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

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

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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

Register at www.capc.org/providers/webinars-and-virtual-office-hours/

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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

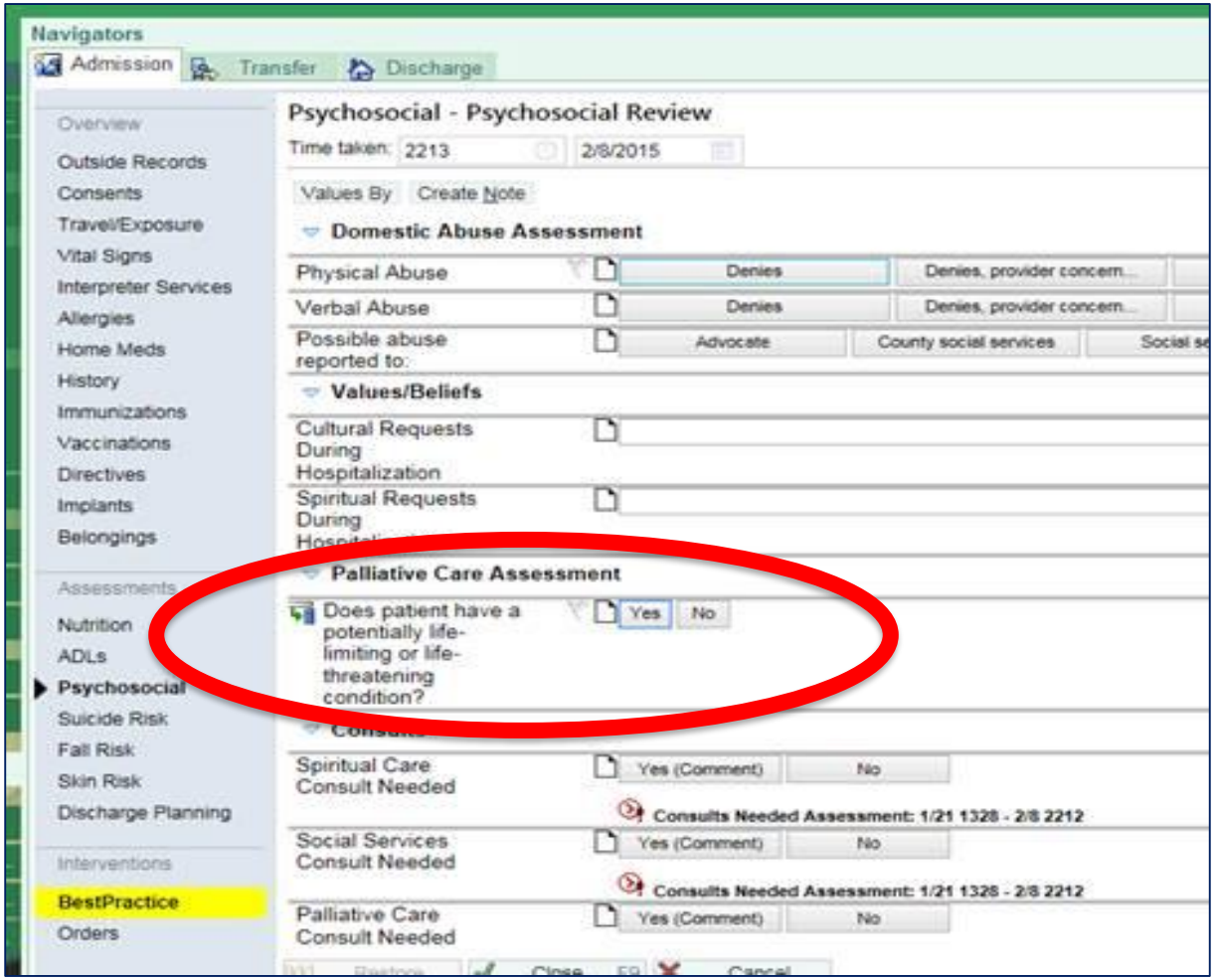
Key Principles

