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Standard Guide for Data Capture through the Dictation Process[1]

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1. Scope

1.1 This guide identifies ways to improve the quality of healthcare documentation through the dictation process. This guide will assist dictating authors (physicians, physician assistants, nurses, therapists, and other healthcare professionals) in facilitating their use of dictation in the healthcare environment, that is, hospital, clinic, physician practice, or multi-campus healthcare system.

1.2 This guide will aid in the continuity of patient care, privacy and confidentiality issues, risk management issues, optimal coding for reimbursement, compliance with legislative and regulatory requirements, and turnaround time.

1.3 The complexity of the language of medicine, the dynamics of the healthcare environment, and the sophistication of the dictation systems present a formidable challenge for dictating authors. This guide will facilitate a quality dictation message.

1.4 This guide does not address the medical transcription process.

1.5 *This standard does not purport to address all of the safety concerns, if any, associated with its use. It is the responsibility of the user of this standard to establish appropriate safety and health practices and determine the applicability of regulatory requirements prior to use.*

1.6 *This international standard was developed in accordance with internationally recognized principles on standardization established in the Decision on Principles for the Development of International Standards, Guides and Recommendations issued by the World Trade Organization Technical Barriers to Trade (TBT) Committee.*

2. Referenced Documents

2.1 *ASTM Standards:*[2]

E1902 Specification for Management of the Confidentiality and Security of Dictation, Transcription, and Transcribed Health Records (Withdrawn 2011)[3]

E2117 Guide for Identification and Establishment of a Quality Assurance Program for Medical Transcription

E2184 Specification for Healthcare Document Formats (Withdrawn 2011)[3]

3. Terminology

3.1 *Definitions:*

3.1.1 *analog, n*—of, relating to, or being a mechanism in which data is represented by continuously variable physical quantities, that is, recording tape.

3.1.2 *blanks, n*—missing text that must be filled in as directed by the dictating author.

3.1.3 *confidential, adj*—status accorded to data or information indicating that it is sensitive, and therefore, it must be protected against theft, disclosure, or improper use.

3.1.4 *dictate workstation (or dictate station), n*—location with a device for input of voice dictation.

3.1.5 *dictating author, n*—one who dictates information to be transcribed, that is, healthcare students and healthcare professionals.

3.1.6 *dictation message (or digital voice file), n*—unit of information that consists of both audio (voice) and its data elements.

3.1.7 *document, n*—report in any form (print, electronic, or voice file).

3.1.8 *healthcare environment, n*—any facility whose primary purpose is delivery of healthcare, that is, hospital, clinic, physician practice, or multi-campus healthcare system.

3.1.9 *medical transcription, n*—process of interpreting and transcribing dictation by physicians and other healthcare professionals regarding patient assessment, workup, therapeutic procedures, clinical course, diagnosis, prognosis, and so forth into readable text to document patient care and facilitate delivery of healthcare services.

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[2] For referenced ASTM standards, visit the ASTM website, www.astm.org, or contact ASTM Customer Service at service@astm.org. For *Annual Book of ASTM Standards* volume information, refer to the standard's Document Summary page on the ASTM website.

[3] The last approved version of this historical standard is referenced on www.astm.org.

3.1.10 *microphone, n*—instrument whereby sound waves are caused to generate or modulate an electric current usually for the purpose of transmitting or recording sound (as speech or music).

3.1.11 *microphone element, n*—diaphragm of the sound-collecting source of a microphone.

3.1.12 *quality assurance, n*—process of review of a healthcare document that will provide adequate confidence that dictated patient care documentation is transcribed in a clear, consistent, accurate, and complete manner.

3.1.13 *quality editor, n*—person who performs quality assurance reviews and/or corrections.

3.1.14 *risk management, n*—healthcare environment activities that identify, evaluate, reduce, and prevent the risk of injury and loss to patients, visitors, staff, and the healthcare environment itself.

3.1.15 *speech recognition, n*—computerized translation of speech to text.

3.1.16 *stat, adj*—high priority, or urgent, such as dictation requiring immediate transcription.

3.1.17 *telephony, n*—the use or operation of an apparatus for transmission of sounds between widely removed points with or without connecting wires.

3.1.18 *template, n*—pattern or guide.

3.1.19 *text, n*—main body of printed or written matter.

3.1.20 *transcribe, v*—see *medical transcription*.

3.1.21 *turnaround time (TAT), n*—elapsed time beginning with availability of the voice for transcription and ending when the transcribed document is available for authentication (see Guide E2117).

3.1.22 *unique identifier, n*—a number used by only one (1) person that identifies that user.

3.1.23 *voice activation, n*—technology that allows recording to begin when dictation message begins.

3.1.24 *voice file, n*—digitalized audio portion of a dictation message.

3.2 *Acronyms, Abbreviations, and Short Forms:*

3.2.1 *AAMT*—American Association for Medical Transcription

3.2.2 *HIPAA*—Health Insurance Portability and Accountability Act of 1996[4]

3.2.3 *MR#*—medical record number

3.2.4 *MT*—medical transcriptionist

3.2.5 *QA*—quality assurance

3.2.6 *TAT*—turnaround time

4. Significance and Use

4.1 This document provides guidelines for dictation techniques and environments that contribute to quality documentation, that is:

4.1.1 Educational facilities for the purpose of introducing and training of dictation techniques, and

4.1.2 Healthcare professionals for preferred dictation techniques.

4.2 This document provides recommendations to help create quality documentation for the following reasons:

4.2.1 *Correct Coding for Reimbursement*

4.2.1.1 Reports that require no QA intervention increase efficiency of the reimbursement process and reduce discrepancies for the healthcare environment and healthcare provider.

4.2.2 *Risk Management, Legal, and Peer Review*

4.2.2.1 Reports that require no QA intervention reduce legal exposure for the healthcare environment and the healthcare provider.

4.2.3 *Improved TAT*

4.2.3.1 Reports that require no QA intervention reduce turnaround time, are more cost-effective, and possibly reduce delay in patient care.

4.2.4 *Legislative and Regulatory Compliance*

4.2.4.1 Dictation performed in preferred environments would not compromise patient confidentiality and the patient's right to privacy and would be compliant with legislative and regulatory requirements.

4.2.5 *Continuity of Patient Care*

4.2.5.1 Documents with missing text (blanks) compromise quality. These should be filled in or corrected as directed by the dictating author upon authentication of the report.

4.2.6 *Improved Communication Between Healthcare Professionals*

4.2.6.1 Timely quality documentation can enhance communication within the dynamic healthcare setting. Patient safety may also be improved when transcribed documents are used to replace handwritten documentation by healthcare professionals.

4.3 This document does not address security issues. Refer to Specification E1902.

5. Dictation and Orientation Principles

5.1 Quality documentation begins with quality dictation. The quality of transcribed documents is dependent in part on the quality of the dictation message.

5.2 Formal orientation within healthcare environments for dictating authors makes the process easier and improves the quality of the dictation message (see Guide E2117).

5.2.1 All dictating authors should receive training on the dictation processes and the overall documentation within their healthcare environments initially and when changes occur in policies or equipment.

5.2.1.1 Address any regulatory requirements and institutional policies and guidelines for report formats and organization of content.

5.2.1.2 Provide guidelines for report turnaround times and the appropriate use of a stat designation for prioritizing reports.

5.2.1.3 Use only facility-approved abbreviations within the dictating message and avoid the use of other abbreviations, jargon, slang, acronyms, and/or coined terms.

[4] Available from U.S. Government Printing Office Superintendent of Documents, 732 N. Capitol St., NW, Mail Stop: SDE, Washington, DC 20401.