HITT 2360
AUSTIN COMMUNITY COLLEGE
Semester
Course Dates

PROGRAM: Health Information Technology

COURSE NUMBER: **HITT 2360--Clinical**

COURSE TIME/LOCATION: **Clinical Site**

FACULTY NAME:
OFFICE HOURS/LOCATION:
Phone:
Email:
Website:

Arranging conferences/appointments: by appointment

COURSE DESCRIPTION: A health-related work-based learning experience that enables the student to apply specialized occupational theory, skills, and concepts. Direct supervision is provided by the clinical professional. Clinical hours can vary during the week.

COURSE PREREQUISITES: HITT 1305, HITT 1213, and HITT 1341.

COURSE RATIONALE: To provide the Health Information Technology student with a more thorough overview of the functioning of the HIM department; its inter-relationships within the healthcare organization including the role of healthcare statistics, healthcare coding, and special clinical data reports. To prepare the student to recognize trends as they relate to Health Information Technology and clinical practice as well as the role of professional organizations in the field of Health Information Technology.

COURSE OBJECTIVES:
Upon completion of HITT 2360 the students will be able to:

1. Define data elements for institution wide data collection and design forms for data collection.
2. Collect and report data on incomplete records and timeliness of record completion.
3. Retrieve patient data from departmental databases.
4. Interpret statistical data.
5. Attend and take minutes at committee meetings.
6. Collaborate with clinical agencies to apply clinical vocabularies and terminologies used in the organization's health information systems.

7. Perform quantitative record analysis to evaluate compliance with regulations and standards.
8. Release patient specific data to authorized users and request patient specific information from other sources.
9. Maintain and enforce patient health record confidentiality requirements to include HIPAA guidelines.
10. Analyze records for compliance with accreditation, certification and licensure.
11. Design a performance improvement plan based on review of specified data.
12. Compare risk management strategies utilized by the clinical facility.
13. Use common software packages (e.g., spreadsheets, databases, word processing, graphics, presentation, statistical, email).
14. Analyze the components of the EMR system.
15. Protect data integrity and validity using software or hardware technology.
16. Demonstrate knowledge of current technology (e.g., Electronic Medical Record or Electronic Health Record software).
17. Support accurate billing through coding, Chargemaster, claims management and bill reconciliation processes.
18. Collaborate with clinical agencies to determine strategies for conversion to ICD-10.
19. Demonstrate competency in interpersonal skills.
20. Communicate information regarding class material to others and instructor.

COURSE STUDENT LEARNING OUTCOMES:

The curriculum of the Austin Community College Health Information Technology program is designed to meet or exceed the professional course content as published in the AHIMA Model Curriculum that includes the HIM Entry-Level Competencies and Knowledge Clusters. This course addresses the specific Domains, Subdomains, and Competencies identified below:

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

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. Maintain the accuracy and completeness of the patient record as defined by organizational policy and external regulations and standards.
4. Assist in preparing the organization for accreditation, licensing, and/or certification surveys.

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 according to current nomenclature.
3. Ensure accuracy of diagnostic/procedural groupings such as DRG, MSDRG, APC, and so on.
4. Adhere to current regulations and established guidelines in code assignment.
5. Validate coding accuracy using clinical information found in the health record.
6. Use and maintain applications and processes to support other clinical classification and nomenclature systems (ex. DSM IV, SNOMED-CT).
7. 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. 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.
3. Support accurate billing through coding, chargemaster, claims management, and bill reconciliation processes.
4. Use established guidelines to comply with reimbursement and reporting requirements such as the National Correct Coding Initiative.
5. Compile patient data and perform data quality reviews to validate code assignment and compliance with reporting requirements, such as outpatient prospective payment systems.
6. Ensure accuracy of diagnostic/procedural groupings such as DRG, APC, and so on.

Domain II: Health Statistics, Biomedical Research, and Quality Management

Subdomain A: Healthcare Statistics and Research

1. Collect, maintain, and report data for clinical indices/databases/registries to meet specific organization needs such as medical research and disease registries.
2. Collect, organize, and present data for quality management, utilization management, risk management, and other related studies.
3. Comprehend basic descriptive, institutional, and healthcare vital statistics.

Subdomain B: Quality Management and Performance Improvement

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 III: Health Services Organization and Delivery

Subdomain A: Healthcare Delivery Systems

1. Apply current laws, accreditation, licensure, and certification standards related to health information initiatives from the national, state, local, and facility levels.

2. Differentiate the roles of various providers and disciplines throughout the continuum of healthcare and respond to their information needs.

Subdomain B: Healthcare Privacy, Confidentiality, Legal, and Ethical Issues

1. Adhere to the legal and regulatory requirements related to the health information infrastructure.
2. Apply policies and procedures for access and disclosure of personal 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. Apply and promote ethical standards of practice.

Domain IV: Information Technology and Systems

Subdomain A: Information and Communication Technologies

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 to 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.
5. Participate in the planning, design, selection, implementation, integration, testing, evaluation, and support for EHRs.

Subdomain B: Data, Information, and File Structures

1. Apply knowledge of database architecture and design (such as data dictionary) 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 using appropriate software.

Subdomain D: Data Security

1. Apply confidentiality and security measures to protect 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 trails and data quality monitoring programs.

Domain V: Organizational Resources

Subdomain A: Human Resources

1. Apply the fundamentals of team leadership.
2. Participate in and work in teams and committees.
3. Conduct orientation and training programs.

4. Monitor and report staffing levels and productivity standards for health information functions.
5. Use tools and techniques to monitor, report, and improve processes.
6. Comply with local, state, and federal labor regulations.

Subdomain B: Financial and Resource Management

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.

DISCIPLINE/PROGRAM STUDENT LEARNING OUTCOMES:

Upon completion of the **Associate of Applied Science Degree in Health Information Technology**, the student will be able to:

1. Appropriately manage and use health data.
2. Collect report and interpret database information and compute related healthcare statistics.
3. Apply and participate in the implementation of laws and policies and procedures within healthcare delivery systems as they relate to payment systems, healthcare provider information needs, patient privacy and disclosure and ethical standards of practice.
4. Utilize technology, including specialized hardware and software applications to ensure accurate data collection, record tracking, and analysis, reporting and will be able to apply and contribute to the application of electronic health records and to the maintenance and design of patient information retrieval systems, while maintaining confidentiality and security of information.
5. Apply the fundamentals of team and financial resource management, including budgeting, teamwork, education, communication and interpersonal skills in order to contribute to work plans.

