EASING THE DOCUMENTATION BURDEN FOR NURSES: A "COLLABORATIVE" APPROACH

Lisa Gulker, DNP RN ACNP-BC

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CONFLICT OF INTEREST DISCLOSURE

Lisa Gulker is an associate (employee) of Cerner Corporation.

This educational offering is not promotional.

No contact hours will be offered for this presentation.

ECD

Essential Clinical Dataset **Collaborative**

Understanding Essential Documentation within the EHR

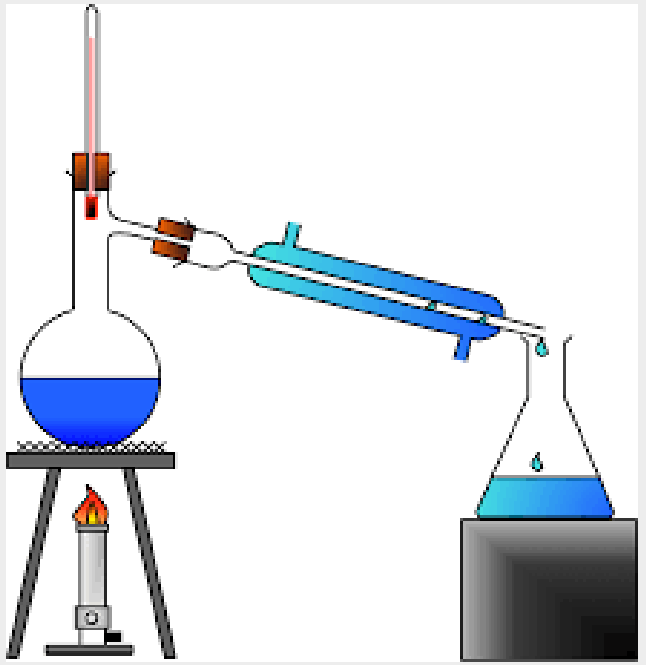
Acknowledgement to Darinda Sutton and the members of the ECD Collaborative!

Darinda Sutton MSN, RN-BC, FACHE
Cerner Vice President and CNO U.S. Premier Focus
ECD Collaborative Program Chair

Cerner

DOCUMENTATION BURDEN

- Documentation burden is that part of clinical documentation which is clerical in nature:
  - No value added to clinical care or outcomes
  - Unrelated to fundamental purpose connecting clinicians to their work
- Clinical systems increasingly function to support administrative requirements
  - Regulatory and quality reporting
  - Billing



Q: “Why did you become a nurse?

A: “I felt a calling to spend almost 50% of my time checking boxes, cutting and pasting, copying forward, and clicking past dozens of alerts - all in support of safeguarding taxpayer dollars and digitizing healthcare processes.”

“ I listened to the patient closely…and taking into account her preferences, health status, risk factors, important physical assessment findings, and test results, the following interventions were added to her plan of care”…..SAID NO EHR EVER.

WHY – ECD Collaborative Overview

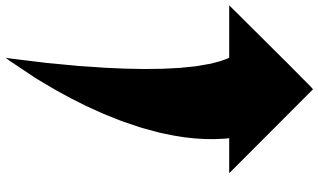
- Most organizations have over-designed their EHRs resulting in a lot of “noise” and non-value added data elements

- There is not an established standard for the essential clinical data requirements for nursing documentation in an EHR

- **Anticipated Outcomes:**
  - ECD will establish a national (international) standard, leverageable across all EHR vendor platforms (EHR agnostic)
  - Organizations will use the ECD as the foundation for EHR optimization
  - ECD will become Cerner Model Experience content

8 Processes & Workflows → 6 Work Teams
Initial Scope: Adult Acute Care

1. Admission History and Intake
2. Physical Assessment – Initial and Ongoing
3. Ongoing Care: Interventions, Observations and Responses
4. Medication Process, Reconciliation and Administration
5. Discharge Process
6. Transitions of Care
7. Plan of Care
8. Patient Education and Teaching



1. Admission History and Intake
2. Physical Assessment
3. Ongoing Care & Medication
4. Discharge Process & Transitions of Care
5. Plan of Care
6. Patient Education and Teaching

ECD Collaborative Approach

- **Structure & Methodology** – 3 pronged approach to review documentation elements of interest

