## Palliative Care Appropriate Screening Tool

### Section 1
**Diagnosis: 2 points for each**
- Dialysis dependent renal failure or need for acute dialysis
- Oxygen dependent COPD or Gold 3 and 4 criteria patients (FEV1<50%)
- Progressive or metastatic malignancy
- Severe neurological injury including CVA, trauma, anoxic encephalopathy
- CHF/CAD cardiomyopathy ACE or NYC III or IV
- ICU patients not progressing after 5th day of mechanical ventilation (including BIPAP)
- 2nd readmission for same diagnosis in last 60 days
- Liver failure with encephalopathy or major bleeding episode
- Other life limiting or serious progressive illness

**Total Points Section 1**

### Section 2
**Modifiers and Situations: 1 point for each**
- Transplant or organ donation being considered
- PEG, tracheostomy, AICD or other long term device placement being discussed (or already in place)
- Unrealistic or divergent family opinions about care (including not following advanced directives)
- No advanced directives, spokesperson or loss of primary care giver ability to continue care
- Complex situation or need for ongoing care coordination
- Uncontrolled or unsatisfactory symptom control of pain, nausea, delirium, etc, >24 hours
- Medical team and family unable to resolve conflicts regarding level of care, prognosis, etc.

**Total Points Section 2**

### Section 3
**“Surprise” Question: 2 points**
Would you be surprised if patient died in next 12 months? (Yes=0 points; No=2 points)

**Total Points Section 3**

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Over
### Section 4

**Functional Status of Patient**

**Eastern Cooperative Oncology Group (ECOG) Performance Status Scale**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Fully active able to carry on all pre-disease activities without restriction.</td>
</tr>
<tr>
<td>2</td>
<td>Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature (e.g. light housework, office work).</td>
</tr>
<tr>
<td>3</td>
<td>Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.</td>
</tr>
<tr>
<td>4</td>
<td>Capable of only limited self-care; confined to bed or chair more than 50% of waking hours.</td>
</tr>
<tr>
<td>5</td>
<td>Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.</td>
</tr>
</tbody>
</table>

**PPS**

<table>
<thead>
<tr>
<th>%</th>
<th>Ambulation</th>
<th>Activity and Evidence of Disease</th>
<th>Self-Care</th>
<th>Intake</th>
<th>Consciousness Level</th>
</tr>
</thead>
</table>
| 100 | Full | Normal Activity  
No evidence of Disease | Full | Normal | Full |
| 90  | Full | Normal Activity  
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  
Some evidence of Disease | Full | Normal or Reduced | Full |
| 60  | Reduced | Unable Hobby/House Work  
Significant Disease | Occasional Assistance Required | Normal or Reduced | Full or Confusion |
| 50  | Mainly Sit and/or Lie | Unable to Do Any Work  
Extensive Disease | Considerable Assistance Required | Normal or Reduced | Full or Confusion |
| 40  | Totally Bed Bound | Unable to Do Any Work  
Extensive Disease | Mainly Assistance | Normal or Reduced | Full or Drowsy or Confusion |
| 30  | Totally Bed Bound | Unable to Do Any Work  
Extensive Disease | Total Care | Reduced | Full or Drowsy or Confusion |
| 20  | Totally Bed Bound | Unable to Do Any Work  
Extensive Disease | Total Care | Minimal Sips | Full or Drowsy or Confusion |
| 10  | Totally Bed Bound | Unable to Do Any Work  
Extensive Disease | Total Care | Mouth Care Only | Drowsy or Coma |
| 0   | Death | | | | |

*This scale is a modification of the Karnofsky Performance Scale. It takes into account ambulation, activity, self-care, intake, and consciousness level.

- ECOG=2 or PPS=70 (1 point)
- ECOG=3 or PPS=50/60 (2 points)
- ECOG=4 or PPS=30/40 (3 points)

**Total Points Section 4**

Add Points: Section 1____ +Section 2____ +Section 3____ +Section 4____ =Total Points______

Patients with total score ≥ 5 should be considered for ASPIRE HEALTH TEAM CONSULT.

If in doubt, please contact our office to request a consult and we will be happy to provide an opinion.

