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A Word From the President

I am always amazed when I reflect back onto "things my father said", especially when it comes to the speed at which the passage of time seems to accelerate as we get a bit older. I've only just become accustomed to the fact that I am the President of our Society – and now realize that I am already half way through my term of responsibility!

This has so many implications! First, I have several personal goals that I'd set, which I have only partially achieved. Secondly and most importantly, is our Association name change, which was voted on and accepted at the 2005 Annual General Meeting in Kelowna. In case you'd missed reading the last AGM minutes, or are new to our Association, we will soon be making application to change our name from the **Health Record Association of BC** to the **Health Information Management Association of British Columbia**.

Interestingly, we actually made the official transition to the HRABC in July 1976 – so thirty years later, as technology changes...so do we.

One issue which I would love to see us make some advancement toward – and one I can call on your help with – is surrounding membership. **Jane Kitazaki**, Membership Chair, had set a personal target of 350 members for this year. We have just passed the cut-off point for renewals and as of the first part of March; we had only arrived at 250! This is very disappointing to all of us on the executive, and despite all

of the various encouragements we apply, there seems to be a resistance for people to renew or join the Association.

Honestly, people ask why the Association does not have more programs or more activities to promote ourselves. It comes back to the "double-edged sword" concept – that cuts both ways. We don't have the financial resources to do more than we do [and really compared to other Associations, we do very well] – AND we don't have the human resources to take on more tasks. We have enough challenges as it is to fill our executive vacancies every year without adding more!

So, over to you...if each one of us took the time to endorse, promote and generally encourage Health Information Professionals to become **ACTIVE** members – we could do much more...talk to a coworker, an old classmate [a current classmate] or your boss – and get them to become members. Show off the on-line copy of the Printout, the web site **www.hrabc.net** and tell them about the success of our annual conferences – for education, fun and networking. There are so many positive reasons for belonging – I honestly could not imagine not being a member.

Speaking of executive positions, **Sharon Baigent**, our esteemed Past-President is seeking names of members who are willing to serve on the Association executive for the 2006 – 2007 years. She is looking for volunteers for President-Elect, Secretary, Membership and Credentials, and Programs & Arrangements.



Gary Arnold
HRABC President 2005-2006

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DATE FOR NEXT SUBMISSION IN 2006

May 10th, 2006
May / June edition

2005 - 2006 HRABC EXECUTIVE COMMITTEE:

President:

Gary B Arnold,
604-466-7901
gary.arnold@fraserhealth.ca

Past President:

Sharon Baigent
604-984-5909
sharon.baigent@vch.ca

President Elect:

Janet Pitts

janet_p@shaw.ca

Treasurer:

Tena Peters
604-708-5271
tena.peters@vch.ca

Secretary:

Donna Wong
604-984-3751
donna.wong@vch.ca

COMMITTEE CHAIRS:

Data Quality Committee:

Hanifa Ladhani
604-875-2382
hanifa.ladhani@fraserhealth.ca

Membership & Credentials:

Jane Kitazaki 250-314-2531
Jane.Kitazaki@interiorhealth.ca

Programs & Arrangements

Angie Kinrade
250-709-3000 (local 4230)
angelina.kinrade@viha.ca

Communications:

Teresa Ward
250-638-4039
teresa.ward@northernhealth.ca

HEALTH RECORD ASSOCIATION OF BRITISH COLUMBIA

200 - 4170 Still Creek Drive
Burnaby, BC, V5C 6C6
1-800-573-4555
www.hrabc.net

I have to confess the pay on the executive is poor [in fact, non existent], demands can be high, but the rewards are amazing! There are any number of applicable, transferrable skill sets which can be carried over to your workplace, networking connections which can turn out to be future friends, consultants or employers. And a lot of fun, too!

Angie Kinrade, Programs and Arrangements Chair reports that she is busy lining up speakers and vendors for our 2006 Annual General Meeting and Conference at beautiful **Tigh-na-Mara at Parksville, BC – September 21 – 23, 2006**. I am sure you will see some promotional material arriving in your mail soon. For those of you who attend regularly – I am looking forward to seeing you – and for those who can't always make it – try to attend this year. As a former Island resident, I know the reputation of Tigh-na-Mara and I know it will be a great place for our gathering. Set aside these dates in your calendar now and plan on being there.

