Core Screening Tools

**TOOLS YOU CAN USE IN YOUR PALLIATIVE CARE SERVICE
AND SHARE WITH PRIMARY CARE AND SPECIALISTS.**

NHPCO
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Core Screening Tools to Identify and Care for Individuals that may Benefit from Palliative Care

TOOLS YOU CAN USE IN YOUR PALLIATIVE CARE SERVICE AND SHARE WITH PRIMARY CARE AND SPECIALISTS.

Intended audience: Palliative care teams, primary care providers, specialist providers

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Introduction

This resource was created to assist primary care and specialists to identify patients in their care that might benefit from palliative care services. Palliative care programs can use this resource as part of orientation for new staff and share with the referring practices they collaborate with. The information may inform your program's workflows and electronic medical record optimization. The tools can also be used in the development of an individualized care plan and evaluate the ongoing effectiveness of care provided to inform revision of the care plan.

Early access to palliative care can assist seriously ill individuals and their families to actively engage in decision-making about treatment preferences, goals of care, and quality of life based on what matters most to them. The interdisciplinary palliative care team provides an added layer of support to the primary care provider and disease specialist, particularly focusing on symptom management related to disease progression and disease-modifying treatments.

According to the NCP Clinical Practice Guidelines for Quality Palliative Care (2018), "palliative care focuses on expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. Palliative care attends to the physical, functional, psychological, practical, and spiritual consequences of a serious illness. It is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of an illness. Through early integration into the care plan for the seriously ill, palliative care improves quality of life for the patient and the family.
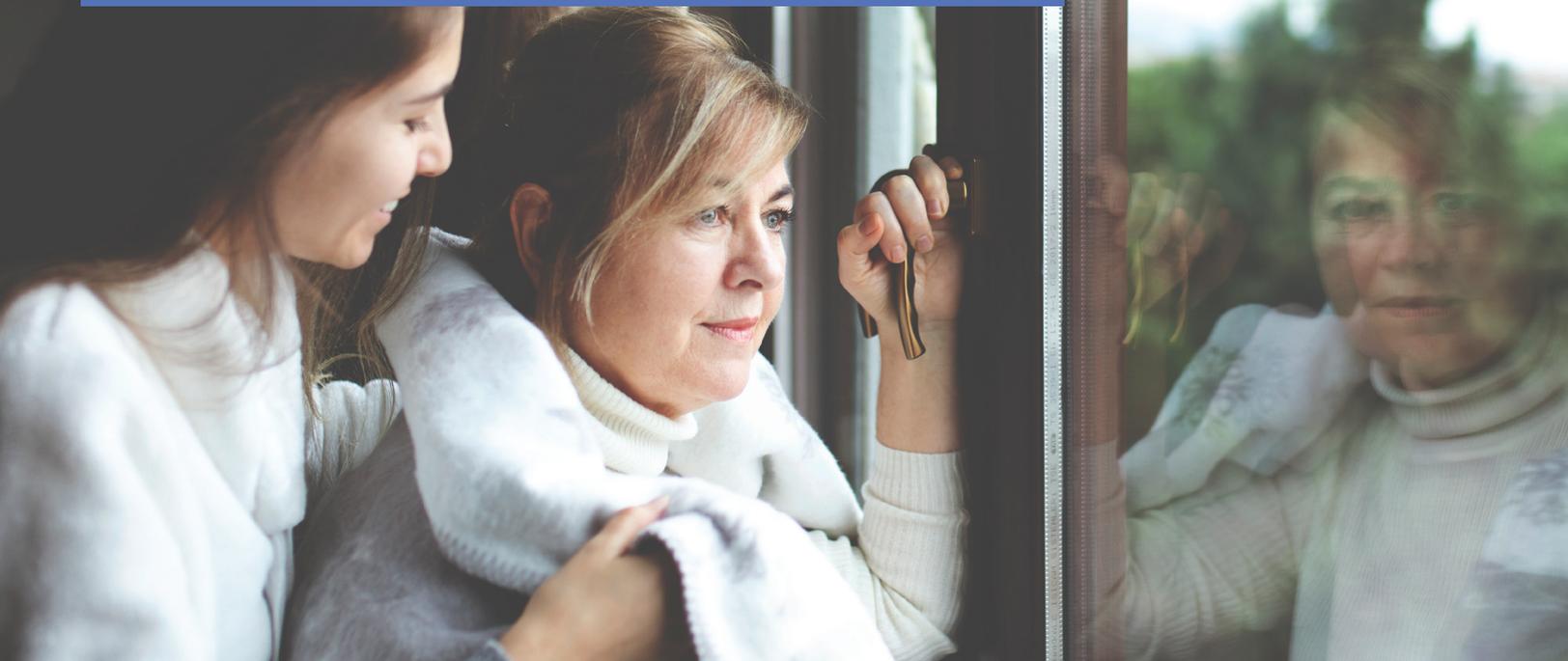
Palliative care is:

