gilchrist

Hospice Care Prognostic Booklet

When is my patient eligible for hospice?

For urgent questions, call Gilchrist at 443.849.8200

Our Mission

To provide counseling, support and care to anyone with a serious illness, so they may live life to the fullest.

Our Vision

We are deeply committed to giving people the clear information and loving support they need to make informed choices about their care.

Dear Provider,

Some of the most challenging discussions a medical provider will have with a patient suffering with a serious illness is what will happen next and when.

Prognostication is not an exact science and knowing when to refer to hospice can be a challenge. Gilchrist can help.

Please accept this guidance which presents the Medicare guidelines for disease specific prognostication. As you will see, these guidelines are not perfect and depend upon your clinical judgment regarding the normal course of the illness. Medicare realizes the uncertainty of this process.

However, we are required to use these guidelines as a baseline to determine appropriateness for a hospice referral. The general guidelines are provided here along with the specific criteria for patients with:

Cancer	ALS	Heart Disease	HIV Disease
Liver Disease	Pulmonary Disease	Renal Disease	Stroke and Coma

Patients who have other disease processes or multiple medical complexities may still be eligible for hospice. Ask yourself, "Would I be surprised if this patient died in the next six months?" If the answer is "no," Gilchrist can help with the eligibility determination. Even if your patient is not eligible for hospice, they may be eligible for other Gilchrist services. We offer at-home Elder Medical Care aimed at the last three years of life (see p. 34, Other Gilchrist Services). Please call your Gilchrist representative or 443.849.8200 with any questions about a particular patient, and we will help determine the appropriate service.

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Certification/Recertification

In order for patients to elect their hospice benefit, all of the following criteria should be met:

- Patients must be considered to **have a life-limiting condition with documented evidence of decline in clinical status** based upon the guidelines below. **A "life-limiting condition" may be due to a specific diagnosis, a combination of diseases, or there may be no specific diagnosis defined.** It's important to note the term "decline" presumes assessment of clinical status over time, so documentation of both baseline and follow-up determinations is essential.
- The patient's **condition is life limiting, and the patient and/or family have been informed of this determination**. The patient and/or family have elected treatment goals directed towards relief of symptoms, rather than curing the underlying terminal condition.
- The patient has **either A or B:**

  A. Documented clinical progression of a terminal disease, which may include:

  1. Progression of the terminal disease process as listed in the disease specific criteria, as documented by physician assessment, radiologic, laboratory, or other studies.
  2. Multiple emergency room visits or inpatient hospitalizations in the past six months.
  3. For homebound patients with home health or other in-home services, documented nursing or provider assessments demonstrating decline.

4. For patients who do not qualify according to the preceding guidelines, a recent decline in functional status should be documented.

    a) Functional decline should be recent and not reversible (due to depression, use of diuretics, etc.) to distinguish patients who are terminal from those with chronic illness. Clinical judgement is required for patients with a terminal condition and subsequent impaired status due to a different non-terminal disease (e.g., a patient chronically paraplegic from a spinal cord injury who is recently diagnosed with cancer).

    b) Diminished functional status can be documented by either:

        - Palliative Performance Score < 50%

            OR

        - Dependence in at least three of the six ADLs

B. Documented impaired nutritional status related to the terminal illness.

1. Unintentional progressive weight loss of greater than 10% over the prior six months (not due to depression or diuretics use).

2. Serum Albumin less than 2.5 mg/dl may be a helpful prognostic indicator but should not be used in isolation from other factors as in A.

Clinical Variables

Clinical variables provided in this booklet are general guidelines in relation to specific disease processes. In addition, information is provided on non-disease specific clinical indicators in order to support your clinical decision-making process, when referring your patient for hospice care. **Patients who meet these guidelines are expected to have a life expectancy of 6 months or less if the terminal condition follows its normal course.**

Some patients may not meet these guidelines, yet still have a life expectancy of 6 months or less. Coverage for these patients may be approved with documentation of clinical factors supporting a prognosis of less than 6 months. Please contact Gilchrist at 443.849.8200 if you have any questions related to these guidelines or would like to make a referral.

