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10-2-2018

Clinical Documentation received by Referring Provider

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Recommended Citation

Butler, Linda; Plourde, Julie; Fuller, Nate; Brown, Brandy; Gerwin, Roslyn; Gaudette, Alyssa; Wilbur, Cheryl; Garnsey, Rachel; and Bailinson, Jim, "Clinical Documentation received by Referring Provider" (2018). *Maine Medical Center*. 505.

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Project: *Clinical Documentation received by Referring Provider*

Last Updated: 10/2/18



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Facilitator: *Julie Plourde*



Team Members: *Nate Fuller-Data Analyst; Brandy Brown-LCSW, Gender Clinic Coordinator; Roslyn Gerwin-Child Psychiatrist; Alyssa Gaudette-HIM; Cheryl Wilbur-HIM; Rachel Garmsay-HIM Supervisor; Jim Bailinson-Maine Health Legal*

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.

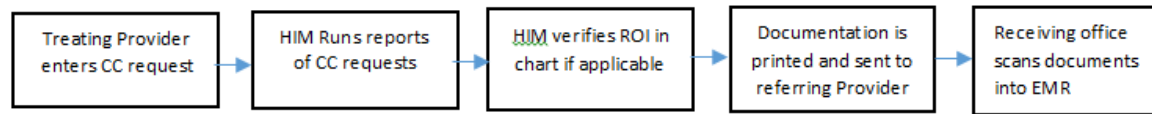
Scope:

In Scope: Child & Adolescent Psychiatry

Out of Scope: Geriatric and Adult Psychiatry

Goal/Objective:

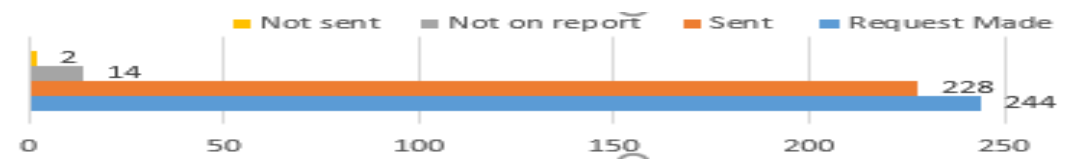
100% of the time referring Providers will have documentation at the time of appointment.



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.

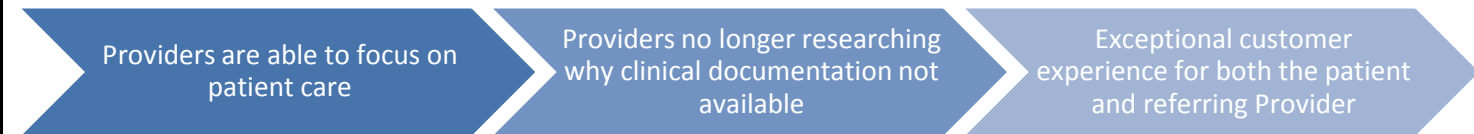
| Solution Description | Root Cause Addressed | CTQ Impact | Implementation Effort | Quick Win |
|--|--|------------|-----------------------|-----------|
| CC request will be entered correctly into EMR | Not all staff were trained to enter correctly resulting in not all requests being captured on report | 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