

*The Model Curriculum for
Healthcare Documentation*
6th Edition

Developed by



Association for Healthcare Documentation Integrity

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The Model Curriculum for Healthcare Documentation, 6th Edition

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Preface to the Sixth Edition

The Association for Healthcare Documentation Integrity (AHDI) published the first Model Curriculum for Medical Transcription 42 years ago. This 6th edition, like its predecessors, has been updated to keep pace with technological, regulatory, and structural changes in healthcare documentation, recognizing the reality of a rapidly evolving workplace.

The 6th edition aligns with the *Book of Style & Standards for Clinical Documentation, 4th Edition* (BOSS4CD), published in 2020, and the blueprints and exams for AHDI's Registered Healthcare Documentation Specialist (RHDS) and Certified Healthcare Documentation Specialist (CHDS) credentials.

As the writers and editors of the 5th Edition foresaw, the changes in healthcare information and documentation continue to offer new opportunities for well-educated, well-trained individuals. In fact, the anticipated changes we are seeing in the second decade of the 21st century are so significant that this 6th Edition continues to provide recommendations to educational programs for a broadly conceived suite of still-emerging roles under the label of healthcare documentation.

The 6th edition of the AHDI *Model Curriculum for Healthcare Documentation* affirms our commitment to the highest standards in education and training in healthcare documentation. As with the previous editions, adherence to this curriculum will establish consistency and quality in medical transcription/healthcare documentation educational programs everywhere.

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Introduction

LAYING THE FOUNDATION

For at least 60 years, America’s healthcare records have been passing through the minds and hands of medical transcriptionists (MTs). MTs shape the content of healthcare documents, transforming the spoken words of clinicians into accurate, consistently formatted records of millions upon millions of encounters between healthcare providers and their patients.

Evolving from scribes and secretaries taking shorthand dictation in healthcare settings to computer-savvy medical language experts working in the cloud, medical transcriptionists have continually adapted, acquiring new skills, constantly updating their medical knowledge, and broadening their scope of work according to the needs of their employers and clients. The one constant for transcriptionists, as for clinicians, has been a drive to achieve the highest standards in patient care and safety.

For more than 30 years, AHDI’s members and leaders have created and continually updated education standards for those workers at the heart of healthcare documentation. Now, as always, education looks to the future. We are preparing students for jobs that exist today and giving them knowledge and skill sets with which to build a foundation for emerging roles. Each new edition of the Model Curriculum incorporates evolving technologies and places increased attention on regulatory and workflow environments, providing for expanded knowledge about documentation security and augmented editing skills. The Model Curriculum is in harmony with a proliferation of new techniques, technologies, and institutional structures in instructional design and delivery. Additionally, curriculum revisions coordinate with changing standards for credentialing.

Model Curriculum revisions are never trivial. In 2011 the revision task force confronted a greatly accelerated pace of change in technology and its adoption, specifically with reference to the national initiative to implement the electronic health record (EHR). The immediate impetus for the current revision was a significant exam rewriting for the Registered Healthcare Documentation Specialist (RHDS) and the Certified Healthcare Documentation Specialist (CHDS) credentials. As the task force work proceeded, it became clear that more is at stake. The scope of revision thus expanded to encompass reconsideration of the very nature of healthcare documentation and the role of medical transcriptionists.

The Model Curriculum task force recognized the need for an expansion of medical transcription roles that required rebranding and that a better fit was needed between job titles and roles. AHDI’s Board of Directors, in this evolving healthcare documentation environment, created a new title: healthcare documentation specialist. This title includes medical transcription practice. All expanded roles must begin with the core knowledge and skill set of what we have always called medical transcription. The title healthcare documentation specialist (HDS) encompasses individuals who build on the core knowledge and skills to follow varied career paths.

Clinical documentation—the core process in which a clinician dictates and a healthcare documentation specialist documents—is alive and well. Despite forecasts to the contrary, demand for healthcare documentation specialists remains robust. At the same time, the amount of traditional documentation in certain sectors of health care is decreasing, and those healthcare documentation specialists need to retool. The trend toward ever-increasing use of alternative means of document creation continues even while the dictate-transcribe model remains in parallel with other documentation strategies.

What does this mean for the Model Curriculum? It must reinforce the basic knowledge and skill sets for the dictation-transcription model and emphasize that accurate content remains key in healthcare documentation. In addition, the Model Curriculum must encompass elements that point to a more expansive concept of our role. A vision of future roles led to specific changes in competencies and course objectives within the Model Curriculum. For example, a new competency under the heading of Medicolegal Aspects of the Healthcare Record, competency H8, requires students to “understand general documentation concepts related to optimizing reimbursement.” Furthermore, the competencies have been generalized and simplified to provide more instructional flexibility and to allow for shifts in the documentation landscape.

Many schools and programs are taking steps to enhance their approach to career preparation for students of healthcare documentation. To some extent, then, the title healthcare documentation specialist recognizes not only new realities of the workplace but also evolving thinking among educators.

The Model Curriculum, 6th Edition, accommodates a variety of educational programs and delivery methods. Online education has become an increasingly preferred method of instruction, but traditional instructional settings continue to be important. Any program, regardless of delivery, can adopt the Model Curriculum either in part or in whole. The Model Curriculum is the best way for schools to provide quality education and prepare students for roles in clinical documentation. A school applying for AHDI approval must, of course, adopt the full Model Curriculum.

PROGRAM GOAL STATEMENT

An educational program in healthcare documentation will prepare the student for entry-level employment as a healthcare documentation specialist by providing the basic knowledge, understanding, and skills required to transcribe clinical dictation and prepare patient care documents with accuracy, clarity, consistency, and timeliness, applying the principles of professional and ethical conduct.

PROGRAM PREREQUISITES

Student readiness for a healthcare documentation education should include the following:

- English comprehension, spelling, and usage competency (spoken and written) equivalent to that of a high school graduate.
- Minimum keyboarding speed of 45 corrected words per minute.
- Intermediate word processing skills, including ability to create, save, format, and copy and paste documents.
- Intermediate computer skills including ability to troubleshoot basic computer problems, install software, manage files, send and receive emails with attachments, and use the Internet for research purposes.
- Normal level of audiometric acuity.

These prerequisites help potential students to choose their career paths carefully and knowledgeably. They also assist instructors, counselors, and program directors in accepting and advising potential students. Methodologies and techniques for determining whether potential students meet the program prerequisites remain under the direction of individual programs and schools.

Each program should incorporate an advisory board of individuals with expertise in healthcare documentation and other relevant areas. An advisory board provides invaluable assistance in ongoing quality assessment of curriculum elements. Advisory board members would include industry experts and employers, healthcare documentation scholars, sector recruiters, and others who can contribute a variety of perspectives and insights to the medical transcription/healthcare documentation educational program.

COURSE DESCRIPTION AND OBJECTIVES

Course descriptions briefly summarize the content of each course and are designed for use in course syllabi, program catalogs, or anywhere succinct descriptions of course content are needed. Following each course description, competencies for that course are listed. Course objectives describe what the students will be able to do at course completion. Statements that are quantifiable in terms of number, percentage, or other forms of measurement are not included in course objectives so that instructors or programs may use a variety of teaching materials and evaluation techniques.

QUALIFICATIONS FOR INSTRUCTORS AND CONTENT DEVELOPERS

Content development for the healthcare documentation curriculum must include expertise in both healthcare documentation and instructional design. At least one member of the content development team must be a Certified Medical Transcriptionist (CMT) or Certified Healthcare Documentation Specialist (CHDS) through the Association for Healthcare Documentation

Integrity (AHDl). Expertise in instructional design requires experience or training in the field of education with credentialing as appropriate. Content developers for areas other than healthcare documentation practice must possess credentials relevant to that subject matter. Content developers must demonstrate current knowledge in course content through appropriate professional development activities.

