Message from the president:

Lorraine Nicholson, IFHRO-President 2007-2010

Dear National Directors, dear friends of IFHRO,

The IFHRO Executive Committee met in Amsterdam on 10th & 11th June 2008 at the VU Medical Center in Amsterdam. The Dutch Association (NVMA) graciously hosted our meetings and we express our grateful thanks for this generous and very welcome support for IFHRO.

As you all know IFHRO’s main source of income is member dues from both national and individual associate members. We noted during our meeting that a number of national members have not yet paid their national dues and I will be writing to individual national IFHRO Directors concerned to ask them to ensure that their dues are paid as quickly as possible.

At the EC meeting discussion took place regarding a letter that I had received from two members who attended the IFHRO General Assembly in Seoul in May 2007. They queried the correctness of two US individuals voting at the GA. Lorraine will send a response back. They were fact correct as each country receives one vote only and we are grateful to them for pointing out this error to the EC. It was clarified, as per the constitution, that if an EC member is in attendance they should cast the vote as representative of their country. If a country does not have a member on the EC then one individual in attendance representing their country can vote. It was suggested in such cases when both are present as was the case for the US in Korea, that they sit together to ensure there is consensus on how issues should be voted on. In the scenario described above Margaret Skurka would vote as IFHRO President Elect and Bryon Pickard would not as US IFHRO Director. Please ensure that your Executive Board and the Alternate IFHRO Director in your country are aware of this.

The next IFHRO Congress will be held in Milan 8th - 12th November 2010 and the congress theme will be “Better Information for Better Health”. I would be very grateful if you could publicise and promote this congress through your association’s publications and website. The Italian Organising Committee are already working very hard to ensure that this event is a great success and your help and support for them will be greatly appreciated. The conference will be held at the Milan International Conference Centre http://www.fieramilanocongressi.it/Home_en.html.

Milan is a wonderful city and most of its attractions are concentrated in its centre. Its hub is the Duomo, a fantastic Gothic cathedral topped by the Maddonina (our little Madonna), Milan’s protectress. Not far away is La Scala, one of the world’s great opera houses. Milan also ranks alongside Paris and London as one of Europe’s greatest places to shop and fashion is its lifeblood, and it is home to some of the world’s most exclusive boutiques.

At the IFHRO General Assembly we will be selecting the venue for the 2013 IFHRO Congress and national IFHRO Directors are requested to investigate whether their association would be willing to...
put in a bid to host this congress. Invitations to present a bid will be sent out well in advance of the General assembly but it is not too early to start doing some preliminary work!

I am delighted to announce that the first IFHRO Conference in the South East Asia region will be held later this year. It will be held at the Patra Bali Hotel, Kuta, Indonesia. 21st - 24th October 2008 and the theme of the conference is “Consolidation & Strengthening in Health Information Management (HIM) Among IFHRO SEAR Countries in the 21st Century”.

Please publicise and promote this conference in your country and try to attend if you can. I will be attending and so will Margaret Skurka, President Elect of IFHRO.

Angelika Haendel, Regional IFHRO Director for Europe and German IFHRO Director, produced the first edition of the IFHRO Global News newsletter. I attach a copy herewith. Angelika has put in a great deal of hard work to make this newsletter a reality but she needs help from you to provide her with suitable topical material and photographs for the next edition due in the next couple of months. Please do try to help by sending in one small article in the next two weeks to her email-address: angelika.haendel@uk-erlangen.de

IFHRO has the Electronic Health Record as one of its key strategic areas and we would like to compile a status report on EHR development around the world. I would be grateful if you could provide an update or EHR status in your country for posting on the website to enable IFHRO to start building up a world-wide picture. To further progress this initiative work will commence very soon to develop a standardised questionnaire in advance of the Milan congress in 2010 for member countries to complete on progress on the electronic record and this will be sent to national IFHRO Directors. A summary will then be done before the congress and then shared with the representatives and observers at the General Assembly. Angelika Haendel will be starting work on this project very soon.

The IFHRO EC also discussed the production of a global map of HIM education around the world? This would be one of IFHRO's goals for 2010. We want to develop a compendium of current information about educational provision around the world similar to what we are going to do with the status of development of the EHR. It would be helpful therefore if you could provide me with details of types of Health Records and Information Management programmes/courses, the academic level of the various courses, titles of courses, credentials/qualifications that the courses offer, opportunities for distance education etc in your country.

IFHRO is 40 years old this year and it would be fitting for all member nations to have some small celebration of IFHRO’s special birthday at their national conference this year. Please let me know how your association will mark this occasion and please let me have some photographs and a short article that we could post on the website and include in Global News.

IFHRO's 40th Anniversary provides a great opportunity to increase individual associate membership and I would be grateful if you could promote IFHRO membership as much as possible this year.

