Newfoundland & Labrador
Centre for
Health Information

PROVINCIAL REGISTRATION STANDARD

March 2020

Approved by the
Provincial Health Information Management Leadership Committee
June 8, 2011
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The Provincial Health Information Management Leadership Committee plays a key role in setting provincial health information standards, particularly those related to clinical and administrative data standards, and facilitating implementation within the public health system. The Committee also fulfills the role of the Client Registry Advisory Committee, by providing advice and making recommendations to the Newfoundland and Labrador Centre for Health Information, on matters related to the provincial Client Registry (a component of the Newfoundland and Labrador Electronic Health Record known as HealtheNL).

PROVINCIAL REGISTRATION STANDARD

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BACKGROUND

Accurate demographic information is essential for positive patient identification and the foundation for effective and efficient health information management regionally and provincially. This information is generally collected through the registration/admitting functions related to the provision of health services and is recorded in multiple information systems which support those services. Accurate demographic information is also key to exchanging health information between systems and using health data for secondary purposes such as health system planning, management, evaluation, policy development and research.

The Client Registry is the cornerstone of the provincial electronic health record (EHR) known as HEALTHe NL. Demographic and administrative data is collected at many points of registration within the Newfoundland and Labrador health system. Similar information is collected by community-based pharmacies that exchange demographic and drug information with the provincial Pharmacy Network, physician offices using the provincial electronic medical record (EMR), and the Department of Health and Community Services as residents of the province register for provincial health insurance coverage known as the Medical Care Plan (MCP).

The information captured within the registration module of MEDITECH, the Client and Referral Management System (CRMS), MCP, Vital Statistics, the Pharmacy Network, and Med Access (the provincial EMR) flow into the provincial Client Registry for use by these and other stakeholders. Information received from one source is available to the other approved sources to update the records of individuals as they present for services. Therefore, it is vital that only the most accurate, complete and up-to-date information be collected and exchanged.

To support the collection and exchange of high quality demographic and administrative data, the following registration protocol must be followed by all staff who enter this information into their local information system(s). Lack of adherence to these standards will cause incomplete and inaccurate information to be exchanged within the Client Registry and among stakeholder source and receiving systems, increasing the potential for health record mix-ups and overlays, privacy breaches, and decision-making based upon erroneous information.

PURPOSE

The purpose of this standard is to ensure accurate and complete demographic and administrative information is collected through standardized registration processes at all points within the health system. This includes situations where the patient is not available or not able to confirm demographic and/or administrative information.

REQUIREMENTS

When registering the patient/client/resident, staff must adhere to the following procedures. DO NOT register unidentified persons, stillbirths or individuals dead on arrival (DOAs) in this manner. See Appendices A and B for specific guidance related to registration for these groups. Specific guidance related to registration for Telehealth services is included in Appendix C.

SEARCH METHOD

To find the correct patient/client/resident in the most accurate and efficient manner, the search criteria order should be:

1. MCP number, e.g., #123456789001 (This typically results in a direct match.)
2. Hospital Card, CRMS ID, Unit numbers, e.g. U12345678
3. Patient/client/resident demographic information, e.g. Brown, Mary Date of Birth: 1980-01-01

Staff must validate and update information as appropriate by asking specific questions such as: What is your first/middle/last name? What is your mother's first name?

FULL LEGAL NAME FIELDS

Record the full legal name of the patient/client/resident in the last name, first name, and middle name fields of the registration system where available. In the MEDITECH system, a single name field is provided in which the name is entered as Last Name, First Names (separated by a comma and a 'space' between each first and middle names). The information should align with the name on the MCP card with few exceptions. In the case of long names and hyphenated names, MCP truncates the name to 28 characters and removes punctuation, including hyphens (due to MCP card physical limitations). Otherwise, registration staff are strongly discouraged from making changes to name fields unless the changes align with the information on the MCP card.

Use approved punctuation only, e.g. hyphen (-), apostrophe ('), period (.) and number sign (#) when the legal name includes such characters e.g., MARY-ANN, O'REILLY, ST. CLARE, BROWN-SMITH. All other punctuation, including quotation marks (""), parentheses (), asterisk (*), back slash (\),colon (:) and forward slash (/) is prohibited.

In cases where the middle name on the MCP card or registration system is blank or an initial, registration staff should ask the client for the middle name and update. Do not delete an initial unless more information can be added.

MCP inserts a '.' on the card when the person has no first or last name. Regardless of the system used, when a person has no first name and one or more surnames, enter the phrase "NO FIRST NAME" in the first name field and the person's single or multiple surname(s) in the LAST NAME field. In the case of a person with a first name but no surname, enter the person's name in the FIRST NAME field and the phrase "NO SURNAME" in the LAST NAME field.

If there is a typo on the MCP card (e.g. Mayr instead of Mary), it is recommended registration staff telephone MCP and advise of the discrepancy; or advise the patient to do so. If MCP can verify the correct data against its records, it will issue another card immediately. If MCP has no record of the typo, it requires legal documentation to make the change.

