HIM 100 Health Data Content and Structure

Credit Hours:

4 Hours (includes lab component)

Instructor:

Pamela Chandler, M.Ed., RHIT, CDIP

Pamela.chandler@wku.edu

270-745-3087

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 6th Ed, Sayles, 2020, American Health Information Management Association, ISBN: 978-1-58426-720-1

 DO NOT PURCHASE YOUR EHRGo SUBSCRIPTION UNTIL THE 4TH WEEK OF SCHOOL BECAUSE YOU WILL ONLY HAVE 12 WEEKS TO WORK ON YOUR ASSIGNMENTS WITHIN EHRGo.

Instruction to follow in order to purchase this subscription. Students will need to purchase an EHR-Go subscription for access to the Electronic Health Record. You will purchase it at www.ehrgo.com   At the right hand side of the page at the top, click on subscribe.

On the next page enter your program key which is; S23T22. Press the tab, "validate program key". Next you will fill out the registration form and submit it. You will need to purchase the 12 week subscription.

Examinations:

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

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

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 Complete all assignments in a timely manner.

Instructional Methods:

Power Points and other electronic venues
Review of Medical Records
Utilization of Computer
Lab Activities
Others, as appropriate

Schedule Note:

- **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.**

- **At the beginning of the semester 16 of your modules will be open for you to complete. You MUST complete at least, one module per week. The due date for each week's assignments and quiz must be completed before 11:59 each Sunday night. When you are finished with a module you may work ahead on the next modules.**

- **Modules 1-8 must be completed by March 19th @ 11:59 PM. After March 19th you will not be allowed to complete anything in Modules 1-8.**

- **IMPORTANT Information: Have all Lab assignments, and Quizzes for Modules 1-8 completed by March 19th @ 11:59 pm**

- **Modules 9-15 will be due before May 1st @ 11:59 pm for 5 extra points to your assignment score.**

- **IMPORTANT Information: Have all Lab assignments, and Quizzes for Modules 9-16 completed by May 4th @ 11:59pm.**

- **Final exam must be completed by May 4th @ 11:59pm.**

Rev. 1/2023

ADA Accommodation

In compliance with University policy, students with disabilities who require academic and/or auxiliary accommodations for this course must contact the Student Accessibility Resource Center located in Downing Student Union, Room 1074. The SARC can be reached by phone number at 270-745-5004 [270-745-3030 TTY] or via email at sarc.connect@wku.edu. Please do not request accommodations directly from the professor or instructor without a faculty notification letter (FNL) from The Student Accessibility Resource Center.

COVID-19

All students are strongly encouraged to get the COVID-19 vaccine. In accordance with WKU policy, all students must call the WKU COVID-19 Assistance Line at 270-745-2019 within 4 hours of testing positive for COVID-19 or being identified as a close contact to someone who has tested positive. The COVID Assistance Line is available to answer questions regarding any COVID-19 related issue. This guidance is subject to change based on requirements set forth by federal, state, and local public health entities. Please refer to the Healthy on the Hill website for the most current information. www.wku.edu/healthyonthehill

Title IX/Discrimination & Harassment

Western Kentucky University (WKU) is committed to supporting faculty, staff and students by upholding WKU's Sex and Gender-Based Discrimination, Harassment, and Retaliation (#0.070) and Discrimination and Harassment Policy (#0.2040). Under these policies, discrimination, harassment and/or sexual misconduct based on sex/gender are prohibited. If you experience an incident of sex/gender-based discrimination, harassment and/or sexual misconduct, you are encouraged to report it to the Title IX Coordinator, Andrea Anderson, 270-745-5398 or Title IX Investigators, Michael Crowe, 270-745-5429 or Joshua Hayes, 270-745-5121. Please note that while you may report an incident of sex/gender based discrimination, harassment and/or sexual misconduct to a faculty member, WKU faculty are "Responsible Employees" of the University and MUST report what you share to WKU's Title IX Coordinator or Title IX Investigator. If you would like to speak with someone who may be able to afford you confidentiality, you may contact WKU's Counseling and Testing Center at 270-745-3159.

