An Rx for America’s Healthcare: Health IT & E-Prescribing
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Right Information Where It’s Needed, When It’s Needed:</td>
<td>3</td>
</tr>
<tr>
<td>A Vision for 21st Century Healthcare</td>
<td></td>
</tr>
<tr>
<td>E-prescribing: An Rx For Better Healthcare</td>
<td>4</td>
</tr>
<tr>
<td>In Today’s World, It Takes a Village to Care for a Patient</td>
<td>6</td>
</tr>
<tr>
<td>The Front Lines of Care Quality</td>
<td>7</td>
</tr>
<tr>
<td>“With the Push of a Button...”: The Blue Button Initiative</td>
<td>8</td>
</tr>
<tr>
<td>Preventing the Preventable: E-prescribing and Immunization</td>
<td>9</td>
</tr>
<tr>
<td>E-prescribing: An Rx For America’s Prescription Drug Abuse Epidemic</td>
<td>10</td>
</tr>
<tr>
<td>A Text, A Shot and a Healthier Outlook</td>
<td>11</td>
</tr>
<tr>
<td>An Rx for Reducing Readmissions: The Script Your Future Initiative</td>
<td>12</td>
</tr>
<tr>
<td>Quantifying Quality Measures: The Surescripts White Coat of Quality Initiative</td>
<td>13</td>
</tr>
<tr>
<td>Coming Out From Behind the Counter:</td>
<td>14</td>
</tr>
<tr>
<td>The Expanding Role of Pharmacy in Our Healthcare Delivery System</td>
<td></td>
</tr>
<tr>
<td>Saving a Million Hearts is Just the Beginning</td>
<td>15</td>
</tr>
<tr>
<td>Author Biographies</td>
<td>16</td>
</tr>
<tr>
<td>Health IT Glossary</td>
<td>19</td>
</tr>
</tbody>
</table>

By Harry Totonis

If there was ever a time in which our healthcare system consisted of a single physician meeting all of a patient’s medical needs, that system certainly doesn’t exist today. Today, a patient’s well-being rests in the hands of not only multiple professionals – including primary care providers, specialists, surgeons, pharmacists and nurse practitioners – but sometimes in the palm of your own hand. As a result, today’s patients are not limited by provider or geography in the care they receive – the challenge is that unless the care is coordinated, the risk of errors and adverse events may outweigh the benefits.

In this environment, the key to safe, high-quality healthcare is information – information that is reliable and that is easily and instantly accessible.

As a nation, we have just begun to explore what can be achieved in the digital age to elevate the state of healthcare. Here at Surescripts, the nation’s largest e-prescribing network, we have gotten a decade-long sneak peak.

Through e-prescribing alone, a tremendous impact is being made in both improving patient safety and achieving better health outcomes. Just take the 2010 National Institute of Health (NIH) study, which found that there is a significant drop in medication errors – from 37 down to 7 per 100 prescriptions – when physicians switch from paper-based prescribing to electronic prescriptions; a perfect example of how “e-health” can save lives.

E-prescribing isn’t just reducing errors, though – it is also improving outcomes and cutting costs. Studies have shown that e-prescribing increases medication adherence among patients. When the prescription goes straight to the pharmacy instead of into the patient’s pocket or purse, it is far more likely to be filled and taken. According to a study released earlier this year, that means savings of as much as $240 billion over the next 10 years through improved health outcomes.

As important as it is, I recognize that e-prescribing is just the beginning of healthcare’s digital revolution. With a data-sharing network in place like we have at Surescripts, it becomes possible to instantly exchange messages and share lab results, patient charts, discharge summaries and other essential information among providers no matter where their offices or hospitals are based. This means providers are working from the same base of knowledge and better able to provide superb, data-driven care to patients.

As part of our commitment to helping clinicians provide data-driven care, Surescripts recently announced that it has formed a partnership with Epic Systems. Through this partnership, Surescripts, with the nation’s largest interoperable healthcare data network, and Epic’s Care Everywhere platform will allow providers, prescribers and pharmacists to provide data-driven, evidence-based, coordinated care for Epic’s approximately 150 million patients.

You can’t help but be excited about the future of healthcare in this country. All of the challenges we face – reducing errors, providing evidence-based medicine to every patient, curbing health costs through coordinated care and improved outcomes – are obstacles we can hurdle. Some of these solutions are wide-reaching and systemic, while others are small enough to fit in the palm of your hand.

The key is a willingness to transform our healthcare system. And with that willingness, we already have the tools and technologies to make sure the right information is in the right place at the right time to protect Americans’ health.
E-prescribing: An Rx For Better Healthcare

By David Yakimischak

The mandate for American healthcare couldn’t be clearer. It’s expressed succinctly through what is now commonly referred to as the Triple Aim – improve the patient experience, elevate population health and achieve better patient outcomes at reduced cost. To address the cost and quality challenges facing the U.S. healthcare system, we need to find innovative ways to do better and do it for less.

It is equally clear that data is a critical, if not the critical, component in the solution to these challenges. With reliable patient information at the fingertips of every participant in the health delivery continuum – from the physician to the local pharmacist – we can indeed help patients stay healthy, reduce avoidable medical errors and, yes, wring unnecessary costs out of the healthcare system.

In this case, e-prescribing is more than an effective case study of these lessons. It’s already making a profound difference in strengthening quality and safety.

Let’s review what we know. E-prescribing is on the rise – a rapid rise. Today, approximately 6 of every 10 office-based physicians are prescribing medicines electronically instead of by paper. That’s almost 130,000 more doctors using handheld devices than were doing so just two years ago.

The impact of this digital transition has been striking:

» A Weill Cornell Medical College study found that physicians who are still using handwritten prescriptions had 88 legibility errors per every 100 prescriptions. This can cause both dangerous medication errors and delays in getting patients the medicines they need. It’s no wonder that the Institute of Medicine (IOM) has estimated $2 billion in annual costs stemming from adverse drug events.

» The same study found just 7 errors per every 100 prescriptions using e-prescribing software.

» And when the prescription gets sent to the pharmacist electronically instead of being written on paper and handed to the patient, it’s more likely to get filled. The World Health Organization has estimated that there are 125,000 premature deaths and billions in preventable costs due to patients failing to adhere to medication treatments. Surescripts has analyzed that up to $240 billion in healthcare savings can be achieved through the greater medication adherence achieved through e-prescribing.

This information is a clear demonstration that digitizing patient data and transporting it safely, securely and quickly over electronic networks can improve health, reduce costs and save lives.

But what’s genuinely exciting is that this is just the tip of the proverbial iceberg. As we use data networks to move clinical information to every point of the healthcare ecosystem, we make it possible for evidence-based healthcare to be delivered to every patient and healthcare consumer. We can eliminate the disparities that exist in the system and make sure that safe, quality care is extended to everyone regardless of their income or whether they live in a suburb, an inner city or a sparsely-populated rural area. That’s the future and we’re moving toward it at high speed.
Leading the Way to Better Healthcare: The Safe-Rx Awards

By Mary Ann Chaffee

In July of 2012, Surescripts presented its 7th Annual Safe-Rx Awards, which recognize the states that have made the greatest progress in the adoption and utilization of e-prescribing. When you’ve given an award enough times that it makes the transition from a novelty to an institution, it prompts a certain amount of reflection on the strides that have been made over these eight years.

