NATIONAL
QUALITY FORUM

NQF health information technology glossary

a guide to HIT jargon

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Health Information Technology Glossary

Accountable Care Organization

An organization of health care providers that agrees to be accountable for the quality, cost, and overall care of assigned Medicare beneficiaries. Also referred to as an ACO.

Alert

An alert is a programmed notification that occurs at specific point(s). Common alerts associated with an EHR system include two types, prescription and clinical-decision support. Prescription alerts warn physicians of potential adverse drug events such as interactions with other medications, along with allergy warnings. EHR systems can also provide physicians with alerts that support clinical decisions. These alerts remind physicians about patient tests, procedures or screenings that might be necessary.

American National Standards Institute (ANSI)

The current ONC-Approved Accreditor (ONC-AA) for the Permanent Certification Program (PCP). The ONC-AA will accredit organizations to certify EHR technology and perform other responsibilities under the PCP.

Attestation

The process by which an Eligible Professional (EP) or Eligible Hospital (EH) legally states through Medicare or Medicaid that they've demonstrated Meaningful Use (MU) with Certified EHR Technology (CEHRT).

Attribute

An attribute provides specific detail about a QDM element. QDM elements have two types of attributes, datatype-specific and data flow attributes. Datatype-specific attributes provide detail about a QDM element based on its datatype. Data flow attributes provide specific detail about the location of data represented by a QDM element.

Bonnie

Bonnie is a tool for testing electronic clinical quality measures (eCQMs). This tool is designed for use by measure developers as part of their development process and validates that the eCQM logic matches the measure's intent. Bonnie uses patient scenarios to represent each logic component of the measure specification such as the IPP, denominator, numerator, exclusions, etc. Health IT developers and implementers may also use the tool to evaluate measure implementation into their systems. Measure developers use both Bonnie and MAT in concert to promote test driven development.

Care coordination

A function that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites that are met over time.

Clinical decision support

A process for enhancing health-related decisions and actions with pertinent, organized clinical knowledge and patient information to improve health and healthcare delivery. The information delivered can include general clinical knowledge and guidance, intelligently processed patient data, or a mixture of both. Information delivery formats can include data and order entry facilitators, filtered data displays, reference information, alerts, and others. Also referred to as CDS.

Clinical Document Architecture (CDA)

The HL7 Version 3 Clinical Document Architecture (CDA®) is an HL7 standard in XML-based document markup standard that specifies the structure and semantics of "clinical documents" for the purpose of exchange between healthcare providers and patients. It defines a clinical document as having the following six characteristics:

- Persistence
- Stewardship
- Potential for authentication
- Context
- Wholeness
- Human readability

A CDA can contain any type of clinical content—typical CDA documents would be a Discharge Summary, Imaging Report, Admission & Physical, Pathology Report and more. The most popular use is for inter-enterprise information exchange, such as is envisioned for a US Health Information Exchange (HIE).

Clinical quality measures (CQM)

Clinical quality measures, also called CQMs, are tools that help us measure and monitor the quality of healthcare and the contribution of those healthcare services towards improved health outcomes. In the past, quality measures primarily used data that came from claims, but as technology has improved and become more prominent in the healthcare setting, many quality measures now use data that comes from a provider's electronic health record (EHR). These electronic CQMs use EHR data to measure health outcomes, clinical processes, patient safety, efficient use of healthcare resources, care coordination, patient engagement, and population and public health improvement.

Continuity of Care Document

An HL7 standard containing a core data set of the most relevant information necessary for continuity of care. It is used to share summary information about the patient within the broader context of the personal health record. Also referred to as CCD.

Continuous Variable Measure

Measure components include initial patient population, measure population, measure observations, stratification and supplemental data elements.

Current Procedural Terminology (CPT)

This code set is maintained by the American Medical Association. The CPT code set describes medical, surgical, and diagnostic services and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes. CPT coding is similar to ICD-9 and ICD-10 coding, except that it identifies the services rendered rather than the diagnosis on the claim. ICD code sets also contain procedure codes but these are only used in the inpatient setting. CPT is currently identified by the Centers for Medicare and Medicaid Services as Level 1 of the Healthcare Common Procedure Coding System.

