# Concentric Circles: How Laws, Economics, and the Healthcare Environment Have Changed HIM

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*From the early 20th century, HIM professionals have been part of the turbulent story of healthcare in America. How has the profession, and AHIMA, evolved along with the industry? The author describes the environmental changes that have shaped the profession.*

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Chaos creates a need for order. In the past century, we've seen this principle at work, even in the development of HIM. From the chaos wrought by social, industrial, and technological change, the HIM profession has evolved, organized, reorganized, and formed links. What does the future hold? This article offers an overview of HIM's place in the context of healthcare's history and shows how the profession continues to grow.

## Early Years: Creating a Core

The "ancestors" of today's HIM professionals, medical record librarians, emerged from a confluence of several streams of social change early in the 20th century. Strong public faith in science, the industrial revolution, rapid urban development, and a wave of immigrants created a turbulent social environment and mechanisms to exert control over that turbulence.

Lack of close kin for many people in urban areas created social needs that were necessarily met by strangers. As a society, we shifted away from family- and community-centered services to contractual ones. Social welfare agencies, hospitals, factories, and many other impersonal groupings arose to meet needs, including the overarching need to create social order. This was a profound evolutionary phase in our history: it was the birth of a society of organizations.

In workplaces, the theory of Taylorism-scientific management-rationalized work practices by standardizing tasks and scientifically determining effective and efficient work behaviors. Not only was this cost-effective, but it eliminated idiosyncratic practices and work habits that were counterproductive for industrial production and corporate growth.

At the same time, medical care was fragmented and chaotic. Physicians, particularly those from well-established, elite schools, wanted to establish standards for medical education to increase the credibility and status of physicians and medical practice and to provide the public with high-quality medical care.

Establishing and maintaining the centrality of hospitals and physicians in the US healthcare system was an important focus of both private and public activity during a large part of the 20th century. Hospitals, more successful because of technological change and scientific discoveries, attracted more middle- and upper-class patients who could pay for care. Buoyed by this success, the hospital industry expanded from fewer than 200 organizations in 1873 to more than 6,000 in 1920.[1]

Continued patient satisfaction was an important consideration for increasing trust, utilization, and revenue for hospitals and physicians. Hospital administrators encouraged validating the quality of care in hospitals by setting standards and having routine inspections. This validation would give institutions a competitive edge for attracting patients. Establishing standards for hospitals and doing routine inspections required keeping records. Concurrently, physicians and administrators became interested in routinely gathering and recording data about clinical outcomes. Scientific management had entered hospitals, and medical recording became an institutional practice.

## Dawn of the Record Librarian

Early record managers were called clerks, then librarians. Initially, their work consisted of compiling, typing, and storing patient information, and the job was an amalgam of administrative, archivist, and clerical responsibilities. Medical librarians worked collaboratively with physicians and administrators to develop standards and systems. Training was experimental and informal, and record librarians communicated through meetings and a newsletter until education evolved into hospital-based training programs and degree programs in medical record library science.[2] Recruitment to the field quickly became a priority as demand for trained medical librarians' services exceeded the supply.

When the Great Depression forced closure of many individually owned small hospitals and greatly reduced revenue for others, employment-based hospitalization insurance emerged to ensure surviving hospitals' viability. These financing arrangements promoted hospitalization and expansion of medicine's domain. Many life events became medical, insurable events. For example, by 1960 almost all births occurred in hospitals, as did about half of all deaths.[3]

## The Great Expansion

In 1960, the US population was more than 180 million. Physicians and hospitals were the central features of healthcare, and most households had some insurance to cover hospitalization costs. Public policy supported construction and expansion of hospitals, and between 1946 and 1960 the number of hospitals and aggregate bed capacity increased. Americans spent almost $27 billion dollars for healthcare in 1960, and recipients of care paid for most of it themselves. Private insurance covered 21.2 percent of costs, and public funds, specifically state and local government (12.6 percent), and the federal government (9 percent) covered the rest.[4]

Technological and scientific knowledge, applied in medical settings, led to even more hospital use, cost increase, and a more specialized division of labor within hospitals. Acute care hospitals employed about 1 million people in 1960.[5] More than 4,000 of these employees were members of the American Association of Medical Record Librarians (AAMRL), and many of them were college-educated head librarians.[6]

There was a great demand at that time for trained medical record librarians and technicians. Computer technology developed rapidly, but computers in business and particularly in health settings represented the future, rather than current reality. Medical record librarians focused on planning for and organizing record storage, training personnel, and overseeing the technicians who worked directly with the records. As they had before, they performed administrative, archival, and clerical duties. What had changed, in many settings, was a division of medical record labor that partitioned these duties into separate roles and jobs and added a specifically technical role.

