CENTRAL TEXAS COLLEGE
SYLLABUS FOR POFM 2333
MEDICAL DOCUMENT PRODUCTION

Semester Hours Credit: 3

Instructor: _____________________

Office Hours: _____________________

I. INTRODUCTION

A. Course Description: Create, format and produce publishable documents.

B. This is a required course in the Medical Documentation Specialist certificate of completion and associate of applied sciences degree. The course may be used in the Medical Office Technology associate of applied sciences degree or Medical Coding and Billing associate of applied sciences degree. You will be required to demonstrate proficiency in the skills learned in this course in the internship or clinical courses.

C. This course in conjunction with other appropriate courses prepares students to enter the health related career fields.

D. Alphanumeric coding used throughout this syllabus denotes integration of SCANS occupational competencies (C1, etc.) and foundation skills (F1, etc.).

II. LEARNING OUTCOMES

Upon successful completion of Medical Document Production, the student will:

A. Produce publishable medical documents (C1, C5, C6, C7, C8, F1, F2, F11, F12, F16).

B. Transcribe abbreviations to proper form for context (C5, C6, C7, C8, F1, F2, F10, F11, F12).

III. INSTRUCTIONAL MATERIALS

A. Instructional Materials for this course may be found at www.ctcd.edu/books

B. Supplementary Materials:
Medical dictionary (virtual acceptable)

August 1, 2015
IV. COURSE REQUIREMENTS

A. Class Assignments: Assignments must be completed by the due date to receive credit for the assignment. Assignments may include
   a. Editing of speech recognition transcripts of authentic dictation
   b. Electronic health record exercises and abstraction of authentic paper record content into electronic health record format
   c. AHDI (Association for Healthcare Documentation Integrity) RHDS (Registered Healthcare Documentation Specialist) Certification Exam review quizzes

B. Class Performance: All work must be completed using a computer or word processor. Assignments must be turned in to the instructor by the due date. LATE WORK IS NOT ACCEPTED. Students enrolled in distance learning courses are expected to maintain constant progress throughout the course. Failure to do so may result in the student being administratively withdrawn by the instructor.

V. EXAMINATIONS

A. There will be exams (quizzes) to accompany the lessons of the course. These exams will cover information in the class assignments and the multimedia activities. The majority of exam questions will be objective-type.

B. Dates for completion of the lessons, including the quizzes, will be announced in the schedule provided in the online or classroom syllabus.

VI. SEMESTER GRADE COMPUTATION

A. Exams/Quizzes 50%
B. Class Assignments 50%

100%

For this course to be used to satisfy the requirements for an Office Technology certificate, a student must make at least a grade of C. A student may repeat the course until he or she achieves a grade of C or better.

VII. NOTES AND ADDITIONAL INSTRUCTIONS

A. Withdrawal from course: It is your responsibility as a student to officially drop a class if circumstances prevent attendance. Any student who desires to, or must, officially withdraw from a course after the first scheduled class meeting must file an Application for Withdrawal or an Application for Refund. The withdrawal form must be signed by the student.

Application for Withdrawal will be accepted according to the following schedule

Friday of 3rd week for 5-week courses
Friday of 4th week for 6-week courses
Friday of 6th week for 8-week courses
Friday of 7th week for 10-week courses
Friday of 9th week for 12-week courses
Friday of 12th week for 16-week courses

The equivalent date (75% of the semester) will be used for sessions of other lengths. The specific last day to withdraw is published each semester in the Schedule Bulletin.

Students who officially withdraw will be awarded the grade of "W," provided the student's attendance and academic performance are satisfactory at the time of official withdrawal. Students must file a withdrawal application with the College before they may be considered for withdrawal.

A student may not withdraw from a class for which the instructor has previously issued the student a grade of "F" or "FN" for nonattendance.

B. **An Administrative Withdrawal:** Results when a student is absent an excessive number of times as defined in the current Central Texas College catalog and/or other published amendatory documentation. In such a case, the student is dropped from the course with a grade of F.

