Capturing Cancer Data in Real Time

Electronic reporting shapes up as a game-changer

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A MEASURED APPROACH TO HEALTH CARE

By Lee DeOrio

I have no idea how I’m feeling. Am I happy? Sad? Bored? Thank goodness there’s a device that can quantify these data because, if nothing else, life is all about data these days. Come December 31, I can tally the numbers and figure out if I had a “good year.” Think of the memories. Daydreaming in my rocking chair, I may wonder, “Was I happy in 2017? Let’s check the data. According to the report, I smiled 33% of the time. Wow, what good times.”

Don’t snicker at such a scenario. In reality, there’s a company that claims it can measure “emotional arousal” by using a webcam to detect whether you smile at a video. Not only that, there’s a wrist sensor version that detects galvanic skin response to read a person’s emotional state. It’s currently being used for research purposes, but plans are afoot to introduce it to the general population.

Besides monitoring emotional highs and lows, devices these days can capture a multitude of readings. Body temperature, sleep patterns, heart rate, blood pressure, weight, and blood glucose are just a few of the measurements capable of being determined by intricate sensors. If the basics aren’t enough, there are gadgets to track where and when asthma patients use their inhalers and how well chronic conditions such as diabetes are being managed.

What do we do with all the data being amassed? Are physicians willing to accept the data that are being generated by these devices? Proponents of monitoring technology cite how it simplifies data collection and can lower costs. Hurdles to more widespread use include getting the data into a physician’s hands through an interoperable platform and convincing consumers that so-called fitness wearables are worth the cost.

According to research firm Forrester, most US adults are not willing to pay for a device that measures something they believe physicians are supposed to monitor. The perception is that such technology is more for the chronically ill than for everyone who shows no signs of illness. This line of thinking illustrates the general public’s penchant for not taking action until the need arises—or is it merely a matter of cost?

That could very well be the case because, according to a Manhattan Research report, 70% of surveyed physicians said at least one of their patients was sharing health measure information with them. However, handwritten notes or printouts were the preferred method to relay those data. According to research firm Forrester, most US adults are not willing to pay for a device that measures something they believe physicians are supposed to monitor. The perception is that such technology is more for the chronically ill than for everyone who shows no signs of illness. This line of thinking illustrates the general public’s penchant for not taking action until the need arises—or is it merely a matter of cost?

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Dear Editor,

After reading “Hello EHR, Good-Bye HIM?” in the March issue, I felt compelled to further explore the premise that an HIM career track may be in jeopardy. As a longtime AHIMA member who completed my RHIT internship in the late 1980s at St Mary’s Hospital in Leonardtown, Maryland, I was greatly saddened to read Richard Braam’s statement that outsourcing HIM was one of the best decisions that he ever made. Although this may be a financially wise decision in the short term to an accountant, as a certified RHIA raised in St Mary’s County, Maryland, I know the repercussions of outsourcing as well as assuming any HIM function can be efficiently handled by IT or nursing. Some of the concerns are lack of oversight (covered entities), lack of experienced input for actual health information analysis, inability to correct erroneous entries, and overloading remaining credentialed staff with tasks outside their normal job scope.

Braam states in the article that the decision was partly formulated as a result of St Mary’s rural isolation and difficulty in finding qualified staff. St Mary’s County may have qualified as isolated in the late 1960s but with an exploding population of more than 109,000; home to Patuxent Naval Air Station, one of the largest naval bases in the United States; and situated just 65 miles south of Washington, DC, I find this an unlikely scenario. If physicians and nursing staff can be hired, qualified HIM staff should be available as well. I surmise that falling under the umbrella of MedStar, which allows for a wide off-site pool of staff who can perform functions elsewhere, frees up costly hospital square footage and provides at least short-term financial incentives. The directive to have nursing staff cover release of information seems to be a misuse of expensive and valuable nursing time. Did the nurses really take this on willingly? As for the two data technicians pursuing formal HIM training while monitoring transcription, are they going to have a job when they are credentialed?

IT staff can make a wonderful commitment to EHR implementation, but rarely do they know how health information data flows, the reasoning behind coding guidelines, the nuances of federal requirements, or what it takes for true record analysis. If the EHR turns on, IT is happy. If the data are incorrect, inaccessible, inappropriate, or not serving changing certification/survey requirements, it is very difficult to get these issues resolved without HIM professionals.

I am currently working in the Department of Behavioral Health and Developmental Services in Virginia, which is undergoing a massive EHR implementation project. This is most definitely IT driven with clinical staff input. HIM is not at the forefront and has only minor input. How much this will affect usability and relevance remains to be seen. As HIM professionals who understand the ramifications of poor data input, no relevant usable data output, and poor survey prep, we need to speak up loud and clear. Unfortunately, it may take poor outcomes for us to be heard.

I do feel that AHIMA, a staunch supporter of the EHR, has been caught behind the eight ball on this. HIM professionals are not making the decisions—CEOs and IT programmers are. Where will AHIMA and the HIM profession go from here?

This was a thought-provoking article with a frightening title. For a true HIM data analysis professional, it’s a disturbing reality to consider.

Tammy Lynn Berryhill, MA, RHIA, CTR
Program administrative specialist II, HIM
Williamsburg, Virginia

Dear Editor,

Since the inception of the Inpatient Prospective Payment System, companies have helped get hospitals appropriate reimbursements from Medicare and other diagnosis-related payers. As time progressed, some of them went on to skirt the rules to increase payments, using marginally ethical tactics. That’s bad enough, but when mistakes in the definitions of ICD codes and how to assign these ICD codes lead to increased reimbursement through errors under the control of the federal health care system, that’s inexcusable.

Since 2005, I have been communicating with the National Centers for Health Statistics, AHIMA, the American Hospital Association’s Coding Clinic, and the Centers for Medicare & Medicaid Services (CMS) about these errors. I have provided them with internationally known experts in the field, and I have gone through the red tape and roadblocks with which they presented me over and over again for the past eight years. Some individuals seem to get it, while others throw more obstacles in the way. All it would take is a stroke of the pen to fix these things, and they won’t do it.

Maybe it’s because many of the issues seem to be taken care of in ICD-10. But why should we continue to pay an extra $7 billion per year until then? That’s inexcusable.

This country’s statistics regarding sepsis (both medical and surgical cases), postoperative respiratory complications, acute respiratory distress syndrome, consequences of hypotension, acute renal failure (or acute kidney injury and not acute kidney failure), and birth complications are totally skewed in the world because of our leaders’ lack of resolution to correct errors now. They’ve been wrong since 2004 and even before that, and that’s led to about $63 billion being thrown away for conditions patients don’t have. And with the sequester and the pay cuts physicians are taking, wouldn’t it be nice to have that money in reserve?

I was able to get one significant thing through several years ago: correction of the definition of a code for percutaneous endoscopic gastrojejunostomy, a procedure which had never been performed on a human being in the United States and

Tammy Lynn Berryhill, MA, RHIA, CTR
Program administrative specialist II, HIM
Williamsburg, Virginia
possibly in the world), and advice on how to assign the code, which led to thousands of cases being reported per month. That alone probably saved $1 billion per year. So they can listen.

I have approached physicians in Congress, and they won’t do anything. They feel that the inertia of the CMS is the most severe of all elements of the federal government (I actually doubt that). Leaders in the coding world are either too embarrassed to fix things because they might not look so smart or they have been coerced into thinking we should wait and fix it all with ICD-10 and then we won’t look so bad. You know, if it’s wrong, someone should have the guts to stand up and say so—and fix it now.

Robert S. Gold, MD
CEO, DCBA, Inc

Dear Editor,

I read with interest your Editor’s Note from the April issue of For The Record titled “Transcription in Transition.” I agree with everything you stated with the exception of your last sentence: “Those who are willing to think progressively and acknowledge the shifting landscape stand a much better chance than those still living in the past.”

The only way I can interpret this sentence is that I’m supposed to happily and graciously accept the substantial pay cuts that I have been forced to take over the past three years while employed as a medical transcriptionist. I would like to know who else in the medical field has been forced to take pay cuts like those in the medical transcription field? I’m sure if it were nurses, technicians, other medical information personnel or any other ancillary service in the medical field that they would be screaming long and loud.

Am I considered “living in the past” because I want to be able to make a decent wage for the amount of expertise that I am required to have to be a medical transcriptionist these days? Everyone wants us to be faster, better, smarter, and more technologically savvy, but nobody wants to pay us a decent wage for our services. And now I’m supposed to call myself a “medical language specialist,” which is a very fancy title. For what?

Unfortunately, I don’t see the picture for the medical transcription industry getting any better any time in the near future. The rest of the medical field has basically turned their backs on us. All we want is a little bit of respect, and that respect includes compensating us fairly for the job that we do every day to ensure patient safety.

A CMT in Ohio

Editor’s Note: “Living in the past” was a reference to transcriptionists unwilling to keep pace with changes in the HIM profession. Nevertheless, the reader makes several salient points.
MOBILE TOOLS BOOST CARE
By Maura Keller

As smartphones continue to make inroads within the medical arena, key strides are being made to utilize the technology for patient care in unique and vital ways.

When it comes to chemical dependency, smartphones can be used as a tool for addiction monitoring and treatment. For example, Eagle Advancement Institute in West Bloomfield, Michigan, recently began using Internet and smartphone technology to implement its Clarity Continuing Care program that focuses on both short- and long-term recovery for those addicted to opiates.

“The short-term intervention is built around a detoxification protocol,” says Ricardo Borrego, MD, a board-certified anesthesiologist at Eagle Advancement Institute. “As part of the long-term recovery process, support groups are enabled and made available through secure Web conferencing. Eagle also has a highly secure smartphone app for Apple- or Android-based phone operating systems that allows patients to self-report, access scheduling information for personal or group meetings, and access physicians to update prescriptions or ask other questions relative to their ongoing treatment and recovery.”

The Clarity process is most beneficial to adult patients who are still leading high-functioning lives and may find traditional services impractical because of schedule or geographic constraints, Borrego says. For example, a white-collar executive with an addiction to pain medication may be too busy for an in-person visit. “The Clarity opioid-addiction reversal and recovery program is not structured to monitor drug use,” he says. “Rather, it is a technology-enabled process designed to support patients through the recovery process.”