◼ *Appropriate at any stage in a serious illness,* and it is beneficial when provided along with treatments of curative or life-prolonging intent.
◼ *Provided over time* to patients based on their needs and not their prognosis.
◼ *Offered in all care settings* and by various organizations, such as physician practices, health systems, cancer centers, dialysis units, home health agencies, hospices, and long-term care providers.
◼ *Focused on what is most important to the patient, family, and caregiver(s),* assessing their goals and preferences and determining how best to achieve them.
◼ *Interdisciplinary* to attend to the holistic care needs of the patient and their identified family and caregivers."[1]

Resource Intention and Limitations

This practical resource is intended to provide evidence to support the use of these core tools, including a literature review. This is not a comprehensive list of available screening and assessment tools. Our hope is that by limiting the focus to this core set of tools we can assist providers in best practices and continuous quality improvement while minimizing the burden to patients and their families. The limited focus on this core set of tools also reduces burden for clinicians. The tools can easily be incorporated into existing workflows and the electronic medical record, allowing for data extraction to inform key clinical quality metrics. The resource includes interventions based on screening results and recommended frequency for re-screening. The patient self-report tools lend themselves to individualizing treatment/care plans with examples for use provided.

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1   National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018. https://www.nationalcoalitionhpc.org/ncp.

Population Health Risk Stratification

The palliative care core screening tools complement claims-based data to further risk stratify seriously ill individuals within the chronically ill patient population. Consistent use of these types of tools may help your practice proactively identify and manage care of seriously ill individuals, leading to better outcomes: improved quality and patient experience, while reducing utilization of emergency room and hospital. Tracking clinical outcomes measures can be a competitive advantage when seeking contracts with health plans or managed care entities. Users of this resource will note that in a couple categories we include more than one tool option.

The table below provides information on criteria considerations to determine value of use and adoption per tool.

Screening Tool	Research to support validity? *Yes/No*	Valid in these settings *Hospital/Clinic/ Home/SNF/ICF/ ALF/All*	Valid in these Specialties *Hospice/PC/BH/ Onc/Pulm/Card/ Other/All*	Source of info (Who reports)? *Patient/CG/ Clinician/Other/All*	Informs Risk Stratification? *Yes/No*	Can be Integrated Into EMR? *Yes/No*	Estimated Minutes to Complete & Document *2/5/10/15+*
Palliative Performance Scale (PPS)	Yes	All	All	All	Yes	Yes	5 min
Functional Assessment Staging Tool (FAST)	Yes	All	PC & Hospice	CG / clinician	Yes	Yes	5 min
Edmonton Symptom Assessment System – revised (ESAS-r)	Yes	All	All	Patient first/if unable then CG, then clinician	Yes	Yes	< 2 min
Patient Health Questionnaire 4 & 9 (PHQ-4 & PHQ-9)	Yes	All	All	Patient	Yes	Yes	5 min
Cognitive Assessment (CDT, Mini-Cog, MoCA, MMSE)	Yes	All	All	Varies by tool	Yes	Yes	Varies by tool but approx. 5 min

Please see the reference page for research that supports the validity and reliability of the core screening tools, including their use in primary care and specialty settings.

