# CCHCS Care Guide: Palliative Care

## Summary

<table>
<thead>
<tr>
<th>GOALS</th>
<th>ALERTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Identify patients in early stages of a progressive disease</td>
<td>Early identification of patients nearing the end of life is subjective and challenging.</td>
</tr>
<tr>
<td>✓ Timely identification and documentation of goals of care</td>
<td>Common Indicators:</td>
</tr>
<tr>
<td>✓ Reduce performing unnecessary invasive interventions</td>
<td>• Frequent hospitalizations/interventions</td>
</tr>
<tr>
<td>✓ Identify/refer patients who would benefit from Hospice</td>
<td>• End stage progressive illness or cancer diagnosis</td>
</tr>
<tr>
<td>✓ Document Advance Directive (AD) CDCR 7421, and Physician Orders for Life-Sustaining Treatment (POLST) CDCR 7465</td>
<td>• Cognitive decline, dementia</td>
</tr>
<tr>
<td>✓ Consider Compassionate Release or Expanded Medical Parole</td>
<td>• Progressive weight loss and/or frailty</td>
</tr>
<tr>
<td>✓ Optimize pain relief and quality of life</td>
<td>• Frequent or high risk for falls</td>
</tr>
<tr>
<td></td>
<td>• Polypharmacy</td>
</tr>
</tbody>
</table>

## Diagnostic Criteria

Palliative care is an approach that focuses on improving the quality of life for patients facing chronic debilitating and life-limiting illness. Early identification is a key first step in engaging the eligible patient to consider this approach to care.

- Factors that may suggest eligibility include various clinical manifestations, lab parameters, service utilization, and/or declining functional performance ([page 3](#)).
- The CCHCS Medical Classification System may assist with identifying patients at highest risk for life limiting conditions and patients who are HIGH RISK (especially High Risk 1) are most likely appropriate for palliative care.

## Evaluation

Comprehensive assessment and development of an individualized plan of care both guide the prevention and relief of suffering and reduce unnecessary and/or unwanted interventions. Assessment considers needs in each of these domains:

- Ethical and legal
- Social
- Psychological
- Spiritual and religious
- Cultural
- Physical

A key characteristic of palliative care is the interdisciplinary and collaborative process for treatment planning that involves providers, nurses, chaplains, social workers, mental health providers, pharmacists, dieticians, etc.

- When feasible, and in accord with the patient’s wishes, involvement of family members in family conferences and/or care coordination can also be included.
- Considerations for referral to hospice ([page 18](#)) and/or referral for consideration of compassionate release or expanded medical parole ([pages 15-17](#)) may be appropriate for many patients.
- If a patient lacks decision-making capacity, initiating the conservatorship process (PC 2604) ([page 5](#)) and/or a referral to the CCHCS Ethics Committee ([page 8](#)) may be appropriate.

## Treatment

Palliative care/treatment covers a broad range of strategies that focus on comfort and quality rather than duration of life.

- Identifying the patient’s end-of-life wishes is the primary objective of the Goals of Care Conversation (GoCC) ([page 5](#)).
- Treatment approaches should align with the patient's goals and wishes and thus may vary accordingly.
- It is important to anticipate the patient's needs as their condition progresses and to frequently revisit their goals of care.
- Specific recommendations for optimizing the patient's care/comfort in the 6 domains listed above should be considered ([pages 8-9](#)). Managing physical symptoms can often be complex, but very rewarding ([pages 10-13](#)).

## Monitoring

- To assure smooth care transitions across settings or providers, communication with the entire care team should be anticipated, planned, and coordinated whenever the patient changes housing, level of care, or institution.
- Ideally, interdisciplinary care coordination occurs throughout the course of a patient’s condition.
- It is important that care teams create an environment of resilience, self-care, and mutual support to alleviate the stress of caring for patients with serious illness nearing the end of life.

### Treatment Algorithm

<table>
<thead>
<tr>
<th>References</th>
<th>19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative Care Worksheet</td>
<td>20</td>
</tr>
<tr>
<td>Patient Education (English)</td>
<td>PE-1-PE-4</td>
</tr>
<tr>
<td>Patient Education (Spanish)</td>
<td>PE-5-PE-8</td>
</tr>
<tr>
<td>Disease-Specific Prognostic Tools</td>
<td>Attachments A-E</td>
</tr>
<tr>
<td>RUG IV Assessment</td>
<td>Attachment F</td>
</tr>
<tr>
<td>Montreal Cognitive Assessment</td>
<td>Attachment G</td>
</tr>
</tbody>
</table>

Information contained in the guidelines is not a substitute for a health care professional's clinical judgment. Evaluation and treatment should be tailored to the individual patient and the clinical circumstances. Furthermore, using this information will not guarantee a specific outcome for each patient. Refer to “Disclaimer Regarding Care Guides” for further clarification.
Identify eligible patients (page 3)
- Patient presents with new or established diagnosis of a serious illness
- Review QM Master Registry to identify High Risk 1 patients

Does patient have medical decision-making capacity? (page 4)
Yes
- Initiate CCHCS Goals of Care Conversation (GoCC) - (pages 5-7)
  - Elicit patient’s values, goals, preferences
  - Palliative Care Worksheet can assist with defining patient’s specific preferences for life-sustaining treatment (page 19)
  - Provide Patient Education (PE1-4)

No
- Document GoCC (page 7)
  - Complete POLST (CDCR 7465) / AD (CDCR 7421) ASAP (These forms are scanned into EHRS)
  - Complete POLST Ad Hoc Form in EHRS – This triggers EHRS banner bar alert

Assess patient’s palliative care needs based on the following domains of palliative care (pages 8-13)
- Ethical and legal
- Social
- Psychological
- Spiritual and religious
- Cultural
- Physical

Is patient eligible for Compassionate Release (CR) or Expanded Medical (EMP) Parole? (page 15)

- Develop or revise palliative care plan based on patient’s/surrogate’s goals
- Reassess end-of-life wishes frequently

Document conversation/changes in EHRS and update POLST (Scan & AdHoc) as necessary

Does patient meet hospice criteria and wish to consider? (page 18)*

- Refer to Hospice (page 18)
  - Women: CIW and CCWF
  - Men: CMF
  - Hospice care team coordinates care

- Implement palliative care plan ensuring all 6 domains of care needs are being met (pages 8-13)

- Periodic reassessment: Is the care plan meeting the patient’s needs?

- Death

*Use general/disease specific prognostic tools as needed (Attachment A-E)
### Identifying Eligible Patients

Clinical factors that may be useful in identifying eligible patients are shown in the following table:

<table>
<thead>
<tr>
<th>Clinical Manifestations</th>
<th>Lab Parameters</th>
<th>Service Utilization</th>
<th>Functional Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; 4 high risk chronic conditions</td>
<td>Albumin &lt; 2.5</td>
<td>&gt; 2 hospitalizations / 6 months</td>
<td>Adjustment difficulty</td>
</tr>
<tr>
<td>Cancer diagnosis</td>
<td>Creatinine &gt; 2.0</td>
<td>&gt; 2 urgent admissions / 12 months</td>
<td>Falls</td>
</tr>
<tr>
<td>Cognitive decline / dementia</td>
<td>INR &gt; 2.0</td>
<td>TTA / OHU / SNF admissions</td>
<td>Lay-ins</td>
</tr>
<tr>
<td>Weight loss / frailty</td>
<td>Bilirubin &gt; 2.0</td>
<td>Bone marrow biopsy</td>
<td>ADL assistance needed (bath, dress, toilet, eat, transfers)</td>
</tr>
<tr>
<td>Pressure ulcers</td>
<td>PSA &gt; 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infections</td>
<td>AFP &gt; 500</td>
<td>Polypharmacy</td>
<td></td>
</tr>
<tr>
<td>Dysphagia</td>
<td>CA125 &gt; 35 U/mL</td>
<td>Recurrent Antibiotic RXs</td>
<td></td>
</tr>
<tr>
<td>Cardiac disease</td>
<td>FIB4 &gt; 3.25</td>
<td>Appetite Stimulants</td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td>Nutritional Supplements</td>
<td></td>
</tr>
<tr>
<td>COPD</td>
<td></td>
<td>Imaging:</td>
<td></td>
</tr>
<tr>
<td>End Stage Liver Disease</td>
<td></td>
<td>Pharmacy:</td>
<td></td>
</tr>
<tr>
<td>End Stage Renal Disease</td>
<td></td>
<td>Recurrent Antibiotic RXs</td>
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<tr>
<td></td>
<td></td>
<td>Appetite Stimulants</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Nutritional Supplements</td>
<td></td>
</tr>
</tbody>
</table>

Note that Palliative Care is applicable early in the course of illness *in conjunction with* other therapies (including curative) that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.

- As the patient’s disease state progresses, more of a palliative care approach is used as shown in the figure below. See [Attachments A-E](#) for general and disease-specific prognostic tools.

### Palliative Care

- Provides relief from pain and other distressing symptoms.
- Affirms life and regards dying as a normal process.
- Intends neither to hasten or postpone death.
- Integrates the psychological and spiritual aspects of patient care.
- Offers a support system to help patients live as actively as possible until death.
- Uses a team approach to address the needs of patients.
- Enhances quality of life, and may also positively influence the course of illness.
- Is utilized in hospice settings, but hospice is not required to receive palliative care.
While palliative care focuses on achieving the highest quality of life until death, when patients die, there are specific policies and procedures governing actions taken in response to this event. When a provider documents that death is anticipated within 6 months, completes a POLST (see page 7) that incorporates “Do Not Resuscitate” and places an order in EHRS for “Registered Nurse (RN) May Pronounce Death” that allows an RN to pronounce death, these steps help to ensure timely pronouncement of death by an RN when death is expected and the attending provider is not available onsite (see HCDOM 3.1.18). For all deaths, the notified supervisor or nursing program lead shall immediately contact the Chief Executive Officer (CEO), who shall then determine which additional institution staff must be apprised of the situation and within what timeframes. All deaths are reported to the death report unit (see HCDOM 1.2.10) by 1200 hours on the next business day following the patient’s death, and a death review summary is submitted within five calendar days. In the setting of hospice or complex end-of-life medical management, medical providers are often involved with notifications to family members/next of kin and can answer questions that family members may have.

## Determining Medical Decision-Making Capacity

Medical decision-making capacity is the basis of informed consent. Patients have medical decision-making capacity if they can:

1. **Understand** the details of their medical condition and treatment plan options and re-state the important features to demonstrate understanding.
2. **Express a choice** and sustain that choice. If the patient changes their mind frequently, then they may not be able to demonstrate capacity.
3. **Appreciate** and acknowledge the information applies to them. If the patient does not acknowledge that the information applies to them or the patient does not think their diagnosis/treatment is correct, they may lack capacity.
4. **Reason** and provide a rationale for their decisions. Reasoning is influenced by values and beliefs and some rationale (i.e., “too risky”) supports capacity.

- It is important to distinguish between patients who cannot understand the medical situation (and thus may lack decision-making capacity) from those who understand your viewpoint, but do not agree with it.
- No particular form or specific process is needed to determine capacity in most cases. During a typical interaction, the primary care provider (PCP) can see that the patient is following the conversation, asking pertinent questions and demonstrates understanding of what is being said including the risks/benefits of possible testing/treatments. Consider using this phrasing:

  “We have talked about the medical situation you are facing and possible treatments for these problems. Just to make sure we are on the same page, can you describe for me the medical problems you are dealing with now?”

  “Can you also describe the possible treatments we have discussed?”

  Presence of capacity should be documented in EHRS.

- In cases where medical decision-making capacity is NOT clearly evident, the PCP can use the validated Aid to Capacity Evaluation (ACE) tool to help evaluate and document capacity in a more formal manner. Examples for when to use the ACE:
  - Patient has an acute change in mental status
  - Patient refuses clearly beneficial recommended treatment
  - Patient readily agrees to an invasive or risky procedure without considering the risks and benefits

### Tips on Capacity Assessment:

- The PCP is responsible for determining whether a patient is capable of making health care decisions in most cases. Mental Health (MH) input should be sought if the patient has a significant co-existing mental illness.
- Capacity is assessed intuitively at every medical encounter and is usually readily apparent.
- Remember that people are presumed to have medical decision-making capacity, therefore, if there is some modest uncertainty, generally err on the side of considering the patient to have capacity.
- Request assistance from the CEO/CME/CP&S if the patient’s medical decision-making capacity remains in question.
- If the patient refuses life-sustaining medications, the prescriber shall assess the patient’s decision-making capacity and document it in the health record. If a mental health referral is needed, the PCP shall make a referral to the psychiatric physician for a determination of capacity to refuse treatment and inform the patient of the reason for the referral.

### Patients Without Medical Decision-Making Capacity Who Have A Surrogate Medical Decision-Maker

If a patient lacks medical decision-making capacity, a surrogate medical decision-maker will need to be contacted.