Phone: (423) 553-1823        Fax: (423) 553-1829
## CRITERIA FOR PALLIATIVE CARE ASSESSMENT AT THE TIME OF HOSPITAL ADMISSION AND DURING HOSPITAL STAY

### At Time of Hospital Admission

<table>
<thead>
<tr>
<th>Primary criteria*</th>
<th>A potentially life-limiting or life-threatening condition AND</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not surprised if the patient died within 12 months</td>
</tr>
<tr>
<td></td>
<td>More than one admission for same condition within several months</td>
</tr>
<tr>
<td></td>
<td>Admission for difficult physical or psychologic symptoms</td>
</tr>
<tr>
<td></td>
<td>Complex care requirements (e.g., functional dependency, complex home support for ventilator/antibiotics/feedings)</td>
</tr>
<tr>
<td></td>
<td>Failure to thrive (decline in function, feeding intolerance, or unintended decline in weight)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary criteria†</th>
<th>A potentially life-limiting or life-threatening condition AND</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Admission from long-term care facility</td>
</tr>
<tr>
<td></td>
<td>Older age, with cognitive impairment and acute hip fracture</td>
</tr>
<tr>
<td></td>
<td>Metastatic or locally advanced incurable cancer</td>
</tr>
<tr>
<td></td>
<td>Chronic use of home oxygen use</td>
</tr>
<tr>
<td></td>
<td>Out-of-hospital cardiac arrest</td>
</tr>
<tr>
<td></td>
<td>Current or past hospice program use</td>
</tr>
<tr>
<td></td>
<td>Limited social support</td>
</tr>
<tr>
<td></td>
<td>No history of advance care planning discussion/document</td>
</tr>
</tbody>
</table>

### During Hospital Stay

<table>
<thead>
<tr>
<th>Primary criteria*</th>
<th>A potentially life-limiting or life-threatening condition AND</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not surprised if the patient died within 12 months</td>
</tr>
<tr>
<td></td>
<td>More than one admission for same condition within several months</td>
</tr>
<tr>
<td></td>
<td>Stay in intensive care unit of 7 days or more</td>
</tr>
<tr>
<td></td>
<td>Lack of documentation of goals of care</td>
</tr>
<tr>
<td></td>
<td>Disagreements or uncertainty among the patient, staff, and/or family about major medical treatment decisions, resuscitation preferences, or use of nonoral feeding or hydration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary criteria†</th>
<th>A potentially life-limiting or life-threatening condition AND</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Awaiting, or deemed ineligible for, solid-organ transplantation</td>
</tr>
<tr>
<td></td>
<td>Patient/family/surrogate emotional, spiritual, or relational distress</td>
</tr>
<tr>
<td></td>
<td>Patient/family/surrogate request for palliative care/hospice services</td>
</tr>
<tr>
<td></td>
<td>Patient is a potential candidate for feeding tube placement, tracheostomy, initiation of renal replacement therapy, placement of left ventricular assist device or automated implantable cardioverter-defibrillator, bone marrow transplantation (high-risk patients)</td>
</tr>
</tbody>
</table>

*Primary criteria are the minimum indicators for screening patients at risk for unmet palliative care needs.

†Secondary criteria are more specific indicators of a high likelihood of unmet palliative care needs.
### Tennessee Physician Orders for Scope of Treatment (POST, sometimes called “POLST”)

This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

#### Section A

**CARDIOPULMONARY RESUSCITATION (CPR):** Patient has no pulse and is not breathing.

- [ ] Resuscitate (CPR)
- [ ] Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death)

When not in cardiopulmonary arrest, follow orders in B, C, and D.

#### Section B

**MEDICAL INTERVENTIONS.** Patient has pulse and/or is breathing.

- [ ] Comfort Measures Only. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. Treatment Plan: Maintain comfort through symptom management
- [ ] Limited Additional Interventions. In addition to care described in Comfort Measures above, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. Treatment Plan: basic medical treatments.
- [ ] Full Treatment. In addition to care described in Comfort Measures Only and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. Treatment Plan: full treatment including in the intensive care unit.

