



epSOS Introduction to Semantic Services



January 26th, 2010



Once upon a time......





Semantic Interoperability WP 3.5





Once upon a time......





- Semantic Interoperability is the ability of communicating entities to share unambiguous meaning
- The sender of the document must be able to reliably transmit all sufficient and necessary information
- The receiver of the document must be able to correctly interpret its interlocutor
- Both must be aware of, and agree upon, each other behaviors for given interactions.



Once upon a time......





- **Semantic Interoperability** needs to have the same
 - –Concepts
 - -Syntax
 - –Terminology



Flashback – April 2009





- Data elements being defined by functional work packages (WP3.1 and WP3.2)
- Elements need to be coded as much as possible
- Keep contextual meaning
- Different code systems
- Looking for already existing and tested solutions present in the industry
- Solution tested
- =============
- Integration Statements (IHE) 2 X Connectation proven solutions part of RFP – save time & costs

(Semantic-tathon) - ?





Some...coded data elements

1	A B			
1	Number	Coded element name		
2	1	Patient Information		
3	2	Patient Name		
4	3	Family Name/Surname		
5	4	Given Name		
6	5	Gender		
7	6	Birth Date		
8	7	Patient Identifiers		
9	8	Primary Patient Identifier		
10	9	Regional/National Health Id		
11	10	Secondary Patient Identifier		
12	11	Social/Insurance Number		
13	12	Patient Address		
14	13	Street		
15	14	Number of Street		
16	15	City		
17	16	Postal Code		
18	17	State or Province		
19	18	Country		
20	19	Patient's Telecommunication		
21	20	Telephone		
22	21	E-mail		

116	115	Duration of treament
117	116	Date of onset of treatment
118	117	Date of end of treatment
119	118	Instructions to patient
120	119	Advise to the dispenser
121	120	Substitution
122	121	Patient Summary
123	122	Allergy
124	123	Allergy Description
125	124	Allergy description id code
126	125	Allergy Onset Date
127	126	Allergy Agent Description
128	127	Allergy Agent Code
129	128	Medical Alerts
		Medical Alert Information (other
130	129	alerts not included in allergies)
131	130	Health Care Alert description
132	131	Health Care Alert Code
		History of past illness and
133	132	disorders
134	133	Problem Description
135	134	Problem Code





Tasks

- T3.5.1: Establishing a common definition of the medical knowledge to be used
- T3.5.2: Examine the existing terminology used
- T3.5.3: Determine a mechanism for managing terminology
- T3.5.4: Defining a common clinical data structure



Results – January 2010

Page 8





- D.3.5.2_Appendix_A_Glossary_v0.0.2_20100118.pdf
- D.3.5.2_Appendix_A_Glossary_v0.0.2_20100118.doc
- D3.5.2_Appendix_B_Data Elements Correspondence_v0.0.5_20100122.doc
- D3.5.2_Appendix_B_Data Elements Correspondence_v0.0.5_20100122.pdf
- D3.5.2_Appendix_C_Specifications_v0.0.5._Pivot_Documents_Specifications.doc
- D3.5.2_Appendix_C_Specifications_v0.0.5._Pivot_Documents_Specifications.pdf
- D3.5.2_Appendix_D_epSOS_Master_Value_Set_Catalogue_v0.0.2_20100118.doc
- D3.5.2_Appendix_D_epSOS_Master_Value_Set_Catalogue_v0.0.2_20100118.pdf
- D.3.5.2_Appendix_E_Ontology_v0.2_20100118.doc
- D.3.5.2_Appendix_E_Ontology_v0.2_20100118.pdf
- D3.5.2_Appendix_F_Terminology_Access_Services_v0.0.3_20100122.doc
- D3.5.2_Appendix_F_Terminology_Access_Services_v0.0.3_20100122.pdf
- D3.5.2_Appendix_G_EN13606_implementation_v20091007.doc
- D3.5.2_Appendix_G_EN13606_implementation_v20091007.pdf
- D3.5.2_epSOS_WP3_5_v0.0.4_20100125.doc
- D3.5.2_epSOS_WP3_5_v0.0.4_20100125.pdf
- epSOS_MTC_V0.01.xls
- psos_MVC_V0.82.xls



