Table 1

Patient Health Information—Terms and Definitions

Term	Definition
ASTM Continuity of Care Record (CCR)	**"The ASTM CCR standard is a patient health summary standard, a way to create flexible documents that contain the most relevant and timely core health information about a patient, and to send these electronically from one care giver to another. It contains various sections—such as patient demographics, insurance information, diagnosis and problem list, medications, allergies, care plan, etc.—that represent a 'snapshot' of a patient's health data that can be useful, even lifesaving, if available when patients have their next clinical encounter. The ASTM CCR standard is designed to permit easy creation by a physician using an electronic health record software program (EHR) at the end of an encounter."[1]**
HL7 Clinical Document Architecture (CDA)	**"The HL7 Clinical Document Architecture (CDA) is a document architecture standard designed to represent medical legal health care encounter documents in a standardized format. CDA r2 (Release 2) was balloted and approved in June 2005."[2]**
HL7 EHR System Functional Model	**"The HL7 EHR System Functional Model and Standard Draft Standard for Trial Use (DSTU) is intended to provide a summary understanding of functions that may be present in an Electronic Health Record System (EHR-S), from a user perspective, to enable consistent expression of system functionality. This EHR-S Model describes the behavior of a system from a functional perspective and provides a common basis upon which EHR-S functions are communicated. The DSTU can help vendors describe the functions their systems offer, and help those planning new purchases or upgrades to describe the functions they need."[3]**
Computer-based Patient Record (CPR)	**"Computer-based Patient Record is a compilation in electronic form of individual patient information that resides in a system designed to provide access to complete and accurate patient data, alerts, reminders, clinical decision support systems, links to medical knowledge, and other aids."[4]**

Electronic Health Record (EHR)	**"The Electronic Health Record (EHR) is a secure, real-time, point-of-care, patient-centric information resource for clinicians. The EHR aids clinicians in decision-making by providing access to patient health record information when they need it and incorporating evidence-based decision support. The EHR automates and streamlines the clinician's workflow, ensuring all clinical information is communicated, and ameliorates delays in response that result in delays or gaps in care. The EHR also supports the collection of data for uses other than clinical care, such as billing, quality management, outcomes reporting, and public health disease surveillance and reporting."[5]**
Electronic Medical Record (EMR)	**"Electronic Medical Record—A computer-based patient medical record. An EMR facilitates access of patient data by clinical staff at any given location; accurate and complete claims processing by insurance companies; building automated checks for drug and allergy interactions; clinical notes; prescriptions; scheduling; sending to and viewing by labs. The term has become expanded to include systems which keep track of other relevant medical information. The practice management system is the medical office functions which support and surround the electronic medical record."[6]**
Electronic Patient Record (EPR)	**"Electronic Patient Record (EPR) describes the record of the periodic care provided mainly by one institution. Typically this will relate to the healthcare provided to a patient by an acute hospital."[7]**
Personal Health Record (PHR)	**"The Personal Health Record (PHR) is an electronic, universally available, lifelong resource of health information needed by individuals to make health decisions. Individuals own and manage the information in the PHR, which comes from healthcare providers and the individual. The PHR is maintained in a secure and private environment, with the individual determining rights of access. The PHR is separate from and does not replace the legal record of any provider."[8]**

Sources

1. Kibbe, D. C. "Unofficial FAQ of the ASTM Continuity of Care Record (CCR) Standard." Posted on March 28, 2006. Available at www.centerforhit.org/x1750.xml#whatstandard (accessed July 18, 2006).

2."Essential Similarities and Differences between the HL7 CDA/CRS and ASTM CCR." Available at http://www.centerforhit.org/x7.xml (accessed July 18, 2006).

3. Dickinson, G., L. Fischetti, and S. Heard. "HL7 EHR System Functional Model Draft Standard for Trial Use." July 2004. Available at www.sanita.forumpa.it/documenti/0/100/140/148/EHR-SWhitePaper.pdf (accessed July 16, 2006).

4. Field, M. J., ed. *Telemedicine: A Guide to Assessing Telecommunications in Health Care*. Washington, DC: National Academy Press, 1996, pp. 239–250.

5. HIMSS. "HIMSS Electronic Health Record Definitional Model, Version 1.1." Available at www.himss.org/content/files/ehrattributes070703.pdf (accessed April 11, 2006).

6. Gallagher, P. "Glossary of Selected Health Information Technology Terms." Pinellas County Health Dept. Available at www.pinellashealth.com/RHIO/Terminology_Master.pdf (accessed April 11, 2006).

7. HIMSS. "HIMSS Electronic Health Record Definitional Model, Version 1.1."

8. AHIMA e-HIM Personal Health Record Work Group. "The Role of the Personal Health Record in the EHR." *Journal of AHIMA* 76, no. 7 (July–August 2005): 64A–D. Available at http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_027539.hcsp?dDocName=bok1_027539 (accessed July 18, 2006).