TALKING POINTS

What is Medical Transcription?

- Medical transcription is the act of translating from oral to written form the record of person's history, diagnosis, treatment, prognosis, and outcome.
- Medical transcriptionists (MTs) serve on the frontline of health information and risk management. They create accurate, reliable, and complete transcribed documents that help prevent medical errors, improve patient safety, and facilitate the coding and billing process for insurance programs.

Who Are We?

- AHDI
  - AHDI has been the professional organization representing MTs since 1978.
  - AHDI sets standards of practice and education for MTs, administers a certification program, has established a code of ethics, and advocates on behalf of the profession.
  - There are over 100 components associations of AHDI throughout the country, each of which holds regular educational meetings and symposia.
- MTIA
  - MTIA is the world's largest trade association serving medical transcription service operators.
  - MTIA's vision is to create an environment in which its member companies can prosper by integrating people with technology to improve clinical documentation solutions for healthcare delivery systems.
- Estimated Size of Medical Transcription Sector
  - Approximately 300,000 MTs
  - Approximately 1,700 medical transcription service organizations
  - Approximately $15 billion in annual revenue

The Contributions of Our Sector to EHR Adoption and How Legislators Can Support Our Value Proposition

1. **Regulate/require that EHR technologies include functionality for free-form physician narrative.**

   a. The Importance of Telling the Patient's Full Story:

      i. The documentation of most encounters will not be readily facilitated by template solutions. The breadth and scope of the full "story" of a patient's health history, treatment, and intervention cannot be forced into an unyielding, field-driven EMR/EHR (Electronic Medical Record/Electronic Health Record).

      ii. Physicians and practitioners need the flexibility of documentation technologies that allow for complex narrative – the ability to capture critical patient data when a pre-form template does not provide a drop-

down menu “option” to document that information. To 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.

iii. There must be standards that support the flow of information between narrative documents and EHRs. The adoption of such standards will unlock the valuable data from narrative documents, facilitate the unrestricted flow of narrative-source data into EHRs, and promote the development of interoperable clinical documentation registries for use within healthcare enterprises and regional/national networks.

b. <u>Medical Transcription-Doctors’ Preferred Method of Documentation:</u>

i. Approximately 1.2 billion clinical documents are produced in the United States each year. Dictated and transcribed documents make up nearly 60% 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.

ii. It has historically been and continues to be the documentation method of choice for physicians because it facilitates 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.

iii. Given doctors’ preference for and familiarity with the dictation-transcription process, physicians would be more likely to embrace EHR adoption if certified EHRs were required to include narrative insertion. This would, in turn, lead to greater and more successful EHR adoption.

2. Sponsor and/or support legislation that allocates funding to workforce development in allied health, *specifically* to those organizations and programs whose roles link directly to EHR adoption and integration.

a. <u>A Skilled and Knowledgeable Workforce for an EHR Environment:</u>

i. Medical transcriptionists represent a technologically trained and clinically knowledgeable workforce whose skill set can be readily deployed to facilitate EHR adoption by integrating emerging technologies (SRT (Speech Recognition Technology), EMR/EHR) into the data capture process while ensuring accurate capture and documentation of patient care encounters.

ii. Healthcare documentation workers partner with physicians to provide oversight and interpretive review of health information and will provide a

value-add risk management service as healthcare delivery migrates to a fully interoperable EHR.

b. A Growing Industry and Profession That Boost Job Creation:

    i. 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.

    ii. Demand for medical transcription services will increase due to a growing and aging population. Older age groups receive proportionately greater numbers of medical tests, treatments, and procedures that require documentation.

    iii. Funding for education and apprenticeships will help spur further job creation within the medical transcription sector.