



OPUS COMMUNICATIONS  
A Division of *hcPro*

# Finder's Keepers: Recruiting & Retaining Coders & Transcriptionists

Dear HIM professional:

It's no secret that there aren't enough coders and transcriptionists to satisfy the demand. Nonetheless, you're expected to maintain—and even increase—production without compromising quality.

We have assembled this special report to help you accomplish your coding and transcription goals with a limited staff. The articles that follow were taken from the pages of **Medical Records Briefing**. They report success stories and effective strategies from the front lines. It's our hope that by learning from the success and failures of your peers, you won't be forced to reinvent the proverbial wheel.

If you've found an innovative way for your coders or transcriptionists to do more with less, I'd love to hear it. Drop me a line a [kraines@hcpro.com](mailto:kraines@hcpro.com).

Sincerely,



Kim Raines  
Managing Editor

## TABLE OF CONTENTS

Don't fill HIM vacancies with unqualified candidates . . . . .	3
Start tracking coder productivity, and watch it soar . . . . .	5
Hospitals cover all transcription bases with staff and services . . . . .	6
Find new coders within your facility . . . . .	8
Texas hospital uses residents to fill coder shortage . . . . .	9
Three benefits of using physician coders . . . . .	10
Recruit and retain quality coders by letting them set their own schedules . . . . .	12
Larger hospitals feel brunt of coder shortages . . . . .	13
Whose line is it anyway? . . . . .	14
Send your transcriptionists home: They'll be happier, and so will you . . . . .	15

02/02

SR702

This special report is published by Opus Communications, Inc., 200 Hoods Lane, Marblehead, MA 01945. • Copyright 2002 Opus Communications, Inc. All rights reserved. Printed in the USA. Except where specifically encouraged, no part of this publication may be reproduced, in any form or by any means, without prior written consent of Opus Communications or the Copyright Clearance Center at 978/750-8400. Please notify us immediately if you have received an unauthorized copy. • For editorial comments or questions, call 781/639-1872 or fax 781/639-2982. For renewal or subscription information, call customer service at 800/650-6787, fax 800/639-8511, or e-mail: [customerservice@hcpro.com](mailto:customerservice@hcpro.com) • Opinions expressed are not necessarily those of the editors. Mention of products and services does not constitute endorsement. Advice given is general, and readers should consult professional counsel for specific legal, ethical, or clinical questions. Opus Communications is not affiliated in any way with the Joint Commission on Accreditation of Healthcare Organizations.

# Don't fill HIM vacancies with unqualified candidates

Your coding department is short-handed. The available job has been posted internally and advertised in the local newspapers. Everyone—from your staff to administration and finance—is feeling the strain as the work and accounts receivable continue to back up. Do you yield to the pressure and hire a noncredentialed person to fill the job? Your colleagues in South Dakota hope your answer is a resounding “No!”

During a South Dakota Health Information Management Association's (SDHIMA) meeting, the marketing and recruitment committee discussed the challenges of recruiting for HIM positions, the need they see to raise administration and human resource (HR) awareness of HIM skills, and the importance of hiring qualified, credentialed persons to fill HIM positions.

**Dorine Bennett, MBA, RHIA**, is the chair of the marketing and recruitment committee. She is also the director of health information management (HIM) at Dakota State University in Madison, SD.

“From an educator's point of view, I've gotten calls for training and coding,” Bennett says. “There is a shortage of coders. Facilities need to get the money in, and they just want a coder. They're using people who are not credentialed and training them on the job.”

It gets discouraging for those who have spent two or four years in college getting a degree and credentials, only to compete in the job market against noncredentialed workers who are willing to take available jobs for less money, she adds.

## Holding out for credentials

It took Director of Medical Records **Carol Person, MS, RHIA**, four months to find the right person for a coding job at Sioux Valley Hospital and the University of South Dakota Medical Center in Sioux Falls, SD. She refused to hire a coder with no credentials.

As time passed and the position went unfilled, the accounts receivable backlog began to climb. When hospital administrators questioned why the job was

still open, she stood her ground, adamant to hold out for a qualified applicant.

She rallied the 80 employees on her staff, and they stood by her decision to wait and hire a qualified candidate. “They knew what I was doing and why I was doing it,” she says. “They all pitched in. I told them I believed we needed someone with credentials and they agreed. Together, we did it.”

Eventually the salary range was reviewed, Person says. The HR department and administration began to look at increasing salaries and offer retention and hiring bonuses—which they do when there is a shortage of other professionals. “I believe that everyone in the organization came to a greater recognition of what the coding staff is to the organization,” she says.

When it comes to reviewing applications for open positions, Person will consider a candidate with the CCS credential (certified coding specialist), because of what she calls the “tremendous experience” needed to pass the exam. But her preference is to hire a candidate with the RHIA or RHIT credential.

“Those credentials say to me, ‘I not only understand coding and disease process but health information practices as well. I have a much broader background, so when I apply these codes I have a better understanding of what I'm doing and why, and the quality of what I do will be much better,’ ” she says.

## Supply and demand

Person set out to determine why she was having trouble attracting qualified, credentialed people for the job. She wondered why there aren't more people choosing the coding profession. To Person, this trend looked like it was driven by money. It's less expensive to hire a noncredentialed candidate and train that person in-house than it is to hire someone with the college degree.

“The problem is that people are *continued on p. 4*

accepting substitutes, and training them on-the-job, or taking somebody with similar qualifications and working with them to make them what [they] want them to be.

