



## FACILITATE EMR SUCCESS: Discrete Reportable Transcription Shifts Documentation Burden Off Physicians

### The Challenges of Traditional EMRs

For years, health care providers have envisioned electronic medical records, or EMRs, as an important tool for improving patient care and reducing costs. However, to date, the adoption of electronic recordkeeping systems has been surprisingly limited. According to a 2008 article in *The New England Journal of Medicine*, only 4 percent of physicians reported having a full-scale EMR system in place. Only 13 percent said they had a basic system.<sup>1</sup>

The significant capital expenditure needed to implement an electronic system is certainly one of the factors contributing to this sluggish pace. Initially, some providers believed this up-front cost would be offset by a reduction in operating expenses. Specifically, EMRs were thought to eliminate the need for medical transcriptionists (MTs) because the doctor could enter patient data directly into the computer system. For many hospitals and clinics, these cost savings never materialized. Facilities that cut medical transcription out of the process found that doctors required extensive training to master the technology and ended up spending large parts of their day entering information into an EMR system themselves. Consequently, a 2010 study in *The American Medical Journal* concluded that hospitals with relatively advanced computer systems experienced no reduction in administrative or overall costs.<sup>2</sup>

In terms of the upfront cost of implementing EMRs, providers will get help from the federal government beginning in 2011. The Health Information Technology for Economic and Clinical Health (HITECH) Act, which President Obama signed into law in February 2009, will provide physicians up to \$44,000 through Medicare and up to \$65,000 through Medicaid for showing they make “meaningful use” of electronic records. Hospitals and clinics are eligible for several million dollars of their own Medicaid and Medicare incentives based on multiple criteria. Payments will continue through 2016, with reimbursements diminishing over time. Providers that fail to make meaningful use of EMR systems, meanwhile, will see their Medicare payments drop by up to 3 percent.<sup>3</sup> Due in large part to these substantial government incentives, the Congressional Budget Office estimates that roughly 90 percent of doctors and 70 percent of hospitals will be using fully functional EMRs by 2020.

However, the challenge of realizing lower operating costs from electronic recordkeeping remains. Online platforms that seamlessly integrate medical transcriptions with EMRs represent an important



breakthrough in this regard. Health care providers who use this new “hybrid” approach transfer data-entry responsibilities away from physicians, allowing them to concentrate on actual patient care. At the same time, they benefit from the richer narrative information and increased accuracy that a medical transcription service can provide.

### Improving Physician Satisfaction With DaRT™

Most physicians today update patient records by dictating their notes into a phone or computer and sending them to a MT company, a practice that’s been around for decades. According to industry trade groups, nearly 60 percent of all patient notes are created using the dictation-transcription method.<sup>4</sup> One of the advantages of this system is that, for a doctor who may see more than 20 patients a day, it’s a quick process that allows them to lay out their observations in a straightforward, narrative format.

---

“We operate under the assumption that the physician is the most skilled — and most expensive — person in the office and should only do what no one other than a physician can do.”

*Richard Baron, MD et al.  
on his practice’s experience with a standalone EMR*

---

By synchronizing this common practice with EMRs, health care providers get the best of both worlds. Emdat, an online medical transcription platform, recently launched a technology solution that uses XML coding to tag “discrete” data within a transcribed physician’s note; when the transcription is sent electronically to the medical provider, the tagged data automatically populates the appropriate electronic patient record. This innovative process, called discrete reportable transcription (DRT), offers physicians a convenient way to view the history of a single patient — or search data for multiple patients — without requiring them to spend much of their day inputting information. Emdat has entitled its interface solution DaRT™ — short for Discrete *accurate* Reportable Transcription — to reflect the company’s emphasis on the reliability of transmitted data.

One of the potential results of using DaRT is increased “buy-in” from physicians, who receive the benefits of electronic records without having to do time-consuming clerical work. According to the AC Group, a health care technology consultancy, a physician who sees 40 patients a day will spend an average of 30 minutes dictating his or her notes and searching for data. However, when using a traditional EMR system, doctors would have to spend 140 minutes entering the data themselves.<sup>5</sup> As one group of physicians put it after adopting a standalone system, “the process of radically redesigning 15 years of accumulated work flow in a short interval was extremely stressful.”<sup>6</sup> After the transition, they reported feeling like “data input drones.”

