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Winners demonstrate transformative journeys toward new and innovative HI practices that generate better patient outcomes. Consider your organization’s accomplishments and celebrate your success.

Applications are now being accepted.
AHIMA.org/grace

* 2020 winner will be honored at the AHIMA20 Health Data and Information Conference, October 14-17 in Atlanta, GA.
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AS I WAS writing this message, the world was just beginning its long fight against the coronavirus pandemic. The scope and cost of this global crisis will be staggering and without precedence in modern times. However, in the face of fear and uncertainty, I have been profoundly inspired by the courageous response of healthcare professionals around the world, all of whom are working tirelessly and selflessly in the face of great danger to their own well-being to protect us all.

Through our collective efforts—from our government’s decisions to the average person’s commitment to social distancing—we will win this fight.

AHIMA is preparing health information management professionals to help their clinical and technology partners access the information they need to serve the health needs of their communities.

To that end, AHIMA developed a COVID-19 Resource Page, a comprehensive—and growing—compendium of tools, resources, and best practices to equip HIM departments to meet the challenges of the days and weeks ahead. As of press time, our most recent updates include:

- A joint American Hospital Association-AHIMA FAQ on the use of the new coding for COVID-19
- An article in the Journal of AHIMA that explores telehealth’s role in the coronavirus response
- Best practices and news from AHIMA members on how they are preparing their colleagues for privacy challenges, operational continuity, and coding

These are trying times for all of us and we must all work together to stay informed, remember simple things such as handwashing are very important, make wise decisions, and take care of ourselves and our families.

Connecting and hearing from our members is important to me as well as the rest of the AHIMA Board. During the House of Delegates meeting in September I reinforced my commitment to communicate with the members. The board sends monthly communication to the CSAs and shares a recap of pertinent information. I would like to highlight two items that have recently been shared with the CSAs.

First, after previous discussion, the board of directors unanimously voted to allow the speaker-elect to join the board of directors for their meetings. The board recognized there is a steep learning curve and allowing the speaker-elect to be a part of the board as a non-voting guest during the year will help him or her be better prepared as a board director when ascending to the speaker position.

Second, the formation of the Governance Task Force was announced during the House of Delegates meeting last year. The task force charter states: “To ensure AHIMA is positioned with an optimal, nimble, and agile governance structure, the Governance Task Force is charged with reviewing and transforming the governance of AHIMA. This will include AHIMA’s Board of Directors, House of Delegates, Nominating Committee, CEE, CCHIIM, and CSAs, and each segment’s role in the overarching governance structure. The outcome is an integrated and aligned governance structure that demonstrates purpose in relation to AHIMA’s mission, vision, and strategic plan.” They will meet monthly for one year, with a mission to achieve the goals set out in the charter. If at the end of the year there is still work to be done, the Governance Task Force will present recommendations to the AHIMA Board of Directors and the House of Delegates on how to proceed.

As Simon Sinek said, "Together is better. If we each do our part to help advance a shared vision, we can build the world we imagine."
IN SUPPORT OF AHIMA’s vision of a world where trusted information transforms health and healthcare by connecting people, systems, and ideas, AHIMA’s 2020 advocacy priorities are focused on advocating for legislation and regulations in the areas of integrity, access, and connection. One of the ways HIM professionals can effectively advocate for AHIMA’s priorities is by reaching out and engaging with their elected officials.

Did you know that in addition to their offices in Washington, DC, members of Congress typically have an office in their congressional district and/or in their state? Having a meeting with elected officials and their staff is an effective and easy way to get to know them and to express your views on key issues impacting the HIM profession.

Members of Congress are often less distracted by the demands of Washington when in their district offices and are excited to meet with their constituents. The recent outbreak of the COVID-19 pandemic in the United States means that many in-person interactions are not currently advised. Keep social distancing practices in mind as needed, and consider arranging a video conferencing call instead.

Meeting with your Senators and House Representatives is a great way to build relationships with elected officials while demonstrating the importance of the HIM profession to them. Meeting with your elected officials in their district offices provides an opportunity to highlight the important and transformative work you do while providing a platform for talking about AHIMA’s legislative priorities. These interactions make you a resource to elected officials on HIM matters and fosters stronger ties with them.

For many HIM professionals, it may seem intimidating to meet with a member of Congress. Yet when HIM professionals have reached out to their congressional leaders, many have found that they have much more influence than they realized. Legislators want to hear from their constituents about the issues they are facing within their district, their state, and around the country.

To assist you, AHIMA developed a Congressional District Meeting Resource Guide that contains a wealth of tips for setting up a meeting with your elected representatives in their district offices. Included in this comprehensive resource are sections on identifying your representatives, drafting an invitation to meet with them, preparing for and conducting the meeting, following up after the meeting, and maintaining ongoing rapport with your elected officials. There are also a variety of tips for successful advocacy included throughout the resource guide.

AHIMA’s policy and government affairs team is here to help. We can provide you with materials to help you conduct the meeting successfully. We recommend you reach out to the team by emailing us at advocacy@ahima.org at least one week prior to the meeting. If you need any additional guidance on contacting your elected officials or assistance in preparing for the visit or following up afterwards, feel free to email us.

Want to be an advocate for AHIMA but can't meet with your elected officials in person? Check out the AHIMA Advocacy Action Center for advocacy and policy updates and to take action on current priorities by emailing your elected officials on the website. It only takes a few minutes and you will be making a positive influence on the profession.

Note
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Let's discover opportunities to make an impact.
IT'S HARD TO chart a course when the way forward is unclear.

As I write this, the world is responding to the pandemic spread of the COVID-19 virus. Healthcare organizations are gearing up, schools and businesses are closing down. We wash our hands relentlessly and deep clean our offices and homes to protect against an unseen enemy.

By the time you read this, we'll know if all this preparation was effective. But right now, in late March, it feels like every map is blank. Our organization is more than 90 years old, and throughout pandemics, world wars, and economic downturns, HIM professionals have endured. In 1943, halfway through World War II, AHIMA's founder Grace Whiting Myers observed:

"It has been a hard year for everyone, and I believe particularly so for those connected with any kind of hospital work. Record librarians, along with others, have been faced with a shortage of materials and also with a curtailment in number of assistants and a constant change in personnel, always disrupting to any work of importance. However, I am proud of all that I have read and heard of your splendid efforts in carrying on, and especially am I proud of those who have gone into actual war service. It is what I have hoped would happen."

Grace knew, as we know today, that health information professionals will do what they have always done in a time of crisis: show up and step up.

We do this because we know that health information is human information, and that behind every piece of data, there's a patient.

We know, too, that as we find a post-pandemic "new normal," there will be opportunities for innovation, creativity, and leadership. This year AHIMA is introducing new training to support you as you take advantage of these opportunities. We are working with the leader in management training, the Ken Blanchard Group, to offer a series of courses for how to be a better leader. These courses, some virtual and some face-to-face, offer learning opportunities both for individual contributors and managers to improve their skills. Look for more communications about this program in e-mail and on ahima.org.

In addition to covering breaking news related to the COVID-19 pandemic online, the Journal of AHIMA looks at ongoing issues where HIM has an opportunity to solve problems and lead. In "If Patients only Knew..." Mary Butler asked HIM professionals what they wished patients knew about how they can take responsibility for their own health data and avoid problems related to duplicate records and identity mismatches.

Lisa Eramo reports on five trends that will affect patient matching in 2020 and beyond. Climate disasters, like pandemics, can cause health problems; Allison Viola examines ways we can understand this connection and put systems in place to prepare for future scenarios in "Preparing Healthcare for Climate Change."


The way forward will require authentic, insightful, and confident leadership, and as HIM professionals, we can do that.

Note
1. Grace Whiting Myers, letter to the AAMRL 15th Annual Convention, September 15, 1943.
Responding to the Challenges of COVID-19

The challenges around COVID-19 have been difficult and altered nearly every aspect of our lives, from work to home. We’ve all done our best to curb the pandemic and as your professional home, AHIMA has worked diligently to bring you the news and resources you need—because we’re all in this together.

AHIMA’s primary resources include:


- **AHIMA.org COVID-19 Index**. Continuously updated with resources, AHIMA news, and navigable links to public health and professional organizations (www.ahima.org/topics/covid-19)

- **AHIMA Engage—COVID-19 Community**. A digital networking page to exchange ideas, information, and perspectives. (https://engage.ahima.org/home)

As you know, the collection, timely distribution, analysis, and protection of health data is critical to our ability to be effective to this pandemic. AHIMA has aimed to be flexible so that even in a constantly shifting environment, health information professionals can still impact our healthcare system. When it became evident we would be unable to host our Advocacy Summit in Washington, DC, we quickly pivoted and focused on a virtual summit that led to many members contacting their congressional representatives.

As this is written in late March, we’re all unsure what will happen in the days and weeks ahead. But there are two things we can count on—health information professionals stepping up to make a difference, and AHIMA being here for you. We are, indeed, all in this together.

Apply to Become an AHIMA Fellow

The AHIMA Fellowship Program is a program of earned recognition for AHIMA members who have made significant and sustained contributions to the profession. Review the eligibility criteria and use the Fellowship Eligibility Tracking Tool to see if you qualify.

The second application deadline for 2020 is May 22. Email volunteer.services@ahima.org to request an online application.

Now Accepting Nominations for the 2020 Grace Award

The annual Grace Award recognizes an outstanding organization’s journey toward new and innovative HIM practices that deliver better patient outcomes. The 2020 recipient will be honored at the AHIMA20: Health Data and Information Conference in Atlanta. The Grace Award is an opportunity to celebrate your team’s success with AHIMA. This year’s application has been shortened and simplified, allowing applicants to easily document their hard work and achievements. Applications are due by May 22 at 11:59 p.m. CT.

Contribute to the Foundation’s HIRO Fund

The effects of COVID-19 have escalated and impacted our lives in ways we could not have foreseen. In response, the AHIMA Foundation updated eligibility criteria for the Health Information Relief Operation (HIRO) Fund to assist members of the AHIMA living or working in FEMA-designated COVID-19 disaster areas. You can donate to the AHIMA Foundation and help members build greater economic security for themselves and their families during these uncertain times.

Health Information professionals are making a tremendous difference as our world tries to curb COVID-19. By doing their jobs effectively, health Information professionals, enable providers more time to focus on patient care. Visit ahimafoundation.org/donate/ to donate to the AHIMA Foundation and stand with the health information community in these trying times.

AHIMA Triumph Award Nominations Due June 1, 2020

AHIMA Triumph Awards are designed to honor and recognize the excellence, dedication, and service of those professionals or groups whose steadfast efforts have enriched the HIM profession.

To learn more about award categories, descriptions, and guidelines, as well as past recipients, and about the 2020 nomination form, visit https://app.smarterselect.com/programs/59205-AhimaAhima-Foundation. Nominations are due by June 1, 2020.

**IMPACT AREAS: INTEGRITY, CONNECTION, AND ACCESS**

*Journal of AHIMA* readers are going to be seeing—and hearing and reading—a lot about “Integrity,” “Connection,” and “Access” this year. Cornerstones of health information management, all *Journal* feature content in the year ahead will highlight one or more of these areas.

- **Integrity**: Advancing the knowledgeable, contextual, secure, and appropriate creation and use of health data, leading industry conversations on innovative ways to ensure integrity

- **Connection**: Facilitating optimal sharing of data between providers, consumers, health information networks, and health plans through technology-enabled, secure access to electronic health information

- **Access**: Guiding the industry toward the most effective policies and practices to balance the ever-evolving need for appropriate access to protected health information with ensuring the confidentiality, integrity, and security of protected health information
Social determinants of health (SDOH) are the economic, social, and behavioral conditions that influence the health and quality of life of individuals and populations—data that HIM professionals are uniquely equipped to capture. The Journal of AHIMA created a landing page on the Journal website dedicated to SDOH in order to provide a navigable resource for SDOH-related content. Here you will find articles from the Journal exploring the topic of SDOH as well as information on events and other resources from AHIMA and the across the healthcare industry. You can find this information at: https://journal.ahima.org/social-determinants-of-health/
‘If Patients Only Knew…’

HIM TACKLES THE THREAT OF PATIENT MISIDENTIFICATION

By Mary Butler
If patients knew more about the risks then they would be less likely to make mistakes. This is a persistent belief that many patients have, according to HIM professionals who work closely with patient identity management. When patients are undergoing an outpatient procedure, their internal alarm bells go off when they notice that the home address listed on a prescription print-off was not their own.