You are all IFHRO’s "eyes and ears" in your own countries and because of the way that the Federation is organised and managed we rely very much on you and the Alternate IFHRO Director to ensure that IFHRO’s messages and requests for help and information are received and acted upon promptly. I want to thank you in anticipation of your continued help and support for IFHRO.

With best wishes to all,

Lorraine
August, 30th, 2008

Lorraine Nicholson,
President of IFHRO,
141 Leander Drive,
Castleton,
Rochdale OL11 2XE
Tel & Fax: 01706 355957
Mobile: 07788 405910
www.ifhro.org
INTRODUCTION

Sir Run Run Shaw Hospital (SRRSH) is a public teaching hospital located in the eastern coastal city of Hangzhou, People’s Republic of China. It was opened in 1994 with 400 beds, and has gradually increased to 990 beds. It was managed for the first five years by Loma Linda University (LLU) in California. The hospital continues to be affiliated with LLU and also with Zhejiang University School of Medicine for training in all specialties except pediatrics.

The Health Information Department (HID), Quality Management Department, and Forms Management at SRRSH were started by co-author Audrey Shaffer, MA, RHIA according to Western standards. She continues as a periodic administrative consultant. The HID department is operated efficiently under the direction of co-author Cheng Li Jun (Jane). The hospital had 33,765 discharges, 19,450 surgeries, and 645,984 outpatient visits in 2007.

DIFFERENCES BETWEEN OTHER GOVERNMENT HOSPITALS AND SRRSH

Most hospitals in China do not keep outpatient records. The original records are given to the patients. The health information departments usually receive completed and assembled inpatient records several days after discharge. The diagnoses are entered into computer programs which assign ICD-10 codes. Many hospitals do not record all complications and co-morbidities. Often these departments are responsible for keeping statistics. Many of the large urban hospitals are using computer programs to capture demographic and statistical data, and a few have developed some electronic inpatient records.

At SRRSH we started using computers shortly after the hospital opened to capture financial data. No vendor programs were available in Mandarin characters at that time, so our Information Technology (IT) department has developed all of our software. Over the years we have added programs for the master patient index, coding, statistics, incomplete charts, order entry, all ancillary reports, and most recently for nursing and physician documentation.

The Chinese government requires that inpatient medical records be kept in paper format, so we must print out and file all the reports. However, having electronic records is a great advantage to all caregivers who now have the records available throughout the hospital whenever needed.

HID employees pick up all inpatient charts the day after discharge, assemble and analyze them for statistical reports and for incomplete documentation. Physicians are notified to complete their records either on paper or computer. Our coders still use ICD-9-CM books for all coding in order to capture surgical data. Every diagnosis and procedure is coded. A cross walk to ICD-10 was created for reporting diagnoses to the provincial government.

All functions in the HID are monitored semiannually to determine compliance with hospital standards. Inservice is provided as needed in weekly department meetings. Announcements from the department head meetings are also presented to keep employees informed about hospital progress. Employees who are not present for the meetings can obtain the information on the hospital computer net.

We have kept all original outpatient records since the hospital opened. Copies are given to patients. It is the practice in China for patients to pay prior to receiving care, so they need copies of their records in order to collect from their insurance companies as well as to take to other facilities where they may be treated.

A much-needed program for electronic outpatient records is ready to initiate. This will eventually eliminate the need to pull and file over 2,500 records per day. We already have nine rooms overflowing with one and a half million outpatient charts.
Joint Commission International Accreditation

SRRSH spent five years preparing for an accreditation survey by Joint Commission International (JCI). JCI is a subsidiary corporation of the Joint Commission which is responsible for the accreditation of most hospitals in the United States. JCI’s mission is to improve the quality of health care in the international community by providing worldwide accreditation services. The purpose of JCI is to offer the international community a standards-based, objective process for evaluating health care facilities. The goal is to stimulate continuous, sustained improvement in health care by applying international standards adaptable to local culture and needs.

Accreditation benefits an organization by showing its commitment to improve the quality of patient care in a safe environment, and to continually strive to reduce risks to patients and staff. Worldwide attention is being focused on accreditation as an effective tool to evaluate and manage quality.1

The Administration of SRRSH has been committed to gaining accreditation as a benchmark of high quality in this internationally recognized hospital. This is demonstrated by sending numerous personnel to LLU, and to accredited hospitals in Hong Kong and in Thailand to gain knowledge about JCI accreditation preparation. The Administration encourages and supports all departments in their efforts to comply with the JCI standards.

A Quality Management (QM) Coordinator was first hired in 2002. Gradually the QM Department has been increased to seven personnel. They began by helping all departments to write policies and procedures. Prior to that time, only a few departments such as HID and Nursing had policy and procedure manuals which had been written by LLU personnel. The next step was to help the departments develop indicators and start monitoring their functions. Safety and cleanliness were other major areas that needed improvement. Quality of patient care and service attitude of employees were stressed.