“Salaries are not going to rise unless we as HIM professionals promote our own profession and say that we don’t believe in substitutes,” Person adds. “Only with a shortage will salaries rise.

“As HIM professionals, we need to promote our profession and work with human resources to say that in this role, ‘I will not accept anything but a credentialed individual,’ ” Person says. “Let that opening stay there and have discussions about what are we going to do in the interim until someone can be found. Does that mean outsourcing? What is the cost? You begin to explore the alternatives when you say you won’t accept a substitute.

“We need to band together as professionals and stand up for what the profession is. It will bring more value to the credential itself, and people will recognize the credential as important.”

### **Education across the board**

The SDHIMA’s marketing and recruitment committee discussed the fact that job placement companies consider HIM candidates clerical workers instead of placing them in professional categories, as they should be. That shows a need to educate the career placement community about the skills required in the HIM field.

It is often the HIM practitioners themselves who hurt the profession by hiring less qualified employees to “get the job done,” thus “devaluing” the professional credentials and skills.

“When there’s a nursing shortage, you don’t grab a nursing aide to do nursing duties,” Bennett says.

Bennett offers a few words of advice. “Rally together. Hang in there,” she says. “Stick to your guns and raise the salary to make [the job] more attractive. Make your administration see that it can’t be just anybody. They may have to pay more to get skilled qualified, trained people in. It won’t help in the short-term. It’s a long-term solution.” -🌟-

### **Tip: Improve turnaround time by offering incentive pay to coders**

Wondering how to attract new coders or keep the ones you do have from taking off for another position? At Children’s Medical Center, in Dallas, incentive bonuses for productivity are a good idea for the hospital and the coders, says **Pam Marshall, RHIA**, health information management director. The facility benefits from the quick turnaround, and the coders average \$300 to \$1500 per month in extra salary. But Marshall says the facility is careful about placing quality of coding above all other priorities, including speed.

“The quality of coding is very important,” say

Marshall. “We have a coding compliance plan that includes quality monitors and tracking. The results of the daily quality checks are aggregated and reported to the hospital quality improvement committee quarterly.”

“If a coder’s performance is substandard, the incentive is revoked until consistent performance has been proven,” she adds. The incentives are not available until the coders have completed a 90-day probation period and have exceeded standards in performance—both quality and quantity, adds Marshall. -🌟-

# Start tracking coder productivity, and watch it soar

The more productive your coders, the fewer you need. And right now, the fewer coders you need the better, because they're hard to come by.

One of the best ways to increase coder productivity is simply to find out how productive they are right now and start keeping track of their progress, says **Darice Grzybowski, MA, RHIA**, national manager of health information management (HIM) industry relations for 3M HIS. "When HIM directors started tracking transcription, all of a sudden productivity went up 20%," says Grzybowski.

Coder productivity can be more difficult to calculate than transcription productivity because there are more variables to consider. For example, it should take a lot less time to code the chart of a healthy newborn than it would to code the chart of a patient with several diagnoses who has complicated surgery and a long recovery.

But don't get tricked into equating length of stay with complicated coding, Grzybowski warns.

"There's nothing that's ever been proven that just because the chart is thicker it takes longer to code."

For example, the chart of a patient who is admitted to the hospital on a ventilator and dies 60 days later is much easier to code than the record of a cardiac patient with several complications who dies after only three days.

That's why it's better to keep track of the severity of cases rather than length of stay and factor that into your productivity statistics. It will make them more legitimate. Coders won't be able to use the argument, "my patients are sicker," says Grzybowski.

Before implementing a productivity program, explain your intention to the coders and find out what they think is a reasonable standard, she says. "The worst thing a coding manager could do is set an arbitrary standard."

Ask how many records they think they can code per hour or per day. Instead of picking a single number as a minimum standard, set a range (such as 15–20 with 90%–95% accuracy) for a productivity target, suggests Grzybowski.

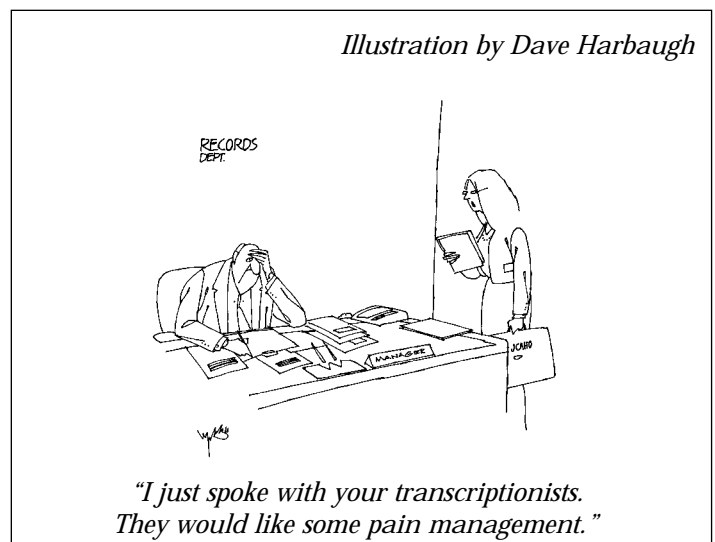
Some computer systems have the capability to do most of the hard work—the data collection—for you. Find out from your vendor whether your system has this reporting capability.

If not, start tracking manually, says Grzybowski. "Take little baby steps," she says. "Start at the beginning."

