



BROWARD COMMUNITY COLLEGE COURSE OUTLINE

LAST REVIEW: 2008-2009
(i.e. 2003-2004)

NEXT REVIEW: 2013-2014
(i.e. 2008-2009)

STATUS: A
(A, I, D)

COURSE TITLE: Health Data Concepts

COMMON COURSE NUMBER: HIM 1110L

CREDIT HOURS: 1

CONTACT HOUR BREAKDOWN
(per 16 week term)

CLOCK HOURS:
(Voc. Course ONLY)

Lecture: Lab: 48

Clinic: Other:

PREREQUISITE(S): HIM 1000,

COREQUISITE(S): HIM 1110L

PRE/COREQUISITE(S):

COURSE DESCRIPTION *(750 characters, maximum):*

This course provides an introduction to the basic concepts and techniques for managing and maintaining health record systems. Through the Virtual Healthcare Systems Lab, students will be given access to work on a variety of healthcare electronic system enhancing their technology skills and knowledge such as: Athens/Cerner Electronic Health Records, QuadraMed Smart ID, QuadraMed Encoder, and McKesson Horizons. Students will be given the opportunity to utilize and practice with current software packages common to the industry.

UNIT TITLES

1. Registration and numbering of health records
2. Record retention, storage, and retrieval
3. The acute care record
4. The ambulatory care record
5. The long term care and mental health record
6. Forms/screens design & data collection technology



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UNITS

Unit 1 Registration and numbering of health records

General Outcome:

- 1.00 The students should recognize the importance of the role played by the Admitting/Registration Department and should be able to identify various systems of numbering, filing, and circulation of health records, citing their advantages and disadvantages.

Specific Learning Outcomes:

Upon successful completion of this unit, the students should be able to:

- 1.01 Perform a hospital registration procedure when given a procedure and forms.
- 1.02 Role play obtaining necessary information from the patient tactfully and accurately.
- 1.03 Use the information obtained in the hospital registration interview to correctly complete the identification section of the medical record.
- 1.04 Transcribe a history and physical.
- 1.05 File 20 master patient index cards in an alphabetical system, applying all appropriate rules.
- 1.06 Code 20 names for the phonetic filing system and file them.
- 1.07 Demonstrate how pseudo-social security numbers are assigned.
- 1.08 Describe the advantages and disadvantages of using social security numbers to number health records.
- 1.09 Discuss the trends in patient record numbering.



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Unit 2 Record Retention, Storage, and Retrieval

General Outcome:

- 2.0 The students should be able to apply techniques for systems to health record retention, storage, and retrieval.

Specific Instructional Objectives:

Upon successful completion of this unit, the students should be able to:

- 2.01 File in serial and in terminal digit order
- 2.02 Describe the relationships between numbering and filing systems.
- 2.03 Perform appropriate record tracking in both manual and computer-based systems.
- 2.04 Perform microform retention procedures in a given situation, including patient record preparation, microfiche filming and processing, duplication of microfiche, and daily maintenance of microfilm equipment.



BROWARD COMMUNITY COLLEGE COURSE OUTLINE

Common Course Number: HIM 1110L

Unit 3 The Acute Care Record

General Outcome:

3.0 The students should be able to identify and apply the principles of acceptable acute care health record form and content.

Specific Instructional Objectives:

Upon successful completion of this unit, the student will be able to:

- 3.01 Demonstrate the ability to identify and apply the principles of acceptable form and content according to:
 - A. Administrative policy (simulated)
 - B. Bylaws of the Medical Staff (simulated)
 - C. Standards of the Joint Commission on Accreditation of Healthcare Organizations specifically, and other examining bodies such as the American College of Obstetrics Association, and the Social Osteopathic Association, and the Social Security Administration and Regulations for Federal Health Insurance for the Aged.
- 3.02 Assemble given selected records simulating the previous day's discharges.
- 3.03 Review given selected reports of history, physical exam, discharge summary, operative report, progress notes, doctors' orders and consultations according to JCAH standards and state areas where deficient.
- 3.04 Describe good documentation practices and identify absence of good practices in records.



Common Course Number: HIM 1110L

Unit 4 The Ambulatory Record

General Outcome:

- 4.0 The students should be able to identify and apply the principles of acceptable ambulatory health record form and content.

Specific Instructional Objectives:

Upon successful completion of this unit, the student will be able to:

- 4.01 Demonstrate the ability to identify and apply the principles of acceptable form and content according to:
- A. Administrative policy (simulated)
 - B. Bylaws of the Medical Staff (simulated)
 - C. Standards of the Joint Commission on Accreditation of Healthcare Organizations specifically, and other examining bodies such as the American College of Obstetrics Association, and the Social Osteopathic Association, and the Social Security Administration and Regulations for Federal Health Insurance for the Aged.
- 4.02 Assemble given selected records simulating the previous day's discharges.
- 4.03 Review given selected reports of history, physical exam, discharge summary, operative report, progress notes, doctors' orders and consultations according to JCAH standards and state areas where deficient.
- 4.04 Describe good documentation practices and identify absence of good practices in records.
- 4.05 Compare and contrast the acute care and ambulatory care record.



BROWARD COMMUNITY COLLEGE

COURSE OUTLINE

Common Course Number: HIM 1110L

Unit 5 The Long Term Care and Mental Health Record

General Outcome:

- 5.0 The students should be able to identify and apply the principles of acceptable long term care and mental health record form and content.

Specific Instructional Objectives:

Upon successful completion of this unit, the student will be able to:

- 5.01 Demonstrate the ability to identify and apply the principles of acceptable form and content according to:
- A. Administrative policy (simulated)
 - B. Bylaws of the Medical Staff (simulated)
 - C. Standards of the Joint Commission on Accreditation of Healthcare Organizations specifically, and other examining bodies such as the American College of Obstetrics Association, and the Social Osteopathic Association, and the Social Security Administration and Regulations for Federal Health Insurance for the Aged.
- 5.02 Assemble given selected records simulating the previous day's discharges.
- 5.03 Review given selected reports of history, physical exam, discharge summary, operative report, progress notes, doctors' orders and consultations according to JCAH standards and state areas where deficient.
- 5.04 Describe good documentation practices and identify absence of good practices in records.
- 5.05 Compare and contrast the acute care, ambulatory care, long term care, and mental health records.



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Unit 6 Forms/screens design & data collection technology

General Outcome:

- 6.0 The students should be able to identify and apply the principles of good forms/screens design and demonstrate an awareness of data collection technology.

Specific Instructional Objectives:

Upon successful completion of this unit, the student will be able to:

- 5.01 Demonstrate the ability to identify and apply the principles of acceptable form and content according to:
- A. Administrative policy (simulated)
 - B. Bylaws of the Medical Staff (simulated)
 - C. Standards of the Joint Commission on Accreditation of Healthcare Organizations specifically, and other examining bodies such as the American College of Obstetrics Association, and the Social Osteopathic Association, and the Social Security Administration and Regulations for Federal Health Insurance for the Aged.
- 5.02 Assemble given selected records simulating the previous day's discharges.
- 5.03 Review given selected reports of history, physical exam, discharge summary, operative report, progress notes, doctors' orders and consultations according to JCAH standards and state areas where deficient.
- 5.04 Describe good documentation practices and identify absence of good practices in records.
- 5.05 Compare and contrast the acute care, ambulatory care, long term care, and mental health records.