

**[Southern Health-Santé Sud]
Quality Improvement Project
Report Out
Southern Turn Around Time
(STAT) Team**

[July 29, 2013]

Learning To See



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Define

What process did we look at?

The Team looked at:

- 1. Turnaround time on transcribed reports and the impact of not meeting benchmarks.**
- 2. Time spent on Chart Count of Physician Deficiencies**
- 3. Percentage of blind coded charts at year end**

Define

What were the main perceived problems with the process?

Failure to meet turnaround times according to benchmarks set for transcribed reports may affect continuity of patient care. This also impacts the ability to meet coding deadlines and increases the number of records blind coded and revisited when documents become available.

Tracked signatures on transcribed reports increases the number of physician deficiencies and time required to manage these.

Blind coding results in inadequate and incomplete data for internal and external reporting and impacts time spent coding by HIM Professionals.

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Measure

What did we measure and why?

We measured the turn around time per report, per site, and per transcriptionist to gain an understanding of possible patterns and identify which benchmarks were not met.

We also looked at the number of outstanding physician deficiencies related to missing signatures on transcribed reports (Bethesda) to determine impact of new process. A restructuring of Physician Deficiency Area was undertaken at PDGH to reduce time spent on Physician Deficiency Counts.

We calculated the % of blind coded data as well as # of outstanding charts at year-end to determine a process to reduce these challenges in the future.

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Measure

How are the measures related to the process?

The measures helped the Team understand the challenges of meeting benchmarks and the impacts on numerous other functions within the department as it related to transcription turnaround times and management of physician deficiencies.

The Team recognized that the % of blind coded data submitted results in the same % of skewed data which impacts the information used for evidence based decisions and ultimately funding.

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Analyze

What story did our measures tell us about our system?

Did the measures validate what we initially thought the problem was?

Transcription - The measurements confirmed that transcriptionists dedicated to the task had higher productivity rates. The Team recognized that sites where staff are responsible for all Health Information tasks, this is not an attainable goal. Even at regional centres, the dedicated time may be attainable only as a daily goal.

Centralization was discussed; however, with different systems in place, this was not feasible.

Discharge summaries consistently did not meet benchmark turn around times although other reports did more so than initially expected.

Analyze (cont'd)

What story did our measures tell us about our system?

Did the measures validate what we initially thought the problem was?

Physician Deficiencies – Considerable amount of time was spent counting and communicating the number of deficient records – up to 15 hours per month.

Blind coding – The Team recognized a significant concern with the # of outstanding blind coded charts at year-end with a baseline of 6.7% at BTHC, 9.3% at PDGH, and 16.9 % at Bethesda.

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Improve

What improvements did our team come up with?

- Revise queues so that when a discharge summary reaches benchmark it will automatically be assigned to staff. Begin at 96 hours and goal of 72 hour turnaround.
- Assist sites during vacation and sick relief to meet benchmarks. This process is solid in the former S. Eastman.
- Identify transcription courses available.
- Weekend transcription services
- Centralized transcription
- Review distribution requirements, i.e. to Records at Bethesda of all discharge summaries
- Review which reports are transcribed i.e. ER, IPNs at PDGH – this relates to physician practices and has not been successfully discontinued in the past!

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Improve

What improvements did our team come up with?

- Review reports requiring physician signature – Bethesda and histories at BTHC
- Reorganize to a numerical sequencing of charts to decrease time spent on Physician Deficiencies at PDGH.
- Standardize collection of Blind Coding with use of Basic Options feature instead of manual processes.
- Monitor blind coded charts on a monthly basis to reduce year-end outstanding charts and report quarterly.

