



# NEWS & VIEWS

Ontario Health Information Management Association

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## President's Message



Hello everyone. This is my first official message as your new president. It has been a busy time and I look forward to updating you on some of the current issues.

Since our annual general meeting in November the executive has had one in-person meeting and two teleconferences.

Over the next couple of months the executive will be reviewing and revising the strategic plan for OHIMA and the By-laws. We are planning to hold a special general meeting at the spring conference to review and hopefully have these revised bylaws member approved.

Two new members have joined our executive. Janice Soltys is Manager, Health Records at Sault Area Hospitals. Janice will be taking over the portfolio of Professional Education. Debra Tetreault is responsible for Education/Data Quality Review at Salumatics and will take over the position of Treasurer. We are thrilled to welcome both.

We bid a sad farewell to Kim Irvine. Due to other commitments and workload, Kim has stepped down from the executive. We do wish her well.

We are still looking for a member to represent either region 2 which covers the Greater Toronto Area, or region 3 which covers Eastern Ontario. Paula Weisflock lives in one region and works in another and is willing to represent either region. I can speak from personal experience of the advantages to serving on the Executive. I have learned so much from so many aspects of our profession, such as data quality, privacy, utilization etc. Since we are representing the association at various levels of the Ministry, we learn first hand of upcoming issues and potential changes on the horizon. I have

also had the opportunity to work with some amazing people on the executive and form some great friendships. Our executive members are very dedicated to the association and I know I will rely on them heavily to assist me in my role as president.

In addition to our executive we have other members who volunteer to represent the association. Marci MacDonald is representing OHIMA on the CRIM project. This is a ministry project to develop a province-wide client registry and identification management system.

Maria Muia represents OHIMA on the OHISC Board. You will find Maria's detailed report elsewhere in this newsletter.

Navid Nabavi has agreed to develop a detailed Access database of our membership, attendees at our conferences, etc.

We are also seeking a volunteer to update our web site.

As you may remember, our past president, Charmaine Shaw was instrumental in starting discussions with the National Alliance of Health Information Management Associations to form a single National organization (CHIMA) with provincial chapters. Most of the other provinces have now voted on this issue. It is my intention to continue to work with CHIMA and the other provinces in investigating the feasibility/possibility of this project. It is membership renewal time again. Our membership runs April 1 to

March 31<sup>st</sup>. Look for the membership form in this newsletter. Please complete and send in this membership form. Notifications will not be sent out.

We need your membership dollars to continue to represent our association as well as our profession at important committees that will determine our role in the future healthcare vision. Remember the OHIMA is your association and I urge everyone to consider taking an active part. If you would like to help in any way please contact a member of the executive.

Please feel free to contact me with any issues, questions, ideas, etc. that you may have. My contact information is available on the Executive listing page of this newsletter.

*Regards, Lynne Hopper*

**MINISTRY OF HEALTH INITIATIVES.....**

*Submitted by Brenda Antliff, Information Management Coordinator, Ministry of Health & Long Term Care*

**Role change....**

Helen Whittome has assumed a new role at the MOHLTC. She is now leading the "Producing Better Data" strategy for the Transformation Health Results Team on Information Management. Helen will have a dual reporting to both Steini Brown of the Health Results Team and also to John McKinley, Executive Director in the Acute Services and Community Health Division.

The Producing Better Data strategy will focus on the following:

- A data quality management model/framework
- Ontario Health Data Standards Rationalization of health information holdings & contents
- Local Data Management Partnerships
- Data Management Best Practices
- Nursing Health Outcomes
- Integrated information holdings

Helen will be contacting as many groups involved with data as possible, including the UMNO, to determine how they might become involved in the strategy, particularly around local data management partnerships and best practices

**And.....Clinical Data Blitz**

This is a joint initiative by the Ministry of Health, Hospital Report Research Collaborative, CIHI, JPPC and ICES regarding the Clinical Data Quality. A pilot session is to be held on April 14<sup>th</sup> for Central South and Central West Region Hospitals in the Hamilton Area.

The intent of the pilot is to highlight the importance of data quality and provide some education to facilities as to how their data is being utilized outside their facilities. The Information Management Unit within the Ministry of Health is currently reviewing the Discharge Abstract Data and the NACRS data for 2004-05 for areas within the data that do not comply with CIHI Coding Standards or incorrect abstracting practices. Reports will be

made available for facilities for review and corrections are to be resubmitted to CIHI before the year-end closure deadline.

Once the results of the pilot have been reviewed it is expected the remaining regions will have an opportunity to be involved in a Clinical Data Day. There have ongoing reviews of the Financial and Statistical information by the Ministry of Health over the past few years and now the Clinical data has been developed into similar sessions for the Regions.

For further information, please contact:  
 Brenda.antliff@moh.gov.on.ca

-If a diabetic complication is treated while in hospital, it is coded separately under that complication as an M or type 1.

-Generally if a condition is not treated during the admission, it will go under the multiple complication code as a type 3 should the hospital choose to code them.

All diabetic codes on the same chart must have the same level of control (sixth digit)

Watch for 2005 diabetes updates from CIHI for new process on level of control.

Helen Whittome at the MoH, and comes with past CIHI experience, which will make her a definite asset in this capacity and to our profession! Brenda will continue to liaise with the OHIMA Executive.

**Client Registry and Identification Management Project (CRIM)**

This is a MoH group, formed in May 2004, after the disbanding of the OHA Unique Patient Identifier group. CRIM includes members from the former UPI, OHA group, with basically the same mandate, but at the MoH level, and is directly linked to the work being done by Canada Health Infoway. The mandate of this group is to deliver a provincial Client Registry and Identification Management infrastructure for Ontario's health system.

Canada Health Infoway is an independent corporation with a mission to foster and accelerate the development and adoption of compatible EHR solutions in Canada.

At the end of the day, CRIM wants to be able to deliver a provincial system for the identification of people receiving health services – regardless of entitlement for provincial health insurance – and create a link electronically to access and distribute personal health information for use by authorized health care providers at the point of care.

With the OHA involvement in Unique Patient Identifier, I was

**TIPS FOR SUCCESS - DIABETIC CODING**

-Ensure you follow the dagger & asterisk coding standard

-Every diabetic complication package will have at least three codes with the exception of foot ulcer.

Example

**E11.224**      **1**      Diabetic Code (dagger)

**N08.3**        **3**        Mandatory Asterisk code \*

\* Asterisk code must be type 3

**N18.9**        **3**        Complication code – must be a type 3

-Diabetic control can not be determined using glucometer readings.

-Diabetic typing will only be M or 1 when the condition is treated, never a type 2.

**MARCI'S CORNER...**

**An update on Marci's initiatives on our behalf-Feb 1-2005**

*(Respectfully Submitted by Marci MacDonald, Member at Large)*

I would like to take this opportunity to update you on a few initiatives I have had the pleasure of being involved with on behalf of OHIMA. Please don't hesitate to contact me if you require any clarification or have any questions whatsoever!

**ICD-10 National Advisory Committee**

I have had the pleasure of representing Ontario on this committee for the past couple of years on behalf of our MoH, but as of February 2005, this post will be filled by a new MoH employee, Brenda Antliff. Brenda will be working with

asked to sit on this group, to give a voice to the hospital perspective. I have also asked to be listed as representing OHIMA, as well as Acute Care Hospitals.

We have recommended that the existing OHIP number be the Unique Identifier in Ontario, and this has been accepted by the MoH. We are now discussing how to implement this number, independent of an individual's eligibility for health insurance coverage.

**Provincial Data Quality Task Force**

I've written a great deal about this group in the past, and the work and recommendations are very much in line with other undertakings, such as the recent Ontario audit conducted.

