



HOSPITAL PAYMENT & INFORMATION MANAGEMENT™

INSIDE

■ **Realities of disaster prep:**

Here's an inside look at what happened when planning and reality unexpectedly collided at one New York hospital on Sept. 11. Cover

■ **Disaster response:** 'We've tested it and it works' 19

■ **HEICS plan:** This one's endorsed by AHA, JCAHO. . . 20

■ **Plugging holes:** Hospital fine-tunes disaster plan . . . 22

■ **DRG Coding Advisor:** Expert offers advice for initiating a data quality improvement process 23

■ **Patient privacy:** Make sure privacy is protected in a disaster. 29

■ **Plan B:** Here are essentials of a contingency plan 30

■ **Strengthening skills:** Staff line up to take part 31

**FEBRUARY
2002**

**VOL. 20, NO. 2
(pages 17-32)**

Saint Vincents had a plan and used it when faced with New York's tragedy

HIM department was not prepared for volume

(Editor's note: This is the second part of an occasional series about disaster planning in the wake of Sept. 11. Articles in the January 2002 issue of Hospital Payment & Information Management focused on what HIM departments can do to fully prepare for terrorism-related disasters.)

St. Vincent Catholic Medical Centers - Saint Vincents Manhattan in New York City became one of the best-known hospitals in the country after Sept. 11. The hospital handled hundreds of victims of the disaster and fielded inquiries by thousands of family members, media, insurers, and others.

SPECIAL REPORT: PLANNING FOR ULTIMATE DISASTERS

From the HIM department's perspective, the disaster was handled by the book. The only major problem was not enough disaster records for all of the patients handled Sept. 11-13, says **Dianne Chappelle**, MPA, RHIA, director of health information management.

"We had 250 disaster records and we needed over 600," Chappelle recalls.

The disaster records were recreated in the event a disaster required an entirely manual system, and it involved a different registration system.

"Part of our protocol calls for HIM staff to track patients, register, and know patients' whereabouts," Chappelle says. "And that puts some stress on our department because disasters are expected to go a certain length of time."

The department's disaster plan was geared toward a disaster with a short duration, and no one anticipated a disaster that would last three days, Chappelle adds.

On the other hand, the disaster's timing was optimal.

**NOW AVAILABLE ON-LINE: www.ahcpub.com/online.html
Call (800) 688-2421 for details.**

Saint Vincents replay offers lessons learned

On Sept. 11, Saint Vincents hospital in Manhattan, a Level 1 trauma center located two miles from the World Trade Center, found itself at the center of an unthinkable tragedy. A Code Three was called after two hijacked airliners slammed into the twin towers, ultimately destroying both buildings, as well as other buildings in the surrounding area.

This tragedy put Saint Vincents' staff and its disaster plan to the ultimate test. Physicians and nurses scrambled to treat the flood of injured that were brought in. Many of the injured were rescue workers who were treated and released and who then returned to the World Trade Center site.

On Nov. 14, American Health Consultants presented "Responding to the Unimaginable: How Saint Vincents Hospital Coped With the World Trade Center Attack," a 100-minute-long audio conference conducted by four clinicians from Saint Vincents who were there as the crisis unfolded. The clinicians discussed in depth how they coped, where their disaster plan worked, where it didn't, and the lessons they learned. If you missed out on the audio conference on Nov. 14, the complete conference will

be available for replay at your convenience on Wednesday, Feb. 20, and Thursday, Feb. 21.

Representatives from the emergency department, case management, and supportive care services of Saint Vincents shared unique insights from their different perspectives. ED physicians and nurses encountered documentation nightmares when cases were not properly recorded. Hear how staff were cut off as communications went down and how the hospital successfully used its supply of two-way radios to bridge the communications gap.

Case managers scrambled to discharge patients in order to free up beds for the anticipated onslaught of injured victims. Learn how supportive care stepped in to treat the emotional scars for the injured, the community, and hospital employees.

The cost for the audio conference is \$249 per facility, which includes 2 nursing contact hours or 1.5 AMA Category 1 CME credits for every participant. Call our customer service department at (800) 688-2421 to receive instructions for accessing the conference and downloading handouts and continuing education materials. Don't miss out on the opportunity to learn from another facility's first-hand experience. Use Saint Vincents' experience to re-evaluate your current disaster plan so that you're ready if the unimaginable happens in your community. ■

"The best time to have a disaster is at 9 a.m. because you're fully staffed and you have other areas fully staffed too," Chappelle explains. "So our entire department did not have to be mobilized, because other departments came to assist us."

Ambulatory care and clerical staff helped the HIM staff with emergency department intakes.

Another problem concerned the way patients were routed through the hospital. In the department's disaster plan, it was expected that patients would enter the hospital through the emergency department. Instead, patients arrived through every entrance, Chappelle says.

"That caused confusion, especially for those of us who were trying to keep track of the whereabouts of patients," Chappelle says. "As we're going through the disaster we can't just say, 'Don't bring them here or there.'"

Although many of the patients arrived without identification and in a state of shock, there were

very few patients who were not immediately identified, Chappelle says.

However, the disaster plan called for attaching identification bands to each patient, and this proved to be a problem for patients who were burned or had other kinds of injuries on their arms and legs.

"So we're going to look to where else we could possibly put ID bands and how else to tag patients," Chappelle says.

The hospital also was expected to track emergency service workers, including police officers, fire fighters, and ambulance crews, and that proved to be difficult.

"The need to know more quickly and identify them more quickly was an issue," Chappelle says. "People wanted to know who was in the hospital and who wasn't, and they needed the information right then."

The HIM department created a log to track emergency service workers, she adds.

Other issues the department encountered involved a duplication of records, patients listed more than once, misspellings, and demographic information gaps.

"We were making modifications as we went along, but we couldn't sit down to address the problem on that day," Chappelle says.

Many patients were hysterical upon admittance and were unable to provide the necessary information. Taking this problem into account, the department has revised the disaster plan to call for obtaining demographic and some other pertinent information at discharge, instead of when patients are admitted, Chappelle says.

"The registration process will continue throughout the disaster mode, resuming later when patients are much calmer," Chappelle says.

Since the week of the disaster, there have been many requests from the city's health departments that want to know how patients were treated, what services were provided, and the outcomes. The health department is looking at the types of injuries and whether anything biological, nuclear, or chemical was involved, and this has required HIM staff to retrieve medical records and make them available to public health officials, Chappelle says.

