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ASSOCIATION

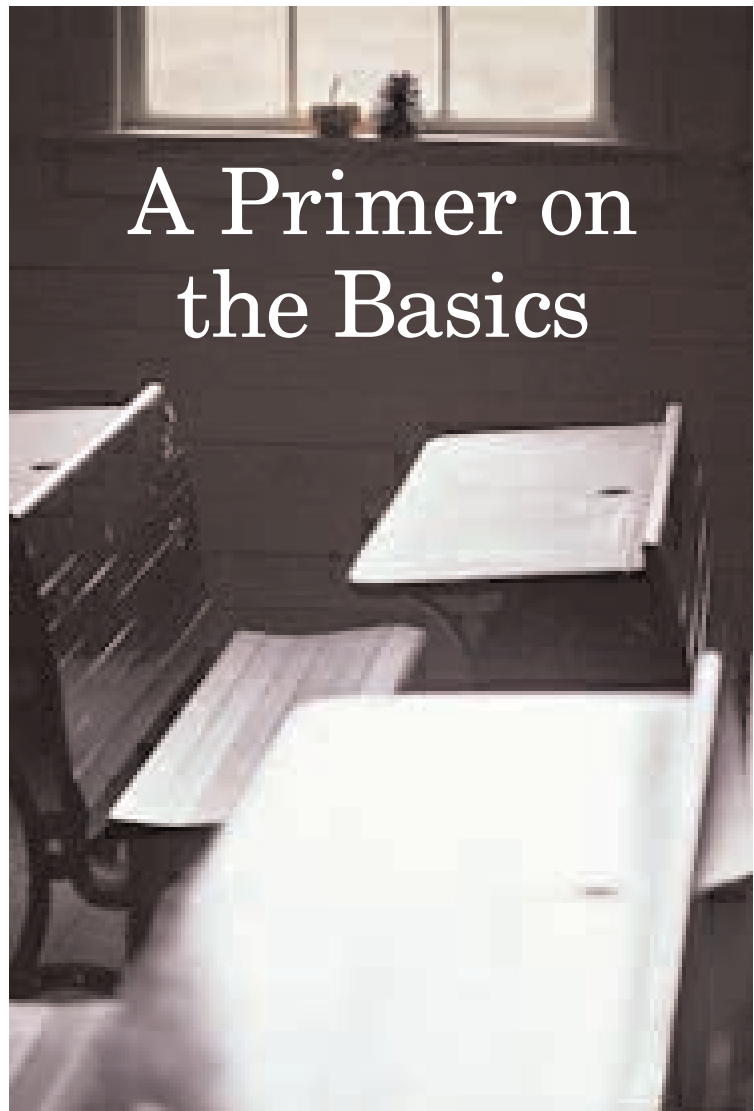
February/March/April 2002



Disclosures of Protected Health Information in Texas With a Focus on Proactive Risk Management – “The Basics”



Coding Innovations: Like Martha Says, “It’s a Good Thing”



TxHIMA Journal Publication

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Renewal & Growth

The last time I wrote the President's Message, it was the beginning of the fall season. Now it is the beginning of the spring season. The flowers are beginning to bloom and the trees are beginning to produce their various colored leaves. It is a time for growth and renewal. My, my how time flies.

I look back and I have already been the President of TxHIMA for nine months. It feels like yesterday when I was installed at the annual meeting in Arlington, Texas. This past weekend, the TxHIMA Board members spent two days working on the next fiscal year's budget and finished planning the last minute details of the Annual Meeting to be held in Corpus Christi, Texas this year. The final touches were also made to the upcoming ballot for the TxHIMA board. The board continually looks for opportunities to support and renew the membership. It is quite an amazing process to watch and I am grateful to have an opportunity to participate. I cannot convey to the level that I would like, my sincerest gratitude for being able to share this time with the board members and the membership as a whole. It has meant so much to me. I just hope I have played a role in someone's life the way the organization and membership have played a role in my own life.

Like I said, the ballot was finalized over the weekend. The ballot will be mailed out to all the voting members within a matter of weeks. I strongly encourage all members to

exercise their patriotic duty and VOTE. Every vote counts. Every member counts. Please vote this year! Let's show the world we are alive and we are interested in what happens around us and to us. We have a great slate of volunteers running for office this year. I am so thrilled to see others wanting to get involved and make a difference. We have one of the best ballots ever. We

The educational opportunities will be vast and the speakers will be upbeat and encouraging while providing great educational materials.

have the best state organization in the country. STAND UP and make a difference.

TxHIMA is working very diligently along with the Planning Committee, to give the membership and attendees a wonderful annual meeting in June of this year. The

meeting will be held in Corpus Christi, Texas. The registration materials will be forthcoming. This is a wonderful city to bring family and



Donna Bowers, JD, RHIA

friends as well. I plan on bringing my own family with me for a couple of days. I plan on playing for a couple days and then getting down and working very hard. I encourage you all to do the same. The educational opportunities will be vast and the speakers will be upbeat and encouraging while providing great educational materials. Let's all participate and show up for the meeting. Let's strive to have the best attendance ever. This is always a good time to network, meet new people and rekindle old relationships. On top of all this, you will learn. We look forward to seeing you there.

Talking about renewal and growth, that is exactly what TxHIMA is all about. Has everyone logged in and looked at the new web page? If not, you need to. New information is being added almost daily. The new web page has been a big success. We have received a number of compliments from the members. Our goal was to meet the needs of the members and it appears that we are achieving that goal. I want to thank **Diann Brown** and **ZMAC Technologies** for a wonderful job.

