Maximizing the electronic medical record; Best practices, Tips and discussion

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Objectives

• Relate and differentiate various electronic medical record applications and discuss the process of adopting a new EMR, creating buy in and mutual purpose with staff, superusers, administrators and IT support personnel.
• Review APTA’s “Defensible Documentation” and barriers for producing high-quality documentation in practice.
• Identify tips and best practices for individual EMRs
• Participate in group discussion specific to various EMR systems (EPIC model, EPIC with CPM, Cerner)

Introduction

Electronic Medical Record (EMR) systems should:
• Enhance clinician productivity
• Foster communication
• Ensure excellent patient care
• Enable valuable data collection

Cerner claims biggest market share in EMR industry

Cerner’s growth, partly spurred by its acquisition of Siemens in 2015, has led the vendor to claim the largest market share in the $27 billion EMR industry, according to a report from Kalorama Information, an independent medical market research firm.

Cerner surpassed McKesson as the market share leader in 2015, and McKesson still holds the second largest market share in the EMR industry. Epic comes in third in terms of market share, the vendor has climbed from ninth place in 2012. AdvancedMD is in fourth.

Bruce Carlson, publisher of Kalorama Information, said that most of the activity in the EMR market is around EMR specialist companies, not IT companies or diversified healthcare companies. What’s more, he said mergers and acquisitions among IT companies are on the rise.
Introduction

Henry Ford Health System, Detroit, MI
- Multi-hospital system includes flagship, Level 1 academic, trauma, not-for-profit hospital: Henry Ford Hospital (650 beds, 168 Critical care beds)
- Also includes 4 community hospitals (level 2 and 3 trauma centers), 2 inpatient rehab units and over 20 ambulatory sites

Introduction

Christus St. Vincent Regional Medical Center, Santa Fe, NM
- Private, faith-based, not-for-profit community hospital (260 inpatient beds, 18 critical care beds)
- Only Level III trauma in northern New Mexico
- Includes acute care, emergency services, 18 bed inpatient rehab unit, and outpatient services (adult and pediatrics)
EMR Selection

• Selecting the best EMR for your site that works for acute care, outpatient surgery centers, inpatient rehab units, or other branches of the hospital system is a challenge and one you may have little influence over.
• BUT you have plenty of influence over workflow and how you use the EMR.

Strategies for Success

• Be empowered
• Create mutual purpose and respect
• Identify Champions
• Seek advice and Best Practices

Be empowered

• Each professional needs to adapt quickly to change, accept change faster and do it without negativity or resentment.

Impact Effort Matrix

http://www.sixsigmadaily.com/tag/impact-matrix/

Creating Buy in and Mutual Purpose

• Creating buy in and mutual purpose with staff, superusers, administrators and IT support personnel.
• Mutual Purpose: When others believe you are genuinely committed to their best interests, they stop resisting you and become more open to your interests.

Identify Champions

• Designate superusers and champions
• Form a committee to help shape and develop the software - initially and long term
• “Train the trainer” method, identifying key members of the department who will serve as educators and resource people.
Responsibilities of superusers

• Great opportunity for leadership in your dept.
• Proactive not passive. It is your responsibility to bring issues from staff to the team.
• Communicate what’s broken, lead huddles, emphasize how optimizations affect workflow
• Audit and follow up on best practices
• At the elbow support

Go Live Recommendations

• Increased staffing needs when we “go live” to account for decreased productivity
• Request a contact for a comparable system to discuss pros/cons and demo live environment via video conferencing
• Superuser to staff ratio: 6 users to 1 superuser
• Superuser to attend all EMR training sessions (training sessions typically led by IT and helps to have a therapist involved)
• Stay organized and help staff log hours

Upgrade Recommendations

• Provide summary of changes most relevant to therapists
• Create tracking form

Training sessions

• Providing training sessions with “mock patients” on a simulated network
• Scavenger Hunt
• Training materials
• Practice scenarios
• Screenshots when able
• Tracking sheets

Scavenger Hunt

Training materials: Screen shots
Summary

- Important to include clinicians in the process and for the system to meet our needs
- But one challenge we face as clinicians is how to continue to produce high-quality documentation in light of electronic forms and department standards

Producing High Quality Documentation with the EMR

APTA Defensible Documentation
Producing High Quality Documentation with the EMR

• Review APTA’s “Defensible Documentation”
• Discuss Obstacles to producing quality documentation
• Address challenges of instructing students in documentation in acute care
  • Therapists are responsible for holding each other accountable for “best practice,” which applies to high-quality documentation 100% of the time

APTA’s Top 10 tips

1. Limit use of abbreviations.
2. Date and sign all entries.
5. Document at the time of the visit when possible.
6. Clearly identify note types (eg, progress reports, daily notes).
7. Include all related communications.
8. Include missed or cancelled visits.
9. Demonstrate skilled care and medical necessity.
10. Demonstrate planning throughout for the conclusion of the episode of care.