Palliative Care Network of Wisconsin Fast Facts

Palliative Care Network of Wisconsin (PCNOW) through their Fast Facts library: https://www.mypcnow.org/fast-facts/ provides additional resources related to the core screening tools. Fast Facts provide concise, practical, peer-reviewed, and evidence-based summaries on key palliative care topics important to clinicians and trainees caring for patients facing serious illness. Palliative Care Fast Facts and Concepts were originally published by End of Life/Palliative Education Resource Center (the EPERC is now closed) since 2000. Fast Facts are edited by Sean Marks, MD, Associate Professor of Medicine at the Medical College of Wisconsin. Fast Facts is also available via a downloadable app to have this resource at your fingertips.

The Fast Facts Core Curriculum: https://www.mypcnow.org/fast-facts/core-curriculum/ contains the most important Fast Facts within a particular palliative care domain or specialty area. These can be used to supplement a Generalists Palliative Care training initiative, for on-boarding new palliative care specialists, for health professional trainees working in hospice and palliative medicine or for "just in time" education to meet a clinical problem.

Geriatric Fast Facts: http://www.geriatricfastfacts.com/ are accessible, concise, and clinically actionable 1–2-page reports on Geriatric topics applicable across medical specialties. Fast Facts are interdisciplinary, spanning the progression of medical education.

Below are applicable Fast Facts related to the core screening tools included in this resource.

https://www.mypcnow.org/fast-fact/the-palliative-performance-scale-pps/

https://www.mypcnow.org/fast-fact/functional-status-assessment-in-serious-illness/

https://www.mypcnow.org/fast-fact/prognostication/

https://www.mypcnow.org/fast-fact/prognostication-in-dementia/

https://www.mypcnow.org/fast-fact/prognostication-in-heart-failure/

https://www.mypcnow.org/fast-fact/prognosis-in-hiv-associated-malignancies/

https://www.mypcnow.org/fast-fact/prognostication-in-patients-receiving-dialysis/

https://www.mypcnow.org/fast-fact/screening-for-depression-in-palliative-care/

https://www.mypcnow.org/fast-fact/assessing-depression-in-advanced-cancer/

https://www.mypcnow.org/fast-fact/anxiety-in-palliative-care-causes-and-diagnosis/

https://www.mypcnow.org/fast-fact/chemotherapy-related-cognitive-impairment/

https://www.mypcnow.org/fast-fact/illness-trajectories-description-and-clinical-use/

Palliative Performance Scale version 2 (PPSv2)

https://www.albertahealthservices.ca/assets/info/peolc/if-peolc-ed-esasr-admin-manual.pdf

The PPSv2 is a tool that assists in prognostication. For a primary care or specialist provider, the PPSv2 can help you monitor decline which can trigger timely referrals to palliative care or hospice to further support seriously ill individuals and their families in aging in place. The tool has been validated in all settings and can be administered by clinical or non-clinical staff. There are over 200 published studies supporting the validity and reliability of the PPSv2. Training on proper use of the tool is recommended. An online course is available through the document accessible by clicking the link in the header above. The PPSv2 tool is available and validated in several languages. Contact Victoria Hospice Society via the link in the header to complete permission to use form.

Key Points for Proper use of the PPSv2:[2]

- ❚ "Leftward" parameters take precedence
- ❚ Find the best "horizontal fit"
- ❚ Clinical judgement of best horizontal fit– overrides any ambiguities

- ❚ Not what patient is/observed doing, but what is able/capable to do
- ❚ Definitions are important
- ❚ PPS is simple, but not easy

Suggested frequency of use for the Primary Care Practitioner (PCP) or Specialist: Every visit for patients with one or more chronic or serious conditions.