- **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



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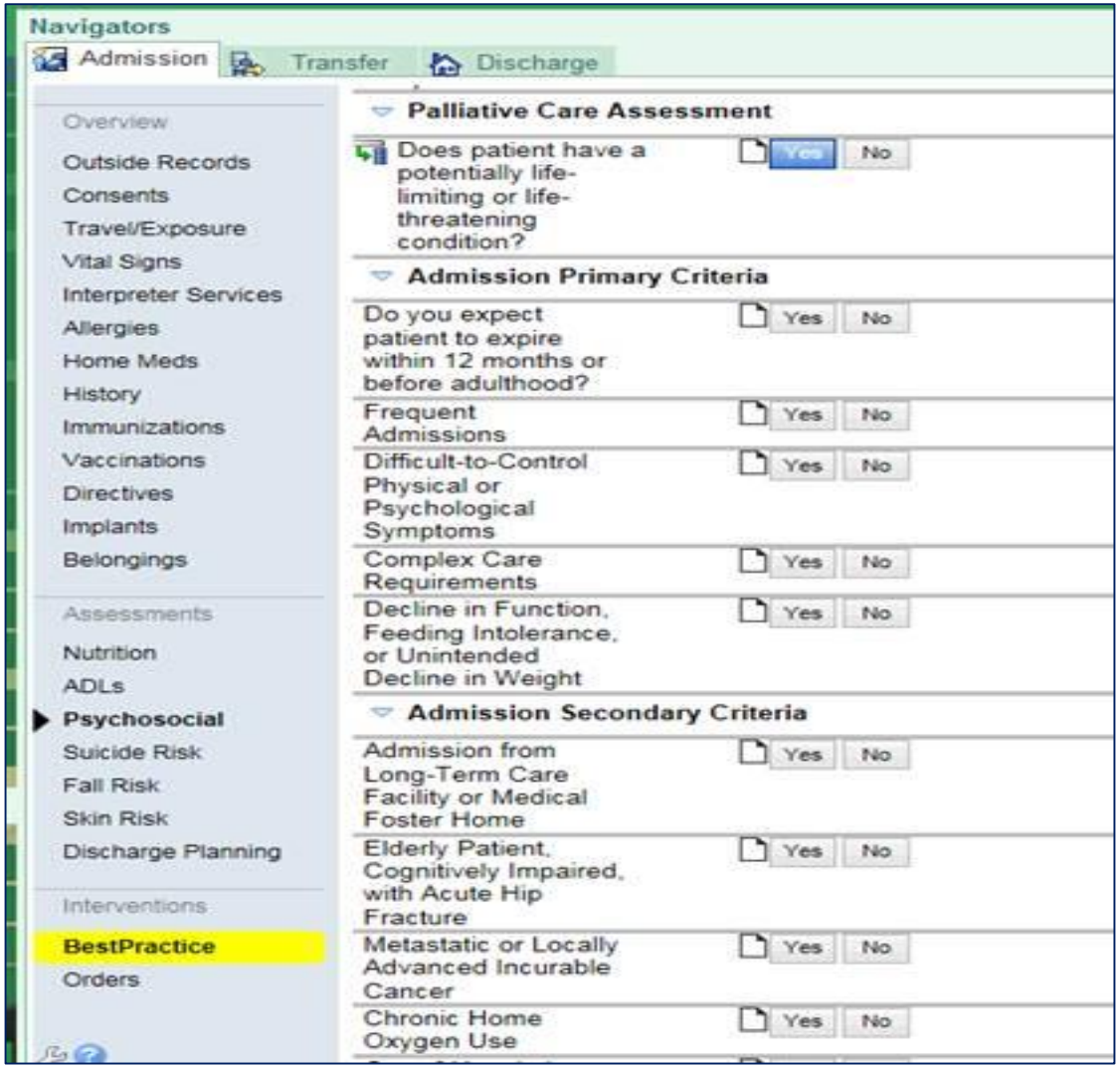
Palliative Care Screening Tool



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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 Fatiqued	5	4
10 = Most Pain	7.33	8.66
10 = Best Physical Function	7.5	7.5

Sponsorship: UVA Cancer Center

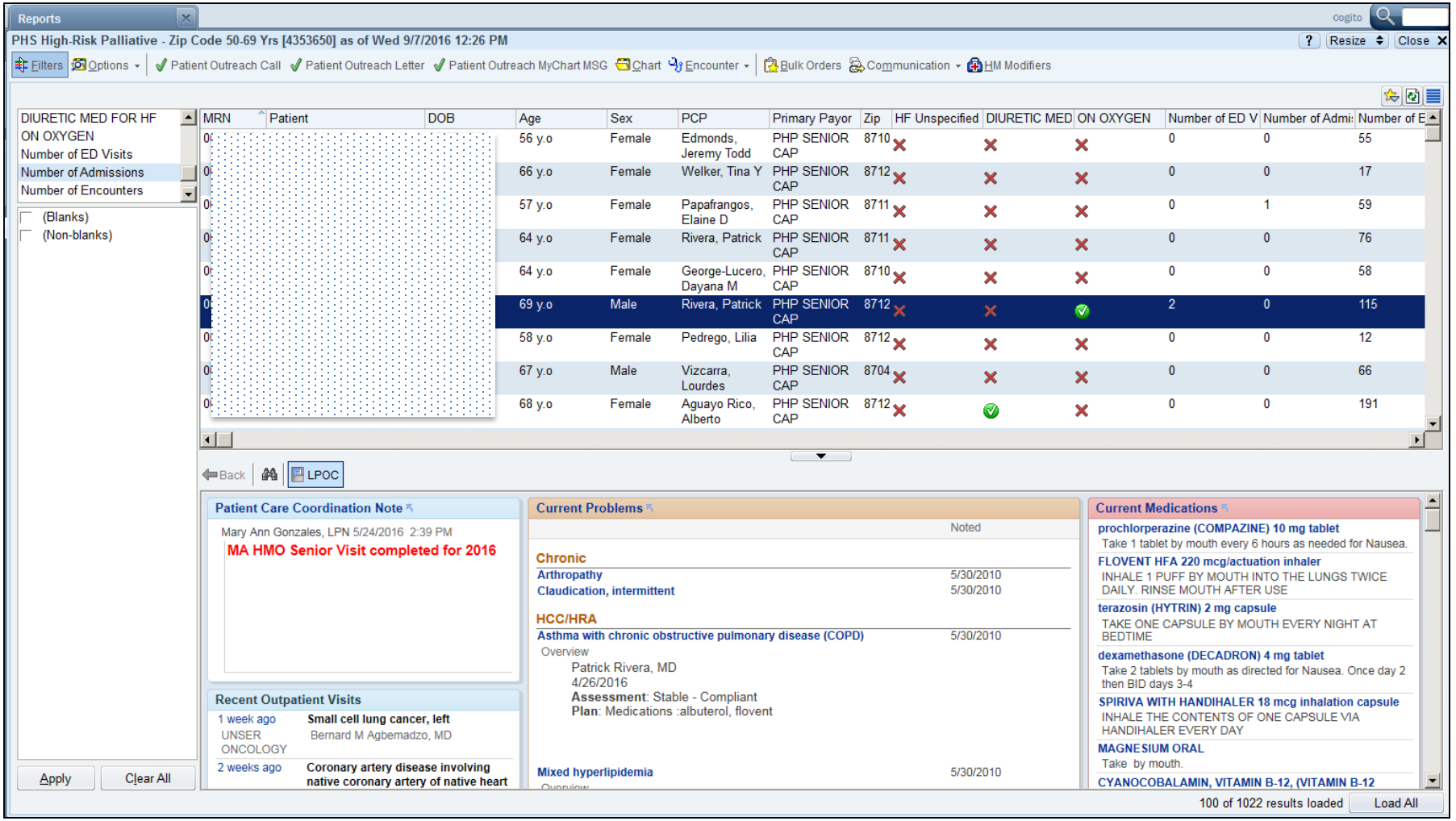
Version number 1 (September / 2014)

