AHIC  American Health Information Community

The American Health Information Community (AHIC) was a federal advisory body, chartered in 2005 to make recommendations to the Secretary of the U.S. Department of Health and Human Services on how to accelerate the development and adoption of health information technology. The AHIC successfully concluded its operations at the final meeting on November 12, 2008. According to the Secretary’s original intent, the AHIC was transitioned from a Federal Advisory Committee to a private-public organization, the National eHealth Collaborative (NeHC). The NeHC intends to work cooperatively and aggressively in the months ahead to accelerate progress on a number of initiatives critical to the achievement of a secure, nationwide electronic health information network.

AHRQ  Agency for Healthcare Research & Quality

The Agency for Healthcare Research and Quality’s (within HHS) mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. Information from AHRQ’s research helps people make more informed decisions and improves the quality of health care services. AHRQ was formerly known as the Agency for Health Care Policy and Research.

AMDIS  Association of Medical Directors of Information Systems

Founded in 1997, the Association of Medical Directors of Information Systems is the premier professional organization for physicians interested in and responsible for healthcare information technology.

ASP  Application Service Provider

An application service provider (ASP) is a business that provides computer-based services to customers over a network. Software offered using an ASP model is also sometimes called On-demand software or software as a service (SaaS). The most limited sense of this business is that of providing access to a particular application program (such as customer relationship management) using a standard protocol such as HTTP.
ASTM  American Society for Testing & Materials (now, ASTM)

ASTM International is one of the largest voluntary standards development organizations in the world - a trusted source for technical standards for materials, products, systems, and services. Known for their high technical quality and market relevancy, ASTM International standards have an important role in the information infrastructure that guides design, manufacturing and trade in the global economy.

ARRA  American Recovery & Reinvestment Act of 2009

This is the 2009 federal stimulus bill passed by the US Congress on 2/16/09

CAHPS  Consumer Assessment of Healthcare Providers & Systems

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a public-private initiative (sponsored by the AHRQ) to develop standardized surveys of patients’ experiences with ambulatory and facility-level care.

CCHIT  Certification Commission for Health Information Technology

Founded in 2004, and certifying electronic health records (EHRs) since 2006, the Commission established the first comprehensive, practical definition of what capabilities were needed in these systems. The certification criteria were developed through a voluntary, consensus-based process engaging diverse stakeholders, and the Certification Commission was officially recognized by the Federal government as a certifying body.

CCN  CMS Certification Numbers

In order to avoid confusion with the NPI, the Medicare/Medicaid Provider Number has been renamed the CCN. When the Medicare/Medicaid Provider Number (also known as the Online Survey, Certification, and Reporting (OSCAR) Number; Medicare Identification Number; or provider number) is requested, the CCN should be provided.

CCR  Continuity of Care Record

The CCR standard is a patient health summary standard. It is 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 and care plan. These represent a “snapshot” of a patient's health data that can be useful or possibly lifesaving, if available at the time of clinical encounter. The ASTM CCR standard is designed to permit easy creation by a physician using an electronic health record (EHR) system at the end of an encounter.

Continuity of Care Document (CCD) and Continuity of Care Record (CCR) are often seen as competing standards

CDA  Clinical Document Architecture

The HL7 Document is intended to be the basic unit of a document-oriented Electronic Patient Record (EPR). In the document-oriented patient record, whether computer- or paper-based, the patient’s medical record is represented as a collection of documents. The Patient Record Architecture (PRA) does not specify the management of such documents, only the documents themselves.

CDR  Computerized Data Repository

See Operational Data Store
CDS   Computerized Decision Support
This is a classification for a number of different technologies that can be used to assist a health care practitioner in delivering safe and effective patient care. Providing diagnosis-related clinical information or guidelines, complaint-based flow sheets, medication interaction alerts, and test result anomaly alerts are all examples of this kind of technology.

CFR   Code of Federal Regulations
The Code of Federal Regulations (CFR) is the codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government. It is divided into 50 titles that represent broad areas subject to Federal regulation.

CHAMPS   Community Health Automated Medicaid Processing System
This is the new state of Michigan Medicaid Management Information Systems being launched starting in 2009.

CPOE   Computerized Physician Order Entry
This is an electronic health care orders system, frequently also known as Computerized Order Entry system.