Ask coders to record how many charts they code each day. Take the number of charts per day per coder, and divide by the number of hours that coder worked. The work hours should be available in the personnel payroll system.

Get a handle on collecting these figures, then try to adjust for severity.

"[Tracking productivity] is something you have to be dedicated to doing," she says. "Just like everything else, it takes a lot more time if you don't have a computer and have to do it manually." 🏠



# Hospitals cover all transcription bases with staff and services

*Editor's note: Figures represent the responses of 639 hospitals in these bed-size categories:*

- 322 small hospitals (fewer than 150 beds)
- 185 medium hospitals (150–300 beds)
- 132 large hospitals (more than 300 beds)

For many hospitals, there's no right way to get transcription done, according to a July 2000 **Medical Records Briefing** benchmarking survey. Of the 639 hospitals in the survey, nearly 83% use facility employees for transcription, while 50.6% use transcription services, and 17.2% contract with individual transcriptionists. That can mean only one thing. Many of you have more than one solution to the ever-increasing transcription workload. (See Figure 1.)

"Certainly the volume of transcription is growing," says **Claudia Tessier, CMT, RHIA**, former executive director of the American Association for Medical Transcription. "My guess is what you're looking at is an attempt to both keep up with what they want very quick turnaround time on, as well as handle backlog. What we hear, but it's anecdotal, is that a lot of times services are used to catch up with backlog."

Large and medium-sized hospitals are much more likely to use transcription services than small hospitals. Only 34% of small hospitals use transcription services, compared to 67% of large and medium hospitals. Likewise, small hospitals are the most likely to keep transcription in-house, with 87.5% responding that they use facility employees, compared with 76.8% of medium-sized hospitals, and 80.3% of large hospitals.

Compared to a January 1998 survey, overall use of in-house employees is down, while contracts with transcription services are up. In 1998, 88% of responding hospitals used facility employees and only 41% contracted with transcription vendors.

## Rewards for productivity

Hourly is by far the most common way hospitals pay their transcriptionists (80.3%), but nearly four of

every 10 respondents are either augmenting an hourly salary with pay according to the amount of work produced or paying their employees based solely on the amount of work they produce.

More than a quarter of those surveyed said they give employees bonuses based on productivity, with far more large hospitals doing so (47.8%) than medium (35.7%) or small (11.6%) facilities. (See Figure 2.)

## Home sweet home

Larger hospitals seem to offer greater flexibility when it comes to allowing employees to work at home. That may be due to the fact that they are likely to have a larger work force, and can allow some employees to work at home, while still retaining a significant number of them at the facility, Tessier says.

Of all hospital sizes combined, slightly more than half keep all of their staff transcriptionists on-site, while 38.3% have some home-based and some on-site employees, and 11.4% employ only home-based transcriptionists. (See Figure 3.)

Although 61.8% of small hospitals employ only on-site employees, only 41.3% of medium-sized hospitals and 32.1% of large hospitals do.

## Is change good?

Although many survey participants indicated that they had not determined the most cost-effective or efficient way to handle transcription, only 15.9% said they had changed the way they handle transcription in the past year. Tessier says she hasn't found an overwhelming move toward one way of handling transcription.


"What we hear through inquiries here and discussions that we have with people at health care institutions—[medical transcription] supervisors, medical records people—is that if they outsource, they're thinking of bringing it in; if they've got it in-house,

they're thinking of outsourcing. So, when I'm asked [whether the trend is] to outsource or . . . to bring it in-house? I say, 'yes,' " she says.

Many seem to be settling on the middle ground of outsourcing some of the transcription, and keeping some staff on hand to handle the rest. That way they're not "fully dependent" on any one method.

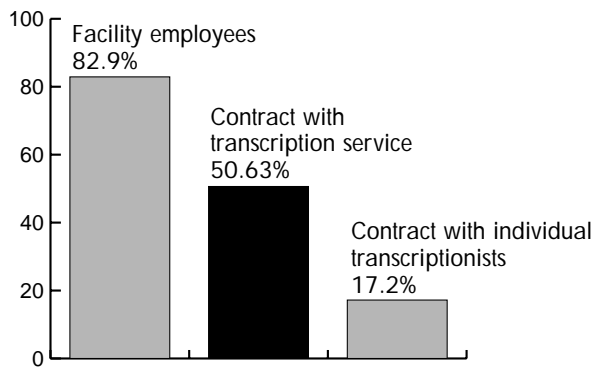
"I think that there's an increasing realization that

whether you do it on-site or off-site, you have to have control. You have to know what's going on. You have to be aware of the volume and the turn-around," Tessier says.

"I think there was a hope in the past that if it was outsourced, you could kind of forget about it. I think increasingly there is an awareness that you cannot escape monitoring and quality assurance and being on top of it." 

