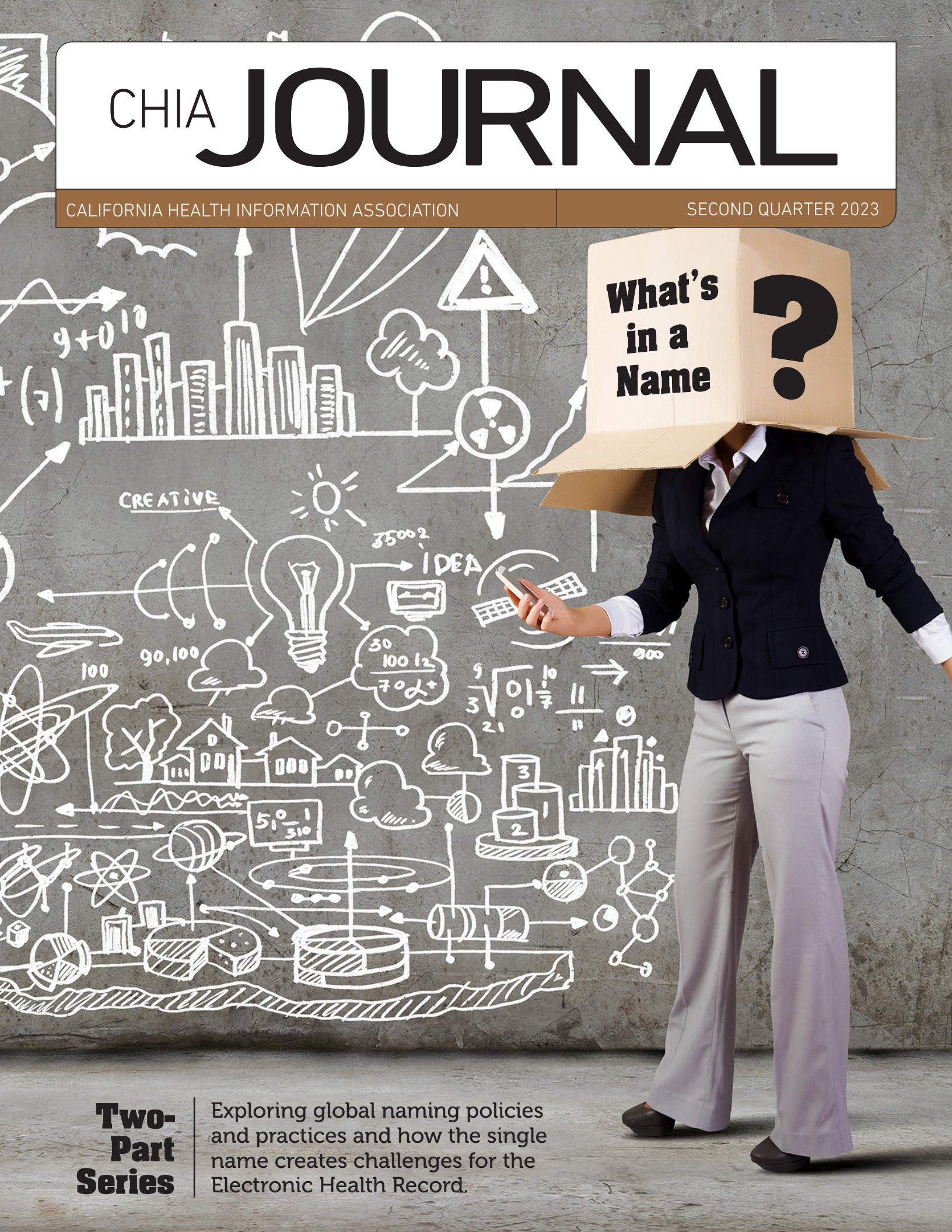
CHIA JOURNAL

CALIFORNIA HEALTH INFORMATION ASSOCIATION | SECOND QUARTER 2023



Two-Part Series

Exploring global naming policies and practices and how the single name creates challenges for the Electronic Health Record.

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CHIA JOURNAL

The CHIA Journal is an official publication of the California Health Information Association (CHIA).

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CHIA is a professional association chartered under California's non-profit corporate law. The quarterly *CHIA Journal* informs members about the activities of the association and educates readers in matters pertaining to health information.

Unsolicited articles are accepted for consideration at any time and should be sent to Journal@CaliforniaHIA.org. Requests for reprints should also be sent to this address.

A subscription to the *CHIA Journal* is included with CHIA membership. Complimentary copies are distributed to various affiliated healthcare organizations and to California Health Information Administration, Health Informatics, and Health Information Technology college programs.

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In Loving Memory

Marilyn Taylor, RHIT
1937 - 2023

CHIA is honored to dedicate this issue of the CHIA Journal to the late Marilyn Taylor, RHIT, whose legacy includes her contributions to the CHIA Editorial Advisory Board (EAB) and the many improvements to this award-winning publication over many years.

Marilyn joined CHIA in 1981, and for over 34 years served the association as an integral part of the Executive Office team. She held the title of Operations Manager and the Coordinating Editor of the peer-reviewed CHIA Journal, where she contributed much more than the operating procedures, checklists, and manuals. It was Marilyn's leadership that led to the formation of the EAB and the successful evolution and success of the bi-monthly association's publication.

In addition to her dedication to the Journal, Marilyn served as CHIA's Volunteer Coordinator where she brought her skills and knowledge of CHIA operations, strategies and goals to the grass-roots level of the volunteer committees and task forces. Marilyn's knowledge of CHIA's history and journey was extraordinary. She impacted many of our CHIA members with her many contributions that will continue to benefit the association and its membership for years to come.

Ellen MacDonald, MPH, RHIA, CCS was an alumnus of UCLA and began her career in medical records immediately after graduation. She served in several health information professional roles over the years which led her to AMI-Tenet as President, and STAT Healthcare Inc. as Vice President. She consulted in the health information field until her retirement. Ellen was a long-standing CHIA and AHIMA Professional member and a respected association leader. Ellen was active in the professional association and served as CHIA President during 1989-90 and served as President of AHIMA in 1994. She received CHIA's Distinguished Member Award in 1994 and AHIMA's Distinguished Member Award in 2002. Ellen was a professional mentor and friend to many and will be missed.

Ellen Kaye MacDonald,
MPH, RHIA, CCS
1950 - 2023

President's Message

Last Inning, Final Quarter, Second Half

THE BIG FINISH: HOMERUN, TOUCHDOWN, FINAL BASKET, GOAL

by Roberta Baranda, MS, RHIA, CHP

It is hard to believe that finishing the CHIA Presidency term is also the end of an important aspect of my professional journey. Being elected as CHIA President-elect by my peers was a dream come true. Knowing that my peers respected me enough to allow me to help lead them professionally through CHIA, inspired me in every way.

Recently, while enjoying my Saturday morning coffee and reading "one of my favorite magazines", yes, the Costco magazine, I discovered the article *Humble Leaders: How you see others is a key factor for success.* This article was written by Marilyn Gist, who is the author of *The Extraordinary Power of Leader Humility.* It opened with the question, "Should you care about being a leader everyone admires?" My first response after reflecting on this question was, absolutely. Beyond the goals I set for my Presidency, which included being inspirational, ensuring CHIA remains inclusive and always speaking with transparency; it was my hope that as an elected leader I served admirably and remained humble.

Humility in leadership is the ability to consider others' opinions, act with self-awareness and lead from a spirit of generosity. Humble leaders will lead with emotional intelligence and show appreciation for others while curating a work environment that prioritizes empowerment. Leaders that practice humility take responsibility for mistakes, strive for continual growth and encourage teamwork.

At a time when our organization and profession are undergoing very significant change, it is imperative that as CHIA professionals we are very self-aware and transparent. Without inspiration, transparency and humility, CHIA leadership will be challenged to pivot in the future. By the end of this term, together with the 2022-2023 CHIA Board and the House of Delegates (HOD), we are setting in motion changes that position CHIA in a favorable direction for the future.

Thank you to the 2022-2023 CHIA House of Delegates (HOD), in advance, as it continues to provide direction-setting guidance for CHIA's future. Thank you to the CHIA Board of Directors for its hard work and support throughout this year. Thank you to the Executive Office team and especially Sharon Lewis, CEO/Executive Director, for unyielding patience as I navigated the Presidency, and learned to lead through her support and direction from the CHIA staff.

As I prepare to become a Proud Past President and "pass the baton" on to Sally Gibbs, I share what I have learned this year in a few words:

- Be open to ideas and listen
- Be kind and be humble
- Connect with emerging professionals and "sponsor" their success
- Acknowledge the great ideas of others
- Find the "nugget"; there will be good days and bad days, but every day has gifts
- Care and volunteer

In closing, I am grateful and privileged to have had the opportunity to serve as a President of CHIA. As members of this esteemed association, we are fortunate to be part of an organization that values and recognizes the key contributions of HI professionals across the entire State of California. I look forward to having the opportunity to thank many of you in person at CHIACON23 this month.

Roberta Baranda, MS, RHIA, CHP
CHIA President, 2022-2023

Inside the California Health Information Association

THINGS YOU HAVE ALWAYS WANTED TO KNOW BUT WERE AFRAID TO ASK

by Sharon Lewis, MBA, RHIA, CHPS, CPHQ, CAE, FAHIMA and Cindy Doyon, RHIA

Have you ever wondered how things work at the California Health Information Association (CHIA)? CHIA CEO/Executive Director, Sharon Lewis answers questions about CHIA's structure, functions, mission and vision, branding, website, acronyms, etc.

What is CHIA? The California Health Information Association (CHIA) is a premier state association and the largest affiliate of the American Health Information Management Association (AHIMA). CHIA is California's voice for health information (HI) professionals. Our certified professionals serve as the State's leading voice and authority in health information, wherever it is found. We see the person connected to the data, ensuring information stays human – because when information stays human, it stays relevant. We are leaders, bridging roles in healthcare committed to *improved health through trusted information* with accurate, accessible, private and complete health information. Our professionals are dedicated to practice excellence because health information is human information.

How is CHIA structured? There are two distinct parts to CHIA. First is an Executive Office (EO) function that supports the activities, goals and initiatives of the membership. The EO is staffed by the CEO/Executive Director – Sharon Lewis, Operations and Finance Manager – Debi Boynton, Accounting and Member Database Administrator- Stefanie Granada, Membership & Event Coordinator - Janessa Moya,

Marketing/Communication Specialist - Mary Kay Campbell and Copy Editor – Cindy Doyon.

The second part of CHIA has several components. There is the Board of Directors (BOD) which includes a president, past president, president-elect and four board members. They are all elected positions. The BOD's primary responsibility is to ensure the association is fiscally sound and to meet the needs of California's HI Community. The Board determines strategies and initiatives, including defining numerous committees, task forces and short-term work groups that support CHIA's mission and vision and the directives of the Board. Its focus is on governance, being visionary and strategically moving CHIA forward. The BOD makes policy and financial decisions and sets a course for the future.

