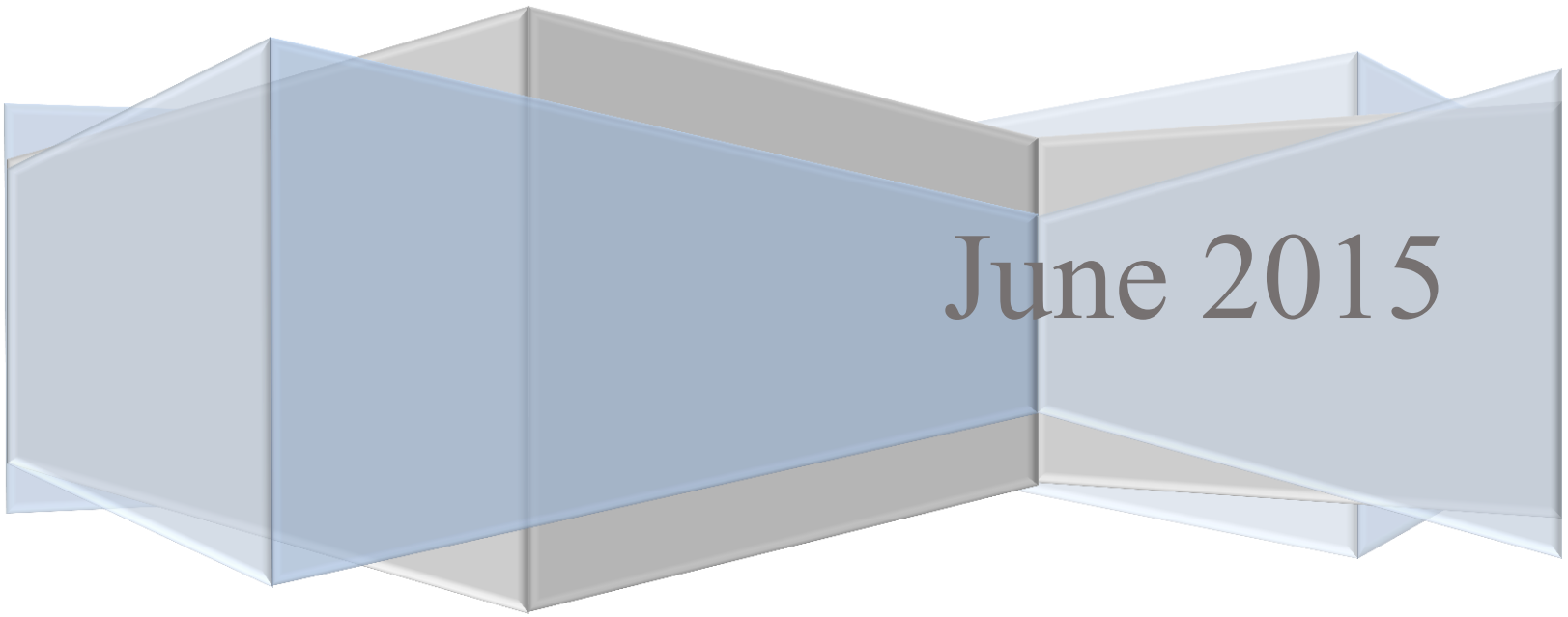
Association for Healthcare Documentation Integrity

Compensation Best Practices Toolkit

Application and Relevance of Compensation Best Practices for Healthcare Documentation



Application and Relevance of Compensation Best Practices in Healthcare Documentation

Compensation is an important factor in recruiting, maintaining, and sustaining a talented workforce. As roles and responsibilities change within a workforce due to new technologies, work processes, or methods/procedures, compensation is normally reevaluated and adjusted accordingly. In healthcare documentation, such decisions are often made by individuals or departments who are dependent on medical transcription/healthcare documentation managers to inform them of relevant changes. If you are a manager in such a changing work environment, are you equipped to describe the new demands on your workforce? Can you effectively describe the skill sets that your team has developed over the years, or skills now required of new recruits to be able to hit the ground running as an effective team member? The Compensation Best Practices Toolkit, created by AHDI, can help answer some of these questions.

The creation of this Compensation Best Practices Toolkit has been motivated by two major developments in healthcare documentation. First, technological changes have transformed the documentation landscape, processes, and workflow, leading to a disjunction between compensation and skill requirements for both traditional and emerging roles. Second, an increasing focus on cost control in health care coupled with mistaken assumptions about productivity has created extraordinary pressures around compensation practices.

Considering the impact of technological changes on compensation practices in healthcare documentation, it is obvious that the widespread adoption of an electronic health record (EHR) has resulted in a rapid and dramatic evolution in modes of healthcare document creation. One early assumption that featured conspicuously into EHR adoption scenarios was that medical transcriptionists (MTs)/healthcare documentation specialists (HDSs) would be eliminated from the documentation process and replaced by a variety of new tools, including direct provider entry with automated procedures and front-end speech recognition.

