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FOCUS

NEWSLETTER OF THE MICHIGAN HEALTH INFORMATION MANAGEMENT ASSOCIATION

HIM Awareness of Bioterrorism Surveillance Efforts

Claire Dixon-Lee, PhD, RHIA
President, MC Strategies, Inc.

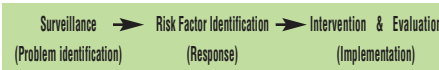
In the weeks following the events of September 11, 2002, public health programs around the nation quickly and painfully realized that the information they routinely receive, and the communication links to healthcare providers and the laboratory networks, are inadequate to meet the needs of true public health surveillance. For those of us who work in healthcare facilities processing health information on a daily basis, we realize that most public health reporting is based on standard criteria, confirmed diagnoses, and the informed, alert healthcare provider's attention to follow through on routine public health reporting. Some public health agencies at the local level may have as few as one or two staff to process information generated from numerous sources and for varied purposes. The majority of information is retrospectively collected, often in paper form requiring data entry which runs the risk of error-prone surveillance data and results so old their beneficial shelf life can only provide analytical perspectives for trending in the past tense.

Public health disease surveillance information is time-sensitive and requires a direct link in real time to its source, to be viewed, trended and analyzed in order to detect the presence of an unusual health event or bioterrorist threat as evidenced by one or more individuals in a population. Too often, epidemiologists must rely on subsets of data, piecemeal reports, phone calls and faxes. The bulk of their work today is based on "passive reporting", after the fact, once a condition is officially confirmed. Unfortunately, by

the time you are symptomatic, results and treatment options may be poor.

For decades the U.S. public health system has relied upon weekly reporting of morbidity and mortality statistics, but various sources indicate that public health agencies don't know what percent of infections actually go unreported. To effectively conduct concurrent surveillance for infections, bio-incident reporting and even realistic chronic disease trending, a new approach or paradigm shift is necessary for the public health network. The pressure is on public health to develop an early-warning, early-response tracking system for bio-incident reporting, as well as a user-friendly, efficient, cost-effective means for routine provider submission of chief complaints, diagnostic and laboratory information. Whether for purposes of identifying single cases (covert), large populations (overt), or emergency department cases in the context of major events (syndromic), the current system offers little more than disconnected, multi-data sources (clinical, pharmacies, laboratories, 911 calls, suspicious absenteeism reports, etc.).

The Centers for Disease Control and Prevention (CDC) have several programs focused on the following model:



The CDC with cooperation from the public health sector including local and state public health departments and the National Association of County and City Health Officials (NACCHO) has created the Health Alert Network (HAN) which is designed to provide resources for building information technology capacity

within our local public health system.

To begin this process, the National Electronic Disease Surveillance System (NEDSS) was created. NEDSS began in 1999 with its first release of an automated technology application in summer 2002. NEDSS represents an attempt at standardized data elements fundamental to support public health database development and epidemiological population and person analysis. The system of data elements is HL7 compliant and would

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MICHIGAN'S HEALTH INFORMATION LEADERS

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TO STRENGTHEN THE ACCURACY, USE AND AVAILABILITY OF HEALTHCARE INFORMATION FOR HEALTHCARE PROFESSIONALS, CONSUMERS, AND PROVIDERS SO THAT THE QUALITY OF HEALTHCARE DELIVERED IN MICHIGAN WILL BE IMPROVED.



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HIM Awareness

(Continued from page 1)

populate the public health conceptual data model. The long range goals are to (1) automatically gather health data from various sources on a real-time basis, (2) assist in the on-going analysis of trends and detection of emerging public health problems, (3) facilitate the monitoring of the health of communities, and (4) provide information for setting public health policy. The core of the dataset relies on person identification (legal under HHS/HIPAA Privacy Regulations), chief complaints, physician orders and microbiology results. The state of Nebraska is currently testing the feasibility of a NEDSS-based system, but already emphasize a breakdown in routine communications between public health labs and public health authorities within the state. They have realized that laboratory information systems do not lend themselves to data mining functionality, only to basic functional summary reports consisting of proprietary, proscriptive data sets.

