NOVA COLLEGE-WIDE COURSE CONTENT SUMMARY
HIM 251 – CLINICAL PRACTICE I (3 CR.)

Course Description

Supervises student practice in health information activities conducted in a variety of clinical settings. Clinical 6 hours per week.

General Course Purpose

This course is designed to prepare the Health Information Technology student to perform all functions commonly allocated to health record services. Students will practice skills in various settings under the supervision of a clinical practice supervisor. The purposes of the clinical experiences provided in the course are to expose the student to the work place setting and to permit the student to demonstrate entry-level competencies in various health record services settings.

Course Prerequisites/Co-requisites

Students must be able to read and write at a college level, and have a willingness to learn.

Course Objectives

Upon successful completion of the course, the student will demonstrate entry-level competencies in the following areas:

- Accessing the computer for patient numbers on lab and other reports
- Inputting data into computerized databases
- Following existing procedures for the manual or automated issuing of patient numbers
- Answering telephone requests for patient numbers
- Performing quality checks on the database
- Filing complete records into permanent files
- Filing incomplete records and loose papers
- Completing request slips
- Performing quality checks in the files
- Searching for misfiles
- Pulling records from file on request
- Filing and reproducing microfilm
- Preparing records for microfilm
- Scanning documents for optical disk storage
- Initial or second analysis of incomplete records
- Reading suspension policies and procedures
- Notifying physicians of delinquent records
- Determining and tabulating incomplete and delinquent records
- Assisting physicians and other health care providers with timely record completion
- Identifying potential “risk” cases
- Maintaining a database for control of incomplete records
    - Logging in requests for information
    - Maintaining a computerized database
    - Reading and responding appropriately to requests; checking authorizations for validity and authenticity
- Ensuring confidentiality of health information is maintained
- Maintaining security of computerized information
- Mailing information
- Accepting valid subpoenas according to procedure

- Preparing records for court proceedings
- Coding and classifying inpatient and ambulatory care records using ICD-9-CM and CPT using existing procedures for coding diagnoses, symptoms, procedures and external causes of injury.
- Applying definitions and guidelines to determine the principal diagnosis for DRG assignment
- Performing DRG, AP-DRG, and APC assignment utilizing an automated grouper
- Discussing case mix management reports
- Discussing the impact of DRGs, AP-DRGs, and APCs on health information services, OIG fraud and abuse investigation impact, and compliance program operation
- Accepting patients for admission and doing pre-admission preparations
- Identifying room or surgical suite assignment
- Performing admission functions
- Preparing patient bills for insurance company or managed care submission
- Tracking outstanding unpaid bills
- Tracking payments received
- Reviewing existing policies for departmental functions and following existing procedures of departmental functions
- Identifying and accessioning cases
- Assigning ICD-O codes to diagnoses
- Entering data into automated or manual databases
- Computing statistics and preparing reports
- Completing follow-up activities
- Attending Tumor Board or Cancer Committee meeting
- Preparing for Medical Staff committee which performs information management, performance improvement, or other function required by JCAHO standards
- Reading all policies and procedures relating to the selected committee
- Preparing of committee agenda
- Sending of meeting notices to committee members
- Preparing of information and reports for committee consideration
- Writing and typing committee meeting minutes
- Reviewing patient health records, internal databases and external reference databases to identify actual practice data
- Identifying pattern variations and correlating actual practice to pre-identified criterion or guideline
- Displaying actual practice data and identifying key information for variation analysis and practice improvement
- Assisting in preparing for committee or team meetings or external survey inspections
- Performing pre-admission or admission certification
- Performing continued stay review
- Participating in discharge planning
- Participating in clinical pathway development or monitoring
- Assisting in report preparation

Major Topics to be Included

a. Records Management
b. Record Completion Management
c. Correspondence Management
d. Coding/Classification/Case Mix Management
e. Admission Office
f. Business Office
g. Cancer Registry
h. Committee Preparation/Attendance
i. Quality/Performance Management
j. Utilization Management/Clinical Pathways