Under Section 51.907 of the Texas Education Code, “an institution of higher education may not permit a student to drop more than six courses, including any course a transfer student has dropped at another institution of higher education.” This statute was enacted by the State of Texas in spring 2007 and applies to students who enroll in a public institution of higher education as first-time freshmen in fall 2007 or later.

C. **An Incomplete Grade:** In keeping with College policy, the instructor may grant an incomplete grade in cases in which the student had completed the majority of the course work, but because of extenuating circumstances, is unable to complete the requirement for the course. Prior approval from the instructor is required before the grade of “IP” is recorded. Deadline for changing the IP grade is 110 days after the scheduled end of the course. An IP grade can be replaced with the student’s actual grade, including an F; but it may not be replaced with a W. At the end of the 110 calendar days if the student has not completed the remaining coursework as required by the instructor, the IP will be converted to an FI and appear as an F on the student’s official transcript.

D. **Cellular Phones:** Cellular phones will be turned off while the student is in the classroom or laboratory.

E. **Americans With Disabilities Act (ADA):** Disability Support Services provide
services to students who have appropriate documentation of a disability. Students requiring accommodations for class are responsible for contacting the Office of Disability Support Services (DSS) located on the central campus. This service is available to all students, regardless of location. Explore the website at www.ctcd.edu/disability-support for further information. Reasonable accommodations will be given in accordance with the federal and state laws through the DSS office.

F. **Instructor Discretion**: The instructor reserves the right of final decision in course requirements.

G. **Civility**: Individuals are expected to be cognizant of what a constructive educational experience is and respectful of those participating in a learning environment. Failure to do so can result in disciplinary action up to and including expulsion.

H. **Scholastic Honesty**: All students of the Office Technology program are required and expected to maintain the highest standards of scholastic honesty in the preparation of all work and in examinations. Each student should avoid:

1. **Plagiarism**: the taking of passages or ideas from writings of others without giving proper credit to the source.

2. **Collusion**: working together with another person in the preparation of work unless such joint preparation is specifically approved in advance by the instructor.

3. **Cheating**: giving or receiving information on an examination, homework, or projects.

4. Students found guilty of scholastic dishonesty are subject to the Office Technology Department’s disciplinary action and Central Texas College’s disciplinary committee; in addition, students are subject to having credit for courses canceled.
VIII. COURSE OUTLINE

A. **Lesson 1: Cardiology Speech Recognition Editing Part 1; Neehr Perfect Electronic Health Record (EHR) Scavenger Hunt Level I-Level IV**

1. **Learning Outcomes:** Upon completion of Lesson 1, the student will achieve the following outcomes with at least 70% accuracy on a lesson assessment:
   a. Accurately edit original cardiology healthcare dictation representing various specialties and varying degrees of complexity, by authors with and without accents and dialects, emphasizing a variety of healthcare documents.
   b. Utilize language skills to appropriately edit, revise, and clarify while transcribing cardiology dictation, without altering the meaning of the dictation or changing the author's style.
   c. Understand and apply *Book of Style* (BOS) standards to speech recognition editing.
   d. Utilize software in the completion of health information processes.
   e. Introduction to Neehr Perfect, navigating the EHR and beginner level use of an EHR.
   f. Essential skills needed to navigate the EHR, using filters, setting preferences and more detailed aspects of the electronic chart.
   g. EHR coded and non-coded data, health factors, purpose of meaningful use.

2. **Learning Activities:**
   a. Edit/Proofread Original Cardiology Healthcare Dictation
   b. Electronic Health Record Exercises
      i. Level I Scavenger Hunt – EHR Orientation
      ii. Level II Scavenger Hunt – Essential Skills & Usability
      iii. Level III Scavenger Hunt – Meaningful Use
      iv. Level IV Scavenger Hunt – Final Evaluation

B. **Lesson 2: Orthopedics Speech Recognition Editing Part 1; Neehr Perfect Electronic Health Record Understanding the EHR Series**

