

Course Objectives/Course Outline
Spokane Community College

Course Title: HIM Theory and Practice

Prefix and Course Number: HIM 103

Course Learning Outcomes:

By the end of this course, a student should be able to:

- Collect and maintain health data (such as data elements, data sets, and databases)
- Conduct analysis to ensure that documentation in the health record supports the diagnosis and reflects the patient's progress, clinical findings, and discharge status
- Apply policies and procedures to ensure the accuracy of health data
- Verify timeliness, completeness, accuracy, and appropriateness of data and data sources for patient care, management, billing reports, registries, and/or databases
- Monitor and apply organization-wide health record documentation guideline
- Apply policies and procedures to ensure organizational compliance with regulations and standards
- Maintain the accuracy and completeness of the patient record as defined by organizational policy and external regulations and standards
- Assist in preparing the organization for accreditation, licensing, and/or certification surveys
- Apply policies and procedures to comply with the changing regulations among various payment systems for healthcare services such as Medicare, Medicaid, managed care, and so forth
- Differentiate the roles of various providers and disciplines throughout the continuum of healthcare and respond to their information needs
- Use technology, including hardware and software, to ensure data collection, storage, analysis, and reporting of information
- Differentiate the roles of various providers and disciplines throughout the continuum of healthcare and respond to their information needs

Course Outline:

I. Data Analysis and Management

- A. Describe and demonstrate how data is abstracted from the health record
- B. Explain how data abstraction is used for various indexes and registries
- C. Apply documentation guidelines to determine completion of the health record I.3:
Define filing and retrieval systems for health records
- D. Explain the various numbering and filing systems and demonstrate how to file and retrieve charts using the various systems
- E. Explain the MPI and how it is maintained and used in a facility
- F. Demonstrate how to eliminate duplicate data in the MPI
- G. Explain how data is organized into a useable format
- H. Describe how data is gathered from multiple sources
- I. Identify the various registries and explain how data is input into the registries
- J. Demonstrate how to input data into the MPI
- K. Describe the function of data archive

II. Coding

- A. Breakdown the guidelines for provider documentation

- III. **Compliance**
 - A. Explain federal and state regulations regarding patient record documentation
 - B. Explain how access to health information is controlled
 - C. Explain and demonstrate how health record documentation is monitored for completion
 - D. Name and describe accrediting, licensing, and certification bodies in healthcare
 - E. Explain the role of HIM in forms/screen design, revision, and implementation
- IV. **Information Technology**
 - A. Describe the disclosure standard for the health record
 - B. Explain how Health Information Management is the custodian of the health record
- V. **Quality**
 - A. Apply content, completeness, accuracy, and timeliness to health record audits
 - B. Apply standards, guidelines, and/or regulations to health records during an audit
 - C. Identify when an audit is necessary for chart completeness and accuracy
 - D. Explain how and why HIM professionals consult internal and external users on health information rules and regulations
 - E. Demonstrate how to audit a health record for completeness
- VI. **Legal**
 - A. Define organizational bylaws, rules and regulations
 - B. Describe record retention and destruction
 - C. Explain the difference between consents, advanced directives, DNRs and power of attorney
- VII. **Knowledge Statement**
 - A. State how computer applications and support systems are used in healthcare
 - B. Explain the various computer applications and support systems used in healthcare
 - C. Demonstrate the use of the electronic health record
 - D. Define transcription
 - E. Define abstraction
 - F. Explain and demonstrate the various types of health information filing systems
 - G. Explain how Medicare Conditions of Participation (COP) apply to health care settings
 - H. Explain the functions of AHIMA
 - I. Define the functions of the AMA
 - J. Define the functions of the AHA
 - K. Explain CMS
 - L. Recall the definitions of vocabularies, terminologies, and classifications systems
 - M. Explain the various government programs
 - N. Explain the managed care components
 - O. Explain insurance
 - P. Explain Workman's comp
 - Q. Differentiate between data structure, content, and standards
 - R. Describe healthcare delivery systems
 - S. Describe the function of vital statistics and the responsibilities HIM has regarding vital statistics
 - T. Define Joint Commission
 - U. Explain the "Do Not Use" abbreviation list for health record documentation
 - V. Define CARF
 - W. Define AOA
 - X. Define AAACF
 - Y. Define ACOS
 - Z. Define case management
 - AA. Define utilization management
 - BB. Define risk management

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CC. Explain the role of HIM in forms/screen design, revision, and implementation