If there are other name changes or discrepancies, advise the patient/client/resident to submit the *Information Update* form to MCP with accompanying legal documentation (e.g. birth certificate). Alternatively the regional health authority (RHA) has the option to submit (fax) the completed documentation to MCP on behalf of the patient/client/resident.

When registering newborn babies or neonates, the mother's surname is used in combination with the first name expressed as BB OF_____ or BG OF _____, e.g. Brown, BB of Mary. The number sign (#) is added to indicate the birth order of multiple births as described below:

- BROWN,BB#1 OF MARY and BROWN,BB#2 OF MARY for same sex twins
- BROWN,BG#1 OF MARY and BROWN,BB#2 OF MARY for twins of both sexes
- BROWN,BG#1 OF MARY, BROWN,BB#2 OF MARY and BROWN,BG#3 OF MARY for triplets involving both sexes.

In systems that cannot accept numbers in the name field, the birth order number of multiple births should be spelled out, i.e. BB one, BB two.

When a newborn or neonate is determined to be intersex, or sex is unknown, register as:

- BROWN, BU OF MARY with Sex entered as "U".

For multiple births involving intersex or unknown sex, follow the above guideline using BU where appropriate.

This naming convention is used for the duration of the newborn's admission unless an MCP# is issued under the child's full legal name during the admission. In this case, the name can be updated in the registration system in accordance with the name on the MCP card. When the name is updated, 'BB of' or 'BG of' should be retained in the OTHER NAMES field.

MEDITECH, MedAccess (EMR) and CRMS users should register with the name as provided by the parent if a child returns for service after discharge but before an MCP card has been issued. CRMS users should apply the above newborn guidelines if the proper name is not recorded on the Live Birth Notification form. Any subsequent change to the name after first entering the child's name into the system requires the legal name change process.

Babies born of a surrogate mother should be registered in the same manner as other babies, using the birth mother's name and baby's name, if known. If a legal name change is ordered, the baby's name should be revised but not the mother's name. Once the adoption goes through, then the mother's name should be changed as well.

In the case of an unidentifiable person, register as JOHN or JANE DOE #1, #2 OR #3 as specified in Appendix A.

MOTHER'S NAME FIELD

Mother's Name Field is used to record the birth (or adoptive) mother's first name only; the names of step-mothers, other relatives, non-relatives or guardians are not permitted. This information is used for patient identity management purposes only and in the interest of patient safety to distinguish patients from those with the same or similar names. It is not used for notification purposes. Information recorded in the Mother's Name Field is exchanged with the Client Registry.

In the case of two same-sex parents, record both first names, separated by a space, in the Mother's Name Field.

This field is mandatory in some, but not all, systems. If the mother's first name is not known or available in the Client Registry, where mandatory, enter 'unknown'; where not required, leave blank.

While changes to the Mother's Name Field are uncommon, changes may be made upon request if the mother has made a legal name change which may or may not be associated with a gender change as well.

MAIDEN NAME FIELD

This field records patient/client/resident surname prior to first marriage.

OTHER NAMES FIELD

This field records additional names, derivatives or nicknames of a patient/client/ resident if required. It can record multiple surnames.

SEX FIELD

This field is used to record the sex at birth of the patient/client/resident and must align with the data in the Client Registry. Gender information cannot yet be recorded in RHA registration systems; however, currently individuals are given the opportunity to choose to change the sex previously recorded as Male or Female to Unknown or in the case of errors or gender transformation from/to Male or Female. This may change in the future as new standards are developed for recording sex and gender information.

ADDRESS FIELDS

Address Fields are used to record a single, primary mailing address for the purpose of mail notifications or appointments and other correspondence. The primary address recorded for a person should be the mailing address of the permanent home; temporary addresses are considered secondary.

CRMS has the capability of recording the mailing address and the street address in separate fields. Some facilities have MEDITECH customer defined screens to collect this information.

Post office box, Box number or Rural Route should be recorded as:

When there is a mailing address in addition to a street address:

Line 1: PO Box 555	Line 1: Box 555	Line 1: RR 6 Station Main
Line 2: 70 O'Leary Avenue	Line 2: 70 O'Leary Avenue	Line 2: 70 O'Leary Avenue

When there is a mailing address only (no street address provided):

Line 1: PO Box 555	Line 1: Box 555	Line 1: RR 6 Station Main
Line 2:	Line 2:	Line 2:

Street address only should be recorded as:

Line 1: 70 O'Leary Avenue	Line 2:	Line1: 70 O'Leary Avenue
Line 2:		Line 2: Apt 22

General Delivery should be recorded as such, not abbreviated as G/D, GD, GenDel or any other variation.

Line 1: General Delivery

Line 2:

It is at the discretion of the patient/resident/client to provide a mailing address when s/he is living in a temporary shelter. If desired by the patient/resident/client, staff shall collect the mailing address of a friend or relative or the mailing address of the shelter (do not include shelter names, e.g. Iris Kirby House) to receive correspondence.

- MEDITECH users record "No Known Address" if no address is available
- CRMS users record a blank Mailing Address Field if no address is available. The shelter address (but not name) may be recorded as the Preferred Address (Temporary).