HID Participation in JCI Preparation

The Health Information Department had a key role in the preparation for the JCI accreditation survey. Department Director Jane was the Chairperson of the Management of Information (MOI) Team. This team consisted of members from Information Technology, Nursing, Central Files, Medical Affairs Department, and Laboratory.

JCI’s Management of Information standards are designed to help organizations become more effective in

- identifying information needs
- designing an information management system
- defining and capturing data and information
- analyzing data and transforming it into information; and
- integrating and using information.

The duties of this team were to educate all departments in the hospital on MOI standards, help staff to implement the standards, and evaluate their compliance with the standards.

Jane’s first activity was to translate the MOI standards into Mandarin. This translation was integrated into the hospital-wide standards book in Mandarin which was distributed to all departments in both written form and on the hospital’s computer net.

She then held periodic meetings of the team to

- develop a plan of action
- obtain pertinent government rules related to data and information
- revise hospital policies regarding the management of information
- revise hospital forms related to confidentiality of patient information
- survey the entire hospital to assess confidentiality of patient records and computer screens and
- educate staff during the survey when breeches of confidentiality were observed.

After evaluating the results of the original survey of the hospital, Jane developed a power point presentation on the MOI confidentiality standards and the findings of the team’s survey. She presented this as training for all hospital employees. It was also made available on the hospital’s computer net so that the information could be disseminated to employees not present at the training sessions.

Extensive training was been given to all employees in the HID on protecting the confidentiality of medical records and on the semiannual performance improvement monitoring that is done on all HID functions.

The release of information function had originally been done inside the HID department. This presented a problem in that patients and relatives could view computer screens and medical records on desks. Last year this function was moved to a new area where a window was cut through into a hallway. Now patients and relatives can obtain copies of their medical records through the window, and they no longer can observe...
confidential information inside the department.

A mock survey was conducted by three JCI surveyors in 2005. The HID provided data for the team including the top diagnoses and procedures, demographic data, and they prepared charts for the surveyors. HID personnel participated in the chart review with the surveyors. Jane was interviewed regarding the MOI Team activities.

The recommendations from the surveyors were then used by Jane and the MOI Team to help bring the hospital into compliance with the MOI standards. Our continuing activities included:

- writing "Smart Tips," posted in every department, related to the process of ordering prior records for patients that are readmitted, using appropriate computer programs; and reminders to minimize computer screens when they are not in use, and to close or cover patient records no longer being used at nursing stations and in physicians' offices;

- revising the MOI Plan for the hospital to include a more extensive section on confidentiality and privacy;

- initiating a multidisciplinary medical record committee to regularly audit a sample of inpatient and outpatient records, both active and closed, using combined criteria of JCI, hospital policies, and government rules for documentation;

- Conducting another survey of the entire hospital. It was gratifying to find much better compliance with confidentiality than during the previous year's team survey.

The JCI Survey

In December 2006, four JCI surveyors spent five days assessing all functions at Sir Run Run Shaw Hospital. HID personnel were actively involved in preparing information for the surveyors, pulling medical records, and participating in review of the records with the surveyors. Jane was interviewed by the physician surveyor regarding her MOI Team activities.

At the exit conference the JCI team leader declared that our hospital had successfully met the requirements for accreditation. The official survey findings report which arrived in March 2007 indicated that 1,033 of the measurable elements were completely met, and the remaining 30 were partially met. Celebrations were held both at Loma Linda University for all their personnel who have been involved in helping the hospital as well as at SRRSH to honor all the employees who have worked to accomplish this milestone. This hospital which is a recognized international facility serves as a model for other hospitals throughout China.

Conclusion

The Health Information Department at Sir Run Run Shaw Hospital was actively involved in preparation for both the mock survey and for the official Joint Commission International survey which resulted in accreditation in 2007. We are proud to be a part of the first public hospital on the Chinese Mainland to achieve JCI accreditation as a benchmark of optimal quality of patient care and service.

Audrey Shaffer, RHIA, MA
Consultant for Loma Linda University
at Sir Run Run Shaw Hospital
Home address: 880 Encanto Street
Corona, CA 92881
U.S.A.
Telephone and Fax: 001-951-737-5240
NVMA-Congress in Amsterdam

IFHRO Representatives of The Netherlands: Wybe Dekker (left) and Marcel van der Haagen (right)

On Thursday, June 12th, 2008 the 13th EPD - congress of electronic patient records was held in Amsterdam, in the wonderful rooms of the Royal Tropical Institute. This congress was organized by the Dutch Association of Health Information Management NVMA (Vereniging voor Zorgadministratie en Informatie). The congress was themed “Across the borders of EPR: milestones, barriers, pitfalls, communication and bottlenecks”.