## Extending the Core

The enactment of legislation to establish Medicare and Medicaid in 1965 marked the entry of the federal government into the business of medical care insurance and regulation. Government involvement in healthcare was not new, but the role of government changed during the 1960s as its provider role began to diminish and its insurer role for individual healthcare expanded dramatically. Policy initiatives in areas of quality of care and cost effectiveness reshaped the healthcare system and the HIM profession.

In 1970, Americans spent $63 billion on healthcare, and 39 percent of it, substantially less than previously, came directly out of our pockets. Insurance companies' share increased slightly, but the federal government share increased substantially to 23 percent.[7]

The responsibility for financing medical care shifted away from the consumer and toward the federal government largely because of Medicare and Medicaid payments. During this decade, medical care costs escalated in general, and Medicare and Medicaid use and costs were grossly underestimated. Hospital lengths of stay, occupancy rates, and total hospital expenditures all increased dramatically.

The overall cost increase was linked to both private and public insurers' acceptance of the customary fee-for-service arrangement and the belief that the market and professional ethics would take care of adjusting costs. They did not. Medicare mandated utilization review, but only about half of all hospitals complied.[8]

## Impact of Medicare

During the 1970s, a sluggish economy and huge budget deficit contributed to the financial burden of healthcare costs. Generally, there was public concern about these cost increases and about the quality of medical education and medical care. In addition to general public concern, corporate risk managers, insurers, and the government (the most likely payers) were concerned about these unusually high healthcare costs.

When federal and state government cost control programs decreased payments to hospitals and other providers to make up the deficit, care providers shifted costs to private insurers. When they were allowed to do so, insurers raised premiums to cover their increased payments for care, and employers balked at the larger cost of employee benefits. Insurers and risk managers then began their own campaign to reduce costs. The issues of cost, effectiveness, and quality of care became more critical and intertwined, and health policy in the 1970s began to address ineffective and inappropriate care as both a cost and a quality problem.

One attempt to shift the direction of healthcare away from expensive crisis care and toward prevention was the HMO Act of 1973, which resulted in the establishment of more health maintenance organizations (HMOs), although fewer than anticipated. The establishment of more nursing homes, psychiatric treatment agencies for Medicare patients, outpatient service organizations, and some home healthcare agencies added significantly to the size of the healthcare system.

At the same time, hospitals consolidated for economies of scale. The number of for-profit chains increased, and the overall number of voluntary hospitals increased. Healthcare organizations were becoming more complex in structure and more hybridized as private, for-profit, and non-profit organizations began to form systems.

HIM felt the effects of Medicare legislation in several ways. There was tremendous demand for medical record personnel to manage the larger flow of records in busy, more complex, and more technologically oriented hospitals. Hospital employment increased as a result of increasing specialization and the need for physician and nurse extenders. Allied health programs, established to educate more hospital-based workers, produced new technical specialists to fill available positions.

Between 1960 and 1970, the total number of hospital employees approached 2,000,000 and the number of AAMRL members more than doubled, reaching 9,024.[9],[10] Membership increased most dramatically after Medicare implementation. Still, the growing need for information generated by utilization review, a larger team of providers, many more complex forms of treatment, and the sheer volume of patients produced more job opportunities than AAMRL could fill.

In addition, tumor registries emerged and Medicaid payment to nursing homes led to the expansion of nursing homes. These additional care settings added to the health system's complexity, and they also had information management needs.

## A Profession Turns Outward

Although some AAMRL members were actively involved in collaborative planning efforts with the American Medical Association and the American Hospital Association, the majority of medical record personnel were either invisible to other professionals or perceived as clerical, record completion, and filing personnel.

Many members sought more respect and a professional status. Educational requirements strengthened, and at this time, roles for medical record administrators included administrative duties, planning, consultation, education, and research.[11] Record protection, legal concerns about the nature and completion of documentation, and the need to design integrated record systems within institutions also contributed to role expansion for all medical record personnel. Quality assessment and utilization review required information standards and assessment tools.

