



Best Practices for Measuring Quality In Medical Transcription

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Executive Summary

The issue of quality is of vital importance within healthcare documentation. Patient safety, document integrity, and containing healthcare costs are the impetus for renewed efforts by accreditation and healthcare compliance agencies and health information managers to inspect records for dictation and transcription quality. This document will address quality assessment (QA) in the aspects of the voice-to-text conversion, introducing policies, procedures, and standards.

Quality in medical transcription voice-to-text conversion can be defined as clear, consistent, accurate, and complete patient healthcare documentation derived from the dictator's vocal communication.

The QA process has a two-fold goal:

- Improved documentation through identification and explanation of errors.
- Improvement of dictator and transcriptionist skills through evaluation of error patterns found and followup educational efforts.

PARTICIPANTS

MTs requiring improvement should be supported in that goal by a thorough review of their work, including resultant trending reports that enable analysis of problem areas.

Dictators requiring improvement cause serious difficulties in transcription that result directly from the quality of the voice file. These should not redound against the transcriptionist (i.e. with negative point values) in a quality review. Rather, these should be indicators for further investigation of specific dictation flaws so that remedial action in keeping with the institution's policies may be taken with the dictator.

AAMT believes that dictation and transcription flaws can pose patient safety risks, negative financial impact, or negative document integrity impact (i.e., a pattern of unprofessional behavior in a physician's documentation patterns). Therefore, some method of reviewing and communicating these flaws should be part of the overall quality evaluation.

The Quality Editor understands the intricacies of the interpretive process that is so unique to medical transcription and has the mental skills to review this process. Effectiveness of the Quality Editor's work is measured through statistical reporting of the quality improvements of both the transcriptionist and dictator. The Quality

Editor must provide feedback and education to both transcriptionist and dictator to reach the goal of improved documentation.

CRITERIA

Establishing the criteria for a quality review and the method for its implementation requires careful planning and input. There are areas that can be measured objectively within a transcribed document. In order to enable a true definition of quality in the medical transcription industry which allows a proper comparative assessment, AAMT is making specific recommendations as to errors and error values and providing conversion factors for those values in given line length situations. AAMT now recommends the following detailed classifications:

- Critical Errors, defined as those which impact patient safety.
- Major Errors, defined as those which impact document integrity.
- Minor Errors.
- Dictation Flaws.

Due to the impact of potential transcription errors on patient care, AAMT recommends 98% and above as the appropriate accuracy percentage goal. This percentage is arrived by assigning weight values to errors.

SCOPE AND TIME FRAME

The two basic divisions of quality editing timeframes are concurrent and retrospective. These two areas require different approaches in terms of work distribution.

- **Concurrent review** is required when the documents reviewed are not yet delivered to the medical record. This will be true for flagged documents and documents completed by transcriptionists requiring 100% review (trainees, cross-trainees, probationers).
- **Retrospective review** is utilized for random audits of transcriptionists who are meeting the quality standards of the department. It is recommended that random audits be performed within each pay period, across the spectrum of the transcriptionist's work, preferably not culled from the same date, and equal to 3% to 5% of the transcriptionist's volume.

QUALITY ASSESSMENT

As identified in the ASTM standards for quality in medical transcription, there are various areas of interest applicable to transcription. These include:

- **Voice capture**, including the document identification process, the use of dictation equipment, the dictated content, confidentiality, security, and the education of dictators.
- **Voice-to-text conversion**, encompassing the production of a healthcare document derived from the voice capture methodology.
- **Voice and text distribution**, including efficient, secure, and timely management of work distribution based on the needs of the department and the skills of the individual transcriptionists.
- **Interfacing**, including confidential, secure, and efficient exchange of document ID elements, and export and/or import of records.
- **Management support**, including follow-through on HIPAA compliance, timely problem resolution, and provision for audit trails.

This Document will address quality assessment in the aspects of the voice-to-text conversion, introducing policies, procedures, and standards. Quality in medical transcription voice-to-text conversion can be defined as clear, consistent, accurate, and complete patient healthcare documentation derived from the dictator's vocal communication. This quality is affected by the auditory quality of the voice being transcribed, by the education and skills of the dictator, and the education and experience of the medical transcriptionist (MT).

The QA process has a two-fold goal:

- Improved documentation through identification and explanation of errors.
- Improvement of dictator and transcriptionist skills through evaluation of error patterns found and followup educational efforts.

The quality review process needs to provide a pathway towards continuing education policies that encourage growth of dictators in their communication skills and growth of transcriptionists in their knowledgebase and discernment process. The method of review and the communication of results must be thorough, fair, consistent, and understood by all parties. As noted in the ASTM standards, the

opportunity for challenge of the review by the transcriptionist should be enabled, reflecting a true improvement process ideology.

QUALITY ASSESSMENT WORK FLOW

The scope of work to be reviewed within voice-to-text quality evaluation includes a number of areas. The broadest classification involves concurrent and retrospective documents. To more specifically classify these quality review opportunities, the following areas are identified:

- Review of trainees and new hires. (Concurrent. Review 100% of the reports.)
- Review of those involved in cross-training on new accounts, new dictators, or new work types. (Concurrent. Review 100% of the involved training-related reports.)
- Review of those assigned to QA probation because of sub-standard work (Concurrent. Review 100% of the reports.)
- Review of flagged reports. (Concurrent. Review 100% of the reports.)
- Review of archived work of transcriptionists who are meeting the department quality standards. (Often Retrospective. Review 3% to 5% recommended.)

