Criteria for Determining Hospice Appropriateness

General Guidelines for Determining Prognosis
(Local Coverage Determinations)

Patient should meet the following criteria:

1. Life limiting condition
2. Patient/family informed of condition
3. Patient/family have elected palliative care
4. Clinical progression of the disease evidenced by one or more of the following:
    A. Serial physician assessment
    B. Laboratory studies
    C. Radiologic or other studies
    D. Multiple ER visits
    E. Inpatient hospitalizations

    AND 5 AND/OR 6:

5. Recent decline in functional status as evidenced by either A and/or B:
    A. Karnofsky Status ≤ 50%
        50% Requires considerable assistance and frequent medical care
        40% Disabled; requires special care and assistance; unable to care for self; disease may be progressing rapidly
        30% Severely disabled although death is not imminent
        20% Very sick; active supportive treatment is necessary
        10% Moribund; fatal processes progressing rapidly.

    B. Dependence in 3 of 6 ADLs
        - Bathing
        - Dressing
        - Feeding
        - Transfers
        - Continence of urine and stool
        - Ambulation to bathroom

6. Recent impaired nutritional status evidenced by:
    A. Unintentional, progressive weight loss of 10% over the past 6 months;
    B. Serium albumin less than 2.5 gm/dl (indicator not to be used in isolation)

Cancer

Specific Guidelines for determining Prognosis

The patient should meet the following criteria:

1. Cancer diagnosis is confirmed through pathology or radiology.
2. Patient is no longer receiving curative treatment.
3. There is evidence of end-stage disease and / or metastasis.
4. Lab / diagnostic studies have been done recently to support disease progression.
5. Karnofsky Performance Score of ≤ 70%. (See Appendix A)
6. Modified ADL score of ≤ 18. (See Appendix B)
7. Descriptive score of ≤ 25. (See Appendix A)

End-Stage Dementia

Specific Guidelines for determining Prognosis

Patients with dementia must show all of the following characteristics.

1. Stage seven or beyond according to the Functional Assessment Staging Scale (FAST). (See Appendix C).
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 consistent.
6. No meaningful verbal communication, stereotypical phrases only, or ability to speak is limited to six or fewer intelligible words.
7. Patients must have one of the following within the past 12 months.

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

Heart Disease

Specific Guidelines for determining Prognosis

Factors 1 and 2 must be present; factors from 3 will add supporting documentation:

1. At the time of certification and re-certification, the patient is already optimally treated with diuretics and vasodilators, usually angiotensin-converting enzyme (ACE) inhibitors. (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 has significant symptoms of recurrent congestive heart failure (CHF) at rest, and is classified as New York Heart Association (NYHA) Class IV. (Class IV patients with heart disease have an 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 in increased.) Significant congestive heart failure may be documented by an ejection fraction of ≤ 20%, but is not required if not readily available.

3. Documentation of the following factors will support eligibility determination.

    - Treatment resistant symptomatic supraventricular or ventricular arrhythmia's.
    - History of cardiac arrest or resuscitation
    - History of unexplained syncope
    - Brain embolism of cardiac origin
    - Concomitant HIV disease

HIV Disease

Specific Guidelines for determining Prognosis

Factors 1 and 2 must be present; factors from 3 will add supporting documentation:

1. CD4+ < 25 cells/mcL or persistent viral load > 100,000 copies/ml, plus one of the following:

    - CNS lymphoma
    - Untreated, or not responsive to treatment, wasting (loss of 35% lean body mass)
    - Mycobacterium avium complex (MAC) bacterium, untreated, unresponsive to treatment, or treatment refused.
    - Progressive multifocal leukoencephalopathy.
    - Systemic lymphoma, with an advanced HIV disease and partial response to chemotherapy.
    - Visceral Kaposi's sarcoma unresponsive to therapy.
    - Cryptosporidium infection.
    - Toxoplasmosis, unresponsive to therapy.

2. Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of ≤ 50%. (See Appendix A).

3. Documentation of the following factors will support eligibility determination.

    - Chronic persistent diarrhea for one year;
    - Persistent serum albumin < 2.5;
    - Concomitant, active substance abuse;
    - Age > 50 years;
    - Absence of antiretroviral, chemotherapeutic and prophylactic drug therapy related to HIV disease;
    - Advanced AIDS dementia complex;
    - Congestive heart failure, symptomatic at rest.

Liver Disease

Specific Guidelines for determining Prognosis

Factors 1 and 2 must be present; documentation of factor 3 will add supporting documentation:

1. The patient should show BOTH a and b.

    a. Prothrombin time prolonged more than 5 seconds over control, or international Normalized Ration (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:

    - Ascites, refractory to treatment or patient non-compliant;
    - Spontaneous bacterial peritonitis;
    - Hepatorenal syndrome (elevated creatine and BUN with oliguria <400 ml/day and urine sodium concentration < 10 mEq/1;
    - Hepatic encephalopathy, refractory to treatment, or patient non-compliant;
    - Recurrent variceal bleeding, despite intensive therapy.