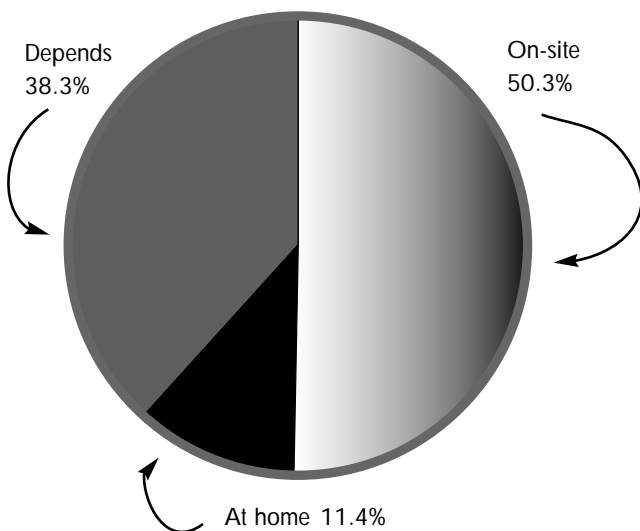
**Figure #1**

**How do you meet your transcription needs?**



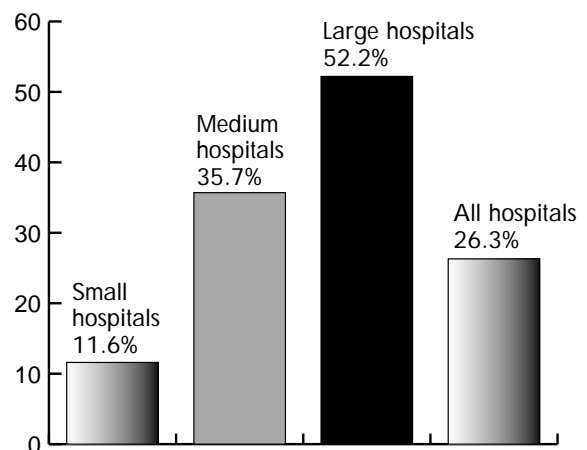
**Figure #3**

**Where do your staff transcriptionists work?**



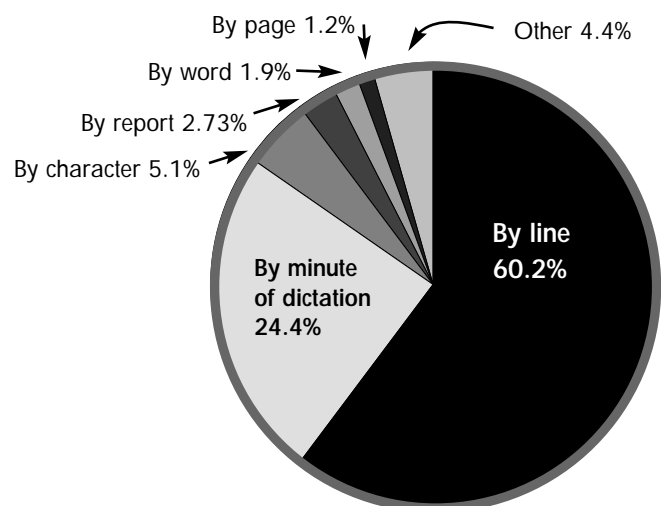
**Figure #2**

**Percentage of hospitals that give bonuses for productivity**



**Figure #4**

**How do you measure productivity?**



# Find new coders within your facility

Brigham and Women's Hospital in Boston had tried everything—higher salaries; referral, signing, and fiscal year-end bonuses; and opportunities to telecommute. But even with all those benefits, the hospital still averaged five vacancies for full-time coders on any given day.

“We were at our wit's end as far as what else we could do to recruit and retain quality coders,” says **Jackie Raymond, RHIA**, director of health information services at the hospital.

Despite offering higher pay than most, Brigham and Women's—situated in the heart of the city—had trouble competing with suburban community hospitals where traffic isn't awful, parking is free, and the cases are easier to code.

The hospital didn't have much luck with the traditional hiring methods, such as newspaper and Web site ads and listings in trade publications, says **Karen Grant, RHIA**, corporate director of health information services for Partners Health System, Inc., Brigham and Women's parent organization. And the few who did apply for coding jobs often couldn't pass the screening.

So instead of searching externally for seasoned coders, Grant and Raymond looked for ambitious employees who wanted to train for a new career. They teamed up with Northeastern University in Boston—a school known for its extensive co-op program—and created their own batch of new coders.

## Partners' approach

Admissions committees from each of Partners' hospital chose a total of 20 students and five alternates from the 70 applicants. The committee members evaluated the applicants' computer skills, read their essays about why they wanted to participate, and evaluated their school records, paying particular attention to how applicants fared in science courses.

Because it secured a \$208,000 grant from the De-

partment of Labor, Partners had to shell out little of its own money to establish this program and didn't charge the students for the training. Some of the money was used to hire a trainer to work with the students in the on-the-job training portion of the program. The rest was used to provide full scholarships and books to the chosen participants.

Northeastern brought its nine-month coding certificate program, which included a class in medical terminology, three anatomy and physiology classes, two pathophysiology classes, two ICD-9-CM coding classes, and one current procedural technology class, to the hospital so students didn't have to travel to the college. The Partners trainer developed five coding modules based on the types of cases its coders deal with most often.

In completing this practicum, the students served as interns in the health information management department. “The trainer made sure that as [the students] were going along, they got to actually code records,” under close supervision, explains Raymond.

Of the eight students selected from Brigham and Women's, four graduated and will be hired by the hospital. This will help to cut the amount the hospital spends on contract employees from \$600,000 to \$300,000 annually.

Several students dropped out or were unable to complete the program. Raymond attributes this to the enormous workload of the program plus the participants' full-time hospital jobs.

## Another approach

Baylor Health Care System had the same recruiting and retention problems as Partners, and found a similar solution, says **Donna Bowers, JD, RHIA**, vice president of Baylor University Medical Center in Dallas. But instead of partnering with an area college, the organization came up with its program.

