

**Adult Medicaid
Quality Grant
Electronic Health
Records Toolkit**

SoonerCare
Oklahoma Health Care Authority

Table of Contents

Information About AMQG	3
AMQG EHR Provider Specialist Program	4
Clinic EHR Quality Reporting Plan	9
Goals and Objectives Worksheet	10
Measures to Report Worksheet.....	11
Common EHR Data Extraction Barriers	12
Identify Data Quality Dimensions	13
Example Part A Exploration	14
Example Part B Action Plan	15
Example of Workflow Diagram	16
Monthly Calendar	17
Clinic Quality Reporting Activity	23
Template Part A Exploration	24
Template Part B Action Plan	25
Data Mapping Elements Log.....	26
Notes	27
Quality Improvement Plan	33
PDSA Directions	34
PDSA Worksheet for Testing Change	36
Resources	40

Adult Medicaid Quality Grant (AMQG)



The Oklahoma Health Care Authority (OHCA) was awarded \$2 million for the Adult Medicaid Quality Grant (AMQG) from the Centers for Medicaid and Medicare Services (CMS) on December 21, 2012.

The grant will be used to increase the OHCA's capacity for standardized data collection and reporting of the data on quality of health care provided to approximately 430,812 adults currently eligible for Medicaid.

Additionally, grant funds will be used to conduct two quality improvement projects focusing on two out of the 26 Initial Core Set of Adult Health Measures: cervical cancer screening and Hemoglobin A1C testing. OHCA's goal is to increase awareness for preventive services and improve the number of adult preventive screenings received by SoonerCare members.

Through provider training (e.g. academic detailing, quality improvement activities, PDSA, CQM Data Extractions, etc.) and member outreach (telephonic), OHCA hopes to increase the percentage of Oklahoma SoonerCare members receiving cervical cancer screenings by 7.5 percent, increasing the HEDIS 2012 percentage to meet 50 percent for SoonerCare women.

OHCA also hopes to increase the HbA1c testing by 14.5 percent, increasing the HEDIS 2012 percentage to meet 85 percent for SoonerCare members.

Retrieved from: <http://okhca.org/providers.aspx?id=15006>

ADULT MEDICAID QUALITY GRANT EHR PROVIDER SPECIALIST PROGRAM

Provider Presentation

Background:

- **Centers for Medicare and Medicaid Services (CMS)**
 - \$112 million for the collection and reporting of healthcare data- funds appropriated by the ACA (FY 2012-FY 2014)
 - Adult Medicaid Quality Grant-AMQG (FY 2012 – 2013)
 - \$56 Million
 - 56 grant awards available
 - \$1 million for each 12-month budget period
 - Estimated \$2 million per Grantee
 - OHCA received \$1,984,180 (2012-2014)
 - Dec. 21, 2012-Dec 21, 2014

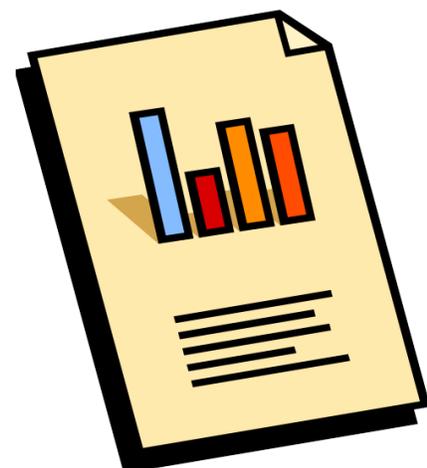
About: AMQG Year 1

- In year one of the grant, 114 providers participated.
 - Participating providers received an Unmet Needs and Provider Performance Feedback Reports
 - Participating providers began a Plan-Do-Study-Act (PDSA) Cycle
- OHCA reported on 15 of the 26 Initial Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid were selected and reported from OHCA claims data to CMS.



About: AMQG Year 2 and beyond

- In year 2 of the grant, the Electronic Health Record (EHR) Provider Specialist position was added.
- The EHR Provider Specialist will assist with building the capacity of Patient Centered Medical Home (PCMH) providers to collect and report data from their own EHR System.



Goal of the EHR Provider Specialist Program

- To report to OHCA on 3 Clinical Quality Measures (CQM) as providers' system allows.
- To assist providers with the use of their electronic health record system.
- To assess the barriers to reporting through the electronic health record system.
- To use data in practice PDSA cycles for continued process and practice improvement.

