HEALTHCARE DOCUMENTATION QUALITY ASSESSMENT AND MANAGEMENT BEST PRACTICES

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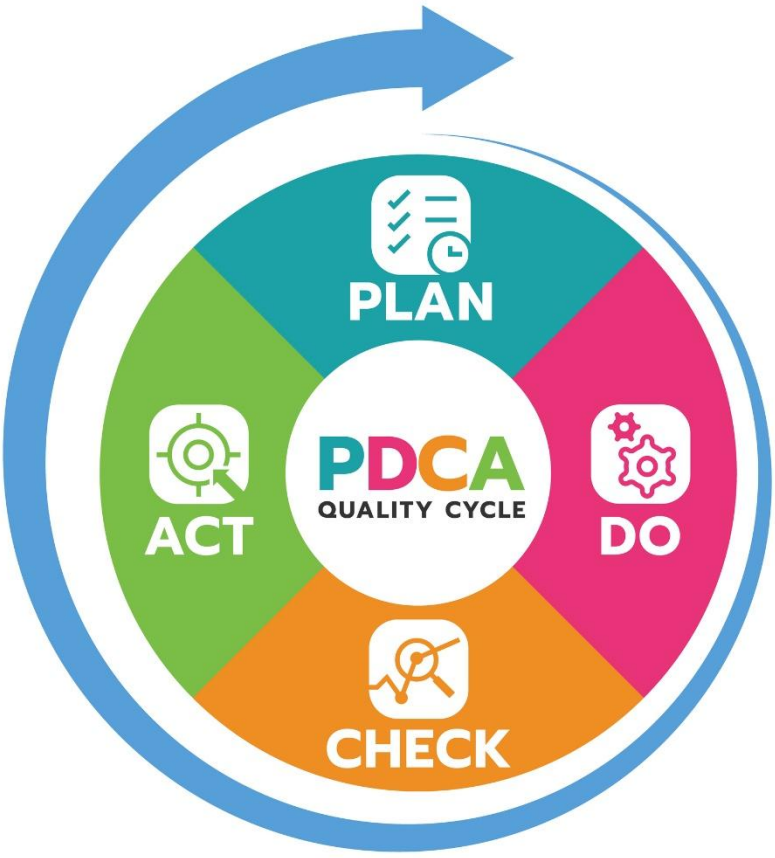

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The Association for Healthcare Documentation Integrity (AHDI) is a not-for-profit association representing individuals and organizations in healthcare documentation. AHDI has established a code of ethics, administers a credentialing program, leads, educates, and advocates for professional excellence and integrity in healthcare documentation policies and practices. We envision a future where optimal healthcare delivery and outcomes are facilitated by complete, accurate, and timely clinical documentation to convey patient health stories. Learn more about AHDI by visiting our website, www.ahdionline.org.

AHDI would like to recognize and thank the American Health Information Management Association (AHIMA) for contributions to the original *Healthcare Documentation Quality Assessment and Management Best Practices* (published July 2010)—the foundation on which this updated information was built.

AHIMA is a global nonprofit association of health information (HI) professionals with more than 67,000 members and 100,000 credentials worldwide. AHIMA's mission of empowering people to impact health® ensures that health information remains accurate, accessible, and trusted—enabling quality care for patients everywhere. For more information, visit ahima.org.

AHDI would like to recognize and thank the following task force members for their hard work and contributions to the latest *2025 Healthcare Documentation Quality Assessment and Management Best Practices*, as well as those who contributed to the 2017 and 2010 editions.

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AHDI would like to recognize and thank the following task force members for their hard work and contributions to the original *Healthcare Documentation Quality Assessment and Management Best Practices* (published July 2010)—the foundation on which this updated information was built.

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Introduction

AHDI's Quality Assessment and Management Best Practices toolkit has been updated to provide relevant practices and policies for quality assurance of healthcare documentation as methods for producing this documentation continue to evolve. Quality of healthcare documentation is a crucial element in the patient record, influencing patient safety and treatment as well as offering protection for the providers and facilities. Quality assurance includes several elements, the first of which is accuracy. Accuracy of data is required in both form and content. The determination of accuracy requires specifications and criteria against which to measure. Context is critical, and the data must satisfy the requirements of its intended use. To satisfy the intended use, the report must be accurate, timely, relevant, complete, understandable, and authentic or trustworthy. "Authenticity of documentation" means that the data is what it purports to be.

Quality can best be achieved through a planned set of actions designed to provide the end-user with the product they expect to receive. This *Healthcare Documentation Quality Assessment and Management Best Practices* (also known and referred to as the QA Best Practices) toolkit provides a blueprint for the implementation of an exceptional quality assessment program, a guide for updating an existing program and assessment for process improvement over time.

The intended audience for this toolkit includes facility directors of health information management, transcription supervisors and managers, and medical transcription service organizations (MTSOs) as well as attending physicians, residents, mid-level providers, C-suite, physician management, medical executive committees, and quality committees. This toolkit is intended to aid in ensuring quality and consistency of healthcare records for patient safety and care, decision support, research, core measure outcomes, and medicolegal purposes as well as the coding, billing, and reimbursement functions of the healthcare business.

Additional end-users include the patients themselves, who may be actively involved in their own healthcare decision-making processes through independent research, family interaction, health-related support groups, and online resources. More and more patients access their electronic health record via a patient portal. These patients rely heavily on the accuracy and comprehensibility of their own healthcare documentation to understand their condition and to compare their situation with other patients and/or treatment strategies. Additionally, the content of the healthcare record and its accuracy have a direct impact on patient satisfaction.

Healthcare researchers also rely on the quality of documentation for aggregation of data to assess treatment effectiveness, evaluate core measures, and provide information to the National Cancer Registry and other outcomes-related studies. Clinical documentation improvement initiatives can be enhanced by ensuring the completeness, thoroughness, and accuracy of the record of each patient encounter. Consequently, the quality of these measures, including research data, is directly dependent on the quality of the documents being mined for specific words or phrases.

These quality best practices align with the well-known and proven method: Plan → Do → Check → Act (PDCA). Continual healthcare documentation improvement using this process will provide education for all healthcare documentation specialists and providers creating documentation as well as recommendations for corrective processes with the goal of minimizing errors going forward.