EHR   Electronic Health Record
This is 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.

[In spite of the ONC’s efforts to define this as the generally-available electronic record on an individual patient, the ARRA treated this acronym as a general class of HIT technology, and the resulting CMS regulations had to follow suit.]

EMR   Electronic Medical Record
This is the single patient record maintained by a single health care delivery organization/entity. It also encompasses various electronic record processing features within that single provider (especially the case for a hospital).

EMPI   Enterprise Master Patient Index
An Enterprise Master Patient Index (EMPI) is a database that contains a unique identifier for every patient in the enterprise. This would include the medical center, outpatient clinics, practice offices and rehabilitation facilities. All registration systems would look to the EMPI to obtain patient information based upon several identifiers. Sometimes this is completed on the front end by having the registrar utilize the EMPI searching capabilities. In other instances it is done after the registration process is completed via the system. An EMPI will have either deterministic indexing where one can search based on an exact match of the combination of name, social security number, date of birth, and sex. The other searching mechanism is rules-based via the first 4 letters of the last name, or other key identifiers.

EP   Eligible Practitioners
These are covered practitioners in Medicare and Medicaid who are also eligible for the CMS EHR meaningful use incentives.

ePrescribing System
While there are products that address various elements of this service, generally, electronic prescribing is the electronic transmission of prescription information from the prescriber’s computer to the pharmacist’s computer.
HCPCS  Healthcare Common Procedure Coding System

Each year, in the United States, health care insurers process over 5 billion claims for payment. For Medicare and other health insurance programs to ensure that these claims are processed in an orderly and consistent manner, standardized coding systems are essential. The HCPCS Level II Code Set is one of the standard code sets used for this purpose. The HCPCS is divided into two principal subsystems, referred to as Level I and Level II of the HCPCS. Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT codes, the Level II HCPCS codes were established for submitting claims for these items.

HEDIS  Healthcare Effectiveness Data and Information Set

This is the health care data reporting program and standards-setting program operated by the National Center for Quality Assurance.

HIPC  Health IT Policy Committee

The HIT policy committee was established by ARRA and advising the ONC on HIT standards, implementation specifications, and certification criteria.

HISC  Health IT Standards Committee

The HIT standards committee was established by ARRA and advising the ONC on developing, recognizing, and harmonizing standards, as well as implementation specifications.

HIE  Health Information Exchange

HIEs provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to and retrieval of clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. HIE is also useful to Public Health authorities to assist in analyses of the health of the population.

HIMSS  Healthcare Information Management Systems Society

HIMSS is a comprehensive healthcare-stakeholder membership organization exclusively focused on providing global leadership for the optimal use of information technology (IT) and management systems for the betterment of healthcare.

HIT  Healthcare Information Technology

Health information technology (HIT) is the application of information processing involving both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.

HITSP  Healthcare Information Technology Standards Panel

The mission of the Healthcare Information Technology Standards Panel is to serve as a cooperative partnership between the public and private sectors for the purpose of achieving a widely accepted and useful set of standards specifically to enable and support widespread interoperability among healthcare software applications, as they will interact in a local, regional and national health information network for the United States. HITSP is a strategic partnership established through a contract with the US Department of HHS.
Health Informatics

Health informatics, health care informatics or medical informatics is the intersection of information science, computer science, and health care. It deals with the resources, devices, and methods required to optimize the acquisition, storage, retrieval, and use of information in health and biomedicine. Health informatics tools include not only computers but also clinical guidelines, formal medical terminologies, and information and communication systems. It is applied to the areas of nursing, clinical care, dentistry, pharmacy, public health and (bio) medical research.

HIPAA  Health Insurance Portability & Accountability Act of 1996 et. Seq

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, included Administrative Simplification provisions that required HHS to adopt national standards for electronic health care transactions and code sets, unique health identifiers, and security. At the same time, Congress recognized that advances in electronic technology could erode the privacy of health information. Consequently, Congress incorporated provisions into HIPAA that mandated the adoption of Federal privacy protections for individually identifiable health information.

HITECH  Healthcare Information Technology for Economic and Clinical Health Act

This is Title XIII of the ARRA of 2009 which legislatively created the Office of the National Coordinator, its funding, and the associated policy groups on HIT.

