Seirbhíse Sláinte
Health Service Executive

ERS
Electronic Record Services BV

HEALTH SERVICE EXECUTIVE

ICT National Integrated Services Framework Project

Mini Tender: Information Architecture

(work components 1 - 4)

I. Document Control

1. Version History

Version date	Version	Author	Changes and Comments
5-11-2013	0.1	Gerard Freriks	Set-up of document structure Initial filling
25-11-2013	1.0	René Schippers Gerard Freriks	First draft
9-12-2013	1.01	Gerard Freriks	Added text about All documents describing the epSOS Data Set. International developments
12-01-2014	1.1	Gerard Freriks	Extension epSOS chapter
20-01-2014	1.2	Gerard Freriks	IM-RM hoofdstuk
29-01-2014	1.3	Gerard Freriks	Aanvullingen IA-RM
30--02-14	1.4	Gerard Freriks, René Schippers	Review v1.2 comments processes
30-01-2014	1.5	Gerard Freriks, René Schippers	Summaries + Comments from René Schippers
	1.6	Gerard Freriks, René Schippers	

2. Approvals

Approval Authority	Name	Version date	Approval date

3. Distribution

Name	Title	Date of Issue	Version
Peter Connolly	HSE ERS Deliverable Part 1 Master GF v03.pages-tef	25-11-2013	draft 0.30

Executive Summary

[tbp Rene Schippers]

2. Reading Guide

The structure of this document is:

- Purpose of the document
- Description of work for this project
- Introduction
  Some generic topics are presented that provide background information
- Information Architecture Reference Model (IA-RM)
- Subject Area Models (SAM)
- Technical Systems that support IA-RM and SAM
- Recommendations for deployment
- Recommendations for Governance
- Catalogue of standards that are part of the recommendations
- Appendixes
  epSOS SAM description
  Glossary
  The HSE Questionnaire /workshop results

Many of the chapters have as substructure:

- Introduction
- Reasons why
- Technical matters providing more technical details
- Summary

Table of Contents

<blank>

3. Purpose of this document

The purpose of this document is to describe an Information Architecture Reference Model for Ireland based on open International standards.

4. Description of work

5. Introduction: Back ground information

This chapter is an introduction to several basic generic topics that are essential to understand the next chapters about the proposed choices for an Irish National Infostructure.

Topics that will be presented are:

- Semantic Interoperability
- Logical model of the EHR
- Standards and standardisation
- National INFOstructure / Semantic Stack
- Structures and coding systems
- State of the Art Developments

5.1. Introduction: Why is this background information important?

Without some knowledge about topics related to semantic interoperability many actors fail to see the challenges that needs to be addressed before data can be safely, flexibly, exchanged between IT-systems.

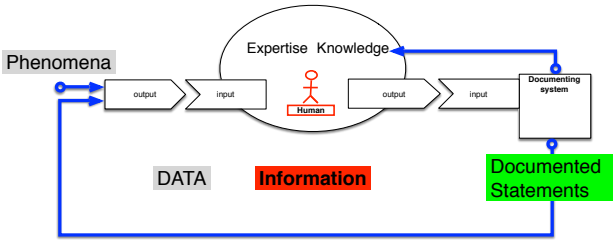
Reading the topics in this chapter will become clear that:

- Large-scale patient safe semantic interoperability will not be possible without a co-ordinated set of executable policies at a national scale
- an INFOstructure, consisting of several tools for editing, governance and publishing of shared artefacts in libraries, is a conditio sine qua non
- such an national INFOStructure needs to be based on national and international open standardard in order to create a level playing field for the IT-Industry
- the use of open international standards allows cross border interactions between healthcare organisations but also the IT-industry products
- a list of open international standards for the structuring of health information, using codes from coding systems, and local, regional, national, arrangements with respect to data sets are needed

5.2. Introduction: Interoperability

Semantic Interoperability is a keyword in this document. This concept will be defined and explained for the purpose of this project.

The general concept ‘Semantic Interoperability’ can be explained by the phrase: ‘the facility, the services, that a healthcare provider can re-use data about a patient now and in the future’.



Many definitions exist each addressing an aspect of the problem stack associated with complex communication between persons, organisations and there IT-systems.

Before discussing semantic interoperability it is necessary to define what is involved in documentation and exchange between communicating parties.

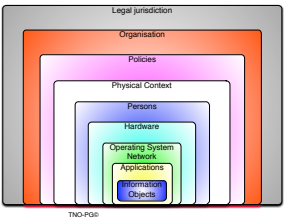
The figure XXX explains the concepts: 'Data', 'Information', 'Documented statements', that all three play their role.

Data is read from a documentation system or data is observed as the result of phenomena that occurred and are perceived and observed. All data is the output of something and read as input by humans. Together with existing implicit and explicit knowledge and expertise the data is interpreted and transformed into 'Information'. After the interpretation of the data inferences are made that result in output such as orders, and explanations, that can be documented in a documenting system. Information is documented. Observe that when read again it has to be interpreted as data again.

