Guidelines for Hospice Eligibility

It can be challenging to recognize when a patient could benefit from palliative care and hospice services.

This booklet describes clinical guidelines for determining whether and when to refer a patient for palliative or hospice care.

Thank you-

It's not every day that we receive a patient referral from a highly-recognized physician in our community with an incredible reputation for compassion and integrity. Thank you so much for putting your confidence and trust in us by referring an end-of-life patient to Hospice del Valle. We look forward to collaborating with you on this patient and many others. We want you to know that this wonderful patient and family will receive excellent services from our agency, and will be treated with the utmost care and respect.

We greatly appreciate you thinking of us as referrals are the only way we are able to provide a much-needed service to a very unique population of patients, and it's so nice to know that you are willing to work in partnership with us to ensure that comfort and quality focused care can be provided during a time when patients need it the most. Please let us know if there are any questions or concerns that you have, we are happy to help.

Professionally,

Overview of Programs

Palliative Care

- **Last 12-18 Months of life**
- **Limited Supportive Care**
  - Hospice Team
    - Nurse- every 4-6 weeks
    - Social Worker- every 4-6 weeks
    - Spiritual Care- every 4-6 weeks
    - Volunteer
- **Provided at no cost to the patient and family**

Hospice Care

- **Last 6 Months of life**
- **Intense holistic care**
  - Hospice Team
    - Doctor
    - Nurse- Weekly
    - Social Worker- Weekly
    - Spiritual Care- Weekly
    - Hospice Aide- 1-3 X Weekly
    - Volunteer
- **Medicare/Medicaid or Private Insurance is billed**

Grief and Bereavement

- **Support during Hospice and continued 13 Months after death**
- **Grief Groups and Workshops**

Table of Contents

Thank you 1

Overview of Hospice Programs 2

What to Include in a Referral 4

Identifying a Primary Diagnosis & Supporting Information 5

- Amyotrophic Lateral Sclerosis (ALS) 6
- Cancer 7
- Cerebral Vascular Accident/Stroke or Coma 8
- Dementia/Alzheimer's 9
- Heart Disease/CHF 10
- HIV Disease 11
- Huntington's Disease 12
- Liver Disease 13
- Lung Disease/COPD 14
- Multiple Sclerosis 15
- Muscular Dystrophy 16
- Parkinson's Disease 17
- Renal Failure Chronic 18

Appendices 19

- Appendix A- NYHA Functional Classification 19
- Appendix B- Palliative Performance Scale (PPS) 20
- Appendix C- Functional Assessment Stating (FAST) 21

Important Information/Reminders 22

Guidelines in this booklet are based on LCDs to provide guidance in determining medical necessity of services for Hospice care.

What to Include in a Hospice Referral?

Hospice del Valle has made it easy to get hospice-eligible patients and their families the support they need as quickly as possible and can frequently offer same-day hospice admissions.

Hospice del Valle staff is available to provide a no commitment consultation to a patient and family to offer an opportunity to learn more about Hospice care and services specific to their situation.

1. In order to make the referral process and transition to Hospice care as smooth as possible please provide the following information:
    a. **Patient Demographics-**
        i. Primary emergency contact/MDPOA
        ii. Primary Caregiver information
        iii. Physical address
    b. **History and physical-**
        i. Documentation of primary terminal illness diagnosis.
        ii. Clinic notes that demonstrate history
    c. **Supporting Documentation specific to primary diagnosis-**
        i. Examples may include:
            1. Echocardiogram, CT, EGD, PFT, Renal function labs, Hepatic Function labs, NYHA Score, FAST Score or PPS Score
            2. ER or clinic visit frequency, oncology notes demonstrating failed treatment
    d. **Current Medication List-**
    e. **Physician Certification of Terminal Illness Form-**
        i. Please complete a short narrative explaining why the patient has a 6-month or less prognosis (if disease runs normal/expected course) and all supporting information.

Hospice del Valle is available 24/7 to assist in identifying whether a patient may be eligible for hospice services.

* See Pages 19-21- Appendix A, B, and C for determination of NYHA, PPS, and FAST Scores.

