BOOK REVIEW

Health Information Management: Principles and Organization for Health Information Services

Reviewed by Bilal Daouk, Wayne State University, USA

Margaret A. Skurka, Editor
Health Information Management: Principles and Organization for Health Information Services 5th ed.
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INTRODUCTION

This book examines the role of the HIM departments and professionals in healthcare facilities, and how the rapid advancement in Information technology is affecting the HIM field. The book is edited by Margaret Skurka, and comprises 12 essays (chapters) contributed sometimes by different authors. This review is broken into three sections, each covering 4 chapters of the book, and will report the essence of what is discussed in the respective chapters for each of these sections.

Chapters 1-4

As in other organizations, a board of trustees, who appoints a CEO that overlooks the medical and non-medical staff, heads a health care facility. The board of trustees monitors the organization’s long term goals, establishes policies, and draws the management plans. In contrast, the CEO works on implementing the established management planning, follows federal regulations and local policies, and reports on the day-to-day activities of the facility to the board. The medical staff is responsible for the development, adoption, and periodic review of medical staff bylaws, rules, and regulations.

A joint commission among the board, CEO, medical and non-medical staff is assembled to administer, track, and measure the institution’s quality of health care it’s providing. A major component of the non-medical staff is the HIM (Health Information Management) department. HIM professionals are accredited by AHIMA (American Health Information Management Association), and are knowledgeable about current federal and state requirements in terms of maintaining the health information system whether it’s computerized or paper based. Information provided by HIM professionals is used by the board in making business decisions, by the CEO in measuring the effectiveness of management guidelines, and by the medical staff in making medical decisions.

The HIM department is responsible for maintaining the patient’s health record in healthcare institutions. This record captures all vital information about patients that is needed upon admittance, during care giving, and after they depart for future retrieval. Furthermore, the health care record serves as a measurement.
of the institution’s overall performance and efficiency, and future healthcare research and documentation for reimbursement of healthcare expenditures. Healthcare institutions are voluntary accredited by organizations such as JCAHO (Joint Commission on Accreditation Of Health Care Organizations), and CARF (Commission On Accreditation Of Rehabilitation Facilities). Moreover, these institutions are certified for Medicare & Medicaid reimbursement by CMS (Center for Medicare & Medicaid), and follow any federal or local regulations and policies. While content of the health record is dictated by JCAHO, AHIMA, and specific state regulations, its structure follows only a guideline, and typically falls into one of these three categories: 1- Source Oriented Record (arranged chronologically and based on information provided by healthcare givers) 2- Record with Integrated Progress Notes (like the previous health record with the ability to add progress notes on one form) 3- Problem Oriented Medical Record (Divides the health record into four sections: database, problem list, initial plan, and progress notes). Regardless of the structure followed, the HIM professional makes sure the health record is complete, accurate, and easy to retrieve by authorized individuals.

The electronic patient record (EPR) systems are aimed to electronically collect, store, and manage patient health information (record). Several systems has emerged in the last two decades, but the legacy of using paper-based information systems makes it challenging to convert to an electronic based record system in a timely and cost efficient fashion. AHIMA provides guidelines for information capture, and the medical form committee overlooks new/old forms, while the HIM department follows their principals and guidelines to design forms that capture all vital information, implement, test and maintain such systems. The implementation of a new Information System is a challenging task in any business setting. The success of such an implementation is contingent by the end users’ perceived ease-of-use, their willingness-to-use, and the benefits to users within the business entity.

Chapters 5-8

After assembling the patient health records and updating the MPI (Master Patient Index), quantitative and qualitative analysis are performed by the HIM department. Even though, the HIM professionals do not render any health care judgments, their reviews of the record’s thoroughness, promptness, and accuracy serve as a mean for other health care professionals to gauge the health care quality they’re providing and help them in improving the care process. Health record reviews may be performed while patients are being hospitalized or after they have been discharged. Regardless, the promptness and accuracy of these reviews will speed the reimbursement process. Lately, the HIM department health record analysis has shifted from looking for delinquencies to preventing incomplete health records.

Even so, healthcare institutions may opt to choose any format for record identification, filing, and tracking systems. HIM departments are responsible for maintaining a record identification and filing systems and a method to request and track the health record. The main reasons for selecting a particular system are related to the ease and speed of record retrieval, maintenance, and cost efficiency. A master patient index (MPI) is typically assigned to secondary health data that are set into indexes, databases, and registers and used to classify and locate health records and other health information. The HIM department is responsible for maintaining the quality, confidentiality, and backup of the MPI.

Accurate health record coding and compliance with federal and state laws are directly related to efficient billing and timely reimbursement. Healthcare billing is mostly governed by 1- the International Classification of Diseases, 9 revision, Clinical Modification (ICD-9-CM), and 2- the Physicians’ Current Procedural Terminology (CPT). ICD-9-CM is developed by the World Health Organization (WHO) that helps in monitoring mortality rates and disease information. CMS (Center for Medicare and Medicaid Services) requires health care facilities to follow ICD-9-CM reporting diagnostic and procedural
data as a prerequisite for payment. On the other hand, Physicians’ offices and ambulatory care facilities are required to use HCFA’s Common Procedure Coding System (HCPCS), which includes CPT for reimbursement by Medicare and third parties. Coding will help in locating and identifying the services offered by a health facility to a patient in order to generate and verify billing. Computerized coding systems are in use in many health care facilities, and the coder’s job is becoming more for verification to the outcome of such systems rather than coding itself.