Palliative Performance Scale

%	Ambulation	Activity Level Evidence of Disease	Self-Care	Intake	Level of Consciousness	Estimated Median Survival in Days		
100	Full	Normal *No Disease*	Full	Normal	Full	N/A	N/A	108
90	Full	Normal *Some Disease*	Full	Normal	Full			
80	Full	Normal with Effort *Some Disease*	Full	Normal or Reduced	Full			
70	Reduced	Can't do normal job or work *Some Disease*	Full	As Above	Full	145		
60	Reduced	Can't do hobbies or housework *Significant Disease*	Occasional Assistance Needed	As Above	Full or Confusion	29	4	
50	Mainly sit/lie	Can't do any work *Extensive Disease*	Considerable Assistance Needed	As Above	Full or Confusion	30	11	41
40	Mainly in bed	As Above	Mainly Assistance	As Above	Full or Drowsy or Confusion	18	8	
30	Bed Bound	As Above	Total Care	Reduced	As Above	8	5	
20	Bed Bound	As Above	As Above	Minimal	As Above	4	2	6
10	Bed Bound	As Above	As Above	Mouth Care Only	Drowsy or Coma	1	1	
0	Death							

Mitchell Mortality Risk Index

Points	Risk Factor
1.9	Complete dependence with ADLs
1.9	Male gender
1.7	Cancer
1.6	Congestive heart failure
1.6	O2 therapy needed within 14 day
1.5	Shortness of breath
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 years
1.4	Not awake most of the day

Risk estimate of death within 6 months

Score	Risk %
0	8.9
1-2	10.8
3-5	23.2
6-8	40.4
9-11	57.0
≥12	70.0

Karnofsky Performance Status Scale

The Karnofsky Performance Scale Index allows patients to be classified as to their functional impairment. This can be used to compare effectiveness of different therapies and to assess the prognosis in individual patients. The lower the Karnofsky score, the worse the survival for most serious illnesses.

Karnofsky Performance Status Scale Definitions Rating (%) Criteria

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

Flacker Mortality Score Sheet

Characteristic	Scoring Instructions	Score
Functional Ability Score*	If summary functional ability score is greater than 4, **score 2.50**	
Weight Loss	If lost five or more pounds in the last 30 days, or 10 or more pounds in the last 180 days, **score 2.26**	
Shortness of Breath	If patient has shortness of breath, **score 2.08**	
Swallowing Problems	If patient has swallowing problems, **score 1.81**	
Gender	If male, **score 1.76**	
Body Mass Index	If BMI is less than 22 kg/m, **score 1.75**	
Congestive Heart Failure	If patient has CHF, **score 1.57**	
Age	If greater than 88 years old, **score 1.48**	
	Total Flacker Score	

Using the Flacker Score for Ongoing Eligibility

The purpose within Hospice is to carefully track the gradual decline in ADL and Function within our elderly dementia patients. Getting this score each Benefit Period can add critical numeric data to verify continuing eligibility.

The Flacker Score is a Mortality Index indicating the approximate mortality within one year.

If the Flacker Score is:

0-2 → 7 Percent Mortality
3-6 → 19 Percent Mortality
7-10 → 50 Percent Mortality
11+ → 86 Percent Mortality

ADLs		Description	Score (0-4)					
1	Bed Mobility	This includes how a resident moves and turns their body position while in bed.	0	1	2	3	4	
2	Transfer	This includes how a resident moves between surfaces such as a bed and chair.	0	1	2	3	4	
3	Locomotion	This includes how a resident moves between locations in their room and corridor outside their room.	0	1	2	3	4	
4	Dressing	This includes how a resident puts on, fastens, and takes off all items of street clothing.	0	1	2	3	4	
5	Eating	This relates to how a resident eats and drinks, including other means of intake of nourishments such as tube feeding.	0	1	2	3	4	
6	Toilet Use	This includes how a resident uses a toilet, commode, bedpan or urinal and transfer on and off the toilet.	0	1	2	3	4	
7	Personal Hygiene	This relates to how personal hygiene is maintained, including combing hair, brushing teeth, washing and drying face and hands but excluding baths and showers.	0	1	2	3	4	
		Total ADL Ability (Score 0-28):						

How to Score the Seven ADLs Ability Scale

0 = Independent
1 = Supervision provided three or more times during last seven days
2 = Limited assistance by staff with the resident highly involved in activity
3 = Extensive assistance by staff with the resident performing part of the activity
4 = Total Dependence – full staff participation in activity during the entire seven days

Disease Specific Guidelines

Note: These guidelines are to be used in conjunction with the "Non-disease specific baseline guidelines."

