UTILIZATION: The Good, the Bad, and the Ugly – What’s A Transfusion Committee To Do?

I CAN SEE CLEARLY NOW: Utilization Reports For Your HTC

Monday February 24th 2014, 13:45 – 14:15
Omni King Edward Hotel, 37 King Street East, Toronto

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I CAN SEE CLEARLY NOW:
Utilization Reports for Your HTC

Another colleague proposed (& generated the title of) this talk…

WHAT PUN WAS SHE HAVING FUN WITH?
32 months or 2 “TCF”s ago…

**ORBCoN’s 4th Annual Transfusion Committee Forum**

*Transfusion Committee Tools: Small Steps; Big Impacts*

Friday, September 23, 2011

Delta Chelsea Hotel, Toronto, ON

*Mountbatten Salon*

John Lentz MD
Dept of Laboratory Medicine; Chair, Transfusion Committee
York Central Hospital
Mackenzie Health – Richmond Hill, ON, L4C 4Z3

The Nidus of a Crystal: Making Utilization Reports Perfectly Clear

*Learning Objectives:*
1. Discuss strategies to clearly present blood product utilization reports to Transfusion Committees (TCs)
2. Promote awareness of the potential for interhospital comparison of utilization data
Figuratively to Literally: 

Crystal Reports

- A business intelligence application marketed by SAP AG for designing & generating reports from various data sources
  - PostgreSQL, Sybase, IBM DB2, Ingres, Microsoft (Access, Excel), Microsoft SQL Server, MySQL, Interbase, Btrieve, Oracle
  - HCLL & Meditech … (& even OLIS)

- Originally “Quick Reports” by Crystal Services Inc, filling a commercial report-writing void for their own accounting software
- Now up to version 14 after various mergers/acquisitions/re-branding
  - UHN on version XI
- Cost: $400 to 7000 USD

- Competitors in Microsoft market:
  - SQL Server Reporting Services, XtraReports, ActiveReports, List & Label

No affiliations/employment/honoraria/financial interests/stocks or shares (past/present/future)/material support/consultant or speaker contracts/subsidized product- featuring grants or research/desire to promote or monopolize
Words That We in Transfusion Medicine Live By

- “What gets measured gets managed.”

- “What doesn’t get measured doesn’t get managed.”

- “What gets measured gets done.”

- “To measure is to know.”

William Thomson, Scottish physicist, aka Lord Kelvin
Objectives

• Consider & identify the data which are relevant ± available for you to report to the Hospital Transfusion Committee (HTC).

• Envision the formats & construct the methods by which to provide these data.

• Deliver data in a manner that the HTC can strategically use & respond to.
What’s Relevant & Why?

Royal Commission of Inquiry on the Blood System in Canada, aka Krever Report, November 1997

• 20% of (10/50) recommendations apply to hospitals
  – 20% not applicable (!)
  – 40% relate to / incorporate informatics

#2: sufficiency of collections for patient access
#15: hospitals pay
#21: integrated database (donors, donations, & recipients)
#22: effective communication between NBS & hospitals
#23: supply by adequate storage (information & products)
#28: inform recipients of exposure
#40: active post-market surveillance of products & science
#47: report notifiable diseases & enforce this practice
#48: adverse reaction reporting to NBS ± manufacturers
#50: encourage the practice of transfusion medicine

Horace Krever, Final report: Commission of Inquiry on the Blood System in Canada [Krever report],
http://epe.lac-bac.gc.ca/100/200/301/hcan-scan/commission_blood_final_rep-e/
Informatics Mandates

In our information age society, data generated in the practice of TM will likely become increasingly viewed as a **product rather than as a byproduct**.

As a group, TM professionals have all the core skills necessary to obtain, maintain, transfer, monitor, retrieve, and guarantee the regulatory compliance of, quality of, and proper use of products. **Through partnerships with informaticians**, and targeted training for those with interest and aptitude, we can redeploy these core skills to supply high-quality data to improve transfusion care.”

