NEWS & VIEWS

October 2003

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President's Message

By Charmaine Shaw, President, OHRA

As promised, this newsletter is being delivered on schedule. It may not be pretty, but it IS............and it has content. We deliberate a lot on what you would like to see in a professional newsletter. Your feedback and suggestions would be highly welcomed. An article of contribution would be revered! Please give some consideration to writing an article for the winter newsletter edition. You could write about a new initiative or even a new twist on an old program or process. We'd love to hear from those of you serving as Chief Privacy Officer – tell your peers about your exciting program.

Here are some issues of monumental purport for your consideration:

1. <u>NAME CHANGE</u>

The former Canadian Health Record Association (CHRA) is now the Canadian Health Information Management Association (CHIMA). This motion was ratified at the CHRA annual conference in June/03. I'm sure you agree that the name change more closely reflects our day-to-day reality and aligns us with our fellow Health Information Management Professionals to the South. What to do about our provincial association name is the looming question. Should we remain the OHRA or become the OHIMA? Please cast your vote!!

2. <u>PARTNERSHIP WITH NATIONAL ORGANIZATION</u>

At the June 4, 2003 in person meeting of the Provincial Association Alliance, I put forward a proposal that the national and provincial health record associations develop a partnership resulting in only one association with one membership fee.

My rationale for making this proposal included the following points:

- In Ontario, only one-fifth of health information professionals belong to the OHRA while many more belong to CHIMA.
- It is difficult for the OHRA to accomplish tasks because of the limited membership and it is a concern that the OHRA does not truly represent the

provincial health information professionals.

- CHIMA has a mechanism in place to collect membership fees, provide education initiatives etc., and the provinces currently duplicate these efforts.
- The provinces could take on some of the tasks currently performed by the CHRA.

I also suggested that the provinces establish local chapters in order to maintain provincial identity and deal with local issues and initiatives. In effect, the OHIMA (if name change is ratified) would become a provincial chapter of CHIMA.

If you agree, you would have membership in one professional organization only! Membership fees would need to be established and may be more than the current CHRA dues but would certainly be less than the combined OHRA/CHRA dues. You would receive one newsletter but that newsletter would be of both national and provincial flavours. Please vote to demonstrate your support or condemnation of this proposal.

3. MEMBERSHIP DATES

Please remember that we operate on a fiscal year for membership dues (April 1 – March 30). If you pay your membership on March 15 it will expire in a few weeks! Please bear this in mind when submitting your dues – and get those dues in ASAP. You still have 6 exciting months of membership!

4. WEBSITE

I think the only thing we can say about it is that it is a big fat zero. Finally, we have a web designer and a web master in our grips, however. We plan to launch the new website soon after the OHA Convention. Who knows – we may have a new name by then? Between now and then, we need to consider design and content. How would you like our web site to look and what should it contain? Please forward your comments to Paula Weisflock, Board member for Communications.

5. RECOGNITION AWARD

It is time to nominate "…an individual who has advanced the ideals of the Ontario Health Record Association through leadership, promotion and representation of the profession". Criteria include:

- Holds active membership in the OHRA for not less than five years
- Participates actively within the association
- Successfully represents the profession within the employment environment
- Actively promotes the profession and the Association

Your nomination should include: Candidate's name, current place of employment and position summary, candidate's past work experiences, candidate's volunteer experience, and a summary of specific achievements to be considered for the award.

Please send your nomination to Jody McKie, Board member for Public Relations and Liaison.

6. PARTICIPATION IN THE ASSOCIATION

As somebody famous once said: "Ask not what the Association can do for you, rather, ask what you can do for the Association". Please contact any of the Board members if you are interested in helping us out in any of our initiatives.

7. SPRING CONFERENCE

We are planning an OHRA Spring Conference. Your feedback regarding: location, program content, timeframe would be valued. Please contact Mary Lou Kennedy, Board member for Education, with all your good ideas and feedback.

Sincerely,

(Ms) Charmaine Shaw, CCHRA(c), BA, MA, President, OHRA

Editor's note
Paula Weisflock, CCHRA (A)
OHRA Director, Communications

I trust that you all enjoyed your summer and are ready to tackle the ever increasing workload that we all seem to be experiencing these days. The addition of high cost/high volume clinics for many facilities is sure to add another dimension to our already taxed health information professional resources. Special thanks to Navid Nabavi who assisted me with formatting this newsletter.

Please note the call for interested members to become involved with OHRA as a committee or Executive member. This could be your year to enhance the organization with your experience and commitment to personal and professional development.

Outsourcing Coding

By Sandra Norton, CCHRA (A)

Leamington, Ontario, a beautiful community with a population of about 25,000 on Lake Erie and the Tomato Capital of Canada! Like many of you out there, this 81 bed Acute Care Community Hospital is struggling to find qualified coders to meet the Ministry's ever growing mandated data collection. In addition, there are the year end data submission deadlines where not making it means facing significant financial penalties that your hospital can't afford. For those of you who may not believe they exist, trust me, they do.

Over the last few years there were several factors that lead us down the path to contract outsource coding companies. Recruitment & retention has been difficult. We are a small community hospital only 45 minutes away from Windsor. It is difficult to compete with a large hospital salary scale as well as the daily commute issue if the person chooses to reside outside of Leamington. Also, the appeals of working for outsource coding companies in the comfort of your own home is becoming more prevalent.

As a result, LDMH contracted several companies over the last two years to deal with the backlog and work toward meeting the deadlines on an ongoing basis. Based on these experiences, I have broken the process down into seven categories and outlined key information for each below.

Administrative Support:

Gaining the support of administration is critical. Fortunately, for me, Warren Chant our CEO, and the rest of the senior management team were sensitive to the situation and in turn supportive of what had to be done. To facilitate senior administration support I suggest you:

- Communicate the impending situation long before it is too late to deal with using a well thought out, organized plan (the quote, contract and setup process can take a few months)
- Be prepared to back your request with supporting data i.e. in depth analysis of the backlog, available FTE's, deadline dates and an estimate of financial penalties that you could face.

