Does format matter?
Exploring the use of a template for documentation in the EMR

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Objectives

* Explore the value of utilizing a template for palliative and hospice social work documentation in the electronic medical record (EMR)
* Review an example of a palliative psychosocial assessment and f/u note template
* Identify tools and strategies that can be utilized in the EMR to optimize documentation of social work contributions and support outcomes measurement
???
Principles of Documentation

- Structural factors
- Note length
- Information density
- Informational quality
- Document quality
What do the data show?

* Shen et al (2012)
* Neri et al (2014)
* Rose et al (2001)

* Template = document quality for specialists
* Template = document quality
## Use of Template

<table>
<thead>
<tr>
<th>Advantages/Benefits</th>
<th>Disadvantages/Burdens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased efficiency</td>
<td>Focus on “checklist”</td>
</tr>
<tr>
<td>Increased organization</td>
<td>Focus on sequence</td>
</tr>
<tr>
<td>Increased comprehensiveness</td>
<td>Decreased evaluation time</td>
</tr>
<tr>
<td>Enhance interdisciplinary communication</td>
<td>Increase in gross billing</td>
</tr>
<tr>
<td>Promote uniformity</td>
<td>Poor design</td>
</tr>
<tr>
<td></td>
<td>Less patient/family centered</td>
</tr>
</tbody>
</table>
SW in PC and hospice

- Documentation Guidelines
  - NASW, NHPC, Joint Commission, CMS

- Setting specific (? Institution guidelines)
  - Unit SW?
  - Specific job description/requirements

- SWAT, PIP
Domain 1: The Structure and Processes of Care

- Emphasis on Interdisciplinary team (IDT) engagement and collaboration with patient and families
- **Emphasis on coordinated assessment and continuity of care**
- Clarity and specificity of interdisciplinary team composition
- **Quality assessment process**
Affirmation of NASW Standards for Palliative and EOLC

- **Standard 7. Documentation.** Social workers shall document all practice with clients in either the client record or in the medical chart. These may be written or electronic records.
- Standard 8. Interdisciplinary Teamwork.
PALLIATIVE CARE PSYCHOSOCIAL ASSESSMENT

Preferred language:
Language Used:
Sources of Information:
Barriers to assessment: None

Next of Kin (NOK): ***
Primary Caregiver:
Other Contacts: ***

Chief Complaint: I am feeling***

HPI: This consultation was requested by ***

Support system: ( ) Strong ( ) Fair ( ) Limited support system
Comments:

Coping status - patient:
Coping status - family:

Physical aspects:

Learning needs? ( ) Language ( ) Cultural ( ) Developmental ( ) Motivational ( ) Cognitive
Comments:

Religious/Spiritual/Existential aspects: ( ) Yes ( ) No
Comments:

Assessment:

Plan of Care:

Core Measures:

<table>
<thead>
<tr>
<th>Core Measures</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative Care Education</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pastoral Care</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Therapeutic Counseling</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Advanced Care Planning</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Assess Stress</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Assess Coping</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Assess Anxiety</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Assess Anticipatory grief</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Family Meeting</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Bio-ethics consult</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>PCS Interdisciplinary Rounds</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Palliative psychosocial assessment template components

- Contact information
- Reason for consult
- Interventions
- Psychosocial History
- Advanced care planning
- Assessment
- Plan of care
PALLIATIVE CARE PSYCHOSOCIAL ASSESSMENT

Preferred language: 
Language Used: 

Sources of Information:

Barriers to assessment:

Next of Kin (NOK):

Primary Caregiver:

Other Contacts:
Chief Complaint: I am feeling***

HPI: This consultation was requested by ***

Support system: ( ) Strong  ( ) Fair  ( ) Limited support system

Coping status - patient:

Coping status - family:

Physical aspects:

Learning needs? ( ) Language  ( ) Cultural  ( ) Developmental  ( ) Motivational  ( ) Cognitive

Religious/Spiritual/Existential aspects: ( ) Yes  ( ) No

Advanced Care Planning: Patient does not have an advanced directive.

Goals at this time: ( ) Curative  ( ) Restorative  ( ) Longevity  ( ) To relieve difficult symptoms

Code Status: Full  POLST (Practitioner Orders for Life Sustaining Treatment): Candidate

Assessment:

Plan of Care:
<table>
<thead>
<tr>
<th>Core Measures:</th>
<th>Yes</th>
<th>No</th>
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</thead>
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<tr>
<td>Palliative Care Education</td>
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</tr>
<tr>
<td>Assess Coping</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Assess Anticipatory Grief</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Reiki Session</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Family Meeting</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Bio-ethics consult</td>
<td></td>
<td>X</td>
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<tr>
<td>PCS Rounds</td>
<td>X</td>
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</tbody>
</table>
HPI: This consultation was requested by ***. Pt is a *** with PMH of***. Following for palliative psychosocial assessment and intervention in setting of serious illness trajectory. Met with pt bedside. Introduced self and supportive role. Pt able to participate with assessment. Amenable with intervention. Pleasant and easily engaged.

Pt readily discusses illness describing ***
Expressing feelings of **** around***. Feelings validated, normalized.
Explored ways in which illness has impacted life, such as***
Confirms/denies that pain/symptoms have impacted coping
Explored helpful coping strategies such as***
Reinforced ongoing availability for psychosocial support in setting of serious illness trajectory.
Psychosocial History

Support system:
Coping status - patient:
-Pleasant and easily engaged.
-Describes normative feelings of sadness and loss around decline in function.
-Able to self soothe. Able to look forward to the future.

