Consider using electronic charts instead of dictation

Save more than $400,000 in transcription costs

Switching to an all-electronic system in the ED for charting and other functions is only a dream for some cash-strapped facilities, but an Ohio hospital is showing that the high initial cost can be recouped quickly through the money saved on transcription and other services. The hospital is saving more than $400,000 a year in transcription costs alone.

Mount Carmel St. Ann’s, a community hospital in Westerville, OH, adopted an electronic system July 10, 2001, for physician and nurse documentation, triage, interfaces, and an ED tracking board.

With more than 65,000 annual patient visits for the 40-bed ED, hospital leaders hoped the updated systems would increase efficiency and improve the quality of patient charts, says Sonja Howard, RN, DSN, system administrator for the ED computer information system and clinical educator for the ED.

Hospital leaders anticipated the system eventually would pay for itself though improved efficiency, but Howard says they were surprised at how quickly they recouped the investment.

Mount Carmel St. Ann’s uses a comprehensive electronic ED system manufactured by A² Health Systems in Cary, NC. Many other manufacturers offer similar systems promising the same results. A spokeswoman for A² tells ED Management that the hospital spent about $1 million for the entire system.

That cost is being recouped in about two years almost entirely through the savings in transcription costs, Howard says.

“We were 100% transcription in the past, and we set a goal with the new system that wanted charts to be 80% on the new system and 20% transcription,” she says.

“From the beginning, we were at 92% usage of the system, and we’ve never been below that. It’s worked much better than we thought it would.”

All of Mount Carmel St. Ann’s emergency physicians and about 50 nurses are documenting patient information with the new electronic system. A 92% reduction in dictated charts means the ED no longer has to pay for transcribing about 58,500 charts per year.

At an average cost of $7 per transcription, the ED is saving about $409,500 per year. Two years of those savings almost covered the large start-up costs for the whole system, Howard says.
More savings with less use of paper forms

And those weren’t the only savings. Switching to an electronic system helped Mount Carmel St. Ann’s eliminate much of the paperwork that is standard in an ED, so there was the added savings of not having to buy the forms.

In the year before adopting the electronic format, Mount Carmel St. Ann’s spent $41,200 on forms for the ED. The electronic system cut the need for those forms in half, saving $20,600 each year.

Processing written charts cost an estimated $16,000 per year in staff time, which is eliminated with the new electronic system. That amount went straight to the bottom line. So adding the savings from transcription costs, forms, and processing charts yielded a total savings in the first year of $446,100.

Two years after implementing the system, Mount Carmel St. Ann’s had recovered $892,200 of its $1 million investment.

But if you add in other savings for the hospital, the break even point was passed even earlier. Improved charting and documentation led to an increase in gross charge capture per day of about $10,000, yielding a gross increase per year of $360,000.

With a contractual allowance of 50% and a collection rate of 60%, the facility improved charge capture by $1,080,000 in the first year. Better documentation also helped physicians increase their net collections per patient by an average of $20, yielding $1.2 million more reimbursement for ED physicians in the first year.

Howard says the switch to an electronic system was so successful partly because Mount Carmel St. Ann’s adopted the entire system at once instead of phasing in the different parts.

After a 10-month installation and training process, more than 140 clinical and nonclinical users in the ED started using the entire electronic system one morning. One day the ED functioned on paper, and the next it was entirely electronic.

“That was painful, but it’s the way you need to go to be successful,” Howard says. People often want to phase in different portions to make it easier, but you get “stuck” when you do that, she says.

“No matter what you do, there will be difficulties, and that implementation over time gives naysayers the chance to say, ‘I don’t want to do this. It’s not working,’” she says.

Howard also attributes much of the success to the time spent customizing the different screens used for information input. Some physicians were reluctant to adopt the system at first and cited justifiable concerns that the input screens might restrict the type of data they could put on patient charts and water down the quality of the information.

The biggest hurdle was the history of present illness (HPI). Physicians were concerned that telling the patient’s story can be difficult on a screen where you select from a list of options, Howard says.

“But we worked with that concern and built lists that would meet the needs for the top chief complaints like chest pain and abdominal pain,” she says.
They customized those enough that the doctors became comfortable using the lists” Howard says.

“If you look at dictated notes, they pretty much say the same thing over and over again,” she says. “They may say it a little differently each time, but they follow a pattern, and you can build that pattern into the system.”

**Supportive physician can smooth transition**

Enlist a physician to champion the adoption of such an electronic system, Howard advises. It is normal for physicians to be skeptical of a system in which they won’t dictate notes in the style they’re used to, she says. A physician champion can be the one who takes the heat from colleagues who aren’t as enthusiastic and helps bring them around.

Nurses use the electronic system for triage, and then a physician reviews that information and can agree or amend it. Then the physician uses another screen to enter the HPI, with the system prompting the physician with common questions about the patient’s chief complaint.

The next step for the physician is to go to the review of systems, which can be minimal or extensive depending on the severity of the patient’s condition. The system also includes screens for documenting the physician’s examination of the patient.

They go through each one of those to build their documentation. “In the old world, they would have dictated all of that,” Howard says.

They still have the option of dictating if they think they can’t tell the story adequately with the system. “Physicians will still dictate notes for some psychiatric cases and others where they can’t get everything they want in the system,” she adds.

**Sources**

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