MA-775: MEDICAL SCRIBE

Effective Term
Fall 2026

BOT Approval Date
12/11/2025

Discipline
MA - Medical Assisting

Course Number
775

Course Title
Medical Scribe

Short Title
Medical Scribe

Credit Status (CB 04)
D - Credit - Degree applicable

Units

Lecture Units
3.00

Total Units
3.00

Hours

Lecture Contact Hours
48-54

Out of Class Hours Lecture
96-108

Total Contact Hours
48 - 54

Total Out of Class Hours
96 - 108

Total Student Learning Hours
144 - 162

Distance Education
Yes

Distance Education

Distance Education Type
Both Fully Online and Hybrid Online

Fully Online Delivery Requirements:
a. Students must be notified via the college schedule of classes and the syllabus for the class if proctored tests are required for this course
b. Any planned face-to-face meetings, such as an orientation or study session, must be optional

c. The MSJC curriculum committee requires the use of accessible, asynchronous discussion as a component of every fully online course

Are you using publisher content?

No

Regular Substantive Interaction

Instructor-to-student, student-to-student, and student-to-content contact shall be distributed in a manner that will ensure regular substantive interaction (RSI) is maintained not only weekly but also for the duration of the course. Instructor interactions should be equivalent in time, quality and consistency to the engagement students would receive in a face-to-face course—for example, through announcements, discussion participation, personalized feedback, video messages, or other instructional communications. Instructors are expected to be responsive to student inquiries within a 24-72 hour time frame excluding holidays. RSI will be maintained through a variety of methods: • Orientation - Students must be oriented to the online and face-to-face portions at the start of the course. • Announcements - Announcements using the course management system must be posted at least weekly to keep students current on course events, due dates, materials, etc. • Discussion Forums - Content-related discussion forums within the designated CMS will include appropriate instructor participation and will be initiated and maintained, with timely feedback provided. Instructors are required to monitor the discussions and related activities to provide guidance and direction. Open-ended discussion boards may be used to further learning and interaction. • MSJC Communication – Instructor will use MSJC-administered communication tools (such as email or the designated CMS communication tools) to regularly communicate with and provide ease of access to students. • Timely Feedback - Timely feedback on student work will be provided by the instructor, which may include comments and/or rubrics, within the Grades area of the designated CMS. • Scheduled Meetings – Hybrid and synchronous courses will meet at regularly scheduled times. ADA Compliance - All course interactions and content must be designed with accessibility in mind and meet ADA requirements.

Catalog Description

This course provides students with the knowledge and skills to develop accurate, timely charting of patient encounter, including but not limited to patient history, physical exams, diagnostic and laboratory tests results, procedures and diagnosis codes.

Requisites

Prerequisite(s)

Prerequisite(s) (must be taken before)
AH-105 (with a grade of C or better)

Codes

TOP Code (CB 03)

1208.20* - *Administrative Medical Assisting

CIP Code

51.0711 - Medical/Health Management and Clinical Assistant/Specialist.

Repeatability Code

No

Grading Option

Letter grade OR P/NP

Minimum Qualifications

Minimum Qualifications	And/Or
Health (Masters Required)	Or
Health Information Technology	Or
Health Services Director/Health Services Coordinator/College (Masters Required)	End

Learning Objectives

Learning Objectives

Learning Objective
1. Apply medical terminology, anatomy/physiology, and disease concepts in clinical documentation.
2. Create legible and compliant patient records in an industry-standard format.
3. Demonstrate accurate transcription and documentation of provider dictation and live clinical encounters with accurate spelling, grammar, and timing.
4. Analyze legal, ethical, and professional standards when documenting patient encounters.
5. Integrate HIPAA privacy and security rules when creating and managing health information.
6. Synthesize terminology, procedures, and basic coding context when scribing across specialties.
7. Differentiate between the various levels of patient history: history present illness (HPI), review of systems (ROS), past, family, surgical, and social history (PFSH), and physical examination (PE) when scribing provider/patient encounter.
8. Document patient encounters using person-first, bias-aware language that reflects culturally responsive, equitable care.