CVX/MVX

The CDC's National Center of Immunization and Respiratory Diseases (NCIRD) developed and maintains the CVX (vaccine administered) code set. The CVX code is a numeric string, which represents the type of product used in an immunization. Every immunization that used a given type of product will have the same CVX, regardless of who received it. The MVX is an alphabetic string, which represents the manufacturer of a vaccine. CVX/MVX includes both active and inactive vaccines available in the US. CVX codes for inactive vaccines allow transmission of historical immunization records. When a MVX (manufacturer) code is paired with a CVX (vaccine administered) code, the specific trade named vaccine may be indicated.

Cypress

Cypress is an open source certification testing tool for evaluating the accuracy of clinical quality measure calculations in electronic health records (EHRs) systems and EHR modules. Cypress enables testing of an EHR ability to accurately calculate eCQMs. Cypress serves as the official eCQM testing tool for the 2014 EHR Certification program by the Office of the National Coordinator for Health IT (ONC).

Data Element Feasibility

The likelihood that data elements are available and a significant number of organizations can capture and access the data element in a consistent manner.

Data exchange

The process of sending and receiving data in such a manner that the information content or meaning assigned to the data is not altered during the transmission.

Data Infrastructure

Technology, processes, tools, and standards needed to promote data sharing and consumption.

Denominator

The denominator can be the same as the initial patient population or a subset of the initial patient population, to further constrain the population for the purpose of the eMeasure. Different measures within a set may have the same initial patient population but different denominators. Continuous Variable measures do not have a Denominator, but instead define a Measure Population. For proportion or ratio measures, the verbiage "Equals Initial Patient Population" with no additional criteria indicates the denominator is identical to the initial patient population. It can be the same as the initial patient population or a subset of the initial patient population to further constrain the population for the purpose of the eMeasure. Different measures within an eMeasure set may have different Denominators. Continuous Variable eMeasures do not have a Denominator, but instead define a Measure Population.

Denominator Exceptions

Denominator exceptions are those conditions that should remove a patient, procedure or unit of measurement from the denominator only if the numerator criteria are not met. Denominator exceptions allow for adjustment of the calculated score for those providers with higher risk populations. Denominator exceptions are used only in proportion eMeasures. They are not appropriate for ratio or continuous variable eMeasures. Denominator exceptions allow for the exercise of clinical judgment and should be specifically defined where capturing the information in a structured manner fits the clinical workflow. Generic denominator exception reasons used in proportion eMeasures fall into three general categories: medical reasons, patients' reasons, and system reasons.

Denominator Exclusions

A denominator exclusion describes the population who should be removed from the eMeasure population and denominator before determining if numerator criteria are met. Denominator exclusions are used in proportion and ratio measures to help narrow the denominator.

eCQM

Electronic clinical quality measures, or eCQMs, are eMeasures specified for use in the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. Eligible professionals, eligible hospitals and critical access hospitals (CAHs) are required to submit CQM data from certified EHR technology, to help measure and track the quality of health care services provided within our health care system. These measures use data associated with providers' ability to deliver high-quality care or relate to long term goals for quality health care.

e-Iatrogenesis

e-Iatrogenesis is defined as harm caused to a patient directly by health information technology.

Electronic Health Record (EHR)

An EHR is a longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data and radiology reports. The EHR automates and streamlines the clinician's workflow. The EHR has the ability to generate a complete record of a clinical patient encounter - as well as supporting other care-related activities directly or indirectly via interface - including evidence-based decision support, quality management, and outcomes reporting.

Electronic Measure (eMeasure)

Electronic measures (eMeasures) are standardized performance measures in an electronic format. eMeasures can promote greater consistency in measure development and in measuring and comparing performance results

Electronic Medical Record (EMR)

A digital version of a paper chart that contains all of a patient's medical history from one practice. An EMR is mostly used by providers for diagnosis and treatment. The difference between an EMR and an EHR is that an EHR is designed to share information with other health care providers, such as laboratories and specialists, The National Alliance for Health Information Technology stated that EHR data "can be created, managed, and consulted by authorized clinicians and staff across more than one healthcare organization."

