Information Governance’s NEXT PHASE
MOVING HIM FROM THE ‘WHY’ OF IG TO THE ‘HOW’
Slideshow: IG As Mission Control

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RHIA, CDIP, CCS, CCS-P, CIRCC
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* Source: Department of Health and Human Services, April 2015
Information Governance’s Next Phase
Moving HIM from the ‘why’ of IG to the ‘how’
By Mary Butler
AHIMA has grabbed the figurative white board marker and begun leading the discussion on and development of HIT standards that support HIM practices.

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Slideshow: IG As Mission Control
Representation from a variety of departments is the best way to ensure an IG program’s successful liftoff.

Live Coverage of AHIMA’s 2015 CDI Summit
The summit will be held August 6-7 in conjunction with the AHDI Healthcare Documentation Integrity Conference.

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NOT A DAY goes by for HIM and healthcare industry leaders without challenges that result from a lack of trust in the data and information we encounter in our work—or in caring for our loved ones. Years ago, when I was working as the director of quality and resource management at a well known healthcare organization, an unfavorable article was printed on the front page of the newspaper. The article referenced a piece published in the New England Journal of Medicine that stated people living in La Jolla, CA had a twofold chance of having heart surgery over those living in comparable cities. After the initial shock of the article subsided, I decided to dig in and analyze the data at our facility. I determined that a large number of patients—40 percent—had the hospital address listed in their record rather than an actual home address.

Deeper digging revealed a health plan contractual arrangement that required suppression of the patient’s copy of the hospital bill. The hospital’s legacy system vendor identified listing the hospital address for patients as a workaround to ensure the bill did not reach the patient’s doorstep. Though the newspaper printed retractions, the IT issue was addressed, and the error was corrected, the organization had to pay a sizeable fine to address the data integrity issues with the State of California’s discharge reporting program.

This personal experience of mine is just one of many examples that demonstrate the price of bad data—from a reputation, financial, clinical, and service delivery standpoint. Today, there are risks associated with value-based reimbursement and inaccurate data, which result in costly denials of payment due to collection or reporting error. Organizations also face losing their status in networks of care when saddled with unfavorable rankings amongst comparable hospitals.

The ability to trust in data that is translated to information and used for clinical, financial, and operational decision making is a business imperative, and is essential to the many industry initiatives currently underway as we work toward the ultimate goal of improving population health.

When I reflect on the work accomplished during my tenure on AHIMA’s Board of Directors, beginning in the fall of 2013, I am proudest of what we have done in the area of information governance (IG). We have made an indelible mark on the healthcare industry, built on a solid foundation of accomplishments in business and industry. The complete transition to electronic systems is hampered by the lack of agreed upon standards and oversight, lack of interoperability, and poorly designed workflows that do not address accurate, timely, and complete capture of documentation. These issues, coupled with consolidation and the proliferation of health information exchange in the healthcare marketplace, represent a growing and increasingly complex challenge. As the healthcare industry strives for interoperability, and increasingly shares information with engaged consumers, the work of ensuring information is trustworthy can be greatly enhanced with the implementation of an IG program. Adopting an IG program demonstrates an organization’s commitment to managing its information as a valued strategic asset.

AHIMA has developed a treasure trove of resources to fuel IG in healthcare and will continue to build the HIM Body of Knowledge as our work continues. More information is available at www.ahima.org/topics/infogovernance. Now is the time to realize our IG vision!

Cassi Birnbaum (cassi.birnbaum@ahima.org) is senior vice president of HIM and consulting at Peak Health Solutions.
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Providers See Benefits of HIEs—Still Face Challenges

Health information exchanges (HIEs)—along with the providers who rely on them to meet the “meaningful use” Electronic Health Record (EHR) Incentive Program payment requirements and improve care—have experienced a shift in priorities since HITECH and the American Recovery and Reinvestment Act (ARRA) of 2009 formed them.

A new report on the state of HIEs, released by NORC at the University of Chicago, a contractor reporting to the Office of the National Coordinator for Health IT, identified successes and challenges facing select state HIEs. NORC conducted an in-depth analysis of HIEs in six states: Iowa, Mississippi, New Hampshire, Vermont, and Wyoming. NORC investigators talked to stakeholders in each of these states, including hospitals and integrated delivery networks, hospital associations, health centers, physician associations, critical access hospitals, long-term care and home health vendors, and developers and health information service providers to extract four common themes:

1. Providers’ HIE needs have evolved beyond connecting disparate systems and meeting meaningful use exchange requirements. Providers highlight the potential for HIE to ease access to “actionable” data that integrates data from across the care continuum and provides clinicians with information at the point of care to improve care delivery and care coordination. Provider priorities for exchanges include admission, discharge, transfer alerts, services that facilitate care coordination, and interstate exchange.
2. Providers anticipate a growing need for vendor-provided HIE services and infrastructure as expectations for electronic exchange of health information increase under this shift.
3. Providers have struggled with managing competing priorities and multiple funding streams, and have trouble getting support from

New Bills Address HIPAA Concerns in Mental Healthcare

Two bills have been introduced in Congress in recent months seeking to improve communication between mental health professionals and patients’ families, and to dissolve provider fears about compliance with HIPAA.

Rep. Tim Murphy (R-PA) introduced a new version of the Helping Families in Mental Health Crisis Act following the Newtown, CT school shooting in 2012.

The updated bill would create a new US Department Health and Human Services (HHS) position, assistant secretary for mental health and substance abuse disorders, and establishes a national mental health policy laboratory to develop new models of care, Modern Healthcare reported.

It also would address six HIPAA provisions that regulate how and when mental health providers can release diagnosis and treatment information to the family members of patients under their care.

Another bill, introduced by Rep. Doris Mitsui (D-CA) would clarify current HHS guidance which states that the provider does have the discretion to share patients’ information when it is in the patients’ best interest to do so.

Her bill would allocate $5 million for fiscal year 2016 and $25 million to be used between fiscal year 2017 and fiscal year 2022 for increased training programs for mental health providers, patients, and their families.

American Psychiatric Association CEO Dr. Saul Levin wrote in support of Mitsui’s bill. “It’s often the case that the management of professionals’ interactions with patients and caregivers is complex,” Levin wrote. “It is important that confidentiality protections, which are a central pillar to appropriate and effective therapeutic relationships, be balanced with the availability of legal tools that are necessary for psychiatrists to be able to act in the best interests of their patients when disclosure of protected health information to third parties is necessary,” Modern Healthcare reported.

VA Testing New EHR System

The Department of Veterans Affairs (VA) is testing a new electronic health record (EHR) application that will pull health records from the Department of Defense (DoD) and VA hospitals and care centers, among other databases, into one place for providers to review. The VA plans to launch three pilot programs to test the application, called the Enterprise Health Management Platform (eHMP), this summer, according to an article in Federal Times.

The application’s interface shows physicians what tests have been ordered, when those tests were ordered, past prescribed medications, past medical notes, and allergies, according to the article. Another useful feature of the application is an adjustable timeline window, which allows physicians to take a broad view of the patient’s history—as far back as 1960—or to focus in on a specific time period.

The eHMP hopes to improve interoperability, and is currently set to roll out across the VA by the end of 2017.
HIE and EHR vendors. Lack of interoperability has also hindered their efforts.

4. Providers understand the benefits of HIEs. Even though the meaningful use program did not provide incentive payments to long-term care and behavioral health providers, the state HIE program was instrumental in engaging these providers and identifying their specific needs and the gaps that grantees needed to fill, particularly around care continuity.

“Awareness of and demand for HIE has been steadily increasing throughout the life of the program,” the report states. “Providers we spoke with in previous and current activities reported an appreciation for the state HIE program’s role in communicating with providers of all types, bringing together stakeholders, and communicating the value of HIE. Now that HIE is better established—both in terms of visibility and available services—providers have identified new priorities and challenges. “These have evolved from early issues surrounding basic implementation and awareness of the benefits of HIE into a search for solutions to meet greater demand for information, while balancing cost and multiple information exchange priorities,” the authors wrote. ☐

### Survey: ICD-10 Training Reaching New Heights

The majority of provider organizations have trained staff on ICD-10-CM/PCS, according to the results of the third annual eHealth Initiative survey conducted in conjunction with the American Health Information Management Association. Specifically, 72 percent of survey respondents overall said they have trained staff on ICD-10. Other methods survey respondents are using for ICD-10 preparations include providing resources to staff, creating special readiness assessment teams, updating systems, and reviewing internal processes and workflows. The survey also found that the larger organizations have reported more progress in transition preparations. ☐

#### Top Five ICD-10 Preparations by Providers

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
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<tbody>
<tr>
<td>78%</td>
<td>Providing ICD-10 resource materials to staff</td>
</tr>
<tr>
<td>73%</td>
<td>Forming teams to assess readiness, prepare for implementation</td>
</tr>
<tr>
<td>72%</td>
<td>Training staff on using ICD-10</td>
</tr>
<tr>
<td>66%</td>
<td>Updating systems to support ICD-10</td>
</tr>
<tr>
<td>64%</td>
<td>Evaluating internal processes, workflows, and resources</td>
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The College of Healthcare Information Management Executives sent a comments letter to the Senate Committee on Finance that outlines the key role information technology plays in managing chronic conditions.

Consulting firms Leavitt Partners and the Brookings Institution are merging to form the largest accountable care collaborative in the world.

A survey from Software Advice found that the number of electronic health record buyers looking to replace their systems has increased by 59 percent since 2014.

The Health Resources and Services Administration’s Bureau of Primary Health Care will grant $12 million to 37 Health Center Controlled Networks to support health IT adoption.

Cerner and Vectramind have developed a multi-channel messaging system that can be incorporated into Cerner’s population health and electronic health record systems.

Deven McGraw has been appointed the deputy director for health information privacy at the Department of Health and Human Services’ Office for Civil Rights.

A web portal, the Massachusetts Clinical Gateway, has been launched to link several teaching hospitals to support clinical research and academic medical center initiatives in Massachusetts.

The Centers for Medicare and Medicaid Services has awarded a $24 million Big Data contract to Data Computer Corp. of America.

Joe White, former chief financial officer of a Texas hospital chain, was sentenced to 23 months in prison following a guilty plea last year to lying about falsifying electronic health record meaningful use data. ☐
A randomized controlled trial of telemedicine for Parkinson’s disease (Connect.Parkinson) in the United States: interim assessment of investigator and participant experiences


A study evaluated the use of predictive modeling to identify patients in the Veterans Health Administration at risk for suicide. After identification, ongoing care was supplemented with risk-stratified interventions. Study authors concluded that predictive modeling can effectively identify high-risk patients that were not identified on clinical grounds.

Predictive modeling and concentration of the risk of suicide: implications for preventive interventions in the US Department of Veterans Affairs


A nationwide survey on Direct messaging from the Healthcare Information and Management Systems Society found that 51 percent of health information organizations say the cost of implementing the protocol is worth the health data sharing benefit gained. The survey found substantial use of Direct in support of care coordination, and that “most participating organizations support Direct as the method choice for exchanging data.”

Report: Use of Patient Engagement Tools Shows Growing Promise

Patient engagement through wearable health tracking devices is at an all-time high, with both patients and physicians finding significant return on investments in such technologies, according to a new digital health report from Accenture.

According to an Accenture survey of patients and physicians, 49 percent of patients globally are using or would be willing to use wearable technologies to measure and track fitness and/or vital signs. What’s more, 73 percent of physicians surveyed revealed that they have seen positive ROI with such personalized health devices.

The report identified and discussed five key trends:

1. Intelligent Enterprise: a focus on data to help improve clinical outcomes
2. Internet of Me: personalized medicine
3. Outcome Economy: a system focused on “delivering results,” in part through increased data accessibility
4. Platform (R)evolution: the increasing prevalence of mobile and cloud platforms that focus on interoperability
5. Workforce Re-imagined: the emergence and implementation of new machine technologies

The report also offers some statistics and predictions about electronic health record (EHR) use by patients and their engagement with portals. It noted that the proliferation of patient data governed by providers has grown drastically. Forty-one percent of healthcare executives reported that patient data volume has grown as much as 50 percent in one year. Also, 52 percent of patients surveyed said they want access to their EHR data related to physician notes.

New EHR System Designed to Combat Disease Outbreaks

An electronic health record (EHR) system designed for use in highly infectious medical outbreaks, developed for use in the treatment of Ebola, can now be adapted for use in future medical crises and natural disasters. The specialized EHR was developed by software company ThoughtWorks in partnership with international non-governmental organization Save the Children, and was first used at Save the Children’s Ebola Treatment Centre in Sierra Leone.

Having use of an EHR for Ebola treatment was invaluable, as the decontamination standards necessary for Ebola treatment prevent paper medical records from traveling between patient treatment areas and all other non-patient areas—including physician meeting rooms and the pharmacy. “The complexity of the current West African Ebola epidemic—which is the largest and most widespread Ebola outbreak ever recorded—has created enormous barriers for patient care,” said Darius Jazayeri, global health technical principal at ThoughtWorks, in a press release.

“Even seemingly straightforward tasks like collecting and accessing quality patient clinical records have been nearly impossible using conventional methods. “The patient data collected using our electronic medical record platform allows Save the Children not only to collect invaluable patient data to be used for immediate care, but also allows us to better understand a disease about which so little is still known.”

