Medical Transcription Relevance: DRT Aids Meaningful Use

By George Catuogno

Electronic Medical Records (EMR) adoption is a national concern. President Obama's ARRA stimulus and HITECH Act provides $44,000 incentives for clinicians who adopt EMR technology. Last year, a New England Journal of Medicine survey indicated that only 4% of clinicians have a fully functional EMR (with order-entry and clinical-decision support capabilities) and only 13% have a basic system.

If outpatient healthcare organizations and private clinicians are unsuccessful in the deployment of EMR technology, how will health information be exchanged between healthcare organizations and personal health records universally supported? At as more basic level, if documenting patient encounters through EMR technology slows clinicians down from conventional practice, how can widespread adoption be practically anticipated? How might this loss of efficiency impact the "meaningful use" requirements?

Going Digital
Percentage of physicians who use electronic health records

Basic system 13%
No record system 83%
4% Fully functional system

Note: From survey of 2,758 U.S. physicians conducted September 2007–March 2008
Source: New England Journal of Medicine

Since the emergence of EMR technology, many EMR companies have taken aim at medical transcription as a costly and obsolete part of healthcare documentation. In reality healthcare documentation continues to depend significantly on the work of medical transcriptionists while the Medical Transcription Industry Association (MTIA) continues to retool the next generation of "knowledge workers" trained in specialized crafts such as backend speech recognition editing, Discrete Reportable Transcription (DRT), Clinical Documentation Improvement (CDI), E&M coding review audit, risk management review audit and other services inherently linked to healthcare documentation.

As noted by the American Health Information Management Association (AHIMA) in a Practice Brief entitled *Speech Recognition in the Electronic Health Record,* "MTs are poised to evolve into clinical data, data quality, and decision support specialists."

Efficient clinical documentation practices are historically based on narrative dictation. When clinicians are asked to change these habits and engage technology rather than patients, they not only incur the cost of the technology, they incur the cost of their lost time and the cost the distraction this effort has on the intimacy and quality of the patient encounter. In many cases they incur the cost of how their own clerical restraints impact the quality of documentation, which may lead to risk management issues, inaccurate or incomplete coding for treatment and reimbursement, and other problems.

In an article by Peter Waegemann, CEO of Medical Records Institute, and in reference to the findings of the New England Journal of Medicine, he remarks, "It is time to stop and have a hard look at what needs to be changed; it is time for all the committees, associations, and others who are touting EMRs to confront this dismal picture and find ways to help correct our national strategy".

Waegemann notes several key issues and asks technology providers to work cooperatively in driving solutions that will overcome issues such as usability related to data capture methods as well as the high cost of EMR technology.

Clinician behavior should not have to change when loss of time and efficiency are among the consequences of that change. The answer to Waegemann's charge is cooperation between healthcare documentation solution stakeholders (i.e., EMR, speech recognition and medical transcription) to bring strategies that drive practical, efficient and cost-effective solutions.
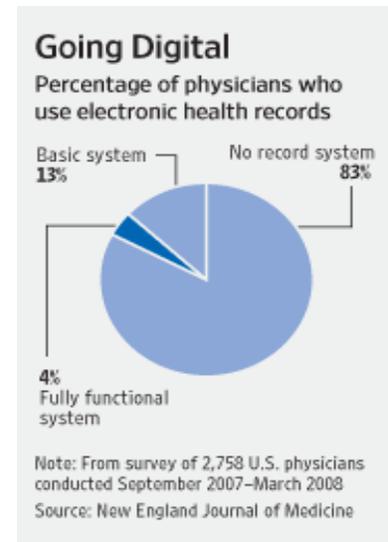
On April 6, 2009 at the HIMSS conference in Chicago, a group of constituents from the various healthcare documentation sectors, led by Mark Anderson, CEO of AC Group, a consulting firm that engages in EMR industry assessment studies, met to discuss strategies for cooperating rather than competing to drive the national EHR adoption initiative more effectively.