Eligible Hospital (EH)

An eligible hospital includes any hospital that wishes to participate in the EHR Incentive Program.

Eligible Professional (EP)/Eligible Provider

Individual physicians and private practices that wish to participate in the EHR Incentive Program.

eMeasure Identifier

The eMeasure identifier represents the globally unique measure identifier for a particular quality eMeasure, assigned by the Measure Authoring Tool. This identifier will remain consistent throughout all versions and drafts of a measure. Once an eMeasure Identifier has been generated, the user will not be able to modify or remove it from any draft or version. The eMeasure identifier will be unique to that measure (and its versions or drafts); it will not be assigned by the MAT to any other measure.

eMeasure Version Number

The eMeasure Version Number is automatically assigned by Measure Authoring Tool and has three components: The major version, minor version, followed by the number of times the measure version has been packaged. The number of times the selected measure has been packaged is called the revision number.

FHIR

Fast Healthcare Interoperability Resources (hl7.org/fhir) – is a next generation standards framework created by HL7. FHIR combines the best features of HL7's Version 2, Version 3 and CDA® product lines while leveraging the latest web standards and applying a tight focus on implementability.

FHIR solutions are built from a set of modular components called "Resources". These resources can easily be assembled into working systems that solve real world clinical and administrative problems at a fraction of the price of existing alternatives. FHIR is suitable for use in a wide variety of contexts – mobile phone apps, cloud communications, EHR-based data sharing, server communication in large institutional healthcare providers, and much more.

Grouped Value Set

Two or more value sets that share the same category and that are grouped together by the user into a parent value set.

Grouping

Groupings are value sets (value sets) that have nested within them other value sets. Groupings are used for two reasons: 1. To combine value sets for the same concept, each in different taxonomies (e.g., ICD-9-CM, ICD-10, SNOMED-CT) 2. To combine objects that can be used independently but for the specific data element are used together This type of grouping is a convenience grouping to avoid the need to create an additional value set (e.g., "all encounters") or to provide more lengthy logic descriptions.

Health Information Exchange

A term used to describe both the sharing of health information electronically among two or more entities and also an organization which provides services that enable the sharing electronically of health information. Also referred to as an HIE.

Health Information Technology Advisory Committee (HITAC)

The Health IT Advisory Committee (HITAC) provides ongoing guidance to NQF's HIT portfolio and offers specific expertise on HIT projects, including specification of testing requirements for eMeasures and maintenance of the quality data set. HITAC is a standing committee of the Board of Directors and was created in December 2009.

Health Information Technology for Economic and Clinical Health (HITECH) Act

The HITECH Act provides HHS with the authority to establish programs to improve health care quality, safety, and efficiency through the promotion of Health IT, including EHRs and private and secure electronic health information exchange.

Health Insurance Portability and Accountability Act (HIPAA)

HIPPA provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information.

Health IT Policy Committee (HITPC)

A Federal Advisory Committee that coordinates industry and provider input regarding the Medicare and Medicaid Incentive Programs, as well as in consideration of current program data for the Medicare and Medicaid EHR Incentive Programs.

Health Level Seven (HL7)

Health Level-7 or HL7 refers to a both a set of international standards for transfer of clinical and administrative data between software applications used by various healthcare providers, and a not-for-profit, ANSI-accredited standards developing organization. Hl7 standards focus on the application layer, which is "layer 7" in the OSI model. The HL7 standards are produced by the Health Level Seven International, an international standards organization, and are adopted by other standards issuing bodies such as American National Standards Institute and International Organization for Standardization.

Healthcare Common Procedure Coding System (HCPCS)

A set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT). HCPCS was established in 1978 to provide a standardized coding system for describing the specific items and services provided in the delivery of health care necessary for Medicare, Medicaid, and other health insurance programs to ensure that insurance claims are processed in an orderly and consistent manner. With the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) use of the HCPCS for transactions involving health care information became mandatory HCPCS is divided into two principal subsystems, referred to as Level I and Level II. Level I is comprised of the CPT-4 to identify medical services and procedures furnished by physicians and other health care professionals. The Level II HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT-4 codes. It is maintained and distributed by CMS.