Unlike replacement therapy-based programs that ultimately transfer an addict from heroin or OxyContin to an alternative substance, such as methadone or buprenorphine, Borrego says the Clarity process helps patients to pursue a drug-free life. “This is done through an initial outpatient procedure to cleanse the body; immediate initiation of extended-release naltrexone therapy, which prevents opioid receptors from being activated even if an opioid-based substance is taken; and highly flexible access to ongoing counseling support enabled by Internet and mobile technologies for a period of one year,” he explains.

According to Borrego, the Clarity process is a next-generation therapy engineered for safety and efficacy throughout the entire spectrum of the recovery process. It has averaged an 80% success rate, which is approximately four times greater than the industry average, he notes. One year after initial treatment, patients are monitored via an independent third party to verify they are living drug free.

Combining the use of Internet and smartphone technology with substance abuse treatment means privacy is a top concern for patients and practitioners alike. “The Clarity aftercare program was designed with successful professionals in mind,” Borrego says. “The Web conferencing and mobile application were both engineered to be highly secure and allow patients to experience their treatment follow up in a discrete and private manner. It is our hope that this type of treatment will provide a new and successful option in an industry where the societal stigma of addiction and low success rate of available therapies has resulted in a large and underserved patient population.”

Physiologic Monitoring

While mobile and Internet technologies are helping patients overcome addiction, they also are making it easier for healthy individuals to keep track of vital physiological data.

Mobile health monitoring devices have become popular among sports and fitness aficionados who wear the gadgets for conditioning and weight management purposes. No doubt swayed by this trend, more physicians have become interested in utilizing similar mobile devices to monitor their patients’ physiological data and provide real-time feedback.

While hospitals and other health care organizations are taking advantage of networking technology to improve the quality of
their services, patients also are benefiting from networking advances, according to Jim Gerrity, director of global industry marketing at Ciena, a network specialist company.

“For example, patients are using smartphones and tablets to take control of their own health care via mobile applications that can monitor blood pressure and glucose levels or heart rate levels during physical activity to help reduce risk of heart attacks, diabetes, and obesity,” he says. “These mobile platforms can be connected wirelessly to physiologic monitors worn on a patient’s body or embedded into a patient’s garment and require only minimal space.”

Mobile monitoring devices are making a splash within the medical community as patients and physicians embrace the idea of “health care on the go.” According to the IMS Research report “World Market for Wearable Technology — a Quantitative Market Assessment 2012,” wearable technology revenues are expected to exceed $6 billion by 2016, with medical and wellness applications at the forefront of the growth.

“With ubiquitous Internet access, patients can communicate and consult with physicians in real time via their mobile device,” Gerrity says. For example, mobile monitoring allows patients to make baseline measurements at any time, resulting in a database of information from which health care providers can detect possible health concerns.

To make mobile physiologic monitoring more appealing, health care providers, technology developers, and patients agree the devices need to be nonintrusive, easy to use, comfortable, energy efficient, and privacy compliant. Gerrity says one of the biggest benefits of mobile health care monitoring is that it can eliminate the laborious long-distance travel that many patients must endure to receive care from specialists.

“With the rising adoption of consumer applications like FaceTime, Google Circles, and Skype, video communications have increasingly become a mainstream consumer activity,” he notes. “When in-person assessments are required, follow-up visits can be accomplished through video interaction via one of the aforementioned applications. In fact, in 2012, 800 million webcams were shipped, doubling the amount in 2011."

There also are economic benefits to using mobile phones to monitor physiologic data. According to economist Robert Litan, remote monitoring technologies could save as much as $197 billion over the next 25 years in the United States. What’s more, real-time management of chronic diseases can help providers keep closer tabs on a patient’s progress, a potential money-saver in the long run.

— Maura Keller is a Minneapolis-based writer and editor.
A Kentucky project is laying the groundwork for more widespread electronic reporting of cancer cases to state registries.

By Susan Chapman
In October 2012, the University of Kentucky launched the country’s first working model for EHR reporting of cancer cases to a state’s cancer registry. The project marks a milestone in the operation of cancer registries, institutions that have been collecting and analyzing cancer-related data for nearly 100 years.

Cancer registries, which exist in every state, typically fall into three categories: those that function within a health care facility, locale-specific registries that gather information across a specified geographic area, and purpose-specific registries that collect data on particular cancer types. Among the information amassed by cancer registries are patient demographics and medical histories, diagnoses, types and stages of cancer, and treatment. Following treatment, they track patients to gather data on cancer recurrence, survival, and death rates.

Once all this information is gathered, it is analyzed, consolidated, and forwarded to state registries. Then states send the findings to the National Program of Cancer Registries at the Centers for Disease Control and Prevention (CDC). Additionally, state registries sponsored by the National Cancer Institute (NCI) send their data to the Surveillance, Epidemiology, and End Results Program (SEER).

The entire process is invaluable. For example, the wealth of data is critical to determining the location of cancer clusters as well as for the development and tracking of the most effective therapies, treatments, and cancer-control interventions. Public health officials also use the data to make decisions on research funding and educational and screening programs.

The new EHR model at the University of Kentucky offers oncologists and other providers in the state, which has the nation’s highest incidence of cancer, the opportunity to provide clinical data for the Kentucky Cancer Registry in real time, enabling epidemiologists to observe trends in cancer statistics more quickly.

“This is an important step toward making cancer-related comparative effectiveness research studies possible in Kentucky,” says Tom Tucker, MPH, PhD, director of the Kentucky Cancer Registry.

Funded as part of the ARRA’s comparative effectiveness research activities at the CDC, the Kentucky EHR project is an important step toward meeting the needs of cancer-control efforts by ensuring that the most current cancer diagnosis and treatment information is available. The project’s principal investigators, Tucker and Eric Durbin, DrPH, MS, the registry’s director of cancer informatics, were awarded a nearly $1 million subcontract over three years to develop the methods and standards for EHRs to report information directly to Kentucky’s cancer registry.

“The Kentucky Cancer Registry, the Kentucky Regional Extension Center, and the Kentucky Health Information Exchange are currently partnering with 43 additional cancer care providers across the state to establish EHR reporting to the registry,” Durbin says. “This project is laying the groundwork for electronic reporting not only in Kentucky but across the United States.”

Broader Benefits

In the past, cancer registries collected vast amounts of data from paper. From these documents, staff would follow up to gather missing information and create a consolidated report. Overall, the process could take more than one year to complete.

“With EHRs, rather than doctors’ offices sending paper, we’re now moving toward a paperless system,” says Edmund Lattime, PhD, deputy director of The Cancer Institute of New Jersey, director of the New Jersey State Cancer Registry, and principal investigator for the NCI-SEER Registry. “Even from smaller practices, which relied much more heavily on paper, we’re receiving more up-to-date information faster.”

When a patient has a biopsy, the findings go to the pathology laboratory, the report is read, and a document is created. Now, by using electronic pathology reports, many state cancer registries are bypassing hospitals and receiving preliminary information directly from these reports. “States are going directly to the pathology labs because of time,” says Dianne Cleveland, RHIA, CTR, a Commission on Cancer-trained consultant and a senior national compliance manager at Kforce Healthcare. “Not all hospitals are Commission on Cancer-approved and must be constantly contacted for information. States contact the hospitals and ask, ‘Why haven’t you reported this information yet?’ Sometimes, it’s timing and sometimes it’s just missed. Additionally, not all hospitals have registries.”

Serious ramifications are a possibility for organizations that don’t follow protocol. “There can be penalties for hospitals that don’t report,” Cleveland says. “It can impact Medicare reimbursement or there can be fines. One state told a hospital it couldn’t receive a certificate of need to construct a new building because the facility was behind in its reporting.”

Increasingly, cancer patients are receiving chemotherapy and other treatments in physician offices and similar ambulatory centers, not in hospitals. By inputting cancer information directly into an EHR in these settings, cancer organizations gain greater insight into the current landscape. “It’s important to receive this data from ambulatory settings,” Durbin says. “As we take information from the EHR, we get a more complete picture of actual treatment. It allows us to collect more complete data on therapy in particular and gives us greater accuracy in evaluating cancer treatment and outcomes.”

The timeliness of EHR information gathering also receives high marks. “Having information in real time improves programs and record completeness,” Lattime says. “Real time
allows the registry to consolidate a record sooner, and the goal is to have as much of this reporting to come in as complete as possible."

A common complaint among cancer registry staff revolves around their ability to handle an overwhelming workload with limited manpower. However, when using an EHR to report data, abstraction can be done more quickly, easing some of the burden on registry staff.

“It’s absolutely helping with staffing,” Lattime says. “It’s very challenging to find certified tumor registrars [CTRs]. It’s a specialized position that requires an undergraduate degree along with many hours of training. Candidates must also pass a national examination. The pool is very limited, and we’re currently experiencing a shortage of CTRs. Therefore, the more we can do electronically, the better.”

Challenges

For real-time data delivery to cancer registries to be successful, organizations must employ a certified EHR that can export the standard electronic message structure, Durbin says. Currently, because of variations in EHR software, not all vendors support the process.

New Project to Develop Big Data Cancer Database

The American Society of Clinical Oncology (ASCO) has announced that it has completed a prototype of CancerLinQ, an HIT initiative to achieve higher-quality, higher-value cancer care with better outcomes for patients. The prototype demonstrates the feasibility of an HIT-based learning health system, which the Institute of Medicine (IOM) has defined as critical to the future of the nation’s health care system.

The ASCO is developing a knowledge-generating computer network that will collect and analyze cancer care data from millions of patient visits with expert guidelines and other evidence to generate real-time, personalized guidance and quality feedback for physicians.

“Today we know very little about the experiences of most people with cancer because their information is locked away in unconnected servers and paper files,” says ASCO President Sandra M. Swain, MD. “Only the 3% of patients who participate in clinical trials are able to contribute to advances in treatment. CancerLinQ will transform cancer care by unlocking that wealth of information and enabling every patient to be a cancer knowledge donor.”

CancerLinQ realizes the vision of a learning health system as described in a landmark 2012 IOM series of reports. In the IOM’s vision, “Science, informatics, incentives, and culture are aligned for continuous improvement and innovation—with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience.”

