



**HEALTH INFORMATION TECHNOLOGY
STUDENT HANDBOOK
2016-2017**

**For information about CF's Associate in Science in Health Information Technology,
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www.CF.edu/HIT

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PROGRAM FACILITATOR'S WELCOME

Welcome to the Health Information Technology (HIT) program at the College of Central Florida. 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 contributions to this health profession.

The HIT profession finds itself at a pivotal point in its history. It is on the cusp of change and of ever increasing professional opportunities. The Bureau of Labor Statistics projects 22 percent growth in employment for HIT professionals from 2012 to 2022. 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 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 CF 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 College of Central Florida is (as of April 2005) accredited by the Commission on the Accreditation for Health Informatics and Information Management Education (CAHIIM). 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 telephone, email, or drop in to see me. I especially want to see each of you prior to each semester's registration so we can keep you on track!

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

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VISION STATEMENT

To be the first choice for quality higher education in our community

MISSION STATEMENT

College of Central Florida provides access to high quality, high value baccalaureate degrees, associate degrees, certificates and diplomas, and promotes the economic, social and cultural development of our community.

CORE VALUES

Empowerment: Cultivating individual and collective strength.

Engagement: Being fully present and involved in the success of our students, faculty, staff and community.

Excellence: Committing to the highest standards of academic quality, performance and service.

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 managing and processing health information. This can involve collecting, scanning, analyzing, coding, transcribing, querying it; displaying it in various formats, releasing it legally, all while complying with state and federal statutes and regulatory guidelines.

Nature of the Work

Every time a health care personnel treats 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.

The technicians who specialize in coding the patients' medical information for retrieval and reimbursement purposes are called coding specialists or medical coders. These technicians assign a code to each diagnosis and procedure based on information given by the attending physician. 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. Coders may use other coding systems, such as those geared toward ambulatory settings.

The increasing use of electronic health records (EHRs) will continue to broaden and alter the job responsibilities of health information technicians. For example, with the use of EHRs, technicians must be familiar with EHR computer software, maintaining EHR security, and analyzing electronic data to improve health care information. Health information technicians use EHR software to maintain data on patient safety, patterns of disease, and disease treatment and outcomes. Technicians also may assist with improving EHR software usability and may contribute to the development and maintenance of health information networks.

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 from a two-year 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 exam offered by the American Health Information Management Association (AHIMA). To take the exam, a person must graduate from a two-year associate degree program accredited by the Commission on Accreditation for Health Informatics and Information Management Education (CAHIIM). The HIT program at CF was accredited by this organization in April 2005 and has met re-accreditation requirements each year since. A baccalaureate degree in health information technology from a CAHIIM accredited school will allow the graduate to sit for the AHIMA exam leading to the credential for the Registered Health Information Administrator. A post-graduate degree is also available.

In addition, AHIMA offers coding credentials. These include the certified coding assistant credential (CCA) and the certified coding specialist credential (CCS) and CCS-P for physician office specialization. The American Academy of Professional Coders (AAPC) offers coding credentials, as well.

EARNINGS

The median annual earning of health information technicians was \$35,900 in 2015, the latest year available, or \$17.26/hour. The highest 10 percent earned more than \$61,400. 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. This information is compiled nationally and does not necessarily reflect regional/county/city earnings or the salaries available in specific facilities.

(Compiled by CF HIT Department from the Bureau of Labor Statistics website:
<http://www.bls.gov/ooh/healthcare/medical-records-and-health-information-technicians.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 website provides 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 10 of these 20 hours must be in core content areas defined by AHIMA; e.g., clinical data management, external forces, technology, and management. AHIMA also offers coding and other credentials.

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 of AHIMA”, access to a wealth of information on the website, and membership in the Florida Health Information Technology Association. The Florida Health Information Technology Association holds its annual meeting during the summer and publishes “Coastlines”.

There are other professional organizations that are relevant to the health information professional. The American Academy of Professional Coders (AAPC) offers coding credentials. The Board of Medical Specialty Coding (BMSC) and Professional Association of Health Care Coding Specialists (PAHCS) both offer credentialing in specialty coding. The National Cancer Registrars Association (NCRA) offers a credential as a Certified Tumor Registrar (CTR). To learn more about the credentials and specific requirements, contact the credentialing organization directly.

ESTIMATED FEES

70 credit hour A.S. degree in Health Information Technology:

- ❖ 2016-2017 Credit Hour Cost: \$107.10 (For Florida Residents: estimated \$7,497)
- ❖ 2016-2017 Credit Hour Cost: \$421.88 (For Nonresidents): \$29,531.60
- ❖ Estimated Book Costs for A.S. Degrees: \$2,500-\$5,000
- ❖ Practicum fees for background check (\$50) and health certificate, including office visit, immunizations for tetanus/diphtheria, MMR, chicken pox, and Hepatitis B, and a chest X-ray
 - ★ Required AHIMA Membership: \$35 for students. (Needed for access to the Virtual Lab exercises)
- ❖ There may be an additional lab fees within classes

HEALTH INFORMATION TECHNOLOGY PROGRAM HISTORY

Planning for a health information technology program at then 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 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 1999. A request for an accreditation survey was made in January 2004 and, after a survey in January 2005, the program was accredited in April 2005.

