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A Word From the President

Hi everyone! I hope you are all having a great Summer. If you haven't already set off on vacation, I'm sure you are looking forward to getting away from it all. I hope that part of your travels includes the annual conference in Kelowna this year. I'm looking forward to seeing everyone there.

Updates on the activities of your Executive:

Association Name Change – As noted in the last issue, the British Columbia Health Information Management Association (BCHIMA) name that we were hoping to update to was rejected by the Ministry responsible. We will be tabling a new motion at the AGM with another idea for an Association name. The proposal will be the Health Information Management Association of BC (HIMABC). If anyone has any other ideas we would be happy to hear them now or at the AGM. Put your thinking caps on.

Membership – We continue to work on ways to improve the way that membership renewals are dealt with. We are also reviewing the membership information from past years to determine any trends.

Conference 2005 – planning continues for the 2005 Conference to be held in Kelowna from September 15 – 17. See you at the Coast Capri.

Website – I hope everyone takes a few moments to have a look at our website updates and revisions. It has been redesigned and now includes a members only section that will be accessible with a password. This is where in future you will find the Printout.

Policy and Procedure Updates – We have updated several of the Association policies and procedures.

I had the opportunity to attend the CHIMA conference in Winnipeg in early June. This conference had a lot of great sessions and we heard many interesting things from all facets of Health Information Management. I also attended a pre-conference workshop put on by the American Health Information Management Association (AHIMA). This workshop was entitled "Turning Theory into Practice: The Next Steps for e-HIM." This was a well attended session that focused on:

- Skills needed to for planning and implementing the E.H.R.
- Ideas on how to get the Health Information Management (HIM) perspective to your organization's planning table.
- See how HIM departmental needs fit in with the E.H.R.
- Find out how to analyze your organization's E.H.R. to see if your HIM and departmental needs are met.
- In-depth look at the migration path to achieving the E.H.R.
- Up to date review on what is happening at the international and national level on the subject of the E.H.R.

This was a very worthwhile session and we learned a lot about the migration path to an E.H.R. and how important it is that HIM professionals are involved along this path. We were encouraged to gain knowledge about the language of Information Technology so that we can converse with the IT side. We were also encouraged to be at the planning table, not as minute takers, but as full-fledged participants in the planning for the E.H.R.

Have a great summer. If you have any comments, questions, or concerns for myself or any of the Executive members, please do let us know.



Sharon Baigent
HRABC President 2005-2006

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DISCLAIMER

The information contained in this newsletter does not necessarily reflect the views of the Membership or the Editor, but is offered as a source of information only.

DATE FOR NEXT
SUBMISSION IN 2005
September 7th
Sept / Oct edition

2004 - 2005 HRABC
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Harvesting Our Innovations

KELOWNA IN SEPTEMBER....HAVE YOU MADE PLANS TO JOIN US YET?

HRABC ANNUAL CONFERENCE

SEPTEMBER 15 – 17, 2005

COAST CAPRI HOTEL

EARLY BIRD REGISTRATION DEADLINE IS JULY 22, 2005

VISIT THE HRABC WEBSITE FOR CONFERENCE REGISTRATION PACKAGE

www.hrabc.net

SHOWCASING OUR TALENTS:

DOES ANYONE OUT THERE KNOW OF AN HRABC MEMBER THAT IS

INVOLVED IN SOME INTERESTING, INNOVATIVE WORK OR

PROJECT??? ANY SPECIAL ACHIEVEMENTS THAT A

MEMBER MAY HAVE ACCOMPLISHED? WE WOULD LIKE TO DO

SOME BRIEF "SPOTLIGHTS" THROUGHOUT THE CONFERENCE ON

THESE MEMBERS. PLEASE SEND ALONG AN EMAIL WITH ANY

SUGGESTIONS TO:

CATHE JOHNSON, CHAIR, PROGRAMS & ARRANGEMENTS COMMITTEE

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**Do you enjoy pleasant surroundings, with good friends
away from your workplace?**

**Do you enjoy learning new methods & procedures to
augment your knowledge base?**

**Do you want to meet with your peers and create new
friendships and professional associations?**

**Then attend the HRABC conference in Kelowna, BC
15 – 17 September 2005**

**(We are still talking about the last conference
in Kelowna! Remember Wine Boy?)**

FROM MY DESK

By **Gary B Arnold, CCHRA(C)**
President-Elect/Chair, Public Relations & Publications
HRABC

It's summertime! According to the calendar anyway – although at this writing, the weatherman is predicting a change to warmer temperatures and sunnier skies. I think we all need that infusion to help us with our outlook and coping skills – which always seem easier to handle under blue skies.

In two months, our full focus will be on the HRABC conference and AGM in Kelowna, which in case you had not heard, will be happening 15 – 17 September this year. A bit earlier than we traditionally schedule, but we can certainly expect some of that wonderful Okanagan weather [which for those of us on the coast, we store for the winter months]. The agenda this year [available on the HRABC website – www.hrabc.net] is a good one and offers a lot of educational sessions which will enable us to perform our various jobs better.

I know many long-term members who have never been to a conference and don't feel that it is worth the cost to travel, staying in a hotel and paying the registration fees – when the funds can be utilized in other areas of their lives. Yet, despite this reluctance to consider the conference, it really should be a part of our own personal, professional development. Continuing education is part of our mandate as professionals – to grow and learn new skills, concepts and develop new ideas – and this can be done through the annual conferences! And yet, some don't see the value in attending!

If we were to consider a two-day workshop at a community college which offered insights into advances into the role of our profession, the electronic health record, coding and abstracting, project management and many other topics – by the leaders in these fields – it would cost far more than the sum total of attending the conference. And yet, some don't see the value in attending!

