

## **Documenting the Patient Encounter Without the Data Entry Bottleneck**

**by James M. Maisel, M.D.**

**Chairman, ZyDoc Medical Transcription**

Dictation and transcription have remained the predominant mode of medical documentation for the past several decades. The clear advantages of dictation over alternative means of documenting medical records account for its enduring popularity.

All physicians learn how to dictate early in their training, because it allows unimpeded flow of thought for creation of a detailed, granular record. Nothing is faster than speech. Dictation of a comprehensive detailed encounter typically produces efficient documentation within 2 minutes.

Handwriting, normally at 20 words per minute, is slow and has legibility problems. A 2006 report from the National Academies of Science's Institute of Medicine shockingly concluded that doctors' sloppy handwriting kills more than 7,000 people annually. Legibility becomes especially important when groups share records and patient care.

Direct data entry is not the answer. Clicking and navigating through picklists is very tedious and takes more than 10 minutes per encounter. Very few people can type 80 words per minute and they have to be tied to a keyboard. Dictation can be done anytime, from anywhere, using a phone or a handheld digital recorder. Typical dictation rates are 180 words per minute, 9 times faster than handwriting. This is the fastest, most detailed method of data capture for documenting a patient's record, and is used by virtually all high-volume physicians. Saving even half a minute per patient encounter per day allows physicians to increase the daily number of encounters, or to finish earlier. One of the top reasons for failure of EMR adoption has been the data entry bottleneck. To increase user acceptance, many EMR companies are now upgrading their products to include an integrated dictation solution.

Dictating for transcription does not require any substantial investment in training, education, changes in culture, or physician behavior. Proponents of standalone EMRs and other data capture methodologies point to the cost of transcription, up to several dollars per document, but ignore the 10-minute productivity loss that may cost \$100 per encounter. Transcription costs, however, are more than offset by increases in productivity, improved legibility, and higher billing charges as a result of more accurate coding.

Dictation and transcription provide the basis for a comprehensive medical record that other members of the healthcare team can share. With modern transcription systems, the audio dictation can immediately be made available to other physicians. Transcription turnaround times can be expedited to several hours when necessary.

The word processing records have other substantial advantages intrinsic to electronic documentation. With fingertip control, the records can be sorted, searched for keywords, and remotely viewed with HIPAA security as web-based documents. They can be distributed, electronically signed within hours of dictation, and then immediately distributed again via secure record sharing or Efax applications. If the dictation and transcription process is integrated into the EMR system, the power of the medical record is exponentially extended, without the necessity of time-wasting, redundant keyboarding.

A transcribed medical record serves as proof of quality of care for a provider, and furnishes billing personnel with a fully documented encounter that can be coded, shared, and discussed with other billing staff. Doctors who dictate patient encounters and letters while the patient listens rate high in patient satisfaction. Time spent in dictation in front of a patient extends the patient encounter with the doctor an average of 2 minutes, and the additional feedback mechanism ensures that data is captured appropriately. In the case of a lawsuit, the general dictum is that “if it was not documented, it was not done.”

Complete and accurate documentation is not only the proper thing to do for patient care, it facilitates billing and protects the physician in the case of a lawsuit. Other methods cannot match the granularity and ease of use of a high quality dictation and transcription solution for including all aspects of patient care in medical records.

For tertiary care physicians, transcription and correspondence with referring doctors is a tremendous practice builder. A referring primary care physician can send a patient for consultation and receive back an electronic or faxed transcribed report the next morning. This rapid documentation and distribution cycle eliminates much of the inefficiency in healthcare. The referring physician knows that the patient was seen and that the question in hand has been addressed. He also receives the added value of educational information to augment his base knowledge of the problem for future care. The written documentation avoids the necessity of phone tag and interruptions for both physicians.

Poor medical documentation, such as records with incomplete or illegible handwritten notes, can be dangerous for patient care, costly, and inefficient, and afford little protection in lawsuits or audits. In contrast, doctors have learned to rely on dictation and transcription for detailed legible electronic notes documenting a high level of care. These transcribed documents can improve medical care, allow physicians and referring doctors to work efficiently, and encourage referrals. The detailed records can justify higher levels of coding, help withstand a billing audit, and reduce malpractice risks.