

Case Study #7: UW Medicine's Collaborative Policy Development and Staff IG Education

Save to myBoK

By Christine Taylor and Kristi Fahy, RHIA

Editor's Note: This is the seventh installment in an ongoing series highlighting information governance case studies.

Consistency in any enterprise-wide initiative is a key for success. To achieve this, it is often as simple as policy and procedure updates and education about the updates. Organizations can develop excellent policies and procedures that have great intent but lack overall execution; consequently, change is never fully implemented. For many information governance (IG) projects, awareness and education becomes critical for success. An organization must ensure that all business units and employees receive updates as change is put into action.

The benefits of defining terms that are commonly used throughout organizations can lead to more efficient workflow processes, decreased risk, and cost avoidance. It is important to reduce any confusion that is associated with these terms and ensure that the workforce is adequately educated on the agreed-upon definitions. At this point, the terms are more likely to be successfully adopted and utilized.

This case study will discuss how the University of Washington Medicine Health System's (UW Medicine) health information management (HIM) department took the lead in developing and updating policies to better explain the definitions of the terms "legal medical record" and "designated record set." These policy updates filtered through a number of internal committees and workgroups in order to ensure they were clearly defined and will be successfully implemented throughout the entire UW Medicine system—not just one facility.

This IG project addresses four of the Information Governance Adoption Model (IGAM™) competencies: privacy and security, enterprise information management (EIM), awareness and adherence, and legal and regulatory.

UW Medicine's Organizational Description

UW Medicine is comprised of nine entities:

- Harborview Medical Center (HMC)
- University of Washington Medical Center (UWMC)
- Northwest Hospital and Medical Center (NWH)
- Valley Medical Center (VMC)
- UW Neighborhood Clinics (UWNC)
- University of Washington School of Medicine
- University of Washington Physicians
- Airlift Northwest

UW Medicine employs more than 26,000 employees who contribute to the strategic plan, which supports the three major activities that advance the UW Medicine mission: providing outstanding patient care and health promotion programs; advancing medical knowledge through research; and training the next generation of healthcare professionals and scientists. Patient care, teaching, and research activities are integrated to support better care for individual patients, better health for the population, and reduced per capita costs for patients.

