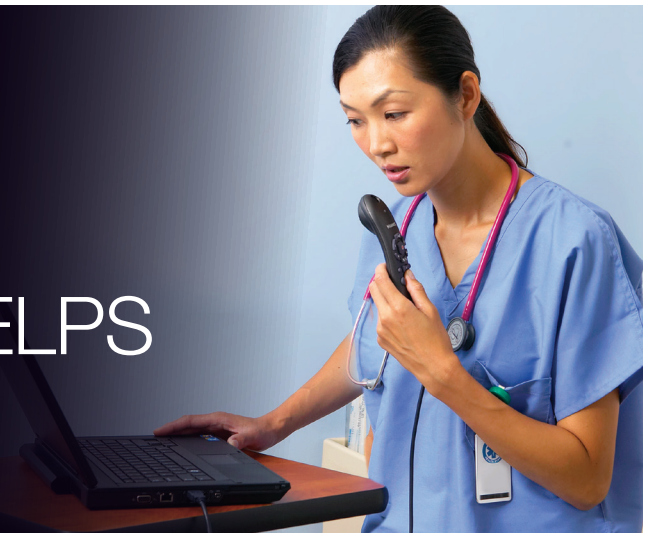
INNOVATIONS IN CLINICAL LANGUAGE **UNDERSTANDING** HELPS PREPARE FOR ICD-10



Computer Assisted Physician Documentation

Facilitates Higher-Quality Clinical Documentation, Improved Reimbursement, and Easier Transition to ICD-10

CHALLENGE:

Healthcare in the United States is entering a new era of accountability. Health systems are under pressure to optimize clinical documentation practices to align reimbursement with delivered care and clinical outcomes. The impending migration to ICD-10 in 2014 is one of many manifestations of the expanding complexity of government and private payers' clinical documentation rules and regulations. Missing or unclear information in clinical documentation impacts data integrity and does not adequately hold up to compliance audits, or provide the specificity or detail required for analysis and process improvement. And a changing payment environment will require new ways to maintain current reimbursement levels.

SOLUTION:

Computer Assisted Physician Documentation (CAPD) offers you a more sophisticated approach to tackling the most complex documentation challenges. With revolutionary Clinical Language Understanding (CLU) technology and over 20 years of innovation

KEY BENEFITS

- Prepare for transition to ICD-10 today through continuous documentation improvement
- Accurately capture the level of care provided to ensure appropriate reimbursement
- A clinically focused approach to documentation improvement improves the ability to manage population health and function successfully in an ACO and shared payment models
- Concurrent clarifications reduces the number of retrospective queries from coding teams and reduces A/R time

KEY FEATURES

- Automated, fast, and consistent feedback to physicians
- Cloud based solution integrates with: Dragon® Medical 360 | Network Edition, Dragon Medical 360 | eScription™, Dictaphone® Enterprise Speech System, and direct entry into EHR documentation workflows
- Creates detailed audit trail of clarifications and physician responses to facilitate continuous process improvement

driving Clinical Documentation Improvement (CDI) success, Nuance® Healthcare solutions powered by J.A. Thomas Advanced Practice Clinical Documentation Improvement strategies go beyond just using documentation to support coding. Automated, clinically appropriate guidance and clarifications are presented to physicians at natural points during their workflow. It is imperative that physicians document the care provided as well as the rationale behind their actions.

Unlike retrospective coding based programs, our solution offers a concurrent review process, with appropriate clinical guidance allowing physicians to accurately capture compliant documentation, complexity levels and severity levels in their documentation from the moment the patient enters the healthcare system.

INTEGRATES INTO PHYSICIANS' WORKFLOW

CAPD is designed to integrate into physician clinical documentation workflow and deliver clarifications before physicians complete and sign their documentation. This design increases acceptance by physicians and improves the response rate to clarifications. All clarifications and responses are recorded in a detailed audit trail that can be used to generate operational and administrative reports, to help evaluate organizational compliance and identify challenging areas for additional focused training.

