Leveraging Opportunities to Gain Buy-In for Information Governance

Save to myBoK

By Suzanne Goodell, MBA, RHIA

Recently, I have been talking with our CMIO, working to gain her executive sponsorship for implementing system-wide policies for patient naming, matching, and identification. She was receptive to my suggestions, but her plate was already full, and she didn't seem ready to lead a new system-wide patient identity initiative. However, her willingness to address patient identity was heightened by two interesting issues that recently came to our attention. Both issues advanced the case to adopt patient identity standards because they were raised by physicians and directly impacted patient care.

In the first case, a pediatrician complained that his office was not able to match the hospital newborns' CCDs with new babies' registrations in his practice's electronic health record (EHR). Both the hospital and the pediatrician use the same EHR vendor but have separate systems. Health information management (HIM) professionals are very familiar with the challenges of registering newborns, and the following is a fairly typical example. In this particular case, our hospital registered the baby as John Smith, with Smith being the mother's last name. But when the mother took the baby to the pediatrician, she registered him as John Jenkins, using the father's last name of Jenkins. By design, when John Smith's electronic summary of care arrived at the pediatrician's office, it did not match with the record of "John Jenkin's."

Hours after the newborn's first appointment ended, the pediatrician's office jumped through numerous hoops with our hospital to resolve the patient identity conflict. They were so annoyed that they contacted our CMIO and requested access privileges to our EHR, privileges normally reserved for our HIM staff and IT analysts. They wanted access so they could link their records with the records in our system. Our CMIO was naturally unwilling to grant the pediatrician's requested access privileges, so she looked for another solution. Then she remembered the sample patient naming policy I had mentioned earlier.

Within a week or two, our CMIO received a second complaint, this time from a local surgeon. The surgeon was unable to obtain patient records from our health system on a complex patient he was evaluating for surgery. After significant time spent investigating, we determined the patient was registered at our health system as Thomas D. Wheeler (name has been changed).. At the surgical practice, the patient was registered as T.D. Wheeler. The patient swore up and down that his name was T.D. Wheeler. In fact, his wife said even the IRS would substantiate his claim. Once again, coordination of care and medical decision-making were delayed due to non-standardized naming conventions. The CMIO remembered our conversations about implementing a patient naming policy and procedure.

After the second patient-naming incident, our CMIO was ready to act. At our next meeting, we identified stakeholders and put together a strategy for building executive and department head buy-in for a patient-naming policy and procedure. Our CMIO offered to first enlist a couple of key individuals. She quickly achieved their buy-in, and then asked me to work with our Director of Patient Access to finalize the list of stakeholders and draft an agenda.

During my first call with our Director of Patient Access, we discussed the scope of work that we should address. Our first thought was to address the problem of how to identify people in an age of interoperability. The CMIO and I agreed that establishing a patient naming policy was an important and achievable first step.

I have contacted a few experts on standards at AHIMA as well as HIM professionals working in this area to better understand the current state of national patient naming and identity standards. Once these contacts have been made, we will identify the value proposition, conduct our patient naming meetings, and develop a standardized patient naming policy and procedure.

I am encouraged by our progress so far. I have completed two of the three elements of Step 1 in the process of developing and sustaining information governance outlined in AIHMA's IG tool kit. I have built the case for change, using the power of real-life patient care examples. I have aligned to business strategy: our strategy for health information exchange required by

Stage 3 Meaningful Use rules. When I complete our information gathering, we will present the value proposition, and Step 1 will be complete.

The progress our health system has made on its IG journey is exciting. Momentum for standardized patient-naming is building, we have an executive sponsor, and we will continue to build buy-in with key stakeholders. We have definitely traveled further down the Yellow Brick Road to IG.

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Original source:
Goodell, Suzanne. "Leveraging Opportunities to Gain Buy-In for Information Governance" (Journal of AHIMA website), November 21, 2016.
