

Clinical Reference Guide



Medical signs that a person
may need hospice care

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Evercare™ Hospice and Palliative Care

About Palliative Care

Palliative care provides support for patients with advanced illnesses who may want to continue with aggressive curative therapies.

Specialists work with the patient, their family and the attending physician. The goal is to:

- » Relieve suffering
- » Optimize function
- » Improve quality of life, and
- » Help with care planning for patients with advanced illness and their families



About Hospice


Hospice professionals strive for “a good death,” where patients receive personal, emotional and spiritual comfort; are free from pain and suffering, and are surrounded by loved ones. A team of specially trained professionals offers tools, experience and interventions to facilitate a peaceful death with respect and dignity.

Evercare Hospice and Palliative Care provides end-of-life care coordination and services with our holistic team approach, working to fulfill the physical, psychological and spiritual needs of patients and their families during a uniquely personal time of transition.



Hospice has been demonstrated to improve the quality of life for patients with life-limiting conditions and disease, including:

- » Cancer
- » Cardiovascular Disease
- » Congestive Heart Disease
- » Chronic Obstructive Pulmonary Disease (COPD)
- » Dementia or Alzheimer's Disease
- » Neurological Disease (Parkinson's, ALS, etc.)
- » Renal Disease
- » Liver Disease
- » Acquired Immune Deficiency Syndrome (AIDS/HIV)



Under Medicare, and most other insurance, people are eligible for the Hospice benefit if two physicians certify that they have a life expectancy of six months or less if the disease runs its normal course.

Some indications that people may meet this criteria include:

- » Progressive decline in functional status despite curative treatments
- » Frequent hospitalizations or ER visits
- » Repeat or multiple infections
- » Increased or uncontrolled pain
- » Progressive/profound weakness and fatigue
- » Shortness of breath with or without oxygen
- » Dependency (decrease in ADLs)
- » Alterations in mental status
- » Weight loss

Medical Indicators for Hospice



Medical Indicators for Hospice

The evidence-based best practices on the following pages are accepted medical indicators for hospice eligibility.

The PPS values given are taken from the Victoria Hospice Palliative Performance Scale,* which can be found at:

www.victoriahospice.org/pdfs/PPSv2.pdf

* Copyright Victoria Hospice Society, BC, Canada
(2001)
www.victoriahospice.org

Cancer

Cancer

Cancer

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

The guidelines given for each disease are predictive for patients with a single condition. Additional comorbidities or complications should be taken into consideration when evaluating appropriateness for hospice care.

Congestive Heart Failure (CHF)

Congestive Heart Failure
(CHF)

Congestive Heart Failure (CHF)

- » Class IV functional status (NYHA)
- » Ejection fraction <20%
- » Optimal diuretic and vasodilator therapy
- » Recurrent symptoms of CHF at rest
- » Persistent symptomatic supraventricular or ventricular arrhythmia
- » History of cardiac arrest or resuscitation
- » History of unexplained syncope
- » Brain embolism of cardiac origin

The guidelines given for each disease are predictive for patients with a single condition. Additional comorbidities or complications should be taken into consideration when evaluating appropriateness for hospice care.

Chronic Obstructive Pulmonary Disease (COPD)

Chronic Obstructive
Pulmonary Disease (COPD)

Chronic Obstructive Pulmonary Disease (COPD)

- » Disabling dyspnea at rest
- » Oxygen dependent
- » O₂ saturation less than 88% on room air
- » Recurrent infections
- » Poor response to bronchodilators
- » FEV₁ after bronchodilator less than 30% of predicted
- » Heart failure secondary to pulmonary disease
- » Resting tachycardia greater than 100 beats per minute
- » Weight loss greater than 10% over previous six months
- » Increasing visits to the emergency department or hospitalization, or increased MD/NP visits to maintain patient in current living situation

The guidelines given for each disease are predictive for patients with a single condition. Additional comorbidities or complications should be taken into consideration when evaluating appropriateness for hospice care.

