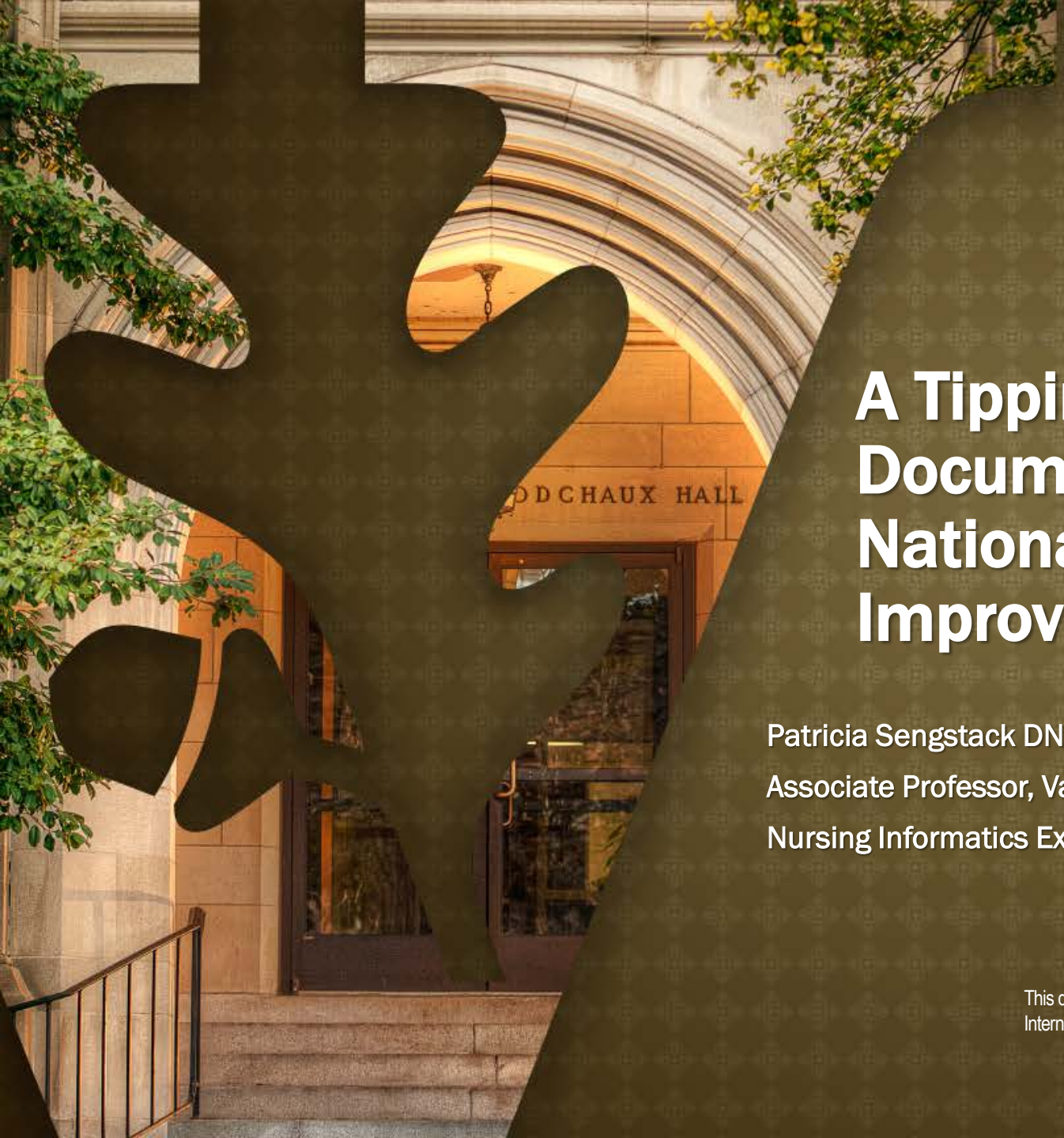


A Tipping Point? Documentation in the EHR – National Efforts Toward Improvement

Patricia Sengstack DNP, RN-BC, FAAN

Associate Professor, Vanderbilt University School of Nursing

Nursing Informatics Executive, Vanderbilt University Medical Center

Objectives

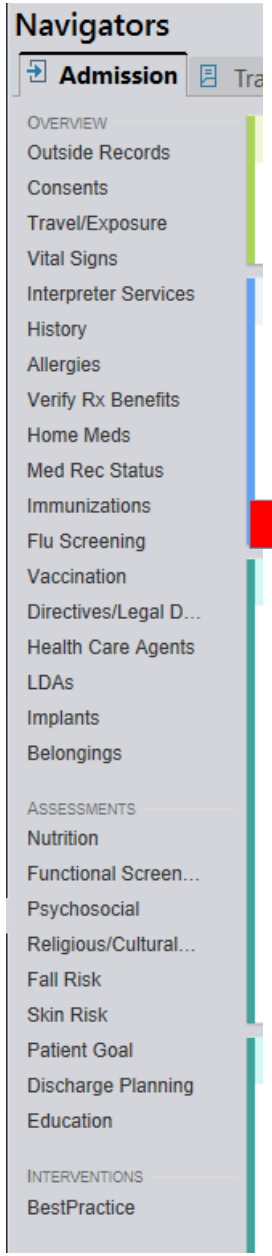
- Identify contributing factors to the burden of clinical documentation in the EHR
- Describe work underway at the national level to address the burden of clinical documentation

The story of hundreds of clicks

Socioeconomic	0	5	0	5
Surgical History	0	18	0	8
Subtotal including History:	**17**	**316**	**153**	**385**
Admission Physical Assessment	13	59	0	108
Vital Signs	1	36	0	46
Final Total including Physical Assessment and Vital Signs:	**31**	**411**	**153**	**539**

Nursing Admission Assessment Documentation

- Bon Secours = 539
- Virginia Mason = 459
- Vanderbilt = ?



