

Unit 1- History of Health Information

Introduction

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Health information management or HIM has been recognized as an allied health profession since 1928. HIM professionals play a more significant and multifaceted role in today's healthcare environment than in the past. With the industry being more information and technology driven than ever before, HIM professionals are essential to the healthcare setting. The American Health Information Management Association (AHIMA) was designed only 10 years after the hospital standardization movement. At the time AHIMA was known as The Association of Record Librarians of North America (ARLNA). The name has changed numerous times throughout the years to match the changing healthcare environment. When ARLNA was formed its original objective was to raise the standards of clinical recordkeeping in all healthcare facilities.

Today the association's primary purpose remains the same, to ensure quality, confidentiality, and accessibility of health information throughout healthcare facilities.

In this unit we will be looking at the history of HIM professionals and Health Information Technology. We will also provide understanding into the current and future roles and purpose of health information management. Future HIM professionals are greatly benefited from the commitment and determination of previous professionals in the HIM field. To carry on the same level of assurance, it is important for today's HIM professionals to not only be as committed to the goal of "elevating standards for clinical records" but also fulfilling the responsibilities of healthcare professionals.

Theory into Practice

Technology has taken over. What once existed as a paper-based medical record system is now completely electronic. The HIM director is responsible for quality and accessibility of health

information for real-time healthcare distribution and critical health-related assessments. Although HIM is a virtual department, the HIM director is still in charge of overseeing the traditional HIM functions. Such as record processing, analysis and completion, release of information, medical transcription, and forms management. The functions may be the same but the way they are handled today is much different from the past. The HIM directors today must have increased understanding and ability in capturing, using, and managing information. Included is knowledge of terminology mapping, data modeling, data governance, data flow design and development, data mining, and workflow organization and managing. Upholding a large staff of file clerks is no longer essential in the virtual department of HIM today. The information is created at the time of care and stored electronically, making the turnaround time of record completion.

Although an extensive staff of filing clerks is no longer needed, many functions of HIM are performed by employees that are not only associated with HIM but also with other departments. The HIM director oversees several data entry positions that are located in different departments, such as, laboratory, radiology, admitting, billing, and so on. Not only do these positions play a role in HIM but also employees of the virtual HIM department whom work remotely, for example, medical transcriptionists and clinical coders.

One of the most important parts of a HIM director’s work includes monitoring and merging interfaces, running electronic data integrity audits, attending design meetings for new EHR claims, and resolving health information exchange, privacy, and security matters. An HIM director and their staff works with many different computer programs: the master patient index (MPI), the healthcare information system (HIS), the clinical information system (CIS), the electronic health record system (EHR), the electronic document management system (EDMS), the HIM department information system (HIMIS), the revenue cycle management system (RCM), the voice/text/ speech (VTS) system, and the registry information system (RIS). In today’s HIM professions, technology and automation impacts every part of the customary HIM functions. (table 1.1)

Function	Automated by Line-of Business Information Systems									
Master Patient index management	MPI									
Medical record processing (e.g. chart assembly)		CIS	HIS	EHR	EDMS					
Medical record analysis			HIS	EHR	EDMS	HIMIS				
Medical record coding and abstracting	MPI					HIMIS	RCM			
Medical record report dictation and transcription								VTS		

Release of information			HIS	EHR	EDMS	HIMIS			
Medical record file services			HIS	EHR	and/or EDMS				
Medical record data collection and analysis		CIS	HIS	and/ or EHR		HIMIS			
Department organization and management			HIS	EHR	EDMS	HIMIS			
Registry management						and/or HIMIS			RIS
Forms management (format and content)			HIS	EHR	and/or EDMS				
Information Confidentiality and security	MPI	CIS	HIS	EHR	EDMS	HIMIS			

Table 1.1

Early History of Health Information Management

Health information professionals today can trace their lineage from a long line of people whose wisdom, fortitude and commitment is mirrored in today's dynamic profession. This history is a testament to how a small group of people can come together and make a difference for years to come.

Three separate steps influenced the development of the profession. These include Hospital standardization, the organization of record librarians, and formal educational curriculum.