“I called my doctor’s office and I said, ‘I think my information has been overlaid with another patient in your office,’” Hunsaker says. When the person on the other end of the phone didn’t know what an overlay was, Hunsaker asked to speak to the office manager so she wouldn’t have to explain it again.

“I explained what I do for Banner Health. And I said, ‘Here’s what happened. I would like for you to please, instead of going into my record that you’re probably looking at right now and just updating the address to what I’m about to tell you it should be, please check and see if you can see the name history. Because I’m about to go and to have this procedure in two days, and I don’t want there to be any complications’.”

When the office manager assured her that there was no further evidence of an overlay, Hunsaker tried to relax. Laughing—nervously—Hunsaker said, “OK, I’m going to trust you that nothing terrible is going to happen during my procedure.”

Due to her professional history of managing Banner Health’s enterprise master patient index (EMPI), Hunsaker knew exactly what could go wrong if someone else’s medical history was interspersed with her own. But this incident was a reminder that most patients don’t realize this is a scenario that HIM professionals work valiantly to prevent.

There are myriad ways providers work to prevent the intrusion of harmful medical mistakes in the care they deliver to patients.

There are myriad ways providers work to prevent the intrusion of harmful medical mistakes in the care they deliver to patients. Physicians offices and specialty clinics give patients lists of sound-alike medications to combat confusion between prescription drugs such as Celebrex and Celexa or Toradol and Tramadol.

It’s also a best practice for hospitals to survey patients after an inpatient stay to ask questions about whether their caregivers washed their hands or changed gloves between patients. And, since 2007, as part of its National Patient Safety Goals, the Joint Commission has required that healthcare organizations encourage patients’ active involvement in their own care as a patient safety strategy.

At the same time, patient safety experts caution against leaning too hard on patients to report errors or unsafe conditions when they witness them. An analysis of studies by the Agency for Healthcare Research and Quality (AHRQ) found that engaging patients in medical error prevention “risks simply shifting the responsibility for safety from providers and institutions to patients themselves.”

HIM professionals who work closely with patient identity and on EMPI management are all-too-familiar with patient safety events that can arise from patient identity mismatches and poor data collection, and many of them report a persistent belief that if patients knew more about the risks then they would be less guarded about sharing additional identifiers with registrars during the intake process.

For example, people readily understand that when surgeons use a marker to put an X on the body part where they’ll be performing surgery, they’re doing so for the patient’s own safety, says Rebecca Way, RHIA, director of revenue cycle and business operations for Northwell Health.

“When I’m about to get on a plane and they say, ‘We need to have a mechanic come on and look at something,’ we don’t second guess that. We say, ‘OK,’” she explains. “I think we, as patients, need to understand what we’re really being asked and why it’s being asked of us, and then I think it would be easier to say, ‘Oh, sure. I understand now.’”

As Way is quick to note, identity, by nature is deeply personal and so are the questions that surround it. While the collection of basic demographic data may feel mundane to the staff members typing it in, it might not feel that way to the worried parent of a sick child.

The good news is that consumers are more open to identity verification now than they used to be.

“I was just telling someone last week that every time I log into my bank to check my account and pay a bill, or I go download a song, I’m going through multiple validations to confirm my identity. And yet, we don’t even do a two-factor authentication when we’re treating patients,” Way says.

She notes that since patients are already being asked to jump through multiple hoops to verify their identity in other aspects of their online lives, it’s logical to believe they’d be willing to do so when they go to the doctor or log in to view their patient portal.

“I kind of feel like right now is a perfect time because we’re all doing that everywhere already,” Way says. “There’s such awareness on identity theft and fraud that in the digital world right now, I don’t think young people would even think twice about continuing to give information,” she adds.

Way oversees a team that follows up with patients individually when they identify mismatched information in Northwell’s patient portal, FollowMyHealth. Way’s team members have found that patients are much more forthcoming with identifiers over the phone versus during an in-person encounter.

“These patients are much more precise in a portal setting than when they’re sitting at a registrar’s desk. Patients tend to say, ‘Oh, I don’t have a phone,’ or, ‘I don’t have an email,’ when they’re sitting in an office,” Way explains. “In the doctor’s office you don’t want to stand around and fill out five pages of information, so you shorten everything. But when you’re sitting at home online trying to join the portal, you tend to give more information or different information.”

In healthcare organizations across the country, HIM professionals are actively engaged in empowering patients to own their health data and take responsibility for it. But duplicate records still proliferate and patient safety events tied to identity mismatches are still cause for alarm.

To get a better sense of what is and is not working and to get
ideas on new ways to involve patients in identity management, the Journal of AHIMA asked HIM professionals closely involved with data integrity and EMPI management what they wished patients knew, as well as for their ideas on bringing patients into the verification process.

These individuals also shared some strategies for reconfiguring electronic health records (EHRs) to capture sexual orientation and gender identity (SO/GI) data, tips for thoughtfully integrating biometric devices into identity verification workflows, and ideas for tweaking the scripts that registrars and front-office staff employ when checking patients into electronic systems.

Sexual Orientation and Gender Identity Data Capture

According to the Institute of Medicine’s landmark report Crossing the Quality Chasm, patient-centered care helps foster a culture of safety. It defines patient-centered care as care that is “respectful of and responsive to individual patient preferences, needs, and values and ensures that patient values guide all clinical decisions.”

This mandate presents a challenge and an opportunity to healthcare systems and HIM departments tasked with ensuring the integrity of demographic data collected for the LGBTQ patient population.

Although the US Department of Health and Human Services (HHS) published rules in 2015 requiring that EHRs certified by the Centers for Medicare and Medicaid Services’ Meaningful Use EHR Incentive Program must include fields for SO/GI data, compliant systems and the sensitivity training that’s crucial to successfully using the SO/GI fields haven’t seen widespread adoption.

In a poll conducted at a session during AHIMA19: Health Data and Information Conference, only 46 percent of respondents surveyed said their organizations were capturing SO/GI data.

EHRs that don’t adequately capture data such as legal name, preferred name, preferred pronouns, legal sex, sexual orientation, gender identity, and sex assigned at birth puts patients at risk for identity mismatches and record overlays. As a result, physicians may not be able to view their patient’s entire medical history, which could lead to redundant tests, overlooked drug allergies, or use terminology that insults or alienates the patient.

Chris Grasso, MPH, associate vice president for informatics and data services at the Fenway Institute, says a typical example of how this might happen is a transgender patient who changes their legal name and gender and asks their primary care physician’s office to update their information there, but that information isn’t carried over to the hospital where they receive specialty care.

“There’s different reasons that people may decide to change it [their gender] in one area and not in other areas. And that’s one of the things that we’ve been really interested in actually working on, especially around some of the claims forms,” Grasso says. “Because so many of the algorithms that insurance providers use to either approve or reject a claim is oftentimes based on gender and not a person’s body parts...these patients have a much higher risk of being mismatched in an EHR system.”

Unfortunately, the burden of helping providers sort out their records and assuring their own physical safety too often falls on the patient in these cases—which is exactly the scenario AHRQ warned against when it said engaging patients in error prevention risked shifting the burden away from providers and onto the patient.

“It’s important for providers to help patients understand that their interests are aligned in terms of helping them prevent a lot of downstream headaches. But I do think it’s a lot of work,” Grasso says, for the providers and the patients. “If somebody decides to change their legal name and gender and asks their primary care physician’s office to update their information there, but that information isn’t carried over to the hospital where they receive specialty care.

Way’s organization, Northwell Health, which serves the New York City and Long Island metropolitan areas, went live with its EHR’s updated SO/GI modules over a year ago, and it’s already made a huge difference for the system’s LGBTQ patients.

Prior to the SO/GI data field updates, Way’s team was spending a lot of time merging duplicate records and dealing with concerns from patients who would walk into their doctor’s office only to be called by a name they no longer used.

“I would get calls constantly from our main physician who works with those individuals going through the [gender transition] process and he expressed how frustrating it was for him and his patients,” Way says. Thankfully, this issue has improved since the update.

The Fenway Institute, where Grasso works, has created an extensive trove of materials designed to help providers sensitively roll out SO/GI-compliant platforms.
“We have actually developed very short tutorial videos that people can use as part of their training with their staff. These three-minute videos walk people through a bad interaction and a good interaction, and we also have lots of pamphlets and other documentation that people can download for free,” Grasso says.

Making Biometrics Patient-Friendly
In the absence of a unique patient identifier (UPI) and broad adoption of interoperable EHRs, many healthcare organizations are turning to biometric devices, such as palm vein, retina, and facial recognition scanners, as well as photographs of patients to improve the accuracy of their patient matches. Each of these technologies have their own set of pros and cons, but there’s research to suggest that they’re popular with patients.

According to a 2018 report from the Pew Charitable Trusts, “patients interviewed in focus groups overwhelmingly preferred the use of a unique identifier to improve patient matching, with very few individuals expressing reluctance. Participants said that a unique identifier would decrease medical mistakes, give clinicians a more complete picture of their health, and be more secure than demographic data.”

Patient comfort levels with biometrics, according to the researchers, stem from the fact that these methods are deeply embedded in the habits of individuals who are already using facial recognition and thumbprints to unlock their cell phones and other devices.

Lorraine Possanza, DPM, JD, MBE, program director, Partnership for Health IT Patient Safety at the ECRI Institute, a nonpro- fit organization that focuses on patient safety, says one provider organization she worked with successfully reduced its duplicate record rates by 50 percent thanks to palm vein scanners.

This organization was very deliberate in where and how they deployed the technology, though. First, the provider looked at all the different locations where patients registered when they arrived at the facility and tried to reduce the number of access points so that patients only had to register at one point.

Then they made sure that registrars gathered the same information from patients, in the same manner, at every point and kept their explanations about the palm vein scanners consistent. The only pushback this particular provider received was from its own infection control department, which was concerned about asking patients to touch the same surface repeatedly.

Grant Landsbach, RHIA, CHDA, MSHA, system manager, data governance and interoperability, at SCL Health in Colorado, who has considered several biometric strategies, has found some drawbacks to palm vein scanning systems, including the need for large databases and complicated interfaces to support it.

“What we are starting to implement is the regular practice of taking a patient’s photo at regular intervals in some of the situations where they’re coming into the hospital. But, of course, that’s completely at their discretion,” Landsbach says.

“If we do scan their IDs, and that means their insurance card and their driver’s license, which is pretty standard in any healthcare setting these days. In the ER, of course, we don’t do that until they’re admitted. But we’re not experts on this yet.”

Landsbach and his team are still working through.

“I think there is a barrier with that that maybe other biometrics wouldn’t have,” Landsbach says. “There are some patients for whom photographs aren’t their thing. Now, we do have some settings, like alcohol and drug rehabilitation and some psych and behavioral settings that use pictures too. If a patient is in a mental hold or in something like that, those pictures are taken for their safety and they’re included in their general consents.”

What Patients Need to Know
While more patients are aware than ever of the role they play in helping providers avoid medical mistakes, many only notice the burdens placed on them to mitigate safety issues—such as repeated requests to verify their name and date of birth. Patients understand that their wristbands are supposed to help nurses and doctors identify them, and that barcode scanning helps ensure that medications they receive during inpatient stays are going to the right person.

But in most healthcare access points, there isn’t signage or brochures set out to remind them why it’s important to be thorough and forthcoming when they’re asked for registration information. Northwell’s Way says there are many situations that have her wishing, “If patients only knew.” For example, she would love to
EXTREME WEATHER EVENTS are becoming increasingly common in the United States and around the world, from chronic, long-term events like droughts to acute, seasonal events like wildfires and floods. As these events continue to increase in frequency and severity, America’s healthcare infrastructure and its ability to deliver quality care will continue to be impacted in ways beyond its original limits.
Extreme weather events, while not new, challenge the physical and operational infrastructure that supports our healthcare system—and yet are often minimized and treated as local problems.

While the acute impacts of natural disasters—casualties, damaged infrastructure, disruptions to people’s daily lives, and negative impacts for businesses—are top of mind in the wake of natural disasters, extreme weather events also exacerbate chronic health conditions such as asthma, expand the range of infectious diseases, and have a negative impact on mental health. Over the long term, these events may also trigger persistent health risks that will develop long after the event occurred. Perhaps synthesizing and analyzing patient data with climate data will be the key that unlocks the answers on how our healthcare delivery can prepare for and better serve our population as these changes take place.

According to the Centers for Disease Control and Prevention (CDC), climate change impacts a wide range of health outcomes. Figure 1 illustrates the most significant climate change impacts, their effect on exposures, and the subsequent health outcomes that can result from these changes in exposures.