Just before launching the Safe-Rx awards in 2004, there were approximately 2,500 office-based physicians nationwide who sent their prescriptions to the pharmacy digitally instead of scribbling them out on a pad. These were the early adopters, the pioneers. They saw the value of working electronically when few others were ready to make the leap. Only 4 of every 100 office-based doctors were using e-prescribing tools at that time.

Compare those statistics to what we know today. In 2011, a majority – 52 percent – of office-based physicians were actively using e-prescribing. That’s up from 10 percent just three years earlier. And more than 9 out of every 10 pharmacies in the US are linked to the Surescripts networks and are receiving and filling e-prescriptions every day.

That rapid escalation in e-prescribing adoption made the 7th Annual Safe-Rx Awards particularly noteworthy and rewarding. It was not only an opportunity to recognize states like Minnesota, the number one state, for engaging providers, pharmacies and payers in making e-prescribing a staple of healthcare practice, but provided a forum to recognize that what was once a shiny, new technology has now become the standard for providing safe, high-quality care.

This year’s Safe-Rx Awards recognized additional notable achievements in e-prescribing adoption and utilization as well. In Massachusetts and New Hampshire, for example, 86 percent of physicians have adopted e-prescribing. Nine states have adoption rates over 70 percent.

Healthcare officials and medical practitioners in various states have been abundantly clear in explaining why e-prescribing is on the rise...it reduces errors and improves patient care. It makes medical practices more efficient and improves work flow. And, as we hear time and time again from public health officials, the networks used to transmit prescription information can be expanded and utilized to improve healthcare delivery through electronic data exchange.

So, in one sense, this year’s Safe-Rx awards recognized those states and individual leaders who have demonstrated the commitment and vision connected with e-prescribing adoption. In a larger sense, though, this ceremony is helping to usher in an entire new era in healthcare delivery, one in which accessible data is driving improvements in public health and cost-effectiveness.
In Today’s World, It Takes a Village to Care for a Patient

By David Yakimischak

There is broad consensus in the healthcare community that we need a greater emphasis on care coordination if we are to going to improve patient outcomes while also constraining costs. In fact, I think the Aetna Foundation may have said it best by observing that “repairing a fractured healthcare system and eliminating gaps in shared information and communication that detract dramatically from patient safety and quality in healthcare are two goals of integrated healthcare.”

We’re really getting to the core of this issue when we talk about information sharing, aren’t we? We can no longer think of the patient care universe as being limited to one doctor seeing one patient. In today’s system, there are multiple players involved – primary care physicians, specialists, surgeons, radiologists, nurses, walk-in clinics, pharmacists and the list goes on. To paraphrase a popular saying, it takes a medical village to ensure that a patient is getting effective care.

Complicating this process is the increased mobility of our society. Over a patient’s lifetime, his or her interaction with healthcare professionals can take place in several locations, leaving a trail of important data at each stop.

Information is the critical linkage that empowers each participant in the healthcare ecosystem to deliver the right, most effective care at the right time. Care coordination doesn’t happen if accurate, reliable data isn’t readily available.

Let me provide one small, but meaningful, example. Surescripts has begun working with Walgreens, the nation’s largest drugstore chain. There are thousands of individuals who come into Walgreens and their in-store Take Care Clinics™ to get immunization shots. Using the Surescripts interoperable data network, Walgreens can communicate with the primary care physicians for each of those customers and let them know what immunizations have been delivered. That enables the patient record to be kept up-to-date and eliminates any confusion on the part of the patient or their doctor as to what immunizations have been received.

As we progress toward the optimal 21st century healthcare system we’re capable of creating, both the public and private sectors need to work to accelerate information-centered care coordination. It’s happening in bilateral fashion, such as the way physicians are using e-prescribing technologies to communicate with pharmacists and increase medication safety and drug adherence. But it can and must happen as well in more complex exchanges, in which we can use network connectivity to provide instantaneous, reliable data sharing between multiple healthcare professionals collaborating on a single patient’s care.

We know that making care coordination the accepted, always-practiced standard in healthcare isn’t necessarily easy, but the available technological tools will make it easier.
The Front Lines of Care Quality

By Mary Ann Chaffee

There is probably no single network of individuals as large in number and as geographically diverse as the veterans whose healthcare is overseen by the Department of Defense (DoD) and the Department of Veterans Affairs (VA). It is no wonder that the VA would have been one of the first institutions interested in the potential of data networks to strengthen the quality of healthcare provided to those who have served in the armed forces.

Care for military veterans would not be particularly complicated if all healthcare services were provided entirely within the VA system of doctors and medical facilities. That’s not what happens, though. In reality, thousands of veterans may have some of their healthcare needs met by the government, but they also often choose to go outside that system and see healthcare providers and pharmacies in the private sector. That’s where things can get complicated.

When Surescripts announced its initiative to open our data networks beyond e-prescribing services and use them as well to allow all types of health providers to share patient data over a secure, interoperable network, one of the first groups that applauded was the Department of Veterans Affairs.

As Roger Baker, the assistant secretary for information and technology at the Department of Veterans Affairs said in conjunction with the Surescripts announcement, “Our intention is to facilitate secure, standards-based health information exchanges between the VA and the private sector. A large number of Veterans receive some portion of their care from community providers and this initiative will assist us in improving the continuity of care for our Veterans.”

The fact is that America’s military veterans have earned the best possible healthcare, whether that comes from within the VA system or outside that system from private hospitals, doctors, clinics and pharmacies. There shouldn’t be a diminishment of care for a veteran who chooses to move between the public and private sector. That’s where reliable information networks are so essential; to make certain that the information derived from care delivered in varied settings can be brought together into a single, portable digital record.

There are certainly unique aspects to the way healthcare is delivered to those men and women who have served our country in the armed forces. Fortunately, we have the evolving information technology to meet those unique and important needs.
“With the Push of a Button...”:
The Blue Button Initiative

By David Yakimischak

“With the push of a button.....”

That’s a phrase we’ve heard used countless times in the decades since push-button technology was invented and used for everything from televisions to kitchen appliances. But pushing a button has now taken on a much more important and profound meaning for our lives, health and wellness.

The Blue Button initiative was launched in 2010 by the Department of Veterans Affairs to give military veterans the ability to retrieve, download and print all of their medical records with, yes, the push (or click) of a button on a computer screen.

This was a tremendous development. For military veterans, many of them with multiple and complex health issues and having been treated by several healthcare professionals in various locations, it is extremely advantageous to have all of their health records in one place where they can be provided to the physician currently treating them. This ensures more reliable and effective healthcare and also enables the veterans to update their own files.

It didn’t take long for the private sector to take notice. Large insurance providers like UnitedHealthcare, Aetna and Kaiser Permanente began to adopt the “Blue Button” approach, giving their customers greater control over their own health information.

