

ROLES, SKILL SET, and WORK SETTINGS

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LEVEL 1 (includes entry level)

BASIC to GOOD SKILLS

Roles

Medical transcriptionist

Back-end speech editor

Environment

May be an individual or multispecialty facility; outpatient surgery/procedure center; a radiology, pathology or oncology center; individual practitioner(s); hospice; research facility; or general hospital.

A healthcare documentation specialist (HDS) who wishes to work as a traditional medical transcriptionist and/or back-end speech editor requires the following skills at a BASIC TO GOOD LEVEL, entry basic level.

HDS Skills

- Understanding of medical terminology, anatomy and physiology, disease processes, treatment techniques, surgery processes and instrumentation, and pharmacology relevant to the specific specialty/specialties of the facility.
- Ability to correctly translate abbreviations into their expanded forms.
- Ability to recognize and utilize appropriate flagging of discrepancies and unclear dictation for QA auditor, lead, supervisor and/or dictating provider.
- Good listening skills; a keen ear to identify and learn various speech patterns, dialects and accents of providers whose second language is English.
- Knowledge of state and federal laws and regulations regarding privacy and security, such as HIPAA regulations.
- Strong ability to maintain confidentiality both within the work environment and maintain that confidentiality no matter what.
- Referencing and researching skills, using books and the internet.
- Knowledge of facility's documentation requirements.
- Written and oral communication skills, including grammar and spelling.
- Knowledge of common sound-alike words, both English language and medical terminology.
- Ability to operate a computer, use basic software applications (Microsoft Office), use basic dictation/transcription software and equipment, and to learn EHR platforms.
- Awareness of what may constitute a potential liability issue for patients, dictating providers and/or the healthcare facility; ability to appropriately flag reports for review by QA auditor, lead, supervisor and/or dictating provider.
- Ability to meet minimum accuracy standards of employer (AHDI recommendation of 98.0% or higher), meet minimum productivity standards of employer, and work under turnaround time pressures.
- Ability to work independently with minimal supervision and as part of a team.
- Knowledge of medical transcription guidelines and practices (*The Book of Style for Medical*

Transcription by AHDI).

- Willingness to grow professionally through acceptance and incorporation of feedback and continuing education

Soft Skills

- Acts professional demeanor at all times.
- Reliable and dependable in timeliness and attendance.
- Adheres to employer's policies and guidelines for all aspects of employment.
- Keeps an open mind; approaches new ideas and technology with willingness.
- Accepts feedback in a positive manner.
- Treats everyone respectfully.
- Good work ethic; accepts responsibility; takes initiative; has good follow through.
- Supports management decisions and policies.
- Good problem solving skills.
- Values and produces high-quality work.
- Demonstrates personal accountability for errors.
- Recognizes strengths of others; show appreciation for others' abilities and skills.
- Cultivates the skills of listening and presenting ideas.
- Resolves conflict in a fair manner that leads to positive change.
- Is honest, authentic and inclusive; has integrity.
- Ability to apply critical thinking in all matters.
- Ability to adapt, learn and change as technology advances.

LEVEL 2

SOLID/STRONG SKILLS

Roles

Medical transcriptionist

Back-end speech editor

Environment

May be an individual or multispecialty facility; outpatient surgery/procedure center; a radiology, pathology or oncology center; individual practitioner(s); hospice; research facility; general hospital; acute care hospital; trauma center; or teaching hospital.

A healthcare documentation specialist (HDS) of this level requires competence in all of the basic skills of Level 1 to progress to the SOLID / STRONG, experienced skills of Level 2.

Additional HDS Skills

- Ability to discern technical jargon.
- Ability to multi-task.
- Well-trained ear for the various speech patterns, dialects and accents of providers whose second language is English.
- Willingness to continue to grow professionally through continuing education and/or certification.

Additional Soft Skills

- Ability to problem-solve, motivate others, team build, take initiative.
- Recognize strengths of others and encourage them to use their strengths.
- Ability to advise others according to the policies and guidelines of the employer.

LEVEL 3

ADVANCED SKILLS

Roles

Medical transcriptionist
Back-end speech editor
Quality assurance auditor
Trainer/mentor
Lead

Environment

May be an individual or multispecialty facility; outpatient surgery/procedure center; a radiology, pathology or oncology center; individual practitioner(s); hospice; research facility; general hospital; acute care hospital; trauma center; or teaching hospital.

A healthcare documentation specialist (HDS) of this level requires competence in all of the basic skills of Levels 1 and 2 to progress to the ADVANCED, excellent skills of Level 3.