5 – 10 fields → 5 – 10 fields

Clinical Documentation

- The medical record dates back to Hippocrates in the fifth century B.C.
- He noted that the patient's record should accurately reflect the course of the disease and indicate the probable cause of the disease

National Institutes of Health National Center for Research Resources (NIH NCRR). (2006). Electronic health records overview. McLean, VA: The MITRE Corporation (contractor). Retrieved from http://www.himss.org/files/HIMSSorg/content/files/Code%20180%20MITRE%20Key%20Components%20of%20an%20EHR.pdf

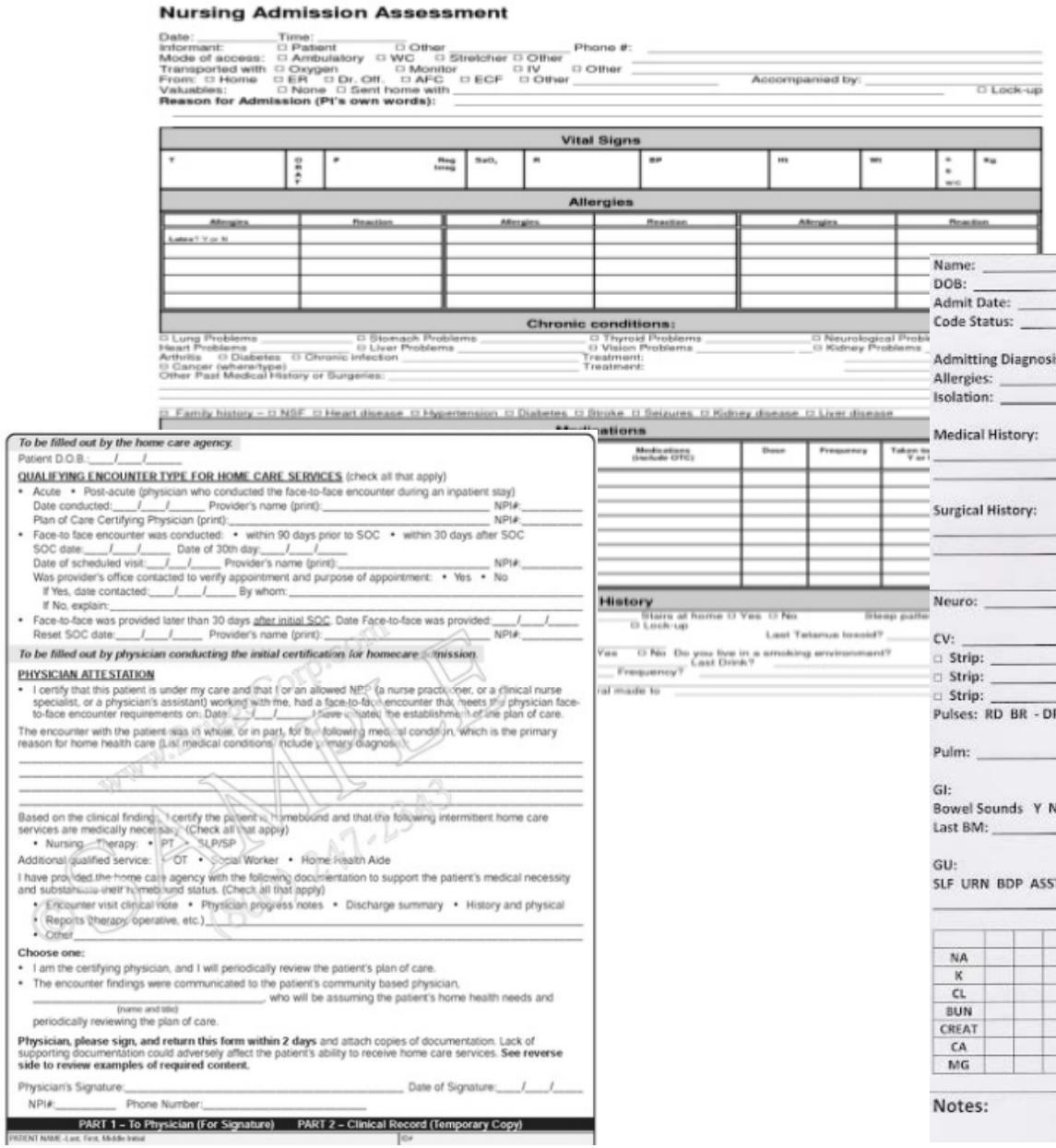
Information Nurses Document

- Assessments
- Clinical problems
- Communications with other health care professionals regarding the patient
- Communication with and education of the patient, family, and the patient's designated support person and other third parties
- Medication records (MAR)
- Order acknowledgement, implementation, and management
- Patient clinical parameters
- Patient responses and outcomes, including changes in the patient's status
- Plans of care that reflect the social and cultural framework of the patient

