MN State Death Data Delivery Process Improvement

SOLVE

What is the Gap?

1. STARTING POINT

Currently gaps exist in the timeliness, accuracy, and usability of vital record death data which hampers effectiveness in its use. Additionally, this data and its timely availability on individual certificates are important to the families of the subjects of the records.

2. VISION Customers have complete and accurate death data to make informed decisions and take actions & real-time death data is regularly available.

3. CURRENT STATE

Customers & Financial	• Families, requestors, and funeral establishments need complete death certificates (fact and cause) and sometimes they must wait a long time before the records are available. • Physicians/ME's spend valuable time entering cause of death
Society & Team	• MN takes 9-22 months after a death is registered to share the data

What is the Goal for Improvement?

4. GOAL OR TARGET CONDITION

TO: Reduce the time for

- A death record to have complete death data to be available to families for issuance of a certificate.
- Real-time cause of death data to be available to consumers of data..

5. CUSTOMERS AND BENEFICIARIES FOR: Families of decedents, Data Users, VR and VS teams, NCHS

6. BENEFIT SO THAT:

• Families of decedents can conduct estate activities and have closure sooner
• VR/VS staff & users of the MR&C system can complete their activities related to filing accurate and complete death records sooner
• Data users have data for surveillance, program planning and evaluation, making informed decisions, guiding programs, and ultimately improving health outcomes

7. MEASURES AND TARGETS

% of records that require re-work to obtain ICD10 codes	
Elapsed time from OVR receiving ICD10 coded records to sharing real-time death data via a routine mechanism or method.	From: 9-22 months To: 1 week
Elapsed time from fact of death registration to issuance of a death certificate	From: 81% <= 10 days To: >= 91% of data <= 10 days
Elapsed time from fact of death registration to coded death data being available.	

8. CONDITIONS

• Negotiate and approve system change priority among other IT project and maintenance needs
• OVR staff have the training, tools, authority and support to take action and implement change
• Project aligns with MDH and OVR mission, vision, values.

What is the Approach?

9. TEAM MEMBERS AND ROLES

10. PROJECT SCHEDULE

DATE	ACTIVITY
Feb-March 2015	Define project, secure commitment for MDH-Office of vital records to participate in the RWJF QI Forum with a demonstration project
April 2015	Select team members attend QI Team Leader and QI Seeing the Possible training in Washington D.C. with Continual Impact and ASTHO
May 18–22, 15	Kaizen Event
May-July 2015	Implement new process. Measure success. Practice continual process improvement

11. DATA & INFORMATION

Elapsed time per each process step

What are your Conclusions?