The MoH has been very appreciative of the work conducted by this group, and we are hopeful that once all the collective concerns are pulled together, we will all see even more of a commitment towards our goal of clean, accurate, reliable and useable data within our province.

We have had no further meetings since my last update letter. So nothing new to report at this time! And that's it, that's all! Questions?...please contact:

Marci MacDonald  
Clinical Information Services  
Halton Healthcare Services  
905-338-4634  
[mmacdonald@haltonhealthcare.on.ca](mailto:mmacdonald@haltonhealthcare.on.ca)

**2003-2004 OHIMA  
RECOGNITION AWARD  
RECIPIENT**



The Ontario Health Information Management Association is pleased to announce that Marci MacDonald is the winner of the 2003-2004 OHIMA recognition award. Marci emerged as the single member who most embodied the professional recognition criteria, including advancing the ideals of the OHIMA and actively promoting both the profession and the Association. Marci was presented with her award at the Annual General Meeting held during the OHA conference in early November 2004.

Marci MacDonald is the Director of Clinical Information Services and newly appointed Privacy Officer, for Halton Healthcare Services which is comprised of the Oakville-Trafalgar & the Milton District Hospitals. Marci holds a number of leadership positions provincially such as; Chair of the Provincial Clinical Data Quality Task Force, Past Co-Chair of the Smart System for Health - Ontario Health Informatics Standards Council, previously has served as the Ministry of Health representative on the National ICD-10 Advisory Committee. Marci is on the Planning Committee for Ryerson University's Health Information Management Degree Program, served on the Utilization Manager's Network of Ontario executive committee for several years, is past president of Ontario Health Information Management Association and Marci serves on the e-Health Council and Ministry of Health, CRIM – Client Registration and Information Management, Team. Marci is a current a Board Member with the Canadian Health Information Management Association. I am sure you will all agree, Marci has certainly earned this award many times over.

Thank you Marci, from the membership of OHIMA for all you have done for the profession over the years.

## OMHRS IMPLEMENTATION MINISTRY UPDATE

*Submitted by Brenda Antliff, Information Management Coordinator, Ministry of Health & Long Term Care*

### **A. Data Set Specification Signoff - Ontario Mental Health Reporting System**

CIHI prepared the list of MDS-MH data elements to be collected by Ontario hospitals for signoff by the ministry. This included demographic data, clinical data required by RAI-MH and several essential items required by the ministry (e.g. ALC data).

The signoff is for the initial completeness of the data elements and whether each element should be made mandatory or optional for various assessment types (i.e. Short-Stay, Admission, Discharge, Quarterly and Change in Status).

Signoff is expected to be completed by end of this week. CIHI will provide vendors with final specifications during March 2005, updating the preliminary specs provided at the Jan 10 vendor meeting.

### **B. Mental Health Master Number Assignment**

In December 2004, FIM sent a survey to all the Regional Offices to update the list of hospitals with designated mental health beds. All the hospitals with MH beds have now been assigned a new "MH" number, to be used effective October 1, 2005. While there are several operational

issues remaining to be resolved with specific hospital sites.

Regional Directors will be informing their hospitals regarding the new "MH" numbers that have been assigned within the next few days.

The ministry has also identified the need to formalize a process to allow the regions to notify the FIM Branch of ongoing changes to hospital types. A draft of the process is currently in progress. This will allow the hospitals to receive the appropriate hospital type designation (e.g. new mental health beds) as soon as the Minister approves the requisite funding to prepare for the integration of systems/processes, and training and education for their staff in a timely manner.

### **C. Daily Census Summary**

The Daily Census Summary is being enhanced to accommodate, among other improvements, the capture of extended LOA days required as a result of OMHRS implementation. The proposed MH section of the new form will allow for the recording of LOA between 4 and 90 days. In cases where patients are discharged during a leave, patient-days will be recalculated based on the leave date.

The ministry is currently working with several hospitals to test the functionality of the proposed system. No date has been decided for the introduction of the new system as this point.

### **D. Acute Master Number Assignment**

The Ministry is currently consulting with CIHI's acute section and several acute care hospitals regarding options to reassign the "AP" numbers. The alternate number is to be effective April 1, 2006. The two proposed options are:

1. New AT numbers to be assigned for non-mental health beds
2. Change the hospital type from AP to AT but retain the same 4-digit master number used in AP.

No decision has been made regarding the preferred option. The Ministry is consulting with CIHI and with hospitals with designated mental beds in various sectors.

### **E. Validation of SCIPP Algorithm**

The Ministry plans to apply SCIPP (System for the Classification of Inpatient Psychiatry) case-mix for hospital mental health funding starting 2006-07. Advance work is being carried out to validate the SCIPP algorithm using phase 2 pilot data collected from hospitals and case-costing data for the same hospitals.

The ministry will also have access to the data to be collected from research work current undertaken by the CCC to enhance the RAI-MH instrument. The research project has been funded through the PHCTF (Primary Health Care Transition Fund) [Bill.Ng@moh.gov.on.ca](mailto:Bill.Ng@moh.gov.on.ca)

**REABSTRACTING STUDY PROJECT**

*Submitted by: Deb Tetreault*

**WHAT AN EXPERIENCE!!!!!!**

Three organizations teamed together to do this study. The Ministry of Health and Long Term Care (MOHLTC), The Canadian Health Information Management Association (CHIMA) and the Canadian Institute for Health Information (CIHI). Having the opportunity to work directly with CIHI was fabulous. First and foremost for obtaining an understanding of coding standards first hand in regards to the how and why, also learning that the CIHI professionals are people just like you and I trying their best to provide you with accurate information. There are coding dilemmas in their world too.

For me the networking between coworkers on the study and other sites was priceless. Being away from home during the week was sometimes tough as things seemed to wait for your return but having your bed made, meals cooked and housekeeping done daily on the road was a real treat.

Developing good friendships that will last a lifetime was one of the best parts. Building a network of peers...no matter how far away, as they have had the same CIHI training and experience you had and now you can go to them for their opinion on a coding issue. I worked on the Project as an 'On Site' Re-

abstractor/coder for both Phase I (2002 data) and Phase II (2003 data) traveling for six months July/04 to January/05. There was also another type of Re-abstractor, the 'Remote' one that could not travel but was able to work remotely from their home part time. When the project came to an end for me on January 7<sup>th</sup>, there were some tears as the day to day six month companionship would be broken. Some of the Re-abstractors were from other provinces and the likelihood of seeing them again would be slim. Thank goodness for email.

**Would I do it again?**

**In a HEART BEAT!!!**

There will be more studies coming in the future. If you are given the opportunity to experience this, take it and run with it. You will not regret it. Don't be shy, CIHI will give you all the support and tools you need.

I am unable to actually comment on the study itself or the results as these have not been put together yet. What I can share is that these three organizations will be using the data collected for many purposes (Education, Stats, Decisions, etc.) and that the results will be coming out in the near future.

**INTRODUCING 2 NEW HEALTH INFORMATION MANAGEMENT COLLEGE PROGRAMS-FALL 2004**

Sir Sandford Fleming College in Peterborough and St. Lawrence College in Kingston introduced two year diploma programs in Health Information Management this past September. Contact information for both schools as well as the program coordinators is listed below for your future reference.

