WHITE PAPER

5 High-Value Hospital Processes to Enhance your Digital Health Strategy

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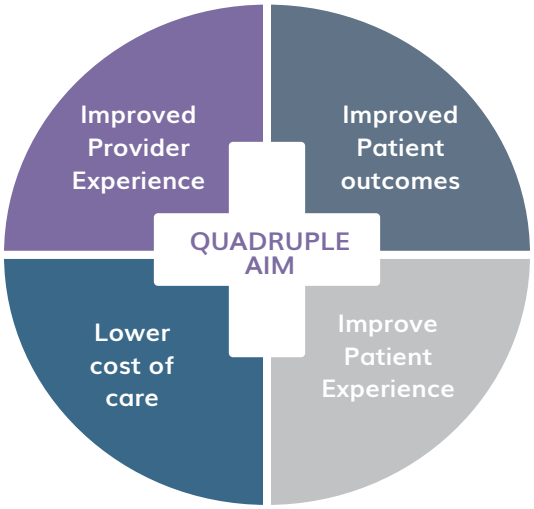
Modern healthcare is at a crossroads. In one direction - endlessly increasing demand and complexity. In the other - higher costs and shrinking budgets. We've walked both of these paths and tried what feels like every permutation of possible tracks towards sustainable, safe, economically viable healthcare.

It is time to look beyond outcome measures and consider how healthcare process improvements can improve the system, support clinicians to work efficiently and ensure safe healthcare is accessible to all who need it.

Workflows that enhance system efficiencies and make the clinician's job less administratively burdensome while crucially, partnering with the patient at the centre of the service are essential to providing high-quality care.

Governments and healthcare providers aim to reduce cost and effort in an efficient, streamlined system. Known now as the 'Quadruple Aim' in the Digital Transformation space, it is acknowledged that successful implementation of the modern electronic medical record (EMR) must address all four elements.



We propose that five key workflows enhance the patient experience and support health professionals to provide the best care available.

- **Referral management process**
- **Clinician order entry process**
- **Clinical coding and billing processes**
- **Discharge planning and summary process**
- **Health Information Management**

Each of these workflows will be explored in this white paper from the perspective of clinician engagement, administration demand, and patient experience.

We consider how a well-implemented electronic medical record solution can support these workflows by utilising a process improvement model leveraging data to inform practice and system development.

The utilisation of a patient-facing information and engagement portal is also considered the key facilitator to a person-centred model of care.

The provision of safe, reliable, and consistent healthcare is an expectation all Australians hold as a right that they recognise as a benefit of living in this country. National economic systems have been built around ensuring high quality, evidence-based healthcare is accessible to all citizens irrespective of location or income.

The private health system augments and builds upon the public system, providing an alternative to care by location, provider and/or services available. Australian healthcare providers have capped budgets within which they are expected to achieve responsive services to an

ever-increasing demand [3] and cost per episode of care.

Patients have access to a wide range of information about healthcare options and data which informs their expectations of what 'good care' looks like. Health professionals then need to negotiate the competing demands of compliance and accountability frameworks with patient expectations and budgetary limitations.

It's a conundrum; well-trodden solutions can no longer be relied upon to avert the inevitable juncture where resourcing doesn't meet demand.

On top of this, the Covid19 pandemic has pushed the resilience of clinicians to the brink.

Medical, nursing and allied health professionals work together to provide team-based, coordinated care from admission to recovery supported by outpatient specialist clinics and community-based services.

Therefore in this paper, we will refer to the 'clinician' and mean any of the health professionals involved in the care of the patient. Attraction and retention of staff committed to ongoing employment in our hospital system have become a significant issue threatening access to care, particularly in rural and regional Australia.

Processes that improve clinicians' ability to do their jobs efficiently are key to improving the clinician experience. Well-designed processes and systems can relieve them from administrative tasks that do not contribute directly to patient care which can improve patient outcomes, and safety while reducing risk.

Every single process undertaken in the delivery of Australian organisation healthcare creates data that, when well analysed, can be applied to the complex challenge of process improvement. Ideally access to care and flow through the system should be consistent, timely and appropriate.