Healthcare Quality Measures Format (HQMF)

A Health Level 7 (HL7) international standard that serves as a wrapper into which a health quality measure using the QDM can be placed. The HQMF serves as a means to share and distribute a clinical quality measure as an electronic document.

Human readable

Each eCQM exported from the Measure Authoring Tool (MAT) includes the measure specifications in an HTML human readable format so that the user can understand both how the elements are defined and the underlying logic used to calculate the measure.

International Classification of Diseases (ICD)

The ICD terminology is maintained by the World Health Organization, the directing and coordinating authority for health within the United Nations System. The ICD is designed as a health care classification system, providing a system of diagnostic codes for classifying diseases, including nuanced classifications of a wide variety of signs, symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. Diagnosis codes are key for determining coverage and are used in treatment decisions. From plan design to statistical tracking of disease, these codes are a crucial part of the way health plans — including State Medicaid agencies — run their programs. Current health plan systems and health care providers are required by the Health Insurance Portability and Accountability Act (HIPAA) to use a standard code set to indicate diagnoses and procedures on transactions. For diagnoses, the ICD-9-CM code set is used. The ICD-9-CM procedure code set was initially specified for inpatient hospital procedures, but is transitioning to the ICD-10CM/PCS code set. ICD-10CM/PCS more accurately reflects the current practice of medicine, and has the flexibility to adapt as medicine changes.

Initial Patient Population

The initial patient population refers to all patients to be evaluated by a specific performance eMeasure. These patients share a common set of specified characteristics within a specific measurement set to which a given measure belongs. This –initial patient population is present regardless of the measure scoring type; i.e., proportion, ratio and continuous variable measures all have an initial patient population section. Details often include information based upon specific age groups, diagnoses, diagnostic and procedure codes, and enrollment periods. The initial patient population refers to all patients to be evaluated by a specific performance eMeasure who share a common set of specified characteristics within a specific measurement set to which a given measure belongs. Details often include information based upon specific age groups, diagnoses, diagnostic and procedure codes, and enrollment periods.

Interoperability

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

Logical Observation Identifiers Names and Codes (LOINC)

LOINC is a database and universal standard for identifying medical laboratory observations. It was developed and is maintained by the Regenstrief Institute, a US non-profit medical research organization, in 1994. LOINC was created in response to the demand for an electronic database for clinical care and management and is publicly available at no cost.

Meaningful Use

The American Recovery and Reinvestment Act of 2009 authorizes the Centers for Medicare & Medicaid Services (CMS) to provide incentive payments to eligible professionals (EPs) and hospitals who adopt, implement, upgrade, or demonstrate meaningful use of certified electronic health record (EHR) technology.

Measure Authoring Tool (MAT)

The Measure Authoring Tool (MAT) is a web-based tool that allows measure developers to author electronic Clinical Quality Measures (eCQMs) using the Quality Data Model (QDM). The tool provides the capability to express complex measure logic and export measures in several formats, including a human-readable document that can be viewed in a web browser, the fundamental green eCQM XML syntax (SimpleXML), and an eCQM HQMF XML document for integration with EHRs. The data expressed in the tool by users serves as the input for the 'transform' process which ultimately supports the defined export files. Under contract with the National Quality Forum, a Beta version of the tool was initially developed and released in January 2011. The Basic version of the tool was released in September 2011, followed by the Enhanced version in January 2012. Effective January 2013, the Centers for Medicare & Medicaid Services assumed ownership of the MAT and has contracted with Health Care Innovation Services (HCIS), a Joint Venture between Telligen and Net-Integrated Consulting (NIC) for the ongoing development, maintenance, and support.

Measure Authoring Tool (MAT) Artifacts

The MAT produces the following eMeasure artifacts in a zip file; the HQMF XML document, eCQM XML syntax (SimpleXML), the HTML human-readable document, and an Excel spreadsheet of the value sets specified for the measure

Measure Population

Measure population is used only in continuous variable eMeasures. It is a narrative description of the eMeasure population. (e.g., all patients seen in the Emergency Department during the measurement period).