Paula Weisflock-Coordinator  
Health Information Management

**Sir Sandford Fleming College**  
Sutherland Campus  
599 Brealey Drive  
Peterborough, ON K9J 7B1  
**Phone:** 705-749-5530 ext 1718  
**Email:** [pweisflo@flemingc.on.ca](mailto:pweisflo@flemingc.on.ca)  
**Web:** [www.flemingcollege.com](http://www.flemingcollege.com)

Sharon MacKenzie-Coordinator  
Health Information Management

**St Lawrence College**  
100 Portsmouth Ave Kingston, ON  
**Phone:** 613-544-5400 ext. 1121  
**Email:** [smackenzie@sl.on.ca](mailto:smackenzie@sl.on.ca)  
**Web:** [www.sl.on.ca](http://www.sl.on.ca)

## WHAT?! CODING QUALITY LACKING IN OUR CODING WORLD?!!

*Submitted by Deb Tetreault*

At an OHIMA meeting in London back in the fall of 2003, a concern was brought forth that Coding Quality and consistency was lacking in coding and a potential solution was suggested, **that, being a Task Force**. After much discussion, one lonely hand went up to take on the task of organizing this with others offering to help. A committee was formed growing to eight Health Record Professional volunteers working in many capacities of Health Records offering a variety of experience. In January 2004, at a little restaurant in North London, is where the brainstorming began.

A Kick off Conference was held in April 2004 in London inviting anyone that was interested with over 100 coders and managers attending. The Speakers consisted of representatives from the MOHLTC, CHIMA and CIHI who spoke on their concerns over the coding quality in Ontario and how hospitals are doing their own thing. In some cases was not in line with the newly outlined Standards. The Committee then proposed a solution. Workshops would be offered twice a year (spring and fall) to tackle some of the dilemmas facing the coding

world and to develop a networking group. A topic would be chosen via questionnaires from the participating hospitals/Health Records Professionals from the Workshops. The participants will receive an actual chart to code who would then send their coding selections to the committee with any questions they would like addressed by the committee, CIHI or the physician speaking at the Workshop. At our first Workshop, we were unable to have the responses from CIHI. Since then, CIHI has offered to work with us on the chart and questions prior to the Workshop so we can have their response the day of the Workshops. Thank you CIHI.

The first Workshop was held November 1, 2004 where the topic was *Diabetic Coding*. YIKES!! Although all went well. numerous questions were raised to the physician, Dr. McManus, Endocrinologists who gave an excellent overview of the Diabetic Disease. Further coding questions were sent to CIHI who has given very valuable feedback on Diabetic Coding. The next Workshop is scheduled for April 14, 2005 where we will be discussing yet another controversial topic - *Post Operative Complications*.

When all is said and done, the participating hospitals/Health Records Professionals will then receive a copy of the Q&A from CIHI and the physician along

with the Power Point Presentation from the Workshop via email. As OHIMA also has the passion to improve Coding Quality in Ontario, they have offered to put the Workshop information on their website for your convenience. Please feel free to go to – [www.ohima.ca](http://www.ohima.ca) for this. You will find this information under the professional development tab and then data quality initiatives. If you have any questions or comments about the Coding Quality Task Force, the Committee and their email addresses are listed below and will be added to the website for future reference.

### CODING QUALITY TASK FORCE ORGANIZATIONAL COMMITTEE MEMBERS

Deb Tetreault - Chair  
[deb.tetreault@salumatics.com](mailto:deb.tetreault@salumatics.com)

Lynne Hopper  
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In their November 1<sup>st</sup> workshop on diabetic coding, the above coding quality task force reviewed a diabetic chart and the documentation below defines the coding selection chosen by the classification specialist team at CIHI. Following that are the questions raised at the workshop and CIHI's response. We are looking at the possibility of posting past and future coding quality taskforce workshop information to the OHIMA website. The next workshop is scheduled for April 14<sup>th</sup> in London, ON with a topic of postoperative complications. Please check the website for more information. [www.ohima.ca](http://www.ohima.ca) "The comments and recommendations from CIHI are accurate for fiscal 2004, but we have been informed by CIHI that there will be changes in fiscal 2005." Watch for them!!

CIHI Coding/Typing Recommendations

| ICD-10-CA | Dx Type | Code Description   |
|-----------|---------|--|
| E11.704   | M       | Diabetes Mellitus type 2 with foot ulcer   |
| L97.9     | 3       | Foot ulcer   |
| L03.11    | 1       | Cellulitis   |
| B95.6     | 3       | Staphylococcus Aureus  |
| A41.9     | 1       | Sepsis   |
| E11.224   | 1       | Diabetes Mellitus type 2 with renal complications  |
| N08.3     | 3       | Glomerular disorders in diabetes mellitus  |
| N17.9     | 3       | Acute renal failure, unspecified   |
| I12       | 3       | Hypertensive renal disease   |
| N18.9     | 3       | Chronic Renal Failure  |
| E86.0     | 1       | Dehydration  |
| N39.0     | 1       | Urinary Tract Infection  |
| I95.2     | 3       | Hypotension due to drugs   |
| Y52.4     | 9       | Angiotensin-converting-enzyme inhibitors   |
| L40.5†    | 3       | Arthropathic psoriasis   |
| M07.3     | 3       | Other psoriatic arthropathies  |
| K52.9     | 3       | Noninfective gastroenteritis and colitis, unspecified  |
| Y41.8     | 9       | Drugs, medicaments and biological substances causing adverse effects in therapeutic use, other specified systemic anti-infectives and antiparasitics |
| D64.9     | 3       | Anemia, unspecified  |

The codes listed above represent the CIHI coding query team's assessment of the diagnoses that should be coded for this particular chart. It should be noted that the absence of a comprehensive discharge summary made the coding of this chart difficult and somewhat controversial. While we have agreed that E11.704 is acceptable as the MRDx for this case, it does appear that the focus of care for this patient may have been septicemia. We strongly recommend that the facility where this chart originated verify the correct coding of this case with the attending physician. The importance of consistent, complete documentation cannot be overemphasized.

THESE ARE SOME OF THE COMMITTEE'S CONTROVERSIAL ISSUES:

**Question:** Acute renal failure? This was only documented once in a consultation but not again– Should it be coded? If so, would it go under the E11.224 as a type 3 or on its own as a type 1?

**Answer:** We have also selected the code E11.224 as the patient has chronic renal failure. As acute renal failure is classified under E11.28, we would suggest adding N17.9 as a type 3 to the diabetic package. The

diabetic code that is selected should reflect the highest level of progression which in this case would be E1122^ .

**Question:** Patient has hypertension and renal failure. Have we coded both these conditions correctly by putting them under the E11.224 both as type 3? Or would the acute renal failure be coded separately as a type 1?

**Answer:** We have linked the hypertension with the renal failure by selecting code I12 because a cause/effect relationship is assumed between chronic renal failure and hypertension. In a case such as this, it is not clear if the renal conditions are due to the hypertension or the diabetes. One cannot assume a cause/effect relationship between *acute* renal failure and hypertension and therefore N17.9 is coded as part of the diabetic package.

**Question:** Hypotension/Hypertension - The physician in the consultation appears to link the hypotension with the hypertensive medications and alters the Altace. In this case, would the hypertension be captured as a type 1 or 3 as part of the diabetic package?

**Answer:** We agree that the physician in the consultation appears to link the hypotension with the hypertensive medications and alters the Altace and have coded the hypotension as such. The hypertension is already coded in the I12. We have considered this a type (3).

**Question:** Septicemia is documented. In your opinion, is the source of the infection from the foot and captured with the B95.6 or do we need to code A41.9? In a consultation, it says overwhelming septicemia so we are thinking it has gone systemic.

**Answer:** This patient had several infections and throughout the course of treatment, investigations were underway to determine if there were others present. Chest infection and a possible periumbilical abscess due to the psoriasis were queried. The consultation makes note of the fact that the source of infection was not determined and for this reason we have typed the cellulitis and the UTI as a type (1). Please note however that if localized infections are documented as the source of septicemia, these conditions should be diagnosis typed as (3) or not coded at all. Please see coding queries 8735, 9989 and 10856 for further information.

