HOW REAL-TIME DATA CAN CHANGE THE PATIENT SAFETY GAME

INFORMATION GLEANED FROM MEDICAL DEVICES AND RETROSPECTIVE EHR DATA CAN IMPROVE PATIENT SAFETY, INFORM CLINICAL DECISION SUPPORT, AND SHAPE GOVERNANCE STRATEGIES
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President’s Message

‘A Time for Health Information Professionals to Make a Difference’

By Ginna Evans, MBA, RHIA, CPC, CRC, FAHIMA

SUMMERTIME IS HERE, but it seems like just yesterday we were fully entrenched in the beginning of the COVID-19 pandemic. I have no doubt that the past few months have been busy and likely stressful at times for many of you. We are a strong and resilient group, but even during the overwhelming days I hope you have been stopping to take a little time for yourself—whether that’s to catch a quick dose of sunshine, go for a walk, or just slow down and catch your breath.

COVID-19 brought about many changes for the AHIMA enterprise. I loved the agility the staff exhibited to quickly pivot and develop the COVID-19 resource page. For each of us the changes since March have been many—and I’m sure there are more to come. Within two weeks of many cities going into lockdown, the AHIMA Board had a two-day virtual meeting in place of the in-person meeting we would have held during our Advocacy Symposium in Washington, DC. The staff worked so hard to prepare for a successful meeting and I’m so thankful that the Board came prepared and were so engaged. I think we were all a little hesitant but concluded the meeting feeling very good about what was accomplished. As you reading this column in the July issue, it would be about time for representatives from each CSA to travel to Chicago, IL for our annual Leadership Symposium. With input from CSA leaders and in the best interest of all involved, it was decided to make this a virtual event. I understand moving to a virtual meeting takes away the personal interaction between us, but this was the right decision as everyone’s health and wellness should be the priority.

Health information professionals are creatures of habit, but I also know we are good at adapting to change. Our future may be different than we envisioned at the start of the year; however, we are a talented group of professionals accustomed to making difficult decisions and, when necessary, reinventing ourselves.

I care deeply for AHIMA and each of you, our members. The work of AHIMA and health information professionals has never been more important. Working together and supporting each other as a strong house of health information will help us move forward stronger and better through the financial and organizational challenges that follow COVID-19.

I recently read this quote on the AHIMA website: “This is a time when health information professionals can make a difference.” Whether we are working together as AHIMA, working with our coworkers, or working individually, we can and will make a difference.

I encourage each of you as members to take the time to review the 2020 ballot candidates and their profiles, available at https://journal.ahima.org/ahima-election-2020/. Voting will open on July 13 and continue through July 27. Your vote matters. Let’s support the candidates with a great voter turnout.

In closing I leave you with this thought. This quote is often attributed to Charles Darwin, but it was Leon Megginson who wrote: “It is not the strongest of the species that survives, nor the most intelligent, but the one most adaptable to change.” Let’s work together to embrace the changes as we move forward.

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Under the Dome

Bringing Together Administrative and Clinical Data

By Chantal Worzala, PhD

THROUGH A COMBINATION of public and private sector efforts, the health information underlying our healthcare system has undergone digital transformation, leading to great promise for better informed and safer care, increased individual engagement in health, and improved efficiency. However, the two main streams of health data the system relies on—administrative and clinical—have developed on separate trajectories, use different technical standards, and are not yet easily integrated. This reality leads to less than ideal consumer experiences, significant provider burden, and excessive administrative costs. Delays in care and missing information also can lead to adverse outcomes for patients.1

These challenges have recently caught the attention of federal policymakers. This spring, two federal agencies joined forces in releasing a report on how to reduce the burden of using health information technology (IT). One aspect that the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC) focused on was reducing the burden of prior authorization and other administrative transactions that require sharing administrative and clinical information across providers and payers. These agencies are actively considering how to better integrate administrative and clinical data.

Separate Data Streams, Separate Rules
Until now, the rules for how to record and share administrative and clinical data have traveled separate tracks. CMS generally sets the policies and adopts the standards for administrative transactions, as required by the Health Insurance Protection and Portability Act (HIPAA). These transactions, such as eligibility, claims submission, and remittance advice, are at the heart of the revenue cycle. By contrast, ONC adopts standards and certification criteria for electronic health records (EHRs) that generate and store clinical data, as set forward in the Health IT for Economic and Clinical Health (HITECH) Act. That data supports care provision but is also used to document and justify provider billing.

We Live in a Digital World
Both administrative and clinical data are now largely digital. For example, more than 3 billion medical claims were processed electronically in 2018, representing 96 percent of all claims, according to the 2019 CAQH Index.2 And, according to federal statistics, 96 percent of hospitals and nearly 80 percent of physicians have adopted certified EHRs.3,4 However, when it comes to sharing clinical data to support administrative processes, or integrating clinical and claims data to support value-based care, automation is not a given. In fact, many times, provider organizations are forced to default to web portals, fax, and phone to justify an admission, treatment, or prescription.

Benefits and Barriers
Creating ways to bring together the two tracks of clinical and administrative data would ease these provider pain points. For patients, there is the potential to decrease wait times and interactions needed to complete authorizations and provide a better understanding of financial obligations at the point of care. For clinicians, these improvements could reduce burden in responding to data requests and decrease time spent on administrative activities. For payers, more efficient exchange of clinical data could provide more usable information for tasks such as proving medical necessity and identifying fraud and abuse, among other things. In short, all parties stand to benefit.

However, greater sharing of data across provider and payer settings will require trust. For example, how will providers know whether payers use clinical data
exchanged to adjudicate payment for other purposes, such as setting premiums or benefits design? Could greater payer access to clinical data lead to greater second-guessing of clinical judgment? There are also many aspects to be worked out beyond automation. For example, prior authorization and authorization for inpatient care currently is characterized by variability in the data requested to make a determination—both across payers and across plans offered by a given payer. More standardization of business rules will be needed to really reduce burden. Creating greater integration may also require looking at operational issues, workflow, changes to IT systems, and how to ensure the workforce has the right skills to manage a more automated approach. Additional key issues include data integrity, protecting patient privacy, and implementing adequate security tools.

Policy Priorities
Increasingly, policymakers see that finding ways to better integrate these data streams could allow for better automation of some of the biggest sticking points in healthcare—inpatient authorizations, prior authorizations, utilization review, case management, and medical necessity review, to name a few. For example, CMS has implemented a pilot program to facilitate real-time sharing of clinical data in support of existing fee-for-service Medicare documentation requirements. The pilot covers oxygen and continuous positive airway pressure (CPAP) devices. Three other efforts are notable:

- CMS recently finalized a rule requiring the payers and plans it regulates to make claims and other data available to third parties by apps via an application programming interface (API) that uses a standard adopted by ONC (HL7 FHIR 4.0.1).
- ONC finalized a rule requiring EHR vendors to make clinical data available to third-party apps using the same API standards. This creates a technical framework to support sharing.
- A joint task force of two federal advisory committees, the National Committee on Vital and Health Statistics and the ONC Health IT Advisory Committee, is working to develop recommendations for the federal government on how to "support the convergence of clinical and administrative data to improve data interoperability to support clinical care, reduce burden and improve efficiency." The joint task force plans to make recommendations in September and NCVHS will separately address the issue this year.

CMS and ONC have also shown interest in the Da Vinci Project, which is an undertaking of the HL7 standards body to leverage new technical approaches, such as the FHIR API, to share data across providers and payers. Among other use cases, the DaVinci Project is tackling real-time interactions to automate payer/provider communication mechanisms on coverage requirements discovery, documentation templates and coverage rules, prior authorization support, and data exchange for quality measures.

Increasingly, technical solutions to facilitate the flow of data across administrative and clinical purposes are being developed. Policy actions will be needed to ensure that the many factors beyond automation—such as trust, standardization of business rules, privacy, and security—are adequately addressed. And health information professionals should be at the table to ensure that their perspectives and operational know-how inform policy. To that end, AHIMA is actively monitoring policy efforts and has created a work group to inform [advocacy efforts].

Notes

Chantal Worzala is principal at Alazro Consulting and is currently working as a consultant to the policy and government affairs team at AHIMA.
“MOST OF US don’t change until we have to, and crisis is often what obliges us to do so. Crises are often resolved only through a new identity and new purpose, whether it’s that of a nation or of a single human being.”

As I write this column, the world is still struggling through the COVID-19 pandemic. COVID-19 has altered our perception of normalcy and stretched the limits of our ability to adapt. But...adapt we have.

So now is not the time to buckle. This is the season to take the lessons we’ve learned since the beginning of this crisis and apply those to the process of evaluation and rebuilding.

Loss is not without value. Challenge is not without growth. As a society, we understand that we must operate differently. We must think differently.

This quote from writer Rebecca Solnit applies not just to individuals and nations, but to disciplines such as health information. Our healthcare ecosystem is building, adjusting, applying the lessons learned—creating or accelerating the systems needed to address the evolving needs of patients, providers, and systems.

Moreover, we strive for a culture that embraces this evolution of thought and process. Chief among these must be the embrace of a “culture of safety” across the global healthcare enterprise. Because when we come out of this pandemic, we will be stepping into a new world—and we have an opportunity to do better.

In this issue of the Journal, we take a look at what a culture of patient safety will take. Our July issue also delves into how the COVID-19 pandemic is redefining and expanding the role of health information professionals, as detailed in “Credibility in Times of Crisis” by Dwan Thomas Flowers, MBA, RHIA, CDIP, CCS, FAHIMA, AHIMA-approved ICD-10-CM/PCS Trainer.

As we examine the impact of COVID-19 on healthcare and its systems, we recognize the importance of continuous and comprehensive surveillance that provides real-time data to identify the onset of deteriorating conditions, to identify trends across multiple data points, and to divert adverse events. In “How Continuous Surveillance Can Change the Patient Safety Game,” Genevieve Diesing examines tools that aggregate continuous streams of data from multiple patient monitoring devices, as well as retrospective information from electronic health records (EHRs) and advanced analytics that produce a holistic picture of a patient’s condition which can reveal “subtle trends about a patient’s health early on, giving clinicians valuable lead time in cases of deleterious conditions.”

Other articles in this issue include “COVID-19 Across the Pond,” which features an interview with Roger Lim, senior policy advisor at the Dutch Ministry of Health, Welfare and Sport, in the Netherlands. Lim is responsible for ensuring the contact tracing apps developed by the European Union are interoperable and comply with the strict standards of the General Data Protection Regulation.

Overcoming a pandemic does not happen immediately or easily. Similarly, building a culture of patient safety takes time. But with a concerted commitment to innovation and healthier outcomes, we will get there.

Note
HOW REAL-TIME DATA CAN CHANGE THE PATIENT SAFETY GAME
How Real-Time Data Can Change the Patient Safety Game

In the 20 years since the publication of To Err Is Human—the landmark Institute of Medicine report that documented the extent of US medical errors—hospitals still struggle to control hospital-acquired conditions, avoidable readmissions, and healthcare-associated infections.

But some of providers’ most insidious safety problems—such as unrecognized patient deterioration, opioid-induced respiratory depression (OIRD), and sepsis—are almost entirely preventable.

Continuous clinical surveillance solutions, or tools that use real-time patient data to identify the early onset of patient deterioration, can help clinicians do just that.

These tools aggregate continuous streams of data from multiple patient monitoring devices, as well as retrospective information from electronic health records (EHRs), and combine them with advanced analytics to produce a holistic picture of a patient’s condition.

That picture could reveal subtle trends about a patient’s health early on, giving clinicians valuable lead time in cases of deleterious conditions.

Continuous surveillance is also necessary because at-risk patients, especially those who require respiratory support or monitoring, do not always visibly fit the profile of a highly sick person. These patients often exist, undetected, across the care continuum, not just within high-acuity areas.

According to a 2018 Journal of Critical Care study, 46 percent of patients on the general care floor suffer from OIRD, which causes more than half of medication-related deaths in care settings, 97 percent of which were preventable.1

How Continuous Surveillance Works

In contrast with traditional patient monitoring (or the periodic measure of a patient’s heart rate, blood pressure, respiratory rate, oxygen level, and temperature), continuous surveillance involves the continuous acquisition of patient data and uses predictive analytics to identify trends across multiple data points over time.

Specifically, continuous surveillance technology pulls information from EHRs and other data sources, sorts and analyzes that information, and, when applicable, automatically sends pertinent alerts back to clinicians.

Continuous surveillance solutions ideally enable hospitals to create tailored rules based on their needs, coordinate with their EHRs, provide support from a clinical team on the vendor’s side, and pull information from the EHR and other data sources in near-real time.

Outsmartering Alarm Fatigue

With intuitive predictive data at their disposal, clinicians can make appropriate care decisions without being inundated by alarms, says Mary Jahrsdoerfer, PhD, director of graduate healthcare informatics at Adelphi University College of Nursing and Public Health.

While an expert nurse might anticipate patient decline
based on the siloes of clinical data gleaned from typical patient monitoring, “the sheer volume of data collected from patients is beyond the capacity of the human brain to analyze,” Jahrsdoerfer says.

By moving away from reactive, intermittent monitoring and toward comprehensive surveillance, clinicians can use real-time data to divert adverse events. With a complete view of a patient’s illness and past medical history, clinicians are much better prepared to diagnose and treat him or her.

While typical patient monitoring requires clinicians to individually observe patients during singular moments while using individual devices, continuous surveillance is team-based, enabling multiple caregivers to view an inclusive image of multiple patients from either a centralized location or through mobile alarm notifications. Additionally, conventional monitoring practices often result in alarm fatigue.

The flood of false alarms has desensitized caregivers, Jahrsdoerfer says, which presents its own patient safety danger.

“What will happen is, sometimes the alarm will be real,” Jahrsdoerfer says. “And [clinicians] didn’t tend to it and a patient dies. So, we have to have smarter alarms.”

Continuous surveillance presents an opportunity to screen out false alarms or artifact signals that typically contribute to alarm fatigue.

By using analytics based on multiple sources of data, providers can take a system-wide inventory of alarms, evaluate their existing algorithms and decide where real-time data can be used to improve sensitivity and specificity to reduce false positives.

