Determining Hospice Eligibility

Pike County Hospice

Caring for our Communities since 1993

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"I do what I do because I feel no one should face death or loss alone, but should be held in love.

It is an Honor to journey beside so many"

Part One

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 examples of findings that generally connote a poor prognosis. However, some are clearly more predictive of a poor prognosis than others; significant ongoing weight loss is a strong predictor, while decreased functional status is less so.

A. Progression of disease as documented by worsening clinical status, symptoms, signs and laboratory results.

Clinical Status:

- Recurrent or intractable serious infections such as pneumonia, sepsis or pyelonephritis;
- Progressive inanition as documented by:
- Weight loss of at least 10% body weight in the prior six months, not due to reversible causes such as depression or use of diuretics;
- Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics;
- Observation of ill-fitting clothes, decrease in skin turgor, increasing skin folds or other observation of weight loss in a patient without documented weight;
- Decreasing serum albumin or cholesterol.
- Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption.

Symptoms:

- Dyspnea with increasing respiratory rate;
- Cough, intractable;
- Nausea/vomiting poorly responsive to treatment;
- Diarrhea, intractable;
- Pain requiring increasing doses of major analgesics more than briefly.

Signs:

- Decline in systolic blood pressure to below 90 or progressive postural hypotension;
- Ascites;
- Venous, arterial or lymphatic obstruction due to local progression or metastatic disease;
- Edema;
- Pleural/pericardial effusion;
- Weakness;
- Change in level of consciousness.

Laboratory: *(When available. Lab testing is not required to establish hospice eligibility.)*

- Increasing pCO2 or decreasing pO2 or decreasing SaO2;
- Increasing calcium, creatinine or liver function studies;
- Increasing tumor markers (e.g. CEA, PSA);
- Progressively decreasing or increasing serum sodium or increasing serum potassium.

B. Decline in Karnofsky Performance Status **(KPS*)** or Palliative Performance Score **(PPS*)** due to progression of disease.

C. Progressive decline in Functional Assessment Staging **(FAST*)** for dementia (from 7A on the FAST)

D. Progression to dependence on assistance with additional activities of daily living (see Part II, Section 2).

E. Progressive stage 3-4 pressure ulcers in spite of optimal care.

F. History of increasing ER visits, hospitalizations, or physician visits related to the hospice primary diagnosis prior to election of the hospice benefit.

*See the following pages for detailed documents and/or visit our website for printable PDF's

*Karnofsky Performance Status (KPS)

KARNOFSKY PERFORMANCE STATUS SCALE

DEFINITIONS	RATING (%)	CRITERIA
Able to carry on normal activity and to work; No special care needed.	100	Normal no complaints; no evidence of disease.
	90	Able to carry on normal activity; Minor signs or symptoms of disease.
	80	Normal activity with efforts; some signs or symptoms of disease.
Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed.	70	Cares for self; unable to carry on normal activity or to do active work.
	60	Requires occasional assistance, but is able to care for most of his personal needs.
	50	Requires considerable assistance and frequent medical care.
Unable to care for self; Requires equivalent of institutional or hospital care; diseases may be progressing rapidly.	40	Disabled; requires special care and assistance.
	30	Severely disabled; hospital admission is indicated although death not imminent.
	20	Very sick; hospital admission necessary; Active supportive treatment necessary.
	10	Moribund; fatal processes progressing rapidly.
	0	Dead

Oxford Textbook of Palliative Medicine, Oxford University Press. 1993;109.

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*Palliative Performance Scale (PPS)

Palliative Performance Scale (PPSv2)

version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work 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 Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Instructions for Use of PPS (see also definition of terms)

1. PPS scores are determined by reading horizontally at each level to find a 'best fit' for the patient which is then assigned as the PPS% score.

2. Begin at the left column and read downwards until the appropriate ambulation level is reached, then read across to the next column and downwards again until the activity/evidence of disease is located. These steps are repeated until all five columns are covered before assigning the actual PPS for that patient. In this way, 'leftward' columns (columns to the left of any specific column) are 'stronger' determinants and generally take precedence over others.