"Another major impact is how a disaster impacts your staff," Chappelle says. "People were very upset and distraught, and this is a city where everyone travels by mass transit, so people are worried about taking mass transit and having it available during off times."

Because some of the city's subway lines were shut down, some staff had trouble getting in to work in the first days after the disaster. This meant rescheduling and finding staff to fill in when those who lived in outer boroughs were unable to make it to work.

In the weeks afterward, the hospital offered employees counseling services, stress management, acupuncture sessions, and handouts about what to expect and what's normal to experience after a disaster.

"At first, people come in and go through the motions and productivity is down, but it eventually gets back up," Chappelle says. "It wasn't such a problem that we couldn't do our billing or coding or releasing information, but there was a different mood in the city."

In retrospect, the HIM department did a good job of handling the disaster, Chappelle says. "Thank goodness we had a disaster plan that worked very well." ■

'It works. Now we're ahead of the game'

Disaster prep: Time well spent

When hospitals across the country began re-evaluating their disaster response plans in the wake of Sept. 11 and anthrax, Riverside HealthCare in Kankakee, IL, found itself in better shape than most.

Riverside had gone through a mock disaster drill for a hazardous chemical spill the previous May, says **Cindy Hagenow**, director of patient access, and in

SPECIAL REPORT: PLANNING FOR ULTIMATE DISASTERS

March 1999 had experienced a true disaster when an Amtrak train crashed in its community.

"We thought we had a good plan, but after you have a real disaster you have to review your plan," Hagenow explains. "There were lessons learned and there were things that went well. There were things that happened that you couldn't have imagined."

HEICS plan used by 800+ hospitals

After the Amtrak disaster, **Sherry Mayes**, RN, BSN, the hospital's trauma coordinator and disaster chairwoman, attended a workshop on the Hospital Emergency Incident Command System (HEICS). That plan, developed in California and now in effect at more than 800 hospitals, is endorsed by the American Hospital Association, which encourages all hospitals to adopt it.

After attending the workshop, Mayes notes, she was so excited about HEICS that she came back and rewrote the hospital's plan over the course of a year, modeling it on that system. Since Sept. 11, she says, the Illinois Department of Public Health has recommended that all hospitals adopt HEICS, as has the Joint Commission on Accreditation of Healthcare Organizations.

"We've tested it, and it works," Mayes says, "and now I feel like we're ahead of the game."

"It's a system that's based on an organizational chart and a job action sheet," she says. "Old disaster plans are basically in paragraph form, and in a disaster, people don't read paragraphs." (See "HEICS: The way to go, but it takes time, money," p. 20.)

Riverside already had made it a priority to

develop a biological exposure plan, and completed it in September as the anthrax cases were beginning to surface, Mayes says. "We had inser- vices for all of the safety representatives from each department and reviewed the new plan."

Registrars were instructed on what to do if someone came to their desk with a potentially hazardous substance, she adds. "I trained the safety reps and then they were to do an inservice with their staffs. So Cindy trained her employees and then I double-checked their knowledge, asking what they would do if this happened."

That training was put to the test when a man approached the emergency department (ED) registration desk, explaining that he had opened an envelope containing white powder and soon after had developed a rash.

The registrar directed the man back through the door he had just entered, to an outside entrance to the decontamination shower, and then called back to the ED to have someone unlock the door, she says. From a safe distance, ED staff questioned the man and determined that he had opened the envelope two days before, and so had showered since that exposure, Mayes adds.

Meanwhile, the registrar called the operator and had security personnel paged to contain the area, she notes.

"As it turned out, the rash and the envelope had nothing to do with each other, but we called the police and they picked up the envelope and treated it as suspicious," Mayes says.

With the May 2001 countywide hazardous materials disaster drill, the focus for patient access personnel was on identifying ways to register patients and gather demographic information without exposing themselves to the hazardous material, Hagenow says. That drill, conducted by the Federal Emergency Management Administration (FEMA) and funded through a FEMA grant to the county in which the hospital is located, was based on the premise that the driver of a chemical truck had lost control and backed into a dock, leaking anhydrous ammonia, she notes.

Patients were triaged under a covered area outside the ED ambulatory entrance, Hagenow explains, and those who were exposed to the chemical and had not been decontaminated in the field were taken to the decontamination shower entrance outside the ED. In the shower, she notes, air is circulated so as not to send any contaminants into the normal air of the hospital.

"It's like a filtration system."

An ED "float nurse" who works outside the negative pressure room has radio communication with the staff in the room with the patient, Hagenow says, and passes information on to patient access personnel. "We do any rework that needs to be done."

There is a difference in the way chemical and biological disasters are handled, Mayes points out. "With the chemical, people have immediate reactions, and with the biological, the reaction can be days later." For that reason, she adds, the decontamination process is much more involved with chemical exposure.

"People are very sick and can't do it themselves, and the staff have to wear respirators," Mayes says. "The training is a lot more detailed."

As part of the FEMA grant, Riverside was given a hazardous materials software program, she notes. "We can look up any hazardous chemical in the computer database and get immediate information on antidotes and decontamination."

Before the chemical drill was conducted, Mayes says, the hospital ran a tabletop drill with the hospital leadership to acquaint them with the new HEICS job action sheets and test Riverside's emergency preparedness.

"We had an incident command table," she adds, "and the administrator on call had to pull the files out of the disaster response cabinet and distribute them to the appropriate people." ■

HEICS: The way to go, but it takes time, money

This plan puts hospitals on same page

After Riverside HealthCare in Kankakee, IL, dealt with the crash of an Amtrak train in March of 1999, hospital officials took a hard look at their disaster response plan and decided some changes were called for, says **Sherry Mayes**, RN, BSN, trauma coordinator and disaster chairwoman.

Riverside took a year to rewrite its plan, modeling it on the Hospital Emergency Incident Command System (HEICS), a plan first tested by six hospitals in Orange County, CA, and released

SPECIAL REPORT: PLANNING FOR ULTIMATE DISASTERS

in 1992 for general use. Copies of the plan have been sent to facilities throughout the United States and Canada, as well as to other countries, according to information on a web site devoted to HEICS. (To download a copy of the third edition of HEICS, go to www.emsa.cahwnet.gov.)

A customized approach

HEICS features a flexible management organizational chart that allows for a customized approach to the crisis at hand, according to the web site. The organizational chart has 49 positions grouped into one of four sections, a structure designed to provide a platform for common terminology to enhance communication and improve documentation.

