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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

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

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

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

questions are becoming more complex in the computerized environment. For further guidance, see Guides E 1902 and E 1869.

7.7 *Disaster Recovery*—The computerized environment has also engendered specific types of requirements for disaster recovery. Planning may involve the MTS's hardware and software at a healthcare client site and also at the MTS's own sites. Ongoing work could be affected, as could the stored documents or data, or both.

7.8 *Document and Data Destruction*—Transcribed documents and other patient information should be retained no longer than necessary to satisfy the terms of the contract, for example, when delivery and receipt of transcribed documents have been verified and the services invoiced and validated. The healthcare client's requirements for destruction of dictation and transcription and other confidential patient information should be clearly stated, as well as any restrictions from data mining or extraction of data to be used for other purposes. See Guide E 1902 regarding document storage, retention, and destruction.

7.9 *Vendor Disclosure*:

7.9.1 The healthcare client requires disclosure of adequate information on the vendor's business history, financial and staffing resources, and ownership of the MTS (current and pending) in order to make an informed judgment on its ability to serve the institution well. In today's global economy, it may be important to note interstate and international staffing locations, as many of the liabilities involved in the contract may be affected by relevant laws or legal issues. The MTS must provide proof of various kinds of business licenses and insurance, including liability, workers' compensation, unemployment, and possibly vehicle liability. Business practices such as data mining should be disclosed.

7.9.2 Part of the vendor disclosure process should include the healthcare client's making a site visit to the MTS's location to ascertain the credibility of the represented facts. In addition, the healthcare client may invite interested vendors to an interview at the client's site at some time preceding or during the RFP process. The RFP needs to present these particulars.

7.10 *Reference Requests*:

7.10.1 MTSs can expect to be asked to list all pending or past litigation concerning a confidentiality breach or quality of service breach for all branches of the company. Also subject to revelation and explanation may be any contracts terminated in the previous 12 months. This leads directly to requests for references. Rather than asking for a reference from every customer ever served, it is reasonable to request recent references from comparable healthcare clients.

7.10.2 If hardware is to be provided by the MTS as well, references may be requested for users with similar installations. All the above may serve to portray the MTS as an ethical and responsible candidate for partnership in service to the healthcare client.

7.11 *Scope of Services*—The scope of services area of the RFP addresses the most elementary benefits to the healthcare client. Identified areas for inclusion as either requirements or requests for information from the MTS are presented in 7.11.1-7.11.15.

7.11.1 *Infrastructure to Support Client*:

7.11.1.1 *Medical Transcriptionist Staffing*—First and foremost within the infrastructure to support the healthcare client are the medical transcriptionists. While the healthcare client needs assurance that an adequate number of qualified staff are available to execute the contract, the medical transcription vendor cannot be constrained to assign the current staff specifically to this contract, and when a vendor has multiple office locations, it becomes increasingly difficult to specifically list staff and qualifications. There may be other ways to provide information to verify staff adequacy and yet meet the needs of both parties. One way is to list the medical transcriptionists, without names, but with individual qualifications: years of experience, credentials (for example, academic degree and relevant certification, including source and date), previous education and training, continuing educational activities **(3-5)**, the work location (specified vendor office or home office) and work hours of each, whether the individual will work exclusively on this contract, and the employee or independent contractor status (if allowed) of each. Alternatively, the vendor may reply with a summary per location of the number of medical transcriptionists, the number or summary percentage of those who are CMTs or otherwise credentialed in a related discipline (including source and date), the FTE per work-hour designation, whether any will be exclusive to this contract and how many, and the employee or independent contractor status. The locations involved in servicing the contract should be named.

7.11.1.2 *Quality Assurance Personnel*—Quality assurance personnel, administrative and technical, will also be listed or summarized, with position and credentials, office location, the hours available, and methods of access (telephone number, e-mail address, etc.).

7.11.1.3 *Administrative and Management Personnel*—Administrators and managers will be listed or summarized, giving the position and authority of each, including credentials if applicable, office location, hours available, and methods of access.

7.11.1.4 *Proposed Additions*—If additions to staff are anticipated to handle the account specified in the RFP, details should be listed as to how those staff members will be qualified, selected, and supported with training or continuing education, or both.

