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School of Nursing

SoCal ANIA Chapter Conference

Using Data to Tackle the Burden of Nursing Documentation in the Electronic Health Record

Patricia Sengstack DNP, RN-BC, FAAN

patricia.r.sengstack@Vanderbilt.edu

BOTCHED OPERATION

Death By 1,000 Clicks: Where Electronic Health Records Went Wrong

The U.S. government claimed that turning American medical charts into electronic records would make health care better, safer and cheaper. Ten years and \$36 billion later, the system is an unholy mess. Inside a digital revolution that took a bad turn.

By Fred Schulte and Erika Fry, Fortune • MARCH 18, 2019

(The Voorhes for Fortune)

Source: <https://khn.org/news/death-by-a-thousand-clicks/>



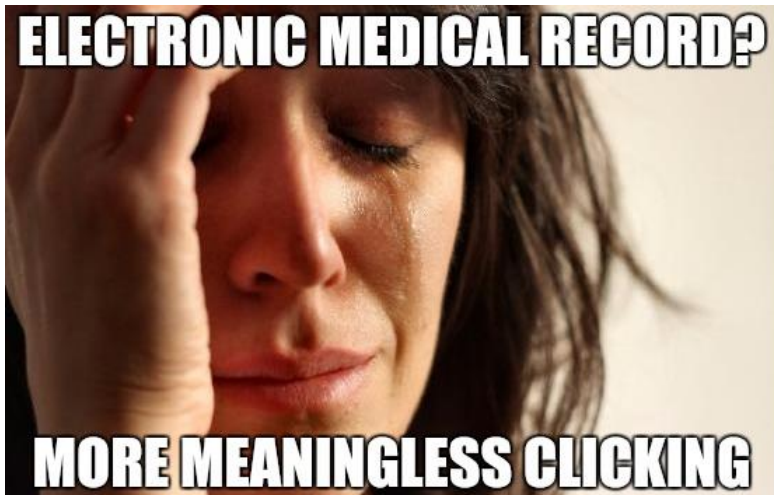
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Agenda

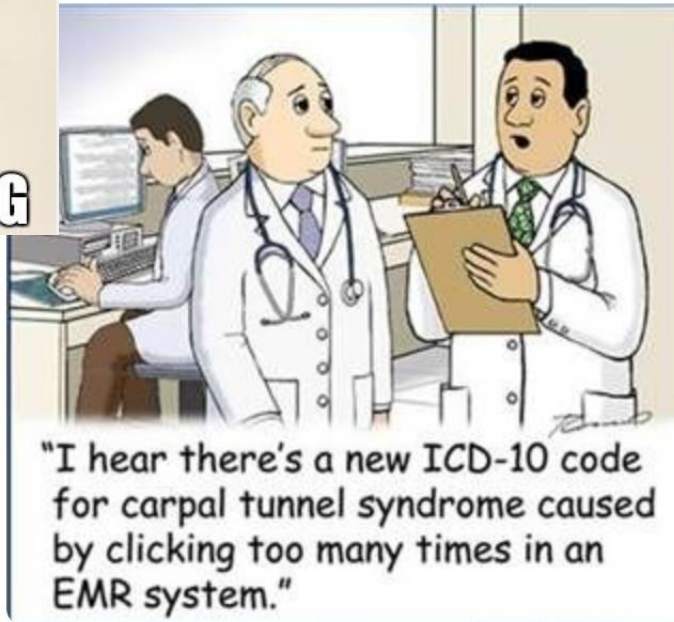
- ▶ Review current issues related to the burden of clinical documentation in the electronic health record
- ▶ Propose a framework to address the “Burden”
- ▶ Share emerging data and tools measuring EHR use
- ▶ Identify data driven organizational strategies to help reduce documentation burden for nurses – aka – what you can do today!



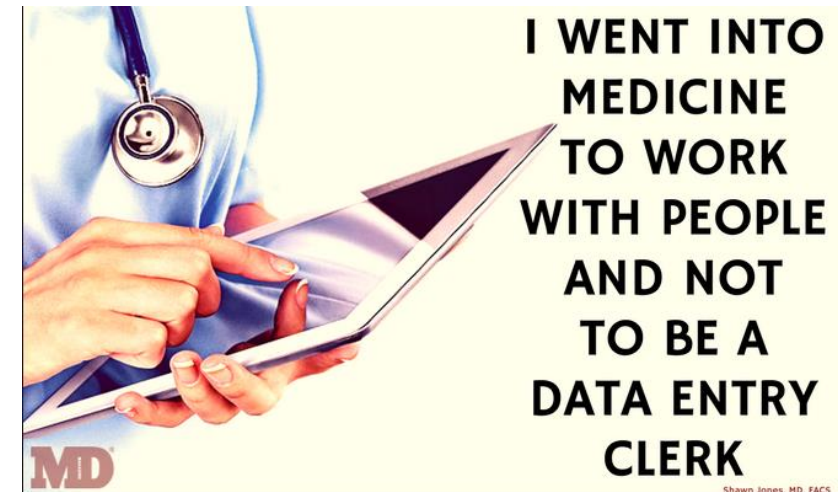
Headlines, Cartoons and Memes



<https://imgflip.com/i/15v4s7>



<https://www.pinterest.com/pin/381961612125245061>



<https://www.mdmag.com/medical-news/why-are-emrs-so-terrible>



11/9/2018

Why Doctors Hate Their Computers | The New Yorker

THE
NEW YORKER

WHY DOCTORS HATE THEIR COMPUTERS

Digitization promises to make medical care easier and more efficient. But are screens coming between doctors and patients?

By Atul Gawande

<https://www.newyorker.com/magazine/2018/11/12/why-doctors-hate-their-computers>



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AAMC**NEWS**

PATIENT CARE



Tuesday, March 27, 2018 | by Gregg Breining, special to *AAMCNews*

Reducing the Stress Associated With Electronic Health Records

Physicians cite electronic health records (EHRs) as a leading contributor to burnout. Learn about solutions academic medicine could employ to help eliminate the stress EHRs cause.

<https://news.aamc.org/patient-care/article/reducing-stress-electronic-health-records/>



Google Search:
"Stress, depression
and burnout related
to use of an EHR"
757,000 results

Innovative approaches to solve physician burnout - KevinMD.com

<https://www.kevinmd.com/.../innovative-approaches-to-solve-physician-burnout.html> ▼

Apr 8, 2019 - **Burnout** is **associated with** higher rates of major medical errors, ... factors, such as untreated **depression**, **stress** about medical school debt, the ... or hiring IT technicians to work with clinicians to streamline **use** of the **EHR**. 4.

Physician Burnout Costs The U.S. Health Care System Billions Each ...

<https://www.npr.org/sections/health-shots/2019/.../whats-doctor-burnout-costing-america>

May 31, 2019 - "Everybody who goes into medicine knows that it's a **stressful** career ... "Cumbersome, inefficient" **electronic health record** systems; ... "**Burnout** is highly, highly **associated with** major **depression**," she says. ... This site is protected by reCAPTCHA and the Google Privacy Policy and Terms of Service **apply**.