What Data Does My EHR Have?

- The data stored in the EHR system depends on how you currently utilize your system.
- Certified EHR systems can report on the CQM's that they are certified for¹.
 - These Measures are then used to Attest for Meaningful Use in the EHR Incentive program.
 - Different measures selected for different initiatives.
Ex: EHR incentive, AMQG, HEDIS, CHIPRA
some measures overlap between initiatives.

1. <http://www.ecfr.gov/cgi-bin/text-idx?SID=583ea42bdd8901c9d82d0a0cfd09b5d8&node=45:1.0.1.4.80&rgn=div5>

How Will My Data Be Used?

- The CQMs reported to OHCA **ARE NOT** used in an audit or evaluation situation.
- The data **ARE** used to test the ability of the agency to store clinical quality measures produced by providers.
- In no way will it be used against, or in favor of, the clinic at a later date.



The Value To Your Practice

- Practice and EHR specific solutions
- Improved patient care
- Improved usability of EHR
- No cost to clinic



Process

OBJECTIVE	TIME	TASK
Orientation and Engagement	1 st visit	Provider overview of AMQG and the EHR program. Engagement of all clinic stakeholders. Discuss clinic goals and objectives for program
Analysis	2 nd and Reoccurring Visits 4-6 Weeks	Identify Measures and data elements, Make data map, Confirm ability to extract data
Design and Implement	2-3 Weeks	Review workflows around data elements, Provide training, Implement PDSA Cycles
Test and Monitor – Control Phase	1-3 Weeks	Test accuracy of reporting and PDSA cycle, Reassess objectives and EHR usability
	Total: 7-12 Weeks	

Toolkit

- Health IT and EHR overview
- Used to track and plan the practice’s program
- Resource for staff education in case of turnover

CLINIC EHR QUALITY REPORTING PLAN

Goals:

Objectives:

Measures to Report:

1.

2.

3.

Common EHR Data Extraction Barriers¹

Barrier	Description and Example
Unavailable queries (database-level, table-level, or item-level)	A particular database or table is not included in the system's reporting capabilities and is not able to be queried. The system can pull some items, but not all, for a given query. For instance, it can pull the ordering physician's name, but not his or her specialty.
Inconsistency across data elements	Two items that the organization wants to compare are incompatible. For example, lab results could be linked with the original order while radiology report narratives and impressions could be received as notes without the associated order information.
Timeframe restrictions	A query asks for all data in the last 12 months, but it can only report for a given calendar year.
Data segmentation	It is impossible to segment data for a given population (e.g., mental health) because the data lacks sufficient specificity or the reporting tool is not robust enough to identify these data sets.
Tracking completed tasks	It is impossible to report on whether an action has been taken because the workflow does not provide a way for users to document that it is complete.
Information not stored	The EHR does not track a given function (e.g., chart last viewed by) for use by the reporting system.
Data stored in multiple places	An EHR, for example, could have two places to document an assessment, like smoking cessation, but the reporting tool could pull data only from one location and miss the other documentation for that patient.

¹ <http://www.healthit.gov/sites/default/files/onc-beacon-lg3-ehr-data-quality-and-perform-impvt.pdf>

Identify Data Quality Dimensions²

The decision on which assessment method to use influences which and how many dimensions of data quality can be effectively measured. Five major dimensions of data quality are: (1) completeness, (2) correctness, (3) concordance, (4) currency, and (5) plausibility, as identified through empirical research. The exhibit below defines each data quality dimension.

EHR Data Quality Dimensions

Data Quality Dimension	Definition
Completeness	Is a truth about a patient present in the EHR?
Correctness	Is an element that is present in the EHR true?
Concordance	Is there agreement between elements in the EHR or between the EHR and another data source?
Currency	Is an element in the EHR a relevant representation of the patient state at a given time?
Plausibility	Does an element in the EHR make sense in light of other knowledge about what the element is measuring?

² <http://www.healthit.gov/sites/default/files/onc-beacon-lg3-ehr-data-quality-and-perform-impvt.pdf>

Example

Crescent City Beacon Community (New Orleans) Pap Test Data Quality Assurance Plan Model³

Goal: Incorporate data-entry protocols into care management processes and protocols to facilitate quality measurement and reporting.