This revolution, though, is far from over.

The partnership between Surescripts, with the nation’s largest interoperable healthcare data network, and Epic’s Care Everywhere platform, which holds medical information for approximately 150 million patients, creates an opportunity to take the “Blue Button” approach to an entirely new level.

We will now have the ability to transmit patient-specific information for nearly half of the healthcare consumers in the United States to providers across multiple technology platforms. This will vastly increase a patient’s (or provider’s) capability to keep all of a patient’s records – no matter how many healthcare professionals they’ve seen, even if they’re in various, disparate locales – easily accessible in one place. There is a tremendous feeling of security knowing that all of your medical information is just one click away, and there is a tremendous opportunity for improvement in healthcare quality when physicians can be assured they know everything they need to know about the patient they’re treating.

Our nation has a long history of adopting its medical best practices from those procedures being practiced at the front lines of battle. As the Blue Button initiative suggests, the procedures and practices our nation’s armed forces’ and veteran’s healthcare providers are utilizing at home are worth following.
Preventing the Preventable: E-prescribing and Immunization

By Mary Ann Chaffee

We have a growing immunization problem in the United States. Before we get into the severity of the problem, let’s put it in perspective. Just a one percent decrease in the number of children being immunized against illnesses like measles or whooping cough could mean literally hundreds of thousands of potential contagious illness cases that could have easily been prevented. It becomes a major public health issue.

And the fact is, it’s happening right now. Last year, there were over 27,000 cases of whooping cough in the United States, more than double the number reported in 2007. In fact, according to the Infectious Diseases Society of America, we’re seeing 85,000 cases of vaccine-preventable diseases in the U.S. each year – and those are just the cases being reported.

So how do we get a handle on this problem? How do we better identify the households in which children are not getting recommended vaccinations? How do we make certain parents are properly informed about the vaccines their children should be receiving? For that matter, during flu season, how can physicians be assured that their patients are receiving protective flu shots?

The potential exists for a data network, not unlike Surescripts’ national interoperable network, to address this challenge. A Surescripts survey of physicians found that a major contributing factor is the difficulty of maintaining complete medical records. Nearly 39 percent of doctors said they are frequently missing immunization records when they see patients.

Paper-based records can’t handle the problem. Paper doesn’t allow the rapid, unfettered movement of patient information between physicians, hospitals, clinics, nurses and other healthcare professionals who see patients and can advise on vaccination issues. Electronic data enables the presence of a complete medical record every time a patient interacts with the healthcare system. Therefore, when a child has not received a recommended vaccination, that can be flagged and protocols can be put in place to automatically alert physicians and parents accordingly.

At Surescripts, we’re already putting this theory into practice. This past March, we entered into an agreement with Walgreens. All of the nearly 8,000 Walgreens and Duane Reade pharmacies and the company’s 350 Take Care Clinics™, located in many of its stores, will use the Surescripts network to provide immunization reporting to primary care providers as well as state and local public health agencies.

This is just the beginning of a process that will one day allow every healthcare professional to not only know what care a patient has received but, just as importantly, what they have not.

The protection of public health depends on using every tool available to us to guard patients from preventable, communicable diseases. A comprehensive data network is one of these tools, and another one of the ways that health IT stands to improve public health in this country.
E-prescribing: An Rx For America’s Prescription Drug Abuse Epidemic

By Paul Uhrig

There are different types of adverse drug reactions. There are the kinds that patients can’t control, but that e-prescribing may prevent – when pharmacists can’t read a physician’s handwriting or when different doctors prescribe potentially conflicting drugs. We already know that the use of digital information creates a firewall to minimize these mistakes.

But then there are the drug events that people inflict upon themselves. More than 15,000 people die annually from prescription drug abuse. In fact, according to the Centers for Disease Control, misuse of prescription medication kills more people than the use of cocaine or heroin combined. There’s a large and growing black market in America, driven by individuals seeking prescription painkillers for non-medical purposes. That population is estimated at 12 million and rising.

By better understanding how people gain access to prescription drugs not prescribed for them, we can develop a strategy to prevent it. The key lies in utilizing data to stop what is commonly known as ‘doctor shopping.’

Doctor shopping occurs when patients count on the fact that physicians don’t have the means to share information with each other. In such a situation, a patient might see one doctor for a physical ailment and get a prescription for Percocet, then drive a couple of counties over, see a different doctor and take the prescription to a different pharmacy to collect a bottle of Vicodin. Multiple doctors, multiple pharmacies and you have the recipe for prescription drug abuse.

But by using electronic prescription drug data, authorities are able to fight back. A total of 3 states have now created prescription drug monitoring databases (PDMPs) to keep track of when pharmacies are being asked to fill prescriptions for powerful pain relievers. With a PDMP in place, it will become easier to determine when an individual visits different pharmacies to acquire those medicines on the target list.

That’s one level of protection, but we can do even better. We’re gradually moving toward using e-prescribing data networks to do more than transmit prescription drug information. Each day, we’re adding more physicians and clinics that are plugging into the network to share clinical information. As this evolution occurs, we’ll not only enable better healthcare but we’ll add another layer of detection against prescription drug abuse. Every physician should, and eventually will, have the ability to see a patient’s complete medical record before determining treatment and prescribing medications. So before they prescribe a patient a prescription, they will be able to quickly review their medical records to make sure they haven’t already received a prescription for the same or a similar medication. This data interoperability will make ‘doctor shopping’ virtually impossible.

Just as data can be used to do a better job of preventing disease, it can also be used to keep patients from inflicting harm upon themselves. We have a growing prescription drug abuse problem in this country. Let’s use every technological tool at our disposal to defeat it.
A Text, A Shot and a Healthier Outlook

By David Yakimischak

The Beacon Community Program is one of the most promising federal initiatives happening today. A creation of the Office of the National Coordinator for Health Information Technology (ONC), Beacon involves $250 million over three years being provided to 17 communities across the country to see how they can improve healthcare through the use of health information technology.

To understand how this is working, though, we should leave the background papers behind and see what’s happening on the ground – in this case, in San Diego. There are some interesting inroads being made in getting young children immunized against disease.

It’s not a well-known fact that one of every three toddlers in this country is not receiving all of their recommended vaccines to prevent against 14 different diseases. This became a more visible problem earlier this year when several states saw an outbreak of whooping cough among small children.

As part of the Beacon Community program, San Diego is enrolling 600 parents of toddlers in a program to test the effectiveness of text messaging as a tool to remind parents to schedule doctor visits for vaccinations. This kind of experiment makes sense. A PEW study found that over 95 percent of U.S. residents in their prime child-bearing years regularly send and receive text messages, thus this may be one of the best communications tools for the healthcare system to reach today’s parents.

What the San Diego initiative says is that we’ve barely begun to scratch the surface of what the digital information revolution can mean for the delivery of healthcare in this country. If we can increase the number of timely immunizations simply by tapping out a message on a phone and sending it to millions of parents of young children, there are countless other benefits that we haven’t even begun to fully optimize.