Approach to semantic interoperability

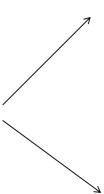






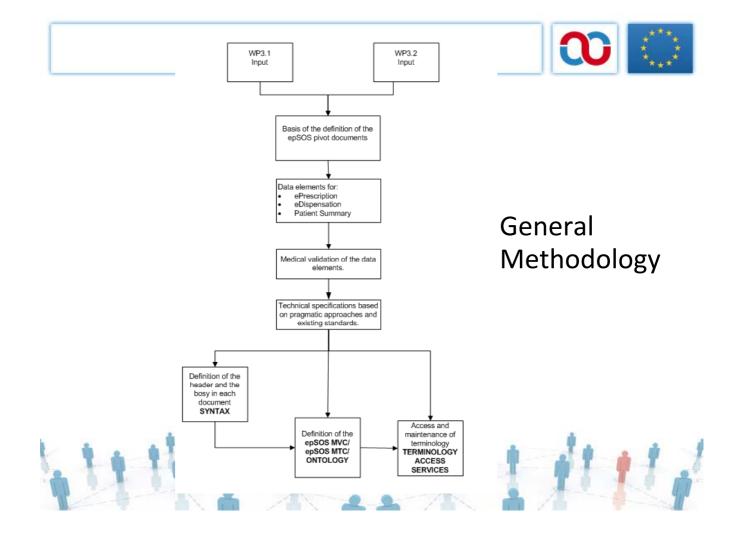
For Regulatory purposes, we'd like to enter this as "Data Element B"

Syntax = How the data is structured (archetypes or templates)



Terminology = How the data is coded in different coding systems (LOINC, SNOMED)

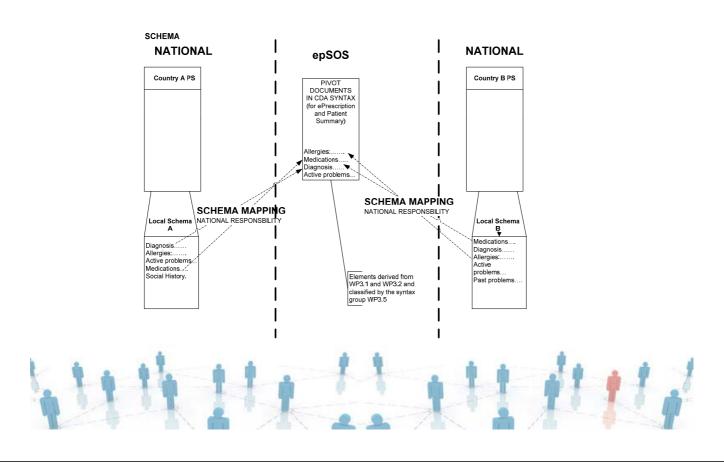
[Standards & Terminologies The Drive to Achieve - Computable Semantic Interoperability - Charles Jaffe, MD, PhD]