However, the connection between extreme weather events and long-term health effects is not the focus of the data and information systems supporting the healthcare infrastructure. To mitigate and prepare for what may be considered the “new normal” in care, we must have a better understanding of information that is collected.

In tandem, there needs to be greater clarity as to how health information management and other informatics professionals are preparing for long-term weather event impacts of climate change—if they are preparing at all. To become better prepared for these impending changes, leveraging and synthesizing health, climate, community, and other sources of data to analyze and develop solutions is necessary.

Three to five months after the 37,000-acre Tubbs Fire in the Napa and Sonoma Valleys of California that took place in October 2017, the region’s emergency rooms treated approximately 20 percent more patients for respiratory and cardiac ailments compared with previous years, according to the state data analysis.

At the time, the Tubbs Fire was the most destructive in California history, killing 22 people and destroying nearly 6,000 structures. These respiratory and cardiac issues will persist locally in the region, yet there is no explicit way of connecting the illnesses to the wildfire just yet. There is currently a lack of comprehensive longitudinal research that monitors health conditions and their relationship to persistent severe weather changes.

As we continue to experience a changing climate worldwide, people may be exposed to more vulnerabilities and require more attention from their healthcare providers. With the cycle of rising temperatures, persistent extreme weather events, rising sea levels, and degradation of air and water, quality healthcare organizations will need to prepare for the changing needs of their patient populations, healthcare workforce, medical supplies, pharmaceutical supplies, telemedicine capabilities, and community health service offerings. Research indicates that there is an absence of data and corresponding analysis regarding weather events as it relates to impacts on health over the long term. While providers have known anecdotally there is a need to conduct long-term studies, they acknowledge that now is the time to make a concerted effort towards collecting and studying the data, according to Walter Suarez, MD, MPH, public health and medical information systems specialist and executive director of health IT strategy and policy for Kaiser Permanente. This effort will enable healthcare organizations, communities, lawmakers, and public health experts to make informed decisions on determining a longer-term path forward. For example, as wildfires persist in California and the seasons extend for longer periods of time, providers will need to prepare a shift in their workforce and medical supplies for an increase in cardio-respiratory patients, infant and maternal mortality, asthma in children, and behavioral health needs.

**Overview of Recent Wildfire Disasters and Impact**

The 2018 Camp Fire in Paradise, CA, was a significant health event, killing 85 people and causing over 52,000 people to be evacuated. However, the health impact of the fire spread hundreds of miles away, causing school closures as far away as the San Francisco Bay Area, home to over 7 million people. Its long-term health impacts are sure to be seen, as well as the mental health impact for those who were evacuated or lost their community to the fire. These types of occurrences have expanded beyond California and beyond just wildfires. Given the breadth of the area impacted by the Camp Fire, the true scale of the impact on the healthcare infrastructure in California is unknown. What makes this more challenging is the siloed nature of natural disaster data and health data, and the inability to seamlessly communicate information across the country. Pairing health data with climate data and weather data, and possibly other data sources, will enable preparation and assessment of those high-impact areas and populations and help drive more effective care management for the long term.

Another complication is the uncertainty of when extreme weather events will occur, and most healthcare systems are focused on maintaining fiscal responsibility and not necessarily planning for events they are unable to predict. Standardizing how healthcare systems can forecast and plan for extreme events is a necessity but putting this process into place is no small task. Organizational obstacles in the public and private sector need to be removed and the importance of this challenge must be elevated in multiple public service communities.

**Legislative Activity**

Authorized by HR 6 on January 9, 2019, the US House Select Committee on the Climate Crisis was charged with “delivering ambitious climate policy recommendations to Congress, in order to achieve substantial and permanent reductions in pollution and other activities that contribute to the climate crisis.” Chaired by Rep. Kathy Caster (D-FL), the committee members include experts in environmental justice, coastal flooding, clean energy development, and other areas vital to addressing the climate crisis. In a short time, the committee has helped to support the passage of several key bills addressing climate change activity, to secure critical funding, and to conduct over 100 hearings, several of which were hosted by the committee. In early 2019, Sen. Chuck
Schumer (D-NY) introduced a resolution to establish a similar committee within the Senate, but the resolution did not advance. According to Lauren Riplinger, JD, vice president, policy and government affairs at AHIMA, getting any bills passed into law in 2020 will be difficult, as “there are many competing issues such as the Coronavirus Disease 2019 (COVID-19) pandemic, the upcoming election, not many working days left in Congress before the end of the session, and several competing healthcare issues that are resonating with both sides of the aisle right now, such as surprise billing and prescription drugs.” She anticipates that if the Senate flips to a Democratic majority in the new Congress, there may be opportunities to make some progress in climate change laws. However, there will still need to be a president who supports signing bills into law to make any progress.

Historic Event Spurred Environmental Action

The connection between extreme events and long-term health is not new. One of the deadliest air pollution disasters in US history occurred over Halloween in 1948. In Donora, PA, a small town on the Monongahela River approximately 30 miles south of Pittsburgh, 20 people died from what is now known as the Deadly Donora Smog of 1948. In the early 1900s, Carnegie Steel, American Steel & Wire Company, and others joined the industrial revolution and replaced farming communities with mills. The mills’ furnaces produced combinations of poisonous gases, heavy metals, and fine particulate matter. Shortly before Halloween, a dense yellow fog blanketed the town, creating a haze so thick that townspeople were barely able to see in front of them. Within days of the arrival of the fog, 20 people were dead and hundreds more with respiratory or cardiac problems were advised to evacuate the city to avoid potential death. From 1948 to 1957, the rate of death from cancer and cardiovascular disease in Donora was significantly elevated. It wasn’t until rain arrived on the fifth day of the fog that it dissipated. If not for the rain, experts believed thousands more would have perished.

The Donora Smog incident sparked an interest in public health that elevated research beyond investigating epidemics such as polio or cholera. It ushered in a new era of focusing on chronic exposure to pollutants and their health impacts and initiated the first national air pollution conference in 1950, convened by President Truman. The Clean Air Act wasn’t passed until 1963, but President Nixon created the Environmental Protection Agency shortly after in 1970. Today there is a need for renewed attention to long-term health events and extreme or unpredictable weather events, just as resources were applied to identify and implement solutions to safeguard public health from extreme events in the past. With the capability to integrate diverse and disparate data streams with adaptable data privacy and governance approaches firmly within reach for US data scientists, developing a consistent approach to connect extreme weather events with long-term health impacts would, in essence, cast a light on this current blind spot in the country’s delivery of care.

Implementing Change in Health Systems

A good methodology for creating the connection between extreme weather events and the impact to healthcare systems and care delivery would be to use the “Plan-Do-Study-Act” (PDSA) approach, as recommended by the Institute for Healthcare Improvement. This system enables one to test and implement
change in a structured system. While the concepts of “extreme weather events” and “long-term impacts on healthcare delivery” are large and vague, it is important for all those working in these systems to test and observe how these two concepts can interact.

Below is an example of how the interactions can be tested or observed using the PDSA approach:

- **Plan:** In this phase, one sets the boundaries of investigation. For example, one can look to investigate the interaction of flooding on long-term mental health impacts and communicable diseases in a certain region over a given time. Ideally, individual health systems will choose a specific impact over a specific time, so as not to overwhelm the implementers.

- **Do:** In this step, one carries out an investigation, testing the data availability and associated concerns. The responsible party tracks the extreme event and gathers data associated with that event, tracks the associated health impacts, generates hypothesis of correlation and causation between the events and the readiness of the healthcare system to provide adequate care, and validates the observations with on-the-ground local weather and health experts. It is also possible to do a historical evaluation, using past events as a marker.

- **Study:** Reflecting on the preparedness of the health system, investigate the ability to inform the connection using data. The investigator observes which data were available and which were not relative to the ideal data set, observes what challenges existed or will exist in data format, transfer, availability, and governance. In addition, one would determine how the key stakeholders understand both the connection between the event and the health effects, and the data challenges associated with them.

- **Act:** In this final stage, one asks, “How can systems be put in place to prepare for future extreme events?” It is essential to determine what agreements need to be put in place between key public and private stakeholders, what physical (or virtual) systems need to be put in place in order to store and manage data, and how current systems of early warnings of both natural disasters and health event outbreaks better incorporate data. Lastly, one could identify which kinds of alarms or alerts are needed for each major stakeholder group.

The PDSA approach is intended as an iterative cycle. Solving or event identifying the connections between health systems and extreme weather events will not be complete in one iteration of the cycle. We are in the early stages of observing and managing long-term impacts from climate change; we will need to address these issues with an ongoing process.

**Notes**


7. Ibid.


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Journal of AHIMA Continuing Education Quiz

**Quiz ID:** Q2029105 | **EXPIRATION DATE:** MAY 1, 2021
**HIM Domain Area:** Clinical Data Management
**Article—"Preparing Healthcare for Climate Change"**

Review Quiz Questions and Take the Quiz Based on this Article Online at https://my.ahima.org/store
CONSIDER THIS SCENARIO: A 50-year-old female presents to the emergency room with shortness of breath, chest and shoulder pain, and nausea. A registrar quickly collects the patient’s name, date of birth, and insurance information before a nurse begins an assessment to rule out a heart attack.

Meanwhile, the registrar performs a quick search and doesn’t find an exact match. They create a new medical record number under which all of the patient’s care is documented and billed without realizing a medical record number already exists. The result? A duplicate record. The number of times this scenario occurs at most hospitals? Far too often.

Patient matching challenges aren’t new, says Letha Stewart, RHIA, director of customer relations at QuadraMed Corporation. What’s novel is the increased focus on these challenges and the downstream effects on outcomes and cost—particularly as more providers consolidate, participate in health information exchange (HIE), and join accountable care organizations (ACOs). Stewart identified five trends that will affect patient matching in 2020 and beyond.

1. Growing desire to learn more about patients across care settings, systems. Prior to ACOs and HIE, providers were primarily concerned with patient matching within their organization and mostly for the purpose of preventing medical errors, says Stewart. However, with value-based payment models, providers are starting to consider the bigger picture—that is, how patient matching (or lack thereof) across inpatient and outpatient settings contributes to costs. For example, a primary care physician can educate high-cost patients about the importance of medication adherence to minimize unnecessary trips to the emergency room. This intervention is nearly impossible without the ability to match patients correctly and analyze cost trends, she adds.

Where health systems go wrong is assuming that if they migrate all providers to the same electronic health record (EHR), they’ve solved the problem of patient matching. In reality, the problem is only solved at a local level, says Stewart. If a hospital or health system is part of an ACO, it also needs to share information with other entities that are part of that same ACO, many of which may not share the same EHR, she adds.

According the Office of the National Coordinator (ONC) for Health IT, there’s a 50 percent to 60 percent match rate as data is shared across unaffiliated organizations. This less-than-optimal rate leads to duplicates, overlays, and overlaps, says Stewart.

The value proposition for matching patients within an ACO is relatively clear: All providers benefit financially when patients achieve positive outcomes at the lowest cost. Being able to match and track those patients is critical. However, one hurdle is that entities within the same ACO may also be vying for the same patients. This means these entities are often only willing to share the minimum amount of information necessary to satisfy the conditions of the ACO, says Stewart.

For example, a hospital may not want to share demographic information for its entire patient population with a competitor, such as a third-party lab vendor. If the lab has access to that information, it could theoretically market its services to patients who haven’t ever used the lab, she adds.

2. Framing patient matching in the context of patient satisfaction. Patients don’t want multiple bills from multiple providers for a single episode of care, says Stewart. When records are accurately linked, organizations can send one consolidated bill for hospital and physician services. This may improve patient satisfaction rates and the likelihood that patients will pay their bills, she adds. In addition, accurate matching prevents patients from receiving duplicate services that also drive up costs, such as a lab or other test linked to a duplicate record, says Stewart. When a provider can’t find the results because they’re in the duplicate record, they may ask the patient to repeat the lab or test.

3. Use of referential data. With referential matching, organizations use information from multiple sources, including but not limited to credit bureaus and the US Postal Services, to accurately identify patients.

“Referential data is an important tool in patient matching because it’s current and updated automatically with no specific action on the part of the patient,” says Stewart.

As patients move, for example, referential databases capture new addresses from utility and mortgage companies as well as

Five Trends in Patient Matching for 2020

By Lisa A. Eramo, MA
the US Postal Service. As patients get married, referential databases capture name changes from DMV records. Healthcare organizations aren’t privy to these changes unless and until patients return for care, and even then, there’s no guarantee that patients will provide updated information, says Stewart. The more referential data sources, the better. For example, hunting and fishing licenses can help organizations match minors who may not have a credit history or a wealth of other public records, she adds.