Instructors for Healthcare Documentation Practice content areas must be a CMT or CHDS through AHDl. Instructors for areas other than healthcare documentation practice must possess a credential or proof of expertise relevant to the courses they are teaching. Instructors must demonstrate current knowledge through appropriate professional development activities.

REQUIRED TEXTS AND TEACHING MATERIALS

It is vital to use reference materials that are geared toward healthcare documentation practice. Dictation products should come from actual clinical provider dictation. Required and recommended text and teaching materials are listed at the end of this workbook.

Content Areas and Suggested Courses

Healthcare documentation training falls into five distinct content areas: English Language, Medical Knowledge, Technology, Medicolegal Aspects of the Healthcare Record, and Healthcare Documentation Practice. Competencies for each content area are threaded throughout the sample courses presented in this Model Curriculum. For example, medical language skills are introduced and applied in the Medical Language content area and are also applied throughout the healthcare documentation practice courses.

E. ENGLISH LANGUAGE

These competencies require that students be able to apply rules of proper grammar, punctuation, and medical style and to use correct spelling and logical sentence structure. These competencies are taught in the course listed below and applied throughout the healthcare documentation curriculum.

Courses in the English Language Content Area

- Medical Style and Grammar

M. MEDICAL KNOWLEDGE

Medical knowledge competencies require thorough knowledge of the core aspects of medicine, including medical terminology, anatomy and physiology, clinical medicine, laboratory tests, pharmacology, surgery, imaging techniques, and pathology. These competencies are taught in the courses listed below and are applied throughout the healthcare documentation curriculum.

Courses in the Medical Knowledge Content Area

- Medical Terminology
- Anatomy & Physiology
- Pathophysiology
- Pharmacology
- Diagnostic Medicine

T. TECHNOLOGY

Technology competencies require students to develop computer skills and documentation equipment proficiency and to understand technological security and confidentiality issues. They must also be aware of trends and developments in the ever-advancing area of healthcare documentation technology. These competencies are taught in the course listed below and are applied in Medicolegal Aspects of the Healthcare Record, Beginning Healthcare Documentation, Intermediate Healthcare Documentation, and Advanced Healthcare Documentation.

Courses in the Technology Content Area

- Healthcare Documentation Technology

H. MEDICOLEGAL ASPECTS OF THE HEALTHCARE RECORD

Healthcare documentation competencies require students to understand the format, content, purpose, and legal aspects of healthcare records. Students must also acquire general knowledge of standards and regulations for healthcare documents, including Health Insurance Portability and Accountability Act (HIPAA) and risk management. They must thoroughly understand and apply the AHDI Code of Ethics. Competencies are taught in the course listed below and are applied throughout the courses in the Healthcare Documentation Practice content area.

Courses in the Medicolegal Aspects of the Healthcare Record Content Area

- Medicolegal Aspects of the Healthcare Record

P. HEALTHCARE DOCUMENTATION PRACTICE

In this content area, students put into practice the skills acquired in all other content areas. It emphasizes direct practice using actual clinician-originated dictation while applying professional and ethical conduct.

Courses in the Healthcare Documentation Practice Content Area

- Beginning Healthcare Documentation
- Intermediate Healthcare Documentation
- Advanced Healthcare Documentation
- Healthcare Documentation Practicum
- Professional Development

Healthcare Documentation Competencies

ENGLISH LANGUAGE

Competencies (E)

- E1** Students will apply correct English usage and the rules of proper grammar, punctuation, and style; and will use correct spelling and logical sentence structure.
- E2** Students will evaluate the reliability of English and medical grammar and style references, as well as references for research and practice, and will apply information from selected references.
- E3** Students will apply correct medical style as defined by authorities such as AHDI's *Book of Style & Standards for Clinical Documentation, 4th Edition*, and/or the *AMA Manual of Style*, especially rules that specifically apply to healthcare documentation and editing.

MEDICAL KNOWLEDGE

Competencies (M)

- M1** Students will construct and deconstruct medical vocabulary by analyzing its structure, including prefixes, suffixes, combining forms, root words, plurals, nouns, and adjectives.
- M2** Students will distinguish between or among medical homophones (soundalikes), commonly confused medical terms, and synonyms.

- M3** Students will categorize and interpret abbreviations, brief forms, acronyms, eponyms, and foreign words and phrases commonly used in clinical practice.
- M4** Students will use terms and discuss concepts of gross and microscopic human anatomical structure, physiologic functioning, and homeostasis.
- M5** Students will categorize surgical procedures and other interventional diagnostic and treatment modalities by specialty, indications or related diagnoses, technique, and typical findings.
- M6** Students will discriminate among procedures, techniques, and findings in diagnostic and interventional imaging.
- M7** Students will differentiate among common clinical laboratory medicine tests, including diagnostic indications, techniques, normal or physiologic and abnormal findings, and the correct expression of values.
- M8** Students will identify, pronounce, spell, define, and apply pharmacological terminology.
- M9** Students will differentiate among common drug classes, forms, dosages, and routes of administration.
- M10** Students will compare and contrast the etiologies and pathologies of diseases and trauma within a specialty or body system.
- M11** Students will identify and define methods of diagnosis and treatment of common diseases and conditions.
- M12** Students will appropriately select and use medical reference materials (i.e., word books, dictionaries, Internet, and electronic resources).
- M13** Students will identify and analyze current trends and advancements in medicine.

TECHNOLOGY

Competencies (T)

- T1** Students will demonstrate a general knowledge of and the ability to operate computers and related technologies.
- T2** Students will appraise potential security and privacy risks within their work environment, and how to mitigate those risks with adherence to regulatory protocols.

- T3** Students will apply correct ergonomic habits.
- T4** Students will appropriately use electronic references and other resources for research and practice.
- T5** Students will demonstrate a general knowledge of speech recognition and related technologies.
- T6** Students will define common terminology, acronyms, abbreviations, and medical nomenclatures related to the healthcare industry.

MEDICOLEGAL ASPECTS OF THE HEALTHCARE RECORD

Competencies (H)

- H1** Students will explain the purpose of the healthcare record.
- H2** Students will describe the content and format of healthcare documents.
- H3** Students will demonstrate an understanding of standards and regulations related to healthcare documentation.
- H4** Students will identify and apply medicolegal concepts and the role of the healthcare documentation specialist in risk management.
- H5** Students will apply the AHDI Code of Ethics.
- H6** Students will understand the overall workflow process in healthcare documentation.
- H7** Students will appropriately use related medicolegal and HIM resources for research and practice.
- H8** Students will understand general documentation concepts related to optimizing reimbursement.

HEALTHCARE DOCUMENTATION PRACTICE

Competencies (P)

- P1** Students will accurately transcribe and/or edit a minimum of 2100 minutes of authentic clinician-generated dictation during the program.

- P2** Students will demonstrate the ability to proofread and correct transcribed healthcare documents, including using critical thinking and editing skills.
- P3** Students will recognize, evaluate, and call attention to inconsistencies, discrepancies, and inaccuracies in healthcare dictation while transcribing/editing, without altering the meaning of the content.
- P4** Students will apply productivity and accuracy standards and definitions.
- P5** Students will meet progressively demanding healthcare documentation accuracy and productivity standards.
- P6** Students will describe the functions, operations, and dynamics of healthcare documentation work environments.
- P7** Students will practice professionalism in the classroom and workplace.
- P8** Students will appraise and articulate opportunities in healthcare documentation and related careers.
- P9** Students will accurately transcribe/edit a minimum of 600 minutes (equivalent to 10 dictation hours and 100 transcription hours) of authentic clinician-generated documentation in an externship or simulated professional practice setting.

Note: See the Appendix for more information.

