Palliative Care Quality Improvement Program (QIP)

2017-18 Measurement Specifications

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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 will likely be on or after January 1, 2018. However, Partnership’s board of directors has approved expansion of the pilot program, based on the favorable clinical and financial outcomes of our pilot program.

The expanded pilot implementation began on July 1, 2017, and includes incentives used in the pilot. The incentives in the expanded pilot will be monitored by the PHC Quality Department under the name “Palliative Care Quality Improvement Program (QIP)” consistent with terminology used for other value-based payment programs at PHC.

Participation Requirements
All contracted Intensive Outpatient Palliative Care provider sites participating in the expanded pilot will be automatically enrolled in the Palliative Care QIP, and therefore 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 measurement set is approved for the full 2017-18 measurement year, which runs from July 1, 2017 to June 30, 2018. Within the measurement year, there are two six-month measurement periods, at the end of each performance is evaluated. Payment will be disbursed four months after the end of the measurement periods to allow time for payment calculation. This six-month – as opposed to annual – payment schedule is to ensure provider engagement during the transition from the PHC pilot to the implementation of the Medi-Cal benefit. To illustrate, for the measurement year 2017-18, there are two measurement periods:

- Measurement Period I: July 1, 2017 – December 31, 2017, with payment date on April 30, 2018
- Measurement Period II: January 1, 2018 – June 30, 2018, with payment date on October 31, 2018
Measure I. Avoiding Hospitalization and Emergency Room Visits

**Description**
The number of members enrolled in the Intensive Outpatient Palliative Care program who did not get admitted to the hospital or emergency department.

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 admission or ED visit per member per month.

**Measurement Period**
Monthly, from July 1, 2017 to June 30, 2018.

**Specifications**
$200 per member enrolled in the palliative care program per month only if there are no hospital admissions or ED visits that month.

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

**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 in the sixth month of the measurement period (i.e. December and June, prior to payment) to help providers monitor performance. Providers can also request member-level reports of admissions and ED visits on an ad hoc basis.
Measure II: Completion of POLST and use of Palliative Care Quality Network (PCQN) 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 Network System (PCQN).

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 do want and avoid those treatments that they do not want. The PCQN 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 contribute data, learn about best practices, and capture the key components of care delivery.

### Measurement Period
Monthly, from July 1, 2017 to June 30, 2018.

### Specifications
$200 per member enrolled in the palliative care program per month upon completion of a POLST and documentation using the PCQN tool.

At least two entries reflecting patient contact into the PCQN tool must be submitted. Encounters must include minimum data elements exhibited in Appendix II: PCQN Data Elements.

### Reporting
Palliative care sites are required to enter data elements in PCQN. Separate reporting by palliative care provider sites to PHC is not required. PHC will send preliminary reports in the sixth month of the measurement period (i.e. December and June, prior to payment) to help providers monitor performance. Providers can also request member-level reports on this measure on an ad hoc basis.

### Example
For a member enrolled on February 25, with at least two visits documented on PCQN each month but the POLST completed and entered into PCQN 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 PCQN of $600.
### Appendix I: Palliative Care Quality Network Data Elements

#### CORE DATASET ITEM

<table>
<thead>
<tr>
<th>Item</th>
<th>Choices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Location / Type of Visit</td>
<td>Clinic, Home, Telehealth, SNF/Nursing Home</td>
</tr>
<tr>
<td>Visit type</td>
<td>Initial consult</td>
</tr>
<tr>
<td>Date of Visit</td>
<td>YYYY-MM-DD</td>
</tr>
<tr>
<td>Medical Record Number</td>
<td></td>
</tr>
<tr>
<td>Encounter #</td>
<td></td>
</tr>
<tr>
<td>First Name, Last Name</td>
<td></td>
</tr>
</tbody>
</table>

#### PATIENT / DEMOGRAPHIC INFO

<table>
<thead>
<tr>
<th>Item</th>
<th>Choices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Male, Female, Unknown</td>
</tr>
<tr>
<td>Age at time of visit</td>
<td></td>
</tr>
<tr>
<td>Primary diagnosis leading to PC consult</td>
<td>Cancer (solid tumor), Cardiovascular, Pulmonary, Vascular, Complex chronic conditions/failure to thrive, Renal, Trauma, Congenital/chromosomal, Gastrointestinal, Hepatic, Hematology, Infectious/ immunological/HIV, In-utero complication/condition, Neurologic/stroke/ neurodegenerative, Dementia, Other: ____________________________</td>
</tr>
<tr>
<td>Reasons given by referring provider for initial PC consult (check all)</td>
<td>Goals of care discussion/Advance Care Planning, Pain management, Other symptom management, Withdrawal of interventions, Comfort Care, Hospice referral/discussion, No reason given, Support for patient/family, Other: ____________________________</td>
</tr>
</tbody>
</table>
Referral Source |  □ Inpatient Palliative Care  

