

HEALTH STORY

PROJECT



August 22, 2013 | REV 1.0

HIMSS HEALTH STORY PROJECT VALUE STATEMENT

This document articulates the value of the HIMSS Health Story Project from the vantage point of diverse stakeholders. It will support recruitment and advocacy in combination with statements on the Health Story Project Mission, the value of HIMSS membership, and the benefit of HIMSS affiliation to the Project.

PROJECT OBJECTIVES

All Health Story stakeholders share these objectives and beliefs, which are embodied in the Project:

1. *A health record is the patient's "health story" and is shared by the patient and the circle of caregivers involved in his/her care. Sharing encompasses both access and authorship.*
2. *The primary purpose of the record is to support care delivery, which in turn, will support better health. Secondary reuse should be supported.*
3. *The transition from paper to electronic records must produce a longitudinal record of lasting value. That record must express the thought processes behind the delivery of care, preserving this for future readers.*
4. *Clinical records must be complete, well organized, easy to navigate, concise, logical, adaptable to the needs of the user, sharable, and secure.*
5. *The electronic record and associated new technologies support shared decision-making, document use of practice guidelines, and support evidence-based practice.*

CLINICIANS

Clinicians assess the value of a complete and useful electronic record in several ways. The Health Story Project advocates for these principles:

QUALITY OF DOCUMENTATION

A complete health story is told and structured in a manner that works for clinicians.

- *A short narrative that pinpoints the key aspects of a patient's care is more functional than auto-generated, multi-page "summaries."*
- *"Note bloat" — notes that are overly long — is indicative of colorless, uniform documentation that may meet fixed criteria for comprehensiveness, but which obscures essential clinical information.*
- *A record chopped into unconnected pieces, without context, lacking pertinent details is not useful.*
- *Data formats and applications should support linking and referencing related content within or across organizations.*
- *Standards for clinical records should respect the need for local variation while increasing consistency across practitioners.*

EASE OF USE

A health story is the natural by-product of and supports an efficient clinical workflow, integrating structured and unstructured information.

- *Policy on where to require structured and coded data must:*
 - *be selective about where and how to apply structure*
 - *give priority to what is practical to capture*
- *Structured information should be easy to capture.*
- *Unstructured or semi-structured information must retain a place in the record. It improves the quality of documentation and supports clinical workflow.*
- *Documentation requirements should not sacrifice the quality of patient-provider interactions.*

SUPPORT FOR CLINICAL DECISION-MAKING

A health story must support good clinical decision-making.

- *The record must accommodate and reflect the clinical thought process.*
- *Structured records should be standardized such that they:*
 - *facilitate decision support, benefiting patients and clinicians*
 - *increase patient safety*
- *The record should support a clinical process that increases the degree to which patients share in decision-making.*

CONTINUITY OF CARE

A complete health story supports continuity of care.

- *Specifications must support the assembly of a complete view of the patient record, across all settings and areas of care from basic safety information such as food allergies to emerging diagnostic information such as genetic markers.*
- *The record must be organized and classified for easy access to pertinent information.*
- *It's not enough that critical information be captured and stored; it should be easily collated, transferred, and understood.*
- *The source of information should be clear and easy to understand, making it easy to apply the appropriate level of trust.*

HEALTH INFORMATION MANAGERS (HIM)

Health Information Managers value an accurate and complete electronic record.

The Health Story Project will advocate for these principles:

- *Sufficient information must be preserved in the record to support local management of the primary and secondary purposes of the health record.*
- *Policy on implementation of an electronic record must be reconciled with regulatory and accreditation requirements for the management of records including creation, retention, and destruction.*
- *The health record must be sufficient to support an audit trail, tracking modifications, and to support regulatory compliance.*

PATIENTS

The Health Story Project opens the electronic record to a new era of participation by patients, families, and their caregivers, thus changing what is possible, by:

- *Providing guidance on how patients can participate in development and use of their personal health story and by doing so, optimizing engagement in their own care*
- *Identifying what types of implementation guides are needed to make this engagement possible and supporting their development*
- *Supporting methods for patients to close the loop on the record of care, providing feedback and increasing accuracy*
- *Supporting shared decision-making*
- *Making it easier to capture a complete, holistic, view of health including personal circumstances, values, perspectives, priorities, goals, and choices*
- *Making it evident that patients and clinicians share an interest in the health story*

PAYERS

The Health Story Project provides value to the payer community by providing authorized access to a complete record to support:

- *Payment and pre-certification adjudication — the core record and attachments can encompass the complete record, accessible electronically*
- *Lower costs through continuity of care, clinical guidelines, and automated quality measurement and documentation tools*
- *New care models that promote payers participating with patients and clinicians in a novel, trusted manner*
- *Value based reimbursement through a complete, usable record*

RESEARCHERS, ANALYSTS

While direct delivery of care is primary, the Health Story Project recognizes and supports secondary use of data.

- *A complete, cohesive record is the basis for Big Data analytics.*
- *More information can be derived from text processing, pattern matching, and natural language processing against a complete, cohesive record rather than running queries against a perfectly structured but impoverished database.*
- *Quality measurement in a shared-care environment demands a complete record valid across settings.*

VENDORS

The Health Story Project provides value to HIT vendors of clinical, administrative, and analytical applications by:

- *Articulating a comprehensive roadmap for interoperable electronic records supporting active coordination of the process of care in which records are captured and shared*
- *Encouraging and supporting development of cohesive, harmonized specifications covering all aspects of the record uniting clinical, administrative, and analytical applications into a comprehensive and interoperable EHR environment*

CREDITS

Those working on this draft:

- *Lisa Nelson (MSc, MBA)*
- *Reed Gelzer (MD, MPH, Provider-Resources)*
- *Thomson Kuhn (ACP)*
- *Edward Ambinder (MD, ASCO)*
- *Lisa Taylor (AHIMA)*
- *Julie Dooling (AHIMA)*
- *Sarah Willis-Garcia (IHE USA, HIMSS)*
- *Alex Lippitt (HIMSS)*
- *Joyce Sensmeier (RN, HIMSS, IHE USA)*
- *Liora Alschuler (Lantana, Health Story Executive Committee)*
- *Nancy Ramirez (HIMSS)*

With support from the Health Story Project members, 2006-2013, and those fellow travelers yet to join.