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Standard Guide for Requests for Proposals Regarding Medical Transcription Services for Healthcare Institutions[1]

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1. Scope

1.1 This guide covers recommended guidelines to healthcare institutions for the development and issuance of requests for proposals, as well as guidelines for medical transcription services responding to RFPs. It does not purport to address all of the legal aspects of a request for proposal, if any, associated with its use. It is the responsibility of the user of this guide to establish appropriate legal guidelines prior to use.

1.2 It is appropriate for healthcare institutions to issue requests for proposals (RFPs) from time to time or at regular contractual intervals for the purpose of facilitating the process of contracting for medical transcription services.

2. Referenced Documents

2.1 *ASTM Standards:*

E 1384 Guide for Content and Structure of the Computer-Based Patient Record[2]

E 1762 Guide for Electronic Authentication of Health Care Information[2]

E 1869 Guide for Confidentiality, Privacy, Access, and Data Security Principles for Health Information Including Computer-Based Patient Records[2]

E 1902 Guide for Management of the Confidentiality and Security of Dictation, Transcription, and Transcribed Health Records[2]

3. Terminology

3.1 *Definitions:*

3.1.1 *authentication*—process of (*1*) verifying authorship, for example, by written signature, identifiable initials, or computer key, or (*2*) verifying that a document is what it is purported to be, such as comparison with other records, or both.

3.1.2 *certified medical transcriptionist*—medical transcriptionist who has met the qualifications for voluntary certification set by the American Association for Medical Transcription (AAMT), by demonstrating proficiency in the field, meeting accepted standards, and maintaining the designation through continuing education activities as required by the Medical Transcriptionist Certification Program at AAMT.

3.1.3 *compliance clause*—item in a contract that defines remedies for default of contract specifications.

3.1.4 *data destruction*—eradication of data to a useless and irretrievable state.

3.1.5 *data disposal*—transference of data to a medium or form that renders it inaccessible or useless.

3.1.6 *data elements*—units of fundamental information from a healthcare record, organized in an analytical manner.

3.1.7 *data extraction*—specification of a subset of data from a master data source for a new data format.

3.1.8 *data mining*—extraction of selected elements of stored data to be used for a purpose other than the one for which the information was originally intended.

3.1.9 *dictation*—information that is stated or read aloud to be transcribed by another.

3.1.10 *dictator*—one who dictates information to be transcribed by another; also known as originator.

3.1.11 *digital dictation*—information which is stated or read aloud and recorded by a digital recording system.

3.1.12 *document*—report in any form (print, electronic, or voice file).

3.1.13 *document access*—ability to enter, exit, and, in some circumstances, edit or make use of a document.

3.1.14 *document destruction*—eradication of all elements of a document to a useless state.

3.1.15 *document disposal*—transference of all elements of a document to a medium or form that renders it inaccessible or useless.

3.1.16 *document distribution*—delivery of a document or documents (original or copies) to appropriate recipients, in any form (print, electronic, or voice file), authenticated or not authenticated.

3.1.17 *document storage*—repository for reports in any form (print, electronic, or voice files), authenticated or not authenticated, for later use or retrieval.

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[2] *Annual Book of ASTM Standards*, Vol 14.01.

3.1.18 *electronic authentication*—verification of authorship of a document or verification that a document is what it is purported to be, or both, accomplished by electronic means or in an electronic format.

3.1.19 *full-time equivalent*—work force equivalent of one individual working full-time for a specific period, which may be made up of several part-time individuals or one full-time individual. **(1)**[3]

3.1.20 *healthcare institution*—any facility whose primary purpose is delivery of health care, for example, hospital, clinic, physician practice, multi-campus healthcare system.

3.1.21 *medical transcription*—process of interpreting and transcribing dictation by physicians and other healthcare professionals regarding patient assessment, workup, therapeutic procedures, clinical course, diagnosis, prognosis, etc., into readable text, whether on paper or on computer, in order to document patient care and facilitate delivery of healthcare services. **(2)**

3.1.22 *medical transcription service (MTS)*—provider of transcribed healthcare documentation; also referred to as vendor or contractor.

3.1.23 *on-site users*—individuals who use a facility's computer system via a terminal and other hardware elements that are physically connected to that system.

3.1.24 *remote users*—individuals who use a facility's computer system via modem or wide area network connection.