"We have tested the [HEICS] plan and it works a lot better," says **Cindy Hagenow**, director of patient access at Riverside. "You have a command center set up, and the incident commander will open that center and assign people on that [organizational] chart.

Under the HEICS plan, Mayes says, "all of the key players have 'job action sheets' and know who to report to immediately and what to do." If the disaster occurs at 3 or 4 a.m., she points out, "I may have to do three or four people's jobs temporarily, but at least the little details won't be missed because it's all written down in order of priority."

In line with the HEICS plan, she says, people in key positions now have vests to wear that say "incident commander" or "public information officer" in bold letters. "You can go to any area and know who's in charge."

Another change has been the addition of portable radios, which become critical to communication when all the telephone lines are tied up, Mayes adds.

Registration personnel "have a big job" when a disaster occurs, Hagenow notes. "When we've done some of our drills, one of the pitfalls has been that an access person was not initially assigned to one of the other victim care areas [apart from the main triage area] where patients were being treated."

If the drill was being conducted after normal business hours, there would be no registration personnel in, for example, the outpatient center, she says. That resulted, Mayes adds, in some of the "walking wounded" patients being treated and released without any type of registration occurring.

With the revised plan, she says, "we get staff in key areas right off the bat. With the job action sheets, the manpower unit leader assigns a registrar to each area."

As victims arrive under the ED canopy, Mayes explains, the triage physician takes a look at them, even though they may already have been triaged in the field and given color-coded tags indicating the severity of their conditions. "Red is for critical patients, yellow is for serious but not life-threatening conditions, and green is for 'first-aid' patients."

Registration staff, who are under the canopy with the physician, put pre-numbered bracelets on the patients, and record the same number on a patient log sheet, Hagenow says. That number is used to identify blood specimens or any other items associated with that patient, she adds.

Under the plan, Mayes says, patients are taken to various care areas, depending on the color of their tags. "Red" patients go to the ED, "green" patients are assigned an escort who takes them to the hospital's outpatient center, and "yellow" patients are taken to the endoscopy procedure lab.

'Mini-admission' takes place in care areas

"[Access employees] are assigned to all of the victim care areas," Hagenow notes, "and their job is to make sure that as the patients arrive, the number on the bracelet goes on the log sheet." When they get to the various care areas, the patients are "mini-admitted," she says, with admitters entering just their name and basic demographic information into the computer. In some cases, she adds, patients may be listed simply as John Doe, with a number instead of a middle initial to distinguish one from the other.

"In a disaster, the other hospitals, Red Cross, everybody wants to know where this or that person is," Hagenow says. "Anybody from any area can pull up the list [on the computer] and get an up-to-the-moment list of where these people are."

Identifying the location of patients was one of the biggest challenges during the Amtrak disaster, Mayes notes. "We had people calling from all over the world. Now we've redesigned the system so we can get that list in an expeditious manner."

If the computers go down, Hagenow says, staff fall back on the disaster log, which has three-ply sheets. "We have runners that come from the command center to pick up the log sheets. That's our backup system."

In Mayes' opinion, HEICS "is the way to go. The advantage of it is that if all hospitals had that plan, we would all be on the same page," she says. "If I call [another hospital] and want to talk to the incident commander, they know who I'm talking about."

Having the support of hospital administration is crucial to the successful adoption of the HEICS, Mayes points out. "It costs money and it takes a lot of time to educate people. You have to educate the whole hospital from the top down." ■

For access departments, communication is accented

Key link is between the ED and admitting

St. Joseph's Hospital of Atlanta conducts disaster drills three or four times a year, says registration supervisor **Felicia Dafivbiroro**, but it is another world since Sept. 11 for the access department and the rest of the hospital.

In the following days, and in the wake of mailed anthrax, the hospital has made some revisions to its response plan.

"We thought it would be a good time [to conduct a drill], and we did see some different things we should be doing," adds Dafivbiroro, who is a member of the hospital's emergency preparedness committee.

SPECIAL REPORT: PLANNING FOR ULTIMATE DISASTERS

Previously, for example, the procedure has been to contact the administrator on call when conditions warrant and have that person declare a disaster, she says. "That way, by the time we got the notification, the clearance [to put the disaster plan into effect], took about 20 minutes."

That meant a delay in deploying extra clinical and administrative staff to the emergency department (ED), Dafivbiroro adds, because those people don't report until they hear the official declaration. "Now the ED physician present will make that decision."

A subcommittee of the emergency preparedness committee — charged with critiquing the response plan and suggesting revisions — also has pointed out the need for a method of assigning access staff

to do follow-up on disaster victims, she says.

That step takes place after access staff receive an initial list from the triage area, Dafivbiroro notes. Complicating the process is the fact that the main admitting department is in a different area than the ED, she says.

Records staff update info every 15 minutes

St. Joseph's disaster procedure is to have medical records personnel on duty with the triage nurse to get victims' names and as much demographic information as possible, Dafivbiroro explains. Every 15 minutes, the medical records staff brings a list to admitters, who do a more complete registration and assign the patient a "real" medical record number that is then linked to the number they were given upon arrival.

That initial, temporary number is associated with the packet of information that is assigned to each disaster victim, she notes. In addition to a numbered armband, the packet contains clinical data sheets, informed consents, assignment of benefits documents, etc., all with the same number, Dafivbiroro says.

"If the triage nurse sends patients to other areas, we need to have one or two people working each of those areas," she adds, "and we need a method for deploying them to those areas."

Meanwhile, other access personnel will be working to obtain telephone consents and to gather additional patient information, Dafivbiroro explains. "Once we get additional information — from family members or as patients are able to give information — we update the list and send copies to the command center."

The committee also wants to find the best place to accommodate family members who are concerned that their loved ones may have been involved in the disaster, she adds. "We wanted somewhere that we didn't have to install new telephone lines," Dafivbiroro says, noting that an auditorium first considered for the purpose would have required more lines.

Now, she adds, the hospital is looking at using five classrooms on the ground floor beneath the ED as a place where families can come for information.

The most recent drill, which dealt with a hypothetical smallpox outbreak, highlighted the fact that because the ED would be contaminated and therefore under quarantine, a runner would not

(Continued on page 27)

DRG CODING ADVISOR.

Take these tips for preventing APC data quality gaps

For HIM department, preparation is key

As HIM professionals continue to struggle with data quality issues embedded in Medicare's Outpatient Prospective Payment System (OPPS) 18 months after the system went into effect, there are various lessons to be learned from early trials and errors.

First, HIM professionals need to know exactly what the terms mean.

