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# Clinical Documentation received by Referring Provider

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**Project:** *Clinical Documentation received by Referring Provider*

**Last Updated:** 10/2/18



**Executive Sponsor:** *Linda Butler*

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### Problem/Impact Statement:

At the time of follow up appointments, referring providers do not always have access to the documentation needed for continuum of care. Providers are spending time researching why their documentation was not sent. One doctor stated she feels the clinics reputation is not great in the community due to this.

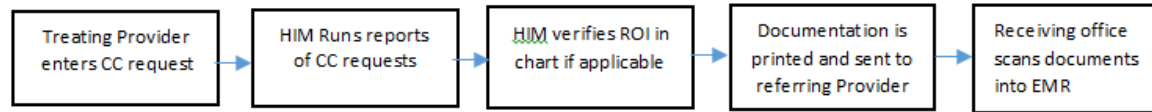
### Scope:

In Scope: Child & Adolescent Psychiatry

Out of Scope: Geriatric and Adult Psychiatry

### Goal/Objective:

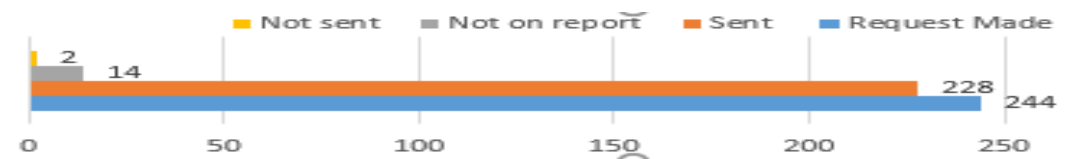
100% of the time referring Providers will have documentation at the time of appointment.



The current process for Referring Providers to receive the CC Requests.

### Baseline Metrics/Current State:

The graph below displays CC requests made. All requests on the report were sent out, requests not sent were not on the report, 2 examples were deleted by Provider for unknown reasons and not sent. A total of 6.57% were not sent.



### Root Cause Analysis:

- The KPI was created to rule out the fact that requests were not being sent due to notes not being signed, the misses were sent, just not within 48 hours stated on the KPI.
- It was discovered that the cc requests never sent did not appear on the report run by HIM department daily. This is a glitch with the EMR currently being used, the Data Analyst is working with their team to resolve.

Goal: Progress notes signed within 48hrs  
 Department: HIM Current Month: May  
 Start Date: 5-1-18 End Date: 5-31-18

AIP Strategy: Patient Centered Care  
 Driver: Communication between frontline team members

**Quality Goal**  
 100% of the time progress notes will be signed by providers within 48 hours to facilitate sending CC's in a timely manner.

Improvement Plans:  
 Notifying program directors which providers are not signing in time.

### Countermeasures

July 1, 2018 is the target date to correct all steps below. It was discovered that the only documentation not sent was documentation not on the report.

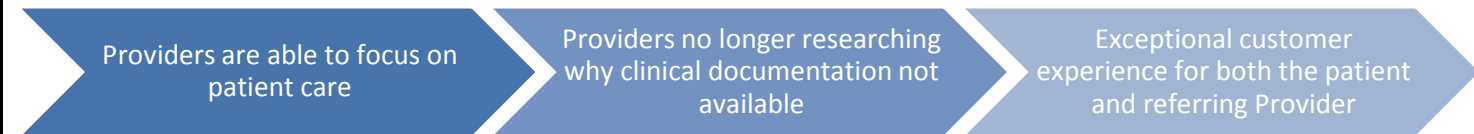
Solution Description	Root Cause Addressed	CTQ Impact	Implementation Effort	Quick Win
CC request will be entered correctly into EMR	Not all staff were trained to enter correctly resulting in not all requests being captured on report	High	High	Yes
Clinical documentation will be signed within 48 hours so CC request can be sent timely	HIM staff cannot send notes in draft, note must be final signed	High	High	Yes
Meditech report will be corrected to capture all CC requests	If signed by multiple providers the request is not showing on report	High	High	Yes
Do all staff involved with appointment need to sign the note	Notes signed by multiple providers are not pulling on the report	High	High	Yes
All Maine Health Departments will be on the same EMR	Different EMR's throughout the system delay documentation being readily available to Providers	High	Low	Yes

### Outcomes

Below is the temporary process put into place until report was corrected:



This chart displays all request made were captured on the report. The 3 requests not sent were at the Providers request, not an error.



### Next Steps

Health Information Management	Providers	Management Team
Run CC request daily, follow up all pending requests	Enter CC request correctly	Monitor staff performance
Director will inform and educate staff of all policy changes	Record and final sign all notes within policy guidelines	Educate staff on all policy and procedure changes

Plan

Do

Study

Act