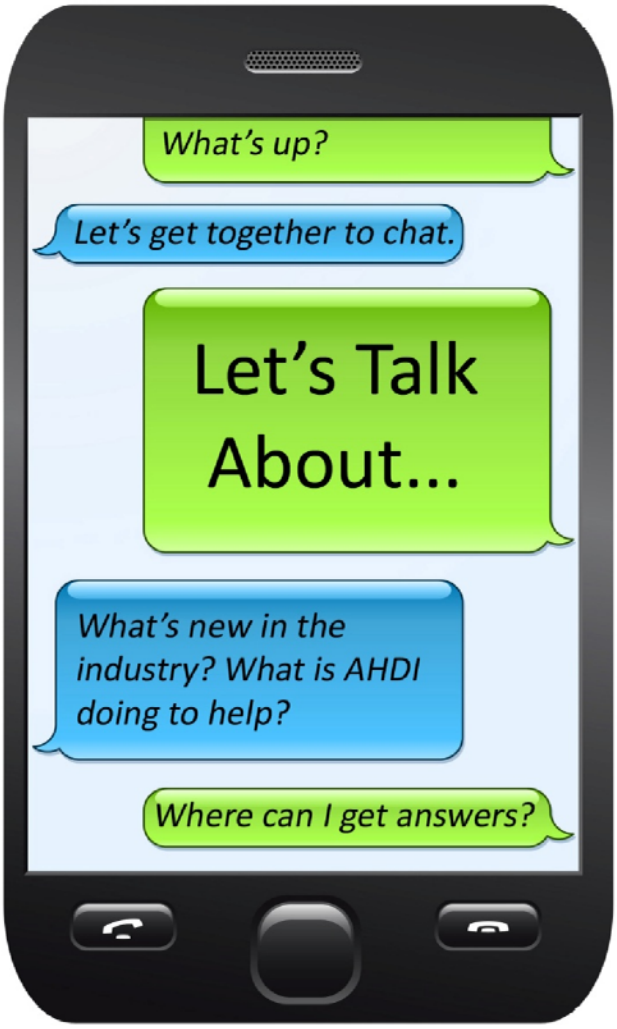

Offshore Transcription

BY

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Open Letter Series

AHDI Board of Directors

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Dear Colleagues,

The ability to have transcription performed outside of either a doctor's office or a hospital setting is something I think we take for granted now, and it's been the advances in technology and the growth of the Internet (and before that the advent of phone-in systems) that have truly allowed us to perform our work at home. So, let's start with some definitions. ***Outsourcing*** is transcription performed off-site (usually work from home) and can be performed by independent contractors or employees of facilities or MTSOs. The terms ***offshore***, ***overseas***, and ***international*** are synonymous with transcription that is performed by workers who do not live in the United States.

One of the most visible overseas transcription stories is that of the University of California San Francisco Medical Center/Pakistan breach back in 2006. Many considered it a "sentinel event" that brought attention to the growing trend of using offshore labor for transcription service support. I've heard colleagues tell of the Portland annual meeting, where you could hear a pin drop when the topic of offshore transcription was raised. Most recently, I was at an AHDI meeting in Orange County in November 2010, and one of their prominent members had just lost a significant account to an "Indian" transcription company. There is no doubt it is an impacting trend, and one not to be ignored or dismissed.

I, too, lost an account a few years ago to a company based out of Oakland, but they hired MTs from overseas. It was a small account, but I had a desire to keep my quality standards high and the volume was growing, and if I had to hire subcontractors, I needed to charge accordingly, but in the end, it came down to the issue of total transcription cost to the physician, and thus, the reason he changed service providers. Often we see contract decisions based on price and not necessarily the quality of the end product. That is, unfortunately, the reality of business. We also know that competitive contract bids come from everywhere, not just overseas. Not too long after switching, that particular account I lost moved to a new EHR system, so the action my client took was really just an interim solution anyway.

I have also met colleagues who perform work overseas in a variety of countries, and they share similar struggles as we do here. Difficult dictation, too much work and not enough time, wanting to get credentialed, tough career for not enough pay; for MTSOs, the ability to find good MTs, and then they have the added challenge of not always being accepted as colleagues by their peers.

These are real stories, with real people, whose lives and the livelihoods of the MTs in their employ depend on successful transcription businesses regardless of where the work is performed.

For those who may not have heard the UCSF med center story, a transcriptionist in Pakistan was not getting paid for her transcription services so she went public, threatening to use the Internet to expose the names of the patients and the records she was transcribing. What UCSF discovered was that the transcription they had outsourced to a company in Sausalito, California, was then outsourced multiple times, first to a company in Florida, and then, I

believe, to Texas and eventually Pakistan. There are many things wrong with this entire scenario – the fact UCSF did not know where the documentation was truly being transcribed, the obvious concern about how "cost-effective" and secure it is to subcontract work 3+ times, and then, of course, the alarming realization that (and potential for) someone would use exposure of patient medical records as a blackmail strategy. The UCSF breach became national news for a while and statewide news in California for longer.