SCANS Competencies

In 1990, the U.S. Department of Labor established the Secretary's Commission on Achieving Necessary Skills (SCANS) to examine the demands of the workplace and whether our nation's students are capable of meeting those demands. The Commission determined that today's jobs generally require competencies in the following areas:

Resources: Identifies, organizes, plans and allocates resources
Interpersonal: Works with others
Information: Acquires and uses information
Systems: Understands complex interrelationships

Technology: Works with a variety of technologies

The Texas Higher Education Coordinating Board requires that all degree plans in institutions of higher education incorporate these competencies and identify to the student how these competencies are achieved in course objectives.

HITT 2360 COMPETENCE	**EXAMPLE OF LEVEL**
Resources	Identifies procedure for HIM function. Allocates time for studying.
Interpersonal	Shares experiences and knowledge with classmates, works as a member of a team for any assigned activities. Works with members of the HIM staff, hospital committees and HIM Director.
Information	Identifies release of information needed in order to release patient information.
Systems	Identifies systems to use such as encoder, quadramed or AS400.
Technology	Discusses special electronic health record with members of the HIM staff.
Basic Skills	Reads assigned pages.
Thinking Skills	Identifies and prepares charts for filing, assembly and analysis and release of information. Identifies and prepares charts for coding or special audits.
Personal Qualities	Works as a team member for any assigned activities. Asserts self and networks with classmates and HIM staff and director to obtain information on current topics.

TEXTBOOK: **None**

INSTRUCTIONAL METHODOLOGY: Experiential clinical rotation. Required attendance of 192 hours on Monday, Tuesday, Wednesday, Thursday or Fridays (during the day) or as assigned by department chair and clinical site. Attendance is required at your clinical site. If you are absent you have to make up the day(s) prior to the end of the semester. There is to be no lateness in your arrival at the clinical sites. If you are late more than once, you will have to make up the time. This course will be taught in an off-site facility to be prearranged by the Department Chair. The student will complete 192 hours, within the assigned period given above.

The clinical students will return to ACC and present a 15-minute summation of their practicum experiences. This will be a wonderful learning experience for all. Attendance and a presentation are a mandatory part of the practicum, no exceptions. The date for this is [date] (this time will be credited towards your practicum). After the presentations you will take a second mock exam.

ABSENCES: Should you have any reason to be absent from your clinical site on an assigned day, you **MUST** notify the **Clinical Site Supervisor as soon as possible.** You do not need to contact the ACC faculty immediately; however, you are to leave a message at 223-5928. A weekly Coding Practicum Report should be completed for the day missed stating that you were out on that day and the reason you missed clinical site. Another report has to be filled out for the made up day. This day must be arranged with your clinical site supervisor. You must attend all 192 hours in order to receive a grade for the course. **ALL ABSENCES MUST BE MADE UP.**

ENROLLMENT: If a student enrolls in HITT 2360 Clinical and then drops, they may re-enroll only once. There will be no exceptions. Enrollment is limited due to the shortage of clinical sites. ***Students that do a no show/no call at their clinical sites will be dropped from the program.***

CLASS MEETING: All students must attend a meeting with the Dept. Chair on [date]. This time will be credited towards your coding practicum. **Attendance at the clinical site begins [DATES] (or as assigned by Department Chair).**

GRADING SYSTEM: The Health Information Technology courses use the following scale for determination of final grades:
A = 90-100%
B = 80-89%
C = 70-79%
F = 69% and below

A grade of 70% or above is required for passing any subject area.

METHOD OF EVALUATION: Will be based on:
Attendance at the clinical site - 50%
Evaluation by the Clinical Site Supervisor - 25%
Submission of all required assignments - 25%

To earn **an A** one must:

- Attend required number of days at assigned site with any absences made-up by the end of the semester (192 at the site).
- Receive acceptable evaluation from clinical site supervisor
- Submit a Coding Practicum Report for each day at the site on due date
- Submit notebook following guidelines on due date

If students miss one day and do not make up this time, their grade is an automatic B (or less) for the class.

If students do not turn in their notebooks, the grade will be an automatic C (or less) for the class (if attendance at the clinical site is complete).

Dress: You must present a neat, professional appearance that follows the dress code of your clinical site. Do not wear blue jeans or scrubs at any time. You must wear your badge at all times.

Ethics and Confidentiality
Students are expected to:

- Adhere to the ethical guidelines set forth by the American Health Information Management Association (AHIMA) (see HITT Student Handbook or ahima.org)
- Abide by the school's Code of Student Conduct in Austin Community College catalog and handbook
- Abide by applicable facility policies and procedures. You can review these with your department mentor.
- Abide by HIPAA rules

Conduct
Students should demonstrate professional conduct throughout the course of the PPE.

- Demonstrate initiative by completing activities as assigned.
- If you complete your assignments early, ask for additional work rather than waiting for someone to notice.
    - There may be times when clinical personnel are unavailable to work with you. During those times use initiative to interview staff, maintain PPE log of activity, review policy manuals, and so on.
- Do not use your cell phone during working hours, this includes texting. Make personal calls and texts only at break and lunch times.
- Demonstrate a professional attitude during any unexpected situations that might occur.
    - Assist, if you can. Otherwise, be a silent observer or remove yourself from the situation.
    - Remember, much can be learned by observing how other professionals handle difficult situations.
- Utilize professional communication.
    - Students should contact their PPE site manager prior to their PPE to make introductions, obtain driving and parking information, and ask questions related to appropriate attire.
    - Maintain professional relationships by avoiding personal discussions.
    - As a professional you are expected to handle minor difficulties that arise on your own. However, if attempts to solve the situation have been unsuccessful, these matters should be brought to the attention of the PPE site manager and the academic program director.

- Avoid gossiping or complaining about your PPE with site staff or other students. If you have issues, you should be discussing them with your PPE academic program director.
- Students should maintain a daily log of activities that they accomplish during their PPE. This log should be shared with their site manager periodically to see what has been accomplished, what needs to be completed in the time remaining, and perhaps to delete or add some new activities.
- Students are encouraged to send personal, handwritten thank-you notes to their PPE sites and those specific individuals who contributed to their experience.

