

# PALLIATIVE CARE QUALITY IMPROVEMENT PROGRAM DETAILED SPECIFICATIONS

2023

**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, 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, 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 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 October 31, and Part II check mailed by April 31).

Meas	surement Period	Payment Distribution
Part I	January - June	October 31
Part II	July - December	April 30

### 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**

\$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 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 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 (2) patient encounters per month, documented using PCQC tool.

Example: For a member enrolled on February 25, with at least two (2) 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.

### **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 <a href="mailto:info@palliativequality.org">info@palliativequality.org</a>.

# 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 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
Troi Zang (coloct ono).		□ Spanish
		□ Other Indo-Euro lang
		☐ Asian & PI lang
		☐ Other languages:
		☐ Unknown
		= N ( D ) ( )
Gender Identity		
Gender identity		
		☐ Female
		☐ Transgender Male (FTM)
		☐ Transgender Female (MTF)
		□ Non-Binary
		□ Prefer to Self-Describe:
		□ Unknown
		□ 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		
Hospital Admission Date		mm/dd/yyyy
Manner of Visit	Refers to Visit Type (does	□ In-person
	not refer to location of visit)	□ Video Visit
		□ Telephone Visit
		□ 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
L	<u> </u>	1

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

	1	
		☐ Hematology (non-cancer)
		<ul> <li>Prematurity/Complications</li> </ul>
		related
		□ Fetal
		□ Other
		□ Unknown
Manner Visit Conducted		☐ In-person
Warmer Visit Correducted		1
		☐ Telephone Visit
		□ Unknown
Consultation Location		☐ Outpatient Clinic
		□ LTC
		☐ Assisted Living Facility
		□ Other Domiciliary
		□ Home
		□ Other
		☐ Unknown
GOC Discussed		
GOC Discussed		
		□ No
		☐ Unknown
Resuscitation Preference	Refers to Code Status	□ Full code
	(at the time consult was	<ul> <li>DNR, not DNI Other Limited</li> </ul>
	requested)	DNR
		□ DNR/DNI (DNAR+AND)
		□ Unknown `
Advanced Directive Completed		□ Yes
During Consult?		
During Consult:		
		□ NA - No POLST Program in state
DOLOT/MOLOT O		Unknown
POLST/MOLST Completed		□ Yes
During Consult?		□ No
Palliative Performance Scale (PPS)		(0% - 100%)
Screen for Pain	Refers to symptoms under	□ Nausea
	Patient's Assessment. Use	□ Drowsiness
	"Other" to enter the following	□ Appetite
	additional symptoms not	☐ Constipation
	listed to the right:	☐ Other:
	Depression, Anxiety, Well-	
	being, Shortness of Breath	
Screen for Psychosocial Needs	ang, ensured of Broad	□ 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
Disorial ge Disposition		
	PC Sign-off	□ Dead