What to do with the information: According to the General Guidelines in the Hospice Local Coverage Determination eligibility criteria both of the following must be met:

1. 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.**
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

The following table provides a breakdown of PPSv2 prognostication accuracy (of < 6 months to live) by disease[3]

Adjusted Probability of Death within Six Months (95% Confidence Interval)*

Diagnosis	PALLIATIVE PERFORMANCE SCALE SCORE				
	<30	30	40	50	≥60
Cancer	99.6 (98.9-100)	98.3 (97.0-99.1)	95.5 (91.9-97.5)	92.8 (87.5-95.9)	89.1 (86.0-91.7)
Debility	96.3 (90.4-98.6)	83.6 (73.2-90.5)	67.1 (54.6-77.6)	57.6 (42.7-71.2)	47.4 (34.2-61.0)
Cardiovascular Disease	97.6 (93.6-99.2)	89.8 (82.9-94.1)	74.2 (55.3-87.0)	65.3 (47.5-79.6)	51.8 (34.5-68.6)
Dementia	93.2 (76.7-98.3)	73.6 (56.6-85.7)	54.9 (44.9-64.5)	51.4 (31.8-70.6)	36.6 (20.9-55.9)
Pulmonary Disease	98.4 (94.9-99.5)	92.4 (88.0-95.3)	79.9 (72.2-85.8)	71.6 (62.4-79.3)	63.8 (58.2-69.1)
Stroke	92.8 (84.5-96.8)	67.4 (44.1-84.5)	48.4 (18.4-79.5)	39.4 (13.9-72.5)	32.6 (12.6-61.8)
Other	99.1 (97.3-99.7)	95.0 (91.3-97.2)	88.3 (79.6-93.6)	81.9 (70.9-89.4)	79.2 (72.1-84.8)

*Probabilities of 6-month mortality adjusted for age (<65 vs. ≥65), gender, and site of care at the time of hospice enrollment (home, nursing home, hospital).

2   Downing, M. & Victoria Hospice Society. (2020). PPSv2 QA Instructions and Definitions. Retrieved from https://victoriahospice.org/wp-content/uploads/2020/08/PPSv2-QA-Instructions-and-Definitions-updated-July-2020.pdf

3   Harris, P. S., Stalam, T., Ache, K. A., Harrold, J. E., Craig, T., Teno, J., Smither, E., Dougherty, M., & Casarett, D. (2014). Can hospices predict which patients will die within six months?. *Journal of palliative medicine*, 17(8), 894–898. https://doi.org/10.1089/jpm.2013.0631

Functional Assessment Staging Tool (FAST)

https://www.mccare.com/pdf/fast.pdf

The FAST is a tool that assists in diagnosis and staging of Alzheimer's Dementia (AD). For a primary care or specialist provider, longitudinal use of the FAST can help you monitor effectiveness of treatment. When treatment may no longer be effective, consider timely referrals to palliative care or hospice to further support seriously ill individuals and their families in aging in place. The tool has been validated in all settings and can be administered by clinical or non-clinical staff. The FAST is the most validated measure of the course of AD in published, scientific literature. Training on proper use of the tool is minimal. The document is accessible by clicking the link in the header above.

Key Points for Proper Use of the FAST:

▮ The FAST or adapted FAST can be administered by interviewing a caregiver who is an accurate reporter, the patient (if at a high cognitive stage) and/or by watching the person engage in activity.

▮ The description that best fits the person's performance may be the stage in which the person is functioning.

▮ If an individual's change in function is due to AD progression, then any changes on the FAST scale will be in sequence—**AD-related changes do not skip FAST stages.**

Suggested frequency of use: Use the FAST tool at each office visit to measure treatment effect in each patient. This information can then guide treatment recommendations made by the interdisciplinary care team.

What to do with the information: The longitudinal view of the FAST shows how long a patient has spent in each FAST stage, plus its average expected untreated duration. The difference, which appears in the column, "Actual minus Expected Untreated AD Duration", indicates whether treatment has delayed AD progression.[4]

Consider palliative care referral for stage 6 or 7. Consider hospice referral for stage 7 per the CMS Hospice Local Coverage Determination for "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. Patients with dementia should show all the following characteristics:

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

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

1. Aspiration pneumonia.
2. Pyelonephritis or other upper urinary tract infection.
3. Septicemia.
4. Decubitus ulcers, multiple, stage 3-4.
5. Fever, recurrent after antibiotics.
6. 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, such as multi-infarct dementia."