7.11.2 *Turnaround Time (TAT)*—The turnaround time per healthcare document type is a crucial issue and should already have been defined. In this section, the healthcare client would request a specified TAT per healthcare documentation type, being certain to differentiate between routine turnaround time and expectations for weekends or holidays. It is vital to be clear about the parameters of the turnaround: Does it begin upon dictation, or upon receipt by the MTS? Does it end when the report is transcribed, when it is delivered to the healthcare client, or when it is charted? How are these points tracked? What elements on the clients' side could adversely affect the ability of the vendor to provide delivery as required?

7.11.3 *Equipment Type*— Specifications of the type of equipment to be used (dictation, alternative input devices, text processing, telecommunications, storage and retrieval) may be delineated by the healthcare client, or the client may be open to

specific suggestions while listing only the parameters required. These issues have far-reaching effects on every aspect of the proposal, including the price. Requiring a particular type of stand-alone mainframe-style terminal for text processing may greatly hamper the ability to provide a product efficiently and cost-effectively, although the healthcare client information systems (IS) department may feel that interface capabilities are essential. Communication must be clear and open on all sides of this matter, with all users aware of the global effects these specifications have on a practical level.

7.11.4 *Equipment Ownership and Location*—The ownership of the equipment and its location may also be variables within the RFP. Ownership carries with it obligations and responsibilities, as well as implications regarding continuity upon contract termination, and thus may be a significant issue in the RFP.

7.11.5 *Software*—Software presents yet another challenge in specifications. Interface and integration requirements between information systems and dictation systems, or between dictation systems and computer networks, or between information systems and computer networks, or between remote users and on-site users are all possible links to be defined. With the multitude of possibilities available, defining the specific software results may be the best way to handle this detail. Among the defined results, the timeliness of the availability of required interfaces may be a consideration. For example, the MTS cannot complete demographic information on a document with a 2-h TAT if the demographic interface is not available within the same time frame. In this instance alternative procedures may be needed to satisfy the terms of a contract. Also, request the listing of technical and service contracts for hardware or software provided in the contract by the MTS.

7.11.6 *Quality of Work*— The healthcare client should state clearly its definition of quality work and then ask the MTS for a description of its quality assurance processes, as well as a description of the policies and procedures that apply when there are questions about dictation that is difficult to understand, inappropriate, incomplete, and so on.

7.11.7 *Volume of Work*— The anticipated volume of work by document or report type to be contracted needs to be delineated by the healthcare client, as mentioned in 7.1 and 7.2. An annual volume should be stated, but quarterly, monthly, weekly, or daily volumes may be appropriate as well in order to convey some sense of distribution over the year.

7.11.8 *Electronic Authentication*—If electronic authentication issues will be part of the RFP, the specifications of the institution should be outlined, referencing applicable state, federal, ASTM, HCFA, and JCAHO standards, and any other applicable standards. See Guide E 1762.

7.11.9 *Management Report Specifications*—Management reports from the MTS will be key to the implementation of its partnership with the healthcare client. Specifications for these reports should be clearly stated by the healthcare client, with room for input by the MTS as to enhancements.

7.11.10 *Specifications for Adaptation and Transition Period*—There is almost always an adaptation and transition period upon initiation of a contract. Recognizing this within the RFP process leads to more realistic goals for initial training and facilitates a gradual movement into the expectations of quality, quantity, and turnaround. A length of time for adjustment of the healthcare client and MTS to the process should be suggested, as well as specific performance goals within the transition period.

7.11.11 *Ongoing Support Specifications and Charges*—Ongoing support specifications (such as for additional distribution of documents, additional or expanded production reports, or other services) and charges, if any, should be established in the RFP. This often-overlooked area of cost can be due to orientation of the client's new staff members (dictating physicians) throughout the life of the contract, orientation of client and vendor staff to new or upgraded hardware or software, and client-requested changes or modifications in services.

7.11.12 *Client Changes or Modifications*—It is appropriate for the MTS to present the procedures to initiate such changes and the related cost methodology.

7.11.13 *Document and Data Storage and Retrieval Requirements*—If the healthcare client requests, or if the vendor offers or provides, storage of voice, data, or text files (or any combination) and retrieval of same, then the length of time stored, the method of storage, access, audit trails, retrieval response time, security precautions, disaster recovery, and backup system software and hardware requirements (if any) should be stated. See 7.8; also refer to Guide E 1902.

