TAKING YOUR CLINICAL DOCUMENTATION TO THE NEXT LEVEL WITH VOICE RECOGNITION

Does it sometimes feel like the medical world is the last to adapt to new technologies, no matter how helpful they might be? A revealing 2017 article in the Pharmacy and Therapeutics journal cited the astonishing fact that an estimated 63% of physicians were still using the fax machine as a primary means of communication as recently as 2012!

Despite all the advances in technology and digital communications, many medical practitioners still rely on what they consider to be a tried and true approach. While they might not use an adding machine for their billing and insurance claims, some are still dictating their notes into a recording device for later transcription. Many have used this approach for years and say they just simply feel more comfortable with it. The thought of learning a new technology can be alarming, but sometimes the results can be worth the effort.

Since the 2009 adaptation of the Health Information Technology for Economic and Clinical Health (HITECH) Act, the move toward electronic health records (EHRs), increased patient communication, and the requirement for interoperability among health care providers is forcing the issue with many practices. In order to be compliant with this legislation, providers must be able to demonstrate "meaningful use" of an EHR system to improve the quality, safety, and efficiency of patient care.

As the number of providers that utilize EHRs rises, it would seem that the use of voice recognition would also rise accordingly, but many still pine for the "good old days" of dictation and typing. Surprisingly enough, though, a study cited in the Journal of the American Medical Informatics Association found that continuing to use dictation as the primary means of documentation instead of adapting to EMR and voice recognition may actually result in an inferior level of patient care quality.

The idea of involving additional players in a transcription scenario can also increase the possibility of medical errors. If the transcriber is distracted or does not hear the recording properly, an instant error appears in the patient's medical record. This may be caught in the review process, but unnecessary steps might have been taken in the interlude. In a worst-case scenario, some practices rely on outsourced medical transcription services in an effort to reduce costs, but this can lead to even more problems when transcribers who do not use English as their primary language try to decipher complicated medical terminology. Other problems associated with the dictation and transcription system include:

- There can be problems understanding and transcribing accents, idioms, and use of medical terminology.
- Different transcribers might interpret the same information in different ways.
- A poor audio recording quality can lead to poor results.
- The time lag between the patient visit and the dictation may lead the provider to forget certain details of the patient interaction.
- The need for the provider to review transcribed notes results in an additional drain on time.
- Administrative costs can be high for medical transcription time.
- Additional time is required for transcription, which may result in a lapse in patient care if an incident should occur during the transcription period.

The use of voice recognition software in conjunction with an in-house EHR system can deliver many benefits related to clinical documentation. The practice can save time, develop more detailed documentation, comply more fully with government regulations, improve overall care, and even find additional time for patient visits.

WHAT IS VOICE RECOGNITION AND WHY SHOULD MEDICAL PRACTICES USE IT?

There is no quarrel about the need for clinical documentation. Proper charting is crucial for effective patient care. The physician or provider needs to accurately summarize medical history, symptoms, treatment plans, and other observations in order to properly diagnose and treat patients. This step is also important for justifying bills and insurance claims, and may be crucial evidence in any potential litigation cases.

In 2017, the Wisconsin Medical School conducted a study regarding the use of doctor time during the day. It found that doctors spend over 50% of their time typing or inputting data – an astonishing 1500 work hours every year! And that might be just the providers who actually know how to use a keyboard properly. Who knows how much time is invested by those who rely on the "hunt and peck" method? While somewhat better than the expense and time delay of dictation, a doctor using precious time for typing is really not very cost-effective either.

Fortunately, modern technology offers a very simple solution to the documentation conundrum: voice recognition software. This technique has numerous advantages that can free providers from the torpor of typing and the drudgery of dictation, and will finally reduce the mounds of paperwork long associated with paper charts.

Voice recognition combines the best of all worlds. It allows the provider to continue to use the time-efficient method of speaking over typing, yet still provides the benefits of instant viewing and access. The provider can immediately review the results of the charting session, correct any errors and fill in any missing pieces without having to rely on written notes or memory. Once the system learns to recognize a particular voice pattern, there are far fewer errors than a human typist – either the provider or a transcriber – would make.