One caveat is that patients themselves don’t validate information flowing into the referential database, making it easy for registrars to draw inaccurate conclusions. For example, a referential database may list a patient as living at a specific address when in reality they’ve lived at a nursing home for several years. Registrars may assume that it’s two different individuals when in fact, it’s the same individual, she adds.

“As an industry, we all need to agree on what constitutes a match when we’re looking at referential data,” says Stewart. “How much data is necessary, and what specific data is necessary? There’s no standard currently. All vendors that use referential data have their own proprietary algorithms for matching. Standards will help the industry gain the most value from referential data while also minimizing the risk of inaccurate matches.”

4. Tailoring matching algorithms to specific patient populations. Although referential data is beneficial to patient matching, one limitation is that it tends to focus on national data rather than regional nuances, says Stewart.

For example, the percentage of Hispanic individuals is higher in Texas than it is nationally. This means certain names may appear more frequently in Texas, reducing providers’ ability to rely on those names as unique identifiers. Increasingly, providers will use statistical frequency analyses of specific populations within a geographic area or even within a single health system to weight certain identifiers appropriately.

5. Greater reliance on cell phone numbers. Organizations are starting to rely more frequently on cell phone numbers as unique identifiers because patients tend to keep the same number for years, says Stewart. In addition, children and teenagers increasingly use cell phones. Unlike the Social Security number (SSN), patients willingly provide their cell phone number so they can receive appointment reminders and other alerts.

Although healthcare organizations often collect email addresses to sign patients up for portals, this information isn’t necessarily helpful in terms of patient matching, says Stewart. Registrars can easily make mistakes when typing email addresses into the EHR. In addition, patients often have more than one email address, and they may not provide the same address at each encounter, she says.

The same is true for social determinants of health (SDOH) data. Organizations increasingly collect this data, but it isn’t necessarily helpful for patient matching because it can change very quickly. For example, a patient may be homeless at one encounter but then find housing a week later.

An Ongoing Debate
Stewart says the national patient identifier (NPI) will continue to receive attention in the next couple of years. “I think it’s a good idea, but I don’t think it’s going to be an easy transition,” she adds. She provides the following challenges that could result in patient matching errors even when using an NPI:

- Patient is unable to provide their NPI (e.g., they’re unconscious or forgot the number)
- Registrars mistype the NPI during a current or previous encounter
- Patient doesn’t yet have an NPI because they were born shortly after the government issued numbers
- Patient isn’t a US citizen

In addition, there are privacy and security concerns. “Hackers can do anything,” says Stewart. “Once they have your NPI, they could access all of your clinical and financial information across systems if they wanted to do so.”

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Abstract
As health information management (HIM) shifts from paper-based medical records to electronic medical documentation, HIM professionals must appropriately manage their resources to produce higher results for their organization’s operational and financial indicators. This case study highlights the experience of the HIM department in a small Florida community hospital in analyzing existing productivity standards and developing new standards with the purpose of improving the document imaging process. The research produced new productivity standards that more accurately represent the time HIM technicians spend performing their everyday tasks. The data collected during this period indicate that the average HIM technician was prepping 844 images an hour, scanning 601 images an hour, and indexing 482 images an hour. While a trend in productivity cannot be identified because different types of data were collected, the department’s standards are now based on more consistently measurable output. The data collected during this study were used to manage the continuously changing workflow processes; improve the staff’s knowledge, skills, and abilities; and identify potential areas of process improvement.

Keywords: productivity; document imaging; process improvement; electronic medical records; calculating benchmarks

Introduction
Since the enactment of HITECH Act in 2009, the US has experienced a rapid acceleration in the development and implementation of electronic health records (EHRs). The systems’ sudden growths led to an incomplete transition from paper medical records, causing a rise of hybrid records consisting of the EHR, paper records, and scanned images. The paper portion of a hybrid record comes at a high cost for healthcare organizations, with an average 1,500-bed hospital producing more than 96 million sheets of paper annually, resulting in costs of up to $3.8 million a year. These costs can be attributed to the large amounts of paper purchased for the hospital to print medical records. As maintaining a hybrid environment can be difficult and expensive, HIM professionals are increasingly challenged with heavy workloads, complex workflows, and added documentation requirements. Balancing the complexities and the confusion of health information technology initiatives, especially the EHR, requires HIM managers to be change agents while seeking higher levels of productivity and quality from employees. Ensuring the efficiency and effectiveness of the document management process provides healthcare organizations with an opportunity to improve on performance measures including continuity of care, length of stay, patient satisfaction, coding quality, and billing denials.

Background
Continuity of patient care following discharge from an inpatient stay
Productivity standards and turnaround times provide needed tools for the healthcare manager. To ensure completion of post discharge document processing in a timely manner, Bhat and colleagues applied Lean Six Sigma techniques to turnaround time for discharged-patient records. With new efficiencies introduced and waste eliminated, they were able to decrease paper record processing time from 19 to eight minutes with assembly, analysis, coding, and filing of the record completed and backlogs eliminated. While this set of medical record processes is not equivalent to EHR processes in the United States, it does provide some basis for comparison and comment. As in the processes noted by Bhat and colleagues, conducting timed observations to determine exactly how much time is spent on different work types provides a baseline for performance improvements.

Existing HIM research has focused on transcription and coding productivity or the effects of productivity on quality, leaving a knowledge gap in information on measuring productivity in the document imaging process. When developing productivity standards, management must consider the specialized skill set of HIM technicians and other employees, factoring in learning curves. Establishing industry benchmarks for HIM document imaging functions has proven difficult because of factors that can affect the process, such as fluctuations in workflow, documentation practices, turnaround time requirements, and equipment. In addition to the core responsibilities of the document imaging process, HIM technicians usually have other responsibilities that vary by facility. Examples of other tasks include answering phone calls and emails and attending to other urgent requests, such as faxing documentation to nursing units and locating documentation for coders. As there is limited published guidance or research on establishing benchmarks, facilities should seek to develop specific productivity measures that have been tailored to account for their organization size, technology, staffing, and designated record set (DRS).

When looking at organizational financial and operational indicators driven by HIM data, such as staffing, reimbursement, length of stay, and compliance, managers need accurate productivity data to make strategic decisions about the future of the organization. As each phase in the document imaging process is reviewed, management should ask: Why are we performing this task? Is there a more efficient or effective approach to completing this task? What are the consequences of removing this task? How does this task affect the department or organization? Therefore, the purpose of this case study was to revise the existing productivity standards established during the original implementation of the EHR in 2015 so that new productivity benchmarks would reflect the current practices that have evolved as a result of technology and workflow changes occurring in the HIM industry.

Methods
This case study looks at a 210-bed public acute-care community hospital. As the hospital transitioned to a hybrid EHR system, the workflow of the HIM department changed significantly. A hybrid structure requires the HIM staff to be skilled in both paper documentation and use of the EHR software, and processes had to be adjusted to accommodate health information in both media. The HIM department faced challenges such as navigating the new EHR, prepping and scanning the remaining paper documentation, creating forms for information not captured in the EHR, and adding barcodes and patient labels to expedite the indexing process. Also, the organization evaluated its DRS to determine what documentation would remain in the DRS and the legal health record, and what documentation should be converted into the EHR vs. remain paper based.

Defining Process Measures
At this hospital, the HIM document imaging team consisted of three technicians who were cross-trained in all steps of the process. Breaking down each step in the process allows management to identify variables that could be causing bottlenecks. The processes used in this case study are defined as follows (see Figure 1):

- **Chart retrieval.** Unit nurse secretaries assemble charts each night after patient discharge if the documentation has not been picked up concurrently while the patient is in house. The following morning, HIM staff pick up the charts from each nursing unit. This step includes chart checks to ensure that all documentation from each patient is received in the HIM department. The chart check process is completed by comparing a list of discharged patients to the charts that have been sent down from the nursing floors to confirm that no patient chart has been misplaced.

- **Chart preparation.** Disassembling the chart involves preparing the chart to be scanned. It encompasses removing staples, grouping similar documents together, rearranging documents in chronological order, taping down monitor strips, verifying that all documents belong to the identified patient, adding patient labels, and discarding documentation that is not part of the DRS. Documents are scanned to produce an electronic version of the documentation. Because of the low volume of paper at the hospital, individual desk scanners are used instead of industrial scanners. During this portion of the document imaging process, the HIM technicians will also apply electronic deficiency indicators to documentation needing signatures.

- **Quality check.** The quality check includes reviewing the scanned documentation and determining if the images are the
best possible quality before they are transferred into the EHR.

**Incident reports.** This step involves reporting errors in documentation that have the potential to affect patient safety and require a full investigation from risk management. Examples could include lost documentation or documentation sent from the nursing floor with incorrect patient identifiers. Incident reports can be recorded at any point in the document imaging process.

**Miscellaneous time.** This category includes nonproductive time spent working on tasks that are not directly related to the document imaging process, such as attending meetings or answering phone calls from other departments.

### Developing Benchmarks (Calculating Productivity Expectations)

After time studies were performed, the process of establishing benchmarks began with calculation of the average amount of time each technician takes to complete tasks. Labor productivity was calculated using the following formula:

\[
\text{Labor productivity} = \frac{\text{Total work produced}}{\text{Total time to complete work}}
\]

In this formula, labor productivity indicates the amount of time taken to complete the work produced. Benchmarks were established by dividing the amount of work produced in the department (i.e., chart retrieval or scanning) by the time it took the technicians to complete the tasks.

The original productivity standards that previously existed in the HIM department were measured by inches, not images, so it is not possible to provide a direct comparison between the two sets of productivity benchmarks.

### Establishing Hours Worked

Determining the number of hours that employees are required to be productive is necessary to ensure accuracy and accountability. Each technician was responsible for 7.5 hours of work daily or 37.5 hours weekly to account for paid and unpaid breaks. Paid time off requires hours to be adjusted on a weekly basis. Time spent on miscellaneous tasks is logged as well.

### Creating a Productivity Log

Maintaining a productivity log provides a mechanism for technicians and managers to track efficiency trends over time (see Figure 3). Using spreadsheet or database software such as Microsoft Excel or Access, technicians can enter their work produced daily. This includes the amount of miscellaneous "trash" documents (documents not prepped and scanned) to ensure that the technicians receive proper credit for their time.

### Implementing New Benchmarks

After the new productivity benchmarks were established, the process of implementation involved transitioning from the previously established standards to the newly created standards. Because the last set of time studies concluded in August 2018, the implementation date was set for October 2018 to allow time for employee education and to coincide with the start of the new fiscal year. In the time between August and October, management trained the HIM technicians on the new benchmarks, explaining the reasons for the revisions to the existing standards, the methodology used to arrive at the new standards, and expectations for performance according to the new standards. Starting in September 2018, the new standards were implemented on a trial basis to identify any potential variances, and in October 2018, the new productivity standards went live.

### Results

Commencing with the EHR implementation in 2015, HIM technicians measured the total inches of chart documentation picked up each morning. Documentation produced over the past four years shifted from 20-inch batches to batches of less than one inch, making it difficult to obtain an accurate measurement. Another prevalent method of measuring productivity is by weight; however, the light amount of documentation picked up in each round made it difficult to attain an accurate weight on the scale.

Although the units of work are different for the original and the revised productivity standards, the data from the original benchmarks are included in Figure 4 to allow for further analysis. The new benchmarks, based on the results of the productivity studies, are shown in Figure 5. The time studies indicated that, on average, a technician scanned 600 images in 60 minutes, indicat-
ing that the benchmark for scanning should be 600 images in one hour, or 10 images per minute. Figure 6 shows one technician’s productivity compared with the newly established benchmark for image scanning. On average, the data indicate that the technician was able to exceed the benchmark on most days.

Spreadsheets are used to compare technicians’ results to the benchmarks to determine if the technicians are sufficiently productive according to current productivity standards. These spreadsheets also allow for data analysis by specific measures including type of task, individual technicians, or time period.

Discussion

Changes in technology and organizational workflow processes such as electronic forms and order sets, signature pads, and desktop faxing resulted in a gradual reduction in the amount of paper generated and placed into the charts. Smaller paper charts led the HIM department to consider alternate measurement methods. With implementation of a system based on the number of sheets (or images), potential error caused by human measurement is limited, as the EHR measures the number of images scanned and indexed, and the number of images prepped is measured in the quality check process.

Ultimately, because of the various changes mentioned in this article, HIM leadership made an organizational decision in summer 2017 to change the timing of the document imaging process and chart analysis from post discharge to concurrent (while patients are still in house) to improve continuity of care and optimize resources. HIM technicians now visit the nursing unit multiple times a day instead of doing a single early-morning pickup. This allows the HIM department to begin the document imaging process immediately upon the patient’s admission, resulting in quicker analysis and record completion.

