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How 'Leaning' Your EMR Improves Quality, Safety, Efficiency and Regulatory Compliance

We have all had beliefs we held to be true, only to find out at some point in the future that those beliefs were myths. And most of us have experienced or witnessed the crippling effects that the belief "more is better" can have.

Steve Bryant, senior vice president and managing director of The Greeley Company, understands how regulatory myth, over interpretation, and complexity manifests itself in hospital policy, EMR design and clinical practice. Developing a robust process is rather easy. Taking a complicated process and making it simple and practical is hard.

Mr. Bryant likens what he observes in hospitals to The Greeley Company's own M&A activities. He describes how Greeley's first M&A contract was a succinct and practical 5-page document, but each acquisition resulted in added structure and bureaucracy to a once efficient contract.

"We convinced ourselves that the 10-page contract was better than the five-page document, and the 15-page contract was better yet."

Each M&A resulted in more complexity and the resulting "new" document became the basis for the next acquisition.

"The reality was that the added structure impeded our ability to efficiently close acquisitions. We realized that 'less is more' and went back to the original five-page document as our base contract."

When thinking about "leaning" an EMR or regulatory compliance, Greeley subscribes to the following two Albert Einstein quotes:

> *"Everything should be made as simple as possible, but not simpler."*

> *"We cannot solve our problems with the same thinking we used when we created them."*

Simplifying compliance

CMS, state regulators and accreditation agencies all have a similar overarching requirement for hospitals: They must comply with federal law, state law and applicable accreditation standards — and they must also comply with hospital policy.

Mr. Bryant says the strictest variable he sees, 90 percent of the time, is the hospital policy. In trying to be the most compliant organization possible, hospitals end up inadvertently sabotaging themselves. They build overcomplicated sentiments into their compliance strategies, year after year, based on regulatory myths, historical over-interpretations, advice from consultants and regulators, and previous overcommitted corrective action plans, which results in an enormous amount of waste and workarounds.

Mr. Bryant suggests hospitals take a fresh look at their EMR with the goal of simplifying or "leaning" expectations that are simply no longer required or that don't enhance quality or patient safety.

To assure sustained regulatory compliance, hospitals must meet three criteria in the design of clinical process:

1. **Processes must be quality-driven.** The process must result in a high-quality outcome and garner support and satisfaction from patients, physicians and hospital staff.
2. **Processes must be safe.** Hospitals cannot perform compliance processes that occasionally result in a poor clinical outcome.


Steve Bryant

3. **Processes must be efficient.** If the process is inefficient, it will have sporadic compliance among staff and clinicians.

In addition to meeting the three critical criteria above, hospitals must assure that policy, documentation expectations and actual clinical practice align. This may sound intuitive, but in reality, these three things seldom line up.

Mr. Bryant often sees complex, detailed and multipage policies that require clinicians to document aggressively. But when the EMR is reviewed, it is not structured to align with the documentation expectations outlined in policy. Further, when visiting the patient care units and interacting with staff, Mr. Bryant finds that actual clinical practice doesn't align with either policy or EMR design. The irony is that of the three — policy, EMR design and actual clinical practice — it is actual clinical practice that most closely meets the regulatory requirement.

The tragedy is that even if a hospital with the above scenario is meeting the requirement, it will be cited by the CMS, state or accreditation body, as it failed to meet the strictest standard: its own expectations.

Mr. Bryant can think of several examples where the above scenario plays out, including requirements about how clinicians renew orders for medical restraints.

The Joint Commission once required physicians to reorder medical restraints every 24 hours, but transitioned years ago to every calendar day. And CMS modified the patient rights condition of participation, requiring clinicians to renew medical restraint orders according to hospital policy. CMS collaborated with accrediting agencies to assure standardized requirements for all hospitals that use accreditation for "deemed status" purposes. The result was a level-setting of restraint requirements across the CMS and hospital accreditors.

What does this mean? "You only need an initial order from the physician, 'Restrain the patient until criteria are no longer met,'" says Mr. Bryant. This eliminates the need for the physician to reorder the medical restraint every day and eliminates not only an unnecessary burden on the physician, but also an aggressive internal expectation with a high degree of failure.

