

**HEALTH STORY
PROJECT SESSIONS**



WEDNESDAY | 11:15 a.m.–12:15 p.m.
Hot Topic: Medical Data Exchange and Health Story Project
Osceola A 1–3

Project Allows EHRs to Tell Full Health Story

Every patient has a story. Unfortunately, many electronic health record systems are unable to efficiently tell their full tale.

Narrative and transcribed clinical notes are typically being entered into EHRs in an unstructured way. While these notes can be accessed and read, their unstructured format makes the information impossible to electronically search, data mine, or use for quality measures.

Over half of all clinical documents created in the US are dictated and transcribed documents, leaving many in healthcare feeling that the bulk of clinical information is underutilized by their EHR.

But an organization has formed that is determined to electronically integrate narrative notes into computer-based systems and finally allow the EHR to tell a patient's entire health story.

The Health Story Project, now entering its third year, is a nonprofit alliance of healthcare vendors, providers, and associations that have come together for a rapid-development initiative aiming to produce data standards for the flow of information between common types of healthcare documents and EHRs.

Progress on Technical Implementation Guides

The project is nearing completion on its seventh of nine technical implementation guides. These guides use Health Level Seven's Clinical Document Architecture (CDA) data standards to allow transcribed clinical documents like consultation and history and physical notes to be electronically and systematically entered into the EHR.

Key words in the document are tagged and structured using CDA language then placed into the system along with the entire note.

The documents can then be electronically searched and utilized in ways that affect public health initiatives, quality and compliance reporting, and direct patient care, according to Susan Lucci, RHIT, CMT, AHDI-F, the AHIMA representative on the executive committee of the Health Story Project and vice president of field operations for Webmedx, based in Atlanta, GA.

While symptoms, diagnoses, and other hard-fact terms entered into an EHR through drop-down menus are informative, narrative notes contain specific information that distinguishes the patient's condition and helps providers make care decisions, Lucci said. Most narrative notes are unstructured and put into the EHR as "a black blob of information."

"There can be a kind of overkill when providing too much information versus a good synopsis—the story of 'Here is what happened to the patient, why they are here, what their situation is, what we did, and what the expected outcomes can be,'" Lucci said. "I think in the interest of time and efficiency in the healthcare delivery system, you can get to that place better through keeping narrative dictation in the patient's record. And that is what Health Story does."

Work has just begun to develop project standards for progress notes, which document a patient's clinical status during a hospitalization or outpatient visit. Future projects also include building standards for billing and reimbursement requirements.

Interest Growing

Interest in the project has been steadily growing, with standing room only crowds showing up for project presentations and hundreds listening in on Health Story Project informational webinars, Lucci said.

"There is much more interest in this now, and for obvious reasons," she said. "I think we are at a place where this is becoming critical."

At one time, physicians had to choose between entering clinical notes into the EHR through either rigid drop-down menus, which provided structure but few details, or free-form dictation, which gave a narrative but was unstructured. Health Story allows physicians to use either method, when appropriate, with the same end result—searchable data.

This freedom could help physicians more readily accept an EHR implementation, Lucci said.

Improved staff buy-in and more thorough electronic searches using Health Story guides could also help facilities better reach "meaningful use" of EHR requirements. These requirements come from the American Recovery and Reinvestment Act and are linked to incentive payments.

"An EHR implementation, and getting it to meaningful use, is only going to be as good as that EHR is being utilized," Lucci said.

For their part, HIM professionals should request that their transcription and EHR vendors include Health Story Project standards in their systems, Lucci said. Current EHR systems can also be converted to include Health Story standards.

"As we get closer to meaningful use we need to get our HIM counterparts to really request this, insist upon it," she said. ♦

Visit These Health Story Members in the Exhibit Hall

Founders

AHIMA	#1928
AHDI	#2233
M*Modal.....	#2109

Promoters

3M	#1100
A-Life Medical.....	#2317
EMDAT	#1134
Fujitsu	#1909
MedQuist.....	#1017, #1314
Nuance.....	#902
Webmedx.....	#2125

Participating Members

All Type	#1616
BayScribe.....	#311
Documentation Services Group.....	#1629
New England Medical Transcription	#1118