

EHR Strategies for the Palliative Care Team: A Town Hall Discussion

Leslie Blackhall, MD, MTS, University of Virginia Health System
Associate Professor of Medicine and Palliative Care Leadership Center™ Faculty

Nancy Guinn, MD, Presbyterian Healthcare Services
Medical Director, Presbyterian Healthcare at Home and Palliative Care Leadership Center™ Faculty

David Ling, MD, FACP, FHM, University of Virginia Health System
Associate Chief Medical Information Officer

Facilitated by: Brynn Bowman, MPA, Center to Advance Palliative Care
Vice President of Education

Join us for upcoming CAPC events

→ Upcoming Webinars:

- **Hospices as Providers of Community-Based Palliative Care: Demystifying the Differences**
 - Friday, June 1, 2018 1:30 pm
- **Improving Team Effectiveness: An Interdisciplinary Team (IDT) Panel Discussion**
 - Tuesday, June 12, 2018 3:00 pm

→ Virtual Office Hours:

- **Billing for Community Based Palliative Care with Anne E. Monroe, MHA**
 - Thursday, May 24, 2018 12:00 pm
- **NEW! For the Established or Mature Hospital Program with Rodney Tucker, MD, MMM, FAAHPM**
 - Tuesday, May 29, 2018 4:00 pm

EHR Strategies for the Palliative Care Team: A Town Hall Discussion

Leslie Blackhall, MD, MTS, University of Virginia Health System
Associate Professor of Medicine and Palliative Care Leadership Center™ Faculty

Nancy Guinn, MD, Presbyterian Healthcare Services
Medical Director, Presbyterian Healthcare at Home and Palliative Care Leadership Center™ Faculty

David Ling, MD, FACP, FHM, University of Virginia Health System
Associate Chief Medical Information Officer

Facilitated by: Brynn Bowman, MPA, Center to Advance Palliative Care
Vice President of Education

Objectives

→ **Attitude:**

- Reflect on the challenges and barriers in making the most of your EHR
- Share motivations to create an improved system of documentation and data capture

→ **Knowledge:**

- Identify key components of a usable and helpful EHR toolkit for palliative care
- Identify partners and stakeholders in designing and building EHR tools
- List informatics strategies to identify palliative care patients that leverage EHR functions

→ **Skills:**

- List the necessary components of documentation and how they can be incorporated in an EHR
- Understand how data capture can be embedded within EHR workflows

Audience Poll

- Why do you want to improve your EHR?
 - Identify patients for palliative care consult
 - Improve communication with team and referrers
 - Get documentation for billing
 - Build workflow reminders
 - Improve tracking and usability of clinical data
 - Capture quality data

What is an “EHR?”

Electronic Health Record:

→ Goes beyond a paper chart and allows us to communicate across systems, track patient data over time...

Five Key Values of Well-Designed EHR Tools

1. Triggers to identify patients who need services
2. Documentation templates that help to standardize work, communicate effectively and support billing
3. Reminders to ensure that all tasks are completed
4. Data captured through EHR documentation that forms the basis for reporting
5. Functions to track patients longitudinally for transitions and continuity

Key Principles

- **Interoperability** - ability to track key information across care settings
- **Usability** - easy of use with little “double work”
- **Accessibility** – key information for all team members (e.g. Advance Care Planning)
- **Patient engagement** – Easy access for patients to their own information (e.g. Patient portal)
- **Care coordination** – Improved communication results in better care.

1. Identifies Patients

- Screening tools for referrals to Palliative Care
 - Screening embedded in the EHR
 - Uses logic that is based on EHR data that can trigger a referral (or a reminder for referral)
 - Diagnoses in a Problem List (ICD-10)
 - New Patients scheduled to a specific clinic, admissions to a specific unit
 - Recent Admissions or ED visits
 - Embedded items in a Home Health admission involving functional decline
 - Nursing admission questions upon hospital admission
 - Patient distress or symptom screenings in a clinic
 - Registries

Palliative Care Screening Tool

Navigators

Admission Transfer Discharge

Psychosocial - Psychosocial Review

Time taken: 2213 2/8/2015

Values By Create Note

Domestic Abuse Assessment

Physical Abuse Denies Denies, provider concern...