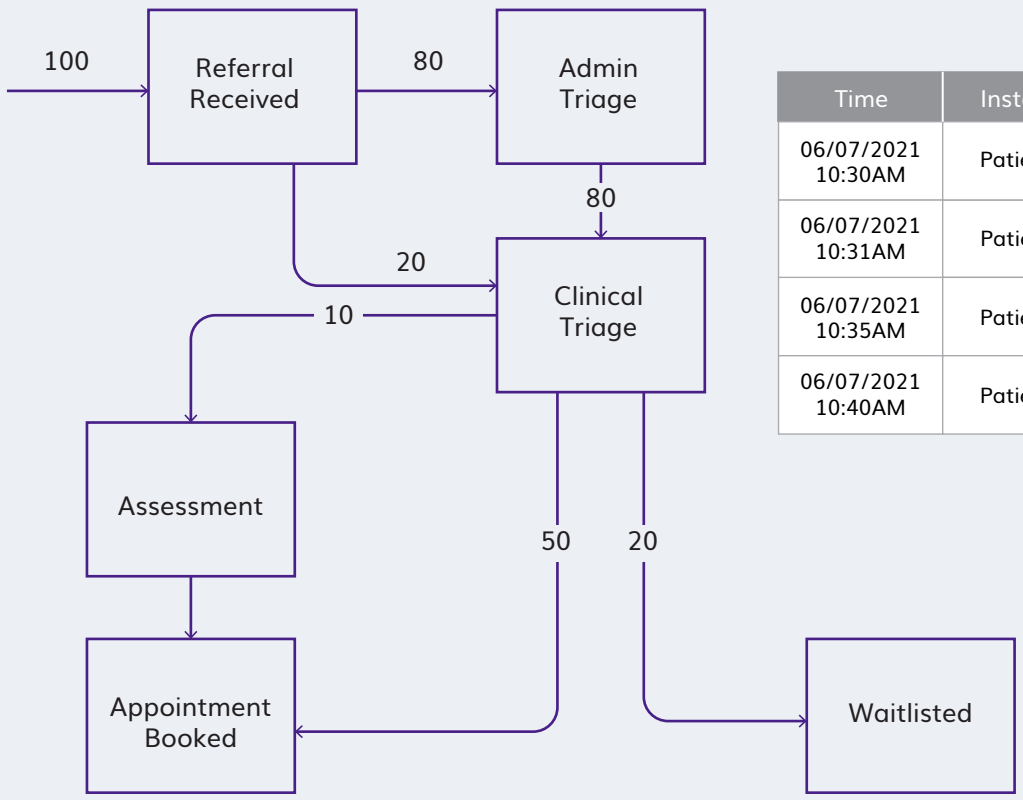
We know that any delay or interruption to the process of care ultimately impacts the patient's experience of care. After so many years of dedication to the creation of a healthcare system of such high quality, where do we go now to take the next leap into system improvement?

The answer lies in the application of a process improvement model. Process improvement science collates multiple data points from a system and gives visibility to the performance of the process across multiple unique instances.

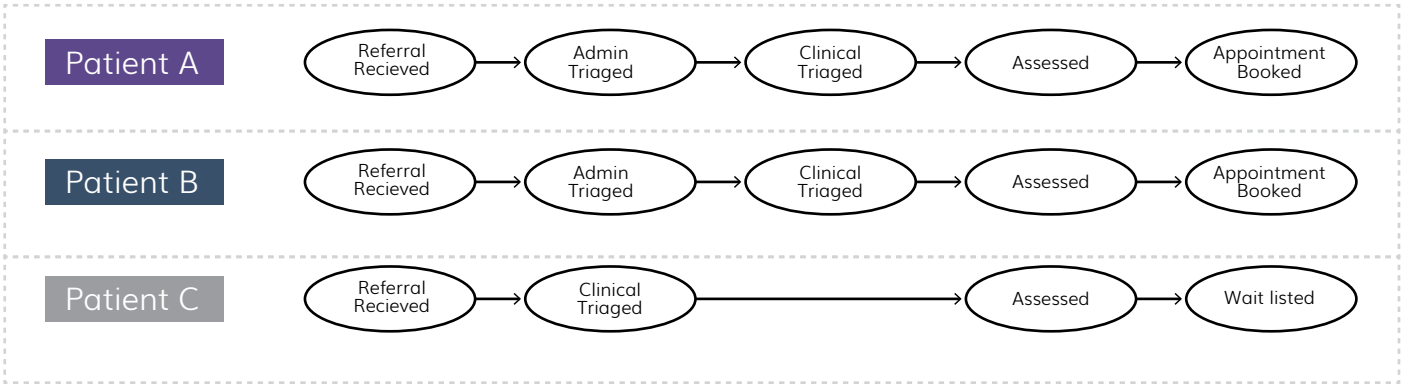
Application of analytics to the data then enables a service to identify where there is variance in a system, where there is an opportunity to improve a process to be leaner, more cost-effective, more consistent or even where there are redundant steps.

When we capture the right data, in the right place, we get the analytics of actual pathways and flow. Only then can we make informed decisions when it comes to resource allocation or system development.

Process measures are the steps that are taken by a multi-disciplinary team during the course of providing care. Some of those processes are undertaken by admin, nursing, medical, pharmacy, allied health staff – with different purposes and in different environments. Healthcare Processes are rarely a linear workflow – there is variety and rules and exceptions.



Time	Instance	Event
06/07/2021 10:30AM	Patient A	Admitted
06/07/2021 10:31AM	Patient B	Pre-admission
06/07/2021 10:35AM	Patient A	Triaged
06/07/2021 10:40AM	Patient C	Discharged



