

CENTRAL FLORIDA COMMUNITY COLLEGE

Ocala, Florida

HEALTH INFORMATION TECHNOLOGY

STUDENT HANDBOOK

2008/2009

**FOR INFORMATION ABOUT CFCC'S ASSOCIATE OF SCIENCE DEGREE IN HEALTH
INFORMATION TECHNOLOGY**

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PROGRAM FACILITATOR'S WELCOME

Welcome to the Health Information Technology (HIT) Program at Central Florida Community College (CFCC). I am pleased to have you as a student in our program. This program, of which you are now a part, answers a real need in the health care community of Marion, Citrus, and Levy counties for qualified HIT professionals. As a graduate you will be able to make your own contribution to the health profession.

The HIT profession finds itself at a very pivotal point in its history. It is on the cusp of change and of ever increasing professional opportunities. A report from the Bureau of Labor Statistics cites that Health Information Technology is projected to be one of the twenty fastest growing occupations in the country. A recent study ranked HIT fifth out of ten jobs that are projected to grow in Florida. This means that it is a great time to be a student and that more jobs will be available for you when you graduate!

Your fellow students come from a variety of backgrounds and experience. Some are deciding for the first time on a career while others are changing careers or going back to work after a period of time in which they did not work. What you have in common is the desire to qualify yourselves to work in an interesting and challenging profession.

The HIT program at CFCC has an experienced, professional, and well-trained faculty who are here to facilitate your learning experience. The faculty can provide the tools and guidance. You need to provide the enthusiasm and the desire to learn and achieve. Together, faculty and students can make this an enjoyable experience.

The Health Information Technology Program at Central Florida Community College is (as of April, 2005) accredited by the Commission on the Accreditation for Health Informatics and Information Management Education in cooperation with the Council on Accreditation of the American Health Information Technology Association. Because the program is accredited, graduating students will be eligible to take the national qualifying examination for certification as a registered health information technician.

This handbook is designed to answer some of your questions about the HIT program. This is an exciting time in your life and you may be feeling some anxiety about this step you are taking. Hopefully, we can allay some of these concerns with the information in this handbook.

Please contact me should you have further questions. I maintain an "open-door" policy for HIT students and encourage you to phone, e-mail, or drop in to see me. I especially want to see each of you prior to each term's registration so we can keep you on track!

We wish you the very best in the coming academic years.

Suzanne B. Garrett, MSA, RHIA
HIT Program Facilitator
5/2008

A. CENTRAL FLORIDA COMMUNITY COLLEGE

B.

C. Vision Statement

Energetic, purposeful, creative, Central Florida Community College promotes learning in an open, caring, inclusive environment which encourages individual and community development inspired by shared values of integrity, service, responsibility, and dignity.

D. Mission Statement

Central Florida Community College offers educational opportunities which are accessible, affordable and high quality. In a climate that nurtures excellence, CFCC provides undergraduate instruction and awards associate degrees and certificates; prepares students for careers requiring professional and technical training; encourages student success through a variety of support services; and promotes the economic, social, and cultural development of the community.

E. Guiding Principles and Major Directions

To guide the college in the pursuit of its vision, four major directions have been developed. Each year, a set of college goals is developed for each major direction, and all annual planning relates to one or more college goals. The college also focuses on four guiding principles.

Guiding Principles:

We will partner with those who share our vision for learning and development.

We will strive to improve continuously every aspect of the college.

We will strive to exceed the expectations of those we serve.

We will strive in all our actions to honor the public trust placed in us by our community.

Major Directions:

To provide learning opportunities which meet students' lifelong learning needs.

To provide a caring environment which supports learning and development.

To contribute to the cultural, social, and economic development of our communities.

To value our employees.

AN OVERVIEW OF THE HEALTH INFORMATION TECHNOLOGY PROFESSION

The health information technology (HIT) professional is a key player on the health care delivery team. This is one of the few health occupations in which there is little or no direct contact with patients. In an ordinary day, the HIT professional is responsible for the managing and processing of health information. This can involve collecting, assembling, analyzing, coding, transcribing, filing, retrieving, querying it; displaying it in various formats, releasing it legally, all while complying with state and federal statutes and regulatory guidelines. It may even involve working with an electronic health record!

Nature of the Work

Every time health care personnel treat a patient, they record what they observed, and how the patient was treated medically. This record, whether paper or electronic, includes information the patient provides concerning their symptoms and medical history, the results of examinations, reports of x-rays and laboratory tests, diagnoses, and treatment plans. Medical records and health information technicians organize and evaluate these records for completeness and accuracy.

Medical records and health information technicians begin to process patients' health information by first making sure their initial medical charts are complete. They ensure all forms are completed and properly identified and signed, and all necessary information is in the computer. Sometimes, they communicate with physicians or others to clarify diagnoses or to get additional information.

Technicians assign a code to each diagnosis and procedure. They consult classification manuals/software and rely, also, on their knowledge of disease processes. Technicians then use a software program to assign the patient to one of several hundred "diagnosis-related groups", or DRGs. The DRG determines the amount the hospital will be reimbursed if the patient is covered by Medicare or other insurance programs using the DRG system. Technicians who specialize in coding are called health information coders, medical record coders, coder/abstractors, or coding specialists. In addition to the DRG system, coders use other coding systems, such as those geared towards ambulatory settings.

Technicians also use other computer programs, in addition to an electronic record format, to tabulate and analyze data to help improve patient care, control costs, for use in legal actions, in response to surveys, or for use in research studies.

Medical records and health information technicians' duties vary with the size of the facility. In large to medium facilities, technicians may specialize in one aspect of health information, or supervise health information clerks and transcriptionists while a medical records and health information administrator manages the department.

TRAINING, QUALIFICATIONS, AND ADVANCEMENT

Health information technicians entering the field usually have an associate degree from a community college. In addition to general education, coursework includes medical terminology, anatomy and physiology, legal aspects of health information, coding and abstraction of data, statistics, database and electronic health record management, quality improvement methods, HIT science, and computer training.

Most employers prefer to hire Registered Health Information Technicians (RHIT), who must pass a written examination offered by the American Health Information Management Association (AHIMA.) To take the examination, a person must graduate from a two-year associate degree program accredited by the Commission on Accreditation for Health Informatics and Information Management Education in cooperation with the Council on Accreditation of the American Health Information Management Association (AHIMA). The Health Information Technology Program at CFCC was accredited by this organization in April, 2005.

EARNINGS

Median annual earnings of health information technicians were \$28,030 in May, 2006. The middle 50 percent earned between \$22,420 and \$35,990. The highest 10 percent earned more than \$45,260. Median annual earnings were greatest in general medical/surgical hospitals and by nursing and personal care facilities, followed by outpatient care centers and physician offices.

(Compiled by CFCC Health Information Technology Department from the Bureau of Labor Statistics website: <http://www.bls.gov/oco/ocos103.htm>.)

PROFESSIONAL ASSOCIATIONS

The health information technology professional organization is the American Health Information Management Association (AHIMA). Its inception was in 1928 and, while undergoing various name changes through the years, it continues to reflect the requirements of an ever-changing health care system. Its professional publication is the Journal of AHIMA, published monthly. An informative web site is maintained which can provide valuable information to enhance student learning at www.ahima.org. AHIMA offers seminars, annual meetings, and Communities of Practice (designed for specific interest groups, such as students, coding, education, quality assessment, etc.) To promote continued competency, AHIMA requires mandatory continuing education. Registered Health Information Technicians are required to earn 20 continuing education hours every two years in order to retain credentialed status. At least ten of these 20 hours must be in core content areas defined by AHIMA; e.g., clinical data management, external forces, technology, and management.

HIT students are required to join AHIMA at the beginning of the fall semester of their first year in the program. Student membership comes with a subscription to the

Journal, access to a wealth of information on the web site, and automatic membership in the Florida Health Information Technology Association.

The Florida Health Information Technology Association holds its annual meeting during the summer and publishes Coastlines.