Learning Outcome Information

Course Learning Outcomes

Learning Outcome
1. Students will apply HIPAA and patient privacy file in the professional healthcare setting.
2. Students will develop skills in documentation of provider-patient encounter.
3. Students will utilize utilities assigned to format and protocol documentation and recording of medical procedures, vebalized interaction with patient and provider, physical exam findings, medical decision making, laboratory results, radiological reports and consultations.
4. Students will use appropriate software to input patient data in a manner that meets industry-approved format.
5. Students will synthesize and associate medical terminology, procedures, billing, and coding when scribing for various specialties.
6. Students will differentiate between the various levels of patient history, review of systems, and physical examination when scribing for a provider/ patient encounter.
7. Students will demonstrate accurate and timely documentation of clinical encounters.

Content

Course Lecture Content

Course Content

A. Medical Terminology and Anatomy Review

1. Body systems, organ functions, and terminology application.
2. Word roots, prefixes, and suffixes for clinical documentation.
3. Integration of terminology into electronic health records (EHR).

B. Clinical Documentation Standards

1. Components of accurate and compliant documentation.
2. Record formatting, structure, and audit readiness.
3. Common documentation errors and correction procedures.

C. Provider Dictation and Transcription

1. Real-time dictation techniques.
2. Listening and transcription accuracy.
3. Spelling, grammar, and medical abbreviation conventions.

D. Legal, Ethical, and Professional Documentation

1. Medico-legal considerations and professional accountability.
2. Confidentiality, informed consent, and patient rights.
3. Ethical decision-making and error reporting.

E. HIPAA and Privacy Compliance

1. HIPAA privacy and security standards.
2. Data integrity and patient confidentiality.
3. Reporting and handling breaches of protected health information.

F. Terminology, Procedures, and Coding Context

1. Relationship between medical terminology, CPT, and ICD-10 codes.
2. Workflow connections between documentation and billing.
3. Multispecialty examples of scribing across departments.

G. Patient Histories and Examinations

1. History of Present Illness (HPI) and Review of Systems (ROS).
2. Past, Family, Social History (PFSH).
3. Physical examination documentation (focused vs. comprehensive).

H. Culturally Responsive Documentation (DEI)

1. Person-first, bias-aware language and inclusive phrasing.
2. Documenting interpreters, pronouns, and cultural preferences.
3. Recognizing and eliminating stigmatizing language.
4. Connecting documentation to health equity and patient-centered care.

Methods of Instruction

Method

Activity

Integration

Students engage in cooperative group activities to simulate provider-patient interactions and practice real-time documentation using case study dialogues.

In-Person (Hybrid): Students participate in both large and small group activities, using scripted case studies to role-play provider-patient conversations. One student will act as the scribe, documenting the encounter using either an EMR system or a provided template.

Online: Students collaborate through the Course Management System (CMS) using discussion boards, shared documents, or breakout group tools to analyze case studies and simulate documentation. One group member completes the chart using a template or EMR platform and submits it via Canvas for feedback.

DE Adaptations for MOI

DE Adaptation: Peer collaboration will occur through the Course Management System (CMS) via discussion forums, shared case study analyses, and optional group spaces for documentation exercises.

Students engage in peer feedback using structured rubrics, ensuring meaningful student-to-student interaction and reflection on the accuracy, professionalism, and ethics of their documentation.

All collaborations will be facilitated via Canvas-integrated tools in the Course Management System (CMS).

All instructional materials, tools, and activities meet ADA and Section 508 accessibility standards, ensuring that all accessibility requirements are met.

Method

Individual Projects

Integration

Students complete an individual charting project by converting case studies into accurate patient records. This may be done by either:

Using Electronic Medical Record (EMR) software such as SIMS or SimChart, or standardized documentation templates

In the hybrid format, students complete EMR activities in the classroom using SIMS or an assigned charting template, which they can complete during or after class sessions.

Online: Students access the case studies remotely and complete the same documentation assignments through the Course Management System (CMS) using the provided templates or EMR tools when available. All submissions are uploaded for instructor feedback and grading.

DE Adaptations for MOI

DE Adpations: Students independently complete assigned documentation projects, converting case studies into SOAP notes or EMR entries.

