

APPENDIX 8

Best Practice

Improving Access to Medical Services Routine Sick Call Referrals, Chronic Care, Return from Higher Level of Care

REVIEW:

- 1 Summary tab**
Learn about results of this best practice
- 2 Plan tab – Replication Checklist**
See high – level steps to implement this at your institution
- 3 Improve and Evaluate tabs**
Get details about key changes and links to tools

SUMMARY

PLAN

IMPROVE

EVALUATE

Primary Care Domain:	Scheduling and Access to Care – Medical Services
Appropriate For:	Institutions of any mission type
Originated From:	California Institution for Women (CIW)

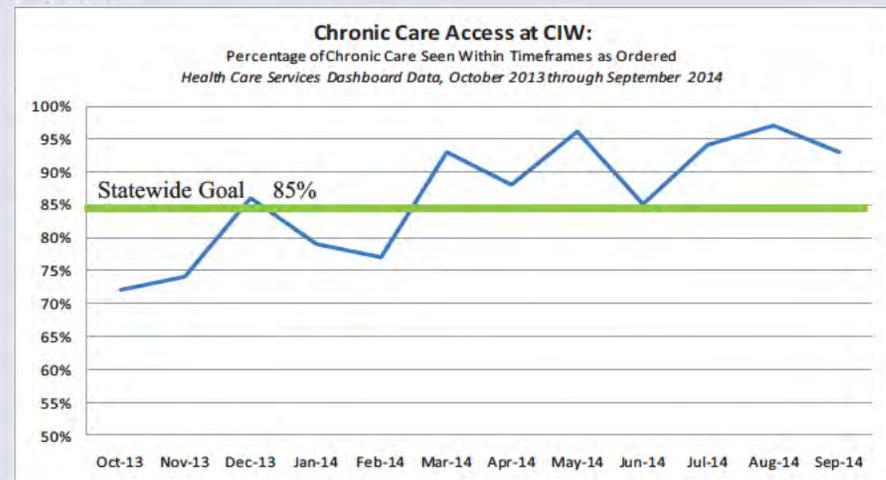
Summary

CIW improved chronic care access by more than 20 percentage points over the course of twelve months by:

1. Making scheduling improvement a major improvement priority and communicating that to staff.
2. Revamping the management structure for the scheduling program and educating staff about the new system and the tips and tools available to improve the effectiveness and efficiency of the scheduling system.
3. Conducting daily and weekly reviews to ensure that scheduling procedures are followed appropriately and providing continuous feedback to schedulers and clinicians about their adherence to procedures.
4. Addressing non-value added appointment demand and eliminating unnecessary visits.
5. Proactively managing patients with high appointment demand.
6. Monitoring progress toward institution goals on an ongoing basis.

The Evidence

- In the past twelve months, CIW has increased chronic care access scores from 72% of chronic patients receiving a visit as ordered to more than 90% receiving timely services and has been able to maintain that level of access over multiple months. Please see chart at right.
- Per September 2014 data, CIW was one of four Intermediate Institutions across the state that had achieved more than 90% in chronic care access.
- For eleven of the past twelve months, CIW scores on routine sick call and follow up after return from higher level of care measures have exceeded the statewide goal of 85%, with more than half of those scores at higher than 95%.



SUMMARY

PLAN

IMPROVE

EVALUATE



REPLICATION CHECKLIST: IMPLEMENT THIS BEST PRACTICE AT YOUR INSTITUTION

Follow these high level steps to put a scheduling model similar to CIW's in place at your institution. For more information about any particular step in this checklist and links to available tools, please see the "Improve" and "Evaluate" tabs.

PLAN

- Make medical access a PIWP project.**
 - Include a scheduling improvement initiative in your PIWP. Assign a subcommittee to "own" the project (provide monitoring and oversight) and executive staff to sponsor it. At the subcommittee level, create a step by step action plan to manage the project with major tasks, assigned staff and due dates.
- Document procedures for sustainability.**
 - Once you have a scheduling process with demonstrated positive results, make sure that you create desk procedures, flow charts, and other types of decision support that will keep the process going even if your scheduling experts are promoted or retire.

IMPROVE

- Revamp your scheduling management model as necessary.**
 - Designate a manager who will serve as the Institution's MedSATS expert and overall manager of the medical scheduling process.
 - Assign staff in each clinic site to oversee scheduling at that particular location, conduct daily and weekly reviews of the scheduling process, investigate problems, and provide continuous feedback to clinical and scheduling staff.

IMPROVE CONT.