**Question:** When Sepsis, Septicemia, Bacteremia, urosepsis is mentioned, this seems to be a very controversial issue. Do you have any advice on coding these? Particularly the urosepsis, do we capture both the A41.^ and N39.0?

**Answer:**

Septicemia [sepsis] is an acute invasion of the bloodstream by microorganisms. It can be a serious, rapidly progressive, life-threatening infection that may arise due to localized infections of the respiratory, gastrointestinal tract, genitourinary system or from the skin. Symptoms include fever, chills, tachycardia, tachypnea, petechiae, decreased or no urine output, and altered mental state such as lethargy, agitation, and irritability. Patients with underlying diseases such as diabetes, cirrhosis, alcoholism, or cancer may be at a higher risk for septicemia.

The term bacteremia should not be confused with septicemia. Bacteremia, in which organisms enter and circulate in the blood stream in small numbers for a short time, may occur as a transient problem. The organisms are usually removed by circulating phagocytes. Bacteremia denotes a laboratory finding. Septicemia denotes acute illness. Undocumented bacteremias occur frequently and usually abate spontaneously. Physicians sometimes use these two terms interchangeably. Coders must be aware of the difference between the two conditions and verify the diagnosis with the physician when it is unclear. Simple bacteremia is not coded unless it represents a clinical condition of concern documented by the physician.

The term urosepsis is defined as a septic poisoning due to retention and absorption of urinary products in the tissues. If the term urosepsis is documented, the physician should be queried. Coding Clinic 1Q 1998 states, "the physician should be asked if the diagnosis urosepsis is intended to mean (1) generalized sepsis (code septicemia) (2) urine contaminated by bacteria (code UTI)." Only the physician can diagnose this condition.

[Source: Journal of AHIMA/March 2000/Reviewing the Details of Coding Septicemia, ICD-10-CA/CCI Classification Primer, second edition, page 6.4]

**Question:** Is dehydration part and parcel of the chronic renal failure? In the Standards, it does mention if dehydration is documented and IV fluids are given, we should code it. Are we understanding this standard correctly in this case?

**Answer:** Yes, we agree with your interpretation of the standard and have coded the dehydration as a type 1.

**Question:** Urinary Tract Infection. Was it significant enough to code as a type 1?

**Answer:** See responses above.

**Question:** Psoriasis – Was it significant enough to code as a type 1?

**Answer:** No, we have coded it as a type 3 but note the change in code selection for psoriasis and psoriatic arthritis.

**Question:** Foot Ulcer – It does not appear that the L97.9 is an asterisk code. Would this be a type 1 or 3?

**Answer:** The L97.9 code is providing additional information and should be considered a type 3.

**Question:** Diabetic Pop Ups - Should all diabetic pop ups be a type 3? If so, can CIHI add this to the coding standards? If not, what would determine a type 1? We were thinking codes in the diabetic package are descriptors to better describe the diabetic complications and all should be type 3.


**Answer:** Yes, we agree that the pop-ups would be a type 3. These codes just add more specificity to the diabetic code. The standards will not be changed for this regard in 2005, but there will be changes to diabetes codes and standards for v2006 of ICD-10-CA.

**Question:** Level of Control – If the glucose blood work does not state fasting, such as random, do we use the level of 14 and above? Can we use glucometers to determine level of control?

**Answer:** If lab values do not indicate fasting glucose vs. random glucose then you would be correct in using the level of 14 and above. We have stated that glucose meters should not be used.

**There are multiple other conditions mentioned in the chart such as GERD, obesity, degenerative disc disease and even the COPD that may also be coded as diagnosis type (3).**





**REMINDER!! 2005-2006**

Membership fees are coming up soon. We trust you are finding good membership value in the newsletters and the web site. Please fill out the enclosed membership renewal form and make your cheque payable to the Ontario Health Information Management Association and mail to the address on the executive listing enclosed in this newsletter. Please enclose your email address so that future newsletters can be emailed.

**FROM PRACTITIONERS TO PROFESSIONALS:  
WHAT'S AHEAD FOR HEALTH INFORMATION MANAGEMENT?**

*Submitted by: Virginia Flintoft, RN MSc, Gail Crook CHE, CCHRA(C), Helen Whittome, CCHRA (C)*

On September 9, 2004 the Honourable George Smitherman announced the creation of the Ministry of Health and Long-Term Care Transformation Leadership Teams. The seven teams have been charged with the responsibility to lead the implementation of each part of the transformation plan. The teams will work with all other parts of the ministry, health providers, community groups and associations to get this mission accomplished for Ontario patients.

Minister Smitherman appointed Adalsteinn Brown, Assistant Professor in the Department of Health Policy at the University of Toronto and principal investigator for the Hospital Report Research Collaborative, as the Lead of the Health Information Management Team. He and his team are responsible for creating systems to collect timely and accurate information that will drive informed decision-making. This will be critical to our ability to evaluate and plan health services, and particularly invaluable for measuring and reporting to Ontarians on wait times.

Dr. Brown understands that technology in the absence of

good quality data won't get the job done for Ontario patients. As part of his mandate to reconcile healthcare data across the province he appreciates the critical role that Health Information Management practitioners play in the delivery of quality healthcare data.

Accordingly a survey was designed to determine if opportunities existed for partnering between Health Information practitioners, their existing organizations and other agencies, to help promote the professional status of Health Information Management (HIM) practitioners in Ontario. In December, 2004 the survey was distributed to a select group of leaders, educators and practitioners in the HIM community. Results of the survey and discussion are reported here.

**Results:**

The standard educational preparation for most positions within HIM is currently perceived to be at an acceptable level with the exception of Vice President responsible for HIM. In the opinion of respondents the minimum educational preparation for this level of employment should be at the Masters level (Science or Arts) with or without completion of the Certified Health Executive (CHE) program. Persons responsible for storage and retrieval of patient documents should have successfully completed a Medical Secretarial diploma program and all educators at the university level should be PhD prepared.

Sixty percent of responders believe enrollment in existing HIM certification programs in Ontario is inadequate. Close to 75% of responders believed that while Regional Education Networks designed to help HIM practitioners stay up-to-date on new standards or best practices existed, e.g. GTA Coding Network, the networks were not available province-wide. The only HIM peer-reviewed journal identified by responders was the *Journal of AHIMA*. There are no HIM peer-reviewed journals published in Canada.

No responders were aware of any specialized certification courses e.g. oncology or cardiac coding, available in Canada. Nine out of 10 responders believed specialty sections within the College e.g. cardiac, oncology, mental health, would contribute to improving the professional status of HIM practitioners.

Everyone agreed that HIM practitioners should be accountable and responsible for meeting legislated standards of practice; required to understand, uphold and promote ethical practice; demonstrate leadership through provision, facilitation & promotion of best professional service; and establish and maintain respectful, collaborative & professional relationships. All but one responder believed HIM professionals should maintain and improve competence through Quality Assurance Programs; possess knowledge relevant to professional practice through basic & continuing education; and continually

improve the application of professional knowledge.

Sixty percent of responders believed that the Canadian College of Health Record Administrators (CCHRA/CHIMA) should be responsible for reviewing the standards of practice while the remainder believed it should be the responsibility of a Provincial Body reporting to the CCHRA. Over 60% believed standards of practice should be reviewed annually while others preferred every three to five years.

All respondents agreed that certification of HIM practitioners contribute to the professional status of these practitioners and that in order to use the title Health Information Management professional the individual must be a member of a Provincial or National Certifying body. Furthermore, all survey participants agreed that hospital policies or by-laws should specify that HIM practitioners must hold current CCHRA certification as a condition of employment.