The Health Information Technology Program at College of Central Florida 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



Program graduates will be awarded an Associate in Science in Health Information Technology.

PROGRAM GOALS AND TARGET OUTCOMES

CURRICULUM: The program must assess the appropriateness and effectiveness of the curriculum, with the results of the program assessment used as the basis for ongoing planning and program improvement. *TARGET OUTCOME:* The program will include the content and courses identified in the associate HIT level curriculum map.

FACULTY: The program must provide a plan for faculty that establishes or assesses the knowledge, skills, qualifications, and experience pertinent to the professional curriculum content that they are assigned to teach. *TARGET OUTCOME:* All credentialed full-time faculty will adhere to the continuing education requirements of AHIMA.

STUDENTS AND GRADUATES: The program must provide assurance that the educational needs of students are met and that graduates demonstrate at least entry-level competencies. *TARGET OUTCOME:* Eighty percent of program graduates who sit for the RHIT examination within six months of graduation will attain the RHIT credential.

COMMUNITIES: The program must indicate how it assesses the needs of its communities of interest and how it interprets these needs into education a competent workforce. *TARGET OUTCOME:* The program conducts a biennial assessment of education needs in the local market.

ADVISORY BOARD: State the target outcome for the Advisory Board in the current academic year. *TARGET OUTCOME:* To formulate suggestions for providing acute care practicum experiences in place of term-long site exposure.

PROGRAM GOALS AND STANDARDS

GOAL 1: *To prepare competent entry-level health information technicians in the cognitive (knowledge), psychomotor (skills), and affective (behavior) learning domains.*

STANDARDS:

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 required in the health information technology program.
3. Formal and informal feedback from employers indicates 100 percent 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.

EVALUATION METHODS:

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 he/she 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 exam results.

GOAL 2: *To deliver an academically rigorous, all-encompassing program required for the HIT student to be a success in the field.*

STANDARDS:

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.

EVALUATION METHODS:

1. Assess curriculum against knowledge cluster content assessment form.
2. Assessment and input from Advisory Committee.

GOAL 3: *To recruit and retain competent faculty.*

STANDARDS:

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.

EVALUATION METHODS:

1. Documentation of continuing education hours.
2. Review of summary reports submitted by the faculty member at the conclusion of the internship.

GOAL 4: *The HIT program will demonstrate responsiveness to the needs of the community (ies) of interest.*

STANDARDS:

1. The program conducts a biennial assessment of education needs in the local market.
2. The program will provide job placement assistance to the community and to our graduates.

EVALUATION METHODS:

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 CF 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.* 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 HIT program must demonstrate the following minimum abilities:

- ✓ Acquire and apply information from classroom instruction, laboratory and practicum experience, independent learning, and team projects
- ✓ 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 databases maintained in Health Information Technology departments
- ✓ Complete computer-based assignments in a timely fashion
- ✓ Function (consult, negotiate, share) as part of a team
- ✓ Delegate effectively
- ✓ Read materials used in HIT settings such as; coding manuals, policy and procedures, and patient medical records
- ✓ Calculate mathematical information such as; hospital statistics, budgets, and productivity information
- ✓ Perform with the dexterity that is necessary to manually file medical records and cards, as well as assemble paper medical record forms
- ✓ Perform with the dexterity that is necessary to manually and visually prepare office layouts and to design forms and computer screens
- ✓ Operate equipment such as; word processors, transcription equipment, electronic movable files, copiers, etc.
- ✓ Synthesize information regarding health care outcomes for formal, verbal and/or written presentation to health care professionals.

These essential abilities 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 requests with Access Services, 352-854-2322, ext. 1580. Assistance is available at all CF locations by appointment.

*** Students must complete a criminal background check (NO FELONIES) and must submit a health certificate showing proof of good health and of immunization prior to registering for the practicums.**

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:

- ✓ Advocate, uphold and defend the individual's right to privacy and the doctrine of confidentiality in the use and disclosure of information.
- ✓ Provide service for both 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.
- ✓ 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.
- ✓ Refuse to participate in or conceal unethical practices or procedures.
- ✓ Advance health information management knowledge and practice through continuing education, research, publications, and presentations.
- ✓ Recruit and mentor students, peers and colleagues to develop and strengthen professional workforce.
- ✓ Represent the profession accurately to the public.
- ✓ 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.
- ✓ State truthfully and accurately their credentials, professional education, and experiences.
- ✓ Facilitate interdisciplinary collaboration in situations supporting health information practice.
- ✓ Respect the inherent dignity and worth of every person.

CONFIDENTIALITY

College of Central Florida does not discriminate against any person on the basis of race, color, ethnicity, religion, gender, age, marital status, national origin, genetic information or disability status in its programs, activities and employment. For inquiries regarding nondiscrimination policies contact Equity Officer, Ocala Campus, Ewers Century Center, Room 201C, 3001 S.W. College Road, 352-854-2322, ext. 1437, or smithc@cf.edu.