Source: ANA's Principles for Nursing Documentation Guidance for Registered Nurses (2010). http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/NursingStandards/ANAPrinciples/PrinciplesforDocumentation.pdf

Major Forces Driving Changes In Clinical Documentation

- Computerization of the patient medical/health record
- Documentation of services is a requirement for payment – coding and billing (new payment models)
  - Medicare/Medicaid
  - Private Payers
- Regulation and legislation (Meaningful Use, eCQM)



Nursing Admission Assessment

Date: Time:
Informant: ☐ Patient ☐ Other Phone #:
Mode of access: ☐ Ambulatory ☐ WC ☐ Stretcher ☐ Other
Transported with ☐ Oxygen ☐ Monitor ☐ IV ☐ Other
From: ☐ Home ☐ ER ☐ Dr. Off. ☐ AFC ☐ ECF ☐ Other Accompanied by:
Valuables: ☐ None ☐ Sent home with ☐ Lock-up
Reason for Admission (Pt's own words):

Vital Signs

T	O2 sat	P	Reg Irreg	SaO2	R	BP	Ht	Wt	Wt (kg)	Kg

Allergies

Allergies	Reaction	Allergies	Reaction	Allergies	Reaction
Latex? Y or N					

Chronic conditions:

☐ Lung Problems ☐ Stomach Problems ☐ Thyroid Problems ☐ Neurological Probl
Heart Problems ☐ Liver Problems ☐ Vision Problems ☐ Kidney Problems
Arthritis ☐ Diabetes ☐ Chronic infection Treatment:
☐ Cancer (where/type) Treatment:
Other Past Medical History or Surgeries:

☐ Family history – ☐ NSF ☐ Heart disease ☐ Hypertension ☐ Diabetes ☐ Stroke ☐ Seizures ☐ Kidney disease ☐ Liver disease

Medications

Medications (include OTC)	Dose	Frequency	Taken by Y or N

History

Stairs at home ☐ Yes ☐ No Sleep patte
☐ Lock-up
Last Tetanus toxoid?
Yes ☐ No Do you live in a smoking environment?
Last Drink?
Frequency?
ial made to

To be filled out by the home care agency.

Patient D.O.B.: ___/___/___

QUALIFYING ENCOUNTER TYPE FOR HOME CARE SERVICES (check all that apply)

- Acute • Post-acute (physician who conducted the face-to-face encounter during an inpatient stay)
  Date conducted: ___/___/___ Provider's name (print): NPI#:
  Plan of Care Certifying Physician (print): NPI#:
- Face-to face encounter was conducted: • within 90 days prior to SOC • within 30 days after SOC
  SOC date: ___/___/___ Date of 30th day: ___/___/___
  Date of scheduled visit: ___/___/___ Provider's name (print): NPI#:
  Was provider's office contacted to verify appointment and purpose of appointment: • Yes • No
  If Yes, date contacted: ___/___/___ By whom:
  If No, explain:
- Face-to-face was provided later than 30 days after initial SOC. Date Face-to-face was provided: ___/___/___
  Reset SOC date: ___/___/___ Provider's name (print): NPI#:

To be filled out by physician conducting the initial certification for homecare admission.

PHYSICIAN ATTESTATION

- I certify that this patient is under my care and that I or an allowed NP (a nurse practitioner, or a clinical nurse specialist, or a physician's assistant) working with me, had a face-to-face encounter that meets the physician face-to-face encounter requirements on: Date ___/___/___. I have authorized the establishment of the plan of care.

The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care (List medical conditions. Include primary diagnosis.)

Based on the clinical findings, I certify the patient is homebound and that the following intermittent home care services are medically necessary. (Check all that apply)

• Nursing • Therapy: • PT • SLP/SP
Additional qualified service: • OT • Social Worker • Home Health Aide

I have provided the home care agency with the following documentation to support the patient's medical necessity and substantiate their homebound status. (Check all that apply)

• Encounter visit clinical note • Physician progress notes • Discharge summary • History and physical
• Reports (therapy, operative, etc.)
• Other

Choose one:

- I am the certifying physician, and I will periodically review the patient's plan of care.
- The encounter findings were communicated to the patient's community based physician, _____ (name and title), who will be assuming the patient's home health needs and periodically reviewing the plan of care.

Physician, please sign, and return this form within 2 days and attach copies of documentation. Lack of supporting documentation could adversely affect the patient's ability to receive home care services. **See reverse side to review examples of required content.**

Physician's Signature: Date of Signature: ___/___/___
NPI#: Phone Number:

PART 1 – To Physician (For Signature) PART 2 – Clinical Record (Temporary Copy)

PATIENT NAME-Last, First, Middle Initial ID#

Name:
DOB:
Admit Date:
Code Status:

Admitting Diagnosis:
Allergies:
Isolation: for

Medical History:

Surgical History:

TIME	T	P	R	BP	O2	BG	I/O
8AM							
12PM							
4PM							

Surgery Type:

Surgery Date:

Tubes/Drains:

Incisions/Wounds:

Neuro:

CV:
☐ Strip:
☐ Strip:
☐ Strip:
Pulses: RD BR - DP PT

Pulm:

