HIM 100 Health Data Content and Structure

Credit Hours:

4 Hours (includes lab component)

Instructor:

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Prerequisites:

None

Description:

Emphasis on the health information profession, interdisciplinary relationships, health care data management, documentation standards, methods of access and retention of image-based information and maintenance of health information in acute and non-acute care facilities.

Procedures for maintaining vital statistics and specialized registries will be included.

Textbooks:

Health Information Management Technology: An Applied Approach 5th Ed, Sayles, 2016, American Health Information Management Association, ISBN: 978-1-58426-517-7

Students will need a Networked Educational Electronic Health Record (**Neehr Perfect**) subscription for access to the Electronic Health Record.

Description: Quarterly (up to 3 months)

ISBN: 978-0-9858379-3-8

Additional Requirements:

-AHIMA Student membership

Examinations:

Eleven chapter quizzes and a Comprehensive Final Examination will be given.

Make-up Exams-(for extreme circumstances only) will only be given during finals week at the time to be determined by the course instructor.

You will be permitted only one make-up exam for the semester.

What to do if you have technology issues:

For any type of email and/or computer problems you will need to contact the IT helpdesk via wku.edu/it/chat or via phone @ 270-745-7000 so that you can give your instructor the ticket # in the event you need to have your exam/quiz reset.

Evaluation:

The final course grade will be derived for the following:

11 Chapter Quizzes and 1 Examination	100 points= 1200
21 Lab/Clinical Skills	100 points= 2100
11 Proof of Readings	35 points= 385

The following Grade System will be used:

Test scores will be worth 70% of your grade.

Total points divided by the possible points multiplied by .7=Answer

POR and Lab/clinical skills will be worth 30%.

Total points divided by the possible points multiplied by .3=Answer

Add both answers to get your percentage

100-90	A
89-80	B
79-70	C
69-60	D
59 and below	F

Attendance:

Students are expected to attend all scheduled class meetings.

Instructional Methods:

Power Points and other electronic venues

Review of Medical Records

Utilization of Computer

Lab Activities

Others, as appropriate

Disability Accommodations:

In compliance with University Policy, students with disabilities who require accommodations academic adjustments and/or auxiliary aids or services for this course must contact the Office for Student Disability Services, Room DSU-1074. The OFSDS telephone number is (270) 745-5004 V/TDD. Please Do

Not request accommodations directly from the professor or instructor without a letter of accommodations from the Office for Student Disability Services.

Once disability services/accommodations have been granted and initiated, please contact me with any questions or concerns. Also, if you believe that you are not receiving the disability services to which you are entitled, please address this concern with me immediately so discussion and/or adjustments can occur.

Schedule Note:

Class and exam schedules are subject to change according to class progress.

Disclaimer:

References to external websites are provided for the convenience of the student. These sites may contain articles on politically and socially controversial topics and are presented from the prospective of providing information. The instructor is not responsible for the content of these external sites and does not necessarily endorse the views or agree with the information held on these sites; the instructor does not take moral stances on issue.

Rev. 07/2016

One of the first things that you need to do is to place the schedule of this class in your calendar in order to keep up with when assignments/quizzes are to be completed.

HIM 100- HEALTHCARE DATA CONTENT AND STRUCTURE

WEEK	TOPIC	ASSIGNMENT
1	Module #1: Syllabus	Purchase text; Orientation Quiz over Syllabus; HIM Handbook Crossword Activity
2	Module #2: Ch. 1 HIM Profession	Read Introduction and Pages 3-16; On Bb submit POR over reading; Chapter 1 Quiz
3	Module #3: Ch. 2 Healthcare Delivery System	Read Pages 19-47; On Bb submit POR over reading; AHIMA Career Mapping and Continuum of Care ; Chapter 2 Quiz
4	Module #4: Ch. 3 Health Information Functions, Purpose, and Users	Read Pages 51-76; On Bb submit POR over reading; Level I Scavenger Hunt; Level II Scavenger Hunt; Chapter 3 Quiz
5	Module #5: Ch. 4 Health Record Content and Documentation	Read Pages 81-109; On Bb submit POR over reading; Introduction to Chart Deficiencies; CPRS Analyzing for Chart Deficiencies; Chapter 4 Quiz
6	Module #6: Ch. 5 Clinical Terminologies, Classifications, and Code Systems	Read Pages 113-135; On Bb submit POR over reading; UHDDS & the EHR; Hospital Inpatient Quality Measures; Chapter 5 Quiz
7	Module #7: **Fall Break**	
8	Module #8: Ch. 6 Data Management	Read Pages 139-146 & 165-166; On Bb submit POR over reading; Quality Improvement Utilizing the EHR; Chapter 6 Quiz
9	Module #9: Ch. 7 Secondary Data Sources	Read Pages 171-189; On Bb submit POR over reading; Communication within the EHR; Data Entry; Retrieval of Data; Chapter 7 Quiz
10	Module #10 Ch. 8 Health Law	Read Pages 195-209; On Bb submit POR over reading; Health Information Terminology; Understanding the Joint Commission's Tracer Methodology; Chapter 8 Quiz
11	Module #11	Release of Information; Introduction to Privacy, Security, & Confidentiality in the EHR; Release of Information & Accounting for Disclosure
12	Module #12: Ch. 9 Data Privacy and Confidentiality	Read Pages 218-228 & 243-248; On Bb submit POR over reading; Introducing HITECH & the History of EHRs; Legal Record Comparison; Chapter 9 Quiz
13	Module #13: Ch. 12 Healthcare Information	Read Pages 330-334; On Bb submit POR over reading; Introduction to the Cancer Registry; Chapter 12 Quiz
14	Module #14: Ch. 21 Ethical Issues **Thanksgiving Break**	Read Pages 603-619; On Bb submit POR over reading; Watch Health Literacy Video; Chapter 21 Quiz
15	Module#15: Legal Record Comparison	Legal Record Comparison
16	Finals week	Comprehensive Final should be taken by **December 5th before 4:00 p.m.**