Part A (Exploration)

STEP 1 Measure Title: Pap Tests	STEP 2 Description	STEP 3 Performance	STEP 4 Location of data field in EMR	STEP 5 Structured Data field? Able to be pulled into report via Code, value, etc.? (Y/N/ Unsure)	STEP 6 Consistently used by appropriate staff? (Y/N/ Unsure)	STEP 7 Action needed? (Y/N)
Numerator	The number of patients included in the denominator who have had a pap test performed during the reporting period or the 2 years prior to the reporting period	15.5%	Chart→Path/Lab CPT codes: 88141- 88145, 88148, 88150, 88152-88155, 88164- 88167, 88174- 88175 Medcin (to capture patients having test done outside of center) Medcin findings: 3380, 3381, 4073, 105565, 13051, 29285, 105575, 105577, 220432 (has to have the onset date to be counted)	Yes	Yes	No
Denominator	The number of female patients 24–64 years of age during the reporting period who have had at least one encounter during the period		Pt Admin→DOB, Gender Chart→Encounter Date (Visit Count)	Yes	No	Yes

³ <http://www.healthit.gov/sites/default/files/onc-beacon-ig3-ehr-data-quality-and-perform-impvt.pdf>

Example⁴

Part B (Action Plan)

Quality Control:

- Describe your process to identify errors or issues affecting data quality of this measure (e.g., who will do what, how frequently).
- Data Manager—Run a list of females included in the denominator and identified as not having a pap test.
- QI Manager or other team member—Check the charts of several patients on the list and look for patterns.
- Frequency—Monthly

Reporting Results:

- INSERT FINDINGS: After checking 20 charts, it was identified that 15 of the 20 patients had had the test performed outside of the practice. The provider or staff documented that the test was performed but did not include the onset data, and the actual result was scanned into the patients' medical records.

Correction Process:

- Describe steps needed (who will do what, by when, and how will monitoring ensure that the process is working?)
- Designate staff to work the list and update those charts with the documentation scanned into the chart.
- Develop a protocol, have staff sign off that they have received the protocol, and quiz staff on the protocol.
- Train staff on the process for documenting pap test results when the test is performed by an outside facility. Monitor the list monthly.

Review Priorities:

- What can be easily solved? What depends on something out of the staff member's control?
- Training staff on the correct process for documenting.
- Protected time to go back and add the onset date.

Training Needs:

- Describe the training topic needed, who needs the training, how will it be conducted, who will lead the training, etc. Providers and support staff (M.A., L.P.N., R.N.) lead training—QI staff, chief medical officer, health IT staff, super user of the EHR (any one of these people).
- Group training—Presentation showing the results of the audit, walk-through of the workflow in the EHR for documenting pap tests performed at an outside facility.

