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# e-Coastlines

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**July-August 2008**

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## President's Message

Stacie L. Buck, RHIA, CCS-P, LHRM, RCC, CIC  
FHIMA President



I can't believe that my term as FHIMA President is almost over and that this is my final President's message for e-Coastlines. This year certainly has flown by. It has been an honor and a privilege to serve the members of FHIMA as President this past year and I will certainly miss leading such an impressive organization.

I am looking forward to an exciting convention in July. This year we have an unprecedented number of sessions to better meet the educational needs of our membership. I am also excited to be hosting a President's Reception on Tuesday evening July 15<sup>th</sup>. The reception is open to everyone that registers for the full 3 days or for Tuesday only. The reception has been made possible by an extremely generous donation from Dwayne Lewis, President of DML Consulting. When you see Dwayne at convention please be sure to thank him for his generosity and support and please consider his company for your coding consulting needs.

Before we let our hair down and party on Tuesday evening, many of us have lots of work to do on Monday before convention. This year we are holding a formal orientation session for all incoming board members, committee chairs, appointed positions and regional Presidents. Orientation will begin Monday morning at 9 A.M. and will be followed by a Leadership Luncheon for all incoming and outgoing positions. After lunch, HOD will start promptly at 1 P.M. with a jam packed agenda. In addition to voting on proposed bylaws changes we will be showcasing our online goal tracking system used for executing our strategic plan, sharing a new regional affiliation agreement, and holding a demonstration of Voter Voice. We will also have open discussion on the following three topics:

- Alternative paths to the RHIA credential
- Development of a health data analytics credential
- Leadership development

When I look back at all that we have achieved this year I am filled with a great sense of pride and accomplishment. When I began my term as president I had a very ambitious to do list and it is only through the tireless efforts of the committee chairs, committee members and those special appointments, that everything on that list was accomplished (and even beyond!) I could not have asked for a more talented and dedicated team of HIM professionals then the one I have had the pleasure of working with this past year. Our results this year far exceeded my expectations. I would like to take this opportunity to extend my heartfelt thanks and appreciation to all the committee chairs, committee members and fellow Board members for their dedication and support during this past year.

I am proud to say that we have met all of the strategic goals that we set for the past year. Our 5 objectives were:

- Facilitate effective communication between FHIMA, regional leadership and our members.
- Create an environment that identifies recruits, prepares and supports leaders within the organization.
- Facilitate the employment of new graduates from HIM programs at the baccalaureate and associate degree levels, and coding programs at the pre-degree level
- To be recognized by Florida State Senators and Representatives as the leading authority on legislative issues affecting health information management in our state
- Form professional alliances with other healthcare related organizations.

During my outgoing President's Message at Convention, I will highlight the specific accomplishments in each of these areas.

I am also proud to announce that this year we had an unprecedented number of submissions for AHIMA's CSA Core Service Achievement Awards. The purpose of the CSA Core Service Achievement program is to recognize excellence in Component State Association (CSA) efforts and to provide all CSAs with information and ideas that can be applied to their own state efforts. FHIMA submitted nominations in 6 out of 8 possible categories:

- Continuing education programs relating to coding (including Coding Roundtable activity)
- Member communications (such as a website, newsletter, geographic CoP, or periodic releases of relevant news)
- Recruitment and retention activities for students
- Support for local accredited HIM education programs (professional practice experience support, educator support)
- Legislative and regulatory advocacy
- Diversity programs (member or student recruitment, volunteer leadership development, mentoring programs)

The winners will be announced in mid July.

I want to encourage those of you who have not yet served in a volunteer capacity to do so. My years of service to FHIMA have

been extremely rewarding both personally and professionally. I have gained many new skills and refined others all of which have benefitted me in my career and I have also grown tremendously as a person, but perhaps the most important benefit gained is the close friendships that I have developed with so many other HIM professionals not only in Florida, but across the country. I can honestly say that volunteering in your organization is one of the best decisions that you will ever make.

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## FHIMA News

### **FHIMA Announces 2008 Service Award Winners!**

Congratulations to our deserving winners!

Distinguished Member- William Kelly McLendon, RHIA

Distinguished Service --Marjorie H. McNeill, PhD, RHIA, CCS

Distinguished Service-- Linda L. Renn, RHIT, CCS, CPC, CPC-H

Educator Award-- Sheila A. Newberry, MEd, RHIT

Literary Award-- Stacie L. Buck, RHIA, CCS-P, LHRM, RCC, CIC

Mentor Award-- Barbara R. Bermudez, RHIT

Outstanding Student -- Jenese L. Fuller

Outstanding New Professional -- Brittany T. Scriven, RHIA

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### **Congratulations to the 2008 FHIMA Scholarship Recipients**

#### **HIM Program**

Janine Vance  
University of Central Florida

Brenda Church, RHIT, CCS  
St. Stephens College

#### **Charlotte Stockton Memorial Scholarship**

Bethany Briggs  
Seminole Community College, Coding Certificate Program

*Thanks to the following who contributed to the scholarship funds this year.*

3M Health Information Systems  
Central Florida Health Information Management Association  
Gulf Coast Health Information Management Association  
Iqueu Consultants, Inc.  
Ocean Health Information Management Association  
Outsourcing Solutions, Inc. (OSi)  
Panhandle Health Information Management Association  
Professional Outsourcing, Inc.  
Pyramid Healthcare Solutions  
Southwest Health Information Management Association  
Stat Solutions, Inc.  
Suncoast Health Information Management Association

*FHIMA 2008 Scholarship Contributors for Charlotte Stockton Memorial Scholarship*

Professional Outsourcing, Inc.  
Stat Solutions, Inc.

It is such a worthy cause for the future of our Health Information leaders and FHIMA is proud to be able to provide these scholarships for many years to come!