- Ideally the patient has completed an AD naming the person(s) they wish to be their surrogate medical decision-maker(s). In this case, the care team is able to immediately utilize the identified surrogate for decisions when the patient lacks capacity.
- It is important for the patient to talk with those individuals they are considering to designate as their surrogate medical decision-maker, and the surrogate should be agreeable to serve in this role.
- Anytime a surrogate is appointed, be sure to document contact with the surrogate for any significant patient care decisions.
- A new AD should never be completed if a patient’s medical decision-making capacity is in question.
DETERMINING MEDICAL DECISION-MAKING CAPACITY (continued)

PC 2604: Court Appointment of a Surrogate Medical Decision-Maker (AKA Medical Conservator)

Some providers think a “crisis” situation is needed to initiate a PC 2604. To the contrary, this process should be started early for any patient who does not have an identified surrogate medical decision-maker and who lacks capacity.

- Contact Office of Legal Affairs (OLA) at (916) 445-0495 for help identifying the patient’s next of kin and initiating a PC 2604.
- Any insight on possible surrogates or knowledge of bias, conflict of interest, etc., about potential surrogates should be shared with OLA.
- Be cautious with informal contact with a family member not previously identified by the patient; it is best to get formal assignment.
- Where medical decision-making is needed urgently for “unrepresented patients,” the CCHCS Health Care Ethics Committee can be of assistance (page 8).

PC 2604 Process:

- The PCP will complete CDCR 7702, Petition for Capacity Determination, which describes a summary of medical and mental health problems.
- OLA initiates the PC 2604 process by filing with the Office of Administrative Hearings (OAH).
- The PCP will be expected to appear for the court proceeding(s), which are usually held at the institution or facility where the patient is located.
- PC 2604 requires annual renewal.

Important to note:

- Send surrogate assignment (PC 2604) with a patient if they transfer to a hospital or other external facility.
- At time of release, county conservatorship may need to be arranged.
- All patients who have an assigned surrogate via PC 2604 process are on the PC 2604 patient registry (with flags on Patient Summary and Master Registry) to support providers and care teams in managing this subset of patients.

Contact Office of Legal Affairs at (916) 445-0495 to help guide you if you have questions throughout the process.

INITIATE GOALS OF CARE CONVERSATION

Elicit Patient’s Values, Goals, and Preferences

Once a patient is determined to possess medical decision-making capacity, the table on page 6 provides a 6-step strategy along with examples that can help with defining patient’s wishes and goals of care. The Goals of Care Conversation (GoCC) should occur early and often in the course of a life-limiting illness. Expect that patient will need time to process information and make decisions.

Good communication is a cornerstone of high-quality medical care, and is linked with better patient outcomes and improved patient and family satisfaction with care.

- Active discussion about an individual’s goals and preferences, specifically as they relate to end-of-life issues, is linked to reductions in hospital utilization and aggressiveness of care at end of life.
- Keep in mind, however, even when providers use good communication techniques, progress toward big decisions may be slow, especially if a patient has just realized that their illness is imminently terminal. People need time to process this information and will likely need to hear the information repeatedly. Be deliberate but patient with this process.
- The effects of a conversation may not be apparent until much later. Simply initiating the conversation will likely have a big impact on the patient’s thinking, even when there is apparent refusal/difficulty. If there are differences of opinion, it is particularly important to reinforce that the patient won’t be abandoned. Proceed to kindly agree to disagree and make sure the patient understands that you’re always going to be there for them. When confronted with refusal such as, “I don’t want to talk about code status,” consider a response such as, “I want to make sure your wishes are heard.”

Motivational interviewing techniques can be useful in helping to explore and resolve ambivalence. Please select the link provided for additional information on motivational interviewing: http://healtheknowledge.org/course/view.php?id=190.
### Elicit Patient’s Values, Goals, and Preferences (continued)²,¹⁰,¹¹

The six-step strategy, also known as SPIKES can help facilitate difficult conversations with patients.

<table>
<thead>
<tr>
<th>Setting</th>
<th>When introducing the GoCC, think about what you want to say in advance.</th>
<th>Select a quiet and private space and allow time for the patient to express their emotions and ask questions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perception</td>
<td>Assess the patient’s understanding of their medical condition using open-ended questions: Open-ended questions can be more efficient because they elicit reliable and complete information, but need to be skillfully managed so to not lead to lengthy discussions.</td>
<td>“What do you understand about your medical condition?”</td>
</tr>
<tr>
<td>Invitation</td>
<td>Ask permission to engage in conversation about a sensitive topic: When the patient gives permission, they are open to the conversation.</td>
<td>“Would it be okay if we talk about services and treatments that might be needed to support your health care goals?” “Have you ever thought about who should make health care decisions for you if you are too sick to speak for yourself?”</td>
</tr>
<tr>
<td>Knowledge</td>
<td>Give the patient information about their condition, treatment plan, discuss the prognosis, and provide support. Remember to use language that is nontechnical and at their comprehension level, give information in small chunks, and check in with the patient regularly to make sure they understand: This builds the patient’s confidence that they have been heard and are being taken seriously, helps the patient feel more comfortable and open to feedback, and builds a therapeutic alliance. Providing options whenever possible can be helpful. Options offered should not include futile therapies (i.e., feeding tubes in patients with dementia).</td>
<td>“Here are some typical changes that occur with your condition...I understand this can be very confusing, do you mind telling me your general understanding of what I have been saying to make sure I have explained it clearly?” (Reinforce what is accurate in their words). “Do you have any concerns?”</td>
</tr>
<tr>
<td>Empathy</td>
<td>Being empathetic can soften the impact of bad news and permits moving forward to discuss strategies that address the disease and its implications: This aids in building rapport, particularly in difficult discussions.</td>
<td>“I can see that this is a difficult time for you.”</td>
</tr>
<tr>
<td>Summarize or Strategize</td>
<td>Ask the patient if they understand the plan and if it makes sense. Using reflection is often helpful: Hearing someone repeat back to you what you are saying often increases insight and self-reflection.</td>
<td>“What I hear you saying is that you’re afraid of dying and aren’t ready to make such difficult decisions.”</td>
</tr>
<tr>
<td></td>
<td>Close with a clear summary of the situation and ask if the patient has any more questions: Summaries help patients and surrogates organize their experience and brings closure, consensus, and sets up for next steps.</td>
<td>“The information you have provided is very important and I want to make sure I understand...”</td>
</tr>
</tbody>
</table>

In light of COVID-19 pandemic, end-of-life conversations have become even more important. A pandemic, such as COVID-19, clearly changes everyone’s risk profile and should be used as a catalyst to visit or revisit end-of-life conversations. The COVID Ready Advance Care Communication Playbook developed by VitalTalk provides a roadmap for providers on how to have these difficult conversations with their patients.

Incarcerated persons retain the right to autonomy in medical care, despite the limitation of their autonomy in their daily activities. When faced with a refusal of care that is considered important or potentially life-saving, a medical provider should consider four areas in determining next steps (adapted from Robert Arnold MD, PCNW Fast Facts #56).

1) Decision-making capacity – See page 4 for key features of medical decision capacity.

2) Validate concerns - Often when we try to convince others of our position, we may not acknowledge the reality of their concerns. This makes them feel unheard and under-appreciated. It is helpful to initially respond with statements that show you are truly listening to what they are saying. Before trying to offer more information, consider reflecting back to the patient:

   “I hear that you are worried if you have surgery you will X,” or
   “It is understandable that you might be afraid of Y.”

   Leave some space for them to discuss those concerns, which shows you are listening.

3) Explore fears - Fears are stronger motivators than positive encouragements. Try to understand the incarcerated person’s fears, and incorporate possible solutions with your proposed plan of care. It may not be immediately obvious what aspect of the treatment plan is causing them fear or distress. In order to better understand, consider exploring this with a question like:

   “Can you tell me if there is something about this decision that frightens you?”

For example, losing one’s cellmate or fear of losing one’s property while away could outweigh the possible health benefits of hospitalization. Acknowledging this fear or concern as real and important to them is the first step in addressing it.
### What you should know:

- The POLST does not have space for a patient to designate a surrogate medical decision-maker. This is an important item to identify in the GoCC and can ideally be documented with an AD or alternatively, in a progress note.
- During GoCC, ensure the patient has an up-to-date contact on custody next-of-kin form and determine if this is the person they would like to speak for them if needed. A Release of Information form (ROI), [CDCR 7385](https://www.cdc.gov/correctional/health/geal/caremgldk/) will need to be filled out prior to talking to next of kin.

### DOCUMENTING GOALS OF CARE CONVERSATION(S)

The GoCC should be explicitly documented in an easily searchable location or separate document. The POLST Ad Hoc form in the EHRS provider documentation folder is a useful place to document and track ongoing discussions about the patient’s goals and preferences for life-sustaining treatments. Note that documentation in the Ad Hoc form does not preclude completion of the POLST document (CDCR 7465).

If outcomes are not as serious or not as time sensitive, the provider should plan to re-evaluate the patient again in a timely manner. Any person should be allowed to change their mind and accept (or refuse care), and that is no different for an incarcerated person.

If a patient consistently refuses potentially life-saving medical care, then ask them for permission to speak to family, friend or surrogate decision-maker. Not only should the named person(s) be aware of the situation, but they may be able to help advocate for needed care or to help understand the reasons for refusal of care.

Keep in mind that a patient’s goals for care can, and do, change over time and it is important to update documentation so that the patient’s evolving wishes are evident to other team members and can be carried out. These discussions help to inform later conversations between the patient (or surrogate) and clinician as the patient’s wishes/goals evolve with their illness.

Documenting the GoCC should efficiently describe and reflect the patient’s:

- Medical decision-making capacity
- Next of kin or identified surrogate medical decision-maker
- Understanding of their health condition
- Goals, preferences, and values

While similar, the POLST and AD each have distinct features which are outlined in the table below.

- It is important to share patient education material that explains each of these forms (see PE 1-4).
- Many patients confuse these documents with a “Last Will and Testament” likely because an AD used to be called “Living Will” so patients may need education/reassurance that an AD is solely related to health care decisions.

<table>
<thead>
<tr>
<th>POLST - CDCR 7465</th>
<th>AD - CDCR 7421</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate for patients who are frail, elderly, or have a life-limiting illness or injury.</td>
<td>Appropriate for all patients regardless of age and health status.</td>
</tr>
<tr>
<td>Provider completes the form to reflect the patient’s wishes.</td>
<td>Patient completes the form - discusses with PCP.</td>
</tr>
<tr>
<td>Four parts:</td>
<td>Four parts:</td>
</tr>
<tr>
<td>- Part A: Resuscitation Status (CPR - Yes/No)</td>
<td>- Part 1: Power of Attorney for Health Care</td>
</tr>
<tr>
<td>- Part B: Medical Interventions (Full/Selective/Comfort-Focused Treatment)</td>
<td>- Part 2: Instructions for Health Care</td>
</tr>
<tr>
<td>- Part C: Artificially Administered Nutrition (Feeding Tube - Yes/No/Limited Trial)</td>
<td>- Part 3: Donation of Organs at Death</td>
</tr>
<tr>
<td>- Part D: Signatures/Summary of Medical Condition</td>
<td>- Part 4: Verification of Understanding, Signature, Witnesses</td>
</tr>
</tbody>
</table>

A notary is not required; the form can be witnessed by institution staff, including health care staff, as long as they do not currently have primary responsibility for the patient’s health care.

### What you should know:

- The AD provides instructions for health care and does not function as an order.
- Patient preferences are optional, so often there is no explicit documentation/expression of whether the patient wants CPR, ventilation, hospital transfer, feeding tube, etc.
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<table>
<thead>
<tr>
<th>SUMMARY</th>
<th>DECISION SUPPORT</th>
<th>PATIENT EDUCATION/SELF MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ASSESSING ALL DOMAINS OF PALLIATIVE CARE</strong>&lt;sup&gt;3,4,5,6&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The overarching goal of palliative care is to reduce suffering and maintain an acceptable quality of life throughout the course of a progressive illness and throughout the dying process.</td>
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</tbody>
</table>

Often, focus is predominantly placed on physical symptom management, whereas ALL of the 6 domains of palliative care need to be considered. Each domain is briefly described below:

### Ethical and Legal Aspects of Care

When a patient loses decision-making capacity, having previously identified surrogate medical decision-makers and documented medical care preferences/goals are very helpful in supporting the autonomy of the patient and guide ongoing palliative care.

- This is why engaging a patient in the GoCC early in the course of illness is so important. If the patient was not able to identify a surrogate medical decision-maker and a surrogate medical decision-maker is needed, the search for family or other suitable surrogates should be reasonable and should be documented to show diligence.
- The Office of Legal Affairs (OLA), (916) 445-0495, is an important resource to contact when the patient lacks or loses medical decision-making capacity especially when the need for legal conservatorship (PC 2604) is identified (page 4).
- The CCHCS Ethics Committee can be used as a resource in difficult end-of-life cases, such as when a patient lacks capacity and is unrepresented, or when the patient or family is insisting on care which has no chance of benefiting the patient, (previously called “futile care”). This multidisciplinary committee provides guidance based on standard practices from the ethics literature in order to facilitate resolution of bioethical dilemmas.
- For Ethics Committee consultation requests, please contact the warmline at CDCR CCHCS HQ Ethics Committee.

