National Media

To Whom It May Concern:

I am the Founder/CEO of Transcription Plus, LLC in Bristol, CT. (www.transcriptionplus.net). *[also see **LINKs #1, #2, #3 below]* **Please let me state up front, my commentary below is NOT intended as a negative assault on the medical community but rather an informative wake-up call to medical professionals and the common doctor-going person (pretty much everyone!).**

THE POINT: THE DECLINE IN ACCURACY OF HEALTH RECORDS

I feel that the subject of the Federal Government-mandated switch to Electronic Health Records for all hospitals, private practices and State-run facilities [http://www.medicalrecords.com/physicians/will-i-be-assessed-penalties-for-not-utilizing-emrehr-by-2015] is EXTREMELY important knowledge to have. It is imperative for not only the health care professional to understand all the complications, road-blocks, costs, misconceptions and fears associated with this mandate, but also for State Vendor Procurement staff, as well as each and every private individual whose lifetime healthcare record and present/future medical treatment plan will be affected and to realize there are OPTIONS *[*#13, #14]* readily accessible..

I am not alone in my concern. Please reference the report published by the NATIONAL ASSOCIATION for HEALTHCARE INGETRITY [http://www.ahdionline.org/Portals/0/downloads/White_Paper-Medical_Transcription-Proven_Accelerator_of_EHR_Adoption.pdf]

VERY little perceptive public education on this subject is available on the 'surface' for the general population to "easily" digest and most are ignoring it because they do not understand what is transpiring behind the scenes and how it will ultimately affect them. However, the substructure of the State and Country-wide Health Care Industry "noise" presents an entire industry in discord and anxiety.

Simply stated, [or not!]
**Whether one believes that the Electronic Health Record (E.H.R.) offers positive progress in overall health care [I do believe this is a good tool]…

**Whether one believes that the government has the right to dictate mandatory implementation – initially costing upwards of $75,000+ in addition to monthly/yearly maintenance upkeep for a solo medical practice, with government retribution of withholding large sums of Medicare/Medicaid reimbursements if a medical facility is not in compliance [many medical professionals feel this is a difficult 'pill' to swallow'—especially in this economy]…

**Whether doctors are embracing the task of having to learn to be clerical workers, wasting their time typing, editing speech-recognized "word salads" for detailed accuracy, having to refer to "HELP" before hitting any computer button for fear that the information will be interpreted incorrectly *[#6, #9, #11, #12]*, losing many tens of thousands of dollars each year spending their time on documentation tasks rather than healing patients. I.E.: SPENDING AN INORDINATE NUMBER OF DOCTOR-HOURS DOING CLERICAL WORK;

SIGNIFICANTLY DECREASING PRODUCTIVITY OF ACTUAL DOCTOR FUNCTIONS WITHIN THE PATIENT CARE RHEALM…

**Whether you and I are concerned that many of these doctors admittedly are NOT taking all that time to scrutinize your medical record for precision, which can and will affect your health and life. [Obviously you will never get any of them to admit this to the public but all you need to do is read a few electronically-generated reports…all you need to do is to get a pharmacist to tell you the problems they encounter with prescription medications that are "electronically incorrect" sent from the doctor's offices. This is something that gives me great concern.] *[#9, #10]…*

**Whether the doctors and E.H.R. systems procurement staff believe the rhetoric being sold to them from the E.H.R. companies that "it's easy", "you can do it yourself without the overhead of your clerical staff", "our system that your are spending BIG on will definitely integrate with all others [most have no clue how to integrate nation-wide] and you will never have to revisit this expenditure…..not all the truth…
**Whether you realize how much time, effort and money has been wasted on promises from E.H.R. companies that don't meet current or future expectations *[#7]*…

**Whether you question..HOW MUCH OF THIS COST IS ABSORBED BY YOU AND ME? [ALL OF IT….whether it be through our taxes [$20 billion has been set aside by the Federal Government to pay incentives to healthcare facilities for implementation], co-pays, health insurance costs or final balances that are not covered by insurance]…