Assignments are submitted via the Course Management System (CMS) for instructor grading and timely feedback (within seven days). Feedback includes rubric scoring, written comments, and optional short video messages for clarification and engagement.

All instructional materials, tools, and activities meet ADA and Section 508 accessibility standards, ensuring that all accessibility requirements are met.

Method

Activity

Integration

Students complete patient documentation exercises using simulated EMR software (e.g., SimChart or SIMS) or, when access is unavailable, by using standardized charting templates provided by the course.

In the hybrid format, students complete EMR documentation during in-person class sessions using available software systems. If software is not accessible, students will complete the same activities using printed or digital charting templates aligned with the course documentation standards.

Online: Students complete browser-based EMR activities (if available) or download the provided templates to manually complete each patient record. All completed documentation will be uploaded to the Course Management System (CMS) for review, instructor feedback, and grading.

DE Adaptations for MOI

DE Adaptations: Students complete browser-based EMR activities (if available) or download the provided templates to complete each patient record manually. All completed documentation will be uploaded to the Course Management System (CMS) for review, instructor feedback, and grading.

All instructional materials, tools, and activities meet ADA and Section 508 accessibility standards, ensuring that all accessibility requirements are met.

Method

Role Playing/Simulation

Integration

Students use scripted provider-patient case studies to practice creating accurate and complete patient charts. These simulations are designed to build clinical listening, real-time documentation, and communication skills.

In the hybrid format, students take turns acting out the roles of provider and patient during in-person sessions. A third student will serve as the scribe, documenting the encounter in real time using either EMR software (e.g., SIMS) or course-provided templates. Role rotation allows all students to experience each perspective in a clinical interaction.

Online: Students independently complete scripted simulations by recording brief role-play videos or writing dialogues based on assigned scripts. They then create corresponding patient charts using course templates or EMR software and submit all materials through the Course Management System (CMS).

DE Adaptations for MOI

DE Adapations: Students complete asynchronous scribing simulations using de-identified case videos or written scripts.

For each simulation, students act as the medical scribe by documenting encounters in real time using course-provided templates or simulated EMR platforms (e.g., SimChart or SIMS).

Optional synchronous meetings via district-approved, accessible video software may be held for demonstration or live feedback.

Documentation assignments are uploaded through the Course Management System (CMS) and graded using the same rubric applied in the face-to-face course.

All course materials, tools, and activities meet ADA and Section 508 accessibility standards, ensuring accessibility requirements are met.

Method

Lecture

Integration

Foundational content is delivered through instructor-led lectures, demonstrations, and multimedia presentations designed to reinforce documentation and communication skills.

In-Person (Hybrid): Lectures use presentation software, videos, and discussion to connect documentation skills with real-world applications. Lectures are delivered live using presentation software, diagrams, and videos. Students participate in class discussions and guided question sessions.

Online: Students access recorded video lectures, narrated presentation software, and downloadable lecture notes through the Course Management System (CMS). Canvas. Optional interactive knowledge checks and short reflections support engagement and comprehension.

DE Adaptations for MOI

DE Adaptations: Instructor-recorded video lectures, narrated presentation software, and supplemental multimedia are hosted through the Course Management System (CMS) and paired with transcripts or captions to ensure accessibility.

Knowledge checks, auto-graded quizzes, and short reflections are provided at the end of each module to reinforce comprehension and maintain weekly instructor-to-student contact.

Instructors are to post weekly announcements, participate in discussions, and provide personalized feedback through the Course Management System (CMS) to replicate real-time guidance.

Regular substantive interaction (RSI) is maintained through announcements, feedback, and active participation in discussions.

Instructor response time to student inquiries is 24–72 hours (excluding weekends and holidays).

Optional synchronous office hours are available using district-approved, accessible video software.

All course materials, tools, and activities meet ADA and Section 508 accessibility standards, ensuring accessibility requirements are met.

Methods of Evaluation

Method

Exams/Tests

Integration

Students complete a midterm and final exam designed to assess their ability to critically analyze and synthesize course content, including lectures, terminology, and case studies.

In-Person (Hybrid): Exams delivered through the Course Management System (CMS) Canvas during scheduled class sessions and timed. Students complete scenario-based and knowledge-based questions under instructor supervision using classroom devices.