Obtaining Quotes:

This was the most interesting part of the whole process. The clearer you are with what your specific needs are the more time you will save going back and forth. Consider the following:

- Create a common data sheet to work from with your particulars and questions you want answered e.g. total charts to be abstracted, type of charts, complexity of charts, average number of pages per type of chart (needed for scanning purposes), turnaround time expected. How do they select their coders? What does their QA process consist of? What are their expectations of you? E.g. running reports & statistics. Have this information ready before you contact companies.
- Talk to your Information Services people. There can be significant hardware/software issues making it difficult or impossible to work with a company. Make sure they are available to speak directly to the companies IS staff if necessary.
- Get as many quotes and references as possible. Ensure references have gone through a similar process to get a true reflection of what may be in store for you.
- Remember, the highest quote doesn't necessarily mean the highest quality.

<u>The Contract</u>:

- Have your IS department review to ensure technological components are clearly outlined.
- Ensure timelines for completion and responsibility for all late submission fees & penalties are clearly outlined.

The Setup Process:

- Be realistic, between your schedule and theirs and working through all the details, as I said earlier, it can take a few months before any coding starts.
- Develop a manual with your particulars like special coding requirements or data collection unique to your institution. (some companies will work through this process with you)

Chart Prepping/Scanning:

- The clerical support to process charts in preparation & return for either on-site or off-site scanning is extensive. Don't under estimate this cost!
- When scanning on-site, ensure enough workspace to accommodate the equipment, the charts and the staff.
- If sending charts off-site for scanning, this process involves a lot of boxes. Ensure adequate floor space and easy accessibility, as you will more than likely be retrieving charts from the boxes before the shipment date and after the return before all re-filing is complete.

The QA Process:

- The company should be sending any problems and or questions your way. I am that contact person (as no staff available to delegate to). Again, this can be extremely time consuming. Don't under estimate this cost!
- Complete as many data quality checks as you can especially when first starting out.

Communication:

- -Frequent communication is imperative.
- -If there is not explicit or clear communication from both sides it's possible that the outcome may be less than satisfactory.
- -Don't hesitate to bring any suggestions forward. I must say every company was more than willing to listen to our input & implement or change a process when & where necessary.

Please appreciate I've only scratched the surface of what can be done to make the best of the situation.

Out of sight, out of mind is not the reality. We are doing what we have to, to get the job done but we are working towards a solution to eliminate the need for outsource coding and regain day-to-day control of our own data & processes. LDMH continues to search for 2 qualified coders and is also supporting two hospital staff through educational training established by CHA- Health Information Services program.

...there is still no place like home!

Sandra Norton, CCHRA (A)
Director-Health Records & Patient Registration

Get Published!!

If you, or someone you know, would like to write an article for publication in News and Views, please contact Paula Weisflock (contact information on page 19 of this newsletter)

Best Wishes!

The Board of Directors for OHRA wish the very best to all of the students challenging the CCHRA certification exam this Fall.

REGION 3

It is time for me to step aside and let some new blood into the executive group!

Do you want to be part of the group making the decisions, or sit back and be spoon fed what others have created?

Please consider becoming the OHRA Representative for Region 3 which spans from Scarborough to Niagara Falls. Have fun, work with stimulating people!! Don't let this great opportunity pass you by!!

Please contact Marci MacDonald at 905-338-4634 if you are interested!

Development of an EMR at Sault Area Hospital

By Lori Bertrand & Marie MacKay

Located in Sault Ste. Marie, Sault Area Hospital (SAH) is an amalgamation of two longstanding acute care community hospitals, the Plummer Memorial Public Hospital and the Sault Ste. Marie General Hospital. Included in the hospital family are two satellite hospitals, Matthews Memorial Hospital and Thessalon Hospital, located east of the city. The Plummer and General amalgamated in 2002 after operating in partnership since 1993. The partnership was one of the first in Ontario between a Catholic and a non-denominational hospital. Sault Area Hospital includes a total of 364 beds and 15 bassinets, with the breakdown as follows: 232 acute care beds, 50 chronic care beds, 23 rehab beds, 10 Modified Level-3 NICU beds and 49 interim nursing home beds. Sault Area Hospital serves as a referral hospital for the District of Algoma.

Automation began at SAH in 1994 with an aggressive roll out of automation in support departments, including: Admitting/Registration in September 1995, Diagnostic Imaging in February 1996, Pharmacy in March 1996 and the Laboratory in February 1997. Other system implementations occurred simultaneously including Payroll, Staff Scheduling, Accounts Receivable, General Ledger and the Surgical Suite application. During the roll out of the department systems, the vendor introduced a new clinical application, which provided a central repository of patient record data (results, orders, documentation,) for easier, more complete chart access and storage. Implementation of this clinical application was added to the plan.

Introduction of a clinical information system required complex physical restructuring, process and role redevelopment, change management, and education to clinical users. The implementation team was formed including physicians, nurses and other representatives from the clinical and support departments, analysts with a clinical background, and Information Technology staff. The group was responsible for conducting process review and redesign activities, configuration of the application, and development and delivery of the education program.

In order to accommodate the added equipment necessary for automation, major renovations to most nursing units were required. An intensive review was undertaken in order to review space and hardware requirements and conduct ergonomic assessments. Major renovations were conducted at some nursing stations and modular furnishings installed; mobile furnishings were used in other areas. A commitment was made by the organization to maintain the concept of modular furnishings to facilitate future movement to our new facility, and to standardize the future purchase of desks, equipment and chairs to those selected through the process.

In order to facilitate training of clinical users, assessment of existing computer skills was completed through surveys. Basic computer skills training sessions were offered as well as a payroll purchase option for home computers, to better acquaint the staff with the impending technology. The education plan was structured upon the schedule of the roll out, providing training to unit staff just prior to the "go live" in their area. A "train the trainer" approach was utilized to assist with the education and ongoing support of the clinical users. Super Users were chosen from each unit by their peers and functioned as auxiliary trainers in the classroom and provided ongoing support to the staff and physicians during go-live. The education plan for the physicians was structured to offer training in a classroom setting or on an individual basis. In order to accommodate the physicians' schedules and facilitate participation, training was offered in the location of the physician's choice.