When a child in protective custody presents to an RHA for service, the onus is on the person accompanying the child (e.g. social worker, foster parent) to register according to the appropriate Department of Children, Seniors, and Social Development (CSSD) guideline/s. When recording the mailing address for CSSD clients, do not include the phrase or acronym 'Department of Children, Seniors and Social Development (CSSD)' in any of the address fields.

The local address of transient workers, incarcerated persons or vacationers (e.g. cottagers, travelers) is considered a temporary residence and the family home should be recorded as the permanent address.

The phrase "No Known Address" should be used to record the address of homeless people and unidentifiable people (e.g. John and/or Jane Doe).

In the case of people who refuse to, or cannot, provide their address to registration/clinical staff upon presentation for services, staff who are Meditech users should query the Client Registry and accept Client Registry information if available. Users without Client Registry query capability should use local information (if it exists) otherwise a new record should be added to the local system using "No Known Address," which can be updated if/when the patient/resident/client can be identified.

POSTAL CODE FIELD

Format must be alphanumeric (e.g. A1B 2C7). Visit www.canadapost.ca *'Find a Postal Code'* to use Canada Post's free Postal Code look-up tool.

Do not skip, bypass or add incomplete/invalid data such as a mini postal code (NL), XIX IXI or other variations as these actions cause data quality issues and impact use of the data. There are two exceptions to this rule:

- In the case of unidentifiable people (i.e. John and/or Jane Doe), use the postal code of the registering facility as specified in Appendix A.
- In the case of postal codes that are unknown, unavailable or not yet assigned by Canada Post, use A9A 9A9.

EMAIL ADDRESSES

Email addresses are not collected as part of the core registration information but may be recorded in customer-defined screens within the MEDITECH ADM module if a person has identified email as the preferred mode for receiving appointment notifications.

PHONE NUMBER FIELDS

Must include the area code (e.g. 709-752-6006). If the phone number is unknown, enter 000-000-0000. Do not add text based qualifiers or any other punctuation, e.g. 709-752-6006 (father).

DATE OF BIRTH FIELD

This field is used to record the patient's date of birth (DOB).

MEDITECH users enter January 1, 1850 if date of birth is unknown (e.g. in the case of unidentifiable people such as John and/or Jane Doe). CRMS users leave this field 'blank' if the date of birth is unknown.

If a date of birth discrepancy is discovered during the registration process, no change to a DOB should be made unless it is supported by appropriate legal documentation (e.g. birth certificate). If there is an error in the DOB recorded on the MCP card, advise the client to request correction by submitting the *Information Update* form to MCP with accompanying legal documentation (e.g. birth certificate).

REGISTRATION OF LABORATORY SPECIMENS

In addition to the above: LABORATORY Staff require additional registration procedures when processing 'Requisition Only' rather than in-person registration.

Situations occur where the patient does not present for services but services are provided on behalf of the patient, e.g., specimen analysis. When the registration is performed based on a requisition:

- Users with CR query capability (such as MEDITECH users) should query the Client Registry and accept Client Registry information if available, matching at minimum two of three key identifiers (1. MCP number, 2. Name, 3. Date of Birth)
- Users without CR query capability should use local information (if it exists), matching at minimum two of three key identifiers (1. MCP number, 2. Name, 3. Date of Birth)
- When no match occurs, a new record should be added to the local system

When Med Access (EMR) generated requisitions are received, staff must accurately enter the EMR Clinic mnemonic into the MEDITECH system in the Other Provider field. This is required to ensure correct routing of lab results to the requesting provider within the EMR. Do not enter it in the Consulting Provider Field as it creates an error in the system and the results do not go to the correct clinic/provider.

Changing administrative or demographic information based on the information provided on the requisition and/or specimen is strongly discouraged. In limited situations, test results are de-identified to some degree to protect the patient/resident/client's privacy. To avoid potential re-identification and linkage to the patient/resident/client's record in the Client Registry, staff should seek direction from their manager.

AUTHORIZATION TO CHANGE REGISTRATION DATA

The following table identifies the demographic and administrative data elements commonly collected through registration processes and the appropriate person(s) authorized to make changes to this information.

DATA ELEMENT	Can be updated at a self-registration kiosk by the patient; identity is verified by MCP# for NL residents. Can also be updated by a registration clerk during a fact-to-face registration.	Can be updated by phone; identity is verified by name, date of birth and HCN (MCP# for NL residents). Can also be updated by a registration clerk during a fact-to-face registration.	Can be updated by letter or email; identity is verified by name, date of birth and HCN (MCP# for NL residents). Can also be updated by a registration clerk during a fact-to-face registration.	**Must be updated by a Registration Clerk/Clinical Service registration lead.** Identity is verified through the usual registration process, supported by official documentation for name/sex change requests.
Name				✓
Address	✓	✓	✓	
Telephone Numbers	✓	✓	✓	
Date of Birth				✓
Sex				✓
Health Care Number (HCN) (both MCP and out of province/country HCNs)				✓
Next of Kin	✓	✓	✓	
Marital Status	✓	✓	✓	
Person to Notify	✓	✓	✓	
Mother's First Name				✓
Preferred contact method for automated notifications	✓	✓	✓	
Family Physician		✓	✓	✓
Attending Physician				✓
MCP Expiry Date				✓
Other Insurance Details				✓

Changes to demographic and administrative data collected during registration processes can only be requested by the individual, a parent, guardian, or substitute decision-maker as designated in an Advanced Health Care Directive. In the case of a child in care, the social worker assigned to that child may make the request.