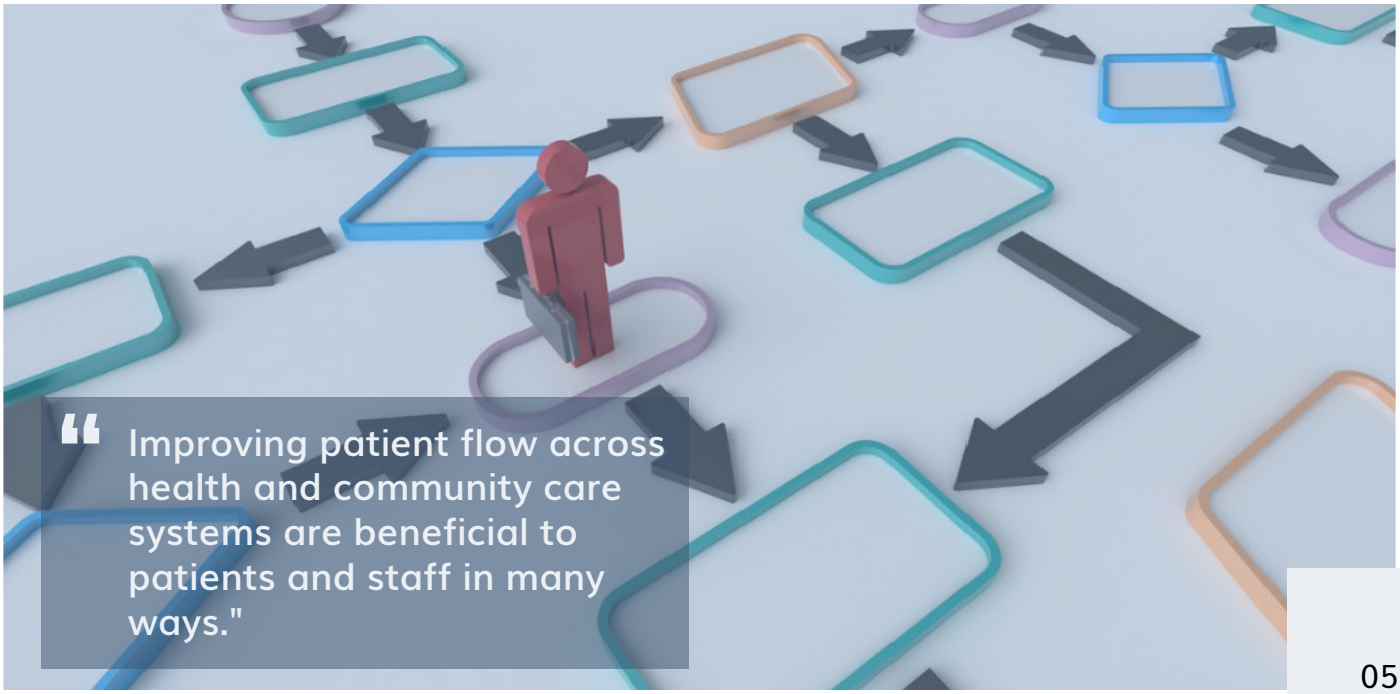
Patient care could be compromised when the step in a process are not all followed – or not in the right order.

Process analytics requires the data for every step to be captured digitally so that it can be analysed both vertically and horizontally – by patient and by task.

The analysis of this data can help examine if the process needs improving, if there are too many exceptions, how often compliance is met.

This paper outlines five key processes that can ultimately improve the patient experience of healthcare and:

- Streamline clinician workflow at the bedside
- Increase available time for direct care by reducing clinician administrative effort
- Standardise administrative processes supporting access and flow
- Improve the lived experience of the patient receiving care
- Make patient information accessible and
- Make compliance and accountability to standards and funding simple and consistent



PROCESS #1
Referral Management process

Referral = sending a patient to the right service with the right knowledge and the right resources to provide the right care, ideally at the right time.

Health professionals use terms like 'warm handover', 'warm referral', and 'hand to hand'. These are all examples of behavioural referral processes whereby one health professional or service introduces their patient to another to ensure a seamless and safe transition between services.

This model exists for two reasons. One is to give a personalised approach to the transfer of care from one service to another, usually in the community system. It builds trust and confidence and increases the likelihood of patient engagement in their care.

The other? A long history of patients lost to the system or receiving delayed or incomplete interventions due to missing, incorrect, or misdirected referrals that sit in email inboxes, as paper in a pile on the side of an administrative officer's desk or in the ether of a stand-alone electronic system.

Entry to Australian healthcare services and achievement of integrated care planning is dependent on successful information sharing and transfer of patient data between healthcare services.

We know that the referral management process must be improved because:

- Clinicians are frustrated at the time and effort required to create accurate referrals.
- Clinicians are frustrated when their referrals are delayed or lost, and their patients don't get the care they have requested.
- Patients are frustrated by the need to repeat their personal information which raises questions about the competence of the service and the security of their data.
- Patients are frustrated by the need to chase up where referrals have gone to activate the care that they need.
- Health services require accurate referral information that meets funding requirements.
- Health services bear an intense resource demand to manage the referral burden.

Between the admitted hospital system and non-admitted outpatient services, tens of millions of referrals move through the Australian health system annually.

> "Incomplete and inappropriate referrals to specialist clinics can contribute to large wait lists and increase the waiting time for patients attending their first appointment."

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When referrals go wrong, the impact on patient care, service reputation and the business bottom line can be significant.

The periods of shut down of elective surgery due to Covid19 pandemic responses in most states have highlighted just what can happen when a referral isn't triaged and processed through to care in as consistent and timely a manner as would ideally be clinically indicated. Patients have had to wait longer for non-urgent surgical reviews than pre-2020. In the extended time between identification of need and the resumption of elective surgery, many patients have found their condition deteriorating, ultimately resulting in a more severe presentation, longer inpatient lengths of stay and rehabilitation.

The social and economic impact of this includes increased absences from work and school and reduced participation in usual activities of daily living. [6] We must learn from this experience. The impact of delayed treatment is increased costs to our healthcare system in domains of time, complexity, inpatient and outpatient length of stay (LOS) and patient satisfaction. Understanding the detail of what is happening in the system between generating a referral and the patient walking through the door into their patient walking through the door into their appointment is data that has the power to help improve this process to meet our expectations of person-centred care.