- P10** Students will appraise, and articulate awareness of, the value of continuing education and professional credentials relevant to healthcare documentation practice.
- P11** Students will appropriately evaluate the reliability of and use all resources for research and practice.
- P12** Students will interpret and explain the content of medical records.
- P13** Students will analyze their errors and devise corrective strategies.

Content Areas, Competencies, and Objectives

ENGLISH LANGUAGE

Suggested courses in this content area include Medical Style and Grammar

MEDICAL STYLE AND GRAMMAR

The study, synthesis, and application of the rules of English language and medical style as reflected by AHDI's *Book of Style & Standards for Clinical Documentation, 4th Edition*, or other medical style manuals such as the *AMA Manual of Style*.

Competencies

- E1** Students will apply correct English usage and the rules of proper grammar, punctuation, and style, and will use correct spelling and logical sentence structure.
- E2** Students will evaluate the reliability of English and medical grammar and style references, as well as references for research and practice, and will apply information from selected references.
- E3** Students will apply correct medical style as defined by authorities such as AHDI's *Book of Style & Standards for Clinical Documentation, 4th Edition*, and/or the *AMA Manual of Style*, especially rules that specifically apply to healthcare documentation and editing.

Objectives

Upon completion of this course, students will be able to:

1. Apply the rules of spelling, including forming plurals and adjectives, of English words.
2. Define, spell, and use English words commonly used in healthcare documentation.
3. Recognize, correctly spell, and use commonly misspelled English words.
4. Recognize, correctly spell, and use commonly misused English words.
5. Recognize, correctly spell, and use common English homophones (soundalikes).
6. Correctly use arabic numerals, roman numerals, and units of measure as designated in the most recent edition of *the Book of Style & Standards for Clinical Documentation, 4th Edition*.
7. Transcribe abbreviations, acronyms, and brief forms in accordance with the most recent edition of AHDI's *Book of Style & Standards for Clinical Documentation, 4th Edition*.
8. Correctly assign the parts of speech (nouns, verbs, prepositions, etc.) to words in context.
9. Use rules of correct grammar, including verb tense, subject-verb agreement, and pronoun-antecedent agreement.

10. Correct syntax errors, avoiding dangling modifiers and awkward, unclear, or humorous wording.
11. Apply the rules of punctuation to ensure clarity and accuracy of communication.
12. Recognize and appropriately transcribe, edit, or flag jargon, slang, street talk, regionalisms, profanities (derogatory or inflammatory remarks), obscenities, and vulgarities, in accordance with AHDI's *Book of Style & Standards for Clinical Documentation, 4th Edition*.
13. Appropriately transcribe or translate foreign abbreviations and phrases in accordance with the *Book of Style & Standards for Clinical Documentation, 4th Edition*.
14. Identify and use appropriate references and other resources.
15. Evaluate and choose appropriate Internet references.

See suggested references for this course on page 30.

MEDICAL KNOWLEDGE

Suggested courses in this content area include Medical Terminology, Anatomy & Physiology, Pathophysiology, Pharmacology, and Diagnostic Medicine

MEDICAL TERMINOLOGY

A study of medical language including the use of word components (prefixes, roots/combining forms, and suffixes) to build and spell medical terms as well as to divide, analyze and define terms in context. This will include eponyms, abbreviations, acronyms, brief forms, slang, jargon, disease entities, and diagnostic and imaging terms that are not easily defined by analyzing word components. All body systems and major medical specialties and terms related to anatomy and physiology, directional terms, body planes, cavities, and regions are included. Pronunciation and spelling are emphasized as is distinguishing between medical homophones (soundalikes) and commonly confused/misused medical terms.

Competencies

- M1** Students will construct and deconstruct medical vocabulary by analyzing its structure, including prefixes, suffixes, combining forms, root words, plurals, nouns, and adjectives.
- M2** Students will distinguish between or among medical homophones (soundalikes), commonly confused medical terms, and synonyms.
- M3** Students will categorize and interpret abbreviations, brief forms, acronyms, eponyms, and foreign words and phrases commonly used in healthcare practice.
- M4** Students will use terms and discuss concepts of gross and microscopic human anatomical structure, physiologic functioning, and homeostasis.

- M5** Students will categorize surgical procedures and other interventional diagnostic and treatment modalities by specialty, indications or related diagnoses, technique, and typical findings.
- M6** Students will discriminate among procedures, techniques, and findings in diagnostic and interventional imaging.
- M12** Students will appropriately select and use medical reference materials (i.e. word books, dictionaries, Internet and electronic resources).

Objectives

Upon completion of this course, students will be able to:

1. Divide, analyze, and define complex medical words by recognizing their components: prefixes, suffixes, combining forms, and root words.
2. Build basic medical words using prefixes, suffixes, root words, and combining forms.
3. Correctly pronounce, spell, and use medical terms in context, including medical homophones (soundalike terms) and commonly confused/misused medical terms.
4. Name major organs and structures by body system and describe their locations and function.
5. Categorize major pathological conditions and disease processes by body system.
6. Identify and categorize electrodiagnostic and imaging modalities by specialty.
7. Categorize common clinical laboratory tests.
8. Identify and use common abbreviations and brief forms pertaining to each body system.
9. Describe and use common eponyms pertaining to each body system.
10. Identify, pronounce, spell, and define commonly used foreign-language medical words and phrases.
11. Apply correct suffixes for plurals, nouns, and adjectives, including those of Greek and Latin origin.
12. Locate and identify terms describing anatomical positions, directions, and planes of the body; identify body cavities and recognize organs contained therein; locate and identify the anatomical and clinical divisions of the abdomen.
13. Identify and use appropriate medical references and other resources to research, study and stay current with trends and developments in medicine.

See suggested references for this course beginning on page 31.

ANATOMY AND PHYSIOLOGY

A study of the structural organization and function of the human body, with an introduction to some aspects of chemistry and microbiology related to the practice of medicine. Knowledge of

anatomy and physiology of the human body is essential as a basis for later study of disease processes for students in the health professions.

Competencies

- M4** Students will use terms and discuss concepts of gross and microscopic human anatomical structure, physiologic functioning, and homeostasis.

- M11** Students will appropriately select and use medical reference materials (i.e., word books, dictionaries, Internet, and electronic resources).

Objectives

Upon completion of this course, students will be able to:

1. Describe the structure and function of cells, tissues, organs, and systems.
2. Identify body cavities and the organs they contain.
3. Describe the position or relationship of one part of the body to another incorporating directional and positional terms as well as anatomic planes and regions.
4. Classify tissue by type, including epithelial, connective, muscle, and nerve tissues.
5. Locate organs, muscles, bones, and other structural components of the body on a graphic.
6. Categorize anatomical structures by each body system.
7. Apply the concept of homeostasis to human physiological activity.
8. Relate and summarize the body's immune system and defense mechanisms.
9. Identify and use appropriate medical references and other resources to research and study common diseases and conditions and to stay current with trends and developments in medicine.

See suggested references for this course on page 32.

PATHOPHYSIOLOGY

Study of the functional changes associated with or resulting from disease or injury by body system and/or specialties, including etiology, signs and symptoms, diagnostic procedures, diagnoses, treatment modalities, prognoses, and prevention.

Competencies

- M5** Students will categorize surgical procedures and other interventional diagnostic and treatment modalities by specialty, indications or related diagnoses, technique, and typical findings.

- M6** Students will discriminate among procedures, techniques, and findings in diagnostic and interventional imaging.
- M7** Students will differentiate among common clinical laboratory medicine tests, including diagnostic indications, techniques, normal or physiologic and abnormal findings, and the correct expression of values.
- M8** Students will identify, pronounce, spell, define, and apply pharmacological terminology.
- M10** Students will compare and contrast the etiologies and pathologies of diseases and trauma within a specialty or body system.
- M11** Students will identify and define methods of diagnosis and treatment of common diseases and conditions.
- M12** Students will select and use appropriate medical reference materials (i.e. word books, dictionaries, Internet and electronic resources).