The shortcomings of the NEDSS first release include (1) reliance on manual copies of lab reports, emergency room information, physician reporting, etc. with manual data entry and no obvious means to expedite communication of this information in any systematic manner; (2) there has existed for decades the accepted minimum uniform hospital discharge data set (UHDDS) and various data sets for other healthcare levels, which do not match element for element the contents of NEDSS; (3) a need to examine the HIPAA electronic data transaction standards against the NEDSS dataset; and (4) without a wide variety of commercial interface capabilities, connection to the many existing proprietary healthcare databases will postpone the wide acceptance of NEDSS for practical use. Of even greater concern is the development of this system outside the context of the provider sector of healthcare delivery. There is no doubt that an agreed upon public health data model for electronic transmission across local, state and national public health networks is imperative, and would greatly improve the analytical power of public health services and the CDC to measure and project disease and wellness among US populations. But, unless federal legislation requires universal

compliance to the NEDSS dataset, the usefulness of this system for routine bio-incident surveillance remains in question and the US is still greatly at risk.

The eHealth Initiative and the Foundation for eHealth has launched a collaborative effort with the CDC, state and local health departments, NACCHO, NAHDO, Rand Corp., CMS and many others to address the issues of data transmission standards and strategies. AHIMA is a member of the eHealth Initiative, as are many corporations, several healthcare organizations, other federal agencies and professional associations. The Foundation seeks funding and issues grants to bolster the public health infrastructure and connectivity between multiple health care organizations. Goals of the eHealth Initiative include:

- Message standards and implementation guides for lab results, diagnostic information and pharmacy data;
- Architectural models for the integration of data from sources with various coding and transaction formats;
- Vocabulary management strategies to translate variable text content into standard content or codes;
- Security techniques that can be applied to protect data in transit and authenticate senders and receivers;
- Applications of currently available data repositories to monitor trends in key indicators that may signal a potential disease outbreak;
- Practical approaches for encouraging and maximizing the participation and flow of data required by laboratories, vendors, hospitals, and other healthcare providers;
- Identification of research areas that should be explored in the demonstration projects to determine the cost and value of alternative approaches.

The goals of the eHealth Initiative are vast and complex, although necessary; yet the plan for a demonstrable, uniform, inexpensive process for bio-incident surveillance today remains speculative. As a nation, there is no lack for experimental projects and varied initiatives. What is lacking is overall coordination, active cooperation and financial resources to support connectivity at the local hospital level. Sporadic funding has attempted to strengthen the effectiveness of local, community health

departments, but many of these have inadequate staffing, lack Internet access, computers or in some cases even fax machines. There are variations among states in what is considered "conditions under surveillance", multiple, disparate sources of data and inefficient communications from local to state public health levels.

Tracking diseases is becoming a surveillance activity rather than a reporting activity, and requires the shift to concurrent methods of information transfer. Will all of these new systems communicate with each other? Should we have a universal patient identifier to effectively recognize and link incidents? How can local health departments access and conduct the surveillance processes that bio-incident reporting requires?

As health information professionals, awareness is the first step in recognition of the data needs external to our healthcare organizations, critical to the health and welfare of our nation. The threat of bioterrorism remains real and potential. We are all required by JCAHO to plan and rehearse for medical emergencies. In addition to this fundamental and accepted responsibility of healthcare organizations, the notion of information resources and development of a routine, real time process of data element submission within the course of normal, clinical work performance is necessary to provide our public health system with vital surveillance information to prevent an act of bioterrorism and save lives.

As a nation, we were tested last year, and as health information professionals we have a real responsibility to demon-

strate and share our knowledge and expertise in building an improved US public health system.

"The difference between the people who died and the people who lived was 24 hours. Late response is like no response."

- Dr. Mohammed Akhter, Executive Director of the American Public Health Association discussing the Anthrax terrorist event.

Reference Websites

- www.cdc.gov
- <http://frwebgate.access.gov>
- www.apha.org
- www.ehealthinitiative.org
- www.webinservice.com



About The Author

Claire Dixon-Lee, PhD, RHIA is President of MC Strategies, Inc., a national health care consulting and training services company. Dr. Dixon-Lee has served as Chair of the Board of Directors of the Joint Healthcare Information Technology Alliance (JHITA) and is a past president of the American Health Information Management Association (AHIMA). She currently chairs AHIMA's Workforce Study Project Advisory Committee (2002-2004), charged with taking Vision 2006 to the next dimension.