Alzheimer's Dementia

Alzheimer's Dementia

Stage 7 or higher on FAST:

- » Unable to ambulate alone
- » Unable to dress, bathe or feed self
- » Incontinent of bowel and bladder
- » Unable to speak or communicate meaningfully

Presence or history of at least one co-morbid condition in the past year, such as:

- » Weight loss
- » UTI
- » Aspiration
- » Pneumonia
- » Decubitus ulcers
- » Septicemia

The guidelines given for each disease are predictive for patients with a single condition. Additional comorbidities or complications should be taken into consideration when evaluating appropriateness for hospice care.

**Neurological
(CVA, Coma,
Parkinson's, etc.)**

**Neurological (CVA, Coma,
Parkinson's, etc.)**

Neurological (CVA, Coma, Parkinson's, etc.)

- » Karnofsky or PPS value less than 40%
 - Unable to ambulate alone
 - Unable to dress, bathe or feed self
 - Incontinent of bowel and bladder
 - Speech limited
- » Poor nutritional status, dysphagia, and/or more than 10% weight loss
- » Serum albumin less than 2.5 grams per dl
- » Dysphagia (history of aspiration)

The guidelines given for each disease are predictive for patients with a single condition. Additional comorbidities or complications should be taken into consideration when evaluating appropriateness for hospice care.

Liver Disease

Liver Disease

Liver Disease

- » Documentation of specific liver disease
- » Jaundice
- » Ascites
- » Abnormal liver enzymes
- » Elevated PT greater than 5 seconds; INR >1.5
- » Encephalopathy
- » Spontaneous bacterial peritonitis
- » Recurrent variceal bleeding
- » Positive HBSAG (Hepatitis B)
- » Hepatitis C refractory to interferon

The guidelines given for each disease are predictive for patients with a single condition. Additional comorbidities or complications should be taken into consideration when evaluating appropriateness for hospice care.

Debility Unspecified

Debility Unspecified

Debility Unspecified

While many providers use “adult failure to thrive” to describe irreversible decline in the elderly, fiscal intermediaries for Medicare more often utilize the term “debility unspecified.”

Debility unspecified syndrome is characterized by unexplained weight loss, malnutrition and disability. The syndrome has been associated with multiple primary conditions, but always includes two defining clinical elements, namely nutritional impairment and disability. The nutritional impairment and disability associated with the debility unspecified syndrome may be severe enough to affect the patient’s short-term survival.

Debility unspecified syndrome may manifest as an irreversible progression in the patient’s nutritional impairment/disability despite a trial of therapy. The presence of co-morbid conditions may hasten the patient’s clinical progression and as such should be identified and addressed.

The guidelines given for each disease are predictive for patients with a single condition. Additional comorbidities or complications should be taken into consideration when evaluating appropriateness for hospice care.

The medical criteria below supports the terminal prognosis for patients with debility unspecified syndrome:

- » Nutritional impairment is severe enough to impact patient's weight; Body Mass Index (BMI) is below 22 kg/m²
- » Patient declines enteral/parenteral nutritional support, or
- » Does not respond to nutritional support, despite adequate caloric intake
- » Karnofsky or PPS value less than or equal to 40%

The guidelines given for each disease are predictive for patients with a single condition. Additional comorbidities or complications should be taken into consideration when evaluating appropriateness for hospice care.

ALS

ALS

ALS

1. The patient must demonstrate critically impaired breathing capacity as demonstrated by all the following characteristics occurring within the 12 months preceding initial hospice certification:

- » Vital capacity (VC) less than 30% of normal
- » Significant dyspnea at rest
- » Requires supplemental oxygen at rest
- » Patient declines artificial ventilation

2. Patient must demonstrate both rapid progression of ALS and critical nutritional impairment as demonstrated by all the following characteristics occurring within the 12 months preceding initial hospice certification:

- » Progression from independent ambulation to wheelchair or bedbound status
- » Progression from normal to barely intelligible or unintelligible speech
- » Progression from normal to pureed diet

The guidelines given for each disease are predictive for patients with a single condition. Additional comorbidities or complications should be taken into consideration when evaluating appropriateness for hospice care.