Each conference is also attended by many industry related vendors who are able to share their expertise into the

advances that they have made in product developments and are more than willing to discuss individual issues and problems you might be experiencing in your workplace. Of course, their bottom line is to develop contacts to sell their products – but they are also willing to share their expertise! That expertise can solve problems for you and your site – and make your worklife simpler and more productive! And yet, some don't see the value in attending!

Most important to me, is the opportunity I have to share the time with my peer group – my cohorts – the people who understand the issues and problems I deal with. It is the contacts made with people in our industry as a whole – who can serve to help with advice, problem solving - and for some, employment contacts! Not just the leaders of departments – but the people who work the front lines in ROI, coding and abstracting, analytical work, research and others.

Beyond that, it is the friendships that are made – and the pleasure of spending social time with people you come to know at the annual gatherings. Annually, we expect about one hundred members to attend – some you know from your own region – some are complete strangers – but we share a common interest and goal – so these really can be friends you have not met yet. ...! And yet, some don't see the value in attending!

My last thought on this is that it is a great opportunity for a couple to spend some time away from the normal happenings of life – in a nice facility, in a good area, usually with recreation or tourism opportunities – so why not attend with your significant other? Spend an extra day or so – make a mini-holiday out of the event – and at the same time offer them some insights into the type of work you do, the complexity of your knowledge base and some of the people you know from around the province. And yet...some still don't see the value in attending.

All I know is that I will be there! Not only because of my executive responsibilities, but because it is THE place for Health Information Professionals to be in September! I hope you will be, too!

On a similar, but different note, is the need we have for members to step forward to volunteer to serve your profession through the HRABC executive. **Michelle Bamford**, Past President of the association is responsible for filling five vacancies this year. I know some members have stepped forward already, but we still have core executive and Chair positions which need a new person to fill these particular roles... All have their unique challenges – so it is a great opportunity to fill in some blanks on a resume or use some of the skills you've gained "on the job" – and contribute toward the betterment of our organization as a whole.

I've said much on this topic in the past, so won't press the point here, but executive responsibilities offer an expansion to our normal work routine – enhancing the expectations that our employer gives us – and promotes self confidence in our skills to accept projects and meet deadlines. For newer members, these positions can look great on a resume – AND teach skills that you may never have the opportunity to learn in a normal workplace environment. As well, you get the opportunity to be "in the loop" for job postings while becoming recognized and known by potential employers!

So, not only would you be giving to the professional association, but you would also be gaining "value added" training from the exposure in this role.

Let's enjoy our summer, camping, hiking, fishing, swimming, travelling, lounging, enjoying family and friends or dozens of other outdoor activities. Use caution in all that you do so that you can be ready to attend the 2005 Annual Professional Development Conference & General Meeting in Kelowna – September 15 – 17, 2005.

British Columbia Perinatal Database Registry

YOUR PROVINCIAL PERINATAL DATABASE REGISTRY

... a day in the life of data quality at the BCPDR

Written by
Lisa Miyazaki and the BCPDR Staff

In the previous edition of the PrintOut, the British Columbia Reproductive Care Program (BCRCP), in collaboration with the HRABC Data Quality Committee, presented an overview of the program as well as a brief introduction to the British Columbia Perinatal Database Registry (BCPDR) data quality initiatives. In this article, the details of the data quality measures used by the BCPDR will be described.

Data quality can be defined in basic terms as data that is of high quality. However, contemporary definitions of data quality are much more extensive and comprehensive with data quality being recognized as a multidimensional concept (Klein & Rossin, 1999). Data is considered high quality if the consumer can rely on the data for operations, decision-making and planning (Strong, Lee & Wang, 1997). The Canadian Institute for Health Information (CIHI) describes the dimensions of data quality as accuracy, comparability, timeliness, usability and relevance. An additional dimension meriting inclusion is consistency of data or data that is without contradiction. Consistency of data relies heavily on the establishment of data definitions and data standards and is a critical component in ensuring that data is invariable and can be used reliably for comparative purposes.

When the BCPDR was established in 1994, the design of the database included defining the scope of the database, determining the data sources, implementing standardized data definitions with internal validation checks and establishing data quality monitoring procedures. Initially, data collection was restricted to a small number of facilities, but by 2000/2001, participation had progressively increased to full provincial data collection. Currently, with complete provincial data, the BCRCP is accountable for providing stakeholders with useful, reliable, valid and accurate perinatal information.

The information provided through the BCPDR is not only used for reporting (e.g., research requests, Annual Report, Reporting Tool, Comparison Reports), but for the purposes of decision-making, for health services planning, as a program assessment tool, as a quality assurance tool, for accreditation and for clinical practice guideline assessment by clinicians, managers and health care leaders. Moreover, the data is accessible and available for use by each facility contributing this information. With increase in the use of the data, the significance of providing quality information is without question. Data quality measures at the BCPDR reflect a program approach to data quality including comprehensive instruction in the use of the database, a series of validation checks, numerous queries to verify the data, a variety of integrity checks on the data and follow-through with the contributing facilities on any resultant data quality concerns. Data quality for the BC Perinatal Database can be divided into two major phases – At the Hospital and At the BCPDR office.