GI:
Bowel Sounds Y N
Last BM:

GU:
SLF URN BDP ASST FLY

Pain:
☐
☐
☐

Pre-Assessment:

	T	P	R	BP	O2

Post-Assessment:

	T	P	R	BP	O2

NA					
K					
CL					
BUN					
CREAT					
CA					
MG					

WBC					
HGB					
HCT					
PLT					
PT					
INR					
APTT					

Last PRN Pain Med @

Night Shift Information:

PCA:
mg
mg/4hr
lockout (min)

Activity: PT OT

Diet:
Tube Feed: Rate:
Contact:

Diagnostics:

Fluids:

Notes:

To Do:

Meds @
8 9 10 11 12 13 14 15 16 17 18 19

The Purpose of Documentation Today

- Capture the clinical care provided to patients
- Communication with other professionals
- Reimbursement
- Regulation and legislation
- Quality processes and performance improvement
- Accreditation
- Legal purposes
- Research

Impact of the Burden

Nurses and physicians spend as much as

30 – 50%

of their day performing documentation activities

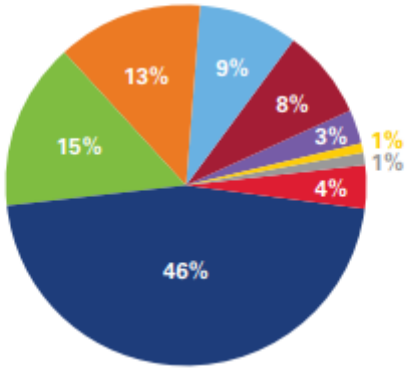
- Munyisia EN, et al. The impact of an electronic nursing documentation system on efficiency of documentation by caregivers in a residential aged care facility. J Clin Nurs. 2012.
- Oxentenko AS, West CP, Popkave C, Weinberger SE, Kolars JC. Time spent on clinical documentation: a survey of internal medicine residents and program directors. Arch In Med. 2010;170:377–380.
- Block L, Habicht R, Wu AW, et al. In the wake of the 2003 and 2011 duty hours regulations, how do internal medicine interns spend their time? J Gen Intern Med. 2013;28(8):1042–1047.
- Kelley TF, Brandon DH, Docherty SL. Electronic nursing documentation as a strategy to improve quality of patient care. J Nurs Scholarsh. 2011; 43(2):154–162.

Regulatory Burden Overwhelming Providers, Diverting Clinicians from Patient Care

$39 BILLION Spent by health systems, hospitals, and post-acute care providers each year on non-clinical regulatory requirements

629 mandatory regulatory requirements

- Hospitals have to comply with 341 mandatory regulatory requirements.
- Post-acute care providers have an additional 288 requirements.



Percent & Number of Regulations, by Domain

- **7** - Billing & Coverage
- **8** - Program Integrity
- **26** - Health IT/ Meaningful Use
- **288** - Post-acute Care
- **96** - Hospital Conditions of Participation
- **78** - Privacy & Security
- **58** - Quality Reporting
- **52** - Fraud & Abuse
- **16** - New Models of Care

$7.6 MILLION per community hospital spent annually to comply

- This figure rises to $9 million for those hospitals with post-acute care.
- For the largest hospitals, costs can exceed $19 million annually.
- The average hospital also spends almost $760,000 annually on the information technology investments needed for compliance.

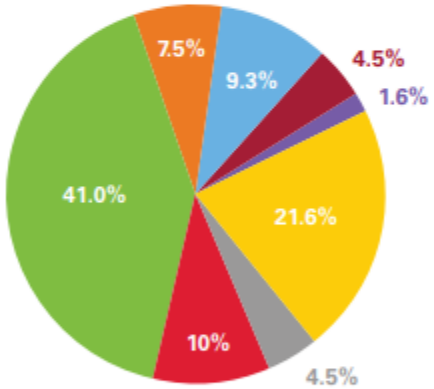
Patients are affected by excessive regulatory burden through:

- Less time with their caregivers
- Unnecessary hurdles to receiving care
- Higher health care costs.

Source: American Hospital Association, ihttps://www.aha.org/system/files/2018-01/regulatory-burden-overwhelming-providers-infographic.pdf

Medicare conditions of participation; billing and coverage determinations are the most costly areas:

- The Medicare COPs are important to ensure that care is provided safely and meets standards.
- However, these requirements need to be evaluated carefully to ensure they actually improve safety.
- Existing guidance to simplify billing and coverage determinations should be adopted universally by payers and others to achieve savings.



Percent of $7.6 Million per Hospital Spent on Regulatory Burden

- $1.6M - Billing & Coverage
- $340K - Program Integrity
- $760K - Health IT/ Meaningful Use
- $3.1M - Hospital COPs
- $570K - Privacy & Security
- $710K - Quality Reporting
- $340K - Fraud & Abuse
- $120K - New Models of Care

