consultation can identify specific modifications in the plan of care to reflect the current change in medical conditions, limited prognosis, and re-evaluation of the goals of care. Identifying and implementing the additional resources available, outlining the components of the end-of-life process, and providing education for the resident, family, and staff are important expected outcomes of these discussions.

Note: See Appendix F for additional resources.

Discussion with Resident and Family About Prognosis and Goals

Talking with residents and families about prognosis and treatment goals is never easy, but it becomes especially difficult when the resident's prognosis is pointing toward a life expectancy measured in weeks or months rather than years. As difficult as it may be, it is essential the resident and family have accurate

and complete information, and that they express preferences clearly. Many journal articles address the issue of communication strategies for this conversation, a number of which are listed in Appendix C.

Important: Strategies for successful communication of difficult topics may be strongly influenced by the religious, ethnic, or cultural background of your resident. For instance, in some cultures there is a strong emphasis on collective involvement and shared decision making, such that inclusion of many family members in the conversation might be very important. In other cultures, “bad news” must not be given to the resident but only to another family member, often the eldest son or daughter. In some cultures, direct eye contact or touching is considered rude or threatening. In others, it is found reassuring. As with the advance care planning conversation, it is best not to assume, but to ask: “I’d like to talk with you about how we can care for you better. Who would you like to have with you for that conversation?” Resources in Appendix B can provide additional guidance.

The general strategy recommended by many experts (Ambuel & Weissman, 2009a, b; Casarett & Quill, 2007; Schofield, Carey, Love, Nehill, & Wein, 2006) follows this outline:

1. Pick a good time and place.

- Privacy, comfort, and a peaceful atmosphere will help put everyone at ease.

2. Find out what the resident and family understand about the resident’s current situation.

- Use open-ended questions such as, “What has your doctor told you about your condition?” If you uncover misunderstandings or inaccuracies, review the medical facts as clearly as possible, pausing to assess understanding as you go.
- Encourage questions. Residents and family members may want detailed information about diagnosis, progress of the condition, treatment options, chance of cure, side effects, and precise prognosis.
- Allow time for questions and give answers as completely and accurately as possible.
- Avoid saying, “There’s nothing more we can do.” A more appropriate statement could be, “It may be time to shift the focus of your care.” Emphasize that care will continue, even if cure is not likely.

3. Determine what the resident’s goals are for their current comfort and future care.

- Again, use open-ended questions such as, “What is most important for you now?” or “Is there anything you are especially concerned about or afraid of?” Your questions can become more specific as you get more information.
- Confirm your assumptions by asking reflecting questions such as, “From what you’ve told me, it sounds like you really don’t want to go back to the hospital, is that right?” or “Is being unconscious for a long time what you are most afraid of?”
- If you can, try to elicit preferences here about CPR, hospitalization, use of antibiotics, surgery, artificial nutrition and hydration, mechanical ventilation, pain medication, and any other essential end-of-life treatment choices particular to the resident’s situation (e.g., blood transfusions, dialysis). The MOST form can be used to document these choices as you go.
- If the resident has an implantable defibrillator, introduce the idea of perhaps deactivating it as the resident’s condition declines.
- In discussing these items, be sure the resident is taking in the information and responding in a way that indicates understanding. If you sense overload, set aside the specifics for now and continue with a more general discussion.

4. Connect goals with options for care.

- For instance, if the resident's goal is to avoid pain, stay out of the hospital, and support his or her family, discuss how hospice and palliative care can help achieve those goals. This is the best way to introduce hospice and palliative care as services to help the resident meet his or her needs and maintain independence and control.
- If the resident's goal is to "go out fighting" or to "do everything," find out what these phrases mean to the resident and be sure he or she understands the likely progression of the illness and effectiveness or futility of continued aggressive treatment.
- Information should be shared completely and clearly so residents and their families can make the best decisions and identify their wishes clearly. Your job is not to talk the resident out of his or her choices, but to make sure the choices are based on accurate and complete information.
- Be sure to document any clear decisions or preferences and update advance directives and the MOST forms.

5. Watch for and respond to emotions.

- Throughout the discussion, the resident or family members may express a range of emotions. Allow plenty of room and time for these to be expressed.
- If concerns or fears are voiced, let the individual say as much as needed about those feelings before you offer reassurance. Not every emotion needs to be soothed at this point. Sometimes the best answer is just silence or sympathetic expressions like, "I know this must be difficult for you" or "I can see that you are very sad to hear this."
- Avoid saying, "I know just how you feel" because it is most likely that you do not. Do reassure the resident that no matter what, you and your staff (and the hospice staff, if appropriate) will be there, providing care throughout the process.

6. Develop a plan.

- Based on the resident's expressed wishes and preferences, establish next steps, which may include: arranging a palliative care or hospice evaluation, addressing changes in care or treatment plan, updating advance directives, scheduling discussions with additional family members, identifying steps to accomplish personal goals, etc.
- A thorough review of systems and physical assessment should be done by the palliative care team in collaboration with the facility care team to address and provide optimal symptom management.

6-Month Prognosis

When the care provider's best judgment and/or available tools indicate that the resident's diagnosis or terminal condition has a prognosis of 6 months or less if the disease process follows the expected course, it is appropriate to consider transitioning the resident to hospice care. This is especially the case if there has been an observable decline or significant change in condition. Important steps to take at this time include:

- Discussing with the resident and family the resident's disease process and prognosis and assessing their understanding;
- Providing, with compassion, accurate information to correct any misunderstandings or gaps;
- Reviewing advance directives and treatment choices in light of current condition and prognosis, focusing particularly on the resident's current goals and values;
- Clarifying preferences regarding CPR, hospitalization, antibiotics, IV fluids, artificial nutrition

and hydration, and other interventions that may be available to the resident. If a cardiac defibrillator is in place, address the need to deactivate it;

- Updating the resident's MOST with any changes in choices. If changes are significant (such as a change from Yes for CPR to No), void the old form and complete a new one; and
- If appropriate and desired, introducing the resident and family to the option of hospice care.

What Is Hospice Care?

The term *hospice* describes a method of care for persons with terminal illness and their family. The method focuses on comfort rather than cure, aggressively addressing pain and distressing symptoms of advanced illness as well as emotional, psychosocial, and spiritual discomforts at the end of life.

Backed by more than 40 years of service and research, hospice providers offer expertise in pain relief and symptom management for end-stage disease. The combination of skilled nursing provided by the long-term care facility and whole-person terminal care provided by hospice offers residents the most comprehensive care possible during this difficult time.

Hospice involves a team of professionals working together and in concert with other healthcare professionals such as nursing facility, assisted living, or hospital staff to support the resident's independence, comfort, choice, and control to the maximum extent possible. A hospice physician specializing in end-of-life care works with the hospice registered nurse to provide aggressive symptom management. A social worker addresses social, emotional, practical, and financial troubles. A chaplain (if desired) assists with religious and/or spiritual issues. Certified nursing assistants and volunteers provide important personal care such as bathing, dressing, preparing meals, running errands, washing laundry, or providing companionship. The hospice team works collaboratively with the facility team and the attending physician. Other disciplines are included as the plan of care dictates.

In hospice, the resident and the family are considered the "unit of care." The resident defines his or her family, whether it includes a spouse, child, cousin, close friend, companion, or partner. These individuals also receive care and attention from the team. After the resident's death, family members are offered grief counseling and bereavement care for 13 months. Many hospice organizations also offer grief education and support groups to the wider community, including long-term care staff and other facility residents.

Hospice in Long-Term Care Settings

Most hospice care is delivered to the resident in whatever setting the resident calls "home." For many, this is their private residence, but this can also be a skilled nursing facility, assisted living residence, or hospital. The goal of hospice is to support residents in their own living environment for as long as possible and, in particular, to prevent avoidable hospitalizations.

Some newly admitted nursing facility residents may already be enrolled in a hospice program and are transferring to the facility because their care needs have exceeded their own or their family's ability to care for them at home. Other long-term care residents may develop terminal diseases or already have conditions that eventually decline to an end stage, indicating the need for specialized end-of-life care. The hospice team is available to the resident and facility 24 hours a day, 7 days a week, 365 days a year.

In the long-term care setting, some services and tasks (such as personal care) might be performed by the long-term care professionals. Medicare certification rules and state regulations require hospices and skilled nursing facilities to develop a contract to govern their working relationship. This contract should clearly state which entity is responsible for each aspect of care. (See the Developing a Coordinated Care Plan section.)

The separate and joint responsibilities of the hospice and skilled nursing facility are outlined in Table 1.

When It's Time for Hospice

As noted in the Advance Care Planning for Long-Term Care section of this document, the resident's condition and care needs should be reassessed periodically, especially if there is any abrupt or noticeable change. These reassessments should explicitly include the consideration of whether it might be appropriate to involve hospice. Ideally, hospice enrollment would occur at the time of terminal diagnosis or at the time when the resident's assessed condition suggests a prognosis of months rather than years. An earlier-rather-than-later enrollment in hospice allows for a more successful experience for all parties, including the nursing facility staff. If the resident has already been receiving palliative care, this transition is likely to be less abrupt.

Important information to consider:

- In 2009 1.6 million Americans received care from the nation's hospice providers. However, less than 10 percent of skilled nursing facility residents in the United States currently elect the Medicare Hospice Benefit, even though 20–25 percent of deaths in the United States occur in a skilled nursing facility (Bercovitz, Decker, Jones, & Remsburg, 2008).
- Hospice in nursing facilities offers high-quality end-of-life care and other benefits such as reduced hospitalizations and improved pain management.
- Hospice social workers and chaplains have specialized skills to counsel and support individuals at the end of life. Additionally, hospice bereavement services support residents' families up to 13 months after the death of a loved one.
- Research has indicated that some residents actually live longer with hospice care than those receiving traditional care (Connor, Pyenson, Fitch, Spence, & Iwasaki, 2007; Temel et al., 2010), and many studies indicate higher quality of life for residents receiving hospice care (Stevenson & Bramson, 2009).
- Hospice provides end-of-life education and grief support to nursing facility staff.
- The Medicare Hospice Benefit and many private insurance hospice benefits cover all medications, supplies, and durable medical equipment related to the terminal illness as well as the services of the interdisciplinary team. This provides financial relief to private-pay residents and their families.
- Hospice offers support and education to family members around decline, disease process, and symptom management.

Table 1. Responsibilities of the Hospice and Skilled Nursing Facilities

Service	Skilled Nursing Facility	Hospice	Joint
Nursing services	<p>RNs, LPNs, and CNAs in role of daily caregivers.</p> <p>Continue provision of care as with all residents.</p>	<p>RN coordinates and reviews care plan.</p> <p>Makes intermittent but regular visits based on resident need.</p> <p>Educates SNF staff, resident, and families.</p> <p>Reviews record. Assigns and supervises hospice CNAs as needed.</p>	<p>Maintain communication to fulfill coordinated plan of care and inform each other of changes in resident status and care plan.</p>
Physician services	<p>Attending physician and SNF medical director continue to follow SNF state and federal regulations for visitation schedules.</p>	<p>Hospice medical director/team physician complements attending physician's care as a resource on palliation.</p> <p>Provides for unmet medical needs related to terminal diagnosis.</p> <p>Part of the interdisciplinary team.</p>	<p>Each provider shall identify lines of communication for medical care.</p>
Medical social services: spiritual, dietary, bereavement, and other counseling	<p>Performs these services as agreed in the coordinated plan of care and contract with hospice in accordance with SNF state and federal regulations.</p>	<p>Performs these services as indicated in the coordinated plan of care, contract with SNF, and in accordance with Hospice Medicare Conditions of Participation.</p> <p>Medical social service provider, spiritual care counselor, and dietician are part of the interdisciplinary team.</p>	<p>Maintain open communication between hospice and SNF for services performed and for status changes that affect plan of care.</p>

Source: Adapted from *Hospice in a skilled nursing facility: A model for success*, by Hospice in the Nursing Home Work Group, 1999.

Hospice Enrollment and Discharge

Hospice enrollment requires the following:

1. A physician's order
2. Certification by a hospice medical director and the attending physician that the person is terminally ill and has a life expectancy of 6 months or less
3. A decision by the resident not to pursue aggressive, life-extending, or curative treatments.

There is no strict limit on the amount of time a resident can continue to receive hospice services. Once admitted to a hospice program, the resident can be enrolled for any length of time necessary, as long as his or her condition continues to meet certain criteria. After enrollment, the resident's condition is reassessed at two 90-day intervals and at 60-day intervals thereafter. Once enrolled in hospice, a resident may decline certain services if he or she does not wish to receive them, and the resident may withdraw from the program at any time.

Some residents are discharged from hospice when their condition stabilizes or improves such that their prognosis extends beyond 6 months. In this case, the resident is discharged from the hospice program but remains in the care of the nursing facility.

Methods of Payment

All operating hospices in Colorado are licensed by the state, and most are certified by Medicare and eligible to care for individuals receiving Medicaid. All Medicare-certified hospices will care for individuals who have Medicare. If a nursing facility resident has some other form of insurance (commercial or Medicaid), it is best to check with the individual hospice to make sure the insurance will be accepted. For individuals who are uninsured, many hospices have a commitment to providing care regardless of the individual's ability to pay.

As noted earlier, for qualified individuals, Medicare covers all hospice services, supplies, and medications related to the terminal diagnosis under the Medicare Hospice Benefit, Medicare Part A. Items and services not related to the terminal illness are paid in the same manner they were before hospice enrollment.

Most often, room and board in a long-term care setting is paid privately by the resident or by Medicaid. In some specific circumstances, room and board is covered by Medicare or commercial insurance. Table 2 summarizes the typical arrangements.

Table 2. Medicare, Medicaid, and Resident Payment Arrangements

Resident Has	Hospice Care Paid by	Room and Board Paid by
Medicare and Medicaid	Medicare	Medicaid
Medicare only	Medicare	Private pay from resident
Medicaid only	Medicaid	Medicaid
Commercial insurance only	Commercial insurance (usually)	Private pay from resident

Because hospice care is very individualized, there are exceptions to these general rules. Residents and families, as well as the nursing facility staff, should have frequent and clear conversations about what is being covered by whom and when.

Helping Residents Choose a Hospice

At the time of this writing, there are 60 licensed hospices in Colorado serving residents from 82 locations. In some parts of the state, especially our rural and mountain areas, there may be only one hospice choice. In other areas, notably the Denver Metro region, there are many.

Each hospice organization is unique, and variation will be found among admissions policies and range of offerings beyond the core, mandated services. A meeting with a hospice representative to get acquainted and to discuss services offered is recommended.

Although many nursing facilities have long-standing relationships with particular hospice agencies, residents and their families must be offered a choice of hospice care providers if there is more than one in the area. Nursing facility staff members are encouraged to get to know their local hospice providers so they can help residents make appropriate choices based on personal priorities and care needs.

Appendix P provides basic information for all licensed hospices in Colorado, including

- Contact information and website where available;
- Counties served by the hospice;
- Whether the hospice has a dedicated, standalone residence and, if so, how many beds; and
- Whether the hospice offers bereavement services to the community, in what form, and whether there is a fee.

The Colorado Department of Public Health and Environment provides a list of licensed hospice providers in Colorado that is updated weekly:

<http://www.hfemsd2.dphe.state.co.us/hfd2003/homebase.aspx?Ftype=hospice&Do=list>.

The website <http://www.HospiceAnalytics.com> offers the National Hospice Locator, a searchable, interactive database of all hospices nationwide.

Here are some key questions that your residents and their family members should ask of any hospice they are considering:

- How long have you been operating as a state-licensed hospice?
- Are you certified or accredited to receive Medicare payment?
- (If the resident is not currently enrolled in Medicare or Medicaid) Will you take my insurance?
- What services do you provide?
- What services are not covered by the Medicare Hospice Benefit or my other insurance?
- How can my current doctor(s) continue to be involved in my care?
- How often will your hospice team members visit?
- How will care be coordinated with the nursing facility staff?
- How do you provide services after hours and on weekends or holidays?
- What kind of support is available to my family/caregiver?
- In what ways do you provide bereavement care and grief counseling?
- (If applicable) Do you accept Medicaid residents?
- (If applicable) What services do you offer for those without the ability to pay for them?

Developing a Coordinated Care Plan

A written, individualized plan of care (POC) is established for each patient/family by the hospice interdisciplinary team (IDT) in collaboration with the attending physician, facility staff, the hospice medical director or physician designee, the patient or authorized surrogate, and the primary caregiver. The care provided to an individual, regardless of setting, must be in accordance with the POC, and if in a facility, both teams (hospice and facility) need to identify and address the same issues and problems. Collaboration between hospice and facility staff members is critical to provide the most appropriate and patient-sensitive care. Collaborating on planning in the first week after hospice admission typically eliminates any confusion of goals by both hospice and facility teams.

In developing the POC, several components need to be addressed and agreed upon by both the facility and the hospice staffs: communication, medications, collaborative care, levels of hospice care, hiring and training practices, care plans, and care conferences.

Communication

Typically, the hospice's professional staff (e.g., nurse, social worker, chaplain, etc.) will meet with the facility's professional staff (e.g., nurse manager, case manager, or social services director) on each visit to discuss any resident changes of condition and review services provided. If the facility's professional staff is unavailable to meet, a message (voice message or note) can be left for them (this communication should not be left with line/bedside staff). Other staff members (e.g., CNA) can communicate with line/bedside staff, or professional staff, if appropriate.

If hospice staff members need assistance or have difficulty obtaining assistance, they should contact the facility's professional staff to avoid putting a resident at risk.

Ensure everyone is clear about their own and each other's responsibilities by establishing communication priorities with facility staff and hospice physicians regarding the following:

- **General:** Who will contact the physician for medications, lab tests, and so on? Establish communication protocol between facility and hospice staffs regarding all physician order changes.
- **Crisis:** Establish communication protocol regarding death, pain, and other issues that may arise.
- **Situation specific:** Establish communication protocol regarding pain, skin care, and wound care.

Set up an orientation process for new hospices, or hospices that haven't been in the facility for more than a month. Include the following specific components:

- Orientation for all hospice staff members providing resident care in the facility. Orientation is optional for hospice staff members not providing resident care in the facility.
- Orientation is a separate meeting from in-services.
- Provide written documentation of general long-term care regulations and facility-specific preferences to the hospice staff.

Conduct at least one annual in-service at the facility, with all hospices providing services in that facility, to discuss long-term care and hospice regulatory updates and changes. Provide a written summary of the in-service to staff members who are unable to attend.

Provide the hospice with a list of E-kit (emergency medication kit) contents and the contract pharmacy name.

Medications

Who in the facility or hospice will be responsible for each individual medication including orders, re-orders, and payment? Establish a uniform way to identify who is responsible for each medication (e.g., stickers in the medication record and/or on the bottle, additional column in the medication record, etc.).

Long-term care regulations require a proper diagnosis and specific symptom/behavior (tracked every shift) for every medication ordered. The hospice staff documents accordingly when initiating medications, and the facility is required to document attempts to decrease medication doses every 6 months. All appropriate medications that may benefit the resident should be considered. Hospice staff members document and provide education as needed for the facility staff regarding justification for hospice-recommended medications.

The facility and hospice both need specific orders for E-kits and as-needed medications. Medication orders should be for a specific dose for a specific reason (i.e., not a dose range or general reason for use). For pain treatment specifically, medications must be dosed for mild/medium/severe pain according to the pain scale used in the facility. (Refer to the Aggressive Management of Pain, Symptoms, and Suffering section for other specific diagnoses and symptoms.)

Collaborative Care

Establish who is responsible for providing each aspect of care. Even if it seems obvious that either the facility or hospice will provide a certain type of assistance (showering, for example), include it in writing in the POC so that there is no confusion or assumptions made.

Assistive Devices Who will be responsible for providing and maintaining assistive devices or durable medical equipment (e.g., mattresses, wheelchairs, etc.)? Discuss each item with the facility director of nursing or designee, including

- The rationale for use;
- The diagnosis, including whether this is related to the terminal diagnosis and related decline along the trajectory of the illness; and
- Whether the facility or hospice is responsible for payment for durable medical equipment. (If the hospice is responsible, it should provide the equipment.)

Showers Typically, the nursing facility staff is responsible for providing resident showers per long-term care regulations, although hospices may assist.

Therapy Issues Determine when additional therapy issues will be addressed. First, have a discussion about goals. Second, clarify that no dual billing is taking place. Appropriate documentation of therapy visits must occur in the medical record.

Special Needs Encourage discussion of special palliative care needs that may be met by the hospice.

Note: Additional care services available are hospice-specific.

Skin and Wound Care Establish during the first week's care plan meeting who will be responsible for skin care and wound care. Other important questions include:

- If an advanced treatment is recommended, will hospice cover the cost? For most hospices, aggressive treatments such as wound vacs, debridement, and wound care clinics are not covered. The goals are to keep wounds free from infection and well maintained and to ensure the resident's comfort.
- Is hospice providing wound care products? If treatment changes occur, there should be discussion between the facility and hospice, particularly regarding payment concerns.

Notes:

- There is an inherent conflict between long-term care and hospice regulations regarding documentation of changes in condition: Long-term care must document improvement (or at least no change), whereas hospice must document decline. "Improvement" and "decline" can be documented in multiple ways so that these are not necessarily in conflict (e.g., is this "avoidable" or "unavoidable"?).
- Facilities and hospices agree to share medical records, assessments, and documentation for best resident care (per HIPAA, legal issues, ethics, etc.).
- The team must consistently measure, treat, and document skin care and wound issues. The Braden scale is one of the common scales used, but more important is that both the hospice and facility teams agree on the scale they will use. This is an important issue because facilities are regularly cited and fined for skin care and wound care issues.
- Hospices document education of family and residents regarding the dying process (for specific resident diagnoses) in the facility medical record.

Levels of Hospice Care

Hospice offers three levels of care: routine, general inpatient, and respite.

Routine Care This level of care is provided by a team including the physician/medical director, nurse, social worker, CNA, and chaplain whose visit frequency is based on the resident's level of acuity, goals, and needs. Additional team members, available on request, may include volunteers, dietitians, physical therapists, and others.

