# PALLIATIVE CARE
## QUALITY IMPROVEMENT PROGRAM
## DETAILED SPECIFICATIONS

# 2024

## MEASUREMENT YEAR

Published: January 1, 2024

Revised: January 31, 2024

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ACCREDITED NCQA HEALTH PLAN

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## Program Overview

Partnership HealthPlan of California (PHC) has value-based programs in the areas of primary care, hospital care, specialty care, community pharmacy, and mental health. These value-based programs align with PHC's organizational mission to help our members and the communities we serve be healthy.

In 2015, PHC developed a pilot pre-hospice intensive palliative care program, called *Partners in Palliative Care*. The legislature of California passed a bill (SB 1004) in late 2015, requiring the development of a similar program as a state wide benefit for Medicaid. Implementation of this benefit occurred on January 1, 2018. In 2017, PHC started the Palliative Care Quality Improvement Program (QIP) for providers.

### Participation Requirements

All contracted Intensive Outpatient Palliative Care provider sites participating will be automatically enrolled in the Palliative Care QIP. Providers must have a PHC contract within the first (3) months of the measurement year. The provider must remain contracted through the end of the measurement year to be eligible for payment. Provider sites must be in good standing with state and federal regulators as of the month the payment is to be disbursed. Good standing means that the provider site is open, solvent, not under financial sanctions from the state of California or Centers for Medicare & Medicaid Services.

### Patient Eligibility

Providers may earn incentives from the Palliative Care QIP based on care provided to PHC eligible members, 18 years or older, who have an approved Intensive Outpatient Palliative Care Treatment Authorization Request (TAR) on file. For more information about how members qualify for the program, please contact palliativeQIP@partnershiphp.org for a detailed policy.

### Payment Methodology

The incentives provided through the Palliative Care QIP are separate and distinct from a palliative care provider site's usual reimbursement. Each provider site's earning potential is based on its volume of members approved for enrollment in the palliative care program. Please refer to the measure specifications for the incentive amount and payment calculation for each measure.

### Program Timeline

The Palliative Care QIP is administered in 6-month measurement periods: Part I runs from January - June, and Part II runs from July - December. This document details requirements and specifications for both Part I and Part II. Performance and payments are calculated at the end of each 6-month period, and incentive payments are distributed four (4) months after the end of each measurement period, as follows: (i.e. Part I check mailed by November 30, and Part II check mailed by May 31).

| Measurement Period | | Payment Distribution |
|---|---|---|
| Part I | January - June | November |
| Part II | July - December | May |

## Measure I. Avoiding Hospitalization and Emergency Room Visits

### Description

The number of members enrolled in the Intensive Outpatient Palliative Care program who were not admitted to the hospital and did not have an emergency department visit.

One goal of palliative care is to improve quality of life for both the patient and the family. For members who have serious illnesses and are in the palliative care program, we expect the palliative care team to be the first point of contact, which in turn minimizes unnecessary hospitalizations and emergency department visits.

### Measurement Period

Monthly, from January to June for Part I, and July to December for Part II.

### Target

Zero admissions or ED visits per member per month.

### Specifications

$240 per member enrolled in the Intensive Outpatient Palliative Care program per month, only if there are no hospital admissions or ED visits during that month.

Hospital admissions and ED visits are identified through data sources including encounters, claims, and treatment authorization requests (TARs) submitted to PHC. Observation stays are included.

Refer to Appendix I for codes used to identify hospital admissions and ED visits.

Example: For a member who is enrolled in the program on February 25, seen in the emergency room on March 9, admitted from April 23 through April 30, and dies on June 2 at home, the number of months with no hospital encounters or ED visits is 3 (February, May and June). The palliative care provider site will be eligible for a total payment for avoiding hospitalization and ED visits of $720.

### Reporting Guidelines

Reporting by palliative care provider sites to PHC is not required. PHC will send preliminary reports after the end of the measurement year and prior to payment to help providers confirm and correct performance data, if needed. Providers can also request member-level reports of admissions and ED visits on an ad hoc basis.

## Measure II: Completion of POLST & Use of Palliative Care Quality Collaborative (PCQC) Tool

### Description

To align best practices, the Palliative Care QIP includes an incentive for the completion of a signed Physician's Orders for Life Sustaining Treatment (POLST) with documentation in the Palliative Care Quality Collaborative (PCQC) system.