Standardization of Hospital Records

Prior to 1918, the management and creation of records were the sole responsibility of the attending physician. Physicians in the early 1900's, like many physicians today, often dislike paperwork. The medical records in the early 1900's were not effective.

Health records during that time did not contain much of the information needed today; the incomplete records did not provide much help for other physicians in caring for the patient. Hospitals made no effort to make sure that records were updated and complete. In addition to inaccurate and incomplete records no standardization of vocabularies was used in the health record as to reason for the hospital admit or final diagnosis upon discharge.

In 1918, the standardization movement started by the American College of Surgeons (ACS). The reason for the standardization program was to increase the standards of surgery by establishing

minimum quality standards for hospitals. ACS realized that complete and accurate reports improved care, and outcomes for the patient. The standard required the following:

- * Accurate and complete health records must be written for all patients and filed in an accessible manner in the hospital.

- * A complete health record is one which includes identification, complaint, patient and family history, physical and special examinations, clinical laboratory, x-ray, and other examinations; provisional or working diagnosis; medical or surgical treatments; pathological findings; progress notes; final diagnosis; follow-up; and in case of death, autopsy findings.

Hospitals realized that to meet those standards, a new process had to be considered. New staff had to be hired to make sure the new process was followed. In addition hospitals recognized that health records must be filed and maintained in a proper manner with cross indexing of diseases, operations, and physicians. And so the job position of medical records clerk was established.

The Association of Record Librarians

35 members of the Club of Record Clerks met and the Hospital Standardization Conference in Boston in 1928. At the close of the meeting, the Association of Record Librarians of North America (ARLNA) was formed. During its inaugural year, the association had membership of 58 people. Members were admitted from 25 of the 48 states, the District of Columbia, and Canada. The ARLNA was the forerunner of the American Health Information Management Association (AHIMA).

Approval of Formal Education and Certificate Programs

At the start these professionals recognized that for the organization to be effective there must be training. In addition they realized that the training required needed to be separate from mere skill. It needed to be intellectual in character, involving knowledge based learning outcomes. Work started on a course of study in 1929. In 1932 the association adopted a formal curriculum.

The first schools were approved by ARLNA in 1934. By 1941, 10 schools had been approved to provide training for medical record librarians. This accreditation process was the forerunner of the current accreditation process still sponsored by AHIMA today.

The Board of Registration was implemented in 1933. The founders of the profession realized that the employment of unqualified workers lowered the standards of their profession. They implemented a certification board so that there would be a base-line to measure qualified medical record librarians. The board of Registration established criteria for eligibility for

registration. This board also developed and administered the examination. Today, the role of the Board of Registration is administered by AHIMA's Commission on Certification for Health Informatics and Information Management (CCHIIM).

Development of the HIM profession coincided with the professionalization of other healthcare specialties such as nursing, x-ray technology, and laboratory medicine technology. All these disciplines established registration and training standards and educational programs around the same time.

The professional membership of the association of HIM professionals grew rapidly over the last few decades. Even though the names of the association and credentials have changes several times, the basic elements of the profession, formal training and certification exams have remained the same.

Evolution of the Practice

The various names given to medical records association and its credentials reveal a lot about the evolution of the profession. In 1928, the organization's name was the Association of Record Librarians of North America (ARLNA). In 1944, Canadian members founded their own organization, thus the name was changes to the American Association of Medical Librarians (AAMRL). In 1970, the organization once again changes the name to eliminate the term librarian. The organization's name became the American Medical Record Association (AMRA). And in 1991 became the American Health Information Management Association (AHIMA).

The title changes in 1970 and 1991 reflected the changing nature of the roles and functions of the professional membership. In 1970, the term administrator reflected the work performed by members more accurately than the term librarian. Likewise, in 1991, the association leaders believed that the management of information, rather than the management of records, would be the primary function of the profession in the future. The names of the credentials offered by the organization changed as the association's name changed. In 1999, the AHIMA House of Delegates approved a credential name change. Registered record administrator (RHIA), and accredited record technician (ART) became registered health information technician (RHIT).