General Inpatient Care This is hospice's version of skilled care and is offered for two possible scenarios: First, hospice patients may be admitted to nursing facilities for short-term general inpatient (GI or GIP) care when the hospice interdisciplinary group or team (IDT) agrees that the resident needs more intensive pain control, or acute or chronic symptom management, which cannot feasibly be provided in other settings. Second, a current long-term care resident receiving hospice care has a change in status resulting in a higher level of intensity of care while in GI. Other indications for GI care include a hospice patient in need of medication adjustment, observation, or other stabilizing treatment that requires the care of trained professionals and RN supervision/monitoring/titration. The hospice and facility together must clearly document reasons why a patient requires GI services. Generally, the maximum length of a GI stay is 7 days.

Documentation and justification of this level of care are imperative. The intention of hospice GI-level care is to provide intensive treatment and resolution of acute symptoms as quickly as possible.

As with all skilled care, the team (hospice and facility staff) must demonstrate collaboration through documentation of the care each entity delivers to the patient and that it follows the GI/skilled plan of care (see Charting Guidelines: General Inpatient in Appendix K for use as a charting tool for the staff).

Respite Care Many hospice patients have their own caregivers; often, these are family members. When caregivers need a rest from their caregiving responsibilities, the Medicare Hospice Benefit provides payment for patients to stay in a skilled nursing facility for up to 5 days. Most hospices do not provide more than one respite stay per benefit period, but Medicare does not specify how often the benefit may be used.

Hiring and Training Practices

Long-term care and hospice regulations both require background checks for all employees coming into the facility. Specific abuse prevention training is required in long-term care and can be addressed in the orientation.

Both long-term care and hospice regulations require tuberculosis vaccinations and encourage flu vaccinations for all employees coming into the facility. Some facilities will not allow employees without the flu vaccination to work during a flu outbreak. The facility notifies the hospice in the event of a flu outbreak.

Many long-term care facilities require drug screen checks for all employees, but this is optional for hospices. This is particularly important to note in diversion and abuse surveys.

Long-term care regulations require 12 inservices per year and specific abuse and neglect prevention training. Hospices require 20 hours of ongoing education per year, although abuse and neglect topics are not specified. Hospices are welcome to attend, participate in, and/or present at these long-term care inservices.

Care Plans

Long-term care regulations require care plan documentation of current activities only; don't list activities on the care plan that are not currently being implemented. Activities may be designated "per resident/family/facility request" rather than "as needed." Both long-term care and hospices may list activities available for anticipatory needs; however, this must be documented separately from the current activities documented on the facility care plan. Discuss care plan documentation in the orientation.

Update the care plan with the implementation of care. If there is a conflict in physician orders, the facility or the hospice may initiate communications between the facility MD and the hospice team.

Care Conferences

Long-term care regulations require care conferences to be held within 21 days of admission and then quarterly at a minimum. Hospice regulations require care planning at least every 2 weeks. Best practice recommends that the initial care conference occurs within 2 weeks of admission to hospice. The facility and the hospice should notify each other of care conferences and family meetings in advance of the meeting, allowing enough time to plan ahead, if possible.

The facility and hospice need to be aware of each other's policies during the declining and dying process, including

- Documentation of activities of daily living during the declining and dying process;
- Coordination of education on dying processes during care conferences (some facilities designate specific individuals to participate in these conversations with residents and families); and
- Planning for care of the actively dying resident prior to the need for it (e.g., notifying the hospice, determining who will be present with the resident, who will support family members, etc.).

Aggressive Management of Pain, Symptoms, and Suffering

Palliative care is directed toward the quality of life of individuals who have chronic conditions, pain, or other discomfort, or are nearing the end of life. The care of the seriously ill resident should be guided by the values and preferences of the individual resident. Palliative care is an interdisciplinary undertaking that attends to the needs of both the resident and family. Care for the resident should focus on relief of symptoms and should be addressed through both pharmacologic and nonpharmacologic interventions.

Tables 3 and 4 illustrate the guidelines for management of pain, symptoms, and suffering developed by the Nurse Executive Council of the Colorado Health Care Association (CHCA) in 2002 and updated and revised by the Center for Improving Value in Health Care (CIVHC) Palliative Care Task Force in 2011. They are intended as tools for long-term care practitioners to assess and manage individuals who are near the end of life and make a successful transition to hospice care for all involved. These guidelines should be adapted to each facility's unique setting.

Table 3. Guidelines for the Management of Pain, Symptoms, and Suffering

Problem	Goal	Intervention
End-of-life decision making and care planning	<p>Resident's advance directives will be followed.</p> <p>In the event of no advance directives, direction for care will be sought from MDPOA.</p> <p>If no MDPOA, interested persons will select a proxy and selection will be documented in chart.</p>	<p>Meet with resident and/or resident's agent (MDPOA) to ascertain the level of aggressive intervention the resident should receive.</p> <p>Review previously documented advance directives.</p> <p>Provide education/information on interventions such as: hospitalization, IVs, artificial nourishment, mechanical ventilation, dialysis, blood transfusions, antibiotics, diagnostic testing, and pain medication. Document in advance directives or Medical Orders for Scope of Treatment (MOST).</p> <p>Instruct on hospice care benefit and provide resources. Determine if family consents to hospice care.</p>
Knowledge deficit	<p>Resident/family will have understanding of the plan of care.</p> <p>Resident/family will verbalize their wishes and desires to be incorporated into plan of care.</p>	<p>Identify resident/family readiness to learn about trajectory of illness/prognosis including attitudes toward death and dying.</p> <p>Ensure they understand prognosis and have declined more aggressive treatment options. (If wanting to continue aggressive treatment, stay on palliative care program.)</p> <p>Provide resources on what to expect, what signs and symptoms the resident may display, how impending death will present (e.g., Cheyne Stokes, mottling, death rattle).</p> <p>Discuss and document funeral arrangements.</p> <p>Discuss process on disposition of the body, coroner involvement, and disposition of belongings.</p> <p>Discuss need for spiritual care and provide support as requested.</p>

Table 3. Continued

Problem	Goal	Intervention
Pain or discomfort	<p>Pain scale will be used.</p> <p>Resident will achieve and maintain tolerable level of physical comfort.</p>	<p>Assess pain every shift (or more frequently if pain is greater than goal) until under control.</p> <p>Change or titrate pain meds per doctor’s orders. Offer different routes for pain meds.</p> <p>Provide comfort measures such as positioning, turning, calm/quiet atmosphere, relaxation, music, massage.</p> <p>Educate resident/family on pain and pain relief.</p>
Dyspnea and shortness of breath	<p>Resident denies dyspnea or reports it as tolerable.</p>	<p>Promote maximal inspiration (elevate head of bed, increase air circulation, use fan, allow for rest periods).</p> <p>Titrate oxygen as ordered.</p> <p>Medicate as ordered with opioids.</p> <p>Manage secretions including suctioning and medication.</p>
Decreased cardiovascular circulation	<p>Alleviate distressing symptoms such as edema, cold, or heat.</p>	<p>Monitor resident for comfort. Respect patient/MDPOA or proxy requests for nonintervention.</p> <p>Assess activity tolerance, ranging from frequent rest periods to complete bed rest.</p> <p>Elevate lower extremities to prevent edema. Compression hose if ordered.</p> <p>Environmental control.</p>
Anorexia and decreased food and fluid intake related to nausea, fatigue, opioids, underlying disease, fasting	<p>Maintain nutritional status within disease limitations.</p> <p>Awareness that anorexia, weight loss are typical natural trajectories of the underlying illness.</p>	<p>Assess resident’s dietary preferences and tolerance.</p> <p>Lift dietary restrictions.</p> <p>Offer small frequent meals, snacks, and fluids as resident will tolerate.</p> <p>Offer assistance to eat and drink.</p> <p>Honor resident’s wishes to not eat.</p> <p>Medicate with antiemetics as ordered.</p>

Table 3. *Continued*

Problem	Goal	Intervention
Risk for skin breakdown related to poor intake, hydration, mobility	Maintain skin integrity without signs and symptoms of infection.	<p>Turn and position for comfort PRN and as resident tolerates.</p> <p>Assess for skin integrity with turning and positioning with supports.</p> <p>Teach family that effects of poor nutrition and compromised circulation may result in impaired skin integrity despite vigorous intervention.</p> <p>Keep skin clean and dry; keep linens smooth and wrinkle free. Use pressure-reducing devices if resident appears at risk.</p>
Need for frequent mouth care related to thirst, dry mouth, dehydration, reduced oral intake, opioids, and mouth breathing	Resident will maintain intact mucosa.	<p>Assess oral mucosa every shift or PRN.</p> <p>Provide mouth care BID and PRN to include cleansing, swabbing, and lip moisteners.</p> <p>Offer ice chips, hard candy when appropriate.</p>
Urinary elimination	Maintain urine output within disease limits.	<p>Assess for signs and symptoms of urinary retention.</p> <p>Assess for need for catheter during end-of-life care.</p> <p>Pericare BID and PRN.</p> <p>Assess for signs of renal shutdown. Instruct family on relevance.</p>
Risk for constipation related to decreased food intake and use of analgesics	Maintain bowel elimination within limits of disease process.	<p>Use bowel protocol PRN.</p> <p>Encourage fluids/activity within limits of disease process.</p> <p>Assess for signs and symptoms of discomfort related to constipation.</p>

Table 3. Continued

Problem	Goal	Intervention
Sleep pattern disturbance	Resident will achieve adequate rest and sleep.	Assess sleep quality and quantity. Arrange care schedule to limit sleep disturbances. Medicate with hypnotics/anxiolytics as ordered.
Impaired neurological function	Resident will be safe. Seizures/agitation will be managed within disease limitations.	Implement seizure precautions where this risk is probable. Medication with psychotropics and antiseizure medications as ordered.
Grief and spiritual needs of resident and family	Resident and family will receive culturally sensitive emotional and spiritual support as needed.	Chaplain and/or social worker to be available for counseling and emotional support. Encourage verbalizations of feelings and concern. Resident room is comfortable and supports family visiting and confidentiality. Family to participate in care as desired. Integrate spiritual/cultural care within practice. Educate staff and other residents on cultural and spiritual practices. Offer memorial services for staff and families, if available. Notify staff and residents of where and when services are to be held.

Note: See Appendix L for detailed information.

Note: It is strongly recommended that all residents with defibrillators are identified so care plans can include discussion of appropriate timing for deactivation. Defibrillator discharge during active dying can be extremely painful to the resident and distressing for the family and staff. Deactivation is entirely ethical and in keeping with the goals of comfort care. It will not, in itself, hasten death. With consent, arrangements should be made with a trained technician for timely deactivation of such devices. For more information, see the Colorado Center for Hospice & Palliative Care Commentary and Policy Statement on Deactivation of Cardiac Devices in Hospice Patients in Appendix G or the HRS Expert Consensus Statement on the Management of Cardiovascular Implantable Electronic Devices (CEIDs) in Patients Nearing End of Life or Requesting Withdrawal of Therapy. *Heart Rhythm*, Vol. 7, No. 7, July 2010.

Table 4. Palliative Care Orders

Discuss the need for the following orders when the physician recommends palliative care.

Treatment	Discussion
Oral meds	Recommend discontinuing oral meds that are not directed toward comfort care plan.
Pain	Obtain orders for strong analgesia with ability to titrate up to hourly
Fever	Obtain orders for acetaminophen suppositories PRN. Consider an anti-inflammatory suppository if required.
Nausea	Request orders for an antiemetic.
Excess secretions	Where there might be excessive amounts of airway secretions, consider orders for atropine sl or eye drops. This will reduce the need for suctioning. Obtain orders for suction PRN.
Anxiety/ Agitation	Consider a sublingual anxiolytic for calming and rest promotion.
Oxygenation	Oxygen can ease rapid respirations, provide for energy conservation, and reduce hypoxia-type restlessness.
Foley catheter	Consider for situations where moving the resident for pericare is too uncomfortable or distressing.
Constipation	Use a range of osmotics, stimulants, and suppositories and increase when narcotics dosage is increased.
Seizure	Consider seizure medications.
Vital signs	Consider vital signs PRN, discretion of the nurse to assess for discomfort if no other means are present.

Source: The preceding tables reproduced with permission from CHCA's *Pathways to Excellence*, 2008.

Death Practices

The long-term care facility is a special kind of community. Residents and staff can develop close relationships after years of care. However, staff must maintain professional relationships with the residents and their families. When residents approach the end of life, and especially when they enter the time of “active dying,” the community as a whole will experience loss and grief to some degree that must be addressed.

Important: As previously noted, religious, cultural, and ethnic background can strongly influence a resident’s or family’s preference for treatment at death. Some religions have very specific (sometimes lengthy and loud) rituals that must be performed during the active dying phase. Others have particular rules about handling the body after death and who is allowed to do so. Some cultures traditionally include large numbers of family members to sit vigil with the resident during their final days; others value more privacy. Again, do not assume. Ask questions and try to accommodate. Refer to Appendix O for additional resources.

Here are some suggestions and examples for supporting the community—residents, families, volunteers, and staff—through difficult times.

As Death Approaches

- Set aside time to listen to dying residents so they can talk through their fears and final wishes.
- If the resident has a terminal diagnosis but is still capable, ask if there is a regret in his or her life that can be resolved before dying or a final dream the facility or hospice staff can help realize.
 - *Suppose a patient’s dying wish is to have her poetry published. Locate a graphic design service that will agree to typeset, bind, and provide a few copies of the book without charge. Present the book to the author at a tea party for all residents, families, and staff. Provide and serve iced tea and petit fours to all the guests. Arrange for a family member or resident to read selected poems to the group, and for a professional photographer to take pictures of the resident at her special event. Retain a copy of the book for residents to enjoy.*
- When someone is dying, ensure quiet and peaceful surroundings. Make sure there is privacy for the resident and family and provide for their needs (e.g., a reclining chair or cot so they can rest, a visit from the facility or hospice chaplain, keeping the door to the hallway closed and minimizing noise outside the room).
- Provide refreshments for visitors and family such as cool drinks, hot coffee and tea, crackers and cheese, fruit, or passes/meal tickets for the dining room.
- Provide especially soft pillows and linens for the resident. Make sure they have something beautiful to look at from every angle while in bed or up in a chair.
 - *Provide flower boxes on each resident room window, and hang photographs or posters on the ceiling or mobiles that sway as people walk by.*
- Set up a cart with a CD player and CDs of relaxing music or nature sounds and aromatherapy items. This cart can be taken to the resident’s room when desired.

- Always make sure pain is controlled. Try alternative comfort measures such as massage, acupuncture, music therapy, and meditation. These complementary services are offered by many hospices.
- Let residents know when one of their peers is dying so they can spend time with him or her if they choose to do so.
 - *Schedule staff members and residents to participate in a 24-hour vigil with residents who do not wish to die alone.*

At the Time of Death

- Be sensitive to the perceptions of the family. Make up the deceased's bed with fresh linens, so family members do not come to the resident's room after the death to find a stripped bed.
 - *Use a special white bedspread with a fresh rose laid on it. Include a card of sympathy signed by the residents and staff, placed next to the rose.*
- Do not pack up the deceased's belongings in leftover supply boxes or plastic trash bags.
 - *Show respect by purchasing special white boxes with lids for the resident's belongings. Provide help with loading the items in the car for the family.*
- In a frame, post a notice in a common area to let the community know when a resident has died.
 - *Set up a special table with a lace tablecloth. On it place a beautiful plant and a framed notice that includes a photo and brief summary of the person's life. Give the information and plant to the family on the day of the memorial service.*

After the Death

- Conduct a memorial service in the facility for any resident who dies. This allows other residents and staff to celebrate the resident's life and express their own sadness at the passing. The facility and/or hospice chaplain can facilitate, but residents and staff members should be encouraged to participate by sharing memories and appreciation. This ritual is important to other residents who see that the lives of residents are respected and honored.
 - *Fill a formal decorative bowl with water. Next to it, place a bouquet of fresh flowers. As each person shares a story about the deceased, cut a flower off at the stem and float it in the water. Live music—often a harp—is nice, to set the mood and fill in periods of silence.*
- With the assistance of the deceased's family, put together a collage with photos and items that represent the person's life. Display it in a common room for people to enjoy before and after the formal service.
 - *For a resident who owned a lot of costume jewelry, the family might choose to offer it to others as a remembrance of the deceased. At the memorial service, place the jewelry on trays and pass them around to let each attendee select a piece.*

How Can We Honor Residents Who Have Passed From Our Communities?

It is important to acknowledge the passing of residents in long-term care. The topic of death is certainly a frequent visitor to the minds of the elderly. To not acknowledge a fellow resident's passing tells the others that when they, too, are gone, they will be just as quickly forgotten, their passing unacknowledged, their life uncelebrated.

From your resident council, develop a memorial committee of residents. Family members and staff may also participate. The memorial committee is in charge of acknowledging deaths in the facility and planning memorial services.

To acknowledge and honor a life passed,

- Send a memorial gift to the resident's family or to the memorial service: flowers, a plant, an attractive photo of the resident, a card from the resident council or memorial committee, another card sent from the care staff with personal messages.
- Make a small remembrance book about the resident for the family—or for the roommate, if they were close. Include pictures, stories, and thoughts of the resident.
- After their passing, place a single rose on the resident's bed for at least 24 hours.
- Place a rose at their place in the dining room.
- Place a photo of the resident, and flowers, at the front desk or at the nurses' station on the unit.
- Acknowledge the passing to the resident's roommate. Treat them as a grieving family member. Include them in the planning of the facility service and invite them to the family service.
- Acknowledge each person's passing, individually, in the weekly religious services, the "community meetings," if you have them, and/or resident council. If need be, obtain permission to make appropriate announcements from the resident (care planning) or the family.
- Announce each person's passing before the midday meal. Have a moment of silence or prayer in their memory.
- Have an individual memorial service for each resident. Group memorial services show no recognition of the resident as a special and unique individual. Prior to each quarterly care conference, encourage each resident to indicate how they would like to be remembered and whether or not they want a service after their passing.
- Invite residents and staff to visit the resident in their room before the passing and after the passing, just as would happen at a funeral home or their "real" home.
- If the resident is religious, hold a prayer service in the room with the resident before they die. You may want to hold a bedside service after the passing, as well, for the staff and residents.

Source: Adapted from material prepared by Julie Christiansen, ombudsman, with permission.

Bereavement Care

Hospice care does not end at the death of the resident. Because the family is considered part of the “unit of care,” support from the hospice team continues for 13 months following the death. Many hospices also offer bereavement support and grief counseling to anyone, whether or not their loved one was cared for by the hospice agency. Hospices with regular bereavement services open to the community are noted in Appendix P.

Nursing facilities, due to their special nature as a community, can adopt their own bereavement support practices to honor the losses felt by other residents and staff. Suggestions include:

- Don't underestimate the relationship between residents in the facility. Be sure to offer support services to roommates, table mates, smoking buddies, etc. of a resident who has died.
- When more than one death occurs in a relatively short period of time, acknowledge this impact on the community. Sometimes residents wonder why this is happening and fear that they are “next,” or may feel guilty that a friend has died and they are still alive.
- Be sensitive to the timing of placing another resident in the deceased resident's chair in the dining room and/or bedroom. Residents and staff often find a premature replacement to be disrespectful.
- Find time for spontaneous, casual conversation about residents who have died, and allow the other residents to share their memories. Keeping residents “alive” through memories can validate the importance and reassure others that all residents will be remembered.
- During the holidays, provide some activity or event to commemorate those who have died over the past year such as a memory tree, group memorial service, or a memory plaque on a wall for year-round opportunities for reflection on those who have died.
 - *Make ornaments for the Christmas tree from photos of residents who have died in the past year.*

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Appendix A: Advance Directives and Medical Orders for Scope of Treatment for Colorado

The following forms are included in this section:

- Living Will
- Medical Durable Power of Attorney
- Proxy Decision Maker by Statute
- Cardiopulmonary (CPR) Directive
- Medical Orders for Scope of Treatment for Colorado (MOST)

Advance Directive for Surgical / Medical Treatment (Living Will)

On completion, give copies to your physician, family members, and Healthcare Agent.

If you wish to revoke or replace this document, mark it clearly as "Revoked" or destroy it and all its copies, if possible.

If you do not understand the choices and options, seek advice from a healthcare provider or other qualified advisor.

I. DECLARATION

I, _____, am at least eighteen (18) years old and able to make and communicate my own decisions. It is my direction that the following instructions be followed if I am diagnosed by two qualified doctors to be in a terminal condition or Persistent Vegetative State.

A. Terminal Condition If at any time my physician and one other qualified physician certify in writing that I have a terminal condition, and I am unable to make or communicate my own decisions about medical treatment, then:

I. Life-Sustaining Procedures (initial one)

_____ (Initials) I direct that all life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____ (Initials) I direct that life-sustaining procedures shall be continued for/until (state timeframe or goal):

2. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

_____ (Initials) Artificial nutrition and hydration shall not be continued.

_____ (Initials) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

_____ (Initials) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

B. Persistent Vegetative State If at any time my physician and one other qualified physician certify in writing that I am in a Persistent Vegetative State, then:

I. Life-Sustaining Procedures (initial one)

_____ (Initials) I direct that life-sustaining procedures shall be withdrawn and/or withheld, not including any

procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____ (Initials) I direct that life-sustaining procedures shall be continued for/until (state timeframe or goal):

2. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

_____ (Initials) Artificial nutrition and hydration shall not be continued.

_____ (Initials) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

_____ (Initials) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

II. OTHER DIRECTIONS

Please indicate below if you have attached to this form any other instructions for your care after you are certified in a terminal condition or Persistent Vegetative State (for instance, to be enrolled in a hospice program, remain at or be transferred to home, discontinue or refuse other treatments such as dialysis, transfusions, antibiotics, diagnostic tests, etc.) (initial one):

_____ (Initials) Yes, I have attached other directions.

_____ (Initials) No, I do not have any other directions.

III. RESOLUTION WITH MEDICAL POWER OF ATTORNEY (initial one)

_____ (Initials) My Agent under my Medical Durable Power of Attorney shall have the authority to override any of the directions stated here, whether I signed this declaration before or after I appointed that Agent.

_____ (Initials) My directions as stated here may not be overridden or revoked by my Agent under Medical Durable Power of Attorney, whether I signed this declaration before or after I appointed that Agent.

