



**If You Think Over Half of Your EMR
Clinical Documentation Is
Unnecessary, You're Right. Want to Do
Something About It?**

Becker's 8th Annual Meeting

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President & CEO
The Greeley Company*

Today's Agenda

- Who is The Greeley Company?
- Lessons learned from SIA, Termination, & IJ Services
- Unintended consequences of over documentation
- Feedback and discussion

Who is The Greeley Company?

- Greeley is a healthcare solutions company that provides innovative consulting and professional services to healthcare organizations nationwide
- More than 25 years of thought leadership
- Served over 700 hospitals and health systems in all 50 states within the past three years
- Span all markets from large systems and academic medical centers to critical access hospitals

Services



* Medical Staff Services Department

Areas of Focus

Greeley serves clients in three critical areas



Medical Staff Optimization & Physician Alignment

- Physician-hospital collaboration
- Peer review & medical staff quality
- Bylaws and governance
- Clinical integration
- Optimization of service lines and centers of excellence
- Conflict resolution and trust-building

Accreditation, Regulatory Compliance & Quality

- CMS and accreditation assessment, crisis response, and remediation
- Post-survey assistance
- CMS Systems Improvement Agreement (SIA) services
- Documentation & clinical process simplification
- Quality & patient safety services
- Environment of care/life safety

Credentialing & Privileging

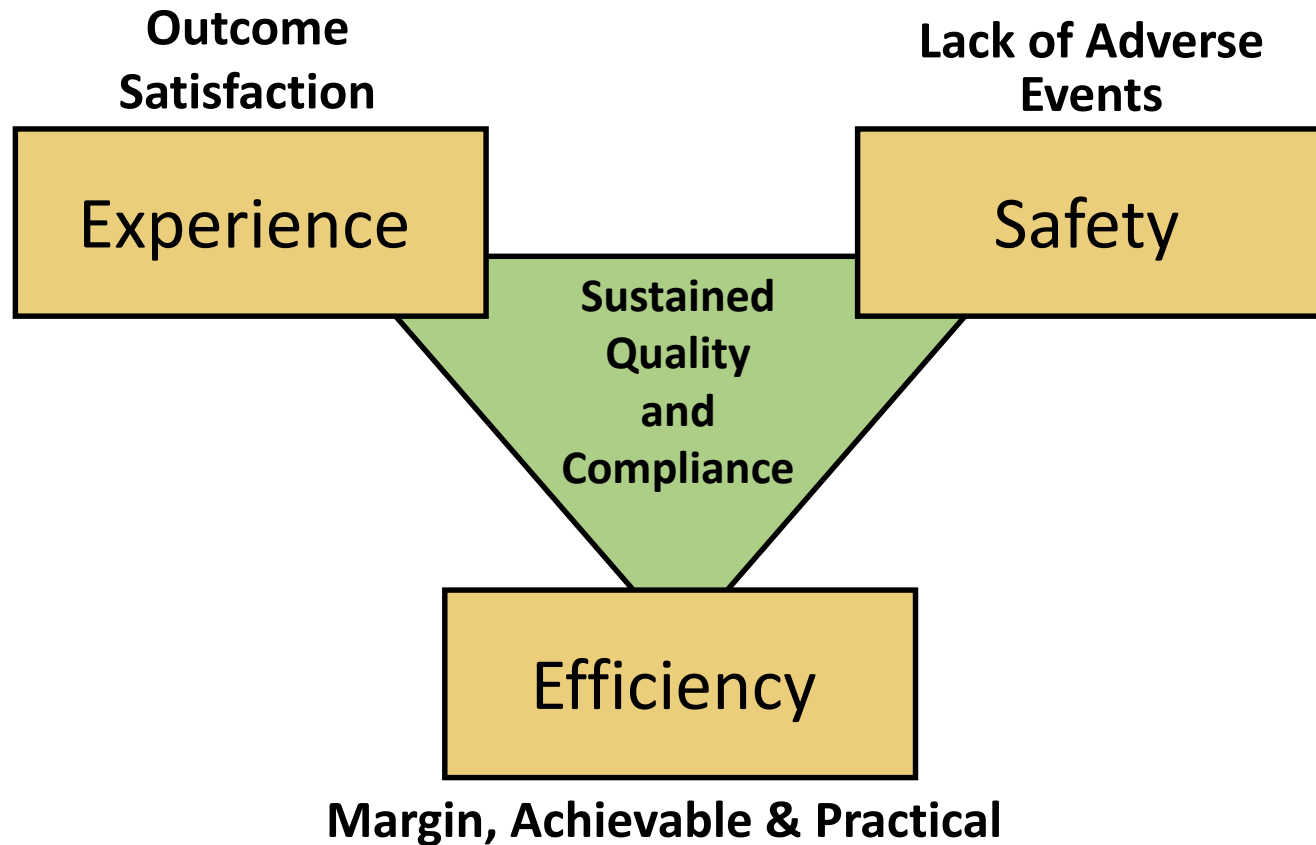
- Integration initiatives (e.g. centralization, recruitment, provider enrollment)
- Delegated credentialing
- Quality & compliance
- Policy & procedure development and implementation
- Training & education
- Criteria-based clinical privileging
- Medical Staff Services Department (MSSD) business process outsourcing

