

# The Role of Clinical Documentation in Meaningful Use

*From the HIT Policy Committee (HITPC) to the American Hospital Association (AHA), influential organizations are seeking to include clinical documentation as a Stage One criterion for meaningful use under the Health Information Technology for Economic and Clinical Health (HITECH) Act.*

Currently, clinical documentation recorded within the electronic health record (EHR) isn't specifically named until Stage Two (2013), as recommended to the Centers for Medicare and Medicaid Services (CMS) by HITPC. However, pro-inclusion organizations recognize the significant impact the electronic capture and exchange of accurate procedure/patient information has on care outcomes – as evidenced by the role it plays in achieving many aspects of Stage One compliance.

For example, by 2011, hospitals must perform medication reconciliation for at least 80% of relevant encounters and transitions of care, and must be able to electronically transmit patient summary records. Stage One criteria also call for the ability to record, modify and retrieve vital signs, demographic data, smoking status and patient lists by specific conditions; provision of electronic copies of discharge instructions and procedure and clinical information; and the ability to measure and report on certain quality measures.<sup>i</sup>

Despite its important role in achieving the goals of HITECH – improved quality of and access to affordable health care through the adoption of HIT – little attention has been paid to the role of

clinical documentation. Discussion and debate surrounding meaningful use has instead focused on EHRs, CPOE and other HIT systems.

Yet without efficient and accurate clinical documentation, meaningful use of HIT, and therefore the goals of HITECH, cannot be achieved.

## **THE ROLE OF CLINICAL DOCUMENTATION IN HIT**

More than 1 billion clinical notes are created by physicians in the U.S. each year. They comprise about 60% of all clinical information and are used as the primary source of information for reimbursement and proof of service.<sup>ii</sup> It was this significant role within clinical information, as well as recognition of the potential benefits associated with electronic recordkeeping, that was the catalyst behind the initial push to improve the capture and use of clinical documentation through technology.

Adding to the push for improved documentation was the decision by the Joint Commission to conduct compliance audits without notice, a change from its previous policy of notifying provider organizations in advance of an inspection.

By transitioning to an electronic documentation and charting environment, hospitals are able to leverage available technology tools to eliminate inconsistencies in documentation. This, in turn, enables full compliance with all required elements of clinical documentation and ultimately leads to enhanced quality and patient safety.<sup>iii</sup>

It is not just hospitals that benefit from the emergence of electronic documentation and charting. Physician practices, ambulatory surgery centers and other ambulatory providers – the setting in which most care is provided – are also transitioning to an electronic environment to streamline workflows, increase documentation accuracy and achieve compliance with increasingly stringent accreditation and regulatory bodies.

Whether care is provided in an inpatient or ambulatory setting, the methods of data capture are the same. It happens in one of four ways, often with two or more methods in play at any given time:

1. Data is entered directly via software systems and is completed by the end user
2. Handwritten documents are scanned into the system, in many cases as static PDFs
3. Text reports are transcribed from dictated notes or via speech recognition
4. Data is exchanged across interfaced systems (i.e., laboratory or radiology systems, blood pressure monitors, electrocardiographs, etc.)

Many consider direct data entry to be the most desirable method because it produces discrete, structured data that can easily be analyzed and reported. It also takes full advantage of the “collect once and use many” principle.

Clinicians, however, are not typically among the direct entry method’s biggest fans. They often argue that the built-in edits, drop-down lists and dialogue boxes that require the user to select from certain values do not allow them to describe the specifics of individual patients and their conditions. Individualization, they argue, is essential to the document and the provision of quality care.<sup>iv</sup>

This lack of clinician support can negatively impact both adoption of electronic documentation and charting and the organization’s return on its technology investments. This is particularly true when ROI calculations are based on the assumption that transcription costs would be significantly reduced or eliminated. In fact, an AC Group survey found that 53% of physicians had reverted back to dictation or handwriting and 18% had stopped using their organization’s EHR altogether just one year after implementation.<sup>v</sup>

Further, HIMSS Analytics reports that fewer than 2% of U.S. hospitals had achieved Stage 6 of its EMR Adoption Model, which requires physician documentation using structured templates.<sup>vi</sup> A survey of Stage 6 hospitals also found a mix of data capture methods in place, including structured templates within the EHR (35%), dictation and transcription (62%) and voice recognition (4%).<sup>vii</sup>

For some organizations, the solution to the clinician adoption challenge is integrating medical transcription as a component of the EHR. This helps balance clinician satisfaction, achieve meaningful use of EHRs and ensure accurate clinical documentation for quality patient care.

## CLINICAL DOCUMENTATION & MEANINGFUL USE

Electronic clinical documentation is vital to achieving meaningful use of HIT and is directly related to advancing care processes and improvements in quality, safety and efficiency. It is also central to the delivery of high quality care and improved coordination of care.

For example, it overcomes the weaknesses inherent in handwritten medical records, which take more time to decipher and can be so illegible that important information is obscured.

Electronic documentation also ensures vital information is always available, unlike its handwritten counterpart.

