

LIFE BEYOND HUFFMANN: future directions for health information management

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Abstract

Advancement of the art and science of medical record administration was the vision for Edna K Hoffmann. Now, almost 70 years later, she is regarded as having pioneered an era where the accurate medical record was completed in a timely fashion, ensuring critical information needed for the care of the patient, fiscal patency; clinical research and development of sound health policy were readily available [1]. Since then, we have crept ever closer to the launch of the Electronic Health Record (EHR)[2] and have reached a point where we need to reconsider our standards and guidelines for medical record documentation in all its presenting formats. Health Information Managers (HIMs) need to influence the clinical drivers for what should be documented, how and when to ensure patient safety [3], activity-based funding and all the other traditional reasons for competent medical record management [4] are upheld. HIMs need to review their place in the electronic era and what this might mean for their profession, further education and their value to health management in all health environments and at all levels therein.

In conclusion:

- i) Competent clinical documentation is an essential requirement for good health care [5]. Standardisation of clinical documentation is needed for patient safety, the development and use of the EHR, research, medicolegal requirements and the proposed national activity-based funding model.**
- ii) Completion of clinical documentation to required standards in a timely and accurate manner should be a core health care performance indicator in the near future.**
- iii) HIMs should play a critical role in data/information quality control by contributing to the maintenance of high quality standardised documentation and the future health information environment.**
- iv) Continuing education and updating relevant skills to meet future health information management needs is an ongoing requirement for HIMs.**