Currently there are seven Component Local Associations. They are geographic regions throughout the state. They have their own BODs and committees. They also have delegates that represent the best interests of their members by participating in a year-round virtual House of Delegates (HOD) and an annual business meeting. The HOD provides input to the BOD regarding direction, priorities, projects, initiatives and many other activities. The delegates are also elected.

CHIA is accountable to AHIMA and must meet its obligations under an affiliation agreement. There are Bylaws that govern CHIA's activities along with articles of incorporation. CHIA is a 501(c)(3) nonprofit public benefit corporation, first established in 1949 and can support no political activities.

The BOD and EO are a partnership and are in alliance, collaborating to achieve the goals of the organization.

Why does CHIA have an Executive Office and staff?
The EO and staff support the activities, mission and vision and the HI members of CHIA – the day-to-day operations. They often answer HI-related practice questions. They schedule, coordinate, and promote learning, making sure there are speakers for educational sessions including face-to-face education events, webinars, eLearning programs, the annual CHIACON meeting along with working with vendors coordinating the Exhibit Hall. They process all the payments for the annual dues, educational sessions and products such as the Subpoena and Release of Information manuals. Staff coordinate obtaining, organizing and publishing the peer-reviewed *CHIA Journal*. Staff also support the BOD and all of the volunteer activities including committees and task forces by communicating agendas and minutes, scheduling face-to-face and online meetings and regular follow-up. Staff coordinates the annual CHIA and CLA elections processes and member recognition awards. At the Board's direction, the staff holds and administers CHIA's annual Awards and Scholarship Program that provide student scholarships, research support, CAHIIM-accredited California Health Information and Informatics program grants, certification exam reimbursement and awards for active member continuing education, along with recognizing HI professionals accomplishments. Lastly, they maintain the CHIA Website, including the membership database and learning management system.

What are the CHIA Vision, Mission and Core Values?

Vision - Improved health through trusted information

Mission - Develop health information professionals and advocate for practice excellence

Core Values - Collaboration / Diversity / Innovation / Leadership / Integrity / Transparency

Why do CHIA members pay additional dues when AHIMA says State membership is complimentary?
HI professionals who are members of AHIMA are automatically members of CHIA, the largest state association. They receive basic benefits such as access to continuing education, membership communication and advocacy initiatives. In order to access more robust and expanded benefits, including local educational and networking opportunities, a nominal fee of less than a monthly cup of coffee for an upgraded membership is needed. These somewhat intangible benefits include building meaningful relationships through collaboration with California's HI leaders. CHIA's upgraded membership provides a platform to discover new networking opportunities, innovative HI pathways and lifelong partnerships that can make a difference in a career. For a minimal investment, discounted leading-edge member-driven education programs, an online subscription to the *CHIA Journal* and more are received.

What are the additional benefits of an upgraded membership?

- The recently improved CHIA website provides its members a place to discover new and innovative HI pathways, access CHIA member-only content, view leading-edge resources, uncover educational content, connect with HI professionals across California and develop life-long relationships that make a difference

What kind of memberships are available in CHIA?
CHIA has three membership categories. Each category pays a different amount of dues.

- **CHIA Professional Member -** AHIMA Professional members who designate California as their state association and are invited to upgrade their membership to CHIA Professional level
- **CHIA Emerging Professional (Student) Member -** AHIMA Student members who designate California as their state association and are invited to upgrade their membership to CHIA Emerging Professional
- **CHIA Professional Emeritus Member -** AHIMA Professional Emeritus members who designate California as their state association and are invited to upgrade their membership to CHIA Professional Emeritus

Why should I pay the additional dues? What do I get for the money?
For less than a monthly cup of coffee, expanded members receive additional value when they invest and upgrade their membership. Their professional value is elevated with CHIA, through **LEAD –** *Leadership, Education, Advocacy* and *Discovery.*

- *Leadership* through mentorship, development, and volunteer opportunities
- *Education* that is California-focused, member-driven and relevant at CHIA-exclusive discounts
- *Advocacy* as a voice for legislation that positively affects the State's healthcare landscape
- *Discovery* of new and innovative HI pathways, networks and partnerships that make a difference through community connection and content using CHIA's technology platform

What does LEAD stand for? ***L***eadership, ***E***ducation, ***A***dvocacy and ***D***iscovery. These are the four member initiatives that drive CHIA's strategy and direction. CHIA community engagement prepares passionate forward-thinking HI leaders to be catalysts in driving improved health through trusted information

Leadership

- Build meaningful relationships through collaboration with California HI leaders from major healthcare entities
- Mentorship from seasoned career HI Professionals dedicated to developing future leaders who advocate for practice excellence
- Member-leader growth through service: CHIA/Regional Board of Directors; House of Delegates; Committee/Task Force Chair or Member

Education

- Leading-edge member-driven education programs, including eLearning Programs, Live Webinars, Webinars on Demand, CHIACON, publications and more. Obtain valuable continuing education (CEUs) at a "CHIA membership-only discount" (up to 25%).
- Career-relevant expertise from management to the governance of health information and proven leading-practice solutions
- Preparation of members to serve as educational resources for patients and healthcare providers across the entire continuum of care
- *CHIACON: CHIA's* annual education, networking convention and exhibit

Advocacy

- Advances California's health information advocacy initiatives while serving on CHIA's Legislation and Advocacy Committee
- Prepares HI professionals to advocate for meaningful state legislative and regulatory changes impacting HI across the information lifecycle
- Member-to-Member coalition catalyzes the HI professional's confidence in advocating for health information integrity and the individual's right to access their health information
- Endorses *improved health through trusted information* and maintain *health information is human information.*

Discovery

- Discovers peers, colleagues and mentors open to sharing HI operational insight and proven best practices
- Discovers various health information pathways while engaging with California's seasoned health information professionals
- Discovers opportunities to demonstrate value as a health information professional
- Discovers confidence, inspired by sharing health information knowledge and expertise with new and emerging professionals

How is the CHIA BOD structured?
There are currently seven elected members of the BOD - a past president, president, and president-elect, four members who are on the BOD for a two-year term which is staggered so that there is consistency every year and CHIA's Executive Director who serves as an additional non-voting resource.

How many CHIA Committees and Task Forces are there?
For the 2022-23 year (which runs from July to June) there are eleven groups, supporting CHIA's mission and vision.

Why are there so many CHIA emails?
CHIA publishes a weekly bulletin that includes events and news. Other emails that you may receive are related to CLA communication, purchases and committee/task force responsibilities. In addition, you may receive emails if you have signed up for them when using the CHIA website and the HI Community platform.

What social media sites does CHIA actively post on?
LinkedIn, Facebook, Twitter and Instagram.

Sharon Lewis, MBA, RHIA, CHPS, CPHQ, CAE, FAHIMA | CHIA
Cindy Doyon, RHIA | CHIA

Coding Changes

MID-YEAR 2023

by Monica Leisch, RHIA, CDIP, CCS

The Centers for Disease Control and Prevention (CDC) released coding changes effective April 1, 2023. Let's look at the changes and how coding will be affected.

There are 42 diagnosis code additions, seven deletions and one code revision. *The ICD-10-CM Official Guidelines for Coding and Reporting* now include more guidance on Social Determinates of Health (SDOH). There are no changes to the PCS data set.

Chapter 19, Injuries, Poisoning and Other Consequences of External Causes (S00-T88) has new codes for adult or child financial abuse.

Chapter 20, External Causes of Morbidity (V00-Y99) includes many changes. Perpetrator of maltreatment and neglect was further subdivided to allow for the capture of current or former husband, wife, male and female partner. Non-binary partner, child, grandchild, grandparent, parental sibling, and acquaintance or friend perpetrator of maltreatment and neglect were added.

THE ICD-10-CM OFFICIAL GUIDELINES FOR CODING AND REPORTING NOW INCLUDE MORE GUIDANCE ON SOCIAL DETERMINATES OF HEALTH (SDOH).

Chapter 21, Factors Influencing Health Status and Contact Health Services (Z00-Z99) also reflects many changes. A new code for problems related to health literacy was added. Two codes to designate services unavailable in the physical environment were added; one to show unavailable basic and one to show other services. The code for inadequate housing was further separated to include a subdivision for environmental temperature, inadequate housing, utilities, other and unspecified. The Material hardship code was revised to include hardship due to limited financial resources. Personal history of abuse added codes for child financial abuse, intimate partner abuse in childhood, adult financial abuse and adult intimate partner abuse. The code for patient other noncompliance with medication regimen was further divided to include a code for other noncompliance with medication regimen due to financial hardship and one for other reasons. The code for Patient's noncompliance with renal dialysis was also divided to show noncompliance for financial hardship and other renal dialysis for other reasons.

The Official Guidelines for Coding and Reporting added revisions to better define SODH by incorporating the words "social" and "condition" and include situations documented during the current episode of care. Further examples for the coding of SODH were added. An example cited is that of a patient living alone who may suffer an acute injury temporarily impacting their ability to perform routine activities of daily living would support assignment of code for Problems related to living alone. However, if the patient is living alone and a risk or unmet need for assistance at home is not documented, the case would not qualify for the assignment of this code.

Becoming familiar with these changes will provide for better coding and reporting when the documentation is present.

