

A Day in the Life of a Medical Transcriptionist (home-based position)

Medical transcription is a fast-paced, specialized healthcare field with our own language, rules and regulations. More appropriately, today we are known as a Medical Language Specialist (MLS) with responsibilities to preserve the accuracy and integrity of legal medical documents. No two days are the same on the job, and the learning never ends. Although we sometimes face challenges; they are resolvable, and there is always an abundant workload. Moreover, the ability to work from home makes this position highly desirable provided one is disciplined and focused.

At the medical center where I work, dictation can be done from either inside or outside the hospital for all physicians with staff privileges by dialing into the dictation system to a designated number. All dictation is recorded through a digital system and is managed through an application called DVI that is now supported by Word Systems, Inc. At our institution, dictation and transcription are separated into two separate categories; radiology and medical. An on-staff dials into the DVI phone line and keys in the pertinent information for the dictation. The dictations are set up in work types designated for the specific report that they wish to dictate; i.e., history and physical, consultation, operating report, discharge summary, cardiology procedure, radiology, etc. Once the dictation is recorded on the DVI system, it is immediately off-loaded to our transcription program.

The transcription platform used is an Internet-based system called TA Client and is a program that was created and supported by Arrendale Associates out of North Carolina. Within the TA application, the “jobs,” (each dictated report) are housed in an area called job administration. This area holds all dictation that is waiting to be transcribed. Each document is assigned a work type and is weighted according to priority. Each transcriptionist has the capability to view job administration, which allows them to manipulate documents (should the need arise) for problematic dictations, to move them to a higher or lower priority, change the work type as necessary when there is an error, to work through a specific backlog or dictator, as well as to route preoperative reports to a designated area until the patient is assigned a current account number if the report is being dictated preoperatively so it is not kicked around by multiple associates until they are assigned an appropriate number.

The transcription system is set up such that when a transcriptionist signs in to the program, the jobs auto-route to available transcriptionists two jobs at a time. As they complete one job and submit it, the queue will refresh and load another job. Each time a transcriptionist call up a report to do, she is prompted by a demographic screen that populates the patient demographic information that the dictator has keyed in (on a good day), providing there are demographics available. Sometimes, little to no information is given wherefore the MLS detective skills come into play. Again, the patient’s medical record is a number that stays the same no matter how many times they come to the medical center. The different stays are called encounters, and those numbers change each time they visit. These are called account numbers.

When the patient demographics populate on the screen and the transcriptionist has verified through her headphones and the main frame (AS400) that the dictated text and the patient information match, she then clicks the button on the TA demographic screen that performs a lookup on the AS400 that will then link the patient demographics with a Word document that is created. Now finally, the transcriptionist can begin the transcription! With practice and repetition, this process moves quickly. The transcriptionists at our institution have three packets that have been distributed that outline our Transcription Overview, Transcription Style Guide, and Transcription Formats set forth by the department and the medical center that are to be followed when transcribing dictated documents. We also closely follow the AHDI (Association for Healthcare Documentation Integrity) Medical Transcription Book of Style. IT is the responsibility of each transcriptionist to also keep a medical library up to date concurrent with use of reputable references from Internet web sites.

Once the medical document has been transcribed, it is the responsibility of the transcriptionist to spell check the document and make any revisions necessary and adding any carbon copies that need to be sent before submitting the completed record. Once the document has been submitted, it flows back to the hospital main frame (AS400) and from there is interfaced to the HPF (Horizon Patient Folder) in the form of a preliminary document. At this point in time, a deficiency is created for the physician to sign the document. It is imperative that the physician carefully reviews the content and makes any necessary edits or changes before affixing their signature. This is now considered a legal medical document. Once their signature has been affixed to the document, they can no longer edit the report and would have to make any further changes or additions in the form of a dictated "addendum or corrected copy," that would require another signature.

We have the capability to create our own short cuts within the TA Client program and have created normals and samples that help to enhance and boost our production. The medical center has set average turnaround times for our specific report types. The system is capable of monitoring these and we have the means to monitor how many jobs are out of turnaround by the job summary function of our TA (transcription) program. These turnaround times are monitored closely and are reported to our HIM director at the end of each month, who then in turn reports them to administration.

Medical transcriptionists are paid by productivity and are paid by the 65-character line. Our minimum requirement is equivalent to 150 lines per hour (for part-time) or an average of 12,000 lines per pay period (two weeks) for a full time employee (80 hours). Production statistics are submitted weekly by the individual transcriptionist and are checked against the production report run from the transcription application. On the medical side, we have a three-tier incentive program that affords the opportunity for a greater earning depending on the lines per hour the transcriptionist transcribes and their accuracy. All transcriptionists, while earning by production, are schedule for specific shifts and punch their time through a time and attendance program, which is necessary for calculation of their lines/reports per hour. Our part of the department is typically considered a 24/7 department and our staff coverage complies with this time frame.

Each transcriptionist receives an annual evaluation at which time a transcription quality assessment/audit is done to calculate average production (quality/quantity/accuracy) as part of an overall assessment for potential merit increase. Included in this annual evaluation are other things pertinent to our medical center as an individual institution and includes pieces like compliance with Net Learning. These mini in-service modules set up by the medical center for the purpose of continuing education that help us to stay abreast of JCAHO requirements, medical center policies and procedures, patient safety goals, OSHA requirements, hazardous materials and the like.

Medical transcription is an exciting but ever-changing field regardless as it is critical that the medical documentation as dictated is as accurate as possible in order that we can provide the most current and complete up-to-date electronic medical record possible with the information that we are given. The medical record will follow the patient their entire life and we try to make certain that while transcription, we consider that the patient we are serving could be our own family members. It is through the documentation as a joint effort between the dictator and the transcriptionist that other healthcare providers may be basing their current assessment of a patient and their subsequent ongoing care.