- Educate staff about MedSATS scheduling processes.**
 - Ensure that the executive sponsors of the scheduling process (e.g., the Chief Medical Executive and Chief Nurse Executive) know in detail how MedSATS works and the tricks and tips that contribute to better access and higher accuracy. [Access Scheduling Process Improvement materials by clicking here.](#)
 - Provide initial and ongoing training for OTs.
 - Provide initial MedSATS training for all OTs. (QM Section staff can help – contact QMStaff@cdcr.ca.gov.)
 - Pair new OTs with seasoned schedulers when you have turnover in staff.
 - Provide OTs with a package of decision support materials they can keep at their desks to remind them of important information, such as access timeframes and scheduling process steps.
 - Have the scheduling managers over each health care setting give daily and weekly feedback to OTs about their adherence to MedSATS procedures.
 - Cross train OTs so that they can cover scheduling in different settings (e.g., primary care clinic and specialty clinic) as needed.
 - Train clinicians in the importance of completing closeout sheets.
 - Talk to providers about the importance of closeout sheets as a tool for accurate scheduling and show them what a complete closeout sheet looks like.

IMPROVE CONT.

- Have scheduling managers over each health care setting review a sample of closeout sheets and give feedback to providers on an ongoing basis.
- Complete the same activities in the two previous bullets for nursing staff.
- ☐ **Use MedSATS management reports on a routine basis to identify patients who need services and analyze gaps in the scheduling process.**
 - Have scheduling managers in each health care setting verify that OTs are reviewing “To be scheduled” lists daily. Each day, OTs should be looking for any patients on the “To Be Scheduled” list who do not have housing information included, using SOMS to look up and find housing for each patient, and entering it into MedSATS to ensure that the “To Be Scheduled” list is accurate and complete.
 - Use patient level data in MedSATS to investigate gaps in the scheduling process when Dashboard scores are low. Scores may be low due to data entry errors.
- ☐ **Eliminate non-value-added visits.**
 - Train physicians to make chrono determinations based on chart reviews rather than face to face visits whenever appropriate.
 - Monitor referral rates from nurses to providers and provide training and support to nurses if referrals are inappropriately high.
 - Train nurses to co consult with providers whenever possible to reduce the need for patients to return for an appointment with the provider at a later date.
 - Train schedulers to continuously review future appointments and bundle certain types of appointments.
- ☐ **Proactively manage high-demand patients.**
 - Provide individual case management for patients who repeatedly request services or are seen often.

EVALUATE

- ☐ **Review MedSATS management reports weekly to assess the efficiency of the scheduling process.**
 - Have scheduling managers in each health care setting review Aging, Unclosed Appointment, Productivity, and Compliance Reports to determine how efficient and effective the scheduling system is within that setting, and act on findings weekly.
- ☐ **Report monthly to the designated oversight committee on the progress toward scheduling performance objectives.**

Best Practice

SUMMARY

PLAN

IMPROVE

EVALUATE

Make Scheduling a Major Improvement Priority – PIWP Scheduling Initiative

Make scheduling process improvement a priority in your Performance Improvement Work Plan (PIWP).

Scheduling improved at CRC/CIW after leadership made improving medical scheduling a priority and worked together to focus on all aspects of access and scheduling. The scheduling process and access to care was an initiative on the 2014 PIWP at both CRC and CIW. The plan included detailed action steps and performance metrics.

Click on the image below to view CIW’s 2014 PIWP:

**California Institution for Women
Performance Improvement Work Plan**
Date: January 2014

Plan 1: Access to Care and Scheduling Process Improvement Project

The Statewide Process Improvement (SPI) Project includes activities to achieve accurate scheduling data and reliable performance and patient reports as well as activities to redesign the scheduling processes and improve access to care, which continue to be priorities in the Statewide Performance Improvement Plan 2013-2015 and displayed on the Dashboard. In addition, the workflow analysis and redesign required in this project will help to prepare institutions for similar activities required during implementation of the Electronic Health Record System.

During the first half of 2015, California Correctional Health Care Services (CCHCS) implemented a standardized medical scheduling system at all 34 California prisons, referred to as the Medical Scheduling and Tracking System, or MedSATS. When accurate data is entered into MedSATS, the reports that are produced can assist institutions in tracking services provided to patients and coordinating patient care. MedSATS provides information on access, business, workload and productivity efficiencies and other domains of the scheduling process, allowing institution leadership the information necessary to identify problems in the scheduling process and determine when those problems have been effectively resolved.

Plan 1A: Scheduling Process Improvement Project - Validation of MedSATS Compliance Reports

► **OHG / ACA / Audit / Policy Reference – IMSRP Volume 4, Chapter 3; IMSRP Volume 4, Chapter 4; IMSRP Volume 4, Chapter 8; IMSRP Volume 7, Chapters 1A and 1B; OHG Reference Numbers 01.025, 01.027, 02.018, 03.076, 07.035, 21.249**

Primary Care Component
 OCT Pop Sched Med HWK Resource (E)

Action Steps	Responsible	Deadline	Committee/Status
1. Convene a team of staff with subject matter expertise in different aspects of the scheduling process, including: DOM, CNE, CPKS, CNE, SRN/II's, OP's	CME	1.31.14	Complete
2. Evaluate accuracy of MedSATS scheduling at CIW to determine which processes to address first:	C P&S SRN/II's	1.31.14	Complete
◦ Review the institution's MedSATS Validation Findings and identify scheduling processes with suboptimal accuracy.		Ongoing	
◦ Review the noncompliant scheduling data from compliance reports	C P&S		