### Social Aspects of Care (Including family and friends)

Serious illness can be a frightening and lonely experience. Involving family in the patient’s care can be helpful. Many patients will consider reaching out to long-estranged family members or friends during this period. For other patients, their cellmate or other friends in the prison now serve as their family and they wish to remain in their current housing as long as possible. There are many ways the treatment team can help patients and their families including:

- Having appropriate team members encourage/facilitate difficult, but important, discussions between patients and families.
- Providing emotional support by just sitting and talking with the patient about their fears, anxiety, and sadness.
- Assisting patients who have been estranged from family for years and want closure. A chaplain or other team member may be able to assist in trying to reconnect the patient and family members.
- Hints for finding information on family members/friends: SOMS, Electronic Records Management System (ERMS), visiting office records, or inmate record (C-File). In addition, there are a handful of free websites that can be used, and hospital admissions or attorney records may also contain information regarding next of kin.
- All patients receiving palliative care should have an initial consult with an identified treatment provider to assist with obtaining an ROI and to assist with facilitating family contact for support and placement if compassionate release (page 15) is approved.

### Visits and Phone Calls

**Visits:** [Availability and some processes may vary depending on institution and patient’s custody factors]. If a family member wishes to visit the patient, the patient (or treatment team if patient needs assistance) will need to do the following:

- The patient signs and sends the CDCR 106, Visiting Questionnaire to the prospective visitor.
- The visitor sends the completed/signed CDCR 106 form to the institution’s Inmate Visiting Department.
- If the visitor is approved, the patient will be notified, and they must notify the visitor. If the visitor is disapproved, the patient and visitor will receive a Notice of Disapproval and information on how to appeal the decision.
- Approved visitors may visit during regular visiting days and hours. They must comply with all visitation rules.
- Visits for patients in a community hospital may be approved under the following conditions: the patient has a life-threatening or critical illness/injury, the visitor is an immediate family member including registered domestic partner, the visitor has prior approval to visit the patient in the institution/facility, head or designee approves it, or the attending physician authorizes the visit.
- Hospice patients: staff may assist in the notification of the family member or friend if requested by the patient. Custody can make adjustments to this process if the patient is on VIGIL (having 72 hours or less to live). All hospice patients on VIGIL may receive visits seven days a week from approved visitors. The initial visit can be any time within a 24 hour period.
- See CDCR Department Operations Manual, Chapter 5, Article 42, Section 54020.8 – Visitor Application Procedure for detail.

**Phone Calls:** Many times a patient wants to discuss health care decisions with family before agreeing to a specific plan of care. This is allowed, but must involve custody. There is no specific policy regarding seriously ill (often hospitalized) patients discussing their health care with family, but custody will need to approve and monitor the call to ensure security for all involved.
Depression can be triggered by different factors as the terminally ill patient begins to contemplate death. Sometimes depression can be triggered by a need for reconciliation with family members or friends before death occurs. Depression can also be associated with the loss of control over life events experienced by the patient. As death nears, it is easier to slip into a state of passive resignation and despair. Depression in dying persons may be either due to one's pre-disposition to depression or response to stress, or as a result of the disease itself or the result of treatments.

Treatment strategies may include both pharmacologic and non-pharmacologic modalities.

- Assess for suicidal risk and refer to MH as appropriate
- Assess for medication toxicities (i.e., beta-blockers, corticosteroids)
- MH referral is often necessary for psychotherapy and the consideration of pharmacotherapy
- Educating the patient/correcting misconceptions regarding their condition/treatment, can be consoling

Simply acknowledging the possibility of underlying grief can improve one's rapport with a patient and open the conversation to exploring other related aspects of care. Consultation requests are recommended as needed to leverage the expertise of MH and pastoral colleagues and can be key to addressing/relieving psychological sources of suffering and adds to a multidisciplinary approach to patient care. Delirium can be common in the week or two before death and at any time in patients with pre-existing dementia. Be aware of other possible contributors such as urinary retention, constipation, inadequate oxygenation, metabolic abnormalities, infection, or drug toxicities. Neuroleptic agents are sometimes used to calm agitation.

Spirituality refers to the way individuals seek and express meaning and purpose in regards to the spirit, soul or what they hold sacred, as opposed to their physical or material well-being. Chaplaincy services are available to assist with this aspect of assessment and care. Every institution has several chaplains from a variety of religious traditions available for consultation. The CDCR Chaplain Directory or your local leadership can provide a list of resources. If a patient is located in restricted housing they may submit CDCR 22, Inmate/Parole Request For Interview, Item or Service to request a chaplain visit.

Spiritual/Religious/Chaplain Services:

- Assesses and supports the patient's faith and unique spiritual and cultural beliefs (identifies what gives them hope)
- Provides religious materials when needed/requested
- Solicits/Secures the assistance of community spiritual leaders of a patient's particular spiritual/religious practice
- Maintains the psycho-spiritual dignity of the patient
- Provides interventions for specific symptom relief from spiritual pain (e.g., guilt, anxiety, anger, loss, and aloneness)
- Assists staff in locating a patient's family/nest of kin
- Assists patients with visiting forms (CDCR 106), letters, cards when needed/requested
- Supports/facilitates the patient's decision to create a living legacy or life review
- Prepares patient and family for reconciliation and restoration when needed/requested
- Provides supervised phone calls with families and patients
- Provides a safe environment for a patient to explore and grow in their chosen faith
- Consults and collaborates with the interdisciplinary team
- Provides grief and bereavement follow-up as needed
- Assesses patient satisfaction of the psycho-spiritual care and support
- Provides a follow-up bereavement letter to family of deceased, including a patient family satisfaction sheet (gives the family a voice and helps the program make positive adjustments if needed)

Culture plays a significant role in shaping the way people make meaning of illness, suffering, and dying.

- Culture helps guide decisions about what kind of care a patient chooses to receive, who it should be provided by, and under what conditions.
- Cultural aspects of care may include language (interpreters), values, rituals, and dietary needs.
- In order to provide the best possible care to patients in end-of-life situations, it is important to understand their cultural constructs as well as their individual preferences.
- There are multiple language versions of the POLST and the AD on Lifeline under Health Care Department Operations Manual Resources > Forms. It is very important for a patient to sign a POLST and/or AD in both an English version as well as a version in their primary language to ensure personnel can interpret the patient’s wishes.

It is also important to remember that each provider brings their own set of biases to these discussions based on their own cultural and religious background and personal experiences. The CDCR Approved Inmate Religious Vendors list can be used to identify allowable religious items.
ASSESSING ALL DOMAINS OF PALLIATIVE CARE (continued)

Physical Aspects of Care

Common physical symptoms of patients receiving palliative care include, but are not limited to: pain, anorexia/cachexia, dyspnea, excess secretions, fatigue, agitation, nausea and vomiting, cough, hiccups, ascites/pleural effusions, skin breakdown, pruritus, sleep disturbances, and bladder/bowel control issues. Some of the most common symptoms are described below. A list of commonly used medications for palliative care that are on the CCHCS formulary are listed on page 14. Additional support for managing complex physical symptoms can be obtained at: CCHCSComplexCare@cdcr.ca.gov.

PAIN

Pain can be one of the most prevalent symptoms near the end of life. Unrelieved pain can be a source of great distress for patients and may exacerbate other symptoms. Therefore, the adequate management of pain at the end of life is imperative. See CCHCS Pain Management Guidelines for additional information. General principles include the application of non-pharmacologic therapies; consider radiotherapy for bone pain and tumor infiltration; physical therapy, braces, and support items when needed; and the role of relaxation, distraction; and other coping strategies. The emphasis is on reducing suffering and optimizing quality of life during the dying process.

Consider multiple underlying etiologies for pain:
- Tumor infiltration
- Nerve compression
- Skin breakdown
- Other comorbid conditions such as arthritis.

Depending on the setting of care, aggressive analgesic delivery can be achieved. See CCHCS Pain Management Guidelines Part 3 Opioid Therapy.

Tips:
- Consider breakthrough pain dosing using Immediate Release (IR) medications and more frequent dosing as setting permits.
- Transition to Sustained Release (SR) medications once a baseline analgesia requirement is determined.
- Use the oral route wherever possible.
- Avoid polypharmacy where possible to minimize adverse effects.
- Opioid rotation may be helpful if tolerance develops, there is poor response, or in cases of toxicity.
- Consultation with a pain management specialist and/or pharmacist may be useful (especially with converting to Methadone).

STOMATITIS (inflammation and/or ulceration of the oral mucosa)

Commonly caused by chemo or radiation therapy, other causes may include poor dental hygiene, infection, poorly fitting dentures, and blood dyscrasias. Treatment generally includes the use of opioid analgesics and attention to regular mouth care.

Tips:
- Magic mouthwash which contains Maalox and viscous lidocaine can offer relief.
- Avoid any mouthwashes or rinses that contain alcohol.
- Alternative nutritional support may need to be considered.
- Limit use of petroleum based products to prevent lip cracking.
- Patients on immunosuppressive drugs should be examined regularly for thrush.
- Treat evident candidiasis or thrush with Nystatin or Fluconazole.

EXCESS SECRETIONS

Either as a result of avoiding painful swallowing (which occurs with severe stomatitis), dysphagia (caused by other conditions such as stroke, head injury, dementia), or oral/esophageal cancers, managing excess secretions may become necessary.

Tips:
- Positioning the patient on their side or semi-prone can facilitate postural drainage.
- Gentle periodic suctioning can be useful when available.
- Opioids may mitigate excess secretions.
- Addition of an anti-sialagogue (i.e., atropine, amitriptyline) may be needed.

ANOREXIA / CACHEXIA

Loss of appetite and lean body mass can be due to a variety of metabolic, neuroendocrine, and/or immunologic abnormalities induced by tumor, catabolic states, or prolonged inactivity. Minimizing dietary and consistency restrictions may facilitate improved intake. There are generally limited roles for nutritional supplements and parenteral hydration at end of life. Appetite stimulants such as megace, mirtazapine, or decadron, may be considered.
**Physical Aspects of Care (continued)**

### Cough / Hiccups

Often caused by irritation of the airway or other structures (such as the pleura, pericardium, diaphragm) triggering the cough reflex such as that created by tumor infiltration, infection, pulmonary edema, gastroesophageal reflux disease (GERD)/aspiration, post-nasal drip, or chronic obstructive pulmonary disease (COPD).

**Tips:**
- Depending on the underlying cause, positioning or chest physiotherapy may be useful.
- Opioids may suppress cough; Dextromethorphan may have a synergistic effect.
- Chlorpromazine can help with intractable hiccups.
- Haloperidol and metoclopramide have been used successfully.
- Anticonvulsant agents (e.g., phenytoin, valproic acid, and carbamazepine) have effectively treated intractable hiccups.

### Dyspnea

Subjective air hunger that may or may not be accompanied by hypoxia.

**Tips:**
- First rule out/rectify contributors such as airway obstruction, interrupted oxygen source, or bronchospasm.
- Positioning more upright and increasing air movement (fan, open window, blow-by oxygen) can be helpful.
- Offer supportive reassurance.
- Opioids can effectively relieve the discomfort of air hunger.
- Anxiolytics may be useful if there is a severe anxiety component.

### Fatigue

Most patients living with a terminal illness will experience fatigue at some point. Fatigue can be upsetting and frustrating for patients so they should be specifically asked about it to encourage open discussions about its impact and acknowledge fatigue as a common experience.

**Tips:**
- Treat reversible causes when feasible
- Conserving energy
- Keeping active
- Use good pacing techniques

### Depression / Grief

Psychological distress is common in terminally ill persons and can be a source of great suffering. Grief is an adaptive, universal, and highly personalized response to the multiple losses that occur at the end of life. This response may be intense early on after a loss manifesting itself physically, emotionally, cognitively, behaviorally, and/or spiritually; however, the impact of grief on daily life generally decreases with time.

**Tips:**
- Pharmacologic interventions are not warranted for uncomplicated grief.
- Support patients by acknowledging their grief and encouraging the open expression of emotions.
- Feelings of pervasive hopelessness, helplessness, worthlessness, guilt, lack of pleasure, and suicidal ideation are present in patients with depression. If these symptoms are present, consult MH.
- Refer to MH for consideration of antidepressant medications if necessary.

### Skin Care

Skin may become mottled or discolored near the end of life. Patches of purplish or dark pinkish color can be noted on back and posterior arms/legs. See [CCHCS Wound Care Guide](#) for guidance. Goals of wound care for Stage III and IV decubiti should be to promote comfort and prevent worsening rather than healing since healing most likely will not occur. Consider application of specialized products such as charcoal or metronidazole paste (compounded) if odors are present.

**Tips:**
- Keep sheets clean and dry.
- Apply lotion as tolerated.
- Decubitus ulcers may develop from pressure of being bedbound and/or decreased nutritional status.
- Red spots to bony prominences are first signs of Stage I decubiti and open sores may develop.
- Relieve pressure to bony prominences or other areas of breakdown with turning, positioning, and cushioning as tolerated.
- Use Duoderm or specialized skin dressings as needed.
Physical Aspects of Care (continued)

PRURITIS

Pruritus (itching) is a common and often distressing symptom near the end of life. Pruritus can be described as an unpleasant sensation of the skin or mucous membranes that provokes the desire to scratch or rub. The pathophysiology of pruritus is important and guides effective therapeutic choices.