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 AND/OR ASSIGNMENTS: All exams must be taken on assigned days. Unexcused absence results in a grade of zero for the missed exam. 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 as well as for turning in your homework that day. The lowest exam grade will be dropped. There will be no exam make-ups. All assignments are due during the class period. No late assignments will be accepted.

CHEATING/PLAGIARISM: The CF Code of Student Conduct specifies that any student found to have committed acts of dishonesty, including but not limited to cheating, plagiarism, or other forms of academic dishonesty is subject to disciplinary sanctions. Plagiarism or cheating will result in disciplinary action such as being dropped from the course, suspension, expulsion from school, or other appropriate action. (See Student Handbook). Other appropriate actions include: a lower or failing grade in the course; a lower or failing grade on the assignment or examination; assignment of additional work to provide evidence of the student's academic performance or understanding of the course material; or referral to the Academic Integrity Seminar. If a student is referred to the Academic Integrity Seminar, attendance is required and costs the student \$35.

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 completed at the beginning of the semester. Call 352-854-2322, ext. 1209, or email access@cf.edu.**

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. CF 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 semester.

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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 nonattendance. 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 GPA. Students should be alerted to the fact that (1) withdrawals do not count in the CF GPA., 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 AND OTHER ELECTRONIC DEVICES: Cell phones must be turned off during class and placed in a purse or book bag. Students may not leave class to respond to calls or text messages. Other electronic devices such as MP3 players will be put away at the beginning of class. Unless prior approval is granted, laptops will also be put away during class. Disregarding these rules will adversely affect the student's professional points or participation grade.

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 all 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.

AHIMA MEMBERSHIP: Students must join AHIMA in order to access the Virtual Lab exercise. The cost is \$35.

HIT PROGRAM COURSES: Students must attain a minimum grade of C in all courses required by the program 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.

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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.

GRADUATION: Please see an advisor before registering for final semester of program so that the graduation application can be properly completed.

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	C	70-76
B+	87-89	D	60-69
B	80-86	F	59 and lower
C+	77-79		

2012 PROGRAM CHANGES: The HIT program expanded from 67 hours to 70 hours by state mandate in fall 2012. This action accommodated additional ICD-10 classes. ICD-10 implementation has been postponed until 2015.

HEALTH INFORMATION TECHNOLOGY COURSE DESCRIPTIONS

HIM 1800- Introduction to Health Information Technology (3 credits)

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 (3credits)

Pre-requisite: 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 credits)

Pre-requisites: 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 2722- ICD-10-CM coding (3 credits)

Pre-requisites: CGS 1100, BSC 2085C, BSC 2086C, HSC 2531, HIM 1430

This course provides instruction in the basic principles and guidelines for using the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD -10-CM) in the coding of diagnoses and procedures.

HIM 2723- ICD-10-PCS coding (3 credits)

Pre-requisites: CGS 1100, BSC 2085C, BSC 2086C, HSC 2531, HIM 1430, HIM 2722

This course provides instruction in the basic principles and guidelines for using the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD -10-PCS) in the coding of diagnoses and procedures.

HIM 2253- CPT coding (3 credits)

Pre-requisites: CGS 1100, BSC 2085C, HSC 2531 Co-requisites: HIM 1430, BSC 2086C

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 2214- Health Care Statistics (3 credits)

Pre-requisites: CGS1100, HIM 1800, MAC1105

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 credits)

Pre-requisites: HSC 2531, BSC 2085C

Co-requisites: HIM 1430, BSC 2086C

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 (3credits)

Pre-requisite: 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 credits)

Pre-requisite: 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 credits)

Prerequisites: CGS 1100, HIM 1800, HIM 1949

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 credits)

Pre-requisites: HIM 1800, HIM 1949, HIM 2214

This course is designed to introduce the student to supervision and management of the resources found in health information management settings, including staff, budget, space and equipment. Quality management including process, collection tools, data analysis, and reporting techniques will be a focus. Utilization review, risk management, and the importance of patient safety will be studied in depth.

HIM 1949- Practicum I – Acute Care Setting (3 credits)

Pre-requisites: 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 2941- Coding Professional Practice Experience (3 credits)

Prerequisite: HIM 2253 and HIM 2722 and HIM 2723.

This class and lab course provides the Health Information Technology student an opportunity to apply basic concepts and techniques for CPT/ICD-10 Coding using actual health records in both paper and electronic format from various health care facilities. The student will also utilize the 3M Encoder software in the lab and in performing outpatient and inpatient coding. Each student will be responsible for completion of a professional practice experience binder. Traveling to clinical sites may be required.

