Meaningful Use and Clinical Documentation

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By Sean Benson

Little direct attention has been paid to clinical documentation in the context of meaningful use. Discussion and debate instead focused on electronic health records (EHRs), computerized physician order entry, and other health IT systems.

However, the electronic capture and exchange of accurate, comprehensive clinical, procedural, and patient information is directly related to advancing care processes, enhancing coordination of care, and improving quality, safety, and efficiency. As such, efficient and effective clinical documentation within the EHR is vital to achieving meaningful use of health IT.

For evidence of this, one need look no further than the meaningful use criteria. Although clinical documentation recorded within the EHR is not currently a meaningful use criterion, it plays a significant role in achieving many aspects of meaningful use compliance.

For example, hospitals must perform medication reconciliation for more than 50 percent of transitions of care and provide a summary of care record for more than 50 percent of patient transitions or referrals. Stage 1 criteria also call for:

- The ability to record, modify, and retrieve vital signs, demographic data, smoking status, and patient lists by specific conditions
- The ability to measure and report on certain quality measures
- The provision of electronic copies of discharge instructions to more than 50 percent of requesting patients
- The provision of an electronic copy of health information within three business days to more than 50 percent of requesting patients
- The recording of at least one entry to a problem, medication, and medication allergy list as structured data for more than 80 percent of patients

Without efficient and accurate clinical documentation, these fundamental steps cannot be fully achieved. For this reason, healthcare organizations should consider their documentation systems and process now.

What is a proactive, voluntary initiative now may be a requirement sooner rather than later. The Centers for Medicare and Medicaid Services has made clear its intention to raise the bar on adoption and use of health IT in successive stages of the meaningful use program, and it can be expected that electronic clinical documentation will be a requirement in time.

Clinical Documentation Needs for Meaningful Use

To get and stay ahead of the meaningful use curve, organizations should ensure that their clinical documentation systems offer the features and functionality necessary to capture the foundational data that advance meaningful use compliance with multiple established and proposed criteria. Thus, the focus should be on systems that enable the capture of discrete information regarding a patient's status, including comprehensive documentation of assessments, interventions, treatments, progress notes, and procedures.

First and foremost, vendors should be transparent regarding their clinical documentation solutions' ability to aid clients in complying with stage 1 criteria. This includes providing details on whether their software can play a direct or indirect role in compliance.

If vendors do not offer this information, facilities should conduct their own internal evaluations of existing and prospective systems. The first step is to identify which meaningful use criteria are driven by the capture of compliant clinical data. Then evaluate how a system's specific features and functionality enable and accelerate the demonstration of meaningful use for these criteria.

For example, the right clinical documentation solution will enable compliant point-of-care capture of key meaningful use data, including patient demographic information, vital signs, and even smoking status in a standardized format that allows for easy retrieval and modifications as necessary. Further, clinical documentation plays an important role in meeting patient requests for electronic copies of discharge summaries or health information and ensures facilities are able to provide electronic copies of procedure or clinical information in a timely manner as required.

Comprehensive capture of patient condition, demographics, and results is another key element of the meaningful use objectives. For maximum impact, clinical documentation systems should facilitate the expedient capture of this information and enable easy report generation and transmission in multiple appropriate formats.

In addition, when systems feature built-in reporting and analytics tools, they simplify quality reporting and audit preparation with prebuilt reports or customized query-writing capabilities that enable every captured data element to be queried. This functionality will have a long-term impact on stage 1 meaningful use compliance and on meeting future criteria that are likely to be even more heavily performance- and quality-based than the current threshold measures.

Ease of Use Spurs Adoption

In addition to ensuring documentation systems enable an organization to meet meaningful use requirements, the systems must also be clinician friendly to drive adoption. As such, it is important to look for systems that have been designed specifically for and by physicians and that can demonstrate a high clinician satisfaction and use rate.

These clinical documentation systems will typically include intuitive navigation that efficiently leads clinicians through menu-driven documentation processes. Such navigation results in more efficient capture of compliant data at the point of care, including sufficient discrete data elements for each patient interaction.

These systems also tend to feature medical content–driven menus that emulate common physician workflows and follow logical paths that automatically adapt to each piece of information the physician selects. Menu selections made by the physician should also create detailed notes, complete with diagrams, when appropriate, that read as if they were dictated-all of which will allow a physician to complete documentation faster and more accurately.

Finally, the ability for physicians to create and electronically sign notes immediately after an encounter will speed and streamline the overall documentation process.

Clinical documentation criteria have been discussed for stage 2, which begins in 2013. Whether the Centers for Medicare and Medicaid Services ultimately includes such measures or not, electronic documentation systems are vital to achieving many of the existing 2011 requirements. As such, hospitals, physician practices, and other provider organizations should take the time now to ensure their systems are capable of capturing and utilizing data in the multiple ways required for meaningful use compliance in stage 1 and beyond.

Sean Benson (sean.benson@provationmedical.com) is cofounder and vice president of consulting with ProVation Medical.

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