The **Douglas College class of 2006** will be into their senior practicum experiences by the time this copy comes

to print – the conclusion of two years of hard work...and the beginning of their professional lives as working members of our craft. I have met many of them and they are an enthusiastic bunch and I hope they quickly find employment in the areas they'd love to work in... Good Luck to you all! And save some time and energy to get involved with YOUR association.

I have a National Health Information Management Alliance [all the Canadian Association Presidents, plus CHIMA representation] Teleconference on March 16 and will be traveling to Saint John, New Brunswick for the CHIMA annual conference on 01 June, which should be an interesting experience.

Please feel free to contact any of the current executive, or myself if you have a concern or question. We are all here for your benefit and are ready to assist you where we can.

The 2006 Executive



From left to right: Hanifa Ladhani, Teresa Ward, Tena Peters, Janet Pitts, Gary Arnold, Sharon Baigent, Donna Wong, Jane Kitazaki.

HRABC DATA QUALITY REPORT

DATA QUALITY MATTERS!

The HRABC Data Quality Committee will provide brief updates to the Electronic PrintOut pertaining to data quality initiatives within the British Columbia Health Authorities. The topics will range from various aspects of information management such as electronic health record development, policy and procedures, re-abstraction studies, authority wide data collection, partnerships and coding issues and standards.

FRASER HEALTH AUTHORITY

FHA Obstetrical and Newborn Re-abstraction Study 2005

By Gerald Yu, MHA, CCHRA(C)
Coordinator of Coding Standards and Data Quality
Fraser Health Authority

Gerald.Yu@fraserhealth.ca

Last fall, we partnered with the British Columbia Perinatal Database Registry (BCPDR) and conducted a joint re-abstraction study on obstetrical and newborn cases. Our authority re-abstracted charts from 8 of our 12 hospitals with a Maternal Program. Our study focus as suggested by the title was on coding (examining variations) but a few DAD elements crucial to case costing were too examined. At the same time, BCPDR conducted its own study on the Perinatal Database Registry portion. Watch for our joint results soon!

The study was challenging logistically as CIHI and CHIM Information Consulting would attest – sample size, methodology, re-abstractors and so on. Luckily, we

were not the first ever to undertake this type of resource intensive activity and were fortunate to adopt many aspects of the studies both CIHI and CHIM have conducted – a big heartfelt thank you for sharing.

What is the role of a re-abstractor?

By Kam Gill
Family Birthing Unit
Surrey Memorial Hospital
Kamaljit.Gill@fraserhealth.ca

What is the role of a re-abstractor? The re-abstractor recodes a chart, compares the two sets of codes and analyzes the differences between them. To recode a chart is one thing, to find the reasons for the discrepancies between your codes and the original codes selected by the facilities coder is another. I find this to be the most challenging aspect of my role as a re-abstractor. With the aid of the CIHI guidelines and standards, CIHI coding query database and the FHA guidelines, I was able to establish some meaningful conclusions.

We all strive towards consistency, accuracy and quality. However, we know that in the real world, consistency is difficult to achieve. Comparison of codes for obstetrics and newborns across the authority allowed the re-abstractors a snapshot of each facility. For this reason, I found this study to be very beneficial as I compared codes given by another facility to mine. As we progress on this journey towards continuously improving the quality of coding, this re-abstraction study has been one step closer to our achievement.

Interior Health Authority

By Karen Tonn
Kelowna General Hospital
Karen.Tonn@interiorhealth.ca

Since March 2004 coders/abstractors from the IHA have been meeting to discuss coding issues and standardize practice within IHA. We meet 2 to 3 times a year via teleconference and are known as the **Health Information Practitioners Group**. The IHA encompasses a large geographic region and includes fourteen hospitals, ranging from 14 to 330 beds. One of the first issues the HIP Group tackled was to standardize patient servicing. The difference in facility size has caused some challenges in that the smaller sites do not have all the same specialities as the larger sites. We developed a servicing template based on diagnosis with a medical/surgical break-down. All sites now follow this template for patient servicing. The template undergoes review periodically and changes can be made at the new fiscal year. We have found this to be a useful tool as previously some diagnoses were being serviced several different ways depending on surgeon/resources involved. Servicing consistency is being achieved!