Everyone agreed that minimum practice requirements must include: completion of an approved HIM program and clinical practicum; and the successful completion of the Canadian HIM certification examination. Eighty percent or more of survey participants believed that evidence of an acceptable standard of practice, participation in continuing education programs and the annual renewal of certification should also be required. Renewal of certification should be contingent upon a minimum number of hours of professional practice over a specific timeframe. Of interest was that only 60% believed that

fluency in one of the two official languages should be considered a requirement for certification.

Ninety percent (90%) of responders believed that the certifying body should also be responsible for standards of practice, complaints, discipline and to a lesser degree, quality assurance.

All respondents believed HIM should report to a Vice President of HIM or Chief Information Officer (CIO). Those currently reporting to Finance believed that co-reporting to the VP-HIM and Finance would be preferable. Finally, survey participants were asked to select how they, other HIM Practitioners, other healthcare professionals and the Public would rank the professional status according to the criteria listed in figure 1 (below). Ninety-one percent of respondents believed there was moderately strong to virtually certain evidence that HIM practitioners have achieved professional status. Seventy-three percent believed that if asked, other HIM practitioners would respond in the same way. Eighty-two percent believed that if asked, other healthcare professionals i.e. doctors, nurses, physiotherapists etc. would agree with the HIM practitioners. However, seventy percent believed that if the general public were asked, they would respond that there was virtually no to only slight evidence that HIM practitioners have achieved professional status.

**Discussion:**

The survey was a preliminary attempt to gather information in preparation for follow-up inter-

views. Although it had limited distribution and response rate, a few themes persist. First, as for nursing, physiotherapy and other allied healthcare personnel, annual renewal of national or provincial registration should be a requirement of employment. Secondly, there appears to be a need for sharing and promoting best practices either by a province-wide network or a vehicle for publishing Canadian-specific peer reviewed research. Finally, there clearly exists professional pride in HIM both among practitioners and across other healthcare workers. However, the message has to be shared with the public who most likely have no familiarity with the group.

Over the past few years CHIMA has been developing a number of strategies aimed at promoting the professional status of HIM practitioners including lobbying Human Resources and Development Canada to have the National Occupation Code (NOC) for Health Information Professionals changed from clerical to healthcare. Others have pursued the possibility of having HIM included under the Regulated Health Professions Act. In order to be successful both options will require multi-disciplinary support over the long term.

Efforts should be made to establish and sustain a relationship between providers, HIM and data users i.e. government and researchers. Participation in National meetings of medical societies i.e. Canadian Cardiovascular Society may be an effective platform for sharing best practices and establishing a

link with the physicians and surgeons for education purposes. The advancement of the professional status of HIM practitioners is contingent on: the continued strength of leader-

ship at national and provincial levels; the support of multi-disciplinary stakeholders; and most importantly, the committed contribution of all HIM practitioners through member-

ship in provincial and national HIM associations. A copy of the survey questions will be posted to the OHIMA website for your reference.

Figure 1.

| <b>Professions:</b>  |
|--|
| • Are Intellectual operations with large individual responsibility |
| • Depend upon science and learning                                 |
| • Put their learning to a practical and definite end               |
| • Possess an educationally communicable technique                  |
| • Engage in self-organization and self-regulation                  |
| • Tend to become increasingly altruistic in their motivation       |

## MEMBER PROFILE



**Maria Muia, BHA, MHSc, CCHRA(A), CHE**

“How do you do it?” I’m constantly asked. My response is: anyone can be successful. All you need is a vision, some goals and lots of hard work. When you are working towards achieving your vision, the hard work is not hard at all because you know in the end you will reach your goal.

Personally, I attribute my success to my health records background. I started working in a health records department as an evening clerk, filing loose reports some - few years ago. That is where I learned about and became interested in the health

record profession. I wanted to go back to school full time into the health records program, but by this time I was already a mom of three young children and full time school was not practical for me. So I opted for the Health Records program by correspondence through the Canadian Healthcare Association. After completing the program, I successfully challenged the Canadian College for Health Record Administrator’s exam. I became certified and began my work as a health record technician. Although I enjoyed coding, I knew it was not what I wanted

to do permanently. I wanted to continue to grow professionally but in order to do so; I knew I had to continue with my education. Knowing that having a family, going to school and working full time would not be easy, and after a lot of thought, I made my decision to go back to school.

I always found it easier to have small goals along the way. That way you can see your achievements and it keeps you motivated. Therefore, although, I knew that I would eventually want to earn a Masters degree, I opted for smaller goals. With

that in mind, I applied to York University for a Certificate in Health Administration. At the same time I looked for opportunities to advance my career. It was a combination of my health records background and the fact that I was enrolled in university that really got me my first management job.

After completing the certificate program at York, I gave myself a further goal and that was to complete my undergraduate degree in Health Administration. I applied to Ryerson University where I completed the Bachelors in Health Administration (BHA). By this time I had further advanced in my career as a Director of Health Records of three community hospitals.

As I continued my education, another opportunity came along working as a coordinator for Health Information Management in a large multi-site hospital.

This was a challenging role in that it required the use of all kinds of skills such as leading, facilitating, coordinating, influencing, planning etc. in order to align and gain consistency in practices across multiple health records and registration departments. In this particular role, I worked with colleagues who had one or two masters or a PHD. I realized then, that an undergraduate degree would not do, if I was to further advance in my career. After graduating with my BHA, I applied to The University of Toronto for a Master in Health Science Administration (MHSc).

I graduated with the MHSc in April of 2004, at which time I also successfully challenged the certification exam with the Canadian College of Health Executives (CHE). Today, I am employed as the Director of Health Information Management in the second largest multi-site

hospital in Ontario. In this role, I am responsible to oversee the operations of the Health Records Program and to develop and ensure implementation of the Information Management Strategic Plan. One of the many exciting projects that I am currently working on is the implementation of the electronic health record.

Health Information Management is an exciting field to be in today. It is receiving a lot of attention at the Federal and Provincial levels of government with investments in the development of a Federal and Provincial Electronic Health Record. Quality, accessible and timely health information is at the heart of a sustainable health care system. I feel very fortunate to be in this exciting field and owe my success to my health records roots.

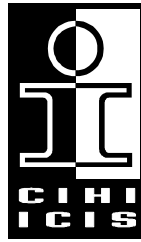
### Member Profile

Each issue we like to do a profile of a member of OHIMA. This article could be highlights of someone's career in healthcare/health information management or their experiences as a health information management professional in a non traditional role. Please send your submissions to [communications@ohima.ca](mailto:communications@ohima.ca)

**Update from CIHI**

Striving to meet your needs!

***Just-in-Time Learning-A shared responsibility***



CIHI Education and Conferences

*By: Kent Maclean, Manager*

When we consider our audiences, it's very apparent that there is a need for the health care workforce to have rapid and efficient access to information, knowledge and skills so that they can stay current and competent. In today's world, a critical ingredient to an individual's and organization's success is 'just-in-time training.'

It is also clearly evident that technology has not only changed the way we work, think, and live but it has especially changed the way we learn. The increase in technology's accessibility and reliability has meant that training providers must adjust the way they develop and deliver education content.

CIHI is strategically realigning itself to meet this 'emerging world'. Up to now our predominant mode of delivery medium has been Instructor-Lead-Training (ILT). The past 18 months have seen the early transformation of our education program into one that represents a blend of all available mediums: e-Learning, web conferencing, teleconferencing and videoconferencing. As you

review the accompanying education schedule, you will note that many of the current deliverables are using one of the fore mentioned mediums to augment our 'core' education plan.

Early indications suggest that distant clients are slowly increasing their access to CIHI education content. As a result, they are spending less time away from their health care facilities. And, for those sessions that can be recorded, it means that archived versions are readily available for future referral.

