

**J. Sargeant Reynolds Community College
Course Content Summary**

Course Prefix and Number: HIM 141

Credits: 3

Course Title: Fundamentals of Health Information Systems I

Course Description: Focuses on health data collection, storage, retrieval, and reporting systems, with emphasis on the role of the computer in accomplishing these functions. Part I of II. Prerequisite: Passing score on the computer competency exam, ITE 115, or permission of the instructor. Lecture 3 hours per week.

General Course Purpose: Required for the Medical Records Coder Career Studies Certificate, this course is designed to allow students to gain an understanding of the data elements that comprise a patient information system; to develop skills in analyzing data for completeness and accuracy; to understand the vision of the computer-based patient record (CPR) and their role in its development; to gain knowledge of the various methods for filing, storage, and retention of health records; and to develop requisite skills in the filing and storage of health records.

Course Prerequisites and Co-requisites:

Prerequisites: Passing score on the computer competency exam, ITE 115, or permission of the instructor

Student Learning Outcomes:

Upon completing the course, the student will be able to

- a. Discuss health care data elements and documentation standards, including documentation for inpatient, psychiatric, managed care, hospice, long-term care, and ambulatory surgery institutions;
- b. Apply policies and procedures for quantitative and qualitative analysis of primary health care data;
- c. Evaluate the accuracy of quantitative analysis;
- d. Evaluate and review primary and secondary health care data for institutional effectiveness;
- e. Apply and follow policies and procedures for data information reports by collecting, maintaining, analyzing, and displaying data based on external regulatory and accrediting agency standards;
- f. Employ accreditation standards for patient-related data;
- g. Discuss the role and purpose of the patient record;
- h. Evaluate appropriate user needs for computer-based patient records;
- i. Select and utilize appropriate technologies for computer-based patient records (storage, retention, and retrieval); and
- j. Construct a health record data filing system for retrieval, retention, archival storage, and destruction of health care data.

Major Topics to Be Included:

- a. External regulatory agencies and accreditation standards
 1. HIPAA
- b. Health care data elements and documentation standards
 1. Primary and secondary
- c. Quantitative and qualitative data analysis
- d. Computer-based patient record (CPR)

- e. Technology
- f. Health data record
 - 1. Filing
 - 2. Retrieval
 - 3. Retention
 - 4. Archival storage
 - 5. Destruction

Date Created/Updated (Month, Day, and Year): February 15, 2019