HEALTH STORY PROJECT

2013 HIMSS POLICY SUMMIT

September 2013

VISION

Comprehensive electronic records tell a patient's complete health story. Today, most electronic patient records and health information exchanges operate on a small percentage of the available information. The HIMSS Health Story Project is dedicated to a comprehensive electronic record that, of necessity and by permission, is shared to improve care through collaboration and analysis[1].

OUR APPROACH TO ELECTRONIC RECORDS

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

- *Use simple, stable, established formats for information exchange. These exist, are inexpensive to implement, and will lower the barriers to information sharing.*
- *Set the barrier to information sharing low, like the Web, and less like a database.*
- *Open exchange networks to Big Data, incrementally structured.*
- *Benefits of this approach:*
  - *Less disruptive – adapts to wider range of technology, giving clinicians more choice in how they capture and communicate information.*
  - *More useful – the record is more complete, mitigating the distortion introduced by single-minded focus on structured data capture*

OUR APPROACH TO ELECTRONIC RECORDS

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

- *Health Story was founded in 2006 as a non-profit consortium of vendors and professionals to ensure that exchange standards went beyond a narrow, common data set to encompass the most common types of clinical records.*
- *Where the Office of the National Coordinator (ONC) has focused on achieving a highly structured data set, Health Story has taken the same foundational standards and integrated them into specifications covering the full range of clinical information.*
  - *Within four years, Health Story supported eight specifications including Consult Notes, History & Physical, Procedure Note, Progress Note, plus others, and to cover all remaining documentation, a simple standard for Unstructured Documents using common identifiers and codes.*
  - *Health Story initiated the simplification and harmonization which created the HL7 Consolidated Clinical Document Architecture (Consolidated CDA) cited in Meaningful Use Stage 2.*
- ***Meaningful Use Stage 2 does not leverage the simple, low-end of the standard.*** *Instead, it focuses exclusively on exchange of a narrow set of highly-structured data elements.*
- *Our position is consistent with and builds upon HIMSS "ask" #3:*
  - *"Interoperability is the ability of an information technology system or software application to work with other systems or products without special effort on the part of the client or customer. Equally important, interoperability is the ability of an end-user to utilize these systems and applications to communicate, to exchange data accurately, effectively, and consistently, and to use the information that has been exchanged."* [2]

WE ARE LOOKING FOR A SHIFT IN POLICY

- *Lower the barriers to information exchange so that all may participate – retain current standards for MU but augment with, and incentivize, low-end specifications. It is insufficient to reward a percentage of a record or percentage of patients – we need a program that will get us quickly to near 100% of the records of near 100% of patients.*
- *Incentivize participation at all levels with higher reward where there is higher potential to automate reuse.*
- *Recognize diversity of applications originating, managing, and analyzing clinical information – the EMR is one such, we need many additional types of applications across the continuum of care.*
- *Respect the clinical voice – emphasize quality of documentation along with quality of care. Verbose computer-generated "summaries" should be deprecated and not rewarded.*

SUPPORT FOR THIS POSITION

- *See our bibliography of recent sources here:* ***http://www.himss.org/health-story-project***
- *Some highlights include the following:*
  - *Positions taken by the American College of Physicians (ACP), the American Medical Association (AMA), the American Medical Information Association (AMIA), Association of Medical Directors (AMDIS), and numerous studies stress the need for usability in electronic documentation.*
  - *Innovation can address the data capture problems, if we let it. See studies by Hripsak, Rosenbloom, Resnick, and others.*
  - *A complete record, even if not coded, is critically important for analytics – better to be complete and partially coded than missing critical information. See Dolin (pre-publication), Burstin.*

CONCLUSION

Federal regulators should ensure that regulations encouraging and incentivizing information sharing are:

- *Incremental, setting a low barrier to initial entry*
- *Inclusive of all participants in shared care, including patients*
- *Open to diverse applications, inviting innovation*
- *Minimally disruptive to care delivery*
- *Non-destructive of the permanent record of care*

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PLEASE ADDRESS QUESTIONS AND INQUIRIES:

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[1]See our Health Story Value Statement: http://himss.files.cms-plus.com/Health%20Story%20Project%20Value%20Statement%20FINAL_Approved.pdf

[2]HIMSS ASK #3: http://himss.files.cms-plus.com/HIMSSorg/Congressional_Asks3_2013StandardsInteroperability.pdf