Solutions might come in the form of a single risk score based on medications, nursing assessment, and medical history, says Shannon Sims, MD, physician informaticist at Vizient, a healthcare performance vendor.

As Edward Pollak, MD, medical director and patient safety officer at the Joint Commission, puts it, clinicians could choose to configure their continuous surveillance tools to cut through data overload and get “a single roll up” of the patient’s overall condition, presenting only comprehensive, need-to-know information—such as the need for potential patient interventions, department transfers, or discharges.

Although such automated patient safety monitoring systems supplement human oversight, they are not a replacement for clinical judgement, says Sims.

As such, automated safety monitoring and alerting approaches should be continuously reviewed and refined to ensure clinical validity, efficacy, and avoidance of unintentional outcomes, such as unnecessary testing or provider alert fatigue, he says.

Proactive Measures

Stephen Morgan, MD, chief medical information officer at the Carilion Clinic in Roanoke, VA, says the health system’s continuous surveillance tool has been a proactive measure in flagging patients “before they become really, really sick.”

While Carilion hasn’t yet measured the overall quantitative impact of the tool—the health system uses PeraHealth’s Rothman Index—Morgan says its ability to predictively identify at-risk patients has enabled Carilion to reduce ICU readmissions, and to potentially predict patients’ lifespans during end-of-life care.
"When we have a conversation with a family [of a dying patient], we’re able to use this as just one more data point to help people make a decision for their loved ones," Morgan says. Pollak notes that providers are particularly successful with continuous surveillance in areas where they’ve used medical devices the longest, such as in remote blood glucose monitoring—where wireless insulin pumps react to feedback loops via algorithms—and cardiac implants, which adjust themselves based on algorithms and can detect arrhythmias through monitoring.

“We’ve seen some pretty good outcomes,” he says.

**Systemwide Support**
In addition to improving patient safety, information gleaned from real-time devices and EHR data can also inform hospitals’ emerging patient safety strategies and approaches to governance.

Organizations can use EHR data and information from other devices to support retrospective analyses of safety, which enable hospitals to determine the efficacy of their patient safety policies, clinical protocols, and automated interventions such as decision support alerts, says Sims.

This might include root cause analyses or routine monitoring to support continuous improvement and regulatory compliance, he says.

Additionally, retrospective analyses help organizations to examine their compliance with clinical protocols and the success of their patient harm prevention alert strategies. For example, they might mine the EHR for use of rescue agents such as naloxone and monitor lab data for drug-related harm such as hypoglycemia.

In addition to preventing patient harm, continuous surveillance tools create efficiencies that potentially reduce a patient’s length of stay, which help hospitals comply with value-based reimbursement regulations, saving them money.

**Predictive Monitoring in the Age of COVID-19**
The Carilion Clinic is using real-time data to manage the availability of its beds, materials, and personal protective equipment, a process it has had to accelerate in light of COVID-19.

“We had a fairly robust process of tracking the data for bed availability, ventilator availability, etc., but we’ve really had to step that up to be able to track those more in real time to be able to manage the hospital,” Morgan says.

Carilion Clinic’s Patient Deterioration Index has also been “very, very helpful” in monitoring patients with COVID-19 remotely, Morgan says.

The health system is monitoring patients’ oxygen saturation levels at home through remote patient monitors. Although Carilion has previously used the technology to monitor patients for chronic obstructive pulmonary disease and congestive heart failure, it has become particularly useful for keeping patients infected with the virus at arms’ length while still observing them, Morgan says.

“You want to get [COVID-19 patients] out of the hospital when it’s appropriate, and not have them expose others,” he says. “But you’re still keeping an eye on them.”

Continuous surveillance tools can help providers to improve patient outcomes, assess bed capacity, and better time the utilization of personal protective equipment, says Sims.

“By assessing risk of respiratory failure, for example, you can determine likely ICU/ventilator utilization or conduct controlled respiratory intubations, rather than emergency intubation,” he says.

Emergency intubations increase patient risk and can potentially transmit COVID-19 to the care team, so it’s important to avoid them as much as possible, he says.

Additionally, early recognition and transfer to ICU, when needed, may decrease ICU length of stay and improve mortality rates, Sims says.

Accurate data is key to meaningful analytics, and COVID-19 has shed additional light on this, Pollak says.

Because organizations can sometimes misclassify their data—just as public health officials didn’t immediately attribute COVID-19 deaths to the virus—predictive analytics predicated on those inaccuracies lose their meaning.

“The problem with all of these big data sets is that they’re vulnerable,” Pollak says. “A lot of times organizations slap really nice data analytics on really poor data sets. And you just add to confusion.”

At the very least, there will be more data to work with going forward, Morgan says, as providers across the country are sharing analytics to create better predictive models.

“I think more people will be sharing data going forward and there will be more collaboration between health systems,” he says. “It’s already really created some nice synergies to help fight COVID.”

Reference

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CREDIBILITY IN TIMES OF CRISIS

IN THE AGE OF COVID-19, HEALTH INFORMATION PROFESSIONALS MUST ASSERT THEIR EXPERTISE—AND EXPAND THEIR HORIZONS

By Dwan Thomas Flowers, MBA, RHIA, CDIP, CCS, FAHIMA, AHIMA-approved ICD-10-CM/PCS Trainer
HEALTH INFORMATION MANAGEMENT (HIM) as a profession has morphed into a variety of roles, functions, and responsibilities within and outside of the traditional HIM department. While many healthcare stakeholders still associate HIM with medical record stewardship, it is clear that tracking, organizing, and disseminating rich data—as well as bridging the gap between what information is needed versus what information may be requested—is still central to HIM professionals’ expertise.

The COVID-19 pandemic presents numerous challenges and opportunities for HIM professionals, who are generally solutionists by nature. Thus, where there are opportunities, they can credibly contribute. This global crisis calls for creativity. While the circumstances of the pandemic are unfortunate, resourceful HIM professionals have identified more efficient ways of doing business and have turned a spotlight on their profession’s contributions to the healthcare ecosystem in the process, including:

Privacy and Security. There is a stigma associated with COVID-19. Because any contagious disease can cause panic and fear, healthcare professionals need to be very careful with any disclosures regarding potentially affected individuals. At the same time, the healthcare community is also aware of the need to balance patient privacy with the need to track the spread of a rapidly spreading disease. There have been ongoing discussions regarding COVID-19 surveillance, which involves tracking the movements of positive individuals; monitoring the proximity of others to positive individuals; and studying the activity of residents’ comings and goings in areas where stay-at-home mandates are in place. All of these raise privacy issues in the eyes of many Americans and must be weighed against public health risk.

Code Assignment. That HIM professionals are considered the experts in code assignment for ICD-10-CM, ICD-10-PCS, and CPT coding is no surprise. However, the pandemic has triggered the Centers for Disease Control and Prevention (CDC) to exercise its right to activate an ICD-10-CM code for COVID-19 with an effective date of April 1, 2020. Because it is well known that these new codes are typically effective October 1 of each year, the beginning of the government’s fiscal year, this may present difficulties in accurate coding of COVID-19 cases. The new code, U07.1, is not retroactive so initial cases had a different code assigned, which might further complicate future inquiries for retrospective case studies. This is also an ideal time to ensure that social determinants of health are documented and coded.

Additionally, new CPT and HCPCS codes were made available for COVID-19 lab tests. These codes are retrospective in nature, which may prove to be yet another layer of complexity for future data reconciliation. The first, U0001, is for SARS-CoV-2 diagnostic testing for CDC. The next code, U0002, was released to allow for expanded laboratory billing for non-CDC lab tests.

Clinical Documentation Integrity. CDI professionals are tasked with reviewing specific populations of patients. For example, OB-GYN, ophthalmology, or plastic surgery cases may not be prioritized for review, depending on size and maturity of the CDI program. However, during a pandemic, it may be prudent to have CDI review 100 percent of COVID-19 admissions to ensure the most complete documentation, reflecting the most accurate severity of illness and risk of mortality is represented upon discharge. While this high level of quality is always necessary for every patient, it is times like these that remind healthcare professionals that coding was put in place initially for tracking and trending of diseases. The retrospective studies, research, and requests for information for these patients will be accessed and dissected for many years to come. If there are any other patient characteristics, socioeconomic circumstances, or other risk factors that may predispose patients to respond to the virus differently, it is incumbent upon healthcare professionals at every level to ensure that they are documented, captured, and reported with the highest level of integrity.

Data Disparities. There are challenges with understanding how to use the various code sets outside of the coding department. For example, when the finance department tries to gain an accurate count for the number of COVID-19 patients seen at their organization, if there is no collaboration with HIM, there could be problems. Pulling data using the wrong code or an incomplete code will not yield the results expected. Trying to capture a patient count by counting the number of positive test results or using the number of tests ordered may or may not result in the information needed. For example, if a patient tested positive in the community was admitted from another healthcare facility. Discussions with HIM and coding leaders to find out the intent and to assist with reconciliation of the data is paramount.

Workforce Impacts
COVID-19 affects HIM professionals in other ways that are more personal and career-oriented, such as:

Work From Home Policies. HIM leads the way in sharing best practices with other departments on effective telecommuting. Because social/physical distancing is one of the most effective ways to slow the spread of COVID-19, many employers were immediately tasked with mobilizing their employees to work from home. Generally, this is only allowed after extensive pilot periods—where groups that are working from home report their progress to taskforces set up to study it. Implementing a policy can take years. However, because this is a prevalent practice in HIM, particularly for coding professionals, they can share agreements, policies, and equipment checklists available to other departments.

Still, another factor to consider is staying connected via remote work. This often means the increased use of videoconferencing, such as WebEx and Zoom. In some cases, HIM has finessed this skill. In other cases, this is a new opportunity for providing guidance. One Midwestern medical facility shared that before COVID-19, they used approximately 300,000 minutes of web-based conferencing time per month, but post-COVID-19, utilization was tracked at over 1.4 million minutes. Most importantly, not all platforms are equal. Be sure to check into the security of the platform, especially if protected health information (PHI) will be discussed.
Employment Impact. The US response to the virus has caused many unforeseen consequences, such as reduced hours, furloughs, and job losses for many coders—particularly for outpatient coders. This notion is contrary to the previous predictions of the ever-increasing volumes of outpatient services. While the inpatient volumes were also severely reduced, due to the canceling of many outpatient visits and elective surgeries, the inventory of accounts available for coding diminished across the board. Also, managers of HIM staff whose jobs may be difficult to perform from home may have had difficult choices to make.

Although the vast majority of HIM work can be performed remotely thanks to electronic health records (EHRs), not all documentation in health is computer generated. There are often still paper documents that may need to be retrieved from the units, floors, and departments in order to be scanned. HIM professionals that perform these and other vital roles face a difficult choice between staying employed with fear of COVID-19 exposure or minimizing risk by staying at home.

Many HIM leaders combat this loss of employment by focusing on special projects for these employees. Additionally, some organizations have redeployed some of the professionals to work at temporary temperature screening locations to ensure the clinical workers, patients, and visitors are not symptomatic for COVID-19 prior to entering the building.

Unique HIM Needs During the Pandemic

Today’s healthcare environment is especially fraught with new federal and state regulations—some that are temporary that deal directly with the pandemic, and some that are not. HIM professionals are still navigating the landscape of waivers, stimulus funding, and loosened regulatory requirements aimed at decreasing administrative burdens.

Regulatory Environment. The Coronavirus Aid, Relief, and Economic Security (CARES) Act was passed by Congress on March 27. It provides $100 billion in stimulus funding to hospitals caring for COVID-19 patients. The government also issued waivers, which providers can apply for, that continue to allow reimbursement and care for uninsured individuals and other emergency benefits.2,3

Chart Completion/Deficiencies. The crisis has allowed some hospitals to accept help from physicians from other countries who are not as familiar with American documentation standards. At one organization, HIM and coding professionals stepped in to coach an Australian cardiovascular surgeon through the documentation standards required for accurate code assignment.

Skilled Nursing Facility Transfers. Skilled nursing facilities (SNFs) have been particularly impacted by transfers of COVID-19 patients. Initially, there were discussions about SNFs not being available to accept some of these patients that met criteria for discharge from acute care status. While subsequent interim guidance for COVID-19 patients in SNFs issued by the CDC may have decreased the frequency of this scenario, HIM is greatly impacted. When patients cannot be discharged in a timely fashion and there is no interim coding or review of these records, code assignment post discharge can be daunting.4

Telehealth. This time of social distancing and stay-at-home orders has been an ideal testing ground for expanding the capabilities of telehealth. Many regulations surrounding telehealth have also been relaxed—primarily, the HIPAA requirement for secure devices. This means the patient can connect using the device or platform of their choice. But pre-existing HIM challenges around telehealth remain. There is little interoperability between telehealth platforms and EHRs, which creates difficulties sharing secure and compliant documentation between providers. Furthermore, reimbursement varies, if it is covered at all by private insurance.

Because many outpatient, clinic, office, or other ambulatory visits were canceled, telehealth has its time to shine. Still, “while it is clear its use has skyrocketed in recent weeks — it went from comprising virtually no visits as late as March 8 to 30% as of April 12—it is not even close to completely replacing in-person encounters. In-person encounters were down 67% as of April 12 (versus a 54% decline in all visits in total),” according to a Healthcare Dive article. Ultimately, telemedicine encounters replaced less than 20 percent of the pre-COVID-19 volume of patient visits. Some companies, such as Teladoc, have seen patient visits more than double compared to early March.5

Teamwork. Collaboration during time of crisis is a necessity. Now is the time for HIM professionals to offer their input for solutions. Teaming with departments such as revenue cycle, finance, IT, informatics, legal, and compliance is required to stay abreast of the rapid regulatory changes and internal directives. Certainly, HIM plays an important role in data reconciliation and integrity to ensure accuracy of documentation and to ensure appropriate reimbursement is received for the care of COVID-19 patients. When inventory is low, HIM professionals may be able to help in other areas such as screening stations, maximize opportunities for education and training, and take the lead on other special projects.