"The term 'outpatient' needs to be dissected more," says **Cynthia Pugliese**, MS, RHIA, CPHQ, director of health information management at Hartford (CT) Hospital. "When we're talking about ambulatory surgery, it's very different from the emergency room and diagnostic services, and you can't have an outpatient process that speaks for all outpatient services."

One model won't work for all, Pugliese says. "You have to look at distinct services and decide what makes the most sense."

Now, more than a year into OPPS, facilities that prepared for the implementation of OPPS are generally faring much better than those that did not, says **Cheryl D'Amato**, RHIT, CCS, director of HIM for HSS Inc. of Hamden, CT.

"Unfortunately, hospitals were not aware of the huge resource requirements that were necessary to implement the system and were not prepared for the quarterly changes that have occurred," D'Amato adds. "One of the major challenges hospitals must now address is evaluating the actual financial impact that OPPS has had."

For instance, Year 2 of OPPS should be focused on evaluating the impact of OPPS and putting processes in place to handle ongoing changes to the system, D'Amato says. **(See story about how to handle OPPS challenges, p. 25.)**

Pugliese and D'Amato spoke about improving ambulatory payment classification (APC) data quality at the American Health Information Management Association's (AHIMA's) 73rd National Convention and Exhibit, held Oct. 13-18, 2001, in Miami Beach.

One reason HIM staff should target outpatient services for a data quality initiative is that outpatient encounters are very short, leaving staff less time — typically less than one day — to clarify, verify, and edit data in the registration system and the medical record.

At Hartford Hospital, a back-end data scrubber checks APC coding data to ensure bills are correct before they are sent to Medicare, Pugliese says.

The data scrubber applies all coding edits and looks at the line-item charge information to make certain all charges will be reimbursable under Medicare guidelines, she explains.

For example, if the coding data for a particular lab charge indicate there were 26 units for the charge but Medicare says there are 25 maximum allowable units for the charge, the data scrubber would flag this for review. It will also edit for any instances of two CPT codes on the same bill, which may indicate bundling, Pugliese says.

Even when facilities cannot assign one position to data scrubbing, there are various strategies that will ensure cleaner and more accurate data under OPPS. Here are some of Pugliese's suggestions:

1. Form a charge description master (CDM) committee.

Much of the data required under APCs can be found on the CDM, so Hartford Hospital formed a multidisciplinary CDM committee.

The committee's role is to implement necessary changes to the CDM, according to a recent assessment conducted by an outside consultant. The

committee will educate staff on how to maintain the CDM on an ongoing basis and will develop processes for adding, deleting, and modifying entries to the CDM, Pugliese says.

The committee includes representatives from HIM, finance, patient accounts, information services, and a clinical department representative.

“We focus primarily on the outpatient area right now, and we have a consultant help with this committee,” Pugliese says.

The committee, founded last summer, meets every other week.

CDM committee educates staff

So far, the committee has drafted a process policy for ongoing CDM maintenance, and a committee point person has visited task forces throughout the hospital to discuss and educate staff about the CDM, Pugliese says.

The committee will continue to educate staff about the role each department plays in completing the CDM. At these educational sessions, committee members obtain feedback that is brought back to the committee.

2. Start a denials management group.

The hospital also formed a denials management group to understand the patterns and trends of outpatient claim denials, Pugliese says.

“We want to know why denials may be occurring and what we need to do to improve our data submission,” Pugliese explains.

Like the CDM committee, this group also consists of representatives from HIM, finance, patient accounts, and the information services and clinical departments.

The committee will assess claims denials according to whether these types of denials have high volume, high risk, or high cost, and the group will establish processes to prevent denials from happening, Pugliese says.

Staff from patient accounts and finance collect the data about various denials, and then the committee will look at the aggregated facts, Pugliese explains.

For example, the hospital might have had 10 denials for the same reason in the emergency department. So the committee will notify the ED staff and give them a list of contact people in the HIM department who can be called whenever they have a question about a coding-related issue.

3. Hire an HIM coding consultant.

The hospital hired an HIM coding consultant to serve as a liaison with the clinical areas that

complete encounter forms and to assist them with ongoing maintenance of encounter forms, Pugliese says.

“The consultant will educate staff about coding issues and will support their CDM maintenance as it relates to coding,” she adds.

The consultant/liason also can be the person who is called by other departments when there are coding questions and changes to regulations.

In addition, the hospital has instituted various audit cycles and compliance policies with regard to APCs, including the installation of an APC grouper with software that will enable HIM staff to examine edits in outpatient coding, Pugliese says.

4. Design process to improve APC data quality.

The finance department took the lead and developed an APC management report, but the report also was the result of input from patient accounts, HIM, patient registration, and clinical departments, Pugliese says.

Here are a few of the changes Pugliese suggests for improving the APC data collection process:

- Redesign the process. HIM professionals might define outpatient medical record types and corresponding documentation requirements, ensuring that similar services provided in multiple areas have the same documentation requirements.
- The process should define who documents each requirement and how.
- Hospitals should define in writing the scope and depth of the initial patient assessment for all patient types.
- The process should determine what documentation is required from referring physicians and in what format, including a definition of requirements for appropriate diagnosis for ancillary testing.
- The medical staff should be involved and educated on documentation policies.

5. Educate other departments about APCs.

“There has been a major cultural shift as a by-product of the APCs,” Pugliese notes. “We have focused so long on inpatient coding and bill processing, but with the advent of APCs there was a shift, and now we have PPS with outpatient and a lot of other issues that have come to the top of the priority list.”

At Hartford Hospital, for example, it has been an issue to define who owns CDM maintenance, Pugliese says.

“Many organizations have a function where

the CDM sits in finance and it is a finance department thing,” she says.

At Hartford Hospital, CDM maintenance is seen as a partnership between the clinical department and finance. HIM supplies coding expertise, and patient accounts supplies revenue codes and payer-specific information, Pugliese says.

“That’s a huge shift for clinical areas to understand that they are a driver in what charges are in the CDM,” she adds.

This is why staff education is a crucial element of the process to improve data quality.

Each clinical department at Hartford Hospital has specific APC task forces that include a clinical department head as the team leader, as well as representatives from clinical, finance, HIM, and patient accounts. These task forces will range in size from four to 12 members and sometimes include nurses, directors, physicians, and clerical staff.

The HIM, finance, and patient accounts representatives educate other task force members about APCs, the CDM, and other data and coding quality issues. The task forces meet weekly, biweekly, or monthly, depending on the need.