Student Responsibilities:

1. This experience should prepare you for the workforce. Professionalism is a must while representing Austin Community College. Be familiar with that site's policy and procedures regarding apparel and work. Students must be well-groomed and wear professional apparel.
2. Wear your badge at all times at the practicum site, and be sure to ask questions about the particular process you are completing.
3. Notify your instructor of your progress by email weekly. Give an account of the total number of hours completed and the tasks performed in your email.
4. If, for any reason, a student has issue with a person or circumstance, do not discuss this with any employee or other student. Notify me immediately. Students are guests at facilities, but if the need arises, your instructor will handle any issue that may arise between students and clinical sites.
5. If you miss any scheduled day of your clinical, you must call the office and the facility site and leave a message about your absence PRIOR to the time you are scheduled to arrive. **(One letter grade deducted for each absence). Missed days must be made up.**
6. Review the Conduct section above. Practice these while attending clinicals. All of these traits are sought after by most companies when looking to fill positions. This will also be a portion of your grade.
7. Review the subject matter in your books, especially Johns' text, prior to attempting this part of your field experience. Example: Review filing concepts before attempting to file at the facility. Remember to take notes for your reports.
8. Remember you are your best marketing tool to promote yourself as a competent potential employee. Your appearance, attitude, and performance counts. Be goal oriented and show good work ethics. Use your time wisely. This may be a long interview process as the clinical site may be evaluating you for future employment.
9. Read the syllabus carefully.

CONFIDENTIALITY: Remember that all information you will be dealing with is confidential. Do not talk about any identifying information with friends and relatives. This information is **CONFIDENTIAL.** Please conduct yourself in an ethical and professional manner and abide by the rules of confidentiality when dealing with the medical and non-medical information at your clinical site. Ask your clinical site supervisor for additional information if you do not know what to do.

COURSE POLICIES:

Withdrawal Policy
It is the responsibility of each student to ensure that his or her name is removed from the roll should he or she decides to withdraw from the class. The instructor does, however, reserve the right to drop a student should he or she feel it is necessary. If a student decides to withdraw, he or she should also verify that the withdrawal is submitted before the Final Withdrawal Date. The student is also strongly encouraged to retain their copy of the withdrawal form for their records.

The student is required to turn in their program student ID and any equipment or items that belong to the department. Failure to do so may compromise their standing at ACC.

Students who enroll for the third or subsequent time in a course taken since Fall, 2002, may be charged a higher tuition rate, for that course.

State law permits students to withdraw from no more than six courses during their entire undergraduate career at Texas public colleges or universities. With certain exceptions, all course withdrawals automatically count towards this limit. Details regarding this policy can be found in the ACC college catalog.

Incompletes
An instructor may award a grade of "I" (Incomplete) if a student was unable to complete all of the objectives for the passing grade in a course. An incomplete grade cannot be carried beyond the established date in the following semester. The completion date is determined by the instructor but may not be later than the final deadline for withdrawal in the subsequent semester.

Statement on Scholastic Dishonesty
A student attending ACC assumes responsibility for conduct compatible with the mission of the college as an educational institution. Students have the responsibility to submit coursework that is the result of their own thought, research, or self-expression. Students must follow all instructions given by faculty or designated college representatives when taking examinations, placement assessments, tests, quizzes, and evaluations. Actions constituting scholastic dishonesty include, but are not limited to, plagiarism, cheating, fabrication, collusion, and falsifying documents. Penalties for scholastic dishonesty will depend upon the nature of the violation and may range from lowering a grade on one assignment to an "F" in the course and/or expulsion from the college. See the Student Standards of Conduct and Disciplinary Process and other policies at http://www.austincc.edu/current/needtoknow.

The complaints and grades dispute process can also be found at the above site and is located in your Health Information Technology Program handbook at
http://www.austincc.edu/health/hitt/resources.php

Student Rights and Responsibilities
Students at the college have the rights accorded by the U.S. Constitution to freedom of speech, peaceful assembly, petition, and association. These rights carry with them the responsibility to accord the same rights to others in the college community and not to interfere with or disrupt the educational process. Opportunity for students to examine and question pertinent data and assumptions of a given discipline, guided by the evidence of scholarly research, is appropriate in a learning environment. This concept is accompanied by an equally demanding concept of responsibility on the part of the student. As willing partners in learning, students must comply with college rules and procedures.

Statement on Students with Disabilities
Each ACC campus offers support services for students with documented disabilities. Students with disabilities who need classroom, academic or other accommodations must request them through the Office for Students with Disabilities (OSD). Students are encouraged to request accommodations when they register for courses or at least three weeks before the start of the semester, otherwise the provision of accommodations may be delayed.

Students who have received approval for accommodations from OSD for this course must provide the instructor with the 'Notice of Approved Accommodations' from OSD before accommodations will be provided. Arrangements for academic accommodations can only be made after the instructor receives the 'Notice of Approved Accommodations' from the student.

Students with approved accommodations are encouraged to submit the 'Notice of Approved Accommodations' to the instructor at the beginning of the semester because a reasonable amount of time may be needed to prepare and arrange for the accommodations. Additional information about the Office for Students with Disabilities is available at http://www.austincc.edu/support/osd/

Safety Statement
Austin Community College is committed to providing a safe and healthy environment for study and work. You are expected to learn and comply with ACC environmental, health and safety procedures and agree to follow ACC safety policies. Additional information on these can be found at http://www.austincc.edu/ehs.

Because some health and safety circumstances are beyond our control, we ask that you become familiar with the Emergency Procedures poster and Campus Safety Plan map in each classroom. Additional information about emergency procedures and how to sign up for ACC Emergency Alerts to be notified in the event of a serious emergency can be found at http://www.austincc.edu/emergency/.

Please note, you are expected to conduct yourself professionally with respect and courtesy to all. Anyone who thoughtlessly or intentionally jeopardizes the health or safety of another individual will be dismissed from the day's activity, may be withdrawn from the class, and/or barred from attending future activities.

You are expected to conduct yourself professionally with respect and courtesy to all. Anyone who thoughtlessly or intentionally jeopardizes the health or safety of another individual will be immediately dismissed from the day's activity, may be withdrawn from the class, and/or barred from attending future activities.

Use of ACC email
All College e-mail communication to students will be sent solely to the student's ACCmail account, with the expectation that such communications will be read in a timely fashion. ACC will send important information and will notify you of any college related emergencies using this account. Students should only expect to receive email communication from their instructor using this account. Likewise, students should use their ACCmail account when communicating with instructors and staff. Instructions for activating an ACCmail account can be found at http://www.austincc.edu/accmail/index.php.

For help setting up your ACCeID, ACC Gmail, or ACC Blackboard, see a Learning Lab Technician at any ACC Learning Lab.

