The theme of this issue, ‘classifications and terminologies’, is critically important for the future of health information management at a global level and also for health information managers and clinical coders at the workplace level. We have therefore invited Kathy Giannangelo to write an article for this issue of the journal; her excellent piece, entitled ‘Making the connection between standard terminologies, use cases, and mapping is a ‘must read’ for all health information management professionals (Giannangelo 2006). Giannangelo is a recognised leader, internationally, in the study of nosology and clinical terminologies. In her capacity as Manager, Practice Leadership for the American Health Information Management Association, she operates at the cutting edge of trends and developments in clinical coding, terminologies, and EHRs.

Whereas Giannangelo’s article focuses on the importance of the integrity and relevance of mapping systems for clinical and administrative data in the electronic health record (EHR) environment, Sue Walker’s piece is a world-view of clinical coding, specifically the disparate workforce of coders of morbidity and mortality data around the world. Walker (National Centre in Health [Brisbane]), a recognised international expert in clinical coding, describes the ground-breaking collaborative, international coding workforce needs assessment conducted by the Education Committee of the World Health Organization Family of International Classifications (WHO-FIC) and the International Federation of Health Records Organizations (IFHRO) (Walker 2006). This study provides essential baseline data on the knowledge and skills of clinical coders which, of course, have a direct bearing on the quality and the status of coded data around the world. You will learn, for example, that only 16% of the respondent countries have a dedicated morbidity and mortality coding workforce, 66% undertake routine hospital morbidity coding, and only 82% routinely code the underlying cause of death.

Wood and Pritchard (2006) describe Australian mortality coding, specifically the introduction of multiple cause coding and its significance to the national cause of death statistical profile. Mortality coding enables shifts in national public health status to be compared internationally, both concurrently and longitudinally. Incidentally, the authors’ reference to developmental work on ICD-11 will strike a chord with many health information managers and clinical coders in Australasia!

The National Allied Health Casemix Committee (NAHCC) and representatives of the Australian allied health professional associations created, in 2000, a separate ‘Indicator for Intervention’ (IFI) dataset to enable focus on the client’s needs for intervention, because the disease focus inherent in ICD-10-AM did not provide sufficient flexibility. Stokes, Matthews and Shafik-Eid (2006) describe the process of reviewing the recently created IFI dataset and evaluating the WHO’s International Classification of Functioning, Disability and Health (ICF) as an alternative, and the decision to use the latter as the preferred classification system for allied health interventions and as a platform for describing costs in the outpatient setting.

At the hospital level, Krypuy and McCormack (2006) report on their practical study of a provisional coding trial. They found their hospital’s clinical documentation standards to be of sufficient quality to support both accurate clinical coding and diagnosis related group (DRG) assignment. The authors are to be congratulated on their innovative study, which shows that applied research can be conducted effectively in the health information management-clinical
coding workplace and, importantly, the results published to inform colleagues and to stimulate further workplace-based studies in this area.

Whilst the journal has a ‘theme’ for each issue, we also aim to include articles that are representative of the various sub-disciplines of health information management, thereby making each issue relevant to all members of the profession regardless of their work specialty. In the health informatics area, we are pleased to include the peer-reviewed article by MacGregor and colleagues (2006) on their pilot study of the adoption and use of information communications technology (ICT) in medical practices throughout regional Australia. They found the benefits, as perceived by the GP users, to be more business-related than clinically-related. This important study demonstrates the need, in the development and implementation of health information technologies, for identification of the real needs of the users and the myriad variables which may influence their ongoing and beneficial use of technology.

In the management area, we include K-C Kon’s (2006) case study of the strategic and practical issues associated with the integration of a stand-alone mental health record system with the central medical record system of a major tertiary teaching hospital and its subsidiary facilities.

The professional profiles segment of the journal is designed to demonstrate the diversity of careers available in health information management. Those illustrated in this issue are the role of Health Information Co-ordinator for Haematology and Oncology Clinics of Australasia (Gatehouse 2006), and Health Information Manager for the Queensland Royal Flying Doctor Service (Carter 2006), both of which involve challenging and inherently interesting work. As usual, we include some brief reports of recent conferences to keep readers informed of current events.

I would like to acknowledge the very substantial contribution to the compilation of this issue of the journal by Joy Smith (Queensland Health), as Associate Editor.

We hope that you enjoy reading the smorgasbord of articles contained herein!

References


Kerin Robinson
Editor