The initial scope of the project was to include implementation of results review and order entry, however, due to implementation delays, the growing hospital deficit, and concerns with some of the order entry functionality of the application, the decision was

made to move forward with results review only. The clinical information system went "live" in two pilot areas in March 2000; post evaluation of the pilots in the Renal Dialysis area and on a Medical Unit were positive, clearing the way for a global implementation to continue across the hospital for the next six months.

The next release of the clinical information system occurred in January 2001; in order to remain current with the software and to correct outstanding defects in the current version, an upgrade was completed in October 2001. Because the applications were very similar and no new functionality was being implemented at the time of upgrade, it was accomplished with minor disturbance to the users. Extensive communication and demonstrations were conducted with all of the clinical users prior to the upgrade.

The clinical users use the clinical information system to view: (a) patient personal demographic data including name, unique identifier, visit data, visit history, contact information; (b) patient health information including presenting complaint, health history, allergies; (c) diagnostic test results from the laboratory and diagnostic imaging with the exception of images or graphs; (d) documents dictated by physicians and transcribed in the Health Records department, with the exception of mental health notes and physician progress notes; and (e) a daily / weekly medication report for inpatients generated from the pharmacy department system. SCM can generate lists of patients based upon the date, a location, or a specific care provider to allow easy access to patient charts. Options exist to view result information in summary, expanded, filtered and trended (numeric only) form, as well as produce printed copies. Historical result and document information is available to a care provider viewing a current visit from any workstation. There are presently almost 50 physicians who are connected remotely to the hospital and are able to use the system from their offices.

As with any project, there were a multitude of challenges; the majority can be grouped into categories of human resources, financial constraints, change management and organizational culture. Projects of this magnitude require sufficient dedicated human resources, a well-organized core of team members as well as an appropriate committee structure within which the project team can function. The organization may not always understand the magnitude of clinical computerization and its impacts; directives regarding every departments' and individuals' commitment and collaboration can assist with the promotion of the project.
The continued evolution of the EMR is one of the main components of an Information Management and Technology Strategic Plan which has been formulated as the roadmap for SAH for the next few years. The plan includes strategies, timelines, and recommended resources to automate the remaining components of the manual chart while realigning global and department procedures to meet this common outcome. The automation of the physician order and clinical documentation processes are the next key steps in the plan. It is envisioned that the EMR will be comprised of all of the current chart elements, and be utilized for all inpatient and outpatient departments within the SAH. The long-term goal is to have a regional Electronic Patient Record (EPR), which could be shared with other health care partners.

Lori Bertrand, RN BScN, Clinical Analyst
Marie MacKay, System Analyst

UMNO News

Attention to all those OHRA members who do not know what the abbreviations U.M.N.O. represent. Most commonly pronounced as umm no .
We are the Utilization Managers' Network of Ontario, a grass roots collection of people with an interest in Utilization Management. We come from all walks of life; health records, research, discharge planning, nursing, decision support and finance.

We organize and host three **affordably priced** educational days every year on a variety of interesting and hot topics. Not only do we have interesting speakers with very practical tips, we have CIHI, MoH and JPPC updates from our executive

representatives at every educational day. We try to provide an opportunity to share our utilization successes and not so great successes. The educational days also provide a great networking opportunity not mention a highly acclaimed lunch. Our next educational session is **September 26, 2003 on Data Quality at the Yorkdale Holiday Inn.**

Come join us! For more information, please visit our website at www.umnoonline.com

Keary Fulton-Wallace, U.M.N.O.

Update from OHRA Region 6

My (extended) term as a Board member is coming to a close. It has been an extremely positive experience and I would encourage members to become involved.

A Regional Data Quality Working Group has been struck. Monthly, this group will participate in data quality "rounds", as well as provide a response to any queries submitted to OHRA.

A Regional Health Records Managers forum is held 3-4 times per year, hosted by our most westerly members.

At this time, there is no replacement for me on the Board. The **Regional Chair** acts as a liaison between regional and provincial membership on issues related to the profession. Any member interested in participating on the Board is asked to contact me (or any other Board member) for further information.

Jody McKie, BSc, CCHRA(A)

Member Update

Respectfully Submitted by Marci MacDonald

It has been a busy few months, and as you can see by this newsletter, your executive has been very productive! We thank you all for your support.

I would like to take this opportunity to update you on a few initiatives I have had the pleasure of being involved with:

Unique Patient Identifier:

OHRA is sitting at the table with this OHA, Ontario Hospital eHealth Council, Working Group, known as the "UPI Working Group".

It is well recognized that in order to integrate the health care system, to improve patient care and lower costs, there is a need to exchange health information. In order to meet this objective, there is a requirement of a unique personal identifier for the population of Ontario, as a means to ensure accurate identification of individuals.

OHRA brings to light the concerns of security, privacy, and protecting the confidentiality rights of individuals, as well as hi-lighting the need for a trusted registration process.

Since the formation of this group in August of 2002, we have recommended to the Minister of Health and Long Term Care, Mr. Tony Clement, that the existing OHIP Number be utilized as the Unique Patient Identifier for Ontario.

We are now conducting focus groups to discuss the development of a registration process, being mindful of creating a system whereby each person receiving health care receives a UPI, including those not eligible for OHIP (eg. Visitors, new immigrants, inmates in penitentiaries, etc.).

Smart Systems for Health – Ontario Health Informatics Standards Committee

OHRA is very pleased to be now serving as Co-Chair of OHISC, which is a provincial committee, working on developing the standards for the entire provincial electronic health information infrastructure.

The Mission of the Smart Systems for Health Agency is:

"Smart Systems will provide a secure, integrated, province-wide information infrastructure to allow electronic communication among Ontario's health service providers."

The Mandate is:

"SSH has the mandate to recommend data and technology standards to the Minister of Health and Long-Term Care that

support the Smart Systems Infrastructure and the provider communities it supports.

The Ontario Health Informatics Standards Committee was established to develop the standards recommendations that SSH will take to the Minister of Health and Long-Term Care."