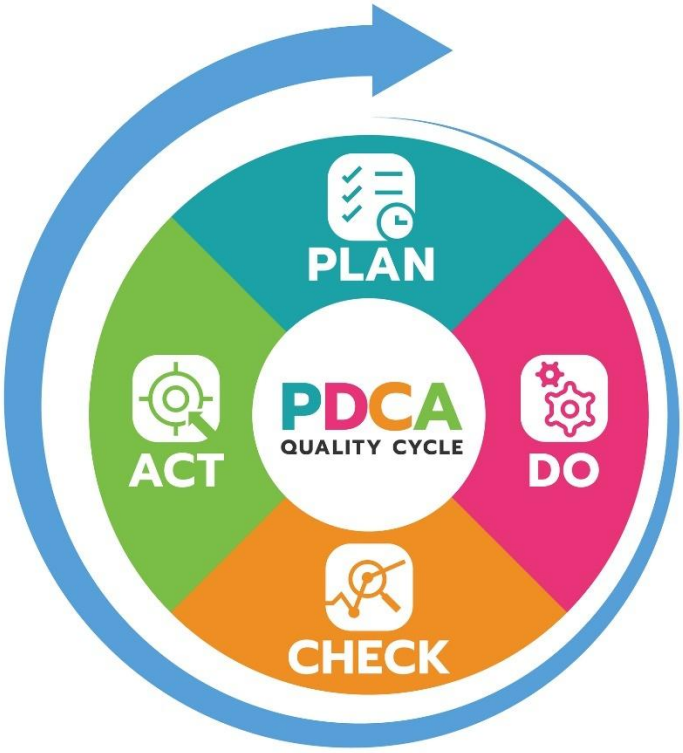
– Julia Dyviniak, CHDS, AHDI-F

Toolkit Terminology

Please note that the terms "healthcare documentation specialists" and "healthcare documentation professionals" are umbrella terms used for all who document health care—in human and in veterinary medicine. These terms are used synonymously in this text.

Some other job role titles that fall under the umbrella terms healthcare documentation specialist/professionals may include, but are not limited to, medical transcriptionist, medical language specialist, data analyst, medical scribe, clinician-created documentation integrity auditor, coder, HIM technician, medical secretary, quality assurance specialist, clinicians, veterinary scribe, and veterinary technician.

The Plan, Do, Check, Act Cycle for Quality Assurance



4 Steps of PDCA

PLAN	An analysis that establishes the objectives or the expected results and creates a plan of action. By starting with the objective and desired result, each step of the process can be included in the analysis and in the solution.
DO	Implementation of the plan.
CHECK	Measurement of objectives to see how closely they meet expectations. This is an important step, as it allows for the adjustment of the plan as needed.
ACT	Implementation of changes identified in the CHECK phase.

PLAN

PRINCIPLES OF QUALITY

The principles of quality as they relate to healthcare documentation can be defined as comprehensive codes of conduct that ensure the accuracy, accessibility, and overall integrity of the medical record for understanding patients' symptoms, treatments, and progress. To serve the needs of all end-users and to ensure quality through the assessment of healthcare documentation during the healthcare documentation process, the following principles apply:

Verifiability

Quality procedures are documented and communicated throughout the organization, and quality check schedules and results are made available to a client should routinely and/or upon request. The results of a quality check are verifiable. This is important whether the reports are transcribed by a healthcare documentation professional, entered by a scribe, or created by a clinician within the electronic health record (EHR). The results of quality checks must be easily understood, with no areas of ambiguity. Customers who have quality standards as a part of the contractual agreement must be able to verify the results of quality checks performed. The key to verifiability lies with clearly defined error definitions.

Definability

Error definitions provide a clear understanding of the nature of an error and in turn facilitate the production of quality healthcare documentation that meets with recommended industry standards.

Measurability

A healthcare documentation quality assessment program allows for complete understanding of the methodology and formulas used in its calculation. It is transparent and verifiable by all parties, showing results in a clear and concise quality rating that is statistically valid.

Consistency

A healthcare documentation quality assessment program produces consistent and reproducible results. Consistency in quality is achieved by standardizing variables, including the definitions of errors and their point values, and then applying a standardized method of error determination. This ensures that if a document goes through several quality assessment processes it will always be measured the same way. Organizations providing feedback should ensure consistency in the application of the program among all quality

assessment staff members. Stakeholder collaboration and training are also critical elements to achieving and maintaining consistency.

Integrity

Healthcare documentation integrity is achieved through a partnership between the clinician author, and, when using their professional assistance, the healthcare documentation professional (HDP), also called healthcare documentation specialist (HDS) and scribe who completes the report. The author is responsible for clear, unambiguous, and complete documentation and dictation. The HDP or scribe is responsible for preserving the author's style and intended meaning with reports transcribed or edited in their entirety, including accurate demographics and appropriate distribution notations. Additionally, HDPs and scribes bring integrity to the process through continuing education and commitment to the documentation process. Reporting errors as well as problematic practices that could cause errors brings further integrity to the quality assurance process. Ultimately, the final responsibility for document integrity falls on the shoulders of the clinician author when their documentation is authenticated.

QUALITY GUIDELINES

A comprehensive and effective quality assurance program is based on the following guidelines:

- Healthcare documentation must accurately reflect the complete details of the patient encounter.
- Documents must be accessible to the intended users in a timely manner.
- Quality assurance must be routinely performed on a statistically valid random sampling of documents using full audio review (when available) to ensure the accuracy of the document.
- Quality assurance should be performed on patient documentation, regardless of how it was created.
- Documents must be reviewed and scored (according to facility preference) in a consistent and unbiased manner.
- Error categories and point values must be clearly defined.
- Identified errors must be communicated promptly for quality improvement and continuing education purposes.

- Up-to-date references and account specifications must be available and easily accessible

A comprehensive quality assurance program is:

- **Proactive**. An effective program seeks to resolve problems before they occur. A proactive approach benefits all users, improves efficiencies, and ultimately contributes to improved patient care and experience.
- **Educational**. An effective program provides constructive feedback. An educational culture encourages quality improvement, consistent and beneficial feedback, and positive information exchange.
- **Realistic, scalable, and financially feasible**. The process must be easily duplicated on all scales, from small facilities to large MTSOs, and expectations should be realistically attainable, both financially and procedurally.
- **Straightforward and easy to implement**. The process must be straightforward and easily understood by all participating parties.
- **Secure and confidential**. Feedback and processes must be compliant with HIPAA privacy and security guidelines, applicable state laws, as well as those requirements established within the department or facility.
- **Inclusive of all aspects of the author-to-text process**. A complete quality assurance program evaluates software, equipment, and workflow processes for all authors, healthcare documentation professionals, quality personnel, and scribes.
- **Reportable for tracking and trending purposes**. A complete quality assurance program includes methods of tracking and reporting trends to detect areas needing improvement.
- **Timely**. Quality reviews should be completed on a routine basis to provide timely feedback that positively impacts the overall quality of documentation.

FACTORS AFFECTING QUALITY

Each of the following factors influence quality and should be considered in a comprehensive quality assurance program:

- The author's natural ability to organize and articulate his/her thoughts.
- Background noise, rapid speech, heavy accents, poor articulation, low volume, and audio quality (See also Healthcare Documentation Creation Best Practices Toolkit.)
- Knowledge and experience of the HDS, scribe, quality editor and/or clinician.
- Technology used to create audio files (telephones, mobile phones, computers, internet speed and reliability, etc.) should be up to date, tested regularly, maintained adequately, and used properly.
- Omitted, incomplete, or erroneous demographics can result in patient safety issues, unnecessary delays, incomplete or misidentified reports, and HIPAA violations.
- Account/Organization specifications
- Resources. It is highly recommended that the current version of AHDI's *Book of Style and Standards for Clinical Documentation, 4th Edition*, be used to address issues of style and format.
- Spellcheck and text expansion software can increase both accuracy and productivity but should not replace traditional proof reading.

