HIM & ONCOLOGY SUPPORT SERVICES Backlog woes?

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## President's Message

**January/February 2005**

**President's Message**

*Barbara J. Flynn, RHIA, CCS*

I hope everyone had happy holidays and have been able to get out from under the blue tarps from the hurricanes. It is time to plan for the future now that we have taken care of the past.

Carolyn Glavan, FHIMA Executive Director has sent out several e-mail blasts on important issues before us. These include: FHIMA Hill Day which is scheduled for March 10th in Tallahassee, the changes to the UB-92 which will make it the UB-04, Call for Nominations by the Nominating Committee and several others. We are trying to send out e-mail blasts on important issues that we need your input on in order to respond for FHIMA as a group. I know that sometimes it seems that you may receive two e-mail blasts in one week and you may not feel that you have time to review the information right away. Please be

assured that we really need your input on these issues.

We also need your participation in FHIMA Hill Day. There are actually two ways that you can participate. The first is the easiest. You can participate by sending your State Representatives a letter of introduction. A basic letter has been prepared for your use. You can use the AHIMA Advocacy Assistant to identify your representatives by entering your zip code. You can send your letter by e-mail which is actually the most efficient way to send your letter. In the letter, be sure to let the representative know that you would like the opportunity to come by their in-district office before the legislative session begins to talk about the issues that will face the legislature. Then, make an appointment and introduce yourself and FHIMA and AHIMA to the representative. The Legislative Committee has prepared "talking points" and literature to get you started when talking to your representative.

The second way to become involved in FHIMA Hill Day is to meet with our representatives in Tallahassee on March 10th. A delegation of FHIMA representatives will be in Tallahassee on that day where we intend to meet with our representatives and discuss issues currently before the legislature. We will not know all the issues we wish to discuss with our representatives until shortly before our meetings. However, the purpose of our meetings is to become more visible and be recognized as a major stakeholder in all health information related issues. Last year, we had a significant showing in Tallahassee for our first Hill Day. It is our hope that we will have an even larger impact this year. We have some new representatives that have never heard of HIM professionals. So we need to educate them.

To become involved in Hill Day 2005, please contact Carolyn Glavan, FHIMA Executive Director. Carolyn can provide you with the tools to meet with your representative in your district and she is also making the room reservations in Tallahassee. The year is already going fast, so we need your assistance quickly go make an impact. Please look at your calendar and figure out a day within the next couple weeks when you could send your letters to your representatives. Your representatives are interested in talking to their constituents. I have already received responses from my representatives verifying their interest in meeting with me. Together, we can make a difference.

Barbara J. Flynn, RHIA, CCS
President FHIMA

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## FHIMA News

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**January/February 2005**

### *FHIMA Annual Convention 2005*

***July 25-28, 2005 (Monday - Thursday)***
***Gaylord Palms Resort***
www.gaylordpalms.com

Gaylord Palms Resort & Convention Center is a total destination resort offering world class meeting facilities, exceptional service, family entertainment, a Canyon Ranch Spa Club and recreation. Enjoy this grand Florida mansion! Guest rooms include:

No charge for local and 800 calls

Complimentary in-room internet access (T-1 capacity)

Bottled water, orange juice, coffee & tea in each

room replenished daily

Access to fitness club at the Canyon Ranch Spa

Free transfers to and from Disney Theme Parks

Complimentary transfers to and from Falcon's Fire at

**SERVICE AWARDS**
**ATTENTION: All FHIMA Members**

**Nominations are now open for the following awards:**

- Distinguished Member
- Distinguished Service (FHIMA Member or Non-member)
- Literary
- Outstanding Student
- Outstanding New Professional
- Outstanding Professional (Practitioner or educator)

We have many deserving members. Please review the criteria and submit your nomination to:

**Jennifer Vinson, RHIA**
**1050 Royal Fern Drive**
**Melbourne, FL 32940**
**(W) (321) 434-5484**
**jennifer.vinson@health-first.org**

***Deadline for receipt of nominations is March 15, 2005.***

**Please Note: As per 2000-2001 policy and procedures **nominees** will be contacted to provide supporting information to the committee.

**Nomination Form - Service Awards**

Distinguished Member

Outstanding Student

Distinguished Service

Outstanding New Professional

Literary Award

Outstanding Professional

**Click Here For The Service Awards Nomination Form.**

**Click Here For The FHIMA Resume Criteria for Awards Nomination.**

**2005 FHIMA SCHOLARSHIP**

**F**lorida **H**ealth **I**nformation **M**anagement **A**ssociation is pleased to announce a continued support of individuals pursuing Health Information Management careers. FHIMA has again voted to provide scholarships this year to students enrolled in both undergraduate and graduate studies related to the Health Information Management field.

As in years past, scholarships will be awarded to FHIMA members to defray the cost of a Health Information Management related education. Awards will be presented at the Membership Luncheon during the 2005 Annual Convention. Scholarship recipients will be notified in writing of their award in June. Scholarship recipients are strongly encouraged to be present at the Annual Convention Membership Luncheon to accept the award.

**APPLICATION INFORMATION:**

Applications are available from Program Directors, on the FHIMA website, or by contacting the Scholarship Chairperson. Your completed scholarship application and required attachments must be received by the FHIMA Scholarship Chairperson no later than published deadline.

**Eligibility Requirements:**

Applicants must be presently enrolled in one of the following program

Health Information Management Program.

Health Information Technology Program.

Graduate level degree seeking program relevant to H.I.M. (Graduate applicants must be either an RHIA or RHIT and have a bachelor's degree)

Current membership in AHIMA/FHIMA .

An individual is only eligible to win one scholarship for each category.

**APPLICATION DEADLINE: March 31, 2005**

**Mail Applications & Attachments To:**
**Kim Wheeler, RHIA**
**3328 Hidden Lake Drive W**
**Jacksonville, FL 32216**
**(W) (904) 399-6720**
**kim.wheeler2@hcahealthcare.com**

**SCHOLARSHIP SELECTION:**

FHIMA utilizes a point system to evaluate scholarship applicants. Scholarship Committee members will review the applications for the following criteria:

***Properly completed application*** -- with attachments present

***Scholastic ability*** -- official transcripts will be reviewed

***Leadership ability*** -- the resume and/or other documents will be reviewed. The following areas will be considered: awards/honors, previous and current employment (if any), school activities, volunteer work etc...

***Potential contribution to the profession*** -- the essay titled "How I Plan to Achieve My Long Range Professional/Career Goals" (undergraduates) or career objectives (graduate) will be reviewed.

