Health Information Technology Definitions

**Overview**

Health information technology will transform health care including long term care. It is important to understand commonly used terms in health information technology (HIT).

**Electronic Health Record (EHR):** is an electronic record of patient health information. This can include medications, demographics, past medical history, progress notes, lab data and many much more information. This record is used across health care organizations. According to the 2010 National Survey of Residential Care Facilities, 17% of RCFs use electronic health records.

**Electronic Medical Record (EMR):** Defined by the Office of the National Coordinator for Health Information Technology (ONC) as “a digital version of the paper charts in a clinician’s office.” EMRs are within a health organization and the term is not interchangeable with EHR.

**Electronic Medication Administration Record (eMAR):** Technology that automatically documents the administration of medication into certified HER technology using radio frequency ID or bar coding.

**Health Information Exchange (HIE):** The exchanging of health information across providers, purchasers, regulators.

**Health Insurance Exchange (HIE or HIX):** An online marketplace for health insurance.

**Mobile Health (m-Health):** Health care through mobile devices.

**Basic interoperability:** The ability to electronically communicate health data.

**Semantic interoperability:** To enable the receiving computer to display the text or data received AND accurately interpret the meaning of the data.

**Levels of Interoperability:**
- Non-electronic data (paper)
- Machine transportable data (fax/e-mail)
- Machine-organizable data (structured messages, unstructured content –documents and images)
- Machine-interpretable data (structured messages, and standardized content) – The ultimate goal!


4) Other definitions from “Journey Destination: Better Health, Better Care, Lower Costs” presented by Patricia MacTaggart, MBA, MMA.