Handout 2018 Physician Burnout Crisis - The Doctors Company

<https://www.thedoctors.com/contentassets/.../handout-2018-physician-burnout-crisis.pdf>

2018 Medscape National Physician **Burnout** and **Depression** Report **associated with** clinician **stress** by sharing information ... Full **EHR Use** with Redesign.

5 Ways to Reduce Physician Burnout Caused by EHRs

<https://www.softwareadvice.com/resources/reduce-physician-burnout/> ▼

Find out how you can reduce physician **burnout** resulting from **EHR usage**. ... Read about how you can reduce physicians' **stress** to help them provide better ... This can result in **severe** breach of patient data confidentiality, because multiple ...

Electronic Health Records Contribute To Major Burnout And Stress For ...

<https://www.techtimes.com> › Home › Health › Public Health ▼

Jun 30, 2016 - Having to deal with **electronic health records** may be contributing to the ... **Electronic Health Records** Contribute To Major **Burnout** And **Stress** For Doctors ... who **use** order entry software and **electronic health records** (**EHR**) tend to become ... how to make the tools more clinically **relevant** and user-friendly





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Burnout Among Health Care Professionals: A Call to Explore and Address This Underrecognized Threat to Safe, High-Quality Care

By Lotte N. Dyrbye, Tait D. Shanafelt, Christine A. Sinsky, Pamela F. Cipriano, Jay Bhatt, Alexander Ommaya, Colin P. West, and David Meyers

July 5, 2017 | Discussion Paper

<https://nam.edu/burnout-among-health-care-professionals-a-call-to-explore-and-address-this-underrecognized-threat-to-safe-high-quality-care/>



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NAM - What Is Driving Burnout Among Health Care Professionals?

► Work-Related Stress – fueling burnout and job dissatisfaction

- Excessive workload
 - work hours
 - overnight call frequency
 - nurse-patient ratios
- Moral distress
 - perceived powerlessness
 - Unnecessary/futile care
 - Inadequate informed consent
- Work process inefficiencies – CPOE and Documentation

<https://nam.edu/burnout-among-health-care-professionals-a-call-to-explore-and-address-this-underrecognized-threat-to-safe-high-quality-care/>



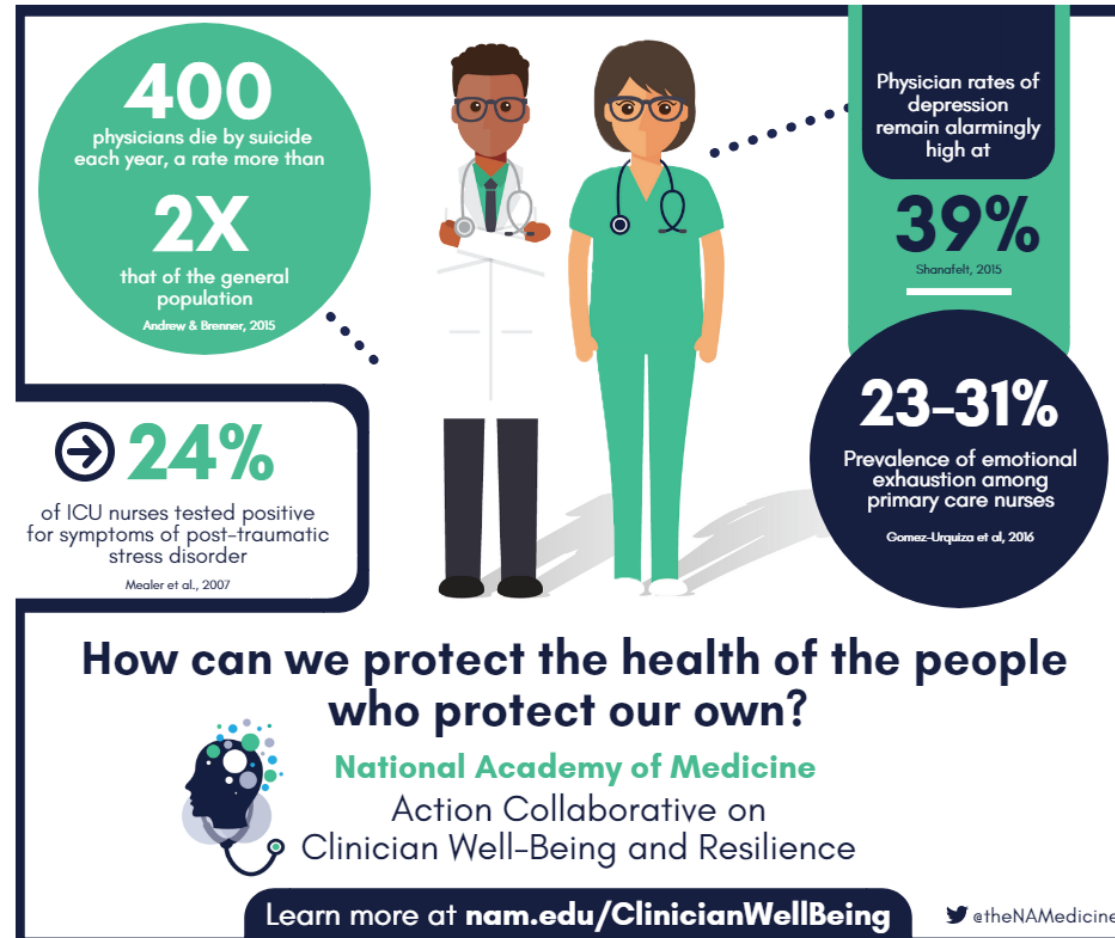
NAM - Why Should We Be Concerned About Burnout Among Health Care Professionals?

- ▶ Medical Errors
- ▶ Malpractice Suits
- ▶ Depressive Symptoms
- ▶ Decrease in Quality of Life
- ▶ Average burnout levels among hospital nurses are an independent predictor of **health care–associated infection**
- ▶ **Emotional Exhaustion** – as mean emotional exhaustion levels of physicians and nurses working in intensive care units rose, so did standardized **patient mortality ratios** - and perceived quality of **interpersonal teamwork** deteriorated

<https://nam.edu/burnout-among-health-care-professionals-a-call-to-explore-and-address-this-underrecognized-threat-to-safe-high-quality-care/>



Some Stats from the National Academy of Medicine



<https://nam.edu/initiatives/clinician-resilience-and-well-being/>



Original article

Estimating the association between burnout and electronic health record-related stress among advanced practice registered nurses

Daniel A. Harris, MPH^{a,c}, Jacqueline Haskell, MS^c, Emily Cooper, MPH^{c,*}, Nancy Crouse, CNS^d, Rebekah Gardner, MD^{b,c}

- Administered by the Rhode Island Department of Health
- A state-wide electronic survey was sent to all 1,197 APRNs licensed and in practice in Rhode Island
- The survey period was from May 8th, 2017 to June 12th, 2017
- A total of 371 APRNs contributed data for a response rate of 31.0%

Harris, D.A., Haskell, J., Cooper, E., Crouse, N. & Gardner, R. (2018). Estimating the association between burnout and electronic health record-related stress among advanced practice registered nurses. *Applied Nursing Research*. 43(2018), 36-41.