Additional HDS Skills

- Excellent understanding of advances in the medical field.
- Advanced ability to discern technical jargon.
- Excellent ability to demonstrate/train appropriate flagging of discrepancies and unclear dictation and excellent judgment in regards to when leaving a blank is the most appropriate course of action.
- Excellent discernment/listening skills; an expert ear.
- Ability to perform concurrent/retrospective accuracy reviews and provide useful feedback in a constructive and educational manner to prevent repetitive errors and to promote confidence and skill building of others.
- Ability to troubleshoot and train others on use of computer and multiple, various software applications.
- Ability to cross-train staff on additional/new specialties and report types.
- Proficient in referencing, researching, reporting, tracking and monitoring the workload.
- In-depth knowledge of medical transcription guidelines (*The Book of Style for Medical Transcription* by AHDI) and practices.
- Willingness to grow professionally through continuing education and certification.
- Welcomes additional responsibilities to help explore ways to increase productivity, efficiency and meet the goals of the department and facility both inside and out in the community.

Additional Soft Skills

- Ability to lead others.

LEVEL 4

EXPERT or MASTER SKILLS

Roles

Medical transcriptionist
Back-end speech editor
Quality assurance auditor/educator
Trainer/mentor
Lead
Supervisor or manager (additional managerial skills required)
Emerging roles

Environment

May be an individual or multispecialty facility; outpatient surgery/procedure center; a radiology, pathology or oncology center; individual practitioner(s); hospice; research facility; general hospital; acute care hospital; trauma center; or teaching hospital.

A healthcare documentation specialist (HDS) of this level requires competence in all of the basic skills of Levels 1, 2 and 3 to progress to the EXPERT or MASTER skills of Level 4.

Additional HDS Skills

- Ability to compare/assess new software and work flows, train, troubleshoot through the process of technology changes. May have responsibility for making decisions regarding software and/or equipment and/or to report up line.
- Experienced ability to assess workload and balance staffing and productivity.
- Excellence in referencing, researching, reporting, tracking and monitoring the workload.
- Willingness to grow professionally through continuing education.
- Participation in department/professional projects.
- Assures that the work environment contributes to the well-being of all employees.
- Has pursued, attained and maintains AHDI certification or greater.

Soft Skills

- Experienced ability to interview and evaluate candidates and make hiring recommendations/decisions.

Future Roles Job Descriptions

Healthcare Documentation Integrity Auditor, Level 1

Position Description

Healthcare documentation integrity auditor, level 1, audits and ensures the integrity of healthcare documentation created by physicians and other healthcare practitioners. Quality is monitored, measured, and reported on by verifying content and context for inconsistencies, discrepancies, and inaccuracies. Level 1 individuals possess proficient medical knowledge, basic computer and Microsoft Office skills, and EHR familiarity. AHDI certification preferred (RMT, RHDS, CMT, or CHDS).

Organizational Summary

Reports to: healthcare documentation integrity manager

Provides Supervision to: no direct reports; however, audits the work of physicians and other healthcare practitioners

Primary Customer Groups: physicians, physician assistants, residents, nurse practitioners and other medical practitioners documenting patient care

Patients Served: no direct patient care

Qualifications

Education

- High school diploma required
- Associate's degree or equivalent (in terms of medical experience) preferred
- Demonstrate continuing education credits in the medical field

Experience

- Over 3 years' experience with emergency department, general inpatient community hospital and/or ambulatory healthcare documentation and/or quality assurance work in these settings
- Experience with general computer usage and basic skills using Microsoft Office applications (Word, Excel, and Outlook)
- Experience with electronic medical record applications (Cerner, Epic, etc.)
- Experience using medical reference materials (hard copy and/or electronic)

Licensure/Certification

- Registered or Certified Medical Transcriptionist (RMT or CMT) or Registered or Certified Healthcare Documentation Specialist (RHDS or CHDS) preferred
- Other healthcare experience and certifications may be acceptable

Knowledge/Skills/Abilities

Knowledge

- Knowledge of medical terminology, anatomy and physiology, pharmacology, and disease

processes used within the facility or certain areas of expertise

- Knowledge of, and experience in, facility or specific medical specialty documentation requirements (including, but not limited to, histories & physicals, discharge summaries, consultations, operative notes, emergency department notes, radiology reports, cardiology reports, and physician office notes and correspondence)
- Knowledge of medical documentation guidelines and best practices
- Knowledge and use of Microsoft applications, electronic health record software (Cerner, Epic or Comparable system); and general computer and keyboarding usage
- Knowledge of, and ability to identify, patient safety and risk management issues within medical documentation

Skills/Abilities

- Ability to understand and compare information entered into the medical record by numerous sources and able to accurately assess that information is consistent and appropriate for the patient
- Ability to process, assess, and/or decipher information entered into the electronic medical record; including the ability to verify information that may appear incorrect or ambiguous
- Ability to multi-task (perform more than one task at a time and/or quickly switch back and forth between tasks), while working under pressure of time constraints
- Ability to meet minimum established departmental quality and productivity expectations
- Ability to work independently with minimal supervision