3. Documentation of the following factors will support eligibility for hospice care.

    - Progressive malnutrition
    - Muscle wasting with reduced strength and endurance
    - Continued active alcoholism (>80 gm Ethanol/day)
    - Hepatocellular carcinoma
    - HBsAg (hepatitis B) positivity
    - Hepatitis C refractory to interferon treatment.

NOTE: Patients awaiting liver transplant who otherwise fit the above criteria may be certified for the Medicare Hospice Benefit, but if a donor organ is procured, the patient must be discharged from hospice.

Multi System Failure (Debility Unspecified)

Specific Guidelines for determining Prognosis

The distinguishing feature of this patient population is that no single, anatomically defined disease is sufficiently dominant so as to warrant, by itself, designation as the terminal diagnosis. Rather it is the cumulative frailties of multiple intercurrent co-morbidities that renders the patient's condition terminal. Patients will be considered to be in decline of their health status (life expectancy of six months or less) if changes in status in the following clinical variables are documented:

1. Progression of disease as documented by symptoms, signs and test results.

2. Decline in Karnofsky Performance Status of Palliative Performance Score/Adapted Karnofsky. (See Appendix A).

3. Weight loss, decreasing anthropomorphic measurements, such as, mid-arm circumference or abdominal girth (not due to reversible causes as depression or use of diuretics), and decreasing serum albumin or cholesterol.

4. Dependence on assistance for two or more ADLs (feeding, ambulation, continence, transfer, bathing, dressing). (See Appendix B).

5. Dysphagia leading to inadequate intake or recurrent aspiration.

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

7. Increasing ER visits or hospitalizations related to the hospice primary diagnosis.

8. Decline in Functional Assessment Staging (FAST) for dementia. (See Appendix C)

9. Progressive stage 3-4 pressure ulcer in spite of optimal care.

These changes in clinical variables apply to patients whose decline is not considered to be reversible due to intercurrent illness or condition. The clinical variables are listed in order of their power to predict poor survival, the most predictive first and the least predictive last. No specific number of the above criteria must be met, but fewer of those listed first (more predictive) and more of those listed last (less predictive) would be expected to predict longevity of six months or less.

Pulmonary Disease

Specific Guidelines for determining Prognosis

Factors 1 and 2 must be present; documentation of 3, 4 and / or 5 will add supporting documentation:

1. Severe chronic lung disease as documented by both A and B:

    A. Disabling dyspnea at rest, poorly or un-responsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough. (Documentation of CForced 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 ER or hospitalizations for pulmonary infections and/or respiratory failure. (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 $p0_2 \leq 55$ mmHg and oxygen saturation ≤88% on supplemental oxygen. Or hyercapnia, as evidenced by $pCO_2 \geq 50$ mmHg. (These values may be obtained from recent hospital records.)

3. Cor Pulmonale and right heart failure (RHF) secondary to pulmonary disease (e.g., 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/min.

End Stage Renal Disease

Specific Guidelines for determining Prognosis

Acute Renal Failure (1 and either 2 or 3 must be present. Factors from 4 will lend supporting documentation).

1. The patient is not seeking dialysis or renal transplant;

2. Creatinine clearance < 10 cc/min (<15 cc/min for diabetics); OR < 15 cc/min (<20 cc/min for diabetics) with comorbidity of congestive heart failure;

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. Immunosuppression/AIDS;
    H. Albumin < 3.5 gm/dl;

I. Cachexia;
J. Platelet count < 25,000;
K. Disseminated intravascular coagulation;
L. Gastrointestinal bleeding.

Chronic Renal Failure (1 and either 2 or 3 must be present as outlined above. Factors from 5 will lend supporting documentation.)

5. Signs and symptoms of renal failure:
    A. Uremia;
    B. Oliguria (< 400 cc/24 hours);
    C. Intractable hyperkalemia (> 7.0) not responsive to treatment;
    D. Uremic pericarditis;
    E. Hepatorenal syndrome;
    F. Intractable fluid overload, not responsive to treatment.

<u>Stroke and Coma</u>

Specific Guidelines for determining Prognosis

Acute phase of hemorrhagic or ischemic stroke: Factors 1, 2 or 3 must be present.

1. Coma or persistent vegetative state secondary to stroke, beyond three days duration.

2. In post anoxic stroke, coma or sever e obtundation, accompanied by severe myoclonus, persisting beyond three days past the anoxic event.

3. Dysphagia which prevents sufficient intake of food and fluids to sustain life in a patient who does not receive artificial nutrition and hydration.

Chronic phase of hemorrhagic or ischemic stroke: Factors 1, 2, or 3 must be present.

1. Post stroke dementia (all of the following):
    A. Stage seven or beyond according to the Functional Assessment Staging Scale (FAST) (Appendix C);
    B. Unable to ambulate without assistance;
    C. Unable to dress without assistance;
    D. Unable to bathe without assistance;
    E. Urinary and fecal incontinence, intermittent or constant;
    F. Ability to speak is limited to six or fewer intelligible words.