WEEK	TOPIC	ASSIGNMENT
1	START HERE: Syllabus	Purchase text; Orientation Quiz over Syllabus; HIM Handbook Crossword Activity
2	Module #2: Ch. 1 HIM Profession	Read Introduction and Pages 3-16; Chapter 1 Quiz
3	Module #3: Ch. 2 Healthcare Delivery System	Read Pages 19-47; 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; EHR Orientation Assignment; Tools and Resources; Chapter 3 Quiz
5	Module #5: Ch. 4 Health Record Content and Documentation	Read Pages 81-109; **Lab Assignment submission (Develop a check list for physicians to go by while dictating their patient's H&P) Use your book to find the information needed for this assignment.** Introduction to Chart Deficiencies; Introductory Evaluation; Analyzing for Chart Deficiencies; Chapter 4 Quiz
6	Module #6: Ch. 5 Clinical Terminologies, Classifications, and Code Systems	Read Pages 113-135; UHDDS & the EHR; Understanding TJC's Tracer Methodology; Chapter 5 Quiz
7	Module #7: Ch. 6 Data Management	Read Pages 139-146 & 165-166; Quality Improvement with the EHR; Chapter 6 Quiz
8	Module #8: Ch. 7 Secondary Data Sources	Read Pages 171-189; Communication within the EHR; Data Entry; Retrieval of Data; Chapter 7 Quiz
9	**Have all assignments/quizzes for Modules 1-8 completed March 19th @ 11:59 pm**	**Have all assignments/quizzes for Modules 1-8 completed March 19th @ 11:59 pm**
10	Module #9 Ch. 8 Health Law	Read Pages 195-209; Health Information Terminology; Chapter 8 Quiz
	Module #10	Release of Information; SAFER analysis: Clinician Communication; Release of Information & Accounting for Disclosure
11	Module #11 Ch. 9 Data Privacy and Confidentiality	Read Pages 218-228 & 243-248; Introducing HITECH & the History of EHRs Chapter 9 Quiz

12	Module #12: Ch. 12 Healthcare Information	Read Pages 330-334; Introduction to the Cancer Registry; Chapter 12 Quiz
13	Module #13: Ch. 21 Ethical Issues	Ethical Issues in HIM assignment Chapter 21 Quiz
14	Module #14:	Read Pages 603-619; Watch Health Literacy Video and submit a recap of the Video
15	Module#15: Legal Record Comparison	Legal Record Comparison **Have all Lab assignments, and Quizzes for Modules 9-15 completed by May 1st @ 11:59; you will receive 5 points to your assignment grade for the semester**
16	Finals week	Comprehensive Final should be taken by **May 4th @ 11:59**

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

HIM 100 BS CAHIIM 2018

Domain I. Data Structure, Content, and Info Governance			
I.1. Compare diverse stakeholder perspectives through the delivery of health care services.	Stakeholders, External Forces, Internal Forces	HITECH and The History of the EHR; Understanding TJC's Tracer Methodology	
I.2. Analyze strategies for the management of information.	IG Strategies, Policy Strategies, Organizational Strategies	Analyzing for Chart Deficiencies; Introduction to Chart Deficiencies; Quality Improvement with the EHR	
I.3. Evaluate polices and strategies to achieve data integrity.	Data Governance, DM Software, Technology and Tools, Data Standards, Data Integrity Policies and Strategies, Data Reporting	Quality Improvement with the EHR; Communication in the EHR	
I.4. Recommend compliance of health record content across the health system.	Health Records Requirements, Health Records and the Continuum of Care, General Requirements (Promoting Interoperability)	Analyzing for Chart Deficiencies; Introduction to Chart Deficiencies; UHDDS and the EHR; Understanding TJC's Tracer Methodology	
Domain VI. Organizational Management & Leadership			

VI.1. Facilitate fundamental leadership skills.	Leadership Skills, Personal Leadership Skills, Team Leadership	EHR Implementation; SAFER Analysis; Clinician Communication	
VI.6. Examine behaviors that embrace cultural diversity.	Diversity Topics, Managing Cultural Diversity	Literacy Video & descriptive paper	
VI.7. Assess ethical standards of practice.	Ethical Issues and Standards, Compliance Strategies	Workbook assignment on Ethical Judgments of employees. Using the AHIMA ethics standards, students will complete scenarios based on the workplace	

Health Data Content and Structure

Course Content

I. **Healthcare Delivery**

A. Introduction

III. Principal and Ancillary Functions of the Healthcare Record

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

V. Clinical Information and Nonclinical Data

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

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