Like the many advances achieved through the adoption and utilization of e-prescribing and the Surescripts national healthcare network, the Beacon Community Program is another example of the enormous potential that exists for improving our healthcare delivery system through data-driven healthcare and health information technology. There’s an old saying that information is power. But, as we’re seeing in San Diego and so many other venues from coast to coast, information is also health.
An Rx for Reducing Readmissions:  
The Script Your Future Initiative

By Mary Ann Chaffee

Healthcare analysts have narrowed down the source of a large share of our avoidable healthcare costs in this country, and it comes from hospital readmissions. Too often, patients who have just come out of the hospital have to be readmitted a few days later because of a reoccurrence of their symptoms. Our healthcare system is spending billions of dollars treating people who should be recovering in their own homes.

Frequently, the reason for many of these rehospitalizations is a simple one -- patients aren't taking the medicines their doctors prescribed for them, or aren't taking them as directed.

A Stanford University study, for example, found that elderly patients who have suffered heart attacks were taking their prescribed post-discharge drugs only about 50 to 60 percent of the time. Multiple studies have shown that this lack of drug adherence leads to health complications and, often, the need to be readmitted to the hospital.

To combat this problem and improve medication adherence, The National Consumers League, together with partners from every sector of the healthcare system (including Surescripts) launched the Script Your Future campaign. In six test cities around the country, campaign partners are spreading the word to remind people of the importance of medication adherence through live events, advertising and targeted messaging. We believe that by reminding people about the importance of taking prescription medications as directed can make a difference in curbing rehospitalizations.

Of course, at Surescripts, we've already documented successful methods to improve medication adherence. Our study released earlier this year found that e-prescribing leads to a significant increase in first-fill prescription drug adherence. In other words, when there is an electronic prescription transmitted directly from the physician to the pharmacist, the patient is more likely to pick up their medication. Not only does this increased medication adherence improve patient outcomes, it has the potential to generate up to $240 billion in health system cost-savings over 10 years.

There's no question that prescription drug adherence can be the difference between staying healthy and being back in a hospital bed. We're making important progress in this area and we're proud to be a part of the Script Your Future campaign to keep more Americans on the path to recovery and good health.
Quantifying Quality Measures:
The Surescripts White Coat of Quality Initiative

By David Yakimischak

It’s always important to recognize the connection between principles and practice and, at the same time, the differences between the two.

Take, for example, e-prescribing. The principles behind e-prescribing are unassailable. Digitizing the information a physician provides to a pharmacist significantly reduces medication errors. It takes the guesswork out of pharmacists trying to read doctors’ handwriting. Studies have shown it also boosts medication adherence among patients. If a prescription goes electronically from the doctor to the pharmacy without going into a patient’s pocket, wallet or pocketbook in between, there is a much greater likelihood that prescription will be filled and utilized as the physician intended.

But in order for these e-prescribing principles to be effective, there must be constant vigilance in the way they are put into practice. And that’s why Surescripts created the White Coat of Quality program – to ensure that physicians who had adopted e-prescribing had done so in such a way that it yields increased care quality and patient safety.

This is an award presented to vendors who not only apply best practices to the use of e-prescribing technology, but also engage in continuous quality improvement and training of prescribers. There are four criteria involved in selecting White Coat of Quality recipients:

» It is essential for senior leadership of the organization to formally, in writing, affirm their commitment to a goal of zero electronic prescription content errors.

» Organizations must keep detailed metrics on their e-prescription content errors and report those findings to Surescripts.

» Vendors must be diligent in making necessary software changes in order to minimize any e-prescription clinical content errors.

» Organizations must provide educational programs to help e-prescribing users better understand and utilize the technology to minimize their own clinical content errors.

The effectiveness of evolving technologies must be mirrored by the commitment of the professionals who put those technologies into practice. That’s certainly Surescripts’ intent with e-prescribing. We have never accepted the notion that simply having a good idea is good enough. Constant improvement must be part of the equation.

The good news is that we are not the only ones who recognize this, as evidenced by the fact that the number of White Coat awardees keeps rising, which means that the quality and safety of the care patients are receiving is improving. In which case, it seems to me that everyone wins.
It only makes sense that pharmacies and pharmacists would be playing an increasingly important role in our healthcare system. One basic reason is proximity. More than 90 percent of Americans live within five miles of a community pharmacy. Even in less-populated rural areas, a drugstore is normally close by. That’s not always the case with hospitals and clinics that provide comprehensive health services.

So, it’s very positive that we’re seeing an evolution of the role of the pharmacist in the nation’s healthcare system. More often than not, today’s pharmacy is more than just a place to pick up a bottle of pills. Chains like Walgreens, CVS and Wal-Mart, as well as independent community pharmacies, are increasingly offering wellness programs, health screenings, immunizations and disease management services. Many provide in-store health clinics. Pharmacies are transforming themselves into multi-purpose health centers.

This significant change is being empowered, in large part, by information technology. Interoperable data networks began improving the pharmacy component of the healthcare continuum through e-prescribing. Roughly 95 percent of the nation’s pharmacies are linked to the Surescripts interoperable network. This makes it possible for the rapidly rising number of physicians using e-prescribing technology to communicate digitally with pharmacists, improving both patient safety and medication adherence. Reduced drug-related medical errors and greater prescription adherence are also significantly reducing health system costs.

But we’ve only begun to tap into the potential of digital networking. As pharmacists begin offering more healthcare services, particularly through in-store clinics that can conduct physical examinations and offer routine immunizations, it becomes increasingly important to link those pharmacies with patients’ primary healthcare providers. This two-way electronic street over which patient information can flow enables the best possible care to be delivered wherever the patient happens to be – in the pharmacy, in the hospital, or in the physician’s examination room.

A research paper published by the consulting firm Booz and Company, written by the company’s global healthcare experts, noted that “pharmacies are uniquely positioned to help meet the top two goals of reform: providing convenient, expanded access to medical care and controlling costs.”

This can only happen effectively if the pharmacy is linked electronically to the other players in the healthcare continuum. With that data linkage, the options for quality healthcare available to American patients and healthcare consumers are dramatically and beneficially expanded.
Saving a Million Hearts is Just the Beginning

By Seth Joseph

Right now, heart disease is responsible for one out of every three deaths in the United States. It's a staggering statistic, and one that is especially tragic when you consider that many of those deaths could have been prevented.

That's why Surescripts is proud to be partnering with the Department of Health and Human Services (HHS) and the Office of the National Coordinator for Health Information Technology (ONC) on their Million Hearts™ initiative, employing a variety of proactive strategies to prevent one million heart attacks and strokes by the year 2017. It's an ambitious, but incredibly worthwhile, goal.

It's estimated that, by 2016, 350 million working adults will be using smartphones. Seeing the potential benefits mobile applications could have on public health, the American healthcare industry is beginning to develop mobile applications to help people take steps to protect and strengthen their own well-being. Million Hearts™ is one such initiative that will enable us to test the linkage between mobile technology and improved healthcare.

