Recipe for Information-based Healthcare

by Linda Kloss, RHIA, CAE, chief executive officer

Creating an information-based health system is like following a recipe. First, include essential ingredients, such as accurate and complete clinical documentation organized in architectures that enable access and interoperability. Then add protocols, terminologies, and classification systems to organize data into usable and interpretable information. Add technologies to automate classification, extraction, and analysis to impart new knowledge for a variety of uses and users. Take care to stay focused on the quality of that information and the efficiency with which it is handled.

Okay, it's not exactly a recipe with readily available ingredients and techniques that can be replicated with uniform results. But information-based healthcare systems are taking shape, and promising work is taking place across the US and in other countries.

Iron Chefs of Quality Information

The HIM field was founded on quality information, which is even more important in the era of electronic health records (EHRs), as Mark Hagland reports in "The Perfect Time for Documentation Improvement." HIM professionals describe the importance of improving clinical documentation through computerized physician order entry and other systems. Whether designed in or added later, improved clinical documentation must be a goal.

Information systems implemented at the Veterans Affairs and Department of Defense are providing invaluable lessons on how to build a nationwide health information network in the US. In "Architecture of the FHIE" Greg W. Donham and Tony Mallia describe the architecture and highlight three issues that have proved more challenging than expected: person identity matching, clinical record identity, and validation of upstream system data quality. These are not new challenges for HIM, but they are now more widely recognized as critical for an information-based, interoperable system.

Expanding Our Repertoire

Margaret Foley and Gail Garrett report on the work being done by AHIMA's Clinical Terminology and Classification Practice Council in "The Code Ahead." The council's study confirms that coding is transforming from a role of translating narrative clinical text to diagnosis and procedure codes to one of managing the capture of healthcare data in formats that have universal meaning and support multiple uses.

Anthea Ward provides a glimpse of this future in "Implementing SNOMED CT in England." As EHRs and controlled medical vocabularies are deployed, a new HIM role of terminology facilitator is emerging.

In "A Look at LOINC" Marilyn Stark describes how the Logical Observation Identifier Names and Codes system is used for managing laboratory data in interoperable EHRs.

In "Computer-Assisted Coding: What's Here, What's Ahead" James Flanagan and Karen Doyle provide an overview of computer-assisted coding and abstracting and their technologies. Flanagan and Doyle urge HIM professionals to educate their organizations on data standards, data dictionaries, and standards for interoperability. They also advise HIM professionals to actively engage vendors to advance standards compliance and to participate with health information exchange efforts.

AHIMA's Board of Directors and staff are putting the finishing touches on a three-year plan that places high priority on advancing the body of knowledge for ensuring high quality clinical information in EHRs and secondary data sets. While the association and the HIM field face many challenges, we understand that this is our most important contribution to an information-based healthcare system.

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