Student And Instructional Services
ACC strives to provide exemplary support to its students and offers a broad variety of opportunities and services. Information on these services and support systems is available at: http://www.austincc.edu/s4/

Links to many student services and other information can be found at:
http://www.austincc.edu/current/

ACC Learning Labs provide free tutoring services to all ACC students currently enrolled in the course to be tutored. The tutor schedule for each Learning Lab may be found at:
http://www.autincc.edu/tutor/students/tutoring.php

COURSE REQUIREMENTS: MATERIALS TO BE SUBMITTED

I. **Departmental Orientation:** If the site supervisor has a planned orientation, follow that plan. If they do not have anything planned, let the clinical site supervisor know what areas you would like to cover. Keep a copy of anything that is given to you for your notebook. During your orientation process, obtain information on your responsibilities and expectations. This should include such things as confirmation of reporting and leaving practices, times for breaks (if allowed) and lunch, where to keep personal items and location where you will sit and who will supervise your work.

II. **Clinical Report**: A separate report form is to be completed for each day at the clinical site; a minimum of one for each day you attend. These must be placed in your notebook each day under the tab for Coding Practicum Report.

III. **Student Evaluation Report:** This evaluation form is designed to allow you to provide us with feedback on the site and the clinical experience as a whole. The completed form is due at the time your notebook is submitted and may be typed or handwritten.

IV. **Binders: Binders are to be no larger than 1 inch.** You are to compile a binder of your Clinical assignment. This will later serve as a valuable resource tool for you. You are to use a three ring binder with dividers so it can be organized appropriately and material can be easily added. You may want to use dividers with pockets for loose items. All material is to be presented in a logical sequence with a table of contents to facilitate access. All text is to be typed; forms and other resources from the site may be copied. The binder should be professional in appearance. Do not wait until the last day to complete this assignment. Everything in the notebook is yours to keep and will not be removed. This notebook is due no later than [August 1, 2012] **at [12 noon}.** You will be given 4 hours credit towards your 192 hours. They will be returned to you during the week of finals.

NOTEBOOK/Binder CONTENT:

A. Documentation of participation in departmental coding function.

1) Obtain copies of job descriptions for each clinical site you attend.
2) Obtain copies of worksheets or forms you will use during the coding practicum.
3) Obtain copies of related policies and procedures.
4) Other information-you may include any other pertinent information/attachments. Remember to ask permission for copies of these documents from you clinical site supervisor.

B. **Other –** You may include anything else that you deem appropriate and that you would like to include that will further illustrate your assignment at the facility and/ or will be something that you would like to have as a reference regarding this site or assignment. Facility brochures, job descriptions, facility newsletters, etc. are examples of things you may include in your notebook.

DEPARTMENTAL FUNCTIONS: Your time this semester should be spent on an introduction to medical coding and various other functions of the department.

Clinical Report (You are to record the activities you complete daily at your coding practicum. At the end of the semester you will have one of these for each day of your practicum. This form may be copied.)

STUDENT EVALUATION REPORT
(Please provide feedback on your clinical site)

Student Contract – Clinical Experience

Instructions: Sign and date this form, and have a witness (at the clinical site) sign/date the form. Fax or scan signed document to: Norma Mercado, Health Information Technology, 512-223-5895 (fax) or nmercado@austincc.edu by the 2nd clinical visit. The original document should be placed in the clinical notebook.

PERSONAL UNDERSTANDING OF PROFESSIONAL PRACTICE RESPONSIBILITIES AND OBLIGATIONS

My professional practice experience is a vital part of my education, and I accept the responsibility of carefully reviewing the contents of the student handbook. I further accept responsibility for completing and submitting all assignments contained within the student handbook. I understand that I am to submit the written assignments to the professional practice coordinator by no later than the last day of my professional practice. The final grade for my professional practice course(s) is based upon my completion of assignments and submission of PPE journal, and submission of the clinical supervisor's evaluations, my student evaluation of the site. I realize I have been amply prepared for this on-site experience and I shall approach the professional practice with enthusiasm and a positive attitude so that I gain maximum benefit from this worthwhile educational experience.

I understand that absenteeism and tardiness are considered unprofessional and undesirable traits, and that the only reason for an absence from attendance at the professional practice site would be due to illness or another valid reason. I accept responsibility for making up any lost time; I understand that if I do not make up lost time, one letter grade will be deducted for each absence not made up. **If I am excessively absent and/or tardy from the professional practice site, my Professional Practice Experience coordinator will counsel me and if necessary, administratively terminate my professional practice experience.** I understand that if this occurs, the College has no obligation to place me in another professional practice site. I further understand that I am responsible for promptly reporting any absences directly to the practice site supervisor at the site and the appropriate Austin Community College faculty member by leaving voicemail at (512) 223-5928 before the schedule time to arrive at the site.

I am expected to adhere to the professional practice site's dress code, and I will dress in suitable office attire. If I am female, I will wear skirts, dresses or dress slacks and tops. If I am male, I will wear shirts, ties, and dress slacks. I will not wear jeans, shorts, knickers, sundresses, sneakers, sandals, or anything similar. I understand that I am expected to wear proper foot attire (e.g., no bare feet in sandals or shoes) and avoid extremes in jewelry, hairstyles, body piercing, perfume and make-up.

Hazards can be associated with participating in professional practices as a student in a health science program including, but not limited to needle sticks, inhalation of microorganisms, and contact with infected body fluids. I am responsible for following infection control guidelines at the professional practice site, maintaining safe practices, and

providing my own health insurance. If I become injured or ill during the course of the professional practice, I will immediately notify my professional practice supervisor. The supervisor will in turn notify the professional practice faculty member. The decision to seek medical attention and the resulting financial responsibilities are my responsibility alone. I realize that I am not to be substituted for paid staff during any professional practice experience assignments. I may not take the responsibility or the place of "qualified" staff. However, after demonstrating proficiency, I may be permitted to perform procedures with careful supervision. I may be employed by the professional practice site outside regular education hours provided the work is limited so it does not interfere with regular academic responsibilities. I further understand that my obligations concerning the protection of the confidentiality of personal health information relate to all personal health information whether I acquired the information through my association with the College and/or facility.

I also understand that unauthorized use or disclosure of such information will result in a disciplinary action up to and including involuntary expulsion from the College, the imposition of fines pursuant to relevant state and federal legislation, and a report to my professional regulatory body.