Online Adaptation: Exams administered through the Course Management System (CMS)Canvas as timed assessments, with the option for remote proctoring if required. Exams include multiple-choice, short-answer, and documentation-based questions, and may be open-note, depending on the instructor's guidelines.

DE Adaptations for MOE

DE Adaptations: Exams are administered through the Course Management System (CMS)Canvas as timed assessments, utilizing a combination of multiple-choice, short-answer, and documentation-based questions.

Instructors enable question randomization, time limits, and lockdown browser tools to promote academic integrity and prevent cheating.

Remote proctoring (using district-approved, accessible software) may be used if required.

Students receive exam scores and rubric-based feedback within seven (7) days of submission.

Accommodations are available for students registered with DSPS or requiring alternative formats.

All course materials, tools, and activities meet ADA and Section 508 accessibility standards, ensuring accessibility requirements are met.

Method

Quizzes

Integration

Students complete weekly quizzes that assess their understanding of medical terminology, clinical concepts, and their ability to apply critical thinking and problem-solving skills to course material.

In-Person (Hybrid): Quizzes administered through the Course Management System (CMS)during scheduled class sessions using classroom devices. All quizzes are timed and may include randomized question sets to maintain academic integrity.

Online Adaptation: Quizzes are completed remotely through the Course Management System (CMS) with time limits and randomized questions to ensure fairness and rigor. Students complete quizzes independently by the assigned weekly deadlines.

DE Adaptations for MOE

DE Adaptations: Weekly quizzes are hosted through the Course Management System (CMS) and may be auto-graded or include short written responses. Quizzes are timed and randomized to maintain fairness and exam integrity.

Immediate scoring is provided for auto-graded items; written components receive instructor feedback within 72 hours.

Accessibility standards are met through screen-reader compatibility and alternate text formats.

Late or makeup quiz options are managed through the Course Management System (CMS) to ensure equity and consistency.

All course materials, tools, and activities meet ADA and Section 508 accessibility standards, ensuring accessibility requirements are met.

Method

Role-playing/Simulation

Integration

Students participate in scripted provider-patient-scribe role-play scenarios to demonstrate their ability to accurately and professionally document real-time medical encounters. Each student rotates through the roles of provider, patient, and scribe.

In-Person (Hybrid): Role-plays conducted live during class sessions. Students observed and evaluated using a standardized rubric that assesses communication, documentation accuracy, and adherence to clinical protocols.

Online Adaptation: Students complete the simulation independently by recording a video or submitting a written script along with their completed chart via the Course Management System (CMS). Submissions are assessed using the same rubric to ensure consistency in grading.

DE Adaptations for MOE

DE Adaptations: Students complete simulated provider–patient–scribe scenarios asynchronously using video submissions, case study documentation, or audio-based encounters through the Course Management System (CMS).

Simulation rubrics assess accuracy, completeness, professionalism, and compliance with HIPAA and documentation standards.

All materials (scripts, templates, videos) are available within the Course Management System (CMS) and include accessible captioning and formatting.

Students upload documentation files through the Course Management System (CMS) Assignments; instructors return scores and comments within seven (7) days.

Optional synchronous feedback sessions, conducted via district-approved, accessible video software, allow for clarification or review of key errors.

All course materials, tools, and activities meet ADA and Section 508 accessibility standards, ensuring accessibility requirements are met.

Method

Simulation

Integration

Students evaluated on their ability to convert clinical case studies and simulated encounters into complete and accurate patient records using either SimChart or course-provided charting templates.

In-Person (Hybrid): Students complete live documentation exercises in class, using EMR software to chart patient-provider encounters based on video clips or scripted interactions. Performance is evaluated based on accuracy, completeness, and the use of appropriate terminology.

Online Adaptation: Students complete EMR-based assignments remotely, submitting patient records electronically through the CMS (Canvas). Simulated encounters are presented as videos or written case studies, and documentation will be assessed using a standardized rubric.

DE Adaptations for MOE

DE Apdaptations: Students complete simulated provider–patient–scribe scenarios asynchronously using video submissions, case study documentation, or audio-based encounters.