While significant workflow changes occurred within the HIM department and the organization, these changes had a positive effect on productivity. Using technology to reduce the amount of paper and reorganizing the flow of work into the department decreased the volume of work needing to be completed and made the work more manageable for staff, thereby decreasing daily employee burnout.

Using the productivity log to investigate trends in the HIM workflow allowed management to identify potential process improvements that would remove bottlenecks delaying the progression of document imaging in the department. Designing the productivity tracker to identify trends in aggregate data from all the technicians, as well as in data from individual technicians, allowed for comparisons of individual technician performance based on the organization’s needs. For example, in this hospital, the tracker identified poor productivity in one otherwise high-performing technician, which allowed management to pinpoint certain processes where the employee needed retraining. Analysis revealed that the low productivity was not directly connected to performance but to secondary factors including the technician’s scanner and chart pickup route. Additionally, the tracker trended an increasing amount of miscellaneous “trash” documents being picked up from the floors, which directly correlated to increased amounts of time spent on prepping. Identifying this trend presented an opportunity to provide nursing staff with education on documentation.

Although the methods used for measuring productivity in this case study were designed to account for several variables, the use of self-reported data is a limitation. Numbers reported by different members of the HIM team may be over- or understated. However, comparison of the benchmarks to information from AHIMA shows that the department is in the range of industry standards. To verify the accuracy and consistency of reported numbers, organizations should regularly review and update their HIM document imaging processes and productivity expectations.

The researchers identified two potential areas for future investigation. First, re-creation of this study in a larger hospital or multihospital system would assist in validating the productivity rates. However, as noted, internal processes, equipment, and other factors vary greatly in different facilities, making comparisons difficult. A second area to consider is the document imaging productivity data created by the EHR, which may provide the HIM industry with information regarding which EHR software has more efficient scanning and indexing functions.

Conclusion

Determining standardized industrywide HIM productivity measures for operational tasks is nearly impossible because of variables within hospitals. It’s crucial that HIM departments develop their own organization-specific productivity measures to ensure they are accounting for all variables that could affect the document imaging process. Overall, the process of designing an accurate productivity system at a small community hospital can present unique challenges. Although EHR-generated reports are useful to compare to the time studies for a well-rounded picture, one must also account for potential inaccuracies. The report may not include images that were rescanned for quality, or it may not account for technical issues with the scanners. An accurate and complete medical record includes high-quality images of all scanned documents, and continuity of care relies on availability of the information. In this manner, efficiency in the HIM department translates into efficiency in patient care.

Notes

5. The Joint Commission. ”Transitions of Care: The Need for Collaboration across Entire Care Continuum.” Hot Topics in

Continued on page 43
Patient Record Integrity is Prerequisite for Patient Safety, Interoperability

Erin Benson, MA, MBA
MATCHING A PATIENT to his or her correct medical record is critical to the success of a healthcare organization. Attributing information to the wrong patient’s record or creating a duplicate record not only puts the patient’s safety at risk, but also decreases productivity and can lead to lower reimbursements.

Moreover, ensuring patient data integrity goes hand in glove with efforts to achieve interoperability. The Office of the National Coordinator (ONC) for Health Information Technology recently unveiled its strategic health IT draft plan on data sharing that presupposes that patients and providers trust in the integrity and safety of electronic health information. ONC’s interoperability goals will be hard to achieve for organizations that do not have records accurately linked to their patients, whose information is within the walls or systems of each healthcare organization and is not being linked correctly to one record for each patient. The goal of the ONC’s strategic plan is to give consumers access to the data, but who secures it and its integrity? And does the patient understand the implications of sharing the data?

A Trickle-Down Effect on Revenue, Patient Satisfaction
The accurate patient record issue extends to the financial health of an organization. Research found that 33 percent of all denied claims cost an average hospital $1.5 million annually—and the US healthcare system as a whole more than $6 billion a year. The loss was credited to incorrect patient record data, which often led to redundant testing and denied claims.

Having to repeat tests or have their benefits denied and care delayed is certainly cause for frustration for patients, who expect the same seamless and customer-focused experience in healthcare as they receive in retail, banking, and other services. Patients may be prompted to score providers lower on CAHPS surveys, which impact provider quality ratings and the ability to collect reimbursement. With rising high-deductible health plans, patients are becoming more attuned to the costs they have to pay directly before benefits kick in.

Solving the Challenge One Unique Patient Identifier at a Time
The good news is many organizations have taken notice and are focusing proactively on patient record integrity. Many stakeholders advocate for a national patient identifier; meanwhile, the industry can tackle the problem by capitalizing on unique patient identifiers to uniquely identify each patient, link records together as they come in from disparate sources on the same patient, and keep the patient’s contact information up to date. For example, referential matching technology uses unique identifiers and third-party data to pair duplicates, identify and resolve linking discrepancies, and provide continuous updates to the record.

Among healthcare organizations spearheading their own efforts to address preventable errors is the National Council for Prescription Drug Programs (NCPDP). Its members chose to use a vendor-agnostic universal patient identifier (UPI) to help ensure accurate identification of patients. LexisNexis® Risk Solutions LexID® is a unique patient identifier the industry partners will be able to use in their pharmacy billing and e-prescribing transactions to help avoid preventable errors.

The technology gives patients, hospitals, payers, physicians, and pharmacies the confidence to link records regardless of health IT systems to get a clear picture of the entire patient journey. Achieving an accurate view of the patient population through correct records builds the foundation for delivering high-quality and safe patient care and fulfills a prerequisite to interoperability.

Patient data inconsistencies also generate numerous challenges as organizations seek patient care improvements, plan additional expansion, launch population health initiatives, implement new information systems, navigate payment policies, and assess organizational performance. Additionally, inaccurate population count and lack of updated contact information undermines other efforts to succeed in value-based care, including preventive care, social determinants of health (SDOH)-based outreach, and population health management.

Patient Safety, Outcomes Depend on Correct Records
Patient record errors pose a direct risk to patient safety. A study conducted by the Institute for Safe Medication Practices found that wrong-patient errors happen about once for every 1,000 prescriptions filled. At the top of the ECRI Institute’s 2019 Top 10 Patient Safety Concerns was diagnostic stewardship and test result management in electronic health records (EHRs)—indicating just how important it is to make sure information can be properly communicated to the clinical care team. That starts with getting that information attributed to the right patient record.

Patient Safety Concerns was diagnostic stewardship and test result management in electronic health records (EHRs)—indicating just how important it is to make sure information can be properly communicated to the clinical care team. That starts with getting that information attributed to the right patient record.

Erin Benson, MA, MRA, is senior director, market planning at LexisNexis Risk Solutions, works with a focus on the development and execution of strategic planning for member identity and socioeconomic determinants of health solutions.
Assessing the cause and severity of renal abnormalities should be the initial approach to kidney disease for all clinical documentation integrity (CDI) professionals. Hypertension, edema, nausea, or hematuria may be early clinical indicators of kidney disease.

The assessment of kidney disease includes:

- Determining the duration of the disease
- Examination of the urine
- Glomerular filtration rate (GFR) assessment

According to the Association of Clinical Documentation Integrity Specialists (ACDIS), “the H&P provides concise information regarding a patient’s history and exam findings at the time of admission, and it outlines the plan for addressing the issues that prompted the admission.”

Discussing specific symptoms and signs related to kidney disease found in the history and physical (H&P) is beneficial and vital when conducting a medical record review. Reviewing the H&P is essential in outlining the plan for addressing the issues that prompted this admission. CDI professionals need to see and compare how the chief complaint contrasts with the diagnosis or how it relates to the principal diagnosis.

Interpreting Underlying Kidney Disease

Conditions and diagnoses need to be supported clinically; if not, a validation query is warranted. Identifying causative factors and relationships among medical conditions is essential in supporting the identification of the principal diagnosis. Furthermore, there is relevant past medical history found in the H&P.

CDI professionals need to review the H&P thoroughly and capture chronic conditions not included in the documentation. Clarifying current symptoms against past medical conditions and determining the true baseline is essential in differentiating between acute kidney injury (AKI) and chronic kidney disease (CKD) or establishing the CKD level.

CDI specialists should place significant emphasis on conditions not supported or no longer supported clinically by making sure to check this information during follow-up reviews. Based on the information found in the record and H&P, some queries might be issued right away, and some might be postponed until further information is available. Diagnostic testing results are essential because queries can be written on them to help rule in or rule out a diagnosis.

Common signs and symptoms of kidney failure may include:

- Lethargy, seizures, coma
- Epistaxis
- Anemia (mucosal pallor)
- Sallow pigmentation
- Pruritic excoriations
- Bruising
- Amenorrhea, impotence, infertility
- Myopathy
- Peripheral neuropathy
- Frost
- Red-eye
- Anorexia, nausea, vomiting
- Hypertension, pericarditis, heart failure
- Pleurisy, dyspnea on exercise
- Nail changes
- Bone pain
- Edema
Kidney disease can be acute or chronic. AKI is worsening of kidney function over hours to days, while CKD is the abnormal loss of kidney function over months to years. Clinically, AKI can be conveniently grouped into three primary etiologies: prerenal, renal, and postrenal. The most common causes of AKI include decreased renal blood flow, toxic injury of kidney cells, or extracellular volume depletion. Differentiating between AKI and CKD is important for CDI professionals, and different tests help in this process. For example, oliguria is often observed in AKI, while anemia (low kidney erythropoietin production) might suggest CKD. Small kidney size on ultrasound or other imaging is more consistent with CKD. That’s why it is essential for reviewing the radiology reports and other diagnostics.

Urinalysis or examination of the urine is essential in finding important clues to underlying kidney disease. Anytime there is an abnormal urinalysis that hasn’t been addressed by a provider, a query is warranted. Queries should not be leading in nature and include all the pertinent clinical findings. CDI specialists should look for clinical indicators such as pelvic pain, hematuria, burning sensation when urinating, bacteriuria, flank pain, or fever. Pigmented granular casts (also termed “muddy brown casts”) and renal tubular epithelial cells alone or in casts are hallmarks of acute tubular necrosis (ATN). ATN caused by ischemia is the most common cause of intrarenal AKI. It occurs most often after surgery (40 percent to 50 percent of cases) but is also associated with severe sepsis, obstetric complications, and severe trauma, including severe burns.

It’s important that CDI professionals understand the differences between AKI and ATN to prevent denials and effective appeals. CDI professionals should investigate the post-op diagnosis and see if it is different from the pre-op diagnosis. CDI review process should not only focus on the DRG optimization but other aspects as well, such as patient safety indicators, hospital-acquired conditions (HAC), and mortality risk (observed vs. expected metrics). Analyzing healthcare data during the CDI review process by payer, service line, primary diagnosis, or mortalities leads to performance improvement and better healthcare outcomes. Taking a holistic view of all aspects of patient comorbidities is essential in the reporting of quality measures. Furthermore, aligning record reviews to organizational goals is one of the greatest challenges, and that’s why CDI specialists should review all records, regardless of the payer, ensuring documentation integrity across all patient populations.

Impact of Kidney Disease on Reimbursement

Assessing the severity of each condition by assigning the right severity of illness (SOI) and risk of mortality (ROM) will impact the APR-DRG assignment and drive payment and related quality measures. Capturing the true severity of each condition will
decrease the mortality risk because it will directly impact the expected cases (by increasing them). The Affordable Care Act included the development of quality reporting and pay for performance programs in all practice settings (including hospitals, outpatient facilities, physician practices, and post-acute care). The Centers for Medicare and Medicaid Services (CMS) hospital and physician Pay for Performance (P4P) programs are a major component of Medicare’s effort to shift healthcare away from fee-for-service reimbursement.

According to the Centers for Medicare and Medicaid Services, there are three Medicare hospital P4P programs and one physician P4P program. Thirty-day mortality rates for acute myocardial infarction (MI), heart failure, pneumonia, and elective total hip arthroplasty (THA)/total knee arthroplasty (TKA) complication rate is included in the clinical care domain of hospital value-based purchasing (VBP). Readmission is formally defined as a patient who is readmitted for any reason to the same or another acute care hospital within 30 days of discharge. The Hospital Readmissions Reduction Program (HRRP) imposes a monetary penalty on hospitals for excess readmissions of Medicare patients 65 years of age, or older admitted initially with any four diagnoses (acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disorder) or two procedures (coronary artery bypass graft and elective hip or knee replacement).

