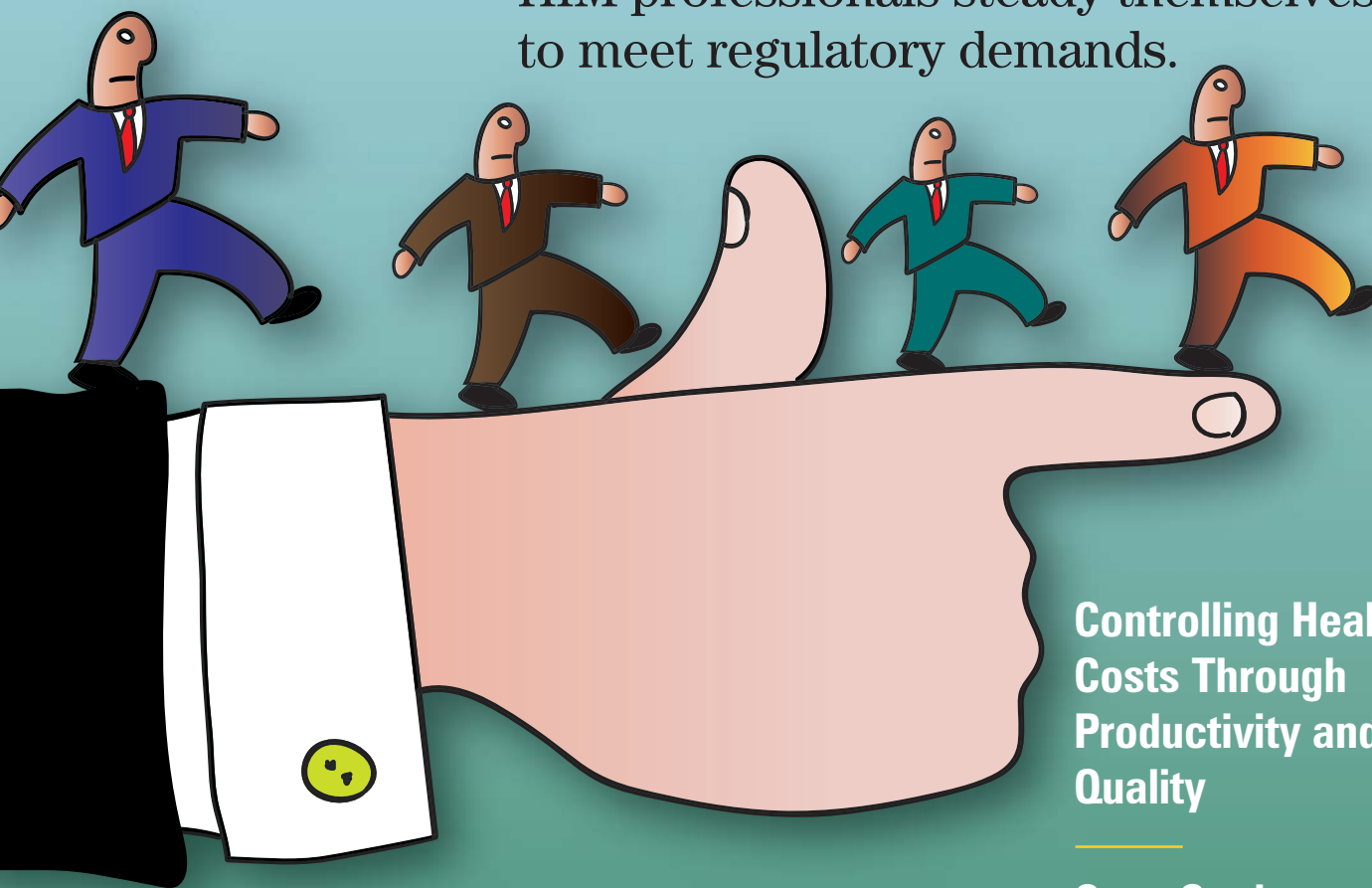


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## Walking the Compliance Plank

HIM professionals steady themselves to meet regulatory demands.



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# transcription trends



## Managing Physician Compliance

BY CHRISTOPHER REHM, MD

**M**any HIM supervisors and managers may not realize they have the resources to streamline the transcription process and minimize human errors at their disposal. And, little do they realize that a number of simple techniques and new technologies are available to increase physician compliance and decrease turnaround times (TATs).

At major hospitals, annual transcription costs often exceed \$1 million. Since the accuracy and speed of transcription services is directly tied to the welfare of patients, HIM managers should be proactive about training hospital personnel on the proper procedures and adopting new

technologies that can simplify the process.

The two most important measures of transcription service are quality and TAT. Avoiding mistakes at the start of the transcription process—specifically, in dictation—can prevent costly delays and potential confusion. The following steps will help HIM managers understand and correct the most common mistakes physicians make during transcription.

