



PALLIATIVE CARE

QUALITY IMPROVEMENT PROGRAM

DETAILED SPECIFICATIONS

2025

MEASUREMENT YEAR



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Program Overview

Partnership HealthPlan of California has value-based programs in the areas of primary care, hospital care, specialty care, community pharmacy, and mental health. These value-based programs align with Partnership's organizational mission to help our members and the communities we serve, be healthy.

In 2015, Partnership 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 statewide benefit for Medicaid. Implementation of this benefit occurred on January 1, 2018. In 2017, Partnership 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. Providers must have a Partnership contract within the first (3) months of the measurement year. The provider must remain contracted through the end of the measurement year to be eligible for payment. 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 Partnership 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.

Payment Dispute Policy

Providers are strongly encouraged to review their Preliminary Reports during the designated preliminary review periods. If a provider does not notify Partnership of a calculation error during these periods, resulting in a potential under or over payment, the error may be corrected by Partnership post-payment through a formal appeal process. The formal appeal process is available for **up to 30 days after the provider has received their final payment statement**. Additionally, Partnership may recoup overpayments any time after payment is distributed. All formal appeal requests are reviewed by Partnership's Executive Team.

Program Timeline

The Palliative Care QIP is administered in six-month measurement periods: Part I runs from January - June, and Part II runs from July - December. This document details the requirements and specifications for both Part I and Part II. Performance and payments are calculated at the end of each six-month period, and incentive payments are distributed four (4) months after the end of each measurement period. Partnership HealthPlan of California reserves the right to adjust QIP payment timelines due to holidays and extensive validation processes.

Measurement Period		Payment Distribution
Part I	January - June	November
Part II	July - December	May

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

\$240 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 Partnership. 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 three (February, May and June). The palliative care provider site will be eligible for a total payment for avoiding hospitalization and ED visits of \$720.

Reporting Guidelines

Reporting by palliative care provider sites to Partnership is not required. Partnership 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 the completion of a signed Physician's Orders for Life Sustaining Treatment (POLST) with documentation 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

\$120 per member enrolled in the palliative care program per month upon:

Completion of a signed POLST and documentation using the PCQC tool.

Example: A member is enrolled from February 25 to May 30. A signed POLST was completed in February and was documented using the PCQC tool. The palliative care provider site will be eligible for payment for the months of February through May for a total incentive of \$480 for completing a signed POLST and documenting using PCQC.

Reporting Guidelines

Palliative care sites are required to enter Partnership required data elements into PCQC on a monthly basis to meet the requirements of this measure.

Reporting by palliative care provider sites to Partnership is not required. Partnership will obtain monthly and bi-annual reports from PCQC. Partnership 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.

Measure III: Completion of Standardized Palliative Care Quality Collaborative (PCQC) Assessments & Use of PCQC Tool

Description

The Palliative Care QIP includes an incentive for the completion of two (2) standardized PCQC assessments, within the designated thresholds for capturing required data elements, and documented in the PCQC system.

In a Palliative Care Quality Collaborative assessment form, information typically includes patient demographics, medical history, symptom management, psychosocial support, communication preferences, and satisfaction with care. The goal is to comprehensively evaluate and improve the quality of palliative care provided to patients. 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

Up to \$120 per member enrolled in the palliative care program per month upon:

At least two (2) patient encounters per month, completing a standardized PCQC assessment within the designated thresholds for capturing required data elements per encounter, and documented using the PCQC tool.

Example: For a member enrolled from February 25 to May 30, with at least two (2) visits documented on PCQC with the completion of a Palliative Care Quality Collaborative assessment form per visit within the designated thresholds for capturing required data elements each month, but entered PCQC in April and May, the number of months meeting this measure is two (April and May). The palliative care provider site will be eligible for payment for using PCQC, if they are compliant with the reporting requirement per the designated thresholds:

- Thresholds:
 - > 85% of required data elements (Appendix IV) entered on assessments = Full points (\$120 Per Member Per Month (PMPM))
 - 70-84.9% of required data elements (Appendix IV) entered on assessments = Partial points (\$60 PMPM)

Threshold Benchmarks for Payment

Assessment 1	Assessment 2	Credit for Payment
85% or more	85% or more	Full credit (\$120)
85% or more	70-84.9%	Partial credit (\$60)
85% or more	Less than 70%	Partial credit (\$60)
70-84.9%	70-84.9%	Partial credit (\$60)
70-84.9%	Less than 70%	Partial credit (\$60)
Less than 70%	Less than 70%	No credit

Reporting Guidelines

Palliative care sites are required to enter Partnership required data elements (Appendix IV) into PCQC monthly to meet the requirements of this measure.