While infrequent, there are situations in which patients cannot provide their health care card for registration. Registration may be conducted if supported by presentation of a picture/photocopy of a health care card, or a representation of a card on a mobile app; however, any requests for information changes are limited to those allowed at a self-registration kiosk.

When a request for change is made that is not attached to a specific appointment or visit, the requester may be asked to sign a release to ensure a record of the request for change is available for audit purposes.

Questions regarding this standard can be directed to:
Clinical and Administrative Standards
Health Information Standards and Quality Division
Newfoundland and Labrador Centre for Health Information (NLCHI)
Telephone: (709) 752-6000

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Issued: 2008-12-09, Re-issued 2011-06-08, 2013-06-13, 2016-04-14, 2017-02-27, 2019-02-28, 2019-09-25; 2019-12-10
Distribution: Provincial HIM Leadership Committee, Provincial Registration Committee, NLCHI, CRMS Standards Sub-Committee, and DHCS (MCP)

APPENDIX A: REGISTRATION OF UNIDENTIFIABLE PERSONS

Purpose

This standard has been developed to standardize the data collected during the registration of unidentifiable persons. This will improve the consistency and accuracy of the information within the local MEDITECH system and the data shared with the provincial Client Registry. This will minimize the risk of duplicate records and erroneous patient/record identification once the identification of the person is established.

Registration Requirements

Prior to initiating a new registration in the MEDITECH system for an unidentifiable person, staff should do a look up in the system for any existing John/Jane Doe's. Each John/Jane Doe registered should receive a new unit number.

The following data fields are required as a minimum data set to save a registration record for an unidentified person in the MEDITECH systems of the regional health authorities. Where necessary, the applicable valid value is prescribed and noted below. Where a selection from a dictionary is required and will be dependent on the situation, the phrase 'dictionary selection' is noted for the field.

Data Field	Prescribed Value to Record for an Unidentifiable Person
DEMOGRAPHIC INFORMATION SCREEN	
Name	JOHN OR JANE DOE #1, #2 OR #3, etc #1 should be included even if there is no other John/Jane Doe registered at that time.
Street 1	NO KNOWN ADDRESS
City	NO KNOWN ADDRESS
Province	NL
Postal code	Postal code of the facility
Home phone	000-000-0000
REGISTRATION SUMMARY SCREEN	
Registration category	Dictionary selection
Date of birth	01/01/1850
Sex	Dictionary selection
DOCTOR AND LOCATION INFORMATION SCREEN	
Attending physician	Dictionary selection
MEDITECH location	Dictionary selection
Service date	Dictionary selection
Service time	Dictionary selection
Admitting physician	Dictionary selection
Service	Dictionary selection
Admit priority	Dictionary selection
Requested ward accommodation	Dictionary selection
Smoke/object/neither	Dictionary selection
Room	Dictionary selection
Room rate accommodation	Dictionary selection

APPENDIX B: PROVINCIAL STANDARD RELATED TO REGISTRATION AND ABSTRACTING OF STILLBIRTHS AND MEDICAL OR SPONTANEOUS ABORTIONS RESULTING IN LIVE BIRTHS

Approved by the
Provincial Health Information Management Leadership Committee
April 20, 2012
Revised June 6, 2019

EFFECTIVE IMMEDIATELY

Background

Stillbirths

It has been mandatory to submit stillbirth abstracts to the Discharge Abstract Database (DAD) since April 1, 1995 as per direction from the Department of Health at that time.

In 2011, CIHI identified inconsistency between the stillbirth definition applied in the DAD and the classification of a stillbirth in ICD-10-CA. The previous DAD manual allowed for submission of a stillbirth abstract in the circumstances of a missed abortion (i.e. fetal death occurring before 20 weeks gestation) and in the circumstances of a termination of pregnancy before 20 weeks. For classification purposes in ICD-10-CA, a stillbirth is defined as any intrauterine fetal demise or termination of pregnancy occurring at or after 20 completed weeks of gestation in which the fetus shows no sign of life.

To align with the ICD-10-CA classification definition, the 2012-2013 DAD manual criteria for creating a stillbirth abstract was updated to read "any uterine fetal demise or termination of pregnancy occurring at or after 20 completed weeks of gestation in which the fetus shows no signs of life".

As of 2012-2013, it became optional to submit stillbirth abstracts to the DAD but Newfoundland and Labrador continued to submit this information as a mandatory requirement upon the request of Perinatal Program NL (PPNL). PPNL does not have a complete provincial database at this time and is using the DAD data (as well as additional fields not submitted to DAD) contained in the stillbirth abstracts on a provincial level for perinatal and maternal reviews.