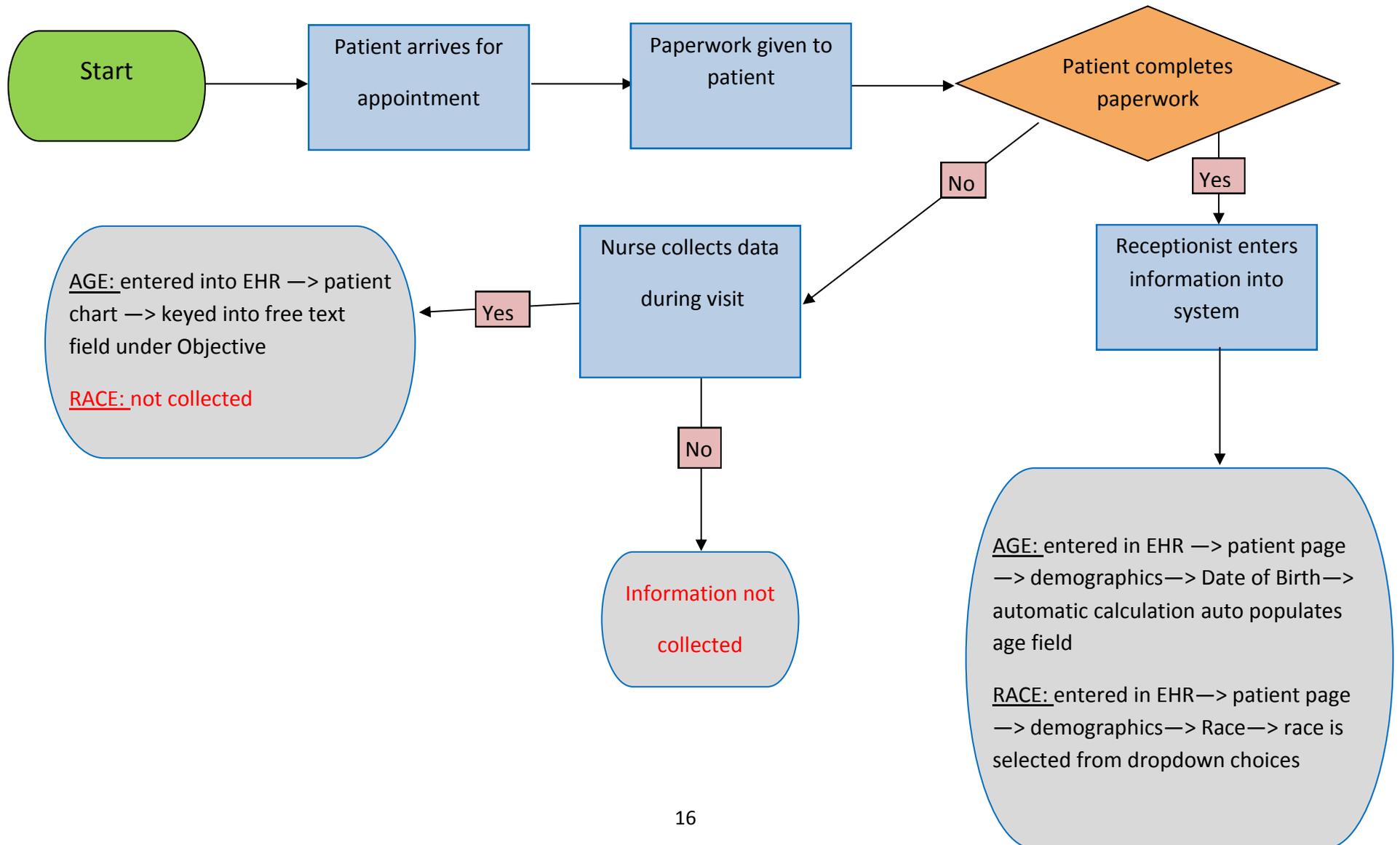
Quality Assurance:

- Describe your proactive process for avoiding these types of errors in the future.
- Train new staff, monitor performance on the measure monthly, and retrain staff. Have cheat sheets available, and report to the team the progress made on the measure.

⁴ <http://www.healthit.gov/sites/default/files/onc-beacon-lg3-ehr-data-quality-and-perform-impvt.pdf>

Example of a Workflow Diagram

Process: Collection of Patient Demographics– Age, Race



SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
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7	8	9	10	11	12	13
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19	20	21	22	23	24	25
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SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
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30						

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CLINIC QUALITY REPORTING ACTIVITY

Template

Title: _____

Goal: _____

Part A (Exploration)

STEP 1 Measure Title: Pap Tests	STEP 2 Description	STEP 3 Performance	STEP 4 Location of data field in EMR	STEP 5 Structured Data field? Able to be pulled into report via Code, value, etc.? (Y/N/ Unsure)	STEP 6 Consistently used by appropriate staff? (Y/N/ Unsure)	STEP 7 Action needed ? (Y/N)
Numerator						
Denominator						

Template

Part B (Action Plan)

Quality Control:

Reporting Results:

Correction Process:

Review Priorities:

Training Needs:

Quality Assurance:



Data Mapping Elements Log

Adult Medicaid Quality Grant: EHR Provider Specialist

Who	When	What Action	Findings
Ex: Catherine Miley-OHCA, Jim Thomas-Clinic Manager	Ex: 8/19/2014	Ex: Created structured data flow sheet for diabetic care	Ex: Structured data is now available for use by practice in tracking diabetic care. PDSA cycle 1 is testing this new function

NOTES:

Notes:

Notes:

Notes:

Notes:

Notes:

QUALITY IMPROVEMENT PLAN

PDSA Directions

The Plan-Do-Study-Act Method⁵ is a way to test a change that is implemented. By going through the prescribed four steps, it guides the thinking process into breaking down a task into steps and then evaluating the outcome, improving on it, and testing again. Most of us go through some or all of these steps when we implement change in our lives, and we don't even think about it. Having them written down often helps people focus and learn more.