Your Feedback?

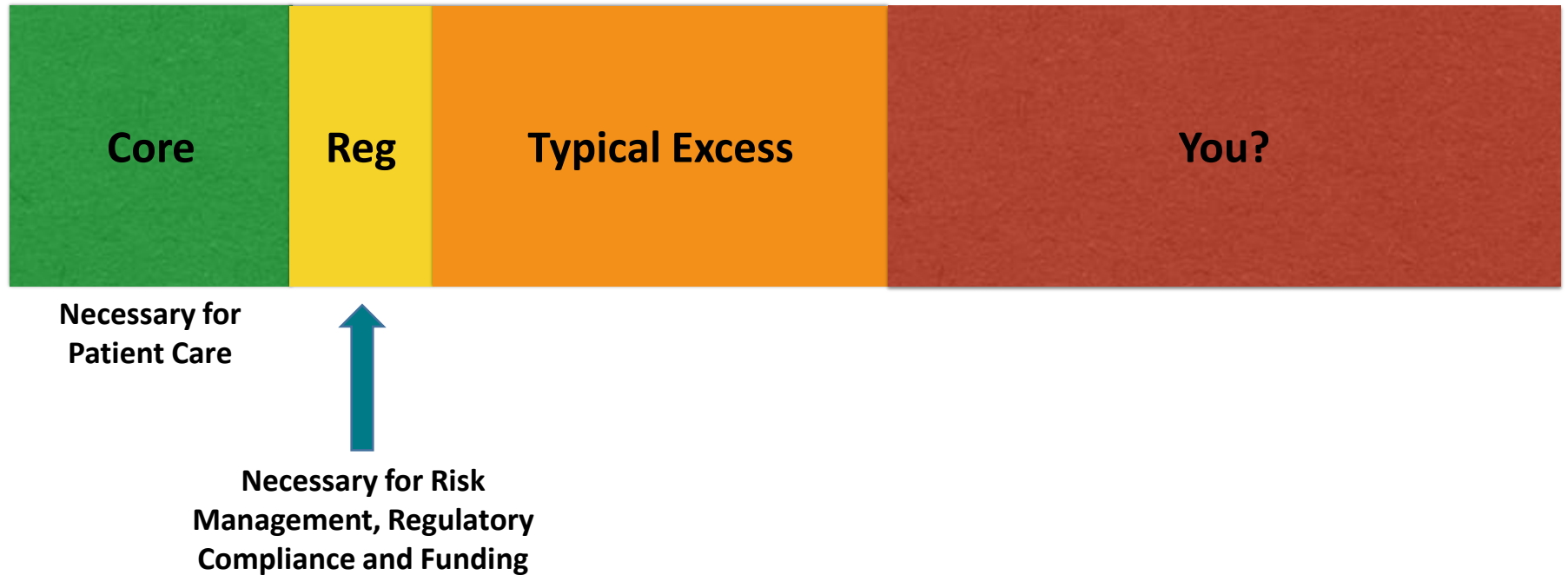
- Is regulatory compliance really on your radar?
- Which regulatory agency do you focus the majority of your efforts toward:
 - CMS
 - JC/DNV/HFAP
 - State
 - Other
- Does your clinical documentation (EMR) concern you?
- What do your physicians and nurses think of your clinical documentation (EMR) ?

