

PALLIATIVE CARE QUALITY IMPROVEMENT PROGRAM DETAILED SPECIFICATIONS

2022

MEASUREMENT YEAR

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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, 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).

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.

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.

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

\$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.

Reporting

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.

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



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
		□ Non-Hispanic/Latino
		□ Unknown
		□ Declined to Say
Date of Birth		mm/dd/yyyy
Pref Lang (select one):		□ Eng
,		□ Spanish
		□ Other Indo-Euro lang
		□ Asian & PI lang
		☐ Other languages:
		☐ Unknown
		□ Not Reported
Gender Identity		□ Male
Condent ruemany		□ Female
		☐ Transgender Male (FTM)
		☐ Transgender Nate (FTM)
		□ Non-Binary
		□ Prefer to Self-Describe:
		Unknown
		_
Page (select all that apply)		□ Declined to Say
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
Hospitalization ID		/ 1 1/
Hospital Admission Date	D () () () ()	mm/dd/yyyy
Manner of Visit	Refers to Visit Type (does	□ In-person
	not refer to location of visit)	□ Video Visit
		☐ Telephone Visit
D (() () ()		□ Unknown
Date of Visit		mm/dd/yyyy
Date of Consult		mm/dd/yyyy
Referral Service (select one)	Refers to medicine services	☐ General Medicine
	patient is on at time of	☐ Hospital Medicine
	referral	□ Oncology
		□ Hematology
		□ Cardiology
		□ Neurology
		□ Pulmonary
		□ Critical Care

Ped Critical Care Neonatal Critical Care Other Internal Medicine or Peds Subspecialty Surgical Specialties OBIGYN & Mother-Fetal Emergency Med Self Other Unknown Emergency Med Self Other Unknown Emergency Dept Group Home Health Plan Health Plan Home Health Agency Hospice Hospital Inpatient PCS Other Hospital Inpatient PCS Primary Care Practice Primary Care Practice Primary Care Practice Primary Care Practice Ambulatory Primary Care Practice Primary Primary Practice Pri			
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Surgical Specialties ORGYN & Mother-Fetal Emergency Med Self Other			Other Internal Medicine or Peds
Surgical Specialties OB/GYN & Mother-Fetal Emergency Med Self Other			Subspecialty
GB/GYN & Mother-Fetal Emergency Med Self Other Unknown			
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□ Trauma □ Vascular □ Metabolic/Endocrine			
□ Vascular □ Metabolic/Endocrine			Infectious
□ Metabolic/Endocrine			Trauma
□ Metabolic/Endocrine			Vascular
		П	
(Henetic/Chromosomal			Genetic/Chromosomal

		☐ Hematology (non-cancer)
		 Prematurity/Complications
		related
		□ Fetal
		□ Other
		☐ Unknown
Manner Visit Conducted		
Mariner visit Conducted		□ In-person
		□ Video Visit
		□ Telephone Visit
		□ Unknown
Consultation Location		 Outpatient Clinic
		□ LTC
		☐ Assisted Living Facility
		□ Other Domiciliary
		☐ Home
		□ Other
000 Pi		
GOC Discussed		□ Yes
		□ No
		□ Unknown
Resuscitation Preference	Refers to Code Status	□ Full code
	(at the time consult was	□ DNR, not DNI Other Limited
	requested)	DNR
	' '	□ DNR/DNI (DNAR+AND)
Advanced Directive Completed		
Advanced Directive Completed		□ Yes
During Consult?		□ No
		□ NA - No POLST Program in state
		□ Unknown
POLST/MOLST Completed		□ Yes
During Consult?		□ No
Palliative Performance Scale		(0% - 100%)
(PPS)		(676 16676)
Screen for Pain	Refers to symptoms under	□ Nausea
	Patient's Assessment. Use	
	"Other" to enter the following	□ Drowsiness
	_	□ Appetite
	additional symptoms not listed to the right:	□ Constipation
		□ Other:
	Depression, Anxiety, Well-	
0 (being, Shortness of Breath	
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
Team Members Involved in Visit		
Discharge Disposition	Refers to Patient Status at	□ Alive
	PC Sign-off	□ Dead