POR- Proof of Readings Schedule is subject to change. Rev. 08/17

HIM 100 AS CAHIIM 2017

Subdomain I.A. Classification Systems		
1. Apply diagnosis/procedure codes according to current guidelines, 3	* Principles and applications of Classification Systems (ICD, CPT, HCPCS, SNOMED, DSM)	Data Entry (3) Communication within the EHR(3)
	* Taxonomies (Healthcare data sets such as OASIS, HEDIS, UHDDS, DEEDS)	UHDDS and the EHR(3) Tests question
	* Nomenclatures	Test Question
	* Terminologies (SNOMED)	Test Question
	* Clinical Vocabularies	Test Question
2. Evaluate the accuracy of diagnostic and procedural coding, 5	* Principles and applications of classification, taxonomies, nomenclatures, terminologies, clinical vocabularies, auditing	Communication within the EHR(3)
Subdomain I.B. Health Record Content and Documentation		
1. Analyze the documentation in the health record to ensure it supports the diagnosis and reflects the patient's progress, clinical findings and discharge status, 4	* Content of health record	Introduction to Chart Deficiencies(3) CPRS Analyzing for Chart Deficiencies(4)
	* Documentation requirements of the health record	Introduction to Chart Deficiencies(3) CPRS Analyzing for Chart Deficiencies(4)
	* Health information media (paper, computer, web-based document imaging)	Introduction to Chart Deficiencies(3) CPRS Analyzing for Chart Deficiencies(4)
2. Verify the documentation in the health record is timely, complete, and accurate, 4	* Documentation requirements of the health record for all record types	Introduction to Chart Deficiencies(3) CPRS Analyzing for Chart Deficiencies(4)
	* Acute, outpatient, LTC, rehab, behavioral health	Introduction to Chart Deficiencies(3) CPRS Analyzing for Chart Deficiencies(4)
3. Identify a complete health record according to organizational policies, external regulations, and standards, 3	* Medical staff By-laws	
	* The Joint Commission, State Statues (Legal health record and complete health record)	UHDDS and the EHR(3) Introduction to Chart Deficiencies(3) CPRS Analyzing for Chart Deficiencies(4)

Subdomain I.A. Classification Systems		
		Understanding TJC's Tracer Methodology
4. Differentiate the roles and responsibilities of various providers and disciplines to support documentation requirements throughout the continuum of healthcare, 5	* Health Information System as it relates to the roles and responsibilities of health care providers	
	* Administrative (patient registration, ADT, billing) and Clinical (lab, radiology, pharmacy)	
Subdomain I.C. Data Governance		
1. Apply policies and procedures to ensure the accuracy and integrity of health data, 3	* Data stewardship	Quality Improvement Utilizing the EHR(4)
	* Data and data sources for patient care (management, billing reports, registries, and/or databases)	
	* Data integrity concepts and standards	
	* Data Sharing	Health Information Exchange(3)
	* Data interchange standards (X2, HL-7)	Health Information Exchange(3)
	* By-laws (Provider contracts with facilities, Medical staff By-laws, Hospital By-laws)	
Subdomain I.D. Data Management		
1. Collect and maintain health data, 2	* Health data collection tools (Screen design, screens)	Quality Improvement Utilizing the EHR(4) UHDDS & the EHR(5)
	* Data elements, data sets, databases, indices	Test Question
Subdomain I.E. Secondary Data		
1. Identify and use secondary data presentations, 3	* Data sources primary/secondary (UHDDS, HEDIS, OASIS)	Health Information Exchange(3) Using the Tools & Resources in the EHR(3)
	* Registries	Test Question
Domain II. Information Protection: Access, Disclosure, Archival, Privacy & Security		
Subdomain II.A. Health Law		
1. Apply healthcare legal terminology, 3	* Healthcare legal terminology	Health Information Terminology(3)

