



HCA Healthcare

The AHA Physician Alliance provides resources to connect hospitals with work being done across the field to address the individual, environmental, and systemic factors that contribute to burnout and to foster resilience and well-being. You may find more case studies at our [knowledge hub](#).

Overview

HCA Healthcare (HCA) consists of 178 hospitals and 1,800 sites of care located in 20 states and the United Kingdom. HCA had three different EHRs (Meditech Magic, Meditech 6.0, and Epic) and tremendous variation in documentation content. HCA's council of 14 regional Chief Nursing Officers (CNOs) were driven to tackle clinical documentation redesign, fueled by nursing engagement surveys listing documentation as a leading pain point. In 2007, the system embarked on a data-driven journey to standardize nursing documentation over its multiple EHR platforms. HCA aimed to substantially reduce documentation time and produce information from electronic documentation to inform clinical decision-making. A new nursing clinical documentation program was created.

The documentation content was developed by small design teams of practicing nurses, with feed-

back from large review groups. The teams were tasked with defining a singular ideal workflow agnostic of EHR

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vendor. The small teams also identified the data flow that would support the ideal workflow. Finally, the teams identified the total documentation content for the rebuild. Regulatory experts then

Impact

Automation of vital sign data entry allowed any clinical team member to see real-time vital signs and enabled timely decision support. HCA can now describe the differences in patient needs for nursing care among patient care areas, which allows for tailored RN staffing and RN education plans. Both system- and individual-level data are available to evaluate compliance with clinical protocols and checklists, without additional documentation burden to nurses. To date, HCA has had no adverse regulatory findings as a result of this documentation redesign.

reviewed the streamlined documentation to insure all compliance requirements were addressed.

A New Paradigm for Documentation

The new program shifted documentation from a comprehensive plan of care to a focused plan for the current episode of care. Documentation of data with no clinical value was eliminated, e.g., inventory of patient belongings. Data entered on behalf of other clinicians was also restricted, such as data needed in the event of a complicated discharge. Data entry was automated whenever possible, starting with the uploading of patient vital sign data directly into the EHR from mobile monitors. Data collection for process improvement purposes

shifted to non-EHR systems. Data elements from the documentation program were mapped to HCA's national data repository.

The program was piloted and refined at one hospital and then extended to 10 additional hospitals, using live support from pilot site champions. The program is currently used in 172 hospitals within the system.

To allow for continuous input from frontline nurses to improve the program, a governance structure was formed. Review of proposals starts with local hospitals and then continues with a chain of review leading to the national CNO council.

Results

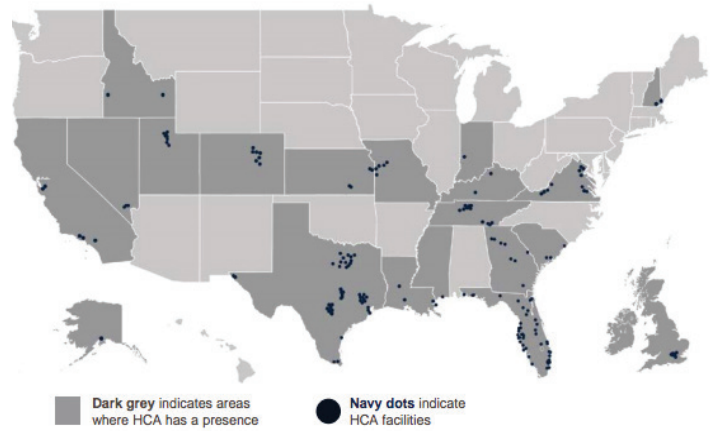
The new documentation program resulted in a time savings of 30 minutes per 12-hour nursing shift when tested at 30-days post-implementation. Automation of vital sign data entry saved an additional 30 minutes per shift and shortened the time to view "real-time" vital signs from 41 minutes to 23 seconds.

Lessons Learned

A longer pilot phase to work out implementation challenges paid big dividends. After a year-long pilot, the operational process grew so streamlined that only one of the two weeks budgeted for go-live support were required by hospitals.

Senior leadership buy-in is a must to support success on the frontlines. Strong CNO council support empowered nurses to stop unnecessary documentation without fear of retribution and prepared them to respond to inquiries during site visits by the state health department and other regulatory bodies.

The EHR implementation change required HCA to also to address resulting impact on culture and workflow in a multidisciplinary way. Both clinical and IT staff had to adapt to the EHR changes implemented. HCA's IT staff prides itself in being very



HCA Healthcare map

responsive to local nursing leadership; the IT staff often made technical changes in the EHR whenever requested. After the redesign, IT needed to instead triage some EHR requests to the governance process rather than addressing them independently.

Having a means for continued end-user input and support is just as important as the initial effort for EHR workflows. With clear governance and a review process for updating nursing documentation, HCA is set to stay nimble with changing regulations.

Future Goals

Future plans include a review of the design of clinical documentation to optimize data extraction "on the backend" for system-wide process improvement. There are also plans to expand the documentation redesign to additional clinical areas that are using separate electronic documentation platforms, such as obstetrics.

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