The program's instructor is a long-time Baylor coder

who had expressed interest in becoming a trainer.

Baylor's six-month hospital-based program pays participants \$8 per hour for the 40 hours a week of classroom time.

"We looked for people who were outstanding, but couldn't go to school at night because they have families and couldn't go to school during the day because they needed the money," says Bowers.

The screening process at Baylor is similar to Partners'. Applicants must have a high school diploma and complete a written essay. "We find that we gain a lot of information from them on the essay question, 'Why do you want to be a coder?'" Bowers explains.


The admission committee chooses seven students after narrowing the candidates down to a small pool for panel interviews. With only internal advertising, Baylor received 55 applicants for the first program.

This past July, 90 people from five states applied, even though Baylor spent no money to recruit applicants from outside the organization. The new batch of seven students started the program on October 1.

The curriculum of Baylor's program is nearly identical to Partners'. The students are trained in anatomy and physiology, medical terminology, pathophysiology, ICD-9-CM coding, CPT coding, Centers for Medicare & Medicaid Services coding guidelines, and some pharmacology. Students must maintain a 75% or above in each class, or they are dismissed from the program and terminated from employment.

Of the seven students chosen for the first program, all graduated and were hired to work at one of Baylor's facilities. The graduates sign a work agreement when they enter the program committing to work for Baylor for a minimum of two years. However, if there are no coding positions available in the system, the graduates are free from their obligation.

"They can be placed in any of our Baylor facilities," says Bowers. "If they leave before two years, they have to pay us back \$7,500 for the classroom time."

The program cost Baylor \$450,000 in its first year. But once the vacancies are filled with program graduates, the health system stands to save more than \$2 million each year because of the reduction in contract costs, recruitment costs and accounts receivable, says Bowers. 

---

## Texas hospital uses residents to fill coder shortage

A new batch of coders is right under your nose. They already know medical terminology and disease processes inside and out. And with only 12 hours of training, they could start coding records for you.

Who are these saviors and where are they hiding? They're residents, and they're all over your hospital.

When the coder shortage started to hit home in Dallas, Baylor University Medical Center decided to recruit residents to earn extra cash coding records, says **Dana Choate, RHIA**, associate director of the health information management department.

"We found we were losing coders to contract agen-

cies that were offering better base salaries and a more flexible work environment," she says. "The number of coders available in the marketplace was impacted significantly by the [low] unemployment rate in the Dallas/Fort Worth area and the declining number of schools offering coding classes in their curriculum."

The interest from the medicine and surgical residents was overwhelming. More than 35 came forward in October 2000 when Baylor first launched the initiative. Choate selected 12 to participate by considering the candidates' year in the residency program and the time commitment they were able to make. "We required that they provide us 10 hours *continued on p. 10*

per week of coding support,” says Choate. “From the very beginning we required that they meet our coding quality and coding productivity standards. If they were unable to meet the time commitment and maintain the standards, they were dropped from the program.”

As time passed and the hospital’s need for extra coders diminished, Choate found she could be less stringent with the time commitment. “We afforded them some flexibility if they were experiencing a tough rotation in the month, such as emergency/

trauma care, where it would be difficult for them to fulfill their time commitment.”

**Training the docs**

The coding education instructor, who oversees Baylor’s in-house coder education program, and the coding coordinator provided 12 hours of paid training to the residents.

“This training primarily focused on maneuvering around our coding and abstracting system and understanding encoder logic,” says Choate. “We found that this was

**Three benefits of using physician coders**

As soon as Baylor University Medical Center started using residents to code records, it became clear it was the right choice, says **Dana Choate, RHIA**, associate director of the health information management department. Choate says the hospital recognized the following benefits immediately:

- **Decrease in accounts receivable.** Baylor’s backlog of records waiting for coding dropped dramatically when the residents started helping out.

Because the doctors only needed 12 hours of training and about one month of constant supervision, Baylor almost immediately recognized a return on investment. The hospital paid resident coders an hourly rate at the low end of the contract scale, so it saved money using them instead of agencies or contract employees.

- **Learning environment for coders and residents.** The coders took advantage of the residents’ extensive medical training by asking them questions when they were having trouble with a case.

Residents, on the other hand, learned the importance of appropriate documentation and shared

this with their peers.

Choate knew Baylor’s program was a success when a resident came into her office looking very concerned and told her, “I feel that I have been dictating my discharge summaries inappropriately all along.”

“This type of knowledge will now follow him into his medical career and into his private office practice,” she says.

Choate plans to have the resident coders provide case studies during rounds to highlight the importance of clear and appropriate documentation.

- **Improved reputation for the coding profession.** Having done the job themselves, doctors come to appreciate that coding is hard work.

“Some skeptics of this program spout that you are jeopardizing the coding field by allowing another professional the opportunity to provide these services,” says Choate. “However, I don’t see physicians giving up their medical profession to become coders. In addition, I feel that it almost takes a physician to be a medical coder. What better compliment to the coding profession can you give?”

a fairly easy task as many of the residents were computer-savvy.” The rest of the training focused on coding guidelines and *Coding Clinic*. Resident coders handle only inpatient charts, and are not permitted to code their own cases.

Once the residents started coding charts, supervisors reviewed 100% of their work until they met Baylor’s accuracy and productivity standards—95% accuracy and 3.3 inpatient charts per hour. The residents achieved these goals far more quickly than nonphysician coders. Coders usually take three months to meet the accuracy standard and one year to meet the productivity standards, Choate says. The residents met both standards in approximately one month.