“…databases shall no longer be graveyards with terabytes of data rarely looked at after the direct course of patient care. We need to support physicians with tools, to dig for hidden gold, to uncover the treasures buried in hospital medical records and to apply those data for strategic management decisions and research.”

Regulators & Accreditors

• domestic standards ± auditing bodies:
  – Canadian Statues & Regulations
    • Accreditation Canada (previously Canadian Council on Health Services Accreditation [CCHSA]).
    • Standards Council of Canada (SCC)
    • Canadian Standards Association (CSA) “Blood and Blood Components” Z902-10
    • Canadian Society for Transfusion Medicine (CSTM) Standards for Hospital Transfusion Services, Ver 3
  – Ontario:
    • Quality Management Program-Laboratory Services (QMP-LS): Ontario Laboratory Accreditation (OLA) & External Quality Assessment (EQA) via Institute for Quality Management in Healthcare (IQMH) [distributor]

• openness to standards ± audit from the US & beyond:
  – Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
  – American Association of Blood Banks (aaBB)/College of American Pathologists (CAP)
  – Clinical & Laboratory Standards Institute (CLSI) [formerly the National Committee on Clinical Laboratory Standards (NCCLS)]
  – International Standards Organization (ISO)
QMPLS – OLA, EQA, & IQMH: Laboratory Accreditation

- ISO 15189:2012 Medical laboratories – Requirements for quality and competence
- ISO 15190:2003 Medical laboratories – Requirements for safety
- ISO 22870:2006 Point-of-care testing (POCT) – Requirements for quality and competence
- CSA Z316.7-E12 Primary sample collection facilities and medical laboratories—Patient safety and quality of care—Requirements for transporting, and storing samples.

4.4 Transfusion committee

The transfusion service shall have a transfusion committee with documented terms of reference (defining, for example, its membership, scope of activity, and meeting frequency). The role of the committee shall be to provide consultative and support services with relation to transfusion practices and activities. The committee membership shall include key stakeholders, including physicians, nurses, transfusion staff, hospital administration, and other personnel as needed. It shall meet at least quarterly.

The purpose of the transfusion committee shall be to:

(a) help define blood transfusion policies as appropriate to the local clinical activities;
(b) ensure that regular evaluations of blood transfusion practices are conducted;
(c) set criteria for the evaluation of ordering practices, usage (including the discarding of blood and blood components), administration policies, and the ability of services to meet recipient needs;
(d) recommend corrective measures, if necessary;
(e) disseminate transfusion medicine information and education;
(f) evaluate reports of adverse transfusion events and all transfusion errors within the facility, as well as relevant federal and provincial or territorial reports on adverse transfusion events; and
(g) review available alternatives to allogeneic blood transfusion and make appropriate recommendations on their use.

Note: A transfusion committee may serve more than one facility, e.g., in a regional health care organization.

4.6.3 Periodic review and audits

4.6.3.1

The facility management shall review the quality system at specified intervals. Internal audits shall be performed at least annually to verify the continuing effectiveness of the system. These audits shall be carried out in accordance with an established program by trained personnel with well-defined responsibilities and authority who do not have direct responsibility for the procedures being audited. The findings of reviews and audits shall be documented.
1.8
A transfusion committee shall be established to:
   a. identify transfusion policies as appropriate to local clinical activities
   b. identify criteria for blood component and blood product utilization
   c. ensure regular audits of transfusion practices are performed, reviewed and appropriate corrective action taken
   d. identify inappropriate use of blood components and blood products and facilitate corrective action
   e. identify available alternatives to allogeneic blood transfusion and development of recommendations on their use
   f. ensure the dissemination of transfusion medicine information and education
   g. review reports of adverse reactions and errors in the facility, as well as relevant governmental reports on adverse transfusion events

9.2
Internal and external audit observations should be reviewed on a periodic basis to measure progress and to identify areas for improvement.

9.4
There shall be a process for preventive action following the review of the following sources:
   a. deviations, non-conformances and complaints
   b. self-assessment and audits
   c. external proficiency testing
   d. quality control records
What Are You Doing?