Dr. Dixon-Lee has over 30 years of HIM experience and has worked for some of the industry's significant technology companies in product design, coding, grouping, data abstracting, modeling and dictionary development. She has had an academic career as an assistant professor and department head of the Health Information Management undergraduate and graduate programs at the University of Illinois at Chicago. Dr. Dixon-Lee has been employed by AHIMA as director of the HIM academic programs, continuing education and research. In 1993, she was

awarded the first Alexander M. Schmidt Fellowship at the University Healthsystems Consortium in Chicago. She has authored numerous articles, book chapters, served as a research journal editor, and presented seminars nationally and internationally on clinical data quality, documentation, work-process improvement, medical vocabularies and computer-based patient records.

Dr. Dixon-Lee holds a master's degree in Medical Epidemiology and a doctoral degree in Public Health Policy and Administration from the University of Illinois at Chicago - School of Public Health.

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TREASURER'S REPORT

MAY 31, 2002

Total MHIMA Assets

05/31/02

\$119,329.32

MHIMA MEMBERSHIP - APRIL 2002

MICHIGAN HEALTH INFORMATION MANAGEMENT ASSOCIATION

CODE	CLASSIFICATION	MEMBERSHIP 3-31-02	MEMBERSHIP 5-31-02	CHANGE
10	Active RHIT & RHIA	1446	1501	+55
11	Active Senior	27	28	-
20	Associate	58	67	+1
21	Student	135	156	+9
50	Corporate	10	10	+21
	Honorary	1	1	-
	TOTAL	1678	1764	+86
	Maint. of Cert.	556	5551	-5

PLEASE NOTE: When choosing your category of membership, be aware your choice of selecting a student classification may prevent you from voting in National and State Association elections.

*Inactive category deleted via AHIMA House of Delegates, 1996

President's Message



Amy Savage, RHIA

As I began writing my first President's message for the 2002-2003 year and prepare to sail on my voyage of leading our forward-thinking association, I found myself reflecting about the adventures that happened in my life that ultimately lead me down a path to a career in health information management. I thought I would share a bit of my personal journey with the hope that you might get to know me just a little bit better.

When I was a little girl and would play with friends, we pretended many times to play "school". I played the part of the teacher on many occasions, using chalk and a blackboard in the basement of our home. Writing sentences and spelling words on the board were favorite activities. As I matured, I continued to strengthen some of those fine art skills. In addition, being a musician also played a large role in my life. Knowing that my strengths were reflected in these areas, I embarked on a quest to focus on my areas of potential growth, which were math and science. I even chose a science-based field of study in college (Pharmacy), determined to prove to myself that I could indeed overcome those weaknesses! Well, to make a long story short, I was not as successful as I had hoped.

Subsequently, I began to revisit my strengths, and chose a career that would enable me to nurture the teacher hidden within, that so long ago was ignored. I acquired a bachelor degree in Medical

Record Administration, from Ferris State College (I'm dating myself!), which is now Ferris State University. I began my career in a hospital setting, moved to a consulting group, then back into the hospital arena once again. As I was making these changes in my life and building my knowledge and skill level, I continued to look towards my long-term career goal of being employed in education. Each employment opportunity afforded me the chance to "teach" others with whom I interacted. The Health Information Management profession has, as one of its professional tenets, a goal of lifelong learning for every member. When the opportunity was presented, I applied for and was selected for my current position as Associate Dean of the Health Information Technology program at Baker College. This was the start of fulfilling a lifelong goal to be in education.

In the five years that I have been at the college, I have made many changes in the way I prepare and present material to my students. It is a continual learning experience that is unparalleled by any of my previous professional opportunities, and I view myself as a facilitator of learning in the classroom. Perhaps in some way you, the membership, are my classroom as well, and as President of MHIMA I can facilitate learning by continuing to support changes that were instituted this past year and move forward with new challenges.

