

Appendix K

HEALTH INFORMATION MANAGEMENT - HIM

Health Services Youth Apprenticeship –

Health Information Management

Course Outcome Summary

Course Information

Description

The Health Information Management (HIM) Youth Apprenticeship (YA) curriculum was created to allow students to explore careers in the Health Science pathway of Health Information Services.

The student will learn concepts and skills in various Health Information departments. The units were directly derived from the National Consortium on Health Science and Technology Education: Health Information Services Knowledge, Skills, Standards, and Accountability Criteria. In the unit “Documentation” students will work with medical records professionals to manage information within medical records. In the unit “Operations” students will further use skills to access and prepare reports taken from multiple information sources. In the unit “Information Systems” students will be introduced to the computer systems that control and manage information. In the unit “Abstracting and Coding” students will work with professionals to gather and report specific pieces of data from multiple records required by various departments or agencies.

SEE the Health Services YA Program Guide for Recommended Related Technical Instruction- Appendix C. Coursework chosen should coincide as much as possible with the curriculum to be learned and the student's career goals.

Target Population

For the student interested in the business and administrative aspects of health care. Health Information service providers record and manage the documentation of the health care industry. There is no direct hands-on patient care involved and tasks revolve around record keeping, administrative, and information technology duties. The ability to be detail oriented and interested in documentation and computer work is essential.

Types of Instruction

Instruction Type	Contact Hours	Credits
On-The-Job Work Experience	450	
Related Technical Instruction	180	

CURRICULUM SOURCES:

1. Madison Area Technical College, Health Unit Coordinator Course, 510-330, printed 9/12/2006
2. Mid-Continent Research for Education and Learning, Career Education, Health Education Standards, 4th Edition, printed 2006
3. National Consortium on Health Science and Technology Education, Information Services Knowledge and Skills Chart, 2007
4. National Consortium on Health Science and Technology Education, Information Services Standards and Accountability Criteria, 11/18/2002
5. Oklahoma Department of Career and Technology Education, Health Information Skills Standards, OD1048, 1996
6. Wisconsin Technical College System program information for Health Information Technology 2/17/2006; Medical Coding Specialist 11/5/2003; Health Unit Coordinator 4/25/2006
Wisconsin Technical College System articulated course curriculum for Healthcare Legal and Ethical Issues, 530-178, 12/1/2005; Introduction to Computing for Health Care, 501-107, 4/6/2006; Healthcare Information Systems, 530-190, 12/1/2005; Health Data Management, 530-176, 12/1/2005; Healthcare Statistics and Research, 530-177; 12/1/2005; Health Unit Coordinator Clinical, 510-303, 11/3/2003; Health Unit Coordinator Procedures I, 510-301, 4/6/2006; Health Unit Coordinator Procedures II, 510-302, 4/6/2006
7. Wisconsin's Worknet, Occupational Skills and Tasks for Medical Records and Health Information Technicians, 6/27/2006
8. Youth Apprenticeship Health Information Management Review Group, Winter 2006-2007

Health Services Youth Apprenticeship- Health Information Management

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Unit 1: Documentation

Competency

1. Create and/or maintain the client record

Performance Standard Condition

Competence will be demonstrated

- o at the worksite
- o with a client record

Performance Standard Criteria

Performance will be successful when:

- o Learner follows department/facility guidelines for creating and/or maintaining the client record
- o Learner verifies data/information
- o Learner includes/verifies client identification on each record or form used
- o Learner enters/updates required information in the electronic and/or manual client record in accordance with federal regulations and professional standards
- o Learner confirms accuracy of entered/updated client information
- o Learner uses only approved abbreviations on client record
- o Recorded data/information is accurate
- o Recorded information is legible and can be understood by others

Content to Know

Learning Objectives

- a. Explain the legal purposes and ownership of the client record
- b. Describe the content within a typical client record
- c. Compare and contrast the different types and functions of the client record
- d. Define the electronic medical record (EMR)
- e. Discuss the impact of the EMR on healthcare consumers and professionals
- f. Compare and contrast electronic and manual client record systems in your department/facility
- g. List the general guidelines for charting/recording/entering information within your job role
- h. Identify the abbreviations that are approved for use in your department/facility
- i. Describe how to convert time to military time AND why military time is used
- j. Outline the procedure used in a typical health service facility for creating the client record
- k. List the ways in which identification of client documents is confirmed
- l. Explain the use of bar codes for identification in health care settings
- m. Explain the term "routing" as it pertains to manual client record and/or client documents

