Where Health Information Experts Come Together

PLEXUS

MARCH 2012

VOLUME 8, ISSUE 2

WHAT NOT TO DO

Strategies for PowerPoint Makeovers

Is the Harmonious Relationship Between You and Your Physician Clients in *Danger?*

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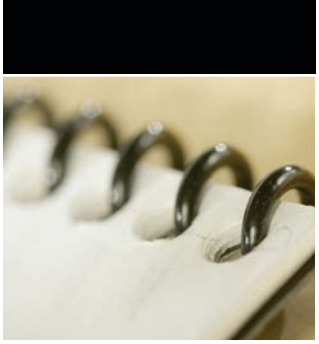

EDITOR'S MESSAGE

Wash, Rinse, Repeat

My husband owns a high-performance auto shop where they do custom builds and installs as well as sophisticated performance tuning using a DynoJet dynamometer on a variety of sports cars and trucks. It is a niche market as there are very few knowledgeable people in the country who are qualified to perform these services well. This weekend I had the pleasure of assisting him as he calibrated a modified Corvette. "Wash, rinse, repeat" was a phrase he uttered often as he explained what he was doing each step of the process.

Anytime you install performance parts on a modern-day electronic fuel-injected stock vehicle you will find yourself in uncharted territory, which requires recalibration of the vehicle's software. The process commences with an educated guess (*wash*), and through extensive performance testing (*rinse*), an evaluation of the results and further testing (*repeat*) leads to changes that achieve the desired result. Continual improvement is the goal.

As technology explodes at an exponential rate, having the patience to stick with the process of the testing-and-evaluation phase is often the greatest challenge. We are seeing many such challenges with the implementation of EHRs, which clearly has affected medical transcription as we've known it. Most people are naturally adverse to change, but if you have passion for what you do, having the courage and perseverance to get through the process is definitely worth the effort put forth for the fruit it ultimately bears. Seeking further education and understanding of these new processes and technologies will help keep our sector viable and relevant. See page 7 to learn more about the resources AHDI offers to help you further your knowledge and skills. If there ever was a time for complacency, this is not it.

In this issue you'll learn some professional and technology-building skills to help you stay relevant in today's world. Our clinical medicine topic covers the ever increasing topic of bullying and how self-esteem and self-confidence are protective factors on both sides of bullying. **P**

As technology explodes at an exponential rate, having the patience to stick with the process of the testing-and-evaluation phase is often the greatest challenge.

Kristin M. Wall, CMT, AHDI-F
Editor-in-Chief, Senior Communications Coordinator, AHDI

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American Healthcare Documentation Professionals Group

Developing the Next Generation
Workforce For Healthcare Documentation

Medical Billing and Coding Jump Start Program

The Medical Billing and Coding Jump Start Program is designed for **practicing medical transcriptionists or other allied health professionals** who are looking to make a career change. The program will pre-qualify your previous experience in medical terminology, anatomy and physiology and pharmacology thereby accelerating your education.

Why Train for a Career in Medical Billing and Coding?

- Medical Billing and Coding Specialists are the backbone of today's complex healthcare delivery system
- According to the U.S. Department of Labor, medical billing and coding is one of the ten fastest growing allied health occupations and employers are actively seeking qualified candidates.
- On October 1st, 2013 our national healthcare system will move to a new coding system, ICD-10.

Why the Jump Start Program?

- The program is designed to save students time and money by pre-qualifying their knowledge of medical terminology, anatomy & physiology and pharmacology.
- Our training programs are led by certified American Academy of Professional Coders (AAPC) instructors and mentors.
- The entirely online training program provides maximum flexibility and interactive feedback.
- A structured, step by step curriculum offers multiple phases of study to meet student needs.
- Comprehensive program includes textbooks, fees and materials.
- Students graduate with a certificate of program completion and are prepared to work in a variety of healthcare settings including hospitals, physician's office, insurance companies, private billing companies and self-employment as a biller or coder.
- Successful completion of the program prepares the student for certification as a Medical Billing and Coding professional.

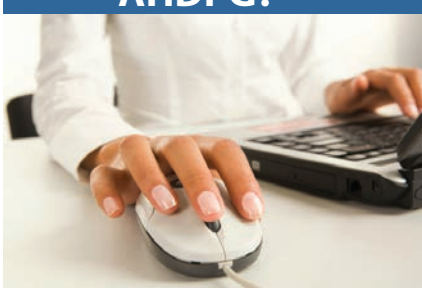
We're here to bring new people into our industry and help existing professionals transition to the future!

Contact us to Learn More About Your Career!
Toll Free: 800-407-1186, ext 0
Online: www.ahdpg.com

AAPC APPROVED ONLINE EDUCATION PROVIDER

Scan for Contact Information

Why Choose AHDPG?



- AAPC approved training programs are led by credentialed experts and industry leaders.
- Online format includes networking on student forums, web classes, and interactive feedback.
- Personal guidance from caring Instructors and Education Assistants.
- A structured, step-by-step curriculum.
- All inclusive program fee include textbooks, materials, and all fees.
- A provider of online training and workforce development services to the healthcare documentation industry since 1992.

THE FINE PRINT

1 CEC

This symbol identifies creditworthy items preapproved by AHDI. To earn CE credit, CMTs should submit a brief (300-word) summary of a preapproved article. Article summaries preapproved by AHDI can be written and submitted at the end of your recertification cycle every 3 years. Do not submit them upon completion. Alternately, AHDI members may log in at *www.ahdionline.org* to see if an online quiz is available. Permission to reproduce copies of articles for educational use may be obtained from the editor at *kwall@ahdionline.org*.

☑ QUIZ

CMTs may opt to take the online quiz in lieu of an article summary for any article where this symbol is also indicated. You can find these CE quizzes at the AHDI website under Member Center > My Benefits > Online CECs. *Members must first log into the AHDI website to access these quizzes.*

TO SUBMIT CONTENT FOR PUBLICATION: AHDI welcomes industry contributions, and all submissions for publication are welcome for review and consideration by the editor. Any individual or group interested in submitting an article or column content should follow the guidelines below for submission:

1. Articles must be submitted in MS Word format and should not exceed 1500 words (some exceptions will be made depending on content).
2. Articles should include full name and contact information for each author/contributor as well as a brief bio (2–3 lines) for each author/contributor.
3. Consider including a 15- to 20-question multiple-choice quiz with your article to facilitate online continuing education (CE) access for credentialed MTs.
4. Articles must be submitted with a signed Author Agreement. An Author Agreement for both *Plexus* and *Matrix* can be requested from the senior communications coordinator at *kwall@ahdionline.org*.
5. Articles should be emailed to *kwall@ahdionline.org*.
6. Author Agreements should be signed and faxed to 209-527-9633 or scanned and emailed to *kwall@ahdionline.org*.

NOTE TO READERS: In keeping with other publications in the industry, *Plexus* has been edited to comply with the style and standards as outlined by the *American Medical Association (AMA) Manual of Style*, 10th ed. In any instance where the application of AMA style conflicts with *The Book of Style for Medical Transcription, 3rd edition*, the AMA standard is used to comply with industry publishing standards, because those outlined in *The Book of Style for Medical Transcription, 3rd edition,* are specific to documentation in a transcription setting and not to formal publication.

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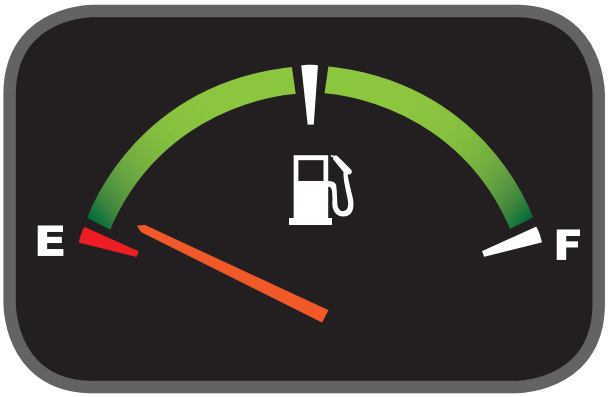

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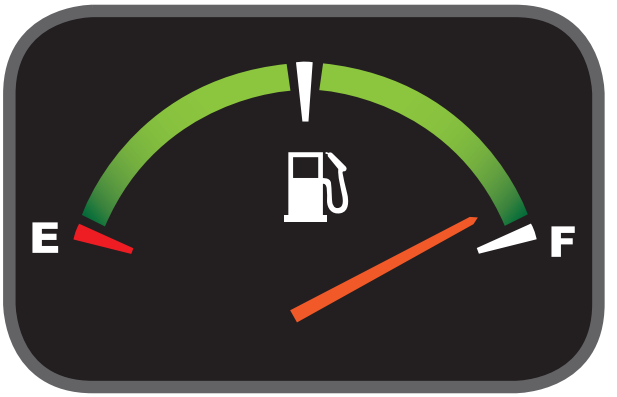

With BenchMark KB™
Patent-pending HIM Knowledge Base

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"As a transcriptionist, having a reliable source to turn to for researching terminology is of the utmost importance. This program gives this to you without your fingers having to leave the keyboard, helping to increase your production."

–Amy Davis, MedQuist

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Go to: **http://www.ahdionline.org/BenchmarkKB** for more information and to order Benchmark KB.

In partnership with InterFix, AHDI has created the first application that sets universal health data quality standards and deploys them to the workstation level, integrating them into the document creation process. That means improved health data quality and improved patient care. BenchMark KB is a patent-pending HIM knowledge base—a comprehensive information portal that brings new data standards to the medical documentation process and incorporates real-time access to best-of-breed tools, databases, and electronic membership to AHDI. Benchmark KB delivers a universal quality standard for health information in a single, trusted source and includes:

- Access to the complete medical reference library from Stedman's in a single user interface
- A continuously updated and searchable national physician database (1 million+)
- Quality alerts library highlighting common transcription style errors, including Joint Commission dangerous abbreviations
- AHDI Book of Style. 3rd edition, in searchable format
- Integration with all popular transcription and EHR platforms
- New terminology updates researched and added by AHDI every week!

PRESIDENT'S MESSAGE

To Be Proactive or Reactive—That is the Question

SHERRY DOGGETT

As the deadline approaches to write the President's Message for *Plexus*, I always jot down the publication theme on a sticky note to place on my work PC. It helps me think about the theme as I prepare for the approaching deadline. Oh, those dreaded deadlines! This time, though, I really didn't ponder too long. Technology is everywhere and no more than in our profession.

Those of us at a certain age (enough said about age!) are amazed at the changes we've seen during our careers, but I personally am amazed at the rapid changes in the last five years. Back-end speech recognition has really taken off, moving us from traditional transcription to editing—and the EHR is an entirely different conversation. So what can we, as MTs, speech editors, quality assurance staff members and managers, do to prepare for the future? For some of us, the future has arrived and for others the future is coming fast and furious.

With the Internet at your fingertips, it is extremely easy to begin your research. There are many articles available about speech technology (good and bad).

RESEARCH AND READ EVERYTHING YOU CAN ABOUT TECHNOLOGY CHANGES TAKING PLACE IN OUR PROFESSION

With the Internet at your fingertips, it is extremely easy to begin your research. There are many articles available about speech technology (good and bad). There are various electronic health record websites. One of the very best is Office of the National Coordinator (HealthIT.HHS.gov), a division of the Health and Human Services branch of government. The website explains the driving forces of our national EHR initiative and provides an overview of "meaningful use" requirements that both hospitals and physician offices must meet over the next few years. Do a search on information technology (IT). There are many free e-newsletter subscriptions available to healthcare workers, and I would encourage you to sign up. A wealth of knowledge will appear in your email without any further effort on your part. From the comfort of your home, you can perform research and educate yourself.

SEEK EDUCATIONAL OPPORTUNITIES

AHDI offers a variety of educational opportunities. Study guides are available for the RMT and CMT credentials. Other programs, such as Benchmark KB, are available for easy referencing while you work. Moving to speech editing? Check out the AHDI SRT online course. There are a variety of skill-building courses available online through Oak Horizons, one of our vendor affiliates. While you are checking that out, take a look at the entire vendor affiliate program tab. If you are short on technology skills, check out classes at your local community college. You may not need another degree, but a few courses can certainly assist you to become more comfortable with technology.

There comes a point when you must decide if you are going to take a proactive stance to plan in advance and initiate action to deal with issues, or if you will be reactive and simply respond to events after they happen.

I am sure by now you are getting the point. We may not exactly know what the future will bring but, by preparing ourselves for whatever the future holds, we can be ready. Knowledge is power to chart your future. I encourage you to utilize your AHDI membership to drive your future. I am excited—come join me. **P**

Sherry Doggett *is the director of the UC Health Corporate Transcription Department. UC Health is a multi-hospital integrated delivery system located in Cincinnati, Ohio. Sherry currently serves as President of AHDI. Sherry.Doggett@UCHealth.com*

QUICK-LINK RESOURCES TO HELP YOU PREPARE FOR THE FUTURE

AHDI Lounge: www.ahdilounge.blogspot.com/

AHDI Blog: www.ahdionline.blogspot.com/

AHDI Special Interest Alliances: www.ahdionline.org under Get Connected
- Advocacy Alliance
- Educators Alliance
- Managers/Supervisors/QA Alliance
- New Professionals Alliance

Benchmark KB: www.ahdionline.org/BenchmarkKB

CDIA Health e-brief: Sign up for free at www.multibriefs.com/briefs/MTIA/

Office of the National Coordinator: www.HealthIT.HHS.gov

Online Courses: www.ahdionline.org under Continuing Education > Online Education
- Oak Horizons Specialty Modules
- RMT/CMT Exam Prep Assessment and Preparation
- AHIMA (variety offered in areas of medicine, healthcare delivery, medical terminology, and coding
- SRT Training
- Acute Care Module
- Introduction to the EHR

Vision 2012—What is in Your Future?

