

Newfoundland and Labrador Health Record Association

May 1993

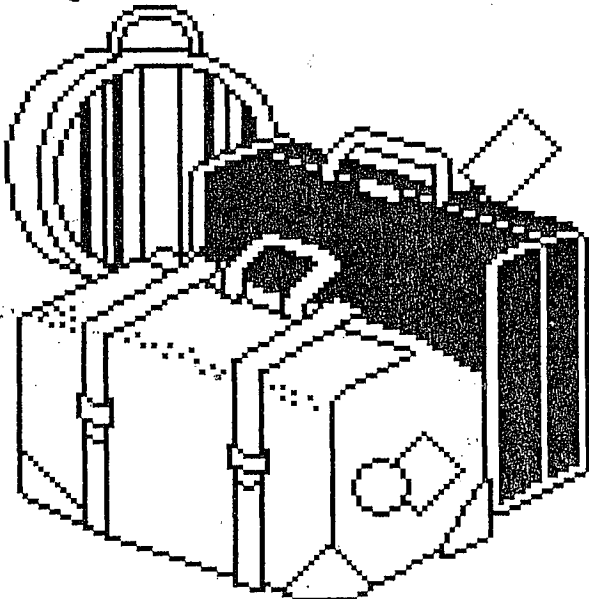
NEWSLETTER

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HAVE A SAFE
AND
HAPPY HOLIDAY
THIS SUMMER!!!!

EDITOR'S NOTE

The Newsletter Committee has met three times (teleconferences) since our last issue was distributed in December of 1992. The major time and effort has been spent on the solicitation of articles. We have written! We have called! We have called again! (Is anyone starting to feel a bit guilty yet???)

We have succeeded in producing this Spring Issue. In future we hope to have two updates to be produced in June and December and the regular Spring and Fall issues to be produced in April and September. The following regular features will hopefully appear in each newsletter:

- President's Message
- Committee Reports
 - Education
 - Professional Review
 - Coding Consistency
 - Legislation
- Editor's Note
- In Focus Report
- Suggested Reading List/
Resource Material.

The newsletter is meant to be a communication tool for its members. If you have any questions or answers that are of particular interest to our members why not

seek comments and input via the newsletter? If you have come across a story or a cartoon that might lighten our day why not share it with other members?

"PARTICIPATION" is good for the mind as well as the body and the more energy that is put into the activity the more return you get for your effort. Please take the time to read your newsletter and respond to any questionnaires that have been circulated.

*Evelyn Connors
Janeway Child Health Centre
Send articles, comments etc. to Evelyn Connors -
Janeway Child Health Centre*



PRESIDENT'S MESSAGE

Cutbacks, layoffs, regional boards, rationalization of services, budget restraint, labour negotiations, operational reviews, strategic planning - what is happening in health care? What does the future hold for our jobs? Our hospitals? When will it end? These are stressful times as we all face an uncertain future in a changing health care system.

All of the areas of health record practice are changing; to deny this is to write your professional obituary. Voice recognition technology is changing the role of transcriptionists; optical disk technology will influence document filing and retrieval; encoders will change the role of technicians; data analysts had better be cognizant of funding changes and their impact, database experts and information specialists; and managers are being threatened from a number of sources - administration, finance, and the evolution of new roles within institutions which assume many of the traditional 'Health Record' responsibilities.

I know that some of you reading this article think I am a dooms monger, and believe that I exaggerate the impact of change on

our profession. To those of you who think this, look at what is happening in this province: the position of 'Director' made redundant in one hospital; nurse managers assuming responsibility for Health Record Departments; the functions of utilization management and impact analysis being performed by non-health records personnel, and at least one hospital has an OR Booking package providing all the operative data, including relevant codes, which would normally be captured in Records. These changes are not restricted to Newfoundland and Labrador - they are happening across the country. To quote from a Letter to the Editor in the British Columbia Health Record Association Newsletter: "We know of a situation where research nurses are employed in a hospital to complete a study of drug usage within the hospital. This study entailed the collection of information, statistical analysis and presentation of the data to Administration. This despite the expertise available in the Health Record Department and the skills of health record professionals as researchers and data analysts. Why?"