The ASCO built the CancerLinQ prototype to demonstrate the feasibility of such a system and provide lessons about the technological and logistical challenges involved in full-scale implementation. The prototype includes de-identified data from 100,000 patients with breast cancer who were treated at leading cancer care institutions in the United States. It reflects more than one year of formative work, including consultation with the oncology and IT communities; efforts to improve oncology data standards; and extensive technology and legal analysis.

To build the prototype quickly, the ASCO linked together several open-source IT applications, encompassing CancerLinQ’s planned core functions, including the following:

- **Real-time data collection:** The prototype can successfully accept any cancer care data in any standard directly from EHRs and other sources, overcoming the longstanding hurdle posed by inconsistent health data standards. Data can range from genomic profiles to lab tests and even physicians’ notes.

- **Clinical decision support:** The prototype can generate individualized guidance on the care of any given patient with breast cancer based on automated, machine-readable versions of the ASCO’s expert breast cancer guidelines. The full CancerLinQ system, when implemented, also will provide guidance based on the collective experiences of other similar patients.

- **Data mining and visualization:** The prototype allows exploration of an extensive database of information on the care of patients with breast cancer, including patient characteristics, treatments, and outcomes, to identify real-world trends and associations and new research hypotheses.

- **Quality feedback:** The prototype can provide immediate feedback on physicians’ performance against 10 quality measures from the ASCO’s Quality Oncology Practice Initiative.

The prototype ultimately will include data on more than 133,000 cases from oncology practices across the country, far exceeding initial expectations and lending further strength to the lessons that can be drawn from the prototype.

— SOURCE: AMERICAN SOCIETY OF CLINICAL ONCOLOGY
Elizabeth Ward, PhD, an epidemiologist and the national vice president for intramural research for the American Cancer Society who works with cancer registries, says the lack of uniformity among different types of EHR software can cause problems, including having some fields coded systematically while others are just text. This makes it challenging to harvest the pertinent information. “Data are not always recorded in such a way that they are able to be extracted,” she says. “And with less standardization, there is more text mining that needs to be done. This can be time consuming.”

While gathering the necessary information can be challenging, Ward says there is hope that as EHRs become better equipped to exchange information with disparate systems, the process will become more efficient.

**Security**

Some patient privacy advocates are concerned that using EHRs to report cancer data will raise the prospect of patient information being exposed to unauthorized personnel. However, registry experts believe proper precautions and safeguards have been implemented. Throughout the process, patient information is kept confidential per HIPAA requirements, with no identifiers used in analysis or publication.

“Cancer is a reportable disease,” Durbin says. “We’re required by law to protect patient confidentiality, yet we have to receive the information. Safe transmittal—an encrypted connection from the EHR to the cancer registry database—ensures that information cannot be read by a third party.”

As long as registries are reporting required data elements, there is no HIPAA violation, according to Cleveland, who adds that states receive all data, including patient information, cancer details, extent of the disease, treatments, and outcomes, and consolidate them into a succinct summary.

Lattime says patient confidentiality is a top priority at cancer registries. “Registries don’t provide protected health information [to unauthorized entities],” he says. “Electronics have the potential of making the data more secure in that there is less use of paper documents and thus, in addition to accuracy, the potential of increased confidentiality.”

Ward believes most registries have taken privacy concerns to heart. “The registries are sensitive [to the issue] and there are safeguards built in,” she says. “Registries have specific authorization to collect and use data. Of course, there’s always a risk of breaching confidentiality. However, we will become more sophisticated as more and more physicians use an EHR.”

**The Road Ahead**

Lattime hails the University of Kentucky team as a national leader in electronic cancer reporting, while Ward believes its work is an important step forward that needs to be built on. “It’s really important that we continue to fund and support this methodology for cancer registries for two reasons,” she says. “We want to continue to accurately capture data from physicians’ offices, and we also want to gather information on all treatment. The latter is especially important to obtain because it will increase the value of the information. Right now, treatment data are especially hard to capture. However, as this changes, everyone benefits.”

Other states have noticed the Kentucky program’s success and followed in its steps. For example, Missouri has undertaken an expansive project to identify nonhospital sources, such as physician offices, which can use EHRs to report cancer data. The idea is that cancer cases diagnosed and treated in ambulatory settings are underreported and require greater cooperation from smaller facilities to gather data effectively.

It’s also important to note that stage 2 of meaningful use calls for physician EHR reporting to cancer registries for comparative effectiveness research. In that regard, much work still needs to be done, Durbin says. “We’re working to overcome all the challenges we’ve identified and while we’re still not yet at the point of receiving all information in real time, we’re working closely with providers and EHR vendors to improve the process,” he notes.

— Susan Chapman is a Los Angeles-based writer and author.
Dual Coding

An IC

By adopting this strategy, health care organizations can accelerate the transition process.
There has been a palpable shift in the conversation surrounding the transition to ICD-10. No longer is it focused on whether the Centers for Medicare & Medicaid Services (CMS) will extend the deadline yet again (it won’t). Instead, it centers on just how soon organizations should start coding in ICD-10 to minimize operational and financial impacts once the October 1, 2014, deadline hits.

For early adopters, the opportunity to code in a dual ICD-9/ICD-10 environment can generate benefits that outweigh negatives such as productivity declines and revenue cycle slowdowns. “There is a cost factor [to dual coding]. You have to have the ability to capture the ICD-10 codes in your system, and doing it earlier in the process means incurring those costs earlier,” says Chris Armstrong, a principal with Deloitte Consulting. “But there are also risks [to not dual coding]. If you haven’t had the practice, if you don’t do the claims testing, you face some pretty big risks on October 1, 2014.”

Mitigating the Impact
Coding in a dual environment allows organizations to test clinical documentation to identify weak areas “so you don’t have to start with a ‘big bang’ situation,” Armstrong says. “There is also the advantage of having a larger set of data that enables you to test ICD-10 claims data in your system.”

Dual coding also enables financial modeling. For example, coding a subset of claims in ICD-10 sets the stage for closer collaboration with payers through claims testing to determine how certain diagnosis-related groups (DRGs) might be weighted differently, how the new codes will affect reimbursement levels, and what edits may be required. This yields insights into the impact on net revenue or where additional or more comprehensive documentation will be required.

“It’s been pretty illuminating for both sectors to see what these cases really look like when they’re coded in ICD-10 from a DRG perspective,” Armstrong says. “Another form of financial modeling is when organizations cross-map data and performance to [create] early scenarios for a better idea of what the net revenue impact will be for [certain] claims when they build in assumptions. Those doing early adoption will have better outcomes they can look at before and after.”

More accurate predictions of the impact on productivity, staffing, and documentation improvement needs and training requirements are another bonus for organizations that opt to code in a dual environment in advance of the transition deadline.

Productivity under ICD-10 is expected to decline by anywhere from 30% to 60% and, based on Canada’s experiences with the transition, never fully recover. As such, knowing in advance how hard the hit will be helps organizations make informed decisions on how best to mitigate the damage.

“Plus, if you have coders doing dual coding, you have that education, that familiarity, so when you get to October 1 and have to flip that switch, it’s not as big of a deal as far as the learning curve. It has already happened,” says Karen M. Karban, RHIT, CCS, director of coding integrity for HIM ON CALL, which provides HIM and coding services to hospitals.

Dual coding also helps evaluate vendor readiness and support. Karban notes that while most encoder systems can code in both ICD-9 and ICD-10, the mechanics and processes for doing so may need refinement to ensure the transition goes as smoothly as possible. “That is the first thing hospitals need to do: define what they hope to accomplish with dual coding, such as abstracting, data capture, and time studies, and what vendors can do to support those,” she says, adding that the final impact “very likely depends on how well tuned the data systems are and what bells and whistles can be put in.”

Vendor readiness also extends to payers. Not all payers are expected to be ready to accept ICD-10 codes by the deadline. Organizations that have established a dual coding environment “can adapt to changing timelines and readiness situations within their trading partner environment,” says Deepak Sadagonpan, general manager of provider segments and clinical solutions for Edifecs. “Dual coding also allows a provider to be ready for ICD-10 earlier and creates an opportunity for greater rigor in the testing and validation before the deadline arrives. Their coders will get hands-on experience by applying their ICD-10 training in a production environment well in advance of the deadline, which means the transition will be a lot smoother.”

Two organizations that are making the leap to dual coding are Vanderbilt University Medical Center in Nashville, Tennessee, and the University of Utah Hospitals and Clinics. In both cases, the goal is to get coders up to speed and ensure the proper systems and processes are in place to lessen the blow on revenues and productivity.
ARE YOU READY FOR DUAL CODING?

At some point, every health care organization will need to code in both ICD-9 and ICD-10 for claims testing. How early they begin that process and how much they benefit depends on their individual organizational readiness.

Andy Sager, product marketing manager for the 3M Coding & Reimbursement System, notes that one of the first evaluation points is whether an organization’s upstream and downstream systems are ready to support ICD-10. “Start with an evaluation of your HIM applications,” he says. “Are they ICD-10 ready? Have your vendors communicated release timelines? Vendor readiness will influence when dual coding can be initiated.”

That evaluation also should extend to workflow analysis, which will determine whether double coding (coding first in ICD-9 and then recoding in ICD-10) or dual coding is the best approach. This determination relies heavily on the application that calls for the codes and the level of ICD-10 training for coders. “Determining when and how to implement a dual coding approach depends on many factors,” Sager says. “Coder education, vendor readiness, physician documentation, and the overall ICD-10 rollout plans of your facility should all be considered when making the decision to dual code.”

Deepak Sadagopan, general manager of provider segments and clinical solutions for Edifice, says not every scenario should be dual coded, a process that can be labor intensive and cost prohibitive. Instead, hospitals should identify the scenarios and variables for dual coding based on the following criteria:

- level of complexity in transitioning from ICD-9 to ICD-10;
- level of financial risk or reimbursement impact; and
- level of complexity in the ICD-10 codes.

To evaluate readiness, Sadagopan suggests first conducting a documentation audit to determine whether sufficient specificity exists to support ICD-10. Then evaluate impacted systems to ensure they can handle the new code set. Finally, “Ensure an optimal resource mix by using computer-assisted coding to automate the simpler scenarios and leveraging coders well trained in ICD-10 to manage more complex scenarios.”

