Establishing an HIM Clerk Orientation Program

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Once you have hired the right candidate for your vacant position, it's time to orient and train. When I had access to a plethora of qualified candidates, managed a department with infrequent turnover, and employed credentialed staff who were all cross-trained to handle other positions in the department, I considered this task relatively easy.

When I needed to orient and train, I merely scheduled the new employee to attend the facility's orientation class and spent a little time with this individual reviewing policies, procedures, and guidelines. In addition, I asked the most qualified staff member to train the new employee and to monitor and report progress.

What I once considered simple, however, became much more challenging when I entered the ambulatory care arena. On two occasions, I stepped into positions where there were no credentialed staff, turnover was 100 percent, clerks numbered 25 to 100 FTEs, and qualified candidates were impossible to find.

Because turnover was high, new employees lacked previous training, and existing staff members were inexperienced. As a result, I developed an HIM clerk orientation program.

A Much-needed Solution

As a first step, I located the materials covered in the facility's overall orientation program. Typically, such programs include personnel and payroll matters, safety, hazardous waste, universal precautions, and incident reporting. Some organizations include confidentiality and compliance.

Then, using the HIM clerk job description and performance standards, I made a list of the subjects that were not covered in the facility's orientation program but were essential to HIM clerk success and the achievement of certain facility and departmental goals. Click here to view Topic List for HIM Clerk Orientation.

Then, I developed quizzes for medical record content, medical terminology, abbreviations, and number/color association. I also decided that new clerks should practice terminal digit and loose filing. Further, I added computer lab training to the orientation because new clerks would need to learn how to look up medical record numbers, compose and send electronic messages, and track charts in and out of the department. Click here to view Training an HIM Clerk.

With an outline in hand and after considering the time required to cover this material, I began discussions with the human resources department. The department agreed to:

- arrange additional classroom and computer lab space
- communicate the new orientation plan to their employees
- develop procedures to route all new clerks to the additional orientation program
- modify orientation packets

While the human resources department worked on these tasks, I developed a script, exercises, and handouts for the orientation topics and activities. The script included a welcome, announcements, ice breaker, and preview of each day's agenda. When there were transitions between morning and afternoon or from one day to another, I inserted a review of the materials covered in the preceding session and provided an opportunity for clerks to ask questions. Toward the end of the script, I inserted a request for both positive and negative feedback relative to the content of the orientation class.

Once the script and exercises were complete, I contacted human resources to confirm the start date for the new program and began preparing the outguides, sample charts, and student handouts that would be required in class.

Another Necessity: Staff Commitment

During regular HIM staff meetings, we discussed the new HIM clerk orientation, reviewed the content, and talked about expectations of existing staff in training new employees. Staff were asked to train any new clerk assigned to them and to monitor his or her productivity and accuracy. They were also asked to work through the orientation checklist and provide their own supervisor with feedback.

The initial HIM clerk orientation classes went well. As time went by, we made a few adjustments to the agenda, but found that in general the materials worked well.

Although the time commitments were significant, the effort spent orienting and providing new clerks with classroom training and reference materials at the beginning of their employment maximized consistency, minimized errors, and made for a much stronger HIM department.

HIM Clerk Job Description

Position Title: File Clerk 1 **Date:**
Department/Unit: HIM **Supervisor:**

A. Basic Purpose To collect, maintain, and make available to authorized users timely, accurate, and complete patient health information.

B. Reporting This position reports to the assistant manager of the Health Information Department.

C. Essential Functions

1. Prioritizes, locates, pulls, assembles, electronically tracks, and sees to the appropriate transport of records requested by other departments in accordance with established standards.
   Performance Standards
   a. retrieves all chart requests from in box no less than every five minutes
   b. pulls, assembles, delivers, and electronically tracks charts requested stat within 15 minutes of receipt
   c. pulls, assembles, electronically tracks, and delivers via cart runner charts requested for appointments prior to the appointment
   d. pulls, assembles, electronically tracks, and delivers via cart runner all other charts requested within one hour of receipt
   e. replaces charts pulled with an outguide that reflects where the chart is being delivered
   f. for patients with two appointments on the same day, completes appropriate transfer slip notifying first appointment to transport record to second appointment and second appointment record location at first appointment site
   g. places current year sticker on chart
   h. prior to delivery, correctly organizes documents in each patient's record according to the chart order policy