Please feel free to contact members of the Data Quality Committee for additional information.

ONTARIO SEEKS TO BOOST THE QUALITY OF HEALTHCARE INFORMATION COLLECTED

By Jerry Zeidenberg

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Ontario is embarking on a major effort to improve the quality of healthcare information that's collected through the medical system. Steps will also be taken to consolidate databases and enhance access to the data.

In particular, the government is establishing 14 Local Data Management Partnerships across the province. They're designed to bring together health information management professionals from hospitals and the community care sector in each of the 14 new Local Health Integration Networks (LHINs).

According to the government, they will work together to identify best practices, standards, tools and policies for better data quality and management.

"The quality of the [current] data is poor," asserted Dr. Adalsteinn Brown, information management lead for the Ministry of Health and Long-Term Care's Results Team. Dr. Brown spoke at a recent healthcare IT breakfast meeting in Toronto, sponsored by ITAC Ontario (www.itacontario.com).

He outlined many of the problems with the data – including patients who are declared dead by hospitals, only to be readmitted a few weeks later. He quipped that while many might see this as a tremendous medical success story, it's actually a troubling data quality problem.

Dr. Brown noted that steps will be taken to check and improve the quality of the information that's entered into the system. In part, this will be accomplished through the use of standard methodologies – such as the Canadian Classification of Interventions (CCI), ICD-10-CA and possibly SNOMED-CT encoding techniques – and common information technologies.

On the tech front, he said a drive will be made to standardize the methods and tools that are used to pull together the data on which the management of the system depends.

Significantly, steps must be taken to pull all the data together in one place, said Dr. Brown. As it stands, information is currently housed in too many places – there are more than 100 healthcare databases – and can't be readily accessed.

In order to obtain a picture of the healthcare system as a whole, more than a dozen analysts must be contacted to pull together the appropriate data.

At the best of times, that's a cumbersome task.

As a result, "We don't know what healthcare costs, especially across providers and communities." Because the data quality is questionable, and because it's so hard to extract on a system-wide basis, there is little information about costs or levels of quality throughout the system.

"We don't know how good the care is, we don't know if patients have pain or trouble breathing when they leave the hospital," said Dr. Brown. "We're working on this."

He emphasized that once this information is available it must be linked to a strategy. "It must be connected to what you're doing, and what you hope to achieve," said Dr. Brown. "We've never had a provincial healthcare strategy before. Now we have a need for it [alluding to the proposed Local Health System Integration Act]."

Dr. Brown noted that the province has already made progress on improving data management. On the Community Care Access Centre front, "we've cut one-quarter of the data reporting to the Ministry of Health. That's a reduction of 20,000 hours a year of paperwork."

"Those savings can be turned into performance management and patient care hours," he said. "This new regimen for the CCAC world will take effect in April."

Dr. Brown said his team is now looking at reducing the reporting requirements in acute care hospitals. He believes the load can be reduced there, too, by a quarter to a third.

The drive to improve the quality of healthcare information in Ontario is being supported at high political levels. In a government news release, Health Minister George Smitherman said:

"Quality patient care requires quality information. We are building an information system management system to

support a new, patient-focused system of care that will consolidate and standardize the way data are managed.”

Still, there are problematic areas for healthcare information collection and management in Ontario:

- ✘ Data on the use and efficiency of hospital care requires more than eight months to process – the same as it did in the 1960s.
- ✘ Right now, there are more than 100 separate health information databases in Ontario, many of which contain the same data.
- ✘ There are nearly 2,000 separate performance indicators in use in Ontario. Many are of limited use because they are either difficult to interpret, they provide only limited information, or they do not relate to the government’s key health priorities.
- ✘ Hospitals are submitting up to 200 separate data reports, some on a daily basis.

Healthcare in Ontario is an enormously complex system that depends on information. At the most fundamental level, it is used by doctors to decide on the best possible treatment options for their patients. At a system level, where decisions about the management and delivery of healthcare services are made, the data that healthcare providers across the province collect about patients is studied and analyzed to identify trends in population health, such as the incidence of stroke and obesity.