“They talk about the process changes that may be needed to support the APC environment,” Pugliese says.

Also, Pugliese suggests that all staff be educated on issues related to APCs, ICD-9-CM diagnosis codes, HCPCS codes, HCPCS modifiers, OCE edits, and NCCI edits. HIM professionals could provide this education in partnership with patient registration, patient accounts, and finance experts. ■

To improve quality data, HIM pros face challenges

Here are five of the most common problems

HIM professionals in acute care hospitals are key players in the collection and assessment of the data required under the Medicare Outpatient Prospective Payment System (OPPS).

While it’s their job to maintain quality data, there are certain challenges and requirements that must be kept in mind when undertaking the task of improving data quality under the OPPS, says **Cheryl D’Amato**, RHIT, CCS, director of HIM for HHS Inc. of Hamden, CT.

D’Amato suggests HIM professionals watch for these data quality challenges:

1. Invalid, missing, or incorrect reason for visit.

The determination of the medical necessity of many procedures performed depends on accurate coding of the reason for the visit. These diagnoses often are assigned by scheduling and registration staff not familiar with ICD-9-CM coding, D’Amato says.

“The staff in these scheduling and registration areas do not realize the potential impact of incorrect information on the data quality and reimbursement to their facility,” she says.

“Consider assigning an HIM coder as a liaison to the scheduling and registration areas of the facility who can be called on for coding questions and who can provide continuing education on coding and regulation changes,” D’Amato suggests.

Other strategies include using software and initiating operational changes to provide editing to determine medical necessity before the services are rendered.

2. Invalid, missing, or incorrect diagnoses and procedure codes.

Prior to the implementation of OPPS, outpatient coders typically were not credentialed and did not have any real knowledge of the ICD-9-CM and HCPCS classification systems, D’Amato notes.

HIM ambulatory surgery coders, especially in light of OPPS, should have an in-depth knowledge of ICD-9-CM diagnoses and HCPCS coding, D’Amato says.

Emergency departments (EDs) may have HIM coders assign diagnoses and most procedure codes, while nursing may assign evaluation and management codes.

Coding for procedures performed in ancillary departments is generally chargemaster-driven or is performed by inexperienced coders. Diagnosis coding for these services is generally performed by HIM coders with little or no documentation, D’Amato says.

“The challenge for diagnosis coding on these accounts is the lack of information with which to determine the ‘medically necessary’ code assignment,” D’Amato explains. “Often, charges are entered on these accounts by the ancillary department providing the service, with little collaboration with the diagnosis coding function.”

So the solution is to document the entire coding function, including responsibility and necessary skills.

For example, consider requiring credentialed coders in the HIM department, D'Amato says.

"There is a critical shortage of credentialed coders," she says. "Because coding requires a variety of different skills, it is important to educate and cross-train other staff on those issues and coding requirements related to their specific department or service. Then consider assigning an HIM coding professional as a liaison to ancillary departments to answer questions and to evaluate requisition and charge forms."

Another strategy is to audit high-volume and high-cost services to evaluate coding and resulting reimbursement and to utilize the findings of these audits to educate coders and to revise policies.

3. Obsolete, inaccurate, or incomplete charge description master (CDM).

There are a number of data quality challenges related to the CDM.

The fact that two-thirds of all outpatient reimbursement is generated by the CDM must be taken very seriously, D'Amato says.

For instance, HCPCS codes are updated quarterly, but if these changes are not made in the CDM, it will become outdated. When this happens, facilities will miss new transitional pass-through payments or may be reimbursed incorrectly, D'Amato says.

"Each department has traditionally been responsible for updating their chargemaster, but staff are not often familiar with the HCPCS classification system," D'Amato says.

A solution would be to create a CDM team or department to be responsible for educating and assisting departments in the CDM evaluation and update process.

"Communicate regulatory and HCPCS code changes to all relevant departments," D'Amato advises. "Creating a structure that keeps everyone on top of the changes is critical to the process."

Also, HIM professionals should consider utilizing software to assist in the CDM process, and they might use credentialed HIM coders as a resource or as members of the team.

4. Inadequate or improper use of modifiers.

Two key areas where modifiers are missed are in the ED and in CDM assigned codes.

Modifier -25 is often missed in the ED when nursing assigns the evaluation and management code and the HIM coder assigns the diagnosis and procedure codes, D'Amato says.

"One solution for both of these issues is to allow the CDM codes to be available to the HIM coders so that they may add these modifiers

when appropriate," she adds. "Missing modifier -25 on ED claims will have significant reimbursement implications."

For example, the medical services provided may not be reimbursed, so HIM staff should consider including modifiers in the CDM for some services.

5. Outpatient Code Edit (OCE) failures.

In addition to editing outpatient claims, the OCE dictates claim and line-item reimbursement.

The OCE includes a portion of the national Correct Coding Initiative edits as well as code validity edits, unit edits, and a number of other types of edits, D'Amato says.

Unfortunately, there are no complete quarterly revisions to the OCE published by the Centers for Medicare and Medicaid Services, she notes.

This is a problem, because program memorandums do not explain how the OCE works, and nowhere is there a complete code list for each edit.

Pass all claims through OCE software

"Nor is there documentation of all of the changes from one version to the next," D'Amato adds. "Therefore, it is important that facilities utilize OCE software during the coding process to identify edits before the claim is sent to billing, and it's even more important that a batch process be in place so that all claims are passed through OCE edit software before the bill drops."

This will ensure that claims are not being submitted for payment inappropriately, D'Amato says.

OPPS poses other challenges, as well. For instance, providers will continue to struggle with ever-changing OPPS requirements, D'Amato says. But this will be less of a struggle if procedures are in place to deal with these changes. "Monitor the CMS OPPS web site, communicate changes to all relevant departments, evaluate how to deal with these changes, and continue to evaluate operations and make improvements," she recommends.

Also, it will be crucial to educate all departments about medical necessity, ICD-9-CM, and HCPCS coding, D'Amato says.

HIM professionals should keep in mind that implementation of the 2002 OPPS changes has been delayed.

"Documentation requirements and other OPPS issues will continue to be a challenge but are essential for assuring that there are no gaps in data quality that affect reimbursement," D'Amato says. ■

(Continued from page 22)

be able to take information back and forth between there and the command center, Dafivbiroro says.

"In the future we will use fax machines, wireless phones, and the Internet to communicate," she says. "If you only have one or two or three phone lines, you need to come up with alternate ways."