The open-source software platform runs on laptops and tablets and supports patient registration, bed allocation, discharge of patients, recording of vital signs and symptoms, ordering and administration of medications and IV fluids, laboratory results, clinician notes, and data export for analysis.
Experts Fear that Data of ACA Enrollees is Not Secure

Data privacy experts and legislators are raising concerns about the security of the patient data collected from Healthcare.gov enrollees, which are stored in a government data warehouse. The warehouse, known as the Multidimensional Insurance Data Analytics System (MIDAS) is operated by CACI, a contractor for the Centers for Medicare and Medicaid Services (CMS).

According to a report from the Associated Press (AP), CMS has not developed a retention policy concerning the information stored in MIDAS, and that the National Archives recommends that the data be stored for no longer than 10 years. Results of a federal privacy assessment published in January suggested that the information “is maintained indefinitely at this time,” according to the AP.

The data MIDAS maintains was collected from people who signed up for health insurance through the Affordable Care Act, and includes names, Social Security numbers, birthdates, addresses, phone numbers, passport numbers, employment status, and financial accounts, as well as information provided by former customers, such as those who left their applications incomplete or people determined eligible for Medicaid, according to a report from the Government Accountability Office. The same report also found that MIDAS was implemented without completing a privacy assessment, the AP reported.

Recent privacy breaches of health data, such as the recent hacking of federal government employee databases, has driven calls for more safeguards of MIDAS data.

“When people go to government services sites, they don’t have a choice. That means the privacy and security bar should be very high,” Michelle De Mooy, deputy director for consumer privacy at the Center for Democracy and Technology, told the AP.

Pricing Data Identifies Costly Hospitals, Consumers Want More

Consumer demand for healthcare pricing data is picking up steam. A recent study from non-profit research organization Public Agenda, supported by the Robert Wood Johnson Foundation, found that 56 percent of Americans have sought out information on healthcare pricing.

Among those consumers who have not sought out the information or compared providers, “57 percent say they are interested in finding out this information,” according to an article in Healthcare Informatics. While only 21 percent of respondents compared prices between providers, 62 percent of those consumers reported that it saved them money.

The study, which included survey responses from 2,010 adults, found that American consumers “do not equate lower quality of care to lower prices,” according to the article. But the ability to identify those hospitals which may be charging more for the same services could be an important factor for uninsured and out-of-network patients, which are often asked to pay a large portion of the full charges, as noted by researchers at Johns Hopkins Bloomberg School of Public Health and Washington and Lee University, who recently published a study in Health Affairs that identifies the 50 US hospitals with the highest charge-to-cost ratios in 2012. According to the study, some hospitals are marking up prices for services more than 1,000 percent when compared with the Medicare-allowable cost. By comparison, the national average falls in the 3 percent range.
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SOMETIMES THERE’S VALUE in thinking big and starting small.

That idea might be of some comfort to AHIMA members who want to take up the banner for information governance (IG) but who find it hard to know where to begin.

We’re not alone, as it turns out. This spring, a keynote panel at the National Conference on Managing Electronic Records compared launching an IG program to the nation’s early space program. A panel of IG experts noted that “the federal government, the American public, and key stakeholders were united behind the same goal of launching a successful Apollo mission during the space race,” the Journal of AHIMA reported. “By contrast, only a handful of stakeholders within any organization typically see the need for information governance, and they face an uphill battle in establishing their own mission control.”

Small wonder that HIM professionals may feel overwhelmed in starting an IG program. But while we want to shoot for the moon, it may be easier to start one step at a time.

A good approach to starting IG is to find a problem, fix it, and move on. Start with a gap analysis and begin to address just one problem in your organization. It may be writing a new policy and procedure, updating record retention policies, or addressing problems in data capture.

Don’t ask for permission to start. A track record of solving problems will help your organization see the value of IG; then, with a few successes, you’re on your way.

This special issue of the Journal offers a rich selection of IG how-tos and examples for how to begin. In “Information Governance’s Next Phase,” Mary Butler explains how cutting-edge healthcare organizations have implemented IG programs and the results they have seen. Lesley Kadlec, MA, RHIA, and her co-authors offer a simple approach to getting off the ground in “Getting Started with Information Governance.” Erin Head, MBA, RHIA, CHTS-TR, explains “Owning the EHR and Information Governance at Your Facility” with tips on how to get a seat at the table. Real-life stories of early successes and challenges with IG are highlighted by Rita Bowen, MA, RHIA, CHPS, SSGB, and her co-authors in “IG Roundtable—Assessing Organizational Progress in Implementing IG Practices.” One organization shares its experiences in IG improvement in registration and release of information in “IG from the Ground Up” by Mary Beth Haugen, MS, RHIA, and Janell Madonna.

Ensuring compliance with health information exchange (HIE) participation agreement requirements, federal and state laws, and existing policies and procedures can be a daunting task. “Policy and Procedure Considerations for Health Information Exchange Organizations” provides guidance in sorting out and meeting HIE requirements.

As you know, AHIMA has developed an impressive number of resources for our information governance initiatives. This summer we’ve released a second white paper with results from our latest IG survey, and a new toolkit is in the works as well. Additional resources can be found at www.ahima.org to help you take your next step... or your first step in IG.

Note

Information Governance’s NEXT PHASE

MOVING HIM FROM THE ‘WHY’ OF IG TO THE ‘HOW’

By Mary Butler
Prior to the 2010 signing of the Patient Protection and Affordable Care Act (ACA) by President Obama, nearly anyone who had interacted with the American healthcare system could agree that it was, in many ways, broken. Millions of Americans were uninsured—due to either pre-existing conditions, lack of employer-backed options, or gaps in Medicaid eligibility. Healthcare professionals—from physicians to payers—were also frustrated by the system’s inability to allow them to provide care for patients clearly in need.

But anyone who was paying attention to the news at the time, both before and after implementation of the ACA (also known to many as Obamacare), could see how fearful politicians and the American populace were of such a sweeping overhaul of the system. Everyone was certain “why” reform needed to happen, they were just very scared about “how” it would happen. To explain the “how,” federal officials held town hall events, unleashed healthcare “Navigators” to every state to explain the sign up process, and undertook a massive marketing campaign to dispel myths.

So far, ACA has withstood Supreme Court challenges, congressional efforts to repeal it, and the early crash-and-burn of the program’s centerpiece website, Healthcare.gov. Both critics and supporters of the law agree that it’s far from perfect. While the legislation’s merits will continue to be debated and dissected for years to come, anyone looking to effect major change at an institutional level would do well to study the ACA’s history—health information management (HIM) professionals included.

It can be a challenge to move from the “why” of an initiative to the “how”—something many in HIM are currently facing with their move to information governance practices.

AHIMA Leads the ‘How’ of IG
Currently, HIM professionals are poised to enact comparable changes by implementing information governance (IG) programs in their hospitals and other healthcare facilities. For the last two years, AHIMA has been helping these providers by actively promoting the “why” of IG. It has done so by surveying the state of IG practice, generating IG white papers, identifying best practices, conducting live and virtual events, and planning educational products.

Just as the ACA’s Navigators helped Americans sign up for insurance coverage, AHIMA has begun shepherding providers into the “how” of IG. To help achieve actual implementation of IG practices, AHIMA developed resources such as the Information Governance Principles for Healthcare (IGPHC)*, available online at http://research.zarca.com/survey.aspx?k=SsURPPsUQRsPsPsPsPsPslang-0&data. And a yet-to-be-released IG maturity model will help providers self-assess their IG maturity and readiness. AHIMA credits ARMA International for sharing their Generally Accepted Recordkeeping Principles, which provides guidance in the governance of information, to help develop the IGPHC and maturity model for the healthcare industry.

AHIMA’s ultimate vision relates to what IG will do for healthcare, says Deborah Green, MBA, RHIA, executive vice president, chief innovation and global services officer, at AHIMA. “With widespread adoption, and movement toward high levels of IG maturity, we envision that IG will ultimately and consistently ensure reliable and trusted data and information,” Green says.

Mature IG programs, in the long run, will help ensure the safe use of health IT, enable evidence-based healthcare practices, improve effective coordination of care across the healthcare continuum, and reduce costs, according to Green.

The draft IG maturity model is a five stage model for self-scoring an organizations’ current adoption of IG. The model contains “maturity markers” by stage, specific to essential functions of IG. Maturity markers at lower levels indicate an organization that can be characterized as fragmented and technology-oriented. Markers at the higher levels indicate that an organization can be characterized as holistic and business-driven in approach. Prioritization of remediation steps can be undertaken based on the degree of risk to the organization, Green explains.

Is Healthcare Ready for IG?
There have been several IG pioneers in healthcare that launched and implemented IG or IG-like programs simply because a business or organizational need was identified. In many ways, the healthcare industry has been involved in IG for decades without calling it IG.

Jaime James, MBA, RHIA, senior director of HIM at Banner Health, based in Phoenix, AZ, says IG has been going on in her organization for nearly 10 years in some form or another. Banner has created teams over the years to deal with the biggest health IT initiatives, such as the enterprise master patient index (EMPI), electronic health records (EHRs), and HIPAA compliance. When James joined Banner eight years ago she was on the EHR team, which has since transitioned into the enterprise information management (EIM) committee. Its members comprise of individuals from departments including risk management, compliance, legal, and health information management services. James said Banner is introducing concepts related to IG through this committee.

“So we have all of these HIPAA, security, EMPI, EIM teams, and our IT governance structure for EMRs. [We’re talking about] how do we pull it all together under one information governance umbrella? There’s recognition that we have IG going on, versus a formal structure,” James says.

She hopes that AHIMA’s IG maturity model will help the organization put these disparate teams together under one IG umbrella. While AHIMA advocates for an IG framework that operates from the top down—with leadership and the C-suite jump-starting efforts—James said her facility has been doing the reverse. They’ve started multiple projects at the small department level in an effort to build a case strong enough to take to the C-suite.

People who are experts on IG and healthcare agree there’s a growing interest in how to begin and structure IG efforts. According to a recent survey into IG readiness, which was completed by AHIMA and Cohasset Associates, 44 percent of survey respondents indicated that over the past 12 months IG advancement has begun in their organizations. However, nearly one-third (32 percent) of survey respondents reported no progress in their organizations, with another 24 percent indicating that IG simply is not yet an organizational priority.

Consultant Karen Lawler, RHIA, CHPS, principle adviser at KJL Consultants, says the healthcare systems she advises have come to her for help in framing what they’re already doing into a full-time IG project. When organizations reach out to her, their motive is usually...
HEALTHCARE SYSTEMS WITH and without formal IG infrastructures can still proceed with IG activities that improve operational efficiency and deliver quality care. However, LifePoint’s Joe Ponder points out that the most successful programs tend to be those that are both dedicated to IG and widely supported by the business.

“An organization can have a successful IG program without an IG department. However, in my experience, if IG becomes just another hat for someone already tasked with a myriad of responsibilities, it becomes difficult to introduce organizational changes that are transformational in nature,” Ponder says.

With that in mind, here are some basic IG tenets that can help move any healthcare organization down the path of IG.

1. Streamline Master Patient Indices: With mergers and acquisitions rates at an all time high, having a uniform process of positively identifying patients thrown into databases that aren’t interoperable is critical.

2. Information Mapping: Understand the critical information assets of the business, including data ownership and management.

3. Information Retention: Establish clear standards for retaining critical and valuable information while allowing disposition of the rest.

4. Information Planning: Establish a go-forward strategy surrounding how you want data to be stored and managed, closely tying the management of that information to retention schedules.

5. Storage Management (Electronic and Paper): Improve the processes that are used to store and archive information to promote recall, usage, and destruction.

function-based. For instance, their quality scores and metrics may be low, or they’re having trouble with their patient portal implementation. These problems become opportunities to start IG projects.

“When I look at a department, I say ‘What is your core business, what is your scope of service? How do you look at information as an asset and how do you see your role in it as the HIM professional? That is your job, to protect patient information,’” Lawler says. “Build a governance structure on the goals you want to accomplish.”

Michele O’Connor, MPA, RHIA, FAHIMA, director of sales operations, identity and information governance at QuadraMed, says that despite what surveys may show healthcare has been ready for IG for decades. “I think we continue to want to take shortcuts that despite what surveys may show healthcare has been ready for IG for decades. “I think we continue to want to take shortcuts that despite what surveys may show healthcare has been ready for IG for decades. “I think we continue to want to take shortcuts that despite what surveys may show healthcare has been ready for IG for decades. “I think we continue to want to take shortcuts that despite what surveys may show healthcare has been ready for IG for decades. “I think we continue to want to take shortcuts that despite what surveys may show healthcare has been ready for IG for decades. “I think we continue to want to take shortcuts that despite what surveys may show healthcare has been ready for IG for decades. “I think we continue to want 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Those shortcuts she’s referring to include record retention and disposition policies that HIM departments typically set up, “but they’re not coordinated across the organization and they’re not tied to organization-specific initiatives but rather tied to systems that are up for specific purpose. And most importantly, I don’t really see a broad C-suite involvement,” she adds.

Pleading Your IG Case

When the Obama administration pitched the idea of healthcare reform to the American public, it started with informal discussions in individual voting districts, publishing editorials in newspapers, and appealed to young people on social media networks like Facebook and Twitter. When it came time for legislators to vote on the law, their constituents had plenty of time to evaluate the law’s proposals and let their representatives know how they felt. Additionally, since the ACA is being rolled out over a period of several years, stakeholders have had time to adapt and anticipate changes headed their way.