In reminiscing from those college years to the 21st century, I am amazed at some of the challenges that we have faced in our profession. Back then, ICD-9-CM was just a few years old and provided me with much frustration when trying to figure out how my coding instructor, Mrs. Sicklesteel, came up with 6 codes when I only had 3 (that "double coding" demon). I remember saying that I would never take a job in which I would code all day! (isn't there an old adage that says something about "eating your words"?) We learned to manually abstract chart

information onto PAS forms - encoders and DRGs, what were those? Spending what seemed like hours learning medical transcription by listening to and watching belts go around on spindles (being careful not to get dizzy while mesmerized with watching) that contained the dictated information, was not the best confidence builder if you had weak typing skills, not to mention the amount of "white out" that was used! Thank goodness for the emerging technology of housing dictation on cassette tapes! I'm sure many of you can relate.

Now many of you may be wondering how we ever coded and abstracted without the encoder, let alone figure out the DRG! There is no argument that improved technology has made our lives easier, and we continue to develop new ways to communicate in a timely manner with members, both at the state level and from AHIMA. A prime example is that of Association business (primarily AHIMA at this point) now beginning to be conducted electronically, which certainly provides convenience and is cost effective.

In the coming months MHIMA will be migrating to a web-based platform for the FOCUS by posting it on our newly enhanced website, while continuing to print a hard copy per individual member request. If you haven't yet paid a visit to the website, I encourage you to do so. I would also like to extend an invitation to all of you to come join us at a board meeting. The schedule can be found in our Calendar of Events section of FOCUS. Please don't hesitate to contact me by phone or email to share any comments or concerns. I look forward to this new adventure of serving as your President.

– Amy Savage, RHIA



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Patricia A. Rubio, MSA, RHIA

Program Coordinator, Health Information Technology Program Coding Program/Medical Transcription/Medical Assisting - Schoolcraft College
Member Nominating Committee- National Network of Health Career Programs in Two-Year Colleges 2002- Representative of Native American Women Educators and Healthcare Workers at the White House unveiling of the US Mint's Sacajawea Gold dollar

Currently Treasurer of the MI Association of Allied Health Professionals
Past Chair and Member Mental Health Committee, MHIMA 1986-99; Past President of MHIMA, 1995-96; President, MHIMA, 1994-95 President Elect, MHIMA, 1993-94; Co Chair and Member CDIP 1985-94; Delegate, Speaker, Education Com. Member, MHIMA 1984-89; President, SEMHIMA, 1994-95; Past- President, President Elect, Co-chair and member Education, Member Consultants, SEMHIMA, 1984-95. Outstanding professional contributions at the regional, state, and national level

MHIMA Convention 2002

The 2002 MHIMA Convention was held at the Holiday Inn Fairlane, Dearborn Michigan from May 14-17, 2002. From all accounts and observations this convention was wildly successful with great presentations and large attendance with lots of networking going on!!

Karen Cole, SEMHIMA President welcomed the attendees on Wednesday May 15, 2002. Brian Peters from MHA then gave the keynote address on "The Future of Michigan Healthcare - The Legislative Arena." Brian provided excellent information to our group on the upcoming legislation which will affect all of us personally and professionally. He encouraged us to stay abreast of all the changes and proposals and to get more involved. Our state and national organizations provide a useful tool in this matter. Next Jill Callahan-Dennis updated us on "AHIMA Initiatives and Member Services." AHIMA is but a keystroke away from us and provides us with necessary and helpful information - and boy, are those Communities of Practice a big success. The afternoon of the first day was packed with useful information. Veronica Marsich, JD, gave a 2.5 hour presentation on the timely topic of HIPAA - "HIPAA privacy compliance - The Self-Evaluation Process." Need we say more - Veronica gave an excellent presentation on very complex issues which are at the forefront of our profession. At the same time, Virginia Pitts and AnneMarie Gerard conducted a JCAHO session with presentations on 3 hospitals having recent surveys and discussed with the group the various "hot buttons" and JCAHO preparation techniques. This

was much appreciated by those in the audience with upcoming surveys. Immediately after that, Midge McCaustlan from Consumer and Industry Services discussed the process of "CMS Validation Surveys" These are becoming much more prevalent - in addition, Virginia Pitts was able to discuss this experience personally since her facility had been on the receiving end of a CMS validation survey in January 2002. Day one down and two exciting more days to go. We also thanked Peggy Chapo that evening for a job well done as our President.