How many times have we heard the phrase, "the future is now"? For our members and our profession, as cliché as it sounds, we are IN the "new age" of clinical documentation. No longer are we wondering if "something" is going to happen or whether we are going to go by way of the telephone operator or the horse-drawn carriage. The ways in which we perform our craft and apply our skills are being challenged and the electronic health record is here to stay. It is in the backdrop of the new dawn for clinical documentation that we must assess our careers and set goals for the future and AHDI is resource central to get you on that path.

- **Education:** SRT editing, BenckMark KB; ACE in Indianapolis August 9-11, 2012; national webinars, local/state/regional conventions, CEC quizzes in Plexus and as AHDI individual professional member benefit, medical language skill building, exposure to HIPAA rules and enforcement policy, electronic BOS, ACE 2011 DVD with 30+CECs, Compliance and Best Practices: The EBP Manual

- **Credentialing:** Quantify knowledge and skills to include our new RMT, CMT or CQE exams, prep assessment tools and study groups

- **Membership:** Build a sense of community , engage subject-matter experts, invite diverse colleagues, network with others who share similar experiences, join an alliance

- **Advocacy** and alliance outreach: Advocate individual pride – Every member should market the contribution we make to patient care to every audience who will listen

AHDI is made up of a diverse group of healthcare documentation specialists with multiple titles and myriad roles. While we may not have the hands on relationship with patients like doctors and nurses do, what we do have is expertise in documentation supporting the clinical decisions that impact the patient's health experience every single day. We also clearly understand documentation integrity equals data integrity. As you explore your career path, could you see yourself in any of these future roles that expand across the workflow in healthcare? The roles today and in the future could include traditional dictation/transcription, speech editing, quality assurance editing, quality content reconciling, EHR/NLP documentation/data reconciling, EHR content enhancement, ICD-10 coding, documentation/data analysis, EHR template building, EHR implementation, EHR user training, becoming a patient advocate or PHR consultant. Would you consider diversifying your skills?

The Association for Healthcare Documentation Integrity is a member-based, volunteer-directed organization – lead by and for its membership – with fabulous staff and tireless volunteers helping us attain our goals – your goals. This association is about each and every member and what will make each of us a better professional, how to generate experiences we might otherwise never explore, and enhance our sense of community amidst trying times.

With warm regards, I thank you for being a member of this special entity we call AHDI.

-KAREN L. FOX-ACOSTA, CMT, AHDI-F
President-elect 2011-2012

career connection

Find Your Dream Job on the AHDI/CDIA Career Connection!

Get your résumé seen by potential employers

Whether you are looking for a new position now or just planning for the future, adding your professional résumé to the Career Connection database will put you in front of the industry's most sought-out employers.

The best niche market job board

The Career Connection offers:

- Free access for job seekers
- User-friendly navigation
- Access to industry jobs on the Career Connection and the National Healthcare Career Network
- Job seeker resources (including résumé writing tips)
- And more!

Visit ahdionline.org/careers to begin your search now!

EMPLOYERS:

Post a job on the AHDI/CDIA Career Connection Today!

Employers interested in posting a job on the Career Connection have access to the largest base of career-oriented professionals and the best resources our professional association has to offer. Visit **ahdionline.org/careers** to post a job and start viewing résumés for future employees of the month!

Take advantage of these other great benefits:

- Easy résumé viewing
- Discounted job post pricing for AHDI & CDIA members
- Immediate RSS feeds to social networks
- Added market reach to national healthcare networks
- And more!

Is Your Component Connected?

KRISTIN M. WALL, CMT, AHDI-F

In 2011 AHDI's Outreach Workgroup for News & Networking (OWNN) developed a position called Social Media Specialist (SMS) to help components with their outreach and to better connect AHDI to its members, the MT community at-large, public sector, and trade press through social media.

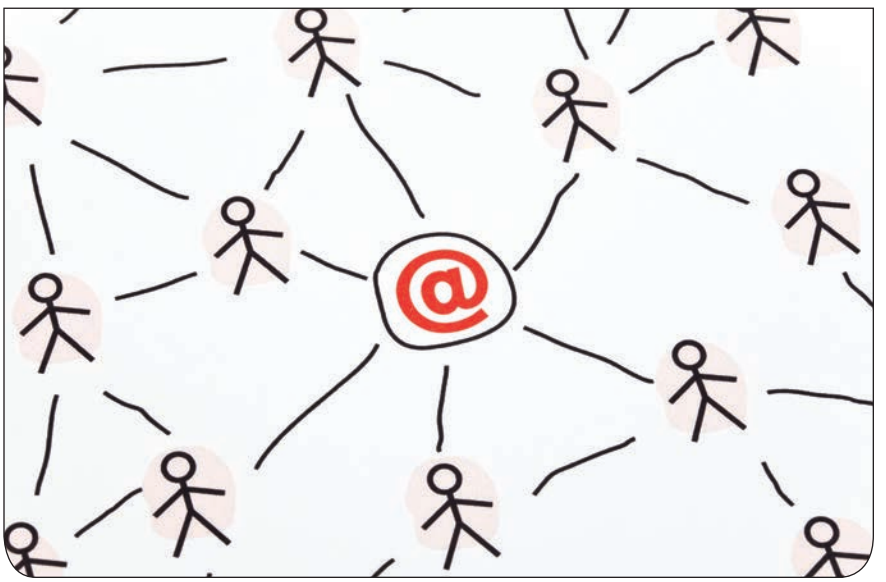
Over the past year OWNN has put out calls for volunteers for the social media specialist position. We are pleased to say that we currently have 26 social media specialists, and this number continues to grow. If you are not familiar with the SMS position, below is a recap of frequently asked questions.

Why are social media specialists needed?

The world of social media has grown tremendously over the past five years and has become a significant tool in which people can share information with mass numbers/groups, connect, learn, and socialize. Social media avenues are continually evolving and new types are popping up. While not every type of social media may be right for you personally, the fact is that there are millions of people using and following social media, making this an efficient and productive way to reach many with little effort.

What does a social media specialist do?

Social media specialists are positioned not only to learn the intricacies of various social media avenues through trainings that OWNN hold, they then take this information back to their components to help train and motivate team leaders and members to engage in online communities. The SMS also helps post items pertinent to the component (events, tips, membership info, reminders, etc.), monitor posts and answer questions, and interact with visitors of their social media outlets to build rapport and connections to ensure they are meeting the component's goals and initiatives.



Social media avenues are continually evolving and new types are popping up.

What does it take to be a social media specialist?

It takes an interest in learning about various social media outlets and the desire to help train and share your knowledge with others. We record all trainings and post the recordings and PowerPoint slides on our Social Media Resource web page so that SMSs can refer back to these and/or use them in their components. Although you may think social media is only for those who are outgoing and talkative, you don't have to be a social butterfly to be an SMS. In combination with trainings

provided, you will work with your component leaders to devise a plan for what tools (Facebook, Twitter, Linked In, etc) your component wishes to utilize, who all will contribute content and posts, and how often.

What support do SMSs have?

Along with the information contained on the Social Media Resource web page, found there is a Facebook group called "AHDI-SMS" set up so that SMSs can communicate with each other and with members of OWNN and AHDI staff. You have our support every step of the way!

The Social Media Resource page can be found at ahdionline.org under Get Connected >> Leadership >> Component Management Center >> Leadership Toolbox >> Social Media Specialist Resources.

How much of a time commitment is involved?

The amount of time you spend in your role as a social media specialist will vary depending on if you have additional support from members of your component, how many events your component has during the year, as well how organized and prepared you are in your approach to using social media. Once you have your social media outlets in place and you have a good understanding of how to use them, it is estimated that SMSs spend one to two hours a month with training and planning, and one hour or less posting items and responding to others' posts.

There are tools to help minimize effort and maximize outcomes. Programs such as TweetDeck and Hootsuite make social media easier by linking together multiple outlets (Facebook, Twitter, RSS feeds, etc.), so you go to one place to post your message, which is then sent to these multiple places—no need to go to each outlet to repost the same information! **P**

Kristin M. Wall, CMT, AHDI-F, *is Editor-in-Chief, Senior Programs Coordinator, AHDI*

BECOME AN AHDI E-MENTOR TODAY!

Are you a CMT looking for continuing education credits (CECs)?
Develop and enhance your leadership, coaching, and communication skills while sharing both life and work lessons with an MT student or postgraduate. You will also earn one CEC toward recredentialing. Don't miss out on this opportunity to help future MTs succeed by guiding, encouraging, and inspiring them to achieve their goals. For more information on this valuable program, visit www.ahdionline.org under Get Connected > Volunteer Central or email dshelton@ahdionline.org to volunteer.

1 CEC
QUIZ
PROFESSIONAL DEVELOPMENT

Strategies for PowerPoint Makeovers

It's a familiar picture. A session speaker is standing at a podium delivering a presentation on a topic with which you are unfamiliar or about which you have little vested interest. The speaker is walking you through a technical pile of PowerPoint slides with bullets, graphs, and research data. On slide 33, your mind begins to wander, and by slide 45, the stage and speaker are a blur, you begin looking at your watch, and you surreptitiously reach for your phone to catch up on a few emails. The speaker has lost your attention, your interest, and your potential buy-in.

We have all been there, and sadly, a few of us have been that speaker, committing at least a half a dozen of the deadly sins of dynamic presentations, often without even realizing it. It can be a challenge to figure out how to present a topic in a compelling and engaging manner, but there are some strategies you can deploy to capture and retain the full interest and attention of your audience.

I am a big fan of makeover shows, none more so than the TLC series *What Not to Wear*. I am always amazed at the extremes of "fashion" represented by the show's makeover candidates, who usually are completely unaware of their fashion faux pas and often quite ready to defend their approach to dressing themselves. One of the first things that Stacey London and Clinton Kelly do when preparing their candidate for a makeover is to assess their current behaviors and choices. In other words, they start by looking at the fashion choices and decisions their candidate has been making in order to identify underlying patterns and prevailing attitudes that need to be addressed and eliminated. So let's take a look at the most common presentation faux pas that you might be making.

WHAT NOT TO DO

If your presentations lack dynamics and tend to fall flat on your audience, you may be guilty of:

1. Using too many slides. The core message of your presentation will likely be lost if it's buried in an unending march of slides that take your audience on a dizzying ride of information. Typical sessions run for an hour, and given the fact that you'll want to leave time for questions and feedback, your presentation time should run no longer than 45-50 minutes.

2. Including too much information. This may seem like the same thing as having too many slides, but even with the right number of slides, you can still load them down with too much text, too many graphs and graphics, and an excess of confusing information. The audience spends more time squinting at the screen trying to interpret the maze of graphs and arrows than they do listening to *you*. More on that important point later.

3. Lacking organization. Nothing is worse than sitting through a presentation where it's glaringly apparent that the speaker had little sense of where he/she wanted to take the audience in terms of storytelling, case-building, and momentum. Slide decks that resemble a set of rapidly scribbled notes on a napkin do very little to build speaker credibility or make your case. If you don't start with an outlining process or some kind of roadmap, you are likely to end up with a disorganized, lackluster brain dump of slides that may make sense to you but result in a huge disconnect with your audience.

4. Letting your deck take the lead. This may be the biggest mistake rookie presenters make. How many times have you witnessed a presentation where the speaker relied so heavily on the content of their slides that something close to a verbatim reading of the slides took place? The speaker added no value to the experience.

5. Forgetting to edit or proofread. I've been in more than my fair share of presentations where the speaker had taken no time to proofread, and I've been guilty of this myself as a speaker. Most of the time, this is due to haste and oversight, but there is really no excuse for a presentation riddled with grammatical errors and typos. But even if your deck is technically free from those kinds of mistakes, it may still lack the right eye on word choice, grammar, and parallel structure. Sometimes what's lacking in a presentation is the impact that results from well-executed mechanics.

6. Using meaningless animations. The amateur will attempt to "jazz" up a presentation by adding random slide transitions and fancy text animations. The last thing an audience wants to be subjected to is a distracting array of pixilated dissolutions and flying objects or a parade of flashing, swirling, spinning, checker-boarding, and/or vanishing information.

7. Ignoring the need for diversity. Let's face it. Nothing is going to put your audience in a late afternoon coma like a boring slide deck. This could mean anything from a presentation that contains slide after slide of text (no graphics) to the monotonous use of font sizes and colors, or it could mean the information itself is expressed in such a mechanical or sterile fashion that it elicits (at best) a smothered yawn from the audience. ■

TOO many people make the mistake of assuming the PowerPoint is the presentation.

At this point, Stacey London is furiously tapping one of her exquisite Jimmy Choo's and with hands on her hips declares your slide deck an abysmal creative failure. *"Where is your sense of style?"* she asks indignantly. *"What were you thinking?"* Clinton echoes with a disapproving nod. *How can you be such a smashing professional success and turn yourself out in such an uninspiring, diluted fashion?* How, indeed.

Aha! Let the makeover begin! This is where the fun usually begins, and Clinton and Stacey commit themselves to the task of transformation—taking that which lacks luster and turning it into a diamond. They help our candidate define a personal style, recognize the right creative elements that suit them best, and help them build a new wardrobe.

WHAT TO DO

Obviously the most critical first step in creating a high-impact presentation is to have something important to say. No PowerPoint presentation can pretty up a weak message. But if you have confidence in the depth, scope, and potential impact of your message, here are some things to make your presentation one your audience will remember long after it's over:

1. Draft your story first. Presentations are no different than writing assignments. You have a story to tell, and it has a beginning, middle, and end. You want to take your audience on a journey, so start with map-questing your journey—ie, make a roadmap of how you are going to get there. Start with an outline of your presentation by drafting learning objectives for your audience and fleshing out the topics and information you'll provide under each objective. Then create a series of place-holder slides in PowerPoint that follow your outline. Put a note on each slide that indicates what the future content of that slide will be. This will be your working deck.

