Course Description

HSA2532 | Medical Documentation in Health Care | 1.00 credit

Medical Documentation in Health Care will introduce the student to documentation in the written patient chart or electronic medical record. Through case discussions and in-class writing assignments, the student will acquire the necessary skills to document in the patient's medical record utilizing medico-legal principles and evaluation and management criteria. Patient confidentiality, billing, and coding will also be discussed. Prerequisite: PAS1800C, PAS1803, PAS1831, PAS2936.

Course Competencies:

Competency 1: The student will be able to understand the medico-legal principles of clinical documentation by:

1. Identifying groups of people who may access medical records
2. Identifying general principles of documentation
3. Discussing the benefits of electronic medical records
4. Identifying challenges and barriers to using the EMR
5. Identify the components of HIPAA

Competency 2: The student will be able to correctly identify documentation needed for various levels of care by:

1. Defining E&M services
2. Researching CPT codes
3. Documenting a level 1, 2, 3, and 4 visit notes

Competency 3: The student will be able to document a comprehensive history and physical examination by:

1. Discussing the importance of a well-documented comprehensive and physical examination
2. Describing how the comprehensive history and physical examination may be adapted for various medical disciplines and practice settings
3. Identifying the components of a comprehensive history and physical examination
4. Analyze sample comprehensive histories and physical examinations in-class writing assignments based on case scenarios

Competency 4: The student will be able to document an adult preventive care accurately visit by:

1. Describing the major components of an adult preventive care visit
2. Discussing the importance of documenting a patient's personal and family medical history
3. Stating the five P's of the sexual history
4. Identifying several screening questionnaires used to identify tobacco, alcohol, and substance abuse
5. Describing occupational hazards that should be identified
6. Discussing the goals of patient education and counseling related to preventive care

Competency 5: The student will document utilizing the SOAP format based on a case scenario by:

1. Defining the Subjective, Objective, Assessment, and Plan components of a SOAP note
2. Organizing pertinent positive and negative aspects of the history in the subjective portion of the note
3. Organizing pertinent positive and negative findings of the physical examination in the Objective portion of the note
4. Generate assessments by analyzing information from the Subjective and Objective portions of the note
5. Identifying components of patient management that should be documented in the Plan section of the note

Competency 6: The student will be able to verbalize an oral case presentation inwritten form based on a case scenario by:

1. Collecting all-important history components
2. Performing a physical examination and recording the findings
3. Analyzing objective data to formulate a differential diagnosis list
4. Evaluating all facts to determine a plan of action
5. Presenting the case scenario to another colleague

Learning Outcomes:

- Communicate effectively using listening, speaking, reading, and writing skills
- Solve problems using critical and creative thinking and scientific reasoning
- Formulate strategies to locate, evaluate, and apply information
- Use computer and emerging technologies effectively