HIM 100 Health Data Content and Structure

Credit Hours:

4 Hours (includes lab component)

Instructor:

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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 for purchase of 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.

Additional Learning Resources:

- Mediasite (video/audio)
- Flip (Interactive Video Tool)
- AHIMA Body of Knowledge
- AHIMA Career Map
- YouTube

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.

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 should 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 17th @ 11:59 PM. After March 17th 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 17th @ 11:59 pm**

- **Modules 9-15 will be due before April 30th @ 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 April 30th @ 11:59pm.**

- **Final exam must be completed by December 6th @ 11:59pm.**

Rev. 1/2024

Regular and Substantive Interaction in Online and Distance Learning:

The U.S. Department of Education requires that distance education courses must include regular and substantive interaction between students and faculty. For more information about Regular and Substantive Interaction at WKU, please visit the Regular and Substantive Interaction in Online and Distance Learning webpage.

In this course, regular and substantive interaction will take place in the following ways:

- Timely and detailed feedback on assignments, as appropriate
- Direct instruction occurring through recorded course lectures/tutorials that are posted on Blackboard
- Responsive to questions about the course content in a timely manner
- Assignments and assessment deadlines set throughout the semester (for more information, see class schedule below)

Academic Misconduct: (Information below on Academic Misconduct, along with additional information, can be obtained from https://www.wku.edu/studentconduct/process-for-academic-dishonesty.php)

The University expects students to operate with the highest standard of integrity in all facets of the collegiate experience. Broadly defined, academic misconduct is any unethical self-serving action in the performance of an academic activity, deliberate or unintentional, that affords a student an unfair, unearned, or undeserved advantage. (Excerpt from the WKU Student Handbook, 2016)

The maintenance of academic integrity is of fundamental importance to the University. Thus it should be clearly understood that acts of plagiarism or any other form of cheating will not be tolerated and that anyone committing such acts will be held accountable for violation of the student code of conduct.

Students who commit any act of academic dishonesty may receive from the instructor a failing grade in that portion of the course work in which the act is detected or a failing grade in a course without possibility of withdrawal. The faculty member may also present the case to the Office of Student Conduct.

Dishonesty

Such as cheating, plagiarism, misrepresenting of oneself or an organization, knowingly furnishing false information to the University, or omitting relevant or necessary information to gain a benefit, to injure, or to defraud is prohibited.

Cheating

No student shall receive or give assistance not authorized by the instructor in taking an examination or in the preparation of an essay, laboratory report, problem assignment or other project which is submitted for purposes of grade determination.

Plagiarism
To represent written work taken from another source as one's own is plagiarism. Plagiarism is a serious act. The academic work of a student must be his/her own. One must give any author credit for source material borrowed from him/her. To lift content directly from a source without giving credit is a flagrant act. To present a borrowed passage without reference to the source after having changed a few words is also plagiarism.

Examples of Areas Where Academic Misconduct Most Likely Occurs
"Essentially, students are expected to do work that is assigned to them and submit products that represent personal and individual effort only."

1. In an exam setting
a. Presenting as your work, test answers that are not your work, including the following:

i. Using resources other than those specifically allowed by the instructor (e.g., notes or another person)

ii. Copying from another student's test

ii. Using notes from any source during a test when notes are not allowed

iv. Using materials that the instructor is not making available to the whole class (Exception: students with disabilities needing accommodations)

v. Recycling an assignment that has been used in another course (unless approved by the instructor)

b. Acquiring a copy of the exam without permission

c. Providing answers for or soliciting answers from another student with or without permission of the other student (Note: This may either be an attempt to help or harm the targeted student)