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4   Medical Care Corporation Simple and Accurate Memory Assessment www.mccare.com • (888)565-5535

Edmonton Symptom Assessment System Revised (ESAS-r)

https://www.albertahealthservices.ca/frm-07903.pdf

The ESAS was originally developed approximately 30 years ago by Dr. Eduardo Bruera and colleagues to quantify the level of symptom burden experienced by seriously ill individuals with cancer diagnosis on a palliative care unit. Over time, the tool has been validated in all care settings for a variety of serious illness diagnoses based on multiple research studies. Research led to revisions of the tool. The ESAS-r consists of 9 core symptoms (pain, tiredness, nausea, depression, anxious, drowsiness, appetite, feeling of well-being, shortness of breath) and an optional 10th symptom.[5] The tool is used across the world and available in over 20 languages. Research examined the ESAS's predictive validity and found that "higher ESAS symptom burden was associated with more emergency room visits in the next 7 days and a shorter survival" (Hui & Bruera, 2017, p. 3, paragraph 1). The tool is accessible by clicking the link in the header above.

Key Points for Proper Use of the ESAS-r

According to Hui and Bruera (2017) the revised ESAS includes:

▮ stated the time frame of symptom assessment as "now",
▮ added brief explanations for tiredness ("lack of energy"), drowsiness ("feeling sleepy"), depression ("feeling sad") and anxiety ("feeling nervous") and well-being ("how you feel overall"),
▮ changed "appetite" to "lack of appetite",
▮ adjusted the order of symptoms,
▮ removed the horizontal line over the numbers and shaded alternate items in gray for readability, and
▮ suggested constipation as the tenth item.

Suggested frequency of use: Frequency of use varies by site of care. In a clinic or home setting, the tool should be used at the beginning of each visit. The tool can also be completed at assigned intervals between scheduled visits to proactively monitor and manage symptoms, and triage visits based on symptom burden. In non-acute settings it may be more practical and useful to rate symptom burden for the past 24 hours. In acute settings or in acute situations in the home, a rating for "now" may be more informative.

What to do with the information: The tool is used to identify patients' unmet needs, manage symptom burden, and inform an individualized plan of care or treatment plan. ESAS scores generally equate to mild/moderate/severe terminology as follows: 0 = none, 1–3 = mild, 4–6 = moderate, and 7–10 = severe in clinical practice, although seriously ill individuals may interpret scores differently. A change of 1 point was found to be the optimal cutoff for both improvement and deterioration for all of the 10 symptoms. The ESAS-r is a screening tool which informs the need for deeper clinical assessment to determine etiology and treatment.

Clinicians should engage in a conversation with the patient about their interpretation of scores and their goal for symptom management. The question, "Using the same 0–10 scale, at what level of (specific symptom) would you feel comfortable?" can elicit the information needed to identify the patient's personal goal for symptom management

Monitoring the longitudinal results, help clinicians analyze effectiveness and monitor overall decline to inform prognosis. Primary care and specialists can use the ESAS-r to trigger referrals to the palliative care team, especially for severe (scores of 7-10) in either physical or emotional symptoms. Consider a hospice referral when fatigue, appetite, drowsiness, shortness of breath, and well-being worsen over time. Fatigue and well-being may deteriorate rapidly.

Documentation of the ESAS-r should include who is completing the tool. Ideally, the patient should self-report whenever possible. A primary caregiver can assist or report if necessary. Clinician report is the least valid. Several electronic medical record software products have the ESAS-r embedded. If the tool is available as separate data elements, specific symptoms can be pulled for clinical outcome metric reporting either at a patient or aggregate level. Some organizations are using the ESAS-r on patient portals or electronic devices at assigned intervals or as prep for an office visit.