Date Signed	Signature of Student	Print Name
Date Signed	Signature of PPE mentor	Print Name

Clinical Placement Site:

_____

Student Email address:

_____

To the Clinical Site:

Clinical II Professional Practice Schedule (192 hours on site and classwork): **Please be sure student completes the number of hours below for each activity; the hours below can be modified to serve the needs of the facility if a service listed below is not provided:**

Suggested Hours by category	
Hours	**Activity**
4-8	Medical Staff/QI/PI
4	Tumor Registry
4	Utilization Review/Risk Management
40	Inpatient Coding
20	Observation and Day surgery Coding
12	Emergency Department coding
8	Hospice, Rehabilitation, ICF charts coding
20-24	Billing and Chargemaster
72	Management Project/Supervision
192	**Total hours**
	If opportunities are available, students are encouraged to attend meetings that the HIM Director or Coding Supervisor attend (or any meeting related to interdepartmental functions – chargemaster, utilization review, etc.) **Students are also encouraged to work on a project for the HIM director if the HIM director has such a need: such as productivity comparisons, performance improvement data analysis or graph preparation, review of current policy and procedure compared to actual work process, etc.**

A copy of this contract should be kept by the PPE mentor for reference.

Student Name _____

Submit the completed assignments below no later than the conclusion week #3 of your professional practice experience. Enter your answers on these pages. Staple attachment's to the back of this document for submission

ORIENTATION TO THE HEALTH CARE FACILITY

Purpose: The first assignment during the professional practice experience is to gain an understanding of the functioning and services provided by the health care facility.

The student should become oriented to the facility by answering the following:

Name and address of institution _____
Type of hospital _____
Number of physicians on staff _____
Is there a residency program? _____
Accrediting agencies _____

Descriptive statistics:

Number of beds _____
Average LOS for adults and children, newborn _____

Other Services Provided (Group practices, skilled nursing care, Community Mental Health Center, Home Health, and Hospice)

_____
_____
_____

ORIENTATION TO THE HEALTH INFORMATION DEPARTMENT

Purpose: The purpose of this assignment is to better acquaint the student with understanding the functioning of the Health Information Department. The student should provide the following information:

Name and credentials of the Health Information Department Director _____
_____

How many people in the department are credentialed? _____
How many people are employed by the health information department? _____
Department hours: (is the department open nights and/or weekends and if so, how many employees work and what are their major functions? _____
_____

Obtain or draw an organizational chart of the department. (Attach the chart to this document.)

Review policies and procedures for the HIM department and comment on specific areas of interest.

HITT 2360 - Clinical Experience Activities, Objectives, and Assignments

ANCILLARY DEPARTMENTS

Purpose: To acquaint the student with HIM systems in departments other than the HIM department, as well as to facilitate student understanding of relationships among the HIM department and other facility departments.

Starting with this section of the assignment, submit the question and your response, creating an MS Word (or other word processing) document for submission to your instructor. An electronic version of these questions is available to you to facilitate this process.

A. Tour of Facility

Objectives/Tasks

Upon completion of this activity, the student should be able to:

1. Describe the facility in terms of type of facility, ownership and control, services offered, and number of beds/ambulatory care visits.
2. Describe the health information department in terms of numbers of credentialed personnel and the basic functions performed.
3. Discuss the flow of the record through the department.
4. Demonstrate a basic orientation to/understanding of the equipment utilized in the health information department.

Assignments

Write a narrative on the tour of the site and the health information department describing the site and the functions reviewed. (1-2 pages in length)

B. Tumor Registry

Objectives/Tasks

Upon completion of this activity, the student should be able to:

1. Explain the contents and arrangement of the tumor registry files.
2. Describe the flow of data from accession of the patient into the tumor registry through the follow-up procedures.
3. Discuss the flow of information between the Regional Tumor Registry and the hospital registry.
4. Assist in interpretation of data.
5. Prepare data for presentation.
6. Analyze institutional data for variances from internal and external standards.

7. Present data.
8. Design reports using databases report generation.
9. Design department systems for collection or processing of patient records.
10. Participate in institutional committees/projects.
11. Participate in institution-wide committees that rely on medical records.
12. Monitor compliance with governmental and organizational regulations and accreditation standards.
13. Prepare for accreditation surveys.

Assignments

Review Questions

1. What is the time frame in which Tumor Registry abstracts should be completed?

2. What are the overall objectives of the Tumor Registry Function?

3. How are cancer cases identified?

4. Describe four (4) different ways in which follow-up can be performed.

5. What is the standard time in which follow-up should be performed?

6. Describe the numbering system. Include how, when and by who assigned.

7. Describe the components of the cancer committee. How often are the committee meetings held?

8. What is the procedure for completing follow-up?

9. How often are Tumor Registry conferences held?

10. What types of Quality Controls are in place within the Tumor Registry?

Performance Evaluation of Student/Tumor Registry

Please evaluate the student on a scale of 1 to 5:

1 - poor
2 - below average
3 - average
4 - above average
5 - excellent

	Score
1. Accurately identifies cancer cases.	_____
2. Performs follow-up accurately.	_____
3. Accurately completes Tumor Registry master patient index card.	_____
4. Demonstrates an understanding of the numbering system.	_____
5. Ability to follow directions.	_____

Comments by Evaluator:

_____ _____

Signature of Student/Date Signature of Evaluator/Date

C. Medical Staff Professional

Assignment due before visit

Complete the 8 hour Medical Staff Professional module. Present the module to the Medical Staff Professional for review. Ask questions to the answer the objectives/tasks below.

Objectives/Tasks

Upon completion of this activity, the student should be able to:

1. Delineate the responsibilities of the medical staff secretary.
2. Describe the organizational structure of the medical staff.
3. Demonstrate an understanding of the function of and activities of the various medical staff committees.
4. Explain any certifications required for the position of Medical Staff Professional and the minimum job requirements.

D. Utilization Review

Objectives/Tasks

Upon completion of this activity, the student should be able to:

1. Describe the UR process used at the site.
2. Determine the patient's necessity for admission according to the established UR plan.
1. Determine the patient's necessity for continued stay according to the established UR plan.
2. Complete appropriate notifications for situations that do not meet the necessity for admission and continued stay.
3. Abstract data from patient records for performance improvement, utilization review, and research.