Reviewing readmissions is one of the goals of the CDI review process, and it also requires understanding your organization’s overall mission and goals. Setting clear goals and merging organizational goals with CDI workflows can be difficult, as it requires access to leadership. Different programs review VBP quality measures by focusing on first diagnosis assignment and other diagnoses reported under the Uniform Hospital Discharge Data Set (UHDDS) that drive risk adjustment on these measures. Furthermore, appropriate reimbursement is dependent on the review’s capture of severity, clinical validation, coding accuracy, medical necessity, and quality outcomes.

The terms renal insufficiency, renal failure, uremia, and azotemia are associated with decreasing renal function but are not specific to kidney function. Furthermore, the term acute kidney injury is preferred to the term acute renal failure as it captures the diverse nature of this syndrome ranging from minimal changes in renal function to complete renal failure. The clinical progression of acute renal failure occurs in three phases: the initiation phase, maintenance phase, and recovery phase. Renal insufficiency is insufficient. Generally, renal insufficiency refers to a decline in renal function to about 25 percent of normal or a GFR of 25 to 30 ml/min. If acute renal insufficiency is documented when the patient is in acute renal failure, we will be missing the severity of illness. Documenting the stage of CKD per KDIGO Guidelines and considering RIFLE (risk, Injury, failure, loss of kidney function, and end-stage kidney disease) or AKIN (Acute Kidney Injury Network) criteria for AKI is essential in documenting the condition to the highest accuracy and receiving the right reimbursement.

Analyzing Kidney Function
The GFR provides a useful measure of kidney function at the level of the glomerulus and is important for CDI professionals when reviewing the medical record. Any process that causes loss of nephron (and thus glomerular) mass can cause decreased GFR in patients with kidney disease. GFR is generally accepted as the best overall index of kidney function. Even if it’s not a complication or comorbidity or a major complication or comorbidity, you still need to specify if the patient has CKD because that’s a comorbid condition that does affect morbidity and mortality statistics and risk adjustments. According to National Kidney Foundation, CKD is classified based on the presence or absence of systemic disease and the location within the kidney of observed or presumed pathologic-anatomic findings on kidney biopsy or imaging.

There is no specific treatment for acute renal failure and management principles include:
- Correcting fluid and electrolyte disturbances
- Managing blood pressure
- Treating infections
- Maintaining nutrition
- Remembering that drugs or their metabolites are not excreted

The general term dialysis means to separate substances using a permeable membrane. Dialysis is used in the treatment of chronic, end-stage renal failure, as well as in acute renal failure (ARF). Most cases of ARF resolve without requiring dialysis. However, intensively ill patients with ARF have high mortality. Hemofiltration and hemodiafiltration employ extremely high-porosity dialyzers that permit transmembrane filtration of large volumes of plasma ultrafiltrate. Peritoneal dialysis, like hemodialysis, affords gradient-driven solute clearance. The ICD-10-PCS procedure codes for the hemodiagnosis would be assigned based on the duration of the session or individual sessions of hemodialysis received. Cardiovascular complications occur more frequently with hemodialysis than with other blood purification techniques. Hypotension is the most common complication and its pathology is multifactorial. Hypotension of hemodialysis can be controlled or prevented by the cooling of dialysate, which promotes vasoconstriction and improved myocardial contractility and careful volumetric control of ultrafiltration. Providing care for patients with chronic kidney disease, end-stage renal disease, and for those on dialysis can be complicated. It is important to document Z99.2 (dependence on renal dialysis) for patients on dialysis after also documenting N18.6 (end-stage renal disease). These conditions must be documented together in the medical record.

Renal transplantation is the procedure of choice and the most cost-effective strategy for the management of patients with end-stage renal disease. The great advantage of transplantation is the re-establishment of nearly normal constant body physiology and chemistry. The disadvantage includes bone marrow suppression, susceptibility to infection, cushingoid body habitus, and the physiologic uncertainty of the homograft’s future. Most of the disadvantages of transplantation are related to the medicines given to counteract the rejection. Later problems with transplantation include recurrent disease in the trans-
planted kidney and an increased incidence of cancer. Code T86.1- should be assigned for documented complications of a kidney transplant, such as transplant failure or rejection or another transplant complication.

The medical review process usually starts with the emergency department documentation and continues to the history and physical, progress notes, query, and follow-up. Many CDI programs began with a goal of DRG optimization. But, this approach could lead to busy clinicians missing comorbidities in the documentation, resulting in an inaccurate patient classification in the DRG system.

In recent years CDI has evolved, taking a holistic view of all aspects of patient comorbidities, including the impact on reporting of quality measures. Clinical documentation specialists should be focusing on capturing the medical diagnosis to the highest specificity and educating providers on the importance of linking AKI with the underlying etiology. Staging CKD is essential as well because it impacts the severity of illness.

Notes

References

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Many coding professionals, auditors, clinical documentation integrity (CDI) specialists, and healthcare professionals struggle with applying guidelines B4.1c and B3.2 in the ICD-10-PCS Official Guidelines for Coding and Reporting because they both describe multiple body parts. Confusion seems greatest when coding bronchoscopies and applying these guidelines.

According to the Centers for Medicare and Medicaid Services (CMS), tubular body parts are defined in ICD-10-PCS as “those hollow body parts that provide a route of passage for solids, liquids, or gases.” They include the cardiovascular system, and body parts such as those contained in the gastrointestinal tract, genitourinary tract, biliary tract, and respiratory tract. The issue seems to be in making a distinction between the application of guidelines B4.1c and B3.2b.

Guideline B4.1c directs code assignment of the body part value corresponding to the furthest anatomical site from the point of entry when a procedure is performed on a continuous section of a tubular body part. On the other hand, guideline B3.2b directs the code assignment of multiple procedures when the same root operation is repeated in multiple body parts, and those body parts have separate and distinct body parts classified to a single ICD-10-PCS body part value. Professionals should not overanalyze and misinterpret the meanings of each individual procedural coding guideline because this can cause confusion.

The key in helping to differentiate between these guidelines is in applying them based on the objective of the procedure being performed. Another important factor is determining the appropriate ICD-10-PCS root operation definitions that are relevant to tubular body parts. The ICD-10-PCS root operation groupings that are applicable to tubular body parts include:

- Bypass—altering the route of passage of the contents of a tubular body part
- Dilation—expanding the orifice or lumen of a tubular body part
- Occlusion—completely closing off the orifice or lumen of a tubular body part
- Restriction—partially closing off the orifice or lumen of a tubular body part

Guideline B4.1c would be applied to these root operations since the procedural objective refers to a tubular body part.

Other ICD-10-PCS root operations, such as excision, resection, destruction, and extraction are grouped into a procedural category that takes out some or all of a specified body part. Health information management (HIM) professionals should remember the procedural objective with this group of root operation involves cutting out or off, pulling out of or off, or eradicating without replacement all or some of a body part. Examples of procedures that match these procedural objectives are suction dilation and curettage, breast lumpectomies, endometrium fulguration, and total lobectomy of the right upper lobe of the lung. These procedures can be performed within the tubular body part as well but distinguishing the reason for the procedure will help reduce the confusion when applying these particular guidelines.

Additionally, root operations drainage, extirpation, and fragmentation are categorized as root operations that take out solids, liquids, or gases from a body part. These ICD-10-PCS root operations should be separately identifiable because the objective of these procedures involves taking out solids, fluids, or gases from within a specified body part. Thrombectomies, bronchoalveolar lavages (BALs), and lithotripsies are just a couple of procedures that are categorized into these root operation groupings. Many coding, auditing, and CDI professionals get lost in the root operation forest and fail to focus on the objective of the procedure that is being performed. Remembering to determine the objective or...
reason the procedure is being performed will help HIM professionals to minimize getting lost in the root operation woods.

Furthermore, when you are coding bronchoalveolar lavage (BAL), coding experts should understand that a BAL involves washing out and sampling alveoli of the lung (also known as the air sacs) and is normally performed using a bronchoscopy.

The objective of this procedure is draining fluid from within the bronchus and typically involves removing fluid from the bronchus, which is coded to ICD-10-PCS root operation, drainage. Remember to meticulously review the details of the operative report and the pathology report to further pinpoint the type of specimen that was collected or removed. In addition, take caution when relying on the encoder to guide you through the coding pathway, because sometimes the incorrect selection can be made which could result in an incorrect procedure code assignment.

Lastly, there are a few important questions to consider when assigning ICD-10-PCS procedure codes. What was the objective of the procedure being performed? What body part was the procedure limited to, lung tissue or within the bronchus? Where was the procedure performed, on a specific lobe of the lung or within the bronchus? Always remember to query the provider in cases where the procedural objective or type of material examined is not clear within the documentation.

Lastly, do not confuse the multiple procedure coding guidelines with the most distal tubular body part guideline because they both have distinct procedural objectives. Assign the specific root operations that apply to a tubular body part and keep a separate distinction from the multiple procedures coding guidelines. The multiple procedures coding guidelines refer to multiple procedures being performed during the same operative session when performed on separate body parts, the same procedure performed on separate and distinct body parts distinctly identified by a single ICD-10-PCS body part value, and multiple distinct procedural objectives performed on the same body part.

Notes

References

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Red Flags for HIPAA Policy Compliance

By Kelly McLendon, RHIA, CHPS

Health information management (HIM) professionals tend to take for granted that written policies and procedures are required to comply with the full scope of HIPAA’s Privacy and Security rules.

However, HIPAA and similar regulations are long and technically complex, which can make it a daunting task to institute and maintain a fully compliant set of policies. There have been few efforts to standardize policies—or the content they should contain—to address HIPAA compliance for covered entities (CE) and business associates (BA). It’s up to each organization to determine what policies it needs and get them implemented. But beware red flags that can attract unwanted attention from the Office for Civil Rights (OCR).

OCR has specific rules about mandated policy documentation, which are used as key evaluation materials. This article looks at the 10 most common red flags for HIPAA policy compliance.

Red Flag #1: Policies and procedures are not searchable
Searchability is critical for two reasons:
- OCR investigations often require procurement of specific policies.
- The ability to surface the appropriate policies and procedures is essential to effective workforce training.

Finding the correct content is often difficult because different methods of storage and indexing do not always tie types of policies together well (e.g., it may be difficult to find all HIPAA-related privacy policies). HIM departments should implement defined processes to create, maintain, and use all content associated with job roles as well as the wider compliance programs they are associated with.

Red Flag #2: Policies and procedures are not well formatted or indexed
Policies are different from—but related to—procedures. Policies are more generalized whereas procedures are more granular. Whether policies are included in the same document as procedures is not mandated by HIPAA—that is an organizational decision. Indexing should include names descriptive of their purpose and version-controlled documentation.

Red Flag #3: Unclear and non-standardized formatting of policy document sections
Formatting that identifies the title, effective dates, revision versions, approvals, target workforce members, purpose, policy discussion, related forms, procedures, and references should all have their own headings and clearly identified structure.

Healthcare organizations can develop their own formatting and indexing procedures. However, there are numerous resource vendors that offer specialized HIPAA policy and procedure templates and compliance document templates that can be customized to the format of your organization’s existing policies and procedures.

Red Flag #4: Policy and procedure documents too long and complex
HIM departments should be concise, logical, and deliberate in the creation and maintenance of all policy and procedure documentation.

For example, some organizations index their policies and procedures as standalone documents. Other organizations include some procedures in policy documents, along with more granular details in other procedure documentation.

Where policy documents end and procedure documents...
begin is not mandated; any logical system can be used. Best practice is to keep policies separate from most procedures and include interrelated links.

Many times, policy documents may have an overview or links to more detailed procedures, which can increase usability and convenience. Procedures may change based on regulatory guidance or changes in supporting processes or software applications. Procedures may need to be updated and formatted with more flexibility than the broader policy documents. Take this into account when creating the structure in relationship between policy and procedure documentation to avoid dysfunction during maintenance or updates.

Additionally, HIM departments should try to keep each policy document within four pages—although that can be tricky with highly complex subjects, such as protected health information (PHI) disclosures and data breaches.

**Red Flag #5: Approval processes are inefficient**
The formal process for the creation, implementation, and ongoing maintenance of policies and procedures is often dictated by the size and complexity of the organization. In large organizations, information governance determines formats, approvals, implementations, and review schedules. In small organizations, the process may be controlled by an individual or a small team. It is important to have a structure where all policies are written, approved, dated, version-controlled, and stored for at least six years after their effective date.

**Red Flag #6: Tracking of who was trained on which policies and procedures is never or infrequently performed**
HIPAA rules require that workforce members be trained on current, comprehensive policies and procedures. The documentation of who was trained when and on what should be stored for six years.