Blanks

A blank space is typically used to indicate missing, incorrect, or questionable information within the body of a document. It occurs when an HDS or scribe does not have a clear understanding of what was intended, resulting in an inability to confidently insert the correct text. The use of a blank is a conscious decision by the HDS or scribe when information cannot be verified and should be used rather than guessing. A "best guess" in healthcare documentation is *never* appropriate. The presence of blanks has the potential to affect patient care and should be used prudently. An accurate report is more important than a complete report.

Blanks result in clinician queries and/or quality reviews before the document can be authenticated. Clinicians are expected to resolve blanks prior to authentication and some EHR software can be programed to require this. Inaudible or compromised voice files that may require re-dictation should be brought to the provider's attention if faulty equipment is to blame.

Causes for blanks include:

- Audio file distortion
- Clipped, cut off, incomplete, or omitted dictation
- Suboptimal dictation practices
- Discrepancy in dictated details
- Author-requested blanks (information to be filled in after document is complete)
- Inability to verify terminology
- Unknown person or place
- Preexisting blank within text that has been copied forward.

The presence of excessive blanks in a document may indicate that an HDS or scribe requires further education or training. Alternately, the ongoing use of excessive blanks may represent research avoidance or an attempt to improve productivity. Coaching for improved performance is always a top priority, but in rare instances performance correction measures may be warranted.

Blanks play a vital role in patient safety and the accuracy of the legal medical record. Best resolution practices should be employed to resolve blanks. Proper research techniques, contextual clues, referencing appropriate samples and previous reports, and re-listening to voice files when available should be used to resolve blanks. There are, however, legitimately unresolvable blanks that may remain.

Despite pressure to create complete reports, accuracy should always take precedence. Guessing or making up content just to fill a blank is dangerous, irresponsible, and unethical. It could put patients at risk and lead to poor outcomes. Guessing at blanks may become costly when coding, billing, reimbursement, audits, and even medicolegal consequences come to bear. It is for these reasons that attempting to resolve unresolvable blanks is strongly discouraged.

Documents that have been outsourced frequently contain more blanks per document and number of documents with blanks than those created “in house.” Despite pressure to return complete documents, their HDSs and scribes typically do not have the same level of access to a patient’s medical record or to the dictating provider himself that in-house staff does. The integrity of outsourced voice files can also be compromised depending on the interface being used. All of these things contribute to the customer’s perception that an MTSO may be delivering too many blanks.

Resolving Blanks

Use a stepwise approach to resolve blanks:

1. Adjust the speed of dictation to optimize clarity (try both faster and slower speeds).
2. Look for repetitive or collaborative information elsewhere within the document.
3. Use reference materials including approved online reference sites.
4. Review the patient's chart (other documents/results etc.) if available.
5. Request a review of the report by QA or next level personnel.
6. Make note of any feedback received and update sample reports as needed to avoid a repeat of the blank or problem.
7. Resolve as many blanks as possible **before** delivery.

Roles and Responsibilities

The creation of healthcare documentation is a collaborative effort, requiring all of those involved to properly carry out their role to ensure accuracy and integrity. It is essential that all involved be conscientious in performing their role and recognizing the roles of others, which are outlined below.

Clinician/Author

- Organize notes prior to recording.
- Use the highest-quality recording method available.
- Choose a HIPAA-compliant dictation location that is quiet and secure, away from background noises, such as ringing phones, music, shuffling papers, and other conversations.
- Familiarize yourself with how to adjust the volume and all equipment features, such as pause, review, insertion, and new report modes.
- Dictate one patient report per voice file.
- State and spell patient names and give patient identifiers.
- Dictate date of service and other essential dates as required.
- Hold handheld dictation devices four to six inches from the mouth.
- Speak at conversational rates.
- Pronounce sound-alikes clearly.

- Enunciate clearly and spell new terminology, drugs, equipment, proper names, and geographic locations.
- Dictate first and last name and location (if available) if a report is to be sent to another provider.
- Speak numeric values clearly including ages, drug dosages, and laboratory values.
- Comply with the facility's abbreviation policy.
- Report technical issues promptly.

Facility Staff

- Investigate faulty equipment.
- Provide training in dictation best practices to all authors including new residents.
- Collaborate with author for resolution of discrepancies and missing information.
- Review chart for resolution of discrepancies and provide feedback to MTSO/HDS/Scribe.
- Provide the most current reference materials, including updated lists of active physicians and other members of the healthcare team.
- Maintain a complete and up-to-date list of macros and templates for providers, staff, and the MTSO.
- Ensure accuracy and timeliness of admission, discharge, and transfer (ADT) data and other references for patient demographics.
- Provide feedback on recurring blanks to MTSO/HDS/Scribes.
- Provide sample reports to MTSO/HDS/Scribes.
- Provide reliable document upload and transfer mechanisms (interface).

Healthcare Documentation Professional/Scribe

- Adjust the speed of dictation to optimize clarity.
- Use reference materials including approved online reference sites, AHDI's Book of Style and Standards for Clinical Documentation, 4th Edition, and any facility-specific requirements.
- Request review of blanks or questionable areas of dictation.
- Review other documents or records (if available) to resolve any discrepancies within the report.

- Apply feedback received for continuous quality improvement.
- Follow appropriate procedures to escalate concerns to the next level.

MTSO

- Implement procedures for identifying and reporting concerns to the facility contact.
- Report suspected faulty equipment to provider or facility contact.
- Provide feedback to the provider or facility contact regarding dictation best practices and training for all authors including new residents.
- Maintain a complete and up-to-date list of macros and templates for all providers, distribute to documentation and editing staff, and notify provider or facility contact of missing macros and templates.
- Coordinate with the facility contact to obtain accurate and timely ADT feeds.
- Provide ongoing education and support for HDSs/Scribes about questions, errors, and blanks.
- Enable HDSs/Scribes to access and use a full range of reference materials and resources to minimize blanks.

Author/Authenticator

- Review report content for accuracy.
- Edit the document as necessary.
- Provide feedback as needed to the appropriate department.

DO

WORKFORCE

The training and experience of the HDS/editor/scribe has a direct impact on the quality and turnaround time of the final report. Because the experience of healthcare documentation specialists varies widely, it is important to be familiar with the capabilities of the staff and assign the workload accordingly. Even after careful screening and selection, it is important to identify the actual competency level, critical-thinking skills, strengths, and weaknesses of each member of the team. The role of the healthcare documentation specialist may include a variety of positions with varying levels of experience, competency, and responsibility. For more information, please refer to the Career Map.

