



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

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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 = ?

Navigators

 **Admission**  Tra

OVERVIEW

- Outside Records
- Consents
- Travel/Exposure
- Vital Signs
- Interpreter Services
- History
- Allergies
- Verify Rx Benefits
- Home Meds
- Med Rec Status
- Immunizations
- Flu Screening
- Vaccination
- Directives/Legal D...
- Health Care Agents
- LDAs
- Implants
- Belongings

ASSESSMENTS

- Nutrition
- Functional Screen...
- Psychosocial
- Religious/Cultural...
- Fall Risk
- Skin Risk
- Patient Goal
- Discharge Planning
- Education

INTERVENTIONS

- BestPractice

 **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

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: _____
 Valsalvas: None Went home with _____
Reason for Admission (PI's own words): _____

Vital Signs									
T	P	R	SpO ₂	BP	HR	RR	W	H	Temp

Allergies					
Allergens	Reactions	Allergens	Reactions	Allergens	Reactions

Chronic conditions:
 Lung Problems Stomach Problems Thyroid Problems Neurological Problems
 Heart Problems Liver Problems Vision Problems Kidney Problems
 Anemia Diabetes Chronic Infection Treatment: _____
 Cancer (where type) _____
 Other Past Medical History or Surgeries: _____
 Family history - NSF Heart disease Hypertension Diabetes Stroke Seizures Kidney disease Liver disease

Medications			
Medication (include OTC)	Dose	Frequency	Taken in Year

History
 Starts at home Yes No Sleep partner
 Lock-up Last Tetanus boost?
 Yes No Do you live in a smoking environment?
 Last Drink? _____
 Frequency? _____
 Fall made to _____

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 initiated the establishment of a 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/STP
 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: _____

Name: _____
 DOB: _____
 Admit Date: _____
 Code Status: _____
 Admitting Diagnosis: _____
 Allergies: _____
 Isolation: _____ for _____

Medical History: _____

 Surgical History: _____

Neuro: _____
 CV: _____
 Strip: _____
 Strip: _____
 Strip: _____
 Pulses: RD BR - DP PT

Pain: _____

 Pre-Assessment:

T	P	R	BP	O2

Pulm: _____
 GI: _____
 Bowel Sounds Y N
 Last BM: _____
 GU: _____
 SLF URN BDP ASST FLY

NA	WBC
K	HGB
CL	HCT
BUN	PLT
CREAT	PT
CA	INR
MG	APTT

Notes: _____
 To Do: _____

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

Surgery Type: _____
 Surgery Date: _____

Tubes/Drains: _____

 Incisions/Wounds: _____

Last PRN Pain Med @ _____
 Night Shift Information:

PCA: _____
 _____ mg
 _____ mg/4hr
 _____ lockout (min)

Activity: _____ PT OT
 Diet: _____
 Tube Feed: _____ Rate: _____
 Contact: _____

Diagnostics: _____

 Fluids: _____

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

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 home care admission:
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 NPI#: _____ Phone Number: _____

PART 1 - To Physician (For Signature) PART 2 - Clinical Record (Temporary Copy)
 PRINT NAME, LAST, FIRST, MIDDLE INITIAL



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

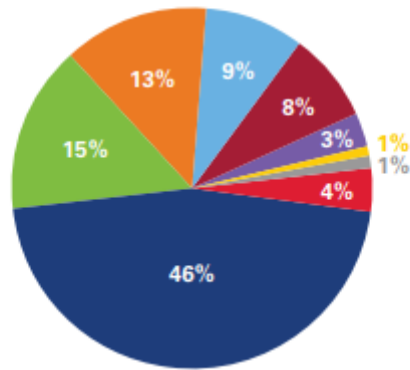
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- Block L, Habicht R, Wu AW, et al. In the wake of the 2003 and 2011 duty hours regulations, how do internal medicine interns spend their time? *J Gen Intern Med*. 2013;28(8):1042–1047.
- Kelley TF, Brandon DH, Docherty SL. Electronic nursing documentation 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.

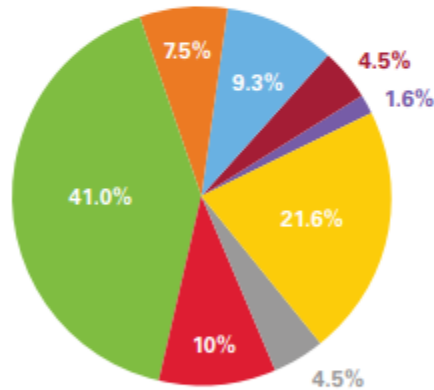
Patients are affected by excessive regulatory burden through:

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



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

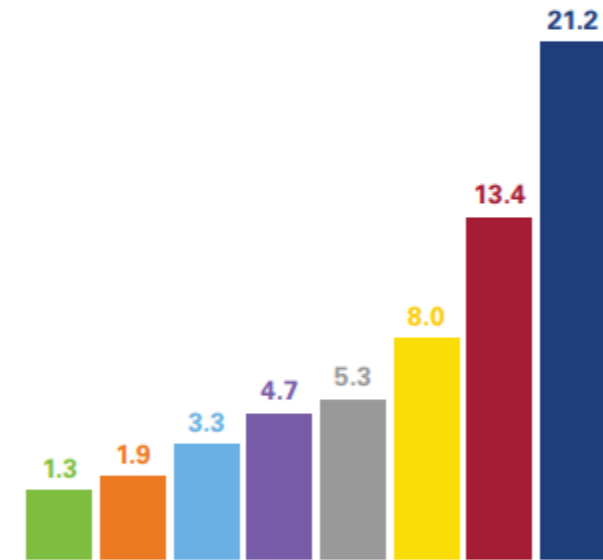
- \$1.6M - Billing & Coverage
- \$570K - Privacy & Security
- \$340K - Program Integrity
- \$710K - Quality Reporting
- \$760K - Health IT/ Meaningful Use
- \$340K - Fraud & Abuse
- \$3.1M - Hospital COPs
- \$120K - New Models of Care



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.