- Used/unused
  - YES
  - NO

- Harms/incidents
  - YES
  - NO

- Advanced analytics
  - YES
  - NO
Deducible HTC Reportables

- Component utilization
- Blood product wastage
- Blood product deviations
- Transfusion reactions
- Sentinel events, mistransfusions, near misses
  - Blood product utilization review
  - Transfusion profiles by clinical service
  - Other advanced user metrics

OrbCon Toolkits: Hospital Transfusion Committee downloadable documents
http://transfusionontario.org/en/cmdownloads/categories/transfusion/
Most US Transfusions Unnecessary

- vast majority of blood transfusions given to stable, non-bleeding patients are inappropriate, according to an expert consensus panel (15 researchers in anesthesiology, intensive care, hematology, oncology, surgery, and patient blood management) who reviewed 494 studies published over ~14 years (1/95 – 10/08)

<table>
<thead>
<tr>
<th>Scenarios</th>
<th>Medical (n = 180)</th>
<th>Surgical (n = 234)</th>
<th>Trauma (n = 36)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate, n (%)</td>
<td>23 (12.8)</td>
<td>27 (11.5)</td>
<td>3 (8.3)</td>
</tr>
<tr>
<td>Inappropriate, n (%)</td>
<td>94 (52.2)</td>
<td>148 (63.3)</td>
<td>25 (69.5)</td>
</tr>
<tr>
<td>Uncertain, n (%)</td>
<td>63 (35.0)</td>
<td>59 (25.2)</td>
<td>8 (22.2)</td>
</tr>
</tbody>
</table>

As little as 10%

Up to 70%


- **WHAT**:
  - ordered & received from CBS
  - used (vs remainder… [why not?])

- **SPACE (WHERE)**: if multi-site:
  - where you use it (as a surrogate for service),

- **TIME (WHEN)**: using it:
  - chronologically: annually, quarterly, monthly, daily, hourly

- **USER (WHO)**:
  - individuals or groups

- **INDICATION/JUSTIFICATION (WHY)**: How it is being used/appropriateness
  - qualitative vs quantitative indications (pre/post-Hb)
Our Place

University Health Network (UHN)
802 beds,
901,966 annual visits
(2012-2013)

Toronto General Hospital (TGH) -
416 beds; 235,766 visits

Princess Margaret Hospital (PMH)
124 beds; 403,868 visits

Toronto Western Hospital (TWH)
262 beds; 262,332 visits

Dominant programs requiring transfusion support

Red Blood Cell Disorders Program
Multi-Organ Transplant Program
Peter Munk Cardiac Centre
Surgery & Critical Care

Medical Oncology & Hematology:
Chemotherapy & Transfusion Centre
Blood & Marrow Transplant Program

Surgery & Critical Care
Krembil Neuroscience Centre
Arthritis Program
Levels of Inventory (RBCs) at TMC Hospital Sites

Timmins Region 1: Hornepayne, Hearst, Smooth Rock Falls, Kapuskasing
Timmins Region 2: Cochrane, Iroquois Falls, Kirkland Lake, Matheson, Englehart, Timmins
2012 Transfusion Utilization for Larger TMC Hospital Sites

<table>
<thead>
<tr>
<th>Units/Doses of Product</th>
<th>RBC Units Transfused</th>
<th>Plt Doses Transfused</th>
<th>Plasma Doses Transfused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toronto...</td>
<td>18326</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toronto...</td>
<td>14208</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Princess...</td>
<td>6140</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sunnybr...</td>
<td>10541</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women...</td>
<td>1161</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lakeridg...</td>
<td>5897</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lakeridg...</td>
<td>721</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lakeridg...</td>
<td>178</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Saull Area</td>
<td>3594</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>260</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1328</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2012 Transfusion Utilization for Smaller TMC Hospital Sites

- **RBC Units Transfused**
- **Plt Doses Transfused**
- **Plasma Doses Transfused**