2. Keeps the requester of any record that was not in file notified of efforts to locate.
   Performance Standards

   a. notifies the requester of locate efforts prior to re-request

   b. documents notifications

3. Accurately files all charts belonging to assigned aisles to the appropriate location hourly.
   Performance Standards

   a. charts are filed accurately

   b. charts are filed hourly

   c. removes corresponding outguides

   d. transfers any loose filing in the outguide to the chart

   e. discards chart request slips from outguides removed

4. Accurately files all loose papers for assigned aisles within one business day of receipt.
   Performance Standards

   a. drop filing is performed accurately

   b. drop filing is completed within one business day of receipt

5. Maintains a clean aisle
   Performance Standards

   a. incomplete loose filing is properly sorted in aisle station

   b. incomplete chart pulls are readily found by anyone filling in during absence

   c. garbage is discarded d. work area is free of dirt, spillage, etc.

6. Assists aisle partner as needed
   Performance Standards

   a. pulls charts that can't wait when aisle partner is out of the department for breaks or lunch

   b. performs all aisle clerk duties that cannot wait until the next day when aisle partner is absent and other coverage is unavailable.

   c. if own work is complete, assists aisle partner in completing his/her work

7. Performs other work as needed/assigned.

Tools for Training an HIM Clerk

Topic List for HIM Clerk Orientation Program

- definition of a medical record
- the reason medical records are originated and maintained
- documents common to this facility's records
- medical terminology
- abbreviations
- chart order
- the HIM department's mission
- department performance standards
- HIM clerk job description
- confidentiality
- terminal digit filing
- terminal digit color codes
- outguides
- interpeting computer generated chart requests
- prioritizing chart requests
- locating charts that are not in file
- cleaning charts (anchoring loose filing)
- tracking charts in and out of the department
- delivering charts
- use of computers and software
- dress code, breaks, lunch, absences

Exercises for HIM Clerk Orientation

Quizzes

- medical record content quiz
- medical terminology
- number/color association

Computer Lab Activities

- master patient index introduction
- electronic mail introduction
- chart tracking introduction

How to Implement an HIM Clerk Orientation Program

1. Review the script and exercises.
2. Obtain a list of the subjects covered in your facility's orientation program.
3. Using the description and performance standards as a tool, generate a list of further topics to be covered.
4. Decide which subjects demand practice, quizzes, and computer lab training.
5. Determine how much time you need to cover the material.
6. Discuss your idea and develop an implementation plan with the human resources department.
7. Build a script.
8. Create icebreakers, exercises, and quizzes.
9. Assemble charts and outguides to be used in the exercises.
10. Design employee handouts.
11. Create the agenda.
12. Develop an orientation checklist.
13. Discuss the plan and expectations with existing staff.
14. Take existing staff through the new material.
15. Set a start date for the new program with human resources.
16. Make sure you have everything ready for the new class.
17. After teaching the first class, obtain feedback from students.
18. Make any program modifications necessary.

Sample HIM Clerk Orientation Program Script

Introduction to Medical Records and Record Contents

Medical Record Content Quiz

Chart Order Quiz

Introduction to Medical Terminology

Medical Terminology Quiz and Discussion

Introduction to Medical Abbreviations

Medical Abbreviation Quiz

HIM Department Mission and Performance Standards

Introduction to Confidentiality

Introduction to Terminal Digit Filing

Number/Color Association Quiz

Medical Record Filing Tips

Introduction to Medical Records and Record Content

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatments, and a plan for future care or treatment.

Why Are Medical Records Maintained?

Your medical record provides details about your health. Your record serves as a:

- basis for planning your care and treatment
- means of communicating between the many health professionals who contribute to your care
- legal document describing the care you received
- verification of services for which you or a third-party payer were billed
- source of data for health research and planning

Documents Common to This Facility's Medical Records

In your handouts is a sample chart containing many of the documents common to this facility's records. Please open your sample chart and let's talk about the documents it contains.