Verbal Abuse Denies Denies, provider concern...

Possible abuse reported to: Advocate County social services Social se

Values/Beliefs

Cultural Requests

During Hospitalization

Spiritual Requests

During Hospitalization

Palliative Care Assessment

Does patient have a potentially life-limiting or life-threatening condition? Yes No

Consent

Spiritual Care Consult Needed Yes (Comment) No

Social Services Consult Needed Yes (Comment) No

Palliative Care Consult Needed Yes (Comment) No

Consults Needed Assessment: 1/21 1328 - 2/8 2212

Consults Needed Assessment: 1/21 1328 - 2/8 2212

Close Cancel

Palliative Care Screening Tool

Navigators

Admission Transfer Discharge

Overview

Outside Records

Consents

Travel/Exposure

Vital Signs

Interpreter Services

Allergies

Home Meds

History

Immunizations

Vaccinations

Directives

Implants

Belongings

Assessments

Nutrition

ADLs

► **Psychosocial**

Suicide Risk

Fall Risk

Skin Risk

Discharge Planning

Interventions

BestPractice

Orders

Palliative Care Assessment

Does patient have a potentially life-limiting or life-threatening condition? ☒ Yes ☐ No

Admission Primary Criteria

Do you expect patient to expire within 12 months or before adulthood? ☐ Yes ☐ No

Frequent Admissions ☐ Yes ☐ No

Difficult-to-Control Physical or Psychological Symptoms ☐ Yes ☐ No

Complex Care Requirements ☐ Yes ☐ No

Decline in Function, Feeding Intolerance, or Unintended Decline in Weight ☐ Yes ☐ No

Admission Secondary Criteria

Admission from Long-Term Care Facility or Medical Foster Home ☐ Yes ☐ No

Elderly Patient, Cognitively Impaired, with Acute Hip Fracture ☐ Yes ☐ No

Metastatic or Locally Advanced Incurable Cancer ☐ Yes ☐ No

Chronic Home Oxygen Use ☐ Yes ☐ No

Symptom-based trigger

Patient-Reported Symptoms Require Intervention

WHO: Oncology patients with elevated scores on symptom screening

ACTION:

- Please review scores below, address as indicated and click "reviewed" and "accept."
- The Care Tracks team will inform social work about patients with anxiety or depression score of 8 or more ("often" anxious or depressed).
- Patients with a pain score of 8 or more (pain "often" interferes with activities), will be offered for discussion at Supportive Care Tumor Board.


MYCOURSE BPA UVA	12/1/2017	2/1/2018
10 = Most Anxious	5	8.5
10 = Most Depressed	6.5	7
10 = Most Fatigued	5	4
10 = Most Pain	7.33	8.66
10 = Best Physical Function	7.5	7.5

Sponsorship: UVA Cancer Center

Version number 1 (September / 2014)

[Review Flowsheets](#) 

The following actions have been applied: _____

✓ Sent:  This advisory has been sent via In Basket

Patient Registry

Reports

PHS High-Risk Palliative - Zip Code 50-69 Yrs [4353650] as of Wed 9/7/2016 12:26 PM

Filters Options Patient Outreach Call Patient Outreach Letter Patient Outreach MyChart MSG Chart Encounter Bulk Orders Communication HM Modifiers

DIURETIC MED FOR HF ON OXYGEN Number of ED Visits Number of Admissions Number of Encounters	MRN	Patient	DOB	Age	Sex	PCP	Primary Payor	Zip	HF Unspecified	DIURETIC MED	ON OXYGEN	Number of ED V	Number of Admi	Number of E
	01			56 y.o.	Female	Edmonds, Jeremy Todd	PHP SENIOR CAP	8710	X	X	X	0	0	55
	01			66 y.o.	Female	Welker, Tina Y	PHP SENIOR CAP	8712	X	X	X	0	0	17
	01			57 y.o.	Female	Papafrangos, Elaine D	PHP SENIOR CAP	8711	X	X	X	0	1	59
	01			64 y.o.	Female	Rivera, Patrick	PHP SENIOR CAP	8711	X	X	X	0	0	76
	01			64 y.o.	Female	George-Lucero, Dayana M	PHP SENIOR CAP	8710	X	X	X	0	0	58
	01			69 y.o.	Male	Rivera, Patrick	PHP SENIOR CAP	8712	X	X	✓	2	0	115
	01			58 y.o.	Female	Pedregro, Lilia	PHP SENIOR CAP	8712	X	X	X	0	0	12
	01			67 y.o.	Male	Vizcarra, Lourdes	PHP SENIOR CAP	8704	X	X	X	0	0	66
	01			68 y.o.	Female	Aguayo Rico, Alberto	PHP SENIOR CAP	8712	X	✓	X	0	0	191

