

Electronic Medical Records Glossary

Agency for Healthcare Research and Quality (AHRQ): The lead federal agency charged with improving the quality, safety, efficiency and effectiveness of health care. AHRQ supports health services research that will improve the quality of health care and promote evidence-based decision-making. Its Web site is www.ahrq.org.

American Health Information Community (AHIC): A federal advisory body, chartered in 2005 to make recommendations to the secretary of the U.S. Department of Health and Human Services on how to accelerate the development and adoption of health information technology. AHIC was formed by the secretary to help advance efforts to achieve President Bush's goal for most Americans to have access to secure electronic health records by 2014. Plans are now underway to transform AHIC into a public-private partnership based in the private sector. The AHIC successor will be independent and sustainable and will be expected to bring together the best attributes and resources of public and private entities. This new public-private partnership is to develop a unified approach to realize an effective, interoperable nationwide health information system that supports the health and well-being of the people of this country. The successor will be designed and ready for initial operation by Spring 2008, with full transition from AHIC to the successor to be completed by Fall 2008. The agency's Web site is www.hhs.gov/healthit/ahic.html.

Audit Trail: A software tracking system that chronologically records the history of who used a specific computer, when they used it, what information they accessed, and any action(s) taken or modification(s) made to computer files or programs.

Authentication: A method that many computer software programs use to confirm the user's identity before allowing him or her access to the software.

Backward Compatibility: The capability of software to work with earlier versions. It is important that new software programs can work with older versions.

Centers for Medicare and Medicaid Services (CMS): A federal agency within the U.S. Department of Health and Human Services. Programs for which CMS is responsible include Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), HIPAA and CLIA. Formerly was HCFA. Centers for Medicare & Medicaid Services has historically maintained the UB-92 institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

Certification Commission for Healthcare Information Technology (CCHIT): A recognized certification body for electronic medical records and their networks, and an independent, voluntary, private-sector initiative. Its mission is to accelerate the adoption of health information technology by creating an efficient, credible and sustainable certification program. Its Web site is <http://www.cchit.org>.

Central Data Repository: A central place where data are stored and maintained.

Clearinghouse: A central agency for the collection, classification and distribution of information.

Computerized Patient Record (CPR): Also known as an EMR or EHR. A patient's past, present, and future clinical data stored in a server.

Current Procedural Technology (CPT) Code: A nationally recognizable five-digit number used to represent a service provided by a health care provider.

Data Use Agreement (DUA): HIPAA Regulation states that a health care entity may use or disclose a "limited data set" if that entity obtains a data use agreement from the potential recipient. It can be used only for research, public health or health care operations. It relates to privacy rules of HIPAA. A satisfactory assurance between the covered entity and a researcher using a limited data set is that the data will be used only for specific uses and disclosures. The data use agreement is required to include the following information: to establish that the data will be used for research, public health or health care operations (further uses or disclosure are not permitted); to establish who is permitted to use or receive the limited data set; and to provide that the limited data set recipient will: (1) not use or further disclose the information other than as permitted by the data use agreement or as required by law; (2) use appropriate safeguards to prevent use or disclosure of the information other than as provided in the agreement; (3) report to the covered entity any identified use or disclosure not provided for in the agreement; (4) ensure that any agents, including a subcontractor, to whom the limited data sets are provided agree to the same restrictions and conditions that apply to the recipient; and (5) not identify the information or contact the individuals.

Deidentified: Under the HIPAA Privacy Rule, data are deidentified if either (1) an experienced expert determines that the risk that certain information could be used to identify an individual is "very small" and documents and justifies the determination, or (2) the data do not include any of the following 18 identifiers (of the individual or his/her relatives, household members, or employers) that could be used alone or in combination with other information to identify the subject: names, geographic subdivisions smaller than a state (including zip code), all elements of dates except year (unless the subject is greater than 89 years old), telephone numbers, FAX numbers, e-mail address, Social Security numbers, medical record numbers, health plan beneficiary numbers, account numbers, certificate/license numbers, vehicle identifiers (including license plates, device identifiers and serial numbers), URLs, Internet protocol addresses, biometric identifiers, full face photos and comparable images, and any unique identifying number,

characteristic or code. Note that even if these identifiers are removed, the Privacy Rule states that information will be considered identifiable if the covered entity knows that the identity of the person may still be determined.