Leadership. COVID-19 presents many opportunities for HIM to take the lead. Perhaps new policies are needed to accommodate many of the regulatory changes. There may be a need to craft a disaster documentation requirements policy. Also, as leaders, staying positive for your team, your family, and yourself is critical. Check on your staff to ensure their well-being. The pandemic causes some concerns related to isolation for some even while the solitude is embraced by others. Avoiding crowded places can affect the psyche of some. For others, staying in close proximity with children and spouses is new territory. Make sure to share resources such as employee assistance programs.

On the Horizon

Although recovery plans are already being initiated, agility is still key. In some states, healthcare facilities are planning to begin seeing some surgical patients—especially those not requiring an overnight stay. How to prioritize and reschedule the massive amounts of patients may be daunting. Surgeries are starting to ramp up again. However, the fear of coming to a healthcare facil-
Credibility in Times of Crisis

Unemployment also leads to loss of health insurance for many. Health information professionals have the experience and creativity to navigate a new and different healthcare landscape. Their expertise with data integrity and compliant documentation are skills that will continue to be necessary to combat COVID-19. Unusual circumstances call for unusual solutions. With practices such as social distancing and work from home mandates, it is entirely possible that a new norm is forming. Remaining calm during chaos and finding alternative approaches to performance while motivating others to do the same will help prepare for what is on the horizon.

Author’s Note: Join me in the AHIMA Engage community to keep the discussion going. Sharing best practices among HIM professionals is a part of what makes our community thrive.

Notes

Sources


References

Dwan Thomas Flowers (HIMprofexcl@bellsouth.net) is an independent healthcare consultant currently serving as interim administrative director of medical information management for Maxim Healthcare. She also serves as a director for the AHIMA Foundation Board.
Having an Effective Risk Discussion with Senior Leadership

By Marti Arvin, JD, CHCC
The Culture of Privacy and Information Security

“Tone at the top” is important when discussing these topics because the organizational culture is as important as any other business topic. Cybersecurity is not an IT issue nor is privacy a compliance officer issue—these are business issues. Helping board members understand this will be key to engaging and involving them in good privacy and information security governance.

A key factor is helping them think about good privacy controls and cybersecurity hygiene in context of their oversight. This includes considering strategic decisions and staying informed of the risk environment, revenue implications, their personal obligations as board members, and, most importantly, the organization’s obligation to the patient.

Linking privacy and information security risks to the traditional business oversight areas helps board members relate it to the business of healthcare. Board members should understand why good privacy and information security are part of a strong strategic plan. All healthcare organizations are interested in ensuring the operations are as efficient and effective as possible, and they need to consider the significant impact to operations that a significant privacy or cybersecurity event will have.

Strategic Implications for the Business

If the organization is looking at implementing a new electronic health record or initiating a telemedicine program, there are key privacy and security considerations. Discussing the implementation strategy while incorporating how key privacy and information security decisions can impact the organization’s risk profile with the new system or program will be important to bring to the board’s attention. The board members will not be exercising their fiduciary responsibility if they make decisions without a good understanding of the risk associated with the decisions. Quite simply, they don’t know what they don’t know.

Revenue Implications Beyond Response

A significant privacy and cybersecurity event can have numerous impacts on a healthcare organization. The initial impact will be the work of responding to the event. This not only includes the work of the IT staff, but the work of executives and others as well. Events like a ransomware attack have the potential to shut down or significantly slow down business. Solid incident response plans and downtime procedures can help, but executives need a clear understanding of their roles in these processes. Depending on the nature of the attack and how prepared the organization is to deal with it will determine how quickly the organization can return to normal operations.

The initial response to the attack may have costs associated with hiring third-party vendors for forensic analysis and/or breach response and call center services. There could also be impact to the bottom line due to the cost of lost clinic days, lost revenue from elective procedures put on hold, and increased inefficiency because downtime procedures are more time-consuming and cumbersome.

If the CPO and CISO are trying to educate the board members on the risk of a privacy and/or cybersecurity event, the board...
THE EUROPEAN UNION’s response to the COVID-19 pandemic is a mix of disease suppression techniques that includes temporary travel restrictions, shelter-in-place orders, social distancing guidance, and lockdowns of certain economic sectors vulnerable to the viral spread.

The next phase is a more precision-based strategy of widespread and on-demand testing, digital- and human-based contact tracing, and self-quarantines for confirmed and suspected cases of infection.

Complicating these efforts are the challenges of utilizing digital technology that is interoperable among the 27 member states and adheres to the European Union’s (EU’s) strict patient privacy regulations.

To get a better idea of how the EU—and, more specifically, the Netherlands—is grappling with these issues, the Journal of AHIMA spoke with Roger Lim, senior policy advisor at the Dutch Ministry of Health, Welfare and Sport.

The Ministry, which Lim joined in January 2019, plays a significant role in finding a balance between privacy and adequately responding to the most significant public health emergency in more than 100 years. This conversation was lightly edited for clarity and length.

JAHIMA: Can you give me an overview of the Netherlands’ response to COVID-19?

Roger Lim: What we are doing is an “intelligent lockdown,” because our economy is not on full lockdown. This fits very well within the culture of the Netherlands, where the central government is calling upon the responsibility of the citizens. This is different from other countries, like France, where there is a very strong central government saying, “You have to do this.”

Now, we are in a process of relaxation. The first set of relaxations came two weeks ago, where primary schools could open again under certain conditions, like enhanced hygiene measures and [social distancing] in the classrooms. On June 1, a new set of relaxation measures will be announced. Bars, terraces, and restaurants can open again, under the condition that within that confined space, a limited number of people could sit there at one-and-a-half-meters distance. Outdoors, there is no limitation to the number of people, as long as everyone maintains one-and-a-half-meters distance. Also, high schools can open again on the first of June.

We gradually lift measures until we get to the new normal, as we call it. We will never be able to go back to the normal situation as we had before the crisis. We have to live as a one-and-a-half-meter society until we have found a vaccination or a proper treatment against COVID-19.
JAHIMA: What are your responsibilities at the Dutch Ministry of Health, Welfare and Sport, and how have they changed since the pandemic started?

Lim: Until recently, my main task was to coordinate the European development of cross-border interoperability, to make sure that health information systems are connected in Europe.

Since the outbreak, the EU has tasked the eHealth Network to come up with a common approach on the use of contact tracing apps. The whole topic of contact tracing apps is very new for all of us. The EU has 27 member states, and each member state wants to develop its own app. The biggest challenge is making sure that these apps are interoperable. So, for example, how can we make sure that when a Dutch citizen crosses the border to Germany or to Belgium that the app is still working, without having to download 27 apps for the whole of Europe?

JAHIMA: What progress has the Netherlands made on an app?

Lim: When the crisis started, the Outbreak Management Team, which consists of epidemiologists and virologists, advised the minister to look into the possibility of using a digital solution for contact tracing purposes.

So, we performed a market scan. We approached the whole matter very technically, looking at what is available already in the market. We came to the conclusion that currently we do not have a solution that is sufficient and that complies with the strict privacy regulations in our country.

We are now working on our own app. We have, for that purpose, created several workstreams. One is the epidemiological workstream that provides inputs to our technical work team. We also have a behavioral team that advises us on how we can make sure that this app is downloaded properly by as many people as possible and is used properly.

JAHIMA: What are the challenges of app development, especially around interoperability and privacy?

Lim: The basic challenge, when it comes to cross-border interoperability, is how to enable connections among the backends of the various systems used by other countries. How can we ensure that data being collected in one backend can also be shared with another backend?

Within Europe, there’s a split between countries following a decentralized model and others choosing a centralized model.* The biggest challenge will be to connect these two different models and make sure Europe is interoperable.

When it comes to privacy, the European Commission has set up a working group of legal experts from all member states to discuss any legal barriers when it comes to cross-border interoperability.

JAHIMA: In the United States, we’ve waived certain provisions of our HIPAA privacy law to help stand up and scale widespread telehealth initiatives. Have you had to waive or modify any of your existing healthcare privacy regulations—either within the EU or in the Netherlands—to accommodate the COVID-19 response?

Lim: Not yet. Everything that we’re doing is within the European regulations of the GDPR, the General Data Protection Regulation. And the Netherlands has, on top of that, some additional strict measures. We’re not changing laws at the moment, but we are investigating what impact privacy has on the COVID-19 response.

JAHIMA: Can you describe specific privacy considerations that are being built into your app?

Lim: We’re building this app with the notion of data minimization, meaning that the app should never collect more data than necessary for contact tracing purposes. In principle, that means that the app only collects ephemeral keys that are being generated by a specific device, which cannot be traced back to a specific individual. We have such strict laws on privacy. We have also decided to do a decentralized model. In a decentralized model, the app is designed to prevent any central authority from identifying users.

JAHIMA: Is the Netherlands’ strategy to make contact tracing almost or primarily digital rather than to use people?

Lim: No. Contact tracing apps are only in addition to manual contact tracing. We are investing more in resources when it comes to manual tracing, hiring more people. We’d like to implement as soon as possible because contact tracing apps and increasing the capacity of manual tracing capabilities need to go hand in hand.

JAHIMA: Have you determined how many contact tracers you would need to cover your country?

Lim: We need thousands of extra contact tracers to cover the whole country. Our country has around 17.5 million people. This is organized per region, because the virus is not spread equally within the country. Most cases are in the southern provinces of the country. What I foresee is increasing contact tracing capacities of the local healthcare services in the south.

JAHIMA: Contact tracing is most effective when you have widespread testing and a public willing to comply with self-quarantine measures as needed. Can you tell me a little bit about your concurrent efforts to scale up testing and your strategy of communicating with citizens about submitting to compliance measures that would normally be seen as intrusive?

Lim: The government has announced publicly that they will increase their testing capacity as of the first of June. Until then, only the high-risk professions are entitled to get a test. But we are now increasing capacity so that we can test the whole population as of the first of June. So come the first of June, everyone can request a test the moment anyone reports the slightest symptoms of a flu or a cold. They can call the services and they can go to a drive-by or a drive-in testing facility, and they get tested. And within eight hours, they get their results.

*Editor’s Note: Lim is referring to a debate among the 27 member states of the EU between centralized or decentralized architecture for Bluetooth-enabled disease surveillance apps. A centralized approach would store and process anonymized data on a server controlled by a national or central authority, like a healthcare service. A decentralized architecture stores data locally on a device and is only uploaded with the express consent of the user.

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Health Information Management Best Practices for Quality Health Data During the COVID-19 Global Pandemic

By Mary H. Stanfill, MBI, RHIA, CCS, CCS-P, FAHIMA, Kathy Giannangelo, MA, RHIA, CCS, CPHIMS, FAHIMA, and Susan H. Fenton, PhD, RHIA, CPHI, FAHIMA

Introduction

The emergence of the deadly COVID-19 virus, resulting in the current worldwide pandemic requires effective information management and accurate data reporting to enable the healthcare community’s efforts to learn as much as possible about this specific strain of coronavirus and halt the pandemic. Therefore, it is essential that health information management (HIM) professionals ensure COVID-19 documentation, data capture, data analysis and reporting, as well as coding are accurate and reliable to support clinical care, organizational management, public health reporting, population health management, and scientific research. However, many health information (HIM) professionals in inpatient and ambulatory care settings are struggling to provide direction on COVID-19 data capture due to evolving guidance ranging from what needs to be captured to how the data should be coded and reported to how to accurately present the data both internally and externally. Detailed clinical documentation for COVID-19 data collection is also a challenge due to unprecedented demands on healthcare providers.

For example, though the first COVID-19 case in the US was confirmed on January 21\(^1\), the first coding guidance was not available until late February. The National Center for Health Statistics (NCHS) developed interim COVID-19 coding advice in a supplement to the ICD-10-CM Official Coding Guidelines that was effective February 20, 2020.\(^2\) This guidance provided advice on which existing coronavirus and infection codes to use until a specific code for COVID-19 could be implemented in the US. A new ICD-10-CM code (U07.1, COVID-19) was subsequently released, effective for discharges on or after 4/1/2020.\(^3\) The American Hospital Association and the American Health Information Management Association released further clarification and guidance on correct coding for COVID-19 in March, 2020.\(^4\) This initial uncertainty and evolving guidance and coding change in the midst of the pandemic is likely to result in extreme variability in the clinical and administrative data spanning the full course of the pandemic. Administrative data are patient-identifiable data used for administrative, regulatory, healthcare operations, and payment (financial) purposes.\(^5\) Clinical data is information that is recorded about a patient and their care in a patient’s medical chart, in an electronic health record, or in a clinical data registry.\(^6\)

This variability and the complexity of the data that will be needed for clinical care, public health reporting, population health management, and scientific research makes it imperative that HIM professionals look beyond administrative data, such as the ICD-10-CM/PCS and HCPCS/CPT code sets used for financial and other purposes, to more detailed clinical data. Administrative data alone is unlikely to be adequate for the comprehensive data required for the COVID-19 pandemic. HIM professionals should take the lead in assisting healthcare organizations to ensure that both clinical and administrative data capture is accurate and reliable for internal and external purposes. This paper presents best practices from three authors with a collective 112 years of health information management experience across a wide range of organizational and public health settings. These best practices for ensuring quality health data, include proactive steps during the pandemic, as well as retrospective data validation practices to apply to both clinical and administrative data.
Data Quality Management Best Practices

General best practices for interactive data quality management in both inpatient and ambulatory care settings involve the iterative steps found below. While the steps may differ in actual practice between the electronic health record (EHR) and paper record, the basics remain the same.

- Identify specific data elements that can be or should be collected for a specific data capture need. This includes identifying all relevant data fields, data types, data definitions, and the associated data values using the applicable data dictionary. Create a template containing these data elements. Each data element listed should have a standard definition and standard value. The goal is to have a template that enables structured data capture and a standard way to collect the data elements. For coded data specifically, identify all relevant code values.

- Consider the expected data results (i.e., data output) for the identified data elements that are specifically associated with the data collection need. For coded data, that may include identifying changes to codes during a reportable time period or documentation and reporting guidelines such as code sequencing and bundling or unbundling to determine normative coded data patterns.

- Run a time-limited report, either on the full set of the template data elements or on selected data elements, to obtain data output for a time-limited subset of data.

