DATA TRACKING WITHOUT CHAPLAINCY SERVICES HCPCS CODES

Chaplain Visit Note → **Chaplain Manager Review** → **External Data Report**

Chaplain visit is documented in the patient's electronic medical record (EMR). Uses a template that is often text only with no searchable data fields. Does not include HCPCS encounter codes for visit type, key words, or time spent.

Chaplain Manager must visually and manually review chaplaincy visits, finding data such as visit types, key words, and length of time spent, for reporting.

Chaplain Manger must enter data manually into an external reporting tool such as Excel to generate reports.

PROCESS FEATURES

- Manual
- Time consuming
- Low accuracy
- Low quality
- Provides no system-wide visibility for chaplain's work

Typical of many chaplaincy departments in organizations with an EMR today, the chaplain writes a templated visit note in text that contains no searchable fields for things such as visit type (spiritual assessment, follow on visit, ordered by nurse, etc.) reason for visit, interventions applied, outcomes noted, length of visit, and ongoing plan of care. Such notes are primarily used by other members of the interdisciplinary team for care coordination and the Chaplain Manager for chart review, quality improvement, staff determinations, etc. Such a review is manual, time consuming, and prone to error, as the Chaplain Manager must enter the relevant information in each chaplain visit note into a separate reporting tool such as Excel, aggregate and sort the data, and produce a report.

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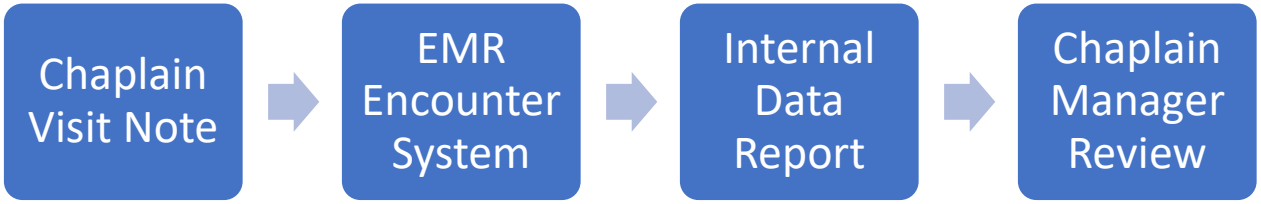

Chaplain visit documented in the patient's electronic medical record (EMR). Uses a template that combines text with searchable data fields. Includes HCPCS encounter codes and time spent, which are visible in the EMR

EMR encounter system recognizes Chaplaincy Services HCPCS Codes:

Q9001 – Assessment
Q9002 – Individual visit
Q9003 – Group visit

Also recognizes time spent in actual minutes or in multiples of the EMR's time units, often 15 minute increments.

Internal data reporting features of the EMR can access the Q code, time spent, and key words entered in the chaplain's visit note. These are the basis of a report that can be generated automatically for the Chaplain Manager.

Chaplain Manager regularly reviews system-generated reports on Chaplaincy visits, visits types, length of time spent, as well as relevant key words included in the chaplain visit note.

PROCESS FEATURES

- Automatic
- High accuracy
- High quality
- Provides system wide visibility and credit for chaplaincy work done.

With the introduction in 2023 of the Healthcare Common Procedure Coding System (HCPCS) codes for Chaplaincy Services, chaplains can now add encounter codes to their documentation. Encounter codes are used in EMRs to describe the type of healthcare service provided during a patient's visit. Chaplain visits can now be classified by use of the codes as a spiritual assessment (Q9001), a visit with an individual patient (Q9002), or a group session with multiple patients (Q9003). These codes will be recognized by the EMR the same as any HCPCS codes entered by other clinicians. They can be used by the Chaplain Manager for automatic reporting functions and, when combined with searchable data fields and time stamps, can provide a fuller, more accurate, more timely view into the work of the chaplains and the value of chaplaincy care to the healthcare system, not just to the interdisciplinary team to which the chaplain reports.