Directly Identifiable Health Information: Any information that includes personal identifiers. To determine what data may be considered identifiable, please see items that must be removed under the definition of Deidentified.

Drug Formulary Database: This EMR feature is used for electronic prescribing, electronic medical record (EMR), and computerized physician order entry (CPOE) systems to present formulary status to the provider during the prescribing decision.

eHealth Initiative: The eHealth Initiative (eHI) and the Foundation for eHealth Initiative are independent, non-profit affiliated organizations whose missions are to drive improvement in the quality, safety, and efficiency of health care through information and information technology. Their Web site is <http://www.ehealthinitiative.org>.

Electronic Data Interchange (EDI): The automated exchange of data and documents in a standardized format. In health care, some common uses of this technology include claims submission and payment, eligibility, and referral authorization. It refers to the exchange of routine business transactions from one computer to another in a standard format, using standard communications protocols.

Electronic Eligibility: This EMR feature accesses a payer to deliver up-to-date insurance benefits eligibility information on patients.

Electronic Health Records (EHR): Patient health records including treatment history, medical test reports, and images stored in an electronic format that can be accessed by healthcare providers on a computer network. Also known as a computer-based patient record (CPR) or electronic medical record (EMR).

Electronic Media Claims: A flat file format used to transmit or transport claims, such as the 192-byte UB-92 Institutional EMC format and the 320-byte Professional EMC NSF.

E/M level coding: Evaluation and Management level coding – documentation of each visit that identifies each service provided during an office visit.

Electronic Medical Records (EMR): Computerized records of a patient's clinical, demographic and administrative data. Also known as a computer-based patient record (CPR) or electronic health record (EHR).

Encryption: The process of transforming text into an unintelligible string of characters using a mathematical formula. Encryption allows computer users to share sensitive or confidential information over the Internet with a high degree of security. Encryption prevents hacking or illegal access by unauthorized persons. All EMR medical software systems should offer data encryption.

Epic Systems Corporation: A company in Madison, Wis., that specializes in health care software.

Electronic Prescribing: e-Prescribing enables a physician to transmit a prescription electronically to the patient's choice of pharmacy. It also enables physicians and pharmacies to obtain information about the patient's eligibility and medication history from drug plans.

Firewall: A computer or software system that prevents unauthorized or suspicious information from being downloaded onto a computer. In other words, a firewall is a security barrier to control access and communication.

Federally Qualified Health Center (FQHC): A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act.

Federally Qualified Health Center Look-Alike: An organization that meets all of the eligibility requirements of an organization that receives a Public Health Service Act Section 330 grant, but does not receive grant funding.

Health Care Authority (HCA): See West Virginia Health Care Authority.

Health Information Exchange (HIE): The mobilization of health care information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information between disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. Formal organizations are now emerging to provide both form and function for health information exchange efforts. These organizations (often called Regional Health Information Organizations, or RHIOs) are ordinarily geographically defined entities that develop and manage a set of contractual conventions and terms, arrange for the means of electronic exchange of information, and develop and maintain HIE standards.

Health Information Network (HIN): See West Virginia Health Information Network.

Health Information Security and Privacy Collaboration (HISPC): This organization comprises 33 states and one territory, Puerto Rico. It was set up in 2005 under an \$11.5 million contract awarded to RTI International by the U.S. Department of Health and Human Services. The goal was to assess and develop plans to address variations in organization-level business policies and state laws that affect privacy and security practices that may pose challenges to interoperable health information exchange. There was only one subcontracted organization per state or territory, and each subcontracted entity was designated by the governor. Each state and territory identified a steering committee that is a private-public partnership composed of leaders from state government

and stakeholder organizations, and all work was conducted through a series of coordinated work groups with specific charges.