<table>
<thead>
<tr>
<th>CORE DATASET ITEM</th>
<th>ITEM CHOICES</th>
</tr>
</thead>
</table>
| □ Other Inpatient Team  
| □ ED  
| □ Primary care  
| □ Outpatient Palliative Care  
| □ Other Outpatient Specialist  
| □ Self  
| □ Other: ____________________  
| □ Unknown  

Advance directive on chart at the time of consult | □ Yes  
| □ No  

POLST on chart at the time of consult | □ Yes  
| □ No  

Palliative Performance Scale (PPS) at time of consult | (0% to 100%)  

**ESAS Measures**  
Pain | 0-10 scale (77= pt unable)  
Tiredness | 0-10 scale (77= pt unable)  
Nausea | 0-10 scale (77= pt unable)  
Depression | 0-10 scale (77= pt unable)  
Anxiety | 0-10 scale (77= pt unable)  
Drowsiness | 0-10 scale (77= pt unable)  
Appetite | 0-10 scale (77= pt unable)  
Well-being | 0-10 scale (77= pt unable)  
Short of breath | 0-10 scale (77= pt unable)  
Constipation | 0-10 scale (77= pt unable)  
Composite score | Auto calculated  

Are you at peace? | □ Not at all  
| □ A little bit  
| □ A moderate amount  
| □ Quite a bit  
| □ Completely  
| □ Patient unable to rate  

How much distress have you been experiencing the past week including today? | 0-10 scale (Distress thermometer) (77=pt unable to rate)  

How would you rate your overall quality of life? | □ Very poor  
| □ Poor  
| □ Fair  
| □ Good  
| □ Excellent  
| □ Patient unable to rate
| PRO C E S S E S/ | PC team members involved in visit | □ Physician  
 □ Clinical Nurse Specialist  
 □ Nurse Practitioner |
| --- | --- | --- |
| CORE DATASET ITEM | ITEM CHOICES | □ Physician Assistant  
 □ Nurse  
 □ Social Worker  
 □ Chaplain  
 □ Pharmacist  
 □ Psychologist/Psychiatrist  
 □ Other |
| Screening Status | Pain | □ Negative  
 □ Positive |
| Non-Pain Symptoms | □ Negative  
 □ Positive |
| Psychosocial needs | □ Negative  
 □ Positive  
 □ Patient/Family declined  
 □ Patient/Family unable to be screened |
| Spiritual needs | □ Negative  
 □ Positive  
 □ Patient/Family declined  
 □ Patient/Family unable to be screened |
| Advance care planning/Goals of care needs | □ Negative  
 □ Positive  
 □ Patient/Family declined  
 □ Patient/Family unable to be screened |
| Intervention | Pain | □ Yes |
| Non-Pain Symptoms | □ Yes |
| Psychosocial needs | □ Yes |
| Spiritual needs | □ Yes |
| Advance care planning/Goals of care needs | □ Yes |
| Other outcomes | Preference for life-sustaining treatment clarified | □ Yes |
| Advance directive completed | □ Yes |
| POLST completed | □ Yes |
| Preference for life-sustaining treatment | □ Full code  
 □ Partial code  
 □ DNR/DNI  
 □ Unknown (default if no code status In system) |
| Surrogate decision maker identified | □ Surrogate decision maker identified and documented  
 |  | □ Attempted to identify but not confirmed  
 |  | □ Not addressed  
| Support for family/caregiver provided | □ Yes  
 |  | □ No caregiver present  

<table>
<thead>
<tr>
<th>CORE DATASET ITEM</th>
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</tr>
</thead>
</table>
| Services referred to | □ Hospice  
 |  | □ Home Health  
 |  | □ Home-Based Palliative Care  
 |  | □ Admission to Hospital  
 |  | □ Emergency Department  
 |  | □ Community Services  
 |  | □ Physical Therapy  
 |  | □ Integrative Therapies  
 |  | □ Social Work  
 |  | □ Mental Health  