Reporting by palliative care provider sites to Partnership is not required. Partnership will obtain monthly and bi-annual reports from PCQC. Partnership 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.

Payment Methodology Examples

Measure I. Avoiding Hospitalization and Emergency Room Visits

Hospital admission claims data, emergency department visit claims data, and palliative care TAR approval data are used to configure a provider’s incentive payment for Measure I. These reports reflect data for the measure period being processed for payment.

Hospital admissions are identified by the “**ADMIT_DATE**” and “**DISCHARGE_DATE**” columns. These columns capture the duration of an inpatient stay.

Hospital Admissions '01jul2023'd and '31dec2023'd Based on Claims paid through 29MAR2024			
CIN	HOSPITAL	ADMIT_DATE	DISCHARGE_DATE
MEMBER #1	NO HOSPITAL ADMISSIONS		
MEMBER #2	NO HOSPITAL ADMISSIONS		
MEMBER #3	CLEARLAKE ADVENTIST HLTH	29JUL2023, 15AUG2023, 04SEP2023, 27SEP2023	05AUG2023, 21AUG2023, 06SEP2023, 02OCT2023
MEMBER #4	NO HOSPITAL ADMISSIONS		
MEMBER #5	NO HOSPITAL ADMISSIONS		
MEMBER #6	NO HOSPITAL ADMISSIONS		

Emergency department visits are identified by the “**ADMIT_DATE**” column. This column captures the day the member was seen in the emergency department.

ED Admissions '01jul2023'd and '31dec2023'd Based on Claims paid through 25MAR2024		
CIN	HOSPITAL	ADMIT_DATE
MEMBER #1	NO ED ADMISSIONS	
MEMBER #2	LAKESIDE HOSP SUTTER	26SEP2023
MEMBER #3	NO ED ADMISSIONS	
MEMBER #4	NO ED ADMISSIONS	
MEMBER #5	CLEARLAKE ADVENTIST HLTH	02SEP2023, 12OCT2023
MEMBER #6	NO ED ADMISSIONS	

Qualifying months for payment are identified by first looking at the TAR approval data for the member (highlighted in **gold above**). The TAR approval data determines the months the member had an approved TAR for palliative care within the measure period. Next, the measure period is reviewed to identify any hospital admissions and/or emergency department visits. There are six columns with the year and month which represent the measure period being processed for payment. Measure period months that are blank and are covered by a TAR approval qualify for payment (highlighted in **green below**). Measure period months that have a year and month noted indicate a hospital admission or emergency department visit and do not qualify for payment (highlighted in **red below**).

Examples:

Member #1 has TAR approval for the months September 2023 through December 2023. In looking at the measure period, Member #1 does not have any hospital admissions or emergency department visits from September 2023 through December 2023. The total number of months that qualify for payment is four months.

Member #3 has TAR approvals for the months of July 2023 through December 2023. There are hospital admissions and/or emergency department visits noted for the months of July 2023 through October 2023. Only November 2023 and December 2023 show no hospital admission or emergency department visits and only 2 months would qualify for payment.

UNIQUE_CINS	TAR Start Month	TAR End Month	2023-07	2023-08	2023-09	2023-10	2023-11	2023-12	Months eligible for Payment based on Start Month and End Month
MEMBER #1	202309	202312			No Hospital Admissions/ED Visits				4
MEMBER #2	202307	202312			202309				5
MEMBER #3	202307	202312	202307	202308	202309	202310			2
MEMBER #4	202307	202312							6
MEMBER #5	202307	202312			202309	202310			4
MEMBER #6	202307	202312							6

Measure II: Completion of POLST & Use of Palliative Care Quality Collaborative (PCQC) Tool

Palliative care TAR approval data and PCQC POLST data are used to configure a provider’s incentive payment for Measure II. These reports reflect data for the measure period being processed for payment.

Palliative care TAR data is reviewed to identify a member’s TAR approvals for palliative care during the measure period. The “**START_DATE**” column notes the TAR approval start date and the “**END_DATE**” column notes the TAR approval end date. These columns determine the duration of a TAR’s approval.

