ADMISSION HISTORY AND CURRENT STATE SCREENING

NKBD: Preconference
Track 3

PURPOSE AND OBJECTIVES

Purpose: To collect input on the Admission History Task Force from a diverse group of stakeholders.

Objectives:

1. Review Admission History Task Force Charter and progress to date.
2. Critically examine Guiding Principles.
3. Review and refine content for six components of Admission History and Screening.

AGENDA

8:30	**Welcome, Overview & Introductions**
9:00	Critique of Guiding Principles: Review the work of the taskforce and specifically critique the Guiding Principles document that will be used throughout the day. Jane Englebright, PhD, RN, CENP, FAAN, Senior Vice President Chief Nurse Executive at HCA Healthcare
10:00	Break
10:30	Draft recommendations for standardizing the Admission History and Screening: A draft document of admission history and screening questions was developed. Participants will work in groups to review and provide feedback to increase the generalizability of the recommendations. Shannon Hulett, DNP, RN, CNL; Sarah Michel, MBA, BSN, RN, NE-BC
12:00	Lunch
1:00	Report outs from groups on Draft Recommendations
1:30	Information Modeling and Coding: In this presentation, participants will learn about the process of creating an information model from the admission history and screening and the next steps of standardizing data elements with LOINC and SNOMED CT. Stephanie Hartleben, RN-BC, MSN, MHA, Product Manager, Elsevier; Theresa (Tess) Settergren, MHA, MA, RN-BC, Director, Nursing Informatics, Cedars-Sinai
2:30	Break
3:00	Dissemination Planning: Participants will engage in brainstorming strategies for dissemination of the admission history and screening when it is complete. The goal is to strategize how the model will be implemented. David Boyd, DNP, RN-BC
3:30	Summary and Wrap up Jane Englebright, PhD, RN, CENP, FAAN
4:00	Return to the Meridean Ballroom for a panel discussion

ADMISSION HISTORY AND CURRENT STATE SCREENING TASK FORCE

Origins: 6 Workgroups came together to form the Task Force

Problem to Solve:

An opportunity exists to define the ideal Admission History content that provides important data and information for patient care, patient population management and research while minimizing documentation burden for the nurse.

STEP 1: CHARTER

The ideal content for Nursing Admission History is not clearly defined within the nursing profession. There is wide variation in the approach to Admission History across hospitals and health systems and within the model content provided by EHR vendors. This variability inhibits reuse of data for decision support and research.

The Admission History: NKBD Cross-Workgroup Task Force is charged with defining a model for Admission History for the adult patient admitted to an acute care facility for medical/surgical care.

STEP 2: GROUND RULES

1. Task force will make decisions by evidence and consensus
   - Voting and polling may be used when clear consensus is not achieved
   - Decisions which cannot be determined will be brought to NKBD Steering
2. Decisions will be stated clearly in the minutes
3. We will use direct, honest and productive communication—minimize interruptions and side conversations; everyone's voice is heard and all members have equal influence
4. We will begin and end meetings in a timely fashion
5. Meeting minutes and attachments will be sent electronically via e-mail within 2 weeks of the meeting being held. Final copy housed in Drop Box.
6. All members will monitor the work plan and fully participate in output development
7. Members will participate in scheduled meetings and respond with feedback on task force working deliverables as a result of meetings by agreed upon milestone dates unless unforeseen circumstances arise and connection with project manager is attempted/occurs
8. If member is unable to attend meeting or meet milestones s/he will access Dropbox and email documents and network with other members to catch up on content

STEP 3: GUIDING PRINCIPLES

1. Content for admission history is:
   - Interview questions that are asked one time to establish a baseline, identify problems and individual considerations for care.
     - Content that needs to be repeatedly assessed for ongoing care evaluation is out of scope. (Example: chronic pain history is part of Admission History, ongoing pain assessment is not)
   - Questions and answers are mapped to concepts to facilitate data reuse (step 2).
     - Narrative or free text data is limited
2. Content must be:
   - Essential to patient care decisions
   - Necessary for regulatory or billing requirements
3. Evidence-based vs. Consensus-based (Step 2)

STEP 3: GUIDING PRINCIPLES - CONTINUED

4. Patient-focused vs. discipline-focused
   - Data is shared among caregivers to eliminate duplication but one caregiver should not perform data collection work for others.
   - Nursing is screening patient needs to determine whether other disciplines need to engage with the patient.

5. Design for health literate patient-entered data in the future and joint patient/caregiver collaboration. (Step 2)

6. Focus on WHAT (content) not HOW (build or system)
   - Each item of content will address a single concept
   - Options within answer sets will be semantically consistent
   - Options within answer sets will be limited to 12, whenever possible

STEP 3: GUIDING PRINCIPLES - CONTINUED

7. Documentation is designed for the ethical and competent clinician
8. Leverage historical data from previous episodes, when appropriate
9. Documentation incorporates decision support to minimize error and maximize effect
10. Clearly define policy issues vs data entry requirements

TABLE EXERCISE:

1. Discuss each guiding principle
   - Is it clear?
   - Is it pertinent to defining the CONTENT for Admission History and Current State Screening?
   - Is it IMPORTANT to reducing documentation burden and producing actionable data for patient care?