Back LPOC

Patient Care Coordination Note
 Mary Ann Gonzales, LPN 5/24/2016 2:39 PM
MA HMO Senior Visit completed for 2016

Recent Outpatient Visits
 1 week ago Small cell lung cancer, left
 UNSER Bernard M Agbemadzo, MD
 ONCOLOGY
 2 weeks ago Coronary artery disease involving native coronary artery of native heart

Current Problems

Chronic

Arthropathy 5/30/2010

Claudication, intermittent 5/30/2010

HCC/HRA

Asthma with chronic obstructive pulmonary disease (COPD) 5/30/2010

Overview

Patrick Rivera, MD
 4/26/2016
Assessment: Stable - Compliant
Plan: Medications :albuterol, flovent

Mixed hyperlipidemia 5/30/2010

Overview

Current Medications

prochlorperazine (COMPAZINE) 10 mg tablet
 Take 1 tablet by mouth every 6 hours as needed for Nausea.

FLOVENT HFA 220 mcg/actuation inhaler
 INHALE 1 PUFF BY MOUTH INTO THE LUNGS TWICE DAILY. RINSE MOUTH AFTER USE

terazosin (HYTRIN) 2 mg capsule
 TAKE ONE CAPSULE BY MOUTH EVERY NIGHT AT BEDTIME

dexamethasone (DECADRON) 4 mg tablet
 Take 2 tablets by mouth as directed for Nausea. Once day 2 then BID days 3-4

SPIRIVA WITH HANDIHALER 18 mcg inhalation capsule
 INHALE THE CONTENTS OF ONE CAPSULE VIA HANDIHALER EVERY DAY


MAGNESIUM ORAL
 Take by mouth.

CYANOCOBALAMIN, VITAMIN B-12, (VITAMIN B-12)

Apply Clear All

100 of 1022 results loaded Load All

2. Documentation templates

NoteWriter 

Consults **Supportive Services note**

Reason for initial consult?

Pain control	Establish goals of care	Non-pain symptom management
Hospice referral	Terminal care	Psych, social or spiritual support
Complex chronic conditions	Family / clinician negotiation	Eval for hospice house admit
Interfamily conflict	Withdrawal of life supporting treatment	Disposition
Other		

Referring Provider?

Referring Specialty?

Adult Foster Home	Assisted Living Facility	Cardiology	Dialysis Clinic
DME Services	Emergency Medicine	Hospice and Palliative Medicine	Hospitalist
Infusion Clinic	Intensive Care	Intermediate Care Facility	Long Term Acute Care Hospital
Memory Care	Oncology	Oncology Clinical Social Worker	Oncology Financial Counselor
Oncology Pharmacist	Pastoral Care	Registered Nurse	Skilled Nursing Facility
Social Services	Social Worker	Surgery	Ventilator Services

Primary diagnosis leading to consult?

Cancer (solid tumor)	Cardiovascular	Complex chronic condition(s)	Failure to thrive
Congenital or chromosomal	Dementias	Gastrointestinal	Hematologic
Hepatic	Infectious or immunologic	Pulmonary	Renal
Stroke	Trauma	Vascular	In-utero complication or condition
Neurodegenerative			

Code status at time of consult?

DNR ☐ Full ☐

Advance directive in chart at time of consult?

Yes ☐ No ☐

POLST in chart at time of consult?