**Red Flag #7: Policy manuals for privacy and security are printed out and have dust on them**
Hard copy versions of policy and procedure documents are...
HIPAA PRIVACY AND SECURITY RULES

Below are relevant and abridged excerpts of the HIPAA Privacy Rule (45 CFR § 164.530 Administrative requirements) and HIPAA Security Rule (45 CFR § 164.306 and § 164.308 Administrative Safeguards). The full rules can be found at www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/combined-regulation-text/index.html

HIPAA Privacy Rule:

(i) A covered entity’s designation of a privacy official.
(b)(1) Standard: Training.
(2) Implementation specifications: Training.
(C) Pertaining to the covered entity’s workforce.
(ii) A covered entity must document that the training
(d)(1) Standard: Complaints to the covered entity. A covered entity must provide a process for individuals to make complaints concerning the covered entity’s policies and procedures
(e)(1) Standard: Sanctions. A covered entity must have and apply appropriate sanctions against members of its workforce who fail to comply with the privacy policies and procedures of the covered entity or the requirements of this subpart or subpart D of this part. This standard does not apply to a member of the covered entity’s workforce with respect to actions that are covered by and that meet the conditions of § 164.502(j) or paragraph (g) (2) of this section.

(f) Standard: Mitigation. A covered entity must mitigate, to the extent practicable, any harmful effect that is known to the covered entity of a use or disclosure of protected health information in violation of its policies and procedures or the requirements of this subpart by the covered entity or its business associate.

(ii)(1) Standard: Policies and procedures. A covered entity must implement policies and procedures with respect to protected health information that are designed to comply with the standards, implementation specifications, or other requirements of this subpart and subpart D of this part. The policies and procedures must be reasonably designed, taking into account the size and the type of activities that relate to protected health information undertaken by a covered entity, to ensure such compliance

(2) Standard: Changes to policies and procedures.
(i) A covered entity must change its policies and procedures as necessary and appropriate to comply with changes in the law, including the standards, requirements, and implementation specifications of this subpart or subpart D of this part.

(ii) A covered entity may make any other changes to policies and procedures at any time, provided that the changes are documented and implemented in accordance with paragraph (i)(5) of this section.

(3) Implementation specification: Changes in law.
(4) Implementation specifications: Changes to privacy practices stated in the notice.

(i) To implement a change as provided by paragraph (i)(2)(ii) of this section, a covered entity must:
(A) Ensure that the policy or procedure, as revised to reflect a change in the covered entity’s privacy practice as stated in its notice, complies with the standards, requirements, and implementation specifications of this subpart;
(B) Document the policy or procedure, as revised, as required by paragraph (j) of this section; and
(C) Revise the notice as required by § 164.520(b)(3) to state the changed practice and make the revised notice available as required by § 164.520(c). The covered entity may not implement a change to a policy or procedure prior to the effective date of the revised notice.

(5) Implementation specification: Changes to other policies or procedures. A covered entity may change, at any time, a policy or procedure that does not materially affect the content of the notice required by § 164.520, provided that:

(i) The policy or procedure, as revised, complies with the standards, requirements, and implementation specifications of this subpart; and

(ii) Prior to the effective date of the change, the policy or procedure, as revised, is documented as required by paragraph (j) of this section.

(j)(1) Standard: Documentation. A covered entity must:
(i) Maintain the policies and procedures provided for in paragraph (i) of this section in written or electronic form;

(ii) If a communication is required by this subpart to be in writing, maintain such writing, or an electronic copy, as documentation; and

(iii) If an action, activity, or designation is required by this subpart to be documented, maintain a written or electronic record of such action, activity, or designation.

(iv) Maintain documentation sufficient to meet its burden of proof under § 164.414(b).

(2) Implementation specification: Retention period. A covered entity must retain the documentation required by paragraph (j) (1) of this section for six years from the date of its creation or the date when it last was in effect, whichever is later.

HIPAA Security Rule:

(a) A covered entity or business associate must, in accordance with §164.306:

(i) Standard: Security management process.
(1)(1) Standard: Documentation. A covered entity must:

(i) Maintain the policies and procedures provided for in paragraph (i) of this section in written or electronic form;

(2) Standard: Assigned security responsibility. Identify the security official who is responsible for the development and implementation of the policies and procedures required by this subpart for the covered entity or business associate.
not required by HIPAA, but some sites still use them. There are stories of regulators being handed dusty, unused policies, especially in physicians’ practices, which would indicate they are not being used for training or staff lookup (oops). But paper is no longer needed for master policy management. In fact, printing and collating is a time-consuming process that is unnecessary, unless the hard copy has to be used for training. Having policies in a central location that is known and used by staff is far preferable to a few hard copies. Over time it has become commonplace to create all policies online and to use workflow to get them approved, including electronic approval processes and workflows. The copies must be well indexed and sorted into virtual folders or pre-set searches for easier retrieval.

**Red Flag #8: Going it alone**
It is possible for organizations to create privacy and security policies from scratch, but it’s rare. Typically, a concerted effort to build policies, usually with third-party guidance, is undertaken to get an organization’s policies implemented.

Policy-creation resources are available online for free, but it’s advisable to consider a specialized consultant. The point is to get the policies and procedures to capture as much regulatory and best practice content as possible.

Regulatory content is not hard; taking the HIPAA rules line by line can produce that. However, best practices—the operational glue that holds operational processes together—is harder to come by.

Many healthcare consultants and sources of HIPAA policy templates tend to break down into approximately 20 to 25 policy templates per rule. (See sidebar for a list of suggested policies.)

**Red Flag #9: Policies are outdated**
Policy documents with review dates that are not reflected in the document or policies that are several years old with no indication of review can count toward financial penalties. Policies must be reviewed on a regular basis, the timeframe for which is not defined within the rules. But a common best practice is to review them annually or bi-annually at the longest. Whatever time frame is chosen should be well documented within an information governance program policy and consistently performed, including sign-off and version updates/review being noted. Under HIPAA it is required to address adding new or updated language for policies whenever there have been changes in rules (or guidance) that introduces material changes to processes which then must be updated in policy and procedure.

**HIM departments should be concise, logical, and deliberate in the creation and maintenance of all policy and procedure documentation.**

**Red Flag #10: Policies lack security risk analysis or privacy compliance assessments**
Security risk analysis (SRA) and assessments of privacy program should include questions about policies for each part of the HIPAA rules. Any missing policies and processes or content must be placed on a prioritized remediation list to be addressed in order of importance. SRA, which is a form of security program assessment as well as privacy assessment, are typically 100-200 questions each that may be answered with “yes” and “no”–type answers, along with comments and attachments. These assessments are typically performed with application software or spreadsheet-based tracking of answers and hopefully prioritized remediation lists. The answers to the questions many times produce scoring, although there is no specific score needed to “pass” for HIPAA compliance. The use of scoring assists facilities to measure their own progress toward heightened compliance with the entire privacy and security rule sets.

Having well-thought out, documented, indexed policies and their associated procedures is critical for HIPAA compliance, especially given the fact that they are requested for nearly every OCR investigation. Additionally, the policies must not be ignored or hard to find. Each workforce member should know where the policies and procedures are stored and how to access them. Using the policies themselves for workforce member training is also essential and the best way to impart all of the requirements each one addresses. A best practice is to discuss one different policy at each workforce member meeting. Not only does this uncover areas that are not well understood, often it can lead to changes that foster better compliance—and that is goal of any well functioning HIPAA program.

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State Privacy Laws May Have Implications for Healthcare Providers
By Ronald J. Hedges, JD, and Gail L. Gotttehrer, JD

As long as HIPAA has been the law of the land, the Covered Entities (CEs) that comply with it have always had to consider state privacy laws—which often are more stringent—and operate in concert with both. With the passage of the California Consumer Privacy Act (CCPA) and the Stop Hacks and Improve Electronic Data Security Act (SHIELD Act) in New York, CEs would be wise to consider how this new legislation, HIPAA, and existing state cybersecurity and privacy frameworks interact.

The California Consumer Privacy Act
The California legislature passed the CCPA in 2018 and enforcement of the law by the attorney general begins on July 1, 2020. The CCPA defines “personal information” broadly, as “information that identifies, relates to, describes, is capable of being associated with, or could reasonably be linked, directly or indirectly, with a particular California resident or household.” Personal information includes:
- Personal identifiers, such as a real name, alias, postal address, unique personal identifier, IP address, email address, account name, Social Security number (SSN), driver’s license number, passport number, or other similar identifiers
- Commercial information, including records of personal property; products or services purchased, obtained, or considered; or other purchasing or consuming histories or tendencies
- Internet or other electronic network activity information, including but not limited to browsing history, search history, and information regarding a California resident’s interaction with an internet website, application, or advertisement
- Geolocation data
- Biometric information
- Audio, electronic, visual, thermal, olfactory, or similar information
- Professional or employment-related information
- Education information

The CCPA confers various rights on California “consumers,” who are defined broadly to be persons who are California residents, including individuals who are in the state for something other than a temporary or transitory purpose, and individuals who are domiciled in California who are outside the state for a temporary or transitory purpose. California consumers have the right to:
- Know what personal information is being collected about them
- Know whether their personal information is sold or disclosed and to whom
- Say no to the sale of personal information
- Access their personal information
- Equal service and price, even if they exercise their privacy rights

According to the CCPA, a business is subject to the CCPA if it is a legal entity (sole proprietorship, partnership, limited liability company, corporation, association) organized or operated for the profit or financial benefit of its shareholders or other owners, that collects consumers’ personal information, or on the behalf of which such information is collected and that alone, or jointly with others, determines the purposes and means of the processing of consumers’ personal information, that does business in the state of California, and that satisfies one or more of the following criteria:
- Has annual gross revenues in excess of $25 million
- Alone or in combination, annually buys, receives for the business’ commercial purposes, sells, or shares for commercial purposes, alone or in combination, the personal information of 50,000 or more consumers, households, or devices
- Derives 50 percent or more of its annual revenues from selling consumers’ personal information
Given the breadth of these definitions, at least some healthcare providers or business associates should expect to be subject to the CCPA. The CCPA, however, has a HIPAA-related exception that appears to take any protected health information (PHI) governed by HIPAA outside the scope of the CCPA. In other words, given HIPPA’s comprehensive approach to PHI, the CCPA has deferred to federal enforcement of HIPAA for any PHI that is governed by it. So, for example, although the CCPA would not apply to a data breach of PHI held by a healthcare provider, it would apply to a breach of personal information of its employees (unless that breach involved an employee’s PHI). The text of the exception is as follows:

“This act shall not apply to protected or health information that is collected by a covered entity governed by the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56 of Division 1)) or governed by the privacy, security, and breach notification rules issued by the federal Department of Health and Human Services, Parts 160 and 164 of Title 45 of the Code of Federal Regulations, established pursuant to the Health Insurance Portability and Availability Act of 1996. For purposes of this subdivision, the definition of ‘medical information’ in Section 56.05 shall apply and the definitions of ‘protected health information’ and ‘covered entity’ from the federal privacy rule shall apply.”

The New York SHIELD Act

The SHIELD Act, which went into effect in 2019, defines “private information” broadly, to include either personal information (explained in the next paragraph) or a username or email address “in combination with a password or security question and answer that would permit access to an online account.”

The SHIELD Act outlines several forms of personal information that would be considered private information. In this context, personal information consists of any information in combination with any one or more of several data elements, where either the data element of combination of personal information and data element is not encrypted—or is encrypted with an encryption key that has been accessed or acquired. These data elements include:

- A SSN
- A driver’s license number or non-driver ID number
- An account number, credit or debit card number, in combination with any required code or information that would permit access to an individual’s financial account
- Account number, credit or debit card number, if circumstances exist wherein the number could be used to access an individual’s financial account without additional identifying information, security code, access code, or password
- Biometric information, meaning data generated by electronic measurements of an individual’s unique physical characteristics (e.g., fingerprint, voice print, retina or iris image) used to authenticate or ascertain the individual’s identity

The SHIELD Act applies to any person or business that owns or licenses private information of a New York resident. Given the breadth of these definitions, at least some healthcare providers or business associates should expect to be subject to the SHIELD Act. See the last section of this article for discussion of what this might look like for providers.

The SHIELD Act expands the notification requirement for the entities it regulates regarding breach notification following the unauthorized access to, or acquisition of, computerized data that compromises the security, confidentiality, or integrity of private information maintained by a covered entity. Moreover, covered entities must develop, implement, and maintain reasonable safeguards to protect the security, confidentiality, and integrity of the private information, including a data security program that has reasonable administrative, technical, and physical safeguards. Unlike the CCPA, the SHIELD Act does not have “minimum” criteria for it to be applicable to a business—it applies regardless of the volume of information collected or the amount of revenue derived from the use or licensing of data of New York residents.

