El Paso Community College
Syllabus
Part II
Official Course Description

SUBJECT AREA	**Health Information Management**
COURSE RUBRIC AND NUMBER	**HITT 1301**
COURSE TITLE	**Health Data Content and Structure**
COURSE CREDIT HOURS	**3 (Credits) 2 (Lec) : 3 (Lab)**

I. Catalog Description

Introduction to systems and processes for collecting, maintaining, and disseminating primary and secondary health related information including content of health record, documentation requirements, registries, indices, licensing, regulatory agencies, forms, and screens. A grade of "C" or better is required in this course to take the next course. **(2:3). Lab fee.**

II. CAHIIM Mandated Outcomes

1. Analyze the documentation in the health record to ensure it supports the diagnosis and reflect he patient's progress, clinical findings, and discharge status (4)

2. Verify the documentation in the health record is timely, complete, and accurate (4)

3. Identify a complete health record according to, organizational policies, external regulations, and standards (3)

4. Collect and maintain health data (3)

5. Explain current trends and future challenges in health information exchange (2)

III. Course Objectives

A. Unit I. Health Care Delivery System

1. Trace the history and development of the health care delivery system in the United States.
2. Summarize the impact of federal and state legislation on the health care delivery system.
3. Relate the history and development of the field of medicine to the health care delivery system of today.
4. Identify important individuals in medicine and their major contributions.
5. Describe and explain the major components of the health care delivery system.
6. Define terms related to the health care delivery system.
7. Trace the historical development of the major types of health care facilities.
8. Display knowledge of current trends in the health care delivery system through written and/or oral reports.
9. Describe and explain licensing, regulatory, and accrediting agencies and functions.
10. Name the various classifications of patients admitted to a hospital.

11. Describe the roles of the departments in the hospital organizational structure and their relationship to the health information department.
12. Describe the role of the admitting office within the hospital organization.
13. Demonstrate an understanding of the process by which the initial database is gathered on an individual patient upon entering the health care system.
14. When given a situation related to deletion, addition, or change of patient upon entering the health care system.
15. Describe roles, education, certification and/or licensure for various members of the health care team including health information practitioners.
16. Through the assigned cooperative learning techniques, display organizational skills and relationships necessary for interdisciplinary communication.

B. Unit II. The Health Information Professional

1. Trace the development of the health information profession from its beginning to the present day.
2. Discuss the future role of the health information practitioner in the health care delivery system.
3. State the educational requirements for RHIT, RHIA, CCS, CCS-P, as well as other AHIMA credentials.
4. Name and define the categories of AHIMA membership.
5. Explain the relationships that exist between/among the Executive Board, the Executive Office and the House of Delegates.
6. Explain the relationship that exists between/among national, state and local levels.
7. Describe basic characteristics of the American Health Information Management Association's organizational components and Code of Ethics.
8. Apply principles of medical ethics as a practitioner, both in professional relationships and in the professional organization.
9. Utilize AHIMA Code of Ethics as appropriate in the simulated laboratory setting.
10. Attend specified meetings of the District III-Mountain View Health Information Management Association, as determined by the instructor.

C. Unit III. The Health Record: History, Development, Analysis, and Use

1. Trace the history and development of health records.
2. Name the major functions of the Medical Record Department/Health Information Management Department.
3. State the purpose of the health record.
4. Summarize the uses of the health record.
5. Differentiate between personal and impersonal use of the health record.
6. Trace the development of a health record from the time a patient is admitted until he/she is discharged.
7. Name the main sections of the health record and completion of these sections.
8. Name the parts of the nurses section of the health record, stating the purposes, and give examples of the type of information found in this section.

9. Describe the difference in arrangement of the health record during patient's hospitalization and after the patient has been discharged and the reasons for the arrangement.
10. Describe the format of the paper and/or hybrid health record and forms on which it is recorded, citing examples of applicability of snap-out forms, shingle type arrangement, interleaved NCR paper, as applicable.
11. Differentiate between the problem oriented health record and the source oriented health record.
12. Create a sample form and explain the rationale of forms control.
13. Explain the need for and value of current, timely recording.
14. Cite Joint Commission and Medicare requirements regarding signatures in health records, including countersignatures, rubber stamp signatures, initials in place of signatures, and automated signatures/ authentication.
15. Define and list purposes of the provisional and final diagnosis.
16. Interpret abbreviations appearing routinely in the medical/health record.
17. Cite Joint Commission and Medicare requirements regarding originals of report forms in the health/medical record.
18. Cite Joint Commission and Medicare requirements on time periods for completion of Health/medical records.
19. Define as it pertains to the medical record and give the Joint Commission and Medicare requirements for:
    a. "History" and its five subdivisions as discussed in class
    b. "Physical examination" and cite examples of poor and good entries
    c. "Interval History"
    d. "Routine laboratory tests" and reports
    e. Other laboratory test and reports
    f. X-ray examinations and reports
    g. Consultations, being able to list the three sections
    h. Operation report, being able to list five essential items of information which must be provided by the surgeon;
    i. Anesthesia report, giving examples of information recorded
    j. Tissue report
    k. Authorization for operation and administration of anesthesia, being able to give example of a good authorization form and a poor authorization form
    l. Physical Therapy and report, including requirement for referral to P.T.
    m. Occupational Therapy and report, including requirement for referral to O.T.
    n. Progress Notes, citing examples of good and poor entries
    o. Final Progress Note or summary
    p. Integrated progress notes Physician's Orders
    q. Autopsy (necropsy) report
    r. Final Diagnosis, including the principle, secondary, and complications
    s. Special records, to include:

       Obstetrical records (prenatal, labor and delivery records and postpartum records) and Newborn records

t. Short stay records, giving examples of types of cases in which they are applicable and inapplicable

u. Outpatient records, including emergency, referred outpatient, and clinical outpatient

v. Other reports or forms which may be found in the health record, including, release against medical advice, transfer from one clinical service to another, correspondence regarding the patient's admission and other correspondence regarding the patient

w. Follow-up data, including how it may be obtained, its purpose, and where it may be found in the health record

20. Distinguish between quantitative and qualitative analysis of health information.

21. Trace the steps needed for assembly, analysis and completion of health information, from the point of patient discharge through final audit.

22. Assess completeness and accuracy of HIMA laboratory records.

23. Assemble patient records received from "nursing units" into permanent filing page order using commonly accepted practice.

24. Recognize when a record is technically complete.

25. Evaluate the adequacy of records to meet established requirements of various agencies.

26. Explain various mechanisms which may be effectively employed to indicate deficiencies and to disseminate information to responsible persons.

27. Discuss and define the legal aspects of medical records related to confidentiality.

28. Display basic knowledge related to the confidential nature of health information.

29. Identify and explain the use and differences in records of emergency room, outpatient services, hospice, long-term care facility, and psychiatric facilities.

30. Describe mandatory content of specialized health records.

31. Differentiate regulations and standards for non-acute health care settings.

D. Unit IV. Responsibility for the Medical/Health Record

1. Describe the medical staff structural organization in typical hospital settings.

2. Identify the minimum content of medical staff by laws.

3. Explain the basis for departmentalization of the medical staff.

4. Draw an organization chart demonstrating the relationship of authority and communication of the medical staff to the governing body, hospital administration, and the various services of the hospital.

5. Describe the major responsibilities of the medical staff.

6. Name and differentiate between/among the categories of medical staff membership.

7. Describe the required characteristics of quality improvement as it pertains to duties of the medical staff.

8. List the components of departmental review, surgical review, drug usage, medical record review, blood usage, and pharmacy and therapeutics functions.

9. Describe the purpose and functions of infection control, and how this relates to quality improvement as defined by the Joint Commission.

10. Describe the purpose and functions of internal/external disaster plans, and how this relates to quality improvement as defined by Joint Commission.

11. Describe how the medical staff fits into hospital safety committee functions; the purpose and functions of hospital safety, and how this relates to quality improvement as defined by the Joint Commission.
12. Describe the purpose and functions utilization management, and how this relates to quality improvement, as defined by the Joint Commission.
13. Define the concept of peer review and relate its historical development.
14. Identify the roles of major allied health care practitioners in the documentation of patient care
15. Discuss the role of the health information practitioner in relation to the medical staff.

E. Unit V. Master Patient Index

1. Define master patient index to include the purpose and content.
2. Describe methods of filing master patient index data.
3. Given a set of 25 patient names. Demonstrate with 100% accuracy, the ability to file alphabetically.
4. Given a set of 15 patient names, demonstrate with 100% accuracy, the ability to file phonetically (i.e., Soundex).
5. Discuss advantage and disadvantages of alphabetical filing
6. Discuss advantage and disadvantages of phonetic filing.
7. Using manual and computerized methods, create update master patient index data.
8. Describe supplies and equipment commonly used for maintenance of a master patient index/indexing data base.
9. Define how the medical staff fits into hospital safety committee functions; the purpose and functions of hospital safety, and how this relates to quality improvement as defined by the Joint Commission.
10. Describe the purpose and functions utilization management and how this relates to quality improvement as defined by the Joint Commission.
11. Define the concept of peer review and relate its historical development.
12. Identify the roles of major allied health care practitioners in the documentation of patient care.
13. Discuss the role of the health information practitioner in relation to the medical staff.