Subdomain I.A. Classification Systems		
2. Identify the use of legal documents, 3	* Health information/record laws and regulations (Consent for treatment, retention, privacy, patient rights, advocacy, health power of attorney, advance directives, DNR)	Release of Information(3)
3. Apply legal concepts and principles to the practice of HIM, 3	* Maintains a legally defensible health record (Subpoenas, depositions, court orders, warrants)	Release of Information(3)
Subdomain II.B. Data Privacy, Confidentiality & Security		
1. Apply confidentiality, privacy and security measures and policies and procedures for internal and external use and exchange to protect electronic health information, 3	* Internal and external standards, regulations and initiatives (State and federal privacy and security laws)	Release of Information(3) Intro To Privacy, Security, & Confidentiality (3)
	* Patient verification (Medical identify theft)	Release of Information(3) Intro To Privacy, Security, & Confidentiality (3)
2. Apply retention and destruction policies for health information, 3	* Data storage and retrieval	ROI Accounting of Disclosures(3)
	* E-Discovery	
	* Information archival, data warehouses	
Subdomain II.C. Release of Information		
1. Apply policies and procedures surrounding issues of access and disclosure of protected health information, 3	* Release patient specific data to authorized users	Release of Information(3) ROI Accounting of Disclosures(3)
	* Access and disclosure policies and procedures	Release of Information(3) ROI Accounting of Disclosures(3)
Domain III. Informatics, Analytics and Data Use		
Subdomain III.A. Health Information Technologies		
1. Utilize software in the completion of HIM processes, 3	* Record tracking, release of information, coding, grouping, registries, billing, quality improvement, imaging, natural language processing, EHRs, PHRs, document imaging	ROI Accounting of Disclosures(3) Understanding TJC Tracers Methodology (3)
2. Explain policies and procedures of networks, including intranet and Internet	* Communication and network technologies (EHR, PHR, HIEs,	Health Information Exchange (3) Test Questions

Subdomain I.A. Classification Systems		
to facilitate clinical and administrative applications, 2	portals, public health, standards, telehealth)	
Subdomain III.F. Consumer Informatics		
1. Explain usability and accessibility of health information by patients, including current trends and future challenges, 2	* Mobile technologies, patient portals, patient education, outreach, patient safety, PHRs, patient navigation	Cases Studies from Registries for Evaluation Patient Outcomes
Subdomain III.H. Information Integrity and Data Quality		
1. Apply policies and procedures to ensure the accuracy and integrity of health data both internal and external to the health system, 3	* Case management/care coordination	Case Study Review(3) Quality Improvement Utilizing the EHR(3) Communication within the EHR(3)
Domain IV. Revenue Management		
Subdomain IV. A. Revenue Cycle and Reimbursement		
1. Apply policies and procedures for the use of data required in healthcare reimbursement, 3	* Payment methodologies and systems (Capitation, PPS, RBRVS, case mix, indices, MSDRGs, healthcare insurance policies, Accountable Care Organizations)	CMD 1500 Billing Form(3)
	* Utilization review/management (Case Management)	Case Study
Domain V. Compliance		
Subdomain V.A. Regulatory		
2. Collaborate with staff in preparing the organization for accreditation, licensure, and/or certification, 4	* Accreditation, licensure, certification	Legal Record
Subdomain V.B. Coding		
1. Analyze current regulations and established guidelines in clinical classification systems, 4	* UHDDS guidelines	UHDDS and the EHR(5) Classification & Terminology(5)
Domain VI. Leadership		
Subdomain VI.A. Leadership Roles		
1. Summarize health information related leadership roles, 2	* Leadership roles (Healthcare providers and disciplines)	