ENTRY LEVEL

Healthcare Documentation Specialist Level 1

Healthcare documentation specialist, level 1, transcribes and/or edits basic patient healthcare documentation dictated by physicians and other healthcare practitioners. Level 1 individuals possess basic or entry-level knowledge with little to no transcription or editing experience. The nature of work performed starts at entry level and increases proportionately with knowledge and exposure to new specialties, dictators, and document types over time.

Support Staff

Support staff may be needed to assist with the processing and delivery of healthcare documentation. They may act as liaisons between providers, MTSOs, HDSs, scribes, and/or QA personnel. Support staff frequently troubleshoot documentation and demographic issues, respond to questions, track, and follow up on documentation needs. Extensive knowledge and experience of healthcare documentation, regulations, the EHR and all relevant software applications is required.

Mid-Level

Healthcare Documentation Specialist Level 2

Healthcare documentation specialist, level 2, transcribes and/or edits patient healthcare documentation dictated by physicians and other healthcare practitioners. Level 2 individuals possess proficient knowledge within certain areas of expertise and can meet departmental expectations. The nature of work performed is for a specific medical specialty or at a community hospital level with limited dictators and/or types of documentation produced. AHDI certification is preferred (RHDS, CMT, or CHDS).

Medical/Veterinary Scribe

Medical and veterinary scribes play an integral role in allowing healthcare providers to focus directly on patients in the clinical setting. By assuming responsibility for capturing the interaction between patient and provider for documentation within the electronic health record, the scribe contributes to overall efficiency and patient satisfaction. Scribes are virtually or discreetly and unobtrusively present for the encounter but do not touch the patient or engage in any type of patient care. All scribe-created documentation is reviewed and/or edited by the provider, who is the one ultimately responsible for its content. An attestation is added to all documents to ensure that the scribed chart accurately reflects all work performed by the provider. Scribes may perform other clerical duties as needed. Training and ongoing support to be provided. AHDI certification is preferred (CHDP, CHDP-S, CVHDP, or CHDS).

Advanced

Healthcare Documentation Specialist Level 3

Healthcare documentation specialist, level 3, transcribes and/or edits patient healthcare documentation dictated by physicians and other healthcare practitioners. Level 3 individuals possess proficient knowledge in the field of healthcare documentation. The nature of work performed crosses all medical specialties in a large acute care setting. Individuals may perform QA tasks, mentor peers, and/or assist with projects.
AHDI certification is preferred (RHDS, CMT, or CHDS).

Quality Assurance Specialist

The quality assurance specialist reviews work performed by HDSs/Scribes. Different facilities use different titles, such as QA editors or analysts. The ideal quality assurance specialist is both a competent healthcare documentation specialist or scribe and an educator. The quality assurance specialist must be a higher level HDS or scribe with proven skills in the applicable work types, medical specialties, accents, and dialects. The QA specialist must be proficient in referencing and researching and have excellent communication skills to give constructive feedback to HDSs, Scribes, and providers. AHDI credentials preferred. The quality assurance process may occur pre-delivery and/or post-delivery in a retrospective review.

Senior or Chief Medical/Veterinary Scribe

In addition to the regular duties of a medical or veterinary scribe, the senior scribe acts as supervisor and liaison between the scribe team and the clinical team. The senior scribe provides administrative support and quality assurance while ensuring proper staffing levels/shift coverage/training support. The senior scribe may mentor other scribes. They serve as a local point of contact with the facility, ensuring effective two-way communication between the scribes and the facility. May require some travel between facilities. AHDI certification is preferred (CHDP, CHDP-S, CVHDP, or CHDS).

QUALITY ASSESSMENT POLICIES AND PROCEDURES

A quality assurance program for healthcare documentation emphasizes assessment, education, and improvement throughout the documentation process. For a quality assurance program to be effective, it must be comprehensive, involve every step of the author-to-text process, incorporate quality checkpoints at effective stages in the workflow process, and be fully transparent to all parties involved.

A quality review process should involve comparison of the transcript with the original voice file, when available, or by referencing the patient's medical record. The quality review should also assess for meaning of content. Using established style guides (such as the current *Book of Style and Standards for Clinical Documentation, 4th Edition*) and supplementing that with facility-specific guidelines, reduces subjectivity of the quality review process. Citing references for all corrections will help maintain objectivity. Automation and technology can and will standardize some components; however, clear, and consistent communication will be key to the implementation and adoption of a standardized approach to resolving inconsistencies.

The goal of routine quality assessments is to promote documentation improvement through the identification and evaluation of error patterns and provision of instructive/constructive feedback. Optimal workflow models support the swift delivery of an accurate document as well as the prompt and specific feedback to the author, HDS, and/or Scribe. Checkpoints for quality assurance should be set within the workflow process, including audio creation, documentation, editing, and review. A higher-quality first draft is more likely in environments where the provider, HDS, and Scribe have access to data, information, and resources that will ensure accurate capture and document creation.

Concurrent Review

To fully assess the abilities of a newly hired or inexperienced HDS/Scribe, 100% of their work should be reviewed before delivery to the medical record (concurrent review). This level of review should be considered a transitional stage, with the expectation that the HDS/Scribe will apply the feedback given and gain knowledge through experience that leads to consistently high accuracy. As they meet departmental quality goals, it may be appropriate to reduce the 100% review incrementally or to limit reviews to only certain work types or authors. Those who are cross training on new specialties or work types may also require 100% concurrent review. Once an HDS/Scribe has proven their ability to perform at the quality level required, sampling rates can be reduced to coincide with general departmental guidelines. Concurrent review is also frequently performed when MTSOs begin transcribing a new account or a new dictator to ensure that quality standards required for that account or dictator are fully understood and applied.

Retrospective Review

Although random quality reviews would ideally be performed in a concurrent timeframe, this is often not feasible due to turnaround-time constraints. When such constraints require that quality reviews be performed retrospectively, that is, after the completed documents have been authenticated, procedures should be established for retrospective review before the audio files (if available) are purged. Any necessary corrections would then be made according to the organization's policies.

Flagged Documents

The workflow process should include the ability to force a document (by flagging) for review by a member of the quality assurance staff or support staff before the document is authenticated, thereby allowing resolution of the flag/blank. If flagging is part of the normal workflow for delivered documents, then flagged reports should be included in the QA audit pool and subject to random selection (*see the Sampling Guidelines section*).

Feedback

Quality feedback should be delivered to the provider, HDS, or Scribe in a timely and professional manner. Education and/or process improvement should be the goals of any feedback provided. Quality assessments should be as concise as possible but include enough information to allow the recipient to learn and understand the feedback.