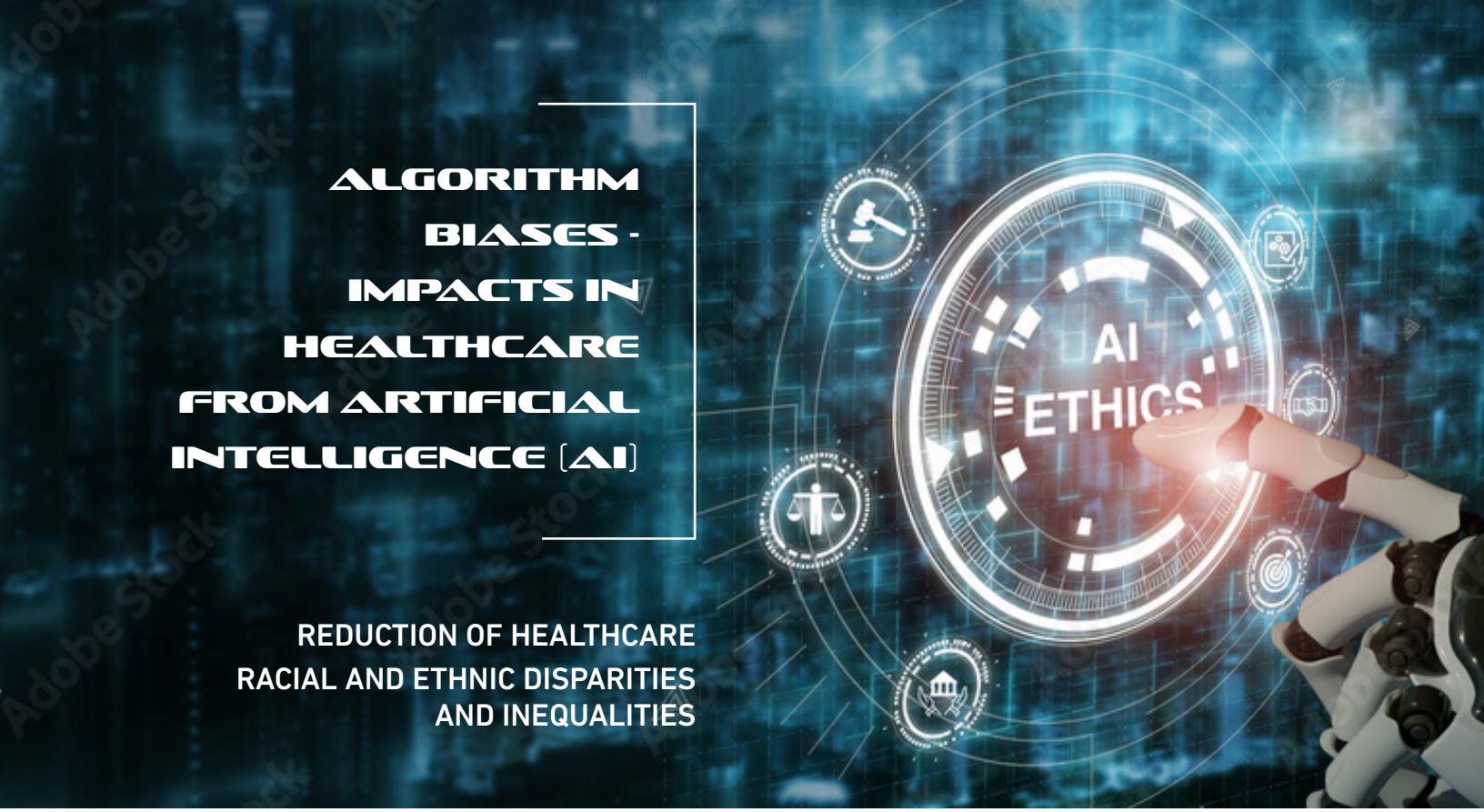
Resources

https://www.cms.gov/medicare/icd-10/2023-icd-10-cm

Official Guidelines for Coding and Reporting, April 1, 2023

Monica Leisch, RHIA, CDIP, CCS, Member CHIA CDQ Committee

ALGORITHM BIASES - IMPACTS IN HEALTHCARE FROM ARTIFICIAL INTELLIGENCE (AI)



REDUCTION OF HEALTHCARE RACIAL AND ETHNIC DISPARITIES AND INEQUALITIES

by Sharon Schuman, RHIA, CDIP, CCS and
Timothy (Tim) Cole, MS, RHIT, CCPHM

Do you have an ingrained idea that machines, computer programs and coded language are somehow missing the ingredients that make us human, and sometimes, those things that make us ashamed to be human? Machines don't have empathy and they are supposed to be "color-blind." In an introduction to computer science class, many learn software programs are written in a language of 0s and 1s, using mathematical logic to perform functions. So, how can Artificial Intelligence (AI) algorithms be racist, sexist or exhibit those human characteristics we find problematic (at the very least) and reprehensible (at the very worst) when expressed in ourselves as humans?

One definition of algorithms from the Agency for Healthcare Research and Quality (AHRQ, 2022) states: "Algorithms are defined as mathematical formulas and models that combine different variables or factors to inform a calculation or an estimate – frequently an estimate of risk". Healthcare algorithms are used to guide clinical decision-making, resource allocation and health information (HI). Resource allocation includes utilization of worksites, equipment, supplies and workforce staffing. Health information includes administrative/clinical input, storage, retrieval and output – such as a designated record set as defined by a covered entity following HIPAA

requirements. Algorithms' importance has increased with the growth of electronic health records (EHRs) throughout healthcare systems.

Algorithms, as stated in an article by Jim Hoover, titled: "Algorithmic Bias, Be Aware of the Possibility", published in the CHIA Journal Jan-Feb, 2022 edition, are integral to software programs used in healthcare decision tools, such as support programs (automatic reconciliation - master patient index correct identification of a patient with a correct medical record number, therefore the elimination of overlays and overlaps), in electronic health records (EHRs) and operational systems used by healthcare systems and payers (health reimbursement payments). It is an easy stretch to understand how the ills of societal or historical inequities are propagated in computers in AI. These inequities involving racism, sexism, classism, colorism, caste, negative religious denomination views and ethnic or cultural biases, can permeate computer programs and machine learning.

Computer programming and AI development are largely the functions of systematic work hegemony among a significant number of influential Caucasian white males of privilege. Many examples of algorithmic bias can be seen, most notably in facial recognition software programs; however, in HI systems, they are most glaring in medical record searches and retrieval. Medical record patient information data is codified and stored by last name, first name, middle initial or middle name and often suffix. This does not account for common naming conventions for those from other countries.

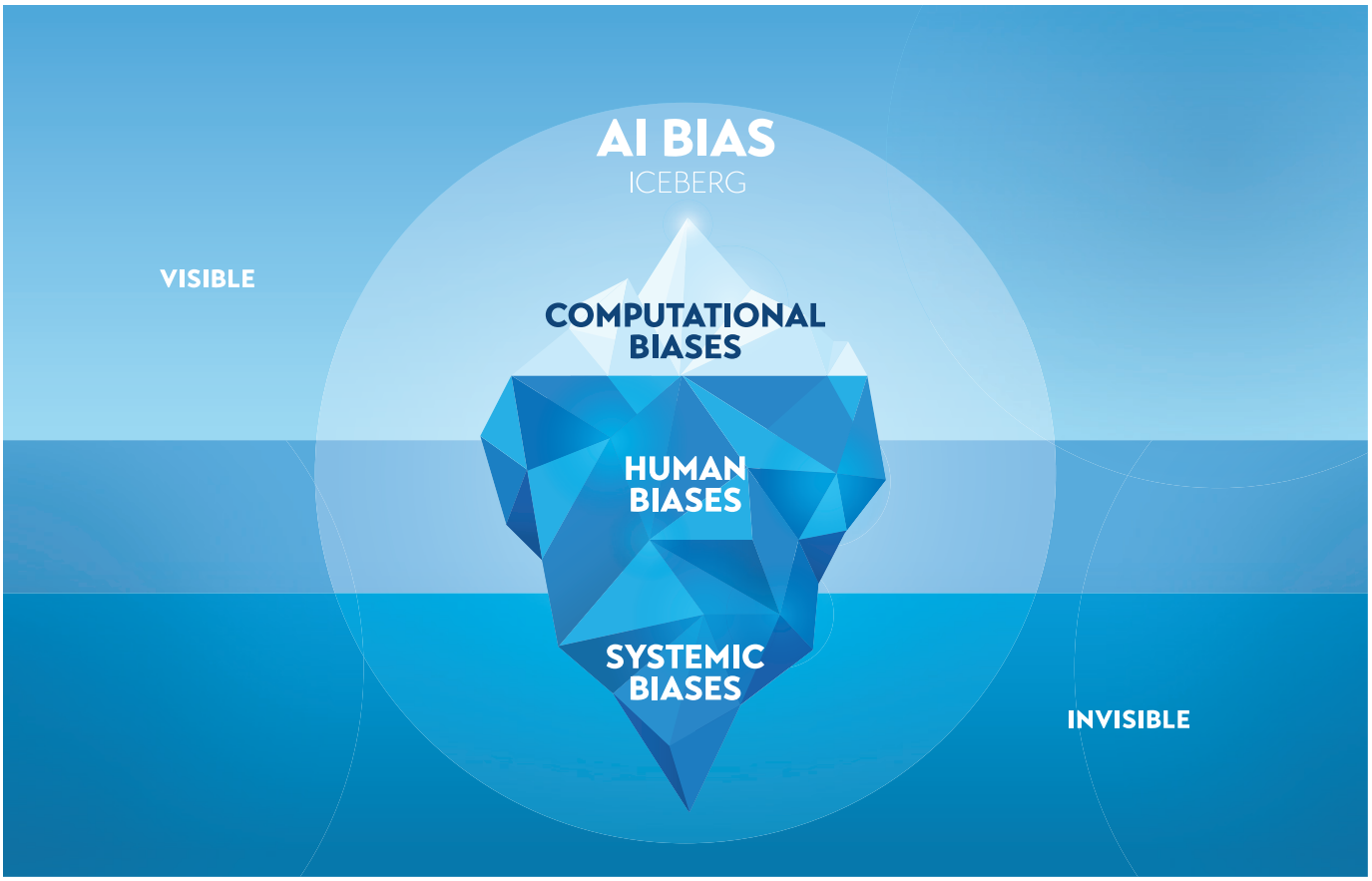
Dr. Tinmit Gebru PhD., is the Founder & Executive Director at the Distributed AI Research Institute (DAIR). She is a female, Ethiopian-born, American computer scientist and leading researcher with expertise in algorithmic bias and data mining disciplines. Dr. Gebru is an advocate for diversity in e-technology and co-founder of Black in AI, which is a community of Black researchers working in AI. Her name was widely mentioned in AI press circles because of controversy about whether she was forced to resign or willingly left her position at Google as a top ethics researcher in December of 2020 (Gao). Her resignation was believed to be the result of a draft research paper she and her coauthors were getting ready to publish. The findings of the research draft highlighted four main risks of large language models: (1) environmental and financial costs; (2) massive data and inscrutable models; (3) research opportunity costs; and (4) illusions of meaning. The conclusion found the resources required to build and sustain such large AI construct models would benefit wealthy organizations and continue the marginalization of poorer communities.

The training of large AI models requires the large consumption of computer processing power. Computer processing power, in turn, requires large amounts of electrical power. Wealthy countries are disproportionately consuming natural resources. Also, large language models are also trained by using massive amounts of text. Researchers collect all the data they can from the internet, so there is a risk of racist, sexist and otherwise abusive language ending up in the training data for natural language processing. Additionally, misinformation, advertisements and propaganda have corrupted the data.

Research opportunity cost is the third highlighted risk of large language models. Gebru and her researchers summarized this as "misdirected research effort." Most AI researchers acknowledge large language models don't "understand language" as a human would, but language models are excellent at manipulating language. Gao wrote: "Big Tech can make money from models that manipulate language more accurately, so it keeps investing in them". Gebru's research found that more effort should go into working on AI models to understand language (rather than just manipulate or mimic it) and better results could be received with smaller, more carefully extracted data sets. Using smaller data sets would also use fewer energy resources. Large language models are very good at emulating human language as if you are speaking to a real person. For instance, it is common to "chat with a representative" who is not a real person "representing" the company. These "bots" easily fool people into thinking they are speaking to real people. Illusions of meaning can be more nefarious; for example, one government generates misinformation or propaganda to sway the electorate of another country.

