Frequently Asked Questions – Physicians

General pre-implementation questions regarding the Dictation/Speech Recognition/Transcription (DST) Consolidation Project can be sent to dst@albertahealthservices.ca. You will receive a reply within 2 business days.

Q=Question    A=Answer

1. Go Live and Accessing the new DST System

Q: When will I be able to use the new dictation system?
A: Your zone Medical Affairs representatives or your zone Clinical Department will be sending you details by email.

Q: Who can I contact if I encounter difficulties during and after Go-live of the new DST system?
A: Contact the DST Hotline at 1-844-944-3099 for rapid resolution to urgent issues. For Non-urgent issues contact HIM.support@albertahealthservices.ca or your local IT Helpdesk.

Q: What training will I receive?
A: You will receive a DST Resources package http://goo.gl/ioIfpE containing tools required to successfully use the system. This will include: facility codes, work types, work type mapping, instruction sheets on how to use the system, keypad prompts, Physician FAQ’s, system access form and an elearning module for you to learn all the functionality of the Clinician Access and Electronic Signature module.

Note: Trained HIM support staff will be onsite at go-live to aid you in the transition to eScription

Q: How will I access the new system?
A: You can access the system from any telephone using a provincial toll free number (the telephone number is included in the DST Resources package).

Q: What if I dictate from multiple facilities?
A: You will be able to dictate from multiple facilities – depending on the implementation phases, you will use the old process until the facility has implemented the new system. When dictating in multiple facilities that use the new system, you will use the provincial toll free number or the facility speed dial if available in your area, enter the same speaker code, patient number and work type but will enter the facility specific code to ensure the report is attached to the correct patient. Instructions and speed dial numbers will be provided during implementation.

Q: What are the benefits for me using this new system?
A: The new system eliminates the use of outdated technology and other associated issues encountered such as the inability to repair outdated input devices like c-phones. Other benefits include; increased productivity of Medical Transcriptionists by as much as 60 – 100%; improved workflow efficiency and quality of dictation through streamlined processing of medical reports from dictation/transcription through to document distribution and electronic signatures; ability to receive timely accessible information; streamlined workflows and decreased turnaround times (for continuity of care and distribution); ability to provide metrics and scorecard reporting.

Q: Can I dictate and use eScription remotely?
A: Yes, the new system provides the convenience of being able to remotely access eScription from most devices with internet access. The toll free number provides the same convenience for dictation. All of the tools for eScription can also be accessed remotely through this link so all dictation practices can be done remotely http://goo.gl/ioIfpE.

Q: I currently dictate in the UCMG dictation platform, will I be affected?
A: Yes, the two platforms will remain separate, however, for ease of use for those who may dictate into the AHS platform as well, we have made speaker codes the same for both systems. Work types will be different for each system and you will need to be speech recognized separately in both systems.
2. Workflow and Functionality

Q: How will my workflow change? Or will it?
A: If you are currently using a landline telephone to do dictation the overall process will have little change. If you are using tapes or the Dictaphone handset, there will be a greater change.

Q: What can I do as a Physician or Provider to help the transcriptionist with the new system?
A: Please include as much information as possible when dictating as the time a transcriptionist spends looking for missing information delays the completion of your dictation. Critical components include:

- Physician’s full name
- Medical Record Number
- Stating the Patient’s Full Name
- Personal Health Number
- Date of Admission/Discharge
- Selecting the correct work type (stopping to change the template takes precious minutes away from transcription)
- Providing all cc physician information (first and last name, specialty, city, etc.)
- For surgical reports, include the date of surgery (a requirement for Netcare distribution)
- Any information you want included in the report (the transcriptionist does not readily have access to information such as the anesthetist, the family physician, lab results, information from previous transcribed reports, etc.)

Q: How long does it take to become voice recognized?
A: It takes approximately 60 minutes of dictation and 50 dictations per work type.

Q: Will I be able to use the same toll free number and author identification/pin at all sites?
A: Yes, the single toll free number is a provincial number with technology embedded to withstand high call volumes. In addition, the Speaker Code, Facility Code and work type numbers are standardized throughout the province and each Clinician has a unique ID allowing Clinicians to use the same Speaker Code at each facility.

Note: Personal speaker codes are assigned to all users including residents. Speaker codes cannot be shared or the voice recognition functionality will not function as intended. Speaker codes will be delivered to you via email approximately 1 week prior to your go-live.

Q: What if I am unable to find an available telephone on a hard wired land line? Can I use my cell phone to dictate?
A: Using a telephone connected to a land line is the preferred method to access the dictation system as this provides the best dictation quality. We are reviewing common dictation areas to upgrade (where necessary) with reliable phones. If the only option is to use a cell phone, please ensure there is good reception (i.e. 5 bars), that there is little background noise and speak clearly while dictating.

Q: Am I able to use the same telephone keypad functions as I always have?
A: We have tried to use similar keypad functions wherever possible. However, because not all facilities are using the same prompts provincially, there will likely be some change for everyone; a detailed list of the prompts will be provided to help you familiarize yourself with the new system.

Q: What keypad functions are changing?
A: There are various changes depending on the area you are currently dictating from. A detailed sheet of the new prompts will be provided to you via project messaging, pocket cards that are available at each site or via the DST Resource Repository.

Q: What happened to all our work types?
A: The Standards Working Group in collaboration with Physicians and medical transcriptionists from each zone worked to consolidate similar work types to facilitate an improved workflow and reduce turnaround times.