Physical Demands/Work Environment

- Ability to sit and view a computer monitor for long, uninterrupted periods of time
- Ability to switch between multiple computer programs while typing and assessing documentation (requiring strong hand/eye coordination)
- Ability to lift materials/files/equipment up to a 20-pound weight limit
- Moderate noise levels in the work environment
- Normal office environment
- Occasional exposure to strains, sprains, cuts, eye strain, etc.
- Stressful conditions may exist due to prolonged periods of concentration and scheduled deadlines

Essential Functions

- Recognize, evaluate and verify clinical documentation content and context for inconsistencies, discrepancies, and inaccuracies within the EHR that would be deemed critical and could impact patient care.
- Recognize, evaluate and verify clinical documentation for spelling, grammar or punctuation errors that would be deemed non-critical to patient care but compromising to documentation, organizational and/or clinician integrity.
- Verify patient demographics and information to ensure documentation is on the correct patient, and/or correct visit encounter.
- Verify correct documentation template was utilized placing the correct documentation in the correct location within the EHR.
- Communicate and collaborate with other members of the team in order to ensure continuity of

care and coordination of services. Communicate unusual circumstances with possible risk factors or medicolegal issues to the manager.

- Ability to multi-task and work under pressure with time constraints.
- Ability to work independently with minimal or no supervision.
- Engage in the continuous study of clinical documentation and terminology to maintain competence, knowledge and skills necessary for the satisfactory performance of all assigned responsibilities.
- Provide quality assurance and/or mentoring support to the healthcare documentation department and/or transcribe as needed.
- Meet or exceed quality and production expectations as defined by departmental policy and procedure.
- Operate and maintain computer equipment and software and other office equipment in an effective, skillful, efficient and safe manner.
- Perform such individual assignments as directed.
- Establishes and maintains effective working relationships within the organization.

Healthcare Documentation Integrity Auditor, Level 2

Summary

Healthcare Documentation Integrity Auditor, Level 2 audits and ensures the integrity of healthcare documentation created by physicians and other healthcare practitioners. Quality is monitored, measured and reported on by verifying content and context for inconsistencies, discrepancies and inaccuracies. Level 2 individuals possess expert medical knowledge, advanced computer and Microsoft Office skills, and EHR mastery. Nature of work performed crosses all medical specialties in an acute care setting. AHDI certification preferred (RMT, RHDS, CMT, or CHDS).

Organizational Summary

Reports to: Documentation Integrity Supervisor/Manager

Provides Supervision to: No direct reports; however, audits the work of physicians and other healthcare practitioners

Primary Customer Groups: physicians, physician assistants, residents, nurse practitioners and other medical practitioners documenting patient care

Patients Served: no direct patient care

Qualifications

Education

- High school diploma required
- Associate's degree or equivalent (in terms of medical experience) preferred
- Demonstrate continuing education credits in the medical field

Experience

- Over 3 years' experience with healthcare documentation large acute care facility and/or quality assurance work in a large acute care facility
- Extensive experience with computers and advanced skills using Microsoft Office applications (Word, Excel, and Outlook)
- Experience with electronic medical record applications (Cerner, Epic, etc.)
- Experience using medical reference materials (hard copy and/or electronic)

Licensure/Certification

- Registered or Certified Medical Transcriptionist (RMT or CMT) or Registered or Certified Healthcare Documentation Specialist (RHDS or CHDS) preferred
- Other healthcare experience and certifications may be acceptable

Knowledge/Skills/Abilities

Knowledge

- Knowledge of medical terminology, anatomy and physiology, pharmacology, and disease processes, as pertains to all specialties in an acute care facility
- Knowledge of, and experience in, documentation requirements of a large acute care facility (including, but not limited to, histories & physicals, discharge summaries, consultation, operative

notes, emergency department notes, radiology reports, cardiology reports, etc.)

- Knowledge of medical documentation guidelines and best practices
- Knowledge and use of Microsoft applications, electronic health record software (Cerner, Epic or Comparable system); and general computer and keyboarding usage
- Knowledge of, and ability to identify, patient safety and risk management issues within medical documentation

Skills/Abilities

- Ability to understand and compare information entered into the medical record by numerous sources and able to accurately assess that information is consistent and appropriate for the patient
- Ability to process, assess, and/or decipher information entered into the electronic medical record; including the ability to verify information that may appear incorrect or ambiguous
- Ability to multi-task (perform more than one task at a time and/or quickly switch back and forth between tasks), while working under pressure of time constraints
- Ability to meet minimum established departmental quality and productivity expectations
- Ability to work independently with minimal supervision

Physical Demands/Work Environment

- Ability to sit and view a computer monitor for long, uninterrupted periods of time
- Ability to switch between multiple computer programs while typing and assessing documentation (requiring strong hand/eye coordination)
- Ability to lift materials/files/equipment up to a 20-pound weight limit
- Moderate noise levels in the work environment
- Normal office environment
- Occasional exposure to strains, sprains, cuts, eye strain, etc.
- Stressful conditions may exist due to prolonged periods of concentration and scheduled deadlines

