On the Yellow Brick Road to IG: part 3

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By Suzanne Goodell, MBA, RHIA

In early 2016, Suzanne Goodell, co-chair of AHIMA's Information Governance Practice Council and director of meaningful use in a large regional health system, invited our blog readers to accompany her on her IG Journey. This is the third blog post describing how the journey is going.

Last week I took a few more steps down the IG Yellow Brick Road by meeting with our director of patient access. It was a productive meeting; we both learned from each other and agreed to work together.

I started by asking her to explain our current state: who oversees registration, existing policies and procedures, and her key issues related to patient registration. Here's what I learned:

- From a system-wide perspective, our director of patient access only manages a relatively small number of registrars. Her staff registers all hospital inpatient admissions and patients registered for high-dollar procedures. These procedures can be done in the hospital (i.e. day surgery), or in an outpatient diagnostic department such as MRI. (Can you tell she reports up through the revenue cycle?)
- The majority of patient registrations at our health system are done by registrars in the ED and schedulers in our physician practices, hospital outpatient clinics, and hospital diagnostic departments. Each registrar or scheduler reports to their site manager, so we don't have system-wide centralized oversight of our registration processes. Given the fact we have well over 100 clinical sites, six hospitals, and dozens of hospital-based departments and EDs, there is significant probability for variation in registration procedure.
- Once I understood how registration is managed system-wide, I asked about a system-wide registration policy and procedure. Apparently we do not have such a policy. Our director of patient access drafted a policy when she first came to Cone Health and submitted it to the policy committee. Her draft policy was sent back to her, unadopted, because it was considered a "departmental policy," not a system-wide policy. Since then, we have taken major organizational steps to consolidate and function as a health system. This might be the right time to re-introduce the subject of a system-wide policy and procedure.
- It was interesting to hear our director of patient access' key concerns about patient registration: collecting accurate data for the revenue cycle, and preventing duplicate or overlaid patient records. Naturally, her focus was on creating accurate registrations to benefit *internal functions*, which have historically been critical to business operations.

Now it was my turn. I explained my interest in registration data and how it directly impacts our ability to match incoming electronic health records (EHRs). I described the Centers for Medicare and Medicaid Services' interoperability goals and the meaningful use stage 3 interoperability objectives. Though our director of patient access had not thought about implications for electronically matching our records with inbound records from another care provider, she was eager to work together on issues related to interoperability.

I started by showing her Table 1 from Kathleen Lusk's article "Recommended Primary and Secondary Data Attributes to Facilitate Patient Matching." We went through the entire list of data attributes and she confirmed which attributes we are currently collecting. Although we are collecting most recommended primary data attributes, we are missing a few primary and several key secondary data attributes. She also noted which data attributes are entered using free text.

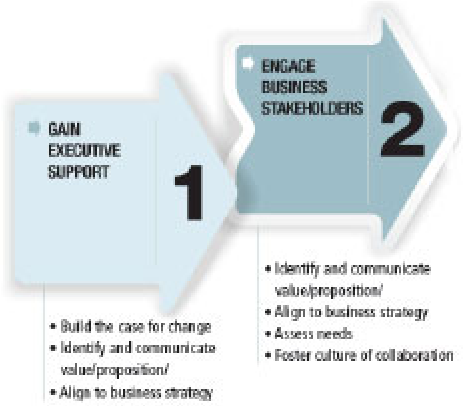
Lusk's article recommends that the only free text registration entry be patient name. In addition, they published a sample patient naming policy and procedure that is very clear and helpful. Our director of patient access was enthusiastic about the naming policy, but wasn't sure about the feasibility of using structured data for street address. Nor could she speak to the technical feasibility of adding the missing primary and secondary data attributes.

I offered to meet with the IT manager of our EHR’s patient identity, patient registration, and HIM teams to lay the groundwork and learn more about our possibilities for registration data attributes.

At the end of our meeting, we laid out some key next steps:

1. She would find out what our registrars do when the patient won’t give their Social Security number.
2. She will write a procedure for patient naming at registration. The procedure will only apply to the people she manages, but it’s a start.
3. I will speak to my boss about the importance of having a system-wide policy and procedure for patient registration.
4. I will meet with our IT manager to learn more about the possibilities for capturing recommended data elements as structured data, along with our current experience with internal patient record duplicates and overlays.

What did I accomplish? One more tiny step down the IG Yellow Brick Road. I gathered information about the current state of patient registration and enlisted an ally on the revenue cycle side of our health system. Both contribute to step 2 shown in the figure below.



This is but one issue that requires coordination of stakeholders and governance in our health care system. The hope is that we can successfully address the issue together and eventually leverage this success into a broader governance approach to address other questions and issues.

Onward.

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