Palliative Care Provider Medical Record Review Tool

MPQP1022 – Attachment M

Health Plan	PHC	**IPA**		**Site ID No.**		**Review Date**		**Last Review Date**	

Provider Name/ Address		**Phone**		**Fax**	

Contact Person/Title		**Reviewer/Title**	

Visit Purpose:

_____ Initial Full Scope _____ Monitoring _____ Periodic Full Scope _____ Follow-up _____ Focused Review _____ Ed/TA _____Other _____

EHR System used:

Site Scores

	Points Poss.	**Yes Pts. Given**	**No's**	**N/A's**	
Documentation	**90**				
	Total Pts. Poss.	**Yes Pts. Given**	**No's**	**N/A's**	

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all six sections.
3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 95 total points poss.
4) Divide total points given by 95 or by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

_____ ÷ _____ = _____ X 100 = _____%

Points Given / **Total / Adjusted Points** / **Decimal Score** / **Compliance Rate**

Compliance Rate

_____ **Exempted Pass: 90% or above**

_____ **Conditional Pass: 80-89%**

_____ **Not Pass: Below 80%**

_____ CAP Required

_____ Other follow-up

Next Review Due: _____

Palliative Care Provider Medical Record Review Tool

Purpose: Site Review Guidelines provide the standards for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Compliance levels include:

1) Exempted Pass: 90% or above
2) Conditional Pass: 80-89%
3) Not Pass: below 80%

Compliance rates are based on 90 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Reviewers are expected to determine how to ascertain information needed to complete the survey. Survey criteria to be reviewed only by a R.N. or physician is labeled **RN/MD Review only**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Provide assistance/consultation as needed for CAPs, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for both sections to determine total points given for the site.
3) Subtract all "N/A" items from 90 total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on 90 points.
4) Divide the total points given by 90 or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section. Example: 87 points for Documentation	**Step 2**: Subtract "N/A" points from total points possible (90). 90 (Total points possible) – 1 (N/A points) 89 ("Adjusted" total points possible)

Step 3: Divide total points given by 90 or by the "adjusted" points, then multiply by 100 to calculate percentage rate.

$$\frac{\text{Points given}}{100 \text{ or "adjusted" total}} \quad \text{or} \quad \frac{87}{89} = 0.977 \times 100 = \mathbf{98\%}$$

Palliative Care Provider Medical Record Review Tool

Criteria	Documentation
1. Written patient specific care plan (intake, engagement visit or initial care plan)	
a. Medical History	A complete and accurate history including pre-existing medical conditions and current comorbidities needs to be present in the patients chart.
b. Medication reconciliation	Medication lists need to be addressed and updated at each visit to provide the most current information.
c. Social history	Social history is to include documentation of discussion regarding needs pertaining to patient/family support, grief, legal issues, funeral arrangements, discharge planning.
d. Emotional needs	An ongoing discussion needs to be documented in visit notes that patient and/or family member's emotional state is being discussed and addressed.
e. Spiritual concerns	Identification of patient or family member spiritual needs and/or distress and if further assessment or intervention is needed and completed.
f. Written documentation of goals of care	Documentation of collaboration between PC team and patient/family member to create a personalized plan of care so healthcare professionals know how to respond in the event that the patient is unable to speak for him/herself. This is assessed and updated throughout progression of care.
2. Does the care plan document interdisciplinary team evaluation: medical, social services, emotional and spiritual needs?	As a part of the member engagement and enrollment process a multidisciplinary comprehensive assessment is required, which includes: Medical, Social Services, Emotional and Spiritual needs. Services may be refused, but must be documented.
3. **Advance Care Plan**	
a.) Written documentation of ACP discussion	Documentation of a member of the Palliative Care (PC) team directing questions at the patient to identify 1) patient's preferences for care in the event that patient is unable to speak for him/herself and/or 2) patient's preferences about current plan of care. **(PHC Policy- MCUP3137 Attachment C, 1)**
b.) POLST completed and signed by patient and provider	Is there a POLST on File and is it signed by both the provider and the patient/Durable Power of Attorney for Health Care? This is not mandatory to maintain compliance with PHC standards, however there is a monetary bonus that is given for each POLST on file. **(no points associated with this)**
c.) Durable Power of Attorney for Health Care (DPAHC) on file?	If there is someone other than the patient making decisions regarding healthcare, a DPAHC needs to be on file. **(no points associated with this)**
4. Contact was made with member within seven days of referral	Contracted intensive palliative providers will contact members referred to their program for evaluation within 7 calendar days to arrange an evaluation and assessment.
5. Common symptoms associated with the qualifying diagnosis are consistently assessed at each visit.	Nursing discretion will be used to determine if symptoms associated with individual patient's qualifying diagnosis and comorbidities are consistently addressed and followed up on by the provider (MD, DO, NP, PA, RN)
6. Each visit type documented appropriately? (Spiritual, Medical, Social Services, etc.)	There has to be clear documentation of who is providing care at each visit.
7. Use of a Palliative Performance Score sheet or Karnofsky Performance Scale score sheet.	Documentation of a score, 70 or below, on a standardized form. Could be Palliative Performance Score sheet or Karnofsky Performance Scale score sheet.

Palliative Care Provider Medical Record Review Tool

Documentation	MR #1	MR #2	MR #3	MR #4	MR #5	Wt.	Site Score
1) Written patient specific care plan upon intake, engagement visit or initial appointment:							
a) Medical history						1	
b) Medication reconciliation						1	
c) Social history						1	
d) Emotional needs						1	
e) Spiritual concerns						1	
f) Written documentation of goals of care						1	
2) Does the care plan document interdisciplinary team evaluation: medical, social services, emotional and spiritual needs?						1	
3) **Advance Care Plan**							
a) Written documentation of ACP discussion						1	
b) POLST completed and signed by patient and provider (Y/N only)	Y/N	Y/N	Y/N	Y/N	Y/N	0	N/A
c) Durable Power of Attorney for Health Care (DPAHC) on file?	Y/N	Y/N	Y/N	Y/N	Y/N	0	N/A
4) Contact was made with member within seven days of referral						1	
5) Common symptoms associated with the qualifying diagnosis are consistently assessed at each visit.						1	
6) Each visit type documented appropriately (Spiritual, Medical, Social Services, etc.)						1	
7) Use of a Palliative Performance Score sheet or Karnofsky Performance Scale score sheet.						1	

Total pts possible this page: 60

Palliative Care Provider Medical Record Review Tool

Criteria	Documentation
8) Does the documentation reflect interdisciplinary team involvement at least monthly for each member on palliative care?	Does documentation support that each disciplinary team (Medical, Social Services, Emotional and Spiritual) is meeting with member at least monthly.
9) Visit frequency minimum is documented via face to face, telemedicine or telephonically (RN, FNP, PA, or MD)	Enrolled members must have at minimum: • One in-person or video visit by an RN every month (the RN must see the member face to face at a minimum of once every 12 weeks) • One in-person or video visit by a social worker every month • Standardized assessments of symptoms must be done approximately every 14 days. Assessments may be completed face to face, via telemedicine or telephonically

Palliative Care Provider Medical Record Review Tool

Documentation	MR #1	MR #2	MR #3	MR #4	MR #5	Wt.	Site Score
8) Does the documentation reflect interdisciplinary team involvement at least monthly for each member on palliative care?						1	
9) Visit frequency minimum is documented via face to face, telemedicine or telephonically (RN, FNP, PA, or MD) (5 pts possible)						5	
Yes							
No							
N/A							

Total pts possible this page: 30. Total pts possible this domain: 90