### Community Based PC Visits

4								community base	a i e violes		
PATIENT DETAILS											
(1) Patient ID #:(should be PHC C	IN#)						(5)	Gender Identity (select one)	:		
(2) First name:						_	01	□ Female □ Male □ Transgender Male (FTM)			
(3) Last name:						_	01	☐ Transgender Female (MTF) ☐ Non-Binary			
(4) Date of birth:/_	— .							Prefer to Self-Describe:	Unknown 🗆 Declin	ed to Say	
(6) Ethnicity (select one):		(7) Rac	e (se	lect a	all tha	at ap	ply):	□ White □ Black or African-A	American 🗆 Asian		
☐ Hispanic/Latino ☐ Non-Hispanic/	Latino	□ Nati	ve Ha	awaii	an or	Oth	er Pac	cific Islander 🛭 American Indi	an or Alaska Native		
□ Unknown □ Declined to Say		□ Othe	er:				ot Reported Declined to 9	iay			
(8) Pref Lang (select one): Eng Spanish Other Indo-Euro lang Asian & PI lang Other languages:OUnknown ONot Reported											
REFERRAL INFORMATION (INITIAL	Visit on	ILY)									
(9) Referral ID:		(11)	Refe	rral S	ourc	e (se	lect o	ne): 🗆 Emergency Dept 🗅 Gr	oup Home 🗆 Health Plan	1	
(10) Date of Referral://		□но	me I	Healt	h Age	ncy	□ Но	spice 🗆 Hospital Inpatient PC	S 🗆 Other Hospital IP Ser	vice	
(12) Reason(s) for Referral (select a	II):	□ N	ursin	g Ho	me/L	тс 🗆	Prim	ary Care Practice 🗆 Primary (	Care Practice – Ambulato	ry	
☐ Symptom Management ☐ Decision		g 🗆 Þi	imar	y Car	e Pra	ctice	- Ho	me 🗆 Specialty Practice – On	co/CC		
☐ Providing Support to Patient & Fa	mily	□ Sp	ecia	lty Pr	actic	e – C	ardio	logy/HF Clinic 🗆 Specialty Pra	actice – Neurology		
□ Other □ Unknown		□ Sp	ecia	lty Pr	actic	e – N	eph/	Dialysis Cntr□ Specialty Pract	ice – Geriatrician		
		□ sp	ecia	lty Pr	actic	e – P	alliati	ve Care Clinic 🗆 Other 🗅 Unk	nown		
(13) Primary Diagnosis:   Cancer (s	olid tumo	or) 🗆 Ca	ncer	(Hen	ne) 🗆	Can	diova	scular  Pulmonary  Gastro	intestinal 🗆 Hepatology	□ Renal	
☐ Dementia ☐ Neurology (includes	Neuromu	usc./nor	-den	nenti	a Net	ırode	egen)	□ Infectious □ Trauma □ Va	scular   Metabolic/Endo	crine	
☐ Genetic/Chromosomal ☐ Hemato	ology (no	n-cance	r) 🗆 I	Prem	aturi	ty/Co	ompli	cations related 🗆 Fetal 🗆 Oth	er 🗆 Unknown		
CONSULT (ALL VISITS)											
(14) Encounter ID:	(15)	Date: _						16) Time::			