The POLST was designed for seriously ill patients with the goal of providing a framework for healthcare professionals so they can ensure the patient received the treatments they want and avoid those treatments that they do not want. The PCQC tool is an online system where palliative care providers share data, and from that data can identify possible quality improvement opportunities. This measure will incentivize providers in our program to capture the key components of care delivery, contribute data, and learn about best practices.

### Measurement Period

January to June for Part I, and July to December for Part II.

### Specifications

$120 per member enrolled in the palliative care program upon:

Completion of a signed POLST and documentation using the PCQC tool.

Example: A member is enrolled from February 25 to May 30. Documentation of a completed signed POLST, using the PCQC tool within the enrollment timeframe, will meet this measure. The palliative care provider site will be eligible for a total payment for completing a signed POLST and documenting using PCQC of $120, if they are compliant with the reporting requirement.

### Reporting Guidelines

Palliative care sites are required to enter PHC required data elements into PCQC on a monthly basis to meet the requirements of this measure.

Reporting by palliative care provider sites to PHC is not required. PHC will obtain monthly and bi-annual reports from PCQC. PHC will send preliminary reports to palliative care provider sites prior to payment (October for Part I and April for Part II) to help providers confirm and correct performance data, if needed.

For questions related to entering data into the PCQC platform or other PCQC related questions, please reach out to the PCQC team at info@palliativequality.org.

## Measure III: Completion of Standardized Palliative Care Quality Collaborative (PCQC) Assessments & Use of PCQC Tool

### Description

The Palliative Care QIP includes an incentive for the completion of two (2) standardized PCQC assessments, within the designated thresholds for capturing required data elements, and documented in the PCQC system.

In a Palliative Care Quality Collaborative assessment form, information typically includes patient demographics, medical history, symptom management, psychosocial support, communication preferences, and satisfaction with care. The goal is to comprehensively evaluate and improve the quality of palliative care provided to patients. The PCQC tool is an online system where palliative care providers share data, and from that data can identify possible quality improvement opportunities. This measure will incentivize providers in our program to capture the key components of care delivery, contribute data, and learn about best practices.

### Measurement Period

January to June for Part I, and July to December for Part II.

### Specifications

Up to $120 per member enrolled in the palliative care program per month upon:

At least two (2) patient encounters per month, completing a standardized PCQC assessment within the designated thresholds for capturing required data elements per encounter, and documented using the PCQC tool.

Example: For a member enrolled from February 25 to May 30, with at least two (2) visits documented on PCQC with the completion of a Palliative Care Quality Collaborative assessment form per visit within the designated thresholds for capturing required data elements each month, but entered into PCQC in April and May, the number of months meeting this measure is 2 (April and May). The palliative care provider site will be eligible for payment for using PCQC, if they are compliant with the reporting requirement per the designated thresholds:

- Thresholds:
  > 85% of data elements entered on assessments = Full points ($120 Per Member Per Month (PMPM))

  70-84.9% of data elements entered on assessments = Partial points ($60 PMPM)

## Threshold Benchmarks for Payment

| Assessment 1 | Assessment 2 | Credit for Payment |
|---|---|---|
| 85% or more | 85% or more | Full credit ($120) |
| 85% or more | 70-84.9% | Partial credit ($60) |
| 85% or more | Less than 70% | Partial credit ($60) |
| 70-84.9% | 70-84.9% | Partial credit ($60) |
| 70-84.9% | Less than 70% | Partial credit ($60) |
| Less than 70% | Less than 70% | No credit |

## Reporting Guidelines

Palliative care sites are required to enter PHC required data elements into PCQC on a monthly basis to meet the requirements of this measure.

Reporting by palliative care provider sites to PHC is not required. PHC will obtain monthly and bi-annual reports from PCQC. PHC will send preliminary reports to palliative care provider sites prior to payment (October for Part I and April for Part II) to help providers confirm and correct performance data, if needed.

For questions related to entering data into the PCQC platform or other PCQC related questions, please reach out to the PCQC team at info@palliativequality.org.