Tips:
- Histamine release does not play a meaningful role in the pruritus typically observed in palliative patients; therefore, antihistamines are not usually beneficial.
- Emollients should be considered, as dry skin is often an exacerbating factor for most palliative patients with pruritus.
- Consider treating pruritus secondary to uremia, cholestasis, or malignancy with paroxetine or mirtazapine.
- In certain cases, stenting for biliary obstruction is an effective non-pharmacologic treatment that often obviates pharmacotherapy, eliminating potentially adverse side effects.

SLEEP DISTURBANCES

Insomnia affects a majority of palliative care patients and evaluation should start with factors that may be contributing and potentially addressed. There is no single pharmacologic approach that can be recommended for all patients and the lowest effective dose should be administered. As with most drugs, patients in palliative care must be carefully and continually monitored for both positive effect and the development of adverse effects, particularly as the patient’s disease progresses.

Tips:
- Addressing factors such as room temperature, ventilation, lighting, and limiting other stimuli may be useful.
- Reducing or avoiding daytime naps, large meals before bedtime, large fluid intake in the evening, or use of stimulants.
- Increasing daytime light exposure and activity levels when possible.
- Behavioral therapies should be tried initially because they avoid the potential risks associated with medications.
- Patients may be more susceptible to adverse effects of pharmacotherapy due to the presence of end-organ impairment.
- Consult MH for consideration of pharmacotherapy.

EDEMA / ASCITES / PLEURAL EFFUSIONS

Fluid volume, pressure, and levels of sodium and albumin are the keys to maintaining fluid balance between the intracellular and extracellular spaces. As metabolic imbalances set in at the end of life and serum protein levels decline, capillary permeability and lymphatic congestion increase, and fluid begins to shift from the intravascular space to the interstitial space. Further, as the heart gets weak and kidney filtration reduces, fluids move from the intravascular space into the surrounding tissues. This causes edematous extremities, astasis, and/or pulmonary edema.

Tips:
- Diuretics generally do not have a role here.
- It is generally futile and unrealistic to try to fix this problem.
- Decrease fluid intake and offer a wet cloth to have the patient suck on and moisten the mouth; this reduces the sensation of thirst without adding more water to the edema, or body swelling.

BLADDER CONTROL

Numerous factors may contribute to urinary incontinence at the end of life including, but not limited to, neurological problems, cognitive impairment, metastatic disease of the spine or pelvis, stroke, and drug toxicities. Urinary incontinence can be deeply distressing so its assessment and symptomatic management should be as important as that of all other end-of-life symptoms.

Tips:
- Ensuring a person has a regular toilet or pad regimen will help to promote comfort and dignity.
- A commode near the bed, bedpan, or urinal can facilitate continence until very close to the end of life.
- Incontinence pads may be the least invasive option.
- Indwelling catheters are a suitable option to improve skin care or to reduce movement and suffering.
- The choice of catheterization is generally based on the estimated time it will be in place and patient preference.
- Catheter management at the end of life requires attention to comfort, infection prevention, and dignity.
- Skin care is part of continence management in the frail and immobile.
- Barrier creams, repositioning, and constant reevaluation are key to preventing pressure ulcers and further discomfort.
### Physical Aspects of Care (continued)

#### BOWEL CARE

Attention to maintaining bowel function is important in palliative care. Opioids and anticholinergic agents commonly used in palliating other symptoms, as noted above, can aggravate the development of constipation in patients already at risk because of poor oral intake, dehydration, and decreased mobility.

*Whenever starting an opioid agent, simultaneously initiating a regularly administered bowel stimulant such as senna can help to prevent significant constipation and or bowel obstruction. Attention to maintaining bowel function, especially when using opioids, is a crucial aspect of care.*

**Tips:**
- Dosage adjustments and additional adjuvants such as Colace, Bisacodyl, Lactulose, or Milk of Magnesia should be utilized as needed to assure the patient has a reasonably soft and formed bowel movement every 1-2 days.
- If there is no bowel movement in 3 days, the use of an enema or Magnesium Citrate may be needed. Once a response is achieved, additional daily bowel regimen dose adjustments will be necessary in order to maintain regular bowel activity.
- Different agents (softeners, stimulants, osmotic, and lubricant laxatives) can play a useful and potentially synergistic role.
- Bulk-forming (fiber) laxatives (FiberCon, Citrucel, Metamucil) have little role in palliative care and should be avoided.
- Enemas to facilitate a bowel movement come in various formulations from plain water, to solutions containing osmotic agents, such as sodium chloride or baking soda, that help draw water out of the bloodstream back into the colon, to solutions with a lubricant such as mineral oil or a cleansing agent, such as soap. The liquid solution softens the stool and make it easier to pass. When possible, use the least invasive combination of oral agents, diet and mobility first.
- Symptomatic care for concerning bowel obstruction may include one or more of the following: glucocorticoids, octreotide, anticholinergics, and/or analgesics, with or without gastrointestinal (GI) decompression.

#### NAUSEA / VOMITING

It is helpful to determine the underlying etiology of nausea which can be caused by a multitude of possibly overlapping factors:

- Intermittent nausea associated with early satiety and postprandial fullness or bloating
  - Nausea is relieved by vomiting that is usually small volume, occasionally forceful, and may contain food
  - This clinical picture suggests impaired gastric emptying
  - This is the cause in 35%–45% of cases of nausea and vomiting
- Persistent nausea, aggravated by the sight and smell of food, unrelied by vomiting
  - This suggests chemical causes, activating the chemoreceptor trigger zone
  - It is found in 30%–40% of cases
- Intermittent nausea associated with abdominal cramps and altered bowel habit
  - The nausea is relieved by vomiting that may become large in volume and bilious or feculent
  - This suggests a bowel obstruction and is the cause in 10%–30% of cases

The variety of drug classes utilized in management of nausea reflects the complex pathophysiology:

- **Prokinetics**
  - *Metoclopramide, Mirtazapine*
- **Dopamine Antagonists**
  - *Prochlorperazine, Chlorpromazine, Haldol*
- **Antihistamines**
  - *Meclizine, Hydroxyzine, Diphenhydramine, Promethazine*
- **5-HT3 Antagonists**
  - *Odansetron*
- **Other**
  - *Benzodiazepines (Lorazepam)*
  - *Corticosteroids (Dexamethasone), Octreotide*

**Tips:**
- In the setting of delayed gastric emptying, prokinetics are agents of first choice.
- Antihistamines, Dopamine Antagonists, and 5-HT3 antagonists are often first-line agents used for persistent nausea.
- Combination therapy (agents from different classes) is often needed to manage persistent nausea.
- Benzodiazepines are best suited for the anticipatory component of post-operative or chemotherapy-induced nausea.
- Corticosteroids and Octreotide are useful in malignant bowel obstruction.
- Chronic symptoms are challenging and the central pathways are very close to chronic neuropathic pain. Thus, similar therapeutic options may be utilized including low dose tricyclic antidepressants.
<table>
<thead>
<tr>
<th>Medication</th>
<th>Formulations</th>
<th>Palliative Care Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen</td>
<td>325 mg tablets; Rectal suppository 650 mg</td>
<td>Pain—mild to moderate</td>
</tr>
<tr>
<td>Acetaminophen/Codeine</td>
<td>30/300 mg tabs; Elixir 12/120/5ml</td>
<td>Pain—mild to moderate</td>
</tr>
<tr>
<td>Amitriptyline</td>
<td>10 mg, 25 mg tablets</td>
<td>Neuropathic pain, bladder spasm, excess secretions</td>
</tr>
<tr>
<td>Atropine</td>
<td>Injectable: 0.1 mg/ml; Ophthalmic solution: 1%</td>
<td>Excess secretions (apply 1-2 gtts ophthalmic solution under tongue)</td>
</tr>
<tr>
<td>Bisacodyl (e.g., Dulcolax)</td>
<td>5 mg tablets; 10 mg rectal suppositories</td>
<td>Stimulant laxative</td>
</tr>
<tr>
<td>Chlorpromazine</td>
<td>10, 25, 50,100, and 200 mg tablets; Injectable: 25 mg/ml</td>
<td>Intractable hiccups</td>
</tr>
<tr>
<td>Citalopram</td>
<td>10, 20, 40 mg tablets</td>
<td>Depression</td>
</tr>
<tr>
<td>Dexamethasone</td>
<td>0.5, 0.75, 4, 6 mg tabs; Injectable: 4 mg/ml</td>
<td>Anorexia, nausea/vomiting</td>
</tr>
<tr>
<td>Diphenhydramine</td>
<td>Injectable 50 mg/ml (all other forms non-formulary/restricted)</td>
<td>Nausea/vomiting, itching, anaphylaxis</td>
</tr>
<tr>
<td>Docusate Sodium</td>
<td>100 mg capsule</td>
<td>Stool softener</td>
</tr>
<tr>
<td>Duloxetine</td>
<td>20, 30, 60 mg capsules</td>
<td>Neuropathic pain</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>0.5, 1, 2, 5, 10, 20 mg tabs; Oral Soln: 2 mg/ml; Inj: 5mg/ml</td>
<td>Delirium, terminal restlessness</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>200, 400, 600, mg tablets; Suspension 100 mg/5 ml</td>
<td>Pain—mild to moderate</td>
</tr>
<tr>
<td>Lactulose</td>
<td>Oral Solution: 10 gm/15 ml - 473 ml</td>
<td>Osmotic laxative</td>
</tr>
<tr>
<td>Loperamide</td>
<td>2 mg tablets</td>
<td>Diarrhea</td>
</tr>
<tr>
<td>Lorazepam</td>
<td>1 mg tablets; Injectable 2 mg/ml</td>
<td>Anxiety, insomnia, nausea</td>
</tr>
<tr>
<td>Magic Mouthwash</td>
<td>Maalox 60 ml + viscous lidocaine 2% 30 ml</td>
<td>Stomatitis</td>
</tr>
<tr>
<td>Magnesium Citrate</td>
<td>300 ml oral solution</td>
<td>Osmotic laxative</td>
</tr>
<tr>
<td>Magnesium Hydroxide</td>
<td>400 mg/5 ml, 1200 mg/5 ml oral solution</td>
<td>Osmotic laxative, constipation, indigestion</td>
</tr>
<tr>
<td>(e.g., Milk of Magnesia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meclizine</td>
<td>25 mg tablet</td>
<td>Antiemetic</td>
</tr>
<tr>
<td>Megestrol Acetate (e.g., Megace)</td>
<td>20, 40 mg tablets; Oral Soln: 40 mg/ml</td>
<td>Anorexia; caution: thromboembolism</td>
</tr>
<tr>
<td>Methadone</td>
<td>5, 10 mg tablets</td>
<td>Pain—moderate to severe</td>
</tr>
<tr>
<td>Metoclopramide</td>
<td>5, 10 mg tablets; Injectable 10 mg/2 ml</td>
<td>Prokinetic—nausea/vomiting</td>
</tr>
<tr>
<td>Mirtazapine</td>
<td>7.5 mg, 15 mg, 30 mg, 45 mg tablet</td>
<td>Depression, anorexia, insomnia, nausea, itching</td>
</tr>
<tr>
<td>Morphine</td>
<td>IR: 15, 30 mg tabs; SR: 15, 30, 60 mg tabs; Soln: 10 mg/5ml; Inj: 10 mg/ml</td>
<td>Pain—moderate to severe; dyspnea</td>
</tr>
<tr>
<td>Odansetron</td>
<td>4 mg, 8 mg Orally Dissolving Tablet</td>
<td>Antiemetic</td>
</tr>
<tr>
<td>Octreotide</td>
<td>100 mcg/ml Subcutaneous Soln; 10 mg Long-acting depot IM</td>
<td>Malignant bowel obstruction</td>
</tr>
<tr>
<td>Prochlorperazine</td>
<td>5, 10 mg tablets; Injectable 5 mg/ml</td>
<td>Nausea/vomiting</td>
</tr>
<tr>
<td>Promethazine</td>
<td>25 mg tablets; Injectable 50 mg/ml; Rectal Suppository 25 mg</td>
<td>Nausea/vomiting</td>
</tr>
<tr>
<td>Sennosides (e.g., Senna)</td>
<td>8.6 mg tablets</td>
<td>Stimulant laxative/constipation</td>
</tr>
<tr>
<td>Sennosides/Docusate</td>
<td>8.6 mg/50 mg tablets</td>
<td>Stimulant laxative/constipation</td>
</tr>
<tr>
<td>Sodium Phosphate (FLEET) enema</td>
<td>Rectal solution: 118 ml</td>
<td>Additional doses not recommended within 24 hours</td>
</tr>
</tbody>
</table>
Unless a patient with a terminal or significantly incapacitating illness is either serving a sentence of life without parole or is condemned (sentenced to death), consider the need to initiate an application for compassionate release or expanded medical parole. The differences between each of these programs are outlined below:

<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Terminally ill with an incurable condition that is expected to cause death within 12 months</td>
<td>Suffers from a significant and permanent condition, disease, or syndrome resulting in the patient being physically or cognitively debilitated or incapacitated</td>
</tr>
<tr>
<td></td>
<td>Permanently medically incapacitated with a condition that renders the patient permanently unable to perform activities of basic daily living, and results in the patient requiring 24-hour total care, including, but not limited to, coma, persistent vegetative state, brain death, ventilator dependency, loss of control of muscular or neurological function, and the incapacitation from the terminal illness did not exist at the time of the original sentencing</td>
<td>Patient qualifies for placement in a licensed health care facility, as determined by the Resource Utilization Group Assessment form (RUG IV)</td>
</tr>
<tr>
<td></td>
<td>Suffers from a significant and permanent condition, disease, or syndrome resulting in the patient being physically or cognitively debilitated or incapacitated</td>
<td>Patient has an EPRD of 18 months or greater</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parole Status</th>
<th>Compassionate Release</th>
<th>Expanded Medical Parole</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Recalls original sentence, meaning patient will not be returned to custody if condition improves</td>
<td>Original sentence cannot be recalled</td>
</tr>
<tr>
<td></td>
<td>Ultimate determination made by the Board of Parole Hearings (BPH) for indeterminate cases and a judge makes the determination for determinate cases</td>
<td>Conditions set by Division of Adult Parole Operations (DAPO) and/or BPH. May include electronic monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical parole voided if the patient recovers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Returned to prison unless parole date reached</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitoring Release</th>
<th>Compassionate Release</th>
<th>Expanded Medical Parole</th>
</tr>
</thead>
<tbody>
<tr>
<td>Released as free citizen</td>
<td>DAPO and CCHCS (for medical condition improvements)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment</th>
<th>Compassionate Release</th>
<th>Expanded Medical Parole</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family, self, insurance plan, or county aid (if qualifies)</td>
<td>Medi-Cal or Medicare if qualifies; CDCR will make hospital provider whole</td>
<td></td>
</tr>
</tbody>
</table>

Compassionate Release Application Process - See [Compassionate Release Flowchart](#)

**California Correctional Health Care Services - CCHCS**

A) Primary care physician completes [CDC Form 128-C](#), Medical Chrono and submits it to the Institution Chief Medical Executive (CME) for review/signature.

B) The CME and Deputy Medical Executive (DME) shall have 5 working days to review and sign the CDC Form 128-C, approving the physician’s prognosis. The signed CDC Form 128-C shall be submitted to the Classification and Parole Representative (CP&R).

C) Alert the Complex Care team of the submission ([CCHCSComplexCare@cdcr.ca.gov](mailto:CCHCSComplexCare@cdcr.ca.gov)).

**Classification and Parole Representative (C&PR)**

A) C&PR shall review the CDC Form 128-C and the patient’s central file.

1) If the patient is not sentenced to death or to life without possibility of parole, health care staff shall explain the recall of commitment process to the patient within 48 hours of notification and arrange for the patient to designate a family member or other outside agent on [CDCR Form 7385](#). Authorization for Release of Information, which is incorporated by reference. The patient’s designee shall be informed about the recall of commitment process and the patient’s medical condition. The C&PR shall submit the CDC Form 128-C to the patient’s Correctional Counselor (CC I).

B) Correctional Counselor shall have 5 working days to prepare the [Diagnostic Study and Evaluation Report](#).

C) C&PR shall review Diagnostic Study and Evaluation Report and forward the evaluation report to the Warden or Chief Deputy Warden within 3 working days.

D) The Warden or Chief Deputy Warden shall review and sign the evaluation report and ensure it is forwarded to Classification Services Unit (CSU) within 3 working days.
**COMPASSIONATE RELEASE VS. EXPANDED MEDICAL PAROLE**

### Compassionate Release (continued)

**Classification Services Unit (CSU)**

A) CSU reviews case for statutory requirements.

B) CSU completes an evaluation report and the packet goes to CSU Chief for review and recommendation.

C) The packet goes to the Statewide Deputy Director for recommendation and signature.

D) CSU forwards to the Undersecretary for review and consideration.

1) If a positive recommendation for recall is made, the recommendation shall be referred directly to the sentencing court and shall include one or more medical evaluations, the findings of which must determine the patient meets the criteria set forth in PC section 1170(e)(2), and a post-release plan.

E) Pursuant to PC section 1170(e)(9), if the sentencing court grants the recall and resentencing application, the patient shall be released by the department within 48 hours of receipt of the court's order, unless a longer time period is agreed to by the patient or ordered by the court. If the patient has agreed to waive the 48-hour release requirement, the department shall request the sentencing court include in its order that the patient shall be released within 30 calendar days to allow for the coordination of their housing and medical needs in the community to a location where access to care is available.

F) If DAPO is coordinating the patient's placement within the community, the C&PR shall provide a copy of the release order to DAPO upon receipt from the sentencing court.

G) At the time of release, health care staff shall ensure the patient has each of the following in their possession; a discharge medical summary, full medical records, state identification, parole medication, and all property belonging to the patient. After discharge, any additional records shall be sent to the patient's forwarding address.

### Determinate vs. Indeterminate Sentencing:

The difference between determinate sentencing and indeterminate sentencing lies in whether the court has any flexibility in assigning a sentence.

- **Determinate sentencing** is the process by which a judge sentences an offender to a specific amount of time in prison or jail, the judge does not have authority to alter the sentence.

- **Indeterminate sentencing**, however, is the more common method of sentencing. This is the process by which an offender is sentenced to a range of time in custody, or five years to life.

*All Compassionate Release forms can be found in the Medical Services Clinical Resources page, within the Medical Services Resources tab, under the "Compassionate Release" heading.*

### Expanded Medical Parole Application Process - See EMP Flowchart

**California Correctional Health Care Services - CCHCS**

A) A licensed nurse shall complete a Level of Care (LOC)/Resource Utilization Group (RUG) PowerForm within the Electronic Health Record System (EHRS). Patients must score 1 or greater on the LOC/RUG or meet the cognitive impairment criteria regardless of the LOC/RUG score, to be considered for EMP (see Attachment F).

- **LOC/RUG Score of 1 or greater**: An automated electronic order shall be sent to the PCP to approve or deny for EMP.

- **LOC/RUG Score of 0**: Nursing shall refer to the PCP to determine whether it would be appropriate to assess for any cognitive impairment that would require 24-hour nursing supervision. If deemed appropriate, a mental health provider shall complete the Montreal Cognitive Assessment (see Attachment G).

B) PCP completes sections 1-4 on page 1 and the top of page 2 (Patient’s Name and CDC Number) of the CDCR 7478-EMP (Expanded Medical Parole) Form.

C) A **CDCR Form 7385-MP** (Medical Parole) Authorization for Release of Information, must be filled out by the patient or patient’s designee (surrogate medical decision-maker) if they are able to provide consent to release the patient’s medical information. If the patient/designee is unable to provide consent to release the patient’s medical information, the corresponding box shall be marked in Section 4 of the CDCR 7478-EMP form.

D) PCP signs CDCR 7478-EMP and forwards original form to the institution’s CME. The CME shall have 3 working days to review the CDCR 7478-EMP form and determine if patient is eligible. A copy of all paperwork shall be sent to the Utilization Management (UM) mailbox at MedicalParole@cdcr.ca.gov.

*The PCPs are reminded the CDCR 7478-EMP is for use in the EMP review process by non-health care personnel. Terms used to describe the patient’s medical condition should be easily understood by non-health care personnel.*

### Classification and Parole Representative (C&PR)

A) Upon receipt of LOC/RUG PowerForm, CDCR 7478-EMP, and CDCR 7385-MP (if applicable) from the CME, the C&PR shall have 3 working days to review the forms and the patient’s case factors to ensure the patient meets the custody requirements of the EMP Program.

B) C&PR completes and signs page 2, section 5 of CDCR-EMP. Within 3 working days, the C&PR shall ensure a copy of the CDCR 7478-EMP is forwarded to the patient’s CC I to request CC I prepare the Expanded Medical Parole Evaluation Report.
Expanded Medical Parole (continued)

Correctional Counselor (CC I)
A) Upon direction from the C&PR or their supervisor, the CC I shall prepare an EMP Evaluation Report (Example of EMP Evaluation Report) within 5 working days. CC I will also complete a CDCR 611, Release of Program Study and will submit both the EMP Evaluation Report and CDCR 611 to C&PR for review.

B) C&PR shall have 3 working days to review and forward the EMP Packet (see below) to the Warden or Chief Deputy Warden for signature. The Warden or Chief Deputy Warden shall review and sign the EMP Evaluation Report and will ensure the EMP Packet is to be forwarded to the CSU within 3 working days, and a copy of all paperwork sent to the UM mailbox at MedicalParole@cdcr.ca.gov.

Classification Services Unit (CSU)
A) Upon receipt of the EMP Packet from the institution, the CSU shall have 3 working days to ensure the packet is complete and contains the documentation required by the BPH to process the case. CSU will obtain the supporting documentation noted below as (a.) through (f.) in the patient’s ERMS to complete the EMP packet. CSU ensures all forms are complete and appropriately signed and sends EMP packet to the BPH.

The complete Expanded Medical Parole Packet consists of the following documents:

1. Expanded Medical Parole Evaluation Report
   a. Abstract of Judgement (AOJ)
   b. Probation Officer’s Report (POR)
   c. Legal Status Summary (LSS)
   d. Institutional Staff Recommendation Summary (ISRS)
   e. Criminal Identification and Information Number issued by the California Department of Justice, Bureau of Identification
   f. Most recent CDC Form 128-G, Classification Chrono, with the patient’s full case factors.

2. CDCR Form 7478-EMP
3. CDCR Form 7478-A, Expanded Medical Parole Form Addendum (if provided by DAPO or the UM Unit)
4. CDCR Form 7385-MP (included only if the patient or patient’s surrogate medical decision-maker was able to provide consent for the release of the patient’s medical information)
5. CDCR 611-Release of Program Study
6. LOC/RUG PowerForm

Board of Parole Hearings (BPH)
A) Upon receipt of the EMP Packet from the CSU, the BPH shall confirm the packet is complete. If the packet is complete, the BPH will schedule the patient for an Expanded Medical Parole Hearing within 3 working days.

B) The BPH shall be responsible for notifying any registered victims of the patient’s hearing 90 days in advance, as well as the District Attorney (DA) of the patient’s county of commitment at least 30 days in advance.

C) The BPH shall be responsible for compiling and distributing hearing packet documents to the hearing panel, DA, and the patient’s attorney.

D) The BPH shall notify the Case Records Unit and the CSU of the scheduled EMP hearing date within 5 working days.

Notification of BPH Decision
A) The BPH shall provide a copy of its proposed decision to the patient’s institution, HQ UM, CSU, and DAPO within 10 working days of the hearing.

B) If approved for medical placement, the proposed decision shall include any facility requirements and patient restrictions imposed by BPH. The proposed decision shall become invalid if an appropriate medical facility is not verified by DAPO within 120 days of the hearing. Notification that an appropriate medical facility has been verified by DAPO shall be submitted by HQ UM to BPH via a CDCR Form 7478-EMP, indicating the placement has been approved. The CDCR Form 7478-EMP shall be submitted via electronic mail to BPH BPHmedicalparole@cdcr.ca.gov.

Finding Placement
A) If the BPH approves the patient for EMP placement, HQ UM shall propose an appropriate medical facility for the patient within five working days.

B) HQ UM staff who confirmed the patient’s placement approval shall complete Page 2, Section 6, Placement Plan Approvals, “For CCHCS Completion” of the CDCR 7478-EMP.

C) UM Program staff shall forward the original CDCR 7478-EMP, attachments listed on Page 2, Section 5, Eligibility Approvals, “For C&PR Completion” of the CDCR 7478-EMP, and original CDCR 7385-MP, if the patient or patient’s designee was able to provide consent, to the appropriate DAPO re-entry unit, within three working days of a proposed medical facility being identified.
HOSPICE SERVICES

Hospice care is a type of palliative care which involves a multidisciplinary team of providers, nurses, chaplains, social workers and others who work to address all of the patient’s needs within the 6 domains. A patient does NOT need to be in an “official” hospice unit to receive palliative care. That said, many hospice units are set up to offer focused end-of-life care as their primary mission.

MEN - California Medical Facility (CMF) - Vacaville

The nation’s first licensed prison hospice is located within CMF and has a 17-bed unit that uses an interdisciplinary team approach in care planning and delivery. This closed unit attempts to maintain a “homelike” inpatient setting within the prison. Hospice services are available as follows:

- An interdisciplinary team who specializes in end-of-life care
- Spiritual support services and access to the pastoral care services workers (patient caregiver supports)
- Assistance in locating and contacting family
- A relaxed and open 4-day weekly visiting policy (children can visit in a supportive environment)
- Friends from the mainline may visit (if cleared by custody)
- A decrease in unnecessary/futile hospitalizations
- Timely submission of compassionate release and medical parole application processes.

Admission Criteria:
- Documented clinical progression of disease and prognosis for imminent death within 6 months.
- Custody review (some custody levels require housing in single cell only and single rooms are limited).
- POLST completed; DNR recommended, but not required.
- AD; recommended, but not required.

