ASSIGNMENT 2: THE HEALTHCARE RECORD AND HEALTHCARE DOCUMENTATION TECHNOLOGY

Read Chapters 2 and 3 in your textbook, *Healthcare Documentation: Fundamentals and Practice.* Then read Assignment 2 in this study guide.

The healthcare documentation profession has undergone many changes throughout the years. In the beginning, physicians documented patient care themselves on paper. As the medical field progressed, medical record formats became more standardized. First, medical stenographers began taking shorthand while physicians spoke. Long-hand documentation later became easier with the aid of abbreviations.

As technology progressed, so did the field, which came to be called medical transcription. Medical transcriptionists first used typewriters and later graduated to computer systems and software. Today, many healthcare documentation specialists work from home by accessing a system through the Internet to transcribe or edit medical documents.

Health Care Record

As you're probably aware, a patient's medical record plays an important role in the career of a healthcare documentation specialist. Medical records record patient information and treatment to communicate, evaluate, and assist in care.

There are many different components to a patient's health care record. A record is made up of physician orders, laboratory and test information, nursing notes, operative reports, and many other reports and entries that work together to give an overall picture of the patient's care.

Types of Reports

You'll transcribe different reports depending on the type of facility or your specialty. These include the following:

- H&P
- SOAP note
- Chart note
- Radiology report
- Operative report
- Pathology report
- Consultation
- Discharge summary
- Death summary
- Autopsy report

Health information management (*HIM*) and *health information technology* (*HIT*) are two big concepts in today's practice and hospital management environments. The fields are growing and will continue to grow at least until we have a better handle on the whole field of *electronic health records* (*EHRs*) and the evolving field of documentation and patient care. Your textbook gives insight into the HIM director position on pages 28–31.

Review the description of each type of document found in a health care record on pages 31–38 of your textbook. Review the "Sample Reports" on pages 50–57 to help you understand the layout of various reports.

There is an introduction to the field of pharmacology on pages 40–44. New pharmaceuticals are constantly developed, so this is an area in which you'll always be learning something new. It's important to know, or know how to find, the correct spellings and normal doses of medications when you're working with a record. Dictated numbers can sound similar, and if a dosage is documented incorrectly, it will negatively impact a patient's care. If you hear a dosage that doesn't sound right, this is something you should flag for

recheck by the dictator before the record is finalized. Pharmacology makes up a great deal of a healthcare documentation specialist's knowledge.

After you've read the material, complete the Exercises on pages 46–49. Check your answers in the Answer Keys to Practice Exercises link on your My Courses page.

Technology in Transcription

Technology has greatly altered the way an HDS performs daily work. In many ways, the advancements in transcription technology have made the job easier and more efficient. Gone are the days of cassette tape dictations. They've mostly been replaced by digital or online dictation systems, so you use the same system as the person speaking.

Even with the most advanced technology, it's vital that transcriptionists understand the basics. Without a full understanding of grammar, styles, and transcription rules, a healthcare documentation specialist will fail to provide quality reports.

Speech recognition technology (*SRT*) (also called *Voice recognition technology,* or *VRT*) is the most recent technology that many felt would be the end of transcription. In fact, speech recognition has been a tool of the healthcare documentation specialist for many years. It also caused many transcriptionists to branch out into the field of *Speech recognition editing* (*SRE*). Editing is very different from traditional transcription, but it's a skill that must be developed just like transcription. It's not easy to listen to an audio recording or read a transcript that contains errors and fix those errors on the fly. Without training, when we read something while listening to the same content, our brains tend to pay attention to the correct one. As long as one of them makes sense, we don't worry about the incorrect one. So, without training, it's easy to miss errors in the transcribed record because our brains correct for it. It takes concentration and skill to be an SR editor!

The text goes into detail about speech recognition platforms and how they're used in the industry. This is, certainly, a field that continues to improve and find new applications in healthcare. However, it's a long way from replacing a skilled HDS.

The most recent technological development is the *electronic health record* (*EHR*). While there have been many challenges as this new technology takes hold in the industry, HDS skills are crucial for maintaining the integrity of the patient record in this challenging environment. Narrative text is an important part of a patient's record. So many of today's electronic health record elements are included via pull-down menus and templates, the patient's unique story gets lost in the shuffle. Initiatives like the Health Story Project **(http://www.himss.org/health-story-project)** have gained strength in the field, reminding physicians that each patient is unique, and personal details must be included as part of a comprehensive health record.

Even though we like to preserve traditional parts of the health record, HDSs are often fans of new technology. There are some interesting productivity tools out on the market today, and the textbook introduces you to some on pages 69–71.

After you've read the material, complete the Exercises on pages 74–76. Then complete *Self-Check 2.* When you're ready, move on to Assignment 3.

Self-Check 2

Indicate whether each statement is True or False.

_____ 1. A recovery audit contractor reviews records for the Centers for Medicare and Medicaid Services, looking for fraud and evidence of overcharging by facilities.

_____ 2. Planning and communication among caregivers is one of the purposes of a medical record.

_____ 3. An integrated transcription platform uses a foot pedal to control the audio recording.

_____ 4. In an operative report, any dictated references to drains, packs, and dressings can be omitted from the report because these portions are recorded by the operating room nursing staff.

_____ 5. CPOE stands for computerized provider order entry.

Check your answers with those on page 97.