Essential Functions

- Recognize, evaluate and verify clinical documentation content and context for inconsistencies, discrepancies, and inaccuracies within the EHR that would be deemed critical and could impact patient care
- Recognize, evaluate and verify clinical documentation for spelling, grammar or punctuation errors that would be deemed non-critical to patient care but compromising to documentation, organizational and/or clinician integrity
- Verify patient demographics and information to ensure documentation is on the correct patient, and/or correct visit encounter
- Verify correct documentation template was utilized placing the correct documentation in the correct location within the EHR
- Communicate and collaborate with other members of the team in order to ensure continuity of care and coordination of services
- Communicate unusual circumstances with possible risk factors or medicolegal issues to the manager
- Ability to multi-task and work under pressure with time constraints

- Ability to work independently with minimal or no supervision
- Engage in the continuous study of clinical documentation and terminology to maintain competence, knowledge and skills necessary for the satisfactory performance of all assigned responsibilities
- Provide quality assurance and/or mentoring support to the healthcare documentation department and/or transcribe as needed
- Meet or exceed quality and production expectations as defined by departmental policy and procedure
- Operate and maintain computer equipment and software and other office equipment in an effective, skillful, efficient and safe manner
- Perform such individual assignments as directed
- Establishes and maintains effective working relationships within the organization

Healthcare Documentation Integrity Auditor/Educator

Summary

The healthcare documentation integrity auditor/educator audits and ensures the integrity of healthcare documentation with a focus on physician training needs. Quality is monitored, measured, and reported on by verifying contents and context for inconsistencies, discrepancies, and inaccuracies. Develops and conducts individual or classroom training of physicians and other healthcare practitioners in the entry of medical documentation into the EHR. Auditor/Educator individuals possess proficient medical knowledge, basic computer and Microsoft Office skills, and EHR mastery. AHDI certification preferred (CMT or CHDS).

Organizational Summary

Reports to: documentation integrity manager

Provides Supervision to: no direct reports; however, provides education and training to physicians and other healthcare practitioners

Primary Customer Groups: physicians, physician assistants, residents, nurse practitioners and other medical practitioners documenting patient care

Patients Served: no direct patient care

Qualifications

Education

- High school diploma required
- Associate's degree or equivalent (in terms of medical experience) preferred
- Demonstrate continuing education credits in the medical field

Experience

- Over 5 years' experience with healthcare documentation large acute care facility and/or quality assurance work in a large acute care facility
- Experience with general computer usage and above-average skills using Microsoft Office applications (Word, Excel, and Outlook)
- Experience with training electronic medical record applications (Cerner, Epic, etc.) and front-end voice recognition software (Dragon)

Licensure/Certification

- Certified Medical Transcriptionist (CMT) or Certified Healthcare Documentation Specialist (CHDS) preferred
- Other healthcare experience and certifications may be acceptable

Knowledge/Skills/Abilities

Knowledge

- Knowledge of medical terminology, anatomy and physiology, pharmacology, and disease processes, as pertains to all specialties in an acute care facility
- Knowledge of, and experience in, documentation requirements of a large acute care facility

(including, but not limited to, histories & physicals, discharge summaries, consultation, operative notes, emergency department notes, radiology reports, cardiology reports, etc.)

- Knowledge of medical documentation guidelines and best practices
- Knowledge and use of Microsoft applications, electronic health record software (Cerner, Epic or Comparable system); voice recognition software (Dragon); and general computer usage
- Knowledge of, and ability to identify, patient safety and risk management issues within medical documentation

Skills/Abilities

- Effective organizational skills and the ability to effectively communicate both verbally and in writing
- Ability to understand and compare information entered into the medical record by numerous sources and able to accurately assess that information is consistent and appropriate for the patient
- Ability to process, assess, and/or decipher information entered into the electronic medical record; including the ability to research to verify information that may appear incorrect or ambiguous
- Ability to multi-task (perform more than one task at a time and/or quickly switch back and forth between tasks), while working under pressure of time constraints
- Ability to meet minimum established departmental quality and productivity expectations
- Ability to work independently with minimal supervision

Physical Demands/Work Environment

- Ability to work in a fast-paced clinical setting supporting physicians and other healthcare practitioners
- Ability to stand or sit for long uninterrupted periods of time
- Ability to view a computer monitor for long, uninterrupted periods of time
- Ability to switch between multiple computer programs while typing and assessing documentation (requiring strong hand/eye coordination)
- Able to lift materials/files/equipment up to a 20-pound weight limit
- Able to handle moderate noise level in the work environment
- Exposure to normal clinical environment and/or office environment
- Occasional exposure to strains, sprains, cuts, eye strain, etc.
- Stressful conditions may exist due to prolonged periods of concentration and scheduled deadlines