Subdomain I.A. Classification Systems		
3. Organize and facilitate meetings, 3	* Roles and functions of teams and committees (Work in teams/committees, consensus building)	
	* Communication and interpersonal skills	
	* Critical thinking skills	
Subdomain V.I.C. Work Design and Process Improvement		
2. Identify cost-saving and efficient means of achieving work processes and goals, 3	* Incident response	Test Question
	* Medication reconciliation	Test Question
	* Sentinel events	Test Question
Subdomain VI.F. Strategic and Organizational Management		
2. Understand the importance of healthcare policy-making as it relates to the healthcare delivery system, 2	* Health People 2020	Introducing HITECH & the History of EHRs(3) Understanding TJCs Tracer Methodology(3)
	* CDC	Test Question
	* State, local and federal policies	Test Question
3. Describe the differing types of organizations, services and personnel and their interrelationships across the health care delivery system, 2	* Managed care organizations	Introducing HITECH & the History of EHRs(3) Understanding TJCs Tracer Methodology(3)
	* Payers/providers, all delivery settings	Test Question
4. Apply information and data strategies in support of information governance initiatives, 3	* Information and data strategy methods and techniques	Meaningful Use Stage 1 for Providers(3)
	* Data and information stewardship	Test Question
	* Critical thinking skills	Test Question
Subdomain VI.H. Ethics		
1. Comply with ethical standards of practice, 5	* Professional and practice-related ethical issues	Ethics Lab
	* AHIMA Code of Ethics	Ethics Lab
2.Evaluate the consequences of a breach of healthcare ethics, 5	* Breach of healthcare ethics	Ethics Lab
3. Assess how cultural issues affect health, healthcare quality, cost and HIM, 5	* Cultural competence	Diversity awareness training program
	* Healthcare professionals self-assessment of cultural diversity	Diversity awareness training program
	* Self-awareness of own culture	Diversity awareness training program

Subdomain I.A. Classification Systems		
	* Assumptions, biases, stereotypes	Diversity awareness training program
4. Create programs and policies that support a culture of diversity, 6	* Diversity awareness training programs: age, race, sexual orientation, education, work experience, geographic location, disability	Diversity awareness training program Creating a Respectful WorkPlace Training Video