Harris, et. al. - Article Highlights

- ▶ Almost one in five APRNs are experiencing at least one burnout symptom
- ▶ Insufficient time for documentation was the strongest predictor of burnout among APRNs
- ▶ 64 (19.3%) reported spending a moderately high to excessive amount of time on their EHR at home
- ▶ 165 (50.1%) agreed or strongly agreed EHRs add to their daily frustration
- ▶ 97 (32.8%) reported insufficient time for documentation

Harris, D.A., Haskell, J., Cooper, E., Crouse, N. & Gardner, R. (2018). Estimating the association between burnout and electronic health record-related stress among advanced practice registered nurses. Applied Nursing Research. 43(2018), 36-41.

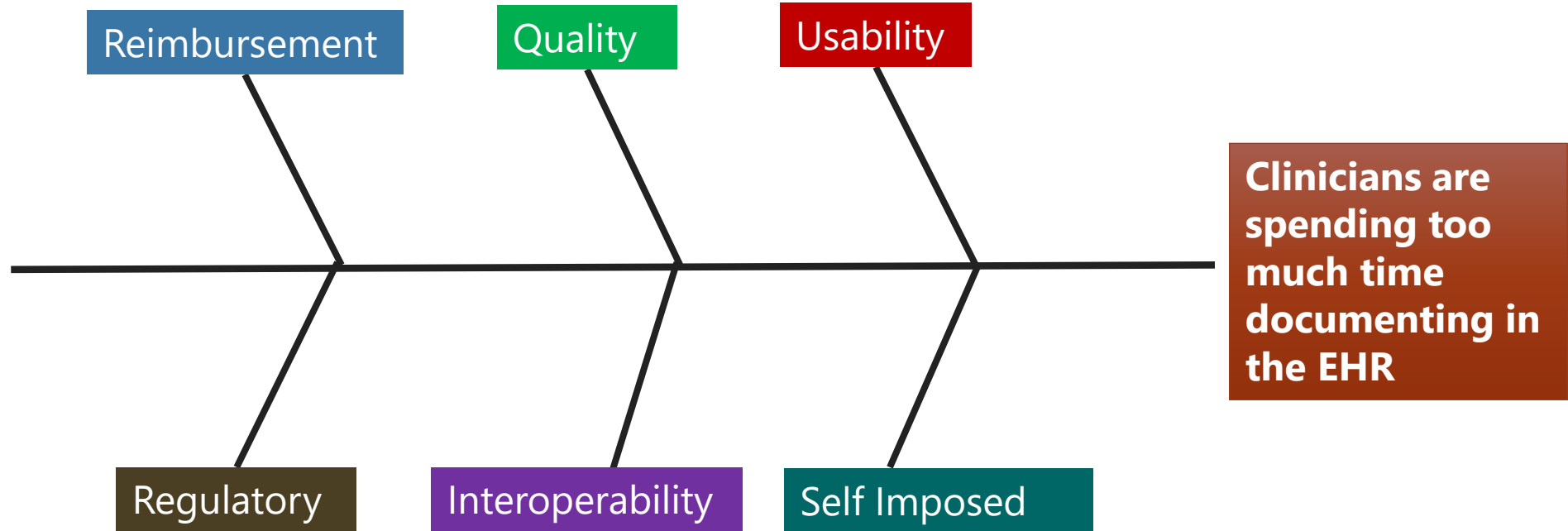


What is “Burden”?

- ▶ We are hearing this term often – in the literature, blogs, social media
- ▶ Merriam-Webster: Duty or responsibility, something oppressive or worrisome
- ▶ The problem – no definition for *burden* related to health IT and documentation in the EHR.
- ▶ Need to look at burden more holistically
- ▶ Need to address the various domains of causation to help focus improvement efforts as work is conducted, evaluated, categorized and reported



Proposal – Use of a Framework to Address the Burden of Documentation in the EHR: The Six Domains of Burden



Reimbursement/Billing

- ▶ Documentation, coding and other administrative data entry tasks required for payment
- ▶ Examples:
 - _ Evaluation and management (E & M) documentation
 - _ Prior authorization documentation
 - _ New payment models: Merit-based Incentive Payment System (MIPS) and the Advanced Alternate Payment Models (Advanced APMs) – require use of certified EHR technology to exchange information across providers and with patients to support improved care delivery, including patient engagement and care coordination. All requiring documentation.



ONC/CMS Reducing Documentation Burden for Reimbursement



Our top priority at CMS is putting patients first

CMS is committed to reducing unnecessary burden, increasing efficiencies, and improving the beneficiary experience.

Burden Reduction Initiatives

Centers for Medicare & Medicaid Services

Dr. Kate Goodrich
Melanie Combs-Dyer

**PATIENTS
OVER PAPERWORK**

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>



Regulatory

► Accreditation agency documentation requirements

- _ The Joint Commission
- _ Healthcare Facilities Accreditation Program
- _ State Regulatory Agencies



TJC's Project Refresh

- ▶ Multi-phased effort to modernize and streamline Joint Commission requirements by deleting non-value-added requirements and consolidating redundant requirements. Throughout 2016 and 2017, almost 300 hospital elements of performance (EPs) were removed

What is Project Refresh?



- ▶ A series of inter-related and/or inter-dependent process improvement initiatives underway at The Joint Commission
 - Guiding principles: **Simplification, Relevancy, Innovation, Transparency**
- ▶ Refresh projects are implemented in a phased and coordinated approach, that began in June 2016 and continue.

https://www.jointcommission.org/assets/1/6/Revised_Survey_Report_Presentation.pdf



Quality

- ▶ **Documentation required to demonstrate that quality patient care has been provided. This includes documentation requirements by the healthcare organization itself, as well as by governmental and regulatory agencies**
 - _ The Hospital Inpatient Quality Reporting (IQR) Program,
 - _ The Hospital Outpatient Quality Reporting (OQR) Program,
 - _ The Physician Quality Reporting System (PQRS)
 - _ National Database of Nursing Quality Indicators (NDNQI)



CMS's Meaningful Measures initiative

- ▶ “Meaningful Measures” framework is the Centers for Medicare and Medicaid Services’ new initiative which identifies the highest priorities for quality measurement and improvement. It involves only assessing those core issues that are the most critical to providing high-quality care and improving individual outcomes.
- ▶ Its purpose is to improve outcomes for patients, their families and providers while also reducing burden on clinicians and providers.