Review Flowsheets

The following actions have been applied:

✔ Sent: This advisory has been sent via In Basket

Patient Registry



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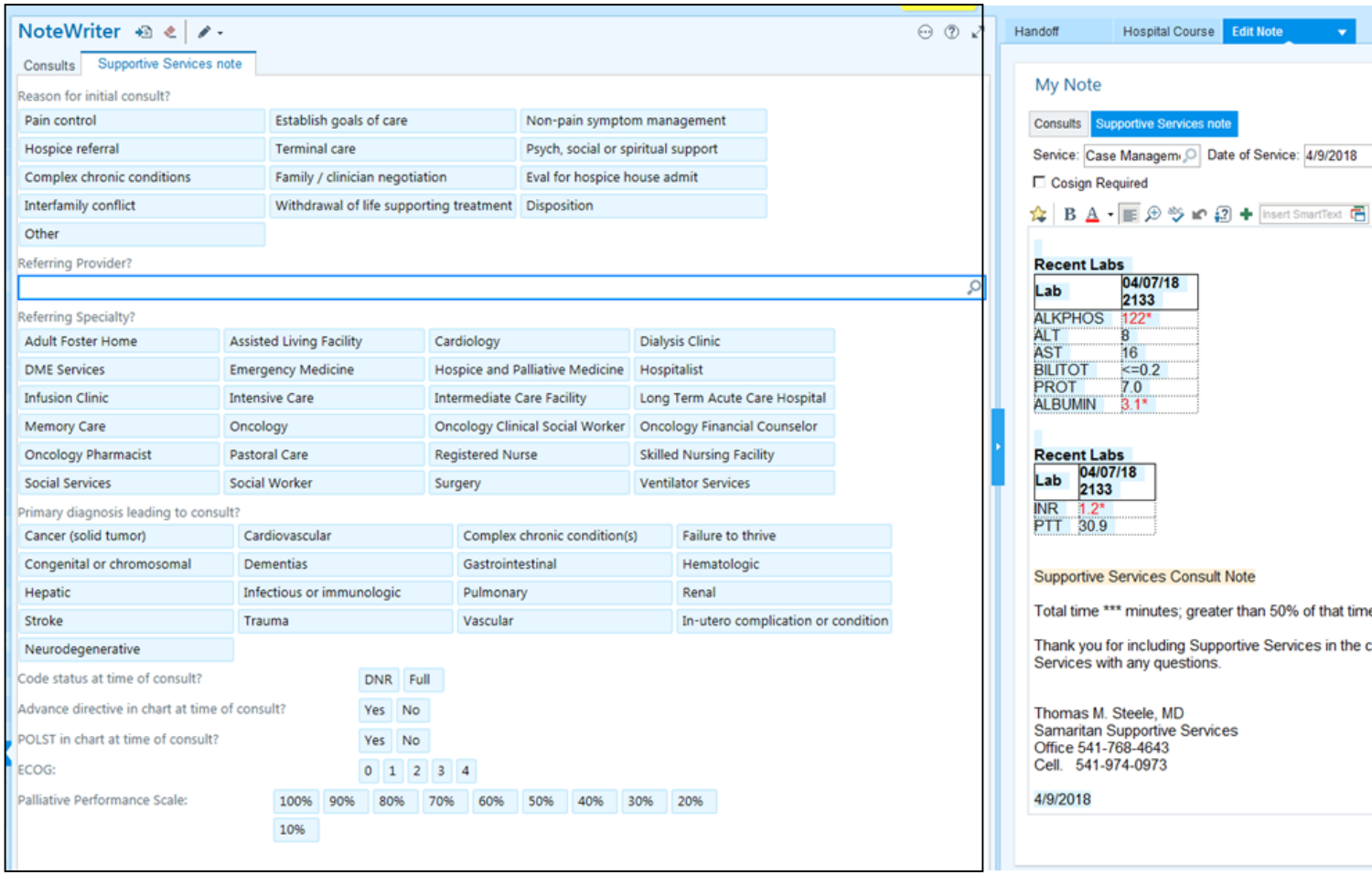
2. Documentation templates