At the beginning of this project in June 2005, the U.S. Department of Health and Human Services (HHS) published the *Summary of Nationwide Health Information Network Request for Information Responses*, which contained responses from 512 organizations and individuals. In that report, privacy and security considerations were crosscutting, and nearly every response cited the importance of “patient privacy and reiterated that the American public must feel confident that their health information is secure, protected, portable, and under their control.”

In July 2007, the collaboration released a report whose conclusion, among other things, was that “to reduce variation in practice, policy, and law to a manageable range for nationwide electronic health information exchange, state teams will need to work with one another and with existing federal initiatives. To reduce variation moving forward, a coordinated effort will be required so the 34 state teams can work with teams from the remaining 22 states and territories to resolve key issues and to ensure agreement on a manageable range of solutions that can be translated into the privacy and security requirements for nationwide health information exchange.”

(More information is available at http://www.wvmi.org/corp/proj_hispc/default.aspx.)

Health Information Technology (HIT or Health IT): The U.S. Department of Health and Human Services says health information technology “allows comprehensive management of medical information and its secure exchange between health care consumers and providers. Broad use of health IT will:

- Improve health care quality;
- Prevent medical errors;
- Reduce health care costs;
- Increase administrative efficiencies;
- Decrease paperwork; and
- Expand access to affordable care.

Interoperable health IT will improve individual patient care, but it will also bring many public health benefits including:

- Early detection of infectious disease outbreaks around the country;
- Improved tracking of chronic disease management; and
- Evaluation of health care based on value enabled by the collection of de-identified price and quality information that can be compared.”

Health Information Technology Standards Panel (HITSP): The mission of the Healthcare Information Technology Standards Panel is to serve as a cooperative

partnership between the public and private sectors for the purpose of achieving a widely accepted and useful set of standards specifically to enable and support widespread interoperability among health care software applications, as they will interact in a local, regional and national health information network for the United States. Comprised of a wide range of stakeholders, the panel assists in the development of the U.S. Nationwide Health Information Network (NHIN) by addressing issues such as privacy and security within a shared health care information system.

The panel is sponsored by the American National Standards Institute (ANSI) in cooperation with strategic partners such as the Healthcare Information and Management Systems Society (HIMSS), the Advanced Technology Institute (ATI) and Booz Allen Hamilton. Funding for the panel is provided through a contract awarded by the U.S. Department of Health and Human Services.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): The act is a set of federal regulations which establishes national standards for health care information.

Health Level Seven (HL7): One of several Standards Developing Organizations (SDOs) accredited by the American National Standards Institute. Most SDOs produce standards (sometimes called specifications or protocols) for a particular health care domain, such as pharmacy, medical devices, imaging or insurance (claims processing) transactions. Health Level Seven's domain is clinical and administrative data.

Headquartered in Ann Arbor, Michigan, Health Level Seven is like most of the other SDOs in that it is a not-for-profit volunteer organization. Its members – providers, vendors, payers, consultants, government groups and others who have an interest in the development and advancement of clinical and administrative standards for health care – develop the standards. Like all ANSI-accredited SDOs, Health Level Seven adheres to a strict and well-defined set of operating procedures that ensures consensus, openness and balance of interest. A frequent misconception about Health Level Seven (and presumably about the other SDOs) is that it develops software. In reality, Health Level Seven develops specifications, of which the most widely used is a messaging standard that enables disparate health care applications to exchange key sets of clinical and administrative data.

Members of Health Level Seven are known collectively as the Working Group, which is organized into technical committees and special interest groups. The technical committees are directly responsible for the content of the standards. Special interest groups serve as a test bed for exploring new areas that might need coverage in HL7's published standards.

