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Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445–G
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Washington, DC 20201

To Whom It Concerns at the Centers for Medicare & Medicaid Services:

The Association for Healthcare Documentation Integrity (AHDI) and the Medical Transcription Industry Association (MTIA), the professional and trade associations representing a sector that produces approximately 60% of the medical record through its nearly 1,700 employers and 300,000 healthcare documentation professionals, have prepared the following comments related to the proposed rules for the electronic health record (EHR) incentive program.

First, we applaud the federal government's role in promoting EHR adoption to assist in reforming healthcare delivery and improving the quality of patient care. The medical transcription and documentation industry has long supported technological advances that have improved patient safety, ensured the privacy and security of health information, and created greater efficiency in capturing patient care encounters, resulting in the integrity of healthcare records. In fact, AHDI and MTIA helped launch two consortia that will accelerate EHR adoption and meet criteria for "meaningful use" pertaining to health information exchange and record integrity. The first consortium, Health Story Project, formed to establish uniformly structured and coded document formats commonly used in healthcare practice based on HL7 Clinical Documentation Architecture (CDA). These structured documents will enable the sharing of narrative reports among healthcare facilities, allowing access to the rich and nuanced clinical information stored in narrative notes for both clinical and reimbursement decision support. The second consortium with Verizon Business and ICSA Labs has built a digital platform called Medical Data Exchange that will both encourage and facilitate secure transfer of medical record information between EHRs. We are confident that our work will enhance and expedite the goals laid out for EHRs while preserving the integrity of a full narrative health record with little interference in the dictation-transcription process, the preferred and current method of documentation employed by most hospitals, clinics, and physician practices in the United States.

In relation to the proposed regulations, AHDI and MTIA still remain concerned that physicians have a choice regarding how they document healthcare encounters and that the value of the patient narrative be preserved for clinical and reimbursement decision making. Below we offer our suggestions for language that will make the proposed regulations stronger and still achieve the goals set forth by the Administration for EHR adoption. Our industry is committed to working with the Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health

Information Technology (ONCHIT) in the coming years to drive greater specificity for meaningful EHR use as it pertains to electronic record keeping.

We understand this is the first attempt to outline meaningful EHR adoption and subsequent iterations of the rule will be published in 2011 and 2013; however, we believe it is immediately necessary to ensure that the dictation-transcription process is explicitly included as a legitimate means for capturing discrete data elements in the electronic medical record.

The dictation-transcription process remains physicians' preferred method of documenting healthcare encounters because it is easy to use and is time-efficient, thus allowing physicians more time to focus on treating their patients. In addition, narrative reports generated from the dictation-transcription process tell the whole patient story and are easier to read and understand among clinicians for coordinating and continuing care. By acknowledging and including the dictation-transcription process as one of the methods to capture health information in the "meaningful use" regulations, physicians will be more likely to embrace the push for greater EHR adoption and to find the experience of using an EHR positive and less cumbersome when it comes to the documentation process.

We, therefore, request that the proposed regulations on "meaningful use" and EHR certification capitalize on the medical transcription sector's valuable contribution by incorporating the following language:

(A) "To encourage widespread EHR adoption and to avoid making the meaningful use criteria overly burdensome for physicians, hospitals, and their patients, we have created flexibility in the criteria by not mandating a specific method of data capture. We recognize that several means of data capture would allow a physician or hospital to meet the Stage 1 criteria, including utilization of the dictation-transcription process to feed structured narrative reports and discrete data elements through data tagging into the EHR." (Section II(A)(2)(c): Considerations in Defining Meaningful Use. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule. Page 1852.)

To be clear, the medical transcription sector is capable of tagging discrete data elements in the dictated narrative report to maintain an up-to-date problem list of current and active diagnoses, active medications, and an allergy list. Rather than require physicians to input these data elements into a template EHR system, medical transcriptionists can tag these data elements from the narrative report and abstract the data into the specified lists.

Since the proposed regulations do not specify how discrete data elements are to be captured, we propose the rules acknowledge that discrete data elements be captured through the dictation-transcription process, structured narrative reports, and data tagging. This capability should be explicitly acknowledged as a possible means by which to maintain an up-to-date problem list of current and active diagnoses, an active medication list, and active allergy list; to incorporate clinical lab results into an EHR as structured data; and to generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, and outreach. (Table 2: Stage 1 Criteria for Meaningful Use. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule. Page 1867.)