Amyotrophic Lateral Sclerosis

General Considerations:

1. ALS tends to progress in a linear fashion over time. Thus, the overall rate of decline in each patient is fairly constant and predictable, unlike many other non-cancer diseases.
2. However, no single variable deteriorates at a uniform rate in all patients. Therefore, multiple clinical parameters are required to judge the progression of ALS.
3. Although ALS usually presents in a localized anatomical area, the location of initial presentation does not correlate with survival time. By the time patients become end-stage, muscle denervation has become widespread, affecting all areas of the body, and initial predominance patterns do not persist.
4. Progression of disease differs markedly from patient to patient. Some patients decline rapidly and die quickly; others progress more slowly. For this reason, the history of the rate of progression in individual patients is important to obtain to predict prognosis.
5. In end-state ALS, two factors are critical in determining prognosis: ability to breathe, and to a lesser extent ability to swallow. The former can be managed by artificial ventilation, and the latter by gastrostomy or other artificial feeding, unless the patient has recurrent aspiration pneumonia. While not necessarily a contraindication to Hospice Care, the decision to institute either artificial ventilation or artificial feeding will significantly alter six-month prognosis.
6. Examination by a neurologist within three months of assessment for hospice is advised, both to confirm the diagnosis and to assist with prognosis.

Critically Impaired Respiratory function as defined by:

FVC < 40% predicted (seated or supine) and two or more of the following symptoms and/or signs:

- Dyspnea at rest
- Unexplained sweating
- Patient declines mechanical ventilation
- External ventilation used for comfort measures
- Orthopnea
- Use of accessory respiratory musculature
- Paradoxical abdominal motion
- Respiratory rate >20
- Grunting
- Frequent awakening
- Reduced speech/vocal volume
- Chest retractions
- Weakened cough
- Daytime somnolence/excessive daytime sleepiness
- Unexplained headaches
- Unexplained anxiety
- Unexplained nausea
- Nose flaring
- Symptoms of sleep disorder breathing

If unable to perform the FVC test, patients meet these criteria if they manifest three or more of the above symptoms.

Cancer Diagnosis

Note: Certain cancers with poor prognoses (e.g., small cell lung cancer, brain cancer and pancreatic cancer) may be hospice eligible without fulfilling the other criteria in this section.

A. Disease with distant metastases at presentation OR
B. Progression from an earlier stage of disease to metastatic disease with either:
    1. A continued decline in spite of therapy
    2. Patient declines further disease-directed therapy

Dementia Due to Alzheimer's Disease and Related Disorders

Note: This section is specific to Alzheimer's Disease and related disorders, and is not appropriate for other types of dementia, such as multi-infarct dementia.

Patients will be considered to be in the terminal stage of dementia (life expectancy of six months or less) if they meet the following criteria. Patients with dementia should show all the following characteristics:

1. Stage seven or beyond according to the Functional Assessment Staging Scale
2. Unable to ambulate without assistance
3. Unable to dress without assistance
4. Unable to bathe without assistance
5. Urinary and fecal incontinence, intermittent or constant
6. No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words

Patients should have had one of the following within the past 12 months:

1. Aspiration pneumonia
2. Pyelonephritis or other upper urinary tract infection
3. Septicemia
4. Decubitus ulcers, multiple, stage 3-4
5. Fever, recurrent after antibiotics
6. Inability to maintain sufficient fluid and calorie intake with 10% weight loss during the previous six months or serum albumin <2.5 gm/dl

Functional Assessment Staging (FAST)

The Reisberg Functional Assessment Staging (FAST) scale is a tool used to describe Medicare beneficiaries with Alzheimer's Disease with a prognosis of less than six months. The FAST scale is a 16-item scale designed to outline the progress and expected declines associated with Alzheimer's Disease. Stage 7 is aligned with the activity limitations that would support a six-month prognosis.