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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 coordinatio 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:	{N/V?: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
	) PM	9	7/20/2016 12:16:00 PM	Same
	) AM	4	7/29/2016 12:12:00 PM	Same
	) PM	4	7/23/2016 12:59:00 PM	Improved
	) PM	0	7/5/2016 11:30:00 AM	Improved
	) AM	0	7/30/2016 12:25:00 AM	Improved
	) PM	0	7/9/2016 1:15:00 PM	Improved
	) AM	3	7/15/2016 10:51:00 AM	Improved
	) PM	0	8/1/2016 7:43:00 PM	Improved
	) PM	0	7/8/2016 2:15:00 PM	Improved
	) AM	0	7/20/2016 4:00:00 AM	Improved
	) PM			Not Recorded
	) PM	7	7/30/2016 4:40:00 PM	Worse
	) AM	0	7/26/2016 3:27:00 AM	Improved
	) PM			Not Recorded
	) PM	0	7/28/2016 7:00:00 PM	Improved
	) PM	0	7/12/2016 1:30:00 PM	Improved
	) AM	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

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Nausea / Vomiting: {N/V?:15270}

Dyspnea: {Dyspnea?:15271}

Additional Review of Systems

SOCIAL HISTORY / SPIRITUAL

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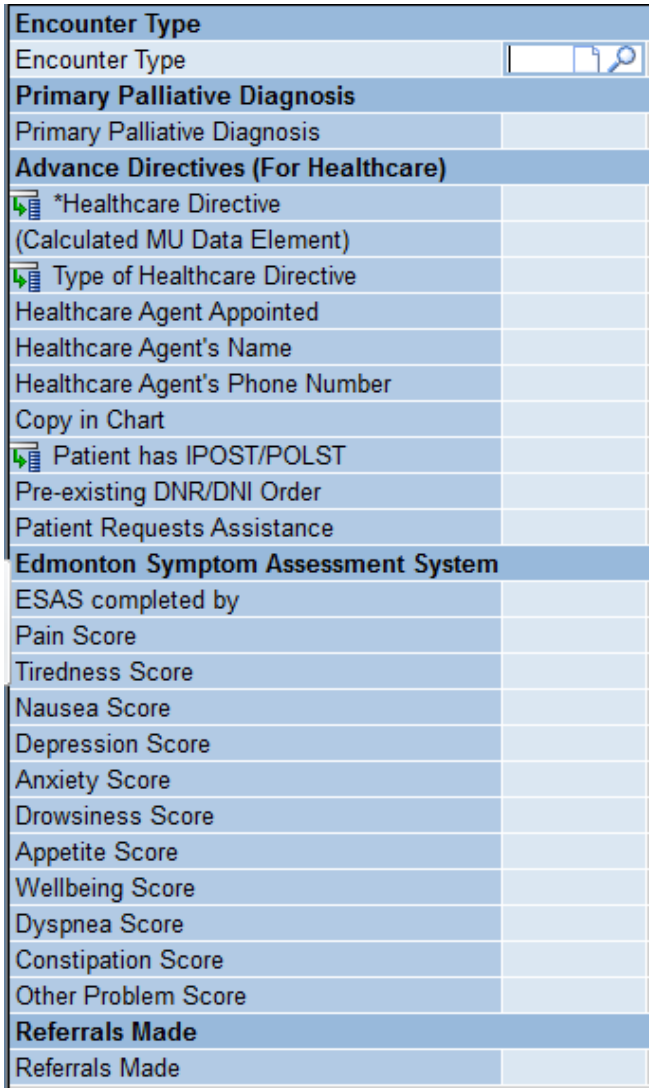
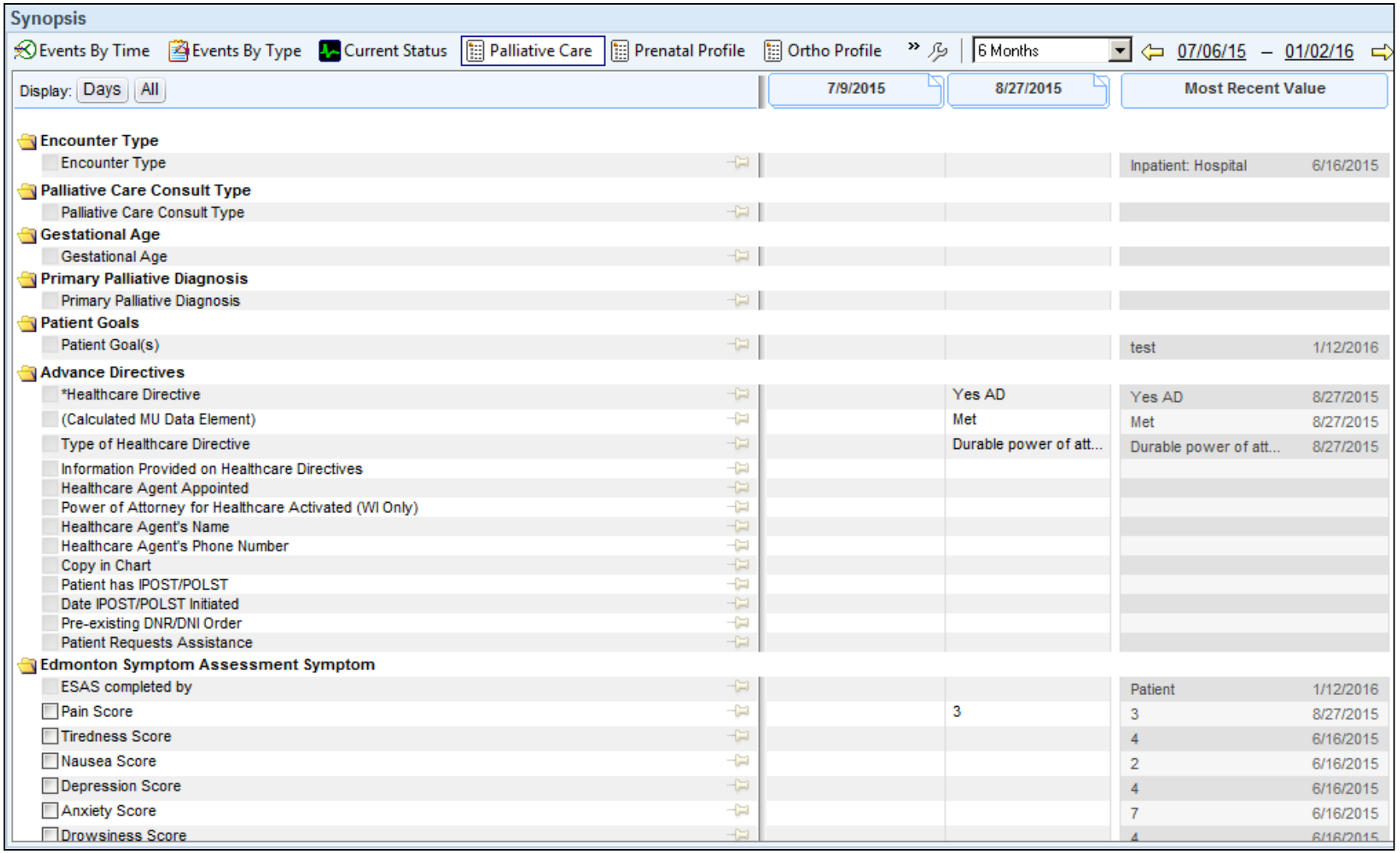
Examples of Metric Data in Flowsheet