Part of the Million Hearts™ initiative involves community pharmacies providing health screenings, enabling people to know if they're at risk for a serious heart-related health episode. And that's where Surescripts, which has interactive connectivity with approximately 95 percent of the nation's pharmacies, has an important role to play.

ONC envisioned the creation of a mobile application that would have health self-assessment tools for consumers and also the ability to locate nearby pharmacies offering health screenings. To accomplish this, ONC issued the Million Hearts™ Risk Check Challenge – charging developers with the task of creating an app to help the millions of Americans at risk for cardiovascular disease take action to improve their health. Surescripts is supporting the technology development and connectivity to make that happen.

As much as we discuss the ability of data networks to enable healthcare functions like e-prescribing and the sharing of patient data between health providers, it seems that even those of us who work with these networks every day are still realizing the enormous potential of digital connectivity to create a healthier society. Imagine what kind of healthy society we can achieve simply by enabling tens of millions of people to proactively protect against a health crisis simply by using a device they carry with them every day.

It makes you think that stopping one million strokes and heart attacks might just be the beginning of what we can do.
Harry Totonis
President & CEO

Harry Totonis is the President and Chief Executive Officer of Surescripts. An executive with extensive experience in information services and a track record of running successful network-based businesses, Mr. Totonis joined Surescripts in March of 2009.

Prior to Surescripts, Mr. Totonis was head of Advisors Services at MasterCard, the professional and information services arm of MasterCard Worldwide. While at MasterCard, Mr. Totonis expanded the company into decision analytics and information-based products. He was responsible for a global team that spanned business development and sales, product innovation, technology development and customer delivery. During his tenure, Mr. Totonis developed and executed the strategy for Advisors Services’ and MasterCard’s information and analytics services - a board level initiative - while expanding service offerings and streamlining operations. This resulted in significant overall revenue growth and substantial increases to revenue and net income per employee for Advisors Services.

During 14 years with Booz Allen Hamilton, Mr. Totonis focused on strategy consulting for large global companies across network-intensive sectors including technology, processing, consumer banking, insurance and airlines. He served in several executive positions, including managing partner of the firm’s global banking and insurance practice and as a member of the firm’s executive leadership team. His clients included Visa International, American Express, IBM, JPMorgan Chase and others.

Prior to MasterCard, as CEO of Kinexus, Mr. Totonis led the development and growth of a private banking network that enabled banks to share information and deliver better financial advice to their customers.

Mr. Totonis earned an undergraduate degree in computer science from The Ohio State University and an MBA in finance from Fisher College. While at Ohio State he worked on National Science Foundation computing research grants, which included responsibility for the development of price indices that measured national spending on education on behalf of the federal government.

Mr. Totonis was featured in the top selling book: “The 5 Patterns of Extraordinary Careers.”

Paul L. Uhrig
Executive Vice President, Chief Administrative & Legal Officer; Chief Privacy Officer

As Executive Vice President, Chief Administrative & Legal Officer; Chief Privacy Officer, Paul oversees legal matters, finance, federal and state legislative/regulatory affairs, certification policy and compliance, privacy, and internal audit for Surescripts. Mr. Uhrig came to Surescripts from the law firm of Gardner Carton & Douglas LLP in Washington, D.C., where he was vice chairman of the firm’s corporate department, chairman of the corporate department’s regulated industries transactions practice group, and a member of the firm’s health department. Prior to joining Surescripts, Mr. Uhrig represented Surescripts as its outside general counsel since its inception.

Mr. Uhrig brings 20 years of legal experience to Surescripts, focusing on the healthcare industry throughout that time. At Gardner Carton & Douglas, Mr. Uhrig focused on mergers, asset and stock acquisitions, joint venture formation and corporate planning with healthcare clients. His clients included private equity investors in middle market transactions, portfolio companies, healthcare systems, ancillary providers of healthcare services, physician groups, and investors involved with health industry projects and various other enterprises related to the healthcare industry. Prior to joining Gardner Carton & Douglas, Mr. Uhrig was a partner in the Washington office of Akin Gump Strauss Hauer & Feld LLP.

Mr. Uhrig has extensive experience structuring joint ventures and business arrangements in compliance with applicable corporate, securities and tax laws, federal and state fraud and abuse provisions, privacy laws, fee-splitting statutes and other corporate and healthcare regulatory provisions. Mr. Uhrig received his law degree from the American University, Washington College of Law, and his BA in Economics from The University of Notre Dame.
David Yakimischak
Senior Vice President &
General Manager, E-prescribing

David Yakimischak is Senior Vice President and General Manager, E-prescribing. In this capacity, Mr. Yakimischak is responsible for the business strategy and P&L of the core e-prescribing businesses: routing, benefit, and history. He also has responsibility for additional pharmacy and PBM services such as prescription drug monitoring programs, electronic prior authorization and adherence messaging.

From 2009 to 2012, Mr. Yakimischak led the Quality Office at Surescripts. In that role, he ensured the quality of the end-to-end e-prescribing process - from the time a prescription is first considered by a prescriber to the time the medication is dispensed to the patient and all intermediate points.

From 2006 to 2009, and prior to his role in the Quality Office, Mr. Yakimischak was EVP & Chief Technology Officer for Surescripts (legacy Virginia operation) where he was responsible for product development, product management, technical operations, implementation and certification, and customer support.

Mr. Yakimischak has 25 years of experience in technology management and product development in the healthcare, financial and publishing industries.

From 1999 to 2002, Mr. Yakimischak was the CTO at MedicaLogic/Medscape, a leading provider of electronic medical record (EMR) software and developer of the leading clinical reference web site for physicians and medical professionals. He played an important role in taking the company from early start-up through an IPO, a merger with two other healthcare companies and, finally, through its acquisition by WebMD and GE Medical Systems (now GE Healthcare). Mr. Yakimischak was responsible for all technology, including development, operations, information technology and business systems.

Prior to his work with MedicaLogic/Medscape, Mr. Yakimischak served as the director of product development at Dow Jones Interactive where he worked to transform the Wall Street Journal and Dow Jones News Retrieval into a leading supplier of news and information via the web. He had responsibility for product development, project management, quality assurance, technical support and consulting services.

Mr. Yakimischak started his career at Merrill Lynch Canada, where he was responsible for telecommunications and data center operations. Yakimischak has also served on the editorial advisory board of InfoWorld magazine, is a founding member of the CTO Club in New York City and completed his BA in computer science at the University of Toronto.

Mary Ann Chaffee
Senior Vice President,
Health Policy & External Affairs

Mary Ann Chaffee is Senior Vice President for Health Policy and External Affairs at Surescripts. She has over 30 years of experience in public policy and legislation. She came to Washington as a Presidential Fellow and subsequently held positions in the Department of Health and Human Services and the Office of Management and Budget. On Capitol Hill, she worked in both the House and Senate as senior committee staff and legislative director with a focus on public health and healthcare financing.