BSC 2085C- HIM Anatomy and Physiology I and Lab (4 credits)

An introduction to the human body. Examines the molecular, cellular and tissue levels of organization and these organ systems: integumentary, skeletal, muscular and nervous. (3 hours of lecture and 2 hours of laboratory per week)

BSC 2086C- HIM Anatomy and Physiology II and Lab (4credits)

Pre-requisite: BSC 2085C

A continuation of BSC 2085C that covers the following organ systems: endocrine, cardiovascular, lymphatic, respiratory, immune, digestive, urinary and reproductive. Metabolism, fluid balance and homeostatic mechanisms are included. (3 hours lecture and 2 hours laboratory per week)

HIM 2932- Health Information Technology Special Topics (3 credits)

Pre-requisites: HIM 2253, HIM 2722, HIM 2723, HIM 2260

This course consists of special sessions centering on variable topics designed to enhance specific professional skills. Topics may vary. They will be selected on the basis of what is new or currently relevant in the field, what students may need to develop proficiency, or in response to the results of the registered health information technology examination.

★NOTE: CGS 1100 Microcomputer Applications must be taken within five years of graduation.

COURSE PREREQUISITES AND CO-REQUISITES

COURSE		PRE-REQ	CO-REQ
BSC 2085C	Anatomy and Physiology I		
CGS 1100	Microcomputer Applications		
HSC 2531	Medical Terminology		
HIM 1800	Introduction to HIM		CGS1100
BSC 2086C	Anatomy and Physiology II	BSC 2085C	
HIM 2442	Pharmacology	BSC 2085C HSC2531	BSC 2086C HIM 1430
HIM2253	CPT Coding	CGS1100 HSC 2531 BSC 2085C	HIM 1430 HIM1454C
HIM 2012	Legal Aspects	CGS 1100 HIM 1800	
HIM 1430	Concepts of Disease	HSC 2531	
HIM 1949	Practicum I	HIM 1800 HIM 2012	
HIM 2214	Health Care Statistics	MGF1106 Or MGF1107 Or STA2023 CGS 1100 HIM 1800	
HIM 2260	Billing and Reimbursement	CGS 1100	
HIM 2722	ICD-10-CM Coding	CGS 1100 HSC 2531 HIM 1430 BSC 2085C BSC 2086	
HIM 2723	ICD-10-PCS Coding	CGS 1100 BSC 2085C BSC 2086C HSC 2531 HIM 1430 HIM 2722	
HIM 2211	Health Information Systems	CGS 1100 HIM 1800 HIM 1949	
HIM 2510	HIT Management Principles	HIM 1800 HIM 1949 HIM 2214	
HIM 2201	Comparative Records	HIM 1800	
HIM 2949	Coding PPE	HIM 2253 HIM 2723 HIM 2722	

HIM 2930	HIT Special Topics	HIM 2722 HIM 2723 HIM 2253 HIM 2260	
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RECOMMENDED HIT SCHEDULE FOR NEW STUDENTS

SEMESTER I (FALL)		SEMESTER II (SPRING)		SEMESTER III (SUMMER)	
BSC 2085C/L	Anatomy & Physiology (4) (F)(S)	BSC 2086C	Anatomy & Physiology (4) (F)(S)	HIM 1949	Practicum I – Acute Care (3)(F,S, Su)
CGS1100	Microcomputer Applications (3)(O)(F, S, Su)	HIM2442	Pharmacology (2)*(S)	MGF 1106 or 1107 or STA2023	Liberal Arts Math (3)(O)(F, S, Su)
HSC2531	Medical Terminology (3)(O) (F, S, Su)	HIM2012	Legal Aspects (3)*(S)	ENC1101	English Composition (3)(O)(F, S, Su)
HIM1800	Introduction to HIT (3)*(F)	HIM1430	Concepts of Disease (3)(O)(F,S,Su)		
		HIM 2253	CPT Coding (3) (S)		
	Total Hours: 13		Total Hours: 15		Total Hours: 9
SEMESTER IV (FALL)		SEMESTER V (SPRING)		SEMESTER VI (SUMMER)	
		HIM2211	Health Information Systems (3)**(S)	HIM2949	Practicum II – Alternate Care (3)(F, S, Su)
HIM2214	Health Care Statistics (3)*(F)	HIM2510	HIT Management Principles (3)*(S)	HIM 2930	HIT Special Topics
PSY2012**	General Psychology (3) (F, S, Su)	HIM 2201	Comparative Health Records(3)(O)* (S)		
HIM2260	Medical Billing & Reimbursement(3) (F, S)	HUM1020**	Introduction to Humanities (3)(O)(F, S, Su)		
HIM2722	ICD-10-CM Coding (3) (F,S)	HIM2723	ICD-10-PCS Coding (3) (F,S)		
	Total Hours: 12		Total Hours: 12		Total Hours: 6

- * Only offered during that semester.
- ** Or other course listed in catalog used to satisfy requirement.
- The State of Florida has increased the number of HIT program hours to 70 to accommodate ICD-10 classes. (2012)
- (O) Online (F, S, Su) Courses offered in fall, spring, and summer semesters. Most courses are not offered every semester so plan accordingly.
- Note: This program is designed to prepare the student for certification, that is, the successful completion of the RHIT exam. Due to ongoing changes in the health care field, it is advisable to consider taking at least two classes per semester to maintain currency. It is strongly recommended that students meet with the program facilitator to discuss their course schedules prior to registering. **The student must earn at least a C in all courses required by the HIT program in order to graduate.**