HIM 100-Health Data Content and Structure

Course Content

I. Healthcare Delivery

A. Introduction

B. Modern Healthcare Delivery

C. Healthcare Providers and Facilities

D. Healthcare Services

E. Trends in Healthcare Delivery

F. Hospital-Based Services

G. Continuum of Care

H. Clinical Documentation in Healthcare: Moving Toward the Electronic Health Record

I. President Obama's Healthcare Reform

J. Personal Health Records

K. Health Information Exchange

II. Clinical Documentation and the Health Record

A. Introduction

B. Clinical Documentation and the Health Record

C. Purpose and Value of Documentation

D. Owners of the Health Record

E. Users of the Health Record

F. Definition of the Health Record for Legal Purposes

G. Legal Health Record

H. Patient-identifiable Source Data

I. Administrative Information

J. Derived Data

K. Emerging Issues

L. Personal Health Records

M. Types of PHRs

N. Documentation Guidelines

O. The Future of Clinical Documentation

P. Appendix 2A: Fundamentals of the Legal Health Record and Designated Record Set

Q. Appendix 2A.1: Health Record Matrix

R. Appendix 2A.2: Comparison of the Designated Record Set versus the Legal Health Record

S. Appendix 2A.3: Considerations for the Legal Health Record and Designated Record Set

T. Appendix 2A.4: Documents that Fall Outside the Designated Record Set and Legal Health Record

U. Appendix 2A.5: Policy Definitions

V. Appendix 2A.6: Legal Health Record Sample Template

W. Appendix 2A.7: Sample Designated Record Set Template

III. Principal and Ancillary Functions of the Healthcare Record

A. Introduction

B. Principal Functions of the Health Record

C. Administrative Information and Demographic Data

D. Admitting and Registration Information

E. Patient-Care Delivery

F. Patient-Care Management and Support

G. Billing and Reimbursement

H. Ancillary Functions of the Health Record

I. Accreditation, Licensure, and Certification

J. Biomedical Research

K. Clinical Education

L. Medical Staff Appointments and Privileges

M. Risk Management and Incident Reporting

N. Health Records as Legal Documents

O. Morbidity and Mortality Reporting

P. Management of the Healthcare Delivery System

Q. Form and Content of Health Records

R. The Consumer's Right to Health Record Access

S. Release and Disclosure of Confidential Health Information

T. Redisclosure of Confidential Health Information

U. Retention of Health Records

V. Destruction of Health Records

W. Summary

X. References

Y. Appendix 3A: Sample Informed Consent Document

Z. Appendix 3B: Maintaining a Legally Sound Health Record—Paper and Electronic

VI. Documentation for Statistical Reporting and Public Health

A. Introduction

B. Research and Statistics

C. Public Health Reporting

D. Centers for Disease Control and Prevention WONDER Database

E. National Center for Health Statistics

F. Department of Health and Human Services Data Council

G. The National Health Care Survey

H. Vital Statistics

I. Facility-Specific Indexes

J. Master Patient Index

K. Physician Index

L. Disease and Operation Indexes

M. Registries

N. Healthcare Databases

O. National Practitioner Data Bank (NPDB)

P. Data Quality Issues

Q. Primary and Secondary Data Sources

R. Standardized Clinical Data Sets

S. Summary

T. References

U. Appendix 4A: Fundamentals for Building a Master Patient Index/Enterprise Master Patient Index

V. Appendix 4A.1: Recommended Core Data Elements for EMPIs

W. Appendix 4A.2: Glossary

X. Appendix 4A.3: Sample Job Description

V. Clinical Information and Nonclinical Data

A. Introduction

B. Data Versus Information

C. Administrative Information

D. Demographic Data

E. Financial Data

F. Preliminary Clinical Data

G. Consents and Acknowledgments

H. Clinical Information

I. Who Documents in the Health Record?

J. Who Regulates Health Record Content?

K. Clinical Reports in Health Records

L. Medical History

M. Report of Physical Examination

N. Physician's Orders

O. Progress Notes

P. Outpatient Services Provided in Acute-Care Facilities

Q. Specialty-Care Documentation

R. Discharge Summaries

S. Autopsy Reports

T. Clinical Information as the Basis for Uniform Data Sets

VI. Health Record Design

A. Introduction

B. Paper-Based Health Records

C. Source-Oriented Health Records

D. Problem-Oriented Health Records

E. Integrated Health Records

F. Limitations of Paper-Based Health Records

G. Electronic Health Records

H. Definition of the Electronic Health Record

I. Data, Information, and Knowledge

J. Benefits of and Barriers to the EHR

K. Components of the EHR

L. Federal Policies Driving EHR Implementation

M. National Infrastructure for the EHR

N. Healthcare Providers and the Infrastructure for EHRs

O. Case Study: VistA—Veterans Health Information Systems and Technology Architecture

P. VistA Overview

Q. VistA for Patient Care

R. VistA for Research

S. The Hybrid Health Record

T. Definition of the Hybrid Health Record

U. Format of the Hybrid Health Record

V. Health Record Storage Systems

W. Paper-Based Storage Systems

X. Microfilm-Based Storage Systems

Y. Image-Based Storage Systems

Z. Health Record Formats' Impact on HIM Functions

AA. Authentication of Health Record Entries

BB. Guidelines to Prevent Fraud and Ensure EHR Documentation Integrity

CC. Authorship Integrity

DD. Auditing Integrity

EE. Documentation Integrity: Automated Insertion of Clinical Data

FF. Corrections in Clinical Documentation

GG. e-Discovery: Developing a Litigation Response Plan

HH. New Requests, New Responsibilities

II. The Duty to Preserve

JJ. The Legal Hold

KK. The e-Discovery Litigation Response Team

LL. Disaster Planning

VII. Best Practices in Health Record Documentation

A. The Importance of Clinical Documentation

a. Evidence-based Documentation: The Theory of High-Quality Clinical Documentation
b. Seven Criteria for High-Quality Clinical Documentation
c. The Clinical Documentation Specialist
d. CDI and the EHR

B. Translating Clinical Documentation into Coded Data

a. How a Coding Professional Views an Inpatient Health Record
b. The Relationship Between Clinical Documentation and Coding
c. Basic Coding Guidelines
d. Example of Coding for a Myocardial Infarction (Heart Attack)

C. Clinical Documentation Analysis and Assessment

a. Data Review
b. What Data Matter?
c. Qualitative Analysis
d. Ongoing Record Review