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



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

Palliative Care Synopsis Report



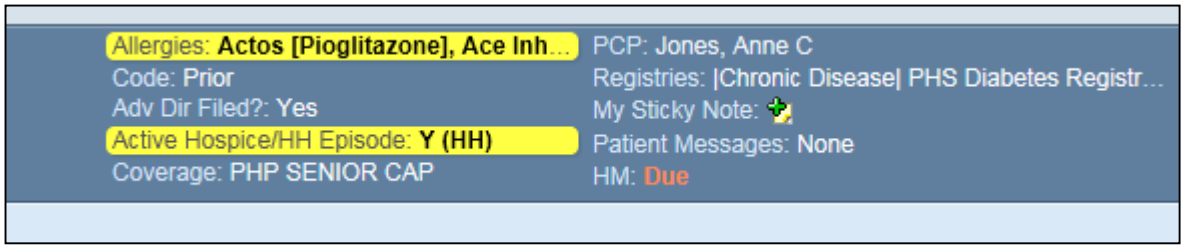
Synopsis

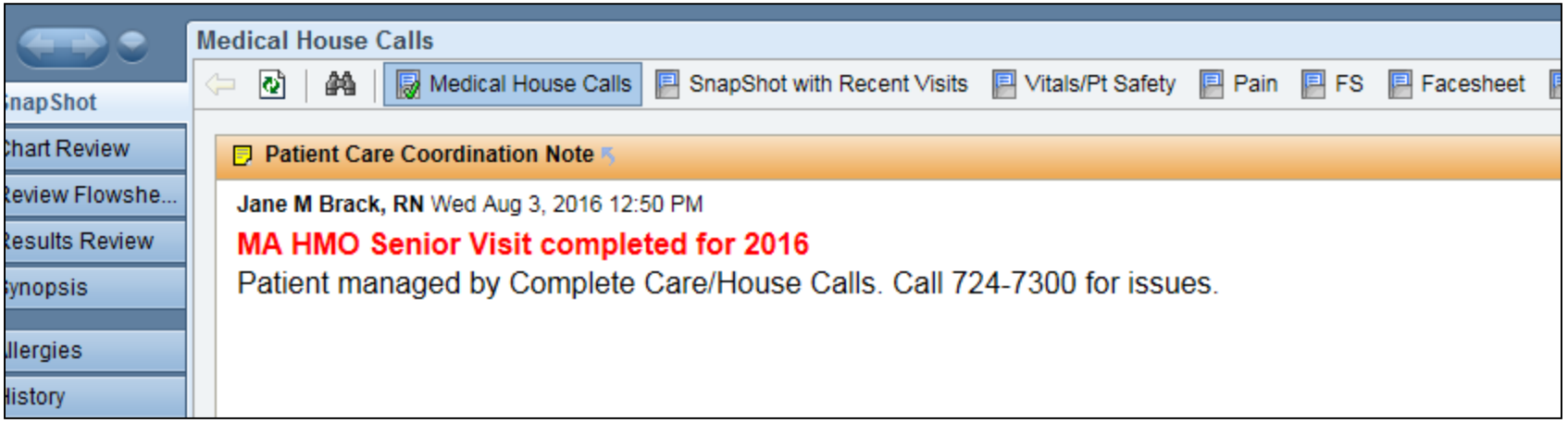
Events By Time | Events By Type | Current Status | Palliative Care | Prenatal Profile | Ortho Profile | 6 Months | 07/06/15 – 01/02/16