**Other Instructions:**

#### Section C

**ARTIFICIALLY ADMINISTERED NUTRITION.** Oral fluids & nutrition must be offered if feasible.

- [ ] No artificial nutrition by tube
- [ ] Defined trial period of artificial nutrition by tube
- [ ] Long-term artificial nutrition by tube

**Other Instructions:**

#### Section D

**Discussed with:**

- [ ] Patient/Resident
- [ ] Health care agent
- [ ] Court-appointed guardian
- [ ] Health care surrogate
- [ ] Parent of minor
- [ ] Other: (Specify)

**The Basis for These Orders Is:** (Must be completed)

- [ ] Patient’s preferences
- [ ] Patient’s best interest (patient lacks capacity or preferences unknown)
- [ ] Medical indications
- [ ] (Other)

**Physician/NP/CNS/PA Name (Print) **

<table>
<thead>
<tr>
<th>Physician/NP/CNS/PA Signature</th>
<th>Date</th>
<th>MD/NP/CNS/PA Phone Number</th>
</tr>
</thead>
</table>

**Signature of Patient, Parent of Minor, or Guardian/Health Care Representative:**

Preferences have been expressed to a physician or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your agent/surrogate.

**Name (print) **

<table>
<thead>
<tr>
<th>Signature</th>
<th>Relationship (write “self” if patient)</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

**Agent/Surrogate **

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Phone Number</th>
<th>Date Prepared</th>
</tr>
</thead>
</table>

**Health Care Professional Preparing Form **

<table>
<thead>
<tr>
<th>Preparers Title</th>
<th>Phone Number</th>
<th>Date Prepared</th>
</tr>
</thead>
</table>

Revised June 25, 2015
COMMUNICATING
End-of-Life Wishes

Caring Connections
a program of the National Hospice and Palliative Care Organization
When it comes to creating memories, the family is often at the heart of sharing in life events.

We plan for weddings, the birth of a child, going off to college, and retirement. Despite the conversations we have for these life events, rarely do we have conversations about how we want to be cared for at the end of our lives.

With roughly 2.4 million Americans dying each year, it is important that personal conversations take place about the kinds of experiences you want for yourself and the wishes of your loved ones before facing an end-of-life situation. We know from research that Americans are more likely to talk to their children about safe sex and drugs than to talk to their parents about end-of-life care choices.
Communicating End-of-Life Wishes

Experts agree the time to discuss your views about end-of-life care, and to learn about the end-of-life care choices available, is before a life-limiting illness occurs or a crisis happens. By preparing in advance, you can help reduce the doubt or anxiety related to making decisions for your family member when they cannot speak for themselves.

Plan Ahead

The time to communicate end-of-life care wishes is now when you and your loved ones are still able to discuss your choices. Review the steps below and share them with your friends and family to communicate end-of-life wishes.
The following are simple steps to ensure that end-of-life care wishes are followed:

- Draw up a living will of written instructions to communicate care and treatment wishes and preferences in the event you cannot speak for yourself.
- Have a durable power of attorney in place that allows a person of your choosing to make medical decisions for you if you become unable to do so.

Provide your family doctor with a copy of this document. Make sure to communicate your wishes to this person and make sure that this person agrees to assume the responsibility.

Since every state has different laws it is important to use state-specific advance directives. Contact NHPCO to receive a state-specific advance directive:

- www.caringinfo.org  caringinfo@nhpco.org  HelpLine 800.658.8898  Multilingual Line 877.658.8896

Advance directives can be useful tools for making end-of-life care wishes known, however it is just as important to have personal conversations with family and loved ones about these issues.

Discuss Your Wishes Early

Discuss your end-of-life care wishes with family and loved ones now — before a crisis happens. The following can be used as opportunities for having this conversation:

- Around significant life events, such as marriage, birth of a child, death of a loved one, retirement, birthdays, anniversaries, or college graduation
- While drawing up a will or doing other estate planning
- When major illness requires that you or a family member move out of your home and into a retirement community, nursing home, or other longterm care setting
- During holiday gatherings, such as Thanksgiving, when family members are present
- When a friend or another family member is facing illness or an end-of-life situation
Whenever possible, include your children in these conversations, not just your parents, spouse or partner. It is never too early to start thinking about these issues. Have regular discussions about your views on end-of-life care, since they may change over time. And don’t forget to discuss your end-of-life care wishes with your doctor. Here are a few helpful pointers to keep in mind as you plan for having this conversation:

1. **Do Your Homework**
   Before beginning the discussion, learn about end-of-life care services available in your community. Become familiar with what each option offers so you can decide which ones meet your loved one or your own, end-of-life care needs and wants.