- Evaluate the data output to determine if the results are consistent with what is expected.

- Analyze the result. For example, does the data output indicate under-reporting due to lack of an available specific coded value?

- Document findings and explanations in a data quality issue log for future reference when reports are run using the identified data elements.

- Follow up to resolve any aberrant data patterns identified. For example, work with Clinical Documentation Improvement (CDI) staff to develop scenarios to increase awareness around the importance of data quality. Likewise, an investigation may be needed to address any missing data elements, especially if clinical data is missing from the EHR.

This process of pulling a small set of data to validate that documentation and data entry (i.e., data capture) is consistent with expectations should be done following specific identified transition points and at appropriate intervals to ensure data is accurate and reliable.

The rest of this paper discusses how to employ these data quality best practices more specifically for the purpose of ensuring COVID-19 data quality in administrative as well as clinical data during the current pandemic.

Administrative Data Quality Reporting Best Practices

In order to ensure the accuracy and reliability of administrative COVID-19 data capture for both internal and external uses, HIM professionals should follow best practice steps. The application of best practices in the steps below gives examples using data coded with the standard transaction code sets. However, these steps are repeatable to explore logical, expected coded data patterns associated with the COVID-19 relevant data elements used for administrative reporting. For example, the concepts here could also be used to validate use of a new condition code, DR, Disaster Related, established for reporting on the Uniform Bill X12 837I Version 5010A.7

1. Identify all codes from the standard transaction code sets (e.g., ICD-10-CM/PCS, HCPCS Level II, CPT) that might be associated with a COVID-19 episode, starting from a potential COVID-19 exposure to a death due to complications from infection with COVID-19. Sources to identify all codes include the CDC and NCHS2,3, AHA4, CMS8, and the AMA9. A sample list of ICD-10-CM codes is included in Appendix A.

2. Consider the anticipated COVID-19 data for the health system. Consult the local public health department, the facility Medical Director or Infection Control Manager to determine the onset of COVID-19 within the health system. Speak with more than one person to validate the date and establish a shared understanding of the “beginning” of COVID-19 for data analysis purposes. The health system’s start date might be January 21st in the state of Washington, or on/after January 27, 2020, the date that the US Department of Health and Human Services declared the COVID-19 crisis as a federal public health emergency.10

   a. For example, ask “In order to track these cases, we need to define, as a system, the window of time that we are going to call our COVID-19 treatment window. I need a starting date so that I can compartmentalize the data to provide accurate reporting.”

3. Run pre-COVID-19 reports to identify whether and if so, how the identified existing codes were used in the organization to report cases unrelated to COVID-19. The report should be prior to the defined begin date for COVID-19 in the organization.

   a. Evaluate the data output to determine whether or not there was a significant number of patients using any of the codes prior to the beginning of the health system’s COVID-19 window. Codes utilized significantly before COVID-19 began [e.g., reported for 15 or more patients within the last three months] may not be useful for uniquely identifying COVID-19 patients during the pandemic. If this is the case, the health system may need to rely more on clinical data, encoded in SNOMED CT for example (see the section below on clinical data quality practices).

   b. Analyze the results to determine why the codes were used prior to the emergence of COVID-19 in the health system to ensure a good understanding of the data in order to inform appropriate use and interpretation.
Clinical Data Quality Reporting Best Practices

HIM professionals also have a key role in ensuring the accuracy and reliability of clinical COVID-19 data capture for both internal and external uses. The following steps illustrate the use of clinical data quality reporting best practices.

1. Examine the clinical information systems data dictionaries to identify data elements and fields relevant to identifying exposure to, symptoms of, testing for, diagnosis of, and/or treatment of COVID-19.
   
   a. If no data dictionary is present, collaborate with the appropriate clinical professionals within the organization to identify and collate these data elements for COVID-19. Refer to the CDC COVID-19 Data Dictionary11 and CDC COVID-19 Patient Impact & Hospital Capacity Module Form12 as a starting point.
   
   b. If the data dictionary is present, identify relevant data elements for COVID-19.

   2. As described for administrative data, run pre-COVID-19 reports to identify whether and if so, how the identified existing clinical data elements and clinical concept identifiers were utilized in the organization prior to the beginning of the health system's COVID-19 window.
   
   a. Review reports to determine whether or not there was a significant number of patients using any of the clinical identifiers prior to the beginning of the health system's COVID-19 window.
   
   b. Document findings and explanations in a data quality issue log for future reference when reports are run using clinical data elements.
   
   c. Conduct an investigation to determine the root cause of aberrant data and follow up to resolve the problem.

3. Run reports within the health system’s active COVID-19 window to determine if clinical information systems (e.g., the electronic health record), are capturing expected clinical COVID-19 data for identified data elements, including SNOMED-CT and LOINC concept identifiers.

   a. Relevant clinical data may be found for example in new screening tools to capture information on suspected cases (e.g., travel to different countries and other exposure risks) and SNOMED-CT concept identifiers are likely to be used for example in the problem list. Appendix B includes a table with examples of expected SNOMED CT coded data patterns.

   b. Evaluate the data output to determine if the clinical data follows the expected pattern. For example, if care providers are not completing data fields in new screening tools, the report will show little or no data. This might indicate a need to establish or re-visit documentation priorities. Minimal reporting or skipping important documentation elements will impact an organization’s ability to fully analyze and understand the COVID-19 pandemic now and in the future.

   c. Analyze the results. Use the reports to confirm SNOMED and LOINC identifiers are in use in clinical information systems and ensure a good understanding of the data.
Conclusion
Utilizing these recommended best practices increases the HIM professional's understanding of the clinical and administrative data collected and reported for a COVID-19 episode. They also provide a mechanism for data validation to ensure that clinical and administrative data is captured, reported, used, and interpreted appropriately.

The best practices described in this article should be taken proactively and iteratively, at the start of and during the pandemic, in order to validate COVID-19 data and ensure consistent data capture. It is imperative that HIM professionals follow these best practices and stay abreast of coding and data reporting changes as they are announced to have the high-quality data needed, as well as consider how both administrative and clinical data can be appropriately used and interpreted for clinical care, public health reporting, population health management, trending and scientific research to address COVID-19. With these best practices in place, HIM professionals can be a trusted advisor during a global pandemic and influence patient health outcomes now and into the future.

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Notes

Resources

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It remains to be seen whether the past few months represent the worst of the COVID-19 pandemic for the US, or the beginning of a long fight. Many were caught off guard when the outbreaks first hit US locales hard, and it has created enormous challenges for the healthcare industry. It is essential that we ensure we are better prepared for any additional outbreaks. Because US providers’ experiences with COVID-19 have differed widely across the country, now is a good opportunity to regroup and assess what we think we know about the virus and how it could impact clinical documentation integrity (CDI) and coding professionals in the future.

First, we continue to learn more ways the body is affected by COVID-19. There is not a one-size-fits-all disease pattern; while some have only mild symptoms or are asymptomatic when infected, others experience severe symptoms that affect the gastrointestinal, neurological, and respiratory systems—among others.¹ According to the Centers for Disease Control and Prevention (CDC), most people infected by COVID-19 will experience:²

- Fever (83–99 percent)
- Cough (59–82 percent)
- Fatigue (44–70 percent)
- Anorexia (40–84 percent)
- Shortness of breath (31–40 percent)
- Sputum production (28–33 percent)
- Myalgias (11–35 percent)

Initial reports focused on the respiratory symptoms of hospitalized patients, which often culminated in pneumonia, hypoxemic respiratory failure/acute respiratory distress syndrome, sepsis, and septic shock.³

What does this mean for CDI and coding professionals? Most are aware of the implementation of the new code U07.1 to capture COVID-19. However, many are still struggling with sequencing guidance. According to the ICD-10-CM Official Coding and Reporting Guidelines for April 1, 2020 through September 30, 2020, the following guidance should be applied for sequencing of codes regarding coronavirus infections:⁴

When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated manifestations, except in the case of obstetrics patients as indicated in Section I.C.15.s. for COVID-19 in pregnancy, childbirth, and the puerperium.

For a COVID-19 infection that progresses to sepsis, see Section I.C.1.d. Sepsis, Severe Sepsis, and Septic Shock

See Section I.C.15.s. for COVID-19 in pregnancy, childbirth, and the puerperium

This guidance is reinforced by the associated Addenda for the 2020 ICD-10-CM Tabular List of Disease and Injuries, which includes the new code U07.1 for COVID-19 and specifies to use additional code to identify pneumonia or other manifestations.

Further guidance can be found in the recently published “AHIMA/AHA FAQ: ICD-10-CM Coding For COVID-19,” available online at journal.ahima.org. This FAQ addressed the following question, among others:⁵

**Question:** Is the new ICD-10-CM code U07.1, COVID-19, a secondary code? (rev. 4/1/2020)

**Answer:** When COVID-19 meets the definition of principal or first-listed diagnosis, code U07.1, COVID-19, should be sequenced first, and followed by the appropriate codes for associated manifestations, except in the case of obstetrics patients. However, if COVID-19 does not meet the definition of principal or first-listed
COVID-19 as a principal diagnosis typically maps to MS-DRGs 177, 178, or 179, Respiratory Infections and Inflammations, depending on the presence of secondary diagnoses classified as a complication or comorbidity (CC) or major complication or comorbidity (MCC).

The CDC warns that clinicians should be prepared for the condition of patients hospitalized with COVID-19 to deteriorate, as a range of 26 percent to 32 percent of patients were admitted to the intensive care unit (ICU) among all hospitalized patients. CDI and coding efforts seek to capture that severity through COVID-19’s manifestations. Most CDI professionals are very familiar with the diagnoses of pneumonia and acute respiratory failure; however, ARDS is a less common diagnosis and is not synonymous with acute respiratory failure within the ICD-10-CM code set. If fact, there is an Excludes Note for J96, Respiratory failure, not elsewhere classified that prevents the coding of both a J96- respiratory failure code and ARDS (J80). However, both categories of codes are classified as MCCs when classified as secondary diagnoses.

Acute respiratory failure can be further specified as hypoxic or hypercapnic within ICD-10-CM and is defined by impairment of the respiratory system to maintain normal oxygen and carbon dioxide (CO2) levels when breathing room air. The National Heart, Lung, and Blood Institute defines ARDS as an increase in fluid within the alveolar (air sacs) of the lungs in conjunction with the breakdown of surfactant, a foamy substance that keeps the lungs fully expanded to support breathing. ARDS prevents the lungs from properly filling with air, leading to hypoxia as less oxygen enters the blood stream and resulting in clinical and radiographic manifestations of acute pulmonary inflammatory status. The CDC found that, among all COVID-19 patients, a range of 3 percent to 17 percent developed ARDS compared to a range of 20 percent to 42 percent for hospitalized patients and 67 percent to 85 percent for patients admitted to the ICU. ARDS can lead to permanent damage if the lung tissue scars, leading to stiffness of the lungs.

Based on the above coding guidelines and tabular list, as well as additional guidelines under acute respiratory illness due to COVID-19, a patient with COVID-19 who develops ARDS would result in a principal diagnosis of U07.1 with ARDS as a manifestation or secondary diagnosis that results in MS-DRG 177. The same MS-DRG would result if the patient was diagnosed with acute hypoxic respiratory failure.

It is important to note that although the guidelines use the phrase “due to COVID-19,” the provider is not required to link respiratory or other manifestations directly to COVID-19. It is sufficient for the patient to be diagnosed with COVID-19 and for there to be documentation of acute respiratory or other conditions in the setting of COVID-19. In fact, this topic is addressed in the recently published “AHIMA/AHA FAQ: ICD-10-CM Coding For COVID-19.”

**Question:** Based on the recently released guidelines for COVID-19 infections, does a provider need to explicitly link the results of the COVID-19 test to the respiratory condition as the cause of the respiratory illness to code it as a confirmed diagnosis of COVID-19? Patients are being seen in our emergency department and if results are not available at the time of discharge, we are reluctant to query the physicians to go back and document the linkage when the results come back several days later. (rev. 4/1/2020)

**Answer:** No, the provider does not need to explicitly link the test result to the respiratory condition, the positive test results can be coded as confirmed COVID-19 cases as long as the test result itself is part of the medical record. As stated in the coding guidelines for COVID-19 infections that went into effect on April 1, code U07.1 may be assigned based on results of a positive test as well as when COVID-19 is documented by the provider. Please note that this advice is limited to cases related to COVID-19 and not the coding of other laboratory tests. Due to the heightened need to uniquely identify COVID-19 patients, we recommend that providers consider developing facility-specific coding guidelines to hold back coding of inpatient admissions and outpatient encounters until the test results for COVID-19 testing are available.

In the early stages of the COVID-19 pandemic, most hospitalized patients with respiratory symptoms were placed on a mechanical ventilator as supportive therapy. Although mechanical ventilation is not a surgical procedure, it can move a medical MS-DRG within the respiratory major diagnostic category, resulting in MS-DRG 207 (Respiratory system diagnosis with vent > 96 hours) or MS-DRG 208 (Respiratory system diagnosis with vent £ 96 hours) depending on the duration of ventilation, which is usually more than 96 consecutive hours.

As mentioned earlier, the CDC also found many COVID-19 patients develop sepsis and septic shock. If the patient is not admitted with sepsis or septic shock, the CDI or coding professional should query the provider to establish whether sepsis was present on admission, as it affects sequencing and the resultant MS-DRG.

The relationship between COVID-19 and sepsis may be a little less obvious than other infection processes, as some patients have mild symptoms for about a week before their condition rapidly deteriorates. The Global Sepsis Alliance found that “COVID-19 does indeed cause sepsis” and that “virtually all other organ systems can be affected,” supporting severe sepsis or septic shock. The most common types of organ failure accompanying sepsis are critical illness polynephropathy/myopathy, liver injury, and acute kidney failure as well as "septic shock severe enough to require drugs to support the heart and circulation in almost 70% of patients." CDI and coding professionals should be looking for evidence of severe sepsis and septic shock in hospitalized COVID-19 patients, who are also likely to be diagnosed with pneumonia and acute respiratory failure or ARDS and may be on a mechanical ventilator—increasing their severity of illness and risk of mortality, especially in the setting of underlying chronic illness.
In most cases, especially when sepsis is present on admission, sepsis will be the principal diagnosis. COVID-19 is classified as a MCC when sequenced as a secondary diagnosis leading to MS-DRG 870 (Septicemia or severe sepsis with mechanical ventilation > 96 hours, when applicable) or MS-DRG 871 (Septicemia or severe sepsis without MV > 96 hours with MCC).