IOPC APPROVED TARS			
MbrCIN	AuthorizationNbr	START_DATE	END_DATE
MEMBER #1	TAR	➡ 19Sep2023	➡ 11Dec2023
MEMBER #1	TAR	12Dec2023	4Mar2024
MEMBER #1	TAR	5Mar2024	27May2024

PCQC POLST data is reviewed to determine the qualifying months for payment for each unique member (highlighted in **gold below**). POLST completion is shown in columns titled “**POLST**” and “**Otherout_POLST**”. An indication of (1) notes the completion of a POLST and an indication of (0) is given when a POLST completion is not present. The column titled “**Visit_YrMnth**” indicates the months where a visit took place. “**POLST_Final**” column indicates the months that qualify for payment (highlighted in **green**).

Name	Visit_YrMnth	DOB	POLST	Otherout_POLST	TarStatus	POLST_Final
MEMBER #1	2024-02	3/24/1960	1	0	ValidTar	1
MEMBER #1	2024-03	3/24/1960	1	0	ValidTar	1
MEMBER #1	2024-04	3/24/1960	1	0	ValidTar	1
MEMBER #1	2024-05	3/24/1960	1	0	ValidTar	1

Examples:

Member #1 has confirmed visit dates from February to May of the measure period (highlighted in **gold**). The “**POLST**” column shows a (1) indicating there is a signed POLST (highlighted in **blue**). This member has a valid TAR that covers the measure period being processed for payment under the “**TARStatus**” column (highlighted in **orange**). The total number of months that qualify for payment is four months (highlighted in **green**).

Name	Visit_YrMnth	DOB	POLST	Otherout_POLST	TarStatus	POLST_Final
MEMBER #1	2024-02	3/24/1960	1	0	ValidTar	1
MEMBER #1	2024-03	3/24/1960	1	0	ValidTar	1
MEMBER #1	2024-04	3/24/1960	1	0	ValidTar	1
MEMBER #1	2024-05	3/24/1960	1	0	ValidTar	1

Member #2 has confirmed visit dates from January to June of the measure period (highlighted in gold). The "POLST" and "Otherout_POLST" columns show a (1) indicating there is a signed POLST beginning in March (highlighted in blue). This member has a valid TAR that covers the measure period being processed for payment under the "TARStatus" column (highlighted in orange). The total number of months that qualify for payment is four months (highlighted in green).

Name	Visit_YrMnt	DOB	POLST	Otherout_POLST	TarStatus	POLST_Final
MEMBER #2	2024-01	6/3/1986	0	0	ValidTar	0
MEMBER #2	2024-02	6/3/1986	0	0	ValidTar	0
MEMBER #2	2024-03	6/3/1986	1	1	ValidTar	1
MEMBER #2	2024-04	6/3/1986	1	0	ValidTar	1
MEMBER #2	2024-05	6/3/1986	1	0	ValidTar	1
MEMBER #2	2024-06	6/3/1986	1	0	ValidTar	1

Measure III: Completion of Standardized Palliative Care Quality Collaborative (PCQC) Assessments & Use of PCQC Tool

Palliative care TAR approval data and PCQC supplemental data, which captures the required data elements from the PCQC assessment form, are used to configure a provider’s incentive payment for Measure II. These reports reflect data for the measure period being processed for payment.

Palliative care TAR data is reviewed to identify a member’s TAR approvals for palliative care during the measure period. The “**START_DATE**” column notes the TAR approval start date and the “**END_DATE**” column notes the TAR approval end date. These columns determine the duration of a TAR’s approval.

IOPC APPROVED TARs			
MbrCIN	AuthorizationNbr	START_DATE	END_DATE
MEMBER #1	TAR	➡ 19Sep2023	➡ 11Dec2023
MEMBER #1	TAR	12Dec2023	4Mar2024
MEMBER #1	TAR	5Mar2024	27May2024

Qualifying visit months are identified by looking for at least two (2) visits within a month (highlighted in **gold below**). Completed assessments are identified for each qualifying visit month (highlighted in **orange below**). Please note, the assignment of “**Ratio_1stAssessment**” and “**Ratio_2ndAssessment**” indicates the order that the assessments were completed for the qualifying visit month. The “**Ratio**” tab shows the percentage of required elements captured on the assessment (see the list of required data elements (Appendix IV). The percentage under the “**Ratio**” tab is noted under the appropriate threshold column: “**85% or more**”, “**70-84.9%**” and “**Less than 70%**” (highlighted in **green**).