Comments:

Unit 1: Documentation

Competency

2. Verify client and/or insurance information (HIM)

Performance Standard Condition

Competence will be demonstrated

- o at the worksite
- o with a client, third party payer, healthcare professional, and/or client record

Performance Standard Criteria

Performance will be successful when:

- o Learner follows department/facility guidelines to verify and/or reconcile insurance information, authorizations, medical, and/or client information
- o Learner reviews record(s) for incomplete or inaccurate information or authorizations
- o Learner locates and/or requests appropriate information required to complete the insurance claim, authorizations, medical and/or client record
- o Learner verifies revised information with worksite professional
- o Learner provides additional information as requested or required within the scope of the job role and HIPAA regulations
- o Learner updates and revises information in the client record within the scope of their job role
- o Learner submits revised claim electronically according to department/facility guidelines, if applicable

Content to Know

Learning Objectives

- a. Define terms used in insurance plans such as third-party payer, deductible, co-payment, HMOs, PPOs
- b. Illustrate the medical services reimbursement cycle
- c. Compare and contrast major types of insurance plans
- d. Compare non-government payers (commercial insurance, managed care) to government payers (Medicare, Medicaid)
- e. Identify advantages and disadvantages of participating and non-participating insurance companies for health care professionals and health care facilities
- f. Explain the purpose of Worker's Compensation and why it is considered a health insurance plan
- g. Discuss issues and trends in insurance plans and health care financing
- h. List the categories of information common to most insurance claims
- i. Describe the information on a typical explanation of benefits (EOB) form
- j. Discuss challenges faced when health insurance limits the amount and type of health care and treatment covered
- k. Discuss issues related to financing preventive care
- l. Explain ways in which long term care is financed

Comments:

Unit 1: Documentation

Competency

3. Perform records management

Performance Standard Condition

Competence will be demonstrated

- o at the worksite

Performance Standard Criteria

Performance will be successful when:

- o Learner verifies authorizations and/or other required medical information, such as, transcription orders, prior to filing/storage
- o Learner follows up to obtain missing signature(s) and/or required medical information as directed, if applicable
- o Learner uses department/facility filing and indexing guidelines to add information to the client record
- o Learner stores information (client records/reports/forms) promptly and accurately
- o Learner uses the department/facility filing and indexing guidelines to retrieve information from the client record
- o Learner stores, retains, and/or destroys manual records as directed by the worksite professional
- o Learner assists with cross referencing file procedures used in the department/facility
- o Learner adheres to the legal storage, retention, and destruction requirements for client records
- o Learner collects and enters data for special programs such as staff credentialing, utilization management, risk management, and/or infection control programs
- o Learner performs all critical steps in the right order
- o Records are accessed and stored correctly
- o Records contain complete documentation in the correct placement

Content to Know

Learning Objectives

- a. Compare indexing and filing methods used for filing in health care organizations
- b. Explain how client records are cross referenced manually and electronically
- c. Explain the reasons for cross referencing and cross indexing
- d. Outline the procedures for finding specific client records/information manually and electronically
- e. List the legal guidelines governing storage and retention of documents
- f. Compare retention requirements for manual and electronic documentation
- g. List the legal guidelines for record destruction
- h. Explain your role in maintaining the legal record
- i. Summarize attributes of proper information storage (accessibility, quality, security, flexibility, connectivity, efficiency, etc.)
- j. Identify storage options (imaging, CDs, platters, portable devices, etc)
- k. Discuss hybrid storage systems
- l. Compare and contrast electronic and hybrid data storage systems

Comments:

Unit 1: Documentation

Competency

4. Process health information requests

Performance Standard Condition

Competence will be demonstrated

- o at the worksite

Performance Standard Criteria

Performance will be successful when:

- o Learner receives request for health information
- o Learner reviews request for appropriate legal requirements and authorization according to department/facility guidelines and HIPAA regulations
- o Learner accesses and obtains only health information requested
- o Learner verifies information to be disclosed with worksite professional
- o Learner completes applicable tracking logs to record information disclosure
- o Learner provides requested information confidentially to authorized requesting party only