This is the bigger picture, of which the UPI feeds into.

OHISC initially looked at de facto (commonly accepted and utilized throughout the industry) standards, and developed a listing – termed the "Inaugural Standards". This list of inaugural standards were then distributed by the sector representatives, to the sector, for input and discussion, prior to being brought back to the OHISC table.

Standards that were on the listing of 200, nearest and dearest to us, would be ICD-10 CA, and CCI.

GOOD NEWS! At the end of August 2003, the Minister of Health and Long Term Care, Tony Clement, approved OHISC's inaugural standards! Time to break out the champagne!!

SSH – Standards Management Process Working Group

This work group of the larger OHISC team was struck to assess at a provincial level, the monitoring and compliance of standards, and the entire processes around ensuring the latter. A large undertaking! Up until accepting the Co-Chair position, this group was chaired by your OHRA OHISC rep, but has now been taken over by a MoH representative member.
We are involved, but we can't Chair each and every group! OHRA input is still very much in play, as this group reports to OHISC.

Pilot Clinical Data Quality Audit Project

As you are all now aware, OHRA had partnered with the Canadian Health Record Association and CIHI, to undertake an audit, as requested by the Ministry of Health, in order for the MoH to understand the concerns expressed around the entire complexity coding issue, and to grasp a clearer understanding of the issues facing hospitals and health care providers, that translates into the coded data submitted.

10 Ontario hospitals were selected, coders from the field hired (thanks to you all who participated and to those of you that allowed your personnel the opportunity to participate), and the re-coding completed late Spring.

It is hoped that this model created in Ontario can be utilized by other provinces.

By the end of July, the MoH received the final report, and will be analyzing the results.

Provincial Coding 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 audit conducted above.

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. That's all for now folks!

Guidelines for Contributions

Submission to be made by e-mail to the Communications Director 2 weeks before published deadline date

Submission in WORD format preferably Tahoma font style

Indicate your name, professional designation, title and place of employment with your submission

If article is a reprint from another publication, ensure you have obtained written reprint approval from the author or publication.

Update on Canada Health Infoway

Respectfully submitted by Marci MacDonald

Many of us have heard about Canada Health Infoway ("Infoway") – but know little about the organization, it's business plan and the projects currently underway. This article

will attempt to shed a bit of light on this federal initiative.

The First Ministers stated on September 11, 2000:

"All governments have made major investments in health information technologies in recent years to improve care and health systems management. First Ministers agree to work together to strengthen a Canada-wide health info-structure to improve quality, access and timeliness of healthcare for Canadians. First Ministers also commit to develop electronic health records and to enhance technologies like Telehealth over the next few years. Governments will continue to work collaboratively to develop common date standards to ensure compatibility of health information networks. This will lead to more integrated delivery of healthcare services. They will ensure the stringent protection of privacy, confidentiality and security of health information."

Infoway was incorporated on January 22, 2001 as an independent, not-for-profit corporation with the power to borrow and invest.

The Members of the Corporation are eleven of the federal/provincial and territorial Deputy Ministers of Health. Quebec has elected not to participate, to date (there is hope they will decide to come board in the near future). The Board of Directors is representative of a wide range of private and public stakeholders who are considered essential partners. The Directors include 2 federal appointments, 5 regional appointments and 4 members elected at-large. The President and CEO of Infoway is accountable to the Board of Directors.

Canada Health Infoway is fully funded by federal dollars. In March 2001, $500,000.00 was transferred to the Corporation with the Execution of the Memorandum of Understanding. In 2003, an additional $600,000.00 was given to Infoway at the First Minister's Conference. Now THAT is a lot of cash, and illustrates the federal support of this dynamic plan!

One component of Infoway is the <u>EHR Enterprise Architecture</u> – dealing with Process, Components, and Perspective.

The idea is NOT to build one large database housing all health care data, but rather, create a system whereby all data holders are exchanging and sharing information. For example, the thought is to develop a mechanism that allows interoperability across many systems. The perception is to have clusters of healthcare organizations, interacting with the EHR, with multiple systems communicating with each other.

Of course, initially, Electronic Health Records will be the primary focus. The goal is to have the major components of interoperable Electronic Health Record solutions in place within 5-7 years across Canada. The thought being that an EHR provides each individual in Canada a secure and private, "womb to tomb" lifetime record of their key health history and care within the health system. The record will be available electronically to authorized health care providers, as well as the individual, anywhere, anytime. In addition, a comprehensive Electronic Health Record <u>Solution</u> (EHRS) is needed to deliver the individual Electronic Health Records to Canadians. The Electronic Health Record Solution is a combination of people, organizational entities, business processes, systems, technology and standards that interact and exchange clinical data to provide high quality and effective healthcare, and is made up of:

- Mechanisms to find and uniquely identify people, providers and locations
- Patient-centric Electronic Health Record (EHR)
- Presentation solutions and intelligent agents
- Common services and standards to enable integration and interoperability
- Workflow and Case Management
- Decision support services
- Services to support health surveillance and research
- Services to ensure privacy and security
- Physical infrastructure to support reliable and highly available electronic communications across Canada

The value created by an EHR is well known to all of us in the industry –

- Healthcare professionals make clinical decisions based on better information
- Knowledge starts with accurate and relevant clinical information
- Better knowledge translates to better decisions which translates to better care
- The EHR contains relevant clinical information to enable the 5 R's:
  - The **R**ight Information
  - About the **R**ight Person
  - Available to the **R**ight Person
  - In the **R**ight Place
  - At the **R**ight Time
- Four things that an interoperable EHR does well:
  - Accumulates vast amounts of structured patient centric data
  - Processes vast amounts of data on queries to find patient information
  - Transports information between points of care insuring levels of speed, accuracy, completeness, reliability and clarity never before achievable
  - Enables decision support (not decision making) by applying validated scientific and business oriented rules to patient information

EHR Data Definitions and Standards Project – Infoway's Role and Approach

- Not building a pan-Canadian EHR, but rather defining the pan-Canadian approach
  - Architecture based upon local, regional and provincial level implementations with national interoperability
  - A significant effort will be spent achieving local interoperability
    - Incremental efforts to achieve regional, then provincial and then national interoperability
- Current and past initiatives have grown an indispensable body of knowledge around the challenges associated with the EHR
  - Leveraging those learnings and the experience of stakeholders across the country
- A need exists to establish a shared set of standards in order to move forward with the interoperable-EHR
- Infoway has established a relationship with CIHI as a "preferred partner" for the establishment and maintenance of these standards in Canada

Currently, the Project Team is cataloguing all EHR standards in existence nationally and internationally. The team is also looking at what information models and messaging systems are available. Although there are few existing mature operating systems globally to currently validate the strategy against, there are similar initiatives underway in England and Australia, with a comparable architectural approach.

