Strategies and Tools for Improving Transcription and Documentation

Failure to accurately document care provided is a significant threat to hospital revenue and compliance. What's more, it's only expected to become more important as documentation efforts grow increasingly more sophisticated to respond to the requirements of severity-based payment, as is being seen with Medicare severity-based diagnosis-related groups (MS-DRG). With this in mind, the following discussion, sponsored by 3M Health Information Systems, explores use of process change and technology to improve transcription and clinical documentation activities. Hospital executives also share their strategies for engaging physicians in these efforts and optimizing technology investments.

What are some of the greatest challenges hospitals face with regard to documentation and transcription quality?

David E. Owen: Hospital volume has been growing, which is increasing the amount of transcription needed, and at the same time, labor shortages are common. Such demand has led some hospitals to use offshore transcription services to meet this need, but many that do so haven't been satisfied with the level of quality that results.

In addition, hospitals now are addressing MS-DRGs. As a result, accurate documentation not only depends on correctly transcribing what the physician said, but also requires capturing all of the information needed to properly code the record and bill the payer. If physicians thought the old rules were complicated, the new MS-DRGs have brought it to a whole other level.

Gloryanne Bryant: Part of this challenge in moving toward severity-based payment is that there's a gap in the healthcare system that often divides physicians and hospitals. Physicians use documentation for patient care that is often different from what is used in the coding classification system. Physicians need to appreciate the direct use of documentation for capturing clinical data and the specifics of the ICD-9 codes themselves. The documentation a physician may use in day-to-day communications about a plan of care may not correlate directly to the terminology needed to identify the patient's severity of illness, acuity, and risk of mortality. Hospitals will then say to physicians, "You're not giving us what we need." But, often the physicians don't really understand what's needed, and the rationale behind that.

What metrics do you use to monitor physicians' transcription and documentation performance?

Bryant: I can't speak specifically to transcription, but our corporate coding HIM compliance department does look at specific documentation areas where we typically see variances and incompleteness. Examples include the terminology for anemia, the terminology for respiratory failure, and identification of the specific type of pneumonia. Generally, about 30 of these "hot target areas" tend not to be specified in the medical record. By tracking the volume of queries or clarifications by physician and the responses to the queries, you can determine where the issues are and which physicians have more issues than others.

Christopher A. Clarke: At UCSD Medical Center, we have a quality assurance area that's run by a nurse. She has access to audit software that allows her to analyze all of the different records and how they were coded. She compares the data with standards established by hospitals of similar type and size in our region. Using the results we get from these reports and the benchmarking performance data, we are able to teach physicians how to more effectively document their work with patients.

Edward A. Barreto: In terms of monitoring individual physician documentation performance at UCSD Medical

Center, we have metrics that our medical records informatics committee put forward. These include targets based on Joint Commission standards. We also track problems such as misuse of abbreviations and diagnoses sections, and attempts to format fields that can't be modified. We communicate these performance measures to the physicians. If there are ongoing problems with a physician's documentation and this communication doesn't resolve them, then we may take away the physician's ability to provide specific edits through the self-documentation system. In some instances, the physician may even be excluded from using the system and have to go back to the old method of dictating all reports and amendments. Also, there would be increased monitoring of the physician's work.

Additional monitoring of documentation performance is done through patient tracer teams made up of staff from our administrative services and compliance areas. They have a checklist that includes questions like: Was the brief post-op note done? Were all handwritten notes dated and timed? Was the H&P [history and physical] cosigned by the attending physician, and was it completed within the necessary guidelines?

What sort of performance monitoring occurs in relation to outsourcing of transcription?

