

# PCQC Dataset Review and Q&A

April 17, 2020

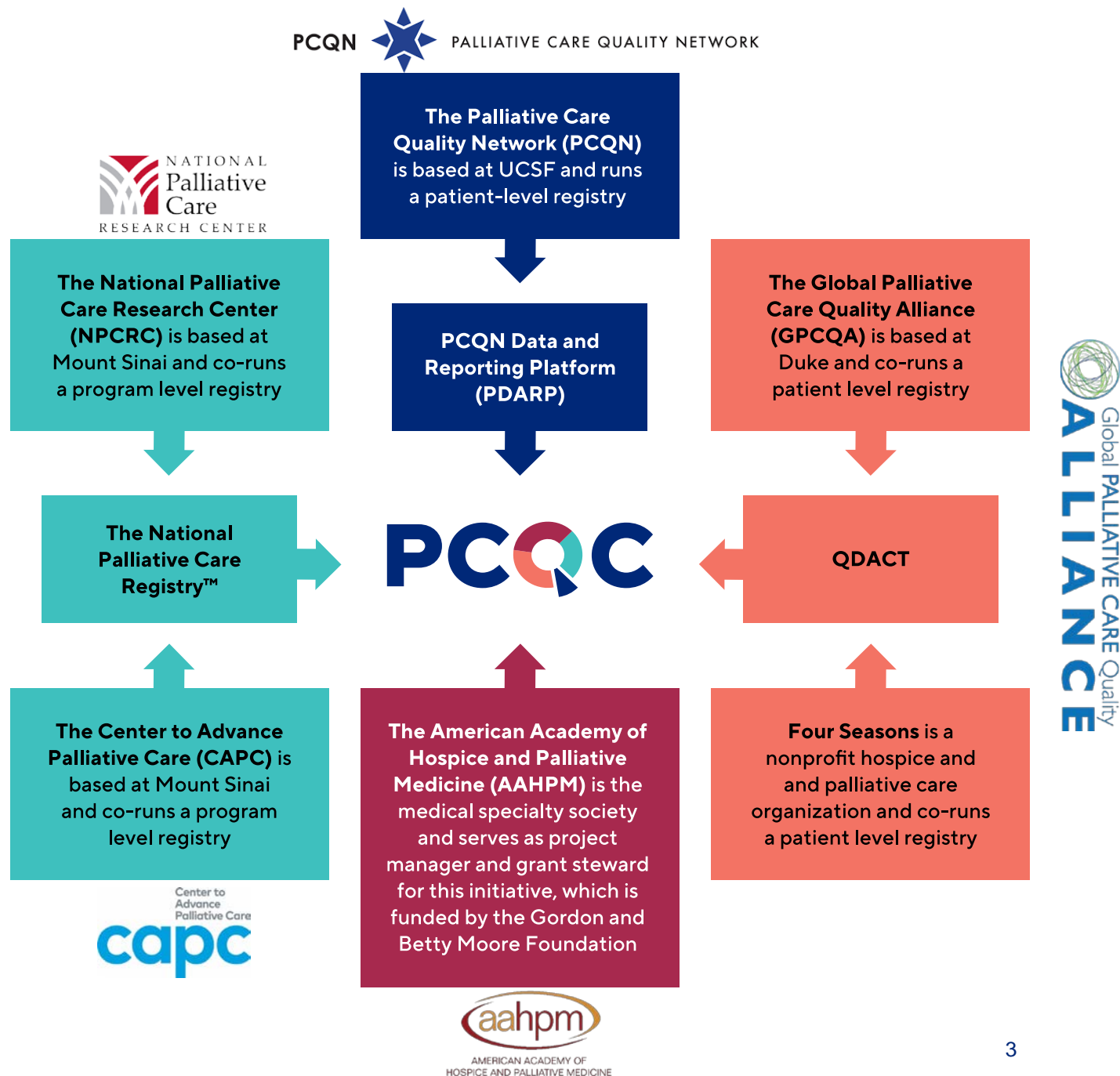


# PCQC Background

# The PCQC Project Team

The PCQC is a new 501(c)(3) organization that will house a **new national palliative care collaborative and data registry system** that will capture both program and patient-level quality data.

The goal is to have the new registry system operational by summer 2020.



