El Paso Community College
Syllabus
Part II
Official Course Description

SUBJECT AREA	**Health Information Management**
COURSE RUBRIC AND NUMBER	**HITT 1353**
COURSE TITLE	**Legal and Ethical Aspects of Health Information**
COURSE CREDIT HOURS	**3 (Credits) 2 (Lec) : 2 (Lab)**

I. Catalog Description

Studies the concepts of privacy, security, confidentiality, ethics, health care legislation, and regulations relating to the maintenance and use of health information. A grade of "C" or better is required in this course to take the next course. **Prerequisites: HITT 1341. (2:2).**

II. Course Objectives

A. Unit I. American Legal System.
1. Name the lowest and the highest courts in the state system.
2. State the jurisdiction of Federal and State Courts.
3. List the officers of the court and their functions.
4. Name and define the parties in a lawsuit.
5. Define the term "common law" and its origin.
6. List the three (3) branches of government and their broad functions.
7. Define the most common legal terms in the practice of medical records.
8. Demonstrate proper use of legal references by accessing at least one cited court decision and discussing the outcome in class,
9. Explain the origin and purpose of the "Code of Federal Regulations"/Federal Register.
10. Explain the origin and purpose of the Texas Codes of Civil Statutes (Vernon's).

B. Unit II. Patient Record Requirements
1. Cite the value and uses of maintaining medical records.
2. List the four (4) types of health data collected (personal, social, financial, and medical) with examples of each.
3. Delineate record content requirements as they relate to acute care facilities, ambulatory care facilities (including hospice and home care records), long term care facilities and mental health facilities.
4. Cite the applicable sources for record content requirements in each type of health care facility.
5. Discuss differences in record keeping requirements in a manual vs. automated system.
6. Explain the term "retention" as it relates to maintenance of health records.
7. Cite applicable statutes and national standards for the retention of commonly maintained medical and health records (hospitals, ambulatory care facilities, hospice, and home care facilities, long term care facilities, physician office records mental health facilities).
8. Cite applicable statutes and national standards for maintenance of back-up health records, i.e, statistical reports, pathology, radiology, laboratory reports/specimens and hospital financial data.
9. Outline the major factors used in decisions regarding retention of health records.
10. Given hypothetical situations, analyze and present solutions for retention of specific health records.

11. Define the term "Statute of Limitations" and explain how this affects the retention of medical records.
12. List five to eight (5-8) alternatives and technology for the long- and short-term retention of health records.
13. Distinguish between use the medical record as a personal document and impersonal document.
14. Explain the most common documentation standards for entries by physicians and allied health care personnel in the medical record.
15. Define and give examples of legible, complete and accurate entries in the medical record.
16. List the provisions for "authentication" of medical record entries as defined by national, state and accrediting statutes and standards.
17. Write a general policy for legally acceptable corrections and alternatives for medical entries.

C. Unit III. Confidentiality of Patient Health Information and Release of information.
1. Explain the property rights of the medical record.
2. Define and give examples of a proper authorization for release of medical information
3. Identify information normally collected in patient health records which may be released without the consent of the patient and cite factors which would change this practice.
4. Identify information in the health record which requires patient authorization prior to release. 9.2,9.4
5. Given hypothetical situations, abstract information from a medical record.
6. Define the hospital lien law and give an example of its application to the release of information from the medical record.
7. Cite the four to five (4-5) types of information covered in the "Freedom of Information Act".
8. Given sample authorization, analyze each for appropriate content.
9. Given appropriate solutions for the release of information in cases involving celebrities and photographs.
10. Summarize the Federal Privacy Act and its impact upon the provisions for confidentiality of health information.
11. List the three (3) essential elements of physician-patient privileged communication.
12. State the hospital's and the patient's rights to the medical record and its informational contents.
13. Discuss security measures necessary within a medical record department for confidentiality and protection of information, to include computerized records.
14. State the general provisions for patient access to medical record information.
15. State the general provisions for third party access to medical record information.
16. Discuss the access provisions for minors to their medical records.
17. Review provisions for patient and third party access to psychiatric records.
18. Identify standard charges for reproduction of medical records.
19. Explain access rights of patients, persons acting on behalf of the patient and other third patients.
20. List the federal statutory provisions for access to medical records.
21. Define secondary records and access standards which should be maintained in health care facilities regarding these records.
22. Define specific guidelines used in Texas for the release of medical information to patients, third parties and other interested parties.
23. List commonly released non-confidential items of information also maintained in the patient medical record.
24. Identify the major penalties for improper disclosure of medical records.
25. Explain the grounds for liability for unauthorized and improper disclosure of medical records.
26. List the nine (9) requirements for a proper release authorization for the release of medical record information.
27. Discuss the AHIMA recommendations for proper release of information as published in the position statement "Release of Information".
28. Give the examples of authorized release of information which do not require patient authorization.
29. Explain the two (2) guidelines published by AHA and the Joint Commission for confidentiality and release of information.
30. Explain the (1) model medical record policy and procedure for the release of confidential patient information to patients and their authorized representatives, government agencies, law enforcement officials, insurance companies and third party payors, attorneys and other health care providers.