(17) Manner Visit Conducted:   In-	person			(18	3) Cor	nsult	ation	Location: Outpatient Clinic	□ LTC □ Assisted Living	Facility	
□ Video Visit □ Telephone Visit □	Unknown	1			Othe	r Dor	micilia	ary 🗆 Home 🗅 Other 🗅 Unkno	own		
(19) Primary Caregiver (select one):	□ Snous	e or Da	tner	Пс	hild/c	child	.in.la	v □ Parent/Parent.in.law □ S	ihling/Sihling.in-law		
☐ Grandparent ☐ Grandchild ☐ Fos										Unknown	
	OC Discu		iei ie	_	_	_					
1	O No O		/n	l -				cision Maker/MDPA:   Surro  Onfirmed   Not Addressed			
				_	WO 50	irrog	ate C	(24) AD Completed During			
(23) AD Present at Start of Consult:					1 NIA	No	nois			Unknown	
(25) POLST/MOLST Present at Start		_									
(26) POLST/MOLST Completed Duri	_										
(27) Resuscitation Preference:   Fu	II DNF	R, not Di	NI D	Othe	er Lim	nited	DNR	□ DNR/DNI(DNAR+AND) □ U	nknown		
(28) PPS (circle): 0% 10% 20% 3	0% 40%	6 50%	609	6 70	% 8	0% 9	90% :	100% (29) Patient BM in las	t 48 hrs: 🗆 Yes 🗆 No 🗅 U	Inknown	
(30) Patient's assessment of their "	sympton	now"?	(0 (n	no syi	mpto	ms) 1	to 10	(worst possible symptoms):			
a. Pain 0 1 2	3 4	4 5	6	7	8	9	10	Pt Declined/Prov Unable	Pt Unable to Respond	Unknown	
b. Nausea 0 1 2	3 4	4 5	6	7	8	9	10	Pt Declined/Prov Unable	Pt Unable to Respond	Unknown	
c. Depression 0 1 2	3 4	4 5	6	7	8	9	10	Pt Declined/Prov Unable	Pt Unable to Respond	Unknown	
d. Anxiety 0 1 2	-	4 5	6	7	8	9	10	Pt Declined/Prov Unable	Pt Unable to Respond	Unknown	
e. Drowsiness 0 1 2	-	4 5	6	7	8	9	10	Pt Declined/Prov Unable	Pt Unable to Respond	Unknown	
f. Appetite 0 1 2	-	4 5	6	7	8	9	10	Pt Declined/Prov Unable	Pt Unable to Respond	Unknown	
g. Well-being 0 1 2	-	4 5	6	7	8	9	10	Pt Declined/Prov Unable	Pt Unable to Respond	Unknown	
h. Shortness of breath 0 1 2	-	4 5	6	7	8	9	10	Pt Declined/Prov Unable	Pt Unable to Respond	Unknown	
i. Constipation 0 1 2	3 4	4 5	6	7	8	9	10	Pt Declined/Prov Unable	Pt Unable to Respond	Unknown	
j. Other:			<u> </u>				<u>.</u>		7		
(33) Patient/Family screened for sp			_						•		
(33) Patient/Family screened for ps		al need	s: 0	No 🗆	Yes	□ Pa	tient	/Family Refused D Patient/Fa	amily Unable		
(34) Team Members involved in vis	rt:										

