# HIM-2910: HIM PROFESSIONAL PRACTICE EXPERIENTIAL LEARNING

## Cuyahoga Community College

### Viewing: HIM-2910 : HIM Professional Practice Experiential Learning

**Board of Trustees:**
January 2024

**Academic Term:**
Fall 2024

**Subject Code**
HIM - Health Information Management

**Course Number:**
2910

**Title:**
HIM Professional Practice Experiential Learning

**Catalog Description:**
Supervised field experience designed to allow student to apply technical knowledge and skills learned in the classroom to procedures performed in the health information management department. Assignments may be made to various types of health care facilities, or may be virtual at the discretion of the program director.

**Credit Hour(s):**
1

**Other Hour(s):**
80

**Other Hour Details:**
80 clock hours of directed practice in either a local health care facility or with virtual assignments, within a 5-week rotation, two days a week, for a total of 10 days

### Requisites

**Prerequisite and Corequisite**
Departmental approval, or Health Information Management Technology Program director approval.

### Outcomes

**Course Outcome(s):**
Apply technical knowledge and skills to create and maintain accurate patient records in any format in accordance with the department procedures.

**Essential Learning Outcome Mapping:**
Not Applicable: No Essential Learning Outcomes mapped. This course does not require application-level assignments that demonstrate mastery in any of the Essential Learning Outcomes.

**Objective(s):**
1. Obtain selected factual information pertaining to ownership, organization, services, facilities and patient population of the health care facility; the organization of the medical staff, and the organization and functions of the health information management (HIM) department/Medical Record Department.
2. Utilize and maintain electronic applications and work processes to support clinical classification and coding to abstract and maintain data for clinical databases and registries.
3. Accurately identify patient names and medical record numbers, retrieve records from storage in electronic format utilizing the Master Patient Index
4. Validate patient names and medical record number using the Master Patient Index to check for duplicate numbers and correct any duplicate numbers found in accordance with department policy and procedures.

5. Validate diagnoses codes and verify clinical documentation in the health record supports the diagnosis and reflects the patient's progress, clinical findings, and discharge status, and apply policies and procedures to ensure the accuracy of health data.
6. Retrieve patient records from the various storage areas/media used, according to department policy and procedure.
7. Review policies and procedures for: patient record storage and retrieval; processing discharged patient records; processing incomplete patient records and physician suspension; disclosure of personal health information (release of patient-specific data to authorized users); gathering hospital-based statistics; completing birth and death statistics.

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**Course Outcome(s):**

Utilize professional behavior consistent with the environment of the affiliating institution and develop an appreciation for the professional image of the health information practitioner.

**Essential Learning Outcome Mapping:**

Not Applicable: No Essential Learning Outcomes mapped. This course does not require application-level assignments that demonstrate mastery in any of the Essential Learning Outcomes.

**Objective(s):**

1. Adapt and adhere to the specified schedule assigned at the clinical site with regard to start and stop times, lunch and break periods, and promptness in keeping appointments and attending meetings.
2. Manage time appropriately to arrive on time for meetings and assigned clinical schedule. Avoid tardiness and absenteeism.
3. Comply with facility/departmental dress code attire that is business appropriate, including clothing, hairstyle, makeup, and body art (i.e.: tattoos and body piercings)
4. Engage in training and ensure retention of departmental training by actively taking notes. Avoid unnecessary cell phone usage or screen time.

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**Course Outcome(s):**

Communicate effectively in a written and oral format.

**Essential Learning Outcome Mapping:**

Oral Communication: Demonstrate effective verbal and nonverbal communication for an intended audience that is clear, organized, and delivered effectively following the standard conventions of that language.
Written Communication: Demonstrate effective written communication for an intended audience that follows genre/disciplinary conventions that reflect clarity, organization, and editing skills.

**Objective(s):**

1. Complete all assignments in a timely manner as assigned by site supervisors
2. Communicate in writing using appropriate vocabulary, grammar, punctuation and spelling
3. Effectively communicate orally without the use of slang or offensive language. Use medical terminology appropriately.