Since that time, PPNL has requested data be collected and submitted to the DAD based on the definition of a stillbirth in the Vital Statistics Act 2009 of the province of Newfoundland and Labrador (NL) which is:

> "*the complete expulsion or extraction of a fetus of at least 500 grams in weight or at least 20 weeks gestation in which, after the expulsion or extraction, there is no breathing, beating of the heart, pulsation of umbilical cord or unmistakable movement of voluntary muscles".*

In addition to abstracting inconsistencies, registration practices for stillbirths vary across the regional health authorities (RHAs). This has implications for local and provincial information systems such as the EHR.

Medical and Spontaneous Abortions Resulting in Live Birth

There are additional variations between abstracting and registration practices for medical and spontaneous abortions resulting in live birth. There have been cases where an abortion (medical or spontaneous) have resulted in signs of life. From a Classification perspective, a live birth resulting from a medical or spontaneous abortion prior to 20 weeks is considered pre-viable; therefore, a code from category Z37 Outcome of delivery is not assigned on the mother's abstract and a newborn abstract is not created.

According to the Vital Statistics Act 2009, a live birth is:

> *"the complete expulsion or extraction from its mother, irrespective of the duration of pregnancy, of a product of conception in which, after expulsion or extraction, there is breathing, beating of the heart, pulsation of the umbilical cord, or unmistakable movement of voluntary muscle, whether or not the umbilical cord has been cut or the placenta is attached*".

A Live Birth Notification Form must be completed on all Live Births, regardless of the gestational age.

Purpose

In an effort to standardize the collection of data related to stillbirths in NL, as well as medical or spontaneous abortions resulting in live births, this standard has been revised to include direction for abstracting, RHA registration, Vital Statistics registration and PPNL data collection.

Stillbirths

Registration Practices related to Stillbirths

- Stillbirths should not be registered in the ADT module of Meditech. An account under the mother's name in Lab census should be used when available for all lab related work; the paper record should be placed in the mother's chart.
- For radiology follow up, RHAs should use the mother's account (e.g. PACS, X-rays). If paper chart diagnostic imaging records and reports exist, these should be placed in the mother's chart.
- As stillbirths are not registered in the Meditech system, an abstract will not be triggered in the
  3M Coding System and must be created through a manual process.

Registration of Stillbirth for Vital Statistics Purposes

- Stillbirth cases that meet the definition of a stillbirth according to the Vital Statistics Act 2009 must be reported to the Vital Statistics Division of Service NL via the Registration of Stillbirth form.
- A copy of the form is retained on the health record of the mother.
- RHA staff are referred to Vital Statistics for general information and recording requirements for a registration of a stillbirth.

Abstracting Requirements for Stillbirths

- Stillbirth cases that meet the definition of a stillbirth according to the Vital Statistics Act 2009 must be abstracted and submitted to the DAD (mandatory requirement). This will be noted as a provincial variation to Section 3, Stillborn Abstracting in future DAD manuals.
- HIM coders will create an abstract when a Registration of Stillbirth form is attached to the mother's chart.
- HIM coders are referred to the Stillborn Abstracting section of the DAD manual for general information and recording requirements for a stillborn abstract.

Perinatal Program Newfoundland and Labrador (PPNL) Data Collection Requirements for Stillbirths

- Additional data elements are collected within the 3M System upon the request of PPNL to augment the information collected on the DAD abstract related to stillbirths.
- Coders are referred to PPNL documentation for general information and specific recording requirements related to this additional data collection and reporting process.

Medical or Spontaneous Abortions Resulting in Live Births

Registration Practices related to Medical or Spontaneous Abortions Resulting in Live Births

- When a medical or spontaneous abortion results in a Live Birth, regardless of gestational age, weight or the duration of signs of life, register both the mother and the newborn in the appropriate category in Meditech.
- If the live born subsequently passes away, the discharge disposition must be "Expired".

Registration of Live Birth for Vital Statistics Purposes

- In accordance with the Vital Statistics Act 2009, a Live Birth Notification Form must be completed on all Live Births, where, irrespective of the duration of pregnancy, there are signs of life (breathing, beating of the heart, pulsation of the umbilical cord or unmistakable movement of voluntary muscle, whether or not the umbilical cord has been cut or the placenta attached). A copy of the form is retained on the health record of the liveborn.

- RHA staff are referred to Vital Statistics for general information and recording requirements for a registration of a live birth.

Abstracting Requirements for Medical or Spontaneous Abortions Resulting in Live Births

- When a medical abortion at or after 20 weeks gestation results in a liveborn, abstracts are completed for the mother and the liveborn.
- When a medical or spontaneous abortion prior to 20 weeks gestation results in a liveborn, an abstract is completed for the mother only. There is no abstract completed on the liveborn. Due to the difference in direction from registration versus coding requirements, HIM coders will be required to delete the liveborn abstract that is created from the registration (in jurisdictions with an interface from the ADT module in Meditech to 3M).