In the early days of Google, their mantra was "don't be evil" and to not let advertisers buy their way to the top of the search results. Their current mission statement is "to organize the world's information and make it universally accessible and useful. Dr. Gebru lifted the mirror in front of Google executives themselves, and these same Google executives did not like the reflection they saw.

The federal government is highly concerned with algorithm biases in healthcare. For example, the governmental entity AHRQ held a symposium on March 2nd and 3rd, 2023 entitled: Impacts of Healthcare Algorithms on Racial and Ethnic Healthcare Disparities. One of the speakers at this symposium, Helen Burstin, MD, in her presentation titled: "Strategies to Address Algorithmic Bias in Medicine" recommended migration actions for medical specialty societies: 1) Collaborate with policymakers to review clinical algorithms (review the algorithms that produced racial and ethnic inequities); 2) Allocate support for additional studies to evaluate the algorithms bias outcomes leading to racial and ethnic disparities as a preventative step before dispersion within the health field; 3) Promote stakeholder awareness (including patients) of potential algorithmic risk and 4) Ensure that algorithms



included in clinical guidelines and recommendations statements are assessed from a health equity lens and that methods are adequately reported.

At the same symposium, Dr. Crystal Grant's, PhD (Privacy, and Technology Project, American Civil Liberties Union) presentation titled "Addressing Racial Bias in Healthcare Algorithms: Steps You Can Take Today", detailed these core statements on algorithm biases during the presentation: "The data on which algorithms are trained reflects all sociocultural and environmental realities of racism in America's present and past and its effects on people's biology". "While techniques exist that attempt to mitigate these biases in the training data, they too present limitations". "Algorithm developers are not subject matter experts in patient care. Yet, in creating a healthcare tool, they are making what amount to clinical and medical decisions". Grant states, "assume the algorithm is incorrect".

According to CMS, one component required to meet the definition of "meaningful use" for Electronic Health Records (EHR) is to improve quality, safety, efficiency and reduce health disparities. With large language systems in AI, healthcare disparities and inequities are known factors. What we are experiencing is "garbage in, garbage out".

Resources

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Impact of Healthcare Algorithms on Racial and Ethnic Disparities in Health and Healthcare Research Protocol Jan 25, 2022. Agency for Healthcare Research and Quality (AHRQ) Retrieved April 6, 2023 from https://effectivehealthcare.ahrq.gov/products/racial-disparities-health-healthcare/protocol.

Sharon Schuman, RHIA, CDIP, CCS
Editorial Advisory Board Member

Timothy (Tim) Cole, MS, RHIT, CCPHM
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What's In a Name? - Part 1

SELECTED PERSONAL NAME RULES FROM AROUND THE WORLD

by Jim Hoover

Naming convention issues and concerns in health information (HI) for Master Patient Index (MPI) data integrity are critical to HI professionals charged with protecting patient data. In this two-part series, Jim Hoover explores global naming policies and practices, and how the 'single name' creates a challenge for the Electronic Health Record (EHR).

America has incredible freedoms - many of which we do not often consider or are even aware of, such as what names are permissible for a newborn baby or a subsequent name change. However, much of the world is less permissive than the United States regarding personal names. For example, prohibited names worldwide often focus on trademarks, obscenities or religious words. In addition, many countries, such as Denmark, Iceland, China, Saudi Arabia and others, have several thought-provoking name restrictions.

In Denmark, parents must select from approximately 7,000 *pre-approved names* or request permission to use names outside of this list from its official Naming Committee. Danish parents must also seek permission for spellings that deviate from the standard spelling for a specific name (Allen, 2018). Denmark charges its Naming Committee with preserving the island's ancient naming conventions. Its decisions are often contentious - Internet searches reveal many news articles detailing lawsuits from parents or children suing for the right to use specific names. The country's naming policy focuses on homogeneity – it does not want unique personal names (Alvarez, 2004). Denmark also rejects names if they do not match the birth gender of the child. Denmark does, at times, seek to modernize its naming laws. In 2018, it repealed the enforced use of patronymic[1] last names (Allen, 2018).

Like Denmark, Iceland has very restrictive laws regarding personal names. Personal names must be selected from a government-approved list, or parents must apply for permission from Iceland's Personal Names Committee to use non-listed names. A famous legal battle in Iceland occurred over the use of the name "Blær" as it was deemed "too masculine" for a girl. Upon rejecting the name, the state named the child "Stúlka" (Icelandic for girl). The family lived with the official name on the child's passport, school registration and all documents. The family sued Iceland when "Stúlka" turned 15 to have Blær recognized as her official name. The Icelandic courts ruled for the family, finding that denying the use of this name was a violation of their privacy rights (Beckett, 2013). Finally, Iceland relaxed its naming laws in 2019 to allow any gendered name to be used by babies of either sex (Kyzer, 2019).

Unlike Denmark, Iceland still requires the patronymic last names of its citizens, born in Iceland or abroad. Last names are not considered "family names" that are passed down between generations. Instead, last names combine the father's first name with the added suffix "-son" or "-dóttir," depending on whether the child is male or female. For example, the daughter of a Father named "Jón" would have *-dottir* appended to his first name to form her last name as "Jónsdottir," or a son would have the last name of "Jónsson." It is for this reason that many Icelandic people do not like to be called "Mr. *(lastname)*" or "Miss *(lastname)*."

It follows that Icelandic siblings of different genders will have different last names. It should be noted that the rules for matching algorithms or contact tracing routines may need to be adjusted for patient populations with these names. Iceland recently passed the Gender Autonomy Act (Kyzer, 2019), allowing a gender-neutral option, "-bur" for children, but only if the child is officially registered as gender-neutral ("X"). Icelanders have also started to use the mother's first name as the base last name of their children too, but this is not as common as using the father's name. The combination

[1]A patronymic name is one that is derived from the father's first name with the appropriate suffix added to indicate if the child is a boy or girl. This ancient practice clearly predates the modern acknowledgement of non-binary persons.

[2]Eastern Slavic languages include Russian, Belarusian, Ukrainian, Kazakhstanian and others.

of both the father's and mother's last names is even less common, followed by the appropriate suffix (Tomlin, 2022). Fortunately, family names in Iceland can be passed down by non-Icelandic citizens with children there.

Rather than last names, patronymic names have survived in Eastern Slavic Languages[2] (Family Search, 2022), such as Russian and Ukrainian as middle names (Ohbaidze et al., 2022). Thus, children carry on their father's name with a gender prefix in the middle name and still inherit the father's surname as it is passed down from generation to generation.

The naming laws in Indonesia are possibly the least restrictive compared to the rest of the world. Names can be virtually any combination of words and can be changed by the individual at any time. Indonesian names do not have the concept of first, middle or last names; they only have just a name. Unlike Icelandic or Danish names, Indonesian names tend to be much more individualistic. Naming children after others, including males, is uncommon (Evason, 2021). Indonesia started to impose more structure on names only recently in 2022, when it restricted names to no more than 60 characters. Also, Indonesia passed new laws that require newborns to have at least *two words* in their names, which may or may not be a family surname. This regulation will help remove the challenge that mononymous persons[3] face when traveling to parts of the world where both a given name and surname are expected (Cekatan, 2022). In addition, Indonesia no longer permits "weird" names, per Coconuts Jakarta (2022).

For a certain majority of the population, Balinese names share just a handful of common names: Wayan, Putu, or Gede for the first-born child; second-born children are named Made or Kadek; third-born children are called Nyoman or Komang; and the fourth child receives the name Ketut. The naming cycle repeats for the fifth child and thereafter. In addition, people earn nicknames over the years that serve as adjectives to these names, such as "Made Germuk (fat Made)" (Ultimate Bali, 2013).

Unlike much of the world, Sweden requires both given names and surnames, which are highly regulated. The Swedish Act on Personal Names (2016) reduced some of the restrictions on names from its 1982 Act, giving more flexibility for non-binary citizens, but still retained much of the original regulations around naming. Every name is subject to approval. Some names are prohibited with good reason. Consider the name "Brfxxccxxmnpccccllllmmnprxvclmnckssqlbb11116", pronounced "Albin" per the child's parents. Parents submitted this name in protest after being fined for not submitting the paperwork to name their child within five years of birth. Alas, the child was not allowed to be officially called Brfxxccxxmnpccccllllmmnprxvclmnckssqlbb11116.

Challenges with Language Scripts

Written languages use scripts[4] that contain letters or symbols, for example, A-Z in the Latin alphabet used in English, and many of the world's laws for names revolve around restricting the script that can be used for names. Specific names or names with certain sounds are not permissible due to the lack of a particular letter in the language script used in the name or to letters to make the sounds in the name. For example, the Iceland Naming Committee has rejected names with the hard "C" sound, as in Cleopatra ("klee·uh·**pa**·truh") because that sound cannot be made in the Icelandic alphabet (Tammet, 2017).

And regarding name sounds, Saudi Arabia prohibits some, but not all, Western-sounding names, such as Linda, Alice or Elaine (The Independent, 2014). In addition, Saudi laws prohibit names that sound like royalty or have divine meanings, such as "angel." The laws also prohibit compound names and only pertain to Muslim citizens (Haddad, 2023).

Chinese Names

Similarly, Chinese authorities have rejected names for using letters in the Latin alphabet (Xinhua News Agency, 2009). Chinese logograms[5] are so numerous that not do not all fit into various standard font sets. For example, the Chinese standard font, GB18030-2000, only contains 6,763 simplified Chinese characters out of over 100,000 possible Chinese characters (Cahill, 2022). As such, Chinese authorities often ban names that are not included in the standard font set, such as the name "Shan,"[6] and the surnames of approximately 200 village residents were changed to "Xian" so that the name could be recorded in a computer used to issue IDs (Reuters, 2010).

China has also restricted the religious names of its Uyghur population, banning any Islamic name that it considers "extreme." Police have unilaterally changed the names of children 16 and under, as reported by Radio Free Asia in 2017.

Names in America

America has been called the great melting pot in homage to our history of accepting immigrants worldwide. This mix of cultures has brought tremendous variety to our given names and surnames here in America. For many immigrants and first-generation children, the Anglicisation of their name was part of their assimilation to a new country and culture.

[3]A mononymous person is someone with a single name, which may be multiple words but intended to be the entire name and is considered their given name, not a surname.

[4]A language script is the writing system that is used for the printed words. Many languages use a specific alphabet, for example the Latin characters used in English, but many languages are logographic in nature, such as Chinese, that use pictures for entire words or parts of words. Something in the middle of these are syllabary languages that use characters to produce syllables that are combined with other characters to form words.