2. Document any recommendations for improvement from your group on the flip chart.

NEXT STEPS: INITIAL MODEL & KEY DECISIONS

4. Initial Model & Key Decisions
5. Today's work session
6. Finalize content
7. Disseminate

RECOMMENDATIONS FOR STANDARDIZING THE ADMISSION HISTORY AND SCREENING

Shannon Hulett, DNP, RN, CNL

Sarah Michel, MBA, BSN, RN, NE-BC

CATEGORY, CONCEPT, COMPONENT, RESPONSE

1. Patient preferences
2. Social and Behavioral Determinants of Health
3. Psychosocial/Emotional
4. Physical
5. Functional

Category	Concept	Component/ Question	Response/Answer

COMPONENTS NOT IN THE DATA MODEL

Below is an example of what is not currently part of the admission process for:

HCA

- **Sleep**
- **Elimination/Bowel and Bladder**

For GHS

- **Travel screening** *(*unless auto-populated from initial TB 'cough' screening question)*

HCA or GHS

- **Clear water and non-polluted air**
- **Education level**
- **Family dynamics (*other than concepts embedded in other questions)**
- **Patient's perception of health/healthcare**
- **Sexually active, using birth control** *(*unless it were to come up in medication history)*
- **Sleep Apnea Screening**

REMOVALS AND ADDITIONS

HCA

- Evaluated the medical record and eliminated what was not necessary for patient care, billing or regulatory
  - Had 178 EHR's, all with different content
  - Currently have streamlined to one EHR with parameters for state specific regulatory needs

GHS

- Eliminated redundancy & non-value added rows
  - Respiratory, Diabetes, Skin, Mobility/daily living 'extras', Discharge destination, Care team, Spiritual care 'extras', Chronic pain 'extras', Homicide
- While elimination of nonessential rows was a goal, the main goal was to implement a *valuable* set of admission screens in a usable design
  - Added sleep, voiding concerns, equipment needs, and ability to document 'inability to screen'

CURRENT PROPRIETARY SCREENING INSTRUMENTS USED ON ADMISSION FOR ADULTS

HCA

- **Suicide = SAFE-T**
- **Depression = PHQ2 & PHQ9**

GHS

- **Suicide: CSSRS = Columbia Suicide Severity Rating Scale**
- **Falls: Morse**
- **Skin: Braden**
- **Tuberculosis screening**