HL7's mission is to provide standards for interoperability that improve care delivery, optimize workflow, reduce ambiguity, and enhance knowledge transfer among all of its stakeholders, including health care providers, government agencies, the vendor community, fellow SDOs and patients.

Hybrid Record: A provider's use of a combination of paper and electronic medical records during the transition phase to EMR.

Information Technology (IT): This includes computer hardware and software, operating systems, Web-based information and applications, telephones and other telecommunications products, video equipment and multimedia products, information kiosks, and office products, such as photocopiers and fax machines.

Legacy System: Term used to describe an old system (usually hardware and software), i.e., old medical billing software system.

Master Patient Index: An index referencing all patients known to an area, enterprise or organization.

Nationwide Health Information Network (NHIN): This initiative provides the foundation for interoperable, secure and standards-based health information exchange nationally. It is a key element of the national health information technology strategy.

National Provider Identifier (NPI): A unique number to define health care providers.

Office of the National Coordinator for Health Information Technology (ONCHIT): A presidential executive order created this agency in April 2004 to address strategic planning, coordination and analysis related to key technical, economic and other issues surrounding the public and private adoption of Health IT. This office is part of the U.S. Department of Health and Human Services.

Patient Portal: A secure Web-based system that allows a patient to register for an appointment, schedule an appointment, request prescription refills, send and receive secure patient-physician messages, view lab results, pay bills electronically, and access physician directories.

Personal Health Record (PHR): A health record that is initiated and maintained by an individual. An ideal PHR would provide a complete and accurate summary of the health and medical history of an individual by gathering data from many sources and making this information accessible online to anyone who has the necessary electronic credentials to view the information.

Portal: A point of access to information on the World Wide Web. Portals present information from diverse sources in a unified way. Popular portals include MSN, Yahoo and AOL. Aside from the search engine standard, Web portals offer other services such as news, stock prices, infotainment and various other features. Portals provide a way for enterprises to provide a consistent look and feel with access control and procedures for multiple applications, which otherwise would have been different entities altogether.

Practice Management System: A category of software that deals with the day-to-day operations of a medical practice. Such software frequently allows users to capture patient

demographics, schedule appointments, maintain lists of insurance payers, perform billing tasks, and generate reports.

Quality Improvement Organization (QIO): An entity that works with consumers, physicians, hospitals and other caregivers to monitor the appropriateness, effectiveness, and quality of care provided to Medicare beneficiaries. QIOs are private contractor extensions of the federal government that work under the auspices of the U.S. Centers for Medicare and Medicaid Services (CMS). In recent years, QIOs have undertaken to facilitate continual improvement of health care services within their constituent communities in addition to their original and ongoing statutory audit/inspection role of medical peer review.

Regional Health Information Organization (RHIO): The terms “RHIO” and “Health Information Exchange” or “HIE” are often used interchangeably. RHIO is a group of organizations with a business stake in improving the quality, safety and efficiency of health care delivery. RHIOs are the building blocks of the proposed National Health Information Network (NHIN) initiative proposed by David Brailer, M.D., and his team at the Office of the National Coordinator for Health Information Technology (ONCHIT). To build a national network of interoperable health records, the effort must first develop at the local and state levels. The concept of NHIN requires extensive collaboration by a diverse set of stakeholders. The challenges are many to achieve success for a health information exchange or a RHIO.

RTI International (RTI): One of the world’s leading research institutes, dedicated to improving the human condition by turning knowledge into practice. With projects in more than 40 countries and a staff of more than 2,600, RTI offers research and technical solutions to governments and businesses worldwide in the areas of health and pharmaceuticals, education and training, surveys and statistics, advanced technology, democratic governance, economic and social development, energy, and the environment. For more information, visit www.rti.org.

SureScripts: Electronic exchange that links pharmacies and health care providers. It was founded in 2001 by NACDS to make the prescribing process safer and more efficient.