When doctors are asked to do non-value-added tasks such as data entry, it has the potential to hurt not only morale, but the bottom line. At typical billing rates, that additional 110 minutes a day not seeing patients could lead to hundreds or even thousands of dollars a day in lost revenue. Multiple studies have shown that the loss of physician productivity following EMR implementation leads to roughly \$7,500 in lost revenue per doctor.<sup>7</sup> By contrast, DaRT-enabled systems help ensure that physician groups and hospitals use their human capital more efficiently.

In addition to potentially cutting operational expenses, providers using DaRT-enabled systems are poised to receive reimbursements for front-end EMR costs under the HITECH Act. Eligibility for Medicare and Medicaid incentives hinges on a provider’s “meaningful use” of electronic records, and many experts believe a hybrid approach would accomplish this goal just as well as a standalone EMR platform. The Centers for Medicare and Medicaid has proposed initial guidelines for the term “meaningful use,” which, though not formally ratified, provide valuable direction to health care providers. According to CMS, the criteria for meaningful use, beginning in 2011:

“focus on electronically capturing health information in a coded format, using that information to track key clinical conditions, communicating that information for care coordination purposes, and initiating the reporting of clinical quality measures and public health information.”<sup>8</sup>

CMS has proposed adding to these “Stage 1” criteria in subsequent years by requiring electronic records to play a role in disease management, clinical decision support, medication management and other key aspects of medical care. By populating roughly 60 percent of the patient chart, a DaRT-enabled EMR system provides the electronic repository of patient information needed to perform all these important functions.

## Richer, More Accurate Patient Records

In addition to freeing up physicians to focus on patient care, this new medical records paradigm results in several notable quality improvements over standalone EMR systems:

- The ability to populate EMRs with narrative information in the form of a physician note offers a more contextual, meaningful way for physicians to view a patient’s history. Doctors who plug information into a computer themselves often provide “discrete” data only, unlike those who use dictation. The note generated by a standalone EMR can be several pages long and difficult for other physicians to decipher.
- Electronic MT platforms such as Emdat’s already have previous transcriptions on file for thousands of patients. This allows DaRT users to upload histories into an EMR, giving physicians valuable background information on the individual they’re treating.
- A trained medical transcriptionist can often identify obvious errors in a physician’s dictation, leading to increased data accuracy. A recent study showed that medical documentation specialists identified errors — many of them critical — in 33 percent of all physician-created dictations.<sup>9</sup> Having information reviewed before it becomes part of the record is consistent with EMR vendors’ mission of improving the quality of patient records.

---

“When you’re trying to read the notes of your colleague [in an electronic record], it’s almost impossible to figure out what happened to the patient. You have to read through two pages of all this junk that’s put in to increase billing.”

*Rushika Fernandopulle, internist and instructor at Harvard Medical School, on the non-narrative notes generated by standalone EMRs. Quote taken from The Wall Street Journal, April 13, 2010.*

---

Getting physicians to embrace electronic records can be a difficult process when they’re expected to do much of the input themselves. However, DaRT-enabled EMRs give them virtually all the advantages of a standalone system — the ability to mine patient data for lab values or medications, for example — while allowing them to focus on patient care. This significant benefit, along with the potential to improve the quality of records, enhances the prospects for doctors buying into EMRs.

## The Future of 'Hybrid' Solutions

The availability of DaRT represents an important shift in the way health care providers can approach EMR implementation. By reducing data entry costs and allowing for more accurate, complete patient information, this burgeoning technology solution helps alleviate some of the obstacles that have to this point hampered the widespread adoption of electronic records. The flexibility of DaRT — the solution already works with several major EMR systems — provides the opportunity for significant growth in this area.