<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/MMF/General-info-Sub-Page.html>



Usability

- ▶ **Limited and insufficient use of human factors engineering and human-computer interface principles resulting in extra time spent entering data, scrolling, clicking and searching for pertinent information in the record**
 - _ Lack of support of optimal workflows
 - _ Inefficient use of clinical decision support tools
 - _ Limited vendor use of human factors engineering principles and usability standards
 - _ inappropriate use of copy and paste functionality



National Institute on Standards and Technology (NIST)

► The NIST Health IT Usability Initiative:

- Focused on establishing a framework that defines and assesses health IT usability.
- Conducted (in collaboration with ONC) and the Agency for Healthcare Research and Quality (AHRQ)
- <https://www.nist.gov/programs-projects/health-it-usability>

NISTIR 7804-1

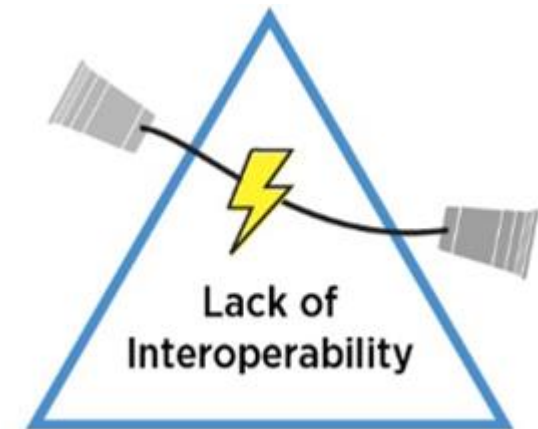
**Technical Evaluation, Testing, and Validation of the Usability of Electronic Health Records:
Empirically Based Use Cases for Validating Safety-Enhanced Usability and Guidelines for Standardization**

<https://nvlpubs.nist.gov/nistpubs/ir/2015/NIST.IR.7804-1.pdf>

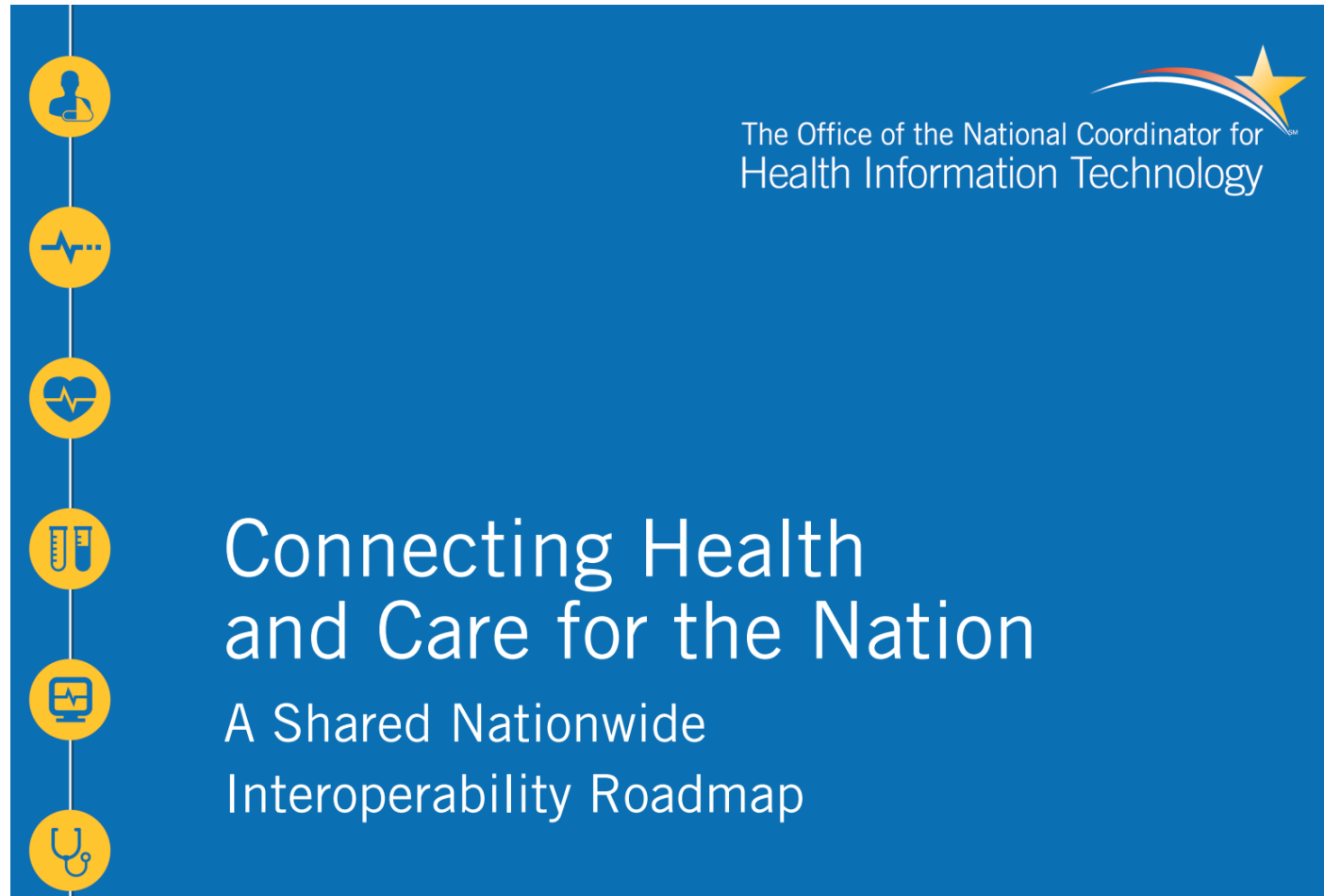


Interoperability

- ▶ **Insufficient configuration standards resulting in duplication and re-entry of data even though it resides elsewhere, either internal to the organization or in an external system.**
 - _ Duplication of documentation that's already in an organization's electronic system – somewhere
 - _ Duplication of documentation due to inability to integrate external patient data into workflow of clinician.



ONC's Interoperability Roadmap



<https://www.healthit.gov/sites/default/files/hie-interoperability/nationwide-interoperability-roadmap-final-version-1.0.pdf>



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Self Imposed

- **Organizational culture's influence on what should be documented can exceed what is needed for patient care, including:**
 - _ “We’ve always done it this way” mentality
 - _ Misinterpretation of regulatory standards
 - _ Over zealous risk managers
 - _ Outdated organizational policies