2. Have the end in mind. For every presentation, with or without PowerPoint support, you should have a landing point. It's the take-away concept or idea you want your audience to consider and remember. Traditionally, this landing point comes toward the end of your deck, and all slides that precede it should carefully and powerfully build a case toward that point. It has also become somewhat trendy to hit your audience with the big idea up front, and then build the back-story and supporting arguments to that point over the course of your presentation. Either way, *be intentional* and build momentum toward or in support of your big idea.

3. Create natural transitions. If you've created a strong outline or roadmap, this part should happen easily, but be mindful of how your slides and concepts transition from one to the next. Those transitions should make sense. They shouldn't jump around from financial data to market research to development concepts and back again. Again, this is a journey and you're building a case for your audience.

4. Create your deck to support your narrative, not the other way around. Too many people make the mistake of assuming the PowerPoint is the presentation. But *you are the presenter*. The content and narrative need to come from you. The PowerPoint deck should support the delivery of your narrative, not vice versa. Don't create the slides first and assume you're just supposed to talk about the slides. The slides present you! You don't present the slides!

5. Create a concise, high-impact deck. When it comes to slides, *think quality over quantity.* For a 45- to 50-minute presentation, stick to 20 to 25 hard-hitting slides (2 to 3 minutes per slide). Of all the things you want to *say* to your audience, create slides only for those ideas and concepts you want to visually support in some way. There is no rule that says all of your ideas and explanations must have an accompanying slide. The more strategic you are with your slide selection, the more impactful the use of them will be. Ideally, the slides you create should give your audience something extra or data-driven to chew on while you continue your powerful narrative around that information.

6. Limit your elements. An excess of text, long sentences, lengthy bullets, small graphs with illegible content—all of these can lend to a burdensome experience for your audience. Text slides should lead with a simple statement followed by quick, concise bullets of no greater than two lines each. Avoid long sentences. Let your narrative provide the detail and your deck provide the punch. Use clean, legible graphs and charts. Again, it is the strength or weakness of your narrative that will make you or break you.

7. Use meaningful animations. Dynamic animations and slide transitions do have their place in a well-executed presentation. Use them with purpose and intent. Animated bullet points can pace the release of information and ensure the audience doesn't get ahead of your narrative, but charts and graphs that fly in from left field with no real purpose in the delivery scheme can just be distracting. The best animations are those that demonstrate a process or concept (moving arrows in a work cycle diagram, for example), but keep in mind that timed animations can be a nightmare for a presenter and/or an assistant, and they can be more distracting than useful during live presentations.

8. Proofread. Proofread. Proofread. Do it yourself and enlist a few other eyes to assist you. If nothing else, your deck should be squeaky clean of typos and errors in grammar, spelling, and capitalization. Make sure your bullet points are drafted in parallel structure—you wouldn't believe how distracting faulty parallelisms are for an audience even when they don't always know exactly why the slide doesn't "read well."

Just like the candidates on *What Not to Wear,* your presentation "style" tends to be a reflection of *you.* The more organized and creative you are, the more likely you'll find those attributes reflected in your presentations. Some of the work to create more dynamic presentations has to start with your own dynamics. Training and practice in the art of speech-giving will go a long way in building confidence and power around what you have to say, but a well-executed PowerPoint or multi-media presentation can give you that "pop of color" needed to transform your presentation into an *experience.* **P**

Lea M. Sims, CMT, AHDI–F, *senior consultant for healthcare product marketing for Verizon's Innovations Incubator Group; formerly director of professional programs for AHDI/CDIA (2004-2011).*

MEANINGFUL USE

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PROFESSIONAL DEVELOPMENT or MEDICOLEGAL

Rebecca McSwain, PhD, CMT

Since President George W. Bush inaugurated the Office of National Coordinator for Health Information Technology (ONC) in 2004, medical transcriptionists (MTs), along with everyone else in healthcare and the healthcare documentation sector, have been swept up in the sometimes raging tide of the electronic health record initiative. At the heart of this initiative is the concept of meaningful use of EHR systems. All healthcare providers who wish to benefit from the various governmental financial rewards and benefits for EHR adoption must set up their systems and practices to meet the requirements of meaningful use as defined by the ONC. This article will provide a detailed introduction to meaningful use, including an exploration of the requirements, where to find more information and what to look for, some guidance about possible impacts on MT practice, and some suggestions about ways to use this information.

Meaningful use requirements for hospitals are somewhat different from those for physician offices and clinics. Additionally, Medicare (federal) incentive program parameters are different from Medicaid (state) incentive programs. In this article, I will focus on the requirements around Medicare participation that apply to physicians

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EHR INITIATIVE

Why Should MTs Care?

and a few other categories of clinicians, known in ONC parlance as "eligible professionals" (EPs).

It's not too late to get involved. A study done in 2011 suggested that some 20% of physician offices had never heard of the government EHR incentive program.[1] Given a time table in which the first stage of EHR implementation must be concluded by 2014, we can expect many more eligible professionals to be informing themselves about meaningful use over the next year or two. Medical transcriptionists who work closely with these offices may be able to make a valuable contribution to these local projects.

HISTORY AND DEFINITION OF MEANINGFUL USE OF ELECTRONIC HEALTH RECORDS

When President Bush established the ONC within the Dept. of Health and Human Services, the stated national goal was for most Americans to have access to an interoperable (exchangeable) electronic health record (EHR) by 2014. In 2009, under President Barack Obama, the American Reimbursement and Recovery Act (ARRA) designated $2 billion for the ONC to accomplish its work; this was the first actual funding for the EHR national project. The year 2011 was the first year in which hospitals, physicians, and clinics were able to

Be proactive! Don't wait for your clients and employers to forge ahead into the EHR and meaningful use without you.

participate in the Medicare EHR Incentive Program to receive payment for instituting electronic health records. The last year to begin participation in the incentive program will be 2014.

But not only must hospitals and eligible professionals buy EHR systems; they must buy systems that are certified by government standards, and must use those systems in specific meaningful ways. To avoid a situation in which EHR systems are purchased but never actually used to improve medical practice, the ONC embarked on the process of defining meaningful use of EHRs and setting up appropriate rules.

In January 2010 the Department of Health and Human Services (HHS) issued proposed meaningful use rules for public comment. In July 2010, after over 2000 comments were received from the public, HHS issued final rules that must be met in 2011 and 2012. This is Stage 1. In November 2011, HHS set the date for Stage 2 implementation at 2014. Ultimately, all meaningful use requirements will have to be met by everyone who wishes to participate in the incentive programs.

OPERATIONALIZING MEANINGFUL USE

Any provider, clinician, or hospital seeking to receive government incentives for EHR implementation must first be using an EHR system that has been certified by a testing entity empowered by the Authorized Testing and Certification Body of the ONC (ONC-ATCB) to certify such systems. An important characteristic of every certified EHR is that it will have built-in functionalities to meet meaningful use requirements.

You can find all the information you'll ever need about meaningful use at the website of the Centers for Medicare and Medicaid Services (CMS).[2] It isn't possible to include in this short article everything you need to know. You'll be able to supplement your knowledge by studying the CMS materials with your own clients and prospective clients. A basic document you'll see at the CMS website is a table listing the meaningful use Stage 1 rules. This is a good starting place from which you can explore the details of each rule.

The meaningful use requirements include both a "core set" and a "menu set" of objectives that are specific to eligible professionals. (There are other, slightly different, core and menu sets for hospitals.) For EPs, there are 25 meaningful use objectives. To qualify for an incentive payment, in Stage 1, 20 of the 25 objectives must be met.

- There are 15 required core objectives. Most of these have to be met by most eligible professionals (though there are "exclusions" for some objectives, meaning that some EPs are not required to meet some objectives).
- The remaining 5 objectives may be chosen from the list of 10 menu set objectives.

When you have gone to the CMS website and found the tables, you can click on any one of the requirements listed, and you will be taken to a site dedicated exclusively to that particular requirement. At that site, you'll find detailed information about (1) the objective of that requirement, (2) how it must be measured, (3) conditions under which providers are excused or excluded

from having to meet this requirement, (4) definitions of terms used in discussing this requirement, (5) rules about how compliance with the requirement must be stated or "attested," and (6) a list of frequently asked questions with answers.

HERE IS THE LIST OF CORE OBJECTIVES FOR EPS:

1. Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.
2. Implement drug-drug and drug-allergy interaction checks.
3. Maintain an up-to-date problem list of current and active diagnoses.
4. Generate and transmit permissible prescriptions electronically (eRx).
5. Maintain active medication list.
6. Maintain active medication allergy list.
7. Record all of the following demographics:
    a) Preferred language
    b) Gender
    c) Race
    d) Ethnicity
    e) Date of birth
8. Record and chart changes in the following vital signs:
    a) Height
    b) Weight
    c) Blood pressure
    d) Calculate and display body mass index (BMI)
    e) Plot and display growth charts for children 2–20 years, including BMI
9. Record smoking status for patients 13 years old or older.
10. Report ambulatory clinical quality measures to CMS or, in the case of Medicaid EPs, the states.
11. Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with that rule.
12. Provide patients with an electronic copy of their health information (including diagnostic test results, problem lists, medication lists, medication allergies) upon request.
13. Provide clinical summaries for patients for each office visit.
14. Capability to exchange key clinical information (for example: problem list, medication list, allergies, and diagnostic test results), among providers of care and patient-authorized entities electronically.
15. Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities.

ONE EXAMPLE OF ONE MEANINGFUL USE CORE MEASURE

Let's focus, as an example, on the information given for EPCMU-01 (Eligible Professional Core Meaningful Use requirement #1). Computerized physician order entry (CPOE) is the process of entering medication orders electronically into the patient record instead of on paper charts. It is anticipated that the use of a CPOE system can help reduce errors in medication orders. The rationale for this requirement is that when orders are entered electronically into certified EHR systems, the system provides alerts about allergies and possible drug interactions, thus enhancing patient safety. From the CMS table mentioned above, clicking on the meaningful use objective #1 will take you to the detailed page dedicated to fully explaining the CPOE objective. Here you'll find the objective itself restated, a description of what measurements must be used to demonstrate that the requirement is met, a comment about exclusion (which EPs may be excluded from having to meet the requirement), along with sections presenting definitions of terms, other instructions for reporting compliance with the objective, and additional information relevant to the objective. An example of "additional information" for EPCMU-01 is: "The order must be entered by someone who could exercise clinical judgment in the case that the entry generates

> A strictly defined turnaround time is probably the most significant and immediate result of the meaningful use implementation process.

any alerts about possible interactions or other clinical decision support aides."

MEANINGFUL USE AND PRACTICE WORKFLOW

It turns out that some of the meaningful use objectives will affect workflow in physician offices. That is, in order to meet the requirements, the offices will need to work in different ways from those they are accustomed to. Let's again take EPCMU-01 as an example.

Use computerized provider order entry (CPOE) for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.

In many offices today, medication orders are entered by an MA, not a licensed healthcare professional under the CMS definitions. But to satisfy this objective, the order must be electronically entered by a physician, registered nurse, or physician assistant.[3]

EPCMU-07 can also affect workflow. It requires recording of demographic information, some of which is not commonly recorded by offices, and which can be difficult, politically or personally sensitive information to obtain. If a patient declines to provide information, that patient preference must be entered as structured data in the same way that the demographic information would be entered. And MU-07 does not allow any exclusions: all eligible providers must meet this requirement in Stage 1 of the meaningful use process.

IMPLICATIONS OF EPCMU-01 FOR MTs

Not only can EPCMU-01 affect workflow in the office, it may have an indirect effect on the future of medical transcription. Because this core measure requires "hands on" in the electronic system, it enforces direct clinician engagement with the EHR and, if correctly adhered to, will inevitably increase clinician engagement of entering information into the EHR across the board. The more comfortable the clinician becomes with the EHR, the more likely he or she is to reduce or eliminate the use of "traditional" dictation/transcription.

OTHER IMPLICATIONS OF MEANINGFUL USE FOR MTs

A strictly defined turnaround time is probably the most significant and immediate result of the meaningful use implementation process. For example, EPCMU-12 requires that 50 percent of all patients who request an electronic copy of their health information must receive it within three business days. EPCMU-13 requires that a clinical summary for each office visit, for more than 50 percent of all office visits, must be provided within three days. The only exclusions granted are for EPs who get no requests from patients for such records and for EPs who do not have any office visits take place during a given reporting period.

I've given you a speedy overview of meaningful use, and I've also mentioned a couple of aspects of MU that could negatively affect the traditional dictation/transcription workflow.

Is there good news for MTs in an EHR world?

MTs IN THE MEANINGFUL USE ENVIRONMENT

People who know what you know can find a place in the EHR environment.

What you already know

- Medical terminology
- The physiology of disease
- Medicolegal aspects of the medical record
- The nuts and bolts of clinical practice

The first and most critical thing to keep in mind is that you already have extremely valuable basic knowledge about how medicine is practiced, about its language, about disease (and wellness, for that matter), and about how medical records are obtained, organized, and safeguarded.

At the same time, to find a role for yourself in this environment, you will need to learn some new things. This is no problem for MTs; most of us are lifelong learners—our daily work requires it!

What you can learn

- What meaningful use core measures and menu set measures are;
- How they are recorded and measured;
- Who must meet the objectives;
- When and how they must be met;
- What the documentation workflow implications are with each meaningful use objective.

SO JUST KEEP LEARNING! MOST OF US ENJOY IT.

What you can do with what you learn

- Let clients and potential clients, employers and potential employers know that you understand meaningful use.
- Use this understanding to help in both selection and implementation of EHR systems for clinician clients, or to help your MTSO employer understand the EHR transition and its impact on workflow.
- Keep learning: take seminars, webinars, courses—often free—about meaningful use.
- Build on what you know about meaningful use and become more technically savvy about the EHR.
- Use your critical thinking and creative imagination, coupled with your knowledge of your clients or employer to imagine new roles for yourself. For example, EPCMU-13 states that EPs must "Provide clinical summaries for patients for each office visit." How can you use your skills in documentation to create a patient-friendly clinical summary? Is there a role for you in creating or editing those clinical summaries?

