SONDER
HOSPICE

Dear Colleague:

Locally owned and CHAP accredidated, Sonder Hospice, is here to help you, the referring physician: 1) determine hospice eligibility in terminally ill patients, 2) have the hospice conversation with patients and their families, and 3) take the best care of your patient who is coping with the multitude of symptoms, practical issues and emotions that arise at the end of life.

Referring eligible patients to hospice sooner after a terminal diagnosis augments the excellent care you are already giving those patients. At Sonder, we do our best work when our caring team has a longer time to get to know patients and their families, to manage patients' symptoms and help them prepare for the final days.

On average, hospice patients live about two-and-a-half months after being given a six-month prognosis. This means most patients who come into hospice care were actually eligible for services months before the referral was made. Patients miss out on the benefits of our comprehensive services and support when the referral is made too late.

To help you determine the earliest time a patient is hospice eligible, refer to the following information:

- How to Estimate a Six-Month Prognosis
- CMS' Disease Specific Criteria
- Decline in Clinical Status Guidelines
- NYHA Functional Classification for Congestive Heart Failure
- The Palliative Performance Scale
- The Functional Assessment Staging (FAST) for Hospice

Along with these tools, please remember that a Sonder consultation or patient evaluation is always just a phone call away.

We look forward to working with you.

The Sonder Team

How to Estimate a Six-Month Prognosis

A patient is eligible for hospice when 1) he has less than six months to live, and 2) he chooses to forego aggressive curative treatment. While we can help you make that six-month determination — just call Sonder 24/7 for a patient evaluation or consultation — in general, there are two paths to hospice eligibility:

1. **One Major Terminal Diagnosis**
   Your patient meets CMS' "Disease Specific Criteria" listed below.
2. **Multiple Comorbidities Contributing to Terminal Decline (formerly Debility and Decline)**
   Your patient has multiple signs and symptoms that suggest a terminal course, but does not meet the current "Disease Specific Criteria" for any one diagnosis. **Please see pages 1-5 for "Disease Specific Guidelines."** Often a combination of diagnoses is accelerating decline and, if we wait until one diagnosis meets the "Disease Specific Criteria," the referral may be too late to be of maximum benefit. **In these cases, please refer to the "Decline in Clinical Status Guidelines" listed on page 6.** This list of elements of decline gives examples of how to document your patient's terminal trajectory. A patient does not have to meet all the criteria on the list. By documenting several areas of decline, you can paint the picture of a poor prognosis.

SONDER

HOSPICE

Determining a Patient's Prognosis of Six Months or Less for Hospice

CMS Disease Specific Guidelines (Local Coverage Determinations) • Clinical Status Guidelines • Helpful Staging Tools (Functional Assessment Staging (FAST), NYHA Functional Classification for Congestive Heart Failure, Palliative Performance Scale)

CMS Disease Specific Guidelines (LCDs)

A patient is eligible for hospice services if he meets these three criteria:

1) has a Palliative Performance Scale of less than 70%

2) is dependent on at least two Activities of Daily Living, and

3) meets the Disease Specific Guidelines below.

Cancer Diagnoses

A. Disease with metastases at presentation OR

B. Progression from an earlier stage of disease to metastatic disease with either:

1. A continued decline in spite of therapy; or

2. Patient declines further disease directed therapy.

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

Non-Cancer Diagnoses

Amyotrophic Lateral Sclerosis

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.

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 three or more of the above 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.

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:

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

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

a. Aspiration pneumonia;
b. Pyelonephritis;
c. Septicemia;
d. Decubitus ulcers, multiple, stage 3-4;
e. Fever, recurrent after antibiotics;
f. 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.*

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.

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

a. Treatment-resistant symptomatic supraventricular or ventricular arrhythmias;

b. History of cardiac arrest or resuscitation;
c. History of unexplained syncope;
d. Brain embolism of cardiac origin;
e. Concomitant HIV disease.

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:

a. CNS lymphoma;
b. Untreated, or persistent despite treatment, wasting (loss of at least 10% lean body mass);
c. Mycobacterium avium complex (MAC) bacteremia, untreated, unresponsive to treatment, or treatment refused;
d. Progressive multifocal leukoencephalopathy;
e. Systemic lymphoma, with advanced HIV disease and partial response to chemotherapy;
f. Visceral Kaposi's sarcoma unresponsive to therapy;
g. Renal failure in the absence of dialysis;
h. Cryptosporidium infection;
i. Toxoplasmosis, unresponsive to therapy.