VIII. Federal and State Requirements and Accreditation

A. Introduction

B. Federal and State Requirements

C. Federal Healthcare Statutes

D. HIPAA

E. HITECH Act

F. Federal Patient Safety Legislation

G. CMS Regulations

H. Medicare Conditions of Participation

I. Medicare Compliance Surveys

J. CMS Quality Measures

K. Healthcare Corporate Compliance

L. Office of the Inspector General (OIG)

M. OIG Work Plan: HIM-related Activities

N. Federal Requirements for Special Health Record Protection

O. Records of HIV/AIDS Diagnosis and Treatment

P. HIV testing

Q. Confidentiality issues

R. Genetic information Nondiscrimination Act (GINA)

S. Definition of genetic information

T. State requirements

U. Licensure

V. Medicaid eligibility and administration

W. Compliance program

X. Accreditation Requirements for acute care hospitals

Y. The Joint Commission

Z. Priority focus process

AA. Sentinel event policy

BB. National patient safety goals

CC. ORYX

DD. American Osteopathic Association

EE. Internal Hospital Policies and Procedures

FF. HIM policies and procedures

GG. Medical staff bylaws, rules, and regulations

HH. Medical records committee

IX. Health Records in Ambulatory Care

A. Introduction

B. Governmental Regulation of Ambulatory Care

C. Ambulatory Care Accreditation Standards

D. Advantages

E. The Joint Commission

F. Elements of performance

G. National Patient Safety Goals

H. Sentinel Event

I. Accreditation Association for Ambulatory Health Care

J. American Association for Accreditation of Ambulatory Surgery Facilities

K. American College of Radiology

L. CARF

M. Accreditation Commission for Healthcare

N. Community Health Accreditation Program

O. College of American Pathologists

P. Commission on Cancer

Q. National Committee for Quality Assurance

R. Ambulatory Care Health Record Content and Formats

S. Registration record

T. Problem/Summary List

U. Medication list

V. Medical history

W. Progress notes

X. Physician orders

Y. Patient Instructions

Z. Missed appointment forms

AA. Telephone encounters

BB. Regulation and Policy

CC. Risk management and liability

X. Long-Term Care Hospitals

A. Introduction

B. Long-Term Care Hospital Settings

C. Regulations

D. Federal regulations

E. State regulations

F. Accreditation regulations

G. Future regulations

H. LTCH Health Record Content

I. LTCH Policies and Procedures

XI. Facility-Based Long-Term Care

A. Introduction

B. Adult foster care

C. Board and care homes

D. Assisted living

E. Continuing care retirement communities

F. Nursing homes

G. Skilled Nursing Care

H. Health Record Content

I. Resident assessments

J. Resident assessment protocols

K. Physician documentation

L. Other documentation

M. Accreditation Standards and Regulations

N. Medicare Quality Indicators

O. Risk Management and Liability

XII. Home Care and Hospice Documentation, Accreditation, Liability, and Standards

A. Introduction

B. Background

C. Home Health and Hospice Record Content

D. Home are and hospice assessment information

E. Home care and OASIS

F. Hospice and assessment

G. Home health plans of care

H. Physician orders

I. Hospice clinical and progress notes

J. Home health aide documentation

K. Dietary and nutritional information

L. Progress notes and the discharge transfer record

M. Facsimile signatures

N. Electronic signatures

O. Medicare Hospice Benefit

P. Provision of care

Q. Volunteer documentation

R. Bereavement documentation

S. Justification of care levels

T. Medicare Home Care Benefit

U. Home health PPS

V. Documentation of eligibility

W. Home health under care of physician

X. Skilled services requirement

Y. Certification and plan of care

Z. Medicare Home Care Surveys

XIII. Behavioral Healthcare

A. Settings

B. Inpatient facilities

C. Residential programs

D. Outpatient facilities

E. Community behavioral health centers

F. Employee assistance programs

G. Schools and universities

H. Documentation Issues to Consider

I. Seclusion and restraints

J. Suicide watch

K. Minors seeking treatment

L. Diagnostic interview examination

M. Psychological testing

N. Medication management

O. Psychotherapy sessions

P. Conservatorship

Q. Health Record Content

R. Accreditation, Regulation, Industry, and Advocacy

S. Accrediting bodies

T. Joint Commission

U. Commission on Accreditation of Rehabilitation Facilities

V. American Osteopathic Association

W. National Committee for Quality Assurance

X. Council on Accreditation

Y. Government regulation

Z. HIPAA privacy rule

AA. Healthcare industry forces

BB. Organizations and advocacy groups

CC. HIM Professional's Role in Behavioral Healthcare

DD. EHRs in Behavioral Healthcare

XIV. Exploring Other Healthcare Settings

A. Regulations Common to All Healthcare Providers

B. Outpatient private practitioners or solo practitioners

C. Outpatient ambulatory integrated clinical settings

D. Government healthcare settings

E. Other healthcare settings

F. Coordinated school health programs

G. University-based student health service

HIM 100-Health Data Content and Structure

Course Objectives

I. Health Care Delivery

A. Outline the basic structure of the US healthcare delivery system

B. Explain the significance of recent trends in healthcare delivery

C. Distinguish between inpatients and outpatients

D. Explain the concept of continuum of care

E. Present the model of the patient-centered medical home

F. Describe healthcare's migration to the electronic health record

G. Explain current challenges of the hybrid health record

H. Describe the use of personal health records

I. Explain the role health information exchange plays in improving healthcare

II. Clinical Documentation and the Health Record

A. Discuss the purposes of health records

B. Describe the functions of clinical documentation and health records

C. List users of health records

D. Explain the importance of defining the legal health record

E. Review documentation requirements in the health record

F. Discuss factors driving healthcare organizations toward the EHR

III. Principal and Ancillary Functions of the Healthcare Record

A. I Identify and explain the principal functions of a health record

B. Define the terms information and data and distinguish between them

C. Identify the ancillary functions of the health record; explain the special roles health records play in accreditation, licensure, and certification, biomedical research, clinical education, credentialing and privileging, legal proceedings, and reporting morbidity and mortality rates