At the Hospital

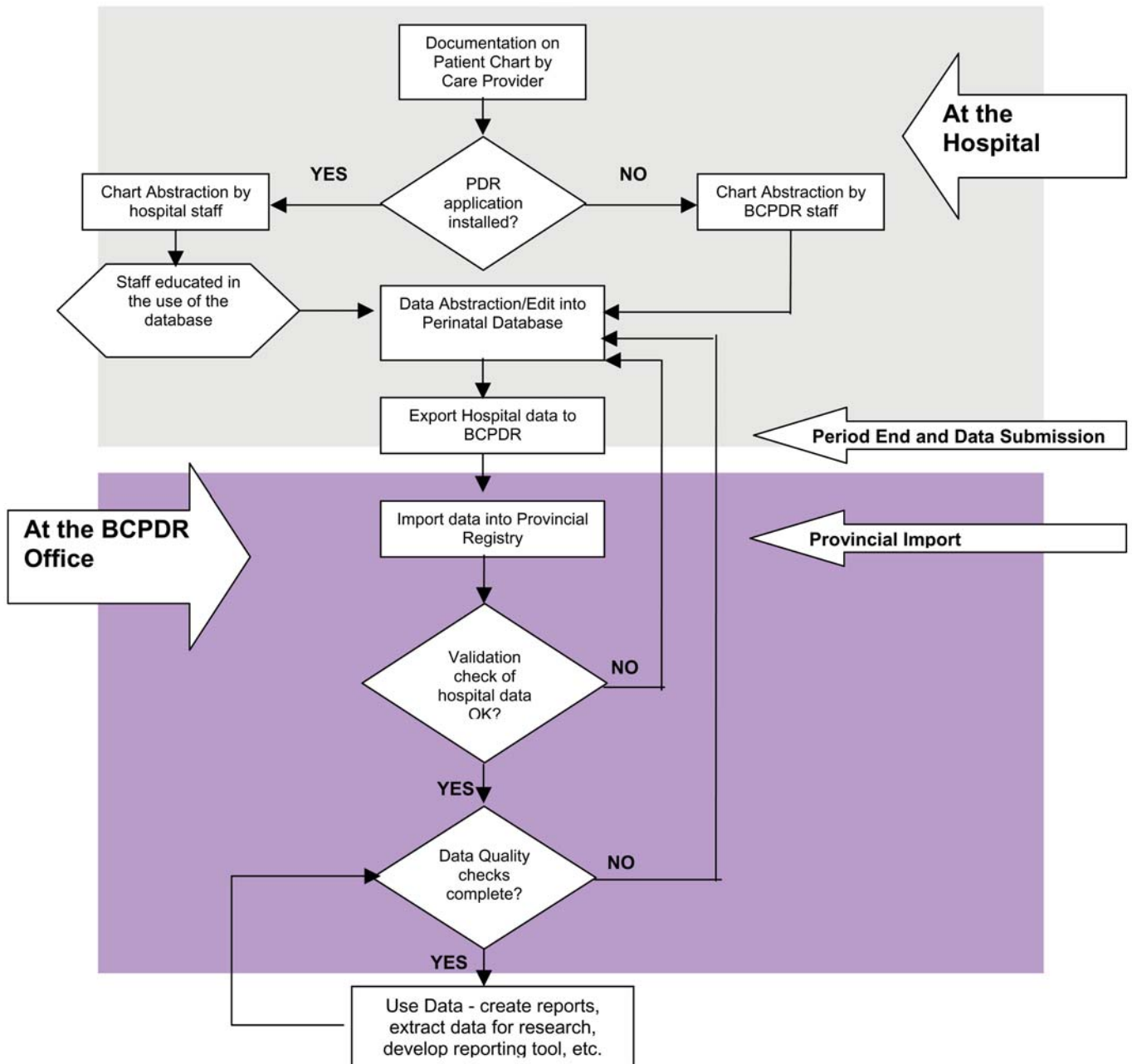
Education and Data Entry

Stakeholders of the perinatal information provided by the BCPDR can be reassured that extensive data quality measures are undertaken prior to dissemination of the data. Key to data quality is ensuring that the initial data abstraction is accurate and complete. It is recommended by the BCPDR that qualified health information management professionals (HIM) preferably with experience in perinatal and obstetrics perform the data abstraction. In essence, data quality for the BCPDR commences with a full day of instruction at the client facility site where functional knowledge of the database as well as a fundamental understanding of the application are established to ensure that the point of data capture is consistent and accurate.

A brief history of the Perinatal Database Registry as well as a summary of the uses of the registry information is also provided. The details of each screen are explained during the course of the instruction using the reference manual as a guide followed by concrete application of the software with the user abstracting information directly into the database. The hands-on portion of the orientation process is imperative in order to apply the newly acquired skills and to identify immediate problems in data abstraction. Thereafter, several reference sources are available to the user should questions or difficulties transpire following the educational process. Some of these resources include the comprehensive reference manual, the Helpline and/or direct calls to the designated BCPDR client support representative as well as the BCPDR newsletter, which provides application updates and reminders.

In order to assist the abstractor during data abstraction, the reference manual has been incorporated into the database in an electronic format. Both the text version and the electronic version of the reference manual provide definitions for each field to promote consistency and uniformity in data abstraction. Additionally, numerous internal validations are integrated into the system, warning the user of inconsistencies in data abstraction. Some validation checks are strictly warnings (greater than 200 checks) and are descriptive of scenarios that are possible, but should not normally happen and can be ignored if the data is correct, while other validation checks cannot be ignored (greater than 100 checks) and must be corrected before data abstraction can continue. These validation checks verify individual fields within the same screen as well as fields with related information from different screens. Some examples follow:

WORK FLOW PROCESS PERINATAL DATABASE REGISTRY¹



¹ This work flow diagram provides an outline of the process followed at the British Columbia Perinatal Database Registry in attaining perinatal data for the Provincial Registry. The comprehensive data quality strategies of the BCPDR are described in detail within this article.