What does the changing of the credentials names say about the profession? Probably one of the most significant things is that it indicates is a major shift in the duties of the professional and how they fit within the workforce. The combined forces of new information technologies and the demands for increased, better, and more timely and accurate information require the profession to change radically.

Traditional Practice

The origins of health information management were based on the Hospital Standardization Program, started in 1918. The program centered on the need to ensure that complete and accurate health records were organized and maintained for every patient. Accurate records were needed to support the care and treatment provided to the patient as well as to conduct research. This focus remained fundamental to the profession through 1990. A review of the professional practice standards by AMRA in 1984 and again in 1990 shows a model of practice that was highly quantitative and department based.

Further evaluation of the 1990 professional practice standards shows that the tasks of medical record practitioners at that time involved planning, development and implementing systems to control, track and monitor quantity of record content and the storage, flow, and retrieval of medical records within the record as a physical unit rather than on the data that made up the information.

At that time, very few standards addressed the issues relating to determination of the completion, significance, organization, timeliness, or accuracy of information contained in the health record or its usefulness to decision support.

Information-Oriented Management Practice

The traditional model of practice would not be appropriate for 21st century information-intensive and automated healthcare environment. The traditional model of practice is department focused. Tasks are centered on processing and tracking records rather than processing and tracking information.

Studies have shown that 25 to 40 percent of a hospital's operating costs are devoted to information handling. This study made an obvious conclusion that information management has become a top priority in a healthcare institution. In today's information age, information is used across departmental boundaries and is disseminated throughout the organization and beyond. Information grows out of data manipulation from a variety of shared data sources. An information oriented management system model includes tasks associated with a broad range of information services. The duties performed as a health information manager in contrast to tasks performed as a medical record manager are information based, with concentration of data manipulation and information management focusing in the provision of a range of information services.

The Future of HIM

In 1996, AHIMA started an initiative called Vision for the future of the HIM profession, the initiative identified many new roles that information managers would likely assume in the upcoming information oriented practice. Differences in tasks performed by traditional-focused practice and AHIMA's Vision show that activities under the traditional model are department based, in the new model, tasks are information based and many of the health information manager's activities are performed outside of the of the HIM department. Below is a comparison of traditional HIM and the new vision roles.

Department based

Physical records

Aggregation and display of data

Forms and records design

Confidentiality and release of information

New Vision

Data definition

Data modeling

Data administration

Data auditing

Electronic searches

Shared knowledge sources

Statistical and modeling techniques

Logical data views

Data flow and reengineering

Application development

Application support

Security, audit, and control

Risk assessment and analysis

Prevention and control measures

Indeed many health information managers today work entirely other areas of the facility and in other settings. They work in a variety of functional areas, such as quality improvement, decision support, information systems, utilization management, data privacy, data security and so on.

Another important difference is that the traditional model of practice is based on creating, tracking, and storing physical records. In today's information intensive environment, the physical (paper-based) health record is being replaced by the electronic health record. The information in the HER is created, compiled, and stored in various areas of the organization and is brought together electronically only when needed. The tasks performed by a health information manager focus on such activities as maintaining data dictionaries, developing data models, performing data administration tasks, and ensuring data quality through a variety of auditing tasks.

A third difference between the two models concentrates on tasks associated with data analysis and interpretation. In the traditional role, the tasks involved the aggregation and display of data. In today's technology based practice information is much more complicated than it was 20 or 30 years ago and contains more enabling technologies to search and analyze data. Thus the information manager who works in decision support or quality improvement today uses sophisticated computer based tools to analyze data from a variety of data sources.

With more emphasis being placed on the development of an electronic record, health information managers find that the tasks they perform are less focused on paper forms design and focused instead on developing good user interfaces for electronic medical records.

Finally, health information practitioners have always been concerned with the privacy and confidentiality of data. The tasks in the traditional model of practice were confined to issues involving release of information. In today's more sophisticated world, these tasks are shifting to include enterprise wide responsibilities for computer data security and privacy programs as well as functions in health information exchange organizations.

AHIMA's e-HIM Task Force in 2003 confirmed the information handling focus of HIM practice where the state of health information is described as electronic, patient centered, comprehensive, longitudinal, accessible, and credible.