Yes ☐ No ☐

ECOG:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐

Palliative Performance Scale:

100% ☐ 90% ☐ 80% ☐ 70% ☐ 60% ☐ 50% ☐ 40% ☐ 30% ☐ 20% ☐

10% ☐








Handoff **Hospital Course** **Edit Note**

My Note

Consults **Supportive Services note**

Service: Case Management Date of Service: 4/9/2018

☐ Cosign Required

 **B**      Insert SmartText 

Recent Labs

Lab	04/07/18
2133	
ALKPHOS	122*
ALT	8
AST	16
BILITOT	<=0.2
PROT	7.0
ALBUMIN	3.1*

Recent Labs

Lab	04/07/18
2133	
INR	1.2*
PTT	30.9

Supportive Services Consult Note

Total time *** minutes; greater than 50% of that time

Thank you for including Supportive Services in the c
Services with any questions.

Thomas M. Steele, MD
Samaritan Supportive Services
Office 541-768-4643
Cell. 541-974-0973

4/9/2018

2. Documentation templates

ASSESSMENT / PROGNOSIS	

RECOMMENDATIONS	
Goals of Care:	***
Symptom Management:	***
Psychosocial:	***
Intervention(s) made by team:	{Select all that apply:15273}
Spent {Care Coord. Time:13938} out of {Total Time:13941} minutes in care coordination with the medical team and in education of {Patient family members:11427} on prognosis, disease process and symptom management.	
{Select for prolonged service - otherwise DELETE:15272}	

- Symptom management
- Establish surrogate decision maker
- Completion of Advance Care Directives
- Change in code status
- Participation in family meeting
- Defined goals of care
- Psychosocial support
- Medical Crisis Counseling
- Resources / education
- Documentation of no escalation of care
- Defined goal of no future re-hospitalization
- Transition to Comfort Care
- Transition to Home Hospice
- Transition to IPU or Hospital Hospice
- Facilitated discharge to Palliative Home Care

3. Reminders for tasks

HISTORY OF PRESENT ILLNESS	
Information for this consult was obtained from:	{Select source(s):15269}
HPI	
Pain Regimen:	{Regimen?:15289}
Review:	I have reviewed the {Reviewed:14835} in the electronic medical record and have made updates as needed.
PERTINENT REVIEW OF SYSTEMS	
Pain:	{Select Scale:15288}
Nausea / Vomiting:	{NV?:15270}
Dyspnea:	{Dyspnea?:15271}
Additional Review of Systems	
SOCIAL HISTORY / SPIRITUAL	

RECOMMENDATIONS	
Goals of Care:	***
Symptom Management:	***
Psychosocial:	***
Intervention(s):	{Select all that apply:15272}

4. Capturing data for reporting

C	D	E	F	G
First value	First Recorded Time	Last value	Last Recorded Time	Improved
6	7/9/2016 4:51:00 AM	6	7/9/2016 4:34:00 PM	Same
4	7/12/2016 8:30:00 AM	0	7/12/2016 9:00:00 PM	Improved
2	7/19/2016 9:35:00 PM	0	7/20/2016 8:40:00 PM	Improved
8	7/15/2016 11:45:00 AM	6	7/16/2016 11:00:00 AM	Improved
10	7/17/2016 10:41:00 PM	0	7/18/2016 10:15:00 PM	Improved
7	7/28/2016 2:45:00 PM	0	7/29/2016 3:00:00 AM	Improved
8	7/12/2016 9:22:00 PM	6	7/13/2016 8:28:00 PM	Improved
		9	7/20/2016 12:16:00 PM	Same
		4	7/29/2016 12:12:00 PM	Same
		4	7/23/2016 12:59:00 PM	Improved
		0	7/5/2016 11:30:00 AM	Improved
		0	7/30/2016 12:25:00 AM	Improved
		0	7/9/2016 1:15:00 PM	Improved
		3	7/15/2016 10:51:00 AM	Improved
		0	8/1/2016 7:43:00 PM	Improved
		0	7/8/2016 2:15:00 PM	Improved
		0	7/20/2016 4:00:00 AM	Improved
				Not Recorded
		7	7/30/2016 4:40:00 PM	Worse
		0	7/26/2016 3:27:00 AM	Improved
				Not Recorded
		0	7/28/2016 7:00:00 PM	Improved
		0	7/12/2016 1:30:00 PM	Improved
		0	7/6/2016 6:08:00 AM	Improved