Syntax - Perimeter



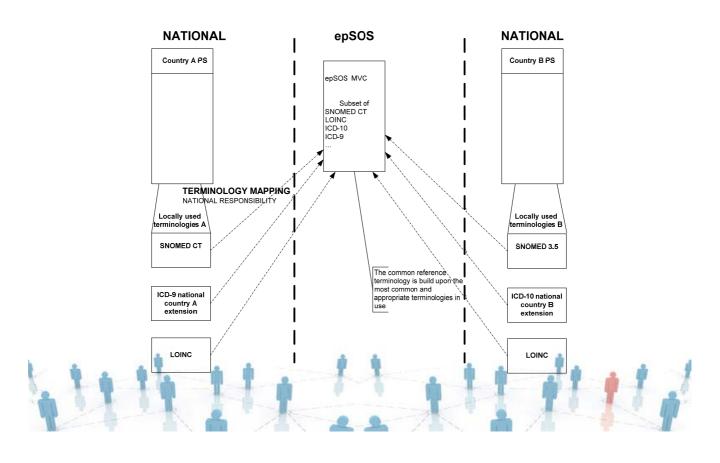




Terminology - Perimeter



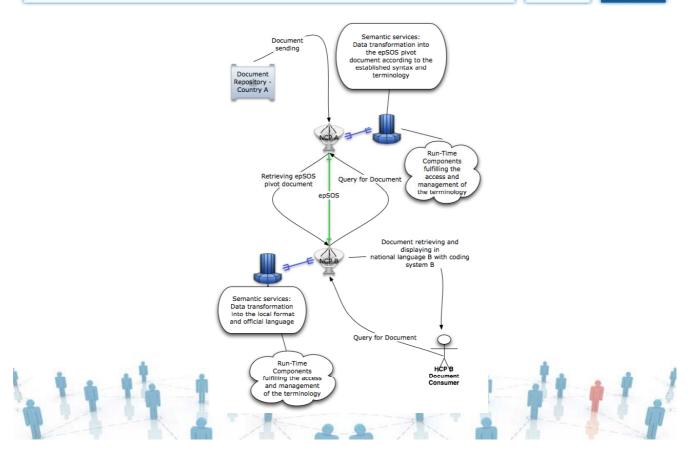




General Flow of Information



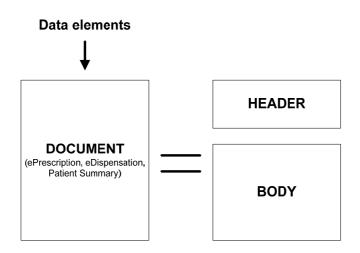




Document Structur







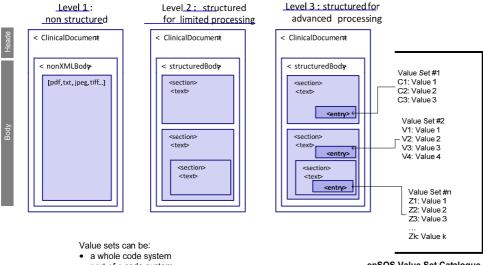


Clinical Document Architecture





CDA: Three levels of structuration



- part of a code system
- a locally created value set.

epSOS Value Set Catalogue on which the epSOS Ontology is based.



Clinical Document Architecture





```
<code code="10153-2" codeSystem="2.16.840.1.113883.6.1"</pre>
    codeSystemName="LOINC"/>
                                                                            Narrative
   <title>Past Medical History</title>
                                                                            Block
   <text>
    There is a history of <content ID="a1">Asthma</content>
   </text>
      codeSystem="2.16.840.1.113883.6.96"
           codeSystemName="SNOMED CT
                                                                           Correspond-
         displayName="history taking (procedure)"/>
<value xsittype="CD" code="195967001"
codeSystem="2.16.840.1.113883.6.96"
                                                                           ing coded,
                                                                           structured
           codeSystemName="SNOMED CT"
                                                                           part
           displayName="Asthma">
             <originalText>
     <reference value="#a1"/>
             </originalText>
         </value>
      </observation>
   </entry>
</section>
```



IHE PCC Content Modules





- History of Present Illness
- Hospital Course
- Active Problems
- Discharge Diagnosis
- History of Past Illness
- Encounter Histories
- History of Outpatient Visits
- History of Inpatient Visits
- List of Surgeries
- Coded List of Surgeries
- Allergies and Other Adverse Reactions
- Family Medical History
- Coded Family Medical History
- Pre-procedure Family Medical History
- Social History
- Functional Status
- Coded Functional Status
- Pain Scale Assessment
- Braden Score Assessment
- Geriatric Depression Scale
- Physical Function
- Review of Systems