Be proactive! Don't wait for your clients and employers to forge ahead into the EHR and meaningful use without you. Talk to them, share your knowledge, look for niches.

Meaningful use—the key to the EHR—is complex but not terribly difficult in its basics. You just need the right knowledge and the right techniques, along with careful preparation, courage and persistence, and an open mind, to find that niche for yourself. **P**

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1. See http://www.marketwatch.com/story/electronic-health-records-ehr-adoption-reaches-75-for-larger-physician-offices-2011-10-24.
2. See https://www.cms.gov/EHRIncentivePrograms/30_Meaningful_Use.asp and http://www.cms.gov/EHRIncentivePrograms/Downloads/EP-MU-TOC.pdf.
3. Some hospital-based EHR systems are including a requirement (not specifically mandated by meaningful use rules) that a pharmacist sign off on all computerized physician order entries, in order to catch any errors in clinician-entered orders.

Rebecca McSwain, PhD, CMT, *is an educator, researcher and writer, and a medical transcriptionist with over 30 years of acute care, clinic, and office experience. She has worked as an on-site and home-based production MT, supervisor, and QA manager.*

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VINCENT D. O'CONNOR AND
ANNETTE HOFFMAN, CMT, CPC-A

The rate of change in today's world is sometimes overwhelming. Communication is faster, the world's population is growing, there is increasing competition, and old guards are falling. This is especially true in the world of technology, where every month brings new innovation. Over 40 years ago, Intel co-founder Gordon Moore famously predicted that the number of transistors on a microchip would double every two years. If this was applied to population growth, a city with a population of 250,000 people (for example, Saint Petersburg Florida) would have a population almost large as New York City within a decade. Within two decades, the city's population would hit 256 million—almost double that of Russia.

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His comment, dubbed "Moore's Law" by computer scientists, has been used countless times over the past several decades to describe how rapidly changes to technology have and will continue to occur. Make no mistake--technological advances are altering our world at an unprecedented pace, and the healthcare industry is no exception. Here are just a few samples of how technology is changing the healthcare landscape.

HEALTH INFORMATION TECHNOLOGY

Health Information Technology (HIT) includes a variety of integrated data sources, including patient Electronic Medical Records, Decision Support Systems, and Computerized Physician Order Entry for medications. As part of the American Recovery and Reinvestment Act of 2009 (ARRA), $20 billion was allocated to help pay for the switch-over to Electronic Health Records (EHR). Then in July 2010, the U.S. Department of Health and Human Services released documents that set forth the directives for implementing the provisions of the act, including the meaningful use incentive program. This program, operated by the Centers for Medicare and Medicaid Services (CMS), provides eligible providers and eligible hospitals payment incentives to acquire, adopt, and meaningfully use certified EHRs.

ELECTRONIC HEALTH RECORDS

Electronic Health Records are the digitized version of a patient's medical history, from demographic information and medical history to progress notes, medications, vital signs, lab data, radiology reports, and more. As the adoption of EHRs grows, it will be critical to assure their quality, security, efficiency and access. The Certification Commission for Health Information Technology (CCHIT®) is an organization that provides certification for electronic health record systems and their security, functionality, and interoperability. This organization is officially recognized by the federal government.

LANGUAGE PROCESSING TECHNOLOGY

Natural language processing is the computer-aided processing of language produced by a human. This type of processing may be done on text records or on human speech. Products based on textual processing are already being developed. MedLEE, for example, is a text processor developed by Columbia University over 20 years that is designed to extract and structure clinical information from textual reports such as transcriptions of doctor's notes and encode all relevant clinical information so that it can be easily extracted for use in a variety of health care programs.

Speech recognition technology converts spoken words to text, using either "live" or recorded speech. Basic versions of this technology have been built in to the last two versions of the Microsoft Windows operating system, and there are both commercial products such as Nuance's Dragon® Medical Practice Edition for dictation directly into electronic medical record software, and open source software such as Sphinx-4.

But human language is inherently irregular, and the most reliable results to date are obtained when a human is involved in at least some part of the processing. In a recent paper in Qualitative Research,[1] Johnson reiterates that a comparison between using voice recognition software, as compared to the traditional listen-and-type method found that the listen-and-type transcription took 14.2 percent less time than the voice recognition software-assisted approach, and resulted in a more accurate transcript.

ICD-10 MEDICAL CODING

ICD-10 Medical Coding is an upgraded diagnostic and procedural medical coding system mandated by the US Department of Health and Human Services (HHS), and must be implemented throughout the healthcare industry by October 1, 2013. The classification system incorporates much greater specificity and clinical information than ICD-9. For example, under ICD-9 there is a single code for angioplasty (39.50), but there are 854 codes for angioplasty under ICD-10. It also includes risk factors frequently encountered in a primary care setting, and allows for the possibility of greater expansion of code numbers. This will affect the coders and billers of the world, but it will also affect the transcription and health care documentation industry.

CLOUD COMPUTING

Cloud computing has become one of tech's biggest buzzwords. Generally speaking, it is the use of the Internet to run programs or store data. Traditionally, most software programs ran on your personal computer. Cloud computing changes that: Programs run on a remote server (or servers), accessed by (but not stored on) your computer. Such services are offered by Google, Microsoft, Amazon, and many others. However, using such services requires that the user be aware of data integrity, recovery, and privacy. It also requires an evaluation of legal issues in areas such as e-discovery, regulatory compliance, and auditing.

Cloud computing also changes the dynamics of HIPAA security. There are three parts to the security requirement of HIPAA—administrative, physical, and technical—and each has specifications that describe how the standards should be carried out. Normally, the entity covered by HIPAA implements these specifications, but with cloud computing, the vendor providing the cloud services will have to be responsible for the part of actual implementation of certain operational aspects of security,

and entities will need to ensure their cloud vendors properly address the specific mandates of HIPAA security as required by the Health Information Technology for Economic and Clinical Health (HITECH) Act.

The speed of change is going to require that healthcare documentation professionals keep up with the changes through additional or continual training. Peter Preziosi, PhD, CAE (former AHDI Chief Executive Officer), and Susan Lucci, RHIT, CMT, CHPS, AHDI-F (2009 AHDI President), both spoke on this topic at the 2009 Wisconsin-Minnesota AHDI chapter conference. They mentioned that transcription is not getting any easier, continued education is a must, and suggested training in database administration, editing, information technology and systems, as well as business and interpersonal skills.

Sherry Doggett, AHDI President, reinforced the need for training when speaking at the Wisconsin-Minnesota AHDI chapter conference in October 2010. She suggested that Certified Medical Transcriptionists continue to prepare themselves in as many ways as possible for the uncertainty of where technology will lead. Some of her suggestions included training in coding or electronic health records. Both suggestions for training could also lead to additional certification opportunities for medical transcriptionists. There are two professional organizations that certify medical coders and billers, AHIMA (American Health Information Management Association) and AAPC (American Association of Professional Coders). AHIMA offers training in several areas of HIT that would be interesting to current MTs.

EDUCATE

There are many educational resources to pursue. These resources will benefit you in many ways but most notably in preparing for the future and earning those continuing education credits! Start with www.ahdionline.org and click on the Continuing Education menu. There are many links to training in this menu. Check out www.ahima.org and click on the Continuing Education menu and review all of the choices available. AHIMA (American Health Information Management Association) can connect you to training on coding and electronic health records. If you are not familiar with HL7, SNOMED, or other acronyms used in the health care documentation industry, take some classes and learn what they are all about. If you don't know much about the coming changes in ICD (International Classification of Disease) or CPT (Current Procedural Terminology), learn about them. Knowledge of these terms and coding systems will only help you prepare for the future.

CERTIFY

In addition to the educational opportunities, there are also many emerging certification opportunities. Recently, AHIMA announced an addition to their list of credentialing programs. They now offer a Certified Documentation Improvement Practitioner (CDIP) exam. Many medical transcriptionists would have the experience and education to sit for this national exam. All AHIMA certification opportunities are guided by the Commission on Certification for Health Informatics and Information Management (CCHIM). AHIMA also has many other certification programs: Certified in Healthcare Privacy and Security (CHPS), Certified Health Data Analyst (CHDA), and Certified Coding Specialist (CCS), to name a few.

NETWORK

Plan to include networking opportunities into that already busy schedule. Meet more people in the health care documentation industry. This is one way to stay abreast of new technology and developments within the industry. Start with a local AHDI chapter. Attend chapter meetings, regional meetings, and national meetings. Not only does this activity enrich life in general, but networking also has been shown to provide job opportunities, add to knowledge base, and increase personal potential.

In consideration of this topic, all health care professionals need to engage in continuing education according to their code of ethics. The AHDI Code of Ethics states "Continue professional growth by enhancing knowledge and skills, including continuing education, networking with colleagues, professional reading, certification, and advocating for the profession and the industry." This can be found at ahdionline.org under Member Center, then Code of Ethics. In other words: Train, Train, Train! It can only bring benefits! **P**

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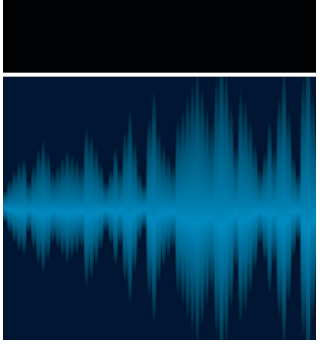

TECH TALK

The Economics of Offshoring

KENNETH W. SCHAFER

Companies that offshore transcription are not doing the devil's work. In fact, they are simply responding to our market's mantra of "better, faster, and cheaper."

Let me say at the outset that very few people appreciate medical transcriptionists as much as I do. In addition to performing every other transcription job imaginable, I've actually been a working MT, paid on production as an independent contractor, with the attendant advantages and difficulties that accompany that position. It is because I value the skill set and the practitioners so highly that I've watched the offshoring debate with such interest. Of the three forces influencing the futures of our transcription professionals (speech recognition, EMRs, and off-shoring), by far the most polarizing is the offshoring of medical transcription.

Perhaps because it is so polarizing—or maybe because there is a degree to which offshoring is old news—I have avoided writing about the issue in any depth. However, I recently had the opportunity to watch a hospital reverse its position on offshore transcription. Observing the circumstances surrounding the decision to allow the offshoring of work has caused me to further solidify my own opinions about market drivers in our industry.

Here is what I watched unfold: A venerable non-profit institution, once flush with cash, had struggled financially for years. Various attempts to resuscitate the viability of the organization were unsuccessful, and the hospital was eventually sold to a for-profit hospital corporation. Although all historical transcription providers to the hospital had contract clauses prohibiting the offshoring of work, the hospital's new owners had agreements with preferred vendors that allowed work to be done overseas. A change of ownership signaled an effective change in policy, and the offshoring of work is now permitted by this facility.

What was the driver? Money, obviously. Perhaps a better question, though, is who was driving? In this case, the hospital—not the MTSO—led the charge to move work offshore, presumably to spend less money on documentation. Which leaves us with an even more interesting question: If you don't like the fact that an increasing percentage of our medical documentation goes overseas, at whom should you direct your ire?

No matter your opinion on the appropriateness, patriotism, or security of offshoring work, it is patently obvious to any observer in our industry that the companies that provide offshore services are doing

so in response to client demand. Companies that pride themselves on their U.S. workforce are also making business decisions in response to client demand. Different clients demand different solutions at different price points. In the same week this hospital reversed its offshoring policy, I met with the owner of a nonaffiliated clinic who told me that she would not allow work to go overseas for any reason!

I'm not suggesting for a minute that MTSOs are powerless in their choices about how and where their labor is sourced. Of course companies make strategic decisions about the best way to serve their target markets. My point is that competitive forces beyond the control of any individual—or company—determine the trends that influence transcription purchasing decisions.

Now look at it in a different way. In all of my years as a business owner, I never provided health insurance that my employees thought was reasonably priced. Every year, the cost of insurance went up—and every year, someone would ask me why I charged so much for healthcare coverage. These folks failed to understand that I was passing along a cost, not creating one.

And do you know what is a part of that health insurance cost, albeit a very small component? That's right—the cost of documentation. Now, don't get mad. I am not saying that the entire U.S. healthcare system can be balanced on the backs of medical transcriptionists. As a strictly philosophical exercise, I'm just pointing out that there is a certain dichotomy in saying that health care should cost less but transcriptionists should get paid more!

Here is my big, overarching idea for this issue's column: Companies that offshore transcription are not doing the devil's work. In fact, they are simply responding to our market's mantra of "better, faster, and cheaper." Note that these are the same three deliverables that moved transcription from typewriters to word processors, from cassette tapes to dictation systems, and in-house transcription to outsourced work. They are the same three drivers that determine if and when speech recognition solutions or template-driven EMRs are adopted.

Incidentally, they are the same three drivers that exert downward price pressure on everything we buy, including food, transportation, housing, and—yes—even health care.

Do I believe that free markets solve all problems? No, not really. Sometimes the markets make huge mistakes. In any case, economists and business owners often forget that there are people with families behind the unemployment statistics, and that folks who give their lives to their jobs are often the unwitting victims of technological advances or macroeconomic changes. However, these same individuals sometimes benefit—in less direct ways—from the forces that displace them from jobs that they love.

Perhaps the wisest thing I've ever heard said about economics is that all of us want competition in what we buy, but a monopoly in what we sell. The reality is that this is simply not the case for most goods and services in free market systems. I'm not placing a value judgment on that, merely restating an observed reality.

