



Statewide Dual Credit Health Information Technology Objectives (HIT 1011)
(Health Information Technology #5997)

Objective 1.0

1. Describe the functions and various uses of the health record.
2. Describe medical record storage, control and retention.
 - a. Compare local, state and federal regulations concerning record retention and record content.
 - b. Identify record storage methods.
 - c. Differentiate between ownership and accessibility to record content.
3. Compare and contrast numbering and filing systems used in health information departments.
 - a. Apply alphabetical, numerical, and terminal digit filing methods to patient records.
 - b. Explain health record numbering systems including: enterprise wide numbering, unit numbering, serial numbering, and serial-unit numbering.
4. Discuss the basic organization of the various types of hospitals and healthcare organizations.
 - a. Contrast various healthcare settings including facilities, services, and type of patients.
 - b. Explain the organizational structure of an acute care facility.
 - c. Diagram the organizational structure of an acute care facility.
 - d. Summarize the various types of funding for healthcare.
5. Identify content of health record reports such as history & physical, discharge summary, operative report, and consultations.
 - a. Identify components of health record including the following documents:
 - i. History and physical
 - ii. Discharge summary
 - iii. Progress notes and orders
 - iv. Nursing notes
 - v. Operative reports
 - vi. Preoperative and postoperative anesthesia notes
 - vii. Pathology reports
 - viii. Consultation reports
 - ix. Medication Administration Records
 - x. Consent Forms
 - xi. Ancillary reports (xray, lab, therapy reports)
 - xii. Advance Directives-DNR, living will, power of attorney, etc.
 - xiii. Specialty Records, including but not limited to OB records, NB records and Emergency Department Records
 - b. Assemble health record components into order established by facility.
6. Analyze health records to verify completeness and accuracy
 - a. Evaluate components of health record including the following documents for completeness and accuracy.
 - i. History and physical
 - ii. Discharge summary



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- iii. Progress notes and orders
 - iv. Nursing notes
 - v. Operative reports
 - vi. Preoperative and postoperative anesthesia notes
 - vii. Pathology reports
 - viii. Consultation reports
 - ix. Medication Administration Records
 - x. Consent Forms
 - xi. Ancillary reports (xray, lab, therapy reports)
 - xii. Advance Directives-DNR, living will, power of attorney, etc.
 - xiii. Specialty Records, including but not limited to OB records, NB records and Emergency Department Records
- b. Compare and contrast qualitative and quantitative record analysis.
7. Apply record content standards from outside agencies and facility policies to health records.
- a. Appraise Joint Commission or other accrediting body standards .
 - b. Recognize that a healthcare facility may establish stricter policies controlling record content than accrediting body standards.

Objective 2.0

- 1. Construct an appropriate electronic business communication.
- 2. Demonstrate professional telephone communication, including telephone etiquette, telephone messaging, telephone triage, and telephone referrals.
- 3. Describe the purpose, development, and maintenance of registries and indexes such as the master patient index, disease index and operation index.
 - a. Illustrate the purpose, content, and use of registries, such as:
 - i. Tumor Registry
 - ii. Birth Registry
 - iii. Trauma Registry
 - iv. Brain Injury Registry
 - v. Implant Registry
 - vi. Immunization Registry
 - vii. Diabetes Registry
 - b. Compare content and purpose of disease index and operation index.
 - c. Recognize significance of master patient index.
- 4. Distinguish between primary and secondary data and between patient-identifiable and aggregate data.



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Objective 3.0

1. Outline and describe the basic components of the Health Insurance Portability and Accountability Act (HIPAA).
2. Analyze and describe methods to ensure data security and confidentiality by controlling access and release of information using Health Insurance Portability and Accountability Act (HIPAA) and applicable state laws.
 - a. Recognize multiple outside agencies may have need to access the health record and are subject to HIPAA rules. These may include state licensing boards, subpoenas, insurance companies, law enforcement, government agencies, and other health care providers.
 - b. Validate authorization to release health information.
 - c. Categorize and prioritize the release of health information requests.
3. Apply American Health Information Management Association (AHIMA) Code of Ethics to case studies involving ethical behavior.
4. Identify the impact of Affordable Care Act on healthcare.

Objective 4.0

1. Discuss the development of the health information management profession.

Objective 5.0

1. Identify and define sources of reimbursement for healthcare services including:
 - a. Capitation
 - b. Medicare
 - c. Medicaid (TennCare)
 - d. Prospective payment systems
 - e. Relative Value Resource Based Systems
 - f. Case mix
 - g. MS-DRGs
 - h. Healthcare insurance
 - i. Accountable care organizations
2. Discuss capabilities of modern medical computer systems.



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Objective 6.0

1. Recognize standardized coding systems, may include ICD-9-CM, CPT, ICD-10-CM, ICD-10-PCS, DSM, SNOMED, and HCPCS.
2. Identify the users and purpose of standardized insurance claim forms, such as UB-04 and CMS-1500.
3. Identify the users and purpose of data sets, such as OASIS, HEDIS, UHDDS, DEEDS, and MDS 3.0.