HIT ASSOCIATE DEGREE ENTRY-LEVEL COMPETENCIES

Implementation Date: August 2017

Domain 1. Data Content Structure and Standards

Subdomain 1.A. Classification Systems

1. Apply diagnosis/procedure codes according to current guidelines
2. Evaluate the accuracy of diagnostic and procedural coding
3. Apply diagnostic/procedural groupings
4. Evaluate the accuracy of diagnostic/procedural groupings

Subdomain 1.B. Health Record Content and Documentation

1. Analyze the documentation in the health record to ensure it supports the diagnosis and reflects the patient's progress, clinical findings, and discharge status
2. Verify the documentation in the health record is timely, complete, and accurate
3. Identify a complete health record according to organizational policies, external regulations, and standards
4. Differentiate the roles and responsibilities of various providers and disciplines, to support documentation requirements, throughout the continuum of health care

Subdomain 1.C. Data Governance

1. Apply policies and procedures to ensure the accuracy and integrity of health data

Subdomain 1.D. Data Management

1. Collect and maintain health data
2. Apply tools for data presentation

Subdomain 1.E Secondary Data Sources
<ol style="list-style-type: none"> 1. Identify and use secondary data sources 2. Validate the reliability and accuracy of secondary data sources
Domain II. Information Protection: Access, Disclosure, Archival Privacy and Security
Subdomain II.A. Health Law
<ol style="list-style-type: none"> 1. Apply health care legal terminology 2. Identify the use of legal documents 3. Apply legal concepts and principles to the practice of HIM
Subdomain II.B. Data Privacy, Confidentiality and Security
<ol style="list-style-type: none"> 1. Apply confidentiality, privacy and security measures and policies and procedures for internal and external use and exchange to protect electronic health information 2. Apply retention and destruction policies for health information Apply system security policies according to departmental and organizational data/information standards
Subdomain II.C. Release of Information
<ol style="list-style-type: none"> 1. Apply policies and procedures surrounding issues of access and disclosure of protected health information.
Domain III. Informatics, Analytics and Data Use
Subdomain III.A. Health Information Technologies
<ol style="list-style-type: none"> 1. Utilize software in the completion of HIM processes. 2. Explain policies and procedures of networks, including Intranet and Internet to facilitate clinical and administration applications.
Subdomain III.B. Information Management Strategic Planning
<ol style="list-style-type: none"> 1. Explain the process used in the selection and implementation of health information management systems. 2. Utilize health information to support enterprise wide decision support for strategic planning.
Subdomain III.C. Analytics and Decision Support
<ol style="list-style-type: none"> 1. Explain analytics and decision support. 2. Apply report generation technologies to facilitate decision-making.
Subdomain III.D. Health Care Statistics
<ol style="list-style-type: none"> 1. Utilize basic descriptive, institutional, and health care statistics. 2. Analyze data to identify trends.
Subdomain III.E. Research Methods
<ol style="list-style-type: none"> 1. Explain common research methodologies and why they are used in health care.

HIT ASSOCIATE DEGREE ENTRY-LEVEL COMPETENCIES Cont.
Subdomain III.F. Consumer Informatics
1. Explain usability and accessibility of health information by patients, including current trends and future challenges.
Subdomain III.G Health Information Exchange
1. Explain current trends and future challenges in health information exchange.
Subdomain III. H Information Integrity and Data Quality
1. Apply policies and procedures to ensure the accuracy and integrity of health data both internal and external to the health system.
Domain IV. Revenue Management
Subdomain IV.A. Revenue Cycle and Reimbursement
1. Apply policies and procedures for the use of data required in health care reimbursement. 2. Evaluate the revenue cycle management processes.
Domain V. Compliance
Subdomain V.A. Regulatory
1. Analyze policies and procedures to ensure organizational compliance with regulations and standards. 2. Collaborate with staff in preparing the organization for accreditation, licensure, and/or certification. 3. Adhere to the legal and regulatory requirements related to the health information management.
Subdomain V. B. Coding
1. Analyze current regulations and established guidelines in clinical classification systems. 2. Determine accuracy of computer assisted coding assignment and recommend corrective action.
Subdomain V. C. Fraud Surveillance
1. Identify potential abuse or fraudulent trends through data analysis.
Subdomain V. D. Clinical Documentation Improvement
1. Identify discrepancies between supporting documentation and coded data. 2. Develop appropriate physician queries to resolve data and coding discrepancies.

