PALLIATIVE CARE
QUALITY IMPROVEMENT PROGRAM
DETAILED SPECIFICATIONS

2023

MEASUREMENT YEAR

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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, 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).

Measurement 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 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 ☐ 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 ☐ 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 not refer to location of visit)	☐ In-person ☐ 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 patient is on at time of referral	☐ 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
Referral Source (select one)		☐ 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 ☐ Other ☐ Unknown
Reason(s) for Referral (select all)		☐ Symptom Management ☐ Decision Making ☐ Providing Support to Patient & Family ☐ Other ☐ Unknown
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
Manner Visit Conducted		☐ In-person ☐ Video Visit ☐ Telephone Visit ☐ Unknown
Consultation Location		☐ Outpatient Clinic ☐ LTC ☐ Assisted Living Facility ☐ Other Domiciliary ☐ Home ☐ Other ☐ Unknown
GOC Discussed		☐ Yes ☐ No ☐ Unknown
Resuscitation Preference	Refers to Code Status (at the time consult was requested)	☐ Full code ☐ DNR, not DNI Other Limited DNR ☐ DNR/DNI (DNAR+AND) ☐ Unknown
Advanced Directive Completed During Consult?		☐ Yes ☐ No ☐ NA - No POLST Program in state ☐ Unknown
POLST/MOLST Completed During Consult?		☐ Yes ☐ 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 ☐ Drowsiness ☐ Appetite ☐ Constipation ☐ Other:_____
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 PC Sign-off	☐ Alive ☐ Dead

PCQC
Palliative Care Quality Collaborative

Community Based PC Visits

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

Referral Information (Initial Visit only)

(9) Referral ID: _____
(10) Date of Referral: __/___/___
(12) Reason(s) for Referral (select all):
☐ Symptom Management ☐ Decision Making
☐ Providing Support to Patient & Family
☐ Other ☐ Unknown

(11) Referral Source (select one): ☐ 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 ☐ Other ☐ Unknown

(13) 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 (All visits)

(14) Encounter ID: _____ (15) Date: ____/____/____ (16) Time: __ __ : __ __

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

(18) Consultation Location: ☐ Outpatient Clinic ☐ LTC ☐ Assisted Living Facility
☐ 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
☐ Grandparent ☐ Grandchild ☐ Foster Parent ☐ Other relative ☐ Legal Guardian ☐ Non-relative (e.g., neighbor, friend) ☐ None ☐ Unknown

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

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

(22) Surrogate Decision Maker/MDPA: ☐ Surrogate/MDPA Identified & Documented
☐ 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 *

1 of 2

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 ☐ Video ☐ Telephone ☐ Unknown	☐ Same as previous ☐ New:_____	☐ Same as previous ☐ New:_____	☐ Same as previous ☐ Yes ☐ No ☐ Unknown	☐ Same as previous ☐ ID & Doc ☐ None confirmed ☐ Not addressed ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Pain: _____	Nausea: _____	Anxiety: _____	Shortness of Breath: _____	Constipation:_____	BM 48 Hr:	Screen - Spiritual Care:	Screen – Psychosocial:
☐ Pt Decline/ Prov Unable ☐ Pt Unable ☐ Unknown	☐ Pt Decline/ Prov Unable ☐ Pt Unable ☐ Unknown	☐ Pt Decline/ Prov Unable ☐ Pt Unable ☐ Unknown	☐ Pt Decline/ Prov Unable ☐ Pt Unable ☐ Unknown	☐ Pt Decline/ Prov Unable ☐ Pt Unable ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ No ☐ Yes ☐ Patient/Family Refused ☐ Patient/Family Unable	☐ No ☐ Yes ☐ Patient/Family Refused ☐ 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 ☐ Video ☐ Telephone ☐ Unknown	☐ Same as previous ☐ New:_____	☐ Same as previous ☐ New:_____	☐ Same as previous ☐ Yes ☐ No ☐ Unknown	☐ Same as previous ☐ ID & Doc ☐ None confirmed ☐ Not addressed ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Pain: _____	Nausea: _____	Anxiety: _____	Shortness of Breath: _____	Constipation:_____	BM 48 Hr:	Screen - Spiritual Care:	Screen – Psychosocial:
☐ Pt Decline/ Prov Unable ☐ Pt Unable ☐ Unknown	☐ Pt Decline/ Prov Unable ☐ Pt Unable ☐ Unknown	☐ Pt Decline/ Prov Unable ☐ Pt Unable ☐ Unknown	☐ Pt Decline/ Prov Unable ☐ Pt Unable ☐ Unknown	☐ Pt Decline/ Prov Unable ☐ Pt Unable ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ No ☐ Yes ☐ Patient/Family Refused ☐ Patient/Family Unable	☐ No ☐ Yes ☐ Patient/Family Refused ☐ 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: ☐ Full ☐ DNR, not DNI ☐ Other Limited DNR ☐ DNR/DNI(DNAR+AND) ☐ Unknown	AD Present at Discharge: ☐ Yes ☐ No ☐ Unknown	POLST/MOLST Present at Discharge: ☐ Yes ☐ No ☐ Unknown ☐ N/A – No POLST in state
Date of Hospital Discharge: _____/_____/_____ Time: __ __:__ __		