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

Register at www.capc.org/providers/webinars-and-virtual-office-hours/
EHR Strategies for the Palliative Care Team: A Town Hall Discussion

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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
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
Palliative Care Screening Tool
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.

<table>
<thead>
<tr>
<th>MYCOURSE</th>
<th>BPA</th>
<th>UVA</th>
<th>12/1/2017</th>
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<td>5</td>
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<td>10 = Most Depressed</td>
<td>6.5</td>
<td>7</td>
<td></td>
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<td>5</td>
<td>4</td>
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<td>10 = Most Pain</td>
<td>7.33</td>
<td>8.66</td>
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<tr>
<td>10 = Best Physical Function</td>
<td>7.5</td>
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</table>

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

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
<th>PCP</th>
<th>Primary Payor</th>
<th>Zip</th>
<th>HF Unspecified</th>
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<th>Number of ED Visits</th>
<th>Number of Admissions</th>
<th>Number of Encounters</th>
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<tbody>
<tr>
<td>56 y.o</td>
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<td>Edmunds, Jeremy Todd</td>
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<td>68 y.o</td>
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<td>191</td>
</tr>
</tbody>
</table>

---

**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
  - Dr. Bernard M. Abernathy, MD

- 2 weeks ago: Coronary artery disease involving native coronary artery of native heart
  - Dr. Patrick Rivera, MD

**Current Problems**

- Chronic:
  - Arthritis
  - Classication, intermittent

- MCC/HRA:
  - Asthma with chronic obstructive pulmonary disease (COPD)
    - Overview:
      - Patrick Rivera, MD
      - 4/26/2016
    - Assessment: Stable - Compliant
    - Plan: Medications: albuterol, rovent

**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 1 capsule by mouth every night at bedtime.
- Decadron (DECA) 4 mg tablet
  - Take 1 tablet by mouth as directed for nausea. Once daily for 2 days 3-4.
- SPIRIVA HANDIHALER 10 mcg inhalation capsule
  - INHALE THE CONTENTS OF ONE CAPSULE VIA HANDIHALER EVERY DAY.
  - MAGNE SIUM ORAL
    - Take by mouth.
- CYANOCORALAMIN, VITAMIN B-12, (VITAMIN B-12)
2. Documentation templates
# 2. Documentation templates

## ASSESSMENT / PROGNOSIS

| *** |

## RECOMMENDATIONS

**Goals of Care:**

| *** |

**Symptom Management:**

| *** |

**Psychosocial:**

| *** |

**Intervention(s)** (Select all that apply: 15273)

- [ ] Made by team:

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)
### 3. Reminders for tasks

**HISTORY OF PRESENT ILLNESS**

| Information for this consult was obtained | [Select source(s): 15289] |
| from: | |

| Pain | [Regimen?: 15289] |
| Regimen: | |

| 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: 15270] |
4. Capturing data for reporting

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<thead>
<tr>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
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<td>First Recorded Time</td>
<td>Last value</td>
<td>Last Recorded Time</td>
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<td>6</td>
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<td>6</td>
<td>7/9/2016 4:34:00 PM</td>
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<td>4</td>
<td>7/12/2016 8:30:00 AM</td>
<td>0</td>
<td>7/12/2016 9:00:00 AM</td>
<td>Improved</td>
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<tr>
<td>2</td>
<td>7/19/2016 9:35:00 PM</td>
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<td>7/20/2016 8:40:00 PM</td>
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<td>8</td>
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<td>7/16/2016 11:00:00 AM</td>
<td>Improved</td>
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<td>10</td>
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<td>6</td>
<td>7/13/2016 8:28:00 PM</td>
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**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 14935] in the electronic medical record and have made updates as needed.

**PERTINENT REVIEW OF SYSTEMS**

Pain: [Select Scale: 15288]

Nausea / Vomiting: [Vomiting: 15270]

Dyspnea: [Dyspnea: 15271]