Although random audits for the purpose of employee review would ideally be performed in a concurrent timeframe, this is often not feasible due to turnaround time constraints. If it is possible, then the comments found below are salient to the situation.

In the case of trainees, new hires, cross-trainees, and probationers, 100% of the work needs to be reviewed before delivery to the medical record (concurrent review) in order to ascertain the best possible documentation. Work flow needs to support the purpose of swift delivery of an accurate document, along with the purpose of transcriptionist education. In each of these improving transcriptionist categories, the goal is both broad-based and specific education. Prompt and specific feedback is crucial. As MTs within these categories make progress, it may be appropriate to reduce the 100% review figure as they meet department quality goals.

QA of flagged reports may be approached as a separate process within the QA department, one that is always done concurrently, giving immediate attention to the document before forwarding to the healthcare record. The purpose of QA for flagged reports is for accurate completion of the report, as well as the education of the transcriptionist on a specific flagged area.⁴ The work flow needs to support these two purposes by swiftly processing the flagged report to the QA department for remediation or completion, followed by delivering the completed report to the

healthcare record, and finally forwarding information concerning the flagged area to the transcriptionist.

Flagged reports are not necessarily the best type of reports to be used for a general review of a transcriptionist's performance since these reports ordinarily present the most difficulties, thus requiring the flag. It may be a department's choice to keep these types of reports outside the QA department or as a separate arm of the QA department. Nevertheless, flagged reports may come under the purview of the QA department, often bringing to the forefront the difficulties caused by poor dictation. Serious difficulties in transcription that result directly from the dictation should not be held against the transcriptionist (i.e. with negative point values) in a quality review. Rather, these should be indicators for further investigation of specific dictation flaws so that remedial action in keeping with the institution's policies may be taken with the dictator.

In the next step of evaluating the dictator (a separate QA process), they can be evaluated based on vocal variations (accent, speed, articulation, volume), content errors (terminology, grammar, completeness of information, style), and environmental effects (background noise, equipment, general environmental practices).

AAMT believes that because of the impact these flaws have on the ability to properly transcribe the dictation, there can be patient safety risks, negative financial impact, or negative impact to the document's integrity (i.e., a pattern of unprofessionalism in a physician's documentation patterns). Therefore, some method of reviewing and communicating these flaws should be part of the overall quality evaluation.⁵ These communications with dictators would include the frequency of occurrence of the specified critical, major, and minor flaws found in regular random samplings of their documentation. Additionally, the overall rating of their vocal variation, content, and environmental effects should also be communicated at regular intervals when improvements are desired.

Fairness and consistency needs to be applied to the number of randomly sampled archived reports reviewed for those MTs meeting the department standards. It is AAMT's recommendation that 3% to 5% of a transcriptionist's work be randomly reviewed within a specific timeframe, typically a pay period or month. A meaningful percentage over an extended period of time is needed for regular sampling. However, the majority of this sampling should not be culled from flagged reports. Timely feedback to the transcriptionist is important.

QUALITY ASSESSMENT PERSONNEL

The elements of an effective Quality assessment program include the personnel involved and their level of education, the various types of quality editing situations mentioned previously, the work flow situation, the procedures required, proper analysis of the results, and the followup educational efforts to maintain and improve quality.

Medical Transcriptionists *(See Appendix A for AAMT's Job Description)*

In building a solid foundation for quality within a department, care should be taken to screen prospective medical transcriptionists with the department's quality standards in mind, selecting candidates with a strong foundation in medical terminology, anatomy, physiology, human disease processes, pharmacology, subspecialty terminology, medical report formatting, English and medical spelling (including medications and laboratory technology), and English grammar. Required proficiencies are keyboarding with speed and accuracy, proofreading skills, editing skills, keen hearing and auditory discrimination, efficient use of technical references, knowledge of the current acceptable standards of style and professionalism in medical transcription, and basic knowledge of technology currently in use within the industry.

Successful MTs who are meeting the quality standards set within the department are best supported in a QA environment wherein their quality reviews are used as positive feedback, leading them to better understanding of their work and reference materials available to them. They should find the QA experience an ideal forum for the ways and means to produce excellent documentation.

The followup work with trainees, new hires, cross-trainees, and probationers needs to be structured for the best possible educational results in the participants' transcription work. A great deal of exposure to a variety of dictating voices in the various reports types, with careful quality guidance and feedback on all reports initially, will produce high-quality transcriptionists. The percentage of 100% reports can be gradually reduced as quality measurements are met until the normally-required 3% to 5% are considered adequate.

Quality Editors *(See Appendix B for AAMT's Job Description)*

The experience, education, and skills required in a quality editor will depend upon the requirements of the particular work environment and the skill levels of the existing staff. The breadth of experience and expertise will need to exceed that which is being reviewed. So this would assume a similar educational and experience background to the medical transcriptionist in medical terminology, anatomy and physiology, human disease processes, laboratory procedures, pharmacology,

medicolegal issues, grammar, formatting, proofreading and editing, along with referencing skills.⁶ It also assumes experience in the complexities of each particular specialty or report type being reviewed, since oftentimes there are peculiarities indigenous to each specialty that need to be taken into consideration while reviewing.