Individual sectors and services have established referral management processes to suit their businesses. Systems exist already that can receive an electronic referral and pre-fill the details into the patient record, reducing duplication and effort required in the transition of data from one system to another. These systems are built to augment clinical referral workflows, make them easier to apply, to streamline visibility of the process, while not replacing clinical decision making.

The Mental Health Royal Commission in Victoria acknowledged this situation of service-specific systems, noting that while individual solutions may achieve the intended function for one provider, the lack of integration across the sector actually contributed to the risk of harm.

The record should be a single system created and maintained for the whole state across age cohorts'. [5]

The application of data analytics has already identified common process improvements across the healthcare system that streamlines referral management. How can a holistic, whole-of-sector record improve care and reduce the risk of a referral going wrong and failing to perform its function? By:

- Capturing patient information the first time, every time, completely and correctly.
- Enabling patients to provide identifying information once only and then see it captured correctly in their record and at subsequent interactions with healthcare via the patient portal.
- Removing the risk of errors in information when shared.
- Requiring no administrative repetition or duplication.
- Capturing data that complies fully with funding obligations
- Is easy to access - no need to print paper copies, file duplicates.
- Is available to access - Multiple people, sites and services (clinicians, patients and administration) can view and interact with the information at the same time.
- Coordinating care planning involving both patients and clinicians across multiple care providers

A fully integrated EMR holds service information and facilitates simple, error-free access to service databases ensuring that clinicians no longer need to search separate sites, are unaware of a patient's full history or care plan, and enables patients to work with their providers to ensure their care is coordinated, planned, and visible to all involved.

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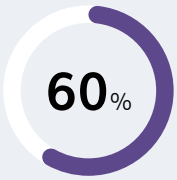
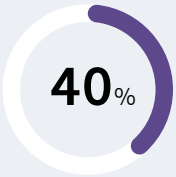
Misuse (of information) or errors affect up to 20% of hospital admissions. [7]

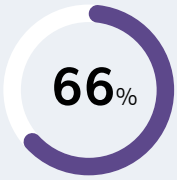
Of 11.1 million admissions for admitted inpatient care in 2019-2020



60% were in public institution



40% in private hospitals



66% of elective surgery is performed in private hospitals.

Australian Institute for Health and Wellbeing [8]

YEAR	2019-2020
Admitted	11.1 million hospitalisations
Non admitted	38 million events
Elective surgery waiting list additions (Public hospitals)	837,839 (+6.6% prev year)
Elective surgery waiting times (ave days) (Public hospitals)	39 (20th %) - 281 (90th %)

66% of health professionals identified improved, easy-to-use patient identification, booking and registration systems as something that would make their jobs easier. [9]

PROCESS #2
Clinician Order Entry process

Pharmacy. Pathology. Imaging.

Every day in specialist clinics, hospital wards and doctors' rooms, clinicians place orders for tests, prescriptions and for myriad treatment regimes for the patients in their care. Australian government data shows that more than 500 million pathology orders are written, conducted and reported on each year and play a key role in more than 70% of medical diagnoses. [10] Thankfully, we have moved on from handwritten prescription notepads with stereotypically illegible handwriting. Electronic order systems marry intuitive technology with data into order sets that facilitate a precision medical model. EMR modules are designed utilising data from process analytics to meet the specific needs of specialist fields such as Oncology medication ordering systems or Diagnostic Cardiology reporting and monitoring systems. As with other functions of an EMR, electronic ordering is important as it:

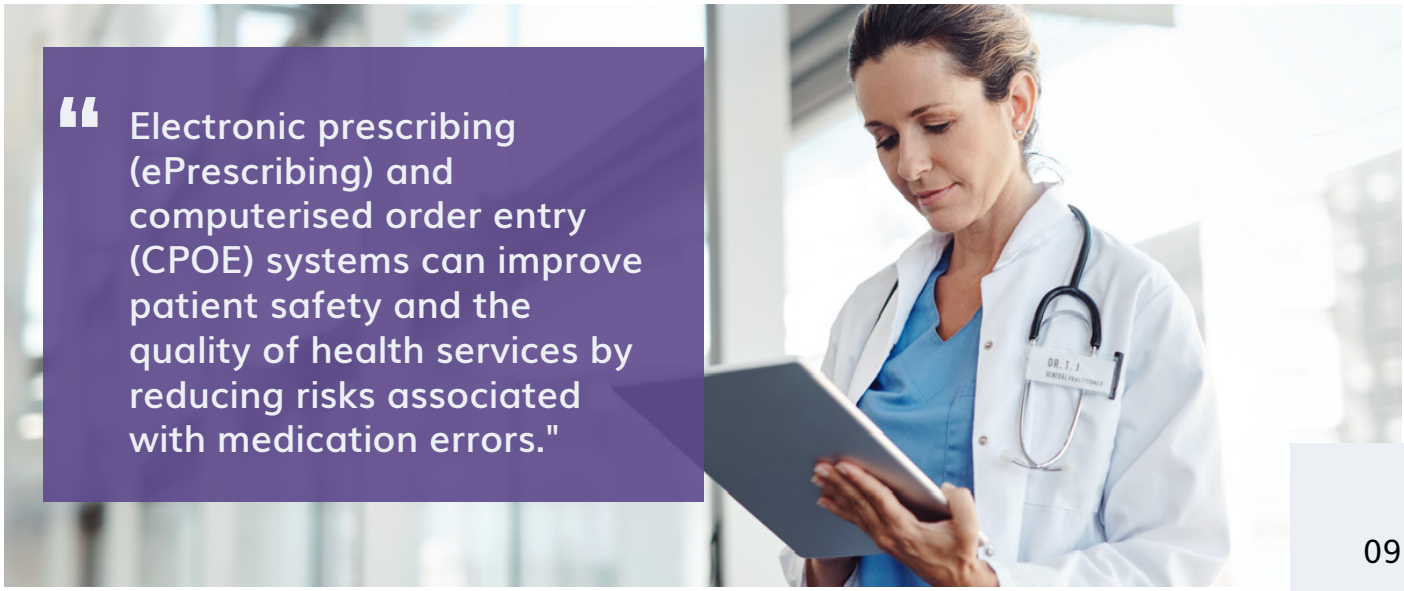
- Improves accuracy and efficiency
- Reduces errors
- Reduces storage and handling

