Yellow Brick Road to IG

By Suzanne Colbert Goodell, MBA, RHIA

I am the director of meaningful use for a health system with 6 hospitals, 400-plus employed physicians, and a regional presence in my state. I suspect my healthcare system isn't the only one using patient registration practices better suited to a bygone era. Recently I stumbled across one such practice.

I was investigating the status of our electronic laboratory results (ELR) reporting to the state reporting agency. We have been in the onboarding phase for well over a year now. We first attested to meeting the ELR measure of the "meaningful use" EHR Incentive Program in 2014. When I was preparing our 2015 meaningful use attestation, I was dismayed to learn that we are still "onboarding."

My first call was to our interface manager. She told me we are stuck in the onboarding process because our testing has not been successful. The one remaining issue: certain records keep failing because the state can't accept patient names registered in our unique, home-grown format. If an inpatient doesn't want us to disclose they are in the hospital, we register them like this: XXXDoe, Jane. Staff uses the XXX as a visible reminder to honor the patient's confidentiality.

The practice is a throwback to the days when our Master Patient Index consisted of index cards, and when paper face sheets were the first page of every medical record. Perhaps it made sense years ago, but today's EHR offers plenty of other options for flagging a patient's confidentiality requirements.

Once I understood the problem, I was confident we could "fix" the issue quickly. I told the interface manager that I would meet with our director of patient access, sure that she would agree our practice was archaic and should be replaced. The interface manager was less optimistic that we would be able to get rid of "XXX" registrations. She said the nursing staff would never agree to the change and I would be beating my head against a wall. Instead, she offered to strip the XXX from each patient name before she sent it across the interface to the state.

Although this solution offered a tempting conflict-free path forward, it occurred to me that stripping the "XXX" was a bandage for the ELR issue, but only the tip of the iceberg when it comes to interoperability.

The Centers for Medicare and Medicaid Services' (CMS) acting administrator, Andy Slavitt, recently said that CMS is "deadly serious about interoperability," especially for patient engagement and care coordination. In addition, the Office of the National Coordinator for Health IT published a Shared Nationwide Interoperability Roadmap, which we will all follow to achieve better care, smarter spending, and healthier people by 2024. As professionals, we know we must develop and adhere to health IT standards to achieve national interoperability. Appropriately, AHIMA has been a leader in standards advocacy and development.

Given the direction we are headed, I am certain that our XXX registrations will not stand up to the interoperability challenge. In fact, in 2015 I know we sent more than 33,000 continuity of care documents (CCDs) to follow-up providers at transitions of care. Looking back, I wonder how many CCDs were actually matched with a patient and incorporated into the follow-up provider's EHR. I also wonder how many other idiosyncratic registration practices we follow that undermine interoperability.

Last fall I was inspired by Katherine Lusk's article on patient matching and health information exchange. She makes a strong case for nationwide patient identification and matching standards. The appendices include specific sample patient naming policies and rules, along with recommended patient identity data elements and attributes. I sent the article to our HIM executive director for her consideration. Though I felt that patient registration policy and procedure was outside the scope of my role, I wanted to be sure she had seen the article and could weigh in when appropriate.

Now that I see patient registration data in light of interoperability, I feel a direct responsibility for its integrity. Without interoperability we cannot use our EHR in a meaningful way. And if I don't address barriers to interoperability, who in my

organization will? I feel called to step up and begin the process, even though it may be fraught with skirmishes, toward ending XXX registrations. It's the right thing to do and will start the conversation about standardizing our patient registration data.

I know I have to start an IG journey to effectively change our XXX registration practice. Why? Because I have no direct authority or responsibility for patient registration data, but its impact on our organizational goals is huge. I will start at the beginning by finding an executive sponsor. I am targeting my boss, the chief medical information officer. I know I will only be successful if I identify an executive sponsor, enlist her support, and confirm that my goals align with our organizational strategy. I have no idea how she will respond, but she's the right person to start the conversation.

I feel like I am Dorothy taking the first step on the yellow brick road. I don't know where the path will lead or if I will be successful. But I'm willing to try, and plan to take readers along with me by providing updates on my IG journey along the way. It should be quite an adventure.

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