Example:

Member #1 has a valid TAR approval for palliative care for the measure period being processed for payment. Two visits are identified in the months of February, March, April, May and June. Each month has two (2) assessments that were completed with 100% of the required data elements. The assessments for each month fall under the “**85% or more**” threshold. The total number of months qualifying for the full incentive is five (5) months (see the Benchmark Thresholds for Payment table on pg. 7)

Assessments	Member_Name	Visit Months	Ratio	TarStart	TarEnd	TAR_Validation	First_85% or more	First_70-84.9%	First_Less than 70%
Ratio_1stAssessment	MEMBER #1	April	100%	2/8/2024	8/9/2024	Valid	1	0	0
Ratio_2ndAssessment	MEMBER #1	April	100%	2/8/2024	8/9/2024	Valid	1	0	0
Ratio_1stAssessment	MEMBER #1	February	100%	2/8/2024	8/9/2024	Valid	1	0	0
Ratio_2ndAssessment	MEMBER #1	February	100%	2/8/2024	8/9/2024	Valid	1	0	0
Ratio_1stAssessment	MEMBER #1	June	100%	2/8/2024	8/9/2024	Valid	1	0	0
Ratio_2ndAssessment	MEMBER #1	June	100%	2/8/2024	8/9/2024	Valid	1	0	0
Ratio_1stAssessment	MEMBER #1	March	100%	2/8/2024	8/9/2024	Valid	1	0	0
Ratio_2ndAssessment	MEMBER #1	March	100%	2/8/2024	8/9/2024	Valid	1	0	0
Ratio_1stAssessment	MEMBER #1	May	100%	2/8/2024	8/9/2024	Valid	1	0	0
Ratio_2ndAssessment	MEMBER #1	May	100%	2/8/2024	8/9/2024	Valid	1	0	0

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 Partnership CIN #	
Patient Last Name		
Patient First Name		
Ethnicity (select one):		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to Say
Date of Birth		mm/dd/yyyy
Pref Lang (select one):		<input type="checkbox"/> Eng <input type="checkbox"/> Spanish <input type="checkbox"/> Other Indo-Euro lang <input type="checkbox"/> Asian & PI lang <input type="checkbox"/> Other languages: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Not Reported
Gender Identity		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male (FTM) <input type="checkbox"/> Transgender Female (MTF) <input type="checkbox"/> Non-Binary <input type="checkbox"/> Prefer to Self-Describe: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to Say
Race (select all that apply)		<input type="checkbox"/> White <input type="checkbox"/> Black or African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other: _____ <input type="checkbox"/> Not Reported <input type="checkbox"/> 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)	<input type="checkbox"/> In-person <input type="checkbox"/> Video Visit <input type="checkbox"/> Telephone Visit <input type="checkbox"/> 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	<input type="checkbox"/> General Medicine <input type="checkbox"/> Hospital Medicine <input type="checkbox"/> Oncology <input type="checkbox"/> Hematology <input type="checkbox"/> Cardiology <input type="checkbox"/> Neurology <input type="checkbox"/> Pulmonary <input type="checkbox"/> Critical Care

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

		<input type="checkbox"/> Other <input type="checkbox"/> Unknown
Manner Visit Conducted		<input type="checkbox"/> In-person <input type="checkbox"/> Video Visit <input type="checkbox"/> Telephone Visit <input type="checkbox"/> Unknown
Consultation Location		<input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> LTC <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Other Domiciliary <input type="checkbox"/> Home <input type="checkbox"/> Other <input type="checkbox"/> Unknown
GOC Discussed		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Resuscitation Preference	Refers to Code Status (at the time consult was requested)	<input type="checkbox"/> Full code <input type="checkbox"/> DNR, not DNI Other Limited DNR <input type="checkbox"/> DNR/DNI (DNAR+AND) <input type="checkbox"/> Unknown
Advanced Directive Completed During Consult?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA - No POLST Program in state <input type="checkbox"/> Unknown
POLST/MOLST Completed During Consult?		<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Nausea <input type="checkbox"/> Drowsiness <input type="checkbox"/> Appetite <input type="checkbox"/> Constipation <input type="checkbox"/> Other: _____
Screen for Psychosocial Needs		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Patient/Family Declined <input type="checkbox"/> Patient/Family Unable <input type="checkbox"/> Not screened
Screen for Spiritual Needs		<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Patient/Family Declined <input type="checkbox"/> Patient/Family Unable <input type="checkbox"/> Not screened
Team Members Involved in Visit		
Discharge Disposition	Refers to Patient Status at PC Sign-off	<input type="checkbox"/> Alive <input type="checkbox"/> Dead

Appendix III: PCQC Data Collection Examples- Community Based & Inpatient Intake Forms