Perinatal Program Newfoundland and Labrador (PPNL) Data Collection Requirements for Medical or Spontaneous Abortions Resulting in Live Births

- When a medical abortion at or after 20 weeks gestation results in a liveborn, abstracts are completed for the mother and the liveborn, and PPNL information is collected.
- When a medical or spontaneous abortion prior to 20 weeks gestation results in a liveborn, PPNL information may be collected on the mother's abstract.
- Coders are referred to PPNL documentation for general information and specific recording requirements related to this additional data collection and reporting process.

Questions regarding this standard can be directed to:

Clinical and Administrative Standards
Health Information Standards and Quality Division
Newfoundland and Labrador Centre for Health Information
Telephone: 752-6000

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Revised: June 6, 2019

APPENDIX C: REGISTRATION FOR TELEHEALTH SERVICES – THIS STANDARD IS CURRENTLY UNDER DEVELOPMENT

Background

Telehealth is defined as the use of communications and information technology to deliver health care services over large and small distances, including remote and rural areas (Canada Health Infoway).

Telehealth enables the delivery of equitable health services to patients in Newfoundland and Labrador, regardless of location. By reducing the need for patients, family and specialist travel, Telehealth enhances the continuity and capacity of care throughout the health care system.

Registration Guidelines

The method of service delivery should not be the determining factor in registration. All patients/clients/residents presenting for services must be registered to the applicable functional centre providing the service.

Registration is necessary for several reasons:

- Accurate identification of the person to receive services within the information system of the regional health authority (RHA) and access to the health record belonging to that person;
- Continuity of care;
- Accountability from a risk management perspective; and
- Accurate utilization statistics derived from the registration system.

In the case of a Telehealth visit, there are usually two different sites (and their applicable functional centres) involved with that visit; a referral site to which the person presents for service and a host site in which the primary provider is located. The person must be registered at the referral site as well as at the host site providing the consultative service. By doing so, clinicians can access the person's health record in local electronic systems for review and documentation as well as support tracking of services.

During the MEDITECH registration process the functional centre providing the service to the patient is identified in the 'LOCATION' data field within the MEDITECH registration screens. The functional centre should be a valid functional centre, in compliance with the Provincial Chart of Primary Accounts. When a client presents for a Telehealth visit at a community health office, the person may be registered in MEDITECH or registered in CRMS and the applicable program/service (i.e. functional centre) is associated with that visit.

There is significant variation in how Telehealth services are supported within the RHAs. In some situations, a person may present for a Telehealth service but not receive any services from a health care provider at that site, e.g. a person registers upon arrival at the local Health Centre, proceeds to a videoconference-equipped room and has a half hour session with a specialist located in another facility.) Registration is still required for purposes of continuity of care and risk management in such situations. In this scenario, the applicable referral site functional centre cannot be identified so the 'LOCATION' can be recorded as 'Telehealth'. By doing so, visit statistics will be accurately reported for each valid functional centre and not overstated while still capturing those that did not involve a health care provider on the referral site.

The physician/service provider providing the service remotely can be recorded as the 'Attending Physician' if the visit does not include a physician on the referral site. This information may be found on Telehealth iScheduler reports provided to registration staff or provided directly by the patient/resident/client.

Additional details related to a visit can be recorded in the 'REASON FOR VISIT' field. Such details would be visible in the Visit History of the Meditech Patient Care Inquiry (PCI) but would not be useful for statistical reporting purposes.

APPENDIX D: PROVINCIAL REGISTRATION STANDARD FOR AUTOPSY SERVICES

Approved by the
Provincial Health Information Management Leadership Committee
Initial Approval 2015 -03-13, - Revised 2016-12-09
EFFECTIVE IMMEDIATELY

Background

Over time, the regional health authorities have adopted inconsistent registration practices related to autopsy services. These practices cause difficulty in managing the health record of the deceased person at the regional level as well as impact provincial information systems such as the provincial electronic health record.

Purpose

This standard has been developed to promote consistency in registration processes related to autopsy to ensure accuracy and completeness of the local health record while minimizing negative impacts on the quality of data exchanged with provincial information systems.

Scope

This standard does NOT apply to forensic autopsies. The findings of forensic autopsies are usually documented external to the local Meditech system, as per the direction of the Medical Examiner.

In addition, this standard does NOT apply to bodies brought directly to the morgue that have already been pronounced and for whom no further intervention services are required; such bodies should not be registered.

Registration Requirements of Related to Autopsy Services

- In the case of bodies brought to hospital (usually to the Emergency Department) **for pronouncement**, the decedent should be registered in the ADT module of the hospital information system with an ER account. The ER account should be used to attach diagnostic testing and results.

  If a person dies post CPR or other treatment in the Emergency Department and is pronounced dead, diagnostic imaging and laboratory testing done after death for autopsy purposes should be attached to the ER account.

