



AHIMA's Long-Term Care Health Information Practice and Documentation Guidelines

Role of Health Information Staff in Long-Term Care Facilities

- [Job Qualifications, Responsibilities, and Functions of Health Information Staff in a Long-Term Care Facility](#)
 - [Role of the Credentialed Consultant](#)
 - [Role of the Credentialed Practitioner Working in a Long Term Care Facility](#)
 - [Role of the Non-Credentialed Practitioner Working in a Long Term Care Facility](#)
 - [Role of the Health Unit Coordinator \(Unit Clerk/Secretary, Health Information Assistant\)](#)
 - [Evolving Role of Health Information](#)
 - [Health Information Department Staffing](#)
-

In order to maintain quality health information systems, properly trained staff and allocation of resources is necessary. The following guidelines provide an outline on the recommended qualifications, responsibilities, and functions that would be performed by four different types of positions to include the following:

- A Health Information Consultant
- A credentialed health information practitioner working in a facility
- A non-credentialed practitioner working in a facility
- A health unit coordinator

As documentation and clinical record systems increase in complexity in response to the changes in the LTC environment, HIM professionals and staff provide valuable expertise and assistance to maintain health information systems that impact quality of care including regulatory, legal, compliance and financial issues.

Job Qualifications, Responsibilities, and Functions of Health Information Staff in a LTC Facility

Role of the Credentialed Consultant:

Many long term care facilities have access to a Health Information Management Consultant to provide expertise on manual and automated health information medical record systems issues, documentation requirements, and assistance with the implementation of the electronic health record. Consultants are usually contracted independent of the organization to support non-credentialed staff or they are employed at the corporate level. Consultants may also serve as an additional resource to a HIM corporate consultant to assist with state specific issues, and/or assist with implementation of corporate policies and procedures. Consultants may also be used for special projects, independent auditing/monitoring services, staff training, etc, even when a credentialed practitioner is employed by the facility.

Qualifications of a Consultant:

The following qualifications are recommended for a consultant in long term care.

- Credentialed as a Registered Health Information Administrator (RHIA) or a Registered Health Information Technician (RHIT). Note: A RHIA (previously a RRA) holds a 4 year bachelor degree. A RHIT (previously an ART) typically has a 2 year associate degree or technical training. Many state licensure bodies require a consultant for a facility which does not have a credentialed person on staff.
- Experience in long term care.
- Knowledge of regulations, survey process, accreditation standards and professional standards of practice pertaining to long term care.
- Understanding of payment systems for SNF/NF including Medicare and Medicaid.
- Knowledge and application of the International Classification of Disease coding in long term care.
- Knowledge of documentation and legal issues pertaining to health information.
- Knowledge of quality assurance/improvement and the ability to apply a quality improvement process to problem solving.
- Superior presentation skills, both oral and written.
- Solid clinical understanding of anatomy, physiology, pathophysiology, and the clinical/nursing process.
- Ability to teach using a variety of methods
- Computer skills and understanding of electronic information systems as used in long term care.
- Ability to assist a facility's move toward an electronic medical record.
- Supervisory and management skills and experience.
- Organizational skills.

Personal attributes of a qualified consultant should include:

- Ability to perform critical thinking, analysis, and problem solving.
- Leadership abilities preferred with the necessary inter-personal skills to function within a team.
- Flexibility, creativity, and adaptability in dealing with problems and facility/corporate staff.
- Good communication skills with the ability to provide constructive information while being sensitive to the customer's/facilities needs.

Reporting:

The Health Information Management Consultant should report to the Administrator or Executive Director of the organization to assure that he/she is aware of findings and recommendations that affect the facility operation and risk factors. The Administrator may choose to delegate direct reporting during a visit to another staff member such as the Director of Nursing Services or the Coordinator of Health Information Services. It is advisable that both the Administrator and the Director of Nursing are aware of the findings and recommendations of the Consultant.

Common Functions Performed by a Health Information Consultant:

- Provide expertise on compliance issues and the integration of clinical documentation and coding with the billing process.
- Develop, implement, and monitor health information department policy and procedures and job descriptions.
- Assist with implementation and function as a key resource on the Health Insurance

Portability and Accountability Act (HIPAA), including information system security issues and privacy.