Simulation rubrics assess accuracy, completeness, professionalism, and compliance with HIPAA and documentation standards.

All materials (scripts, templates, videos) are available through the Course Management System (CMS) and include accessible captioning and formatting.

Students upload documentation files through the Course Management System (CMS) Assignments; instructors return scores and comments within seven (7) days.

Optional synchronous feedback sessions, conducted via district-approved, accessible video software, allow for clarification or review of key errors.

All course materials, tools, and activities meet ADA and Section 508 accessibility standards, ensuring accessibility requirements are met.

Assignments

Assignment Type

Other

In-class and/or outside of class

In-class
Outside of class

Formative or Summative

Formative

Assignment

Quizzes: Weekly quizzes test comprehension of medical terminology, body systems, documentation structure, and compliance concepts. Each quiz reinforces lecture content and prepares students for case studies, charting, and simulations.

You will complete a 15-question quiz on the components of the History of Present Illness (HPI), identifying correct terminology and documentation order.

How assignment will be adapted in online format

Hosted in Canvas using auto-graded multiple-choice and true/false formats. Randomized questions maintain integrity. Immediate scoring is provided; any short-answer components receive feedback within 72 hours.

Assignment Type

Other

In-class and/or outside of class

In-class

Formative or Summative

Summative

Assignment

Role-Play Simulation: You will act out patient-provider-scribe scenarios and document their encounters in real time using course templates or EMR software (SimChart or SIMS).
The exercise builds active listening, medical reasoning, and documentation speed.

Three students role-play a scenario involving a patient with abdominal pain. The "scribe" documents the full encounter, including the chief complaint, HPI, ROS, PE, and plan, while the "provider" dictates and the "patient" responds.

How assignment will be adapted in online format

You will record short videos or submit written scripts with completed charts through Canvas.
Rubrics assess accuracy, completeness, professionalism, and compliance with relevant standards. Feedback and grading are returned within seven (7) days.

Assignment Type

Writing

In-class and/or outside of class

In-class
Outside of class

Formative or Summative

Summative

Assignment

Case Study Charting: You will convert assigned case studies into SOAP notes or EMR-formatted documentation using accurate terminology and structure. This reinforces correct note formatting and integration of diagnostic results.

A case study describes a diabetic patient with foot ulcers. You must chart the visit, including subjective data, objective findings, assessment, and treatment plan, while using proper medical abbreviations and complying with applicable compliance standards.

How assignment will be adapted in online format

You will complete documentation digitally in Word, an EMR template, or Canvas charting tools and upload their files.

Instructor provides rubric-based feedback and correction suggestions within seven (7) days.

Assignment Type

Reading

In-class and/or outside of class

Outside of class

Formative or Summative

Formative

Assignment

You will complete assigned textbook readings and review instructor-provided visual media and lecture notes each week to prepare for class discussions, simulations, and quizzes.

The readings reinforce medical terminology, anatomy, and clinical workflow concepts used in charting, dictation, and EHR documentation.

Week Topic: History of Present Illness (HPI) and Review of Systems (ROS)

Reading: The Complete Medical Scribe, Ch. 2–3 (pp. 35–67)

Task: As you read, highlight key HPI elements (location, quality, severity, duration, timing, context, modifying factors, associated symptoms).

Application: Bring one patient scenario example or a short paragraph demonstrating how these HPI elements could be documented in a SOAP note.

This activity connects reading comprehension to real-world charting and prepares students for their upcoming role-play simulation.

Purpose:
Encourages pre-class preparation, strengthens terminology fluency, and builds confidence in applying textbook concepts to clinical documentation.

How assignment will be adapted in online format

All readings and lectures are delivered using presentation software and visual media, and supplemental materials are posted in Canvas Modules.

You will complete short reading checkpoints or interactive knowledge checks (e.g., Canvas quizzes or annotated PDFs).

The instructor provides weekly feedback or summary notes in announcements to confirm understanding and maintain Regular Substantive Interaction (RSI).

Assignment Type
Writing

In-class and/or outside of class
Outside of class

Formative or Summative
Formative

Assignment
Discussion Posts: Students discuss real-world scenarios involving documentation errors, ethics, or workflow challenges. They post an initial response and reply to at least two peers using professional, constructive feedback.