Content to Know

Learning Objectives

- a. Define PHI (Protected Health Information)
- b. Describe the impact of HIPAA on the development of health informatics
- c. Describe the code of ethics from the American Health Information Management Association (AHIMA)
- d. Explain the required elements on release of information authorizations
- e. Discuss the difference in procedures for release of information to internal and external users
- f. Describe systems used to track access and disclosure of health information
- g. Explain how data is kept secure and confidential through control of access and release of information in your facility
- h. Describe uses of healthcare data by providers, review agencies, researchers, administrative planners, payers, public health agencies, employers, governmental agencies, judicial process and patients
- i. List users and uses of secondary data sources (e.g. disease, operative, physician's indexes, registries, healthcare databases such as NLM, NPDB, MedPAR)

Comments:

Unit 1: Documentation

Competency

5. Manage business documentation functions (HIM)

Performance Standard Condition

Competence will be demonstrated

- o at the worksite

Performance Standard Criteria

Performance will be successful when:

- o Learner follows legal and department prioritization guidelines for documentation in responding to requests for information
- o Learner opens, date stamps, and checks contents
- o Learner routes written, electronic, and oral requests for information, purchase orders, checks, and other business documents to appropriate parties
- o Learner sorts and distributes correspondence accurately
- o Learner addresses and sends requests/correspondence correctly according to department/facility guidelines for inter-office, registered, and certified mail, if applicable
- o Mail Addressing and Folding are correct

Content to Know

Learning Objectives

- a. Compare and contrast the different methods of mailing: certified, registered, inter-office, first class
- b. Describe how to appropriately fold business correspondence and address a business envelope
- c. Describe how to use a postage meter
- d. Compare and contrast specific postal services and private mailing services
- e. Discuss accounts payable processes (order invoices, shipping, receiving) as they apply to your department/facility
- f. Explain the importance of tracking and monitoring accounts receivable payment for health services
- g. Describe how employee payroll processes are handled in your department/facility

Comments:

Unit 1: Documentation

Competency

6. Assist with performing admit, discharge, and transfer functions

Performance Standard Condition

Competence will be demonstrated

- o at the worksite
- o with a client to be admitted, discharged, and/or transferred to a unit OR facility
- o while assisting a worksite professional

Performance Standard Criteria

Performance will be successful when:

- o Learner assists worksite professional to obtain client information necessary for the admission, discharge, or transfer
- o Learner assists worksite professional to admit client manually and/or electronically
- o Learner assists worksite professional to transfer client manually and/or electronically
- o Learner assists worksite professional to discharge client manually and/or electronically
- o Learner assist worksite professional to discharge a post-mortem client manually and/or electronically
- o Learner creates/updates client record

Content to Know

Learning Objectives

- a. Examine types of admissions, discharges, and transfers
- b. Outline the procedural steps for admitting a client to your department/facility
- c. Identify the client information usually gathered as part of the admission interview
- d. Explain the client registration process in your facility
- e. Compare and contrast common types of Advanced Medical Directives
- f. Discuss the importance of a client's authorized release from the health care facility
- g. Outline the steps to take when a client decides to leave without a medical order
- h. Describe post-mortem discharge procedures

Comments:

Unit 2: Operations

Competency

1. Use computer systems to process information

Performance Standard Condition

Competence will be demonstrated

- o at the worksite OR in the facility's test (simulated) computer environment

Performance Standard Criteria

Performance will be successful when:

- o Learner selects source of information and systems needed for task completion
- o Learner uses operating system or database commands appropriately
- o Learner demonstrates appropriate file naming conventions
- o Learner performs operating system commands in the DOS shell
- o Learner performs basic file commands on the network drive
- o Learner prints using a network printer