Advance Directive for Surgical / Medical Treatment (Living Will) (continued)

IV. CONSULTATION WITH OTHER PERSONS

I authorize my healthcare providers to discuss my condition and care with the following persons, understanding that these persons are not empowered to make any decisions regarding my care, unless I have appointed them as my Healthcare Agents under Medical Durable Power of Attorney.

<i>Name</i>	<i>Relationship</i>
_____	_____
_____	_____
_____	_____
_____	_____

V. NOTIFICATION OF OTHER PERSONS

Before withholding or withdrawing life-sustaining procedures, my healthcare providers shall make a reasonable effort to notify the following persons that I am in a terminal condition or Persistent Vegetative State. My healthcare providers have my permission to discuss my condition with these persons. I do NOT authorize these persons to make medical decisions on my behalf, unless I have appointed one or more of them as my Agent(s) under Medical Durable Power of Attorney.

<i>Name</i>	<i>Telephone number or email</i>
_____	_____
_____	_____
_____	_____
_____	_____

VI. ANATOMICAL GIFTS

_____ (*Initials*) I wish to donate my (check one or both)
 organs and/or tissues, if medically possible.

_____ (*Initials*) I do not wish donate my organs or tissues.

VII. SIGNATURE

I execute this declaration, as my free and voluntary act, this day of _____, 20____.

Declarant signature

VIII. DECLARATION OF WITNESSES

This declaration was signed by (*name of Declarant*)

in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We did not sign the Declarant's signature. We are not doctors or employees of the attending doctor or healthcare facility in which the Declarant is a patient. We are neither creditors nor heirs of the Declarant and have no claim against any portion of the Declarant's estate at the time this declaration was signed. We are at least eighteen (18) years old and under no pressure, undue influence, or otherwise disqualifying disability.

Signature of Witness

Printed Name

Address

Signature of Witness

Printed Name

Address

Notary (optional)

State of _____

County of _____

SUBSCRIBED and sworn to before me by

, the Declarant,

and _____

and _____

witnesses, as the voluntary act and deed of the Declarant

this day of _____, 20____.

Notary Public

My commission expires: _____

Medical Durable Power of Attorney for Healthcare Decisions

I. Appointment of Agent and Alternates

I, _____,
Declarant, hereby appoint:

Name of Agent

Agent's Best Contact Telephone Number

Agent's email or alternative telephone number

Agent's home address

as my Agent to make and communicate my healthcare decisions when I cannot. This gives my Agent the power to consent to, or refuse, or stop any healthcare, treatment, service, or diagnostic procedure. My Agent also has the authority to talk with healthcare personnel, get information, and sign forms as necessary to carry out those decisions.

If the person named above is not available or is unable to continue as my Agent, then I appoint the following person(s) to serve in the order listed below.

Name of Alternate Agent #1

Agent's Best Contact Telephone Number

Agent's email or alternative telephone number

Agent's home address

Name of Alternate Agent #2

Agent's Best Contact Telephone Number

Agent's email or alternative telephone number

Agent's home address

II. When Agent's Powers Begin

By this document, I intend to create a Medical Durable Power of Attorney which shall take effect either (initial one):

_____ (*Initials*) Immediately upon my signature.

_____ (*Initials*) When my physician or other qualified medical professional has determined that I am unable to make my or express my own decisions, and for as long as I am unable to make or express my own decisions.

III. Instructions to Agent

My Agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way. If I have not expressed a choice about the decision or healthcare in question, my Agent shall base his or her decisions on what he or she, in consultation with my healthcare providers, determines is in my best interest. I also request that my Agent, to the extent possible, consult me on the decisions and make every effort to enable my understanding and find out my preferences.

State here any desires concerning life-sustaining procedures, treatment, general care and services, including any special provisions or limitations:

My signature below indicates that I understand the purpose and effect of this document:

Signature of Declarant

Date

Addendum to Medical Durable Power of Attorney — recommended, not required

I. Signature of the Appointed Agent

Although not required by Colorado law, my signature below indicates that I have been informed of my appointment as a Healthcare Agent under Medical Durable Power of Attorney for (name of Declarant)

_____ .

I am at least eighteen (18) years old. I accept the responsibilities of that appointment, and I have discussed with the Declarant his or her wishes and preferences for medical care in the event that he or she cannot speak for him- or herself.

I understand that I am always to act in accordance with his or her wishes, not my own, and that I have full authority to speak with his or her healthcare providers, examine healthcare records, and sign documents in order to carry out those wishes. I also understand that my authority as a Healthcare Agent is only in effect when the Declarant is unable to make his or her own decisions and that it automatically expires at his or her death.

If I am an alternate Agent, I understand that my responsibilities and powers will only take effect if the primary Agent is unable or unwilling to serve.

Primary Agent's Signature

Printed Name

Date

Alternate Agent #1 Signature

Printed Name

Date

Alternate Agent #2 Signature

Printed Name

Date

2. Signature of Witnesses and Notary

The signature of two witnesses and a notary are not required by Colorado law for proper execution of a Medical Durable Power of Attorney; however, they may make the document more acceptable in other states.

This document was signed by (*name of Declarant*)

in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We are at least eighteen (18) years old.

Signature of Witness

Printed Name

Address

Signature of Witness

Printed Name

Address

Notary (optional)

State of _____

County of _____

SUBSCRIBED and sworn to before me by

_____, the

Declarant,

and _____

and _____

witnesses, as the voluntary act and deed of the Declarant this day of _____, 20____.

Notary Public

My commission expires: _____

Proxy Decision Maker by Statute

IMPORTANT INFORMATION ABOUT PROXY SELECTION

Pursuant to C.R.S. 15-18.5-101-105, if an individual does not have capacity to name a surrogate decision maker and has not designated a Medical Durable Power of Attorney (MDPOA) or does not have a Guardian, decision-making authority does NOT default to any member of the patient's family. Instead, Colorado law allows family members and close friends to select a proxy decision maker through mutual agreement.

The physician (or designee) has the responsibility to locate and contact as many "interested persons"—persons with close relationships to the patient and an interest in his or her well-being (including but not limited to spouse, life partner, adult children, parents, siblings, and close friends), and ask them to select a decision maker by consensus.

Under Colorado's proxy law, no member of the group has "automatic" priority. The person chosen should be the one who knows the patient's medical wishes the best.

Reasonable efforts must be made to tell the patient who the proxy is, and the patient has the right to object to the proxy selected and any proxy's decision.

If any of the interested persons disagree with the choice of proxy, or with the proxy's actions, or no proxy can be agreed upon, then any member of the group may ask the court to start a guardianship.

A proxy can make decisions about personal and medical care, and shall comply with the patient's wishes for medical care, if known. If the patient's wishes are not known, the proxy is to act in the patient's best interests, in consultation with the patient (to the extent possible) and with the other interested parties.

The proxy can decide to stop, or not to start, tube feeding *only* when two physicians (one trained in neurology or neurosurgery) agree that tube feeding would only prolong dying and is unlikely to help the patient recover.

If the patient is re-examined later and has regained decision-making capacity, the proxy is relieved of duty. If the patient does not regain decision-making capacity and has an ongoing need for surrogate decision making, guardianship proceedings are recommended.

Determination of lack of capacity and selection of the proxy decision maker must be documented in the medical record by the examining physician, using this or another similar form.

Patient's Name

has been determined to lack capacity to make medical decisions due to a diagnosis of _____.
The following interested persons have been contacted and have participated in the decision to designate a proxy (substitute) decision maker to act in the best interest of the patient:

_____	_____
_____	_____
_____	_____
_____	_____

All reasonable efforts have been made to ensure no other legal authority, including guardian, MDPOA, or other advance directive exists, and reasonable attempts to contact all interested persons has been made. Consensus has been reached and the below-named individual will act as proxy decision maker. Reasonable attempts have been made to inform the patient of their condition and the person selected as proxy.

Name of Proxy

Relationship

Signature

Date

Address

Phone Number

Patient's or Authorized Agent's Directive to Withhold Cardio-Pulmonary Resuscitation (CPR)

This template is consistent with rules adopted by the Colorado State Board of Health at 6 CCR 1015-2

Patient's Information

Patient's Name _____
(Printed Name)

If Applicable Name of Agent/Legally Authorized Guardian/Parent of Minor Child _____
(Printed Name)

Date of Birth ____ / ____ / ____ Gender Male Female Eye Color _____ Hair Color _____

Race Ethnicity Asian or Pacific Islander Black, non-Hispanic White, non-Hispanic
 American Indian or Alaska Native Hispanic Other

If Applicable Name of hospice program/provider _____

Physician's Information

Physician's Name _____
(Printed Name)

Physician's Address _____

Physician's telephone () _____ Physician's Colorado License # _____

Directive Attestation

Check **ONLY** the information that applies:

- Patient** I am over the age of 18 years, of sound mind and acting voluntarily. It is my desire to initiate this directive on my behalf. I have been advised that as a result of this directive, if my heart or breathing stops or malfunctions, I will not receive CPR and I may die.
- Authorized Agent/Legally Authorized Guardian/Parent of Minor Child** I am over the age of 18 years, of sound mind, and I am legally authorized to act on behalf of the patient named above in the issuance of this directive. I have been advised that as a result of this directive, if the patient's heart or breathing stops or malfunctions, the patient will not receive CPR and may die.
- Tissue Donation** I hereby make an anatomical gift, to be effective upon my death, of:
- Any needed tissues
- The following tissues Skin Cornea Bone, related tissues, and tendons

I hereby direct emergency medical services personnel, health care providers, and any other person to withhold cardio-pulmonary resuscitation in the event that my/the patient's heart or breathing stops or malfunctions. I understand that this directive does not constitute refusal of other medical interventions for my/the patient's care and comfort. If I/the patient am/is admitted to a healthcare facility, this directive shall be implemented as a physician's order, pending further physician's orders.

 Signature of Patient
 Authorized Agent/Legally Authorized Guardian/Parent of Minor Child

Physician Signature

Date

Date

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Colorado Medical Orders for Scope of Treatment (*MOST*)

- **FIRST** follow these orders, **THEN** contact Physician, Advanced Practice Nurse (APN), or Physician Assistant (PA), for further orders if indicated.
- These Medical Orders are based on the person's medical condition & wishes.
- Any section not completed implies full treatment for that section.
- May only be completed by, or on behalf of, a person 18 years of age or older.
- **Everyone shall be treated with dignity and respect.**

Last Name		
First Name/Middle Name		
Date of Birth	Sex	
Hair Color	Eye Color	Race/Ethnicity

For easy identification, form should be photocopied onto "Mausau Astrobrights Vulcan Green" 65lb paper. However, plain white photocopies, faxes, and electronic scans are valid.

A	<p>CARDIOPULMONARY RESUSCITATION (CPR) <u>Person has no pulse and is not breathing.</u></p> <p><input type="checkbox"/> No CPR Do Not Resuscitate/DNR/Allow Natural Death</p> <p><input type="checkbox"/> Yes CPR Attempt Resuscitation/ CPR</p> <p align="center"><i>When <u>not</u> in Cardiopulmonary arrest, follow orders B, C, and D</i></p>
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B	<p>MEDICAL INTERVENTIONS <u>Person has pulse and/or is breathing.</u></p> <p><input type="checkbox"/> Comfort Measures Only: Use medication by any route, positioning, and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <i>Do not transfer</i> to hospital for life-sustaining treatment. <i>Transfer only</i> if comfort needs cannot be met in current location; EMS-Contact medical control.</p> <p><input type="checkbox"/> Limited Additional Interventions: Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. <i>Transfer to hospital if indicated. Avoid intensive care;</i> EMS-Contact medical control.</p> <p><input type="checkbox"/> Full Treatment: Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. <i>Transfer to hospital if indicated. Includes intensive care.</i> EMS-Contact medical control.</p> <p><i>Additional Orders:</i> _____ (EMS=Emergency Medical Services)</p>
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C	<p>ANTIBIOTICS</p> <p><input type="checkbox"/> No antibiotics. Use other measures to relieve symptoms.</p> <p><input type="checkbox"/> Use antibiotics when comfort is the goal.</p> <p><input type="checkbox"/> Use antibiotics.</p> <p><i>Additional Orders:</i> _____</p>
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D	<p>ARTIFICIALLY ADMINISTERED NUTRITION AND HYDRATION</p> <p align="center">****Always offer food & water by mouth if feasible****</p> <p><input type="checkbox"/> No artificial nutrition/hydration by tube. (NOTE: Special rules for proxy by statute on page 2)</p> <p style="padding-left: 20px;"><input type="checkbox"/> Patient has executed a "Living Will" <input type="checkbox"/> Patient has not executed a "Living Will"</p> <p><input type="checkbox"/> Defined trial period of artificial nutrition/hydration by tube. (Length of trial: _____ Goal: _____)</p> <p><input type="checkbox"/> Long-term artificial nutrition/hydration by tube.</p> <p><i>Additional Orders:</i> _____</p>
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E	<p>DISCUSSED WITH:</p> <p><input type="checkbox"/> Patient</p> <p><input type="checkbox"/> Agent under Medical Durable Power of Attorney</p> <p><input type="checkbox"/> Proxy (per statute C.R.S. 15-18.5-103(6))</p> <p><input type="checkbox"/> Guardian</p> <p><input type="checkbox"/> Other: _____</p> <p align="center"><i>(SECTION RESERVED FOR FUTURE USE)</i></p>	<p>SUMMARY OF MEDICAL CONDITION(S):</p>
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Physician/APN /PA Signature (mandatory)	Print Physician/APN/PA Name, Address and Phone Number	Date
Colorado License #:		

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

SIGNATURE OF PATIENT, AGENT, GUARDIAN, OR PROXY BY STATUTE (MANDATORY)

Significant thought has been given to the desired scope of end-of-life treatment and these instructions. Preferences have been discussed and expressed to a health care professional. This document reflects those treatment preferences, which may also be documented in a MDPOA, CPR Directive, Living Will, or other advance directive (attached if available). To the extent that my prior advance directives do not conflict with these *Medical Orders for Scope of Treatment*, my prior advance directives shall remain in full force and effect.

(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)

<i>Signature</i>	<i>Name (Print)</i>	<i>Relationship/ Surrogate status (write "self" if patient)</i>	<i>Date Signed (Revokes all previous MOST forms)</i>
<i>Primary Contact Person for the Patient</i>	<i>Relationship and/or MDPOA, Proxy</i>	<i>Phone Number/Contact Information</i>	
<i>Health Care Professional Preparing Form</i>	<i>Preparer Title</i>	<i>Phone Number</i>	<i>Date Prepared</i>
<i>Hospice Program (if applicable)</i>	<i>Address</i>	<i>Phone Number</i>	<i>Date Enrolled</i>

DIRECTIONS FOR HEALTH CARE PROFESSIONALS

COMPLETING THESE *MEDICAL ORDERS*

- Must be completed by a health care professional based on patient preferences and medical indications.
- These *Medical Orders* must be signed by a physician, advanced practice nurse, or physician assistant to be valid. *Physician Assistants must include physician name and contact information.*
- Verbal orders are acceptable with follow-up signature by physician or advanced practice nurse in accordance with facility policy.
- Original form strongly encouraged. Photocopy, fax, and electronic image of signed *MOST* forms are legal and valid.

USING THESE *MEDICAL ORDERS*

- Any section of these *Medical Orders* not completed implies full treatment for that section.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation."
- Comfort care is never optional; Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only," should be transferred to a setting able to provide comfort (e.g., pinning of a hip fracture).
- A person who chooses "Comfort Measures Only" or "Limited Additional Interventions," should not be entered into a trauma system. *EMS should contact Medical Control for further orders or direction regarding transfers.*
- IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- Treatment of dehydration is a measure that may prolong life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."
- If a health care provider considers these orders medically inappropriate, he or she may discuss concerns with the patient or authorized surrogate and revise orders with consent of patient or surrogate.
- If a health care provider or facility cannot comply with the orders due to policy or personal ethics, the provider or facility must arrange for transfer to the patient to another provider or facility and provide appropriate care in the meantime.
- **Proxy by statute is a decision maker selected through a proxy process** according to C.R.S. 15-18.5-103(6), who *may not* decline artificial nutrition/hydration (ANH) without an attending physician and a second physician trained in neurology certifying that provision of ANH would merely prolong the act of dying and is unlikely to result in the restoration of the patient to independent neurological functioning.

REVIEWING THESE *MEDICAL ORDERS*

These *Medical Orders* should be reviewed regularly and when the person is transferred from one care setting or care level to another, there is a substantial change in the person's health status, the person's treatment preferences change, or when contact information changes.

REVIEW OF THIS *MOST* FORM

Review Date	Reviewer	Location of Review	Review Outcome
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New Form Completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New Form Completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New Form Completed
			<input type="checkbox"/> No Change <input type="checkbox"/> Form Voided <input type="checkbox"/> New Form Completed

HIPAA PERMITS DISCLOSURE OF THIS INFORMATION TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Appendix B: Resources for Understanding and Accommodating Religious, Cultural, and Ethnic Variations

- Connors, R. B., & Smith, M. L. (1996, July–August). Religious insistence on medical treatment: Christian theology and re-imagination. *Hastings Center Report*, 26(4), 23–30.
- Cook, A. S., & Jenkins, L. E. (1982, April). Implications of ethnicity in the care of the terminally ill. *Social Casework: The Journal of Contemporary Social Work*, 215–219.
- Evans, I. M., & Carter, J. (1995). The lesbian perspective on death and dying. In J. K. Parry & A. S. Ryan (Eds.), *A cross-cultural look at death, dying, and religion* (pp. 131–144). Chicago, IL: Nelson-Hall Publishers.
- Galanti, G. A. (1991). *Caring for patients from different cultures: Case studies from American hospitals*. University of Pennsylvania Press.
- Hayslip, B. Jr., & Peveto, C. A. (2005). *Cultural changes in attitudes toward death, dying, and bereavement*. New York, NY: Springer Publishing Company, Inc.
- Housel, D. A. (1995). Spirituality and death and dying from a gay perspective. In J. K. Parry & A. S. Ryan (Eds.), *A cross-cultural look at death, dying, and religion* (pp. 117–130). Chicago, IL: Nelson-Hall Publishers.
- Johnson, C. J., & McGee, M. (Eds.). (1991). *How different religions view death and afterlife*. Philadelphia, PA: The Charles Press.
- Kalish, R. A., & Reynolds, D. K. (1981). *Death and ethnicity: A psychocultural study*. Farmingdale, NY: Baywood.
- Ma, G. X., & Henderson, G. (Eds.). (1999). *Rethinking ethnicity and health care: A sociocultural perspective*. Springfield, IL: Charles C. Thomas.
- McQuay, J. E. (1995). Cross-cultural customs and beliefs related to health crises, death, and organ donation/transplantation: A guide to assist health care professionals to understand different responses and provide cross-cultural assistance. *Critical Care Nursing Clinics of North America*, 7(3), 581–594.
- Mondragon, D. (Ed.). (1997). *Religious values of the terminally ill: A handbook for healthcare professionals*. Scranton, PA: University of Scranton Press.
- Murphy, S. T., Palmer, J. M., Azen, S., Frank, G., Michel, V., & Blackhall, L. J. (1996). Ethnicity and advance care directives. *Journal of Law, Medicine & Ethics*, 24, 108–117.
- Parkes, C. M., Laungani, P., & Young, B. (Eds.). (1996). *Death and bereavement across cultures*. New York, NY: Routledge.

- Parry, J. K., & Ryan, A. S. (Eds.). (1995). *A cross-cultural look at death, dying, and religion*. Chicago, IL: Nelson-Hall Publishers.
- Puchalski, C. (2006). *A time for listening and caring: Spirituality and the care of the chronically ill and dying*. New York, NY: Oxford University Press.
- Spiro, H. M., McCrea Curnen, M. G., & Wandel, L. P. (Eds.). (1996). *Facing death: Where culture, religion, and medicine meet*. New Haven, CT: Yale University Press.
- Veatch, R. M. (Ed.). (2000). *Cross-cultural currents in medical ethics* (2nd ed.). Sudbury, MA: Jones & Bartlett.

Appendix C: Resources for Conducting Difficult Conversations

- Ambuel, B., & Weissman, D. E. (2005, July). Delivering bad news—part 1 (2nd ed.). *EPERC Fast Facts and Concepts #006*. Available online: http://www.EPERC.mcw.edu/fastfact/ff_06.htm
- Ambuel, B., & Weissman, D. E. (2005, September). Delivering bad news—part 2 (2nd ed.). *EPERC Fast Facts and Concepts #011*. Available online: http://www.EPERC.mcw.edu/fastfact/ff_011.htm
- Balaban, R. B. (2000). A physician's guide to talking about end-of-life care. *Journal of General Internal Medicine, 15*, 195–200.
- Casarett, D. J., & Quill, T. E. (2007). "I'm not ready for hospice": Strategies for timely and effective hospice discussions. *Annals of Internal Medicine, 146*(6), 443–449.
- Duggleby, W., & Popkin, D. (2006). Effective patient–physician communication at the end of life: What patients want to hear and how to say it. *Geriatrics & Aging, 9*(2), 129–132.
- Huggins, M. A., & Brooks, L. (2007). Discussing end-of-life care with older patients: What are you waiting for? *Geriatrics & Aging, 10*(7), 461–464.
- von Gunten, C. F. (2002). Discussing hospice care. *Journal of Clinical Oncology, 20*(5), 1419–1424.
- von Gunten, C. F. (2005, July). Discussing hospice (2nd ed.). *EPERC Fast Facts and Concepts #038*. Available online: www.EPERC.mcw.edu/fastFact/ff_038.htm

Appendix D: Resources for Life Review

Baines, B. K. (2006). *Ethical wills: Putting your values on paper* (2nd ed.). Boulder, CO: Perseus Books. See also website: www.EthicalWill.com

Birren, J. E., & Cochran, K. N. (2001). *Telling the stories of life through guided autobiography groups*. Baltimore, MD: Johns Hopkins University Press.

Freed, R. (2003). *Women's lives, women's legacies: Passing your beliefs and blessings on to future generations: Creating your own spiritual-ethical will*. Minneapolis, MN: Fairview Press.

