Providence
Medical Center

Clinical Documentation Improvement

Presenters

- Kathy Jasa CDIP, CCS
  - Director of Medical Records
- Valerie Hangman BSN, RN
  - Director of Quality Assurance and Performance Improvement

- 21 bed critical access hospital located in Wayne, Nebraska
- Services-emergency, inpatient, skilled, obstetrics/newborn, surgery, outpatient, home health, hospice, 20+ specialty clinic providers, ambulance, retail pharmacy
- 200+ staff members

Mission, Vision and Values

Our Mission: Providing Quality Healthcare in the Spirit of Christ

Our Vision: To be the hospital and employer of choice

Our Values:

H – Honesty: Maintaining integrity by doing the right thing the right way.

E – Excellence: Exceeding expectations by committing to quality performance in all we do.

A – Accountability: Accepting and acknowledging personal responsibilities.

R – Respect: Considering the feelings, wishes and rights of others.

T – Teamwork: Working together to set and achieve shared goals.

Objectives

- Describe the steps to implement a documentation improvement program as it relates to providers and frontline staff
- State the benefits and lessons learned when collaborating with an internal documentation improvement committee
- Plan documentation improvement techniques to drive improvement and sustainment

How we got started

In 2018, we received approval from Administration/Governing Board to form a Clinical Documentation Improvement Program at PMC to include

- Provider based
- Staff/Facility based

This two-pronged approach would address documentation issues identified by peers, payers, utilization review, coders, and patients who use the health portal.

Committee Setup

Provider CDI

- Two physicians and a mid-level
- CEO
- CNO
- COO
- Director of Quality Assurance and Performance Improvement
- CDIPs who are from Medical Records and Utilization Review

Staff/Facility CDI

- CNO
- COO
- Director of Quality Assurance and Performance Improvement
- CDIPs from Medical Records and Utilization Review
- Subject matter experts based on the current topic of discussion

Accomplishments

- 2 Staff members got CDIP certification
- Charter for committees
- Orders policy update
  - This had a huge impact on our nurses as the policy gave clear direction on how to utilize electronic orders to accurately reflect patient care.
- Documentation policy updates to include language specific to CDI principles
- Education-policies and NHA documentation video
- Provider adoption of SOFA scoring

Provider CDI

- Dynamic documentation in Cerner
- Anesthesia documentation improvements encompassing updates to the Cerner module and specific changes to CRNA documentation practices.
- Population of the diagnosis list on admission
- Automated process to encourage providers to document need for continued stay at the 96-hour mark
- Ongoing discussion about the quality and content of provider documentation

Staff/Facility CDI

- Identifying areas for improvement (brainstorming)
- Priority matrix
- Maintenance of chronic problem list for staff/facility
- Utilization of Cerner workflow M pages for outpatient clinic nursing documentation
- Updates and standardization of staff/facility workflow including
  - Clinician notification
  - IV documentation in I-View
  - Foley catheter documentation
  - Blood administration
  - Vital signs

Lessons Learned

System

- Use your EHR and Excel for data collection and review as much data as you can-Electronic 16 hours per year vs. Manual 780 hours per year
- Keep group membership small-20 initially vs. 8 now
- Keep education on a specific topic simple and test it on a staff member before you put it out to all
- If possible, standardize and teach new EHR documentation from the beginning

People

- If possible, utilize provider champion
- Give your staff the why for doing or changing something
- Create an atmosphere of collaboration
- Be willing to listen to all participants and adapt as needed.
- Not everyone sees everything in the same way, literally

Change

- Know the end goal before you start and agree on it
- Determine what you will do with your data to make a difference
- Make sure your admin staff on the committee know the end goal and are willing to ensure accountability.
- Change is better accepted when all involved feel like they have input. However you can't make everyone happy and someone may have to change.
- Do not be discouraged if there is pushback about a change.

Replicate and Sustain

- Replicate reports or Excel spreadsheets from one topic to the next
- Sustain improvement by continuing to show them the data and letting them know where the problem areas are
- Show staff how their department compares to other departments and how they compare to other staff
- Support and accountability start at the top “With the support of our board and board quality committee holding staff, directors and administration accountable through our strategic goals, we will continue to improve our documentation and the care we give the patients of Providence Medical Center.”

Next Steps

- ER documentation improvement to support provider and facility charges
- Facility chart review policy update
- Continue to standardize the more difficult facility documentation topics, such as wounds
- Capitalize on our new CEO's enthusiasm for data and patient safety as it relates to documentation improvement
- Continue to use the query process and stay compliant with changing CDI query guidelines

- For the future: Nursing peer review

Contact Info

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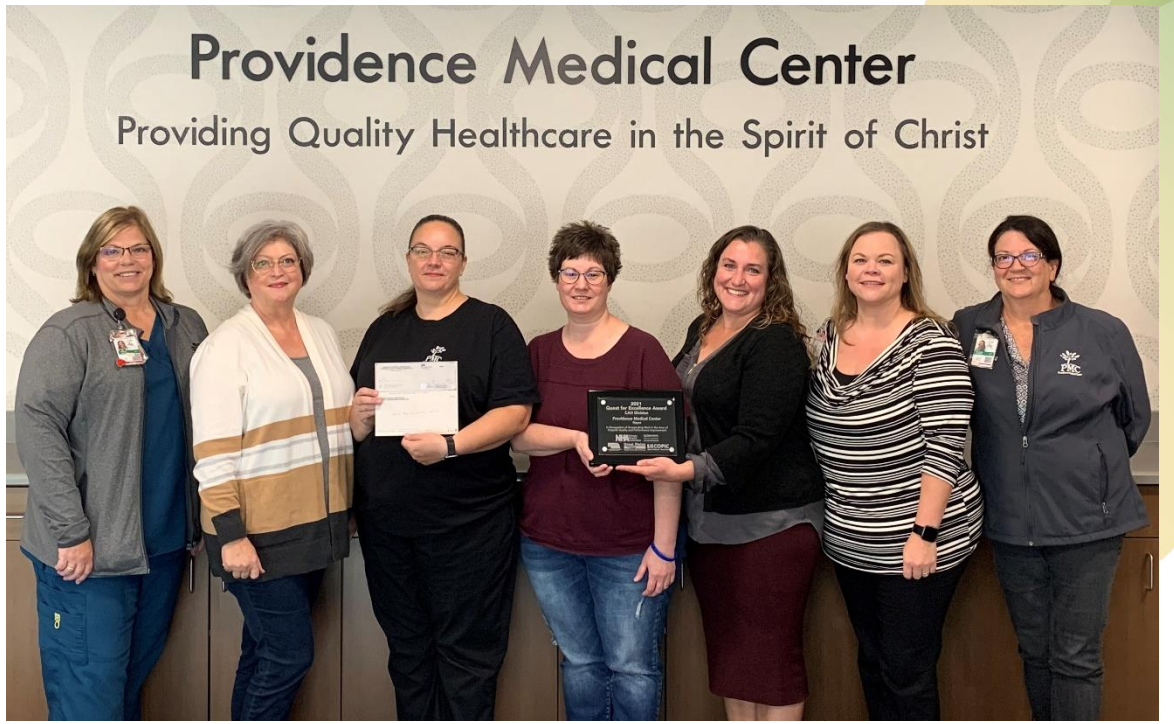

Left to right: Tammie Thomsen, Kathy Jasa, Valerie Hangman, Wendi Dwinell, Margaret Woeppel, Nicole Haglund, Melissa Wimmer, (not pictured Kris Giese, Marcia Spahr, Brittany Peters)

Questions?