Community Based PC Visits

Quality Cellaborative	Collinating based FC visits						
PATIENT DETAILS							
(1) Patient ID #: (should be PHC CIN #)	(5) Gender Identity (select one):						
(2) First name:	☐ Female ☐ Male ☐ Transgender Male (FTM)						
(3) Last name:	□ Transgender Female (MTF) □ Non-Binary						
(4) Date of birth:/	☐ Prefer to Self-Describe:☐ Unknown ☐ Declined to Say						
(6) Ethnicity (select one): (7) Race (select all to	nat apply): White Black or African-American Asian						
☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Native Hawaiian o	r Other Pacific Islander 🛘 American Indian or Alaska Native						
□ Unknown □ Declined to Say □ 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 Sour	ce (select one): Emergency Dept Group Home Health Plan						
	ency 🗆 Hospice 🗆 Hospital Inpatient PCS 🗆 Other Hospital IP Service						
(12) Reason(s) for Referral (select all):	LTC 🗆 Primary Care Practice 🗅 Primary Care Practice – Ambulatory						
☐ Symptom Management ☐ Decision Making ☐ Primary Care P	ractice – Home Specialty Practice – Onco/CC						
	ce – Cardiology/HF Clinic 🛚 Specialty Practice – Neurology						
□ Other □ Unknown □ Specialty Practi	ce – Neph/Dialysis Cntr□ Specialty Practice – Geriatrician						
☐ Specialty Practi	ce – Palliative Care Clinic 🗆 Other 🗅 Unknown						
(13) Primary Diagnosis: Cancer (solid tumor) Cancer (Heme)	□ Cardiovascular □ Pulmonary □ Gastrointestinal □ Hepatology □ Renal						
☐ Dementia ☐ Neurology (includes Neuromusc./non-dementia N	eurodegen) 🗆 Infectious 🗅 Trauma 🗅 Vascular 🗅 Metabolic/Endocrine						
☐ Genetic/Chromosomal ☐ Hematology (non-cancer) ☐ Prematu	ity/Complications related 🗆 Fetal 🗆 Other 🗅 Unknown						
CONSULT (ALL VISITS)							
(14) Encounter ID:(15) Date:/	/ (16) Time:::						
(17) Manner Visit Conducted: In-person (18) Conducted:	onsultation Location: Outpatient Clinic LTC Assisted Living Facility						
□ Video Visit □ Telephone Visit □ Unknown □ Oth	er Domiciliary 🗆 Home 🗅 Other 🗆 Unknown						
(40) Primary Caracinas (calast analy El Sanusa as Partner El Child	(child in law C Passat/Passat in law C sibling/sibling in law						
(19) Primary Caregiver (select one): Spouse or Partner Child Considerate Consideration Control of the contro							
	Legal Guardian □ Non-relative (e.g., neighbor, friend) □ None □ Unknown						
	rrogate Decision Maker/MDPA: Surrogate/MDPA Identified & Documented						
	urrogate 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 No							
(26) POLST/MOLST Completed During Consult: Yes No No No							
(27) Resuscitation Preference: Full DNR, not DNI D Other Li	mited 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 sympt							
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 g. Well-being 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 h. Shortness of breath 0 1 2 3 4 5 6 7 8	9 10 Pt Declined/Prov Unable Pt Unable to Respond Unknown 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:	Tronder to respond Official						
(33) Patient/Family screened for spiritual care needs: No Yes	s □ Patient/Family Refused □ Patient/Family Unable						
(33) Patient/Family screened for spiritual care needs. O No O Ye	· · · · · · · · · · · · · · · · · · ·						

(34) Team Members involved in visit:

^{*} Discharge Information on other side *



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

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INPATIENT - Initial Consult

PATIENT DETAILS

										-					
	(1) Patient ID #: <u>(should be PHC CIN #)</u> (5) Gender Identity (select one): (2) First name: Female Male Transgender Male (FTM)														
									_	1		_			
(3) Last name:									_	1	Fransgender Fe			-	
(4) Date of birth:											Prefer to Self-D	escribe:	🗆 Un	known 🗆 Dec	lined to Say
(6) Ethnicity (select one)):			(7)	Ra	ce (s	elect	all th	at ap	ply):	□ White □ Bla	ck or African	-American	☐ Asian	
☐ Hispanic/Latino ☐ No	n-Hispa	nic/La	atino		Nat	ive H	lawai	ian or	Oth	er Pac	cific Islander 🛚	American Inc	dian or Ala	ska Native	
□ Unknown □ Declined	d to Say				Oth	ier:_					lot 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	4														
(12) Referral ID:		(13) D	ate o	f Refe	erra	l:			(14)	Refe	rral Service (se	lect one):	General M	edicine 🗆 Hos	pital Medicine
(15) Reason(s) for Refer	ral (sele	ct all	that	apply):			\dashv	0 0	ncolo	gy 🗆 Hematolo	gy 🗆 Cardiok	ogy 🗆 Neu	rology 🗆 Puln	nonary
☐ Symptom Manageme	nt 🗆 De	cisior	ı Mak	ing					o c	ritical	Care 🗆 Ped Cr	itical Care 🗆	Neonatal (Critical Care	
☐ Providing Support to F	Patient	& Fan	nily	_					0 0	ther	nternal Medici	ne or Peds Su	bspecialty	☐ Surgical S	pecialties
□ Other □ Unknown									0 0	B/GY	N & Mother-Fe	tal 🗆 Emerge	ency Med (□ Self □ Othe	r 🗆 Unknown
(16) Primary Diagnosis:	□ Canc	er (so	lid tu	mor)	о c	ance	r (He	me) C) Car	diova	scular 🗆 Pulmo	nary 🗆 Gastr	ointestina	I □ Hepatolog	v 🗆 Renal
□ Dementia □ Neurolog															-
☐ Genetic/Chromosoma															
CONSULT			-67 (,-			-,, -						
(16) Encounter ID:			(1	7) Da	te:		_/_		/		18) Time:	:			
(19) Manner Visit Condu	ıcted: C	ln-p	erson	1			(20) Con	sulta	tion I	ocation: 🗆 Ho	spital Genera	l Floor 🗆 H	Hospital ICU	□ Hospital
□ Video Visit □ Telepho	one Visi	t 🗆 U	nkno	wn			Ne	onata	ıl ıcu	Он	ospital PC Unit	□ Emergency	Dept 🗆 O	ther 🗆 Unkno	wn
(22) Code Status (at the	time th	e con	sult 1	was re	equ	estec	i): 🗆	Full (J DN	R, no	t DNI 🗆 Other	Limited DNR	□ DNR/DN	II(DNAR+AND	□ Unknown
(21) PPS at time of initia	l consu	lt (cir	cle):	0	%	10	%	20%	309	6 4	40% 50%	60% 709	% 80%	90% 10	0%
(23) Primary Caregiver (select o	ne): (□ Spc	use o	r Pa	artne	r 🗆 (child/	Child	-in-la	w 🗆 Parent/Pa	rent-in-law 🗆	Sibling/Sil	bling-in-law	
☐ Grandparent ☐ Grand		-	-										_	_	Unknown
(24) GOC Documented:	_	_		cusse	_		_	_	_		ision Maker/M				
☐ Yes ☐ No ☐ Unknown		Yes C] No	O Uni	kno	wn	l * '		-		nfirmed 🗆 Not		_		
(27) Advance Directive (omple	ted D	uring	Cons	ult:	□ Ye	s 🗆 I	No 🗆	Unkn	own					
(29) POLST/MOLST Com	pleted	Durin	g Cor	sult:	□ Y	es 🗆	No C	J NA	- No	POLS	r Program in sta	ate 🗆 Unkno	wn		
,															
(30) Patient's assessmen	nt of th	eir "s	ympt	om no	w"	? (0 (no sy	mpto	ms)	to 10	(worst possible	e symptoms):	:		
a. <mark>Pain</mark>	0 1	. 2	3	4	5	6	7	8	9	10	Pt Declined/P	rov Unable	Pt Unabl	le to Respond	Unknown
b. Nausea	0 1	. 2	3	4	5	6	7	8	9	10	Pt Declined/P			le to Respond	Unknown
c. Anxiety	0 1	-	3	4	5	6	7	8	9	10	Pt Declined/P			le to Respond	Unknown
d. Shortness of breath	0 1	-	3	4	5	6	7	8	9	10	Pt Declined/P			le to Respond	Unknown
e. Constipation	0 1	. 2	3	4	5	6	7	8	9	10	Pt Declined/P	rov Unable	Pt Unabl	le to Respond	Unknown
(31) Patient Bowel Mov		_					_			_					
(32) Patient or family scr				al care	e ne	eds:	l - '				ily screened fo				
□ No □ Yes □ Patient/F		efuse	d				01	No 🗆	Yes C) Pati	ent/Family Ref	used 🗆 Patie	ent/Family	Unable	
☐ Patient/Family Unable															
(34): Names of team me	mbers	involv	red in	cons	ult:										