- on the top left side, you'll see a **growth chart**, a document on which a child's height and weight and sometimes head circumference are plotted on a graph, which allows easy comparison with what is considered normal
- on the bottom left side, you'll see a **registration form** or **face sheet**, a form originated at the time of registration. The registration form includes demographic information such as the patient's name, birthdate, social security number, address, telephone number, insurance type, and policy number
- the **health maintenance sheet** is a list of significant illnesses and surgeries, and a checklist of certain procedures, immunizations or tests a physician wants to conduct periodically, and the last time they were performed
- the **medication record** on the back side of the health maintenance sheet is a list of all the medications prescribed for a patient
- the **immunization record** documents immunizations given for diseases such as polio, diphtheria, pertussis, tetanus, measles, mumps and rubella, polio, and influenza. This document is most commonly found in the charts of children and

young adults. In your sample chart, this document is placed immediately behind the health maintenance record

- **progress notes** are typed or handwritten notes made by the doctors, nurses, medical assistants, therapists, and other staff providing healthcare to a patient. They reflect the patient's response to treatment, and the writer's observations and plans for continued treatment. In this facility's record, progress notes are placed right behind the health maintenance and immunization records. The notes are placed in reverse date order. In other words, the most recent is on top
- a **history and physical** is a document that describes any major illnesses and surgeries a patient has had, any significant family history of disease, health habits, and current medications. In addition, it usually documents the patient's height, weight, blood pressure, pulse, respiration, any symptoms the patient described, and the physicians' findings on examination. When the history and physical is performed at this facility, it is filed as if it is a progress note

- A **consultation** is an opinion about a patient's condition made by a physician other than the primary care physician. Sometimes a consultation is performed because a physician would like the advice and counsel of another physician. At other times, a consultation occurs when a patient requests a second opinion. A consultation may look like a letter or it may be recorded on a specific consultation form. A consultation performed by one of our physicians or at the request of one of our physicians, at a facility other than a hospital, is also filed as if it were a progress note

- **lab reports** describe the results of tests conducted on body fluids and waste products such as blood, sputum, and urine. Common examples would include a throat culture, urinalysis, cholesterol level and complete blood cell count. Pathology reports describe tissue removed during an operation and give a diagnosis based on examination of that tissue. Regardless of type, these lab and pathology reports are filed in reverse date order behind the "Lab" divider. Note: your health record does not usually contain your blood type. Blood typing is not part of routine lab work

- **imaging and x-ray reports** are documents describing x-ray results, mammograms, ultrasounds, CT, MRIs, or other scans. The actual films are maintained in the radiology or diagnostic imaging department. Regardless of test type, imaging and x-ray reports are filed behind the "X-ray" divider in reverse date order

- An **electrocardiogram (EKG or ECG)** report is the cardiologist's interpretation of graphic tracings that represent the electrical changes in the heart as it beats. It is one of many tests that are not considered lab, x-ray, or diagnostic images. An EKG report is filed behind the "Procedures" divider

- There are many legal documents that may become part of a patient's medical record. These legal documents might include guardianship or custody papers, or advance directives such as a living will or durable power of attorney. At the present time, these documents are filed behind the "Special Records" divider. Other reports that might be considered particularly sensitive are also placed behind the "Special Records" divider. Examples include child abuse report forms and HIV test results. We'll talk a little more about the reason for placing these records behind this tab when we discuss confidentiality

- a **discharge summary** is a concise summary of a hospital stay including the reason for admission, significant findings from tests, procedures performed, therapies provided, response to treatment, condition at discharge and instructions for medications, activity, diet, and follow-up care. Discharge summaries are filed behind the "Hospital" divider

- an **operative report** is a document describing any surgery performed, the names of surgeons and assistants. Operative reports generated at a hospital or are also found behind the "Hospital" divider. When consultations and history and physicals are generated during a hospital stay, they too are filed behind the "Hospital" divider

- **authorization forms** include copies of consents for admission to hospitals, treatment, surgery, release of information, as well as PPO and HMO authorization and referrals. These forms are intermingled behind the "Authorization" divider

As a general rule, most of the documents filed in a medical record are filed in reverse date order (latest on top) to make it easier to find the most pertinent material and easier to file.