Objectives

Upon completion of this course, students will be able to:

1. Describe the fundamental nature of disease, including injury and repair, inflammation, immunopathology, infectious disease, cancer, hemodynamic disorders, genetic disorders, and pathologies of selected body systems.
2. Identify the predisposing factors and etiologies of human diseases and disorders including the effects of homeostasis.
3. Explain the principles of infection, the concept of immunity, and methods of transmission, prevention, diagnosis, and treatment of infectious and blood-borne diseases.
4. Differentiate among classification systems (including scoring methods, scales, or grades) for disease, injury, or anatomic anomaly.
5. Categorize signs and symptoms of diseases and syndromes by body system or specialty.
6. Identify diagnostic procedures for diseases and syndrome by body system or specialty and explain the implications of physiologic or abnormal diagnostic findings.
7. Classify treatment modalities for diseases, syndromes, and trauma by body system or specialty.
8. Categorize common drugs according to their indications by symptom or disease.
9. Discuss the prognosis of diseases and syndromes by body system or specialty.
10. Recognize and practice infection control measures.
11. Identify and use appropriate medical references and other resources to research and study common diseases and conditions and to stay current with trends and developments in medicine.

See suggested references for this course on page 32.

PHARMACOLOGY

A study of the principles and language of pharmacology, including drugs and drug classes.

Competencies

- M8** Students will identify, pronounce, spell, define, and apply pharmacological terminology.
- M12** Students will select and use appropriate medical reference materials (i.e. word books, dictionaries, Internet and electronic resources).

Objectives

Upon completion of this course, students will be able to:

1. Describe pharmacological nomenclature and principles.
2. Classify routes of administration and drug forms.
3. Describe the relationships of drug classes with disease processes and medical specialties.
4. Recognize commonly prescribed medications, including indications, actions, dosages, and routes of administration.
5. Recognize and use correct pharmacological names and dosages.
6. Use appropriate pharmacological references.

See suggested references for this course on page 33.

DIAGNOSTIC MEDICINE

A study of the principles and language of imaging, diagnostic, and laboratory medicine, including types of imaging studies, diagnostic tests, indications, techniques, expressions of values, and significance of findings.

Competencies

- M6** Students will identify procedures, techniques, and findings in diagnostic and interventional imaging.
- M7** Students will differentiate among common clinical laboratory medicine tests, including diagnostic indications, techniques, normal or physiologic and abnormal findings, and the correct expression of values.

M12 Students will select and use appropriate medical reference materials (i.e., word books, dictionaries, Internet, and electronic resources).

Objectives

Upon completion of this course, students will be able to:

1. Use appropriate imaging, diagnostic, and laboratory medicine terminology.
2. Identify imaging, diagnostic, and laboratory medicine testing methods and procedures used for various diseases and conditions.
3. Identify normal laboratory value ranges.
4. Recognize and correctly express laboratory values.
5. Identify and define common abbreviations used in imaging, diagnostic, and laboratory medicine.
6. Students will select and use appropriate medical reference materials for diagnostic imaging (i.e., word books, dictionaries, Internet, and electronic resources).

See suggested references for this course on page 33.

TECHNOLOGY

A suggested course in this content area is Healthcare Documentation Technology

HEALTHCARE DOCUMENTATION TECHNOLOGY

This course is designed to introduce students to computers, word processing applications, electronic resources/references, and healthcare documentation technologies to enhance computer skills, proficiency, and accuracy. It is designed to study, synthesize, and apply technologies used in healthcare documentation, as well as to stimulate an awareness of related emerging technologies.

Competencies

- T1** Students will demonstrate a general knowledge of and the ability to operate computers and related technologies.
- T2** Students will appraise potential security and privacy risks within their work environment, and how to mitigate those risks with adherence to regulatory protocols.
- T3** Students will demonstrate correct ergonomic habits.

- T4** Students will appropriately use electronic references and other resources for research and practice.
- T5** Students will demonstrate a general knowledge of speech recognition and related technologies.
- T6** Students will define common terminology, acronyms, abbreviations and medical nomenclatures related to the healthcare industry.

Objectives

Upon completion of this course, students will be able to:

1. Identify and use basic features of word processing programs (to include inserting text, deleting text, creating macros, saving, general key commands) and general operating system functions.
2. Identify security and confidentiality issues related to technology and apply system security concepts (e.g., password protection, antivirus software, encryption).
3. Differentiate between stand-alone and networked computers.
4. Recognize the functions of computer components and peripherals (e.g., printer, modem).
5. Differentiate and evaluate different Internet connections (cable, DSL, satellite) and their impact on productivity and reliability.
6. Identify general knowledge of speech recognition technology and editing concepts.
7. Identify and utilize a personal computer maintenance plan (e.g., virus protection, defragmenting disk drives, deleting temporary files, and data backup).
8. Explain basic concepts of the healthcare documentation process and technology.
9. Use designated transcription/editing equipment (e.g., analog, digital, sound card, foot pedals, headsets, software) to complete healthcare documentation assignments.
10. Demonstrate appropriate use of telecommunications (including security) and send, receive, forward, respond to, and attach documents to email (e.g., fax, modem, Internet).
11. Install software programs on a personal computer and adhere to copyright law.
12. Employ electronic media for accuracy (e.g., spell checker).
13. Use productivity software and keyboard shortcuts (e.g., macros, word expanders, mouse versus keyboard).
14. Demonstrate and apply correct ergonomics.
15. Identify a variety of reliable electronic references, websites, and resources.
16. Troubleshoot basic computer and transcription equipment problems.
17. Explain basic concepts of an electronic healthcare record (including the healthcare documentation process).
18. Demonstrate an understanding of the differences between an electronic medical record, electronic health record, and a personal health record.

19. Recognize and define common terminology related to electronic healthcare records (HL7, SNOMED, HTML, XML, CPOE, HIE, REC, NHIN, Health Story Project, parsing, data tagging, structured/unstructured text, narrative data, meaningful use, ICD-10, etc.).

See suggested references for this course on page 34.

MEDICOLEGAL ASPECTS OF THE HEALTHCARE RECORD

A suggested course in this content area is *Medicolegal Aspects of the Healthcare Record*

MEDICOLEGAL ASPECTS OF THE HEALTHCARE RECORD

Introduction to healthcare documentation, including the voluntary and regulatory standards related to the healthcare document and the study and application of medicolegal concepts and ethics.

Competencies

- T2** Students will appraise potential security and privacy risks within their work environment, and how to mitigate those risks with adherence to regulatory protocols.
- H1** Students will explain the purpose of the healthcare record.
- H2** Students will describe the content and format of healthcare documents.
- H3** Students will demonstrate general knowledge of standards and regulations related to healthcare documentation.
- H4** Students will identify and apply medicolegal concepts and the role of the healthcare documentation specialist in risk management.
- H5** Students will apply the AHDI Code of Ethics.
- H6** Students will understand the overall workflow process in healthcare documentation.
- H7** Students will appropriately use related medicolegal and HIM resources for research and practice.

Objectives

Upon completion of this coursework, students will be able to:

1. Describe the characteristics and use of the healthcare record as a legal document.
2. Identify required content of the healthcare document and its components.
3. Analyze the relationship of healthcare documentation to the healthcare record.
4. Recognize the role of healthcare documentation in the health information workflow process.
5. Demonstrate the importance of delivering healthcare documentation in a timely manner.
6. Explain the HIPAA privacy and security rules as well as other legal, regulatory, and standards requirements for healthcare documentation and related processes used by healthcare documentation specialists.* (*see also note below*)
7. Define basic medicolegal terminology as it pertains to healthcare documentation (business associates, covered entities, PHI, reportable and nonreportable breaches).
9. Describe the influence of voluntary and regulatory agencies on standard setting for healthcare documentation.
10. Describe, explain, and comply with medical and professional ethics, including the AHDI Code of Ethics.
11. Recognize risk management implications within healthcare documents and report them appropriately.
12. Explain and comply with patient rights to privacy, confidentiality, and release of patient information.
13. Identify potential liability issues for medical transcriptionists.
14. Identify continuing education resources in medicolegal issues regarding healthcare documentation.
15. Identify and use appropriate references and other resources (including Joint Commission's Do Not Use Abbreviation List).
16. Understand the importance of quality assurance and best practices (audits, feedback).