Community Based PC Visits

PATIENT DETAILS

(1) Patient ID #: _____ (2) First name: _____ (3) Last name: _____ (4) Date of birth: ___/___/___	(5) Gender Identity (select one): <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male (FTM) <input type="checkbox"/> Transgender Female (MTF) <input type="checkbox"/> Non-Binary <input type="checkbox"/> Prefer to Self-Describe: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to Say
(6) Ethnicity (select one): <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to Say	(7) Race (select all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black or African-American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Other: _____ <input type="checkbox"/> Not Reported <input type="checkbox"/> Declined to Say
(8) Pref Lang (select one): <input type="checkbox"/> Eng <input type="checkbox"/> Spanish <input type="checkbox"/> Other Indo-Euro lang <input type="checkbox"/> Asian & PI lang <input type="checkbox"/> Other languages: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Not Reported	

REFERRAL INFORMATION (INITIAL VISIT ONLY)

(9) Referral ID: _____ (10) Date of Referral: ___/___/___	(11) Referral Source (select one): <input type="checkbox"/> Emergency Dept <input type="checkbox"/> Group Home <input type="checkbox"/> Health Plan <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Hospice <input type="checkbox"/> Hospital Inpatient PCS <input type="checkbox"/> Other Hospital IP Service <input type="checkbox"/> Nursing Home/LTC <input type="checkbox"/> Primary Care Practice <input type="checkbox"/> Primary Care Practice – Ambulatory <input type="checkbox"/> Primary Care Practice – Home <input type="checkbox"/> Specialty Practice – Onco/CC <input type="checkbox"/> Specialty Practice – Cardiology/HF Clinic <input type="checkbox"/> Specialty Practice – Neurology <input type="checkbox"/> Specialty Practice – Neph/Dialysis Cntr <input type="checkbox"/> Specialty Practice – Geriatrician <input type="checkbox"/> Specialty Practice – Palliative Care Clinic <input type="checkbox"/> Other <input type="checkbox"/> Unknown
(12) Reason(s) for Referral (select all): <input type="checkbox"/> Symptom Management <input type="checkbox"/> Decision Making <input type="checkbox"/> Providing Support to Patient & Family <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
(13) Primary Diagnosis: <input type="checkbox"/> Cancer (solid tumor) <input type="checkbox"/> Cancer (Heme) <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Pulmonary <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Hepatology <input type="checkbox"/> Renal <input type="checkbox"/> Dementia <input type="checkbox"/> Neurology (includes Neuromusc./non-dementia Neurodegen) <input type="checkbox"/> Infectious <input type="checkbox"/> Trauma <input type="checkbox"/> Vascular <input type="checkbox"/> Metabolic/Endocrine <input type="checkbox"/> Genetic/Chromosomal <input type="checkbox"/> Hematology (non-cancer) <input type="checkbox"/> Prematurity/Complications related <input type="checkbox"/> Fetal <input type="checkbox"/> Other <input type="checkbox"/> Unknown	

CONSULT (ALL VISITS)

(14) Encounter ID: _____	(15) Date: ___/___/___	(16) Time: ___:___
(17) Manner Visit Conducted: <input type="checkbox"/> In-person <input type="checkbox"/> Video Visit <input type="checkbox"/> Telephone Visit <input type="checkbox"/> Unknown	(18) Consultation Location: <input type="checkbox"/> Outpatient Clinic <input type="checkbox"/> LTC <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Other Domiciliary <input type="checkbox"/> Home <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
(19) Primary Caregiver (select one): <input type="checkbox"/> Spouse or Partner <input type="checkbox"/> Child/Child-in-law <input type="checkbox"/> Parent/Parent-in-law <input type="checkbox"/> Sibling/Sibling-in-law <input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other relative <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Non-relative (e.g., neighbor, friend) <input type="checkbox"/> None <input type="checkbox"/> Unknown		
(20) GOC Documented: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	(21) GOC Discussed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	(22) Surrogate Decision Maker/MDPA: <input type="checkbox"/> Surrogate/MDPA Identified & Documented <input type="checkbox"/> No Surrogate Confirmed <input type="checkbox"/> Not Addressed <input type="checkbox"/> Unknown <input type="checkbox"/> N/A – Patient is Minor
(23) AD Present at Start of Consult: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		(24) AD Completed During Consult: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
(25) POLST/MOLST Present at Start of Consult: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA - No POLST Program in state <input type="checkbox"/> Unknown		
(26) POLST/MOLST Completed During Consult: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA - No POLST Program in state <input type="checkbox"/> Unknown		
(27) Resuscitation Preference: <input type="checkbox"/> Full <input type="checkbox"/> DNR, not DNI <input type="checkbox"/> Other Limited DNR <input type="checkbox"/> DNR/DNII(DNAR+AND) <input type="checkbox"/> Unknown		
(28) PPS (circle): 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%		(29) Patient BM in last 48 hrs: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Patient/Family Refused <input type="checkbox"/> Patient/Family Unable		
(33) Patient/Family screened for psychosocial needs: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Patient/Family Refused <input type="checkbox"/> Patient/Family Unable		
(34) Team Members involved in visit:		