It is the job of the media to provide FAMILIARTIY AND AWARENESS regarding
THE POINT: THE DECLINE IN ACCURACY OF HEALTH RECORDS

Not only are many private doctors and medical facilities scrambling to purchase systems, many, if not all, States are currently preparing requests for bids for E.H.R. systems for the State-run facilities. There are over 1000 certified E.H.R. vendors in this country; I'm sure many of them are reputable and are on the right track. HOWEVER, the majority of them are simply not presenting all the facts and all the OPTIONS to the end consumer (the medical field), which ultimately affects every person that will ever be treated by a doctor. The consumer is being told about all the clerical costs they will save….they are NOT being told about the extensive aggregate dollar-per-hour of doctor time they will spend; [a doctor can spend upwards of $50,000 to 100,000/year of their time on clerical concerns; this "savings" certainly does not equate to what they pay their clerical staff.]… They are NOT being told about the unprofessional and error-laden records that will be representing them, harming their patients and possibly putting them in legal hot water; they are not taking into consideration the legal ramifications down the road; they are not contemplating the well-being of their patient's. I have been told a number of times from physicians, "We were absolutely not aware of the OPTIONS of being able to continue to document the way we are used to within the E.H.R. system; of not knowing that our speech-recognized digital voice could be accessed by a professional clerical worker and edited for accuracy. We kept being told "We can do it ourselves!" Had we been aware, there would have been much less frustration, negativism and fear on our parts much less of our time wasted."

Many doctors that work in a multi-doctor facility have been given no choice but to conform to the system that has been placed in front of them. They loathe it…they spend an inordinate amount of time learning, then documenting…they work until all hours of the night at home…documenting….sacrificing what precious little family time they have. **And when they decide to stop all of that 'extra' effort, THAT IS WHEN THE ACCURACY OF OUR HEALTH RECORDS ARE COMPROMISED.** Many others are being dragged kicking and screaming to this E.H.R. mandate because they have heard such horror stories from their contemporaries.

If they were educated regarding the OPTIONS *[#13]* available AND THE IMPORTANCE OF THE OPTIONS – ACCURACY -- to meld the whole system into a smooth and accurate machine, everyone concerned would be in a better place.

Yes, I own a transcription company (23 years!!) and, yes, we are losing a portion of our medical nitch because doctors are spending their high-priced time being clerical workers. **BUT the fact that I DO own a transcription company is the exact reason that I can see the good and the bad of what is transpiring.** I can guarantee that I would not do a satisfactory job of fixing your broken leg; I can also guarantee that the accuracy of YOUR health records are being greatly compromised by extremely busy (understandably so!) and un-trained doctors moonlighting as clerical workers.

It is projected that there are approximately 110,000 medical transcriptionists in the United States. Contrary to the projections listed in Bureau of Labor Statistics Handbook 2010-2011 Edition [http://www.bls.gov/oco/ocos271.htm], the "insiders" of this industry are experiencing a factual rapid, startling decline in the use of their expertise; brought about by the belief that doctors can do it all on their own and can save the costs. Tens of thousands of jobs are being terminated (so much for putting middle-class America back to work); hundreds of thousands of errors are occurring in your health records.

Prior to the implementation of E.H.R., it was estimated that upwards of 200,000 deaths were caused each year due to medical errors [http://www.transcriptionplus.net/newsletters/2011_03AbsolutelyAccurate.html]. If that's not bad enough, that figure is about to become much, much higher directly related to this factual disregard for documentation accuracy. Recent Studies have proven that at least one MAJOR error was discovered in almost a quarter of the speech recognition reports (23%), while only 4% of reports generated by conventional dictation transcription contained errors. Errors included a missing or prepended "no", missing words, incorrect measurement units (metric, therefore off by a factor of 10!), and nonsense phrases. The research should not be surprising: transcribers (being trained, experienced and paid for transcribing) are better typists than doctors. http://www.diagnosticimaging.com/radblog/display/article/113619/1997757 According to another study, radiologists can expect 8 times as many errors in dictated breast imaging reports generated with automated speech recognition software as with conventional transcription. [Putting my expertise aside, I don't want one of those reports to be my personal health report.]