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**Course Outcome(s):**

Observe and carry out assigned procedures appropriately as assigned by clinical site supervisor(s)

**Essential Learning Outcome Mapping:**

Not Applicable: No Essential Learning Outcomes mapped. This course does not require application-level assignments that demonstrate mastery in any of the Essential Learning Outcomes.

**Objective(s):**

1. Accurately identify patient names and medical record numbers, retrieve records from storage in either paper or electronic format utilizing the Master Patient Index
2. Analyze patient record documentation as assigned to confirm documentation in the health record supports the diagnosis and reflects the patient's progress, clinical findings, and discharge status, and apply policies and procedures to ensure the accuracy of health data.
3. Apply organization-wide health record documentation guidelines, policies and procedures to ensure organizational compliance with regulations and standards by maintaining the accuracy and completeness of the patient record as defined by the organizational policies and external regulations and standards.
4. Support patient privacy in all aspects of clinical assignments as directed under the Health Insurance Portability and Accountability Act (HIPAA).

**Course Outcome(s):**

Justify the importance of maintaining patient confidentiality and privacy as defined by law.

**Essential Learning Outcome Mapping:**

Civic Responsibility: Analyze the results of actions and inactions with the likely effects on the larger local and/or global communities.

**Objective(s):**

1. Apply confidentiality and security measures to protected electronic health information and protected information to ensure integrity and validity of data.

**Methods of Evaluation:**

1. Written and oral assignments
2. Participation at clinical sites
3. Behavior at clinical sites
4. Final presentation at end of the semester

**Course Content Outline:**

1. Orientation to medical record department and hospital
    a. Obtaining selected information pertaining to
        i. Ownership
        ii. Organization
        iii. Services
        iv. Facilities
        v. Patient population of health facility
    b. Organization of the medical staff
    c. Organization functions of the Health Information Management Department
2. Health record processing: description of policies and procedures for
    a. Patient/record identification system
    b. Record analysis and incomplete record control
    c. Storage and retrieval system
    d. Release of information
    e. Coding and abstracting
    f. Medicare Severity diagnostic related group
    g. Ambulatory Payment Classification group
    h. Statistics
    i. Forms control
    j. Special registries (tumor, trauma, adverse drug reaction, etc.)
3. Patient/record identification system
    a. Suggest a visit to Registration (Patient Access Department) for assigning and verifying the patient/medical record number for patients upon admission in accordance with department policy and procedures
    b. MPI (Master Patient Index) patient index data analysis
        i. Accurately comparing patient/medical record number assignments
        ii. correcting any discrepancies noted
        iii. correcting duplicate numbers found
4. Quantitative analysis: analyzing health records of discharged inpatients for quantitative deficiencies according to department polices and procedures
5. Retrieval of health records: accurate retrieval of health records from various storage areas/media used
6. Retention and destruction of health records
7. ICD-10-CM and PCS coding
    a. Accurate coding, using health records, of all diagnoses and procedures relevant to
        i. Emergency Room reports
        ii. Ambulatory surgery records
        iii. Inpatient records
    b. ICD-10-CM and PCS coding used to represent varied diagnoses/procedures

8. Adjunct departments: description of major functions/activities of following, with special attention to their relationships to the HIM/MRD
    a. Patient Access Department (Registration or Admitting departments)
    b. Patient Financial Services
    c. Clinical Documentation Improvement
    d. Outpatient Registration
    e. Outpatient Department
    f. Social Service Department
    g. Clinical laboratory
    h. Health Unit Coordinator
    i. Human Resources Department
    j. Emergency Department
    k. Information Services / Information Technology department
    l. Quality Management department
    m. Risk Management/Utilization Review

## Resources

Sayles, Nanette B. and Leslie L. Gordon, eds. *Health Information Management Technology: An Applied Approach*. 6th ed. Chicago, IL: AHIMA Press, 2020.

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