PALLIATIVE CARE
QUALITY IMPROVEMENT PROGRAM
DETAILED SPECIFICATIONS

2022

MEASUREMENT YEAR

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PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ACCREDITED NCQA HEALTH PLAN

Table of Contents

Program Overview

Partnership HealthPlan of California (PHC) has value-based programs in the areas of primary care, hospital care, specialty care, long-term 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, Partnership HealthPlan of California (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.

Participation Requirements

In 2017, PHC started an incentive program for Palliative Care providers. This incentive program is monitored by the PHC Quality Department under the name "Palliative Care Quality Improvement Program (QIP)". All contracted Intensive Outpatient Palliative Care provider sites participating will be automatically enrolled in the Palliative Care QIP, and therefor eligible for the Palliative Care QIP payments. 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 payment will be calculated at the end of each 6 month period, and a check for the incentive payment will be mailed out four months later (i.e. Part I check mailed by October 31, and Part II check mailed by April 31).

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.

Target

Zero admissions or ED visits per member per month.

Measurement Period

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

Specifications

$200 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 $600.

Reporting

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 1) completion of the Physician's Orders for Life Sustaining Treatment (POLST) in conjunction with 2) documentation of POLST and patient encounters in the Palliative Care Quality Collaborative (PCQC) system and 3) PCQC report submission to PHC.

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, learn about best practices, and share data with PHC.

Measurement Period

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

Specifications

$200 per member enrolled in the palliative care program per month upon:

1. POLST completion and documentation using the PCQC tool.
2. Completion of at least two patient encounters per month, documented using PCQC tool.
3. Download and submission of all-member reports to palliativeQIP@partnershiphp.org on a **monthly and semiannual basis.**

Encounter data criteria and report download instructions available in Appendix II: PCQC Data Elements and Report Download Instructions.

Reporting

Palliative care sites are required to enter data elements into PCQC, and to download and send reports to palliativeQIP@partnershiphp.org on a **monthly and semiannual basis** to meet the requirements of this measure. Reports should be submitted to PHC by the 7th of each month (after the close of the month).
See Appendix II for step by step instructions to generate and submit reports.

Example

For a member enrolled on February 25, with at least two visits documented on PCQC each month but the POLST completed and entered into PCQC on April 20, the number of months meeting this measure is 3 (April, May, and June). The palliative care provider site will be eligible for a total payment for using PCQC of $600, if they are compliant with the reporting requirement.

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		EMERGENY DEPARTMENT	ED
M, MX		15	COMMUNITY HOSP OUTPATIENT DEP	ED
M, MX		61	COUNTY HOSP OUTPATTIENT DEP	ED

PCQC
Palliative Care Quality Collaborative

	CORE DATASET ITEM	ITEM CHOICES
IDENTIFIERS	Medical Record Number	
	Encounter #	
	Patient Last Name	
	Patient First Name	
	Location / Type of Visit	□ Clinic □ Home □ Telehealth □ SNF / Nursing Home
	Visit type	□ Initial consult
	Date of Visit	mm/dd/yyyy
	First Name, Last Name	
ITEM #	**ITEM**	**ITEM CHOICES**
1	Date of PC Consult Request	mm/dd/yyyy
2	Hospital Admission Date	mm/dd/yyyy
3	Age at time of visit	
4	Gender	□ Male □ Female □ Unknown
5	Patient Location at Time of Referral	□ Med/Surg Unit □ Critical Care □ Emergency Department □ Labor & Delivery □ Skilled Nursing Facility (SNF) □ Telemetry/Step Down □ Ambulatory/Outpatient □ Pediatrics □ Acute Rehab □ Other □ Unknown
6	Reasons given by referring provider for initial PC consult (check all)	□ Goals of care discussion/ Advance care planning □ Pain management □ Other symptom management □ Withdrawal of interventions □ Assess for transfer to comfort care bed or PC unit □ Comfort care □ Hospice referral/discussion □ Support for patient/family □ No reason given