Stage 1	No difficulty, either subjectively or objectively
Stage 2	Complaints of forgetting location of objects; subjective work difficulties
Stage 3	Decreased job functioning evident to co-workers; difficulty traveling to new locations; decreased organizational capacity
Stage 4	Decreased ability to perform complex tasks (e.g., planning for dinner for guests, handling finances – e.g., forgetting to pay bills)
Stage 5	Requires assistance in choosing proper clothing for the season or occasion (e.g., wearing same clothes repeatedly)
Stage 6	Occasionally or more frequently decreased ability to perform ADLs (dress, bathe, and toileting independently)
Stage 7	Loss of speech, locomotion, and consciousness • Sub-stage 7a: Ability to speak limited (less than six intelligible words in the course of an average day) • Sub-stage 7b: All intelligible words are lost • Sub-stage 7c: Ambulatory ability is lost • Sub-stage 7d: Unable to sit up unassisted (e.g., would fall over without lateral arms on the chair) • Sub-stage 7e: Loss of ability to smile • Sub-stage 7d: Loss of ability to hold up head independently

Heart Disease

Patients will be considered to be in the terminal stage of heart disease (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present. Factors from 3 will add supporting documentation.)

1. At the time of initial certification or recertification for hospice, the patient is or has been already optimally treated for heart disease or is not a candidate for a surgical procedure or has declined a procedure. (Optimally treated means that patients who are not on vasodilators have a medical reason for refusing these drugs, e.g., hypotension or renal disease.)
2. The patient is classified as New York Heart Association (NYHA) Class IV and may have significant symptoms of heart failure or angina at rest. (Class IV patients with heart disease have an 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.) Significant congestive heart failure may be documented by an ejection fraction of ≤20%, but is not required if not already available.
3. Documentation of the following factors will support but is not required to establish eligibility for hospice care:
    a. Treatment resistant symptomatic supraventricular or ventricular arrhythmias
    b. History of cardiac arrest or resuscitation
    c. History of unexplained syncope
    d. Brain embolism of cardiac origin
    e. Concomitant HIV disease

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Additional indicators of a poor prognosis with heart disease patients. These may be due to associated co-morbid conditions (e.g., COPD, diabetes, renal disease, anemia).

- Advanced Age
- Hemoglobin <10 g/dl
- Hypotension
- Serum Sodium < 136 mEq/L
- Serum Creatinine >2.0 mg/dl
- Cardiac Cachexia: Nonintentional nonedema loss of >7.5% of body weight over the previous 6 months

Signs and Symptoms of Heart Failure:

Left Sided Heart Failure	Right Sided Heart Failure
• Dyspnea	• Nocturia
• Exercise intolerance	• Ascites
• Wheezing	• Peripheral edema
• Dizziness, confusion	• Congestive hepatomegaly
• Cool extremities at rest	

HIV Disease

Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present; factors from 3 will add supporting documentation.)

1. CD4+ Count <25 cells/mcl or persistent (two or more assays at least one month apart)

   Viral Load > 100,000 copies/ml, plus one of the following:

   a. CNS lymphoma
   b. Untreated, or persistent despite treatment, wasting (loss of at least 10% lean body mass)
   c. Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused
   d. Progressive multifocal leukoencephalopathy
   e. Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy
   f. Visceral Kaposi's sarcoma unresponsive to therapy
   g. Renal failure in the absence of dialysis
   h. Cryptosporidium infection
   i. Toxoplasmosis, unresponsive to therapy

2. Decreased performance status, as measured by the Karnofsky Performance Status (KPS) Scale, of ≤50% or Palliative Performance Scale (PPS), of ≤50%

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3. Documentation of the following factors will support eligibility for hospice care:
    a. Chronic persistent diarrhea for one year
    b. Persistent serum albumin <2.5 gm/dl
    c. Concomitant, active substance abuse
    d. Age >50 years
    e. Absence of, or resistance to, effective antiretroviral, chemotherapeutic and prophylactic drug therapy related specifically to HIV disease
    f. Advanced AIDS dementia complex
    g. Toxoplasmosis
    h. Congestive heart failure, symptomatic at rest
    i. Advanced liver disease

Liver Disease

Note: Patients awaiting liver transplant who otherwise fit the below criteria may be certified for the Medicare hospice benefit, but if a donor organ is procured, the patient should be discharged from hospice.