Subdomain VI.B. Change Management
1. Recognize the impact of change management on processes, people, and systems.
Subdomain VI. C. Work Design and Process Improvement
1. Utilize tools and techniques to monitor, report, and improve processes. 2. Identify cost-saving and efficient means of achieving work processes and goals. 3. Utilize data for facility-wide outcomes reporting for quality management and performance improvement.
Subdomain VI. D. Human Resources Management
1. Report staffing levels and productivity standards for health information functions. 2. Interpret compliance with local, state, and federal labor regulations. 3. Adhere to work plans, policies, procedures, and resource requisitions in relation to job functions.
Subdomain VI. E. Training and Development
1. Explain the methodology of training and development. 2. Explain return on investment for employee training/development.
Subdomain VI. F. Strategic and Organizational Management

Domain VI. Leadership
Subdomain VI.A. Leadership Roles
1. Summarize health information related leadership roles. 2. Apply the fundamentals of team leadership. 3. Organize and facilitate meetings.
1. Summarize a collection methodology for data to guide strategic and organizational management. 2. Understand the importance of health care policy-making as it relates to the health care delivery system. 3. Describe the differing types of organizations, services, and personnel and their interrelationships across the health care delivery system. 4. Apply information and data strategies in support of information governance initiatives. 5. Utilize enterprise-wide information assets in support of organizational strategies and objectives.
Subdomain VI.G. Financial Management
1. Plan budgets. 2. Explain accounting methodologies. 3. Explain budget variances.
Subdomain VI.H. Ethics

1. Comply with ethical standards of practice.
2. Evaluate the consequences of a breach of health care ethics.
3. Assess how cultural issues affect health, health care quality, cost, and HIM.
4. Create programs and policies that support a culture of diversity.

Subdomain VI.I Project Management

1. Summarize project management methodologies.

Subdomain VI.J. Vendor/Contract Management

1. Explain vendor/contract management.

Subdomain VI.K. Enterprise Information Management

1. Apply knowledge of database architecture and design.

Supporting Body of Knowledge (Prerequisite or Evidence of Knowledge)

Pathophysiology and pharmacology

Anatomy and physiology

Medical terminology

Computer concepts and applications

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 2941 – Coding PPE (Professional Practice Experience)

This class and lab course provides the HIT student an opportunity to apply basic concepts and techniques for CPT/ICD 10 Coding using actual health records; both paper and electronic format from various health care facilities. The student will also utilize the 3M Encoder software in the lab and in performing outpatient and inpatient coding. Each student will be responsible for completion of a PPE binder. **SPECIAL NOTE:** Traveling to clinical sites may be required.

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

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



Background check/health certificate/immunizations prior to registration with advisor (Ewers Century Center, Room 103C).

COURSE OBJECTIVES: The practicum is designed to:

- Integrate classroom learning with field experience
- Enable the student to gain work experience in Health Information Technology
- Provide exposure to advanced skills and knowledge
- Develop foundation workplace competencies
- Provide exposure to job opportunities and potentials
- Clarify and confirm career goals
- 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 by going to the Criminal Justice Department at the Ocala Campus, 352854-2322, ext. 1569. The cost is \$50; results will be sent to the HIT program facilitator.

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 semester prior to registering for the practicum. Students will be notified of the meeting date to receive assignments in the CANVAS class email.

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. Students who have felonies in their backgrounds may petition the college to gain admittance into the program. However, program admittance is no guarantee that facilities will accept students for a practicum assignment.

 If you have questions or concerns about this requirement, please make an appointment to discuss them with Virginia M. Delgado-Oakwood, HIT Program Facilitator, at 352-854-2322, ext. 1429

HEALTH CERTIFICATE AND IMMUNIZATIONS: Prior to registering for a practicum, HIT students must have a health certificate completed and signed 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 and a drug screen. This documentation must be made available to the HIT program director before the practicum assignment will be made. Health certificate forms may be found at the end of this handbook.

★ **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 semester prior to registering for the practicum. The health certificate form may be found in this handbook on page 7.

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 telephone calls or emails. 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.

✂ 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 CF 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.

DRESS CODE:

- 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.

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/HIM Orientation:** Obtain information describing the facility’s ownership, organization, patient population, medical staff, and the organization and function of the health information management 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 HIM
- ix. Statistics (such as)
 - Number of beds
 - Number of admissions/discharges
 - Average daily census
 - Occupancy rate
 - Number of births, if applicable

x. Organization, functions, and personnel in HIM

- ✦ Organization chart/reporting structure
- ✦ Name of department
- ✦ Goals and objectives
- ✦ Functions and services
- ✦ Number of employees in each position/title/function
- ✦ Technology in use in HIM
- ✦ Computer systems
- ✦ Dictation systems
- ✦ Filing systems
- ✦ EHR (Electronic health record)
- ✦ Scanning systems
- ✦ Other

☺ 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 if allowed to copy:

- Patient/record identification system
- Record components/forms/filing order
- Record assembly, analysis, and incomplete record control
- Storage and retrieval systems
- Dictation and transcription of clerical reports
- Release of information
- Statistics
- Forms control

b. Describe in narrative form the major components of each function, if not allowed to copy, including:

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

Note: For the following also refer to the Sayles text book.