- Provide training and orientation to health information personnel on functions of the department and facility staff on documentation and the use of an electronic health information system.
- Develop and maintain health information systems and processes that meet regulatory requirements (both State and Federal), professional practice standards, legal standards, and management/corporate policy.
- Establish a process for systematically reviewing documentation on an ongoing basis for both quality and quantity of documentation.
- Ability to complete manual and electronic (via a variety of computer systems) documentation/medical record audits and monitoring with an ability to assess the quality of documentation.
- Ability to recommend corrective actions for findings on medical record audits/monitoring.
- Initiate clinical record systems and indexes.
- Assist with forms development and forms analysis/flow.
- Support compliance process for facility/organization.
- Support quality assurance/quality improvement process of the facility/organization.
- Train staff on quality assurance/quality improvement process related to health information management and appropriate methods for the collection of data.
- Develop educational programs on multiple health information related topics for presentation to clinical staff.
- Understand all aspects of clinical computer system.
- Provide resources to the facility on health information, documentation, regulations, standards of practice, disease coding, etc.
- Ability to provide assistance and function as a key resource for the development, transition, and maintenance of an electronic medical record.
- Develop and provide consultation reports in a timely manner.
- Communicate findings and recommendations effectively to facility administration and interdisciplinary team members.
- Maintain good communication with facility staff and interdisciplinary team members.
- Empower staff to work independently
- Be available to address situational problems via email, phone, on-site visits as appropriate

Role of the Credentialed Practitioner Working in a Long Term Care Facility

A growing trend in the LTC industry is to hire credentialed practitioners to manage the health information department in a facility. Facilities who hire a credentialed practitioner often forego contracting with a consultant or they will utilize a consultant for independent audit and training services. The following list provides the recommended qualifications for a credentialed practitioner working in long term care. If you are hiring a practitioner new to long term care, additional training specific to long term care regulations and documentation will be needed.

Qualifications of a Credentialed Practitioner:

- Credentialed as a Registered Health Information Administrator (RHIA) or a Registered Health Information Technician (RHIT). Note: A RHIA (previously a RRA) holds a 4 year bachelors degree. An RHIT (previously an ART) typically has a 2 year associate degree or technical training.

- Experience in long term care preferred.
- Knowledge of regulations, survey process, accreditation standards and professional standards of practice related to long term care.
- Knowledge of and access to the various entities to obtain revisions to the regulatory/accreditation requirements
- Understanding of payment systems including Medicare and Medicaid.
- Knowledge and application of the current International Classification of Diseases coding appropriate to long term care.
- Knowledge of documentation and legal issues pertaining to health information.
- Computer skills and understanding of electronic information systems used in long term care.
- Supervisory and management skills and experience preferred.
- Basic understanding of the budget and monitoring process.
- Planning and organizational skills.

Personal attributes of a credentialed health information management practitioner should include:

- Leadership abilities preferred with skills to function within a team.
- Ability to provide instruction or guidance and communicate effectively.
- Ability to perform critical thinking, analysis, and problem solving.
- Flexibility, creativity, and adaptability in dealing with problems and staff.
- Good customer service and telephone skills.
- Empathy for the elderly with ability to be sensitive to resident and family needs/concerns

Reporting:

It is recommended that this position report directly to the Administrator of Executive Director in a facility. There are a number of reasons why reporting to the Administrator is important for this position. First, the medical record is a multidisciplinary record. Overall decisions made about the record, use of data and analysis should not be influenced by one discipline over another. Second and most important, full disclosure of audit and quality monitoring findings should be reported to the facility administrator and the quality assurance committee. Many of the functions, data gathering and analysis directly influence the administrative and clinical management of the facility.

Common Functions Performed by a Credentialed Health Information Practitioner:

The following functions are recommended for a credentialed health information management practitioner and represent the core functions for health information. Facility size, admission and discharge rates, department staffing and other non-HIM responsibilities assigned to the position should all be considered when developing the final job description for a facility. In a facility that also employs health unit coordinators; some of the functions outlined may be managed by this position but performed by the health unit coordinator. It should be noted that the majority of facilities may have one HIM staff person in a 'Department', however there are instances when the HIM Director may supervise the Unit Clerks or other staff members outside the confines of the HIM Department.

Supervisory/Management Functions:

- Maintain current policy and procedures and job descriptions for the health information department.
- Manage human resource functions for the department including interviewing, hiring, staff scheduling, performance evaluations, disciplinary actions, and terminations.