Yet to be truly effective, clients need to be supported by management and an infrastructure that allows them to take full advantage of the related benefits and ultimately the education offerings. This means that facilities will need to be similarly equipped with such resources as current desktop computers, Internet access, videoconference, teleconference, and web conference equipment/capability. Moreover, staff needs to be provided with the opportunity to 'study' (e.g. access the course components and assignments) during their work hours. And finally, it

depends on CIHI's ability to provide appropriate content; content that can be delivered successfully via these mediums; content that is succinct and modularized and which thereby respects available learning time and needs; and content that can be readily transferred/applied to the job at hand.

CIHI is committed to providing relevant, quality, and just-in-time education to our clients. Using these alternate mediums is the best means of meeting these objectives. As you participate in these programs, we seek your comments on how we can improve the content as well as the success of these different delivery methods. Only with your feedback will we best be able to accommodate your learning styles and environments and provide the 'just-in-time' education opportunities so critical to your success.

*The Board of Directors of OHIMA would like to thank CIHI for supporting our membership by sharing information within our newsletters on a regular basis including articles, updates and education session schedules.*

# CIHI 2004 – 2005 EDUCATION

## **Management Information Systems Guidelines**

|  |  |  |
|--|--|--|
| • Introduction to the MIS Guidelines for Acute Care Facilities                             | e-learning                                 | Apr./04 – Mar/05*                                    |
| • Introduction to the MIS Guidelines for Community Health Service Organizations (CHSO)     | e-learning                                 | Apr./04 – Mar/05*                                    |
| • Introduction to the MIS Guidelines   | e-learning                                 | Apr./05 *  |
| • MIS Guidelines for Respiratory Services  | e-learning                                 | Apr./05 *  |
| • MIS Guidelines for Diagnostic Imaging  | e-learning                                 | Apr./05 *  |
| • MIS Guidelines for Electrodiagnostics, Non-Invasive Cardiology and Vascular Laboratories | e-learning                                 | Apr./05 *  |
| • Cost per Weighted Case Methodology for Rural Hospitals                                   | Recording                                  | Oct./05 – Mar/05*                                    |
| • Conducting a Financial Data Quality Audit  | Kingston                                   | Mar. 10/05   |
| • Conducting a Statistical Data Quality Audit for Therapeutic Services                     | Guelph                                     | Jan. 13/05   |
| • Integrating Financial and Clinical Data  | Toronto<br>Hamilton<br>Kingston<br>Toronto | Feb. 15/05<br>Feb. 16/05<br>Mar. 11/05<br>Apr. 12/05 |

## **Discharge Abstract Database**

|                                    |                |            |
|------------------------------------|----------------|------------|
| • What's New for DAD/NACRS 2005-06 | Teleconference | Mar. 10/05 |
|                                    | Teleconference | Mar. 17/05 |

## **ICD-10-CA & CCI**

|  |                        |                                  |
|--|------------------------|----------------------------------|
| • Applied ICD-10-CA & CCI (Case Studies)                             | e-learning             | Apr./04 – Mar./05                |
| • Introduction to ICD-10-CA & CCI (SLP 2003)                         | PDF                    | Apr./04 – Mar./05                |
| • Introduction to ICD-10-CA and CCI for Physicians                   | PowerPoint             | Apr./04 – Mar./05                |
| • The Canadian Coding Standards and Diagnosis Typing for DAD (2-day) | Toronto<br>Thunder Bay | Jan. 26 & 27/05<br>Mar. 8 & 9/05 |

## **National Rehabilitation Reporting System**

|  |                                   |                   |
|--|-----------------------------------|-------------------|
| • National Rehabilitation Reporting System: Indicators & Report Interpretation | Toronto                           | Feb. 28/05        |
| • National Rehabilitation Reporting System Trainer Refresher                   | Web-conference<br>(3-part series) | Feb. 8, 15, 22/05 |

## **National Ambulatory Care Reporting System**

|   |                                  |                          |
|---|----------------------------------|--------------------------|
| • An Introduction to the CACS Grouper     | e-learning                       | Apr./05 *                |
| • Coding in the NACRS Environment         | e-learning                       | Apr./05 *                |
| • NACRS: From Abstraction To CACS Grouper | Recording                        | Jan. /05 – Mar. /05      |
| • What's New for DAD/NACRS 2005-06        | Teleconference<br>Teleconference | Mar. 10/05<br>Mar. 17/05 |

## **Continuing Care Reporting System**

|   |        |            |
|---|--------|------------|
| • Data Applications/CCRS: Accountability, Quality Improvement & Resource Planning | Ottawa | Feb. 10/05 |
|---|--------|------------|

## **Privacy**

|  |                  |                          |
|--|------------------|--------------------------|
| • Conducting a Privacy Impact Assessment | Ottawa<br>London | Feb. 16/05<br>Feb. 23/05 |
|--|------------------|--------------------------|

*\*Note: Dates are tentative for the launch of these e-learning programs.*

*For more information on registering on-line & e-learning, check our education web site <http://ecommm.cihi.ca/ec/educat.asp>*

**The Ontario Health Informatics Standards Council (OHISC) Approves Two New Standards**

*Respectfully submitted, Maria Muia, OHISC member representing OHIMA.*

At the January' 05 meeting, the OHISC council approved the following two standards for Ontario:

- 1. Data Standards:
  - Codes for the Representation of Names of Countries and their Subdivisions (ISO3166-1 (alpha 3) and ISO 3166-2)
  - Codes for the Representation of Languages (ISO 639-2)
- 2. Information Security Standard:
  - Code of Practice for Information Security Management (ISO17799) – three components were recommended as normative (mandatory)
    - i. Risk Assessment and Treatment – Assessing Security Risk
    - ii. Security Policy – Information Security Policy
    - iii. Organizing Information Security – Internal Organization

Both standards are important to Ontario in that they facilitate secure “interoperability” among e-Health Information Technology Solutions. There is an expectation that all participants within the e-Health Strategy will adopt these standards in their solutions when exchanging or providing data.

ISO3166-1 and 2 and ISO639-2 are recognized internationally and define a coding scheme that identifies names of countries, their subdivisions and language. Once adopted, variability in data coding by sending systems is eliminated as is the variability in interpreting and receiving data.

The Information Security Standard too is internationally recognized. For Ontario, it is intended to complement and facilitate the implementation of the Personal Health Information Protection Act (2004).

Because The Ontario Health Information Management Association is a voting member on the OHISC council, it (we as members) is expected to promote the use and adoption of these standards by providing education and advice for incorporating these into information technology and information management projects (e.g. educational material, process tools, templates for Requests for Proposals (RFP’s) etc.) We as a sector are also responsible to report on activities and methods used to promote the approval of these standards on an annual basis.

All OHIMA members should familiarize themselves with these standards and promote them within their respective organizations. **Further News from OHISC.....**

The OHISC council will be undergoing some changes in governance and accountability. Currently OHISC is a committee of the Smart Systems for Health Agency which reports directly to the Ministry of Health and Long Term Care (MoHLTC). The changes will see the OHISC council reporting to the Ontario e-Health Council which is responsible for setting e-health priority and strategic direction. The e-Health council reports to the Deputy Minister who in turn reports to the Minister of MoHLTC. The change in governance may mean a review of membership

The mandate of OHISC council is to define standards through development – only in terms of identifying gaps, recommend standards for implementation and promote the implementation of approved standards. It is important that OHIMA maintains a seat on this very important council because; it is this council who is, and will continue to set the standards for the electronic health record. And we, as the health information management experts in the province should have a voice in the approval process. Watch for FAQ’s on HL7 in the next issue of this newsletter.

