

## **COURSE SYLLABUS**

Program: Health Information Management (HIM)/Coding Certificate

Course Title: Intro to Health Information Management

Course Number: Method of Delivery: Web

Hours: 4 credit hours

Prerequisites: BIO 111, CHE 100 or 110 or BIO 100

### **Required Textbook and Course Materials**

Documentation for Health Records, Fahrenholz, Russo,  
ISBN: 9781584262626, AHIMA

Health Information Management Technology: An Applied Approach,  
4<sup>th</sup> edition, Nanette Sayles  
ISBN: 9781584263527, AHIMA

One year subscription to ArchetypeInnovations web-based EHR

### **Other Requirements:**

- Access to a personal computer or laptop with current hardware and software including: Firefox 18 or higher and/or Microsoft Internet Explorer 8.0 or higher; and, Microsoft Office applications 2003 or above.
  - (If using Internet Explorer 9.0 or above, some Blackboard functionality does not work. Must change compatibility.)
- Printer as necessary
- AHIMA student membership

- Paper and supplies to print assignments, course materials, etc.

**Course Description:** An introduction to the health information management profession, the functions of a HIM department, and clinical documentation in healthcare settings. Students will learn about HIM department functions in both electronic and paper environments, the role of the health record, and clinical documentation requirements in acute care and non-acute care settings. Healthcare organization accreditation and regulatory body documentation requirements will also be reviewed.

**Course Objectives:** At the conclusion of this course, the student will be able to:

1. Describe the roles and responsibilities of the HIM profession and the purpose of the American Health Information Management Association.
2. Identify the roles of the health care settings and health care professionals that comprise the continuum of care.
3. Provide examples of the influence that legislation, regulatory bodies, reimbursement and technology advances have on healthcare delivery.
4. Identify the functions and users of the health record and the importance of the health record to its users.
5. Identify secondary health data sources and explain the purpose of each data source.
6. Identify the components of the health record and documentation requirements in the acute and alternative health care settings.
7. Describe best practices in health record design and documentation.
8. Describe the functions of a health information management department in both paper and electronic health record environments.
9. Recommend and use health record storage, filing, and numbering systems.
10. Perform quantitative analysis for health record documentation.
11. Apply regulatory/accrediting body standards to health information practices.
12. Begin to develop a personal brand.

## **Topics:**

1. HIM Profession/AHIMA
2. Health care delivery systems
3. Health record functions
4. Regulatory/accrediting bodies
5. Health record documentation in acute care
6. Joint Commission standards and accreditation
7. HIM department functions (paper-based, electronic-based)
8. Record storage, numbering and filing systems
9. Health record documentation in non-acute care settings
10. Personal branding

## **Learning Tools for Course:**

1. Lecture Notes/Power Point presentations
2. Reading and Case Study Assignments
3. Discussion board assignments
4. Web activity assignments
5. Quizzes/Tests
6. Article research assignment
7. Lab activities

## **2011 AHIMA Associate Degree Entry-Level Competencies:**

### 1.A. Subdomain: Health Data Structure, Content, and Standards

1. Collect and maintain health data.
2. Conduct analysis to ensure that documentation in the health record supports the diagnosis and reflects the patient's progress, clinical findings, and discharge status.
3. Apply policies and procedures to ensure the accuracy of health data.
4. Verify timeliness, completeness, accuracy, and appropriateness of data and data sources for patient care, management, billing reports, registries, and/or databases.

### 1.B. Subdomain: Healthcare Information Requirements and Standards

1. Monitor and apply organization-wide health record documentation guidelines.
2. Apply policies and procedures to ensure organizational compliance with regulations and standards.
3. Maintain the accuracy and completeness of the patient record as defined by organizational policy and external regulations and standards.
4. Assist in preparing the organization for accreditation, licensing, and/or certification surveys.

### III.A. Subdomain: Healthcare Delivery Systems

1. Apply current laws, accreditation, licensure, and certification standards related to health information initiatives from the national, state, local, and facility levels.
2. Differentiate the roles of various providers and disciplines throughout the continuum of health care and respond to their information needs.

### IV.A. Subdomain: Information Technology & Systems

1. Use technology, including hardware and software, to ensure data collection, storage, analysis, and reporting of information.
2. Use common software applications such as spreadsheets, databases, word processing, graphics, presentation, e-mail, and son on in the execution of work processes.
3. Use specialized software in the completion of HIM processes such as record tracking, release of information, coding, grouping, registries, billing, quality improvement, and imaging.