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### **Congratulations to the 2008-2009 FHIMA Board of Directors!**

On Tuesday, July 15, 2008, the 2008/2009 Board of Directors will be installed at the Annual Membership Luncheon. The new officers will be:

**President**

*Dwan Thomas Flowers, MBA, RHIA, CCS*

**President-Elect**

Kimberly Eichner, MBA, RHIA

**Past President/Director**

*Stacie Buck, RHIA, CCS-P, LHRM, RCC, CIC*

**Directors**

*Barbara Bermudez, RHIT*

*Monica Cole, RHIA, CCS*

*Lisa Libby, RHIA, CCS*

*Dean Ritchey, RHIA*

*Diana Spaulding, RHIT, CCS*

*Kelly Wilson, MBA, RHIA, CHP*

**Chief Delegate**

*Lori Langley, RHIA*

**Executive Director**

*Carolyn Glavan, MS, RHIA*

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### **Seminole Community College Starts Programs**

Seminole Community College will start offering an associate degree in science and health information management later this fall at its new Altamonte Springs campus.

See reprints of articles showcasing this program by clicking on the following links:

The Orlando Business Journal announces Seminole Community College's new A.S. in HIM:

<http://www.bizjournals.com/orlando/stories/2008/06/09/daily29.html>

You can find specific information about the curriculum by visiting: <http://www.scc-fl.edu/medicalcoding/media/info-packet.pdf>

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### **FHIMA presents... CCS/CCS-P Exam Preparation Workshop**

**Are you preparing for the exam? Attend this workshop and you will feel more prepared!**

When: Saturday, SEPTEMBER 13th 2008 8:30am-4:00pm

Location: Miami Dade College

More information and registration information will be posted on the FHIMA website in the coming weeks. Please

check the What's New section of the FHIMA website ([www.fhima.org](http://www.fhima.org)) for more information when available.

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## An Invitation to attend the FHIMA Leadership Conference

FHIMA would like to extend an invitation for members to attend the FHIMA Leadership Conference. This conference will be held Friday, September 19<sup>th</sup> and Saturday, September 20<sup>th</sup> at the Marriott Renaissance Hotel in Tampa, Florida.

The Leadership Conference has been a forum for the state's regional HIM association leaders to gather to discuss and plan the leadership direction of FHIMA and regional associations. It is an educational opportunity as well as an excellent opportunity to start getting involved with your association! The FHIMA Board of Directors is committed to improving communications with members so we have opened up the conference to all FHIMA members! Come see what it is all about, get inspired to volunteer for your professional association, meet new colleagues and earn CEU's!

Meeting information and registration is still being developed at this time. Check the What's New section of the FHIMA website as details on cost, registration and hotel information will be posted there when available. The conference will start at 1pm on Friday, September 19<sup>th</sup> and end at 5pm. On Saturday, September 20<sup>th</sup> we will start at 8am and end around 4pm.

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## Articles

### Compliance Alert

*By: Kathy Reep  
Florida Hospital Association*

#### **Subcommittee on Regulations, Health Care, and Trade Hearing on "The Impact of CMS Regulations and Programs on Small Health Care Providers"**

##### **Background and Overview**

The House Small Business Subcommittee on Regulations, Health Care, and Trade held a hearing May 14 to discuss the impact of Medicare CMS regulations and programs on small health care providers. Testifying before the Subcommittee was the Chief Financial Officer (CFO) for the Centers for Medicare & Medicaid Services (CMS), **Timothy Hill**, whose testimony largely focused on CMS' implementation of the Medicare Recovery Audit Contractor (RAC) program.

##### **Hearing Summary**

At the outset of the hearing, Subcommittee Chairman **Charles Gonzalez (D-TX)** noted that the Small Business Committee has jurisdiction over the **Regulatory Flexibility Act (RFA)**. As such, the Committee is charged with ensuring that CMS and other Agencies comply with the provisions set forth in the Act, including those pertaining to small businesses. According to Gonzalez, several of CMS' current programs are "causing particular concerns among small providers," including the Medicare RAC program – a program that was initially authorized by the **Medicare Modernization Act of 2003 (MMA)** as a three-year demonstration project but has since been made a permanent fixture of the Medicare program via the **Tax Relief and Health Care Act of 2006 (TRHCA)**. Under TRHCA, the Department of Health & Human Services (HHS) is required to expand the RAC program from a demonstration operating in only three initial states (California, **Florida**, and New York) to a nationwide program no later than January 1, 2010.

Gonzalez cited CMS statistics, noting that CMS under the RAC demonstration program recovered over \$371 million in improper Medicare payments paid to providers and suppliers in 2007. Of that amount, approximately 96 percent of payments recovered were considered Medicare "overpayments" to providers and suppliers with only an estimated four percent of payments termed "underpayments." "I find it hard to believe that this represents the true proportion of underpayments," Gonzalez stated. Furthermore, Gonzalez went on to express concern over CMS' payments to RACs (on a contingency fee basis), as well as what he considers to be a "lack of proper oversight" on CMS' part.

In testimony to the Subcommittee, CMS CFO Timothy Hill stated the Agency's work with respect to the RAC program and its overall efforts to restore fiscal integrity in the Medicare program. Hill pointed out that in January of 2008, the Office of Management & Budget (OMB) listed Medicare as one of the top three federal programs making improper payments – with an estimated \$10.8 billion in improper payments made during fiscal year (FY) 2007. "Since 1996,

CMS has reduced the Medicare fee-for-service error rate from 13.8% to 3.9%," Hill noted in his written testimony.

According to Hill, CMS has been working very closely with physicians and other providers to improve the current RAC program prior to its nationwide deployment. For instance, CMS convened monthly meetings with various state and national associations to discuss issues pertaining to the current RAC program as well as ways to improve the demonstration and the upcoming permanent nationwide program. As a result of those efforts, CMS has incorporated a number of changes into the Request for Proposal (RFP) for the permanent RACs, including: (1) requiring that the permanent RACs employ a medical director (an M.D. or D.O.) and a certified coding expert; (2) requiring that permanent RACs pay back their fees if they lose at *any* level of appeal (as opposed to under the demonstration when the RACs were only required to pay back their contingency fees if they lost at a 1st-level appeal but not at subsequent levels); (3) allowing permanent RACs to review claims in the current FY; (4) imposing a maximum look-back date for improper payments – permanent RACs will have a three-year look-back window (though no earlier than claims paid before October 1, 2007); (5) requiring permanent RACs to operate a web-based system to provide transparency and access to providers involved in the audit process; (6) establishing a limit on the number of records a RAC may request from a provider; and (7) emphasizing provider education and training with respect to the RAC program.