# The PCQC:

- Program-level structure and process measures and reporting
- Patient-level outcome measures and reporting
- Network of like-minded people
- Practice improvement/QI collaboratives
- Research and measure development
- Technical assistance

# PCQC Dataset

#	Data Label	Description	Format	Data Validation Rules	Inpatient	CB
<b>Patient Demographics / Identifiers</b>						
REQ 1	Medical Record Number (MRN)	The medical record number is organization specific. The number is used by the hospital as a systematic documentation of a patient's medical history and care during each hospital stay.	Numeric	N/A	Yes	Yes
REQ 2	Encounter or Visit Number	The encounter or visit number is the unique identifier assigned by the hospital that's given to a patient for that particular admission to the hospital.	Alpha Numeric	N/A	Yes	
REQ 3	First Name	All alphanumeric characters, empty space, and the characters: - (dash), . (period), , (comma) are allowed.	Text	N/A	Yes	Yes
REQ 4	Last Name	All alphanumeric characters, empty space, and the characters: - (dash), . (period), , (comma) are allowed.	Text	N/A	Yes	Yes
REQ 5	Gender Identity	What is the patient's current gender identity? One's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. One's gender identity can be the same or different from their sex assigned at birth.	Single-select	Female Male Transgender Male/Female-to-Male (FTM) Transgender Female/Male-to-Female (MTF) Non-Binary Prefer to Self-Describe (Write-in)	Yes	Yes
REQ 6	Birthdate	Patient's date of birth	Numeric	N/A	Yes	Yes
REQ 7	Ethnicity	Does the patient identify as Hispanic and/or Latino?	Single-select	Hispanic or Latino Non-Hispanic or Latino	Yes	Yes
REQ 8	Race	Does the patient identify as belonging to one or more of the following race categories?	Multi-select	White Black or African-American Asian Native Hawaiian or Other Pacific Islander American Indian or Alaska Native Other (Write-in) Not Reported Unknown	Yes	Yes
REQ 9	Preferred Language	What is the patient's preferred language?	Single-select	English Spanish Other Indo-European languages Asian and Pacific Island languages Other languages (Write-in)	Yes	Yes
REQ 10	Primary Caregiver	Which term best describes the person who is considered this patient's primary caregiver?	Single-select	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 (informal e.g. neighbor, friend) None Unknown	Yes	Yes
<b>Referral Information</b>						

# PCQC Dataset

## Program-Level Data

- **Program information** (e.g. location, type of hospital, number of hospital beds)
- **Staffing levels**
- **Program features** (e.g. coverage levels, certifications, EMR systems)
- **Referral locations and specialists**

## Patient-Level Data

- **Patient and consult characteristics** (e.g. diagnosis, reason for referral)
- **Advanced care planning** (e.g. advanced directive complete)
- **Screenings items and interventions** (e.g. psychosocial needs screened)
- **Symptom scores and improvement**

# PCQC Core Dataset Review

## Inpatient

# Inpt Core Dataset Review

-  New core data elements
-  Revised categories

## Patient Demographics

- MRN
- Encounter number
- First Name, Last Name
- **Gender identity**
- **Birthdate**
- **Ethnicity**
- **Race**
- **Preferred language**
- **Primary caregiver**

## Referral Information

- **Referral service**
- **Reasons for initial referral**
- Date of referral

## Consult Characteristics

- Date of admission
- Date of consult / visit
- Initial / follow-up visit
- **Telehealth**
- **Consultation location**
- **Primary diagnosis that lead to consult**



# Inpt Core Dataset Review

-  New core data elements
-  Revised categories

## Advance Care Planning

- Documentation of goals of care
  - If no, were goals of care discussed?
- Code status at consult and after/at discharge
- Preferences for life sustaining treatments
- Presence of AD
  - Was an AD document(s) completed during the consultation?
  - If no, was one discussed?
- Presence of POLST/MOLST
  - Was an POSLT/MOLST completed during the consultation?
  - If no, was one discussed?
- Surrogate decision maker/medical durable power of attorney identified

## Disposition/Death-Related Items

- Date of palliative discharge/sign-off
- Date of discharge from the hospital
- PC disposition status

## Misc. Processes

- PC team members involved in care of patient
- If referral service = Emergency Medicine, avoided admission

## Functional Status

- PPS at time of consult/visit

# Inpt Core Dataset Review

-  New core data elements
-  Revised categories

## Daily Symptom Assessment (0-10 scale)

- Pain
- Nausea
- Anxiety
- Shortness of breath

## Symptom Assessment (continued)

- Bowel movement in the last 48 hours (Y/N)

## Additional Screens / Assessments

- Was the patient screened for spiritual care?
- Was the patient or family screened for psychosocial needs?