Essential Functions

- Communicate and educate physicians and other healthcare practitioners on clinical data entry into the EHR
- Recognize and evaluate when a clinician needs additional assistance in proper encounter selection, proper template selection and in creating macros to ensure proper medical documentation is met
- Recognize, evaluate and verify clinical documentation content and context for inconsistencies, discrepancies, and inaccuracies within the EHR that would be deemed critical and could impact patient care
- Recognize, evaluate and verify clinical documentation for spelling, grammar or punctuation

errors that would be deemed non-critical to patient care but harmful to documentation, organizational and/or clinician integrity

- Verify patient demographics and information to ensure documentation is on the correct patient, and/or correct visit encounter
- Verify correct documentation template was utilized placing the correct documentation in the correct location within the EHR
- Communicate and collaborate with other members of the team in order to ensure continuity of care and coordination of services
- Communicate unusual circumstances with possible risk factors or medicolegal issues to the manager
- Ability to multi-task and work under pressure with time constraints
- Ability to work independently with minimal or no supervision
- Engage in the continuous study of clinical documentation and terminology to maintain competence, knowledge and skills necessary for the satisfactory performance of all assigned responsibilities
- Provide quality assurance and/or mentoring support to the healthcare documentation department and/or transcribe as needed
- Meet or exceed quality and production expectations as defined by departmental policy and procedure
- Operate and maintain computer equipment and software and other office equipment in an effective, skillful, efficient and safe manner
- Performs such individual assignments as directed. Establishes and maintains effective working relationships within the organization

Healthcare Documentation Integrity Coordinator

Summary

The healthcare documentation integrity coordinator acts as a lead team member providing assistance and/or education to healthcare documentation integrity auditors, healthcare documentation integrity auditor/educators and/or healthcare documentation specialists. Coordinator performs data analysis on audited results and assists in process improvement initiatives. Coordinator may perform documentation corrections and may communicate with clinicians. AHDI Certification Required (CMT or CHDS).

Organizational Summary

Reports to: documentation integrity supervisor/manager

Provides Supervision to: no direct reports; however, audits the work of physicians and other healthcare practitioners

Primary Customer Groups: physicians, physician assistants, residents, nurse practitioners and other medical practitioners documenting patient care; mentors all levels of healthcare documentation specialist and auditors

Patients Served: no direct patient care

Qualifications

Education

- High school diploma required
- Associate's degree or equivalent (in terms of medical experience) preferred
- Demonstrates continuing education credits in the medical field

Experience

- Over 5 years' experience with healthcare documentation large acute care facility and/or quality assurance work in a large acute care facility
- Extensive experience with computer usage and above-average skills using Microsoft Office applications (Word, Excel, and Outlook)
- Experience with electronic medical record applications (Cerner, Epic, etc.)
- Experience using medical reference materials (hard copy and/or electronic)
- Experience in mentoring and teaching others

Licensure/Certification

- Certified Medical Transcriptionist (CMT) or Certified Healthcare Documentation Specialist (CHDS) required.
- Other healthcare experience and certifications may be acceptable.

Knowledge/Skills/Abilities

Knowledge

- Knowledge of medical terminology, anatomy and physiology, pharmacology, and disease processes, as pertains to all specialties in an acute care facility
- Knowledge of, and experience in, documentation requirements of a large acute care facility

(including, but not limited to, histories & physicals, discharge summaries, consultation, operative notes, emergency department notes, radiology reports, cardiology reports, etc.)

- Knowledge of medical documentation guidelines and best practices
- Knowledge and use of Microsoft applications, electronic health record software (Cerner, Epic or Comparable system); and general computer and keyboarding usage
- Knowledge of, and ability to identify, patient safety and risk management issues within medical documentation

Skills/Abilities

- Ability to communicate effectively and demonstrate good interpersonal communications with team members and across departments
- Ability to understand and compare information entered into the medical record by numerous sources and able to accurately assess that information is consistent and appropriate for the patient
- Ability to process, assess, and/or decipher information entered into the electronic medical record; including the ability to research to verify information that may appear incorrect or ambiguous
- Ability to multi-task (perform more than one task at a time and/or quickly switch back and forth between tasks), while working under pressure of time constraints
- Ability to meet minimum established departmental quality and productivity expectations
- Ability to work independently with minimal supervision

Physical Demands/Work Environment

- Ability to sit and view a computer monitor for long, uninterrupted periods of time
- Ability to switch between multiple computer programs while typing and assessing documentation (requiring strong hand/eye coordination)
- Ability to lift materials/files/equipment up to a 20-pound weight limit
- Moderate noise levels in the work environment
- Normal office environment
- Occasional exposure to strains, sprains, cuts, eye strain, etc.
- Stressful conditions may exist due to prolonged periods of concentration and scheduled deadlines