## Appendix I: Table of Hospital Admissions and Emergency Department Codes

| CLAIM TYPE | LOCATION CODE | SERVICE PROVIDER TYPE | DESCRIPTION | TYPE |
|---|---|---|---|---|
| H, HX | 3 | | INPATIENT HOSPITAL | Admissions |
| H, HX | 21 | | INPATIENT HOSPITAL | Admissions |
| H, HX | 51 | | INPATIENT, PSYCHIATRIC FACILITY | Admissions |
| H, HX | 61 | | INPATIENT, REHAB | Admissions |
| M, MX | 23 | | EMERGENCY DEPARTMENT | ED |
| M, MX | | 15 | COMMUNITY HOSP OUTPATIENT DEP | ED |
| M, MX | | 61 | COUNTY HOSP OUTPATIENT DEP | ED |

## Appendix II: PCQC Core Dataset Elements Table

PCQC
Palliative Care Quality Collaborative

| PCQC CORE DATASET ITEM | ELEMENT DESCRIPTION | DATA ELEMENT CHOICES |
|---|---|---|
| Patient ID # | Please enter PHC CIN # | |
| Patient Last Name | | |
| Patient First Name | | |
| Ethnicity (select one): | | ☐ Hispanic/Latino<br>☐ Non-Hispanic/Latino<br>☐ Unknown<br>☐ Declined to Say |
| Date of Birth | | mm/dd/yyyy |
| Pref Lang (select one): | | ☐ Eng<br>☐ Spanish<br>☐ Other Indo-Euro lang<br>☐ Asian & PI lang<br>☐ Other languages: _____<br>☐ Unknown<br>☐ Not Reported |
| Gender Identity | | ☐ Male<br>☐ Female<br>☐ Transgender Male (FTM)<br>☐ Transgender Female (MTF)<br>☐ Non-Binary<br>☐ Prefer to Self-Describe: _____<br>☐ Unknown<br>☐ Declined to Say |
| Race (select all that apply) | | ☐ White<br>☐ Black or African-American<br>☐ Asian<br>☐ Native Hawaiian or Other Pacific Islander<br>☐ American Indian or Alaska Native<br>☐ Other: _____<br>☐ Not Reported<br>☐ Declined to Say |
| Hospitalization ID | | |
| Hospital Admission Date | | mm/dd/yyyy |
| Manner of Visit | Refers to Visit Type (does not refer to location of visit) | ☐ In-person<br>☐ Video Visit<br>☐ Telephone Visit<br>☐ Unknown |
| Date of Visit | | mm/dd/yyyy |
| Date of Consult | | mm/dd/yyyy |
| Referral Service (select one) | Refers to medicine services patient is on at time of referral | ☐ General Medicine<br>☐ Hospital Medicine<br>☐ Oncology<br>☐ Hematology<br>☐ Cardiology<br>☐ Neurology<br>☐ Pulmonary<br>☐ Critical Care<br>☐ Ped Critical Care<br>☐ Neonatal Critical Care |

| | | |
|---|---|---|
| | | ☐ Other Internal Medicine or Peds Subspecialty<br>☐ Surgical Specialties<br>☐ OB/GYN & Mother-Fetal<br>☐ Emergency Med<br>☐ Self<br>☐ Other<br>☐ Unknown |
| Referral Source (select one) | | ☐ Emergency Dept<br>☐ Group Home<br>☐ Health Plan<br>☐ Home Health Agency<br>☐ Hospice<br>☐ Hospital Inpatient PCS<br>☐ Other Hospital IP Service<br>☐ Nursing Home/LTC<br>☐ Primary Care Practice<br>☐ Primary Care Practice – Ambulatory<br>☐ Primary Care Practice – Home<br>☐ Specialty Practice – Onco/CC<br>☐ Specialty Practice – Cardiology/HF Clinic<br>☐ Specialty Practice – Neurology<br>☐ Specialty Practice – Neph/Dialysis Cntr<br>☐ Specialty Practice – Geriatrician<br>☐ Specialty Practice – Palliative Care Clinic<br>☐ Other<br>☐ Unknown |
| Reason(s) for Referral (select all) | | ☐ Symptom Management<br>☐ Decision Making<br>☐ Providing Support to Patient & Family<br>☐ Other<br>☐ Unknown |
| Primary Diagnosis | | ☐ Cancer (solid tumor)<br>☐ Cancer (Heme)<br>☐ Cardiovascular<br>☐ Pulmonary<br>☐ Gastrointestinal<br>☐ Hepatology<br>☐ Renal<br>☐ Dementia<br>☐ Neurology (includes Neuromusc/ non-dementia Neurodegen)<br>☐ Infectious<br>☐ Trauma<br>☐ Vascular<br>☐ Metabolic/Endocrine<br>☐ Genetic/Chromosomal<br>☐ Hematology (non-cancer)<br>☐ Prematurity/Complications related<br>☐ Fetal<br>☐ Other<br>☐ Unknown |