## **AHIMA Knowledge Clusters:**

- I.A.1. Data versus information (4)
- I.A.2. Health information media (such as paper, computer, web-based) (4)
- I.A.3. Structure and use of health information (individual, comparative, aggregate) (4)
- I.A.4. Health record data collection tools (forms, screens, etc.) (4)
- I.A.5. Data sources (primary, secondary) (4)
- I.A.6. Data storage and retrieval (4)
- I.A.7. Healthcare data sets (such as OASIS, HEDIS, DEEDS, UHDDS) (2)

- I.B.1. Type and content of health record (paper, electronic, computer-based, e-health-personal, web-based) (5)
- I.B.2. Health record documentation requirements (such as accreditation, certification, licensure) (5)
- I.B.3. Data quality and integrity (4)
- III.A.1. Organization of health care delivery in the U.S. (4)
- III.A.2. Healthcare organizations structure and operation (4)
- III.A.3. External standards, regulations, and initiatives (such as licensure, certification, accreditation, IPAA, ARRA) (4)
- III.A.4. Healthcare providers and disciplines (4)
- I.V.A.1. Common software applications(3)
- I.V.A.3. Health information systems (4)

**Grade Determination:** The grade is determined by the average of all assignments, quizzes, and tests over the content areas. The final course grade will be calculated as follows:

Quizzes and assignments	30% of the final grade.
Tests and Final Exam	70% of the final grade

**Grading Scale:**

93-100	A
85-92	B
84-77	C
76-67	D
66 or below	F

**NOTE:** Students enrolled in the Health Information Management Program must obtain a final course grade of "C" or better in order to graduate. If the course grade is below a "C", the student is required to repeat the course. A student, who receives a grade of "U" "D" "F" or "W" twice for any technical course, or for two different technical courses, may be dismissed from the program for one year and cannot reapply for one year from the date of dismissal. The student must meet with the \_\_\_\_\_ advisor and his/her program advisor to develop a re-entry plan at least one semester prior to continuation in his/her program. All entrance requirements to the program must be met prior to re-entry to the program or prior to placement on the waiting list. See Health Technologies Division Student Handbook.

**Grading Process:**

- Due dates will be posted for all graded assignments, quizzes, tests, the midterm and final exam. Assignments and quizzes submitted one to seven days after the due date will be accepted, but will result in a grade reduction of one letter grade.
  - Assignments and quizzes submitted more than seven days after the due date **will not be accepted**.
  - Due date extensions will be given at the discretion of the instructor and only if the student communicates extenuating circumstances to the instructor within at least one week prior to the assignment due date or within 2 days after the assignment due date.
  - Vacation time **will not** be considered as an extenuating circumstance. Students are strongly encouraged to refrain from taking vacations during the semester.
- Grading criteria for each assignment is included with the assignment instructions.
- **Tests and Final Exam.**
  - Tests are administered online for a minimum of three days.
  - Tests are not open book or open notes, unless instructor specifically states otherwise.
  - It is common for computers to freeze, experience power outages, etc. Students are strongly recommended to refrain from taking tests and quizzes close to the due date deadline as the instructor may not be available to unlock the test online. Students who repeatedly have problems with tests locking up prior to completion may be required by the instructor to come to campus to complete their tests.
  - Make-up tests are given at the discretion of the instructor in the event a student cannot complete a test by the due date because of an extenuating circumstance. Documented proof of illness is required if applicable. Make-up tests are held on campus at a schedule time arranged by the instructor and student.
  - The final exam is a comprehensive exam on all material covered during the course.

- Final exams are proctored. Options for taking the final exam by proctor are:
  - Scheduled times for taking the exam on the last Saturday of the semester at the \_\_\_\_\_ will be posted by the instructor. Students may come during these scheduled times and take the final exam.
  - The student may find a proctor within close proximity to his/her home. The proctor must meet the qualifications included in the Proctor Agreement form. The student is responsible for completing the Student- Proctor Agreement form as well as ensuring that the proctor receives, completes, and returns the Proctor Agreement form to the instructor. Forms must be received no later than two weeks prior to the scheduled proctor exam. (See attached Student/Proctor Agreement forms.)
  - Students may schedule an alternate time to take the final exam at the \_\_\_\_\_ with the instructor.

## **Academic Integrity**

It is assumed that students are honest. However, any observed dishonesty or plagiarism on a test or an assignment will result in either required revision (with points deducted), a grade of "0" for the assignment, a grade of "F" for the course or dismissal from the Health Information Management/Coding Certificate program (refer to College catalog/handbook). Each situation will be handled individually according to the discretion of the instructor.

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