To determine which diagnosis-related groups (DRGs) are most appropriate to target in a dual coding environment, Karen M. Karban, RHT, CCS, HIM ON CALL coding integrity director, recommends several approaches. One is a baseline review of 100 records to determine where the documentation is in terms of readiness. Alternatively, identify the top 25 DRGs and drill down on the complexity of cases to create a DRG review list.

Whatever you do, she warns, “Don’t put it off. Every hospital is unique. ... It’s really on a case-by-case basis and all over the board, so I really hesitate to put forth an ‘expert’ opinion on how best to do it ... but ‘don’t wait’ is a really good theme.”

— ESR

Vanderbilt University Medical Center

Vanderbilt won’t go live in a dual coding environment until January 2014. However, planning has been under way since late 2011 when an early-adoptions committee was assembled with representatives from HIM, finance, informatics, administration, and managed care contracting.

“We wanted to make sure our coders were proficient in ICD-10 before the go-live date and to ensure the documentation was ready and the specificity needed was there,” says Jennifer Causey, MSHA, MBA, RHIA, administrative director of Vanderbilt’s ICD-10 transition. “We also wanted to make sure our systems were ready. We didn’t want to do a big bang. Right now, we have 72 applications with ICD-9 codes, so we can’t just flip the switch on October 1.”

In addition to integrated testing and phase-in of ICD-10, Vanderbilt is conducting a reimbursement analysis to identify high-impact areas in the hopes that it will provide a framework for provider education. The health system also is currently implementing 360 Encompass from 3M, which enables it to track documentation gaps, a previously labor-intensive process.

“In the past, all of our query information was stored in e-mails and hard to analyze. ... We are looking forward to having tools that will allow us to say we lack ICD-10 specificity in documentation,” says Theresa Zuckowsky, CBCCP, MMHC, Vanderbilt’s IT program director for ICD-10. “This will drive education down to the physician level.”

Coders will phase in ICD-10, beginning with cardiology. Coding will be done in ICD-10 where appropriate and then mapped back to ICD-9 prior to the compliance date. Mappings deemed to be high risk will be extracted and audited or natively coded to mitigate risk.

Vanderbilt also is in the process of implementing computer-assisted coding (CAC), which Causey says should help limit the expected drop in productivity. However, the health system has budgeted for additional coders if necessary to deal with any backlog. In addition, it is working closely with its various system vendors to ensure everyone is ICD-10 compliant prior to the transition date.

“We have a solid plan, and we’re progressing. We have really good relationships with our vendors, and that is paying off now,” Zuckowsky says, noting that success also rests on how well the transition team communicates with every staff member affected by the transition. “We’ve tried to create an environment where people want to communicate with us because ICD codes are everywhere. ... We can’t be everywhere, so we have to rely on people feeling comfortable to help us and look under every rock to find every code.”

For example, the emergency department white-board system contained ICD codes. By working with the clinical leadership to review processes and systems, it was possible to eliminate the codes from that particular system.
“You’ve got informatics and then you’ve got the business side, so this has been a really good opportunity to cross-pollinate the two. Show informatics how change impacts business, and business gets to see what it takes from an informatics perspective to get the job done,” Causey says. “We’re using the ICD-10 transition to improve processes. Even if it’s delayed again, we’re getting value from the work that’s being done now.”

University of Utah Hospitals and Clinics

University of Utah Hospitals was inspired to launch dual coding because of numerous key influences, particularly the need to differentiate between coding skill and system issues. This was particularly crucial because the academic health system is also undertaking an enterprisewide Epic conversion.

“We needed to make sure that we could separate out issues related to coding and coding skills from the issues around new systems that we have coming on just before the implementation, and the potential for all the remediation and all things coming together at the implementation date. We didn’t want to overlap technical and coder skills,” says Connie Tohara, RHIT, director of health information. “We’ve got to do all these things with physicians so we’re not competing on October 1 for their attention.”

By implementing dual coding well in advance of the mandated transition date, the organization hopes to get a better read on ICD-10’s impact on cash flow and reimbursement levels. Having data coded in both ICD-9 and ICD-10 enables true apples-to-apples comparisons.

The data warehouse pushed to start dual coding to enable remediation of data and to ensure the structures and data mapping were complete so reports could be built and ready for use on the go-live date. “My concern was productivity,” says Michelle Knuckles, RHIT, manager of inpatient coding and clinical documentation improvement. “Education is imperative, so we are fully up to speed with ICD-10 to maintain an acceptable level of productivity and to produce accurate codes. One issue that we have to deal with is the lack of documentation to support full codes in ICD-10, so we’re working on how to manage that. It is easier to walk through one coding pathway to get to both codes than it is to code in ICD-9 and then again in ICD-10.”

Clinical documentation improvement and physician education also are key. How do physicians get up to speed on the documentation needs for ICD-10 when they already have so little time to devote to learning? “We don’t want them to be coders, but the documentation they give us makes all the difference in the world,” Tohara says. “Part of the dual coding process is getting our people coding early enough so that they can be talking to the physicians.”

To help with the process, the health system leaned on 3M for its 360 Encompass, CAC, and clinical documentation improvement systems. “We are counting on the CAC productivity enhancement to allow us to stay on top of ICD-10. It’s the only way to manage a year’s worth of dual coding without adding a bunch of staff,” Knuckles says. “If we can’t enhance productivity, we’re in trouble. We’ve been worried about that since the beginning because we can’t lose half our productivity.”

The technology alleviated another challenge to dual coding: where to actually store the codes. Under the implementation plan, the new Epic system won’t be ready to accept ICD-10 codes until May 2014, which leaves little time for data collection and testing, much less training and documentation improvement activities. “It was tough for us to know that although we saw the value of dual coding, we were maybe not going to have anywhere to put it,” Tohara says.

The health system also brought in a data analyst to ensure that the reports needed to fully analyze the impact of the ICD-10 transition are properly created and available in a timely manner. “With data becoming as important as it is, it just all fits together. There are a lot of reasons why we wanted to go in this direction and dual coding is just a piece of it,” Tohara says.

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Identifying harmful copy-and-paste documentation can help curb serious coding errors.

By Lisa A. Eramo
Like any good story, a medical record should be consistent and relatively easy for the reader to follow, presenting events in a logical sequence. However, as physicians begin to document in the EHR, the patient’s story—the crucial element necessary for coding—can become jumbled and sometimes even unreadable. Coders may begin to see non-sequential dates on progress notes, repetitive documentation that includes no new information, diagnoses that don’t correspond with treatments, or even inconsistent demographic information such as the patient’s name.

The culprit? Experts say EHR functionality that allows clinicians to copy and paste documentation within a record or from one record to another likely is to blame. This practice, sometimes referred to as cloned documentation, creates a host of problems for coders trying to ensure coding accuracy and data integrity.

“You lose the patient’s story in these notes that replicate what has been previously documented,” says Cassi Birnbaum, MS, RHIA, FAHIMA, CPHQ, vice president of HIM at Peak Health Solutions. “It’s hard to tell the old from the new and the relevant from the irrelevant. It becomes completely unreadable.”

Experts say the problem is growing, and it may spiral out of control if hospitals don’t develop policies to address it and/or work with their EHR vendor on potential solutions.

The Office of Inspector General (OIG) is aware of how an EHR may contribute to fraud and abuse, including inaccurate coding. In its work plan for fiscal year 2013, the OIG stated it will look at fraud vulnerability presented by EHRs “as articulated in literature and by experts to determine how certified EHR systems address these vulnerabilities.” Experts say copy-and-paste documentation likely is on its list of targets.

**Coding Dilemmas Abound**

When clinicians copy and paste information, it potentially can wreak havoc on coding compliance. “If coders are reading information that’s copied and pasted, they may be looking at incorrect or inappropriate documentation that they’re then using to assign codes,” says Ann Barta, MSA, RHIA, director of HIM solutions at AHIMA.

For example, a physician may copy and paste a condition from a previous encounter that a patient no longer has or that isn’t even relevant to the current hospital stay. In the inpatient setting, this frequently occurs with patients who have longer lengths of stay or those who are admitted frequently because of chronic illnesses, Barta says.

Copy-and-paste documentation doesn’t affect only coding compliance; it also can negatively impact productivity—no coder wants to contend with that, particularly as the industry moves toward ICD-10. “It affects coders because they need to read through a lot of extraneous information,” Birnbaum says. “They might miss [diagnoses] that are really pertinent to the stay and that support treatment or make a difference from a CC [complication/comorbidity] and MCC [major CC] standpoint.”

The surge in EHR implementations has exacerbated problems with copy and paste, according to Birnbaum, who says the situation is primarily a “by-product of a poorly designed EHR” that encourages clinicians to take shortcuts that ultimately could put the facility and themselves at risk. For example, Birnbaum recently consulted at a provider site where the EHR automatically created a progress note based on the previous date and autopopulated it with previous information. It’s far too easy for clinicians to save the note and move on rather than take the time to validate the information’s accuracy, she says.

Ironically, many clinicians are equally as frustrated by copy-and-paste documentation, says Jon Elion, MD, founder and CEO of ChartWise Medical Systems, who says he experienced that frustration firsthand when a coder recently queried him regarding the location of a patient’s heart attack. He had clearly documented an anterolateral myocardial infarction (MI), but when browsing through the chart, he realized that a physician assistant had indicated a posterior MI.

“Every other progress note in the chart propagated the fact that it was a posterior MI,” Elion says. “My note was correct, but everyone else had copied and pasted this erroneous note.”

Physicians themselves should be concerned with copy-and-paste documentation not only because it affects clinical care but also because it can affect proper evaluation/management (E/M) code assignment, says Jacqueline Thelian, CPC, CPC-I, CEO of Medco Consultants, who notes that physicians frequently copy and paste the review of systems and exam portions of a visit without thinking about whether it might raise a red flag for an auditor. “When we code it out, usually the history and physical meet higher criteria but the medical decision making doesn’t,” she says. “Clients will ask us to downcode based on the medical decision making, which is the right thing to do.”

In its work plan, the OIG said it will monitor potentially inappropriate E/M payments because “Medicare contractors have noted an increased frequency of medical records with identical documentation across services.” This identical documentation doesn’t meet medical necessity criteria, Thelian says.