As more cases of COVID-19 are diagnosed in the US, there is also evidence that COVID-19 can manifest as neurological symptoms that range from loss of smell and inability to taste to seizures, delirium, metabolic encephalopathy, and stroke. The CDC reports thromboembolism secondary to COVID-19 infection, which appears to be manifesting as a greater-than-expected number of younger patients without traditional risk factors being hospitalized for, and sometimes dying from, serious strokes. More research is needed to understand the relationship between COVID-19 and thromboembolism, but CDI and coding professionals need to be aware of this relationship so they are checking the results of COVID-19 testing in these types of patients to ensure proper sequencing of U07.1 as the principal diagnosis followed by a secondary diagnosis of stroke, adding a MCC.

As discussed, COVID-19 can lead to a variety of health issues and it is an important diagnosis to capture. Unlike most other diagnoses, the ICD-10-CM Official Coding and Reporting Guidelines only allows for the reporting of confirmed cases. But what makes reporting COVID-19 tricky is the prevalence of inaccurate test results, which in turn leads to an inability to “confirm” the diagnosis of COVID-19. According to the Wall Street Journal, health experts believe nearly one in three patients who are infected with COVID-19 are getting a negative test result. The “AHIMA/AHA FAQ: ICD-10-CM Coding For COVID-19” clarifies: “The intent of the guideline is to code only confirmed cases of COVID-19. It is not required that a copy of the confirmatory test be available in the record or documentation of the test result. The provider’s diagnostic statement that the patient has the condition would suffice.” This is important guidance because the ICD-10-CM Official Coding and Reporting Guidelines also specifically state: “If the provider documents ‘suspected,’ ‘possible,’ ‘probable,’ or ‘inconclusive’ COVID-19, do not assign code U07.1.”

CDI and coding professionals should recognize that this guideline is similar to what we currently practice in regard to HIV. Likely the best way to address this conundrum is to leverage the guidance regarding “presumptive positive COVID-19 test results should be coded as confirmed.” The ICD-10-CM Official Coding and Reporting Guidelines document continues by defining a presumptive positive test as one that has yet to be confirmed by the CDC, but has tested positive elsewhere; however, in light of the frequency of false negative COVID-19 results, one could argue that providers need the ability to make a clinical diagnosis of COVID-19 as they are able to do with HIV disease based on the patient’s symptomology and manifestations. In other words, CDI and coding professionals should educate their providers to document “presumptive COVID-19 with a suspected false-negative result” or “evidence of COVID-19” as a prior publication of the AHA’s Coding Clinic determined “evidence of” a diagnosis “is not considered an uncertain diagnosis and should be appropriately coded and reported.”

Learning how to accurately report COVID-19 and its manifestation has been a whirlwind process and we will continue to refine our CDI and coding practices as healthcare professionals better understand this virus and its impact on the human body. For now, be sure you understand how to apply current coding guidance and how the infection can manifest so we can obtain accurate data to allow a better understanding of COVID-19.

Notes
3. Ibid.


19. Ibid.


25. Ibid.


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Journal of AHIMA Continuing Education Quiz
Quiz ID: Q2039107  |  EXPIRATION DATE: JULY 1, 2021
HIM Domain Area: Data Structure, Content and Information Governance
Article—“Integrating COVID-19 into CDI and Coding Practice”

Review Quiz Questions and Take the Quiz Based on this Article Online at https://my.ahima.org/store
Health information management (HIM) professionals in privacy and cybersecurity functions have some of the most difficult jobs in the healthcare industry. The privacy role is challenged to balance electronic health information (EHI) accessibility with patient protection, made more complex by the information blocking rules.

Those charged with cybersecurity roles work to protect their organizations and the patients they serve against the reality that every new year brings more medical record breaches. There was an approximately 66 percent increase in the number of patient records exposed between 2018 and 2019. There were more records breached in 2019 alone than the period between 2009 and 2014, according to the HIPAA Journal. These breaches challenge privacy professionals who are also currently dealing with the privacy and security challenges of telemedicine and enabling a remote workforce amidst the COVID-19 pandemic.

In addition to these daunting tasks, there is also a need to balance the cybersecurity concerns regarding unauthorized access to health data with the privacy concerns related to protecting a user’s identity. To manage the overlap of these competing concerns, it is important to understand the answers to five fundamental questions:

1. What’s in the data?
2. Who touched it?
3. Where did it come from?
4. How did it change?
5. Where did it go?

Finding answers to these questions is a common cause for cybersecurity and privacy professionals. For cybersecurity purposes, those answers are needed to ensure that proper controls are in place to protect the organization. For privacy needs, that knowledge can provide context for nuanced understanding of the data given that user identity has different considerations for access based upon purpose.

Understanding Data Foundationally
Due to that shared interest and the fact that privacy functions often rely upon cybersecurity teams to help execute its duties, how can they best work together to deliver for their companies and patients? To do so, they must do two things:

1. Gain visibility into their data in a scalable and sustainable way
2. Understand that data’s lineage

Gaining visibility to answer the first question is a well-known part of information governance that can be challenging to implement. When undertaking this task, cybersecurity must understand that privacy may require more detailed understanding of data to operationalize what and when specific information can be accessed.

That need for specificity should be kept in mind when the two groups collaborate on how best to define sensitive information to be identified and develop a categorization framework to aggregate similar data that can be used by both groups.

A best practice to gain that level of insight and make the process reliable and repeatable is for companies to leverage dynamic technologies that can customize and automate identification and categorization of sensitive information to the particulars of that company. If done correctly, the ability to tailor identification allows cybersecurity and privacy teams to find and classify information at the data element level. That knowledge can then serve effectively as building blocks for the different solutions both groups need.

Data Lineage Differentiator
While sensitive data identification and categorization is the key to
answer the first question, data lineage is the key to the remaining four. Unfortunately, most companies do not know how data flows through their business: who’s touched it, how it has changed over time, and where it’s come from and gone both physically and logically. Without that knowledge, cybersecurity and privacy groups are making decisions about access and technical controls without understanding how data is being used. Having actual insight on data lineage helps cybersecurity teams understand the operational reality of the company and implement controls that prevent the type of activities that create risk. Understanding data lineage for privacy purposes assists with that important question of context—under what circumstances is access to certain data elements acceptable? That also helps to tune security controls to allow the type of flexibility that patients desire while delivering the type of patient protections that HIPAA demands.

Blockchain Data Lineage
Data lineage can be an incredibly powerful amplifier to the effectiveness of HIM privacy and cybersecurity programs and can tighten the connection between the two functions. The challenge is determining a way to understand data lineage that is efficient and cost-effective. Although the concept of data lineage has existed for some time, it has largely been addressed via interviews and surveys. Those methods often capture data flows at a point in time and are subject to the judgment and recollections of those questioned. More recently, technologies have attempted to transcend those challenges by leveraging machine learning and artificial intelligence to create a more informed view of data flows on certain data sets. While that can be a better solution, it is still limited to a date range and can be expensive. Most recently, some technologies are using blockchain principles to provide high-fidelity data lineages that track the history of changes and access to provide a complete view of a data element’s lifecycle.

By doing so, those lineages can provide immutable data flows that HIM professionals can use to support both security and privacy needs at a reasonable cost for most companies.

Future-Proof Against Change
The complexity of laws, rules, regulations, and operating environments will continue to increase for the healthcare industry. By architecting solutions that harness agile sensitive information identification, categorization, and data lineage to answer the five questions, HIM professionals can future-proof their organizations for change. Doing so will go a long way to provide complete visibility into cybersecurity and privacy’s threat landscape so they can rise to meet those challenges together.

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Think Ahead for Telehealth Security and COVID-19

By Michael Hawkins

It was announced in March that in light of the COVID-19 pandemic and the need for speed in related testing and treatment, the federal government would waive certain sanctions and penalties for HIPAA violations related to telehealth services. The goal of loosening the restrictions is to enable providers that don’t have a robust telehealth setup already in place to more easily make the transition, potentially using applications such as Google Hangouts and Facebook chat to converse with patients.

While the loosened restrictions have helped providers and patients alike in the emergent pandemic situation, it’s important to remember that the government—and other entities—will likely be taking a long, hard look at privacy and security issues once the current crisis has passed.

Health information management (HIM) professionals need to think not just about what is necessary to enable clinicians to communicate and exchange information in the moment but also about the impact that relaxed standards for privacy and security may have in the future. In other words, it’s essential to think about what may occur after the fact of the COVID-19 pandemic well before we get to that point. And while the currently relaxed atmosphere for some regulations means the government will not penalize healthcare organizations for looser standards in guarding protected health information (PHI) during telehealth visits, that does not release those organizations from their moral obligation to do so.

HIM professionals responsible for managing privacy and security must find a way to balance risk and protection. They shouldn’t be so fearful or spend so much time analyzing the risks that they do nothing to help expedite the exchange of data. But they also cannot allow the desire to implement or expand telehealth in this time of need to turn their telehealth processes and procedures into the wild west.

Fortunately, most of the security and privacy protocols needed to take advantage of telehealth should already be in place. A good example is using a secure virtual private network (VPN) rather than standard open internet connections to access applications and share information from remote locations. All telehealth communications should be conducted over a VPN.

HIM professionals should ensure their VPNs (and other systems) are prepared to scale, especially with the increased demand of multiple video calls. Other recommendations to keep in mind include:

- **Ensure any telehealth applications have HIPAA compliance baked in.** This should be a given for any application developed specifically for healthcare, although HIM professionals should confirm it anyway, just to be safe. If the organization decides to use an application that was not specifically designed for healthcare, those systems should have HITRUST certification, SOC 2 compliance, and be approved for HIPAA. Zoom, for example, has a business version that is HIPAA-compliant, but its consumer version is not. HIM professionals should exercise caution when multiple versions of a product exist. Selecting solutions that meet these standards protects not just the data itself, but also the organization in the future.

- **Provide proper education and training.** Clinicians who are new to telehealth may not think about the fact that PHI,
passwords, or other confidential information may be readable in the background when they are conducting a video call. Likewise, they may not think to check whether such information is also accidentally included in a screen-share view of their desktop. Anyone who uses the telehealth systems should be trained—and reminded frequently—to be aware of their surroundings at all times as well as other best practices for securing PHI over video.

- **Remind users about best practices they should already be following.** When looking at the sources of new threats, it’s easy to overlook the threats that everyone “should” already know about. That can be a mistake. For example, electronic health records should always be closed when the clinician is finished and leaving the data terminal. Additionally, clinicians should only use secure, HIPAA-approved email, text, and other communications applications whether communicating internally or externally, and all files that are being shared should be encrypted in transit. Users should also be reminded about ways to detect phishing scams that are used to gain access to hospital networks. Overloaded physicians, nurses, and other employees may not think twice about clicking on a link or document that appears to be from someone they know (especially a clinical leader), so it’s up to HIM professionals to ensure they exercise extreme caution before doing so. All those best practices were implemented for a reason. They are more important than ever when working in a crisis.

- **Drive home the importance of proper documentation.** Just as with face-to-face encounters, it is important for clinicians to understand that all telehealth calls must be logged in the electronic health record (EHR). If they are working remotely, they should log in via the VPN to do so. If they are unable to access the EHR at the time of the encounter they should know it is permissible to log the information in a secure Word document, but it should then be logged into the EHR as soon as possible. Sharing documents via some of the popular Internet-based open systems should be forbidden. Only those that are willing to sign a business associate agreement (BAA)—such as Dropbox, for example—should be authorized. In the worst-case scenario, where a Word or other document must be emailed over an open system so the data can be entered by someone else, the document should first be encrypted. The encryption key should then be forwarded separately, preferably using a different mode of communication such as a phone call or secure text.

- **Continue to perform regular user reviews.** If your organization is new to telehealth, you may want to increase the pace of reviews to understand which users are using the VPN (if you have one) and following other rules as well as which are not. The earlier you can remediate any issues, the better off patients and the organization will be. These reviews can be performed without slowing down the healthcare professionals for whom every minute is precious right now. Additionally, demonstrating you were actively managing the situation is likely to be viewed favorably should a problem come up in the distant future.

It may be difficult to imagine at the moment, but we will get through the COVID-19 pandemic. When we are no longer dealing with the emergent crisis and are able to look back, “we were pressed for time” will not be an acceptable excuse if PHI is purposely stolen or accidentally released. HIM professionals must take the proper steps today to ensure their organizations are protected for tomorrow.

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The National Center for Health Statistics estimates that US emergency departments (EDs) see more than 138 million visits each year. Research into factors beyond clinical need that drive ED utilization include healthcare access and availability, patient preferences, demographics, and policies such as the Emergency Medical Treatment and Labor Act (EMTLA). The EMTLA requires EDs to provide care for anyone regardless of their ability to pay. More recently, as new care delivery and payment models bring a shift from fee-for-service to value-based models, health systems, health insurers, and policymakers are recognizing the significance of social and economic factors—referred to as social determinants of health (SDOH)—on ED utilization.