We will continue to strive to

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meet our membership's needs for the remaining fiscal year and over the next year as well. At the board meeting this past weekend, the board voted on several initiatives that would continue to support the membership and continue to expand the services provided. TxHIMA is headed toward on-line voting, more on-line communication opportunities and enhanced educational opportunities. The board looked over all the programs planned this fiscal year and it appears that TxHIMA will be providing over 20+ educational programs. This is a record. TxHIMA will continue to offer a myriad of educational opportunities this next year, both face-to-

face as well as more audio conference programs. TxHIMA had their first program this year and it was a huge success based on the feedback. For next year, you will see an increased emphasis on HIPAA since we are about one year away from the compliance date. As long as the membership supports the educational sessions, TxHIMA will be making them available.

Make sure you read your on-line journal. Everyone should know by now that we no longer print the journal. All members can sign onto the web page and sign up for automatic announcements. I strongly encourage you to do this. I have

already signed up. I don't want to miss anything; you shouldn't either.

Please remember that TxHIMA is here for you. The board members are truly dedicated to you. I strongly encourage more people to get involved and make a difference. The professional and even personal satisfaction that is gained from volunteering is overwhelming. Take this year to renew and revitalize yourself. Get out of the old ruts and routines and make a commitment to add more to your life. TxHIMA can help you achieve that goal.

I will close for now and I look forward to seeing each and every one of you at the annual convention. We will all have a great time. ☺

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St. Scholastica Takes the Lead With New Informatics Certificate Programs

DULUTH, MN – The College of St. Scholastica has announced new academic offerings in the area of informatics and data management in health care, with four graduate-level certificate tracks designed for delivery to working professionals across the nation.

The new graduate certificate programs offered through the Department of Healthcare Informatics and Information Management (HIIM) are:

- Healthcare Informatics
- Nursing Informatics
- Healthcare Data Privacy and Security Management
- Project Management

These new certificate tracks are designed for distance delivery and each can be completed in three academic terms or less. The programs will begin in fall term 2002.

“Informatics” refers to the application of computers to managing information. The growth of health care-related informatics as an academic discipline is a reflection of the rapid growth of sophisticated computer-based applications within the healthcare industry that are used

directly by managers and care providers to support both administrative and clinical decision-making.

“The computerization of health-care data and information is crucial to providing quality care in an environment that is pressing for significant cost reduction,” said Shirley Eichenwald, coordinator of the HIIM department’s Master of Arts in Health Information Management program. “The federal government is requiring increased standardization of data to facilitate the business of health care delivery, as well as stringent security measures to preserve the integrity and privacy of health care information. St. Scholastica is leading the nation in developing academic coursework to prepare health-care professionals to assume new roles and to practice effectively in this rapidly emerging computerized information-intensive environment.”

Dr. Larry Goodwin, president of St. Scholastica, notes: “This initiative



is the latest in a long tradition of innovation from our HIIM department. The field of medical records was created as an academic discipline at St. Scholastica in the 1930s, and ever since we have been on the forefront of health care management in this specialized area.”

In December 2001, St. Scholastica’s Master of Arts in Health Information Management program became the first in the nation to receive approval from the American Health Information Management Association (AHIMA). St. Scholastica continues to offer an undergraduate program in health information management, including a distance-based BA degree completion program for working professionals.

For more information on graduate certificates or the master’s program contact **Shirley Eichenwald** at (218) 723-6448. For information on undergraduate programs contact **Kathy LaTour**, Chair of the Department of Healthcare Informatics and Information Management, at (218) 723-6011. ☺



Coding Innovations: Like Martha Says, “It’s a Good Thing”

Dana M. Choate, RHIA, Associate Director, HIM, Baylor University Medical Center

One of the fastest ways to get the attention of your Chief Financial Officer is to allow the number of accounts held for coding to rise. If your institution is like mine, there are more sets of eyes on your uncoded billhold report than the actual number of discharges from the previous day! In the fall of 2000, we found our institution with a severe coding shortage. There were a number of factors that lead Baylor University Medical Center down this path. As with any situation in which you are challenged, you have to consider both traditional and creative measures for resolution. For Baylor University Medical Center, we did a combination of both.

How did we find ourselves in this situation you might ask? We found that we were experiencing the impact of the current market within the Dallas-Fort Worth area. At that time, the unemployment rate hovered around 4.3%. For the economy, that was great. However, from any employer’s standpoint, our recruitment base was critically low. Within our area we were also seeing a number of our educational institutions closing or restructuring due to poor enrollment. Additionally, we noticed a lack of interest in the health profession, in general, by our young adults. Many of them were seeking a higher paying and more glamorous professions than Health Information Management. However, the biggest challenge before us was the tremen-

dous competition for qualified coders in the non-traditional hospital setting. We found that our experienced coders could easily find jobs outside our hospitals walls. Typically, we could not compete with the salary offers, but more often, we could not compete with the flexible schedule and work environments.

The impact from all of these factors left us with a lack of skilled workforce, the inability to recruit experienced coders and a stressed coding and management team. We



found that we were not alone in this situation. In a February 2001 article from “Medical Records Briefing,” the percentage of large hospitals having difficulty recruiting and retaining qualified coders totaled 74.2%. Although we were in fine company, it did not make our accounts receivable management predicament any easier.