HDS/Scribe Assessment

For the HDS, feedback provided should include corrected or inserted text with references to support the edits made. An opportunity to challenge the review should be offered, reflecting

a true commitment to process improvement and professional development. All feedback procedures, including email and email attachments, should be compliant with HIPAA privacy and security guidelines as well as those established within the department or facility.

Transparency

A well-defined and clearly documented QA program is essential in any healthcare documentation environment. Transparency of expectations, processes, error categories, and scoring is critical. Staff should be aware of what steps they can take if they disagree with the results. Some organizations or businesses appoint one or more individuals as the final authority in the event such conflicts cannot easily be resolved. If the MTSO or facility uses corrective counseling for failed QA assessments, the corrective counseling procedures should also be well-defined, clearly documented, and transparent. For further information and resources, see the AHDI Compensation Best Practices Toolkit.

CHECK

SAMPLING GUIDELINES

A statistically valid sampling methodology ensures a comprehensive and consistent assessment of overall quality. The method used must be able to accommodate the volume of review needed and include a minimum sampling size. A predetermined minimum amount/percentage of lines or reports, for example, could be used.

Sample Selection

For scores to be valid, the samples must be representative and selected at random. Random sampling allows all reports to have an equal chance of being selected as part of the sample. Many applications contain an algorithm that will enable the user to randomly select reports. If no algorithm is available, then a mutually agreed upon method may be used. One common selection technique used in health care is the 5/3 method. Documents with account/encounter numbers or medical record numbers that end in 5 or 3 are selected until the desired sample size is reached. If not using an algorithm, be cautious of unconscious bias.

ERROR CATEGORIES, DEFINITIONS, SCORING, AND ENSURING CONSISTENCY

Error Categories

Healthcare documentation errors may be divided into categories such as **critical**, **noncritical**, and/or **educational feedback or minor errors** as described below. Transparent guidelines and processes will be most important to any quality assurance methodology regardless of the way a document is created

Critical errors have the potential to affect patient safety, care, or treatment. Likewise, they have the potential to adversely impact the accuracy of coding and billing or medicolegal outcomes, and they may even result in a HIPAA or other regulatory violation. Such errors include, but are not limited to, the use of incorrect terminology, omission, insertion of incorrect information, or incorrect patient identification.

Noncritical errors impact the integrity of a document but do not change the intended meaning or have the potential to affect patient safety, care, or treatment. Examples of

noncritical errors include, but are not limited to, incorrect verbiage, minor medical misspellings, and protocol errors.

Educational feedback or minor errors have no impact on patient safety, care, or treatment and no impact on the integrity of the document. Such errors include, but are not limited to, grammar, typographical errors, and simple misspellings.

Error Values and Definitions

The following is a suggested list of potential error categories for use in a quality assurance program. Careful review of these error categories is recommended. Adoption will be based on the various methods of documentation creation used, the EHR, as well as the HDSs, scribes, and clinicians. Some organizations may differ in opinion regarding which errors are critical, which are noncritical, and which require further education of the HDS, scribe, or clinician using the EHR. Likewise, some facilities or businesses may choose to focus on error categories as a means of evaluating HDS or scribe performance for reward or corrective counseling. AHDI, in its Mission Statement and Bylaws, stresses the importance of education in the field of healthcare documentation integrity. (Also see the AHDI Compensation Best Practices Toolkit.)

Errors are assigned a category (critical, noncritical, educational feedback or minor) and are also given a point value relative to the error's potential adverse consequences. Error types, values, and categories are described below.

Critical Errors (-3 points)

Definition: A critical error is any error in a patient care record that:

1. Adversely impacts patient safety.
2. Alters the patient's care or treatment.
3. Adversely impacts the accuracy of coding and billing.
4. Results in a HIPAA or other regulatory violation.
5. Adversely affects medicolegal outcomes.

Types of Critical Errors

ITEM	DESCRIPTION	EXAMPLE(S)
Patient demographics	Wrong patient, content, or encounter; incorrect or omitted date of service.	
Wrong work type/template	Such errors may result in improper filing of the document and/or incorrect content.	
Wrong provider information	Incorrect author, authenticating provider, or distribution list. The addition of incorrect providers to the distribution list may result in privacy violations.	
Terminology misuse	Use of incorrect terminology, medical or English, which alters, obscures or opposes the meaning of what was dictated or entered.	hypo/hyper; negative/positive; regular/irregular; no/known.
Wrong medication, wrong dose/dosage	Incorrect, inserted or omitted medication name, dose or dosing schedule, method of medication administration, or unit of measure.	15/50 mg/mcg Zantac/Xanax
Wrong lab or lab value	Incorrect lab values have the potential to impact patient safety/care.	AST is ~~58~~. AST is 50 Chloride ~~97~~. Chloride 95.
Unapproved abbreviations	The Joint Commission list of Dangerous Abbreviations, for example, along with any facility-specific	Institute for Safe Medication Practices at www.ismp.org. The Joint Commission www.jointcommission.org

	unapproved abbreviations for healthcare documentation.	
Inserted text	Text not intended for inclusion – extra or unedited words, instructions, unneeded portions of templates, or inadvertent word expander results.	
Omitted text	Relevant information appears to be missing (i.e., incomplete sentence, blanks, etc.)	Neurologic: 2+ ___ ; Extremities show 2 to 3 over 4 ___; X-ray shows pathologic fracture, no acute ___.
Failure to Edit/Nonsense Text	Unedited speech recognized text that has the potential to impact meaning and/or care.	"Patient diagnosed with HIV" (dictated HIE)
Incorrect side/site		Right/left; humerus/femur; peroneal/perineal.
Failure to flag	Failure to bring critical inconsistencies or discrepancies to a provider's attention for handling.	
Failure to follow author instructions		"Go back up and add to the diagnosis ___." "Go back up and delete the procedure ___."
Inconsistencies/discrepancies		HPI: Patient has weakness. Musculoskeletal: Normal strength.
Unauthorized substitution		Transcription of generic vs. dictated trade name drug, or vice versa; misuse of word expander, short cut, etc.

Types of Noncritical Errors

ITEM	DESCRIPTION	EXAMPLE(S)
Typographical errors/Misspellings	Minor typos/misspellings within the document that do not impact patient care or intended meaning.	
Incorrect word form		Complete, completed; given, giving.
Incorrect, inserted, or omitted text	Erroneous text or text inserted/omitted in error but does not impact patient care or intended meaning.	
Nonsense text	Unedited speech recognized text that does not have the potential to impact meaning and/or care.	
Punctuation	Punctuation that alters or obscures the intended meaning.	Let's eat Grandma vs Let's eat, Grandma
Failure to Flag	Failure to call out noncritical inconsistencies/discrepancies.	
Sound-alikes		Hear, here; 8, ate; gait, gate.
Protocol failure	Errors resulting from failure to follow a procedure determined by the facility/organization's own platform, formatting, training and Style Guide, or account specifics.	