3. **Record Assembly:** Accurately assemble 10 records of discharged inpatients according the department procedure IF manual process is used. IF not, skip to “g”
 - 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.
 - d) Obtain a minimum of 10 unassembled records and assemble them without assistance.
 - e) Ask supervisor (or designee) to review your assembled records for accuracy and to complete and sign evaluation form (attached).
 - f) Describe the experience in narrative form, including:
 - i. Steps in process
 - ii. Attach form order
 - iii. Your personal observations as you performed the function yourself
 - Ease with which you performed function
 - Problems, if any
 - g) Describe how record assembly takes place in the EHR environment.
4. **Record Analysis:** Accurately analyze 10 records of discharged inpatients for quantitative deficiencies according to departmental procedure IF manual process is used. IF not, skip from “a” to “g.”
 - a. Review policies and procedures policies and procedures.
 - b. Sit with the responsible individual and first observe the activity; ask questions.
 - c. Review a sample of analyzed records.
 - d. Obtain a minimum of 10 unanalyzed records and analyze them without assistance.
 - e. Ask supervisor (or designee) to review your analyzed records for accuracy and to complete and sign evaluation form (attached).
 - 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
 - Problems, if any
 - g. Describe the record analysis process as it occurs in the EHR environment.
5. **Record Retrieval:** Accurately retrieve at least 20 medical records from various filing sites and media according to department procedure IF manual system is used. IF not, skip to from “a” to “g.”
 - a. Review policies and procedures.
 - b. Work with the responsible individual and first observe the activity; ask questions.
 - c. Obtain a minimum of 20 requests for records from whatever source (telephone, in-person, etc.).
 - d. Complete work sheet with retrieval information as you retrieve records to fulfill requests.

- e. Ask supervisor (or designee) to review records and requests before releasing any records to requestors and to sign off 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
 - g. Describe the record retrieval process in the EHR environment.
6. **Record Filing:** Accurately file at least 20 medical records and at least 20 reports from loose filing according to department procedure IF manual system is used. IF not, skip from “a” to “g.”
- a. Review policies and procedures.
 - b. Work with the responsible individual and first observe the activity; ask questions.
 - c. Obtain a minimum of 20 records and a minimum of 20 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 (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
 - g. Describe how reports are added to the record in the EHR environment.
 - h. Describe how records are located in the EHR environment.
7. **Master Patient Index**
- a. Manual or computerized?
 - b. What information is collected?
 - c. How is integrity of the system maintained?
 - i. How are duplicate entries handled?
 - ii. Who is responsible for corrections?
 - iii. What steps are taken to prevent errors?
8. **Release of Information:** Process at least 10 requests for information following department procedure, whether manual or electronic.
- 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 10 requests for information and the corresponding medical records, if on paper system.

- e. Copy requested information, placing it on top of medical record for accuracy verification, prepare response to request and complete worksheet.
- f. Complete "Release of Information 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
- h. Describe differences in how this function is carried out in the manual environment and in the EHR environment.

9. Coding: You may or may not be allowed to recode records at the facility and you may or may not have had the ICD-CM and ICD-10-PCS

- a. How many coders are on staff? Is there turnover? Are there contract coders? If yes, what is the name of company; used for backlog only or for all coding?
- b. What are the credentials of the coders?
- c. If some of the coders are non-credentialed, how did they obtain their training?
 - On-the-job training
 - Formal in-service training
 - AHIMA coding program
 - Other
- d. Do coders regularly attend continuing education workshops on coding issues? If so, what type?
- e. Has the facility used coding/reimbursement consultants to help optimize coding and DRG assignment? If so, which company?
- f. Does the department have an automated encoder? If so, what type?
- g. Is a DRG grouper part of the encoding system?
- h. Is the department satisfied with the encoder? Why or why not?
- i. What is the average time lapse between discharge and coding?
- j. Are Medicare records handled differently from non-Medicare records?
- k. How are records divided among coders?
- l. Do coders have other responsibilities such as abstracting or analysis?
- m. Are there current backlogs in coding?
- n. Is coding productivity monitored? Are there coding standards?
- o. As to see the coding compliance plan, if there is time.

10. Ancillary Departments: Describe the functions and activities of other departments within the facility and the relationship with the HIM department, as time permits, especially those departments that are bolded: a. Admitting/registration

- b. Patient accounting
- c. Case management
- d. Quality assessment/risk management
- e. Privacy/security officers
- f. Clinical laboratory
- g. Imaging services
- h. Pharmacy
- i. Ward clerk
- j. Human Resources
- k. Emergency Department
- l. Food Services

11. **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.

12. **Reflection:**

- a. What did you actually learn?
- b. Did you have any “WHAT?” moments?
- c. Describe your strengths and weaknesses?
- d. Where do you need to improve?

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 HIM department.
 - Obtain or draw an organization chart of the HIM department.

- Describe the duties of the HIM personnel.
 - Comment on the major committees in the facility and how they are organized. Discuss the role of HIM, if any.
2. Attach facility brochures, pamphlets, forms and other documentation pertinent to this objective.
- a. Print, review, and attach applicable state and federal guidelines specifically dealing with this type of facility.
3. Describe the facility's policies and procedures.
- a. 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. Coding classification systems, indexes, and registries
 - viii. Quality improvement and performance measurement
 - ix. Utilization management
 - x. Reimbursement processing/billing/business office
 - b. Attach policies and procedures, if available.
 - c. 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 (**Coding**)
- Are diagnoses, problems, and/or procedures coded and indexed?
 - What classification system is used?
 - How many coders are on staff? Is there turnover?
 - What are the credentials of the coders?
 - If some of the coders are non-credentialed, how did they obtain their training?
 - a) *On-the-job training*
 - b) *Formal in-service training*
 - c) *AHIMA coding program*
 - d) *Other*
2. Do coders regularly attend continuing education workshops on coding issues? If so, what type?
 3. What is the average time lapse between discharge and coding?
 4. Are Medicare records handled differently from non-Medicare records?
 5. How are records divided among coders?
 6. Do coders have other responsibilities such as abstracting or analysis?
 7. Are there current backlogs in coding?