Best Practice

SUMMARY	PLAN	IMPROVE	EVALUATE
Key Change: Revamp the Scheduling Management Structure	<p>For each major scheduling process, assign a manager to oversee OT schedulers, run/review reports, and provide feedback to providers, OTs and institution leadership regarding scheduling compliance and efficiency.</p> <p>When MedSATS was being “rolled out” three staff members were sent from CIW for the training. By the time MedSATS actually started at CIW, only one of those staff members was still working in the same position – Supervising Registered Nurse II (SRN II) Paula Clark. By default, she became the MedSATS specialist at CIW, and then, because there was no OT supervisor, she took on the role of training and meeting regularly with OT schedulers, reviewing reports and providing feedback.</p> <ul style="list-style-type: none"> • Subsequently SRN II Clark trained the other SRN IIs at CIW. Each SRN II is responsible for closely monitoring a set of access measures related to their area: <ul style="list-style-type: none"> ○ Primary Care Clinics: Face-to-Face Triage, nursing referral to Primary Care Provider (PCP), episodic (sick call) and chronic care visits ○ Specialty Scheduling: Routine and high priority specialty referrals and associated follow-up appointments ○ Follow-up Upon Discharge from Higher Level of Care 		
Key Change: Educate Staff about the Medical Scheduling Processes – Executives	<p>Help your medical and nursing leadership become actively involved and knowledgeable regarding scheduling processes/MedSATS.</p> <p>Scheduling improved at CRC/CIW after leadership made improving medical scheduling a priority and worked together to focus on all aspects of access and scheduling.</p> <ul style="list-style-type: none"> • Scheduling/Access was an initiative on the PIWP at both CRC and CIW. • The CME became very engaged in the project. It became clear to him and other Institution leaders that they needed to use MedSATS as it was designed, so that they could then use it as a reporting tool. At that point, they invested in actually learning the system and the nuances of MedSATS in order to schedule appropriately. • The CME finds it crucial that both nursing and medical leadership are intricately involved in MedSATS and that they review the various scheduling management reports on a regular basis. Unless the leadership is engaged, they cannot understand how inappropriate scheduling can affect the institution’s ability to meet compliance mandates and ensure patients are seen as medically appropriate. 		<p style="text-align: center;">Tools</p> <p style="text-align: center;"><u>Scheduling Process Improvement Initiative Page</u> <u>QM Portal</u></p> <div style="border: 1px solid gray; padding: 5px; margin-top: 10px;"> <p><i>CME noted that all the “tricks” and best practices they use are actually in the MedSATS decision support documents found on the QM Portal. (He said they had to just actually read and follow it).</i></p> </div>
Key Change: Educate Staff about the Medical	<p>Provide intensive, ongoing training to OT staff.</p> <p>Initially, the OTs received MedSATS training in a big class, using training materials provided by the MedSATS development team. Later, for the Scheduling Improvement Initiative, SRN IIs held additional training, meeting monthly for over 4 months.</p>		<p style="text-align: center;"></p> <p style="text-align: center;">Want help training schedulers? Contact the QM Section for</p>

Scheduling Processes – Training and Mentoring for OTs

- In one meeting, they quickly reviewed most of the tip sheets on how to schedule specific appointments (found on the Scheduling Process Improvement (SPI) site), because by then the OTs were fairly well versed in scheduling appointments.
- In the following meetings, they looked at other tools from the SPI site, including various reports such as the Compliance Reports, Aging Report, and To Be Scheduled Reports.
 - SRN IIs would bring examples of patients who were out of compliance and show the OTs where the error occurred, especially focusing on recurrent themes such as the issue of duplicate appointment “trees” being created.
- The SRN IIs reviewed the most recent MedSATS updates document and noted specifically some of the changes and the problem areas at CIW. They trained schedulers on those using real examples such as the creation of duplicate trees. They developed a specific process to eliminate one of the trees by closing the appointment with "scheduling error".

There is an extremely high rate of turnover in this position so processes were developed to train new OTs as they come on board.

- When a new OT starts they are paired with a seasoned and well-trained OT.
- They are provided materials from the scheduling process improvement website including the OIG timeframe requirements.
- They are also taught what to do if a provider calls in sick. Specifically, OTs learn which patients are able to be rescheduled without discussion and which need to be elevated to the Chief Physician and Surgeon to arrange for another provider to see the patient, especially if the patient’s appointment is about to be out of compliance.

CIW feels it is critical to cross-train the scheduling OTs. Once an OT is trained and comfortable in one area, such as Primary Care Clinic, they may be transferred to learn to schedule nursing lines and then Specialty Clinic, so that they are able to schedule in any area if they are needed to fill-in in the future.

assistance at QMStaff@cdcr.ca.gov. QM can visit your institution or provide training on MedSATS via webinar.