Prompt: Describe an example where missing or incorrect documentation could lead to a patient safety issue. How would you prevent it?

Students analyze causes, propose prevention strategies, and evaluate peers' responses.

How assignment will be adapted in online format
Completed in Canvas Discussions. Instructor posts guiding questions, joins threads, and provides weekly summary feedback to sustain Regular Substantive Interaction (RSI).

Assignment Type
Reading

In-class and/or outside of class
Outside of class

Formative or Summative
Formative

Assignment
Reflection Journal: You will reflect on your growth in documentation accuracy, comprehension, and professionalism after each simulation or case study.

This assignment encourages self-assessment and goal-setting.

Prompt: After this week's simulation, identify one documentation error you made and one strength you demonstrated. How will you improve next time?

How assignment will be adapted in online format
You will submit as written entries or short recorded reflections in CMS Assignments.
Instructor responds with written or video feedback within seven (7) days, highlighting progress and next steps.

Assignment Type
Other

Formative or Summative
Summative

Assignment

Final Exam: For the final exam, you will be given a cumulative assessment covering all course chapters, terminology, lecture topics, and documentation principles introduced throughout the semester.
You will be evaluated on your ability to recall key concepts, apply terminology correctly, and demonstrate understanding of the medical scribe workflow, including compliance, professionalism, and documentation accuracy.

The exam consists of multiple-choice and true/false questions drawn from prior weekly quizzes, lecture content, and assigned readings. Questions assess both knowledge recall (e.g., anatomy and terminology) and conceptual understanding (e.g., ethical charting practices, HIPAA compliance, EHR navigation).

Identify the correct documentation component for this note entry:
“The patient reports sharp chest pain lasting 3 hours, worsened by movement.”

A) Review of Systems

B) History of Present Illness

C) Physical Examination

D) Assessment

This final exam demonstrates mastery of course learning outcomes, integrating terminology, charting accuracy, and compliance knowledge into a single comprehensive evaluation.

How assignment will be adapted in online format

You will be given a cumulative assessment covering all course chapters, terminology, lecture topics, and documentation principles introduced throughout the semester. You will be evaluated on your ability to recall key concepts, apply terminology correctly, and demonstrate understanding of the medical scribe workflow, including compliance, professionalism, and documentation accuracy. You will submit the final exam through the Course Management System (CMS).

The final exam will be administered via the Course Management System (CMS) as a timed, randomized assessment composed of multiple-choice and true/false questions.

To preserve exam integrity, the Course Management System (CMS) settings include shuffled questions and limit the number of attempts. Feedback and final grades are posted within seven (7) days.

If required, district-approved, accessible remote proctoring software may be used for verification.

Assignment Type

Writing

In-class and/or outside of class

Outside of class

Formative or Summative

Summative

Assignment

Culturally Competent Documentation in Diverse Patient Encounters

This assignment develops awareness of bias in medical documentation. It strengthens skills in equitable communication and accurate, culturally sensitive charting, which are the core competencies for healthcare professionals working in diverse environments.

You will reflect on how cultural, linguistic, religious, gender, or socioeconomic differences influence patient–provider communication and the accuracy of documentation. You will select one of several scenarios (e.g., patient using an interpreter, elderly patient with cultural treatment beliefs, or patient with financial barriers to medication) and write a 2–3-page reflection analyzing: Communication

or documentation barriers, the impact of culture or identity on patient interactions, and strategies scribes can use to ensure accurate, unbiased, and respectful charting.

Part 1. You will choose one of the following scenarios (or propose your own with instructor approval):

a. A patient with limited English proficiency describing symptoms through an interpreter.

b. An older adult with cultural beliefs that affect treatment adherence.

c. A patient from a low-income background is hesitant to discuss medication affordability.

d. A Native American patient who prefers traditional healing methods and is hesitant about prescribed Western treatments.

e. A deaf or hard-of-hearing patient using an ASL interpreter during a telehealth visit.

f. A patient experiencing homelessness with inconsistent follow-up and limited access to medications.

g. A Jehovah's Witness patient refusing a blood transfusion after trauma.