- Supervise health information staff to assure staff competency and performance.
- Provide guidance, motivation, and support to health information staff.
- Monitor department budget as directed.
- *If designated:* May serve as the HIPAA Privacy Officer or Security Officer depending on expertise and facility need.

Quality monitoring and quality assurance functions:

- Participate in the facility quality assurance committee and process. *Optional: Coordinate the facility quality assurance program.*
- Maintain a qualitative and quantitative audit/quality monitoring process.
- Conduct and maintain routine audits including admissions/re-admission, concurrent/quarterly, MDS, diagnoses, acute problems, and discharge.
- Conduct and maintain focus audits on problem areas, QA concerns, Quality Measures, and survey issues.
- Collect and report data from audit findings to QA committee.
- Develop an action plan for identified problems/concerns.

Health Information Management Functions:

- Maintain security of health information systems and medical records.
 - Assure physical protection is in place to prevent loss, destruction and unauthorized use of both manual and electronic records.
 - Assure facility safeguards are in place such as record sign-out systems, assignment of computer passwords/log-on.
 - Assure systems are in place for securing file cabinets and file rooms where overflow and discharge records are stored.
 - Assure systems are in place to maintain confidentiality/privacy of both manual and electronic health information.
- Manage the release of health information functions for the facility including review and processing of all requests for information.
- Maintain facility policies and standards of practice to assure release of information requests are appropriate and meet legal regulations.
- Maintain a forms management system for development, review, and reproduction of facility forms.
- Maintain a forms manual and/or electronic templates.
- Maintain systems for filing, retention and destruction of overflow/thinned records and discharge records that are compliant with State, Federal, and HIPAA guidelines.
- Develop systems for retention and destruction of medical records stored in an electronic format.
- Complete facility statistical reports such as monthly facility statistics, daily census, and licensure reports as applicable.
- Participate in meetings and committees such as daily stand-up, PPS, Administrative/department head, Quality Assurance/Quality Improvement, Medicare documentation review, etc. as appropriate
- Provide in-service education as applicable on health information issues.
- Provide orientation to new employees on topics such as the medical record organization and content, record completion, confidentiality, documentation standards and error correction procedures.

- Provide orientation to new employees regarding facility specific HIPAA privacy and security safeguards.
- Support and assist in carrying out corporate compliance initiatives as assigned by the Administrator/Executive Director.
- Manage the credentialing process for physicians and other professional staff when applicable.
- *Optional: Review MDS validation reports and take appropriate actions to ensure errors are corrected.*
- Retrieve and analyze Quality Measure reports and other MDS management reports from MDS submission Website.

Computerization/Automation:

- Understand all aspects of clinical computer system.
- Participate in decisions related to the computer system including systems selection, planning, and future expansion.
- Provide resources for training on computer system and use of clinical applications.
- Monitor security of the system such as assuring audit trails and password security are in place.
- Monitor audit trails and follow up with possible breaches in confidentiality/privacy/security per regulations.
- Assure the current International Classification of Diseases.
- Assure systems are in place to maintain up to date resident-specific information in the clinical information system.
- Complete data entry functions as applicable.
- *Optional: Maintain the Care Plan and MDS schedule and transmit MDS information.*

Oversight Records Management Functions:

The following list outlines the records management functions that are the responsibility of the health information management department on admission, during the resident's stay, and upon discharge. Depending on the facility size and department staffing, some or all of these functions may be completed by other department staff such as a health unit coordinator.

Admission:

- Complete the appropriate information in the census register.
- Complete and file as applicable the master patient index information (computerized or manual).
- Initiate the inpatient medical record and in-house overflow file, prepare labels, etc.
- *Optional: May prepare admission records (face sheet) for the medical record.*
- Complete admission checklist and admission audits.
- Complete coding and indexing of admission diagnoses.

During the resident's stay:

- Conduct concurrent audits/quality monitoring at regular scheduled intervals.
- Code diagnoses at regularly scheduled intervals and update concurrently throughout resident's stay.
- Thin in-house records in accordance with the written policy and procedure and file in chart order for discharge in the in-house overflow file.
- Contact physician or departments/disciplines as appropriate when signatures or

information as needed.