***Professionalism*** – supporting letters and professional organization membership

**Click Here For The FHIMA Scholarship Application AND Reference Criteria Form.**

**GET THE ALL NEW 2003 Medical/Legal Guide to Health Care Records in Florida**

The new Medical/Legal Guide to Health Care Records in Florida is now available and ready for purchase. The manuals are $135. Students enrolled full-time in an accredited HIT/HIM program may purchase the guide for $65.

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## Articles

**January/February 2005**

**Colonoscopy Confusion**
*Margi Brown, RHIA, CCS, CCS-P, CPC*

Per AHIMA, apply ICD-9 rules/guidelines to ICD-9 coding, and CPT rules/guidelines to CPT coding. This should be the guideline. There still is confusion because there is disagreement between the two coding systems. The people in these organizations who make the rules for ICD-9 and CPT always check in with each other or read each others guidelines)!

(1) Guidelines for a colonoscopy that starts out as a screening exam (i.e. the MD documents that he intends to do a screening colonoscopy), and during the exam a polyp is found and removed.
• First-listed diagnosis: V76.51, Screening for malignant neoplasm of colon
• Secondary diagnosis: 211.3, Benign neoplasm of colon
• HCPCS: Do not use the G-code for screening colonoscopy when a "surgical" procedure is done. Assign the appropriate CPT surgical colonoscopy code (such as 45380 for colonoscopy with polypectomy using cold biopsy forceps).
(2) On the issue of colonoscopy with polypectomy, there's a good clarification article in the most recent CPT Assistant (July 2004), following the January 2004 issue. The following is a guideline summary:

Related codes:
• 45380, Colonoscopy...with biopsy, single or multiple [tissue removal using technique other than snare or hot biopsy forceps]
• 45384, Colonoscopy...with removal of tumor/polyp/lesion by hot biopsy forceps or bipolar cautery
• 45385, Colonoscopy...with removal of tumor/polyp/lesion by snare technique

Important points:
• Code assignment for colonoscopy with polypectomy is based solely on the TECHNIQUE used.
• The amount of tissue removed (biopsy specimen vs. "entire" lesion) has no effect on CPT code assignment.
• A forceps (cold biopsy, cold biopsy forceps, or biopsy) is not a snare.
• "Polypectomy" does not automatically mean snare polypectomy.
• Therefore, code 45385 should not be used for removal of polyp(s) using forceps, as

this code identifies snare technique removal.
• Use code 45385 only when the polypectomy technique is documented as snare.
• Use code 45380 for polypectomy using cold biopsy forceps (even though the code description says "biopsy").
• Use code 45384 for polypectomy using hot forceps or cautery.

**Florida's Health Information Infrastructure**
*Jacquie Jones, MBA, RHIA, CPHQ*

Governor Jeb Bush and his staff welcomed the Florida Health Information Infrastructure (FHII) Advisory Board and interested parties to a 2-day workshop dedicated to identifying a desired functionality of Florida's Information Infrastructure.

The mission of the FHII is simple: develop a model, which demonstrates a technical and operational solution to health information interoperability among major health care institutions and providers. The proposal commits to the development of a local health information infrastructure (HII) to provide electronic access to "core health care data" among participating practitioners within a community and/or within a provider demonstration region. AHCA Secretary, Alan Levine believes that as "builders" of this infrastructure WE have two choices. We can encourage, prod and push the use of health information through "reformation or transformation". An example of reformation – Physicians must write prescriptions legibly. And in the same example, transformation exists when the physician prescribes electronically to pharmacies with drug-to-drug interaction checking, benefit plan checking of covered drugs, clear, legible prescription and transmission of the information to a pharmacy.

In Florida, Medicaid has promoted e Prescribing successfully with over 1000 providers and plans to increase the number to 3,000 over the next 12 months. An example of transformation with practical and definable results. Florida benefits from this project through improved health care quality, improved patient outcomes and lowering cost. Studies show, that developing market driven access to care has a positive effect on quality and decreases costs through effectiveness. **Patient Safety is Florida's No. 1 concern**.

The current system has many flaws – the biggest problem… *our physicians rely on the patient for information*; they order duplicative tests when information is unavailable and decision making is critical; they practice defensive medicine (i.e. ordering unnecessary tests) to mitigate the risk of litigation, and they order and prescribe based on the patient or family's inclination.

The Board articulated three objectives for the 2-day meeting: 1) Gain an understanding of the national landscape, 2) Learn about health information infrastructure issues as a group, and 3) Refine the Board plan of action.

Two days of great speakers would be hard to condense into one article! Listed below are a few of the most notable.

**Dr. David Brailer**, the National Coordinator of Health Information Technology was on hand to give an overview of the national landscape. President Bush is determined that the health care market progress to "real care for real people." As an employer, the government is a huge consumer (e.g. 2 billion/year) and has a place at the table to discuss what health care, as an industry is not doing on their own.

"Science says information technology and tools saves life, reduces errors and makes peoples lives better." Dr. Brailer suggests that information technology and tools must be available to the physician to support communication with the patients, and other physicians as we focus on patient outcomes. Health care information after all, is a public good.

One of the key strategies – RIOS (regional health information organizations) which works if all stakeholders are working in a fudicary fashion. "Most would agree that in

order for the regional health information organization system to be effective, community physicians must participate. Another important attribute, "personal health records" – our patients needs more information in order to make an informed choice about where to seek quality health care.

"Population Health Improvement" was also mentioned. Surveillance for public health and bioterrorism to connect to health care providers/pharmacies to monitor potential threats.

In all this, we heard that individual practitioner adoption of electronic health records is influenced by cost of technology (capital and implementation costs), and high failure rate, "This economic reality has prompted proponents of health information exchanges to explore methods of developing the network infrastructure that do not require physicians to make significant economic investment." One method under consideration is financing support via grants, and low interest loans. "Pay-for-use" and "Pay-for-Performance" options are under consideration as well. If a physician is reimbursed for using information technology, it will accelerate the rate at which Electronic Health Record systems are adopted. There is some movement on a federal level to give "preferential treatment" to plans and providers which support electronic health records.

Why the interest in providers? Physicians? The amount of money spent on physician office visits equals that spent on acute care, emergency room care, and ambulatory surgery care rendered. And in numbers, the number of times a patient visits a physician compared to seeking care at a hospital is 50:1. Therefore, if the "feeders" to the acute care system have the tools and resources available, and the consumer knows which health care provider to visit based on public data, cost will be driven down and quality will go up.

Central to implementation of this "landscape" is the patient and individual understanding of the information. So consumer involvement in developing RIOS is critical. Also critical is **patient identification and authorized access rights**. Dr. Brailer does not support unique patient identifiers but prefers a code number access. He envisions no central storage of data and heavy utilization of audit logs. Dr. Brailer also believes that a breach of privacy will be inevitable and an opportunity to identify improvements to the process going forward.