| | | |
|---|---|---|
| Manner Visit Conducted | | ☐ In-person<br>☐ Video Visit<br>☐ Telephone Visit<br>☐ Unknown |
| Consultation Location | | ☐ Outpatient Clinic<br>☐ LTC<br>☐ Assisted Living Facility<br>☐ Other Domiciliary<br>☐ Home<br>☐ Other<br>☐ Unknown |
| GOC Discussed | | ☐ Yes<br>☐ No<br>☐ Unknown |
| Resuscitation Preference | Refers to Code Status (at the time consult was requested) | ☐ Full code<br>☐ DNR, not DNI Other Limited DNR<br>☐ DNR/DNI (DNAR+AND)<br>☐ Unknown |
| Advanced Directive Completed During Consult? | | ☐ Yes<br>☐ No<br>☐ NA - No POLST Program in state<br>☐ Unknown |
| POLST/MOLST Completed During Consult? | | ☐ Yes<br>☐ No |
| Palliative Performance Scale(PPS) | | (0% - 100%) |
| Screen for Pain | Refers to symptoms under Patient's Assessment. Use "Other" to enter the following additional symptoms not listed to the right: Depression, Anxiety, Well-being, Shortness of Breath | ☐ Nausea<br>☐ Drowsiness<br>☐ Appetite<br>☐ Constipation<br>☐ Other:_____ |
| Screen for Psychosocial Needs | | ☐ Positive<br>☐ Negative<br>☐ Patient/Family Declined<br>☐ Patient/Family Unable<br>☐ Not screened |
| Screen for Spiritual Needs | | ☐ Positive<br>☐ Negative<br>☐ Patient/Family Declined<br>☐ Patient/Family Unable<br>☐ Not screened |
| Team Members Involved in Visit | | |
| Discharge Disposition | Refers to Patient Status at PC Sign-off | ☐ Alive<br>☐ Dead |

## Appendix III: PCQC Data Collection Examples- Community Based & Inpatient Intake Forms

PCQC

### Community Based PC Visits

**PATIENT DETAILS**

| | |
|---|---|
| (1) Patient ID #: _____<br>(2) First name: _____<br>(3) Last name: _____<br>(4) Date of birth: _____/_____/_____ | (5) **Gender Identity (select one):**<br>☐ Female ☐ Male ☐ Transgender Male (FTM)<br>☐ Transgender Female (MTF) ☐ Non-Binary<br>☐ Prefer to Self-Describe: _____ ☐ Unknown ☐ Declined to Say |
| (6) **Ethnicity (select one):**<br>☐ Hispanic/Latino ☐ Non-Hispanic/Latino<br>☐ Unknown ☐ Declined to Say | (7) **Race (select all that apply):** ☐ White ☐ Black or African-American ☐ Asian<br>☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native<br>☐ Other: _____ ☐ Not Reported ☐ Declined to Say |
| (8) **Pref Lang (select one):** ☐ Eng ☐ Spanish ☐ Other Indo-Euro lang ☐ Asian & PI lang ☐ Other languages: _____ ☐ Unknown ☐ Not Reported | |