First Coast Service Options, the current Medicare administrative contractor for Puerto Rico, the US Virgin Islands, and Florida, published information about cloned documentation and
medical necessity in 2006, and many other contractors have followed suit since. In its Medicare A Bulletin for the third quarter of 2006, First Coast noted the following:

Cloned documentation does not meet medical necessity requirements for coverage of services rendered due to lack of specific, individual information ... Providers frequently ‘over document’ and consistently select and bill for higher-level E/M codes than medically reasonable and necessary. Word processing software, the electronic medical record, and formatted note systems facilitate the ‘carry over’ and repetitive ‘fill in’ of stored information. Even if a ‘complete’ note is generated, only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate level of an E/M service. Information that has no pertinence to the patient’s situation at that specific time cannot be counted.

When providing physician education, Thelian focuses on medical necessity and accuracy. “I tell them, ‘Write your note the way you would have to defend it at an ALJ [administrative law judge] hearing,’” she says.

Thelian recalls attending an ALJ hearing that featured a patient record with 10 pages of current medications. Two of the medications listed had a deadly interaction, suggesting that the provider had simply copied and pasted information without taking the time to verify or update it.

Accuracy is essential, Elion says. “I want physicians to verify information themselves,” he says. “I want the patient to be asked questions two or three times even though they may find it annoying. I don’t want errors to get propagated and promulgated through the chart.”

Attacking the Problem

Documentation and coding always should reflect a patient’s current circumstances, says Claudia Tessier, RHIA, MEd, a Boston-based HIM/HIT consultant. “If data being copied and pasted appear to be current, then it’s misleading to the next physician, and it’s misleading to the coder,” she says. “It creates a medical record that’s, in a sense, fabricated.”

Perhaps the most egregious example of inappropriate copying and pasting is when a clinician mistakenly copies information from one patient chart into another. “It’s really about patient care and the accuracy of the data on which you base patient care,” Tessier says. “It’s a clinical issue that impacts coders.”

Experts agree that errors involving information from another patient’s chart are difficult to spot because coders may not even be aware that the information is inaccurate. It’s also extremely difficult to monitor and control copy-and-paste documentation simply because of the sheer number of clinicians who may document in the EHR, Tessier says. However, she suggests coders ask the following questions when reviewing documentation for coding:

- Is it current?
- Is it relevant to the encounter?
- Does it relate to the current admission?
- As for indications that information has been copied and pasted, coders should be alert to the following clues:
  - incorrect patient name and/or sex (eg, the physician documents that the patient is female, but the review of systems repeatedly uses the pronoun “he”);
  - incorrect or nonsequential dates, particularly when those dates fall outside the parameters of the particular hospital stay or encounter;
  - a comprehensive history for a patient who presents regularly or was seen recently; and
  - the review of systems doesn’t match the presenting problem. For example, a patient presents because of joint pain and swelling, but the musculoskeletal review of systems is negative, and the patient denies joint pain and swelling. “It’s cut and pasted,” Thelian says. “You get conflicting information within the note itself.”

She notes that coders in a physician practice setting may want to consider accessing the audit trail when coding. “We’ve always been detectives, and we question the integrity of the data,” she says. “We do this because we want to make sure that our providers are compliant and that they’ll be able to keep the money that they’re paid.”

However, reviewing the audit trail may not always be practical or even possible in the facility setting. “If you think about a typical inpatient chart where five or six providers are documenting and the stay is three or four days, it would probably more than double the amount of time it would take the [inpatient] coder to code,” Barta says.

As with any inconsistent documentation, coders must query for clarification. However, in a suspected copy-and-paste situation, it’s best to step gingerly. “You wouldn’t want to come out and accuse a provider of copying and pasting,” Barta says. “You’d have to word it clinically and ask the question for clarification.”

Finding a Fix

Many hospitals are starting to draft policies on proper use of copy-and-paste documentation, Barta says. “Copy and paste is getting a lot of publicity, and most of the time it’s not positive,” she says. “I think it’s more on the radar screen now than it has ever been.”

Such a policy should include input from HIM, HIT, the C-suite, medical staff, quality assurance, risk management, and coders, Tessier says. Essential policy elements include the following:

- a definition of what constitutes copy-and-paste documentation (eg, a reproduction of a substantial portion of text from somewhere else in the chart);
- an explanation of how copy-and-paste documentation will be identified. Will the EHR automatically identify it or must
clinicians use a citation or preface documentation, such as “As stated in Dr Smith’s note on March 30”?

• a list of what information can be copied and pasted. Physicians should be able to copy and paste abnormal lab values into a progress note or another document, Birnbaum says. Also consider X-ray and pathology reports, Elion says. If physicians can copy and paste an X-ray report into their progress notes and then comment on that report, coders can immediately code from that information. Otherwise, they can’t code directly from the report, he notes. The same is true for a pathology report after a biopsy. Instead of documenting “The pathology report confirms cancer,” the physician can copy and paste the specific findings and details—all of which are relevant for coding.

• a list of what information cannot be copied and pasted (eg, substantial portions of a physical exam).

• protocol for how coders, clinicians, and others should address potential copy-and-paste documentation. Tessier says coders may need to notify a supervisor or clinical documentation improvement specialist. “Coders should be part of the solution and team to deal with and diminish copy-and-paste documentation,” she says. “Their role beyond that will need to be determined by the institution.”

Peer (ie, physician-to-physician) pressure may be one way to address the problem. As with coders, physicians must search among pages of irrelevant information to find pertinent details for clinical care. Birnbaum says it may be effective for physicians themselves to raise awareness and provide feedback to one another about how copy-and-paste documentation can affect—and potentially delay—important clinical decisions.

EHR vendors also need to play a larger role in compliance, according to Birnbaum. For example, when documenting progress notes, clinicians should be able to hyperlink back to original information in the EHR rather than copy and paste that information into a new document. EHRs also should be able to automatically populate the discharge summary with pertinent diagnoses, treatments, and procedures but require physicians to summarize the postdischarge plan and any medications. “It really obviates the need for copy and paste,” Birnbaum says. “It also provides a carrot to the physician because he or she only needs to focus on the new documentation.”

Elion agrees, stating that EHRs should be able to clearly identify information that has been copied as well as the source (attribution) of that information. If EHRs had this functionality, clinicians would be more accountable because others would be able to easily detect any shortcuts they take, he notes.

According to Tessier, some organizations are incorporating plagiarism software into their HIT systems to identify documentation that has been copied and pasted. However, Elion says this approach is backward thinking. “Computer systems should always assist you in doing the right thing up front and not catch you doing the wrong thing,” he says. “Guide me how to correctly write a progress note using copy and paste. Don’t go back afterward and try to detect my use of it.”

Tessier recommends asking an EHR vendor the following questions:

• Does the system allow physicians to copy and paste? If so, how does the system identify that information? For example, is the text highlighted?

• Can physicians attribute copied information to the original author? If so, how?

• Is there an option to completely disable the copy-and-paste function? If not, how does the system facilitate audits? Is there an audit trail that can be monitored regularly?

Looking Ahead

Once ICD-10 goes live, hospitals must pay even closer attention to the perils of copy-and-paste documentation. Tessier says coders will be more dependent on procedure-specific details, increasing the possibility of significant errors and closer scrutiny. “With ICD-10, documentation will be increasingly important and increasingly referred to,” she says. “It’s going to be looked at more and more by payers and auditors.”

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By Susan Chapman
Hurricane Sandy, which wreaked havoc in New Jersey and New York this past October, was a perfect example of why hospitals need to be prepared for what Mother Nature can bring. In addition to major weather events, there also are instances, albeit less far reaching, when data need to be recovered because of a system malfunction. Regardless of their source, disasters happen and hospitals need to ensure uninterrupted service and business continuity to continue to meet patients’ needs.

**Moving From Disaster Recovery to Business Continuity**

“I think it’s important to be clear on semantics when we talk about disasters and disaster recovery,” says Rob Drewniak, vice president of strategic and advisory services at Hayes Management Consulting. “For instance, a disaster recovery plan primarily deals with recovery of information technology and services following a disruption. Then there is a business resumption plan, which typically describes how operations will resume after such an event. Both types of plans imply a reactive response to an outage in critical operations or services.”

Recently, more health care organizations have taken steps to create a business continuity plan (BCP), he says. “This is especially important in the health care environment where, as in the case of Hurricane Sandy, outage time turned out to be significant, and it would not have been enough to just resume services,” Drewniak explains. “Those services have to be provided continuously, so the focus has shifted to sustaining delivery of those services.”

He adds that organizations can minimize the risks associated with outages, downtime, and data loss by developing and implementing a solid, comprehensive BCP designed to maintain patient care and operational stability.

To safeguard business continuity, how each component of the plan is governed and structured must be clearly understood and agreed upon within the organization from the leadership down. Likewise, goals and objectives must be defined. BCPs must be patient centered, with solid lines of communication, a well-prepared staff, and a well-conceived strategy to mitigate disruption.

**Be Thorough**

To create a comprehensive BCP, Drewniak says hospitals must conduct a business-impact analysis to identify and distinguish between critical and noncritical operational functions and processes. For example, in health care, functions related to patient safety would be considered critical.

“To create this type of plan, you have to do a number of things,” he explains. “For instance, the organization must do a threat analysis and look at all potential threats to the facility’s ongoing operation: fire, earthquake, cyberattack, and weather events. Then the planning team has to make recommendations as to how the hospital will recover from each threat. From that information, the team has to do a dependency analysis; What are the internal and external dependencies of critical services? How do they fit together?”

Brian McCrory, a solutions architect at SunGard Availability Services, seconds the notion that hospitals must be certain they understand the interdependence of applications, processes, and departmental recovery. For example, take a patient visit to the emergency department (ED), where clinical applications are tied to common departmental processes. “When a patient goes into the ED, the attendant takes that individual’s information,” he says. “That process is based on previously offered information if that individual has been seen there in the past, which is likely in the case of a neighborhood hospital. The entire process depends on another process in the system, and those interdependencies must continue to work seamlessly.”

McCrory says it’s essential when planning to take into account every component that could be affected in a disaster to make sure operations are in place and can continue. To that end, he recommends the BCP include a site-event management strategy that’s tailored to a facility’s specific needs. “The site-event management plan documents how you deal with the BCP at a very specific location,” he says. “If it’s a cardiac or brain facility, for example, the plan will be different than if it’s a trauma unit.”