For more information on the Plan-Do-Study-Act, visit the Institute for Healthcare Improvement (IHI) website.

<http://www.ihl.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx>

Keep the following in mind when using the PDSA cycles to implement the health literacy tools:

- **Single Step** – Each PDSA often contains only a segment or single step of the entire tool implementation.
- **Short Duration** – Each PSDA cycle should be as brief as possible for you to gain knowledge that it is working or not (some can be as short as 1 hour).
- **Small Sample Size** – A PDSA will likely involve only a portion of the practice (maybe 1 or 2 doctors). Once that feedback is obtained and the process refined, the implementation can be broadened to include the whole practice.

Filling out the worksheet

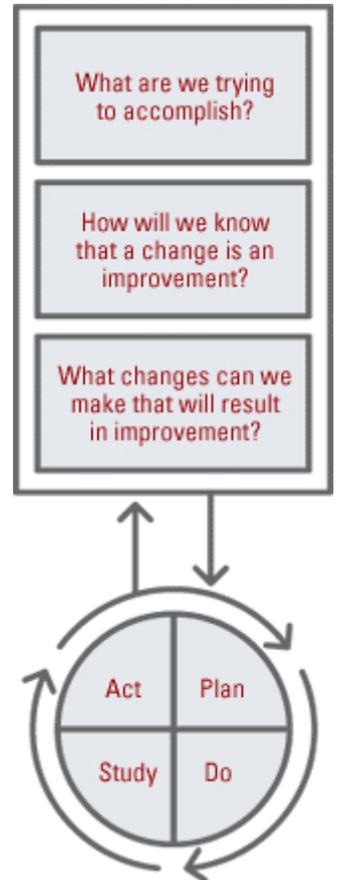
Tool: Fill in the tool name you are implementing.

Step: Fill in the smaller step within that tool you are trying to implement.

Cycle: Fill in the cycle number of this PDSA. As you work through a strategy for implementation, you will often go back and adjust something and want to test if the change you made is better or not. Each time you make an adjustment and test it again, you will do another cycle.

PLAN

I plan to: Here you will write a concise statement of what you plan to do in this testing. This will be much more focused and smaller than the implementation of the tool. It will be a small portion of the implementation of the tool.



⁵ http://www.integration.samhsa.gov/pbhci-learning-community/PDSA_Worksheet.pdf

I hope this produces: Here you can put a measurement or an outcome that you hope to achieve. You may have quantitative data like a certain number of doctors performed teach-back, or qualitative data such as nurses noticed less congestion in the lobby.

Steps to execute: Here is where you will write the steps that you are going to take in this cycle. You will want to include the following:

- The population you are working with – are you going to study doctors’ behavior or the patients’ or the nurses’?
- The time limit that you are going to do this study – remember, it does not have to be long, just long enough to get your results. And, you may set a time limit of 1 week but find out after 4 hours that it doesn’t work. You can terminate the cycle at that point because you got your results.

DO

After you have your plan, you will execute it or set it in motion. During this implementation, you will be keen to watch what happens once you do this.

What did you observe? Here you will write down observations you have during your implementation. This may include how the patients react, how the doctors react, how the nurses react, how it fit in with your system or flow of the patient visit. You will ask, “Did everything go as planned?” “Did I have to modify the plan?”

STUDY

After implementation, you will study the results.

What did you learn? Did you meet your measurement goal? Here you will record how well it worked, if you meet your goal.

ACT⁶

What did you conclude from this cycle? Here you will write what you came away with for this implementation, if it worked or not. And if it did not work, what can you do differently in your next cycle to address that. If it did work, are you ready to spread it across your entire practice?

⁶ http://www.integration.samhsa.gov/pbhci-learning-community/PDSA_Worksheet.pdf

PDSA WORKSHEET FOR TESTING CHANGE

Aim: (overall goal you wish to achieve)

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change:	Person responsible	When to be done	Where to be done

Plan

List the tasks needed to set up this test of change	Person responsible	When to be done	Where to be done

Predict what will happen when the test is carried out	Measures to determine if prediction succeeds

Do

Describe what actually happened when you ran the test

Study

Describe the measured results and how they compared to the predictions

Act

Describe what modifications to the plan will be made for the next cycle from what you learned

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Notes:

RESOURCES

Differences Between EHR and EMR⁷

Electronic Health Records

Electronic Health Records (EHRs) are built to go beyond standard clinical data collected in a provider's office and are inclusive of a broader view of a patient's care. EHRs contain information from ***all the clinicians involved in a patient's care*** and all authorized clinicians involved in a patient's care can access the information to provide care to that patient. EHRs also share information with other health care providers, such as laboratories and specialists. EHRs follow patients – to the specialist, the hospital, the nursing home, or even across the country.