There is no question that market forces are causing the displacement of many U.S. transcriptionists, who are among the most talented and under-recognized workers in America today. However, it is a gross oversimplification to attribute this trend to the avarice of MTSOs, or the seismic shifts represented by EMR and speech recognition technologies. The simple fact is that because of our societal ambition to deliver health care "better, faster, and cheaper," all healthcare industry expenses are constantly subjected to downward pricing pressure.

An interesting footnote on the hospital mentioned at the beginning of this column. Although it had been unprofitable for years, rumor has it that six months of new ownership with a profit-oriented company resulted in a complete financial turnaround. How was it accomplished? As far as I can tell, a change in business philosophy resulted in the elimination of many positions. The corporation used its buying power to bring in more cost-effective contracts, including contracts with medical transcription companies. New management talent was brought on board. Was the process perfect? By no means! But, on the whole, it seems to be working.

And that is good news for the patient population, which will now enjoy access to a hospital that is better positioned to serve its community for many years to come. **P**

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Wishful Thinking

JILL DEVRICK

1 CEC QUIZ
PROFESSIONAL DEVELOPMENT

Often, upgrades can be like Christmas with new features of varying size and complexity. Take advantage of those upgrades before looking for other solutions.

Although you are probably reading this in March, as I write it is the week before Christmas. My seven-year-old son has been fine-tuning his wish list for months. Santa got an ear full when my son sat on his lap twice in the past few weeks. When he came home from school the other day, he was completely appalled that one of his classmates doesn't believe in Santa. "Can you believe that, Mommy? How could he not believe in Santa? That's just crazy." I love being a mom.

My son and the holidays have gotten me thinking about wishes, and since this issue is about technology, I thought I would share my thoughts on technology wishes, or as they are more commonly known, enhancement requests. In previous articles I have recommended creating a wish list of features you would like your technology to have, and I've also advised you to have a good working relationship with your technology vendors. Now I want to get into more detail about how this works from both your perspective and the vendors' perspectives, who work with you to make all your dreams come true.

Over the years, I have reviewed and processed many enhancement requests, so I've seen just about everything--although I do still get an occasional surprise. Here's what I have learned by making a list and checking it twice. Actually, there are many lists checked many times, but I'm still on the Christmas kick.

So, you have a brilliant idea that you think your technology provider needs to hear. There are several things you should do before communicating your idea.

First, do some research and ask the experts if your idea can already be accomplished with existing features. Software used to manage dictation, transcription, and speech recognition can have complex configurations, and sometimes you may not be using parameters and settings because you didn't know you needed them. Make sure you are taking advantage of every available feature, especially if the technology vendor has an upgrade that you haven't applied yet. It is common for upgrades to get applied over the years without revisiting the system's configuration to see what's new. Often, upgrades can be like Christmas (there

I go again), with new features of varying size and complexity. Take advantage of those upgrades before looking for other solutions.

If you come up empty in your research, then look at your idea in the context of your organization's workflow. Think about how your idea could be used in a broader context rather than just in your environment. As an enhancement reviewer, I can tell you that technology companies are more likely to invest resources on ideas that have a far-reaching appeal rather than in a one-off idea that would only benefit one client. So if you really want it, think about how other organizations could use the same feature. Better yet, call your connections in other organizations and get their feedback about your idea, especially if they use the same product that you want to enhance. Two heads or more are definitely better than one when designing a solid, practical new feature.

So now you have a great idea that can't be accomplished without some elbow grease by your technology vendor. How urgent is this request? How much will it impact your productivity, profitability, and general sanity? Occasionally, a request is urgent and significant enough to get immediate attention. However, enhancement requests should not be treated like an issues list. Error messages and bugs are handled differently and should be addressed via the client support channels you have available.

Most technology companies are planning out their development projects months, if not years, in advance because they want to be as efficient and effective with their resources as possible. It is not efficient or effective to drop really big long-term projects to tackle a single enhancement request that may have nothing to do with the previous or next project on the list. Please consider this when communicating the level of urgency and voicing your frustration. I can confidently say that you will be much happier with the periodic software update that contains many related enhancements all at once rather than getting one intermittent enhancement at a time. In this case, slow and steady wins the race.

Every enhancement request should have three parts to be considered complete. In my company, we use agile software development, and as part of that methodology, we create what are called "user stories." The three questions to ask when creating a user story are:

Who needs the new feature?
Would the idea benefit an MT, a supervisor, a senior manager, an IT person, a QA reviewer, or someone else? Who will be doing this task? This gives the idea a context for those who will design and develop the feature.

What are they trying to accomplish with the feature?
When answering this question, focus on the "what" and not the "how" of the idea. For example, if my goal is to make a peanut butter and jelly sandwich, is it important what kind of bread or jelly? Should I toast the bread first? In an enhancement request, your concern should be the end result. Many people will be involved in determining how to accomplish it.

What is the business justification/return on investment you expect from the feature?
This is the part of an enhancement request that is most often overlooked, but it is very important because it establishes the "why" of your idea and justifies the level of effort and urgency of getting it done. Your justification will probably fall into one of these categories:

- Increase efficiency (eliminate steps, integrate data, improve turnaround times, etc.)
- Enhance user experience (more intuitive or aesthetically pleasing, increased productivity, etc.)
- Improve accuracy and/or quality (tools, references, collaboration, etc., to produce better output)
- Adapt to different standards (compatibility with new hardware, regulations, industry best practices, etc.)
- Update internal architecture and logic (stuff that happens behind the scenes to store, manipulate, and use data)

After you have answered the three questions, you put them together into a single, concise statement:

"As a <role>, I want <goal/desire> so that <benefit>."

The essence of my sandwich example would be:

"As a mother, I would like to make a peanut butter sandwich so that my son can have the energy he needs to get through the afternoon."

To break this statement down, the "mother" part is important because the person designing my sandwich-making methodology may do it differently if my seven-year-old is the one making the sandwich. Then I explain what I want to do very generally, and why. I would probably put the "energy he needs" in the "internal architecture and logic" category I described above. He needs to eat to grow and survive. That's a good way to think about it: Your enhancement ideas should be tied back to how they can help your organization grow and survive.

When a new feature is initially designed, the user story may start out

more general, or what I would call "epic." For example, "As a mother, I would like to make lunch so that my son can have the energy he needs to get through the afternoon."

However, there are several parts to making a healthy lunch, so this epic user story would have to be broken down into all of the parts, including what beverage and other foods will be prepared. When you are submitting a request, think about whether you should split your idea into multiple ideas. If you aren't sure, just submit the big one, and if necessary, someone will contact you to help break it down later.

After you have submitted your idea, keep an open mind about how the idea is interpreted and implemented. Your vendor may come up with several ways to accomplish what you need. Even though they may achieve the end result you are looking for, it may not happen in the same way you envisioned, but hopefully it is beyond your expectations.

Also keep in mind that not all enhancement requests are created equal. Some are small and can easily be added to current projects. Some are unrelated to anything else in the hopper and have to be tabled for a while. Others are huge endeavors that would require big changes to internal architecture and logic. Trust me, the companies you work with want to give you everything you ask for, in such a way that you, and the majority of their customers, will be happy with the result.

Build a good working relationship on a first-name basis with your technology vendors, and you can expect mutual success for the long haul. I'm not saying that the squeaky wheel always gets the grease, but I am saying that the more you, as a user of their product, can tell them about your experience and evolving needs, the easier it will be for them to deliver on-target solutions as changes occur in your organization and the HIM world. **P**

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Bullying : Identifying Factors, Treatment Options, and Cultural Responsibility

MIRIAM K WILMOTH, CMT, AHDI-
AND JERRY HESTON, MD

1 CEC QUIZ
CLINICAL MEDICINE

When the President of the US (and his wife) launch initiatives to battle a specific healthcare-related problem,[1] we know it is serious. Bullying has recently risen to the forefront of our consciousness due to high-profile cases of several adolescents committing suicide after being bullied—primarily over LGBT issues. Even celebrities (Madonna, Anderson Cooper, Hillary Clinton, Lady Gaga, others) have gotten on this bandwagon, trying to infuse bullied kids with both the will to live and the will to fight those who make them feel bad about themselves.[2]

With this in mind, Dr. Jerry Heston of Child and Adolescent Psychiatry Associates in Memphis, Tennessee, sat down with *Plexus*, addressing first a definition of bullying that appears in a joint position paper by the APA and AACAP:

"Bullying is a serious form of mistreatment manifested by the repeated exposure of one person to physical and/or relational aggression where the victim is hurt with teasing, name calling, mockery, threats, harassment, taunting, social exclusion or rumors."[3]

PLEXUS: Some things like name-calling, social exclusion, and rumors have traditionally been "rites of passage" every child experiences. What is the tipping point that now makes it bullying?

HESTON: The definition is broad in order to include the point of view of the person who is being bullied. If they are called names, it might have a bigger effect on them than somebody else who would brush it off. The other thing is that "rite of passage, everybody's exposed to it" may be true, but that's not where we should leave it. In the past, women might have said, "Being sexually harassed is just part of the job," but as we've changed we've said, "No, that's not the way it should be—not acceptable"—and that's where we are with bullying and kids. It's very common and it affects some kids more than others, but just because it's widespread doesn't mean it's okay.

PLEXUS: Do you see more bullying cases now?

HESTON: I don't know that I'm seeing more…society is paying more attention to something clinicians have always seen. It doesn't fall into any one category like

a "field of bullying," but some therapists deal with it. Parents say, "We've got other problems and, by the way, we have this bullying thing." It's not typical for it to be the chief complaint, but it comes out when you're talking about other things.

PLEXUS: The cases that hit the media are gender bias, obesity, religious and racial prejudice. Are there other issues you see that set kids up to being bullied?

HESTON: Those are the ones, with variations. Parents would have to look at the group their child is in. In an all-boys high school where there is a lot of athletic emphasis, a non-athletic boy might get teased or bullied. In a school where there is a lot of academic achievement, it's the one who's average or has a learning disability. Bullying is often done to the kids who are not as smart, who have learning disabilities, frequent tardies.

So much of the literature about bullying has to do with gender and sexuality issues, and I think a big part of it is losing control over their identity and not being able to choose when they come out, who they come out to.

PLEXUS: Does psychopathology drive bullying, or does psychopathology come from bullying?

HESTON: I don't know which is first. There seems to be a connection on both sides, where kids who have emotional and behavioral disorders are more at risk of being bullied, but also more at risk of being affected. If you already have something going on, when you're also being bullied, certainly that would be worse.

It is the same on the bully side: They may have emotional or behavioral problems and they figure out a way to make themselves feel a little bit better by bullying somebody, then that makes their ADHD symptoms worse. It's always something: The teachers are always complaining about them, they're under-achieving, frustrated at home because their parents are saying, "You're smarter than this—you should do better than this," and they already have impulse control problems, so things that might pass through other kids' minds pass through theirs and they act on it, and then they become a bully. Then that makes their ADHD worse, because then you have to deal with why.

PLEXUS: What do you see in home-of-origin issues?

HESTON: Some bullies may have been exposed to bullying, either from a peer and then they kind of went with that, or with a parent. In Freudian theory there was the concept of identification with the aggressor; one way kids coped with adversity was to take on the characteristics of the perpetrator. You can see that working in a family dynamic, where a kid is always put down and then they get out into the community with their peers and they "kick the dog," in a sense.

Bullying is usually peer-to-peer, maybe older peers to younger peers, but once it gets to adult-to-child, it takes on a different meaning. Within a bullying situation, there could be a power dynamic, but with an adult, it's a caregiver, an authority person to a younger person. It's a different category than what we are talking about with bullying because it could be much more damaging. Could there be a genetic component to it that's passed down? Possibly. Could it be exposure to parents that bully? Several parents come to mind, right when you say that.

PLEXUS: Is it harder if a child experiences being bullied young, or is it just as damaging if it happens later, say with onset during adolescence rather than childhood?

HESTON: High profile cases where bullying resulted in suicides involved teenagers. A big part of adolescent development is being accepted by your peers. If somebody is having difficulty with that, one way they may find to be less different is by pointing out somebody who is more different than them. That person gets bullied, ostracized, and put down, while the bully raises himself up to fit in with everybody else. An adolescent wants to feel like he's part of the big group, so he identifies somebody else who "doesn't fit in; therefore, I do fit in." With the other kid who is also struggling to fit in, it puts him further outside the group and has a more negative effect.

PLEXUS: What do you do therapeutically when a child comes in who bullies?

HESTON: To treat bullies, you have to treat whatever other condition they have. Using the ADHD example, treat their ADHD. You discover their vulnerabilities, why they see the need to bully, and you try building them up. Maybe they have an assumption they're stupid because they've heard, "You're a loser – you won't amount to anything," and it gets ingrained in their thinking. You step back and say, "Well, let's look at that. Your IQ certainly doesn't mean that. You may have had some

difficulty with grades, but let's look at why. That was because of not getting your homework assignments in." You can address those issues using a behavioral model. Sometimes it's other things: If they're more than a bully, really aggressive across the board, there are specific therapies for aggressive kids, which overlaps with the bullying, but we usually think of them as highly aggressive kids who are a category unto themselves.

PLEXUS: What about the kids who are bullied, therapeutically?

HESTON: Basically, the same thing: Take care of their condition. If it's depression or anxiety, you deal with that, helping them see that whatever has happened may be due to the bullying, but—and this may also apply with the bullies—bring this out into the wider system and say, "This is something that we don't tolerate," so it's not something you ignore or you learn to deal with—we have to intervene. We teach them how to get help, how to speak up for themselves, how to be more assertive. It's about bringing in support in a sensitive way. At times when I've talked to patients about that, the kids would say, "Oh, that will make it worse. If my parents complain about him, that'll just make it worse on me." I think now most teachers, educators, and principals are more aware of this and they are doing it sensitively, anonymously. "We've had this report about you having some trouble with some peers." I see that as more effective, where the school intervenes to say, "We are not going to tolerate this."

