NUANCE

Three great reasons (and the evidence) to speech-enable your clinical documentation

The pressure is on for healthcare organisations to improve the quality and volume of clinical documentation. For healthcare professionals, high quality, accurate, up-to-date patient records enable better teamwork and collaboration, improve the speed and accuracy of clinical decision making, and boost productivity. For patients, complete records enhance communication and continuity of care leading to better outcomes and improved safety. For everyone in Australia's healthcare system, complete clinical documentation makes claiming and budgeting more efficient and improves regulatory, legal and financial reporting. Good quality clinical documentation captures the full patient story and is a rich source of data (once patient privacy has been assured) for medical research that benefits the whole community.

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Stay ahead of evolving healthcare

Technology is changing modern healthcare at an unprecedented rate. More than two-thirds of Australian GPs now exclusively use electronic medical records.¹ However, despite extensive investment and widespread computerisation, many healthcare professionals are struggling to harness the full benefit of a paperless system.²

Health professionals under pressure

Healthcare professionals are already bearing the brunt of formidable challenge and reform in the industry – tighter resources, rising costs, greater treatment complexity and escalating patient expectations. The growing demand for comprehensive, high quality documentation is adding to the pressure.

An Australian Medical Association survey on red tape says doctors spend nine hours a week on administrative duties and four hours on Government paperwork alone, at a cost of around \$15,000 a year in lost income.³ A study published in the Medical Journal of Australia shows more than 12% of GP⁴ consultations involve additional unbillable time arranging tests and referrals, consulting specialists or allied health professionals, medication renewals, and advice and education, all of which require documentation. If claimable through Medicare, the value of this time ranges from \$10 000 to \$23 000 per annum per GP⁴ - a significant drain on practice income and our fee-for-service system.

The heavy documentation load also poses a risk to crucial doctor-patient relationships. Focus inevitably shifts to the device rather than the patient, as clinicians scroll and hunt through screens in all the various clinical software, navigate pull down menus and check boxes, and labour over their typing. Factor in the effort needed to complete all the requisite paperwork and there is a real risk that the essence of the patient story becomes overly distilled. So often, the nuances of the patient journey can disappear replaced instead with a collection of unconnected data points.



Understand the clinical process impacts of documentation in acute care. Source: Accuracy and completeness of clinical documentation Report June 2015^{\prime}

Challenge

How can we make it easier and quicker for doctors, nurses and other health professionals to meet high clinical documentation standards and provide exceptional care to patients?

Speech recognition - tomorrow's solution today

Automated speech to text software works with all kinds of record-keeping applications, from the GP desktop and office software, to electronic health records (EHR) and Patient Administration Systems (PAS). In a report from the UK's Nuffield Trust⁵ on the benefits of digital healthcare, 'voice-recognition' technology is highlighted as one of the most obvious ways healthcare professionals can reduce the time spent on routine communication and administrative tasks.

In Australia too, speech recognition technology is helping to bring Australia's plans for a truly integrated digital health network to life. Great strides have been made in the quality, accuracy, performance and affordability of clinical speech recognition tools and healthcare uptake is growing fast as more users experience its speed, efficiency and ease of use.

Why does speechenabled clinical documentation make sense now?

For the healthcare professional

The time healthcare professionals dedicate to interacting directly with patients is shrinking and can account for less than 13 per cent of their day.⁶ In addition, research shows that healthcare professionals spend more than 50 per cent of their working day creating, reviewing and updating clinical documentation.⁷ In the US, a busy doctor can produce enough clinical documentation to fill 40 books of 400 pages each year – the equivalent of 7.2 million words.⁸

Quality time with the patient

Speech recognition tools allow healthcare professionals to capture patient data and complete clinical documentation more than twice as fast as typing and with greater accuracy and completeness.⁹ Using voice to text, users can navigation more quickly around the software, use voice commands to automate repeat functions or jump to specific screens, call up templates and associated documents, and insert often repeated standard texts. Virtually all mouse actions can be replaced with voice commands and tailored to create a completely personalised workflow. Practitioners who are using Nuance's Dragon Medical speech recognition solutions report significant time savings – from 40 minutes for a nurse on an intensive care ward¹⁰ to as much as 2 hours in a typical day at the surgery for a GP.¹¹

Despite all the extra work and time pressures, healthcare professionals want time to understand the complexities of each case, listening to and counselling patients, putting them back at the centre of care. Patients too highly value having sufficient opportunity for discussion, advice and recommendations, privacy and engagement with their healthcare provider.¹²

Speech-enabling clinical documentation not only saves time but also frees the healthcare professional from their keyboard and the screen, enhancing their communication and relationship with their patients.

Quality documentation

The use of speech recognition improves the quality of documentation by reducing repetition and the potential for errors and eliminating duplication of effort. Not only does it streamline the process of recording 'structured' information in forms and health records but speech recognition also encourages healthcare professionals to document the patient story (narrative) more fully, including all its subtleties and uniqueness. A recent study⁷ shows 68 per cent of clinical documentation is narrative. The rate at which speech recognition speeds record creation demonstrates its potential to improve both the volume and quality of time available for patient care. A complete, detailed patient record that goes beyond basic facts makes it quicker and easier for healthcare professionals to share vital information and helps guide and speed the transfer of care as patients move along the care pathway, from triage to consultation, referral and discharge.



or more is the time doctors and nurses spend with clinical documentation processes.⁷

Enjoyment and satisfaction at work

A substantial 80 per cent of healthcare professionals say good patient relationships are the most satisfying part of their job.⁶ However, many are becoming de-motivated and frustrated because of administrative overload and a consequent lack of time to spend with patients.⁶ Speech-recognition improves the day-to-day working lives of healthcare professionals by enabling them to produce detailed, accurate clinical records as quickly as they can think and speak. It puts them in control, giving them more time to focus on patients, confident that the documentation they produce sets the standard for better quality care.⁶

"Speech recognition has raised the bar on the quality of our clinical notes. There is much more detail, the notes are easier to read and the quality of the information is so much better."