13. IMPROVEMENT HYPOTHESIS

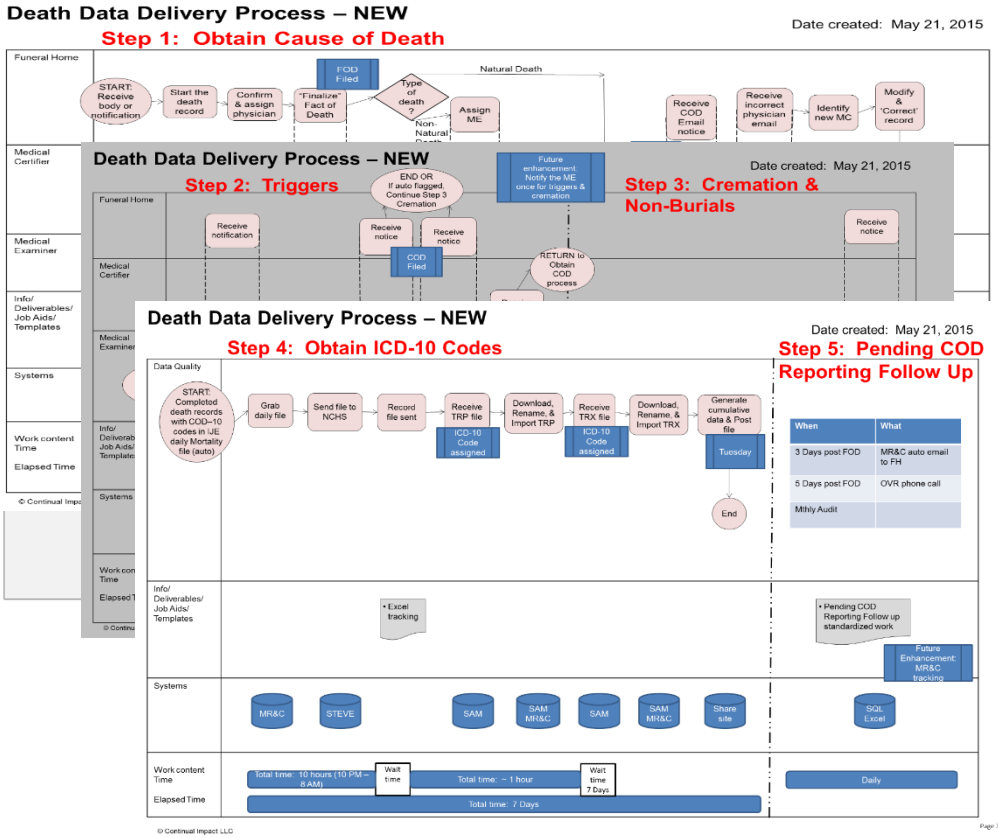
Issue	Improvement
Inconsistent work processes	COD entered earlier in the process; Involve the FH more in providing accurate & timely data) AND install this process effectively AND communicate to users data is available
Usable data is not easily available for use	Process the ICD 10 coded data that is auto corrected from NCHS immediately ("80%" TRP file) AND create a process for uploading of data (once/week) AND create a place for users to access the data AND communicate to users data is available.
Expectations & Roles are not clear	Establish clear expectations for roles; tasks and timeframes for completion; clearly communicate expectations AND provide help where appropriate
The system's usability deters some MCs	Make MR&C system more user friendly (e.g. improved triggers, focused data entry, screen access, work queue improvements)
A manual process is used to move along stalled records	Establish clear instructions and content in e-mails use plain language and other messages

NC State Death Data Registration Process Improvement

SOLVE

Understanding the Problems:

11. NEW PROCESS



12. ROOT CAUSE ANALYSIS

Category	Issues/Wastes	Root Causes
Things Gone Wrong (TGW)	Wrong Physician/ MC	Roles, responsibilities and expectations unclear for process partners particularly funeral homes; Knowledge and guidance for selection incomplete or inconsistently used; Process and system allows wrong information.
Waiting	Complete record set from NCHS & upload of data	Perceived historical lack of need for real time data; Reconciliation of statistical data set; Perception more work required; Traceability concern
TGW; Waiting	Physician access	No requirement to use system exists; Seen as more work; importance not understood; Infrequent use makes effective use difficult

TRY, LEARN, INSTALL

Try Solutions; What did you learn?

14. TEST PLANS 15. TEST RESULTS

Tests	How	Who	Successful if…
Database: Content useful-ness & friendly-ness	Survey (“quantitative”; questions judging whether content adequate for hypothetical analysis)	Metro Analysts (6-7)	100% deem adequate
Auto emails	Send to FHs & MCs	Roberta	100% know what to do & think it will reduce time to obtain COD

16. LEARNING

Reasons	Learning: Why?	Direction: Actions to be taken
Data is useful in its immediate format	The data provided is not perfect but still helpful.	Not prevent sharing; use current content & format
Testers liked getting death record referred in the email. not necessary – but helpful. The MC-need to reassign is their biggest problem	Using emails will allow users to not have to log into MR&C therefore saving time and moving the process along Continue to implement the auto emails as planned	Consider adding to the subject line – “Action Needed” Long term – may be too many emails – direction – consider a system report (table with: decedent, DOD, do state filing, date, time filed, status) Recommend to FH – put all emails in the folder.

17. INSTALLATION PLAN

PROJECT ROLL OUT
Launch—NOW through 6/12 (getting the SharePoint site up and first file, communication plan, training plan, stakeholder analysis, measurements, project tracking, Present info about project at NAPHSIS conference innovations session 5/31)
PHASE 1—6/15 through 7/3 (communications, new MR&C features and functionality, e-mails)
PHASE 2—7/6 through 7/31 (physician password reset, more MR&C features and functionality, e-mails)
PHASE 3—8/3 through 9/2 (performance management, stakeholder input, training, outreach, more MR&C features and functionality)
PHASE 4—9/6 through 11/1 (performance management, stakeholder input, training, communication, outreach, more features and functionality)
Continuous Improvement--ongoing

18. MEASURE RESULTS