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	<ul style="list-style-type: none"> 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




The Office of the National Coordinator for
Health Information Technology

ONC/CMS Reducing Clinician Burden Public Meeting

Thursday, February 22, 2018

10:00 am – 4:30 pm ET

Hubert H. Humphrey Building Auditorium



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



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>



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.

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

“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



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



ANA and ONC: Care Planning and Documentation Burden/Standardization



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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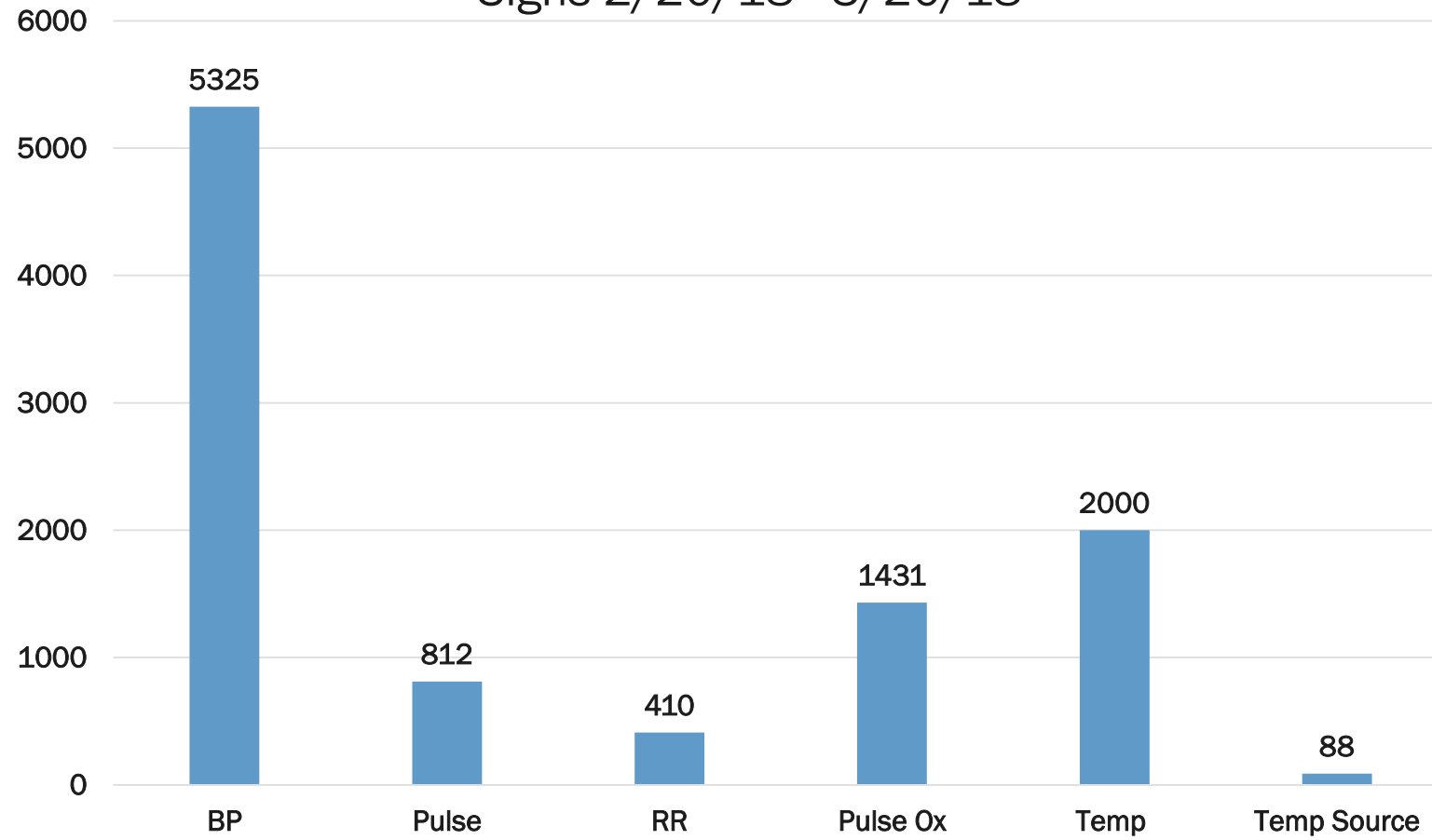
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Use Data to Make Informed Decisions

- ▶ 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





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

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.

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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In summary, what should we do?

- ▶ 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
- ▶ 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 standardize where possible
- ▶ Innovate – voice recognition software, mobile technologies
- ▶ Develop guiding principles for improving/enhancing clinical documentation.



Thank You!

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