**REFERRAL INFORMATION (INITIAL VISIT ONLY)**

| | |
|---|---|
| (9) **Referral ID:** _____ | (11) **Referral Source (select one):** ☐ Emergency Dept ☐ Group Home ☐ Health Plan<br>☐ Home Health Agency ☐ Hospice ☐ Hospital Inpatient PCS ☐ Other Hospital IP Service<br>☐ Nursing Home/LTC ☐ Primary Care Practice ☐ Primary Care Practice – Ambulatory<br>☐ Primary Care Practice – Home ☐ Specialty Practice – Onco/CC<br>☐ Specialty Practice – Cardiology/HF Clinic ☐ Specialty Practice – Neurology<br>☐ Specialty Practice – Neph/Dialysis Cntr ☐ Specialty Practice – Geriatrician<br>☐ Specialty Practice – Palliative Care Clinic ☐ Other ☐ Unknown |
| (10) **Date of Referral:** __/___/___ | |
| (12) **Reason(s) for Referral (select all):**<br>☐ Symptom Management ☐ Decision Making<br>☐ Providing Support to Patient & Family<br>☐ Other ☐ Unknown | |
| (13) **Primary Diagnosis:** ☐ Cancer (solid tumor) ☐ Cancer (Heme) ☐ Cardiovascular ☐ Pulmonary ☐ Gastrointestinal ☐ Hepatology ☐ Renal<br>☐ Dementia ☐ Neurology (includes Neuromusc./non-dementia Neurodegen) ☐ Infectious ☐ Trauma ☐ Vascular ☐ Metabolic/Endocrine<br>☐ Genetic/Chromosomal ☐ Hematology (non-cancer) ☐ Prematurity/Complications related ☐ Fetal ☐ Other ☐ Unknown | |

**CONSULT (ALL VISITS)**

| | | |
|---|---|---|
| (14) **Encounter ID:** _____ (15) **Date:** _____/_____/_____ (16) **Time:** __ __ : __ __ | | |
| (17) **Manner Visit Conducted:** ☐ In-person<br>☐ Video Visit ☐ Telephone Visit ☐ Unknown | (18) **Consultation Location:** ☐ Outpatient Clinic ☐ LTC ☐ Assisted Living Facility<br>☐ Other Domiciliary ☐ Home ☐ Other ☐ Unknown | |
| (19) **Primary Caregiver (select one):** ☐ Spouse or Partner ☐ Child/Child-in-law ☐ Parent/Parent-in-law ☐ Sibling/Sibling-in-law<br>☐ Grandparent ☐ Grandchild ☐ Foster Parent ☐ Other relative ☐ Legal Guardian ☐ Non-relative (e.g., neighbor, friend) ☐ None ☐ Unknown | | |
| (20) **GOC Documented:**<br>☐ Yes ☐ No ☐ Unknown | (21) **GOC Discussed:**<br>☐ Yes ☐ No ☐ Unknown | (22) **Surrogate Decision Maker/MDPA:** ☐ Surrogate/MDPA Identified & Documented<br>☐ No Surrogate Confirmed ☐ Not Addressed ☐ Unknown ☐ N/A – Patient is Minor |
| (23) **AD Present at Start of Consult:** ☐ Yes ☐ No ☐ Unknown | (24) **AD Completed During Consult:** ☐ Yes ☐ No ☐ Unknown | |
| (25) **POLST/MOLST Present at Start of Consult:** ☐ Yes ☐ No ☐ NA - No POLST Program in state ☐ Unknown | | |
| (26) **POLST/MOLST Completed During Consult:** ☐ Yes ☐ No ☐ NA - No POLST Program in state ☐ Unknown | | |
| (27) **Resuscitation Preference:** ☐ Full ☐ DNR not DNI ☐ Other Limited DNR ☐ DNR/DNI(DNAR+AND) ☐ Unknown | | |
| (28) **PPS (circle):** 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% | (29) Patient BM in last 48 hrs: ☐ Yes ☐ No ☐ Unknown | |

(30) **Patient's assessment of their "symptom now"? (0 (no symptoms) to 10 (worst possible symptoms):**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a. Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pt Declined/Prov Unable | Pt Unable to Respond | Unknown |
| b. Nausea | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pt Declined/Prov Unable | Pt Unable to Respond | Unknown |
| c. Depression | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pt Declined/Prov Unable | Pt Unable to Respond | Unknown |
| d. Anxiety | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pt Declined/Prov Unable | Pt Unable to Respond | Unknown |
| e. Drowsiness | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pt Declined/Prov Unable | Pt Unable to Respond | Unknown |
| f. Appetite | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pt Declined/Prov Unable | Pt Unable to Respond | Unknown |
| g. Well-being | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pt Declined/Prov Unable | Pt Unable to Respond | Unknown |
| h. Shortness of breath | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pt Declined/Prov Unable | Pt Unable to Respond | Unknown |
| i. Constipation | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pt Declined/Prov Unable | Pt Unable to Respond | Unknown |
| j. Other:_____ | | | | | | | | | | | | | | |

| |
|---|
| (33) **Patient/Family screened for spiritual care needs:** ☐ No ☐ Yes ☐ Patient/Family Refused ☐ Patient/Family Unable |
| (33) **Patient/Family screened for psychosocial needs:** ☐ No ☐ Yes ☐ Patient/Family Refused ☐ Patient/Family Unable |
| (34) **Team Members involved in visit:** |