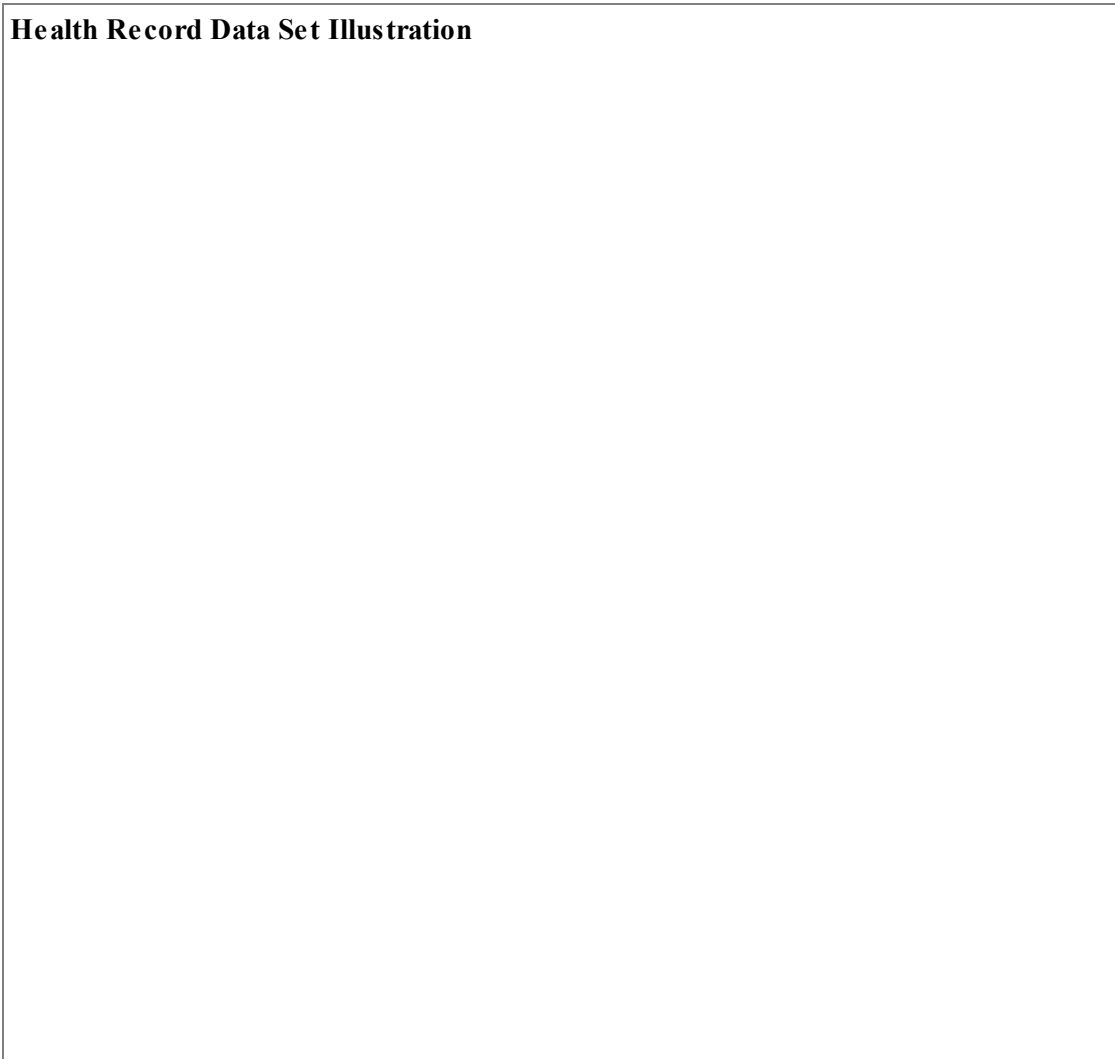
Purpose of Updating Policies

The purpose of this case study is to illustrate the broad collaboration and consultation involved in standardizing and updating the policies regarding the legal medical record and designated record set throughout UW Medicine. This topic was added as an initiative at UW Medicine in an effort to standardize terms and implementation of these policies, and to subsequently incorporate the clarifications published by the Department of Health and Human Services’ Office for Civil Rights (OCR) in the February 2016 FAQ on Access Guidance related to 45 CFR: 164.524 and 45 CFR 164.501. This new set of policies was implemented by four medical centers (including NWH and VMC) and UWNC. And finally, these policies were updated in order to facilitate a review of the records retention schedules regarding medical records and “secondary” medical information found in source systems where a summary of information is kept in the electronic health record (EHR).

Organizational Impact of Changes

This case study highlights the strategic and transactional approaches UW Medicine HIM took in updating the legal medical record and designated record set definitions and policies across UW Medicine entities. It is important to have universal and enterprise-wide definitions for the legal medical record and designated record set as a variety of different UW Medicine staff work with these records. Their approach addressed the enterprise information management, privacy and security, awareness and adherence, and legal and regulatory competencies and reduced the associated risks and costs that were linked to ill-defined terms. In addition, an increase in staff productivity was realized as the release processes were more streamlined.

A workgroup was established to review the existing policies and assess where updates should be made. The workgroup included staff from UW Medicine compliance, UW Medicine HIM, VMC HIM, NWH HIM, and UW medicine records management. The workgroup discussed necessary updates and review of the new policies. They also evaluated the release and disclosure processes to differentiate patient access requests from patient authorizations based on the FAQ guidelines from OCR. The OCR clarifications also helped to standardize terms and definitions used in the policies. UW Medicine developed a graphic that was used to illustrate the data sets, below.





Source: UW Medicine Health Information Management/Records Management Services

The policies were further reviewed and edited by UW Medicine’s Patient Privacy and Access Workgroup and went to the Executive Clinical Compliance Committee for final approval. The Executive Clinical Compliance Committee membership consists of executive leaders from all UW Medicine entities, including physicians, administrators, and directors from inpatient and ambulatory settings, as well as compliance, HIM, and risk management. Once the final approval was granted, it was time for UW Medicine to implement the change.

In order to ensure staff had the proper knowledge and resources available, UW Medicine developed education and training related to the updated legal medical record and designated record set policies. It was particularly important to educate the staff responsible for release activities but also to make certain that all other staff were aware of the updates. The graphic that was developed was a key component of the training, and has proven to be a valuable job aid. The team is planning to implement broader training that can be distributed enterprise-wide more easily.

Information Governance Adoption Model



Results of IG Project

The updated definition and policies resulted in various benefits for UW Medicine, including:

- Better efficiencies gained by a better definition of the legal medical record
- Clearer understanding about what information will be released
- Clearer understanding of what information requires specific request beyond “all medical records”
- The creation of job aids and resources illustrating the difference between the legal medical record and the designated record set
- Opportunities to train and educate staff as well as other stakeholders

With reference to IGAM, all of the benefits realized by updating the policies and procedures on the definitions of legal medical record and designated record set, and developing and delivering staff education and training, has allowed UW Medicine to see more consistent and efficient workflow processes related to the legal medical record and designated record set. The ongoing education process is continuing to expand for staff as it is critical for the overall success of implementing and maintaining UW Medicine’s recent IG efforts.

Christine Taylor (ct24@uw.edu) is the records officer at UW Medicine. Kristi Fahy (Kristi.Fahy@ahima.org) is an information governance analyst at AHIMA.

Article citation:

Taylor, Christine; Fahy, Kristi. "Case Study #7: UW Medicine’s Collaborative Policy Development and Staff IG Education" *Journal of AHIMA* 88, no.7 (July 2017): 38-40.

Driving the Power of Knowledge

Copyright 2022 by The American Health Information Management Association. All Rights Reserved.