Peter White, Paediatric Intensive Care Unit Nurse Alder Hey Children's Hospital

"Thanks to the time speechrecognition saves me, I can now see four or five more patients during the day, and the more patients I can see, the better this is for our patients and, commercially, for the surgery."

Bhagyesh Patel, General Practitioner Station Medical Clinic, Chatswood, NSW

"Today I dictate the conversation I had with the patient right after their consultation. The technology has definitely made my life easier. The accuracy is great. It copes perfectly well with my Scottish accent. I have to say that I love it."

Professor Peter Illingworth IVF Australia, NSW

For the patient

The relationship between healthcare professionals and patients is at the heart of all treatment and healing. This begins with good communication and personal interaction but all too often, technology and the pressure to record the consultation in regimented templates and forms, gets in the way. A patient survey¹², commissioned by Nuance to identify what patients want and need from their doctors, indicates that patients are comfortable with the growing role health IT is playing in their care. However, they are less accepting of technology when it distracts or diminishes conversation time with their healthcare professional. The study shows that 40 per cent of patients feel rushed during a visit to their doctor. For more than 30 per cent, an appointment lasts less than 10 minutes – the time it takes to hard boil an egg.

Quality time

Using speech-enabled clinical documentation frees healthcare professionals from significant red tape and gives them more time to observe, listen and interpret the patient's story thereby putting the patient firmly back at the centre of care.

Speech enablement also encourages complete capture of the patient story – both the detailed narrative as well as the "structured" data pre-set forms and templates require. For complex cases, where patients require multiple treatment protocols and the support of multi-disciplinary teams, the whole team benefits from having a fuller and more accurate picture of the patient and their needs which leads to improved treatment co-ordination and better results.

Continuity and quality of care

Speech–enabled clinical documentation not only frees up healthcare professionals' time and ability to focus on the patient, it also helps improve care. As patients hear what is being said and recorded in their notes during a consultation, they become more informed and engaged in their own case management. Consequently, they are more likely to actively participate in treatment and to experience improved health outcomes.



...of patients feel rushed during the visit with their doctor.



...of clinical documentation is narrative and difficult to capture in the standard templates and click boxes of an EHR.

For Australian healthcare

Digitised clinical documentation is the cornerstone of Australia's vision for a fully-integrated national eHealth network that will deliver productivity benefits for healthcare and quality outcomes for patients.

Ongoing investment by all Australian Governments in the *My* Health *Record* shared EHR demonstrates their commitment to this vision and the pressure is on to show how this investment is paying off in today's tough financial environment.

Accelerate adoption of eHealth

There are technical and cultural barriers to the uptake and adoption of the *My Health Record* and other shared record systems but simplifying and naturalising the user interface, using speech to input the data, removes the greatest barrier of all – that of overloading the healthcare professional with more administrative red tape. Speech recognition technology is fast becoming one of the most used tools in the quest for eHealth adoption because it improves clinical documentation, anywhere, any time, and on any device. It puts healthcare professionals back in control and ensures that there is faster and greater take-up of the national system to more quickly return the investment.

Improve efficiency, productivity and turnaround times

Research from the UK has found that healthcare professionals spend up to half their day creating and updating clinical documentation, and another 52 minutes a day⁷ searching for information they cannot find in shared clinical records.

- Speech-enabled clinical documentation supports the creation of a more complete and accurate patient record at the point of care.^{6,10,12} This offers important flow-on benefits by reducing the incidence of missing information, improving communication between providers and enhancing the patient experience.
- The use of speech-recognition integrated into health records and other clinical documentation also improves individual productivity for healthcare professionals, freeing them from the burden of administration to focus on more patient-centred, higher value tasks.^{10,11,12}
- Speech-enabled clinical documentation helps eliminate paperwork backlogs because referral letters, discharge letters etc can be created, signed and forwarded at the point of care. This enables organisations to achieve turnaround targets and minimises inefficiency related to clinical documentation and communication between healthcare organisations and patients.
- High quality clinical records also deliver more accurate coding for quicker claiming and reimbursement and make it easier to meet regulatory, legal and financial reporting requirements. For medical research, high quality clinical documentation provides a rich source of data (once patient privacy is assured).

Employee satisfaction

Speech-recognition integrated into clinical documentation can help to avoid burnout. Healthcare professionals begin to feel better about documentation, more in control and more satisfied at work. They feel more confident about technology and have a better experience. Now the 80% of healthcare professionals who find patient relationships are the most satisfying part of their job⁶ are free to get back to practising the art of medicine.

\$15,000

a year in lost income is the cost to Australian GPs who are spending 2.5 hours each week on non-billable patient care.³



per annum per GP is the cost of unpaid time spent on patient care, if it was claimable through Medicare.⁴

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Nuance Healthcare is a divison of Nuance Communications, Inc. (NASDAQ: NUAN), the leading provider of voice and language understanding solutions, transforming the way people interact with the devices, systems, apps, and services that surround them. Nuance Healthcare provides solutions and services that improve the entire clinical documentation process - from the capture of the complete patient record to clinical documentation improvement, coding, compliance and appropriate reimbursement. More than 500,000 clinicians and 10,000 healthcare organisations worldwide leverage Nuance's award-winning, voice-enabled clinical documentation and mobility solutions to support the physician in any clinical workflow and on any device.



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