Community HOSPICE

Helping Hands...Healing Hearts

Hospice Admission Guidelines

www.hospiceheart.org

Community Hospice

Patients are eligible for hospice care when their physician determines the patient has a life expectancy of six (6) months or less. The determinants within this guide are to be used as guidelines and should not take the place of a physician's clinical judgement.

When curative treatment is no longer available, hospice can be a beneficial care option for patients and a tremendous source of emotional and physical support for their families. Hospice care includes a full range of services, including medical, pharmaceutical, social and spiritual support.

For questions regarding patient eligibility guidelines call the Provider Hotline at 866.645.4567.

How to Make a Referral

Website:

www.hospiceheart.org/referral
Online referral form is secure and HIPAA compliant.

Email:

referral@hospiceheart.org

Phone:

209.578.6340

Fax:

209.541.3292
When faxing referral, include patient demographics.

Community Hospice Alexander Cohen Hospice House

The Community Hospice Alexander Cohen Hospice House provides 16 private inpatient rooms and 24-hour care in a comfortable home-like setting. Admission to the Hospice House is based on physician approval, acuity/need and available space. The Community Hospice Alexander Cohen Hospice House is essentially a “hospice hospital” and it is intended for short term respite care and symptom management. Once symptoms are managed the patient either returns home or moves to an alternate care facility, and Community Hospice will continue to provide services in the patient’s new residence.

To become a patient at the Community Hospice Alexander Cohen Hospice House, individuals must be a Community Hospice patient.

Hospice Levels of Care

Routine–Patient receives hospice care at the place he/she resides.

Continuous Care–Patient received hospice care consisting predominantly of licensed nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of crisis and only as necessary to maintain the terminally ill patient at home.

General Inpatient (GIP)–Patient received general inpatient care in an inpatient facility for pain control or acute or complex symptom management which cannot be managed in other settings.

Respite–Patient receives care in an approved facility on a short-term basis in order to provide respite for the caregiver.

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Alzheimer's Disease

The patient has both 1 and 2:

1. Stage VII or beyond according to the Functional Assessment Staging Scale* with all of the
2. Following:

*See *Appendix 3 for Functional Assessment Staging Scale*

- Inability to ambulate without assistance
- Inability to dress without assistance
- Urinary and fecal incontinence, intermittent or constant
- No consistent meaningful/reality-based verbal communication; stereotypical phrases or the ability
- to speak is limited to a few intelligible words

AND

Has had at least one (1) of the following conditions within the past twelve (12) months:

- Aspiration pneumonia

- Pyelonephritis or other upper urinary tract infection
- Septicemia
- Decubitus ulcers, Multiple and/or Stage 3-4
- Fever, recurrent after antibiotics
- Inability to maintain sufficient fluid and caloric intake demonstrated by either of the following;

a. 10% weight loss during the previous (6) months

OR

b. Serum albumin <2.5gm/dl

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

Alzheimer's Disease

Amyotrophic Lateral Sclerosis (ALS)

The patient meets at least one of the following (1 or 2):

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 twelve (12) months;
- 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 ADLs

a. Severe nutritional impairment demonstrated by all of the following in the preceding twelve(12) months;

- Oral intake of nutrients and fluids insufficient to sustain life
- Continuing weight loss
- Dehydration or hypovolemia
- Absence of artificial feeding methods

OR

b. Life-threatening complications demonstrated by one or more of the following in the preceding twelve (12) months;

- Recurrent aspiration pneumonia (with or without tube feeding)
- Upper urinary tract infection (Pyelonephritis)
- Sepsis
- Recurrent fever after antibiotic therapy
- Stage 3 or Stage 4 decubitus ulcers(s)

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

Amyotrophic Lateral Sclerosis (ALS)

Cancer

The patient has 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 a Palliative Performance Score *(PPS) <70%.
   *See *Appendix 2 for Palliative Performance Scale*

3. Refuses further curative therapy or continue to decline despite definitive therapy. Decline is evidenced by:
   - Hypercalcemia>12
   - Cachexia or weight loss of 5% in the preceding three months
   - Recurrent disease after surgery/radiation/ chemotherapy

- Refusal to pursue additional curative or prolonging cancer treatment
- Signs and symptoms of advanced disease (e.g., nausea, anemia, malignant ascites or pleural effusion, etc.)