Referral Process
- Hospice Admission Forms - Documentation can be compiled from EHRS or any available source, to include with referral submission.
- Sometimes there is a waiting list for admission, but this varies and providers are encouraged to communicate with CMF if they have an urgent referral.

WOMEN - California Institution for Women (CIW) AND Central California Women’s Facility (CCWF)

CIW and CCWF offer Palliative Care/Hospice type services within their Outpatient Housing Unit (OHU) and Correctional Treatment Center (CTC) - (CIW) and Skilled Nursing Facility (SNF) - (CCWF) settings. All settings offer 24-hour nursing care, assistance with activities of daily living (ADLs) and other services as outlined in the Special Housing Policy. Both Institutions have onsite physical therapy, registered dieticians, and recreation therapy services.

CIW offers a Compassionate Companions Program (CCP) and CCWF offers a Comfort Care Program. Both of these programs involve trained patient volunteers who provide support to patients dealing with the effects of a terminal illness. These patient volunteers can be present at the patient’s bedside in designated settings offering support by way of letter writing, reading to the patient, basic grooming and at the end of life may be present for a bedside vigil to ensure no one dies alone should the patient choose to accept the services.

Patients housed in the CTC at CIW, or in the SNF at CCWF who are too ill to facilitate a visit in the designated visiting area may, with Warden approval, have authorized family/friend visitation at the bedside within the CTC or SNF.

Admission Criteria:
- The patient has a prognosis of ≤ 6 months if the disease follows its expected course (referring provider identifies patient and CIW/CCWF leadership/Palliative Care staff concur).
- The patient and/or designated legal representative request and agree to the Palliative/Comfort Care goals and philosophy.
- The patient requires assistance with ADLs and/or skilled nursing care at a level that is appropriate for the specific unit.
- POLST/AD completed; DNR recommended, but not required.

Referral Process
- Providers with patients meeting admission criteria should contact the Chief Medical Executive at CIW or CCWF.
The validated tools below (and attached) can be used as general or disease-specific prognostic tools to help assess a patient and help begin some estimate of prognosis based on the stage of the illness and the patient's overall condition.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Prognostic Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>Karnofsky or Palliative Performance Scale (PPS)</td>
</tr>
<tr>
<td>Dementia</td>
<td>Functional Assessment Staging (FAST)</td>
</tr>
<tr>
<td>Cancer</td>
<td>Eastern Cooperative Oncology Group (ECOG)</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>New York Heart Association (NYHA)</td>
</tr>
<tr>
<td>Liver</td>
<td>Child-Pugh and Model for End-Stage Liver Disease (MELD)</td>
</tr>
</tbody>
</table>

REFERENCES


2. LeBlanc TW, Tulsky MD. Discussing Goals of Care-UpToDate [Internet]. Available from: https://www.uptodate.com/contents/discussing-goals-of-care


PALLIATIVE CARE WORKSHEET

It's never easy to think about dying, but doing so now will help to decide what you would like to have happen at the end of your life; then you can tell your family and health care team your wishes. What you may want at the end of your life may be very different from someone else. What is important to each person is different.

- For some people, the main goal is to be kept alive as long as possible, even if they have to be kept alive on machines and are suffering.
- For other people, the main goal is to focus on their quality of life and being comfortable, meaning they would prefer a natural death and not to be kept alive on machines.
- Other people are somewhere in between.

Answering the questions below can help you think about the care you would like at the end of your life. It is a good way to tell your wishes to your health care team.

I have a family member or friend that can make medical decisions for me if I become too sick to make my own medical decisions:

- Yes - Name___________________ Phone___________ Address__________________
- No

As I become sicker, I would like to:

- Receive all treatments necessary even though it might cause me to be in pain or uncomfortable.
- Be as comfortable as possible, even though I might not live as long

Specific treatments that might keep me alive longer are listed below. I want the following treatments even if it causes pain/discomfort (See PE-1 - Life Sustaining Treatments)

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Yes</th>
<th>Unsure</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breathing Machine (You can’t breathe on your own):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPR (Your hearts stops beating):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis (Your kidneys are no longer working):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeding Tube (You can’t eat on your own):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following is important to me:

<table>
<thead>
<tr>
<th>Importance</th>
<th>Yes</th>
<th>Unsure</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being able to recognize my family and friends:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not being in constant pain and/or discomfort:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being able to make my own medical decisions:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How important is spirituality or religion to you?

<table>
<thead>
<tr>
<th>Importance</th>
<th>Very Religious</th>
<th>Unsure</th>
<th>Not Religious</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am very religious and/or spiritual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I want to speak to a Chaplain/Spiritual Leader:</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

I am not religious and/or spiritual
What Are Life–Sustaining Treatments?

Life-sustaining treatments are treatments that might help you live a short time longer in some cases. Examples of these treatments are:

**Feeding tubes:** Carry liquid nutrition, fluids, and medications directly into your stomach or intestines. There are two kinds of feeding tubes. One goes into the nose, down through the throat, and into the stomach. The other goes through your skin into your stomach or intestines (requires minor surgery). A feeding tube might be considered if you can't eat or you can't eat safely due to swallowing problems.

**Mechanical ventilation (Breathing Machine):** Helps you breathe when you can't breathe on your own. Being on a breathing machine can be uncomfortable and sometimes patients will need additional medications to help them feel more comfortable.

**Dialysis:** Cleans a person's blood to remove waste products when the kidneys can no longer do the job. This requires large tubes to be placed in the blood vessels and to stay in the blood vessels between treatments.

**Cardiopulmonary Resuscitation (CPR):** Used in an emergency when someone's heart has stopped beating. CPR can help blood and oxygen flow to your brain while medical staff try to get your heart to beat normally again. This may help prevent brain damage. CPR may include:

- Someone pushing on your chest with their hands (chest compressions).
- Artificial breathing. Staff will use a small bag attached to a mask to push air into your lungs.
- Someone giving you medications to stimulate your heart.
- Someone putting a tube into your throat to help air reach your lungs.
- A machine giving you one or more quick electrical shocks to your chest, also known as defibrillation [pronounced: duh-fi-bruh-lei-shn].

Life-sustaining treatments might, or might not work to help you live a short time longer. Life-sustaining treatments do not cure disease or chronic illness. Sometimes they are used for a short time to get a person through a health crisis, like when a chronic illness suddenly gets worse or while a person is being treated for a sudden serious illness. Sometimes life-sustaining treatments cause complications or discomfort.

Your treatment team can give you more information about life-sustaining treatments. Talk with them about how these treatments relate to your health care goals.
What is Hospice?

Hospice is:
- A type of Palliative Care
- Usually for a patient who has 6 months or less to live.
- Care provided by a team made up of doctors, nurses, social workers, other health care staff and chaplains who work together to keep the patient comfortable physically, mentally and spiritually.
- Offered at CMF for men and CCWF and CIW for women.

The hospice care team can help the patient deal with any “unfinished business,” can help the patient get in touch with family, and can provide spiritual/religious support if that is wanted by the patient. Most of the time, your primary doctor will ask you if you are interested in the hospice program when the time is right. You are welcome to ask your health care team about hospice care at any time if you have questions.

Do you have to be in hospice to be considered for Compassionate Release or Expanded Medical Parole?

• No, these programs are different and it does not matter if you are on hospice. Speak to your medical provider if you think you are eligible.
### What is a Medical Decision-Maker?
- A Medical Decision-Maker is a person that you pick to make health care choices for you if there comes a time when you cannot speak for yourself.
- The Medical Decision-Maker is very important.

### What a Medical Decision-Maker Can Do (once you can no longer speak for yourself):
- They can talk with your doctor about your medical problems and agree to start or stop medical treatment including: Medicines, tests, CPR, breathing machines (ventilators), and feeding tubes.
- They can tell others about your wishes for treatment at the end of life and make sure they are followed.

### Choosing a Medical Decision-Maker:
A Medical Decision-Maker can be a family member or friend. They should be someone who:
- You can trust and is willing to do the job.
- Can separate their own wishes from your wishes and can carry out your wishes if necessary.
- Can handle it if others want you to get treated differently than what you want.
- Can easily be reached if they are needed.

Your Medical Decision-Maker cannot be your doctor or another medical provider.

### What is an Advance Directive?
- Advance Directive is a document that allows you to write your wishes about end-of-life care.
- It allows you to say what you want so that family, friends, doctors, nurses, and other health care staff will know for sure what you want if you can no longer speak for yourself.
- In CDCR we use CDCR Form 7421 Advance Directive for Health Care.
- You may request a CDCR Form 7421 at any time, even when you are young and perfectly healthy.
- The Form 7421 Advance Directive allows you to:
  - Name someone to speak for you when you can no longer speak for yourself (Medical Decision-Maker).
  - Say what your wishes are (e.g., “I don’t want CPR, or a breathing machine, a feeding tube is okay.”)

**NOTE:** The Advance Directive is NOT a “Will” and has NOTHING to do with your possessions.

### What is a POLST?
- POLST is short for Physicians Orders for Life Sustaining Treatment
- This is a form used by all hospitals in California (and other states)
- The CDCR POLST Form 7385 is used to write a patient’s wishes about end-of-life care
- The POLST allows a patient to say they want to:
  - Try CPR or Do NOT want to try CPR (allow natural death)
  - Focus on being kept comfortable or want to try all treatments offered, or want something in between
  - Try a feeding tube or NOT try a feeding tube if eating/swallowing becomes difficult
- If you are seriously ill, especially if you have been in the hospital, your health care team should talk with you about filling out a POLST
- If your doctor or health care team has not asked you about your wishes, you should bring it up yourself so that any questions you have can be answered and your wishes can be written down and followed

### What happens if I don’t have a POLST form?
Without a POLST form, emergency medical staff will not know your treatment wishes. You will most likely receive all possible treatments, whether you want them or not. Talking about your treatment choices with your loved ones and doctor before a problem occurs can guide them and help ensure you get the care you want.
# Myths About Death and Dying

<table>
<thead>
<tr>
<th>Myth</th>
<th>Fact</th>
</tr>
</thead>
<tbody>
<tr>
<td>An Advance Directive means “do not treat”</td>
<td>An Advance Directive is a way to tell your health care team what treatment you want or do not want. In an Advance Directive or POLST you tell your wishes. Some people say they do not want a lot of treatment when it is clear they are dying, others want to try more things. It is up to the patient.</td>
</tr>
<tr>
<td>If I name a medical decision-maker, I will be giving up my rights to make my own decisions</td>
<td>Naming a medical decision-maker does not take away any of your authority. You always have the right to make decisions while you are still mentally capable. You may cancel or change your medical decision-maker at any time.</td>
</tr>
<tr>
<td>Choosing hospice means my doctor has given up on me and my medical needs won’t be met</td>
<td>The hospice team usually consists of a doctor, nurse, social worker, chaplain, volunteers, and other specialists if needed. The hospice team will work together to help you feel comfortable and can help support the more personal aspects in your life stage: helping you think about your family and other relationships, how you want to be remembered, and what gives your life meaning.</td>
</tr>
<tr>
<td>Hospice is giving up</td>
<td>Hospice care is not giving up. Hospice services provide comfort and improve quality of life to patients who are dying and to help carry out their wishes. In some cases, a patient’s health can improve and they may be discharged from hospice care.</td>
</tr>
<tr>
<td>Dying is painful</td>
<td>Many people die without having pain. If a patient’s condition causes pain, in most cases the pain can be controlled with medications and other treatments.</td>
</tr>
<tr>
<td>If I go to hospice, I will be stuck there and won’t be able to leave my bed</td>
<td>Patients in the hospice unit can leave their rooms to attend activities including going to the gym and other activities such as groups as long as they are strong enough.</td>
</tr>
<tr>
<td>I don’t want to be around a bunch of patients that are dying</td>
<td>The fact is, patients do die in the hospice unit, but there are also many patients that end up living a long time. Patients respond well to holistic care (when the mind, body, and spirit are treated) and at times, end up living longer than what was expected. Families can usually visit more often and most patients find hospice to be a very positive place.</td>
</tr>
<tr>
<td>Palliative care is just for people with cancer</td>
<td>Palliative care is for anyone suffering with a life limiting illness, including chronic diseases such as kidney, liver, lung, and heart failure, dementia, and other neurological illnesses.</td>
</tr>
<tr>
<td>A Will and Advance Directive are the same</td>
<td>A “Will” is a written set of instructions that allows a person to say what they would like to have happen with their possessions when they die. An Advance Directive is TOTALLY different. An Advance Directive allows a patient to state their wishes for the type of health care they do or do NOT want and also to say who they want to make decisions for them if in the future they cannot make their own decisions.</td>
</tr>
</tbody>
</table>
### ¿Qué son los Tratamientos de Soporte Vital?