Let's take a few minutes to see if what I've talked about makes sense to you. I'm distributing a quiz. I'd like you to take a few minutes to answer questions 1-13. When you're finished, we'll go over them together.

Medical Record Content Quiz

Click here for the answers

Name:_____

Date:_____

Instructions: Use a letter from the table at the bottom of the page to indicate the document on which you would expect to find the following:

Example: chest x-ray (Answer is F)

1. a throat culture___
2. a summary of a hospital stay___
3. a child's height and weight plotted on a graph___
4. the date of a measles, mumps, and rubella shot___
5. the patient's health history and physician's findings on physical exam___
6. a second opinion made by a physician other than the primary care physician___
7. mammogram___
8. blood type___
9. a list of the patient's diagnoses and surgeries___
10. notes made by doctors, nurses, therapists, and social workers that describe their observations and plans___
11. the patient's address, phone number, social security number, and insurance___
12. a description and diagnosis related to tissue removed during an operation___
13. a description of surgery performed___

A. consultation
B. discharge summary
C. growth record
D. health maintenance record
E. history and physical
F. imaging and x-ray reports
G. immunization record
H. lab report
I. not in patient's chart
J. operative report
K. pathology report
L. progress notes
M. registration or face sheet

Answers

1. H
2. B
3. C
4. G
5. E
6. A

7. F
8. I
9. D
10. L
11. M
12. K
13. J

Chart Order Quiz

(answers in Parentheses)

In your handouts you were provided a chart order policy, a sample chart, and some extra documents that need to be place in the correct order. Let's place these documents in the correct location in the chart using the chart order policy as a guide:

documents in packet	placement in chart
1. pap smear	(lab)
2. PSA	(lab)
3. chest x-ray	(x-ray)
4. MRI	(x-ray)
5. phone message (explain treated as progress note)	(progress notes)
6. prescription refill (explain treated as progress note)	(progress notes)
7. lab result letter	(lab)
8. HMO authorization form	(authorizations)
9. old records	(old records)
10. hospital records	(hospital)

Introduction to Medical Terminology

You may find medical records difficult to read. Often, much of the material is handwritten and contains medical terminology and abbreviations.

Much of the medical terminology used in medical records consists of Greek and Latin prefixes, root words, and suffixes. Learning common medical terminology can be both helpful and fun.

Following are a few examples:

- **hyper** at the front of a word means above, beyond or excessive; therefore, hyperthyroidism means the thyroid gland is too active
- **hypo** is a prefix that means below, under, or deficient; therefore, hypothyroidism means the thyroid gland is not as active as it should be
- **itis** is a suffix that means inflammation of; therefore, tonsillitis means inflammation of the tonsils and appendicitis means inflammation of the appendix
- **ectomy** is a suffix that means removal of; therefore, tonsillectomy means removal of the tonsils and appendectomy means removal of the appendix

Let's look at some other prefixes, root words, and suffixes.

Examples of prefixes are:

Prefix	Meaning	Example
ab	away from	Abnormal
bi	twice, double	bilateral;
brady	slow	Bradycardia
dys	bad, difficult	dyspnea
endo above,	within	endoscopy
hemi	half	hemisphere
hyper	above, beyond, or excessive	hyperactive
hypo	below, under or deficient	hypo-thyroidism
inter	between	interstate
intra	within	intravenous
micro	small	microscopic
pre	before	pre operative
post	after	postoperative
sub	below, under	submarine
super	upper, excessive	superman
tachy	fast	tachycardia
trans	across, through, beyond	transcontinental
ultra	beyond, in excessive	ultralight
uni	one	unicycle

Examples of root words and anatomical structures are:

Root	Meaning	Example
adeno	gland	adenopathy
arterio	vessel	arterio-sclerosis
arthro	joint	arthritis
broncho	windpipe	bronchitis
cardio	heart	cardiopathy
cephalo	head	hydro-cephalic
cerebro	brain	cerebro-spinal fluid
cholecyst	gallbladder	cholecyst-ectomy
derma	skin	dermatitis
emia	blood	anemia
encephalo	brain	encephalitis
gastro	stomach	gastritis
hydro	Water	hydro-cephaly
pathy	disease	cardiopathy
hystero	Uterus	hyster-ectomy
hepato	liver	hepatitis
laryngo	larynx	laryngitis
meningo	covering to the brain and spinal cord	meningitis
naso	nose	nasogastric tube
nephro	kidney	nephrology
neuro	nerve	neurology
oculo	eye	intraocular
oto	ear	otolaryngologist
phag phago	eat	dysphagia

pharyngo	throat	pharyngitis
pneumo	lungs	pneumonia
rhino	nose	rhinorrhea
sclerosis	hardening	arteriosclerosis
thryo	thyroid	thyroidectomy
uro	urinary	urography

Common suffixes include:

Suffix	**Meaning**	**Example**
ectomy	removal of	tonsil-ectomy
itis	inflammation of	otitis
ology	the science or study of	cardiology
oma	tumor	lymphoma
oscopy	the act of examining	broncho-scopy
otomy	cutting or incision	laparotomy
pathy	disease	cardiopathy
plasty	repair of	rhinoplasty
plegia	paralysis	hemiplegia
rrhea	flow, discharge	diarrhea

Medical Terminology Quiz/Discussion

(answers in parentheses)

Now let's put these prefixes, root words, and suffixes to work.

1. Children often have earaches. Of course, the doctor doesn't call it an ear ache. He might say the child has _____. Using your handouts, find a root word that means "ear." Now add a suffix that means "inflammation of." What do you get?

   (Answer: oto-itis. Let's eliminate the second "o" so it's easier to pronounce and we get "otitis.")

2. Using the same logic, let's make up a word for inflammation of the nose.

   (Answer nasitis or rhinitis okay. Explain that for some reason nasitis isn't used, but rhinitis is.)

3. Since -ectomy means removal of, tonsillectomy is removal of the tonsils, appendectomy is removal of the appendix, what would removal of a kidney be?

   (Answer: nephro-ectomy. Let's eliminate the second "o" once again so it's easier to pronounce and we get "nephrectomy.")

4. What does gastrology mean?

   (Answer: study of the stomach or digestive system)

5. Using the handout of the root words provided, what would the word for study of the heart would be?

   (Answer: cardiology)
   nervous system?(Answer: neurology)

urinary system? (Answer: urology)

6. Take a few minutes to make up your own medical term using the prefixes, root words and suffixes provided. Then, we'll go around the room and share our word and it's meaning.

Introduction to Medical Abbreviations

Abbreviations are used to save time. Some common abbreviations are:

Abbreviation	Meaning
BP	blood pressure
c	with
CBC	complete blood count
CT	computerized tomography
DPT	diphtheria, pertussis, tetanus
DT	diphtheria, pertussis
ENT	ear, nose, and throat
HA	headache
HCT	hematocrit
HGB	hemoglobin
H&P	history and physical
MMR	measles, mumps, rubella
MRI	magnetic resonance imaging
prn	as often as necessary
Pt	patient

PT	protime or physical therapy
RBC	red blood cell count
OM	otitis media
s	without
SOB	shortness of breath
Stat	immediately
UA	urinalysis
URI	upper respiratory infection
UTI	urinary tract infection
WBC	white blood count
WNL	within normal limits

Some abbreviations have more than one meaning so you may need to ask your supervisor for clarification.

Medical Abbreviation Quiz

(correct answers appear in bold print)

Name:_____

Date:_____

Instructions: Circle the letter to the left of the best answer to each question.