HL7  Health Level 7

Founded in 1987, Health Level Seven International (HL7) is a not-for-profit, ANSI-accredited standards developing organization dedicated to providing a comprehensive framework and related standards for the exchange, integration, sharing, and retrieval of electronic health information that supports clinical practice and the management, delivery and evaluation of health services.

HLV v.3  Current CCD Standard

The HL7 Continuity of Care Document (CCD) is a type of CDA document that attempts to capture a patient’s health summary. CCD adds content to the CDA structure by describing various document sections, such as patient demographics, insurance information, diagnosis and problem list, medications, allergies and care plan that collectively can represent a snapshot of a patient’s health data. The CCD is the result of a collaborative effort between the HL7 and ASTM organizations to harmonize the data format between ASTMs Continuity of Care Record (CCR) and HL7s Clinical Document Architecture (CDA) specifications.
IHE  Integrating the Healthcare Enterprise

IHE is an initiative by healthcare professionals and industry to improve the way computer systems in healthcare share information. In 1997, a consortium of radiologists and information technology experts formed IHE, or “Integrating the Healthcare Enterprise.” IHE aims to create a process through which interoperability can be implemented. The group gathers case requirements, identifies available standards, and develops technical guidelines that manufacturers can implement. IHE also stages “connectathons” and “interoperability showcases” in which many vendors assemble to demonstrate the interoperability of their products.

LIS  Laboratory Information System

A lab information system (LIS) is a class of software that receives, processes, and stores information generated by medical laboratory processes. These systems often must interface with instruments and other information systems such as hospital information systems (HIS). A LIS is a highly configurable application which is customized to facilitate a wide variety of laboratory workflow models. Disciplines of laboratory science supported by LIS include hematology, chemistry, immunology, blood bank (Donor and Transfusion Management), surgical pathology, anatomical pathology, flow cytometry and microbiology.

LOINC  Logical Observation Identifiers Names & Codes

LOINC is one of a suite of designated standards for use in the Federal Government systems for the electronic exchange of clinical health information. It was developed in 1994 and is maintained by the Regenstrief Institute, Inc., a US non-profit medical research organization. LOINC is likely to become a HIPAA standard for some segments of the Claims Attachment transaction. In 1999, it was identified by the HL7 Standards Development Organization as a preferred code set for laboratory test names in transactions between health care facilities, laboratories, laboratory testing devices, and public health authorities.

MARS  Management & Administrative Reporting System

MARS is a required subsystem in a state administered Medicaid Management Information system.

Medical Informatics (see Health Informatics)

MDSS  Michigan Disease Surveillance System

The MDSS is a Web based communicable disease reporting system developed for the state of Michigan. It has been developed to national data standards. It was built to provide for the secure transfer, maintenance and analysis of communicable disease surveillance information.

M-CEITA  Michigan Center for Effective IT Adoption

This cross-stakeholder organization has been created to apply for ONC federal funding as the single Regional HIT Extension Center serving the state of Michigan.

MCIR  Michigan Care Improvement Registry

MCIR was created in 1998 to collect reliable immunization information and make it accessible to authorized users online. In 2006, MCIR was expanded to include adults. MCIR benefits health care organizations, schools, licensed childcare programs, and Michigan’s citizens by consolidating immunization information from multiple providers. This reduces vaccine-preventable diseases, over-vaccination, and allows providers to see up-to-date patient immunization history.
MHIMA  Michigan Health Information Management Association

Founded in 1929 to improve the quality of medical records, MHIMA is committed to advancing the HIM profession in an increasingly electronic and global environment through leadership in advocacy, education, certification, and lifelong learning. Members are experts in securing, analyzing and integrating the information that steers the healthcare industry. MHIMA supports quality patient care through advancing data accuracy, advocating confidentiality and championing new technology. MHIMA members work in all kinds of healthcare settings, from hospitals and physicians’ offices to nursing homes, mental health facilities, health maintenance organizations (HMO), and other insurance companies.

MiHIN  Michigan Health Information Network

MiHIN, Michigan’s HIE strategy, is designed to ensure that all of the information a provider needs about a patient is available at the point of care. The purpose of HIE is to give Michigan providers the right information at the right time to make the most informed decision possible. As providers receive increasing access to timely and accurate patient data through HIE, Michigan citizens will benefit from improvements in efficiency, safety and quality of health care.

