COMP3342:

Health Systems Interoperability and Integration

Electronic Health Records and Related Standards

Time: Tuesday+ Thursday: 11:25-12:40 Location: Masri204

Section: 1



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Medical Terminologies: Coding Standards

Learning Objectives:

- 1. Understand healthcare environment elements, clinical care processes and workflows,
- 2. Understand EHRs objectives, EHR requirements and the difference between different EHR standards
- 3. Understand EHRs structural/framework standards.
- 4. Identify and understand the purpose EHR related standards and their purpose:
 - 1. CEN 13940
 - 2. openEHR and CEN 13606



RECALL: Types of Health Standards

1. Medical terminology/vocabulary or coding standards

- Define standard code-sets for generally used concepts, terms, entity names, disease names, procedures, laboratory tests, observations, clinical findings, body structure names, etc.
- e.g. ICD9/10, SNOMED-CT etc.

2. Electronic Health record or Data-model standards

- Define system modules and module structures, the interfaces between modules, and operations/processes
- openEHR/CEN 13606, etc.

3. Health data exchange or messaging standards

- Provide a comprehensive framework for exchange, integration, sharing, and
 retrieval of electronic health information
- E.g. HL7 v2.x/v3.0, ISO/HL7 27931 etc.



RECALL: Types of Health Standards

4. Architecture or Model-oriented System standards

- Define elements of a health system architecture to support different health functions
- e.g. ISO 12967, ISO 10781, ENV 12443, etc.
- e.g. CDA: Clinical Document Architecture

5. Data formats standards

- Define data formats for different types of health data for laboratory data, medical images
- e.g. DICOM etc.

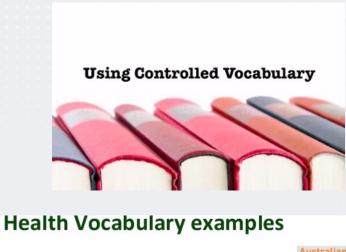
6. Workflows and Process-oriented standards

- describe the semantics of clinical concepts & processes to support continuous care of an individual within an organization and Across organizations
- CEN 13940 etc.



RECALL: Clinical Data Terminology/Vocabulary/Coding Standards

- Controlled Medical Terminology/Vocabulary:
 - ICD9/ICD10 (International Classification of Diseases, ver. 9/ver. 10)
 - SNOMED -CT (Standardized Nomenclature of Medicine, Clinical Terms)
 - LOINC (Logical Observation, Identifiers, Names and Codes) – Lab results
 - RxNorm (normalized naming system for generic and branded drugs)
 - RCT (Read Codes Terms, ver. 2.x, ver. 3.x) specific to the UK
 - NLM UMLS (Unified Medical Language System): inclusive of all coding systems, and mapping between them





SNOMED C

















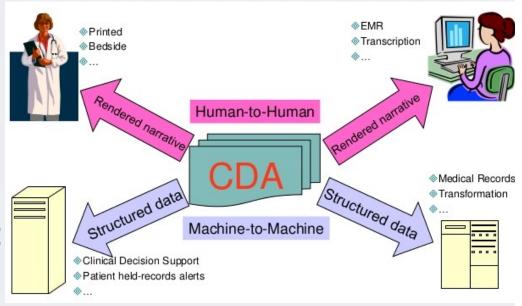
Cumulative Index of Nursing and Allied Health Literature (CINAHL)





RECALL: Clinical Data model and exchange Standards

- Data-model and Architectural standards:
 - CDA (Clinical Document Architecture)
 - CEN 13606 [~openEHR]
 (EHR communication standard)
- Data Exchange standards:
 - HL7 (Health Level 7, v 2.x, v 3.x)
 - CCR (Continuity Care Records)





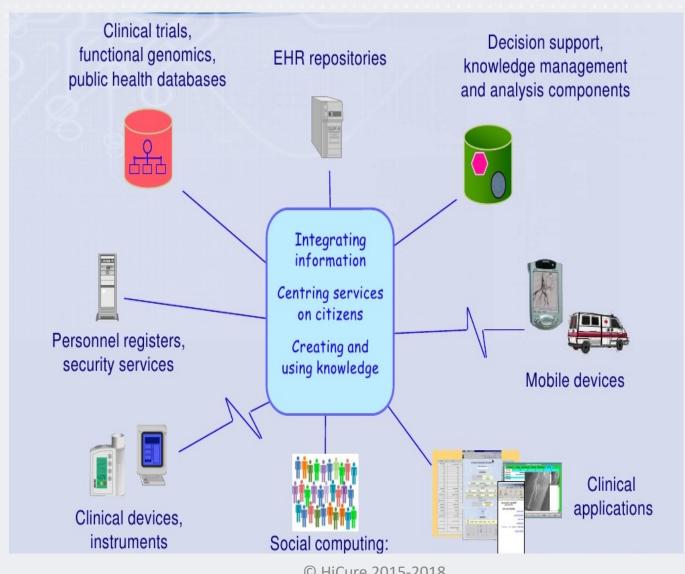
RECALL: Clinical Data format and Privacy Standards

- Data Format standards:
 - DICOM (Digital Imaging and Communications in Medicine)messages for images
- Privacy and Confidentiality:

- HIPPA (Health Insurance Portability and Accountability Act)



Electronic Health Records Land escape



Source: Eurorec



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RECALL: EHR System objectives

- The EHR should enable the <u>consistent</u> capture, processing, retention, protection and communication of health information such that <u>interoperability</u> is achieved in support of shared care, improved quality of care, effective resource management, providing evidence of actions taken in health(care), and in support of the uses of anonymised information for health system management.
- The EHR should enable authorised users to <u>access health information</u> that is relevant, intact, appropriate to their permissions and within a timeframe that is appropriate to the context.
- The EHR should enable the communication (or exchange) of all health information between care settings, subject to appropriate consent and access rights, to a sufficient quality to support safe shared clinical care.