Sparse Data for a Growing Need
While evidence of the impact of social risk factors on health outcomes, utilization, and costs is mounting, the efforts to capture and standardize these data is lacking. A subset of social and economic Z codes found in ICD-10-CM capture “factors that influence health status and contact with health services.” This set of SDOH Z codes have the potential to collect standardized information regarding patients’ social and economic risk factors. However, documentation of these factors and use of these codes are low, likely due to the lack of universally accepted standards and lack of reimbursement for the services that require these specific indicators. The Centers for Medicare and Medicaid Services (CMS) reported that Z codes were documented for only 1.4 percent of the 33.7 million fee-for-service (FFS) Medicare beneficiaries in 2017. This lack of utilization inhibits the proper targeting of resources and poses accuracy limitations when used in advanced analytics to properly identify socially vulnerable patients. Many innovation models and value-based programs will rely on social information to be successful. Those healthcare models include:

- **Community Paramedicine**: Requires an understanding of the social needs of rural patients and prioritizing workloads
- **Accountable Health Communities**: Relies on proper identification of social needs in order to align clinical and community services
- **Hospital Readmission Reduction Program**: Augments clinical, analytical, and operational models with social needs and integrated workflows
- **Population Health Programs**: Helps create robust stratification efforts for success under capitated and shared risk models

An Unstructured Army
As healthcare turns to data in this SDOH integration era, will artificial intelligence lead the way much like its statistical ancestor—randomized controlled trials—did for evidence-based medicine? Health informatics professionals are searching for innovative ways to uncover, define, and supply these SDOH data into clinical practice. Recent advances in natural language processing (NLP) provides a scalable way to broaden the capture of social risk factors from valuable narrative data found in unstructured clinical notes. NLP is a branch of artificial intelligence that enables computers to make sense of free-form text data. Using NLP methods to analyze clinical notes for understanding social and economic needs can contribute to understanding trends in outcomes and utilization without the reliance on broad adoption of SDOH Z codes.

Arming the Value-Based Fight
Specifically, social support has been linked to higher rates of ED utilization. Base Camp Health, a SDOH analytics company, conducted a retrospective case-control study using inpatient admission data from multiple acute care facilities, including SSM...
Health St. Anthony in Oklahoma City, OK, to understand the impact of social support risk factors on ED admission. Less than a third of a percent of admissions recorded an ICD-10-CM Z code related to social support. This volume was not large enough to determine the association between social support risk factors and whether an admission occurred through the ED. Therefore, a lightweight, semi-supervised topic modeling approach was used to identify social support risk factors in clinical notes. The NLP algorithm allows the specification of anchor words that define topics that may otherwise be underrepresented in the data. Specific parts of speech are considered when choosing topics—specifically, verbs and nouns. Rather than simply building topics from single words, the model also defined topics from phrases. Choosing anchor words to guide the model was an iterative process that required the identification of words and phrases that were believed to define social support risk. Key examples include:

- Divorced, estranged, separated from spouse
- Parent, spouse, or caregiver passed away
- Lonely, depressed, isolated, invisible
- [Lack of] intimacy, validation, support
- [Lack of] family, network, friends, community
- [Does not feel] valued, accepted, understood

A total of 741 admissions had indicators of social support risk factors found in the clinical notes associated with the visit, accounting for 10.3 percent of all admissions. Patients with a social support risk factor in clinical notes were more likely to be male, funded through Medicare or directly from the patient, and have a higher count of comorbid conditions.

Adding social support risk factors found in clinical notes allowed for the proper calculation of adjusted odds of ED admission. Patients with a documented social support risk factor, whether from an ICD-10-CM Z code or uncovered in clinical notes, were nearly 1.5 times more likely than a patient with no documented social support risk factor to be admitted through the ED. Without the augmentation of analyzing clinical notes, the ability to analyze the impact of these social support risk factors would be limited.

The Proper Battle Plan

Incorporating NLP methods or insights into electronic health record (EHR) workflows at the point-of-care would be valuable in identifying needs upstream in the primary care and community setting to alleviate barriers to care and aid in avoiding possible unnecessary ED visits and costs. Base Camp Health encourages organizations looking to implement such approaches to consider the following:

- Each organization must still develop the appropriate documentation, ontology and topics, and coding policies and guidelines for the incorporation of SDOH that meets their needs, whether from standardized code sets or analytic methods.
- Organizations must be willing to live within the error that any statistical approach brings and must partner with health informatics professionals that are transparent about how this error translates into operational and financial impact.
- Leaders need to relax the ideology that the EHR is the panacea of documentation and recall, as successful SDOH efforts will require many different data systems and actors, not all of which will be directly compatible with existing EHR vendors.
- Health informatics professionals need to be cognizant of where clinical text data are collected and how that may limit how they can be leveraged. The higher odds of ED admission given the presence of a social support risk factor found in this study may be indicative of screening tools and protocols executed explicitly in the ED versus during an inpatient stay or at discharge.
- Realize that any NLP process is iterative and takes human capital on the front end and throughout the lifecycle to tune and optimize the output.

Winning the War

The current shift in healthcare to value-based efforts will continue to require the understanding of patients’ social, economic, and behavioral needs as a supplement to medical data. However, SDOH data collection and definition will not be standard and universal without proper incentives or policy requirements. With less than three percent of clinicians documenting detailed SDOH, further refinement and adoption of standardized codes for SDOH should be a focus of all value-based initiatives and reform. A draft of the International Classification of Diseases, Eleventh Revision (ICD-11) reveals enhancement in these specific code sets. But we don’t have to sit around and wait. Many healthcare organizations will turn to unique data assets and analytic strategies such as NLP to understand holistic patient risk, properly preparing to better serve patients and the healthcare ecosystem.

Notes


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How HIEs are Achieving Sustainability, Providing Value to Providers and Patients

By Chad Peterson

Across the country, health information exchange (HIE) technology priorities are evolving rapidly as patients, providers, and payers better understand the multiple benefits and requirements associated with information sharing and data aggregation for both individual patient care and population health. The role of data is critical in key initiatives of interest to providers managing patients in traditional care settings as well as coordinating care across the community and to patients as they seek to better understand and participate in their own care.

Historically—especially in the last ten years—HIEs have dealt with myriad challenges to gain adoption in their ecosystems. Early on, many electronic health record (EHR) systems were not ready to connect to an HIE. Similarly, many organizations migrated to new EHRs, which took time and, in some cases, delayed adoption of an HIE. Other challenges faced by HIEs were dealing with potential participant and patient concerns about patient privacy, and payer and provider information being potentially accessible to each other. Some HIEs have been strongly supported by their stakeholders, including state health departments and Medicaid agencies, while others have struggled to gain this support.

The new reality for HIEs is that they are now grappling with the implications of being a part of a national network of networks due to the Trusted Exchange Framework and Common Agreement (TEFCA) while trying to achieve sustainability for their business.

Some HIEs have responded to TEFCA and other new data sharing initiatives by joining the eHealth Exchange, a national query-based network that connects federal and non-federal organizations in all 50 states—enabling connectivity between their stakeholders and participants of the eHealth Exchange, including CommonWell and Carequality participants. Many HIEs have also joined the Strategic Health Information Exchange Collaborative’s (SHIEC) Patient Centered Data Home (PCDH) initiative, which is an admission discharge transfer (ADT) notification system between PCDH participants.

Participating in these national initiatives while continuing to add value at “home” for their participants, including state government agency participants, is exactly where HIEs need to focus.

How HIEs are Achieving Sustainability

Common steps by successful HIEs include providing a public health gateway to state health department labs for participants to exchange immunization, electronic lab, and cancer case reporting data. Additionally, successful HIEs are providing essential syndromic surveillance data feeds to support COVID-19 responses by state and local officials.

A community record, accessed typically in a clinical or provider portal, is a longstanding feature of HIEs, allowing providers access to allergies, medications, encounters, lab results, and other essential clinical and (sometimes) claims data from data sources throughout the HIE ecosystem. Some HIEs are connected to state prescription drug monitoring programs, allowing providers access to essential information while minimizing the number of clicks required to obtain it. Making access to the HIE as seamless as possible, such as allowing providers to stay in their existing EHR workflow, is another way HIEs can ensure successful adoption. This can be accomplished through single-sign-on or API calls from EHRs to HIEs (or vice-versa), an emerging trend among successful HIEs and their participants.

A tremendous asset for HIEs to consider is allowing their participants to access (or query) the eHealth Exchange via the HIE community record. For non-traditional HIE participants such as dentists, optometrists, and chiropractors, this enables access...
HIEs need to continue to evolve to serve their stakeholders and patients within their ecosystem. This means engaging with national networks and being interoperable with an ever-growing number of sharing partners.

to very important information related to the treatment of their patients.
An additional approach HIEs may wish to consider is leveraging tools or modules already embedded in their HIE technology—such as an electronic master patient index, record locator service, event/ADT notification systems, or provider directory tools—to provide essential shared services between HIEs or other stakeholders in their state or region. With the increased focus on how HIEs can support state agencies, adding value to Medicaid or a state health department can move an HIE much closer to sustainability.

The Technology and Data Needs for the Next Generation of HIEs
Interviewing stakeholders and creating short- and long-term plans should be on the to-do list of all HIE leaders and advisory committee members as HIEs look to update their strategies to respond to changes in the industry and achieve long-term suitability. By evaluating what’s been successful and what’s been a struggle, HIEs will be better poised to respond to future challenges and understand what the impact of the 21st Century Cures Act, TEFCA, and other recent mandates will have on the HIE and its participants.
After evaluating their strategies and previous strengths and weaknesses, HIEs should then look at the technology.
With an open and scalable platform for population health, HIEs can deliver a comprehensive approach to acquiring, enriching, analyzing, and presenting actionable clinical and claims data, as well as non-traditional data (e.g., social determinants of health data). With an open and scalable platform, HIEs have a solid foundation to execute population health management programs and support new and emerging value-based care models while also preparing for precision medicine.
HIEs should be attempting to expand access to additional valuable real-time medication data and implementing new reporting tools to proactively monitor patients’ medication management and adherence. HIEs are identifying the link between interoperable technology and improved healthcare quality to advance the adoption and use of technology to exchange health information and improve healthcare quality, patient safety, and overall efficiency of healthcare and public health services across the US.
A secure statewide medical record sharing network for providers and consumers simplifies the medical record sharing process, creating a data roadmap for a more thorough understanding of patients’ conditions, allowing for up-to-the-minute decisions and faster diagnoses. This will help reduce patient intake time, minimize duplicate tests and paperwork, and give providers more one-on-one time with patients.
With an open data platform, providers can make more informed care decisions, improve the coordination of care across the healthcare continuum, and, ultimately, drive better health-care outcomes.
Providers can also seamlessly share, view, and receive patients’ immunization records, medication lists, histories, discharge summaries, lab results, and radiology reports as well as share referrals electronically through the HIE’s open data platform.

What Comes Next?
It all sounds simple, right? HIEs need to continue to evolve to serve their stakeholders and patients within their ecosystem. This means engaging with national networks and being interoperable with an ever-growing number of sharing partners, all while working on changing sustainability models and mandatory requirements.
Success will come when HIEs listen to their stakeholders and identify use cases that can benefit from the HIE or a network of networks approach to solving problems for an ecosystem. By using a short- and long-term planning approach and staying engaged with regional and national trends, HIEs can then utilize their technology stacks to best serve their state or region well into the future. With a solid technology foundation in place to meet today’s population health, medication management, and care coordination needs, HIEs will be prepared to tackle tomorrow’s healthcare challenges.

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Health Data

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Article—“How HIEs are Achieving Sustainability, Providing Value to Providers and Patients”

Review Quiz Questions and Take the Quiz Based on this Article Online at https://my.ahima.org/store
Documenting in the health record, especially in electronic health records (EHRs), is becoming an increasingly challenging task for many providers across the continuum of care. In recent years, many providers have become burned out and frustrated by EHRs, new reimbursement models, increased regulatory requirements related to quality, onerous query practices, and coding guidelines that vary by healthcare setting.

The purpose of this Practice Brief is to describe documentation best practices and serve as a resource in effective and efficient clinical documentation practices without having a negative impact on patient care. Providers should understand how their clinical documentation translates into data that is used for a variety of purposes.

For many years, providers have struggled with how to document clinical status to accurately report inpatient encounters, office visits, and other evaluation and management (E/M) services. With the use of EHRs in both hospitals and provider practices, “note bloat” and the use of cut/copy and paste has caused additional scrutiny on provider documentation. Furthermore, many providers are being queried for additional clarifications that may or may not be appropriate, causing additional documentation discrepancies within a health record. Providers are also frequently using checkboxes to meet documentation requirements, especially in the outpatient setting. As a result, it is very important for the providers to be educated on how to appropriately use these check boxes to avoid note bloat.

Documentation should also be reviewed and validated at the time of entry. The documentation should always be clear, concise, and to the highest level of specificity so that it paints the most accurate clinical picture. Although ICD-10-CM is used to report diagnoses in all settings, different guidelines apply for inpatient and outpatient settings, which may not be understood by providers working in both settings. ICD-10-CM Official Guidelines for Coding and Reporting contains separate guidelines for inpatient and outpatient settings. For example, uncertain diagnoses documented as “probable,” “suspected,” “rule out,” or other similar terms demonstrating uncertainty can be coded in the inpatient setting but not in the outpatient setting. See Table 1 on page 40 for a quick overview of the ICD-10-CM Official Guidelines for Coding and Reporting.

In the outpatient setting, providers are reimbursed for their professional services based on E/M codes. Providers rely on the 1995/1997 Documentation Guidelines for E/M Services. These guidelines assist providers in determining the most appropriate level of service to bill for their E/M services by providing guidance on what elements need to be included in their documentation. Provider documentation must support the history, examination, and medical decision-making (MDM). Providers can use either 1995 or 1997 documentation guidelines when selecting the appropriate level for the patient visit. However, they cannot use both guidelines. It is important for providers to remember that the selected E/M level must be medically necessary and supported by the documented condition/plan. See Table 2 on page 41 for a quick overview of the E/M services.

On November 1, 2019, the Centers for Medicare and Medicaid Services (CMS) finalized a provision in the 2020 Medicare Physician Fee Schedule Final Rule. This provision includes revisions to the E/M office visit CPT codes (99201-99215) code descriptors and documentation standards effective January 1, 2021. This provision was finalized in response to provider burnout due to the administrative burden related to documentation requirements.

In an article published by the American Medical Association (AMA), the key elements of the E/M office visit overhaul include:
• Eliminating history and physical exam as elements for code selection. While significant to both visit time and medical decision-making, these elements alone should not determine a visit’s code level.
• Allowing providers to choose whether their documentation is based on MDM or total time. This builds on the movement to better recognize the work involved in non-face-to-face services like care coordination.
• Modifying MDM criteria to move away from simply adding up tasks to focus on tasks that affect the management of a patient’s condition.