### Paying the residents

Baylor treats its resident coders like contract employees and pays them an hourly wage.

“We evaluated what we were paying our freelance coders as well as the agency coders we were utilizing at the time,” says Choate. “We decided to offer them a rate at the low end of the community standard for agency contract rates.”

This compensation is substantially higher than the rate full-time Baylor coders receive. “We felt that we could do this, as the residents had a higher level of clinical experience and education,” she says. “Their knowledge of disease processes and medical terminology easily justified the difference in pay.” Despite the discrepancy in pay, Baylor’s coders welcomed

the residents’ help both with handling the coding department’s huge workload and answering questions about disease processes and physician documentation.

### Giving coders a break

“Many of them [had been] providing massive hours to keep the department afloat,” says Choate. “They were tired and reaching burnout stage. They understood the reasons we decided to go this route and were actually very supportive.”

The hospital avoided potential problems with the coders by being up-front about the plans and keeping the staff informed, she says.

The only major conflict arose when there wasn’t enough workspace to go around. Coders would often arrive to find a resident working at their station. “Coders are sometimes territorial when it comes to their work areas,” says Choate. “We had to ask the coders to allow for some flexibility and for them to post their work schedules on their desks to avoid confrontation and inconvenience.”

Now that Baylor’s in-house education program has trained enough new coders to fully staff the department, the hospital is using residents less often.

“However, we have an ample supply of coders in the event that we have to staff up for the holiday season or we need to float a coder to one of our Baylor affiliate hospitals,” says Choate. “They are willing to help out wherever needed. We just call them up and say, ‘Come on down.’” ☺

**Need more copies? That's easy**

If you'd like to order extra copies of this special report, please use the coupon below or call customer service at 800/650-6787. Extra copies are \$49 each.

<input type="checkbox"/> I'd like _____ copies. The price is \$49 each. <input type="checkbox"/> Payment enclosed. <input type="checkbox"/> Please bill me. <input type="checkbox"/> Please bill me using PO # _____ Charge <input type="checkbox"/> AmEx <input type="checkbox"/> MasterCard <input type="checkbox"/> VISA Signature _____ <small>(Required for authorization)</small> Card # _____ Expires _____ <small>(Your credit card bill will reflect a charge to "Opus Communications.")</small>	Name & Title _____ Organization _____ Address _____ City _____ State ____ ZIP _____ Phone ( ) _____ Fax ( ) _____ E-mail _____
--	---

Mail to:	Call:	Fax:	E-mail:
Opus Communications, a division of HCPro P.O. Box 1168, Marblehead, MA 01945	800/650-6787	800/639-8511	customerservice@hcpro.com
			www.hcmarketplace.com R0001

# Recruit and retain quality coders by letting them set their own schedules

For coders at Sacred Heart Medical Center in Spokane, WA, working from 9 to 5 is merely one option. Another option is working four 10-hour days each week. Still another choice is to start working early in the morning and leave at 2 or 3 in the afternoon.

In fact, as long as the coders each work 40 hours each week and coordinate their schedules with colleagues to be sure there is phone coverage during traditional working hours, **Jean Carman, RHIA, MBA, CPA**, technical services manager at the 640-bed hospital, doesn't care when they work.

For the past eight years, Carman has been allowing her coding employees to set their own schedules in an effort to keep her staff happy.

She says she decided to give this type of scheduling, known as "flextime," a try when her employees approached her with the idea.

"I wanted to make our hospital the most desirable place to work," says Carman. "I've retained people who I think would have left long ago just because they wanted a change, but have said to me, 'There's no way I'd leave now. I'd never find this flexibility anywhere else.'"

Several of her 16 coders prefer the traditional eight-hour day schedule, but three coders work four 10-hour days, and many others choose five-day weeks with varying hours.

"I've had different people take advantage of it over the years. Some folks have tried [the four-day schedule], and they've gone back to five," says Carman.

"Once they tried it they realized that they spent most of that extra day recovering, and so I have had some folks try it and say, 'It's not for me.'"

One of the coders who takes advantage of flextime

is a single mom, whose schedule changes from week to week depending on when her family members can watch her child.

"Some nights she might not work until 11 o'clock at night. Others, she might work at seven in the morning. So she just posts [her schedule] so that we know when to expect her," says Carman.

Carman says there have been only a few "bumps in the road," when she had to remind her staff that they need to keep her and each other abreast of their schedules, so that the office is not completely without coders on any given day.

"I've got a big enough staff it's not usually a problem, but I would not be happy if every single outpatient coder was gone on a certain day," Carman explains.

"So I just ask them that if they're going to work an unusual schedule that they let me know, so I don't call them at home to see [whether] they're okay, and to work amongst themselves just to make sure I have enough people here to answer the phones."

"The only downside is, it makes scheduling meetings a little bit difficult. It makes scheduling impromptu meetings very difficult," says Carman. "What I have done, though, is said that if I have scheduled a meeting ahead of time, I expect you to be here. And they've always accommodated that."

Because the coders' productivity is monitored by computer, Carman knows that the flextime has not slowed her department down. As for her other employees, Carman decides how much flexibility to allow them depending on the nature of their jobs.