Content to Know

Learning Objectives

- a. Define health care informatics
- b. Classify types of computers
- c. Compare and contrast various forms of health information media (paper, computer, web based)
- d. Explain client server computing
- e. Describe data standards, types, and formats in a computer based environment
- f. Distinguish between system and application software
- g. Compare and contrast different operating systems such as DOS, OS/2, NT, UNIX, Novell
- h. List the operating system commands for formatting, copying and comparing diskettes
- i. List the operating system commands for copying, erasing, and comparing files
- j. Use graphical interface software functions such as operating multiple files in an application, windows, pull down menus, task list, switching applications
- k. Define directory and subdirectory
- l. Explain file naming conventions and wildcard parameters
- m. Understand the basic function of batch files
- n. Outline the components of electronic connectivity in your health care facility
- o. Describe basic network components such as file servers, work station, cabling, and print servers
- p. Compare and contrast database structure models (relational, network, object orientated)
- q. Describe database components

Comments:

Unit 2: Operations

Competency

2. Use common business software applications

Performance Standard Condition

Competence will be demonstrated

- o at the worksite

Performance Standard Criteria

Performance will be successful when:

- o Learner assists worksite professional to prepare a presentation
- o Learner prepares a presentation using a presentation application
- o Learner prepares a summary report and graph with data from calculation fields using a spreadsheet application
- o Learner reviews the materials with the worksite professional
- o Learner assists worksite professional to present the information

Content to Know

Learning Objectives

- a. Define the differences in common software applications (spreadsheet, presentation, relational database, desk top publishing, graphic user interface (GUI) (Windows))
- b. Explain the purpose and use of presentation software
- c. Compare and contrast presentation methods by evaluating audience, intended use of the data, decisions to be made with the data, message to communicate, nature of the data, and presentation form (e.g., report, brochure, oral)
- d. Discuss basic rules for information, data, color, graphics, and font when creating slides in a presentation
- e. Explain the purpose and use of spreadsheet software
- f. Describe the typical structure of a spreadsheet
- g. Discuss how to create a table using a spreadsheet
- h. Describe how to format fields for size, appearance, and calculation
- i. Describe how to sort spreadsheet ranges
- j. Explain how to create a graph using data entered on a spreadsheet table
- k. Give examples of when a spreadsheet would be advantageous to use over other formats

Comments:

Unit 2: Operations

Competency

3. Prepare various reports

Performance Standard Condition

Competence will be demonstrated

- o at the worksite

Performance Standard Criteria

Performance will be successful when:

- o Learner accesses correct Health Information applications and/or databases
- o Learner queries the correct applications and/or databases
- o Learner validates the query parameters prior to execution
- o Learner generates required reports from the HIT applications
- o Learner verifies report content for accuracy and completeness with a worksite professional
- o Learner assists the worksite professional with analysis of health information reports
- o Report meets requester requirements
- o Report is professionally presented with an explanation of the report parameters

Content to Know

Learning Objectives

- a. Describe key components of the following application categories: record tracking, release of information, incomplete record control, coding, grouping, registry maintenance, quality improvement and imaging
- b. Discuss clinical information systems and the connectivity to administrative information systems
- c. Discuss the necessity and use of data standards
- d. Describe the purpose and benefits of standardized data
- e. Define data integrity
- f. Discuss constraints to maintaining data integrity
- g. Define characteristics of data quality
- h. Discuss reasons for development of data sets
- i. Describe the relationship of code sets to health informatics standards in computer based environments
- j. Summarize necessary elements of healthcare data sets (e.g., OASIS, HEDIS, DEEDS, UHDDS, MDS, etc.)
- k. Define query, data warehouse, data mining, and SQL

Comments:

Unit 2: Operations

Competency

4. Maintain equipment (HIM)

Performance Standard Condition

Competence will be demonstrated

- o at the worksite
- o on the department/facility schedule

Performance Standard Criteria

Performance will be successful when:

- o Learner identifies maintenance schedule for equipment that requires routine maintenance
- o Learner identifies the equipment that requires routine maintenance
- o Learner labels equipment appropriately to show malfunction, if applicable
- o Learner identifies location of repair service information, maintenance manuals, and/or troubleshooting guides
- o Learner verifies procedure to follow with worksite professional
- o Learner performs/calls service for routine maintenance or malfunction according to department/facility guidelines in accordance with equipment manual/maintenance instructions and service agreements
- o Learner assists worksite professional with back ups and software/hardware updates
- o Learner documents the maintenance and/or repair/troubleshooting performed