Ms. Chaffee later built and managed a public affairs practice at a Washington-based communications firm specializing in health and science. She has served as a trustee of the Sabin Vaccine Foundation and the Center for Infectious Disease Research and Policy and worked for two years in Africa as senior legislative consultant to the Parliament of Uganda.
Author Biographies

Seth Joseph  
Vice President, Pharmacy
Business Unit

Seth Joseph is a Vice President of Pharmacy Business at Surescripts. Seth’s primary role is in identifying new ways for pharmacies to leverage Surescripts’ e-prescribing and clinical messaging capabilities to enhance pharmacy’s connectivity to physicians and expand its opportunities to participate as a care provider. He also has spent the past several years evaluating e-prescribing data to explore the relationship between federal intervention in the HIT market and physician adoption, and physician use of electronic prescribing and EHRs. Previously, he was at CVS Caremark, where he focused on electronic prescribing, physician connectivity, and innovation for both the pharmacy and PBM. Mr. Joseph holds a BA in Political Science from the University of Wisconsin-Madison and an MBA from Boston University.

Ajit A. Dhavle  
Pharm.D., MBA
Director, Clinical Quality

Ajit Dhavle is a Director of Clinical Quality at Surescripts and in this capacity leads the Clinical Quality initiatives at Surescripts. Ajit was instrumental in building the Clinical Quality program at Surescripts including the development of the proprietary Quality Engine product built to perform semantic electronic prescription content validations for quality check and assurance purposes (United States utility patent pending).

Ajit joined Surescripts in its early stages as a Product Manager to build and deploy a national network for electronic prescribing and health information exchange. Since then, he has been involved in a variety of product management, certification, implementation, NCPDP and X12 standards development and other core development initiatives. He managed the Surescripts’ federal Medicare Modernization Act pilot grant, a multi-stake holder initiative spread over six states, aimed at evaluating advanced electronic prescribing standards and has also led a number of government and private sector benchmark pilot projects. Ajit was involved in the design and execution of various initiatives including development of company’s Health Information Exchange (HIE) strategy and the Office of the National Coordinator (ONC) Regional Extension Center engagement plan. He continues to serve as a subject matter healthcare information technology expert to physician and pharmacy software technology vendors, pharmacy benefit managers, payers, state government agencies and healthcare organizations in the United States.

Ajit received his Doctor of Pharmacy and his MBA degrees from the Bernard J. Dunn School of Pharmacy and the Harry F. Byrd School of Business at Shenandoah University in Winchester, Virginia.
Health IT Glossary

GENERAL

Health Information Technology (health IT or HIT) — “The application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of healthcare information, data, and knowledge for communication and decision making.”  SOURCE

Electronic Health Record (EHR) — A real-time electronic record of patient health information and medical history, generated by one or by multiple visits in any care delivery setting. EHRs provide access to evidence-based decision support tools to aid clinicians in decision making. It can also support the collection of data for uses other than clinical care, such as billing, quality management, outcome reporting, and public health disease surveillance and reporting.  SOURCE 1 and SOURCE 2

Electronic Medical Record (EMR) — Digital record of a patient’s medical and treatment history. The terms EMR and EHR are often used interchangeably, though there is a difference in that EMRs are not meant to store data from multiple providers in one central location.  SOURCE

Clinical Interoperability — The ability to send health data in a secure network between EHR systems at different points of care, thereby allowing for the coordination of one patient’s care among different care providers.  SOURCE

Meaningful Use — A set of standards set by the Health Information Technology for Economic and Clinical Health Act (HITECH), part of the American Recovery and Reinvestment Act of 2009, which require providers and hospitals to demonstrate that they are using EHR systems to meet benchmarks for measurable quality of care, in order to be eligible for financial incentives. The minimum requirements are being rolled out in stages by the Centers of Medicare & Medicaid Services (CMS).  SOURCE

- Stage 1 Meaningful Use — CMS’s first round of requirements. Stage 1 sets the baseline for electronic data capture and information, and includes both core requirements and a menu of other objectives from which a minimum number must be chosen.  SOURCE

- Stage 2 Meaningful Use — The second stage of criteria for incentive payments. Stage 2 will build on the trends and practices that were encouraged in Stage 1, adding requirements regarding data standardization for interoperability, patient engagement and access to information as well as care coordination and quality metrics.  SOURCE

Cloud Computing — Storing data or software in a secure online environment, where it will be accessible from any computer connected to the internet. For the purposes of EHR implementation, cloud computing is an option for storing patient data with less internal IT set-up and maintenance.

Electronic Prescribing (E-prescribing or eRx) — An online system that allows physicians to use handheld or personal computer devices to review drug and formulary coverage and to transmit prescriptions to a printer or to a local pharmacy. E-prescribing software can integrate with existing systems to allow physicians to access a specific patient’s information and history, and screen for drug interactions and allergies.  SOURCE

Health Information Exchange (HIE) — The transmission of electronic health-related information, shared in a manner that meets national standards of reliability, accessibility and security of the information.  SOURCE

Protected Health Information (PHI) — All “individually identifiable health information” held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral”, protected under the Standards for Privacy of Individually Identifiable Health Information (or “Privacy Rule”) issued by HHS.  SOURCE

Accountable Care Organization (ACO) — “A network of healthcare providers that is held accountable for the costs and quality of healthcare services that are provided to a defined group of patients. While ACOs exist in different forms, the general framework is that it is an organization, physical or virtual, that takes on the responsibility of reducing healthcare costs for this population while also meeting predetermined quality standards for its patient population.”  SOURCE 1 / SOURCE 2

Software as a Service (SaaS) — A model in which a consumer/provider can access applications hosted by a vendor or service provider over a network, typically the internet. Multiple people from multiple locations can easily access the application without managing or controlling the underlying cloud infrastructure including network, servers, operating systems and storage.  SOURCE
Clinical Decision Support (CDS) — “A process for enhancing health-related decisions and actions with pertinent, organized clinical knowledge and patient information to improve health and healthcare delivery.” CDS is considered to be one of the many benefits of electronic health records. [SOURCE]

Fee-for-Service — “A payment system by which doctors, hospitals and other providers are paid a specific amount for each service performed as identified by a claim for payment.” This system is generally thought to add to growing healthcare costs because it encourages unnecessary services; health policy experts want to move towards a pay-per-performance model, in which providers are reimbursed based on the quality and utility of care provided. [SOURCE 1, SOURCE 2]

International Classification of Disease, 9th Edition (ICD-9) — “The official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States.” These six digit codes represent extremely specific conditions or treatments, and the system for classification is universal; making the codes extremely useful in an interoperable EHR framework. [SOURCE]

International Classification of Disease, 10th Edition (ICD-10) — An updated version of ICD-9. Although the overall content is similar, it differs in how the conditions are categorized and organized; additional categories have been added, and some minor changes have been made in the coding rules for mortality. [SOURCE]

CPT Procedure Codes — “Current Procedural Terminology (CPT) codes were developed by the American Medical Association and first published in 1966. They are a listing of standardized descriptions and five-character, alphanumeric codes that medical coders and billers use to report healthcare services and procedures to payers for reimbursement. The purpose of CPT® is to provide a uniform language accurately describing medical, surgical and diagnostic services. It serves as an effective means for reliable nationwide communication within the healthcare industry.” [SOURCE]