Interfield Validation

Fields with related information within the same screen must demonstrate consistency. For example,

- Antenatal Screen – if gravida does not correlate with term, preterm and/or abortion number(s), an error message will appear during the saving and validating process.
- Birth Summary Screen – if “indication for operative delivery” has a value other than N/A, caesarean delivery must be marked.

InterScreen Validation

Fields with related information from different screens must demonstrate consistency. For example,

- Antenatal Screen (previous CS entered as “1”) and Birth Summary Screen (“NA” entered for VBAC)
- Antenatal Screen (previous CS entered as “1”) and Birth Summary Screen (“NA” entered for VBAC Attempted). In this situation, because there was a previous CS, there must be an indication that a VBAC was either attempted, not attempted or unknown.
- Antenatal Screen (Blood type is +ve) and Chart Data Screen (Rh Immunoglobulin Postpartum Eligible “Yes” with Date Given entered). Either the blood type is –ve or Eligible should indicate “No”.

Mother and Newborn Validation

- Different surname for Mother and Newborn (warning only)
- When linking Mother and Newborn, if Newborn’s DOB is different from Mother’s Delivery Date, an error message will appear.

Mandatory Fields (fields that require data):

The system checks for field completion. For example,

- Personal Health Number (PHN)
- Date of birth
- Postal code
- Chart number
- Blood type

Period End and Data Submission

The Period End process also validates the data entered and further identifies data irregularities. Once the CIHI data screen of the BCPDR has been populated, a comparison of the CIHI data¹ versus PDR data is completed. In particular, the Hospital Reports will identify errors that require editing prior to data submission to BCPDR.

- PRDEND – Cesarean Section Errors
- PRDEND – CIHI Not Transferred (Babies) – identifies missing CIHI information
- PRDEND – CIHI Not Transferred (Mothers) – identifies missing CIHI information as well as duplicate records
- PRDEND – Discharges not CTS (Babies)
- PRDEND – Discharges not CTS (Mothers)
- PRDEND – Unlinked Baby
- PRDEND – Unlinked Mothers

30% of the information in the Perinatal Database Registry is dependent on the CIHI extract. Specifically, the information provided by CIHI such as the postal code, patient service code, diagnosis codes and intervention codes provides essential information to a significant proportion of the BCPDR, which is subsequently used to categorize patients and determine perinatal outcomes and events. Consequently, import of the

CIHI data into the Perinatal database should always follow completion of the CIHI Default Error Reports.

At the BCPDR Office

Initial DQ of Facility Data

Subsequent to data submission to the BCPDR, a variety of data quality measures are performed. Each of the 12 tables in the files is examined to identify information that may impede import into the Provincial database. For example,

- Dates – identify outliers (e.g., year 2010)
- Times – cannot have “0” (zero) time
- PHN – invalid PHN
- Sex – identify any “unknown”
- Diagnoses – not properly entered
- Postal Code and Residence Code – missing information or invalid entry

Provincial Import

During the import of the data into the Provincial database, further data quality analysis is performed and disparate information is identified. Some of the built-in edits to identify data discrepancies and inconsistencies include:

- The newborn’s PHN with suffix “66-64” etc, does not equal the mother’s PHN
- The postal code is invalid.
- The number of records sent from the hospital does not equal the number of records imported into the

Provincial database for mothers, newborns, and baby transfers/readmissions.

Comprehensive DQ

Following import of the facility data into the Provincial database, more than 120 queries are executed for each facility (e.g., epidural was abstracted in CIHI, but not in PDR’s Birth Summary screen; Newborn discharge date is before Newborn admit date; Living ≥ 1 but Term and Preterm are both 0, etc). A copy of the resultant error report is submitted to the facility for editing. The facility subsequently corrects the error(s), submits another file to BCPDR and the amended information is imported into the Provincial database to update the Registry information. Many of these data quality checks have resulted from dataset extraction by the analysts during preparation for the Annual Report, Reporting Tool, Comparison Reports as well as during the completion of research request.

In addition to completing the 120 queries subsequent to Provincial import, further steps are taken to ensure validity, accuracy and completeness of the data. A comparison is made of the BCPDR data with the BC Vital Statistics Agency to ensure that the number of deaths and stillbirths are comparable. The date and time of death is used to determine if the baby died in the newborn period. Moreover, a number of integrity data quality checks are performed in preparation for the production of a variety of publications such as the Annual Report, Comparison Reports, Reporting Tool, etc. Additionally, data quality validation checks are routinely performed when pulling data for internal and external research requests.

More DQ

The unremitting challenge to ascertain that the data is complete, accurate, valid, reliable and comparable has provided an opportunity for the BCPDR to investigate alternate strategies of data quality. The BCPDR has recently been invited by the Fraser Health Authority to collaborate in a re-abstraction study. This pilot study will focus on the reliability of the abstraction of paper records and concomitantly analyze the reliability of the BCPDR

data fields, thereby testing consistency and reliability of data collected in the database. The re-abstraction study will be followed by a province-wide Validation Study conducted by the BCPDR where data in the Registry will be thoroughly examined for accuracy, reliability, consistency and comparability.

Furthermore, an educational needs assessment was recently conducted to determine the requirement for continuing education related to the Perinatal Database. The response has been very positive. The initial workshop, "Delivering a Baby – How Complicated Can It Be?" will be presented in Kelowna on Thursday, September 15, 2005. Another workshop, "PDR Reporting Level 1" is in the preparatory phase and will be forthcoming in the near future. The workshops PDR Data Abstraction Level 1, PDR Data Abstraction Refresher and PDR Period End Functions are available on request. The BCPDR will continue to offer ongoing educational seminars/workshops as identified by client need and interest.