OT Training Materials:
[MedSATS Scheduling Process Guides](#)

[General Scheduling Process](#)

[Closing Appointments Reasons Not Seen](#)

[Guide to MedSATS Reports](#)

[Table of required access timeframes](#)

Key Change: Educate Staff about the Medical Scheduling Processes – Clinicians and Closeout Sheets

Work with providers and nurses to ensure that they use the Closeout Sheets.

At CIW, the primary care providers needed to be involved with scheduling. Specifically, they needed to personally complete the closeout sheets to directly communicate with and provide clear direction to schedulers.

- Initially, CIW providers did not want to use closeout sheet.
 - Several meetings were held with the CME, providers, and schedulers to engage the providers in the scheduling process and show them the importance of the closeout sheet. During these meetings, examples of appointments or follow-ups that did not occur due to the lack of a Closeout Sheet or an incomplete Closeout Sheet were presented and discussed.
 - Providers are required to complete a blank closeout sheet for add-ons and same-day appointments and provide this information to schedulers at the end of each shift.

Tools

[Blank PCP Closeout Sheet](#)

	<ul style="list-style-type: none"> • In addition, SRN IIs managing different clinics communicated to the providers that it is their responsibility to complete these closeouts. The SRN IIs indicated that there were legal implications to not completing the closeout sheets such that if proper follow-up did not occur because a closeout sheet was not completed then it would be the provider's responsibility. • CIW found that 80% of providers adopted this new process and that it has improved scheduling efficiency quite a bit. • There are a few providers who still want nurses to complete the closeout sheets. The SRN IIs allow this but require that after a closeout sheet is completed by the nurse, the provider must review it and sign it to confirm that it is accurate. • Nurses were instructed to complete the closeout sheets for their encounters as completely and accurately as possible. It was emphasized that the schedulers do not have medical knowledge and can only implement the exact orders requested by the RN/Provider. 	
<p>Key Change: Conduct Daily and Weekly Reviews of Scheduling Data and Give Feedback to Staff</p>	<p>Review "To be scheduled" lists daily. SRN IIs ensure that clinic schedulers open the "To be scheduled" list in MedSATS to see if there are any patients who have an appointment created without a location attached. This is every scheduler's job to complete each morning. If a "To be scheduled" appointment is listed and no location for the patient is found, the scheduler looks the patient up in SOMS and enters the location for the appointment. After this is completed the schedulers can then sort and pull up all the "To be scheduled" appointments.</p> <p>Use MedSATS and Dashboard patient-level data to identify and address barriers to timely access. CIW looked at weak points in their scheduling system and focused there. For example, they would look at the follow-up after an urgent specialty appointment and analyze why that score was low. They would take each case that fell out of compliance and determine the reason for it.</p> <ul style="list-style-type: none"> • Many times they found a small process issue which needed to be changed and they changed it. • Other times they found that the scheduling had actually occurred correctly, however, it had not been documented correctly in MedSATS and therefore no credit was given. 	<p>Tools</p> <p>How to Get to Select MedSATS Reports</p> <p>MedSATS Compliance Report Sample</p> <p>MedSATS Aging Report Sample</p> <p>MedSATS To Be Scheduled Report Sample</p>
<p>Key Change: Eliminate Unnecessary Visits</p>	<p>Address non-value-added demand by eliminating unnecessary visits. CIW eliminated appointments that were administrative in nature and did not require face-to-face visit. The CME worked with providers to determine which "administrative" types of requests could be completed without a face-to-face visit.</p> <ul style="list-style-type: none"> • When a request for a Chrono renewal was received, schedulers did not book a face-to-face appointment with provider, but had this request completed by the provider with only a chart review whenever possible. <p>CIW limited the provision of medically unnecessary appliance/Durable Medical Equipment (DME) equipment that would then drive future unnecessary appointments for renewal, ensuring that providers provide DME only when it was medically indicated and used the new DME policy for guidance.</p>	

- Doing this cut down future follow-up appointments. CIW staff acknowledges that it is hard to say “no” to patients when the request is not medically indicated, but providers all need to practice consistently following the medical necessity criteria.
- CIW staff learned from a pilot in a Special Needs Yard at CRC. The CME worked with a particular provider to ensure that all low bunk chronos, canes, and other items were actually medically necessary. It took several months, but the provider was able to work with each patient and consistently apply the criteria for medical necessity, and the demand for access in that yard decreased significantly without decreasing appropriate medical care.

Monitor nursing referral rates.

CIW monitored nursing referrals to PCPs to decrease or eliminate unnecessary PCP visits stemming from the face-to-face triage process. SRN IIs worked intensively with clinic RNs to ensure that patients were appropriately referred to the physician when needed and were managed solely by nursing protocol or with co-consultation when that was more appropriate. Clinic RNs have various comfort and skill levels with managing patients on their own and the SRN IIs worked at educating each nurse and ensuring that they are working to the full extent of their capacity and license. The goal is to refer only those patients who need a follow-up at a future time or have ongoing complex issues that cannot be managed with a “same-day” co-consultation.