This is the 'Information Age' and it is essential that we, the specialists in health data and information, be involved in the processes which are influencing our functions. As health record practitioners, it is essential that we recognize the challenges and opportunities which are available to us. If we focus only on the negative (and no one denies that the negative is there!), our ability to perceive opportunities and affect change will be limited. Now more than ever it is essential that health records practitioners become involved in hospital operations specifically and the health care system in general. One mechanism by which you can participate is through the NLHRA.

This newsletter is one forum for communication amongst members of our profession. However, the best way to become involved is to participate in a committee or assist in a special project. Some of the tasks which the Association are involved in: creating a mission statement for the NLHRA, the development of a practical retention schedule for Health Records for submission to the government, a presentation to the NHHHA on Health Records, a joint seminar (with Nursing, NHHHA and allied health specialists) on

integrated charting, data quality, and the Annual General Meeting. On the behalf of several members, the NLHRA has requested that the CHRA consider offering an opportunity to write the certification exam for those who did not originally do so. In addition, the necessity of an ad-hoc financial committee is being discussed to address issues such as, should we have a part-time paid clerical position within the Association? Should we sponsor members to attend conferences on behalf of the Association? All activities of the NLHRA affect you; YOUR participation is vital. Please let the Executive know what you think - become involved.

1993-94 will be a year of challenge, upset and opportunity. As health record practitioners, 'we need to be a strong, visible, active presence in health care. We cannot bury our heads in the sand and do nothing. Now is the time to give serious consideration to the future of the association in today's rapidly changing health care industry and to ensure that health records professionals are a recognized cog in the wheel.'*

Sandra Cotton
St. Clare's Mercy Hospital

 *G. Melneck, President HRABC

LEGISLATIVE COMMITTEE

At the Annual General Meeting of the NLHRA in October 1992, it was agreed that a Legislative Committee be developed to identify all existing legislation that affects the creation and maintenance of health records. This information would be compiled in the form of a "Legislation Handbook" which would also include a listing of reference books/journals dealing with legal issues.

The Legislative Committee consists of Debbie Whalen, Chairperson; Faye Drodge, Secretary; Rosalie Haire and Georgina Williams. To date, the Committee has had two meetings and is aiming to have the Handbook available as a resource to Health Record Departments by June 1993. Faye Drodge has written the various Health Record Departments and asked for their input into compiling the reference list. Thank you to those who have submitted references. If you have not responded to date, you are encouraged to do so as soon as possible. Any information will be gratefully appreciated by the Committee.

*Debbie Whalen
Carbonear General Hospital*

CODING CONSISTENCY COMMITTEE

HEAR YE, HEAR YE, our committee is in lift off. We held our first meeting in early December, not much was accomplished at that first meeting, but our next committee meeting was held on March 5, at that meeting we appointed a Chairperson as well as set up our "Terms of Reference". Our primary objective with your help is to develop some guidelines for coding consistency in Newfoundland Hospitals.

At our teleconference we discussed the confusion surrounding the diagnosis typing. We have confirmation that HMRI will be holding a two day seminar on September 21-22, the day prior to our Annual Conference, this will be a great opportunity for some of our out of town members to attend. If there are any questions or concerns you have with regard to diagnosis typing, coding queries etc, drop a note to Sherry Kennedy so that when she comes here she will be able to answer your questions directly.

In order to get some idea as to how we are coding certain diagnosis and procedures it was suggested that we distribute some case summaries via our Newsletter. This is not a contest or a test, we are only trying to determine if we are all consistent in our coding. If there is a large discrepancy in the way we are coding, then this obviously should be addressed. Your co-operation would be greatly appreciated. Our first case summary comes from the HSC.. Please return your completed form to Alicia Trask, Chairperson, Coding Consistency Committee, Janeway CHC, Janeway Place, St. John's, NF, A1A 1R8. We look forward with anticipation to your reply.