The SIMPLE solution for every single situation concerned is to give the doctors OPTIONS *[#13].* OPTIONS to continue to work the way they always have, by dictating their patient findings into digital audio output and letting the DOCUMENTATION PROFESSIONALS (medical transcriptionists/editors) ACCURATELY input them into the E.H.R. (Our company, and hundreds of others, have the training to easily remotely access any E.H.R. system at any facility.) OPTIONS of utilizing the front-end speech recognition capabilities of the E.H.R. systems but instead of wasting countless hours/dollars with physician proofreading/editing, utilize the DOCUMENTATION PROFESSIONALS (medical transcriptionists) to proofread/edit for ACCURACY (this is substantially less costly than full transcription).

POINT: THERE IS ABSOLUTELY NO REASON FOR THE DECLINE IN ACCURACY OF HEALTH RECORDS

The bottom line is that the mandated Electronic Health Record IS definite and far-reaching; it IS going to be a requirement (and once it all fits together as intended, the end result of accessible Electric Health Records will benefit all.) The key is that the Electric Health Records need to be ACCURATE. Not only is this important from a treatment outcome perspective, there is no compromise legally: "Accurate patient records are a fundamental building block of defending an alleged case of medical malpractice. If those records are lost, incomplete, inaccurate, or not accessible the job of your defense counsel just got more difficult."

Again, this is not to be taken as "'Whistle Blowing". I just sincerely feel that this subject is EXTREMELY news-worthy and of great importance for all to know.

I would welcome the opportunity to speak with you further on avenues to advance public knowledge on this essential topic.

Sincerely,

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Please visit our website: www.transcriptionplus.net


**LINK #1: What is medical transcription: http://en.wikipedia.org/wiki/Medical_transcription
**LINK #2: My published article…what to look for in a medical transcriptionist http://jucm.com/read/casereport.php?casereport=28
**LINK #3: Difference between transcriptionist and editor http://www.mygeartools.com/articles/mt-vs-dictation-editor-whats-the-difference/
**LINK #4: Government incentives: The tax dollars of the middle and lower class – to fund and reward medical facilities for implementing E.H.R. https://www.cms.gov/EHRIncentivePrograms/
**LINK #5 E.H.R. may not cut health care costs http://www.mygeartools.com/articles/digital-records-may-not-cut-health-costs-study-cautions/
**LINK #6: EHR Issues in Recording and Documenting Clinical Data http://www.hitechanswers.net/ehr-documenting-clinical-data/
**LINK #7: Practices Are Vulnerable to Failing EHRs http://www.hitechanswers.net/practices-are-vulnerable-to-failing-ehrs/
**LINK #8: Penny-wise, pound-foolish ERRORS!!!! Deaths due to medical errors http://www.transcriptionplus.net/newsletters/2011_03AbsolutelyAccurate.html
**LINK #9: 23% errors!! http://www.diagnosticimaging.com/radblog/display/article/113619/1997757
**LINK #10: http://www.medscape.com/viewarticle/750691
**LINK #11: Is speech recognition all that quick and accurate? http://www.youtube.com/watch?v=cvSrSpjWbpA&feature=results_main&playnext=1&list=PL7CE6A86E790EE33D
**LINK #12: FUNNY MISTAKES…NOT SO FUNNY IF IT AFFECTED YOUR MEDICAL TREATMENT AND/OR LIFE http://www.writeworks.biz/blog/voxrec/
**LINK #13: The OPTIONS http://www.transcriptionplus.net/newsletters/2012_01AbsolutelyAccurate.html
**LINK #14: National ASSOCIATION for HEALTHCARE INGETRITY viewpoint: http://www.ahdionline.org/Portals/0/downloads/White_Paper-Medical_Transcription-Proven_Accelerator_of_EHR_Adoption.pdf