What were our options at this point? Anytime that an institution is faced with significant coding shortages, one of the obvious considerations is to utilize a coding agency. Although they are an excellent

resource in this situation, contracting with an agency has some drawbacks that must be considered. Unless you are fortunate to have someone that can immediately impact production, you are faced with a slow return on investment as they are learning your coding and abstracting system. Additionally, agency staff are typically placed on a progressive review process. For our institution these individuals are placed on a 100% pre-bill review until their coding skills are proven and there is a comfort level with their knowledge of our abstracting requirements. This only adds to the work level of your coding management team and will delay the number of accounts that can be processed each day. The biggest consideration with using agency support is the ramifications that they have on your operating budget. You can generally win over your Administrator if you can demonstrate the cost per hour is worth thousands of dollars in revenue for your facility each day.

Another option that we considered, in addition to utilizing contract agencies, was to enhance our current staff. We felt we had some very dedicated staff and they deserved the investment we considered in this area. We identified three major opportunities to enhance and motivate our existing workforce. We determined that we needed to consider monetary forms of motivation, ways to enhance staff’s need for self-

development and how we could position competition as a motivator.

Money Talks

Although we have been instructed in our management courses that money should not be a motivator, we all know that it is. Money, in fact, is our oldest form of motivation. Most organizations rely on money to not only motivate, but to retain, employees. However, this form of motivation should be considered very carefully. Money has been termed to be “like heroin.” Essentially, it takes more and more of it to create the same effect. One of the first things we did in this area was to do a market salary comparison. We found that we had opportunity to raise our base salary based on this information. In addition, we considered sign-on bonuses, spot bonuses and incremental bonuses. Although this is a typical recruitment tactic for some institutions, it was one that our organization was not willing to implement. However, one that was accepted quite easily was our Baylor Health Care System Coding Production Incentive Program.

This program is based on group and individual goals. Each month, the coding section has a group goal that they must meet. For us, we have established a four-day billhold goal based off our inpatient, day surgery/observation, emergency room and other outpatient volume. At the end of the month, if the coding section meets the overall billhold goal, the coders, coding auditors and the coding manager are eligible to receive the incentive distribution. However, they must meet our coding quality, coding productivity and time and attendance standards.

We found that this model works

nicely. It puts pressure on your coding staff to meet and remain at standards and for the group to pull together so that all can benefit financially. But what about that one coder that only does what they need to do to keep their job? What we have found is that peer pressure will take care of that issue. It goes without saying that in order for this program to be successful, you must have the support of your Administration. However, you must also have the dedication of your coding staff from the very beginning of implementation of this program.

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Growing Our Own

In addition to monetary forms to motivate, Baylor University Medical Center considered ways to enhance self-development in staff. Although we were already cross training staff and providing continuing education opportunities for our employees, we knew we needed to do something radically different. We needed a way to provide formal

training opportunities to existing employees that could not afford to go to school part-time (possibly due to family commitments) and work full time. As a result, and again, with the outstanding support of Administration, Baylor University Medical Center developed an American Health Information Management Association (AHIMA) certified (October 2001) Coding Education Program.

The Coding Education Program is a six-month paid training program in hospital based coding. Classroom time is 40 hours/week and divided into traditional classroom learning in addition to practical experience within the Health Information Management Department. This program is offered in January and July of each year. To apply for the program, the applicant must have a high school diploma and complete a written essay on health information management theory. If the applicant is internal, they must meet our transfer process. However, if we select an external candidate, they must meet the hiring process through Human Resources. The coding management team, along with the coding instructor, evaluates the candidates and selected applicants will go through a panel interview process. Seven coding students are selected for participation in our program and a two-year work agreement is required prior to beginning the program.

The Coding Education curriculum includes program orientation, anatomy and physiology, medical terminology, pathophysiology, ICD-9-CM coding, CPT coding, CMS coding guidelines and some pharmacology. We established this program

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in conjunction with the core AHIMA model curriculum. Each student must maintain a 75% or above in each class and they must maintain acceptable work performance during the practical experience of the program. At the completion of the Coding Education Program, the coder trainee is placed in a Baylor Health Care System facility. If nothing is available, they are free of their two-year work agreement.

We are currently in our third class. The interest in this program has been overwhelming to say the least. We have not advertised this program outside Baylor Health Care System. For our first class, 54 applicants applied. For our second class, 82 applicants applied and in our last class, over 173 applicants applied for seven positions. We have received applicants throughout the United States. In addition, we are enticing the interest of individuals within the profession that want to update or refine their skills.

New Frontiers

Baylor University Medical Center chose to use a form of competition as a method to motivate existing staff. When the Coding Education Program was in place, we still had a minimum of six-months prior to seeing any relief. With that in mind, we considered another source of coders that were right under our noses the whole time – residents. Who else in our institution is familiar with maneuvering around a medical record, understand the disease process and can read physicians hand-writing?

We approached our surgical and medicine resident Chiefs to inquire if any of them would like to code charts for us while completing their

residency at Baylor. We thought there might be one or two that would express interest. However, we quickly had over 25 residents interested in assisting. We selected ten residents based on time commitment per week, the year within their residency and their ability to quickly meet our quality and productivity standards. This was an immediate win for us. We provided an initial 12 hours/training per resident. Within one month, the resident coders were meeting our productivity and quality standards (this is something that a typical coder takes up to one year to accomplish).