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

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

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

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 a and b:
   a. Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio (INR) >1.5;
   b. Serum albumin <2.5 gm/dl.

2. End stage liver disease is present and the patient shows at least one of the following:
   a. Ascites, refractory to treatment or patient non-compliant;
   b. Spontaneous bacterial peritonitis;
   c. Hepatorenal syndrome (elevated creatinine and BUN with oliguria (<400 ml/day) and urine sodium concentration <10 mEq/l);
   d. Hepatic encephalopathy, refractory to treatment, or patient non-compliant;
   e. Recurrent variceal bleeding, despite intensive therapy.

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

a. Progressive malnutrition;
b. Muscle wasting with reduced strength and endurance;
c. Continued active alcoholism (>80 gm ethanol/day);
d. Hepatocellular carcinoma;
e. HBsAg (Hepatitis B) positivity;
f. Hepatitis C refractory to interferon treatment

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 a and b:

   a. 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.)

   b. 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.)

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.

Renal 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. As with any other condition, an individual with renal disease is eligible for the Hospice Benefit if that individual has a prognosis of six months or less, if the illness runs its normal course. There is no regulation precluding patients on dialysis from electing hospice care. However, the continuation of dialysis will significantly alter a patient's prognosis, and thus potentially impact that individual's eligibility.

When an individual elects hospice care for end stage renal disease (ESRD) or for a condition to which the need for dialysis is related, the hospice agency is financially responsible for the dialysis. In such cases, there is no additional reimbursement beyond the per diem rate. The only situation in which a beneficiary may access both the Hospice Benefit and the ESRD benefit is when the need for dialysis is not related to the patient's terminal illness.

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:

   a. Mechanical ventilation;
   b. Malignancy (other organ system);
   c. Chronic lung disease;
   d. Advanced cardiac disease;
   e. Advanced liver disease;
   f. Immunosuppression/AIDS;
   g. Albumin <3.5 gm/dl;
   h. Platelet count <25,000;
   i. Disseminated intravascular coagulation;
   j. 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 isn't seeking dialysis or renal transplant, or is discontinuing dialysis. As with any other condition, an individual with renal disease is eligible for the Hospice Benefit if he has a prognosis of six months or less, if the illness runs its normal course. No regulation precludes patients on dialysis from electing hospice. However, the continuation of dialysis significantly alters a patient's prognosis, and thus may impact that individual's eligibility.

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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:
   a. Uremia;
   b. Oliguria (<400 cc/24 hours);
   c. Intractable hyperkalemia (>7.0) not responsive to treatment;
   d. Uremic pericarditis;
   e. Hepatorenal syndrome;
   f. Intractable fluid overload, not responsive to treatment.

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

Stroke and Coma

Patients considered to be in the terminal stages of stroke or coma (with six months or less) if they meet the following:

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

Coma (any etiology):

1. 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.

2. Documentation of the following factors will support eligibility for hospice care:
   a. Documentation of medical complications, in the context of progressive clinical decline, within the past 12 months, which support a terminal prognosis:
      1. Aspiration pneumonia;
      2. Pyelonephritis;
      3. Refractory stage 3-4 decubitus ulcers;
      4. Fever recurrent after antibiotics.

3. 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: greater than or equal to 20 ml.;
         b. Supratentorial: greater than or equal to 50 ml.
      2. Ventricular extension of hemorrhage;
      3. Surface area of involvement of hemorrhage greater than or equal to 30% of cerebrum;
      4. Midline shift greater than or equal to 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.

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:

a. Recurrent or intractable serious infections such as pneumonia, sepsis or pyelonephritis;
b. Progressive inanition as documented by:
   1. 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;
   2. Decreasing anthropomorphic measurements (mid-arm circumference, abdominal girth), not due to reversible causes such as depression or use of diuretics;
   3. Observation of ill-fitting clothes, decrease in skin turgor, increasing skin folds or other observation of weight loss in a patient without documented weight;
   4. Decreasing serum albumin or cholesterol.
   5. Dysphagia leading to recurrent aspiration and/or inadequate oral intake documented by decreasing food portion consumption.