An opportunity now exists for clinical documentation integrity (CDI) and coding professionals to incorporate this upcoming change into their provider education. Providers can be better prepared by having enough time to learn and understand how these changes might impact their current document practices before January 1, 2021.

Furthermore, telehealth services are increasing in popularity and there are more specific CPT codes that will define the amount of time spent on these services. There are CDI opportunities to ensure the time is documented appropriately and includes only the services allowed for coding and billing.

Reimbursement Methodologies and Quality Initiatives

The Medicare Claims Processing Manual Chapter 23 - Fee Schedule Administration and Coding Requirements Section 10.3 - Outpatient Claim Diagnosis Reporting also provides additional guidance on what types of diagnoses can be reported on outpatient claims. The rule of thumb is for providers to report a complete list of diagnoses that captures all the conditions that warranted the outpatient services. See Table 3 on page 42 for an example.

Many providers may not be aware that the CMS-1500 claim form allows the inclusion of up to 12 diagnosis codes because they have been taught that only four diagnoses can be mapped to a specific CPT code. So why is it important for the providers to report additional diagnoses even though they are not going to link to a service (CPT code) line? The capturing of all diagnoses that are relevant to the treatment, socioeconomic, and/or psychosocial circumstances are important to accurately capture the patient’s clinical picture and potential health hazards, therefore providers should be educated on the impact of these additional diagnoses. For example, if a patient came in for an office visit for a cough and during the examination the provider documented that the patient is also treated with medication for diabetes and hypertension and has a history of right leg amputation status following a motor vehicle accident. These additional diagnoses may impact the patient’s overall risk score and treatment plan across the continuum of care, therefore it is very important for providers to be educated on the importance of documenting and reporting all diagnoses that are relevant and/or addressed during the visit and not to just report the four diagnosis pointers.

As already mentioned, accurate and precise provider documentation is more important than ever in the changing landscape of provider reimbursement and quality initiatives. Provider documentation burden has been debated and addressed by the Centers for Medicare and Medicaid Services, but the need to capture the care of the patient remains. The new mantra is quality over quantity when it comes to documentation, but the concern will always be: Was the full picture of the visit captured to support the level of service that was coded and billed, chronic conditions addressed, and problem list updated? CDI and coding professionals can focus on areas related to coding and reporting as well as other documentation that supports quality initiatives to improve patient outcomes.

Providers who have practiced for years in their own office have been coding their services using charge capture forms or other methods to inform the billing staff of the services provided. With the consolidation of practices into large multispecialty clinics and hospital-owned practices, there are still physicians who code their own cases, and those who have professional coding support. Many larger facilities encourage providers to code their levels of service and procedures performed. However, the documentation of the MDM often lacks specificity that could support a higher level. This is an area where outpatient CDI can be of great value. Providers are also unaware of National Correct Coding Initiative (NCCI) edits and payer requirements such as the appropriate use of modifiers for the claim to be paid.

As the cost of healthcare premiums and copays have increased, many healthcare beneficiaries elected to enroll in managed care programs, which encourages efficient delivery of healthcare services. The traditional fee-for-service model has been declining in popularity by health insurers who have implemented varying types of managed healthcare plans over the years to decrease costs and encourage more efficient delivery of healthcare through risk sharing. The concern over this type of reimbursement was that quality of care was being sacrificed.

Enter alternative healthcare reimbursement models: The Affordable Care Act (ACA) ushered in a new era of healthcare that applies risk adjustment to patient populations and introduced value-based care. The term value-based care encompasses models such as risk sharing (capitation) with quality incentives, accountable care, population health, and bundled payments. These models provide incentives for providers to offer quality care at a lower cost. There are many facets to these models, but one point was clear in the literature, it requires engagement from providers, payers, and patients.

The ACA introduced a permanent risk-adjustment program (Section 1343). The risk-adjustment model is budget neutral and insurers covering healthier patient populations are required to contribute to a risk-adjustment pool that will help other insurers covering a higher-risk patient population. Higher-risk populations consist of patients with chronic conditions that require continuous treatment, monitoring, and maintenance. Providers need to be aware of the various risk adjustment models and rely on complete, timely, and accurate reporting of patient diagno-
The accuracy of clinical documentation and reporting of these diagnoses may impact the patient’s/enrollee’s hierarchy, thus determining reimbursement. Risk adjustment methodologies assign families of diseases to a cost based on severity and projected use of resources.

It will be helpful to educate providers on hierarchical condition categories (HCCs). HCCs are made up of condition categories and the hierarchies are the compilation of related condition categories (CCs). HCCs were designed to predict resource consumption/healthcare costs of certain patient populations. The hierarchy consists of families of diseases that are assigned a cost based on severity of illness and projection of resource use. Theoretically, if a patient’s/enrollee’s chronic condition becomes severe, the patient will then require extra healthcare services. See Table 4 on page 43 for a snapshot of the many different types of HCCs.

### TABLE 1: OVERVIEW OF ICD-10-CM OFFICIAL GUIDELINES FOR CODING AND REPORTING

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Applies to Which Setting (Inpatient or Outpatient)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Section I.A: Conventions, General Coding Guidelines and Chapter Specific Guidelines</td>
<td>This section addresses the conventions for ICD-10-CM. These conventions are incorporated within the Alphabetic Index and Tabular List of the ICD-10-CM as instructional notes. This section also addresses format and structure of the classification.</td>
<td>Inpatient Outpatient</td>
</tr>
<tr>
<td>Section I.B: General Coding Guidelines</td>
<td>This section addresses general coding guidelines. For example: · Locating a code · Level of detail in coding · Signs and symptoms · Acute and chronic conditions · Sequela · Laterality · Documentation of complication of care</td>
<td>Inpatient Outpatient</td>
</tr>
<tr>
<td>Section I.C: Chapter-Specific Coding Guidelines</td>
<td>This section addresses guidelines related to chapter-specific diagnoses and/or conditions. These guidelines apply to all healthcare settings, unless otherwise indicated.</td>
<td>Inpatient Outpatient</td>
</tr>
<tr>
<td>Section II: Selection of Principal Diagnosis</td>
<td>This section indicates that the circumstances of inpatient admission always govern the selection of principal diagnosis. · The principal diagnosis is defined in the Uniform Hospital Discharge Data Set (UHDDS) as “that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care”</td>
<td>Inpatient</td>
</tr>
<tr>
<td>Section III: Reporting Additional Diagnoses</td>
<td>This section provides general rules for reporting additional diagnoses. For reporting purposes, the definition for “other diagnoses” is interpreted as additional conditions that affect patient care in terms of requiring: · clinical evaluation; or · therapeutic treatment; or · diagnostic procedures; or · extended length of hospital stay; or · increased nursing care and/or monitoring</td>
<td>Inpatient</td>
</tr>
<tr>
<td>Section IV: Diagnostic Coding and Reporting Guidelines for Outpatient Services</td>
<td>This section provides coding guidelines for outpatient diagnoses used by hospitals/providers in coding and reporting hospital-based outpatient services and provider-based office visits. Key highlights include: · Principal diagnosis is not used in the outpatient setting, instead the term “first-listed diagnosis” is used · In determining the first-listed diagnosis the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines · Do not code diagnoses documented as “probable,” “suspected,” “questionable,” “rule out,” “compatible with,” “consistent with,” or “working diagnosis,” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit · Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)</td>
<td>Outpatient (provider office, clinics, etc.)</td>
</tr>
</tbody>
</table>
As mentioned above, all risk-adjustment models depend on complete and accurate reporting of patient data. The clinical documentation in the health record must support the presence of all patient condition/diagnoses, along with the provider’s assessment and plan for management of each condition, especially chronic conditions. These documented conditions are then translated into reportable codes and this reported data is then used to predict costs for the following year for Medicare Advantage and/or commercial enrollees. Therefore, it is important for CDI professionals to educate providers on the impact of documenting non-specific diagnoses and the ramifications of not documenting chronic conditions. Providers need to be aware that their documentation can affect not only patient care and outcomes, but also reimbursement for future care due to risk adjustment. Providers should be validating and updating all documented conditions at each visit. The medication list is also a great resource for CDI professionals who are validating diagnoses. Providers should be encouraged to document the condition being treated by each medication, demonstrating its relevance as a current and reportable condition. Educational efforts should also encourage providers to specify the acuity of every diagnosis, especially those only mentioned in the history of current condition section of the history and physical. Specifically, documentation should describe each condition as acute, chronic, exacerbated, or resolved to clearly convey its current status and relationship to the current episode of care.

Data Analytics

There are numerous opportunities now to extract data out of the EHR. For the data to be meaningful, the documentation of the care provided is an essential component of data analytics. Many EHRs now allow the provider to select their own diagnoses (example: drop-down boxes) with some of these diagnoses being identified as HCCs within the EHR. Therefore, providers need to be educated on how to appropriately select the most accurate diagnosis and to not select codes based on the first diagnosis that pops up and/or is identified as an HCC. Providers also need to be aware that their documentation is captured through many types of coded data including, but not limited to, ICD-10-CM/PCS, CPT, RxNORM, SNOMED CT, and Logical Observation Identifiers Names and Codes (LOINC). This may go beyond the realm of the typical CDI professional’s role, but the documentation of the diagnosis and procedures performed is just as important. A CDI professional can also be a valuable part of an analytics team.

Suggestions for data use:
• Physician engagement in data analytics—they should be involved in ensuring data accuracy and leveraging it to make a difference when providing care to specific populations
• Validate whether listed medications have associated diagnoses
• Denial trends, medical necessity, documentation. As the Medicare Claims Processing Manual states, “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported.”

TABLE 2: OVERVIEW OF E/M SERVICES

<table>
<thead>
<tr>
<th>Section</th>
<th>Description and Key Take Away</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Made up of four elements:</td>
</tr>
<tr>
<td></td>
<td>• Chief complaint (CC)</td>
</tr>
<tr>
<td></td>
<td>• History of present illness (HPI)</td>
</tr>
<tr>
<td></td>
<td>• Review of systems (ROS)</td>
</tr>
<tr>
<td></td>
<td>• Past, family, and/or social history (PFSH)</td>
</tr>
<tr>
<td></td>
<td>Documentation will determine type of history:</td>
</tr>
<tr>
<td></td>
<td>• Problem focused</td>
</tr>
<tr>
<td></td>
<td>• Expanded problem focused</td>
</tr>
<tr>
<td></td>
<td>• Detailed</td>
</tr>
<tr>
<td></td>
<td>• Comprehensive</td>
</tr>
<tr>
<td>Examination</td>
<td>Note: Provider cannot use a combination of 1995 and 1997 guidelines.</td>
</tr>
<tr>
<td>1995 Documentation Guidelines:</td>
<td>• Examination can be documented by either body areas or organ systems</td>
</tr>
<tr>
<td></td>
<td>• Explains what documentation is needed to document “abnormal,” “negative,” and “normal.”</td>
</tr>
<tr>
<td>1997 Documentation Guidelines:</td>
<td>• Examinations include general multi-system examination or a single organ system examination. Each contains its own additional details about the required elements of a physical examination.</td>
</tr>
<tr>
<td></td>
<td>• Bullet points are the key component used to determine the type of examination.</td>
</tr>
<tr>
<td>Medical Decision Making (MDM)</td>
<td>Made up of three components:</td>
</tr>
<tr>
<td></td>
<td>• Number of diagnoses or management options</td>
</tr>
<tr>
<td></td>
<td>• Amount and/or complexity of data required for review</td>
</tr>
<tr>
<td></td>
<td>• Risk of complications and/or morbidity or mortality</td>
</tr>
<tr>
<td></td>
<td>Documentation will determine level of MDM:</td>
</tr>
<tr>
<td></td>
<td>• Straightforward</td>
</tr>
<tr>
<td></td>
<td>• Low complexity</td>
</tr>
<tr>
<td></td>
<td>• Moderate complexity</td>
</tr>
<tr>
<td></td>
<td>• High complexity</td>
</tr>
</tbody>
</table>
whether performed verbally, by paper, or electronically, serve the purpose of supporting clear and consistent documentation of diagnoses during a patient’s visit. Professionals performing the query function should maintain a compliant query process. According to the AHIMA/ACDIS Guidelines for Achieving a Compliant Query Practice (2019 Update), all queries, including verbal queries, should be documented in writing to demonstrate compliance with all query requirements to validate the essence of the query. Regardless of how the query is communicated, it needs to meet all of the following criteria:

- Be clear and concise
- Contain clinical indicators from the health record
- Present only the facts identifying why the clarification is required
- Be compliant with the practices outlined in this Practice Brief
- Never include impact on reimbursement or quality measures

Although verbal queries may be prevalent in the physician practice setting due to the close working relationship and quick turnaround of patient visits, it is important to follow guidance requiring their recording. According to the Practice Brief, verbal queries should “include documentation of the conversations that occur with providers regarding documentation of reportable conditions/procedures. Conversations should be non-leading, include all appropriate clinical indicators, and include all plausible options. In capturing the essence of the verbal discussion, timely notation of the reason for the query (exact date/time and signature), clinical indicators, and options provided should be recorded and tracked in the same manner as written queries and be discoverable to other departments and external agencies.” Provider response to the query must be documented in the permanent health record in order to be coded.

Professionals issuing queries must adhere to the following guidelines:

- Do not lead the provider to a certain diagnosis
- Include appropriate clinical indicators to support the query
- A query may be initiated to clinically validate a diagnosis that a prior health record provided evidence to support particularly when clarifying specificity or the presence of a condition which is clinically pertinent to the present encounter supporting accuracy of care provided across the healthcare continuum. Prior encounter information may be referenced in queries for clinical clarification or validation if it is clinically pertinent to the present encounter. However, it is inappropriate to mine a previous encounter’s documentation to generate queries not related to the current encounter.

Please refer to AHIMA/ACDIS’s “Guidelines for Achieving a Compliant Query Practice (2019 Update),” available online in AHIMA’s HIM Body of Knowledge at bok.ahima.org, for additional details on writing compliant queries, including query examples.