5   Hui, D., & Bruera, E. (2017). The Edmonton Symptom Assessment System 25 Years Later: Past, Present, and Future Developments. *Journal of pain and symptom management*, 53(3), 630–643. https://doi.org/10.1016/j.jpainsymman.2016.10.370

Patient Health Questionnaire 4 & 9 (PHQ-4 & PHQ-9)

PHQ-4: https://qxmd.com/calculate/calculator_476/patient-health-questionnaire-4-phq-4
PHQ-9: https://www.apa.org/depression-guideline/patient-health-questionnaire.pdf

Depression is a widely prevalent and treatable mental health disorder. Depression and anxiety are the most common diagnoses and often co-exist creating significant disability. There is a bidirectional relationship between individuals with depression and chronic/serious medical conditions. Depression can increase symptom burden and disease progression in seriously ill individuals. The Patient Health Questionnaire is a self-administered version of the PRIME-MD diagnostic instrument for common mental disorders with the "9" focused on depression.[6] The severity of depression directly correlates to increased scores. The tool has dual purposes: supporting the ability to diagnose and to grade the severity of depression. The PHQ-4 is an ultra-brief patient self-screening tool that combines two questions from the PHQ with two questions from the generalized anxiety disorder screening tool (GAD-7). The PHQ-9 and PHQ-4 were created for use in primary care practice but are widely used across a variety of settings. The tools have been translated in several languages. No permission is required to reproduce.

Key Points for Proper Use of the PHQ-4 and PHQ-9:

- The tools are patient self-report based on frequency of symptoms over the last two weeks.
- Typically, the PHQ-4 is administered first and for score >3, is followed up with the PHQ-9 and/or GAD-7 and clinical interview to assess whether a mental disorder is present.
- Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
- Severity of symptom burden is equated with scores as follows, 5 = mild, 10 = moderate, and 15 = severe levels of depressive symptoms.

Suggested frequency of use: There is not evidence to support a recommended frequency of screening for depression. Use of clinical judgement that takes co-morbidities into account, suggests increased frequency of screening for seriously ill individuals. For ease-of-use screening could be done monthly with a seriously ill individual. If the ESAS-r is being used consistently, a rise in score on emotional symptoms could trigger the use of the PHQ-4 or go directly to the PHQ-9.

What to do with the information: A score of 10 or greater is considered a yellow flag indicating a possible clinically significant condition, while a score of 15 is a red flag targeting individuals in whom active treatment is probably warranted. In seriously ill individuals, clinical interview and assessment can further delineate the impact of chronic/serious illness on severity of depression. Follow up assessment for suicide risk is imperative for those that answer positively to the 9th question on the PHQ-9. Monitoring longitudinal results is useful to evaluate treatment effectiveness.

PHQ-9 Scores and Proposed Treatment Actions*

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0-4	None-Minimal	None
5-9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10-14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15-19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20-27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

From Kroenke K, Spitzer RL, Psychiatric Annals 2002;32;509-521

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6   Kroenke, K., Spitzer, R. L., & Williams, J. B. (2001). The PHQ-9: validity of a brief depression severity measure. *Journal of general internal medicine*, 16(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

Cognitive Screening and Assessment Tools
(Clock Draw Test, Mini-Cog, MoCA, and MMSE)

There are over 30 cognitive screening and assessment tools available. In research review, several considerations led to our focus on the simple Clock-Drawing Test, Mini-Cog, MoCA, and MMSE: ease of use, relationship between the tools, validity in primary care and specialty settings, and applicability for early detection of mild cognitive impairment and impairment of executive function. Earlier diagnosis of cognitive impairment allows for earlier treatment which may slow progression of dementia. Executive function can be impaired before memory problems are evident. Executive functioning, or decision-making capacity, is an important consideration in advance care planning.

Key Points for proper use of Cognitive Screening and Assessment Tools:

▌ Start with simplest tool (Clock-Drawing Test) and advance for score of zero to Mini-Cog, then MoCA, then MMSE

▌ Screening for cognitive impairment is the first step. For an individual that tests positive for cognitive impairment, further evaluation must be done to determine the etiology of the impairment for proper diagnosis, staging, and treatment.