7.11.14 *Document and Data Destruction Requirements*—The client's requirements and expectations for document destruction should be specified for the MTS. See 7.8; also refer to Guide 1902.

7.11.15 *Healthcare Client Organization's Related Policies and Procedures*—It is essential that the MTS be cognizant of and abide by the healthcare organization's related policies and procedures. These should be referenced and made available to the MTS. Without this information, there is a greater risk of violating accreditation or affiliation requirements.

7.12 *Product Pricing*:

7.12.1 Finally, the unit of measurement of the product provided should be explicitly defined and itemized, and the documentation and verification mechanism for the quantity of the product proposed. Other units of measurement used, such as for added services, must also be defined.

7.12.2 This guide acknowledges the rapidly changing technological means to create a document, such as scanning, voice-to-text, editing, electronic abstraction, etc. See Guide E 1384. Methods of measurement of the effort to produce that document will evolve consistent with the effort involved in creating the document. It is the recommendation here that healthcare institutions cautiously approach the method of measurement and describe post-implementation verification processes.

7.12.3 An explicitly defined unit of pricing for the proposal must be the result. The healthcare client may or may not wish to be specific about the unit of measure preferred, but must be able to compare RFPs with equal measure. Additional services need to have a pricing methodology established. There must also be methods of documentation and verification for the

product provided and resultant pricing (such as compatibility with a software package that verifies units).

7.12.4 In today's managed care or capitated environment, the healthcare client may be interested in nontraditional methods of pricing. There may be creative ways of approaching pricing per covered insured, or per visit level, if the healthcare client makes appropriate data for costing available to the MTS.

7.13 *Compliance Clauses*—Compliance clauses deal with failure to meet standards in the contract, such as turnaround time and quality. The key issues will be how these elements are defined, how they are measured, who audits them, and the remedy for noncompliance. The definitions of these elements may be elsewhere in the RFP, but the penalties involved may be defined here.

8. Outline of a Request for Proposals Regarding Medical Transcription Services for Healthcare Institutions

8.1 The following is a summary, in outline form, of topics that should be addressed in an RFP.

8.2 *Current Status of the Healthcare Client*:

8.2.1 Description of existing state of transcription services.

8.2.2 *Organizational Picture*:

8.2.2.1 General description of facility, including financial or corporate structure.

8.2.2.2 Census information.

8.2.2.3 Disclosure of recent or pending changes.

8.2.3 *Healthcare Documents*:

8.2.3.1 Description of types of documents currently transcribed.

8.2.3.2 Actual volume of each document type, defined and verifiable.

8.2.3.3 Percentage of each document type relative to total volume.

8.2.3.4 Percentage of total healthcare documentation currently being dictated and transcribed.

8.2.3.5 Required turnaround time, including present compliance.

8.2.3.6 Anticipated volume of each document type involved in proposal.

8.2.4 *Equipment and Software (or lack thereof)*:

8.2.4.1 Dictation.

8.2.4.2 Transcription.

8.2.4.3 Information systems, including applicable links and disclosure of anticipated information system changes.

8.2.4.4 Telecommunication systems.

8.2.5 *Document Format and Distribution*:

8.2.5.1 Format specifications.

8.2.5.2 Document access specifications.

8.2.5.3 Document distribution forms (print, electronic, and voice file).

8.2.5.4 Document copy requirements.

8.2.5.5 Distribution parameters (where, when, how).

8.2.5.6 Management report format requirements.

8.2.6 Manipulation or extraction of data elements, and distribution of same.

8.2.7 Description of document or data storage, retrieval, and destruction.

8.3 *Expectations of Healthcare Client*:

8.3.1 *Healthcare Document Types Included in Proposal*:

8.3.1.1 Description of types of healthcare documents to be transcribed.

8.3.1.2 Defined volume of each type, including expected percentage or volume to be outsourced relative to total volume.

8.3.2 *Format Specifications for Pertinent Documents and Reports*:

8.3.2.1 Transcribed document formats.

8.3.2.2 Management report formats.

8.3.2.3 Invoice formats.

8.3.3 Document access specifications.

8.3.4 *Document Distribution Specifications*:

8.3.4.1 Turnaround time requirements, by report or document type.

8.3.4.2 Document copy requirements.

8.3.4.3 Distribution parameters (where, when, how).

8.3.5 *Extraction of Data Elements*:

8.3.5.1 Responsibility defined.

8.3.5.2 Distribution parameters (where, when, how).

8.3.6 *Document and Data Storage Specifications*:

8.3.6.1 Timing.

8.3.6.2 Manner.

8.3.7 Document and data retrieval specifications.

8.3.8 *Document and Data Disposal Specifications*:

8.3.8.1 Timing.

8.3.8.2 Manner.

8.3.9 Service enhancement recommendations offered by vendor, other than those requested.

8.4 *Proposal Response Requirements*:

8.4.1 Format.

8.4.2 Date, time, place, method of delivery.

8.4.3 Definition of terms used in proposal.

8.4.4 *Contract terms:*

8.4.4.1 Termination clauses.

8.4.4.2 Exclusivity or non-exclusivity.

8.4.4.3 Payment terms.

8.4.4.4 Shipping terms.

8.4.4.5 Invoice terms.

8.4.5 Length of contract.

8.4.6 Renewal options.

8.4.7 Award of contract.

8.5 *Terms and Conditions of Contract*:

8.5.1 General.

8.5.2 *Protected Information Defined*:

8.5.2.1 Non-disclosure requirement.

8.5.2.2 Indemnification issues.

8.5.3 *Vendor Response Requirements*:

8.5.3.1 Response required to each item as requested.

8.5.3.2 Alternative responses where applicable.

8.5.4 Remedy for default.

8.5.5 Work sample for quality and quantity criteria.

8.6 *Confidentiality*:

8.6.1 Vendor's commitment.

8.6.1.1 Employee training.

8.6.1.2 Employee-signed agreements.

8.6.1.3 Vendor's policy, including enforcement, for staff (employees, subcontractors).

8.6.1.4 Vendor's policy, including enforcement, for dealing with outside equipment or maintenance service vendors.

8.6.1.5 Consequences for breach of confidentiality, including enforcement.

8.6.2 *Liability*:

8.6.2.1 At vendor's site(s).

8.6.2.2 At client's site(s) if vendor's equipment is used.

8.7 *Information Security*:

8.7.1 Vendor's commitment.

8.7.1.1 Policy regarding information security.

8.7.1.2 Methods used, physical and electronic.

8.7.1.3 Individual(s) responsible.

8.7.1.4 Consequences for breach of information security, including enforcement.

8.7.2 *Liability*:

8.7.2.1 During interface, interchange, or transfer of data in any form.

8.7.2.2 Access to software, by employees, subcontractors, vendors, intruders.

8.7.2.3 Access to data, by employees, subcontractors, vendors, intruders.

8.7.3 Commencement of responsibility, client vs. vendor.

8.8 *Disaster Recovery Processes and Procedures*:

8.8.1 Client site backup and recovery.

8.8.2 Vendor site backup and recovery.

8.8.3 Ongoing work backup and recovery.

8.8.4 Storage backup and recovery.

8.8.5 *Vendor's Policy Regarding Disaster Recovery*:

8.8.5.1 Methods used.

8.8.5.2 Individual(s) responsible.

8.8.5.3 Consequences for noncompliance, including enforcement.

8.9 *Document and Data Destruction Specifications*:

8.9.1 Methods.

8.9.2 Frequency.

8.10 *Vendor Disclosure*:

8.10.1 Business history.

8.10.2 Ownership, present and pending.

8.10.2.1 Applicable business license(s) and tax identification number.

8.10.2.2 Disclosure of recent or pending changes.

8.10.3 *Resources*:

8.10.3.1 Financial.

8.10.3.2 Staffing.

8.10.4 *Staff work location(s)*:

8.10.4.1 Impact of applicable laws.

8.10.4.2 Disclosure of recent or pending changes.

8.10.5 *Insurance*:

8.10.5.1 General liability.

8.10.5.2 Worker's compensation.

8.10.5.3 Unemployment.

8.10.5.4 Vehicle liability.

8.10.5.5 Other.

8.10.6 Site visit.

8.11 *Reference Requests*:

8.11.1 Recent references from comparable healthcare clients.

8.11.2 Pending or past litigation concerning breach of confidentiality or quality of service.

8.11.3 Contracts terminated in the previous 12 months, with explanation.

8.12 *Scope of Services*:

8.12.1 Infrastructure to support client.

8.12.1.1 Medical transcriptionist staffing, including qualifications (experience, education, credentials, training), location, work hours or schedule, exclusivity to contract, and employment or subcontractor status.