In response to a question posed by Gonzalez as to how many physicians each RAC would be required to have on staff, Hill noted that while each RAC is required to have a medical director on staff (who is a physician), CMS does not place parameters around the actual number of physicians that must be on staff. It is the job of the medical director, according to Hill, to ensure that the review of the therapist, nurse, or other professional staff auditing the provider, is correct.

When asked about the California RAC program and the 40 percent error rate found in the state's RAC audits, Hill conceded that the California RAC demonstration became a "poster-child for bad decision-making" but was quick to point out that the Agency has taken great measures to ensure that an independent evaluation of the inpatient rehabilitation claims in the state were reviewed and that problems were resolved.

The committee probed Hill about CMS' contingency fee arrangement with the RACs, specifically inquiring as to the percentage of the fees kept by a RAC when an appeal is overturned by a federal judge. In responding, Hill provided the following example to illustrate how the process works. According to Hill, of a sample of 100 claims, about 13-15 of those claims will be appealed. Of that amount, only about four claims are actually overturned – a rate that is consistent with Medicare fiscal intermediaries (FIs) and carriers.

Hill went on to elaborate that most of the improper payments were the result of either: (1) an inaccurate assessment of what is medically necessary – e.g., performing a service that could have been done in a different (and perhaps less expensive) setting; (2) coding inaccuracies; or (3) lack of documentation or insufficient documentation.

Hill later noted that there are similar incentives for RACs to identify underpayments as there are to detect overpayments. However, based on CMS' assessment of claims over the last 10 years, most of the time Medicare is overpaying and there are very few instances in which the program actually underpaid the provider.

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## **Inpatient Prospective Payment System Hospital and Long Term Care Hospital Review and Measurement Fact Sheet**

### **Background**

This fact sheet describes a change that is being made by the Centers for Medicare & Medicaid Services, with regard to the review of acute inpatient prospective payment (IPPS) hospitals and long term care hospitals (LTCHs). Medicare Fiscal Intermediaries (FIs) and Medicare Administrative Contractors (MACs) will now conduct medical review to prevent improper payment of inpatient hospital claims. Medical review is the process performed by Medicare contractors to ensure that billed items or services are covered and are reasonable and necessary as specified under section 1862(a)(1)(A) of the Act. In addition, the Comprehensive Error Rate Testing (CERT) contractor will now conduct medical review to measure inpatient hospital payment error rates.

Previously, in addition to their focus on quality issues, the Quality Improvement Organizations (QIOs)' responsibilities included the following for acute IPPS hospitals and LTCHs:

The Hospital Payment Monitoring Program (HPMP), which was performed on a postpayment basis and consisted of 2 parts:

1. Utilization review of randomly selected claims for payment purposes, and
2. Measurement of the accuracy of Medicare Fee-for-Service (FFS) payments to acute IPPS hospitals and LTCHs (that is, the "error rate")

- Performance of provider-requested higher-weighted diagnosis related group (DRG) reviews;
- Review of Emergency Medical Treatment Active Labor Act (EMTALA) cases; and
- Performance of Expedited Determinations.

QIOs are no longer responsible for the functions previously included in the HPMP. They will retain responsibility for quality oversight in all Medicare FFS settings, provider-requested higher-weighted DRG reviews, EMTALA reviews, provider education on quality of care issues, and expedited determinations.

### **Rationale**

CMS is making this change as part of its commitment to improving the efficiency and quality of health care delivered to Medicare beneficiaries. The transition of responsibility for measuring and preventing improper payments to inpatient hospitals from the QIOs to the FIs, MACs, and the CERT contractors will allow the QIOs to concentrate on improving patient quality of care and maintaining quality improvement and provider assistance efforts. This transition also aligns the oversight of acute IPPS hospital and LTCH claims with that of all other Medicare FFS provider types.

### **Timing**

The transition is occurring in two phases:

- The CERT contractor began reviewing claims for the purpose of measuring error rates for acute IPPS hospital and LTCH claims on April 1, 2008.
- We anticipate FIs and MACs will begin reviewing acute IPPS hospital and LTCH claims, for the purpose of determining the appropriate payment due and preventing or reducing improper payments, this summer.

Hospitals will start receiving medical record requests from the CERT contractor in May, and FIs and MACs will begin requesting medical records later this summer.

### **Responsibilities**

- The activities related to acute IPPS hospital and LTCH review that will now be performed by a different review entity are: FIs and MACs will perform medical review of acute IPPS hospitals and LTCH claims, on either a prepayment or post-payment basis, to ensure that they are for covered, correctly coded and reasonable and necessary services and will conduct claim adjustments, as appropriate, on claims which are not.
- FIs and MACs will conduct provider feedback, through their medical review departments, based on findings from medical review of acute IPPS hospital and LTCH claims. They will also continue to conduct provider education, through their provider outreach and education department, on issues related to submitting inpatient claims correctly as part of their goal to reduce the error rate.
- The CERT contractor will perform reviews on a post-payment basis, in order to determine the degree to which Medicare FIs and MACs are paying acute IPPS hospitals and LTCHs claims appropriately, in accordance with coverage, coding, and medical necessity guidelines.

These utilization reviews, provider education, and error rate measurements will be conducted in a manner consistent with that used by FIs, MACs, and the CERT contractor in the review and error rate measurement for all other Medicare fee-for-service (FFS) claims.

The activities related to acute IPPS hospital and LTCH claims review which will continue to be performed by the QIOs are:

- Quality of Care Reviews due to beneficiary complaints, complaints other than from beneficiaries, and quality of care reviews for cases referred by CMS or CMS designated entities (e.g. FIs, Carriers, MACs, SSAs, OIG).
- Utilization reviews for Hospital requested higher-weighted DRGs;
- Utilization reviews referred by CMS or CMS designated entities (e.g. FIs, Carriers, MACs, SSAs, OIG.) for cases involving issues such as transfers and readmissions;
- Review of Emergency Medical Treatment Active Labor Act (EMTALA) cases;

- Expedited determinations; and
- Provider education on quality of care issues, and other issues under their purview

(e.g. hospital-requested higher weighted DRG review, etc.).

**Claim Review Process**

The coverage and payment guidelines used by the FIs, MACs and CERT contractor will be the same as used in the past by the QIOs, though some claim selection and review procedures will be different.