ITEM #	ITEM	ITEM CHOICES
7	Primary diagnosis leading to PC consult	□ Cancer □ Hematology □ Cardiac □ Pulmonary □ Vascular □ Complex chronic conditions/failure to thrive □ Renal □ Trauma □ Congenital/chromosomal conditions □ Gastrointestinal □ Hepatic □ Infectious/immunological/HIV □ In-utero complication/condition □ Neurologic/stroke □ Dementia
8	Code Status at Time of Consult	□ Full code □ Partial code □ DNR/DNI
9	Advance directive on chart at the time of consult	□ Yes □ No
10	POLST on chart at the time of consult	□ Yes □ No
11	Patient Not Seen	□ Yes
12	Palliative Performance Scale (PPS) (Functional Status) at Time of Consult	(0% - 100%)
13	Number of Family Meetings Held	N/A (text box)
14	PC disciplines involved in consultation	□ Physician □ Certified nurse specialist □ Nurse Practitioner □ Nurse □ Social worker □ Chaplain □ Pharmacist □ Psychologist/Psychiatrist □ Physician assistant □ Other

ITEM # ITEM	ITEM	ITEM CHOICES
15	Screen for Pain	□ Positive □ Negative □ Not Screened
	Screen for Non-Pain Symptoms	□ Positive □ Negative □ Not Screened
	Screen for Psychosocial Needs	□ Positive □ Negative □ Patient/Family Declined □ Patient/Family Unable □ Not screened
	Screen for Spiritual Needs	□ Positive □ Negative □ Patient/Family Declined □ Patient/Family Unable □ Not screened
	Screen for Advance Care Planning/ Goals of Care Needs	□ Positive □ Negative □ Patient/Family Declined □ Patient/Family Unable □ Not screened
16	Intervened Pain	□ Yes
	Intervened Non-Pain Symptoms	□ Yes
	Intervened Psychosocial	□ Yes
	Intervened Spiritual care	□ Yes
	Intervened ACP/Goals of Care	□ Yes
17	Code Status Clarified	□ Yes
	Advance Directive Completed	□ Yes
	POLST Completed	□ Yes
	Avoided Admissions	□ Yes
18	Surrogate Decision Maker	□ Identified and documented. □ Addressed but unable to confirm
19	Code Status Post Consult	□ Full □ Partial □ DNI/DNR
20	Discharge/Sign-off Date	mm/dd/yyyy
21	Discharge Disposition	□ Alive □ Dead
	Discharge Location	□ Home □ Long-term acute care □ Extended care facility □ Hospital inpatient □ Non-hospital inpatient □ Residential care facility/Assisted living □ Respite/Shelter/SRO □ Other

ITEM #	ITEM	ITEM CHOICES
21	Discharge Services	□ Home Health □ Palliative Care: Clinic □ Palliative Care: Home □ Hospice □ Other □ Unknown □ No services

Monthly/Quarterly PCQC Report Download Instructions

On the PCQC Landing page, select "Data"
On the Data page, select "Download Data" on the blue task bar

1) Select the database(s) you would like to download
    a. For "Monthly Reports" select "Quick Download Patient Summary"
        i. Submitted February – January (12 per year)
    b. For "Semiannual Reports" select "Quick Download Patient Summary +POLST"
        i. Submitted in July and January (2 per year)
2) Select the member(s) you would like to include
    a. "individual members" – make sure to pick your PHC account if you have multiple
3) Select the file type
    a. Comma Separated ASCII ".cvs file"
4) Select the delivery method
    a. "send via secure e-mail"
    b. un-check "files in zip archive, protect with my user password"
5) Select the timeframe
    a. For "Monthly Report" select "Entire year(s) based on date of first visit" and include all years (2016 – Current year)
    b. For "Semiannual Report" select "Entire year(s) based on date of first visit" and include all years (2016 – Current year)

E-mail report to palliativeQIP@partnershiphp.org