

MEDICAL TRANSCRIPTION: PROVEN ACCELERATOR OF EHR ADOPTION

The recently enacted Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009 represents an important first step towards achieving the vision of a nationwide, fully interoperable electronic health record (EHR) system. However, the gap between that vision and current reality remains wide. Many healthcare providers still use paper records. Other providers have tried to implement EHR systems, but unfortunately, many such projects have failed. “Industry experts agree that failure rates of electronic medical record (EMR) implementations range from 50 to 80 percent.”¹ Clearly, the challenges of EHR adoption and implementation remain great.

The medical transcription/clinical documentation sector is well positioned to serve as a faster bridge and solution to enabling greater EHR adoption. The medical transcription sector can support the HITECH Act in the following three ways:

- 1. Use Existing and Proven Technology Platforms to Facilitate the Transition to Electronic Records:** Healthcare enterprises facing fiscal and/or worksite challenges in implementing large-scale, fully integrated EHR/EMR platforms can increase adoption by using existing electronic document exchange solutions found in medical transcription service platforms. Standardized healthcare documentation exchange practices will bolster the nationwide electronic exchange for health information in a secure, private, and accurate manner.
- 2. Develop and Support Quality and Security Standards Leading to Greater Document Compliance and Improved EHR Adoption:** When capturing patient encounter information accurately, uniformly, and securely across healthcare enterprises, there is greater likelihood of ensuring quality and compliance of the record for safe patient outcomes and legitimate reimbursements.
- 3. Continue to Create a 21st Century Workforce to Enable EHR Roll-out:** Grow and develop the medical transcription workforce by creating new opportunities for these entry-level, technology-enabled intelligent workers. The tacit knowledge and experience of the medical transcriptionist should be redeployed to support existing workflow practices, assist in migrating the healthcare system from a paper-based record to a fully interoperable electronic system and serve in risk management and document compliance roles to ensure the integrity and security of electronic document management systems.

¹ A Common Sense Approach to EMRs. AdvancedMD, July 11, 2006, https://www.advancedmd.com/pressroom/white_papers/commonsense_to_emrs.pdf.

Medical Transcription as a Faster Bridge to EHR Adoption

- ***The Promises and Challenges of EHR Adoption:*** EHRs promise to lower costs resulting from inefficiency and inappropriate and/or redundant care while improving the coordination of care and exchange of information among healthcare enterprises. However, despite these promises and efforts to date, adoption rates among physicians still remain relatively low, with costs cited as a major deterrent.² Other adoption concerns include complex organizational and system work flow issues and the increased documentation burdens on the part of physicians when they are asked to use direct text entry. Several studies have shown that practice productivity can decrease by at least 10 percent for several months following EHR implementation. In some non-oncology studies, the average drop in revenue from that loss of productivity was approximately \$7,500 per physician.”³
- ***Using Existing, Proven Technologies to Go Paperless:*** While the healthcare industry slowly migrates to broader acceptance and adoption of EHR technologies, the capture, collection, and documentation of health information continues to evolve as well. In fact, electronic document management tools are available now through medical transcription companies without having to implement a full EHR system. This opens up the possibility of providing lower cost solutions to physician practices and healthcare enterprises that cannot afford the higher costs of EHR/EMR platforms in the interim. Electronic document systems have the capability today to eliminate paper charts and improve productivity and efficiency without the multi-year timeframe or high cost of a comprehensive EHR system. Using readily-available technology to create a simplified approach to going paperless has been key to success.⁴
- ***Dictation-Transcription: Doctors’ Preferred Method of Documentation:*** Physicians have long embraced the dictation-transcription process for documenting patient care encounters. At least 1.2 billion clinical documents are produced in the United States each year.⁵ Dictated and transcribed documents make up nearly 60 percent of all clinical notes. These documents contain the majority of physician-attested information and are used as the primary source of information for reimbursement and proof of service. Dictation has historically been and continues to be the documentation method of choice for physicians because it produces complex, specific narrative that ensures accurate capture of patient history as well as the care encounter. In addition, it corresponds intuitively to the physician's usual method of working, it is flexible, data is presented in a predictable order, and it requires the same or less time than other current reporting methods. Further, discrete data contained within these narrative reports can be tagged using XML coding for export to EHR databases. A study by Columbia University concluded that such

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² “Electronic Health Records in Ambulatory Care - A National Survey of Physicians.” New England Journal of Medicine, July 3, 2008.