EHR Key Business Assumptions

- Lifelong longitudinal record of clinical data (womb to tomb)
- Secure and confidential access to data
- Support for accurate, complete, and timely delivery of information
- Shared across multiple organizations and territories
- No data will be modified. All clinical assessments will be made available to authorized users.
- Adaptive to the future of health care delivery in the 21st century
- The EHR will be used for clinical data only – for example – no billing data, and is not meant to replace existing clinical systems.

The tough part: finding answers to some tough questions … and getting consistency among the answers across Canada

- Who is accountable for the information? The person who collected it in the first place. A mechanism for signing will have to be created to determine who entered what and when.
- Who owns the data?
- What information is needed?

- What will the information be used for?
- Who will have access to the information?
- Can we harmonize the definition of roles?
- What needs to be audited?
- Trust relationships between jurisdictions and between information domains?
- Trust relationships between domains within a jurisdiction?
- Digital signatures?
- Consent Issues - How is consent expressed? Canada Health Infoway is very sensitive to consent issues and privacy concerns, so more work will be done in this area. A Privacy expert was hired in May 2003, and will be working on how these items will be incorporated into the Blueprint work.
- Custodianship - The EHRS will not interfere with the custodianship of the health record, and will not replace any existing custodial relationships.
- Does Infoway envisage any supporting legislation, and/or will legislation be required to deliver the Infoway mandate? Infoway has no authority to legislate, but will bring stakeholders together to discuss same. Is likely that prior to implementation, legislation will be needed in order to allow the sharing of information.
- How will Canada Health Infoway be maintained into the future? Not certain, but discussions are underway!

In summary, there are a number of projects underway, to help find the solutions to these and many other questions. Collaborative planning is also underway currently with each provincial Ministry of Health. Consultation is another key component of the process. Canada Health Infoway has held focus groups, workshops and information sessions with stakeholders across the country. From these emerged a list of the "Top Subject Areas" considered priorities. These are:

- Patient/Person demographic/identification information ;
- Patient/Person history and summary information;
- Problem List and Diagnoses;
- Diagnostic procedures and results;
- Medications/Drug Profile, and in addition;
- An acknowledgement that a Stakeholder Engagement Process and an ongoing Communications Strategy is required.

A listing of "Standards Initiatives" was also developed and includes:

- Diagnostic procedures, results and nomenclature
- Unique Identifier
- Encounter information
- Common Clinical Vocabulary
- Clinical Documentation (i.e. standards for Discharge Summaries)
- Pharmacy and Medication history

After months of extensive consultations and collaboration, on July 29, 2003, Infoway released its EHRS Blueprint, a major milestone toward achieving Infoway's mission of accelerating the implementation of interoperable electronic health information systems across Canada.

Focused on interoperability—the capability of computer and software systems to seamlessly communicate with each other—this document provides a fully validated, scalable architecture that lays out the business and technical considerations and approaches that will ultimately guide the sustainable development of EHR systems in Canada.

The EHRS Blueprint promotes reusable and replicable solutions that can be aligned with jurisdictional priorities and deployed across the country more cost-efficiently. It also provides guidance to jurisdictions to develop their strategic, tactical and operational plans to ensure rapid development and deployment of EHR solutions. Without this common framework and sets of standards, EHR solutions across Canada would be a patchwork of incompatible systems and technologies.

This Blueprint is intended to evolve over time and be further refined to take into account new developments and input from health care stakeholders. Currently, work is underway to define the requirements and enabling solutions for privacy and IT security. Next steps also include definition of the data requirements and messaging and vocabulary standards.

Where do we go from here? – Phase II

- Infoway senior management and Board of Directors set direction – Fall 2003
- Refine research

Determine and undertake initiatives to enable adoption of standards in support of Infoway objectives

Speech Recognition Alive and Thriving at Orillia Soldiers' Memorial Hospital

Submitted by:

Charlene Ley, CCHRA(C)
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Why did we make the move to Speech?

Orillia has been a Dictaphone customer since the early 80's and had over the years installed Dictaphone's Enterprise Express dictation and transcription management software. Throughout those years, our representative Aaron Hesson has been keeping us informed of the Dictaphone developments in Speech Recognition.

With the seed being planted when the Radiology Department implemented the now defunct Lernout & Hauspie speech recognition software, senior administration always had an ear for the latest developments. Of course, those developments quickly materialized into what we considered to be a superior product.

After seeing the presentation and the projected productivity increase, senior administration approved the acquisition of the Speech software. This occurred in the late spring of 2002.

Being a pilot site.

Shortly afterwards I was approached by Dictaphone to see if we would be interested in piloting the latest version of the Enterprise Express Speech software. After being reassured that we would be well supported by a full development team and have the opportunity to provide valuable feedback regarding the software and therefore help to enhance it even further, we agreed.

I must say that we were a little nervous agreeing to the pilot participation, but looking back, we have to say that we had a very positive and enlightening experience, so much so that we would be prepared to do it again. Since we are a facility with an IT department of only 3 people at that time, the support provided to us by the on site team was invaluable. We have never had so many people from the states in our hospital all at once. Weekly conference calls expanded our contacts to many more developers and support staff and allowed us to provide timely feedback on the software.

How did we implement it?

Since we already had the voice and text servers in operation, it was a relatively simple addition to incorporate the speech server into the mix. We went from a 2 server to a four server environment for the Dictaphone applications.