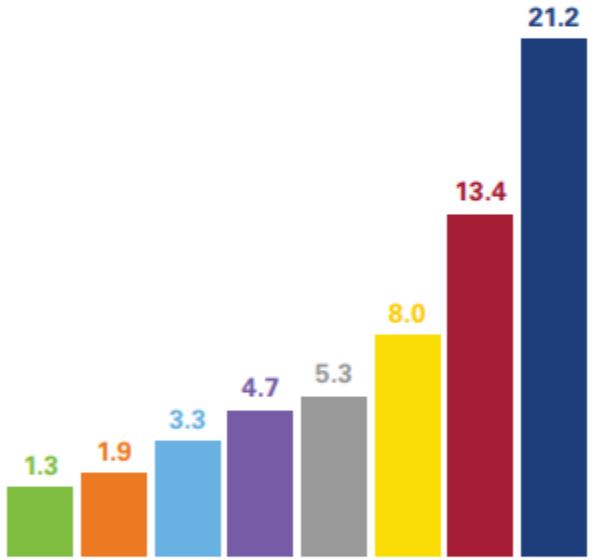
Regulatory burden costs

$1,200

every time a patient is admitted to a hospital

15 doctors & nurses per hospital for compliance

- 59 full-time equivalent staff are required in each hospital to meet the demands of regulations.
- Over one-quarter of these FTEs are doctors and nurses, who could otherwise be caring for patients.



FTEs Dedicated to Regulatory Burden per Hospital

- Legal
- Physician (MD, DO)
- Compliance
- Other Staff
- Health IT Professional
- Management
- Nursing Allied Health
- Other Administrative

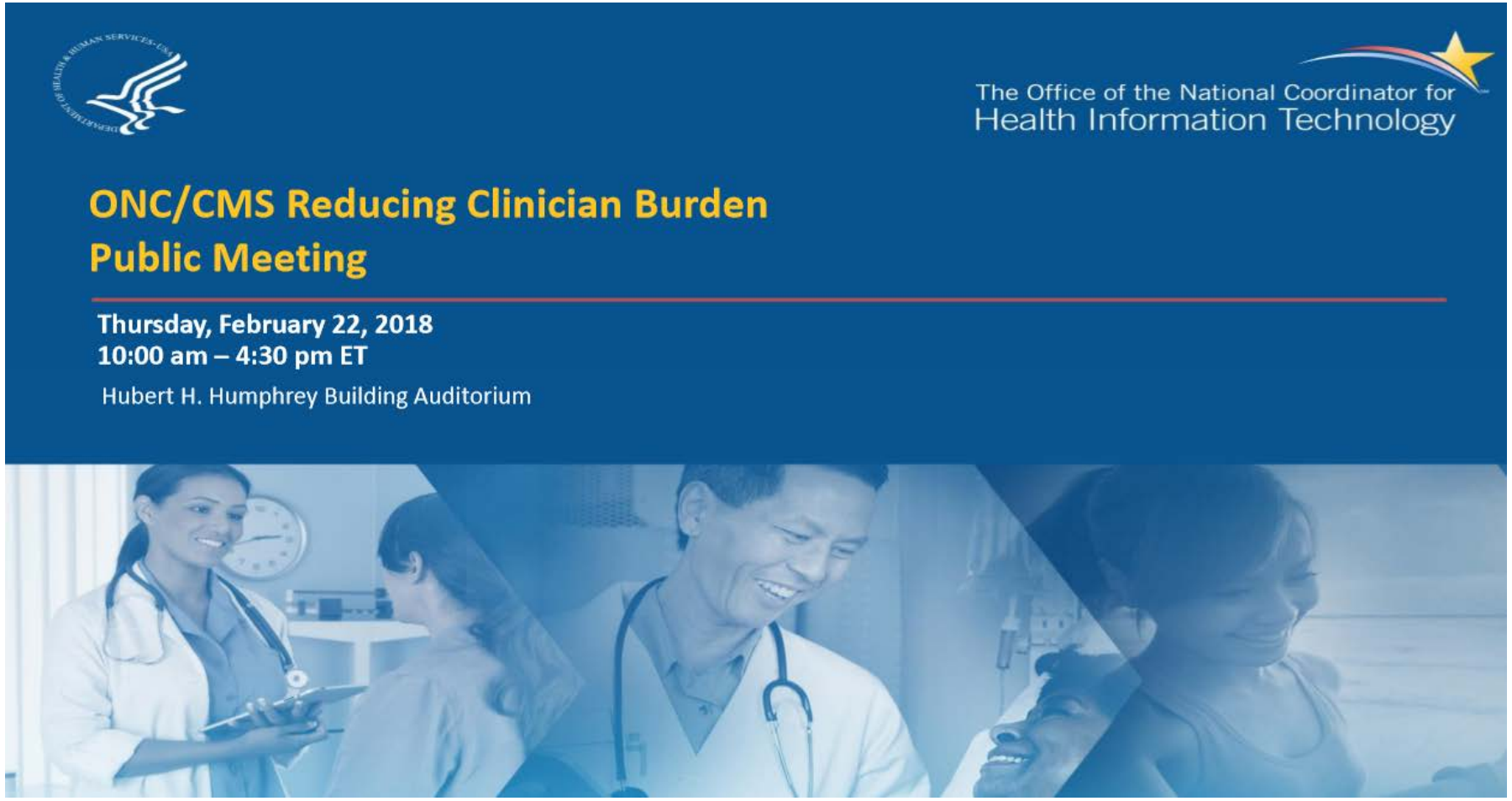
Source: Data from the American Hospital Association Report: Regulatory Overload - Accessing Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers.

Source: American Hospital Association, ihttps://www.aha.org/system/files/2018-01/regulatory-burden-overwhelming-providers-infographic.pdf

Why Do Clinicians Spend So Much Time At The Computer?