Various parties within the health care information industry are working together to ensure discrete reportable transcription provides a dependable, convenient option for hospitals and clinics in the years ahead. Among their top priorities is the creation of technical standards that all software vendors can adopt. The Association for Healthcare Documentation Integrity (AHDI), the Medical Transcription Industry Association (MTIA), Health Level 7 (HL7) and the American Health Information Management Association (AHIMA) joined forces to create the Health Story Project, an industry alliance charged with developing and promoting such standards. The Health Story Project has already developed technical implementation guides for five types of reports — the Consultation Note, History & Physical, Operative Note, Diagnostic Imaging Reports and

Discharge Summary — which Emdat has started to implement in its DaRT solution. According to the AHDI and MTIA, the creation of standardized electronic forms “will unlock the valuable data from narrative documents, facilitate the unrestricted flow of this narrative-source data in the (EMR) and expedite the development of interoperable clinical document registries for use within health care enterprises and health information exchanges.”<sup>10</sup>

Industry organizations are also working together to ensure the continued safety of electronically transmitted health information. AHDI and MTIA are developing uniform security encryption standards that medical transcription service organizations and independent MTs can use to protect information being uploaded to a health care facility's EMR system. In addition, the two groups have announced they're jointly taking on the role of educating and training transcription companies about the stricter security and privacy provisions to which they'll be held accountable under the HITECH Act.

The industry's continued commitment to these issues underscores their importance to the future of DRT-enabled electronic records. Ultimately, health care organizations will benefit from this push toward standardization, as it provides consistent functionality among MT providers and contributes to greater safeguards of patient information.

## References

1. DesRoches CM et al. “Electronic Health Records in Ambulatory Care – A National Survey of Physicians.” *New England Journal of Medicine*. <http://content.nejm.org/cgi/content/full/NEJMsa0802005v1>.
2. Himmelstein, D.U., Wright, A., Woolhandler, S. “Hospital Computing and the Costs and Quality of Care: A National Study.” *The American Journal of Medicine* January 2010, 123(1), 40-46.
3. Health Information Technology for Economic and Clinical Health Act. Committee on Ways and Means. January 16, 2009. <http://waysandmeans.house.gov/media/pdf/110/hit2.pdf>.
4. “Medical transcription: Proven accelerator of EHR adoption.” Association of Healthcare Documentation Integrity and Medical Transcription Industry Association. May 2009. [www.mtia.com/.../White\\_Paper-Medical\\_Transcription-Proven\\_Accelerator\\_of\\_EHR\\_Adoption.pdf](http://www.mtia.com/.../White_Paper-Medical_Transcription-Proven_Accelerator_of_EHR_Adoption.pdf)
5. Anderson, MR. AC Group. DRT-enabled EHRs. [www.acgroup.org/images/2009-02\\_What\\_is\\_DRT.pdf](http://www.acgroup.org/images/2009-02_What_is_DRT.pdf).
6. Baron, R.J. et al. “Electronic health records: Just around the corner? Or over the cliff?” *Annals of Internal Medicine*. August 2005. 143(3), 222-226.
7. Jivesh, S. “Oncology Outlook: The Costs and Benefits of Health IT in Cancer Care.” HCPLive website. August 21, 2008. [http://www.hcplive.com/oncology/publications/oncng-Oncology/2008/Aug2008/Oncology\\_Outlook\\_Costs\\_and\\_Benefits](http://www.hcplive.com/oncology/publications/oncng-Oncology/2008/Aug2008/Oncology_Outlook_Costs_and_Benefits)
8. “CMS proposes definition of meaningful use of certified electronic health records technology.” Centers for Medicare & Medicaid Services. Dec. 30, 2009. <http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3564>
9. Daigh, R. et al. “Improving the accuracy of narrative patient notes: The role of documentation specialists in supporting physician use of EMRs.” Medical Transcription Industry Association. June 2009. [www.mtia.com/downloads/DictationErrorReportAbstract.pdf](http://www.mtia.com/downloads/DictationErrorReportAbstract.pdf)
10. “Medical transcription,” pg. 4.



*We deliver superb functionality and client satisfaction by providing streamlined workflow and EMR integration, all with no contracts, no capital investment and rapid deployment. Contact us to learn more.*

**800-851-3348 ext 230**

**[bbarton@nelsonsystems.com](mailto:bbarton@nelsonsystems.com)**

**[nelsonsystems.com](http://nelsonsystems.com)**

POWERED BY

