



Electronic Health Record and 'Meaningful Use'

Since the emergence of the EHR, healthcare documentation continues to depend significantly on the work of healthcare documentation specialists. Medical transcription, in fact, holds one of the keys to helping solve EHR adoption challenges. That being said, the benefits of the electronic health record include:

- Quick and efficient access to patient health records anywhere they are needed allowing providers the ability to make imperative medical determinations in less time.
- Delays and inefficiencies inherent in paper systems are eliminated thus increasing the actual number of patients seen by practitioners.
- EHR allows information to be exchanged between healthcare providers more efficiently.
- Patients can receive copies of medical records securely over the internet reducing administrative staff workload.
- Government incentives for health care providers to make the switch to EHR.

While the benefits seem clear, most healthcare provider's still use paper based medical record systems. Many providers have not made the switch to EHR due to the complex requirements mandated in order to comply with the definition of 'meaningful use of certified EHR technology'.

According to HIMSS officials, EHR technology is "meaningful" when it has capabilities including e-prescribing, exchanging electronic health information to improve the quality of care, having the capacity to provide clinical decision support to support practitioner order entry and submitting clinical quality measures and other measures such as HIE, CPOE , etc. as selected by the Secretary of Health and Human Services.

HIMSS officials recommend that medical facilities introduce the requirements in 'incremental stages'. Medical facilities must meet the definition within a specified time frame which is described in the American Recovery and Reinvestment Act (ARRA) of 2009.

HIMSS officials have stated that the 'mature' definition of 'meaningful use of certified EHR technology' should include each of the following attributes:

1. A functional EHR certified by the Certification Commission for Healthcare Information Technology (CCHIT);
2. Electronic exchange of standardized patient data with clinical and administrative stakeholders using the Healthcare Information Technology Standards Panel's (HITSP) interoperability specifications and Integrating the Healthcare Enterprise's (IHE) frameworks;
3. Clinical decision support providing clinicians with clinical knowledge and intelligently-filtered patient information to enhance patient care; and

4. Capabilities to support process and care measurement that drive improvements in patient safety, quality outcomes and cost reductions. Transitioning from your traditional documentation methods to a certified EHR system can be a difficult process, not just from a time and money perspective, but from a provider acceptance perspective. By allowing your providers to incorporate what they have been doing, while introducing the added benefits of an EHR, you will greatly increase provider acceptance and buy-in. Dictation and transcription will always be the preferred method of documentation because it is what they (providers) were trained to do, but also because it takes the least amount of time. Any EHR system that takes the user "too much time" to document will prove to be unsuccessful, so choosing a system that incorporates both dictation and transcription will be critical to its success.

Healthcare documentation will continue to depend a great deal on medical language specialists (formerly referred to as healthcare documentation specialist) either for traditional transcription or for speech recognition editing. And now, with the creation of Natural Language Processing (NLP), the role of the medical language specialist will once again be expanded. In this role, rather than transcribing in a completely narrative format, certain data, (aka:meaningful use criteria), will be entered into discreet data fields and then used to populate the EHR. In this regard, the MTSO (medical transcription service organization) that hires and retains only the most knowledgeable medical language specialists will be able to offer advanced services such as, backend speech recognition editing, Discrete Reportable Transcription (DRT), Clinical Documentation Improvement (CDI), and other services that require more advanced skills. MTSO's committed to providing only the highest and most advanced services will become the industry leaders as more medical facilities make the switch to electronic health records systems.

MedScribe has been helping its customers through EHR adoption; first by hiring only the most qualified US-based employees; secondly, by expanding its suite of services to encompass the new EHR requirements; thirdly, by being well versed in streamlining EHR acceptance and integrating the traditional dictation and transcription processes and workflows into the new required processes. MedScribe can help your organization make these important and beneficial changes with minimal interruption to your current day-to-day workflows.

If you would like more information about integrating the EHR into your existing workflow, please contact one of our specialists. 800-329-1601 ext 240 or <mailto:sales@med-scribe.com>



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