Title: Welcome to the future SNOMED CT in a live Primary Care Clinic

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Audience

Clinicians, vendors, standard implementers, digital health industry

Summary

eDOCSNL,Newfoundland and Labrador's provincial Electronic Medical Record program, is working within the Primary Health Care (PHC) community towards enhanced access to high quality health information. In the launch of a new PHC clinic in Western Newfoundland, we deployed a subset of SNOMED CT codes, mapped to ICD9 and ICD9-BILL, for the capture of diagnosis and other clinical concepts. This intervention is anticipated to improve information quality for primary and secondary usage, without interrupting EMR billing functionality.

Abstract

The use of free text and local terms in electronic medical records is widespread and is a source of poor data quality and a barrier to semantic interoperability, data mining, secondary use of data and computerized clinical decision support (1). The tools utilized within clinical practice are critical enablers of quality information capture. Electronic record-keeping presents a key opportunity to reduce usage of free text and unofficial terminology, while simultaneously improving workflow. This may be accomplished in the preparation of templates, care plans and other tools, sequenced and populated in accordance with natural clinical processes. This approach draws upon the use of tick boxes, drop-down menus, intuitive sequencing, and other formatting components designed to collect high quality health information while saving time and reducing errors.

eDOCSNL is working with stakeholders to determine requirements for EMR templates and other components to address a variety of clinical and administrative needs. A key learning is the necessity of designing information capture that respects the EMR software's capability to submit bills. Like many Canadian jurisdictions, Newfoundland and Labrador's public health insurer requires billing submissions to code diagnosis using ICD9-BILL. This limited code set presents a barrier in the ability to capture rich clinical data. In the interests of time and convenience, many clinicians choose to document diagnosis once, using an ICD9-BILL code. Inadequate documentation of clinical scenarios due to limited granularity of ICD9-BILL leads to reduced richness of information for primary or secondary use.

This presentation describes the deployment of SNOMED CT in a PHC Clinic. A subset of SNOMED CT codes was mapped to ICD9-BILL for enhanced capture of diagnosis, and the completion of BETTER Health Surveys. Approximately 230 templates utilizing the SNOMED CT subset are in use. To our knowledge, this is Canada's first example of SNOMED CT in live clinical implementation using EMR.

References

1. JAMIA web page: https://academic.oup.com/jamia/article/21/e1/e11/790126