<table>
<thead>
<tr>
<th>Location</th>
<th>RBC Units Transfused</th>
<th>Plt Doses Transfused</th>
<th>Plasma Doses Transfused</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homepayne</td>
<td>42</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Notre-Dame</td>
<td>79</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sensenbrenner</td>
<td>30</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Smooth Rock Falls</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lady Minto</td>
<td>138</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anson General</td>
<td>137</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bingham Memorial</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Englehart &amp; District</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Kirkland &amp; District</td>
<td>2</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Haldimand</td>
<td>27</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Weensебayko</td>
<td>14</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Sampling of Recent UHN HTC Reportables

- Blood utilization
  - current capabilities, tricks, & analytic plans under development

- Transfusion Reactions

- Safe Transfusion Practice Committee

- Surgical Blood Management Committee

- Blood Shortages

- Massive Transfusions
<table>
<thead>
<tr>
<th></th>
<th>TGH</th>
<th>PMH</th>
<th>TWH</th>
<th>UHN total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>71% of plt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>pRBC units transfused</td>
<td><strong>18,695</strong> 2%↑</td>
<td><strong>12,931</strong> 9%↓</td>
<td><strong>3,358</strong> 5%↑</td>
<td><strong>34,984</strong> 2%↓</td>
</tr>
<tr>
<td>platelet units</td>
<td><strong>2,264</strong> 6%↓</td>
<td><strong>6,419</strong> 5%↑</td>
<td><strong>298</strong> 8%↑</td>
<td><strong>8,981</strong> 3%↑</td>
</tr>
<tr>
<td>(adult doses) transfused</td>
<td>(451 SDAP, 1813 BCP)</td>
<td>(1861 SDAP, 4558 BCP)</td>
<td>(80 SDAP, 218 BCP)</td>
<td>(2,392 SDAP, 6,589 BCP)</td>
</tr>
<tr>
<td>plasma units</td>
<td><strong>9,210</strong> 17%↑</td>
<td><strong>1,053</strong> 35%↓</td>
<td><strong>1,238</strong> 7%↓</td>
<td><strong>11,501</strong> 6%↑</td>
</tr>
<tr>
<td>(250cc dose equivalents) transfused</td>
<td>(6,387 FP, 1,342 CSN, 1,481 SDP)</td>
<td>(789 FP and 264 CSN)</td>
<td>(766 FP and 472 CSN)</td>
<td>(7,942 FP [5%↓], 2,078 CSN [15%↓], 1,481 SDP [from 0])</td>
</tr>
<tr>
<td>cryoprecipitate units</td>
<td><strong>2,221</strong> 41%↑</td>
<td><strong>487</strong> 35%↑</td>
<td><strong>172</strong> 23%↑</td>
<td><strong>2,880</strong> 38%↑</td>
</tr>
<tr>
<td>(~20cc equivalents)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>transfused</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

pRBC to FP ratio: 4.4: 1
6,639 patients transfused 4.9%↑

UHN 2013 Transfusion Reactions
(Jan 1 – Dec 31, 2013)
QUARTERLY TRENDS IN UHN pRBC UTILIZATION

UHN 2013 Transfusion Reactions
(Jan 1 – Dec 31, 2013)
QUARTERLY TRENDS IN UHN PLATELET UTILIZATION

UHN 2013 Transfusion Reactions
(Jan 1 – Dec 31, 2013)

+ Refractoriness Program
High Platelet Use Monitoring

Consecutive Platelet Transfusion over 3 days?

Poor Increments?

Yes

No

Patient Instruction to provide ABO Identical automatically appended

Yes

No

Platelet Antibody Result?