In addition, HIT students can benefit personally and professionally by joining the student organization, *HITS* at CFCC. The organization seeks to promote professionalism, networking opportunities, educational opportunities and pride in the profession.

HEALTH INFORMATION TECHNOLOGY PROGRAM HISTORY

The planning for a health information technology program at Central Florida Community College was initiated in 1996 at the request of a local hospital. Following a needs assessment directed to area hospitals and physicians, it was decided that a need did exist. This assessment was corroborated by the Workforce Board Region and Demand Occupation List on which HIM/HIT specialists contributed. This area of North Central Florida was experiencing an influx of senior citizens coming here to retire at the time and this, in turn, was prompting expansion of health care facilities with the attendant need for qualified employees.

Funds for program development were awarded under Capitalization Incentive Funding from the State of Florida. An advisory committee was formed to assist in providing professional direction in 1997. Students were first accepted in August of 1999. A request for an accreditation survey was made in January 2004 and, after a survey in January of 2005, the program was awarded accreditation in April, 2005.

The Health Information Technology Program at Central Florida Community College is accredited by the Commission on the Accreditation for Health Informatics and Information Management Education in cooperation with the Council on Accreditation of the American Health Information Management Association. Because the program is accredited, the graduating student will be eligible to take the national qualifying examination for certification as a registered health information technician

Graduates of the program will be awarded an Associate in Science degree in Health Information Technology.

A coding certificate program is also offered.

PROGRAM GOALS AND STANDARDS

<p><i>GOAL 1: To prepare competent entry-level health information technicians in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains</i></p>	
<p>STANDARDS:</p> <ol style="list-style-type: none"> 1. Practicum evaluation forms indicate that each student demonstrates entry-level competencies in the knowledge, skills and behavior required for each activity assigned as assessed by the site supervisor. 2. Students attain a minimum grade of “C” in all courses designated with the HIT prefix. 3. Formal and informal feedback from employers indicates 100% satisfaction with the competency and professionalism of each graduate hired. 4. Eighty percent of program graduates who sit for the RHIT exam within six months of graduation will attain the RHIT credential. 	<p>EVALUATION METHODS:</p> <ol style="list-style-type: none"> 1. Practicum evaluation forms will be analyzed by the HIT program facilitator. Deficiencies will be discussed with faculty and advisory committee members to improve the curriculum. The program facilitator will also discuss any deficiency with the student so that it might be corrected. 2. A student will need to repeat any professional course in which (s)he receives a final grade of less than a “C” and must have achieved this grade level in the prerequisite classes before being eligible to enroll in either of the two practicums. Faculty will intervene as soon as it is apparent that a student is requiring assistance. In each case where a student is required to repeat a course, analysis of the course structure will be undertaken to determine if improvements can be made. 3. Annual employer surveys along with any informal feedback from the community of interest (including students, graduates, faculty, employers, and the public) will be evaluated by the program manager to identify opportunities for improvement. 4. Review of AHIMA RHIT examination results
<p><i>GOAL 2: To deliver an academically rigorous, all-encompassing program required for the HIT student to be a success in the field</i></p>	
<p>STANDARDS:</p> <ol style="list-style-type: none"> 1. The program will include the content and courses identified in the AHIMA knowledge cluster. 2. The curriculum will reflect needs of the community as represented by the HIT Advisory Committee. 	<p>EVALUATION METHODS:</p> <ol style="list-style-type: none"> 1. Assess curriculum against knowledge cluster content assessment form. 2. Assessment and input from Advisory Committee.

PROGRAM GOAL AND STANDARDS (Continued)

<i>GOAL 3: To recruit and retain competent faculty</i>	
<i>STANDARDS:</i>	<i>EVALUATION METHODS:</i>
<ol style="list-style-type: none"> 1. All credentialed, full time faculty will adhere to the continuing education requirements of AHIMA 2. All credentialed, full time faculty will participate in an instructor's internship in local health care organizations or equivalent every two years 	<ol style="list-style-type: none"> 1. Documentation of continuing education hours 2. Review of summary reports submitted by the faculty member at the conclusion of the internship
<i>GOAL 4: The HIT program will demonstrate responsiveness to the needs of the community(ies) of interest.</i>	
<i>STANDARDS:</i>	<i>EVALUATION METHODS:</i>
<ol style="list-style-type: none"> 1. The program conducts a biannual assessment of education needs in the local market. 2. The program will provide job placement assistance to the community and to our graduates. 	<ol style="list-style-type: none"> 1. Questionnaire or survey to be sent to a sample of medical facilities to determine their health information needs and the skills they are looking for in employees for those positions. 2. We will market our willingness to help physician offices, agencies, hospitals, etc. find suitable employees through our graduate pool. Graduates will be assisted in finding jobs.

TECHNICAL STANDARDS FOR STUDENTS IN THE HEALTH INFORMATION TECHNOLOGY PROGRAM

The mission of the Health Information Technology Program at Central Florida Community College is to provide high quality education for students in a supportive environment, preparing them for entry-level positions within the health care community, while continually striving to improve every aspect of the educational experience.

The Health Information Technology Program is not a limited access program* at this time. As such, it is open to all students. In order to be successful in the program and later in the work place our students must possess the following general qualities: interest, motivation, critical thinking skills, sound judgment and integrity, emotional stability and maturity, empathy, interpersonal skills, physical and mental stamina, and the ability to learn and function in a wide variety of didactic and clinical settings.

Students in the Health Information Technology Program must demonstrate the following minimum abilities:

- Ability to acquire and apply information from classroom instruction, laboratory and practicum experience, independent learning, and team projects
- Ability to communicate effectively in English in oral and written form with colleagues, patients, third party payers, health care professionals, and others who demonstrate a need for information from patient records or data bases maintained in Health Information Technology departments
- Ability to use computers and complete computer-based assignments in a timely fashion
- Ability to function (consult, negotiate, share) as part of a team
- Ability to delegate
- Ability to read materials used in HIT settings such as coding manuals, policy and procedures, and patient medical records
- Ability to calculate mathematical information such as hospital statistics, budgets, and productivity information
- Manual dexterity necessary to file medical records and cards, as well as assemble paper medical record forms
- Visual ability and manual dexterity necessary to prepare office layouts and to design forms and computer screens
- Ability to operate equipment, word processors, transcription equipment, electronic movable files, copiers, etc.
- Ability to synthesize information regarding health care outcomes for formal, verbal and/or written presentation to health care professionals.

***Students, however, must complete a criminal background check and must submit a health certificate showing proof of good health and of immunization prior to registering for the practicums.**

The essential abilities listed in this document can be accomplished through direct student response, the use of prosthetic or orthotic devices or through personal assistance, e.g., readers, sign language interpreters, or note-takers. Reasonable accommodation in compliance with the Americans with Disabilities Act will be provided on an individual basis. Students seeking accommodations should initiate their requests with the Access Services Office. Contact Access Services at 352.854.2322 Ext. 1580 or smithk@cf.edu. Assistance for students is available at all CFCC locations, by appointment.

CODE OF ETHICS

As health care professionals and students engaged in Health Information Technology, we must all strive, individually and collectively, to maintain the highest ethical standards. As HIT professionals we must base all professional actions and decisions on the following principles and values. These principles and values form the AHIMA Code of Ethics. Health information management professionals:

- 1) Advocate, uphold and defend the individual's right to privacy and the doctrine of confidentiality in the use and disclosure of information.
- 2) Put service and the health and welfare of persons before self-interest and conduct themselves in the practice of the profession so as to bring honor to themselves, their peers, and to the health information management profession.
- 3) Preserve, protect, and secure personal health information in any form or medium and hold in the highest regard the contents of the records and other information of a confidential nature, taking into account the applicable statutes and regulations.
- 4) Refuse to participate in or conceal unethical practices or procedures.
- 5) Advance health information management knowledge and practice through continuing education, research, publications, and presentations.
- 6) Recruit and mentor students, peers and colleagues to develop and strengthen professional workforce.
- 7) Represent the profession accurately to the public.
- 8) Perform honorable health information management association responsibilities, either appointed or elected, and preserve the confidentiality of any privileged information made known in any official capacity.
- 9) State truthfully and accurately their credentials, professional education, and experiences.
- 10) Facilitate interdisciplinary collaboration in situations supporting health information practice.
- 11) Respect the inherent dignity and worth of every person.