This congress was essential for all health information managers, because there was an update as well as a discussion of the latest developments in the field of electronic patient records.

With this congress the NVMA offered an outstanding opportunity to exchange with informatic experts and to meet colleagues from varied services. The program offered different views from specialized speakers, who took reference to their own skills and experiences, too.

There were six parallel sessions, beneath this an international session. The status of the electronic health records of the different countries were presented by IFHRO representatives from The United States, Canada, The United Kingdom, Denmark and Germany. In the following pages there is a summary of some of these presentations. This will be continued in the next issue of the Global News.

During the parallel sessions as well as during lunch break there was the possibility to visit the industrial exhibition to get demonstrated the latest Dutch EPR applications.

This was really a very interesting and very successful congress with 285 attendees.

International Session within the NVMA National Meeting June, 12th, 2008

From left to right: Robert Wamalwa (Kenya), Darley Petersen (Denmark), Angelika Haendel (Germany), Marcel van der Haagen (The Netherlands), Marci MacDonald (Canada), Lorraine Nicholson (UK), Paul Epping (The Netherlands), Margaret Skruka (USA), Wybe Dekker (The Netherlands), Gemala Hatta (Indonesia)
The State of the Electronic Health Record in Canada

Marci MacDonald IFHRO Representative, The Americas

I am looking very forward to meeting you all in June in Amsterdam! During that time, I will have the pleasure of representing the Americas at an IFHRO meeting, as well as attend some local regional meetings. I am hopeful to have a tour of a health information management department as well – and see how you compare to what we do here in Canada!

In addition, IFHRO Representatives will be doing presentations on the electronic health record development in their home country, and I am putting fingers to keyboard to give a summarization of that presentation to you today!

In Canada, we find that health care is probably the most information intensive industry in our country – and unfortunately the last frontier to implement information technology! In spite of spectacular advances in medicine, the foundation of health care is to a large majority, still paper – based.

Each year, approximately the following volumes of records are still being hand-written:
- 100 million physician exam records
- 500 million lab and radiology tests
- 400 million prescriptions
So you can imagine – that is a lot of paper!

Statistics have also shown us that there are a number of adverse events occurring in the provision of health care, for example – adverse drug reactions, duplication of laboratory tests, delay in communication between clinicians – resulting in increased length of stays – as examples.

It is Canada’s perspective that the creation of a national electronic health record would dramatically decrease this wastage, duplication and opportunity for error. We also see pressures from our population as they become more computer literate, the population ages, the pressures on health care resources increase, and we see a shift to providing more ambulatory services and treatment modalities in the patient home setting.

Unfortunately, it is also a reality that Canada spends less in health information technology than it does in various other industries. The top spender in our country being financial services. The UK for example, spends more of their global budget on IT in healthcare than Canada does.

With this information in hand, Canada created an organization entitled “Canada Health Infoway”, is organization has been given the mandate of making a national electronic health record a reality. In doing so, we hope to improve access to patient information, improve quality of health care delivery, and increase productivity in the deliverance of care to patients.

Of course – this is a HUGE undertaking, and we must be foremost cognizant of privacy of patient information at all times! Privacy Impact Assessments are being undertaken every step of the way and provincial Privacy Officers and Ministry of Health representatives meet regularly to ensure patient right to privacy is maintained throughout all stages of planning and implementation. Currently, each province in Canada is working towards a provincial EHR, with a view to linking nationally in the future.

Of course, this in itself is a tremendous challenge, as to link all health care providers, all in various stages of computerization, all utilizing different vendors and programs – is mind boggling! At least to my mind that is! But still we soldier on! The plan is to target an EHR for 50% of the Canadian population by the year 2010. This would include 80% of radiology images being available electronically, 75% of laboratory information and 75% of prescriptions.

Canada currently trails behind New Zealand, Denmark, Norway and Netherlands - in implementation. But we believe we have a strong national strategy and the resources to be on par with those global leaders within the next three years!

Hoping this article will assist you in having a better understanding of where we are in Canada – in terms of creating and utilizing an electronic health record!

Look forward to seeing you all soon!
Rethinking the Application of Electronic Patient Records in Poor Resource Settings: The Case of Kenya

Robert Wamalwa,
Lecturer Department of Health Records and Information and Regional Director for Africa International Federation of Health Records

Job Mabonga
Provincial Health Information and Records Officer
Ministry of Health, Western Province in Kenya

Your Excellency the President of International Federation of Health Records Organizations, organizers of this session on Electronic Patient Records, my fellow colleagues and other distinguished guest.

When I received an invitation letter to attend this particular session among other scheduled events, I shared the information with one of my professional colleagues in the field. He posed for a moment then asked me the implication of the topic in resource poor settings such as Western province of Kenya where he works. He also asked me whether the “Electronic Patient Records” could be modified and adapted to situations where most of health care activities take place outside health facilities such as antenatal care, delivery, post-partum care, nutrition and growth monitoring, sanitation activities, basic curative care among others take place outside the health facilities.