See suggested references for this course on page 35.

***NOTE:** All international programs must ensure they are teaching U.S. HIPAA privacy and security as well as privacy and security standards of their home country (e.g., CIHI, DISHA).

HEALTHCARE DOCUMENTATION PRACTICE

Suggested courses in this content area include Beginning, Intermediate, and Advanced Healthcare Documentation, Healthcare Documentation Practicum, Professional Development

BEGINNING HEALTHCARE DOCUMENTATION

Transcription and/or editing of authentic healthcare documents, incorporating basic-level skills in English language, technology, medical knowledge, proofreading, editing, and research, while meeting progressively demanding accuracy standards.

Competencies

- E1** Students will apply correct English usage and the rules of proper grammar, punctuation, and style, and will use correct spelling and logical sentence structure.
- E2** Students will evaluate the reliability of English and medical grammar and style references, as well as references for research and practice, and will apply information from selected references.
- E3** Students will apply correct medical style as defined by authorities such as AHDI's *Book of Style & Standards for Clinical Documentation 4th edition* and/or the *AMA Manual of Style*, especially rules that specifically apply to healthcare documentation and editing.
- M1** Students will construct and deconstruct medical vocabulary by analyzing its structure, including prefixes, suffixes, combining forms, root words, plurals, nouns, and adjectives.
- M2** Students will distinguish between or among medical homophones (soundalikes), commonly confused medical terms, and synonyms.
- T1** Students will demonstrate a general knowledge of and the ability to operate computers and related technologies.
- T3** Students will apply correct ergonomic habits.
- P1** Students will accurately transcribe and/or edit a minimum of 2100 minutes of authentic clinician-generated dictation during the program.

Note: See Appendix for more information

- P2** Students will demonstrate the ability to proofread and correct clinician-generated healthcare documents, including using critical thinking and editing skills.

- P3** Students will recognize, evaluate, and call attention to inconsistencies, discrepancies, and inaccuracies in healthcare documentation while transcribing/editing, without altering the meaning of the dictation.
- P4** Students will apply productivity and accuracy standards and definitions.
- P5** Students will meet progressively demanding healthcare documentation accuracy and productivity standards.
- P10** Students will appraise, and articulate awareness of, the value of continuing education and professional certification relevant to healthcare documentation practice.

Objectives

Upon completion of this course, students will be able to:

1. Operate designated equipment for healthcare documentation, demonstrating good ergonomic habits.
2. Accurately transcribe and/or edit documents from a variety of medical specialties, with and without accents and dialects, using appropriate formats.
3. Use language skills and medical knowledge to appropriately edit, revise, and clarify documentation, without altering the meaning.
4. Recognize, evaluate, and interpret inconsistencies, discrepancies, and inaccuracies in documentation.
5. Evaluate the accuracy of healthcare documentation.
6. Recognize situations requiring assistance from supervisor, co-worker, or originator in order to understand dictation and transcribe/edit reports.
7. Analyze and provide solutions to common ergonomic problems in the work environment.
8. Identify and use appropriate references.

See suggested references for this course on page 36.

INTERMEDIATE HEALTHCARE DOCUMENTATION

Transcription and/or editing of authentic healthcare documents using intermediate-level skills in proofreading, editing, and research, while meeting progressively demanding accuracy and productivity standards.

Competencies

- E1** Students will apply correct English usage and the rules of proper grammar, punctuation, and style, and will use correct spelling and logical sentence structure.
- E2** Student will evaluate the reliability of English and medical grammar and style references, as well as references for research and practice, and will apply information from selected references.
- E3** Students will apply correct medical style as defined by authorities such as AHDI's *Book of Style & Standards for Clinical Documentation, 4th Edition*, and/or the *AMA Manual of Style*, especially rules that specifically apply to healthcare documentation and editing.
- M1** Students will construct and deconstruct medical vocabulary by analyzing its structure, including prefixes, suffixes, combining forms, root words, plurals, nouns, and adjectives.
- M2** Students will distinguish between or among medical homophones (soundalikes), commonly confused medical terms, and synonyms.
- M9** Students will differentiate among common drug classes, forms, dosages, and routes of administration.
- M13** Students will identify and analyze current trends and advancements in medicine.
- T1** Students will demonstrate a general knowledge of and the ability to operate computers and related technologies.
- T3** Students will apply correct ergonomic habits.
- H1** Students will explain the purpose of the healthcare record.
- H4** Students will identify and apply medicolegal concepts and the role of the healthcare documentation specialist in risk management.
- H5** Students will apply the AHDI Code of Ethics.
- H8** Students will understand general documentation concepts related to optimizing reimbursement.
- P1** Students will accurately transcribe and/or edit a minimum of 2100 minutes of authentic clinician-generated dictation during the program

Note: See *Appendix* for more information.

- P2** Students will demonstrate the ability to proofread and correct transcribed healthcare documents, including using critical thinking and editing skills.
- P3** Students will recognize, evaluate, and call attention to inconsistencies, discrepancies, and inaccuracies in healthcare documentation while transcribing and/or editing, without altering the meaning of the dictation.
- P4** Students will apply productivity and accuracy standards and definitions.
- P5** Students will meet progressively demanding healthcare documentation accuracy and productivity standards.
- P10** Students will appraise, and articulate awareness of, the value of continuing education and professional credentials relevant to healthcare documentation practice.
- P12** Students will interpret and explain the content of medical records.
- P13** Students will analyze their errors and devise corrective strategies.

Objectives

Upon completion of this course, students will be able to:

1. Interpret and transcribe and/or edit a variety of healthcare reports of intermediate difficulty by dictators with and without accents and dialects.
2. Use language skills and medical knowledge to appropriately edit, revise, and clarify while transcribing/editing original healthcare documentation of intermediate difficulty, without altering the meaning of the dictation.
3. Call attention to medical inconsistencies, discrepancies, and inaccuracies in documentation.
4. Evaluate the accuracy of healthcare documents of intermediate difficulty.
5. Define and apply medicolegal concepts to healthcare documents.
6. Meet progressively demanding accuracy standards while transcribing/editing reports of intermediate difficulty.
7. Meet progressively demanding productivity standards while transcribing/editing reports of intermediate difficulty.
8. Identify and use appropriate references, whether written or electronic, while transcribing, proofreading, editing, and revising.
9. Recognize and adhere to account/client specific standards while transcribing/editing.
10. Identify elements in healthcare documentation practice that affect reimbursement (e.g., completeness, timeliness).

See suggested references for this course on page 36.

ADVANCED HEALTHCARE DOCUMENTATION

Transcription/editing of authentic healthcare documentation using advanced-level proofreading, editing, and research skills, while meeting progressively demanding accuracy and productivity standards.