As a child's self-esteem builds, it makes sense that he would be less likely to bully, but also less likely to be a victim. Self-esteem, self-confidence are protective factors on both sides of bullying.

With the current cyberbullying, it's multiplied by however many. If bullying is one-on-one, a victim can always say, "Well, it's just that person's opinion; they don't know me." If it's cyberbullying, they think, "The whole world knows this about me! It's on the Internet forever." And how can you ever get past that? That's one reason we're spending more time, thinking about, looking for, and trying to address bullying now, because cyberbullying has taken it to another level.

PLEXUS: Is there anything else that you think would be helpful for us to know?

HESTON: The main thing is to shift from thinking this is something a child has to deal with because it's a part of growing up, shifting now to it doesn't have to be that way, there are things that can be done and it's not something you can do on your own. You have to involve parents, teachers, etc. It should be viewed as a cultural issue, not just an individual developmental issue. **P**

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LET'S TALK TERMS

BEVERLY SOFKO, CMT

1 CEC
QUIZ
CLINICAL MEDICINE

TERM	DEFINITION	MANUFACTURER
SecureStrap™	A 5 mm absorbable strap fixation device used in laparoscopic hernia repair.	Ethicon
AlumaFoam®	Foam laminated aluminum finger splints, which can be shaped to finger wounds.	Various
Yervoy™	Generic ipilimumab, a prescription injection medication for adults to treat melanoma that has spread or cannot be removed by surgery.	Bristol-Myers-Squibb
monofixator	Also called the unilateral fixator, this external fixation device is used for fractures of the tibia, pelvis, femur, ankle and humerus.	Various
Medrex Ltd.	A healthcare company that scans, stores, shreds, purges and microfilms medical records.	
hot potato voice	Category 2 of adult epiglottitis, so-named because patients talk as if they have a mouthful of hot potatoes, with a muffled voice.	
MILD™	Minimally invasive lumbar decompression (MILD™), a surgical device used for tissue resection of the lamina.	Vertos Medical
intrathalamica	Refers to zona limitans intrathalamica, an area in the brain that separates the thalamus and prethalamus.	
Paradol	A dietary supplement derived from peppers (ammomum, Aframomum and melegueta or grains of paradise). The active ingredient, 6-paradol, is believed to have analgesic properties.	
Zingiberaceae	The ginger family of plants. Ginger may be used as a supplement to reduce nausea, vomiting, sea sickness, morning sickness, and chemotherapy-induced nausea.	

TERM	DEFINITION	MANUFACTURER
anisohyperopia	A pediatric condition in which one eye focuses well and the other eye does not, ie, one eye sends a finer image to the brain than the other eye.	
Stallworthy sign	In obstetrics, slowing of the fetal heart rate when applying pressure to the infant's head down into the pelvis, which recovers, implying low lying placenta, suggesting the presence of posterior placenta previa.	
foramina venarum minimarum atrii dextri	A Latin term, which means openings of smallest cardiac veins.	
Prevotella loescheii	This bacterial species is responsible for human gum disease.	
FerriScan®	A 20-minute MRI-based outpatient procedure for the non-invasive measurement of liver iron concentrations.	
PlasmaBlade®	A line of disposable surgical tools that includes tips for cutting and coagulation in various specific surgeries, such as tonsillectomies and adenoidectomies.	Peak™
GraftRope™	A surgical instrument designed to mend injuries to the ligaments that join the collarbone to the shoulder blade.	
Articul/Eze®	A femoral ball head device is used in total hip arthroplasty.	DePuy
Restoris® MCK (MultiCompartmental Knee) system	Used in knee surgery, a bone-preserving treatment choice used for unicompartmental and bicompartmental disease, designed to treat early stages of osteoarthritis.	Sandvik
Oticon Ponto	A bone anchored sound processor developed for use in patients with conductive/mixed hearing losses or single-sided deafness, who cannot benefit from wearing traditional air conduction hearing aids.	Oticon Medical
Veinlite®	A vein finder for vein access; also provides imaging of varicose veins anywhere on the body for sclerotherapy.	TransLite

CMT CHALLENGE QUIZ

REBECCA MCSWAIN, PHD, CMT

1 CEC QUIZ
CLINICAL MEDICINE

This section is designed for CMTs who wish to earn continuing education credits. Select the most correct answer to the questions provided. You will find answers and study guidance at the end of this section.

1. The medication Spinosad was approved in 2011 by the US Food and Drug Administration; what condition would it be used to treat?
A) Congenital heart disease.
B) Pediculosis capitus.
C) Bronchospasm in children.
D) Varicella zoster.

2. What do the terms "thelarche" and "pubarche" refer to?
A) Abnormal hormonal activity.
B) Diagnoses in pediatric psychiatry.
C) Onset of puberty.
D) Indications of fetal maturity.

3. What condition is suggested by high levels of tTG antibodies?
A) Asthma.
B) HIV.
C) Hodgkin disease.
D) Celiac disease.

4. What is a common procedure used to treat ankyloglossia?
A) Frenotomy.
B) Tonsillectomy.
C) Fistulectomy.
D) Syringectomy.

5. An individual receiving a trivalent inactive influenza vaccine (TIV) is carefully observed for a period after vaccination for signs of possible anaphylaxis. Why is such observation recommended for this patient?
A) Because all vaccinations cause anaphylactic shock.
B) The patient has an egg allergy.
C) Risk managers at clinics and hospitals require all vaccination patients be observed in this manner.
D) The patient is gluten intolerant.

6. The Centers for Disease Control recently recommended treatment with Menactra® for children ages 9 to 23 months who are at risk of exposure to what disease?
A) Meningococcal disease.
B) Malaria.
C) Hepatitis B.
D) Chagas disease

7. What disorder can result from an infection with Group A beta-hemolytic streptococci?
A) Schizophrenia.
B) Prader-Willi syndrome.
C) Sydenham chorea.
D) Marfan syndrome.

8. What is one sign of the presence of Trisomy 13 in a newborn?
A) Very low birth weight.
B) Large for gestational age.
C) Congenital absence of external genitalia.
D) Polydactyly.

9. What disease is caused by a defect in the gene on chromosome 11 that codes for part of the hemoglobin protein?
A) Marfan syndrome.
B) Chagas disease.
C) Sickle cell disease.
D) Patau syndrome.

10. A mutation in the SERPINA 1 gene on chromosome 14 results in a condition affecting the lung alveoli, with symptoms of shortness of breath. What is the name of this condition?
A) Acute bronchitis.
B) Alpha-1 antitrypsin deficiency.
C) Pachyonychia congenita.
D) Cri-du-Chat syndrome.

11. A blood sample taken from a newborn's heel is analyzed for elevated leucine levels. What condition is this test designed to detect?
A) MSUD.
B) ASCVD.
C) HIV.
D) ARDS.

12. What is a mode of transmission of rhinovirus infection?
A) Genetic inheritance.
B) Fecal-oral.
C) Droplet contact.
D) Indirect via vectors.

13. National US guidelines recommend all pregnant women be screened for HBsAg. What is the purpose of this screening?
A) To identify HIV-positive women.
B) To screen for a group of genetic disorders related to blood chemistry.
C) To evaluate for the presence of sickle-cell disease.
D) To check for the presence of maternal HBV infection.

14. Which is considered to be the most commonly inherited neurological disorder?
A) Krabbe disease
B) Charcot-Marie-Tooth
C) Cystic fibrosis
D) Stickler syndrome

15. What neonatal condition often requires surgery soon after birth?
A) Omphalocele.
B) PKU.
C) X-ALD.
D) Cystic fibrosis.

16. Which statement about total bilirubin levels is true?
A) Normal levels in neonates are always less than normal levels for adults.
B) A level of 7 mg/dL would be considered normal in a 2-day-old infant.
C) Normal levels are the same for full-term infants as for premature infants.
D) A level of 0.1 mg/dL would be considered normal in an infant at 24 hours of life.

17. What fetal condition can be detected by maternal AFP screening?
A) Open neural tube defect.
B) Marfan syndrome.
C) Fetal aortic stenosis.
D) IUGR.

18. What is the function of a surfactant?
A) Used as a treatment for gastroschisis.
B) Prevents collapse of lung alveoli.
C) Supports liver function in neonates.
D) Delays the onset of premature labor.

19. What are milia?
A) Warts.
B) Rash caused by coxsackievirus.
C) Microscopic parasites.
D) Keratin-filled cysts.

20. What is fragile X syndrome?
A) A metabolic deficiency that affects only male newborns.
B) The most common form of inherited intellectual disability.
C) A genetic defect that always causes early spontaneous abortion.
D) A metabolic deficiency that affects only female newborns.

FIND ANSWERS AND GUIDANCE ON NEXT PAGE

ANSWERS AND GUIDANCE

1. Answer B: This new insecticide, a combination of spinosyn A and spinosyn D, was approved as a topical suspension in 2011 for treatment of head lice, marketed under the name Natroba.

2. Answer C: "Thelarche" refers to breast development, and "pubarche" refers to the development of pubic hair.

3. Answer D: High levels of anti-transglutaminase antibodies (ATA or anti-tTG) are seen in the vast majority of patients with celiac disease.

4. Answer A: The efficacy of this repair of what is commonly called "tongue-tie" has been demonstrated in a recent study; the procedure results in improved breast-feeding.

5. Answer B: A small amount of egg protein is present in influenza vaccines, but patients with mild egg allergies can receive certain kinds of influenza vaccines without harm; however, it is recommended that some simple precautions, such as careful observation, be taken after administration of the vaccine.

6. Answer A: Children traveling to sub-Saharan Africa, for example, may be exposed to Neisseria meningitidis, the bacterium responsible for this infection.

7. Answer C: This syndrome, once known as St. Vitus' Dance, is characterized by jerking movements of the face, feet and hands, and occurs more commonly in female children under 18 years of age.

8. Answer D: This genetic disorder results from an individual having three copies of chromosome 13 instead of the usual two. It is not thought to be inherited, but to be the result of an adverse event in the sperm or the egg that form the fetus.

9. Answer C: This condition is inherited when both parents transmit a copy of the defective gene to their children.

10. Answer B: Sometimes misdiagnosed because symptoms are similar to other respiratory conditions, this condition has no cure, but progression can be slowed by augmentation therapy with injections of alpha-1 antitrypsin from healthy donors.

11. Answer A: Maple Syrup Urine Disease results from a genetic defect that prevents breakdown of a group of amino acids, including leucine. Build-up of these proteins in the blood can cause degeneration of brain cells and death if left untreated. A sign of the condition is that the infant's urine is sweet-smelling, hence the "maple syrup urine" name.

12. Answer C: This very small enterovirus is responsible for the common cold and can also be transmitted by person-to-person direct contact.

13. Answer D: Neonates born to women infected with hepatitis B are at extremely high risk of developing chronic hepatitis infection unless treated with immunoprophylaxis within 12 hours of birth. Screening for the hepatitis B surface antigen (HBsAg) in pregnant women can identify high-risk infants.

14. Answer B: This disorder (CMT) affects nerves controlling muscle and results in gradual loss of normal function in extremities. It occurs equally in all ethnic groups world wide.

15. Answer A: Protrusion of viscera through the umbilical opening is usually repaired soon after birth, but timing of surgery can depend upon the severity of the defect.

16. Answer B: It should be remembered that normal values for bilirubin, like those for many lab values, can vary from lab to lab and must be evaluated on an individual basis. In general, newborn infants have a higher turnover of red blood cells and thus a higher level of bilirubin (a product of normal red-cell breakdown) than adults. If the level is too high, however, it can result in jaundice and other complications.

17. Answer A: This blood test establishes the level of alpha-fetoprotein in maternal blood; elevated levels can indicate the presence of spina bifida and other conditions; AFP testing is usually done as part of a "triple screen" or "quad screen." Positive results will typically lead to further diagnostic testing.

18. Answer B: A deficiency of this naturally occurring lipid-and-protein substance can occur in premature infants, preventing normal breathing and requiring replacement therapy with a synthetic surfactant.

19. Answer D: These small cysts are fairly common occurrences in newborns, especially around the eyes or inside the mouth (also called Epstein pearls), and heal spontaneously a few weeks postpartum.