Identifying a Primary Diagnosis & Supporting Information

Determining a primary hospice diagnosis can be challenging when a patient has some, but not all, of the clinical indicators of a specific disease or condition. The following clinical signs often support hospice eligibility **in combination with another primary diagnosis.**

1. Rapid decline over the past 3-6 months, evidenced by:
    a. Rapid progression of disease
    b. Progressive decline in Palliative Performance Score (PPS)*
    c. Weight loss not due to reversable causes and/or declining serum albumin levels
    d. Dependence on assistance for 2 or more ADLs: Feeding, ambulation, continence, transfer, bathing or dressing.
2. Dysphagia leading to inadequate nutrition intake or recurrent aspiration.
3. Decline in systolic blood pressure to below 90 systolic or progressive postural hypotension.
4. Increasing ER visits, hospitalizations or physician follow-up
5. Multiple progressive stage 3 or 4 pressure ulcers despite optimal care.
6. Frequent falls or increasing problems with balance and weakness.
7. Increased lethargy/sleepiness.
8. Uncontrolled pain, shortness of breath, nausea/vomiting, anxiety
9. Multiple, recurrent infections.
10. Patient appears to be "giving up" physically and emotionally.

Hospice del Valle is available 24/7 to assist in identifying whether a patient may be eligible for hospice services.

* See Page 20 - Appendix B for Palliative Performance Scale.

Amyotrophic Lateral Sclerosis (ALS)

Patient meets at least one of the two following **1 OR 2 and a OR b**

1. Severely impaired breathing capacity with all of the following findings:
    - Dyspnea at rest
    - Vital Capacity less than 30%
    - Requirement for supplemental oxygen at rest
    - The patient declines artificial ventilation

OR

2. Rapid disease progression with either **a or b** below: Rapid disease progression as evidenced by all of the following in the preceding 12 months:
    - Progression from independent ambulation to wheelchair or bedbound status
    - Progression from normal to barely intelligible or unintelligible speech
    - Progression from normal to puree diet
    - Progression from independence in most or all Activities of Daily Living (ADL) to needing major assistance by caretaker in all ADLs

AND

a. Severe nutritional impairment demonstrated by all of the following in the preceding 12 months
    i. Oral intake of nutrients and fluid insufficient to sustain life
    ii. Continuing weight loss
    iii. Dehydration of hypovolemia
    iv. Absence of artificial feeding methods

OR

b. Life-threatening complications demonstrated by one or more of the following in the preceding 12 months.
    i. Recurrent aspirations pneumonia (with or without tube feeding)
    ii. Upper urinary tract infection (Pyelonephritis)
    iii. Sepsis
    iv. Recurrent fever after antibiotic therapy
    v. Stage 3 or 4 pressure ulcer(s)

In the absence of one or more of the above findings, rapid decline or comorbidities may also support eligibility for hospice care.

Cancer

Patient meets at criteria for **1, 2 and 3**.

1. Clinical findings of malignancy with widespread, aggressive or progressive disease as evidenced by increasing symptoms, worsening lab values and or evidence of metastatic disease.
2. Impaired performance status with Palliative Performance Score (PPS) >70% *
3. Refuses further curative therapy or continues to decline despite definitive therapy. Decline is evidenced by:
    a. Hypercalcemia ≥12
    b. Cachexia or weight loss of 5% in preceding three months
    c. Recurrent disease after surgery/radiation/chemotherapy
    d. Signs and symptoms of advanced disease, e.g. nausea, anemia, malignant ascites or pleural effusions, etc.

The following information will be required:

1. Tissue diagnosis of malignancy

OR

2. Reason(s) why a tissue diagnosis is not available.

Concurrent Therapy:

Hospice del Valle may accept a patient for hospice while the patient continues to receive treatment (such as palliative radiation), under the circumstances such as to meet a time-bound goal or for symptom management. **Please call Hospice del Valle to discuss patients who may need concurrent therapy.**

In the absence of one or more of the above findings, rapid decline or comorbidities may also support eligibility for hospice care.

* See Page 20 - Appendix B for Palliative Performance Scale.

Cerebral Vascular Accident/Stroke or Coma

Patient meets at criteria for **both 1 and 2.**

1. Poor functional status with Palliative Performance Score of 40% or less (unable to care for self) *

AND

2. Poor nutritional with inability to maintain sufficient fluid and caloric intake with either:
   - >10% weight loss over the previous six months
   - >7.5% weight loss over the previous three months
   - Serum albumin <2.5 gm/dl
   - Current history of pulmonary aspiration without effective response to speech language pathology interventions to improve dysphagia and decrease aspiration events.