Stephen S. Cooley: Our particular transcription vendor is beginning to use voice-to-text technology and has started to send some work offshore, so we've set goals of improved turnaround times and reduced costs for these efforts. We also recognize it's the quality piece that we have to monitor and ensure. To date, most quality efforts for us are driven by the vendor's quality reports. However, we are considering whether we need to invest in our own quality control program for transcription. Such a program would involve hiring people to listen to the original dictation and to compare the dictation to the transcribed report. Also, we might add some criteria regarding the quality of the transcription content. Currently, we depend on the physicians and clinicians who are recipients of the transcribed reports to give us feedback on the quality.

In the past, transcription turnaround time was a particular performance challenge. An examination of this trend revealed that we had moved up to a rate of about 60 percent of our documents being requested as "stat." We needed to essentially renegotiate with the transcription company and say, "If you improve your turnaround times, then our physicians will stop sending so many documents as highest priority."

What has helped improve your documentation efforts?

Cooley: I think we are doing a better job at focusing on how the documentation's level of accuracy and completeness affects the billing component. One of the things we've done is have a clinical documentation team conduct concurrent reviews of physician documentation. A nurse will look at lab results and review the supporting documentation. She will then offer the physician feedback on the documentation and, when necessary, suggest ways quality could be improved.

Another area we're starting to look at now is document creation. At my organization, the process currently happens largely through dictation. As we move toward electronic medical records in the future, we would like to have options for putting such things as physician progress notes online. Also, we may move to some sort of technology where the physician dictates and the system transcribes this voice file into text fairly quickly so that the physician can edit the documentation and then electronically sign it. We currently do this in the radiology department.

Bryant: Traditionally, we've done rebill or retrospective querying, where someone from the HIM coding staff will seek clarification from the physician after the patient has been discharged from the hospital. Prior to MS-DRGs, we had limited activity at a handful of hospitals performing concurrent documentation improvement for the inpatient setting where the physician is queried or asked for documentation clarification while the patient is in the hospital. After the introduction of MS-DRGs, we also began engaging in concurrent documentation improvement activities across all of our hospitals. The concurrent querying may be done by documentation improvement specialists, case managers, or inpatient coders using dedicated staff who look for ambiguous nonspecific documentation. They may or may not be assigning the ICD-9 code at that time, but the main focus is

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to capture the documentation necessary to be more specific, clear, accurate, and timely. Beginning in December 2007, we rolled out concurrent querying at all of our hospitals. We're also now investigating computer-assisted coding, where the documentation is supported by computer-based documentation prompts that encourage being specific, complete, and accurate at the time of the encounter. A computer terminal is used to create the actual documentation through templates and drop-down windows, creating a narrative script of a procedure that a surgeon has performed. With these reminders on the computer screen, it's possible to create more specific documentation from the outset, rather than having to wait for the physician to provide dictation and then find out after the fact that what was said wasn't specific enough, adding more work for both the physician and hospital staff.

CAC [computer-assisted coding] not only does the transcription—which saves costs—and creates the documentation, but it also does the coding on an interim basis. The software will actually look at the physician's terminology and assign diagnostic and procedural codes in a draft, and then a hospital coding staff member will validate them. Such tools are particularly helpful because it is difficult for physicians to keep up with coding and terminology changes. CAC can also reduce the days of final coding and A/R [accounts receivable] days.

Has technology improved transcription processes at anyone's organization?

Mike Petronelli: A couple of years ago, we purchased a dictation/transcription system as part of a larger suite of modules to create an electronic medical record. The system includes transcription/dictation templates, electronic signature capabilities, and front-end and back-end speech recognition. With front-end recognition, the physicians are the editors of what they're dictating into the computer. With back-end speech recognition, the computer translates vocal files into text for a transcriptionist to edit.

Because this system is Web-based, we were able to establish a program where transcription and physician responses to queries can be done remotely. Physicians use an account number to access the dictation system that directly links them to the episode of care that they have dictated. This ability eliminated steps for us. When we used to use medical record numbers, either the transcriptionist or clerical support staff had to spend time locating the particular episode of care for which the physician was providing dictation.

