

## **Hospice -- Determining Terminal Status**

### **Stroke & Coma**

**SPECIFIC INDICATIONS:** A patient will be considered to have a life expectancy of six months or less if he/she meets the non-disease specific decline in clinical status guidelines described in Part I. Alternatively, the baseline non-disease specific guidelines described in Part II plus the applicable disease specific guidelines listed will establish the necessary expectancy.

#### **Part I. Decline in clinical status guidelines**

Patients will be considered to have a life expectancy of six months or less if there is documented evidence of decline in clinical status based on the guidelines listed below. Since determination of decline presumes assessment of the patient's status over time, it is essential that both baseline and follow-up determinations be reported where appropriate. Baseline data may be established on admission to hospice or by using existing information from records. Other clinical variables not on this list may support a six-month or less life expectancy. These should be documented in the clinical record.

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

## **Part I. Decline in clinical status guidelines**

1. Progression of disease as documented by worsening clinical status, symptoms, signs and laboratory results
  - A. Clinical Status
    - 1) Recurrent or intractable infections such as pneumonia, sepsis or upper urinary tract.
    - 2) Progressive inanition as documented by:
      - a) Weight loss not due to reversible causes such as depression or use of diuretics
      - b) Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics
      - c) Decreasing serum albumin or cholesterol
    - 3) Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption.
  - B. Symptoms
    - 1) Dyspnea with increasing respiratory rate
    - 2) Cough, intractable
    - 3) Nausea/vomiting poorly responsive to treatment
    - 4) Diarrhea, intractable
    - 5) Pain requiring increasing doses of major analgesics more than briefly.
  - C. Signs
    - 1) Decline in systolic blood pressure to below 90 or progressive postural hypotension
    - 2) Ascites
    - 3) Venous, arterial or lymphatic obstruction due to local progression or metastatic disease
    - 4) Edema
    - 5) Pleural / pericardial effusion
    - 6) Weakness
    - 7) Change in level of consciousness
  - D. Laboratory (When available. Lab testing is not required to establish hospice eligibility.)
    - A. Increasing pCO<sub>2</sub> or decreasing pO<sub>2</sub> or decreasing SaO<sub>2</sub>
    - B. Increasing calcium, creatinine or liver function studies
    - C. Increasing tumor markers (e.g. CEA, PSA)
    - D. Progressively decreasing or increasing serum sodium or increasing serum potassium
2. Decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) from <70% due to progression of disease.
3. Increasing emergency room visits, hospitalizations, or physician's visits related to hospice primary diagnosis
4. Progressive decline in Functional Assessment Staging (FAST) for dementia (from 7A on the FAST)
5. Progression to dependence on assistance with additional activities of daily living (See Part II, Section 2)
6. Progressive stage 3-4 pressure ulcers in spite of optimal care

## **Part II. Non-disease specific baseline guidelines**

(both of these should be met)

1. Physiologic impairment of functional status as demonstrated by: Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) <70%.

Note: two of the disease specific guidelines (HIV Disease, Stroke and Coma) establish a lower qualifying KPS or PPS.

2. Dependence on assistance for two or more activities of daily living (ADLs)

- A. Feeding
- B. Ambulation
- C. Continence
- D. Transfer
- E. Bathing
- F. Dressing

### **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:
  1. Weight loss >10% in the last 6 months or >7.5% in the last 3 months;
  2. Serum albumin <2.5 gm/dl;
  3. Current history of pulmonary aspiration not responsive to speech language pathology intervention;
  4. Sequential calorie counts documenting inadequate caloric/fluid intake;
  5. 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.

#### **Coma (any etiology):**

Comatose patients with any 3 of the following on day three of coma:

- a. abnormal brain stem response;
- b. absent verbal response;
- c. absent withdrawal response to pain;
- d. serum creatinine >1.5 mg/dl.

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:

- a. Aspiration pneumonia;
- b. Upper urinary tract infection (pyelonephritis);
- c. Sepsis;

- d. Refractory stage 3-4 decubitus ulcers;
- e. Fever recurrent after antibiotics.

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

- A. 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.
  
- B. 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.

The baseline guidelines do not independently qualify a patient for hospice coverage.

Note: The word “should” in the disease specific guidelines means that on medical review the guideline so identified will be given great weight in making a coverage determination. It does not mean, however, that meeting the guideline is obligatory.

### **Part III. Co-morbidities**

Although not the primary hospice diagnosis, the presence of disease such as the following, the severity of which is likely to contribute to a life expectancy of six months or less, should be considered in determining hospice eligibility.

- A. Chronic obstructive pulmonary disease
- B. Congestive heart failure
- C. Ischemic heart disease
- D. Diabetes mellitus
- E. Neurologic disease (CVA, ALS, MS, Parkinson's)
- F. Renal failure
- G. Liver Disease
- H. Neoplasia
- I. Acquired immune deficiency syndrome
- J. Dementia