1**) Evidence Based Practice**

Review of literature for content, *not process or workflow*

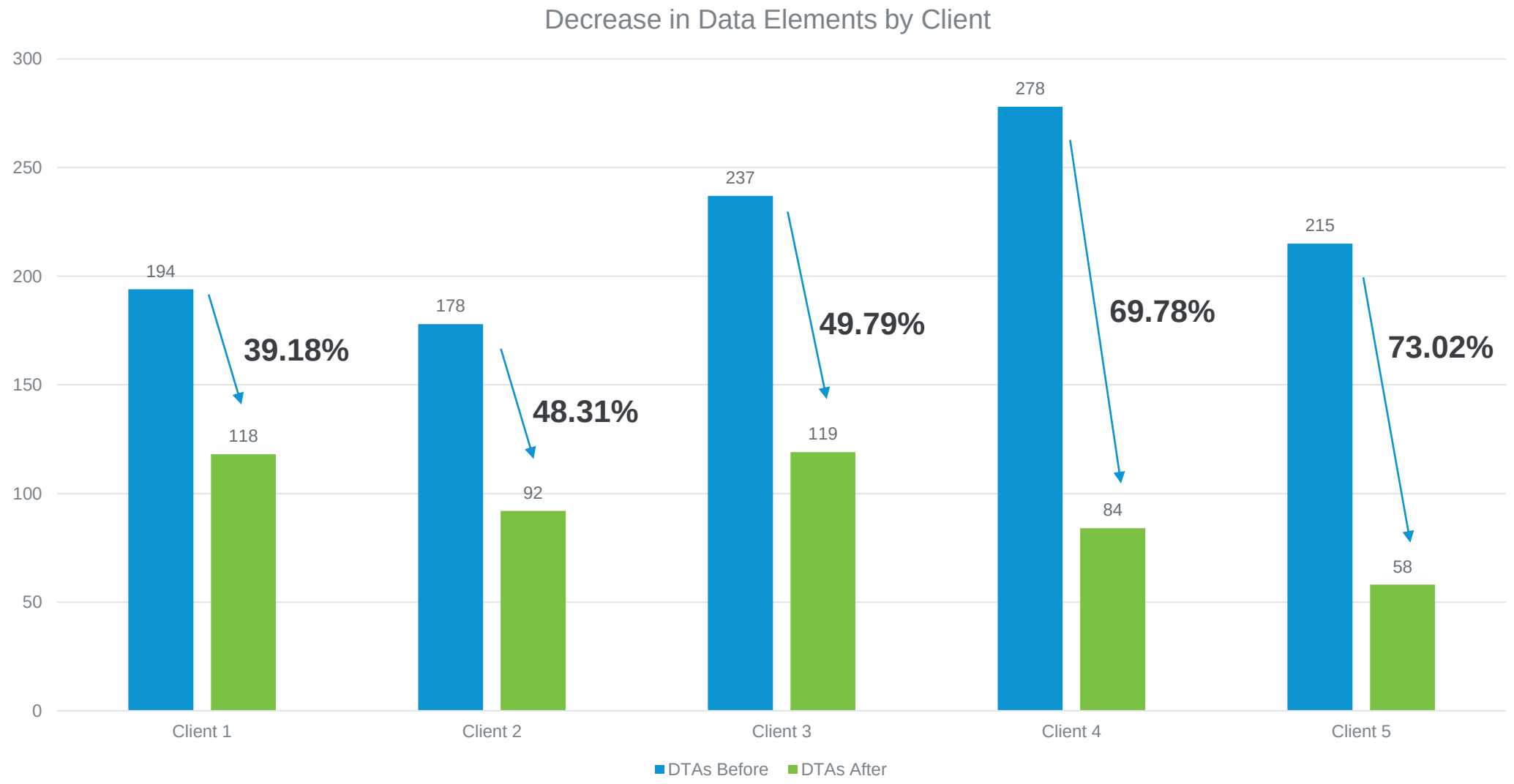
2) **Regulatory**: CMS, TJC, DNV, MU 1-3