APTA’s Defensible Documentation

• Document clinical decision making and problem-solving process.
• Show interventions connected to the impairment in body function and structure, activity limitation, and/or participation restriction.
• Relate interventions to goals stated in the plan of care.
• Explain complications of comorbidities, safety issues, etc.
• Exhibit that services are consistent with nature and severity of illness, injury, and medical needs.

APTA’s Defensible Documentation, cont.

• Document that skilled therapy is needed to maintain function or to prevent or slow its deterioration.
• Include standardized tests and measures in clinical documentation.
• Update patient or client goals regularly.
• Highlight progress toward goals.
• Show a focus on function.

How EMR Upgrade Can Support Defensible Documentation

• Required section for Education (patient, family, staff)
• Designated section to score outcome measures
• Rich text box (with no word limit) for assessment
• Prognostic indications and barriers for discharge
• Response to interventions
• More choices for discharge recommendations
• Better handoff communication between settings
• More detailed descriptions of gait quality, posture, etc.

Postural Analysis and Gait Assessment Examples
Discharge Recs and Education Examples

Obstacles to Documenting in the EMR
- Word limits in text boxes
- Narrative is where therapists demonstrate skill
- Relating the goals to function or participation
- Time constraints for charting
- Leading to abbreviations, simplifications
- Too many forms to complete in a day
- Documentation takes away from pt care
- Staffing concerns
- Minimal accountability/lack of chart audits
- Productivity decreased

Obstacles Continued
- Various audiences
- “Listing” interventions that took place
- Duplications of “click boxes” without definitions
  - E.g. home responsibilities, obstacles to discharge, assessment boxes, etc.
  - Inconsistencies from therapist to therapist
- Therapy diagnosis?
- No spell check
- Not all important sections are required fields
- Computer literacy

Goals Example

Clinical Instruction
Challenges that students face when documenting in the acute care setting:
- Many come from a SOAP note background in the academic setting
- Challenging to incorporate the “SOAP note mindset” into the electronic forms
- Time constraints in the clinical setting
- Spell check
- Limit abbreviations
- Learning a new system for each clinical rotation
- Adhering to department standards

Clinical Instruction
Helping students adapt to the EMR:
- Encourage flexibility and adaptability
- Emphasize assessment & interdisciplinary communication
- Patient-centered goals when given a list of check-boxes
- Difference between medical dx and PT dx
- Considering multiple audiences (supervising PT, case manager, other therapy staff, physician, potential future litigation or audit, etc.)
- Direct students to the important/required sections for this setting without getting hung up in all the additional boxes
- Practice peer chart audits
Tips and Best Practices for Individual EMRs

Cerner (with Rehab Module)

EPIC with CPM

Cerner

Tips and Best Practice Examples

Cerner Powerchart

Pros:
- Better continuity of care (consistent forms between inpatient and outpatient settings)
- Improved communication
- Continuation of goals from one setting to the next
- Customizable rehab forms
- Electronic IRF-PAI that pulls information from therapy notes
- Interface with Affinity for automatic billing

Cons:
- Forms are lengthy and not entirely applicable to one setting
- Lots of extra sections
- FIM charting is a separate document
- Not very useful for Pediatrics
- Lacking smart phrases and spell check
- Unable to use staff assignment
- Still no consistency with local SNFs and Home Health agencies

Applying the same forms to multiple therapy settings...

One size fits all

NONE...