It’s a challenge for health facilities to find reasonably priced resources that will keep operations up and running should a crisis occur. “What a hospital can afford is something every executive has his or her eye on,” Drewniak says.

Besides taking into account the facility’s resources when formulating a plan, the BCP team also needs to ensure that staff members are well prepared and determine who needs to be on site. “Not everyone needs to be at the hospital,” Drewniak says. “Those who do need to be there have to understand the plan and know their respective roles.”

McCrory notes it’s important to be sensitive to facilities’ limited resources and conduct interviews with department heads to ascertain their needs and resources. “We want to know what will happen to your hospital in the event of a disaster,” he says. “Business continuity is about mitigating risk. To build a plan, we examine the functions, determine what can be restored, how much time the process will take, and how much enacting the plan will cost.”

**Business Continuity and IT**

Health care organizations that fail to back up IT systems are playing with fire, says David Whittinger, executive director of the New York eHealth Collaborative. “It’s very important that IT be backed up. In the event of a disaster, whether it’s something as catastrophic as Sandy or a simple power outage, technology can’t be down long,” he says. “Lengthy service interruptions can be mitigated or avoided altogether by using backup centers that are located across the country. When
planning for IT recovery, planners must take into account the system’s size and scope, and focus on restoring those computer systems that safeguard patients and health records.”

According to Whitlinger, numerous hospitals have their own data centers, which offer some level of redundancy. “There are tape backups and, for more mature facilities, ‘hot’ backups, an exact replica of the data on a second set of hard disks that is located physically in a different secure data center but fully accessible via the network,” he says. “However, Hurricane Sandy ripped the whole northeastern seaboard, which posed problems for those facilities that had technological redundancies geographically nearby.”

Whitlinger says the best BCPs allow users to transition seamlessly to the backup system and continue working without ever realizing there was a problem. “But how hospitals address continuity of service depends on how much their levels of service matter to them, how much redundancy depends on this level of service, and also on how affluent the organization is,” he says.

In general, health care facilities want to ensure that service is never interrupted. To this end, they can use automated backup. “Most hospitals rent locations to back up and provide a secondary data service center,” Whitlinger says. “Smaller organizations spend more money on backup generators rather than on off-site locations to ensure redundancy.”

Considering that a protracted loss of power affected a wide area during Hurricane Sandy, New York-based hospitals were fortunate. One reason the situation didn’t worsen was the presence of a statewide health information network. “In New York, there is a statewide network which contains patient records. This provides New York with an advantage of having patient records backed up in the state network,” Whitlinger says. “What hospitals didn’t anticipate in the wake of Hurricane Sandy is that they would be without power for weeks. Thank goodness we had the state network to rely on.”

Because most facilities in other parts of the country may not have such a network at their disposal, Drewniak says hospitals must ask if they “have backup for our backup? And then, do we have backup for that?”

When structuring the IT component of a BCP, McCrory says facilities should examine several aspects. “Hospitals should analyze the crisis management component, a plan that fits the day-to-day operations of the organization,” he says. “They also need a comprehensive technology recovery plan that matches organization needs and resources. Finally, the IT team needs to know how it can recover critical applications and how those applications dovetail with others in the facility.”

Whitlinger points out that because technology changes rapidly, hospitals must test their plans to be sure they are current. “Hospitals must keep information for seven years. When they back up to tapes, they have to remember to have the technology available to read those tapes. So as technology moves forward, facilities need to be mindful of access. Even though we have information, we must be able to access it,” he says.

Testing the Plan

Because technology and other aspects of health care environments evolve, testing a BCP is crucial. “Events such as tornadoes and earthquakes, we don’t know when they’ll happen, so we need to know if the procedures in all areas of the hospital have been tested,” Drewniak says. “Were there tabletop [discussion-only] tests of complete drills? Major department heads should go through tabletop tests quarterly. If you wait or don’t test enough, then you don’t know if the plan is still current or valid when disaster strikes.”

While tabletop read-throughs are effective, Drewniak believes there also needs to be live drills. “These drills have to involve some movement,” he notes. “For example, can people get from the top floor to the bottom if the elevators are out?”

Illustrating the value of such drills, McCrory cites an image from Hurricane Sandy in which a nurse is carrying an infant down the stairs to safety in the midst of the storm. “Was that quick thinking on the staff’s part or the result of a well-tested formal process to preserve life?” he asks.

The frequency of testing is based on several factors, including regulatory requirements, the strategic thinking of hospital decision makers, and the facility’s best-practice policies. Experts agree that if plans aren’t tested, there is a greater likelihood of major problems occurring should an emergency arise.

Drewniak points out that when hospitals have time to prepare—as was the case with Hurricane Sandy—they must take advantage of the situation to perform time-sensitive functions such as transporting patients. Well in advance of any crisis, hospitals have the ability to identify vacant spaces, other hospitals, or alternate facilities that can house patients in the event of an emergency. “There are vacant buildings available,” Drewniak says. “For instance, there are cities where military bases are closed. You can also identify certain other hospitals that have capacity and can take patients. Not everyone is critical so those patients who aren’t in danger can be moved to facilities such as schools.”

Success in a Crisis

Because disaster, whether predictable or unexpected, can never be ruled out, experts encourage all hospitals to have a proven, comprehensive BCP in place.

“In the event of a disaster, businesses can rise and fall on what they do,” McCrory says. “Having a plan that’s well tested, current, and ensures uninterrupted service is critical to patients’ health and well-being, and a hospital’s ongoing success.”

— Susan Chapman is a Los Angeles-based writer and author.
STEM OVERFLOW BY INCREASING EFFICIENCY

By David Yeager

Despite a transcription manager’s best efforts, overflow happens. Managing it can be a challenge, but with some judicious planning, stress levels can be reduced. The first step is to recognize why overflow occurs.

Unsurprisingly, the single biggest cause of overflow is lack of coverage in the transcription department. Often administrators believe that it’s cost-efficient to outsource transcription overflow. However, because of the chain of custody that’s required for medical records, outsourcing frequently has a negative effect on turnaround times.

“It was more time consuming for us to send out the work because you had to keep track of what you sent and then log back in what the transcription company sent you,” says Sara Proctor, CMT, who has worked for both hospitals and transcription companies and is immediate past president of the Missouri Association for Healthcare Documentation Integrity (AHDI). “More importantly, you had less control over quality.”

Proctor says the best way to avoid outsourcing is to gather and present supporting data to management. When she worked in a hospital, she compiled reports that tracked workflow over time to demonstrate that it was less expensive to hire additional transcriptionists than to seek help from outside the organization. It was a successful strategy, but it still was necessary to maintain an outsourcing option for emergencies. However, the department was able to cut down on outsourcing while increasing flexibility and quality control.

Still, even with an appropriately staffed department, transcriptionists can process only what they receive. If physicians don’t keep up with their dictation, the transcription department can quickly find itself digesting a large bolus of reports. Although transcription managers have limited influence with physicians, Proctor says there are a few ways to help them stay on top of their dictation.

One effective method is to maintain turnaround times to the greatest extent possible. Although it may seem counterintuitive, physicians who perceive that the transcription department is falling behind will have less of an incentive to keep up with their dictation. Demonstrating that the work can be done on time provides positive reinforcement. Proctor says her department strived to maintain an aggressive timeline of six hours for history and physicals, operative notes, and physician consults, which left doctors with plenty of time to finalize the reports within 24 hours of dictating them.

Physicians reaching out to other physicians also are extremely important to the process. Proctor says a chief of staff who is on board with having dictations completed in a timely manner can help immensely. Physicians who dictate multiple patients on a single file should be directly spoken to since this makes it extremely difficult to spread the work throughout the transcription department, sapping efficiency.

Unfortunately, the economics of health care require cost cutting wherever possible, which means nearly every department is being asked to do more with less. Debra Hahn, RMT, president of the Kansas AHDI, says it may be a good idea to start training transcriptionists on the technology standards for medical record transfer so they can take a more active role in populating the EHR.

“I think a lot of transcriptionists are not really there yet for the standards like HL7 [Health Level Seven International] and speech and natural language processing as far as going forward into electronic health records,” Hahn says. “And I think that sometimes medical transcriptionists are sort of kept in the dark about that.”

Hahn points out that bringing younger workers into the pool is one way to improve the workforce’s overall efficiency. Toward that goal, the AHDI is working with community colleges and other schools to encourage students to consider a career in medical transcription.

Quality software also can provide help for overburdened transcriptionists. Proctor says good transcription software frees transcriptionists from spending too much time formatting documents and affords them more opportunities to transcribe text. Word-expanding software allows some customization can be valuable, too. Phrases and words that are frequently used can be programmed and then inserted with just a few keystrokes. Headings, boldfaced words, and hyphenated words also can be linked to shortcuts.

“You need software that allows standard entries for your department yet allows your transcriptionists to customize and name entries themselves because that’s going to help them remember the most without having to consult their list all the time,” Proctor says.

A clean document is another key item. If a transcribed file has numerous errors, it’s harder to efficiently spread that work around the department when overflow occurs because the next transcriptionist will have to make the corrections before proceeding. For this reason, implementing an effective quality assurance program is vital to maintaining efficiency.

Encouraging transcriptionists to exceed the standard productivity level can spike efficiency even more. Proctor says an incentive program that allows transcriptionists to earn more while still meeting certain quality benchmarks can be a useful tool. She also has had success with work-from-home programs.

“You’re always trying to think of ways to make staff faster,” Proctor says. “You’re always looking for time-savers. The more time you can save, the less [work] you have to send out.”

— David Yeager is a freelance writer and editor.
**PRODUCTS AND SERVICES**

**HIM ON CALL Launches Dual Coding Service**

HIM ON CALL, an outsourced services company for HIM, coding, and revenue cycle, recently announced the availability of its dual coding services for hospitals migrating from ICD-9 to ICD-10. The new service provides the people, processes, and technology required for dual coding and supports ICD-10 testing with payers.

Features of the new dual coding service include the following:
- perform dual coding (ICD-9 and ICD-10) for up to one year prior to October 1, 2014;
- support end-to-end testing initiatives by providing ICD-10 coded cases; and
- provide monthly summary, data, and analytics of clinical documentation improvement issues (ICD-9 and ICD-10).

