Transcription Beyond Transcription: Health IT allows transcriptionists to assist with CDI, other HIM functions

By Michael Carnrite and Susan Sumner

For decades Medical transcription has been an important fixture of the health information management (HIM) department. Compiling, managing, and retaining transcribed documents as a subset of the entire patient medical record is a foundational role for HIM professionals. And while the electronic health record (EHR) and associated documentation templates have reduced reliance on transcription, dictation remains the most common method used to document encounters.[1]

From progress notes and consultation reports to histories, physicals, and discharge summaries, the spoken words of clinicians are critical to the entire patient care story. They are the basis for hundreds of healthcare delivery functions, including patient care, reimbursement, and quality measurement. Therefore, any shift in clinical documentation capture, maintenance, or use has a dramatic impact on the HIM profession.

As the second decade of a new millennium unfolds, transcription is not simply undergoing a minor shift-it is experiencing an overwhelming degree of change. Speech technologies, EHRs, and natural language processing (NLP) are all leading transcription well beyond its traditional strongholds. Driven by industry pressures such as the Centers for Medicare and Medicaid Services' "meaningful use" EHR Incentive Program, the transition to ICD-10-CM/PCS, and the emergence of accountable care organizations, the demand for clinical documentation is greater than ever before. Along with these changes, new productivity challenges for clinicians and HIM professionals have emerged.

HIM professionals are in a unique position to guide the future of clinical documentation and ensure its usability for decades to come. Transcription technologies, processes, outputs, and roles are evolving, and will help define a new reality in clinical documentation.

New Capture Technologies Emerge

Highly effective second-generation speech and EHR applications are now on the market. Along with them, new options for capturing clinical documentation have appeared. These new options incorporate all possible documentation capture methodologies, including dictation and transcription. In addition, the devices used to capture documentation now include smart phones and tablets, making the actual capture process more mobile and flexible.

The emergence of the EHR is changing the way providers capture documentation on the front end. According to the July 2012 *NCHS Data Brief*, 55 percent of physician groups have already adopted an EHR. Among the 45 percent that have yet to implement an EHR system, nearly half plan to purchase or use a system they have already purchased within the next year.[2] Hospitals are also purchasing and installing EHRs at a rapid rate. This widespread adoption of EHRs has caused a dramatic ripple effect in the medical transcription industry-one in which technology plays the central role.

EHR templates are gaining an adoption foothold among providers, albeit with growing pains. Documenting patient encounters using drop-down menus and checkboxes accommodates discrete data capture, but is a source of growing frustration and debate among clinicians.

According to some medical practices, documenting an encounter via point-and-click templates within the EHR takes physicians up to three minutes longer per visit. For high volume clinics and groups, this equates to a significant drop in physician productivity and overall patient volumes. The RAND Corporation recently released a paper describing the phenomenon that occurs when an industry's technological capabilities improve at such a dramatic pace that end-user productivity actually drops.[3] This has been known to occur with EHR templates for clinical documentation.

To alleviate these productivity concerns, many EHR vendors are incorporating speech options within their systems, giving physicians the flexibility to "speak" their documentation in conjunction with point-and-click templates.

HIM Challenges with EHR-Based Documentation

Along with the highly effective second-generation speech and EHR applications on the market, new options for capturing clinical documentation have appeared that incorporate all possible documentation methodologies. The quickly evolving nature of current clinical documentation and EHR template processes also creates four challenge areas that HIM professionals need to consider when checking quality and accuracy in clinical documentation:

- Readability
- Errors from cut-and-paste
- Over-documenting
- Granularity of ICD-10

Four HIM Challenges Emerge

HIM professionals face four key clinical documentation challenges related to EHR templates. First, readability is more difficult with template-generated reports or notes. Several narrative pages in the dictation/transcription world can easily become a tome of EHR output.

