Washtenaw Community College Comprehensive Report

MED 112 Medical Assistant Administrative I
Effective Term: Winter 2020

Course Cover

Division: Health Sciences
Department: Allied Health
Discipline: Medical Office Worker
Course Number: 112
Org Number: 15900
Full Course Title: Medical Assistant Administrative I
Transcript Title: Medica1 Asst Administrative I
Is Consultation with other department(s) required: No
Publish in the Following: College Catalog , Time Schedule , Web Page
Reason for Submission: Course Change
Change Information:
Consultation with all departments affected by this course is required.
Rationale: Conditionally approved; seeking full approval.
Proposed Start Semester: Winter 2020
Course Description: In this course, students are introduced to the basic administrative procedures performed in an ambulatory setting. Students will also be introduced to the administrative use of the medical record. Also included are professional communications and behaviors, patient reception, office equipment, ethical and legal standards, and the office environment. Students must complete the course with a "C" or higher.

Course Credit Hours

Variable hours: No
Credits: 2
Lecture Hours: Instructor: 30 **Student:** 30
Lab: Instructor: 0 **Student:** 0
Clinical: Instructor: 0 **Student:** 0

Total Contact Hours: Instructor: 30 **Student:** 30
Repeatable for Credit: NO
Grading Methods: Letter Grades
Audit
Are lectures, labs, or clinicals offered as separate sections?: NO (same sections)

College-Level Reading and Writing

Reduced Reading/Writing Scores

College-Level Math

Requisites

Prerequisite
Academic Reading Level 5; Academic Writing Level 3
and
Prerequisite
Admission to the Medical Assisting program

General Education

Request Course Transfer

Proposed For:

Student Learning Outcomes

1. Manage appointment schedule using established priorities.
   Assessment 1
   Assessment Tool: Outcome-related questions on departmental exams and skill checks
   Assessment Date: Fall 2022
   Assessment Cycle: Every Three Years
   Course section(s)/other population: All
   Number students to be assessed: All
   How the assessment will be scored: Answer keys and rubrics
   Standard of success to be used for this assessment: 80% of students will score 75% or better on written exams and 85% or higher on skill tests
   Who will score and analyze the data: Departmental faculty

2. Create a patient's medical record.
   Assessment 1
   Assessment Tool: Outcome-related questions on departmental exam and simulation skill check
   Assessment Date: Fall 2022
   Assessment Cycle: Every Three Years
   Course section(s)/other population: All
   Number students to be assessed: All
   How the assessment will be scored: Answer key and rubric
   Standard of success to be used for this assessment: 80% of students will score 75% or better on written exams and 85% or better on simulations
   Who will score and analyze the data: Departmental faculty

3. Identify different types of appointment scheduling methods.
   Assessment 1
   Assessment Tool: Outcome-related questions on departmental exam
   Assessment Date: Fall 2022
   Assessment Cycle: Every Three Years
   Course section(s)/other population: All
   Number students to be assessed: All
   How the assessment will be scored: Answer key
   Standard of success to be used for this assessment: 80% of the students will score 75% or better on exam
   Who will score and analyze the data: Departmental faculty

4. Input patient data utilizing a practice management system.
   Assessment 1
   Assessment Tool: Skill sheets
   Assessment Date: Fall 2022
   Assessment Cycle: Every Three Years
   Course section(s)/other population: All
   Number students to be assessed: All
   How the assessment will be scored: Rubrics
   Standard of success to be used for this assessment: 85% of the students will score 85% or better
   Who will score and analyze the data: Departmental faculty

Course Objectives

1. Manage appointment schedule using established priorities.
2. Schedule a patient procedure.
3. Create a patient's medical record.
4. Organize a patient's medical record.
5. Utilize an electronic medical record (EMR).
6. Input patient data utilizing a practice management system.
7. Identify different types of appointment scheduling methods.
8. Identify advantages and disadvantages of the manual and electronic appointment systems.
9. Identify critical information required for scheduling patient procedures.
10. Define types of information contained in the patient's medical record.
11. Identify methods of organizing the patient's medical record based on problem-oriented medical record (POMR) and source-oriented medical record (SOMR).
12. Identify equipment and supplies needed for medical records in order to create, maintain, and store.
13. Differentiate between electronic medical records (EMR) and a practice management system.
14. Explain the importance of data back-up.
15. Explain meaningful use as it applies to EMR.
16. Display sensitivity when managing appointments.
17. Explain the difference between a paper-based medical record and an electronic medical record (EMR).
18. List the general functions of EMR software.
19. Describe the organization of a source-oriented medical record and a problem-oriented medical record.
20. List and define the four subcategories included in the progress notes of a problem-oriented record (POR).
21. Describe the usual format of an EMR.
22. List the categories of information obtained on the new patient information form.
23. Describe the function of the Notice of Privacy Practices.
24. Identify the information obtained in each of the following consent documents: procedure consent and release of medical information.
25. Give examples of correspondence and telephone messages often found in the medical record.
26. Complete procedure consent form.
27. Complete release of medical information form.
28. List and describe the components of the medical record database.
29. Describe how the problem list is coordinated with billing in the EMR.
30. Explain the necessity to finalize progress notes in the EMR.
31. Compare storage of laboratory reports, diagnostic tests, and reports of diagnostic tests in the paper-based medical record and the EMR.
32. List and describe other clinical reports that may be found in a medical record.
33. List and describe the seven sections of the health history.
34. List the guidelines that should be followed in recording the chief complaint. Obtain patient history and formulate chief complaint.
35. List and describe the guidelines to follow to ensure accurate and concise documentation.
36. List and describe the types of progress notes that may be documented by the medical assistant.
37. List examples of subjective symptoms and objective symptoms.
38. List and describe common symptoms.

New Resources for Course

Course Textbooks/Resources

Textbooks
Manuals
Periodicals
Software

Equipment/Facilities

Reviewer	Action	Date
Faculty Preparer:		
Rhonda Johns	*Faculty Preparer*	*Sep 09, 2019*
Department Chair/Area Director:		
Kristina Sprague	*Recommend Approval*	*Sep 09, 2019*
Dean:		
Valerie Greaves	*Recommend Approval*	*Sep 09, 2019*
Curriculum Committee Chair:		
Lisa Veasey	*Recommend Approval*	*Oct 04, 2019*
Assessment Committee Chair:		
Shawn Deron	*Recommend Approval*	*Oct 10, 2019*
Vice President for Instruction:		
Kimberly Hurns	*Approve*	*Oct 14, 2019*