Los tratamientos de soporte vital son cuidados que podrían ayudarlo a vivir un poco más en algunos casos. Ejemplos de estos tratamientos son:

<table>
<thead>
<tr>
<th>Tratamiento</th>
<th>Descripción</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sondas de alimentación</strong></td>
<td>Llevan alimentos líquidos, fluidos y medicamentos directo a su estómago o intestinos. Hay dos tipos de sondas de alimentación. Uno va en la nariz, baja por la garganta y llega al estómago. El otro pasa a través de la piel hasta el estómago o los intestinos (requiere cirugía menor). Se considera el uso de una sonda de alimentación si no puede comer o no puede comer con seguridad debido a problemas de deglución.</td>
</tr>
<tr>
<td><strong>Respiración mecánica (respirador)</strong></td>
<td>Lo ayuda a respirar cuando no puede hacerlo solo. Tener un respirador puede ser incómodo y en ocasiones, los pacientes necesitan medicamentos adicionales para ayudarlos a sentirse mejor.</td>
</tr>
<tr>
<td><strong>Diálisis</strong></td>
<td>Limpia la sangre de una persona para eliminar los productos residuales cuando los riñones ya no pueden hacer el trabajo. Esto requiere que se coloquen sondas grandes en las venas y que permanezcan allí entre los tratamientos.</td>
</tr>
<tr>
<td><strong>Reanimación cardiopulmonar (RCP)</strong></td>
<td>Se usa en una emergencia cuando el corazón de una persona deja de latir. La RCP puede ayudar a que la sangre y el oxígeno lleguen a su cerebro mientras el personal médico intenta hacer que su corazón vuelva a latir. Esto puede ayudar a prevenir el daño cerebral. La RCP incluye:</td>
</tr>
</tbody>
</table>

- Una persona presionando su pecho con las manos (compresiones de pecho).
- Respiración artificial. El personal usará una bolsa pequeña conectada a una máscara para enviar oxígeno a sus pulmones.
- Una persona dándole medicamentos para estimular su corazón.
- Una persona colocando un tubo en su garganta para que el aire llegue a sus pulmones.
- Una máquina dándole uno o más choques eléctricos, mejor conocido como desfibrilación.

Los tratamientos de soporte vital pueden o no ayudarlo a vivir un poco más. Estos no curan enfermedades o afecciones crónicas. A veces se utilizan durante un corto período de tiempo para ayudar a una persona a superar una crisis de salud, como cuando una enfermedad crónica empeora repentinamente o cuando una persona está siendo tratada por una enfermedad grave y repentina. Algunas veces, los tratamientos de soporte vital causan complicaciones o molestias.

Su equipo de tratamiento puede darle más información sobre los tratamientos de soporte vital. Hable con ellos acerca de cómo estos tratamientos se relacionan con sus objetivos de atención médica.
¿Qué es el hospicio?
El hospicio es:
- Un tipo de cuidado paliativo
- Usualmente para un paciente que tiene 6 meses o menos de vida.
- Cuidados por parte de un equipo formado por médicos, enfermeras, trabajadores sociales, otro personal sanitario y religiosos que trabajan juntos para mantener al paciente cómodo física, mental y espiritualmente.
- Ofrecido en el Centro Médico de California (California Medical Facility, CMF) para hombres y en el Centro de Mujeres de California (Central California Women's Facility, CCWF) y en la Institución de California para Mujeres (California Institution for Women, CIW).
- El equipo de cuidados de hospicio puede ayudar al paciente a tratar cualquier "asunto pendiente," puede ayudarlo a ponerse en contacto con su familia y puede proporcionarle apoyo espiritual/religioso si así lo desea el paciente. La mayoría de las veces, su médico de atención primaria le preguntará si está interesado en el programa de hospicio cuando sea el momento adecuado. Si tiene alguna pregunta, puede preguntar a su equipo de atención médica sobre el cuidado de hospicio en cualquier momento.

¿Tiene que estar en un hospicio para ser considerado para la Liberación por Compasión o la Libertad Condicional Médica Ampliada?
- No, estos programas son diferentes y no importa si usted está en un hospicio. Hable con su proveedor médico si cree que tiene derecho a la Liberación por Compasión o la Libertad Condicional Medica Ampliada.
¿Qué es el POLST?
El POLST es la abreviación de Physicians Orders for Life Sustaining Treatment (Ordenes del Médico de Tratamiento para el Mantenimiento de la vida).
- Es un formulario usado en todos los hospitales de California (y otros estados).
- El formulario de POLST 7385 se usa para escribir los deseos del paciente sobre el cuidado del fin de la vida.
- El POLST le permitirá al paciente decir si quiere:
  - Intentar o no la RCP (permitir la muerte natural)
  - Enfocarse en mantenerse cómodo o probar todos los tratamientos ofrecidos, o si quiere algo entremedio
  - Usar una sonda de alimentación o NO usar una sonda de alimentación si se hace difícil comer/tragar
- Si usted está gravemente enfermo, en especial si ha estado en el hospital, su equipo de atención médica debe hablar con usted sobre cómo llenar un formulario POLST.
- Si su médico o equipo de atención médica no le ha preguntado acerca de sus deseos, debe mencionarlo usted mismo para que se pueda responder a cualquier pregunta que tenga y se puedan anotar sus deseos y hacer un seguimiento de los mismos.

¿Qué sucede si no tengo un formulario POLST?
Sin un formulario POLST, el personal médico de emergencia no conocerá sus deseos de tratamiento. Lo más probable es que usted reciba todos los tratamientos posibles, los quiera o no. Hablar sobre sus opciones de tratamiento con sus seres queridos y su médico antes de que ocurra un problema puede guiarlos y ayudarlos a asegurarse de que obtenga la atención que desea.
## Mitos Sobre la Muerte

<table>
<thead>
<tr>
<th>Mito</th>
<th>Realidad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Una Directiva Anticipada significa “no tratar”</td>
<td>Una Directiva Anticipada es una manera de decirle a su equipo de atención médica qué tratamiento quiere o no quiere. Algunas personas dicen que no quieren mucho tratamiento cuando está claro que están muriendo, otras quieren probar más cosas. Dependiendo del paciente.</td>
</tr>
<tr>
<td>Si nombro a un Tomador de Decisiones Médicas, renunciaré al derecho de tomar mis propias decisiones</td>
<td>Nombrar a un Tomador de Decisiones Médicas no le quita ninguna de sus facultades. Usted siempre tiene el derecho de tomar decisiones mientras esté mentalmente capacitado. Puede cancelar o cambiar a su Tomador de Decisiones Médicas en cualquier momento.</td>
</tr>
<tr>
<td>Elegir un hospicio significa que mi médico ha rendido y que mis necesidades médicas no serán satisfechas</td>
<td>El equipo de hospicio usualmente consta de un médico, una enfermera, un trabajador social, un capellán, y voluntarios u otros especialistas si es necesario. El equipo de hospicio trabajará en conjunto para ayudarlo a sentirse cómodo y puede ayudarlo en los aspectos más personales de esta etapa de vida: ayudarlo a pensar en su familia y en otras relaciones, cómo quiere que lo recuerden y qué es lo que le da sentido a su vida.</td>
</tr>
<tr>
<td>El hospicio es rendirse</td>
<td>El cuidado de hospicio no es rendirse. Los servicios de hospicio proporcionan comodidad y mejoran la calidad de vida de los pacientes que están muriendo y ayudan a llevar a cabo sus deseos. En algunos casos, la salud del paciente puede mejorar y puede ser dado de alta del cuidado de hospicio.</td>
</tr>
<tr>
<td>Morir es doloroso</td>
<td>Muchas personas mueren sin tener dolor. Si la condición de un paciente causa dolor, en la mayoría de los casos el dolor puede ser controlado con medicamentos y otros tratamientos.</td>
</tr>
<tr>
<td>Si voy a un hospicio, me quedará atrapado allí y no podré salir de mi cama</td>
<td>Los pacientes de la unidad de hospicio pueden salir de sus habitaciones para asistir a actividades como ir al gimnasio y otras actividades como grupos, siempre y cuando sean lo suficientemente fuertes.</td>
</tr>
<tr>
<td>No quiero estar cerca de un grupo de pacientes que se están muriendo</td>
<td>La realidad es que los pacientes sí mueren en la unidad de hospicio, pero también hay muchos pacientes que terminan viviendo mucho tiempo. Los pacientes responden bien al cuidado holístico (cuando la mente, el cuerpo y el espíritu son tratados) y, a veces, terminan viviendo más de lo que se esperaba. Por lo general, las familias pueden visitar más a menudo y la mayoría de los pacientes encuentran que el hospicio es un lugar muy positivo.</td>
</tr>
<tr>
<td>Los cuidados paliativos son solo para personas con cáncer</td>
<td>Los cuidados paliativos son para cualquier persona que sufra de una enfermedad que limite su vida, incluyendo enfermedades crónicas como insuficiencia renal, hepática, pulmonar y cardíaca, demencia y otras enfermedades neurológicas.</td>
</tr>
<tr>
<td>Un testimonio y una Directiva Anticipada son lo mismo</td>
<td>Un testamento es un conjunto de instrucciones escritas que le permite a una persona decir lo que le gustaría que sucediera con sus posesiones cuando muera. Una Directiva Anticipada es TOTALMENTE diferente. Esta le permite al paciente expresar sus deseos sobre el tipo de atención médica que desea o no desea y también decir quién quiere que tome decisiones por él si en el futuro no puede tomar sus propias decisiones.</td>
</tr>
</tbody>
</table>
### GENERAL—Karnofsky Performance Status Scale Definitions Rating (%) Criteria

<table>
<thead>
<tr>
<th>Ability and Conditions</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Able to carry on normal activity and to work; no special care needed.</td>
<td>100</td>
</tr>
<tr>
<td>Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.</td>
<td>70</td>
</tr>
<tr>
<td>Unable to care for self; requires equivalent of institutional or hospital care; disease may be progressing rapidly.</td>
<td>0</td>
</tr>
</tbody>
</table>

**Criteria:**
- 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.
- 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 personal needs.
- 50: Requires considerable assistance and frequent medical care.
- 40: Disabled; requires special care and assistance.
- 30: Severely disabled; hospital admission is indicated but death not imminent.
- 20: Very sick; hospital admission necessary; active supportive treatment necessary.
- 10: Moribund; fatal processes progressing rapidly.
- 0: Dead

### GENERAL—Palliative Performance Scale (PPS)

The Palliative Performance Scale (PPS) is a modification of the Karnofsky and was designed for measurement of physical status in Palliative Care. Only 10% of patient with PPS score of ≤ 50% would be expected to survive for > 6 months.

<table>
<thead>
<tr>
<th>%</th>
<th>Ambulation</th>
<th>Activity and Evidence of Disease</th>
<th>Self-Care</th>
<th>Intake</th>
<th>Level of Consciousness</th>
</tr>
</thead>
<tbody>
<tr>
<td>100</td>
<td>Full</td>
<td>Normal Activity No Evidence of Disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>90</td>
<td>Full</td>
<td>Normal Activity Some Evidence of Disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>80</td>
<td>Full</td>
<td>Normal Activity with Effort Some Evidence of Disease</td>
<td>Full</td>
<td>Normal or Reduced</td>
<td>Full</td>
</tr>
<tr>
<td>70</td>
<td>Reduced</td>
<td>Unable to do Normal Job / Work Some Evidence of Disease</td>
<td>Full</td>
<td>Normal or Reduced</td>
<td>Full</td>
</tr>
<tr>
<td>60</td>
<td>Reduced</td>
<td>Unable to do Hobby / House Work Significant Disease</td>
<td>Occasional Assistance Necessary</td>
<td>Normal or Reduced</td>
<td>Full or Confusion</td>
</tr>
<tr>
<td>50</td>
<td>Mainly Sit/Lie</td>
<td>Unable to do Any Work Extensive Disease</td>
<td>Considerable Assistance Required</td>
<td>Normal or Reduced</td>
<td>Full or Confusion</td>
</tr>
<tr>
<td>40</td>
<td>Mainly in Bed</td>
<td>As Above</td>
<td>Mainly Assistance</td>
<td>Normal or Reduced</td>
<td>Full or Drowsy or Confusion</td>
</tr>
<tr>
<td>30</td>
<td>Totally Bed Bound</td>
<td>As Above</td>
<td>Total Care</td>
<td>Reduced</td>
<td>Full or Drowsy or Confusion</td>
</tr>
<tr>
<td>20</td>
<td>As Above</td>
<td>As Above</td>
<td>Total Care</td>
<td>Minimal Sips</td>
<td>Full or Drowsy or Confusion</td>
</tr>
<tr>
<td>10</td>
<td>As Above</td>
<td>As Above</td>
<td>Total Care</td>
<td>Mouth Care Only</td>
<td>Drowsy or Coma</td>
</tr>
<tr>
<td>0</td>
<td>Death</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>
ATTACHMENT B

DISEASE-SPECIFIC PROGNOSTIC TOOLS (ATTACHMENTS-continued)

DEMENTIA–Functional Assessment Staging (FAST)\textsuperscript{15,16}

The National Hospice and Palliative Care Organization (NHPCO) guidelines state that a FAST stage 7A is appropriate for hospice enrollment, based on an expected six month or less prognosis, if the patient also exhibits one or more specific dementia-related co-morbidities:

- Aspiration
- Multiple stage 3-4 ulcers
- Upper urinary tract infection
- Persistent fever
- Sepsis
- Weight loss >10% w/in six months

The FAST scale has 7 stages:
1. which is normal adult
2. which is normal older adult
3. which is early dementia
4. which is mild dementia
5. which is moderate dementia
6. which is mod-severe dementia
7. which is severe dementia

Check highest consecutive level of disability:

\begin{itemize}
  \item [\square] 1. No difficulty either subjectively or objectively.
  \item [\square] 2. Complains of forgetting location of objects. Subjective work difficulties.
  \item [\square] 3. Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organizational capacity. *
  \item [\square] 4. Decreased ability to perform complex tasks, instrumental ADLs, (e.g., handling personal finances, difficulty shopping, etc.)
  \item [\square] 5. Requires supervision with ADLs (e.g., choosing proper clothing to wear for the day, season)
  \item [\square] 6. a) Needs assistance with dressing (e.g., may put street clothes on over night clothes, or have difficulty buttoning clothing) occasionally or frequently
     b) Unable to bathe properly (e.g., difficulty adjusting the bath-water temperature) occasionally or more frequently in the past weeks. *
     c) Inability to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe proper or properly dispose of toilet tissue) occasionally or more frequently over the past weeks. *
     d) Urinary incontinence (occasionally or more frequently over the past weeks).
     e) Fecal incontinence (occasionally or more frequently over the past weeks).
  \item [\square] 7. a) Ability to speak limited to approximately a half a dozen intelligible different words or fewer, in the course of an average day or in the course of an intensive interview.
     b) Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview (the person may repeat the word over and over).
     c) Ambulatory ability is lost (cannot walk without personal assistance).
     d) Cannot sit up without assistance (e.g., the individual will fall over if there are not lateral rests [arms] on the chair).
     e) Loss of ability to smile.
     f) Loss of ability to hold head up independently.
\end{itemize}

* Scored primarily on the basis of information obtained from knowledgeable informant and/or category.