This evidence is then used to plan for and make decision about which healthcare services will be provided where. Over the last decade, advances in technology have dramatically increased the capacity to collect, store and analyze a large volume of health-related data.

The reality is that collecting all this data is placing a considerable burden on many healthcare providers.

With close to 100 separate health information databases in operation, healthcare planners, researchers and analysts are finding it more and more difficult to access the information they need. At the end of the day, when system planners and managers are looking to evaluate how the system is performing, the data itself is coming up short. Key pieces of information are missing to evaluate basic things like the quality of care overall in the province.

According to a ministry of health release, the Ontario government has committed to breaking the cycle of ever-escalating healthcare costs by instilling a culture of accountability and improved outcomes – one that is tied to results.

It needs accurate and comprehensive information to measure performance and provide a clear indication of the health system’s performance overall. Despite having more than

2,000 indicators in Ontario, many of these are of limited use because they are either difficult to interpret or they do not relate to the government’s health priorities.

According to the health ministry, the objectives of the new information management partnership will be to:

- ✘ Make local data management processes more effective and efficient;
- ✘ Improve the timeliness and quality of data;
- ✘ Make more effective use of scarce health information management resources;
- ✘ Encourage healthcare providers to adopt best practices.

The partnerships will be implemented in four phases, over a two-year period. Each will address a different area within the scope of activities related to health data management.

- Phase I – Health Records/Health Information Management functions
- Phase II – Financial data management functions
- Phase III – Clinical data management functions
- Phase IV – Primary care data management functions.

A provincial Data Management Council will be responsible for overseeing the four advisory committees that will be created for each phase of the partnerships as follows:

- Phase I – Health Records Advisory Committee
- Phase II – MIS Steering Committee
- Phase III – Clinical Data Advisory Committee
- Phase IV – Primary Care Advisory Committee

In Phase I, 14 Local Data Management Partnerships will be established in each of the provinces Local Health Integration Networks. Each partnership will include those responsible for health records/health information management from each hospital (e.g. the director of health records) and those responsible for health information management from each CCAC.

A chair for each partnership will sit on the provincial Health Records Advisory Committee. The committee will be responsible for recommending best practices and providing direction to the partnerships related to the collection and management of data.

A representative from the Ministry of Health and Long-Term Care will chair this committee. Members will include Local Data Management Partnership chairs, as well as representatives from the various Health Information Management (HIM) programs and associations.

During Phase I, the partnerships will also be supported by the Physician Documentation Expert Panel and the Data Consistency Working Group.

Transcription Services Fraser Health

Linda Emes, CCHRA(A)
Coordinator Standards and Data Quality
Transcription Services
Fraser Health

Fraser Health has taken a leadership role developing, enhancing and securing Health Information. This vision and direction, through focus on the Electronic Medical Record (EMR), fostered the creation of a separate portfolio within Health Information Services for Medical Transcription. Transcription Services was founded in December 2004 with the leadership team in place since the fall of 2005.

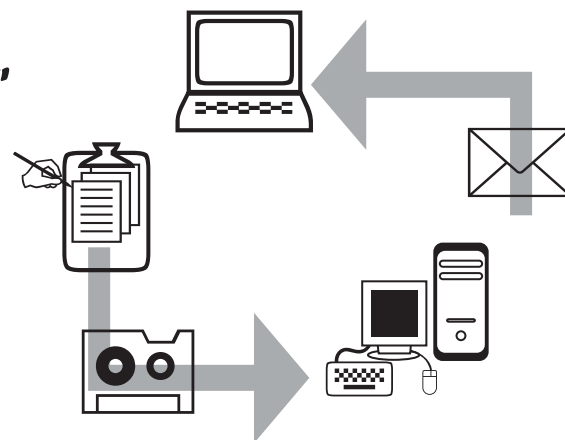
As a newly created corporate portfolio, we are working to refine and enhance the transcription service provided to Fraser Health by developing goals and establishing standards that are in keeping with the guiding principles of Information Management.