1. **Learning Outcomes:** Upon completion of Lesson 2, the student will achieve the following outcomes with at least 70% accuracy on a lesson assessment:
   a. Accurately edit original orthopedics healthcare dictation representing various specialties and varying degrees of complexity, by authors with and without accents and dialects, emphasizing a variety of healthcare documents.
   b. Utilize language skills to appropriately edit, revise, and clarify while transcribing orthopedics dictation, without altering the meaning of the dictation or changing the author's style.
   c. Understand and apply *Book of Style* (BOS) standards to speech recognition editing.
d. Utilize software in the completion of health information processes.
e. Explore the multiple built-in tools and resources in Neehr Perfect.
f. Introduces health information terminology and tests the user’s knowledge by documenting in a templated note the answers to 25 questions.
g. Introduction to the HITECH Act, ARRA, IOM, the evolution of electronic health records and how Neehr Perfect incorporates these pieces of healthcare information technology.
h. Explores health information exchange, what it is and how it is used. The student will use the HealthIT.gov website, VistA Health Data Systems and apply what they learn to using Neehr Perfect.
i. Introduction to the basic aspects related to privacy, security and confidentiality for both the consumer and the healthcare worker.

2. **Learning Activities:**
   a. Edit/Proofread Original Orthopedics Healthcare Dictation
   b. Electronic Health Record Exercises
      i. Using the Tools and Resources in Neehr Perfect
      ii. Health Information Terminology Activity
      iii. Introducing HITECH and the History of EHRs
      iv. Health Information Exchange
      v. Introduction to Privacy, Security and Confidentiality in the EHR

C. **Lesson 3: Gastrointestinal Speech Recognition Editing Part 1; Neehr Perfect Electronic Health Record Chart Development Series**

1. **Learning Outcomes:** Upon completion of Lesson 3, the student will achieve the following outcomes with at least 70% accuracy on a lesson assessment:
   a. Accurately edit original gastrointestinal healthcare dictation representing various specialties and varying degrees of complexity, by authors with and without accents and dialects, emphasizing a variety of healthcare documents.
   b. Utilize language skills to appropriately edit, revise, and clarify while transcribing gastrointestinal dictation, without altering the meaning of the dictation or changing the author's style.
   c. Understand and apply Book of Style (BOS) standards to speech recognition editing.
   d. Utilize software in the completion of health information processes.
   e. Quick Guide giving step-by-step instructions for the student on how to create the ‘shell’ of a patient chart.
   f. The student will learn to register three different patients using Student Tools in the EHR.
   g. The student creates an inpatient chart and adds orders to the chart.
   h. This is a “part 2” to Registering a Patient and Adding Orders I. The student enters new orders to the chart he or she created in the
previous activity.

2. **Learning Activities:**
   a. Edit/Proofread Original Gastrointestinal Healthcare Dictation
   b. Electronic Health Record Exercises
      i. Quick Guide: Adding a New Patient Using Student Tools
      ii. Registering Patients in the EHR
      iii. Registering a Patient and Adding Orders I
      iv. Adding Orders II

D. **Lesson 4: Radiology Speech Recognition Editing; Neehr Perfect Electronic Health Record Data Entry Series**

1. **Learning Outcomes:** Upon completion of Lesson 4, the student will achieve the following outcomes with at least 70% accuracy on a Lesson assessment:
   a. Accurately edit original radiology healthcare dictation representing various specialties and varying degrees of complexity, by authors with and without accents and dialects, emphasizing a variety of healthcare documents.
   b. Utilize language skills to appropriately edit, revise, and clarify while transcribing radiology dictation, without altering the meaning of the dictation or changing the author's style.
   c. Understand and apply Book of Style (BOS) standards to speech recognition editing.
   d. Utilize software in the completion of health information processes.
   e. Beginning documenting skills in the electronic health record focusing on the entering of problems, diagnosis and patient reporting in an inpatient chart.
   f. Beginning documenting skills in the electronic health record: entering a problem, entering orders and documenting vital signs in an inpatient chart.
   g. Intermediate documenting skills in the electronic health record focusing on the entering of problems, diagnosis and the communication of important patient information. Meant to follow Data Entry with/without a note and Entering Inpatient Orders activities.