MITA  Medicaid Information Technology Architecture

The MITA Initiative is to generate a national framework to support improved systems development and health care management for the Medicaid enterprise. The MITA is intended to foster integrated business and IT transformation across the Medicaid enterprise, both internally and externally, to improve the administration of the Medicaid program.

MMIS  Medicaid Management Information System

A CMS approved system that supports the operation of the Medicaid program. The MMIS includes the following types of sub-systems or files: recipient eligibility, Medicaid provider, claims processing, pricing, SURS, MARS, and potentially encounter processing.

MPCC  Michigan Primary Care Consortium

The MPCC currently consists of over 70 diverse organizations committed to transforming primary care to be the cornerstone of health care delivered in Michigan. Early in 2008, the MPCC completed an abbreviated strategic planning process. Priority needs were identified on which to focus over the next few years, and all were directed at promoting and supporting the creation of Patient-Centered Medical Homes throughout Michigan.

MPI  Master Patient Index

An accurate master patient (person) index (MPI), whether in paper or electronic format, may be considered the most important resource in a healthcare facility because it is the link tracking patient, person, or member activity within an organization (or enterprise) and across patient care settings. The MPI identifies all patients who have been treated in a facility or enterprise and lists the medical record or identification number associated with the name. An index can be maintained manually or as part of a computerized system. Retention of entries depends upon the MPI’s use. Typically, those for healthcare facilities are retained permanently, while those for insurers, registries, or others may have different retention periods. MPIs are maintained by HIEs to enable the assembly of comprehensive patient care records spanning health care organizations.

MSSS  Michigan Syndromic Surveillance System

The Syndromic Surveillance system, operated by MDCH, tracks, on a real-time basis, the chief complaints of emergency-care patients in an effort to identify public health threats before confirmed diagnoses are available.
MTA  Health Market Trading Area

These areas are subdivisions of a state, usually defined by its state government, that reflect the patient usage patterns of the principal health care entities in the area. These areas often parallel the boundaries of earlier areas known as health catchment areas. MTAs are commonly used today as geographical definitions of RHIOs/HIEs.

MU  Meaningful Use Criteria

These are the ways in which practitioners must use federally-certified EHR products in order to secure EHR incentive program payments from either Medicare or Medicaid.

Multum

The solutions and databases created by Multum are central to many clinical decision support systems, electronic health records, and integrated healthcare support systems currently in use by multiple acute care and home care providers. Multum’s drug information is a core component of these applications.

NCQA  National Center for Quality Assurance

The National Committee for Quality Assurance is a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality. Since its founding in 1990, NCQA has been a central figure in driving improvement throughout the health care system, helping to elevate the issue of health care quality to the top of the national agenda. NCQA has helped to build consensus around important health care quality issues by working with large employers, policymakers, doctors, patients and health plans to decide what’s important, how to measure it, and how to promote improvement.

NEHC  National eHealth Collaborative

The National eHealth Collaborative (formerly AHIC Successor, Inc.) is a public-private partnership driving the grassroots development of a secure, interoperable, nationwide health information system. The National eHealth Collaborative (NeHC) was established through a grant from the Office of the National Coordinator for Health IT to build on the accomplishments of the American Health Information Community (AHIC), a federal advisory committee to the U.S. Department of Health and Human Services (HHS) until 2008, and is led by some of the nation’s most respected thought leaders in healthcare and health IT.

NIST  National Institute of Standards and Technology

Founded in 1901, NIST is a non-regulatory federal agency within the U.S. Department of Commerce. NIST’s mission is to promote U.S. innovation and industrial competitiveness by advancing measurement science, standards, and technology in ways that enhance economic security and improve our quality of life. From automated teller machines and atomic clocks to mammograms and semiconductors, innumerable products and services rely in some way on technology, measurement, and standards provided by the National Institute of Standards and Technology.

NPI  National Provider Identifier

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.
NQF  National Quality Forum

The National Quality Forum (NQF) is a nonprofit organization that aims to improve the quality of healthcare for all Americans through fulfillment of its three-part mission: (1) Setting national priorities and goals for performance improvement; (2) Endorsing national consensus standards for measuring and publicly reporting on performance; and (3) Promoting the attainment of national goals through education and outreach programs.