Despite these changes, in addition to overstated ordering expectations, nearly every hospital requires nurses to document multiple data points related to patient restraints every two hours. It is not uncommon for hospitals to expect nurses to document 30 data points every 2 hours or 120 data points in an 8-hour shift. Mr. Bryant explains how Greeley helps hospitals reduce the 120 data points to one per shift.

One of the skills Mr. Bryant and his colleagues at Greeley bring to the table is a textured understanding of healthcare's regulatory fine print. He understands how and why various regulations and standards — those from CMS, state and the Joint Commission — mesh with one another. He spots where hospitals require things in policy and documentation that are not legally required and offer no clinical value. This manifests as unnecessary EMR data entries, paperwork and forms, and repeated performances of the same task.

No work that Mr. Bryant and his colleagues eliminate is tied to clinical quality, and none of it affects reimbursement. Quite simply, they cut waste that has infiltrated itself into the hospital's routines for so long that it is hardly detectable. Over time, a hospital's "over-commitments" become the modus operandi or "the way we do it here," and years of this can increase the risk of patient safety issues, poor staff morale and physician dissatisfaction — not to mention issues of noncompliance.

Greeley has reduced clinical documentation by 70 percent for the majority of hospitals it works with. Going back to the patient restraints, Mr. Bryant recently heard from a hospital that simplified its restraint policy down to 19 pages. This was a significant achievement for this hospital and they were naturally proud of their outcome. "How do you expect a clinician to digest a 19-page policy?" Mr. Bryant asks. The Greeley policy is 1.5 pages.

Physicians and advanced care practitioners have little to gain from hospitals' inflated documentation expectations. They find themselves caught in a web of documentation requirements so large, it is nearly impossible to decipher a patient's story. "Clinicians' ability to communicate has been significantly impacted by superfluous and unnecessary documentation," says Mr. Bryant.

Greeley has eliminated more than 8 hours of documentation for a 3.2-day length of stay. Those 8 hours can be reinvested into direct patient care, a huge gain for a healthcare system where nurses, advanced care practitioners and physicians struggle to spend enough time at the patient bedside. As a result, hospitals see an increase in patient, physician and nurse satisfaction after the documentation and processes are simplified. Documentation, after all, should support patient care — not drive it.

"The bottom line? If you are a senior executive, you should not require a clinician to document anything that isn't required by any prevailing law or standard — unless the documentation enhances quality or patient safety," says Mr. Bryant. "If you can't prove that it does so, you are wasting your time."

Instead of overcommitting to do more, hospitals should dig deeper to find where they can and should do less — for the sake of quality, safety and efficiency.

One last caution Mr. Bryant offers: Greeley is often asked to assist hospitals after CMS surveys. By trying to make good, hospitals overpromise, overextend and overestimate themselves in corrective action plans. They make ambitious promises that are nearly impossible to achieve. When CMS returns to survey the hospital and affirm the hospital effectively implemented its corrective action plan, the hospital is surprised to learn that they continue to be "out of compliance".

The root cause of recurrent CMS, state or accreditation agency compliance challenges is the same as the inflated EMR, regulatory myth, over-interpretation and complexity. In responding to regulatory compliance challenges, the biggest mistake a hospital can make is an overly ambitious corrective action plan that is impossible to achieve. Mr. Bryant offers a final thought: "When evaluating policy or your EMR, or responding to a regulatory finding, think less about what you need to add and think more about what you can take away." ■

The Greeley Company provides innovative consulting, education, outsourcing solutions, interim staffing, and external peer review to healthcare organizations nationwide. We focus on contemporary needs and challenges related to medical staff optimization & physician alignment; accreditation, regulatory compliance & quality, and credentialing & privileging. Headquartered in the greater Boston area, The Greeley Company serves administrative and clinical teams in more than 500 healthcare organizations each year—ranging from the largest healthcare systems and academic medical centers to critical access rural hospitals. Greeley's unique approach and commitment to quality can result in marked improvements in efficiency, quality, compliance, cost reduction, revenue, patient satisfaction, and staff engagement and satisfaction.