* Discharge Information on other side *



Community Based PC Visits

PATIENT DETAILS

Patient ID #: _____	First name: _____	Last name: _____
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DISCHARGE INFO

Date of PC Sign-off: ____/____/____	Time: ____:____	Patient Status at PC Sign-off: <input type="checkbox"/> Alive <input type="checkbox"/> Died <input type="checkbox"/> Unknown
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PATIENT DETAILS

<p>(1) Patient ID #: _____ (should be PHC CIN #)</p> <p>(2) First name: _____</p> <p>(3) Last name: _____</p> <p>(4) Date of birth: ____/____/____</p>	<p>(5) Gender Identity (select one):</p> <p><input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender Male (FTM)</p> <p><input type="checkbox"/> Transgender Female (MTF) <input type="checkbox"/> Non-Binary</p> <p><input type="checkbox"/> Prefer to Self-Describe: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Declined to Say</p>
<p>(6) Ethnicity (select one):</p> <p><input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino</p> <p><input type="checkbox"/> Unknown <input type="checkbox"/> Declined to Say</p>	<p>(7) Race (select all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black or African-American <input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> American Indian or Alaska Native</p> <p><input type="checkbox"/> Other: _____ <input type="checkbox"/> Not Reported <input type="checkbox"/> Declined to Say</p>
<p>(8) Pref Lang (select one): <input type="checkbox"/> Eng <input type="checkbox"/> Spanish <input type="checkbox"/> Other Indo-Euro lang <input type="checkbox"/> Asian & PI lang <input type="checkbox"/> Other languages: _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Not Reported</p>	

HOSPITALIZATION

(9) Hospitalization ID: _____ (10) Site: _____ (11) Date & Time of Admission: ____/____/____ : ____:____

REFERRAL INFORMATION

<p>(12) Referral ID: _____ (13) Date of Referral: ____/____/____</p>	<p>(14) Referral Service (select one): <input type="checkbox"/> General Medicine <input type="checkbox"/> Hospital Medicine</p> <p><input type="checkbox"/> Oncology <input type="checkbox"/> Hematology <input type="checkbox"/> Cardiology <input type="checkbox"/> Neurology <input type="checkbox"/> Pulmonary</p> <p><input type="checkbox"/> Critical Care <input type="checkbox"/> Ped Critical Care <input type="checkbox"/> Neonatal Critical Care</p> <p><input type="checkbox"/> Other Internal Medicine or Peds Subspecialty <input type="checkbox"/> Surgical Specialties</p> <p><input type="checkbox"/> OB/GYN & Mother-Fetal <input type="checkbox"/> Emergency Med <input type="checkbox"/> Self <input type="checkbox"/> Other <input type="checkbox"/> Unknown</p>
<p>(15) Reason(s) for Referral (select all that apply):</p> <p><input type="checkbox"/> Symptom Management <input type="checkbox"/> Decision Making</p> <p><input type="checkbox"/> Providing Support to Patient & Family</p> <p><input type="checkbox"/> Other <input type="checkbox"/> Unknown</p>	
<p>(16) Primary Diagnosis: <input type="checkbox"/> Cancer (solid tumor) <input type="checkbox"/> Cancer (Heme) <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Pulmonary <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Hepatology <input type="checkbox"/> Renal</p> <p><input type="checkbox"/> Dementia <input type="checkbox"/> Neurology (includes Neuromusc./non-dementia Neurodegen) <input type="checkbox"/> Infectious <input type="checkbox"/> Trauma <input type="checkbox"/> Vascular <input type="checkbox"/> Metabolic/Endocrine</p> <p><input type="checkbox"/> Genetic/Chromosomal <input type="checkbox"/> Hematology (non-cancer) <input type="checkbox"/> Prematurity/Complications related <input type="checkbox"/> Fetal <input type="checkbox"/> Other <input type="checkbox"/> Unknown</p>	