The SHIELD Act contains an exemption for the reporting of data breaches for HIPAA-related personal information (although notice of the breach must be reported to the New York attorney general).

The SHIELD Act also provides that a business that falls within its scope is deemed compliant with the Act’s reasonable security requirements if it is subject to and in compliance with HIPAA and HITECH regulations. This exception would appear to take any PHI that is subject to a data breach and is governed by HIPAA outside the scope of the SHIELD Act.

Relationship of the CCPA and SHIELD Act with HIPPA

Notably, both the CCPA and the SHIELD Act reference HIPAA and establish exemptions from their reach for data that is subject to HIPAA. The data that is subject to HIPAA is referred to as PHI, or health information that can be tied to an individual.

Under HIPAA, PHI is information that includes one or more of the following 18 identifiers:

1. Names (full or last name and initial)
2. All geographical identifiers smaller than a state, except for the initial three digits of a ZIP code if, according to the current publicly available data from the US Bureau of the Census, the geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people, and the initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000
3. Dates (other than year) directly related to an individual
4. Phone numbers
5. Fax numbers
6. Email addresses
7. SSN
8. Medical record numbers
9. Health insurance beneficiary numbers
10. Account numbers
11. Certificate/license numbers
12. Vehicle identifiers (including serial numbers and license plate numbers)
13. Device identifiers and serial numbers
14. Web uniform resource locators (URLs)
15. Internet protocol (IP) address numbers
16. Biometric identifiers (e.g., finger, retinal, and voice prints)
17. Full face photographic images and any comparable images

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How to Avoid Common Mistakes That Slow Down the ROI Process

By Angela Rose, MHA, RHIA, CHPS, FAHIMA, and Don Hardwick

As demands to share patient information continue to evolve, health information management (HIM) leaders face multiple challenges related to the complexities of release of information (ROI). This article focuses on common mistakes that slow down the ROI process and provides best practices for HIM directors managing internal ROI teams. Priorities include staff efficiency, workflow optimization, and process control.

Deficiencies in the ROI Process

Deficiencies such as missing signatures, invalid dates, and inaccurate demographic data lead to a series of communications with the requesting party. This requires additional time, work, and resources to get the request out the door effectively. Incomplete or inadequate ROI requests like this occur frequently, causing processing delays that prevent the compliant and timely release of information.

Technology can help or hurt depending on how records are set up within a system and where information is located. Some electronic health records (EHRs) expedite the ability to release information if records are electronically aggregated via templates that enable automatic extraction of data.

Without that capability, EHRs can slow the process and delay turnaround time. This can occur with physician practices that still rely on a fax request or phone to request information from the hospital.

Policies and Procedures

Given the rapid pace of change in federal and state rules and regulations, healthcare organizations are challenged to develop and update ROI policies and procedures accordingly. Consider these questions:

- When was the last time you looked at your ROI policies and procedures?
- When was the last time you looked at workflow of your ROI processes?
- Are your technologies, workflows, policies, and procedures current with federal and state laws?
- Can your EHR process ROI requests accurately and efficiently?
- What are your policies around managed care?
- Does your managed care contract language specifically address charges for record copies?
- When was the last time your education and training materials were reviewed and updated?

If policies and procedures are not current and complete, organizations are at risk of increased payer audits, noncompliance, lost revenue, and breach, among many other concerns.

Staff Education and Training

In a constantly changing regulatory environment, ongoing training and education for ROI staff is critical. How often do you provide training and retraining to keep up with changes? Internal HIM departments may have a limited number of employees and insufficient resources for training on new laws and regulations.

ROI can be extremely complex. What is the escalation pathway for difficult ROI questions or decisions that need to be made? With mounting pressure to ensure compliant disclosure of protected health information (PHI) as efficiently and securely as possible, creating sufficient time for education and training can be a challenge. Here are several recommendations:
• Map out a training schedule for each employee based on roles or employment level. For example, management might need general training annually to provide education on the basics, whereas a frontline employee would require thorough and detailed training more frequently.
• Provide a timetable and set expectations so employees can plan ahead to build training into their schedules.
• Incorporate multiple training methods that offer flexibility for employees and accommodate individual learning styles. Virtual training allows employees to complete training at their convenience. In-person training offers a more human touch with real-time interactions.

Privacy, Security, and Compliance Concerns
HIM departments must have competent, reliable resources to mitigate privacy, security, and compliance risk. It is important to follow all requirements by requester type, such as for the patient/patient representative versus an audit, attorney request, subpoena, or court order. Determine the type of information being requested and provide timely and accurate information.

It could be a request for sensitive PHI related to behavioral health or a request for routine lab results. It is important that internal HIM departments have the compliance and legal support required to manage the outcomes of complex requests.

Furthermore, disclosure of PHI from other departments, particularly radiology and the business office, poses significant risk and liability. Those departments typically are not well informed about the ROI process as it is not their core responsibility. With risks including financial penalties and lawsuits, centralized management by HIM is essential to compliant, efficient disclosure of PHI.

Quality Assurance—Any and All Policy
Quality assurance requires verifying that each authorization is valid. For example, make sure that a subpoena or court order comes from your jurisdiction, with the right date and the right signatures.

Also, know your “any and all” policy. Many facilities are choosing to implement a ten-year release policy by which they only release for the past ten years, even though they may have retained all records since their doors opened.

Responding to requests for any and all information is a labor-intensive challenge. There is an increase in any and all requests due to some industry confusion around patient-directed requests (PDRs).

Regardless of requester or request type, always seek guidance from legal counsel, compliance, or the organization’s privacy officer to ensure compliance is met.

Best Practices
As HIM professionals navigate the complexities of the rapidly evolving ROI industry, valuable perspectives are needed to manage multiple challenges. Here are several recommended practices to consider:

• **Staff efficiency**—Know your volumes and appropriate staffing needs. Specialization breeds success—proficiency, productivity, and quality. Allowing staff to focus on one or two functions improves efficiency and accuracy.

• **Workflow optimization**—Establish a system to avoid taking extra steps in the ROI process. Going directly to the source to fulfill the request removes any middlemen. Centralize workflow in one place based on a common set of standards for PHI disclosure.

• **Process control/quality assurance**—Implement enterprise-wide PHI disclosure management. Use technical tools including optical character recognition (OCR) technology to check for quality issues such as commingled records and improper dates of service. Conduct ongoing training and education. Consider a vendor partnership to support a centralized approach.

Legal Disclaimer
The views and opinions expressed in this article are those of the author and do not necessarily reflect or represent the views, opinions, or policies of MRO Corporation.

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A NATIONWIDE SURVEY of senior HIM professionals affirms that increased requests for access to and exchange of health information, compounded by stringent compliance regulations, present multiple challenges for HIM leaders.

**Large volumes of government and commercial payer audits.** There has been a steady increase in DRG post-payment audits and Health Effectiveness Data and Information Set (HEDIS) and Risk Adjustment reviews. This rising volume of requests from payers heightens the burden on HIM to handle the associated ROI demands.

**Enterprise-wide compliance and breach prevention.** Privacy and security within a healthcare enterprise are top of mind in an era of regulatory reform and breach. With risks including financial penalties, lawsuits, and reputational damage, HIM leaders are seeking ways to mitigate risk and close compliance gaps.

**Patient satisfaction.** New privacy rules aim to give patients control over how their information is used and ease their ability to access their records. Situations involving patients’ privacy rights are difficult to navigate. Healthcare organizations must be sensitive and proactive regarding privacy rights and disclosure of PHI.

TOP HIM CONCERNS

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**TOP HIM CONCERNS**
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see brochures or flyers that provide “know before you go” information to patients about the forms of ID they should take with them when they go to the doctor.

“I feel like we have a window of opportunity right now where there’s so much awareness for people—not just patients—about keeping their identities secure. I think that if they could see a flyer that tells them the importance of keeping their information accurate, then they would give us as much information as possible. I don’t know how deep a flyer needs to be—it wouldn’t have to explain overlays, but you could have photos of two different people with the same name, for example,” Way says.

Way and other HIM professionals have a shared frustration when it comes to ways parents sometimes choose to name twins and triplets. It’s trendy and surprisingly common for parents to choose names that rhyme—or give their kids the same first names but different middle names.

While this can create nightmares in a huge EMPI, there’s broad acceptance in the profession that this is something outside of their control. Still, Way has seen instances of twin overlays that have taken months to sort out.

This is definitely a situation where SCL Health’s Landsbach finds himself thinking, “If patients only knew.”

“If you’re the parents of twins, I mean, just saying to the registrar at the beginning of an encounter, ‘Actually, I have two daughters and they’re twins, I just want to make sure you’ve got the right one.’ Obviously, that would go very far because it would slow everybody down.”

Notes


Mary Butler (mary.butler@ahima.org) is associate editor at the Journal of AHIMA.
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9. Sudhakar-Krishnan, V., and Rudolf, M. "How Important Is Continuity of Care?"


17. Weems, S., P. Heller, and S. Fenton. "Results from the Veerans Health Administration ICD-10-CM/PCS Coding Pilot Study." Perspectives in Health Information Management 12 (Summer 2015).

18. Dunn, Rose T. "Benchmarking Imaging: Making Every Image Count in Scanning Programs."


22. Dunn, Rose T. "Benchmarking Imaging: Making Every Image Count in Scanning Programs."

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18. Any other unique identifying number, characteristic, or code except the unique code assigned by the investigator to code the data

If these identifiers are removed, the information is then considered de-identified PHI and thus not subject to the restrictions of the HIPAA Privacy Rule.

The categories of identifiers listed in the definition of PHI are not identical to the types of information contained in the definitions of personal or private information in the CCPA or the SHIELD Act, respectively. Accordingly, healthcare providers and business associates will want to conduct an analysis of the types of information they collect to see what falls within and outside the scope of HIPAA and may, or may not, be excluded from the CCPA and the SHIELD Act. Those entities will want to consider that may mean in terms of their compliance programs and activities.

The US is in the early stages of data privacy and cybersecurity legislation at the state level, and the discussion about possible federal legislation on these subjects continues. Healthcare providers and business associates would do well to investigate what data privacy and security laws might apply to them and to consider how to respond to those laws. 

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Editor’s Note

The views expressed in this column are those of the authors alone and should not be interpreted otherwise or as advice.

Notes


2. Ibid.


5. Ibid.


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HIPAA Rights of Unaccompanied Children are at the Heart of an Immigration Debate

By Mary Butler

FEDERAL IMMIGRATION OFFICIALS HAVE BEEN using mental health evaluations obtained from unaccompanied children (UACs) to support efforts to deport these minors and family members or sponsors living in the United States, which raises questions about HIPAA compliance and the providers involved in their care.

In February, the Washington Post reported on the case of one UAC, a teenaged Honduran asylum-seeker named Kevin Euceda, who underwent the mandatory therapy sessions while detained by the Office of Refugee Resettlement (ORR). Euceda and his lawyers learned that those records—which included memories of traumas and coerced criminal activities—were shared with Immigration and Customs Enforcement (ICE) without consent from him or his therapists. The Post reporting suggests this is common for UACs detained in the United States.

Maya Uppaluru—a healthcare attorney at Crowell & Moring who has analyzed the issues with sharing of mental health records of UACs—told the Journal of AHIMA that this practice could be problematic under federal privacy regulations. In her analysis, it was not clear to what extent UAC facilities operated by ORR, and their mental health employees or subcontractors, would be Covered Entities under HIPAA.

Further, the healthcare providers’ actions—sharing sensitive mental health details to support deportation proceedings—could be unacceptable from an ethical and professional conduct perspective. Uppaluru noted that psychologists and social workers both must adhere to state law and professional codes of conduct that could pertain to a client’s informed consent, as well as any sharing of information for legal or law enforcement purposes.

Legislators appear to agree. Since the Washington Post’s article published, lawmakers in the House and Senate have introduced legislation that would ban federal agencies such as Health and Human Services from sharing therapy disclosures used in detention or deportation proceedings. In a letter to ICE leaders, Senators Ron Wyden (D-OR) and Elizabeth Warren (D-MA) wrote, “Children must have the opportunity to openly share their experiences with their therapists and care providers. They must be able to do so without the fear that what they disclose will later influence their asylum applications. The practice of sharing confidential clinical notes discourages these children from confiding in their therapists and care providers to get the help they need.”

Reference

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