The service also provides a summary of documentation findings by ICD-10-CM/PCS chapter, patient type, medical service, and physician. The potential financial impact due to the lack of specificity in the documentation also is identified with actual and projected decreases in coding productivity by patient type and medical service.

For more information, visit www.himoncall.com.

**Presence Health to Leverage Predictive Analytics**

MEDSEEK has signed an expansion deal to deploy MEDSEEK Predict, a customer relationship management solution, across the Presence Health system.

Leveraging national and local data as well as Presence Health’s patient data, MEDSEEK Predict will allow Presence Health to analyze health patterns in its community and anticipate patients’ future needs. By educating patients about potential health risks and the importance of making lifestyle choices that can help avert chronic disease, Presence Health can help patients live healthier lives.

For more information, visit www.medseek.com/platform/predict.

**Start-Up Fills Records Requests**

5 O’clock Records, an HIT start-up, recently announced its rapid growth results for the first quarter of 2013 and highlights positive customer reports from the use of its flagship product, ChartRequester, a free online medical records request platform that helps physicians with securely fulfilling medical and billing record requests.

Fueling adoption are experiences from practices such as Morristown Medical Group in New Jersey, which began using 5 O’clock Records in February. “Since using 5 O’clock Records, our practice doesn’t wait for unpaid invoices. We made an additional $1,200 in the first month, and calls to the office went down from over seven per day to two per week,” says Shana Healsa, Morristown Medical Group’s medical records assistant.

For more information, visit www.5oclockrecords.com.

**Thermometer Tracks Disease Activity**

Kinsa, a start-up enterprise, recently announced the Kinsa Smart Thermometer, a smartphone-connected medical device that utilizes its mobile connectivity to enhance the features and benefits available to users beyond a fast and accurate temperature reading. Through the free accompanying Kinsa mobile app, users can track their illness history to share with physicians, access tools to better manage and plan around their illness, and view the “health weather” in their local area, including what symptoms and illnesses are going around.

One feature in the app, Kinsa Groups, allows users to see what symptoms and illnesses are going around a custom-created community, such as the parents of a specific first-grade class or a group of close friends.

The Smart Thermometer itself has no batteries, LCD, or processor, instead leveraging the power of the smartphone to allow the device to be thin, flexible, and comfortable to use, especially for children. The thermometer connects to the phone via the headphone jack.

Kinsa expects the Smart Thermometer to be available to the public later this year, upon receiving FDA clearance.

For more information, visit www.kinsahealth.com.

**Alliance Delivers ICD-10 Testing Services**

Lott QA Group, a professional HIT quality assurance and consulting firm, and HRS, an expert clinical coding, audit services, and ICD-10 implementation company, recently announced that they are working together to deliver a collaborative test data approach for ICD-10.

The new collaborative ICD-10 services include the following five components:
- native coding services in ICD-9 and ICD-10;
- clinical documentation reviews at code level;
- a shared ICD-10 test data repository;
- ICD-10 end-to-end testing and certification; and
- coder, billing, and physician education.

For more information, visit www.hrscoding.com or www.lottqagroup.com.
**Cottage Hospital Implements Downtime Reporting System**

Cottage Hospital in Woodsville, New Hampshire, has adopted Summit Healthcare’s downtime reporting system (DRS) to meet its business continuity needs and the data protection requirements that come alongside disaster recovery efforts. With 25 licensed acute beds, the health system serves hundreds of inpatients each year. The Summit DRS will ensure access to critical patient data in the event of a health management system or network downtime.

Summit DRS can support business continuity strategies by providing both clinical and nonclinical users with a snapshot of critical information regardless of planned or unplanned downtime. Report generation and data-capture tools provide the snapshots of vital data, while sophisticated data encryption and secure delivery tools protect information and give health care providers access to content.


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**FairWarning Ready Program Spearheads Privacy Initiative**

FairWarning, Inc, inventor and supplier of patient privacy monitoring solutions for EHRs, recently announced that its FairWarning Ready program now includes FairWarning Ready for Identity Management Systems.

Designed to help customers make better use of their existing investment in IT infrastructure, the FairWarning Ready program enables health care application vendors, enterprise security vendors, and now identity management vendors to seamlessly integrate with FairWarning patient privacy monitoring.

For more information, visit [www.fairwarning.com](http://www.fairwarning.com).

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**Interbit Data, HCISolution Announce Agreement**

Interbit Data, a provider of software and information services, and The HCISolution, a provider of HIT software solutions, recently announced they have entered into a joint marketing and sales agreement. Under the terms of this partnership, Interbit Data will market and sell HCI-developed solutions for health care information systems.

The scope of this agreement includes software solutions and services products system monitoring, and dictionary management, which allow hospitals to increase productivity, enhance reliability, and improve the accuracy of their health care information system implementations.

For more information, visit [http://interbitdata.com](http://interbitdata.com).

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**HITRUST Releases New Cybersecurity Guidance**

The Health Information Trust Alliance (HITRUST) recently announced new guidance for health care organizations wanting to assess the state of their cybersecurity preparedness. It identifies an appropriate subset of controls within the HITRUST common security framework (CSF) that are most directly related to detecting and thwarting cyber-related breaches and allows organizations to receive a snapshot of their cybercapabilities and readiness.

With this guidance, organizations not yet assessing themselves against all CSF controls will be able to focus immediately on the specific set of CSF controls that are highly related to cybersecurity. They then will be well positioned to complete a full CSF assessment in the future.

For more information, visit [www.hitrustcentral.net/news_repository/blog/usingthehirustcsftoassesscybersecuritypreparedness](http://www.hitrustcentral.net/news_repository/blog/usingthehirustcsftoassesscybersecuritypreparedness).

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**Partnership to Distribute ICD-10 Course**

COMFORCE, a national provider of outsourced health care staffing solutions, is partnering with Libman Education as an affiliate and distributor of the online ICD-10 preparation course “Anatomy & Physiology for Coders.” COMFORCE already has 100 full-time medical coders ready to be trained with the course and is marketing “Anatomy & Physiology for Coders” to its clients and coders via Libman Education’s marketing affiliate program.

In this 12-week course, students receive a comprehensive review of the major body systems, all with the benefits of online flexibility. The course includes a variety of teaching tools, such as videos, interactive educational games, and full-color anatomical drawings.

“Anatomy & Physiology for Coders” is designed to give organizations the flexibility to train coding staff so that it doesn’t interfere with day-to-day coding tasks. Courses can be taken any time from any location, and organizations can stagger the times.

“Anatomy & Physiology for Coders” is approved by AHIMA and AAPC for 24 CEUs and 6 CEUs, respectively.


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THE DATING GAME
By Sou Chon Young

A date—the unromantic kind with a month, day, and year—is pretty straightforward until you look at a cash-posting report. Then it can become a health care organization’s version of the Abbott and Costello skit “Who’s on first?”

For example, the finance department uses the deposit date as its date of reference, but patient accounting considers the date of posting as the deposit date. When running reports or examining figures, using different dates can derive different results.

Ultimately, the various dates can cause reconciliation nightmares between—and even within—departments. As a result, it’s important to know all the dates involved in cash posting and which one is being used when a report related to cash posting is requested.

The following are a few of the dates used by a cash-posting team:
- today’s date;
- date of check;
- date check was received (by lockbox vendor or cash-posting area);
- date of transaction;
- date batch opened;
- date batch closed; and
- date of deposit.

To further complicate matters, the manner in which deposits and supporting documentation (i.e., explanation of benefits (EOB) or electronic data interchange files) are received can add their own set of nuances and twists. For example, consider the following scenarios:

**Electronic remittance advice and electronic funds transfer (EFT):**
Because conducting business electronically saves time and decreases transactional costs, this is the best-case scenario. However, there still are a few dates that may cause confusion: the date the electronic remittance advice (835) file was provided by the payer or the clearinghouse, the date the 835 file was downloaded, the date within the 835 file that the hospital system considers to be the transaction date, and the date of the EFT deposit.

Be cautious when using the check issue or EFT effective date (BPR16) to reconcile to the deposit date. For example, a major government payer makes its deposit a few days after the EFT effective date in the 835 file, effectively throwing a kink in any reconciliation with finance if the EFT effective date is used as the “date of truth” from the payer. For these payers, examine the daily bank statement or another bank source to verify the actual deposit date.

**835 electronic data interchange file and check:** A notch below using an EFT, this method conducts a portion of its business electronically. Using the 835 typically will eliminate a user’s ability to select the transaction date when processing the file into the patient accounting system. It also contains the check issue or payment effective date. However, since users are receiving payments via check instead of EFT, there may be complications, such as payment delays.

The amount of risk depends on whether lockbox services are used. If the organization does not have a lockbox, the following dates (in addition to those involved with EFTs) must be considered:
- the date the check was received in-house;
- the date the check was received by the cash-posting team (Depending on the process, a mail sorter may stamp a date received before passing it on to the cash-posting team.);
- the date of the deposit slip used for the check; and
- the date of the actual deposit (This may vary from the date of the deposit slip.).

If there is a lockbox, the following dates must be considered:
- the date on the check;
- the date the lockbox received the check, and
- the date a hard-copy image of the check was received.

Without a lockbox, organizations run the risk of misplacing or losing checks, making it advisable to enroll in an EFT payment program when possible.
Paper EOB and EFT: This combination is similar to using an 835 electronic data interchange file and a check, but it forfeits the ability to post electronically. Once again, lockbox use affects the noteworthy dates. Without a lockbox, organizations must be aware of the date on the paper EOB and the date the EOB was received by the cash-posting team. The presence of a lockbox requires attention to the following dates:

- the date on the paper EOB;
- the date the lockbox received the paper EOB; and
- the date the EOB was received by the cash-posting team or the date assigned to the EOB by the lockbox vendor if the service includes viewing images on the Web.

Organizations still receiving paper EOBs should consider transitioning to the 835. In fact, payers that do not offer the 835 are noncompliant. If an organization is not equipped to accept the 835 (it also technically would be out of compliance) but does have a lockbox, it should ask its lockbox vendor to convert EOBs to electronic images. This will shorten the time it takes for organizations to receive EOBs from the vendor and reduce the amount of paper the organization needs to maintain.