[5]A logograph is a picture that represents a single word or linguistic expression. Logography is one of the earliest known writing systems.

[6]As written in Pinyin. Pinyin is a phonetic-based writing system that uses Latin characters to write Chinese words based on Mandarin pronunciation.

Economists have proven that this practice had a net positive impact on occupational earnings through higher-paying careers over those who did not adopt this practice (Biavaschi et al., 2017). This finding supports a long-suspected bias against names that sound "non-American." However, this potential bias may be fading as the composition of the American population continues to morph.

To wit, many Americans with names from languages from other parts of the world have started to use given names from their culture and language rather than using Anglicized versions of those names or picking entirely new names. For example, Edurne Sosa El Fakih said, "I refuse to change my name because that's not who I am. My name defines me and I love it as it is" (Delgadillo, 2022). Many still struggle though, with the decision to continue using non-Anglo names (Chao, 2021).

A recent onomastic[7] study illustrated that the use of unique names for babies dramatically rose from 1880 – 2017. Specifically, unique female names have increased to 11 per 1,000 and male names to nearly eight (8) per 1,000, both increasing by a factor of four (4). Also, the use of unisex names has more than doubled since the 1950s (He, 2020). Marian Liu (Liu, 2023) attributes the increase in unique names to the influx of immigrants using names from original cultures. In addition, four (4) in ten (10) Americans now identify as non-White, according to the most recent U.S. Census Bureau (Frey, 2020).

The wide variety of names in America originating from other cultures and languages indeed makes it more challenging to spell names correctly. However, the more unique a name is in the master patient index (MPI), the more likely we will find that patient record and the less likely we will confuse that record with another patient. Unique names are a net positive for health information professionals charged with protecting patient data. To that end, providers might want to research how much their EHRs can be "internationalized" to turn on input methods to enter letters commonly found in a patient population, such as "ñ," "é," and others.

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[7]The formal study of the etymology or history, of proper names, especially as applied to personal names.

Continues *on Page 30*

FROM OUR HOUSE TO YOURS

peek

INSIDE THE DOOR OF CHIA HOD

THE BACKGROUND STORY

This past Fall, the House of Delegates (HOD) Leadership and HOD members began discussing the challenges in finding volunteer members to run for CLA officers. Many CLAs have been recycling their leadership. The House asked for help and guidance from the CHIA Board of Directors (BOD).

PEEK INSIDE THE HOD CHIA LEADERSHIP, CLA LEADERSHIP, AND HOUSE OF DELEGATES – WANT TO HEAR FROM YOU!

In January, the HOD and the CHIA Board began discussing and assessing the membership trends from the past six years. In addition, the BOD conducted informational interviews with other state associations. After looking at all of this information the HOD Leadership, HOD members and the CHIA BOD recognized that it was time for a change in the association's organizational structure. Since the association is all about the members, the HOD and BOD recognized the need to collaborate with the association's members. Basically, the question under consideration is 'what are members looking for in their professional association'? To facilitate this collaboration, the HOD and BOD developed a communication plan including several opportunities to hear from the members: 1) A member survey; 2) Two Town Hall Meetings 3) A Virtual HOD Meeting (open to all members) 4) May's Community Chat. Another factor under consideration by the CHIA BOD and its members is that AHIMA is requiring all CAs (Component/State Associations) to revise their Bylaws by July 1, 2024. The timing of AHIMA's requirement coincides with CHIA's need to develop a new organizational structure as the AHIMA Bylaws are incorporated.

Members have participated and provided information to their HOD representatives, CLA leaders and CHIA BOD members through the following communication methods.

- Responses to the "CHIA House of Delegates Health Information Professional Membership Survey".
- Live participation and the opportunity to ask questions and speak with CLA delegates and leaders via one of the Town Hall Meetings held on May 8th and May 10th.
- A virtual HOD session was held on May 18th.
- The May 26th Community Forum session.

Want to let us know more and share your thoughts with the HOD and BOD? Everyone is welcome to attend the in-person HOD meeting at CHIACON23 on June 11, 2023 from 2:00 pm to 5:30 pm in Rancho Mirage.

The BOD wants to hear from members as collaboration is key in the development of our new organizational structure. Please take advantage of the opportunities to share your opinions by contacting your CLA's leadership via the CHIA website under communities, Component Local Associations (CLAs)/ Regions. Or feel free to contact any CHIA BOD member. It is never too late to participate and provide input.

Thank you for your time and engagement as CHIA determines its future organizational structure and needs.

Sally Gibbs, President-elect 2022-23

What's In a Name? - Part 2

PATIENTS WITH ONE NAME - A HEALTH INFORMATION CHALLENGE

by Jim Hoover

This is an abridged version of the author's full article. Scan the QR Code on Page 20 to access the original article.

Native Americans have a long history of using single given names without surnames; examples include *Walks with Pride, Wounded Bear* and *Eagle Eye*. A fascinating aspect of Native American naming customs is they earn new names, given by community members (Schrader, 2015) as they change habits or significant life events occur (Navajo Traditional Teachings, n.d.). "Some people can go their whole lives without being named until the end of their time on this Earth" (Nanticoke Lenni-Lenape Tribal Nation, 2019).

Burmese and Indonesian cultures provide for many name changes over a person's lifetime. In these cultures, however, individuals choose their names, while in Native American practices, names are given to the individual by the community. There is little government oversight on these Burmese name changes, though the changed names are considered legal (Viss, May 2014).

Native American, Burmese and Indonesian cultures share the common trait of not having surnames. Even though their names may consist of multiple words, all words are considered their given or first name.

Mononymous Persons – Those with a Single Name

The term ***mononymous*** refers to persons with only one name. Other cultures besides Burmese (Daw Mi Mi Khaing, 1958) and Indonesian (Van der Meij, 2010) use single names for personal identification. In China, 25 of the 55 national Chinese minorities do not use surnames (Ruofu, 1986). Afghanistan (Goldstein, 2014), Bhutan (Denkar, 2021) and South India (Radhika, 2002) are other examples where surnames are not often used. As a result, *single-named persons are more common* than most Westerners anticipate.

Some inadvertently make assumptions about second names for mononymous persons, such as using a spouse's name for a person without a surname. For example, British psychiatrist Dr. Radhika discusses the cultural significance of having only one name and how she is often referred to by her husband's name, "Dr. Ramkumar." Dr. Radhika resents this because "Ramkumar" is her husband's name, not hers (Radhika, 2002).

Having both a given name *and* a surname is a relatively new part of human culture.

The increasing adoption of the term last name to describe inherited surnames can cause confusion with non-English languages with reverse name orders, such as Chinese, Japanese, Korean, Thai, Vietnamese and others.

Names with Multiple Words are Not Necessarily First, Middle and Last Names

Of note, many mononymous names *may consist of several names separated by spaces,* but all are considered the person's given name. For example, Burmese and Indonesian given names often have more than two words and none of the names are part of a surname (Economist, May 2007). Even though Burmese or Indonesian names might be multiple words long, the names are still considered their given, or first, name (Evason, 2021-b). Examples include the full Indonesian names "Yovan Gunardio Darmawan" (Evason, 2021-a) and "Slamet Hari Natal" (Jakarta Post, 2017), where both names are considered their given name only – neither name has a surname.

In English, linguists call multiple words used as a single name "double names" (Grundy 2022). Examples of double names are "Anne Louise," "Mary Beth," or "Rose Mary." Double names in English and multiple names in other languages are considered *a single name, albeit with multiple words.* As such, IT systems or those doing data entry should not separate multiple-word names into different name parts or fields. Instead, information technology (IT) systems should store these names together in the appropriate name field. Single-name travelers are common throughout the

world. As such, the governing body for worldwide civil aviation standards, International Civil Aviation Organization (ICAO), created an international naming policy for passports for travelers with just one name. The United States is one of 193 nations that are signatories to the International Civil Aviation Organization (ICAO) and follows its policies, *including those for single-name travelers.*

The ICAO has issued over 12,000 international standards and recommended practices (SARPs) since its inception in 1944. One such specification is Doc 9303 regarding *machine-readable travel documents* (MRTDs), otherwise known as *passports* (ICAO, 2021). Doc 9303 specifies how to display traveler names on passports and passenger name records (PRNs), advance passenger information (API) lists and other travel-related documentation.

The U.S. follows ICAO policies for passports for travelers with single names.

Following ICAO, the Department of Homeland Security (DHS) indicates that a *single name is considered a primary or last name* and should be stored in the surname field. The U.S. Department of State suggests that "where a family name does not exist separately and all parts of the name are considered inseparable, or where a single name exists" *to ensure the name is retrievable.* (Department of State, 2012). Also, the U.S. Department of State points to the ICAO standards, which require "one-word names be printed in the last name field." Finally, the default acronym "FNU" (first name unknown) is stored in the first name field for machine-readable visas (MRVs) as required by the U.S. Department of State (Department of State, 2021).

FNU is Not the Best Value for Name Defaults

The Department of State's use of FNU (Department of State, 2022) implies that the first name is *unknown or unavailable.* Instead, the person's given name is known, but they simply do not have a surname. The choice of *FNU* to describe this situation is inaccurate and unfortunate.

DHS does not permit the use of "FNU" in its systems (DHS, 2020), nor the use of "Unknown," "None," or "Not Applicable" in the given name field, thus it might be helpful to avoid any of these default values. Valid DHS defaults for names are "UNK" or "NA" (DHS, 2020). The DNS convention might be a reasonable policy for providers to adopt.

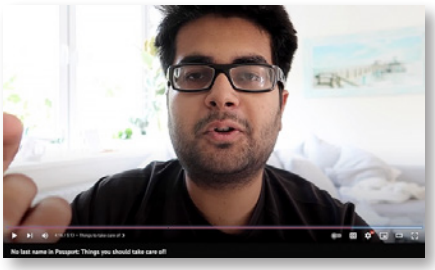
Policies for Single Name Patients

The first and most obvious solution might be to leave the name parts fields empty where there are no values. Ancillary name parts such as prefixes, suffixes and even middle names are almost always allowed to be empty. Unfortunately, most North American software assumes that patients will have *both given names and surnames* and thus require both fields. There are no technical reasons for this requirement, only that most software companies decide to require the presence of both names due to our naming customs[1]. The U.S., however, is known as "the great American melting pot," and our software should handle all potential variations for names used worldwide.

There are two potential cases where presenting patients may provide only one name – those with legal documentation and those without documentation. In the case where a person's legal identification only has one name, providers should honor this choice and follow the name on the identification cards as indicated earlier. The U.S. permits individuals to change their names to most anything, including mononymous names. If a person makes this choice, providers should honor how people wish to be known. Other patients may not have proper identification and prefer to register with only a single name. In both cases, the EHR user should enter a default name value for the required field using the default value set by the local policy.