The resident coders are compensated on the low end of the contract scale. We have found that they are self-managed. There was one resident that was skipping his required rotation in order to put in additional hours in our department. The other resident coders found out about this and called a meeting to resolve this issue before the whole group was stripped of this opportunity. Our Coding Audit team pulls charts for them to code. They are only allowed to code our inpatient charts and they are not allowed to code their own cases.

We have found that this resident coding initiative provided us a number of advantages. They are reliable and cost-effective. These residents are learning first hand the importance of their documentation. In fact, they are using their knowledge to educate their peers and the other medical staff members through grand round presentations. Although there is



some competition among the coders and the residents, we have found that it really has fostered a learning environment for both. The coders can ask questions regarding disease process and the residents continued to learn everyday how this experience will aid them in their professional careers. This initiative really has strengthened the reputation of the coding profession. I believe that you almost have to have the knowledge base of a physician to be a medical coder.

There are certainly more ways to motivate your existing staff to get through any crisis situation. Although these resolution techniques centered on the coding profession, there is no reason why you cannot implement incentive programs, educational programs or peer competition throughout your department. It takes a creative mind, a dedicated staff and the ability to think beyond a short-term fix. I am hopeful that you can take some of these ideas or a variation of them to keep you from being the focus of your CFO. ☺

Disclosures of Protected Health Information in Texas With a Focus On Proactive Risk Management

E. Earl Hauss, B.S.N., R.N., Owner and principal of “PRS of Texas”

Release of Information in Texas or disclosure of protected health information is governed by numerous state and federal statutes, codes, rules and regulations. Each of these addresses particular areas of disclosure or release such as licensed physicians, licensed hospitals, mental health records, workers compensation records, social security disability, etc. The health information management professional handling or supervising disclosures has the responsibility to have a working knowledge and understanding of these various laws and is often called upon as a resource to others on the particulars of disclosing protected health information.

The purpose of this article is to briefly review the three principal statutes and regulations that govern disclosures in Texas. These include the *Texas Health & Safety Code – Chapter 241; Subchapter G. Disclosure of Health Care Information*, which applies to licensed hospitals, *Texas Occupations Code – Chapter 159. Physician-Patient Communication* and *Texas State Board of Medical Examiners Board Rule 165*, which apply to licensed physicians and the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, which applies to most health plans, health care clearinghouses and health care providers. This review includes the history and applicability of each law along with

references and resources available to the health information professional.

These three statutes and regulations were selected because they provide the most comprehensive guidance and specific standards for the disclosure of protected health information in the state of Texas. Essentially, every health care provider or entity within the state of Texas must comply with one or more of these regulations. Thus, health information professionals handling disclosures should have a working knowledge of the laws that apply to their entity and have access to resources for clarification and additional information.

Licensed Hospitals in Texas

In 1995 Senate Bill 667 was enacted and significantly changed various statutes that affected the release of medical records in the state of Texas. This legislation was introduced by The Texas Hospital Association (THA) and the Texas Health Information Management Association (TxHIMA). Four previous attempts at passing similar statutory proposals had failed. This bill was passed after compromises were made between THA, TxHIMA and the Texas Trial Lawyers Association.

Senate Bill 677 amended the Texas Health & Safety Code and added Subchapter G – Section 241 entitled “Disclosure of Health Care Information”. Prior to that time, the

law provided some protection for physicians and mental health records but there was no specific legislation for hospitals. Further, the law required medical records to be provided at “reasonable” costs. This allowed for circumstances in which there would be drastic differences in the cost to obtain copies of medical records between hospitals and instances in which hundreds of dollars had been charge for just a few pages of records. There was concern that this practice was adding to the cost of litigation when records were needed for court cases.

This bill set forth guidelines for the disclosure of health care information and established specific fee limits on the amount hospitals could charge for copies of medical records. Interestingly our representatives’ title for this legislation closely parallels verbiage within HIPAA.

Some of the more specific guidelines enacted by Senate Bill 667 in 1995 included the following:

- The authorization was required to be in writing; dated and signed by the patient or the patient’s legally authorized representative; identified the information to be disclosed, identified the person or entity to whom the information is to be disclosed and would be valid until the 90th day after the date it is

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signed, unless it provides otherwise or unless it is revoked.

- Defined “legally authorized representative”; However, within this definition was the language “a personal representative” of a deceased patient which created some uncertainty as to whether a hospital needed to require a court-appointed representative to sign the authorization or whether one could honor an authorization signed by the patient’s next-of-kin.
- Identified the requirements for a patient to revoke a authorization;
- Provided a lists of exceptions in which disclosures of health care information may be made without a patient’s authorization; One of these exceptions which caused interpretive problems for hospitals allowed for the release of medical records without an authorization “to a court pursuant to a court order or court subpoena.” This issue involved the definition of “court subpoena.” Did this mean the subpoena had to be issued by the court or was an attorney or notary issuing a subpoena considered an “officer of the court.”
- A specific fee structure was established with an allowance for the annual adjustment of the fees each September 1st, based upon the consumer price index as published by the Bureau of Labor Statistics of the United States Department of Labor.
- In addition, this bill required a hospital to adopt and implement reasonable safeguards for the security of health care information and allowed for a statutory remedy to a patient when a hos-

pital violated the statute.

In 1997 Senate Bill 975 was enacted to address several problems that had arisen regarding the interpretation of S.B. 667. Again, one of the important issues at that time involved the interpretation of the term “court subpoena.” This bill amended this exception to now read “to comply with a court order; or related to a judicial proceeding in which the patient is a party and the disclosure is requested under subpoena” rather than to a “court pursuant to a court order or court subpoena.”

