

Hospice -- Determining Terminal Status

HIV Disease

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 pCO₂ or decreasing pO₂ or decreasing SaO₂
- 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

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/ml 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 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 50%
3. 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.

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