The quality editor needs to have the mindset of a transcriptionist. This means the editor understands the intricacies of the interpretive process that is so unique to medical transcription and has the mental skills to achieve this process in a superior manner. The editor also needs to understand the slang and idiomatic expressions that dictators may use in various areas of the country, be aware of the impact these may have on the medical meaning, and understand when and where they are appropriate to the dictator's style.

Quality Editors may “rise from the ranks” of the transcription staff as they master each of the accounts within the transcription department and continue their education regarding industry changes and professional development. They may need mentoring in appropriate editing skills, which include swift visual and auditory error identification, referencing, communication skills, and deftness in computer technology. The mental agility to be swift, yet accurate, is an important issue.

A method of testing the previously mentioned overall skills is appropriate, as well as testing aptitude for editing skills. AAMT certification (CMT) is an excellent indication that the candidate’s skills have been mastered and will continue to grow in their profession, as the CMT regularly participates in continuing education and professional-development activities.

Quality editors may not be tyrannical in their approach.⁸ Rather, they need to achieve an educational approach, a sharing of their expertise. This is part of the communication skills required. If the position is viewed as an opportunity for ongoing training of the transcriptionists, rather than as a “grading” task, there will be a thorough and welcomed opportunity for improvement throughout the organization.

Quality editors also require tactful skills in approaching appropriate HIM and dictation staff for assistance in resolving difficult questions placed before them within flagged reports. These may include incomprehensible phrases that could be researched in the patient record for resolution, risk management issues within the dictation (expletives, inappropriate personal opinions of the dictator, confidentiality breaches), or dictation that appears to be in error.

It is possible that some portions of the QA process within a document can be handled by those with less experience overall, as long as they remain within their area of expertise. Grammar, formatting, and checking demographic data are examples of these areas.

In order to accomplish their tasks well, quality editors will need the most current resource materials of the highest professional caliber, including both hard copy and web-based. It could be difficult to achieve web-based research if the employer's VPN policies preclude access while within patient documents (due to security concerns). This may require other technological solutions so that the editor has all the best possible tools readily at hand.

A new area of medical transcription has come to be identified as transcription reviewers or speech recognition medical transcription editors, and refers to the work done by qualified medical transcriptionists in editing the work produced by speech recognition systems.⁹ This job description differs from the quality editor and is not addressed in this document specifically, although the principles remain the same.

Quality Manager *(See Appendix C for AAMT's Job Description)*

Depending on the size of the medical transcription department, the quality manager may be a full-time position or it may be part of another management job description. The quality manager directs efforts toward quality documentation, providing procedures, training, and resources for all involved (dictators, as appropriate, as well as transcriptionists, clerical staff, and quality staff). Continuing education resources are identified and made available to keep transcription and quality staff updated on healthcare issues such as clinical diagnosis and treatment, medical and professional ethics, professional practice and development, technology, specific editing and proofreading skill enhancements, communication skill enhancements, ergonomics, knowledge of risk management and documentation standards in the industry, and industry trends.

The quality manager should establish guidelines for identifying qualified applicants for transcription and quality assessment staff positions, bearing in mind that these need to be synergistic. The quality manager will develop standards for employee performance review related to quality. The quality manager will provide appropriate reference resources to the staff, including hard copy, digitized, Internet, and phone.

The quality manager will establish a program that produces information which enables conclusions to be drawn concerning individuals and groups in the

transcription department and dictation staff—their accuracy, their deficiencies, and methods to improve those deficiencies.

The quality manager will establish the criteria of the quality reviews with input from appropriate members of transcription and quality staff. This criteria will be thoroughly explained to all staff, with updates being distributed in a timely manner. Although this document addresses the standards of voice-to-text conversion (accuracy and adherence to standards, for example), other quality criteria to be addressed by the quality manager include turnaround time, quality review of the editors, production, dictator practices, protocol compliance regarding risk management and documentation standards, and document distribution process.

The quality manager will establish or give input to the workflow structure to ensure appropriate turnaround time, bearing in mind the need for flagged report responses and concurrent, as well as retrospective reviews. Decisions need to be made concerning timely feedback to the transcriptionist, review challenges, and delivery to the medical record.

An appropriate budget for quality assessment is overseen by the quality manager and department management. Elements of that budget should include appropriate staffing, quality review software, reference books, staff reimbursement for professional activities, and other resource and time allocations as necessary.

Educational Efforts

As mentioned frequently throughout this paper, medical transcriptionists and quality editors need to be supported with a solid educational foundation and continuing education. The recommended way for the transcriptionist and quality editors to obtain this knowledge base is through completion of a well-rounded, reputable medical transcription course and continuing education opportunities provided by AAMT, AHIMA, local technical colleges, other professional outlets, and employers. AAMT certification (CMT) is an excellent indication that these skills have been mastered and continue to be fed. There are numerous books, magazines, and web sites that also act as educational resources for transcriptionists.

In the synergistic relationship between transcriptionist and quality editor, there is an excellent opportunity for education. From specifics concerning an account or dictator, to broadening of terminology or grammar details, feedback from the quality editor is an opportunity for growth.

QUALITY ASSESSMENT METHODS, POLICIES, AND PROCEDURES

The two basic divisions of quality editing timeframes are concurrent and retrospective. These two areas require different approaches in terms of work distribution.