* Discharge Information on other side *

PCQC
Palliative Care Quality Collaborative

# Community Based PC Visits

## Patient Details

| Patient ID #: _____ First name: _____ Last name: _____ |
|---|

## Discharge Info

| Date of PC Sign-off: _____/_____/_____ Time: __ __:__ __ | Patient Status at PC Sign-off: ☐ Alive ☐ Died ☐ Unknown |
|---|---|

# INPATIENT - Initial Consult

## Patient Details

(1) Patient ID #: __ *(should be PHC CIN #)* __
(2) First name: _____
(3) Last name: _____
(4) Date of birth: _____/_____/_____

(5) Gender Identity (select one):
☐ Female ☐ Male ☐ Transgender Male (FTM)
☐ Transgender Female (MTF) ☐ Non-Binary
☐ Prefer to Self-Describe: _____ ☐ Unknown ☐ Declined to Say

(6) Ethnicity (select one):
☐ Hispanic/Latino ☐ Non-Hispanic/Latino
☐ Unknown ☐ Declined to Say

(7) Race (select all that apply): ☐ White ☐ Black or African-American ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native
☐ Other: _____ ☐ Not Reported ☐ Declined to Say

(8) Pref Lang (select one): ☐ Eng ☐ Spanish ☐ Other Indo-Euro lang ☐ Asian & PI lang ☐ Other languages: _____ ☐Unknown ☐Not Reported

## Hospitalization

(9) Hospitalization ID: _____ (10) Site: _____ (11) Date & Time of Admission: _____/_____/_____ __ __ : __ __

## Referral Information

(12) Referral ID: _____ (13) Date of Referral: __/___/___

(14) Referral Service (select one): ☐ General Medicine ☐ Hospital Medicine
☐ Oncology ☐Hematology ☐ Cardiology ☐ Neurology ☐ Pulmonary
☐ Critical Care ☐ Ped Critical Care ☐ Neonatal Critical Care
☐ Other Internal Medicine or Peds Subspecialty ☐ Surgical Specialties
☐ OB/GYN & Mother-Fetal ☐ Emergency Med ☐ Self ☐ Other ☐ Unknown

(15) Reason(s) for Referral (select all that apply):
☐ Symptom Management ☐ Decision Making
☐ Providing Support to Patient & Family
☐ Other ☐ Unknown

(16) Primary Diagnosis: ☐ Cancer (solid tumor) ☐ Cancer (Heme) ☐ Cardiovascular ☐ Pulmonary ☐ Gastrointestinal ☐ Hepatology ☐ Renal
☐ Dementia ☐ Neurology (includes Neuromusc./non-dementia Neurodegen) ☐ Infectious ☐ Trauma ☐ Vascular ☐ Metabolic/Endocrine
☐ Genetic/Chromosomal ☐ Hematology (non-cancer) ☐ Prematurity/Complications related ☐ Fetal ☐ Other ☐ Unknown

## Consult

(16) Encounter ID: _____ (17) Date: _____/_____/_____ (18) Time: __ __ : __ __

(19) Manner Visit Conducted: ☐ In-person
☐ Video Visit ☐ Telephone Visit ☐ Unknown

(20) Consultation Location: ☐ Hospital General Floor ☐ Hospital ICU ☐ Hospital Neonatal ICU ☐ Hospital PC Unit ☐ Emergency Dept ☐ Other ☐ Unknown

(22) Code Status (at the time the consult was requested): ☐ Full ☐ DNR, not DNI ☐ Other Limited DNR ☐ DNR/DNI(DNAR+AND) ☐ Unknown

(21) PPS at time of initial consult (circle): 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