HISTORY OF PRESENT ILLNESS	
Information for this consult was obtained from:	{Select source(s):15269}
HPI	
Pain Regimen:	{Regimen?:15289}
Review:	I have reviewed the {Reviewed:14835} in the electronic medical record and have made updates as needed.
PERTINENT REVIEW OF SYSTEMS	
Pain:	{Select Scale:15288}
Nausea / Vomiting:	{N/V?:15270}
Dyspnea:	{Dyspnea?:15271}
Additional Review of Systems	
SOCIAL HISTORY / SPIRITUAL	

Examples of Metric Data in Flowsheet

- Encounter Type
- Primary Palliative Diagnosis
- Advance Directives
- Edmonton Symptom Assessment System
 - Pain and Dyspnea rows
- Referrals Made

Encounter Type	
Encounter Type	<input type="text"/>
Primary Palliative Diagnosis	
Primary Palliative Diagnosis	<input type="text"/>
Advance Directives (For Healthcare)	
*Healthcare Directive (Calculated MU Data Element)	<input type="text"/>
Type of Healthcare Directive	<input type="text"/>
Healthcare Agent Appointed	<input type="text"/>
Healthcare Agent's Name	<input type="text"/>
Healthcare Agent's Phone Number	<input type="text"/>
Copy in Chart	<input type="text"/>
Patient has IPOST/POLST	<input type="text"/>
Pre-existing DNR/DNI Order	<input type="text"/>
Patient Requests Assistance	<input type="text"/>
Edmonton Symptom Assessment System	
ESAS completed by	<input type="text"/>
Pain Score	<input type="text"/>
Tiredness Score	<input type="text"/>
Nausea Score	<input type="text"/>
Depression Score	<input type="text"/>
Anxiety Score	<input type="text"/>
Drowsiness Score	<input type="text"/>
Appetite Score	<input type="text"/>
Wellbeing Score	<input type="text"/>
Dyspnea Score	<input type="text"/>
Constipation Score	<input type="text"/>
Other Problem Score	<input type="text"/>
Referrals Made	
Referrals Made	<input type="text"/>

Palliative Care Synopsis Report

Synopsis

☒ Events By Time
 ☒ Events By Type
 ☒ Current Status
 ☒ **Palliative Care**
☐ Prenatal Profile
 ☐ Ortho Profile
 »
 | 6 Months
 | 07/06/15 – 01/02/16

Display:
 | 7/9/2015 | 8/27/2015 | Most Recent Value

Encounter Type				
Encounter Type			Inpatient: Hospital	6/16/2015
Palliative Care Consult Type				
Palliative Care Consult Type				
Gestational Age				
Gestational Age				
Primary Palliative Diagnosis				
Primary Palliative Diagnosis				
Patient Goals				
Patient Goal(s)			test	1/12/2016
Advance Directives				
*Healthcare Directive		Yes AD	Yes AD	8/27/2015
(Calculated MU Data Element)		Met	Met	8/27/2015
Type of Healthcare Directive		Durable power of att...	Durable power of att...	8/27/2015
Information Provided on Healthcare Directives				
Healthcare Agent Appointed				
Power of Attorney for Healthcare Activated (WI Only)				
Healthcare Agent's Name				
Healthcare Agent's Phone Number				
Copy in Chart				
Patient has IPOST/POLST				
Date IPOST/POLST Initiated				
Pre-existing DNR/DNI Order				
Patient Requests Assistance				
Edmonton Symptom Assessment Symptom				
ESAS completed by			Patient	1/12/2016
Pain Score		3	3	8/27/2015
Tiredness Score			4	6/16/2015
Nausea Score			2	6/16/2015
Depression Score			4	6/16/2015
Anxiety Score			7	6/16/2015
Drowsiness Score			4	6/16/2015

5. Track patients longitudinally

Allergies: Actos [Pioglitazone], Ace Inh...	PCP: Jones, Anne C
Code: Prior	Registries: [Chronic Disease] PHS Diabetes Registr...
Adv Dir Filed?: Yes	My Sticky Note: +
Active Hospice/HH Episode: Y (HH)	Patient Messages: None
Coverage: PHP SENIOR CAP	HM: Due

← →

Snap Shot

Chart Review

Review Flowshe...