Hospice Foundation of America. *A guide for recalling and telling your life story*. Call toll free 1-800-854-3402 or order on the Internet at www.HospiceFoundation.org

Appendix E: Resources for Palliative Care and Hospice in the Long-Term Care Setting

- Cassarett, D., Karlawish, J., Morales, K., Crowley, R., Mirsch, T., & Asch, D. A. (2005). Improving the use of hospice services in nursing homes: A randomized controlled trial. *Journal of the American Medical Association, 294*(2), 211–217.
- Duggleby, W., & Popkin, D. (2006). Effective physician–patient communication at the end of life: What patients want to hear and how to say it. *Geriatrics and Aging, 9*(2), 129–132.
- Dunn, P. M., Tolle, S.W., Moss, A. H., & Black, J. S. (2007). The POLST paradigm: Respecting the wishes of patients and families. *Annals of Long-Term Care, 15*(9), 33–40.
- Ersek, M., & Wilson, S. A. (2003). The challenges and opportunities in providing end-of-life care in nursing homes. *Journal of Palliative Medicine, 6*(1), 45–57.
- Ersek, M., Grant, M. M., & Kraybill, B. M. (2005). Enhancing end-of-life care in nursing homes: Palliative Care Educational Resource Team (PERT) program. *Journal of Palliative Medicine, 8*, 556–566.
- Flacker, J. M., & Kiely, D. K. (1998). A practical approach to identify mortality-related factors in established long-term care residents. *Journal of the American Geriatrics Society, 46*, 1012–1015.
- Flacker, J. M., & Kiely, D. K. (2003). Mortality-related factors and 1-year survival in nursing home residents. *Journal of the American Geriatrics Society, 51*, 213–221.
- Hanson, L. (2003). Creating excellent palliative care in nursing homes [editorial]. *Journal of Palliative Medicine, 6*(1), 7–9.
- HOPE of Wisconsin. (2001). Hospice/nursing home interface: Guidelines for care coordination for hospice patients who reside in nursing homes. Available online: http://dhfs.wisconsin.gov/rl_DSL/Publications/pdfmemos/01042a.pdf
- Hospice in the Nursing Home Work Group. (1999). Hospice in a skilled nursing facility: A model for success. Available online: www.CDPHE.state.co.us/hf/download/hospicenh.pdf
- Huggins, M. A., & Brooks, L. (2007). Discussing end-of-life care with older patients: What are you waiting for? *Geriatrics and Aging, 10*(7), 461–464.
- Levy, C. (2007). Improving end-of-life care by partnering nursing homes with palliative care specialists: MAPP project. *Long-Term Care Interface, 8*(6), 26–31.
- Miller, S. C. (2007). Nursing home/hospice partnerships: A model for collaborative success through collaborative solutions. Available online: www.NHPCO.org/files/public/nhhp-final-report.pdf
- Miller, S. C. (2010). A model for successful nursing home-hospice partnerships. *Journal of Palliative Medicine, 13*(5), 525–533.

- Miller, S. C., & Mor, V. N. (2002). The role of hospice care in the nursing home setting. *Journal of Palliative Medicine*, 5(2), 271–277.
- Miller, S. C., Teno, J. M., & Mor, V. (2004). Hospice and palliative care in nursing homes. *Clinics in Geriatric Medicine*, 20, 717–734.
- Munn, J. C., Hanson, L. C., Zimmerman, S., Sloane, P. D., Mitchell, C. M. (2006). Is hospice associated with improved end-of-life care in nursing homes and assisted living facilities? *Journal of the American Geriatrics Society*, 54, 490–495.
- Munn, J. C., Zimmerman, S., Hanson, L. C., Williams, C. S., Sloane, P. D., Clipp, E. C., Tulsky, J. A., & Steinhauser, K. E. (2007). Measuring the quality of dying in long-term care. *Journal of the American Geriatrics Society*, 55, 1371–1379.
- Parker-Oliver, D., Porock, D., Zweig, S., Rantz, M., & Petroski, G. F. (2003). Hospice and non-hospice nursing home residents. *Journal of Palliative Medicine*, 6(1), 69–75.
- Researchers define best practices for end-of-life care in nursing homes with hospice services. Summary/References. Available online: www.RWJF.org/reports/grr/049891.htm
- Samala, R. V., Galindo, D. J., & Ciocon, J. O. (2011) Transitioning nursing home patients with dementia to hospice care : Basics, benefits, barriers. *Annals of Long-Term Care: Clinical Care and Aging*, 19(4), 41–47.
- Shega, J. W., Levin, A., Hougham, G. W., Cox-Hayley, D., Luchins, D., Hanrahan, P., Stocking, C., & Sachs, G. A. (2003). Palliative excellence in Alzheimer care efforts (PEACE): A program description. *Journal of Palliative Medicine*, 6(2), 315–320.
- Stevenson, D. G., & Bramson, J. S. (2009). Hospice care in the nursing home setting: A review of the literature. *Journal of Pain & Symptom Management*, 38(3), 440–451.
- Teno, J. M. (2003). Now is the time to embrace nursing homes as a place of care for dying persons [editorial]. *Journal of Palliative Medicine*, 6(2), 293–296.
- Travis, S. S., Bernard, M., Dixon, S., McAuley, W. J., Loving, G., & McClanahan, L. (2002). Obstacles to palliation and end-of-life care in a long-term care facility. *Gerontologist*, 42(3), 342–349.
- Tuch, H., Parrish, P., & Romer, A. L. (2003). Integrating palliative care into nursing homes. *Journal of Palliative Medicine*, 6(2), 297–309.
- Van der Steen, J. T., Mitchell, S. L., Frijters, D. H., Kruse, R.L., & Ribbe, M. W. (2007). Prediction of 6-month mortality in nursing home residents with advanced dementia: Validity of a risk score. *Journal of the American Medical Directors Association*, 8, 464–468.
- Zerzan, J., Stearns, S., & Hanson, L. (2000). Access to palliative care and hospice in nursing homes. *Journal of the American Medical Association*, 284(19), 2489–2494.

Appendix F: Palliative Care and Hospice Resources

American Academy of Hospice and Palliative Medicine (AAHPM) www.AAHPM.org. An organization of physicians and medical professionals dedicated to excellence in and advancement of palliative medicine. The website includes information on membership and benefits, educational opportunities through AAHPM-sponsored programs including the College of Palliative Care, a bookstore, fellowship program directory and other career opportunities, and professional clinical resources.

Center to Advance Palliative Care (CAPC) www.CAPC.org. A clearinghouse of references and resources on palliative care for hospitals and other healthcare settings, palliative care practice guidelines, educational opportunities, clinical tools, and access to other palliative care professionals.

Center for Improving Value in Health Care (CIVHC) www.CIVHC.org. CIVHC's vision is to make Colorado a national leader in health and in high-quality and affordable healthcare, and its mission is to develop and implement strategic initiatives that will improve the health of Coloradans, contain costs, and ensure better value for healthcare received. CIVHC is working to increase access to palliative care, which is much needed but currently under-delivered in Colorado.

Colorado Center for Hospice & Palliative Care (COCHPC) www.COCHPC.org. The COCHPC is Colorado's statewide organization dedicated to ensuring high-quality end-of-life care for all Coloradans through education, technical assistance, and advocacy on behalf of its member hospice and palliative care organizations. The COCHPC website includes a searchable database of member hospice agencies. Resources for consumers are also available on advance care planning, veterans resources, and end-of-life care.

End-of-Life Nursing Education Consortium (ELNEC) www.AACN.nche.edu/ELNEC. The ELNEC develops training programs for nurses in end-of-life care and practice. This website is hosted by the American Association of Colleges of Nursing. It includes current and future offerings of ELNEC programs (specialty programs include core, oncology, pediatric, critical care, geriatric, and graduate); lists of certified trainers for all programs; the ELNEC newsletter, *Connections*, produced quarterly; a list of publications and articles; and links to articles and other end-of-life websites.

GetPalliativeCare.org www.GetPalliativeCare.org. Provides clear, comprehensive palliative care information for people coping with serious, complex illness. Key components of the site include a Palliative Care Directory of Hospitals, a definition of palliative care, and a detailed description of what palliative care is and how it is different from hospice. It also provides an interactive questionnaire to assist people in determining whether palliative care is appropriate for them or their loved ones. The site is provided by the Center to Advance Palliative Care (CAPC).

HealthTeamWorks www.HealthTeamWorks.org. HealthTeamWorks is a non-profit, multi-stakeholder collaborative working to redesign the healthcare delivery system and promote integrated communities of care using evidence-based medicine and innovative systems. Their goals are to optimize health, improve quality and safety, reduce costs, and improve the care experience for patients and their healthcare teams. HealthTeamWorks developed a guideline designed to assist healthcare practitioners treating patients with chronic, serious, or advanced illness in delivering primary palliative services. The guideline and associated resources are available for download at <http://www.HealthTeamWorks.org/guidelines/palliative-care.html>

Hospice and Palliative Nurses Association (HPNA) www.HPNA.org. An organization composed of and for palliative care nurses. The website offers valuable resources for hospice and palliative care nurses, including announcements of annual meetings, information on the certification examination and lists of certified nurses in the United States, career opportunities, education and research committee members, position statements on matters of practice and care, and lists of published materials that can be ordered from the website.

Life Quality Institute (LQI) www.LifeQualityInstitute.org. Colorado's premier provider of palliative care education for practicing professionals and the public. LQI offers inservice presentations, annual conferences, regular series programs at several Denver Metro locations, education days across the state, consulting, and education customized to facility and organization needs. Life Quality Institute is also the statewide coordinator and primary provider of training on the Medical Orders for Scope of Treatment (MOST) program in Colorado.

National Consensus Project www.NationalConsensusProject.org. A collaboration among the National Hospice and Palliative Care Organization, the Hospice and Palliative Nurses Association, and the American Academy of Hospice and Palliative Medicine to promote the value of palliative care and define clinical practice guidelines for palliative care programs. The website includes a downloadable version of current clinical practice guidelines for quality palliative care.

National Hospice and Palliative Care Organization (NHPCO) www.NHPCO.org. NHPCO is the largest nonprofit membership organization representing hospice and palliative care professionals in the nation. This site offers information on educational opportunities and professional resources, a national database of care providers, general information on end-of-life care and advance care planning, and links to partner organizations.

National Palliative Care Research Center (NPCRC) www.NPCRC.org. NPCRC is committed to stimulating, developing, and funding research directed at improving care for seriously ill patients and their families. In partnership with the Center to Advance Palliative Care, the NPCRC will rapidly translate these findings into clinical practice.

Appendix G: Commentary and Position Statement: Deactivation of Cardiac Pacing Devices in Hospice Patients

Introduction

The Colorado Hospice Organization¹ (CHO) advocates for palliative and hospice care through professional and public education, legislative and regulatory advocacy, and technical assistance. CHO is committed to facilitating the highest possible quality of care provided by our member agencies. By formulating and promoting position statements around certain key issues in end-of-life care, CHO can take a leadership role in guiding hospice practice and educating the public.

Background

In 2004, an estimated 135,000 defibrillators were implanted in the United States (nearly triple the number in 2000). In January of 2005, Medicare greatly expanded the appropriateness criteria, such that “hundreds of thousands” of additional patients would qualify to receive one (Meier, 2005). Each year about 600,000 new pacemakers are implanted, the vast majority in persons over 65, and some estimates suggest that more than 3 million people are currently eligible (Harrington et al., 2004). Heart disease now ranks second behind cancer as a major diagnosis for new admissions to hospice (12% as compared to 46%), and, of course, many patients may have a hospice diagnosis other than heart disease but still have implanted cardiac devices (NHPCO, 2007). The number of patients coming in to hospice with implanted cardiac devices is unknown, but given these statistics, the likelihood that a patient seeking admission to hospice has some type of such devices is high.

Defibrillators and pacemakers present particular ethical and clinical challenges at the end of life. Patients, family members, and hospice professionals may not fully appreciate the implications in planning for a peaceful death. Or, conversely, the role of cardiac devices as a possible barrier to a peaceful death may be misunderstood and mishandled.

Key Clinical Facts

Pacemakers and defibrillators have different functions. A pacemaker is intended to correct or keep regular an abnormal heart rate or rhythm. Some patients are only mildly reliant on the device; others are dependent to the extent that if the pacemaker were deactivated, it would cause severe discomfort, degrade quality of life, and, possibly, hasten death.

Defibrillators, on the other hand, are only intended to restart a stopped heart. Deactivation of a defibrillator will not hasten death, except that a deactivated defibrillator will not prevent death from a sudden

1. The Colorado Hospice Organization is now the Colorado Center for Hospice & Palliative Care (www.COCHPC.org).

cardiac event. Likewise, deactivation will not degrade quality of life or create discomfort. If, however, a hospice patient is approaching death or actively dying, defibrillator function could be painful and futile for the patient and extremely distressing for loved ones.

Many current implantable cardiac devices combine the functions of pacing and defibrillation, which can be separately adjusted, deactivated, or reactivated.

Ethical and Legal Considerations

Any person or his or her duly authorized surrogate has a right to accept or reject medical treatment of any kind for any reason, even if hastened death is a probable outcome. Withdrawal of “life-sustaining treatment” with the informed consent of the patient or surrogate is entirely legal and ethical and does not constitute physician-assisted death or suicide. Informed consent should include a complete and accurate appreciation on the patient/surrogate’s part of the risks, benefits, and probable outcomes of the treatment withdrawal.

Both pacemakers and defibrillators can be considered “life-sustaining treatment,” and thus are subject to the same ethical and clinical considerations as, say, dialysis, ventilator support, and other such treatments.

In a way, defibrillators can be thought of as one aspect of traditional CPR (electrical defibrillation). Most patients, as a matter of course, complete CPR directives on admission to hospice. Deactivation of a defibrillator would be entirely consistent with execution of a CPR directive. Pacemakers, on the other hand, can have a role in sustaining quality of life through the course of a terminal illness and will not prevent death. Also, pacemakers can be “turned down” a bit at a time to test for effect—and reactivated as needed to support quality of life.

Requests by patients for deactivation of pacemakers or defibrillators should be probed for underlying motivations, just as any request for withdrawal of life-sustaining treatment should be explored. If the patient seems to be expressing a desire to “die sooner rather than later,” appropriate medical, psychological, and spiritual support should be offered, especially if the request is motivated by unrelieved pain or distress. If the patient understands the implications of deactivation, and such an action is consistent with the patient’s goals, and efforts have been made to mitigate any expressed distress, the hospice should support the patient’s decision and facilitate deactivation. If conflict arises or questions or concerns need further probing, consultation with an ethics committee or expert may be helpful.

Position Statement

It is the position of the Colorado Hospice Organization that

- Pacemakers and defibrillators are medical treatments subject to the same ethical and clinical considerations as any other treatment; that is, subject to an analysis of potential benefits and burdens and subject to competent persons’ rights to accept or refuse for any reason.
- During the hospice admissions interview, patients should be asked if they have any kind of implanted cardiac device; if so, the type and manufacturer (Guidant, Medtronic, St. Jude, etc.) should be noted on the intake form.

- The presence and operation of these devices should be considered in the developing care plan.
- Deactivation of defibrillators in hospice patients is entirely appropriate and consistent with the terms of a CPR directive. Indeed, deactivation prior to active dying is advised.
- The presence of a defibrillator should trigger a prompt, but careful, conversation with the patient and family about the timing of an appropriate deactivation of the device.
- Deactivation of pacemakers may result in increased burdens and distress and an active pacemaker is unlikely to interfere with peaceful dying.
- Requests for pacemaker deactivation should be examined with care: the extent to which the patient is “pacer dependent” should be determined; the patient should be fully informed of possible consequences of deactivation for his or her quality of life; motivation for the request should be probed for expressions of distress; resources of the interdisciplinary team should be utilized in the event of distress.
- If consistent with the patient’s goals, the patient’s request to deactivate the pacemaker should be honored.
- Primary caregivers, family members, hospice staff, and others closely associated with the patient should be informed of the decision; questions and concerns should be addressed and support offered.
- Consultation with an ethics committee can be a useful resource in examining a request for pacemaker or defibrillator deactivation.

Acknowledgments

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Appendix H: How to Identify and Deactivate an ICD or AICD

To provide the best possible care at death for residents, it is critical to identify barriers. Implantable cardioverter defibrillators (ICDs) or automated internal cardiac defibrillators (AICDs) that remain activated at the time of death are a barrier and can cause significant distress and suffering to the patient, family, and hospice staff. At admission, identify patients who have these implanted devices and work gently with patients and families toward a decision to deactivate them.

Identification, Patient/Family Discussion, and Making Arrangements for Deactivation

1. During the initial assessment, a nurse will investigate and document the presence of an ICD or AICD. This information should also be noted in the admission voicemail left for the receiving team.
2. The receiving team should begin discussions with the resident and family immediately about the risks and issues of keeping the ICD or AICD activated. Use the family handout Information About Implantable Cardioverter Defibrillators to aid in these discussions. (A sample for adaptation follows.)
3. When the resident/family has decided to deactivate an implanted device, a physician's order is required.
 - a. The resident's cardiologist is the first option (if resident is still under his or her care). Contact the physician regarding the family's intent to deactivate the device and set up an appointment in the office for the deactivation.
 - b. The primary care physician can also be contacted and the deactivation can be scheduled in his or her office.
 - c. If the resident is unable to travel to the physician's office, an order from a physician is still required. After receiving the order, proceed to Step 4.
4. Contact the manufacturer.
 - a. Use the number provided on the manufacturer's card to schedule a deactivation at the patient's home. (Use the patient's cardiologist for information if the patient doesn't have information or a card about the device.)
 - b. Plan for a nurse, medical director, or the patient's physician to meet the manufacturer's representative at the patient's home for the deactivation of the device.
5. Contact one of the medical directors for assistance if unable to complete Steps 3 or 4.

At Time of Death

1. Notify the coroner of the presence of an ICD or AICD, if autopsy is to be performed.
2. Notify the mortuary of the presence of an ICD or AICD. The device must be removed if the body is to be cremated.

Procedure for Suspending ICD

1. Call device manufacturer representative.
2. Upon admission to the long-term care facility, provide education to the patient and family for any patient with an active ICD regarding the process of deactivation. Also provide them with an ICD teaching sheet; see the sample that follows.
3. If the patient declines quickly and the ICD has not been deactivated by a technical associate of the device manufacturer, the deactivation process is as follows:
 - a. Educate and obtain verbal consent from the MDPOA;
 - b. Obtain an order from the physician;
 - c. Apply a blue-coated, ring-shaped ferrous magnet on the chest over the ICD.
Note: When the magnet is placed over the ICD, the ICD is unable to detect the need for defibrillation.
 - d. Affix the magnet with tape over the ICD and contact the device manufacturer for more permanent deactivation of the ICD, if needed.
 - e. If the patient expires during suspension, the magnet may then be removed. Medtronic does not need to be contacted since the device will not work without viable tissue.

Information About Implanted Cardioverter Defibrillators

What is an ICD?

An ICD is an implanted device that is placed in the heart to sense when the heart is in trouble and needs an electrical shock to keep working. These devices are placed in people with severe heart problems.

When a patient enrolls in hospice, is it a good idea to start discussing the ICD?

Yes, a person is admitted to hospice because their condition has changed and they likely have less than 6 months to live if their disease follows its normal course. Hospice patients need to know that the ICD can get in the way of the body's natural dying process and might cause pain at the end of life.

When the ICD gives off the shock, will it cause pain to my loved one?

Yes, electrical jolts to the heart are painful and continual shocks can cause severe distress and pain.

Should we consider deactivating the ICD before our loved one starts to die?

Yes, having open discussions up front with family and healthcare providers is the best way to ensure that your loved one will have the most peaceful and dignified dying process.

How can an ICD be deactivated?

An ICD can be deactivated by a specially trained representative from the device's manufacturer. The representative can come to wherever your loved one is and deactivate it in moments, without surgery or pain. A deactivation appointment must be scheduled ahead of time, however. An emergency request can result in a delay of several hours, depending on the technician's schedule that day.

Is it painful to deactivate an ICD?

No, deactivation causes no pain or discomfort. Deactivation also does not cause death, but it does mean that the device will not deliver a shock to restart the heart if the heart goes into an abnormal rhythm.

Does deactivation require a physician's order?

Yes, the hospice staff will obtain that order once you and your loved one decide to deactivate the device.

Is there a way to stop the ICD once it has started to deliver shocks?

Yes, if the ICD is still activated when a person begins to die and shocks are delivered, the hospice staff can temporarily deactivate the ICD with a magnet. The patient's healthcare agent must give consent for deactivation. The magnet will stop the ICD from delivering shocks. However, it can take time for the hospice staff person to arrive with the magnet, and shocks will continue until the heart stops or the magnet is applied.

What if I have more questions about the ICD?

Contact your care provider for more information regarding ICDs.

Source: Adapted with permission from Agape Palliative Care and Hospice Services. This page may be photocopied.

Appendix I: Prognostic Tools

Flacker Mortality Score

Use per MDS scores to identify resident at high risk for dying within 12 months.

Resident: _____ Date: _____

Room number: _____ Resident number: _____ MDS date: _____ Reason for MDS: _____

Resident Characteristic	Information Location	Scoring Chart	Score
Age > 88 years	DOB-MDS Section AO 900 or face sheet	If age greater than 88, score 1.48.	
Male Sex	MDS Section AO 800	If male, score 1.76.	
Functional Ability Score	MDS Section G0110 or see following chart to calculate number	If summary functional ability score is greater than 4, score 2.50.	
Congestive Heart Failure	MDS Section IO 600	If has CHF, score 1.57.	
Shortness of Breath	MDS Section J400	If has shortness of breath, score 2.08.	
Swallowing Problems	MDS Section K01004	If has swallowing problems, score 1.81.	
Weight Loss	MDS Section K0300	If lost 5 or more pounds in last 30 days or 10 or more pounds in last 180 days, score 2.26.	
Body Mass Index	MDS Section K0200	If BMI is less than 22 kg/ m ² , score 1.75.	
		Total Score:	

Flacker Mortality Score (continued)

If total score equals	Probability of dying within 12 months is approximately:	Intervention:
0–2	7%	
3–6	19%	
7–10	50%	Begin palliative care best practice and consider hospice discussion.
11+	86%	

Functional Ability Score

To derive the functional ability score, use MDS Section G1 data for the following seven items. Each item is scored on a scale of 0 (no impairment) to 4 (high impairment) for a summary scale score ranging from 0–28.

