



MEMORANDUM

**To: HIT Policy Committee
Meaningful Use, Certification and Adoption Workgroups**

From: John B. Anderson, MD MPH

Date: February 5, 2013

Subject: Voice Recognition for Clinical Documentation

Background

The use of voice recognition for clinical documentation is not a recent phenomenon. This technology has been used in the past with good success in several specialty applications, such as dictating radiology reports or procedure related documentation. With the increasing adoption of Electronic Health Records, the use of voice recognition has found broader adoption as a tool to enhance the “narrative” portion of the clinical record. The technology has significantly improved in both the accuracy and speed of recognition while allowing the user to choose an array of platforms to facilitate voice capture. While voice recognition technology offers multiple enhancements to an EHR platform, there are several key features that deserve further discussion.

- One of the main criticisms of today’s electronic health records is that of templated, “point and click” documentation. Clinicians have expressed concern that this technology fails to adequately capture the patient’s “story” and that it is difficult to document one’s medical decision making. There seems to be an inordinate amount of effort expended on importing data into a note that fails to convey to other clinicians what actually transpired during the encounter. The use of voice recognition as a tool for clinical documentation provides a mechanism whereas a clinician can provide narrative and free-text information. This becomes a more robust note that better captures the patient’s story and provide the clinician with a mechanism to better outline his assessment and plan.
- Voice recognition can also create gains in efficiency and in cost reduction. The need for expensive transcription services no longer exists and notes are immediately available for hand-offs and clinical care. There are programs that allow the use of voice commands to navigate through the EHR and mitigate the



- additional time that is often required for clinicians to function in an electronic environment.
- Electronic health records will provide a rich source of data to enhance our ability to manage populations of patients, improve our patient's experience of care and to help bend the cost curve. Technology is being developed that will allow Natural Language Processing to extract key data elements from narrative text. These discrete data elements can then be used to alert clinicians about possible new therapies, encourage adherence to guidelines and populate registries for reporting purposes.

Areas of Focus

1. The role of clinical documentation for payment purposes: Appropriate documentation in a progress note is critical in order to determine the correct level of reimbursement. Our current reimbursement is linked to the RVU that is assigned to each CPT code. The level of service that correlates to the CPT code is dependent on appropriate documentation to support that code. The use of voice recognition software should serve to facilitate capture of information that appropriately supports the level of coding.
2. Role of documentation under healthcare reform when payment not dependent on transactions: Documentation will still be critical to support care processes and ensure transfer of information for transitions in care. Documentation will always serve a purpose to ensure continuity for clinicians and patients. This will also apply to transitions of care between sites and between primary and specialty care. I expect will also be important so as to ensure appropriate allocation of reimbursement internally, within the organization that is providing care.
3. Policies to mitigate against fraud or misrepresentation: There will always be a role for periodic audits of clinical documentation. May be useful to strategically audit outliers in level of CPT coding. Policies that support move to "value" based reimbursement, with less of a focus on "volume" driven behavior, will encourage documentation that supports population management and appropriate utilization.
4. Technology to support accuracy and efficiency of documentation while avoiding misrepresentation: The accuracy of voice recognition will continue to improve over time. Programs are also designed to function as "learning" systems the more dictation that the clinician speaks into the tool. Software is also available that can review text and monitor for "cloning" of clinical documentation.