CONSULT

<p>(16) Encounter ID: _____ (17) Date: ____/____/____ (18) Time: ____:____</p>																																																																																												
<p>(19) Manner Visit Conducted: <input type="checkbox"/> In-person</p> <p><input type="checkbox"/> Video Visit <input type="checkbox"/> Telephone Visit <input type="checkbox"/> Unknown</p>	<p>(20) Consultation Location: <input type="checkbox"/> Hospital General Floor <input type="checkbox"/> Hospital ICU <input type="checkbox"/> Hospital Neonatal ICU <input type="checkbox"/> Hospital PC Unit <input type="checkbox"/> Emergency Dept <input type="checkbox"/> Other <input type="checkbox"/> Unknown</p>																																																																																											
<p>(22) Code Status (at the time the consult was requested): <input type="checkbox"/> Full <input type="checkbox"/> DNR, not DNI <input type="checkbox"/> Other Limited DNR <input type="checkbox"/> DNR/DNI(DNAR+AND) <input type="checkbox"/> Unknown</p>																																																																																												
<p>(21) PPS at time of initial consult (circle): 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%</p>																																																																																												
<p>(23) Primary Caregiver (select one): <input type="checkbox"/> Spouse or Partner <input type="checkbox"/> Child/Child-in-law <input type="checkbox"/> Parent/Parent-in-law <input type="checkbox"/> Sibling/Sibling-in-law</p> <p><input type="checkbox"/> Grandparent <input type="checkbox"/> Grandchild <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other relative <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Non-relative (e.g., neighbor, friend) <input type="checkbox"/> None <input type="checkbox"/> Unknown</p>																																																																																												
<p>(24) GOC Documented: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>(25) GOC Discussed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>(26) Surrogate Decision Maker/MDPA: <input type="checkbox"/> Surrogate/MDPA Identified & Documented</p> <p><input type="checkbox"/> No Surrogate Confirmed <input type="checkbox"/> Not Addressed <input type="checkbox"/> Unknown <input type="checkbox"/> N/A – Patient is Minor</p>																																																																																										
<p>(27) Advance Directive Completed During Consult: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>																																																																																												
<p>(29) POLST/MOLST Completed During Consult: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA - No POLST Program in state <input type="checkbox"/> Unknown</p>																																																																																												
<p>(30) Patient's assessment of their "symptom now"? (0 (no symptoms) to 10 (worst possible symptoms):</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Symptom</th> <th>0</th> <th>1</th> <th>2</th> <th>3</th> <th>4</th> <th>5</th> <th>6</th> <th>7</th> <th>8</th> <th>9</th> <th>10</th> <th>Pt Declined/Prov Unable</th> <th>Pt Unable to Respond</th> <th>Unknown</th> </tr> </thead> <tbody> <tr> <td>a. Pain</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td></td><td></td><td></td> </tr> <tr> <td>b. Nausea</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td></td><td></td><td></td> </tr> <tr> <td>c. Anxiety</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td></td><td></td><td></td> </tr> <tr> <td>d. Shortness of breath</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td></td><td></td><td></td> </tr> <tr> <td>e. Constipation</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td></td><td></td><td></td> </tr> </tbody> </table>			Symptom	0	1	2	3	4	5	6	7	8	9	10	Pt Declined/Prov Unable	Pt Unable to Respond	Unknown	a. Pain															b. Nausea															c. Anxiety															d. Shortness of breath															e. Constipation														
Symptom	0	1	2	3	4	5	6	7	8	9	10	Pt Declined/Prov Unable	Pt Unable to Respond	Unknown																																																																														
a. Pain																																																																																												
b. Nausea																																																																																												
c. Anxiety																																																																																												
d. Shortness of breath																																																																																												
e. Constipation																																																																																												
<p>(31) Patient Bowel Movement in Last 48 hrs: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>																																																																																												
<p>(32) Patient or family screened for spiritual care needs:</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Patient/Family Refused</p> <p><input type="checkbox"/> Patient/Family Unable</p>	<p>(33) Patient or family screened for psychosocial needs:</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Patient/Family Refused <input type="checkbox"/> Patient/Family Unable</p>																																																																																											
<p>(34) Names of team members involved in consult: _____</p>																																																																																												