³ Oncology Outlook: The Costs and Benefits of Health IT in Cancer Care, Jivesh Sharma, MD, August 21, 2008.

⁴ “Going Paperless Without EHR?” EMR Advice, February 2, 2007.

⁵ National health statistics reports no. 5, 2006 National Hospital Discharge Survey; no. 3, National Ambulatory Medical Care Survey-2006 summary; no. 4, National Hospital Ambulatory Medical Care Survey-2006 outpatient department summary; no. 7, National Hospital Ambulatory Medical Care Survey-2006 emergency department summary; no. 12, Ambulatory Surgery in the United States; Hyattsville, MD: National Center for Health Statistics. 2008.

structured narratives represent “a new vision of electronic health records as collections of rich, interrelated narratives rather than lists of isolated facts” which “serve as a more accurate reflection of a patient’s health and a more effective source of knowledge for clinical decision making.”⁶

- ***MTs Ensure the Accuracy of Data Entered into Electronic Systems:*** One of the primary functions that medical transcriptionists serve is that of a second set of “eyes and ears” to ensure the accuracy of clinical documentation. Medical transcriptionists routinely flag from 10 to 20 percent of dictations for problem analysis. Potential errors such as wrong drug names or dosages, “left-side, right-side” discrepancies, and inconsistent findings (e.g., drug listed under both medications and allergies) are flagged for physicians to review. Because of this editing step, transcribed notes approach 100 percent accuracy when completed. By contrast, electronic data entry by physicians and other caregivers is prone to error. A study of direct text entry into an EMR found that “60 percent of patients reviewed had one or more input-related errors averaging 7.8 errors per patient,” “copying another clinician’s note and making changes had the highest rate of error,” and “overall, MDs make more errors than other clinicians, even after controlling for the number of notes.”⁷ Medical transcriptionists play a key role in ensuring that accurate information is entered into electronic medical records and help prevent the perpetuation of errors.

While electronic data entry by clinicians may solve many of the problems associated with paper records, it also creates new problems and new risks to patient safety.

- ***The Importance of Integrating People with Technology:*** New and emerging technologies can greatly enhance documentation processes but their successful implementation hinges on how they are used and integrated into practice. In a report released by the National Center for Research Resources, electronic clinical documentation systems enhance the value of EHRs by providing electronic capture of clinical notes, patient assessments, and clinical reports.⁸ Implementation of template-based data capture systems will further streamline the process and create greater efficiency in documentation for some patient encounters. However, the documentation of most encounters will not be readily facilitated by template solutions. To

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force complex data into a restricted template could greatly compromise both the scope and quality of the patient encounter record and has the potential for greater fraud and abuse in the system. Speech recognition products are other useful tools for the documentation cycle, especially as a solution paired with a documentation specialist who monitors the quality and placement of the information.

⁶ Johnson SB, Bakken S, Dine D, Hyun S, Mendoca E, Morrison F, Bright T, Van Vleck T, Wrenn J, Stetson P. An Electronic Health Record Based on Structured Narrative. J Am Med Inform Assoc. 2008;15:54–64.
⁷ Wier CR, Hurdle JF, Felgar MA, Hoffman JM, Roth B, Nebeker JR. Direct Text Entry in Electronic Progress Notes: An Evaluation of Input Errors. Methods Inf Med 2003; 42:61-7.
⁸ Electronic Health Records Overview, MITRE Center for Enterprise Modernization, National Institutes of Health, National Center for Research Resources, April 2006.