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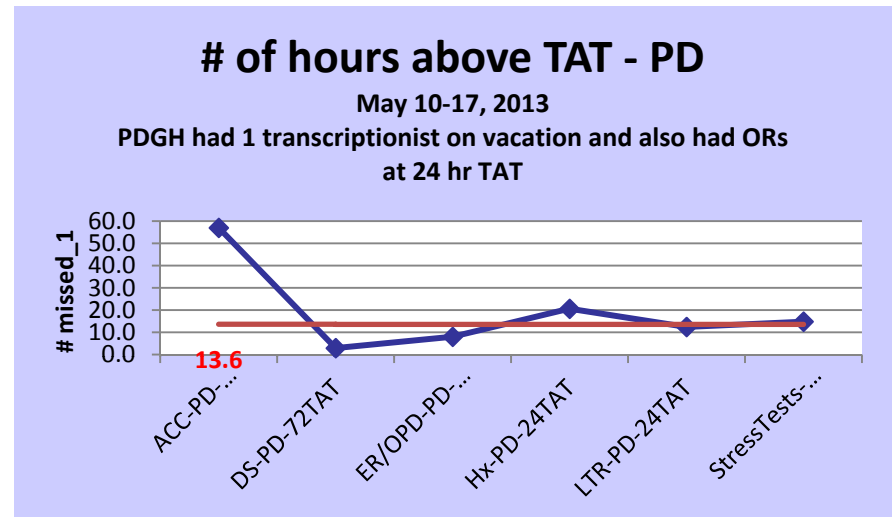
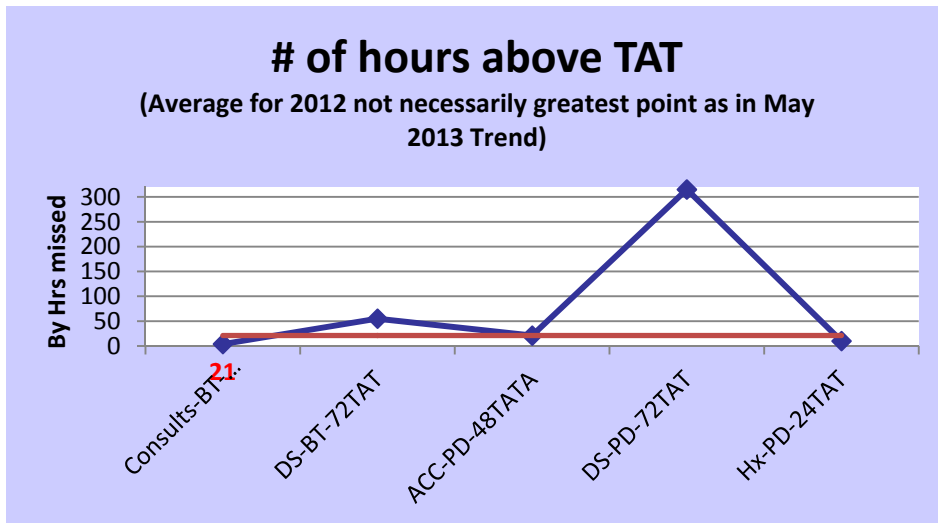
Improve

What changes were implemented:

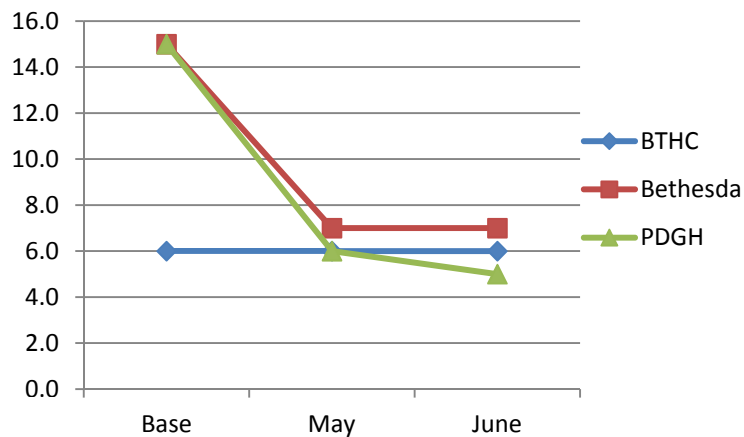
- Transcriptionist queues were revised for May 2013
- Communication for assistance during vacation and sick will occur between sites
- Review reports requiring physician signature – Bethesda and histories at BTHC
- Reorganize to a numerical sequencing of charts to decrease time spent on Physician Deficiencies at PDGH.
- Standardize collection of Blind Coding with use of Basic Options.
- Monitor blind coded charts on a monthly basis to reduce year-end outstanding charts.