Compliance & Documentation Parallels

True compliance is equivalent to high quality



If It's Not Efficient, It's Not Required



Symptoms of Excess

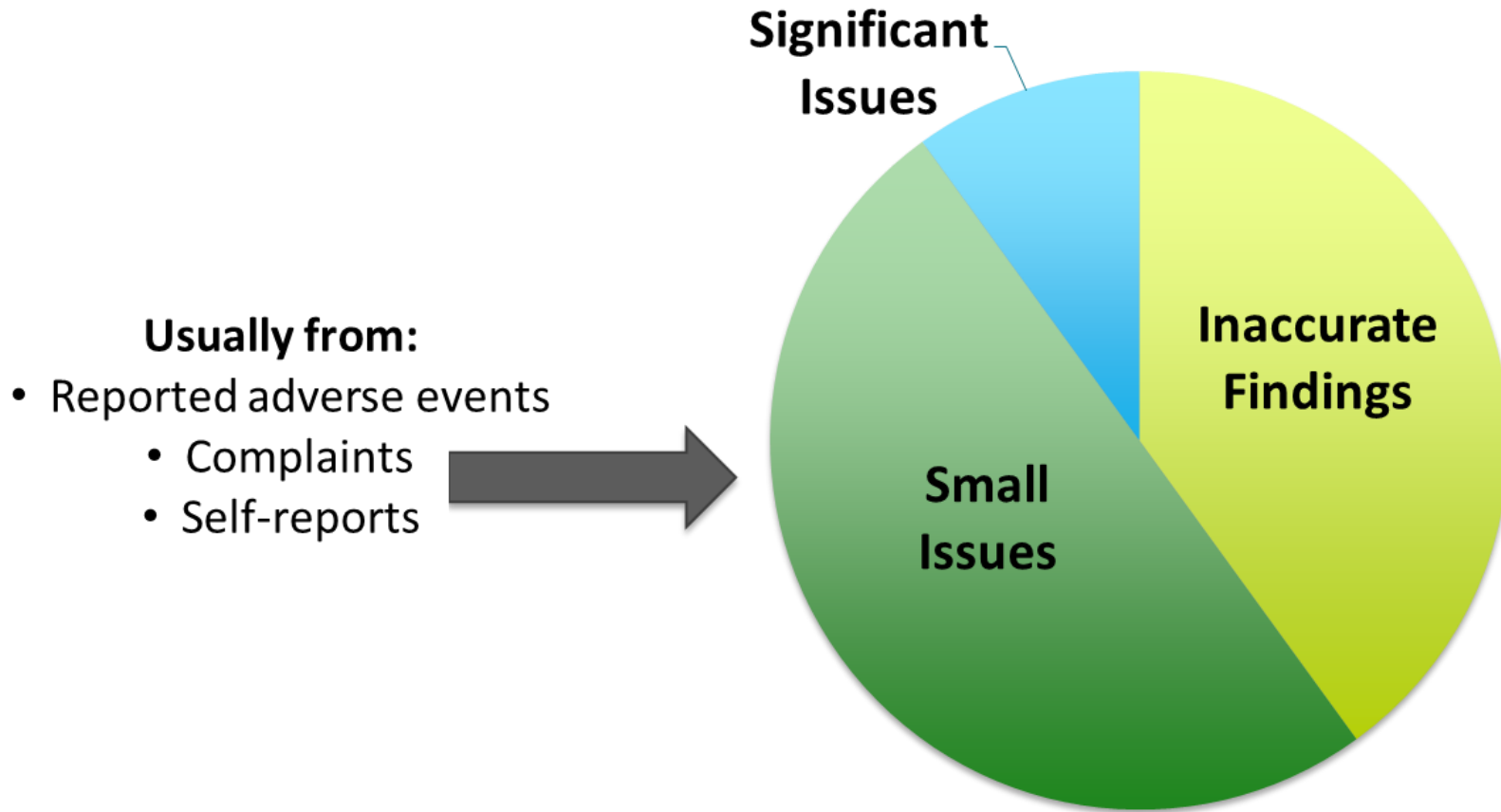
- Do your physicians complain about excessive and non-value-added documentation requirements?
- Are your nurses spending more time at the computer than on patient care?
- Does your institution design processes “because the regulations require it?”
- Are you spending more and more time responding to regulators?