Finally, he asked me whether the conference organizers were aware that the Government of Kenya, has shifted emphasis from areas where things seem to work well e.g. hospitals and other health facilities towards the community where health services or activities do not seem to work well and in the majority of cases whatever goes on is not documented in any systematic way.

In summary, my colleague has issues with blanket expansion of an electronic patient system in situations where most of health care activities take place outside health facilities. He has also a problem with our preference for curative care activities and our emphasis on the importance of health facilities as opposed to preventive and promotive health activities with a strong focus at the community based or village level health activities.

My feeling is that some of the issues he raised are relevant to this meeting and some could apply to many other developing countries, which are still grappling with basic health care issues that could easily be dealt with at the community or household level. We draw on experiences in Kenya’s health sector to provide some insights into the issues raised and the way forward in the rest of the paper.

Levels of provision of health services

The MOH’s key strategy for service delivery is decentralization of health services to the districts in implementation of the minimum essential packages of health, which have been classified into high, medium and low priority packages. In terms of service delivery health services (and facilities) are classified in six Kenya Essential Packages of Health (KEPH), as follows:

- KEPH Level I- Community level
- KEPH Level II- Dispensary
- KEPH Level III- Health Centre, Maternity / Nursing Homes
- KEPH Level IV- Primary Hospital
- KEPH Level V- Secondary Hospital
- KEPH Level VI- Tertiary Hospital

KEPH Level I- Community Level

The main focus of community-based strategic interventions and activities is to promote positive health behaviours and to create demand for health services that are provided at other levels of care, e.g. at the local Dispensary or Health Centre. They also aim to equip communities with comprehensive knowledge and information on practices leading to improved community health. Community level services include activities of Community Own Resource Persons (CORPs) such as CBDs, TBAs, CHWs, etc., and programmes of social marketing (for example, sale of contraceptive commodities and treated bed nets for protection against malaria). In addition, through outreach activities, a range of clinical services can be provided within a community, e.g. antenatal care and surgical contraception.

Public Health Officers (PHO) and Public Health Technicians (PHT) are trained to work with communities as such they provide an important linkage between health facilities and the community, for the promotion of primary health care including reproductive health. Some of critical information that the community members need to be educated on include: RH danger signs; where to get RH services in normal and emergency situations; risk factors that increase undesired RH outcomes; and community-level delays in seeking health care.

KEPH Levels II and III (Primary Level)

The primary level health facilities are the first line of
contact between the health system and the population it serves. The primary level includes the Dispensary and the Health Centre.

KEPH Level IV (District and Sub-District Hospital)
The Primary (District) Hospital should where possible have a full range of specialists, at least one each, in the main clinical disciplines: medicine, surgery, obstetrics and gynaecology, and paediatrics, and equipped to serve as referral centres for Health Centres and Dispensaries. As such they should be able to deal with all the services provided at those levels.

KEPH Level V (Secondary, General, Provincial Hospital)
This level includes regional referral hospitals, which have a full range of specialists including specialists in laboratory medicine, and radiology. All ‘general’ and ‘provincial’ hospitals are classified as secondary hospitals. Secondary hospitals are equipped to deal with all RH problems referred to them, and to undertake operational research.

KEPH Level VI (Tertiary, Teaching Hospital)
This level includes national referral hospitals and University Teaching Hospitals, where there is a full range of specialists including specialists in clinical, laboratory medicine, diagnostic imaging and research. This level can deal with most of the health problems.

Status of health management information system and what has worked before
Some of the data is computerized and some is not. For instance, most of the districts have computerized health facility data, while community based health care data remains largely un-computerized. Experience from the safe motherhood demonstration project in Western province\(^1\) showed that the value attached to the data or information generated at the community level is what determines whether the data will be used or not regardless of whether such data is manual or linked to a computerized health information system in a facility within the catchment area. For instance, field staff (Public Health Officers and Technicians) in collaboration with local leaders used to collect information on a number of health events such as number of deliveries at home and in the facility, number of referrals, number of clients whose antenatal profile had been determined through mobile laboratories, number of facilities with effective referral arrangements/infrastructure in place among others.

This information was discussed in monthly village level meetings by members of the public with a view to addressing some of the bottlenecks that had been identified. This practice is still going on in some communities. This example illustrates the value of community members designing their own information system and using it for planning, monitoring and evaluation purposes at their level.

Overcoming institutional dilemma: to computerize or to strengthen manual HMIS
The following rationale has been advanced to justify the use of computers in decentralised health management information systems.