Content to Know

Learning Objectives

- a. Describe the use and maintenance of your facility's IS/IT equipment such as the copier, fax, imaging equipment, laptops, and work station computers
- b. Explain why performing routine maintenance of equipment reduces the risk of liability and costs to the facility
- c. Describe the materials and information needed to determine an equipment maintenance schedule
- d. Describe the basic procedure to be followed when a piece of equipment is not functioning properly in your department/facility
- e. Discuss how tracking of equipment maintenance and servicing is done in the department/facility
- f. Review each piece of equipment's cleaning and maintenance schedule
- g. List the critical pieces of equipment in your department/facility which require priority repairs when malfunctioning
- h. List the repair and service contractors that service your department/facility and what they service
- i. Explain your department/facility's back up plan and disaster recovery plan

Comments:

Unit 3: Information Systems

Competency

1. **Verify system information is accurate and complete**

Performance Standard Condition

Competence will be demonstrated

- o at the worksite OR in the facility's test (simulated) computer environment

Performance Standard Criteria

Performance will be successful when:

- o Learner assists worksite professional to authenticate computerized medical record entries vs. handwritten entries and signatures
- o Learner tracks incomplete records and follows notification procedures according to department/facility guidelines
- o Learner uses batch files to create a network menuing system
- o Learner uses data dictionary to design reference tables or keys
- o Learner tests parameters and tables for data collection

Content to Know

Learning Objectives

- a. Explain the need for timely and accurate recording of medical data
- b. Describe the documentation requirements of accrediting agencies and state/federal legislation
- c. Define authentication
- d. Explain how information systems interact to facilitate timely and accurate flow of information
- e. Describe how your facility's data system verifies accuracy and completeness of system information
- f. Define data integrity
- g. List characteristics of data quality
- h. List examples of data characteristic types (accuracy, accessibility, definition, consistency, currency, etc.)

Comments:

Unit 3: Information Systems

Competency

2. Assist with analysis of system functions to improve efficiency

Performance Standard Condition

Competence will be demonstrated

- o at the worksite
- o while assisting a worksite professional

Performance Standard Criteria

Performance will be successful when:

- o Learner assists worksite professional to evaluate operational systems and processes for areas of improvement
- o Learner selects or is given a process to evaluate
- o Learner determines what needs to be known about the process and scope of the process
- o Learner assists worksite professional to analyze the process using a performance improvement model
- o Learner assists worksite professional to revise, test, implement, and evaluate the process improved

Content to Know

Learning Objectives

- a. Describe the purpose of analysis to improve efficiency
- b. Define terms related to quality management, such as process, stakeholders, quality assurance, quality management plan, performance measure, etc.
- c. Recognize the role of internal and external customers in quality improvement initiatives
- d. Discuss quality improvement activities required by various accrediting agencies
- e. Describe types of performance measures used in healthcare organizations
- f. Differentiate between measures of structure, process, and outcome
- g. Describe common methods used to establish performance measures
- h. Define sentinel event
- i. Explain the purpose, elements, and features of statistical process control
- j. Describe how to interpret a control chart
- k. List guidelines for choosing process improvement projects
- l. Describe common steps in performance improvement models
- m. Discuss steps of a root cause analysis
- n. Analyze flow charts for process efficiency
- o. Explain the goal of utilization management
- p. Discuss legal guidelines for dealing with risk management information
- q. Identify the component elements of an ideal utilization management plan
- r. Define key terms related to risk management
- s. Define elements of a good risk management program

Comments:

Unit 3: Information Systems

Competency

3. Assist with data security and access control

Performance Standard Condition

Competence will be demonstrated

- o at the worksite OR in simulation
- o while assisting a worksite professional

Performance Standard Criteria

Performance will be successful when:

- o Learner reviews security levels and security access plan with worksite professional
- o Learner supports worksite professional to manage security accessibility levels of staff and customers
- o Learner summarizes audit trail data
- o Learner reviews summary with worksite professional
- o Learner assists worksite professional to investigate a security or confidentiality breach, if applicable