Further, when information is not captured electronically at the point of care, it is lost forever and results in an incomplete medical record. And while a hybrid system of handwritten and electronic documentation may appease clinician critics, it also results in fragmented records and inefficient workflows, both of which can compromise quality and safety.

Some also contend that maintaining paper progress notes will impede a patient’s access to information because there is no structured way to convey necessary context to the data being provided. That alone can prevent the meaningful use of HIT because the ability to share documentation is fundamental to successful care coordination.

For these reasons, HITPC has recommended that, at minimum, electronic progress note documentation be reinstated as a Stage One criterion. In its recommendation letter to CMS, the committee noted that “without an explicit requirement for including progress notes as part of the EHR, we are concerned that a significant

portion of eligible professionals may choose to continue to document patient encounters on paper, which would significantly impede the goals of improving quality of care and care coordination. Furthermore, eliminating this requirement would obviate the need for vendor products to be certified to accommodate inclusion of progress notes.”

It also recommended that CMS “signal clinical documentation as a Stage Two requirement for hospitals”.<sup>viii</sup>

HITPC is not alone in its desire to see electronic clinical documentation as a Stage One criterion for meaningful use.

The AHA, Medical Transcription Industry Association (MTIA) and the Association for Healthcare Documentation Integrity (AHDl) have all called upon CMS to strengthen documentation requirements in the 2011 criteria.

In a joint letter to CMS, AHDl and MTIA expressed concern that “physicians have a choice regarding how they document health care encounters and that the value of the patient narrative be preserved for clinical reimbursement decision making.”

The organizations went on to recommend that CMS “avoid making the meaningful use criteria overly burdensome for physicians, hospitals and their patients” by not mandating a specific method of data capture. Instead, they recommend recognizing multiple methods, including utilization of dictation-transcription to feed structured narrative reports and discrete data elements through data-tagging into the EHR.

To that end, AHDl and MTIA have launched two consortia focused on accelerating EHR adoption and meeting criteria for meaningful use. The Health

Story Project was formed to establish uniformly structured and coded document formats commonly used in health care practices, based on HL7 Clinical Documentation Architecture. This will enable the sharing of narrative reports among health care facilities, allowing access to the rich and nuanced clinical information stored in narrative notes for both clinical and reimbursement decision support.

The second consortium with Verizon Business and ICSA Labs has built a digital platform called Medical Data Exchange that will encourage and facilitate secure transfer of medical record information between EHRs.<sup>ix</sup>

As a result of pressure from leading organizations, as well as the known impact of clinical documentation on the successful use of HIT, health care organizations should consider their systems and processes now rather than later.

### **ELECTRONIC CLINICAL DOCUMENTATION SYSTEMS & MEANINGFUL USE**

To get and stay ahead of the meaningful use curve, provider organizations should ensure that their clinical documentation systems provide the features and functionality necessary to facilitate compliance. The focus should be on systems that drive the capture of information that fully and accurately reflects a patient’s status, including comprehensive documentation of assessments, interventions, treatments, progress and procedures.

For example, systems with intuitive navigation that efficiently leads clinicians through menu-driven documentation processes result in more efficient capture of compliant data at the point of care, including automated capture of sufficient discrete data elements for each procedure.

Built-in reporting and analytics tools are also valuable in that they simplify quality reporting and audit preparation with pre-built reports or customized querywriting capabilities that enable every captured data element – including free text – to be queried.

Other important features include:

- The ability to automatically document items like pre-anesthesia assessments, ASA scores, “timeouts,” informed consent and estimated blood loss as part of an official record
- The ability to include pathology tracking, patient instructions and repeat procedures, recall and surveillance into the system’s flag or reminder functions
- The ability to complete and sign all required point-of-care documentation electronically
- A Standard Content Library including AAAHC, Joint Commission, AORN and SGNA language and practices
- Electronic Patient Consent capabilities
- A scheduling interface that enables patient demographic and scheduling information to automatically populate the system

In addition to ensuring procedure documentation systems will enable a provider organization to achieve compliance, it is also important that they are clinician-friendly to drive high adoption and satisfaction. 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 adoption rate.

Clinician designed systems will feature medical content-driven menus that truly emulate typical procedure workflow and follow logical paths that automatically adapt to each

piece of information that the physician selects. They will speed and streamline the documentation process by allowing physicians to create and e-sign clinical notes immediately after a procedure. Menu selections made by the physician should also create detailed clinical notes complete with diagrams that read just as if

they were dictated – all of which will allow a physician to complete documentation faster and more accurately.

Whether or not CMS bows to the pressure and moves specific clinical documentation up into Stage One of its meaningful use criteria, electronic

procedure documentation systems are vital to achieving many of the existing 2011 requirements. As such, hospitals, physician practices and other provider organizations should take time now to ensure their systems are capable of capturing and utilizing data in the multiple ways required for compliance.

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*For more information on ProVation® software, visit us at [ProVationMedical.com](http://ProVationMedical.com).*

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