Notification and Record Submission: The hospital will know when a claim has been selected for review in slightly different ways, depending on the review entity. For purposes of measuring the error rate, the CERT Contractor will notify providers that claims have been selected for CERT review via letter or telephone contact.

- The medical record request letter will be mailed or faxed according to the hospital’s preference.
- Hospitals may submit medical records via mail or fax.

For prepay review, the FIs and MACs will suspend claims for review and the FIs and MACs will then send out a request for supporting documentation. Providers may use the claim inquiry screen in the Direct Data Entry (DDE) system and verify the status of the claim. They may view the narrative for the reason code that is applied to a suspended claim. The narrative will provide the reason for the suspension. Hospitals submit hardcopy medical records via mail.

For postpay review, the claim is already paid. An FI or MAC performing postpay review will send a request for medical records to the provider. The FIs or MACs will review the claim and make any adjustment necessary to the claim based on the review. Hospitals submit hardcopy medical records via mail.

Screening and Review: Most QIOs used a commercial screening tool as a first-level indicator of the appropriateness of the services billed, though they were not required to use a particular tool. FIs, MACs and the CERT contractor are also required to use screening criteria in the review of acute IPPS hospital and LTCH claims, though, as was true for the QIOs, CMS is not mandating the use of a particular tool.

In addition to use of a screening tool, FIs, MACs, and the CERT contractor will apply coverage, coding, and medical necessity guidelines, utilizing clinical judgment in making payment determinations on each claim, as the QIOs did.

Reviewers: Qualified clinicians, such as nurses and therapists, will perform the reviews, consulting with physicians or other specialists as needed. As is the case with all other Medicare claim types reviewed by FIs, MACs, and the CERT contractor, there is no CMS requirement that physicians be used to review each acute IPPS hospital and LTCH claim on which an adjustment may be made.

**Comparison Chart**

Because of varying statutory requirements, there are some differences in the claim review processes used by various review entities. The following chart provides a comparison of the processes used by the QIOs, CERT contractor, FIs, and MACs.

<b>Side-by-Side Contractor Activity Comparison Chart</b>	<b>QIOs (HPMP)</b>	<b>CERT</b>	<b>FIs/MACs</b>
<b>Issue</b>			
Review selection	Random	Random	Targeted to claims with suspected improper payments. Initially, there may be some random review.

When the claim is selected for review	Postpayment: 3 months after discharge	Postpayment: Medical record request letter sent ~ 35 days after payment	Prepayment: Shortly after the claim is submitted or Post payment: Up to 4 years after payment
Credentials of reviewers	Qualified clinicians	Qualified clinicians	Qualified clinicians
Level of physician involvement in review process	Review all claims where nonphysician reviewer identifies a problem with the claim	As needed for complex cases	As needed for complex cases
Use of coding experts	Mandatory	Mandatory	Mandatory
Distribution of Program for Evaluating Payment Patterns Electronic Report (PEPPER)	Mandatory	N/A	Undetermined

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## Optimal Transcription TAT

*By: Holly Woemmel, MA, RHIA and Barbara Bermudez, RHIT*

*Members of the committee responsible for creating the "Transcription Turnaround Time for Common Document Types TAT4CDT"*

With the ever changing healthcare environment, decrease in number of qualified MTs and increasing demands from healthcare providers and regulation agencies, it was necessary for the American Health Information Management Association and Medical Transcription Industry Association (AHIMA/MTIA) to form a Joint Task Force to recommend standards for turnaround time (TAT) of transcribed reports on selected work types. The research for TAT recommendations included current technology, workforce realities, existing TAT guidelines from authorities such as the Joint Commission (JC) and Centers for Medicare and Medicaid Services (CMS) and to take in consideration patient safety issues and quality patient outcomes.

The goal of this project was to "outline significant findings, contributors, impacts and provide recommendations that will create a framework around which "buyers" and "sellers" of medical transcription services can engage in dialogue and make informed purchasing and contracting decisions related to documentation TATs".[1] It was the Task Force's responsibility to really drive home the recommendations of TAT's with the ultimate goal to improve efficiencies in operations in the HIM department and the patients they serve. The recommendations that came out of this task force mainly focused on hospital's needs, though, we believe that this could also hold true in other settings such as large clinics.

The task force was charged with assessing the environment in a number of ways. Survey data was obtained to measure and analyze current conditions and established real-world practices from both the Health Information Management (HIM) and Medical Transcription Service Organizations (MTSO) management experiences. The main driver for the data collection came from the hospital side of the healthcare industry business. In addition, research and review of existing white papers, journals, articles, webs search's and other publications was performed, with information obtained where available.

The increasing demand for medical transcription of patient care documentation has been particularly notable over the past 10 years. There are a number of reasons for the increasing demand. The following are common, but this list is not all-inclusive:

- An aging population
- A trend away from handwritten reporting
- Provider need for streamlined administrative tasks that provide for more patient care time
- Perceived greater efficiency
- Ease and speed of dictating versus other methodologies
- Correlation of improved accuracy and legibility to transcribed reports
- Belief that dictation allows clinicians to document a more comprehensive report in greater detail
- The need to integrate documentation with the EHR

Also, through the survey results of the HIM Managers and MT/MTSO Managers, there were three main categories that affected compliance with TAT standards. Those were the following:

- Staffing
- Changes in work volume
- Transcription anomalies, examples, mumbling, poor dictation, gaps and blanks in dictation and technology issues.

The dilemma of keeping up with the increasing demand has not been readily solved, and this continues to be an obstacle, with increasing documentation volumes and the concurrent demand for faster TATs both starkly juxtaposed against a critical workforce shortage. There are as many reasons for the workforce shortage as there are reasons for increasing documentation:

- An aging workforce
- Limited access to medical transcription training
- Poor visibility of the profession to the general public and potential workforce candidates
- The long-term learning curve to reach a significant level of expertise
- Competition for workforce from other allied health professions
- Competition from other work-at-home professions
- Declining compensation

The typical laws of supply and demand have little correlation or evident application in medical transcription. When demand is up, prices typically increase but demand for low-cost transcription deliverables has resulted in a paradoxical suppression of wages for those qualified to meet the demand. Pair that with the decreasing number of qualified professionals to do the job, and you have a significant economic conundrum. In reality, the price per unit (line, report, minute, page, character, etc.) of medical transcription has decreased significantly over the past 10 years, as have wages for the MT, despite high demand (increased documentation needs) and low supply (critical workforce shortage).