POSITIVE IMPACT ON PRODUCTIVITY

By focusing on improving quality while clinical documents are being created, CAPD can help reduce disruptions to physicians that may result from manually generated retrospective queries. This innovative technology can also increase staff efficiency by analyzing documentation for all patients, and all payors, automating the most common clarifications and reducing the time CDI specialists and coders spend looking for details and waiting for physicians to respond. Understanding which clarifications have been presented to physicians allows CDI specialists to focus their attention on more complex cases and additional areas for quality improvement.

CONTRIBUTES TO IMPROVED REIMBURSEMENT

CAPD automates the most common clarifications, making the current review process more efficient and speeding up coding and billing. The process changes from coding based retrospective and manual queries to concurrent and automated clinically focused clarifications. By capturing the documentation they need from physicians proactively— while patients are still in the hospital—coding and documentation review teams are more effective, efficient, and productive. Accurate capture of patient complexity, risk of mortality, and complications can help improve hospital's case mix index, which has a direct impact on reimbursement.

PREPARE FOR THE TRANSITION TO ICD-10

The unique combination of CLU technology and the J.A. Thomas clinically focused compliant documentation management guidelines automatically analyze physician documentation and, only when necessary, interactively suggest concurrent clinically appropriate guidance along with supporting evidence. Our clarification strategies are fully compliant with The Coding Clinic and ICD-9-CM Official Guidelines, and they lay the essential foundation for your transition to ICD-10. Improved documentation supports an even more efficient transition to Computer Assisted Coding for your coding teams.

HOW COMPUTER ASSISTED PHYSICIAN DOCUMENTATION WORKS

CAPD seamlessly integrates with the way physicians prefer to document clinical encounters. Using Dragon® Medical 360 | Network Edition physicians can dictate directly into the Electronic Health Record (EHR) system or through traditional dictation and transcription services powered by Dragon Medical 360 | eScription™ and Dictaphone® Enterprise Speech System.

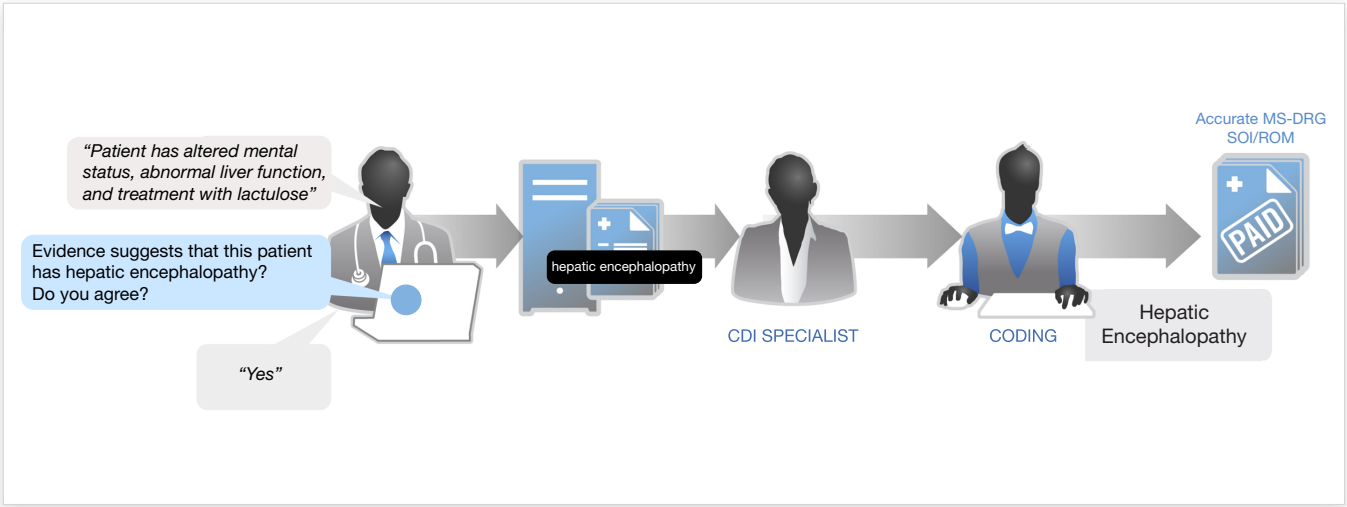
Here's how: CAPD will automatically detect missing diagnoses or procedures strongly suggested by data presented, unclear associations between relevant findings, or unspecified diagnoses.

