HEALTH STORY | PROJECT

Integrating Narrative Notes and the EHR

April 30, 2009

To: National Committee on Vital and Health Statistics
From: The Health Story Project
Re: Written Testimony Regarding "Meaningful Use"

The Health Story Project is an alliance of healthcare vendors, providers and associations that share a vision that all of the clinical information required for good patient care, administration, reporting and research will be readily available electronically – providing patients with a comprehensive electronic clinical record, or complete health story.

The greatest single waste of current health information technology (HIT) resources is the failure to leverage information that is already electronic; this occurs approximately 600,000,000 times each year in the U.S. when dictated notes are printed and the electronic source is not available for exchange and reuse. With the American Recovery and Reinvestment Act (ARRA) there is an opportunity to accelerate transformation of dictation from paper to electronic data and to address this significant gap.

**Meaningful use of the Certified Electronic Health Record (EHR) must encompass dictation for creation and exchange of standards-based clinical documentation. This comprehensive view of the EHR supports the immediate needs of front-line physicians and patients, is complementary with structured data, and lays the ground work for increasing EHR adoption and information reuse.**

It is for this reason that we respectfully submit this written testimony for consideration as you discuss "meaningful use" as referenced in ARRA.

## Stakeholder Communities Addressed in this Testimony

- Physicians: the overwhelming majority use dictation
- Vendors: Medical Records and Document Management, Coding, Dictation, Speech Recognition, Natural Language Processing & EHR
- Transcription/Coding Service Providers: includes over 200,000 U.S.-based knowledge workers
- Patients: want and deserve access to their complete record, including physician narrative and structured data entry

**For Consideration**

***Narrative documentation enhances clinical care****:* Care processes are individual and nuanced. Natural language captures the physician diagnosis and treatment rationale, provides an invaluable vehicle for communicating care details to the care team and ensures that the complete health story will be available.

***Dictation integral to existing workflows and practice***: The dictation/Transcription process delivers electronic content that can be immediately available to EHR systems and Health Information Exchanges (HIEs). Current practice coupled with minimal change to support the standard metadata and structures of a minimally-encoded CDA document can put a critical mass of information onto the networks at minimal cost. Standardizing this process decreases costs in the near-term while supplying immediate benefit to continuity of care.

*(HL7 Clinical Document Architecture (CDA) documents are XML representations of familiar clinical documents designed for exchange, recognized by ISO, ANSI, NCVHS, CHI, HITSP, CCHIT. Health Story supports development of templated CDA specifications for common document types.)*

***Creating structured documentation:*** The minimal structure standardized by templated, CDA-compliant narrative notes establishes an efficient framework for speech recognition and natural language processing – technologies in common use today as productivity tools for transcription and computer-assisted coding. Integrating narrative and coded data using EHR-compatible standards is an essential component of an incremental path to semantic interoperability.

***Every successful national HIE relies on structured documents:*** Those that took this path from the outset have found it easy to augment the degree of structured and coded data; those that aimed too high (i.e., to exchange coded data exclusively) later turned to structured documents with a mix of narrative and coded data to create a meaningful information exchange environment.

As mentioned previously, each year in the U.S., 600,000,000 clinical notes are dictated. This is by far the greatest single channel through which information enters into the patient record and becomes available for secondary use. Bold action can make these notes available for continuity of care within the next 12-18 months. Vendors who have adopted HL7

CDA/Health Story standards for dictated notes have done so to ***lower costs***. Steps forward that ignore this channel will court failure.

This massive data flow must be directed into the standards-based electronic record, raising the level of reuse, supplying consistent metadata to support search and retrieval and supplying the basis for front-line clinician decision making while providing a clear incremental pathway towards discrete data. Failure to value inclusivity and acceptance across the broadest spectrum of providers - not just the exemplars on the cutting edge of HIT and interoperability - will burn both resources and good will. Continuity of care is an empty promise if it excludes the preferred process of 85% of physician providers.

The vendors, service providers, clinicians and standards developers who have written and supported the Health Story specifications for common types of electronic documents - the HL7 CDA Implementation Guides for History & Physical, Consult Notes, Operative Notes and Diagnostic Imaging Reports - urge NCVHS to recognize that today, **the disruptive technology with the greatest capacity to transform practice and deliver the benefits of HIT starts with the standardization of dictated notes. This is an achievable step for providers that will inject massive amounts of important information into our fledgling networks, lower costs, and provide a clear pathway towards standardized computable data.**

Thank you for the opportunity to submit written testimony.

Sincerely,

The Health Story Project Executive Committee

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