"Some of the clerical staff, the only way I know they're working is that I can see them," says Carman. "So their flexibility is based on whether they're auto-monitored." 🏠

# Larger hospitals feel brunt of coder shortages

Figures represent the responses of 606 hospitals in these bed-size categories:

- 283 small hospitals (fewer than 150 beds)
- 188 medium hospitals (151–300 beds)
- 135 large hospitals (more than 300 beds)

*Editor's note: The findings of this article are based on a survey conducted in January 2001.*

The larger the hospital, the more likely it is to have a shortage of coders and have trouble recruiting new ones, according to a **Medical Records Briefings** survey of health information management (HIM) directors across the country.

Less than half of all large hospitals reported having a full staff of coders, compared with more than three-quarters of small hospitals. The majority reported that they would need only one or two additional coders for a full staff.

**Gloryanne Bryant, RHIT, CCS**, director coding/HIM compliance for Catholic Healthcare West in San Francisco says she's surprised that that many hospitals have full staffs.

"Everywhere I go, people are saying there's a real national shortage of qualified coding staff," Bryant says. The shortage has become even more acute with the introduction of ambulatory payment classifications, because hospitals need additional coders to deal with the new outpatient prospective payment system.

"I think since [APC implementation], in fact, it's even gotten more significant, and we're really trying to put qualified people in this outpatient ancillary setting who know coding and know terminology," she says.

Even among those who have a full staff, many re-

ported trouble keeping coders on staff and finding new ones to fill vacancies.

Nearly 75% of respondents at large hospitals and almost 70% of those at medium hospitals said they had trouble recruiting and retaining quality coders. Just about half of those at small hospitals reported the same trouble.

**Most hospitals have kept away from productivity bonuses because quick coding can sometimes result in poor quality.**

## Show them the money

Although large facilities are the most likely to feel the effects of the shortages, according to our survey, they are also the most likely to put their money where their mouths are.

Although the vast majority of all respondents did not have bonus programs for coders, large hospitals are most likely to offer productivity incentives. Nearly 12% of them give their coders

extra cash for productivity, compared with 6% of medium hospitals, and less than 2% of small hospitals.

Several wrote that their facilities were considering a bonus program but had not yet implemented one.

Bryant says most hospitals have kept away from productivity bonuses because quick coding can sometimes result in poor quality. "We have a range that has a minimum and a maximum, and we don't want our coders to code exceedingly too fast, because we believe it compromises accuracy," she adds.

The overall pay scale is also a bit higher in larger facilities. Only 11.3% of large hospitals pay experienced coders \$12 per hour or less, compared with 14.9% of medium hospitals, and 19.6% of small hospitals. About 17% of both medium and large hospitals pay experienced coders more than \$18 per hour, compared with 12% of *continued on p. 14*

small hospitals.

### **Too little, too late**

Overall—regardless of the difference in facility size—the majority of coders earn \$12 to \$16 per hour. That’s simply too low, says Bryant. That’s why so many hospitals say they’re having trouble finding and keeping staff.

“[These salaries] are very close to some positions at Wal-Mart, at McDonald’s, and it’s very troubling when you know that you can be a Wal-Mart greeter and make nine or 10 bucks an hour,” says Bryant.

“We’re not paying to the value of this position. Clearly, we are not as a nation. The industry needs to respond. Health care needs to respond to that, with the shortages we’re experiencing.”

Bryant says she has already seen coder salaries increase in California in the past year or two, and knows of many coders earning between \$20 and \$24 per hour.

“Hopefully, this is a turn of the tide, and we will see that salaries at the facility-base will be increased,” she adds. 🌅

## Send your transcriptionists home: They will be happier, and so will you

Your employees won’t waste their afternoons watching “Days of Our Lives,” just because you don’t have your eye on them. Just the opposite, in fact, according to **Mike Majoras, RHIA**.

When Majoras, director of health information services at Community Health Partners, a 328-bed hospital in Lorain, OH, started sending home his transcriptionists in November 2001, he noticed that their productivity increased, as he expected it would.

“We had been looking at it for a couple of years, and we were outsourcing about half of our work. We were looking to increase the productivity in-house so we wouldn’t have to send as much out,” says Majoras.

But productivity wasn’t the only reason to invest money in a new server, work stations, and phone lines. Majoras also knew that offering at-home employment was more attractive to job seekers.

“Over the past two to three years, when we’ve had transcriptionists leave, it’s been next to impossible to try to recruit and replace them,” he says. “We

would interview [candidates], and that was always one of their first questions. Do we offer at-home transcription, and if not, when will we?”

Some didn’t even bother coming in for an interview when they found out that Community Health Partners didn’t allow them to work at home.

### **Don’t let them leave**

At Rockingham Memorial Hospital in Harrisonburg, VA, the trouble was keeping the transcriptionists they already had from leaving, says **Lisa Blankenship, RHIA**, director of health information management (HIM).

“We had one employee who went part-time, and the other half of the time she was working out of her home for a physician’s office. So, we lost a half FTE [full-time employee] that way,” she says. “We had another one who was having a baby, and wanted to come back part-time, but if she could be at home, she’d come back full-time.”

A different Rockingham transcriptionist was exploring the possibility of working for a local outsourcing company because she could work from home.

The hospital had considered at-home transcription before, but the potential departure of several employees pushed the decision through at the beginning of 1999.

St. Mary's Hospital of Blue Springs, a 199-bed facility located in a suburb of Kansas City, MO, was also competing with an outsourcing company to recruit local transcriptionists.