Based on the analysis of data secured, the task force used a weighted average methodology to calculate the recommendations of TAT for the common document types. The definition for TAT utilized in this white paper is from the time dictation is completed until the time the report is delivered, either by printed medium or electronically to a repository. The basis of these recommendations included survey results and statistics compiled from a number of significant MTSOs currently providing medical transcription services to over 1200 clients nation-wide.

The following recommended TATs are based on these data.

Recommendations for TAT by major work types are as follows:

History & Physical	8 hours
Operative Report	8 hours
Discharge Summary	24 hours
Inpatient Progress Note	8 hours
Consult	12 hours
Radiology	4 hours

The task force closely studied and examined the research and survey data as components and factors directly impacting TAT delivery. Based on the development of new technologies, workforce realities, current practices, implementation considerations, as well as the few existing standards, the key discoveries due to the absence of a collection of such important findings revealed the need to first establish these outcomes as the state of the industry.

Although there is a notable variance in current TAT4CDT as evidenced by the survey contributions, the commonality brought forth throughout is the striking difference in the size and type of healthcare facility where these TATs are in place. The needs and demands in TAT of healthcare facilities vary and this is a major contributor that explains the wide range of the TAT results. With these recommendations, one must remember that if the TAT's are decreased from what your organization is currently utilizing, it may increase the cost of your transcription, whether it is done in house or outsourced. The driver for cost would be increased staffing to meet TAT's, after hour pay for additional coverage or sending additional overflow work to your transcription vendor. One would need to make sure that they are looking at the cost/benefit ratio for their organization

The race down the track to optimal transcription TAT standards has lead to National TAT standards that will ultimately improve efficiency in patient care, meet Joint Commission and other regulatory agency expectations and strengthen the healthcare billing and revenue cycle process.

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## The HPMP Ending

*By: Patty Collier, RN, FMQAI and Ferdinand Richards, MD, FMQAI*

### Transition of HPMP Out of QIO Program

Effective August 1, 2008 with the beginning of the the 9<sup>th</sup> Statement of Work, Quality

Improvement Organizations (QIOs) will no longer be responsible for implementing the Hospital Payment Monitoring Program (HPMP).

The purpose of HPMP was to measure, monitor, and reduce the incidence of improper fee-for-service inpatient acute care Medicare payments. QIOs will no longer be responsible for these functions, and funding for QIO assistance related to these responsibilities will cease. These responsibilities are being transferred to other entities. Hospitals should be aware that support and education provided by QIOs related to payment error reduction will no longer be available. Hospitals may wish to contact the following organizations for questions previously directed to QIOs related to compliance or payment error reduction activities:

- Compliance-related questions: Health Care Compliance Association
- Billing questions: Fiscal Intermediary or Medicare Administrative Contractor

Many QIOs also distributed quarterly hospital-specific comparative data reports (the Program for Evaluating Payment Patterns Electronic Report, or PEPPER). Although not required to do so, QIOs will be able to distribute PEPPERS through the January 2009 data release; FMQAI will not be providing these reports to hospitals. A metric for readmissions within 30 days has recently been added to the PEPPERS to aid QIOs in efforts related to this 9<sup>th</sup> Statement of Work area. It has not been determined at this time whether PEPPERS will be generated after January 2009. The tools and resources posted at [www.hpmpresources.org](http://www.hpmpresources.org) will be available through January 2009.

For error rate calculation, the final sample under HPMP was selected in February 2008; October 2007 discharges were sampled. Sampling after this date was discontinued, as it is not possible to utilize the samples toward the final error estimate that HPMP will contribute, the agency estimate to be released in November 2008. Inpatient records for calculating the national fee-for-service Medicare error rate will be sampled under the Comprehensive Error Rate Testing (CERT) program beginning in April 2008. More information on the CERT program is located at <http://www.cms.hhs.gov/cert>.

QIOs will continue to perform other statutory and regulatory mandated review activity and quality improvement as described in the 9<sup>th</sup> Statement of Work.

Even though HPMP will end at the close of the 8<sup>th</sup> Statement of Work, FMQAI will still be under contract with CMS to provide case review for the Beneficiary Protection aspect of the 9<sup>th</sup> Statement of Work. In the 8<sup>th</sup> Statement of Work, FMQAI completed over 17,000 case reviews, of which 1,100 (6%) were for HPMP. FMQAI will continue to perform a large number of quality, utilization and coding reviews for the 9<sup>th</sup> Statement of Work. As outlined above, however, the educational piece of this process will no longer reside with FMQAI.

After evaluation of case review and HPMP data in the 8<sup>th</sup> Statement of Work, FMQAI would like to share the following information:

### **PTCA, PCI, and AICD Pacemaker Billing**

As technology has progressed and the need for prolonged care after these procedures has become less, FMQAI recommends that these elective procedures be billed as outpatient.

### **Inpatient Only List**

Please remember that Medicare pays by the Federal Register Addendum E Inpatient only list that can be found at: [http://www.cms.hhs.gov/apps/ama/license.aspfile=/HospitalOutpatientPPS/Downloads/CMS1392FC\\_Addendum\\_E.zip](http://www.cms.hhs.gov/apps/ama/license.aspfile=/HospitalOutpatientPPS/Downloads/CMS1392FC_Addendum_E.zip)

### **HPMP SPECIAL PROJECTS**

#### **Case Management Assignment Protocol**

The latest version of CMAP is located on our website at [www.fmqai.com](http://www.fmqai.com). CMS had promoted national attention to CMAP through the ongoing consortium project with six QIOs and their respective hospitals.

#### **Chest Pain Project**

The Chest Pain Project has yielded great success in Florida as well as Arizona, our partner QIO in the project. Both QIOs use the CMAP as one of the interventions to decrease unnecessary chest pain admissions. For more information on the original CMAP and Chest Pain projects, please see the published versions in:

- A Case Management Protocol, Reducing Unnecessary Medicare Admissions in Florida. *Lippincott's Case Management*. 2005 Mar-Apr;10(2):72-20.
- Reducing Unnecessary Medicare Hospital Admissions for Chest Pain in Arizona and Florida. *Professional Case Management*. 2008;13:74-84

### **HPMP ANNUAL REPORT**

#### **Sepsis**

FMQAI data suggest that sepsis is the number one most disagreed with high-weighted DRGs (HWDRG) as well as the leading DRG contributing to the Florida HPMP payment error rate.