HIM professionals should take the same tack in pitching IG to the C-suite and other departments by making a business case for it, says O’Connor. To do that, however, a leadership chain or task force must be established in order to include the right people across the enterprise. Potential task force members include individuals from IT, legal, compliance, security, and HIM.

She notes that an IG program should aim to braid together all of the relevant information one needs for a patient, including clinical data, social data, and business and financial data, and make it accessible to whoever may need it at any time.

“I’m a fan of start small and think big in terms of enterprises. Start to create this culture. Determine what your blueprint is and where you expect to go,” O’Connor says. Once that blueprint—or framework—is laid, the next step is making those proposals measurable. It’s also important to keep in mind that IG projects don’t have an end date—they are continuous, O’Connor emphasizes.

LifePoint Health, a Tennessee-based provider network serving rural communities, tackled IG by establishing an IG council, the formation of which was led by LifePoint’s legal department.

“This provides a solid foundation for building out an IG program, because some of the core challenges faced by most IG programs typically surface when litigation activities are underway,” says Joe Ponder, vice president of information governance at LifePoint Health.

The council, which includes members from the legal, compliance, IT, HIM, finance, human resources, and other departments, meets once a month. To start an IG program, Ponder says, IG needs to be a priority for the business. “Ironically, one of the main drivers for IG has been the impact of not having an IG program,” Ponder says. “It can be hard for the business to understand the value that can be realized from well-managed data, but easy for them to see the impact of improperly managed data. Furthermore, it can be difficult for the organization to harness the real power and see the value of information if they don’t understand the data, if it isn’t mapped, managed, retained, etc.”

Practical IG Examples

Early initiatives of the ACA were almost imperceptible to everyday consumers. Those include pay-for-performance programs, the creation of accountable care organizations, and the ability of adults to keep their children under the age of 26 on their own insurance policies. However, once the insurance marketplace and mandates to purchase insurance hit the scene, Americans had a more tangible sense of how the law would affect them.

Institutional IG programs function this way, too. Ponder empha-
New Survey Shows IG Adoption Lagging in Healthcare

AHIMA AND COHASSET Associates recently conducted a new survey to measure the readiness of healthcare professionals to address the technical and strategic demands they face, as well the opportunities that manifest as they work to advance information governance (IG) in their organizations. The survey and subsequent white paper was underwritten by Iron Mountain and Nuance.

The survey went to healthcare and industry professionals such as clinical and non-clinical leaders, officers, directors, and managers in both provider and non-provider settings, as well as AHIMA members.

The chart below represents the survey question “What is your involvement in your organization’s information governance (IG) oversight body, such as a council, committee or working group?”

The survey reveals that progress in IG is relatively immature in healthcare. For example, the survey found that 40 percent of respondents’ organizations do not have an IG council, committee, or working group, and have no plans to establish one.

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>I am the chair of our IG oversight body</td>
<td>21%</td>
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<tr>
<td>I am a contributing member on our IG oversight body</td>
<td>16%</td>
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<tr>
<td>My organization has an IG oversight body, but I am not a member</td>
<td>19%</td>
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<tr>
<td>My organization does not have an IG oversight body, but we are working to establish one</td>
<td>4%</td>
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<tr>
<td>My organization does not have an IG oversight body, and no efforts are underway to establish one</td>
<td>40%</td>
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sizes that the key to successful IG is not the creation of new practices and policies that support governance, but rather integrating newly defined practices throughout the culture of an organization.

Like many large integrated delivery systems, LifePoint is rapidly acquiring new hospitals and practices, which presents the challenge of trying to standardize the patient records that come with each acquisition. With the help of policies created by their IG council, LifePoint developed a strategy for managing those newly acquired paper and electronic records.

LifePoint started this process by focusing on simplifying retention schedules. “We decided that our legacy schedules were too detailed and needed some enhancements to reflect the growth and change that has occurred throughout LifePoint Health since they were first drafted,” Ponder says. “We have put a lot of effort into simplifying these schedules to ensure that they are easier to understand and implement. Furthermore, we have started working with our preferred records management vendors to integrate these new schedules into their physical records management solutions to ensure that paper records are being properly managed and destroyed.”

KJL Consultants’ Lawler says a common IG activity she’s been involved with is patient portal governance—that is, getting patients to sign up for a portal and interact with it. The first step, says Lawler, was taking a step back and asking: who are the owners of this process? “What type of messaging do we need to collaborate on and control, and what kind of consistent process do we need to develop? The great opportunity for the HIM team was truly to own what we already do. We already communicate with patients about patient information and take it to that next step. And it’s been very successful. The reported metrics of how the patients are engaged have tripled,” Lawler explains.

Furthermore, Lawler says that to get IG off the ground, HIM professionals and their colleagues just need to continue what they’re already doing and take it up a level. For instance, one IG-related project that Lawler took on was managing the master patient index of 30 different physician practices.

“I said to my CIO at the time, ‘The HIM team can do this, but we’ll be spending a lot of time doing corrections. Wouldn’t it be better if we spend a lot of time doing corrections, but if we went out there with a model globally to instruct people how to do patient identification and own a piece?’ So we did that. And I did that in partnership with the director of patient access,” Lawler says. “Now over 300 people have that training toolkit. It made a difference when we went live, enterprise wide, all marching to the same beats.”

While true IG should involve a variety of healthcare professionals across an enterprise, HIM is well suited to lead the effort, especially as IG initiatives fall increasingly under their purview.

“Governing our information will not replace managing it and there will still be HIM and HIM roles,” says AHIMA’s Green. “There will certainly be multiple new and evolving roles in information management, and data and information governance. We do believe that IG in healthcare must encompass all information, not just health and/or clinical information.”

“We also believe that HIM professionals who are qualified to be senior leaders can certainly lead information governance.”

Note


Mary Butler (mary.butler@ahima.org) is associate editor at Journal of AHIMA.
GETTING STARTED WITH INFORMATION GOVERNANCE

WHAT ARE YOU WAITING FOR?

TAking a simplified approach to information governance

By Suzanne Goodell, MBA, RHIA; Lesley Kadlec, MA, RHIA; Karen Lawler, RHIA, CHPS; and Valerie S. Prater, MBA, RHIT
ARE YOU DROWNING in data and information? Do you feel as though your organization has lost its logical approach to the management of health information? As we continue to embrace the transformation that healthcare is undergoing, we recognize that electronic health records (EHRs) and other digital information play a leading role. The US healthcare industry is now truly in the post-EHR era. Healthcare today is undoubtedly far more information-intensive than just a few short years ago.

But EHRs are far from perfect. There are issues with too much data, duplicate data, inaccurate data, and lack of a single unified approach to creation, use, and disposition of data and information across the organization. The challenges are many, but the solution is not to go back to paper. The governance structures that were in place in the paper environment can be used as touchstones for information governance (IG) in the electronic age. Just as medical records and forms committees governed paper records, governance must expand to encompass all types of data and information—regardless of format—created throughout the healthcare organization. The good news for the professionals facing this challenge is that there are opportunities to address the issues through development of strong information governance practices in healthcare.

Our New Opportunity: HIM Leading IG in Healthcare

As healthcare organizations move away from a focus on volume toward the value proposition, executive leaders need quality information that contributes to effective planning and decision making more than ever. Executive leaders require accurate information to:
- Establish a single source of truth for publicly reported quality measures
- Perform health risk stratification of managed health populations
- Initiate and manage interventions for population health
- Give providers feedback data on clinical performance
- Marry cost and clinical data to measure value
- Negotiate at-risk contracts

Healthcare organizations must establish a governance framework to supply the right information at the right time to the right people. One way for HIM professionals to get started: assemble a team of executive leaders and key stakeholders for the organization’s IG initiative—whether it’s population health, reportable quality measures, or establishing provider feedback on clinical performance. Make the case for defining and governing information critical to the initiative’s success. Ask to create a subcommittee to focus exclusively on information governance for the initiative.

This core team must identify key information requirements critical for success, do a gap analysis, establish sources for missing data, and disregard other data that is not critical to business success. Once the team identifies the information to be governed, define the steps that are needed to set up the governance framework. It is important to keep the governance initiative focused on data and information that are required to drive business strategy.

An example of how to begin an approach to a population health initiative is detailed below:
1. Assemble a subcommittee of key stakeholders.
2. Assess the current state of the information available to manage the health of specific populations. Inventory the data available to stratify the members of the population you are managing. This could be patients covered by an accountable care organization (ACO), the uninsured population, or Medicaid patients. Do you have the appropriate data to identify which patients are healthy, have rising risk, or are at high risk for health crises?
3. Next, determine what data are required to develop and evaluate the effectiveness of clinical interventions.
4. Identify a future state, do a gap analysis, and develop a plan for how data required for business success will be created and governed.

Start IG Approach with Existing Committees

Creating a new committee may be met with resistance, and be unproductive. Instead, leverage an existing committee structure and expand their scope to include information governance. Consider drafting a discussion document for the committee’s leadership to use in laying the groundwork for IG. Collaborate with other team members to identify critical processes that require governance oversight, eliminate the silo effect of one area being responsible for corrective action, and recognize that failure to operationalize in a collaborative manner will further compound errors and delay advancement and integrity of information. Ideal committees to begin this discussion and further develop IG processes include:
- **Core measures committee**: Concurrent identification of potential issues; develop robust reporting tools for continuous improvement rather than retrospective correction. Align with clinical documentation improvement activities, potentially combining two committees into one governance structure.
- **Content and records management committee**: Consolidate tasks through the EHR, leverage and educate team members for changing roles. Consider opportunity to develop IG structure with human resources and IT as a collaborative process for future state of patient information capture.
- **Patient engagement committee**: HIM professionals are uniquely positioned to identify issues preventing patients from increasing interaction with their EHR. Identify release of information challenges, portal activity, and availability of information online to the patient. Consider collaboration with patient relations, medical staff, and nursing leadership.

Approaching IG by Identifying a Pain Point

Another way to get started is by identifying a pain point, such as a security breach, litigation, or other issue. HIM professionals are uniquely positioned to lead the information governance journey in their organizations. Many HIM professionals get started by identifying a “pain point”—a strategic issue with which their organization is struggling. What is the biggest problem that people are having difficulty resolving in the organization?

One example of a common pain point in healthcare organi-
zations includes the challenges of “super-utilizers” of inpatient care—repeat visitors to the emergency department with frequent hospital admissions. These individuals have complex physical, behavioral, and social needs that are not well met through the current fragmented healthcare system. As a result, these individuals often bounce from emergency department to emergency department, from inpatient admission to readmission—all costly, chaotic, and ineffective ways to provide care and improve patient outcomes.

Goals of a new approach would include using data to:

- Improve efficiency and quality of care
- Reduce fragmentation of care
- Reduce population health risk and improve health outcomes
- Avoid financial loss/penalties for the organization under new reimbursement models

Using data to address a problem means more than collecting data. Healthcare providers need to take the story to the next level using a logical approach to effect information-driven change. Information governance will assist in managing the information securely, privately, and appropriately as “pain points” are addressed by healthcare organizations.

For descriptions of interdisciplinary approaches to the super-utilizer challenge, both of which rely on data collection and analysis for success (i.e., patient identification, risk assessment, utilization and cost tracking, and care plan development), visit the websites below:

- University of Illinois Hospital and Health Sciences Sys-

Defining HIM’s Role in Information Governance

One way HIM professionals can get started with information governance is by pulling together a group of stakeholders, IG champions, and department leaders who can work collaboratively to solve an identified challenge or “pain point,” as discussed above. Use the success with this initiative as a model for future information governance initiatives.

Some suggestions for roles for HIM in the IG initiative include:

- Educating organizational leadership, highlighting a business need for IG
- Work with leadership to incorporate IG into the agendas of all ad hoc and standing committees; HIM professionals are well-qualified to be a participant and lead the conversation on this subject
- Serve in the role of data steward for patient data
- Identify areas of opportunity and quantify potential positive impact of an IG initiative (financial, quality, risk)
- Perform a current state assessment and look for gaps in policies and procedures
- Assist with strategic IG planning

The expertise that HIM professionals have today, coupled with the knowledge and confidence to lead others, can serve as the foundation for new roles in healthcare information governance. HIM experts are prepared by their training and experience in information management to succeed in governance of any and all types of data and information.

HIM professionals must challenge themselves to move to a proactive role, shifting their way of thinking to get in the driver’s seat as IG leaders. HIM should not wait until we are in a position of having to remediate a problem, such as a major privacy breach.

HIM professionals have always managed legal, risk, and regulatory issues and are familiar with the information technology and how to use it efficiently. The challenge is to take this a step further, working with all information assets that are critical to business continuity and profitability of the organization.

According to the findings in a recent white paper from AHIMA and Cohasset Associates, 65 percent of those surveyed either did not have information governance plans in place or did not know whether their organizations had plans in place. While IG is not limited to the patient information generated, maintained, and stored throughout the organization, HIM professionals can begin by developing a patient information roadmap, which will contribute to the development of an enterprise-wide governance structure and strategy.

IG Resources from AHIMA

To support the journey into IG, AHIMA is building a comprehensive IG framework with tools, guidelines, and other resources for healthcare organizations to utilize as they embark on an IG initiative. As part of this effort, AHIMA has introduced the Information Governance Principles for Healthcare (IGPHC)™, healthcare
industry-specific IG principles adapted from ARMA International’s Generally Accepted Recordkeeping Principles. In addition, along with Cohasset Associates, AHIMA published the 2014 Information Governance in Healthcare Benchmarking White Paper based on the results of the first industry survey of IG practices. AHIMA is developing additional guidelines, resources, and tools that will help healthcare organizations put IG into practice. AHIMA is continuing to launch additional educational programs and webinars to help healthcare professionals gain knowledge about the IGPHC and the introduction of IG into healthcare.

