

# HEALTH STORY | PROJECT

Integrating Narrative Notes and the EHR

**Vision: Comprehensive electronic records that tell a patient's complete health story.**

Much of the information needed for patient care is locked in unstructured documents, such as transcribed notes. We unlock it by developing data standards that support information flow between narrative documents and EHR systems.

## Integrating Narrative Notes and the EHR

Approximately 1.2 billion clinical documents are produced in the United States each year. These documents comprise around 60% of all clinical data. This tremendous source of clinical information is underutilized in today's computer-based record systems.

**Health Story** is an alliance of healthcare vendors, providers and associations that pooled resources over the previous three years in a rapid-development initiative to produce data standards for the flow of information between common types of healthcare documents and electronic medical record (EMR) systems.

Health Story has an Associate Charter Agreement with the HL7 data standards organization. Using HL7 Clinical Document Architecture (CDA), the group developed the following technical guides, which are now being consolidated into one package along with the Continuity of Care Document (CCD) standard. The consolidation project is being supported within the ONC Standards & Interoperability Framework:



1. Consultation Note
2. History and Physical
3. Operative Note
4. Diagnostic Imaging Reports
5. Procedure Note
6. Discharge Summary
7. Unstructured Documents
8. Progress Notes

Adoption of these standards will unlock the valuable data from clinical notes and make possible an unrestricted flow of this narrative-source data into EMR systems and expedite the development of interoperable clinical document databases for use within healthcare enterprises and health information exchanges.

Health Story supports implementation of these standards and works to inform industry about the availability and benefits of the Health Story pathway.

## The Health Story Pathway

The Health Story approach is particularly appealing to providers looking for a glide path to interoperability that allows clinicians to move toward EMR adoption and to meet early ARRA targets for meaningful use of EMRs while retaining their preferred methods of care.

## Call to Action

Support the Health Story approach. Require certified EMR systems to accept Health Story supported HL7 standards for integration of narrative notes and EHRs.

## Founding Members



## Promoter Members



## Requirements

The Health Story Project offers suggested requirements to assist providers and vendors with implementation. These requirements are also included in the AHIMA RFP template for EHR systems<sup>1</sup>, available in the online AHIMA Body of Knowledge, and they are referenced in the HIMSS Analytics EMR Adoption Model<sup>2</sup>.

### Electronic Health Record System Vendors

Electronic health information system shall support HL7's Clinical Document Architecture Release 2 (CDA-R2) standard for the encoding of narrative, text-based clinical information. More specifically, the system shall receive, display, transform, and parse CDA-encoded clinical documents as described in the HL7 Implementation Guides for CDA-R2 for document types including History and Physical Note, Consultation Note, Operative Note, Procedure Note, Progress Note, Discharge Summary, Unstructured Documents and Diagnostic Imaging Report. System shall receive, display, transform and parse CDA-R2 compliant documents with encoded headers (Level 1 encoding).

System should process CDA-R2 compliant documents that include Level 2 encoding, and are encouraged to process CDA-R2 compliant documents that include Level 3 encoding. Systems that support the creation of narrative clinical information shall create CDA-R2 compliant documents, consistent with, at a minimum, the HL7 Implementation Guides for CDA-R2 (US Realm) for document types including History and Physical Note, Consultation Note, Operative Note, Procedure Note, Progress Note, Discharge Summary, Unstructured Documents and Diagnostic Imaging Report.

### Medical Transcription Service Organizations

Transcription system shall support HL7's Clinical Document Architecture Release 2 (CDA-R2) standard for the encoding of narrative, text-based clinical information. More specifically, transcription system shall, at a minimum, support the creation and delivery of CDA-R2 compliant documents with document header information encoded using the CDA-R2 General Header Constraints Template.

Transcription systems should create CDA-R2 documents which comply with Level 2 encoding as specified in the HL7 Implementation Guides for CDA-R2 including History and Physical Note, Consultation Note, Operative Note, Procedure Note, Progress Note, Discharge Summary, Unstructured Documents and Diagnostic Imaging Report. The transcription system is encouraged to support the creation and delivery of CDA-R2 compliant documents that include Level 3 encoding (based on the above-referenced HL7 Implementation Guides).

Note: The Guides listed here are those available at the time of release of these requirements. Final requirements should include the addition of applicable HL7 Implementation Guides published at the time of the actual request for proposal.

"A number of Health Story members can produce electronic documents based on HL7 CDA," said Bob Dolin, MD, Chair of the HL7 data standards organization. "We need to raise awareness of this option," he continued. "Many EMR system vendors do not know that companies in the transcription and clinical documentation industry can produce and offer electronic documents in the HL7 CDA format. And, providers are not aware that they can ask for this approach to discrete data capture, which is minimally disruptive to clinician workflow."

<sup>1</sup> [http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1\\_047959.hcsp?dDocName=bok1\\_047959](http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_047959.hcsp?dDocName=bok1_047959)

<sup>2</sup> [http://www.himssanalytics.org/hc\\_providers/emr\\_adoption.asp](http://www.himssanalytics.org/hc_providers/emr_adoption.asp)