Educational Feedback (-0 points) and/or Minor Errors (-0.25, -0.5 points)

Definition: Minor errors have no impact on patient safety/care and no impact on the integrity of the document.

Best practices dictate that a facility, organization, or business provide educational feedback to the HDS or scribe regarding these errors. It is best not to penalize for occasional random

errors that do not impact the integrity of a document and instead identify them only as educational opportunities.

Nevertheless, a facility, organization, or business may choose to refer to some or all of these error types as minor errors and assign a lesser point value, setting their own threshold for the number of educational feedback errors that can occur in a document before the integrity of the document is compromised.

Types of Educational Feedback and Minor Errors

ITEM	DESCRIPTION	EXAMPLE(S)
Grammatical errors		
Typos, Misspelled, or Transposed words	Minor typos and/or misspellings within the document that do not impact patient care or intended meaning.	
Punctuation/Capitalization errors (other than mentioned above)		
Incorrect, inserted, or omitted text (other than mentioned above)	Erroneous text or text inserted/omitted in error but does not impact patient care or intended meaning.	
Sound-alikes	Nonmedical.	Their, there; where, wear; to, too.
Redundant text		D: "The patient was alert and oriented." T: "The patient was alert and oriented. The patient was alert and oriented." "... who is here to is here for ..."

Scoring Quality Assurance Reviews

The scoring of quality assurance reviews can be assessed in different ways according to the goals and needs of a given facility, organization, or business, and the results of each method may be used to provide a numeric result for documentation of the review. Some facilities use a score or percentage for performance evaluation, and some simply use a Pass/Fail system based on meeting a predetermined standard. Some organizations may choose to offer incentives for above-standard performance. There are advantages and disadvantages to any method used.

AHDI recommends a QA score of 98.0 (or 98%) as the minimum industry standard as best practice for documentation created by an HDS or Scribe.

It is recommended that multiple reports be reviewed, and that the individual scores be averaged together for a final score. Review of multiple reports will identify potential trends that require education or monitoring. See Appendix A: Sample Score Sheet #1.

Error Value from 100 Method

This method subtracts error values from a per-report or job value of 100. Each error is subtracted from a total score of 100, if 100 is a perfect score. ***Note that a single critical error will fail a document in this methodology, regardless of its length, based on a QA score of 98.0% as the minimum industry standard.***

Advantage:

- Supports the values of quality delivery.

Disadvantage:

- A huge disparity of line lengths can exist among documents. If not all HDS staff or scribes transcribe/edit an equal number of short and long documents, this method may not provide an accurate picture of the HDS or Scribe's skillset.

See Appendix A: Sample Score Sheet #2.

Total Errors Divided by Number of Lines Reviewed

This method is based on the total number of transcribed or edited lines in the sample to be reviewed; it is *not* based on the number of reports in a sampling.

The total number of errors is divided by the total number of transcribed or edited lines. The result is then multiplied by 100 and subtracted from 100, yielding the score, which can be called a score or a percentage.

Example (using one 0.5-point error and one 0.25-point error)

0.75 total error value / 206 lines reviewed = 0.00364
0.00364 x 100 = 0.364
100 – 0.364 = 99.636, which can be rounded to a score of 99.6, or 99.6%

Advantage:

- Produces an errors-to-lines ratio that can provide a more accurate picture of the HDS or scribe's skillset.

Disadvantages:

- A single critical error in a document with many lines may yield a percentage that allows the QA assessment to pass.
- A single critical error in a document with very few lines will not only fail the QA assessment but skew an average of several assessments in a downward fashion.

Ensuring Accuracy and Consistency in Your QA Program

Whether an MTSO or healthcare facility has one or multiple QA auditors, it is extremely important to ensure program consistency and accuracy. This guarantees the program is viable for the organization and the application is fair to the HDS staff or scribes. To accomplish such goals, follow one of these recommendations:

Scenario 1:
Step 1: Manager pulls 3-4 sample documents for review by QA staff.
Step 2: Each QA staff reviews and scores the documents individually, without consulting their peers.
Step 3: Manager then reviews the documentation for consistency in application of their organization's QA program.
Step 4: Manager meets with the entire group and reviews their findings.

Step 5: Following the review, manager creates a summary of the findings. If inconsistencies are found, review as a group to determine the issues. Define problems and recommend solutions. Develop an action plan and track for improvements.

Scenario 2:
Step 1: Manager assigns a set number of documents to QA staff member(s) for review.
Step 2: When completed, the Manager assigns to a second QA staff member(s) for a validation review, without consulting their peers.
Step 3: The original QA staff then reviews the QA validation comments.
Step 4: Manager would make final decisions on discrepancies.
Step 5: Original QA staff sends finalized QA review to the HDS or scribe.

If your QA staff transcribes or edits documents, the documents they complete should be reviewed and held to the same standard as the HDS staff or scribe.

ACT

CONTINUOUS QUALITY IMPROVEMENT

Developing an Action Plan

When reviewing the results of any quality review, developing a plan of action should always be considered part of the process. These action plans should be part of an established program for quality improvement, should be developed proactively, and should be made available to all end users. The plans should be easily applied and easily modified based on the review results. Goals and objectives need to be clearly outlined and benchmarks set. The action plan should also take into consideration followup steps to measure progress and clearly define desired outcomes based on the followup reviews. Key steps in a continual improvement program can be summarized as:

- Review
- Revise
- Communicate
- Monitor

As the industry moves forward with benchmarking and further development of workflow optimization, the emphasis will be on the prevention of errors. Analyzing results and pursuing quality improvement strategies are vital to an effective and successful quality assurance program. Based on data obtained through the quality review process, the following recommendations are made:

Technical Considerations

- Utilize the most current/advanced technology your budget will allow.
- Evaluate, update and/or replace equipment (hardware and software) routinely.
- Evaluate, update and/or replace digital security routinely so that it meets regulatory and system requirements.
- Minimize/Eliminate background noise.

Provider Support

- Documentation training for new and existing providers should include dictation instructions, EHR orientation, work type requirements according to facility preference, and understanding of established processes in place for provider feedback.

- Documentation resources should include dictation best practices, quick tips/tricks, standards/smart phrases availability, troubleshooting guidelines, and contact information for further assistance.
- Establish open lines of communication to encourage feedback between the provider and the documentation staff. Documentation staff may provide specific information to avoid repeated errors or to improve dictation quality. Feedback should include specific examples wherever possible.
- Establish procedure to process documentation errors/concerns to provider – flagging, etc.
- Develop policies and procedures to address problematic documentation practices. (See Sample Policies & Procedures.)