#### **Complex Pneumonia 079 vs 089**

Complete pneumonia continues to be a focused concern as pointed out in the Florida PEPPER data as well as demonstrated in HPMP analysis. Aspiration pneumonia was a more prominent area of concern.

#### **30-Day Readmits**

PEPPER data as well as other audits have focused on 30-day readmits as an area of potential recoupment of Medicare funds.

#### **Physician Query Process**

FMQAI supports the physician query process. Non-leading queries, along with appropriate documentation in the medical record, tend to reflect best practices.

FMQAI would like to thank all of Florida's Medicare hospitals that participated in HPMP in both the 7<sup>th</sup> and 8<sup>th</sup> Statements of Work. It is because of hospitals' support that FMQAI completed HPMP for CMS with a grade of Excellent Pass.

Please do not hesitate to call for any questions or concerns.

Patty Collier, RN, 813-354-9111, ext. 3539

Ferdinand Richards, MD, 813-354-9111, ext. 3120

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## Transition of Inpatient Hospital Record Reviews from QIO to FI/MAC

By Barbara Flynn, RHIA, CCS  
Florida Hospital Association

There has been considerable discussion about the change in the scope of work for the Quality Improvement Organizations (QIOs) and what would happen with current reviews for inpatient medical necessity and coding. The attached ADVANCE copy of a CMS fact sheet outlines the plans for transition from review by the QIOs to the Medicare fiscal intermediaries and Medicare Administrative Contractors. Please note that the review at the FI/MAC level could be pre- or post-pay and the contractor must use targeted case review, based on data analysis, to select records and issues for review. There could be some random review early in the transition.

It is our understanding that a CMS transmittal will be issued shortly on this change, but we wanted to make sure you had the information that we have received as early as possible.

If there are questions on the review changes, please do not hesitate to contact either [kathyr@fha.org](mailto:kathyr@fha.org) or [barbaraf@fha.org](mailto:barbaraf@fha.org)

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## Self-Mastery: What Is It, Who's Got It, And How Do We Increase It?

By: [Dr. Brian Higley](#)  
*The Building Blocks, April 12th, 2007*

"Self-Mastery" is a concept that is repeatedly recommended as essential to leadership excellence. Our firm recently polled over 80 individuals - from CEO's at a Fortune 500 level to high-functioning college students working at internships - on their opinions of their own levels of Self-Mastery. We found some very interesting results and wanted to share them in hopes of: (a) facilitating a robust conversation about Self-Mastery and (b) helping individuals conceptualize what Self-Mastery is, why it is so important, and how to move toward increasing it.

- **What is Self-Mastery?** [click here to read more](#)
- **Who Participated In This Poll?** [click here to read more about the participants in this poll](#)

**What Did Participants Report?** Now, on to the "meat and potatoes" of the poll: what did our poll participants have to say about Self-Mastery? First of all, here were the items we asked people to rate themselves on; these items represent the factors that we have found to be most strongly associated with Self-Mastery (with average scores of respondents - based on a 1-5 point scale - in parenthesis):

1. I am conscious of the many opportunities to succeed that lie within myself (average score: 4.42)
2. I am good at identifying and resolving the "hot button" issues (topics that create anger, resentment, or doubt) within myself (average score: 3.90)
3. I am skilled at increasing my positive thoughts and emotions when I would like to do so (average score: 4.06)
4. I consistently identify and pursue the most meaningful goals in my life (at work and outside the office) (average score: 3.67)
5. I find it easy to adjust my behaviors and thoughts to fit my needs across many situations that require both the ability to focus within myself and interact with others effectively (average score: 4)
6. I consistently structure my mind and organize my environment to minimize stress and increase focus (average score: 3.52)
7. I consistently create plans that are likely to succeed based on strategies that have proven to be successful in the past (average score: 3.98)
8. My lifestyle is one that contributes to my energy, focus, and effectiveness levels (average score: 3.80)

9. I am good at opening up enough free time for leisure and using that time to refresh and re-energize myself (average score: 3.33)
10. I have solid influence over my thoughts, feelings, and actions – even when dealing with unplanned-for challenges (average score: 3.98)

As I looked over this data, my mind went immediately to the top three scores and the bottom three scores on this list. I thought a discussion about those scores - and how the results of this poll relates to my experiences researching (in much more scientifically rigorous ways than this poll) and attempting to facilitate Self-Mastery levels in my clients - might be a good place to go next.

**A. The Highest Scores.** The 3 highest scores above were on to what I call the “success” items (items related to achieving goals) - items I’ve seen most high level leaders truly excel in. Most leaders I interact with tend to be:

- aware of the many opportunities to succeed in life (4.42 average in this poll),
- able bring about more positive emotions and thoughts when needed (4.06), and
- skilled at flexing to fit the needs of a situation or environment (4.00).

These abilities are some of the very reasons why leaders rise to their positions. No surprises here, especially since we polled some of the more successful people we know.

**B. The Lowest Scores.** The 3 lowest scores above were on what I call the “satisfaction” items (items related to enjoying life). These scores were also not surprising to me, as they continuously come up as some of the greatest Self-Mastery challenges for most leaders that I’ve encountered over the past 10 years. Even the best leaders often report:

- struggling to prioritize their many goals (3.67 average in this poll),
- wishing that their minds and environments were more focused (3.52), and - perhaps most universally. . .
- not having enough satisfying leisure time (3.33).

It’s been my experience that these 3 items are all interconnected, with less ability to prioritize often leading to less focus, which in turn leaves less time for satisfying leisure.