Day two: May 16, 2002 required a little "juggling" from the program committee. Our motivational speaker, Joanne Sujansky was supposed to present on "Motivating Generation X and Y" but Joanne was forced to cancel due to an illness. Jan Crocker, Virginia Pitts, and AnneMarie Gerard "pinch hit" for this unexpected turn of events. Jan presented a very dynamic and useful presentation on "Dealing with Difficult People.." - anybody know anyone like that?? At the same time, Virginia and AnneMarie presented the "JCAHO and CMS Update" which allowed for those who were unable to attend the previous session. This was a day full of technology and clinical data with Scott Robinson presenting "Document Imaging for Health Information Management", Cory Fleek presenting on "E web coding" and Jon Mabry presenting on "Technology Trends." All presented excellent information on how we can become more technologically advanced and gave us a look in to our future. In addition, Evie Bishop showed us the ins and outs of "Physician Office Coding" along with

Sue Chamberlain presenting on "Physician Office Compliance". Following that Ann Gresowiak from MPRO gave an informative update on "PEPP and Corporate Compliance." All provided excellent information and valuable handouts for us to take back to our facilities. Another great day!!

Day three: May 17, 2002 started with Mark Davidson, and FBI Agent discussing "The World We Live In - Weapons and Mass Destruction. "He gave a very useful presentation which will help us personally and professionally. In the aftermath of September 11 this was most appropriate. The rest of the day was focused on coding, coding, coding,.. Lois Yoder gave her usual brilliant and helpful presentation on "APC's the Hot Spots" and "ICD-10 Update." The general session had Mary Schafianski discussing "High Risk Coding - Guidelines and Documentation." The convention ended with a general session on "CCS -CCS-P preparation" presented by a panel of recent test takers.

The 2002 convention had something for everyone. We also had lots of networking time and some fun things such as free "massages" (who needs them more than we do?) and a Casino Trip for those brave souls who ventured out.

The 2002 convention "BET ON TECHNOLOGY - INVENT THE FUTURE" more than met the needs of the several hundred professionals who attended. Thanks to all who made this convention a huge success!!

- Summarized by Ginny Pitts, RHIA

THE MICHIGAN HEALTH INFORMATION MANAGEMENT ASSOCIATION



Vendor area 2002



President's Reception 2002 – President Peggy Chapo with Leslie Mack.



Congratulations to the 2002 Yvonne Harbert Award Winner – April Martin, Marsha Steele, Pat McLane, Peggy Chapo 2002.



2002 Distinguished Member – Pat Rubio.

2002 Convention Highlights



General Session 2002



BIS Seance 2002



BIS Reception

Future Practice is Now!

As the current “coding shortage” continues to be an area of discussion, many medical record professionals are looking forward to the opportunity to code from home (“remote Coding.”) In order to learn more about this process, we contacted Colleen Morgan, RHIA, who works for United Audit Systems, Inc. (UASI.) Colleen’s job involves directly dialing into the VA Hospital system in Lexington, KY and coding real-time on their EMR (Electronic Medical Record.)

Q. How did you learn about this remote coding opportunity?

A. I chose to advertise myself on AHIMA’s website looking for a remote coding position. I also had sent out applications to many companies wanting to start a remote business. A Headhunter working for UASI contacted me and the rest was history.

Q. How are you paid (hourly, by chart, etc) and is there a certain quota that you must maintain?

A. I am paid on an hourly basis with incentive bonuses every quarter. We must maintain 95% accuracy along with a productive level to qualify for the incentive.

Q. Regarding confidentiality, did anyone inspect your home for appropriate workspace, special firewalls, and computer programs to keep hackers out?

A. We were asked to maintain our equipment in an area where there is no high traffic and to have a door that would facilitate privacy, if possible. Our systems do have firewall and virus software incorporated into them.

Q. Who pays for and upgrades your equipment? Who set up and paid for your workspace?



A. UASI furnished and owns all equipment; computer’s, printers etc. I created an office in my basement for this and paid for it myself. The employee furnishes any desk equipment. We are reimbursed for any supplies utilized, for example paper, pencil/pens, phone-lines, etc. Our IT department supports any upgrades. We also have a software program that enables our IT department to dial into our systems and see what is going on or make any necessary changes.

Q. Does UASI pay for any reference materials you may need i.e., Coding Books, Medical Dictionary, etc., or do you provide those at your own cost?

