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Beware of transcription vendors playing with word counts, accuracy

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Do you want it good, do you want it fast, or do you want it cheap? (Pick two.) Such is the mantra of essentially all service relationships.

Unfortunately in medical transcription, the second most common mantra seems to be 'figures don't lie, but liars can figure.' As soon as everyone agrees on how to measure performance objectives, someone finds a new way to cheat the system.

Document quality: Looking past all the studies that show front-end speech recognition workflow schemes pass along four times more errors than traditional transcription (0.33 to 1.33 errors per report), and point and click systems with physician self-type workflows are considerably worse (7.8 errors per chart), how quality is measured has once again become an issue of ambiguity.

A joint AHIMA, AHDI and MTIA effort defined 'Healthcare Documentation Quality Assurance and Management Best Practices' to provide a straightforward document quality scoring system that assigns point values to different types of errors.

For example, punctuation or spelling errors have a point value of one, while care impacting issues such as misused medical terms or demographic errors have a point value of three.

These scoring standards apply equally, regardless of the document creation method being used (i.e., traditional transcription, front-/back-end speech recognition, physician self-type, etc.)

Most transcription service contracts include a requirement to maintain a minimum 98 percent accuracy. Unfortunately, even expressing the expected performance as 98 percent starts you down the wrong path, as the standard calls for a "score" of 98, not an accuracy "percentage" of 98 and there's a huge difference between the two. That difference is what some vendors are now exploiting.

It's easy to configure speech recognition software to count the number of words in a document that are changed during the initial editing phase. That does not mean the speech recognition draft was accurate or the number of words changed resulted in a true quality document, yet that number of edited or changed words is easy to define and that's how some vendors now measure document quality.

The average acute-care report includes 300 to 350 words. If you only count changes, you can make six or seven corrections and still meet the 98 percent accuracy target. Clearly any document with half a dozen errors is of unacceptable quality, yet that is how some vendors now calculate their quality results.

If your vendor provides you with a slick looking spreadsheet-type "quality report" showing strong numerical scores – with no details – that seems too good to be true given what you see in the delivered reports, you need to call them on it.

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True audits include descriptions of the errors types and the corrective actions taken with staff. Those other scores are an incomplete quality assessment of their speech recognition engine, not a true quality assessment of the completed reports.

Service cost: Pricing seems to always be the most manipulated variable of all. Long ago, you expected to pay by the hour, then by the page, then by the line. Now, you are encouraged to pay by the visual black character (VBC). Each step to a smaller, more precise unit of measure was expected to bring an end to the rampant volume calculating games that have always given the industry a black eye.

In transcription's volume-based pricing market, the 65-character line or VBC rate effectively determines a vendor's life or death. Consequently, those who artificially inflate volumes to offer lower rates while still charging more per document prosper while many who stayed honest are now out of business.

The move to the VBC standard was, in large part, motivated by creative vendors who included credit in their contracts for "all characters that contribute to the final look of the document," which seems straightforward enough.

Unfortunately, this has allowed them to count the electronic data that defined which font to be used, where margins were set, and other document formatting issues that indeed "contributed to the final look of the document" but truly just inflated the expected volumes per report.

Whether selling technology only agreements for in-house staff or full service contracts with separated technology components, some vendors now include an "industry standard" volume to be credited per document for headers and footers. Lately, I've seen multiple contracts that refer to the "industry standard 15 lines of credit" per document for such content, only no such "standard" has ever existed.

The impact of this particular shell game is significant. The average acute care document includes 50 to 55 lines, so crediting an extra 15 lines for headers and footers effectively inflates the document volume by 27 percent to 30 percent. Radiology reports average only 10 lines per document. All of a sudden, that tech savvy vendor's 10 percent to 15 percent lower line rate is not such a good deal, is it?

Conclusion: It's important to remember the lessons learned during the rush of EHR implementations. Separating IT and HIM causes more organizational pain than it ever solves. It's time for HIM to take the lead, data analytics in hand, and do some house cleaning. If your vendor does not follow the AHIMA guidelines for clinical documentation quality management and best practices, or is charging for header and footer "industry standard" volumes, it's time you say game over.

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