**Appendix 1. Health Information Management (HIM) Practice Use Cases by Information Governance Principle**

1. **Information Governance Principle:** Record Availability

**HIM Practice A1**. All documents can be accounted for and the record closed as complete within a specific time period post patient discharge in accordance with State and Federal regulations, accreditation organizations (e.g. Joint Commission, Det Norske Veritas Healthcare - ISO 9000), or organizational policy.[[1]](#footnote-1) [1, p.40]

Use Case A1.1. All documents can be accounted for within a specific time period post patient discharge.

A1.3 the record closed as complete within a specific time period post patient discharge [1, p.40]. – DEFINE IS THIS US A SEPARATE USE CASE – SEE COMPLETE, INCOMPLET, CANCELLED RECORDS BELOW

The term "accounted for" is defined as the following:

System shall support all types of medical records (paper and electronic) generated during a specified timeframe of an encounter.

The time period as well as the type of the record are defined by the type and duration of each specific function/event/step of care within the encounter, i.e., workflow steps and sub-steps. This includes completed, incomplete or cancelled records of the encounter. The types of encounter include

* visit registration/admission
* triage
* nurse's and physician's assessment
* laboratory and diagnostic testing
* diagnosis and care plan
* prescription
* discharge/transfer/disposition and
* other.

Figure 1 presents the examples of the encounter, its functions and records/documents.

Figure 1. Example of Encounter, its Functions and Records/Documents

The decision on the list of the documents that will be accounted for is made by the facility's Form Management Committee[[2]](#footnote-2),[[3]](#footnote-3) comprised of representatives from clinical, business and technology departments. These business actors include

* patient care providers
  + clinicians and
  + staff who supports ancillary services (laboratory, radiology, pharmacy, etc.)
* medical group administrators
* medical information services directors
* medical records directors
* compliance officers (legal and regulatory support)
* purchasing and financial managers and
* other.

The custodian of the forms/documents is the medical records department.

The list of forms/documents and personnel for defining and maintaining these forms/documents are specified by organizational policies.[[4]](#footnote-4) If other facility is involved in providing services, data sharing agreements between two facilities shall define the policies on how documentation will be accounted for when shared.

Definitions:

The terms “**Form**”, “**Document**” and “**Screen**” are used interchangeably in this White Paper. Form/document/screen is the representation of knowledge assembled from data collected during the encounter. Formal definitions of these terms are the following:

“Forms are pages that allow users to fill in and submit information”[[5]](#footnote-5)

“Document is any analog or digital, formatted and preserved “container” of data or information”[[6]](#footnote-6)

“Screen prototype is a sketch of the user interface of each screen that is anticipated in a project”[[7]](#footnote-7)

The **Encounter** is referred to a visit or interaction between patient and provider and/or ancillary services within the facility. The type of encounter is defined by the service type (e.g., inpatient, outpatient, ED, long-term care and others). In this year, we will focus on inpatient facilities only, so the **end of the encounter** is defined as patient discharge or transfer from the facility – TO BE DISCUSSED.

The encounter is comprised of **Functions/Events/Steps**.

The **Function** of the encounter is defined as entity or the activity that involve a single healthcare department, service area or discipline.

The **Event** is defined as an action or activity that occurs within a system and/or network, inclusive of its boundaries.[[8]](#footnote-8)

The **Step** is defined as a sub-action or sub-activity that occurs within a specific event of care.

The **start and the end of each function/event/step within the encounter** are defined by the creation and completion of the correspondent record/document related to the specific function/event/step.

The **start of the encounter** is defined by the **initial interaction** of the patient with the healthcare facility (e.g., visit, e-mail, phone or other). This interaction sets into motion the chain of functions/events/steps defined by the clinical pathway of activities for a specific encounter. This interaction acts as a trigger of a specific clinical pathway (Table 1).

Table 1. Relationship between Encounter’s Flow of Events and Documents

|  |  |
| --- | --- |
| Encounter | |
| Clinical Pathway for <Function: Registration, Assessment, testing, etc.> | |
| Workflow Activities or Flow of Events | Records/Documents |
|  | Initial interaction with healthcare facility (visit, e-mail, phone) |
| Step 1 | Document 1 – output for Step 1 and input /trigger for Step 2 |
| Step 2 | Document 2 – output for Step 2 and input/trigger for Step 3 |
| Step 3 | Document 3 – output for Step 3 |

Example 1: for patient registration, the start of the registration is triggered by the patient presenting at the facility in person or contacting the facility by phone or e-mail. The registar’s person activates the command “Register a New Patient” or “Look up for the Existing Patient” in facility’s health information system (HIS).