---

**TABLE 3**

<table>
<thead>
<tr>
<th>Outpatient Scenario</th>
<th>What is coded?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient presents with a symptom and no definitive diagnosis is made.</td>
<td>The symptom is reported (example: shortness of breath, cough, chest pain, etc.).</td>
</tr>
<tr>
<td>Patient presents with a symptom and a definitive diagnosis is made.</td>
<td>The definitive diagnosis is reported, symptoms integral to a definitive diagnosis are not reported (example: acute systolic CHF, acute bronchitis, CAD with angina, etc.).</td>
</tr>
<tr>
<td>Patient presents at the hospital clinic for examination or testing without a referring diagnosis, symptom, or complaint.</td>
<td>Hospital clinic reports an encounter code that accurately reflects the reason for the encounter (Example: Z00.00; Encounter for general adult medical examination without abnormal findings, Z00.01; Encounter for general adult medical examination with abnormal findings, etc.).</td>
</tr>
</tbody>
</table>

---

**CDI Best Practices**

Provider documentation may lack specificity and/or consist of conflicting documentation. Therefore, it is vital for hospitals and provider practices to have a query process in place to ensure providers have the opportunity to add or clarify documentation in the health record in a compliant manner. Queries, whether performed verbally, by paper, or electronically, serve

- Claim edits and correct coding initiatives
- CMS measures the Medicare Fee-for-Service (FFS) improper payment rate through the Comprehensive Error Rate Testing (CERT) program. The three largest improper payment drivers are insufficient documentation, medical necessity, and incorrect coding. Collaboration between coding and CDI can address many of these issues at the provider level.
- Depending on the type of practice, such as specialty versus general medicine, E/M level distributions should be compared to national trends. A standard bell curve is not always an indication that physicians or coders are coding appropriately.

Additionally, healthcare data can be found in the following:

- Key performance indicators (KPI)/dashboard (for examples, see the online appendix for this Practice Brief)
- Quality indicators
- Care coordination/population health data. It’s important to identify key populations where there is risk, as well as social determinants of health for specific populations. Also important are chronic conditions—what are the most frequently documented conditions, and does documentation exist to show the conditions were addressed during a visit?
Providers frequently benefit from tailored education that they can relate to. The education should include examples and/or illustrations of best practices, along with their current documentation practices and areas of improvement. The following tasks should be considered by the CDI team in both the inpatient and outpatient settings (for example, a large physician practice) when putting together an education program for the providers:

- Perform concurrent reviews and offer providers feedback to improve completeness and specificity in documentation to support ICD-10-CM/PCS, CPT, and HCC coding
- Conduct chart reviews and any necessary provider education for compliance with quality reporting initiatives
- Perform retrospective chart reviews for coding compliance and quality measures
- Collaborate with team members to aggregate findings from clinical documentation reviews (both retrospective and concurrent) and design educational content and remediation strategies for both individual providers and provider groups
- Coach the provider on opportunities for improving clinical documentation based on annual compliance review findings
- Collaborate with team members on ways to improve EHR functionality in support of clinical documentation coding trends and requirements
- Translate feedback from providers, CDI professionals, coding professionals, and compliance into content enhancements in the EHR
- Design, test, and implement revised drop-down menus and other enhancements to assist providers in improved documentation and coding completeness
- Collaborate with providers to improve existing standard note and template functionality
- Collaborate with the EHR vendor to validate the embedded clinical terminology system within the EHR is appropriately mapping to the correct ICD-10-CM and/or SNOMED CT codes
- Prepare physicians for the documentation changes effective in 2021
- Review times documented for telehealth services
- Schedule, prepare, and lead meetings with practices focused on documentation, coding, and quality performance gap closure, and develop and implement follow-up activity
- Lead or provide education/training to clinical care (providers, nurses, etc.) and administrative support team members regarding the clinical documentation requirements

Documentation Education is Vital

It is vital to educate all providers on the importance and significance of the integrity of their documentation along with the
many reimbursement methodologies and coding guidelines and the changes on the horizon. Providing a snapshot from a high-level perspective will help providers gain a better understanding on the importance of documentation across the continuum of care. Healthcare organizations should leverage their coding and CDI professionals to provide this type of provider education. Despite the differences of documentation needs, one message that applies to all settings is that providers should always document to the highest level of specificity (e.g., acuity, chronicity, etiology, etc.) and be as accurate as possible in their initial documentation. With this level of specificity and accuracy, all requirements for coding purposes and quality reporting will fall into place while reducing the volume of queries. Providers should be viewing coding and CDI professionals as their documentation educators. A proactive delivery of provider education tailored to assist them in learning the art of documentation integrity will benefit all stakeholders.

Notes

References


Continued on page 48
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### APPENDIX A

#### SAMPLE LIST OF RELEVANT ICD-10-CM CODES FOR COVID-19

<table>
<thead>
<tr>
<th>Outpatient Scenario</th>
<th>What is coded?</th>
</tr>
</thead>
<tbody>
<tr>
<td>B97.29</td>
<td>Other Coronavirus as the cause of disease classified elsewhere</td>
</tr>
<tr>
<td>B34.2</td>
<td>Coronavirus infection, unspecified</td>
</tr>
<tr>
<td>Z03.818</td>
<td>Encounter for observation for suspected exposure to other biological agents ruled out</td>
</tr>
<tr>
<td>Z11.9</td>
<td>Encounter for screening for infectious and parasitic disease, unspecified</td>
</tr>
<tr>
<td>Z20.828</td>
<td>Contact with and suspected exposure to other viral communicable disease</td>
</tr>
<tr>
<td>U07.1</td>
<td>COVID-19 [effective date 4/1/2020]</td>
</tr>
</tbody>
</table>

#### EXAMPLES OF EXPECTED ICD-10-CM CODED DATA PATTERNS

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Before 4/1/2020</th>
<th>On and After 4/1/2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia due to COVID-19</td>
<td>J12.89 Other viral pneumonia</td>
<td>U07.1 COVID-19</td>
</tr>
<tr>
<td></td>
<td>B97.29 Other coronavirus as the cause of disease classified elsewhere</td>
<td>J12.89 Other viral pneumonia</td>
</tr>
<tr>
<td>Acute bronchitis due to COVID-19</td>
<td>J20.8 Acute bronchitis due to other specified organism</td>
<td>U07.1 COVID-19</td>
</tr>
<tr>
<td></td>
<td>B97.29 Other coronavirus as the cause of disease classified elsewhere</td>
<td>J20.8 Acute bronchitis due to other specified organism</td>
</tr>
<tr>
<td>ARDS due to COVID-19</td>
<td>J80 Acute respiratory distress syndrome</td>
<td>U07.1 COVID-19</td>
</tr>
<tr>
<td></td>
<td>U07.1 COVID-19</td>
<td>J80 Acute respiratory distress syndrome</td>
</tr>
</tbody>
</table>

### Appendix B

#### EXAMPLES OF EXPECTED SNOMED CT CODED DATA PATTERNS

<table>
<thead>
<tr>
<th>Outpatient Scenario</th>
<th>Terminology</th>
<th>Term/Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>840539006</td>
<td>SNOMED CT</td>
<td>Disease caused by severe acute respiratory syndrome coronavirus 2</td>
</tr>
<tr>
<td>840539006</td>
<td>SNOMED CT</td>
<td>Suspected disease caused by severe acute respiratory coronavirus 2</td>
</tr>
<tr>
<td>840546002</td>
<td>SNOMED CT</td>
<td>Exposure to SARS-CoV-2</td>
</tr>
<tr>
<td>840534001</td>
<td>SNOMED CT</td>
<td>Severe acute respiratory syndrome coronavirus 2 vaccination</td>
</tr>
<tr>
<td>94558-4</td>
<td>LOINC</td>
<td>SARS coronavirus 2 Ag [Presence] in Respiratory specimen by Rapid immunoassay</td>
</tr>
<tr>
<td>94559-2</td>
<td>LOINC</td>
<td>SARS coronavirus 2 ORF1ab region [Presence] in Respiratory specimen by NAA with probe detection</td>
</tr>
</tbody>
</table>

#### SAMPLE LIST OF RELEVANT SNOMED CT AND LOINC CONCEPTS FOR COVID-19

<table>
<thead>
<tr>
<th>Scenario</th>
<th>SNOMED CT 2020-03-09 Release</th>
<th>SNOMED CT 2020-07-31 Release</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia due to COVID-19</td>
<td>441590008 Pneumonia caused by Severe acute respiratory syndrome coronavirus (disorder)</td>
<td>882784641000119100 Pneumonia caused by SARS-CoV-2 (disorder)</td>
</tr>
<tr>
<td>Acute bronchitis due to COVID-19</td>
<td>233601004 Acute viral bronchitis (disorder)</td>
<td>138389411000119105 Acute bronchitis caused by SARS-CoV-2 (disorder)</td>
</tr>
<tr>
<td></td>
<td>415360003 Severe acute respiratory syndrome-related coronavirus (organism)</td>
<td></td>
</tr>
<tr>
<td>ARDS due to COVID-19</td>
<td>67782005 Acute respiratory distress syndrome (disorder)</td>
<td>674814021000119106 Acute respiratory distress syndrome caused by SARS-CoV-2 (disorder)</td>
</tr>
<tr>
<td></td>
<td>415360003 Severe acute respiratory syndrome-related coronavirus (organism)</td>
<td></td>
</tr>
</tbody>
</table>
Continued from page 19

needs to be made aware of all of the risks. Not only will the organization have the cost of responding to the event, but the cost of breach notification if the event involves data that triggers such an obligation. According to the “Ponemon 2019 Cost of Data Breach Study: Global Overview,” the average cost of a data breach per record in the healthcare industry is $429. There is also the risk of regulatory enforcement actions and lawsuits.

Multiple health entities have had class action lawsuits filed against them for privacy and cybersecurity incidents. The Office for Civil Rights (OCR) has stated they will investigate all data breaches reported to them involving more than 500 individuals. Between January 1, 2016 and October 29, 2017, OCR settled 28 cases and imposed civil monetary penalties (CMP) against four organization for $60.4 million. The average settlement was over $1.76 million dollars. The average CMP was $2.82 million. Knowing these risks helps the board understand what their action or inaction could mean. Identifying the potential impact to the bottom line is a business risk discussion that is relatable.

Obligations of the Board of Directors
Failing to adequately understand any risk is a risk in and of itself. The board members are expected to exercise their duty of care to the organization—they can’t simply assume their organization is complying with the law.

The board liability for privacy and cybersecurity issues could be created in at least two ways. First, ignoring the risk altogether by failing to ask for any information where a reasonable and prudent person in the same or similar circumstance would ask. Second, if there is evidence the risk was brought to their attention and the risk was not addressed appropriately. It is critical to get the board past viewing such issues as “IT issues,” and to instead understand it is an ERM issue.

The board needs to understand the exposure they face by simply listening to privacy and cybersecurity threats to the organization but failing to act because they don’t understand what they are being told. When the CPO and CISO present the cybersecurity posture of the organization to the board, their presentation should invite questions and include easily understood terminology. Poor presentation skills of the CPO or CISO won’t excuse a failure to exercise proper oversight.

Eliminating jargon and using analogies can help the board’s understanding. Consider, for example, a situation where the CISO is trying to secure funding from the board to implement a security operations center (SOC). Instead of explaining in technical terms what the SOC monitors and the alerts it provides, she could explain by comparing the current system to having locks on the doors and windows of your home. If a break-in occurs when the homeowner is away, there is no way to know it occurred in real time. Adding a monitored alarm system, however, allows the alarm company to provide an alert as soon as the break-in happens.

The home alarm might not stop the theft. However, it does allow the homeowner to respond more promptly and initiate corrective measures. The SOC would serve a similar purpose for the organization’s cybersecurity environment.

The CPO could play off the same analogy to address a related issue by telling the board that while there is a monitoring system and the doors and windows are locked, the valuables the system is designed to protect are in the garage, which is not connected to the home security system. Such an example can provide the board members with an understanding of the purpose and benefit of the SOC and how privacy and security are linked. It can also create an easy way for them to remember the discussion.

Another factor for consideration is how the board’s involvement in the oversight of the privacy and cybersecurity programs is documented. This can prove either highly beneficial or highly detrimental in demonstrating the board’s oversight and is often reflected through the board meeting minutes. Minutes for multiple meetings that reflect discussion of the privacy and information security risks and recommendations for addressing those risks without action by the board could demonstrate a “sustained or systematic failure” of the board to exercise oversight—a circumstance that creates liability on the part of board members, according to the court findings in the case of In re Caremark International. But if the minutes reflect a robust discussion of the risk and possible solutions with action items for implementation, it would likely be viewed as evidence of the good faith oversight required of a director. The case law around director liability makes it clear that if the director acted in good faith, even if the decisions are later discovered to be faulty, there is generally no breach of duty.

Communication is Key
Privacy and cybersecurity risks in healthcare are only continuing to grow. It is imperative that organizations, particularly their governing bodies, shift to understanding this as an ERM issue. Presentations on these topics must be made with easily understood terminology that allows those in leadership roles to engage and make informed decisions. When discussing privacy and cybersecurity with the board and senior leadership, jargon should be avoided in favor of layperson terms and relatable analogies.

Getting the board and senior leadership’s attention for these issues can be difficult. Identifying that under some circumstances there could be personal liability for them in failing to address key risk areas like privacy and cybersecurity can be a helpful motivator. But like many other things in life, success can be found by keeping it simple.

Reference


Marti Arvin (marti.arvin@cynergistek.com) is executive advisor at CynegisTek.
The AHIMA Loyalty Program offers organizations the opportunity to better align their marketing outreach with AHIMA's print, content, and information channels while delivering year-long exposure to AHIMA's 103,000+ health information professionals.

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<table>
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<th>Overall Score</th>
<th>Release of Information Average 89.0</th>
<th>Confidence</th>
<th>Loyalty</th>
<th>Operations</th>
<th>Services</th>
<th>Relationship</th>
<th>Value</th>
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<td>92.5</td>
<td>3</td>
<td>A</td>
<td>A-</td>
<td>B+</td>
<td>A-</td>
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<td>C+</td>
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