**C. How Do The Highest and Lowest Scores Relate to Each Other?** My experience with leaders has led me to believe that many leaders allow their Self-Mastery strengths to create Self-Mastery weaknesses. For example:

- being able to “see opportunity everywhere” (a Self-Mastery strength), as most outstanding leaders tend to be able to do, can also lead to a less focused life (a Self-Mastery weakness); a life of chasing goals without a sense of which ones are truly essential to what they want to get done.
- being able to bring about positive thoughts and feelings when needed can lead to ignoring the leisure activities that bring about these feelings more naturally; most people who cannot influence their emotions absolutely need to put aside leisure time, while those who can bring these feelings about internally can more easily ignore leisure.
- finally, flexibility can also contribute to “flexing” out of some of the most meaningful goals in our lives - goals related to family, leisure, and truly relaxing activities.

**Balancing Success and Satisfaction: How to Avoid Creating Self-Mastery Weaknesses Out of Your Strengths.** The most important way, I think, to avoid creating weaknesses from strengths is not anything that you probably haven’t *heard* before - but might be something that you haven’t actually *done* on a regular basis: prioritizing opportunities and time and spending time to structure you life for more focus and satisfaction while moving toward your most critical goals.

If you agree with this need but do not actually perform this activity on a regular basis - you might want to investigate why you don’t. I’ve been collecting reasons for not doing what’s good for oneself for over 7 years now, so if you’d like to place a reason for not “doing prioritization” in the comment section below, I’d like to hear your view on this (I’ll bet you a dime that the most common reason for this is something like “I don’t have the time” - do you owe me a dime?). Below this section of this article is a link for those who are curious about how we assist people with “doing” Self-Mastery.

- **How to Actually “Do” Self-Mastery.** [click here if you are interested in some suggestions for improving Self-](#)

## [Mastery](#)

**Some Final Words.** Thanks to all who participated in our poll and to everyone who took the time to read this article and/or provide us with comments about either the article or the SBSS. We look forward to hearing more from you all about Self-Mastery, and hope that this article added value to your day.

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### **Jacksonville FHIMA Member Receives Health Care & Natural Sciences Award for Excellence in Instruction**

By: Dwan Thomas Flowers, MBA, RHIA, CCS  
FHIMA President-elect 2007-2008

Eudelia Thomas, MS, RHIA, fondly known to all as "Skip," received the 2008 *Marcus E. Drewa Endowed Chair for Excellence in Instruction Supporting Health Care & Natural Sciences Award*. The award recognizes outstanding contributions of a faculty member whose actions directly impact students seeking healthcare careers. In order to be eligible for such an award, the nominee must have proven service to the community in the area of healthcare continuing education programs; demonstrated innovation in teaching, recruitment and development of programs as well as proven service to the nominee's discipline.

Unequivocally, Skip meets all criteria. Skip has been involved in the Health Information Management (HIM) field for over 25 years. She has been committed to the advancement of the profession. She currently serves as the Chair for the Health Information Management (AS degree) and Medical Coding and Billing (Applied Technology diploma) programs at Florida Community College of Jacksonville. She basically, single-handedly built the program from its inception. The program has progressed over the years from having approximately 12 enrollees to an all-time high of 30 potential, simultaneous graduates. Her impressive energy and passion related to HIM are unrivalled.

Skip is one of the more involved professionals. She emphasizes to her students the importance of professional service via volunteering and ongoing academic pursuits. She leads these students by example and has been intimately involved in various volunteer roles for the Northeast Florida HIM Association (NEFHIMA) as well as FHIMA. She has served as President and Treasurer for NEFHIMA during multiple terms. She has recently served as the Service Awards Chairperson for FHIMA.

One of the more noteworthy projects in which she is involved includes the partnership between Mayo Clinic Jacksonville and FCCJ. The community has a need for educated, credentialed HIM coding professionals, and Mayo's requirements for coding positions are strict, including a minimum of an Associate level degree in a healthcare related field in conjunction with the RHIA, RHIT or CCS credential. Not only is there a strong recruitment presence from the pool of FCCJ's new, HIM graduates but also those existing Mayo employees that did not meet these requirement were given a specified period to meet the requirements. During periods from 2004 through 2007, Skip made quarterly visits to Mayo Clinic to educate the employees on how to enroll in HIM programs. There were also a few hands-on sessions that allowed employees to enroll or register for their next classes during these periods. Eventually, this resulted in the FCCJ classes being offered on the Mayo campus when there was sufficient enrollment. This was a win-win situation and further exhibits how she was willing to go above and beyond to meet the mutual needs of the program and the community.

Skip is a highly visible educator in the allied health arena. She has experience in text book knowledge, real world application and professional affiliations. These qualities continue to make her a sought-after individual for her expert opinions. With this mix of passion for her students' success and dedication to her profession, she proves an excellent candidate for this recognition. Acknowledgment of a HIM professional for an award of this stature is encouraging, refreshing and attracts the type of attention that adds validity to the science of HIM.

We are proud of her accomplishments and congratulate her on behalf of FHIMA!

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## **AHIMA Update**

### **HHS Selects 12 States for Medicare EHR Incentive Project**

Last week, Health and Human Services (HHS) officials selected 12 states and communities to participate in a five-year Medicare demonstration project that will provide local physicians with financial incentives for using electronic health record (EHR) systems. The project is designed to determine whether incentives can encourage small and medium-sized physician practices to increase their use of EHRs. Individual physicians could receive up to \$58,000 over the five years, while physician practices could receive up to \$290,000.

The Centers for Medicare and Medicaid Services (CMS) will evaluate the participating physicians on whether they meet the program's benchmarks, and doctors who meet or exceed the benchmarks will be eligible for the highest incentive payments, according to HHS Secretary Mike Leavitt. In the first year, physicians will be judged on how effectively they use EHRs and in the second year they will be required to report on national quality measures. Click [here](#) for more information.

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### **ONC Commissions Medical Identity Theft Assessment**

The Office of the National Coordinator for Health Information Technology (ONC) awarded an approximately \$450,000 contract to Booz Allen Hamilton to assess and evaluate the scope of the medical identity theft problem in the US. National coordinator for health information technology Robert Kolodner, MD, has noted that medical identity theft stories are being documented at an increasing rate, bringing to light serious financial, fraud, and patient care issues. ONC recognizes that health IT is an important tool to combat the threat of medical identity theft. Public and government input is being sought to better understand how health IT can be utilized to prevent and detect medical identity theft as well as build consumer trust in electronic health information exchange. ONC believes it is imperative to obtain a more comprehensive understanding of this issue from a variety of perspectives and to create an open forum for dialogue to work proactively to address medical identity theft.