   Example 1: A patient who spends the majority of the day sitting or lying down due to fatigue from advanced disease and requires considerable assistance to walk even for short distances but who is otherwise fully conscious level with good intake would be scored at PPS 50%.

   Example 2: A patient who has become paralyzed and quadriplegic requiring total care would be PPS 30%. Although this patient may be placed in a wheelchair (and perhaps seem initially to be at 50%), the score is 30% because he or she would be otherwise totally bed bound due to the disease or complication if it were not for caregivers providing total care including lift/transfer. The patient may have normal intake and full conscious level.

   Example 3: However, if the patient in example 2 was paraplegic and bed bound but still able to do some self-care such as feed themselves, then the PPS would be higher at 40 or 50% since he or she is not 'total care.'

3. PPS scores are in 10% increments only. Sometimes, there are several columns easily placed at one level but one or two which seem better at a higher or lower level. One then needs to make a 'best fit' decision. Choosing a 'half-fit' value of PPS 45%, for example, is not correct. The combination of clinical judgment and 'leftward precedence' is used to determine whether 40% or 50% is the more accurate score for that patient.

4. PPS may be used for several purposes. First, it is an excellent communication tool for quickly describing a patient's current functional level. Second, it may have value in criteria for workload assessment or other measurements and comparisons. Finally, it appears to have prognostic value.

*Palliative Performance Scale (PPS)

Definition of Terms for PPS

As noted below, some of the terms have similar meanings with the differences being more readily apparent as one reads horizontally across each row to find an overall 'best fit' using all five columns.

1. Ambulation

The items **'mainly sit/lie,' 'mainly in bed,'** and **'totally bed bound'** are clearly similar. The subtle differences are related to items in the self-care column. For example, 'totally bed 'bound' at PPS 30% is due to either profound weakness or paralysis such that the patient not only can't get out of bed but is also unable to do any self-care. The difference between 'sit/lie' and 'bed' is proportionate to the amount of time the patient is able to sit up vs need to lie down.

'Reduced ambulation' is located at the PPS 70% and PPS 60% level. By using the adjacent column, the reduction of ambulation is tied to inability to carry out their normal job, work occupation or some hobbies or housework activities. The person is still able to walk and transfer on their own but at PPS 60% needs occasional assistance.

2. Activity & Extent of disease

'Some,' 'significant,' and **'extensive'** disease refer to physical and investigative evidence which shows degrees of progression. For example in breast cancer, a local recurrence would imply 'some' disease, one or two metastases in the lung or bone would imply 'significant' disease, whereas multiple metastases in lung, bone, liver, brain, hypercalcemia or other major complications would be 'extensive' disease. The extent may also refer to progression of disease despite active treatments. Using PPS in AIDS, 'some' may mean the shift from HIV to AIDS, 'significant' implies progression in physical decline, new or difficult symptoms and laboratory findings with low counts. 'Extensive' refers to one or more serious complications with or without continuation of active antiretrovirals, antibiotics, etc.

The above extent of disease is also judged in context with the ability to maintain one's work and hobbies or activities. Decline in activity may mean the person still plays golf but reduces from playing 18 holes to 9 holes, or just a par 3, or to backyard putting. People who enjoy walking will gradually reduce the distance covered, although they may continue trying, sometimes even close to death (eg. trying to walk the halls).

3. Self-Care

'Occasional assistance' means that most of the time patients are able to transfer out of bed, walk, wash, toilet and eat by their own means, but that on occasion (perhaps once daily or a few times weekly) they require minor assistance.

'Considerable assistance' means that regularly every day the patient needs help, usually by one person, to do some of the activities noted above. For example, the person needs help to get to the bathroom but is then able to brush his or her teeth or wash at least hands and face. Food will often need to be cut into edible sizes but the patient is then able to eat of his or her own accord.

'Mainly assistance' is a further extension of 'considerable.' Using the above example, the patient now needs help getting up but also needs assistance washing his face and shaving, but can usually eat with minimal or no help. This may fluctuate according to fatigue during the day.