Results Review

Synopsis

Allergies

History

Medical House Calls

← ↻ 👤 📄 Medical House Calls 📄 SnapShot with Recent Visits 📄 Vitals/Pt Safety 📄 Pain 📄 FS 📄 Facesheet

📄 Patient Care Coordination Note

Jane M Brack, RN Wed Aug 3, 2016 12:50 PM

MA HMO Senior Visit completed for 2016

Patient managed by Complete Care/House Calls. Call 724-7300 for issues.

5. Track patients longitudinally

*Performed on: 08/17/2015 1536 CDT

Follow Up Information

Palliative Care Appointment Scheduled Prior to Discharge

☐ Yes
☐ No
☐ Other:

Palliative Care Appointment to be Scheduled By

☐ Patient ☐ Sibling
☐ Spouse ☐ Significant other
☐ Daughter ☐ Son
☐ Family member ☐ Caregiver
☐ Friend ☐ Readmission preventionist
☐ Parent ☐ Other:

Palliative Care Appointment Date/Time

MM / JJ / AAAA

Palliative Care Appointment Location

Provider Specialist or Clinic

Provider Assigned

Name of Clinic or Healthcare Facility

Provider Appointment Scheduled Prior to Discharge

☐ Yes
☐ No
☐ Other:

Provider Appointment to be Scheduled By

☐ Patient ☐ Friend ☐ Son
☐ Spouse ☐ Parent ☐ Caregiver
☐ Daughter ☐ Sibling ☐ Readmission preventionist
☐ Family member ☐ Significant other ☐ Other:

Provider Appointment Date/Time

MM / JJ / AAAA

Provider Appointment Location

Specialist Appointment Scheduled Prior to Discharge

☐ Yes ☐ Other:

5. Using diagnoses to “flag” patients and track them

Surgery/Anes

Labs

Imaging

Procedures

ECG

Other Orders

Meds

Episodes

Letters

Referrals

PresRecord/Media

Misc Reports

Select All

Review Selected

Master Report

Flowsheet

Route

Encounter

☒ Default Dept Only

Type	Department	Provider	Description
Home Visit	HVP	Gilbert-Savi, Abigail M, CNP	Pain (Primary Dx); Palliative care encounter; Nausea; Constipation, unspecified constipation type; Dyspnea
Telephone	HVP	Gilbert-Savi, Abigail M, CNP	Symptom-related
Telephone	KHOP	Guinn, Nancy, MD	New Medication
Office Visit	KHOP	Guinn, Nancy, MD	Malignant neoplasm of hilus of left lung (Primary Dx); Encounter for palliative care

Z51.5 = Encounter for Palliative Care

Presence of an Advance Directive

Advance Directive	
*Advance Directive <input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> No Advance Directive, information given <input type="radio"/> Unable to answer at this time	Advance Directive Date <input type="text"/>
Type of Advance Directive <input type="checkbox"/> Living will <input type="checkbox"/> Medical durable power of attorney <input type="checkbox"/> Other:	Medical Durable Power of Attorney Name <input type="text"/> Surrogate Name <input type="text"/>
Location of Advance Directive <small>Documenting "Unable to obtain copy" automatically enters a consult order to Social Work</small>	Reason Copy Cannot Be Obtained <input type="text"/>
<input type="radio"/> Copy obtained from previous records <input type="radio"/> Copy placed on paper chart <input type="radio"/> Family to bring in copy from home <input type="radio"/> Scanned into EMR <input type="radio"/> Unable to obtain copy <input type="radio"/> Other:	
Intent of Advance Directive Stated By <input type="radio"/> Self <input type="radio"/> Spouse <input type="radio"/> Friend <input type="radio"/> Other: <input type="radio"/> Relative <input type="radio"/> Significant other	Intent of Advance Directive <input type="text"/>
Patient Wishes to Receive Further Information on Advance Directives <input type="radio"/> Yes <input type="radio"/> No <small>Documenting "Yes" automatically enters a consult order to Social Work except on Long Term Care Encounters</small>	Organ Donation Consent <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unable to determine <small>Review advance directive or drivers license to verify if signature is present for organ donation.</small>