- » Progression from independence in most all ADLs to needing major assistance by caretaker in all ADLs
- » Oral intake of nutrients and fluids insufficient to sustain life
- » Continuing weight loss
- » Dehydration or hypovolemia
- » Absence of artificial feeding methods

3. Patient must demonstrate life-threatening complications as demonstrated by one of the following occurring within the 12 months preceding initial hospice certification:

- » Recurrent aspiration pneumonia (with or without tube feeding)
- » Upper urinary tract infection; e.g., pyelonephritis
- » Sepsis
- » Recurrent fever after antibiotic therapy

The guidelines given for each disease are predictive for patients with a single condition. Additional comorbidities or complications should be taken into consideration when evaluating appropriateness for hospice care.

Renal Disease

Renal Disease

Renal Disease

Any one of the following criteria meets Medicare guidelines:

- » Creatinine greater than 8 mg per dl; or greater than 6 mg/dl in diabetics
- » Urine output <400 ml/24 hours
- » Patient/family choose to discontinue chronic dialysis
- » Hepatorenal syndrome
- » Hyperkalemia not responsive to treatment
- » Intractable fluid overload

The guidelines given for each disease are predictive for patients with a single condition. Additional comorbidities or complications should be taken into consideration when evaluating appropriateness for hospice care.

AIDS/HIV

AIDS/HIV

AIDS/HIV

CD4 lymphocyte count less than 25 with a viral load greater than 100,000 copies, plus one of the following:

- » Central nervous system lymphoma
- » Persistent wasting
- » Mycobacterium avium complex untreated or unresponsive to treatment
- » Progressive multifocal leukoencephalopathy
- » Systemic lymphoma
- » Visceral Kaposi's sarcoma unresponsive to treatment
- » Renal failure
- » Cryptosporidium infection
- » Toxoplasmosis
- » Karnofsky performance or PPS value less than 50

The guidelines given for each disease are predictive for patients with a single condition. Additional comorbidities or complications should be taken into consideration when evaluating appropriateness for hospice care.

Primary Care Guide Opioids

IV and Oral Opioid Therapy

Drug	Equianalgesic Dose (mg)		Usual Starting Dose	
	Oral	IV/SC	Oral	IV
Meperidine (Demerol®) Not recommended by APS	300	75		
Codeine	300			
Morphine, short acting	30	10	5-15 mg q3 hours	2-4 mg q2 hours
Morphine, long acting (MS Contin®, Oramorph SR®)	30		15 mg q12 hours	
Hydrocodone (Vicodin® – with Tylenol®)	30		5-15 mg q3 hours	
Oxycodone, short acting (Roxicodone®, Percocet® – with Tylenol)	20		5-10 mg q3 hours	
Oxycodone, ong acting (OxyContin®)	20		10 mg q12 hours	
Hydromorphone (Dilaudid®)	7.5	1.5	2-4 mg q3 hours	0.5-1 mg q2 hours
Fentanyl		0.8		

Transdermal Fentanyl*

Morphine 37.5 mg orally = Fentanyl 25 mcg/h
in 24 hours transdermal patch

Patch dose as mcg/h ~ Fentanyl IV rate in mcg/h

Requires adipose tissue – Not indicated in adults
under 120 pounds

*Fentanyl potency varies and the patch should be avoided in opiate naive patients to avoid potentially serious complications.

Methadone Conversion Table

Daily Morphine Dose (mg/24 hr PO)	Conversion Ratios	
	Morphine PO	Methadone PO
<100	3	1
101 - 300	5	1
301 - 600	10	1
601 - 800	12	1
801 - 1000	15	1
>1000	20	1

A typical q8-q12h dose is 2.5 - 5 mg q8h.
If converting from high doses of other opioids, the maximum dose after conversion should never exceed 30 mg q8h.