Assignments

Review Questions

1. Which patients are reviewed by the UR Coordinator?

2. What are the responsibilities of the UR Committee and who are the members?

3. What is the overall objective of UR?

4. According to the UR plan, how often must it be reviewed and/or revised?

5. Describe how the Utilization Management concept can be cost effective for a hospital.

6. Briefly explain the denial process in UR.

7. Describe a usual day for the chart reviewer.

8. What functions does the UR coordinator handle?

9. Describe the retrospective review process?

10. Describe the flow of significant findings in the Utilization Review process.

Performance Evaluation of Student/Utilization Review

Please evaluate the student on a scale of 1 to 5:

1 - poor
2 - below average
3 - average
4 - above average
5 - excellent

	Score
1. Accuracy of Utilization Review.	_____
2. Accurately selects patients to be referred.	_____
3. Uses good judgment in making decisions.	_____
4. Accurately completes chart review.	_____
5. Ability to follow directions.	_____

Evaluation by: _____

Comments by Evaluator:

_____ _____

Signature of Student/Date Signature of Evaluator/Date

E. Performance Improvement

Objectives/Tasks

Upon completion of this activity, the student should be able to:

1. Describe the purpose of the QI/PI plan.
2. Describe the objectives of the QI/PI plan.
3. Identify the scope of the QI/PI program.
4. Summarize the organization of the QI/PI program. Who has the authority and responsibility for the QI/PI functions?
5. Summarize the methodology (monitoring and evaluation mechanisms) used.
6. State the composition of the QI/PI committee.
7. Describe the confidentiality policy.
8. State example of QI/PI studies done: (by the medical staff, in medical records, etc.)

PERFORMANCE MEASUREMENT AND QUALITY IMPROVEMENT

1. Draw an organization chart that represents the relationships among the administrative officers, committees and/or departments that carry out key functions of the performance measurement and quality improvement program.

2. Describe methods used in the institution to select performance measures to be monitored, establish standards of quality, collect and organize data, conduct evaluations and make appropriate improvements. Identify appropriate committee, sub-committee, and/or department responsibilities in this process.

3. What is the role of clinical pertinence review in the quality improvement framework?

4. Describe the general methods of communication between the Quality Improvement and Risk Management Departments.

5. Describe specifically the process by which a 'sentinel event' is identified, brought to the attention of appropriate clinical and administrative individuals and reviewed for possible further action.

6. To what extent has the hospital participated in any QIO quality improvement initiatives?

7. Review policies and procedures of the department. Select one you find of interest. Summarize policy and procedures.

Assignments

Write a narrative describing the QI/PI department and plan reviewed. (2-3 pages in length)

HITT 2360
HITT Clinical
Review Questions

CODING, ABSTRACTING, SEVERITY OF ILLNESS CLASSIFICATION AND INDEXING

1. What statistical and summary reports are produced? Are these reports routine or ad hoc (i.e., as needed)? With what frequency are reports generated? How are they used? By whom?

2. What is the usual distribution of the reports? Who is responsible for processing and maintenance of reports?

3. What personnel do the coding and abstracting? What are their qualifications? Do the same personnel perform both the coding and the abstracting?

4. What indices (diagnosis, procedure, physician, etc.) are maintained by the Medical Record Department? In what form, medium or type of equipment are the indices maintained? Who uses the indices? For what purpose?

5. How does the hospital and HIM validate the accuracy, thoroughness and compliance with coding guidelines? Is this function performed by an internal individual? Is this by contract with an outside firm or consultant? What are the qualifications of the person who does the coding validation studies? How were they selected? By whom? How is *their* performance reviewed?

6. How often are coding validations studies done? Describe the coding validation process. How many records are reviewed? How are they selected? Does the validation study encompass data items other than codes (e.g., demographic data, disposition, etc.?)

7. What preparations, if any, are there for conversion to ICD-10-CM ?

8. Does the HIM department assist (formally or informally) with technical coding questions from ancillary departments, affiliated physician offices, etc.? Is there an HIM department employee designated to respond to such queries? What educational programs, if any, has or does HIM provide for employees in these areas?

9. What reference materials are available for coders? To whom do the coders turn with coding questions? Documentation questions? Describe the process for handling such questions. Is a coding clarification sheet (query form) used? How formal or informal is this process.

10. How are new rules and regulations distributed among the coders? If by service, are the coders cross-trained?

11. Are there productivity standards for coders? What are they? How were these standards established? By whom? How is productivity monitored?

PROCESSING FOR REIMBURSEMENT

1. What is the hospital payer mix? Who maintains this information?

2. Is there a DRG coordinator? If yes, identify this individual by position title and credentials. What is the organizational placement of this position?

3. Is there a RAC Coordinator? If so, has the RAC denied any claims at the facility? What measures are being done at the facility to handle regulatory audits?

4. If the Grouper is used does it interface with the billing system? Is it part of a larger computer-based system? If yes, what other components are used by the Medical Record Department?

5. What special reports, if any, are prepared or used by the Medical Record Department to monitor the Case Mix Index (CMI) and/or payment? Who prepares these reports? How are they used? By whom?

6. Who (by job title and qualifications) monitors delayed reimbursement billing? For what reason is billing delayed? Who assigns the "bill hold" cause category (e.g., needs final coding, needs physician signature, etc)? What is the #1 reason for delays in billing at this time (review report if possible)?

Billing Department:

1. What is the schedule of an average day for a biller?

2. From the date of discharge, what is the facility's "goal" to send the patient accounts for billing?

3. What is the average Accounts Receivable?

4. How many billers are at the facility? Are there any with credentials?

5. What is the most common edit/error found on claims?

6. How are edits reconciled? Did you have the opportunity to review claim edits and research resolutions?

7. Does the billing department work closely with the coding department?

8. When a Chargemaster issue is identified by a biller or some other person in the business office, what is the process to have the Chargemaster corrected?

9. If the student is allowed, review several pages of a Chargemaster at the facility. Were the pages sorted by Chargemaster code, CPT code, Chargemaster description, or other text? What did you learn from reviewing the Chargemaster?

10. What would the benefit be of looking at a Chargemaster sorted by CPT code?

Field Experience II Worksheet: ER and Outpatient accounts

Name: _____ Make Copies of this form before beginning.

Instructions: Complete the form showing your work on the accounts. Make any corrections when checking your work against the original.