Significantly, in 1965 the US Public Health Department requested and financed an AAMRL project to develop standard medical and hospital terminology and calculations, and expertise in this functional domain continues to make AHIMA members unique.[12]

In 1970, the American Association of Medical Record Librarians became the American Medical Record Association. This partly reflected roles and membership composition (ARTs were about half of the membership and people from other fields also became accredited or registered), and it conveyed a different image to the general public. Titles changed in 1971 to Registered Record Administrator and Accredited Record Technician. More members were seeking accreditation, mostly through correspondence courses, and the majority of record administrators had at least a baccalaureate degree.

During the 1970s, health information managers were concerned about the increased number of healthcare service organizations and about legal issues pertaining to medical records. Implementing professional standards review organization (PSRO) standards became a major focus.

Demand for medical record personnel remained high, partly in response to Medicare requirements about hiring trained medical record personnel. These professionals had more settings in which to work, and they served more internal and external clients. Because of regulatory change and demands by third-party payers, more organizations, including the Joint Commission, needed more information for their own operations.

In those days, a medical record professional's common activities included transcription services, monitoring data for completeness, and record storage. Other activities included providing data and information to administrators and clinicians for operations, facility policy development, financial management, research, and legal compliance.

Medical record staff members were documentation specialists.[13] Job opportunities opened in emergency rooms, in primary care, and in intermediate care settings.

Expanding roles were associated, clearly, with new clients. Both RRAs and ARTs performed quality assurance work and medical audits, but there was competition for these new niches. Few medical record personnel performed discharge planning or admission reviews, and evaluation activities by medical record departments were disappointingly low.[14]

In response, the field of medical record management, attempting to counter public misperception and to gain professional status, increased educational requirements and stressed medical record managers' unique interdisciplinary stance and knowledge.[15]

Now more firmly established, the profession was turning outward. Members worked in somewhat more diverse settings, and some were more involved with broader scopes of activity such as personnel management. Teaching positions expanded as the number of educational programs increased.

## Reconfigured Boundaries: Consolidation and Diversifying

By the 1980s, the economy, the federal budget deficit, and continued rising costs of healthcare were signals to a conservative US administration to apply business practices to the federal government and to use market forces to remedy overspending and waste in general. It also was a period of rapid technological change, with an effect on medical intervention and HIM.

Microchip development, more and better personal computers, software, and other advances allowed better data storage, more widespread and faster data management, and sophisticated statistical analysis. Communication technologies also changed with the advent of commercial satellites, and, later in the decade, sophisticated fiber optics networks.

During the 1980s, healthcare was big business, with a labor force of about 8 million.[16] In 1980, healthcare costs rose to $247 billion, with the bulk of it spent on hospital care.[17] There were more than 5,700 hospitals, most with low occupancy rates and excess capacity.[18] Health costs rose at significantly higher rates than other products and services. Policy analysts focused on the US's huge investments and low returns in terms of aggregate health status compared with other industrialized countries. We were not getting good value.

The proportion of costs covered by private and public funding did not shift significantly, but some shifts caught the attention of payers and policy makers. Private insurance picked up more costs that had been borne by individual consumers in 1975 (partly due to the shift toward enrollment in toward HMOs), and the federal government had more of the financial responsibility previously borne by state and local governments. Significantly, Medicare was partly responsible for overall cost increases and the increased share paid by the federal government. Close scrutiny of Medicare costs and practices ensued.

Hospitals were the most obvious place to apply cost control measures. In 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA) replaced PSROs with peer review organizations (PROs), state-based physician groups to monitor quality, cost, and use of care by Medicare patients. This act also created Diagnosis-Related Groups (DRGs), which were phased in over several years and revised. In addition, there was a temporary freeze on Medicare payments to physicians.

At the same time, insurers and employers continued to try to decrease their own costs. They insisted on getting better quality for their money and increased their own scrutiny of and cost-cutting measures with providers. The number of HMOs of various types tripled during the decade, and there was a steady increase in enrollment until the middle of the decade as employers encouraged a shift to these lower cost mechanisms. After 1985, HMO enrollment dramatically increased from about 10 million to almost 50 million.[19]

Hospitals continued to merge, consolidate, and redesign for more profitable use of resources. As was the case with other organizations, there was a pronounced shift toward for-profit ownership by the end of the decade. TEFRA mandated contractual relationships between the PRO and hospitals. Other contractual networks formed among employers, insurers, and providers, and clinical case management grew as a practice and occupation as all parties involved in healthcare provision and financing tried to lower their own costs.