Q: Will I be able to use all work types?
A: Please consult the work type mapping document provided for your zone.

Q: How do I make an addendum to a report?
A: Prior to electronically signing the report you are able to update content in the report. Once a report is signed and uploaded to Netcare you are unable to add new content to a report. A new report will need to be dictated for the additional content. This will be added to the original report. Providers using signature authentication or manual signatures are strongly encouraged to dictate any corrections or revisions for the additional content. This will be added to the original report. If these providers choose to make corrections or revisions manually, they must work with HIM to have corrections applied to all copies.
Q: What will happen if I call into the old dictation system?
A: When a provider enters a facility number that has been decommissioned it will continue to prompt you to enter the facility code again. Refer to the DST Resource Repository for the new systems reference materials for future state workflows.

Q: How long will the old dictation system stay active?
A: The old system will be disabled on the morning of go-live at your facility.

Q: Will I be able to continue to send tapes for transcription?
A: No, HIM will no longer continue to transcribe tapes or files from handheld dictation devices.

Q: Who will transcribe my tapes if HIM will not?
A: Outdated Tape technology will no longer be transcribed for the reasons previously stated above as they fall outside the scope of HIM service offerings. It will be the responsibility of the dictating provider to engage appropriate services for transcription should they choose not to adopt the new dictation platform.

Q: Will bolding appear in reports?
A: Reports are transcribed in Nuance then sent through an interface to Clinical Information systems such as Meditech and SCM and Netcare. If any headings are bolded in Nuance, they are stripped when the report passes through the interface. Final reports will not display bolded information.

Q: Are reports still distributed to Netcare in the same manner?
A: As with our previous system, reports are sent to Netcare as soon as transcription is completed with a disclaimer that the report has been distributed prior to provider review. If any corrections are applied to the report, the Netcare, Meditech/SCM, physician office and health record reports are also updated.

Q: How will a revised report be identified?
A: If a date and time appears beside the (R) that is present on all report in the footer section, it has been revised.

Q: What is the difference between front end and back end speech recognition?
A: Front end speech recognition involves the Physician dictating directly into their computer and having the text appear on the monitor. The dictator can edit the report themselves without a Medical Transcriptionist (MT). Back end speech recognition has the Physician dictating on the phone. The MT receives the dictated report and types the reports until the Physician or Provider becomes speech recognized. After this, the MT only reviews and edits reports. This is where the benefits of the system are fully realized.

Q. I have Dragon at my office. Will there be any coordination between DST and my office system? Will there be any impact to the profile that I have at my office?
A: The two systems will remain completely separate from one another. The profile that you have at your office will not be impacted. Dragon used for speech recognition related to the DST is an enhanced version.

Q: Will I still be able to dictate third party reports?
A: As approved by the Clinical Advisory Group in October 2014, transcription of letters for Legal, Insurance or Administrative purposes are out of scope for the provincial transcription service. This has been standardized across the province. Clinicians and care providers who require transcription of this type of document are asked to engage their local administrative/secretarial resources to perform this function.

3. eSignature and Authentication

Q: What is the Clinician Access and Electronic Signature module?
A: The Clinician access and electronic signature system provides electronic signature capabilities and allows clinicians to review, revise, and sign documents securely from anywhere they have an internet browser.

Q: Why are multiple paper copies of the reports distributed during editing by provider?
A: Each time the provider selects the Save button the report is redistributed to the CIS, Netcare and is printed and/or faxed to the author and cc recipients. A timeout period is in place to help avoid the need to do multiple saves.

Q: What is the “time out” period for both dictations and eSignature?
A: dictation - The time out period while dictating on the phone is 75 minutes; however, if you surpass this a message will tell you this and you will be cut off. If you place your call on pause it will hold your place for 60 minutes. You will not lose your report if cut off. If a provider starts dictating again with same MRN and work type, the system will ask if they wish to continue on the dictation they left off at. Otherwise, the physician will have to listen to the old report and continue from there or start from scratch. Best practice is to complete the dictation when you start it to avoid having to re-dictating your report.
**eSignature** - The time out period while reviewing and editing reports on the computer is 60 minutes. If you walk away from your workstation, please use CTRL / L to lock your workstation. It is a patient safety risk to leave this unattended and could lead to another provider signing the incorrect report. If you surpass this time and are timed out, your edits will not be saved. Best practice is to complete the review and editing of the report to avoid having to redo your work. You may save multiple times during your review process; however, it will print and distribute with each save and waste paper, this is the reason for the long time out period.

**Note:** There is no time out warning on eScript, so one needs to be mindful of their time management.

**Q:** I am a resident / non-signing provider. What is my workflow in eSignature?
**A:** Please refer to the quick references section of the DST Resource Repository and review the document for “Non-Signing Provider Instructions” for this workflow.

**Q:** Will I have to use the eSignature function or can I continue to do what I am currently for signing reports?
**A:** eSignature is best practice and it is recommended that Physicians transition to eSignature as soon as possible. Contact your Medical Affairs for details on the transition period.

**Q:** Do I have access to eScript’s eSignature in Netcare?
**A:** Yes. Edmonton Zone users who at present have access to the eSignature (PowerSign) link will be able to see two links “eSignature” and “Provincial eSignature” until such time as Edmonton Zone has completed its implementation to eScript. When that implementation has been completed the “eSignature” (PowerSign) link will be removed from Netcare eSignature menu.