CONFIDENTIALITY

The doctrine of confidentiality is a cornerstone of the Health Information Technology profession. It is our responsibility to ensure that confidential information is protected and that data security measures are in place to prevent unauthorized access. Students will be exposed to this concept throughout their HIT academic career and will have opportunities during their practicums to demonstrate their understanding of it.

Students will also be asked to sign confidentiality statements before beginning the practicums.

HEALTH INFORMATION TECHNOLOGY PROGRAM/COURSE POLICIES

ATTENDANCE AND TARDINESS: You are expected to attend classes and to arrive at or before the designated starting time. Arriving late disturbs the class, especially during testing. Prompt and consistent attendance affects your participation grade favorably. Lateness and absence does not. If you have more than two consecutive unexcused absences for illness, you may be required to provide a physician's excuse to return to class. **Note:** It is *your* responsibility to obtain the class notes, homework, etc., for any day you are absent.

CLASS PARTICIPATION: You are expected to be an active participant in the teaching and learning process.

MISSED EXAMS OR ASSIGNMENTS: *All exams must be taken on assigned days. Unexcused absence results in a grade of zero for the missed exam. Please notify the instructor prior to class if you have a valid reason for being absent. If you are absent the class prior to a scheduled exam, you are responsible for taking it with the rest of the class on the assigned day. Make-up exams are given only if instructor is notified in advance of your absence unless there are extraordinary circumstances that prevent it. You will be allowed one make-up exams during the term. No late assignments will be accepted.*

CHEATING/PLAGIARISM: Cheating and/or plagiarism will not be tolerated and may result in an "F" for the course as well as disciplinary action under the Code of Student Conduct. Students may be asked to sign an honor pledge.

ACCESS SERVICES: It is your responsibility to register with the Access Services Office should you have a verifiable and documented disability which may require reasonable accommodation(s). *Furthermore, it is your responsibility to notify your instructor with the Faculty Notification Sheet, which sets forth the reasonable accommodation(s) determined by the Access Services Office. **Registration with Access Services should be done at the beginning of the Term.*** Contact Access Services at 352.854.2322 Ext. 1580 or smithk@cf.edu. Assistance for students is available at all CFCC locations, by appointment.

CLASSROOM DECORUM: Disruptive behavior will not be tolerated. Disruptive students will be asked to leave the classroom. Continuous disruptive behavior will result in withdrawal from the course and disciplinary action under the Code of Student Conduct.

CREDIT/AUDIT: To audit a class the student must officially register for the class as an audit. CFCC students are not permitted to change from credit to audit status without permission of the instructor. Authorized changes must be made during the schedule change period, which are the first few days of each term.

COURSE SCHEDULE/ASSIGNMENTS: Due to unforeseen happenings it may be necessary for the course assignments to be altered. The instructor will always strive to be fair about any changes.

WITHDRAWAL: Students who miss two or more consecutive unexcused class meetings from the class roll may be dropped/withdrawn by the instructor. The college reserves the right to evaluate individual cases of non-attendance. In general, students are graded on the basis of intellectual effort and performance. Class participation is a significant measure of performance, and non-attendance can adversely affect a student's grade. A student, who is officially withdrawn from a course, shall receive a grade of W. If a student repeats a course, the last grade shall be counted toward graduation and computation of Grade Point Average (GPA). Students should be alerted to the fact that (1) withdrawals do not count in the CFCC G.P.A., but may not be viewed favorably at the university level; (2) a withdrawal counts as an attempt under the forgiveness/withdrawal policy and the course repeat policy; and (3) there are increased costs to take the course on the third attempt.

FORGIVENESS: The forgiveness policy permits a student to repeat a course in an attempt to improve a grade of D or F earned in the course. Only the last grade earned in a repeated course will be computed into the student's grade point average. The student will be limited to three attempts (two repeats) per course, with a grade being given for the third attempt. Withdrawals count as attempts. Attempts prior to Fall 1997 are not counted.

FOOD/DRINK: No food or drink is permitted in any of the classrooms.

CELL PHONES: *Cell phones must be turned off during the duration of class, so students will not be leaving class for purposes of responding to calls. The ringing of phones is rude and disruptive. Disregarding this rule will adversely affect the student's participation grade. Additionally, cell phones will be placed in a purse or book bag during test taking times and not left on the desk or table tops.*

COUNSELING: **All students must meet with the program facilitator at least once a semester and prior to registering for classes. These meetings shall address progress in the program, course sequencing, and addressing of student concerns/issues. Failure to do so could inadvertently affect graduation status. Students may come to the program facilitator at any time for professional or academic counseling.**

ADHERENCE TO CURRENT CATALOG: **It is the policy of this program that students expecting to graduate adhere to the course schedule outlined in the current catalog, not in the catalog with which they began their HIT education. This policy ensures that graduates will have exposure to all required material and be fully prepared to take the national examination.**

HIT COURSES: Students must attain a minimum grade of “C” in all courses designated with the HIT prefix and must repeat any professional course in which (s)he receives a final grade of less than a “C”. The student must have achieved this grade level in the prerequisite classes before being eligible to enroll in either of the two practicums.

LENGTH OF TIME IN PROGRAM: Students are urged to complete the program in three years or less. Professional, health care, and technology changes may necessitate further courses be taken by the student in order for the student to qualify for the national RHIT exam. It is strongly suggested that students take more than one course per semester in order to accomplish this.

ETHICAL BEHAVIOR: It is expected that each health information technology student will engage in ethical behavior. This includes, but is not limited to, the avoidance of cheating and plagiarism on tests and in research papers and that patient and facility proprietary information will remain confidential (that means no discussion with persons without a need to know).

PROGRAM GRADING SCALE:

A	90 - 100
B+	87 - 89
B	80 - 86
C+	77 - 79
C	70 - 76
D	60 - 69
F	59 -

HEALTH INFORMATION TECHNOLOGY COURSE DESCRIPTIONS

HIM 1800: Introduction to Health Information Technology (3)

Co-requisite: CGS 1100

This course is designed to introduce students to the principles of Health Information Technology. It provides an overview of the evolution of health care delivery systems, health-related associations, organizations and agencies in the United States, as well as the history of the Health Information Technology profession. The development, content and management of the hospital medical record will be discussed. Students will be introduced to forms design; filing methods, storage, and retention; coding and classification systems; indexes; health information in reimbursement; health care information; and the impact of technology on health information processes.

HIM 1430: Concepts of Disease (3)

Prerequisite: HSC 2531

This course gives an overview of common diseases and illnesses. It focuses on the anatomy and physiology, common signs and symptoms, diagnostic tests, treatment and pharmacology associated with each condition. Information gained in this course will enable students to abstract, analyze, and code information from the medical record.

HIM 2012: Legal Aspects of Medical Records (3)

Prerequisite: HIM 1800, CGS 1100

This course is designed to assist students with an understanding of the legal principles that govern the health information field. It emphasizes the legal theories underlying lawsuits involving the health care field, medical record content, access to patients' records, confidentiality and informed consent, and disclosure of records in legal actions.

HIM 2222: ICD-9-CM Coding (3)

Prerequisites: CGS 1100, BSC 1080, BSC 1080L, HSC 2351

Co-requisite: HIM 1430

This course provides instruction in the basic principles and guidelines for using the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD -9-CM) in the coding of diagnoses and procedures.

HIM 2253: CPT Coding (3)

Prerequisites: CGS 1100, BSC 1080, BSC 1080L, HSC 2351

Co-requisite: HIM 1430

This course is an introduction to the coding principles, characteristics and conventions of coding using the Physicians' Current Procedure Terminology (CPT) coding nomenclature. A working knowledge of medical terminology is required for this course.