"Transcriptionists in Kansas City are very hard to find, and the ones that are there are working at home for services, and that's what they want," says **Faith Pharr, RHIA**, director of medical records for St. Mary's. "We just kind of felt like it was really necessary for us to [make at-home work an option] in order to pull people."

#### **Consider the cost**

The three HIM directors agree that the rewards of providing home-based transcription were worth the cost of implementation, which varies among facilities depending on their computer systems.

Pharr's organization had to buy a whole new system in order to make it work. But the new system was needed for several other reasons, she says. She estimates the average cost of sending home a transcriptionist at her hospital to be \$5,000–\$6,000. So far, six have chosen to go home.

To send home nine transcriptionists, Community Health Partners spent a total of about \$50,000. That paid for the software, a new server, reference materials, phone lines, and three new work stations—the ones in the office were taken home. The transcriptionists were required to buy their own work station furniture, Majoras says.

With the help of statistics from a neighboring hospital that saw a productivity increase after sending transcriptionists home and input from a consulting group working in the hospital, Majoras was able to show a return on the investment to a skeptical administration.

"I had the consulting group's help to show that if we increased productivity 20%–25%, we could de-

crease our outsourcing by a corresponding amount," says Majoras.

"And we were able to show a cost savings, and a return on the investment within a year for the equipment, and we were able to show savings over a three-year period. So that's finally how I was able to sell it to them."

#### **Increase productivity and flexibility**

So far, Majoras has only seen an average 10-15% increase in productivity, but he expects that to increase as the staff work out the kinks in the system. Individual increases run the gamut from 2%–35%.

"Twenty to twenty-five percent is what we expect to get in the end, but the entire staff has only been home for about two months," he says. "As a group, we're still expecting that to go up. We've been having some problems where sometimes the network is slow and we're not sure what the problem is."

Pharr's staff is producing more work, even though their productivity per hour has not increased significantly. "I can't say that their production per hour is greater," says Pharr. "It is slightly, but they type a whole lot more because they don't have the interruptions that they all got when they were here."

Blankenship isn't sure how much per hour productivity has increased either, but she's seen her staff's willingness to work odd hours skyrocket.

"I can't say for sure that their productivity has gone up, but what we've definitely seen happen is that they are more willing to work more flexible hours," she says. "They're willing to work on Sundays when we need somebody to type stuff. They're more willing to flex their hours and meet the hospital's needs little better."

The transcriptionists themselves also benefit from this flexibility.

"We have a couple of transcriptionists who have young kids, and in the past if the kids were sick or they had to pick them up from school, they were out sick," says Majoras. "Now, *continued on p. 16*

they're still working or they have the flexibility of making up the hours later on that night or on the weekend, which in the past, they didn't do."

### Tout the benefits

Despite flexibility, lack of commute, and comfortable work environment, some transcriptionists may not want to be home. At Community Health Partners, they didn't have a choice, and the couple who were hesitant have grown to like it.

"We have nine transcriptionists and one or two were skeptical, but once they got home they were glad to be there. They were more concerned about being

isolated and adjusting their own schedules. Would they be self-disciplined enough to work alone? Everyone else was really looking forward to it. Most of them couldn't wait to get home. Those one or two who were skeptical now are just thrilled to be home."

At Rockingham Memorial and St. Mary's, the transcriptionists can choose. Most have opted to go home, but a few prefer the office environment. Even though they love the flexibility of working from home, the transcriptionists and other employees who stay behind to handle other HIM jobs that can't be completed remotely can have a hard time adjusting to the new system, too. 🏠

## Countdown to HIPAA with with more than 15 years of HIM guidance. Subscribe to *Medical Records Briefing*.

The time has come to start gearing up for the 2003 effective date of the HIPAA final rule. HIPAA preparedness is just one of the many topics that *Medical Records Briefing* covers.

*Medical Records Briefing* serves as a comprehensive health information management resource by offering: news on APCs, privacy, computerization, records completion, confidentiality, JCAHO, staff management, coding, Medicare, reimbursement, physician relations, HIPAA, and more.



Bonnie Spangler, Director of Medical Records Services, Southwestern Virginia Mental Health Institute, had this to say about:

"The topics covered in *Medical Records Briefing* are always very timely and pertinent to my daily work, as well as being very interesting and informative."

*Medical Records Briefing* also offers:

- Advice from HIM experts with whom we have developed solid relationships over our 15 years of publishing *Medical Records Briefing*.
- "A Minute for the Medical Staff"—a free supplement that helps you educate physicians about the important issues such as DRGs, coding, and records completion.
- Continuing Education (CE) Credits—available four times a year.
- Benchmarking Surveys, conducted every other month, to let you see how your department measures up to other medical records departments nationwide.
- Easy-to-understand explanations of what the JCAHO is looking for, what the most often cited standards are, and how to avoid Type I recommendations.
- Best practices that you can adapt in your HIM department to increase efficiency, decrease delinquency, improve privacy and security measures, and more.
- Tips for strengthening your ongoing record review program.
- Satisfaction guaranteed. Your subscription is covered by a no questions asked, 100% money-back guarantee.

**To order (just \$229 for 12 full issues), simply choose one of the following options:**

1. Go to [www.hcmarketplace.com](http://www.hcmarketplace.com) where you'll save 10%!
2. Call 800/650-6787, fax 800/639-8511, or e-mail [customerservice@hcpro.com](mailto:customerservice@hcpro.com)  
(Pricing good through 12/31/2002)