Concurrent review

Flagged documents represent completed work on which there are questions from the medical transcriptionist. This type of quality editing work may be handled separately from routine reviews because of the turnaround time requirements. The focus is on the questions, not the entire document. For content-related flags, the editors will be retrieving the voice file and transcription file and reviewing those sections marked by the transcriptionist with questions. When those have been answered, feedback will be routed to the transcriptionist, and the document sent to the medical record for dictator authentication. A method needs to be in place for the transcriptionist to respond to the reviewer with additional questions or comments. A concern for the quality department would be that some transcriptionists will minimize the amount of time spent on research and simply send all questions to the QA department in order to improve productivity. This can be addressed by setting percentage limits (i.e., no more than 3% to 10% of a transcriptionist's work should be flagged under normal circumstances) or simply with feedback to the transcriptionist as to the excesses and suggestions as to where research could have been done. This type of transcriptionist could be referred to have work reviewed in a routine quality audit and be downgraded in accuracy due to excessive blanks.

High volume concurrent review documents usually originate from transcriptionists who are under any review standards other than random audit, such as trainees, new hires, cross-trainees, probationers. Typically, 20% to 100% of their work is being reviewed concurrently. The outcome of the quality review should be presented to the transcriptionist in an organized way within 24 hours of transcription. The feedback should include needed areas of improvement with suggestions as to where the required information may have been found, including reference resources or samples of the dictator's work. Aside from identifying areas of improvement, the review should render objective data that result in an accuracy percentage. This combination of objective data and educational information is key to the synergistic relationship desired. A method needs to be in place for the transcriptionist to respond in a timely manner to the reviewer with additional questions, comments, or challenges. The documents reviewed must then be routed appropriately to the transcriptionist and the medical record based on the established distribution practices, bearing in mind confidentiality and security requirements.

Although random audits for the purposes of employee review would ideally be performed in a concurrent timeframe, this is often not feasible due to turnaround time constraints. If it is possible, then the comments found below are salient to the situation.

Retrospective review

Feedback from the quality review should be presented to the transcriptionist in an organized way within 24 hours of review. The feedback should include needed areas of improvement with suggestions as to where the required information may have been found, including reference resources or samples of the dictator's work. Aside from identifying areas of improvement, the review should render objective data that result in an accuracy percentage, and possibly a calculation of the percentage of each type of error to the whole. Evaluation of this information indicates the status of this transcriptionist's accuracy and enables an evaluator to see where the majority of errors may lie, allowing for further recommendations for skill building, if required. This combination of objective data and educational information is key to the synergistic relationship desired. A method needs to be in place for the transcriptionist to respond to the reviewer with additional questions, comments, or challenges. The documents reviewed must then be routed appropriately to the transcriptionist, bearing in mind confidentiality requirements.

PROCEDURES

Establishing the criteria for the quality review and the method for its implementation requires careful planning and input. There are areas that can be measured objectively within a transcribed document. In order to enable a true definition of quality in the medical transcription industry, which allows a proper comparative assessment, AAMT is making specific recommendations as to errors and error values and providing conversion factors for those values in given line length situations.

In its Statement on Quality assessment for Medical Transcription, AAMT has suggested the classifications of critical, major, and minor errors be applied to these types of errors relative to their impact on patient care in particular. This is an excellent approach for the quality editors to follow. AAMT now recommends the following detailed classifications:

- **Critical Errors**, defined as those which impact patient safety: Specifically, AAMT identifies the following: medical word misuse, incorrect drug or drug dosage, incorrect lab values and test names, omitted dictation, patient identification error.

- **Major Errors**, defined as those which impact document integrity: Specifically, AAMT identifies the following: medical word misspelling, English word misspelling, incorrect verbiage, failure to flag a document, abuse of flagging documents, protocol failures.
- **Minor Errors**: Specifically, AAMT identifies the following: grammar, punctuation, typographical errors, formatting errors.
- **Dictation Flaws**: Specifically, AAMT identifies the following: critical, major, and minor as defined by patient safety and document integrity impact. It is crucially important to realize the impact auditory quality of the dictation has on the transcribed document. Recognizing and documenting occurrences allows for identification of flaws and an opportunity for assisting dictators in their quest for patient safety and document integrity.¹¹

These errors are further defined in Appendix D.

Once the errors have been identified for purposes of review, weight values need to be assigned to these errors so that mathematical computations may be done to calculate an accuracy percentage. Due to the impact of potential transcription errors on patient care, AAMT recommends 98% and above as the appropriate accuracy percentage goal. This percentage is arrived at by assigning weight values to errors, subtracting the total number of errors from the total lines then dividing by the total number of lines. Example: If the report is 150 lines and the total number of errors is 2 points, $150 \text{ lines} - 2 \text{ errors} = 148$ divided by 150 lines = 98.7%

If the errors are measured in a 65-character line count setting, weight values varying from 0.25 to 3.00 work well as a range. Consideration should be made, however, with regard to traditionally shorter reports (such as radiology reports) where a single 0.25 error could result in an accuracy score of less than 98%. It is recommended that error weights be lowered accordingly in an environment where the majority of reports are 10 lines or less. These error values are defined by AAMT in Appendix D.