Because of the possibility of contaminated mail, she notes, St. Joseph's now provides protective gowns, masks, and gloves in areas that don't normally have contact with patients.

"Just as a precaution, it is recommended that those who work in the mail room or open mail wear gloves and masks," Dafivbiroro says. That includes financial counselors who open mail from customers, she adds. ■

With possibilities growing, disaster training is needed

Keeping your disaster program flexible is key

Sept. 11th and anthrax bring home one important message to all health care professionals, including access managers: There is no possible way a department can prepare for every contingency.

It's not like the old days of preparing for natural disasters such as fires, hurricanes, tornadoes, earthquakes, and floods. These days, a coding department could be shut down for hours or even a day or longer just by the appearance of an envelope coated in a powdery white substance. Likewise after a hospital has been hit with a large influx of casualties after a terrorist attack, access

SPECIAL REPORT: PLANNING FOR ULTIMATE DISASTERS

professionals could find their time and phone lines taxed from people trying to

locate missing loved ones and insurers trying to identify and quantify covered patients.

The good news is that access departments do not have to prepare for every possible disaster to effectively handle what comes along.

"The value of disaster planning isn't necessarily that you anticipate the right disaster, but that you talk about it with your staff so that you know

what resources are available so these can be applied to a disaster you didn't think of," says **Gwen Hughes**, RHIA, a Belgrade, MT-based professional practice manager with the American Health Information Management Association (AHIMA)."

Some disasters have internal and often unforeseen causes, adds Hughes, who has written articles and spoken to health care groups about disaster planning.

"Say a sprinkler system goes off and sprays everything," Hughes offers as an example. "Then the paper can get wet and be ruined, so you might have tarps in the department to throw over them."

Or if a hospital is flooded from the ground up, as happened last year in Houston, then an access department could save its paper documentation by putting boxes of files on stretchers that are borrowed from the emergency department, Hughes adds.

Access department disasters sometimes are caused by employee sabotage, according to **Jill Burrington-Brown**, MS, RHIA, a Snohomish, WA-based professional practice manager with AHIMA. Burrington-Brown also has written about disaster planning and has studied the problems faced by the Oklahoma City hospitals after the bombing of the federal building in 1995.

"I had a mini-disaster at one facility, where over a six-month period, a clerk whose night job was to file records had been putting files above the ceiling tiles in the department," Burrington-Brown says. "Within four months we knew we were missing a lot of records, but we couldn't figure out where they were."

This caused a great deal of documentation problems when records were being requested and none of the hard copies could be found. Then when the department finally found the files during a heating system check, there was a second mini-disaster because now the staff had to cope with filing an additional 10,000 records and to make them accessible as soon as possible, Burrington-Brown says.

"We made a plan of how to keep up the regular workload while having the records filed as fast as possible," Burrington-Brown adds.

That type of scenario proves that it's impossible to anticipate every type of potential disaster, Hughes says.

"But the value is in going through the process and discussing things with the staff, anyway," Hughes explains. "Sure, if we anticipate employee

sabotage, like someone who is angry getting into the payroll system, then as soon as we plan for it the disaster will be something different.”

Nonetheless, all departments can take some basic disaster planning precautions and follow strategies that will assist them in remaining flexible should an unforeseen disaster event occur.

Here are some suggestions from Burrington-Brown, Hughes, and AHIMA:

- **Know your liabilities and limits.**

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, health care providers are required to maintain patient privacy. Breaches in a department's electronic records and the unintended release of confidential information could result in major regulatory and legal problems, so it's very important to ensure that records remain private and protected during a disaster.

Providers discuss centralized database

For example, if a staff member discovers white powder on a paper document and suspects contamination, then the document must immediately be placed in a plastic bag and delivered to a laboratory for testing, Hughes says. “You should do a chain-of-custody on the paper, including making a loan record to the person who will make certain it's not anthrax,” she advises.

Then, if the paper turns out to be uncontaminated, it can be returned immediately to the department. If it is contaminated, it can be sterilized and returned when it's deemed safe.

After Oklahoma City, health care providers often mentioned that it would be a good idea for the area to create a centralized computer database that all providers could share. This would have the benefit of giving families one place to go for information, Burrington-Brown says.

“HIPAA does allow for disasters and the release of information to agencies who are legally, or by charter, dealing with disasters for the purpose of notification of families of a patient's location, general condition, or death,” Burrington-Brown says.

To prepare for the documentation damage that a disaster could cause, access departments should contact fire or water damage restoration companies to determine what kinds of services they can provide in restoring electronic and paper documentation. **(Read about contracting with restoration companies, p. 29.)**

These companies also might have information

that could help a department better prepare for a disaster. Also, access departments need to assess the facility's insurance coverage to see what costs are covered during a recovery period and what strategies can be taken to limit liability and loss, according to a practice brief Hughes wrote.

When records cannot be reconstructed, a department might look into various strategies, including reprinting documents from undamaged data bases in admission, transcription, etc.; transcribing documents from the dictation system, and obtaining copies from copies that were distributed to physician offices and others.

- **Draft a disaster plan.**

First, use what is already available.

“Most plans could work for all sorts of other disasters, but it would be appropriate for people to revisit those annually and tweak them in some way,” Hughes says.

For instance, probably nearly all departments created extensive electronic disaster plans as they prepared for Y2K. Those plans could be dusted off and used to prepare for a terrorist technology or electronic attack, such as an Internet virus that destroys files.

“What you do is list your core and electronic processes, starting with a master patient index, for example, so that you can locate patient records,” Hughes says.

Then take the function that's electronic and list the various assumptions of what has caused the electronic failure or disaster and describe what might happen, what resulting problems will occur, what is available to the department in the event of the problem, and how to design ways to work around the problem, Hughes adds.

Examples of disasters that should have a similar flowchart or contingency checklist include fire, flood, bioterrorism event, hurricane, explosion, extended power outage, and earthquake.

Plan to receive lots of patients

If there is a terrorism attack or a major natural disaster, it's possible that hospitals will be inundated with more patients than they believe they can handle, and these patients may arrive in unexpected ways, Burrington-Brown says.

“One thing I've seen in the experiences of people who worked through the Oklahoma City bombing or the New York City bombing is that the numbers of people they receive at hospitals is far more than they ever planned for,” Burrington-Brown says. “Departments are saying, ‘Let's plan

for 50 casualties because that's what our hospital can reasonably handle.' But they need to plan for more than they can handle comfortably."