Support from at least two credible references (APA-formatted), such as the CDC Office of Health Equity or The Joint Commission's Cultural Competency Standards.

Part 2. You will participate in a peer feedback activity through the Course Management System (CMS).

a. Review two classmates' reflections.

b. Comment on examples of inclusive or bias-free documentation.

c. Engage respectfully in discussion on how cultural awareness improves patient trust and chart accuracy.

Grading Rubric: Evaluated based on accuracy, cultural sensitivity, reflection depth, and application of equitable documentation strategies.

How assignment will be adapted in online format

Students will submit their written reflection through Canvas and participate in a peer feedback discussion. Each student will review two classmates' submissions and comment on examples of inclusive or bias-free documentation. Follow-up discussion prompts will encourage application of cultural competency concepts to real-world scribing practice.

Course Materials

Textbooks

ABC Scribe LTD. (2023). The Complete Medical Scribe: A guide to accurate documentation. Elsevier. ISBN: 9780323812658

Class Size Information

Class Size

40

Class Size Category

A - Lecture/discussion 40

Diversity and Inclusion

Course Design and Materials: Course will incorporate diverse perspectives, authors, and examples that reflect a variety of cultures, identities, and lived experiences. Instructional materials will be reviewed regularly to ensure representation, inclusivity, and alignment with equity-minded practices across disciplines.

Inclusive Learning Environment: Instructors will establish classroom norms and policies that promote respect, civil discourse, and belonging in both online and face-to-face classes. Clear expectations for communication and engagement will support a learning space where all students feel valued and heard.

Accessible Instruction: Course content will be delivered using accessible design. Materials will follow accessibility guidelines within the CMS, including captioned media, readable document formats, and multiple means of engagement to support diverse learning.

Equitable Teaching Practices: Instructors will use transparent and grading criteria, varied assessment methods, and timely feedback to promote fairness and student success. Opportunities for revision, reflection, and multiple demonstrations of learning may be incorporated when appropriate to the discipline.

Culturally Responsive Pedagogies: Instructional strategies will encourage critical thinking about diverse perspectives and systems of power relevant to the course content. Faculty will foster opportunities for students to connect course material to real-world contexts.

Ongoing Reflection and Improvement: Faculty will engage in continuous professional development related to IDEAA principles and reflect on course practices using metacognition to identify opportunities for increased equity, inclusion, and accessibility.

Explain how diversity and inclusion(e.g., gender, culture/race, sexuality, etc.) is infused into the course.

Diversity and inclusion are embedded throughout MA-775, both in its content and delivery. Case studies, role-play scripts, and patient scenarios represent individuals from varied racial, cultural, gender, age, linguistic, and socioeconomic backgrounds to mirror real-world healthcare diversity. Students learn to apply culturally competent documentation practices by using person-first, bias-aware language and recording interpreters, pronouns, or cultural preferences appropriately in the medical record.

Lecture and discussion materials highlight topics such as health disparities, social determinants of health, and communication barriers that influence patient outcomes. The DEI-Focused Reflection assignment requires students to analyze how identity factors (e.g., language, religion, gender identity, or financial status) affect communication accuracy and documentation quality. Feedback during simulations and chart reviews reinforces equitable and respectful documentation, addressing implicit bias.

Simulations (in hybrid form: in-person role-play; online: video recordings or written scripts) promote equitable care documentation across diverse health scenarios. Culturally competent charting is discussed explicitly in lecture, assignments, and role-play feedback, helping students recognize and mitigate bias in documentation.

Video content and reading materials feature examples from the CDC Office of Health Equity and The Joint Commission's Cultural Competency Standards, connecting classroom learning to national best practices. Collectively, these strategies promote cultural humility, empathy, and professionalism, which are consistent with MSJC's Institutional Learning Outcome #4. Video and lecture content highlight language barriers, health disparities, and real-world examples involving underserved communities.

Describe how assignments, instruction, evaluation, course content, and interactions are contextualized for diverse learners promoting an equitable course.

Online: Students complete assignments through various media (typed notes, scanned notes, videos), allowing flexibility in how they demonstrate their learning.

