

GLOSSARY of COMMON TERMS and ACRONYMS
In
HEALTH INFORMATION TECHNOLOGY*
(April 2011)

AHIC – American Health Information Community

The AHIC was a federal advisory panel created by HHS to make recommendations about the implementation of health information technology. In November 2008, after making more than 200 recommendations, it was decommissioned and became a private organization called *the National eHealth Collaborative*.

ARRA – American Recovery & Reinvestment Act

The ARRA is a law approved by the 111th congress and signed into law by President Obama in February 2009. Also called the economic stimulus bill, ARRA authorized the spending of more than \$750 billion to kick-start the U.S. economy. Part of the ARRA is the HITECH Act, which authorized more than \$20 billion in incentives to help the health care industry adopt health information technology and EMR / EHRs.

CCD – Continuity of Care Document

CCD is a set of specifications and standards for electronic medical records that was developed by HL7. The CCD specification takes HL7's Clinical Document Architecture and combines it with elements of ASTM's CCR specification. CCD is one of two primary standards for the electronic assembly and transmission of medical records. The other is CCR. So far, neither proposed standard has been adopted by CCHIT for use in EMR/EHRs. Chances are you won't even know which standard a program uses — the rules mostly operate at the programming level. For the user entering and sending data, the whole thing will be pretty much invisible.

CCR – Continuity of Care Record

CCR is a set of specifications and standards for electronic medical records jointly designed by the ASTM, medical professionals and health informatics specialists. The continuity of care record contains the core information needed by doctors to treat their patients: patient information, insurance data, medications, diagnoses and problem lists, allergies, etc. The CCR is designed to be easily created by a provider after a patient encounter. The CCR uses the XML data interchange language, so it can easily be read, translated, understood and transmitted by EMR/EHR software. CCR is one of two primary standards for the electronic assembly and transmission of medical records.

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CCHIT Certified – Certification Committee for Health Information Technology

The CCHIT is a non-profit organization founded in 2004 for the purpose of advancing the adoption of Electronic Health Records and health information technology. CCHIT has been designated by the U.S. Government as the organization responsible for

certifying EMR/EHR software. If you want the incentives available from the government to adopt HIT, you'll have to use CCHIT-certified products.

CDR – Clinical Data Repository

The clinical data repository is a name for the database where all the information about a patient resides. It includes such information as X-rays, blood test results, medications and care notes – a continuous, ongoing record of a patient's medical history.

CMS – Centers for Medicare and Medicaid Services

The CMS is the blanket government organization that manages both the Medicare and Medicaid programs. It is also the organization responsible for disbursing the \$20 billion in incentives available for the adoption of HIT.

CPOE – Computerized Physician Order Entry

Every time a provider wants an action to take place, such as giving a patient a medicine, ordering blood samples or changing a diet, he or she writes an order. In the past, the doctor wrote the order by hand, but paper orders can be lost or improperly transcribed, leading to potential problems. With a CPOE, the doctor writes orders using a computer. Patient data and decision support tools are right there to help. One great benefit of CPOE – especially when it comes to medicines – is that it eliminates any problems related to poor handwriting.

Decision Support Systems (DSS)

Computerized programs that can help doctors make decisions. A DSS for prescribing, for example, will generally include a knowledge base of drug interactions. A doctor enters a list of a patient's current medicines and a diagnosis. The decision support system compares that list to its knowledge base and gives the doctor a list of medicines he/she could prescribe that won't create an adverse interaction. The DSS helps the doctor and saves him/her time, but it does not make the decision in the doctor's place.

EHR/EMR/PHR– Electronic Health Record/Electronic Health Record/Personal Health Record

These three are together because people often use them interchangeably. "EMR" stands for Electronic Medical Record, "EHR" stands for Electronic Health Record and "PHR" stands for Personal Health Record. There seems to be a great deal of controversy over which term means what. The definition seems to vary depending on who is doing the defining – a vendor, a doctor or a consultant.

The following three definitions were taken from the U.S. Department of Health and Human Services website:

- **Electronic Medical Record** is "An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization."
- **Electronic Health Record** is "An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and

that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.”

- **Personal Health Record** is “An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.

Encryption

Encryption is the use of a mathematical algorithm (called a cipher) to take unencrypted data (plaintext) and make it an unreadable jumble of characters (ciphertext) to anyone who doesn't have the unique tool to unencrypt it (the key). To anyone intercepting an encrypted message, it will look like gibberish. The key is not a physical key, but rather a string of characters (letters, numbers and symbols) that will tell a computer how to convert the data back into plaintext.

HCPCS – Health Care Common Procedure Coding System

This is a numbering system used by anyone who bills Medicare. Every product or service Medicare might pay for has an alphanumeric code to be used for billing purposes. In order to be reimbursed by the government, the doctor must use this billing code system.

There are two primary levels of codes – Level I and Level II. Level I codes are identical to the CPT codes created by the American Medical Association, and include services rendered by doctors, such as a flu shot (code 90658) or stitching up a 1” cut (code 12002). Level II codes will cover the gauze bandage (code A6216) or the wipes to clean the wound (A4245).

HHS – Health and Human Services

Health and Human Services (HHS) is the department of the U.S. government that is responsible for overseeing the implementation of EMR/EHRs under the HITECH Act. Medicare and Medicaid are part of HHS.

Health Informatics

The use of computers and information management in a health care setting. Things that fall under the banner of health informatics include EMRs, medical coding systems, practice management software and medical records management.

HIE – Health Information Exchange

This is another of those definitions that seems to be in flux. What a health information exchange does is create an environment that facilitates the exchange of electronic medical records across regional and geographic lines. An HIE may be a stand-alone entity or Several RHIOs may comprise an HIE, and all the HIEs around the country will make up the NIHN.