Systemized Nomenclature of Medicine Clinical Terms (SNOMED CT): A systematically organized computer-processable collection of medical terminology covering most areas of clinical information, such as diseases, findings, procedures, microorganisms, and pharmaceuticals. It provides a consistent way to index, store, retrieve, and aggregate clinical data across specialties and sites of care. It also helps organize the content of medical records, reducing the variability in the way data are captured, encoded and used for clinical care of patients and research.

Tier: A formulary tier determines how much, if any, co-payment or coinsurance someone must pay for a drug. Plans differ in the number of tiers they use. Most prescription drug plans use three tiers, but some use four.

Uniform Billing Code of 1992 (UB-92): Bill form used to submit hospital insurance claims for payment by third parties. It is similar to HCFA 1500, but reserved for the inpatient component of health services. It is an electronic format of the CMS-1450 paper claim form that has been in general use since 1993.

West Virginia eHealth Initiative (WVeHI): A coalition of representatives from health care, business and state government. Its purpose is to promote the broad adoption, use and coordination of information technology in health care. WVeHI works with providers, health insurers, businesses, and government to facilitate the use of information technology to improve the quality, efficiency, and safety of health care for all West Virginians. Its Web site is <http://www.wvehi.org>.

West Virginia Health Care Authority (WVHCA): A state agency that, according to its own definition, administers programs with two primary purposes: to constrain the rising cost of health care and to assure reasonable access to necessary health services. In the Rural Health Systems Program, the Planning Division, and in the Certificate of Need (CON) program, access to necessary health service is evaluated. To accomplish these goals, programs such as Rate Review and CON can quantitatively demonstrate some of the costs they constrain. Health care financial disclosure and health planning can also be used to draw logical implications as to how those programs work to constrain costs. Additionally, the authority assures public access to the information compiled under its programs. Its Web site is <http://www.hcawv.org/>.

West Virginia Health Information Network (WVHIN): An agency established in 2006 by the Legislature at the request of the governor to promote the design, implementation, operation and maintenance of a fully interoperable statewide network to facilitate public and private use of health care information in the state while ensuring the privacy and security of patient health care information. It is a public-private partnership for the benefit of all of the citizens of West Virginia. The West Virginia Health Information Network is expected to be operational by 2010.

The network says its vision is to support and facilitate the following types of electronic transactions, activities and systems:

- Secure electronic access to the results of laboratory, X-ray, or other diagnostic examinations and medical record information transfer to medical providers with the patient's consent;
- Disease management and disease surveillance and reporting;
- Health alert systems and other applications related to homeland security;
- Registries for vital statistics, cancer, case management, immunizations and other public health registries;
- Educational offerings for health care providers including links to evidence-based medical practice and patient educational materials;
- Physician order entry, prescription drug tracking, drug and allergy interaction alerts, and secure electronic consultations between providers and patients;

- Single-source insurance credentialing system for health care providers; Electronic health care claims submission and processing; and any other electronic transactions or activities as determined by the Legislature.

The network's Web site is <http://www.wvhin.org/home.aspx>.

West Virginia Medical Institute (WVMI): A nonprofit organization that provides services designed to improve health and maximize the quality of health care nationally and regionally. WVMI strives to help hospitals, medical centers and health care delivery programs provide the highest quality of care to consumers by improving processes and efficiency. WVMI operates two affiliate corporations – Quality Insights of Delaware (QID) and Quality Insights of Pennsylvania (QIP) – which serve as the federally designated Medicare Quality Improvement Organizations for Delaware and Pennsylvania.

Governed by a board of directors consisting of physicians, hospital representatives and consumers, WVMI implements health care improvement projects with the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs, state Medicaid programs, private payers and nonprofit organizations, including the American College of Cardiology. WVMI's projects affect Medicare consumers in three states, U.S. military veterans, Medicaid recipients, and enrollees in private health plans.

WVMI is currently leading efforts to promote the adoption of electronic medical records and the establishment of health information networks. The company is also collaborating with rural hospitals in West Virginia on a ground-breaking patient safety project funded by the Agency for Healthcare Research and Quality.