Historically, Medical Transcriptionists have been a part of the Health Record department, reporting to the site HR Coordinator. While this structure worked well, focus for Transcription technology and processes were not able to be at the forefront of the department. With the corporate portfolio change, MT's now report to a regional Transcription Coordinator for all departmental issues. The basis for this change is partially due to realization that MT's do not necessarily need to be site based, but with the technological road map that FH has created, the MT can be a mobile employee. This can take the form of telecommuting from home while still being employed by FH or off site, as the need for space within the acute care setting is diminishing.

Recently, FHA MT's were invited to take part in a confidential survey and asked if they were interested in working from home. An overwhelming majority answered yes. To that end, Tracey Jarvis (Manager for Transcription Services) will resume talks with Provincial HEU reps in order to come to an understanding for the development of home based MT's that can be mutually beneficial.

At present, the dictation system is completely integrated across Fraser Health with Dictaphone voice. Work is assigned based upon site and pool scripts associated with turn around time objectives. As the voice file comes to the MT, she must identify the patient and correct visit in the Admissions/Discharge/Transfer (ADT) module of Meditech. When the report is complete and filed against the correct visit, it then becomes available for viewing in the Electronic Medical Record (EMR) of Meditech.

Standardizing transcription procedures has been a focus of mine as we develop the department. To do this, a standards



committee was formed which brought together an MT from each site, three Health Record Coordinators, and a representative from the Laboratory and Medical Imaging. We discussed the how, why and when reports are dealt with at each site. Through this committee and number of standards were developed for MT's to handle documents in the same manner across all sites.

Our leadership team is working towards:

- ⇒ Standardizing dictation and transcription technology through the use of the Dictaphone product.
- ⇒ Refining and streamlining processes across FHA, with a goal of decreasing backlog.
- ⇒ Improving distribution processes through the use of auto fax routing. This feature enables physicians involved in patient care to receive a transcribed report in a time and resource efficient manner through the effective use of technology.
- ⇒ Monitoring reports to ensure that they are viewable in the Meditech Electronic Medical Record (EMR).
- ⇒ Developing and providing a Dictating Physician User manual for new and existing physicians.
- ⇒ Establishing communications with the physician community by offering education sessions and creating a physician link specific to Dictation and Transcription on the Fraser Health website.
- ⇒ Partnering with colleges to educate, train and recruit qualified MT's.
- ⇒ Establish a telecommuting option for MT's who request to work from home.
- ⇒ Developing a standard Quality Assurance program in which random audits are done monthly and results are given to each MP for discussion and review.
- ⇒ Raising awareness and appreciation for the MT's who provide high quality reports and take pride in their work.

The challenges are:

- Developing new processes and rolling out Dictaphone exTEXT across FH, while still maintaining sites in their current system. ExTEXT allows the MT to type in a word based document that features auto fax routing for their reports.
- At present we now have 4 sites who transcribe using exTEXT.
- Standardizing processes now across FH so that

procedures are in place to allow for MT to be home based. Home based MT's will need to have a concrete foundation using the same standards as site based MT's. The standards and procedures have been set up and need to be continued using this mindset.

- ◉ Speech development at LMH and SMH.
- ◉ Educate and train MT's to become 'editors'.
- ◉ Alleviating fears amongst the MT's, who see speech technology as the demise of their profession, rather than a tool to help them with their work.
- ◉ Speech is only available to sites that work with exTEXT.
- ◉ Implement and encourage physician usage of auto fax

routing for report distribution.

- ◉ Staying positive in the face of change for the MT's, change is not always easy but necessary as we develop and grow as a region.

Although Transcription Services is a separate department in FH, we continue to value and rely upon our relationship with Health Records and Registration. As a threesome, Registration being the beginning, Transcription the middle, and Health Records the end, we are all essential components of healthcare delivery as well as the basis and backbone of the EMR.

Northern Health Authority Doctors set the pace for EMR Adoption

By Jerry Zeidenberg

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www.canhealth.com

Low-cost access to a high-speed network is spurring doctors in British Columbia's Northern Health Authority to log-on to the system and adopt electronic patient record systems at a torrid pace. Over 90 percent of the region's doctors were expected to be online by the end of 2005 and over 50 percent are using some form of electronic medical records.