Second, the physician's ability to easily copy and paste information heightens the risk of documentation errors and compromises record integrity. Click-happy physicians tend to over-document, opening the door for fraudulent coding and billing. Finally, with ICD-10 rapidly approaching, templates must be evaluated, modified, and updated to support new documentation requirements that can ensure the necessary information is available to coders using the more specific code set.

Some feel that well-engineered templates prepped and ready for ICD-10 will help physicians bridge the gap from ICD-9. Templates will also reduce post-discharge queries and support more efficient and accurate coding in ICD-10. However, HIM professionals must maintain diligence in updating templates for ICD-10 now, allowing sufficient time for documentation patterns to change and physicians to become accustomed to new ICD-10 terminology.

Integrated Documentation Creates Balance

Clinical documentation doesn't always lend itself to keyboard entry. The best approach is one that integrates all options: templates, dictation, transcription, and speech recognition. An integrated documentation approach helps negate the shortcomings of electronic (template-based) data capture by giving physicians the flexibility to dictate when necessary.

Similar to how consumers choose the most appropriate communication tool for a given task-text message, e-mail, telephone, social media, etc.-clinicians can speak, type, or click based on the particular needs of the job at hand. For example, if the physician has time and the note is brief, he or she may simply use speech recognition and self-editing. Such may be the case with an urgent patient transfer note. However, if the report is long and complicated, such as with a discharge summary, the physician may choose to use traditional dictation and send to a medical transcriptionist.

New and Developing Roles in Documentation

While humans will still be required to ensure quality and accuracy, new technologies will streamline processes and open the door for new roles in producing clinical documentation. As processes continue to evolve, additional training and fine-tuning of the core medical transcription knowledge set will be required to adequately prepare professionals to step into these new roles. Emerging roles include:

- Speech Editor

- Documentation Specialist
- Medical Language Specialist
- Documentation Quality Auditor
- Documentation Assistant
- Medical Scribe
- Data Analyst
- ICD-10 Coder

HIM Flexibility Required

As physicians embrace new options for report creation, HIM professionals may find themselves in the middle of a political balancing act between the IT department and the medical staff. Technology must be carefully balanced alongside physician preferences and productivity. HIM professionals in practice settings will have more flexibility to accommodate physician preferences versus their hospital counterparts. However, clinical documentation technology must be flexible and tailored for various staff needs.

Speech recognition software, digital pens, and mobile phones are just a few other technologies being tested in healthcare and receiving rave reviews from physician users. HIM professionals are wise to carefully evaluate all options available for clinical documentation capture during EHR evaluations and implementations.

Workflow Changes Ease Tensions

To help ease tensions and move transcription into a new era, HIM professionals should also re-evaluate the entire documentation process-from initial note to discharge summary and physician query. New roles and workflows have the potential to offset productivity losses while also improving documentation capture, editing, and usability.

Scribes Boost Productivity

Many organizations are bringing medical scribes back into the clinical care setting. The trend is so popular that the Joint Commission has provided online FAQs for hospitals that use scribes to help physicians and other licensed healthcare professionals document patient encounters in an EHR system. Scribes allow physicians to focus on the patient rather than entering documentation into the EHR.

A retrospective study conducted in the emergency department of an urban academic medical center demonstrated that scribes positively impacted overall productivity as measured by patients treated per hour and revenue value units generated per hour.[4] Potential downsides of scribes include additional costs for the provider and inconsistent levels of quality depending on educational background and experience of the scribe.

While often staffed by medical interns, the scribe role is another opportunity for medical transcriptionists and other HIM professionals to further impact the quality of clinical documentation being captured in patient care settings.

Transcriptionists Become Quality Auditors

The next technological step in back-end speech recognition is front-end speech recognition. With front-end speech, physicians dictate and self-edit reports as they create them-online and in real time. Organizations implementing front-end speech recognition weave medical transcriptionists, editors, or speech auditors into the workflow to serve as the second set of eyes and ears for the physician.

While there are times when physicians have the capacity to dictate and self-edit their reports, there are many other times when they do not. It is during these times that a physician may opt to “send to editor” instead of self-editing. The technology’s workflow sends that specific report to an auditor, such as a medical transcriptionist or speech auditor, for editing and quality assurance checks.

The physician's report is their work product. Quality must be ensured regardless of how the report is created. Many are not willing to compromise quality or productivity by self-editing reports. By using medical transcriptionists as back-up editors or auditors, both quality and productivity are maintained.

Transcription Gets Structured

Traditional transcription produces narrative, unstructured, and text-based documents. These unstructured documents create hurdles in multiple downstream functions since data can only be captured and analyzed through human intervention. NLP technologies are changing this paradigm.

By marrying NLP with transcribed reports, providers are able to convert narrative, unstructured text into discrete, structured data. Key words and phrases are tagged, coded, and uploaded into other systems to accommodate computer-assisted coding (CAC), quality reporting, and electronic records.

Bridging Transcription and Coding

Transcription and coding have always enjoyed a symbiotic relationship. NLP creates a bridge between the two with CAC. As CAC technology matures and adoption grows, these two functions will twine closer together, making transcriptionists active players in the revenue cycle. Furthermore, since HealthGrades and other patient care scorecards are based on coded data, quality reporting is also positively impacted through faster, more automated access to narrative information.

To bolster CAC accuracy, HIM professionals should assess their existing clinical documentation for "code-ability" by an NLP engine. Some changes in physician reporting and terminology may need to be implemented for maximum effectiveness.

Automating CDI

Just as coding can be "assisted" through the combination of transcription and NLP, so can clinical documentation improvement (CDI). According to a study published in June 2012, radiologists lose between 2.5 percent and 5.5 percent of their income through incomplete documentation.[5] Other physician specialties and healthcare provider organizations suffer the same fate when clinical documentation falls short.

Medical transcriptionists serve as the first set of eyes and ears for documentation quality. They review reports as they edit them, finding errors and omissions, and report these to HIM staff. With computer-assisted CDI, technology serves as the second set of eyes and ears in this process.

Computer-assisted CDI uses NLP technology to review data and transcribed reports, similar to the CAC process described above. However, the CAC system also tracks incomplete documentation. Whenever the NLP engine lacks sufficient clarification to assign a specific code, the questionable word or phrase is tagged. From there, CDI professionals are alerted in real time and reports are generated.

By sharing these reports with transcriptionists and coders, a closed-loop documentation improvement process is achieved.

Feeding the EHR

Transcription coupled with NLP brings additional structured data to the EHR. The outcome is a metamorphosis of narrative reports into tagged, codified data that populate EHR databases and aid in meeting meaningful use requirements.

Rather than force physicians to change the way they document, as is the case with EHR documentation templates, NLP converts their text into data. Physicians keep what is familiar, dictating their reports. Organizations mine transcribed information behind the scenes for the specific EHR data they need.

Making Transcription Actionable

The Association for Healthcare Documentation Integrity states that of the 1.2 billion clinical documents produced in the US each year, approximately 60 percent contains information trapped in unstructured documents-unavailable for clinical use,

quality measurement, or data mining. By re-evaluating the clinical documentation process and implementing innovative technologies and processes, HIM professionals unlock important data and make transcription truly actionable. HIM professionals are also encouraged to evaluate NLP in conjunction with their EHRs and other clinical documentation technologies mentioned above.

As more and more documentation moves to a template-based approach, HIM professionals should carefully evaluate their medical transcriptionist labor pool and conduct frank discussions on future opportunities. While human eyes and ears will still be required to ensure quality and accuracy, new technologies will streamline processes and open the door for new roles in producing clinical documentation.

All efforts put forth by HIM professionals to re-evaluate transcription technology, processes, and job descriptions should ensure that each patient encounter is effectively documented and that quality information is maintained regardless of how it is captured.

Some of these emerging roles are available in facilities now, while others are to come in the near future. All will require some additional training and fine-tuning of the core medical transcriptionist knowledge set.

Notes

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