Many providers find they actually slow down when dictating or typing on their own, but voice recognition has the capability of understanding up to 200 words per minute – the usual pace that most people use for talking. The system begins to recognize the user's accent, cadence and terminology, and more advanced systems can even begin to incorporate shortcuts where the provider might simply say something like "standard symptoms of diabetes," and the software will automatically enter all of the symptoms without requiring the provider to list each one separately.

What to Look for in Voice Recognition Software

Beyond working with an established and credible supplier, the voice recognition software should easily integrate with the practice's EHR system for maximum efficiency. It should include macros and templates that are specific or customized to practice specialties, and a large vocabulary of medical terminology, in addition to the following features:

- Easy to implement, set up and learn. Minimal training required for team members to get up to speed.
- Can adapt to specific provider accents or speech patterns.
- Incorporates systems that help in streamlining office workflow.
- Includes specialty-specific BS customized voice commands.
- Top voice recognition speed and accuracy.
- Provides secure communication over encrypted channels.
- Compatibility with existing office hardware and software, and ease of integration for future upgrades.
- Standardized output that coordinates with other healthcare providers to meet interoperability requirements.
- Adaptability to various office devices to allow documentation from anywhere on multiple devices.
- Compliance with medical profession privacy and confidentiality requirements.
- Advanced degree of technical support and customer service that is available 24/7.
- Cost benefit that outweighs the expense of purchase, yearly access, and upgrades.

THE BENEFITS OF VOICE RECOGNITION SOFTWARE IN CLINICAL DOCUMENTATION

To keep up with government requirements and increasing documentation needs, implementing voice recognition technology may be a critical key to supporting healthcare providers as they become more productive participants in the clinical documentation process. Voice recognition can significantly improve the effectiveness of any medical facility, from a small independent provider to a larger hospital setting.

While basic health conditions are relatively easy to input using voice recognition, the technology is especially helpful for chronicling the story of the more nuanced, multi-symptom patient. Previous methods of dictation or typing might become cumbersome for these cases, but voice recognition allows the provider to simply relate the patient's story in full detail to provide better insights and treatment plans. Other key benefits of incorporating voice recognition include:

Increased Accuracy

The system immediately leads to an improved quality of documentation. The provider can review and edit as he/she moves along, leading to a more accurate initial record that can be used as the basis for developing a comprehensive treatment plan.

Decreased Turnaround

In certain medical cases, time is everything and treatment cannot wait for a record to be updated. Immediate and more accessible information can lead to faster diagnosis and treatment. The ability to provide a complete report to the entire care team within minutes of a patient interaction or receipt of a report means that prescriptions, specialist appointments, and after-care instructions can be implemented more quickly so the patient gets on the road to recovery faster.

Reduced Errors

The provider can ensure that the record provides an accurate recounting of the patient interaction. Immediate availability for review can lead to diminished charting and treatment errors.

More Productivity

Speaking notes directly into the EHR system frees up precious hours from the practitioner's day, as well as members of the health care team.

Compliance

Putting notes quickly into a coordinated format increases practice compliance with interoperability requirements.

Improved Billing

Better and more accurate clinical documentation leads to more accurate coding and billing processes.

More Revenue

Additional revenue is generated by scheduling appointments during time that may previously have been set aside for charting purposes. In fact, many doctors find that using speech recognition software often enables them to see up to one-third more patients than they were able to accommodate before implementation.

Lower Costs

Practices can save money by eliminating transcription costs, which can vary based on the complexity of the patient record. Software is a set fee that does not change based on record length.

Better Care

Practices can realize an improved quality of patient interactions because of access to more effective charts. In some cases, providers have even found that they can dictate certain portions of the case right during the patient visit. This demonstrates that the provider has an accurate and total understanding of the patient's concerns, gives the patient better insight into what the provider is thinking, and immediately corrects any misunderstandings on the provider's part.

To obtain maximum benefit, look for voice recognition software that has the features and benefits which will help take your clinical documentation to the next level.