



## *What distinguishes Zion's Way from other companies?*

### **Dedicated Team of Professionals:**

*Our interdisciplinary team consists of physicians, nurses, social workers, home health aides, bereavement and spiritual counselors, volunteers, musicians, and physical, occupational, speech and massage therapists. Each team member is actively engaged in providing quality care to all patients and families.*

### **JCAHO Accreditation:**

*Zion's Way meets all requirements for JCAHO - The Joint Commission for the Accreditation of Healthcare Organizations. JCAHO accreditation is a prestigious designation assuring that all agency processes and procedures conform to National Standards of Quality Healthcare and Hospice. Zion's Way Home Health and Hospice is Southwest Utah's only **non-corporate, locally-owned** and **JCAHO accredited** Home Health and Hospice agency.*

### **Complementary Therapies:**

*Zion's Way uses complementary therapies to promote health and treat the various physical, mental, and spiritual needs of all patients and families. Such therapies include **massage, aromatherapy, art, music, sound** and **pet therapies**, and **lymphatic drainage**. Complementary therapies are supplemental to traditional procedures that elevate the patient's quality of life resulting in a more satisfying hospice and home health care experience.*

### **Local Medical Directors:**

*Dr. Wesley Barney is the Medical Director at Zion's Way. He is readily available to our patients and staff. As a local physician and long-time resident of Southern Utah, he understands the needs of the community, hospital and skilled facilities. He certifies prognosis, develops plans of care for the patients, and also performs house calls. His attendance at weekly team meetings keeps him aware of the needs of the patients and families we serve.*

### **Serving Southwestern Utah and Northern Arizona:**

*Zion's Way operates from its home office in St. George, Utah, though full-time members of our interdisciplinary team reside throughout Southwestern Utah and Northern Arizona. Having local employees enables us to respond quickly and provide more personalized home health and hospice care to the residents of Washington, Iron, Kane, Garfield, and Beaver counties in Utah as well as Coconino and Mohave counties in Arizona. Staff members who take pride in their work are available when and wherever their services are needed.*

***The Art of Living Well Every Day of Your Life!***

**Ph: 435.688.0648 / Fax: 435.688.0715 / Toll Free: 888.688.0648 / [www.ZionsWayHospice.com](http://www.ZionsWayHospice.com)**

## Who is Eligible for Hospice Care?

Hospice care is available to anyone regardless of age, sex, ethnicity, religion or national origin. Hospice becomes appropriate when the focus on curing an illness is no longer supporting the patient's quality of life. Whether they have come to this decision on their own, or their doctor has encouraged them to consider it, patients have decided they do not want to spend any more of the time they have left seeking aggressive curative treatment. **Eligibility guidelines for some common Hospice and Home Health diagnoses are listed below.**

## Who is Eligible for Home Health Care?

Home Health Care is available to anyone regardless of age, sex, ethnicity, religion or national origin. When determining whether a patient is eligible for Home Health Care services, the following questions should be asked:

- Does the patient's condition generally keep them **home bound** making it difficult for them to receive outpatient medical care?
- Does the patient's condition require a **nurse, physical therapist**, or other specialists to assist them during their recovery at home?
- Does the patient need help with cooking, bathing, housekeeping, or other activities of daily living?
- Has the patient recently been diagnosed with a medical condition or has a preexisting condition worsened?
- Is the patient recovering from a recent surgical procedure or hospital stay requiring **physical therapy** or **skilled nursing**?
- Has the patient experienced a shift in medical status that requires additional care?