HIM 2283: Advanced Coding (3)

Prerequisites: HIM 2222, HIM 2253

The student will learn to assign CPT and ICD-9-CM codes to complex medical and surgical diagnoses and procedures in the inpatient and outpatient settings. Current concepts and changes related to coding practice and reimbursement by Prospective Payment Systems will be reviewed. The student will have hands-on practice using encoder software.

HIM 2214: Health Care Statistics (3)

Prerequisites: CGS 1100, HIM 1800, MTB 1103

The purpose of this course is to provide students with knowledge and understanding of the statistical information used in health care settings. Emphasis is placed on the terminology, definitions and formulas used to calculate common statistics, including standard rates, percentages, and averages using patient data. Data collection, analysis, and presentation will also be studied.

HIM 2442: Pharmacology for HIT Professionals (3)

Prerequisites: BSC 1080, BSC 1080L, HSC 2531

Co-requisite: HIM 1430

The purpose of this course is to provide students with introductory knowledge and understanding of pharmacology. It will present a basic rationale for understanding current drug therapy.

HIM 2260: Medical Billing and Reimbursement (3)

Prerequisite: CGS 1100

This course serves as an introduction to health insurance claims processing, carrier requirements, and applicable state and federal regulations. It acquaints students with the billing procedures used in physician offices, hospital and ambulatory surgery services. Emphasis is on electronic billing, managed care systems, worker's compensation, Medicare, Medicaid, third-party payers, ethics and confidentiality. Students will have the opportunity to apply their knowledge in a laboratory setting utilizing billing software.

HIM 2201: Comparative Health Records (3)

Prerequisite: HIM 1800

This course presents an overview of the management of health information in sites other than acute care settings, including ambulatory care and specialized treatment facilities. Emphasis is on regulatory issues, documentation, reimbursement and funding modalities, information management, quality improvement, risk management issues, and the roles of health information personnel in each setting.

HIM 2211: Health Information Systems (3)

Prerequisite: HIM 1800, CGS 1100

The purpose of this course is to provide students with knowledge and understanding of the various computer health information systems that are encountered in health information departments. Topics for discussion include clinical data repositories (including the various registries), transcription, the computerized patient record, voice recognition technology and optical disc scanning. Use of data sets and databases, data collection methods and the importance of data quality will be discussed.

HIM 2510: HIT Management Principles (3)

Prerequisites: HIM 1800, MAN 2021, HIM 1949

Co-requisite: HIM 2201

This course is designed to introduce the student to supervision and management of the resources found in HIT settings, including staff, budget and equipment. Additionally, quality management, utilization review and risk management will be studied in depth. The basic management functions of planning, organizing, leading and controlling will be discussed as applied to HIT.

HIM 1949: Practicum I – Acute Care Setting (3)

Prerequisites: HIM 1800, HIM 2012

This course provides students with supervised, practical experience in an acute care facility health information department. Emphasis is placed on providing opportunities for students to relate classroom theory to the actual functions of a health information department, such as record assembly and analysis; medicolegal procedures; information retention, filing and retrieval; and the use of technology. Students will become familiar with policies and procedures and understand the relationships other hospital departments have the health information department. This course also enables students to further develop critical thinking and problem-solving skills in realistic situations.

HIM 2949: Practicum II – Alternate Care Settings (3)

Prerequisites: HIM 1949, HIM 2201

This course provides students with supervised, practical experience in several of the health information departments at alternate care settings. Emphasis is placed on providing opportunities for students to relate classroom theory to the actual functions in settings other than acute care. Emphasis is on the unique regulatory requirements and record keeping practices of these facilities. The types of facilities in which students may gain this experience include public health departments, nursing facilities, large physician practices, hospice agencies, surgery centers, rehabilitation centers, prisons, and mental health centers. This course also enables students to further develop critical thinking and problem solving skills in realistic situations.

**RECOMMENDED *HIT* SCHEDULE FOR NEW STUDENTS
2008-2009
CAHIM Approved**

TERM I (FALL)		TERM II (SPRING)		TERM III (SUMMER)	
BSC1080 BSC 1080L	Anatomy & Physiology (4)(O)	ENC1101	English Composition (3)(O)	MTB1103	Practicum I – Acute Care (3)
CGS1100	Microcomputer Applications (3)(O)	HIM2442	Pharmacology (3)**	HUM1021	Business Math (3)(O)
HSC2531	Medical Terminology (3)(O)	HIM2222	ICD-9-CM Coding (3)**	HIM 1949	
HIM1800	Introduction to HIT (3)**	HIM2012	Legal Aspects (3)**		
		HIM1430	Concepts of Disease (3)(O-Spring 2009)		
	Total Hours: 13		Total Hours: 15		Total Hours: 6*
TERM IV (FALL)		TERM V (SPRING)		TERM VI (SUMMER)	
MAN2021	Principles of Management (3)(O)	HIM2211	Health Info Systems (3)**	HIM2949	Practicum II – Alternate Care (3)
HIM2214	Health Care Statistics (3)**	HIM2510	HIT Mngmt Principles (3)**		Advanced Coding (3)
ISS1010	Introduction to Social Science (3)	HIM 2201	Comparative Health Records(3)**		
HIM2260	Medical Billing &Reimbursement(3)	HIM2283	Introduction to Humanities (3)(O)		
HIM2253	CPT Coding (3)**				
	Total Hours: 15		Total Hours: 12		Total Hours: 6

* Financial Aid students must take at least 12 hours to qualify. (2008)

** Only offered during that term.

(O) Online

Note: This program is designed to prepare the student for certification. Due to ongoing changes in the health care field, it is advisable to consider taking at least two classes per term to maintain currency. It is strongly recommended that students meet with Mrs. Garrett to discuss their course schedules prior to registering.

**RECOMMENDED CODING CERTIFICATE SCHEDULE FOR NEW STUDENTS –
Medical Information Coder/Biller Certificate
2008-2009**

TERM I (FALL)		TERM II (SPRING)	
BSC1080L	Anatomy & Physiology (4)(O)		
CGS1100	Microcomputer Applications (3)(O)	HIM2442	Pharmacology (3)
HSC2531	Medical Terminology (3)(O)	HIM2222	ICD-9-CM Coding (3)
HIM1800	Introduction to HIT (3)*	HIM1430	Concepts of Disease (3)(O Spring 2009)
	Total Hours: 13		Total Hours: 9
TERM IV (FALL)		TERM V (SPRING)	
HIM2260	Medical Billing & Reimbursement(3)	HIM2012	Legal Aspects (3)*
HIM2253	CPT Coding (3)	HIM2283	Advanced Coding (3)
	Total Hours: 6		Total Hours: 6
<p>* Only offered during that term ** Only offered during that term. (O) Online</p> <p>Note: This program is designed to prepare the student for certification. Due to ongoing changes in the health care field, it is advisable to consider taking at least two classes per term to maintain currency. It is strongly recommended that students meet with Mrs. Garrett to discuss their course schedules prior to registering.</p>			

The Medical Information Coder/Biller program may qualify graduates to obtain hospital coding positions or coding positions in a large, multi-specialty physicians' practice but these jobs generally require national certification as a Certified Coder Specialist (CCS or CPC-H) for hospital or a Certified Coder Specialist – Physician Based (CCS-P or CPC) for medical offices. Coding and billing positions in smaller physicians' offices do not require national certification.

