Partnering on Patient Matching: An HIM Committee Helps Steer a RHIO's Patient Index

By Lisa A. Eramo

An HIM committee helps a major RHIO in New York State define sound practices for maintaining an accurate patient index.

Imagine this: You've been tasked with exchanging lab results, radiology reports, and other data for more than 1 million unique patients across 39 facilities and each of their satellite locations.

Sound like a challenge?

In the Bronx Regional Health Information Organization (RHIO)-one of four RHIOs in New York City-data of this magnitude flows among facilities regularly. Ten of these facilities-known as data sources-contribute patient data to the RHIO regularly, while the others simply access it.

New York State has 11 RHIOs in total. Eventually, each of the RHIOs will be able to exchange data with one another, essentially creating an interconnected health information exchange (HIE) for the entire state.

RHIO-to-RHIO exchange and HIE in general is something with which HIM professionals should be closely involved, says Caryl Greaves, RHIA, MPA, CPC, senior HIM director at Montefiore Medical Center in New York City, one of the facilities in the Bronx RHIO.

"Integrity of the patient match is what really makes a RHIO or HIE successful," she says. "We are the people who are most qualified to ensure that."

Leading the Discussion on Patient Matching

Greaves has been involved with the Bronx RHIO since its creation and currently serves as the chair of an HIM committee for the RHIO. She says that in addition to managing data, HIM professionals can also help steer discussions around privacy, disclosure, and consent management within a RHIO or HIE.

Having an HIM committee has helped the Bronx RHIO significantly-particularly in the area of patient matching, says Nance Shatzkin, principal at Shatzkin Systems, Inc. in Croton-on-Hudson, NY, and CIO of the Bronx RHIO.

Although no formal HIM committee existed when the Bronx RHIO was originally launched in 2008, HIM professionals worked in an advisory capacity from the very beginning, providing significant input into the patient matching algorithm on which the RHIO would rely. In 2010, when the Bronx RHIO converted to a new platform, an HIM committee was formally created to better harness HIM's input and expertise.

"We saw the opportunity to build on what we'd learned in the first generation and knew that we could benefit from more involvement," Shatzkin says.

Obtaining buy-in was easy because leadership was already aware of the input that HIM professionals provided during the first iteration of the RHIO, Shatzkin says. Today, the HIM committee is one of the most active and engaged of the eight RHIO committees.

"The HIM professionals get it, and they want to be involved," Shatzkin says.

The HIM committee itself reports to the board of directors of the RHIO. The committee currently includes 15 members, each of whom is appointed by their institution. Members of the committee are primarily HIM professionals; however, anyone who has knowledge of issues related to patient identity can fulfill the role.

The committee's agenda frequently includes HIM-led discussions about best practices for managing data and arbitrating patient identity questions. "You need to have an HIM professional who will help manage that type of discussion," Shatzkin says. RHIOs and HIEs nationwide face many of these same challenges, and having an HIM committee is beneficial regardless of the type, location, or structure of the RHIO or HIE.

The Bronx region also has several unique circumstances that create a more challenging environment in which to exchange information, thus necessitating such a committee.

"New York has lots of different ethnic communities, and they each present different challenges with names," Greaves says. With a wide range of naming and spelling conventions-Hispanic, Russian, Greek, African, and Indian-the potential for mismatching individuals is significant.

For example, some common Hispanic names vary by a letter, such as Gonzalez and Gonzales; in other instances, an individual with two surnames may reverse the order according to gender equality laws, or choose to use only one of their surnames.

Establishing the Standards

As an HIM-driven initiative, the committee's primary objective is to maintain the most accurate community patient index, Shatzkin says. Having HIM representation from each facility makes this possible.

By ensuring an accurate patient index, the HIM committee also helps maintain patient safety. Staffing the committee with HIM professionals makes it much easier to do this because they are the individuals who understand the process for collecting, analyzing, and linking the data on which the RHIO relies, Greaves says.

The committee, which met once a month for the first 18 months and which currently meets once every other month, has the authority to create policies that the RHIO must follow. For example, the committee was instrumental in the creation and final approval of a policy on patient matching that established a standard for linking patient identities throughout the entire RHIO. It also developed a protocol for manual matching.