3.1.25 *taped dictation*—information which is stated or read aloud and recorded by an analog system, as opposed to a digital system. Also called analog dictation.

3.1.26 *turnaround time (TAT)*—elapsed time beginning with availability of the voice file to the contractor (also known as MTS or vendor) for transcription and ending when the transcribed document is delivered to the client.

3.1.27 *unit of measure*—defined unit of production for transcription, for example, character, word, line, minute; measure used to quantify transcription produced.

3.1.27.1 *Discussion*—Because production statistics may vary based on counting methods used, electronic or otherwise, even though units of measure are the same, the contractor should clearly define the unit of measure being used, and the client should require full disclosure of the methods used to quantify production.

3.2 *Acronyms:Acronyms:*

AAMT	=	American Association for Medical Transcription
CHIN	=	Community Health Information Network
CMT	=	Certified Medical Transcriptionist (as designated by the Medical Transcriptionist Certification Program at AAMT)
CPR	=	Computer-based Patient Record
CPRS	=	Computer-based Patient Record System
FTE	=	Full-time Equivalent
HCFA	=	Health Care Financing Administration
JCAHO	=	Joint Commission on Accreditation of Healthcare Organizations
MT	=	Medical Transcriptionist; Medical Transcription
MTCP	=	Medical Transcriptionist Certification Program
MTS	=	Medical Transcription Service
RFP	=	Request for Proposal
TAT	=	Turnaround Time

[3] The boldface numbers given in parentheses refer to the list of references at the end of this standard.

4. Significance and Use

4.1 This guide is intended to assist healthcare institutions in creating appropriate requests for proposals to be issued for medical transcription services.

4.2 This guide provides recommended guidelines for the essential elements to be included in requests for proposals issued to medical transcription services. The purpose of these requests is contracting for production and delivery of transcribed patient care documentation for a healthcare institution.

4.3 This guide does not preclude the necessity of researching local, state, and federal requirements that may apply.

5. The Current RFP Process

5.1 Healthcare institutions often outsource the production of patient care documentation to an external vendor known as a medical transcription service (MTS). Therefore requests for proposals (RFPs) for those services and their attendant awards or possible flaws are more important than ever for health information management consideration. Establishing sensible standards for the RFP process is a necessary beginning for successful partnerships between healthcare clients and medical transcription services. RFP standards will help to ensure that the healthcare client's goals and expectations become an integral part of the working relationship with the MTS.

5.2 In reviewing RFP styles presently in use in the United States, it is clear that no particular standards are being followed in their composition.

5.2.1 Because of the way RFPs are currently written, the information necessary to select the best MTS may not be gleaned, and this may result in inadequate service or other difficulties after the contract is awarded. If an RFP does not ask for sufficient information about the MTS for the healthcare client to be able to judge the company fairly or to make an informed decision, or does not give enough information to enable the MTS to provide an informed response or set up the account adequately for its needs, bidding results can be inferior.

5.2.2 On the other hand, if the RFP is so stringent or unreasonable or detailed that even the best of transcription services cannot meet the demands, then the only bidders will be those who do not recognize that they will be unable to meet the requirements of the contract. If the contract is awarded to a bidder unable to follow through, that medical transcription service is likely to default on the contract, and it will then be awarded to another bidder, or the RFP process will begin again. This may leave the healthcare client with poor service or no service.

5.2.3 The healthcare documentation process and quality of the text are often harmed by this lack of perceptive standards. In the end, this means that patient care may be adversely affected and providers' time may be wasted. Further, the

money spent by the healthcare client on repeatedly reestablishing relationships with medical transcription services can be excessive, and the quality of service during the transition time may be less than optimal.

6. Systematic Approach to Writing RFPs

6.1 A systematic approach to the RFP includes items that make the situation of the healthcare client clear to the MTS, including the client's existing state of transcription, goals for the future, and the requirements for success: response criteria, confidentiality fundamentals, security, disaster recovery, document or data destruction guidelines, or both, as well as vendor disclosure and reference requests. The RFP structure should include:

6.1.1 Current status of the healthcare client,
6.1.2 Expectations of the healthcare client,
6.1.3 Proposal response requirements,
6.1.4 Terms and conditions of contract,
6.1.5 Confidentiality issues,
6.1.6 Information security issues,
6.1.7 Disaster recovery issues,
6.1.8 Document and data destruction,
6.1.9 Vendor disclosure,
6.1.10 Reference requests,
6.1.11 Scope of services (to include quality assurance program and staffing),
6.1.12 Product pricing, and
6.1.13 Compliance clauses.