**CENTRAL FLORIDA COMMUNITY COLLEGE
HEALTH INFORMATION MANAGEMENT A.S. DEGREE PROGRAM
FALL 2008 THROUGH SUMMER 2009 COURSE SCHEDULE**

2008 Fall Semester

Course No.	Course Title	Cr	Day	Time	Bldg/Rm	Instructor
<i>BSC 1080L</i>	<i>Anatomy and Physiology/Lab</i>	4	TBA	TBA	TBA	TBA
<i>CGS 1100</i>	<i>Microcomputer Applications</i>	3	TBA	TBA	TBA	TBA
<i>MAN 2021</i>	<i>Principles of Management</i>	3	TBA	TBA	TBA	TBA
<i>ISS 1010</i>	<i>Introduction to Social Science</i>	3	TBA	TBA	TBA	TBA
HIM 1430	Concepts of Disease	3	M	1:00-3:40	40-208	Garrett
HSC 2531	Medical Terminology	3	M	5:30-8:10	Citrus	Guy
HSC 2531	Medical Terminology	3	T/H	12:15-1:30	40-208	Garrett
HSC 2531	Medical Terminology	3		Online	40-208	Garrett
HIM 2260	Medical Billing and Reimbursement	3	T	5:30-8:10	40-308	Wheeler
HIM 2214	Health Care Statistics	3	T	5:30-8:10	40-208	Garrett
HIM 1800	Introduction to HIM	3	W	5:30-8:10	40-208	Garrett
HIM 2253	CPT-4 Coding	3	H	5:30-8:10	40-308	Wheeler
HIM 1949	Acute Care Practicum	3				Garrett
HIM2949	Alternate Care Practicum	3				Garrett

2009 Spring Semester

Course No.	Course Title	Cr	Day	Time	Bldg/Rm	Instructor
<i>ENC 1101</i>	<i>English Composition</i>	3	TBA	TBA	TBA	TBA
HIM 2201	Comparative Health Records	3	M	5:30-8:10	40-208	Carter
HIM 2442	Pharmacology	3	TH	6:00-8:40	40-204	Sever
HSC 2531	Medical Terminology	3	M	5:30-8:10	Citrus	Guy
HSC 2531	Medical Terminology	3	T/H	12:15-1:30	40-208	Garrett
HSC 2531	Medical Terminology	3		Online	40-308	Garrett
HIM 2012	Legal Aspects of Medical Records	3	T	5:30-8:10	40-208	Garrett
HIM 2260	Medical Billing and Reimbursement	3	T	5:30-8:10	40-308	Wheeler
HIM 2211	Health Information Systems	3	W	2:00-4:40	40-208	Garrett
HIM 2510	HIM Management Principles	3	W	5:30-8:10	40-208	Garrett
HIM 2232	ICD-9-CM Coding	3	W	5:30-8:10	40-308	Heathcoe
HIM 1430	Concepts of Disease	3		Online	40-308	Garrett
HIM 1949	Acute Care Practicum	3				Garrett
HIM2949	Alternate Care Practicum	3				Garrett

2009 Summer Semester

Course No.	Course Title	Cr	Day	Time	Bldg/Rm	Instructor
<i>MTB 1103</i>	<i>Business Math</i>	3	TBA	TBA	TBA	TBA
<i>HUM 1021</i>	<i>Introduction to Humanities</i>	3	TBA	TBA	TBA	TBA
HIM 1949	Acute Care Practicum	3				Garrett
HIM2949	Alternate Care Practicum	3				Garrett
HSC 2531	Medical Terminology	3		Online		Garrett
HIM 12234	Advanced Coding	3	T	5:30-8:10	40-308	Healthcoe Wheeler

Domains, Subdomains, and Tasks For The RHIT Student
For 2006 and Beyond

Domain I: Health Data Management

Subdomain A. Health Data Structure, Content and Standards

1. Collect and maintain health data (such as data elements, data sets, and databases)
2. Conduct analysis to ensure 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. Contribute to the definitions for and apply clinical vocabularies and terminologies used in the organization's health information systems
5. Verify timeliness, completeness, accuracy, and appropriateness of data and data sources for patient care, management, billing reports, registries, and/or databases

Subdomain B. 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. Report compliance findings according to organizational policy
4. Maintain the accuracy and completeness of the patient record as defined by organizational policy and external regulations and standards
5. Assist in preparing the organization for accreditation, licensing, and/or certification surveys

Subdomain C. Clinical Classification Systems

1. Use and maintain electronic applications and work processes to support clinical classification and coding
2. Apply diagnosis/procedure codes using ICD-9-CM
3. Apply procedure codes using CPT/HCPCS
4. Ensure accuracy of diagnostic/procedural groupings such as DRG, APC, and so on
5. Adhere to current regulations and established guidelines in code assignment
6. Validate coding accuracy using clinical information found in the health record
7. Use and maintain applications and processes to support other clinical classification and nomenclature systems (such as ICD-10-CM, SNOMED, and so on)
8. Resolve discrepancies between coded data and supporting documentation

Subdomain D. Reimbursement Methodologies

1. Apply policies and procedures for the use of clinical data required in reimbursement and prospective payment systems (PPS) in healthcare delivery
2. Support accurate billing through coding, chargemaster, claims management, and bill reconciliation process
3. Use established guidelines to comply with reimbursement and reporting requirements such as the National Correct Coding Initiative
4. Compile patient data and perform data quality reviews to validate code assignment and compliance with reporting requirements such as outpatient prospective payment system.

Domains, Subdomains, and Tasks For The RHIT Student Cont.
Domain 2: Health Statistics, Biomedical Research and Quality Management
Subdomain A. Healthcare Statistics and Research
<ol style="list-style-type: none"> 1. Abstract and maintain data for clinical indices/databases/registries 2. Collect, organize, and present data for quality management, utilization management, risk management, and other related studies 3. Compute and interpret healthcare statistics 4. Apply Institutional Review Board (IRB) processes and policies 5. Use specialized databases to meet specific organization needs such as medical research and disease registries
Subdomain B. Quality Assessment and Performance Improvement
<ol style="list-style-type: none"> 1. Abstract and report data for facility-wide quality management and performance improvement programs 2. Analyze clinical data to identify trends that demonstrate quality, safety, and effectiveness of healthcare
Domain 3: Health Services Organization and Delivery
Subdomain A. Healthcare Delivery Systems
<ol style="list-style-type: none"> 1. Apply information system policies and procedures required by national health information initiatives on the healthcare delivery system 2. Apply current laws, accreditation, licensure, and certification standards related to health information initiatives from the national, state, local, and facility levels 3. 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 4. Differentiate the roles of various providers and disciplines throughout the continuum of healthcare and respond to their information needs
Subdomain B. Healthcare Compliance, Confidentiality, Ethical, Legal, and Privacy Issues
<ol style="list-style-type: none"> 1. Participate in the implementation of legal and regulatory requirements related to the health information infrastructure 2. Apply policies and procedures for access and disclosure of protected health information 3. Release patient-specific data to authorized users 4. Maintain user access logs/systems to track access to and disclosure of identifiable patient data 5. Conduct privacy and confidentiality training programs 6. Investigate and recommend solutions to privacy issues/problems 7. Apply and promote ethical standards of practice
Domain 4: Information Technology and Systems
Subdomain A. Information and Communication Technologies
<ol style="list-style-type: none"> 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 so 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 4. Apply policies and procedures for the use of networks, including intranet and internet applications to facilitate the electronic health record (EHR), personal health record (PHR), public health, and other administrative applications

Domains, Subdomains, and Tasks For The RHIT Student Cont.
Subdomain B. Data, Information, and File Structures
1. Apply knowledge of data base architecture and design (such as data dictionary, data modeling, data warehousing) to meet departmental needs
Subdomain C. Data Storage and Retrieval
1. Use appropriate electronic or imaging technology for data/record storage 2. Query and generate reports to facilitate information retrieval 3. Design and generate reports using appropriate software 4. maintain archival and retrieval systems for patient information stored in multiple formats 5. Coordinate, use, and maintain systems for document imaging and storage
Subdomain D. Data Security
1. Apply confidentiality and security measures to protected electronic health information 2. Protect data integrity and validity using software or hardware technology 3. apply departmental and organizational data and information system security policies 4. Use and summarize data compiled from audit trail and data quality monitoring programs 5. Contribute to the design and implementation of risk management, contingency planning, and data recovery procedures
Subdomain E. Healthcare Information Systems
1. Participate in the planning, design, selection, implementation, integration, testing, evaluation, and support for organization-wide information systems 2. Use the principles of ergonomics and human factors in work process design
Domain 5: Organizational Resources
Subdomain A. Human Resources
1. Apply the fundamentals of team leadership 2. Organize and contribute to work teams and committees 3. Conduct new staff orientation and training programs 4. Conduct continuing education programs 5. Monitor staffing levels and productivity standards fro health information functions, and provide feedback to management and staff regarding performance 6. Communicate benchmark staff performance data 7. Prioritize job functions and activities 8. Use quality improvement tools and techniques to monitor, report and improve processes
Subdomain B. Financial and Physical Resources
1. Make recommendations for items to include in budgets and contracts 2. Monitor and order supplies needed for work processes 3. Monitor coding and revenue cycle processes 4. Recommend cost-saving and efficient means of achieving work processes and goals 5. Contribute to work plans, policies, procedures, and resource requisitions in relation to job functions

HIT PRACTICUMS

HIT 1949 – Acute Care Setting

This course provides students with supervised, practical experience in an acute care facility health information department. Emphasis is placed on providing opportunities for students to relate classroom theory to the actual functions of a health information department, such as record assembly and analysis; medicolegal procedures; information retention; filing and retrieval; and the use of technology. Students will become familiar with policies and procedures and understand the relationships other hospital departments have with the health information department. This course also enables students to further develop critical thinking and problem-solving skills in realistic situations.