Electronic Medical Records

Electronic Medical Records (EMRs) are ***digital versions of the paper charts*** in clinician offices, clinics, and hospitals. EMRs contain notes and information collected by and for the clinicians in that office, clinic, or hospital and are mostly used by providers for diagnosis and treatment. EMRs are more valuable than paper records because they enable providers to track data over time, identify patients for preventive visits and screenings, monitor patients, and improve health care quality.

⁷ <http://www.healthit.gov/providers-professionals/faqs/what-are-differences-between-electronic-medical-records-electronic>

Common Acronyms to Electronic Health Records⁸

ACO	Accountable Care Organization
AIU	Adopt, Implement, Upgrade (certified EHR Technology)
ANSI	American National Standards Institute
ARRA	American Recovery and Reinvestment Act of 2009
BHIE	Bidirectional Health Information Exchange
CAH	Critical Access Hospital
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CBO	Community-Based Organization
CCDA	Consolidated Clinical Document Architecture
CCR	Continuity of Care Record
CDS	Clinical Decision Support
CEHRT	Certified EHR Technology
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CHPL	Certified HIT Product List
CHR	Community Health Records
CIO	Chief Information Officer
CISO	Chief Information Security Officer
CLIA	Clinical Laboratory Improvement Amendments
CMIO	Chief medical Information/Informatics officer
CMS	Centers for Medicare & Medicaid Services
CPOE	Computerized Physicians Order Entry
CQM	Clinical Quality Measure
CY	Calendar Year

⁸ http://www.cdc.gov/cliac/pdf/Addenda/cliac0811/O_addendum_EHR_Related_Acronyms_and_Terms.pdf

HHS	Department of Health and Human Services
EH	Eligible Hospital
EHR	Electronic Health Record
EMR	Electronic Medical Record
EP	Eligible Professional
FDA	Food and Drug Administration
FFS	Fee-For-Service
FFY	Federal Fiscal Year
FIPS	Federal Information Processing Standards
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HEDIS	Healthcare Effectiveness Data and Information Set
HHS	Department of Health and Human Services
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Information Technology
HITECH	Health Information Technology for Economic and Clinical Health
HITPC	Health Information Technology Policy Committee
HITSC	Health Information Technology Standards Committee
HL7	Health Level Seven
HMO	Health Maintenance Organization
HOS	Health Outcomes Survey
HRSA	Health Resource and Services Administration
IHS	Indian Health Service
IT	Information Technology
LOINC	Logical Observation Identifiers Names and Codes
MCO	Managed Care Organization

MITA	Medical Information Technology Architecture
MMIS	Medicaid Management Information Systems
MU	Meaningful Use
MU Stage 1	Meaningful Use Stage 1
MU Stage 2	Meaningful Use Stage 2
NCQA	National Committee for Quality Assurance
NIST	National Institute of Standards and Technology
NPI	National Provider Identifier
ONC	Office of the National Coordinator for Health Information Technology
ONC-AA	ONC-Approved Accreditor
ONC-ACB	ONC-Authorized Certification Body
ONC-ATCB	ONC-Authorized Testing and Certification Body
PHO	Physician Hospital Organization
PHR	Personal Health Record
PIHP	Prepaid Inpatient Health Plan
PMR	Personal Medical Record
PPO	Preferred Provider Organization
PQRI	Physician Quality Reporting Initiative
RHC	Rural Health Clinic
RHIO	Regional Health Information Organization
RPPO	Regional Preferred Provider Organization
SNOMED-CT	Systematized Nomenclature of Medicine - Clinical Terms
SOAP	Simple Object Access Protocol
TIN	Tax Identification Number

Terms Related to Electronic Health Records⁹

Certified Electronic Health Record - An electronic health record or module of an electronic health record that has been reviewed by an ONC–Authorized Testing and Certification Body (ONC–ATCB) and determined to be compliant with the standards set forth in the Health Information Technology Standards and Certification requirements (45 CFR 170). Meaningful use incentive payments require participating hospitals and providers to use certified electronic health record systems.