Analyze

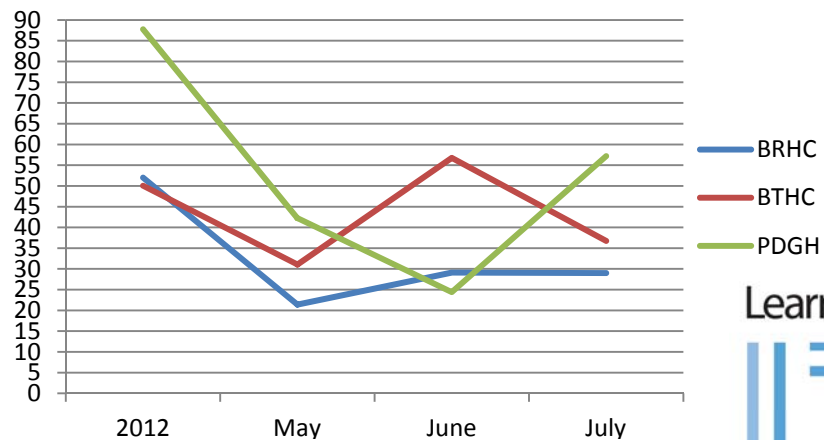
AVG Transcriptionist TAT - Range from 4.2 min of transcription per minute of dictation to 22.2, taking into account multi-tasking requirements vs dedicated time.



Time spent tabulating deficiencies



Avg Turnaround Time of all Reports



9/4/2014

Control

What controls have we put in place to ensure that performance does not lapse?

Transcription: Revisited benchmarks and changed queues - fundamental change. Continue monitoring and spread to HIM Team.

Physician deficiencies: Fundamental change eliminating signatures, and rearranging of Physician slots.

Blind coding: Standard Reporting of blind coded charts quarterly and fundamental change of using the Basic Option feature.

Lessons Learned

What were some of the key things we learned about quality improvement while doing this project?

Transcription:

Need to change culture – ‘this is the way we’ve always done it, doesn’t cut it!’ Discharge summaries DO matter!

Staff became more aware of prioritization of reports and TAT.

Did not envision staff’s time to adjust to new process – more communication on data results prior to implementation may have helped.

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Lessons Learned

What were some of the key things we learned about quality improvement while doing this project?

Physician Deficiencies:

Extensive effort required by HIS to manage these!

The impact of one physician's deficiency on another colleagues delay in timely chart completion.

Opportunity to learn alternative methods of tracking deficiencies.

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Lessons Learned

What were some of the key things we learned about quality improvement while doing this project?

Blind Coding:

Quarterly deadlines are as important as yearly and monthly!!

The impact on integrity of data used for decision support purposes.

Standardization of processes needed to occur i.e. Basic Options and Z code, to allow for accurate reporting.

Other lessons learned:

Other factors came into play that we do not have control over.

Always saw opportunity for improvement when analyzing data

Next Steps

What next QI project is our organization going to be do next?

- Spell check processes
- Client Registry Death chart identification
- Pathology reviews for Standards Committee
- Transcription and distribution of Minutes
- Standards Review
- Signatures on Lab work, EKGs
- Regional Completion of Health Records policy

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The Team!

Black Belt: Susan Enns

Team Members: Tammy Berg, Lee Bassett, Shelley Emerson, Donna Samborski

Missing from photo: Lori Forester-Smith, Teresa Avanthay



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