



**MEANINGFUL USE RULES ROLLED OUT BY THE FEDERAL GOVERNMENT:
WHAT MEANING DO THE RULES HAVE FOR HEALTHCARE DOCUMENTATION WORKERS?**

At a press conference on July 13, 2010, the US Department of Health and Human Services and HHS secretary Kathleen Sebelius introduced rules that define “meaningful use” of electronic health records. These rules will determine the eligibility of healthcare providers for Medicare and Medicaid incentive payments; providers meeting these meaningful use criteria by 2015 will qualify for bonuses. The payments can be as much as \$44,000 to \$64,000 for eligible healthcare providers and millions of dollars for hospitals. These rules, written after an extensive period of public comment, lay the groundwork for a 5-year national initiative to promote the adoption of electronic health records in the United States. See the press release from HHS at <http://www.hhs.gov/news/press/2010pres/07/20100713a.html>. The complete final rules can be found in an 864-page document published by HHS at http://www.ofr.gov/OFRUpload/OFRData/2010-17207_PI.pdf.

A summary of the rules has been published (posted on the same day, July 13), by the *New England Journal of Medicine*. The article was authored by David Blumenthal, MD, national coordinator for health information technology, and Marilyn Tavenner, RN, principal deputy administrator at the Centers for Medicare and Medicaid Services, and is available at <http://healthcarereform.nejm.org/?p=3732&query=home>.

From the NEJM article, here are some examples of meaningful use rules (conditions that providers and facilities must meet to qualify for the payments above) particularly pertinent to our role in the healthcare documentation sector. (Each rule lists both an Objective and a Measure.)

Objective: Maintain an up-to-date problem list of current and active diagnoses.

Measure: More than 80% of patients have at least one entry recorded as structured data.

The problem list and diagnoses must be in an electronic record; paper records or narrative reports will not meet this condition. The requirement here is for “structured data,” the form that all information must have in an electronic record. A medical narrative available online as a word-processed document (the traditional transcribed report) would not meet this requirement: it is not structured data. To meet this condition, information located in such documents will have to be put into the form of structured data for entry into the EHR.*

Objective: For individual professionals, provide patients with clinical summaries for each office visit; for hospitals, provide an electronic copy of hospital discharge instructions on request.

***Measure:** Clinical summaries provided to patients for more than 50% of all office visits within 3 business days; more than 50% of all patients who are discharged from the inpatient department or emergency department of an eligible hospital ... and who request an electronic copy of their discharge instructions are provided with it.*

***Objective:** On request, provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies, and for hospitals, discharge summary and procedures).*

***Measure:** More than 50% of requesting patients receive electronic copy within 3 business days.*

During the broadcast July 13 meeting, Donald Berwick, MD, the newly appointed administrator of the Centers for Medicare and Medicaid Services, commented on the importance of near-immediate availability of medical records. We can see this emphasis on nearly real-time turnaround reflected in the last two Objectives above. Over the past few years transcription services have greatly shortened turnaround times for medical reports. However, again, the traditional dictation-transcription model involves the creation of a word-processed document which does not provide the structured data required by the EHR. Any information contained in those documents would have to be re-entered into the electronic record as structured data. It seems highly likely that healthcare providers and facilities will seek to eliminate any time-consuming extra steps in the creation of a record that must be provided to patients within 3 business days.

What does this mean for AHDI and MTIA members?

Briefly, it means that our future role in the creation of the medical record is going to be entirely shaped by our role in the creation of an electronic record. It means that the traditional word-processed, dictated-transcribed medical documentation process is going to change radically, and – after years of anticipation, speculation, and slow shifts – it is now likely to change very quickly. It means that we're going to have to acquire new skill sets and knowledge, expand service provisions into digitally secured offerings in order to bring our value-adding services to the electronic record process.

What must medical transcriptionists and transcription service owners do?

1. Educate ourselves about the specifics of the EHR: How is the electronic record created? Who initiates it, in what way, and what happens following the initiation? Many MTs and service owners will have opportunities to dialog with their clients, with HIM personnel at healthcare facilities and with one another about developments related to the EHR. We need to make maximum use of those opportunities.
2. AHDI and MTIA will continue to press the Administration and Congress on the inclusion of digitally secure narrative recording of patient healthcare encounters. Narrative reporting captures the whole story and ensures the safest and most effective way of protecting patient care through better care coordination among clinicians and patients. The associations continue to promote this message through our efforts with the [Health Story Project](#) coalition that advances this principle.

3. AHDI is working with NLP International to promote the use of NLP tagging as a critical solution for preserving narrative entry while still capturing discrete data elements that meet meaningful use and other reporting criteria. Both associations will continue to advocate for “structured narrative” to important stakeholder groups, like the American Medical Association and American Hospital Association, so that healthcare delivery is not forced to assume that narrative capture has no place in the EHR future. Physicians who still prefer narrative entry over point-and-click template choices will be able to preserve that option without compromising data capture goals that are critical to meeting Meaningful Use criteria.
4. AHDI and MTIA will also advocate for practical adoption of electronic health record systems to create more efficient ways of capturing health information without overburdening physicians in delivering care. Practical and efficient adoption of EHR systems must also include standardized and secured technology interfaces to the EHR from transcription platforms.
5. AHDI and MTIA have been working to keep members informed about these issues; we welcome and encourage our members to keep us informed about their own experiences in the workplace.
6. Be prepared to acquire new skills and to broaden your clinical documentation services. It seems very probable that a primary function going forward will be some kind of editing, for example, either of speech-generated documents or of sets of structured data initiated by healthcare providers. Notice that our MTs’ core knowledge of anatomy and physiology, medical terminology, pharmacology, clinical practice, etc. will still be required. We will simply add EHR-specific skills and knowledge to those basics as well as training in clinical nomenclatures and natural language processing to support our goals for generating structured data out of narrative reporting.

The HHS introduction of final rules for meaningful use of the electronic health records marks a major turning point in health information concepts, practices, technology, and processes. This is only the beginning. More detailed and specific meaningful use criteria will be released by the federal government in 2013 and 2015. AHDI and MTIA still have the opportunity to influence government regulation of how the healthcare system will capture, record, and exchange health information to optimize patient care delivery and to improve the healthcare system.

* Definition of “structured data” from the American Health Information Management Association: “Documentation of discrete data using controlled vocabulary rather than narrative text.” AHIMA also notes the following definition of “structured input” (essentially the process of creating an EHR): “A form of data entry that captures data in a structured manner (e.g., point-and-click fields, pull-down menus, structured templates, macros).” *See these and other useful definitions in the [AHIMA Library](#).*