Healthcare experts Marion Ball and Roger H. Shannon summarize the status of patient records at this time in a decidedly understated way: the health record "...is no longer the physician's personal diary."[20] A wider variety of external sources now needed health data, measurement, assessment, and statistical analysis either to monitor health practices and expenditures or for their own mission and goals. For health information managers, this was a time during which the alphabet became synonymous with data and information requirements as acronyms representing data demands such as HCFA, OSHA, PSRO, RM, QA, NANDA, and DRGs became standard parts of vocabulary and daily routines.

## HIM Moves Out of the Hospital

In 1980, there were 23,000 AMRA members.[21] As in the past, it was almost exclusively a white woman's field. Most AMRA members continued to work in health service settings, but a significantly lower proportion, only about three-quarters, worked in acute care. Long-term care, ambulatory care, psychiatric, and other facilities and settings employed health information managers. About two-thirds worked in non-profit organizations.[22] Departments in health service settings other than the medical record department also employed AMRA members.

Although there was much more emphasis on computer use and skills, the reality at the time was that in health settings, records still were largely paper ones. Department-based records existed in addition to those in central record departments. Traditional concerns and tasks coexisted with those generated by a transition to computer systems.

As many people did transcription as quality assurance, and tasks ranged from evaluating information systems and vendors, being an authority on ICD-9, and doing case mix analysis and conflict resolution, to processing claims and doing record audits. For most members, their jobs contained some managerial and data management components, and this varied by degree.

A 1989 member employment survey was weighted to obtain information about those members who worked outside of medical record departments.[23] This survey provided information about members who worked in non-traditional settings or jobs. Fewer worked in acute care general hospitals. Some of the alternative work settings are predictable-for example, ambulatory and long-term care settings-but others (fewer than 66 people) worked in banks, manufacturing, insurance companies, pharmaceutical firms, animal medical care, and other uncommon employment settings.[24]

For those employed outside acute care, positions were non-traditional but with some common content. For example, some members worked as nosologists, epidemiologists, officers in the US Public Health Service, or pharmacy DRG researchers. Other job titles appear less related to HIM-for example, accountant, director of guest relations, optician, and realtor. The overall sense is that HIM skills transfer well to other settings and roles.

This nontraditional group was definitely older and less likely to be at entry level than the overall membership. They were also mostly white and female, but there were slightly more males and slightly more African Americans in their number. More people in this group had graduate degrees than in the general membership, and they made more money than did members in general (ARTs in this group had much better salaries than usual).

In addition, there were more people with credentials in other fields (for example, nursing) in addition to AHIMA credentials and others who had only credentials from other professional organizations, indicating some interest in boundary-spanning activity.

Roles for this group were more varied and ranged from president/CEO/VP positions (more than 4 percent), to supervisors of medical record departments (10 percent) and consultants (10 percent). More people involved in this survey worked at for-

profit organizations. And more than 1,000 people in this survey were directors of quality assurance or case mix and within medical record departments, 350 were project coordinators.[25]

Roles and careers for the general membership still seemed to cluster into management/supervisory, technologist, and clerical areas. However, the range of roles and the nature of tasks was more complex, varied, and generally skilled. As level of complexity increased, with more tasks specific to a particular function, these task sets spilt off into new roles that were narrower in scope but had more depth. More role/setting configurations developed, and these varied by degree of technical specificity.

For 1989 medical record professionals, roles varied by level of education and training, institutional policies, and investment in technology. Data aggregation, for example, could mean using a database management tool, or it could mean using a pencil and paper. The potential for being in roles that had autonomy, encouraged judgments based on expertise, and had more status was greater than in the past, but relatively few people seemed to be in this kind of position.

Technological advancement and socially valued skills reshaped some members' skills. Even those in fairly stable roles required more sophisticated skills and tools. Unfortunately, a fairly sizable number of people remained in positions and task environments that changed minimally over many years. The data-driven environment influenced even this group, however, because even more traditional tasks required an updated vocabulary and knowledge base and served a variety of customers and purposes.

The career patterns of the somewhat less traditional group suggested that part of a career trajectory may be to gain experience in the field, then move on. Moving outside healthcare settings was clearly a direction for the future. As jobs in acute care settings diminished, medical records professionals would see themselves increasingly in positions outside of healthcare services, and the move toward interdisciplinary, collaborative work would produce a broader knowledge, wider networks, and new roles.