A Way Forward for Healthcare

Healthcare is virtually drowning in data. But this challenge presents an opportunity for HIM professionals to help executives and healthcare leaders call out, identify, and take a leading role in identifying what information has value as HIM manages the transition:

- Healthcare needs good information—it must be trustworthy and actionable.
- Too much information is not good—retention and disposition are both important aspects to manage as a part of solid information governance.

Remember that IG is not an end unto itself; the goal is to achieve a state of trust in healthcare information such that safe, quality care and effective decision making are enabled and that patients, business partners, and other stakeholders can rely on the information.

Notes


References


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OWNING the EHR and INFORMATION GOVERNANCE at Your Facility

By Erin Head, MBA, RHIA, CHTS-TR
FOR MANY DECADES, health information management (HIM) departments have been the hub for information collected within healthcare organizations. HIM has frequently been referred to as the “medical records department” due to the perceived idea that the department’s main tasks are receiving and storing information to file on a shelf or put into storage.

Behind the scenes, HIM has always been at the forefront of impacting documentation compliance with an emphasis on health information integrity through analysis, as well as accurate reimbursement through coding. But HIM can no longer operate behind the scenes in today’s healthcare environment.

With paper-based medical records, health information typically flowed from clinical departments, where the information originated, to its home in the HIM department to be completed and coded, and then up through the revenue cycle to be processed for billing and reimbursement. This traditional flow of health information had typically been in a non-cyclical pattern. Most of the health information was gathered and put away under lock and key and stored for years without being easily accessible. This method of storing health information with minimal contact or use is no longer a relevant practice in the rapidly advancing healthcare realm. HIM departments must adapt and develop new skills to appropriately meet the needs of the US healthcare system.

Technology advances and a push for making data accessible “now” compels HIM departments to serve the organizational and population needs in a cyclical pattern which is necessary for impacting the constant challenges and changes in healthcare. These changes must be embraced by HIM professionals in order to remain relevant. Many HIM professionals have found themselves having to reestablish their “turf” when it comes to informatics and traditional HIM functions, in terms of HIM “owning” or “being at the table” for electronic health record (EHR) system implementation/governance, data analysis, and other informatics roles. HIM professionals may be wondering how to successfully transition the old-fashioned “medical record department” functions to align skill sets with the needs of today’s data-rich environment.

Invest in HIM Now to Gain Future Roles
The “meaningful use” EHR Incentive Program initiatives have led to many projects that aim to improve quality, safety, and efficiency, reduce health disparities, improve patient engagement, improve care coordination, and strengthen the privacy and security of health information. As a result, EHR implementation projects have been popping up across the healthcare spectrum. HIM professionals must be at the table throughout the continuum of EHR implementation including vetting, testing, modifying, improving, and training users on an EHR system.

Organizations are investing in training for clinical staff to garner new technologically advanced skills and pulling clinical staff from direct patient care positions to serve in new roles centered on informatics and EHR governance. HIM leadership and senior organizational leadership must also invest in enhanced training for HIM professionals to develop the appropriate skill sets for improving clinical EHR workflows and using data analytics for healthcare quality improvement. This training could be offered in a variety of settings, including college or university courses, certificate programs, vendor-specific training, or online webinars. Developing HIM professionals’ skills is a worthy investment in ensuring HIM involvement, leadership, and ownership of major projects and initiatives.

Move On or Get Left Behind
If a HIM department is still operating with the standards of days gone by, there is an imminent need for change. Creating a reorganization plan and communicating the potential impact of any changes on the horizon to key stakeholders within an organization will help HIM directors and managers pave the way for new and exciting accomplishments in the HIM department.

Metrics and visual presentations should be used in the reorganization plan to explain how the changes are going to promote efficiency and allow better use of information. Regardless of an organization’s reporting structure, a plan will be well received if it is presented in an organized, impactful, and strategic fashion.

New positions within the HIM department may need to be created by identifying any significant job duties and projects that are not currently being accomplished by existing staff. HIM professionals who once worked with paper medical records may have become underutilized as paper processing tasks have dissolved with EHR implementations. Existing job descriptions will need to be revised to include EHR workflows and tasks related to data analysis. These new positions and roles also create great opportunities for new HIM graduates to be welcomed into the field.

The core curricula for CAHIM-accredited education programs place emphasis on training future HIM professionals in key domains including health data management, information systems, administrative and clinical workflow, and informatics. AHIMA credentials further validate these competencies by having HIM professionals prove their understanding through best practice application and critical thinking assessments. Thus, it is important for HIM departments within organizations to recruit and further develop educated HIM professionals to build on the foundation provided by the education and credentialing. Key stakeholders must be made aware of the diverse competencies that HIM professionals possess. Human resources associates must be educated on recognizing HIM education programs and AHIMA credentials and should align these abilities with appropriate competitive compensation.

Seasoned HIM professionals, including coders, should focus on sharpening their skills by obtaining continuing education in technology, external forces, and performance improvement among the other HIM domains. Doing so will expand the knowledge of existing HIM professionals and allow the HIM department to keep current with the rapidly changing healthcare environment.

Don’t Wait to Be Invited
When a new project is being introduced to an organization, it is a great opportunity for HIM professionals to acquire new responsibilities and skills. HIM should step in and take ownership of projects, especially those involving templates and other documentation tools such as speech recognition. Setting up the EHR to capture documentation specificity is important to en-
suring the information needed for accurate coding and reimbursement is captured proactively while the physician is documenting within the chart.

Inserting HIM professionals into technology-driven projects such as an EHR implementation may seem like a daunting task, but HIM professionals are the stewards of the medical record content and therefore participation in these projects is critical. While HIM professionals may not always be the builders of the content in the EHR system, HIM input must be sought on what is built and how it will be implemented. HIM department involvement in training physicians to use these documentation tools is vital to ensuring the information is where it should be when and where it is needed. HIM must also be involved to ensure the data generated from an EHR can be analyzed and turned into useful information for quality of care, correct reimbursement, and operational efficiency.

HIM Must Know How to Use Data
As with any business, data has become a major component in analyzing past, present, and future performance in healthcare organizations. Enhanced technology has led to the creation, abstraction, and analysis of dynamic data from many sources in a rush to meet the demands of regulatory agencies, meaningful use, federal payment sources, healthcare reform, research initiatives, and overall population health. Data are also being relied upon for measuring quality outcomes, classification and coding systems, and reimbursement algorithms—and these areas are especially aligned with the skills of HIM professionals.

As a result of the push for data and information, many tools have been developed that can assist in abstracting and analyzing healthcare data. HIM professionals must take ownership of the task of gathering meaningful data and must understand the technology needed to govern this data throughout its lifecycle. Combining EHR technology, reporting tools, and multiple sources of data creates the perfect opportunity for HIM professionals to present the case for owning this information.

Get Involved with IG
One of the ways to accomplish this is for HIM professionals to develop an information governance (IG) task force or committee within the organization. IG is defined by AHIMA as “an organization-wide framework for managing information throughout its lifecycle and for supporting the organization’s strategy, operations, regulatory, legal, risk, and environmental requirements.”

HIM professionals must take a leadership role on the IG committee. The first step to starting the IG process is to identify key departments within the organization that are needed to serve on the committee, including areas such as clinical workflow and informatics, revenue integrity, decision support and finance, compliance, quality resources and risk management, information systems, research and strategy, and senior leadership.

All of the data that is generated from clinical, financial, and operational sources must be modeled into information that can serve many different strategic purposes. As the leaders of IG, HIM professionals can ensure information is available for access through health information exchange (HIE), consolidated for reporting metrics to external sources, and analyzed for internal process improvements while also keeping the information secure and protected.

Own the EHR and IG, Or Someone Else Will
These initiatives are only the beginning of what is to come in the US healthcare system. HIM professionals must act as the experts in gathering information generated at the individual patient level within the EHR, analyzing aggregate patient population data, creating reports for examining documentation compliance, preparing data for health information exchange (HIE), trending financial and reimbursement data, protecting the confidentiality of protected health information, and many initiatives yet to come. HIM professionals must embrace all of the new healthcare changes and enhance skills wherever necessary to keep up with the ever changing healthcare environment. These tasks and future initiatives must be owned by HIM professionals because if they do not step up to govern the information and all of the surrounding implications for using healthcare data, someone else will.

Note

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The ‘Keys’ to Help Solve Patient Data Matching

By Michael L. Nelson, DPM
ACCURATE PATIENT DATA matching is a critical patient safety issue. Overlays that comingle the medical information of two or more people may lead to disastrous adverse medical events and duplicate medical records, which may be fragmented and incomplete and can limit the effectiveness of treatment plans, resulting in less than optimal outcomes.

Patient data matching is also a fundamental core building block for interoperability and health information exchange. After all, what good is it to have disparate electronic medical records speak the same language if they don’t know who they are talking about?

Overlays, mismatches, false positive matches, and false negative matches have plagued the healthcare industry for decades. In spite of the widespread deployment of master patient indexes (MPIs) with sophisticated matching algorithms, a 2008 RAND report noted that, on average, an eight percent duplicate record rate existed in the MPI databases studied.1 The average duplicate record rate increased to 9.4 percent in MPI databases with more than one million records. Additionally, the report identified that the duplicate record rates of the enterprise master patient/person index (EMPI) databases studied were as high as 39.1 percent. According to a 2012 College of Healthcare Information Management Executives (CHIME) survey of healthcare CIOs, error rates due to patient mismatching averaged eight percent and ranged up to 20 percent.2

There are a number of reasons that may lead to high duplicate medical record rates, such as: multiple information systems and databases, merger and acquisition data consolidation, health information technology/electronic health record (EHR) upgrades or replacements, and poor or no system integration.

The biggest culprit, however, is poor data integrity, including:
- Non-standardized data
- Missing or inaccurate data
- Old data
- Name, address, or phone number discrepancies
- Aliases
- Data entry errors

Healthcare organizations may not have the ability or resources required to manage changes to patient demographics, and the effectiveness of MPIs is limited due to unreliable data.

Take, for example, a case in which a female patient returns for care at a single healthcare system after a five-year hiatus. During that time away she has gotten divorced and reverted to her maiden name, moved to her own apartment, and changed employers. This presents a challenge to the organization, which must match her medical record to the original record created five years earlier.

Another example at the macro level could be that of a “snowbird,” an individual who lives and receives medical treatment in their northern home state during the spring and summer and lives and receives medical treatment in a southern state where they reside during the winter. The difference in residential addresses may be a challenge for matching records across the different states.

Organizations including the Office of the National Coordinator for Health IT (ONC), CHIME, AHIMA, and the American Hospital Association have all called for a better way to solve the patient data matching dilemma.

A compelling patient matching strategy would include implementation of a four-pronged, comprehensive approach that:
1. Cleans up the MPI
2. Improves ongoing data integrity
3. Authenticates patient identities
4. Verifies that an authenticated identity belongs to the patient

Cleaning Up the Master Patient Index—‘It’s All About the Data’

MPI cleanups can be quite costly for records that cannot be automatically merged. Time-consuming manual processes are needed to help resolve many questionable medical record matches that require human intervention due to inaccurate, missing, out of date, and/or conflicting demographic data. A practical solution to this data integrity problem is to leverage third party Big Data referential databases and keying technology.

There are a handful of organizations that maintain national databases of individuals that generally include current and historic name, address, and phone number information. These Big Data companies monitor and maintain this information as a business-critical process. When considering such a Big Data company, one should investigate the sources they rely upon for their information. A Big Data company that receives information from financial institutions, the utility industry, and the telecommunications industry generally has more current name, address, and phone information because these sources are consistently conducting financial transactions with their customers. Even though an individual may be “underbanked” with little or no credit history, this person may still pay a utility or cell phone bill.

Maintaining a national database of consumers requires assigning a unique key to the consumer that can be matched to a patient and/or member database so as to facilitate matching patient/member data for providers and payers at both the micro and macro levels. Deterministic matching to third party Big Data, which contains current and historical information about addresses, aliases, and name changes, can be leveraged to assist in dramatically increasing match rates and decreasing the number of questionable matches, resulting in potential lower cleanup costs. This solution does not suggest completely replacing the traditional MPIs in which healthcare organizations have invested a great deal of time and money. Rather, the organization can submit its patient record files to a third party Big Data company for matching and keying against that company’s database.

The potential output would be a more accurate list of unique patients along with a unique “key” that can be consumed by the MPI and utilized as a weighted additional matching attribute to help enable auto-merging of a much greater number of duplicate records. This could significantly lower the potential cost of an MPI cleanup.

There has been much debate over the subject of a national patient identifier. Although the concept was conceived and written into the original HIPAA law, privacy and consumer groups have asked the federal government not to fund such an endeavor. There is now a movement in Congress to stop using Social Security numbers on Medicare cards and institute a new Medicare enumerating system for improved privacy and accuracy. Although the federal government has not pursued a national
patient identifier, there is no reason that the private sector cannot pursue alternatives to address the issue. For example, a Big Data company’s unique “key” for each unique person in its national consumer database, when matched to a patient’s medical record at disparate health systems, can facilitate patient data matching across those systems.