Measure Scoring

Indicates how the calculation is performed for the eMeasure (e.g., proportion, continuous variable, and ratio)

Measure Type

Indicates whether the eMeasure is used to examine a process or an outcome over time (e.g., Structure, Process, and Outcome).

Measurement Period

The time period for which the eMeasure applies.

Medicare and Medicaid EHR Incentive Programs

Provides incentive payments to Eligible Professionals (EPs) and Eligible Hospitals (EHs) as they adopt, implement, upgrade, or demonstrate Meaningful Use (MU) of certified EHRs.

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.

Numerator

Numerators are used in proportion and ratio eMeasures. In proportion measures the numerator criteria are the processes or outcomes expected for each patient, procedure, or other unit of measurement defined in the denominator. In ratio measures the numerator is related, but not directly derived from the denominator (e.g., a numerator listing the number of central line blood stream infections and a denominator indicating the days per thousand of central line usage in a specific time period).

Numerator Exclusions

Numerator Exclusions are used only in ratio eMeasures to define instances that should not be included in the numerator data. (e.g., if the number of central line blood stream infections per 1000 catheter days were to exclude infections with a specific bacterium, that bacterium would be listed as numerator exclusion).

OID, Object Identifier

A dot-delimited string which can use used to uniquely identify objects. OIDs are used within the scope of Meaningful Use to uniquely identify Value Sets. An example of an OID is "2.16.840.1.11 3883.3.526.3.1253" which identifies the Value Set: "Allergy to Eggs".

popHealth

PopHealth is an open source software tool that automates population health reporting quality measures for Meaningful Use. popHealth integrates with a healthcare provider's electronic health record (EHR) system to produce summary quality measures on the provider's patient population. popHealth demonstrates how a healthcare provider can use popHealth to analyze the quality of care provided as part of their existing workflow. popHealth helps healthcare providers easily understand the logic behind clinical quality measures and easily identifies patients requiring follow-up care.

Quality Data Model (QDM)

The QDM is an information model that defines relationships between patients and clinical concepts in a standardized format to enable electronic quality performance measurement. The model is the current structure for electronically representing quality measure concepts for stakeholders involved in electronic quality measurement development and reporting. The QDM is currently being aligned with other relevant clinical decision support (CDS) standards.

Quality Data Model (QDM) Element

A QDM element is a discrete unit of information used in quality measurement to describe part of the clinical care process, including a clinical entity and its context of use. It can include criteria for any relevant metadata about a clinical or administrative concept relevant to quality measurement. A QDM element provides an unambiguous definition and enables consistent capture and use of data for quality measurement. It may be defined for any given measure and reused when the same information is required for another measure. Reuse encourages standardization of quality measures and reduces the generation of additional software requirements for every new measure.

Quality Reporting Document Architecture (QRDA)

The Health Level Seven International (HL7) Quality Reporting Document Architecture (QRDA) is a standard document format for the exchange of electronic clinical quality measure (eCQM) data. QRDA reports:

- Contain data extracted from electronic health records (EHRs) and other health information technology systems.
- Can be used to exchange eCQM data between systems.
- Are the data submission standards for a variety of quality measurement and reporting initiatives.
- Were adopted by the Office of the National Coordinator for Health Information Technology (ONC) as the standard to support both QRDA Category I (individual patient) and QRDA Category III (provider's aggregate) data submission approaches for Stage 2 of Meaningful Use (MU2).