**Dr. Marc Overhage**, CEO of the Indiana Health Information Exchange shared the ID story!! This exchange was forwarded by 13 independent businesses/groups in 1969. He likens the acceptance of varying data sets to Star Trek's Borg persona - "Resistance if Futile…you will be assimilated." Technology is the problem since Indiana uses a federated model. Each providers owns the data and controls the input. The exchange provides standardization of the data in order to gain the full value of the data stored. The reports, regardless of the origin, look identical.

Indiana selected "RESULTS DELIVERY" as the first order of business. The real motto "Connecting Communities for Better Health" is working. Providers spent less time moving paper and finding the patient's record. Physicians consider the system to have value because it supports disease management as well.

When asked, Dr. Overhage indicated there is limited fear of competition in Indiana. The term he used was "Coop-etition". The hospitals and providers in Indiana have decided NOT TO COMPETE on issues like 1) patient safety, 2) same size surgery markings, 3) information availability, 4) abbreviations, and 5) chronic disease management.

Dr. Kibbe from the Academy of Family Practice Physicians emphasized that another critical aspect for physician office adoption– product certification. The current Electronic Health Record group is in the midst of drafting standards to define "core functionality" and "conformance criteria." The thought is to provider the buyer with some guidance and assurance that the product purchased can provide the structure in which results can be operationalized.

The FHII Board also heard about the implications of the current interpretation of the Stark Law. "The Federal Physician Self Referral or (Stark) law prohibits a physician from referring Medicare patients for certain designated health services (DHS) to an entity with

which the physician has a financial relationship, unless an exception applies.

Given that HIM as routinely distributed paper or faxed information to physician offices – it is the mode of delivery and the cost incured by the physician for receipt of electronic information which comes into play. Under the current law, that cost cannot be waived by the health care providers, however there are some exceptions under the Stark law to be explored (e.g. 42 C.F.R. § 411.357(k), 42 C.F.R. § 411.357(m ), 42 U.S.C. 1395nn (e)(8)

Also mentioned, CMS has a new exception that allows a hospital or other health care entity to provide items or services "of information technology" to a physician to allow access to electronic health care records and complementary drug information systems, general health information, medical alerts, and related information for patients. C.F.R. § 411.357(u). The new exception is intended to encourage use of electronic technology.

In conclusion, the FHII Board plans to give Governor Bush a formal report in January 2005. The Board is defining criteria and intends to designate "demonstration projects" in the State of Florida within a 18 months.

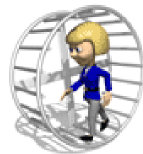
Stay abreast of this project!!! HIM professionals who readily understand privacy, security, access and implementation of electronic systems need to be in the forefront.

Please forward any concerns or comments to me via the Florida CoP on the AHIMA website or by email: jmasjones@aol.com.

For "must" introductory reading

www.hsrnet.net/nhii/materials/strategic_framework.pdf
www.nitrd.gov/pitac/reports/20040721_hit_report.pdf
www.fdhc.state.fl.us/dhit/meetings.shtml

**EMPLOYEE PRODUCTIVITY**
*Rose T. Dunn, RHIA, CPA, FACHE*



There has been discussion on the chat groups about measuring "non-productive time" for coders. Measuring non-productive time is management's responsibility. The approaches described here can be applied to any category of employees—not just coders.

**An FTE is Not an FTE**

In the HcPro book, *More with Less*, we discuss this phenomenon. At the AHIMA National Convention, those at our session on employee productivity identified a nearly endless list of items that account for non-productive time and many are organization-approved. Assuming a 2,080 work hour year, the major items that contribute to non-productive time that a manager must consider when calculating non-productive time are:

- Vacations—80+ hours,
- Holidays—80+ hours,
- Break time—120+ hour,
- Mandated education time—8 hours,
- Department meetings--12 hours, and

- Sick time/other authorized absence—16 hours.

The items above represent 316 hours or 15% of paid annual hours. Knowing the non-productive paid hours is critical for managers. Administration uses various indicators to forecast staffing needs. One measure may your own productivity standards. An example (Exhibit 1) may help emphasize why this piece of information is so important.

| Exhibit 1 Standards vs. Productivity Hours |
|---|
| Charlene has spent hours during the last several months capturing productivity data on her assemblers. She is proud of her analysis of the assemblers production data. Each of her assemblers identified the number of records assembled each day or partial day worked. Having compiled the data, Charlene publishes the production requirement of 10 minutes per inpatient discharge. She shares a summary of her hard work with her boss, Roy, the CFO.<br><br>Roy asks Charlene how many assemblers she has. She has 2. Roy questions her staffing since the hospital has 12,000 discharges a year. Based on 2,080 worked hours and 10 minutes per record, he believes Charlene needs slightly less than 1 FTE. |

**What Did Charlene Fail To Say?**

- She didn't qualify her standard as based on paid worked hours; or
- She didn't inflate the 10 minutes by the organization-approved non-productive paid hour % experienced at her organization and so state that she did; or
- She didn't elaborate on how her staffing level is consistent with the paid productive hours and other duties she has them perform.

Clearly, it is questionable why Charlene has 2 FTEs performing assembly if it only takes 10 minutes per record. Using our 15% non-productive paid hour factor, she has 3,536 paid productive hours remaining for this function. (2,080 x 2FTEs x 85% = 3,536) For 12,000 discharges, Charlene should need 120,000 minutes or 2,000 hours. She needs to explain what the assemblers are doing with their other 1,536 hours.

**Working with the Remaining Productive Hours:**

Again, assuming a 2,080 paid hour year, and deducting vacations, holidays, and sick time, an employee has 238 work days. Managers must attempt to make the most out of those remaining days. However, a day is not a day.

Using the items above:
238 days x 8 paid hours day = 1,904 paid hours

Non-productive paid time = 140 paid hours (breaks, education, dept. mtgs.)

7% expected non-productive time

So, how does management ensure that every employee works 7 hours, 26 minutes a day? You don't! There will be additional lost or non-productive time and, yes, it will be paid time. There will be restroom breaks, social chatter, and the HIM Department everpresent baby or wedding shower that must be set up/cleaned up. These factors are known in the productivity measurement circles as "personal" and "fatigue" factors. But there are numerous other items that steal away from the employee's work day that managers can impact including another productivity measurement factor—"delays." The

P, F, and D factors may equate to 6-7% non-productive time.

Using Charlene's example above, she should make adjustments to her calculation; it must be inflated by the non-work paid time and P, F, and D factors.

Actual production time to do a task x 1.(non-work paid time % + P, F, D %)

10 minutes assembly time x 1.(15 non-worked paid % + 7 PFD%)

10 x 1.22 or 12.2 minutes per record

The 12.2 minutes should be used to estimate staffing requirements. However, the 10 + 7% or 10.7 minutes should be used to monitor productivity during worked paid time. It is important for managers to recognize that "standards" must apply to the situation for which it is being evaluated.