A Paradox

To many "fixes" made in the name of a requirement get in the way of true compliance

Your "fixes" or corrective action plans typically exacerbate the challenge

The Truth about State/CMS Survey Findings

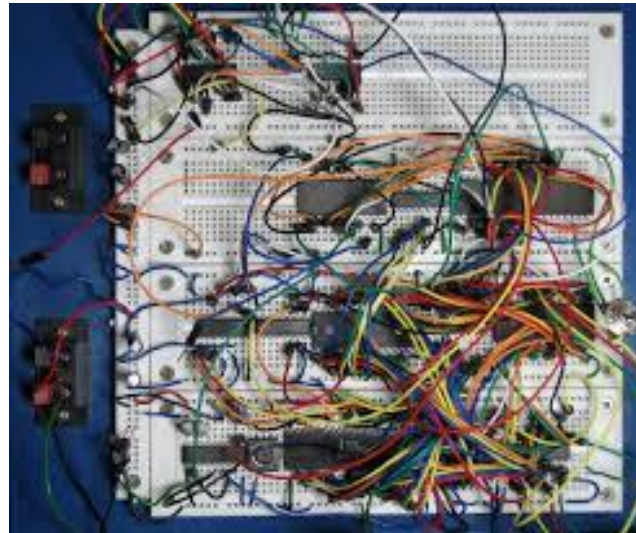


The Truth about Accreditation and “Mock” Survey Findings



Yet We Often Address All Findings with Equal Priority

We layer process upon process . . .
form upon form . . .
and go from bad to worse.



Consider A Different Message

- Invest in quality, safety, and efficiency
- Do not send the message “I want the plan of correction in early and accepted the first time.”

In Opposition to Conventional Wisdom

- Nicolaus Copernicus was a Renaissance mathematician and astronomer who formulated a model of the universe that placed the Sun rather than the Earth at the center of the universe, likely independently



Untying the Gordian Knot

- Stop the madness
- Simplify your expectations based on safety, patient experience, and efficiency