Challenges for Those with a Single Name

Single-named persons have many challenges, including being called by their only name twice. YouTuber Bharat runs a channel called "Bharat in Germany!" and, among many things, offers advice to others with single names. At minute 2:40 in his video, "No last name in Passport: Things you should take care of!" (Bharat, n.d.), Bharat says, "for my visa, it is Bharat, Bharat ... my insurance card is Bharat, Bharat ... I hate it so much [emphasis added]." Bharat continues at minute 3:06; it is "a bit of mental stress. You wouldn't like how they write your name." Finally, Bharat sums it up at minute 4:24, "for everybody who doesn't have a last name and is suffering a lot. ... I just hate this situation, ... I hope it changes really soon."



Similarly, YouTuber Nill commented at minute 9:16 in her video, "A CAT Explains Mononyms (I don't have a last name)," that she does not appreciate when "they put my name twice, which I don't like because that is not my name...give me my actual name" (Nill, 2017).

Healthcare Policies Need to Change with the Times

The healthcare industry is changing, as American culture is changing in how we recognize the unique circumstances of different populations. For example, that patients wish to

present a different gender and be called *preferred names* is no longer debatable; the healthcare community widely accepts this recent policy change. As a result, the industry has learned to be sensitive to this patient population and has adapted its data collection and reporting policies.

Similarly, the healthcare industry should handle single-name patients with the same sensitivity. Providers, HI professionals and patients should no longer accept *"this is how we always have done it"* as a rationale for following policies that are offensive or unwelcome by the single-name patient population. YouTuber Nill

clearly articulates her feelings when she says, "it makes me cry a little bit on the inside because I do not have a last name" (Nill, 2017).

Reduplicated Versus Mononymous Names

Individuals with the same first and last names are said to have *reduplicated names*[2]. In these circumstances, the first and last name fields contain *identical values because this is the patient's actual and true*[3] name, unlike replicated names for single-name patients.

Reduplicated names are in many of the world's languages, including English. For example, the former Governor of New Jersey, Chris Christie, has a form of a reduplicated name, as does writer Gordon Gordon (IMDb, n.d.) and Lauren Lauren[4], who married a man with the same last name as her first name (Fusaro, 2011).

Conclusion

Mononymous persons (those with a single name) have many challenges when dealing with cultures and software systems that expect a given name and a surname. Most North American EHR systems insist on data in both the first and last name fields, but this does not accurately reflect real-world data. Software systems do allow for null (empty) values in the middle name, maiden and other name fields; thus, it is possible to forgo the requirement for either the given name or surname field to accommodate mononymous persons. EHR vendors should address this unnecessary limitation.

Until such time, HI professionals are responsible for leading providers in creating naming policies to ensure accurate EHR data and that they are sensitive to the needs and feelings of those with single names. Naming policies should use default values for first and last name fields just as they use defaults in other fields that require data. And naming policies should not confuse single-name patients with those with the same first and last names. For example, trying to determine if a patient's name is "Madonna" or "Madonna Madonna," or if the name "Yin Yin" is a mononymous person with the name repeated, or if the person has a reduplicated name.

It is best practice to inquire about the name parts of a person's name whenever possible. There is no one-size-fits-all rule that determines which name portions should be entered into the first, middle, or last name fields. Providers should properly handle double names, names with two (2) or more words, those with two (2) last names, as well as those with one (1). Patients will appreciate it when their names are captured correctly and without making up data for another name part, such as repeating their first name in the last name field, for example.

Jim Hoover, Principal
Avant Health Sciences

All author resources/references are available in full article - scan QR Code.

[1]EHR vendors could improve their systems by removing the requirement for both the first and last names to be populated. An alternative data validation methodology might simply be to require the presence of data in either first or last name, not necessarily both fields. Doing so would align EHR software to work better for international usage as well.

[2]Reduplication is common in many of the world's languages. It is beyond the scope of this paper to go beyond reduplicated names, but this linguistic concept applies more generally to repeated sounds that are often used for emphasis or to indicate pluralism. Reduplication is evidenced in English in the use of synonyms in legal writing through terms such as "law and order" or "acknowledged and agreed" or through rhyming pairs such as "flim flam" and "hurly burly" while in languages such as Arabic, Indonesian, Thai, and others, the exact words are directly repeated. An example of using reduplication for emphasis can be found in the Thai word "mak mak" which means "very much."

[3]An example of reduplication in practice in English writing. "Actual" and "true" are synonyms for each other and repetition of the concept of "true" is used for emphasis.

[4]Of note, Lauren Lauren is the Granddaughter of former President George H. W. Bush.

Member Spotlight

LOREN LOPEZ
CCS, CDIP

Consultant
Kaiser Permanente

Loren Lopez is a credentialed Certified Coding Specialist (CCS) and Clinical Documentation Improvement Professional (CDIP); and has been a CHIA member since 1994. For the last 10 years she has worked for Kaiser Permanente as a Lead Consultant for the Quality Review and Education Department for Revenue Cycle Integrity for Kaiser Permanente's Northern California region. Loren has a diverse skill set, and she easily perceives problems and verbalizes solutions. Her expertise extends to helping develop computer software based on translating Medical Coding Operational needs to improve available reporting functions. She has worked remotely for over 10 years and has created her own virtual team of auditors.

Tell me about your professional background, how did you get to where you are today?

I am a third-generation HI Professional and followed in my mother's family's 'matriarchal' footsteps. I started working in HI at a hospital while I was still in Junior High School! My mother, an HI director at the time, put me to work after school to help perform chart pull requests, file backs and find missing charts. "I found that I had a natural knack for finding missing charts, misfiles or duplicate records. It is a family joke that 'HI is part of my DNA'."

"When I was a college student taking pre-law, I got hired by an HI consulting agency doing temp work, but they asked me to work full-time almost immediately." The contracting agency performed medical coding audits, so that was my first introduction to medical coding. I decided to apply and was hired as an HI clerk for the night-time shift, Tuesday through Saturday, 3 to 11:30 pm, at a small hospital that was located close to my home. This made it much easier for me to work while attending college. Even though I was hired as an HI clerk, I worked in assembly and analysis, release of information and was the birth clerk when needed, while doing other functions within the HI Department. "When you work a swing shift, you become a jack of all trades and get to know the ins and outs of the entire department and the workings of the hospital. I learned from the ground up."

I was fortunate to be mentored by one of two medical coders at that small hospital who suggested that I switch to the HIT program and get a medical coding certificate. "I felt so comfortable in Medical Coding Class and at work, I'd write in the medical codes for ED Accounts; the medical coder would check it, and decided I was a natural." I completed my medical coding certificate in 1992 but was already working in my first coding job as an outpatient medical coder at Mercy General.

How has your HI training/credentials benefited you in your career and current job/role?

In 1997, I became accredited as a Certified Coding Specialist (CCS). It wasn't required for me to get my first job as a Medical Coder, but it has helped me get every other job since then. In addition, in 2014, I became a Certified Documentation Improvement Professional.

How did your HI educational background prepare you for your role today?

I worked for Sutter Health for 6.5 years and UC Davis Medical Center for 8.5 years. This required a lot of travel, and getting the work done while on the road was a challenge. "You can't work in a Starbucks where internet is free because of HIPAA privacy, so you have to learn how to be your own IT support." I was working virtually before it became a common option. I had to think outside the box and create an available network for support. I had to be creative because you can't get the work done if your laptop isn't working and the nearest IT support is 4 hours away. It was trial and error. I created a virtual team many years before the COVID-19 Pandemic.

What are some of the greatest challenges that HI professionals have faced over the years and/or what major challenges do you see in the coming years?

Currently, shared services and outsourcing are big challenges. "We are challenged as professionals when efficiencies may get pushed over quality."

What advice do you have for people just starting out their careers in HI?

My advice for people just starting out in their HI careers is education. "Education is number one in importance. Decide what path you may be interested in and get a credential in that area. If there is a gap in your ability to get a job in that area, then volunteer." Don't be afraid to ask an HI Director in a local hospital if you can intern, work a holiday or work a swing shift. Ask other colleagues about their experiences and what transpired in their pathway to set them up for getting into their current position. "What we think our career

Continues *on Page 30*

California Amends Patient Access Law

GOVERNOR APPROVES S.B. 1419

by Allan D. Jergesen, JD

At the end of the 2021-2022 legislative session, the Governor approved S.B. 1419, which amended two separate provisions of the California patient access law. The amendments are worth noting because the California law is generally more stringent than its HIPAA equivalent, meaning that it provides greater rights of access to patients. As a result, California providers will generally look toward its provisions in deciding how and when to release health information to patients and their legal representatives. While both deal with patient access, the amendments focus on two separate issues, namely access by the representatives of minors to information about minors and access by all patients to test results. This legal column deals with each amendment in turn.

Access by Representatives of Minors

The California patient access statute contains special language regarding access by minors to their own health information. In general, minors do not have access, which is allowed by their legal representative, whether it be a parent, guardian or other adult possessing legal authority. There is an important exception, however, that allows minors to have access to information about their own care where they consented, or could have consented, to that care [Cal. Health & Safety Code §123110(a)]. The law then states that, where a minor has a right of access, the minor's representative does not have that right [Cal. Health & Safety Code §123115(a)(1)]. These comprise treatment in the following situations:

- *Outpatient mental health treatment or residential shelter services*
- *Prevention or treatment of pregnancy*
- *Treatment of sexual assault*
- *Diagnosis or treatment related to drugs or alcohol*

Minors who are 12 years of age or older may consent to the following types of care:

- *Diagnosis or treatment of reportable communicable disease (including HIV testing)*
- *Care related to the prevention of sexually transmitted disease (including HPV vaccine)*
- *Treatment for rape*
- *Treatment of injuries resulting from intimate partner violence*

The new law gives minors the exclusive right of access to medical records containing information about the above types of care if they have the mental capacity to consent to the care and are at or above the minimum age required to do so [Cal. Health & Safety Code §123115(a)(3)]. This is the case even if they were not at that age at the time that the care was provided and therefore neither consented nor could have consented to it. Accordingly, a minor who reaches the age of 12 now has the exclusive right of access to information about the care, even though the minor could not have consented to the care at the time that it was given. This effectively extends the minor's access rights and limits those of the minor's representative.

Patient Access to Test Results

The second part of the new law clarifies and expands the rights of patients to have access to their test results [Cal. Health & Safety Code §123148]. The existing law requires health professionals or those acting on their behalf, upon the patient's request, to provide or arrange for the provision of clinical laboratory test results to the patient in oral or written form. In addition, the test results must be provided in electronic form if requested by the patient and deemed appropriate by the health

professional. In the event that the health professional and patient agree upon transmittal in electronic form, the health professional can communicate the results via Internet posting, as long as the patient consents to that mode of communication and the health professional has reviewed the test results and ensured that access to them is restricted by the use of a secure PIN.