1. If a physician were to call and ask for a record stat, what would he mean?

   a. he wants a statistic from a patient's medical record

   b. the physician wants the record delivered the next regular delivery

   c. the physician wants you to deliver the record immediately

2. If a medical assistant were to ask you to find the results of the last UA, what would you be looking for?

   a. an x-ray of an ulna

   b. uric acid test results

c. a urinalysis

3. If a nurse called and needed to know the date of the last tetanus shot, you would look on the immunization record or in the progress notes for the word tetanus or what abbreviation?

   a. DPT

   b. TET

   c. TNS

4. If a physician called and wanted a copy of the last H & P, what is he asking for?

   a. heart and pericarditis findings

   b. history and physical

   c. H2 antagonist test results

5. What does the abbreviation CBC stand for?

   a. complete blood cell count

   b. carcinoma, basal cell

   c. congenital blindness, complete

6. What is a CT report?

   a. computed tomography scan

   b. a record of chemotherapy

   c. a connective tissue test result

The HIM Department's Mission and Performance Standards

The HIM department is comprised of (insert number FTEs) staff at (insert number) sites. Our purpose is to collect, maintain, and make available to authorized users, timely, accurate, and complete patient health information.We are expected to perform these functions in a way that maintains the privacy of each patient's health information.

The performance or success of the department is measured against the following:

- medical records requested stat are delivered within 15 minutes of the request
- medical records requested for appointments are delivered prior to the appointment
- other medical records requested are delivered within 60 minutes of the request
- dictation is transcribed within one business day of receipt
- loose filing is accurately filed in the chart within one business day of receipt

- patient records contain only reports belonging to that patient, and documents are placed in the proper location within the chart 100 percent of the time
- written requests for patient health information from those outside the clinic are responded to accurately and within three business days

Introduction to Confidentiality

To properly diagnose and care for patients, physicians must have accurate histories and honest answers to the questions they ask their patients. Patients need to know that the private information they share with physicians will not be communicated to others without the patient's knowledge and permission. The responsibility to keep this information confidential extends not only to the physician, but to the rest of us who work in healthcare as well.

In the HIM department, we may share health information with other employees who, in performing their job, have a legitimate need to know. We must not share patient health information:

- with employees who do not have a legitimate need to know
- in the hallways, bathrooms and eating areas
- when there are guests in the department who might overhear
- in any manner that is disrespectful

In general, releasing health information outside the clinic is performed by either the physician or his nurse (when referring a patient to another healthcare facility) or by the release of information section of the HIM department.

If you see an authorization to obtain or release copies of a patient's record that has not come in accompanied by a packet of patient health information from elsewhere, then send it to the release of information section who will:

a. process the request

b. sign and date it

c. log it in the computer

d. file it in the patient's chart

In our state, it's against the law to release HIV test results, even when negative, except with the patient's permission or under special circumstances that are spelled out in the law. We should not even confirm that a patient had an HIV test without making sure we're authorized to do so by law. For this reason, we file HIV test results behind the "Special Records" tab in the chart.

In addition to the special precautions we take for HIV results, we should also be particularly sensitive to releasing health information relative to:

- AIDS, for the same reasons we're sensitive to releasing HIV information
- drug and alcohol abuse because release of that information to someone who doesn't already know it could cause the patient harm and particularly in the area of substance abuse, it's possible family members have shared something with the physician the patient doesn't know. We want to avoid creating additional problems in the family
- child abuse because accidental release of this type of information to the wrong individual could cause additional abuse or problems. We will report it to the proper authorities who will investigate and take appropriate action

- minors with sexually transmitted diseases, behavioral health problems, or who are receiving family planning or treatment, because minors with these health care problems are by law, often treated as adults. In other words, the minor may have to give consent before the parent can see the record entries related to these diagnoses or problems.

The bottom line is that patient health information is confidential. If you or I release it inappropriately, we may lose our jobs and/or be sued in civil court. When you're ready to learn more about confidentiality, ask your supervisor for copies of our policies on confidentiality.

Introduction to Terminal Digit Filing

Our facility issues a six-digit number called a history number to each new patient. This history number is used to number the chart and the reports that are to be placed in the chart. Although the numbers are assigned sequentially, i.e., 000001, 000002, they are filed in terminal digit order.

As you know, the word terminal can mean "end." Terminal digit order refers to a filing system in which files are organized starting with the end or terminal digits of the number assigned.

Imagine that a six digit history number has dashes between each two digits. For example, visualize 000001 as 00-00-01, and 000002 as 00-00-02. When we look at only two numbers at a time, we are less likely to make filing errors. Terminal digit filing forces us to focus on two digits at a time.