Coincidentally, around the same time, at a California annual meeting, the California state leadership met the senior advisor to California Senator Figueroa. After the educational session, a small group took this gentleman to lunch and discussed the purpose and vision of our association, PHI (protected health information) and HIPAA, raising the bar through ethical best practices, accountability and transparency regarding where transcription is performed, implementing technologies to keep patient information secure, and credentialing our workforce so there is the same level of privacy and security knowledge across the board. Were we excited? You bet! We had the ear of a state senator.

After the UCSF breach publicity, that relationship with Senator Figueroa actually proved very significant. Senator Figueroa introduced a bill in the California state senate that would have prohibited transcription generated in California from going overseas. The bill was even more far reaching, in essence suggesting that transcription of California patients only be performed in California. Through our connection with Senator Figueroa, AAMT was invited to testify at the state senate hearings about the bill. Amy Buckmaster, AAMT President, and Peter Preziosi, our newly hired CEO, addressed the state senate and issued a joint statement, Regulation of Health Information Processing in an Outsourcing Environment, with the Medical Transcription Industry Association (MTIA) and the American Health Information Management Association (AHIMA).

As we step back from the overwhelming desire to "close our borders" after such a drastic incident, consider the reality of what such a law or regulation could mean, not just to our industry, but to the entire health information workflow process. I would only be able to transcribe audio generated in California, period. Now, I know my state has one of the highest unemployment rates in the country, over 10%, but I don't think this is the solution to our problem. I work on accounts that are all over the US. What if I moved to another country, say to Canada? We are already experiencing more work than we have qualified MTs to perform it. As US healthcare reform takes hold, there's potentially another 30 million people who will have patient encounters to document.

It's hard to say for sure how much of an impact overseas transcription has had on the entire workforce through reduction or repurposing of workload. According to a study conducted by MTIA in 2003, identified in AHDI's Offshore FAQs, only 50% of all transcription was outsourced, and of that percentage only 8%-10% of outsourced work was contracted offshore. If these figures are correct, then 8%-10% of 50% of transcription is outsourced overseas. This translates to 4%-5% of the total volume of transcription performed overseas, and that was in 2003. That figure may be more or less as the marketplace continues to become more fluid. What we have seen is an increase in editing and QA positions generated around overseas transcription work.

We've seen that with speech recognition as well, thus requiring a different set of skills than straight production work. Personally, that's a good thing in my book but not everyone agrees with me. Anecdotally, some of the work being done in various countries is also considered the "easier" work or the "low-hanging fruit." This leaves the more complex and difficult dictated work stateside. Some would say the work is more interesting and challenging; however, for some, it has meant a decrease in production or complete elimination of work.

Ultimately the Figueroa bill failed, in large part due to our associations having the opportunity to educate others on how and where our work is performed, bringing to light the advantages and disadvantages of an entire industry that services healthcare delivery without local or state boundaries when it comes to healthcare facility, service provider, and MT. Some might question why our associations testified *against* the bill, which at first glance might seem as though we were advocating for offshore transcription. In reality, we saw the more alarming implications of a bill that would have prohibited documentation services from going *out of state,* not just out of country, and had a greater responsibility to consider the full impact of such a bill not only on our industry but on the healthcare system.

We also have to remember that what happened in Pakistan could happen anywhere. The rationale some have given for denying offshore transcription (poor quality, in particular) can be found here in the US as well. Beyond the quality issue, many would argue that protected health information (PHI) is no more secure in the home of a domestic MT than in a production center in India. Security breaches and poor quality are not endemic to the offshore market. They are a universal concern.

What the UCSF experience did bring to light were a whole host of issues that AAMT did address then and AHDI continues to address today. Has anyone heard the rumor that AAMT *started* offshore or overseas transcription? I did very recently, and that actually prompted me to write this letter. That rumor was being cited as the reason this person would not sign the AHDI-West Petition Letter we have circulated in support of our position on narrative dictation, EHR adoption, meaningful use, and our role in patient safety. AHDI (formerly AAMT) is a professional association made up of individuals and medical transcription service owners (MTSOs) who tell the patients' healthcare story through a dictation/transcription workflow process, not a transcription company. What prompted overseas or international transcription was the advent of technology that allowed companies to hire and train MTs all over the world and supply them with work. As well, many MTs and MTSOs in the US were at capacity with respect to keeping up with workflow and turn-around times. Some countries became particularly attractive because their governments were supportive of developing workforces in their countries, and thus, it was a win-win-win for many individuals and MTSOs in the marketplace because they could get incentives to develop their business, have transcription performed while the US was sleeping, create better turn-around times (TAT), and operate at lower costs in a way that would help them remain competitive in the Request for Proposals (RFP) process. When cast against the backdrop of an evolving global marketplace, it was inevitability that alternative labor sources would become part of the landscape of healthcare

documentation. Hence, overseas transcription was a business solution borne by the marketplace, not birthed by our association.