**Eliminating the "D" and Other Controllable Factors:**

Management must identify time-wasters, reduce interferences, and encourage employees to utilize their remaining work days effectively. While there are a variety of tools that managers can use, the easiest one is "desk-side observation." Desk-side observation is not sitting at one's desk in an office and watching the employees from the window. This observation technique requires the manager to sit side-by-side with the employees at their desks and observe and understand what they are doing.

During our client operational assessments, we spend time with each employee. It's during that time that we see the telephone calls that interrupt the employee's train of thought, we count the number of steps to retrieve one's work or to file it when they are done with their piece of the process, and we listen to the "noise" that surrounds the work area. However, most importantly, we try to understand what the employee is required to do to get their job done. It's the latter where we identify steps that can (1) be eliminated, (2) assigned to others, or (3) revised to reduce lost time and/or improve performance/productivity.

Examples identified in 2003-2004:

- Employee types on a typewriter, name labels for the file folders.
  - There are several ways to eliminate this timewaster including asking information systems to print a set of labels for the Department daily.
- Staff makes a temporary folder for each discharge and then marries the record with its permanent file after completion.
  - If resources are being spent on making a temporary folder, then why not just make a permanent folder and eliminate the effort to marry the record after completion.
- At record completion, a special document is printed and placed in the folder. The person who checks the record for completion doesn't print the document. The record is set aside for someone else to do this step.
  - Eliminating the duplicate handling created staff time to do other activities.
- Coders are physically located near the front door and the Release of Information area where the most office traffic occurs.
  - The noise level was unacceptable. Suggesting that the coders be moved to the rear of the department made more sense. Also, that's where the assembly and analysis is performed.
- Indexing and scanning different document types.

- o The system being used allowed documents to be indexed after the entire record was scanned or when document types are being scanned. By scanning everything at once and then performing the indexing function, the time savings was significant.

Desk-side observation is time-consuming, but worthwhile. However, other techniques can assist the manager in identifying activities to monitor. Assume we have employees who perform a variety of duties throughout the day. If a manager needs to know how much time is spent each day by a coder on inpatient, ambulatory surgery, and ER records, then a time ladder (see figure 1) could be used. This tool requires the employee to use a gradated time log and notes at the designated times on the log when he/she is coding each group of record types.

When the manager studies the time ladders, the manager obvious other uses of the coder's time are observed. The manager may choose to reassign some of those duties to other staff members.

**Figure 1 Time Ladder**

**TIME LADDER**
**Employee:___Carl Coder**

7:00______Inpt Charts_______________________________

7:15______Inpt Charts_______________________________

7:30______Searching for missing cases_______________

7:45______Call from BO____________________________

8:00______Inpt Charts_______________________________

8:15______Ambi Surg_______________________________

8:30______Ambi Surg_______________________________

8:45______Ambi Surg_______________________________

9:00______Ambi Surg_______________________________

9:15______Break____________________________________

9:30______Inpt Charts_______________________________

9:45______Inpt Charts_______________________________

10:00_____Inpt Charts_______________________________

10:15_____Bathroom________________________________

10:30_____Inpt
Charts_______________________________

10:45_____Inpt
Charts_______________________________

11:00_____Inpt
Charts_______________________________

11:15_____Inpt
Charts_______________________________

11:30_____Lunch____________________________________

11:45_____Lunch____________________________________

12:00_____Lunch___________________________________

12:15_____Searching for path reports_______________

12:30_____Searching for path reports_______________

12:45_____Printing dictated report__________________

1:00______Covering phone for receptionist_________

1:15______Covering phone for receptionist_________

1:30______Covering phone for receptionist_________

1:45_______Inserting Paths and Dictated Reports_____

2:00_______Inserting Paths and Dictated Reports_____

2:15______Ambi
Surg_______________________________

2:30______Ambi
Surg_______________________________

2:45______Restroom/Filing records in Incomplete____

3:00______ Filing records in Incomplete _____________

3:15______ Filing records in Incomplete _____________

3:30_______________________________________________

3:45_______________________________________________

4:00_______________________________________________

4:15_______________________________________________

etc.

This document was used at the 2004 AHIMA National

Convention. "Improving Staff Performance-Measuring Productivity, Setting Expectations, and Establishing Incentive Plans for HIM Staff."

Several of Carl's duties may be prime for assigning to others including filing records, covering the phone for the receptionist and searching for pathology reports. However, in some smaller hospitals, this may accurately depict Carl's day and there may be no one else to assign the work to!

**Productivity Standards:**

Many managers use productivity standards for their staff. Additionally, productivity measurement systems like Premier and other organizations establish staffing expectations. However, every standard or expectation must be tempered with reality. No two organizations are the same and work expectations differ from one facility to the next. Assume that at your organization, the coding staff performs the CMS Demonstration Project abstraction, but when you check with other organizations in your "reporting sector"—your Department is unique. Now the manager must convince their CFO.

To convince the CFO, data will be required. To capture the data, time studies may be necessary. This will require analysis of data from your coding and abstracting systems (see Figure 2). Further, proof that others in your "reporting sector" are not doing what you're doing.

**Figure 2**

| CMS Demo Project Category | Measurement System's Minutes | Actual Minutes (Average) | Difference |
|---|---|---|---|
| AMI | 53 | 55 | (2) |
| CABG | 32 | 31 | 1 |
| HF | 26 | 27 | (1) |
| CAP | 46 | 45 | 1 |
| Knees & Hips | 27 | 30 | (3) |

Using the Measurement System's data, a manager should be able to argue that the remaining productive hours available after deducting all the organization's approved paid time is a critical point. Using the 1,904 hours in our example above, an employee should be able to abstract 2,155 AMI records. However, if the employee also is coding and abstracting the record for the bill drop, the manager will need to add the production standard factor for coding and billing abstract. Let's assume that the coding and bill abstracting standard is 15 minutes. Then our employee should be able to (1) code, (2) bill abstract, and (3) CMS abstract 1,901 records. But, is this true?

Once again, the Measurement System's Minutes, Actual Minutes, and Coding Productivity Standard above do not indicate whether the minutes include non-worked paid time or not. If one takes six months of production data and divides by the number of paid hours to obtain a productivity standard, then it is likely the production standard will reflect some of types of non-work paid hours as well as the P, F, and D factors at the beginning of this article.

Investigating why there are variances between your department and the organization's measurement system will be as important as capturing the abstracting time effort. The two tools described above and the article "Turning Production Data into Management Tools" that appeared in the *Journal of AHIMA* in October 2002 should help in this endeavor.