Steps to an EHR: 101

- Before you ask others to build something for you, decide what you need
 - Consider using an SBAR (Situation, Background, Assessment, Recommendation)

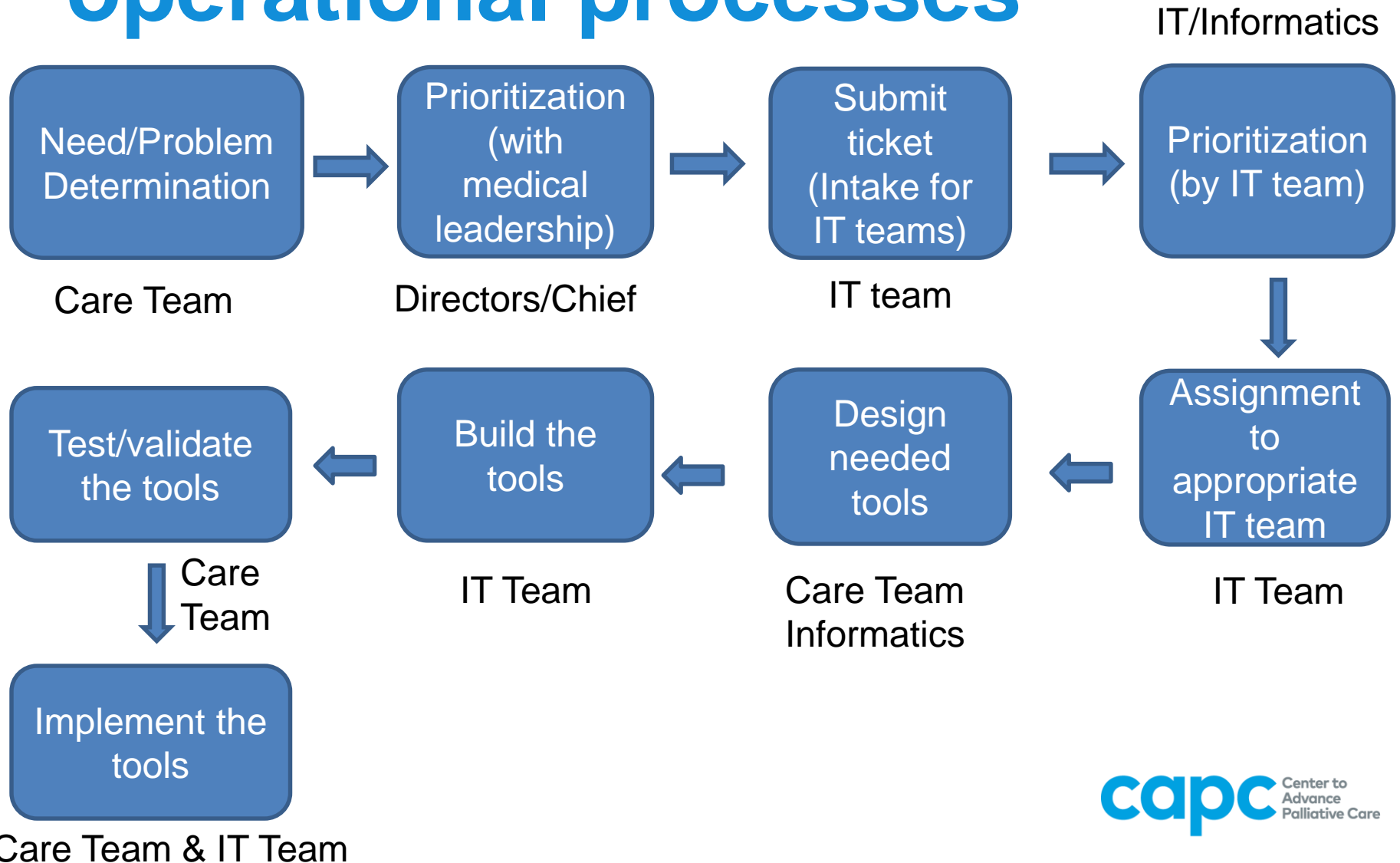
Steps to an EHR: 101

- Work with your team to determine what should be included in your notes
- Create documents that communicate your assessment and recommendations clearly
- Include the key information about what you did and what your patients and families require

Who are the relevant stakeholders who can help you?