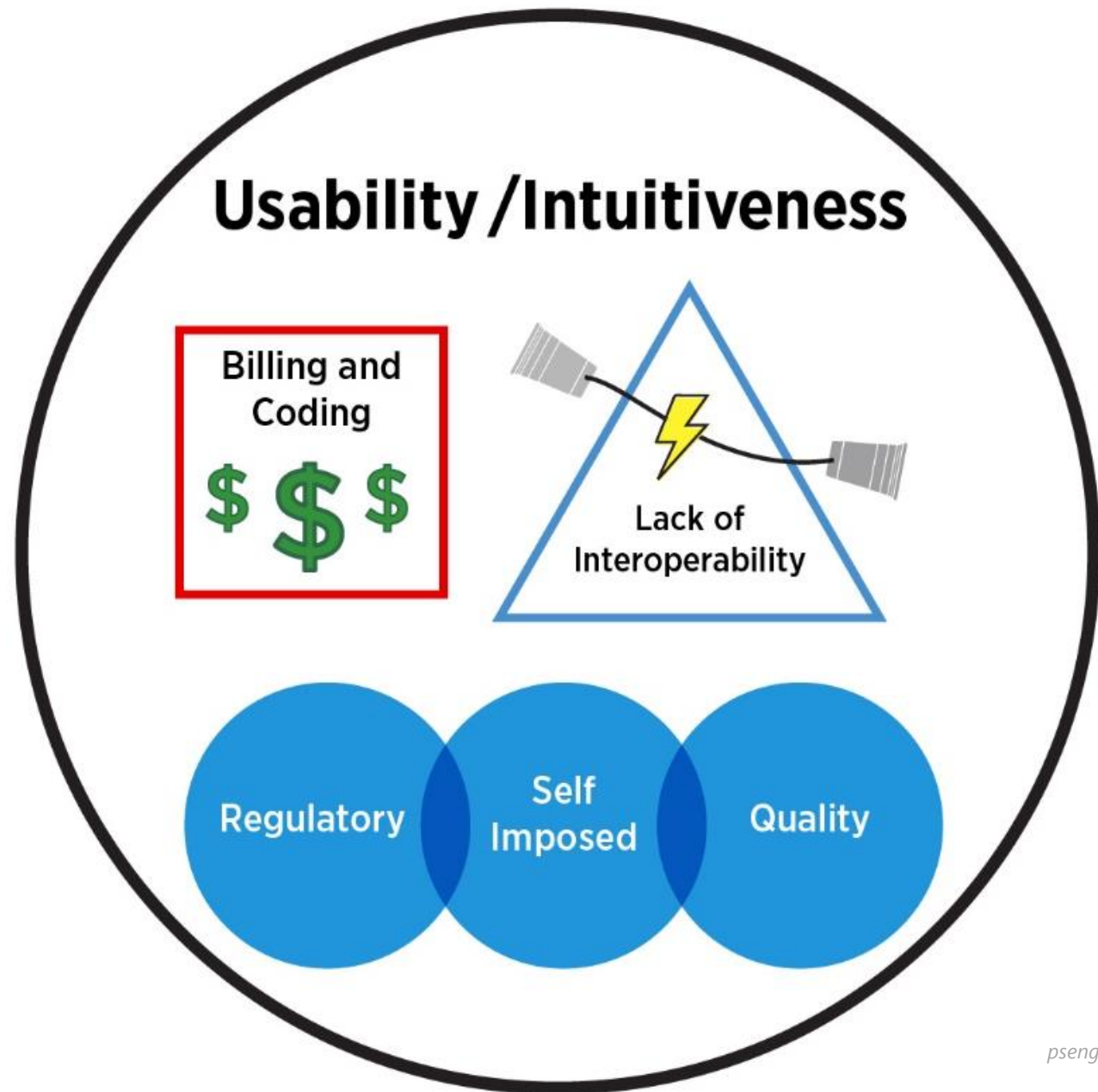


Self Imposed - Examples

- ▶ **“Squeaky wheel” or powerful special interest groups want added documentation by clinicians to meet their needs.**
- ▶ **Excessive documentation on admission to the hospital or an initial visit to a clinic**
- ▶ **End users oftentimes are not aware that the functionality to improve effectiveness is available. It was not taught during initial system use training.**
- ▶ **Extra “CYA” charting (fear of litigation)**
- ▶ **The nature of nursing and the desire to capture more than necessary to provide and communicate the essentials of care**



Domain Relationships



psengstack©

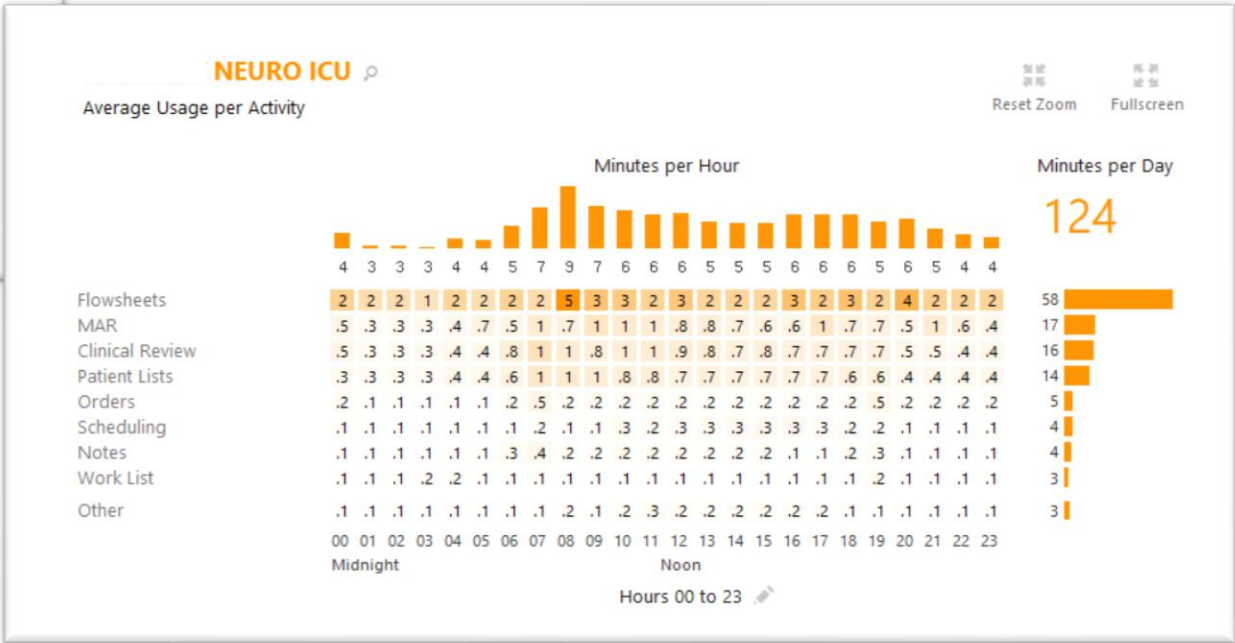
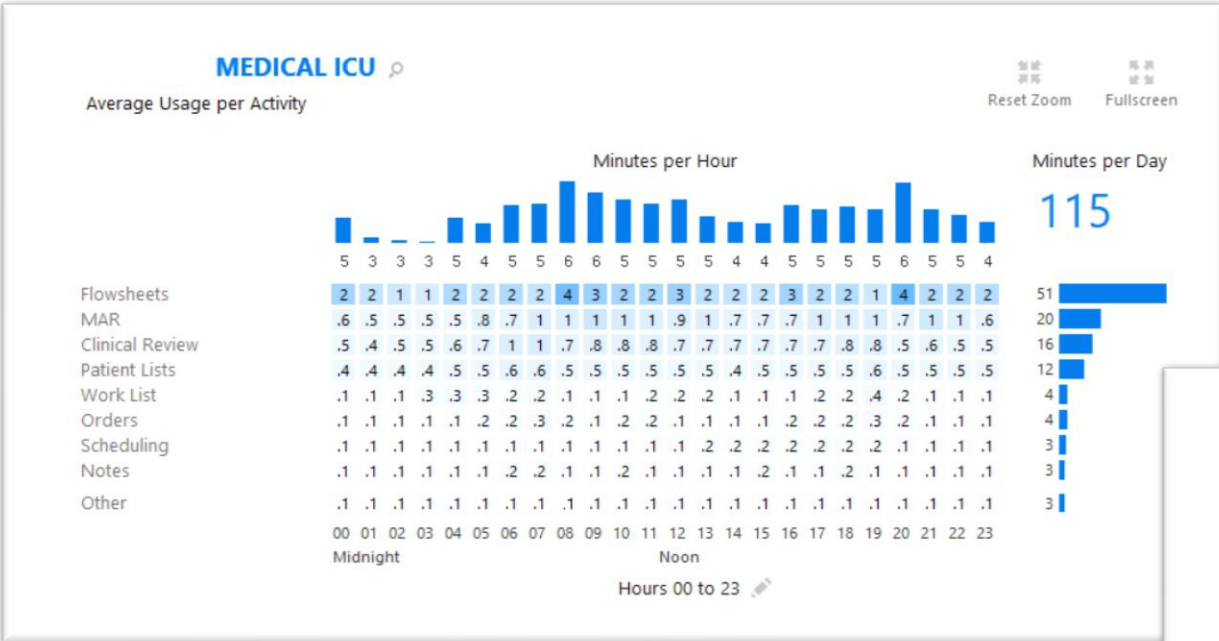