Other approaches that management can consider to improve productivity and reduce non-productive paid time include incentive plans and recognition programs. There are a number of articles that speak about these approaches, including the following:

- "Incentive Programs Offer Aid to Increase Coding Productivity," *Journal of AHIMA,* January 2000.
- "Developing Facility-specific Productivity Measures," *Journal of AHIMA*, April 2001
- "Putting Productivity Plans to Work," *Journal of AHIMA,* October 2001
- "Turning Production Data into Management Tools," *Journal of AHIMA*, October 2002.
- Haimann's Healthcare Management 7th Ed., published by Health Administration Press


Many organizations have established recognition programs to acknowledge those who have high productivity, low absenteeism or other desirable work ethic characteristics. These programs often offer non-financial rewards such as "fish," certificates, trophies or small gifts such as pins. Some employees respond to these type of incentives; others prefer financial rewards that accompany traditional incentive plans.

Knowing the number of productive hours available to perform a job, assessing what it takes to do the job, applying appropriate production standards for monitoring as well as predicting staffing requirements, and recognizing those who perform at and above the expected levels are integral to reducing non-productive time and improve overall performance.

**The Return of the Forms Committee**
*Rose T. Dunn, RHIA, CPA, FACHE*

In years past, the Medical Records Committee had two primarily functions: (1) receive the delinquency report and (2) approve new forms for the patient record. However, as surveyors became more vigilant in their duties, the "receiving" of the delinquency report was not enough without taking action to reduce the number and sanction the regular offenders. On the other side, too much approval of forms has created a record that is a dinosaur as a tool for research and paper care. We have added tabs to help direct users to find the information they need, we have created indexes to tell individuals where to file the many documents, and we have even allowed individuals to design their own forms.

Some organizations have removed the "forms approval" process from the Medical Records Committee. Some have eliminated the Medical Records Committee altogether! The plethora of forms is partially the result of lack of oversight of forms generation. So who controls the forms management function? Who assesses the money wasted every year in the maintenance of outdated forms inventory, inappropriate order quantities, and haphazard development of new forms that are quickly discarded? If HIM professionals are to play a leadership role in developing an electronic health record for their organizations, then they must take the lead in streamlining forms used today and eliminating redundant data collection.

**Why Implement a Forms Management Process?**

Patient Safety and Time Savings: It is difficult to navigate through the paper record. It is even more difficult to provide patient care if the caregivers must find some information on-line and other information in the tome we call the patient record. One performance improvement activity looked at the documentation of allergies in a paper patient record and found both inconsistencies in the drugs noted as well as the indication of "no allergies" in the same patient's record! Why does this happen? Because we allow forms

to be created that require caregivers to record this information and then record it again and then record it again, and again, and again! This is not sloppy documentation—it is the "every body syndrome."

There was an important job to be done and Everybody was sure Somebody would do it. Anybody could have done it, but Nobody did it. Somebody got angry about that because it was Everbody's job. Everybody thought Anybody could do it, but Nobody realized that Everybody wouldn't do it. It ended up that Everybody blamed Somebody when Nobody did what Anybody could have done.

With all the other duties caregivers have, the last thing that should be imposed on them is redundant entry of information. From the patient's point of view, having been there myself, it's exhausting to answer the same questions for the physician, the assigned nurse, the "fill-in" doctor, the "fill-in" nurse, the consultant, the anesthesiologist, the resident, the intern and the med student! It is no wonder they receive and record different information!

Establishing a single document that *is* completed completely and just ONE time will save everyone time and provide the caregivers with ONE place to look for those pertinent data elements needed to treat the patient. This simple change can reduce minutes per day per patient that adds up to hours considering the number of patients served in a healthcare facility in a given day. Those are valuable hours that can be directed to patient care rather than 'writing.'

Eliminates Outdated Forms: Inventorying all the forms of the organization will identify forms in use that are outdated versions and unsurface forms that are no longer used but remain in inventory. The cost of maintaining inventories can be substantial.

**Implementing a Forms Improvement Program**

**Appoint a Team.** The Forms Team should include representatives from patient care functions. They are the principal users of the forms. HIM and Materials Management should be members and, if your organization to moving toward a document imaging system or EHR, then IT should participate. If your organization utilizes a forms vendor, consider adding their representative.

**Create Form's Design Policies.** Include items such as:

Facility Identification: Include the name, address, and telephone number for the facility and it should be placed in a common location such as the upper left-hand corner to avoid interfering with an addressograph block and to facilitate return of a record or document should they "find" themselves outside of the organization.

Form Number: Establish a numbering schema that identifies the originator's department, approval date, and number of forms for that department. The schema should identify recommendations. The number should be located in a common location such as the lower left-hand corner to avoid interfering with the placement of a bar code. The form number may include an additional code that represents where one may obtain additional copies of the form such as OOD (Obtain from the Originating Department); POD (Print on Demand); OPS (Obtain from Materials Management/Print Shop), etc.

Filing Location: Identify the tab behind which the form should be filed. Consider placing this in the center bottom of the form.

Page Numbers: If a form has more than one (1) page, including front and back, all pages should be numbered. The total number of pages will be included on each page. Example 1 of 4, 2 of 4, 3 of 4, 4 of 4. The page numbers will be centered at the bottom of the page.

Multi-Part forms: Should display the distribution location for each part of the form.

Addressograph/ID Label: A standard location should be identified, such as the upper right hand corner. Establishing a standard location and size is important for an imaging system as well.

Form Title: This should appear in a common location—either centered at the top of the form or below the facility identification. Some organizations choose to place the form title centered at the bottom of the form

Form Structure:

- Ø Use check boxes are preferred, rather than brackets
- Ø Avoid abbreviations that are not in the Hospital Approved Abbreviations; Use an abbreviation key on the form to limit misinterpretation
- Ø All print should use upper and lower case and a font size no smaller than Ariel 10 pt font
- Ø Check all spelling and terminology; use spell check
- Ø Avoid colors and shading

Form Size: All forms should be a standard size. Ideally, for photocopying purposes, 8 1/2" X 11" is the best size for a document. Bi-fold and tri-fold documents are difficult to handle and copy in a closed chart

Ink Color: With widespread use of photocopying, imaging, and faxing, the best form colors are black ink on white paper. If color-coding is desired, a strip of color along one margin is the best option

Binding Edge: To permit sufficient space at the margin edge for holes, allow at least a 3/4" margin.

Paper Weight: Forms should be printed on paper that is 20-24 pounds in weight; heavier weighted forms may jam in copiers, faxes, and scanners.