** 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
<input type="checkbox"/> In-person <input type="checkbox"/> Video <input type="checkbox"/> Telephone <input type="checkbox"/> Unknown	<input type="checkbox"/> Same as previous <input type="checkbox"/> New: _____	<input type="checkbox"/> Same as previous <input type="checkbox"/> New: _____	<input type="checkbox"/> Same as previous <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Same as previous <input type="checkbox"/> ID & Doc <input type="checkbox"/> None confirmed <input type="checkbox"/> Not addressed <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pain: _____	Nausea: _____	Anxiety: _____	Shortness of Breath: _____	Constipation: _____	BM 48 Hr:	Screen - Spiritual Care:	Screen – Psychosocial:
<input type="checkbox"/> Pt Decline/ Prov Unable <input type="checkbox"/> Pt Unable <input type="checkbox"/> Unknown	<input type="checkbox"/> Pt Decline/ Prov Unable <input type="checkbox"/> Pt Unable <input type="checkbox"/> Unknown	<input type="checkbox"/> Pt Decline/ Prov Unable <input type="checkbox"/> Pt Unable <input type="checkbox"/> Unknown	<input type="checkbox"/> Pt Decline/ Prov Unable <input type="checkbox"/> Pt Unable <input type="checkbox"/> Unknown	<input type="checkbox"/> Pt Decline/ Prov Unable <input type="checkbox"/> Pt Unable <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Patient/Family Refused <input type="checkbox"/> Patient/Family Unable	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Patient/Family Refused <input type="checkbox"/> 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
<input type="checkbox"/> In-person <input type="checkbox"/> Video <input type="checkbox"/> Telephone <input type="checkbox"/> Unknown	<input type="checkbox"/> Same as previous <input type="checkbox"/> New: _____	<input type="checkbox"/> Same as previous <input type="checkbox"/> New: _____	<input type="checkbox"/> Same as previous <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Same as previous <input type="checkbox"/> ID & Doc <input type="checkbox"/> None confirmed <input type="checkbox"/> Not addressed <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Pain: _____	Nausea: _____	Anxiety: _____	Shortness of Breath: _____	Constipation: _____	BM 48 Hr:	Screen - Spiritual Care:	Screen – Psychosocial:
<input type="checkbox"/> Pt Decline/ Prov Unable <input type="checkbox"/> Pt Unable <input type="checkbox"/> Unknown	<input type="checkbox"/> Pt Decline/ Prov Unable <input type="checkbox"/> Pt Unable <input type="checkbox"/> Unknown	<input type="checkbox"/> Pt Decline/ Prov Unable <input type="checkbox"/> Pt Unable <input type="checkbox"/> Unknown	<input type="checkbox"/> Pt Decline/ Prov Unable <input type="checkbox"/> Pt Unable <input type="checkbox"/> Unknown	<input type="checkbox"/> Pt Decline/ Prov Unable <input type="checkbox"/> Pt Unable <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Patient/Family Refused <input type="checkbox"/> Patient/Family Unable	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Patient/Family Refused <input type="checkbox"/> 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: <input type="checkbox"/> Alive <input type="checkbox"/> Died <input type="checkbox"/> Unknown	
Code Status at Discharge: <input type="checkbox"/> Full <input type="checkbox"/> DNR, not DNI <input type="checkbox"/> Other Limited DNR <input type="checkbox"/> DNR/DNI(DNAR+AND) <input type="checkbox"/> Unknown	AD Present at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	POLST/MOLST Present at Discharge: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> N/A – No POLST in state
Date of Hospital Discharge: ____/____/____ Time: ____:____:____		

Appendix IV: PCQC Required Data Elements

PCQC Data Sheet	First Visit	Subsequent Visits
Patient Details		
CIN	1	1
Name	2/3	2/3
DOB	4	
Gender	5	
Ethnicity	6	
Race	7	
Preferred Language	8	
Referral Information		
Referral Source	11	
Reason for referral	12	
Primary diagnosis	13	
Consult		
Date of Visit	15	15
Consultation Location	18	18
Primary Caregiver	19	19
Goals of care discussed	21	21
Advanced Directive Completed	24	24
POLST Completed during Consult	26	26
Resuscitation Preference	27	27
PPS score	28	28
Patient Assessment		
Pain	30:a	30:a
Depression	30:c	30:c
Anxiety	30:d	30:d
Well-being	30:g	30:g
Shortness of Breath	30:h	30:h
Patient/Family Screened for Spiritual Needs	33	33
Patient/Family Screened for Psychosocial Needs	33	33

The items listed above are the required elements to be addressed for the PCQC QIP. There are 25 questions for the first/initial visit and 16 questions for all subsequent visits. If no box is checked or if the answer is “unknown”, then the item will not be counted as addressed.

The Patient Details and Referral Information are only required for the first consult visit.