

THE HEALTH STORY PROJECT: The Way Forward to Meaningful Use
Health Story Supports Narrative and Data in the Electronic Health Record

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A pressing need

Healthcare reform promises dramatic cost reduction. Irrespective of the future of the Affordable Care Act, getting a handle on costs and shifting the basis for reimbursement deserves bi-partisan support. No business can address cost reduction without adequate information. Dr. David Blumenthal, the outgoing National Coordinator for Health Information Technology, in his introduction to the *Federal Health Information Technology Strategic Plan 2011 – 2015*, refers to electronic health information as the “‘lifeblood’ of modern health care” (2011).

Today, approximately 65%-80% of the clinical record is captured in clinical documents that include a mix of narrative and data. This memo describes the Health Story Project (www.healthstory.com), a clinical document initiative to ensure that the move to electronic health records (EHRs) is done with the least effort and produces the best outcome for both physicians and patients.

An industry initiative

Health Story is a coalition of vendors, providers and standards developers that supports development and implementation of standards for information exchange and reuse. To date, the Project has supported development of eight standards for clinical documents such as Consult Notes, Discharge Summaries, and Imaging Reports. These standards represent national consensus over the content and encoding of the most common document types forming the “primary source” for documentation of the delivery of care. The Health Story standards are balloted through Health Level Seven (HL7) and built on reusable building blocks called “templates”, the same components required today for “Meaningful Use” of EHRs.

Over the past four months, Health Story and HL7 have collaborated with the Office of the National Coordinator (ONC) under the Standards & Interoperability Framework (S&I Framework) to harmonize these building blocks with a related initiative, Integrating the Healthcare Enterprise (IHE) and at the same time, resolve some ambiguities and fill some minor gaps in the specifications cited in the ONC Final Rule on Health Information Technology which identifies standards for certification of “Meaningful Use” of EHRs. This project, called the Consolidation Project, garnered widespread participation and support drawing volunteers from across the industry including private and government sectors, providers, vendors and open source developers.

A way forward

The initial output of the Consolidation Project is currently in ballot within HL7. The collaborative work with HL7, IHE and Health Story joining forces under the S&I Framework continues to populate a growing library of templates based on the HL7 Clinical Document Architecture (CDA). These templates meet the requirements cited in the President’s Council of Advisors on Science and Technology (PCAST) report to the President on “Realizing The Full Potential Of Health Information Technology To Improve Healthcare For Americans: The Path Forward¹.”

The report, however, and the subsequent plan from Dr. Blumenthal leave the impression that the basis for interoperability, for jumpstarting the flow of information to clinicians, public health officials, researchers and not

¹ <http://www.whitehouse.gov/sites/default/files/microsites/ostp/pcast-health-it-report.pdf>

least of all to patients – that the standards required do not yet exist or are inadequate and need to be re-thought, re-factored and re-built.

This position flies in the face of industry success and commitment.

The way forward is clear, it has support across the industry and is ready for the next stage of regulations defining Meaningful Use.

If widely adopted, these existing standards for health information exchange based on this project could resolve many current challenges by capturing, exchanging, and using clinical data electronically in a way that is also meaningful and understandable by human caregivers.

The resulting database of templates combined with the narrative documentation which clinicians use today will facilitate meaningful use of electronic health information by:

- Increasing adoption by allowing physicians to document patient encounters using methods that are efficient, effective, and convenient.
- Improving the usefulness of the data by increasing the likelihood that the required level of specificity and detail will be provided.
- Enabling the expressive information that is relevant to the documentation of patient care but which does not fit with entry by point-and-click methods of information capture.
- By enabling the exchange and use of clinical facts tagged as discrete data elements without losing the narrative – narrative remains an effective tool for communication and collaboration within the patient care team.

Let's get the "life blood" flowing. Let's get the full set of template-driven clinical document standards into Meaningful Use Phase 2.

About Health Story

The Health Story Project was founded a little over three years ago by the Association for Healthcare Documentation Integrity (AHDI), the American Health Information Management Association (AHIMA), Lantana Consulting Group, the Clinical Documentation Industry Association (CDIA, formerly MTIA), and M*Modal. It is now a collaborative of over two dozen healthcare vendors, providers and associations.

Health Story accelerates development of HL7 Clinical Document Architecture (CDA) Implementation Guides for common types of electronic healthcare documents, brings them through the HL7 ballot process and promotes their adoption within the industry. Over the previous three years, the initiative supported the development of eight technical implementation guides for standard electronic documents, including the Consultation Note, Diagnostic Imaging Report, Discharge Summary, History and Physical, Operative Note, Procedure Note, Progress Note and Unstructured Documents. Health Story Promoter members include A-Life Medical, Emdat, Fujitsu, GE Medical, InfraWare, MedQuist, Nuance, Osmosyz, 3M and Verizon.

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Health Story Founders:

About M*Modal

M*Modal, based in Pittsburgh, PA, offers on-demand conversational documentation services that help healthcare providers capture discrete clinical information from dictation to generate complete and timely electronic medical records. The company's unique Speech Understanding technology platform, **AnyModal CDS**, is a vital tool that empowers physicians to capture clinical facts and orders from dictation without requiring any change to their normal dictation routine. M*Modal's focus is on providing hospitals, healthcare IT vendors, and medical transcription service providers with the industry's most comprehensive yet most adaptable solution for creating highly accurate, structured, encoded, and shareable medical documents to increase patient safety, promote continuity of patient care, and reduce cost. For more information on M*Modal, visit its Web site at: www.mmodal.com.

About AHIMA

AHIMA is the premier association of health information management (HIM) professionals. AHIMA's 53,000 members are dedicated to the effective management of the personal health information needed to maintain a quality national healthcare delivery system. Founded in 1928 to improve the quality of medical records, AHIMA is committed to advancing the HIM profession in an increasingly electronic and global environment through leadership in advocacy, education, certification, and lifelong learning. For more information about the Association, go to www.ahima.org

About AHDI

The Association for Healthcare Documentation Integrity (AHDI), formerly AAMT, has been the professional organization representing medical transcriptionists since 1978. AHDI sets standards of practice and education for medical transcriptionists, administers a dual credentialing program, has established a code of ethics, and advocates on behalf of the profession. There are nearly 100 component associations of AHDI, each of which holds regular educational meetings and symposia. For more information, visit www.ahdionline.org.

About CDIA

The not-for-profit Clinical Documentation Industry Association, formerly MTIA, is the world's largest trade association serving medical transcription service operators. Its mission is to create an environment in which medical transcription companies can prosper, grow, and deliver the highest level of healthcare documentation services. For more information, visit www.cdiaweb.org.

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