<sup>\*</sup> 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 #: (shou	ld be P	HC CII	V #)							(5)	Gender Identity (select on	e):	
(2) First name:										01	Female 🗆 Male 🗆 Transgen	der Male (FTM)	
(3) Last name:									_	01	Fransgender Female (MTF)	□ Non-Binary	
(4) Date of birth:	/									0	Prefer to Self-Describe:	□ Unknown □ Decl	ined to Say
(6) Ethnicity (select one)	):			(7)	Ra	ce (s	elect	all th	nat ap	ply):	□ White □ Black or African	-American 🗆 Asian	
☐ Hispanic/Latino ☐ No	n-Hispa	nic/L	atino		Nat	ive H	lawaii	ian o	r Oth	er Pac	rific Islander 🛮 American In	dian or Alaska Native	
□ Unknown □ Declined	d to Say				Oth	er:_					ot 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	1												
(12) Referral ID:		(13) 0	ate o	f Refe	erra	l:/		_	(14)	Refe	rral Service (select one): 🗆	General Medicine 🗆 Hosp	oital Medicine
(15) Reason(s) for Refer	ral (sel	ect all	that	apply	):				<b>0</b> 0	ncolo	gy 🗆 Hematology 🗅 Cardiol	ogy 🗆 Neurology 🗅 Pulm	onary
☐ Symptom Managemer	nt 🗆 De	cisior	ı Mak	ing					ОС	ritical	Care 🗆 Ped Critical Care 🗅	Neonatal Critical Care	
☐ Providing Support to F	atient	& Fan	nily						<b>0</b> 0	ther	nternal Medicine or Peds Su	ubspecialty 🛮 Surgical Sp	pecialties
☐ Other ☐ Unknown									<b>0</b> 0	B/GY	N & Mother-Fetal 🗆 Emerge	ency Med 🗆 Self 🗅 Other	□ Unknown
(16) Primary Diagnosis:	□ Canc	er (so	lid tu	mor)	ОС	ance	r (Hei	me)	□ Car	diova	scular  Pulmonary Gast	rointestinal 🗆 Hepatolog	y □ Renal
☐ Dementia ☐ Neurolog	y (inclu	des N	leuro	musc.	/no	n-de	ment	ia Ne	eurode	egen)	☐ Infectious ☐ Trauma ☐ \	/ascular   Metabolic/End	locrine
☐ Genetic/Chromosoma	l 🗆 He	matol	ogy (r	non-ca	ance	er) 🗆	Pren	natur	rity/Co	ompli	cations related 🗆 Fetal 🗅 O	ther D Unknown	
Consult													
(16) Encounter ID:			(1	7) <mark>Dal</mark>	te:		_/_		/	(	18) Time::		
(19) Manner Visit Condu	icted: (	ln-p	erson	1			(20	) Cor	nsulta	tion L	ocation:	l Floor D Hospital ICU	3 Hospital
□ Video Visit □ Telepho	ne Visi	t 🗆 U	nkno	wn			Ne	onat	al ICU	□н	ospital PC Unit 🗆 Emergency	y Dept 🗆 Other 🗆 Unknow	wn
(22) Code Status (at the	time th	ie cor	sult	was re	eque	ested	i): 🗆	Full	□ DN	R, not	DNI Other Limited DNR	□ DNR/DNI(DNAR+AND)	□ Unknown
(21) PPS at time of initia	l consu	lt (cir	cle):	09	%	109	6	20%	309	6 4	10% 50% 60% 70	% 80% 90% 100	9%
(23) Primary Caregiver (	select o	ne):	Spo	use o	r Pa	artne	r 🗆 (	hild	/Child	-in-la	w 🗆 Parent/Parent-in-law 🗅	3 Sibling/Sibling-in-law	
		-	-								dian 🗆 Non-relative (e.g., ne		Unknown
(24) GOC Documented:				cusse	_			_	_		ision Maker/MDPA:   Surre		
□ Yes □ No □ Unknown		Yes C	] No	🗆 Unk	cno	wn					nfirmed  Not Addressed	_	
(27 <mark>) Advance Directive C</mark>	omple	ted D	uring	Consi	ult:	□ Ye	s 🗆 N	lo 🗆	Unkn	own			
(29) POLST/MOLST Com	pleted	Durin	g Cor	sult:	□ Y	es 🗆	No C	NA	- No	POLST	Program in state 🛮 Unkno	wn	
(30) Patient's assessmen	nt of th	eir "s	mpt	om no	w"	? (0 (	no sy	mpt	oms)	to 10	(worst possible symptoms)	:	
a. <mark>Pain</mark>	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 Move	ement	in Las	t 48 h	rs: 🗆	Yes	O N	o 🗆 t	Jnkn	own				
(32) Patient or family scr	eened	for <mark>sp</mark>	iritua	l care	ne	eds:	(33)	Pati	ient o	r fam	ily screened for <mark>psychosoci</mark>	al needs:	
□ No □ Yes □ Patient/F	amily R	efuse	d					lo 🗆	Yes C	) Pati	ent/Family Refused 🛭 Pati	ent/Family Unable	
☐ Patient/Family Unable													
(2.4), \$1													