Other changes to Subchapter G, Chapter 241 enacted by Senate Bill 975 in 1997 included the following:

- The addition of definitions for “directory information” and modification of the definition of “legally authorized representative”;
- Extended the validity of a patient authorization from 90 to 180 days after the date signed unless it provided otherwise or is revoked;
- Added additional exceptions in which a patient’s health care information was authorized to be disclosed without the patient’s authorization such as the disclosure of directory information, to a transporting emergency medical service provider, to a member of the clergy specifically designated by the patient and others including the modification of the definition of court order and court subpoena.
- Modified the hospital’s requirement to make information available within 15 days of receipt of a written request to also include “and payment authorized”.
- In addition, a hospital was prohibited from charging a fee for

requests under certain circumstances. Modifications were made to the fee schedule for providing health care information, execution of an affidavit or certification of a document and completion of written responses to a written set of questions.

Subchapter G, Chapter 241, Disclosure of Health Care Information of the Texas Health & Safety Code has remained intact since 1997 with the only change being the annual adjustment of fees for copies of records each September 1st.

However, the rules and standards contained within HIPAA will now need to be compared with Texas’ laws and regulations because the health care provider will be required to comply with both laws. The HIPAA privacy rule allows for the preemption of state law under circumstances in which the state law is contrary to the privacy rule. This will require covered entities under HIPAA to make choices between the privacy rule and Texas state laws or what is referred to as a preemption decision.

Licensed Physicians in Texas

In 1995 Senate Bill 667 also amended the Medical Practice Act (Article 4495b, V.T.C.S.) and granted additional rulemaking authority to the Texas State Board of Medical Examiners with respect to the disclosure of health care information. The Medical Practice Act regulates the professional activities of physicians in Texas.

Senate Bill 667 provided for definitions of “legally authorized representative” and “medical records.” They defined “medical records” as “all records pertaining to the history,

diagnosis, treatment, or prognosis of a patient.” In addition, certain exceptions to the confidentiality or privilege of confidential information were added allowing the physician to release such information without a written authorization. The bill also prohibited a patient from maintaining an action against a physician for disclosure of confidential communications made in good-faith, if the physician did not have written notice that the authorization was revoked.

Importantly, one amendment within this bill expressly requires physicians to furnish copies of medical records requested, including records received from another physician or health care provider involved in the care or treatment of the patient, pursuant to a written request. At that time, Texas case law had previously construed that certain provisions of the Medical Practice Act governing the release of medical records were applicable to hospitals, it was considered possible that a court could also require hospitals to provide copies of records received from other health care providers. This is still an issue frequently questioned and debated in hospitals. However, HIPAA appears to allow for the re-release of such records from other health care providers.

The physician was also authorized to delete confidential information about another patient or family member of the patient who has not consented to the release.

Senate Bill 667 authorized a physician to charge a reasonable fee for copying records and provided for the physician to withhold access until payment of the fee. The Senate Bill required the Texas State Board of Medical Examiners, by rule, to prescribe what constituted reasonable

fees. It continued to allow a physician 30 days to respond to a request for copies of medical records. This was subsequently changed in 2000 to conform to the hospital law allowing 15 days.

The Texas State Board of Medical Examiners subsequently enacted Board Rule 165 relating to medical records, which was first published in the Texas Register on April 5, 1996. This rule enacted a fee schedule for copies of medical records from a physician’s office. In addition, the rule allowed for the physician to withhold providing the medical records until payment was received for the copies unless there was a medical emergency. However, the physician could not refuse to provide copies of medical records based on a past due patient account for medical care or treatment previously rendered to the patient.

Over the years the Texas State Board of Medical Examiners has made minor changes to the board rule regarding medical records. This has included the time period to respond to a request being reduced from 30 days to 15. In 1997 modifications were made to the record retention regulations and in 2000 fees for execution of an affidavit of \$15.00 were added. Further, in 1999 the Medical Practice Act (MPA) was recodified and incorporated into the Texas Occupations Code under Subchapter B., Chapters 151-165.

HIPAA in Texas

The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA) has given us “Standards for the Privacy of Individually Identifiable Health Information; Final Rule.” 45CFR Part 160. Federal Register 65, no.

250 (December 28, 2000), also known as the HIPAA Privacy Rule.

In 1996 Congress enacted HIPAA to establish national patient records privacy standards. This act gave congress until August 21, 1999 to pass comprehensive health privacy legislation. Congress did not pass such legislation and the law then required the Department of Health and Human Services (HHS) to promulgate the regulations. The proposed regulations were first published in November 1999 allowing for an extended comment period from the public. The final rules were published in the Federal Register on December 28, 2000. They took effect on April 14, 2001 and covered entities have until April 14, 2003 to comply with the final rules.

However, HHS does have authority to make changes prior to the rule compliance date. Therefore, it will be necessary to monitor these regulations on a regular basis for any changes or modifications. The HHS Office for Civil Rights (OCR) will provide assistance to help covered entities prepare for compliance.

The HIPAA Privacy Rule creates a national standard to protect the privacy of individual’s medical records and personal health information. The Privacy Rule is intended to be a floor or foundation for the regulations that all covered entities will be required to comply with to maintain this privacy. In addition, the Privacy Rule provides for a higher standard of protection for psychotherapy notes.