(1.3.6.1.4.1.19376.1.5.3.1.3.4) (1.3.6.1.4.1.19376.1.5.3.1.3.5) (1.3.6.1.4.1.19376.1.5.3.1.3.6) (1.3.6.1.4.1.19376.1.5.3.1.3.7) (1.3.6.1.4.1.19376.1.5.3.1.3.8) (1.3.6.1.4.1.19376.1.5.3.1.1.5.3.3) (1.3.6.1.4.1.19376.1.5.3.1.3.9) (1.3.6.1.4.1.19376.1.5.3.1.3.10) (1.3.6.1.4.1.19376.1.5.3.1.3.11) (1.3.6.1.4.1.19376.1.5.3.1.3.12) (1.3.6.1.4.1.19376.1.5.3.1.3.13) (1.3.6.1.4.1.19376.1.5.3.1.3.14) (1.3.6.1.4.1.19376.1.5.3.1.3.15) (1.3.6.1.4.1.19376.1.5.3.1.1.9.5) (1.3.6.1.4.1.19376.1.5.3.1.3.16) (1.3.6.1.4.1.19376.1.5.3.1.3.17) (1.3.6.1.4.1.19376.1.5.3.1.1.12.2.1) (1.3.6.1.4.1.19376.1.5.3.1.1.12.2.2) (1.3.6.1.4.1.19376.1.5.3.1.1.12.2.3) (1.3.6.1.4.1.19376.1.5.3.1.1.12.2.4)(1.3.6.1.4.1.19376.1.5.3.1.1.12.2.5)

(1.3.6.1.4.1.19376.1.5.3.1.3.18)



Data Defined by the work packages WP3.1 and 3.2





Requirement number	Data element CDA / IHE PCC	PCC Template CDA XPath expression	Required/ Optional Cardinality (eP / eD / PS)	HL7 V3 Data Type	Note	Vocabulary Code System Name OID
R3.5.1	Patient Information	1.3.6.1.4.1.19376.1.5.3.1.1.1 /ClinicalDocument/recordTarget/patientRole	R/R/R	PN		
R3.5.1.1	Family Name/Surname	1.3.6.1.4.1.19376.1.5.3.1.1.1 /ClinicalDocument/recordTarget/patientRole/patient/name/family	R/R/R 1*	PN		
R3.5.1.2	Prefix O/O/O	/ClinicalDocument/recordTarget/patientRole/patient/name/prefix/	O/O/O 0*	PN	N1	HL7:EntityNamePartQualifier 2.16.840.1.113883.5.1122
R3.5.1.3	Given Name	1.3.6.1.4.1.19376.1.5.3.1.1.1 /ClinicalDocument/secordTarget/patient/Role/patient/name/given	R/R/R 1*	PN		
R3.5.1.4	Gender	1.3.6.1.4.1.19376.1.5.3.1.1.1 /ClinicalDocument/recordTarget/patientRole/patient/ administrativeGenderCode	O/O/R use nullFlavor = UNK 11	CE		HL7:AdministrativeGender 2.16.840.1.113883.5.1
R3.5.1.5	Date of Birth	1.3.6.1.4.1.19376.1.5.3.1.1.1 /ClinicalDocument/recordTarget/patientRole/patient/birthtime	R/O/R 11 The patient DOB may be a partial date such as only the year.	TS		
R3.5.2	Patient Identifiers	1.3.6.1.4.1.19376.1.5.3.1.1.1 /ClinicalDocument/recordTarget/patientRole/patient/id	see R3.5.2.1 and R3.5.2.2	II		
R3.5.2.1	Primary Patient Identifier	1.3.6.1.4.1.19376.1.5.3.1.1.1 /ClinicalDocument/recordTarget/patientRole/patient/id	R/R/R 11	II		
R3.5.2.2	Secondary Patient Identifier	1.3.6.1.4.1.19376.1.5.3.1.1.1 /ClinicalDocument/recordTarget/patientRole/patient/id	O/O/O 0*	П		
R3.5.3	Patient Address	/ClinicalDocument/recordTarget/patientRole/addr	see R3.5.4.X	AD		