Yes

No

PRA > 0%

Laboratory Physician Notified
QUARTERLY TRENDS IN UHN PLASMA UTILIZATION

29% / 20% / 31% / 40% of 2013’s plasma use is accounted for by non-FP products (CSN, SDP) / not applicable to procoagulant restitution

UHN 2013 Transfusion Reactions (Jan 1 – Dec 31, 2013)
Transfusion Reaction Reporting Activity

\[ n = 323 \text{ reaction reports over 365 days}; \quad 1\% \uparrow \]

FREQUENCY: 1 reaction report q 1.14 days

6639 recipients with 323 associated reaction reports: 4.9%
Triggers to Transfuse among Patients with Transfusions Complicated by Reactions

4-17% of events exhibited policy-deviating product use (dubious indication, excess, or over-liberal trigger)

<table>
<thead>
<tr>
<th>Product</th>
<th>Median Triggering Value</th>
<th>Percentage of Transfusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>pRBC</td>
<td>Hb: 73 g/L (IQR 69 – 81)</td>
<td>63% for Hb &gt; 70, 31% for Hb &gt; 80, 0% for Hb &gt; 100 (all thalassemics)</td>
</tr>
<tr>
<td>Platelets</td>
<td>Plt: 9 (IQR 7 – 14)</td>
<td>45% for plt &gt; 10, 0% for plt &gt; 50, 0% for plt &gt; 100</td>
</tr>
<tr>
<td>FP</td>
<td>INR: 1.63 (IQR 1.60 – 3.09)</td>
<td>0 were given for INR &lt; 1.5, 4 (100%) for INR &lt; 2.0</td>
</tr>
<tr>
<td>IVIG</td>
<td></td>
<td>Neurologic (2): MG, MAN Transplant (2): rejection (lung)</td>
</tr>
</tbody>
</table>

UHN 2013 Q4 Transfusion Reactions (Oct 1 – Dec 31, 2013)
Novel Utilization Metrics as a Goal

Not just who uses how much…

But at what trigger & end…


## Peri-Transfusion Relevant Value Linkages

### Transfusion History Report

**Laboratory, Result One**

**DATE RANGE:** 30-Jan-2014 to 30-Jan-2014

#### Blood Product Safety Screen Assessment

- **No Instructions Recorded**
- **No Antibody Information Recorded**
- **No Antigen Testing Recorded**

#### Transfusion Information

<table>
<thead>
<tr>
<th>Product</th>
<th>Unit / Lot Number</th>
<th>Issue Date/Time</th>
<th>Collection Date</th>
<th>Age</th>
<th>Unit ABO</th>
<th>Volume</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCR</td>
<td>C005614030002-0</td>
<td>31-Jan-2014 10:55</td>
<td>30-Jan-2014</td>
<td>O</td>
<td>30 mL</td>
<td>N/A</td>
<td>PT</td>
</tr>
<tr>
<td>PLS</td>
<td>C0556140300107-H</td>
<td>31-Jan-2014 10:55</td>
<td>01-Feb-2013</td>
<td>364</td>
<td>250 mL</td>
<td>N/A</td>
<td>PT</td>
</tr>
<tr>
<td>INR</td>
<td>C0556140300104-N</td>
<td>31-Jan-2014 10:55</td>
<td>01-Feb-2013</td>
<td>364</td>
<td>15 mL</td>
<td>N/A</td>
<td>PT</td>
</tr>
<tr>
<td>APL</td>
<td>C0556140300101-I</td>
<td>31-Jan-2014 10:55</td>
<td>27-Jan-2014</td>
<td>4</td>
<td>300 mL</td>
<td>N/A</td>
<td>PT</td>
</tr>
<tr>
<td>WB</td>
<td>C0556140300101-P</td>
<td>31-Jan-2014 10:55</td>
<td>28-Dec-2013</td>
<td>34</td>
<td>100 mL</td>
<td>N/A</td>
<td>PT</td>
</tr>
<tr>
<td>WRB</td>
<td>C0556140300110-H</td>
<td>31-Jan-2014 10:55</td>
<td>N/A</td>
<td>N/A</td>
<td>100 mL</td>
<td>Washed</td>
<td>PT</td>
</tr>
<tr>
<td>RBC</td>
<td>C0556140300103-D</td>
<td>31-Jan-2014 10:55</td>
<td>21-Dec-2013</td>
<td>41</td>
<td>280 mL</td>
<td>N/A</td>
<td>PT</td>
</tr>
<tr>
<td>PLT</td>
<td>C0556140300102-R</td>
<td>31-Jan-2014 10:55</td>
<td>22-Jan-2014</td>
<td>300 mL</td>
<td>N/A</td>
<td>N/A</td>
<td>PT</td>
</tr>
<tr>
<td>F8 ADI</td>
<td>30012014 Sublot:1</td>
<td>31-Jan-2014 10:55</td>
<td>N/A</td>
<td>N/A</td>
<td>100 IU</td>
<td>N/A</td>
<td>PT</td>
</tr>
</tbody>
</table>