2. **Learning Activities:**
   a. Edit/Proofread Original Radiology Healthcare Dictation
   b. Electronic Health Record Exercises
      i. Data Entry with note
      ii. Data Entry without a note
      iii. Data Entry of Problems and Communication
E. **Lesson 5: Pathology Speech Recognition Editing; Neehr Perfect Electronic Health Record Chart Abstracting**

1. **Learning Outcomes:** Upon completion of Lesson 5, the student will achieve the following outcomes with at least 70% accuracy on a lesson assessment:
   a. Accurately edit original pathology healthcare dictation representing various specialties and varying degrees of complexity, by authors with and without accents and dialects, emphasizing a variety of healthcare documents.
   b. Utilize language skills to appropriately edit, revise, and clarify while transcribing pathology dictation, without altering the meaning of the dictation or changing the author's style.
   c. Understand and apply Book of Style (BOS) standards to speech recognition editing.
   d. Utilize software in the completion of health information processes.
   e. Abstract patient demographic and clinical data from paper health records into a new EHR patient chart.

2. **Learning Activities:**
   a. Edit/Proofread Original Pathology Healthcare Dictation
   b. Electronic Health Record Chart Development

F. **Lesson 6: Cardiology Speech Recognition Editing Part 2; Neehr Perfect Electronic Health Record Chart Abstracting**

1. **Learning Outcomes:** Upon completion of Lesson 6, the student will achieve the following outcomes with at least 70% accuracy on a lesson assessment:
   a. Accurately edit original cardiology healthcare dictation representing various specialties and varying degrees of complexity, by authors with and without accents and dialects, emphasizing a variety of healthcare documents.
   b. Utilize language skills to appropriately edit, revise, and clarify while transcribing cardiology dictation, without altering the meaning of the dictation or changing the author's style.
   c. Understand and apply *Book of Style* (BOS) standards to speech recognition editing.
   d. Utilize software in the completion of health information processes.
   e. Abstract patient demographic and clinical data from paper health records into a new EHR patient chart.

2. **Learning Activities:**
   a. Edit/Proofread Original Cardiology Healthcare Dictation
   b. Electronic Health Record Chart Development
G. **Lesson 7: Orthopedics Speech Recognition Editing Part 2; Neehr Perfect Electronic Health Record Chart Abstracting**

1. **Learning Outcomes:** Upon completion of Lesson 7, the student will achieve the following outcomes with at least 70% accuracy on a lesson assessment:
   
   a. Accurately edit original orthopedics healthcare dictation representing various specialties and varying degrees of complexity, by authors with and without accents and dialects, emphasizing a variety of healthcare documents.
   
   b. Utilize language skills to appropriately edit, revise, and clarify while transcribing orthopedics dictation, without altering the meaning of the dictation or changing the author's style.
   
   c. Understand and apply Book of Style (BOS) standards to speech recognition editing.
   
   d. Utilize software in the completion of health information processes.
   
   e. Abstract patient demographic and clinical data from paper health records into a new EHR patient chart.

2. **Learning Activities:**
   
   a. Edit/Proofread Original Orthopedics Healthcare Dictation
   
   b. Electronic Health Record Chart Development

H. **Lesson 8: Gastrointestinal Speech Recognition Editing Part 2; Neehr Perfect Electronic Health Record Chart Abstracting**

1. **Learning Outcomes:** Upon completion of Lesson 8, the student will achieve the following outcomes with at least 70% accuracy on a lesson assessment:
   
   a. Accurately edit original gastrointestinal healthcare dictation representing various specialties and varying degrees of complexity, by authors with and without accents and dialects, emphasizing a variety of healthcare documents.
   
   b. Utilize language skills to appropriately edit, revise, and clarify while transcribing gastrointestinal dictation, without altering the meaning of the dictation or changing the author's style.
   
   c. Understand and apply Book of Style (BOS) standards to speech recognition editing.
   
   d. Utilize software in the completion of health information processes.
   
   e. Abstract patient demographic and clinical data from paper health records into a new EHR patient chart.

2. **Learning Activities:**
   
   a. Edit/Proofread Original Gastrointestinal Healthcare Dictation
   
   b. Electronic Health Record Chart Development