Failure to recognize the capabilities of the dictation-transcription process as a viable data capture method will lead to the false perception that physician entry in a structured template system is the only option for capturing this information. We do not believe the intention of the HITECH Act was to mandate only one method in the data capture marketplace. However, this omission in the regulations could signal to the marketplace that dictation-transcription may no longer be a viable option, thereby marginalizing the transcription industry and the jobs we create, as well as placing unintended or unwarranted burdens on physicians across America.

Studies have shown that dictated and transcribed reports are more accurate than physician entered documentation.[1] Thus, not only will inclusion of the dictation-transcription process allow for greater physician choice, preservation of the narrative, and more efficient use of physician time, it will also further the governments goals to improve quality, safety, and efficiency and to improve care coordination by exchanging meaningful clinical information among members of a professional healthcare team. (Table 2-Stage 1 Criteria for Meaningful Use. Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule. Page 1867.)

(B) "To support the proposed Stage 1 meaningful use criteria's focus 'on electronically capturing health information in a coded format [and] using that information to track key clinical conditions and communicating that information for care coordination purposes (whether that information is structured or unstructured, but in structured format whenever feasible),' we propose that certified EHR systems should have the functionality to accept structured documents in CDA format from the dictation-transcription process." (Section III(C)(2)(b): Content Exchange and Vocabulary Standards. Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology; Interim Final Rule. Page 2031.)

Effective health IT must enable the telling of a patient's full health story. Requiring certified EHRs to accept structured narrative reports from the dictation-transcription process will improve the flow of information between narrative reports and EHRs, thereby enabling physicians to use the detailed and information-rich data in narrative reports for clinical decision making. By continuing to provide physicians with the option of dictation-transcription, physicians will be more likely to embrace the push for greater EHR adoption and to find the experience of using an EHR to be a positive one for them, their healthcare teams, and patients. In addition, narrative reports will be more meaningful to patients seeking information about their health care than a printout with a mere series of discrete, disjointed data elements. Lastly, as mentioned above, data tagging of a structured narrative report allows for discrete data elements to be extracted from the report and fed into an EHR to generate a problem list, medication list, medication allergy list, and information on labor orders and results. [Table 2A-Adopted Content Exchange and Vocabulary Standards. Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology; Interim Final Rule. Page 2033.)

[1] Association for Healthcare Documentation Integrity and Medical Transcription Industry Association, Improving the Accuracy of Patient Narrative Notes: The Role of Documentation Specialists in Supporting Physician Use of EMRs, June 2009.

The dictation-transcription process is a proven, effective, and shovel-ready documentation method for the EHR. Medical transcription companies and professionals have long worked with physicians to deliver accurate, complete, and secured records in the healthcare system to optimize patient care delivery and to ensure patient safety. By employing healthcare documentation professionals as a solution to the challenges of EHR adoption, the federal government will ensure wider and more successful adoption, while at the same time preserving and creating jobs during what economists predict will be a long, jobless economic recovery.

We have attached the following documents for your review:

1. AHDI/MTIA official comment submitted on June 26, 2009 to the Health IT Policy Committee's concerning the committee's draft description of "meaningful use."

2. Letter submitted on December 14, 2009 to ONCHIT by medical transcription company owners and executives.

3. June 2009 study abstract demonstrating how healthcare documentation professionals ensure the completeness and accuracy of patient records by recognizing and correcting errors in the patient record.

The medical transcription and documentation industry stands ready to work closely with physicians, hospitals, and clinics to achieve "meaningful use" of EHRs. Whatever method used to capture healthcare information, medical transcriptionists can serve as an "extra set of eyes" to ensure the quality, accuracy, and consistency of patient records. With the growing amount of information exchanged across healthcare enterprises resulting from broader EHR adoption, error rates at multiple hand-off points could put patients at greater risk.

We are available to discuss and look forward to working with your office to make sure that the final regulations recognize the important role of the medical transcription and documentation industry. For additional information or if you have any questions, please contact AHDI/MTIA staff member Greg Doggett at (859) 512-3284 or gdoggett@adhionline.org.

Thank you.

Sincerely,

Eileen Dwyer	Susan Lucci, RHIT, CMT, AHDI-F	Peter Preziosi, PhD, CAE
Chairperson MTIA	President AHDI	Chief Executive Officer AHDI/MTIA