Weight values are relative to what the employer is trying to achieve in their quality. For example, placing a high value on inappropriate blanks and defining those blanks as things which could have been found with thorough research, helps to decrease the number of flagged reports submitted to QA. Also, placing high values on critical errors will provide incentive for the transcriptionist to scrupulously avoid such errors.

For some, three (3) error points for a critical error may seem high in one document. But, when kept in perspective, it should be appropriate for a qualified

transcriptionist. The AAMT guidelines state the goal is to have no critical errors. For example, utilizing a 65-character line, one 3-point error in a 45-line document would calculate to 93% percentage accuracy for that document. This is appropriately low, since the error was critical and affecting patient safety.

If a quality review was completed on 16 documents (720 lines) for a MT, as part of a 4% sampling of a month's work, the following scenarios could evolve:

- If there is one 3-point error in a total of 720 lines reviewed, the accuracy percentage would be 99.5%.
- If there is one 3-point error, two 1.5 point errors, and three 0.50 errors within the 720 lines reviewed, the total error points would be 7.5. This subtracted from 720 lines equals 712.50, divided by 720 lines renders a 98.9% accuracy percentage.

The high-point value achieves the goal of emphasizing the importance of avoiding critical errors. AAMT recommends that a single report containing 2 or more critical errors should be considered "failed" for QA purposes, regardless of the length of the report. This can be achieved by arriving at the accuracy percentage in the above-described manner. Then subtract 10 percentage points from that. As an example, if a document's accuracy percentage is 99%, but it includes 2 separate critical errors, subtract 10 percentage points for a result of 89%.

Quality Editors play an educational role in the QA process. The AAMT guidelines found herein give opportunity to correctly identify errors and place them in perspective as to their final effect on the document. The use of weight values can also identify areas where errors in the documents are due to poor dictation. For example, if a critical error is found by the quality editor, but it is clearly due to deficiency in the quality of the dictation, the error can be indicated so the transcriptionist can receive helpful feedback, but the error value can be minimal or zero. This is a method of tracking all types of errors, but keeping the responsibility for some errors where they belong – as dictation problems. The clarification of problem areas is key to problem resolution.

It is important to note that presently 98% accuracy in one QA department is not the equivalent of 98% accuracy in another QA department. The unit of measurement (line count computation) is a differential, the varying weight values assigned to errors are a differential, the method of calculating the accuracy percentage, and the subjective nature of the evaluation is a differential. For example, a single text whose lines are counted as characters divided by 65 will have a different line count than the same text whose lines are counted as characters divided by 60. Computing that

document's accuracy ratio, with the exact same errors and values, would render a different accuracy due to the line count dividend being different. AAMT is addressing these variables by defining the weight values of errors (Appendix D), defining the method of accuracy percentage computation, and providing line count conversions for the defined error values (Appendix E).

The subjective nature of the evaluation cannot be avoided due to human nature, although it can certainly be controlled with clearly defined standards and clearly defined resource materials. When a department applies these standards, a quality handbook developed for the department should clearly define the resource, standard, and style issues. Where there are preferences allowed, it should be clearly stated.

There can be a significant percentage difference among the way individual quality editors may evaluate the same document. To work toward consistency in scoring, distribute identical documents to all quality editors and discuss the differentials found while evaluating the final statistics these editors produced for the quality audit.

Appendix F contains a sample Quality Check Sheet for use by the quality editors when reviewing documents. The document itself would be marked up, but the final tallies of errors found are entered on the Check Sheet. For each document reviewed, follow the column vertically and tally the number of errors in each category. Multiply the total number of errors within each error type by the appropriate point system. Add all these error points together and place in the "Error Points" box for that document. Fill in the number of lines for that document, subtract the total error points from the number of lines, and divide by the number of lines.

In order to be a true Continuous Quality Improvement (CQI) process, it is also helpful to know the percentage of each error type to the total errors. Thus, if a significant number of errors take place in a particular category, appropriate remedies can be offered for improvement. For example, if a large percentage of errors take place in medical word misuse, then anatomy and disease process study may be recommended. To utilize the chart in this area, go across horizontally for each error type and tally the total number of errors for that type in the appropriate column. Total all the errors at the bottom of this column. Then go to the percent errors column and for each error type, divide the total for that type by the total number of errors in order to obtain the percentage errors by that error type.

CONCLUSION

An outstanding quality assessment program will provide daily improved performance and sustained excellence. The result will be clear, consistent, accurate, and complete patient healthcare documentation. Patient safety and document integrity are preserved due to the diligent application of intelligence, discernment, and improvement processes available in a properly structured quality assessment program.

Daily improved performance and sustained excellence is the goal of an outstanding quality assessment program. As noted throughout this document, the key element to that improvement is the educational focus. This cannot exist without the properly qualified quality editor working within a supportive atmosphere and the synergistic partnership made with the medical transcriptionists toward their mutual goal of quality improvement and supportive communication with dictators.

The final result will be clear, consistent, accurate, and complete patient healthcare documentation derived from the dictator's vocal communication. Patient safety and document integrity are conserved due to the diligent application of intelligence, discernment, and improvement processes available in a properly structured quality assessment atmosphere.

APPENDIX A

Medical Transcriptionist Job Description

Professional Levels

In an independent benchmarking study of the medical transcription profession by the Hay Management Consultants (HayGroup), three distinct professional levels for medical transcriptionists were identified and described as presented below. The HayGroup is a worldwide human resources consulting firm with extensive expertise in work analysis and job measurement.