Billing/Coding	Regulatory/Quality	Usability	Fear of Litigation	Lack of Interoperability	We've done it to ourselves
CMS – Medicare/Medicaid	CMS Core Measures and other quality indicators reported to the federal government and other insurers	Limited support of workflow of clinician	"If it's not documented it's not done"	Duplication of documentation that's already in an electronic system – somewhere	Misinterpretation of standards from accreditation agency
New Payment Models – QPP/MIPS/APMS	• The Joint Commission (TJC) • Healthcare Facilities Accreditation Program (HEAP) • Det Norske Veritas Healthcare, Inc (DNV)	Too many clicks, too many screens, too much scrolling	Extra "cya" charting	Duplication of documentation due to different standard taxonomy in use.	Squeaky Wheel / Powerful Special Interest Groups want added documentation
Other health insurers (BC/BS, United Healthcare, etc)	State level healthcare requirements	EHRs not following evidence based usability /human factors design principles			The nature of nursing (we think we need to document everything and then some ☺)

ONC/CMS Reducing Clinician Burden



21st Century Cures Act

21st Century Cures Act (Dec 13, 2016)

- SEC. 4001. (a) ASSISTING DOCTORS AND HOSPITALS IN IMPROVING QUALITY OF CARE FOR PATIENTS.
- (1) (a) Reduction in Burdens Goal.--The Secretary of Health and Human Services (referred to in this section as the `Secretary'), in consultation with providers of health services, health care suppliers of services, health care payers, health professional societies, health information technology developers, health care quality organizations, health care accreditation organizations, public health entities, States, and other appropriate entities, shall:
- 1) establish a goal with respect to the reduction of regulatory or administrative burdens (such as documentation requirements) relating to the use of electronic health records;
- 2) develop a strategy for meeting the goal established; and
- 3) develop recommendations for meeting the goal established

21st Century Cures Act

21st Century Cures Act

- SEC. 4001. (a) ASSISTING DOCTORS AND HOSPITALS IN IMPROVING QUALITY OF CARE FOR PATIENTS.
- (1)(b)(3) Recommendations.--The recommendations developed under paragraph shall address--
  - — actions that improve the clinical documentation experience;
  - — actions that improve patient care;
  - — actions to be taken by the Secretary and by other entities; and
  - — other areas, as the Secretary determines appropriate, to reduce the reporting burden required of health care providers

Updates from CMS (2018):
https://www.ehidc.org/sites/default/files/resources/files/Updates%20from%20CMS.pdf

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ONC/CMS Reducing Clinician Burden

Source: Handout from ONC/CMS Meeting on Clinician Burden, February 22, 2018, Hubert Humphrey Building Auditorium, Washington, DC 20201.
http://365.himss.org/sites/himss365/files/365/handouts/550400239/handout-137.pdf

PATIENTS
OVER PAPERWORK

Burden Examples

Requiring supervising physicians to re-write their medical student's notes for E/M services.

Claims being denied for a chemotherapy agent because the nurse's administration record was initialed rather than signed with a full signature.

Requiring providers to report on several Meaningful Use measures that may have been anything but meaningful to them.

Source: Handout from ONC/CMS Meeting on Clinician Burden, February 22, 2018, Hubert Humphrey Building Auditorium, Washington, DC 20201.
http://365.himss.org/sites/himss365/files/365/handouts/550400239/handout-137.pdf

CMS Burden Reduction Initiatives include:

CCSQ Sub-Regulatory EHR and Quality Payment Program (QPP) Accomplishments

1. Greatly reduced the number of EHR measures and thresholds required for Meaningful Use and QPP
   - Re-engineering these programs for future years to focus on interoperability and further reducing burden for providers
2. Developed an **API** for data submission under QPP that can be used for reporting to MIPS for clinicians using registries or QCDRs
3. Developed a very user friendly **website for QPP** for obtaining information and submitting data.

Documentation Requirements Simplification Accomplishments

- E/M Med Student Documentation
  - Now allow teaching physicians to verify in the medical record student documentation of E/M services, rather than re-documenting the student's notes
- Signature Requirements
  - Claims won't be denied if support staff forget to sign part of the record
- When MACs should check for Proof of Delivery
  - Will not be requested for every item
- Therapeutic Shoe Inserts
  - Now allow payment for inserts made with digital technology, without an actual impression of the foot
- IRF Medical Review Policy
  - Claims won't be denied just because a certain number of therapy hours weren't met

Source: Handout from ONC/CMS Meeting on Clinician Burden, February 22, 2018, Hubert Humphrey Building Auditorium, Washington, DC 20201.
http://365.himss.org/sites/himss365/files/365/handouts/550400239/handout-137.pdf

"Patients Over Paperwork"

- Documentation Requirements Simplification
- CMS Administrator Seema Verma's Charge:
  - —Simplify our requirements
  - —Make them easier to understand
  - —Get rid of requirements we no longer need
  - —Seek input from stakeholders
  - —Challenge the way we have always done things
  - —We Need Your Input: You can email: ReducingProviderBurden@cms.hhs.gov