The following information will be required;

1. Tissue diagnosis of malignancy

OR

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

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

Cancer

Cerebral Vascular Accident/ Stroke or Coma

The patient has both 1 and 2:

1. Poor functional status with Palliative Performance Scale* of 40% or less (unable to care self)
**See Appendix 2 for Palliative Performance Scale*

AND

2. Poor nutritional status with inability to maintain sufficient fluid and calorie intake with either;

- >10% weight loss over the previous six (6) months
- >7.5% weight loss over the previous three (3) months
- Serum albumin <2.5gm/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 third (3) day of coma;

- Abnormal brain stem response
- Absent verbal responses
- Absent withdrawal response to pain
- Serum creatinine> 1.5gm/dl

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

Cerebral Vascular Accident/ Stroke or Coma

Heart Disease/CHF

The patient has 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:
*See *Appendix 1 for New York Heart Association* (NYHA) Functional Classification

- The presence of significant symptoms of recurrent Congestive Heart Failure (CHF) and/or angina at rest
- Inability to carry out even minimal physical activity without symptoms of heart failure (dyspnea and/or angina)

Supporting evidence for hospice eligibility:

- Echo demonstrating and 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 these findings, rapid decline or comorbidities may also support eligibility for hospice care.

Heart Disease/CHF

HIV Disease

The patient must have 1a or b, 2 and 3:

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

OR

1b. 1 Persistent viral load >100,000 copies/ml from two (2) or more assays at least one (1) month apart

AND

2. At least one (1) of the following conditions:

- CNS lymphoma
- Untreated or 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 the absence of dialysis
- Refractory cryptosporidium infection

- 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 Scale* of 5o% (requires considerable assistance and frequent medical care, activity limited mostly to bed or chair)
**See Appendix 2 for Palliative Performance Scale.*

Supporting evidence for hospice eligibility:

- Chronic persistent diarrhea for one year
- Persistent serum albumin <2.5
- Concomitant active substance abuse

In the absence of one or more of these finding, rapid decline and comorbidities may also support eligibility for hospice care.

HIV Disease

Huntington's Disease

The patient has both 1 and 2:

1. Stage VII or beyond according to the Functional Assessment Staging Scale* with all of the following:
*See *Appendix 3 for Functional Assessment*
Staging
- Inability to ambulate without assistance
- In ability to dress without assistance
- Urinary and fecal incontinence, intermittent or constant
- No consistent meaningful verbal communication

AND

2. Has had at least one (1) of the following conditions within the past twelve (12) months:
- Aspiration pneumonia
- Pyelonephritis or other upper urinary tract infection
- Septicemia
- Decubitus Ulcers, Multiple, Stage 3–4

- Toxoplasmosis unresponsive to therapy
- Fever, recurrent after antibiotics
- Inability to maintain sufficient fluid and caloric intake with one of more of the following during the preceding twelve (12) months:

a. 10% weight loss during the previous six (6) months

OR

b. Serum albumin <2.5gm/dl

OR

c. 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 these findings, rapid decline or comorbidities may also support eligibility for hospice care.

Huntington's Disease

Liver Disease

The patient has both 1 and 2:

1. Synthetic failure as demonstrated by a or b and c:

a. Prothrombin time (PTT) prolonged more than five (5) 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, and 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 {<400ml/day})
- Hepatic encephalopathy, refractory to treatment or patient non-compliant
- History of recurrent variceal bleeding despite intensive therapy or patient declines therapy

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 these findings, rapid decline or comorbidities may also support eligibility for hospice care.

Liver Disease

Lung Disease/COPD

The patient has severe chronic lung disease as documented by 1,2,and 3:

Ia. Disabling dyspnea at rest

Ib. Poor response to bronchodilators

Ic. Decreased functional capacity (e.g., bed to chair existence, fatigue and cough)

- 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 three (3) months of a or b or both:

a. Hypoxemia at rest (pO2<55 mgHg by ABG) or oxygen saturation <88%

b. Hypercapnia evidenced by pCO2>50 mm Hg

Supporting evidence for hospice eligibility:

- Cor pulmonale and right heart failure secondary to pulmonary disease
- Unintentional progressive weight loss >10% over the preceding six (6) months
- Resting tachycardia >100 bpm

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

Lung Disease/COPD

Multiple Sclerosis

The patient must meet at least one of the following criteria (1 or 2):