CMS EHR Incentive Program — Program that went into effect in 2011 that will “provide incentive payments to eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology.” [SOURCE]

CMS E-Prescribing Incentive Program — “The Electronic Prescribing Incentive Program is a reporting program that uses a combination of incentive payments and payment adjustments to encourage electronic prescribing by eligible professionals.” The program began in January of 2009. [SOURCE]

Physician Quality Reporting System (PQRS) — “A reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals. The program provides an incentive payment to practices with eligible professionals who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries.” The PQRS program was created in March of 2007. [SOURCE]

Laboratory Information System (LIS) — “A series of computer programs that process, store and manage data from all stages of medical processes and tests physicians and lab technicians use laboratory information systems to supervise many varieties of inpatient and outpatient medical testing, including hematology, chemistry, immunology and microbiology. Basic laboratory information systems commonly have features that manage patient check in, order entry, specimen processing, result entry and patient demographics. An LIS tracks and stores every detail about a patient from the minute they arrive until they leave and keeps the information stored in its database for future reference.” [SOURCE]

Attestation—The process through which eligible professionals qualify for EHR Incentive Programs by providing evidence affirming their meaningful use of a certified electronic records system. [SOURCE]

Clinical Quality Measures (CQMs) — “A mechanism for assessing observations, treatment, processes, experience, and/or outcomes of patient care. CQMs are required as part of meaningful use requirements for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs.” [SOURCE]

Clinical Data Repository (CDR) — A storage mechanism for all clinical electronic data in a hospital or research facility. CDRs can be used to aggregating data for research and are also useful to improve patient care and move toward an integrated and interoperable health IT environment. [SOURCE]

Continuity of Care Record (CCR) — “A standard for the creation of electronic summaries of patient health. Its aim is to improve the quality of healthcare and to reduce medical errors by making current information readily available to physicians.” It can be read by EMR and EHR systems and exported as a PDF or XML file. [SOURCE]
Telehealth — “The use of electronic information and telecommunications technologies to support long-distance clinical healthcare, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.”  

Health App/mHealth App — Application programs that offer health-related services for smartphones and tablets. Some apps offer advice and tracking functionality for healthy living. Some are designed to transmit information between doctors and patients (e.g. glucose readings for diabetes management). Some are meant for doctors to keep accurate, accessible records.

E-PRESCRIBING-SPECIFIC

First Fill Rate — A rate, expressed in a percentage, which represents the likelihood that a patient who has been prescribed a medication will actually fill it at a pharmacy.

Medication Adherence — When a patient takes their medication with adherence to the prescribed quantity and frequency. Every year, almost 125,000 patients die from improper use of their medication, and more than one in three medicine-related hospitalizations occur because the patient did not take their medication as directed. There are many reasons that a patient would not adhere to their prescribed medication regimen, including forgetfulness, not wanting to deal with side effects, cost, and the feeling that they do not need the medication.

Medication Error — “Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient, or consumer. Such events may be related to professional practice, healthcare products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.”

Medication Errors Reporting Program (MERP) — One of two national error-reporting programs operated by the Institute for Safe Medication Practices; a “confidential voluntary program that provides expert analysis of system-based causes of medication error.”

Controlled Substances — Drugs that are regulated by federal and state law; only to be dispensed by prescription; as defined in the Controlled Substances Act: “a drug or other substance, or immediate precursor, included in schedule I, II, III, IV, or V of part B of this subchapter; The term does not include distilled spirits, wine, malt beverages, or tobacco, as those terms are defined or used in subtitle E of the Internal Revenue Code of 1986... the Attorney General shall consider the following factors with respect to each drug or other substance proposed to be controlled or removed from the schedules: (1) Its actual or relative potential for abuse, (2) Scientific evidence of its pharmacological effect, if known, (3) The state of current scientific knowledge regarding the drug or other substance, (4) Its history and current pattern of abuse, (5) The scope, duration, and significance of abuse, (6) What, if any, risk there is to the public health, (7) Its psychic or physiological dependence liability, (8) Whether the substance is an immediate precursor of a substance already controlled under this subchapter... the Schedules of Controlled Substances:

- **Schedule I.**
  - (A) The drug or other substance has a high potential for abuse.
  - (B) The drug or other substance has no currently accepted medical use in treatment in the United States.
  - (C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.

- **Schedule II.**
  - (A) The drug or other substance has a high potential for abuse.
  - (B) The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
  - (C) Abuse of the drug or other substances may lead to severe psychological or physical dependence.

- **Schedule III.**
  - (A) The drug or other substance has a potential for abuse less than the drugs or other substances in schedules I and II.
  - (B) The drug or other substance has a currently accepted medical use in treatment in the United States.
  - (C) Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.
Schedule IV.

(A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule III.
(B) The drug or other substance has a currently accepted medical use in treatment in the United States.
(C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule III.

Schedule V.

(A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule IV.
(B) The drug or other substance has a currently accepted medical use in treatment in the United States.
(C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule IV.”

Drug Enforcement Administration (DEA) — Administration that enforces the controlled substances laws and regulations.

Alert Fatigue — When physicians are overwhelmed by alerts to the point where they begin to ignore them or respond to them at a reduced rate.

National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard—recommendations expected to be followed by the industry for consistent and complete prescription transactions.

Sig Instructions — “Often the abbreviation ‘sig’ will appear just before the directions on the prescription. “Sig” is short for the Latin, signetur, or ‘let it be labeled.’”

Prescription Drug Monitoring Program (PDMP) — “A tool that can be used to address prescription drug diversion and abuse. PDMPs serve multiple functions, including: patient care tool; drug epidemic early warning system; and drug diversion and insurance fraud investigative tool. They help prescribers avoid drug interactions and identify drug-seeking behaviors or “doctor shopping.” PDMPs can also be used by professional licensing boards to identify clinicians with patterns of inappropriate prescribing and dispensing, and to assist law enforcement in cases of controlled substance diversion.”

SURESCRIPTS-SPECIFIC

White Coat of Quality — Award handed out by SureScripts annually to recognize vendors who make improvements in their clinical quality of electronic prescriptions by implementing software changes, communication and education programs, and metrics to measure errors.

National Progress Report — Annual report documenting the growth of e-prescribing as well as other trends of e-prescription adoption and utilization.

Safe Rx Awards — Award handed out by Surescripts annually recognizing those states with the highest rates of e-prescribing.

Independent Pharmacy Hotline — Hotline service for independent pharmacists who are looking for support directly from Surescripts in order to alleviate questions and concerns.

