

A Survey of Health Information Management (HIM)

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Abstract— A Health information management (HIM) is an information management practiced for health and health care. It is the practice of acquiring, analyzing, and protecting digital and conventional medical information vital to providing quality patient care. Now a day's health Information Management is very important one for health care and its research. In this paper explained about the Data Quality and Characteristics of the Health Information Management (HIM).

Keywords— Information management, health care, patient records

I. INTRODUCTION

Health information management professionals plan information systems, develop health policy, and identify current and future information needs. In addition, they may apply the science of informatics to the collection, storage, analysis, use, and transmission of information to meet legal, professional, ethical and administrative records-keeping requirements of health care delivery. They work with clinical, epidemiological, demographic, financial, reference, and coded health care data. Health information administrators have been described to "play a critical role in the delivery of health care through their focus on the collection, maintenance and use of quality data support the information-intensive and information-reliant healthcare system".

The World Health Organization (WHO) stated that the proper collection, management and use of information within healthcare systems "will determine the system's effectiveness in detecting health problems, defining priorities, identifying innovative solutions and allocating resources to improve health outcomes."

II. SECOND HEADING

- The **patient health record** is the primary legal record documenting the health care services provided to a person in any aspect of the health care system. The term includes routine clinical or office records, records of care in any health related setting, preventive care, lifestyle evaluation, research protocols and various clinical databases. This repository of information about a single patient is generated by health care professionals as a direct result of interaction with a patient or with individuals who have personal knowledge of the patient.
- The **primary patient record** is the record that is used by health care professionals while providing patient care services to review patient data or document their own observations, actions, or instructions.
- The **secondary patient record** is a record that is derived from the primary record and contains selected data elements to aid non clinical

persons in supporting, evaluating and advancing patient care. Patient care support refers to administration, regulation, and payment functions.

III. METHODOLOGY TO ENSURE DATA QUALITY

The accuracy of data depends on the manual or computer information system design for collecting, recording, storing, processing, accessing and displaying data as well as the ability and follow-through of the people involved in each phase of these activities. Everyone involved with documenting or using health information is responsible for its quality. According to Data Quality Management Model, there are four key processes for data:

1. **Application:** the purpose for which the data are collected.
2. **Collection:** the processes by which data elements are accumulated.
3. **Warehousing:** the processes and systems used to store and maintain data and data journals.
4. **Analysis:** the process of translating data into information utilized for an application.

Each aspect is analyzed with 10 different data characteristics:

1. **Accuracy:** Data are the correct values and are valid.
2. **Accessibility:** Data items should be easily obtainable and legal to collect.
3. **Comprehensiveness:** All required data items are included. Ensure that the entire scope of the data is collected and document intentional limitations.
4. **Consistency:** The value of the data should be reliable and the same across applications.
5. **Currency:** The data should be up to date. A datum value is up to date if it is current for a specific point in time. It is outdate if it was current at some preceding time yet incorrect at a later time.
6. **Definition:** Clear definitions should be provided so that current and future data users will know what the data mean. Each data element should have clear meaning and acceptable values.
7. **Granularity:** The attributes and values of data should be defined at the correct level of detail.

8. **Precision:** Data values should be just large enough to support the application or process.
9. **Relevancy:** The data are meaningful to the performance of the process or application for which they are collected.
10. **Timeliness:** Timeliness is determined by how the data are being used and their context.

IV. CONCLUSION

A health care information system promises to improve legibility, reduce medical problems, reduce costs and boost the overall quality of health care. Government investments in health care technology are both significant and purposeful in achieving desired outcomes. Nevertheless, there are many challenges resulting from the technology, end-users and environment that continue to undermine these attempts.

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