Members of the committee are:
 Alicia Trask, Janeway Hospital
 (Chairperson)
 Clem Atkins, Health Sciences
 Centre
 Doris Bishop, Dept. of Health
 Pauline Murphy, Western Memorial
 Gloria Perera, Grace General
 Faye Drodge, G.B. Cross Memorial
 Hospital

Alicia Trask
Janeway Child Health Centre

CASE STUDY:

Admitting Diagnosis:
Unstable Angina

History:

This 60 year old patient presented with late Class III angina and underwent Cardiac Catherization which demonstrated tight stenotic lesions of the LAD and 70% stenosis of the intermediate as well as the right coronary artery. It was noted that the LAD was relatively large vessel whereas both the intermediate and the right coronary were small vessels. There was evidence of posteroinferior akinesia in keeping with her history of previous M.I.

Angioplasty was thought to be a preferred option and this was undertaken on 1993 02 22. Initial dilatation appeared satisfactory but an hour after the procedure the patient developed recurrent severe chest pain and was returned to the Cath. Lab. She received intracoronary Streptokinase and several doses of Heparin. Repeat angiography then demonstrated accumulation of clot in the LAD as well as restenosis. Reperfusion catheter was inserted across the lesion and the patient was prepared

for emergency surgery.

During her transport to the Operating Room she once again became very unstable and in the Operating Room she demonstrated diffuse ST changes with a drop in blood pressure, with signs of global ischemia. Crash bypass was undertaken and it was decided to use vein grafts only.

Operation:

As indicated above, rapid preparations were made for surgery and she was placed on cardiopulmonary bypasses as soon as it was feasible. Unfortunately, the vein in her legs were rather small and she required dissection in both legs to obtain enough vein for three bypasses. It was noted after cardiopulmonary bypass that the reperfusion catheter had probably slipped out of place and could well have been obstructing the left main.

Two bypasses were constructed with vein grafts to the LAD and the right coronary artery. The intermediate could not be found and was presumed to be an intramuscular vessel. It was noted also that there was fibrosis across the posterior wall of the heart and this was fairly extensive in a relatively small volume heart.

Postoperative Progress:

Following surgery, initially the patient required a mild to moderate dose of Dopamine to maintain blood pressure. With this and with Nitroglycerin, she seemed fairly stable. Through the night she was found to be stable through the earlier part of the night, but then showed a drop in blood pressure. A small dose of Adrenalin was required initially and this maintained her blood pressure until the latter part of the next morning; at which time she developed signs of low output syndrome again, and it was felt best now to insert intra-aortic balloon with which she showed gradual improvement. Inotropic support was then optimized and with intra-aortic balloon support for about 48 hours she showed gradual improvement. Throughout these happenings, her EKG had not shown any dramatic changes and her CK did not go up very high, and it was felt that this was due to stunned myocardium.

The patient has shown progressive improvement and presently is ambulant and feels quite well. She developed a body rash in response to one of the Medications and this has responded to oral antihistamines as well as topical

antihistamines.

She will be followed in clinic in six week.

Please complete the following and return to Alicia:

Diagnosis: _____

Type: _____

Operations: _____
(for your records)

Diagnosis: _____

Type: _____

Operations: _____

*Name: _____

*Institution: _____

(complete and return)

*Optional

(complete and return)



EDUCATION COMMITTEE
(Annual General Meeting)

Date: September 23-24, 1993

Location: The Battery Hotel;
 St. John's, NF

Theme: Focus on Education and
 Professional Development.

Registration:

Full Registration - \$75.00
 One Full Day - \$50.00
 Half Day - \$25.00

The seminar will begin with a Welcome Reception on the evening of September 22, at the Battery Hotel. The sessions this year will cover a day and a half. Past experience has shown that people like to start the journey home early in the afternoon.

The committee has developed a partial draft programme. Again this year we will have an INFOCUS presentation. Sherry Kennedy will also be speaking to us regarding two very progressive initiatives HMRI is pursuing - Emergency Services Abstracting System and the development of day procedures groups and weights for Same Day Surgery. We are also planning on presenting a Multidisciplinary Panel Discussion

on the Changing Role of the Health Record Professional. Planning is also ongoing to offer concurrent sessions to Nursing Home staff.

The reality of 1993 is that we are living in tough economic times. Start planning now and I look forward to seeing you there.

Georgina Williams
 Co-Chair
 Education Committee

ON FINAL DIAGNOSIS

Please be more specific in your nomenclature, because of the wording, we're sometimes not that sure.