Essential Functions

- Recognize, evaluate and verify clinical documentation content and context for inconsistencies, discrepancies, and inaccuracies within the EHR that would be deemed critical and could impact patient care
- Recognize, evaluate and verify clinical documentation for spelling, grammar or punctuation errors that would be deemed non-critical to patient care but compromising to documentation, organizational and/or clinician integrity
- Verify patient demographics and information to ensure documentation is on the correct patient, and/or correct visit encounter
- Verify correct documentation template was utilized placing the correct documentation in the correct location within the EHR
- Communicate and collaborate with other members of the team in order to ensure continuity of care and coordination of services

- Communicate unusual circumstances with possible risk factors or medicolegal issues to the manager
- Ability to multi-task and work under pressure with time constraints
- Ability to work independently with minimal or no supervision
- Engage in the continuous study of clinical documentation and terminology to maintain competence, knowledge and skills necessary for the satisfactory performance of all assigned responsibilities
- Provide quality assurance and/or mentoring support to the healthcare documentation department and/or transcribe as needed
- Meet or exceed quality and production expectations as defined by departmental policy and procedure
- Operate and maintain computer equipment and software and other office equipment in an effective, skillful, efficient and safe manner
- Perform such individual assignments as directed
- Establishes and maintains effective working relationships within the organization

Manager, Healthcare Documentation Integrity Service

Summary

Manages and oversees all activities of the Healthcare Documentation Integrity Services department, accountable for staff providing quality assessments and physician education, in relation to clinician-created documentation. Support patient care, compliance, safety, and reimbursement through accurate and timely documentation throughout the organization. Coordinates and implements policies and procedures and assumes the responsibility for pertinent medical documentation reviews that assure data validity.

Organizational Summary

Reports to: Director, Healthcare Documentation Integrity and Transcription Services

Provides Supervision to: Healthcare Documentation Auditors, Educators, and Coordinators

Primary Customer Groups: Hospital leadership, physicians, and other healthcare practitioners.

Patients Served: No direct patient care.

Qualifications

Education

- Associate's degree required
- Bachelor's degree preferred

Experience

- A minimum experience of 10 years with healthcare documentation in a large acute care facility and/or quality assurance work in a large acute care facility
- Extensive experience with computer usage and above-average skills using Microsoft office applications (Word, Excel, and Outlook)
- Experience with electronic medical record applications (Cerner, Epic, etc.) or other document-creation toolset (Dragon, 3M ChartScriptMD, etc.)

Skills

- Active listening required
- Communication required
- Computer skills required
- Confidential required
- Time Management required
- Other – Knowledge of and experience in medical documentation guidelines and requirements of large acute care facility (including but not limited to, histories & physicals, discharge summaries, consultations, operative notes, emergency department notes, radiology reports, cardiology reports, etc.)

Physical Demands/Work Environment

- Ability to sit and view a computer monitor for long, uninterrupted periods of time
- Ability to switch between multiple computer programs while typing and assessing documentation (requiring strong hand/eye coordination)
- Ability to lift materials/files/equipment up to a 20-pound weight limit

- Moderate noise levels in the work environment
- Normal office environment
- Occasional exposure to strains, sprains, cuts, eye strain, etc.
- Stressful conditions may exist due to prolonged periods of concentration and scheduled deadlines

Essential Functions

- Manages, leads and assumes 24 hour global accountability of quality services in the execution of documentation integrity services at all hospitals/entities and post-acute business lines. Ensures documentation integrity services are provided in a timely, accurate, and compliant manner.
- Manages the activities of staff engaged in auditing clinician-created documentation and those staff providing follow up and Dragon education to physicians and other healthcare practitioners. Develops processes and education programs for departmental staff, medical staff and other related parties. Establishes reviews and approves departmental policies and procedures. Establishes and maintains standards for overall production.
- Selects, trains, develops, and evaluates subordinates and initiates personnel actions in accordance with departmental policies and organization philosophy. Mentor, coach and develop staff and act as a role model and resource to them.
- Coordinates and maintains individual quality assessment records of all documentation integrity audits. Compiles statistics of work processed tracking critical and non-critical values. Identifies needs for additional physician training. Communicates audit results to physician, other healthcare practitioners and leadership.
- Develops, implements, and maintains departmental annual operating budgets, ensuring that operations and managed within established guidelines.
- Serves as the liaison between clinical, financial and information services staff and activities, for all hospitals/entities. Provides ongoing communication with customers, staff and multidisciplinary teams.
- Actively participates in safety initiatives and risk mitigating measures where appropriate and completes all position and unit safety related competencies and requirements on a timely basis.
- Performs other duties as assigned.

EHR Documentation Trainer

Description

An EHR documentation trainer performs initial analysis of data, develops customized reports to facilitate meaningful interpretation of the data, and provides educational support to users. An EHR documentation trainer is responsible for training clinicians on the use of the electronic health record (EHR), template documentation, and interoperability of front-end speech recognition software. This person must be able to develop, implement, and maintain clinical narrative templates/macros in the EHR. An EHR documentation trainer should have the ability to translate workflow strategies into training documentation, job aids, and promotional materials for the assigned applications. An EHR documentation trainer also maintains accountability for managing software/data needs and technical services, in collaboration with the Information Services and Technology (IS&T) staff.