A. The company purchases a CPT coding manual for their employees. We must purchase any ICD-9 or reference manuals. I have purchased an ICD-9 manual, abbreviation book, drug book and some OPT reference material. We have resources available to us from the office, whether it is other consultants or material that we can have provided to us. I recently received a Coder’s Desk Reference manual from the office to utilize for my own needs. The company is very helpful in getting us any necessary material we need or answering any questions we may have.

Q. Do you use an encoder?

A. We currently are using the HSS encoder and also have CPT Assistant and Coding Clinic available to us on-line.

Q. Is the entire medical record already online, or does someone have to physically scan the record, or parts of it? If it has to be scanned, have you experienced delays in getting records, i.e. waiting for a clerical person to get records scanned?

A. This will depend on the client you are working on. I am currently working on a client where I dial directly into their live system. We also have clients that scan their medical records, which are sent to the server at our Ohio office and then formatted by our employees so we are able to see the records in a clean and orderly fashion. In this case there can be a delay with our employees getting the work to us and also the sites’ employees scanning the records. If we ever experienced a considerably long

delay we were asked to try to get our work completed for the client on over-time.

Q. What if reports are missing?

A. The software we utilize when reading and abstracting the medical records allows us to identify records that may have missing documentation. We can also flag accounts with a diagnosis or procedural question. These records are batched and sent back to our supervisor in Ohio where she can communicate with the client or review our records and answer any questions we have. When the client scans the missing report it is sent back to the appropriate coder and marked as priority within that coder’s queue. We are also able to abstract within the fields to alert the client of any potential issue we may have on the record.

Q. Do you think it would be feasible to code Inpatient medical records from home in the future, or do you think that the size of those records would limit home-based coding to ERs, Observation and Ambulatory Surgery records?

A. I was working for a client who did scan Inpatient records for us to code. These records were limited in size and the largest one I did for them was about a five-week stay. It can be a challenge coding records with long stays because of only having the ability to see one page at a time. You may have to flip from one progress note and back to another to keep your thinking straight. I also believe it could be timely and costly on the sites to have to scan these records. I believe you may be limited in the amount of pages put into the scanner and this may take some time. As far as the coder’s ability in doing these types of records, I see no real difference in working the cases.

Q. Do you ever have to travel to the actual site?

A. Yes, I have been sent to Ohio a few times—whether it is for training or inservices, and the company pays for all my expenses and flights.

Q. How do you get feedback from/communicate with your supervisor?

A. We communicate through E-mail, voice-mail, telephone and even postal mail. I never have a problem getting ahold of the necessary people. With technology these days, I am always able

to get in contact with someone somehow.

Q. Are there any unique challenges of working at home?

A. For me, the challenges of working at home are limited. I have established a work schedule around my children and find it much more relaxing in the mornings. The biggest challenge would be interruptions during the day—whether it is the phone solicitors, personal calls or the doorbell ringing.

Q. Have you experienced any expected or unexpected benefits of working at home?

A. For me, the benefits of working at home outweigh the experience of working away from the home. I have been working for UASI for about 1-1/2 years now and have never called in sick. I find myself able to work still even if it's in my PJ's with a cup of tea by my side for a bad cold. You just don't have to put on that smiling face at the office. I also have met some really nice remote coders that work with me, and I am able to brainstorm with them at any time. The biggest benefits are being able to spend more time with my family. I am not spending 2 1/2 hours on the road in drive time alone

to get to a place of work. I have so much job satisfaction just from that alone.

Q. As many mothers of small children are searching for home-based employment, do you think that they could realistically expect to be able to code while taking care of babies and small children?

A. That may be real tough. I suppose the age of the child would really influence your decision. I currently have 3 children, two in school full-time and a 3-1/2 year old. I still chose to put her in daycare because I felt I would not be able to devote myself 100% to the job. Recently, I had some problems with daycare and pulled her out. She is now home with me and it can be tough at times. I am fortunate that she is able to entertain herself, but I do find myself changing my schedule at times to meet her needs.

Q. Do you miss the interaction with other coders, and do you have a way to discuss a coding issue with other coders?

A. Yes and no. The only time I may miss the interaction is if I want someone to physically see what I'm talking about, otherwise I am in contact all the time

with other coders and management.