- ***Working with EHR Vendors for Successful EHR Adoption:*** Data capture and documentation technologies will continue to evolve as the healthcare system moves toward electronic exchange of health information. EHR systems will need to provide and support protocols that will work interoperably and in conjunction with the virtual medical documentation industry given that a large percentage of healthcare facilities (whether acute-care, ambulatory care, or private practice) long ago transitioned their documentation services off-site, using either an at-home workforce or an outsourced service provider. Most EMR systems do not currently have a way to export voice dictation that is embedded into the EMR software. This greatly limits the outsourcing ability of the practice and restricts transcription or speech-recognition editing to an on-site scenario only. Therefore the clinical documentation sector must work in closer collaboration with EHR/EMR vendors to improve integration of clinical documentation functions as EHR platforms roll out for adoption.

Quality and Security Standards Lead to Greater Document Compliance and Improved EHR Adoption

- ***Creating Document Standards to Improve Patient Care:*** Consistent, complete, and accurate documentation are critical to patient safety and coordination of care. Document standards, particularly in the areas of nomenclature, formatting, quality assessment, privacy, and security, ensure document integrity. The medical transcription sector has begun promulgating these standards. As the industry transitions toward broader adoption of electronic health records, the sector continues to champion the quality and security of documentation and health information.
- ***The Best of Both Worlds: Integrating Narrative Documents with EHR Technology:*** The Health Story Project,⁹ an industry alliance initiated by the Association for Healthcare Documentation Integrity (AHDI), the Medical Transcription Industry Association (MTIA), M*Modal Technologies, Alschuler Associates, LLC, and the American Health Information Management Association (AHIMA), formed to develop and promote implementation guides for common types of narrative notes. The implementation guides are templates for the HL7 Clinical Document Architecture (CDA), balloted by HL7, with whom Health Story has an associate charter relationship. This project bridges the gap between narrative documents produced through dictation and the structured, computable records necessary to feed the EHR by using common metadata and data templates developed for the CDA. Transcription documents can be imported directly into the EHR along with EHR summaries such as the Continuity of Care Document (CCD), another implementation of templated CDA.

The CDA-based EHR data and dictated notes can be aggregated in document registries and document management systems for exchange, reporting, and longitudinal analysis. Over the past two years, the Health Story Project developed four technical implementation guides as draft standards for trial use using. These report types include the Consultation Note, History & Physical, Operative Note, and Diagnostic Imaging Reports, the latter developed in conjunction with DICOM. Adoption of these standardized electronic documents will unlock the valuable data from narrative documents, facilitate the unrestricted flow of this narrative-source data into the EHR, and expedite the development of interoperable clinical document registries for use within healthcare enterprises and health information exchanges. There remain important document types to be defined as well as work to support their implementation. The healthcare industry

⁹ The Health Story Project, www.healthstory.com.

must adopt these standards for narrative document types to reap the full benefits of electronic documents.

- ***Working to Uphold the Privacy and Security of Patient Health Information:*** The HITECH Act has more stringent privacy and security provisions. Under the Act, both medical transcription service organizations (MTSOs) and independent medical transcriptionists (MTs), although still technically considered business associates, will now be held accountable at a covered entity level rather than a business associate level for HIPAA privacy and security rules. The Act requires MTSOs and independent MTs to implement policies that establish administrative safeguards (such as security policies and training), physical safeguards (such as locks and building security systems), and technical safeguards (such as computer encryption, log-in IDs, and auto-log off). In addition, business associates will be subject to direct penalties for violations of the security provisions.¹⁰ AHDI and MTIA will work with the federal government on education, training, and outreach to the clinical documentation sector to ensure compliance with the regulatory requirements.

The Act also expands federal security breach law to mirror protections that many states have passed in recent years. It requires business associates to notify covered entities of any unauthorized access, acquisition, or disclosure of their "unsecured PHI" that compromises not only the patient's privacy and security, but also the integrity of the information.¹¹ Considering the impact of these changes on MTSOs and independent MTs, AHDI and MTIA will work toward establishment of uniform security encryption standards for the exchange of protected health information between MTSOs, independent MTs, and the provider community. In addition, AHDI and MTIA will move toward mandatory certification of documentation specialists handling PHI to validate their full understanding of privacy and security policies.