The new law extends the testing covered by it beyond clinical laboratory results to imaging scans, including x-rays, MRIs, ultrasound and similar technologies. In addition, it defines "Internet posting" as including posting to an online patient portal. The intent is to facilitate patient review of test results, using technologies that are increasingly being used to give patients expedited access to their medical information.

The existing law lists certain test results that cannot be disclosed to the patient via Internet posting or other electronic means unless the health professional has first discussed them with the patient in person, by telephone or by any other means of oral communication. These involve test results:

- *Showing the presence of antigens, including a hepatitis infection*
- *Indicating substance abuse*
- *Relating to routinely processed tissues including skin biopsies, Pap smear tests, products of conception and bone marrow aspirations.*

The new law adds the following to this list:

- *A positive HIV test, unless the test subject is anonymously tested and the test result is posted on a secure Internet website that can be viewed only with the use of a secure code that is not linked to anything that could identify the test subject. This limitation does not prevent the disclosure of HIV test results, including viral load and CD4 count results, via Internet posting or other electronic means if the patient has previously been informed about the results of a positive HIV test.*
- *Imaging scans that reveal a new or recurrent malignancy*

Conclusion

While noteworthy, the new law does not make radical changes in the existing California standards for patient access. In the case of access by minors, it lists the specific situations where minors have access and their representatives do not, even if the minor could not have given consent at the time that the care was received. In the case of patient access to test results, it expands the tests covered and recognizes the use of patient portals, while clarifying the situations where the health professional must first contact the patient personally before posting test results on the Internet or in other electronic form.

Allan D. Jergesen, JD
Partner, Hanson Bridget, LLP

Volunteers Make a World of Difference

Rosie Zamora, RHIT
Torrance Memorial Medical Center

Rosie Zamora has a passion for serving others. Volunteering has always been a way of life for her. She has committed her time to mission work, serving in food pantries, school and church events. When she began her career in Health Information, it was only a matter of time before she became involved in serving on the Professional Education Committee, the Advocacy and Legislative Committee and becoming the Co-Chair of the Membership Engagement Task Force. When she learned that her Component Local Association (CLA) did not have a treasurer, she immediately reached out to become an active part of SCHIA. Rosie recently ran for a CHIA BOD Director position and was elected by the membership. She starts serving her 2023-2024 term this summer. Rosie completed her Bachelor of Science in Health Information Management at Herzing University, located in Wisconsin, in 2018. She is working on a Master of Business Administration in Healthcare Management at Western Governors University.

Rosie will soon celebrate her first year managing the Health Information Department at Torrance Memorial Hospital. She is excited to continue growing educationally, professionally and spiritually.

Describe your volunteer work and why you volunteer.

I have been an active member of the Legislative and Advocacy committee for the past three years, and I am in my second year as Co-Chair of the Membership Engagement Task Committee. I have also served on the Professional Education Committee for four years. For SCHIA, I served as the Treasurer last year, and this year I am the Secretary.

The main reason why I started volunteering was simply because of my desire to meet new people and build professional relationships within the HI community. When you give your time to a noble cause, it opens countless opportunities.

Have you volunteered in other areas of professional associations previously?

In my personal life, I volunteer at church, at the kid's summer camp, during events and I serve in the food pantry. I also enjoy volunteering at my children's school; it gives me a glimpse into their school life.

- **How do you think volunteering connects you to the health information community? Do you feel like you are an advocate for your profession? Describe.**

Volunteering is the best way to connect with the health information community, stay informed on relevant topics and learn best practices. I highly recommend dedicating time and effort to volunteering and engaging with others as the best way to become part of this fantastic community.

- **In what ways has collaborating with other HI professionals impacted your professional development? Elaborate on how your volunteer experience is impacting your leadership development.**

Collaborating with other HI professionals has made me more confident in my leadership abilities and skills. I have learned how to be flexible, learned agility and gained the satisfaction of making a slight difference within my professional community.

- **What do you think is the most rewarding benefit of volunteering?**

The most rewarding benefit of volunteering is the people I get to partner with. I feel joy sharing ideas with like-minded people.

- Tell me about someone who has influenced your decision to volunteer.

Truthfully, there have been two people that have influenced my volunteering life. My first advocate and prominent supporter is my husband. He has always seen volunteering as an opportunity for me to grow in my profession and has constantly supported and pushed me in every way possible.

The next one is my boss, Melany, who continuously pushes me out of my comfort zone. She constantly questions, "My no," and counter offers my "I don't have time, right now." Unbeknown to them, they tag team against me. I am blessed to have them both care so much about shaping my leadership skills and future.

- **What has surprised you most about volunteering?**

I am surprised by how big but small the HI community is. Despite the differences in knowledge and skills, everyone works as a team. There is no idea too small or big; it never feels like a competition of who gives more or less. Everyone has a genuine desire to grow our industry.

- **What discoveries, good or bad, have you made about the health information profession through your volunteer efforts? Or relative to your own career?**

I have learned that volunteering takes little time or effort. Most of the time, it means bouncing off ideas with your committee members.

- **What's the best thing to happen since you started volunteering? What is the key thing you have learned during this time?**

Since initiating this volunteering path, connecting with many knowledgeable individuals has been the best thing that has happened to me professionally. I have learned that everyone will walk alongside you to mentor and encourage you.

- **Tell me about some of the people you've met while volunteering.**

Oh, I have met so many wonderful people volunteering. I would honestly hate to leave someone out. I have always felt welcome and appreciated by everyone I have worked with. I will never forget the very first time I walked into my first volunteering assignment. Ms. Shirley Lewis, Amy Henderson and Pat Medrano were so welcoming that I instantly felt part of the CHIA family. When I met Sharon Lewis for the first time, she embraced me as if she had known me for years. And Debi has always been a constant encouragement in my professional growth. Everyone is simply delightful.

- **Any advice to other members who may want to volunteer?**

I encourage all members of the HI profession to take action and advocate for our profession. Don't be afraid to take on new challenges and dive deeper into growing your network and leadership skills. Be willing to take on opportunities that will challenge you.

Lee Austin, RHIT, CPC
Valley Children's Healthcare

Reflections on the AHIMA Advocacy Summit 2023

FROM OUR CHIA DELEGATE LEADERS

By Marisol Davis, BS, RHIA

The annual *AHIMA Advocacy Summit* brings health leaders and policymakers together to address important key policy issues related to health data and health information. The two-day event took place March 20-21 in Washington, DC, and included a *Public Policy Institute.*

CHIA's delegation this year included twelve (12) CHIA Professional members: Nancy Andersen, Maria Caban Alizondo, Kristin Borth, Debi Primeau, Rhonda Anderson, Roberta Baranda, Freida Smith, Vivian Thomas, Adriana Preciado, Maria Hewitt, Debra McGaskey and Nyunt Than.

On Day One, this year's *Public Policy Institute* focused on:

- Improving individuals' health journey through access to information, privacy and equity
- Ensuring the quality and integrity of health information
- Advancing healthcare transformation

On Day Two, attendees, including our CHIA delegates had the opportunity to advocate for issues impacting the health information profession to our California-elected officials on Capitol Hill.

Three of our CHIA delegates took some time to reflect on their experience this year: Nancy Andersen (**NA**), Roberta Baranda (**RB**), and Adriana Preciado (**AP**).

If this was your first time at the *AHIMA Advocacy Summit* (either in-person or virtual), what surprised you most about the event?

NA | I have had the great fortune to attend the *AHIMA Advocacy Summit* on many occasions, as a director and president of the CHIA Board of Directors and most recently as a Director on the AHIMA Board of Directors. What surprised me the most was the openly partisan perspective of the legislative staff I met with as part of the CHIA contingency.

RB | This was the second in-person *AHIMA Advocacy Summit* event I attended. I attended my first in-person AHIMA Advocacy Summit when I was a first-time, first-year Director on the CHIA Board, several years ago. I will never forget the excitement and how the "Pulse" in Washington was palpable. What surprised me the most this year, despite the years between my participation in the event; AHIMA is still advocating for many of the same initiatives, specifically, the need for a unique patient identifier. Secondly, I was surprised by the difference in the tone of Capitol Hill. During my first in-person Advocacy event, the 'Hill' was much more open to collaboration. It is interesting that the tone of both advocacy topics we discussed appeared to be more partisan.

AP | First, this was my first time traveling to Washington, DC and I have to say it was amazing. Being surrounded by so

much history was nice and I felt blessed to be representing CHIA. This was my third time attending the *AHIMA Advocacy Summit,* but my first time attending in person. I previously attended virtually due to the pandemic and it was a much different experience. The in-person visit to Capitol Hill was exciting and motivating. Being there in person allowed me to feel the energy in the room and meet new health information (HI) professionals from other states. Monday's sessions were educational and the speakers walked us through what to expect for the meetings with the legislators including question suggestions.

Identify something you learned that was new for you as an HI professional because of attending this event.

NA | Something new I learned was that the Office of the National Coordinator for Health Information Technology (ONC) has published a toolkit - *Social Determinants of Health Information Exchange Toolkit. https://www.healthit.gov/sites/default/files/2023-02/Social%20Determinants%20of%20Health%20Information%20Exchange%20Toolkit%202023_508.pdf.*

RB | For me, attending this event opened my eyes to what is happening nationally on many fronts. The education day (Public Policy Institute) is filled with incredibly informative speakers who provide a great foundation on the national and international landscape. Before actually "hitting the pavement and meeting with legislators", I learned that one party does not like the term "Social Determinates of Health" but prefers "Factors that Target Health Outcomes". This brought important awareness to knowing who represents CHIA and our organizations in respective districts. I took this information and perspective back to my organization.

AP | The "something new" I learned is AHIMA's position and support of standardizing the collection, access, sharing and use of Social Determinants of Health (SDOH). One of the AHIMA Advocacy Summit session leaders shared and discussed the importance of SDOH and encouraged members to be well-informed as they advocate for the standardization of SDOH.

What was your favorite part or aspect of the event?

NA | My favorite aspect of this year's Advocacy Summit was recognizing the fantastic representation by the twelve CHIA members and their passion for health information and our profession! AHIMA also brought together a wealth of information during the first day of the summit with great speakers and presentations.

RB | One of my favorite parts of this event is the opportunity to hear the banter about the current climates of each of the parties. Lauren Riplinger, AHIMA's Chief Policy and Impact Officer always organizes excellent speakers who really know the intimate inner workings of the Parties, their priorities and their influences. It is an interesting time to be active on the 'Hill' for healthcare. There are many big issues, especially in women's health. My second favorite part of this event was the opportunity to meet new California HI professionals whose names I often hear. It can be intimidating to attend this event if you are not experienced in Advocacy practices. Our California delegation had several first-timers., It was exciting to watch them grow in both knowledge and confidence in just a few short hours while meeting with legislators. I really enjoyed getting to know these fellow HI professionals.