OASIS  Organization for the Advancement of Structured Information Standards

OASIS (Organization for the Advancement of Structured Information Standards) is a not-for-profit consortium that drives the development, convergence and adoption of open standards for the global information society. The consortium produces more Web services standards than any other organization along with standards for security, e-business, and standardization efforts in the public sector and for application-specific markets. Founded in 1993, OASIS has more than 5,000 participants representing over 600 organizations and individual members in 100 countries.

ODS  Operational Data Store

An operational data store (or "ODS") is a database designed to integrate data from multiple sources to make analysis and reporting easier. In the health care industry, DSs have been used by hospitals to provide comprehensive patient records. Because the data originates from multiple sources, the integration often involves cleaning, resolving redundancy and checking against business rules for integrity. An ODS is usually designed to contain low level or atomic (indivisible) data (such as transactions and prices) with limited history that is captured "real time" or "near real time" as opposed to the much greater volumes of data stored in the data warehouse generally on a less frequent basis.

Patient Portal

Patient Portals are healthcare-related online applications that allow patients to interact and communicate with their healthcare providers, such as physicians and hospitals. Typically, portal services are available on the Internet at all hours of the day. Some patient portal applications exist as stand-alone web sites and sell their services to healthcare providers. Other portal applications are integrated into the existing web site of the healthcare provider. Still others are modules added onto an existing electronic medical record system. What all of these share is the ability of the patient to interact with their medical information via the Internet.

ONC  Office of the National Coordinator for Health Information Technology

This is the agency within the US Department of Health & Human Services that administers the HITECH Act.

PACS  Picture Archiving & Communications System (also see RIS)

In medical imaging, a PACS is a combination of hardware and software dedicated to the short and long term storage, retrieval, management, distribution, and presentation of images. Electronic images and reports are transmitted digitally via PACS; this eliminates the need to manually file, retrieve, or transport film jackets. The universal format for PACS image storage and transfer is DICOM (Digital Imaging and Communications in Medicine). Non-image data, such as scanned documents, may be incorporated using consumer industry standard formats like PDF (Portable Document Format), once encapsulated in DICOM. A PACS consists of four major components: the imaging modalities such as CT and MRI, a secured network for the transmission of patient information, workstations for interpreting and reviewing images, and archives for the storage and retrieval of images and reports. Combined with available and emerging Web technology, PACS has the ability to deliver timely and efficient access to
images, interpretations, and related data. PACS breaks down the physical and time barriers associated with traditional film-based image retrieval, distribution, and display.

**PCMH Patient-Centered Medical Home**

Medical Home, also known as Patient-Centered Medical Home (PCMH), is defined as an approach to providing comprehensive primary care that facilitates partnerships between individual patients, and their personal Providers, and when appropriate, the patient’s family. The provision of medical homes may allow better access to health care, increase satisfaction with care, and improve health.

**Physician Portal**

This is a single, usually web-based, service that allows a practitioner to access a number of “point” information systems using such technologies as a single sign-on. The design of portals is to allow consistent access methods to applications that are based on significantly differing technologies.

**PHR Personal Health Record**

In recent years, several formal definitions of the PHR have been proposed by various organizations. Although each definition is unique, most of the definitions agree that the PHR is a computerized application that stores an individual’s personal health information. Strictly speaking the data is owned by the patient. A patient can, at any time, request their data. The patient portal is typically defined as a view into the health provider’s electronic medical records. In addition ancillary functions that support a health care provider’s interaction with a patient are also found in those systems, e.g. prescription refill requests, appointment requests, electronic case management, etc. Finally PHRs are data that resides with the patient, in a system of a patient’s choosing. This data may have been exported directly from an EMR, but the point is it now resides in a location of the patient’s choosing. Access to that information is controlled entirely by the patient.

**PMS Patient Management System**

A PMS is a class of computer applications used by health care providers to register and schedule patients, retain patient demographic and financial information, and to submit and manage claims with providers.

**PQRI Physician Quality Reporting Initiative**

This is the practitioner quality reporting program launched by the AHRQ and used by CMS.

**Registry**

These are (generally) specified data repositories on patients or conditions that include patient demographics, conditions, and treatments. Generally, registries began as disease-specific repositories to support the evolution of evidence-based research. Today, repository technology is used to capture health care information on defined groups of patients, diseases, and other dimensions of medical practice.