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

OR

2. Rapid disease progression and either a or b below: Rapid disease progression as evidenced by all of the following in the preceding twelve (12) months:
- 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 (ADL) to needing major assistance by caretaker in all ADL

AND

a. Severe nutritional impairment demonstrated by all of the following in the preceding twelve (12) months:

- Oral intake of nutrients and fluids insufficient to sustain life
- Continuing weight loss
- Dehydration of hypovolemia
- Absence of artificial feeding

OR

b. Life-threatening complications demonstrated by one or more of the following in the preceding twelve (12) months:

- Recurrent aspiration pneumonia | (with or without tube feeding)
- Upper urinary tract infections (e.g., Pyelonephritis)
- Sepsis
- Recurrent fever after antibiotic therapy
- Stage 3 or 4 decubitus ulcer(s)

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

Multiple Sclerosis

Muscular Dystrophy

The patient must meet at least one of the following criteria (1 or 2):

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

OR

2. Rapid disease progression and either a or b below: Rapid disease progression as evidenced by all of the following in the preceding twelve (12) months:
- 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 (ADL) to needing major assistance by caretaker in all ADL

AND

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

OR

b. Life-threatening complications demonstrated by one or more of the following in the preceding twelve (12) months:
- Recurrent aspiration pneumonia | (with or without tube feeding)
- Upper urinary tract infections (e.g., Pyelonephritis)
- Sepsis
- Recurrent fever after antibiotic therapy
- Stage 3 or 4 decubitus ulcer(s)

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

Muscular Dystrophy

Myasthenia Gravis

The patient must meet at least one of the following criteria (1 or 2):

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

OR

2. Rapid disease progression and either a or b below: Rapid disease progression as evidenced by all of the following in the preceding twelve (12) months:
- 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 (ADL) to needing major assistance by caretaker in all ADL

AND

a. Severe nutritional impairment demonstrated by all of the following in the preceding twelve (12) months:

- Oral intake of nutrients and fluids insufficient to sustain life
- Continuing weight loss
- Dehydration of hypovolemia
- Absence of artificial feeding

OR

b. Life-threatening complications demonstrated by one or more of the following in the preceding twelve (12) months:

- Recurrent aspiration pneumonia | (with or without tube feeding)
- Upper urinary tract infections (e.g., Pyelonephritis)
- Sepsis
- Recurrent fever after antibiotic therapy
- Stage 3 or 4 decubitus ulcer(s)

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

Myasthenia Gravis

Non-Specific Terminal Illness

The patient has a non-specific terminal medical condition that cannot be attributed to a single specific illness. The physician believed there is a limited life expectancy if six (6) months or less based on a combination of signs, symptoms, test results and/or overall clinical decline.

The clinical impression of six (6) months or less is based on the following:

1. Rapid decline over the past 3–6 months evidenced by:

- Progression of disease evidenced by symptoms, signs, and test results
- Decline in Palliative Performance Scale*
  *See *Appendix 2 for Palliative Performance Scale*
- Weight loss not due to reversible causes and/or declining serum albumin levels
- Dependence on assistance for two or more ADLs: feeding, ambulation, continence, transfer, bathing, or dressing

2. Dysphagia leading to inadequate nutritional intake or recurrent aspiration

3. Decline in systolic blood pressure to below 90 systolic or progressive postural hypotension

4. Increasing emergency visits, hospitalizations, or physician follow-up

5. Decline in Functional Assessment Staging (FAST)*
   *See *Appendix 3 for Functional Assessment Staging*

6. Multiple progressive Stage 3–4 pressure ulcers in spite of optimal care

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

Non-Specific Terminal Illness

Parkinson's Disease

The patient must meet at least one of the following criteria (1 or 2):

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

OR

2. Rapid disease progression and either a or b below: Rapid disease progression as evidenced by all of the following in the preceding twelve (12) months:
- 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 (ADL) to needing major assistance by caretaker in all ADL

AND

a. Severe nutritional impairment demonstrated by all of the following in the preceding twelve (12) months:

- Oral intake of nutrients and fluids insufficient to sustain life
- Continuing weight loss
- Dehydration of hypovolemia
- Absence of artificial feeding

OR

b. Life-threatening complications demonstrated by one or more of the following in the preceding twelve (12) months:

- Recurrent aspiration pneumonia | (with or without tube feeding)
- Upper urinary tract infections (e.g., Pyelonephritis)
- Sepsis
- Recurrent fever after antibiotic therapy
- Stage 3 or 4 decubitus ulcer(s)