Address Content Errors

- Provide consistent, constructive feedback including references and resources cited when possible. Feedback should include excerpts of both the original and corrected versions, with sufficient surrounding context. When available, provide the sound file to increase understanding and retention of corrected information. Verify that feedback is received and acknowledged.
- Encourage feedback to be an opportunity for improvement and invite the HDS/Scribe to ask questions and discuss the feedback received.
- Underscore the importance of the feedback with one-on-one conversations. Again, provide an opportunity for the HDS/Scribe to ask questions and discuss the feedback.
- Distribute sample reports for challenging authors.
- Provide templates and normals/standards.
- Assign mentors to new or struggling HDSs/Scribes.
- Develop policies and procedures for when quality expectations are not met.

Address Account Specification Errors

- Compile concise, organized, and easy-to-use account specifications.
- Review/revise account specifications regularly. Distribute to staff, and communicate changes/updates promptly.
- Maintain provider database for each account.

Set Frequency of Quality Reviews

- Perform regular quality reviews according to predetermined guidelines. Weekly, bi-weekly, monthly, or at least quarterly reviews are recommended.
- Increase frequency for HDSs/Scribes not meeting quality expectations and develop a customized quality assurance plan.

Review "Ensuring Accuracy and Consistency in Your QA Program" on again as needed.

Quality Improvement Planning

1. Review findings with the HDS/Scribe and provide education as needed when quality concerns are identified.
2. Perform additional QA review within prescribed interval according to facility policy.
3. If quality meets expectations on repeat review, return to regular intervals.
4. If quality concerns are still present, repeat steps 1 and 2 until you can get to step 3.
5. Celebrate success!
6. If no improvement is seen despite multiple interventions, consult your facility's performance review process for the next steps.

INDUSTRY RECOMMENDATIONS

Implementing a quality assessment program requires consideration of every step in the voice-to-text conversion process. The following summary recommendations are made:

- The principles of quality (Plan, Do, Check, Act) should be at the core of any quality assurance program, although the process itself may be specific to each organization.
- Assess specific and unique factors that affect the outcome of the documentation process, including workflow, turnaround time, and technology.
- Establish a sufficient budget for QA personnel, resources, software, and continuing education. Based on the selection of sampling guidelines, determine what is best for the organization based on number of HDSs/Scribes and reports required to establish a 95% confidence level. Be mindful that organizational budget constraints may exist.
- Establish quality assessment policies and procedures in each facility/MTSO. Distribute policies and procedures to all documentation authors and documentation staff.

- Establish facility specifications and maintain databases of pertinent, facility-specific information.
- Establish practical workflow procedures in the documentation process so that accuracy and turnaround times are achievable. In the documentation portion of the workflow, allow for 100% concurrent review of entry-level, newly hired, or cross-training HDSs/Scribes, and concurrent review of flagged reports. Establish workflow procedures for routine assessment of the HDSs and scribes who are not under 100% review. If possible, reviews should be performed concurrently. Perform retrospective reviews if necessary to achieve established turnaround times.
- Establish a feedback mechanism for HDSs and scribes that is education-based. Errors should be identified within their context. Track improvements following intervention and map any trends. (See Sample HDS Annual QA Performance Metrics.)
- Train the quality review staff in the computation methods described herein. They should be objective and consistent when reviewing HDSs/Scribes. They should acknowledge and encourage the development of critical thinking skills and provide ongoing education of the quality standards. The ability to develop and mentor others will serve QA staff well.
- Follow guidelines for appropriate intervals for quality assessments.
- Provide ongoing staff development, especially in areas where quality issues are identified.
- Compile results of the QA review findings and provide reporting to various departments or stakeholders at prescribed intervals.

APPENDIX A: Sample Score Sheets

SAMPLE 1 – Quality Assessment Score Sheet

HDS/Scribe Name	
Job #	
Author	
Document Type	
QA Specialist	
Date of Review	

TYPE OF ERROR	ERROR VALUE	NUMBER OF OCCURRENCES	FINAL DEDUCTION
Critical Errors			
1. Patient demographics	-3		
2. Wrong work type, template, provider information	-3		
3. Terminology misuse; wrong lab value	-3		
4. Wrong medication, wrong dose/dosage	-3		
5. Unapproved abbreviations	-3		
6. Incomplete or missing text, inserted/omitted text	-3		
7. Incorrect side/site; unauthorized substitution	-3		
8. Failure to edit; failure to flag	-3		
9. Failure to follow author instructions	-3		
10. Inconsistency/discrepancy	-3		
Noncritical Errors			
1. Misspelled medication, terminology, names	-1		
2. Transposition of proper names	-1		
3. Incorrect word form	-1		
4. Incorrect, inserted, or omitted text	-1		
5. Nonsense text; punctuation; failure to flag	-1		
6. Soundalikes; protocol failure	-1		
TOTAL DEDUCTIONS			

ERROR TOTAL: _____

FINAL SCORE: _____

If the same error is repeated throughout the document, it is only counted once. Score of 98 is considered passing.

COMMENTS:

SAMPLE 2 – Quality Assurance Audit Score Sheet (from 100, Pass/Fail)

HDS/Scribe NAME: QA Initials:
DATE: TYPE:

Account/Job Number	Document Type	Points Possible	Minus Score	Equals Score
		100		
		100		
		100		
		100		
		100		
		100		
		100		
		100		
			AVERAGE	#DIV/0!

If the same error is repeated throughout the document, the error is only counted once.

TYPE OF ERROR	#ERRORS	x VALUE	TOTAL
CRITICAL			
Patient demographics	0	3	0
Work type/template/wrong provider	0	3	0
Wrong provider information	0	3	0
Terminology misuse	0	3	0
Wrong medication, dose/dosage/lab value	0	3	0
Unapproved abbreviations	0	3	0
Incomplete or missing text	0	3	0
Inserted or omitted text	0	3	0
Incorrect side/site	0	3	0
Failure to edit/failure to flag	0	3	0
Failure to follow author instructions	0	3	0
Inconsistencies/discrepancies	0	3	0
Unauthorized substitution	0	3	0
NONCRITICAL			
Misspelled meds, terminology, names	0	1	0
Transposition of proper names	0	1	0

Incorrect word form	0	1	0
Incorrected, inserted, or omitted text	0	1	0
Nonsense text; punctuation	0	1	0
Failure to flag; soundalikes	0	1	0
Protocol failure	0	1	0
MINOR/EDUCATIONAL			
Capitalization/Punctuation	0	.25	0
Soundalikes	0	.25	0
Redundant Text	0	.25	0
TOTALS			