Electronic prescriptions give patients greater choice and autonomy to manage their medication regimes, balance cost, and even choose brands.

How could we improve this process if we already have technological solutions? Why would we consider the modern EMR if what we have is already working?

Data reveals that waiting and searching for the results of tests is still one of the issues that take up clinician time and cause frustration in their busy days. Clinicians are asking for a process that is easy to use, reliable, accessible and, above all, at their fingertips, the moment they need it.

As far back as 2006, an American study identified significant improvements for clinicians working with a new PACS system in Radiology indicating that implementation resulted in a saving of '21 physician years and $2 million annually'. [11] While outcome measures of this magnitude are tempting, they have already been largely achieved just with the introduction of standalone service-specific electronic records already in place in many hospitals and clinics. The demand we need to meet now is a process connecting the data gathered about one set of tests with the information from other systems. The connected, integrated EMR improves processes that result in simple, one-stop-shop access to patient data when it is needed, every time.



> "Electronic prescribing (ePrescribing) and computerised order entry (CPOE) systems can improve patient safety and the quality of health services by reducing risks associated with medication errors."

An example of how process analytics informed improvement is the 'No Unnecessary Tests" (NUTS) program. Launched in Victoria by Eastern Health, the program reduced orders of unnecessary clinical tests by applying evidence-based parameters to a defined set of conditions. The outcomes were better than expected, patient experience was maintained, no harm was caused, and the hospital reduced costs due to reductions including, for example, 38,890 fewer tests ordered in the Emergency Department over the two years of the study. This work is high value, high impact and relies on the rigorous application of consistent well-defined processes. Order sets developed for key clinical specialties such as this are ideal for process improvement within the modern EMR.

Utilising advances in technology to recognise gold-standard assessment and treatment regimes for known conditions, as applied to ePrescribing systems, can also support clinicians to apply clinical decision making to orders. The system is able to match a diagnosis with expected tests, medications or other investigations and can identify any unexpected (or unnecessary) variance from a known treatment plan. It can pre-fill expected orders, suggest options for treatments known to be applied within a specialty, such as oncology, and confirm adherence to prescribed care. All of this can be at the clinician's fingertips, available to professionals involved in the care of a patient at other points in time and even reportable to the patient through their portal.

"A woman visited her health service for a check-up and tests. After the appointment, she heard nothing further so assumed 'no news is good news'. She trusted the team. At a subsequent medical appointment six months later she happened to ask about the results of her earlier tests. The doctor could see no sign of the results being received. He re-ordered the investigations and found invasive, stage 4 cancer. After the woman passed away the original results were located in hardcopy, paper form, in a filing tray. If the doctor and patient had seen these results at the time they were taken, the woman's condition may well have been treatable and she would still be here today."

The declaration was made in a recent communique that also revealed that nearly 12,000 GPs have engaged in ePrescribing, while more than 95% of all Pharmaceutical Benefits Scheme (PBS)-approved community pharmacies are dispensing ePrescriptions. [12]

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PROCESS #3
Discharge Planning and Summary process

The whole-of-service model acknowledges that individual health care is part of a continuum that has origins well before any particular event (such as a hospital admission) and will hopefully continue long after it. Integration of a system that collates and shares information about previous interactions, such as prescriptions dispensed, past pathology results, and current care plans with all providers AND the patient themselves enables informed decision making to occur with all relevant patient information.

Care coordination is often treated as a clinical process separate to care and tends to be reliant on human factors. Many services invest precious funds to employ specific people as 'care coordinators' to carry out this function of collating assessments, results and patient preferences and then negotiating plans. This process is central to health and wellbeing and yet failure to coordinate care in a timely and holistic manner continues to contribute to increased length of stay and unplanned readmissions. Every unplanned readmission signifies a poor patient experience and costs the system.

Every model of patient care contains the same features.

- Presentation
- Assessment
- Diagnosis
- Treatment

Even the most highly specialised areas of medicine follow this general outline of care. Where there is a commonality there is an opportunity to harvest data that will inform and improve the process. An intuitive EMR that can systematise the framework of care coordination, streamline the process and enable the specific requirements of each clinical specialty to input individualised care is a leap into coordinated care planning.