Patients will be considered to be in the terminal stage of liver disease (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present; factors from 3 will lend supporting documentation.)

1. **The patient should show both a and b**:
    a. Prothrombin time prolonged more than five seconds over control, or International Normalized Ratio (INR) >1.5
    b. Serum albumin <2.5 gm/dl
2. End-stage liver disease is present and the patient shows **at least one of the following**:
    a. Ascites, refractory to treatment or patient non-compliant
    b. Spontaneous bacterial peritonitis
    c. Hepatorenal syndrome (elevated creatinine and BUN with oliguria)
    d. Hepatic encephalopathy, refractory to treatment, or patient non-compliant
    e. Recurrent variceal bleeding, despite intensive therapy
3. **Documentation of the following factors** will support eligibility for hospice care:
    a. Progressive malnutrition
    b. Muscle wasting with reduced strength and endurance
    c. Continued active alcoholism (>80 gm ethanol/day)
    d. Hepatocellular carcinoma
    e. HBsAg (Hepatitis B) positivity
    f. Hepatitis C refractory to interferon treatment

Pulmonary Disease

Patients will be considered to be in the terminal stage of pulmonary disease (life expectancy of six months or less) if they meet the following criteria. The criteria refer to patients with various forms of advanced pulmonary disease who eventually follow a final common pathway for end-stage pulmonary disease. (1 and 2 should be present. Documentation of 3, 4, and 5 will lend supporting documentation.)

1. Severe chronic lung disease as documented **by both a and b**:
    a. Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough. (Documentation of Forced Expiratory Volume in One Second (FEV1), after bronchodilator, less than 30% of predicted is objective evidence for disabling dyspnea, but is not necessary to obtain.)
    b. Progression of end-stage pulmonary disease, as evidenced by increasing visits to the emergency department or hospitalizations for pulmonary infections and/or respiratory failure, or increasing physician home visits prior to initial certification. (Documentation of serial decrease of FEV1>40 ml/year is objective evidence for disease progression, but is not necessary to obtain.)

2. Hypoxemia at rest on room air, as evidenced by pO2 ≤55 mmHg; or oxygen saturation ≤88%, determined either by arterial blood gases or oxygen saturation monitors. (These values may be obtained from recent hospital records.) OR Hypercapnia, as evidenced by pCO2 ≥50 mmHg. (This value may be obtained from recent [within 3 months] hospital records.)
3. Right heart failure (RHF) secondary to pulmonary disease (cor pulmonale) (i.e., not secondary to left heart disease or valvulopathy).
4. Unintentional progressive weight loss of greater than 10% of body weight over the preceding six months.
5. Resting tachycardia >100/minute

Renal Disease

Patients will be considered to be in the terminal stage of renal disease (life expectancy of six months or less) if they meet the following criteria.

Acute renal failure:

(1 and either 2 or 3 should be present. Factors from 4 will lend supporting documentation.)

1. The patient is not seeking dialysis or renal transplant or is discontinuing dialysis
2. Creatinine clearance GFR <15 ml/min
3. Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics)
4. Comorbid conditions:

   a. Mechanical ventilation
   b. Malignancy (other organ system)
   c. Chronic lung disease
   d. Advanced cardiac disease
   e. Advanced liver disease
   f. Sepsis
   g. Gastrointestinal bleeding
   h. Disseminated intravascular coagulation
   i. Platelet count <25,000
   j. Cachexia
   k. Serum albumin <2.5 gm/dl
   l. Immunosuppression/AIDS

Chronic renal failure:

(1 and either 2 or 3 should be present. Factors from 4 will lend supporting documentation.)

1. The patient is not seeking dialysis or renal transplant or is discontinuing dialysis
2. Creatinine clearance GFR <15ml/min
3. Serum creatinine >8.0 mg/dl (>6.0 mg/dl for diabetics)
4. Signs and symptoms of renal failure:
    a. Uremia
    b. Oliguria
    c. Intractable hyperkalemia (>7.0) not responsive to treatment
    d. Uremic pericarditis
    e. Hepatorenal syndrome
    f. Intractable fluid overload, not responsive to treatment

Stroke & Coma

Patients will be considered to be in the terminal stage of stroke or coma (life expectancy of six months or less) if they meet the following criteria.