Case #	Admitting Dx.		Other Dx:		
	Principle Dx.				
Procedure Codes					
CPT codes					
				E/M Code	

Case #	Admitting Dx.		Other Dx:		
	Principle Dx.				
Procedure Codes					
CPT codes					
				E/M Code	

Case #	Admitting Dx:		Other Dx:		
	Principle Dx:				
Procedure Codes					
CPT codes					
				E/M Code	

Case #	Admitting Dx:		Other Dx:		
	Principle Dx:				
Procedure Codes					
CPT codes					
				E/M Code	

Case #	Admitting Dx:		Other Dx:		
	Principle Dx:				
Procedure Codes					
CPT codes					
				E/M Code	

Case #	Principle Dx:		Other Dx:		
Procedure Codes					
CPT codes					
				E/M Code	

Field Experience: Worksheet – Observations/Day Surgeries

(Make copies to document work or print coding sheets from Encoder and de-identify. Submit these in notebook at end of semester.)

Students Name: _____ Med Rec #_____

Pt. Age:

Pt. Sex:

Disposition:

LOS:

Service: _____DSURG _____Observations _____Other (_____)

PDX:

Other significant Dxs:

P PX:

Other significant Pxs:

Field Experience II: Worksheet – Inpatient

(Make copies to document work OR print coding sheets from Encoder.)

Payment Type: APC/DRG/____

Students Name: _____ Med Rec #_____
(Example Med Rec #1, #2, #3 . . . etc.)
Age:

Sex:

Disposition:

Service: _____Medical _____Surgical _____OB _____NB

P DX:

Other significant Dxs:

P PX:

Other significant Pxs:

MDC_____
MS-DRG_____
$$$$_____ (rounded)

Date coded: _____

STUDENT EVALUATION OF PROFESSIONAL PRACTICE EXPERIENCE

The student is to complete this evaluation form and submit this signed form with binder at the completion of this course.

STUDENT NAME _____

DATE COMPLETED _____

NAME OF FACILITY _____

NAME OF CLINICAL SUPERVISOR _____

OBJECTIVE: To provide constructive feedback regarding the professional practice experience to the Clinical Supervisor and to the Health Information Technology Program at Midland College.

INSTRUCTIONS: Assign a rating for each of the below. If you assign a rating of "fair" or "poor," explain your rationale with specific examples on the next page **3 = good 2 = fair 1 = poor**

1.	Supervision of student activity by clinical supervisor.	3	2	1	
2.	Adequate direction given to student; employees helpful and willing to answer student inquiries regarding procedures, etc.	3	2	1	
3.	Clinical supervisor demonstrated interest in achieving objectives of clinical affiliation as enumerated in directed practice manual.	3	2	1	
4.	Adequate exposure and practice in the following areas were provided to the student:				
	a. Record storage/retrieval	3	2	1	NA
	b. Microfilming (if applicable)	3	2	1	NA
	c. Chart assembly	3	2	1	NA
	d. Chart analysis	3	2	1	NA
	e. Delinquent chart procedure	3	2	1	NA
	f. Release of medical information	3	2	1	NA
	g. Committee meetings/medical staff	3	2	1	NA
	h. Medical transcription (if applicable)	3	2	1	NA
	i. Statistics/vital statistics	3	2	1	NA
	j. Scanning/Imaging	3	2	1	NA

5. What are the facility's strongest points regarding the professional practice experience?

6. How could the facility improve the professional practice experience for future students?

_____

Signature of Student Date

_____

Signature of Clinical Supervisor Date

To Be Completed by Clinical Supervisor:

HITT Professional Practice Experience Evaluation Form

STUDENT'S NAME: _____
DATE: _____
FACILITY: _____

To the Clinical Supervisor: Circle the grade that corresponds to the student's skill level for each. Meet with the student to discuss the grades selected. Mail the completed evaluation form to: Norma Mercado, Department Chair ACC 3401 Webberville Road Austin, Texas 78702

Instructions: Circle the score for each skill area delineated below to indicate the student's level of performance. Consider the following when determining the score for each area:

- **Productivity** (student completed appropriate volume of work)
- **Application to work** (student demonstrated good evidence of independent study and motivation)
- **Knowledge of HIM principles** (student applied HIM principles to practice in an appropriate manner)
- **Decision-making** (student demonstrated good judgment in making decisions, which were accurate)
- **Understanding of work flow** (student demonstrated an understanding of the task in relation to HIM department work flow).

Key to Selecting Skill Level**: Student consistently performed**

A well above average
B above average
C at an average level
D below average
F below the required level

Skill Area	Circle the Score that Corresponds to the Student's Skill Level for Each Area														
	A			B			C			D			F		
Attendance	100														0
Student completed 120 hours of professional practice															
Promptness	100	96	93	89	85	81	79	75	71	69	65	61	59	55	0
Student reported to the department on time each day; returned from breaks and lunch on time															
Professionalism	100	96	93	89	85	81	79	75	71	69	65	61	59	55	0
Student dressed appropriately, was respectful to colleagues/ superiors, accepted constructive criticism well, etc.															
Communication	100	96	93	89	85	81	79	75	71	69	65	61	59	55	0
Student asked appropriate questions, etc.															
Initiative	100	96	93	89	85	81	79	75	71	69	65	61	59	55	0
Student displays energy and motivation in starting and competing tasks.															
Organization	100	96	93	89	85	81	79	75	71	69	65	61	59	55	0
Student functions in a systematic and logical fashion.															
Supervision	100	96	93	89	85	81	79	75	71	69	65	61	59	55	0
Student was receptive to supervision, etc.															

Hospital Orientation	Yes	No	If no, please explain:
Student was oriented to health care facility functions and operations (e.g., patient confidentiality)			
HIM Orientation	Yes	No	If no, please explain:
Student was oriented to functions and operation of health information management department			

Skill Area	Circle the Score that Corresponds to the Student's Skill Level for Each Area														
	A			B			C			D			F		
Coding Accuracy Inpatient, OBS, Day Surgery, ER	Yes	No	If no, please explain:												
Student used appropriate coding guidelines for inpatient charts.															
Medical Staff	100	96	93	89	85	81	79	75	71	69	65	61	59	55	0
Student was engaged in learning and discussing roles and responsibilities of the medical staff coordinator. Reviewed policy and procedures. Interviewed coordinator in a professional manner.															
Utilization Review	100	96	93	89	85	81	79	75	71	69	65	61	59	55	0
Student reviewed policy/procedures. Student was engaged in learning and discussing roles and responsibilities of the utilization review personnel. Student was competent in abilities to identify criteria for admission. Reviewed policy and procedures. Interviewed coordinator in a professional manner.															
Risk management	100	96	93	89	85	81	79	75	71	69	65	61	59	55	0
Student reviewed policy/procedures. Student was engaged in learning and discussing roles and responsibilities of risk management personnel. Student conducted interview in a professional manner.															
Billing	100	96	93	89	85	81	79	75	71	69	65	61	59	55	0
Student was able to identify cases needing to be reviewed for edits or errors. Student reviewed policy and procedures for billing processes. Student's conduct was professional when inquiring about processes. Student was able to identify chargemaster items and review descriptions, charges, and codes.															