Q. Do you miss the camaraderie of working in an office with other coders, or do you feel you are more productive working at home?

A. Absolutely not. I do not miss the office politics and cliques. I feel more productive at home without the employee interruptions and issues. The best part of all is that, I am able to work with a radio—in the hospital setting that was a “no-no.” I feel much more relaxed in a laid back atmosphere.

In closing, I must say that I am very satisfied as an employee working for UASI. I have never worked for a company that thinks of their employees as much as they do. Best of all, when your employees are satisfied, your clients will be just as satisfied.

Thank you so much for your time, Colleen. This is certainly an area of interest for many of us, and we do appreciate you taking the time to answer these questions about this up-and-coming opportunity.

*Submitted By: Cheryl Gratton, RHIT
Michele G. Pietron, RHIT*

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Update Your Member Profile!

AHIMA is encouraging all members to update their membership profile on the AHIMA website. They are sponsoring a contest to provide incentive for each state to improve the percentage of members who have done this. The state who has the biggest increase in membership profile updates will win a free night for their delegates at the Winter Team Talks hotel! Updating your profile is easy: just go to www.ahima.org <<http://www.ahima.org>> and click on the "Members Only" section. There you will see a link to "Update Member Profile". It only takes a short time to do this.

As of June 30, 2002, Michigan had 1,780 total members. Of these, 56.5% (1,006) had email addresses listed with AHIMA. Out of these 1,006 members, only 293 (16.5%) had updated their member profiles and only 209 (11.7%) had joined a Community of Practice. Please take a moment to update your profile and join a Community of Practice., it will lead to a wealth of contacts and information from colleagues around the country!

Website Update

The Members Only section of the new website is now accessible only with your AHIMA ID number. We are including in the Member Directory, name, address and work telephone number. It will only be available to AHIMA members. You may wish to opt out of the directory by contacting the Central Office by email at marsha@mhima.org, or calling 231-767-9717. Thank you for your help and patience during the development of this new website.

– Marsha Allen, RHIA
MHIMA Central Office Coordinator.

Mark Your Calendars Now!

The Electronic Medical Record: *Local Success Stories*

FRIDAY, OCTOBER 11, 2002

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MICHIGAN HEALTH INFORMATION
MANAGEMENT ASSOCIATION

Calendar of Events

DATE	LOCATION	SPONSOR	TOPIC	CONTACT	PHONE
9/13/02	MHA, Lansing, Michigan	MHIMA	Board Meeting	Central Office	231-767-9717\
9/21-26/02	San Francisco, California	AHIMA	Annual Meeting and Exhibit	AHIMA	www.ahima.org
10/11/02	Troy, Michigan	HISA/MHIMA	The Electronic Medical Record Local Success Stories	Central Office	231-767-9717
11/15/02	MHA, Lansing, Michigan	MHIMA	Board Meeting	Central Office	231-767-9717
1/17/03	MHA, Lansing, Michigan	MHIMA	Board Meeting	Central Office	231-767-9717
3/14/03	MHA, Lansing, Michigan	MHIMA	Board Meeting	Central Office	231-767-9717
5/14-16/03	Traverse City	MHIMA	Annual Meeting	Central Office	231-767-9717
10/18-23/03	Minneapolis, Minnesota	AHIMA	Annual Meeting and Exhibit	AHIMA	www.ahima.org
10/9-14/04	Washington DC	AHIMA	Annual Meeting and Exhibit/IFHRO Health Rec. Cong.	AHIMA	www.ahima.org

DO WE HAVE YOUR E-MAIL ADDRESS?

If not, please e-mail Marsha Allen in the Central Office at Marsha@MHIMA.org



MHIMA Website!

Check Out the new MHIMA website at MHIMA.org!

There is now a job bank. You can post your resume or any jobs you may have open at no cost if you are a member. We are working on the charges for posting jobs for those who are non-members.

Let us know what you think. You can contact the central office through the website. Be sure to let us know what your email address is if you have not already sent it to us.

Any suggestions for improvements or additions to the site will be considered. We are working out a few bugs, but the new site should be much easier to use and beneficial to all members.

Marsha Allen, RHIA
Central Office Coordinator
marsha@mhima.org

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