Compensation

Subsequent to this benchmark study of the job content levels of MTs, the HayGroup conducted a compensation survey, analyzing pay as it relates to these levels. (Hay's survey methodology complied with federal antitrust regulations regarding healthcare compensation surveys.) The results include information on transcription pay at the corporate level (healthcare organizations and MT businesses) and compensation for independent contractors. The data are further presented by geographic region, size of business, types of pay programs (pay for time worked and pay for production), and reward programs (benefits, etc.). The Hay report, "Compensation for Medical Transcriptionists," is contained in a 30-page booklet, which is included with membership or available in the Online Store.

Position Summary

Medical language specialist who transcribes dictation by physicians and other healthcare providers in order to document patient care. The incumbent will likely need assistance to interpret dictation that is unclear or inconsistent, or make use of professional reference materials.

Nature of Work

An incumbent in this position routinely researches and resolves complex questions related to health information or related documentation. AND/OR Is involved in the formal teaching of those entering the profession or continuing their education in the profession. AND/OR Regularly uses extensive experience to interpret dictation that others are unable to clarify. Actual transcription of dictation is performed only occasionally, as efforts are usually focused in other categories of work.

Knowledge, Skills & Abilities

1. Seasoned knowledge of medical terminology, anatomy and physiology, disease processes, signs and symptoms, medications, and laboratory values. In-depth or broad knowledge of a specialty (or specialties) as appropriate.
2. Knowledge of medical transcription guidelines and practices.
3. Proven skills in English usage,

APPENDIX B

Medical Transcriptionist Editor Job Description

Issue

This position statement outlines key areas of proficiency necessary for a medical transcription editor.

Position

The medical transcription editor must be a highly skilled level-2 medical transcriptionist with proven skills in all work types, specialties, accents, and dialects. The MT must possess acute auditory and acoustical sensitivity in coordination with keen hand/eye coordination, as would be expected in an experienced medical proofreader. The editor must also be proficient in referencing and researching, along with excellent communication skills to give consistent constructive feedback to the transcriptionists.

Supervisor Defined

Different facilities use different titles, e.g., editors, proofers, and proofreaders. The editor would report to a lead editor or transcription supervisor, as directed by the facility.

Minimum knowledge, skills, and abilities required

- Must be a qualified professional level 2 transcriptionist.
- Demonstrate ability to work in all work types and specialties.
- Demonstrate quality transcription work, consistently maintaining an accuracy score of 98% or higher.
- Certified transcriptionist preferred.
- Advanced knowledge of medical terminology, anatomy, physiology, disease processes, signs and symptoms, medications, and laboratory values.
- In-depth knowledge of medical transcription guidelines (The AAMT Book of Style) and practices.
- Excellent written and oral communication skills, including grammar, punctuation, and style, in order to provide quality feedback to the transcriptionist.
- Excellent acoustical skills.
- Demonstrate an understanding of the medicolegal implications and responsibilities of the healthcare record, ensuring compliance with local, state, and federal rules and regulations, along with security standards and privacy practices.
- Ability to understand diverse accents, dialects, and varying dictation styles.
- Proficient in referencing and researching.
- Full library of references (books/electronic) and Internet access.
- Ability to multi-task and work under pressure with time constraints.
- Ability to work independently with minimal or no supervision.

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- Ability to operate computer, multiple software applications, transcription equipment, and other office equipment necessary, including the ability to accept voice/text files in multiple formats and word processing software.
- Organizational skills for file management.

Principal duties and responsibilities

- Edit the transcribed document against actual dictation.
- Edit documents consistently and fairly according to transcription guidelines, standards of style, and formats of practice.
- Using preferred standard quality scoring guidelines, calculate and score reports consistently and fairly, weighing the varying degrees of errors against the documentation length.
- Utilize all available reference tools to ensure the accuracy of the transcribed document.
- Provide timely and consistent quality feedback to inform and update the transcriptionists regarding quality issues and areas of concern to help eliminate repetition of errors.
- Recognize, interpret, and evaluate inconsistencies, discrepancies, and inaccuracies in medical dictation and appropriately clarify and flag or report them, as needed.
- Identify potential risk management situations.
- Adhere to policies and procedures to contribute to the efficiency of the transcription department.
- Access patient's health information as needed for further clarification.
- Transcribe reports as needed.

APPENDIX C

Quality Assessment Manager Job Description

Issue

This position statement outlines key areas of proficiency necessary for a Quality Assessment Manager.

Position

The quality assessment manager must be a highly skilled editor with proven experience in the medical transcription profession. He or she must have demonstrated fair and unbiased judgment with the ability to review and coordinate a random review process of documents. This includes the process of monitoring, measuring, and reporting transcribed documents by transcriptionists and documents reviewed by editors.

Supervisor Defined

Different facilities use different titles, e.g., quality assessment coordinator, team leader, lead editor, or quality assessment specialist. The quality assessment manager would report to the transcription supervisor or as directed by the facility.