Primary Care Guide Non-opioids

Neuropathic Pain Analgesics

Drug	Usual Dose Range	Comments
Anti-convulsants		
Carbamazepine (Tegretol®)	Start at 200 mg PO qHS; ↑ dose up to 600-800 mg PO daily (divided BID to TID)	Check serum drug levels and WBC
Gabapentin (Neurontin®)	Start 100 mg PO TID x 1 day, 200 mg TID x 2 days; then ↑ dose; max >4000 mg/d & up	Reduce with renal impairment
Pregabalin (Lyrica®)	Start 50 mg TID Max 600 mg/day	Reduce with renal impairment
Tricyclic Anti-depressants (TCAs)		
Desipramine (Norpramin®)	10-25 mg PO qHS Max 300 mg/day	Preferred TCA in elderly patients
Nortriptyline (Pamelor®)	Start at 25 mg PO qHS; ↑ dose to 75-150 mg qHS	Preferred TCA in elderly patients
Serotonin/Norepinephrine Reuptake Inhibitor (SNRI)		
Duloxetine (Cymbalta®)	60 mg/day	Reduce with renal and no use with liver impairment
Other Options		
Clonazepam (Klonopin®)	Phenytoin (Dilantin®)	
Lidocaine 5% (Lidoderm®)	Tiagabine (Gabitril®)	
Lamotrigine (Lamictal®)	Topiramate (Topamax®)	
Methadone	Valproic Acid (Depakote®)	

Non-steroidal Anti-inflammatory Drugs (NSAIDs) and Non-opioids

NSAID strengths available	Dose (starting)	Max Daily Dose
Acetic Acids		
Diclofenac Sodium (Voltaren®) 25, 50, 75 mg (IR) 100 mg (ER)	50 mg TID (IR) 100 mg daily (ER)	225 mg
Indomethacin* (Indocin®) 25 & 50 mg (IR) 50 mg supp (ER) 75 mg & 25 mg/5 ml (ER)	25-50 mg BID – TID (IR) 75 mg daily (ER)	200 mg
Diclofenac Potassium* (Cataflam®), Sulindac* (Clinoril®), Tolmetin (Tolectin®)		
COX-2 Inhibitors		
Celecoxib (Celebrex®) 100 & 200 mg	100 mg BID or 200 mg qd	400 mg
Naphthylakones		
Nabumetone (Relafen®) 500 & 750 mg	1000 mg daily or may divide BID	2000 mg
Fenamates		
Meclofenamate Sodium* (Meclofenamate®) 50 & 100 mg	50 mg q4-6 hours	400 mg
Mefenamic acid* (Ponstel®)		
Oxicams		
Piroxicam (Feldene®) 10 & 20 mg	10 mg daily	20 mg
Propionic Acids		
Ibuprofen* (Motrin®, Advil®) 200, 400, 600, 800 mg & 100 mg/5 ml	400 mg every 4-6 hours	3200 mg
Naproxen and Naproxen Sodium (Anaprox®, Naprosyn®, Aleve®) 220, 250, 375, 500 mg & 125 mg/5 ml	220 mg-275 mg PO q6-12 hours Naprelan® 750 mg daily	1500 mg Naproxen base
Fenoprofen* (Nalfon®), Flurbiprofen (Ansaid®), Ketoprofen* (Orudis®), Oxaprozin (Daypro®)		