Additional Review of Systems

**SOCIAL HISTORY / SPIRITUAL**

[capc Center to Advance Palliative Care]
Examples of Metric Data in Flowsheet

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

## Synopsis

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<tr>
<th>Display: Days</th>
<th>All</th>
<th>7/9/2015</th>
<th>8/27/2015</th>
<th>Most Recent Value</th>
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<td><strong>Encounter Type</strong></td>
<td>Encounter Type</td>
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<td>Inpatient: Hospital 6/16/2015</td>
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<td><strong>Palliative Care Consult Type</strong></td>
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<td><strong>Gestational Age</strong></td>
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<td><strong>Primary Palliative Diagnosis</strong></td>
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<td><strong>Patient Goals</strong></td>
<td>Patient Goal(s)</td>
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<td>test 1/12/2016</td>
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<tr>
<td><strong>Advance Directives</strong></td>
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<td><em>Healthcare Directive</em></td>
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<td>Yes AD</td>
<td>Met</td>
<td>Yes AD 8/27/2015</td>
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<td>(Calculated MU Data Element)</td>
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<tr>
<td><strong>Type of Healthcare Directive</strong></td>
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<tr>
<td>Information Provided on Healthcare Directives</td>
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<tr>
<td>Healthcare Agent Appointed</td>
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<tr>
<td>Power of Attorney for Healthcare Activated (WI Only)</td>
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<tr>
<td>Healthcare Agent's Name</td>
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</tr>
<tr>
<td>Healthcare Agent's Phone Number</td>
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<tr>
<td>Copy in Chart</td>
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<tr>
<td>Patient has POST/POLST</td>
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<tr>
<td>Date POST/POLST Initiated</td>
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<tr>
<td>Pre-existing DNR/DNI Order</td>
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<tr>
<td>Patient Requests Assistance</td>
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<tr>
<td><strong>Edmonton Symptom Assessment Symptom</strong></td>
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<tr>
<td>ESAS completed by</td>
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<tr>
<td>□ Pain Score</td>
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<tr>
<td>□ Tiredness Score</td>
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<td>□ Nausea Score</td>
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<tr>
<td>□ Anxiety Score</td>
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<tr>
<td>□ Drowsiness Score</td>
<td></td>
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</table>

---

**Edmonton Symptom Assessment Symptom**

- **Pain Score:** 3
- **Tiredness Score:** 3 (8/27/2015)
- **Nausea Score:** 4 (8/16/2015)
- **Depression Score:** 4 (8/16/2015)
- **Anxiety Score:** 4 (8/16/2015)
- **Drowsiness Score:** 4 (8/16/2015)

---

**Edmonton Symptom Assessment Symptom**

- **Pain Score:** 3
- **Tiredness Score:** 3 (8/27/2015)
- **Nausea Score:** 4 (8/16/2015)
- **Depression Score:** 4 (8/16/2015)
- **Anxiety Score:** 4 (8/16/2015)
- **Drowsiness Score:** 4 (8/16/2015)
5. Track patients longitudinally

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

- Medical House Calls
- 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
5. Using diagnoses to “flag” patients and track them

Z51.5 = Encounter for Palliative Care
Presence of an Advance Directive

![Advance Directive Form]

- **Presence of an Advance Directive**
  - Yes
  - No
  - No Advance Directive, information given
  - Unable to answer at this time

- **Type of Advance Directive**
  - Living will
  - Medical durable power of attorney
  - Other:

- **Location of Advance Directive**
  - Copy obtained from previous records
  - Copy placed on paper chart
  - Family to bring in copy from home
  - Scanned into EMR
  - Unable to obtain copy
  - Other:

- **Intent of Advance Directive Stated By**
  - Self
  - Friend
  - Relative
  - Significant other

- **Patient Wishes to Receive Further Information on Advance Directives**
  - Yes
  - No

- **Advance Directive Date**

- **Medical Durable Power of Attorney Name**

- **Surrogate Name**

- **Reason Copy Cannot Be Obtained**

- **Intent of Advance Directive**

- **Organ Donation Consent**
  - Yes
  - No
  - Unable to determine

**Documentation**
- "Yes" automatically enters a consult order to Social Work except on Long Term Care Encounters
- Review advance directive or drivers license to verify if signature is present for organ donation.
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?

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

1. Need/Problem Determination
   - Care Team
2. Prioritization (with medical leadership)
   - Directors/Chief
3. Submit ticket (Intake for IT teams)
   - IT team
4. Prioritization (by IT team)
   - IT/Informatics
5. Assignment to appropriate IT team
   - IT Team
6. Design needed tools
   - Care Team
7. Build the tools
   - IT Team
8. Test/validate the tools
   - Care Team
9. Implement the tools
   - Care Team & IT Team

Care Team & IT Team
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.
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™

<table>
<thead>
<tr>
<th>Site</th>
<th>Location</th>
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<tbody>
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<td>Bluegrass Palliative Care</td>
<td>Lexington, KY</td>
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<tr>
<td>Fairview Health System</td>
<td>Minneapolis, MN</td>
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<td>Mount Carmel Health System</td>
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<td>University of California, San Fran</td>
<td>San Francisco, CA</td>
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<tr>
<td>University of Virginia Health System</td>
<td>Charlottesville, VA</td>
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<tr>
<td>VCU Massey Cancer Center</td>
<td>Richmond, VA</td>
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