Review future appointments for patients continuously and bundle appointments as appropriate.

CIW found that actively managing the scheduling system includes always looking at future appointments before booking another appointment, and bundling appointments as much as possible. Looking at future appointments is critical to prevent duplicate appointments and to give the provider proper "credit" for appointments provided and to ensure that documentation in MedSATS is accurate.

**Key Change:
Proactive
Management
of High
Utilizers**

Pro-actively manage high-utilizers.

At each daily huddle, the CIW team discussed TTA patients, hospital discharges, OHU patients, and Provider and RN clinic lists for the day. The team identified patients who were frequent utilizers and tried to case manage those patients. SRN IIs educated some of these patients and brought them to the clinic to determine if there were additional concerns, such as an undiagnosed mental illness that contributes to the patient frequently accessing the clinic when no specific identified medical problems were being addressed.

Best Practice

SUMMARY

PLAN

IMPROVE

EVALUATE

Monitor Progress Toward Institution Goals: Weekly Monitoring by SRN II

Unclosed Appointments.

SRN IIs review the Aging Report in MedSATS at least weekly and page through it, noting any locations/clinics that have past appointments which have not been closed. If there are areas that have open appointments, this list is printed and forwarded to the responsible OT(s).

Timely Access by Clinic Area.

Each SRN II looks at the Compliance Report for their area weekly and in real-time to determine:

- If appointments are past due and not yet closed.
- If any appointments are approaching their compliance date and have not yet been scheduled. For example, the Primary Care Clinic SRN II will look at face-to-face triage, urgent and routine referral from face-to-face to provider, and PCP and CCP appointment compliance. In each case, the SRN II will contact the involved scheduler and make sure that the required action occurs timely. CIW staff feel active monitoring of the clinic schedule is crucial to providing sustained and timely feedback and believes it has dramatically improved OT performance and timeliness.

Productivity.

SRN IIs review the MedSATS management reports, including the productivity reports for both nurses and providers. If there is a major discrepancy in the amount of patients being seen by certain individuals the SRN II will follow-up to determine whether the current assignment is appropriate for that staff member and will work with the provider/nurse/leadership to be sure that the most efficient work is being done.

Monitor Progress Toward Institution Goals: QM Committee Oversight and Data Investigation

Report performance data to oversight committees monthly.

CIW SRN IIs report access data at the monthly primary care meeting. The Health Care Services Dashboard is reviewed, and if there are any scores showing less than 95%, the involved SRN II will analyze and research each case where non-compliance was found by looking at the reason the patient was not seen according to MedSATS and then comparing this with what is in the eUHR.

- Oftentimes the SRN II will determine that the patient was indeed seen in a timely manner but it was not documented or closed correctly within MedSATS, and therefore the institution did not get credit for their work.
- The SRN II will determine if the lack of reported compliance is a process problem and, if so, will make adjustments to the process.
- If the error resulted from a staff member needing more training, then an in-service will be done and if the problem continues to be an issue additional support is provided.

SRN IIs also report monthly to the Medical Management Committee meeting.

[How to Use the Dashboard Trended View for Scheduling Data](#)

[Dashboard Measures: Medical Access Specifications](#)

Best Practice

Improving Effective Communication

REVIEW:

- 1 **The Summary**
Learn about results of this best practice
- 2 **The Replication Checklist**
See high – level steps to implement this at your institution
- 3 **The “Improve” and “Evaluate” Sections**
Get details about key changes and links to tools

SUMMARY

PLAN

IMPROVE

EVALUATE

Primary Care Domain:	Mental Health
Appropriate For:	All Mental Health Staff
Originated From:	Richard J. Donovan Correctional Facility

Summary

Richard J. Donovan Correctional Facility (RJD) was recognized for its efforts in meeting and maintaining benchmarks in Effective Communication (EC) by the Statewide Mental Health Quality Management Committee. Statewide comparison showed most institutions were struggling in this area. RJD was invited to share its Best Practices process for conducting, documenting and entering EC data into the Mental Health Tracking System (MHTS). It accomplished this goal by doing the following:

1. Increased awareness to staff
2. Highlighted justification for documentation
3. Provision of a step by step process for:
 - a. Utilizing approved CDCR documents
 - b. Audit/Review
 - c. Trending/Monitoring
 - d. Resolution
 - e. Feedback Loop
 - f. Continuous Review and Improvement

The Evidence

Performance Report numbers on Effective Communication at all institutions for the period of February thru November 2014 show the state average to be 86%. RJD has met and maintained a higher overall average of 99%. The patient group covered by this measure includes all Clark/Armstrong class members meeting criteria for hearing impairment, visual impairment, speech impairment, DDP Level 1, 2 or 3 and/or TABE score of 4.0 or less.



