



General Guidelines for Determining Prognosis

The following parameters may be used to help determine whether a patient is appropriate for hospice care and/or eligible for the Medicare/Medicaid Hospice Benefit. These General Guidelines apply to all patients referred to hospice. However, they may be specifically applied to patients who do not fall under any of the specific diagnostic categories for which disease-specific guidelines have been written. An example might be the elderly debilitated patient whose intake of food and fluid has declined to the point where weight loss has become significant, although no specific disease predominates in the clinical picture.

The patient should meet all of the following criteria:

I. The patient's condition is life limiting, and the patient and/or family have been informed of this determination.

A. A "life limiting condition" may be due to a specific diagnosis, a combination of diseases, or there may be no specific diagnosis defined.¹

II. The patient and/or family have elected treatment goals directed toward relief of symptoms, rather than cure of the underlying disease.

III. The patient has *either* of the following:

A. Documented clinical progression of disease, which may include:

1. Progression of the primary disease process as listed in disease-specific criteria, as documented by serial physician assessment, laboratory, radiologic or other studies.
2. Multiple Emergency Department visits or inpatient hospitalizations over the prior six months.²
3. For homebound patients receiving home health services, nursing assessment may be documented.
4. For patients who do not qualify under 1, 2 or 3, a recent decline in functional status may be documented.
 - a. Functional decline should be recent, to distinguish patients who are terminal from those with reduced baseline functional status due to chronic illness. Clinical judgment is required for patients with a terminal condition and impaired status due to a different non-terminal disease, e.g., a patient chronically paraplegic from spinal cord injury who is recently diagnosed with cancer.
 - b. Diminished functional status may be documented by *either*:
 1. Karnofsky Performance Status of less than or equal to 50%^{3 4 5}
 2. Dependence in at least three of six Activities of Daily Living (ADL's).⁶

7 8 9 10 11 12 13 14

¹ Kinzbrunner, BM et al. Debility, unspecified: a terminal diagnosis. Abstract, *J Palliat Care* 1994; vol. 10:4:58.

² Kinzbrunner BM. Non-malignant terminal diseases: criteria for hospice admission. *HospiceUpdate* 1993; 3:3-6.

³ Karnofsky, D.A. et al. The use of nitrogen mustards in the palliative treatment of cancer. *Cancer* 1948;1(4): 634.

⁴ Mor V et al. The Karnofsky Performance Status Scale: an examination of its reliability and validity in a research setting. *Cancer* 1984; 53: 2002.

⁵ Evans C. et al. "Prognostic uncertainty in terminal care: can the Karnofsky index help?" *Lancet* 1985; 1:1204.

⁶ Katz S. et. al. Studies of illness in the aged. The index of ADL: a standardized measure of biological and psychological function. *JAMA* 1963; 185: 914.

“Activities of Daily Living” are:

- i. Bathing
- ii. Dressing
- iii. Feeding¹⁵
- iv. Transfers
- v. Continence of urine and stool
- vi. Ability to ambulate independently to bathroom

B. Documented recent impaired nutritional status related to the terminal process.

1. Unintentional progressive weight loss of greater than 10% over the prior six months. ^{16 17 18 19}

2. Serum albumin less than 2.5 gm/dl^{20 21 22} may be a helpful prognostic indicator, but should not be used in isolation from other factors in I-III above.

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⁷ Donaldson LJ et al. The elderly in residential care: mortality in relation to functional capacity. *J Epidemiol and Comm Health* 1980; 34:96.

⁸ Rudman D et al. Antecedents of death in the men of a Veteran’s Administration nursing home. *J Am Geriatr Soc* 1987; 35:496.

⁹ Wolinsky FD et. al. Changes in functional status and the risks of subsequent nursing home placement and death. *J Gerontol and Soc Sci* 1993; 48 (3): S94.

¹⁰ Narain F et. al. Predictors of immediate and 6-month outcomes in hospitalized elderly patients: the importance of functional status. *J Am Geriatr Soc* 1990; 38:775.

¹¹ Goldfarb AI et al. Predictors of mortality in the institutionalized aged. *Dis Nerv System* 1966; 27(1):21.

¹² Lichtenstein MJ et al. Factors associated with early demise in nursing home residents: a case control study. *J Am Geriatr Soc* 1985; 33:315.

¹³ Reuben DB et al. Value of functional status as a predictor of mortality: results of a prospective study. *Am J Soc* 1992; 93:663.

¹⁴ Clark LP et al. Taking to bed: rapid functional decline in an independently mobile older population living in an intermediate-care facility. *J Am Geriatr Soc* 1990; 38:967.

¹⁵ This may be a factor that independently determines early mortality in selected patients. See Siebens H et al. Correlates and consequences of eating dependency in institutionalized elderly. *J Am Geriatr Soc* 1986; 34: 192.

¹⁶ Murden RA et al. Recent weight loss is related to short-term mortality in nursing homes. *J Gen Int Med* 1994; 9:648.

¹⁷ Dwyer JT et al. Changes in relative weight among institutionalized elderly adults. *J Gerontol* 1987; 42 (3): 246.

¹⁸ Marton KI et al. Involuntary weight loss: diagnostic and prognostic significance. *Ann Int Med* 1981; 95: 568.

¹⁹ Rudman D, op. cit.

²⁰ Corti M-C et al. Serum albumin level and physical disability as predictors of mortality in older persons. *JAMA* 1994; 48:1173.

²¹ Agrawa N et al. “Predictive ability of various nutritional variables for mortality in elderly people.” *Am J Clin Nutr* 1988; 48:1173.

²² Phillips P et al. “Grip strength, mental performance and nutritional status as indicators of mortality risk among female geriatric patients.” *Age and Aging* 1986; 15:53.