Quality Guidelines — Document produced by Surescripts that outlines the expectations and requirements of a high quality electronic prescription assessing accuracy and completeness.
Health IT Glossary

POLICY

Health Insurance Portability and Accountability Act (HIPAA) — 1996 legislation, sponsored by Sen. Nancy Kassebaum (R-KS), that led to HHS’ implementation of the Standards for Privacy of Individually Identifiable Health Information (“Privacy Rule”) which sets privacy standards for individual’s health information. SOURCE

Health Information Technology for Economic and Clinical Health (HITECH) — Legislation passed in 2009, as part of President Obama’s stimulus legislation (the American Recovery and Reinvestment Act), that promotes the adoption and meaningful use of health information technology. SOURCE

American Recovery and Reinvestment Act (ARRA) — President Obama’s stimulus legislation that passed Congress in 2009, which included $787 billion worth of tax cuts and funding for myriad government programs, including HITECH. SOURCE

Patient Protection and Affordable Care Act of 2010 (ACA) — Major healthcare reform legislation expanding insurance coverage to around 30 million Americans through an expansion of Medicaid and creation of subsidies for people to buy health insurance on a new marketplace called an exchange. The ACA also seeks to implement a host of delivery system reforms in Medicare, and has allocated significant funding towards incentivizing EHR adoption. SOURCE

Food and Drug Administration (FDA) — Agency within the Department of Health and Human Services (HHS) that monitors and regulates safety standards of food, medicines, and other health products, currently headed by Margaret Hamburg, the Commissioner of Food and Drugs. SOURCE

Office of the National Coordinator for Health Information Technology (ONC) — Organization within the Office of the Secretary of Health and Human Services that promotes the adoption of health information technology and health information exchange to improve healthcare, currently headed byFarzad Mostashari. SOURCE

Centers for Medicare and Medicaid Services (CMS) — Agency within HHS that administers Medicare, Medicaid, and the State Children’s Health Insurance Program, currently headed by Marilyn Tavenner, the Acting Administrator. SOURCE

Center for Medicare and Medicaid Innovation (CMMI) — Created by the ACA, an agency within CMS that tries to find new ways to pay for and deliver improved healthcare while lowering costs, currently headed byRichard Gilfillan. SOURCE

Department of Health and Human Services (HHS) — Cabinet-level agency that seeks to protect the health of Americans and provide essential services, it includes agencies as varied as the Centers for Disease Control, the Food and Drug Administration, and the National Institutes of Health, currently headed by Secretary Kathleen Sebelius. SOURCE

Regional Extension Center (REC) — Regional offices of the Health Information Technology Research Center, an organization created by the HITECH Act. “The RECs will support and serve healthcare providers to help them quickly become adept and meaningful users of electronic health records (EHRs),” by providing training and support services as well as technical assistance. SOURCE

Regional Health Information Organization (RHIO) — A sub-branch of the ONC, RHIOs are organizations that support local projects that seek to facilitate the exchange of health information; there are currently over 100 RHIOs nationwide that receive some federal funding. SOURCE

Nationwide Health Information Network (NwHIN) — An initiative founded by ONC, NHIN is a network currently under development that seeks to provide a secure and effective infrastructure for connecting providers, consumers, and other key players in healthcare. SOURCE

National Institute of Standards and Technology (NIST) — An agency within the Department of Commerce that is America’s measurement laboratory, seeking to set uniform, accurate standards for measurements, currently led by Director Patrick Gallagher. In addition to their many other endeavors, “NIST has a diverse portfolio of activities supporting our nation’s health IT effort. With NIST’s extensive experience and broad array of expertise both in its laboratories and in successful collaborations with the private sector and other government agencies, NIST is actively pursuing the standards and measurement research necessary to achieving the goal of improving healthcare delivery through information technology.” SOURCE 1, SOURCE 2
National Council for Prescription Drug Programs (NCPDP) — A non-profit organization that seeks to serve as a place where businesses across the whole pharmacy services sector can come together to find solutions; currently led by President Lee Ann Stember. SOURCE

Beacon Community — “The HHS Office of the National Coordinator for Health IT (ONC) is providing $250 million over three years to 17 selected communities throughout the United States that have already made inroads in the development of secure, private, and accurate systems of EHR adoption and health information exchange.” These beacon communities are dedicated to delivering better care at a lower cost through the implementation of health IT. SOURCE

Agency for Healthcare Research and Quality (AHRQ) — An agency within HHS focused on improving the quality, safety, efficiency, and effectiveness of healthcare for all Americans by supporting research to help people make informed medical choices; led by Director Carolyn Clancy. AHRQ has invested over $300 million to encourage health IT adoption. SOURCE 1, SOURCE 2

Blue Button — A download capability that allows individuals to access and download health information from personal health records into a text file or PDF that can be saved on any computer, which enables sharing of this data with healthcare providers. SOURCE

Institute of Medicine (IOM) — An organization that works outside of government to provide advice to decision makers and the public so they can make informed and accurate medical decisions. The IOM is part of the National Academies and is led by President Harvey V. Fineberg. SOURCE

Centers for Disease Control and Prevention (CDC) — The CDC is an HHS agency that collects, tracks, and distributes important statistics about health and medical conditions affecting the US population, promotes research into prevention, and advocate for healthy environments and behaviors. The CDC is led by Director Thomas R. Frieden. SOURCE

Internet System for Tracking Over-Prescribing Act (I-STOP) — Legislation aimed at preventing the misuse of prescription drugs that was adopted in New York in June 2012; The act requires doctors and pharmacists to consult a database containing a patient’s prescription history before distributing a drug, to make sure it isn’t being used irresponsibly; I-STOP will make New York one of the first states to schedule the universal mandate of e-prescribing for controlled substances in December of 2014. SOURCE 1, SOURCE 2, SOURCE 3

Certification Commission for Health Information Technology (CCHIT) — The CCHIT is a nonprofit organization that seeks to provide a comprehensive set of standards to evaluate whether health IT systems are adequate and provide certification to the systems that are up to the standards. SOURCE

Script Your Future — A national campaign run by the National Consumers League, seeking to raise awareness about the importance of medication adherence. Medication adherence is critical to achieving successful long term care, and the Script Your Future campaign hopes to improve health outcomes in patients with conditions such as diabetes, COPD, asthma, high blood pressure or high cholesterol. SOURCE

National Consumers League — An advocacy group for consumers, focusing on issues ranging from the marketplace to the workforce and in areas as diverse as labor rights and product safety. NCL leads the Script Your Future campaign which promotes medication adherence. The NCL is currently led by Executive Director Sally Greenberg. SOURCE

Million Hearts — A national initiative launched by HHS in 2011, seeking to prevent one million heart attacks and strokes over five years by bringing together new and existing programs in the field of cardiovascular health and seeking to improve access and quality of care and education. Led by the CDC and CMS, multiple federal agencies and private sector healthcare organizations have teamed up to take on this challenge. One primary focus of the initiative is to leverage health IT, due to its ability to engage with consumers efficiently and manage chronic health conditions such as high blood pressure and high cholesterol. SOURCE

National Institute of Health (NIH) — An agency of HHS that conducts medical research and is currently led by Director Francis S. Collins, NIH is the largest source of funding for medical research in the world. NIH contains 27 Institutes and Centers, each focusing on a specific body of research, often specializing in one particular disease or body system; these 27 entities are all coordinated by the Office of the Director. SOURCE