'Total care' means that the patient is completely unable to eat without help, toilet or do any self-care. Depending on the clinical situation, the patient may or may not be able to chew and swallow food once prepared and fed to him or her.

4. Intake

Changes in intake are quite obvious with **'normal intake'** referring to the person's usual eating habits while healthy.
'Reduced' means any reduction from that and is highly variable according to the unique individual circumstances.
'Minimal' refers to very small amounts, usually pureed or liquid, which are well below nutritional sustenance.

5. Conscious Level

'Full consciousness' implies full alertness and orientation with good cognitive abilities in various domains of thinking, memory, etc. **'Confusion'** is used to denote presence of either delirium or dementia and is a reduced level of consciousness. It may be mild, moderate or severe with multiple possible etiologies. **'Drowsiness'** implies either fatigue, drug side effects, delirium or closeness to death and is sometimes included in the term stupor. **'Coma'** in this context is the absence of response to verbal or physical stimuli; some reflexes may or may not remain. The depth of coma may fluctuate throughout a 24 hour period.

*Fast Scale Administration (FAST)

The FAST scale is a functional scale designed to evaluate patients at the more moderate-severe stages of dementia when the MMSE no longer can reflect changes in a meaningful clinical way. In the early stages the patient may be able to participate in the FAST administration but usually the information should be collected from a caregiver or, in the case of nursing home care, the nursing home staff.

The FAST scale has seven stages:

1 which is normal adult
2 which is normal older adult
3 which is early dementia
4 which is mild dementia
5 which is moderate dementia
6 which is moderately severe dementia
7 which is severe dementia

FAST Functional Milestones.

FAST stage 1 is the normal adult with no cognitive decline. FAST stage 2 is the normal older adult with very mild memory loss. Stage 3 is early dementia. Here memory loss becomes apparent to co-workers and family. The patient may be unable to remember names of persons just introduced to them. Stage 4 is mild dementia. Persons in this stage may have difficulty with finances, counting money, and travel to new locations. Memory loss increases. The person's knowledge of current and recent events decreases. Stage 5 is moderate dementia. In this stage, the person needs more help to survive. They do not need assistance with toileting or eating, but do need help choosing clothing. The person displays increased difficulty with serial subtraction. The patient may not know the date and year or where they live. However, they do know who they are and the names of their family and friends. Stage 6 is moderately severe dementia. The person may begin to forget the names of family members or friends. The person requires more assistance with activities of daily living, such as bathing, toileting, and eating. Patients in this stage may develop delusions, hallucinations, or obsessions. Patients show increased anxiety and may become violent. The person in this stage begins to sleep during the day and stay awake at night. Stage 6 is severe dementia. In this stage, all speech is lost. Patients lose urinary and bowel control. They lose the ability to walk. Most become bedridden and die of sepsis or pneumonia.

Functional Assessment Staging of Alzheimer's Disease. (FAST)©

STAGE	SKILL LEVEL
1.	No difficulties, either subjectively or objectively.
2.	Complains of forgetting location of objects. Subjective word finding difficulties
3.	Decreased job function 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 (forgetting to pay bills), difficulty marketing, etc.
5.	Requires assistance in choosing proper clothing to wear for day, season, occasion.
6a.	Difficulty putting clothing on properly without assistance.
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 toilet, does not whipe properly or dispose of toilet tissue properly) occasionally or more frequently over the past weeks.*
6d.	Urinary incontinence, (occasional or more frequent).
6e.	Fecal incontinence, (occasional or more frequently over the past week).
7a.	Ability to speak limited to approximately a half dozen different words or fewer, in the course of an average day or in the course of an intensive interview.
7b.	Speech ability limited to the use of a single intelligible word in an average day or in the course of an interview (the person may repeat a word over and over).
7c.	Ambulatory ability lost (cannot walk without assistance).
7d.	Ability to sit up without assistance lost (e.g., the individual will fall over if there are no lateral rests [arms] on the chair).
7e.	Loss of the ability to smile.