Conclusion

The demand for quality data has increased exponentially in recent years. Organizations as well as individual researchers and healthcare professionals are becoming more and more reliant on data for statistical purposes, administrative planning, quality assurance, clinical guidelines and for educational intent, thereby dictating mandatory comprehensive data quality strategies to ensure that the data is relevant for use by stakeholders. Certainly, the BCRCP has realized increased responsiveness in the BCPDR data. As a provincial registry, the BCPDR is an eminent source of perinatal data, which can be used both at the facility level as well as at the provincial level for statistical purposes, research, planning and quality assurance as well as for the development of clinical practice guidelines. Specifically, the BCPDR data has been integrated into BCRCP programs such as evidence based guidelines and outreach educational sessions. The extent to which the BCPDR can successfully provide reliable, valid and accurate perinatal information that is useful,

comparable and comprehensive is dependent on numerous factors. Data quality strategies are never static and the BCPDR will diligently monitor, modify, improve and employ advancements in data quality initiatives. The feedback, commentary and views afforded by the health records staff at the participating hospitals has been invaluable in updating data quality measures and the BCRCP will continue to encourage this input. In addition, the BCPDR will collaborate with the Canadian Perinatal Database Committee in their endeavor to compare perinatal information at the national level. This goal can only be realized through the establishment of common data standards and a robust data quality management program and with this in mind, the BCPDR will evolve with the progressing technological advancements taking into consideration the significance of maintaining data standards and standard definitions, which are critical to the foundations of effecting consistent, reliable, useful information.

The BCRCP/BCPDR wishes to thank the health records staff at the participating hospitals for their ongoing support and assistance such that the information provided through the BCPDR can be shared with individuals and agencies dedicated to improving maternal, fetal, and neonatal health in British Columbia. We hope that this article has been helpful in providing insight into some of the data quality strategies performed at the BC Perinatal Database Registry.

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Klein B, Rossin DF. (1999) Data errors in neural network and linear regression models: An experimental comparison. *Data Quality*; 5(1): 25.

Strong, DM, Lee YW, Wang RY. (1997) Data quality in context. *Communications of the ACM*; 40 (5): 103-11



Back row L - R: Unita Hans, Barb Selwood, Patty Keith, Susan Barker, Linda Cholette, Diane Sawchuk, Cathe Johnson, Sheryll Dale, Romy McMaster, Paula Johal

Middle row L - R: Tanuja Verhoven, Sharon Marshall, Lisa Miyazaki

Front row L - R: Duane Pontenteau, Brian McLean, Kenny Der

¹ The BCPDR has worked with most of the abstracting vendors to create transfer programs to import CIHI data into their PDR systems. In general, CIHI data for hospitals with less than 500 births/year are obtained through the Ministry of Health Services.

The Surreal Life

-Experiences in Saudi Arabia-

by: Anup Parmer

As I saw the police approach the taxi I was riding with my handsome male companion on that lonely desert highway, my heart started to pound. Images of my passport with a deportation stamp "**PROSTITUTION**" flashed thru my mind. This was one of the realities of a woman getting in a cab with a man who was not her husband, father, brother or son in the Kingdom of Saudi Arabia. It did not even matter, as in this case that the man was very committed to his young charming boyfriend.

How did I get to that lonely desert highway in the Eastern Province of Saudi Arabia? Who was I, this foreign woman draped in a long black robe sitting on the backseat of the cab? What was I doing there? The answers I prepared in my mind for the Saudi police were honest but overly simplified and well rehearsed after one year of living and working there.

"I work as a health records technician at King Fahd Military Medical Complex (KFMMC) in Dhahran."

"I am from Canada. I am going back to Canada soon because I have finished my one year contract. I am just going home to KFMMC from my marsallama (farewell) dinner in Al Khobar."

"I came to work here because I like foreign cultures and customs."

"I think Saudi Arabia is a very interesting place."

In 1998, looking for a little adventure and a chance to travel the world, I went to work in Dhahran, a desert town on the Persian Gulf in the Eastern Province of Saudi Arabia. During my 14 months at KFMMC I got all these and an opportunity to lead a life that is too surreal for most western minds to comprehend in a maddening but fascinating country/culture. KFMMC was a military complex that included a 329-bed hospital and a health sciences college, which trained about 300 health professional students. The hospital's purpose was to provide primary, secondary and tertiary medical services to the armed forces personnel, their dependents and other "eligible citizens." Since there were no doctors' offices in the Saudi health care system, the hospital also had many outpatient departments to provide patients with primary care needs. The patients were all Arabic speaking nationals but English was used for patient charting and other

communications among the multinational hospital staff. The Dhahran Military Health Sciences College ran several health professional training programs including Medical Laboratory, Radiology, and Health Information Management Program (HIMP).

The complex also included a single women's housing compound where all single foreign women, such as myself, had to reside. Fifteen feet barb wired fence enclosed this and its gate was guarded by Saudi military 24 hours a day for "the protection of the women." No men were allowed on the women's compound and women were not permitted on the men's area. Single women had to get passes to leave KFMMC and at the tender age of 33, I had a curfew of 11 pm on weeknights and 1:00am on weekends. If I wanted to spend an overnight away from the compound I needed to obtain a special pass. For a weekend pass within the Eastern Province, I needed an invitation letter from a married couple, their personal information, copies of their employment documents and marriage certificate and at least 72 hours for Human Resources & Security to process all these documents. Travel outside of the Eastern Province required all of the above plus an airline ticket and 7-10 days for processing by Human Resources & Security. Our passes were obtained and returned at the Women's Gate but they were checked again at two other gates before we could leave or return to KFMMC.