**Managing the Process.**

Request Form: Many organizations use a request form for its forms management program. Examples of a New/Re-design Form Request Form appears at http://www.rwh.org.au/emplibrary/rwhhis/Guidelines.pdf and http://www.jeffgraphics.com/fma.pdf

No one wants to add any burden to the process, but a form request form can help communicate changes required and approvals as well as help organize the process. The request form can include the "rules" for form design and guide the originating department.

Consider Software: There are many products available to assist in forms design, including FormFast, FormDocs, DesignPro, NCS Design Expert, and OneForm Designer Plus. Some of these applications, such as FormFast, includes a bar coding feature that ties with the ADT system and pulls in demographics. Such a feature facilitates the imaging program's scanning process.

**Transitioning to the EHR.**

Understanding the information required for patient care, where and when certain data elements are needed (in surgery, when lab data is reported, at time of discharge, etc.), who uses it and how it is used, will be crucial in designing e-forms in the EHR and building tables of data elements. Being a pivotal facilitator compiling this massive database will ensure a "place" for the HIM professional at the EHR planning table.

**Other Resources:**

Office of Comptroller General, Core Policy and Procedure Manual;

http://www.fin.gov.bc.ca/ocg/fmb/manuals/CPM/12_Info_Mgmt_and_Info_Tech.htm

Records Management Publications, Texas State Library and Archives Commission:
http://www.tsl.state.tx.us/slrm/recordspubs/fm.html#imp

AHIMA Practice Brief: Developing Information Capture Tools;
http://library.ahima.org/xpedio/groups/public/documents/ahima/pub_bok1_000086.html

Arnot Ogden Medical Center's Forms and Printed Materials Policy

**DOH Announces Revisions to the Florida Birth Certificate**

The Florida Department of Health, in accordance with Senate Bill 160, has made two minor revisions to the Florida Certificate of Live Birth, form DH 511.

Florida law now allows for either a notary or two witnesses when acknowledging paternity on the Florida birth certificate (see September & December issues of the *Vital News*). The form has been redesigned to allow for this change. Another minor change has been made to items 31 & 34, the Hispanic question for the mother and father. It now asks if Hispanic Origin, check Yes or No, &, if Yes, to specify as informed by the parent (no longer says anything about checking more than one item).

The implementation date for this revised form is March 1, 2005.

The State Office of Vital Statistics (OVS) will be working with the Department of Revenue/Child Support Enforcement Office (CSE) in its effort to educate hospitals about the two witness option. CSE, with input from OVS, has developed a *Florida In-hospital Paternity Establishment Resource Guide* that will be distributed to the hospitals as a reference tool. Vital Statistics has abstracted material from this resource guide and provided it to the chief deputy registrars (CDR) in the county health departments, ensuring that all parties have access to the same information. This information will be incorporated into the Vital Records Registration Handbook, as well as the Chief Deputy Registrar Operations Manual. CDRs will be offered the opportunity to accompany the CSE staff to one or more CSE trainings of hospital staff in their area. Once CSE has set the training schedule, CSE will provide specific information regarding dates, times, and locations of training events

The revised forms are available as follows:

- Pre-printed forms are available from the CDR-- hospitals should return all old forms.
- Brookins' updated software, which will generate the revised birth certificate, is available for downloading on their website at: <<http://www.birthtype.com/download.htm>> - go "Software Update" to download.
- SweluSoft software vendor will provide the revised version to facilities using their product.

Any questions regarding the revised birth certificate should be directed to Jim Ballard at 904/359-6951. (Source: Florida Department of Health, Office of Vital Statistics)

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## AHIMA Update

January/February 2005

One Stop Record Services, Inc.
407-523-6511
Serving Florida's ROI needs for over 15 years

### Senators Make Effort to Influence Administration's IT Effort

Senators Michael Enzi (R-WY), Edward M. Kennedy (D-MA), Charles E. Grassley (R-IA), and Max Baucus (D-MT) have forwarded a joint letter to Department of Health and Human Services Secretary Tommy G. Thompson and Office of Management and Budget Director Joshua B. Bolten instructing the administration to provide further detail and guidance surrounding the adoption of healthcare information technology systems. This guidance is to include "the role of public programs and government funding for these initiatives, options for building public-private partnerships and fostering physician involvement in changing the way care is delivered, and ways to address privacy and security concerns." The letter also laid out the importance of providing the healthcare community assistance through financing and other means. Senators Enzi and Grassley chair the Senate Health, Education, Labor and Pensions Committee and the Senate Finance committee respectively. Senators Kennedy and Baucus are the ranking Democratic members on that committee.

### NCVHS Work Group Examines PHRs

The National Committee on Vital and Health Statistics (NCVHS) national health information infrastructure (NHII) work group has continued its look into the structure and role of personal health records (PHRs) in the healthcare industry. At its January meeting, the work group heard reports from Cynthia Baur from the Department of Health and Human Services Office of Disease

Prevention and Health Promotion and David Lansky from the Markle Foundation.

The work group also heard from consumers using different versions of the PHR and from providers on the benefits and shortcomings of PHRs. In this hearing, participants discussed the links between electronic health records (EHRs) and PHRs, and especially the concept of the patient being able to "view" their EHR electronically.

Finally, the work group heard of some of the business cases and business issues related to PHRs and discussed the financial, social, and medical benefits that may have to be identified for movement forward. It was clear from all the discussion that taxonomy is needed to discuss and study PHRs. AHIMA is working on a variety of projects related to the PHR and will be actively engaged in work group discussions. A transcript and some of the handouts for this meeting should be available shortly on the NCVHS Web site at http://ncvhs.hhs.gov/.

## NCVHS Standards and Security Subcommittee Pursues eRx and HIPAA Status

Last week the NCVHS Standards and Security Subcommittee moved forward with additional hearings on the signature, authentication, and security aspects of electronic prescribing (eRx). The committee heard from the federal Drug Enforcement Agency as well as experts in the area of electronic signatures and authentication. The group also heard from the Office of HIPAA Standards that proposed rules on the eRx program, which will be released shortly so that the eRx pilot program can begin in 2006. The subcommittee heard reports from the National Uniform Billing Committee and the National Uniform Claims Committee. Both groups provided an update on their efforts to adopt new claims forms and data sets for the UB-92 and the CMS 1500 respectively. Both groups have invited comments via the Web and hope to come up with their final changes in February 2005.

Also speaking to the subcommittee was the Workgroup on EDI (WEDI) who reiterated their previous May 2004 recommendations to the committee and discussed the current state of the HIPAA transaction implementations. Non-medical and medical coding problems were also discussed. No final recommendations were made, but the subcommittee will meet again at the beginning of February and hopes to make recommendations to HHS in March.

A transcript and some of the handouts for this meeting should be available shortly on the NCVHS Web site at http://ncvhs.hhs.gov/.