AP | The overall experience of the in-person event was my favorite part of this event. As an in-person first-timer, I was nervous about meeting others and sharing my thoughts because I was not familiar with the legislative process. However, I realized quickly that I was not alone and there were many of us who were new to the experience. The AHIMA leadership team embraced us and walked us through the process in the first-timer session during a session on Monday morning. This initial meeting provided guidance and expectations for the 2-day event. In addition, the first-timers were paired with an experienced member. This was helpful in easing the nervousness of speaking with legislative staff on Capitol Hill.

What is your opinion of Legislative officials and their staff on their perspective of the two AHIMA advocacy topics?

NA | Many of the legislative staff I met are familiar with the two AHIMA Advocacy initiatives. These individuals were typically staff members who help guide their congressional leader on legislative policies related to healthcare issues. In general, they are in support of both the national patient identifier (NPI) and want to know more about SDOH issues from a legislative perspective.

RB | There is support for the initiatives, in spirit, but that support is not necessarily bipartisan. I was impressed that the staff we met wanted to hear our stories. They were engaged, supportive and sometimes surprisingly well-informed about why the AHIMA initiatives were priorities. They were also honest about the challenges. This honesty and candor allowed us to "see behind the curtain" and hear about the inner workings of Washington and Capitol Hill. We will need to continue to advocate for the adoption of an NPI and standards for documenting and coding SDOH.

AP | The legislative officials and their staff were knowledgeable of the AHIMA Advocacy initiatives and fully engaged in conversation supporting the national patient identifier and standardizing the collection of SDOH.

Is there anything else you would like to share about your experience at this event?

NA | I would encourage anyone who is interested in the legislative process and how we can have an impact on the future of healthcare in the U.S., to attend a future Advocacy Summit. The opportunity to go to our Nation's capital and meet with legislative staff to discuss important healthcare issues is a very rewarding experience!

RB | This is an event that every HI professional should experience at least once in their professional life, for self-investment and personal growth. I recommend this for the professional bucket list. Taking part in the process helps one mature as a professional and offers the opportunity to understand different perspectives. The chance to meet so many HI professionals from across the country also helps develop relationships that may not have been available to you in any other education forum. You spend two full days focusing on impacting healthcare for all. In that regard, the experience can be pivotal for your career. It is an excellent working vacation of sorts because Washington, DC is gorgeous in early Spring.

AP | As the current Chair of CHIA's Legislation and Advocacy Committee, I felt blessed to have had the opportunity to attend the *AHIMA Advocacy Summit 2023* and would encourage any CHIA member who is interested in building their knowledge and education on legislation and advocacy to sign up to participate next year.

Marisol Davis, BS, RHIA | E-Discovery and Litigation Analyst
UCLA Health Risk Management

NEWLY CREDENTIALED MEMBERS

CHIA would like to congratulate each of these California members who recently earned an AHIMA certification. These individuals studied hard and demonstrated their skill and commitment to the health information field. CHIA looks forward to their continued journey and wishes them success as they further their career pathways.

Certified Coding Specialist (CCS)

Marites Abanes, CCS
Rachel Agbayani, CCS
Joan Agraviador, CCS
Dyreen Alday, CCS
Venida Zabat Antonio, CCS
Paula Baylie, RHIT, CCS
Leilani Beach, CCS
Jennie Blankenship, CCS
Agustin Bustamante, CCS
Rachel Leila Callejas, CCS
Joy Aira Candaza, CCS
Maria Rona Dela Pena, CCS
Anthony Fance, CCS
Mollie Fucilla, RHIT, CCS
Allan Neil Gaba, CCS
Ashley Kennedy, RHIT, CCS, CPC
Mildred Macaraig Barcarse, CCS
Katharine Mraz, CCS
Liliana Muratalla, CCS
Jeannine Nale, CCS
Katheryne Nguyen, CCS
April Oetting, CCS
Kevin Michael Ortega, CCS
Roselyn Ramilo, CCS
Laarni Castillo Sacro, CCS
Terri Sanbrailo, CCS
Cheryl Teodosio, CCS
Matthew Villapudua-Reid, CCS
Diosa Gerarda Wilkie, CCS

Registered Health Information Technician (RHIT)

Sandra Cardenas, RHIT
Marissa Chaidez, RHIT
Kim Farwell, RHIT
Mollie Fucilla, RHIT, CCS
LeCara Harp, RHIT
Renea Holliday, RHIT
Lorena Huerta, RHIT, CCS
Regina Lang, RHIT
Jessica Linnane, RHIT
Jason Louie, RHIT
Lorena Molina, RHIT
Michael Moore, RHIT
Stephanie Navarro, RHIT
Maricela Ochoa, RHIT
Gabriella Pinzon, RHIT
Rosanna Leslie Samayoa, RHIT
Carlos Segura, RHIT
Nicole Selter, RHIT
Dustin Soukhaseum, RHIT
Naga Lakshmi Sudini, RHIT

Certified Coding Associate (CCA)

Juliene Baker, CCA
Andrea Cerda, CCA
Katey Cohen, CCA
Amelia Guerra, CCA
Cheetara Harvey, CCA
Blanca Herrera, CCA
Kirsten Huerta, CCA
Debbie Madrigal, CCA
Angela Montgomery, CCA
Giang Thanh Nguyen, CCA
Maria Rodriguez Gutierrez, CCA
Kristina Sandoval, CCA
Kristine Souza, CCA

Registered Health Information Administrator (RHIA)

Audrey Cox, RHIA
Eddie Cruz, RHIA
Heather Park, RHIA
Toni Reddick, RHIA

Certified Documentation Integrity Practitioner (CDIP)

Kehinde Bamgbopa, CDIP
Charles Brown, MD, CDIP, CCS, CCDS
Gabriel Quinawayan, CDIP, CCS
Michelle Ramirez, CDIP

Certified Coding Specialist-Physician-Based (CCS-P)

Monica Baudour, CCS-P

Certified Health Data Analyst (CHDA)

Justine Arinda, MS-HCI, MBChB, CHDA

AHIMA credentials earned December 2022 - February 2023

Emerging Professionals

HIT/HIM Program Highlighted on Local Radio: Three Perspectives

SHARING THE VALUE OF THE PROFESSION

by Alexis Riley, MA, RHIA, CHPS, CPC with
Julia Venegas, RHIT and Roberta Baranda, MS, RHIA, CHP

*The **Emerging Professionals** column highlights talented and rising professionals across California who have completed recent research on HI-related topics, recently graduated, or are pursuing education and future careers in health information. These Emerging Professionals represent the bright future of the health information industry.*

As a program director at Shasta College (Alexis Riley), it is extremely important to publicize the health information (HI) education programs and the amazing work that its students do. I had a wonderful opportunity to share information about the Health Information Technology Associates program and Health Information Management Bachelor programs in an on-air interview with the local *KCNR Radio* station in Redding, CA, where the college is located. Roberta Baranda, current President of CHIA and Julia Venegas, an Emerging Professional (student) were included in the interview, even though we were in different locations and hundreds of miles apart. This interview allowed us to showcase *Shasta College's* HI online programs, as well as its HIM Bachelor's program which is one of only two such programs in the California community college system, along with the still-new concept of virtual internships.

The perspective of Roberta Baranda from the host internship site, along with the student's viewpoint, provided a rich picture of how educational institutions can offer quality experiences for students who do not have the ability to go onsite. As the instructor of record for *Shasta College,* I have been so impressed with what *Valley Children's Hospital* has been able to accomplish with our students. From department manager interviews to shadowing coders and other HI staff along with having access to meetings not readily available in other facilities; as a host site, *Valley Children's Hospital* (VCH) has raised the bar. Presenting the three perspectives in this interview was an honor. We thank the *KCNR radio* show along with Carl and Linda Bott for the chance to talk about the programs that we are so proud to promote.

About Pursuing a Degree in HI (Julia Venegas)

I am a first-generation American and the first in my family to attend college. Unfortunately, I did not succeed when I attended a university straight out of high school. I took a very long break from school and entered the workforce, where I eventually entered the healthcare space as a food service worker. Later, I had the opportunity to move into an administrative position with our Information Management division where I supported the Clinical Information Systems department, Information Technology and Biomed. It was there that I learned how healthcare was being delivered through technology and how the input of information resulted in positive outcomes that could then be used for clinical decision support. In this role, I not only had the opportunity to be exposed to health IT but was able to grow in my new position. I had a wonderful boss who is still my mentor today. She motivated and encouraged me to go back to school. I was able to register for the HIT and HIM programs offered fully online through *Shasta College.* This was the only way I could return to school, as I could not afford to work

part-time or pay for childcare so that I could attend daytime classes. The online programs have allowed me to be a full-time working professional, a mom, a wife and a student.

About Certification & Exam Prep

The free online exam prep courses have helped me prepare for the certification exams after graduation by breaking out the focus for each week by domain along with a combination of workbook practice exams and timed online exams that simulate what the actual exam will be like. After I earned my associate degree, I sat for the HIT exam, even though I had already enrolled to pursue my Bachelor's in Health Information. My current degree and RHIT credential have helped me in my current role as Jr. Clinical Systems Analyst at the organization I serve. My credential allows me to uniquely stand out amongst my peers and get called to work on projects related to systems and management of health information. I have already signed up for my RHIA exam and I plan to sit for it soon after graduation.

About Graduation

I am excited that graduation is only a few more weeks away. My family and I live in Southern California and will travel to the campus in Redding to attend the ceremony. "My kids don't think *Shasta College* is a real place because they have only seen me on my laptop at home. They are finally going to get to see the actual school!" Obtaining my bachelor's degree is a dream come true for me. It allows me to honor my parents in a very special way while setting a foundation and example for my boys to follow. I am grateful for everyone in my life that has helped me get to this point and I hope my story serves as an example to my kids and others. "No matter where life takes you, it is never too late to go back to school or get started on an educational journey to obtain a degree."

Alexis Riley, MA, RHIA, CHPS, CPC
Program Director HIT/HIM, Shasta College

Julia Venegas, RHIT
Junior Clinical Systems Analyst, truecare and Student at Shasta College

Roberta Baranda, MS, RHIA, CHP
Valley Children's Healthcare

What's in a Name - Part 1 *from Page 15*

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Jim Hoover, Principal, Avant Health Sciences

Member Spotlight *from Page 21*

paths are going to be, are often very different than reality. Be curious. Find out how the HI department works collectively and how each area of the department is important. Figure out how to put the puzzle pieces together. **Read** the *CHIA Journal* articles. **Volunteer. Be willing** to do whatever it takes to get there."

Sharon Schuman, RHIA, CDIP, CCS
CHIA Editorial Advisory Board Member