During the 1980s, business and government organizations continued to transform the healthcare sector by forming networks of organizations that made decisions on behalf of individuals. Corporations depended much more on relationships with other organizations for their survival than they did on revenue from individuals. Negotiations among corporations increased, and the result was increased demand for greater quantities and more sophisticated information. Medical record managers were doing much more than their title suggested.

## Breaching Boundaries, Building Bridges

The 1990s saw a long period of sustained growth and low unemployment. As at the turn of the previous century, immigration rates have been high, partly due to a need for employees in service industries. There also has been a revolution at this century's end, but this one has been technological, centered on communication and information production.

More than ever, we have faith in the possibilities that science offers. We examined scientific progress over the century with awe and look forward to the next developments. The human genome project, robotics, developments in imaging, and integrated network capabilities are indicators that our personal boundaries, demarcated by physical limits, are not as salient for the future as they have been throughout history.

We can see within the smallest components of life; we can program a metamorphosis on a computer that would not be physically possible. We can live and function without the physical capacity to move, and we can generate speech where there is none. The possibilities for the future are stunning.

Medicine has made impressive progress, with far less intrusive surgery, diagnostic imaging, and the development of a young telemedicine component. Applications of discoveries made toward the end of this century will generally transform life and medical care drastically in the future.

## Peaks and Valleys at a Century's End

The US population was 248 million in 1990, and it reached 272 million in 1999.[26] Birth rates and infant mortality declined during the decade. We were concerned with continuing to control the cost of medical spending, and we have succeeded in holding spending growth within targeted limits, at least temporarily.

In 1990, US health expenditures for healthcare were $697 billion. By 1998, we had spent over $1 trillion for the third year in a row, but we have kept the rate of growth to about 6 percent for the past five years.[27] The healthcare sector employed 12 million people in 1994, almost half of them in hospitals. This is double the number employed in 1974.[28]

Hospitals still were very important, but not as central as in the past. In the 1990s, they were mainly places for surgical and highly acute care. Hospitals affiliated with medical schools continued to be sources of treatment for those who did not have the financial resources to pay, although policy analysts worry about the impact of financing changes on both medical education and care for indigent people. Despite a general trend toward profit-making organizations, the majority of hospitals are nonprofit institutions, even if they are part of hybrid networks.

Hospitals continued to reorganize and consolidate. There were almost 600 fewer hospitals in 1995 than in 1985, and number of beds, occupancy rates, length of stay, and admissions have declined.[29] Home healthcare has declined both in terms of the number of agencies and the volume of care. Managed care enrollment has increased dramatically, particularly during the last several years, while the number of organizational providers has decreased because of consolidation in this area as well.

The 1989 the Omnibus Budget Reconciliation Act (OBRA) created global targets for total care costs for Medicare patients and the Resource Based Relative Value Scale (RBRVS), a national fee schedule for physicians. It also created reforms in nursing home care provision. Implementation of these policies during the early 1990s contributed to the slower growth of Medicare costs and overall health costs. Policy-driven prospective payment plans and enrollment of Medicare recipients in managed care plans have also decreased costs.

Quality measurement and development of clinical decision analysis based on outcome assessments continue to create more work for health information managers. The Balanced Budget Act will continue to have an effect on information needs and spending for healthcare when other organizations receive payment prospectively and according to a fee schedule.

The 1996 Health Insurance Portability and Accountability Act (HIPAA) created several important changes for health information managers. For example, it generated attempts to outline standards about confidentiality, disclosure of information, and patient rights issues. Meanwhile, monitoring of billing practices became more critical and more extensive in the last decade, with the emphasis on preventing and uncovering fraud. Just the threat of scrutiny in the future has caused healthcare organizations to monitor billing practices now, which has affected health costs.

## From Medical Records to Health Information

The transition to large, public/private hybrid healthcare organizations and the busy health policy environment have presented options for health information managers now and for the future. Not only is there more interest in health information of all kinds, there are many more settings and opportunities for integrating systems.

Multimedia communication, integrated data networks, and other technology imperatives will change the health system and the nature of work for HIM professionals, who will participate in teams to design health applications.

Already, collaborative efforts between AHIMA and other professional organizations in similar fields hold promise. For example, AHIMA has joined with several other interested, related professional organizations to form the Joint Healthcare Information Technology Alliance (JHITA).[30] Design concerns associated with computer records have provided some AHIMA members with opportunities to collaborate with colleagues in other health information fields to resolve vexing issues about classifications, codes, and languages.