Non-steroidal Anti-inflammatory Drugs (NSAIDs) and Non-opioids

NSAID strengths available	Dose (starting)	Max Daily Dose
Pyranocarboxylic Acid		
Etodolac (Lodine [®] , Lodine XL) 200, 300 & 400 mg (IR) 400, 500, 600 mg (ER)	200-400 mg q6-8 hours (IR) 400 mg daily (ER)	1200 mg
Pyrrrolizine Carboxylic Acid		
Ketorolac (Toradol [®]) 10 mg PO 15 mg/ml, 30 mg/ml IV	30 mg q6 hours IM/IV unless >65 y/o, <50 kg, or renal disease; then 15 mg q6 hrs	120 mg IV unless risks, then 60 mg Max 5 days
Salicylates – Acetylated		
Aspirin* 81, 165, 325, 500 & 650 mg	325-650 mg q4-6 hours	3200 mg
Diffunisal (Dolobid [®])		
Salicylates – Non-acetylated		
Choline Magnesium Trisalicylate (Trilisate [®]) 500, 750 & 1000 mg & 500 mg/5 ml	500-750 mg TID	3000 mg
Salsalate (Disalcid [®]) 500 & 750 mg	500-750 mg TID	3000 mg
Other agents		
Acetaminophen* (Tylenol [®])	325-650 mg q4-6 hours	4000 mg 2000 mg with liver impairment
Tramadol (Ultram [®])	300	50 mg q4-6 hours
Steroidal		
Dexamethasone (Decadron [®]) 0.25, 0.5, 0.75, 1, 1.5, 2, 4, & 6 mg; 0.5 mg/5 ml & 1 mg/ml	2-4 mg q12-24 hours	

IR = Immediate release products

ER = Extended release products

*FDA approved indication for pain

NSAIDS continues on next page

Non-steroidal Anti-inflammatory Drugs (NSAIDs) and Non-opioids

- » All NSAIDs are equally effective
- » Variable pharmacodynamics may be responsible for individual's lack of response
- » Give NSAID adequate trial of 2 – 3 weeks
- » If NSAID does not work, then select from different class or same chemical class

NSAID Side Effects and Precautions

Side Effects:

- » epigastric distress
- » renal insufficiency
- » hepatotoxicity
- » hypersensitivity reactions
- » platelet inhibition (cox-1 NSAIDS)

NSAID Side Effects and Precautions

↑ Risk of GI Bleeding*

- » elderly (age > 65 years)
- » concomitant corticosteroid or anticoagulant use
- » large NSAID doses
- » long-term NSAID therapy
- » history of peptic ulcer disease or GI event (e.g., bleeding)

↑ Risk of Renal Toxicity**

- » elderly (age > 65 years)
- » existing renal problems
- » diuretic use
- » concurrent treatment with nephrotoxic drugs

* Increased risk of GI bleeding with cox-1 NSAID activity. Cox-2 NSAIDs have less GI side effects compared to cox-1.

** Increased risk of renal toxicity with both cox-1 and cox-2 NSAID activity.

Primary Care Guide Non-pain Symptoms

Primary Care Guide
Non-pain Symptoms

Adjuvant Agents

Drug Class Typical 1st Choice	Comments
Antidepressant Desipramine	Adjuvant analgesic, depression
Antiemetic (prokinetic) Metoclopramide	Vomiting 2 ^o gastritis, gastric stasis, & functional bowel obstruction. Anorexia-cachexia, constipation
Antiemetic (area postrema) Haloperidol	Chemical causes of vomiting, e.g., opioids, hypercalcemia, renal failure. Agitation, delirium
Antiemetic (vomiting center) Cyclizine, Meclizine, Scopolamine	Mechanical bowel obstruction, increased intracranial pressure, motion sickness
Antitussive Hydrocodone	
Benzodiazepines Lorazepam	Anti-convulsant, anxiety, delirium, insomnia
Corticosteroids Dexamethasone	Adjuvant analgesic, anorexia-cachexia, antiemetic, asthenia, delirium, dyspnea
Laxative Senna, Lactulose	
Neuroleptics Haloperidol	Agitation, delirium, antiemetic
Stimulant Methylphenidate	Agitation, delirium, antiemetic