Skill Set

- Intermediate to advanced computer use skills including typing skills, Microsoft Office suite, etc.
- Intermediate to advanced background in healthcare documentation and medical terminology a plus
- Experience in EHR platforms and with voice recognition software preferred
- Experience with training in an EHR and/or documentation-related applications
- Experience with creating training plans and training materials utilizing adult learning techniques
- Business unit experience that includes working closely with IS&T in development and implementation
- Application of critical thinking and excellent communication skills in all matters
- Ability to maintain confidentiality
- Knowledge of clinical informatics is a plus

Training/Education

- Education/Experience – Bachelor’s degree in health care/computer science with two to four years of experience in related relevant field or equivalent combination of education and experience in related field preferred. Experience as a trainer is preferred.
- Licensing/Credentialing – Licensure/credentials in accountability as applicable to the position is preferred.

EHR Technician/HIM Analyst

Description

Under general direction, an EHR technician/HIM analyst accesses, inputs, and retrieves information, and solves complex problems using various computer systems. This person acts as the liaison for physician offices. Responsible for verification of completed dictation into system. Performs quality monitoring of patient information in transcribed reports. Trains and mentors HIM technicians and may act as a lead, as necessary. Trains and mentors health information management (HIM) staff. Coordinates work flow on the systems and processes. Performs quality monitoring and participates in activities to improve outcomes for the integrity of the electronic health record (EHR).

Skill Set

- Strong understanding of medical terminology, anatomy and physiology, as well as disease processes, pathology, and treatment techniques, surgery process and instrumentation, and pharmacology
- Ability to interpret technical jargon and translate abbreviations into their expanded forms
- Strong knowledge of HIPAA regulations, Joint Commission standards, and other healthcare regulatory bodies
- Excellent written and oral communication skills with proven ability to convey complex information to a variety of audiences
- Strong group processing, coaching, and interpersonal and social perceptiveness skills required
- Knowledgeable in all areas of documentation and a minimum of two years of experience in medical transcription training/editing is required
- Demonstrated advanced ability to operate computer, multiple software applications (Microsoft Office, dictation/transcription platforms, etc.), and other equipment as necessary
- Proficient in referencing, researching, reporting, tracking and monitoring, and in-depth knowledge of medical transcription guidelines (*The Book of Style for Medical Transcription* by AHDI) and practices
- Demonstrated ability to work independently with minimal or no supervision and as part of a team and to adapt quickly to new technologies
- Excellent research skills

Training/Education

- Associate's degree or equivalent education and experience
- Two years of experience in health care documentation
- Preferred Credentials – Registered Health Information Technician (RHIT), Registered Health Information Administrator (RHIA), or Certified Healthcare Documentation Specialist (CHDS)

Medical Scribe

Position Description

- Accurately and thoroughly document medical visits and procedures as they are being performed by the clinician, including but not limited to:
 1. Patient medical history and physical exam
 2. Procedures and treatments performed by healthcare professionals, including nurses and physicians assistants
 3. Patient education and explanations of risks and benefits
 4. Physician dictated diagnoses, prescriptions and instructions for patient or family or members for self-care and followup
 5. Diagnostic findings, lab and test results, consultations with other providers, treatment course, discharge instructions and prescriptions.
- Comply with specific standards that apply to the style of medical records and to the legal and ethical requirements for preparing medical documents and for keeping patient information confidential.
- Spot inconsistencies or mistakes in the medical documentation and check to correct the information in order to reduce errors. All addenda must be signed off by a physician. Ensure that all clinical data, lab or other test results, the interpretation of the results by the physician are recorded accurately in the medical record.
- Must be able to anticipate physician needs to facilitate the flow of clinic. Must be discreet, tactful, and unobtrusive in performance of duties so as not to distract medical staff from patient care. Good judgment, organizational ability, initiative, attention to detail, and the ability to be self-motivated are especially important. Must be adaptable and versatile
- Must be able to act calmly and effectively in a busy or stressful situation.
- May work in a fast paced environment. May require standing/sitting at a computer for long periods of time. Scribes interact with patients, families, ancillary staff, nurses, physician assistants, and others.