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

Part Two

Non-Disease Specific Baseline Guidelines

A. Physiologic impairment of functional status as demonstrated by: Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS) < 70%. Note that two of the disease specific guidelines (HIV Disease, Stroke and Coma) establish a lower qualifying KPS or PPS.

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

- Ambulation;
- Continence;
- Transfer;
- Dressing;
- Feeding;
- Bathing.

Non-Disease Specific Baseline Guidelines

C. 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.

- Chronic obstructive pulmonary disease
- Congestive heart failure
- Ischemic heart disease
- Diabetes mellitus
- Neurologic disease (CVA, ALS, MS, Parkinson's)
- Renal failure
- Liver Disease
- Neoplasia
- Acquired immune deficiency syndrome
- Dementia
- Aquired Immune Deficiency Syndrome/HIV
- Refractory severe autoimmune disease (e.g. Lupus or Rheumatoid Arthritis)

Part Three

Disease Specific Baseline Guidelines

Note: These guidelines are to be used in conjunction with the "Non-disease specific baseline guidelines" described in Part II.

Cancer Diagnosis:

Patient has life limiting condition, <6 months and patient/family desire no further aggressive treatment or cardiopulmonary resuscitation. Disease with metastases at presentation OR Progression from an earlier stage of disease to metastatic disease with either:

- A continued decline in spite of therapy: or
- Patient declines further disease directed therapy

NOTE: Certain cancers with poor prognoses (eg. small cell lung cancer, brain cancer, and pancreatic cancer) may be eligible without fulfilling the other criteria in this section.

End Stage Heart Disease:

Patients will be considered to be in the terminal stage of heart disease (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present. Factors from 3 will add supporting documentation.)

1. At the time of initial certification or recertification for hospice, the patient is or has been already optimally treated for heart disease, or are patients who are either not candidates for surgical procedures or who decline those procedures. (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. Patients with congestive heart failure or angina should meet the criteria for the New York Heart Association (NYHA) Class IV. (Class IV patients with heart disease have an inability to carry on any physical activity. Symptoms of heart failure or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.) Significant congestive heart failure may be documented by an ejection fraction of less than or equal to 20%, but is not required if not already available.

End Stage Heart Disease(cont.):

3. Documentation of the following factors will support but is not required to establish eligibility for hospice care:

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

End Stage Pulmonary Disease:

Patients will be considered to be in the terminal stage of pulmonary disease (life expectancy of six months or less) if they meet the following criteria. The criteria refer to patients with various forms of advanced pulmonary disease who eventually follow a final common pathway for end stage pulmonary disease. (1 and 2 should be present. Documentation of 3, 4, and 5, will lend supporting documentation.)

1. Severe chronic lung disease as documented by both:

- Disabling dyspnea at rest, poorly or unresponsive to bronchodilators, resulting in decreased functional capacity, e.g., bed to chair existence, fatigue, and cough; (Documentation of Forced 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.)
- Progression of end stage pulmonary disease, as evidenced by increasing visits to the emergency department or hospitalizations for pulmonary infections and/or respiratory failure or increasing physician home visits prior to initial certification. (Documentation of serial decrease of FEV1>40 ml/year is objective evidence for disease progression, but is not necessary to obtain.)

End Stage Pulmonary Disease(cont.):

2. Hypoxemia at rest on room air, as evidenced by pO2 less than or equal to 55 mmHg, or oxygen saturation less than or equal to 88%, determined either by arterial blood gases or oxygen saturation monitors, (these values may be obtained from recent hospital records) OR hypercapnia, as evidenced by pCO2 greater than or equal to 50 mmHg. (This value may be obtained from recent [within 3 months] hospital records.)

3. Right heart failure (RHF) secondary to pulmonary disease (Cor pulmonale) (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.

Dementia Due to Alzheimer's Disease and Related Disorders:

Patients will be considered to be in the terminal stage of dementia (life expectancy of six months or less) if they meet the following criteria.