**Sample Collection Date/Time**

- **PRE FVIII: 0.45 units/mL (28-Jan-2014 10:55)**
- **PST FVIII: 1.00 units/mL (28-Jan-2014 11:49)**
- **PRE aPTT: 45 s (28-Jan-2014 10:55)**
- **PST aPTT: 60 s (28-Jan-2014 11:49)**

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Reported Generated on: 21-Feb-2014 09:27:30

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Version: 3.0

Page: 1/2
Stepping Stones

• **Endgoal:** computer blood product physician order entry (C/BP POE) with accurate prescriber linkage

• **Interim:** most responsible physician (MRP)
  – classification of MD by service, to collate into assessable groups
    • Volumes
    • Triggers
Leveraging:
internal champions & outside help

- Transfusion error surveillance system (TESS)
- Transfusion transmitted injury surveillance system (TTISS)
- Incident reporting systems
- Assumptive trackings (MediTech RN notes, etc)
- Pharmacy! (sometimes co-documentation occurs)
## Laboratory Information Systems

<table>
<thead>
<tr>
<th>HCLL</th>
<th>Meditech</th>
<th>No Lab Info System in Place Currently (for Transfusion Medicine)</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHN</td>
<td>Timmins &amp; District</td>
<td>Horneypayne (Meditech in main lab, but not for TM)</td>
</tr>
<tr>
<td>Sunnybrook (all sites)</td>
<td>Kirkland &amp; District</td>
<td>Sensenbrenner (Meditech in main lab, but not for TM)</td>
</tr>
<tr>
<td></td>
<td>Sault Area Hospital</td>
<td>Smooth Rock Falls (Meditech in main lab, but not for TM)</td>
</tr>
<tr>
<td></td>
<td>Haldimand</td>
<td>Notre-Dame (Meditech in main lab, but not for TM)</td>
</tr>
<tr>
<td></td>
<td>Lakeridge (all sites)</td>
<td>Lady Minto (in process of moving TM to Meditech)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anson (Meditech in main lab, but not for TM)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bingham (NO TESTING DONE ON SITE)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Englehart (NO TESTING DONE ON SITE)</td>
</tr>
<tr>
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<td>Weeneebayko (transitioning to Meditech)</td>
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Making it Personal

- Information to which people respond
  - Inter-hospital comparisons (OrbCon, EQA)
  - Intra-hospital comparisons
    - Competition
    - Embarrassment
    - Pride

- Education to contextualize importance
  - Historic/legal mandates
  - Corporate policies reflecting evidence base
  - Mechanisms/examples of harm
Hazards

• Plunging too far/fast ahead = divergent/incompatible evolution

• Waiting too long (ie- for provincial solutions)
  – delay in fulfilling mandate, missed opportunity
  – unlikely (time, money, corporate-confinement of LIS)
    (OrbCon April 13th 2013)
“(in) today’s electronic records, … the story weaving together social, familial, cultural, and medical contributors to the patient’s health and illness often disappears, obscured by templates.

A boon to billers, quality assessors, and researchers, such records can become formulaic and susceptible to data-entry errors. Moreover, they’re often filled with copied-and-pasted information that buries the essential narrative under voluminous repetitive text.”
"I've not failed. I've just found 10,000 ways that won't work."

Thomas A. Edison

What's out there for you? How do you get it? What's it to them?
Thank You!

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