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



Date of Hospital Discharge: ____/____/ ____Time: ___:___

INPATIENT - Initial Consult

Inpatient: I	Follow-up Visits	s & Discharge Ir	nformat	tion Patient ID:				
Encounter ID:		Date: /	,	_ Time::				
Manner of Visit:	Consultation Location:		Primary Caregiver: GOO		SDM/MPDA	GOC discussed	AD Complete	POLST/MOLST Complete
☐ In-person	☐ Same as previou	s 🗆 Same as pr	evious	☐ Same as previous	☐ Same as previous ☐ ID & Doc	□ Yes □ No	□Yes	□Yes
□ Video	□ New:			□ Yes □ No	☐ None confirmed ☐ Not addressed	Unknown	□No	□No
☐ Telephone				□ Unknown	□ Unknown		Unknown	Unknown
□ Unknown								
Pain:	Nausea:	Anxiety:	Shortne	ss of Breath:	Constipation:	BM 48 Hr:	Screen - Spiritual Care:	Screen – Psychosocial:
☐ Pt Decline/	☐ Pt Decline/ Prov	☐ Pt Decline/ Prov	☐ Pt Decl	ine/ Prov Unable	☐ Pt Decline/ Prov Unable	□Yes□No	□ No □ Yes □	□ No □ Yes
Prov Unable	Unable	Unable	☐ Pt Una	ble	☐ Pt Unable	□ Unknown	Patient/Family Refused	☐ Patient/Family Refused
☐ Pt Unable	□ Pt Unable	☐ Pt Unable	□ Unkno	wn	□ Unknown		☐ Patient/Family Unable	☐ Patient/Family Unable
Unknown	□Unknown	□Unknown						a radicity annual character
Names of tean	n members involve	d in visit:						
Encounter ID:		Date: /	,	::				
Manner of	Consultation		Primary Caregiver:		constants.	GOC	A D. Commoloto	
		Primary Car	egiver.	GOC Doc	SDM/MPDA		AD Complete	POLST/MOLST
Visit:	Location:				-	discussed		Complete
☐ In-person	Location:	is Same as pr	evious	☐ Same as previous	☐ Same as previous ☐ ID & Doc	discussed □ Yes □ No	□ Yes	Complete O Yes
☐ In-person ☐ Video	Location:	is Same as pr	evious	☐ Same as previous ☐ Yes ☐ No	☐ Same as previous ☐ ID & Doc ☐ None confirmed ☐ Not addressed	discussed	□ Yes	Complete Yes No
☐ In-person ☐ Video ☐ Telephone	Location:	is Same as pr	evious	☐ Same as previous	☐ Same as previous ☐ ID & Doc	discussed □ Yes □ No	□ Yes	Complete O Yes
☐ In-person ☐ Video	Location:	Same as pr	evious	☐ Same as previous ☐ Yes ☐ No ☐ Unknown	□ Same as previous □ ID & Doc □ None confirmed □ Not addressed □ Unknown	discussed □ Yes □ No	Yes No Unknown	Complete Yes No Unknown
☐ In-person ☐ Video ☐ Telephone	Location:	is Same as pr	evious	☐ Same as previous ☐ Yes ☐ No	☐ Same as previous ☐ ID & Doc ☐ None confirmed ☐ Not addressed	discussed □ Yes □ No	□ Yes	Complete Yes No
□ In-person □ Video □ Telephone □ Unknown Pain: □ Pt Decline/	Location: Same as previou New: Nausea: Pt Decline/ Prov	Same as pr New: Anxiety:	Shortne	☐ Same as previous ☐ Yes ☐ No ☐ Unknown	□ Same as previous □ ID & Doc □ None confirmed □ Not addressed □ Unknown	discussed Yes No Unknown	Yes No Unknown	Complete Yes No Unknown
□ In-person □ Video □ Telephone □ Unknown Pain: □ Pt Decline/ Prov Unable	Location: Same as previou New: Nausea: Pt Decline/ Prov Unable	Anxiety:	Shortne	Same as previous Yes No Unknown Ss of Breath:	□ Same as previous □ ID & Doc □ None confirmed □ Not addressed □ Unknown Constipation: □ Pt Decline/ Prov Unable □ Pt Unable	discussed Yes No Unknown BM 48 Hr:	□ Yes □ No □ Unknown Screen - Spiritual Care:	Complete Yes No Unknown Screen – Psychosocial:
□ In-person □ Video □ Telephone □ Unknown Pain: □ Pt Decline/ Prov Unable □ Pt Unable	Location: Same as previou New: Nausea: Pt Decline/ Prov Unable Pt Unable	Anxiety: Pt Decline/ Prov Unable Pt Unable	Shortne	Same as previous Yes No Unknown Ss of Breath:	□ Same as previous □ ID & Doc □ None confirmed □ Not addressed □ Unknown Constipation: □ Pt Decline/ Prov Unable	discussed Yes No Unknown BM 48 Hr:	□ Yes □ No □ Unknown Screen - Spiritual Care: □ No □ Yes □	Complete Yes No Unknown Screen – Psychosocial: No Yes