2. **Select an Appropriate Setting**
   Plan for the conversation. Find a quiet, comfortable place that is free from distractions to hold a one-on-one discussion or family meeting. Usually, a private setting is best.

3. **Ask Permission**
   People cope with end-of-life care issues in many ways. Asking permission to discuss this topic assures your loved one that you will respect and honor his or her wishes.

   Some ways of asking permission are:

   “I’d like to talk about the best way someone might care for you if you got really sick. Is that okay?”

   “If you ever got sick, I would be afraid of not knowing the kind of care you would like. Could we talk about this now? I’d feel better if we did.”

   “I want to share my wishes about how I’d like to be cared for in the event I was sick or injured; can we do that now?”

Another method of beginning the conversation is to share an article, magazine, or story about the topic with your loved one. Even watching a TV show or movie on the topic together can encourage the conversation. If you think your loved one would be more comfortable with someone else, you can suggest they talk to another family member, a friend or faith leader.

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Decide what you want for your own end-of-life care.
4. Begin the Conversation

Keep in mind that you started this conversation because you care about your loved one well-being — especially during difficult times. Allow your loved one to set the pace. Nodding your head in agreement, holding your loved one hand, and reaching out to offer a hug or comforting touch are ways that you can show your love and concern.

Understand that it is normal for your loved ones to avoid this discussion. Don’t be surprised or upset; instead, plan to try again at another time.

Questions to ask your loved one about his or her end-of-life care:

“How would you like your choices honored at the end of life?”

“Would you like to spend your final days at home or in a homelike setting?”

“Do you think it’s important to have medical attention and pain control to fit your needs?”

“Is it important for you — and your family — to have emotional and spiritual support?”

If your loved one responds “yes” in answer to these questions, he or she may want the end-of-life care that hospice provides.

5. Be a Good Listener

Keep in mind that this is a conversation, not a debate. Sometimes just having someone to talk to is a big help. Be sure to make an effort to hear and understand what the person is saying. These moments, although difficult, are important and special to both of you.

Some important considerations:

- Listen for the wants and needs your loved one expresses.
- Make clear that what your loved one is sharing with you is important.
- Show empathy and respect by addressing these wants and needs in a truthful and open way.
- Acknowledge your loved one right to make life choices — even if you do not agree with them.
6. Call Hospice

If you — or those you love — are struggling to cope with a life-limiting illness, help is available through hospice. Hospice programs provide quality care focusing on comfort and dignity for persons who are ill, and their loved ones. Here are some important things to know about hospice:

- Hospice provides a team of professionals that offer expert medical care, pain management, and emotional and spiritual support to meet the needs and wishes of the person who is ill.
- Emotional support is also provided to the patient’s loved ones.
- Hospice focuses on aggressively treating pain or symptoms to make the person as comfortable as possible. Care is usually provided in the person’s home.
- Hospice also is provided in hospice facilities, hospitals, and nursing homes and other longterm care facilities.
- Hospice services are available to patients of any age, religion, race, or illness, regardless of their method of payment.
- Members of the hospice staff make regular visits to assess the person who is ill and provide extra care or other services. Hospice staff is on-call 24 hours a day, seven days a week.
- The hospice team — which includes the person who is ill, family/caregivers, doctors, nurses, social workers, spiritual caregivers, counselors, home health aides, and trained volunteers — develops a care plan that meets each person’s individual needs for care and support.
- The care plan describes the services needed such as nursing care, personal care (dressing, bathing, etc.), emotional support, and doctor visits. It also identifies the medical equipment, tests, procedures, medication and treatments necessary to provide high-quality comfort care.
- After death, hospice provides grief services and support for family members for at least 12 months.
- Hospice is a benefit under Medicare and is often covered by private insurance.

Put your end-of-life wishes in writing.