31. Explain proper procedures for the maintenance of hospital committee reports and minutes in reference to non-discoverability rulings vs. discoverability rulings.
32. Explain the most common provisions promulgated in TDH Regulations for the maintenance of medical records and recommended policies for handling of this information.
33. Explain the purpose of HIPAA and the purposed privacy rules.
34. Discuss the impact of HIPAA on the HIM Department.

D. Unit IV. Consents
1. Cite instances in which a minor can consent to his own treatment.
2. Identify, in given hypothetical situations, which person may give consent for treatment of another.
3. Define the three (3) types of consent forms commonly used in the U.S.A.
4. Identify the three (3) commonly used refusal forms seen in the patient record.
5. Identify responsibility for the securing informed consent in treatment of patients in health care institutions.
6. Given sample consent forms, analyze for content and recognize a correctly executed signature.

E. Unit V. Special Medical Record Problems.
1. Identify three (3) common documentation problems which must be addressed in the handling of child abuse cases, emergency room records, a patient leaving against medical advice (AMA), disagreements among professional staff, terminally ill patients, autopsies, hostile patients, celebrity patients and adopted patient records.
2. Define an incident report per AHA guidelines.
3. Compare the handling of administrative and social service records service records with the normal handling of patient medical records.
4. Summarize release of information policies related to special cases such as adoptions, child abuse, alcohol and drug abuse patient records, and HIV/AIDS patient records.
5. Discuss the major guidelines for use in health care facilities which must release information on psychiatric patient records.
6. Given national and state statutes regarding release of information from Mental Health Records, identify instances in which information may be released.
7. Define "Coroner's Case" and explain how this affects autopsy consents.
8. Explain the "Uniform Anatomic Gift Act."
9. Discuss "Natural Death Act and Living Wills" as they to medical records documentation and informed consent.

F. Unit VI. The Medical Record in Court
1. Define subpoena, deposition, subpoena duces tecum, notary public subpoena, subpoena fee and summons.
2. Describe the valid service of a subpoena duces tecum.
3. Properly accept a subpoena duces tecum for a medical record.
4. List the eight (8) steps employed in a subpoena deposition for health record information.
5. Describe proper courtroom behavior in response to a subpoena duces tecum for the custodian of medical records.
6. Cite instances in which the principles of discoverability may affect hospital liability in relationship to valid court proceedings.
7. Given a hypothetical situation, explain the preparation of a medical record for court from time of receipt of subpoena to production in court.
8. List two (2) controls to be established for the return of the record from court.

G. Unit VII. Principles of Hospital Liability and Risk Management
1. Define Good Samaritan statute, malpractice and negligence.
2. Describe the need for confidentiality of an incident report.
3. List the four (4) factors which must be proved in order to prove a negligence claim against a hospital.
4. Explain the doctrine of "res ipsa loquitur".
5. Explain the importance of Darling v. Charleston Community Memorial Hospital in overturning the doctrine of charitable immunity.
6. Define risk management and its component parts.
7. Explain how risk management is related to the practice of medical records.

Unit VIII. Interdisciplinary Relationships

8. Explain the AHIMA Code of Ethics as it relates to confidentiality and release of information procedures.
9. Explain communication that is necessary for formulation of policies and procedures within a health care facility involving the maintenance, handling and dissemination of health record information.

H. Unit IX. Current Trends

1. Participate in professional association activities as they related to current medical records and health care trends.
2. Using professional resources, define, and describe recent legislation of the Federal/State level in health care and comment on how it may affect the health information management field.

III. THECB Learning Outcomes (WECM)

1. Apply local, state, and federal standards and regulations for the control and use of health information.
2. Demonstrate appropriate health information disclosure practices.
3. Identify and discuss ethical issues in health care.