Minimum knowledge, skills, and abilities required

- Must be a highly qualified editor.
- Demonstrated leadership/management skills.
- Demonstrate ability to work in all work types and specialties.
- Demonstrate quality transcription work, consistently maintaining an accuracy score of 98% or higher.
- Certified transcriptionist preferred.
- Advanced knowledge of medical terminology, anatomy, physiology, disease processes, signs and symptoms, medications, and laboratory values.
- In-depth knowledge of medical transcription guidelines (The AAMT Book of Style) and practices.
- Excellent written and oral communication skills, including grammar, punctuation, and style, in order to provide consistent quality feedback to the transcriptionists, editors, and supervisors.
- Excellent acoustical skills.
- Demonstrate an understanding of the medicolegal implications and risk management responsibilities of the healthcare record, ensuring compliance with local, state, and federal rules and regulations.
- Ability to understand diverse accents, dialects, and varying dictation styles.
- Proficient in referencing, researching, reporting, tracking, and monitoring.
- Ability to multi-task with multiple priorities and timeframes.
- Ability to work independently with minimal or no supervision.

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- Ability to operate computer, multiple software applications, transcription equipment, and other equipment necessary, including the ability to accept voice/text files in multiple formats and word processing software.
- Organizational skills for file management.
- Mathematical skills, including calculations and statistics.
- Ability to communicate QA concerns/questions effectively with client/user.

Principal duties and responsibilities

- Direct efforts toward quality documentation, including providing procedures, training, and resources for transcription team members.
- Establish guidelines for identifying qualified applicants for transcription and quality assessment staff positions.
- Develop standards for employee performance review related to quality documentation.
- Establish criteria for quality reviews.
- Establish policies and procedures that contribute to the efficiency of the transcription department.
- Through a standard random selection process, select randomly transcribed or edited reports for review.
- Review the transcribed report against actual dictation, applying industry-specific standards provided by current resources and references.
- Using preferred standard quality scoring criteria, calculate and score reports consistently and fairly, weighing the varying degrees of errors against the documentation length.
- Provide timely and consistent feedback to the medical transcriptionist or editor in order to eliminate repetition of errors, build skills, and mentor the medical transcriptionist/editor.
- Recognize, interpret, and evaluate inconsistencies, discrepancies, and inaccuracies in the medical dictation, and appropriately clarify and/or report them as required.

APPENDIX E

DEFINITION OF ERRORS AND ERROR VALUES

CRITICAL ERRORS

A critical error is given the highest negative point value because of the seriousness of its consequences. With 98% accuracy as a benchmark, a report containing a critical error should not pass QA. A critical error should be reserved for only those errors which directly compromise patient safety.

Error #1: Medical Word Misuse – 3.0 pts

This category includes wrong drug or drug doses, wrong lab values, and/or wrong test names that directly compromise patient safety. For instance, a wrong disease could be incorrectly attributed to a patient and then carried in the medical record for life, causing incorrect treatment and incorrect medical decisions, as well as inaccurate billing of the patient's accounts. Similarly, a wrong lab value could result in a patient not receiving treatment or further testing when such treatment or testing is warranted.

If a misuse is repeated throughout the entire report, it should be counted as only one error in the report since it reflects one wrong piece of information on the part of the transcriptionist.

This category also includes improper use of abbreviations, acronyms, and symbols that are not to be used according to NPSG Standard 2b.

Error #2: Omitted Dictation – 3.0 pts

This category covers dictated information of a critical nature that was either carelessly omitted by the transcriptionist or deliberately omitted because the transcriptionist did not understand what was being said. Examples include omission of an entire laboratory finding because the value itself could not be heard, deleting negative or normal findings, or omitting entire sentences because the main part of it could not be understood. Creative transcription is also included in this category. This refers to "making up" dictation (words and/or phrases) when what is dictated is not clear. Consideration should be given for difficult authors or dictation of poor quality.

Research, assistance from others, flagging the report, and leaving a blank constitute appropriate actions rather than omission. This category does not apply to missing words which are inconsequential, such as articles or conjunctions. It also does not apply to what appear to be words missed (adjectives, adverbs) from typing too fast, unless they have serious consequences to the medical meaning. In these types of

situations, the error would be downgraded to major or minor, depending on the consequence to the document. Clipped sentences are allowed if their use reflects the dictator's style. This category is meant to apply to purposeful and/or serious omissions and/or fabrication(s).

Error #3: Patient Identification Error – 3.0 pts

A patient identification error is one in which the wrong patient information is tied to the dictation. For example, a report that is dictated for 50-year-old John E. Doe (male) but is attributed to a chart for 20-year-old Joni Do (female). As with the other critical errors in this category, the error must directly compromise patient safety in order to be assessed this error weight (see error #12).

Error #4: Upgrade of Major or Minor error due to patient safety impact – 3.0 pts

This category is for major or minor errors from the categories below that directly compromise patient safety. For example, "failure to flag" is considered a major error worthy of 1.0 pt., but a right/left discrepancy that poses a risk management issue and is not flagged by the transcriptionist could be upgraded to a critical error.

MAJOR ERRORS

A major error carries a higher negative point value because of the impact it has on the integrity of the document. Major errors in this category do not pose a risk to patient safety. A major error that impacts both the integrity of the document AND patient safety should be upgraded to a critical error.