ONC/CMS Reducing Clinician Burden Public Meeting 2/22, 2018

Collaboration: ONC/ANA/AAN/WG 10 Transforming Nursing Documentation

The Office of the National Coordinator for Health Information Technology

ANA
AMERICAN NURSES ASSOCIATION

ANA and ONC: Care Planning and Documentation Burden/Standardization

AMERICAN ACADEMY OF NURSING
transforming health policy and practice through nursing knowledge

Collaboration: ONC/ANA/AAN/WG 10 Transforming Nursing Documentation

- Goal – to reduce the burden of clinical documentation
- Identified two areas of focus
  - —Nursing admission assessment documentation
  - —Patient plan of care documentation

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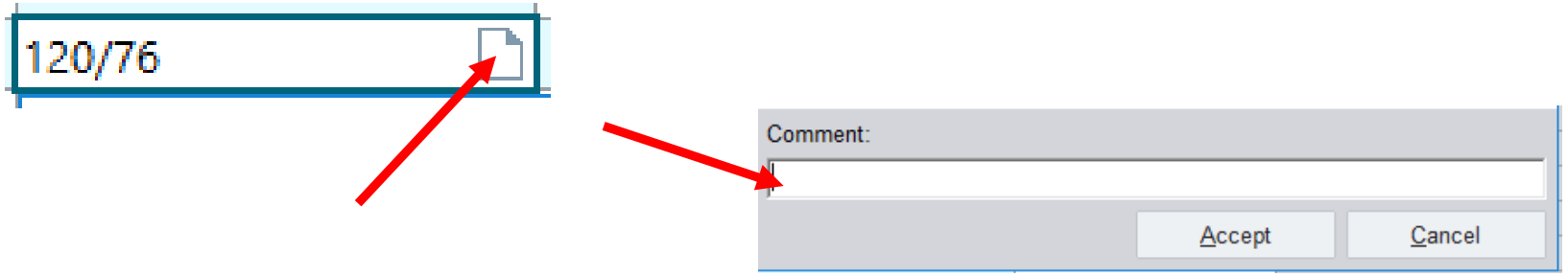
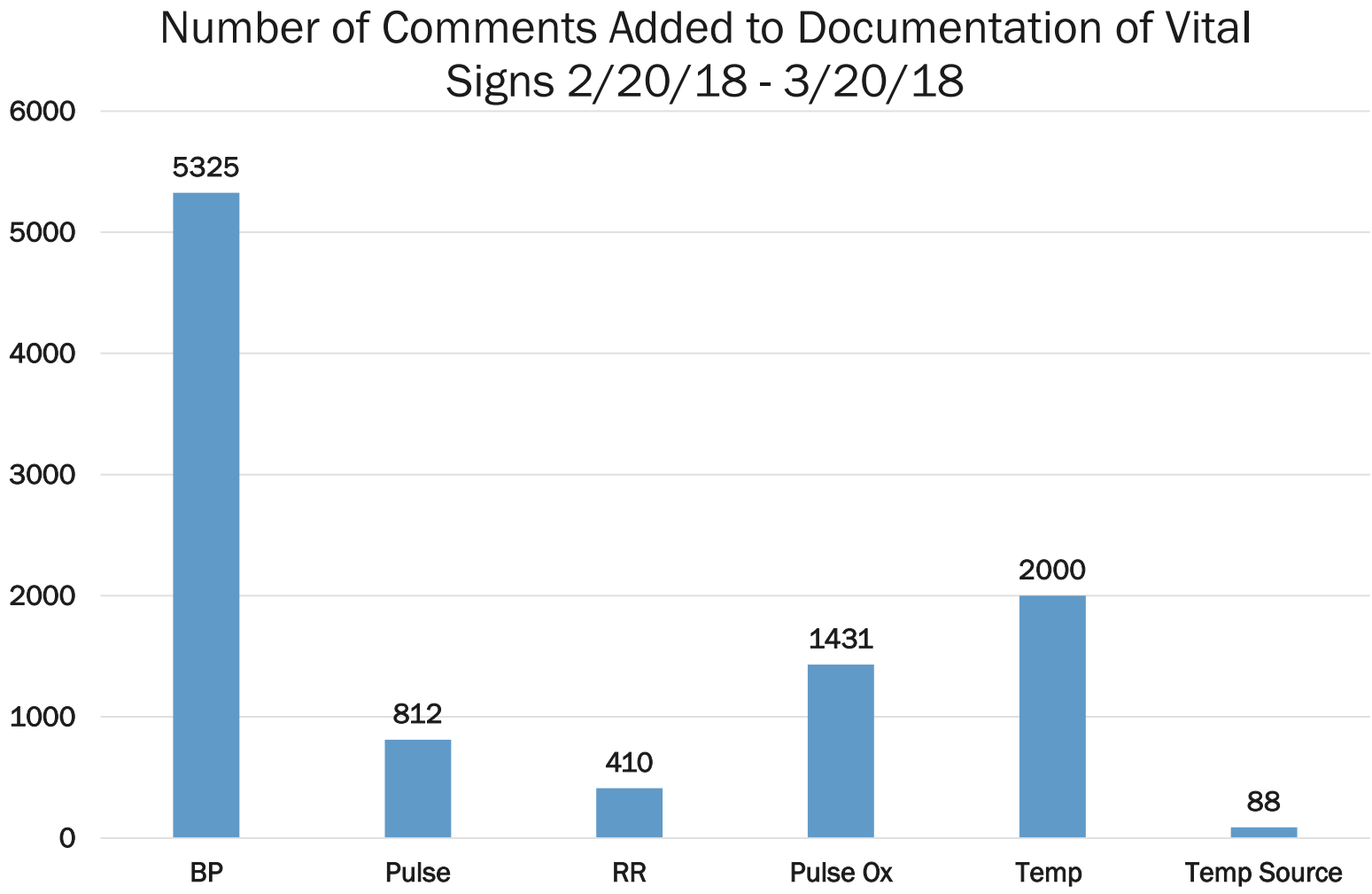
Use Data to Make Informed Decisions