Paper EOB and check: The least efficient of all combinations, this scenario hinders an organization’s ability to maintain a healthy revenue cycle. For those unfortunate enough to be burdened with this setup, there are several dates to keep in mind when dealing without a lockbox:

- the date on the paper EOB;
- the date the EOB was received by the cash-posting team;
- the date the check was received in-house;
- the date the check was received by the cash-posting team;
- the date of the deposit slip used for the check; and
- the date of the actual deposit.

With a lockbox, consider the following dates:

- the date on the paper EOB;
- the date the lockbox received the paper EOB;
- the date the EOB was received by the cash-posting team or the date assigned to the EOB by your lockbox vendor if your service includes viewing images on the Web;
- the date on the check;
- the date the lockbox received the check; and
- the date a hard-copy image of the check was received.

No matter the technology (or lack thereof) involved, determining an exact cash-posting date frequently is an inexact science. Ask an analyst or a cash-posting manager to run a report based on date parameters between X and Y, and there’s no guarantee the date of interest will be included.

In short, revenue cycle professionals may never know what they’ll get when they ask for a date.

— Sou Chon Young is a senior revenue cycle consultant at Hayes Management Consulting.
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The digital edition of this issue is also viewable on our Facebook page.
www.Facebook.com/ForTheRecordmag
The Office of the Vice Dean at New York University’s School of Continuing and Professional Studies (NYU-SCPS) currently seeks skilled medical coding professionals with a deep understanding of ICD-10 to teach in-person and/or online coursework within our Medical Coding continuing education program area.

For the upcoming academic year, we seek part-time faculty to teach in the following content areas:

- Anatomy and Physiology
- Medical Terminology

Candidates must possess at least a Bachelor’s degree and 3-6 years experience as a working professional within the medical coding industry. Masters degree preferred, prior teaching experience strongly preferred.

The School of Continuing and Professional Studies (NYU-SCPS) offers a broad range of degree and noncredit programs that are professionally oriented, integrate theory with real-world applications, and are taught by faculty members who are leaders and innovators in their fields. NYU-SCPS captures the expertise of the key sectors that make New York City a great global capital, such as communications/media, global affairs, philanthropy and fundraising, finance, marketing and public relations, writing, the arts professions, and others. Full- and part-time students enroll in on-site and online credit programs, including graduate degrees, graduate certificates, and undergraduate degrees and working professionals and other adult learners pursue career objectives or intellectual discovery in over 2,500 continuing education courses, certificate programs, conferences, and seminars annually.

To apply go to: www.nyuopsearch.com/applicants/Center?quickFindId=51612

NYU encourages applications from women and members of minority groups.

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Requirements include an Associate’s degree in Health Administration or Registered Health Information Technician (RHIT) certification, and a minimum of four years of relevant coding experience in a health care setting, including experience with ICD-9 and CPT coding. The ideal candidate will have a thorough understanding of the effect of data quality of potential payment, utilization and reimbursement for multiple medical professional service specialties. Experience conducting training and educational sessions required. Working knowledge of Allscripts preferred. Additional certifications: CPC, CPC-H, or CCS/CCS-P through the AAPC; CPMA and CCS required within one year of employment; AHIMA approved ICD-10 trainer preferred. A valid Illinois driver’s license and, experience with Microsoft Office Suite required.

Qualified candidates please visit our website for an online application at www.nch.org
Central Peninsula General Hospital, located in Soldotna, AK, is seeking to fill a FULL TIME CODING SUPERVISOR

Responsibilities include:
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Requirements include:
- High school diploma or GED.
- Coding Specialist Certification (CCS), 3 years of experience with full range of hospital coding, 1 year of experience with HIS data management system, and 1 year of supervisory experience.

Preferred Qualifications:
- Coding supervisory experience and RHIT or RHIA.

For more information and to apply, please visit our website at www.cphg.org or e-mail dhoener@cphg.org.

For more information and to apply, please visit www.trinityhealth.org or inquire at Lelia.Wilson@Trinityhealth.org.

To apply: https://rn21.ultipro.com/PRO1004/JobBoard/ListJobs.aspx or visit our website at www.antheliohealth.com

Antelio is the largest independent provider of information technology (IT) and business process services to hospitals, physician practice groups and other healthcare providers. Antelio is the only healthcare services company that has “end-to-end” services expertise, including IT, electronic medical record (EMR) implementations, clinical transformation, coding, ICD-10 and revenue cycle management services.

Antelio seeks experienced facility medical coders with RHIT/RHIA/CCS required, CPC-H with relative experience will be considered, to join our team. We offer great benefits and a culture that promotes quality and excellence.

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www.ahima.org

**JUNE 9-12, 2013**
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Palm Desert, California
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**JUNE 9-12, 2013**
New York Health Information Management Association 78th Annual Conference
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**JUNE 11-12, 2013**
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**JUNE 12-13, 2013**
Kentucky Health Information Management Association Annual Meeting
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**JUNE 13-14, 2013**
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**JUNE 16-19, 2013**
ANI: The Healthcare Finance Conference
Orlando, Florida
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PHRs Work Wonders for Seniors With Coronary Diseases

Often considered a population “too old” for computer-based communication tools, a recent study found that seniors who had undergone cardiac revascularization and used electronic PHRs were more engaged, with improved clinical outcomes. When Fort Wayne, Indiana–based Parkview Physicians Group Cardiology provided a prepopulated PHR to approximately 200 cardiac patients (most older than age 55), it found a significant improvement in hemoglobin A1c (HbA1c) levels over a six-month period as well as improved patient activation scores.

“Lifestyle modification and medication adherence are crucial to improving intermediate health outcomes that influence morbidity and mortality among cardiac patients,” says Michael Mirro, MD, of Parkview Hospital. “This study shows that health care technology can increase patient engagement, which then leads to more positive health outcomes.”

The study was part of an initiative by Indiana Health Information Technology, Inc (IHIT) and PHR vendor NoMoreClipboard to make health information exchange (HIE) data available to patients. Working with IHIT and NoMoreClipboard, data from the Parkview EHR were routed through the area HIE to populate patient PHRs.

Personnel from the Parkview Research Center (PRC) worked with patients to set up their PHR account and provided training. Parkview’s EHR system was configured to support PHR account creation and population. With the patient present, PRC staff sent a continuity-of-care document (CCD) and the patient’s medical record number to the PHR from the patient’s chart in the EHR. The CCD was then routed through the Med-Web HIE, which serves northeast Indiana, and NoMoreClipboard returned a PHR account activation code.

When a PHR account was created, the activation code was entered, establishing a match with the patient’s medical record number at Parkview and releasing discrete data from the CCD to populate the PHR. When new data are available in the Parkview EHR system, the practice can post those data to NoMoreClipboard with a single click.

Of the 184 patients who completed the six-month study, 70% were aged 56 to 74. About 64% were covered by Medicare, and the majority were college educated. There also was a high prevalence of diabetes in the study population (33%).

Study results include the following:

• Active PHR users and superusers experienced significant declines in HbA1c percentages. The mean HbA1c dropped from 6.25% to 6%.
• Patients with a history of diabetes showed a significant statistical improvement in glycemic control.
• Patients with access to a PHR had a greater understanding of their conditions and adopted healthier lifestyle behaviors.
• Over the duration of the study, data have been imported from Parkview’s EHR to patient PHR accounts more than 600 times, and patients have logged into the PHR more than 2,400 times. On average, patients logged in 8.7 times over a six-month period. Approximately 15% of the patients are using the health diary to self-report and share health measures.

— SOURCE: NOMORECLIPBOARD

MARKETPLACE

Product Preview

Clinical documentation without hassle: use Instant Text 7 if your concern is timeliness, cost-efficiency, and accuracy. A productivity software offering unique features:

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Intelligent InSites, Inc will provide the enterprisewide software solution for the VA’s $543 million real-time location system project. The five-year contract will provide this number of medical centers in the 21 veterans-integrated service networks and seven consolidated medical outpatient pharmacy facilities with a real-time, systemwide solution to help improve operational efficiency, quality, satisfaction, and compliance.

According to a Berg Insight report, at the end of 2012, around this number of patients worldwide were using a home monitoring service based on equipment with integrated connectivity. This includes all patients who were using dedicated devices for remote monitoring but not those using their personal mobile phone, tablet, or PC.

Berg Insight forecasts that the number of home monitoring systems with integrated communication capabilities will grow at a compound annual growth rate of 26.9% between 2011 and 2017 to reach this number of connections worldwide.

An analysis by the West Health Institute estimates that medical device interoperability—the ability of medical devices and health care systems to seamlessly communicate and exchange information—could save more than this amount per year and improve patient care and safety. In a typical ICU, patients are treated with six to 12 medical devices, including defibrillators, electrocardiographs, vital sign monitors, ventilators, and infusion pumps, which often are from different manufacturers and not connected, requiring a costly, complex IT infrastructure and introducing the potential for miscommunication that adversely affects patients.

According to a survey by Nuance Communications, Inc, this number of physicians believe that by 2018, virtual assistants, powered by clinical language understanding, will drastically change how physicians interact and use EHRs and other health care apps, making them more efficient and freeing up time to spend on patients. One in three physicians spends 30% or more of their day on administrative duties, which could be redirected or removed using voice-enabled virtual assistants.

This percentage of physician respondents to a Nuance Communications survey about the effect virtual assistants will have on health care said the top role for a virtual assistant is more accurate, timely information to support care or alerting physicians to missing information in patient records. Additionally, 73% expected virtual assistants could improve health care and patient engagement by helping to coordinate care among multiple caregivers, and 80% believed virtual assistants will benefit patients most by engaging them in the care process, prompting them to adhere to health advice, and modifying behaviors.

This percentage of respondents to a Global Information Security Workforce Study by (ISC)² said bring-your-own-device (BYOD) technology is a significant security risk, and 74% reported that new security skills are required to meet the BYOD challenge.
Impact Patient Care

as a Certified Tumor Registrar

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The online Cancer Registry Management Program is an NCRA-accredited component for Certified Tumor Registrar (CTR) exam Eligibility Route A—Path A2.* AHIMA continuing education units (CEUs) are available.

*Visit ncra-usa.org for more information.

For more information, visit ahima.org/crm.
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