HIPAA administration is also a topic of discussion. Integrated networks and computer-based records have generated wide interest in, and attention to, issues of privacy and security. As traditional stewards of health information and security, HIM professionals have been involved in discussions about these concerns. These roles will continue and will evolve to fit the new information systems.

These very innovative endeavors coexist with a variety of roles that are still needed for electronically bereft organizations: records still need audits, monitoring for compliance, filing, and traditional data management in an information-hungry environment. That really is a challenge.

Administrative roles still are needed as well, and the management of a busy department, although it is still the same role, is more complex, with multiple tasks that require more sophisticated knowledge. Newer task sets attached to older roles. Recent articles in the *Journal of AHIMA* attest to the need to provide more on-the-job training and to continue with personal education.

By 1990, there were more than 30,000 AMRA members.[31] In the following years, while a slightly lower percentage of AHIMA members worked as directors or assistant directors of medical record departments, there has been a slight move toward management in other departments and a higher percentage of supervisory and non-supervisory technicians since 1988.[32] This is congruent with the tendency within healthcare to substitute less expensive employees for more expensive ones.

Today, some AHIMA members work in facilities with no beds.[33] Although these individuals represent a small proportion of the membership, this may be an avenue of change. Changes, too, are reflected in the most recent credential change earlier this year, as RRAs and ARTs became registered health information administrators (RHIAs), respectively and registered health information technicians (RHITs). With electronic records, there may be less of a need in the future to have a physical department, and jobs may consist of many different, short-term roles. New settings often provide opportunities to transform traditional roles. Transitional roles, such as liaison positions and task force membership, may actually be precursors of future roles.

## Laws, Technology, Healthcare, and HIM

If it seems that the HIM professional's work environment is chaotic, that perception is accurate. The basis for most of this turbulence is the fragmented healthcare policy process and policies that have developed from this process.

Because health policy derives from political process, policies reflect the culture and political system within each country. The US, founded on principles of individualism, freedom from oppressive government intrusion, federalism rather than centralized power, capitalist principles, and representative democracy, has developed health policies that reflect these principles.

As a result, we have no centralized, national planning for health resource development, allocation, and use, nor do we have national financing or global budgeting. Instead, we have a hybrid system in which the health-related roles of federal government, state governments, and various private stakeholder groups (profit-making and not for profit) shift over time as their ability to affect decisions shifts.

Ultimately, the regulation of healthcare through public policy process, coupled with the de facto regulation derived from corporate decisions to contain costs, has resulted in a more complex and diffused healthcare system. The number of organizational providers (including professional practice groups) has increased, as has the number of utilization management companies and oversight organizations, without counting temporary organizations designed to plan and to solve problems.

Information needs became complex as well. There is more demand for data and information from a variety of sources. There are more settings and levels of scrutiny for information managers. There is a complex web of legal mandates, regulatory requirements, and private payer conditions that healthcare institutions and the HIM professionals within them must understand and meet.

## Fewer Boundaries, More Roles

In terms of roles and niche, the 1960s were a development phase. It was a time for growth and then finding the boundaries of the niche. The 1970s were a period of expansion, mostly of existing services. The 1980s were a period of standardizing, rationalizing, and increased task and role sophistication. The 1990s were a time for integration and shifting identification, and they ended with a diminished focus on boundaries, which became less relevant.

While so much has changed for HIM, its historical roots still are obvious. The field is still focused on the management of information, nomenclature, and protecting and monitoring records.

What has changed? There is more information. There is more sophisticated information. There is increasingly rapid manipulation of data and creation of information. There are many more standards and codes for many purposes. There are many more customers, internal and external to organizations, and there are many more settings. Role structures incorporate these changes.

It is important to recognize that the entire domain of the profession expanded and changed; the role of the professional organization changed; and the roles of professionals changed within these two organizational environments.

The next decade will be a time for multitasked jobs and flexibility, for boundary spanning by forming cooperative alliances, and for reconfiguring roles. Doing so will enlarge professional perspective and flexibility while increasing knowledge and expertise. But there is a split, possibly, between those with advanced technical skills and resources and those who have less opportunity for development. There may be roles that remain department-based, whether that department is in a hospital or in another setting.

## What's Next?

HIM professionals' jobs have been profoundly affected by the policy initiatives that have relentlessly emerged since the mid-1960s, but particularly during the last 25 years.