(23) Primary Caregiver (select one): ☐ Spouse or Partner ☐ Child/Child-in-law ☐ Parent/Parent-in-law ☐ Sibling/Sibling-in-law
☐ Grandparent ☐ Grandchild ☐ Foster Parent ☐ Other relative ☐ Legal Guardian ☐ Non-relative (e.g., neighbor, friend) ☐ None ☐ Unknown

(24) GOC Documented: ☐ Yes ☐ No ☐ Unknown

(25) GOC Discussed: ☐ Yes ☐ No ☐ Unknown

(26) Surrogate Decision Maker/MDPA: ☐ Surrogate/MDPA Identified & Documented
☐ No Surrogate Confirmed ☐ Not Addressed ☐ Unknown ☐ N/A – Patient is Minor

(27) Advance Directive Completed During Consult: ☐ Yes ☐ No ☐ Unknown

(29) POLST/MOLST Completed During Consult: ☐ Yes ☐ No ☐ NA - No POLST Program in state ☐ Unknown

(30) Patient's assessment of their "symptom now"? (0 (no symptoms) to 10 (worst possible symptoms):

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| a. Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pt Declined/Prov Unable | Pt Unable to Respond | Unknown |
| b. Nausea | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pt Declined/Prov Unable | Pt Unable to Respond | Unknown |
| c. Anxiety | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pt Declined/Prov Unable | Pt Unable to Respond | Unknown |
| d. Shortness of breath | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pt Declined/Prov Unable | Pt Unable to Respond | Unknown |
| e. Constipation | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Pt Declined/Prov Unable | Pt Unable to Respond | Unknown |

(31) Patient Bowel Movement in Last 48 hrs: ☐ Yes ☐ No ☐ Unknown

(32) Patient or family screened for spiritual care needs:
☐ No ☐ Yes ☐ Patient/Family Refused
☐ Patient/Family Unable

(33) Patient or family screened for psychosocial needs:
☐ No ☐ Yes ☐ Patient/Family Refused ☐ Patient/Family Unable

(34): Names of team members involved in consult:

** Record data for subsequent visits and discharge information on other side.**

## Inpatient: Follow-up Visits & Discharge Information  Patient ID:_____

**Encounter ID:** _____ **Date:** _____/_____/_____ **Time:** __ __ : __ __

| Manner of Visit: | Consultation Location: | Primary Caregiver: | GOC Doc | SDM/MPDA | GOC discussed | AD Complete | POLST/MOLST Complete |
|---|---|---|---|---|---|---|---|
| ☐ In-person<br>☐ Video<br>☐ Telephone<br>☐ Unknown | ☐ Same as previous<br>☐ New:_____ | ☐ Same as previous<br>☐ New:_____ | ☐ Same as previous<br>☐ Yes ☐ No<br>☐ Unknown | ☐ Same as previous ☐ ID & Doc<br>☐ None confirmed ☐ Not addressed<br>☐ Unknown | ☐ Yes ☐ No<br>☐ Unknown | ☐ Yes<br>☐ No<br>☐ Unknown | ☐ Yes<br>☐ No<br>☐ Unknown |

| Pain: _____ | Nausea: _____ | Anxiety: _____ | Shortness of Breath: _____ | Constipation:_____ | BM 48 Hr: | Screen - Spiritual Care: | Screen – Psychosocial: |
|---|---|---|---|---|---|---|---|
| ☐ Pt Decline/ Prov Unable<br>☐ Pt Unable<br>☐ Unknown | ☐ Pt Decline/ Prov Unable<br>☐ Pt Unable<br>☐ Unknown | ☐ Pt Decline/ Prov Unable<br>☐ Pt Unable<br>☐ Unknown | ☐ Pt Decline/ Prov Unable<br>☐ Pt Unable<br>☐ Unknown | ☐ Pt Decline/ Prov Unable<br>☐ Pt Unable<br>☐ Unknown | ☐ Yes ☐ No<br>☐ Unknown | ☐ No ☐ Yes ☐ Patient/Family Refused<br>☐ Patient/Family Unable | ☐ No ☐ Yes<br>☐ Patient/Family Refused<br>☐ Patient/Family Unable |