When signing the chart off, remember - SPECIFICS! It's hard enough trying to read hieroglyphics.

Without attempting to second guess- Is the "Depression" endogenous? Due to stress?

Sometimes we have to read through the whole chart, To find if "Hypertension" is renal or heart.

Essential, Secondary, Malignant, Benign.....

At times it can be very tryin'

Torn meniscus-- new or old tear?
Anterior, Posterior? Please tell us
where.

"Glomerulonephritis" is OK
But if there's a lesion, mention it,
eh?

We have a code to pinpoint the zone
And the very same goes for a kidney
stone.

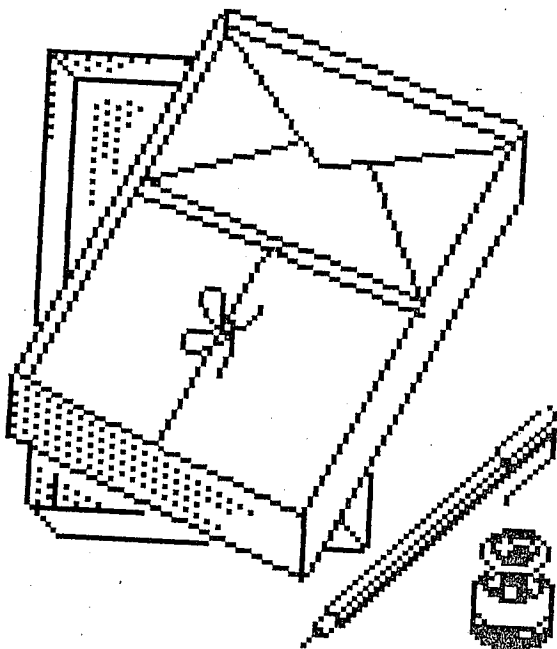
"Alcoholism" Now, there's a beaut!
Is it chronic , episodic, sometimes
acute?

Is it associated with any
psychoses?
Please be specific in your
diagnosis!

"O.D." is another that just makes us
shrug.
See, we have a code for each
specified drug.

We code ICD-9 and it's very
concise,
Therefore, more detail from you
would be nice!

*Reprinted from Feb '81 HMRI Newsletter
Submitted by Doris Bishop
Dept. of Health*



Hey!! You don't need fancy
stationery to let us know what
you think of our newsletter, all
suggestions are welcomed. Nor
do you need fancy stationery to
write an article for YOUR newsletter
Send your comments, articles etc.
to Sharon Penney at the Janeway.

PROFESSIONAL REVIEW COMMITTEE

The Professional Review Committee has met four times by teleconference since December 1992.

Since that time the committees Terms of Reference have been reviewed and revised and an Action Plan was created for the fiscal year 1993-94. The Action Plan as shown on the next page, outline what the committee hopes to accomplish.

The primary purpose of the committee is to create generic Position Descriptions for positions in the Health Record Department which are acceptable to the NLHRA membership. A working brief will then be submitted for use by appropriate organizations

(Collective Bargaining Unions, NHHHA, etc) in proposing changes to the Health Record Department classifications.

As well the committee is canvassing institutions nationally for position descriptions. This will enable the committee to compare the generic description to other position descriptions in relation to the scope of duties and responsibilities and education requirement.

I would like to thank the committee members for their continued support. If there are any other NLHRA members interested in serving on this committee feel free to contact me at 778-4651.

*Sharon Penney
Chairperson
Janeway Child Health Centre*

ACTION PLANDEADLINE

- | | | |
|----|---|------------|
| 1. | First revision: Generic Position Description Draft in conjunction with Provincial Responses to Draft. | 1993 04 30 |
| 2. | Draft letter for national institutions/ provincial CPD's and distribute letters. | 1993 04 15 |
| 3. | Deadline for return from national institutions/provincial CPD's. (Classification & Pay Divisions) | 1993 05 31 |
| 4. | Comparison of National Descriptions. | 1993 06 30 |
| 5. | Second revision: Generic Position Descriptions Draft in conjunction with National findings. | 1993 09 15 |
| 6. | Research format for preparation of brief. | 1993 10 31 |
| 7. | Preparation of brief. | 1993 03 31 |