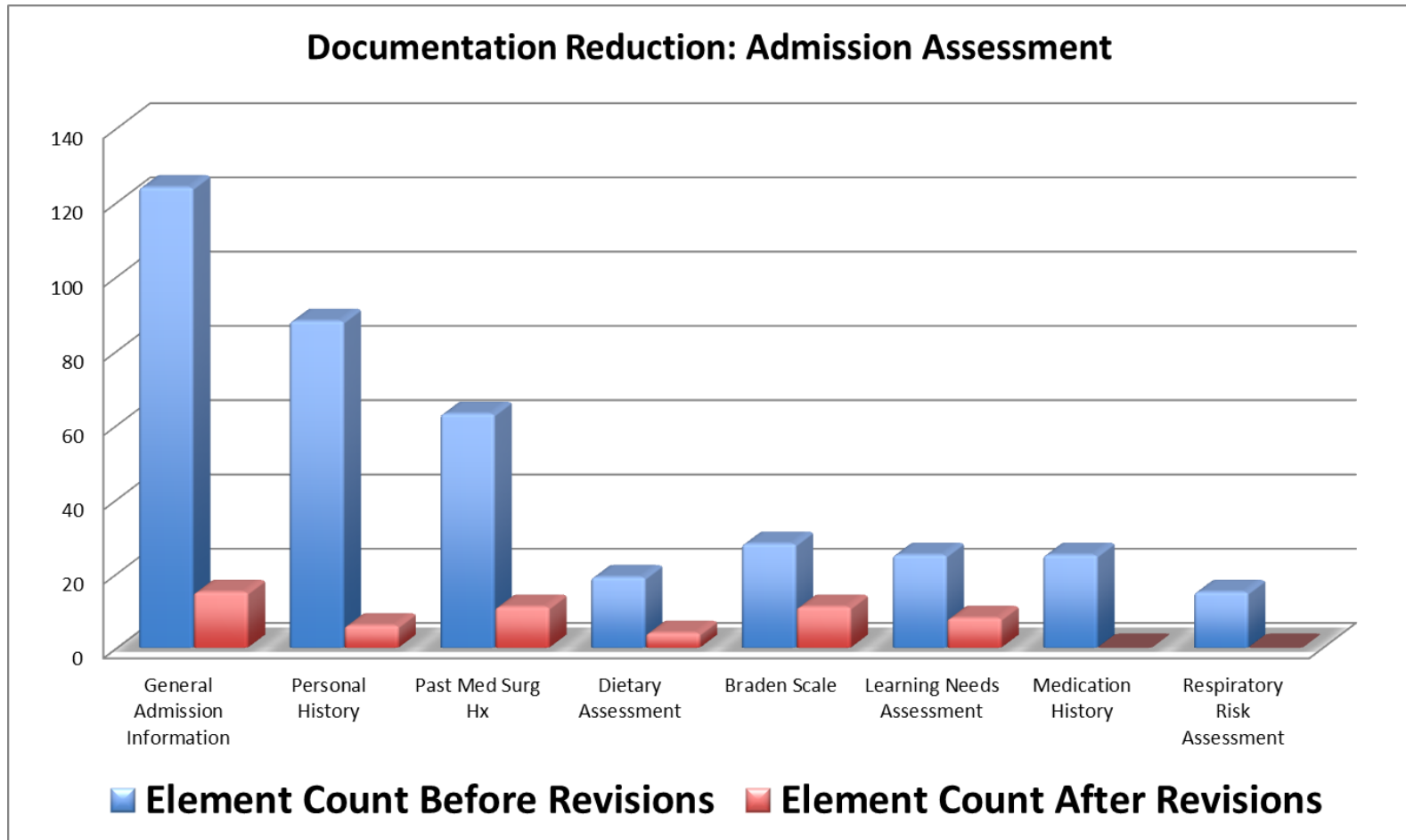


Document for Efficiency, Safety, and Experience

- Use your existing EMR . . . no vendor changes
- Comply with all meaningful use indicators
- Less is more
 - One-page policies
 - Fewer “clicks”
 - Better communication
- Start with redefining your clinical expectations