DEMENTIA–Mortality Risk Index Score (MRI)\textsuperscript{17}

The Mortality Risk Index (MRI), a composite score based on 12 risk factor criteria has been suggested as an alternative to FAST. Mitchell developed and validated the MRI by examining data from over 11,000 newly admitted nursing home patients. Among patients with a MRI score of \( \geq 12 \), 70\% died within 6 months. Compared to FAST Stage 7C, the MRI had greater predictive value of six month prognosis.

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|}
\hline
Mortality Risk Index Score (MRI) & Risk estimate of death within 6 months & \\
\hline
Points & Risk factor & Score & Risk % \\
\hline
1.9 & Complete dependence with ADLs & 0 & 8.9 \\
1.9 & Male gender & 1.2 & 10.8 \\
1.7 & Cancer & 3-5 & 23.2 \\
1.6 & Congestive heart failure & 6-8 & 40.4 \\
1.6 & O2 therapy needed w/in 14 day & 9-11 & 57.0 \\
1.5 & Shortness of breath & \( \geq 12 \) & 70.0 \\
1.5 & < 25\% of food eaten at most meals & & \\
1.5 & Unstable medical condition & & \\
1.5 & Bowel incontinence & & \\
1.5 & Bedfast & & \\
1.4 & Age > 83 y & & \\
1.4 & Not awake most of the day & & \\
\hline
\end{tabular}
\end{table}
ATTACHMENT C

DISEASE-SPECIFIC PROGNOSTIC TOOLS (ATTACHMENTS-continued)

CANCER—Eastern Cooperative Oncology Group \(^{18}\) (ECOG)

The Eastern Cooperative Oncology Group (ECOG) is one of the largest clinical cancer research organizations in the United States, and conducts clinical trials in all types of adult cancers. They developed the ECOG Performance Status. These criteria are used by providers and researchers to assess how a patient's disease is progressing, assess how the disease affects the daily living abilities of the patient, and determine appropriate treatment and prognosis.

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

Scoring: ECOG > 3 roughly correlates with median survival of 3 months

ATTACHMENT D

HEART FAILURE—New York Heart Association \(^{20}\) (NYHA)

Based on data from SUPPORT, Framingham, IMPROVEMENT, and other studies, 1-year mortality estimates are below. The National Hospice and Palliative Care Organization’s guidelines for Heart Disease admission criteria include: NYHA class IV heart failure (Symptoms at rest).

<table>
<thead>
<tr>
<th>Class</th>
<th>Symptom Severity</th>
<th>1 year Mortality Estimates (Support Study)</th>
</tr>
</thead>
</table>
| Class II
Patients with slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain. | Mild | 5-10% |
| Class III
Patients with marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain. | Moderate | 10-15% |
| Class IV
Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased | Severe | 30-40% |
Child-Turcotte-Pugh is a tool used to help assess prognosis in patients with liver disease. Variations in the timing and subjectivity inherent in the scoring (e.g., in grading ascites or encephalopathy) are its major limitations.

### Child-Pugh Points

<table>
<thead>
<tr>
<th>Encephalopathy</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>Grade 1-2</td>
<td>Grade 3-4 (or chronic)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ascites</th>
<th>None</th>
<th>Mild/Moderate (diuretic-responsive)</th>
<th>Severe (diuretic-refractory)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Bilirubin (mg/dl)</th>
<th>&lt; 2</th>
<th>2-3</th>
<th>&gt; 3</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Albumin (g/dl)</th>
<th>&gt; 3.5</th>
<th>2.8-3.5</th>
<th>&lt; 2.8</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>PT (seconds prolonged)</th>
<th>&lt; 4</th>
<th>4-6</th>
<th>&gt; 6</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>INR</th>
<th>&lt; 1.7</th>
<th>1.7-2.3</th>
<th>&gt; 2.3</th>
</tr>
</thead>
</table>

### Encephalopathy Grading

- Grade 1: Mild confusion, anxiety, restlessness, fine tremor, slowed coordination
- Grade 2: Drowsiness, disorientation, asterixis
- Grade 3: Somnolent but arousable, marked confusion, incomprehensible speech, incontinence, hyperventilation
- Grade 4: Coma, decerebrate posturing, flaccidity

### Child-Pugh Cirrhosis Scoring

<table>
<thead>
<tr>
<th>Class</th>
<th>Points</th>
<th>One year survival (%)</th>
<th>Two year survival (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class A</td>
<td>5-6</td>
<td>95</td>
<td>90</td>
</tr>
<tr>
<td>Class B</td>
<td>7-9</td>
<td>80</td>
<td>70</td>
</tr>
<tr>
<td>Class C</td>
<td>10-15</td>
<td>45</td>
<td>38</td>
</tr>
</tbody>
</table>

### Ectracepathy Grading

- Grade 1: Mild confusion, anxiety, restlessness, fine tremor, slowed coordination
- Grade 2: Drowsiness, disorientation, asterixis
- Grade 3: Somnolent but arousable, marked confusion, incomprehensible speech, incontinence, hyperventilation
- Grade 4: Coma, decerebrate posturing, flaccidity

### LIVER DISEASE– Model for End-Stage Liver Disease (MELD)

Originally derived from patients with cirrhosis undergoing elective Transjugular Intrahepatic Portosystemic Shunt (TIPS) procedures to predict 3 month mortality post procedure. Adopted by the United Network for Organ Sharing (UNOS) in 2002 for the prioritization of patients waiting for liver transplants.

- **Note:** There are some conditions associated with chronic liver disease that may result in impaired survival but are not directly accounted for in the MELD scoring system; such as: HCC, Hepatopulmonary Syndrome; therefore these should not be the only tools used for accessing overall prognosis.

- **MELD formula:**
  \[
  \text{MELD} = 3.78 \times \ln(\text{serum bilirubin (mg/dL)}) + 11.2 \times \ln(\text{INR}) + 9.57 \times \ln(\text{serum creatinine (mg/dL)}) + 6.43
  \]
  - \( \ln = \text{natural logarithm} \)

- **MELD Score Three Month Mortality:**

<table>
<thead>
<tr>
<th>MELD Score</th>
<th>3 Month Mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>40 or more</td>
<td>71.3% mortality</td>
</tr>
<tr>
<td>30-39</td>
<td>52.6% mortality</td>
</tr>
<tr>
<td>20-29</td>
<td>19.6% mortality</td>
</tr>
<tr>
<td>10-19</td>
<td>6.0% mortality</td>
</tr>
<tr>
<td>&lt;9</td>
<td>1.9% mortality</td>
</tr>
</tbody>
</table>

- **Online Calculator:** [https://www.hepatitisc.uw.edu/page/clinicalcalculators/ctp](https://www.hepatitisc.uw.edu/page/clinicalcalculators/ctp)
## Resource Utilization Group (RUG-IV) Assessment

The RUG-IV assessment is a patient classification system for skilled nursing patients that is used to assess the type and quantity of care required for an individual.

### Patient Information

<table>
<thead>
<tr>
<th>Patient's Name:</th>
<th>CDCR#:</th>
<th>DOB:</th>
<th>Assessment Date:</th>
</tr>
</thead>
</table>

### Self Performance

<table>
<thead>
<tr>
<th>Activity</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0—Independent (no help)</td>
<td>0</td>
</tr>
<tr>
<td>1—Supervision (oversight, encouragement, cueing)</td>
<td>1</td>
</tr>
<tr>
<td>2—Limited Assistance (staff provide guided maneuvering of limbs)</td>
<td>2</td>
</tr>
<tr>
<td>3—Extensive assistance (staff provider weight bearing support)</td>
<td>3</td>
</tr>
<tr>
<td>4—Total dependence—full staff performance every time 7 days/week</td>
<td>4</td>
</tr>
<tr>
<td>7—Activity occurred only once or twice</td>
<td>7</td>
</tr>
<tr>
<td>8—Activity did not occur</td>
<td>8</td>
</tr>
</tbody>
</table>

### Support

<table>
<thead>
<tr>
<th>Activity</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0—no physical help from staff</td>
<td>0</td>
</tr>
<tr>
<td>1—set up help only</td>
<td>1</td>
</tr>
<tr>
<td>2—one person physical assist</td>
<td>2</td>
</tr>
<tr>
<td>3—2 persons physical assist</td>
<td>3</td>
</tr>
<tr>
<td>8—ADL activity itself did not occur or family and/or non facility staff provided care</td>
<td>8</td>
</tr>
</tbody>
</table>

### Bed Mobility

- Bed mobility—how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture
- Score: ____________

### Transfer

- Transfer—how resident moves between surfaces including to and from chair, wheelchair, standing (excludes to/from bath/toilet)
- Score: ____________

### Toilet Use

- Toilet Use—how resident uses toilet room, commode, bedpan, or urinal; transfer on/off toilet, cleanses self after elimination, changes pad, manages ostomy and catheter, adjusts clothes. Excludes emptying of bed pan, urinal, bedside commode, catheter bag or ostomy bag.
- Score: ____________

### Eating

- Eating—how resident eats and drinks regardless of skill. Excludes eating/drinking during med pass. Includes tube feeding, TPN, IV fluids for nutrition or hydration
- Score: ____________

**Total Score:** ____________ (max of 16)
### Montreal Cognitive Assessment (MOCA)

The Montreal Cognitive Assessment is a cognitive screening test designed to assist providers in the detection of mild cognitive impairment and Alzheimer’s disease.

#### MONTREAL COGNITIVE ASSESSMENT (MOCA)

<table>
<thead>
<tr>
<th>VISUOSPATIAL / EXECUTIVE</th>
<th>Copy cube</th>
<th>Draw CLOCK (Ten past eleven)</th>
<th>POINTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>END</td>
<td></td>
<td>(3 points)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAMING</th>
<th>Contour</th>
<th>Numbers</th>
<th>Hands</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>MEMORY</th>
<th>FACE</th>
<th>VELVET</th>
<th>CHURCH</th>
<th>DAISY</th>
<th>RED</th>
<th>No points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Read list of words, subject must repeat them. Do 2 trials. Do a recall after 5 minutes.</td>
<td>1st trial</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>2nd trial</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ATTENTION</th>
<th></th>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Read list of digits (1 digit/sec). Subject has to repeat them in the forward order</td>
<td></td>
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<tr>
<td>Subject has to repeat them in the backward order</td>
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<tr>
<td>Read list of letters. The subject must tap his hand at each letter A. No points if ≥ 2 errors</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>LANGUAGE</th>
<th></th>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Repeat: I only know that John is the one to help today.</td>
<td></td>
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<tr>
<td>The cat always hid under the couch when dogs were in the room.</td>
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<tr>
<td>Fluency / Name maximum number of words in one minute that begin with the letter F</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ABSTRACTION</th>
<th>Similarity between e.g. banana - orange = fruit</th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>train - bicycle</td>
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<tr>
<td>watch - ruler</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>DELAYED RECALL</th>
<th>FACE</th>
<th>VELVET</th>
<th>CHURCH</th>
<th>DAISY</th>
<th>RED</th>
<th>Points for UNCUED recall only</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Has to recall words</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WITH NO CUE</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ORIENTATION</th>
<th>Date</th>
<th>Month</th>
<th>Year</th>
<th>Day</th>
<th>Place</th>
<th>City</th>
<th></th>
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</thead>
</table>

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Normal ≥ 26 / 30
Add 1 point if ≤ 12 yr edu

TOTAL  / 30