Let's look at what is behind this issue with timely reports and how it is the creation of a discharge summary process itself that needs overhaul and improvement. It is time-intensive for the doctor, who is already looking after another cohort of patients, tasked with completing the summary on behalf of the care team. Over 8.1 million hospital separations every single year in Australia of which at least 43% would require a discharge summary developed and sent to any of some 22,589 primary care practitioners.[9]

A good discharge summary is part of the continuum of ongoing care, not just a summary of notes taken during an inpatient stay. For it to be useful the patient should have it in their hands when they walk out the door of the hospital and back into the community. The summary must be easily and securely sent through to the GP, ideally with minimal effort from the hospital clinical or administration team to create, complete or send it. The GP should have it on the system before the patient has even arrived home and they may respond to any actions in a timely, informed manner.

> "Discharge planning for the patient should begin from admission and include early involvement of all allied health and community services."

These reports frustrate clinicians, patients, community care providers and hospital administration. It is a drain on clinicians who struggle to find time to create a valuable summary; for the administrative team who are scrambling to collate information from various files and clinicians to cobble together some information for the patient; and for the hospital administration team who shake their heads in frustration at yet another unsatisfactory audit and wonder why it seems to be so hard to write a simple report! And yet, less than half of the required discharge summaries are completed and available within 48 hours of discharge. [9]

To have any real impact on this process, an understanding of the data behind every step in the creation of the report needs to be collected and analysed. Data analytics tells us that we could revolutionise the process if we can reduce the time and input required to create the summary while ensuring it meets compliance requirements and systematises delivery to the correct end users. The modern EMR facilitates informed, multidisciplinary, coordinated planning, and the inclusion of information required, ensuring documentation is compliant, and ultimately making discharge from a hospital admission simple. The system leveraging the best of digital abilities provides instant, secure electronic information transference. It's fast, it's safe and it's reliable, the report gets to those who need to receive it.

The system that connects information, automates reporting, complies with regulatory frameworks and incorporates plans for future care saves resources, time and money and places the patient back at the centre of their own care.

"A collection of information about events during care by a provider or organisation."

Compared with patients in Major cities, patients in Remote/Very remote areas were more likely to report that:

- their usual GP or place of care was not informed after their most recent visit to a specialist (10% and 19%, respectively)
- there was at least one time when their specialist doctor did not have their medical information or test results (8% compared with 15%)
- their usual GP or place of care did not seem informed of their follow-up needs or medication changes from their last admission to hospital (14% and 25%, respectively).

"1 in 4 patients who visited and emergency department said information was not shared with their GP" [8]

PROCESS #4
Health Information Management

Let's have a look at the Health Information Management (HIM) function.

Australian health services are rightly held to high standards of quality and safety. Compliance with regulations and with the legal system requires reliable access to accurate, legible, medical notes. Australia has moved on from maintaining enormous warehouses filled with hardcopy patient files to accessing electronic databases of patient information.

An example of a process in HIM is the response to a Freedom of Information (FOI) request. This can be a lengthy search process that can still involve locating a paper file, searching through hundreds of pages filled with handwriting of all grades of legibility and attempting to decode this information to meet the legal obligation. The HIM team provides the data and information required to demonstrate compliance during audits and assures the public that their personal health information is safe and secure and privacy maintained. While personal information is owned by an individual, the system can take 45-60 days to facilitate visibility of this data. Under legislation, the service has 30 days to respond with the requested information. It takes both the patient and the service team considerable effort and money to request, approve and provide information that potentially could have been available to the person all along.

It's no small task.

The application of a process improvement model to HIM activities can transform this function, returning time and resources to the system.

The opportunity inherent in the modern EMR is reliable access to the data for both the patient and the HIM team. Patient information can be available instantly across the full continuum of health care, even integrating with the MyHealthRecord, the national online system built to capture health data for Australia. FOI requests might decrease if the patient, via the patient portal, has easy and instant access to their health records without needing to ask someone else to provide them . A system that is built to collate and format patient information in a manner that meets regulatory requirements would save the HIM team hours and effort, enabling them to be more responsive, accurate and compliant.

Improvement of maintenance, storage of and access to personal medical information engages a patient in their own care, improves the security and compliance of medical file documentation and gives the Health Information Management team back time and confidence that the information they require will be at their fingertips the moment they need it.

Who can argue with that?

"The health service organisation has healthcare records systems that"

1. *Make the healthcare record available to clinicians at the point of care*
2. *Support the workforce to maintain accurate and complete healthcare records*
3. *Comply with security and privacy regulations*
4. *Support systematic audit of clinical information e. Integrate multiple information systems, where they are used.* [15]

PROCESS #5
Clinical coding and billing process

"If it's not documented, it didn't happen". This frequently quoted reminder drilled into all clinicians during training meaning that only what is included in the patient's file can be proven as having happened is both a teaching tool and an explicit warning - be clear, be complete and be correct.