# Technology Corner

## Technology Corner-

Submitted by: Navid Nabavi, BSc, MSc, CCHRA(C)

### e-HIM and Security Weaknesses:

Hospitals are going to invest more in IT; "After years of lagging behind, hospitals will spend 5.5 percent of revenue on IT"<sup>1</sup>. The rapid growth of Information Technology (IT) has made a great impact on the Health Information Management profession. Having access to affordable multi megahertz processors, hundreds of gigabits of storage and user-friendly input/output devices has paved the way for the hidden explosion of health information.

For health care workers, health records are bound with security. This is a traditional and fundamental part of working in this field. The traditional concern of safety and security was mainly limited to the level of professionalism of the HIM staff; the one and the only gate keeper for health information. They were trained to know what and when to release information and how to do that. This traditional view of health information which is based on

paper is going to be replaced with the electronic version. Through current state of the art technology all health care workers with access privileges; can retrieve any information from the convenience of their workstations.

The new privacy legislation - The Personal Health Information Protection Act (PHIPA) came into force Nov 1 2004 – and should have minimal impact on HIM professional that already have good privacy and confidentiality practices in place. However there is a catch here, are we ready to implement and maintain the electronic health records security at the same level as the paper records?

The key question is what are the security consequences of this migration from paper to electronic database? Coordinated planning and development through "Ontario eHealth Blueprint and Strategic Agenda" in July 2002, contains six areas, one of them is privacy and security. Let us have a look at the description of "establishing privacy and security requirements"; outlined by the working group of the Ontario Hospital eHealth Council.

*"The impact of privacy legislation on the operations of health care means that electronic health information systems & processes to share data must be well planned, properly designed and regularly monitored. They must include security requirements to provide protection of confidentiality for individually identifiable health information."*<sup>2</sup>

I would like to bring to your attention this statement. "Health information systems and processes to share data must be well planned, properly designed and monitored." Implementing this idea demands an in-depth understanding of Information Systems in order to monitor the process and prevent the threats by implementing tools and protocols.

The following is being brought to your attention with an eye on "What you don't know that can hurt you" from the book called "Inside Internet security" by Jeff Crum. This is a glance at the potential weaknesses of (EHR's)

<sup>2</sup> Ontario Hospital eHealth Council "Progress Report - Moving Ontario's eHealth Vision into Action,"

<sup>1</sup> July issue of the Healthcare IT "Forecast: Heating up" by Eric Brown

electronic health records if not designed properly.

**A Firewall is not as secure as we think:**

A firewall consists of software or hardware to audit the flow of information and grant access to authorized data. However a password is all you need to get by the firewall and passwords are vulnerable in nature. Hackers in some cases initiate their attack with guessing the password. They know that in many cases the password partially contains the username, organization name or the application name. They also know that people tend to add numbers or names to the basic part of the password. It seems very difficult to think of all the combinations however do not forget that they are equipped with all the recent high tech tools that can perform the guessing part for them. It takes a fraction of a second in order to crack a 4 digit numeric password. In order to maximize the password security each password should consist of alpha and numeric characters. It is a good practice not to use the name of the application or the organization as a password and finally be creative and think like a hacker.

There is potential danger in using the firewall alone! Vendors do their best to add new features in order to make applications easy to install and use

'plug and play' components. Some of these exciting features are defaults. The hacker who knows the application defaults can use them to break into the network.

**Wide Area Network (WAN) Email usage should be limited:**

Human error can lead to a break in security. A chain is only as strong as its weakest link, and human fallibility rather than technology itself is likely to be the link that breaks in the IT security defense system.

As you know email is not a secure way to transfer data and there are many tools such as "package sniffers" that can monitor the network traffic and retrieve the information. I was in the cab a few weeks ago, I overheard a driver giving out a passenger credit card number via the cab radio. You probably agree with me that this is a very unprofessional and insecure way to send personal and critical data. Sending data via email is just the same as broadcasting it over the radio. People who are equipped with hacking tools can easily extract the information that they are looking for.

**Up-to-date Information Technology is a must**

Critical applications specifically Operating Systems, Database Management Systems & security

applications need constant upgrading according to the latest available technology. Old software has proven weaknesses and could be an easy target for a hacker who is on top of the technology.

It is obvious that the future of HIM is tied with the Information Technology industry. This is probably why the American Health Information Management Association (AHIMA) & Healthcare Information and Management Systems Society (HIMSS) jointly sponsor the HIM security and safety credential.

With current legislation it is up to the leadership of the Health Information Management professionals nationwide to deal with security weaknesses. They should work shoulder to shoulder with the IT department, and be serious about staff training in order to facilitate a secure infrastructure for personal health information. Just remember that a hacker is not necessarily a person with financial or professional reasons/he might be a teenager anywhere in the world, trying to impress his/her friends.

Furthermore, according to AHIMA "*Identity theft is the fastest growing crime in the US, and patient identity theft is a serious part of this trend*".

Submitted by: Joanne Habib, MLT, CIC.  
Clinical Leader of Infection Prevention and Control at  
Lakeridge Health Corporation

# Clinical Corner

CLINICAL CORNER.....NEW SECTION to assist coders!

## LEARNING ABOUT .... WEST NILE VIRUS INFECTION

### West Nile Virus (WNV):

- Is caused by the bite of a mosquito carrying the virus
- WNV illness can be considered to consist of 2 clinical pictures. WNV fever and
- WNV neurological illness such as west mile virus encephalitis (inflammation of the brain) or
- WNV meningitis
- Everyone is at risk

### Signs & Symptoms:

The incubation period for WNV ranges from 3-14 days. WNV Fever - the milder form of WNV illness. Symptoms include sudden onset of fever plus one or more of the following; malaise, anorexia, nausea, vomiting, headache, eye pain, sudden sensitivity to light, muscle weakness, myalgia, maculopapular rash and swollen glands.

### Clinical Criteria:

2 or more of fever, malaise, anorexia, nausea, vomiting, headache, eye pain, sudden sensitivity to light, arthragia, myalgia, maculopapular rash and

lymphadenopathy.

### West Nile Virus Neurological Manifestations

May include the symptoms of west nile virus fever. Symptoms of encephalitis are more commonly reported than meningitis. Symptoms may include change in mental status, severe muscle weakness, flaccid paralysis, myelitis, seizures, cranial nerve abnormalities including optic neuritis, ataxia and extrapyramidal signs.

### Clinical Criteria:

Fever AND 1 or more of associated neurological syndromes such as encephalitis, meningoencephalitis or viral meningitis or acute flaccid paralysis poliomyelitis-like syndrome or Guillain-Barre-like syndrome  
Diagnosis:

### Laboratory Findings (in recent outbreaks):

Total leukocyte counts in peripheral blood are mostly normal or elevated, with lymphocytopenia and anemia also occurring. Hyponatremia is

sometimes present, particularly among patients with encephalitis.

Examination of the cerebrospinal fluid (CSF) shows pleocytosis, usually with a predominance of lymphocytes. Protein was elevated. Glucose was normal. Computed tomographic scans of the brain mostly did not show evidence of acute disease, but in about one-third of patients, magnetic resonance imaging showed enhancement of the leptomeninges, the periventricular areas, or both.

### Treatment:

Treatment is supportive, often involving hospitalization, intravenous fluids, respiratory support, and prevention of secondary infections for patients with severe disease. Ribavirin in high doses and interferon alpha-2b were found to have some activity against WNV in vitro, but no controlled studies have been completed on the use of these or other medications, including steroids, antiseizure drugs, or osmotic agents, in the management of WNV encephalitis.

**In case you missed this opportunity in the last newsletter....Exciting Volunteer Opportunity**

The National Health Information Management Alliance is currently recruiting a new chairperson to commence June 1, 2005 for a two-year term. This role offers you the opportunity to use your strong leadership and facilitation skills within a nation-wide health information network.