CHRA INFOCUS UPDATE

I am sure that the majority of members of the NLHRA are familiar with the term "INFOCUS" which has been adopted by the Canadian Health Record Association. For those members who attended the NLHRA 1992 Annual Conference you will recall the INFOCUS update by the Executive Director of the CHRA, Deborah Del Duca. To reiterate, INFOCUS is a long term CHRA initiative to strategically direct the future role of CHRA members as health information professionals in the Canadian health industry. I have been asked to serve as the provincial liaison for INFOCUS. The objective for the provincial liaison is to create a strong link between the CHRA and each provincial health record association so that health record practitioners will be informed about the INFOCUS project. In this capacity the liaison representative has specific duties and responsibilities defined by CHRA's Terms of Reference. This includes liaison between the CHRA and the NLHRA, update the provincial membership on INFOCUS, prepare articles in accordance with CHRA protocol, act as communications facilitators, and provide CHRA with an update on provincial activity, concerns and questions.

I would like to bring you up to date as to the progress of INFOCUS since its inception: Phase I consisted of the 'Role Clarification Project' which produced the 'Role Statement Report'. Phase II is currently underway and addresses eight defined areas which include:

- curriculum development
- health information theory
- professional education
- delivery of education programs
- membership communications
- organization changes
- marketing the project
- revenue generation

INFOCUS brochures are available which I will send to you upon request. If you have any question regarding INFOCUS please let me know and I will seek clarification from CHRA.

Sharon Penney
NLHRA Provincial INFOCUS Liaison

RESOURCE CATALOGUE

For the benefit of all members, the Executive would like to compile a catalogue of resource material - a listing of readings, books, journals which relate to Health Record practice. By compiling a master list, members could access relevant information from each other rather than duplicating search procedures or incurring costs of ordering books. The

Executive is asking each member to compile a list of resource material which they have and send this to the Executive. Once responses have been received, a master list will be compiled and circulated to the members. Please format your responses as indicated in the next column. Send these along to Sandra Cotton, Director of Health Records, St. Clare's Mercy Hospital, St. John's, NF, A1C 5B8.

*Sandra Cotton
St. Clare's Mercy Hospital*

Hospital/Department: St. Clare's Mercy Hospital, Health Records Department.

Subject	Title	Format	Author
Info Management	Managing Information in Canadian Health Care Facilities.	Book	M. Ogilvie/CHA
New Technologies	Input Video	VHS	Lanier

OCCURRENCE SCREENING

Occurrence screening is the title of a specific quality assurance process whereby specially trained staff review current patient charts to identify occurrences or deviations from practice standards or expectations of patient outcome.

At the present time in the Dr. G. B. Cross Memorial Hospital, Clarendville, occurrence screening is being done by the Health Record Technicians. General surgery, gynaecological surgery, and obstetrics are the services presently being monitored but all patient services will eventually be covered.

As the charts are being coded the technicians look for charts that fall within the category for occurrence screening. Both services have their own unique set of criteria to be looked at as well as their own sheets. If a chart falls within the criteria the chart number is recorded on the front of the sheet with the problem identified by ticking the appropriate box. All surgery or obstetrical charts for the month without problems have their chart numbers listed on the back of the appropriate sheet.

When the total discharges for the month are coded and abstracted all which are acceptable to the NLHRA membership. A working brief will the charts with occurrences for the month are pulled and kept in the coding room. When we have the charts for two months ready, the Quality Assurance Coordinator is contacted and she arranges a meeting with the required physicians, herself, appropriate head nurse, and a Health Records Technician. There is a separate meeting arranged per service.

The meetings provide an educational opportunity for those health professionals to review the events that happened during the patients stay. The health records technicians identifies which criteria applies to the chart being reviewed, the physicians try to determine why it occurred and along with the nurses try to develop a plan to prevent future occurrences. All criteria are reviewed with the view to delete or add as necessary to capture the required information or identify other criteria for future use. To date the adverse patient incidents have been identified. We have been successful in gaining more accurate coding, improving documentation, reviewing utilization of staffing and identifying topics for continuing education, eg. consents.