Competencies

- E1** Students will apply correct English usage and the rules of proper grammar, punctuation, and style, and use of correct spelling and logical sentence structure.
- E2** Students will evaluate the reliability of English and medical grammar and style references, as well as references for research and practice, and will apply information from selected references.
- E3** Students will apply correct medical style as defined by authorities such as AHDI's *Book of Style & Standards for Clinical Documentation, 4th Edition*, and/or the *AMA Manual of Style*, especially rules that specifically apply to healthcare documentation and editing.
- M1** Students will construct and deconstruct medical vocabulary by analyzing its structure, including prefixes, suffixes, combining forms, root words, plurals, nouns, and adjectives.
- M2** Students will identify, pronounce, spell, define, and understand medical terminology related to anatomy, physiology, general medicine, general surgery, medical specialties, surgical specialties, diagnostic and interventional procedures, pathology and laboratory medicine, health and wellness, imaging techniques, medications, and alternative or complementary medicine.
- M9** Students will differentiate among common drug classes, forms, dosages, and routes of administration.
- M13** Students will identify and analyze current trends and advancements in medicine.
- T1** Students will demonstrate a general knowledge of and the ability to operate computers and related technologies.
- T3** Students will apply correct ergonomic habits.
- H1** Students will explain the purpose of the healthcare record.
- H4** Students will identify and apply medicolegal concepts and the role of the healthcare documentation specialist in risk management.
- H5** Students will apply the AHDI Code of Ethics.

- H8** Students will understand general documentation concepts related to optimizing reimbursement.
- P1** Students will accurately transcribe and/or edit a minimum of 2100 minutes of authentic clinician-generated documentation during the program.
- Note: See Appendix for more information.*
- P2** Students will demonstrate the ability to proofread and correct transcribed healthcare documents, including using critical thinking and editing skills.
- P3** Students will recognize, evaluate, and call attention to inconsistencies, discrepancies, and inaccuracies in healthcare documents while transcribing/editing, without altering the meaning of the dictation.
- P4** Students will apply productivity and accuracy standards and definitions.
- P5** Students will meet progressively demanding healthcare documentation accuracy and productivity standards.
- P10** Students will appraise, and articulate an awareness of, the value of continuing education and professional credentials relevant to healthcare documentation practice.
- P12** Students will interpret and explain the content of medical records.
- P13** Students will analyze their errors and devise corrective strategies.

Objectives

Upon completion of this course, students will be able to:

1. Interpret and transcribe and/or edit a variety of healthcare documents of advanced difficulty by dictators with and without accents and dialects.
2. Use language skills and medical knowledge to appropriately edit, revise, and clarify while transcribing/editing advanced, original healthcare documentation without altering the meaning of the dictation.
3. Evaluate the accuracy of transcribed/edited healthcare documents of advanced difficulty.
4. Define and apply professional and ethical conduct.
5. Meet progressively demanding accuracy standards while transcribing/editing reports of advanced difficulty.
6. Meet progressively demanding productivity standards while transcribing/editing reports of advanced difficulty, making use of tools such as expanders, keyboard shortcuts, and macros.

7. Identify and use appropriate medical references and other resources.
8. Discuss the differences between traditional transcription and editing, demonstrating the ability to produce accurate work in any documentation environment.
9. Identify elements in healthcare documentation practice that affect reimbursement (e.g., completeness, timeliness).

See suggested references for this course on page 36.

HEALTHCARE DOCUMENTATION PRACTICUM

A minimum of 100 transcription/editing hours in an externship or simulated professional practice setting using clinician-generated documents, including a balanced variety of specialties, report types, and account specifics.

Competencies

- E1** Students will apply correct English usage and the rules of proper grammar, punctuation, and style, and will use correct spelling and logical sentence structure.
- E2** Students will evaluate the reliability of English and medical grammar and style references, as well as references for research and practice, and will apply information from selected references.
- E3** Students will apply correct medical style as defined by authorities such as AHDI's *Book of Style & Standards for Clinical Documentation, 4th Edition*, and/or the *AMA Manual of Style*, especially rules that specifically apply to medical transcription/editing.
- M9** Students will differentiate among common drug classes, forms, dosages, and routes of administration.
- M13** Students will identify and analyze current trends and advancements in medicine.
- T3** Students will apply correct ergonomic habits.
- P5** Students will meet progressively demanding medical transcription/editing accuracy and productivity standards.
- P9** Students will accurately transcribe/edit a minimum of 600 minutes (equivalent to 10 hours) of authentic clinician-generated documentation in an externship or simulated professional practice setting.

Note: See Appendix for more information.

- P10** Students will appraise, and articulate an awareness of, the value of continuing education and professional credentials relevant to healthcare documentation practice.
- P12** Students will interpret and explain the content of medical records.
- P13** Students will analyze their errors and devise corrective strategies.
- H8** Students will understand general documentation concepts related to optimizing reimbursement.

Objectives

Upon completion of this course, students will be able to:

1. Accurately transcribe and/or edit authentic clinician-generated documents representing various specialties, report types, and account specifics.
2. Use language skills and technology to appropriately edit, revise, and clarify while transcribing/editing dictation, without altering the meaning of the dictation.
3. Apply medicolegal concepts as they relate to healthcare documentation.
4. Meet accuracy and productivity standards.
5. Practice professional behavior and ethical conduct.
6. Identify and use appropriate references and resources.
7. Identify elements in healthcare documentation practice that affect reimbursement (e.g., completeness, timeliness).

See suggested references for this course on page 37.

PROFESSIONAL DEVELOPMENT

Development of professional work behaviors, analysis of the dynamics of the work environment, and exploration of professional development and career opportunities.

Competencies

- M12** The student will identify and analyze current trends and advancements in medicine.
- T3** Students will apply correct ergonomic habits.
- T4** The student will appropriately use electronic references and other resources for research and practice.
- H5** The student will apply the AHDI Code of Ethics.

- P6** The student will describe the functions, operations, and dynamics of healthcare documentation work environments.
- P7** The student will practice professionalism in the workplace.
- P8** The student will appraise and articulate opportunities in healthcare documentation and related careers.
- P10** The student will appraise, and articulate awareness of, the value of continuing education and professional credentials relevant to healthcare documentation practice.
- P11** The student will appropriately evaluate the reliability of and use all resources for research and practice.

Objectives

Upon completion of this course, the student will be able to:

1. Demonstrate effective interpersonal communication and teamwork skills in problem solving and/or conflict management.
2. Identify and implement time and stress management techniques.
3. Explain the importance of flexibility and adaptability in the workplace.
4. Define components of a professional image and demonstrate professionalism.
5. Delineate career and alternative career paths in the healthcare documentation industry that build on a core healthcare documentation education.
6. Prepare a resume, complete an employment application, recognize value of the different social media platforms, and participate in a job interview.
7. Identify and prioritize work-related obligations.
8. Analyze the importance of ethical conduct in the workplace.
9. Describe the characteristics of various work settings (e.g., hospital-, service-, and home-based offices).
10. Differentiate among features (e.g., compensation, benefits, schedules) of different work environments and display skill in negotiating terms of employment, incorporating the differences in compensation methods.
11. Relate procedures and requirements for practicing as an independent contractor (e.g., business licensing, contracts, taxes, space, equipment, pricing).
12. Use varying techniques for measurement of outcomes (e.g., quality, turnaround time, productivity).
13. Illustrate the basic differences among employee, statutory employee, and independent contractor status, as well as the potential tax, insurance, and liability implications of each.
14. Demonstrate the value of affiliating with professional organizations such as AHDI.
15. Recognize the value of AHDI and other professional credentials.

16. Practice networking skills such as virtual meetings, social media, and webinars of AHDI, etc.).
17. Formulate a plan to implement successful continuing education.
18. Identify and use appropriate references and resources.

See suggested references for this course on page 38.

References, Textbooks, and Dictation Product Recommendations

REQUIRED TEXTS & TEACHING MATERIALS

The following is a list of required items:

- *Book of Style & Standards for Clinical Documentation, 4th Edition*, Association for Healthcare Documentation Integrity (current edition)
- Authentic clinical dictation
- Industry-standard software and equipment

All textbooks must be commercially published. A commercially published textbook is one that is written by an expert on the subject and published by a commercial publisher, university, trade or professional association, research center, or the government. It will be well written, well organized, and well researched. The textbook will be peer-reviewed and/or edited by a knowledgeable editor. It will be copyrighted, up-to-date, and comprehensive enough to thoroughly cover the subject based on its intended purpose and audience. Features of a commercially published textbook include the following: table of contents, index, illustrations (art, graphs, charts, etc.), objectives, exercises or activities for application, and a bibliography. There is no requirement that every course has a commercially published textbook, and it is recognized that not all academic materials must be commercially published materials.