According to Saudi laws and customs a woman is the responsibility of her husband, father, brother or son and therefore can only travel with this male relative's permission. Since all my immediate male relatives were in North America, the hospital was responsible for me and I needed its permission to move around the country. The single men didn't have curfew, didn't need to get any passes or anyone's permission to travel around the country. Saudi Arabia is definitely a man's world!

Even though the rules and regulations were old and rigid, the compound was new and modern with a weight room, swimming pool, bank, beauty salon, restaurant, post office and a small but efficient supermarket. Recreation

facilities' usage was divided into male and female times and strictly enforced. The recreation department sometimes arranged day excursions to local attractions. This was one of the few ways to explore the surrounding country since women were not legally permitted to drive and public transportation system was not user friendly for women. KFMMC provided private bus services every evening and Thursday afternoons between our compound and Al Khobar, the closest town for shopping about 35 minutes away. These buses dropped you in downtown and two and half hours later picked you up from the same place. There were separate buses for women, men and families.

Shopping in Al Khobar was a shopping experience like no other. All women, including non-Muslim foreigners are required to wear an *abbhaya* (the long loose black robes the women are required to cover themselves with according to Saudi customs and laws). We had to walk around town in these long black robes in the blazing sun with temperatures of 45-50 degrees Celsius. The shops were usually air-conditioned but during prayer call all the shops have to shut down while all male staff are required to go pray at the local mosque by law. The shopkeepers may be back in 15 minutes, 20 minutes, 30 minutes while you wait in the blistering heat in your black robe - or a woman could take advantage of all the men, including the religious police praying and click a few forbidden photos. It is forbidden to take pictures of women, public buildings and most other public areas in Saudi.

All the shopkeepers/salespeople in Al Khobar were men including the ones in the lingerie, cosmetic and jewelry shops. There were no fitting rooms so you had to buy your clothing including your bras and lingerie, take them home, try them on, then if they didn't fit, take them back and go thru the whole process again. The men in the cosmetic shop gave advice on flattering make-up colours to the Saudi women who were covered from head to toe in black. The western women got the free advice, great

discounts and bags full of free samples of the finest perfumes and beauty products from France. One of the jewelry shops used to give me and my single friends substantial *mafi husband* (no husband) discounts compared to our married friend because the shopkeeper said we didn't have husbands to buy us nice things like jewelry. In another gold shop, my friend was interested in purchasing a gold necklace. After the usual bartering, seeing my camera, the young shopkeeper requested in exchange for an enormous discount if he could have a picture of him with my blue-eyed, strawberry blonde friend. After my friend agreed to the photo, he phoned to get his wife's permission.

Most social activities after working hours were segregated by nationals and non-nationals. Alcohol is illegal in Saudi but there were some pubs and alcohol was usually available at the many ex-pat parties. Some ex-pats resorted to making their own moonshine. I preferred the trips into the desert to the pubs but they carried their own risks.

The KFMMC sat in the middle of the desert enclosed by a wired fence similar to one surrounding the women's housing. No one was permitted to go into this desert for "security reasons." Security guards also monitored this by driving around the compound every 45 minutes. For New Year's Day, a group of us wanted to go for a pot luck picnic on a tiny oasis in this beautiful but prohibited desert. The night before, some of the men dug the sand underneath the fence and placed large rocks to cover their work. The next day, we moved the rocks and quickly crawled under the fence then moved them back to cover our escape route before the security drove by!

Health Records Department at KFMMC was managed by Karolyn, an American from Oregon who was not only a great boss but also an excellent mentor and friend. Our department consisted of Karolyn and I and about 25 very hard working and enthusiastic female clerical and technical staff from the developing countries. We also had several HIMP male students doing various practicum's on various days of the week. We also had two really nice Saudi HIMP graduates from the college interning with us for one year. The Saudi government was trying to slowly train its own health care workers to replace the ex-pats it has relied on for decades. Our two interns, Hussein and Khalid were being trained

to take over my and Karolyn's jobs. The HRD was also an extremely social and tight-knitted department. With about thirty regular staff representing various nationalities, there was always someone's birthday or some special festival to celebrate with plenty of mouth savouring international cuisine.

The HRD was opened 24 hours a day and 7 days a week. I worked 9 hours a day on Saturdays to Wednesdays and alternated with Karolyn on Thursdays. My duties included the usual clerical, technical and administrative duties of a typical health records department as well as planning and supervising the Saudi interns' and various other practicum's for the HIMP students. The Health Information Services Program at the college was very similar to the two-year program I had taken at BCIT but the students had to take an additional year of English. This program was only offered to the Saudi men.

Since the Saudi education system is segregated by gender, the women had to attend an all female school in Riyadh. We had a six-week practicum for these female students during which time we had to arrange different practicum sites for the HIMP male students due to the country's rigid laws and customs. The ladies' practicum was a great time for me to get to know the ways of women behind the veil.

