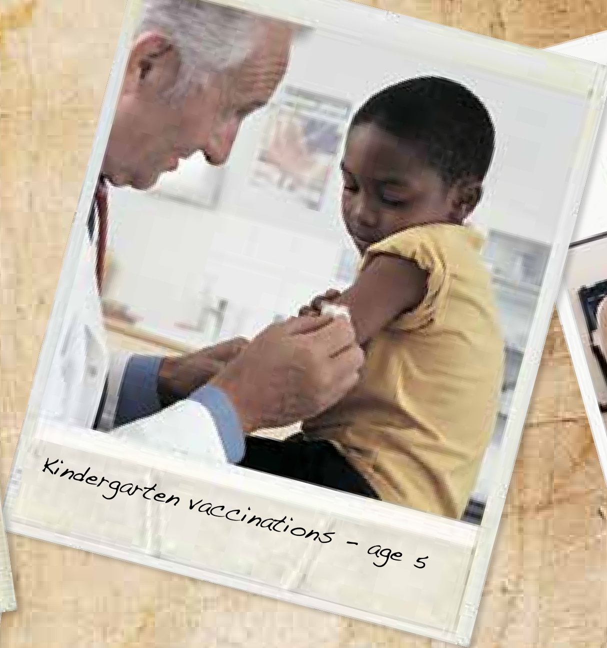
Well-baby visit – age 6 months



Kindergarten vaccinations – age 5

Fall from the balance beam – age 12

Appendectomy age 26

CAPTURING

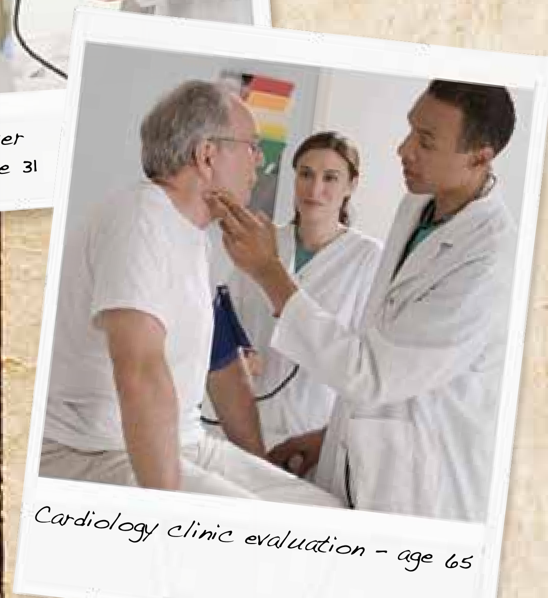
America's Healthcare Story

Every American citizen has a health story. And we can't afford to lose it. It is more than a database of care statistics. It is the chronicle of every care encounter, treatment decision, clinical conversation, and health outcome in a patient's life from birth to death. Preserving that story will be critical to:

- Capturing an information-rich care record for coordinated care and treatment decisions.
- Facilitating truly practical adoption and integration of electronic health record (EHR) systems.
- Engaging patients in their own care story in a way that empowers them to make better health decisions and meet care compliance goals.

The healthcare documentation sector is innovating around technology solutions that will preserve that full patient story and help the US healthcare system meet its goals for EHR adoption. Healthcare documentation specialists (ie, medical transcriptionists and editors) play a critical role in capturing and preserving America's health story. They partner with physicians and other providers to ensure an accurate, secure, and meaningful health record.

Third-trimester checkup – age 31



Cardiology clinic evaluation – age 65

What is a patient health story?

A patient's health story starts at birth and ends at death. It is the chronology of a patient's health history – ie, changes in health status, experiences of illness or injury, and encounters with a healthcare provider. A complete health story keeps patients safe because it includes full narrative history of the patient's healthcare needs and experiences beyond vital statistics and treatment data.

It is also the story of how a patient thinks and feels about their care, the scope of discussion that takes place between the patient and their doctor, and the record of all treatment that has been offered, discussed, attempted, and provided to that patient as well as outcomes of that treatment, both good and bad. Historically, this story has been captured by the healthcare team and documented in a patient's permanent health record.

For years, patient narratives have existed in disjointed pieces, scattered amongst various doctors' offices as well as hospitals. As the US healthcare system builds a national health network through electronic health record (EHR) systems, the pieces of a patient's health story can be reconnected to form a comprehensive health picture.

How will the EHR impact your health story?

Few within or outside of healthcare delivery would argue the benefits of having patient health data captured, stored, and archived in a way that will make that information accessible to both healthcare providers and to patients in a useable and meaningful way.

Unfortunately, some EHR systems are currently being constructed to allow for just the bare facts of a patient's care – statistics and data elements that will easily "fit" into the structure of an EHR. A great deal of critical detail necessary for coordinating your care will be lost in that process if the DHHS regulations allow for these types of systems to qualify for funding. EHR systems can be designed to allow for the detail generated by physician narrative, enabling a patient's full health story to find its home in the EHR.

Often, you may be the only one who knows and understands your full health history or that of your loved one. Making sure those details get recorded in a way that assists the healthcare team in coordinating your care is important. **It can save your life.** Talk to your physician about your medical record and the system they use. Make sure you have access to it, understand it, and are confident that your care story has been captured accurately to protect you and your family in the future.

Who We Are

Your health story is created through a partnership between healthcare providers and documentation experts (medical transcriptionists, editors, and quality-assurance professionals) who make sure that all the details of your healthcare experience have been accurately documented. The Association for Healthcare Documentation Integrity (AHDI) and the Clinical Documentation Industry Association (CDIA) represent the sector of healthcare delivery responsible for ensuring that patient health records are created in a secure, accurate way that truly preserves your health story.

How We are Advocating for Your Health Story

AHDI and CDIA fully support our nation's goals for EHR adoption. Our sector has historic perspective, expertise, and innovative solutions that address how those health stories need to be captured and documented. We have the unique ability to facilitate truly practical EHR adoption in a way that preserves America's healthcare story – so that the focus isn't just on patient health data, but rather on meaningful patient health information.

We advocate for:

- A federal requirement for EHR systems to receive narrative documentation so that your physician can capture your full health story and still meet federal requirements for EHR adoption.
- The use of currently existing innovative technologies that will convert narrative text into the kind of codified data needed for use in EHR systems.
- The role of the documentation knowledge worker in partnering with physicians and these emerging technologies to ensure that the focus is not just on how health information is captured but also on how well and how accurately it's being recorded.

For more information about the healthcare documentation sector and our efforts to preserve your health story, visit our association websites and click on "Advocacy and Public Policy."

ahdi
www.ahdionline.org

CDIA
CLINICAL DOCUMENTATION INDUSTRY ASSOCIATION
www.cdiaweb.org