**Improving Ongoing Data Integrity**

Once the MPI is cleansed, it is vital that it be kept clean moving forward by capturing accurate data at registration. Optical character recognition of identifying documents such as driver’s licenses can help eliminate transcribing errors. Instituting policies that require capturing specific data elements in specific formats will also assist to keep the MPI clean and help prevent the creation of duplicate medical records. For missing or questionable demographic data, the third party Big Data companies can offer one-stop shop web service lookups of current and historical demographic data. Such a web service can be valuable when there are language barriers or to help prevent the creation of duplicate medical records in the emergency department when patient registration may be secondary to patient care.

**Authenticating Patient Identities**

Fraud in healthcare is growing—particularly identity-based fraud. At registration, patients must confirm that their identity is real. Synthetic identities can come in multiple guises. For instance, it is possible to fabricate a completely new false identity with phony demographics and identifiers. Another identity thief might use real demographic and identity information from multiple real people to create a new false identity. A web service call from registration to a credit bureau can often help authenticate whether or not the identity is real.

**Verifying That an Authenticated Identity Belongs to the Patient**

Once the registrar authenticates the identity, the next step is to verify that the identity belongs to the person who is registering for services. There are various options to do so—in face-to-face registration usually the patient is asked for a government-issued photo ID. In most cases this is a driver’s license that then is scanned into the electronic medical record. However, care should be taken to ensure that the ID itself is not fraudulent. Suppose the patient does not have a government-issued photo ID, or there is something questionable about the ID the patient presents. An effective alternative identity-proofing solution is to ask knowledge-based authentication (KBA) challenge questions that the patient must answer correctly to prove their identity. KBA questions should be based on information that may not be publicly available, making it more difficult for a fraudulent patient to answer correctly.

Biometrics, smart cards, and unique patient identifiers can help prevent the creation of overlays and duplicate medical records from the day they are implemented. However, the healthcare organization should attempt to validate a patient’s proof of identity prior to issuing him or her a biometric, smart card, or unique patient identifier. There should also be a linkage to historical medical records at the facility. Do not underestimate the importance of medical history. One must know where one comes from before determining which path to take.

**Bringing it All Together**

Accurate patient data matching is a core element in building a foundation for interoperability and health information exchange, and is a critical component of patient safety. A comprehensive patient data matching solution should include third party Big Data referential databases and technologies to drive processes that link historical medical records, biometrics, smart cards, and unique identifiers to the patient wherever the patient seeks treatment. O

**Notes**


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WHILE SOME HEALTHCARE organizations have made progress in formalizing information governance (IG) programs, many remain in the infancy phase of planning and implementation. At the 2015 Annual HIMSS Conference and Exhibition, the session “Seven Opportunities for Stronger Information Governance” attracted 800 attendees. Of the 400 attendees who had initiated a program, fewer than 20 said they were 25 percent of the way through implementing their programs, according to estimates given by meeting organizers. Challenges included leadership support, proving a need for IG, education, planning, and monitoring.

As healthcare continues the transition to an electronic environment, enterprise information governance must pick up the pace. Poor IG practices affect quality of care, patient safety, compliance, and financial performance. Information is a strategic asset that requires effective IG practices.

In a roundtable discussion led by Rita Bowen, MA, RHIA, CHPS, SSGB, senior vice president of HIM at HealthPort, HIM professionals discussed the status of organizational IG and data governance implementation, challenges that hinder progress, and strategies for securing support and charting a course for the future.
Rita Bowen: Where is your organization in the process of implementing information governance?

Cindy Phelps, RHIA, director of HIM at Carilion Clinic’s technology services group: We’ve adopted a data governance framework that builds on AHIMA’s IG principles, but have not begun full implementation. As an initial step, we established data definitions to ensure consistency throughout the organization. Additionally, IT governance, data stewardship, data quality, and policies alignment are quickly developing. It’s a work in progress, with a solid foundation.

Maria Muscarella, RHIA, assistant vice president, HIM, EMR and privacy officer at Newark Beth Israel Medical Center: We’re in the early phase as well. Our EMR [electronic medical record] has been up and running for a year and a half, and we’re currently introducing IG at the traditional medical record committee level.

Bowen: In your experience, what are the main challenges to initiating an IG program?

Muscarella: Getting everyone to understand why we need IG is a hurdle. Prior to implementing the EMR, many were under the impression that it would cure all that was wrong in the paper world. However, like most organizations, we’ve identified new issues with the EMR. The integrity of the record has taken on a life of its own, one that requires enterprise-wide governance and management.

Phelps: Securing leadership support is a key challenge. Without top-level involvement, we have no chance of succeeding. Providing education is also important for adoption. We’re in the process of educating everyone in the organization about IG, seeking every opportunity to give presentations at management meetings to make the case. Alignment with similar programs is essential to longevity. If competing programs drift, rather than converge, IG may suffer unrecoverable collateral damage.

Muscarella: Another pressing challenge is that we want to avoid adding another committee. We need everyone who documents in the record to own IG—physicians, nurses, and other ancillary disciplines. As HIM professionals it is our role to ensure that clinicians understand the importance of concise, clear, quality documentation. In so doing, we also have to make it as user friendly as possible, so that time spent caring for patients is not diminished by time spent documenting.

Bowen: What is the role of HIM in the process? How are they taking the lead in IG?

Phelps: I’m not as involved in the IG project as I would like, though I keep pushing. HIM professionals have to be assertive to assume a lead role. I am primarily involved in security governance which falls within the overall IG program. I do see HIM roles changing, increasingly embedded throughout healthcare organizations like Carilion Clinic, a multi-specialty system including six hospitals and six HIM departments. The opportunities are there for HIM to guide IG implementation.

Muscarella: I see HIM taking a lead role. In our organization, I’ve engaged the medical record committee as a vehicle for getting started. While it’s a multidisciplinary group that looks at basic documentation discrepancies, I don’t see it becoming the IG team. We need a dedicated IG group to identify and address the complexity of documentation challenges. We’ve performed qualitative reviews to focus on issues from a data integrity perspective. We also have a significant role with IT, working hand in hand to identify IT issues that are hindering progress. HIM is definitely steering the effort.

Bowen: Do you have executive support, and who are your most valuable champions?

Muscarella: The CMO and medical department chairpersons, along with the assistant vice president of standards and the assistant vice president of quality will play an active role as champions of the IG initiative.

Phelps: We have strong executive support from our chief strategy officer, chief operating officer, chief financial officer, chief information officers, and chief medical information officer. Working closely with HIM and other disciplines, they have emerged as our most valuable champions.

Bowen: How do you engage senior leadership?

Phelps: Senior leadership evolved through the CMIO, chief strategy officer, and an IT director who is passionate about data governance and has helped drive IG for the organization. We have to show how IG enables the organization to set strategic priorities and achieve its goals, such as quality of care, cost reduction, compliance, improved outcomes, and accurate reimbursement.

Muscarella: HIM must be assertive to be heard amid competing priorities. This is a challenge. Patient safety is a priority for all disciplines at all levels. There is a strong focus on core measures, as well as the patient safety indicators. Given such quality initiatives, it is the perfect platform to move into the data governance realm. We’re strengthening the effort, engaging clinicians who are already pro quality and patient safety—clinicians who understand the importance of quality documentation. As a result, the chairperson of the patient safety committee and chairperson of the department of surgery have also stepped up as key leaders.

Bowen: Discuss the importance of collaborative leadership and creating a multidisciplinary team.

Phelps: Enterprise-wide collaboration among disciplines is critical. Our multidisciplinary team includes quality, auditing, reporting, medical management, privacy and security, compliance, and IT. The emphasis is on three aims: data governance, security governance, and technology governance. Our chief strategy officer is leading projects focused on pay for performance, population health, patient engagement, and others that require governance and management practices. Simply put, IG really comes down to everyone doing the right thing. Bringing the entire organizational family together and sharing in this effort is required.

Muscarella: Having a multidisciplinary team is essential to
Five Strategies for Making the Case for IG

1. **Assess the current information landscape.** Take an inventory of policies, procedures, and systems for capturing, processing, delivering, and storing information.

2. **Secure executive support.** Show the business value of IG as a strategic asset. Focus on organizational goals—quality of care, cost reduction, compliance, improved patient outcomes, risk mitigation, accurate reimbursement.

3. **Engage a multidisciplinary team.** Include all stakeholders—members from HIM, IT, compliance, C-suite, revenue cycle, legal, and risk management to promote partnership. Establish IG priorities and best practices.

4. **Identify opportunities for collaboration.** Participate in board meetings, intern programs, and events. Find a champion—CFO, CEO, CIO, CMO, compliance officer, or other executive leader in the organization.

5. **Create a plan for implementing AHIMA’s Information Governance Principles for Healthcare™.** With decades of experience as data stewards, HIM professionals must use their unique competencies to advance enterprise-wide IG.

Bowen: How are you working with IT to achieve IG?

**Phelps:** I have the security governance piece—oversight and controls of information flow, how information is requested and provided. IT is driving the information governance effort with a primary focus on shared enterprise-wide partnership and accountability. It is important to note that our CIO and other executive champions support all aspects of IG, not just the privacy and security components.

**Muscarella:** In our organization, teams at the corporate level look at EMR data from a structured perspective—templates, documentation. All change requests are channeled through a dedicated change request group to ensure standardization across the board at a local level. We work closely with IT to ensure any issues are addressed immediately.

Bowen: How can HIM professionals help make the case for IG?

**Muscarella:** It’s up to HIM to demonstrate why governance is necessary, how to get there, and develop an effective IG process that is functional and makes a positive difference. Our role requires bringing a multidisciplinary team to the forefront to prove the value of information governance. HIM must be active, assertive, informed, and keep pushing to be heard. Some of the data integrity challenges we face are the result of not being at the table when systems were developed and rolled out. Taking a seat at the development table—invited or not—is critical.

**Phelps:** With a strong clinical, regulatory, and financial background, HIM professionals have the knowledge and expertise to lead an interdisciplinary approach. HIM is well positioned to help senior leadership make the case for IG. HIM knows how information is collected, where it’s going outside the organization, and how it is used during the patient stay and after discharge. We bring unique talent and experience to the C-suite table.

Bowen: What challenges do you see ahead, and how should HIM assume a leadership role?

**Phelps:** One big challenge is the acquisition of ambulatory practices. As these offices are on-boarded, HIM plays a key role incorporating records from other systems. HIM leadership is essential in this process. I’ve invested a significant amount of effort reaching out to help establish best HIM practices, assisting with standardization—setting up ROI processes and transferring paper records to the EMR.

**Bowen:** This is definitely an avenue for the expansion of HIM leadership roles. Many larger systems are establishing a service line for HIM across all settings, versus a single department as in the past. This is being done through knowledge of information governance.

**Muscarella:** From a larger perspective, we don’t know how data will be used in the future. With ICD-10, data quality becomes even more critical. EMR technology is in the early stages of development, much like a Model T Ford versus the vehicles of today. We can’t be sure where we’re going with all the data collection. That’s why it is so important for HIM to serve as responsible stewards and leaders of IG, managing information assets for all stakeholders as we bring the future of health data forward.

**Bowen:** Yes, and if we don’t get the foundation right internally, we are at risk of having government regulations manage healthcare information for us.

Looking to the future, AHIMA recently announced plans to launch pilot projects in which organizations will use the IG principles and IG maturity self-assessment in actual practice. AHIMA has also recently completed another IG survey focused on professional IG knowledge and readiness, along with organizational progress in implementing IG practices.

HIM professionals have an ideal opportunity to guide enterprise-wide information governance and management for their organizations. Now is the time to lead the way as catalysts for change—making the case for IG.

Acknowledgement

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POLICY AND PROCEDURE CONSIDERATIONS FOR HEALTH INFORMATION EXCHANGE ORGANIZATIONS
POLICIES AND PROCEDURES govern the operations of health information exchange (HIE), and many factors must be taken into consideration during their development or revision. They set expectations for the workforce, delineate staff training and accountability, and must be part of an ongoing education and compliance program, enforced by leadership.

A health information organization (HIO) is defined by the National Alliance for Health Information Technology as “an organization that supports, oversees, or governs the exchange of health-related information among organizations according to nationally recognized standards.” Ensuring compliance can be a daunting task, especially related to HIO participation agreement requirements and federal and state laws with corresponding and existing policies and procedures.

In today’s landscape, healthcare providers may participate in the exchange of protected health information (PHI) either internally within an organization or externally with various HIOs or other key stakeholders.

Existing resources, such as those available through the website HealthIT.gov, the Agency for Healthcare Research and Quality (AHRQ), and the Electronic Healthcare Network Accreditation Commission (EHNAC) accreditation guidelines, provide healthcare organizations and individual health care providers guidance on first considerations when forming or joining a health information exchange. Connecting for Health Common Framework provides a policy matrix that includes strategies for developing HIE policies and procedures with lessons learned.2,3

HIE accreditation through EHNAC ensures compliance that the company has the appropriate administrative, technical, and physical policies and procedures.4 These are in place to ensure the integrity and confidentiality of PHI and protection against any anticipated threats or hazards to the security or integrity of such information.

Health information management (HIM) professionals possess the expertise and experience in developing policies, procedures, standards, and guidelines that add value to effective planning and implementation of HIOs, while ensuring compliance with the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. A collaborative relationship between HIM professionals and clinical and administrative stakeholders will help the HIO achieve successful implementation and sustainability.