Best Practice

SUMMARY

PLAN

IMPROVE

EVALUATE



REPLICATION CHECKLIST: IMPLEMENT THIS BEST PRACTICE AT YOUR INSTITUTION

Follow these high level steps to meet and maintain compliance for EC similar to what RJD uses at your institution. For more information about any particular step in this checklist and links to available tools, please see the "Improve" and "Evaluate" information in the remaining pages of this document.

PLAN

- Facilitate staff discussions of requirements and expectations.
 - Meetings with Senior Psychologist, Supervisor, Specialist, Office Technician Supervisor, Office Technician and other staff.
 - Explain the clinical importance of EC in addition to audit result numbers and mandates.
 - Highlight importance to leadership for distribution to line staff.

IMPROVE

- Establish requirements for use of current/revised documents.

EVALUATE

- Routinely pull and audit document samples
 - Medical Records audit/log prior to scanning and reject all incomplete forms.
 - Armstrong audit/log.
 - Agreement audit
 - Tracking Rejection audit/log

Best Practice

SUMMARY	PLAN	IMPROVE	EVALUATE
Key Change: Office Technician review of documents	Use current CDCR Form 7230 Interdisciplinary Progress Note and tracking (activity log) to document encounter. Forward tracking to Office Technician (OT) for entry into MHTS. Office Technicians triage and reject documents with missing, incomplete or mismatched information. <ul style="list-style-type: none"> RJD identified mental health documents that required the EC sticker and focused training and auditing on those documents. RJD staff recommend that every discipline identify the encounters and documentation types that must meet EC requirements – staff may not be aware of all of the work they do that involves EC, and raising this awareness not only helps supervisors to more effectively focus their training and auditing efforts, but helps staff to better understand what activities are considered patient communication activities. 		Tools
Key Change: Tracking returned documents	Errors are logged for Inmate Patient (I/P) CDCR#, date, appointment type, provider, program, supervisor and error type. A copy of the entry is scanned in the OT tracking folder on the shared drive to ensure no loss of data. <ul style="list-style-type: none"> RJD created a unit of staff to compile, analyze, and report performance data. The group designed reports for the EC process that gave supervisors the right amount of information to correct problems in the EC process and support staff who weren't yet meeting program standards. By reporting performance at the provider level, RJD was able to identify providers who had a pattern of not following EC requirements. Those providers were given more intensive training on EC and monitored closely to ensure that they understand what was expected of them and put it into practice. Prior to the provider specific reports, RJD managers trained all staff repeatedly on the same EC concepts when they found deficiencies, without a significant impact on performance. Being able to be specific about each individual's performance made a big difference in assigning accountability, making training messages more targeted and effective, and motivating people to change behavior. 		
Key Change: Provider response	Document is returned to provider, supervisor is notified. Upon rejection provider reviews note for EC information, completes tracking and returns document to OT by COB.		

Best Practice

SUMMARY	PLAN	IMPROVE	EVALUATE
<p>Local Committee discussion</p> <p>Corrective Actions</p>	<p>Trend Log data and Monitor reports: Quality Management/data unit monitors progress on MHTS Performance Report and trends data log for monthly and cumulative totals by provider, program, and supervisor.</p> <p>Report is sent to supervisor if continued problem with program or provider. Outline steps in OJT, corrective feedback, progressive discipline if not remediated. Remind supervisor to follow steps and mirror management response. If supervisor does not take appropriate action provide first step of OJT to supervisor and begin corrective feedback.</p>		<p>Tools</p>

Best Practice

Improving Availability of Dental Documentation

REVIEW:

- 1 **The Summary**
Learn about results of this best practice
- 2 **The Replication Checklist**
See high - level steps to implement this at your institution
- 3 **The "Improve" and "Evaluate" Sections**
Get details about key changes and links to tools

SUMMARY

PLAN

IMPROVE

EVALUATE

Primary Care Domain:	Health Information Management – Non-Dictated Dental Records
Appropriate For:	Institutions of any mission
Originated From:	California Institution for Women (CIW) and California Rehabilitation Center (CRC)