- Improving programme efficiency by processing and analysing large amounts of data quickly.
- Improving the quality of data collection through automatic validation during data entry.
- Improving analysis and information presentation to facilitate data interpretation and use for decision-making.
- Managing the data for monitoring the attainment of health programme targets and objectives.
- Serving as an opportunity to review and improve dysfunctional manual systems and procedures.

The decision to computerize should also take into account some of the following factors:

- The complexity of analysis required
- How well the existing system functions
- The volume of data to be processed
- The costs of the technology vis-à-vis the cost and availability of skilled personnel to process the data manually
- Existence of appropriate structures for managing and maintaining computer system.

Where these factors are not met, it is preferable to improve a manual system.

Community based health information system
Community-based information system (CBHIS) refers to the information required, gathered, analysed and used by the community and other levels for planning, monitoring and decision-making. A strengthened CBHIS will facilitate the collection, analysis; reporting and use of health and health-related information not only at the community level but at all levels of the healthcare system. In addition, a strengthened CBHIS will easily be integrated with the facility-based health information system.

A major justification for the community-based health information system has to do with the fact that households not only take the

---

\(^1\) The Safe Motherhood Demonstration project was implemented by the Ministry of Health in collaboration with the University of Nairobi through technical assistance of Population Council. Between 2001 – 2005.
majority of preventive and promotive health actions, they also provide clinical care of the critically and chronically ill. Studies in Tanzania and Malawi have shown that majority of child deaths occur at home, without any contact with the health system, caused by preventable or easily curable diseases such as malaria, measles, acute respiratory infections (ARI), pneumonia, diarrhoea and malnutrition. Hence a community-based health system needs to be supported by a strong community-based health information system. A strengthened CBHIS will easily be integrated with the facility-based health information system with regard to issues such as:

- Health promotion
- Disease prevention
- Care seeking and compliance with treatment and advice
- Governance and management of health services
- Claiming rights
- Broader development agenda including investments in health development

How can the objectives and activities of IFHRO complement CBHIS/CBHC?

The objectives of IFHRO are to:

- Promote the development and use of health records/information management in all countries

IFHRO activities include:

- International Health Records Congress: Every three years the Congress is hosted by one of the national member organizations. This is an opportunity to bring together member countries.
- Newsletter: The International Health Records Newsletter, “The Link” is published at least annually on the website and provides information about health records activities in member countries.
- Educational programs: Educational programs and consultations may be provided to countries as and when required.
- International Committees, Task Groups and Projects: Members have the opportunity to serve on international committees, task groups or projects, which focus on health information management and health records.

Way Forward and Conclusions

As seen from figure 1 (left), the decision for computerizing HMIS or improving the manual system is dependent on proper identification of data required for monitoring selected health indicators and the nature of strategies for strengthening information systems. From the foregoing, in contexts where it is easy to collect data computerization is an attractive option. However, in situations where most of the health activities are at community level, it maybe attractive to improve the manual system for two reasons: health care at the community level is seen as being part of the overall social economic activities. Secondly, a manual system maybe more responsive to community felt needs since they vary from one community to the other.

Conclusion

Therefore, it is our considered opinion that in a developing country setting there is need to achieve the right mix of computer and manual systems, and to ensure that they are fully integrated. This enables units which do not have computers to produce their analyses manually. Decisions about whether or not to computerize, and at what level, should take into account:

- The availability of local resources to support computer equipment, software main tenance, and training; and
- The volume of data to be processed.
Development and implementation of electronic health records in Denmark

Darley Petersen
Health Information Manager, Unit of Clinical Research. Odense University Hospital, Denmark.

History
The first generation of electronic health record systems in Denmark was based on Danish needs, which has caused limitation for developments and expansion. Future systems on electronic health records (EHR), therefore, will be developed according to international standardized models.

The National Board of Health has launched a fundamental concept of an EHR (G-EHR) and this concept will be integrated in national standard for exchange and communication in Health Level 7 from USA. This model has the purpose to create a coordinated structure for formalizing of data and concept model as well as for working process.

In 2006, a national EHR Steering Group launched a strategy for coordinated development and implementation of an electronic health record (EHR) on a national basis. In the steering group were members from the five Danish Regions, Ministry of Interior and Health (1), the National Board of Health (2), and the Ministry of Finance.

Actual strategy
The actual national strategy runs from 2008 till 2012 and includes the national health system – social as well as private hospitals, specialists’ clinics and GP’s as well as primary care.

The ambition is to give doctors and health professionals access to necessary health information regardless where in the system the citizen asks for treatment or advice of prevention. The goal is to give citizens the best possibilities to seek information about their own health, to give the best conditions for effectiveness in treatment and to reduce possibilities for mistakes in treatment.

The new strategy invites to step-wise development of IT. It will be based on manageable projects, and local as well as regional experiences will have a decisive impact on the development of the system.