F. Unit VI. Filing Methods; Storage and Retention

1. Define centralized and decentralized filing, and summarize the advantages of centralization of medical records.
2. Explain the various systems and procedures available to ensure record control in a health information department.
3. State the purpose and recommended retention period for specific types of records.
4. Demonstrate understanding of the unit and serial methods of numbering by defining and giving specific examples of the assignment of numbers.
5. Describe the relationship of the method of numbering to filing and cite advantages and disadvantages of various methods.
6. Demonstrate understanding of terminal digit and middle digit filing using both the 2-2-2 and 2-1-2 division by arranging numbered files in the correct sequence.
7. List four advantages of terminal digit filing over straight numeric.

8. List three advantages of color-coding folders for filing health records
9. List two advantages and two disadvantages of each of the following types of filing equipment: open shelf, various filing cabinet styles, rolling shelving, automated bins.
10. Cite two advantages and two disadvantages in using Social Security numbers for record identification; define pseudo numbers and show how this relates to the use of the Social Security number.
11. Using legal and regulatory guidelines, review a model retention policy for sample laboratory records.
13. Using laboratory records, review, implement a policy for record tracking and control.
14. Correctly retrieve and file in the HIMA laboratory.

G. Unit VII. Microfilm/Digitized images and Medical/Health Records

1. Define and describe the purposes and types of microfilming/digitizing used for health records.
2. Define "microfilm" and explain the different types of microfilming.
3. Contrast microfilming performed at the health care facility with having the microfilming outsourced.
4. Explain why it is necessary to microfilm the entire record of a patient in certain instances.
5. Explain the difference between a "reader" and a "reader-printer" as it relates to microfilm.
6. Cite the legal authority for the acceptance of microfilmed and/or digitized records in court.
7. Demonstrate understanding of what is meant by commercial storage of health records by citing two advantages and disadvantages of this method of retiring records.

H. Unit VIII. Current Trends

Develop written and oral reports regarding current trends as they impact upon course content, through library research and reading.

I. For All Units

1. Adhere to the Health Occupations Division Criteria for Course Pursuit. (See attached.)
2. Adhere to the Health Occupations Division Scholastic Dishonesty Policy. (See attached)

III. THECB Learning Outcomes (WECM)

1. Analyze health record content; describe health information management department function and purpose.
2. Differentiate the various types of health care facilities and their records.
3. Identify the various licensing and regulatory agencies in the healthcare industry.

IV. Evaluation

A. Pre-assessment

The instructor will review and discuss the course prerequisite on the first day of class. Due to specialized admission requirements for the HIMA Program, all students should have the necessary prerequisites prior to enrollment.

B. Post-assessment

A unit exam will be administered at the completion of each unit in this course. Quizzes over lecture/lab material and/or assigned reading are at the discretion of the instructor.

Unit activities/assignments will assigned by the instructor to further enhance students' understanding of the course objectives.

A comprehensive final examination will be administered for this course.

The instructor will maintain a continuous record of each student's progress. Students not performing at a C level or better in the course will be referred for tutoring and/or counseling.

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.

Students not adhering to the Health Occupations Criteria for course pursuit may be administratively withdrawn from this course. (See attached)

C. Grading Scale

93-100=A

83-92=B

75-82=C

63-74=D

0-63= Failing (The student must receive a grade of "C" or better to pass this course.)

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.

VII. Title IX and Sex Discrimination

Title 9 (20 U.S.C. 1681 & 34 C.F.R. Part 106) states the following "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any educational program or activity receiving Federal financial assistance." The Violence Against Women Act (VAWA) prohibits stalking, date violence, sexual violence, and domestic violence for all students, employees and visitors (male and female). If you have any concerns related to discrimination, harassment, or assault (of any type) you can contact the Assistant to the Vice President for Student and Enrollment Services at 915-831-2655. Employees can call the Manager of Employee Relations at 915-831-6458. Reports of sexual assault/violence may also be reported to EPCC Police at 915-831-2200.

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 requirement of course HITT 1301. In order to pursue the course, the student must attend a minimum of 72 hours of instruction. (Meets a total of 80 hours).
2. The student will not be able to make up theory hours.
3. Tardiness will be defined as being fifteen (15) minutes or more late to theory sessions. Students will be allowed two (2) events of tardiness, after which the tardiness will be considered an absence.
4. If required by instructor/coordinator, student also must follow the standards established in the El Paso Community College Health Occupations Programs Students Handbook for Allied Health Students and/or program addendum. The student is bound by standards in the El Paso Community College Health Occupations Programs Student Handbook for Allied Health Students as evidenced by the return of a signed/dated acknowledgement sheet.
5. Where the student continues to pursue the course objectives but is 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 that 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 these rules and regulation and is punishable as prescribed by Board policies. Scholastic dishonesty shall include, but not limited to, cheating on a test, plagiarism, and collusion. "Cheating on a test" shall include:

1. Copying from another student's paper.
2 Using test materials 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 or 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 this 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 as cheating, precludes the instructional faculty's ability to declare prospective graduates to be reliable and ethical.