HIMSS – Health Information and Management Systems Society

The HIMSS is a 23,000-member group dedicated to improving medical care through the use of health information technology. While based in Chicago, HIMSS members are actively involved in implementing, developing and improving every aspect of HIT throughout the world.

HIPAA – Health Information Portability and Accountability Act

While most people think of HIPAA as the set of laws that regulates the privacy and security of medical information, it is actually a much broader piece of legislation. HIPAA rules also regulate:

- how health insurers deal with pre-existing conditions
- the transfer of coverage from one health insurer to another
- the mechanics of the exchange of health information
- claims to Medicare and Medicaid

HIPAA was passed in 1996, and has been constantly amended and changed in the years since. The HITECH Act, passed in 2009, significantly changed many of the requirements of HIPAA.

HIPAA Compliant – personal health information is protected

HIT – Health Information Technology

HIT is an umbrella term covering any technologies that improve the collection and sharing of health information among doctors, patients, hospitals, insurers and other stakeholders in the health care system.

HITECH ACT – Health Information Technology for Economic and Clinical Health Act

Enacted in 2009 as part of ARRA (see above), the primary purpose of the HITECH Act is to encourage the adoption of EHR/EMR by providing billions of dollars in financial incentives. The HITECH Act also made significant changes to the security and privacy requirements already in place under HIPAA, expanding their scope and coverage and strengthening penalties for non-compliance.

HITSP – Health Information Technology Standards Panel

The Department of Health and Human Services (HHS) awarded a contract to the American National Standards Institute (ANSI) to establish the HITSP in 2005, in response to then-President Bush's desire to improve health care through the use of technology. ANSI, working with HIMSS, consulting firm Booz Allen Hamilton and the Advanced Technology Institute created the HITSP to facilitate cooperation between the public and private sectors and serve as an intermediary when existing standards and laws conflicted. Its overall goal is to achieve standards for interoperability among all the components of the NHIN.

HL7 – Health Level 7

Health Level Seven is an international non-profit group of scientists and researchers dedicated to creating standards and protocols for the sharing and communication of health information. Headquartered in Ann Arbor, Michigan, HL7 concentrates its work

on the sharing of clinical and administrative data, and is accredited by the American National Standards Institute (ANSI).

HL7 Compliant – this is the level of functionality that software systems must be at in order to exchange data from one system to another.

ICD-9 or ICD-10 – International Classification of Diseases

Technically known as the International Statistical Classification of Diseases and Related Health Problems but commonly referred to as the ICD, this is a set of international standards used to classify diseases, injuries and medical conditions. Each is assigned a unique, six-digit code which is used by doctors throughout the world for a variety of purposes including insurance, billing and public health statistics. It will also be an important part of EHR/EMRs.

The ICD system was created by the World Health Organization and is currently in its tenth version (ICD-10), although in some places ICD-9 is still in use. A new version is tentatively planned for 2015.

Integrated system – software that contains both a Practice Management function and EHR

Meaningful Use

When the HITECH Act was passed in 2009, it set forth incentives to be made available for the adoption of EHR/EMRs. To qualify for the incentives, a provider must demonstrate “meaningful use of an approved” EMR/EHR. The exact definition of meaningful use has not yet been determined. The ONC (see below) is still creating it with the help of a number of advisory groups and panels. A good way to track developments on the definition of meaningful use will be to [regularly check with the DHHS](#).

NHIN – National Health Information Network

The NHIN isn't an actual organization or physical thing so much as it is an idea. Starting in 2004, HHS started looking at how to create a nationwide network in which all health care providers could share health information in a secure environment. It began by creating a basic architecture, standards and protocols for such a system and then awarding contracts for trial implementations. HHS wanted to create certain core capabilities such as the correct matching of information to patients and the secure transmission of that data from one place to another. The NHIN will include sets of rules, protocols and standards to ensure that all the various health information technologies in tens of thousands of doctors offices and hospitals around the country will all work together to achieve the goals of improved patient care and lower costs. A good analogy here might be the internet. Millions of different websites and computer applications all work on the internet because they follow certain sets of protocols, rules and conventions that govern how the internet works.

ONCHIT / ONC – Office of the National Coordinator Health Information Technology

Known as both ONC and ONCHIT, the Office of the National Coordinator was created by President Bush in 2004 to coordinate and lead efforts to improve health care in the U.S through the use of health information technology. The ONC is a part of HHS. Its mission and responsibilities were expanded significantly by the passage of the HITECH Act.

PQRI – Physician Quality Reporting Initiative

A voluntary program through which physicians can earn incentive payments from the government for simply reporting quality data on covered Medicare procedures to CMS. Each year CMS chooses which quality measures will be part of the program. In 2008, more than 85,000 physicians elected to participate and were awarded more than \$92 million in incentive payments.

Practice Management – encompasses the scheduling, demographic information, billing & payment of services, insurance & Medicaid payers

REC – Regional Extension Center

Think of this as the medical equivalent of the agricultural extension center you call when you have a question about flowers or boll weevils. The government will be setting up some 70 of these centers around the country. Their purpose will be to provide help to primary-care physicians as they implement EMR/EHRs.

RHIO – Regional Health Information Organization

An organization created to serve as the infrastructure through which health information will be transmitted within a given geographic area and to other RHIOs. A RHIO will serve as an intermediary between providers, patients, insurance companies and other “stakeholders” who have or need access to medical records. The RHIO will ensure that the data remains secure, yet available to those organizations that have a legitimate need for it, whether they be local or in another part of the country.

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