That compares with most estimates of 10 percent EMR adoption by physicians in Canada and the United States.

It helps that local physician leaders have encouraged the trend, along with regional healthcare executives. Indeed, the Northern Health authority – one of six regional health authorities in British Columbia – recently took upon itself the task of building a network that would deliver "last mile" high-speed connectivity to doctors' offices throughout the region, an area bigger than France.

With just 445 doctors spread across Northern Health, getting broadband to the physicians' offices was a dilemma – as it is in most rural areas. But Northern Health solved the problem using a made-in-Canada solution.

When dropping fibre to doctors' offices is too expensive or troublesome, Northern Health is employing a microwave technology from Wi-Lan, Inc., of Calgary. The microwave system beams high-speed signals from base stations to physician offices and back again, often over long distances.

It's a licensed wireless technology that operates in the 3.5 Gigahertz frequency. When hooked up to the doctors' offices, it delivers real-world throughput of up to 12 meg/second, fast enough to support instant downloads of web-based information

and easily able to support applications like videoconferencing.

The broadband network that's now fanning out across Northern Health, a project dubbed Physician Connect, offers a whole host of benefits.

Not only do the doctors obtain high-speed internet services, but the network is basically a closed system, or intranet, that comes with three layers of security. Those security features take a load off the minds of many doctors who are worried about patient information floating around the internet.

It's also simple to use.

"With respect to connectivity and authentication, we treat the doctors just like staff members," says Joseph Mendez, chief information officer for Northern Health. "Like everyone else, they log-on with a user name and password and they're authenticated and gain single sign-on to the Northern Health network.

Doctors can obtain access to Northern Health's help desk and I.T. support services, in case they've got a snag with their network connectivity. It's reassuring to know that help is just a phone call away.

A key feature of the system is that it's relatively low-cost. Northern Health used a \$1.2 million contribution from the federal government's Primary Healthcare Transition Fund, funneled through the province, to foot the bill for the wireless infrastructure.

Mendez salutes the province, too, for its support of the Physician

Connect project. It's a one-time investment in equipment that will provide service to the region's doctors for at least 10 years.

The on-going operating costs, to pay for the wireless spectrum rental, are cheap – about \$25 per month per doctors' office. If there are five doctors at a site, they simply split the \$25 monthly fee – about \$5 a month for each physician.

That compares with a typical \$50 monthly bill that an office would otherwise pay for a DSL or cable line in a large city.

The broadband network has proven to be a springboard for the use of electronic solutions by docs in Northern Health.

For example, Northern Health's physicians have become heavy users of the provincial online toolkit for chronic disease management. (More information about the system is available at www.healthservices.gov.bc.ca/cdm/cdminbc)

In brief, the toolkit is a web-based service that allows doctors to maintain electronic records for their patients presenting with chronic diseases, "in addition to paper-based records and memory," comment Paula Young, project manager for Northern Health's Physician Connect program.

She adds that the toolkit also keeps track of patient information for a variety of chronic medical conditions, tests, medications and recalls, as well as protocols for the best care.

Uptake of the toolkit by Northern Health Physicians stands at 63 percent. That compares with just 17 percent when looking at the province as a whole! Access to a high-speed, secure network is given a good deal of the credit, as the docs can access records quickly and securely.

The CDM toolkit covers a limited number of disease and conditions, but has been an excellent introduction to using technology in the medical practice. Seeking a more comprehensive solution, Northern Health's docs have also embraced full-fledged EMRs to an astonishing degree. Again, access to a low-cost, high-speed communications network is cited for spurring the use of yet another electronic solution.

"Secure, reliable, fast internet access is a prerequisite to having an electronic health record," says Terrace family practitioner Dr. Bill Redpath.

About 50 percent of the physicians currently using the high-speed network are also using full-bore electronic medical record (EMR) systems. That compares with industry estimates of just 10 percent for doctors across Canada and the United States.