In essence semantic interoperability is the feature where Information in one person's brains can be transformed to a signal that when received by another can be interpreted by a third party without a loss of meaning.

Interoperability can take many shapes and forms: between humans, humans and machines, between machines in the form of: sound and other human signals, or via print, digital images, Word files, more and less digital exchange formats.

Complicating factor is the fact that humans are active in work processes and legal systems. Each of these contexts will influence what and how phenomena are observed and interpreted and named. Adding these social and legal contexts make semantic interoperability more complex. In addition there are differences in IT-systems that impact the exchange between communicating parties.



In summary many and different aspects play a role in semantic interoperability.
Interoperability is a property referring to the ability of diverse systems and organizations to work together (inter-operate).
The IEEE defines interoperability as the ability of two or more systems or components to exchange information and to use the information that has been exchanged.

What is needed for full patient safe Semantic Interoperability?

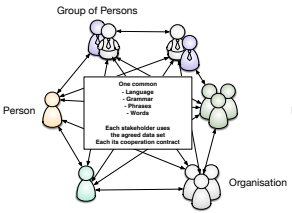
Technical interoperability
In order to convey a message from one communicating party to another a mutually agreed medium is needed for the transport. E.g. air for sound, paper and the postal system for written letters, or electronic messages via the e-mail system on the Internet or another network.
This level needs standards for Common Transport Models.

Syntactical interoperability
For this level of sophistication agreements between the communicating parties are necessary about formats such that the texts can be read and interpreted. For example both must agree on a Word, or PDF, or image format, or XML formats that can be used to hold the message that is to be exchanged. This level of interoperability needs the interpretation by humans to decipher the message. IT-Systems can display and print the message but cannot interpret it and act upon it.
This level needs Common Message Models.

Semantic interoperability
At this level of sophistication the message that is exchanged contains not only human readable text but additions that allow IT-systems to interpret it and act upon it safely.
Two sub-levels can be discerned: Partial Semantic Interoperability and Full Semantic Interoperability.

Partial Semantic Interoperability
For semantic interoperability between humans to work agreements are necessary on the topics of: language to be used, character set that is associated with the language, its grammar (syntax) and the common dictionary with the meanings of the words, plus standard phrases.

When persons, groups of persons or organisations make use of IT-systems, these systems must be able to read and produce similar constructs. E.g.: Language, Reference Model, Data Sets, and Codes.



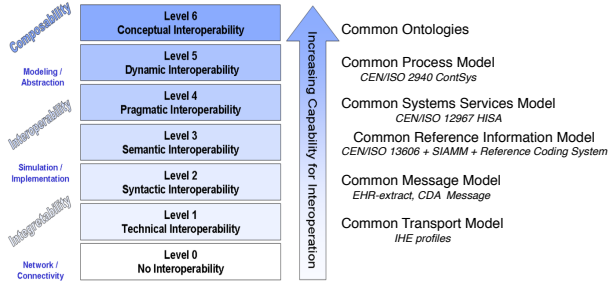
A r-

rangements on these topics between two or more communicating parties allow humans to interpret the data safely.

Humans need a lot of implicit knowledge to interpret the concepts designated by codes from the coding system. E.g. Humans know what the meaning of a word is when they read the dictionary. Because of a lot of learning in their childhood they have a lot of shared implicit expertise and shared implicit knowledge about the word. Humans know what 'cold' or 'heat' means, or a 'tree', or 'chair'. In healthcare they know what the intravenous systolic blood pressure is.
This level needs a Common Reference Model plus one supporting Reference Coding System.

Conceptual Interoperability
Full Semantic Interoperability
IT-systems can deal in a limited way with the data using software, since they do not have access to all this implicit encyclopedia knowledge. A full understanding by the IT-system is possible only when the IT-systems have a complete knowledge about the world. For full Semantic Interoperability they must have access to an Ontology as analogue to the encyclopedia.
This level needs Common Ontologies.

The present state of the art has not reached the level of full semantic interoperability. Ontologies and healthcare are considered open for academic studies and experimentation.
Partial semantic interoperability is achievable.



Pragmatic Interoperability

Technical It-System Co-operability

Persons, groups and organisations make use of IT-systems and shared services. This means that IT-systems of various vendors need to be able to deal with these common services. Examples of services are facilities to look for codes or translations of codes from one language to another, etc.

At present IT-systems have proprietary solutions for these internal and external services. Sharing of services is limited.

This level needs one Common Systems Services Model.

Dynamic Interoperability

Process Co-operability

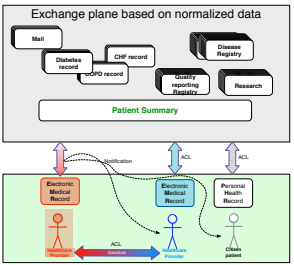
Each healthcare provider and organisation is using its own work processes. Increasingly there is the need for co-operation between the different stakeholders in clinical pathways. To reach this level of interoperability shared agreements (models) are needed to map the various process steps between organisations and the data collected and shared.