## Joint Commission, NQF Aim for Deep Vein Thrombosis Standards

The Joint Commission on Accreditation of Healthcare Organizations and the National Quality Forum (NQF) are seeking to

create national voluntary standards for performance measures to assess the quality of care for persons at risk for deep vein thrombosis and to achieve consensus on evidence-based best practices and model organizational policies and procedures for prevention and care. The project seeks participants for its steering committee, technical advisory panel, and model organization policies and procedures. The Joint Commission will review and develop performance measures while the NQF will evaluate evidence-based best practices and policies and procedures.

To respond to the call for steering committee nominations and technical advisory panelists, go to http://www.qualityforum.org/txDVTSCTAPcallfinal12.17.04.pdf. To respond to the call for measures, evidence-based best practices, and model organization policies and procedures, go to http://www.qualityforum.org/txDVTmeasurebestpracticescallfinal12.22.041.pdf. The submission deadline for both is February 7. Respondents must complete and include the proprietary agreement with their measure submission(s), available at http://www.qualityforum.org/txproprietaryagreetemplate.doc.

## Summary of 2005 OPPS Payment Policy Changes

The Outpatient Prospective Payment System (OPPS) update will affect hospitals and other providers billing Medicare fiscal intermediaries. The January 2005 OPPS Outpatient Code Editor and OPPS PRICER will reflect the Healthcare Common Procedure Coding System, Ambulatory Payment Classification, HCPCS Modifier, and Revenue Code additions, changes, and deletions identified in Change Request 3632. To review the 2005 summary of OPPS payment policy changes, go to http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3632.pdf.

## Collaboration Responds to ONCHIT RFI

On Tuesday, AHIMA joined 12 other major health and information technology organizations to endorse a "Common Framework" to support improved health information exchange in the US while protecting patient privacy. The joint document identified vital design elements of standards, policies, and methods for creating a new environment that would allow healthcare professionals, institutions, and individuals to exchange health information in order to improve patient care. The response was directed to a request for information issued in mid-November by the Office of the Coordinator for Health Information Technology (ONCHIT).

Linda Kloss, RHIA, CAE, executive vice president and CEO stated, "This request for information from ONCHIT provides an outstanding opportunity to gather and organize the industry's collective intelligence and begin mapping out a course of action. Creating a national health information network is a complex yet critical challenge but one that must not wait any longer to address. The

health of patient and the systems that serve them are depending on it." A copy of the full document from the collaborative can be found on the AHIMA Web site at http://www.ahima.org/dc. The Connecting for Health project, who coordinated the response, has also developed some additional material related to the document and this information can be found at http://www.connectingforhealth.org.

## Second Annual HIPAA Privacy and Security Compliance Survey Begins This Week

AHIMA's second annual HIPAA Privacy and Security Compliance Survey begins this week. Approximately 13,000 survey e-mails will be sent to AHIMA members and others who work in privacy and security roles. This survey is an important tool that will help us guide policy makers through the development of potential HIPAA privacy and security modifications. Your input may very well be the basis for future HIPAA changes, so please respond quickly and accurately to the survey. The second annual AHIMA HIPAA Privacy and Security Compliance Survey and Report will be released during National Health Information Privacy and Security Week, April 10–16.

## AHIMA Hill Day Set for March 16

Are you interested in being an ambassador for HIM? AHIMA needs you to join us on March 16 for our Capitol Hill Day in Washington, DC. Every member counts, and AHIMA's Hill Day provides an outstanding opportunity for you to be an ambassador for AHIMA by establishing relationships with your elected officials to support issues critical to the HIM profession. Our advocacy success begins with you, and Hill Day is a great way to educate lawmakers and also receive first-hand training in advocacy.

In addition to Hill Day, AHIMA has planned two other member events in Washington, DC. Preceding Hill Day, on March 14, AHIMA has planned the face-to-face work group educational session "Migration Path to the Electronic Health Record." On March 17, the day following Hill Day, plan to attend AHIMA's Winter Team Talks. These events will be held at the Hotel Washington. Keep visiting http://www.ahima.org/dc/hilldayinfo.cfm and AHIMA's Communities of Practice for further information.

## 2005 Nominations Deadline Nears

Each year future leaders of the Board of Directors, the Commission on Accreditation for Health Informatics and Information Management Education, and the Council on Certification are selected through a national election. The Nominating Committee, based on criteria for the elected positions, selects the slate of candidates for the election. As we begin the process of selecting

those individuals who will assume office in January 2006, our first appeal is to you, the member. We encourage you to seek one of the national elected positions or assist the Nominating Committee by identifying AHIMA members who will provide strong leadership for AHIMA in the years ahead. To find out more, log in and go to http://www.ahimanet.org/COP/StateLeadersandHOD/ or look for the "Call for Nominations" document in the Resources section of the State Leaders and HOD CoP. Feel free to submit your nominations electronically to marilyn.render@ahima.org.

## Join Us in March for 2005 Winter Team Talks

Join us in March for Winter Team Talks:

- March 3, Sheraton Atlanta Hotel, Atlanta, GA
- March 10, Luxor Hotel, Las Vegas, NV
- March 12, Sheraton Suites Country Club Plaza, Kansas City, MO
- March 17, Hotel Washington, Washington, DC

Meeting and hotel registration forms and details for the 2005 Winter Team Talks meetings are available in the Resources section of the State Leaders and HOD Community of Practice. Hotel cut-off dates vary per city. For registration and details, log into the Communities of Practice at http://www.ahima.org and go to the State Leaders and HOD Community.

For those who cannot attend the face-to-face meeting for Winter Team Talks, we are offering a **Virtual Winter Team Talks on March 30, 12–2 p.m. CST**. For registration and details, log into the Communities of Practice at http://www.ahima.org. A Virtual Winter Team Talks Meeting registration form is available in the Resources section of the State Leaders and HOD Community.

## Upcoming Leadership Seminars

Sharpen the skills you need to lead a successful transition to an electronic healthcare landscape, while dramatically broadening your take-charge abilities in all areas of life.

"Renaissance for the 21st Century: Leading the Change to E-HIM™" helps you look inside to become the best leader you can be. Gain expert information and unique insight. For example, do you know how to predict the reaction to change within your department or hospital and how to be ready to effectively manage it? You will after the conference. Best of all, the cost includes personal coaching after the seminar!

**Sign up today!** The schedule for 2005 seminars is now available. The next seminar will be held on February 28–March 1. All seminars will be held at the AHIMA office in Chicago, IL. Visit http://www.ahima.org/renaissance for complete information and

registration.

## Try out AHIMA's New Search Engine

AHIMA recently implemented a new upgraded search engine on http://www.ahima.org/. The new search function searches all AHIMA domains including the FORE Library: HIM Body of Knowledge, ahima.org, Communities of Practice, the AHIMA bookstore, the AHIMA campus site, and more. Next time you are looking for information on our Web site, give it a try. The search bar is located at the top of the main page on http://www.ahima.org/.

