Dictation and EMR's: A Winning Combination

Electronic medical records (EMR's) aim to improve patient care and reduce costs while complying with Meaningful Use guidelines. However, most EMR's require doctors to enter patient data directly into the computer system, causing a drop in the physician's productivity and, consequently, facility revenues.

Medical facilities want to make the best operational choices for their physicians, patients and bottom line. Therefore, let's compare the options for populating an EMR.

Studies show that it takes a physician an average of 4.5 minutes per patient to document a visit using canned, point and click, text/templates in an EMR system. By contrast, dictation takes only 1.5 minutes per patient. The result? Doctors will either see fewer patients or they will work longer hours. All this results in thousands of dollars in lost revenue. If you consider the calculated hourly wage for physicians and their medical assistants, point and click options are significantly higher than that of a dictation/transcription. In addition, doesn't high quality patient care mean focusing on patients instead of computer screens? Of course it does.

The first consideration is Speech Recognition:
Speech recognition programs such as "Naturally Speaking by Dragon" while this sounds nice; speaking into a microphone and having the computer understand everything that you as a dictator says, the final product is less than desirable.

The cons are cost of using speech recognition software and also in maintenance contract that goes with purchasing the software, as well as the actual time spent dictating within the parameters of the program. The time the physician uses to dictate and edit the document is calculated at his own billing rate ($300+ an hour instead of a transcriptionist pay rate $15 an hour).

This is a frustrating experience and takes a long time to do. The final product does not meet HL7 Meaningful Use criteria.

You still need to hire a proofer or editor to review the document for errors. This expense is incurred by the physician on top of his hourly calculated rate.

Our next consideration is Point-and-Click Notebooks or I-Pads:
It sounds technical enough to get you excited if you are a tech person, and in the end, you get a medical record that meets HL7 Meaningful Use criteria.

The cons tend to outweigh the pros on this one. You must purchase the hardware and software to run it—this is often rather expensive. You must take the time to work through the menus to find the memorized or canned text you are looking for.

That time must be viewed as physician billing time ($300+ an hour, compared to the cost of paying a transcriptionist to do this type of work, $15 an hour).

There is a loss of eye contact with the patient and a concomitant loss of halo data as well as a failure in

identifying and bonding with the patient.

The final product is a stylized and generic document that misses subtle details of the patient's actual condition. Its ultimate value is thereby limited.

Lastly let us take a look at:

CDA (Clinical Data Architecture) insertion directly to EMR:
You dictate, as normal, and we put it into your EMR just as if you typed it there yourself.

You need no special software or hardware to dictate—outside of a good recorder. Your time investment is limited to the time needed to do the dictation. The cost is limited to the cost of the transcription and is not associated with the cost of consuming the physician's time to create the document.

If desired, residual data is included in the medical record by the physician, i.e. work, family, finances, stress, etc. The ultimate document is of the highest quality, exactly what the physician wanted in the record. The final product fully meets HL7 Meaningful Use criteria.

 The CDA insert by DTI is *free* to the physician.

If necessary you may view all your transcriptions on your smart phone 24/365.

The cons to this are quite limited. You must pay the cost of the transcription to create the document.

More importantly is the ratio of errors for each of the above outlined products.

The chart below shows the differences in errors.

Average Errors Per System:
Speech Recognition: 1.48 errors per report.

Point and Click: 7.8 errors per report.

Traditional Dictation / Transcription: .33 errors per report.