The Case for A Credentialed Workforce

Medical Transcription & Healthcare Delivery

When considering the potential implications, risks and benefits of pursuing mandatory credentialing in any profession, it must be determined if ultimately the industry is better served by the adoption of regulations that restrict entry to practice and access to the public sector than if those regulations did not exist. In some cases, it could be argued that an industry is hindered by such regulations. Where mandatory credentialing of medical transcriptionists is concerned, however, attention must turn to what is ultimately in the best interest of patient care delivery. In what measurable ways would restricting entry to practice for medical transcription potentially protect patients, enhance the delivery of patient care services, and create operational efficiencies in healthcare delivery? This is the question that should be at the center of any discussion of mandatory credentialing of medical transcriptionists or speech-recognition editors.

While certainly there is much that has and can be said about protecting the privacy and security of patient records, it cannot be overlooked here that an unregulated, unmonitored transcription workforce creates an access point to patient records that is incongruent with the intent of HIPAA. It might be tempting to stop at the access point and argue that transcriptionists do not need to be credentialed in order for their unique access to patient records to be tracked and monitored. However, of more critical concern than their access to patient records is the ability of medical transcriptionists to modify and alter the patient record. Safeguarding patient records does not just involve protecting the access points. It should likewise involve protecting patient record outcomes by ensuring that only skilled, qualified and *accountable* individuals have access to patient records for the purpose of creating, modifying and formatting the clinical care record (CCR).

Medical transcription involves a highly interpretive skill set, where these medical language specialists partner with providers to create an accurate reflection of a patient care encounter. Like interpreters for the deaf, medical transcription involves the application of informed judgment and interpretive skill that extends beyond just what they are *hearing*. It requires a foundational understanding of the diagnostic process, clinical medicine, treatment and care to be interpreted accurately and applied within the context of complex narrative dictation that is often very difficult to understand. Dictation challenges continue to be an ongoing problem for the transcription sector – where providers who speak English as a second language, those with disjointed and rambling narrative, and/or those who dictate at accelerated speeds continue to demand that medical transcriptionists bring a strong interpretive skill set to the process.

Medical transcriptionists cannot bring that interpretive skill set to the table without a significant foundation of knowledge and training. The pace at which healthcare delivery is moving does not provide a space for taking someone off the street and training or mentoring them on the

job. Such an unregulated training scenario creates unpredictable and dangerous gaps of knowledge and understanding that impact the interpretive process and limit the ability of the transcriptionist to identify errors and inconsistencies in the dictated narrative – a role that is critical in the continuum of deployed risk management. Flagging inconsistencies and discrepancies in the health record is the guardian role of the MT, and providers rely on the keen eyes, ears and interpretive mind of the MT to ensure that health data is captured and recorded accurately, that inconsistencies are addressed, and that the amended record is authenticated by the provider.

Creating a mandatory credentialing entry point to the profession will ensure healthcare delivery that medical transcriptionists have met the minimum standards to engage in this risk management role. Given the vital role that health encounter documentation plays in continuity of care and accurate, timely reimbursement, healthcare delivery would be well served to understand and recognize the pivotal difference a *skilled, credentialed* MT can make to that process. A medical transcriptionist with questionable or marginal skills, at the very least, is going to be limited in his/her ability to play a contributory role in risk management and chart error analysis. But beyond that, providers need to be looking at the fiscal impact to healthcare delivery of an unregulated and questionably prepared transcription workforce.

Every time a report is transcribed by an MT with a low level of knowledge and interpretive skill, the healthcare system as a whole takes the following risks:

- That the MT will misinterpret key clinical data being dictated, resulting in the potential for this to be overlooked by the provider at the authentication point, and for the error to become part of the patient's permanent record, upon which ongoing care decisions are based.

- That the MT will miss or fail to hear critical information, resulting in omitted words or phrases that the provider may not recognize are missing at the authentication point.

- That the MT will fail to recognize dictated errors and inconsistencies and therefore neglect to flag them to the dictator's attention, again with the potential of those errors becoming part of the patient's permanent record.

- That the MT will struggle with challenging dictation or unfamiliar terminology, leaving blanks in the record that have to be routed back to and filled in by the provider or forwarded to a QA department for review and correction – processes that suspend the forward progress of that record.

All of the above scenarios represent widespread impact and immeasurable cost to healthcare on a daily basis. How much does it cost a healthcare facility for records to be suspended in QA and correction rather than being coded and processed for reimbursement? Great attention is often paid to how long dictated reports sit on the dictation system before they are transcribed, but how closely are healthcare facilities and providers watching the delay between transcription and the release of that document for continuity of care and reimbursement?

In a study conducted by the American Association for Medical Transcription in 2004 involving error analysis and quality review of a random sampling of acute care records across multiple US facilities, 63% of the errors found in those records were deemed to be critical and major errors, i.e., those defined by the study as having a potential impact on patient safety. Of that

63%, errors specifically attributed to the *dictator* totaled 27%.[1] This study draws into sharp relief the role an MT plays in both accurate capture and interpretation of what is being dictated *and* being able to recognize, correct and/or flag dictator errors and inconsistencies.

While providers bear some responsibility in this scenario for ensuring that they are providing the kind of high quality dictation that facilitates accurate capture and documentation, it must be stressed that healthcare facilities and providers across the nation are incurring hidden costs and risk on a daily basis by failing to set the same kind of credentialing and best practice standards for medical transcriptionists that they do for all other members of the allied health team. Whether he/she is a physician assistant, a nurse, a radiographic technologist, or a medical transcriptionist, any worker with marginal or substandard skills and preparation is a potential risk and cost to healthcare delivery and the facility that employs him/her.

While transcriptionists do not provide hands-on patient care, they are part of a critical process to create an accurate record of that care and, if unprepared, carry the potential for adversely affecting that process and/or hindering operational efficiency. At a time when healthcare delivery desperately needs to create processes and procedures that create *greater* operational efficiencies and reduced costs, tightening the restrictions around this sector of healthcare administration could serve to eliminate an ongoing drain of resources.

The only MTs who would be adversely impacted by a mandatory credentialing regulation are those who bring the greatest risk (as outlined above) to the documentation process. An MT who is already working in a contributory, risk-management-impacting role through highly skilled and informed interpretive judgment has little to fear from mandatory credentialing and everything to gain by stepping across the line of accountability set by the standard. Healthcare providers likewise have so much to gain and very little to lose by drawing a line in the sand that will ensure the workforce assigned to this process is capable of doing it accurately and with a measurable impact on healthcare's fiscal bottom line.

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[1] "AAMT Quality Assurance Report: A Survey of Error Trends." 8 March 2007. <http://www.aamt.org/scriptcontent/Downloads/AAMTQAReport.pdf>