Pharmacological Symptom Management

Drug	Usual Dose	Onset to Peak	T ½
Anorexia			
Dexamethasone	2-8 mg PO/IV qAM	1-2h	36-54h
Megestrol Acetate	400 mg PO BID	1-5h	1h
Dronabinol, eicosapentaenoic acid, melatonin, metoclopramide, mirtazepine			
Anxiety/Agitation			
Lorazepam	0.5-2 mg PO/SL q4h PRN	1-6h	10-20h
Alprazolam, chlorpromazine, escitalopram, haloperidol, midazolam, mirtazepine, paroxetine, quetiapine, sertraline			
Asthenia (Weakness)			
Dexamethasone	2-8 mg PO/IV qAM	1-2h	36-54h
Methylphenidate	5 mg PO qAM & qnoon	1-3h	3-4h
Megestrol acetate			
Oral Secretions (Death Rattle)			
1% Atropine Eye Drops	1-3 gtts qhour	10 min	2-3h
Scopolamine 1.5 mg Patch	apply q3days	24 hours	5h
Glycopyrrolate	0.2 mg (IV/SC) or 2 mg (PO) q6-8h	1-45 min	1.7h
Hyoscyamine			
Constipation			
Sennosides (Senna®)	15-100 mg PO daily	6-12h	?
Bisacodyl, docusate sodium, lactulose, magnesium hydroxide, metoclopramide			

Pharmacological Symptom Management

Drug	Usual Dose	Onset to Peak	T ½
Delirium – Terminal Restlessness			
Haloperidol	0.5-2 mg PO/SC/IV BID and q4h PRN	10-20 min	17h
Chlorpromazine, lorazepam, midazolam, olanzapine, quetiapine			
Depression			
Desipramine	25-300 mg daily	2-6h	14-62h
Citalopram, duloxetine, escitalopram, methylphenidate, mirtazapine, nortriptyline, paroxetine, pemoline, sertraline, venlafaxine			
Dyspnea			
Morphine	5-30 mg PO/SL/PR q3h	½-1h	2-4h
Albuterol, aminophylline, dexamethasone, ipratropium, oxygen, theophylline			
Insomnia			
Temazepam	7.5-30 mg qHS	1-2h	8-10h
Chlorpromazine, eszopiclone, indiplon, ramelteon, trazodone, zaleplon, zolpidem			
Nausea/Vomiting			
Haloperidol (decrease motility)	0.5-2 mg PO/SC/IV q4h PRN	3-6h	17h
Metoclopramide (increase motility)	10-20 mg PO/SC/IV TID or QID	½-2h	4-6h
Meclizine (central, vestibular)	25 mg PO BID	1h	6h
Chlorpromazine, dexamethasone, diphenhydramine, dronabinol, lansoprazole, ondansetron, olanzapine, omeprazole, prochlorperazine, ranitidine, quetiapine			

Primary Care Guide Useful Resources

Primary Care Guide
Useful Resources

Useful Resources

Breaking Bad News

(Baile, Buckman et al, 2000)

SPIKES

Setting

Appropriate and without interruption

Perception

What do you know/understand of the condition?

Invitation

Is everyone present, and how much information do you want?

Knowledge

Deliver the information as appropriate

Empathize

And explore emotion

Strategy

Summarize and make a plan

Pronouncing a Death

- » Recognize the extreme emotional significance.
- » Introduce yourself and establish eye contact.
- » Identify the patient by ID bracelet.
- » Assess response to verbal and gentle tactile stimulus.
- » Examine patient for absence of breath and heart sounds.
- » Note time of death.

Pronouncing a Death (continued)

- » When confirmed, verbally acknowledge death to family.
- » Communicate condolences verbally or non-verbally.
- » Inform family about formalities as appropriate.
- » Notify nursing staff and attending of time of death.

Anticipatory Grief

Five things patients and families need to say:

- 1. Forgive me**
- 2. I forgive you**
- 3. Thank you**
- 4. I love you**
- 5. Good-bye**

Hospice

What is it?

Some helpful descriptions:

- » A program emphasizing quality of life rather than prolongation of life
- » An insurance benefit that is provided by an interdisciplinary team available 24 hours a day regardless of patient setting
- » All services (interdisciplinary team, medications, supplies, bereavement) related to the terminal condition are covered

Eligibility

- » Two physicians certify prognosis averages less than 6 months (Usually the primary and the Hospice medical director)
- » Patient and family goals are maximizing quality over quantity

Typically Does Not

- » Cover treatments that do not target specific symptoms
- » Provide caregivers or custodial care

Spirituality

“That which gives meaning to one’s life and draws one to transcend oneself”