Paula Young noted that most of Northern Health's physicians use a solution from local supplier MedOffis, which is based in Prince George, BC (see <http://www.pg-famedres.bc.ca/mois/moisindex.htm>)

A few other systems are also being used, almost all of them developed in Western Canada. They include Wolf Medical Systems Corp., of Surrey, B.C., Osler Systems Management Inc., of Sidney, B.C., Jonoke Software Development Inc., of Edmonton, Clinicare

of Calgary and Montreal-based Purkinje of Montreal (which recently merged with Wellinx, of St. Louis, Mo.)

MedOffis is developed and implemented by Prince George physician Dr. Bill Clifford, who says the emergence of the secure, broadband network has done wonders for the uptake of EMRs and usage of online resources.

"As a result," says Dr. Clifford, "adoption of the technology has blossomed. Fifty percent of primary care practitioners in the Prince George area use an EMR, with no subsidy other than that provided by the NHA for the network infrastructure."

Dr. Clifford and his colleague, Dr. Redpath, are no doubt correct in saying the high speed network has stimulated the rapid uptake of electronic solutions. But other areas of Canada have had this infrastructure for years, yet their physicians have been slow to adopt computerized applications.

In addition to the high-powered infrastructure, you've got to credit the healthcare leadership in Northern Health – they include Dr. Clifford, Dr. Redpath, the staff at the Northern Health authority, and CEO Malcolm Maxwell and many others – with believing in the technology and convincing physicians across the region to use it.

As well as the provincial toolkit for Chronic Disease Management, high-speed networking allows access to tools such as UpToDate Online. Decision-support systems of this sort give rural physicians, like those in Northern B.C., a quick second-opinion on many difficult medical issues. That kind of feedback might take hours or days to obtain by traditional means, such as phoning or even emailing colleagues.

UpToDate Online (www.uptodate.com) is a web-based service that answers clinical questions that arise in daily medical practices, including information pertaining to 15 different specialties such as pediatrics, cardiology and infectious diseases.

Young observed that decision support tools like UpToDate really only become feasible for a doctor when he or she has access to high-speed services.

By tapping into the hospital portal, the physicians can now obtain access to diagnostic images on Northern Health's Picture Archiving and Communications System – its repository of X-rays, CTs and other scans. Those test images currently reside in PACS supplied by Agfa and McKesson.

What's more, in 18 months, when Northern Health will convert its current electronic record system over to leading-edge Cerner applications, the docs will begin to have access to lab reports, pharmacy records and general electronic medical records.

That information – such as lab test results and discharge summaries – currently takes days or weeks to arrive by fax or mail. Once the electronic connections are in place, it will be available in seconds.

**MAKE A DIFFERENCE FOR YOUR
FUTURE – AND THE FUTURE OF YOUR
PROFESSION!**

***MAY 16, 2006
IS CENSUS DAY***

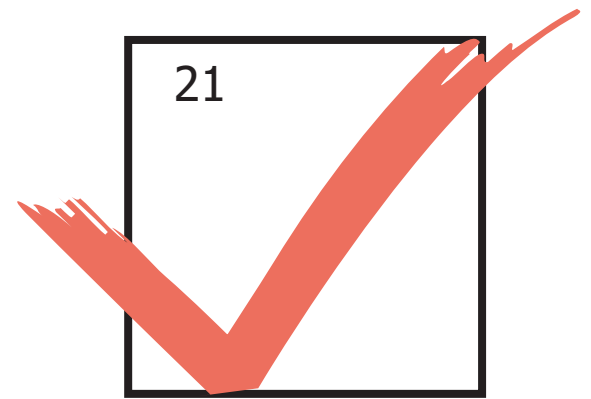
***IDENTIFY YOURSELF PROPERLY
AS A HEALTH INFORMATION
MANAGEMENT PROFESSIONAL***

**SEE THE ARTICLE IN THE CHIMA
SOURCE VOLUME 2 ISSUE 4,
FALL 2005**

OR

**THE HRABC PRINTOUT
JANUARY / FEBRUARY 2006
– VOLUME 14 No. 1**

Mark Your Calendars and Come Join Us for the:



2006 HRABC Annual Professional Development Conference and
General Meeting

When: September 21 – 23, 2006

Where: Tigh Na Mara Seaside Spa Resort and Conference Centre
Parksville, BC

Watch for details in upcoming Printouts and the HRABC Website