



June 26, 2009

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HIT Policy Committee
c/o Office of the National Coordinator for Health Information Technology
200 Independence Ave, SW
Suite 729D
Washington, DC 20201
Attention: HIT Policy Committee Meaningful Use Comments

Dear Members of the HIT Policy Committee:

On behalf of the Association for Healthcare Documentation Integrity (AHDI) and the Medical Transcription Industry Association (MTIA), which represent approximately 300,000 healthcare documentation professionals, 1,700 employers, and \$15 billion in annual revenue, we are writing to you concerning the crucial role the medical transcription sector plays in clinical documentation by ensuring the accuracy and completeness of patient health records. We are submitting this letter in response to the HIT Policy Committee's notice requesting comments regarding its draft description of "meaningful use." Our concerns specifically relate to the description's following goals and objectives:

1. Improve safety and quality by recording clinical documentation in the EHR (p. 1 of the "Meaningful Use Matrix") and documenting a progress note for each encounter (p. 2) and;
2. Improve care coordination by exchanging meaningful clinical information among a professional health care team (p. 5), producing and sharing an electronic summary care record for every transition in care (p. 5), and accessing comprehensive patient data from all available sources (p.5).

We propose that the following comments be incorporated into the "meaningful use" definition to improve quality without sacrificing physician efficiency:

- 1. Use consistent formatting and coding for documents entered into the EHR and ensure quality by recognizing the need for skilled and knowledgeable healthcare documentation professionals to review patient health records and;**
- 2. Include the ability of certified EHRs to accept interfaced data from the dictation/transcription process, and thereby enabling the use of healthcare documentation professionals, since this is the most common method used by physicians to enter care encounter data into the health record and ensures the accuracy and integrity.**

The quality of patient reports is essential to reducing errors in healthcare delivery and preserving the integrity of health information, especially as information is increasingly exchanged across healthcare enterprises, potentially worsening errors at an exponential rate and thereby putting patients at greater risk. While healthcare documentation has evolved due to the introduction of new technologies such as EHR systems and speech recognition, the need for skilled, knowledgeable, and experienced healthcare documentation professionals remains strong. An "extra set of eyes" is still needed to ensure the accuracy and completeness of patient health records. By capturing and correcting errors that otherwise would exist in records and be transmitted across providers and enterprises, healthcare documentation professionals greatly improve the quality of narrative reports, structured data, and documents.



Documentation integrity is further enhanced if reports are uniformly formatted and coded. Such standards preserve the integrity of reports as they are shared among providers for care coordination and read by consumers to better understand their care process.

Since physicians have a high level of familiarity and comfort with the dictation/transcription process and narrative reports, it is important to ensure that certified EHRs can accept interfaced data from the dictation/transcription process. At least 1.2 billion clinical documents are produced in the United States each year. Dictated and transcribed documents make up nearly 60 percent of all clinical notes. These documents contain the majority of physician-attested information and are used as the primary source of information for reimbursement and proof of service. Dictation has historically been and continues to be the documentation method of choice for physicians because it produces a complex, specific narrative that ensures accurate capture of patient history, as well as the care encounter. We propose the inclusion of uniformly formatted and coded narrative reports through the dictation-transcription process as a common method of getting information into the health record to increase physicians' willingness and ability to transition to EHRs.

Using consistent formatting and coding for documents, recognizing the need for knowledgeable and skilled professionals to ensure document integrity, and requiring certified EHRs to accept interfaced data from the dictation/transcription process amount to a simple, yet proven and highly effective, way to ensure that improved health information capture supports and improves the quality of patient care delivery. It also will add no cost to the system and will likely save money using more cost effective healthcare documentation professionals to capture data rather than expensive physicians. For more information about how our organizations and professionals stand ready to support greater EHR adoption, please see the following four attached documents:

1. A white paper discussing in detail how medical transcription can help accelerate EHR adoption;
2. A handout outlining the value and benefits of medical transcription for EHR adoption;
3. An abstract of a study revealing the crucial role that healthcare documentation professionals play in correcting dictation errors and ensuring the accuracy of patient health records; and
4. A handout on the need to include "practical use" within the definition of "meaningful use."

We hope you find this information helpful as you discuss and revise the committee's definition of "meaningful use." Please do not hesitate to contact me if you have any questions or would like additional information.

Sincerely,

A handwritten signature in black ink that reads "Peter Preziosi". The signature is written in a cursive, flowing style.

Peter Preziosi, PhD, CAE
Chief Executive Officer
Association for Healthcare Documentation Integrity/
Medical Transcription Industry Association