Approximately 2 percent of the total number of links in the RHIO are performed manually based on the policy that the HIM committee created. Shatzkin attributes the success of the manual linking process directly to the framework developed by the HIM committee.

In addition to creating policies, the HIM committee also identifies best practices that help its participating facilities improve processes that directly affect the quality of local data as well as data that is exchanged through the RHIO. For example, committee discussions caused Montefiore to realize that it needed to tighten its process regarding the registration of unidentified patients (e.g., Jane and John Doe). As a result, registration staff members now review the charts after admission to determine whether a provider (e.g., a social worker) documented a more definitive name. If so, this information is entered into the facility's registration system. Subsequently, the data loads into the RHIO.

In addition to addressing patient identity issues, the HIM committee creates a venue for discussing other issues that occur when data flows electronically from one health record to another. One ongoing debate among participants in the Bronx RHIO concerns the integration of data obtained via the RHIO from another facility. If the data is integrated, should the original source of the data be identified? Can this information be re-disclosed to third parties? How ready is the local EMR to identify and control data received electronically?

There are no universal guidelines to address these types of questions, and RHIOs and HIEs must determine for themselves how they will handle the issues, Shatzkin says. "These issues are much better discussed with an HIM professional in the room," she adds.

Monitoring and Sharing the Results

The committee is supported by RHIO staff members who regularly share listings and statistics with the HIM committee members. Committee members then use these reports to follow-up with staff members at their individual organizations. Reports include the following:

- Duplicates: A duplicate refers to a patient with at least two medical record numbers who appears to be the same person at the same facility. Duplicate reports include a list of such patients that the RHIO has linked according to policy and that the facility should merge as a result.
- Potential duplicates/linkages: A potential duplicate refers to two or more patients seen at the same facility who have sufficient similarities to warrant a review. A potential linkage refers to two or more patients seen at more than one facility who have sufficient similarities to warrant a review. These are cases the RHIO staff members couldn't link based on policy.
- Other cases: This report includes a list of fictitious names, including unnamed babies, Jane and John Does, and other questionable names that require further investigation.
- Statistics: This report includes the total number of unique patients for each facility in the RHIO, the number of linkages established across facilities, the number of duplicates generated by each facility, and the number of duplicates adjudicated.

Working through the Issues along the Way

Even though the HIM committee continues to provide input into the development of the Bronx RHIO, the process of exchanging information will never be easy… or predictable. For example, one of the facilities in the RHIO treated brothers named Steven and Stephen born one year apart.

"Their medical records are so inexorably intertwined that I don't know that anybody will ever separate them. But the RHIO helped identify the problem and sensitize the source facility. Going forward their charts are likely to be kept straight," Shatzkin says.

The ability to match a baby's birth record with their named record presents another challenge. Each facility may have its own policy on updating birth records with the official name. This occurs when the birth record at one facility says "Baby Boy [insert last name]," and the ongoing record at another facility actually includes a name.

"We had to develop policies around that and work with different organizations to improve their methods of assigning real names to babies after they were named," Greaves says.

There are also policy-related challenges, and the RHIO's policies must be flexible to adapt to new information, Greaves says. For example, in an initial policy, Medicaid ID numbers were used to distinguish between patients. The HIM committee subsequently discovered that this cannot be applied to patients younger than one year old because Medicaid temporarily assigns the mother's number to the baby. As a result, the committee had to update its policies to reflect this reality.

There are financial challenges as well. "Resources are a huge challenge for many HIM departments," Greaves says. "Different facilities staff differently and have different resources. Sometimes we know what to do and how to fix something, but the resources are just not there to do what has to be done."

The sooner HIM professionals can get involved in their state's RHIO or HIE, the better, Shatzkin says. "It really makes sense to have HIM professionals engaged in the process from the beginning as policies are being developed, as software is being configured and tested, and as operational workflows are being developed," she adds.

Greaves encourages her colleagues to contact their HIE and find a way to get involved. Articulate some of the challenges inherent in managing patient identity so that the key stakeholders become aware of these issues, she recommends. Consider partnering with HIM directors from other facilities participating in the HIE to approach the HIE board of directors as a group. "Do what it takes to be at the table!" Greaves says.

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