Electronic Health Record (EHR) – 1. 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. 2. A comprehensive, structured set of clinical, demographic, environmental, social, and financial data and information in electronic form, documenting the health care given to a single individual.

Electronic Health Record System (EHR-S) - An information technology system designed to store and manage Electronic Health Records.

Electronic Laboratory Reporting (ELR) - The transmission of data of public health importance (specifically notifiable diseases) from clinical laboratories to public health agencies using electronic format and data specifications defined by public health partners.

Electronic Medical Record (EMR) - 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.

Federal Health Interoperability Modeling and Standards (FHIMS) - Federal initiative intended to coordinate the efforts of the partner agencies with respect to information and terminology standards.

Health Information Exchange (HIE) - The electronic movement of health-related information across organizations within a region, community or hospital system and according to nationally recognized standards.

Interoperability - Refers to the ability of health information systems to work together within and across organizational boundaries in order to advance the effective delivery of healthcare for individuals and communities.

Laboratory Results Interface (LRI) Initiative - An initiative under the S&I framework tasked with addressing interface interoperability challenges associated with laboratory reporting to ambulatory primary care providers. Challenges include mapping, interface configuration, and harmonization of core subsets of LOINC codes.

Laboratory Results Reporting (LRR) - The transmission of laboratory results in an electronic format from a clinical laboratory to Electronic Health Record System (EHR-S) for association with a patient's electronic health record (EHR).

Meaningful Use (MU) - Federal incentive program and regulations administered by CMS defining the minimum requirements that providers must meet through their use of certified EHR technology in order to qualify for the payments.

⁹ http://wwwn.cdc.gov/cliac/pdf/Addenda/cliac0811/O_addendum_EHR_Related_Acronyms_and_Terms.pdf

Nationwide Health Information Network (NwHIN) - A federal initiative for the exchange of healthcare information that supports meaningful use, being developed under the auspices of the U.S. Office of the National Coordinator for Health Information Technology (ONC). Formerly also known as NHIN.

ONC–Approved Accreditor (ONC–AA) - An accreditation organization approved by the National Coordinator to accredit electronic health record certification bodies under the permanent certification program, namely the National Institute of Standards and Technology (NIST).

ONC–Authorized Certification Body (ONC–ACB) - An organization or a consortium of organizations that has applied to and been authorized by the National Coordinator to perform the certification of Complete EHRs, EHR Module(s), and/or other types of health information technology under the permanent certification program.

ONC–Authorized Testing and Certification Body (ONC–ATCB) - An organization or a consortium of organizations that has applied to and been authorized by the National Coordinator to perform the testing and certification of Complete EHRs and/or EHR Modules under the temporary certification program.

ONC Permanent Certification Program - A program that provides a way for the Office of the National Coordinator to authorize organizations to test and certify electronic health record (EHR) technology. The permanent certification program will eventually replace the temporary certification program, as early as December 31, 2011.

ONC Temporary Certification Program - A temporary program that provides a way for the Office of the National Coordinator to authorize organizations to test and certify electronic health record (EHR) technology. The permanent certification program will eventually replace the temporary certification program, as early as December 31, 2011.

Personal Health Record (PHR) - 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 that individual.

Personal Medical Record (PMR) – See PHR. Terms used interchangeably.

Regional Health Information Organization (RHIO) – An organization that brings together health care stakeholders within a defined geographic area and governs health information exchange (HIE) among them for the purpose of improving health and care in that community. RHIOs are a component of the structure intended to implement the Nationwide Health Information Network (NwHIN).

Standards and Interoperability (S&I) Framework - A set of integrated functions, processes, and tools being guided by the healthcare and technology industry to achieve harmonized interoperability for healthcare information exchange.

Surescripts - Private Company authorized to test and certify EHR modules. One of six ONC-Authorized Testing and Certification Bodies. Awarded CDC grant, along with the College of American Pathology (CAP) and the American Hospital Association (AHA), to electronically link hospital laboratories and public health agencies to support meaningful use.

Technology Transfer & Technology Transfer Office – Government agency function and office intended to support collaboration and transfer of federal technology to the commercial marketplace and/or research community.

For more information please contact:

Oklahoma Healthcare Authority
Medicaid Adult Health Quality Grant
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105
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