- Flowsheet Usage by Department
- Flowsheet Usage by Template
- Flowsheet Custom List Usage
- Flowsheet Row Comments
  - —Example: Blood Pressure Comments




Number of Comments Added to Documentation of Vital Signs 2/20/18 - 3/20/18
6000
5000
4000
3000
2000
1000
0
5325
812
410
1431
2000
88
BP
Pulse
RR
Pulse Ox
Temp
Temp Source

Blood Pressure Comments

- pt states he felt dizzy when he leaned back his head
- MD paged
- nurse notified
- 100ml bolus of ns given
- Paged Phy. Gave pain med. Awaiting pharm. to send Catopril.
- will re-check.
- appears to be sleeping.
- Pt screaming and crying about hedache. Will recheck
- MD notified, no new orders received at this time.
- NP notified; no HA, no worsening chest pressure c pepcid adm
- I went in to assess the pt's BP and realized the BP cuff was on the pt's left arm which had a fistula. I placed the BP cuff on the pt's right arm and reassessed the BP.
- pre-nitroglycerin paste administration
- Cuff adjusted
- right arm sitting
- manual recheck after auto read 162/105, pt refusing BP med

Collaboration: ONC/ANA/AAN/WG 10 Transforming Nursing Documentation

- First steps
  - —Environmental Scan – to identify work already underway or improvements already achieved by other committees, groups or organizations
  - —Literature Review

National Academy of Medicine (IOM)

DISCUSSION PAPER

Care-Centered Clinical Documentation in the Digital Environment: Solutions to Alleviate Burnout

Alexander K. Ommaya, DSc, MA, Association of American Medical Colleges; **Pamela F. Cipriano, PhD, RN, NEA-BC, FAAN,** American Nurses Association; **David B. Hoyt, MD, FACS,** American College of Surgeons; **Keith A Horvath, MD,** Association of American Medical Colleges; **Paul Tang, MD, MS,** IBM Watson Health; **Harold L. Paz, MD, MS,** Aetna; **Mark S. DeFrancesco, MD, MBA, FACOG,** American College of Obstetricians and Gynecologists; **Susan T. Hingle, MD,** American College of Physicians; **Sam Butler, MD,** Epic; **Christine A. Sinsky, MD,** American Medical Association

January 29, 2018

Source: https://nam.edu/wp-content/uploads/2018/01/Care-Centered-Clinical-Documentation.pdf

National Academy of Medicine

- We recognize that the primary drivers for current capabilities in EHRs include regulatory requirements, and documentation to support coding and billing.
- Clinicians spend much of their time focused on documentation and related coding issues. This use of highly specialized clinical knowledge seems to be a misapplication of resources.
- Meanwhile, the patients have been left in their exam rooms or hospital beds wondering if all the activity going on is helping to address their needs.

Source: https://nam.edu/wp-content/uploads/2018/01/Care-Centered-Clinical-Documentation.pdf

National Academy of Medicine

Box 1 | Recommendations

- Clinicians should be responsible only for essential primary data entry that is required to support the care of a patient.
- EHR developers should increase the development of capabilities that allow clinicians to understand the previous medical, health, and social history of the patient.
- CMS should deemphasize documentation requirements as a condition of payment for health care services.
- CMS should clarify that elements of the HPI drafted by an assistant, and confirmed with the patient by the provider, should count for reimbursement.
- An authoritative body, such as the NAM, should initiate a study focused on redesigning clinical documentation suited to the modern digital age, with a primary focus on informing clinical management and improving patient outcomes and health.

SOURCE: Ommaya et al., "Care-Centered Clinical Documentation in the Digital Environment: Solutions to Alleviate Burnout," National Academy of Medicine.

https://nam.edu/wp-content/uploads/2018/01/Care-Centered-Clinical-Documentation.pdf

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Other health insurers (BC/BS, United Healthcare, etc)	State level healthcare requirements	EHRs not following evidence based usability /human factors design principles			The nature of nursing (we think we need to document everything and then some ☺)

In summary, what should we do?

- Stay informed of changes by federal and regulatory agencies. If we don't know - we cant capitalize on their efforts to streamline and reduce the documentation burden
  - —TJC efforts – Project REFRESH
  - —CMS – Patients over Paperwork
- Get involved
- Learn from our colleagues
- Re-evaluate interpretation of regulations
- Review and revise our own written policies and procedures as appropriate
- Clean up the clutter (using data available)
- Work with our vendor to improve usability and increase efficiencies
- Continue to standardized where possible
- Innovate – voice recognition software, mobile technologies
- Develop guiding principles for improving/enhancing clinical documentation.

Thank You!

Patty Sengstack DNP, RN-BC, FAAN
patricia.r.sengstack@Vanderbilt.edu