20. Answer B: This condition results from a defect in a gene called FMR1 located on the X chromosome; it tends to affect boys more severely than girls, but occurs in both sexes, and causes a suite of various behavioral and physical changes. **P**

Rebecca McSwain, PhD, CMT, *serves the health documentation industry as Professional Programs Associate at AHDI. Rebecca is an educator, researcher and writer, and a medical transcriptionist with over 30 years of acute care, clinic, and office experience. She has worked as an on-site and home-based production MT, supervisor, and QA manager.*

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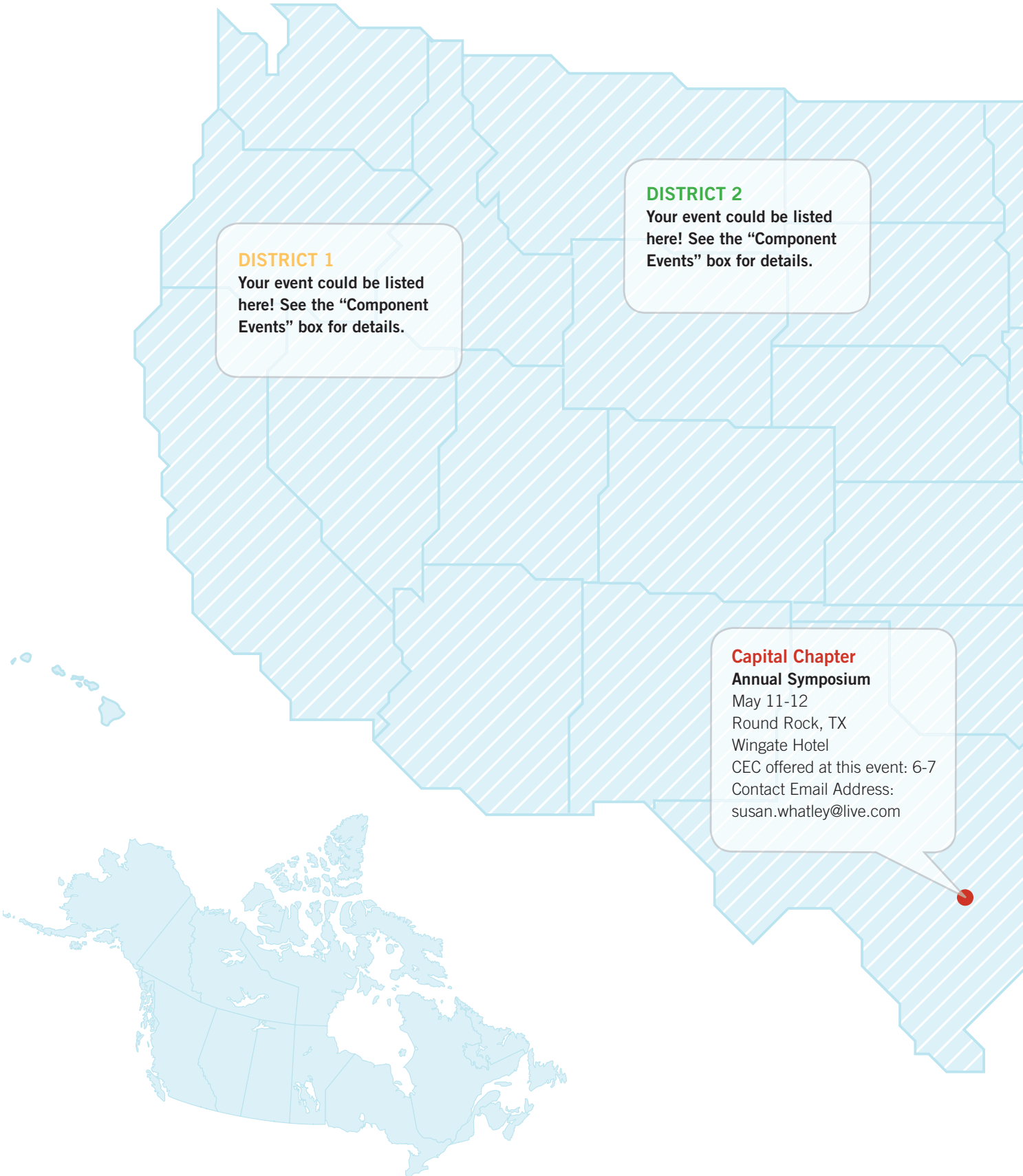

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West Michigan Chapter
Spring Symposium
April 28
Grand Rapids, MI
Hilton Grand Rapids Airport
Contact Email Address:
cklipski@comcast.net

Mid-Michigan Chapter
March 10
Bavarian Inn Lodge
Frankenmuth, MI
5 CECs offered at this event
Contact: kdmngz@yahoo.com
Website: mmc-ahdionline.org

Granite State Chapter
Business Meeting
March 10
Concord Hospital
Concord, NH
2 CECs offered at this event
Contact Email Address:
dmariejacobs@comcast.net

AHDI Annual Conference & Expo (ACE)
August 8-11
JW Marriott Indianapolis
Indianapolis, IN
Website: ACE365.org

Ohio Valley Chapter
Spring Symposium
April 13-14
Oglebay Resort & Conference Center
CECs Offered: 7
Contact Email Address:
lawilmotcmt@comcast.net
Website: www.ov-ahdi.com

AHDI-Florida
Annual Meeting & Educational Conference
May 4-5
Daytona Beach, FL
The Shores Resort & Spa
CECs offered: TBA
Contact:
susan.whatley@live.com
Website: ahdi-fl.org

COMPONENT EVENTS

Do you know of an educational seminar, study group, webinar, or other event of interest to members not listed here? Get the word out about your component's event by submitting your event information at www.ahdionline.org / Get Connected / Events / Event Calendar. Your information will appear in AHDI's Online Event Calendar as well as in *Plexus* magazine, and it's free!

Check the Online Event Calendar frequently for events and updates not listed here.

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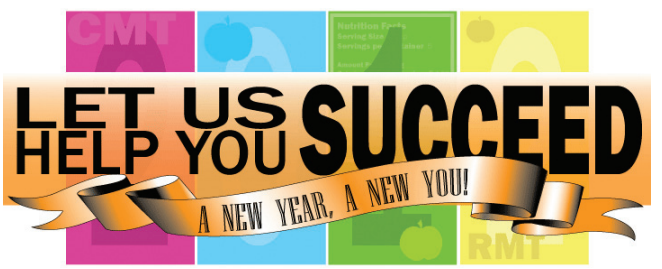
Funds from our new Visa program go to benefit the Association for Healthcare Documentation Integrity. Thank you for choosing and using your favorite card.

ACE 2012 REGISTRATION NOW OPEN AND PAYMENT PLAN OPTION AVAILABLE!

Spark Your Growth at the 2012 Annual Convention and Expo! Registration for this exciting event is now open and payment plans are available. Register for this event today to be one of the first 250 registrants and get our early-bird discount!

Make the most of your ACE 2012 experience by booking your room at the JW Marriott Indianapolis and becoming an ACE VIP! Find out more about the ACE VIP program at ACE365.org.



THIS IS THE YEAR TO GET CERTIFIED—AND WE'RE GOING TO HELP YOU DO IT!

The Let Us Help You Succeed program is our way of reaching out to MTs and providing them with the tools, knowledge, and resources they need to succeed with their credentialing goals. It's a forum where we can provide tips on setting a credentialing resolution that you can keep, and a place where we're always cooking up new "Recipes for Success." This is the place to come to help you refocus on your goals and propel yourself forward on the path to achieve them! Read full details of this program at ahdionline.org/succeed.

TIMELINE OF ACCOMPLISHMENTS—2011

Thanks to the engagement of all our volunteers and the work of staff during 2011, AHDI's many accomplishments continue to push this sector to the forefront of key industry stakeholder groups. Despite an unstable economy and the rate of change that's occurring in our sector, we have endured to offer relevant member programs and services. Take a moment to reflect on our 2011 achievements and ponder the possibilities for 2012 by clicking on "Timeline of Accomplishments" from the site index at ahdionline.org.

2012 AHDI INTEGRITY AWARDS—NOMINATIONS CLOSE APRIL 30, 2012

With the demands and challenges facing our sector, we hear so much about recognition of our workforce and the need to acknowledge the outstanding work being done by so many across the industry and within the association. AHDI's Integrity Awards program is designed to shine a spotlight on those individuals, organizations, and volunteer groups who are truly making a difference in our industry. Not only does this recognition program impact the individuals who are nominated and chosen for these awards, but it generates visibility around best practices and drives recognition of our industry in a public way. Do you know a CMT who has a passion for credentialing and helping others get credentialed? What about an MT educator who really made a difference to you as a student? Do you belong to an AHDI component that has done something innovative and engaging this year? Is your employer creating a corporate culture that has inspired you to excel? Every one of us knows someone who has made a professional impact over the last year.

Be a proactive colleague. Take the time to nominate that person or organization for one of these awards:

- **Hall of Fame Award**
- **Employer of the Year Award**
- **Membership Impact Award**
- **Rising Star Award**
- **Excellence in Credentialing Award**
- **Innovation through Technology Award**
- **Educator of the Year Award**
- **Advocate of the Year Award**

Nominations should be submitted electronically and are due no later than Friday, April 30, 2012. Nominees will be notified of nomination after committee vote and winners will be announced at the Integrity Awards Luncheon at AHDI Annual Convention and Expo in Indianapolis, IN. Visit the AHDI Integrity Awards page at ahdionline.org / Professional Practices / AHDI Integrity Awards for more information.

ACE 2011 DVD BOX SET

Give the gift of education this holiday season with the ACE 2011 DVD box set.

Over 30 CECs' worth of noteworthy material is available in this eight-disc set, which is ready just in time for the holidays!

Packed with fantastic educational sessions and keynotes, The Great Debate, and lots of bonus material, including the 2011 AHDI Integrity Awards, this DVD is the perfect opportunity to see everything you missed at ACE!

As an added bonus, there are three FREE sessions from the 2011 Annual Convention and Expo DVD available now - and they're all credit-worthy! Order your DVD and download your free sessions today from ahdionline.org/ACEDVD.

ACE CLUE GAME WINNER ANNOUNCED

Congratulations to **Kimberly Dingman** on winning the ACE 2012 Clue Game! Kimberly wins a free full registration to ACE 2012 in Indianapolis, Indiana, August 8 - 11.

Information about this year's conference can be found in this issue on pages 46-49 or visit www.ACE365.org.

SPARK YOUR GROWTH WITH DYNAMITE KEYNOTES AND EDUCATION

Keynote: Regina Holliday

Here, I Take My Stand

In her keynote presentation, patient advocate and artist Regina Holliday shares her personal story of trials with the health-care system and the struggle to get appropriate care for her ill husband.

At AHDI's 2012 Annual Conference, Regina will focus on the benefits of patient/caregiver access to the electronic health record (EHR), the great potential for catching errors in the medical record when multiple eyes combine with the tools of technology to focus on the record, and the improvement seen in emotional and clinical health when open communication in relation to the EHR is established.

Keynote: Karen Loucks Rinedollar

Working for Peanuts and Loving it!

Award winning speaker Karen Loucks Rinedollar uses her presentation to detail a journey of comforting young cancer patients with handmade security blankets, a project she aptly entitles Project Linus.

ACE 2012 attendees will not only be inspired by her efforts but will emerge with renewed commitment to achieve the seemingly unachievable, move past unexpected obstacles and endless challenges, and embrace a new spirit toward their lives and work. Karen's program personifies the spirit of commitment and perseverance that will compel listeners to conquer life's challenges—one day at a time.

Dynamic EHR—Related Break-Out Sessions

The national project to implement electronic health records for all Americans is in full swing. With a July 2013 deadline looming, 2012 and 2013 are shaping up to be landmark years in EHR adoption. AHDI is excited about the variety of opportunities that are going to open up for proactive MTs in clinical documentation and is sharing the excitement at ACE in 2012. These stimulating sessions will explore EHR technologies, explaining meaningful use, and study real-world cases of EHR implementation. Join us for a series of sessions that will help you find your future in this challenging new environment.

2012 Managers/Supervisors Workshop

Friday, August 10, 2012, 7:45 a.m. – 10:45 a.m.

Join us for the 7th annual Managers/Supervisors Workshop at ACE 2012. This workshop focuses on how managers and supervisors can contribute to their organization's initiatives to improve patient safety, increase reimbursement, promote better clinical outcomes, lower risks, etc. Interactive sessions throughout the morning will explore the evolving role and contribution of medical transcription in healthcare organizations, as well as provide practical guidance on monitoring and maintaining productivity, quality, and staff satisfaction.

ACE 2012

ENJOY INDY IN THE SUMMER!

Reserve Your Room at the Conference Hotel!

By making your reservation at the AHDI conference hotel, you're supporting your organization and helping us to keep our contractual requirements.

The JW Marriott is located conveniently in downtown Indianapolis, just steps away from over 200 shopping, dining, and entertainment options! Complete with a lounge, a 24-hour full-service business center, distinctive dining, day spa service, and a state-of-the-art fitness center and indoor pool, the JW Marriott Indianapolis is the premier choice.

AHDI has secured a room rate of $175 plus tax per night (single/double) at the JW Marriott Indianapolis. Room-sharing options are also available. To book your hotel online or for more information about room-sharing, visit www.ACE365.org.

Summer Fun Welcome Reception & Exhibit Hall Opening

Celebrate summer in true Indy style at our Summer Fun Welcome Reception & Exhibit Hall Opening! Don't miss this opportunity to visit with exhibitors and fellow attendees and partake in your favorite summer treats, all in your flip-flops and favorite pair of shorts. This is the backyard barbeque you won't forget—done up in true ACE-style!

Stay at the JW Marriott and Be a VIP!

Staying at the JW Marriott allows you to reap even more rewards! ACE 2012 full registrants who book three (3) or more nights at the JW Marriott are automatically registered for the ACE 2012 VIP Package, which includes the following benefits not included in full registration:

ACE 2012 benefits

- VIP Meet & Greet Lunch on Friday, August 10, with ACE keynote speaker Karen Loucks Rinedollar
- Buffet lunch on Saturday, August 11
- Two (2) free drink tickets for the Closing Awards Banquet on Saturday, August 11
- Entry into VIP exclusive raffles for limited edition framed/signed images developed by ACE 2012 Opening Keynote Regina Holliday (15 winners)
- Entry into VIP exclusive raffles for original paintings created on-site by Regina Holliday at ACE 2012 (5 winners)

JW Marriot benefits

- 50% off Internet in the JW Marriott
- 10% discount in the JW Marriott's restaurant outlets
- Self-parking discounted to $20

Visit www.ACE365.org to book your stay at the JW Marriott today!

Register Early!

The early-bird rate is available to the first 250 registrants, across all categories, so don't delay!

REGISTRATION FORM • AHDI 34th Annual Convention & Expo, Indianapolis, IN, August 8-11, 2012

Please print your name as it should appear on your badge. AHDI ID# _____
First name _____ MI _____ Last name _____
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Daytime Phone _____ Email _____

❑ Check here if you are disabled and require special services. Attach a written description of needs.

NOTE: Early bird price will be available to the first 250 full registrants across all categories. Regular price takes affect after 250 has been reached. Cancellation Policy: Refund requests must be written: $50 administration fee, No refunds after July 24, 2012.