Content to Know

Learning Objectives

- a. Discuss network security issues
- b. Identify data security risks
- c. Compare and contrast security risk assessment tools and techniques
- d. Describe systems used to track access and disclosure of health information
- e. Explain how data is kept secure and confidential through control of access and release of information in your facility
- f. Describe the HIPAA security component
- g. Explain security levels
- h. Discuss access controls
- i. Describe audit trails
- j. Identify security countermeasures

Comments:

Unit 4: Abstracting and Coding

Competency

1. **Locate information in the client record**

Performance Standard Condition

Competence will be demonstrated

- o at the worksite
- o with a client record

Performance Standard Criteria

Performance will be successful when:

- o Learner accesses appropriate client record
- o Learner correctly navigates the client record to locate the information needed
- o Learner assembles accurate and appropriate information for the task to be completed
- o Learner interprets information from the client record within the scope of their learning
- o Learner verifies information located with worksite professional
- o Learner maintains confidentiality of client information according to department/facility guidelines and HIPAA

Content to Know

Learning Objectives

- a. List the ways in which identification of clients is confirmed when client records are added to the system
- b. Explain why accuracy in client identification is important
- c. Describe the systems in place to ensure that the identity of the client is correct
- d. Explain the use of bar codes for identification in health care settings
- e. Explain reasons for obtaining a thorough client history
- f. Detail the common medical history components of the client record

Comments:

Unit 4: Abstracting and Coding

Competency

2. Assist with transcribing medical orders

Performance Standard Condition

Competence will be demonstrated

- o at the worksite OR in simulation
- o using the appropriate resource materials
- o while assisting a worksite professional

Performance Standard Criteria

Performance will be successful when:

- o Learner assists the worksite professional to choose appropriate order statements for client diagnosis and/or tests(s)/treatment(s) conducted
- o Learner accurately verifies order statements for client testing and treatments with the worksite professional
- o Learner verifies with the worksite professional that the selected ordering phrases are consistent with the physician order
- o Learner seeks additional clarification as directed if information is unclear or missing
- o Learner uses medical documentation/references as necessary
- o Learner assists worksite professional to transcribe order according to department/facility guidelines
- o Learner transcribes order legibly, accurately and completely

Content to Know

Learning Objectives

- a. Describe the purpose of medical transcription orders for the client and the client record
- b. Describe typical orders that are encountered that need to be transcribed, i.e., medication/infusion, activity, nursing, dietary, imaging, lab, etc.
- c. Explain the process of order transcription
- d. Describe how medical documentation/references are used with medical orders
- e. List approved medical abbreviations commonly used with medical orders in your department/facility
- f. Identify orders by classification and category
- g. List commonly ordered tests and procedures in your department/facility
- h. Differentiate between the routes of medication administration such as oral, intramuscular, intravenous, subcutaneous, inhalation, etc.
- i. Examine common transcribing errors and methods of avoiding them

Comments:

Unit 4: Abstracting and Coding

Competency

3. Assist with coding for client billing

Performance Standard Condition

Competence will be demonstrated

- o at the worksite OR in simulation
- o with limited coding requirements
- o using applicable coding references
- o while assisting a worksite professional

Performance Standard Criteria

Performance will be successful when:

- o Learner assists worksite professional to choose codes for billing client services according to department/facility guidelines
- o Learner seeks additional information as directed if information is unclear or missing
- o Learner applies accurate medical terminology within the scope of their learning
- o Learner utilizes appropriate coding references
- o Learner assists worksite professional to enter/update coding

Content to Know

Learning Objectives

- a. Describe the use of coding in billing for client services and how that affects payment for services
- b. Describe the basic steps in the coding process
- c. Describe the Health Care Financing Administration (HCFA) guidelines for coding and reimbursement
- d. Compare types of coding systems
- e. Define terms associated with clinical classification and terminology (classification system, nomenclature, terminology, vocabulary)
- f. Explain the format and conventions of the CPT (Current Procedural Terminology) coding system
- g. Explain the use of modifiers in CPT coding
- h. Explain the format and conventions of the ICD (International Classification of Diseases) procedural and diagnostic coding systems
- i. Describe the difference between using coding books and the electronic end coder
- j. Describe how/where to access client information needed for coding and billing purposes

Comments:

Unit 4: Abstracting and Coding

Competency

4. Assist with reporting health care statistics

Performance Standard Condition

Competence will be demonstrated

- o at the worksite
- o while assisting a worksite professional
- o with the appropriate resource materials