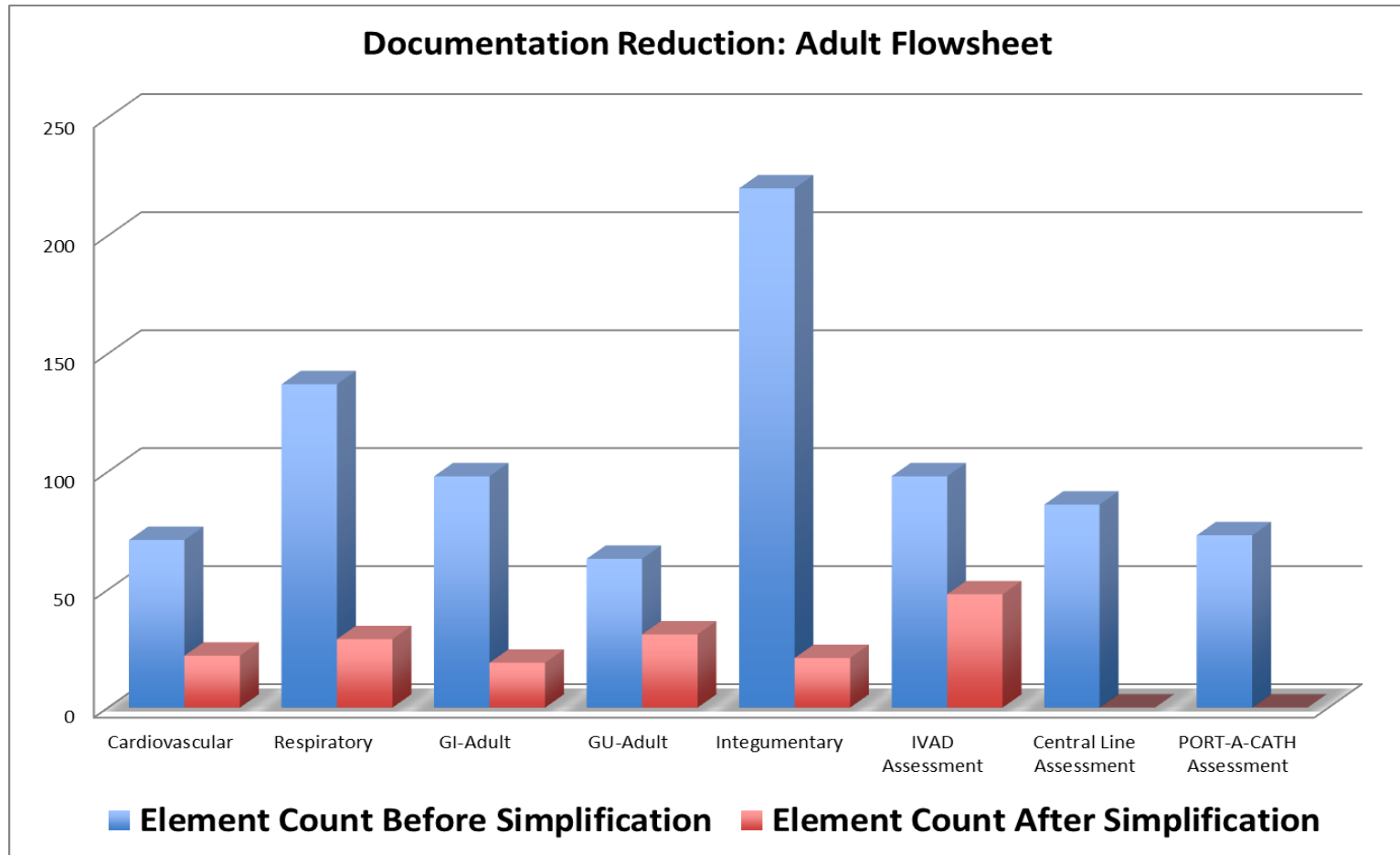
Case Study

Total admission assessment went from 387 elements to 55!



Case Study

Adult flow sheet assessment went from 1,081 elements to 250!



We Became Too Complicated

In our attempt to capture every little thing..... we found we had submerged the nurse's documentation and were collecting data just for the sake of collecting data.

As a result, we couldn't see the patient's *story* in the record

We have to get back to basics...

- ✓ Assess
- ✓ Plan
- ✓ Intervene
- ✓ Evaluate



We Rely too Heavily on Electronic Documentation?

- Check boxes, radio buttons, reminders, prompts, and alerts lead to documentation fatigue and unreliable data collection
- Nurses are dependent on the computer telling them when and how to care for patients
- Critical thinking gets lost in the process



Migrate to a “Less is More” Concept

- Only Collect Information that makes clinical sense
(If not required by law, doesn't improve Quality/Safety/Revenue don't collect)
- Implement a Philosophy of “Assess, Plan, Intervene, Evaluate” – requiring documentation to be realistic
Documentation is primarily free text – requiring the nurses to **CRITICALLY THINK**
- Integrated the Care Plan Into the Assessment Process
The CoPs do not require long and short term goals – *care planning* is required – we know the long term goal, tell us what you are going to do for the patient while he is under your care today
Combined assessment, care plan and documentation of interventions into one activity - Streamlined documentation

Loop closure with end of shift evaluation

OLD Documentation Requirements

- Admission Assessment
- Recent Travel History
- Past Medical History
- Family History Assessment
- Physical Assessment
- Patient assessed by RN
- Skin Risk Assessment Scale (Braden)
- Fall Risk Assessment
- Pain Assessment
- Vital Signs-CNA/tech
- Daily CNA/Tech Activity
- Intake and Output
- Assess feeding method and intake
- Monitor laboratory values
- Assess learning readiness
- Teaching Record
- Physician visited patient
- Report given to:
- Report Received From:
- Physician Notification
- Assess IV/Invasive line status
- Shift Assessment/Reassessment
- DVT Assessment
- Patient Safety Checks/Hourly Rounds
- SBAR Hand Off Communication Report
- Patient Off Unit
- Re-site IV every 72 hours
- Pharmacy Rounds
- Time Patient to Room
- Discharge Summary, Interdisciplinary
- Care Plans reviewed & updated PRN
- Family/visitor here:
- Non-pharmacological measures provided
- Nurse notification
- Reassess for meds to bed program
- Reassess flu vaccination status
- PICC/Central line in place prior to ADM
- 12 hour chart review completed
- PCC discharge planning
- Readmission assessment tool
- LACE index score
- Assessment for Breastfeeding patients

NEW Documentation Requirements

- NEW Admission Interview
- NEW Daily Assessment
- End of Shift Note
- Vital Signs, I/O