Supporting evidence for hospice eligibility:

Coma (any etiology) with **three (3)** of the following on the **3rd** day of coma:

Abnormal brain stem response

Absent verbal responses

Absent withdrawal response to pain

Serum Creatinine >1.5 gm/dl

In the absence of one or more of the above findings, rapid decline or comorbidities may also support eligibility for hospice care.

* See Page 20 - Appendix B for Palliative Performance Scale.

Dementia/Alzheimer's

Patient meets at criteria for **both 1 and 2**.

1. Stage 7 or beyond according to the Functional Assessment Staging Scale (FAST) * with all of the following:
   - Inability to ambulate without assistance
   - Inability to dress without assistance
   - Urinary and fecal incontinence, intermittent or constant
   - No consistent meaningful/reality-based verbal communication, or the ability to speak is limited to a few intelligible words.

AND

3. Has had at least one of the following conditions within the past 12 months:
   - Aspiration pneumonia
   - Pyelonephritis or other upper urinary tract infection
   - Septicemia
   - Pressure ulcers, multiple and/or stage 3 or 4
   - Fever, recurrent after antibiotics
   - Inability to maintain sufficient fluid and caloric intake demonstrated by either of the following:
     i. At least 10% weight loss during preceding six months
     OR
     ii. Serum albumin <2.5 gm/dl

In the absence of one or more of the above findings, rapid decline or comorbidities may also support eligibility for hospice care.

* See Page 21 - Appendix C for Functional Assessment Staging Scale (FAST).

Heart Disease/CHF

Patient meets at criteria for **1 OR 2 and 3**.

1. Poor response to (or patient's choice is not to pursue) optimal treatment with diuretics, vasodilators and/or angiotensin converting enzyme (ACE) inhibitors.

OR

2. The patient has angina pectoris at rest resistant to standard nitrate therapy and is not a candidate for invasive procedures and/or has declined revascularization procedures

AND

3. New York Heart Association (NYHA) Class IV symptoms with both of the following:
   a. The presence of significant symptoms of recurrent Congestive Heart Failure (CHF) and/or angina at rest
   b. Inability to carry out even minimal physical activity without symptoms of heart failure (dyspnea and/or angina)
   c. Poor functional status with Palliative Performance Score of 40% or less (unable to care for self) *

Supporting evidence for hospice eligibility:

Echo demonstrating an ejection fraction of 20% or less

Treatment-resistant symptomatic dysrhythmias

History of unexplained or cardiac related syncope

CVA secondary to cardiac embolism

History of cardiac arrest or resuscitation

In the absence of one or more of the above findings, rapid decline or comorbidities may also support eligibility for hospice care.

* See Page 19 - Appendix A for New York Heart Association (NYHA) Functional Classification.

HIV Disease

Patient meets at criteria for **1a OR 1b, 2 and 3**.

1a. CD4 + Count <25 cells/mm^3

OR

1b. Persistent viral load > 100,000 copies/ml from **two** or more assays at least one month apart

AND

2. At least one of the following conditions:

- CNS lymphoma
- Untreated refractory wasting (loss of >33% lean body mass)
- Mycobacterium avium complex (MAC) bacteremia, untreated refractory or treatment refused
- Progressive multifocal leukoencephalopathy
- Systemic lymphoma
- Refractory visceral Kaposi's sarcoma
- Renal failure in absence of dialysis
- Refractory toxoplasmosis
- Treatment resistant symptomatic dysrhythmias
- History of unexpected or cardiac-related syncope
- CVA Secondary to cardiac embolism
- History of cardiac arrest or resuscitation

AND

3. Palliative Performance Score of <50% (Requires considerable assistance and frequent medical care, activity limited mostly to bed or chair) *

Supporting evidence for hospice eligibility:

Chronic persistent diarrhea for one year

Persistent serum albumin <2.5mg/dl

Concomitant active substance abuse

In the absence of one or more of the above findings, rapid decline or comorbidities may also support eligibility for hospice care.

* See Page 20 - Appendix B Palliative Performance Scale (PPS).

Huntington's Disease

Patient meets at criteria for both **1 and 2**.