Comments or additional information about student clinical experience:

Signature of Clinical Supervisor _____Date _____

Signature of Student _____Date _____

Facility Supervisor, please return to:
Norma Mercado, Department Chair
ACC
3401 Webberville Road #9210
Austin, Texas 78702

HITT 2360 Clinical
Sign-In Sheet (To be filled out at each day at the site)

Date	Subject/Task	Time From	Tine Ending	Evaluator signature	Total Time

COURSE OUTLINE/CALENDAR:

SCHEDULE FOR HITT 2360 Clinical

[Dates]	**Clinical Assignments**
[Date]	**Mandatory Meeting EVC room 9209** **-Apply for graduation** **-Handout syllabus** **-Photo ID will be taken** **-HIPAA Test** **-Modules for specific clinical site**
[TBA]	**Mandatory Advising Meeting with Department Chair**
[Date]	**Notebooks/binders are due by [12 noon]**
[Date]	**Notebooks/binder returned**

HITT 2360 Clinical - Course Calendar/Outline

WEEK/ DATES	TOPIC AREA/OBJECTIVE	READING OTHER ASSIGNMENTS	ACTIVITIES** **(see Blackboard and this syllabus for descriptions of activities)**
1	• Define data elements for institution wide data collection and design forms for data collection. • Interpret statistical data. • Protect data integrity and validity using software or hardware technology. • Protect data integrity and validity using software or hardware technology. • Demonstrate knowledge of current technology (e.g., Electronic Medical Record or Electronic Health Record software). • Use common software packages (e.g., spreadsheets, databases, word processing, graphics, presentation, statistical, email).	Virtual Lab	Form Development Exercise: Record Deficiencies Statistical Data Gathering – Clinical Site Clinical Notebook Submission: Facility Statistical Data Clinical Notebook Submission: Identification and use of software for Statistical Data Presentation Clinical Notebook Submission: Analysis of facility data integrity, security and monitoring plan Facility EHR documentation conversion exercise and clinical notebook documentation Written documentation of clinical facility project: Data Storage needs Quantitative and Qualitative Data analysis table Clinical Notebook Submission: Narrative of QIO Dept processes on data security, integrity and monitoring and comparison to standards
2	• Interpret statistical data. • Retrieve patient data from departmental databases. • Compare risk management strategies utilized by the clinical facility. • Design a performance improvement plan based on review of specified data.	Virtual lab	Clinical Notebook Submission: Analysis and Validity of Hospital Data Clinical Notebook Submission: Documentation of current and archival retrieval of patient information Clinical Notebook Submission: Comparison Report – Facility Risk Management Practices vs. Best Practices Clinical Facility Assignment – CQI or Q10 meeting attendance and documentation

3	Use common software packages (e.g., spreadsheets, databases, word processing, graphics, presentation, statistical, email).	Virtual lab	Clinical Notebook Submission: Development of Descriptive Statistics table at assigned facility
4	• Use common software packages (e.g., spreadsheets, databases, word processing, graphics, presentation, statistical, email). • Support accurate billing through coding, chargemaster, claims management and bill reconciliation processes.	Virtual lab	Clinical Notebook Submission Exercise: Table Design – Statistical Software Uses and Comparisons for Assigned Facility Clinical Notebook Submission: Billing and Reimbursement Report at Clinical Facility
5	• Maintain and enforce patient health record confidentiality requirements to include HIPAA guidelines. • Attend and take minutes at committee meetings.	Virtual lab	Clinical Notebook Submission: Policy and Procedures for Research Protocol Monitoring: Analysis and Congruency with Privacy Rule Clinical Notebook Submission: Committee Attendance Information Clinical Notebook Submission: Committee Function/Structure/Overview/Actions Narrative
6	• Interpret statistical data. • Compare risk management strategies utilized by the clinical facility.	Virtual lab	Clinical Notebook Submission: Statistical Presentation of Facility LOS Data Clinical Notebook Submission: Comparison Report – Facility Risk Management Practices vs. Best Practices
7	Define data elements for institution wide data collection and design forms for data collection.	Virtual lab	Clinical Notebook Submission: Institutional Review of Performance Measures and Quality Improvement Processes
8	Analyze records for compliance with accreditation, certification and licensure	Virtual lab	Clinical Notebook Submission: Response to UR/UM Management Questions Mock Survey Development and Analysis of Findings: Clinical Notebook

9	Perform quantitative record analysis to evaluate compliance with regulations and standards.	Virtual lab	Clinical Notebook Submission: Perform And Report on Physician Data Quality Monitoring Quantitative and Qualitative Analysis of Discharged Patient Records Written exercise: Summary/comparison of institutional quality/performance measures and identification of organizational structures and functions Submission: Utilization Review Questions Clinical Notebook Submission: DRG Questions
10	• Maintain and enforce patient health record confidentiality requirements to include HIPAA guidelines. • Release patient specific data to authorized users and request patient specific information from other sources.	Virtual lab	Clinical Submission: Review and analysis of authorizations for release of information Clinical Notebook Submission: Report on student compliance with health information/records laws and regulation in assigned facility Clinical Notebook Submission: Development of HIPAA Comprehension Survey; Data Analysis and Training Program Development Recommendations for facility policy and procedures changes related to release of patient information
11	• Release patient specific data to authorized users and request patient specific information from other sources. • Demonstrate competency in interpersonal skills. • Collaborate with clinical agencies to determine strategies for conversion to ICD-10.	Virtual lab	Clinical Notebook Submission: Facility Release of Information audit and analysis and report on findings. Clinical Notebook Submission: EHR vs Paper Records Comparison Clinical Notebook Submission: Comparative Table Development: Software Systems and Functions Data Release Preparation Exercise Student Assignment: Design Strategies to Address Ineffective Communication

	• Analyze the components of the EMR system.		Written response to ICD-10 Conversion preparation by clinical agency. Clinical Project: Design of EMR Implementation Timeline EMR Departmental Meeting Attendance and documentation – Clinical Notebook