Coping status - family: Themes of cumulative caregiver fatigue

Physical aspects: Reports he/she was independent with ADL’s prior to hospitalization

Learning needs? ( ) Language ( ) Cultural ( ) Developmental ( ) Motivational ( ) Cognitive

Religious/Spiritual/Existential aspects: ( ) Yes ( ) No
Utilizes faith to cope with stress of serious illness.
Important spiritual resources include: ***
While he/she has no formal religious affiliation, he/she does have a spiritual philosophy that guides his life.
Confirms awareness of pastoral care as a resource.
Coping status - patient: Pleasant and easily engaged. Describes normative feelings of sadness and loss around decline in function. Pt expresses depressive symptoms including insomnia, anhedonia, hopelessness, poor interest or concentration, low energy. Patient denies any suicidal/homicidal ideations with intent or plan.
Advanced Care Planning: Patient does not have an advanced directive. Patient has an AD. Reviewed, copy located in chart.

Code Status: Full
POLST (Practitioner Orders for Life Sustaining Treatment): Candidate

When asked, "What should HackensackUMC know about you and your loved ones in order to take better care of you?" *****

Assessment: Mr/Ms.***
-Current pain level acceptable.
-Appears to be having understandable difficulty coping around***
-Understandable themes of loss, sadness, anticipatory grief noted.
-Like all patient/families experiencing serious illness, Mr/Ms***. and family confront several emotional challenges which may be supported with ongoing monitoring, exploration and support.
Plan of Care:

- Will continue to explore ways to enhance adaptive such as cognitive-behavioral, strengths-based and short term treatment interventions.
- Will continue to monitor pt/family coping and remain available for psychosocial intervention as pt/family system integrate illness trajectory and it's impact on their lives.
- Will continue to liaise with unit social work/CM and JTCC psychosocial staff to ensure communication of goals & preferences, care coordination and continuity.
- Palliative care education ongoing; scope of practice and philosophy discussed. Palliative care contact information given.
PALLIATIVE CARE PSYCHOSOCIAL FOLLOW-UP

Preferred language: 
Language Used: 
Sources of Information: 
Barriers to assessment: None

Next of Kin (NOK): ***
Primary Caregiver: 
Other Contacts: ***

Chief Complaint: I am feeling***

Interval History:

ACP:

Assessment:

Plan of Care:

Core Measures: Yes No
Palliative Care Education X
Pastoral Care X
Therapeutic Counseling X
Advanced Care Planning X X
Assess Stress X
Assess Coping X
Assess Anxiety X
Assess Anticipatory grief X
Family Meeting X X
Bio-ethics consult X X
PCS Interdisciplinary Rounds X X
Comparison w/Team notes

Differences

* Content
  * Biopsychosocial assessment
  * Interventions

Similarities

* Overall Format (SOAP)
* Integration of palliative domains
* ACP
* Dignity Question
* Core Measures
* Plan of Care
<table>
<thead>
<tr>
<th>Issue</th>
<th>Target/Goal</th>
<th>Intervention</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustment Crisis</td>
<td>Emotional regulation</td>
<td>Psycho-education: SFBT</td>
<td>IRS; practitioner observation/log; “Golden Question”</td>
</tr>
<tr>
<td>Mobilization for disease management</td>
<td></td>
<td>CBT</td>
<td>IRS; Client log</td>
</tr>
<tr>
<td>-Stable Living situation</td>
<td>-Family Functioning: wellbeing</td>
<td>-Resource identification &amp; referral; collateral communication -Family counseling</td>
<td>Checklist; client report Family Wellbeing Log</td>
</tr>
<tr>
<td>Reduced anxiety, increased perceived ability to manage stress</td>
<td>CBT</td>
<td>IRS; Client satisfaction measure</td>
<td></td>
</tr>
</tbody>
</table>
“For me the contact information for the patient is key during integral times where I need a quick reference guide on who to call.”

“I use the social hx as a prompt or talking point of getting to know the patient as a person.”

“I always check: if you completed advance care planning I would pull from this and copy and paste it into my note to stay correlated with yours”

“I love that if you read our notes from admission through discharge it tells a patient-focused palliative care story.”
Outcomes Measurement

- There is now doubt that SW services are important in effective hospice & palliative care
- Literature specifically centered on outcomes measurement of HPC social work interventions is sparse
- Utilizing a template may support monitoring of outcomes and data collection
What/How do we measure?

* What?
  * Patient/family progress re: their own goals
  * Clinician effectiveness

* How?
  * SWAT
  * PIP
  * PHQ4 or PHQ9
  * Beck Depression Scale
  * Hospital Depression and Anxiety Scale (HADS)
  * Center for Epidemiology Studies - Depression (CES-D) (Boston short form – 10 items)
  * Geriatric depression Scale (short form) – 15 items
Conclusion

- Document quality impacts usefulness
- There is association between structural characteristics (i.e. template) and document quality
- Use of template may enhance communication and cohesion between HPC social work and the team
- Use of template may highlight the unique contributions of SW in HPC
- Can assist with better patient outcomes and data collection
Thank you!
References