2. Poor functional status with Karnofsky score of 40% or less. (See Appendix A).
3. Poor nutritional status whether on artificial nutrition or not, with the inability to maintain sufficient fluid and calorie intake with ≥10% weight loss during the previous six months or serum albumin < 2.5 gm/dl.

Coma (any etiology): Any of the following are present 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.

MAKING A HOSPICE REFERRAL

The patient must meet the criteria for hospice care.

- The patient has a limited life expectancy, usually six (6) months or less, as certified by their physician and the Hospice Medical Director.

- The patient understands that hospice care is palliative, focused on pain and symptom control, rather than a cure for the disease, and chooses a palliative focus.

1. The Attending Physician's order for hospice is obtained.

2. Hospice care is chosen by the patient and/or family.

3. Call Hospice of the Twin Cities at 763-531-2424 or 1-800-364-2478 to make a referral.

4. An information/admission meeting is arranged with the hospice, patient, family and/or any other individuals involved in providing care.

5. The patient or designated decision-maker signs consents for hospice care to begin.

6. The hospice team assigned to the patient develops a plan of care and begins to provide care and services.

SCALES USED IN LOCAL COVERAGE DETERMINATION CRITERIA

Appendix A

Karnofsky Scale

10	Normal: no complaints; no evidence of disease.
9	Able to carry on normal activity; minor signs or symptoms of disease.
8	Normal activity with effort; some signs or symptoms of disease.
7	Cares for self; unable to carry on normal activity or to do active work.
6	Requires occasional assistance, but can care for most of own needs.
5	Requires considerable assistance and frequent medical care.
4	Disabled; requires special care and assistance.
3	Severely disabled; hospitalization would be indicated although death is not imminent.
2	Hospitalization would be necessary; very sick; active supportive treatment necessary.
1	Moribund; fatal processes progressing rapidly.
0	Dead.

Descriptive Scale

Anorexia
5 normal
4 Decreased intake
3 Some soft foods
2 Some fluids
1 No fluids

Cachexia
5 Heavy
4 Normal build
3 Very thin
2 Extreme cachexia
1 Skin and bones

Mobility
5 Normal
4 Limited walking
3 Bears weight
2 Sits up
1 Unable to turn over

Pain
5 None
4 Mild
3 Moderate
2 Severe \
1 Incapacitating

Dyspnea
5 None
4 Mild
3 Moderate
2 Severe
1 Incapacitating

Descriptive Scale Total: _____

Appendix B

Modified ADL Scale

Bathing
4 Independent
3 Uses a device (shower stool, etc.)
2 Needs personal assistance (in and out of tub)
1 Completely dependent (bed bath)

Dressing
4 Independent
3 Uses a device (i.e. reacher)
2 Needs personal assistance (buttoning, choosing clothes)
1 Completely dependent

Toileting (getting to toilet, on or off, opening clothing
4 Independent
3 Uses a device (walker, cane)
2 Needs personal assistance
1 Completely dependent

Transfer
4 Independent
3 Uses a device (walker, cane)
2 Needs personal assistance
1 Completely dependent

Continence
4 Independent
3 Uses a device (urinal or bedpan)
2 Needs personal assistance (to position urinal/bedpan)
1 Completely dependent (catheter or diapers)

Feeding
4 Independent
3 Uses a device
2 Needs personal assistance (fed by another)
1 Completely dependent (feeding tube or not eating)

Modified ADL Scale Total:_____

Appendix C

Functional Assessment Staging (FAST)[1]

(Check highest consecutive level of disability)

_____ 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 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.*

_____ 6a. Improperly putting on clothes without assistance or cuing (e.g., may put street clothes on overnight clothes, or put shoes on wrong feet, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks.*

_____ 6b. Unable to bathe properly (e.g., difficulty adjusting bath-water temperature) occasionally or more frequently over the past weeks.*

_____ 6c. Inability to handle mechanics 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.*

_____ 6d. Urinary incontinence (occasionally or more frequently over the past weeks).*

_____ 6e. Fecal incontinence (occasionally or more frequently over the past weeks).*

_____ 7a. Ability to speak limited to approximately a half a dozen intelligible different words or fewer, in the course of an average day or in the course of an intensive interview.

_____ 7b. 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).

_____ 7c. Ambulatory ability is lost (cannot walk without personal assistance).

_____ 7d. Cannot sit up without assistance (e.g., the individual will fall over if there are not lateral rests (arms) on the chair).

_____ 7e. Loss of ability to smile.

_____ 7f. Loss of ability to hold up head independently.

* Scored primarily on the basis of information obtained from a knowledgeable informant and/or category.

[1] Reisberg, B. Functional assessment staging (FAST). Psychopharmacology Bulletin, 1988; 24:653-659.