Data Defined by the work packages WP3.1 and 3.2





Require- ment number	Data element CDA / IHE PCC	PCC Section Template ID Or CDA expression Section number in Appendix C	Entry content modules	Required/ Optional (eP/eD/PS) Cardinality	Note	HL7 V3 Data Types	Vocabulary Code System OID
			Code='ACTI']/ingredient/code				
		Prescription Section 1.3.6.1.4.1.12559.11.10.1.3.1.2.1	Prescription Item Entry Content Module 1.3.6.1.4.1.12559.11.10.1.3.1.3.2 entry/substanceAdministration[templateId]@root=' 1.3.6.1.4.1.12559.11.10.1.3.1.3.2]/consumable/madication/administerable/Madicine/ingredient/@class Code='ACTI]/ingredient/code				
		Dispensation Section 1.3.6.1.4.1.12559.11.10.1.3.1.2.2	Dispensed Medicine Entry Content Module 1.3.6.1.4.1.12559.11.10.1.3.1.3.3 entry/supply[templateld/@root='1.3.6.1.4.1.12559. 11.10.1.3.1.3.3]product/medication/admninisterable/Medicine/ingredient/[@classCode='ACTT]/ingredient/code				
		Medication Summary Section 1.3.6.1.4.1.12559.11.10.1.3.1.2.3	Medication Item Entry Content Module 1.3.6.1.4.1.12559.11.10.1.3.1.3.4 entry/substanceAdministration[templateld/[@root=' 1.3.6.1.4.1.12559.11.10.1.3.1.3.4*]/consumable/code/originalText	R/R/RNFA			
R3.5.18.4	Strength of the medicinal product	Prescription Section 1.3.6.1.4.1.12559.11.10.1.3.1.2.1	Prescription Item Entry Content Module 1.3.6.1.4.1.12559.11.10.1.3.1.3.2 entry/substanceAdministration[templateld/[@root=' 1.3.6.1.4.1.12559.11.10.1.3.1.3.2]/consumable/code/originalText	R/R/RNFA	NFA TXT		
		Dispensation Section 1.3.6.1.4.1.12559.11.10.1.3.1.2.2	Dispensed Medicine Entry Content Module 1.3.6.1.4.1.12559.11.10.1.3.1.3.3 /entry/supply[templateId/@root='1.3.6.1.4.1.12559. 11.10.1.3.1.3.3]/product/code/originalText	R/R/RNFA			
R3.5.18.5	Medicinal product package	Medication Summary Section 1.3.6.1.4.1.12559.11.10.1.3.1.2.3	Medication Item Entry Content Module 1.3.6.1.4.1.12559.11.10.1.3.1.3.4	R/R/NS		CD	epSOS:Package

epSOS Master Value-set Catalogue (1)





Active ingredients: full ATC

Adverse Event Type: Snomed CT (9 codes)

Allergies without Drugs: Snomed CT (84 codes)

Blood Group: Snomed CT (12 codes)

Blood Pressure: LOINC (2 codes)

CodeNoMedication: Snomed CT (3 codes)

CodeProb: Snomed CT (7 codes)

Confidenciality: HL7 Confidenciality (7 codes)

Country: ISO 3166-1

Document Title: LOINC (3 codes)

Dose form: EDQM (490 codes)

EntityNamePartQualifier: HL7 (11 codes)

Gender: HL7 administrative gender (3 codes)

HCP: International Standard Classification of Occupations (ISCO) (8 codes)

IHEActCodeVocabulary: IHE (8 codes)

IHERoleCodeVocabulary: IHE (4 codes)

IllnessesandDisorders: ICD10-WHO-en (1726 codes)

epSOS Master Value-set Catalogue 100





Medical Devices Implants: Snomec CT (223 codes)

Nullflavor: HL7 (12 codes) Package: EDQM (75 codes)

ParticipationTypePatientContact: HL7 (3 codes)

PersonalRelationshipRoleType: HL7 (34 codes)

PregnancyInformation: LOINC (3 codes)

Procedures: Snomed CT (62 codes)

ReactionAllergy: Snomed CT (8 codes)

RoutesofAdministration: EDQM (69 codes)

Sections. LOINC – IHE template (17)

Severity: Snomed CT (from 3 to 8 codes)

StatusCode: Snomed CT (4 codes)

TelecommunicationAddressUse: HL7 (8 codes)

Units: UCUM (27 codes)

unknownInformation: Snomed CT (7 codes)