- In the case of bodies dead on arrival (DOA) to the health care facility that **have already been pronounced** but require further diagnostic interventions, registration is required as follows:

- If only diagnostic imaging (DI) services are needed, register the body in the Admissions (ADM) module as a DI Referred registration with a location of Autopsy. The service date/time of the account must be the same as the date/time of death.
- If only laboratory autopsy services are needed, register the body in the Laboratory module in Lab Census with a designated location as specified by the regional health authority.
- If both diagnostic imaging and laboratory autopsy services are needed, register the body in both the Radiology/Diagnostic Imaging and Laboratory modules of the hospital information system as noted above.

- Autopsy services conducted and documented after the death of a registered inpatient should be attached to the inpatient registration only when the autopsy is performed within the same facility. When a body is sent to another facility for autopsy, it should be considered a DOA and registered as per the directions above.

Questions regarding this standard can be directed to:

Clinical Standards and Information
Data Quality and Standards Division
Newfoundland and Labrador Centre for Health Information
Telephone: 752-6000

Master Index Reference No: 2015-01; Appendix D of the Provincial Registration Standard Master Index Reference No: 2008-07
Issued: May 8, 2015, Re-issued 2016-12-09

Distribution: Provincial HIM Leadership Committee, Provincial Coding Committee, Provincial Registration Committee, Lab Advisory Committee and NLCHI

APPENDIX E: PROVINCIAL GUIDELINE FOR USE OF LEAVE OF ABSENCE FEATURE IN ACUTE AND LONG TERM CARE SETTINGS

Approved by the
Provincial Health Information Management Leadership Committee
December 9, 2008

Background

Over the past two years, the Health Information Management Leadership Committee has discussed the use of the Leave of Absence (LOA) feature in various health care settings. This issue was identified through the development of a provincial mandate to address coding and abstracting practices related to patients failing to return from pass. That mandate was approved on September 28, 2006 and regional policies were to be updated to reflect this decision. Questions arose regarding the appropriate handling in the registration system of patients that leave the hospital on a pass.

On November 30, 2006, the Provincial HIM Leadership Committee agreed that the LOA feature would be used in the Meditech registration system when patients leave an acute care facility on pass. Although the LOA feature was being used by some long term care facilities for residents who leave for short periods of time, this practice was not approved for use in long term care settings until further research was undertaken regarding the impact on financial systems of adopting this same practice in that setting.

Use of the LOA feature in the acute care setting was reaffirmed by the Committee on March 12, 2007 but implementation remained slow and inconsistent. Use in the long term care sector was still being considered.

Members of the Committee consulted with various people within their organizations, particularly risk managers, utilization managers, nurse managers, finance, IT and Health Information Management staff regarding use of the proposed standard in both the acute care and long term care settings. To date, no significant deterrent to using this feature from a financial systems point of view has been raised by the regions. Feedback from some have questioned the need for use of the LOA feature if the absence of the patient or resident is documented elsewhere, e.g. on the patient/resident chart. While this type of documentation meets the most basic need to know if a patient/resident is not “in house”, it does not ensure accurate statistical reporting.

Several regions currently use or are planning to use the leave of absence feature as the means to identify patient and /or resident absences.

Purpose

To standardize the use of the LOA feature in the Meditech registration systems to ensure:

- Patients/Residents whereabouts are clearly identified on a patient roster,
- Beds remain assigned to a specific person,
- Patient/Resident days are accurately recorded, and
- Patient/Resident billing practices are not adversely affected.

Requirements

Regional health authorities are encouraged to consider this guideline in the development of regional policies and procedures related to patients/residents on a leave of absence. Adoption of this guideline will ensure consistent practice in identifying patient/resident whereabouts, as well as accurate statistical reporting throughout the province.

Admission Update Process

When a patient leaves an **acute care facility** on pass or for a short period of time and is expected to return, the nursing unit staff will notify the Admitting Department **upon departure**. Upon notification, admitting staff will activate the Leave of Absence (LOA) feature in the Meditech Admission system. Upon the patient's return to the facility, the nursing unit staff will notify Admitting. The Admitting staff will return the patient from the leave of absence. If the patient is on an LOA, the patient must be returned from the LOA status before being discharged.

When a resident leaves a **long term care facility** on pass or for a short period of time and is expected to return, the Leave of Absence (LOA) feature in the Meditech registration system should be activated by way of the process noted above. The most common situation in which the LOA feature would be used is that of a resident transferred to an acute care facility and **is expected to return** within a relatively short period of time (days, weeks) rather than an indefinite period of time or a resident who returns 'home' for Christmas.

When implemented, regional admission policies should be updated to reflect this guideline. Members of the Provincial HIM Leadership Committee are available within each region to assist in policy development and implementation.

Questions regarding this guideline can be directed to:

Health Information Standards and Quality Division
Health Data and Information Services
Newfoundland and Labrador Centre for Health Information
Telephone: (709) 752-6000

Master Index Reference No: 2008-04; Appendix D of the Provincial Registration Standard Master Index Reference No: 2008-07
Issued: January 13, 2009

Distribution: Provincial HIM Leadership Committee, Provincial Coding Committee, and NLCHI. Regional representatives to distribute to registration/admitting staff, nursing staff and those with registration duties after hours within the region.