– (Center to Improve Care for the Dying)

SPIRIT (Maugen, 1996)

Spiritual belief system –
what is important and of value

Personal spirituality –
where does the person get support





Integration with a spiritual
community

Ritualized practices and
traditions

Implications of medical care –
what is the meaning of the illness

Terminal events planning –
unfinished business

Wong-Baker **FACES** Pain Rating Scale

10	Hurts worst	
9		
8	Hurts whole lot	
7		
6	Hurts even more	
5		
4	Hurts little more	
3		
2	Hurts little bit	
1		
0	No hurt	

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Karnofsky Performance Status

Karnofsky Performance Status

General Category	Index	Specified Criteria
Able to carry on normal activity and to work; no special care needed	100	Normal, no complaints; no evidence of disease
	90	Able to carry on normal activity; minor signs or symptoms of disease
	80	Normal activity with effort; some signs or symptoms of disease
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed	70	Cares for self; unable to carry on normal activity or to do active work
	60	Requires occasional assistance, but is able to care for most of his or her personal needs
	50	Requires considerable assistance and frequent medical care
Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly	40	Disabled; requires special care and assistance
	30	Severely disabled; hospital admission is indicated although death not imminent
	20	Very sick; hospital admission necessary; active supportive treatment necessary
	10	Moribund; fatal processes progressing rapidly
	0	Dead

Palliative Performance Scale version 2 (PPSv2)

Palliative Performance Scale version 2*

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity with effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable normal job/work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or confusion

Palliative Performance Scale continues on next page

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Palliative Performance Scale version 2* (continued)

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
50%	Mainly sit/lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or confusion
40%	Mainly in bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or drowsy +/- confusion
30%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Normal or reduced	Full or drowsy +/- confusion
20%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Minimal to sips	Full or drowsy +/- confusion
10%	Totally bed bound	Unable to do any activity Extensive disease	Total care	Mouth care only	Drowsy or coma +/- confusion
0%	Death				

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In-patient or Continuous Care

In-patient or
Continuous Care

In-patient or Continuous Care

General in-patient or continuous care is designed for people that require acute medical management in licensed facility or in-home RNs respectively. Licensed facilities must have an RN on premises 24 hours a day, and continuous care is at least eight hours of nursing a day and at least half must be delivered by an RN. Indications include the following:

Intractable pain

- » Unmanageable pain, whether or not it can be expressed verbally or through nonverbal signs
- » Ongoing pain control/management requiring frequent adjustment in dose; or analgesia requiring constant monitoring and evaluation
- » Non-verbal signs of pain (groans and grimaces)

Severe intractable symptoms

- » Nausea, vomiting, diarrhea, etc.
- » Respiratory distress, including hypoxia, airway compromise, and dyspnea

Complicated medical care

- » Complicated wound care or dressing changes
- » Complex medication administration

Abrupt changes in psychosocial problems and uncontrolled symptoms, which can create significant stress on the patient/family:

- » Abrupt change in behavioral or cognitive abnormalities causing severe agitation, disorientation, or combative behavior
- » Severe depression and/or anxiety necessitating a change in environment for safety
- » Suicide ideation, gestures, attempts, threats of euthanasia
- » Acute breakdown or disruption in family dynamics, preventing family members from functioning as adequate caregivers (either physically or emotionally)
- » Death is imminent with unstable symptoms and caregiver distress

Seizures requiring intensive intervention, continuous monitoring, and medications

Hemorrhage or bleeding causing symptoms that are difficult for the family to manage

Other symptoms defined by the interdisciplinary team as unmanageable by the family

About Evercare[®] by UnitedHealthcare

In the complex world of health care, we strive to make getting care easier with health plans, programs and services for those who need it most.

Our goal is to improve the health and well-being of people who have long-term or advanced illness, are older or have disabilities, whether they live alone, with family or in a facility.

As part of UnitedHealthcare, we're more than just a trusted name in health care. We're people who care, dedicated to helping you get the health care you deserve.

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7 days a week



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