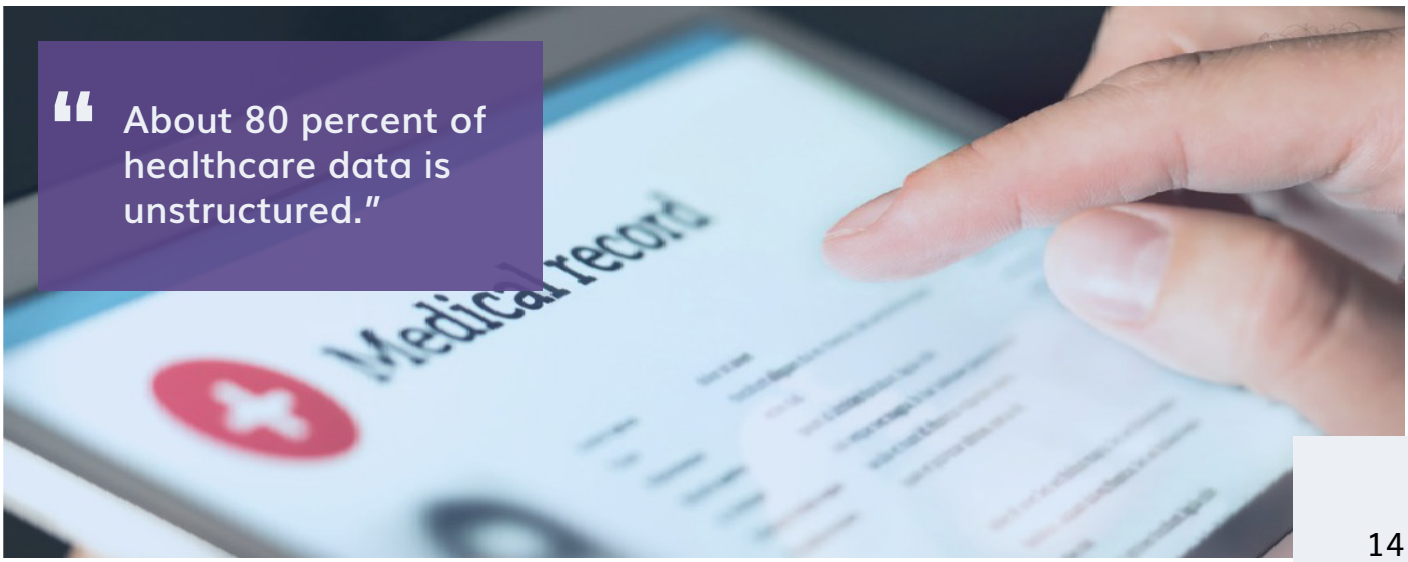
For clinicians and patients, this accuracy contributes to agreed care provision and planning. For the administrative behemoth behind all healthcare services it is equally important.

Clinical coders review every single patient file, without exception, and code diagnoses, interventions and orders, until every aspect of an occasion of service has been sliced and diced and recorded in the service database. More succinctly, the job of clinical coders is to 'convert information from a patient's medical record into alphanumeric codes according to a health classification system'. The codes are used for funding, research, and healthcare planning'.[13] Clinical coding requires attention to detail and a high level of ability. Substantial effort expended in the clinical coding process could be saved with improvement by utilising safe and reliable technology in the process of documentation and record development. Supported by intuitive datasets drawn from the Australian regulatory context provides a clinician at the bedside with the acceptable terminology to meet coding requirements and ensure that the data is correct at the time of entry. And we can't forget: competition for the finite funding dollar is intense.

Improving the process of data entry can impact the healthcare bottom line. The modern EMR can increase data reliability and allows a healthcare provider to receive the funding needed to pay for the services they offer.

Healthcare is heavily subsidised by the Australian Medicare system but it is not free. Providers must comply with funding models to be reimbursed for care. Co-payments, full fee recovery, and myriad other costs are charged to consumers, to the government via the Medicare system and to private health insurance companies. Like coding, the billing process is complex and the maximisation of income relies upon the integrity and accessibility of the data available to the administrative team. Improving the system to automatically align with known funding models and capturing the detailed data required to comply with a model can reduce time and complexity and increase accuracy.

Scheduling (appointments for the patient, schedule for the clinician, access to rooms and resources) is another key process ripe for improvement. At the moment appointments may be booked in a central system, duplicated into a clinician's personal calendar followed by a manual process of booking the room required and any other resources needed to provide care. Such schedules are service-specific and coordination of care is not visible nor editable across sectors or even to the patient. An incredible number of process data points exist in this system where variation is rife even where processes are in place.



> "About 80 percent of healthcare data is unstructured."

Application of process improvement methodology to scheduling systems can revolutionise administration and patient engagement in care. Identifying points of consistency and systematising them into the process can simplify resource allocation and ultimately streamline compliance with funding models. The patient has access to their appointments via a patient portal and can see where they must go, who they will see and when to be there, giving them confidence and engaging them in their own care. Our technologically familiar community are used to, and now expect, system reminders in the form of text messages or emails to ensure they don't forget appointments.

A patient can change their own appointment if needed, omitting the need for phone calls or texts to an administration team or even costly failure to attend. The system that can respond to the appointment change with all the associated changes required behind this would then rebook the room, clinician, and resources in one process. The clinician's diary is updated and an alert is sent. The modern EMR can capture the data required to drive this complex process of coordination and align it with the funding model. A process improvement of this magnitude would transform healthcare in Australia, making it easy for patients, clinicians and the administrative team to work together.