8.12.1.2 Quality assurance personnel, including position, credentials, location, hours available, and methods of access.

8.12.1.3 Administrative and management personnel, including position, credentials, location, hours available, and methods of access.

8.12.1.4 Proposed additions to staff to service this account.

8.12.2 *Turnaround Time per Report Type*:

8.12.2.1 Definition of routine turnaround time.

8.12.2.2 Definition of weekend or holiday expectations.

8.12.3 Equipment type and specifications.

8.12.4 Equipment ownership and location.

8.12.5 *Software*:

8.12.5.1 Specifications for interface between vendor and client.

8.12.5.2 Specific software results desired (if product is to interface to other software).

8.12.5.3 Timely availability of information required for interfaces.

8.12.5.4 Listing of verifiable, applicable technical and service contacts.

8.12.6 *Quality of Work*:

8.12.6.1 Definition, expectations.

8.12.6.2 Description of quality assurance processes.

8.12.6.3 Description of policies and procedures regarding editing, difficult dictation, clarification of inconsistencies.

8.12.7 *Volume of Work*:

8.12.7.1 Exclusive to client versus nonexclusive.

8.12.7.2 Annual volume expected.

8.12.8 Electronic authentication policies and procedures.

8.12.9 Management report specifications.

8.12.10 *Specification for Adaptation and Transition Period upon Initiation of Contract*:

8.12.10.1 Initial training of staff.

8.12.10.2 Transition to expected levels of quality, quantity, and turnaround time.

8.12.10.3 Time period allowed for adjustment of client and vendor.

8.12.11 *Ongoing Support Specifications and Charges*:

8.12.11.1 New staff orientation/training, and charges if applicable.

8.12.11.2 New or upgraded hardware or software acquisition, or both, and orientation/training, and charges if applicable.

8.12.11.3 Support personnel, including availability.

8.12.12 *Client Changes or Modifications*:

8.12.12.1 Procedure to initiate changes or modifications.

8.12.12.2 Cost methodology.

8.12.13 *Document and Data Storage and Retrieval Requirements*:

8.12.13.1 Length of time stored.

8.12.13.2 Storage media (print, electronic).

8.12.13.3 Retrieval response time.

8.12.13.4 Backup system software and hardware requirements.

8.12.14 *Document and Data Destruction Requirements*:

8.12.14.1 From equipment.

8.12.14.2 From backup systems/media.

8.12.14.3 From storage.

8.12.15 Healthcare organization's relevant policies and procedures.

8.13 *Product Pricing*:

8.13.1 Defined unit of measurement of product.

8.13.1.1 Method of computing charges.

8.13.1.2 Verification mechanism for quantity of product.

8.13.2 Proposed pricing.

8.13.2.1 Explicitly defined unit of pricing per proposal.

8.13.2.2 Additional services, apart from document creation, and pricing methodology.

8.13.2.3 Method of evaluation.

8.13.2.4 Possible alternative pricing methods, for example, in managed care or capitated pricing environment.

8.13.2.5 Length of contract and proposed pricing changes within it.

8.14 *Compliance Clauses*:

8.14.1 Turnaround time.

8.14.1.1 Definition of measurement.

8.14.1.2 Method of measurement.

8.14.1.3 Audit process.

8.14.1.4 Consequences of noncompliance and enforcement procedures.

8.14.2 *Quality*:

8.14.2.1 Definition of measurement.

8.14.2.2 Method of measurement.

8.14.2.3 Audit process.

8.14.2.4 Consequences of noncompliance and enforcement procedures.

9. Keywords

9.1 analog dictation; compliance clause; data mining; digital dictation; disclosure; disaster recovery; document access; document distribution; document storage; medical transcription service; request for proposal; taped dictation; turnaround time; unit of measure

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