Summary

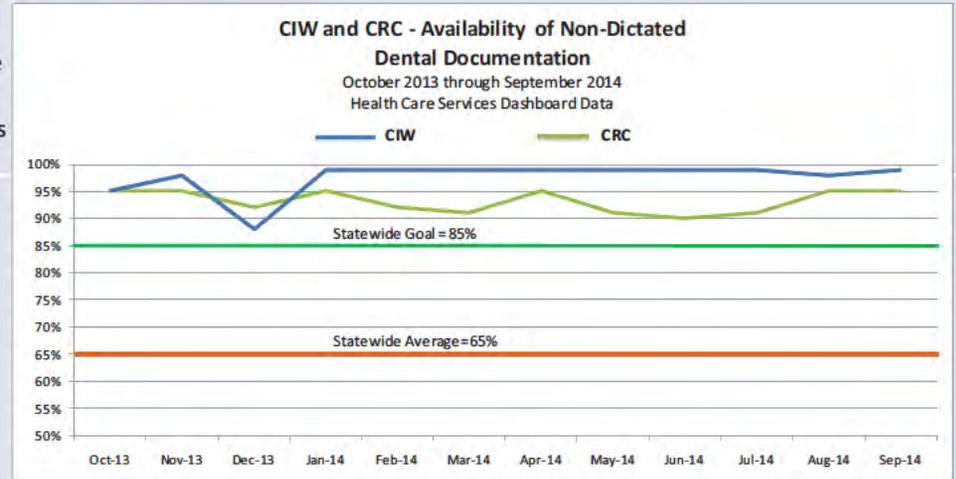
CIW and CRC used several strategies to achieve excellent performance in the availability of dental records, including:

- Making health information management a priority at both locations.
- Developing strong relationships between the Dental Program and Health Records and members of the dental team.
- Requiring Dental Program staff to submit documentation on the same day as the associated patient encounter and that document deficiencies be addressed within one business day of notification by dental staff auditing dental documentation or Health Records staff.
- Making multiple runs to collect documentation from dental clinics throughout the day.
- Having at least two sets of eyes review the documents, prior to the documents leaving the clinic, for any errors or missed documentation.
- Closely monitoring health information processes through the Dental Subcommittee and local QMC.
- Continuing to check on the quality of new processes and adherence to expectations even after performance goals are reached.

The Evidence

Both CIW and CRC have achieved and sustained excellent performance in the availability of dental records over the past year.

- From October 2013 through September 2014, CIW was able to submit internally-generated, non-dictated dental documents within 3 calendar days 98% of the time, on average; CRC's average was 93%. Please see chart at right.
- These two institutions beat the statewide average for the same twelve-month time period by nearly 30 percentage points. Please see chart at right.
- As of September 2014, CIW had achieved the highest score in the state in this metric. CRC tied with CCI for second highest.





REPLICATION CHECKLIST: IMPLEMENT THIS BEST PRACTICE AT YOUR INSTITUTION

Follow these high level steps to put in place a health information management model similar to what CIW/CRC uses at your institution. For more information about any particular step in this checklist and links to available tools, please see the "Improve" and "Evaluate" information in the remaining pages of this document.

PLAN

- Make health information management a priority in your PIWP and the focus at Subcommittee meetings, QMC, trainings, staff meetings, etc.

IMPROVE

- Develop strong relationships between the Dental Program and Health Records and members of the dental team to support improvements in health information management
- Require Dental Program staff to submit documentation on the same day as the associated patient encounter.
- Require that document deficiencies be addressed within one business day of notification by dental staff auditing dental documentation or Health Records staff.
- Make multiple runs to collect documentation from dental clinics throughout the day.
- Have at least two sets of eyes review the documents, prior to the documents leaving the clinic, for any errors or missed documentation.
- Provide Supervising Dentist and Health Program Manager III with information about documents that are incomplete or otherwise deficient so they can ensure that documents are quickly completed or corrected and resubmitted. In the event that any documentation needs to be returned to the clinic, have the Supervising Dentist ensure that it gets corrected and sent back to scanning the same day.

IMPROVE CONT.

- Provide initial training for dental program staff on documentation requirements and required timeframes for submission and correction of documents, and have Office Technicians (OTs) and Dental Assistants continuously work with staff to help them follow the new process/requirements.
- Once you have hit program goals, continue to check on the quality of new processes and adherence to expectations.

EVALUATE

- Make health information management a standing agenda item at Quality Management Committee (QMC), other leadership team meetings, and discuss the initiative and progress to date at staff meetings.

SUMMARY	PLAN	IMPROVE	EVALUATE
<p>Key Change: Strong Relationships Between Program Areas and Within the Dental Team</p>	<p>Develop strong relationships between the Dental Program and Health Records and members of the dental team to support improvements in health information management. CIW and CRC built relationships between programs and team members as a foundation to their improvement project.</p> <ul style="list-style-type: none"> • CRC's Health Program Manager III (HPM III) met with the Correctional Healthcare Services Administrator I (CHSA I) who oversees the Health Records Program to begin collaboration between the two programs on improving dental records access. Then the HPM III met with the Health Records Technician II to get a detailed understanding of how health records are processed. • Dental team members were assigned specific roles and responsibilities in the process of generating, reviewing, correcting, and submitting dental records. Dental leadership orchestrated meetings between dental team members so that they could understand each other's roles in the process and how they needed to help each other in order to reach their common goal. During monthly staff meetings, those roles were revisited and coordination issues between team members addressed. 		
<p>Key Change: Same-Day Submission</p>	<p>Require clinical staff to submit documentation on the same day as the associated patient encounter. CIW/CRC dental facilities issued a mandate that clinicians must submit documentation by close of business on the same day of the encounter.</p>		
<p>Key Change: Follow Up On Document Deficiencies within 1 Business Day</p>	<p>Require that document deficiencies be addressed within one business day of notification by dental staff auditing dental documentation or Health Records staff (and get the Supervising Dentist involved to make this happen). CRC and CIW issued the expectation to all dental staff that deficiencies must be followed up with in one business day. The Supervising Dentist sends the corrected documentation back to Health Records, which enables the Supervising Dentist to be aware of pervasive documentation issues or clinicians that may need individual reminders of standards. The HPM III is also provided with information about document deficiencies so he can assist with timely follow up.</p>		
<p>Key Change: Multiple Clinic Runs by Health Records</p>	<p>Make multiple runs to collect documentation from dental clinics throughout the day. CIW/CRC Health Records Staff make it easy for dental staff to submit documents timely by making multiple daily runs from the clinic areas to Health Records. Initially, Health Records staff made frequent runs to only medical and mental health clinics to pick up documentation. Health Records agreed to add dental clinics as stops on these frequent runs, and Dental Program staff worked with their dental teams to make sure that dental documents were</p>		