6.2 The RFP should be set up in such a way that it will allow the MTS an optimum opportunity to present the full scope of services to the healthcare client as a partner in achieving the client goals. It should not be so rigid that the vendor cannot demonstrate creative solutions and approaches to service and pricing. This sort of openness, while making clear the requirements of the institution, promotes a response of cooperation toward a common goal.

6.3 In each of the sections of the RFP, the document should set out the requirements in such a way that the compliance or noncompliance of the MTS can be verified. This should be followed by a field for comment by the MTS. In areas where the healthcare client has a preference, but not necessarily a demand, the same format can be followed. Some sections may be an invitation for information from the MTS and should be so arranged. Such an invitation acknowledges respect for the MTS's expertise in its field, while wisely protecting the interests of the healthcare institutions.

7. Structure of the RFP Document

7.1 *Current Status of the Healthcare Client*:

7.1.1 A complete description of the healthcare client's existing transcription practices and status characteristics enables the MTS to formulate comprehensive answers to the requirements listed in the RFP. If the current status differs vastly from the expectations of the client, stating those differences allows the MTS to more intelligently present pricing solutions. An RFP that simply asks for a price per unit of measure without indicating, for example, that tape dictation equipment is being used now, but there are plans for a change to digital equipment in six months, as well as purchase of ten physician clinic groups, is ignoring the vast impact such changes will have on an MTS.

7.1.2 *Organizational Picture*—In describing the current status, the entire picture should be delineated, not just the portion to be involved in the contract. A general description of the healthcare facility, with financial or associated corporate structures, should be specified. It makes a difference to the MTS to know that a healthcare facility may include three hospitals at various campus locations, with sixteen additional clinic locations at varied sites. The total census information at these sites will also make a difference. Referencing the healthcare facility's policies and procedures, and their availability to the MTS, is not only helpful but makes a clear statement of their importance.

7.1.3 *Healthcare Documents*—A description of healthcare documents presently generated for each site should be specified and described:

7.1.3.1 Healthcare document description.

7.1.3.2 The actual defined volume of each document type by number of lines, minutes, or other explicitly definable unit of measure appropriate for input measurement.

7.1.3.3 The percentage of each document type relative to the total volume.

7.1.3.4 The percentage of total healthcare documentation currently being dictated and transcribed.

7.1.3.5 The required turnaround time mandated by the facility's policies, and the present achievement level in meeting turnaround requirements.

7.1.3.6 The anticipated volume of each document type to be involved in the proposal.

7.1.4 *Equipment and Software*—The current status of equipment and software used at the various sites should be indicated, including dictation and word processing or transcription equipment, as well as information system links and phone systems. Disclosure of anticipated information system changes is vital to the MTS.

7.1.5 *Document Format and Distribution*—Specifications as to the actual documents presently produced should include the following areas:

7.1.5.1 Format,

7.1.5.2 Document access (for example, by dictators, consultants, and coding specialists),

7.1.5.3 Document distribution forms (print, electronic, and voice file),

7.1.5.4 Document distribution copy requirements,

7.1.5.5 Document distribution parameters (where, when, and how), and

7.1.5.6 Management report formats.

7.1.6 *Data Extraction*— The nature of any extraction of data elements, by whom and for what purpose, as well as the distribution process for these data elements, should be revealed insofar as it may affect the product the MTS must provide. This situation may arise in system respositories, CHINs, or research databases. See also 7.5.3.

7.1.7 *Document and Data Storage, Retrieval, and Destruction*—Specifications of the document and data storage, retrieval, and destruction parameters as they may affect the MTS are also required, since interfacing to the mainframe or to

optical disk storage could affect the scope of the customized programming required. Multiple layers of storage, retrieval, and destruction requirements also add to the complexity of the services necessary.

7.2 *Expectations of the Healthcare Client*:

7.2.1 Having given the current status of the organization, a well-written RFP will state the reasonable expectations of the healthcare client. If these expectations differ significantly from the current status, the difference should be highlighted. For example, if the achievement level for turnaround time in operative reports is presently 48 h and the expectation is 12 h, this should be clearly stated. As another example, imminent implementation of a computer-based patient record system (CPRS) could significantly affect interface requirements, as well as electronic document distribution and electronic signature concerns. For further guidance, see Guide E 1384.