# PCQN Inpt Data Elements Not Included in PCQC Inpt Dataset

## Patient/consult characteristics:

- Patient not seen
- Number of family meetings

## Advanced care planning:

- Code status clarified (*removed as a discrete data element, but can be deduced*)

## Disposition/Death-Related Items:

- Discharge location
- Discharge services (*moved to optional*)

## Additional screens/assessments:

- Screen for pain (*removed as a discrete data element, but can be deduced from pain scores*)
- Screen for non-pain symptoms (*removed as a discrete data element, but can be deduced from non-pain scores*)
- Screen for ACP/GOC (*removed as a discrete data element, but can be deduced from ACP data elements*)
- Intervention for pain
- Intervention for non-pain symptoms
- Intervention for psychosocial needs
- Intervention for spiritual needs
- Intervention for ACP/GOC

# PCQC Core Dataset Review

## Community-Based

# CB Core Dataset Review

-  New core data elements
-  Revised categories

## Patient Demographics

- MRN
- First Name, Last Name
- Gender identity
- Birthdate
- Ethnicity
- Race
- Preferred language
- Primary caregiver


## Referral Information

- Referral source / location
- Reasons for initial referral
- Date of referral

## Consult Characteristics

- Date of consult / visit
- Initial / follow-up visit
- Telehealth
- Consultation location
- Primary diagnosis that lead to consult

# CB Core Dataset Review

-  New core data elements
-  Revised categories

## Advance Care Planning

- Documentation of goals of care
  - If no, were goals of care discussed?
- Resuscitation preference (at time of visit)
- Preferences for life sustaining treatments
- Presence of AD
  - Was an AD document(s) completed during the consultation?
  - If no, was one discussed?
- Presence of POLST/MOLST
  - Was an POSLT/MOLST completed during the consultation?
  - If no, was one discussed?
- Surrogate decision maker/medical durable power of attorney identified

## Misc. Processes

- PC team members involved in care of patient

## Functional Status

- PPS at time of consult/visit

# CB Core Dataset Review

-  New core data elements
-  Revised categories

## Symptom Assessment (ESAS)

- Pain
- Tiredness
- Nausea
- Depression
- Anxiety
- Drowsiness
- Appetite
- Well-being
- Shortness of breath
- Other

## Symptom Assessment (continued)

-  Bowel movement in the last 48 hours (Y/N)

## Additional Screens / Assessments

- Was the patient screened for spiritual care?
- Was the patient or family screened for psychosocial needs?

# PCQN CB Data Elements Not Included in PCQC CB Dataset

## Advanced care planning:

- Support for caregiver provided
- Preference for life sustaining treatment clarified

## Misc. processes:

- Services referred to (*moved to optional*)

## Overall symptom assessment tool/approach:

- Are you at peace
- Overall quality of life
- Distress thermometer (*moved to optional*)

## Additional screens/assessments:

- Screen for pain (*removed as a discrete data element, but can be deduced from pain scores*)
- Screen for non-pain symptoms (*removed as a discrete data element, but can be deduced from non-pain scores*)
- Screen for ACP/GOC (*removed as a discrete data element, but can be deduced from ACP data elements*)
- Intervention for pain
- Intervention for non-pain symptoms
- Intervention for psychosocial needs
- Intervention for spiritual needs
- Intervention for ACP/GOC



# Q&A

**PCQC**

# PCQC COVID-19 Case Report Form

- **Short case report form** to collate experiences of PC clinicians in caring for COVID-19 positive, PUI (Persons Under Investigation), and recovered patients
- Data entry is only **a few minutes** per patient
- **Free to use**
- **Does not require you be a member of PCQC**
- <https://palliativequality.org/covid-19-case-report>

## PCQC COVID-19 Case Report

In the wake of the COVID-19 crisis, the PCQC has developed a voluntary, short case report to collate experiences of palliative care clinicians in caring for COVID positive, PUI (Person Under Investigation), and recovered patients. These experiences are shared with the palliative care community to foster continuous learning.

Please complete the case report for each patient. The case report includes data on the final status of the patient and therefore should be submitted after the consult is completed. We recommend collecting data on paper, using the PCQC COVID-19 data collection card. We would like you to answer as many questions as you can, but all responses are optional. At the end of the case report, you have the option to enter another case report.

You do not need to be a member of PCQC to participate. The case report is free and voluntary. You can learn more about the case report [here](#). If you have any questions, please reach out to [lmueller@palliativequality.org](mailto:lmueller@palliativequality.org). Thank you!

The Palliative Care Quality Collaborative is the new, unified quality registry for specialty palliative care. Its mission is to provide palliative care clinicians and programs with actionable information to improve the quality of palliative care delivery. If you are interested in becoming a member of PCQC, click [here](#).

This form only takes a few minutes to complete per patient.

**Palliative Care Quality Collaborative**

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