1. Patients with dementia should show all the following characteristics:

- Stage seven or beyond according to the Functional
- Assessment Staging Scale;
- Unable to ambulate without assistance;
- Unable to dress without assistance;
- Unable to bathe without assistance;
- Urinary and fecal incontinence, intermittent or constant;
- No consistently meaningful verbal communication: stereotypical phrases only or the ability to speak is limited to six or fewer intelligible words.

Dementia Due to Alzheimer's Disease and Related Disorders(cont.):

2. Patients should have had one of the following within the past 12 months:

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

Note: This section is specific for Alzheimer's disease and Related Disorders, and is not appropriate for other types of dementia.

Amytrophic Lateral Schlerosis (ALS):

General Considerations:

1. ALS tends to progress in a linear fashion over time. Thus the overall rate of decline in each patient is fairly constant and predictable, unlike many other non-cancer diseases.
2. However, no single variable deteriorates at a uniform rate in all patients. Therefore, multiple clinical parameters are required to judge the progression of ALS.
3. Although ALS usually presents in a localized anatomical area, the location of initial presentation does not correlate with survival time. By the time patients become end-stage, muscle denervation has become widespread, affecting all areas of the body, and initial predominance patterns do not persist.
4. Progression of disease differs markedly from patient to patient. Some patients decline rapidly and die quickly; others progress more slowly. For this reason, the history of the rate of progression in individual patients is important to obtain to predict prognosis.

ALS(cont.):

5. In end-state ALS, two factors are critical in determining prognosis: ability to breathe, and to a lesser extent ability to swallow. The former can be managed by artificial ventilation, and the latter by gastrostomy or other artificial feeding, unless the patient has recurrent aspiration pneumonia. While not necessarily a contraindication to Hospice care, the decision to institute either artificial ventilation or artificial feeding may significantly alter six month prognosis.
6. Examination by a neurologist within three months of assessment for hospice is advised, both to confirm the diagnosis and to assist with prognosis.

Patients are considered eligible for Hospice care if they do not elect tracheostomy and invasive ventilation and display evidence of critically impaired respiratory function (with or without use of NIPPV) and / or severe nutritional insufficiency (with or without use of a gastrostomy tube).

Critically impaired respiratory function is as defined by:

1. FVC < 40% predicted (seated or supine) and 2 or more of the following symptoms and/or signs:

- Dyspnea at rest;
- Orthopnea;
- Use of accessory respiratory musculature;
- Paradoxical abdominal motion;
- Respiratory rate > 20;
- Reduced speech / vocal volume;
- Weakened cough;
- Symptoms of sleep disordered breathing;
- Frequent awakening;
- Daytime somnolence / excessive daytime sleepiness;
- Unexplained headaches;
- Unexplained confusion;
- Unexplained anxiety;
- Unexplained nausea.

2. If unable to perform the FVC test patients meet this criterion if they manifest 3 or more of the above symptoms/

ALS(cont.):

2. If unable to perform the FVC test patients meet this criterion if they manifest 3 or more of the before mentioned symptoms/signs.

Severe nutritional insufficiency is defined as:

Dysphagia with progressive weight loss of at least five percent of body weight with or without election for gastrostomy tube insertion.

These revised criteria rely less on the measured FVC, and as such reflect the reality that not all patients with ALS can or will undertake regular pulmonary function tests.

Stroke & Coma:

Stroke

1. Karnofsky Performance Status (KPS) or Palliative Performance Scale (PPS) of < 40% .

2. Inability to maintain hydration and caloric intake with one of the following:

- Weight loss > 10% in the last 6 months or > 7.5% in the last 3 months;
- Serum albumin < 2.5 gm/dl;
- Current history of pulmonary aspiration not responsive to speech language pathology intervention; Sequential calorie counts documenting inadequate caloric/fluid intake;
- Dysphagia severe enough to prevent patient from continuing fluids/foods necessary to sustain life and patient does not receive artificial nutrition and hydration.