Bed mobility _____
 Transferring _____
 Eating _____
 Toileting _____
 Hygiene _____
 Locomotion on unit _____
Total _____

Source: Flacker, J. M., & Kiely, D. K. (1998). A practical approach to identifying mortality-related factors in established long-term care residents. *Journal of the American Geriatrics Society*, 46, 1012–1015. Adapted with permission.

Advanced Dementia Prognostic Tool (ADEPT)

Risk Factor	Points	Example
Nursing home stay < 90 days	3.3	<input type="checkbox"/>
Age 65–69	1.0	<input type="checkbox"/>
70–74	2.0	<input type="checkbox"/>
75–79	3.0	<input type="checkbox"/>
80–84	4.0	<input checked="" type="checkbox"/>
85–89	5.0	<input type="checkbox"/>
90–94	6.0	<input type="checkbox"/>
95–99	7.0	<input type="checkbox"/>
≥100	8.0	<input type="checkbox"/>
Male	3.3	<input checked="" type="checkbox"/>
Shortness of breath	2.7	<input type="checkbox"/>
At least one pressure ulcer ≥ stage 2	2.2	<input type="checkbox"/>
Activity of daily living score = 28 ^a	2.1	<input checked="" type="checkbox"/>
Bedfast most of the day	2.1	<input type="checkbox"/>
Insufficient oral intake ^b	2.0	<input checked="" type="checkbox"/>
Bowel incontinence ^c	1.9	<input checked="" type="checkbox"/>
Body mass index < 18.5 kg/m ²		<input type="checkbox"/>
Weight loss ^d	1.6	<input type="checkbox"/>
Congestive heart failure	1.5	<input checked="" type="checkbox"/>
Total Points		14.8

^a Activities of daily living score (0–28) is the sum of scores in 7 domains of function including: bed mobility, dressing, toileting, transfer, eating, grooming, and locomotion. Each is scored on a 5-point scale (0, independent; 1, supervision; 2, limited assistance; 3, extensive assistance; and 4, total dependence). A score of 28 represents complete functional independence.

^b Insufficient oral intake; not consuming almost all liquids in previous 3 days or ≥ 25% of food uneaten at most meals.

^c Bowel incontinence occasionally; frequently or always (vs. rarely or never).

^d Recent weight loss defined as > 5% of body weight in the prior 30 days, or > 10% in the prior 180 days.

If total risk score is...	Risk estimate of death	
	within 6 months	Example
1–6.4	7%	<input type="checkbox"/>
6.5–7.9	10–11%	<input type="checkbox"/>
8.0–8.9	13–14%	<input type="checkbox"/>
9.0–9.7	14–16%	<input type="checkbox"/>
9.8–10.5	17–19%	<input type="checkbox"/>
10.6–11.5	20–23%	<input type="checkbox"/>
11.6–12.5	23–28%	<input type="checkbox"/>
12.6–14.0	28–33%	<input type="checkbox"/>
14.1–16.1	34–43%	<input checked="" type="checkbox"/>
> 16.1	49–62%	<input type="checkbox"/>

Source: Advanced Dementia Prognostic Tool (ADEPT) reproduced with permission from Mitchell, S. L., Miller, S. C., Teno, J. M., Kiely, D. K., Davis, R. B., & Shaffer, M. L. (2010). Prediction of 6-month survival of nursing home residents with advanced dementia using ADEPT vs. hospice eligibility guidelines. *Journal of the American Medical Association*, 304(17), 1929–1935. ©2010, American Medical Association. All rights reserved. Reprinted with permission.

Mini-Cog Assessment Instrument for Dementia

Another brief screen for cognitive impairment is the Mini-Cog. It takes approximately 3 minutes to administer. It has minimal language content, which reduces cultural and educational bias. The Mini-Cog combines a 3-item recall component with a Clock Drawing Test (CDT).

Administration

Note: A clock should not be within the resident's view when administering this test.

1. Make sure you have the patient's attention. Instruct the resident to listen carefully to and remember 3 unrelated words and then to repeat the words back to you, so you will know they hear the words correctly.
2. Instruct the resident to draw the face of a clock, either on a blank sheet of paper or on a sheet with the clock circle already drawn on it. After the resident puts the numbers on the clock face, ask him or her to draw the hands of the clock to read a specific time (11:10 and 8:20 are most commonly used and are more likely to elicit a meaningful result from the subject than other times). These steps can be repeated, but no additional instructions should be given. If the resident cannot complete the CDT within 3 minutes, move on to the next step.
3. Ask the resident to repeat the 3 previously presented words (see Step 1).

Scoring

Recall Score A score of 0 to 3 is given for the recall test. A point is given for each recalled word after the CDT distractor.

Clock Drawing Test Score A score of 0 to 2 is given for the CDT test. Two points are given for a normal CDT. No points are given for an abnormal CDT. For a normal CDT, all numbers must readably display the requested time.

Mini-Cog Score To obtain the mini-cog score, add the recall and CDT scores:

- 0–2 indicates positive screen for dementia.
- 3–5 indicates negative screen for dementia.

Source: From Borson, S., Scanlan, J., Brush, M., Vitallano, P., & Dokmak, A. (2000). The Mini-Cog: A cognitive 'vital signs' measure for dementia screening in multi-lingual elderly. *International Journal of Geriatric Psychiatry, 15*(11), 1021–1027.

Resources for Prognostic Tools

Anderson, F., Downing, G., Hill, J., Casorso, L., & Lerch, N. (1999). Palliative performance scale (PPS): A new tool. *Journal of Palliative Care, 12*(1), 5–11.

ePrognosis.org, a website offering interactive tools of the most accurate and useful prognostic assessments.

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Appendix J: Eden Alternative® Language for Hospice

Many long-term care and skilled nursing facilities are adapting the Eden Alternative approach to caring for their residents in a more holistic fashion that respects and honors our elders. (For more information on the Eden Alternative, visit www.EdenAlt.org.) A collaborative team of the Colorado Health Care Association Nurses Executive Council reflected on the Eden principles and created Eden language to reflect residents' stages/goals as they move toward the end of life. The language, using seasonal metaphors, is intended to help the nursing facility staff understand more concretely and in very visual terms why residents start to change as they approach the end of life (*table continues on overleaf*).

Season:	Spring	Summer	Autumn	Winter
Clinical focus	Individualized care (rehab, med adjustments)	Continues to be individualized care	Nutritional supplements, pressure reduction, symptom management, restorative programs, encouragement	Pain, anxiety, insomnia, confusion, agitation, constipation, depression, dyspnea, nausea/vomiting, activities and meals as tolerated
Psychosocial focus	Re-engagement: has interest in forming friendships, attending activities	Self-actualization	Psychosocial support, family preparation, hospice referral	Encourage conversation re: fears, guilt, anxieties, anger, meaning of life
End-of-life planning	Healthcare decision maker, CPR directive, Five Wishes, decision-making capacity	Update advance directives	Discuss levels of interventions/life-sustaining treatment, IVs, hospitalizations, feeding tubes, unnecessary testing	Comfort care orders, look at unnecessary meds; focus on relief of pain, symptoms
Descriptor	Rejuvenation	Blossoming	Journey	Threshold

Season:	Spring	Summer	Autumn	Winter
Goal of care	Curative	Curative/ Restorative	Curative/ Restorative Hospice descriptor: approaching death— early phase	Comfort/quality of life Hospice descriptor: impending death— middle phase Activity and care are dependent on resident energy level
Resident developmental stages	Fulfillment, life review, getting affairs in order, exploration, growth	Self-directed, active, engaged	Acceptance, preparation	Reflective, resolution, farewells, near-death awareness
Resident exhibits		Engaged, satisfied, weight is stable	Consumes < 25% of meals weight loss, low functional ability, less engaged Medical decline: CHF, DM, renal failure, termi- nal agitation, cancer	Increased sleepiness, less active, bed rest increases, agitation/restlessness, confusion, shortness of breath/ dyspnea, inconti- nence, pain

Appendix L: Pain and Symptom Management Protocols

Note: This document is not intended as medical advice, and should not be relied on as a substitute for consultations with qualified health professionals who are familiar with a patient's individual medical needs. The Center for Improving Value in Health Care (CIVHC) and associated authors make no warranties of any kind regarding this document, including but not limited to any warranty of accuracy, completeness, currency, reliability, merchantability, or fitness for a particular purpose, and such warranties are expressly disclaimed.

Medications

Coumadin and Monitoring Serum Levels

Indication A medication used for the treatment of pulmonary emboli, prevention and treatment of deep vein thrombosis, myocardial infarction, rheumatic heart disease with heart valve damage, and atrial arrhythmias.

The hospice registered nurse will assess the resident on an ongoing basis for possible drug interactions or drug toxicity.

If the hospice resident is on therapeutic warfarin (Coumadin), hospice may or may not be financially responsible for the medication. However, the hospice RN is responsible for monitoring safe serum levels intermittently as directed by the attending physician.

Therapeutic INR serum levels are usually 2.0–2.5 INR.

The hospice nurse must educate the resident and family on the potential side effects and safety factors with this medication.

Phenytoin Management

Indication A medication used for generalized tonic-clonic (grand mal) seizures, status epilepticus, nonepileptic seizures, or post head trauma.

Assess the resident on an ongoing basis for possible drug interaction or drug toxicity.

If the hospice resident is on therapeutic phenytoin (Dilantin), hospice may or may not be financially responsible for the medication. However, the hospice RN is responsible for monitoring safe serum levels intermittently as directed by the attending physician. Therapeutic phenytoin (Dilantin) serum levels are 10–20mg/ml.

The hospice RN must educate the resident and family on the potential side effects and safety factors with this medication.

Conditions/Symptoms

Anxiety

Indication Unpleasant emotion. Physical symptoms may be exhibited: palpitations, chest pain, dyspnea, dry mouth, dizziness, headache, sweating, unable to relax, poor concentration.

Psychological symptoms may include inability to relax, worry, fearfulness, and sense of dread.

Assess for possible causes/etiology:

- Situational anxiety
- Explore feelings/thoughts
- Ask about worries
- Medical conditions
- Uncontrolled pain
- Assess for dyspnea
- Assess for insomnia
- Assess for nausea
- Assess for distended bladder
- Drug related
- Steroids
- Neuroleptics
- Abrupt drug withdrawal
- Psychological
- Denial
- Anger
- Preexisting disorders
- Depression
- Delirium
- Existential concerns

Pharmacological interventions may include:

Medication	Dose Range	Route	Frequency
Alprazolam	0.25–2.0 mg	PO, SL, R	Q4-6 PRN
Diazepam	2–20 mg	PO, SL, R	Q8 PRN
Lorazepam	0.5–2.0 mg	PO, SL, R	Q8 PRN
Clonazepam	0.25–0.5 mg	PO, SL, R	Q8 PRN
For anxiety with major paranoia or hallucinations, consider starting:			
Haloperidol	0.5–4 mg	PO, SL, PR, SC	BID and Q4 PRN
In extreme cases consider:			
Midazolam	1m/hr	Continuous infusion with titration to comfort*	
*It is highly recommended that a physician with palliative care experience manages this medication.			

Nonpharmacological interventions may include:

- Explore fears with the resident, discuss anxiety; offer reassurance.
- Assess level of emotional functioning including past and present coping skills of the resident. Explore and support previous mechanisms used in coping and reducing anxiety.
- Encourage expression of feelings.
- Provide active listening and validate feelings.
- Provide clear instructions/information regarding resident condition, changes and disease progression to aid the resident and family in understanding and coping with condition.
- Provide psychosocial and/or spiritual support as necessary.

Constipation

Indication Resident experiences a decrease in the frequency, volume, or ease of stool passage. Symptoms may include irregular bowel movements, diarrhea, nausea, vomiting, discomfort, and obstruction.

Prevention is first and foremost. Initiating a bowel program with an opioid regimen is imperative.

Assess for possible causes/etiology:

- Decreased nutritional intake (low fiber diet/decreased amounts)
- Dehydration
- Inactivity/immobility
- Inadequate doses of laxatives
- Hypercalcemia, hypokalemia
- Side effects of medications
- Autonomic neuropathy associated with advanced cancer
- Pain medicines (opioids)
- Anticholinergics
- Diuretics
- Chemotherapy
- Abdominal tumors

Pharmacological interventions may include, initially, bowel stimulant (senna) and stool softener (docusate sodium).

Medication	Dose Range	Route	Frequency
Senna/docusate sodium	1–2 tabs	PO	BID-QID
Lactulose	15–30 cc	PO	QD-TID
Bisacodyl	suppository	rectal	May repeat × 1
Milk of magnesia	30–60 cc	PO	May repeat × 1
Magnesium citrate	5–10 ml	PO	per orders
Fleets enema/cleansing enemas		rectal	per orders

Bowel program A laxative and/or stool softener combination should be used daily (suggest Senekot-S or Colace).

Increase amount of laxative/stool softener as pain medication dosage increases to maintain adequate bowel activity.

If no bowel movement in 24–48 hours, consider:

- Bisacodyl or glycerin suppository rectally; may repeat one time. Or milk of magnesia 30–60 cc PRN; may repeat one time.

If still no bowel movement:

- Fleets enema or cleansing enema may be given or magnesium citrate 5–10 ml PO.
- Check and remove any stool that resident is unable to evacuate independently.

Nonpharmacological interventions may include:

- Increase fluids as able
- Increase activity as able
- Have resident use commode versus bedpan
- Prop feet on footstool if using commode to aid abdominal muscles

Pharmacological interventions may include:

Type	Name	Dose	Onset	Mechanism of Action
Bulk	Methylcellulose Psyllium Polycarbophil	4–6 gm/day	12–72 hours	Causes stool to retain water (usually the safest but often not adequate with opioids)
Lubricant	Mineral oil	15–30 ml/PO	6–8 hours	Softens stool, slows colonic absorption of water from feces
Saline	Epsom salts Magnesium citrate Fleet phospho-soda	10–15 gm/300 ml water 240 ml PRN 20–30 ml/glass water	30 min.–3 hours	Causes water to be attracted/retained in colon, increases intraluminal pressure (may cause fluid/electrolyte imbalance)

Type	Name	Dose	Onset	Mechanism of Action
Osmotic	Lactulose	15–30 ml	24–48 hours	Metabolized by gut bacteria, acids that osmotically draw water to colon
	Glycerine supplement	1–2 supp. PRN		
	Sorbitol 70%	15–60 ml Qd		
	Magnesium citrate	½ to 1 bottle		
Softener	Docusate	1–5 caps/daily	24–72 hours	Acts as a detergent by drawing fat and water to stool—not good as a single agent with opioids. Use docusate in residents with fluid/water retention.
	Castor oil	30–60 mi		
Large bowel stimulants	Senna	Up to 8/day	6–10 hours 15 min.–hour	Direct stimulating action on intestinal mucosa. Do not give within 1 hour of antacids or milk.
	Bisacodyl (suppository, pills)	1 suppository 1–3 tabs		
	Milk of magnesia	15–30cc/QD		
Miscellaneous/ Prokinetic	Metoclopramide	10 mg QAC and HS		Prokinetic works in stomach and small intestine, useful in automatic dysfunction
Enemas	Small volume: Fleets (Phospho-soda & oil retention)	May be used 1–3x/week. Use before large-volume enemas.		Stimulates lower bowel, softens hard stool.
	Milk & molasses	Softens hard, impacted stool.		Sugar is an irritant to bowel lining; sugar and milk make gas that distends bowel, causes pressure, peristalsis, and evacuation.
	Large volume: Tap water Soap suds Saline	Warming solution helps; mineral oil may be added to any enema to soften stool. Can be irritating.		Induces peristalsis Stimulates lower bowel

Bowel management is a significant comfort issue. While the table is a resource, individual needs and preferences must be addressed periodically by the nursing staff. Education regarding bowel management and the disease process must also be addressed.

Pain

Indication The resident complains of pain or discomfort. Objective observations are restlessness, grimacing, refusal to move, diaphoresis, and tachycardia. These signs are most evident in residents with acute pain. Many residents with chronic pain may not demonstrate any physical signs. There are four components that are the hallmark features of “total pain”: physical, social, emotional, and spiritual.

Assess for possible causes/etiology.

Characterize the pain by location, intensity, and etiology (e.g., recent events, suspected causes of the pain). Essential to initial assessment are a detailed history, psychological assessment, and physical examination.

The nurse performs a complete pain assessment using a pain scale and pain assessment form describing the resident’s pain including location, intensity, aggravating and relieving factors, and cognitive response to pain.

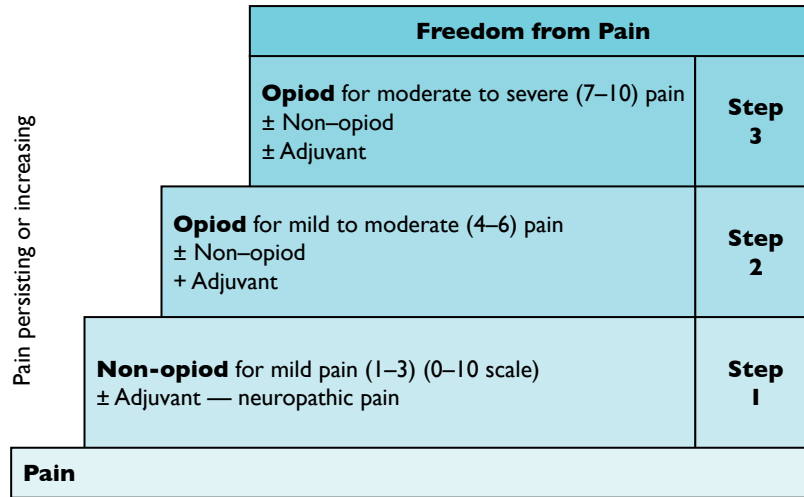
Support and reassure the resident and the resident’s family that he or she will be kept comfortable.

Most residents can be comfortable with oral medications until the last days or hours of life. Consider all routes of administration appropriate for the resident’s needs: oral, sublingual, rectal, topical, subcutaneous, or transdermal.

Referrals may be made to other team members to assess and treat for other types of pain (social, emotional, spiritual, etc.).

A physician may order pharmacological intervention based on the WHO model illustrated in Figure 4.

Figure 4. WHO Analgesic Ladder



Mild pain (PRN is acceptable if pain is intermittent, otherwise around the clock is more effective.)

Medication	Dose Range	Route	Frequency
Acetaminophen	325–650 mg, 1–2 tabs	PO	Q 4h (ceiling 3,000 mg/D)
Ibuprofen	200–800 mg, 1–2 tabs	PO	Q 6–8 H
Naprosyn	500 mg, 125 mg/5cc	PO or suspension	Q 12 H

Moderate Pain (Medication should be scheduled in order to avoid under-treatment of pain.)

Medication	Dose Range	Route	Frequency
Oxycodone/APAP	5–10 mg	PO	Q 3 H
Hydrocodone/APAP	5–10 mg	PO	1–2 tabs not to exceed 200 mg APAP/day
APAP with Codeine	1–2 tabs	PO	Q 4 H

Note: Opioid medications in combination with APAP have a ceiling dose of 3,000 mg of APAP/day.

Severe Pain (Schedule doses with appropriate breakthrough medications; long-acting preparations should be initiated.)

Medication	Dose Range	Route	Frequency
Oxycodone	5–30 mg	PO	Q 3 H
Morphine sulfate	5–20 mg	PO	Q 3–4 H
Morphine sulfate Oxycodone	20 mg/ml	PO	Q 1 H
Hydromorphone	2–8 mg	PO	Q 4 H PRN

Sustained-release opioids for use with severe pain:

Medication	Dose Range	Route	Frequency
Morphine sulfate	15, 30, 60, 100, or 200 mg tabs	PO, rectal	Q 8–12 H
Fentanyl	25, 50, 75, 100 mcg	patch	Q 72 H
Methadone	Variable dosing regimens	PO, SL, rectal, subQ	Recommended that palliative care or hospice physician manages methadone
Oxycodone	10, 15, 20, 30, 40, 60, 80 mg tabs	PO, rectal	Q 8–12 H

If the resident has uncontrolled pain or an inability to swallow, convert to SQ/IV continuous opioid infusion. (It is highly recommended that a physician with palliative care experience manages opioid infusion.)

Points to remember:

- Pain medications are more effective when given on a routine, around-the-clock basis.
- As-needed “rescue doses” for breakthrough pain are to be ordered with all long-acting opioids.
- Calculate the 24-hour opioid doses taken.
- The breakthrough dose should be approximately 10–20 percent of the 24-hour baseline dose.
- Breakthrough doses can be given as frequently as every 1 hour.
- If the resident requires more than 2–3 breakthrough doses within 24 hours, consider increasing the long-acting (primary) dose.
- There is no upper limit to opioid dosage. The correct dose is the one that relieves the pain appropriate to the resident’s goals.

- Constipation can be anticipated and should be treated aggressively when pain medications are started. A bowel management program must be initiated when an opioid is started.
- Sedation may occur when pain meds are introduced or the dosage increased.
- Residents will usually develop a tolerance to the sedation and be more alert in about 48–72 hours. Explain and prepare the resident and family for this.
- Use an equianalgesic table when
 - Doing an opioid rotation for correct dosing;
 - Reducing the dose by 1/3 when changing opioids for incomplete cross tolerance; or
 - Changing from an oral route to parenteral.
 - Monitor and frequently assess for opioid-induced neurotoxicity.

Nonpharmacological interventions may include:

- Heat: warm packs/heating pads— 15 minutes (May not be allowed in some facilities.)
- Cold: ice packs— 15 minutes
- Referral to complimentary/alternative therapies
- Exercise/range of motion
- Repositioning
- Relaxation and imagery

Pruritus

Indication Resident complains of itching skin.