If schools or programs incorporate outsourced online courses as prerequisites or part of their program, these courses must meet the same requirements for commercial published textbooks. That is, the course should be developed by an expert on the subject, commercial publisher, university, trade or professional association, research center, or the government. It will be well written, well organized, and well researched. The course will be peer-reviewed and/or edited by a knowledgeable editor. It should be copyrighted, up-to-date, and comprehensive enough to serve its intended purposes. Features include the following: table of contents, index, illustrations (art, graphs, charts, etc.), objectives, exercises or activities for application, and a bibliography.

Web content used for instruction must meet similar standards: authoritative, free of content errors, well-organized, up-to-date, and peer-reviewed. The provider/organization/owner of the web content must be a commercial publisher, university, trade or professional association,

research center, scholarly journal, the government, or an individual recognized as an expert who provides sources to support the content. If the information comes from a news bureau, the original source of the news must be authoritative (a peer-reviewed medical journal, for example). The intended audience for Internet resources and instructional material should be clinicians, medical students, or allied health professionals rather than patients or consumers. Blogs, forums, social media, email, wikis, and listservs are not considered authoritative resources or instructional except to the extent that they can be used as illustration or to generate discussions about industry issues, networking, ethics, critical thinking, etc.

RECOMMENDED TEXTS, REFERENCES, DICTATION PRODUCTS (CURRENT EDITIONS ONLY)

List compiled in order of suggested courses

The following are texts, references, and materials recommended by AHDI for various content areas. Some programs may use the items listed in different courses or content areas than others do. For example, one program may require specialty medical word books in their Healthcare Documentation Practice section, while others may require that in their Medical Knowledge section. It is strongly recommended that programs use texts and courseware developed by credentialed authors and commercial publishers.

English Language

MEDICAL STYLE & GRAMMAR (see page 10)

Suggested Texts

- *The Book of Style for Medical Transcription, 3rd Edition*, and accompanying workbook, AHDI
- *Medical Transcription Techniques and Procedures*, (Diehl) Elsevier
- *Grammar and Writing Skills for the Health Professional* (Oberg and Villemaire), VitalSource
- *The Book of Style, 3rd edition, Grammar & Usage Resource (BOS3 Resource)*, AHDI

Suggested Resources

- *American Medical Association Manual of Style*, American Medical Association
- *The Gregg Reference Manual* (Sabin), McGraw-Hill
- *Webster's Collegiate Dictionary*, G. C. Merriam Company

- *The American Heritage Dictionary of the English Language*, Houghton Mifflin
- *The Oxford Dictionary of American English*, Oxford University Press

Medical Knowledge

MEDICAL TERMINOLOGY (see page 11)

Suggested textbooks

- *The Language of Medicine* (Chabner), W.B. Saunders
- *Medical Terminology: A Short Course*, Davi-Ellen Chabner (Saunders/Elsevier)
- *Exploring Medical Language: Understand and Be Understood* (Lafleur), Elsevier
- *Medical Language: Immerse Yourself* (Turley), Prentice Hall
- *Medical Terminology: A Body Systems Approach* (Gyls), F.A. Davis Co.
- *Medical Terminology: A Living Language* (Fremgen, Frucht), Pearson
- *Medical Terminology for Health Care Professionals* (Rice), Pearson

Suggested references

- *Stedman's Medical Dictionary* (full size), Lippincott Williams & Wilkins
- *Dorland's Medical Dictionary* (full size), W. B. Saunders
- *Vera Pyle's Current Medical Terminology*, Health Professions Institute
- *Medical Phrase Index* (Lorenzini & Lorenzini Ley), Practice Management Information Corporation
- Benchmark KB, Interfix
- Medical specialty word books and electronic references published by:
 - Stedman's (Lippincott Williams & Wilkins)
 - W. B. Saunders
 - Health Professions Institute
 - Prentice Hall

- Elsevier
- McGraw-Hill
- Pearson

ANATOMY & PHYSIOLOGY (see page 12)

Suggested textbooks

- *Essentials of Human Anatomy & Physiology* (Marieb), Addison-Wesley (Pearson)
- *Essentials of Anatomy and Physiology* (Scanlon), F.A. Davis
- *Anatomy and Physiology for Health Professionals* (Colbert, Ankney & Lee), Pearson

Suggested resources

- *Gray's Anatomy: The Unabridged Edition* (Williams), Churchill Livingstone
- *The Anatomy Coloring Book* (Kapit), Pearson Education, Inc.
- *Barron's Essential Atlas of Anatomy* (Parramon Studios), Barron's Educational Series (Simon and Schuster)
- *Atlas of Human Anatomy* (Netter), Elsevier
- Multimedia such as YouTube videos, A.D.A.M., innerbody.com, broadcastmed.com, anatomyarcade.com

PATHOPHYSIOLOGY (see page 13)

Suggested textbooks

- *Human Diseases* (Dirckx), Health Professions Institute
- *H&P: A Nonphysician's Guide to the Medical History and Physical Examination* (Dirckx), Health Professions Institute
- *Introduction to Human Disease* (Crowley), Jones and Bartlett
- *Introduction to Human Disease: Pathophysiology for Health Professionals* (Hart, Loeffler), Jones & Bartlett
- *The Human Body in Health & Disease* (Memmler), Lippincott Williams & Wilkins
- *The Human Body in Health & Disease* (Thibodeau), Mosby

Suggested References

- *The Merck Manual of Diagnosis and Therapy*, Merck & Co.
(<http://www.merckmanuals.com/professional>)
- *A Practice Guide to Clinical Medicine* (<http://meded.ucsd.edu/clinicalmed>)
- Screening Physical Exam
(<http://www.meddean.luc.edu/lumen/MedEd/medicine/pulmonar/pd/contents.htm>)
- eMedicine Specialties; requires registration
(<http://www.emedicine.com/specialties.htm>)
- Centers for Disease Control and Prevention (<http://cdc.gov/>)
- Family Practice Notebook (<http://www.fpnotebook.com/index.htm>)

PHARMACOLOGY (see page 15)

Suggested References

- *Pharmacology: An Introduction* (Hitner, Nagle), McGraw-Hill
- *Understanding Pharmacology for Health Professionals* (Turley), Pearson
- *Lippincott Illustrated Reviews: Pharmacology* (Lippincott Illustrated Reviews Series) 7th Edition (Whalen), Lippincott Williams & Wilkins

Multimedia

- <https://www.accessdata.fda.gov/scripts/cder/daf/>
- drugs.com (has phonetic and wildcard search; search by condition)
- rxlist.com
- pdr.net

DIAGNOSTIC MEDICINE (see pages 15)

Suggested References

- *Laboratory Tests and Diagnostic Procedures in Medicine* (Dirckx), Health Professions Institute
- *Mosby's Manual of Diagnostic and Laboratory Tests* (Deska), Elsevier

- *Mosby's Diagnostic and Laboratory Test Reference* (Deska Pagana), Elsevier
- *A Manual of Laboratory and Diagnostic Tests* (Fischbach), Lippincott Williams & Wilkins
- *Laboratory Tests and Diagnostic Procedures with Nursing Diagnoses* (Corbett, Banks)
- *Book of Style & Standards for Clinical Documentation, 4th Edition* (Bryan), AHDI

Multimedia

- Labtestsonline.org
- Benchmark Knowledge Base (Interfix)

Technology

HEALTHCARE DOCUMENTATION TECHNOLOGY (see page 16)