During last century, the healthcare field has transformed in ways no one could have imagined. The irony is that the dramatic changes of the past several decades, although drastically different from anything before them, emerged from combination of social changes similar to those at last century's end.

This period is as revolutionary as the period during which physicians and hospitals became the dominant features of the "modern" scientific age of medicine and healthcare. It differs in part because we speak less about individuals and more about corporate entities within a society of organizations.

We might examine the past few decades and conclude that a truly postmodern era of healthcare is emerging, and it is a scientific revolution. We have seen the deconstruction of many assumptions and structures of power in healthcare through critical analysis, using the most modern scientific tools.

Healthcare is experiencing a paradigmatic shift, and this shift will affect all healthcare professionals. For all professions, knowledge and expertise carry authority. Who will become the experts and authorities in health? If information is the most important resource for the foreseeable future, so are the professions that control the keys to the information.

## Overlapping Circles

Roles as educators and consultants have been a part of health information managers' heritage. During the 1950s, AMRA worked with several other organizations, such as the FDA, the American Society of Hospital Pharmacists, and the Joint Commission on Maternal Welfare and did records consulting and education for the US Public Health Service and the Joint Commission on Accreditation of Hospitals.[34] Today, many professional groups and occupations seem to be working in areas that are similar to or overlap with AHIMA.

The field of nursing informatics has been developing since the early-to mid-1980s, with interest focusing on decreasing the cost (personnel time and other resources) of providing documentation of nursing care in a standardized, but comprehensive way.[35]

Availability of technology concerns about the cost and quality of care in health services and a continued effort to distinguish the profession and its work from the work of other occupations and professions led to creating a specific subfield of informatics within nursing. For nursing, long subordinated to medical authority and organizational demands, maintaining a unique body of knowledge and skills has been particularly important.

As with other providers, the basis for nursing care is and always has been information.[36] Currently, nursing informatics focuses on several project areas that resemble some of what AHIMA members do. These include developing terminology and classification systems that reflect nursing diagnoses and care patterns, developing information systems that will facilitate recording, manipulating, aggregating, and storage of nursing patient care information, continuing to do research on nursing care outcomes, quality assessment, and cost, and linking nursing theory, research, and actual clinical care.

The field of nursing informatics, however, has become more aligned with the American Medical Informatics Association (AMIA) than with AHIMA. Nurse researchers and other nurses who are interested in informatics are predominately those with doctorates, and medical informatics focuses on the scientific development of documentation, systems, and information

management, which is congruent with the more medically aligned nursing profession. The National Institute for Nursing Research recognizes the need for collaboration with other informaticians.

AMIA, founded in 1990, resulted from a merger of the American Association of Medical Systems and Informatics and The American College of Medical Informatics. Membership has grown rapidly from 800 members in 1990 to 2,200 members in 1992 and almost 4,000 members today.[37],[38] Members come from a variety of disciplines, including HIM, but most tend to be physicians, biomedical scientists, information systems scientists, and medical librarians.

The organization has focused on developing medical information technology and educating physicians about its use. More recent concerns have been about developing data and information standards and methods of developing these standards, in conjunction with other groups that have expertise, and extending the type of medical care data that becomes coded (for example, progress notes). Part of AMIA's strategic plan was to become a "...clearinghouse for medical record, message, and coding standards" although the organization strongly wishes inclusiveness with others in science, healthcare provision, and management.[39] Professional recognition of this discipline by peers, government, and the general public is a primary goal.

The American Telemedicine Association is also a new organization of corporate and individual members who are interested in developing and promoting telemedicine. For AHIMA members, the related function is to become a clearinghouse for "...all aspects of telemedicine and related use of telecommunications to provide information and services affecting patient care."[40]

Dozens of other organizations with similar interests exist. At this time, quite in line with our dominant ideology, many organizations protect their boundaries and compete for similar niches. Not all of them will survive. Survival may depend on consolidation as it has in our general economy and in healthcare. How the field of health information will solve the turf issues is not clear, but collaboration is one path.

## What's in a Name?

AHIMA has seen a number of name changes since its inception in 1928.
Here's a timeline:

1928-Association of Record Librarians of North America founded

1944-renamed American Association of Medical Record Librarians

1970-renamed American Medical Record Association (AMRA)

1991-renamed American Health Information Management Association (AHIMA)

## Notes

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