Assess for possible causes/etiology:

- Eczema or allergy history
- Medication reactions
- Fungal infections
- Cholestasis (due to bile-salt retention)
- Infections

Pharmacological interventions may include:

Medication	Dose Range	Route	Frequency
Hydroxyzine	10–25 mg	PO/SQ	Q 4 H PRN
Cholestyramine	4 grams	PO	TID
Chlorpromazine	25–50 mg	PO/IV	Q 6 H
Dexamethasone	2–8 mg	PO/SQ	BID
Diazepam	2–10 mg	PO	TID

Nonpharmacological interventions may include:

- Avoid heat.
- Treat dry skin.
- Apply calamine and other topical medications such as benzocaine spray, topical steroid, or lidocaine gel.

Nausea/Vomiting

Indication The resident complains of nausea and/or vomiting.

Assess for possible causes/etiology:

- Cortical
 - Increased intracranial pressure
 - Uncontrolled pain
 - Anxiety
 - Central nervous system tumor
- Vestibular
 - Motion sickness
 - Middle ear infection
 - Meniere's disease
- Chemoreceptor Trigger Zone (CTZ) (most common causes of nausea and vomiting are mediated by the CTZ)
 - Drugs: chemotherapy, opioids, and antibiotics
 - Metabolic/electrolyte disturbances: renal/liver failure, hyponatremia, hypercalcemia
- Gastrointestinal
 - Gastritis
 - Tumors
 - Obstruction
 - Constipation

Take a history of the symptoms.

Assess for a pattern of nausea/vomiting (e.g., after certain meals, drugs, upon movement, in certain situations, related to certain smells, etc.).

Ask about other symptoms related to nausea/vomiting (e.g., constipation, dysuria, epigastric pain, pain with swallowing, thirst, etc.).

Temporal association with initiation of a new medication regimen.

Pharmacological intervention (directed by etiology of the nausea and vomiting) may include:

Cortical

Medication	Dose Range	Route	Frequency
Dexamethasone	2–8 mg	PO/SQ	QD–Q8H
Anxiolytics (refer to anxiety section)			
Opioid pain management			

Vestibular

Medication	Dose Range	Route	Frequency
Consider antibiotic			
Transdermal scopolamine patch			
Meclizine	25 mg	PO	TID

Chemoreceptor Trigger Zone (CTZ) (Review medication and consider stopping offending agent.)

Medication	Dose Range	Route	Frequency
Haloperidol	5 mg	PO/SQ	Q 4 H PRN
Prochlorperazine	25 mg	PO, IV, rectal	Q 4 H PRN
Ondansetron (if nausea and vomiting are secondary to chemotherapy)	5–10 mg	IV/O	Q 6 H PRN
Hydration/correction of electrolyte abnormality			

Gastrointestinal

Medication	Dose Range	Route	Frequency
Prokinetic agent: Metoclopramide	5–10 mg	PO/ SQ	QAC and QHS
Haloperidol	5 mg	PO/SQ	Q 4 H PRN
Hydroxyzine	10–25 mg		TID
H2 blockers			
Proton pump inhibitors			
Treat constipation			

Nonpharmacological interventions may include:

- Active listening and reassurance
- Discuss resident fears/anxiety
- Serve cold foods at room temperature
- Clear liquid diet
- Consider complementary therapies

Wound Care

- Ensure consistent wound care that will help to
 - Provide comfort and pain control;
 - Prevent or limit progression of a wound;
 - Provide drainage containment;
 - Limit infection and control odor;
 - Enable hospice to coordinate the plan of care with the facility regarding wound protocols and products used.

Procedure

- Wash hands before and after every dressing change and anytime gloves are removed or changed.
- Lay out all necessary supplies on a clean surface (e.g., a clean underpad or Chux), including a disposal bag, prior to removing the old dressing.
- Premedicate the resident if indicated in order to reduce pain and/or anxiety.
- Remove the old dressing, soaking off any material stuck to the wound with CarraKlenz or saline spray.

- At every dressing change done by hospice staff, document type, size, depth, and appearance of the wound as well as the amount and type of exudate and presence of odor and pain. If SNF staff is regularly attending to the resident's dressing changes, the hospice staff will assess the wound at least once per week and record the information.

Definitions of Stages

- Soft tissue injury: Purple/maroon in color, localized under intact skin. Can give appearance of blood-filled blister. Etiology is secondary to underlying soft tissue injury/damage.
- Stage I: Nonblanchable erythema of intact skin.
- Stage II: Partial-thickness loss of dermis, shallow open ulcer with erythematous wound bed. No sloughing noted.
- Stage III: Full-thickness tissue loss, subcutaneous fat visible, may have tunneling and undermining.
- Stage IV: Full-thickness tissue loss, muscle, tendon, bone exposed, may have tunneling and undermining.
- Unstageable: Thick/brown/black tissue slough of devitalized necrotic tissue overlying an ulcer; debridement is imperative

Stage I and Stage II decubitus ulcers: Clean the area with wound-cleansing spray and pat dry with clean gauze. Apply foam dressing or transparent film to the area and leave in place for 5–7 days. Attempt to reduce or eliminate pressure to area.

Stage III decubitus ulcers with no infection present and minimal exudate: Clean the area with wound-cleansing spray and gently pat dry with clean gauze. Cover the wound with foam dressing and leave in place for 5–7 days.

Stage III and Stage IV decubitus ulcers with slough, necrosis, possible infection, and/or moderate to heavy exudate: Clean the area with wound-cleansing spray and pat dry with clean gauze. If slough is present-use the stream setting on the nozzle to get adequate pressure to remove as much slough as possible without causing pain to the resident. Cut a debridement dressing sheet to fit the area of affected tissue (debridement dressing should not come in contact with healthy tissue) and apply to the wound. Cover the entire wound area with a nonadherent dressing (bordered gauze/gauze with paper tape, or foam dressing if skin is very fragile). If the wound is highly exudative but not infected or sloughing, gently pack the wound with a sheet of an alginate dressing to absorb drainage and cover the wound with a nonadherent dressing. Change the dressing and assess wound daily.

Unstageable ulcers with no exudate on lower extremities: Clean the area with wound-cleansing spray and pat dry with clean gauze. Make sure the area is entirely dry; cover with foam dressing and leave in place for 7–10 days. Attempt to eliminate pressure on the area.

Unstageable ulcers with no exudate on upper extremities or trunk: Clean the area with wound-cleansing spray and pat dry with clean gauze. If debriding the wound is warranted, apply a thin layer of hydrogel to the eschar (dead tissue) and cover with a nonadherent dressing of choice. Change the dressing and assess the wound daily. As the eschar pulls off the wound bed, treatment will need to change as appropriate.

Skin tears: Clean the area with wound-cleansing spray and pat dry with clean gauze. If the skin flap is viable, reposition the flap to the approximate wound edges with a moistened applicator. Cover the wound with Steri-Strips and dress with a nonadherent dressing. Change the outer dressing PRN and leave the Steri-Strips in place up to 10 days to avoid disturbing the wound bed. When removing or changing the Steri-Strip, pull it away from the attachment side of the flap first to avoid putting further stress on the wound. If the skin flap is dead or dry, gently remove it with clean scissors, then dress the wound with a foam dressing and leave in place for 5–7 days.

Surgical wounds and incisions: Treat as per physician’s/surgeon’s orders. Staple removers and suture removal kits are available and may be used per physician’s orders.

Bullae/blisters: Clean the area with wound-cleansing spray and pat dry with clean gauze. Cover the blistered area with foam dressing and secure with rolled gauze. Change the dressing every 3–5 days if exudate is minimal, every 2–3 days if more drainage is present.

Fungating tumor: Clean the area with wound-cleansing spray and pat dry with clean gauze. Cover for 3 days or PRN. If the wound bed has a significant odor or purulent drainage, use a silver foam dressing to cover the wound area and adhere to dry, intact skin with paper tape or a porous dressing base if the skin is extremely fragile or irritated.

Secretion Accumulation

Indication Increased respiratory secretions; the resident is too weak to cough up secretions; “death rattle” heard at the end phase of terminal illness.

Assess for possible causes/etiology.

Assess for congestion.

Assess for weak, ineffective cough.

Assess for fluid overload.

The key to controlling secretions is to initiate treatment in a timely fashion for maximal benefit.

Pharmacological interventions may include:

Medication	Dose Range	Route	Frequency
Hyoscyamine	0.125–0.25 mg	PO/SL	Q 4 H
Scopolamine transdermal patch		topical	Q 3 D
Atropine 1% ophthalmic drops	1–3 drops	SL	Q 4 H
Glycopyrrolate	0.2–0.6 mg	PO/SQ	TID

Nonpharmacological interventions may include:

- Reposition for comfort
- Keep head of bed elevated
- Reassure family, keep resident comfortable
- Frequent, excellent mouth care
- Oral suctioning only to help with pooled secretions, no deep suctioning
- Decrease IV fluid, tube feedings

Seizures

Indication Observable involuntary contractions resulting from abnormal cerebral functioning. Partial activity may only involve one body part.

Assess for possible causes/etiology:

- Assess seizure history
- Evaluate compliance with anticonvulsant medications
- Evaluate Dilantin level (if appropriate)
- Cerebral tumors

Pharmacological interventions may include:

Medication	Dose Range	Route	Frequency
Diazepam	10 mg	rectal	Q 5–15 M until seizure resolved (max dose 80 mg/8 H)
Lorazepam	2–4 mg	IV, SL, SQ	Q10–15 M (max dose 8 mg)
Phenobarbital	120 mg	SQ/IV	Daily in divided doses. Load 300–800 mg then 120 mg Q 20 M until controlled (max dose 1,200 mg day)
Midazolam	5 mg	Bolus and start basal rate at 1 mg/H via CADD pump titrate as needed	

Nonpharmacological interventions may include:

- Reassure resident/family
- Protect resident from harm

Diarrhea**Indication** Frequent or fluid bowel movements.

Assess for possible causes/etiology:

- Fecal impaction/incontinence
- Obstruction/fecal impaction
- Overuse of laxatives
- Radiation colitis
- Medication side effects
- Infections
- Antibiotics, antacids
- Direct treatment to underlining etiology

Pharmacological interventions may include:

Medication	Dose Range	Route	Frequency
Bismuth subsalicylate	60–120 ml	PO	After each loose stool
Diphenoxylate & Atropine	5 mg	PO	1–2 tabs QID
Loperamide	1–2 tabs	PO	BID–QID
<i>For Radiation Colitis:</i>			
ASA	325 mg	Q D	
Cholestyramine	4 mg	TID	
Bulk-forming agents	4–6 grams	PO	daily

Nonpharmacological interventions may include:

- Frequent perineal care
- Protect skin with a barrier cream or a protective skin barrier
- Adjust diet as necessary

Hiccups**Indication** Spasms of the diaphragm.

Assess for possible causes/etiology:

- Gastric distention
- GERD
- Anxiety
- Direct external pressure on phrenic/vagus nerve (e.g., tumor)
- Following extubation

Pharmacological interventions may include:

Medication	Dose Range	Route	Frequency
Metoclopramide	5–10 mg	PO	QAC and QHS
Chlorpromazine	25–50 mg	PO/PR	Q 8 H PRN
Haloperidol	1 mg	PO	Q 4 H PRN
Baclofen	5–10 mg	PO	Q 8 H PRN
Gabapentin	400 mg	PO	TID
H2 blocker	Dependent on specific medication	PO	BID
Proton pump inhibitor	Dependent on specific medication	PO	daily

Nonpharmacological interventions may include:

- Breathing in and out of a paper bag sometimes causes the hiccups to cease.
- Holding one’s breath or drinking water slowly may alleviate hiccups.
- Gargling
- Pineapple juice, lemon wedges with bitters, sugar, honey with vinegar
- Iced water, ice chips
- Gentle massage of neck (to calm the phrenic nerve)

Dyspnea

Indication Dyspnea is a subjective sensation described as an “uncomfortable awareness of breathing.”

Assess for possible causes/etiology (include characteristics of dyspnea, severity, prior treatments, lung assessments, etc.):

- Assess for dyspnea related to cancer/debility
- Anemia
- Pleural effusion
- Lung obstruction due to tumor
- Abdominal distention
- Pneumonia
- Cachexia–anorexia syndrome
- Anxiety
- Excess secretions
- Assess for dyspnea related to treatment
- Radiation-induced fibrosis
- Chemotherapy
- Assess for dyspnea related to disease processes
- COPD
- Asthma
- CHF/pulmonary edema
- Acidosis
- ALS and neuromuscular diseases

Opioids are the mainstay of treatment. If the resident is new to opioid treatment, start low, reassess, and titrate slowly to comfort.

Pharmacological interventions may include:

Medication	Dose Range	Route	Frequency
Morphine	2.5–5 mg to start	PO, SL	Q 2–4 H
Anticholinergics (to decrease secretions)	See secretion accumulation sections		
Anxiolytics (if anxiety is present)	0.5–1.0 g	PO, SL, PR	Q 4–6 ATC or PRN
Bronchodilators (if wheezing is present) COPD/Asthma/Pneumonia	MDI or nebulizers	inhalation	Q 4–6 PRN
Oxygen if tolerated and providing relief	Titrate oxygen saturation to > 88%		

Refractory Dyspnea

Medication	Dose Range	Route	Frequency
Trial of dexamethasone	2–4 mg	PO/SQ	BID
Opioid continuous infusion via CADD to be initiated and managed by palliative care or hospice physician			
Midazolam	5 mg bolus with 1 mg/H and titrate		
Diuretics (to reduce vascular congestion) using furosemide, 20–80 mg; PO, SQ; frequency to be determined by response achieved			
Steroids (to reduce airway obstruction) using decadron; 2–16 mg; PO or SQ; daily			
Oxygen (if PO ₂ levels are low); titrate oxygen saturation to > 88%			

Nonpharmacological interventions may include:

- Fans
- Cool cloth on forehead
- Upright position
- Pursed lip breathing
- Massage or other complementary therapies
- Listening/reassurance
- Humidify air

Insomnia

Indication Inability to fall asleep and stay asleep.

Assess for possible causes/etiology:

- Resident’s fears/anxiety
- Pain or discomfort
- Depression
- Late dosing of diuretics or steroids
- Spiritual distress
- Confusion
- Restlessness
- Previous sleep patterns

Pharmacological interventions may include:

Medications	Dose Range	Route	Frequency
Temazepam	15–30 mg	PO	QHS
Trazodone	25–50 mg	PO	QHS
Lorazepam	0.5–1.0 mg	PO	QHS
Clonazepam	0.125–2 mg	PO	QHS

Nonpharmacological interventions may include:

- Counseling by social worker, bereavement coordinator, or chaplain
- Make bedtime the same time every night
- Light snack or warm milk at bedtime
- Encourage reduction of caffeine prior to bedtime

Hyperactive Acute Delirium (Terminal Restlessness)

Indication Inability to rest (distress, suffering, frustration) is a common syndrome occurring in residents during their last days of life. Delirium may go unrecognized and be seen as restlessness. Delirium may be reversible and treatment is indicated. Common symptoms include:

- Frequent, nonpurposeful motor activity, muscle twitching/jerking
- Fluctuating levels of consciousness, cognitive changes over short period of time
- Inability to relax or concentrate
- Inability to sleep
- Visual hallucinations

Assess for possible causes/etiology:

- Pain
- Hypercalcemia
- Constipation/impaction
- Hallucinations/delusions
- Dyspnea/hypoxia
- Unfinished business/existential suffering
- Urinary retention
- Spiritual distress
- Side effects of medications
- Infection
- Rule out opioid-induced neurotoxicity

First-line therapy for pharmacological therapy is:

Medication	Dose Range	Route	Frequency
Haloperidol*	0.5–5 mg	PO	Q 3–4 H PRN
*Count total number of doses given in 24 hours and then give twice daily for maintenance with a half-maintenance dose used as needed every 3 hours. Depending on severity, may need midazolam infusion, managed by a palliative care or hospice physician.			

Nonpharmacological interventions may include:

- Therapeutic listening/support/counseling
- Provide opportunities for resident/family to express worries/concerns
- Identify crises and structure interventions
- Provide frequent reassurance
- Interdisciplinary team involvement: spiritual and social support
- Assess environmental factors
- Complementary therapies
- Allow family rest breaks, volunteer or staff sit with resident

Anorexia/Cachexia

Indication Significant decrease in appetite with subsequent decrease in oral intake, resulting in inability to maintain appropriate weight. There is no evidence to support that parenteral nutrition increases quality of life or life expectancy.

Assess for possible causes/etiology:

- Natural progression of underlying disease process
- Constipation
- Nausea
- Vomiting
- Pain
- Depression

Treat the etiology if possible.

Pharmacological interventions may include:

Medication	Dose Range	Route	Frequency
Trial of dexamethasone	4–10 mg	PO/SQ	QD
Megestrol acetate	160 mg	QD	
Dronabinol/Medical marijuana			

Nonpharmacological interventions may include:

- Education and reassurance to resident and family
- Parenteral nutrition shows no evidence of increase in quality of life or increase in life expectancy

Appendix M: References for Symptom Management Guidelines

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Appendix N: Face-to-Face Visits

As of January 1, 2011, a new rule from the Centers for Medicare & Medicaid Services is in place stating that face-to-face visits must occur by a hospice provider (physician or advanced practice nurse [APN]) in order for a patient to be certified and/or recertified to receive the hospice benefit.

For patients already enrolled in hospice in their third and subsequent benefit periods, a hospice physician or nurse practitioner (employed by the hospice) must complete a face-to-face encounter. An assessment is made at this visit as to whether or not the patient should remain in hospice.

When a patient is admitted, the Medicare common working file is accessed to see if prior hospice benefits were received. If the patient is beginning the third or subsequent benefit period, a hospice physician or APN is required to complete a face-to-face visit prior to the admission.

Appendix O: Resources for Death and Dying, Grief and Loss Activities

Children’s Books About Death and Dying

Bridge to Terabithia by Katherine Paterson
(Ages 13 and up)

Two best friends in the 5th grade build a magical kingdom in the woods. One day, a terrible tragedy occurs and one child comes to finally understand the strength and courage given to him by the other.

The Fall of Freddie the Leaf by Leo Buscaglia
(Ages 5–9)

A story and description of the seasons of life and death through nature and a leaf named Freddie.

Gentle Willow: A Story for Children about Dying by Joyce C. Mills
(Ages 4–8)

A story of a tree and her friends in the forest—it addresses feelings of sadness, love, disbelief, and anger and provides children with a way to view death and dying.

The Grieving Teen: A Guide for Teenagers and Their Friends by Helen Fitzgerald
(Young adult)

Discusses the specific issues of a grieving teen. Written for teens, but insightful for adults.
www.HopingSkillsCompany.com

Healing Your Grieving Heart for Kids: 100 Practical Ideas by Alan D. Wolfelt
(Ages 6–12)

One hundred ideas to help children express their grief.

Healing Your Grieving Heart for Teens: 100 Practical Ideas by Alan D. Wolfelt
(Ages 13 and up)

One hundred ideas to help teens express their grief.

I Miss You: A First Look at Death by Pat Thomas
(Ages 4–8)

A picture book that presents the concept of death in a simple and realistic way for young children.

Lifetimes: The Beautiful Way to Explain Death to Children by Bryan Mellonie and Robert Ingpen
(Ages 5–10)

A story about life and death using nature, animals, and people discussing beginnings, endings, and living in between.

The Next Place by Warren Hanson
(Ages 4 and up)

A story of “the next place,” a place of light and hope where earthly hurt is left behind in a celebration of life. Death is presented in this story in a nonreligious way.

Sad Isn't Bad: A Good-Grief Guidebook for Kids Dealing with Loss by Michaelene Mundy
(Ages 4–8)

Children learn about coping with loss.

Say Goodnight, Gracie by Julie Reece Deaver
(Ages 13 and up)

A chapter book about teen best friends who are always together until one friend dies and the other must learn to grieve and cope with this loss.

Tear Soup: A Recipe for Healing After Loss by Pat Schweibert, Chuck DeKlyen, and Taylor Bills
(Ages 9–12)

The ongoing journey of healing and grief presented through a grandmother's preparation of tear soup. Additional resources are provided at the end of the book for support and coping for different "cooks" (if the child is the cook, if there are two cooks, if a friend is making tear soup).

Teenagers Talk About Grief by June Cerza Kolf
(Ages 13 and up)

Teens talk about the many difficult emotions they faced when coping with the death of a loved one.

The Tenth Good Thing About Barney by Judith Viorst
(Ages 5–9)

A boy learns to understand death as he remembers all the good things about his cat, Barney.

What Does That Mean? A Dictionary of Death, Dying and Grief Terms for Grieving Children and Those Who Love Them by Harold Ivan Smith and Joy Johnson
(Ages 6 and up)

A dictionary guide for talking with children about topics related to death and dying.

What on Earth Do You Do When Someone Dies? by Trevor Romain
(Ages 8–12)

A collection of questions and answers children often ask as well as suggestions for helping them cope with death.

What's Heaven? by Maria Shriver
(Ages 5–9)

A daughter learns about death and heaven when her great-grandmother dies.

When a Friend Dies: A Book for Teens About Grieving and Healing by Marilyn E. Gootman
(Young adult)

A simple book for helping teens cope with the sadness and begin to heal with the loss of a friend.

When Dinosaurs Die: A Guide to Understanding Death by Laurie Krasny Brown and Marc Brown
(Ages 4–10)

A guide to helping children understand what death means and how to cope with feelings.

Where Do People Go When They Die? by Mindy Avra Portnoy
(Ages 5 and up)

In this book, children ask various adults and themselves, “Where do people go when they die?” Each response is different and reflects various beliefs about death. Suggestions on how to help explain death to children are also included.

Activity Books on Death and Dying

Fire In My Heart, Ice In My Veins by Enid Samuel-Traisman
(Ages 13 and up)

A Centering Corporation resource for teenagers experiencing a loss, this book teaches how to journal about themselves and the person who died as well as feelings and coping.

The Grief Bubble: Helping Kids Explore and Understand Grief by Kerry DeBay
(Ages 6–10)

An activity book for writing and drawing on the topics of “normal” life before the death of someone special, feelings, what is different after the death, grief, and the “new normal.”

Help Me Say Goodbye: Activities for Helping Kids Cope When a Special Person Dies by Janis Silverman
(Ages 4–10)

An art book encouraging children to express their feelings in words or pictures. Topics include what to say or do, feelings, and remembering the special friend or relative.

