PROPOSED
RARITAN VALLEY COMMUNITY COLLEGE
ACADEMIC COURSE OUTLINE

HITC 111 Professional Practicum I

I. Basic Course Information

A. Course Number and Title: HITC 111 Professional Practicum I
B. New or Modified Course: Modified
C. Date of Proposal: Semester: Fall Year: 2018
D. Effective Term: Fall 2019
E. Sponsoring Department: Health Science Education
F. Semester Credit Hours: 2
G. Weekly Contact Hours: Clinical: 4

H. Prerequisites/Corequisites:
   HLTH 101 Healthcare Delivery Systems
   HLTH 150 Medical Terminology
   HITC 105 Intro to Health Info Technology
   BIOL 120 Human Biology, OR
   BIOL 124 Anatomy & Physiology I AND
   BIOL 125 Anatomy & Physiology II

I. Laboratory Fees: No

J. Name and Telephone Number or E-Mail Address of Department Chair and Divisional Dean at time of approval:
   Beryl Stetson, Beryl.Stetson@raritanval.edu
   Divisional Dean: Terence Lynn, Terence.Lynn@raritanval.edu

II. Catalog Description

Pre-requisites/Co-requisites:
   HLTH 101 Healthcare Delivery Systems
   HLTH 150 Medical Terminology
   HITC 105 Intro to Health Info Technology
   BIOL 120 Human Biology, OR
   BIOL 124 Anatomy & Physiology I AND
   BIOL 125 Anatomy & Physiology II
This course will provide students with a supervised experience in a Health Information Management department. Emphasis will be placed on the primary functions of record content, assembly and analysis, filing and retention of records. This practicum is designed to allow the student to apply technical knowledge and skills learned in the classroom to procedures performed in a Health Information Management department. Assignments are crafted to allow students to gain exposure to today’s health information practices.

III. Statement of Course Need

A. This course fulfills the “knowledge cluster content and competency” required by the American Health Information Management Association (AHIMA) and its accrediting body, the Commission on Accreditation for Health Informatics and Information Management Education (CAHIIM).
B. There is no lab component for this course.
C. This course generally transfers as a program requirement in health information technology.

IV. Place of Course in College Curriculum

A. Free Elective
B. This course does not serve as a General Education course
C. This course meets a program requirement for the Health Information Technology AAS degree program.
D. To see course transferability: for New Jersey schools go to the NJ Transfer website, www.njtransfer.org; for all other colleges and universities, go to their individual websites.

V. Outline of Course Content

A. A Patient/record identification system
B. Record components, forms and formats
C. Record assembly, analysis and incomplete record control
D. Storage and retrieval system
E. Release of information
F. Statistics
G. Forms control
H. Admitting Office
I. Patient Accounting
J. Outpatient Registration
K. Outpatient Care Services
L. Social Service Department
M. Clinical Laboratory
N. Diagnostic Imaging
VI. General Education and Course Learning Outcomes

A. General Education Learning Outcomes:

At the completion of the course, students will be able to:
1. Utilize relevant statistical reports, depending on the facility, to construct graphs, interpret them, and draw appropriate conclusions. (GE-2)
2. Communicate effectively in written form, specifically producing a written report concerning the organization of the facility, the medical staff, and the medical records department. (GE-1)
3. Use the EMR (Electronic Medical Record) system to process a release of information request according to medical record department and facility policy and procedures. (GE-4)

B. Course Learning Outcomes:

The student will function as a health information practitioner and:
1. Apply information system policies and procedures required by national health information initiatives on the healthcare delivery system.
2. Apply current laws, accreditation, licensure, and certification standards related to health information initiatives from the national, state, local, and facility levels.
3. Apply policies and procedures to comply with the changing regulations among various payment systems for healthcare services such as Medicare, Medicaid, managed care, and so forth.
4. Differentiate the roles of various providers and disciplines throughout the continuum of healthcare and respond to their information needs.
5. Participate in the implementation of legal and regulatory requirements related to the health information infrastructure.
6. Apply policies and procedures for access and disclosure of personal health information.
7. Release patient-specific data to authorized users.
8. Maintain user access logs/systems to track access to and disclosure of identifiable patient data.
9. Apply and promote ethical standards of practice.
10. Collect and maintain health data (such as data elements, data sets, and databases).
11. Conduct analysis to ensure documentation in the health record supports
the diagnosis and reflects the patient’s progress, clinical findings, and discharge status.