Denmark is divided in five regions having a regional council as governing body in every region (3). Each region is responsible for the entire hospital service including mental health treatment and health insurance.

In every region, the hospitals focus on Health-IT, and one of the major challenges will be to coordinate and include already existing individual health record systems in the nationally. As patient administration systems have developed individually in each region, the development and projects around EHR have varied, and to-day this still is a fact.

In Region South Denmark, Odense University Hospital (4) in 2007 has preferred a Swedish Health Care System consisting of several modules (5) to supply already existing system.

The architecture shall provide services within following fields:
- Clinical Care Support (Care Documentation, e-prescribing, Medicine Module and Order Management)
- Patient Administration Systems (PAS – functionality for Pricing and Billing), Scheduling and Bed Management
- Incident Reporting and Intelligence (Statistics)

Method of implementation of the system is divided into 3 superior areas:
- Conditions for implementation through development of infrastructure
- Knowledge of individual departments need for documentation, change of routines
- Teachers staff for supplementary training of personal

Three project groups in the university hospital organisation were responsible for setting up a scenario of step wise implementation of the system:
- The clinical arm
- The organizational arm, and
- The technical arm

Preliminary work in Odense University Hospital:

The clinical arm: Before users in individual departments will be able to log in to set up the first electronic patient record the staff has undergone a training program during the established “EHR-school”. The staff has been trained along with scheduled implementation plan. The teaching personnel (super users) will during implementation period be available for further service.

The organizational arm: For logistics an EHR office has been established with personnel from the three arms to coordinate technical and clinical issues.
The technical arm:
A “technical lift” was necessary in Odense University Hospital. New facilities for server was established, kilometres of cables was integrated in existing system, new ceilings and boxes for printing was established. New rooms for medicine were installed, too.
All departments will be supplied with new lamps, furniture like chairs, and desks electronically able to accommodate a variety of working postures, Also, handheld palm pilots and new computers to match the new needs will be purchased.
IT-Department, Technical Department and IT-User Service Canter has finished reconstruction and all installation of network. Approximately 130 sections will in summer 2008 be fully equipped for implementation for EHR.

Conclusion
In summer 2008 status of implementation in Odense University Hospital in Region South Denmark is:
EHR is in use in several departments and all departments will be enrolled autumn 2009.

Status for The five Danish Regions: Individual digital health programs and implementation plans are ranging from being in the period of decision making according to IT equipment to having implemented several pilot projects on EHR including training of personal.

Literature:
1. Danish Board of Health: www.sst.dk/default.aspx?lang=en
2. Danish Ministry of Interior and Health: www.im.dk/im/site.aspx?p=34
3. Danish Regions: www.rm.dk/files/Webteam/English/Publication%20Danske%20Regioner.pdf
4. Odense University Hospital, http://www.ouh.dk/wm122110

---

**Coordinated Digital Health in Denmark**

The National Strategy for digitalization of Danish Health Sector 2008 – 2010

Administration 20 persons within The National Board of Health established by:
- Danish Government (Ministry of Health and Prevention)
- Danish Regions
- Municipal Association

Responsible for:
- Management
- Structure - Design
- Coordination – Pilot projects - Networking

Each region responsible for individual development and implementation

---

**Architecture - Clinical Care Support**

Care documentation
- E-prescribing
- Medicine module
- Order management

Patient Administration
- Pricing and Billing,
- Scheduling and Bed Management

Incident Reporting and Intelligence
- Statistics

All architecture is built upon existing programs
The Era of HIM
Larger – Louder – Faster

3rd Quarter 2008

Bryon D. Pickard, MBA, RHIA
Vanderbilt University Medical Group, Nashville, Tennessee, United States of America
2007 President – American Health Information Management Association

The expansion and evolution of the electronic health record (EHR) continues to march forward throughout the United States, with an ultimate goal of transforming both health care and health. It is widely acknowledged that EHRs and the power of health information technology will lead to better quality and safety, lower costs and more patient-focused health care, which in turn will lead to improved population health.

Not only has health information technology become a top federal priority in the US, but is being widely embraced by state and local governments, the private business sector and individual citizens. Almost all states have established state-level health information exchange (HIE) initiatives, with primary emphasis to date focusing on governance and system interoperability. Maintaining the public trust by ensuring privacy and security standards are in place, is an essential element toward building a nationwide health information network.

A series of reports providing important health information principles and guidance for advancing HIE development are available at http://www.staterhio.org.

Personal Health Record (PHR)

As the transformation in the US health care system speeds up and new technologies and available EHR tools become more commonplace, the personal health record (PHR) gains prominence toward achieving consumer adoption. The functionality of PHRs is continuing to evolve, and privacy, security, and interoperability with EHRs and other data sources are the attributes of greatest magnitude. The Certification Commission for Healthcare Information Technology (CCHIT), the officially recognized body for ambulatory and inpatient EHR certification will launch a new PHR certification process in mid-2009.