The following list takes the existing federal resources into account and outlines additional considerations for HIM professionals to assist healthcare organizations and other key stakeholders—such as individual providers—in identifying issues and developing pertinent HIE policies and procedures.

This sample checklist may be used as a starting point when developing policies and procedures for health information organizations (HIOs). This resource is not a replacement for seeking legal counsel and does not include all possible considerations.

1. Review Existing Policies and Procedures
   1.1 Identify overlaps and gaps. Gather all stakeholders involved in the process to meet and discuss the design.
   1.2 Create an oversight committee structure that is supported and held accountable by the C-suite (senior leadership, executive sponsors, and board of directors).
   1.3 Catalog all current policies and procedures and participation agreements that are related to HIE and prepare for review by committee.
   1.4 Center initial review on any overlap of policy or contractual language that may create operational inconsistencies or potential compliance issues.
   1.5 Review internal organizational policies not related to the HIO that may conflict with HIO policies.
   1.6 Conduct a comprehensive review of all workflows that may potentially interfere with current or proposed policies and procedures.
   1.7 Include associated internal actions within the policy documents for enhanced data integrity and coordination of versioning.
   1.8 Include management of patient’s opt in or opt out decisions.
   1.9 Include general rules of the road for participating in the HIO.

2. Revise Participation Agreements to reflect AHIMA’s Information Governance Principles for Healthcare
   2.1 Adopt AHIMA’s Information Governance Principles for Healthcare (IGPHC)™, adapted from ARMA International’s Generally Accepted Recordkeeping Principles and available at www.ahima.org/-/media/AHIMA/Files/HIM-Trends/IG_PrinicplesPasehxx, and use standardized, non-prescriptive information governance approaches in current and future agreements.
   2.2 Conduct an inventory of all participation agreements within the HCO.
   2.3 Familiarize yourself with the participation agreement requirements.

3. Establish HIPAA Structure for Provider Relations
   3.1 Form an Organized Health Care Arrangement (OHCA), which is an arrangement or relationship, recognized in the HIPAA privacy rules, that allows two or more covered entities (CEs) who participate in joint activities to share PHI about their patients in order to manage and benefit from their joint operations.5
   3.2 Establish joint Notice of Privacy Practices. Covered entities that participate in an OHCA may choose to produce a single joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service delivery sites to which it applies.6
3.3 Complete a Business Associate Agreement (BAA) with each provider. For more information, refer to the Guidelines for a Compliant Business Associate Agreement in AHIMA’s HIM Body of Knowledge.

4. Review Compliance Processes
4.1 Review handling of privacy, security incidents.
4.2 Review breach investigation and responses.
4.3 Review identification of privacy official or person responsible for oversight.
4.4 Review identification of security official or person responsible for oversight.
4.5 Review business associate agreement process.
4.6 Review management of patient data integrity issues identified.
4.7 Review should include requirements for “meaningful use” protection of patient health information from the Office of the National Coordinator for Health IT. Providers must conduct a risk analysis each year to assess the vulnerabilities of their patients’ information, which includes an annual report.

5. Manage Patient Consent
5.1 Check state law requirements, which may specify one consent model option over another and how they relate to authorization.
5.2 Check consistency of consent model being built off the core domains found in the Nationwide Privacy and Security Framework for Electronic Exchange of individually identifiable health information.
5.3 Consumer education is a critical piece regardless of which consent model is adopted. Patients must understand their rights and responsibilities and clearly understand the potential ramifications of including or excluding all or portions of their health information.
5.4 Understand different types of authorization forms, including state level development and management of standardized consent forms.

5.6 Monitor inactivity.

6. Manage Access to PHI
6.1 Provide a standardized consent form to all data sharing partners for consistency.
6.2 Ensure that the consumer consent form is written with varied literacy levels in mind.

6.2 Ensure that the consumer consent form is written with varied literacy levels in mind.

6.3 Review process for requesting, reviewing, granting, and revoking proxy access to health information; adult child, parent, guardian, or significant other.
6.4 Review privacy/security officer reporting and access requirements.
6.5 Review “break the glass” procedures.
6.6 Review identifying and approving access policies and procedures.

7. Other Considerations
7.1 Provide a standardized consent form to all data sharing partners for consistency.
7.2 Ensure that the consumer consent form is written with varied literacy levels in mind.

Above all a collaborative relationship between HIM professionals and clinical and administrative stakeholders is paramount. Equally important is knowing where to start. Developing HIE policies and procedures begins with solid review of what you have to work with, identification of where changes or clarifications need to be made, and then making the necessary changes. Success is sure to follow when HIM representatives are integrated into the planning and implementation process.

Notes

References
AHIMA. “Guidelines for a Compliant Business Associate


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Guiding the Development of Health Information Technology Standards for HIM Practices

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INTEROPERABILITY OF HEALTH information systems will enable clinicians to communicate with their patients and each other using information and communication technology to enable safer, effective, and efficient care, and improve population health. Health information technology (HIT) standards are the key to interoperability. The American Health Information Management Association (AHIMA) has been leading the process to guide the development of HIT standards to support health information management (HIM) practices.

Working with HIT Vendors on Interoperability Standards
Since September 2014, AHIMA has actively worked with Integrating the Healthcare Enterprise (IHE)—an international collaborative of health professional associations and HIT vendors formed in 1998 to develop interoperability standards (specifications such as technical frameworks, integration profiles, and content profiles) for health information systems. By implementing IHE interoperability specifications, information systems realize efficient data capture, management, exchange, and use. The health information becomes standardized, and as a result enables effective and trusted use of information by clinicians, patients, and other stakeholders. Implementation of IHE standards has been successfully demonstrated since 2006 at the Interoperability Showcases of the Healthcare Information and Management Systems Society’s (HIMSS) annual conferences.1

IHE methodology includes:
1. The analysis of business requirements for a specific clinical scenario (use case)
2. Selection of HIT standards developed by various standards development organizations (SDOs) relevant to the use case
3. Assembly (constraint) of these individual standards in the IHE interoperability specifications
4. Testing these specifications at the IHE Connectathons—the annual HIT industry-based interoperability standards testing forums held in North America, Europe, and Asia

The IHE business model is based on engaging healthcare stakeholders (users) with the standard development process by guiding HIT vendors to develop, test, and implement standards-based HIT solutions—thus ensuring that quality health information is available when needed. IHE methodology was approved as the international standard by the International Organization for Standardization (ISO) Technical Committee 215 Health Informatics.2

Recognizing the urgent need for interoperability (i.e., information sharing) between health information systems, including electronic health record systems (EHRs), laboratory information management systems (LIMs), and other information and communication technology products in healthcare and public health organizations, AHIMA joined the IHE collaborative process to guide standardization of HIT products capabilities in order to support HIM practices.

Since September 2014, AHIMA and IHE have collaborated on developing the white paper “HIT Standards for HIM Practices.” This white paper was developed as a part of a globally focused AHIMA initiative on information governance (IG), defined as an organization-wide framework for managing information throughout its lifecycle and supporting the organization’s strategic, operational, regulatory, legal, risk, and environmental requirements.3,4 This IG initiative is a key component of AHIMA’s overall strategy to develop guidelines, operating rules, and standards for healthcare documentation practices. The AHIMA-IHE white paper describes the need, value, and an approach for aligning HIM business practices with the capabilities of standards-based HIT products to support information governance in healthcare.

AHIMA Sees the Need
Adoption of HIT in healthcare brought new challenges for information management associated with electronic data capture and management, record matching and data provenance, access control and information security, and e-discovery and e-forensics, among others. The following high-level challenges with HIT adoption were identified in prominent literature on the topic:

- EHR system design flaws
- Poor system usability and improper system use
- Inappropriate documentation capture
- Errors related to use of clinical decision support systems
- Errors related to faulty support of HIM practices in health IT systems
- Inadequate training

The creation, sharing, and use of electronic clinical documentation requires standardization of both HIM practices as well as HIT systems capabilities in order to support sound documentation practices and techniques that ensure complete, accurate, timely, and quality information. To address challenges that HIM professionals encounter while transitioning from paper-based records to an electronic environment, there is a need to establish cross-collaboration between HIM professionals, standards developers, and HIT vendors focusing on the following efforts:

- Effort 1: Specify functional requirements for HIM practices needed in HIT products via specific use cases
- Effort 2: Communicate these requirements to standards developers for creating HIT standards
- Effort 3: Adopt HIT standards in the HIT products
- Effort 4: Enable operation of standards-based HIT products that support HIM practices

AHIMA’s Solution—Methodology
The AHIMA-IHE white paper “HIT Standards for HIM Practices” was developed under the IHE Information Technology Infrastructure (ITI) Planning Committee. It was focused on Efforts 1 and 2, listed above, aiming to:

- Organize the HIM community in defining HIM functional requirements for HIM practices (use cases)
- Educate HIT standards developers about HIM practices

The white paper outlines a methodology for aligning HIM practices with the capabilities of HIT products through standards—a systematic approach for specifying functional requirements for HIM practices via use cases in order to validate
existing HIT standards and guide the development of new standards. AHIMA’s methodology includes five steps.

- First, driven by the AHIMA initiative on information governance in healthcare, the association focused its work on three out of the eight Information Governance Principles for Healthcare (IGPHC)™, developed by AHIMA and adapted from ARMA’s Generally Accepted Recordkeeping Principles: information availability, integrity, and protection.
- Second, based on the literature review AHIMA identified HIM best practices and formulated HIM business requirements by principle.
- Third, AHIMA further selected HIM business requirements that involved the use of HIT creating HIM practice checklists by principle.
- Fourth, drawn from the checklist’s items, developed use cases to specify functional requirements for HIT standards.
- Fifth, the association conducted the analysis of HIT standards from various standard development organizations relevant to the use cases.

Figure 1 above presents a high-level overview of the methodology deployed. AHIMA deployed requirement elicitation techniques to develop five use cases for HIM needs in the standard-based HIT products under the information availability principle (see Figure 1). They include:

- Use Case #1: All documents are accounted for within a specific time period post-completion of the episode of care
- Use Case #2: Record is closed as complete within a specific time period post-completion of the episode of care
- Use Case #3: Documents within the record can be viewed by or released to the external requestor
- Use Case #4: An audit log of the episode of care record
- Use Case #5: An audit log of requests for release of information and accounting of disclosures

Recruited from various AHIMA volunteer groups, 19 HIM subject matter experts from the hospital, laboratory, academic, and vendor communities participated in the development of the white paper. Figure 2 on page 43 presents various project activities.

The white paper provides:

- An overview of HIM practices for HIT vendors including a description of HIM professionals’ roles (actors), responsibilities (actions), health information (products), and the eight IGPHC principles (availability, accountability, transparency, integrity, protection, compliance, retention, and disposition)
- Detailed analysis of HIM business requirements and best practices checklists related to information availability, integrity, and protection
- Five use cases derived from HIM business requirements and best practices for information availability to guide the development of the functional requirements for HIT standards
- Definitions of terms, participants (actors), processes (actions), and outcomes of HIM practices related to the use cases
- An initial gap analysis of existing HIT standards to support HIM business requirements
- Recommendations for HIM community and standards development organizations for further standardization of both HIM practices as well as capabilities of HIT products to support these practices

Outcome and Continuing Work

AHIMA established a methodology, or a systematic approach, for continued collaboration between HIM professionals and standards developers via specifying: (a) business requirements for HIM by information governance principle, (b) HIM practice checklist derived from the analysis of the business requirements, (c) use cases and functional requirements to support HIM practices in HIT products, (d) HIT standards gap analysis for HIM practices, and (e) recommendations for both HIM and HIT standards developers.

These recommendations define a roadmap for expanding the list of use cases to support business requirements for HIM practices under other information governance principles in the
future as well as developing HIT standards for interoperable health information systems.

The white paper formed a foundation for collaboration between HIM professionals and HIT vendors at IHE ensuring user-needed capabilities in the interoperable, standards-based HIT products. To continue the work in the future, AHIMA anticipates more collaboration with the IHE community expanding work under Efforts 1 and 2 to specify HIM requirements for new HIT standards via developing new use cases, facilitating HIT standards adoption in HIT products (Effort 3) and providing on-going feedback to improve standards-based HIT product capabilities to support HIM practices as needed (Effort 4).


Notes
IG from the Ground UP
DATA INTEGRITY IS at risk any time inaccurate information is entered into the patient health record, starting with the creation of the encounter in the registration process and continuing through the entire information lifecycle. Errors in the patient record can affect patient safety, clinical decision making, payment, patient satisfaction, and overall quality of care. Healthcare organizations must have information governance (IG) programs that include policies and procedures for ensuring accurate and meaningful information starting with the creation of the patient encounter and continuing through disposition. Data integrity—trust in information—depends on it.

In what has become a common scenario for HIM professionals, inaccurate information may be introduced into the patient health record during the patient’s registration, thereby creating pervasive problems downstream as faulty information flows through the system. The good news is that building IG from the ground up can prevent disasters from occurring down the line.

