

Course Description

HIM1110 | Health Information Technology and Data Collection | 2.00 credits

This course is designed to provide the skills necessary to function in a health information management department. Students will learn health record data collection and informatics. Students will also learn about the various components and approaches of the electronic health record. Prerequisite: HIM 1000, 2472; corequisite: HIM1110L.

Course Competencies:

- 1. **Competency 1:** The student will be able to determine the origin and function of health record forms by: Examining and reviewing components of the health record
- 2. Identifying the fundamental purpose of a health record
- 3. Differentiating between primary and secondary users of health data sources and databases
- 4. Listing the importance of maintaining the confidentiality of health records
- 5. Identifying the critical role of the Health Information Technology professional regarding the health record
- 6. Performing analysis of accuracy, accessibility, comprehensiveness, and consistency of a quality record
- 7. Stating mandated rules and regulations that impact the content of the health record

Competency 2: The student will observe the functions of the paper versus electronic health information management departments and the uses of indexes, registers, and automated systems in managing health information by:

- 1. Reviewing standard Patient Registration procedures
- 2. Stating the various types of numbering systems and filing methods in healthcare
- 3. Reviewing state guidelines on record retention
- 4. Stating methods and standard guidelines of record destruction
- 5. Explaining typical applications to manage health information
- 6. Identifying primary forms and formats of paper-based and electronic health records
- 7. Describing the purpose and function of terminology systems used in electronic health record systems
- 8. Listing networks and organizations requesting or storing health information
- 9. Discussing the role of Certification Commission for Healthcare Information Technology (CCHIT) standards

Competency 3: The student will explain the importance of consistency in data collection, data submission, registers, and reporting using electronic health records by:

- 1. Distinguishing between data dictionary and element domains
- 2. Examining regulatory policies and procedures of a database
- 3. Identifying SEERS criteria to collect cancer data and present data in a graphical format
- Explaining the relationship between healthcare data sets, clinical vocabularies, and terminologies
 Describing the purpose of clinical decision support systems and health informatics standards Stating the
 implication of data tables in electronic health data collection
- 5. Describing baseline data for tracking trends and goals of individual and population health
- 6. Discussing the involvement of information systems in the electronic health record
- 7. Stating the benefits of eliminating duplicate records
- 8. Explaining the need for secondary data collection and quality healthcare
- 9. Comparing and contrasting facility-specific indexes commonly found in healthcare settings
- 10. Discussing approval and standards for registers/databases
- 11. Distinguishing the role of patient advocacy in the Personal Health Record Describing the patient's rights, steps in disclosure, hospital licensure, accreditation (JCAHO, CARF, AOA), incident reporting, and risk management in computer-generated health record settings

Learning Outcomes:

- Communicate effectively using listening, speaking, reading, and writing skills
- Formulate strategies to locate, evaluate, and apply information