1. Stage 7 or beyond according to the Functional Assessment Staging Scale with all of the following: *
    - Inability to ambulate without assistance
    - Inability to dress without assistance
    - Urinary and fecal incontinence, intermittent or constant
    - No consistent meaningful verbal communication

AND

2. Has had at least one of the following conditions within the past 12 months:
    - Aspiration pneumonia
    - Pyelonephritis or another upper urinary tract infection
    - Septicemia
    - Multiple stage 3 or 4 pressure ulcers
    - Toxoplasmosis unresponsive to therapy
    - Fever- Recurrent after antibiotics
    - Inability to maintain sufficient fluid and caloric intake with one or more of the following during the preceding 12 months:
        i. 10% weight loss during the previous six months

        OR

        ii. Serum albumin <2.5 gm/dl

        OR

        iii. Significant dysphagia with associated aspiration measured objectively, e.g. swallowing test or a history of choking or gagging with feeding.

In the absence of one or more of the above findings, rapid decline or comorbidities may also support eligibility for hospice care.

* See Page 21 - Appendix C for Functional Assessment Staging (FAST).

Liver Disease

Patient meets at criteria for both **1 and 2**.

1. Synthetic liver failure as demonstrated by **a or b and c:**
   a. Prothrombin time (PTT) prolonged more than five seconds over control.

   OR

   b. International Normalized Ratio (INR) 1.5

   AND

   c. Serum albumin <2.5 gm/dl

AND

2. End stage liver disease is present at the patient has one or more of the following conditions:
   - Ascites, refractory to treatment, or patient declines or is non-compliant
   - History of spontaneous bacterial peritonitis
   - Hepatorenal syndrome (elevated creatinine with oliguria [<400 ml/day])
   - Hepatic encephalopathy, refractory to treatment or patient is non-compliant
   - History of recurrent variceal bleeding despite intensive therapy or patient declines therapy. Recurrent after antibiotics

Supporting evidence for hospice eligibility:

Progressive malnutrition
Muscle wasting with reduced strength
Ongoing alcoholism (>80 gm ethanol/day)
Hepatocellular carcinoma
Hepatitis B surface antigen positive
Hepatitis C refractory to interferon treatment

In the absence of one or more of the above findings, rapid decline or comorbidities may also support eligibility for hospice care.

Lung Disease/COPD

Patient meets criteria for **1, 2 and 3**.

1a. Disabling dyspnea at rest

1b. Poor response to bronchodilators

1c. Decreased functional capacity, e.g., bed to chair existence, fatigue and cough

a. An FEV1 <30% is objective evidence for disabling dyspnea but is not required.

AND

2. Progression of disease as evidenced by a recent history of increased visits to MD office, home or emergency room and/or hospitalizations for pulmonary infections and/or respiratory failure.

AND

3. Documentation within the past 3 months of **a or b:**
   a. Hypoxemia at rest (pO_2 <55mgHg by ABG) or oxygen saturation < 88%
   b. Hypercapnia evidenced by pCO_2 <50mgHg

Supporting evidence for hospice eligibility:

Cor pulmonale and right heart failure secondary to pulmonary disease

Unintentional progressive weight loss>10% over the preceding six months

Resting tachycardia >100 bpm

In the absence of one or more of the above findings, rapid decline or comorbidities may also support eligibility for hospice care.

Multiple Sclerosis

Patient meets at least one of the two following **1 OR 2 and a OR b**

1 Severely impaired breathing capacity with **all** of the following findings:
   - Dyspnea at rest
   - Vital Capacity less than 30%
   - Requirement for supplemental oxygen at rest
   - The patient declines artificial ventilation

OR

2. Rapid disease progression with either **a or b** below: Rapid disease progression as evidenced by all of the following in the preceding 12 months:
   - Progression from independent ambulation to wheelchair or bedbound status
   - Progression from normal to barely intelligible or unintelligible speech
   - Progression from normal to puree diet
   - Progression from independence in most or all Activities of Daily Living (ADL) to needing major assistance by caretaker in all ADL

AND

a. Severe nutritional impairment demonstrated by all of the following in the preceding 12 months
   - Oral intake of nutrients and fluid insufficient to sustain life
   - Continuing weight loss
   - Dehydration of hypovolemia
   - Absence of artificial feeding methods

OR

b. Life-threatening complications demonstrated by one or more of the following in the preceding 12 months.
   - Recurrent aspirations pneumonia (with or without tube feeding)
   - Upper urinary tract infection (Pyelonephritis)
   - Sepsis
   - Recurrent fever after antibiotic therapy
   - Stage 3 or 4 pressure ulcer(s)

In the absence of one or more of the above findings, rapid decline or comorbidities may also support eligibility for hospice care.