	<p>prepared for pick up during scheduled times. Schedule for clinic runs:</p> <ul style="list-style-type: none"> Health Records Technicians go to yard clinics at approx 8:30 AM, 11 AM, and 2 PM to pick up documents. This schedule makes it easy for any deficient documentation to be returned to the clinic for same day for correction. 	
<p>Key Change: Constant Follow Up on Training</p>	<p>Provide initial training for dental program staff on documentation requirements and required timeframes for submission and correction of documents, and have Office Technicians (OTs) and Dental Assistants continuously work with staff to help them follow the new process/requirements. At CIW and CRC, OTs and Dental Assistants are well versed in the health information management process and help to educate other dental staff on documentation requirements, actions that need to be taken to meet requirements, and timeframes that must be met.</p>	<p>HIM Training Materials for Dental Staff: Policy References</p>
<p>Key Change: Using Monthly Staff Meetings to Reinforce Desired Behavior Change</p>	<p>During routine Dental Program staff meetings, review the required elements for dental documentation and some of the problems that can result in returning documentation, and the requirements for daily submission of documents. CRC and CIW used Dental Program staff meetings to provide targeted training on appropriate documentation to reduce the number of documents that were kicked back by Dental Assistant staff or Health Records (which can easily result in exceeding required timeframes), reminding staff of messages they had received in previous training sessions.</p> <ul style="list-style-type: none"> The Dental HPM III conducted monthly audits of dental patients seen that month to assess accuracy of dental documentation and presented findings at monthly staff meetings. Dental Program staff were regularly advised of the progress to date on the health information management initiative – what was going well, and what still needed work. 	
<p>Key Change: Ongoing Monitoring and Messaging for Sustainability</p>	<p>Once you have hit program goals, continue to check on the quality of new processes and adherence to expectations. The CIW/CRC Dental Management Team continues to provide updates and training to their staff on regular basis to ensure that the quality of health information management remains a focus for staff.</p> <ul style="list-style-type: none"> The HPM III continues to conduct monthly “spot checks” of dental documentation, using a ducat sheet that notes all patients seen to select a group of patients for auditing. He looks at accurate placement in the eUHR, timeliness of record submission, and other documentation quality issues. Regional Dental Program Support Team members help to monitor performance in this area, and the QMC and Dental Subcommittee continue to review performance trends in this and other Dashboard measures. 	<p>Sample Ducat/Document Lists for Monthly Audits</p>

Best Practice

SUMMARY	PLAN	IMPROVE	EVALUATE
<p>Executive Team and QMC Monitoring and Feedback</p>	<p>Make health information management a standing agenda item at Quality Management Committee (QMC) and other leadership team meetings, and discuss the initiative and progress to date at staff meetings. Once CIW/CRC decided that timely health information was going to be a major Quality Improvement priority for the institution, it became a regular focus at executive team meetings and monthly Quality Management Committee (QMC) sessions. At nearly every meeting, institution leaders reviewed the institution’s performance on the Health Information Management performance measures and other Dashboard 4.0 measures in detail and made plans to improve performance.</p> <ul style="list-style-type: none"> • The QMC provided oversight for the duration of the project. Even after CIW and CRC achieved their performance goal, the QMC continued to monitor the sustainability of the improvement. • The Dental Program Subcommittee conducted detailed investigation into the barriers to timely submission of dental documentation. The subcommittee defined the problem, measuring areas of deficiency in the process, and then worked on the process and monitored outcomes until desired results were achieved. • Quality Improvement Teams (QIT) worked on parts of this project. For example, after the roll out of the eUHR, there was a high volume of returned documents due to incomplete or inadequate documentation at CIW and CRC. An interdisciplinary QIT worked to improve performance in this area, which ultimately helped the dental documentation project. 		<p>Tools</p> <p>How to download trended HIM information</p> <p>Reporting template for oversight committees</p>