FINAL SCORE:	98 and above	PASS
	< 98	NEEDS IMPROVEMENT

APPENDIX B: Sample Quality Assurance Scoring Worksheet

QUALITY ASSURANCE SCORING WORKSHEET								
TRANSCRIPTIONIST: SCORE, APPENDIX B			**QUARTER: 1st QUARTER 2025**					
JOB NUMBERS	**WT**	**DATE TRANSCRIBED**	**DATE REVIEWED**	**TOTAL LINES**	**3-Point Errors**	**1-Point Errors**	**0.5-Point Errors**	**0.25-Point Errors**
1459801, 1460168 and	6, 24	12/18, 12/19						
1460549	2	12/20/25	12/28/25	198	0	0	1	1
1466708, 1466843 and	21, 2	1/1, 1/2						
160607	30	1/3/25	1/11/25	211	0	0	0	1
1474534, 1474609 and	4, 2	1/15, 1/16						
1475646	24	1/17/25	1/24/25	216	0	0	0	1
1481712, 1482295 and	6, 4	1/29, 1/30						
1483455	24	2/1/25	2/7/25	231	0	0	0	0
1497143, 1497477 and	2,6	2/26, 2/27						
1498439, 1498927	44, 24	2/28, 3/1	3/7/25	206	0	0	1	2
1506576, 1507959	6, 2	3/16, 3/19	3/21/25	247	0	0	0	0
			TOTALS:	1309	0.00	0.00	1.00	1.25

Total lines counted, all reports = 1309

Total Errors = 2.25

Errors divided by lines = 0.00

Error percentage rate = 0.17 %

ACCURACY % RATE = **99.8**

Total lines transcribed this quarter: 105,531

Actual Percentage of
Lines Reviewed: 1.24%

Accuracy rate must be 98.5% or higher

Critical Errors **-3**

1. Patient demographics
2. Wrong work type, template, provider information
3. Terminology misuse; wrong lab value
4. Wrong medication, wrong dose/dosage
5. Unapproved abbreviations
6. Incomplete or missing text, inserted/omitted text
7. Incorrect side/site; unauthorized substitution
8. Failure to edit; failure to flag
9. Failure to follow author instructions
10. Inconsistency/discrepancy

Noncritical Errors **-1**

1. Misspelled medication, terminology, names
2. Transposition of proper names
3. Incorrect word form
4. Incorrect, inserted or omitted text
5. Nonsense text; punctuation; failure to flag
6. Sound alikes; protocol failure

Minor Errors **-0.5** **-0.25**

Educational Feedback **-0**

APPENDIX C: Glossary

Admission, Discharge, Transfer (ADT) feed	An electronically generated list of patients and their corresponding demographic information.
QA Specialist	A qualified and trained higher-level HDS/Scribe who reviews the work of HDSs/Scribes for essential quality components as deemed necessary by a facility, organization, or business. This work may be done with or without voice files.
Author	An individual who dictates content to be converted to text. This individual may also be referred to as a dictator, originator, clinician, or provider.
Authentication/Authenticator	Refers to the process by which the provider verifies what has been captured in the record and affixes their signature to the report as proof of that verification. According to The Joint Commission, authentication must be done by the author of the record and cannot be delegated to anyone else, regardless of the process for inclusion of signature. Note: The dictator may not be the same as the authenticator, as ancillary personnel may be employed to assist in dictation and information capture.
CHDP	Abbreviation for Certified Healthcare Documentation Professional.
CHDP-A	Abbreviation for CHDP who has demonstrated proficiency as an Auditor/Analyst (CHDP-A).
CHDP-S	Abbreviation for CHDP who has demonstrated proficiency as a Scribe (CHDP-S).
CHDS	Abbreviation for Certified Healthcare Documentation Specialist.
CMT	Abbreviation for Certified Medical Transcriptionist.
Concurrent review	An audit of a document that occurs before the document is authenticated.
Demographics	Information pertaining to the patient, such as name, date of birth, medical record number, encounter number, etc.

Dictator	See Author. Note: The dictator may not be the same as the authenticator, as ancillary personnel may be employed to assist in dictation and information capture.
Facility	A hospital, clinic, physician practice, outpatient surgery center, dental practice, long-term care or skilled nursing facility, birthing center, or other organization that provides healthcare services. Other examples include physical and occupational rehabilitation centers and dialysis centers.
Healthcare Documentation Professional (HDP)	An individual who works within the electronic health record to ensure documentation meets quality, integrity, and regulatory standards.
Healthcare Documentation Specialist (HDS)	An individual who transcribes traditional dictation by physicians and other healthcare providers to document patient care. May also edit draft text created by speech recognition software.
HDS Level 1	The healthcare documentation specialist, level 1, transcribes and/or edits basic patient healthcare documentation dictated by physicians and other healthcare practitioners. Level 1 individuals possess basic or entry-level knowledge with little to no transcription or editing experience. Nature of work performed would start at entry level and increase as depth and breadth of knowledge, exposure to specialties, and dictators and/or types of documentation can be produced while meeting departmental quality and production expectations.
HDS Level 2	The healthcare documentation specialist, level 2, transcribes and/or edits patient healthcare documentation dictated by physicians and other healthcare practitioners. Level 2 individuals possess proficient knowledge within certain areas of expertise and can meet departmental expectations. Nature of work performed is for a specific medical specialty or at a community hospital level with limited dictators and/or types of documentation produced. AHDI certification is preferred (RHDS, CMT, or CHDS).

HDS Level 3	The healthcare documentation specialist, level 3, transcribes and/or edits patient healthcare documentation dictated by physicians and other healthcare practitioners. Level 3 individuals possess proficient knowledge in the field of healthcare documentation. Nature of work performed crosses all medical specialties in a large acute care setting. Individuals may perform QA tasks, mentor peers, and/or assist with projects. AHDI certification is preferred (RHDS, CMT, or CHDS).
Macros	A single instruction that expands automatically into a set of instructions to perform a particular task.
Medical specialty	In this context, a distinct field of study, such as cardiology, orthopedics, gynecology, or psychology.
MTSO	Medical Transcription Service Organization
Normals/Standards	A term used to describe a shortcut for inserting standard text. Authors may request the insertion of a specified standard text in lieu of repeatedly dictating the same information. May also be referred to as “standards” and “templates.”
Originator	See Author.
Retrospective review	An audit of a document that occurs after the document has been authenticated and delivered to the client or the chart.
RHDS	Abbreviation for Registered Healthcare Documentation Specialist.
Account Specifications	Documentation describing a facility or client’s unique requirements and preferences including technical data and issues of style. May also be referred to as a Style Guide for facilities.
Scribe	The medical scribe assumes responsibility for EHR documentation of the interaction between patient and provider. A medical scribe may be present physically or virtually.
Speech Recognition	Technology that enables a device to recognize and understand spoken words, by digitizing the sound and matching its pattern against the stored patterns. It may be used on the back end (dictator is unaware voice is

	being recognized and a draft is created for editing) or front end (dictator sees conversion of voice to text and is responsible for editing in real time).
Template	A standardized layout for a given report type. A template may include placement markers for patient demographic information as well as formatted headings, subheadings, and signature blocks. A clinician EHR template may also draw in discrete data from within the patient's medical record to enhance the final document.
Turnaround time (TAT)	The interval of time measured from dictation to authentication. TAT expectations may vary depending on facility, work type, or other rules and regulations.

See also Career Map Abbreviations.

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