7.2.2 When all future expectations in the areas of healthcare document types, format specifications, document access specifications, document distribution specifications, management reports, data element extraction, document storage specifications, and document or data destruction, or both, have been made clear, including timeliness, a section should be made available for the MTS to recommend service enhancements, other than those required, in line with the stated expectations of the healthcare client.

7.3 *Proposal Response Requirements*—Having given a clear picture of its own position, the healthcare client should now make clear the response and award requirements of this particular proposal. Defining the terms used throughout the RFP is essential to mutual understanding of the details, so a dictionary of terms should be included. The format to be followed in the response, to include both required and alternative responses, should be clearly delineated, easy to follow, and should encourage a succinct response. Particulars as to the delivery site for the RFP, the permissible methods of delivery, number of copies, and the closing date and time for accepting the RFP are crucial.

7.4 *Terms and Conditions of Contract*:

7.4.1 *General*—Terms and conditions of the contract should be clear from the outset, although the healthcare client need not feel obligated to have a particular requirement in every area. Sometimes considering the options presented by the vendors, rather than stating requirements, may reveal very palatable choices. The length of time the contract will be awarded and renewal options, as well as possible adaptability to evolving new industry standards, are some of the terms to consider. The MTS may be adamant about an exclusive versus a nonexclusive contract. The healthcare client may insist that no subcontractors be utilized.

7.4.2 *Protected Information*—Both the healthcare client and the MTS may have concerns about protected information and its definitions and nondisclosure requirements. An MTS, for instance, may want to protect patented work processes or financial information from being made available to competitors in open bidding. The healthcare client may want to protect information such as patient volumes or numbers of covered lives if that were a necessary request for a bid based on managed care data. The conditions of this type of confidentiality need to be clearly defined. Both parties may have indemnification issues to address as well.

7.4.3 *Delivery and Payment Terms*—Other terms of the contract include more mundane items such as payment terms and invoice terms. Shipping terms are less routine, as delivery options are varied and complex, particularly in multi-site and multi-technological healthcare client situations. And again, the definition becomes key, as meeting a turnaround time may be gauged by whatever is defined as the delivery.

7.4.4 *Remedy for Default*—Terms for remedy in case of default of either party should be defined.

7.4.5 *Work Sample*— Finally, a work sample of the healthcare client's choice may be sought in order to further evaluate the quality and quantity criteria of the MTS. This sample should be appropriate to the institution, and the requirements of its transcription quality must be communicated clearly. The quality and production claims of various vendors can then be compared based on the client's defined units of measure.

7.5 *Confidentiality*:

7.5.1 Confidentiality concerns continue to grow in importance. Expectations for the assurance of confidentiality should be spelled out in order to determine the vendor's commitment to it. Does the MTS conduct employee training in confidentiality requirements as well as obtain signed confidentiality agreements from each employee, subcontractor, and outside equipment vendor or maintenance personnel exposed to confidential materials? For further guidance, see Guides E 1902 and E 1869.

7.5.2 How much liability does the MTS bear for confidentiality of the voice and text files at the vendor sites, at the healthcare client sites, or over phone lines or airwaves? Does this liability depend on ownership of the involved hardware and software? Is there a third party to consider for confidentiality liabilities of stored documents or data, or both?

7.5.3 Does the client understand or expect that data will be extracted? If so, by whom and for what purpose? Is data mining allowed? Is the vendor permitted to extract disidentified patient information and provide it to a third party as aggregated data? It is crucial that expectations and restrictions regarding confidentiality be clearly stated by all parties involved in negotiations. Neither the healthcare client nor the MTS should rely on an assumption that confidentiality, as each understands it, will be maintained.

7.6 *Information Security*:

7.6.1 Information security is another technologically evolving area for the healthcare client and the MTS. The healthcare client may or may not have specific requirements but certainly will want to know the MTS's commitment to it.

7.6.2 How much liability does the MTS bear for security of the voice and text files at the vendor sites, at the healthcare client sites, or over phone lines or airwaves? Does this liability depend on ownership of the involved hardware and software? Is there a third party to consider for security liabilities of stored document or data, or both?

7.6.3 At what point during interface, exchange, or transfer of the health information does responsibility for that information begin and end for the MTS and healthcare client? These