URL: HL7 (10 codes)

Vaccination: Snomed CT (16 codes)

MVC/MTC





Parent Code System						
epSOS Value Set Nar	ne: epSOSIlinesses	sandDisorders				
epSOS OID: 1.3.6.1.4.1	12559.11.10.1.3.1.42.5					
website: http://apps.v	vho.int/classificatio	nsłappsłicd/icd10onlineł				
version: 2007						
Keep for traceability purposes, not part of the final MVC		In this case the items are not alphabetically arranged, but they are kept ordered by the code as most countries deal with them like this	Must come out, responsibility of member states, can be included in MTC as a starting quide			
Source	VHOICD10	English Diplay Name	German	Danish	Spanish	Latin
ICD 10 three digits	NIE	Renal tubulo-interstitial disorders in diseases	Tubulointerstitielle Nierenkrankheiten bei anderenorts klassifizierten Krankheiten	Tubulointerstitiel nyresygd ved sygd klass ansted	- Control of the cont	
ICD 10 three digits	N17	Acute renal failure	Akutes Nierenversagen	Akut tubulointerstitiel nyresygd (ATIN)	Insuficiencia renal aguda	Insufficientia renalis acuta
ICD 10 three digits	N18	Chronic renal failure	Chronische Niereninsuffizienz	Kronisk nyreinsufficiens	Insuficiencia renal crĂ²nica	Insufficientia renalis chronica
ICD 10 three digits	N19	Unspecified renal failure	Nicht näher bezeichnete Niereninsuffizienz	Nyreinsufficiens uden specifikation	Insuficiencia renal no especificada	Insufficientia renalis, non specificata
ICD 10 three digits	N20	Calculus of kidney and ureter	Nieren- und Ureterstein	Sten i nyre og urinleder	CÃjlculo del riñòn y del urîter	Nephrolithiasis et ureterolithiasis
ICD 10 three digits	N21	Calculus of lower urinary tract	Stein in den unteren Harnwegen	Sten i nedre urinveje	CĂjlculo de las vĂ-as urinarias inferiores	Calculus tractus urinarii inferioris
ICD 10 three digits	N22	Calculus of urinary tract in diseases classified elsewhere		Urinvejssten ved sygd klassificeret andetsteds		
ICD 10 three digits	N23	Unspecified renal colic	Nicht näher bezeichnete Nierenkolik	Nyrekolik uden specifikation	CĂ*lico renal no especificado	Colica renalis, non specificata
ICD 10 three digits	N25	Disorders resulting from impaired renal tubular function	Krankheiten infolge Schädigung der tubulären Nierenfunktion	Forstyrret tubulær nyrefunktion	Trastornos resultantes de la funciÁ n tubular renal alterada	Dysfunctio tubulorum renis
ICD 10 three digits	N26	Unspecified contracted kidney	Schrumpfniere, nicht näher bezeichnet	Skrumpenyre uden specifikation	RiÃzÃ*n contraÃ-do no especificado	Ren contractus, non specificatus
ICD 10 three digits	N27	Small kidney of unknown cause	Kleine Niere unbekannter Ursache	Små nyrer af ukendt årsag	RiñÃ*n pequeño de causa desconocida	Atrophia renis, causa ignoto
ICD 10 three digits	N28	Other disorders of kidney and ureter, not elsewhere classified	Sonstige Krankheiten der Niere und des Ureters, anderenorts nicht klassifiziert	Sygd i nyre og urinleder, andre ikke klass ansted	del urîter no clasificados en otra parte	Morbi renis sive ureteris alii in morbis

Data Transformation





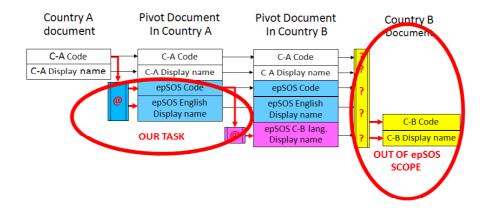
- Data Transformation
 - Syntax Pivot Documents
 - Translation
 - Transcoding (if necessary)



