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White Paper

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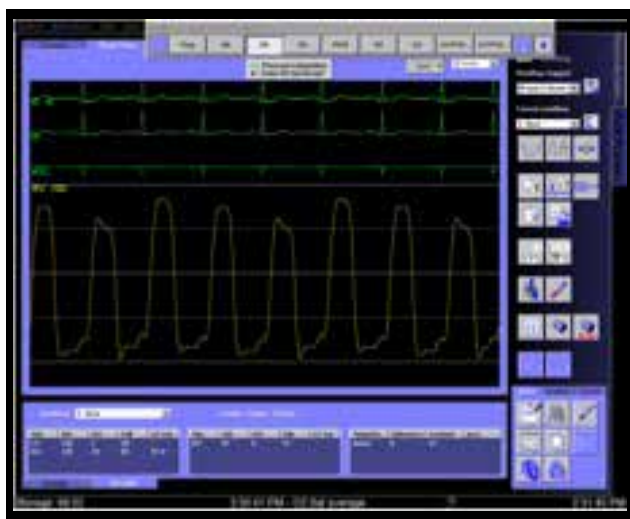
How to Create a 21st Century Cath Lab Reporting Workflow

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by Lyle C. Muhammad



Even as catheterization (cath) labs struggle to find ways to lower costs while improving quality and efficiency, many of them use an antiquated workflow practice that is actually the center of the problem. Despite many advances in digital imaging and the proliferation of digital technology in the cath lab, the cardiologist's report is still dictated.



The patient names used throughout this presentation are fictional and any potential correlation to real persons is purely coincidental.

Executive Summary

Unfortunately, many current catheterization (cath) lab workflows can trace their roots to processes built in the 1980s and 1990s. Although many of the labs are outfitted with sophisticated imaging and hemodynamic system technology, the workflow itself has not been revised in quite a long time. Yet, cath lab workflow can impact every part of the organization—from patient satisfaction and departmental efficiency to coding and billing.

A 21st century cath lab reporting workflow needs to be more integrated to support the overall goals of today's healthcare delivery organization—namely the shift to more efficient, higher quality, value-based care. An innovative, smart reading and reporting tool like *syngo*® Dynamics CPACS (CVIS) can produce reports that are more easily interpreted, understood, and structured. By improving workflow efficiency, a reading and reporting tool like this can also lead to better coding and billing—and be mined for valuable data in the future.

What You May Not Realize About the Cost of Dictation

In many cath labs, the workflow goes like this: the cardiologist comes out of the cath lab, makes his or her way to a nearby telephone or dictaphone system, and dictates the report. Then, the dictation goes to a transcriptionist who transcribes the notes and sends them back to the cardiologist for review and edits. Once the cardiologist notes the edits, the report goes back to the transcriptionist for correction. The report is then reviewed, again, by the cardiologist for accuracy—at this point, however, the cardiologist must rely on his or her memory of the procedure.

Once he or she is satisfied with the final report, the cardiologist will sign it. It will then be sent to the medical record system and to the referring physician to proceed with the recommended treatment.

This workflow, which can take up to four days or more, has been commonly used in cath labs for the last three decades.

There are, though, two inherent problems with it. First, the workflow's accuracy relies on the cardiologist's memory and the information captured by the staff, which is presumably shared with the cardiologist. Often, a cardiologist memorizes a basic script, which becomes the template for many, if not all, of his or her reports. This type of reporting omits much of the tracked information and focuses on the main points or highlights of the procedure, not data necessary for quality or cath lab registries.

Secondly, the turnaround time for the report is too long. It can take four days after a procedure is completed for the referring physician to receive a finalized report. In today's healthcare environment that is simply unacceptable. You need a much more efficient process. Critical patient information captured by the cardiologist needs to flow seamlessly and expeditiously through the system so that patient care can be provided at a much faster pace.

A Simpler Way to Improve Cath Lab Workflow

The ingredients for a successful turnaround of your cath lab workflow are right in your department. The key is to integrate the workflow of your hemodynamic system with your Cardiology CVIS/PACS solution. To do this, you'll need a tool like *syngo*[®] Dynamics CPACS (CVIS), which uses, what I call, point-of-care data capture. This smart reporting CVIS system focuses on the collection and capture of data and integrates it right into your workflow.

With *syngo* Dynamics CPACS, the cath lab staff can document the data as patient care is delivered. That information is simultaneously transmitted electronically to your Cardiology CVIS/CPACS system for reporting. This helps to build the physician's report while the case is in progress.

By capturing data elements for the report while the case is actually happening, your staff can capture much more information with higher accuracy. Every individual on the team does his or her part. And the quality of that data improves because data management is integrated into the workflow.

At the close of the procedure, the physician can step out of the room, walk over to a computer workstation, and begin to complete the report, which was already started during the case. He or she reviews the data that was captured, adds additional information, and then signs the final report at the end of the procedure. This is a significant improvement over the four-day waiting period and all of the back-and-forth revisions.

In addition to improving care and efficiency, an integrated hemodynamic and CVIS/CPAS reading and reporting system can help improve the bottom line. An integrated workflow can actually be cheaper because it uses fewer resources to create a finalized report. The report itself also contains much higher quality data. In fact, a faster, more thorough report can expedite patient care and increase referring physician satisfaction—since physicians know they will receive reports at the end of patients' procedures.

The Advantage of Multi-System Integration

One of the beauties specific to the *syngo* Dynamics system is its ability to integrate with multiple systems. It has a long history of proven integration with hemodynamics systems such as Siemens, Phillips, GE, and now Merge.

syngo Dynamics has an even tighter integration with the Siemens SENSIS Hemodynamics System. This unbeatable combination gives you the added capabilities of bi-directional communication between SENSIS and *syngo* Dynamics.

This multi-system integration can be imperative for administrators who need to work within their current infrastructures. It reduces or in some cases even eliminates the need to build interfaces for desperate systems, simplifies implementation, and encourages buy-in from staff and physicians.

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