Stroke:

1. Karnofsky Performance Status (KPS) or Palliative Performance Scale (PPS) of 40% or less
2. Inability to maintain hydration and caloric intake with one of the following:
    a. Weight loss >10% in the last 6 months or >7.5% in the last 3 months
    b. Serum albumin <2.5 gm/dl
    c. Current history of pulmonary aspiration not responsive to speech language pathology intervention
    d. Sequential calorie counts documenting inadequate caloric/fluid intake
    e. Dysphagia severe enough to prevent the patient from receiving food and fluids necessary to sustain life, in a patient who declines or does not receive artificial nutrition and hydration

Documentation of diagnostic imaging factors which support poor prognosis after stroke include:

Coma (any etiology):

Comatose patients with any three of the following on day three of coma:

1. Abnormal brain stem response
2. Absent verbal response
3. Absent withdrawal response to pain
4. Serum creatinine >1.5 mg/dl

For non-traumatic hemorrhagic stroke:

1. Large-volume hemorrhage on CT:
    a. Infratentorial: ≥20 ml
    b. Supratentorial: ≥50 ml
2. Ventricular extension of hemorrhage
3. Surface area of involvement of hemorrhage ≥30% of cerebrum
4. Midline shift ≥1.5 cm
5. Obstructive hydrocephalus in patient who declines, or is not a candidate for, ventriculoperitoneal shunt

For thrombotic/embolic stroke:

1. Large anterior infarcts with both cortical and subcortical involvement
2. Large bihemispheric infarcts
3. Basilar artery occlusion
4. Bilateral vertebral artery occlusion

Documentation of the following factors will support eligibility for hospice care:

Documentation of medical complications, in the context of progressive clinical decline, within the previous 12 months, which support a terminal prognosis:

1. Aspiration pneumonia
2. Upper urinary tract infection (pyelonephritis)
3. Sepsis
4. Refractory stage 3-4 decubitus ulcers
5. Fever recurrent after antibiotics

Opioid Analgesic Equivalences

It is often necessary to switch from one opioid to a different opioid, a different formulation, or a different route of administration.

	Equianalgesic Equivalences (mg)	
Opioid	**Parenteral**	**Oral**
Morphine	10	30
Fentanyl	.15	N/A
Hydrocodone	N/A	25
Hydromorphone	2	5
Oxycodone	10 (not in US)	20
Oxymorphone	1	10

Hospice & Physician Billing

Can physician visits be billed once my patient elects hospice care?

Absolutely! A primary care physician not affiliated or under contract with the hospice may bill Medicare for services provided to a hospice patient.

How do I bill?

Using the correct modifier codes is key. See the examples below:

Scenario	Modifier to use:
Primary physician visit is related to the patient's terminal diagnosis	GV
Primary physician visit is not related to the patient's terminal diagnosis	GW
Covering physician is a member of the primary physician's practice	Q5 & GV or GW
Covering physician is not a member of the primary physician's practice	Q6 & GV or GW

If you have questions regarding billing, please contact Gilchrist for assistance.

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Other Gilchrist Services

If your patient is not eligible for hospice, Gilchrist may still be able to help. We offer a comprehensive continuum of care for people with serious illness aimed at the last three years of life.

Gilchrist's Elder Medical Care program offers home-based medical care and support for aging adults with chronic and progressive serious illness who have difficulty traveling to medical appointments. Nurse practitioners provide at-home primary care, medication and symptom management, and coordination of care to help seniors age in place. Social workers are available to provide emotional support and connect patients with community resources. Elder Medical Care services are also provided to elders in residential care communities (assisted living, long-term care or skilled nursing facilities).

As a person's illness progresses, **they can seamlessly transition to hospice**. In addition, Gilchrist offers counseling and bereavement services for families after the death of a loved one.

To learn more and discover how Gilchrist can help, call 443.849.8200.

Gilchrist on Social Media


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For urgent questions, call Gilchrist at

443.849.8200

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Gilchrist provides services without regard to race, color, creed, sex, sexual orientation, disability, religion, ability to pay or national origin.