HIT 2949 – Alternate Care Settings

This course provides students with supervised, practical experience in several of the health information departments at alternate care settings. Emphasis is placed on providing opportunities for students to relate classroom theory to the actual functions in settings other than acute care. Emphasis is on the unique regulatory requirements and recordkeeping practices of these facilities. The types of facilities in which students may gain this experience include public health departments, nursing facilities, large physician practices, hospice agencies, surgery centers, rehabilitation centers, prisons, and mental health centers. This course also enables students to further develop critical thinking and problem solving skills in realistic situations.

TEXT: All the student needs to complete the practicum is found in the syllabus.

SUPPLEMENTAL MATERIAL: HIT 1800 and HIT 2201 texts and materials. Copies of applicable regulatory requirements. HIT 2201 notebook.

PREREQUISITES: *HIT 1949* – HIT 1800 and HIT 2012.

HIT 2949 – HIT2201.

Background check/Health certificate/Immunizations Prior to Registration

COURSE OBJECTIVES: The practicum is designed to:

1. Integrate classroom learning with field experience
2. Enable the student to gain work experience in Health Information Technology
3. Provide exposure to advanced skills and knowledge
4. Develop foundation workplace competencies
5. Provide exposure to job opportunities and potentials
6. Clarify and confirm career goals
7. Increase understanding of workplace culture

PRACTICUM COURSE OUTCOMES:

Each practicum has its own set of outcomes which are listed in the syllabus.

REGISTRATION: *Students must be registered for the practicums as early as is possible to allow for placement. The student must present documentation concerning a satisfactory background screening check and a signed health certificate to the program facilitator prior to registration. Completion of registration and documentation is expected at least one week prior to the student practicum meeting. Students will meet with program facilitator as a group to receive site assignments and practicum manuals.*

BACKGROUND SCREENING: Students will be required to complete a background check prior to being approved for the practicum experience. Not only must the safety of patients, students and faculty associated with the educational activities of the students be adequately safeguarded, but local health care facilities are now requiring that this documentation be obtained.

The background check may be completed online by the student for a cost of \$23.00. The student will access the website of the Florida Department of Law Enforcement at www.fdle.state.fl.us. At the FDLE home page, click on “Background Check” located on the right-hand side of the page. On the following screen click on “Public Records”. On the “FDLE Criminal History Information Home Page”, click on the link, “Click here now”. On the following screen, complete the information requested. Press “submit”. If possible, have results e-mailed to me at garretts@cf.edu. If that is not possible, e-mail yourself the results and forward, by e-mail, to me.

Documentation must be received by program facilitator prior to practicum approval and one week prior to the group meeting in which students receive their assignments. If documentation is not received by that time, the student will not be considered for the practicum. No exceptions will be made. Students are encouraged to complete the documentation portion early in the term prior to registering for the practicum.

If the background check reports any arrests pertaining to child or elder abuse, domestic violence, or felony arrest outlined in FS 435.04, 435.03, and 400.215, approval will be withheld. Judgments of guilty or pleas of nol contendere (no contest) to the following crimes will disqualify applicants from participating in the HIT practicums and, ultimately, from graduating with a degree in HIT: murder; manslaughter; vehicular homicide; killing of an unborn child by injury to the mother; assault, if the victim of the offense was a minor; aggravated assault; battery, if the victim of the offense was a minor; aggravated battery; kidnapping; false imprisonment; sexual battery; prohibited acts of persons in familial custody authority; prostitution; lewd and lascivious behavior; lewdness and indecent exposure; arson; theft, robbery, and related crimes, if the offense is a felony; fraudulent sale of controlled substances, only if the offense was a felony; incest; abuse or neglect of a disabled adult or elderly person; exploitation of disabled adult or elderly person;

aggravated child abuse; negligent treatment of children; sexual performance by a child; obscene literature; drug offenses which were a felony or if the offense involved a minor; has not been judicially determined to have committed abuse or neglect against a child as defined in FS.390(2) and (47); does not have a confirmed report of abuse, neglect, or exploitation as defined in FS 415.1075 or 415.504; does not have a proposed confirmed report that remains unserved and is maintained in the central abuse registry and tracking system pursuant to FS 415.1065(2); and has not committed an act that constitutes domestic violence as defined in FS 714.128.

If you have any questions or concerns about this requirement, please make an appointment to discuss them with Suzanne Garrett, HIT Program Facilitator, at (352) 854-2322, X 1466.

HEALTH CERTIFICATE AND IMMUNIZATIONS: *Prior to registering for a practicum, HIT students must have a health certificate completed by a physician, ARNP, PA or DO which states that the student is free from communicable disease and is in good health. The student must provide proof of immunization against tetanus/diphtheria within 10 years or within two years if injured, a PPD or chest x-ray showing that the student is free of active TB, MMR (measles, mumps, rubella, and roseola or titer) , and chicken pox. In addition, the student must show proof of having a hepatitis B vaccination series completed or begun. This documentation must be made available to the HIT program director before the practicum assignment will be made. Health certificate forms may be obtained from the program director. **NOTE: Documentation must be received by program facilitator prior to practicum approval and one week prior to the group meeting in which students receive their assignments. If documentation is not received by that time, the student will not be considered for the practicum. No exceptions will be made. Students are encouraged to complete the documentation portion early in the term prior to registering for the practicum***

ASSIGNMENTS: The HIT Program Facilitator will assign the student to the facility. Consideration will be made for distance to be traveled, but it must be understood that students may not always receive the assignments they have requested.

WORK REQUIREMENT: 8 hours/week minimum – 90 hours total for each practicum. Students arrange with site supervisor(s) for a mutually agreed upon work schedule.

PRACTICUM SITES: Assignments to practicum sites are made at the discretion of the program facilitator. Consideration will be made for student preferences whenever possible, however.

We will add to our list of sites, especially for the alternate care practicum, in order to provide more varied experience and to provide placement for all of our students as our program grows.

COMMUNICATION: Students must communicate with the program facilitator weekly during the practicums through phone calls or E-mails. The purpose of this communication will be to advise the facilitator of progress made in the practicum schedule, of any issues or problems, or questions.