Stakeholders	Roles in the EHR world
The “IT” Team (or the “EHR” team)	“Build EHR tools”
The “informatics” team	“Design tools and reports”
The “reporting” team	“Create Reports”
Your medical directors/division chief/department chair	“Prioritize your missions and objectives”
Your quality team/department	“Collects and reports data – electronically or paper”
Practice manager/division administrator	“Manages ‘inputs’ and ‘outputs’ of a clinic or a inpatient team”

Typical (generic) IT operational processes



Steps to an EHR: 301

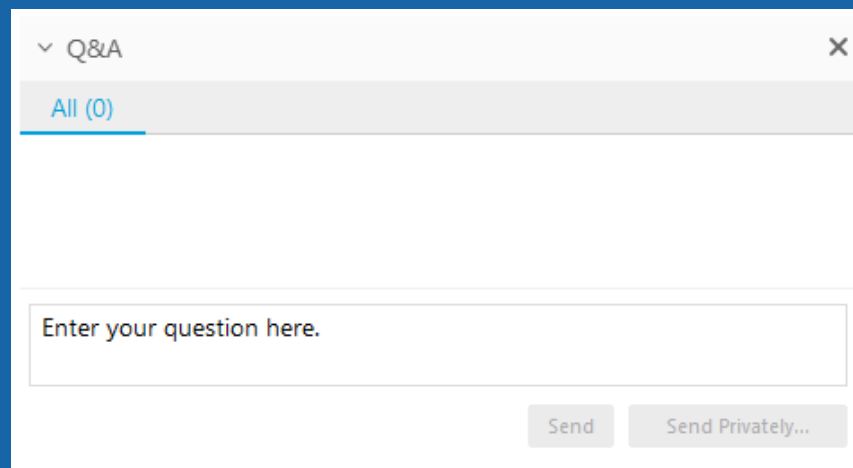
- Develop the ability to report from your documentation
 - Start to include key data points in your documents
 - Determine how the data will be reported *before* incorporating the data points
- Identify what triggers would help identify patients
 - Work with EHR team to find the triggers
 - Be prepared to mix “automated” and manual systems
 - Ex: Diagnosis triggers a nurse navigator to review a chart

Steps to an EHR: 501

- Develop the tools necessary to track your patients across the continuum
 - Patients are flagged or marked
 - Reports identify when patients are admitted or visit the ED
 - Track when patients are seen, due for follow-up
- Incorporate registry features in your build

Questions?

Please type your question into the questions pane on your WebEx control panel.



A screenshot of the WebEx Q&A interface. The window has a title bar with a dropdown arrow, the text "Q&A", and a close button. Below the title bar is a tab labeled "All (0)". The main area is a large text input field with the placeholder text "Enter your question here.". At the bottom right of the input field are two buttons: "Send" and "Send Privately...".

Palliative Care Leadership Centers™ (PCLC)

- Provides customized training and support to organizations interested in starting or growing a palliative care program.
- Focuses on the operational aspects of hospital and/or community-based palliative care program development and sustainability
- Teams work with expert faculty to collaboratively identify topics from a standardized curriculum to cover during the 2-day onsite training.
- Expert faculty serve as mentors for a full year to help teams meet milestones, confront challenges, and celebrate successes.

Palliative Care Learning Centers™

Site	Location
Bluegrass Palliative Care	Lexington, KY
Fairview Health System	Minneapolis, MN
Mount Carmel Health System	Columbus, OH
Northwell Health	New Hyde Park, NY
Presbyterian Health Services	Albuquerque, NM
University of Alabama at Birmingham	Birmingham, AL
University of California, San Francisco	San Francisco, CA
University of Virginia Health System	Charlottesville, VA
VCU Massey Cancer Center	Richmond, VA