HIMSS **HEALTH STORY PROJECT**
VALUE STATEMENT

This document articulates the value of the Health Story Project from the vantage point of diverse stakeholders. It supports Health Story education and recruitment, and reflects its growing impact on health, care and patient empowerment.

Our **vision is**: To build comprehensive electronic records that tell a patient's complete health story.

To learn more, join the Health Story Project Roundtable or visit our **website.**

OUR OBJECTIVES

All Health Story Project members share these objectives and beliefs:

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. *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, and adaptable to the needs of the user, sharable, readily available, and secure.*
5. *The electronic record and 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 obscures essential clinical information.*
- *A record chopped into unconnected pieces, without context and lacking pertinent details, is not useful.*
- *Data formatting and applications should support linking and referencing related content within and 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 as well as supportive of 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, and 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, and increasing 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.*

PATIENTS

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.*

HEALTH INFORMATION PROFESSIONALS

Health information managers value an accurate and complete electronic record.
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 support regulatory compliance.*

PAYERS

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 trusted manner.*
- *Value based reimbursement through a complete, usable record.*

RESEARCHER, ANALYSTS

While direct delivery of care is primary, 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 delivered from text processing, pattern matching, and natural language processing against a complete, cohesive record rather that running queries against a perfectly structured but impoverished database.*
- *Quality measurements in a shared-care environment demand a complete record valid across settings.*

DEVELOPERS AND IMPLEMENTERS

Health Story Project provides value to health IT developers and implementers of clinical, administrative, and analytical applications by:

- *Supporting Electronic Health Record (EHR) developers' need to optimize EHR systems to facilitate longitudinal care delivery, as well as care that involves teams of clinicians.*
- *Advocating for clinical documentation in EHR systems that support clinicians' cognitive processes during the documentation process.*
- *Recommending that EHRs support "write once – reuse many times" and embed tags to identify the original source of information when used subsequent to its first creation.*
- *Wherever possible, ensuring that EHR systems do not require users to check a box or otherwise indicate that an observation has been made, or an action has been taken, if the data documented in the patient record already substantiates the action(s).*
- *Promoting EHR systems that facilitate the integration of patient generated data, and maintain the identity of the source.*

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