Assessment/Care Planning

*Musculoskeletal/Functional Assessment	
Musculoskeletal/Functional WDL?	<input type="radio"/> Yes <input checked="" type="radio"/> No Moves all extremities, has appropriate muscle tone without significant functional impairment. No age appropriate physical decline in ability to perform ADLs. *If NO, describe all findings outside of defined limits.
Musculoskeletal Findings Outside of Defined Limits	MOVES 3 EXTREMITIES WELL. PT HAD FALLEN PREVIOUS TO COMING TO HOSPITAL & HAS LARGE BRUISE ON LEFT HIP. TENDER TO TOUCH & PAINFUL WITH TURNING.
*Musculoskeletal/Functional Plan	
Musculoskeletal Interventions	MAINTAIN BODY ALIGNMENT. POSITION FOR COMFORT
Musculoskeletal Goals	ABLE TO TOLERATE MOVEMENT PT MAINTAINS COMFORT LEVEL WITH POSITIONING
*Gastrointestinal Assessment	
Gastrointestinal WDL?	<input checked="" type="radio"/> Yes <input type="radio"/> No Abdomen soft, non-distended, non-tender, symmetric width. No palpable masses or tenderness. Active bowel sounds in four quadrants. Regular bowel movements. No ostomy present. *If NO, describe all findings outside of defined limits.
Gastrointestinal Findings Outside of Defined Limits	

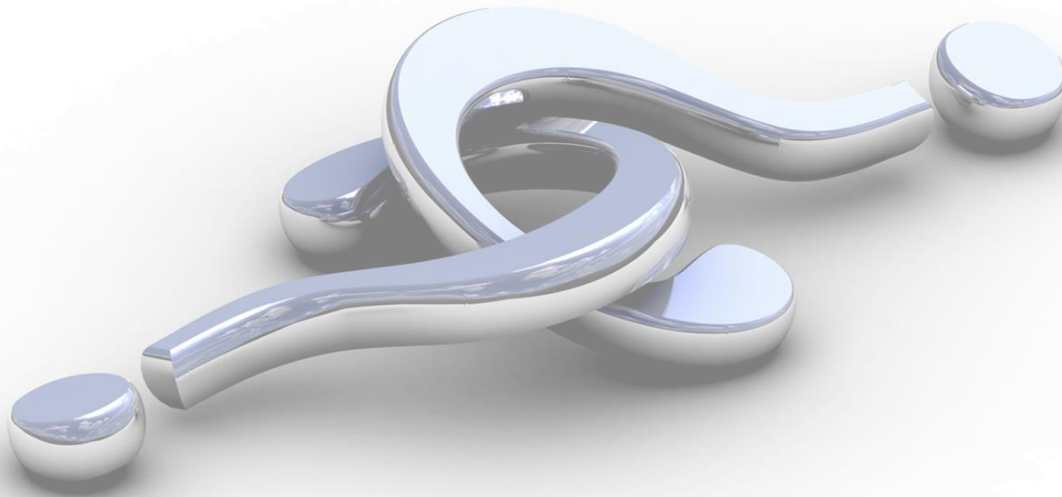
Musculoskeletal is NOT WDL therefore care plan is initiated by nurse

Gastrointestinal is WDL – no care plan needed

How Do I Prevent Falls?

*Fall Risk Assessment	
Pt is an Enhanced Fall Risk d/t Their Condition or Treatment	<input checked="" type="radio"/> Yes <input type="radio"/> No <hr/> ENHANCED FALL RISK FACTORS: * History of Recent Fall * Use of Ambulatory Aides * IV Access * Weakness, AMS * Receiving Diuretics, Sedatives, Laxatives, Antihypertensive Medications
Pt has Enhanced Risk of Injury in the Event of Fall	<input checked="" type="radio"/> Yes <input type="radio"/> No <hr/> INJURY RISK FACTORS INCLUDE: * >65 Years Old * Post-Operative * Bones Susceptible to Fracture * Coagulopathies (Genetic or Medication)
Fall Risk Plan	
Additional Fall Risk Interventions	Hourly rounding to assess for needs Family to remain at bedside and notify nursing if they leave bedside Floor mat Bed Alarm <hr/> List all interventions being performed IN ADDITION to Standard Fall Precautions
Fall Risk Goals	<input checked="" type="checkbox"/> Prevent Fall <input checked="" type="checkbox"/> Reduce Potential Injury

Feedback & Discussion?



Thank You for Joining Us!

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