

Glossary of Common Health IT Acronyms and Terms

ARRA: An acronym for the American Reinvestment and Recovery Act, the economic stimulus program passed by Congress on February 17, 2009 as US Public Law §1111-5.

CCHIT – Certification Commission for Healthcare IT: CCHIT serves as the recognized US certification authority for electronic health records (EHR) and their networks. In September 2005, CCHIT was awarded a 3-year contract by the U.S. Department of Health and Human Services to develop and evaluate the certification criteria and inspection process for EHRs and the networks through which they interoperate.

CCOW – Clinical Context Object Workgroup: An HL7 standard protocol designed to enable disparate applications to synchronize in real-time and at the user-interface level. It is vendor independent and allows applications to present information at the desktop and/or portal level in a unified way. Visit HL7 CCOW website.

CDR – Clinical Document Repository: CDR enables hospitals to build a life-long health record environment using stored health records for the purpose of better treatment, clinical research and health statistics for policy making.

CCD – Continuity of Care Document: The HL7 CCD is the result of a collaborative effort between the Health Level Seven and American Society for Testing Materials (ASTM) to “harmonize” the data format between ASTM’s Continuity of Care Record (CCR) and HL7’s Clinical Document Architecture (CDA) specifications. Read HL7 and Continuity of Care Document white paper.

CCR – Continuity of Care Record: CCR is an XML-based standard for the movement of “documents” between clinical applications. Furthermore, it responds to the need to organize and make transportable a set of basic information about a patient’s health care that is accessible to clinicians and patients. Read Understanding the Continuity of Care Record white paper.

CDA – Clinical Document Architecture: HL7 CDA uses XML for encoding of the documents and breaks down the document in generic, unnamed, and non-templated sections. Documents can include discharge summaries, progress notes, history and physical reports, prior lab results, etc. HL7’s CDA defines a very generic structure for delivering “any document” between systems. CDA was previously known as the Patient Record Architecture (PRA).

EHR – Electronic Health Record: EHR, as defined in Defining Key Health Information Technology Terms (The National Alliance for Health Information Technology, April 28, 2008): 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.

EMR – Electronic Medical Record: EMR, as defined in Defining Key Health Information Technology Terms (The National Alliance for Health Information Technology, April 28, 2008): 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.

ELINCS – EHR-Lab Interoperability and Connectivity Standards: The ELINCS specification provides a profile that refines (or constrains) “standard” HL7 messages to moving lab results from reference labs to physician offices.

HIE - Health Information Exchange: HIE focuses on the mobilization of healthcare 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 safe, and efficient patient-centered care.

HIPAA: The Health Insurance Portability and Accountability Act (HIPAA) was enacted by the U.S. Congress in 1996. Title II of HIPAA, known as the Administrative Simplification (AS) provisions, requires the establishment of national standards for electronic health care transactions and national identifiers for providers, health insurance plans, and employers. This is intended to help people keep their information private, though in practice, it is normal for providers and health insurance plans to require the waiver of HIPAA rights as a condition of service.

HIPAA Privacy and Security Rule: Establishes national standards to protect individuals’ medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rules require appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rules also give patients rights over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

HIPAA – Protected Health Information (PHI): Protected health information (PHI) under HIPAA, is any information about an individual’s health status that identifies or relates to an individual's past, present or future physical or mental health, the provision of health care to the individual, or the past, present or future payment for health care. Information is deemed to identify an individual if it includes either the individual's name or any other information that could enable someone to determine the individual's identity.

HITECH: As a part of the America Recovery and Reinvestment Act (ARRA) of 2009, Health Information Technology for Economic and Clinical Health (HITECH) refers to the portion of the ARRA that is used to increase the use of Electronic Health Records (EHR) by physicians and hospitals. This legislation provides immediate funding for health information technology infrastructure, training, dissemination of best practices,

telemedicine, inclusion of health information technology in clinical education, and State grants to promote health information technology.

HL7 – Health Level Seven : HL7 is a Standards Developing Organization accredited by the American National Standards Institute (ANSI) to author consensus-based standards representing a board view from healthcare system stakeholders. HL7 has compiled a collection of message formats and related clinical standards that define an ideal presentation of clinical information, and together the standards provide a framework in which data may be exchanged.

Interface Engine: An interface engine can transform or map the data to the receiving application’s requirements while the message is in transit so that it can be accepted by the receiving application. The application interface is built with one-to-many concepts in mind. These import/export modules then are connected to an interface engine so that the mapping, routing, and monitoring are managed by this system.

LOINC – Logical Observation Identifiers Names and Codes: LOINC applies universal code names and identifiers to medical terminology related to the EHR and assists in the electronic exchange and gathering of clinical results (such as laboratory tests, clinical observations, outcomes management and research).

Meaningful Use: A term associated with The American Recovery and Reinvestment Act of 2009 (ARRA) that authorizes the Centers for Medicare & Medicaid Services (CMS) to provide reimbursement incentives for medical professionals and hospitals that become compliant in the use of certified electronic health record (EHR) technology. Professionals and hospitals that meet the criteria of “meaningful use” will begin receiving incentive payments in 2011 with a gradual decline in reimbursement amounts until the year 2015. By this date, providers are expected to have adopted and be actively utilizing a certified EHR in compliance with the "meaningful use" definition or be subject to financial penalties under Medicare. Final definitions on meaningful use were published on July 13, 2010.

ONC – Office of the National Coordinator for Health Information Technology: ONC is the principal Federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. The position of National Coordinator was created in 2004, through an Executive Order, and legislatively mandated in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) of 2009.

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PHR – Personal Health Record: PHR, as defined in Defining Key Health Information Technology Terms (The National Alliance for Health Information Technology, April 28, 2008): 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.

QIO – Quality Improvement Organization: Under the direction of CMS, the Quality Improvement Organization (QIO) Program consists of a national network of 53 QIOs, responsible for each U.S. state, territory, and the District of Columbia. QIOs work with consumers and physicians, hospitals, and other caregivers to refine care delivery systems to make sure patients get the right care at the right time, particularly patients from underserved populations. The Program also safeguards the integrity of the Medicare Trust Fund by ensuring that payment is made only for medically necessary services, and investigates beneficiary complaints about quality of care.

REC – Regional Extension Center: Regional Extension Center is part of the federal HiTech Grant Program in the American Recovery and Reinvestment Act. The Extension Program provides grants for the establishment of Health Information Technology Regional Extension Centers (Regional Centers) that will offer technical assistance, guidance and information on best practices to support and accelerate health care providers' efforts to become meaningful users of Electronic Health Records (EHRs).

RHIO – Regional Health Information Organization: The terms “RHIO” and “Health Information Exchange” or “HIE” are often used interchangeably. RHIO (regional health information organization) is a group of organizations with a business stake in improving the quality, safety and efficiency of healthcare delivery. RHIOs are the building blocks of the proposed National Health Information Network (NHIN) initiative proposed by David Brailer, MD, 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 stake holders. The challenges are many to achieve success for a health information exchange or a RHIO.

TCP/IP – Transmission Control Protocol/Internet Protocol: TCP/IP is a low-level communications protocol used to connect hosts on the Internet or a network. TCP/IP connections are established between clients and servers via sockets. TCP/IP is stream-oriented meaning it deposits bits in one end and they show up at the other end.

X12: X12 provides for electronic exchange of business transactions-electronic data interchange (EDI). The American National Standards Institute (ANSI) chartered the Accredited Standards Committee (ASC) X12 to develop uniform standards.