2. On a written assignment
a. Presenting as your own work duplicated work that you did not create

i. Purchasing written work from an external source

ii. Copying work from a free external source (online or otherwise)

iii. Presenting as your work something another person has created

b. Altering text from another source

i. Altering select words of some original text in order to conceal plagiarism

3. Academic dishonesty that is possible in various settings
a. Providing money or favors in order to gain academic advantage

b. Falsely stating that work was given to the instructor at a certain time when it was not

c. Correcting the responses of a graded assignment and presenting them to the instructor as incorrectly graded material

d. Pretending to be someone you are not; taking the place of another

4. Or any other behavior that violates the basic principles of integrity and honesty

(Above is an excerpt from the Academic Integrity Statement Ad Hoc Subcommittee on Academic Integrity in the College of Education and Behavioral Sciences, 2012)

Program Policies state that "Unprofessional conduct or violation of the rules, regulations or policies of the University or Health Information Management Program may result in dismissal from the program."

Cheating:

I expect each student to submit their own work. Sharing your work, assignments, project, or answers with another student or receiving the information from another student constitutes cheating. Any student found to have shared information or obtained information from another student or other source will receive a 0% on that assignment and it may result in dismissal from the program.

Plagiarism

I expect each student to submit their own work or give credit to the appropriate source.

Refer to the wku.edu website http://www.wku.edu/judicialaffairs/process-for-academic-dishonesty.php for information on academic honesty, integrity, and plagiarism. It defines plagiarism as: "To represent written work taken from another source as one's own is plagiarism. Plagiarism is a serious offense. The academic work of a student must be his/her own. One must give any author credit for source material borrowed from him/her. To lift content directly from a source without giving credit is a flagrant act. To present a borrowed passage without reference to the source after having changed a few words is also plagiarism."

Any student found to have plagiarized work from another source will receive a 0% on that assignment and it may result in dismissal from the program.

Title IX Misconduct/Assault Statement:

Western Kentucky University (WKU) is committed to supporting faculty, staff and students by upholding WKU's Title IX Sexual Misconduct/Assault Policy (#0.2070) at
https://wku.edu/eoo/documents/titleix/wkutitleixpolicyandgrievanceprocedure.pdf and

Discrimination and Harassment Policy (#0.2040) at
https://wku.edu/policies/hr_policies/2040_discrimination_harassment_policy.pdf.

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.*

ADA Accommodation Statement:

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, 1074. 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.

Food Security: Food insecurity is defined as a condition where persons, in this case students, do not have adequate resources to feed themselves, either nutritiously or not at all (USDA, 2013). According to a recent national study (Hunger on Campus, 2016), food insecurity is common at colleges and universities across the country, potentially undermining the educational success of untold thousands of students. If food insecurity is an issue you, or someone you know, help is readily available. Contact the WKU Office of Sustainability at (270) 745-2508 or email sustainability@wku.edu.

Emotional Support: WKU offers confidential counseling for students at the WKU Counseling Center. The best way to schedule an appointment is to visit their office in Potter Hall, Room 409 or by calling their office at 270-745-3159. They are open Monday - Friday from 8:00am - 4:30pm. For emergency and after-hours information, call 270-745-3159.

WEEK	TOPIC	ASSIGNMENT
1	Module #1 Welcome to the Class!	Purchase text; Orientation Quiz over the Syllabus; And introduce yourself using Flip.
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	Fall Break 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 October 20th @ 11:59 pm**	**Have all assignments/quizzes for Modules 1-8 completed March 17th @ 11:59 pm**
10	Module #9 Ch. 8 Health Law	Read Pages 195-209; Health Information Terminology; Chapter 8 Quiz
11	Module #10	Release of Information; SAFER analysis: Clinician Communication; Release of Information & Accounting for Disclosure
12	Module #11 Ch. 9 Data Privacy and Confidentiality	Read Pages 218-228 & 243-248; Introducing HITECH & the History of EHRs Chapter 9 Quiz

13	Module #12: Ch. 12 Healthcare Information Module #13: Ch. 21 Ethical Issues	Read Pages 330-334; Introduction to the Cancer Registry; Chapter 12 Quiz 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 April 30th @ 11:59; you will receive 5 points to your assignment grade for the semester.**
16	Finals week	Comprehensive Final should be taken by **April 30th @ 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

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