8. Is coding productivity monitored? Are there coding standards?

ix. Reimbursement

1. Describe the reimbursement process.
2. Who is the primary payer?
3. What is the software used?
4. Are bills electronically submitted to intermediary?

x. Quality Improvement and Performance Measurement

1. Discuss the structure under which any QI program is carried out.
2. Describe the type of studies completed or processes reviewed.

xi. Utilization Management and Reimbursement Processing

1. Is UM conducted?
2. How does patient care documentation relate to reimbursement for patient care?
3. What HIM procedures directly support reimbursement?

4. Observe and practice the technical procedures followed in processing medical records

5. Reflection:

- a. What did you actually learn?
- b. Did you have any “WHAT?” moments?
- c. Describe your strengths and weaknesses? Where do you need to improve?

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 No. on spine and front of notebook

- Coversheet with name, course number, semester, and year
 - Confidentiality statement
 - Co-op Agreement form
 - Schedule used by facility
 - Separate sections (pertaining to objectives) with narrative, including your impressions and recommendations
 - Sample forms/policies and procedures
 - Applicable state/federal guidelines/laws that apply to type of facility h. Evaluations
 - Type and proofread
 - Give your overall impressions, recommendations of your experience
 - Write clearly, using proper punctuation and correct spelling
 - Do not put pages into plastic sleeves
 - Use labeled section dividers
 - Copy of thank you note you send to facility after your experience
 - Grading consists of;
-
- **Evaluation by site supervisor: 10%**
 - **Notebook: 35%**
 - Organization/neatness: 20%**
 - Adherence to instructions: 10%**
 - Completeness: 5%**
 - **Case Studies and assignments: 45%**
 - **Punctuation/spelling/syntax: 5%**
 - **Professionalism: 5%**

ACKNOWLEDGEMENT

Date: _____

I, _____, have received a copy (or viewed online) of the 2016-2017 HIT Student Handbook from College of Central Florida, 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 Suzanne Garrett, program facilitator, prior to registration each semester to discuss my course schedule. Failure to do so may adversely affect my intended graduation date.

Student (print name) _____ CF ID# _____

Student signature _____ Date _____



COLLEGE of
CENTRAL
FLORIDA
-an equal opportunity college-

HEALTH INFORMATION TECHNOLOGY HEALTH CERTIFICATE

STUDENT NAME: _____ SEMESTER: _____

Directions: *Your physical must be completed by a physician, ARNP, PA or DO. All sections of both sides of this form must be completed and any requested information attached. You will need to have a drug screen. Your immunizations can be procured from your healthcare provider, a health department, or some walk-in facilities. You may need to make an appointment.*

IMMUNIZATIONS: The following immunizations and/or testing are required. It is your responsibility that these remain current during the course of the program. You may either attach a copy of the current immunization record and results of the drug screen, signed by the health care provider, to this Health Certificate or the health care provider may complete the section below and date and sign to verify immunizations and/or testing.

T.D. (Tetanus/Diphtheria) within 10 years or within two years if injured
 PPD (Tuberculin) good for one year

Students with a positive TB test must be found free of active TB via a baseline chest x-ray. Each year following the initial testing, the individual must be certified to be free of the signs and symptoms characteristic of active TB. The provider's signature indicates the individual with a positive TB test is free of these signs and symptoms.

MMR (Measles, Mumps, Rubella, Rubeola) or titer
 CHICKEN POX (Verify that you have had, or provide titer verifying you have had, or have the immunization series.)

DATE OF IMMUNIZATION/TEST/DRUG SCREEN	RESULT
T.D.	_____
PPD	_____
MMR	_____
CHICKEN POX	_____
DRUG SCREEN	_____

HEALTH CARE PROVIDER:

I am aware of the physical and emotional requirements listed in the foregoing under Requirements for Health Information Management students and, after a complete examination, I certify that this individual is physically and emotionally capable of participation in this program, including in the practicums, without limitations.

Please print name of provider /credentials (MD, DO, ARNP, PA)

Signature of Provider

ADDRESS: _____ **TELEPHONE:** _____

HEPATITIS B VACCINATION: (You must check one of the responses below and sign.) I

- have received the series of injections for Hepatitis B vaccination. (Attach proof).
- I am in the process of receiving the series of injections and will provide proof upon completion.
- I understand that, because of occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B virus (HBV) infection. I understand to protect myself I need to be vaccinated with the Hepatitis B vaccine. However, I decline the Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series

Signature of Student

Date: MM/DD/YY