According to former AHIMA CEO Linda Kloss, MA, RHIA, FAHIMA, one of the five functional building blocks for information governance is information integrity. Organizations must continuously improve the value and trustworthiness of its information assets by ensuring that data and content are valid, accurate, complete, and timely. Proactive error prevention and correction processes must be aligned with the relative value of the asset. This is further reinforced in the AHIMA Information Governance Principles for Healthcare (IGPHC)\(^1\), eight IG guidelines based on ARMA International’s Generally Accepted Recordkeeping Principles that specifically include integrity and availability as principles.\(^2\)

One organization that has taken a proactive approach is Kootenai Health, a 254-bed community-owned hospital which provides comprehensive medical services to patients in northern Idaho and throughout the Inland Northwest region. As part of their information governance initiative, Kootenai has implemented a training program designed to improve its patient registration processes.

Identifying the Challenges
The two challenges that are most familiar to those who manage a patient access service area are staffing and training. Like many healthcare organizations, Kootenai struggled with a high turnover rate—33 percent in patient registration. Janell Madonna, former patient access manager at Kootenai, saw a need for strong leadership, well-trained staff, and standardized registration processes in the decentralized registration areas.

The high turnover within the department also included management—the patient access manager had recently left the organization, and his replacement soon left as well. Further, the evening shift was staffed by inexperienced employees who lacked training and resources. For example, when the system went down unexpectedly, the staff who had not been trained on down-time processes were unaware of a backup system from which they could pull medical records and account numbers. The combination of turnover, untrained staff, outdated procedures, and inconsistent information resulted in data integrity issues:

- High percentage of duplicate medical records and overlays
- Failure to thoroughly search the master patient index (MPI)
- High claims processing edits to correct errors/denials on the back end
- Numerous errors downstream in the electronic health record (EHR)

Given the lack of education and resources, along with pressure to act quickly, mistakes were prevalent—selecting the wrong insurance or incorrect values or leaving fields blank, or failure to check eligibility resulting in an incorrect claim. Staff did their best under the circumstances, unaware of the clinical and financial impact.

Organizing for Process Improvement
While new hires in patient registration may or may not have prior healthcare experience—often no certification or degree program is required—they still want to perform well and offer good customer service. Investing in a career path that includes ongoing education can significantly increase retention and improve information integrity.

With that in mind, Kootenai established a registration advisory council to garner support from all areas with registration responsibilities, promote collaborative leadership, and explore...
strategies for education and training. The council received approval for a full-time training position and created a charter committed to consistent, improved quality and integrity.

To carry out this charge, the organization partnered with a professional team of instructional designers—including healthcare consultants—to evaluate current practices and develop a custom training curriculum. The resulting curriculum blends instructor-led training, real-world practice, and web-based learning modules. The modules are narrated, interactive, and include a competency assessment to measure training effectiveness. In addition, the program is designed with the flexibility to assign specific modules to target audiences.

The web-based content brings the patient and potential problems to life—focused on the impact of duplicates, overlays, and related issues that affect quality of care. It’s an essential tool for educating staff about HIPAA and other regulatory requirements, and the importance of accurate, complete, and timely data—the foundation for training.

From Patient Access to Enterprise Training

The program began with instructor-led training for registration staff in all departments. Staff then returned to their departments for firsthand experience as a point of reference before transitioning to the learning modules. With so much information to absorb, assessing competency after each module helped ensure step-by-step understanding and the ability to apply learning. This approach ultimately led to better outcomes throughout the organization.

The training program first targeted patient access staff and then expanded to include any staff member who selects patient records, including nurses, health unit coordinators, and even employee health department staff. The revelations confirmed a need for multidisciplinary education. For example, the team knew that patient selection errors led to duplicate records or overlays; what they discovered is that most errors were not created by registration staff. As a result, nursing staff members who selected patient records from the MPI were assigned to complete the patient selection module.

Streamlining workflow in the emergency department (ED) emerged as another main priority. To address issues around ever-increasing backlogs, the training team led efforts to revamp the ED registration process and revamp the patient valued and cash handling policy. In addition, they developed and implemented training focused on quality issues and the importance of accurate, complete, and timely data—the foundation for training.

Measuring Results and Building Best Practices

Implementing a formalized training program with a means to objectively measure competency has already reduced staff turnover. Additional performance indicators show a decrease in Medicare Advantage Plan registration errors by 30 percent, Medicaid HMO registration errors by 56 percent and invalid Medicaid Policy numbers by 73 percent. And with new dashboard reporting in place, the organization is set to track targeted areas for performance improvement. Based on lessons learned and results so far, six best practices for achieving patient access improvement include:

1. Invest in front-end staff education from a data integrity standpoint. Their success is critical to overall organizational performance. Demonstrate the impact of their decisions.
2. Acknowledge the value of patient access and processes. It is important for all staff to develop a full appreciation for the complexity and impact of registration staff responsibilities—accurate and timely data capture, efficient patient flow, and financial viability.
3. Educate all non-registration staff to promote understanding of patient registration challenges and the risks of not taking measures to prevent and correct errors at the source.
4. Analyze the cause of errors to identify preventive measures—use errors to improve processes.
5. Build a program that prepares registration staff for optimal performance, offers long-term career opportunities, and improves retention.
6. Assemble an interdisciplinary team including all key stakeholders working together to advance effective IG practices. Collaborative leadership is essential.

Kootenai is currently developing an IG model from the legal health perspective while working to initiate an enterprise-wide program. Patient access plays a vital role in the success of IG initiatives. HIM professionals should lead efforts to ensure registration staff have the competencies required to be at the forefront of building a foundation for IG.

Note


Mary Beth Haugen (marybeth@thehaugengroup.com) is president and CEO and Janell Madonna (jmadonna@thehaugengroup.com) is director of educational design and client support services at Haugen Consulting Group.
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*Enterprise Health Information Management and Data Governance*
Merida L. Johns, PhD, RHIA
Product Number: AB104213
Price: $84.94 | Member Price: $69.95

Implementing Health Information Governance: Lessons from the Field
Linda Kloss, MA, RHIA, FAHIMA
Product Number: AB100213
Price: $64.95 | Member Price: $54.95
e-book available!

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- Information Governance Principles for Healthcare (IGPHC)™
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THIS ISSUE OF the Journal of AHIMA includes brief biographies and photographs of the 2015 AHIMA Election candidates. This year the Nominating Committee asked candidates for positions with the AHIMA Board of Directors to answer the question “AHIMA’s envisioned future is to ‘Drive the Power of Knowledge—Health Information Where and When It’s Needed.’ What do you see as the priorities to achieve AHIMA’s envisioned future and why?” Candidates for the Commission on Certification for Health Informatics and Information Management (CCHIIM) Commissioner were asked “How do you foresee your role on the Commission related to linking the goals of CCHIIM and the AHIMA strategy?”

New this year, members will be voting for members of the Council for Excellence in Education (CEE). Candidates for the CEE were asked to answer the question “What do you see as the challenges in HIM education, research, and the expanding workforce? How do you see the future of education, research, and leadership in HIM evolving and what will be your contribution?” The candidates’ answers to these questions and detailed biographies are available online via the AHIMA Ballot at ivote.ahima.org. Members may review the candidates’ brief bio, photo, and read their position statement in the AHIMA Membership and Business Community on Engage. To access Engage, visit engage.ahima.org. Enter your AHIMA ID number and password. Locate the AHIMA Membership and Business Community. Select “Libraries” and locate the topic “AHIMA Election – 2015.” To access the secured ballot, visit ivote.ahima.org and enter your AHIMA ID number and password. Results will be announced in late August.
The election begins Monday, August 3, 2015 at 12:00 a.m. CT. Voting will remain open until Monday, August 17, 2015 at 11:59 p.m. CT. All Active AHIMA members are eligible to vote. Student members are not eligible. If you should have any questions, please contact AHIMA’s Customer Services Department at 1-800-335-5535 or e-mail volunteer.services@ahima.org. All members are encouraged to review the candidate information and place their votes.

**President/Chair-elect**

*Vote for one*

Susan W. Carey, MHIM, RHIT, PMP is the system director of health information management (HIM) for Norton Healthcare in Louisville, KY, a not-for-profit system comprised of five hospitals, 19 outpatient centers, and 140 practice sites. With over 30 years of practicing the HIM profession, she has vast experience in all core HIM competencies and with HIM operations, healthcare technology, and healthcare system implementations. A dedicated HIM professional, Carey is committed to demonstrating the value and relevance of the HIM profession and professional to the healthcare ecosystem and the stakeholders within the ecosystem. Carey is a third year director, the treasurer of the AHIMA board, and a charter member of the KYHIE Privacy Council. She is also a certified project manager and an AHIMA-approved ICD-10-CM/PCS trainer. Carey has been published on the topics of project and change management, ICD-10, and the evolution of the HIM profession and HIM professional.

Ann Chenoweth, MBA, RHIA, FAHIMA is an accomplished leader with 30 years of HIM professional experience across health systems and technology companies spanning hospitals, physicians, and payers. Chenoweth has served as an HIM director, consultant, student advisor, account executive, mentor, and volunteer leader. Currently, she is the lead executive and HIM thought leader at 3M Corporation solely responsible for building relationships with industry stakeholders as the HIM expert and champion. Chenoweth currently serves as chair of AHIMA’s Grace Award Committee, and is a member of the ICD-10 Coalition and HIMSS ICD-10 Task Force. She recently completed her three-year term on AHIMA’s Board of Directors where she served as treasurer, chair of the Audit and Finance Committees, and member of the Executive and Governance Committees. She is past president of ILHIMA (Illinois) and UHIMSS (Utah). Chenoweth is a noted speaker and author on such topics as HIM’s role in payment reform and information governance.

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**Committee Chair:**
Jill Finkelstein, MBA, RHIA, CHTS-TR

**Committee Members:**
- DeShawna L. Hill-Burns, RHIA, CHTS-CP
- Sue Powell, RHIA
- Laura Rizzo, MHA, RHIA, FAHIMA
- Patrice L. Spath, MA, RHIT, CHTS-IM
- Renae Spohn, MBA, RHIA, CPHQ, FAHIMA, FNAHQ
- Patty Thierry Sheridan, MBA, RHIA, FAHIMA
- Bill Thieleman, RHIA, CHP
- Melinda Wilkins, PhD, RHIA, FAHIMA

*SPECIAL THANKS to the 2015 Nominating Committee*
Danika E. Brinda, PhD, RHIA, CHPS, HCISPP is an assistant professor in health informatics and information management at the College of St. Scholastica in Duluth, MN. She is also the owner of TriPoint Healthcare Solutions, which provides privacy and security consulting services to healthcare organizations. Brinda has been very active in the Minnesota Health Information Management Association, holding multiple volunteer positions, including president in 2013-14 and Advocacy Co-Chair in 2014-15. Brinda has also volunteered on a variety of different committees for AHIMA, including the Professional Practices Experience (PPE) Workgroup. Brinda serves as an expert in healthcare privacy and security. She is a local and national speaker on topics related to healthcare privacy and security. Brinda recently completed her PhD in information technology with a focus in information assurance and security from Capella University. Brinda resides in Minnesota with her husband and two daughters.

Dan Christopher, MBA, RHIA is the department head for the health information programs at the Pennsylvania College of Technology in Williamsport, PA. He holds a bachelor of science degree in health records administration from York College of Pennsylvania and a master’s degree in business administration from the University of Pittsburgh. Christopher has nearly 36 years of experience in the field of health information, having served as a director of medical records in three healthcare organizations. Christopher has also served as a health information consultant for several acute care and long-term care facilities in central Pennsylvania. In addition to his primary work responsibilities, he has been an active member of AHIMA, the Pennsylvania Health Information Management Association (PHIMA), and the Central Pennsylvania Health Information Management Association (CPHIMA). Christopher is the immediate past president of PHIMA and previously served as president of CPHIMA, as well as serving in various other roles in both organizations.

Jane DeSpiegelaere, MBA, RHIA, CCS, FAHIMA is the HIM director and system privacy officer for Lake Regional Health System in Osage Beach, MO. She has served on the AHIMA House of Delegates’ Envisioning Collaborative Team for the last two terms, is an AHIMA Fellow, and is an AHIMA-approved ICD-10-CM/PCS trainer. In addition, DeSpiegelaere is a member of HIMSS and HFMA, and is a Missouri Quality Award Examiner. She has served two terms as delegate and president for the Missouri Health Information Management Association. DeSpiegelaere works to promote the HIM profession through collaboration with local accredited health IT programs as an advisory committee member and practicum advisor. She has participated in several state-sponsored panel discussions and is acknowledged in many AHIMA Practice Briefs promoting key topics in health information and revenue cycle management.
Sheila Green-Shook, MHA, RHIA, CHP, FAHIMA is the director of HIM and privacy officer at EvergreenHealth in Washington state. She was a member of the AHIMA Program Committee for six years and served as chair in 2008 when the convention was held in Seattle. Green-Shook has served in many positions on the WSHIMA (Washington) board: advocacy, delegate, two consecutive terms as president, and currently works on the Collaborative Task Force. WSHIMA co-hosted the third "Future of Healthcare" one-day conference in partnership with local chapters of HIMSS, HFMA, and WSHEF. She is chair of the advisory board for the HIHIM program at Shoreline Community College and a member of the advisory board for UW HIHIM programs, both baccalaureate and master’s. In 2014 Green-Shook received the WSHIMA President’s Award.