Information on privacy protections and other resources and tools for creating a personal health record (PHR) are available at http://www.myphr.com.

Office of the National Coordinator (ONC)

The Office of the National Coordinator for Health Information Technology (ONC), an office within the Department of Health and Human Services, has developed a health IT strategic plan, outlining action steps to be taken during the next 5-year time period covering 2008-2012. The ONC is charged with facilitating federal health IT initiatives directed toward advancing the federal government goal for a majority of Americans to have access to EHRs by the year 2014. Specified goals and objectives outlined in the strategic plan center around four key areas: 1) privacy and security; 2) interoperability; 3) adoption; 4) collaborative governance.

As of today, there is still much work to be done and adoption of health IT among physicians is at a point where less than one of every five physicians makes use of an EHR in their daily practice. Actual EHR adoption rates and usage of full functionality of the EHR can vary widely depending on the size of a physician practice. Momentum is quickly building, however, and implementation of proper incentives and other specified action items in the ONC strategic plan over the next 5-year period will greatly expand EHR usage and the eventual sharing of data through a national health information network.

In their strategic plan, the ONC acknowledges that the coordinated efforts of health information management professionals are vital to an effective and efficient health care system.

Commission on Accreditation for Health Informatics and Information Management Education (CAHIIM)

The US Department of Labor Bureau of Labor Statistics recognizes a need for skilled health information management (HIM) professionals and projects HIM as one of the higher growth health occupations for the next several years. To help grow and strengthen a qualified HIM workforce in the US, and advance health information management practice education, the Commission on Accreditation for Health Informatics and Information Management Education (CAHIIM) applies approved standards of accreditation to review and accredit degree-granting HIM educational programs.
Currently, over 250 masters, baccalaureate and associated degree HIM educational programs are publicly recognized as having been granted accreditation status by CAHIIM; http://www.cahiim.org.

Proposed Adoption of ICD-10 Code Sets

The Department of Health and Human Services announced a proposed regulation to move forward with the transition to ICD-10 code sets, and replace the existing version ICD-9-CM used for reporting health care diagnoses and procedures in the US. An effective date to be in compliance with the updated classification system is established as October 1, 2011. Additional information on the proposed rule (NPRM) is available in the Federal Register; Modification to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS http://www.cms.hhs.gov/apps/media/fact_sheets.asp.

A final rule on the proposed transition to ICD-10-CM and ICD-10-PCS will be issued after a period of public comment and responses to written comments have been made. The implementation of ICD-10 is widely viewed as a crucial element to moving forward with the transition to electronic nationwide health information network.

Bryon D. Pickard, MBA, RHIA
Vanderbilt University Medical Group
2146 Belcourt Avenue
Nashville, Tennessee 37212
United States of America
bryon.pickard@vanderbilt.edu

http://www.ahima.org
The History of IFHRO

Dear friends,

We hope you enjoy the Power Point Presentation of “The History of IFHRO (1949 – 2004)”. The disc will start automatically after ca. 40 sec. and last for ca. 25 minutes – please turn the speakers on.

It was first presented at the 15th IFHRO Congress held in Seoul / Korea in 2007 along with the full paper version of “The Story of IFHRO” - which was carefully put together by Phyllis J. Watson.

This Presentation is dedicated to all who contributed to IFHRO’s development, particularly Elsie Royle Mansell and the many professionals - not only Presidents and members of the Executive, but also others who have worked on projects, have participated on committees, organized Congresses and given their time to assist developing countries in an endeavour to improve medical record services around the world.

We believe that as members of IFHRO it is important to understand how the International Federation of Health Records Organizations developed from 1949 to today; remember the many ups and downs of the past; and recognize the early pioneers who worked so hard in an honorary capacity to make it an important and viable organization in the 21st Century.

If you are interested in this CD, please let us know, we’ll send it to you in appreciation of your involvement in IFHRO’s activities.

With best wishes,
Yours sincerely
Phyllis Watson and
Ulli Hoffmann
Email: Ulli.Hoffmann@online.de
Calender of Events:

- **Ahima Convention & Exhibit:**
  - **Ahima National Meeting**
  - October 11 – 16, 2008
  - Seattle / USA

- **IFHRO SEAR conference**
  - October 21 – 23, 2008
  - Bali / Indonesia

- **DVMD (German National Meeting)**
  - April 01 – 04, 2009
  - Ludwigshafen / (Germany)

- **16th IFHRO Congress**
  - November 08 – 12, 2010
  - Milan / Italy

---

**Announcement:**


---

**Global News**

**Editorial Board:**

- Lorraine Nicholson, UK
- Margaret Skurka, USA
- Bryon D. Pickard, USA
- Angelika Haendel, Germany