In the event of a major disaster, the people who are injured may not be organized by rescue workers and sent to hospitals in an orderly fashion. It's likely that area hospitals will receive patients through a variety of means, including ambulances, private cars, and walk-ins, and it's likely they'll enter at any door of the hospital, as well as emergency department doors, Burrington-Brown says.

'How do you track these people?'

These types of scenarios affect access departments because patients may not always have identification and insurance coverage information on their person. They may be unconscious or disoriented and unable to answer questions by intake workers. Often their family members do not know where they are.

"You may have large numbers of people for whom you have no name, insurance, or other demographic information. So how do you track these people during their stay?" Hughes asks.

Staff may need to work with intake staff in identifying patients and gathering information, Burrington-Brown says. One strategy under these circumstances is to develop a simple system of identification and clean up the documentation later.

For example, after the terrorism attacks in Oklahoma City and New York City, hospital workers identified patients through tags with check boxes that listed physical characteristics, Burrington-Brown says. "On the back of the tag were stickers with the same numbers as the tags, so that as samples were sent to the lab, the stickers and lab samples had the same numbers."

Even this system posed some unexpected consequences. Some patients were so traumatized by the disaster experience that they could not tolerate having anything tied to them, so the tags had to be put on clips, she adds.

- **Learn from trials, tribulations, and mistakes.**

Access departments can learn from the problems other facilities have had during disasters, as well as from their own disaster drills and actual events. This is why it's important to practice disaster drills twice a year when possible, says Burrington-Brown.

And it's a good idea for an access department to hold its own mini-disaster drill independent of

the hospitalwide drill, Hughes suggests.

"It's not just having a plan written down, but having regular discussions with the staff to talk about what might happen and how any of them might need to be the boss and do what needs to be done when it happens," Hughes says.

An example of learning from others' experience might include stocking a department with identification tags and clips that could be used in the event of an emergency in which victims cannot easily be identified, Burrington-Brown says.

"Stock three to five times more than you think you'll need because you don't know what your numbers will be," Burrington-Brown says. "And make sure the people involved know what to do with them, and that includes admitting people and [access] people."

Finally, keep in mind that after a disaster there may be heightened emotions and staff may be personally impacted by deaths and injuries, so it's important to let employees vent, grieve, and heal emotionally.

Once this process is under way, access professionals may begin to evaluate how the department handled the disaster and what can be done to improve the process in the event of future disasters. ■

Ensure patients' privacy before disaster arrives

An expert offers up some advice for recovery

Every disaster plan should include a strategy for coping with damaged records. It's a crucial first step in the department's recovery.

If the facility contracts with a fire, flood, or storm damage restoration company, it's a good idea to have a contract ready

SPECIAL REPORT: PLANNING FOR ULTIMATE DISASTERS

that would address various provisions for ensuring the privacy of the documentation.

According to a disaster planning practice brief written by **Gwen Hughes**, RHIA, a Belgrade, MT-based professional practice manager with the American Health Information Management Association in Chicago, here are items that

should be included in a damage restoration contract, ensuring the restoration business will:

- specify the method of recovery;
- not use or further disclose the information other than as permitted or required by the contract;
- use appropriate safeguards to prevent use or disclosure of the information other than as provided for by the contract;
- include the items required in business associate contracts per the Health Insurance Portability and Accountability Act privacy rule;
- report to the contracting organization any inappropriate use or disclosure of the information of which it becomes aware;
- ensure that any subcontractors or agents with access to the information agree to the same restrictions and conditions;
- indemnify the health care facility from loss due to unauthorized disclosure;
- upon termination of the contract, return or destroy all health information received from the contracting organization and retain no copies;
- specify the time that will elapse between acquisition and return of information and equipment;
- authorize the contracting entity to terminate the contract if the business partner violates any material term of the contract. ■

Here are the essentials of a contingency plan

AHIMA offers strategies and samples

Among the strategies published by the Chicago-based American Health Information Management Association (AHIMA) is the following advice about how to create a contingency plan, which is part of a paper written by **Gwen Hughes**, RHIA, a Belgrade, MT-based professional practice manager with AHIMA.

Here are some of AHIMA's and Hughes' suggestions for information that should be included in a contingency plan created for each disaster:

1. The facility's name.
2. The department's name.
3. The contingency plan's originator.
4. The date.
5. The major function being addressed, i.e., chart tracking/location, and provision.
6. The disaster being considered, i.e., hurricane.
7. Some assumptions about the disaster, i.e., how will the disaster affect: utilities, staffing, and/or the ability of staff to report to work; security of health information; the facility itself; hardware and software; equipment and supplies; other departments, and patients presenting to the facility for treatment.
8. A description of the existing process used for the particular major function being addressed.
9. An if/then scenario, i.e., if this function is not performed, what will be the result?
10. Interdependencies, i.e., what other processes depend upon the provision of this information or service? On what information or services is this process dependent?
11. Solutions/alternatives, including steps that can be taken to minimize damage or disruption before the disaster, ensure stability, or provide for orderly recovery.
12. The limitations and benefits of each solution or alternative.
13. Activities that will need to be performed before the disaster in order to make this alternative possible; i.e., acquisition of equipment, implementation of backup systems, development of disaster-related forms and materials, procedures, and staff training.
14. The names of the individuals responsible for performing these activities.
15. A list of individuals or departments with phone numbers who should be contacted or notified relative to the disaster and the implementation of this particular contingency plan. ■

SPECIAL REPORT: PLANNING FOR ULTIMATE DISASTERS

COMING IN FUTURE MONTHS

■ Use these tips in preparing for an OIG audit

■ Give physicians pointers on evaluation and management coding

■ Lowering turnover, boosting morale

■ Patient-friendly billing

■ Preparing for HIPAA

Access staff line up to strengthen their skills

Training draws additional takers

If you offer in-depth, relevant access training, your staff will line up to take part.

That's the lesson at the University Hospital of Arkansas in Little Rock, where the Strengthening Bridges program aimed at adding to and reinforcing the just-learned skills of new access employees has become so popular that existing staff are asking for the training.

"We really weren't addressing this to existing employees," says **Holly Hiryak**, director of hospital admissions. "We were going to let them attend as needed, but they're requesting it. They're passing the word to each other."

The whys and why nots

Strengthening Bridges, the second phase of a comprehensive access training initiative, offers detailed information on the various payers, including the ins and outs of how they work and background on each payer or payer category, Hiryak says. "We're explaining the whys and why nots, as well as how to do it, and the employees really appreciate getting that."