> *'The integrity of clinical coding depends fundamentally on the quality of the patient record.'*
>
> *'When the definitions used by clinical coders are out of step with the latest clinical definitions, the integrity of the coded data is compromised.'* [14]

Australian authors, Nguyen et al. (2019) [14], studied the level of agreement between documentation in the medical records and ICD-10-AM coding of mental health, alcohol and drug conditions in trauma patients. These authors concluded that despite documentation in the medical record, these conditions are not always coded, rendering incomplete the administrative databases

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SUMMARY

Victoria's digital health roadmap (the Roadmap) is the Victorian Government's plan for digital health technology over the next five years. It aims to further improve the safety and efficiency of Victoria's healthcare system and to keep patients at the centre of care.[16] The Roadmap describes five programs of work to realise this objective:

1. *Reliable and resilient systems*
2. *Efficient, secure, paper-light health care*
3. *Continuity of care*
4. *Enabling virtual care and care closer to home*
5. *Consumer access and engagement.*

Healthcare outcome measures do not vary across Australia. We all want the right care at the right time in the right place for every single patient. Let's add to that. As members of a society so fortunate to be recipients of this high-quality care as well as contributors to the economy that supports it, we all want healthcare provided by the right clinician for the right cost meeting all the right rules and regulations, as quickly, correctly, efficiently and safely as can be achieved.

In this paper we have explored how improvements made to five key high-value processes embedded in healthcare can help any service achieve exactly that goal.

A healthcare system that leverages process data to inform how the latest technology allows it to truly partner with patients to enable them to be active participants in care, rather than just the recipients of care, is a leap forward that no provider can afford to ignore. An interactive patient portal provides an individual with visibility of their own care and commitments, allows them to interact with services from a virtual platform and integrates with their My Health Record, underpins improved patient experience, engagement in care and the ability to participate fully in planned care across the continuum. The efficiencies in a system that can respond to the changing of an appointment with the automatic and accurate realignment of resources, schedules and billing activity is a godsend to patients, clinicians and administration alike.

An intuitive modern EMR that captures specialist medical practices and then utilises this collected data to make the process of referrals, care plans, order sets and discharge summaries simple, secure and always compliant with the quality, safety and administrative requirements inherent in every occasion of care has been a dream that clinicians are barely able to comprehend could be real. But real it is, and it's available for your health service now.

69% of health professionals surveyed think lack of integration with existing systems and processes is a barrier to successful implementation and utilisation of digital health systems. [9]

Processes that improve how the patient, clinician, and the healthcare system can work together in true partnership are the answer to the current healthcare conundrum. When all three can actively connect with an individual patient record that spans hospital, community and home-based health and wellbeing across time and services we are approaching our ideal person-centred model of care. The technology that takes us to this desired future state is available to Australian healthcare providers right now. The modern integrated EMR integrates seamlessly with My Health Record, is compliant with Australian healthcare standards and regulations, is programmable with local service models and can be central to improved care in your healthcare service now.

What are you waiting for?

"Improving patient flow across health and community care systems is beneficial to patients and staff in many ways."

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	Clinician Engagement	Administration	Patient Experience
Referral Management Processes	Fast, accurate referral system, closed loop assurance of referral receipt and action. Automated resource allocation process and integration with scheduling.	Reduced time handling, correcting, redirecting referrals. Simplified booking and triage processes. Funding requirements and compliance data embedded in system.	Visibility of referrals - source and destination. Reduced repetition of information provision requirements. Ability to manage appointments and coordinate own information flow.
Clinician Order Entry Processes	Unambiguous, systematised order processes (pathology, imaging, medications). Safety net built in educing error or oversight of orders, interpretation of directions and receipt of results. Supports precision medical mode	Cost minimisation sourced from reduced duplication of testing, orders of unnecessary low-value tests.	Assurance of safe, correct, transparent orders. Ability to view and share interventions from inpatient admission with community care providers (eg GP, Pharmacy). Incorporates historical care data.
Discharge Planning and Summary Processes	Automated back-end processes reducing clinician involvement in billing. System supports use of terms and diagnoses to match funding and regulatory data requirements.	Automated compliance, consistency and accuracy, and regulatory accountability	Visibility of costs andresources required. Ability to interact with payment systems online.
Health Information Management	Streamlined process facilitating multidisciplinary input and accuracy of actions and outcomes. Automatically gathers required information to compile into a report.	Regulatory compliance. Automatic, secure delivery of report within mandated timeframe to GP and other identified recipients.	Receives discharge summary at discharge. GP has a copy on the day of discharge. Clear care coordination detail evident and available.
Clinical Coding and Billing Processes	Streamlined, reliable access to the right patient information easily. Automatic access to compliant patient data	Automatic access to compliant, auditable, correct patient data. Reduced time actioning FOI requests	Access to personal health information across time and service modality (hospital, community, home). Holistic approach to individualised care.

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Built for the Australian healthcare system, DC2Vue® provides an integrated electronic medical record with clinical, operational and billing workflows, so that you can deliver compliant quality care for less.

Today with a diverse portfolio of care settings, over 6000+ users leverage DC2Vue® platform to deliver care in acute, mental health, community and aged care settings.

DC2Vue® and the DCE team are uniquely placed to improve quality, safely and efficiency of healthcare through digital clinical transformation.

We invite you to explore all that DC2Vue® has to offer to enhance your Digital Health Strategy.

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