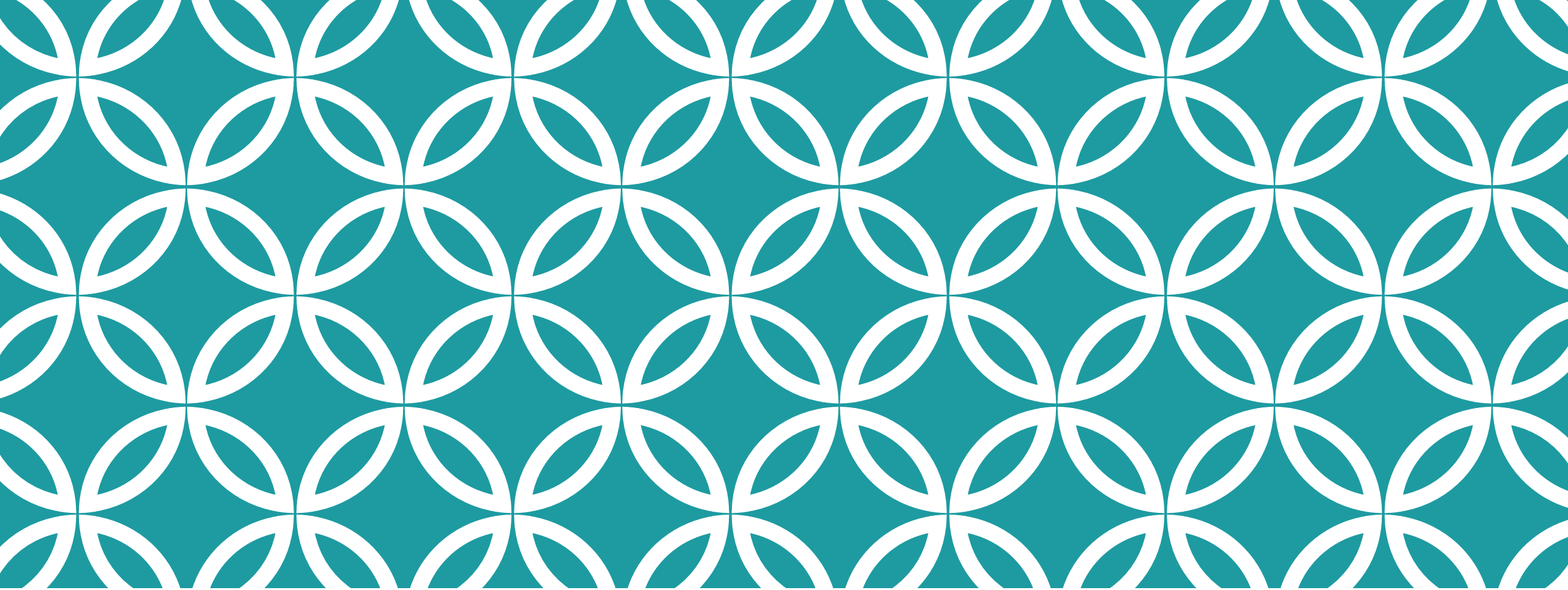
HCA and GHS

- **Alcohol=CAGE/Audit C**
- **Nutrition = Malnutrition Screening Tool (MST)**

BREAK OUT GROUPS

Groups will be divided into four

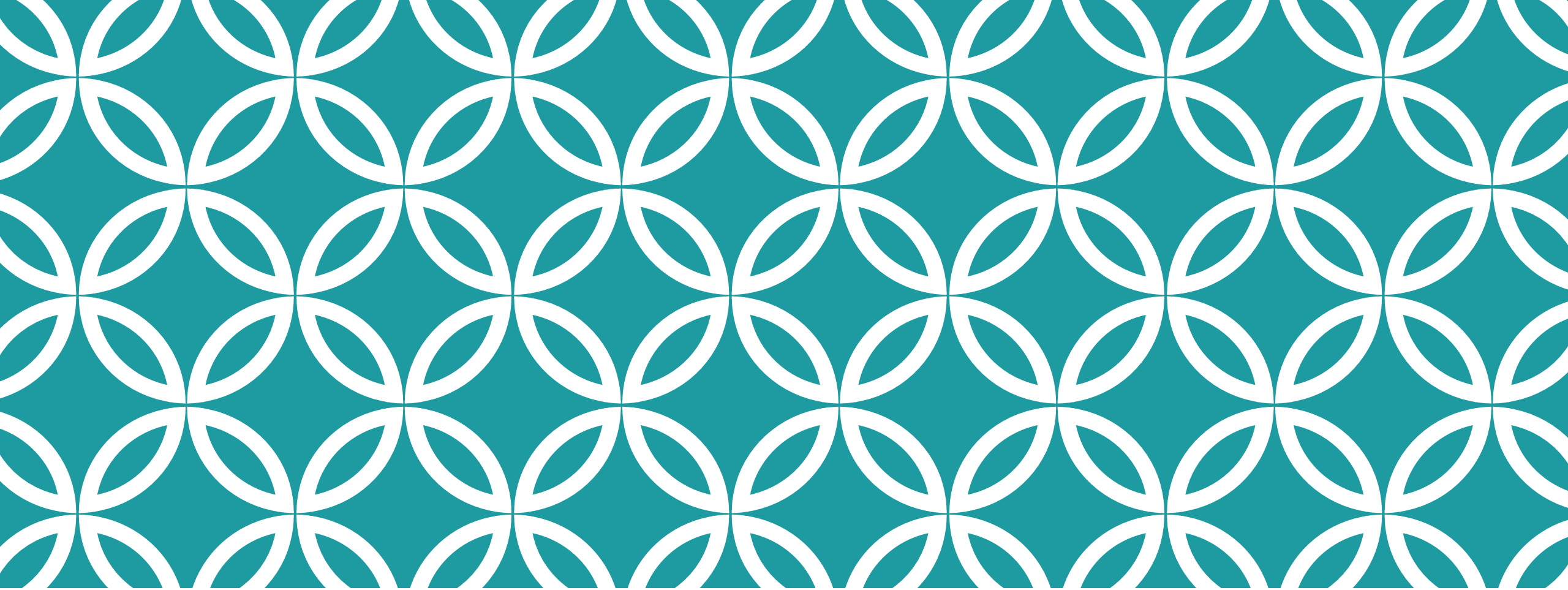
a. Identify scribe
b. Guiding Principles worksheet has been provided
c. Review each item on the Content worksheet, evaluating it against the Guiding Principles
    i. Highlight desired option
    ii. Line-through items that should be eliminated
    iii. Add in any omissions in the far right column
d. Report out will be after lunch, 10 minutes for each group
    i. What did you eliminate?
    ii. What did you add?
e. We will collect master of edits from the Scribe



INFORMATION MODELING AND CODING

Stephanie Hartleben, RN-BC, MSN, MHA

Theresa (Tess) Settergren, MHA, MA, RN-BC



DISSEMINATION PLANNING

David Boyd, DNP, RN-BC