12. Apply policies and procedures to ensure the accuracy of health data.
13. Contribute to the definitions for and apply clinical vocabularies and terminologies used in the organization’s health information systems.
14. Verify timeliness, completeness, accuracy, and appropriateness of data and data sources for patient care, management, billing reports, registries, and/or databases.
15. Monitor and apply organization-wide health record documentation guidelines.
16. Apply policies and procedures to ensure organizational compliance with regulations and standards.
17. Report compliance findings according to organizational policy.
18. Maintain the accuracy and completeness of the patient record as defined by organizational policy and external regulations and standards.

The student will be able to:

1. Obtain selected factual information pertaining to ownership, organization, services, facilities and patient population of the hospital; the organization of the medical staff, and the organization and functions of the Health Information Management department.
2. Accurately assemble and analyze inpatients and ambulatory records according to department procedure.
3. Accurately retrieve medical records from the active file storage area, inactive file area and from other media file areas according to department policy and procedure.
4. Process requests for medical information in accordance with medical record department and hospital policy and procedures; in those instances where the request will be filled, the student shall prepare a response including the necessary information.
5. Describe the policies and procedures for each of the following functions:
   a. Patient/record identification system
   b. Record components, forms and formats
   c. Record assembly, analysis and incomplete record control
   d. Storage and retrieval system
   e. Release of information
   f. Statistics
   g. Forms control
6. Describe the interactions of the following individuals or departments with the Health Information Management department:
   a. Admitting Department
   b. Patient Accounting Department
   c. Outpatient Registration
   d. Outpatient Services
   e. Social Service Department
   f. Clinical Laboratory
g. Diagnostic Imaging
h. Pharmacy
i. Unit manager/ward clerk
j. Human Resources Department
k. Emergency Department
l. Dietetics and Food Services
m. Performance Improvement

7. Communicate effectively in written form; specifically, this includes use of vocabulary appropriate to the topic, clarity of presentation, correct grammar, punctuation and spelling.

8. Demonstrate professional behavior consistent with the environment of the affiliating institution; specifically, this includes:
   a. compliance with all applicable policies, procedures or rules of the Health Information Management department and the hospital, the ethical principles of the health information profession, and the student code of conduct of Raritan Valley Community College.
   b. adherence to the specified schedule with regard to start and stop time, lunch and break periods, and promptness in keeping appointments.
   c. a cooperative attitude and active participation in all assigned tasks and activities.
   d. courtesy and tact in relations with all individuals.
   e. a business-like professional appearance and demeanor.
   f. thorough organization and preparation for each assignment, meeting or interview.
   g. mature behavior and interpersonal communication appropriate to a professional health information manager.

C. Assessment Instruments

   A. Professional Practicum Manual projects
   B. Evaluation by preceptor
   C. Evaluation by Practicum Coordinator

VII. Grade Determinants

   A. Completion of Professional Practicum Manual requirements
   B. Evaluation by preceptor
   C. Evaluation by Practicum Coordinator

Given the goals and outcomes described above, LIST the primary formats, modes, and methods for teaching and learning that may be used in the course:
   A. Ongoing interaction with patients, physicians, office staff, preceptor and Practicum Coordinator
B. Hands-on experience at practicum site
C. Preceptor and Practicum Coordinator’s demonstration and guidance
D. Logging and journaling activities

VIII. Texts and Materials

A. Practicum Manual provided by Practicum Coordinator
B. Manuals provided by facility personnel
C. Reference textbooks from previous health information technology courses

(Please Note: The course outline is intended only as a guide to course content and resources. Do not purchase textbooks based on this outline. The RVCC Bookstore is the sole resource for the most up-to-date information about textbooks.)

IX. Resources

A. Computer with internet access