But it's never a good thing to make assumptions about the trajectory of any marketplace trend or driver. Largely due to more stringent HITECH provisions around the definition of a business associate, we are seeing more facilities, hospitals, and physician groups (including the Veteran's Administration) issue RFPs with the strict requirement that their documentation stay stateside in the hands of a domestic workforce. Is this a good thing? Some would say yes and some would say no. Again, we already have a challenge with workload and TAT. Also, what if you have a military spouse who does not live in the US but certainly should be considered as a viable worker if they've met all the standards of entry into the practice? Again, the marketplace is the driver. What the association and its members can do is educate and provide the expertise and rationale for having standards of practice, ethical best practices, and a credentialed workforce, and be a resource for technology solutions.

AHDI remains committed today to the same principles in our May 2006 white paper on offshore transcription. We even developed FAQs in response to the offshore question. Our major message is reflected in our tag line, *Capturing America's Healthcare Story*. The quality and integrity of patient records, no matter where or how they are generated, is the paramount concern. Our purpose is to protect patients, and we do that through setting standards of education and practice in healthcare documentation. This can be accomplished by monitoring those standards through our education approval process, code of ethics, certification/credentialing, and quality assurance programs that "ensure the highest quality, accuracy, privacy and security of US healthcare documents, regardless of where they are transcribed." We advocate for accurate and secure US healthcare documentation as essential to ensuring the security of PHI and quality patient care.

Back in 2006, I co-chaired the AAMT Name Change Task Force. The two primary controversies that surrounded the name change – ie, taking "American" out of our name and adding "Integrity" to its construction, are brought up in conversation to this day. Changing our name to the Association for Healthcare Documentation Integrity and taking out "American" became a very personal and hurtful issue for many MTs. Many have cited the name change as the reason they are no longer members of our association, vehemently believing that this association does not represent them anymore and that AHDI does not care about the American MT – that action somehow supported the myth that all AHDI cares about is corporations doing business overseas.

But our name change was not about changing our *identity;* it was about changing our *visibility.* It was about bringing more stakeholders in health information capture and management to the table so that we could advocate for our workforce in those discussions. When we talk to healthcare policymakers, legislators, and thought leaders in the HIM and Health IT arenas, we continue to hear overwhelming support of our name change – that our new name moved the focus from *who we are* to *why we matter.* When it comes to telling our story and explaining our contributory value to those stakeholders, they are less compelled by how we choose to define

ourselves and more interested in why what we do is important to the US healthcare system. They don't care if we call ourselves medical transcriptionists, healthcare documentation specialists, or medical language specialists. In years past, when we would say "medical transcription," we'd get a blank look from most policymakers we would speak with. When we started talking about documentation integrity, their response became, "Oh, you're about quality and patient safety, right?" Suddenly, people were focusing on why we were important instead of trying to figure out who we were. Becoming visible around documentation integrity has been very valuable as we strive to publicize the integral nature of the skill sets of our workforce around patient safety, risk management, and reimbursement issues. AHDI has continued to shape itself around the concept that the very best way we can *care about our MTs* is to advocate on behalf of those MTs at every policy table, in every legislative appointment, and through every alliance we build with other healthcare organizations.

As for taking American out of our name, some of that decision was purely practical. Expanding our name to include the phrase "healthcare documentation integrity" was already going to be a mouthful, and keeping "American Association" in that mix would only make our name and our acronym unwieldy. We were also willing to forego that reference in our name because we had to come to terms with the fact that transcription of US health records was being performed globally. If we are truly *the* association providing watchful guardianship over and setting standards for how US health records are transcribed, we had to acknowledge that we were now setting standards for *all* MTs who have access to those records, not just domestic MTs. On some level, it came down to whether it was our mission to protect US MTs or protect US patients, and the only ethical and responsible choice was to protect US patients. AHDI does not promote or support offshore transcription. But we are committed to making sure that anyone who has a hand in a US health record is properly trained, credentialed, and held to the same standards of practice.

What does AHDI do to specifically support the American transcription workforce? We have very active advocacy efforts going on in Washington, DC, with our lobbying firm, Dewey Square Group, and our AHDI legislative leader program. We support allocation of funds for workforce and technology development in the US, incentives for US companies to create internship/externship programs and on-the-job training for new graduates as well as cross-training, re-tooling, and preparing the existing workforce to transition into evolving healthcare documentation roles. We advocate for a fully credentialed workforce for any professional who has a touch-point within the patient record, at home and abroad.

As much as we want to target overseas and offshore transcription for all that ails us, we would be better served to shift our eyes from the flea to the elephant. The EHR business model that continues to convince our provider facilities and clients that it will eliminate transcription is our make-or-break challenge. The conundrum of where our sector will land in the future of health information documentation within an EHR world is still very real, and my hope today is that by dispelling some of the international transcription misperceptions we (our industry and our association) can concentrate on the EHR problem with a higher degree of intensity and

exposure than we have ever had, since, for me, that is the most compelling elephant in the room.

Offshore/overseas transcription is a very complex subject with a lot of history behind it, and mine is only one story. I'd like to hear your views, so let's talk about it.

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AHDI Director 2009-2012