Display: Days All

	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





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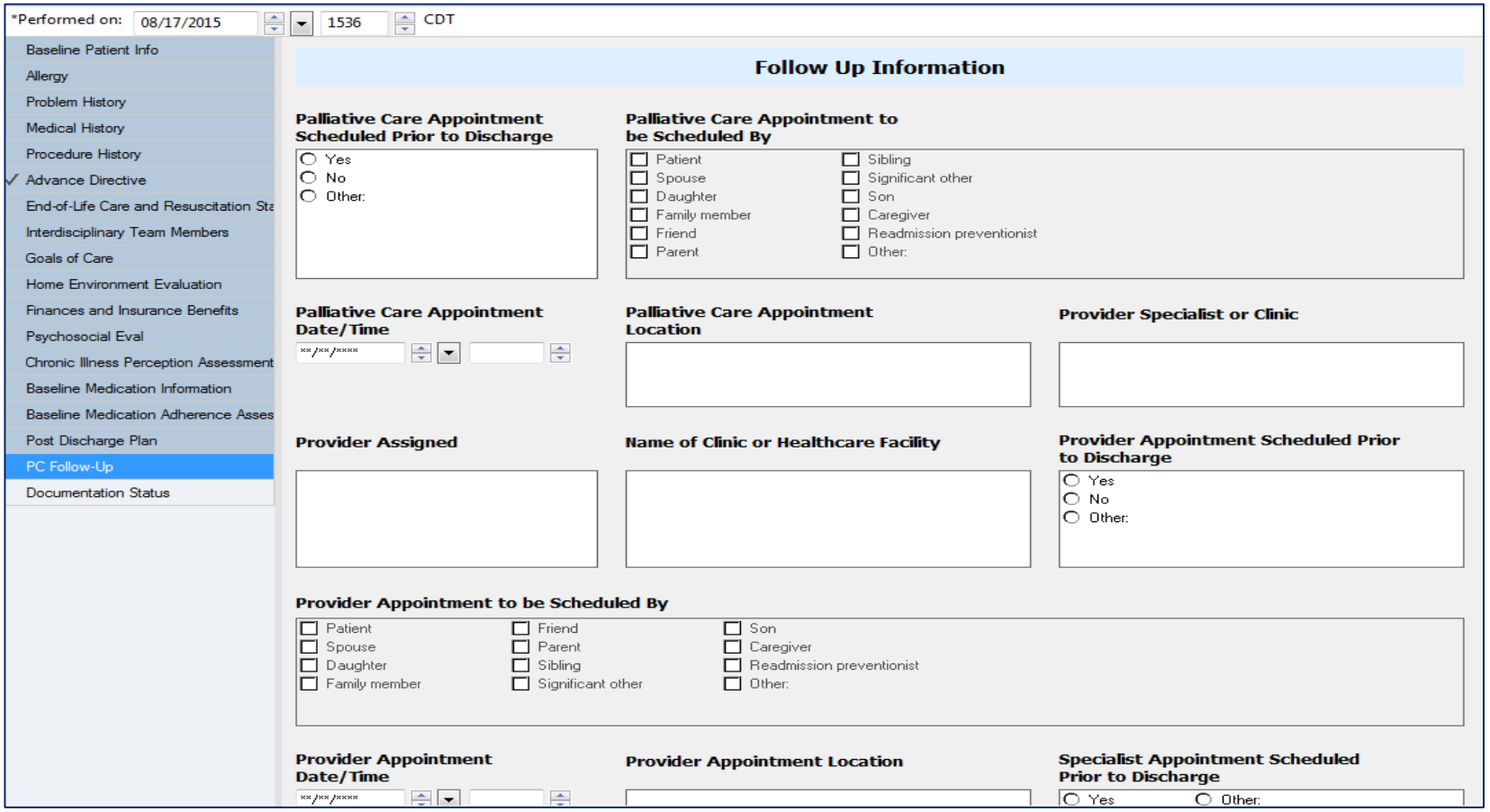
5. Track patients longitudinally



