Banner University Medicine

BUMCT Inpatient Hospice (BGIP)

Provider workflow and requirements for BGIP transition:

1. **Provider** makes Care Coordination aware of need for Hospice Consult and **places order:** *Hospice Consult*, *Comment: Need BGIP Evaluation*
    a. BGIP consult orders may be placed 7 days per week
    b. BGIP admissions are available M-F (8am-430pm), with the goal to have referrals in by 2pm to allow time for processing; consults placed after hours will be addressed the following business day
    c. BGIP is not currently accepting patients for terminal extubation
2. The *Hospice Consult* order initiates:
    a. Patient placed on Case Management Worklist (MPTL)
    b. Care Coordinator sends Hospice of the Valley referral via CarePort
    c. Hospice of the Valley central intake notifies BUMCT Admissions Coordinator of referral
    d. Admissions Coordinator reviews chart, meets with the patient and family to evaluate, and handles electronic consents if patient is approved
3. Patient is approved and a new FIN is generated for the Hospice encounter with the assistance of the Admissions Coordinator
    a. Admissions Coordinator will contact BUMCT provider to begin transition process
    b. If patient is not approved for BGIP, the Care Coordinator will reach out to provider and Admissions Coordinator will write note for reasons in chart
4. **Referring Provider** **next steps:**
    a. If patient is accepted and life expectancy >4 hours, call Medicine Captain
    b. If non-Hospital Medicine Team feels comfortable keeping patient on their team and/or patient is unlikely to survive >4hrs they may keep the patient under their service
5. **Accepting Provider** **next steps:** (Medicine Captain or current team as above)
    a. **Do not discharge your patient's acute care encounter until new Hospice FIN acquired and orders written**
    b. On **Hospice encounter**: new FIN
        i. Use Hospice Powerplan for admission
            1. Hospice Physician Medical Director can be consulted for patient appropriate order recommendations
        ii. Admit under accepting provider; Order: *Admit to Inpatient, Level of Care: Med-Surg, Comment: Hospice*
        iii. Complete H&P
        iv. Assume role of attending
    c. On initial **Acute Care encounter** FIN:
        i. Place order: *Discharge to Other, Complete Diagnosis, When: Now, Discharge to Hospice Facility, Details: HOV (BGIP)* and complete discharge summary within 24 hours
        ii. **Do not** discharge initial patient encounter until new orders are entered under the Hospice encounter FIN
    d. After process complete, Admissions Coordinator will enter order: *Patient Placement Communication, Comment: Close the acute patient chart and activate the Hospice Pending Chart*
        i. Admissions Coordinator may also call patient placement to expedite FIN transfer process
    e. Hospice team and Hospice Physician Medical Director will support primary team provider through the hospice process as patient progresses

6. Hospice RN will visit family after patient is accepted and new encounter generated
7. BUMCT **provider** works with Bedside RN for patient symptom management
8. 2 RNs can declare death on BGIP patients (only specially trained nurses, not all bedside RNs)
9. Death Certificate handled by Hospice of the Valley Physician Medical Director

Important Contacts:

Hospice of the Valley Referral Line
(480) 730-5980

BUMCT RN Admissions Coordinator
480-589-7343

Medicine Captain
Pager: 520-446-1000
Ascom: 520-694-3550

Care Coordination
See individual unit Care Coordination schedules

General Inpatient Level of Care: GIP (BGIP)

- **Documentation upon transfer to GIP should include:**
  - The onset of the uncontrolled symptoms or pain
  - The interventions tried thus far that have been unsuccessful at controlling the symptoms
- **Supporting documentation for pain control may include:**
  - Frequent evaluation by a doctor or nurse
  - Frequent medication adjustment
  - IV medication that cannot be administered at home
  - Aggressive pain management
  - Complicated technical delivery of medication
- **Supporting documentation for symptom control may include:**
  - Sudden deterioration requiring intensive nursing intervention
  - Uncontrolled nausea or vomiting
  - Pathological fractures
  - Open wounds requiring frequent skilled care
  - Unmanageable respiratory distress
  - New or worsening delirium

Symptoms or Conditions for GIP

- Acute pain crisis
- Respiratory distress/Respiratory failure
- Intractable nausea/vomiting
- Intractable diarrhea
- Severe constipation
- Increased agitation
- Combativeness
- New onset hallucinations
- New onset delusions
- Acute altered mental status
- Aggressive/Complex wound care
- Advanced open/complex wounds
- Delirium
- Acute fracture
- Acute infection/sepsis
- Acute hemorrhage
- Dementia with psychosis
- Ascites with pain
- Unexplained fever
- Syncope
- Uncontrolled seizure
- Frequent titration of medications

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HOSPICE ORDER SET: (HOSPICE (ADULT) [PP])

1) Code Status (DNR)
2) Comfort Care: Allow Natural Death
3) Notify Physician (Hospice MD)
4) Notify Rn (HOV Admit Nurse OR On Call Staff)
5) Nutritional: Comfort/Pleasure Feeds
6) Oxygen
7) Vital Signs: Q Shift

Medications (typical example)

1) Morphine Sulfate – 1mg (2mg/1ml) IVP Q 15-60 Minutes* PRN Dyspnea/Pain OR
2) Hydromorphone - 0.2mg IVP Q 15-60 Minutes* PRN Dyspnea/Pain OR
3) Fentanyl - 25mcg IVP Q 15-60 Minutes* PRN Dyspnea/Pain
4) Acetaminophen - 650Mg Q 4 Hours PRN Pain/Temp ≥ 101
5) Haloperidol (5mg/ml) - 0.5mg IVP Q 15 Minutes (2 Doses) PRN Agitation/Delirium
6) Lorazepam (2mg/ml) – 1mg IVP Q 1 Hour PRN Anxiety/Restlessness
7) Bisacodyl – 10mg Daily PRN Constipation
8) Glycopyrrolate (0.4mg/2ml) - 0.4mg IVP Q 4 Hours PRN Oral Secretion Management
   **Consider Opioid Tolerant Patients*

Other Medications and Oral Meds, If Appropriate

1) Atropine Sulfate 1% Ophthalmic Drops - 2 gtts SL Q 2 Hours PRN Oral Secretion Management
2) Ondansetron (4mg/2ml) – 4mg IVP Q 6 Hours PRN Nausea/Vomiting

Other Considerations

1) Deactivate Implanted Device (AICD)
2) Discontinue CRRT/HD/PD/SLEDD
3) Discontinue IABP/LVAD