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How can we use data to reduce documentation time for nurses?



Vendor supplied data



Clinician active time spent in Hyperspace is collected and summarized through our [Nursing Efficiency and Assessment Tool](#). It can be shared with you, via your [Epic ID](#), Inpatient TS, on a quarterly cadence.

166 Average Minutes in Hyperspace

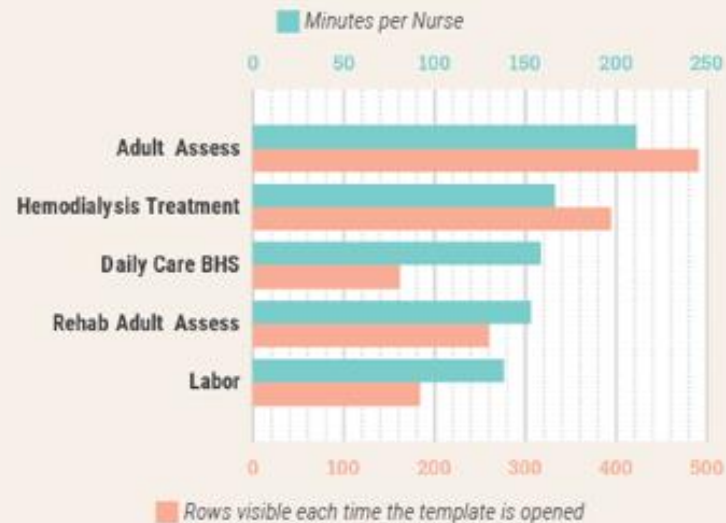
Top Quartile:
152 minutes



54 Average Minutes in Flowsheets

Top Quartile:
56 minutes

Most Used Flowsheet Templates



Departments with Most System Time

Average Minutes

SMC 2 TELEMTRY	259
SCHC 4N CARDIAC	240
BJH ACUTE CARE	234
SMC BEHV SENIOR CARE	230
GSAM 3100 ORTHO	228
SAH 10 MEDICALTEACHING	228

FEATURES FOR IMPROVING NURSING PRODUCTIVITY

		Epic community adoption rate	Efficiency	Safety
OFF	Ventilator Device Integration	(202/322)	63%	
ON	Hemo-dynamic Device Integration	(297/322)	92%	
ON	Point of Care Device Integration	(296/322)	92%	
ON	Flowsheet Copy Forward	(294/322)	91%	
ON	Rover Push Notifications	(170/322)	53%	
Epic 2018	Nursing Assignment	(0/14)	0%	
Epic 2018	The Brain	(13/14)	93%	

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FEATURE ARTICLE

Changes in Efficiency and Quality of Nursing Electronic Health Record Documentation After Implementation of an Admission Patient History Essential Data Set

Eva L. Karp, DHA, MBA, RN-C, FACHE, SVP, Rebecca Freeman, PhD, RN, Kit N. Simpson, DrPH, Annie N. Simpson, PhD

“Clinical informatics professionals should consider the use of EHR event files and timers to gain insight into process and workflow changes. The use of system data can substantiate the transformational value of informatics practice and inform future optimization efforts”

Karp, E., Freeman, R., Simpson, K. & Simpson, A. (2019) Changes in efficiency and quality of nursing electronic health record documentation after implementation of an admission patient history essential data set. CIN: Computers, Informatics, Nursing. 37(5):260–265, MAY 2019



Evaluate What's Currently in the System

ADMISSION ASSESSMENT	Required regulatory field: Yes/No	If yes, list agency	"RN" required: Yes/No	Ask EVERY patient?	Required in first 12 hours?	Needed for discharge planning?	Displayed in patient header?
Would you like information (required if answer to 33 is "no")	N		Y	Y	N	N	N
Pamphlet given to patient (required if answer to 34 is "no")	N		N	N	N	N	N
If advance directive: Has your AD info changed since we last saw you (required if answer to 33 is "yes")	N		N	Y	Y	Y	N
Type of advance directive (required if answer to 34 is "yes")	Y		Y	Y	Y	Y	N
Medical durable power of attorney name and phone number (required if answer to 34 is "yes" - free text)	N		N	Y	Y	N	N
Where is your advance directive	Y		Y	N	N	N	N
Reason copy cannot be obtained (free text)	N		N	N	N	Y	Y
Health History							
Admitted with IV	N		N	N	N	Y	Y
Date and time of insertion (required if answer to 42 is "yes")	Y		Y	N	N	N	Y
RN reviewed health history via:	Y		Y	Y	Y	Y	Y

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DNP Student Use of Data Collection Tool for Admission Assessment Review