[ISO 18308]



Types of health standards **Statistics** STANDARDS Research **Analysis DATA Clinical Trials** Surveillance KNOWLEDGE **Patient Safety Public/Private** Quality **Partnership** Low cost **PROCESS** Vendor/Provider **Partnership** Accessible Privacy, Security, Trust, Integrity

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Standards relevant to the EHR

ISO 18308 EHR Architecture Requirements Business HL7 EHR Functional Model ISO EN 13940 Systems for Continuity of Care requirements

ISO EN 12967-1 HISA Enterprise Viewpoint

EHR system reference model openEHR

EHR interoperability Reference Model ISO/EN 13606-1

Information **HL7 Clinical Message Interoperability**

models

HL7 Clinical Document Architecture (CDA)

Clinical content model representation openEHR ISO/EN 13606-2 archetypes

ISO 21090 Healthcare Datatypes

ISO EN 12967-2 HISA Information Viewpoint

EHR Communication Interface Specification ISO/EN 13606-5 Computational

ISO EN 12967-3 HISA Computational Viewpoint

services HL7 SOA Retrieve, Locate, and Update Service DSTU

EHR Communication Security ISO/EN 13606-4 Security

ISO 22600 Privilege Management and Access Control

ISO 14265 Classification of Purposes of Use of Personal Health Information

Terminologies: SNOMED CT, etc. Clinical knowledge

Clinical data structures: Archetypes etc.



CEN/TC EN 13940

Standardisation of Clinical Processes and Workflows

Defines System of Concepts to Support Continuity of Care



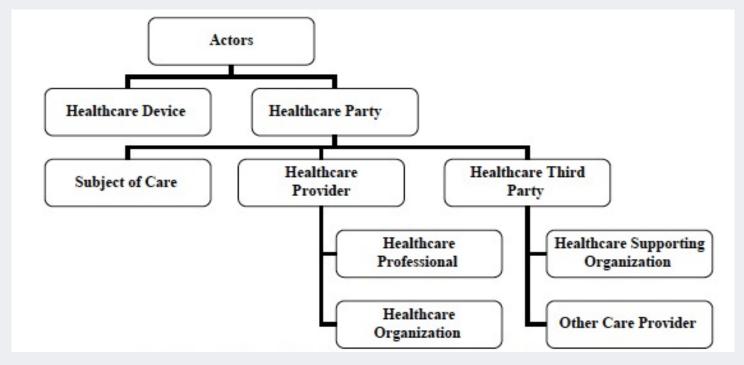
CEN/TC EN 13940

- CEN 13940 standard describes the semantics of clinical concepts & processes to support continuous care of an individual/patient within an organisation and across organisations
 - CEN 13940 main goals:
 - Standardisation of concepts, processes, & workflows in healthcare
 - Facilitate interoperability between health Information systems used in organisations.
- CEN/TC standard has two parts:
 - Part 1 (EN 13940-1): describes the basic concepts within healthcare settings
 - Part 2 (EN 13940-2): describes various core processes involved in healthcare as well as process workflows for different scenarios.

• The basic concepts of **CET/TC EN 13940-1** consists of the following:

1. Actors in continuity of care

- Entities involved in healthcare activities
- Actor might be a healthcare device or healthcare Party





2. Health issues and their management

- Refers to health problem of a subject of care (patient) identified by a healthcare party (doctor or hospital).
- The interpretation of health issues can change over time depending on efforts/actions taken to solve these issues.
 - Health issues can be referred to in none or many health situations and have different interpretations
 - Example
 - "An accident" issue can further be interpreted as "fracture" in diagnosis process.



3. Concepts related to health mandates

- Health mandate → The authorisation given to a healthcare provider for treating a health issue of a patient.
- Health mandates are categorised into:
 - **Demand mandate** → a patient has demanded the care
 - Care mandate → the authorisation given to a healthcare provider for being responsible for care of the patient
 - Mandate to export personal data → the authorisation of sharing patient's data with other healthcare providers during the care process
 - Continuity facilitator mandate → the authorisation to provide continuous sharing of information for supporting continuity of care to a patient

4. Time-related concepts in continuity of care

- Refers to timeframes of interactions among the involved actors that take place for treating a patient.
 - Period of care
 - Duration of clinical activities that are performed for multiple health issues
 - Contact (i.e. encounter)
 - A meeting between a patient and a healthcare professional for addressing one or more health issues
 - Episode of care
 - Collection of contact (i.e. encounters) elements for one particular health issue
 - An episode of care is usually divided into multiple sub-episodes
 - each **sub-episode** of care is aimed at achieving a **specific goal** for the care of the patient.

5. Concepts related to knowledge, activities, & decision support

- Activities preformed in healthcare during the treatment of a patient includes:
 - Healthcare activities such as
 - Provider activity
 - Self-care activity
 - Contributing activity
 - Automated activity
 - Clinical guidelines and protocols
 - Generic clinical guidelines that are followed when healthcare activities are performed by provider for treating patients
 - Programs of care and care plans
 - Protocols followed within a health care organization by its multiple Health care professionals in the care process of a patient.
 - A Program of care can have a number of Care plans



6. Health data management

- Concepts related to management of health data is detailed in a hospital and including sending it to another hospital.
- Health data management deals with assuring correctness of such data generated by means of clinical devices
- Clinical record data in electronic form should also be stored in a shared repository after verification and approval by clinician
- The standards also deals with access rights verification
 - All access information should be logged in the EHR of a patient