To further enhance the program, the access training advisory committee has expanded it from two days to three, and changed the training style to become more interactive, she notes. "Originally there was a more didactic delivery, with no hands-on training. Employees couldn't practice the how to's, and couldn't sit in front of a computer."

Now, Hiryak explains, employees will get an in-depth description of the various players, including:

- rules or laws that govern how University of Arkansas for Medical Services (UAMS) manages the process;
- checklists and tools for access staff to use to ensure appropriate steps and actions have been taken;
- activities specific to the topic to reinforce training.

"Then we have scenarios — or case studies — that we have developed specific to the various clinics and settings on campus," she says. "The access staff will utilize the information to register

a patient in the test system. The test cases will be completed at the end of each session, which is divided by payer categories such as Medicare, Medicaid, commercial payers, managed care payers, etc."

Trainers will attach an insurance card to a patient file and have employees proceed as though there is a patient in front of them, she adds. "They will enter information from this, [addressing such questions as]: 'Where do you put the referral number? Where do you put the effective dates?' That way, if they hit roadblocks, they can ask questions."

Although Strengthening Bridges is exclusively

Hospital Payment & Information Management[™] (ISSN# 1074-8334), including **DRG Coding Advisor**[®], is published monthly by American Health Consultants[®], 3525 Piedmont Road, N.E., Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to **Hospital Payment & Information Management**[™], P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291, (customerservice@ahcpub.com). Hours of operation: 8:30-6:00 M-Th, 8:30-4:30 F, EST.

Subscription rates: U.S.A., one year (12 issues), \$599. Outside U.S., add \$30 per year, total prepaid in U.S. funds. Two to nine additional copies, \$359 per year; 10 to 20 additional copies, \$240 per year; for more than 20, call (800) 688-2421. Missing issues will be fulfilled by customer service free of charge when contacted within one month of the missing issue date. **Back issues**, when available, are \$100 each. (GST registration number R128870672.)

Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact American Health Consultants[®]. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. World Wide Web: <http://www.ahcpub.com>.

Editorial Questions

For questions or comments, call **Chris Delporte** at (404) 262-5545.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: **Melinda Young**, (youngtryon@mindspring.com).

Vice President/Group Publisher: **Brenda Mooney**, (404) 262-5403, (brenda.mooney@ahcpub.com).

Editorial Group Head: **Lee Landenberger**, (404) 262-5483, (lee.landenberger@ahcpub.com).

Associate Managing Editor: **Chris Delporte**, (404) 262-5545, (christopher.delporte@ahc.com).

Production Editor: **Brent Winter**.

Copyright © 2002 by American Health Consultants[®]. **Hospital Payment & Information Management**[™] is a trademark of American Health Consultants[®]. **DRG Coding Advisor**[®] is a registered trademark of American Health Consultants[®]. The trademarks **Hospital Payment & Information Management**[™] and **DRG Coding Advisor**[®] are used herein under license. All rights reserved.



an access program, the first phase of the training initiative, Building Bridges, has been extended to include all 2,100 of the clinical programs employees of UAMS, Hiryak explains. That includes anyone who works in a department or provides a service that contributes to the clinical activities of the hospital, she says.

Having billers and registrars sitting next to pharmacy and radiology technicians during soft-skills training sessions, Hiryak notes, has gone a long way toward tearing down the traditional silos that exist in a hospital.

Originally these new hospital employees went through the typical human resources orientation together before going their separate ways, she says. Now they spend two more days together, focusing on topics such as teamwork, professionalism, confidentiality, and effective communication, as well as a segment called "Introduction to the Revenue Cycle."

Access managers introduced to the Building Bridges program at a retreat suggested that the revenue cycle segment gave employees too much financial information too early in the process, Hiryak says. Despite that feedback, she made the decision to go forward with the original curriculum and it got extremely positive evaluations from the new hires, she adds.

"We gave them an overview of the revenue cycle, where they fit in it, and what could happen if they were not team players," Hiryak says. "They said, 'We never understood this before. Thanks for taking the time to tell us.'" The new employees also gave positive feedback on the other soft-skills topics, she notes.

Strengthening relationships

Having all the clinical programs employees together for this training also has helped build relationships among the participants, Hiryak adds, and in particular has helped elevate access employees, making them feel a part of the clinical areas.

The off-campus retreat for access managers, aimed at ensuring their buy-in for the training initiative, gave the managers a taste of the soft-skills curriculum, she says. "There were a lot of interactive activities, to address all of the various learning styles of adult learners. They absolutely loved it."

The training program originally called for employees to work with a preceptor for 60 days after going through the Building Bridges phase,

EDITORIAL ADVISORY BOARD

Phoebe Bennett, RHIA
Director
Medical Records
Bay Area Hospital
Coos Bay, OR

James H. Braden, MBA
Vice President, EMR
Sharp Health Care
San Diego

Margaret M. Foley, MA,
RHIA
Department of Health
Information Management
Temple University
Philadelphia

Bill French, MBA, RHIA
Vice President
Payment Error
Prevention Program
MetaStar
Madison, WI

Martin J. Gaynes, Esq.
Schmeltzer, Aptaker &
Shepard
Attorneys at Law
Washington, DC

Patricia C. Goebel, MS,
RHIA
Director
Clinical Information
Jennie Edmundson Hospital
Council Bluffs, IA

Darice Grzybowski, MA,
RHIA
National Manager
HIM Industry Relations
3M HIS
Salt Lake City

Lela McFerrin, RHIA
Director
Health Information
Management
Baptist Memorial Hospital
Memphis, TN

and then to proceed to Strengthening Bridges, but that has changed, she notes. Now employees who are catching on quickly may take that step after 30 days, Hiryak says.

Establishing the preceptor program — whereby new hires are paired with experienced access employees for the first one or two months — has been somewhat difficult, she notes.

"Those we identified as preceptors didn't really understand that role," Hiryak says. "We do have a four- to six-hour training session for the preceptor, explaining their responsibility. The difficulty is that some of the clinics are very small and the preceptor is the only [access] person currently employed there. The perception is that [this task] takes them away from their work station."

That perception is not altogether incorrect, she notes. In some cases — in clinics where the single access employee is training someone to replace her, for example — arrangements may be made for the training to be done in another clinic, Hiryak adds.

Generally speaking, she says, the preceptors are beginning to embrace the concept. "It probably is a little more time-consuming, but there is no more putting [a new employee] in front of a computer and telling that person to check with you if there are any problems. They're now committed to be with that employee, not just walk away." ■