Error #5: Abuse of Flagging/Blanks – 2.0 pts

This category covers blanks left which, through research, the transcriptionist could have resolved. This is sometimes referred to as "tossing it over the fence" – when a transcriptionist clearly chooses to leave a blank rather than research a term. The purpose of this category is to limit abuse of blanks for the sake of speed, which reflects a lazy attitude or greed for higher line counts in a production environment. Obviously, students and entry-level transcriptionists will leave more blanks in the beginning and this is preferred to guessing. This error should be used only in those cases where the blank or flag is truly considered abusive.

Error #6: Medical Word Misspelling – 1.5 pts

In addition to any medical words or medications that are misspelled, this category includes the use of an incorrect form of a medical word. For example, lingula instead of lingular or femur instead of femoral. This also includes failure to use combining forms and incorrect entries from text expanders. For instance, an author dictates that the patient is to see physical therapy (dictated PT) for followup; transcriptionist uses pt to expand for patient and the final copy of the report reads, "the patient is to see

patient for followup.” (However, if an incorrect expansion results in a critical error, such as incorrect diagnosis, this would be upgraded to a critical error.)

Error #7: English Word Misspelling – 1.5 pts

In addition to misspelling English words, this category refers to misuse errors, which have more serious consequences, such as nouns, verbs, or important qualifying adjectives and adverbs (e.g. elicit/illicit, dissent/descent, affect/effect, apprise/appraise). These errors directly impact the integrity of the report. For instance: the risks and complications were given allowed (aloud).

Error #8: Incorrect Verbiage – 1.5 pts

This category refers to dictation that is transcribed differently than dictated, but without significant impact on the medical meaning. This includes inappropriate/excessive editing. Care should be taken to remain true to the dictator’s style while still maintaining accuracy. Therefore, this does not pertain to changes made for the purpose of correcting grammar or word usage. This also differs from creative transcription (see error #2).

Error #9: Failure to Flag – 1.0 pt

This category pertains to times when a report should be flagged for clarification and the transcriptionist fails to do so. Failure to flag the following dictation would be an example. “I preferred to do [a certain] procedure, but the HMO would not approve that one, so I am doing this procedure which I do not think will have as good an outcome.”

Error #10: Protocol Failure – 1.0 pt

A protocol failure is one in which a transcriptionist fails to follow a specific protocol or facility preference. For example, a facility may require the date of service be filled in on each document, and the transcriptionist fails to include this.

Error #11: Upgrade of Minor Error due to impact on integrity of document – 1.5 pts

This category is used to upgrade a minor error that compromises the integrity of the document. For instance, a physician dictates an inflammatory or derogatory remark about the patient that puts the physician at risk for a lawsuit, and the transcriptionist fails to edit these remarks.

Error #12: Downgrade of Critical Error due to less than critical impact – 1.5 pts

This category is used to downgrade a critical error that does not compromise patient safety but still impacts the integrity of the document. An example would be using the wrong medical word (medical word misuse) without directly affecting patient safety (stating there is a family history of “corporal” tunnel syndrome, for example).

MINOR ERRORS

A minor error is meant to point out recommended areas of improvement for the transcriptionist. These errors do not compromise patient safety or the integrity of the report. The primary goal of a minor error is instructional.

Error #13: Grammar Error – 0.5 pt

Grammar errors may include incorrect subject-verb agreement, incorrect use of medical abbreviations, use of the wrong part of speech, incorrect use of singular and plural nouns, use of the wrong verb (e.g. laying/lying) or verb tense, failure to correct redundancies and inconsistencies, and failure to edit slang or inflammatory remarks when appropriate.

Error #14: Miscellaneous/Other – 0.5 pt

This category covers errors that do not fit into the other categories. For instance, improper capitalization, addition of words that were not dictated but that do not significantly affect the meaning of the sentence or report, and errors of questionable cause when the recording quality is poor or a foreign accent is at fault. This category also covers formatting errors.

Error #15: Downgrade of Error due to minimal impact – 0.25 pt

This category can be used to downgrade any error that has little to no impact on the integrity of the report and does not compromise patient safety. For example, omitting the word “the” in “The patient was in acute distress.”

Error #16: Punctuation and Typos – 0.0 pt

Punctuation errors may include misplaced commas that do not alter the meaning of the sentence and the improper use of colons or semicolons, quotation marks, and misplaced periods. This category also includes typographical errors that do not significantly affect the meaning of the dictation.

NEGATIVE DICTATOR EFFECT ERRORS

These errors have no point values but are used to recognize a transcriptionist's error or difficulties in the context of poor dictation.

Error #17: Critical Negative Dictator Effect – 0.0 pt

This category would be used to point out an error of a critical nature that was clearly attributed to poor dictation. For example, omitted dictation based on difficulty interpreting a very heavy accent. Another example would be incorrect patient identification due to inaccurate or insufficient information given by the dictator. This error may be utilized whether or not the transcriptionist flagged the document, since

the purpose is to determine the difficulty encountered in producing an accurate document.

Error #18: Major Negative Dictator Effect – 0.0 pt

This category would be used to address a documentation error in any of the major categories that was obviously incurred because of poor dictation quality or inaccurate information given by the dictator. Once again, this error may be utilized whether or not the transcriptionist flagged the document, since the purpose is to determine the difficulties in producing an accurate document.

Error #19: Minor Negative Dictator Effect – 0.0 pt

This category would be used to draw attention to a minor flaw caused by poor dictation. For example, the dictator has used the wrong form of a verb, which may or may not have been corrected by the transcriptionist.