FULL REGISTRATION

Full Registration includes:

First Time Attendee & New Member Orientation, Wednesday
"Summer Fun" Welcome Reception & Exhibit Hall Opening, Wednesday
Keynote Presentation, Thursday
Lunch in the Exhibit Hall, Thursday
Breakfast in the Exhibit Hall, Friday
Keynote Presentation, Friday
Closing Awards Banquet, Saturday
Educational Sessions, Thursday – Saturday
Exhibits, Thursday – Friday

	Assoc. Student, Student/Post-Grad Member	Individual Professional Member	Associate Member	List Price	Enter Fees Here
Early Bird Rate First (250) registrants	$300	$360	$470*	$600	_____
Regular Rate	$385	$460	$570*	$760	_____

*Includes upgrade to Individual Professional Membership

(2) representatives from each Corporate and Educational member may register at the Individual Professional Member Rate

SPECIAL EVENTS/WORKSHOPS (not included in Full Registration)

	Regular	On-site	
Leadership Summit, Wednesday	❑ $20	❑ $30	_____
Managers/Supervisors Workshop, Friday	❑ $75	❑ $85	_____
***VIP Meet & Greet Lunch with Keynote,** Friday	❑ $60	❑ $70	_____
***VIP Lunch Buffet,** Saturday	❑ $60	❑ $70	_____

***These events are included with Full Registration for guests staying at the JW Marriott at least (3) nights**

GUEST TICKETS

	Regular	On-site	
"Summer Fun" Welcome Reception & Exhibit Hall Opening, Wednesday	❑ $65	❑ $75	_____
Lunch in the Exhibit Hall, Thursday	❑ $40	❑ $50	_____
Breakfast in the Exhibit Hall, Friday	❑ $35	❑ $45	_____
Closing Awards Dinner Banquet, Saturday	❑ $65	❑ $75	_____
Exhibit Hall Pass, Friday–Saturday *(does not include access to food in the exhibit hall)*	❑ $85	❑ $105	_____

Note: One exhibit hall guest pass included with purchase of full registration. Guest pass includes access to exhibit hall on Thursday, 8/9 and Friday, 8/10 only. It does not include food and beverage service. **Guest Badge Name:** _____

ONE-DAY REGISTRATION FEES

❑ **Thursday** (keynote, lunch in exhibit hall, ed. sessions, exhibits)
❑ **Friday** (breakfast in the exhibit hall, keynote, ed. sessions, exhibits)
❑ **Saturday** (ed. sessions, closing awards banquet)

	Assoc. Student, Student/Post-Grad Member	Individual Professional Member	Associate Member	List Price	
Regular Rate **By 7/23/12**	$165	$190	$260	$320	_____
On-site Rate **Begins 7/24/12**	$210	$240	$335	$410	_____

DISCOUNTS *(if applicable; discounts cannot be combined)*

❑ Other coupons or discounts (please list): _____

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Check here if you are NOT a Medical Transcriptionist: ❑ Please select your PRIMARY work setting location: ❑ At Home ❑ On-site

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❑ HIT Application/Software Developer

NOTE: All registrants must abide by AHDI policies (1) that restrict the demonstration of products, solicitation of orders, processing of sales, and distribution of advertising matter to individuals, business firms, manufacturers, and dealers who have contracted and paid for space assignments in the AHDI exhibit hall or advertising space in the AHDI Annual Convention program, (2) prohibit the audio or video taping of presentations, except by those authorized by AHDI to do so and (3) state that portions of this event may be photographed, videotaped, or recorded. By registering, you grant to AHDI the right to photograph, videotape, and record you and your property at the event and authorize AHDI to copyright, use, and publish the same in print and/or electronically. If you do not agree, please contact AHDI for special arrangements.

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Payment by personal check, money order, or credit card is accepted (US funds only) payable to AHDI: No purchase orders. Credit card registrations accepted by phone 800-982-2182, fax 209-527-9633, or mail at 4230 Kiernan Ave, Ste. #130, Modesto, CA 95356.

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You're Invited...to ACE, the largest event of the year for the healthcare documentation sector!

Hundreds of your top prospects and customers converge at ACE every year to spark their growth and knowledge on the latest products and services the industry has to offer. Whether your goal is to recruit the best and brightest in the industry, boost brand awareness, or build new business relationships, ACE has you covered! With a big membership increase in a rapidly expanding field, there has never been a more critical time to be at ACE. Prospects/clients need your solutions now more than ever and will be looking for your booth in Indy! Don't miss this opportunity for year-long business development and growth.

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August 8 – 11, 2012

WHERE?

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WHO ATTENDS?

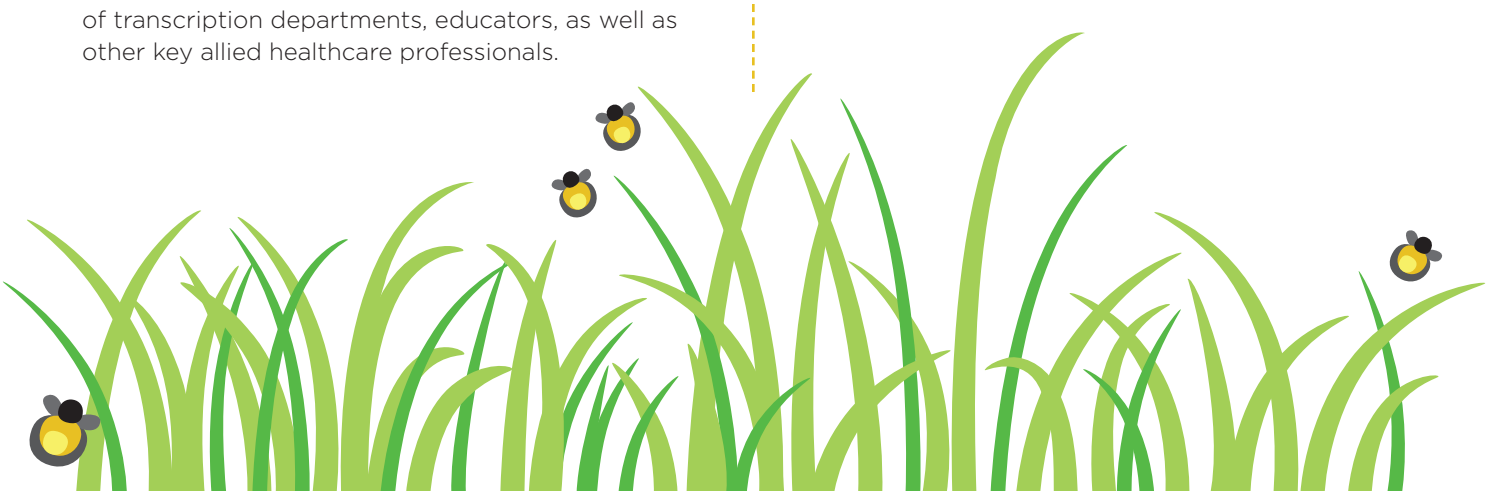
600 of the industry's top professionals and decision makers will be there. Attendees are owners of transcription companies, medical transcriptionists, medical records professionals, managers/supervisors of transcription departments, educators, as well as other key allied healthcare professionals.

TOP REASONS TO EXHIBIT AT ACE 2012

- MORE dedicated exhibit time with your prospects/clients
- REACH the most active members of AHDI as they review the newest products and learn about top employers in the industry
- NETWORK during the popular 3-Hour Welcome Reception on Thursday Night in the Exhibit Hall
- MAXIMIZE year round exposure by promoting your booth on ACE365.org, the 'one stop shop' for ACE 2012 attendees
- BUILD new business relationships to help your company grow along with the changing market

To find out about booth and sponsor availability, contact:

Shannon Reid, Sales Manager
410-584-1952
sreid@networkmediapartners.com



FUNNY BONE

TEACHER TOPICS*

Remembering the Great Charles Dickens

RICHARD LEDERER, PHD

Two centuries ago—on February 7, 1812—Charles John Huffam Dickens entered the earthly stage. Born into an impoverished family, his father having served a term in debtor's prison, Charles worked as a child slave in a London blacking factory.

The rags-to-riches life of Charles Dickens's was more remarkable than any of his stories. From such unpromising origins, he arose to become the best-selling writer of his time and one of the most enduring and quotable writers of all time.

What has been described as the most successful writing career in history was launched when Dickens was 24. On March 31, 1836, he published the first installment of a comic novel about a bunch of bumbling gentlemen who knock about England getting into various scrapes. At the center of the group was one of the greatest comedy teams in all literature—Samuel Pickwick, a fat retired businessman, and a jaunty young cockney by the name of Sam Weller. The novel emerged as *The Posthumous Papers of the Pickwick Club*, popularly known as *The Pickwick Papers*.

Following *Pickwick* came 14 more enormously popular novels, from *The Adventures of Oliver Twist*, or the *Parish Boy's Progress*, to the unfinished *The Mystery of Edwin Drood*, and hundreds of stories, including "A Christmas Carol."

How did Dickens do it? First and foremost, he possessed a preternatural feel and ear for the hum and buzz of human life. People and situations endlessly flared up in his imagination; he said he could literally hear what his characters said before he wrote the words down. A supporting cast of more than 300 fantastic bit players floats in and out of *Pickwick*; over his career Dickens gave birth to thousands of characters.

He possessed a preternatural feel and ear for the hum and buzz of human life.

Dickens not only wrote about people; he spoke to the people, who gobbled up every one of his books and stories. Like most of his works, *The Old Curiosity Shop* (1841) was published in serial form. The novel won a vast readership on both sides of the Atlantic, and as interest in the fate of the heroine, Little Nell, grew intense, circulation reached the staggering figure of 100,000. In New York, 6,000 people crowded the wharf where the ship carrying the final *Master Humphrey's Clock* magazine installment was due to dock. As it approached, the crowd's impatience grew to such a pitch that they surged forward and cried out as one to the sailors, "Does Little Nell die?"

Alas, Little Nell did die, and tens of thousands of readers' hearts shattered. The often ferocious liter-

ary critic Lord Jeffrey was found weeping with his head on his library table. "You'll be sorry to hear," he sobbed to a friend, "that little Nelly, Boz's little Nelly, is dead." Daniel O'Connell, an Irish M.P., burst out crying, "He should not have killed her," and then, in anguish, threw the book out of the window of the train in which he was traveling. A diary of the time records another reader lamenting, "The villain! The rascal! The bloodthirsty scoundrel! He killed my little Nell! He killed my sweet little child!"

That "bloodthirsty scoundrel" was himself shattered by the loss of his heroine. In a letter to a friend Dickens wrote, "I am the wretchedest of the wretched. It [Nell's death] casts the most horrible shadow upon me, and it is as much as I can do to keep moving at all. Nobody will miss her like I shall."

And let us not forget the incredible piston energy that drove the man. His contemporary, Leigh Hunt, said of Dickens: "What a face is his to meet in a drawing room! It has the life and soul in it of 50 human beings." Dickens did indeed possess the capacity of multitudes for work and play. In addition to pouring forth his literary works, he was a journalist, writer of long and vivacious letters, indefatigable walker, amateur theater producer and actor, and vastly popular lecturer and reader.

James Nathan Miller describes the results of Dickens's literary empathy and brimming vitality: "Incredibly, Dickens's career never had a pinnacle. It was *all* pinnacle. From the appearance of Sam Weller in 1836 to the day in 1870 when Dickens died while writing *The Mystery of Edwin Droid*, his career was like a Roman candle that went straight up and just hung there, shooting one brilliant shower after another." We today are still being showered by those sparks, as witness the more than one hundred motion pictures made from Dickens's works.

No wonder that G.K. Chesterton said of him:"Whatever the word *great* means, Dickens was what it means." **P**

Richard Lederer *is the author of more than 40 books about language, history, and humor, including his best-selling Anguished English series and his current book, The Gift of Age. He has been profiled in magazines as diverse as The New Yorker, People, and the National Enquirer, and frequently appears on radio as a commentator on language. Dr. Lederer's syndicated column, Looking at Language, appears in newspapers and magazines throughout the United States. He has been named International Punster of the Year and Toastmasters International's Golden Gavel Winner.*

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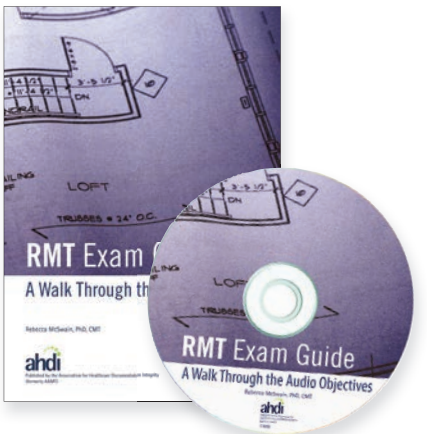

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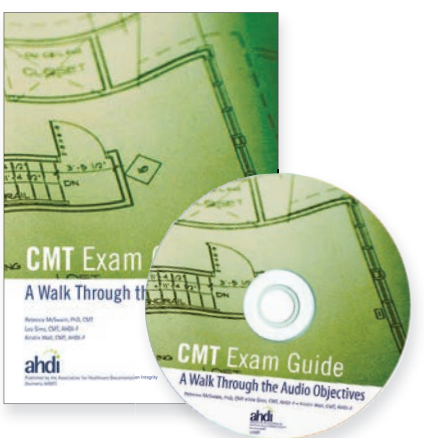

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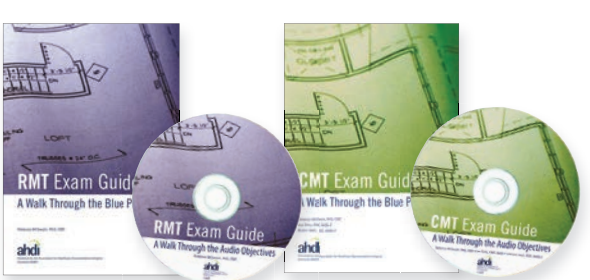

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