Translation/Transcoding





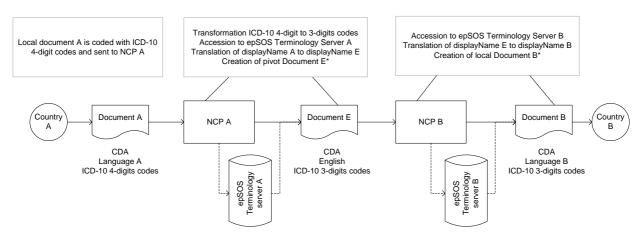




Translation/Transcoding







* Initial 4-digits code with displayName A are kept into CDA documents E and B and are still available



Translation/Transcoding





3. Translation Code

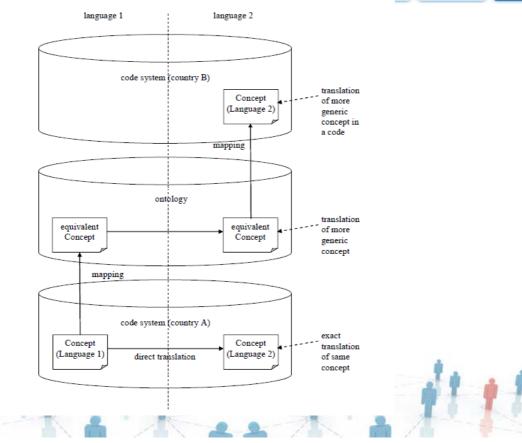
	Country A (France)	NCP A-> NCPB	Country B (Austria)
Document	Document A	Document E	Document B
Code System	ICD-10	epSOSIIInessesandDisorders	epSOSIIInessesandDisorders
Code	\$80.1	S80	S80
Language	French	English	German
DisplayName	Contusion de parties autres et non précisées de la jambe	Superficial injury of lower leg	Oberflächliche Verletzung des Unterschenkels
CDA schema	<pre><value code="S80.1" codesystem="2.16.840.1.113883.6.3" codesystemname="ICD10" displayname="Contusion de parties autres et non précisées de la jambe " xsi:type="CE"> </value></pre>	<pre>cvalue xsi:type="CE" code="S80"</pre>	<pre>cvalue xsi:type="CE" code="S80" codeSystem="1.3.6.1.4.1.12559.11.10.1.3.1.42.5" codeSystemName="epSOSIllnessesandDisorders" displayName="Oberflächliche Verletzung des</pre>



Translation/Transcoding



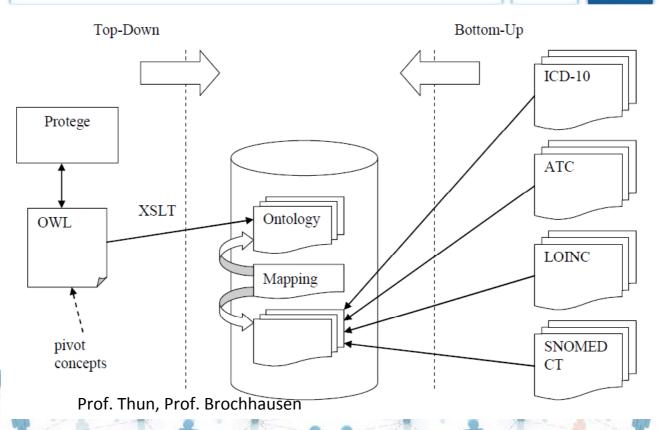




Translation/Transcoding



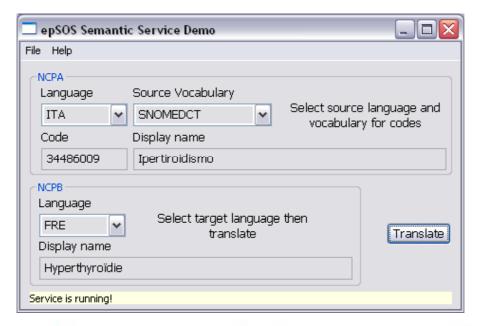




Demonstrator













Thank you for your attention Questions?