The Privacy Rule applies to health plans, health care clearinghouses and health care providers who transmits any health information in

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electronic form in connection with a transaction covered by the subchapter of the privacy rules. Health information is subsequently defined as “any information, whether oral or recorded in any form or medium, that: (1) Is created, or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual”.

As previously mentioned, covered entities will still have to comply with both federal and state privacy laws and regulation. However, the HIPAA Privacy Rule preempts or

“takes the place of” state law when the state law is contrary to the privacy rule. The HIPAA Privacy Rule states that a state law is contrary under the following circumstances:

- A covered entity would find it impossible to comply with both state and federal requirements;
- Adhering to state law would stand as an obstacle to achieving the full purpose of the administrative simplification portions of HIPAA.

In addition, the HIPAA Privacy Rule provides four exceptions in which the state law will prevail. One exception is when State law relates to the privacy of health information and is more stringent than the federal privacy rule requirements. The HIPAA Privacy Rule then provides that the state law must meet one or more of six criteria to qualify as

more stringent. This process is known as making a preemption decision or determination. The preemption questions can range from simple issues such as responding to a request in 15 days vs. 30 days or complicated issues that require involvement of legal counsel.

The HIPAA Privacy Rule will require covered entities to compare each state law which regulates their disclosure of protected health information with the privacy rules to determine if a preemption decisions is indicated. It becomes apparent that the interpretation of “contrary” and “more stringent” could vary between entities and even between employees within an entity. Therefore, some mechanism will need to be established to keep track of preemption decisions along with procedures for making such decisions

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within each covered entity.

This article is not intended to be a comprehensive review of the HIPAA Privacy Rule or a comparison of the HIPAA Privacy Rule with each element of the Texas State statutes and regulations discussed here or any of the other state statutes, rules or regulations that impact disclosure of protected health

information in Texas. Most health care entities are in the process of traveling this road towards achieving compliance in April 2003. While most of the focus is on the HIPAA Privacy Rule, almost as much effort will need to be placed on reviewing the Texas State laws and comparing them with the privacy rule to evaluate and study the preemption issues.



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- Practice Brief “Laws and Regulations Governing the Disclosure of Health Information” AHIMA May 2001.

General Resources

<http://www.txhima.org/currenttexaslaws.htm>.

This section of the TXHIMA web site dedicated to Texas State law and legislation for the health information professional. Obviously, a great overall resource for the HIM professional. This site contains links to numerous laws including the text of Subchapter G, Chapter 241, Disclosure of Health Care Information of the Texas Health & Safety Code which applies to licensed hospitals and the Medical Practice Act (MPA) from the Texas Occupations Code, Subchapter B., Chapters 151-165 which applies to licensed physicians.

<http://www.capitol.state.tx.us/statutes/statutes.html>

This site gives you a direct link to all Texas State Statutes. You can open the statute or download a copy in ASCII or WordPerfect format.

<http://tlo2.tlc.state.tx.us/tlo/billnbr.htm>

This site allows you to pull up any Texas Legislature bill from 1997 through the present. All you need to know is the bill number. You can obtain the bill in its various versions as it passes through the house of representative and senate along with a bill analysis, fiscal implications of the bill along with witness lists and additional information.

Licensed Hospitals in Texas

<http://tlo2.tlc.state.tx.us/tlo/billnbr.htm>

Texas Hospital Association website that includes a legislative update site which monitors current bills along with an Advocacy section available to members of THA.

<http://www.capitol.state.tx.us/statutes/he/he02410Otoc.html>

Texas Health & Safety Code –Chapter 241 – Table of Contents with links to each section. 241.151 is where Disclosure of Health Information begins.

Licensed Physicians in Texas

<http://www.capitol.state.tx.us/statutes/octoc.html>

Texas Medical Practice Act contained within the Texas Occupations Code Chapter 151-165

<http://www.tsbme.state.tx.us/>

Texas State Board of Medical Examiners web site

<http://www.tsbme.state.tx.us/rules/rules/165.htm>

Texas State Board of Medical Examiners Board Rule 165.

<http://www.texmed.org/pmt/le/legalhlrelease.asp>

An excellent article on the Texas Medical Association website “Release of Medical Records: A Guide for Physicians” written by TMA Office of the General Counsel. This was last updated in 1999.

HIPAA

<http://www.txhima.org/hipaa.htm>

This is the section of the TxHIMA web site that links to an excellent resource for HIPAA. The site was created by a law firm Bricker and Eckler, LLP, of Columbus, Ohio and allows you to search HIPAA by subject matter.

<http://www.hhs.gov/ocr/hipaa/>

This is the site of the Office for Civil Rights. They are responsible for providing assistance to help covered entities prepare to comply with the privacy rules. An excellent resource for the privacy rules. This site also offers the option to leave a question and it has been reported that these will actually be answered.

<http://aspe.hhs.gov/admsimp/Index.htm>

U.S. Department of Health and Human Services Administrative Simplification website. The privacy rules can also be accessed through this site.

<http://www.bcm.tmc.edu/compliance/regeds/feb01reged.html>

This is the Baylor College of Medicine’s HIPAA compliance program.

<http://www.ahima.org/>

American Health Information Management Association web site. There are numerous resources for HIPAA.