How I Feel: A Coloring Book for Grieving Children by Alan D. Wolfelt
(Ages 3–8)

A coloring book presenting many feelings grieving children experience, this guide can be read with the child to help share feelings.

Remember... A Child Remembers by Enid Samuel-Traisman
(Ages 8–12)

A Centering Corporation resource, this write-in memory book for bereaved children helps them cope with loss and continue memories. The pages include writing about the person’s life and death, a good-bye letter, a story about us, pages to draw the service, being angry, and being happy.

Books for Parents

My Memory Maker Set by Katherine Dorn Zotovich

A child’s workbook to help them work through the loss associated with long-term illness. A parent companion journal and resource guide is included.

Safe Passage: Words to Help the Grieving Hold Fast and Let Go by Molly Fumial
A book of meditations on grieving.

The Worst Loss: How Families Heal From the Death of a Child by Barbara D. Rosof
A book on parental bereavement.

The Death of a Grandparent

When Your Grandparent Dies: A Child's Guide to Good Grief by Victoria Ryan
(Ages 5–9)

This guide spans the period from the terminal illness of a grandfather to the grandfather's death and discusses saying goodbye, it's okay to cry, what dying means, heaven, feelings, it's not your fault, talking, and funerals (includes references to heaven and God). (This book may be more helpful to read in sections with your child than at one time).

The Death of a Parent

Mama's Going to Heaven Soon by Kathe Martin Copeland
(Ages 5–9)

This story about the upcoming death of a mother who is terminally ill teaches children how to talk about feelings related to understanding the terminal illness, death, and what will happen when the mother dies (includes references to heaven).

Helpful Websites

National Cancer Institute
1-800-4-CANCER
www.Cancer.gov

When Someone in Your Family Has Cancer

This 27-page booklet provides explanations for diagnosis, surgery, chemotherapy, radiation, and side effects. It discusses feelings, reviews common questions and answers, and includes a glossary.

Sympathy Gifts and Grief Resource Center
1-888-815-HOPE

ALS March of Faces
http://www.ALS.ca/_march/

The American Cancer Society
1-800-227-2345
<http://www.Cancer.org>

Cancer Care
1-800-813-HOPE (4673)
<http://www.CancerCare.org>

The Cancer Information Service
1-800-422-6237
<http://www.NCI.nih.gov>

Hospice Net
<http://www.HospiceNet.org>

KidsCope
<http://www.KidsCope.org>

Kids Konnected
1-800-899-2866
<http://www.KidsKonnected.org>

The Leukemia & Lymphoma Society
1-800-955-4572
<http://www.Leukemia.org>

National Organization of Rare Disorders
<http://www.RareDiseases.org>

Appendix P: Licensed Hospice Providers in Colorado

This information was obtained using the hospice facilities listing of the Colorado Department of Public Health and Environment and by telephone and Internet research conducted by the authors of this document. It reflects current information as of January, 2012. Please refer to <http://www.cdphe.state.co.us/hf/index.html> for the most up-to-date information.

Provider Contact Information	Counties Served	Residence/ Beds	Bereavement Services
AccentCare Home Health of Mountain Valley 1180 Main St., Ste. 9 Windsor, CO 80550 Telephone: (970) 346-9700 Fax: (970) 346-9710 Web: www.AccentCare.com Administrator/Contact: Jill Elliott	Adams Boulder Broomfield Larimer	No	Support for individuals/families/caregivers up to 13 months at no charge
Affinity Hospice of Life 2121 S. Blackhawk St., Ste. 110 Aurora, CO 80014 Telephone: (303) 745-3197 Fax: (303) 750-4573 Web: www.AffinityHospice.com Administrator/Contact: Stephanie Silvia	Arapahoe Boulder Broomfield Denver Douglas Jefferson	No	Support for individuals/families/caregivers up to 13 months at no charge Mailings/phone support
Agape Hospice Services 6041 S. Syracuse Way, #220 Greenwood Village, CO 80111 Telephone: (720) 482-1988 Fax: (720) 482-1990 Toll Free: (877) 771-1231 Web: www.Agape-Healthcare.com Administrator/Contact: Larry Woods	Adams Arapahoe Boulder Denver Douglas Elbert Jefferson Weld	No	Up to 6 one-on-one sessions for patients and families Support groups/phone support/mailings/psycho ed/memorials; no charge

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Alpine Home Health and Hospice</p> <p>Grand Junction 2764 Compass Dr., Ste. 110 Grand Junction, CO 81506 Telephone: (970) 245-0188 Fax: (970) 245-0288 Administrator/Contact: Jan Pasquale, RN</p> <p>Glenwood Springs 1316 Grand Ave. Glenwood Springs, CO 81601 Telephone: (970) 245-0188 Fax: (970) 245-0288 Administrator/Contact: Jan Pasquale, RN</p> <p>Montrose 924 Spring Creek Rd., Unit C Montrose, CO 81403 Telephone: (970) 245-0188 Fax: (970) 245-0288 Administrator/Contact: Jan Pasquale</p> <p>Mail C/O: Alpine Home Health and Hospice 2764 Compass Dr., Ste. 110 Grand Junction, CO 81506</p>	<p>Delta Garfield Mesa Montrose San Miguel</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p> <p>Offers community support groups at no charge</p>
<p>Alpine Hospice 691 County Road 233, #A4 Durango, CO 81301 Telephone: (970) 247-0430 Fax: (970) 247-0679 Administrator/Contact: Pamela Henkels</p>	<p>Archuleta Dolores La Plata Montezuma San Juan San Miguel</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p> <p>Grief counseling and grief recovery counseling by a trained spiritual worker and psychologist</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Angel of Shavano Hospice, an Amedisys Partner 8044 W. Hwy. 50, Ste. 202 Salida, CO 81201 Telephone: (719) 539-2467 Fax: (719) 539-5056 Web: www.Amedisys.com Administrator/Contact: Judith McDonough</p> <p>Mail C/O: Angel of Shavano Hospice 8044 W. Hwy. 50, Ste. 202 Salida, CO 81201</p>	<p>Chaffee Custer Fremont Lake</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Arkansas Valley Hospice Inc. 118 W. 4th St. La Junta, CO 81050 Telephone: (719) 384-8827 Fax: (719) 384-2045 E-mail: A.V.Hospice@ArkValleyHospice.org Web: www.ArkValleyHospice.org Administrator/Contact: Jill Rogge</p> <p>Mail C/O: Arkansas Valley Hospice, Inc. PO Box 408 La Junta, CO 81050</p>	<p>Bent Crowley Otero</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p> <p>Mailings/phone support</p> <p>Chaplain services</p>
<p>Baca County Hospice—Southeast Colorado Hospital District 200 E. 10th Ave. Springfield, CO 81073 Telephone: (719) 523-4057 Fax: (719) 523-4575 E-mail: sturner@SECHosp.org Web: www.SECHosp.org/hospice Administrator/Contact: Nyla Hartley</p> <p>Mail C/O: Baca County Hospice 373 E. 10th Ave. Springfield, CO 81073</p>	<p>Baca</p>	<p>No</p>	<p>Affiliated with Southeast Colorado Hospital and Long-Term Care Facility</p> <p>Hospital chaplain and social worker on call</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Bristlecone Health Services Hospice (Centura Health at Home) 18 School Rd., Ste. 100 Frisco, CO 80443 Telephone: (970) 668-5604 Fax: (970) 668-3189 Web: www.BristleconeHealthServices.org Administrator/Contact: Stacy Berry</p> <p>Mail C/O: Bristlecone Health Services PO Box 1327 Frisco, CO 80443</p>	<p>Summit</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p> <p>Quarterly newsletter</p>
<p>Caring Hands Hospice 286 16th St. Burlington, CO 80807 Telephone: (719) 346-5311 Fax: (719) 346-4880 Web: www.KCCMH.org/hospice.htm Administrator/Contact: Joe Stratton</p>	<p>Kit Carson parts of: Cheyenne Yuma</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p> <p>Social worker on staff</p>
<p>Colorado Community Hospice 3501 W. 23rd Ave. Denver, CO 80211 Telephone: (303) 546-7921 Fax: (303) 238-4293 Web: www.ColoradoCommunityHospice.org Administrator/Contact: Christine Zamoni</p>	<p>Adams Arapahoe Denver Douglas Jefferson</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p> <p>Community education</p> <p>Memorial services</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Colorado Department of Corrections Hospice Highway 50 West Canon City, CO 81212 Telephone: (719) 269-4250 Fax: (719) 269-4075 Administrator/Contact: Joyce Crounk Mail C/O: Colorado DOC Hospice–Clinical Services 2862 S. Circle Dr. Colorado Springs, CO 80906</p>	<p>Serving all of Colorado state prison facilities</p>	<p>Yes, 2</p>	<p>Unknown</p>
<p>Colorado Hospice, LLC 1235 W. 124th Ave. Westminster, CO 80234 Telephone: (303) 217-5892 Fax: (303) 654-1877 Administrator/Contact: Jan Pasquale</p>	<p>Adams Arapahoe Boulder Denver Douglas Elbert Jefferson</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Compassionate Hospice Care, LLC 11935 Quay St. Broomfield, CO 80020 Telephone: (303) 465-0944 Fax: (303) 465-0899 Administrator/Contact: Tony Corona</p>	<p>Adams Arapahoe Boulder Denver Jefferson parts of: Weld</p>	<p>No</p>	<p>Support for individuals, families, caregivers up to 13 months at no charge</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>The Denver Hospice The Denver Hospice 501 S. Cherry St., #700 Denver, CO 80246 Telephone: (303) 321-2828 Fax: (303) 321-7171 Web: www.TheDenverHospice.org Administrator/Contact: Bev Sloan</p> <p>The Denver Hospice Inpatient Care Center at Lowry 8299 E. Lowry Blvd. Denver, CO 80230 Telephone: (303) 418-3000 Fax: (303) 766-2631 Web: www.TheDenverHospice.org Administrator/Contact: Janelle McCollum-Orozco</p>	<p>Adams Arapahoe Boulder Broomfield Denver Douglas Elbert Jefferson Weld</p>	<p>Yes, 24</p>	<p>Individual counseling: 3 sessions free, \$65/hour thereafter for family and friends of Denver Hospice patients</p> <p>Individual counseling available to community members for \$80/hour (insurance not accepted)</p> <p>Grief education Grief support groups Children and teen support Healing Hearts newsletter</p> <p>For more info: 303-321-2828</p>
<p>Dignity Hospice of Colorado LLC 14707 East 2nd Ave., Suite 220 Aurora, CO 80014 Telephone: 720-222-3315 Fax: 303-366-9595 Administrator/Contact: Jane Withers</p>	<p>Adams Arapahoe Boulder Broomfield Clear Creek Denver Douglas Elbert Northern El Paso Gilpin Jefferson Southern Weld (Within 50 miles of agency address)</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p> <p>Chapel</p> <p>Medical social workers</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Evercare Hospice and Palliative Care of Colorado Springs 5450 Tech Center Dr., Ste. 120 Colorado Springs, CO 80919 Telephone: (719) 265-1100 Fax: (719) 265-1101 Web: www.EvercareHospice.com Administrator/Contact: Diana Geray</p>	<p>El Paso</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge Community support groups, memorial events, workshops</p>
<p>Evercare Hospice and Palliative Care of Denver 6455 S. Yosemite St., 6th Floor Englewood, CO 80111 Telephone: (303) 714-2400 Fax: (303) 714-2396 Web: www.EvercareHospice.com Administrator/Contact: Debra Reynolds</p>	<p>60-mile radius of Denver</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge Community support groups, memorial events, workshops</p>
<p>Exempla Lutheran Hospice at Collier Hospice Center 3210 Lutheran Pkwy. Wheat Ridge, CO 80033 Telephone: (303) 425-8000 Fax: (303) 403-7295 Web: www.Exempla.org Administrator/Contact: Beth Davis</p>	<p>Adams Arapahoe Boulder Broomfield Clear Creek Denver Douglas Elbert Gilpin Grand Jefferson Morgan Park Summit Weld</p>	<p>Yes, 24</p>	<p>Bereavement and grief services: 303-467-4979</p>
<p>Family Hospice 1790 30th St., Ste. 308 Boulder, CO 80301 Telephone: (303) 440-0205 Fax: (303) 440-0209 Web: www.FamilyHospice.net Administrator/Contact: Melody Stanton</p>	<p>Boulder Broomfield Gilpin Parts of Weld</p>	<p>No</p>	<p>Social worker services Chaplain services Bereavement services to support the family</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Fremont Regional Hospice 1439 Main St. Canon City, CO 81212 Telephone: (719) 275-4315 Fax: (719) 275-8315 Administrator/Contact: Charlene Seaney Mail C/O: Fremont Regional Hospice PO Box 246 Canon City, CO 81212</p>	<p>Custer Fremont Park</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge Grief classes offered to the community twice each year</p>
<p>Front Range Hospice 685 Briggs St., Ste. 200 Erie, CO 80516 Telephone: (303) 957-3101 Fax: (303) 957-3113 Administrator/Contact: Pamela Ware Mail C/O: Front Range Hospice PO Box 724 Erie, CO 80516</p>	<p>Adams Boulder Broomfield Denver Larimer Weld</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Frontier Hospice, LLC 503 N. Main, Ste. 103-W Pueblo, CO 81003 Telephone: (719) 544-5891 Fax: (719) 544-5895 E-mail: LRussell@FrontierHospiceCo.com Web: www.FrontierHospiceCo.com Administrator/Contact: Larry Russell</p>	<p>Crowley Fremont El Paso Pueblo</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Halcyon Hospice and Palliative Care, LLC 209 Main St., Unit B Mead, CO 80542 Telephone: (970) 535-0870 Fax: (970) 535-0871 E-mail: info@HalcyonHospice.org Web: www.HalcyonHospice.org Administrator/Contact: Rod Graber</p> <p>Mail C/O: Halcyon Hospice and Palliative Care, LLC PO Box 177 Mead, CO 80542</p>	<p>Adams Arapahoe Boulder Denver Douglas Jefferson Larimer Weld</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Heart of the Mountains Volunteer Hospice, Inc. 613 First St. Hot Sulphur Springs, CO 80451 Telephone: (970) 725-3378 Fax: (970) 725-3378 E-mail: hospice@co.grand.co.us Web: www.GrandCountyHospice.org Administrator/Contact: Joan Gaskins</p> <p>Mail C/O: Heart of the Mountains Volunteer Hospice, Inc. PO Box 140 Hot Sulphur Springs, CO 80451</p>	<p>Grand</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Heartland Home Health Care and Hospice 8774 Yates Dr., Ste. 100 Westminster, CO 80031 Telephone: (303) 926-1001 Fax: (303) 926-1030 Web: www.HCR-Manorcare.com Administrator/Contact: Elliot Good</p>	<p>Adams Arapahoe Boulder Broomfield Denver Douglas Jefferson Larimer Weld</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Hospice and Palliative Care of Northern Colorado Administrative Office 2726 W. 11th Street Road Greeley, CO 80634 Telephone: (970) 352-8487 Fax: (970) 475-0037 Web: www.HPCNC.org</p> <p>Inpatient facility 1801 16th St., 4th Floor Greeley, CO 80634 Telephone: (970) 475-0041 Fax: (970) 475-0042</p> <p>Mail C/O: Hospice and Palliative Care of Northern Colorado 2726 W. 11th Street Road Greeley, CO 80634 Administrator/Contact: Charles Harms</p>	<p>Morgan Weld</p>	<p>Yes, 22</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Hospice and Palliative Care of the Gunnison Valley 805 W. Tomichi Ave., Ste. C Gunnison, CO 81230 Telephone: (970) 641-4254 Fax: (970) 641-4874 Web: www.GVH-Hospice.org Administrator/Contact: J. Wade Baker</p>	<p>Gunnison Hinsdale Saguache</p>	<p>No</p>	<p>Monthly grief support group Camp Good Grief Journeys newsletter (monthly) Books and reference material available</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Hospice and Palliative Care of Western Colorado</p> <p>Delta County 195 Stafford Lane PO Box 24 Delta, CO 81416 Telephone: (970) 874-6823 Fax: (970) 874-6903</p> <p>Grand Valley 2754 Compass Dr., Ste. 377 Grand Junction, CO 81506 Telephone: (970) 241-2212 Fax: (970) 257-2400</p> <p>Hospice Care Center 3090 N. 12th St., Unit B Grand Junction, CO 81506 Telephone: (970) 255-7263 Fax: (970) 255-7277, clinical Fax: (970) 257-2400, admin</p> <p>Montrose/Ouray Counties 645 S. 5th St. PO Box 1804 Montrose, CO 81402 Telephone: (970) 240-7734 Fax: (970) 240-7263</p> <p>Mail C/O: Hospice and Palliative Care of Western Colorado 3090 N. 12th St., Unit B Grand Junction, Colorado 81506 Toll Free: (866) 310-8900 Administrator/Contact: Christy Whitney</p>	<p>Delta Mesa Montrose Ouray</p>	<p>Yes, 13</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p> <p>Grief support services to anyone in the community dealing with the loss of a loved one</p> <p>Bereavement services for adults, children, teens, caregivers. Individual and family counseling provided at nominal fee or sliding scale. Scholarships available.</p> <p>Additional information available by e-mail: AdultSupport@HospiceWCO.com</p> <p>Web support: www.GrievingCenter.org</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Hospice and Palliative Care Services of Northwest Colorado E-mail: info@NWCOVNA.org Web: www.NWCOVNA.org Administrator/Contact: Shannon Winegarner</p> <p>Steamboat Springs Office 940 Central Park Dr., Ste. 101 Steamboat Springs, CO 80487 Telephone: (970) 879-1632 Fax: (970) 870-1326</p> <p>Craig Office 745 Russell St. Craig, Colorado 81625 Telephone: (970) 824-8233 Fax: (970) 824-2548</p>	<p>Moffat Routt</p>	<p>Yes, short-term respite</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p> <p>Poogie’s Place Youth Bereavement Program</p>
<p>Hospice Del Valle, Inc. 514 Main St. Alamosa, CO 81101 Telephone: (719) 589-9019 Fax: (719) 589-5094 Administrator/Contact: Lois Booth</p>	<p>Alamosa Conejos Costilla Mineral Rio Grande Saguache</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Hospice of CovenantCare 9101 Harlan St., Ste. 135 Westminster, CO 80031 Telephone: (303) 487-1009 Fax: (303) 487-1104 Web: www.CovenantCareAtHome.org Administrator/Contact: Ms. Theresa McCoy</p>	<p>Adams Arapahoe Boulder Broomfield Denver Jefferson</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p> <p>Grief support groups available to community members at no charge</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Hospice of Mercy Corporate Office Centura Health at Home 1391 Speer Blvd., Ste. 600 Denver, CO 80204 Telephone: (303) 561-5000 Toll-Free: (877) 546-8253 Fax: (303) 561-5050 Web: www.CenturaHealthAtHome.org Web: www.MercyHealthAtHome.org Administrator/Contact: Michelle Appenzeller</p> <p>Durango 1 Mercado St., Ste. 270 Durango, CO 81301 Telephone: (970) 382-2000 Fax: (970) 382-2069</p> <p>Pagosa Springs 35 Mary Fisher Cir. Pagosa Springs, CO 81147 Telephone: (970) 731-9190 Fax: (970) 731-9196</p>	<p>Archuleta La Plata Montezuma</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Hospice of Montezuma, Inc. 1345 S. Broadway Cortez, CO 81321 Telephone: (970) 565-4400 Fax: (970) 565-9543 Web: www.HospiceOfMontezuma.org Administrator/Contact: Mary Roussett</p> <p>Mail C/O: Hospice of Montezuma, Inc. PO Drawer 740 Cortez, CO 81321</p>	<p>Dolores La Plata Montezuma San Juan San Miguel</p>	<p>No</p>	<p>Hospice family grief camp Web support</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Hospice of Saint John 1320 Everett Ct. Lakewood, CO 80215 Telephone: (303) 232-7900 Fax: (303) 232-3614 Web: www.HospiceOfSaintJohn.org Administrator/Contact: Jerry Lynn Huson</p> <p>Hospice of Saint John–Inverness Drive 8 Inverness Dr. East, Ste. 250 Englewood, CO 80112 Telephone: (303) 232-7900 Fax: (303) 232-3614</p>	<p>Adams Arapahoe Denver Douglas Jefferson</p>	<p>Yes, 42</p>	<p>Individual/group/ family counseling</p> <p>Drop-in group</p> <p>8-week structured grief group</p> <p>Education, mailings, phone support, referral services</p> <p>Memorials and seasonal events</p> <p>Bereavement department: (303) 232-7900</p>
<p>Hospice of the Estes Valley 555 Prospect Ave. Estes Park, CO 80517 Telephone: (970) 586-2317 Fax: (970) 586-3895 Web: www.EPMedCenter.com Administrator/Contact: Sarah Bosko</p> <p>Mail C/O: Hospice of the Estes Valley PO Box 2740 Estes Park, CO 80517</p>	<p>Boulder Larimer</p>	<p>No</p>	<p>Support for individuals/families/ caregivers up to 13 months at no charge</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Hospice of the Plains, Inc. E-mail: contact@HospiceOfThePlains.org Web: www.HospiceOfTheplains.org Administrator/Contact: Donna Roberts</p> <p>Wray 1017 W. 7th St. Wray, CO 80758 Telephone: (970) 332-4116 Fax: (970) 332-4102</p> <p>Sterling 100 Broadway, Ste. 1-A Sterling, CO 80751 Telephone: (970) 526-7901 Fax: (970) 526-7902</p>	<p>Logan Morgan Phillips Sedgwick Washington Yuma</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Hospice of the Valley 234 Cody Ln. Basalt, CO 81621 Telephone: (970) 927-6650 Fax: (970) 927-6659 E-mail: butlermrky@aol.com Administrator/Contact: Marchita Butler</p> <p>Mail C/O: Hospice of the Valley PO Box 3768 Basalt, CO 81621</p> <p>Edwards Branch 320 Beard Creek Rd. Edwards, CO 81632 Telephone: (970) 569-7455 Fax: (970) 470-6687</p> <p>Mail C/O: Hospice of the Valley—Edwards Branch PO Box 1474 Edwards, CO 81632</p>	<p>Eagle Garfield Pitkin</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>HospiceCare of Boulder and Broomfield Counties Telephone: (303) 449-7740 Fax: (303) 604-5393 E-mail: info@HospiceCareOnline.org Web: www.HospiceCareOnline.org Administrator/Contact: Darla Schueth</p> <p>Lafayette 2594 Trailridge Dr. East Lafayette, CO 80026</p> <p>Longmont 2130 Mountain View Ave., Ste. 201 Longmont, CO 80501</p> <p>HospiceCare Center 1855 Plaza Dr. Louisville, CO 80027</p> <p>Mail C/O:HospiceCare of Boulder and Broomfield Counties 2594 Trailridge Dr. East Lafayette, CO 80026</p>	<p>Boulder Broomfield parts of: Adams Jefferson Larimer Weld</p>	<p>Yes, 10</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Innovative Senior Care Hospice 8030 East Girard Ave. Denver, CO 80231 Telephone: 303-481-0508 Fax: 303-481-0511 Administrator/Contact: Kent Dawson</p>	<p>No information at press time.</p>		
<p>Interim Health Care Hospice 1901 North Union Blvd. Colorado Springs, CO 80909 Telephone: 719-632-9900 Fax: 719-632-2470 Administrator/Contact: April Davis</p>	<p>Douglas El Paso Fremont Pueblo Teller</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Lamar Area Hospice Association 108 W. Olive Lamar, CO 81052 Telephone: (719) 336-2100 Fax: (719) 336-3845 E-mail: LamarHospice@bresnan.net Administrator/Contact: Debra Pelley</p> <p>Mail C/O: Lamar Area Hospice Association PO Box 843 Lamar, CO 81052</p>	<p>Bent Kiowa Prowers</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Legacy Hospice 10248 S. Perry Park Rd. Larkspur, CO 80118 Telephone: (303) 660-6107 Fax: (888) 660-6107 E-mail: lora@MyLegacyHospice.com Web: www.MyLegacyHospice.com Administrator/Contact: Lora Merklng</p> <p>Mail C/O: Legacy Hospice PO Box 1718 Castle Rock, CO 80104</p>	<p>Arapahoe Douglas Elbert El Paso</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Lincoln Community Home Health and Hospice 111 6th St. Hugo, CO 80821 Telephone: (719) 743-2797 Fax: (719) 743-2008 Administrator/Contact: Kimberly Rosler</p> <p>Mail C/O: Lincoln Community Home Health and Hospice PO Box 248 Hugo, CO 80821</p>	<p>Adams Arapahoe Cheyenne Elbert El Paso Kit Carson Lincoln Washington</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>