IV. Evaluation

A. The course grade is determined by

1. Unit Tests/Quizzes	40%	toward final grade
2. Comprehensive Final Exam	20%	toward final grade
3. Lab Project & Participation	30%	toward final grade
4. Current Trends Reports	10%	toward final grade
TOTAL	100%	

B. Students are encouraged to seek direction and help for those areas in which they experience difficulty. The course instructor may assign remedial or tutorial work designed to enhance student proficiency.
C. The student must receive a grade of "C" or better to pass this course.
D. A student not adhering to Health Occupation's Criteria for Course Pursuit may be administratively withdrawn from this course. (See attached)
E. Grading Scale

93 – 100 = A
83 – 92 = B
75 – 82 = C
0 – 74 = Failing

V. Disability Statement (Americans with Disabilities Act [ADA])

EPCC offers a variety of services to persons with documented sensory, mental, physical, or temporary disabling conditions to promote success in classes. If you have a disability and believe you may need services, you are encouraged to contact the Center for Students with Disabilities to discuss your needs with a counselor. All discussions and documentation are kept confidential. Offices located: VV Rm C-112 (831-2426); TM Rm 1400 (831-5808); RG Rm B-201 (831-4198); NWC Rm M-54 (831-8815); and MDP Rm A-125 (831-7024).

VI. 6 Drop Rule

Students who began attending Texas public institutions of higher education for the first time during the Fall 2007 semester or later are subject to a 6-Drop limit for all undergraduate classes. Developmental, ESL, Dual Credit and Early College High School classes are exempt from this rule. All students should consult with their instructor before dropping a class. Academic assistance is available. Students are encouraged to see Counseling Services if dropping because exemptions may apply. Refer to the EPCC catalog and website for additional information.

HEALTH OCCUPATIONS DIVISION CRITERIA FOR COURSE PURSUIT

In order to establish guidelines for determining when a student has ceased to pursue the course objectives, the Health Occupations Division has set the following applicable standards.

1. The student must adhere to the attendance requirements of course HITT 1253. In order to pursue the course, the student must attendance a minimum of 57 hours of instruction. (Meets a total of 60 hours – 40 lecture hours and 20 lab hours).

2. The student will not be able to make up theory hours. The student will be able to make up lab hours at the discretion of the instruction.

3. Tardiness will be defined as being fifteen (15) minutes or more late to laboratory sessions and fifteen (15) minutes or more late to theory sessions. Students will be allow two (2) events of tardiness, after which the tardiness will be considered and absence.

4. If required by instructor/coordinator, student also must follow the standards established in the El Paso Community College Health Occupations Program Students Handbook for Allied Health Students and/or program addendum. The student is bound by standards in the El Paso Community College Health Occupations Program Student Handbook for Allied Health Students as evidence by the return of a signed/dated acknowledgment sheet.

5. Where the student continues to pursue the course objectives but I receiving failing grades, he/she will remain eligible to complete the course, except in instances where unsafe practice occurs.

6. The student must appear for examinations, presentations, or other required class activities and submit required papers, projects, and/or reports as identified in the course syllabus/calendar.

Failure of the student to follow the above will indicate the student is no longer pursuing the objectives of the course and will result in faculty initiated withdrawal.

EL PASO COMMUNITY COLLEGE
HEALTH OCCUPATIONS DIVISION
SCHOLASTIC DISHONESTY

Scholastic dishonesty shall constitute a violation of rules and regulations and is punishable as prescribed by Board policies. Scholastic dishonesty shall include, but not be limited to, cheating on a test, plagiarism, and collusion. "Cheating in a test" shall include:

1. Copying from another student's paper.
2. Using test material not authorized by the person administering the test.
3. Unauthorized collaborating with or seeking aid from another student.
4. Knowingly using, buying, selling, stealing, or soliciting, in whole or in part, the contents of a test.
5. The unauthorized transportation or removal, in whole or in part, of the contents of the test.
6. Substituting for another student, or permitting another student to substitute for one's self, to take a test.
7. Bribing another person to obtain a test or information about a test.
8. "Collusion" shall be defined as the unauthorized collaboration with another person in preparing written work for fulfillment of course requirements.
9. Any student involved in scholastic dishonesty as identified above, or in the Student Handbook, may. At the discretion of the faculty.

    a. Have the test or paper graded zero (0).
    b. Be removed from the class.
    c. Be recommended for administrative dismissal from the course or program.

The stringency of his policy is understandable when read in the context of an educational program preparing individuals for a health career where the safety and well-being of the public are largely dependent upon the knowledge and ethical responsibility of the health personnel. Evidence of unethical behavior, such cheating, precludes the instructional faculty's ability to declare prospective graduates to be reliable and ethical.