- **Explain the importance of entering data completely and correctly.** Identifying the patient is the most critical step in the transcription process. When dictating over the phone, there are typically four pieces of information the doctor

needs to input with each report: physician ID, medical record number or visit code, work type, and location. Entering the proper numbers and codes into the system, however, can be a tedious step that busy physicians may neglect.

Without all the necessary codes, the automated system will not be able to process the transcription file and make it available to a medical transcriptionist (MT). Instead, the file will be removed from the normal workflow for correction. These corrections must be made by a human, which significantly increases TAT.

Whether transcription services are performed in house or outsourced, HIM managers have the opportunity to explain to doctors how data omissions disrupt the normal transcription process and affect the speed of services. Physicians who fully understand the transcription process are more conscientious about entering the data correctly.

- **Encourage the use of correct templates.** Whether dictation is transmitted by phone or digital voice recorder, every healthcare provider and their transcription partner agree in advance on the template to be used with each work type to ensure the transcription information is complete and readily identifiable. Physicians do not always comply with this template, generally because they have not been properly trained or do not understand its importance. When a doctor deviates from the template, it becomes increasingly likely that important information will be overlooked, omitted, or inserted into the wrong place. It also becomes confusing, if not impossible, for the MT to follow the information.

In these cases, the MT may find it necessary to flag the transcription file for additional research. Generally, this is performed by a separate department. Researchers must analyze, organize, and correct the disorganized information in the transcription file before returning it to the customer. Naturally, adding steps and personnel to the process adds time and potentially lowers the quality of patient care.

- **Discourage doctors from stringing dictations together.** Many physicians will properly enter the demographic information for the first patient they saw that day but will then continue dictating for additional patients. When individual reports run together like this, it may lead to physicians accidentally omitting vital patient information, giving incorrect data, or transitioning from patient to patient so quickly that important identifiers become inaudible. It then becomes imperative for the MT to properly identify each patient and separate the appropriate medical information and organize the data accordingly. Not only does this slow down the transcription process, but it also introduces additional opportunities for human error.

- **Train doctors when to use the STAT option.** Transcription providers typically staff an account based on an anticipated amount of reports and the contracted STAT volume to be generated. Unnecessarily using the STAT designation will likely increase the hospital's total volume of STAT jobs, which can disrupt the account staffing, slow the completion of genuinely urgent projects, and lead to long-term degeneration of transcription quality and TAT. Therefore, being compliant with STAT protocols is vital to ensuring the proper document turnaround for patients with emergency needs.

- **Adopt technology that retrieves and organizes data automatically.** New technology is capable of minimizing the risk of human error by reducing the need for physicians to enter codes or follow strict templates. Instead, patient data is auto-

matically retrieved and recorded in the correct format.

A PDA with an integrated schedule allows the physician to open his or her schedule on the handheld computer and then tap the screen to select the appropriate patient. At that point, the physician's ID, patient's medical record number, and possibly work type and location can be automatically attached to the voice file the physician enters into the PDA.

Similarly, a PDA or computer on wheels (often referred to as a COW) can be equipped with a bar code reader. By scanning the patient's bar code into the machine, all relevant patient information is again attached to the digital dictation file.

A tight integration between transcription solution and electronic health record (EHR) is a benefit to physicians and will also help manage physician compliance when it comes to dictation. If the EHR and transcription solution are working together, it will allow physicians to use a PC-based dictation function to automatically pull a patient's historical data into the current voice file being dictated.

- **Offer a variety of dictation options.** With so many options, which one is best? A single dictation method is rarely able to accommodate the needs of every doctor at a hospital. HIM managers should provide a range of dictation options so physicians can choose the method most amenable to their individual work habits. Physicians will be more compliant, more comfortable, and more appreciative if they are allowed to select the dictation method.

- **Solicit help from your transcription**

vendor. A physician's compliance is easy to monitor. Outside transcription partners should be able to compile a report on each doctor, including a compliance percentage and description of any errors. Hospitals should work closely with the account services department of their transcription partners to develop solutions that address the specific noncompliance issues of each physician. The solutions will most likely include a combination of new technologies and physician training.

- **Develop a transcription education program.** Although there are new devices capable of gathering and organizing data automatically, no technology is capable of completely eliminating the need for physicians to understand and comply with the transcription process. With the help of the hospital's transcription partner, the HIM manager should develop a communication program to keep doctors educated about the transcription process. When physicians understand how mistakes complicate the process and how those complications can affect patient care, they become attentive to their own compliance issues.

The HIM staff can take advantage of simple techniques and new technologies to better manage the compliance of their dictating physicians. Engaging physicians in the process, providing appropriate dictation software and hardware, and working with transcription partners are a few specific ways to accelerate and improve the overall transcription process.

— Christopher Rehm, MD, is chief medical officer at Spheris.

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