Stroke & Coma(cont.):

Coma (any etiology)

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

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

2. 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:
- Aspiration pneumonia;
- Pyelonephritis;
- Refractory stage 3-4 decubitus ulcers;
- Fever recurrent after antibiotics.

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

For non-traumatic hemorrhagic stroke:

- Large-volume hemorrhage on CT:
- Infratentorial: greater than or equal to 20 ml.;
- Supratentorial: greater than or equal to 50 ml.
- Ventricular extension of hemorrhage;
- Surface area of involvement of hemorrhage greater than or equal to 30% of cerebrum;
- Midline shift greater than or equal to 1.5 cm.;
- Obstructive hydrocephalus in patient who declines, or is not a candidate for, ventriculoperitoneal shunt.

For thrombotic/embolic stroke:

- Large anterior infarcts with both cortical and subcortical involvement;
- Large bihemispheric infarcts;
- Basilar artery occlusion;
- Bilateral vertebral artery occlusion.

Kidney Disease:

Patients will be considered to be in the terminal stage of renal disease (life expectancy of six months or less) if they meet the following criteria.

Acute Renal Failure *(1 and either 2, 3 or 4 should be present. Factors from 5 will lend supporting documentation.)*

1. The patient is not seeking dialysis or renal transplant, or is discontinuing dialysis.
2. Creatinine clearance < 10 cc/min (<15 cc/min. for diabetics); or < 15cc/min (< 20cc/min for diabetics) with comorbidity of congestive heart failure.
3. Serum creatinine > 8.0 mg/dl (>6.0 mg/dl for diabetics).
4. Estimated glomerular filtration rate (GFR) <10 ml/min.
5. Comorbid conditions:

- Mechanical ventilation;
- Malignancy (other organ system);
- Chronic lung disease;
- Advanced cardiac disease;
- Advanced liver disease;
- Immunosuppression/AIDS;
- Albumin < 3.5 gm/dl;
- Platelet count < 25,000;
- Disseminated intravascular coagulation;
- Gastrointestinal bleeding.

Chronic Kidney Disease *(1 and either 2, 3 or 4 should be present. Factors from 5 will lend supporting documentation.)*

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

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

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

4. Signs and symptoms of renal failure:

- Uremia;
- Oliguria (< 400 cc/24 hours);
- Intractable hyperkalemia (> 7.0) not responsive to treatment;
- Uremic pericarditis;
- Hepatorenal syndrome;
- Intractable fluid overload, not responsive to treatment.

5. Estimated glomerular filtration rate (GFR) <10 ml/min.

Liver Disease:

Patients will be considered to be in the terminal stage of liver disease (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present, factors from 3 will lend supporting documentation.)

1. The patient should show both:

- Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio (INR) > 1.5;
- 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 creatinine and BUN with oliguria (< 400 ml/day) and urine sodium concentration < 10 mEq/l);
- Hepatic encephalopathy, refractory to treatment, or patient non-compliant;
- Recurrent variceal bleeding, despite intensive therapy.

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.

HIV Disease:

Patients will be considered to be in the terminal stage of their illness (life expectancy of six months or less) if they meet the following criteria. (1 and 2 should be present; factors from 3 will add supporting documentation.)

1. CD4+ Count < 25 cells/mcl or persistent (2 or more assays at least one month apart)
   viral load >100,000 copies/ml, plus one of the following:

- CNS lymphoma;
- Untreated, or persistent despite treatment, wasting (loss of at least 10% lean body mass);
- Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused;

Progressive multifocal leukoencephalopathy;
Systemic lymphoma, with advanced HIV disease and partial

Liver Disease(cont.):

- Progressive multifocal leukoencephalopathy;
- Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy;
- Visceral Kaposi's sarcoma unresponsive to therapy;
- Renal failure in the absence of dialysis;
- Cryptosporidium infection;
- Toxoplasmosis, unresponsive to therapy.

2. Decreased performance status, as measured by the Karnofsky Performance Status (KPS) scale, of less than or equal to 50%.

Documentation of the following factors will support eligibility for hospice care:

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

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