Patient’s **registration, admission, disposition, discharge/transfer** are the **states of the patient’s interaction** with healthcare facility. HIS must document change in these states. For example, under disposition when patient is moved to another floor for testing, all previous documents that trigger this new function (input documents) and new documents generated by this new function (output documents) must be captured in the HIS.

The **end** is defined by obtaining digital signature of an authorized person with the time stamp (date and time) on each document.

**Clinical pathway** is defined as a flow of activities and documentation derived from the clinical guidelines as related to a specific episode of care.

Clinical pathway is a tool designed to coordinate multidisciplinary care planning for specific diagnoses and treatments. [[9]](#footnote-9)

**Complete record** is defined as

**Incomplete record** is defined as

**Cancelled record** is defined as

**Completeness:** is defined as …An element of a legally defensible health record; the health record is not complete until all its parts are assembled and the appropriate documents are authenticated according to medical staff bylaw. (AHIMA Pocket Glossary of Health Information Management and Technology. 2014.)

**Record completion:** is defined as…The process whereby healthcare professionals are able to access, complete, or authenticate a specific patient’s medical information. (AHIMA Pocket Glossary of Health Information Management and Technology. 2014.)

**Incomplete records policy:** is defined as…A policy that outlines how physicians are notified of records missing documentation or signatures. (AHIMA Pocket Glossary of Health Information Management and Technology. 2014.)

**Retraction:** is defined as…The act of correcting information that was inaccurate, invalid, or made in error and preventing its display or hiding the entry or documentation from further view. (AHIMA Pocket Glossary of Health Information Management and Technology. 2014.)

**RI.1.4, Function; Record Completeness, Conformance Criteria**:

**Statement:** Manage Record Completeness.

**Description:** The EHR-S must provide the ability for an organization to define minimum elements and timeframes for completion at the report level and at the record level. Provide a report that identifies completion and timeliness status by patient/ health record number or other specified parameters. Prior to disclosure for legal proceedings or other official purposes, an organization analyzes the health record for completeness. EHR systems must provide the ability to define a minimum set of content to be analyzed for timeliness and completeness and provide a report of the status. (ISO/HL7 10781 - Electronic Health Record System Functional Model, Release 2. 2014)

CPS 3.3.12: The system SHOULD provide the ability to render an indicator that a patient record is incomplete (e.g., not finalized or authenticated/signed) when a discharge or transfer order is entered into the system. (ISO/HL7 10781 - Electronic Health Record System Functional Model, Release 2. 2014)

Figure 2 represent example of encounter and various HIS involved in documenting clinical pathway followed in the episode of care. Specific examples of participating information systems ( technical actors) include:

1 – Administrative System

2 – EHR System

3 – Ancillary Systems (Laboratory, Radiology, etc.)

4 – Pharmacy System

Figure 2. Example of Encounter and Various Health Information Systems (Technical Actors) Involved in Documenting Clinical Pathway.

1. Grzybowski, D. (2014). Strategies for electronic document and health record management. Chicago, IL : AHIMA . pages. 31, 40, 47, 159 [↑](#footnote-ref-1)
2. Forms Management. Hospital Policy. University of Vanderbilt, Nashville TN. June 12, 2000 [↑](#footnote-ref-2)
3. Quinsey CA. Managing forms and legal electronic health records. JAHIMA, July 2007, p.58-59 [↑](#footnote-ref-3)
4. Forms Management. Hospital Policy. University of Vanderbilt, Nashville TN. June 12, 2000 [↑](#footnote-ref-4)
5. McGraw Hill Dictionary of Scientific and Technical Terms. 2003 [↑](#footnote-ref-5)
6. AHIMA Pocket Glossary of Health Information Management and Technology. 2014. [↑](#footnote-ref-6)
7. AHIMA Pocket Glossary of Health Information Management and Technology. 2014. [↑](#footnote-ref-7)
8. Health Information Management and Systems Society (HIMSS). Dictionary of Healthcare Information Technology Terms, Acronyms and Organizations. 2010. [↑](#footnote-ref-8)
9. AHIMA Pocket Glossary of Health Information Management and Technology. 2014. [↑](#footnote-ref-9)