United States, Federal, Regulatory, *not state or global*

3) **Practice Based Evidence**

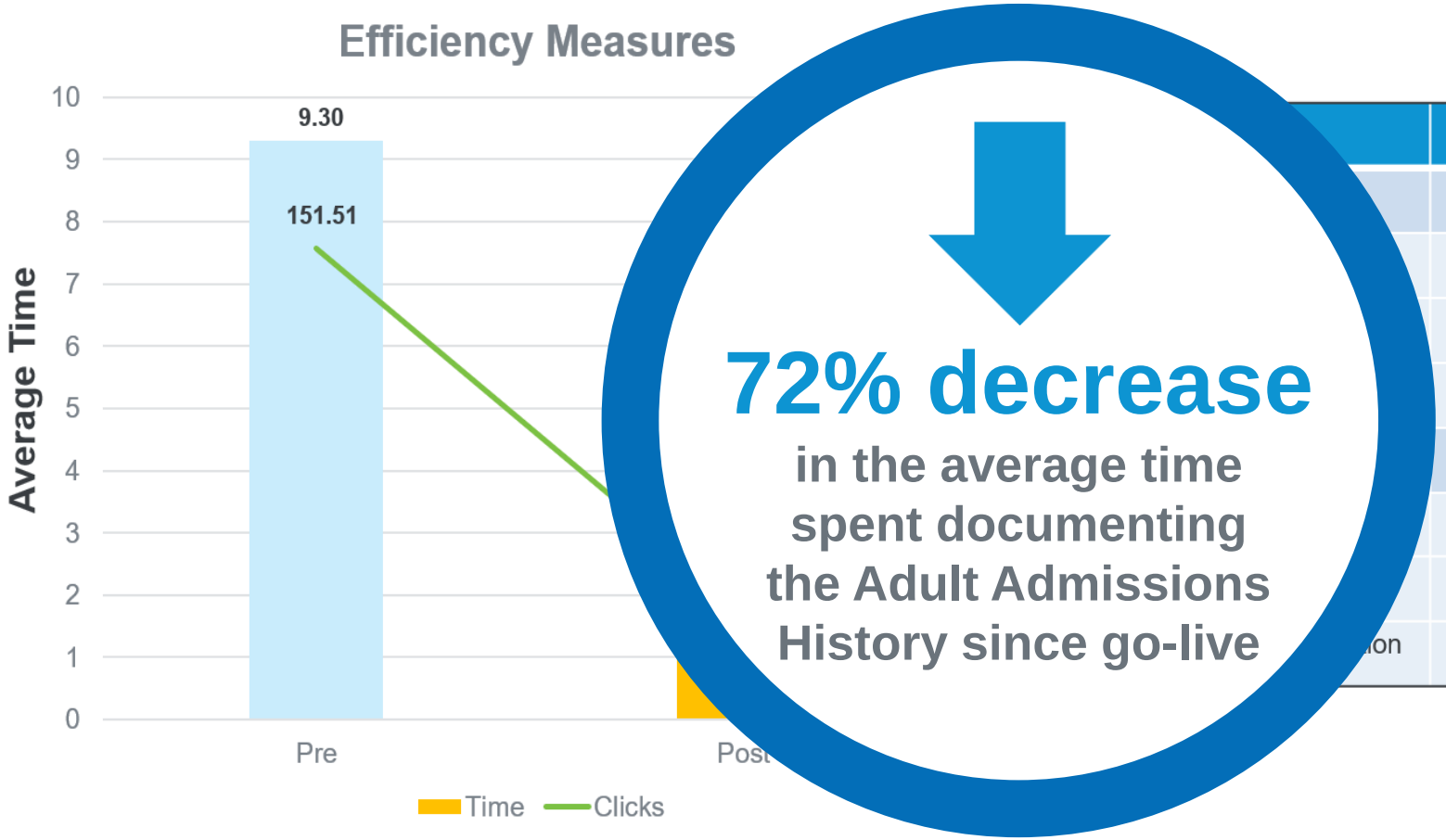
Conduct environmental scans of clients' production data for frequency of data element and utilization metrics

Data Reduction: Baseline vs. Post ECD



Efficiency measures – Time and clicks

(one ECD Collaborative Health system)