We quickly took a look at the high volume dictators to determine which physician voices we would designate to go through the speech server. We did this since senior administration had approved a 25 seat license, so we wanted to make sure we were getting the biggest gains.

After receiving a brief training on the speech administrative software the transcriptionist who was elected to participate as the lead transcriptionist made the adjustments so that the designated voices would be sent over to the speech server. At any given time we could look into the status to see how the voice was performing in terms of meeting the grade of "DRAFT". The system through various analyses, acoustical adaptation and fluency metres, determines if the voice is recognizable enough to make it worthwhile for a transcriptionist to edit the DRAFT document or transcribe the voice from scratch. In a very short time, we obtained the 25 physicians (from a wide range of specialities) and started the editing process.

It took about a week for our transcriptionists to learn the key stroke sequences that Dictaphone has created specially for fast editing. Within 4 weeks the staff was fully comfortable with these new tools.

Did the physicians have to do anything differently?

No, not at all. That is one of the beauties of the software. The physicians in our case were not aware that we were

implementing this. Now we did this on purpose because of our status of being one of the first hospitals in Canada to move to this type of background editing software. I wanted to see for myself what the true productivity impact would be in our environment without having the physicians change their dictating habits and I also did not want to rely on what the vendor was quoting. It was not that I didn't trust Dictaphone, but since the software was so new, I felt that it was important to do a blind study. Dictaphone was very supportive as I believe they wanted to further validate what they were already hearing from some of their US clients.

What was the productivity impact?

Well I can honestly say that our productivity did improve by an average of 18% and in one transcripitionist's case it went as high as 31%. This was without any change in dictation habits of the physicians. We participated in another study to determine the productivity increase if the physicians were to change their dictation habits and the resulting increase amounted to an additional 19%.

How did the transcriptionists feel?

Stated by one of the transcriptionists. "We were involved right from the beginning, kept up to date in all aspects of the process, and attended all the demonstrations of the speech recognition developments over the years. Once we saw the latest software we were impressed. We also knew that the intent was to not put us out of a job, but to be able to maximize our abilities."

"The training was more than we expected however, but we can truly say we're all really happy with the system because it relieves a lot of the stress on our hands. We're not spending seven hours a day just typing up dictations. We're now also editing the voice-recognized copy and that can be done with single key-strokes. As well, the new software editing element has a customization tool. So you can enter as many site-specific words, names of doctors, whatever you'd like, as you go along. That means that there is less editing involved because the system is recognizing those words and names as they are being dictated."

How well does it work with remote transcriptionists?

At the same time we were working on moving the transcriptionists to their home environment. The first two transcriptionists required dial up as high speed is not available in their areas. We were all impressed that the system operated well in this set up.

High speed proved to be a bigger challenge as I believe we are the first to apply this with the Dictaphone speech software. Well in two days time, we hope to have our first high speed connection up and operational sending work home.

What would we have done differently?

We implemented this in the summer of 2002. We only had a one week time frame when all the transcriptionists (6 of them) were available for training. After an approximate training period of 5 days each, followed by the vacation season and a 10% increase in dictation, we were faced with the highest backlog in our history. (52 days for summaries). We recommend avoiding the vacation season or at least have the staffing capacity to provide additional help in catching up.

What would we do in the same way?

We would definitely have the transcriptionists involved right from the beginning.

We consulted with the transcriptionists and it was decided that all the transcriptionists would be involved in the training and that they would all receive draft documents to edit as the reports came to them. We did not pool the documents so that the transcriptionists would get them first. We still agree with this as we did not want to have priorities waiting while speech documents were being edited. Another advantage of training all the transcriptionists, at least in our case, is that when they are working the weekend they are able to handle any speech documents as opposed to reconverting them to regular dictation. (If you have the software, you may as well use it)

What advice do I have for others?

Take a look at the software, it is worth the time to investigate. We would love to implement the physician work station, which is very impressive, unfortunately we have depleted our IT budget at this time, so that will be delayed.

The combination of the both the physician edited and transcriptionist edited applications will help in enhancing the production of text documents.

Spotlight on members performing non-traditional roles

By Charmaine Shaw

This is the first in what we hope will be a series of articles from members who are performing non-traditional roles. If your role is 'out of the ordinary', please consider telling us about it through a future article

The Role

On January 6, 2003, I became the Vice-President of e-Health for Lanier Healthcare Canada. This new executive position was created as a result of the LHCC strategic planning decision to branch further into the health information management arena. Related initiatives include overflow and out sourced transcription services, auto coding and the electronic health record.

Overflow transcription services has been our first undertaking. My role is to screen, interview and hire Medical Transcriptionists; convert client instructions into employee guidelines; interact with current and prospective clients; monitor workflow and perform regular Q.A. reviews; submit payroll entries for all MT staff ; and create client invoices. I was responsible for drafting policies and procedures governing transcription services, corporate privacy, and employee contracts. I also serve as company HIM resource and, as such, it has been my pleasure to present papers at a number of conferences. I've recently been named Corporate Chief Privacy Officer.

Aside from weekly meetings to London and the occasional sojourn to a conference, I work from home. My home office includes all the necessary paraphernalia: phone, fax, scanner, copier, printer, cell phone, pager. I feel as though I'm wired for sound! The role can be both challenging and innervating. Here are some of the advantages and disadvantages.

The Good Stuff

Working from home is great! You can wear whatever is comfortable and you don't need to fuss too much over your appearance. I'm sure the cost savings in coffee and gift contributions is considerable! It is wonderful being able to use your routine bills and mortgage as an income tax deduction. What's not to like about a car allowance? The company incentive plan that includes annual eligibility for an exotic cruise (next year it's Hawaii) is not too hard to take at all.

It is wonderful interacting with staff (the remote Medical Transcriptionists) who are well-motivated and dedicated. I don't think I've ever heard so many people proclaim: "I love what I do". It's great working for a small company and feeling as though you are part of a team. I don't think I've ever felt so appreciated! But then there are bad days................