D. Discuss the right to access, release and disclosure, and retention and destruction of health records; list the most common secondary indexes, registries, and databases maintained by hospitals and explain the content and purpose of each

IV. Documentation for Statistical Reporting and Public Health

A. Study how statistics are used in healthcare

B. Distinguish between primary and secondary data

C. Compare and contrast patient-identifiable data with aggregate data

D. Relate how health record data are used for research and statistics

E. Define healthcare databases in terms of purpose and content

F. Explain the use of health record data in clinical trials

G. Identify the role of health record documentation in public health reporting

H. Define vital statistics

I. Trace the flow of information in reporting vital statistics

J. Identify data quality issues to yield statistical information for administrative and clinical decisions

K. Describe the role and content of a master patient index

L. Recognize secondary data sources

M. Identify facility-specific indexes

N. List routine healthcare databases

O. Identify data elements in standardized clinical data sets

V. Clinical Information and Nonclinical Data

A. List the types of demographic data collected in health records and explain the purpose of each element

B. List the types of administrative information collected in health records and explain the purpose of each element

C. Explain the functions of general and special (or informed) consents

D. Identify the types of clinical information collected in health records and explain the purpose of each element

E. List the data elements collected in the report of history and physical examination and explain their relevance to patient treatment

F. Describe the types of services covered in physicians' orders

G. List the various types of documentation authored by physicians and explain their content and functions

H. Explain the conditions under which medical consultations should be ordered

I. List the various types of documentation authored by nurses and explain their content and functions

J. List the data elements that must be included in laboratory reports

K. List the data elements that must be included in imaging reports

L. Explain the purpose and content of anesthesia assessments and reports

M. List the data elements that must be included in operative reports

N. List the data elements that must be included in pathology reports

O. List the data elements that should be collected in implant and transplantation records

P. Explain the function and content of discharge summaries

Q. Explain the function and content of patient instructions

R. List the various types of specialty documentation maintained in acute-care record

S. List the data elements that must be collected in emergency and trauma records

T. List the uniform data sets that are collected for hospital patients and describe their content

VI. Health Record Design

A. Compare the format, functionality, and features of three different paper-based health record formats

B. List the limitations of paper-based health records

C. Explain the different definitions for the electronic health record (EHR) and list the elements that are common to all definitions

D. Define data, information and knowledge and give examples of each

E. Describe the federal policies and legislation driving national EHR implementation

F. Describe the benefits and barriers to EHR implementation

G. List the 10 components of the EHR

H. Describe HITECH Act criteria for meaningful use of the EHR and list criteria for stages 1, 2, and 3

I. List the organizations that provide guidance toward a standardized nationwide health information network (NHIN) and EHRs

J. Describe the different technical standards used to ensure consistency in EHRs

K. List and define the different standard clinical terminologies and identify which one will likely be used for EHRs and the NHIN

L. Define data dictionary, explain its purpose, and describe the basic steps involved in developing one

M. Define a database and explain the concept of database integration in EHR development

N. Explain electronic forms design concepts and their impact on the functionality of EHRs

O. Explain the functions of clinical decision support systems included in EHRs

P. Define the hybrid health record and the challenges it presents

Q. Describe the different types of electronic document management systems (EDMS)

R. Explain the Veterans Administration EHR system, VistA, and how it facilitates both patient care and healthcare research

S. Define authentication within the context of health records and discuss some of the tools used to achieve it

T. Explain the process for correcting errors in paper-based and electronic health records

U. Identify four areas of concern when working to prevent fraud in the EHR environment

V. Identify and explain three concepts important to developing a litigation response plan for e-discovery

W. Define disaster recovery planning and outline the points an EHR disaster-recovery plan should address

VII. Best Practices in Health Record Documentation

A. Explain the concept and importance of clinical documentation improvement and identify the seven criteria for high-quality clinical documentation

B. Define evidence-based medicine and evidence-based clinical documentation

C. Identify documentation that meets the seven criteria for high-quality clinical documentation and documentation that does not meet the criteria

D. Describe the background and functions of the clinical documentation specialist

E. Explain the physician query process and the difference between a concurrent query and a retrospective query

F. Describe how clinical documentation improvement functions are likely to change once hospitals have made the full transition to an EHR