## **DECLINE IN CLINICAL STATUS**

- Body Mass Index below 22kg/m<sup>2</sup>; BMI=703 x (patient's weight in pounds) ÷ (height in inches)<sup>2</sup>
- Patient declines or is not responding to enteral or parenteral nutritional support
- Recent rapid clinical decline and disease progression
- Decline in functional status
- Weight loss
- Dependence on assistance for two or more ADL's
- Increased ER visits, hospitalization, physician contact
- Progression of cognitive impairment
- Progressive pressure ulcers in spite of optimal care
- Dysphasia with recurrent aspiration

## **HIV DISEASE**

- CD4 count less than 25cells/ml or viral load greater than 100,000 copies/ml on two or more assays at least one month apart.
- KPS less equal or less than 50%
- Supportive factors including: chronic diarrhea for one year, persistent serum albumin < 2.5, concomitant active substance abuse, Age > 50 yr, absence/resistance to antiretroviral, chemotherapeutic, and drug therapy related to HIV, Advanced AIDS dementia complex, Toxoplasmosis, CHF symptomatic at rest, Liver disease.
- One of the following must be present: CNS or systematic Lymphoma, Wasting (10% of lean body mass), MAC bacteremia, Progressive multifocal Leukoencephalopathy, Visceral Kaposi's sarcoma, Renal Failure and no dialysis, Cryptosporidium infection, Toxoplasmosis

## **NEUROLOGICAL DISEASES: ALS, PARKINSON'S, MS**

- Vital capacity (VC) less than 30% of normal
- Significant Dyspnea at rest
- Declines artificial ventilation, external ventilation used for comfort measures only
- Critical Nutritional Impairment and continued weight loss
- Rapid disease progression or complication in the last 12 months
- Critically impaired breathing

## **PULMONARY DISEASE**

- Decreased functional capacity
- Disabling dyspnea at rest or with minimal exertion
- Poor response to bronchodilators
- Disease evidenced by increasing visits to physician, ER, or hospital
- Hypoxemia on room air less than 88% by oximetry
- An FEV1 less than 30% (helpful, not required)

## **CANCER**

- Clinical finding of malignancy with widespread, aggressive or metastatic disease
- Patient no longer seeking curative treatment
- Palliative Performance Scale equal to or less than 70

## **DEMENTIA**

- Inability to ambulate or dress without assistance
- Urinary/fecal incontinence, intermittent or constant
- No consistent meaningful verbal communication
- One of the following within last 12 months: Aspiration pneumonia, Pyelonephritis or other UTI, Septicemia, Decubitus ulcers, multiple stage 3-4, Inability to maintain sufficient fluid calorie intake, Fever, recurrent after antibiotics

## **RENAL FAILURE**

- Patient is not a candidate for nor seeking dialysis
- Creatinine clearance less than 10cc/min (<15cc/min for diabetics)
- Serum creatinine greater than 8.0mg/dl (>6.0mg/dl for diabetics)

## **HEART DISEASE**

- Poor response to optimal treatment with diuretics, vasodilators, or ace inhibitors
- Presence of NYHA Class IV CHF or refractory angina
- Ejection fraction less than 20% (helpful, not required)
- Not a candidate for, or has declined, revascularization procedures

## **STROKE**

- Palliative Performance Scale of 40% or less
- Poor nutritional status with weight loss over 10% in the past six months of 7.5% in the last three months
- Serum albumin of less than 2.5
- Coma with three of the following on third day of coma: Abnormal brain stem response, Absent verbal responses, Absent withdrawal response to pain, Serum creatinine greater than 1.5

## **LIVER DISEASE**

- PT prolonged more than five sec. over control or INR > than 1.5
- Serum albumin less than 2.5 gm/dl
- Must have one of the following: Ascites, Hepatic encephalopathy, History of recurrent variceal bleeding, Spontaneous bacterial peritonitis, Hepatorenal Syndrome

## **REHABILITATION SERVICES: PHYSICAL THERAPY**

In-home rehabilitation plans often include a Physical Therapist who offers the following services: a **complete physical assessment** of the patient's condition and needs; an established **plan of treatment** with input from the patient and primary caregiver; **communication** with the physician and caregiver regarding goals and progress; **individualized safety training, instruction, and home maintenance program**; and **therapeutic exercises** that are personalized to meet the needs of specific patients.