Risk management is adhered to because by having this program in use we are identifying and reporting unusual occurrences as well as identifying trends and patterns which aid in assessment and risk predictions.

One important utilization review resource that has come out of our occurrence screening program is changes made in laproscopic O.R. scheduling time and staffing due to an audit done as a result of a pattern surfacing from the surgery criteria.

According to reports, occurrence screening is more common in the United States than in Canada, and is performed by specialty trained people. The Heath Record Technicians at this hospital are happy to be given the opportunity to prove our value in this very important team.

Pheobe White, CCHAA(A)
Dr. G. B. Cross Memoria Hospital

PROFESSIONAL DEVELOPMENT

I am sure that all of our members appreciate the need for continuing education. Our profession, as we know, it must expand to encompass various areas of expertise and yet we so often find that due to fiscal restraint we are unable to avail of potentially valuable educational sessions.

To date the NLHRA educational inservice for its members has occurred annually in conjunction with the Associations, Annual General Meeting.

Do you feel there is a need for additional educational sessions throughout the year? If so, what are your suggestions for topics and the frequency of such sessions.

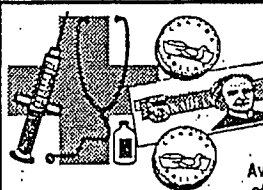
The NLHRA Executive would like your comments, suggestions as to the members needs for additional education sessions. It is only with the memberships participation that the association can meet your requirements and/or needs.

Please direct your responses to
 NLHRA Executive
 P.O. Box 22006
 Long's Hill Post Office
 St. John's, NF
 A1C 6L2

COST AWARENESS AT THE JANEWAY

In early February the staff at the Janeway were asked to do up some cost awareness displays for each of their departments. These displays were to be posted around the hospital for public viewing. The intent was to make the staff and the public aware of the cost of services provided by the hospital. The Health Record Department did up the following charts for display. It was a source of satisfaction to know that one of our charts was published in the Evening Telegram as part of an article on keeping costs down at the Janeway.

*Evelyn Connors
Janeway Child Health Centre*



Medical Money
Average cost per patient based on daily inpatient cost of \$845.00 at the Janeway Child Health Centre.

Patient Service	Average Length of Stay in Days per Patient	Average Cost per Inpatient	# of Patients Discharged 91 / 92
Medicine	6.7	\$5,662	1,265
Cardiology	10.7	\$9,042	62
Neurology	9.4	\$7,943	30
Surgery	5.6	\$4,732	706
Cardiovascular Surgery	4.6	\$3,887	9
Neurosurgery	8.7	\$7,352	90
Oral Surgery	4.8	\$4,056	12
Orthopedic Surgery	7.8	\$6,591	421
Plastic Surgery	6.5	\$5,493	100
Urology	8.0	\$6,760	148
Otolaryngology (Ears, Nose, Throat)	1.7	\$1,437	662
Ophthalmology (Eye)	5.9	\$4,986	49
Psychiatry	25.4	\$21,463	127
Oncology	8.8	\$7,436	169
Infectious Diseases	5.9	\$4,986	191
Neonatology	32.8	\$27,716	193
Total 91 / 92	7.8	\$27,817,400	4,235

Source: The Dr. Charles A. Janeway Child Health Centre Evening Telegram Graphic

RESOURCE INTENSITY WEIGHTS

SOURCE: CHAP RLM REPORT: DOCTOR SERVICE

APRIL 91 - MARCH 92

DOCTOR SERVICE	ACTUAL # OF CASES	WEIGHTED CASES
NEUROLOGIST	25	37
PEDIATRICIAN	1437	1534
SURGEON	722	843
NEUROSURGEON	101	169
ORTHOPEDIC SURG	421	572
PLASTIC SURGEON	104	108
UROLOGIST	23	188
OTOLARYNGOLOGIST	666	297
OPHTHALMOLOGIST	49	42
PSYCHIATRIST	128	256
HAEMATOLOGIST	2	2
NEONATOLOGIST	180	1301
TOTAL	3858	5349

FOR FISCAL 1991-1992 THE 3,858 ACTUAL CASES LISTED FOR THESE DOCTOR SERVICES USED THE RESOURCES OF 5,349 "STANDARD" CASES