The Other Stuff

We typically see our homes as our refuge and sanctuary – our escape from 'work'. But when you work from home, it is hard to make that distinction. If you're not too busy, you can cut off the workday at a predicted time and shut the door to the job. If, however, you are really busy, there is no end to the workday. It plagues you and you find yourself working all the time. Your home may take on an aversive quality.

I would never have imagined it, but you really do miss interacting with people! We learn from others and we get our energy from interactions. Working from home is not for a people-person!!

Published articles are for information sharing only and their content does not necessarily represent the beliefs of the Executive.

Outsourcing Coding and Abstracting: What are the benefits?

Diane Salois-Swallow
Chief Information and Privacy Officer
York Central Hospital

Located just north of Toronto, in one of the fastest growing regions of Ontario, York Central Hospital, has 420 beds, employs over 1,800 staff, 315 affiliated physicians and 500 volunteers. YCH serves over 63,000 Emergency Department patients, 15,000 inpatients, 2,500 births and 55,000 outpatient visits annually. YCH has seven comprehensive programs: Emergency Medicine, Continuing Care, Medicine, Dialysis, Mental Health, Surgery and Woman and Child.

In June 2000, York Central Hospital implemented a major technological innovation in the way it collected, recorded, accessed and permanently stored patient information. The implementation of an electronic patient file (EPF) allowed accessibility from any clinical department within the hospital, as well as providing off-site access for consulting and primary care physicians.

The implementation of the Electronic Patient Folder positioned YCH to outsource coding and abstracting services. In July 2001, YCH has entered into an agreement with THiiNC iMi for outsourcing coding and abstracting services using a secure Internet technology.

The benefits to the hospital, decision-makers and clinicians were clear. These included:

- Avoid a fine for late data submission to CIHI for 1999-2000 data
- Reduce coding backlogs
- Establish a 30 day turnaround time for coding and abstracting of all clinical data on an ongoing basis
- Improve data quality to ensure accurate reporting of clinical practice
- Improve the decision support capabilities by improving timeliness of clinical data
- Eliminate the cost to hire new staff and train current staff on new Ministry reporting requirements (e.g. ICD-10-CA/CCI)

Three key principles underscore the details of the partnership from YCH's perspective:

- Fair treatment of the YCH staff whose jobs were eliminated
- Quality assurance (including improved accuracy, timeliness and productivity of coding)
- Confidentiality of patient records

Existing hospital coding and abstracting staff had the opportunity to be employed by THiiNC iMi and work from home with flexible hours and received a severance package from YCH.

Business is conducted such that security of personal health information is the top priority. Health Information Professionals are not able to download or print files at home, and are closely monitored for security, appropriate access, and quality.

York Central Hospital and THiiNC iMi established a baseline performance scorecard. Initial measurements were taken in the following areas:

Indicators	Baseline April 2001	January 2002	January 2003
Avoid CIHI/MoHLTH fine for late data submission	YCH facing possible fines of up to $36,300.00	Submission deadlines met, no fines incurred	Submission deadlines met, no fines incurred
Coding backlog	Inpatient – 6 months Day surgery – 2 months ER – 8 months	Eliminated	Not applicable
Turnaround time	Jan 2001 post discharges Up to 240 days	December 2001 post discharges 30 days	30 days Post Discharge
Staffing requirements	2 FTE vacancy 8 YCH FTEs on staff (with significant backlog)	Full complement of experienced and qualified Health Information Professionals provided as needed to ensure 30 days post discharge	Full complement of experienced and qualified Health Information Professionals provided as needed to ensure 30 days post discharge
Data Quality	Data Quality program discontinued due to workload issues	Comprehensive data quality program in place with regular coding audits	Comprehensive data quality program in place with regular coding audits
Productivity	Charts per day per YCH HRT: Inpatient - 18 Day Surgery – 42 ER - 14	Charts per day per iMi HRT: Inpatient - 30 Day Surgery – 70 ER - 105	Charts per day per iMi HRT: Inpatient - 30 Day Surgery – 90 ER - 150
Readiness to code ICD10-CA/CCI	Not ready and would have to hire additional staff and train on ICD10-CA/CCI	Ready to start coding ICD10-CA/CCI on April 2002 as mandated by Ministry of Health	Coding ICD10-CA
Access to clinical information for decision support	Reports submitted to Unit Managers and Senior Team delayed by 3 months	Clinical data coded within 30 days post discharge and to Unit Managers and Senior Team within 6 days after that.	Clinical data coded within 30 days post discharge and to Unit Managers and Senior Team within 6 days after that.

Better information is key to making effective decisions. This project has enabled YCH to eliminate a significant coding backlog within 6 months and establish the capacity to maintain a 30 day turnaround time for completion of health record coding and abstracting even as the MoHLTH continues to mandate increased (outpatient clinics) and new (ICD-10-CA/CCI) reporting requirements. This achievement has had a positive impact on York Central Hospital. Clinical information drives hospital decision-making. The improvement in the accuracy and timeliness of the clinical data has provided key stakeholders with the right information to improve York Central Hospital's ability to focus on its core competency – improving patient care.

Stakeholder satisfaction

"York Central Hospital is proud to be the first hospital to outsource its coding and abstracting services to THiiNC iMi. Their remote coding solution has eliminated our coding backlogs. It has also provided YCH with performance guarantees that were going to be increasingly more difficult to achieve in-house because of workload pressures and shortages of qualified staff".

Frank Lussing, Chief Executive Officer, York Central Hospital, January 2003

"From 6 months to 6 weeks…and counting. Getting data in a timely way will make such a difference to developing our operating plan and managing operations throughout the year."