□ In-person □ Video □ Telephone □ Unknown Pain: □ Pt Decline/ Prov Unable □ Pt Unable □ Unknown	Location: Same as previou New: Nausea: Pt Decline/ Prov Unable Pt Unable Unknown	Anxiety: Pt Decline/ Prov Unable Pt Unable Unknown	Shortne	Same as previous Yes No Unknown Ss of Breath:	□ Same as previous □ ID & Doc □ None confirmed □ Not addressed □ Unknown Constipation: □ Pt Decline/ Prov Unable □ Pt Unable	discussed Yes No Unknown BM 48 Hr:	□ Yes □ No □ Unknown Screen - Spiritual Care: □ No □ Yes □ Patient/Family Refused	Complete Yes No Unknown Screen – Psychosocial: No Yes Patient/Family Refused
□ In-person □ Video □ Telephone □ Unknown Pain: □ Pt Decline/ Prov Unable □ Pt Unable □ Unknown	Location: Same as previou New: Nausea: Pt Decline/ Prov Unable Pt Unable	Anxiety: Pt Decline/ Prov Unable Pt Unable Unknown	Shortne	Same as previous Yes No Unknown Ss of Breath:	□ Same as previous □ ID & Doc □ None confirmed □ Not addressed □ Unknown Constipation: □ Pt Decline/ Prov Unable □ Pt Unable	discussed Yes No Unknown BM 48 Hr:	□ Yes □ No □ Unknown Screen - Spiritual Care: □ No □ Yes □ Patient/Family Refused	Complete Yes No Unknown Screen – Psychosocial: No Yes Patient/Family Refused
□ In-person □ Video □ Telephone □ Unknown Pain: □ Pt Decline/ Prov Unable □ Pt Unable □ Unknown Names of team	Location: Same as previou New: Nausea: Pt Decline/ Prov Unable Pt Unable Unknown	Anxiety: Pt Decline/ Prov Unable Pt Unable Unknown d in visit:	Shortne	Same as previous Yes No Unknown Ss of Breath:	□ Same as previous □ ID & Doc □ None confirmed □ Not addressed □ Unknown Constipation: □ Pt Decline/ Prov Unable □ Pt Unable	discussed Yes No Unknown BM 48 Hr:	□ Yes □ No □ Unknown Screen - Spiritual Care: □ No □ Yes □ Patient/Family Refused	Complete Yes No Unknown Screen – Psychosocial: No Yes Patient/Family Refused
In-person Video Telephone Unknown Pain: Pt Decline/ Prov Unable Pt Unable Unknown Names of team	Location: Same as previou New: Nausea: Pt Decline/ Prov Unable Pt Unable Unknown n members involved	Anxiety: Pt Decline/ Prov Unable Pt Unable Unknown d in visit:	Shortne	Same as previous Yes No Unknown ss of Breath: ine/ Prov Unable ble wn	□ Same as previous □ ID & Doc □ None confirmed □ Not addressed □ Unknown Constipation: □ Pt Decline/ Prov Unable □ Pt Unable	discussed Yes No Unknown BM 48 Hr: Yes No Unknown	□ Yes □ No □ Unknown Screen - Spiritual Care: □ No □ Yes □ Patient/Family Refused	Complete Yes No Unknown Screen – Psychosocial: No Yes Patient/Family Refused
In-person Video Telephone Unknown Pain: Pt Decline/ Prov Unable Pt Unable Unknown Names of team	Location: Same as previou New: Nausea: Pt Decline/ Prov Unable Pt Unable Unknown n members involved	Anxiety: Pt Decline/ Prov Unable Pt Unable Unknown d in visit:	Shortne Pt Decl Pt Una	Same as previous Yes No Unknown ss of Breath: ine/ Prov Unable ble wn	□ Same as previous □ ID & Doc □ None confirmed □ Not addressed □ Unknown Constipation: □ Pt Decline/ Prov Unable □ Pt Unable □ Unknown	discussed Yes No Unknown BM 48 Hr: Yes No Unknown	□ Yes □ No □ Unknown Screen - Spiritual Care: □ No □ Yes □ Patient/Family Refused	Complete Yes No Unknown Screen – Psychosocial: No Yes Patient/Family Refused Patient/Family Unable

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