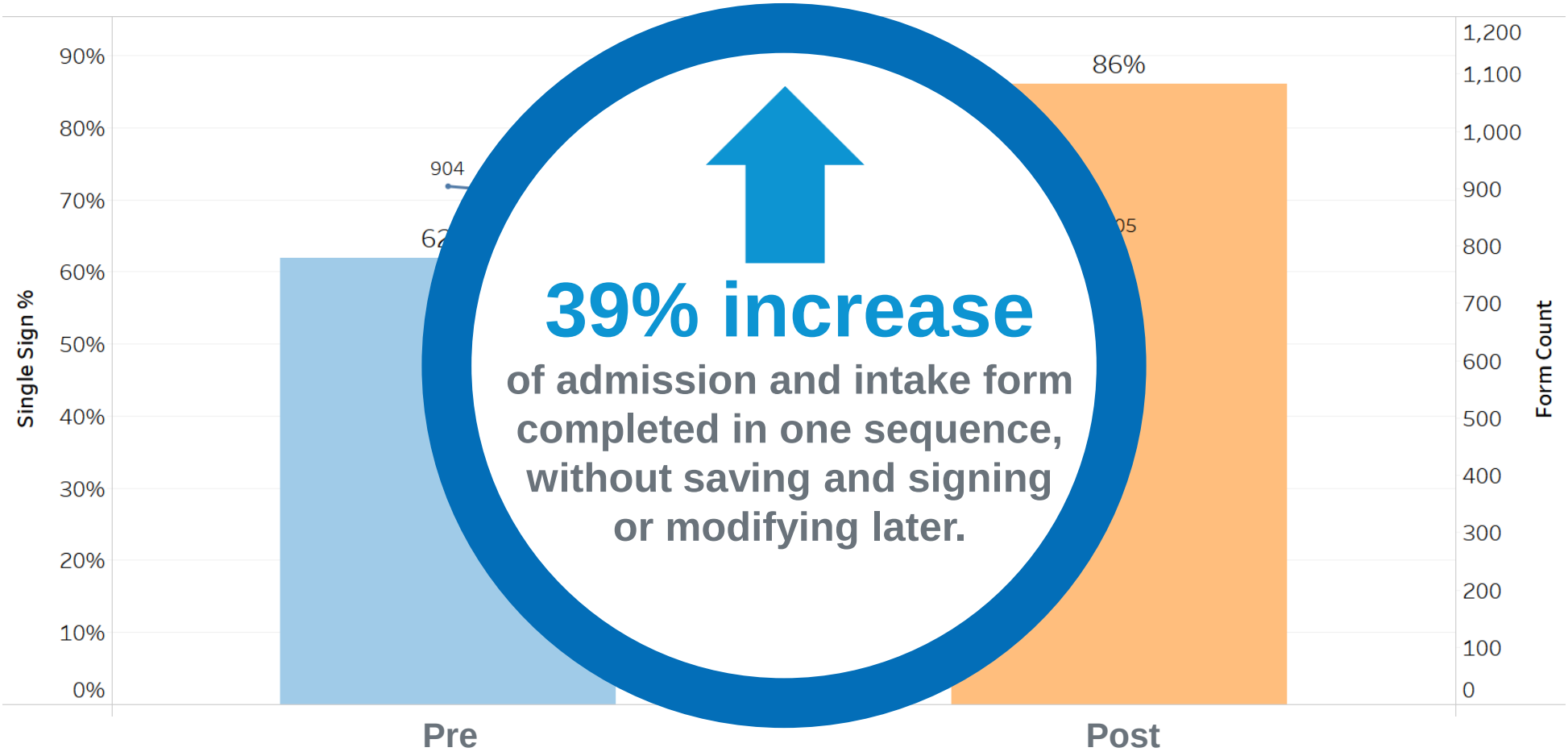
72% decrease

in the average time spent documenting the Adult Admissions History since go-live

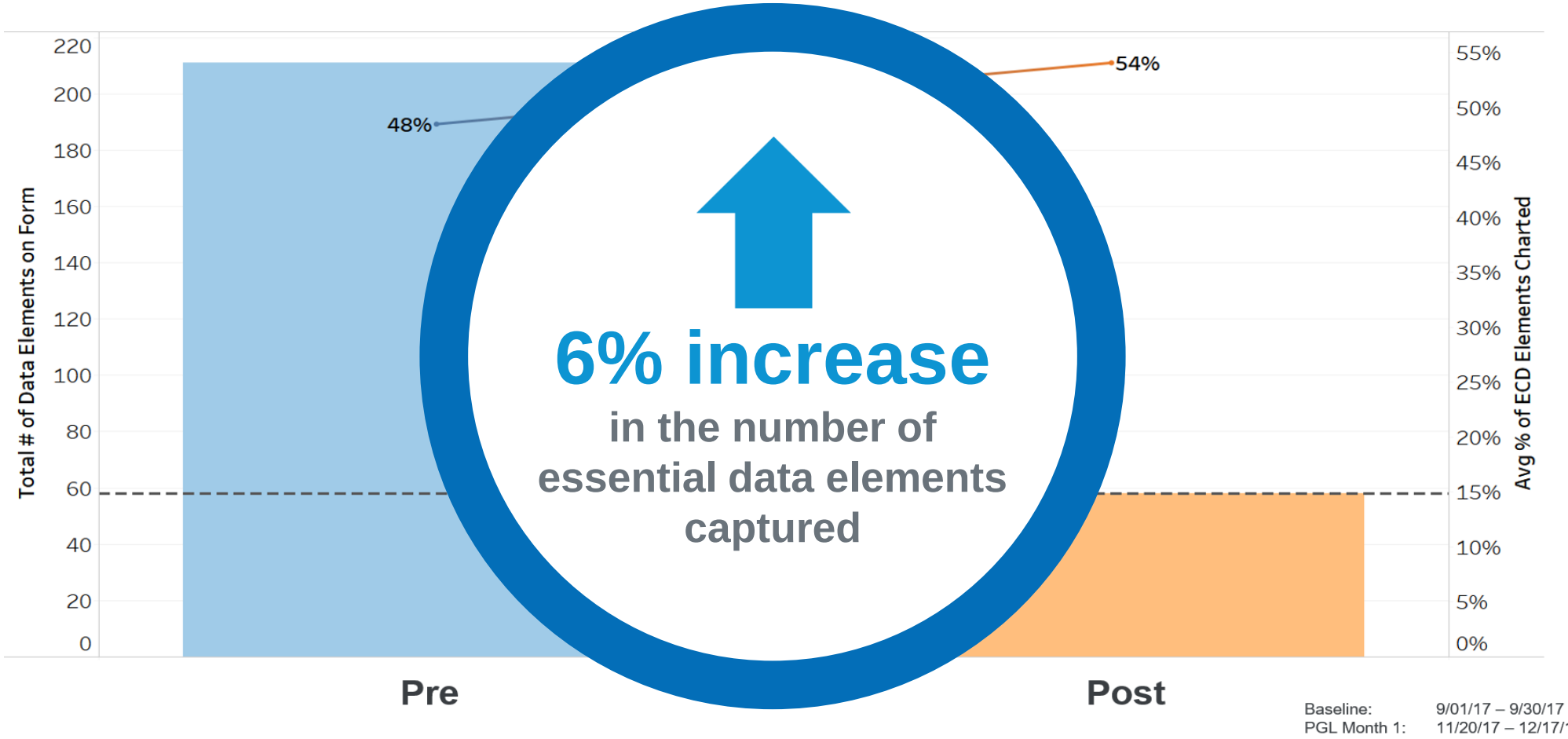
	Pre	Post
	N = 536	N = 640
	09:30	02:55
	8.33	2.21
	4.66	1.65
	N = 536	N = 640
	151.51	35.93
	147.00	33.00
ion	37.25	15.01

Pre: 9/01/17 – 9/30/17
Post: 11/20/17 – 12/17/17

Efficiency – Increased percent of completion in one process



Percentage of essential data elements captured



CURRENT EXPANSION OF ECD COLLABORATIVES

Adult Acute Care, Physical Assessment - USA

Pediatrics

Behavioral Health

Adult Acute Care – Canada

Adult 23 Hour Observation – USA

Adult Rehab - USA

Ommaya, A.K., Cipriano, P. F.,…Sinsky, C.A. (2018) Care-Centered Clinical Documentation in the Digital Environment: Solutions to Alleviate Burnout. *Perspectives, Expert Voices in Health & Health Care*. National Academy of Medicine. https://nam.edu/wp-content/uploads/2018/01/Care-Centered-Clinical-Documentation.pdf

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.

IMPLICATIONS

- Informatics leaders have the knowledge base, skill set, and organizational relationships necessary to address documentation burden
- Clinician well-being, fulfillment, and joy in work are important outcomes related to informatics work
- Technology use expansion in the areas of telehealth, IoT, genetics, CRM, machine learning, AI, etc. will amplify the need for providers and HIT suppliers to **collaborate** around clinical system redesign

THANK YOU!

Time for Questions,
Comments, & Discussion

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QUESTIONS

Lisa Gulker, DNP RN ACNP-BC

lisa.gulker@gmail.com

@LisaGulker