## CMS Clarifies of Use of V codes in SNFs

The Centers for Medicare & Medicaid Services (CMS) released a transmittal clarifying ICD-9-CM coding requirements for skilled nursing facility (SNF) claims, including the use of V codes. In conjunction with members, AHIMA staff has been working with CMS to correct industry misperceptions regarding CMS requirements for reporting ICD-9-CM codes on SNF claims. This transmittal clarifies that the principal diagnosis code must be reported according to the ICD-9-CM Official Guidelines for Coding and Reporting, including any applicable guidelines regarding the use of V codes. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in the ICD-9-CM guidelines. To review the transmittal, go to:
http://www.cms.hhs.gov/manuals/pm_trans/R437CP.pdf.

## OIG Releases Supplemental Guidance for Hospitals

The HHS Office of the Inspector General released a “Supplemental Compliance Program Guidance for Hospitals” (70FR4858). The guidance supplements its prior compliance program guidance for hospitals, issued in 1998, and covers a variety of topics including outpatient procedure coding, use of information technology, substandard care, HIPAA privacy and security rules, and training and education. The complete notices can be found in the January 31, *Federal Register* at:
http://www.access.gpo.gov/su_docs/fedreg/a050131c.html.

## AHIMA’s Comments on UB-04 Posted on Web

AHIMA’s comments to the National Uniform Billing Committee on the proposed UB-04 data set and claim form have been posted on the AHIMA Web site. Comments were submitted on the diagnosis present on admission indicator flag, the increase in number of diagnosis code fields, expansion of size of diagnosis and procedure code fields, and creation of distinct fields for admitting diagnosis

and patient's reason for visit. To view the comment letter, go to: http://www.ahima.org/dc/UB04comments.cfm.

## CMS Explains IPF PPS Policy and Billing Information

CMS released a transmittal clarifying policy and billing information for the new Prospective Payment System (PPS) for inpatient psychiatric facilities. This transmittal clarifies the application of ICD-9-CM "code first" rules. It also corrects errors in the codes listed for oncology treatments in the final rule. The correct ICD-9-CM procedure codes for oncology treatments are 92.21 through 92.29 and 99.25. To review the complete transmittal, go to: http://www.cms.hhs.gov/manuals/pm_trans/R444CP.pdf.

## Medicare Claim Processing Updates Announced

A recent CMS transmittal clarified the use of modifiers 52, 73, and 74 under the hospital outpatient prospective payment system (OPPS). The transmittal provides guidance on how to report and be reimbursed for partial reduction or discontinuation of radiology, surgical, and certain diagnostic procedures. For outpatient billing purposes the definition of anesthesia use is also defined. The updated transmittal information goes into effect on February 22. To view the updates, go to: http://www.cms.hhs.gov/Manuals/pm_trans/R442CP.pdf.

## Study: Clinicians Report Missing Information Is Common

A survey of clinicians indicates that missing clinical information for patients is common and may adversely affect patients, according to a study in the February 2 issue of *JAMA*. The researchers found that clinicians reported missing clinical information in 13.6 percent of visits, including laboratory results and letters/dictation. Missing clinical information was less likely in rural practices and when individual clinicians reported having full electronic records. Read the *JAMA* press release and an accompanying *JAMA* editorial at: http://pubs.ama-assn.org/media/2005j/0201.dtl#clinicians.

## White House Again Adds Budget Funds for HIT

Following Congress' elimination of the $50 million in health information technology (HIT) funding in the fiscal year 2005 Department of Health and Human Services (HHS) appropriations bill, the Bush administration has rededicated its effort to see funding appropriated for HIT and the work of national health information technology coordinator David Brailer, MD, PhD. The administration's fiscal year 2006 budget proposal for HHS includes $125 million for HIT demonstration projects. The White House has

also proposed doubling the $50 million in HIT support funds to $100 million.

## Family Health History Initiative Launched

Healthcare professionals have known for a long time that common diseases can run in families. To help focus attention on the importance of family health history, US Surgeon General Richard H. Carmona, MD, MPH, in cooperation with other agencies within the US Department of Health and Human Services, has launched a national public health campaign called the US Surgeon General's Family History Initiative. The purpose of the initiative is to encourage all American families to learn more about their family health history.

Because family health history is such a powerful screening tool, the Surgeon General has created a new computerized tool to help make it fun and easy for anyone to create a portrait of their family's health. This new tool, called "My Family Health Portrait" can be downloaded free and installed on your own computer at: http://www.hhs.gov/familyhistory/order.html. AHIMA's representatives on this initiative are Julie Wolter, MA, RHIA, Jeanne Donnelly, MBA, RHIA, and Jody Smith, PhD, RHIA, FAHIMA. Details on this initiative can be found at: http://www.hhs.gov/familyhistory/.

## Upcoming FORE Merit Scholarship Program Deadlines

FORE is now accepting applications for its 2005 merit scholarships. The FORE scholarship program was established to ensure that the best and the brightest continue to enter the HIM work force each year. Scholarships are open to students at the associate, baccalaureate, and graduate level.

Applicants eligible for a FORE scholarship must be enrolled in an accredited HIM program, be a member or student member of AHIMA, meet the minimum GPA. requirement (3.0 out of a 4.0) and be enrolled in a minimum of six semester hours.

FORE also offers a variety of other financial assistance options intended to support the various needs of students and professionals who seek to advance in HIM. For more complete information on the variety of financial assistance FORE offers or for an application, please visit: http://www.ahima.org/fore or send an e-mail to: fore@ahima.org with "scholarship question" in the subject line.

Application Deadlines for 2005
Merit Scholarships and Loans—May 27
Grant-In-Aid and Dissertation Assistance Awards—March 25 and September 23
Faculty Development Stipends—March 1, July 1, and October 1

FORE scholarships are underwritten by the following companies at the silver partner level or higher: 3M Health Information Systems, MedQuist, MC Strategies, and Redi-Tag.

## Triumph Awards Nomination Forms Now Available

The Triumph Awards are national awards designed to recognize those special individuals who have made a difference in the HIM profession. This awards program was developed as part of the Foundation of Research and Education to honor leadership in the HIM field, reward contributions that build our knowledge base, recognize excellence in preparing future HIM professionals, and encourage fresh talent and new leadership.

It all starts with a nomination. It's easy to show your appreciation for the outstanding contributions of a remarkable individual. Simply review details of the award categories and complete the nomination form, available at: http://www.ahima.org/fore/practice/awards.cfm. **Don't delay—nominations are due June 3**. Contact Marilyn Render at: marilyn.render@ahima.org with any questions