

Article – “The Source” Newsletter

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Submitted and Written by: Charmaine E. Shaw, MA, BA, CCHRA(c), Chair, Editorial Advisory Committee

19 Richter St.,

Brantford, ON

N3T 6M2

Home: 519-758-0660 Office: 519-750-1473

The Future of the Health Information Management Professional: an insider’s response to an outsider’s view

One of the first C.H.R.A. annual conferences I ever attended, back in the 70’s, featured a session by Lorne E. Rozovsky. Through the years he has addressed us and written books for us, encouraging us to continue the forward march. His article reminds us of our past and urges us towards a future that he asserts will align us with the “...key to provision of health services in Canada.”

One of the primary challenges for us, Mr. Rozovsky asserts, is in expanding our scope beyond a focus on the document and/or record. We should embody the ‘management’ part of our health information title, including the ‘how’. I think he is right on the money!

In your average facility today, information is created, edited, copied, printed, forwarded, faxed, e-mailed, mailed and otherwise duplicated or transmitted by so many people, in so many places and in so many ways that the mind boggles. Some healthcare staffs have been known to cut and paste excerpts from transcribed reports and provide this in response to a request for information. Some healthcare providers capture their notes in a laptop and subsequently print and forward these for inclusion in an official health record. A lot of hospitals use a ‘signature by default’ concept to comprise an electronic signature.

Some documenters have developed templates into which they ‘fill-in-the-blanks’ to create documentation on client encounters. Most computer systems facilitate editing of notes within a certain time frame and lots of systems offer a ‘cancel’ or ‘undo’ feature for documentation. Some healthcare providers use their own speech recognition software, then cut and paste the resultant document into the facility computer system to serve as their official record. Fax servers expedite mass transmission of transcribed reports but ownership of the database from which the fax numbers are retrieved may be nebulous. I’ve even seen a situation wherein a blind healthcare provider transcribed his/her own reports which were subsequently edited by somebody else and then signed by the blind author! My favourite part about that little story is the ‘so what’ and ‘what does that have to do with you’ retorts I received when I proceeded to question it!

All of these issues and many more, have arisen through the advent of the marvellous enabling technologies that have become commonplace. We couldn’t function without these technologies and I would be last to malign them. The technology is the tool and the problem is how the tools are employed, not the tools themselves. For example, fax servers don’t send reports to unauthorized recipients unless we tell them to. When we fail to allocate responsibility for fax-server database integrity to an individual, we facilitate faxing to unauthorized users. How many times have I heard about people not wanting to take on responsibility for database integrity? I.T. wants Health Records to do it and Health Records doesn’t have staff, or money, or time.....

Mr. Rozovsky recommends two solutions: get educated and educate. I agree with both strategies as a good start. Certainly CHIMA has invested in member education and graduates of the university-based programs will embody the higher education concept. Once educated, then, we will be able to educate.

In many cases, however, the problems require standards and guidelines – new ones designed for the new circumstances. For example, there should be a standard that any database used to collect, store or transmit personal health information must have an identified ‘owner’ prior to collection of any data. That owner should be charged with the responsibility of defining every data element captured within the database. This same individual should issue and monitor database access privileges and passwords, and audit the integrity of all entries. All of these concepts may be found in ISO 17799 but who knows about it? Health Information Management professionals need to learn database management skills and healthcare facilities need to recognize the importance of funding these positions. We shouldn’t need a Privacy Commissioner to tell us this is the prudent way to handle health information!

Maybe this is personal pet peeve, but I think somebody should declare ‘signature by default’ authentication to be null and void and meaningless. Health Information Management professionals need to know what comprises a legally admissible signature and need to educate their facilities accordingly. The same applies to cutting and pasting, use of speech recognition, and various methods of data capture. Standards must be

established governing these tools and the Health Information Management professional must be empowered to do something about it.

I think there is a role for the legal profession to be proactive and participate in this standard-setting. How many records have gone to court bearing a 'signature by default'? It's pretty difficult for the Health Information Management professional to assert the need for an express signature (with all its attendant enhanced documenter effort required) when the courts fail to take issue with implied signature. That's a tough sell!

Cutting and pasting medical reports, capturing data on a laptop, using templates, editing after-the-fact and 'undoing' notes are all enablers that need some guidelines, standards, protocols, policies and procedures. Typically, we proceed on the basis that, in law, it is better to seek forgiveness than to seek permission. Maybe that's the problem.....

So while I agree that education and educating are important milestones in this brave new future for the Health Information Management professional, I think there is need for some proactive standard-setting to offer up education about. Lawyers and Health Information Management professionals should collaborate in the creation of these standards for the new age of data capture. Any takers?????????