According to Saudi Arabian customs, girls become women when they start to menstruate. At this time they have to start veiling themselves with the *abhyahas* and *burkakhas* (the black veil required for the face) from all men except for their fathers, brothers, grandfathers and husbands. All Muslim female staff at KFMMC had to cover their heads regardless of nationality. As a non-Muslim foreign woman, I was permitted to lot more liberties than other women. At work, I wore a "pre-approved" uniform provided to me by the hospital. This was a loose white lab coat made of heavy polyester-cotton blend over long dark navy blue pants. All the buttons had to be done up and I had to wear a high neck T-shirt or blouse underneath it. I had to wear closed shoes with socks. Although we had air conditioning, it was still uncomfortable at times in plus 46 degrees Celsius temperatures. On the compound, "conservatively" in loose clothing with arms and legs covered. Outside of KFMMC we had to wear *abhyahas* and carry headscarves since the religious

police have the power to ask non-Muslim women to cover their heads and they did. One day while shopping with a friend, I decided to quickly run into a shop to return something while she went to buy us some fresh juice at the street stall. As I came out of the shop I witness an old Saudi man banging his cane on the sidewalk and then pointing at my friend's long light hair. "Sister! *Abhyaha!* Sister! *Abhyaha!* Sister! *Abhyaha!*" He screamed. He would not stop until she pulled out a headscarf and covered her head - one of those surreal "only in Saudi Arabia" moments.

The few female Saudi staff members we had at KFMMC were mostly doctors and they were required to veil their face with only their eyes showing unless they were in a designated private women's only areas such as the women's cafeteria or on women's wards. Karolyn "allowed" the students to work with their faces uncovered for comfort reasons while in our department. I think this must have sent shockwaves in the Saudi male grapevine because within an hour we had every Saudi male staff member in the hospital trying to get into our department. To my surprise, most of the female students kept running frantically to Karolyn's office and refuse to come out because a man MAY have seen their face. My nursing friends enlightened me about the Saudi women's obsession to keep their face a mystery. The western nurses observed that Saudi women tended to be fine if a male doctor examine their naked bodies for medical purposes as long as their faces were covered; but often became quite anxious if a male doctor needed to examine their face.

It was hard for me to fully understand the logic behind the women's reactions just as they could not comprehend how a 33-year-old woman could be content in life without a husband or babies. My happy single childless state coupled with my constant travels to remote parts of the world alone, were too surreal for most Saudi women's imagination.

The military uniformed policeman with the little moustache looked intensely between my male friend and me as he was questioning me. "You are going back to Canada? Your family will be happy to see you." Then he added with a shy smile and a wave "I hope you enjoyed your stay in the Kingdom. *Salem Egem* (Good Night)."

MAKING THE CLERICAL TRANSITION TO e-HIM

By Karanne Lambton, CCHRA(C)

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As we move forward with the developing electronic health record (EHR), the emphasis on changing work processes, increasing productivity, and eliminating many paper-driven tasks may leave clerical staff fearful of an uncertain future. Helping clerical staff understand how their current skills and knowledge translate to the e-HIM™ environment, as well as how to develop new skills, can help alleviate fear of the unknown and build optimistic anticipation for new roles.

Transforming Tasks and Skills

Ensuring the collection of complete, accurate and timely health information encompasses dozens of tasks. Paper document management includes patient and document identification and location, repair, retrieval, matching, integration and record merging. Record processing requires resources to control, process, duplicate, distribute, store and retrieve information from multiple and often remote locations

Many of these tasks are being replaced by automated record management systems, while others have been modified and transferred to the electronic environment, such as identifying and processing records that are eligible for transfer or destruction, assessing records for completeness and managing record completion queues.

Cognitive skills will continue to be applicable in electronic health record management and include familiar skills such as comparative observation, critical thinking, numerical, problem solving, decision making and interpersonal and communication skills. However new required skills may include greater technological literacy and training.

Consider the following clerical tasks and how each will transform in an e-HIM environment.

Record Control.

If working in a hybrid environment, clerks

may continue to run records to the emergency room and pick up discharges from nursing units. In an e-HIM environment, securing visit records for patients receiving care will still be needed. A comparative audit between the list of new records created or files opened online and the activity census or appointment schedule must be performed to ensure a visit record is established for each patient stay. This process will use the same critical thinking, comparative, numerical and problem-solving skills that were applied in the paper environment.

Document Capture.

Support staff members will use their current skills to confirm that a standardized list of documents has been created or received and is accessible as part of the EHR. Although many record documents are electronic, it is expected that there will always be a small number of paper documents received from other sources, requiring integration with the EHR.

Staff will continue to prepare and repair documents, now for scanner feed. Document preparation for scanning requires observation and dexterity in the way assembly did previously. Outline the steps in the process compared to what was done before, highlighting new steps and steps that are no longer used. By comparing familiar activities, organizations will create a comfort level for staff learning new processes. Once an image is captured, observation and critical thinking skills are applied to assess the image and improve its quality. Include the more detailed disclosure process components, such as cropping or sizing an image, adjusting colour, rotation and resolution.

Record Indexing.

Whatever the indexing order or folder structure, it needs to be simple and familiar to the employees who will be retrieving information or filing the documents.

Steps in document indexing reflect the previous record assembly process, from confirmation of unique patient identifier to matching patient visit dates established within the EHR to choosing a section or document type to categorize the page. Categorical, numerical or date-driven methods may be used to identify the document type, record section or service date.

Distinct assembly order may continue to exist to accommodate EHR viewing and printing requirements. Compare the online indexing tree to previous assembly order. Fastening the document into the folder will now be in the form of saving the image to the correct patient encounter. Reinforcing user's needs will increase employees' confidence with electronic indexing tasks. Explain how the record is used. This will drive how employees are to organize the pages in the EHR.

Reinforce Learning.

Create a multifaceted learning experience for the group. Ask each person to choose a task of the process and teach it to the rest of the group. These skills will increase employee confidence when called upon to impart their knowledge to coworkers, relief staff and students. Each mastered task will increase confidence and decrease levels of fear associated with the new EHR work processes.

