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Health Story Project Offers Perspective on “Meaningful Use” Definition
Testimony Encourages Transmission of Narrative Note Information to the EHR
using Existing Standards

PITTSBURGH, PA, JULY 22, 2009 -- With almost 20 billion dollars recently earmarked to encourage the adoption of the Electronic Health Record (EHR), The Health Story Project defined "meaningful use of the Certified (EHR)" in its testimony to the National Committee on Vital Health and Statistics' (NCVHS) public hearing in May. The key message; for the creation and exchange of standards-based clinical documentation "meaningful use" must encompass dictation and the detailed narrative. The outcome of this hearing will be submitted to the Centers for Medicare & Medicaid Services (CMS), along with the Office of the National Coordinator for Health Information Technology (ONC). The groups will be developing a proposed rule that provides greater detail on the incentive program and proposes a definition of meaningful use in late 2009.

“Because every national Health Information Exchange (HIE) relies on meaningfully, organized clinical information, creating structured documentation that takes the narrative into account from the beginning is crucial to facilitate the electronic exchange of health information,” stated Nick van Terheyden, MD, Interim Executive Committee, The Health Story Project and Chief Medical Officer, M*Modal.

The Health Story Project, founded by M*Modal, American Health Information Management Association (AHIMA), The Association for Healthcare Documentation Integrity (AHDI), and Medical Transcription Industry Association (MTIA) works to develop data standards for

common types of electronic healthcare documents to facilitate the smooth transition from unstructured narrative documentation to structured, discrete, and computer-interpretable electronic documentation that will support standardized electronic health records (EHRs).

Sixty percent of the clinical data included in the 1.2 billion clinical documents produced in the United States each year, is comprised of dictated and transcribed documents -- essentially, the narrative that tells the patient's story. This narrative is the information that forms the basis for reimbursement, proof of service, and quality of care between healthcare providers. It serves as the foundation for why physicians initiate orders and make decisions about patient care. Despite these attributes, many industry professionals say the information is "shockingly" underutilized in electronic medical records (EMRs) and other computer-based record systems.

The Health Story Project's testimony was provided on behalf of all parties whose input is critical to making the meaningful use of the certified EHR a success. These include physicians (the overwhelming majority who continue to use dictation); medical records and document management, coding, dictation, speech understanding, natural language processing and EHR vendors; transcription/coding service providers (over 200,000 U.S.-based knowledge workers); and patients who want and deserve access to their complete record, including physician narrative and structured data entry.

While the industry is beginning to recognize the need for the structured narrative, M*Modal has made this possible since 2001 with its advanced Speech Understanding technology. All of M*Modal's speech understanding/transcription solution content is produced in a format that complies with Health Story Project-sponsored data standards. The company's solutions generate "meaningful clinical documents" that handle structured data and natural language narratives with ease.

According to Michael Finke, CEO, M*Modal, "Clinical documentation is structured to support effective sharing between the narrative in documents and the database centric electronic health record. Our conversational document services turn clinical dictation directly into structured and encoded clinical documents which makes it easy to share information across provider and computer system boundaries while retaining the detailed narrative in one document."

This use of structured narrative and encoded data supports the Committee's observations regarding meaningful use:

- Metrics used in assessing meaningful use need to be easy for providers to report, easy to process for feedback to providers and consumers, adaptable to different clinical environments, and auditable.

- EHR technology must support interoperability for care coordination; population/public health management; and accurate quality measurement, reporting, and improvement - all the while being easy to use.

- The certification process must ensure flexibility and innovation, and must focus on critical capabilities for meaningful use for each set of intended users.

- The role of structured data in support of the definition of qualified EHR and quality measure reporting must be defined.

The Health Story Project, founded a little over two years ago, is a collaborative of healthcare vendors, providers and associations that holds an Associate Charter Agreement with Health Level Seven (HL7). This project develops HL7 Clinical Document Architecture Implementation Guides for common types of electronic healthcare documents, brings them through the HL7 ballot process and promotes their adoption within the industry. Over the previous two years, the initiative supported the development of four HL7 CDA Implementation Guides for standard electronic documents, including the Consultation Note, History and Physical, Operative Note and the most recently-announced Diagnostic Imaging Report. Work is now underway to develop a standard for the Discharge Summary.

By using these implementation guides, transcription documents can be imported directly into the EMR and aggregated with other clinical data and clinical information for exchange, reporting, and analysis.

Education on the Health Story Project and its ongoing five year plan is delivered through speaker presentations, educational papers and white papers around successes, and through its network of partners. For the full transcript of the testimony visit: <http://www.healthstory.com/>

About M*Modal

M*Modal, based in Pittsburgh, PA, offers on-demand conversational documentation services that help healthcare providers capture discrete clinical information from dictation to generate complete and timely electronic medical records. The company's unique Speech Understanding technology platform, **AnyModal CDS**, is a vital tool that empowers physicians to capture clinical facts and orders from dictation without requiring any change to their normal dictation routine. M*Modal's focus is on providing hospitals, healthcare IT vendors, and medical transcription service providers with the industry's most comprehensive yet most adaptable solution for creating highly accurate, structured, encoded, and shareable medical documents to increase patient safety, promote continuity of patient care, and reduce cost. For more information on M*Modal, visit its Web site at: www.mmodal.com.

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