Aligning documentation standards across your specialty practices.

How your documentation solution can make it easier to integrate newly acquired physician groups into your health system

NUANCE

The build-out of health systems

Patient documentation is at the heart of providing quality care and maintaining financial integrity for healthcare facilities. With the trend in consolidation, unifying documentation between the inpatient and outpatient environment becomes a challenge. As IDNs acquire physician group practices, administrators struggle to get the disparate components aligned. Documentation needs to be standardized, compliant and controlled.

Acclimating the hospital workflow to the clinic environment can be like fitting a square peg into a round hole. The high-volume, high-velocity clinic environment is different from the hospital environment, pushing IDNs to find a solution that can meet the distinct ambulatory demands while still integrating with the hospital system. Each specialty practice has unique needs and complexities—multiple locations, a wide range of diagnoses and treatment protocols—that demand independent workflows. At the same time, each clinic must be integrated into the whole for communication across the continuum of care.

Beyond these concerns, organizations are also trying to avoid the operating losses experienced in the late 1990s and early 2000s when physician practices acquired by hospitals didn't earn adequate ROI. Physician productivity is driving the ecosystem, forcing IDNs to focus on integrated, hybrid solutions that are physician-centric and help them achieve their operational goals. Organizations seek to maintain patient volume while still adhering to the growing demands of patient documentation. Not only do EHRs need to be implemented, but they must be used—a goal that is difficult to reach without maintaining physician satisfaction and productivity. With diligent use, organizations can achieve sufficient data collection that leads to proper reimbursement and optimal patient outcomes.

When it comes to documentation, hospitals and clinics often speak different languages. To solve the challenges of communication and productivity, ambulatory documentation solutions must bring together features and value that give IDN clinics the functionality they need, no matter the work style or specialty of the provider, while fully integrating with the hospital system.

Five essential documentation solution deliverables for IDN clinics

When choosing the right documentation solution, organizations must consider compatibility, functionality, features, usability and cost. Outlined below are five key factors that can help improve operations across the IDN ambulatory environment.

1. Unify workflow, command standardization and provide visibility into process success
A documentation platform can serve as a solid base of corporate compliance when technology allows customizable standards that can be set and enforced across clinics. Establishing protocol for letterhead format, documentation workflow and security policies ensures each specialty group works within deliberate guidelines.

Once protocols for documentation workflow, authentication, and delivery are in place, each clinic can use its existing EHR while a consistent documentation environment steers a cohesive workflow and regulated output. Clinics can use EHR structure requirements as a guideline for document content to ensure that documents are formatted consistently and include mandatory content.

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Once the documentation process framework is established, clinics can simply replicate and adopt existing settings and expend a fraction of the effort when onboarding subsequent practices, whether large or small. Extensive monitoring capabilities can provide excellent visibility and allow administrators to:

– Monitor timelines of document creation, review and authentication at the physician level,

– Measure workflow success, and

– Easily determine roadblocks in the system.

2. Improve EHR usability by easing the effort required to create highquality content
Capturing data is only one piece of the puzzle. If the data is not complete, accurate and easily accessible, the goal of the EHR and the core tenet of the HITECH Act and its "meaningful use" efforts—to facilitate quality patient care—is lost. Leveraging the power of voice can enhance EHR documentation and ensure the right amount of information is captured to effectively represent the patient's experience with the provider. Crucial features that maximize usability include:

– **Respect for narrative conten**t
   Dictation makes it easy for clinicians to enhance documentation with a more complete, contextual and meaningful note in the patient's record. Injuries and post-operative complications cannot be described fully with dropdown menus and check boxes. A conversational, narrative expression of the patient story allows clinicians to clearly outline their observations, assessments and the patient's condition, and it facilitates quick review and understanding of the complete picture of health.

– **Auto-population of the EHR**
   Tight integration can ease clinician interaction with EHRs by not only simplifying or even eliminating navigation, but also ensuring that correct patient demographics and test results are associated with the proper patient record. Placing narrative content into specified sections of the EHR automatically—HPI, Physical Exam, ROS, Assessment, Chief Complaint, and Assessment Plan—supports meaningful use, facilitates documentation integrity and aids appropriate coding.

– **Customizable, editable templates**
   The structure of the EHR record can serve as a foundation for custom templates that steer content and optimize the documentation task. Outlining key elements and providing guidance on content can ensure proper coding—specialty, body part-specific, ICD-10 requirements, acute/chronic (degenerative), etc. As an editable guide, content can be altered or enhanced as necessary, giving clinicians the freedom to record unique information accurately and retain only relevant information. Templates speed documentation, make transcription predictable, reduce turnaround times, enhance financial integrity and ensure complete and accurate documentation—all while meeting compliance requirements.

3. Meet the range of needs from corporate to clinic to physician
Every specialty is different. Every physician is different. One size does not fit all. At the parent level, organizations can decree the look and structure of documentation. At the clinic level, the workflow can be customized to mimic the current workflow, while a library of document types driven by the needs of their specialty can prompt required data and ensure proper reimbursement. Templates that generate content automatically require only exceptions be dictated. Simple documentation can be completed with point-and-click or self-edited front-end speech recognition. Alternatively, heavy patient

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workloads, extensive narrative documentation or personal preferences may sway physicians to send their dictation to be transcribed.

Robust, customizable settings mean physicians are presented with everything they want and need to complete the documentation task, all within the constraints set by the practice. Add the convenience and ease of a mobile app, and the benefits compound.

4. Drive physician productivity and satisfaction

Organizations that empower physicians to use their time wisely and provide the best care to their patients see staff morale and productivity thrive. Patients—and, it follows, medical facilities—are best served by providers who are free to focus on patient care and engage with patients rather than computer screens during exams. Dictation allows documentation to be created easily and quickly. If transcription is used, the second set of eyes of the transcriptionist reinforces documentation accuracy. By making EHRs easier to use, by requiring no loss of productivity and no compromises in documentation quality, physicians can see and leverage the benefits of housing patient information in an EHR.

5. Reduce documentation-related hard and soft costs

Faced with financial demands, organizations have begun monetizing the physician encounter—and the adage "time is money" rings true. The process of creating documentation by point-and-click can be cumbersome. Beyond typing or selecting menu items, users spend precious time navigating from screen to screen. Voice-driven documentation solutions can allow providers to use their voice to navigate, or to circumvent system navigation altogether, improving EHR usability and boosting physician productivity. Document and dictation templates further optimize the task of creating documentation by reducing the amount of typing or self-editing required. With less time spent on back office work, providers are free to see more patients. Optimizing physician productivity can maintain patient volume and maintain revenue levels.

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Cohesive success across IDN clinics

A solution that serves the physician, the administration, and the patient will deliver across-the-board success. The power of voice combined with robust technology allows organizations to achieve high quality, complete patient documentation without unduly taxing physicians, compromising thorough documentation or incurring excessive costs.

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