You will encourage and support the goals of the Alliance, which are:

- Represent the health information management profession as a unified organization;
- Promote the expertise of health information management professionals;
- Champion continued professional learning;
- Strengthen the membership; and
- Support and mentor other Alliance members.

You are a current member of the Canadian Health Information Management Association (CHIMA), you have previous experience in a chair or facilitation role, and you have a minimum of five years experience in the health information management profession. Current members of provincial health information management association executive committees or boards are not eligible.

If you would like to be considered for this volunteer position, please contact your provincial Alliance representative for more information.

For a list of provincial Alliance representatives and their contact information, please visit the CHIMA website at [www.chima-cchra.ca](http://www.chima-cchra.ca), go to "About the Organization", choose "Professional Alliances" link at the bottom of the page, and then proceed to the map of Canada. There is a link available on the map for each provincial representative.

**Selection Criteria for the Alliance Chair**

- Must have had previous experience as a chair, preferably at a provincial or national level or equivalent.
- Must be a current member of the Canadian Health Information Management Association (not necessarily active).
- Must have a minimum of five years experience in the health information management profession.
- Must be knowledgeable about current issues in the health information field.
- Must have good communication, facilitation, and organization skills.
- History of volunteerism in provincial and/or national association positions desirable.
- Shall not be a current member of executive committee or board of any health information management association.

*Acceptance by Presidents/Chairs of the Health Information Management Associations*

**Alliance Chair Position: Duties and Responsibilities**

**In-person meetings**

Work with the designated conference office at the Canadian Health Information Managements Association to:

- Book meeting room
- Arrange for table set up, visitor chairs, and any equipment needed
- Arrange coffee breaks and luncheon

- Arrange for welcome reception for in-person meeting
- Set agenda with participation from Alliance members
- Gather and/or provide support materials
- Confirm participation of Alliance members
- Provide business report for completion/return at least two weeks prior to meeting
- Send agenda and other support materials to members no later than two weeks prior to meeting
- Arrange for minutes to be taken
- Chair meeting
- Keep meeting discussions on track according to agenda
- Keep meeting to timeframes specified
- Encourage participation from all representatives
- Complete and distribute draft minutes within two weeks of meeting with final set distributed within one month following meeting
- Complete and distribute Task List identifying meeting action items
- Follow-up on action items from meeting

**Teleconferences**

- Set dates with Alliance members in advance
- Book teleconference call
- Send out call for agenda items
- Complete and send agenda along with instructions for teleconference
- Ensure all Alliance members responsible for items of follow-up have completed their items for the meeting and provide support as needed
- Arrange for minutes to be taken
- Chair meeting
- Keep meeting on track according to agenda
- Keep meeting to timeframes specified
- Encourage participation of all members
- Complete and distribute draft minutes within two weeks of meeting with final set to be distributed within one month following meeting
- Follow-up action items from meeting

**Alliance Chair Nomination**

The Provincial Health Information Management Association of:

Puts forward the following nominee for the position of Chair, 2005-2007 Term:

Name: \_\_\_\_\_ Phone Number (day): \_\_\_\_\_ Email Address: \_\_\_\_\_

Brief outline of nominee's professional/volunteer history:

*Please return the completed Nomination to Shirley Groenen, Chair of the National Health Information Management Alliance, by email ([shirley.groenen@gov.ab.ca](mailto:shirley.groenen@gov.ab.ca)) or fax (780-422-1960) by March 1, 2005)*

## ONTARIO HEALTH INFORMATION MANAGEMENT ASSOCIATION 2004/2005 EXECUTIVE

| Region | Position                           | Name             | Contact Information  |
|--------|------------------------------------|------------------|--|
| 1A     | Secretary                          | Marcia Gillies   | Coordinator, Cancer Centre Health Records<br>Thunder Bay Regional Health Sciences Centre<br>980 Oliver Road<br>Thunder Bay, ON P7B 6V4<br>Phone: 807-684-7268<br><a href="mailto:secretary@ohima.ca">secretary@ohima.ca</a>                                    |
| 1B     | Director, Advocacy                 | Mary Lou Kennedy | Manager<br>Group Health Care<br>240 McNabb Street<br>Sault Ste. Marie, ON P6B 1Y5<br>Phone: 705-541-2289<br><a href="mailto:advocacy@ohima.ca">advocacy@ohima.ca</a>   |
| 1B     | Director, Professional Development | Janice Soltys    | Acting Manager, Registration & Records Services<br>Sault Area Hospital<br>969 Queen Street East<br>Sault Ste. Marie, ON P6A 2C4<br>Phone: 705-759-3635<br><a href="mailto:professional@ohima.ca">professional@ohima.ca</a>                                     |
| 2      | Director, Communications           | Paula Weisflock  | Program Coordinator, Health Information Management<br>Sir Sandford Fleming College<br>599 Brealey Drive<br>Peterborough, ON K9J 7B1<br>Phone: 705-749-5530 ext 1718<br><a href="mailto:communications@ohima.ca">communications@ohima.ca</a>                    |
| 4      | Past President                     | Charmaine Shaw   | Consultant<br>Shaw H.I.M. Services<br>19 Richter Street<br>Brantford, Ontario N3T 6M2<br>Phone: 519-750-1473<br><a href="mailto:pastpresident@ohima.ca">pastpresident@ohima.ca</a>   |
| 5      | President                          | Lynne Hopper     | Clinical Information Analyst<br>Listowel and Wingham Hospitals Alliance<br>270 Carling Terrace<br>Wingham, ON NOG 2W0<br>Wingham Phone: 519-357-3210 X 202<br>Listowel Phone: 519-291-3120 X 220<br><a href="mailto:president@ohima.ca">president@ohima.ca</a> |
| 5      | Treasurer                          | Deb Tetreault    | Data Quality Review/Education<br>Salumatics, Inc.<br>374 Saulsbury Street<br>Strathroy, ON N7G 2B4<br>Phone: 519-245-7307<br><a href="mailto:treasurer@ohima.ca">treasurer@ohima.ca</a>  |

Ontario Health Information Management Association  
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## WELCOME TO OUR 2 NEW EXECUTIVE MEMBERS.....



**Debra Tetreault** is currently employed with Salumatics doing the Education and Data Quality Review. In this capacity, she is responsible for auditing the quality of coded information, providing feedback to queries, responding to queries and developing appropriate education modules. Most recently, Debra has been seconded to CHIMA as one of the Coding Experts reviewing charts for the Ministry of Health and Long Term Care (MOHLTC) Data Quality Review Study. Debra has over 15 years of coding, data analysis and statistical experience in both Canada and the United States. Debra is a certified Health Information Management Professional with the Canadian Health Information Management Association (CHIMA) and chairs the Southwestern Ontario Data Quality Task Force. Debs professional goals are continued education in management, coding and public speaking opportunities, to learn all she can about data quality and to share that newly learned information with others

**Janice Soltys** is currently employed as the Acting Manager for Registration & Records Services at the Sault Area Hospital. In this capacity, she is responsible for day to day operations of the admitting, health record and outpatient booking areas. Janice has been at the Sault Area Hospital for 23 years, the majority of which within health records where she has been a clerk, coder, release of information specialist, Team Leader, Supervisor and now the Acting Manager. In the very near future, Janice is going to be teaching the "maintaining health records" course at the Sault College of Applied Arts and Technology. Janice became involved with OHIMA in order to broaden her network with other professionals across the province and to meet professional development goals. Janice looks forward to serving on the Board of OHIMA and in working on the professional development portfolio which serves the members.



## YOUR 2004-2005 OHIMA EXECUTIVE



From left taken at our in person Board Meeting in January:

Janice Soltys, behind her Mary Lou Kennedy, Lynne Hopper, Deb Tetreault, Marcia Gillies & behind her Paula Weisflock

Missing from picture is: Charmaine Shaw