Changes for the Better: Implementing Four Best Practices

by Cynthia Doyon, RRA, Kim Thompson, RRA, and Lori Meottel

Best practices don't have to be expensive or difficult. Sometimes changing a process for the better simply means looking at it from a new angle. Here's how one hospital staff collaborated on simple changes that made a difference.

When it comes to reengineering processes, success is rarely the product of one person's effort. When our department set about improving the way we worked, we found that the process of change was a group process—involving HIM staff, nurses, physicians, and other facility employees. By working cooperatively, doing our homework, and monitoring our progress, we successfully implemented four "best practices" in our facility. Here's how we did it.

Valley Presbyterian Hospital is a 347-bed, nonprofit acute care facility in Van Nuys, CA. The hospital houses specialty care units including skilled nursing, acute rehabilitation, pediatric intensive care, and newborn intensive care. The facility has a cardiac surgery and rehabilitation program and one of the largest and busiest birthing centers in the San Fernando Valley. Today, the medical record services department (MR Services) has 29 full-time equivalents, including 5.5 transcriptionists. 4.23 FTEs are involved with the discharged patient record retrieval and assembly/analysis processes discussed in this article. When these functions were reengineered in 1991-92, Monica Pappas, RRA, was director of the department.

MR Services had been receiving complaints from both administration and physicians, so the department's management team knew that changes had to be made to improve overall practices within the department. The department was not meeting the needs of its customers—administrators, physicians, or patients. Days in accounts receivable due to outstanding coding were high; physicians were not completing their records in a timely manner; record control was virtually nonexistent; delinquent chart count was high; and the Joint Commission on Accreditation of Healthcare Organizations was coming in several months. To fix the problems, the managers realized process reengineering was necessary.

The group conducted an analysis of the areas receiving the most complaints. Part of this analysis included a survey of the medical staff's satisfaction with the department. Guided by the analysis results and survey recommendations, we conducted a literature search and drew on previous experience at other facilities. Using the results of the review and the research, the management team was able to identify priority areas to be addressed.

Four functions and processes that needed improvement were identified. They were:

- transmittal of readmitted patients records to the nursing units
- medical record number verification
- discharged patient record retrieval
- universal chart order

Making the Changes

We found that the existing procedure to deliver readmitted patient records to the nursing units lacked both timeliness and accountability. One person described the old procedure as "cumbersome." The department would wait for calls from the nursing units, with no follow-up monitoring to ensure that all charts were received in a timely manner.

MR Services worked with the information systems department to create a notification sheet that would print automatically in the department to alert staff of new admissions. The newly designed admission notification system enables HIM personnel to proactively provide information. Staff members now check this printer routinely (every 10-15 minutes) according to a rotating schedule. The notification sheets are removed from the printer, and a folder is prepared for new patients or the existing record is retrieved for recurring patients. Records are then signed out in the chart tracking system and delivered to the nursing unit,

often by volunteers. This has eliminated many of the phone calls the department received from the nursing units—and reduced the number of physicians who had to wait for patient records. We had found a way to provide timely patient care information to healthcare practitioners.

The next process reengineering target was medical record number verification. Preliminary analysis of the existing procedure revealed that this process actually occurred at the time of discharge. Duplicate medical record numbers were researched post-discharge or when a complaint was received from a physician or another department. We again joined forces with the information systems department to create a duplicate medical record number report. The redesigned procedure mandates that this report be checked on a regular basis. We also worked with admitting/registration staff to develop a legal name policy that helps the registration clerks understand how patient names should be consistently entered into the computer system. With these combined efforts, MR Services decreased the number of duplicate medical record numbers significantly, increasing customer satisfaction and reducing risk and quality management issues.

The next process to be reorganized was discharged patient record retrieval from nursing units. The existing system did not include a tracking mechanism to account for all discharges. Records were regularly not ready for pickup, and dividers were frequently taken out, leaving record documentation disorganized. MR Services staff spent too much time unnecessarily reorganizing the record.

Department management worked with nursing administration staff to improve this process. We determined a chart pickup time that met both departments' needs. We also purchased new chart dividers and placed them on all nursing units to maintain an organized and consistent chart order. We now use a discharge list generated by the information system when retrieving charts from nursing units. Retrieved records are verified and documented. New folders are prepared prior to pickup so discharges can be directly placed into the folder upon retrieval. Previous records sent to the nursing unit are also retrieved at this time. "This process has been streamlined to meet the needs of both departments and because of this, records are picked up in a timely, orderly fashion," MR Services office coordinator Ana Hazuka reports. In addition, nurse managers are alerted when records are not available for retrieval. There is daily written communication regarding any missing record until it is received in the department. We also monitor, on an ongoing basis, nursing units that have significant problems.

Another significant change was the implementation of a universal chart order. Previously, chart order differed between nursing units. Post-discharge, MR Services staff would rearrange the chart, putting all pages in chronological order. In the new process, the dividers remain in the discharged patient record when it is picked up. This way, when the chart is taken out of the binder, all contents are in reverse chronological order upon retrieval. The charts remain this way throughout the reduced assembly process in MR Services, with minimal reorganization of the actual divider sections. We determined appropriate headings and colors for the dividers and purchased them. As a result of these changes, when records are retrieved from nursing units, the record is organized and consistent from unit to unit. The dividers are recycled after being checked to see that none are missing and that they are in the correct order. They are placed back on the nursing units each day by MR Services staff responsible for discharged patient record retrieval.