- Maintain a trending and evaluation system that identifies that telephone orders and other information is completed and signed by the physician in a timely manner.
- File all incoming clinical information in the in-house records on a daily basis. If electronic, this material may be scanned into the system.
- Monitor timeliness of physician visits on a monthly basis to assure compliance with Federal and State regulations.
- Report physicians who are out of compliance to facility Administration. (Administrator, Director of Nursing, Medical Director).

Discharge:

- Update discharge information on the master patient index (manual or electronic).
- Record appropriate discharge information in the census register (manual or electronic).
- Initiate the discharge record control log to monitor discharge records processing status.
- Obtain the discharge clinical record from the nursing station within 24 hours (or per facility policy) of discharge or death of a resident.
- Assemble record from the nursing station and the overflow file in established discharge order.
- Analyze the record for deficiencies using the discharge record audit/checklist.
- Follow up and monitor discharge record deficiencies including monitoring mail information to physician for completion as applicable.
- Maintain discharge record control log.
- File discharge record in incomplete clinical record file until completed and then file the discharge record in the complete file.
- Code final diagnoses using the current International Classification of Diseases

Role of the Non-Credentialed Practitioner Working in a Long Term Care Facility

Qualifications of a Non-Credentialed Practitioner Working in a Long Term Care Facility

The qualifications and skills vary widely for a non-credentialed practitioner coordinating the health information functions in a facility. The basic functions of the health information department warrant the following minimum qualifications for an entry-level practitioner:

Minimum Entry Level:

- High School graduate or equivalent.
- Knowledge of medical terminology.
- Basic computer and typing/data entry skills.
- General office skills including filing, organizing, etc.
- Oral and written communication skills.
- Good customer service and telephone skills.
- Ability to work within a team.
- Empathy for the elderly with the ability to be sensitive to resident and family needs/concerns.

Recommended Additional Qualifications:

- Long term care or healthcare experience preferably as a Coordinator of Health Information in another facility.
- Training as a Medical Records Secretary or equivalent.
- Experience with diagnoses coding using the International Classification of Diseases
- Knowledge of documentation and legal issues.
- Knowledge of regulations, accreditation standards, and professional standards of practice for health information in long term care.
- Understanding of payment systems in long term care.
- Ability to provide instruction or guidance and communicate effectively.
- Supervisory and management skills depending on the size of the department.
- Knowledge of the budget process.
- Interest in maintaining professional development and continuing education on health information issues.

Reporting:

It is recommended that this position reports to the Administrator or Executive Director, however, this may vary depending on the skills and expertise of the individual. If the department is responsible for audit and quality management functions and/or supervises a department reporting to the Administrator is imperative.

Common Functions Performed by a Non-Credentialed Health Information Practitioner:

The functions of this position are a subset of those functions outlined in the Credentialed Health Information Practitioner based on training, past experience, and skill level. These functions should be completed (depending on skill and experience) under the direction of a credentialed consultant. At a minimum when hiring for this position, the non-credentialed practitioner should be able to complete the following functions:

Supervisory/Management Functions:

- Maintain current policy and procedures and job descriptions for the health information department.
- Monitor department budget as directed.

Quality Monitoring and Quality Assurance Functions:

- Participate in the facility quality assurance committee and process. *Optional: Coordinate the facility quality assurance program.*
- Maintain a qualitative and quantitative audit/monitoring process.
- Conduct and maintain routine audits including admission/re-admission, concurrent/quarterly, MDS, diagnoses, acute problems, and discharge.
- Conduct and maintain focus audits on problem areas, QA concerns, Quality Indicators, Quality Measures, and survey issues.
- Collect and report data from audit findings to QA committee.
- Assist in the development of action plans for identified problems/concerns.

Health Information Management Functions:

- Maintain security of health information systems and medical records.
 - Assure physical protection is in place to prevent loss, destruction, and unauthorized use of both manual and electronic records.
 - Assure facility safeguards are in place such as record sign-out systems,

assignment of computer passwords/log-ons.