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<sup>\*\*</sup> 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	ion Patient ID:				
Encounter ID:		Date: /	,	Time: :				
Manner of	Consultation	Primary Car		GOC Doc	SDM/MPDA	GOC	AD Complete	POLST/MOLST
Visit:	Location:		-8	300200	25, 24	discussed	no complete	Complete
☐ In-person	☐ Same as previou	is Same as pr	evious	☐ Same as previous	☐ Same as previous ☐ ID & Doc	☐ Yes ☐ No	□ Yes	□ Yes
□ Video	□ New:	□ 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 Dedi	ine/ Prov Unable	☐ Pt Decline/ Prov Unable	□ Yes □ No	□ No □ Yes □	□ No □ Yes
Prov Unable	Unable	Unable	☐ Pt Unab		☐ Pt Unable	□ Unknown	Patient/Family Refused	☐ Patient/Family Refused
☐ Pt Unable ☐ Unknown	□ Pt Unable □ Unknown	□ Pt Unable □ Unknown	□ Unknov	wn	Unknown		☐ Patient/Family Unable	☐ Patient/Family Unable
	n members involve							
ivallies of teal	ii iiieiiibeis iiivoive	a III VISIC.						
Encounter ID:		Date: /	,	Time				
Encounter ID				_ Time::				
Manner of	Consultation		rimary Caregiver: G					
		Primary Car	egiver:	GOC Doc	SDM/MPDA	GOC	AD Complete	POLST/MOLST
Visit:	Location:					discussed		Complete
Visit:	Location:	is Same as pro	evious	☐ Same as previous	☐ Same as previous ☐ ID & Doc	discussed ☐ Yes ☐ No	□Yes	Complete  O Yes
Visit: ☐ In-person ☐ Video	Location:		evious	☐ Same as previous ☐ Yes ☐ No	☐ Same as previous ☐ ID & Doc☐ None confirmed ☐ Not addressed	discussed	□ Yes	Complete  Yes No
Visit: In-person Video Telephone	Location:	is Same as pro	evious	☐ Same as previous	☐ Same as previous ☐ ID & Doc	discussed ☐ Yes ☐ No	□Yes	Complete  O Yes
Visit:  In-person Video Telephone Unknown	Location:  Same as previou  New:	Same as pr	evious	Same as previous See NoUnknown	□ Same as previous □ ID & Doc □ None confirmed □ Not addressed □ Unknown	discussed  Yes No Unknown	□ Yes □ No □ Unknown	Complete  Yes  No Unknown
Visit: In-person Video Telephone	Location:	is Same as pro	evious	☐ Same as previous ☐ Yes ☐ No	☐ Same as previous ☐ ID & Doc☐ None confirmed ☐ Not addressed	discussed ☐ Yes ☐ No	□ Yes	Complete  Yes No
Visit:    In-person   Video   Telephone   Unknown   Pain:   Pt Decline/	Location:  Same as previou  New:  Nausea:  Pt Decline/ Prov	Same as pro	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	□ Yes □ No □ Unknown	Complete  Yes  No Unknown
Visit:    In-person   Video   Telephone   Unknown   Pain:   Pt Decline/   Prov Unable	Location:    Same as previou     New:	Anxiety:	Shortne:	☐ Same as previous ☐ Yes ☐ No ☐ Unknown  ss of Breath: ☐ Ine/ Prov Unable	□ 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 NoUnknown Screen - Spiritual Care:	Complete  Yes  No Unknown  Screen – Psychosocial:
Visit:    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: ☐ Ine/ Prov Unable	□ Same as previous □ ID & Doc □ None confirmed □ Not addressed □ Unknown  Constipation: □ Pt Decline/ Prov Unable	discussed Yes No Unknown  BM 48 Hr: Yes No	□ Yes □ No □ Unknown  Screen - Spiritual Care:	Complete
Visit:    In-person   Video   Telephone   Unknown   Pain:   Pt Decline/ Prov Unable   Pt Unable   Unknown	Location:    Same as previou     New:	Anxiety:  Pt Decline/ Prov Unable Pt Unable Unknown	Shortne:	☐ Same as previous ☐ Yes ☐ No ☐ Unknown  ss of Breath: ☐ Ine/ Prov Unable	□ 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	□ Yes □ No □ Unknown  Screen - Spiritual Care: □ No □ Yes □ Patient/Family Refused	Complete
Visit:    In-person   Video   Telephone   Unknown   Pain:   Pt Decline/ Prov Unable   Pt Unable   Unknown	Location:  Same as previou  New:  New:  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: ☐ Ine/ Prov Unable	□ 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	□ Yes □ No □ Unknown  Screen - Spiritual Care: □ No □ Yes □ Patient/Family Refused	Complete
Visit:    In-person   Video   Telephone   Unknown   Pain:   Pt Decline/   Prov Unable   Pt Unable   Unknown   Names of team	Location:  Same as previou  New:  New:  Pt Decline/ Prov Unable Pt Unable Unknown	Anxiety:    Pt Decline/ Prov Unable   Unknown   University   Universit	Shortne:	☐ Same as previous ☐ Yes ☐ No ☐ Unknown  ss of Breath: ☐ Ine/ Prov Unable	□ 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	□ Yes □ No □ Unknown  Screen - Spiritual Care: □ No □ Yes □ Patient/Family Refused	Complete
Visit:    In-person   Video   Telephone   Unknown   Pain:   Pt Decline/ Prov Unable   Pt Unknown   Names of team	Location:  Same as previou  New:  New:  Pt Decline/ Prov Unable Pt Unable Unknown 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
Visit:    In-person   Video   Telephone   Unknown   Pain:   Pt Decline/ Prov Unable   Pt Unknown   Names of team	Location:     Same as previou     New:     New:     Nausea:     Pt Decline/ Prov     Unable     Pt Unable     Unknown     members involved     Scharge Information-off:	Anxiety:  Pt Decline/ Prov Unable Pt Unable Unknown d in visit:	Shortne:  Pt Decli Pt Unat	□ 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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