Muscular Dystrophy

Patient meets at least one of the two following **1 OR 2 and a OR b**

1. Severely impaired breathing capacity with **all** of the following findings:
   - Dyspnea at rest
   - Vital Capacity less than 30%
   - Requirement for supplemental oxygen at rest
   - The patient declines artificial ventilation

OR

2. Rapid disease progression with either **a or b** below:

   Rapid disease progression as evidenced by all of the following in the preceding 12 months:

   - Progressed from independent ambulation to wheelchair/bedbound status
   - Progressed from normal to barely intelligible or unintelligible speech
   - Progressed from normal to puree diet
   - Progressed from independence in most or all Activities of Daily Living (ADL) to needing major assistance by caretaker in all ADL

AND

a. Severe nutritional impairment demonstrated by all of the following in the preceding 12 months
   - Oral intake of nutrients and fluid insufficient to sustain life
   - Continuing weight loss
   - Dehydration of hypovolemia
   - Absence of artificial feeding methods

OR

b. Life-threatening complications demonstrated by one or more of the following in the preceding 12 months.
   - Recurrent aspirations pneumonia (with or without tube feeding)
   - Upper urinary tract infection (Pyelonephritis)
   - Sepsis
   - Recurrent fever after antibiotic therapy
   - Stage 3 or 4 pressure ulcer(s)

In the absence of one or more of the above findings, rapid decline or comorbidities may also support eligibility for hospice care.

Parkinson's Disease

Patient meets the following criteria:

Rapid disease progression and either **a or b** below:

- Progression from independent ambulation to wheelchair or bed bound status.
- Progression from normal to barely intelligible or unintelligible speech
- Progression from normal to pureed diet
- Progression from independence in most or all Activities of Daily Living (ADLs) to needing major assistance by caretaker in all ADL

AND

a. Severe nutritional impairment demonstrated by all of the following in the preceding 12 months

   i. Oral intake of nutrients and fluids insufficient to sustain life
   ii. Continuing weight loss
   iii. Dehydration or hypovolemia
   iv. Absence of artificial nutrition

OR

b. Life-threatening complication demonstrated by on or more of the following in the preceding 12 months:
   i. Recurrent aspirations pneumonia (with or without tube feeding)
   ii. Upper urinary tract infection (Pyelonephritis)
   iii. Sepsis
   iv. Recurrent fever after antibiotic therapy
   v. Stage 3 or 4 pressure ulcer(s)

In the absence of one or more of the above findings, rapid decline or comorbidities may also support eligibility for hospice care.

Renal Failure- Chronic

Patient has **1 and either 2 or 3:**

1. The patient is not transplant/dialysis or has stopped dialysis

AND

2. Creatinine clearance* (formula below for men and women),10 cc/min or (<15cc/min for diabetics)

*** Creatinine Clearance Calculation for Men**

$$CrCl = \frac{(140 - age\ in\ years)\ x\ (weight\ in\ kg)}{72\ x\ (serum\ creatine\ in\ mg/dl)}$$

***Creatinine Clearance Calculation for Women**

$$CrCl = \frac{(140 - age\ in\ years) x\ (weight\ in\ kg)}{72\ x\ (serum\ creatine\ in\ mg/dl)}\ x\ 0.85$$

OR

3. Serum creatinine >0.8 mg/dl (>6.0 mg/dl for diabetics)

Supporting evidence for hospice eligibility:

Uremia
Oliguria (Urine output < 400cc in 24 hours
Intractable hyperkalemia (greater than 7.0) not responsive to treatment
Uremic pericarditis
Hepatorenal syndrome
Immunosuppression/AIDS
Intractable fluid overload, not responsive to treatment

In the absence of one or more of the above findings, rapid decline or comorbidities may also support eligibility for hospice care.