Organized Health Care Arrangement

Patricia Johnston, FHIMSS, Director, HIPAA PMO, Texas Health Resources

A key requirement of the HIPAA Privacy Rule is the obligation to obtain a Consent from each Individual (patient) for the use and disclosure of their protected health information (PHI) for the purposes of treatment, payment and health care operations. Every provider with a direct treatment relationship with the patient must obtain this Consent. The Rule strictly prohibits one covered entity from obtaining the Consent on the behalf of any other covered entity. Permissible disclosures to another provider without a Consent are limited to treatment purposes only.

The Privacy Rule contains a provision for an “Organized Health Care Arrangement” (OHCA) that gives providers more flexibility and allows providers who are members of such an arrangement to rely on the Consent obtained by any other provider within the arrangement. Without using this arrangement, for instance, a hospital cannot share information with treating physicians for the purposes of the physician billing, without either the patient’s authorization, or the physician obtaining their own Consent. Certainly there are numerous instances in a hospital environment (emergency patients, surgical consultations in the hospital, etc.) where such a requirement would be a major hassle factor for physicians and patients alike.

Definition

So what is an Organized Health Care Arrangement? The preamble to the rule states that the term is

intended to describe certain arrangements in which participants need to share PHI about their patients to manage and benefit the common enterprise. Five arrangements are included in the definition of an OHCA. They may range in legal structure, but a key component of these arrangements is that individuals who obtain services from them have an expectation that these arrangements are integrated.

The first arrangement listed is most applicable to the hospital setting. That first category is defined as a clinically integrated care setting in which individuals typically receive health care from more than one health care provider. The example given was the hospital setting, where a hospital and a physician with staff privileges at the hospital together provide treatment to the individual.

**On the surface
this appears
to be a
“no-brainer
decision”.**

Participants in an OHCA can share the same Consent for the use of PHI for treatment, payment and health care operations. They are required to abide by the same Notice of Privacy Practices, a Joint Notice. This Joint Notice requirement of the Privacy Rule includes the agreement by the covered entities participating in the OHCA to abide by the terms

of the Notice with respect to PHI created or received by the participants. The Joint Notice must inform the patients who the participants of the OHCA are.

The OHCA should also establish reliable procedures to notify its participants when any participant in the OHCA accepts an Individual’s revocation of Consent, or agrees to a restriction on the uses and disclosures of PHI. This would only apply to PHI created or received by each participant as part of its participation in the OHCA.

Issues to Consider

On the surface this appears to be a “no-brainer decision”. Why wouldn’t a hospital want to establish themselves in such an arrangement with their medical staff?

One of the primary concerns is that of the potential for an increase in liability on the part of the hospital for the compliance of its medical staff with the Privacy Rule. Requiring each direct care provider to obtain their own Consent is thought by some to eliminate or at least minimize the potential risk of the entity assuming liability for breaching of health information by the medical staff or their office staff.

An example might be the unauthorized release of PHI by a physician staff member to a pharmaceutical company, resulting in fines and/or criminal penalties to the hospital. The healthcare industry is not in agreement that such a risk exists. But there are those who are con-

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cerned enough that they have decided the Joint Notice and Consent under the OHCA is not for them.

However, in that case we now have the inconvenience of all direct care providers being responsible for their own Consent. Assuming a scenario where a patient is admitted through the Emergency Department, seen by a surgeon and anesthesiologist and then consulted by a cardiologist – well, you can count the number of Consents that would be involved. There is the argument that information could be shared with these providers by the hospital for treatment purposes without their having to obtain a Consent. But that still leaves in question the physicians being able to use the information for billing, as well as their participation in aspects of operations such as mortality reviews and QA functions, where they are accessing the PHI of patients not their own.

It is for these reasons that many covered entities are moving forward to take advantage of the OHCA provisions of the HIPAA Privacy Rule.

Implementation

If an organization does decide to move forward with an OHCA arrangement with their medical staff, there are some mechanisms to consider to increase the likelihood of success and decrease potential risk. These would include the following:

- Involve your physicians in the process of making the OHCA decision and developing the implementation plans.
- Carefully word the Joint Notice so that it is clear that participants are not acting as agents of the other.
- Work with the medical staff to modify By-laws or Rules and Regulations to acknowledge agreement with and intent to abide by the Notice of Privacy Practices and its underlying policies and procedures.
- Update the credentialing process to incorporate agreement with the Notice of Privacy Practices and its underlying policies and procedures.

- Develop comprehensive training strategies that address those aspects of your modified policies and procedures requiring compliance by the medical staff. ∞

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Editor's note: Review the proposed modifications, the privacy rules that were release on March 21, 2002. Changes to the consent and notice potentially may effect how the OHCA is implemented.

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Standards for Privacy of Individually Identifiable Health Information

Proposed Rule Modification

Background

The Standards for Privacy of Individually Identifiable Health Information (Privacy Rule/current rule) took effect on April 14, 2001. As required by the Health Insurance Portability and Accountability Act (HIPAA), the Privacy Rule covers health plans, health care clearinghouses, and those health care providers who conduct certain financial and administrative transactions electronically. Most covered entities must comply with the Privacy Rule by April 14, 2003. Small health plans have until April 14, 2004 to comply with the Rule. The Privacy Rule creates national standards to protect individuals' personal health information and gives patients increased access to their medical records. The Bush Administration is committed to strong patient privacy protections and continues to take steps to protect personal health information while maintaining access to quality health care. To ensure that the provisions of the final rule provide strong privacy protection without hindering access to health care, the Department of Health and Human Services is proposing modifications to the Privacy Rule.