APPENDIX F: PROVINCIAL POLICY RECOMMENDATION FOR DOCUMENTATION REQUIREMENTS FOR CHANGE OF NAME, DATE OF BIRTH AND/OR SEX

Approved by the
Provincial Health Information Management Leadership Committee
2012-03-21
Revised 2013-06-14

PURPOSE

The purpose of this policy recommendation is to standardize the documentation requirements to support a change/amendment to the name, date of birth and/or sex of patients/clients/residents as recorded in the information systems of the Regional Health Authorities (RHAs). This will support accurate patient identification within the registration systems of the RHAs and the provincial Electronic Health Record (EHR) environment.

PROCESS

The Provincial Health Information Management Leadership Committee (Provincial HIM Leadership Committee or Committee) is responsible for setting provincial health information standards and facilitating implementation within the public health sector. The Committee also fulfills the role of the Client Registry Advisory Committee, by providing advice and making recommendations to the Newfoundland and Labrador Centre for Health Information (Centre) on matters related to the provincial Client Registry (a component of the Newfoundland and Labrador EHR.

A working group reporting to the Provincial HIM Leadership Committee was struck in 2011 to develop recommendations to standardize the documentation requirements to support a change/amendment to the name, date of birth and/or sex of patients/clients/residents as recorded in the information systems of the RHAs. Members will facilitate adoption and integration of the recommendations into relevant policies and procedures of the RHAs.

POLICY RECOMMENDATION

SCOPE

This policy applies to all personnel performing registration activities within the Regional Health Authorities.

POLICY

Requests for change of name, date of birth and/or sex will be accepted and changes or amendments will be made to these key identifiers only when supported by the appropriate documentation.

POLICY SPECIFICS

Residents of Newfoundland and Labrador

The name, date of birth and/or sex recorded on the provincial health insurance card (MCP card) is considered the source of truth. Requests for changes will be accepted and changes or amendments made to these identifiers in the information system if the information is contained on the person's active MCP card. No changes should be made in the registration system unless the name, date of birth and/or sex requested matches that on the MCP card.

Residents of other provinces and territories of Canada, with an active Health Care Number (HCN)

The name, date of birth and sex on the provincial health insurance card is considered the source of truth. Requests for changes will be accepted and changes or amendments made to these identifiers in the information system if the information is contained on the person's health insurance card with an active HCN. No changes should be made in the registration system unless the name, date of birth and/or sex requested matches that on the health insurance card.

Residents of NL without an active MCP card
Residents of other provinces and territories without an active HCN
Federal Employees (e.g. Military)
Residents of Other Countries

Requests for changes to name, date of birth and/or sex will be accepted and changes or amendments made to these identifiers if the person presents a government issued photo ID such as a passport, federal identification card, driver's license, or provincial photo identification card to support this change.

NOTE: It is acknowledged that the government departments or agencies that issue such photo identification have vetted the appropriate legal and medical documentation provided by the person to support the application for the card or changes to the name, date of birth and/or sex prior to issuance.

RELATED PROCEDURES

Residents of Newfoundland and Labrador
Residents of other provinces and territories of Canada, with an active Health Care Number (HCN)

Registration systems can be updated based on a client's request for a change to his/her name, date of birth and/or sex when the request aligns with the name, date of birth and/or sex on the person's active MCP card or active health care insurance card from another province or territory. <u>If the information does not match, no change should be made in the registration system.</u>

When a typo is suspected on the MCP card (e.g., Mary vs. Mayr), registration staff should telephone MCP and advise of the discrepancy. If MCP can verify the correct data against its records, it will issue another card immediately and registration staff can make the requested change in the registration system. If not, residents of NL should be advised to complete and submit the *Information Update* form with the required supporting documentation to MCP. Alternatively the RHA has the option to submit the completed documentation to MCP on behalf of the patient/client/resident.

Residents of other provinces should be advised to apply to their provincial health insurance plan for changes to the name, date of birth and/or sex.

Only when the change to the name, date of birth and/or sex has been made on the health insurance card should the change(s) be made in the registration system.

Residents of NL without an active MCP card
Residents of other provinces and territories without an active HCN
Federal Employees (e.g. Military)
Residents of Other Countries
Registration systems can be updated based on a person's request for a change to his/her name, date of birth and/or sex when the request aligns with the name, date of birth and/or sex recorded on the person's government issued photo identification document.

BACKGROUND

A person must be 19 years of age or older to legally change one's name. If under 19 years of age, a parent or legal guardian must complete the process on behalf of the minor unless under circumstances acceptable under *the Act to Provide for Change of Name.* For example, a child may legally change his/her name where he/she has been married, a co-habitating partner, or is a parent of a child. Readers are directed to *the Act* for examples of other exceptions.

Questions regarding this recommendation can be directed to:

Health Information Standards and Quality Division
Health Data and Information Services
Newfoundland and Labrador Centre for Health Information
Telephone: (709) 752-6000

Master Index Reference Number 2012-02
Issued 2012-03-23, Revised and Re-issued 2013-06-14