Three specific deliverables corresponding with each of three phases will result from this assessment.

A comprehensive environmental scan of the medical identity theft problem in the US particularly focusing on the intersection of health IT

A one-day town hall meeting to enable healthcare experts to share knowledge and experience of medical identity theft and how health IT can be utilized to prevent and detect medical identity theft

A final report and road map

To learn more, click [here](#).

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### **Journal Rolls Out New Web Site**

The *Journal of AHIMA* has rolled out a new Web site with a new look and increased functionality. The site is a companion to the print journal, offering additional material related to each month's issue. *Journal* staff will post bonus material, updates to published stories, and highlights of Web-only material such as practice brief extras. The site is also a place to check for new online-only material, such as updated practice briefs and links to resources including sample policies and checklists. Visit the *Journal of AHIMA* online at its new Web site at <http://journal.ahima.org>.

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### **Polls Now Open for AHIMA Election**

The AHIMA Election is now under way so plan to vote and get the message out to your fellow HIM professionals to cast their vote as well. **Please note that the polls will close on June 30 at 6 p.m. ET.** (Please note that since the polls opened an hour later than officially published, they will close an hour later on June 30 .) Remember that AHIMA members will only be able to cast their vote via the AHIMA Web site. The June *Journal of AHIMA* includes each candidate's brief bio, job description, and photo on pages 73-77. The "Resources" section of the AHIMA Community of Practice includes a detailed profile of the candidates and their photo.

To access the CoP, visit [www.ahima.org](http://www.ahima.org) and go to **myAHIMA** on the right side and enter your **AHIMA ID number** (the seven-digit number on your membership card) and your **password**. Once in myAHIMA, select the CoP logo to enter. (See "CoP News You Can Use" in this e-alert for complete voting directions.) The summaries of the discussion threads from the Candidate CoP are posted in the "Resources" section of the AHIMA Community, under the category AHIMA Election-2008.

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### **New HIM Marketplace Now Available**

AHIMA has launched The HIM Marketplace, a new resource offering comprehensive access to HIM industry service and product suppliers. This new product provides a convenient way for customers and providers to interact with each other. Members can visit the HIM Marketplace at [www.thehimmarketplace.com](http://www.thehimmarketplace.com) when researching HIM-industry product and service providers. HIM industry suppliers are welcome to reserve their listings today.

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### **New Article Posted to PHIM Web Site**

The latest article posted to *Perspectives in Health Information Management*, "Record Retention Practices among the Nation's 'Most Wired' Hospitals," examines health record retention practices among HIM professionals in acute care general hospitals in the United States. This second part of a two-part study examines the relationship between researcher-assigned storage media profiles, retention periods, and factors that influence record retention periods such as retention of secondary data, vendor usage, and continued reliance on paper in environments where EHRs exist. Author Laurie A. Rinehart-Thompson, JD, RHIA, CHP, used a self-reporting survey instrument to collect data from randomly selected hospitals. The results showed that HIM professionals exercise considerable responsibility and give a great deal of input relating to the administration and oversight of health record retention policies and the determination of record retention periods. Click [here](#) to view the complete article.

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### **Remember a Loved One with a Memorial Gift**

The Foundation of Research and Education (FORE) accepts contributions from AHIMA members in many ways. For example, memorial gifts are accepted all year long. Contributions can also be made in memory or in honor of colleagues, family, and friends. These contributions are a thoughtful way to remember or recognize members while supporting the FORE Merit Scholarship Program, which awarded 95 scholarships in 2007. To view a list of memorials, click [here](#).

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### **Plan to Attend AHIMA's Summer Meetings**

Plan ahead and visit Chicago in July for summer meetings including the Community Education Coordinator session (by invitation only), Summer Team Talks, Leadership Conference, and the Coding Roundtable Summit. Join your colleagues for these great meetings and receive continuing education units.

**July 17**—Education Coordinator Session: (by invitation only)

**July 18**—Summer Team Talks

**July 19–20**—Leadership Conference

**July 20**—Coding Roundtable Summit

**July 21-24**—Executive Skills Institute (AHIMA Office)

All meetings will be held at the Wyndham Hotel in Chicago, IL. You can register now for the meetings online and find hotel information [here](#). Those who register for the meetings plus the Summer Team Talks Reception online will receive an e-mail confirmation. **The registration deadline is July 13 and the hotel registration cut-off date is June 18.** To register for the Executive Skills Institute click [here](#).

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### **CoP News You Can Use - AHIMA Election Voting Guidelines**

Voting in AHIMA's election via the Communities of Practice is easy and convenient. Follow the instructions below to cast your vote.

Go to [www.ahima.org](http://www.ahima.org) and select **myAHIMA** on the right side.

Enter your **AHIMA ID number** (the seven digit number on your membership card). Make sure you include all numbers, including leading zeros

Enter your **password**. Please note that if you have never created an AHIMA password online or otherwise updated your password with AHIMA, your default password is your last name. If you are a long-time member of AHIMA and have changed

your last name (due to marriage, for example), your password may still be your last name as originally provided to AHIMA. If you applied for membership online and created your own password, use that password. If you have changed your password through the profile, please use that password.

Select the **Enter myAHIMA** button.

Click on the Communities of Practice icon in **myAHIMA**. You will be taken to the CoP.

First-time users will see the Terms and Conditions of use. You will need to click the **Accept** button before you can enter the CoP for the first time.

You will see the screen with a link to the National Election. Click on that to begin the voting process.

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### **Members Experience the Benefits of ACE**

The ACE (Action Community for e-HIM Excellence) Challenge mobilizes a network of experts and change agents by defining, preparing, engaging, mentoring, and recognizing those working to transform HIM practice. Once you become an ACE member, you can track your activities in a database AHIMA provides. If you are already an ACE member, be sure to record your activities. To learn more about ACE and take the self assessment, click [here](#).

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### **AHIMA Convention and Exhibit Registration Now Open**

Plan now to join us at the **80th AHIMA Convention and Exhibit October 11–16 in Seattle, WA**. Equip yourself to navigate challenges, meet today's requirements, and prepare for what's next in the HIM profession. Registration and housing are now open. AHIMA has secured the best hotel rates. Make your reservations before September 12. Click [here](#) for details.

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