Health Story Data Standards Included in Meaningful Use Program

Save to myBoK

posted by Joy Kuhl

Just because information can be exchanged electronically doesn't mean it can be digitally analyzed. Data needs to be structured using clear electronic standards for HIM professionals and other health IT specialists to analyze and use the data. Much of the data generated in healthcare-like progress notes and other transcribed documents-are unstructured and therefore not available for electronic analysis. But work has been done to add structure to this information and allow providers the chance to finally digitally analyze a patients' entire health story.

In 2011, the Health Story Project (Health Story), HL7 International (HL7), and Integrating the Healthcare Enterprise worked in collaboration through the Office of the National Coordinator for Health IT's Office of Standards and Interoperability on a project to improve clinical data exchange through the consolidation and harmonization of health information exchange specifications that support meaningful use of EHR systems.

The project work was published through the HL7 data standards organization in January 2012 as HL7 Consolidated Clinical Document Architecture (CDA). Consolidated CDA is an information exchange standard for common clinical documents such as a consult, history, and physical or progress notes. Consolidated CDA is referenced as a requirement in ONC's stage 2 "meaningful use" EHR Incentive Program.

Use of Consolidated CDA unlocks clinically vital information from narrative documents and facilitates the flow of the necessary data into the EHR. The US produces over a billion clinical documents each year-a tremendous source of clinical information that is underutilized in current computer-based record systems, according to Health Story executives. Having information from clinical documents available in a CDA-structured format will make it easier for providers to participate in quality reporting, improvement, research, and other activities.

Using Consolidated CDA:

- Provides choices to the clinician for efficient, effective, and convenient documentation
- Increases detail in the reports, making the documentation more useful
- Provides availability of detailed narrative information that doesn't conform to point-and-click methods
- Allows for discrete data collection without losing the patient's complete health story

Transcription has long played a major data capture role in health information management. With the introduction of the meaningful use objectives, transcription is now taking on a newly evolved supporting role. To achieve compliance with the meaningful use objectives, healthcare providers are seeking to leverage the best qualities of their transcription technologies to capture structured data within their EHRs. The CDA format helps transform loose information into structured and useable digital data.

Two years before the Health Information Technology for Economical and Clinical Health (HITECH) act was signed into law in 2009, Health Story began work on a vision to apply CDA to common types of clinical documents, allowing for the capture of structured data from traditional transcribed documents.

This consortium was initially titled "CDA for Common Document Types," Eventually, The Health Story Project was chartered by members from the American Health Information Management Association, Association of Healthcare Documentation Integrity, M*Modal, and Lantana Consulting Group.

The consortium embraced as a goal the establishment of explicit guidance for automatically rendering narrative text into structured data. In its first four years, Health Story published eight document standards for common clinical documents

through HL7 that are now part of Consolidated CDA. These standards allow EHRs to efficiently capture needed data with minimal disruption to current provider workflow for documenting patient encounters.

Visit www.healthstory.com for more information on adopting Health Story data standards.

Joy Kuhl (joy@optimalaccords.com) is executive director at Health Story Project.

Original source:
Kuhl, Joy. "Health Story Data Standards Included in Meaningful Use Program" (Journal of AHIMA website), November 2012.