- Assure systems are in place for securing file cabinets and file rooms where overflow and discharge records are stored.
 - Assure systems are in place to maintain confidentiality/privacy of both manual and electronic health information.
- Manage the release of health information functions for the facility including review and processing of all requests for information.
 - Maintain facility policies and standards of practice to assure release of information requests are appropriate and meet legal regulations.
 - Maintain a forms management system for development, review, and reproduction of facility forms.
 - Maintain a master forms manual.
 - Maintain systems for filing, retention and destruction of overflow/thinned records and discharge records that are compliant with State, Federal, and HIPAA guidelines.
 - Develop systems for retention and destruction of medical records stored in an electronic format.
 - Complete facility statistical reports such as monthly facility statistics, daily census, and licensure reports as applicable.
 - Participate in meetings and committees such as daily stand-up, PPS, Administrative/department head, Quality Assurance/Quality Improvement, Medicare documentation review, etc.
 - Support and assist in carrying out corporate compliance initiatives as assigned by the Administrator/Executive Director.
 - Manage the credentialing process for physicians and other professional staff when applicable.

Computerization/Automation:

- Understand all aspects of clinical computer systems.
- Provide input into decisions related to the computer system including system selection, planning and future expansion.
- Monitor security of the system such as assuring audit trails and password security are in place.
- Monitor audit trails and follow-up with possible breaches in confidentiality/privacy/security.
- Assure disease database utilizes the current version of the International Classification of Diseases.
- Assure systems are in place to maintain up to date resident-specific information in the clinical information system.
- Complete data entry functions as applicable.
- *Optional: Maintain the care plan and MDS schedule and transmit MDS information.*

Records Management Functions:

Admission:

- Complete the appropriate information in the census register.
- Complete and file as applicable the master patient index information (computerized or manual).
- Initiate the inpatient medical record and in-house overflow file, prepare labels, etc.

Optional: May prepare admission records (face sheet) for the medical record.

- Complete admission checklists and admission audits.
- Complete coding and indexing of admission diagnoses.

During the resident's stay:

- Conduct concurrent audits/quality monitoring at regular scheduled intervals.
- Code diagnoses at regular scheduled intervals.
- Thin in-house records in accordance with the written policy and procedure and file in chart order for discharge in the in-house overflow file.
- Contact physicians or departments/disciplines as needed when signatures or information as needed.
- Maintain a trending and evaluation system that identifies that telephone orders and other information is completed and signed by the physician in a timely manner.
- File all incoming clinical information in the in-house records on a daily basis. If electronic, this material may be scanned into the system.
- Monitor timeliness of physician visits on a monthly basis to assure compliance with Federal and State regulations.
- Report physicians who are out of compliance to facility Administration. (Administrator, Director of Nursing, Medical Director).

Discharge:

- Update discharge information on the master patient index (manual or electronic).
- Record appropriate discharge information in the census register. (Manual or electronic).
- Initiate the discharge record control log to monitor discharge records processing status.
- Obtain the discharge clinical record from the nursing station within 24 hours (or per facility policy) of discharge or death of a resident.
- Assemble record from the nursing station and the overflow file in established discharge order.
- Analyze the record for deficiencies using the discharge record audit/checklist.
- Follow up and monitor discharge record deficiencies including monitoring mail information to physician for completion as applicable.
- Maintain discharge record control log.
- File discharge record in incomplete clinical record file until completed and then file the discharge record in the complete file.
- Code and index final diagnoses using the current version of the International Classification of Diseases

Role of the Health Unit Coordinator (Unit Clerk/Secretary, Health Information Assistant)

In addition to a health information manager, some facilities may choose to also hire a health unit coordinator(s) depending on a facility size, number of admissions and discharges, or resident acuity level. Although this position is typically found at the nursing station, their functions primarily revolve around the monitoring and completion of the record and nursing station management. Since many of the health information functions are performed by the health unit coordinator position, it was critical to address this position under a health information model.

Qualifications of a Health Unit Coordinator:

Minimum Entry Level:

- High school graduate or equivalent.
- Knowledge of medical terminology.
- Basic computer and typing/data entry skills.
- General office skills including filing, organizing, scheduling and tracking.
- Oral and written communication skills.
- Good customer service and telephone skills.
- Ability to work within a team.
- Empathy for the elderly with the ability to be sensitive to resident and family needs and concerns.

Recommended Additional Qualifications:

- Medical office secretary or health unit coordinator training/certificate (or other applicable course).
- Long term care or healthcare experience preferably as a Health Unit Coordinator.
- Knowledge of documentation and legal issues.
- Knowledge of regulations, accreditation standards, and professional practice standards of practice in health information management in long term care.
- Experience with transcribing physician orders with the knowledge of medications and applicable medical terminology.