**RFI Request for Information**

This is a procurement document sent to one or more vendors, producing similar products, to secure comparative information on product function, ancillary services, and price. An RFI usually provides extensive description(s) of the requirements that the bidder’s solution must satisfy to be acceptable.
RFP   Request for Proposal

This is a procurement document sent to one or more vendors which seeks a proposed solution to the described service needs of the requestor. As a general rule, these proposals do not include detailed specifications on what the requestor needs. The premise is that the bidder has considerable experience in the field and part of their value proposition is the innovation that the bidder provides through their solution.

RFQ   Request for Quotation

Generally, an RFQ is used when the product that is being sought is rather conventional and does not require much description or requirements. This document generally secures vendor prices for commodities.

RHIO   Regional Health Information Organization

A RHIO is a health information organization [HIO] 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. Fundamental to this definition is the meaning of Health Information Exchange and Health Information Organization. A Health Information Organization (HIO) is an organization that oversees and governs the exchange of health-related information among organizations according to nationally recognized standards. Health information exchange (HIE) is the electronic movement of health-related information among organizations according to nationally recognized standards.

RIS   Radiology Information System

A RIS is a computerized database used by radiology departments to store, manipulate and distribute patient radiological data and imagery. The system generally consists of patient tracking and scheduling, result reporting and image tracking capabilities. A RIS complements HIS (Hospital Information Systems) and is critical to efficient workflow to radiology practices.

RLS   Record Locator Service

This is a key service provided by an HIE that allows health care entity information on their patients to remain decentralized. The RLS serves as an index on the location of patient records, and is invoked to assemble a comprehensive patient record when needed. It is also used to route patient health data transactions to physicians and entities authorized by the patient to receive such information.

RxNORM   UMLS data standard electronic prescription transaction data

RxNorm provides normalized names for clinical drugs and links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software, including those of First Databank, Micromedex, MediSpan, Gold Standard Alchemy, and Multum. By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary.

SMHP   State Medicaid Health Information Technology Plan

This is the state Medicaid plan for the implementation of the relevant sections of HITECH and the EHR Incentives. Such plans are expected to explain how existing technologies will be leveraged, as well as how HIEs and other technologies will achieve interoperability with the rest of the health care delivery system.
SNOMED CT  Systematized Nomenclature of Medical Clinical Terms

SNOMED CT (Systematized Nomenclature of Medicine -- Clinical Terms), is a systematically organized computer processable collection of medical terminology covering most areas of clinical information such as diseases, findings, procedures, microorganisms, pharmaceuticals etc. It allows a consistent way to index, store, retrieve, and aggregate clinical data across specialties and sites of care. It also helps organizing the content of medical records, reducing the variability in the way data is captured, encoded and used for clinical care of patients and research.

SOAP  Simple Object Access Protocol

SOAP is a protocol specification for exchanging structured information in the implementation of Web Services in computer networks. It relies on eXtensible Markup Language (XML) as its message format, and usually relies on other Application Layer protocols (most notably Remote Procedure Call (RPC) and HTTP) for message negotiation and transmission. As a layman's example of how SOAP procedures can be used, a SOAP message could be sent to a web-service-enabled web site (for example, a request for a drug price) with the parameters needed for a search. The site would then return an XML-formatted document with the resulting data (unit of measure, price, forms, etc). Because the data is returned in a standardized machine-parseable format, it could then be integrated directly into the original requesting application (an EMR) at the requesting party site.

SURS  Surveillance, Utilization & Review System

SURS is a standard subsystem in certifiable Medicaid Management Information Systems

UMLS  Unified Medical Language System

The UMLS is a compendium of many controlled vocabularies in the biomedical sciences. It provides a mapping structure among these vocabularies and thus allows one to translate among the various terminology systems; it may also be viewed as a comprehensive thesaurus and ontology of biomedical concepts. UMLS further provides facilities for natural language processing. It is intended to be used mainly by developers of systems in medical informatics.

XML  Extensible Markup Language

XML is a set of rules for encoding documents electronically. XMLs design goals emphasize simplicity, generality, and usability over the Internet. It is a textual data format, with strong support via Unicode for the languages of the world. Although XMLs design focuses on documents, it is widely used for the representation of arbitrary data structures, for example in web services. It is common for XML to be used in interchanging data over the Internet.