However, some of these new documentation practices have proven to present clear risks to documentation integrity. A study by Controlled Risk Insurance Company (CRICO),[1] a medical malpractice insurer, found that incorrect information in the EHR accounted for 20% of medical error cases. In a February 2015 Quick Safety alert, The Joint Commission[2] commented on the problematic use of the "copy-and-paste" function in the EHR by providers and recommended implementing a process in which the accuracy of the clinical record is monitored, with a feedback loop to healthcare providers when their documentation is inaccurate or redundant. An April 2015 Quick Safety[3] alert noted that significant errors are being introduced into the EHR by

[1] https://www.rmf.harvard.edu/
[2] http://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_10.pdf
[3] http://www.jointcommission.org/issues/article.aspx?Article=fddvQj8uTBdf1nykmE%2fNC8KiB5mn4Rgtazo2HZz3fmw%3d

a variety of faulty documentation processes that lack quality oversight, and multiple recommendations were made for ensuring accuracy in EHR documents, whatever the mode of creation might be.

Thus, it appears likely that a quality-focused environment, rather than eliminating MTs/HDSs, will make it necessary for them to partner with providers in new ways. The resultant emerging roles require a change in compensation models, as current production pay or pay-for-performance models are not appropriate for the evolving job functions. Compensation models should take into consideration the extensive knowledge required for these positions, as well as the relevant certifications of the specialists, their redefined roles and responsibilities, and the technical skills required to perform these tasks. Certification in particular is an important element in standardizing, identifying, and affirming the skills and experience practitioners bring to their job roles and should be both strongly encouraged and rewarded in compensation models.

EHR technology also has impacted the document creation workflow—for which compensation models have not been adjusted accordingly. For example, healthcare documentation specialists performing traditional transcription and editing now often spend extra time verifying critical information such as encounter dates, work types, and location/facility codes to ensure that documents return to the EHR correctly. Working in an EHR, navigating through multiple screens to access the patient's encounter, is not conducive to fair production pay. Further, MTs/HDSs are often required to work in multiple platforms, and different subtleties of each system may significantly impact productivity and compensation.

A second important development that has impacted compensation is the recent emphasis on cost control across the healthcare system. Due to a variety of factors (e.g., decreased reimbursements) cost control has become the new norm in all areas of health care. Medical transcription, always considered a "cost center," has become a focus of cost-cutting measures. Hospitals are requiring their in-house transcription departments to cut costs, and outsourcing has been seen as a rational business decision for many healthcare organizations. With outsourcing, medical transcription service organizations (MTSOs), like in-house transcription departments, are then pressed by their customers to cut costs. Consequently, both in-house departments and MTSOs have experienced continuous downward pressure on transcription compensation.

At the same time, implementation of speech recognition (SR) engines has been seen as a way to reduce costs. Early in the process of introducing this EHR-related technology, vendors proposed that front-end SR could either completely eliminate the need for MTs or HDSs, as mentioned above, or double productivity when MTs/HDSs are employed as "back-end" editors of SR-generated documents. Embracing these vendor productivity estimates, both hospitals with in-house transcription departments and MTSOs have developed production compensation models that pay edited lines at half the rate for transcribed documents. However, it is now understood that for most MTs/HDSs, editing productivity is not double that for standard transcription. Productivity increases vary widely based on work setting, technology, training, and skill sets.

Meanwhile, continuously decreasing levels of compensation for MTs/HDSs are likely to be driving current practitioners away from the field and reducing the number of practitioners entering the field. Given the quality-related issues noted above and the emergence of new roles

for employees with the skill sets of qualified HDS practitioners, it would seem prudent to review compensation practices that discourage people from entering or remaining in these positions.

In summary, with the marked changes in healthcare documentation technology and considering the negative impacts of sometimes misguided cost-control measures, it is time either to implement an appropriate hourly wage or, if a production-pay model is used, to give consideration to the additional duties now performed by healthcare documentation specialists, the technical platforms being utilized, and the type of work being performed.

Finally, we note that credentialing of healthcare documentation specialists can establish the equality of the MT/HDS skill set to that of other credentialed medical documentation professions such as HIM, coding, clinical documentation integrity, and information technology systems professionals.

Reference:
ECRI Institute's Top 10 Patient Safety Concerns for 2014

In many companies/organizations Healthcare Documentation Specialists are now performing QA reviews for clinician-created documentation within the EHR.

A quality assurance review ensures quality and documentation integrity.

CDI professionals review documentation for "any clinical conditions or procedures to support the appropriate severity of illness, expected risk of mortality, and complexity of care," according to AHIMA.

RESOURCES
Certification for Healthcare Documentation Specialists

Clinician-Created Documentation Resource Kit