G. Explain the role of clinical documentation in the coding process

H. Describe the process of clinical documentation analysis and assessment

I. Describe the type of data reports that can be used in the clinical documentation analysis process

J. Explain the purpose of health record analysis and the differences between quantitative and qualitative analysis

K. Discuss the importance of ongoing record review and data quality management

VIII. Federal and State Requirements and Accreditation Guidelines

A. List and explain accreditation and licensure requirements that apply to acute-care health records

B. Differentiate a statute from a regulation

C. List and explain the documentation standards in the Medicare Conditions of Participation for Hospitals

D. Explain the purpose of Centers for Medicare and Medicaid Services (CMS) quality measures and provide examples

E. Identify the five elements of a healthcare corporate compliance program

F. Explain the purpose of the Office of the Inspector General's (OIG) compliance guidance and annual work plan

G. List the functions of the Office of the National Coordinator for Health Information Technology (ONCHIT)

H. Describe the basic hospital licensure process

I. Clarify the concept of deemed status

J. Identify the difference between regulatory standards and accreditation standards

K. Describe The Joint Commission's accreditation process

L. Define The Joint Commission's sentinel event policy

M. Explain the purpose of tracer methodology

N. Briefly describe the American Osteopathic Association's (AOA) Healthcare Facilities Accreditation Process (HFAP)

O. Describe the purpose of developing health record policies and procedures and explain the difference between a policy and a procedure

IX. Health Records in Ambulatory Care

A. Describe the role of the federal government in regulating ambulatory care providers

B. Explain the role of state governments in regulating ambulatory care providers

C. Identify at least four reasons an ambulatory care provider would seek out voluntary accreditation

D. Evaluate the different accreditation agencies for ambulatory care

E. Describe the Joint Commission's accreditation methodology for ambulatory care, including elements of performance and sentinel events

F. Describe the emerging documentation requirements for each type of accreditation

G. Compare the differences in acute care and ambulatory care documentation

H. Describe the challenges of obtaining informed consent in a large multispecialty setting

I. Explain the unique difference in the internal policies for a multisite ambulatory healthcare organization

J. Outline the internal HIM policies that professionals should address to meet current regulation challenges

X. Long-Term Care Hospitals

A. Define long-term care hospital (LTCH)

B. Describe the differences between LTCHs and acute care hospitals

C. List the types of patient diagnoses commonly treated in an LTCH

D. Explain the federal, state, and accreditation regulations for LTCHs

E. Describe the assignment of a principal diagnosis for a patient in the LTCH

F. Describe the contents of the long-term acute-care hospital and long-term care facility health records

G. Explain the health record review process in the LTCH

H. Describe the current evolution of LTCH patient classification

XI. Facility-Based Long-Term Care

A. Describe the different types of facility-based long-term care

B. Define skilled nursing facility (SNF)

C. Define nursing facility (NF)

D. List the types of services provided at SNFs

E. Describe the Medicare Conditions of Participation for SNFs and NFs

F. Explain federal, state, and accrediting body regulations for SNFs and NFs

G. Describe documentation requirements for orders for restraints

H. Define the resident assessment instrument (RAI) and data collection process

I. Explain documentation requirements for the RAI

J. List Medicare quality indicators for SNFs

K. Explain the method for obtaining and how to use Medicare's SNF Compare website

L. Explain the relationship between health record documentation and Medicare quality indicators for SNFs

M. Describe risk management concerns in the SNF

XII. Home Care and Hospice Documentation, Accreditation, Liability, and Standards

A. Identify the key components of the home care and hospice health record database

B. Develop an understanding of Medicare home care and hospice benefits

C. Introduce the Medicare home care survey process

D. Discuss the documentation challenges for the prospective payment system and Outcome and Assessment Information Set (OASIS)

E. Provide the quantitative record review guidelines

F. Introduce the home care and hospice legal issues

G. Define outcomes management and quality requirements of home care and hospice

H. Reinforce the importance of confidentiality of performance improvement activities and OASIS

XIII. Behavioral Health

A. List and explain the sources of regulations and standards that apply to behavioral healthcare records

B. Describe the variety of settings for behavioral healthcare services

C. List and describe the documentation issues unique to behavioral healthcare settings

D. Describe the content of the behavioral health record

E. Define and describe psychotherapy notes and their special protection under HIPAA privacy regulations

F. List and describe the many outside forces affecting behavioral healthcare

XIV. Exploring other Healthcare Settings

A. Explain services provided by, specific regulations for, professional associations for, and health record requirements for healthcare providers

B. Describe the regulatory and legal standards that apply to all healthcare providers