Order Sets/Automated Orders

Examples:
- Total Joint Arthroplasty
- Hip fx
- Ischemic CVA without thrombolitics
- Mechanical ventilation
- Craniotomy
- Inpatient rehab unit referral

Pathways will trigger:
- Therapy referrals (PT, OT, SLP)
- Activity orders (e.g., “Up with Assist,” “Progressively Mobilize as Tolerated,” “WBAT,” etc.)
- Medical orders (pain management/ anticoagulation/ follow-up labs/etc.)
Order Sets/Automated Orders

Pros:
- Multiple therapies involved right away
- Case management consult early on
- Following a protocol to “keep track” of patients and collect data
- Best practice for stroke patients
- Less likely for physicians to leave out an important piece of the order set (e.g., WB status)
- FIM documentation triggered for IRU referrals

Cons:
- Unnecessary referrals are not a good use of time (e.g., patients with TIA)
- Not always ready for therapy (e.g., patient sedated, or awaiting surgery)
- Duplicate orders (e.g., IRU referral)
- Not individualized for the patient

Observation Patients

- “G codes” required for Observation patients and those patients covered under Medicare Part B
- Our facility uses “6 clicks” to generate G codes
- Applicable to inpatient and outpatient settings
- Therapist must first determine whether the patient is Inpatient or Observation status
- Record G code electronically in the therapy evaluation or daily note form
- G code goal carries through from Evaluation to Treatment

Boston University AM-PAC “6 clicks” basic mobility inpatient short form

6 items addressing basic mobility tasks relevant to the hospital setting:
- How much assistance does the patient currently need for...
  1) Turning over in bed
  2) Sitting down and standing up from a chair
  3) Moving from lying on back to sitting on the side of the bed
  4) Moving from bed to chair
  5) Walk in hospital room
  6) Climbing 3-5 stairs with a railing
Boston University AM-PAC "6 clicks" basic mobility inpatient short form

Scoring:
1 = unable
2 = a lot of help needed, or a lot of difficulty
3 = a little help needed, or a little difficulty
4 = none (able to complete without help)

Raw score out of 24 points, converted to a standardized score and a "G code modifier"

Reliable and valid for hospitalized adult patients

Research also supports the use of "6 clicks" tool for predicting hospital discharge destination

Outcome Measures

Therapy forms now have areas to record scores on specific outcome tools for tracking change and setting goals related to functional status
PT:
• Balance assessments (e.g. Berg, TUG, Tinetti, FIST, Romberg, ABC)
• Gait assessments (DGI, 6MWT, etc.)
OT: primarily FIM scores
SLP: Moca, BDAE, BNT, CLQT, RICE-R, RIPA-Z

EPIC with CPM
Tips and Best Practice Examples
CPM - Care Plan Management

EPIC Model with CPM

Pros:
• Forms are specific to setting minimizing extra rows
• Shared plan of care “patient’s plan of care”
• Spell check, Smart Phrases,
• Searchability, good historical data
• Staff assignment
• Order Sets

Cons:
• Little continuity between settings (home care and ambulatory)
• Recreating the wheel required for best practices
• IPR and ambulatory had to be built from scratch
• Billing charges are entered via EPIC but productivty still requires manual processing
• Still no consistency with local SNFs and Home Health agencies

Order Sets/Automated Orders

• Similar to Cerner
• Same pros and cons
• Progressive Mobility activity order has helped to greatly reduced prolonged unnecessary bedrest

PT and OT Orders

Observation Patients

• Immediate identification on patient list
• G codes
EPIC Top Tips

- Staff Assignment
  - Age of Order in hours
  - Therapist Communication Column/Row
  - Triaging - new order, Next treatment Date,
  - Patient Lists - for weekend, data collection
- Flowsheets and Care Plan
  - one flowsheet for majority of work
  - Creating a care plan individual discipline note while maintaining philosophy of one plan of care
- Smartphrases

Staff Assignment

- My Lists or patient list are assignment driven
- System lists are orders driven; built by EPIC orders team

Census Lists with Master Header

- Built by EPIC team
- Clock starts upon entry of order
- Sorts by age of orders in hours

Age of Orders column

Next treatment dates

- Clock starts upon entry of order
- Sorts by age of orders in hours

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Therapist Communication

- Shared Lists with other disciplines
- Weekend Lists
- Master header lists

Shared Lists

- Vital Signs
- Pain
- Prior Functional Status
- Living Environment
- Activity Level

One Flowsheet

Shared Rows
Smartphrases

Breakout sessions
Discuss the challenges encountered in their own clinical settings and work together to brainstorm solutions.

Questions?

References

Smartphrases - Goals

References
4. Porter SL. Q & A: The perfect fit. How documentation systems have helped streamline operations for PTs, OTs, and SLPs at Tallahassee Memorial Rehabilitation Center in Florida. Interview by Judy D’Royce. Rehab Management. 2010 Aug-Sep;23(7):22-3.

References