**Chapters 9-12**

Creating and maintaining healthcare databases based on a common data dictionary and generating statistical information is part of the HIM department responsibilities. Statistical information serves as a healthcare quality measurement, for education and research, and third party use. Current Medicare prospective payment system (PPS) requires HIM professionals to provide complete, accurate, and timely databases for billing purposes under DRG (diagnosis related group) and APC (ambulatory payment classification) systems. Computerized database management systems of different health care facilities follow standardized data sets that make it possible for databases to be linked together, and derive meaningful data for statistical analysis. Since HIM professionals monitor the quality of healthcare provided by their facility, and derive statistical information that can help in improving the healthcare institution’s performance. Quality management and performance improvement for healthcare facilities are underlined and required by the Joint Commission on Healthcare Organizations for their accreditation.

Finally, health care records are generally retained for ten years in original or reproduced form, and used for patient care needs, educational reasons, and for possible legal issues. After the retention period, records are destroyed with exception to some data required to be retained by AHA (American Hospital Association). Wide spread paper-based health records requires big space for storage, and complicates the retrieval and retention of the records. Some healthcare facilities still use microfilming among other means like optical disks to reduce storage space, while the former is widely used the latter is deemed to be the future of healthcare record retention and retrieval system. Computer-based patient record increases the chances of using computers and web technologies in storing and retrieving healthcare records.

**CONCLUSIONS**

The book, “Health Information Management: Principals and Organization for Health Information Services,” focuses on the role of the Health Information Management (HIM) departments and professionals at healthcare facilities, and surveys fundamental rules that govern health information services. While the content in each chapter is well written, and the transition from one chapter to another appears logical, much of the discussion is based on paper-based HIM departments and health records, while the trend in today’s world is leaping into computerized HIM departments and electronic health records. It would be beneficial if the book is updated with a concentration on the electronic health records and its future. Also, it would have been easier to follow the transition in each chapter from one section to another if there was a numerical or alphabetical system that indicates the discussion breakdown. For instance, I had to divide up the readings into three major sections to help organize my thinking of the area and the discussions presented in the book.

In conclusion, this book serves as an adequate reference, especially for an introduction to the role of HIM and what goes into the health record. Soon (if not already) it will be deemed obsolete in terms of the advancements in technology as it focuses on the paper-based health record system, and does not move along the line of developments with today’s trends in the healthcare industry. The authors and editor have not provided much discussion on the innovative solutions for the function of the HIM sector. A generic discussion of Electronic Patient
Record (EPR) in chapter 3 is not enough for the scope of EHR that would be needed for HIM professionals today. This chapter should have been updated with the feasibility and challenges of implementing such a system, coupled by case studies of health care facilities that implemented electronic patient records. This would bring the book up to date.

The patient health record is governed by many regulations, standards, and is used for different purposes that assist healthcare institutions in measuring the quality of healthcare they are providing, rendering medical decisions, and for future research. It is important to keep health records accurate, updated, and accessible since medical decisions are rendered based on what is in it. The idea of nanotechnology devices implanted in the human body and health smart cards that can store health related information might serve as a mean to correctly ID a patient when health care is needed, but does not replace the need for health care institutions to store and manage patient records at their end. The business community came up with a computerized billing system a long time ago, since getting paid is the bottom line for most healthcare institutions, but few electronic health record systems are available in the market today. The reason for this is that it is a complicated process and the market is primarily limited to big healthcare institutions that can afford to switch from a paper-based system. For those who were able to switch to an electronic health record system, many benefits that offset the cost and confusion in the long run have been realized, which had enhanced the ability to render better quality healthcare services. However, the setback is that the system’s incompatibility with outside entities such as laboratories and ambulatory healthcare providers.

With the lack of common standards, developers are creating isolated healthcare information systems that are limited to local applications and inoperable on a global scale. The successful future of electronic health record lies in developing unified international standards that makes all ends meet, which ISO (The International Organization for Standardization) has been working on since 1998 under ISO/TC (Technical Committee) 215. The scope of TC 215 standards is creating internationally agreed upon health informatics standards. The wide spread of the Internet and its growth in its capability to capture and store data makes it the perfect platform to host a standardized and uniformly codified electronic health record. While Internet security and patient’s privacy should be carefully examined, the Internet provides virtual access points, and allows patients to be proactive in managing their health.

Bilal Daouk is a senior student at Wayne State University majoring in management information systems. The reviewer holds an Associate in Business degree from Henry Ford Community College (2004, Dearborn, Michigan), and a Technical Baccalaureate in Aviation Mechanics (1999, Beirut-Lebanon).