Reporting:

It is recommended that the health unit coordinator position report to the Manager/Supervisor of Health Information Management Services to provide consistent application of health information policies throughout the facility. Because of the unique nature of a health unit coordinator, it is important that this position have an indirect reporting relationship with the nurse manager or supervisor for the nursing station.

Common Functions Performed by a Health Unit Coordinator:

When this position is utilized in a facility, many of the record management functions are performed by the health unit coordinator along with additional functions unique to coordinating a nursing station. This position provides assistance to the nursing staff by moving non-nursing clerical functions away from nursing allowing them to spend more time with direct resident care. If a facility does not utilize a health unit coordinator position or incorporate their functions in another position, the nursing staff is completing many clerical functions keeping them away from delivery of direct resident care.

Records Management Functions:

When a health unit coordinator position is utilized by a facility, the following records management functions are performed by this position:

Admission:

- Initiate the inpatient medical record and in-house overflow file, type labels, etc.
- Coordinate admission process.
- *Optional: Transcribe admission orders after review by clinical staff with proper education and training.*
- Complete admission checklists.

During the resident's stay:

- Thin in-house records in accordance with the written policy and procedure and file in chart order for discharge in the in-house overflow file.
- Maintain the in-house chart appearance and organization.
- Maintain a monitoring system to assure telephone order and other information is signed or returned by the physician and other professionals in a timely manner.
- File all incoming clinical information in the in-house records on a daily basis. If electronic, this material may be scanned into the system.
- Monitor timeliness of physician visits on a monthly basis in conjunction with the manager of Health Information Services. Pull charts for physician rounds and transcribe new orders if applicable.
- Track and schedule routine labs.
- Schedule resident appointments and arrange transportation.
- Transcribe vitals, input/output information, per system.
- Prepare paperwork for transfer or referrals.
- *Optional: Transcribe physician orders once obtained from clinical staff. (Clinical staff to sign off on transcription).*
- *Optional: If data-entry is expected in this position for the MDS or care plan, additional time should be allocated.*

Discharge:

- Prepare paperwork for discharge.
- Assemble record from the nursing station and the overflow file in established discharge order.

Nursing Station-Specific Functions:

- Answer telephones at the nursing station.
- Maintain an organized nursing station.
- Stock forms and clerical supplies on the station.
- Maintain station lists.
- Maintain nursing assistant care cards/assignment sheets.
- Complete station filing of loose reports, policies, etc.
- Assist family, visitors, etc. as needed and appropriate.

Other Functions:

Additional hours should be allocated to this position in non-health information functions are shared with this position,

Evolving Role of Health Information

As computerization continues to evolve, the role of the HIM practitioner will also change. Although some traditional functions in maintenance of a manual record may be eliminated, new issues will take their place. The HIM role will continue to be responsible for oversight of confidentiality, compliance, privacy and security management programs, ongoing auditing of the electronic medical record, and audit trails. HIM practitioners should be responsible for orientation and ongoing training of clinical staff on the information system, and overall administration of the information system. Even with a computerized record system, many of the routine HIM functions will still need to be carried out.

With the implementation of HIPAA, the HIM practitioner will see new roles as a privacy

officer and possibly a security officer. Expertise on code sets will also be necessary for proper coding and reporting under the federal regulation. The HIM role in corporate compliance and billing should also evolve to assure that documentation supports services billed by the facility. This is particularly relevant with the increased focus of external agencies on the documentation process and compliance with the various Medicare, Medicaid and insurance provider requirements.

Health Information Department Staffing

Staffing the health information department is based on five critical issues:

- The time requirements for functions under the responsibility of the health information department (see [Job Qualifications, Responsibilities, and Functions of HIM Staff in a LTC Facility](#)).
- Resident acuity and complexity.
- Census based on number of residents in the facility.
- Number of resident exchanges (admission, discharge, hospital transfer and hospital return).
- Availability of information technology.

[Print/Download](#)

Copyright ©2014 American Health Information Management Association. All rights reserved. All contents, including images and graphics, on this Web site are copyrighted by AHIMA unless otherwise noted. You must obtain permission to reproduce any information, graphics, or images from this site. You do not need to obtain permission to cite, reference, or briefly quote this material as long as proper citation of the source of the information is made. Please [contact Publications](#) to obtain permission. Please include the title and URL of the content you wish to reprint in your request.