Performance Standard Criteria

Performance will be successful when:

- o Learner assists with worksite professional in use of computer programs to access and process required information
- o Learner reviews extracted data for completeness and accuracy with worksite professional
- o Learner assists worksite professional with analysis of the health information according to department/facility guidelines and statistics required
- o Learner assists worksite professional to create and disseminate required report

Content to Know

Learning Objectives

- a. Define statistics and healthcare statistical terms such as mortality and morbidity
- b. Articulate the value of keeping healthcare statistics
- c. Identify the users and uses of healthcare statistics
- d. Explain the role of a health information professional in collecting healthcare statistics
- e. Explain how morbidity and mortality rates and percentages are calculated
- f. Describe how utilization and vital statistic information is captured and calculated in your facility
- g. Describe the census taking process
- h. Define key terms associated with utilization measures such as average daily census, average length of stay, bed occupancy, bed turnover, discharge, and occupancy rate
- i. Define key terms associated with morbidity, mortality and vital statistical rates such as adult, child, newborn, neonate, coroner's/medical examiner's case, death rate - net and gross, discharge, hospital autopsy, hospital patient, inpatient autopsy, inpatient death, nosocomial infection, postoperative period, and surgical operation

Comments:

Unit 4: Abstracting and Coding

Competency

5. Assist with vital statistic and mandatory state reporting functions

Performance Standard Condition

Competence will be demonstrated

- o at the worksite
- o while assisting a worksite professional
- o with the appropriate resource materials

Performance Standard Criteria

Performance will be successful when:

- o Learner assists worksite professional to collect/obtain data for birth, death, and/or mandatory reporting
- o Learner verifies data collected with worksite professional
- o Learner assists worksite professional for create/generate the report for birth, death, fetal death, and/or mandatory reporting statistics according to department/facility guidelines and registry requirements
- o Learner verifies report with worksite professional

Content to Know

Learning Objectives

- a. Explain the purpose for collecting given data elements on birth, death and fetal death certificate
- b. Define key terms associated with vital events
- c. Describe uses of birth and death records and statistics
- d. Identify where specific information items would be retrieved in completing Wisconsin certificates of birth and death
- e. Describe the process and requirements for completing birth certificates
- f. Describe data edit checks built into the state birth certificate system
- g. Describe documentation and reporting requirements in the case of a patient death (coroner's cases)
- h. Identify confidential vs. non-confidential information on certificates of birth and death
- i. List types of deaths that must be reported to the coroner or medical examiner as mandated by Wisconsin Statute
- j. Briefly explain the process of investigation used by a coroner or medical examiner
- k. State the purpose of the Notice of Removal form
- l. Identify types of mandatory reporting
- m. Categorize given communicable diseases and state reporting requirements for each
- n. Define adverse reaction
- o. Explain the purpose of reporting adverse reactions
- p. List examples of communicable disease
- q. Explain the purposes of reporting communicable disease
- r. Describe the use of the cancer data collected in the mandatory reporting system
- s. Describe the role of the Health Information Technician, MD and funeral director in vital statistics registration, communicable disease reporting and cancer reporting

Comments:

Unit 4: Abstracting and Coding

Competency

6. Assist with disease/procedure registry functions

Performance Standard Condition

Competence will be demonstrated

- o at the worksite
- o while assisting a worksite professional
- o with the appropriate resource materials

Performance Standard Criteria

Performance will be successful when:

- o Learner assists worksite professional to collect/obtain registry data according to department/facility guidelines and registry agency requirements
- o Learner verifies data collected with worksite professional
- o Learner assists worksite professional with registry database management (case eligibility, case finding, classification, coding, abstracting)

Content to Know

Learning Objectives

- a. Identify national/regional registries to which health care facilities contribute statistical data (cancer, trauma, implant, other)
- b. Discuss reasons for maintaining medical registries
- c. Describe the use of registry data
- d. Describe components of various medical registries
- e. Describe use of classification and coding systems used in registries
- f. Describe importance of uniformity in data collection and impact of computerization of registry data
- g. Describe proper registry database management (case eligibility, case finding, classification, coding, abstracting)

Comments: