Documentation, the patient and your practice.

Tips to leverage documentation technology to improve service quality.
Today’s consumers are informed consumers. They have immediate access to endless vaults of information that drive purchasing decisions on everything from big ticket items to entertainment to dinner destinations. And healthcare providers are not immune. Physician rating sites are a click away, leaving clinicians and their practices vulnerable to subjective opinion.

There’s more than the online community to consider, too. Patient satisfaction survey results are playing a bigger role in provider success and reimbursement—hospitals and health care systems increasingly reward providers who obtain the highest rates of patient satisfaction. According to the Hay Group, a global management consulting firm, 66 percent of organizations rely on patient satisfaction to measure physician performance, with 50 percent using patient satisfaction to determine incentive pay.¹

Consumer reaction isn’t the only influence at play, either. Considering one out of three patients are referred to a specialist each year, largely by their primary care doctors, physician referrals are the life-blood of specialty practice success.²

It follows that marketplace opinion can affect the health of a practice significantly. So, how can practices ensure that the quality of their service measures up? A recent study³ shows that communication is a major factor when it comes to patient visits. For 73 percent of people surveyed, “time for discussion” was a key component to patient satisfaction, with 66 percent citing “verbal communication of specific recommendations.” For the referring physician, both quality of patient interaction and communication with the intended physician weigh heavily on the decision to refer.⁴ Patients and referring physicians alike are taking note—clinicians need to allot time and attention to build open, trusting relationships.

Time, however, is hard to come by in outpatient centers with high patient volumes, especially considering the corresponding documentation that commands a portion of their day. EHR systems aim to increase provider efficiency, when in fact, a study funded by the Agency for Healthcare Research and Quality found that following implementation, providers often had less time to talk to patients during a visit.⁵ Technology, applied effectively, can help improve care delivery and, consequently, marketplace opinion when it lightens the documentation workload and improves communication. By empowering physicians with the ability to use their voice to document rather than typing into an EHR, voice-driven solutions can free physicians to focus on their patients, increase clinician productivity, enhance documentation quality and support communication across care teams.

² http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160594/
³ “Healthcare from a Patient Perspective” eGuide, Nuance Communications, February 2015
Maximize physician productivity for more time with patients
With the increase in government requirements for documentation and the rise of EHR use, documenting care becomes a time consuming task that can affect the quality and quantity of time with patients significantly. Using speech speeds the process, giving providers precious minutes back to their day—time that can be used to engage with patients more effectively.

First, dictation is the fastest means to create documentation. Second, patient exams and conditions have a wide range of complexity. And clinician work-day demands and personal preferences can vary from moment to moment throughout the day. Documentation technology should allow clinicians to balance the time and effort they spend creating documentation. A library of dictation templates that automatically populate common content can maximize efficiency. If a case is simple, the clinician can dictate only the exceptions, expediting data capture and record completion. If the case is more complex, the clinician can dictate comprehensive narrative data and route the voice file for transcription rather than self-editing or typing. Either way, clinicians are well-served by the power to prioritize their needs at the point of care and complete documentation quickly without interacting with the EHR. Clinicians who feel less rushed are more able to communicate concern, care and priority to their patients.

Technology shouldn’t come between the patient and the provider
A recent study reported that 36 percent of physicians feel EHRs interfere with face-to-face communication with patients. While patients are comfortable with the growing role health IT is playing in their care experience, they are less accepting of the technology if it distracts or interferes with their conversation time with their caregiver. Clinicians who leverage voice-driven documentation methods are free to focus on their patients rather than a computer during exams. Unencumbered by a keyboard and mouse, clinicians can make eye contact, give a handshake, and position themselves near the patient—all factors shown to be important for a positive encounter.

Improve documentation quality and accuracy
The most rewarding part of a clinician’s work is attending to the people who need and appreciate their time, insight and care. The burden of documentation can tempt clinicians to take shortcuts in the EHR—being overly concise, using copy and paste functions—in order to channel more time towards patient interaction. Short-changing documentation can lead to inaccuracies and compliance issues that will ultimately have a negative impact on reimbursement. Using voice-driven methods to document allow clinicians to capture important data quickly and to accurately express the patient’s current health status through narrative documentation—without sacrificing time with patients.

7 Ibid
Speed documentation accessibility
We live in the age of impatience, and people who are sick or in pain want instant results. Delayed documentation can mean delayed treatments, rescheduled procedures and unhappy patients. By helping clinicians capture structured data for the EHR with less time and less effort, the EHR is easier to use and data is stored more immediately. Clinicians can use front-end speech recognition technology to navigate and document into sections of the EHR. With mobile applications, clinicians can dictate and self-edit content generated by a speech recognition, or create voice files that are routed for transcription. Regardless, document creation is more efficient and data is accessible in the EHR quicker than ever. Prompt turnaround means clinicians can make informed decisions faster and documentation can keep pace with patient care demands.

Support care team communication
Primary care physicians are often mainstays in a patient’s life, and a trusted resource when more specialized care is required. When expanding the care team for a patient, primary care physicians seek specialists who faithfully facilitate continued involvement in the patient’s care. Prompt, comprehensive communication allows referring physicians to receive timely updates on the patient’s condition and conduct worthwhile follow up appointments with up-to-date insight and readied compassion. Documentation technology that automatically routes correspondence to physician offices upon authentication can fortify the referring physician relationship and strengthen the continuum of care without burdening administrative staff. Systems that feature electronic tracking of physician referrals can help practices identify both advocates as well as weaknesses in the market—a great resource for marketing campaigns that extend gratitude or grow awareness.

Clinical documentation solutions elevate service
To be successful in the healthcare industry today, physician groups must focus on delivering excellent care by developing protocols that incorporate what matters most to patients and their network. At the root of it all is documentation. When, how and what is captured shapes the patient experience and influences the clinician experience—ultimately helping improve service quality and industry standings.

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