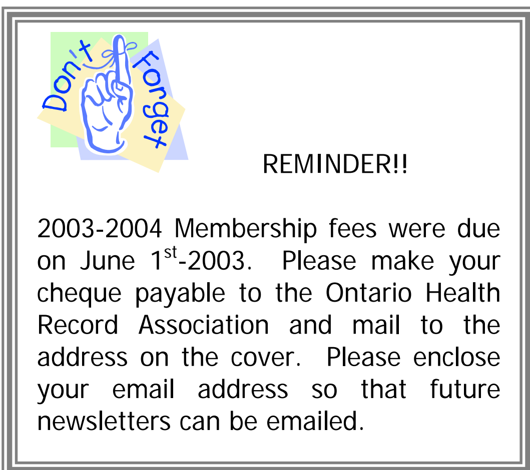
Cheryl Avrich, Director, Quality and Planning, York Central Hospital, January 2003

"The combination of the McKesson Electronic Patient Folder and THiiNC iMi health records coding, has given me easier and faster access to the information I need for decision-making. Utilization of this information gives me the ability to see how York Central Hospital is serving our customers and where improvements can be made."
May Chang, Chief Financial Officer, York Central Hospital, January 2003

Microsoft envisions this e-Health record within the next few years, and aspires to be among the key players in making the dream a reality. According to Microsoft, the following is what is required to make the e-Health record happen:

- Authentication
- Alerts
- A locator system
- Registry
- Document management
- A portal
- Audit trails
- Authorization
- Consent
- Identity management
- Integration

Microsoft has a version of each of the above right now! The only thing missing is sufficient trial!



REMINDER!!

2003-2004 Membership fees were due on June 1st-2003. Please make your cheque payable to the Ontario Health Record Association and mail to the address on the cover. Please enclose your email address so that future newsletters can be emailed.

Watch for our new website information....planning currently underway.

5 Ways to Enhance Your Career

1. **Be an Expert!** If you know your material, you can be the person people come to with questions. Do your homework and study regulations related to security, confidentiality, grouping methodologies, disease processes, then when something new is introduced, you can position yourself as the house expert.

2. **Strive for Accuracy**! Knowledge and skill are impressive. Combine them with accuracy and follow-through for a thoroughly professional impression.

3. **Go Beyond your Job Description**! Take on new projects when they are offered. If the project makes you stretch, even better. For example, offer to serve as a leader for a task force. Offer assistance to others; volunteer for a project no one else wants. Taking on something new can open doors, increase your knowledge, and introduce you to new people who could be helpful as your career advances. In doing so, you demonstrate you are able to work beyond your job description and may be ready for promotion.

4. **Spread the Word!** "Educate" the non-HIM members of your organization on your current job and how it "fits" the organizational objectives and needs of the organization. Demonstrate how HIM professionals add value to an organization.

5. **Specialize!** "Drill down" on a portion of your job and become the resident expert in your organization on it. This is a chance to educate and influence others as well as an opportunity for external speaking engagements and writing opportunities. This added visibility could lead to an internal promotion or a new job opportunity.

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Ontario Health Record Association 2003/2004 Executive

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JOB MARKET

LAKERIDGE HEALTH CORPORATION

Position: Operations Co-ordinator

Location: Oshawa, Whitby, Port Perry, Bowmanville sites ON

URL: http://www.lakeridgehealth.on.ca

Contact E-mail: careers@lakeridgehealth.on.ca

POSITION SUMMARY

Under the direction of the Team Leader, the Operations Co-ordinator is accountable for the daily operations of the Health Records department in a manner which is congruent with the Program's mission, vision and strategic plan. He/she will promote and maintain a positive public relations with customers, visitors, physicians, staff and patients; participate in the long range planning and development of a clear strategic direction. The successful candidate will demonstrate creativity, flexibility and professional knowledge in sharing responsibility for the management of fiscal, material and human resources within the area (including a variety of professional and support staff).

DUTIES AND RESPONSIBILITIES

Assisting in providing forward thinking leadership in human resources management; interviewing, selection, hiring and performance management of staff for all sites. Additional responsibilities include: materials management for the program; serving as a mentor and trainer of staff; development of training tools; quality and risk management; providing input for the budget process; professional accountability and development while promoting the same within the department.

QUALIFICATIONS

- Baccalaureate degree in a clinical/administrative stream or equivalent experience in Health Records Management;
- certified with the Canadian College for Health Records Administrators (CCHRA);
- advanced experience in a management/supervisory capacity in Health Records;
- proven working knowledge of hospital and medical staff functions;
- demonstrated leadership abilities;
- advanced computer skills in Microsoft Word, Excel and Power Point;
- demonstrated strong interpersonal skills with good judgement and tact;
- demonstrated budgeting skills and proven fiscal responsibility of the same;
- demonstrated fiscal management skills;
- demonstrated ability to communicate strategies for staff by fostering awareness, dialogue, trust and cooperation within the program;
- proven knowledge of progressive management theory and practice; and
- demonstrated organizational skills with the ability to effectively set work priorities and without supervision.

Lakeridge Health offers: * Educational Funding & Support & * Relocation Assistance *

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We are one of Ontario's largest community hospital networks, serving more than 500,000 people in the growing urban and rural communities of beautiful Durham Region. On any given day, 1,200 people walk through our doors, and benefit from the expertise and energy of nearly 4,000 staff and physicians committed to putting *patients first*.

Coding Specialist

Apply your knowledge of ICDO-3 morphology coding for oncology programs in this exciting **Oshawa-based** position. This is an excellent opportunity for a highly organized, detail-oriented individual to assume responsibility for accurately coding and electronically abstracting all in-patient, ambulatory (ER and clinic visits), and surgical day care discharges. A graduate from an approved Health Record Technician/Administrator/Practitioner Program, with active CCHRA membership and Certificant/Associate Level certification, you bring 2 to 3 years of Health Records experience, including coding using CCICD-10-CA and abstracting electronically. You have a detailed knowledge of relevant provincial legislation and acts, and an excellent working knowledge of CCICD-10-CA coding and electronic abstracting, CMG, complexity and age adjustment and RIW methodologies, DPG, CACS, medical terminology, anatomy, physiology and pharmacology. As you will travel between sites, a valid driver's licence and access to a reliable vehicle are required.

Consider this your invitation to grow with us! Visit our Web site, call us at **905-576-8711, ext. 4612,** or send your resume to: **Lakeridge Health Oshawa, Human Resources, 1 Hospital Court, Oshawa, Ontario, L1G 2B9. Fax: 905-721-4755. E-mail: careers@lakeridgehealth.on.ca**

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