Proposed Modifications

Consent and Notice – The proposal would promote access to care by removing the consent requirements that would potentially interfere with the efficient delivery of health care, while strengthening

requirements for providers to notify patients about their privacy rights and practices. Specifically, the Department received comments that the consent requirements in the current rule interferes with pharmacists filling prescriptions, referrals to specialists and hospitals, providing treatment over the telephone, and emergency medical providers. Under the proposal, patients would be asked to acknowledge receipt of the notice of privacy rights and practices. This change would give patients the opportunity to consider a provider's privacy policies before making health care decisions, while eliminating barriers that could delay or block patients' access to care. This change to consent only applies to uses and disclosures for treatment, payment and health care operations (TPO) purposes. Patient authorizations are still required to use and disclose information for non-TPO purposes.

Minimum Necessary and Oral Communications – The "minimum necessary" provision is an essential element in the privacy protections for individual health information. This provision requires covered entities to make reasonable efforts to limit the use and disclosure of and request for, protected health information to the minimum necessary to accomplish the intended purpose. The proposal would retain both the oral communication and "minimum necessary" requirements, but it would make clear that a doctor could discuss a patient's treatment

with other doctors and professionals involved in the patient's care without fear of violating the rule if they are overheard. As long as a covered entity met the minimum necessary standards and took reasonable safeguards to protect personal health information, incidental disclosures – such as another patient overhearing a fragment of conversation – would not be an impermissible disclosure.

Business Associates – The current rule requires covered entities – health plans, health care providers and clearinghouses – to have contracts with their business associates to ensure the business associates protect the privacy of the information. The proposal includes model business associate contract provisions, to make it easier and less costly for covered entities to implement the requirements. The changes also would give covered entities (except for small health plans) up to an additional year to change existing contracts, easing the burden of renegotiating contracts all at once.

Marketing – Based on consumer concerns that the marketing provisions in the current rule does not protect individuals' privacy, the proposal would explicitly require covered entities to first obtain the individual's specific authorization before sending them any marketing materials. At the same time, the proposal would permit doctors and other covered entities to communicate freely with patients about treat-

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ment options and other health-related information, including disease-management programs.

Parents and Minors – The current rule may have unintentionally limited a parent’s access to their child’s medical records. The proposal clarifies that state law governs disclosures to parents. In cases where state law is silent or unclear, the revisions would preserve state law and professional practice by permitting a health care provider to use discretion to provide or deny a parent access to such records as long as that decision is consistent with state or other law.

Uses and Disclosures for Research Purposes – The proposal would eliminate the need for researchers to use multiple consent forms – one for informed consent to the research and one or more related to information privacy rights. Instead, researchers could use a single combined form to accomplish both purposes. The proposal would also simplify other provisions so that the existing rule more closely follows the requirements of the “Common Rule,” which governs federally-funded research. The provisions include privacy-specific criteria and apply equally to publicly and privately funded research.

Request for Comments on an Alternative Approach to De-Identification – The Department received comments from the research community on the need for an alternative approach to de-identification. HHS shares these concerns but still believes identifiable information should have strong protections. Therefore, HHS is seeking comments on establishing a limited data set that does not include directly identifiable information but in which certain identifiers remain. In addition, to further protect privacy, the Department

proposes to condition the disclosure of the limited data set on a covered entity’s obtaining from the recipient a data use or similar agreement, in which the recipient would agree to limit the use of the data set for the purposes for which it was given as well as not to re-identify the information or use it to contact any individual.

Uses and Disclosures for which Authorizations Are Required – The proposal would allow the use of a single type of authorization form to get a patient’s permission for a specific use or disclosure that otherwise would not be permitted under the Privacy Rule. Patients would still need to grant permission in advance for each type of use or disclosure, but the proposal would eliminate the need for covered entities to use different types of forms to obtain that advance permission.

Other Provisions

The Department also proposes the following modifications:

- **Sale of Business** – The proposal would clarify that the rule permits disclosures in certain circumstances for the sale of a covered entity’s business.
- **Group Health Plans** – The proposal would clarify that a group health plan or health insurance issuer can disclose enrollment or disenrollment information to a plan sponsor without amending plan documents.
- **Accounting of Disclosures of Protected Health Information** – The proposal would not require the covered entity to account for disclosures for which the individual provided written authorization.
- **Disclosures for Treatment, Payment, or Health Care**

Operations of Another Entity – The proposal would clarify that covered entities can disclose protected health information for the treatment, payment and certain health care activities of another covered entity or health care provider. The proposal would carefully limit the expansion of sharing of information for health care operations to protect the privacy expectations of individuals.

- **Uses and Disclosures Regarding FDA-Regulated Products and Activities** – The proposal would assure that the rule permits covered entities to continue to disclose information to non-government entities subject to FDA jurisdiction about the quality, safety, and effectiveness of FDA-regulated products and activities – such as reporting adverse events related to prescription drug use.
- **Hybrid Entity** – The proposal would permit any entity that performs covered and non-covered functions to elect to use the hybrid entity provisions and would provide the entity additional discretion in designating its health care component. The proposal would clarify that protected health information does not include employment records. The proposal also includes a list of technical corrections and additional clarifications related to various sections of the existing rule. The proposed modifications collectively are designed to ensure that protections for patient privacy are implemented in a manner that maximizes privacy while not compromising either the availability or the quality of medical care. Further information about the proposed rule is available on the Web at <http://www.hhs.gov/ocr/hipaa/>. ☺

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