

Legislation Details (With Text)

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Title:	AHIMA Apprenticeship Program Participation - Riley				
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AHIMA Apprenticeship Program Participation - Riley

Medical Coder-Biller Apprentices: Sharon Samuels - Medical Coding Specialist, Teri Torkelson - Medical Coding Specialist, and Stacy Keating - Lead Billing Specialist, have completed the immersion training and required on-the-job learning for the Medical Coder-Biller Apprenticeship program and received their Certified Coding Associate (CCA) credentials.

After a nearly 2-year learning period, completion of this apprenticeship program has broadened the knowledgebase and skillset of these staff which has enabled more efficient workflows, identification of coding and documentation trends and improvement opportunities.

Professional Fee Coder Apprentices: Sharon Samuels and Teri Torkelson have enrolled in the online immersion training for the Professional Fee Coder Apprenticeship program with an anticipated completion date of June 2020. They will then be eligible to take the Certified Coding Specialist-Physician (CCS-P) office-based credential exam and will participate in on-the-job learning.

Participation in this apprenticeship program will further expand their coding knowledge base and focus in the area of outpatient coding guidelines.

Clinical Documentation Improvement (CDI) Apprentices: Courtney Morrison - Medical Coding Specialist and Tamara Mahan - Health Information Technician, have enrolled in the online Immersion training for the CDI Apprenticeship program with an estimated completion by end of March 2020. They will then be eligible to take the Certified Documentation Improvement Practitioner (CDIP) credential exam and will participate in on-the-job learning.

Participation in this apprenticeship program will enable them to expand on their Health Information Technology degrees and Registered Health Information Technician (RHIT) credentials and learn to specialize in Clinical Documentation Improvement/Integrity. This specialization will allow Health Information Management to have an additional focus on the accuracy, integrity, and completion of patient records in order to be compliant with documentation and coding standards.

None, for information only.