To file the chart 00-00-01, we would first locate the 01 section. The sections are in numerical order, for example 00, 01, 02, 03, 04, etc. To file the chart 00-00-02 we would first locate the 02 section.

After locating the correct section based on the last two digits, we would then look at the middle two digits. If the history number was 12-34-56, we would first find section 56 and then, the 34th place in that section. (In actuality, it's really the 35th place because the numbers begin with zero.)

There would be numerous records that end in 34-56 so we would then look at the first two numbers. If the first two digits were 12, the record would be placed after 11 in the section ending with 34-56.

(At this time, pass clerks a group of records to put in the order as they would appear in a filing cabinet. Look over and discuss any patterns of problems.)

Terminal Digit Filing System Colors

To make it easier to locate charts and misfiles, colors are associated to the last four digits of the patient's history number. The colors used at our facility are as follows:

Number	Color
0	red
1	gray
2	blue
3	orange
4	purple
5	black
6	yellow
7	brown
8	pink

Thus, records that end in 00 always have two red stripes toward the bottom edge (show example). A chart that ends in 56 has a black and yellow stripe toward the bottom edge (show example). Chart number 00-00-00 has four red stripes on the edge (show example). The chart number 00-00-01 has three red stripes over a gray stripe (show example). The chart number 00-00-02 has three red stripes over a blue stripe (show example). Working down the edge, a chart with a history number 12-34-56 has an orange, purple, black, then yellow stripe (show example).

Using the number/color table provided, please take a moment to complete the quiz I'm passing out now.

Terminal Digit/Color Association Quiz

Name:_____

Date:_____

Instructions: For each history number listed below, record the color of the last four stripes, in the order they would appear down the edge of the chart.

History Number	Last Four Stripes Down Chart Edge
00-00-00	red, red, red, red
00-00-05	red, red, red, black
01-01-01	red, gray, red, gray
02-01-01	red, gray, red, gray
03-01-11	red, gray, gray, gray
03-12-59	gray, blue, black, green
59-03-12	red, orange, gray, blue
99-99-99	green, green, green, green
44-47-62	purple, brown, yellow, blue
44-84-90	pink, purple, green, red
35-74-25	brown, purple, blue, black
83-27-23	blue, brown, blue, orange
17-21-33	blue, gray, orange, orange
29-32-45	orange, blue, purple, black
61-52-78	black, blue, brown, pink
79-58-81	black, pink, pink, gray
13-67-32	yellow, brown, orange, blue

Let's review your answers. Grasping the numbering and color system is important to your job. Understanding the numbering is essential for locating and filing charts and documents properly. Recognizing the color patterns will make locating charts faster, you much more efficient, and completing your work less stressful.

If the way I've taught it today doesn't make filing and locating charts by color clear to you, please see me during a break or after class and we'll make arrangements to go to the department where you can see it in a more hands-on way.

Other Filing Tips

A. Outguides

- whenever we pull a chart from a file, we insert a plastic outguide in its place. In the plastic outguide, we insert a piece of paper that identifies the chart by name and number, the date it was sent and where it was sent
- should loose filing come in for a particular patient while the chart is out of the department, we can put the loose filing in the outguide. When the chart returns, we then place the filing in the chart and remove the outguide
- other than when filing a brand new chart, there should always be a corresponding outguide when you file a chart. If there isn't one, then you might want to double check the accuracy of your filing as you may be misfiling the chart
- in addition to outguides, another important rule for filing is to always double check to make sure the name of the chart or report being filed matches either the name on the chart or name on the outguide, as it is possible someone made a mistake in numbering

B. Chart Requests

Most chart requests will print to the department through a software system called (insert name of software used to generate chart requests for appointments.)