▌ Ongoing use of cognitive screening tools can assist with tracking progression of cognitive decline to inform referrals to palliative care and hospice, advance care planning and goals of care discussions

▌ Patients may not express concerns about their cognitive issues (in fact, they might be aware). The family may be the first to bring up concerns. "Other red flag indicators include

- Increase in calls to the office, clinic visits, or emergency room visits
- Poor historian, vague, seems "off," repetitive
- New nonadherence with medications or instructions (loss of ability to manage concurrent medical conditions that they could manage in the past)
- Changes in appearance, mood, personality, behavior
- Word-finding problems, decreased social interaction
- Missing appointments, coming on the wrong day
- Confusion: postoperative delirium or with illness or new medications
- Weight loss in the older person living alone
- Driving: accidents, problems, tickets, family concerns
- Head-turning sign (turning to caregiver for answers)"[7]

Suggested frequency of use: Initial screening any time evidence of potential cognitive impairment exists, then per visit.

What to do with the information: older adults are at higher risk for cognitive impairment than the rest of the population. Changes in cognitive function often call for prompt and aggressive action. These screening tools identify the presence of cognitive impairment; however, further assessment and diagnostics are required to determine the etiology. Cognitive impairment is an important determinant of clinical outcomes Proactive identification and management can prevent crisis and is important for care/treatment planning.

The Clock-Drawing Test: https://www.verywellhealth.com/the-clock-drawing-test-98619 is the simplest and fastest screening tool for cognitive impairment. The simplest (and accurate) scoring method is one point for completing the task correctly and zero points if the clock was not completed correctly. Critical clock-drawing errors including the wrong time, no hands, missing numbers, number substitutions, repetition, and refusal to participate, are predictive in identifying dementia. Further screening and assessment are recommended for a score of zero. Benefits of the CDT are its simple, valid, reliable, free, fast, well tolerated, can be used to screen for delirium and executive function.

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7   Molnar, F. & Frank, C. (2020). Cognitive screening of older patients. Canadian Family Physician. Vol 66: p. 40.

The Mini-Cog: https://mini-cog.com/ combines the Clock-Drawing Test with a three-item recall test for memory. Scoring is based on 1 point for each word recalled and 2 points for the clock drawing portion. The recommended cut score for dementia screening (0-2 = positive; 3-5 = negative) was derived empirically to optimize the balance of sensitivity and specificity. Individuals with mild cognitive impairment (cognitive impairment/no dementia; mild neurocognitive disorder) are often detected by the Mini-Cog, but there is insufficient evidence to recommend the Mini-Cog as a 'screen for MCI.'

The Montreal Cognitive Assessment (MoCA): https://www.mocatest.org/the-moca-test/ is 90% effective in identifying mild cognitive impairment. The MoCA tests "short term memory, visuospatial abilities, executive functions, attention, concentration and working memory, language, and orientation to time and place." The MoCA is accessible for clinicians via an app or paper tool. Please review the Terms of Use. There is a mandatory requirement for training and certification to use this tool. The MoCA is the most accurate screening tool for mild cognitive impairment.

The Mini Mental State Exam: https://www.ncbi.nlm.nih.gov/projects/gap/cgi-bin/GetPdf.cgi?id=phd001525.1 is the most comprehensive of the cognitive screening tools. The MMSE is 11-questions testing five areas of cognitive function: orientation, registration, attention and calculation, recall, and language. The maximum score is 30. A score of 23 or lower is indicative of cognitive impairment. The MMSE takes approximately 5-10 minutes to administer. The MMSE validity and reliability increases in identifying moderate to severe cognitive impairment, as compared to the MoCA which is more accurate in identifying mild cognitive impairment.

Summary

This resource was created to assist primary care and specialists to identify patients in their care that might benefit from palliative care services. Incorporating this core set of screening tools into your annual wellness visit and recurring office visits can assist in proactive identification and management of disease progression and symptom burden. Members of your team can assist in the completion of these screenings. The tools can be used in the development of an individualized care plan and to evaluate the ongoing effectiveness of care provided to inform revision of the care plan.

Early access to palliative care can assist seriously ill individuals and their families to actively engage in decision-making about treatment preferences, goals of care, and quality of life based on what matters most to them. The interdisciplinary palliative care team provides an added layer of support to the primary care provider and disease specialist, particularly focusing on symptom management related to disease progression and disease-modifying treatments.

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