HIT 1949: Acute Care Settings

MRMC	–	Kim Wheeler, RHIA	–	352-402-5013
		1500 SW 1 st Avenue		
		P.O. Box 6000		
		Ocala, FL 34478		
ORMC	–	Becky Dicus, RHIA	–	352-401-1145
		1431 SW 1 st Avenue		
		Ocala, FL 34472		
WMH	-	Becky Dicus, RHIA	–	352-401-1145
		Site– 291-6245		
		4600 SW 46 th Court (Off SR 200)		
		Ocala, FL 34474		
CMH	–			-352-344-6904
		502 W. Highland Blvd.		
		Inverness, FL 34452		
VRH	–			-352-751-8049
		1451 El Camino Real		
		The Villages, FL 32159		
SRRMC	–			-352-795-6560/8339
		6201 N. Suncoast Blvd		
		Crystal River, RL 34428-6712		

HIT 2949: Alternate Care Settings

Oakhurst Rehab and Nursing Center - 1501 SE 24 th Road Ocala, FL 34471 (Long Term/Subacute Care)	- 352-629-8900
Hospice of Marion County and Alliance – Sherry Lee Carter, RHIT – X141 3231 SW 34 th Ave Ocala, FL 34474 (Hospice Care/ Home Care/LTC)	352-873-7400
Marion Physician Associates – Karen O’Conner 1040 SW 2 nd Avenue Ocala, FL 34475	352-732-8900
Laser and Surgery Center – Brenda Ohmer – 2207 SW 1 st Avenue Ocala, FL 34475 (Surgery Center)	352-351-1200
Marion County Dental Clinic Hampton Center (To be added)	
Hospice of Citrus County, Inc. – Suzanne Cauble 4005 North Lecanto Hwy P.O. Box 641270 Beverly Hills, FL 34465	352- 527-2020
Dr. D.P. Raju, MD – Susan 2840 SE 3 rd Court Ocala, FL 34471	352-351-0603

Please note that not all sites are listed and that the student may not visit each site.

PRACTICUM COURSE POLICY

ATTENDANCE AND TARDINESS: You are expected to adhere to the schedule you and the site supervisor agreed to. This means that you also arrive at the time specified. Should you be unable to keep your appointment, you **MUST** notify both the site supervisor and the HIM program facilitator. It is extremely important for you to adhere to your schedule and only emergencies should keep you from doing so. This is an opportunity for you to practice your professionalism and to impress people who might one day want to hire you. If you find that you are unable to complete the practicum due to some serious extenuating circumstance, you must call the CFCC program facilitator for approval and to make arrangements to take an “Incomplete” in the course. Failure to notify the facilitator will result in an “F”.

PARTICIPATION: Behave enthusiastically during the practicum, as if you were eager to learn. (You are, aren't you?). Take the initiative. You would have to if you worked there and you might want a job there someday. If you see that someone needs help, offer to help. You can generally answer a ringing phone, even if you have to put the person on hold to wait for help. Ask questions to clarify your knowledge. Questions show interest. The quality of the practicum is directly related to the student's attitude.

FACILITY POLICIES AND PROCEDURES: Students must at all times adhere to facility policies and procedures. Site supervisors will evaluate students in their compliance.

DECORUM: Dress appropriately. A good rule of thumb is to dress the way the employees in the department dress. (No jeans, **no denims of any color**, no Capri pants, no bare midriffs, no hip huggers, no flip flops, no open-toes shoes, no cleavages, and no revealing slits.) Keep in mind that the facility is a potential employer and that first impressions can make all the difference. Remember that professionalism is exhibited in dress, manner and speech.

Wear name badge at all times.

Do not wear perfume or after shaves. Most facilities have policies in place to limit the impact of odors on those who might be allergic.

Do not chew gum.

Do not wear flashy jewelry.

File your fingernails so that their length does not interfere with the work you have to do.

Turn cell phone off.

Watch your language. No profanity.

Exhibit professionalism in your dress (including make up), manner, and speech.

COMMUNICATION: Students must communicate with the program facilitator weekly during the practicums through phone calls or E-mails. The purpose of this communication will be to advise the facilitator of progress made in the practicum schedule, of any issues or problems, or questions.

CONFIDENTIALITY: You have learned in your classes how vital the concept of confidentiality is in our profession. The practicums are where you must put this knowledge into practice. You must be especially aware of the confidential nature of the information to which you will have access. Take responsibility for any forms that you might be given to illustrate an educational point. You are expected to keep that information confidential. That means not sharing it with anyone else or any other facility. Note: All information may be included in your notebook, but medical record sample forms **MUST** have all identifying information blacked out and re-copied so that it is unreadable. **Warning:** In the event of a breach of confidentiality caused by a practicum student, consequences may include a failing grade to be given for the practicum or expulsion from the program with a failing practicum grade.

PRIOR TO PRACTICUM:

Review the objectives and assignments listed in the syllabus. These are the areas that you must try to cover during your experience. Each objective/facility name/type will serve as a “section”, having a separate divider, in your notebook depending on the practicum. You will complete the activities listed in the “Assignments” section for each facility. Copy the forms attached to expedite your assignments.

Print and review applicable state and federal guidelines specific to the type of facilities being visited. Doing this will help remind you why things are done as they are and it is a requirement for inclusion in your notebook.

Review your textbooks and notes before beginning your practicum.

Note: The program facilitator reserves the right to change or modify these course policies as necessary. Current practicum course policies will be found in the practicum syllabi. Also, changes to requirements are made to accommodate facilities that have an electronic record format. It is understood that students would adapt to the situation.

Acute Care Practicum

1. **Facility/HIT Orientation:** Obtain information describing the facility’s ownership, organization, patient population, medical staff, and the organization and function of the Health Information Technology department
 - a. Describe the facility in terms of:
 - i. Name/address
 - ii. Ownership
 - iii. Accreditation status/date of last survey
 - iv. Licensure status/date of last survey
 - v. Services
 - vi. Organization/chart

- vii.** Patient population
- viii.** Medical staff/Number/Committees/Relation to HIT
- ix.** Statistics
 - Number of beds
 - Number of admissions/discharges
 - Average daily census
 - Occupancy rate
 - Number of births, if applicable
- x.** Organization, functions, and personnel in HIT
 - Organization chart/reporting structure
 - Name of department
 - Goals and objectives
 - Functions and services
 - Number of employees in each position/title/function
- xi.** Technology in use in HIT
 - Computer systems
 - Dictation systems
 - Filing systems
 - EHR (Electronic health record)
 - Scanning systems
 - Other

b. Attach facility brochures, pamphlets, forms and other documentation pertinent to this objective

2. Policies and Procedures:

a. Attach the policies and procedures for the following departmental/facility functions:

- i.** Patient/record identification system
- ii.** Record components/forms/filing order
- iii.** Record assembly, analysis, and incomplete record control
- iv.** Storage and retrieval systems
- v.** Dictation and transcription of clerical reports
- vi.** Release of information
- vii.** Statistics
- viii.** Forms control

b. Describe in narrative form the major components of each function, including:

- Overall description/numbers/org
- Technology used
- Outline steps in accomplishing function; attach procedures
- Forms used in process

3. Record Assembly: Accurately assemble ten records of discharged inpatients according to the department procedure.

- a.** Review policies and procedures related to record assembly
- b.** Sit with the responsible individual and first observe the activity; ask questions
- c.** Review a sample of assembled records either manually or electronically
- d.** Obtain a minimum of ten unassembled records and assemble them without assistance if manual system is used. If not, describe the process used electronically to assemble records
- e.** Ask supervisor (or designee) to review your assembled records for accuracy and to complete and sign evaluation form (attached) if manual system is used

