Hospice Eligibility & Referral

Six months *if the disease runs its usual course* · Not a prediction, a trajectory

REFERRED TOO LATE
median stay is days

GET THE DISTINCTION RIGHT *palliative care and hospice are not the same thing*

PALLIATIVE CARE

Any stage, any prognosis, alongside disease-directed treatment. Symptom control, communication and decision support. **No prognostic requirement**, and early referral in serious illness improves symptoms, quality of life and in some settings survival.

HOSPICE

A **subset** for patients near the end of life. Requires a **prognosis of about 6 months or less if the disease follows its usual course**, and generally a decision to **forgo disease-directed treatment** aimed at cure. Delivered mostly **at home**, with a team, 24-hour advice and bereavement support.

THE COMMON MISCONCEPTION

Hospice is not giving up, and it is not only for the last few days. Patients can be **discharged from hospice if they improve**, and can **re-enrol later**. The prognosis is an eligibility framework, not a promise — **living longer than 6 months does not mean the referral was wrong**.

RECOGNIZE ELIGIBILITY BY DISEASE *general indicators plus a disease-specific picture*

Condition	Typical eligibility picture
General indicators apply across diseases	**Declining functional status**, **progressive weight loss and hypoalbuminemia**, **recurrent hospitalizations**, dependence in activities of daily living, and disease progressing despite treatment.
Cancer	**Metastatic or unresectable disease with progression** despite therapy, or a decision to stop disease-directed treatment, together with declining performance status.
Heart failure	**NYHA class IV symptoms at rest**, optimally treated, with recurrent admissions, refractory symptoms, hypotension limiting therapy, renal impairment, or ejection fraction typically ≤ 20%.
COPD	**Disabling dyspnea at rest**, poorly responsive to bronchodilators, with recurrent infective admissions, **resting hypoxemia on oxygen**, right heart failure, weight loss and tachycardia.
Dementia	**FAST stage 7** — unable to walk, dress or bathe independently, **incontinent, and speech limited to a handful of intelligible words** — plus a complication such as aspiration pneumonia, pyelonephritis, pressure ulcer or persistently poor intake.
Liver & renal	**Liver:** INR > 1.5 with albumin < 2.5 plus refractory ascites, SBP, hepatorenal syndrome or recurrent variceal bleeding, and not a transplant candidate. **Renal:** declining or declining to start dialysis, with a low creatinine clearance and uremic features.

MAKE THE REFERRAL WORK *the practical steps that determine whether it happens*

1. **Ask the surprise question: "Would I be surprised if this patient died in the next 12 months?"** If the answer is no, that is the trigger to begin the conversation — not to make the referral immediately, but to start planning.
2. **Introduce it as an addition, not a subtraction.** "This is a team that comes to your home and focuses entirely on keeping you comfortable and out of hospital." **Lead with what is gained.**
3. **Address the specific fears** — that it means dying soon, giving up, losing their own doctor, being denied treatment for reversible problems, or being unable to change their mind. **Say explicitly that they can leave hospice and re-enrol.**
4. **Sort the practicalities before discharge:** where they will be cared for and **who will provide hands-on care**, **anticipatory medications in the home**, equipment, a resuscitation and escalation plan that travels with them, and **a named 24-hour number** so the default is not an ambulance.
5. **Refer earlier than feels natural.** A large proportion of hospice enrolments occur in the **final days**, which is too late for the family support, symptom optimization and planning that produce most of the benefit.

PROGNOSTICATION *be honest about how imprecise it is*

WHAT HELPS

Functional status is the strongest single predictor across diseases — use a validated scale and track its **trajectory** rather than a single reading. **The rate of decline matters more than the absolute level.** Weight loss, albumin, recurrent admissions and symptom burden add information.

WHAT TO SAY

Clinicians systematically over-estimate survival, often substantially. **Use ranges** — "hours to days", "days to weeks", "weeks to months" — which are more accurate and more useful to families than a number. Acknowledge uncertainty openly, and **advise hoping for the best while preparing for the worst**.

WHAT HOSPICE ACTUALLY PROVIDES *useful to be able to describe concretely*

THE SERVICE

An **interdisciplinary team** — nursing, medical, social work, chaplaincy, and trained volunteers — with **24-hour telephone advice and visits**. Provision of **medication, equipment and supplies** related to the terminal illness. Levels of care range from routine home care through **continuous care during a crisis** to **inpatient symptom control** and **respite** for exhausted carers. **Bereavement support for the family continues after death**, typically for a year.

WHAT IT DOES NOT MEAN

It does **not** mean stopping all medication — symptom-directed and comfort-directed treatment continues, including antibiotics or transfusion where they serve comfort. It does **not** mean losing their usual doctor. It does **not** require a do-not-resuscitate order in every jurisdiction, though this is usually discussed. **Hospice care is compatible with treating reversible problems that cause suffering.**

PEARLS & PITFALLS

- **The disease-specific criteria behind the 6-month prognosis: dementia at FAST stage 7a or beyond plus a complication** such as aspiration, a pressure ulcer or recurrent infection; **heart failure with NYHA IV symptoms and an EF of 20% or less**; **COPD with FEV_1 under 30%, resting hypoxemia or cor pulmonale**. General decline supports any of them: **weight loss above 10%, albumin below 2.5, a falling performance status, and recurrent admissions**.
- **Palliative care needs no prognosis.** Do not delay a symptom-control referral because the patient is not "hospice-eligible".
- **Hospice is reversible.** Patients can be discharged if they stabilize and re-enrol later — say this explicitly, because it removes a major barrier.
- **The surprise question is the trigger.** If you would not be surprised by death within a year, start planning now.
- **Refer earlier.** Most of the benefit needs weeks, not days, and late referral wastes the intervention.
- **Use ranges for prognosis**, and remember the systematic bias is toward over-estimation.
- **Arrange anticipatory medications and a 24-hour contact before discharge**, or the plan collapses at the first crisis and the patient returns by ambulance.

References: Medicare hospice benefit eligibility and Local Coverage Determinations for non-cancer diagnoses · NHPCO guidance · FAST scale for dementia staging · literature on clinician prognostic accuracy in terminal illness.

Educational aid; eligibility criteria and funding vary by country and payer — verify locally.

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