CAPD then generates a clarification that proposes a specific diagnosis or procedure strongly suggested based on evidence from one or more of the patient's documents collected from this admission. The clarifications allow the physician to document their findings in the next progress note or final discharge summary.

Consider for example a new patient to your healthcare system seen in your Emergency Department for altered mental status and severe abdominal pain. Through the course of their initial assessment, documentation includes a past medical history of cirrhosis, lab values including low hemoglobin, high SGOT and melenic stool, an EEG order and prescription for rifaximim and lactulose. While completing the note, the physician is presented with automated clarifications proposing diagnoses of hepatic encephalopathy and anemia of blood loss, as suggested by the evidence shown in the patient's documentation. The physician is able to confirm the relevance of the hepatic encephalopathy and the blood loss anemia and make the appropriate adjustments in the patient's documentation.

Capturing all diagnoses makes it possible to set the principal diagnosis correctly at the beginning of the patient's stay, and helps to ensure that appropriate treatment and care shorten the overall length of stay, guide post discharge care and reduce potential readmission. The severity of illness and risk of mortality will be accurately documented and proper details will be available for coding either manually or using Computer Assisted Coding for the correct DRG assignment.

HOW CAPD WORKS



Additionally, benefits of documented secondary diagnoses include:

- Accurate mortality index, observed and expected mortality stats (O/E)
- Appropriate severity of illness (SOI) for public report cards
- Accurate APR-DRG Severity of Illness and Risk of Mortality
- Favorable preparation for ICD-10

CAPD automatically reviews all physician documentation for a patient's stay, looking at the patient's story in its entirety, and asking physicians for more information only when necessary. As physicians become more specific in their documentation, the number of clarifications will naturally reduce. Clarification response and agreement rates are maintained in a comprehensive audit trail, allowing for evaluation and continuous improvement of clinical documentation improvement processes. Automated review means every document, for every patient, is evaluated with the same level of consistency and high quality, leveraging the latest published guidelines, which are automatically updated on a regular basis. This helps to immediately increase the coverage of concurrent documentation review programs without the need to increase staff.

MAKE ADVANCED PRACTICE CLINICAL DOCUMENT IMPROVEMENT YOUR KEY TO SUCCESS

A clinically focused documentation improvement strategy will ensure your physicians have the tools and guidance they need to approach the challenging new face of documentation requirements with confidence.

CAPD offers both the technology and clinical guidance necessary to help you work smarter to keep up with ever changing demands of clinical documentation. We provide the tools, education and best practices to ensure your success.

NUANCE HEALTHCARE'S VOICE AND CLU SOLUTIONS

Nuance Healthcare is the right partner to help physicians and organizations transition to structured data creation, while enhancing the quality of clinical documentation, adoption, and utilization of the EHR system. Nuance Healthcare leverages its considerable voice and CLU technology assets—the industry's largest portfolio, extensive knowledge and experience, and integration of cutting-edge communication and mobile devices—to create the right solutions for each physician. Moreover, Nuance Healthcare's partnerships with all major EHR vendors ensures clinicians direct access to their choice of clinical documentation workflow while data flows seamlessly into the EHR system.

ABOUT NUANCE HEALTHCARE

Nuance Healthcare, a division of Nuance Communications, is the market leader in creating clinical understanding solutions that drive smart, efficient decisions across healthcare. As the largest clinical documentation provider in the U.S., Nuance provides solutions and services that improve the entire clinical documentation process—from capture of the complete patient record to clinical documentation improvement, coding, compliance and appropriate reimbursement. More than 450,000 physicians and 10,000 healthcare facilities worldwide leverage Nuance's award-winning voice-enabled clinical documentation and analytics solutions to support the physician in any clinical workflow on any device.

To learn more about how Nuance Healthcare can help you improve financial performance, raise the quality of care, and increase clinician satisfaction, please contact us at 866-748-9537 or visit www.nuance.com/healthcare.