Regional Extension Centers (RECs)

The ONC's Regional Extension Centers (RECs), located in every region of the country, serve as a support and resource center to assist providers in EHR implementation and HealthIT needs. As trusted advisors, RECs "bridge the technology gap" by helping providers navigate the EHR adoption process from vendor selection and workflow analysis to implementation and meaningful use. As of May 4th, 2015: Over 157,000 providers are currently enrolled with a Regional Extension Center. Of these, more than 145,000 are now live on an EHR and more than 115,000 have demonstrated Meaningful Use 46% of PCPs nationwide are enrolled with an REC; 54% of rural PCPs are enrolled 93% of REC-enrolled providers are live on an EHR vs. 73% live on an EHR in the general provider population, 1,403 CAHs/RHs are enrolled with an REC. Of these, 84% have demonstrated Meaningful Use. RECs are part of eight working groups on emerging business lines in support of practice transformation including: privacy and security, accountable care organizations, patient centered medical home, health information exchange, and patient engagement

RxNorm

RxNorm is a non-proprietary drug vocabulary maintained and distributed by the National Library of Medicine. It has been identified as the vocabulary-of-choice to be incorporated into government systems as they are updated. 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.

State Health Information Exchange

The state HIE program promotes innovative approaches to the secure exchange of health information within and across states. It also works to ensure that health care providers and hospitals meet national standards and meaningful use requirements. Demonstrating the secure sharing of information among providers is an essential part of using electronic health records in a meaningful way to qualify for the Medicare and Medicaid EHR Incentive Programs. The Office of the National Coordinator for Health Information Technology (ONC) funds the State Health Information Exchange (HIE) Cooperative Agreement Program.

Systematized Nomenclature of Medicine-Clinical Terms (SNOMED-CT)

A comprehensive clinical terminology, owned, maintained, and distributed by the International Health Terminology Standards Development Organisation (IHTSDO).

Taxonomy

A standard vocabulary or other classification system that can be used to define a QDM element's category. For the purpose of the QDM, taxonomy is synonymous with a code system (a collection of codes with associated designations and meanings). Specific taxonomies are used in applying the QDM to quality measures based on the recommendations of the HIT Standards Committee of the Office of the National Coordinator for Health Information Technology (ONC) and established certification rules for meaningful use.

United States Health Information Knowledgebase (USHIK)

A metadata registry of healthcare-related data standards funded and directed by the Agency for Healthcare Research and Quality (AHRQ) with management support in partnership with the Centers for Medicare & Medicaid Services. It is populated with the data elements and information models of Standards Development Organizations (SDOs) and other healthcare organizations, in such a way that public and private organizations can harmonize information formats with existing and emerging healthcare standards.

Value Set

Previously referred to as code list, is a set of values that contain specific codes derived from a particular taxonomy. Value sets are used to define an instance of a category used in a QDM element. A parent value set may also contain child (or nested) value sets that define the same category. The approach is consistent with the HL7 definition for a value set as "a uniquely identifiable set of valid concept representations, where any concept representation can be tested to determine whether or not it is a member of the value set...A sub-value set is a sub-set of a 'parent' value set...When a value set entry references another value set, the child value set is referred to as a nested value set. There is no preset limit to the level of nesting allowed within value sets. Value sets cannot contain themselves, or any of their ancestors (i.e. they cannot be defined recursively)." With respect to value sets, a value is a specific code defined by a given taxonomy. Values are included in value sets. In the context of QDM elements, some categories (e.g., laboratory test) have an attribute of "result." A result may be expressed as a value (numeric or alphanumeric).

Value Set Authority Center (VSAC)

A service provided National Library of Medicine (NLM), in collaboration with the Office of the National Coordinator for Health Information Technology and the Centers for Medicare & Medicaid Services. The VSAC provides downloadable access to all official versions of vocabulary value sets contained in Clinical Quality Measures (CQMs) used in federal programs. Each value set consists of the numerical values (codes) and human-readable names (terms), drawn from standard vocabularies such as SNOMED CT® , RxNorm, LOINC and ICD-10-CM, which are used to define clinical concepts used in clinical quality measures (e.g., patients with diabetes, clinical visit). The content of the VSAC will gradually expand to incorporate value sets for other use cases, as well as for new measures and updates to existing measures

Value Set OID

A unique identifier for each value set and grouped value set. Value sets are the specific codes used by developers to program the system to accurately capture patient data in the EHR system. See OID – Object identifier.

XML (Extensible Markup Language)

This is a computer readable format which enables the automated creation of queries against an EHR or other operational data store for quality reporting. XML provides a basic syntax that can be used to share information among different computers, applications, and organizations without needing to pass through many layers of conversion.

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