Provider Contact Information	Counties Served	Residence/ Beds	Bereavement Services
<p>Living Waters Hospice, Inc. 301 Highway 24 N Buena Vista, CO 81211 Telephone: (719) 395-3124 Fax: (719) 395-3128 Administrator/Contact: Lawanna Best</p>	<p>Chaffee Western Freemont Lake Park</p>		<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Mt. Evans Hospice, Inc. 3081 Bergen Peak Dr. Evergreen, CO 80439 Telephone: (303) 674-6400 Fax: (303) 674-8813 E-mail: info@MTEvans.org Web: www.MTEvans.org Administrator/Contact: Kathy Engel</p>	<p>Clear Creek Gilpin Jefferson Park</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p> <p>Grief support groups</p> <p>Children's grief services</p> <p>Camp Comfort</p>
<p>Namaste Hospice 1633 Fillmore, Ste. 300 Denver, CO 80206 Telephone: (303) 860-9915 Fax: (303) 860-9914 E-mail: Namaste@NamasteHospice.com Web: www.NamasteHospiceCare.com Administrator/Contact: Lynn Dawson</p>	<p>Adams Arapahoe Denver Douglas Jefferson</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Odyssey Hospice 5526 N. Academy Blvd., Ste. 108 Colorado Springs, CO 80918 Telephone: (719) 573-4166 Toll Free: (866) 366-6473 Fax: (719) 573-4164 Web: www.OdsyHealth.com</p>	<p>Douglas El Paso</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Pathways Hospice Web: www.Pathways-Care.org Administrator/Contact: Evan Hyatt</p> <p>Fort Collins 305 Carpenter Rd. Fort Collins, CO 80525 Telephone: (970) 663-3500 Fax: (970) 292-0898</p> <p>Loveland 2000 N. Boise Ave., 3rd Floor Loveland, CO 80538 Telephone: (970) 593-6062 Fax: (970) 593-6063</p> <p>Windsor 1580 Main St., Ste. 2 Windsor, CO 80550 Telephone: (970) 674-9988 Fax: (970) 292-0898</p>	<p>Larimer Weld</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Pikes Peak Hospice and Palliative Care 825 E. Pikes Peak Ave., #600 Colorado Springs, CO 80903 Telephone: (719) 633-3400 Fax: (719) 633-3800 Web: www.PikesPeakHospice.org Administrator/Contact: Martha Barton</p> <p>Inpatient Facility 2222 Nevada Ave., 6th Floor Colorado Springs, CO 80907 Telephone: 719-633-3400 Fax: 719-633-3800</p>	<p>Douglas El Paso Teller</p>	<p>Yes, 16</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Pinnacle Hospice Care 13743 E. Mississippi Ave., Ste. 102 Aurora, CO 80012 Telephone: (303) 344-0051 Fax: (303) 364-1131 Web: www.PinnacleHospiceCare.com Administrator/Contact: Carlos Valle</p>	<p>Greater Denver metro area</p>	<p>No</p>	<p>Support for individual/families/caregivers up to 13 months at no charge</p>

Provider Contact Information	Counties Served	Residence/ Beds	Bereavement Services
<p>Porter Hospice 1391 Speer Blvd., Ste. 600 Denver, CO 80204 Telephone: (303) 561-5000 Fax: (303) 561-5050 Web: www.CenturaHealthAtHome.org Administrator/Contact: Sean Reed</p> <p>Porter Hospice at the Johnson Center 5020 E. Arapahoe Rd. Centennial, CO 80122 Telephone: (303) 694-3545 Fax: (303) 694-5103</p>	Adams Arapahoe Denver Douglas Jefferson Weld	Yes, 18	Support for individuals/families/caregivers up to 13 months at no charge Quarterly newsletter
<p>Prospect Home Care Hospice, Inc. 16222 W. Hwy. 24, Ste. 120 Woodland Park, CO 80863 Telephone: (719) 687-0549 Fax: (719) 687-8558 E-mail: HomeCare@ProspectHCH.org Web: www.ProspectHCH.org Administrator/Contact: Mary Barrowman</p>	Douglas El Paso Park Teller	No	Support for individuals/families/caregivers up to 13 months at no charge
<p>St. Anthony Hospice 1391 Speer Blvd., Ste. 600 Denver, CO 80204 Telephone: (303) 561-5100 Web: www.CenturaHealthAtHome.org</p>	Adams Arapahoe Denver Douglas Jefferson Weld	Yes, 6	Support for individuals/families/caregivers up to 13 months at no charge Quarterly newsletter

<p>Provider Contact Information</p>	<p>Counties Served</p>	<p>Residence/ Beds</p>	<p>Bereavement Services</p>
<p>Sangre de Cristo Hospice and Palliative Care E-mail: info@SOCOHospice.org Web: www.SangredeCristoHospice.org</p> <p>Main Office 1207 Pueblo Blvd. Way Pueblo, CO 81005 Telephone: (719) 542-0032 Fax: (719) 542-1486 Administrator/Contact: Caren Ermel</p> <p>West Office 601 Greenwood Ave. Canon City, CO 81212 Telephone: (719) 275-1261 Fax: (719) 275-3754 Administrator/Contact: Katherine Bueno</p> <p>South Office 124 W. 8th St. Walsenburg, CO 81089 Telephone: (719) 738-2588 Fax: (719) 738-3002 Administrator/Contact: Katherine Bueno</p> <p>Joni Fair Hospice House 1107 Pueblo Blvd. Way Pueblo, CO 81005 Telephone: (719) 296-6205 Fax: (719) 545-4715 Administrator/Contact: Katherine Bueno</p> <p>Mail C/O: Sangre de Cristo Hospice—Main Office 1207 Pueblo Blvd. Way Pueblo, CO 81005</p>	<p>Custer Fremont Huerfano Pueblo</p>	<p>Yes, 10</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>
<p>Shalom Hospice & Palliative Care 14800 E. Belleview Dr. Aurora, CO 80015 Telephone: (303) 766-7600 Fax: (303) 400-6838 E-mail: info@ShalomCares.net Web: www.ShalomPark.org Administrator/Contact: Milissa Barres</p>	<p>Adams Arapahoe Denver Douglas parts of: Weld</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>

Provider Contact Information	Counties Served	Residence/ Beds	Bereavement Services
<p>SolAmor Hospice Colorado Springs 655 Southpointe Ct., Ste. 201 Colorado Springs, CO 80906 Telephone: (719) 226-0091 Fax: (719) 226-7900 Web: www.SolAmorHospice.com Administrator/Contact: Sabrina Evans</p> <p>Denver 7950 E. Prentice Ave., Ste. 101 Greenwood Village, CO 80111 Telephone: (720) 200-1036 Fax: (720) 200-4514 Web: www.SolAmorHospice.com Administrator/Contact: Mandy Hager</p>	Adams Arapahoe Denver Douglas El Paso Jefferson Pueblo Teller	No	Support for individuals/families/caregivers up to 13 months at no charge
<p>VistaCare Hospice 4350 Wadsworth Blvd., Ste. 250 Wheat Ridge, CO 80033 Telephone: (303) 639-9243 Fax: (303) 639-9238 E-mail: Stephanie.Silva@VistaCare.com Web: www.VistaCare.com Administrator/Contact: Gary Walker</p>	Adams Arapahoe Boulder Broomfield Denver Douglas Elbert Jefferson Weld	No	Support for individuals/families/caregivers up to 13 months at no charge
<p>VITAS Innovative Hospice Care 7887 E. Belleview Ave., Ste. 1100 Englewood, CO 80111 Telephone: (888) 634-0784 Fax: (303) 228-2249 Adminstrator/Contact: Catherine Ager</p>	Adams Arapahoe Denver Douglas Jefferson	No	Support for individuals/families/caregivers up to 13 months at no charge Support groups and individual counseling

Provider Contact Information	Counties Served	Residence/ Beds	Bereavement Services
<p>VNA Hospice at Home 390 Grant St. Denver, CO 80203 Telephone: (303) 698-2121 Fax: (303) 698-6373 Web: www.VNAColorado.org Administrator/Contact: Laura Reilly</p>	<p>Adams Arapahoe Denver Jefferson</p>	<p>No</p>	<p>Support for individuals/families/caregivers up to 13 months at no charge</p>

Licensed Hospice Providers by County

Adams

AccentCare Home Health of Mountain Valley
 Affinity Hospice of Life
 Agape Hospice Services
 Colorado Community Hospice
 Colorado Hospice, LLC
 Compassionate Hospice Care, LLC
 The Denver Hospice
 Dignity Hospice of Colorado, LLC
 Evercare Hospice & Palliative Care of Denver
 Exempla Lutheran Hospice at Collier Hospice Center
 Front Range Hospice
 Halcyon Hospice & Palliative Care, LLC
 Heartland Home Health Care and Hospice
 HospiceCare of Boulder and Broomfield Counties
 Hospice of Covenant Care
 Hospice of Saint John
 Lincoln Community Home Health and Hospice
 Namaste Hospice
 Odyssey HealthCare of Denver
 Pinnacle Hospice Care
 Porter Hospice
 Shalom Hospice & Palliative Care
 SolAmor Hospice
 St. Anthony Hospice
 VistaCare Hospice
 VITAS Innovative Hospice Care
 VNA Hospice at Home

Alamosa

Hospice Del Valle

Arapahoe

Affinity Hospice of Life
 Agape Hospice Services
 Colorado Community Hospice
 Compassionate Hospice Care, LLC
 The Denver Hospice
 Dignity Hospice of Colorado, LLC
 Evercare Hospice & Palliative Care of Denver
 Exempla Lutheran Hospice at Collier Hospice Center
 Halcyon Hospice & Palliative Care, LLC
 Heartland Home Health Care and Hospice
 Hospice of Covenant Care
 Hospice of Saint John
 Legacy Hospice
 Lincoln Community Home Health and Hospice
 Namaste Hospice
 Odyssey HealthCare of Denver
 Pinnacle Hospice Care
 Porter Hospice
 Shalom Hospice & Palliative Care
 SolAmor Hospice
 St. Anthony Hospice
 VistaCare Hospice
 VITAS Innovative Hospice Care
 VNA Hospice at Home

Archuleta

Alpine Hospice
Hospice of Mercy

Baca

Baca County Hospice

Bent

Arkansas Valley Hospice
Lamar Area Hospice Association

Boulder

AccentCare Home Health of Mountain Valley
Affinity Hospice of Life
Agape Hospice Services
Compassionate Hospice Care, LLC
The Denver Hospice
Dignity Hospice of Colorado, LLC
Exempla Lutheran Hospice at Collier
Hospice Center
Family Hospice
Front Range Hospice
Halcyon Hospice & Palliative Care, LLC
Heartland Home Health Care and Hospice
HospiceCare of Boulder and Broomfield Counties
Hospice of Covenant Care
Hospice of the Estes Valley
VistaCare Hospice
VITAS Innovative Hospice Care

Broomfield

AccentCare Home Health of Mountain Valley
Affinity Hospice of Life
Agape Hospice Services
The Denver Hospice
Dignity Hospice of Colorado, LLC
Exempla Lutheran Hospice at Collier
Hospice Center
Front Range Hospice
Heartland Home Health Care and Hospice
HospiceCare of Boulder and Broomfield Counties
Hospice of Covenant Care
VistaCare Hospice
VITAS Innovative Hospice Care

Chaffee

Angel of Shavano Hospice
Living Waters Hospice

Cheyenne

Caring Hands Hospice
Lincoln Community Home Health and Hospice

Clear Creek

Dignity Hospice of Colorado, LLC
Exempla Lutheran Hospice at Collier
Hospice Center
Mt. Evans Hospice, Inc.

Conejos

Hospice Del Valle

Costilla

Hospice Del Valle

Crowley

Arkansas Valley Hospice
Frontier Hospice

Custer

Angel of Shavano Hospice
Fremont Regional Hospice
Sangre de Cristo Hospice & Palliative Care

Delta

Alpine Home Health and Hospice
Hospice & Palliative Care of Western Colorado

Denver

Affinity Hospice of Life
Agape Hospice Services
Colorado Community Hospice
Compassionate Hospice Care, LLC
The Denver Hospice
Dignity Hospice of Colorado, LLC
Evercare Hospice & Palliative Care of Denver
Exempla Lutheran Hospice at Collier
Hospice Center
Front Range Hospice
Halcyon Hospice & Palliative Care, LLC
Heartland Home Health Care and Hospice
Hospice of Covenant Care
Hospice of Saint John
Namaste Hospice
Odyssey HealthCare of Denver
Pinnacle Hospice Care
Porter Hospice

Shalom Hospice & Palliative Care
 SolAmor Hospice
 St. Anthony Hospice
 VistaCare Hospice
 VITAS Innovative Hospice Care
 VNA Hospice at Home

Dolores

Alpine Hospice
 Hospice of Montezuma, Inc.

Douglas

Affinity Hospice of Life
 Agape Hospice Services
 Colorado Community Hospice
 The Denver Hospice
 Dignity Hospice of Colorado, LLC
 Evercare Hospice & Palliative Care of Denver
 Exempla Lutheran Hospice at Collier
 Hospice Center
 Halcyon Hospice & Palliative Care, LLC
 Heartland Home Health Care and Hospice
 Hospice of Saint John
 Interim Health Care Hospice
 Legacy Hospice
 Namaste Hospice
 Odyssey Hospice
 Pikes Peak Hospice & Palliative Care
 Pinnacle Hospice Care
 Porter Hospice
 Prospect Home Care Hospice, Inc.
 Shalom Hospice & Palliative Care
 SolAmor Hospice
 St. Anthony Hospice
 VistaCare Hospice
 VITAS Innovative Hospice Care
 VNA Hospice at Home

Eagle

Hospice of the Valley

Elbert

Agape Hospice Services
 The Denver Hospice
 Dignity Hospice of Colorado, LLC
 Exempla Lutheran Hospice at Collier
 Hospice Center
 Legacy Hospice

Lincoln Community Home Health and Hospice
 VistaCare Hospice

El Paso

Dignity Hospice of Colorado, LLC
 Evercare Hospice & Palliative Care of
 Colorado Springs
 Frontier Hospice
 Interim Health Care Hospice
 Legacy Hospice
 Lincoln Community Home Health and Hospice
 Odyssey Hospice
 Pikes Peak Hospice & Palliative Care
 Prospect Home Care Hospice, Inc.
 SolAmor Hospice

Fremont

Angel of Shavano Hospice—an Amedisys Partner
 Fremont Regional Hospice
 Frontier Hospice
 Interim Health Care Hospice
 Living Waters Hospice
 Sangre de Cristo Hospice & Palliative Care

Garfield

Alpine Home Health and Hospice
 Hospice of the Valley

Gilpin

Dignity Hospice of Colorado, LLC
 Exempla Lutheran Hospice at Collier
 Hospice Center
 Family Hospice
 Mt. Evans Hospice, Inc.

Grand

Exempla Lutheran Hospice at Collier
 Hospice Center
 Heart of the Mountains Volunteer Hospice, Inc.

Gunnison

Hospice and Palliative Care of the
 Gunnison Valley

Hinsdale

Hospice and Palliative Care of the
 Gunnison Valley

Huerfano

Sangre de Cristo Hospice & Palliative Care

Jackson

Hospice and Palliative Care Services
of Northwest Colorado

Jefferson

Affinity Hospice of Life
Agape Hospice Services
Colorado Community Hospice
Compassionate Hospice Care, LLC
The Denver Hospice
Dignity Hospice of Colorado, LLC
Evercare Hospice & Palliative Care of Denver
Exempla Lutheran Hospice at Collier
Hospice Center
Halcyon Hospice & Palliative Care, LLC
HospiceCare of Boulder and Broomfield Counties
Heartland Home Health Care and Hospice
Hospice of Covenant Care
Hospice of Saint John
Mt. Evans Hospice, Inc.
Namaste Hospice
Odyssey HealthCare of Denver
Pinnacle Hospice Care
Porter Hospice
SolAmor Hospice
St. Anthony Hospice
VistaCare Hospice
VITAS Innovative Hospice Care
VNA Hospice at Home

Kiowa

Lamar Area Hospice Association

Kit Carson

Caring Hands Hospice
Lincoln Community Home Health and Hospice

La Plata

Alpine Hospice
Hospice of Mercy
Hospice of Montezuma, Inc.

Lake

Angel of Shavano Hospice
Living Waters Hospice

Larimer

AccentCare Home Health of Mountain Valley
Family Hospice
Front Range Hospice
Halcyon Hospice & Palliative Care, LLC
Heartland Home Health Care and Hospice
HospiceCare of Boulder and Broomfield Counties
Hospice of Larimer County
Hospice of the Estes Valley
Pathways Hospice

Las Animas

Lamar Area Hospice Association
Sangre de Cristo Hospice & Palliative Care

Lincoln

Lincoln Community Home Health and Hospice

Logan

Hospice of the Plains, Inc.

Mesa

Alpine Home Health and Hospice
Hospice & Palliative Care of Western Colorado

Mineral

Hospice Del Valle

Moffat

Hospice and Palliative Care Services of
Northwest Colorado

Montezuma

Alpine Hospice
Hospice of Mercy
Hospice of Montezuma, Inc.

Montrose

Alpine Home Health and Hospice
Hospice & Palliative Care of Western Colorado

Morgan

Exempla Lutheran Hospice at Collier
Hospice Center
Hospice and Palliative Care of Northern
Colorado, Inc.
Hospice of the Plains Inc.

Otero

Arkansas Valley Hospice

Ouray

Hospice & Palliative Care of Western Colorado

Park

Exempla Lutheran Hospice at Collier

Hospice Center

Fremont Regional Hospice

Living Waters Hospice

Mt. Evans Hospice, Inc.

Prospect Home Care Hospice, Inc.

Phillips

Hospice of the Plains, Inc.

Pitkin

Hospice of the Valley

Prowers

Lamar Area Hospice Association

Pueblo

Frontier Hospice

Interim Health Care Hospice

Sangre de Cristo Hospice & Palliative Care

SolAmor Hospice

Rio Blanco**Rio Grande**

Hospice Del Valle

Routt

Hospice and Palliative Care Services of

Northwest Colorado

Saguache

Hospice and Palliative Care of the

Gunnison Valley

Hospice Del Valle

Hospice of the Plains, Inc.

San Juan

Alpine Hospice

Hospice of Montezuma, Inc.

San Miguel

Alpine Home Health and Hospice

Alpine Hospice

Hospice of Montezuma, Inc.

Sedgwick

Hospice of the Plains, Inc.

Summit

Bristlecone Health Services Hospice

Exempla Lutheran Hospice at Collier

Hospice Center

Teller

Interim Health Care Hospice

Pikes Peak Hospice & Palliative Care

Prospect Home Care Hospice, Inc.

SolAmor Hospice

Washington

Hospice of the Plains, Inc.

Lincoln Community Home Health and Hospice

Weld

Agape Hospice Services

Compassionate Hospice Care, LLC

The Denver Hospice

Dignity Hospice of Colorado, LLC

Exempla Lutheran Hospice at Collier

Hospice Center

Family Hospice

Front Range Hospice

Halcyon Hospice & Palliative Care, LLC

Heartland Home Health Care and Hospice

HospiceCare of Boulder and Broomfield Counties

Hospice and Palliative Care of Northern

Colorado, Inc.

Hospice of Larimer County—Windsor

Mountain Valley Home Health Care, LLC

Pathways Hospice

Porter Hospice

Shalom Hospice & Palliative Care

St. Anthony Hospice

VistaCare Hospice

Yuma

Caring Hands Hospice

Hospice of the Plains, Inc.

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