	A	B	C	D	E	F	G	H	I	J	K	L	N	C	P	Q
	ADMISSION ASSESSMENT QUESTION	Required regulatory field: Yes/No	If yes, list agency	"RN" required: Yes/No	Ask EVERY patient?	Required in first 12 hours?	Needed for discharge planning	Displayed in patient header	Required for CDS: Yes/No	Communicate with Care Provider: Yes/No	Reported from this element?	Documented elsewhere: Yes/No	Total		MIN number of clicks?	MAX number of clicks?
2																
3	Weight	9	Agency Name	5	1	9	9	1	9	5	5	9	N/A		Count	Count
4	General Admission Information															
5	Information Obtained From	N		N	Y	Y	N	N	N	N	N	N	19		1	2
6	Admitted From	Y	TJC	N	Y	Y	Y	N	N	N	N	Y	28		1	1
7	Reason for Admission (free text)	N		N	Y	Y	N	N	N	N	N	Y	10		1	1
8	Medications															
9	Medications Brought From Home	N		N	Y	Y	N	N	N	N	N	Y	10		0	1
10	Medication Disposition, if yes	N		N	Y	Y	N	N	N	N	N	Y	10		0	1
11	Source of Home Meds Information	N		N	N	Y	N	N	N	N	N	N	18		0	2
12	Medication List Reviewed and Updated	N		N	Y	Y	Y	N	N	Y	N	N	33		1	1
13	Vaccines															
14	Immunization Schedule Status	N		N	Y	Y	N	N	N	Y	N	Y	15		1	1
15	Have you had a flu vaccine this flu season (FLU SEASON ONLY)	Y	CMS	N	Y	Y	N	N	Y	N	Y	N	42		1	1
16	Qualifies for flu vaccine (required if answer to 15 is "no")	Y	CMS	N	Y	Y	N	N	Y	N	Y	N	42		0	1
17	Have you EVER had a pneumonia vaccine	N		N	Y	Y	N	N	Y	Y	N	Y	24		1	1
18	Qualifies for pneumonia vaccine (required if answer to 17 is "no")	N		N	Y	Y	N	N	Y	Y	N	N	33		0	1
19	Pregnancy Status (females only)															
20	Pregnant	N		N	Y	Y	N	N	N	Y	N	Y	15		0	1
21	LMP	N		N	Y	Y	N	N	N	Y	N	Y	15		0	2
22	EDC	N		N	Y	Y	N	N	N	Y	N	Y	15		0	2
23	Breastfeeding	N		N	Y	Y	N	N	N	Y	N	Y	15		0	1
24	Privacy Information															
25	May we share information about you with persons who ask about you by name	N		N	Y	Y	N	N	N	N	N	N	19		1	1
26	Who would you like to delegate (free text name)	N		N	Y	Y	N	N	N	N	N	N	19		1	1
27	Exception person for information (name, relationship, phone)	N		N	N	N	N	N	N	N	N	Y	0		1	3
28	Allergies (may require reconciliation)															
29	Allergies reviewed and updated	Y	ALL	N	Y	Y	N	Y	Y	Y	N	Y	34		1	1
30	Allergy to latex	N		N	Y	Y	N	N	N	N	N	Y	10		1	1
31	Allergy to xray contrast	N		N	Y	Y	N	N	N	N	N	Y	10		1	1
32	Advance Directives															
33	Do you have an advance directive	Y	CMS/TJC	N	Y	Y	N	N	Y	Y	N	Y	33		1	2
34	Would you like information (required if answer to 33 is "no")	N		N	N	N	N	N	N	N	N	N	9		0	2
35	Pamphlet given to patient (required if answer to 33 is "no")	Y	CMS/TJC	N	Y	Y	N	N	N	N	N	N	28		0	2

DNP Student Use of Data Collection Tool for Admission Assessment Review – Weighting Assignments

Criteria	Required regulatory field?	RN required?	Ask every patient ?	Required within 12 hours?	Needed for discharge planning?	Displayed in patient header?	Required for Clinical Decision Support?	Communi- cate with provider?	Reports developed from this data element?	Documented elsewhere?
Weight	Yes = 9 No = 0	Yes = 5 No = 0	Yes = 1 No = 0	Yes = 9 No = 0	Yes = 9 No = 0	Yes = 1 No = 0	Yes = 9 No = 0	Yes = 5 No = 0	Yes = 5 No = 0	Yes = 0 No = 9
	“Yes” if a regulation can be identified and verified as requiring documentation	“Yes” if an RN should complete this field	“Yes” if every patient needs to be asked	“Yes” if this element must be collected within 12 hours following admission	“Yes” if this element supports the discharge planning process	“Yes” if the response displays in the patient header	“Yes” if the response triggers an alert or other clinical decision support	“Yes” if element is needed to inform clinical decision making by care team	“Yes” if response to element is required in a report	“Yes” if the element is documented somewhere else in the record. *Note – score of “0” for Yes.

Analysis of the Nursing Admission Assessment Data Elements

Is it imperative or required to document the data element – 10 Questions

- ▶ Is it required by a regulatory agency? (TJC, CMS, MU, Core Measure – that requires documentation)
- ▶ Is an RN required to document?
- ▶ Is it something that EVERY patient must be asked?
- ▶ Is it required in the first 8 - 12 hours of admission?
- ▶ Is it needed for discharge planning?



Analyze the Nursing Admission Assessment Data Elements

- ▶ Is it pulled into the patient header?
- ▶ Does it trigger an alert?
- ▶ Communication of patient information to the care team?
- ▶ Is it needed for a report?
- ▶ Is it documented elsewhere in the chart?



Marguerite Swietlik, DNP, NEA-BC, RN-BC, CPHIMS
VP, Chief Nursing Informatics Officer
Inova Health System
marguerite.swietlik@inova.org