Bumps in the Road

During our process redesign, the two changes that required the most training were the new dividers and the chart order on nursing units. Department managers met with nursing and ancillary department staff to discuss the implementation process and answer questions. We also tested all new procedures before implementation. We conducted training for department employees on the universal chart order and on the importance of providing records in a timely manner to the units. After the training and testing had been completed, the processes were fully implemented. During the implementation process, follow-up took place regularly with physicians, MR Services staff, and nursing and ancillary department staff. Ongoing monitoring continues, especially when a new manager or unit clerk joins a nursing unit.

Even though training was conducted prior to and during implementation, there were, inevitably, some obstacles. To varying degrees, all parties felt some resistance to the new processes. When using the new colored dividers, for example, clinicians and staff would change the dividers around, placing them in their "old" chart locations. Others would cross out the divider name and add their own. Getting used to the new system was especially challenging for staff who did not work regularly in either the nursing and ancillary departments. But for others, such as nurses in who worked on a variety of units, the change was positive, since the chart order was now consistent between nursing units.

The first key to the success of the education process was demonstrating how the new processes would make things easier for all those involved. Another key to success was using written procedures as reference tools for all the departments affected by the changes. Third, compromise was certainly a key to success. MR Services coding staff initially struggled with the reverse chronological order but understood the impact on productivity related to reshuffling chart documentation.

Since cost is always an issue for HIM departments, it had to be considered at the beginning of the process. Preliminary cost analysis determined, however, that the implementation of these best practices would incur few significant costs, with the exception of new divider sets. The nursing and MR Services departments agreed to share the expense, and nursing also agreed to purchase any necessary replacements.

The benefits gained by the implementation of these best practices were well worth the small additional cost. We no longer have a problem with duplicate medical record numbers. Recently discharged patient records are available for physicians in a timely manner. Furthermore, the department is always in compliance with state and Joint Commission mandates for chart completion time frames, and the facility has received high marks in this area during recent Joint Commission surveys as a result. The changes have brought improved medical staff satisfaction as well. Physicians appreciate that the chart order is now standardized from unit to unit and that they now can easily find what they need in a patient's record. In addition, because patient records are retrieved from nursing units in a more timely manner, accounts receivable days due to outstanding coding have decreased. "Overall, the general flow of processes within the department and on nursing units has improved," says Terry Leggett, Valley Presbyterian chief financial officer. "We attribute this to the changes implemented and to our hard-working staff who remained patient and cooperative throughout the entire process."

Where We Go From Here

Just because the department has seen benefits from implementing best practices doesn't mean the process ends here. We need to follow up to refine processes and continually improve how well we meet our users' needs. Since the implementations were completed, additional improvements have been made, including the placement of a dot on the outside of the folder to signify if a chart has been coded or not. This helps remind staff to check whether the record has been coded so that it can be completed before the record is signed out of the department.

We also refined the organization of the skilled nursing unit patient record. Follow-up studies showed that this unit needed fewer divider headings than the rest of the nursing units. Because this unit had significantly different needs, we modified our processes and ordered corresponding divider sets.

While changes to functional procedures have been implemented and accommodations addressed, new issues require attention. For example, the nursing services department started a new program using patient bedside binders. The bedside binders include the previous day's labs, x-rays, medication records, nursing care plan and critical path, etc., and remain separate from the rest of the record on the nursing unit. Since this information has to be interfiled with the rest of the patient's record at the time of discharge, this new process has affected the effectiveness of the universal chart order. At present, unit clerks have the responsibility for completing this task, which includes placing the documents under the correct dividers.

In Our Experience

Although implementation of best practices within HIM departments is not an easy task, HIM professionals have some valuable resources at their disposal. One of the best information resources is networking with peers in the profession.

Others include:

- AHIMA and state HIM association publications and seminars
- area hospital practices
- employees—especially if they have worked in other facilities
- physicians—especially those who practice at other facilities
- literature searches

Recognizing the lessons learned from implementation of best practices is important for development and education purposes. Clear, frequent communication with all parties is necessary. If people are prepared for change, they are less likely to be

resistant to it. Along with communication, involving key individuals such as HIM staff, physicians, and nursing to provide input helps all involved to "own" the process. Finding a physician and nurse to champion the cause is an effective way to win the support of those departments. But input from others should not sway established plans and goals. Since planning is the key step in the implementation of any type of process, steps should be prioritized in advance.

During the planning and implementation process, conduct continual follow-up. Obtaining reactions and comments from those who use the practice on a daily or weekly basis will encourage compliance and discourage noncompliance with change.

Establishing best practices is an excellent way to meet users' needs and requirements. Developing goals based on a view of internal and external conditions and researching best practices industrywide was key to our success. Our final advice to those who want to effect change—be creative and try something new to see if it works. If it doesn't, don't be afraid to try something else.

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Article Citation:
Doyon, Cynthia, Kim Thompson, and Lori Meottel. "Changes for the Better: Implementing Four Best Practices." *Journal of AHIMA* 70, no. 5 (1999): 40-43.