Ellen Shakespeare Karl, MBA, RHIA, CHDA, FAHIMA is the academic director for the HIM programs and distinguished lecturer at the City University of New York. Prior to entering academia eight years ago, Karl was the director and assistant director of HIM departments at hospitals in New York, New Jersey, and Florida, after starting in the profession working on the SENIC project with the Centers for Disease Control and Prevention. She is currently the past-chair of AHIMA’s Council for Excellence in Education, which was preceded by her holding the roles of chair and chair-elect. She was also a member of AHIMA’s Health Information Exchange Practice Council. Karl served as treasurer, president-elect, president, and past-president of the New Jersey Health Information Management Association (NJHIMA) and is now a member of NYHIMA (New York). She most recently served as chairperson of the NJHIMA Kathleen A. Frawley Memorial Scholarship Board.

Tim Keough, MPA, RHIA, FAHIMA is vice president at the New Jersey Hospital Association, Healthcare Business Solutions where he leads the health information services consulting division. Prior positions include divisional director of HIM for a 500+ bed acute care facility and corporate director of HIM for a multi-state long-term care provider. He has been chair of AHIMA's Nominating Committee, co-chair of the AHIMA House of Delegates’ Environmental Scan Team, and a member of the Program Committee. Within NJHIMA (New Jersey), Keough served two terms as president, chaired the Membership and Industry Recognition Task Group, served as Communities of Practice facilitator, and received the 2002 Distinguished Member award. Over the past three years, he has been workgroup co-chair of the New Jersey Division of Banking and Insurance – NJHA Task Group on ICD-10 Implementation. Keough is an advocate for education and has supported the educational programs around the state by acting as an advisory member as well as volunteering as a professional practice site.
Tarrin L. Degrate, RHIA, CDIP, CCS, CCS-P, CHTS-IM, CPC, CHC is an experienced educator and AHIMA-approved ICD-10 trainer and ambassador. Degrate has over 17 years of healthcare experience relative to coding, billing, compliance, education and training, and documentation improvement. She joined Maxim Health Information Services in January 2015 as a coding auditor/educator. Degrate previously worked as a director of quality coding for Altegra Health. In addition, she has worked for Parkland Health and Hospital System, UT Southwestern Medical Center, and Providence Health and Hospital System. Degrate has also worked as an educator for Rasmussen College and CHCP in the HIM program and Kaplan University in the medical billing and office management program. She is currently an active volunteer for AHIMA, serving on the AHIMA CDIP and CCS Review Committee and the Item Writing Committee. Degrate also served as a coding roundtable coordinator and AHIMA mentor.

Diane E. Ferry, MS, RHIA is founder, president, and CEO of Star-Med LLC, a HIM services and consulting company. She has a bachelor’s degree in HIM, a master’s degree in health services administration, and is a Registered Health Information Administrator. Ferry is a former HIM director at two academic medical centers. A twice-elected president of both the Delaware Health Information Management Association and the Delaware Chapter of the National Association of Women Business Owners, Ferry was elected to the National Association of Women Business Owners National Board beginning June 2015. She is an adjunct faculty member in a HIM college program. Ferry serves on the board of the New Castle County Chamber of Commerce and is a past board member of the Delaware Lacrosse Association. Ferry is active in her church and is passionate about providing patients access to their medical records in a timely, accurate, and secure manner.

Paula M. Warren, RHIA is manager of HIM at Emergency Medicine Physicians in Canton, OH, with over 35 years of experience in HIM. She is serving on the AHIMA Consumer Engagement Task Force, and served on the AHIMA Care Coordination Practice Council in 2014. She has served as president of the Ohio Health Information Management Association (OHIMA) and served three terms as a delegate from Ohio in AHIMA's House of Delegates. She has 25 years of experience working as an adjunct faculty member at Stark State College in Canton, OH in the HIMT program and has served on their Advisory Board for 10 years. Warren received OHIMA’s Professional Achievement Award in 2009 and OHIMA’s highest honor, the Distinguished Member Award, in March 2015.
Dilhari R. DeAlmeida, PhD, RHIA is an assistant professor in the department of HIM at the University of Pittsburgh. She received her bachelor of science degree in cell and molecular biology from the University of Toronto, Canada. Prior to joining the HIM department, she had over 12 years of experience working in government, academic, and private sector settings in the field of molecular biology. She received her master’s of science (HIS/RHIA option) and doctorate degrees from the University of Pittsburgh. Her dissertation research involved evaluating the ICD-10-CM coding system for documentation specificity and reimbursement. She is an AHIMA-approved ICD-10-CM/PCS trainer. In addition to teaching both the undergraduate and graduate courses in HIM, DeAlmeida’s current research focuses on research use case development and data analytics in healthcare, including building clinical alerts for early detection of acute kidney injury within an electronic health record system.

Neisa R. Jenkins, EdD, RHIA is full professor at DeVry University in the College of Health Sciences, based in Downers Grove, IL. She has served on AHIMA’s Council on Excellence in Education Curriculum Workgroup and was recently appointed to a three-year term on the AHIMA Foundation Scholarship Committee. On the e-HIM Workgroup, Jenkins was a contributing author on “Guidelines for Electronic Health Records Documentation to Prevent Fraud.” She presented at AHIMA’s 78th Annual Convention and Exhibit and served as a volunteer at AHIMA’s Annual Convention and Exhibit in 2013. She is a member of the Greater Atlanta Health Information Management Association, where she served on the Membership Drive Committee. She is also a member of the Georgia Health Information Management Association. She is a dedicated, progressive administrator and educator.

Kelly K. Miller (Rinker), MA, RHIA, CPHIMS has over 15 years’ experience in HIM. She is currently an assistant professor at Regis University. She graduated with her bachelor of science in HIM and then completed her master’s in education. She is currently enrolled at Capella University pursuing her PhD in human services with a focus in healthcare administration. In addition to her RHIA, Miller holds a CPHIMS certification with HIMSS. While working as an HIM director, Miller began teaching at Regis University, Arapahoe Community College, Kaplan, and Davenport University before making the transition to being a full-time faculty member at Regis. Miller has donated her time as an AHIMA mentor and has served the positions of director, delegate, and committee chair for the Colorado Health Information Management Board of Directors. In her personal time, she spends time with her son, volunteers at a women’s shelter, and volunteers as a foster parent for an animal rescue organization.
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**A Look Ahead**

Upcoming AHIMA Institutes, Seminars, Workshops, and Webinars

**SEPTEMBER**

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<tr>
<td>14-15</td>
<td>CSA Meeting: Maine, Northport, ME</td>
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<tr>
<td>16-18</td>
<td>Advanced ICD-10-PCS Skills Workshop</td>
<td>Phoenix, AZ</td>
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<tr>
<td>26-27</td>
<td>Certified Health Data Analyst (CHDA) Exam Prep Workshop, New Orleans, LA</td>
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<tr>
<td>26-27</td>
<td>Annual Clinical Coding Meeting, New Orleans, LA</td>
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<td>26-27</td>
<td>Privacy and Security Institute, New Orleans, LA</td>
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<tr>
<td>26-30</td>
<td>AHIMA Annual Convention and Exhibit, New Orleans, LA</td>
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**UPCOMING INSTITUTES, SEMINARS, WORKSHOPS, AND WEBINARS**

- **October 20**
  - Webinar: Revenue Cycle 101: Basics of Organizational Structures, Data Exchange, and Healthcare Reimbursement
- **October 21-23**
  - CSA Meeting: Oklahoma, Sulphur, OK
- **October 21-23**
  - Advanced ICD-10-PCS Skills Workshop, Chicago, IL
- **November 2-3**
  - Brushing Up on ICD-10: A Refresher Workshop, Chicago, IL
- **November 3**
  - Webinar: Three Mistakes in Managing a Privacy Breach
- **November 9-10**
  - AHIMA Academy for ICD-10-CM Trainers: Building Expert Trainers in Diagnosis Coding, Chicago, IL
- **November 9-11**
  - AHIMA Academy for ICD-10-CM/PCS: Building Expert Trainers in Diagnosis and Procedure Coding, Chicago, IL
- **November 12-13**
  - Information Governance: The Value Proposition, A Thought Leadership Summit, Chicago, IL
- **November 12**
  - Webinar: Navigating the Ever-Changing Audit Landscape
- **November 16-17**
  - Brushing Up on ICD-10: A Refresher Workshop, Chicago, IL

Check [www.ahima.org/events](http://www.ahima.org/events) for the latest schedule of institutes, seminars, and workshops.

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**Keep Informed**

Resources and News from AHIMA

**Information Governance Thought Leadership Summit Coming in Fall**

November 12–13, Chicago, IL

AHIMA will host a thought leadership summit titled “Information Governance: The Value Proposition” in Chicago, IL this November. The summit will explore new and innovative ways to gain maximum value from health data and information through information governance (IG).

Summit discussion will center on a new vision of IG as an effective tool to address a variety of both emerging and long-standing issues that prevent or organizations from realizing data and information as an asset that enables improvements in care quality, a reduction of costs, and the ability to thrive in a changing healthcare delivery system.

For more information and to register for the summit, visit [www.ahima.org/events](http://www.ahima.org/events).

**Book Discusses Health IG Implementation**

*Implementing Health Information Governance: Lessons from the Field*, a new text from AHIMA Press, outlines lessons learned from healthcare organizations that have already made progress in formalizing information governance. Healthcare has transitioned from paper to a digital infrastructure over the past decade, but the governance and enterprise management mechanisms have not yet caught up. Current practices remain largely isolated and insufficient for the new digital information environment. The growing volume and sources of electronic data and the complexities of information and communication technologies eclipse the governance capacity of most organizations.

This book offers tested practices for aligning governance to the organization’s goals, organizing and staffing governance and enterprise management, building on what is working, and guiding incremental improvement. For ordering information, visit [www.ahimastore.org](http://www.ahimastore.org).

**Summer 2015 Perspectives Now Available**

The Summer 2015 issue of *Perspectives in Health Information Management* features the latest research on topics such as electronic health record implementation, offers results from a Veterans Health Administration ICD-10 coding pilot study, and discusses benefits of RFID technology. Read the full issue at [perspectives.ahima.org](http://perspectives.ahima.org).

To learn more about how to submit an article for consideration, read the guidelines at perspectives.ahima.org/style-and-submission-guidelines.
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DATE: June 12, 2015

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Situated in the heart of central Maine, the Kennebec Valley region offers an unparalleled quality of life – with strong, safe, and vibrant communities and school systems. Dining, entertainment, and recreational opportunities abound in every direction to include Maine’s largest city (Portland), lakes, mountains, rugged coastline, and quaint villages and small towns all within an hour’s drive. Maine, Vacationland, offers four beautiful seasons, each with incredible opportunity for scenic beauty and outdoor exploration hiking, biking, fishing, boating, photography, gardening- the possibilities are endless.

SALARY: Salary and benefits commensurate with the Agreement between the Maine Community College System Trustees and the MEA Faculty Unit. Range III; Base Salary range $44,692 with commitment to negotiate higher based on skills and experience; Academic year position; Paid holidays.

QUALIFICATIONS: A minimum of a Bachelor's degree required, Master’s degree preferred. Applicants must hold a credential of a Registered Health Information Administrator (RHIA) or Registered Health Information Technician (RHIT). The applicant must have current knowledge in the technical and software applications required in Health Information Management.

RESPONSIBILITIES: The HIT Instructor/Program Coordinator responsibilities include teaching academic courses, student advising, program administration and coordination of professional practice.

APPLICATION PROCEDURE: Initial review of applications will begin immediately and will continue until the position is filled. Submit the following: cover letter, resume, transcript of highest degree earned, KVCC Application for Employment (visit: http://www.kvcc.me.edu/employment and download form), and a list of three (3) professional references with contact information to:

mwood@kvcc.me.edu
Monica L. (Wood) Brennan
Executive Assistant to the President
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INFORMATION GOVERNANCE (IG)—LIKE SO many concepts in health IT and health information management—can be hard to understand, visualize, and articulate. Fortunately, AHIMA has developed an infographic that helps with all three. From defining IG to demonstrating how and why it works, the below infographic makes IG more tangible and communicates its benefits. AHIMA defines IG as “an organization-wide framework for managing information throughout its lifecycle and for supporting the organization’s strategy, operations, regulatory, legal, risk, and environmental requirements.” For more information on AHIMA’s IG initiatives, visit www.ahima.org/igresources.

WHAT IS INFORMATION GOVERNANCE (IG)?

Establishes policy

Determines accountabilities for managing information

Promotes objectivity through robust, repeatable processes

Protects information with appropriate controls

Prioritizes investments

INFORMATION GOVERNANCE FOR HEALTHCARE INCLUDES:

All departments, areas of the organization

All types of organizations

All types of information (clinical, financial, and operational)

Information on all types of media

Adopting an IG program shows an organization’s commitment to managing its information as a valued strategic asset.

HOSPITAL ADOPTION RATE OF EHRS

FACTS:

4X HIGHER

OFFICE-BASED PHYSICIAN ADOPTION RATE OF EHRS

2X HIGHER

2013 59%

2010 14.75%

2009 24%

2013 48%

HIGHER

HIGHER

Info from US Department of Health and Human Services, Office of the National Coordinator for Health IT | HealthData.gov

THERE’S A NEED FOR IG!

Where do organizations stand on IG adoption? A recent study conducted by AHIMA and Cohasset Associates revealed slow implementation:

90% of 1000 respondents agreed on drivers of IG:

- COMPLIANCE
- PATIENT SAFETY
- QUALITY CARE
- COST CONTAINMENT
- TRUSTED ANALYTICS
- CHANGING PAYMENT MODELS

65% recognize need for formal IG

43% have initiated an IG program

Source: ahima.org/IGwhitepaper
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