Organizational Summary

Reports to: Physician practice manager or individual physician

Provides Supervision to: no direct reports; however, audits the work of physicians and other healthcare practitioners

Primary Customer Groups: physicians, physician assistants, residents, nurse practitioners and other medical practitioners documenting patient care

Patients Served: no direct patient care

Qualifications

Education

- High school diploma required
- Associate's degree or equivalent (in terms of medical experience) preferred
- Demonstrate continuing education credits in the medical field

Experience

- Over 3 years' experience with emergency department, general inpatient community hospital and/or ambulatory healthcare documentation and/or quality assurance work in these settings
- Experience with general computer usage and basic skills using Microsoft Office applications (Word, Excel, and Outlook)
- Experience with electronic medical record applications (Cerner, Epic, etc.)
- Experience using medical reference materials (hard copy and/or electronic)

Licensure/Certification

- Registered or Certified Medical Transcriptionist (RMT or CMT) or Registered or Certified Healthcare Documentation Specialist (RHDS or CHDS) preferred
- Other healthcare experience and certifications may be acceptable

Knowledge/Skills/Abilities

Knowledge

- Knowledge of medical terminology, anatomy and physiology, pharmacology, and disease processes used within the facility or certain areas of expertise
- Knowledge of, and experience in, facility or specific medical specialty documentation requirements (including, but not limited to, histories & physicals, discharge summaries, consultations, operative notes, emergency department notes, radiology reports, cardiology reports, and physician office notes and correspondence)
- Knowledge of medical documentation guidelines and best practices
- Knowledge and use of Microsoft applications, electronic health record software (Cerner, Epic or Comparable system); and general computer and keyboarding usage
- Knowledge of, and ability to identify, patient safety and risk management issues within medical documentation

Skills/Abilities

- Ability to understand and compare information entered into the medical record by numerous sources and able to accurately assess that information is consistent and appropriate for the patient
- Ability to process, assess, and/or decipher information entered into the electronic medical record; including the ability to verify information that may appear incorrect or ambiguous
- Ability to multi-task (perform more than one task at a time and/or quickly switch back and forth between tasks), while working under pressure of time constraints
- Ability to work independently

Physical Demands/Work Environment

- Ability to switch between multiple computer programs while typing and assessing documentation (requiring strong hand/eye coordination)
- Ability to lift materials/files/equipment up to a 20-pound weight limit
- Noise levels in the work environment
- Stressful conditions may exist due to prolonged periods of concentration and scheduled deadlines

Essential Functions

- Recognize, evaluate and verify clinical documentation content and context for inconsistencies, discrepancies, and inaccuracies within the EHR that would be deemed critical and could impact patient care.
- Recognize, evaluate and verify clinical documentation for spelling, grammar or punctuation errors that would be deemed non-critical to patient care but compromising to documentation, organizational and/or clinician integrity.
- Verify patient demographics and information to ensure documentation is on the correct patient, and/or correct visit encounter.
- Verify correct documentation template was utilized placing the correct documentation in the correct location within the EHR.
- Communicate and collaborate with other members of the team in order to ensure continuity of care and coordination of services. Communicate unusual circumstances with possible risk factors or medicolegal issues to the physician/manager.
- Ability to multi-task and work under pressure with time constraints.
- Engage in the continuous study of clinical documentation and terminology to maintain competence, knowledge and skills necessary for the satisfactory performance of all assigned responsibilities.
- Operate and maintain computer equipment and software and other office equipment in an effective, skillful, efficient and safe manner.
- Perform such individual assignments as directed. Establishes and maintains effective working relationships within the organization.

FUTURE ROLES AND IMPACT ON WAGES

As traditional transcription roles decrease because of direct physician entry into the EMR and speech recognition tools, documentation integrity is at risk. This opens opportunities for healthcare documentation specialists to partner with providers in new ways. Future roles may include physician-created documentation auditors, physician trainers (EMR and voice recognition), scribes, and physician partners who create templates and macros to aid in consistent and accurate documentation within the EMR.

These new roles are not conducive to production pay or pay-for-performance models that have been customary in the transcription field in the past. Future compensation models need to take into consideration the vast knowledge of the healthcare documentation specialists, the redefined roles and responsibilities, as well as the technical skills required to perform these tasks and pay accordingly.

Healthcare Documentation Specialist Skill Set

- Knowledge of medical terminology, anatomy & physiology, pharmacology, and disease processes, as pertains to the specialties of their facilities
- Knowledge of medical documentation requirements
- Ability to recognize, evaluate, and verify clinical documentation content and context for inconsistencies, discrepancies, and inaccuracies
- Excellent spelling and grammatical skills
- Knowledge and awareness of patient safety & risk management issues

Redefined Roles and Responsibilities

- Experience in training/mentoring
- Knowledge of various learning methodologies
- Willingness to work onsite/travel between facilities
- Commitment to further education
- Willingness to have patient contact
- Expanded knowledge and awareness of patient safety & risk management issues

Technical Skills Required

- EMR workflow knowledge
- Above average skills in Microsoft Office applications
- Broadened computer/software experience
- Knowledge of documentation elements needed
- Analytical skills

Additional certifications may be required.

Soft Skills Required

- Ability to work independently
- Exceptional problem-solving skills
- Critical thinking skills
- Organized
- Excellent communication
- Self-confident
- Assertive/outgoing personality
- Empathic listener

Compensation is an important factor of recruiting, maintaining, and sustaining a talented workforce. As roles and responsibilities change within a workforce, compensation is normally reevaluated and adjusted accordingly.