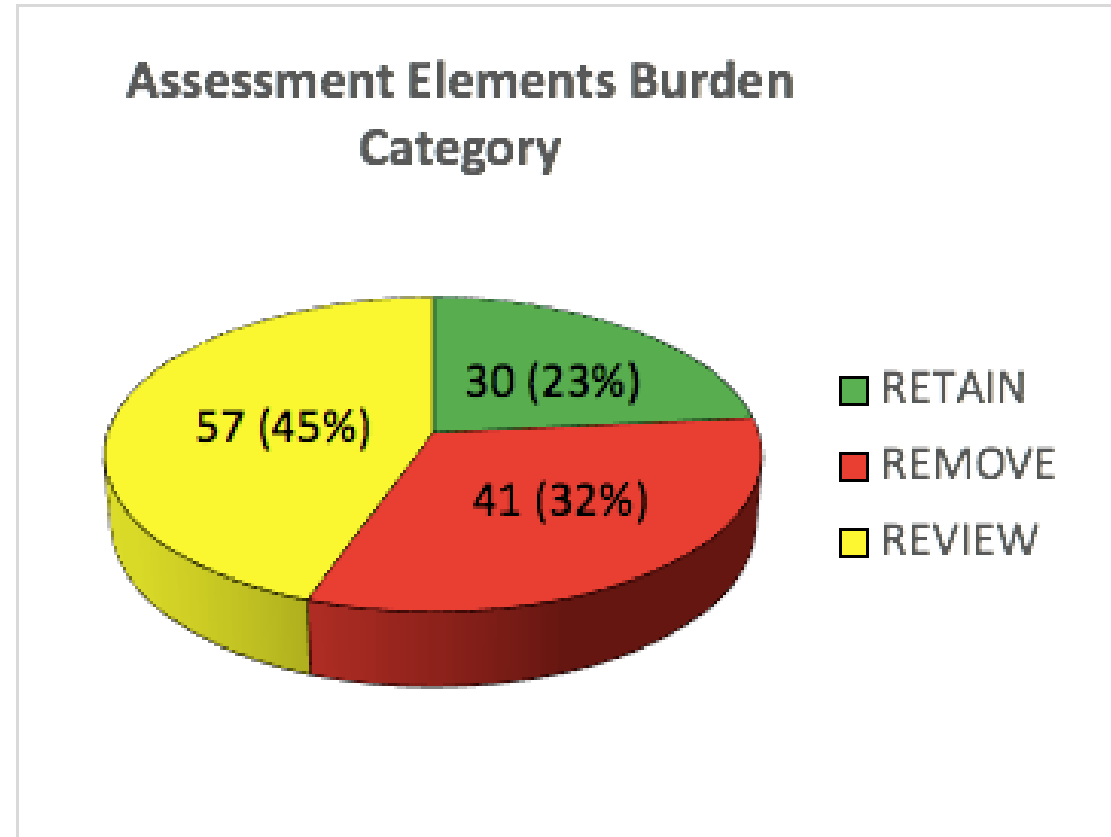


DNP Student - Overall Results

Retain if Scores: 25 – 62

Review if Scores: 15 – 24

Remove if Scores: 0 - 14



RESULT	CRITERIA	COUNT	PERCENT
RETAIN	Count if score = 25 - 62	30	24%
REMOVE	Count if score = 0 - 14	41	32%
REVIEW	Count if score = 15 - 24	57	45%
Total:		127	

Use Data to Make Informed Decisions

► Ask for vendor provided data

- _ Nursing time in chart
 - _ Time spent in various areas of the chart
 - _ With ability to compare across nurses/departments
- _ Flowsheet row data
 - _ Are there any flowsheets we do not use?
 - _ Are there any flowsheet row elements that have not been used?



Use Data to Make Informed Decisions

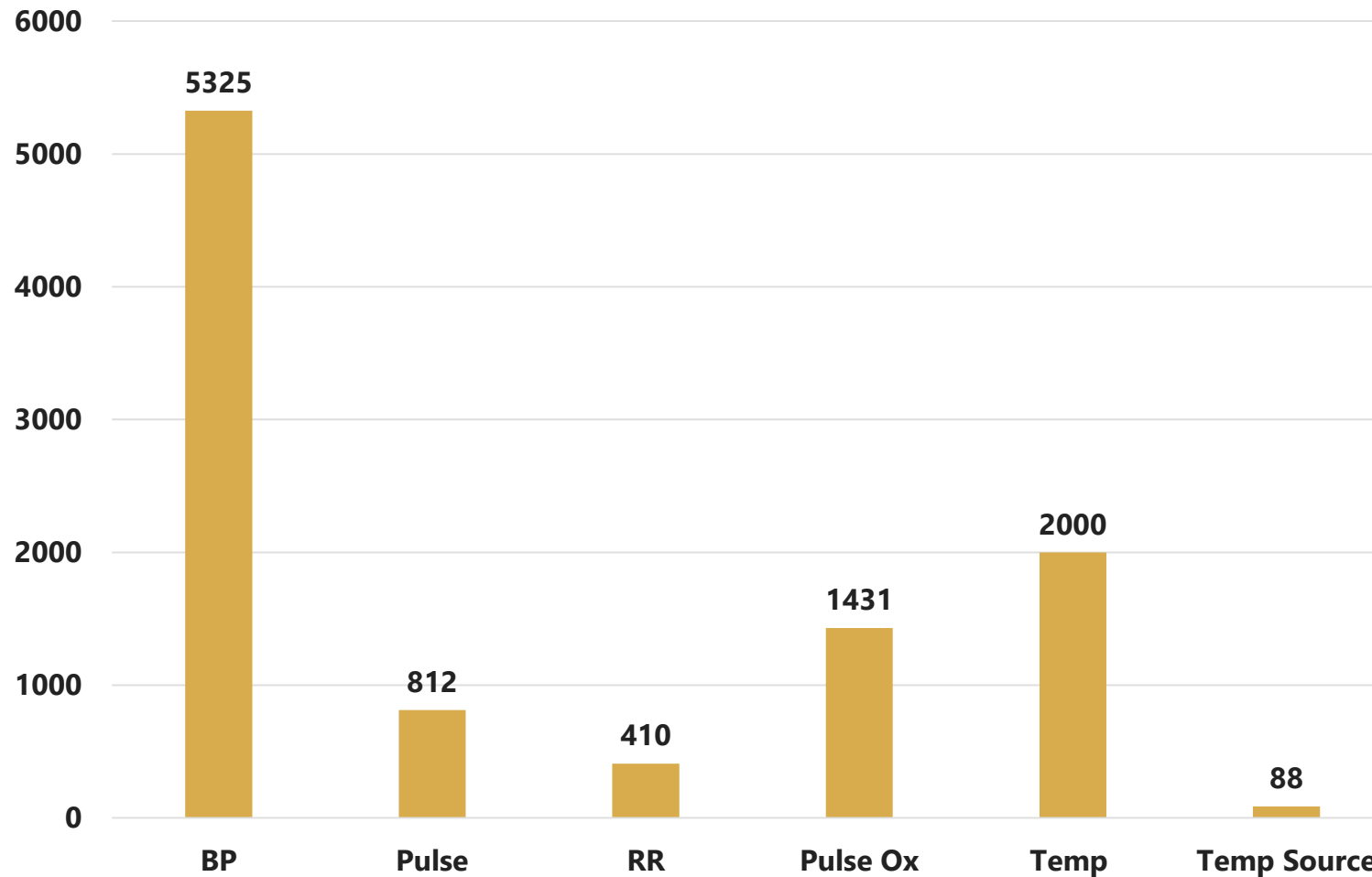
► Flowsheet Usage by Department

► Flowsheet Row Comments

– Example: Blood Pressure Comments



Number of Comments Added to Documentation of Vital Signs 2/20/18 - 3/20/18



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 headache. 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



Call to Action

- ▶ **Stay informed of changes by federal and regulatory agencies. If we don't know - we can't capitalize on their efforts to streamline and reduce the documentation burden**
 - _ TJC efforts – Project REFRESH
 - _ CMS – Patients over Paperwork
 - _ University of Minnesota's - Nursing Knowledge: Big Data Science Initiative
- ▶ **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 your vendor to continue to improve usability and increase efficiencies**
- ▶ **Continue to standardize where possible**
- ▶ **Innovate – Mobile technologies, Voice recognition, Device integration**
- ▶ **Publish!**
- ▶ **Develop guiding principles for improving/enhancing clinical documentation. Such as.....**



Ideas for Guiding Principles

▶ No new documentation

▶ Unless:

- _ Mandated
- _ Based on data/evidence
- _ Identified how the data entered into the new fields will be used and what actions will be taken (and by whom) based on what is entered
- _ The requesting or responsible party for the addition reports out on the outcomes achieved by adding the documentation - at specified time intervals (ie – 3 months, 6 months, 9 months, etc)
- _ The addition is vetted and approved via a governance process
- _ If adding something – need to remove something



patricia.r.sengstack@vanderbilt.edu