At the center of this discussion was Discrete Reportable Transcription. DRT allows clinicians to use EHRs for viewing clinical information without giving up narrative dictation, which can be routed through frontend or backend speech recognition technology or sent to a transcription service. Either way the documentation created is structured (i.e., encoded with XML tags) that can be easily imported and automatically populate any EHR with practice-specific discrete reportable data.

In a study by AC Group involving 573 patient charts, DRT-enabled EHRs averaged 30 minutes per day in clinician documentation time while standard EHR data entry took 140 minutes per day. The monetary cost to a clinician with average earnings of $100 per hour would be approximately $180 per day or $4,000 per month.

In a New England Journal of Medicine publication, *Off the Record – Avoiding the Pitfalls of Going Electronic,* the article notes that template-based documentation may distract from the important cognitive work of providing care, limiting thoughtful review and analysis.

Transcribed Note

|	Time	Physician Cost[1] (per minute)	Transcription Cost[2] (per minute)	Total Cost
Dictate note	1 min	$2.70		$2.70
Transcribe and edit note	4 min		$0.40	$1.60
Total	5 min			$ 4.30

[1] MGMA Dashboard, $340,000 collections for IM professional charges
[2] Outsourced transcription at 16 cents per 65-character line

Structured Data Note

	Time	Physician Cost[1] (per minute)	Transcription Cost (per minute)	Total Cost
Data entry	5 min	$2.70		$ 13.50

Resources Required to Prepare Clinical Notes

"Although completing such templates may help physicians survive a report-card review, it directs them to ask restrictive questions rather than engaging in a narrative-based, open-ended dialogue."

The resulting findings of the AC Group study on DRT-enabled EHR documentation:

- 38% reduction in transcription costs initially
- Transcription costs on follow-up visits decreased by 82%
- No change from traditional practices in interaction with patient
- Ability to capture discrete data using transcription
- Populate EHR via dictation instead of physician data entry
- 80% of discrete data with 18% of the effort
- Documented encounters capture the complete, cognitive analysis of clinicians instead of by one-size-fits-all templates
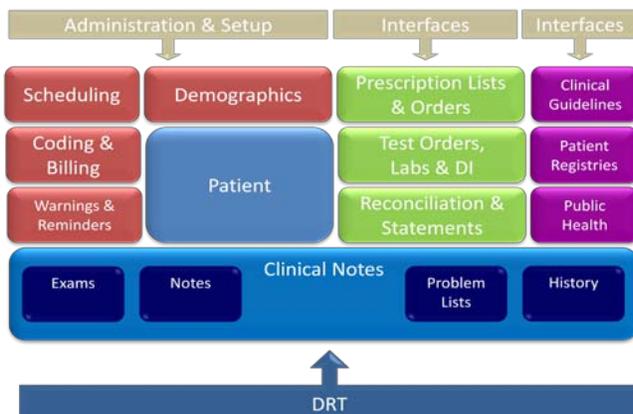
In its traditional form Medical Transcription still serves a significant percentage of the industry; coupled with backend speech recognition, it enables scalable deployment across enterprise healthcare; with HL7-based integration it feeds inpatient and outpatient EMR systems with unstructured data health records; with XML-based DRT it feeds those same systems with structured data health records, leading to improved clinical documentation, decision support and a number of other opportunities to deploy automation and increase the value of those documents, including top-line billing.

Medical Transcription, in fact, holds one of the keys to helping solve EMR adoption problems, and since the meeting between MTSOs and EMR companies, these two groups are beginning to seek ways to work cooperatively through a work group established by the Medical Transcription Industry Association in an effort to raise industry awareness about hybrid solutions involving DRT.

Healthcare Organizations that are focused on using such solutions stand to gain the most in their EMR usage experience, efficiency, value and improved patient care.   In the end this lets clinicians be clinicians, and leaves the data entry work to the documentation professionals, helping to transform this much needed field of specialists into a more valuable asset to healthcare.

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