Symptoms:

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

Signs:

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

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

o. Increasing pCO2 or decreasing pO2 or decreasing SaO2;
p. Increasing calcium, creatinine or liver function studies;
q. Increasing tumor markers (e.g. CEA, PSA);
r. 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.

Some Helpful Staging Tools

Functional Assessment Staging (FAST)

1. No difficulty either subjectively or objectively.

2. Complains of forgetting location of objects. Subjective work difficulties.

3. Decreased job functioning evident to co-workers. Difficulty traveling to new locations. Decreased organizational capacity.*

4. Decreased ability to perform complex tasks (e.g. planning dinner for guests, handling personal finances, such as forgetting to pay bills, difficulty marketing, etc.).

5. Requires assistance in choosing proper clothing to wear for the day, season, or occasion (e.g. may wear the same clothing repeatedly, unless supervised).*

6. a) Improperly putting on clothes without assistance or prompting (e.g. may put street clothes on over their night clothes, or put shoes on wrong fee, or have difficulty buttoning clothing) occasionally or more frequently over the past weeks.*

   b) Unable to bathe properly (e.g., difficulty adjusting bath-water temperature) occasionally or more frequently over the past weeks.*

   c) Inability to handle mechanics of toileting (e.g., forgets to flush the toilet, does not wipe properly or properly dispose of toilet tissue) occasionally or more frequently over the past weeks.*

   d) Urinary incontinence (occasionally or more frequently over the past weeks.)*

   e) Fecal incontinence (occasionally or more frequently over the past weeks.)*

7. a) Ability to speak limited to approximately a half dozen intelligible different words or fewer, in the course of an average day or in the course of an intensive interview.

   b) Speech ability is limited to the use of a single intelligible word in an average day or in the course of an intensive interview (may repeat the word over and over).

   c) Ambulatory ability is lost (cannot walk without personal assistance).

   d) Cannot sit up without assistance.

   e) Loss of ability to smile.

   f) Loss of ability to hold head up independently.

*Scored primarily on the basis of information obtained from knowledgeable informant.

New York Heart Association (NYHA) Functional Classification for Congestive Heart Failure

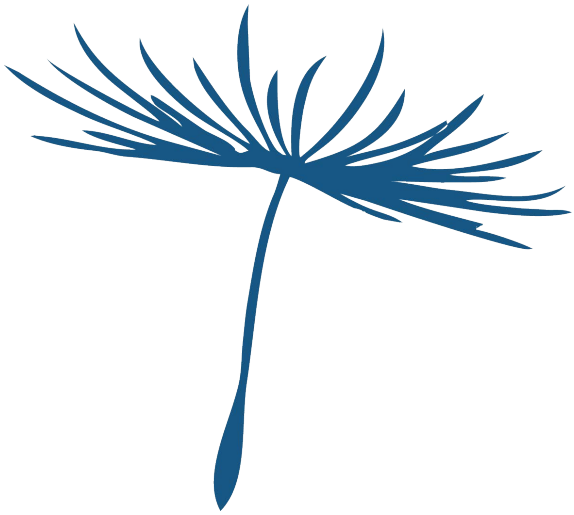
Classification provides a simple way of classifying heart disease (originally cardiac failure). It places patients in one of four categories, based on how much they are limited during physical activity:

Class I: patients with no limitation of activities; they suffer no symptoms from ordinary activities.

Class II: patients with slight, mild limitation of activity; they are comfortable with rest or with mild exertion.

Class III: patients with marked limitation of activity; they are comfortable only at rest.

Class IV: patients who should be at complete rest, confined to bed or chair; any physical activity brings on discomfort and symptoms occur at rest.



Palliative Performance Scale

The Palliative Performance Scale (PPS) is a modification of the Karnofsky Performance Scale intended for evaluating patients requiring palliative care. The score can help determine which patients can be managed in the home and which should be admitted to a hospice unit. It was developed in British Columbia, Canada.

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	-	-	-	-

Sonder Hospice can help physicians, patients and their families during discussions of end-of-life options and hospice support.

24/7 ADMISSIONS

Admissions available weekends and evenings

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