Hybrid: In-person labs emphasize collaboration, feedback, and hands-on simulation, incorporating inclusive language prompts and rotating roles to ensure fairness.

Course Content: Modules incorporate cultural considerations within every major unit, such as HIPAA and confidentiality, patient communication, ethics, and documentation standards, so that students understand how bias or cultural assumptions can impact the medical record.

Instruction: Lectures and demonstrations use inclusive language and examples from a broad spectrum of patients and providers. All course materials are captioned, transcribed, and formatted for accessibility. Instructors model respectful communication and provide optional synchronous support through district-approved, accessible video software to ensure equitable engagement for all students. PowerPoints are paired with narrated videos and transcripts to meet the diverse accessibility needs of learners. Hybrid learners benefit from in-person reinforcement.

Assignments: Activities such as the DEI-Focused Reflection, Discussion Boards, and Role-Play Simulations invite multiple perspectives and allow students to demonstrate understanding through varied media (typed notes, video submissions, or recorded reflections). Scenarios highlight diverse patient populations, communication barriers, and ethical dilemmas, allowing students to practice inclusive documentation and problem-solving.

Evaluation: Rubrics emphasize professionalism, accuracy, and cultural responsiveness rather than subjective style. Feedback is individualized, timely, and constructive, focusing on growth and equitable assessment across all delivery modes. Evaluations include role-plays, quizzes, patient simulations, and open-format case responses, offering multiple ways to succeed regardless of background or preferred learning style.

Interactions: Inclusive discussion prompts and simulation rubrics encourage respectful and diverse student perspectives.

Interactions

Explain how the course will incorporate student-to-student interaction.

Student-to-Student Interaction

Face-to-Face: Students participate in live triad simulations (provider, patient, scribe) and peer chart-review sessions, building teamwork and cultural awareness through real-time interaction.

Hybrid: Through the Course Management System (CMS), rotating triads (provider/patient/scribe) and in-class peer chart reviews foster respectful collaboration and promote an understanding of diverse perspectives.

Online: Through the Course Management System (CMS), peer-review groups and paired note-swap discussions allow students to critique documentation with cultural awareness. Optional study rooms, utilizing district-approved, accessible video software, support synchronous dialogue and community building.

Explain how the course will incorporate instructor-to-student interaction.

Instructor-to-Student Interaction

Face-to-Face: Instructor provides in-class demonstrations, immediate oral feedback, and real-time coaching on documentation tone, structure, and inclusivity.

Hybrid: Through the Course Management System (CMS), real-time coaching during class and “minute-clinic” workshops enable immediate feedback on documentation tone and inclusivity.

Online: Through the Course Management System (CMS) weekly announcements, rubric-based comments, and optional virtual office hours provide consistent instructor presence and personalized feedback within 24–72 hours.

Explain how the course will incorporate student-to-content interaction.

Student-to-Content Interaction

Face-to-Face: Students engage directly with de-identified case materials, audio dictations, and live documentation exercises that connect lecture content to clinical application.

Hybrid: Students complete “listen-and-scribe” activities using de-identified audio recordings through the Course Management System (CMS) that represent multilingual patient encounters.

Online: Students access captioned videos, interactive templates, and culturally varied case studies through the Course Management System (CMS) modules, applying bias-free terminology and inclusive charting techniques.

Explain how the course will incorporate student-to-self interaction (metacognitive).

Student-to-Self Interaction (Metacognitive)

Face-to-Face: Students complete reflection prompts at the end of each class and participate in short verbal debriefs, identifying their documentation strengths and growth areas.

Hybrid: In-class debriefs and reflection cards or through the Course Management System (CMS) journal reflection to encourage students to identify areas for personal growth in cultural sensitivity.

Online: Reflection journals and DEI-focused reflections through the Course Management System (CMS) Canvas prompt; self-assessment of bias, empathy, and professional communication growth over time.

Self-reflection is a critical component of this course. Students will complete reflective journals and debrief activities to assess their documentation accuracy, empathy, and bias awareness. You will reflect on your learning progress, seek instructor feedback to refine your critical thinking, and share insights that support peer learning and professional growth.

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