Hospice Eligibility

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You must present a medical justification for a patient to qualify for hospice benefits. There are no absolute rules but the following should help you determine who is expected to only live for 6 months. Generally speaking, physicians refer patients for hospice at a very late stage in their course. This makes it more difficult for the patients and families to prepare for death and gain full benefits of hospice care.

PATIENT ELIGIBILITY FOR MEDICARE BENEFITS

- Pt must be eligible for Medicare Part A (the hospitalization benefit)
- Pt must have a terminal illness, the prognosis being 6 months or less. This must be certified by 2 doctors, usually the patient's primary care physician and the medical director of the hospice.
- Patient or family (if the patient cannot do so) must give informed consent.
- Care must be provided by a Medicare-certified hospice
- Hospice benefits can also be obtained through private, for-profit insurance policies and Medi-Cal

BENEFIT PERIOD

- Currently the benefits run for two periods of 90 days followed by an unlimited number of 60 day periods. At the end of each period, the patient must have benefits renewed. To be "renewed," a patient must still have the terminal illness and must manifest a functional decline.

GUIDELINES

The following guidelines will help you determine who is **eligible** for hospice benefits.
You are looking for a pattern of functional and physiologic decline. The following characteristics which should be present before the patient enters into a hospice program.

General Guidelines

- Expected life span of 6 months or less. The patient will not have hospice benefits revoked if he/she does not die within this time period but the patient must show persistent decline during this time. If the patient does decline, then hospice benefits can be renewed.
- Pt must have life limiting condition and the pt and/or the family must be aware of this
- Pt/decision maker must desire palliative approach rather than curative focus
- Progression of disease must be documented
    - By disease specific markers—physical examination, labs, imaging
    - Multiple hospital admissions or ER visits
    - Decline in functional status—dependence in 3 BADL's or Karnofsky <51% (performance at baseline must have been higher)
    - Impaired nutritional status—weight loss 10% over past 6 months (serum albumin <2.5 g/L helpful for prognosis)

Disease-specific Guidelines (Non-Cancer Diseases)

These are not Medicare guidelines; they are meant to provide a general prognosis.

Heart Disease

- CHF symptoms at rest (NYHA class IV)
- Must be optimally treated with diuretics and after-load reduction
- The following help predict increased mortality: symptomatic supraventricular or ventricular arrhythmias, prior cardiac arrest, unexplained syncope, cardiogenic stroke,

and concomitant HIV disease.
- An ejection fraction of 20% or less is helpful, but not required for this category.

Pulmonary Disease
- Dyspnea at rest, unresponsive to treatment
- Progressive disease that can be demonstrated with a declining FEV1 (> 40 ml/year) or by increased ER visits/hospitalizations (no specific number of visits, just looking for a trend)
- Cor pulmonale or right heart failure (not due to valvular cardiomyopathy or left heart failure)
- Hypoxemia at rest (PaO_2 <56 mm Hg or sat < 89% on supplemental O_2)
- Hypercapnea ($PaCO_2$ > 49mm Hg)
- Resting tachycardia

Dementia
- MMSE of 0/30 and basic ADL dependency alone are NOT SUFFICIENT; these patients, though profoundly demented, may live for some time.
- Presence of co-morbid conditions are associated with decreased survival:
  - aspiration, pyelonephritis, septicemia, pressure ulcers (stage 3-4), fever despite antibiotics
- If pt has g-tube, must demonstrate (and document) nutritional impairment.
  - Weight loss > 10% over 6 months
  - Hypoalbuminemia

• In the absence of G-tube, decreased oral intake

Liver Disease
- Clinical judgement in this category is essential—the following are guidelines
- Pt must not be a transplant candidate
- Pt should exhibit impaired synthetic function: Albumin < 2.5 g/L and PT < 5 sec over control
- Ascites despite maximum diuretics
- Spontaneous bacterial peritonitis
- Hepatorenal syndrome
- Hepatic encephalopathy
- Recurrent variceal bleeding

Renal Disease
- Creatinine clearance <10cc/min (<15 if diabetic) and serum creatinine >8 (>6 if diabetic)
- Signs or symptoms associated with uremia
- Oliguria
- Intractable fluid overload
- Not on dialysis

PREDICTING MORTALITY FOR CANCER DIAGNOSES

Predicted Survival in Days Based on KPS Scale
Rating Level and Symptom Profile

	KPS Scale Rating Level					
	10-20		30-40		>50	
Symptom Profile	50% Dead	90% Dead	50% Dead	90% Dead	50% Dead	90% Dead
No symptoms	53	23	11	450	172	450
1 symptom	36	168-199	83-98	362-428	125-191	450
2 symptoms	29-38	128-165	63-82	275-356	95-123	413-450
3 symptoms	23-30	10-13	50	218-283	75-93	328-406
4 symptoms	19-23	10-95	41-49	181-215	62-74	272-322
5 symptoms	16	72	36	156	54	234

This table is from a study by Reuben et.al which looked at data from the National Hospice study. They stratified patients according to their Karnofsy Performance Scale (KPS). (This is a measure of performance status—see below).

The authors then looked at the presence of certain symptoms: Dry mouth (D), Shortness of breath (S), Problems eating or anorexis (P), Trouble swallowing (T), and weight loss (W).

Although the chart is detailed, the essential point is that the more symptoms the patients experience the more likely they were to die within a given period of time. Similarly, the more debilitated patients were more likely to have more limited survival.

Karnofsky Performance Scale

Score (%)	Criteria
100	Normal, asymptomatic
90	Able to function normally, minor signs or symptoms
80	Normal activity with effort, some signs or symptoms
70	Able to perform self care, unable to complete normal activity or do active work
50	Requires considerable assistance and frequent medical care
40	Disabled, requires special care and assistance
30	Severely disabled, hospitalization is indicated
20	Very sick, hospitalization necessary with active supportive treatments needed
10	Moribund, fatal processes progressing rapidly

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