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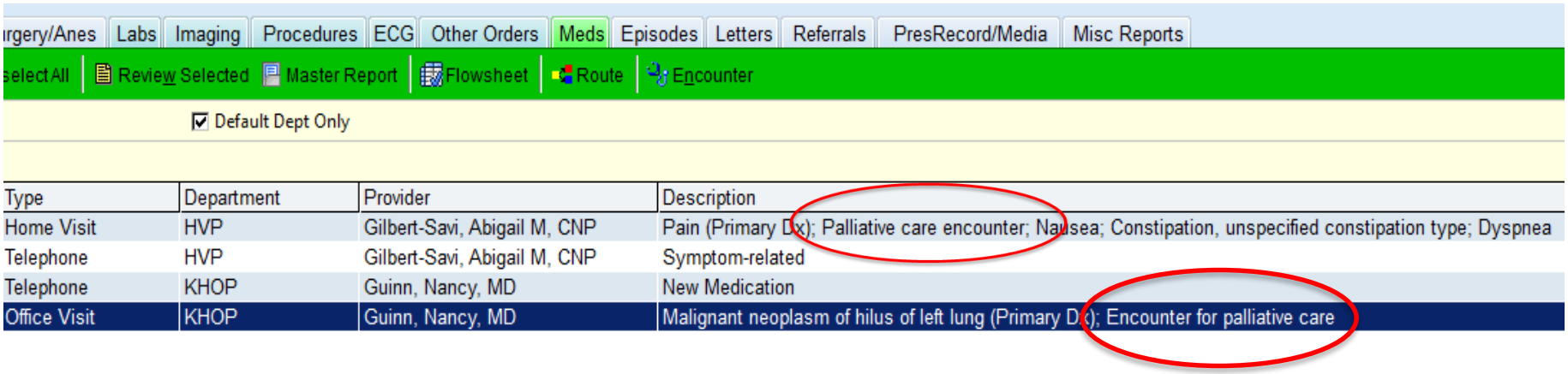
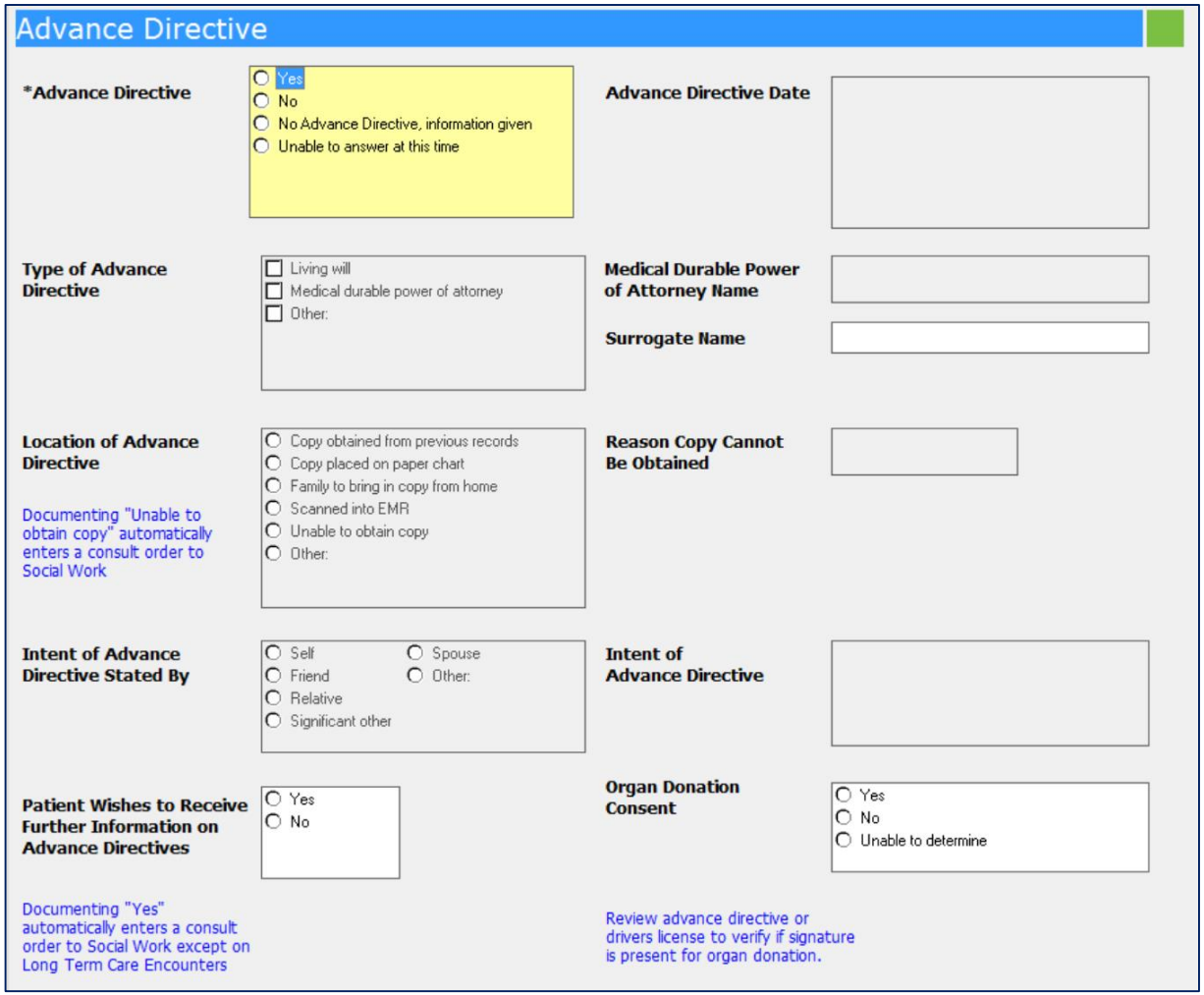
5. Using diagnoses to “flag” patients and track them



Z51.5 = Encounter for Palliative Care

Presence of an Advance Directive



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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)