- **appointments:** the computer automatically prints a chart request for any patient with an appointment to the HIM department at the site of the appointment. I've enclosed samples of chart requests for appointments
    - in the top left corner, you'll see the patient's name
    - on the second line in the right corner, you'll see the history or medical record number
    - under the "Appointment" title, you'll see the appointment scheduled. It will tell you the date, time, and provider . Use this information to help you prioritize your pulls. If all the charts you need to pull are due about the same time, put the chart requests slips in terminal digit order so pulling will go faster.
    - one copy of the chart request slip goes in the front pocket and the other in the outguide. There's a third copy that's sometime used for purposes of measuring how well we're performing. Ask your lead or trainer if you need to do anything with the third copy (at this time)
- **messages/rx refills, etc.:** the computer prints chart requests for messages, prescription refills or other purposes as requested by a receptionist, medical assistant or other staff member
    - these chart requests print to the HIM department at the home chart location (HCL) recorded in the (name of software) system

- there's a field that specifies what the HCL is. If maintained properly, the HCL field should represent the location of the primary care physician

- I've enclosed samples of chart requests that printed to the department for other than an appointment
- on the top left side, you'll see the patient's name
- on the third line in the right corner, you'll see the history or medical record number

- below the chart number, there should be codes for the requester and the reason for the pull
- I've provided a list of the requester codes

- requesters are suppose to use the two digit reason codes below to help us prioritize
- let's look at the chart request slips in your packet and determine where they should be delivered, the reason they're being requested, and how long before they need to be delivered

Reason Codes

Code	Reason for chart request	Expected time of delivery
CH	Change HCL	60 minutes
FM	Form	60 minutes
FO	Front Office	60 minutes
LB	Lab	60 minutes
MG	Message	60 minutes
RE	Referral	60 minutes
RI	Release of Information	60 minutes
RX	Prescription Refill	60 minutes
ST	Stat	15 minutes
XR	X-ray	60 minutes

Telephone Requests: some requests for charts come over the telephone. In your packet, I've enclosed the form we use to take these requests. When taking the request, be sure to record:

- the patient's full name
- the requester
- the history or medical record number
- when the record is needed
- the date and time ordered
- the individual taking the request

When any part of this information is missing, it can make it difficult for the aisle clerk to process the request.

If the caller does not have the history or medical record number, try to get a birthdate or social security number. Then, look up the history number in the computer. That's something we learned when we went to the computer lab.

C. Prioritizing

So, you've got all these chart requests coming in and you have charts to file and loose filing. How do you prioritize?

- remember that we have 15 minutes to deliver a stat chart request so always pull those and deliver them first
- we must get charts to appointments prior to the appointment, so when you pick up your chart requests every five minutes or so, organize them so you're doing them in the order they're needed
- all other charts requested are to be delivered within an hour
- sort your loose filing into a file sorter as you bring it back to your aisle. File loose reports when it's slow in your aisle, for example early in the morning or at lunch
- keep on top of your loose filing. If you let it back up more than one business day, you'll waste valuable time looking for loose filing for callers and fall farther and farther behind
- file your charts back every hour
- find someone in the department who keeps on top of their aisle and makes it look easy. Ask them how they do it.
- everyone struggles to keep up at first. If you're not able to keep up, however, make sure you're not being overly sociable. If you are, socialize less and work more until you learn to perform your duties and have some time to socialize. If that's not the problem, discuss the need for assistance, overtime, or more training with your supervisor

D. Locating When Not in File

What do you do when you have to pull a chart to pull that isn't in file?

- check the outguide to see when and to whom the chart was last sent

- check the chart tracking software (one of the software systems you learned to use during the computer lab)
- if the record says it's at the requester's location, call and tell them it's checked out to them and ask them to double check and make sure they don't already have it. If they insist they don't have it, check charts just returned to the department and/or that await filing. Once you're confident the record is not in HIM, ask the HIM unit liaison for help.
- if locating the chart takes more time than expected, keep the requester informed of your efforts to locate via phone or electronic message. (Messages are something we learned during our computer lab.)

E. Cleaning Charts

Before you send a chart to a requester:

- anchor any loose filing in the appropriate chart location
- glance through the record to make sure things are in the right order
- if you see errors, correct them

F. Tracking Charts In and Out of the Department

It's extremely important that we track records in and out of the department using our chart tracking software, as it can save us hours looking for a chart. You learned how to track records electronically during your computer lab.

G. Chart Delivery

Aisle clerks are expected to deliver their own stat charts to the requester. I've enclosed in your packet a list of physicians and to what medical office their records should be delivered.

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