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

Parkinson's Disease

Renal Failure Chronic

The patient has 1 and either 2 or 3:

1. The patient is not seeking dialysis or transplant

AND

2. Cratinine clearance* <10cc/min
(<15cc/min for diabetics)

*Creatinine Clearance Calculation for men

$$CrCl = \frac{(140\text{-age,in years}) \times (\text{weight, in Kg})}{(\text{serum creatine in mg/dl})}$$

*Creatinine Clearance Calculation for women

$$CrCl = \frac{(140\text{-age,in years}) \times (\text{weight, in Kg})}{(\text{serum creatine in mg/dl})} \times 0.85$$

OR

3. Serum creatinine >8.0mg/dl
(>6.0mg/dl for diabetics)

Supporting evidence for hospice eligibility:

- Uremia
- Oliguria (urine output is less than 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 these findings, rapid decline or comorbidities may also support eligibility for hospice care.

Renal Failure Chronic

APPENDIX I

NEW YORK HEART ASSOCIATION (NYHA)
FUNCTIONAL CLASSIFICATION
(Class & Description)

I Patients with cardiac disease, but without resulting limitation of physical activity.

Ordinary physical activity does not cause undue fatigue, dyspnea, palpitations or angina 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 angina pain.

III Patients with marked limitations of physical activity. They are comfortable at rest.

Less than ordinary physical activity causes fatigue, palpitations, and dyspnea or angina pain.

IV Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort.

Symptoms of heart failure or of the angina syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

APPENDIX 2

PALLIATIVE PERFORMANCE SCALE (PPS)

%	Ambulation	Activity and Evidence of Disease	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 to Do Normal Job/ Work, Some Evidence of Disease	Full	Normal or Reduced	Full

APPENDIX 2

PALLIATIVE PERFORMANCE SCALE (PPS)

%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Conscious Level
60	Reduced	Unable to Do Hobby/ House Work, Significant Disease	Occasional Assistance Necessary	Normal	Full or Confusion
50	Mainly Sit/Lie	Unable to Do Any Work, Extensive Disease	Occasional Assistance Necessary	Normal	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 Bed Bound	Unable to Do Any Work, Extensive Disease	Total Care	Reduced	Full or Drowsy or Confusion

PALLIATIVE PERFORMANCE SCALE (PPS)

%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Conscious Level
20	Totally Bed Bound	Unable to Do Any Work, Extensive Disease	Total Care	Minimal Sips	Full or Drowsy or Confusion
10	Totally Bed Bound	Unable to Do Any Work, Extensive Disease	Total Care	Mouth Care Only	Drowsy or Coma
0	Death	———	———	———	———

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

APPENDIX 3

Functional Assessment Staging (FAST)
Check highest consecutive level of disability:

1. No difficulty either subjectively or objectively.

2. Complains of forgetting of 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 marketing, 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. Improperly putting on clothes without assistance or cueing (e.g., may put street clothes on overnight clothes, or put shoes on the wrong feet, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks.*

a. Unable to bathe properly (e.g., difficulty adjusting the bath-water temperature) occasionally or more frequently over the past weeks.*

b. Inability to handle mechanisms of toileting (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.*

c. Urinary incontinence (occasionally or more frequently over the past weeks).*

d. Fecal incontinence (occasionally or more frequently over the past weeks).*

7. a Ability to speak limited to approximately half a dozen different intelligible 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.

*Scored primarily on the basis of information obtained from knowledgeable information and/or category. Reisberg, B. Functional Assessment Staging (FAST). Psychopharmacology Bulletin 1988; 24:-653-659.

Guidelines for Hospice Admission

For Referrals or Questions:

Community HOSPICE

Helping Hands...Healing Hearts

4368 Spyres Way
Modesto, CA 95356
209.578.6300

2431 W. March Lane
Suite 100
Stockton, CA 95207
209.477.6300

Referrals: 209.578.6340

www.hospiceheart.org

Community Hospice

CHAP

Our agency operates in compliance with Title VI under the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age of Discrimination Act of 1975, and Federal HIPAA Privacy Rules. Our Notice of Privacy Practices describes how we may use or disclose protected health information. You may call our office to request a copy of our Notice of Privacy Practices. Hospice services are available regardless of ability to pay. **CA100000783 | CA100000613**