Barreto: For paper records, our greatest documentation problems right now involve date and time accuracy and inclusion of signatures. Through education, we have gotten to the point where the signatures are there more than 90 percent of the time, but the dating and timing remains a problem for us. As a result, we've been migrating a lot toward online systems that will do it for us.

How do you ensure physician support for using transcription and documentation technology?

Petronelli: I think the best approach is to help physicians embrace the technology because it makes sense to them. Help them see that it won't slow down their patient workload. Whether you are providing physicians with inserts, templates, or front-end and back-end speech recognition tools, just make it as easy as possible for them to get the information they need in an electronic format. Also, your primary goal should first be getting as much of the transcription and documentation process as you can to be electronic. Then you can figure out which physicians have a high adoption rate and which don't, and begin addressing the challenge.

Clarke: Back when we implemented the use of electronic signatures, our director of health information services at the time obtained a mandate from a number of committees to compel every physician in the organization to use an electronic signature with no exception. That made us a little unique. A lot of places try to deploy e-signatures either at the departmental level or divisionally, or they make their use voluntary.

I think such an approach has helped us a lot. Having had the e-signature and the electronic systems in place for so long, our physicians are probably more open now to moving toward either stricter rules or other electronic systems than they might have been. The physicians already are in a position where they've come to expect certain sophistication. Ironically, the most challenging part about introducing our latest form of the e-signature is that the physicians wanted greater functionality than was available.

Of course, for more involved types of projects, setting mandates simply isn't advisable. As an example, we are trying to encourage clinicians to stop using the dictation process—which is so costly—and begin to self-document. We know we're up against a big wall of resistance, because it's typically easier to pick up a phone and talk into it than it is to open up a patient record and begin typing notes. We can't compel everyone across the organization to transition to the technology immediately because we recognize we would have mass revolt and lose all credibility. Instead, we are building support gradually and trying to leverage the successful experiences of staffers who are doing direct entry already.

Barreto: That's right. With use of templates to aid self-documentation, we've seen adoption largely depends on experience of peers. Word of mouth is so strong, that staffers usually come to us and ask about them. Or they realize, "I'm paying a lot for transcription to do the same kind of report over and over again; it's a lot easier if I can just do it myself."

What general advice do you have for providers before they make investments in transcription or documentation technology?

Petronelli: I would strongly recommend looking at the whole suite of modules that will make up what your electronic medical record will become, such as a scanning and indexing system, voice file development and storage, a transcription platform, and an electronic signature. It's really helpful if you have your coding modules integrated with those pieces.

Also, a lot of mainframe vendors will try to say they can do it all, and that's not true. If at all possible, look at best of breed for whatever it is that you're trying to accomplish.

Clarke: We did a lot of on-site analysis. The team was made up of nurses, physicians, information systems administrators, and senior-level managers. They walked through other organizations that were using products that we were considering and got feedback about their experiences. I don't think there is any other way you can figure out what will work for your organization until you talk to people actually using technology in the field. Otherwise, you're just flying blind.

Barreto: Added to this, I think what made us so successful is that we had a very close and strong relationship with the medical staff committees and information services at our organization and there has been a lot of support from the top. I've seen other organizations implement a new system only to find that no one wants to use it and no one compels anyone to use it. So they end up with an investment that really goes nowhere. With us, we have a lot of support from executive leadership to make the project happen.

Owen: I think the most important thing is to keep your focus on the big picture. It's not enough to say, "OK, you can reduce my cost of a transcriptionist, so I've saved $30,000." It's more beneficial to seek a partner that not only improves productivity to reduce costs, but also helps you redeploy these resources to achieve the appropriate payments and reimbursements.

Traditionally, the transcriptionist role has been primarily to clean up a physician's grammar so documentation is more understandable. However, this communication could be at a much higher level—in terms of not only the accuracy of the transcription, but also the actual quality relative to coding and payment. It's painful to watch how much hospital revenue falls off the table. And one of the reasons is simply because the provider gave the care but didn't document it in the right way.