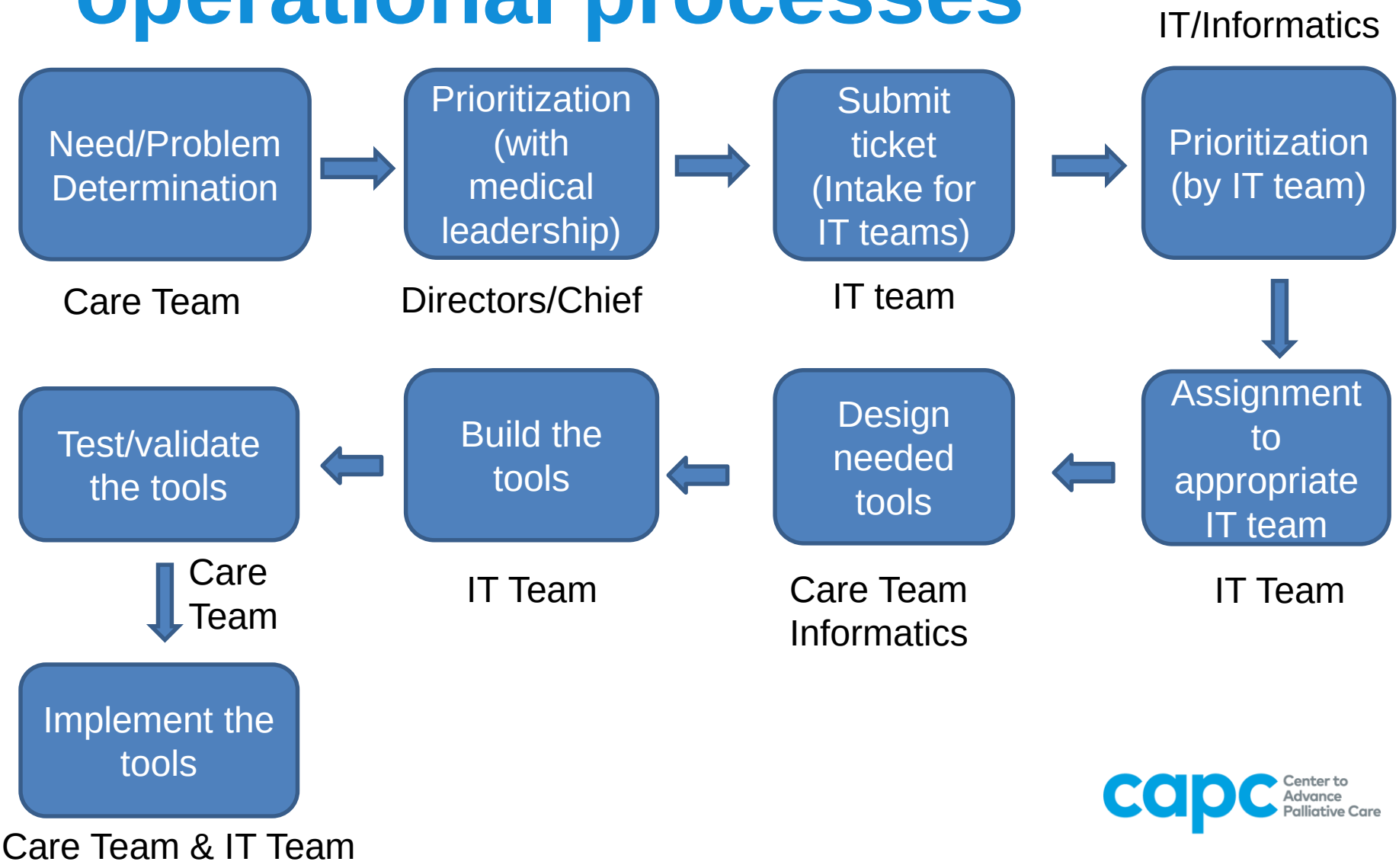
Steps to an EHR: 101

- 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

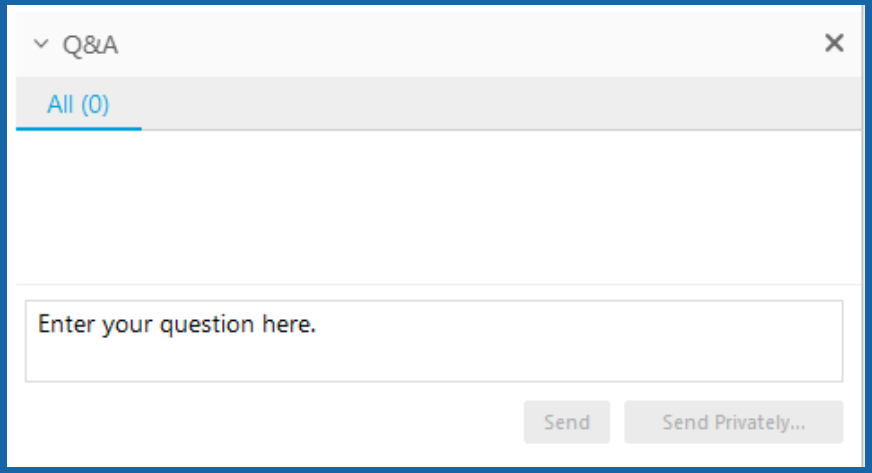
- Develop the ability to report from your documentation
  - Start to include key data points in your documents
  - Determine how the data will be reported *before* incorporating the data points
- Identify what triggers would help identify patients
  - Work with EHR team to find the triggers
  - Be prepared 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.



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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

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