Structuring the Spoken Word: The Role of Transcription in Meaningful Use

By Michael Carnrite and Susan Sumner

The latest data from the Centers for Medicare and Medicaid Services report that Medicare and Medicaid incentive payments for the meaningful use of electronic health records (EHRs) have reached more than $5 billion. Medical transcription has played a role in providers' attainment of these incentives and will continue to contribute in important ways-especially as the spoken word increasingly transforms into structured data.

Transcription plays three main roles in electronic health record (EHR) use, regardless of transcription method:

- Traditional dictation
- Back-end speech recognition and medical transcriptionist editing
- Front-end speech technology with physician self-editing

In addition, new roles for medical transcriptionists are ready to be explored as a practical solution to the human resource demands of meaningful use reporting and attainment.

Medical Transcription Supports Meaningful Use

Transcription supports EHRs and meaningful use in three ways. First and foremost, transcribed reports populate EHRs with important clinical content via HL7 protocol or direct integration. Second, transcription works alongside the EHR's template-based documentation to round out the patient story, filling in clinical content where drop-down menus and check boxes fall short. Finally, transcription is the repository from which unstructured text can be mined, converted to structured data, and uploaded into EHRs to meet meaningful use guidelines.

Populating the EHR

Transcribed documents have been populating patient medical records for decades. First in paper form and now electronically, common EHR contributions include transcribed discharge summaries, operative reports, consultations, history, and physical documents. The past 24 months, however, have seen a steady increase in the volume of dictated and transcribed progress notes that also feed EHRs-especially in the acute care setting.

By dictating or speaking progress notes, instead of writing them by hand, transcription delivers a more structured format for continuing care, meaningful use reporting, data mining, and coding outcomes. The benefits of having progress notes in electronic format far outweigh the cost to transcribe them.

Organizations considering a move to transcribed progress notes should be aware of two key requirements. First, specialty-driven structured templates must be in place for dictating purposes. Second, specific turnaround time requirements must be included for service level agreements.

Once integrated into the EHR, transcribed documents are used in countless ways by a wide range of end users. Technology tools within the EHR also use transcribed documents for meaningful use reporting. HIM professionals should work closely with their transcription service or technology provider and information technology resources to ensure documents are successfully integrated, displayed, and protected in accordance with privacy and security mandates.

Complementing the EHR

With the goal of improving patient outcomes, meaningful use guidelines continually push the need for structured data. Point-and-click documentation is one way to achieve this goal. However, EHRs don't always capture the nuances of patient care. Medical transcription offers another complementary option that is beginning to take hold-hybrid documentation.

Termed "hybrid clinical documentation," a blended data capture environment gives clinicians multiple methods to document encounters, including point-and-click templates, dictation with transcription or speech recognition, free text, or a combination. The option to use speech-based documentation tools is fully integrated within the EHR. Physicians document as much as possible using point-and-click templates, and dictation is used to fill in the gaps when additional details or explanation is required.

This hybrid approach preserves physician efficiency and helps to ensure complete and accurate data capture. Many transcription users are moving rapidly toward this type of blended, hybrid approach to physician documentation, particularly in ambulatory settings. In hospitals, it is not always feasible to provide this type of documentation flexibility at the physician level, but could be more practical and achievable at the service or specialty level.

HIM professionals should note that many other clinicians document through speech (i.e., therapists, nurse practitioners) and virtually any device that captures sound can be interfaced with a transcription or speech recognition system. Smart mobile devices and the use of voice recognition technology on computer workstations will continue to make hybrid clinical documentation a viable option.

By using transcription alongside EHR templates for documentation, clinicians can use a system built to capture complete documentation and ensure proper coding-resulting in enhanced patient safety and continuing care.

Serving the EHR

Finally, transcription serves the EHR with structured data. When coupled with natural language processing technology, transcribed documents can be mined for rich structured data to upload and incorporate into EHR databases. The outcome is a metamorphosis of unstructured spoken text into tagged, codified data used for capturing meaningful use measurements.

In this scenario, there is no impact to physician workflow. Technology is used to identify the specific words and phrases in the clinician's narrative required for meaningful use reporting. The system then converts this unstructured text information into structured data that can be easily uploaded and read by the EHR.

While the day-to-day use of language engines to transform text into structured data is currently limited, industry experts predict a rapid expansion and adoption of this technology in the coming years. Rather than forcing physicians to complete 100 percent of their documentation in the EHR, the use of language technology to convert text into data may become part of future meaningful use guidelines instead. HIM professionals are encouraged to evaluate natural language processing as a key component of any future transcription decisions. Doing so will define a new generation of clinical documentation technology offerings.

Structuring New Roles for Transcriptionists

New responsibilities are emerging and new titles are being introduced in the transcription field. The move to ICD-10-CM/PCS will further increase the need for documentation specialists along every step in the EHR process, opening even more doors for today's narrative experts to become tomorrow's data professionals. Meaningful use, as described above, is also having an impact on transcriptionists' roles. However, new skills, education, and training will also be required if transcriptionists hope to transition into a new role. A few of tomorrow's titles include:

- Speech Editor
- Documentation Specialist
- Medical Language Specialist
- Documentation Auditor
- Documentation Assistant
- Medical Scribe
- Data Analyst

More than a Paycheck

Over 3,000 hospitals have registered for incentive payments, representing thousands of HIM departments and transcription professionals, according to CMS's May 2012 EHR Incentive Program report. Some hospitals have received large checks, but few have received anywhere near the total costs expended to install, implement, and maintain their EHRs. The end goal is not merely financial, but includes an ideal outcome to improve record quality, patient safety, and clinical care.

Medical transcription is an HIM professional's ally and advocate in this journey. While the clock keeps ticking and providers move closer to receiving penalties for noncompliance versus incentives for adoption, the time is right for HIM professionals to consider the potential of medical transcription services and technologies.

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