Suggested Resources

- Stedman's Electronic Medical/Pharmaceutical Spellchecker, Lippincott Williams & Wilkins
- *Dorland's Electronic Medical Dictionary and Spellchecker*, W. B. Saunders
- *Stedman's Electronic Medical Dictionary*, Lippincott Williams & Wilkins
- *Stedman's Electronic Medical Word Book Series*, Lippincott Williams & Wilkins
- Technology for the Medical Transcriptionist (Bryan)
- Medical Transcription: Techniques, technologies, and editing skills (Alice and Blanche Ettinger), Paradigm
- Introduction to Computers for Healthcare Professionals (Joos, Nelson, and Wolfe), VitalSource
- Word Expander Software programs. Examples:
 - Abbreviate
 - FastFox
 - Instant Text
 - Shorthand
 - Shortkeys
 - Smart Type
 - SpeedType
 - Spellex

Medicolegal Aspects of the Healthcare Record

MEDICOLEGAL ASPECTS OF THE HEALTHCARE RECORD (see page 18)

Suggested Resources

- *Book of Style & Standards for Clinical Documentation, 4th Edition*, AHDI
- *Medical Transcription Fundamentals and Practice* (Health Professions Institute) Prentice-Hall
- *The Independent Medical Transcriptionist* (Weil), Rayve Productions
- *Medical Law, Ethics, and Bioethics for Ambulatory Care* (Lewis/Tamparo), Davis, F. A.
- *HIPAA Compliance Guide and Quick Reference eBook – 2nd Edition* (Lucci), AHDI
- *Health Information: Management of a Strategic Resource* (Abdelhak), W.B. Saunders Company
- *A Practical Introduction to Health Information Management* (Aspen Reference Group), Aspen Publishers
- *Medical Law and Ethics* (Fremgen), Pearson
- *Healthcare Ethics and the Law* (Hammaker), Jones & Bartlett Learning
- *Essentials of Health Policy and Law* (Teitelbaum), Jones & Bartlett Learning
- *Contemporary Issues in Healthcare Law and Ethics* (Harris), Health Administration Press
- *Introduction to Health Information Privacy & Security* (Rinehart Thompson), AHIMA
- *Fundamentals of Law for Health Informatics and Information Management* (Brodnik, Rinehart-Thompson, Reynolds), AHIMA
- *Documentation and Information Management in Home Care and Hospice Programs* (Miller), AHIMA
- *Comparative Records for Health Information Management* (Peden), Delmar Learning
- *Health Information Management: Principles and Organization for Health Record Services* (Skurka), American Hospital Association Press
- *Health Information Management Technology: An Applied Approach* (Johns), AHIMA.
- Joint Commission’s website – www.jointcommission.org
- Joint Commission’s Do Not Use List of Abbreviations – [Download PDF](#)

- *Healthcare Documentation Quality Assessment and Management Best Practices*, AHDI
([Download PDF](#))
- *HIPAA Plain and Simple: A Healthcare Professional's Guide to Achieve HIPAA and HITECH Compliance* (Hartley and Jones), Second edition, AMA.

Healthcare Documentation Practice

BEGINNING, INTERMEDIATE, ADVANCED HEALTHCARE DOCUMENTATION (see pages 20-26)

Suggested Resources

- *Medical Transcription Fundamentals and Practice* (HPI), Prentice-Hall
- Benchmark KB, Interfix
- *Dorland's Medical Dictionary*, Saunders
- *Medical Abbreviations: 30,000 Conveniences at the Expense of Communication and Safety* (Davis), Neil M. Davis Associates
- *Mosby's Manual of Diagnostic and Laboratory Tests* (Deska), Elsevier
- *Mosby's Diagnostic and Laboratory Test Reference*, (Deska Pagana), Elsevier
- *Saunders Pharmaceutical Word Book* (Drake), Saunders
- *Sloane's Medical Word Book* (Drake and Drake), Elsevier
- *Stedman's Medical Dictionary*, Lippincott Williams & Wilkins
- *Stedman's Word Books*, Lippincott Williams & Wilkins
- *Stedman's Medical Transcription Dictation*
- SUM Program Beginning, Intermediate, and Advanced Transcription Units, Health Professions Institute

HEALTHCARE DOCUMENTATION PRACTICUM (see page 26)

Suggested Resources

- *Book of Style & Standards for Clinical Documentation, 4th Edition*, Association for Healthcare Documentation Integrity
- *The Book of Style for Medical Transcription, 3rd Edition*, Association for Healthcare Documentation Integrity
- Benchmark KB, Interfix
- *Dorland's Medical Dictionary*, Saunders
- *Interpreting Acute Care Dictation #1*, Career Development Series, Health Professions Institute
- *Interpreting Acute Care Dictation #2*, Career Development Series, Health Professions Institute
- *Interpreting ESL Medical Dictation*, Career Development Series, Health Professions Institute
- *Medical Abbreviations: 30,000 Conveniences at the Expense of Communication and Safety* (Davis) Neil M. Davis Associates
- *Mosby's Manual of Diagnostic and Laboratory Tests* (Deska), Elsevier
- *Mosby's Diagnostic and Laboratory Test Reference*, (Deska Pagana), Elsevier
- *Sloane's Medical Word Book*, Ellen Drake, Saunders
- *Stedman's Medical Dictionary*, Lippincott Williams & Wilkins
- *Stedman's Word Books*, Lippincott Williams & Wilkins
- *Stedman's Medical Transcription Dictation*, DVD with online application
- *Surgical Word Book* (Tessier), Saunders
- *The Language of Medicine* (Chabner), Saunders
- *Understanding Pharmacology For Health Professionals* (Turley), Pearson

PROFESSIONAL DEVELOPMENT (see page 27)

Suggested Resources

- *The Medical Transcription Workbook*, Health Professions Institute
- *The Independent Medical Transcriptionist (Weil)*, Rayve Productions
- *The Medical Transcription Career Handbook (Drake)*, Prentice Hall
- *The CMT Review Guide (Honkonen/AHDI)*, Lippincott Williams & Wilkins
- *The RMT Review Guide (Stroh/AHDI)*, Lippincott Williams & Wilkins
- *RMT Exam Guide: A Walk through the Blue Print (McSwain)*, AHDI (RHDS Ready)
- *CMT Exam Guide: A Walk through the Blue Print (McSwain, Sims, Wall)*, AHDI (CHDS Ready)

NOTES REGARDING DICTATION PRACTICE

- *The dictation cannot be material which has been read or redictated.*
- *2100 dictated minutes is equivalent to 35 dictated hours. Using a standard that assumes most students could transcribe 6 minutes of dictation in 1 hour, instructors could expect students to spend a minimum of 350 transcription/editing hours meeting this competency (with the hours required by P9 included in that total).*
- *AHDI has set a 2100-minute dictation/editing requirement here but urges programs to recognize that this is the minimum exposure to authentic documentation recommended to ensure entry-level interpretive skill. Exposure to 2400 minutes or more of authentic clinician-generated documentation is highly recommended.*

Please note that the 600 minutes specified in competency P9 is included in, not in addition to, the 2100 minutes mentioned in P1.

THE HEALTHCARE DOCUMENTATION PRACTICUM

For the Healthcare Documentation Practicum, a medical transcription/editing work setting is preferred, with student duties focused on medical transcription/editing and/or EHR-related documentation work, emphasizing a balanced variety of healthcare documents, specialties, report types, and account specifics. Students will be evaluated on documentation accuracy and productivity as well as professional and ethical conduct.

DEFINITIONS

Healthcare record, healthcare document, healthcare information—These phrases are used in the Model Curriculum to include all aspects of the information used in medical practice and related domains.

Clinical document, clinical documentation—These phrases refer to documents directly pertaining to patient encounters with the healthcare system, usually understood to be encounters between healthcare providers (such as physicians, nurses, physician assistants, therapists) and the individuals who are their patients.