

Introduction to Health Information Management

Introduction to Health Information Management (HIM)

1. What is Health Information Management?

Aspect	Description
Definition	The systematic collection, storage, retrieval, analysis, and protection of health-related data and information.
Goal	Ensure that accurate, timely, and secure information supports patient care, clinical decision-making, research, public health, and reimbursement.
Core Disciplines	Medical coding, clinical documentation, health informatics, privacy & security, data analytics, records management.

2. Key Functions of HIM

Function	Primary Activities	Typical Roles
Clinical Documentation Improvement (CDI)	Review and clarify physician notes, ensure completeness, align documentation with coding standards.	CDI Specialist, Clinical Documentation Analyst
Medical Coding & Classification	Translate diagnoses, procedures, and services into standardized codes (ICD-10-CM, CPT, HCPCS).	Medical Coder, Coding Auditor
Health Information Technology (HIT) Management	Implement, maintain, and optimize electronic health record (EHR) systems and health information exchanges (HIE).	Health IT Analyst, EHR Trainer
Data Quality & Analytics	Validate data integrity, generate reports, support population health and performance metrics.	Data Analyst, Business Intelligence (BI) Specialist
Privacy, Security & Compliance	Apply HIPAA, GDPR, and other regulations; conduct risk assessments; manage access controls.	Privacy Officer, Security Analyst

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Function	Primary Activities	Typical Roles
Records Management & Release of Information (ROI)	Store, retrieve, and release patient records per legal and institutional policies.	Records Manager, ROI Coordinator
Revenue Cycle Management (RCM)	Link coding and billing processes to ensure appropriate reimbursement.	RCM Specialist, Billing Analyst

3. HIM Workflow Overview

1. **Patient Encounter** – Data captured at point of care (e.g., vitals, notes, orders).
 2. **Documentation** – Clinician creates narrative; HIM staff reviews for completeness.
 3. **Coding** – Assign appropriate codes for diagnoses, procedures, and services.
 4. **Data Entry & Validation** – Codes entered into EHR/RIS; quality checks performed.
 5. **Billing & Reimbursement** – Coded data transmitted to payers; claims processed.
 6. **Storage & Retrieval** – Records archived (on-premise or cloud) with secure access controls.
 7. **Analytics & Reporting** – Data extracted for quality improvement, research, public health.
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4. Standards & Classifications

Standard	Purpose	Example Use
ICD-10-CM	Clinical diagnosis coding (International Classification of Diseases).	Disease prevalence reporting.
CPT	Procedural coding for services rendered by physicians.	Billing for office visits.
HCPCS Level II	Codes for supplies, equipment, and non-physician services.	Billing for durable medical equipment.
SNOMED CT	Comprehensive clinical terminology for EHR interoperability.	Decision support alerts.
LOINC	Lab and test result identification.	Exchange of laboratory data across systems.
HL7 / FHIR	Messaging and API standards for health data exchange.	Interoperable EHR interfaces.

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Standard	Purpose	Example Use
HIPAA	Federal privacy and security rules for protected health information (PHI).	Access controls, breach notification.

5. Legal & Ethical Foundations

Area	Key Requirements
Privacy	Minimum necessary use, patient consent, right to access