ICD-10: the Canadian Experience

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As US healthcare professionals begin preparations for ICD-10, they can draw on the experiences of their counterparts in Canada. In "Implementation of ICD-10: Experiences and Lessons Learned from a Canadian Hospital," two Canadian HIM professionals discussed Canada's ICD-10 implementation, first from a national perspective, then from one hospital's experience.

Lori Moskal, CCHRA, classifications consultant for the Canadian Institute for Health Information, began by identifying two main factors behind resistance to the implementation. The first was a natural resistance to change from older, established coding professionals. Moskal also attributed resistance to the fact that many coding professionals code from memory and do not routinely use the index; others who use a code book find the switch to using a CD-ROM a difficult approach. The second factor is an overall shortage of HIM professionals and the resultant coding backlogs the shortage causes.

Moskal then identified five major hurdles that must be overcome in implementing ICD-10:

- The new code structure itself
- Coding rule changes between ICD-9 and ICD-10
- Conversion process issues related to hardware and software
- Coding errors
- Extrinsic factors, such as the fact that more and more healthcare provision is moving from hospital settings

Although these represent significant challenges, Moskal emphasized, "In our opinion, the benefits of the change did outweigh any of the negatives." These benefits include:

- The ability to update and maintain classifications. For instance, in response to the SARS outbreak in Canada, the government was able to respond via the ICD-10 coding system, introduce a code to track these patients, and thus initiate an appropriate public health response.
- A coding system with plenty of room for expansion. Unlike ICD-9, which has largely exhausted its supply of codes, ICD-10 can accommodate many more codes due to its structure.
- A system with both Canadian-specific and international content.
- A single set of classification standards.
- Greater, more comprehensive scope.
- International comparability.
- More effective structure and presentation.

One Hospital's Experience

Following Moskal's presentation of the national perspective, Kerry Johnson, CCHRA, of Humber River Regional Hospital in Toronto, Ontario, described his hospital's experiences with the implementation of ICD-10. Humber River is a 605-bed facility with 30,000 annual inpatient discharges, 102,000 emergency department visits, and 35,000 day surgery visits. The hospital employs 16 coders and three record analysts. The full implementation process took about two years, Johnson said.

Components of the implementation process included staff education and the required changes in business processes, such as elimination of existing backlogs and identification of key differences between ICD-9-CM and ICD-10, including numeric versus alphanumeric code structure, paper-based versus electronic folio-based, and approximately 10,000 codes compared to 40,000 codes.

This initial phase of staff education was followed by software evaluation and testing, Johnson said, which resulted in the identification of a need to change the initial vendor. All appropriate staff members were fully involved in the process of testing

and evaluation of software, software selection, and implementation. The hospital information technology department participated in the process with hardware needs evaluation, interface development, and system installation.

Key initial findings in the implementation process included the anticipated decrease in staff productivity. This was found to be dependent in large part upon the type of case coded. Approximately three to six months passed before there was any appreciable improvement in coding staff productivity, and productivity eventually peaked at a level below that of the pre-ICD-10 era.

The hospital identified four major sources of implementation costs, Johnson reported:

- Education (tuition and downtime)
- Pre-implementation readiness (removal of backlogs)
- Post-implementation production volume (due to reduced productivity)
- Software and hardware costs

Post-implementation issues included the need for software modifications, clinical documentation support for the most detailed coding possible with ICD-10, development of appropriate interfaces, and vendor readiness.

Johnson's conclusions, likely to be mirrored in any US implementation, included the following:

- It is imperative that adequate resources be allocated for the ICD-10 implementation. Preparation is crucial.
- Teamwork is essential.
- Patience is critical.

For her part, Moskal noted that Canada faced one significant implementation issue that the US will not—in Canada the educational material had to be provided in both official languages of the country, English and French.

Article citation:
"ICD-10: The Canadian Experience (2004 Convention Wrap-Up)" *Journal of AHIMA* 75, no.1 (January 2004): 62-63.