- f. Describe the experience in narrative form, including:
 - i. Steps in process (See 2b)
 - ii. Attach form order
 - iii. Your personal observations as you performed the function yourself
 - Ease with which you performed function if able to do so
 - Problems, if any; describe electronic process, if applicable
- 4. Record Analysis:** Accurately analyze ten records of discharged inpatients for quantitative deficiencies according to departmental procedure
- a. Review policies and procedures
 - b. Sit with the responsible individual and first observe the activity; ask questions
 - c. Review a sample of analyzed records, either paper or electronic records
 - d. Obtain a minimum of ten unanalyzed records and analyze them without assistance if paper records are used
 - e. Ask supervisor (or designee) to review your analyzed records for accuracy and to complete and sign evaluation form
 - f. Describe the experience in narrative form, including:
 - i. Steps in process (See 2b)
 - ii. Attach form order
 - iii. Your personal observations as you performed the function yourself
 - Ease with which you performed function if allowed to do so
 - Problems, if any; description of electronic process, if applicable
- 5. Record Retrieval:** Accurately retrieve at least 20 medical records from various filing sites and media according to department procedure
- a. Review policies and procedures
 - b. Work with the responsible individual and first observe the activity; ask questions
 - c. Obtain a minimum of twenty requests for records from whatever source (telephone, in-person, etc.)
 - d. Complete work sheet with retrieval information as you retrieve records to fulfill requests using either paper records or electronic records
 - e. Ask supervisor (or designee) to review records and requests before releasing any records to requestors and to signoff on worksheet (attached)
 - f. Describe the experience in narrative form, including:
 - i. Steps in process (See 2b)
 - ii. Problems noted in process; how are they handled
 - iii. Your personal observations as you performed the function yourself
 - Ease with which you performed function
 - Problems, if any; describe electronic system, if applicable
- 6. Record Filing:** Accurately file at least 20 medical records and at least 20 reports from loose filing according to department procedure using manual system
- a. Review policies and procedures
 - b. Work with the responsible individual and first observe the activity; ask questions
 - c. Obtain a minimum of twenty records and a minimum of twenty loose reports
 - d. Complete work sheet with file activity information as you file records and reports
 - e. Ask supervisor (or designee) to verify that records and reports were filed accurately and to complete worksheet
 - f. Describe the experience in narrative form, including:
 - i. Steps in process (See 2b)
 - ii. Problems noted in process; how are they handled

- iii. Your personal observations as you performed the function yourself
 - Ease with which you performed function
 - Problems, if any; description of electronic processes, if applicable
- 7. **Release of Information:** Process at least ten (10) requests for information following department procedure
 - a. Review policies and procedures
 - b. Complete “Release of Information Matrix” (attached)
 - c. Work with the responsible individual and first observe the activity; ask questions
 - d. Obtain a minimum of ten requests for information and the corresponding medical records
 - e. Copy requested information, placing it on top of medical record for accuracy verification, prepare response to request and complete work sheet
 - f. Ask supervisor (or designee) to verify that records and reports were filed accurately and to complete worksheet
 - g. Describe the experience in narrative form, including:
 - i. Steps in process (See 2b)
 - ii. If allowed, obliterate all patient and provider identifying information on one request and one copy of record for inclusion in notebook
 - iii. Problems noted in process; how are they handled
 - iv. Your personal observations as you performed the function yourself
 - Ease with which you performed function
 - Problems, if any; description of electronic processes, if applicable
- 8. **Ancillary Departments:** Describe the functions and activities of other departments within the facility and the relationship with the HIT department, as time permits:
 - a. Admitting
 - b. Patient accounting
 - c. Registration
 - d. Case management
 - e. Clinical laboratory
 - f. Imaging services
 - g. Pharmacy
 - h. Ward clerk
 - i. Human Resources
 - j. Emergency Department
 - k. Food Services
- 9. **Other:** You may be given additional opportunities and experiences which go beyond the scope of this syllabus. Please include details of those activities in this section, following the same format as in the foregoing.

Alternate Care Practicum

Note: The student will complete this assignment for each facility visited.

1. Identify and describe the role and environment of the health information manager in the alternate care setting.
 - a. Describe the facility in narrative form in terms of:
 - i. Organizational structure
 - Name of facility
 - Address
 - General environment/geographical setting (comment on what impact, if any, this may have on the institution and its operation).
 - Size of facility in terms of number/classification of beds
 - Ownership, control, sponsorship (comment on how this impacts facility's operation).
 - ii. Patient population
 - Characteristics of patient population
 - Admissions per month/year
 - Breakdown of payer source (Medicare, Medicaid, Private, Other)
 - iii. Regulatory and accrediting agencies*
 - iv. Legal requirements
 - v. Operational requirements
 - Obtain or draw an organizational chart of the facility
 - Comment on the placement of the HIT department
 - Obtain or draw an organization chart of the HIT department
 - Describe the duties of the HIT personnel
 - Comment on the major committees in the facility and how they are organized. Discuss the role of HIT, if any.
 - b. Attach facility brochures, pamphlets, forms and other documentation pertinent to this objective
 - c. Print, review, and attach applicable state and federal guidelines specifically dealing with this type of facility*
2. Describe the facility's policies and procedures.
 - d. Include the following policies and procedures:
 - i. Admission/registration
 - ii. Documentation of patient care
 - iii. Retention requirements for patient records
 - iv. Release of information
 - v. Statistical reports
 - vi. Reporting requirements
 - vii. Classification systems, indexes, and registries
 - viii. Quality improvement and performance measurement
 - ix. Utilization management
 - x. Reimbursement processing
 - e. Attach policies and procedures, if available.
 - f. Describe in narrative form:
 - i. Master file (patient/client/resident index)
 - Form
 - Who maintains it?
 - Who initiates it?

- What information is recorded?
- Updating procedures?
- Obtain a sample master file card, if possible
- ii. Identification System**
 - What type of numbering system or patient record identification system is used?
 - If a numerical system is used, describe the procedure for number assignment
- iii. Storage and Retrieval System**
 - Type of filing system used
 - Is color-coding used?
 - Are records of active patients stored in the same way and location as those of inactive/discharged patients?
 - Describe equipment used to store records
 - Who has access to patient records?
 - How long are records kept?
- iv. Content and Format of Record**
 - Specific types of content included
 - Use of forms, computer-generated documents
 - Type of folder
 - Format of record
- v. Quantitative Analysis**
 - Who reviews records for completeness?
 - When and where is this done?
 - What items are checked?
 - What procedures are used to notify health care providers of deficiencies? Who does this?
- vi. Release of Information**
 - Obtain copy of consent/authorization to release information
 - Who may consent to release information to this facility
 - Special regulations that facility must follow in releasing information
 - Effective time period of authorizations to release information
 - Types of requestors and requests for information
 - Policies regarding patient or family access to records
 - Procedures for complying with subpoenas and court orders
- vii. Statistical Reports and Reporting Requirements**
 - What statistical data and reports are compiled?
 - Identify where the information is obtained
 - What statistical data must be reported to external agencies
 - Is any statistical data calculated manually?
- viii. Classification and Indexing**
 - Are diagnoses, problems, and/or procedures coded and indexed?
 - What classification system is used?
- ix. Quality Improvement and Performance Measurement**
 - Discuss the structure under which any QI program is carried out
 - Describe the type of studies completed or processes reviewed
- x. Utilization Management and Reimbursement Processing**
 - Is UM conducted?

- How does patient care documentation relate to reimbursement for patient care?
 - What HIT procedures directly support reimbursement?
3. Observe and practice the technical procedures followed in processing medical records

NOTEBOOK: The student is required to submit a practicum notebook for grading. The notebook will include documentation concerning the facility, the completion of the assignments, narration, and evaluations. Requirements are also outlined in the syllabus of each practicum.

Notebook requirements: Name/Course/Course # on spine and front of notebook

- a. Coversheet with name, course number, term, and year
- b. Confidentiality statement
 - a. Co-op Agreement form
 - b. Schedule used by facility
- c. Separate sections (pertaining to objectives) with narrative, including your impressions and recommendations
- d. Sample forms/policies and procedures
- e. Applicable state/federal guidelines/laws that apply to type of facility
- f. Evaluations
- g. Type and proofread
- h. Give your overall impressions, recommendations of your experience
- i. Write clearly, using proper punctuation and correct spelling
- j. Do not put pages into plastic sleeves
- k. Use labeled section dividers
- l. Copy of thank you note you send to facility after your experience
- m. Grading
 - a. Evaluation by site supervisor: 50%
 - b. Notebook: 50%
 - i. Organization/neatness: 20%
 - ii. Adherence to instructions: 20%
 - iii. Completeness: 5%
 - iv. Punctuation/spelling/syntax: 5%

ACKNOWLEDGEMENT

Date: _____

I, _____, have received a copy of the 2008/2009 HIT Student Handbook from Central Florida Community College, Ocala, Florida which provides information about the HIT program, its rules and requirements, and its classes. I also understand that it is imperative to schedule a meeting with Mrs. Garrett prior to registration each term to discuss my course schedule. Failure to do so may adversely affect my intended graduation date.

Signed:
