

## **Instructions for Submitting Comments on Proposed Regulations for “Meaningful Use” and EHR Certification**

The federal government recently released proposed regulations concerning what physicians and hospitals must do to qualify for financial incentives being offered by the government for electronic health record (EHR) adoption. The proposed regulations do not explicitly recognize the value of the dictation-transcription process for documenting healthcare encounters or the importance of patient narratives for clinical decision making. Given these concerning omissions, we need as many AHDI and MTIA members as possible to submit comments asking the federal government to acknowledge the medical transcription sector as a vital contributor to quality of care, patient safety, and successful EHR adoption. Please see the information below on how to support this important advocacy effort.

- 1. Draft your letter using the model letter at the end of these instructions.** Personalize your letter with your individual experiences and use whatever portion of the model letter you believe will make the point to your legislators. Note that you must finalize certain sections of the letter before sending it. Those sections are designated as “PERSONALIZE” AND “AND/OR.” If possible, insert a copy of your signature at the bottom of the letter.
- 2. Email a fully copy of your comment, including your address with 9-digit zip code, to AHDI/MTIA staff member Greg Doggett at [gdoggett@ahdionline.org](mailto:gdoggett@ahdionline.org).** He will work with the Dewey Square Group to send copies of your comment to the government agencies responsible for the regulations and your federal legislators. **SINCE ALL COMMENTS MUST BE SUBMITTED TO THE GOVERNMENT BY MONDAY, MARCH 15, PLEASE EMAIL YOUR COMMENT TO GREG BY THE CLOSE OF BUSINESS ON FRIDAY, MARCH 12 TO ALLOW FOR SUFFICIENT TIME FOR DELIVERY.**
- 3. If you have any questions, contact AHDI/MTIA staff member Greg Doggett at [gdoggett@ahdionline.org](mailto:gdoggett@ahdionline.org) or 859-512-3284.**

## Model Comment

(Your Address with 9-digit zip code)

As a professional in the health documentation sector and member of the Association for Healthcare Documentation Integrity (AHDI) AND/OR the Medical Transcription Industry Association (MTIA), I write today to encourage the Centers for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONCHIT) to acknowledge the dictation-transcription process and structured narrative reports are vital elements of electronic health records (EHR) by including in them in the regulations for “meaningful use” and EHR certification criteria.

The medical transcription industry, which employs hundreds of thousands of Americans across the country, enables more efficient EHR adoption. Medical transcription companies and professionals work with physicians to create accurate, complete, and secure records to optimize patient care delivery and to ensure safety. The dictation-transcription process remains physicians’ preferred method for documenting care because it is easy to use and is time-efficient, allowing physicians more time to focus on treating their patients. If the dictation-transcription process is included in the definition of “meaningful use” and if EHRs are required to receive structured narrative report from the dictation-transcription process, 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.

I stand ready to work closely with physicians, hospitals, and clinics to achieve “meaningful use” of EHRs. Most importantly, regardless of the 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 broader EHR adoption, error rates could put patients at greater risk. By employing more documentation professionals **more jobs will be created** while at the same time reducing medical errors in the healthcare record.

Here in (PERSONALIZE: City or State or Region) I work with (PERSONALIZE: Dozens – Hundreds – Thousands) of healthcare providers and I worry that if the dictation-transcription process is left out of “meaningful use” and EHR certification, the quality of patient health records will deteriorate and jobs could potentially be lost across (PERSONALIZE: City or State or Region). The healthcare documentation sector is a solution to the challenges of EHR adoption. Including EHRs in the definition of “meaningful use” and EHR certification criteria would allow for physician choice, uphold the value of the patient narrative, promote more efficient use of physician time, **and preserve and grow jobs in the healthcare documentation field.** I strongly encourage CMS and ONCHIT to acknowledge the dictation-transcription process and structured narrative reports as vital elements of “meaningful use” and EHR certification.

Please do not hesitate to contact me if you would like additional information about our sector and association. Thank you for your consideration, time, and support.

Sincerely,

(Your Signature)

(Your Name Printed)