A 21st Century Workforce to Enable EHR Roll-out

- ***Ensuring Quality of Care, Patient Safety, and Proper Reimbursement:*** The current health IT workforce grew out of a fragmented and manual paper-generated system. As health information demands increase within an automated, electronic environment, the medical transcription workforce will become more integrated, and current roles will transform into new ones. No matter how advanced the technology and standard vocabularies become, clinical providers and documentation specialists entering data into electronic record keeping systems must be precise, specific, and accurate. Medical transcriptionists serve on the front line of risk management by creating accurate, reliable, and complete transcribed documents that help prevent medical errors, improve patient safety, and facilitate the coding and billing process for insurance programs. Without these knowledgeable professionals serving in this essential risk management role, there is greater potential for increased medical error rates as well as documentation fraud and abuse.

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¹⁰ HITECH ACT Sections 13401 & 13404.

¹¹ HITECH ACT Section 13402.

- ***A Skilled and Knowledgeable Workforce That Embraces Emerging Technologies:*** Today's medical transcriptionist, or documentation specialist, represents a growing sector of the U.S. workforce typified by a technology-enabled, knowledge worker employed from home. This environmentally-friendly worker is a computer-savvy, skilled technician who produces the healthcare documents that provide the foundation for the revenue cycle, the front line for patient safety and risk management, and the facilitation of continuity of care. Documents produced by medical transcriptionists eventually become part of patients' permanent files. Many MTs or documentation specialists are embracing new data capture and documentation technologies such as speech recognition to improve the documentation process.
- ***A Growing Industry and Profession That Boost Job Creation:*** New job creation is an essential component of the HITECH Act. According to the U.S. Bureau of Labor Statistics, employment of medical transcriptionists is projected to grow 14 percent from 2006 to 2016, faster than average for all occupations.¹² Demand for medical transcription services will grow as the result of an aging population and individuals living longer with chronic diseases. These populations receive proportionately greater numbers of medical tests, treatments, and procedures that require documentation. The medical transcription workforce will be instrumental in assisting with the transition to EHRs and play a vital role in ensuring documentation integrity within the fully interoperable electronic health environment of the future.
- ***Innovative Initiatives to Prepare the Workforce of the Future:*** To help meet the demand for greater documentation services in healthcare, AHDI and MTIA have worked with the U.S. Department of Defense (DOD) and Department of Labor (DOL) in creating an initiative called *Mission Medical Transcription: a Career that Moves with You*. This career outreach program targets military spouses interested in a portable career in an ever changing and expanding health IT arena. Portable credentials and an environmentally friendly home-based career is perfectly suited to the mobile lifestyle of military families and those seeking re-enlistment. Since Mission Medical Transcription was launched in April 2007, over 800 military spouses enrolled in AHDI approved schools and many have taken advantage of the Career Advancement Accounts offered by DOD and DOL.
- ***Medical Transcription: A Career for the 21st Century:*** A high level of demand for transcription services will be sustained by the continued need for electronic documentation that can be shared easily among providers, third-party payers, regulators, consumers, and health information systems. Growing numbers of medical transcriptionists will be needed to amend patient records, edit documents from speech recognition systems, and identify discrepancies in medical reports. As the healthcare system transitions to greater EHR adoption, documentation specialists are ideally suited to assist with this transition and can be easily retooled and trained to take on new roles in an electronic health environment.

The Association for Healthcare Documentation Integrity (AHDI), formerly AAMT, has been the professional organization representing medical transcriptionists since 1978. AHDI sets standards of practice and education for medical transcriptionists, administers a certification program, has established a code of ethics, and advocates on behalf of the profession. For more information, visit www.ahdionline.org.

The Medical Transcription Industry Association (MTIA) is the world's largest trade association serving medical transcription service operators. Its mission is to create an environment in which medical transcription companies can prosper, grow, and deliver the highest level of healthcare documentation services. For more information, visit www.mtia.com.

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¹² United States Department of Labor, Bureau of Labor Statistics, Occupational Outlook Handbook, 2008-09 Edition.