**Names of team members involved in visit:**

**Encounter ID:** _____ **Date:** _____/_____/_____ **Time:** __ __ : __ __

| Manner of Visit: | Consultation Location: | Primary Caregiver: | GOC Doc | SDM/MPDA | GOC discussed | AD Complete | POLST/MOLST Complete |
|---|---|---|---|---|---|---|---|
| ☐ In-person<br>☐ Video<br>☐ Telephone<br>☐ Unknown | ☐ Same as previous<br>☐ New:_____ | ☐ Same as previous<br>☐ New:_____ | ☐ Same as previous<br>☐ Yes ☐ No<br>☐ Unknown | ☐ Same as previous ☐ ID & Doc<br>☐ None confirmed ☐ Not addressed<br>☐ Unknown | ☐ Yes ☐ No<br>☐ Unknown | ☐ Yes<br>☐ No<br>☐ Unknown | ☐ Yes<br>☐ No<br>☐ Unknown |

| Pain: _____ | Nausea: _____ | Anxiety: _____ | Shortness of Breath: _____ | Constipation:_____ | BM 48 Hr: | Screen - Spiritual Care: | Screen – Psychosocial: |
|---|---|---|---|---|---|---|---|
| ☐ Pt Decline/ Prov Unable<br>☐ Pt Unable<br>☐ Unknown | ☐ Pt Decline/ Prov Unable<br>☐ Pt Unable<br>☐ Unknown | ☐ Pt Decline/ Prov Unable<br>☐ Pt Unable<br>☐ Unknown | ☐ Pt Decline/ Prov Unable<br>☐ Pt Unable<br>☐ Unknown | ☐ Pt Decline/ Prov Unable<br>☐ Pt Unable<br>☐ Unknown | ☐ Yes ☐ No<br>☐ Unknown | ☐ No ☐ Yes ☐ Patient/Family Refused<br>☐ Patient/Family Unable | ☐ No ☐ Yes<br>☐ Patient/Family Refused<br>☐ Patient/Family Unable |

**Names of team members involved in visit:**

### Sign-off / Discharge Information

| Date of PC Sign-off: _____/_____/_____ Time: __ __:__ __ | Patient Status at PC Sign-off: ☐ Alive ☐ Died ☐ Unknown | |
|---|---|---|
| Code Status at Discharge:<br>☐ Full ☐ DNR, not DNI ☐ Other Limited DNR ☐ DNR/DNI(DNAR+AND) ☐ Unknown | AD Present at Discharge:<br>☐ Yes ☐ No ☐ Unknown | POLST/MOLST Present at Discharge:<br>☐ Yes ☐ No ☐ Unknown ☐ N/A – No POLST in state |
| Date of Hospital Discharge: _____/_____/_____ Time: __ __:__ __ | | |

## Appendix IV: PCQC Required Data Elements

| PCQC Data Sheet | First Visit | Subsequent Visits |
|---|---|---|
| **Patient Details** | | |
| CIN | 1 | 1 |
| Name | 2, 3 | 2, 3 |
| DOB | 4 | |
| Gender | 5 | |
| Ethnicity | 6 | |
| Race | 7 | |
| Preferred language | 8 | |
| | | |
| **Referral Information** | | |
| Date of Referral | 10 | |
| Referral Source | 11 | |
| Reason for referral | 12 | |
| Primary diagnosis | 13 | |
| | | |
| **Consult** | | |
| Date of Visit | 15 | 15 |
| Consultation Location | 18 | 18 |
| Primary Caregiver | 19 | 19 |
| Goals of care discussed | 21 | 21 |
| Advance Directive Present | 23 | 23 |
| Advanced Directive Completed | 24 | 24 |
| POLST Completed during Consult | 26 | 26 |
| Resuscitation Preference | 27 | 27 |
| PPS score | 28 | 28 |
| | | |
| **Patient Assessment** | | |
| Pain | 30: a | 30: a |
| Depression | 30: c | 30: c |
| Anxiety | 30: d | 30: d |
| Well-being | 30: g | 30: g |
| Shortness of Breath | 30: h | 30: h |
| | | |
| Patient/Family Screened for Spiritual Needs | 33 | 33 |
| PT/Family Screened for Psychosocial Needs | 33 | 33 |

The items listed above are the required elements to be addressed for the PCQC QIP. If no box is checked or if the answer is "unknown" then the item will not be counted as addressed.

The Patient Details and Referral Information are only required for the first consult visit.