Appendix A- New York Heart Association (NYHA)

New York Heart Association (NYHA) Classification	
I	Patients with cardiac disease, but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, dyspnea, palpitations or anginal pain.
II	Patients with cardiac disease, resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, dyspnea, palpitations or anginal pain.
III	Patients with marked limitations of physical activity. They are comfortable at rest. Less than ordinary physical activity results in fatigue, dyspnea, palpitations or anginal pain.
IV	Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of hear failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Appendix B- Palliative Performance Scale (PPS)

Palliative Performance Scale (PPS)

%	Ambulation	Activity	Self-Care	Intake	Conscious Level
100%	Full	Normal activity, no evidence of disease	Full	Normal	Full
90%	Full	Normal activity, some evidence of disease	Full	Normal	Full
80%	Full	Normal activity, with effort, some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable, normal job/work, some evidence of disease	Full	Normal or reduced	Full
Patient needs to be a 70% or below to meet Hospice criteria					
60%	Reduced	Unable hobby/housework, significant disease	Occasional Assistance	Normal or reduced	Full or Confusion
50%	Mainly Sit/lie	Unable to do any work extensive disease	Considerable assistance	Normal or reduced	Full or Confusion
40%	Mainly in bed	Unable to do any work extensive disease	Mainly Assistance	Normal or reduced	Full or drowsy or confusion
30%	Totally bedbound	Unable to do any work extensive disease	Total Care	Reduced	Full or drowsy or confusion
20%	Totally bedbound	Unable to do any work extensive disease	Total Care	Minimal Sips	Full or drowsy or confusion
10%	Totally bedbound	Unable to do any work extensive disease	Total Care	Mouth Care only	Drowsy or Coma
0%	Death	——	——	——	——

Adapted from Anderson, Fern et al. (1996)Palliative performance Scale (PPS) a new tool. Journal of Palliative Care 12(1), 5-11

Appendix C- Functional Assessment Staging (FAST)

1	No difficulty either subjectively or objectively.
2	Complains of forgetting location of objects. Subjective work difficulties.
3	Decreased job functioning evident to co-workers. Difficulty in traveling to new locations. Decreased organizational capacity. *
4	Decreased ability to perform complex tasks, e.g., planning dinner for guests, handling personal finances (such as forgetting to pay bills), difficulty shopping, etc. *
5	Requires assistance in choosing proper clothing to wear for the day, season, or occasion, e.g., patient may wear the same clothing repeatedly unless supervised. *
6	a. Improperly putting on clothes without assistance or cueing (e.g., may put street clothes on over nighttime clothes, or put shoes on the wrong feet, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks. * b. Unable to bathe properly (e.g., difficulty adjusting the bath-water temperature) occasionally or more frequently over the past few weeks. * c. Inability to handle mechanisms of toileting (e.g., forgets to flush, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past few weeks. * d. Urinary Incontinence (occasionally or more frequently.) * e. Fecal incontinence (occasionally or more frequently.) *
7	a. Ability to speak limited to approximately half a dozen intelligible different words or fewer, in the course of an average day or in the course of an intense 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 armrests on the chair. e. Loss of ability to smile. f. Loss of ability to hold head up independently.
*Scored primarily on the basis of information obtained from knowledgeable information and/or category.	

Important Information & Reminders

Time is of the essence when referring patients to hospice care. Hospice del Valle has made it easy to get hospice-eligible patients and their families the support they need as quickly as possible and can frequently offer same-day hospice admissions.

Hospice del Valle staff is available 24/7 to assist in identifying whether a patient may be eligible for hospice services.

Hospice del Valle Medical Directors are available for a Doc-2-Doc consultation to determine eligibility status, identify primary diagnoses or assist with patient referrals.

Call 719-589-9019 to reach the staff

In the absence of one or more of the findings in any given diagnosis, rapid decline or comorbidities may also support eligibility for hospice care.

OUR MISSION

Hospice del Valle helps to create a peaceful transition for clients with life-limiting illnesses; assisting clients and families in the celebration of life with love, caring and dignity.

CONTACT HOSPICE

Laura Lewis, RN, BSN
Executive Director

514 Main Street, Alamosa, CO 81101
Phone: 719-589-9019
Email: info@hospicedelvalle.org
Web: www.hospicedelvalle.org

Creation: 5/2019