New Education Tools for a New Environment

Different people learn in different ways, and organizations must try to create a communication tool for staff to learn new information no matter what kind of learner they are. Ask your employee training department for assistance in developing a poster or to contribute ideas they have to deliver the same information in interesting ways. We can absorb new information through reading, seeing visual images, listening,

speaking about new information with others or by taking action either by documenting or doing the task.

Ensure your support staff can access an HIM professional on an as-needed basis. Their roles are changing and reinforcement of how their work interfaces as part of the big picture of health care delivery. How HIM interfaces with other departments and users is just as important as ever. A working knowledge of guidelines or rules for decision making builds confidence as they understand why certain actions are taken and decisions are made. Help them understand how the HIM application suite uses data to support related processes and most of all, let them know there is an HIM professional available to support them.

With support and guidance, a cognitively skilled pool of individuals will be developed, available and ready to work in the transition to the electronic health record. Identifying

where knowledge gaps exist provides focus for training programs both before and during change. Sharing how and during change. Sharing how employees already use the skills and understanding needed for the electronic environment will help them embrace change and continue to develop needed skills and knowledge. They will experience learning opportunities, challenging work and personal reward as they relinquish their fear. Increasing an individual's value in the e-HIM labour market can translate into confidence, job satisfaction, organizational commitment and increased productivity – a win-win by anyone's definition.

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Road to Fraser Health Authority (FHA) Alternate Level of Care (ALC) Classification System from Health Record Services' Perspective

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History and Context

Like any journey, there is always a story before setting out on a course from one point to another. The FHA ALC Initiative began with the inability to present a true picture of the ALC population concurrently as well as retrospectively. At any given day or reporting period, one could see that there are many ALC cases being reported either by ADT concurrently or by DAD retrospectively across FHA's twelve acute institutions. However, the data varied between FHA's former three regions. The data was not useful concurrently and/or retrospectively due to insufficient information collected in ADT and DAD. Thus, a steering committee was struck to determine a new authority system. The steering committee wanted various input and held three workshops where 120 participants ranging from care providers to leadership staff determined the

barriers to discharge of non-acute (ALC) patients. The participants also reviewed the current systems and recommended areas of improvement. The outcome was one ALC classification system for FHA.

FHA ALC Classification System

The one ALC classification system will provide common language and definitions to the set of 8 ALC classifications (e.g. Home Health) determined. Most importantly, the new system will provide a standardized designation process for the clinicians to follow as well as a standardized ALC sticker for documentation. In terms of ALC mnemonics in the ADT, all sites will use the same mnemonics for the purpose of consistency.

Implementation Team

Armed with the vision, the Access department (responsible for ALC

clinically) must now make the vision into reality. Immediately, the FHA Project Resource Office was contacted and a senior consultant was assigned to work with Access to deliver the product. An implementation team was assembled and various participants ranging from Health Record Services (HRS) to People Services were asked to participate. Each member of the implementation team brought his or her area of expertise to the table and participated fully in order to make sure all areas were covered. For HRS, besides educating committee members of the ins and outs of CIHI/MOH guidelines, HRS had to ensure that the new system works within the guidelines set by CIHI/MOH for data collection and reporting.

Implementation Plan

Like any new initiatives, the foundation had to be laid by many implementation team members before the new ALC system could go live. The foundation in this case was the finalization of the new categories, the creation of the ALC sticker, the communication plan, the education materials, the trainers, the logistics of booking rooms for training, the clinical process of assigning and changing designation, the notification process in ADT, and so on. For HRS, its contributions were the design of the ALC sticker, the creation of an in-house project to collect ALC on top of CIHI/MOH requirements and internal edits for data quality of ALC. Once the foundation was laid, the go live plan began. A pilot site was selected and after the initial staff training, the pilot site went live at the end of October 2004. Month by month, a few sites were added until April 2005 when the last site went live. During that period, lessons learned from each site were applied to the following site. In all, 8500 staff, mostly clinicians, were trained on the new ALC system.

Sustainability

After each site had gone live, several post implementation meetings were scheduled to discuss areas of concerns, successes as well as improvements. Concurrent audits were also performed and any

discrepancies (errors, guidelines not being followed, documentation, etc.) were discussed with the clinical staff. In a few instances, retraining sessions were given. For HRS, constant feedback to the Access group regarding documentation has provided valuable information for Access in evaluating the compliancy of the new ALC system.

Goals


Needless to say, this initiative was a huge undertaking. The road to a new standardized system for the entire authority was and is still challenging. Nonetheless, the primary goal of the new ALC classification system to meet the health and service needs of clients through the appropriate utilization of acute and community resources is being achieved. Every day the clinical team, using the ADT with the set of 8 ALC categories, is able to plan for the needs of the ALC patients. Retrospectively, with the in-house ALC projects collected through DAD, the clinical team has a sophisticated database to work with in profiling the needs and resources of its patients for planning, comparison, and others.

Health Record Services' Perspective


Like the clinical team, any best plan when put into practice will have holes.

For HRS, the first few initial sites did experience more growing pains than later sites with data collection and documentation issues – mostly from incomplete documentation and/or documentation errors. The three common obstacles in implementing the system (like any new system) for both the clinical team and HRS were resistance to change, the impracticality of a few processes when put to practice, and unforeseen circumstances. Nonetheless, these obstacles were addressed immediately with the focus on continuous improvement. Overall, the best part of the new system is the ownership of the process on the part of the clinical team. As well, the clinical team is very receptive to hearing feedback as well as input from HRS. The partnership between all the departments has made the initiative and the journey very successful even with a few expected hiccups here and there. In the end, the beneficiary of the new system is the FHA residents in which all FHA staff dedicate daily. Better health. Best in health care.

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DELIVERING A BABY – HOW COMPLICATED CAN IT BE?



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