This level needs one Common Process Model.

5.3. Introduction: Logical Model of the EHR

The Electronic Health Record (EHR) is a loosely defined concept.

ISO/TR 20514 defined the Shared EHR as: "*a repository of information regarding the health status of a subject of care in computer process able form, stored and transmitted securely, and accessible by multiple authorised users. It has a standardised or commonly agreed logical information model which is independent of EHR systems. Its primary purpose is the support of continuing, efficient and quality integrated health care and it contains information which is retrospective, concurrent, and prospective.*"



For practical purposes this project will define the EHR as those services that allow the co-operation between healthcare providers and their organisations. Each of the connected systems that healthcare providers use - the Electronic Medical Record (EMR) and Personal Health Record (PHR) - are NOT part of this EHR definition.

The logical model for this EHR is depicted in the figure above.

Healthcare Providers use an Electronic Medical Record system (EMR); patients use Personal Health Record system (PHR). Data that is shared is placed, as it were, on an Exchange Plane. Data can be there for a short period of time or for ever, depending on the needs. Examples are: Patient Summary, discharge and referral letters, disease specific shared records, registries, etc.

All data in that Exchange Plane are outside the confines of user systems. Access and privacy is controlled via an Access Control List (ACL) and Patient Mandates that the author of the published data together with the patient are responsible and accountable for. ACL's are mostly associated with access to services. At the level of the data in the patient record Patient Mandates govern the access to specific kinds of data. Any needed override of the ACL via the 'Red Knob' procedure needs an immediate notification of the author and patient.

Out of hours substitution can be handled in the same way as exchanges between systems, but actually and logically the original other EMR from the Healthcare Provider they substitute, is used.

Other stakeholders (researchers, registries, authorities) can re-use the data that is made available via the data exchange plane.

IT-systems (EMR, and PHR) that exchange data need to have a common interface based on the same specifications for all the models and coding systems needed for Semantic Interoperability, and as described in the previous chapter. Each of the existing EMR and PHR systems internally can be different as long as at the interface with the Exchange Plane they use the same specifications to normalise the exchanged data.

5.4. Introduction: Standards and standardisation

Any infrastructure for the exchange of health data using the common agreed interface specification between health-IT systems must be based on many standards. This chapter will explain standardisation, the need for it, and the most important standardisation organisations. Elsewhere the standards that are needed are listed and explained.

5.4.a. What is a standard?

A standard (French: Norme, German: Norm) is a *technical document designed to be used as a rule, guideline or definition. It is a consensus-built, repeatable way of doing something.*
Standards are created by bringing together all interested parties such as manufacturers, consumers and regulators of a particular material, product, process or service. All parties benefit from standardisation through increased product safety and quality as well as lower transaction costs and prices.

Standards can be organisation specific (industrial standard), in the private (closed) or public domain (open), national (NSAI, ANSI, DIN, BSI, …) or international, regulated or non-regulated.
Most National projects made the choice to rely on open and public standards. In the case of Europe they by preference use European standards.

Because of European Directives and regulations standards can play its role in procurement processes.

5.4.b. European standardisation

Three European Standards Organisations (ESOs) are officially recognised as competent in the area of voluntary technical standardisation. The European Union (EU) Regulation (1025/2012) which settles the legal framework for standardisation, has been adopted by the European Parliament and by the Council of the EU, and entered into force on 1 January 2013.

The three European Standardisation Organisations are:

- CEN[1] – European Committee for Standardisation;
- CENELEC[2] – European Committee for Electrotechnical Standardisation;
- ETSI[3] – European Telecommunications Standards Institute.
- Thanks to European Standards created by the European Standardisation System, manufacturers and service providers get direct access to the market. The ultimate aim is to have a unique standard in 33 European countries and beyond.

[1] www.cen.eu

[2] http://www.cenelec.eu

[3] http://www.etsi.org

Indeed, by creating standards, the ESOs help facilitate trade between countries, create new markets and cut compliance costs. They provide a Standardisation framework to prepare voluntary standards that help to develop the Single European market for goods and services via procurement. European Standards play a crucial role in the development and consolidation of the European Single Market and support other EU policies, providing an efficient co-regulation tool.

Over the years the European Standardisation System has proved to be a successful and well-consolidated model.

The European Standards Organisations formally cooperate with other international standardisation organisations such as: ISO4, IEEE5, GS1, etc..

5.4.c. Other International Standardisation Organisations

In the field of healthcare other standardisation organisations play an important role: HL7[6], IHTSDO[7], LOINC[8], etc..

5.4.d. National INFOstructure / Semantic Stack

When in a region or country the various stakeholders need to exchange data about patients a set of shared agreements is necessary.
This set of agreements is about topics such as:

- semantic aspects
  - unique identifiers for objects: patients, healthcare providers, provider organisations, other stakeholders, services, etc.
  - unique codes from relevant coding systems and mappings between them
  - data set definitions of what is exchanged between stakeholders
- technical exchange formats
- governance of the common and shared agreements.

5.4.e. What is the 'INFOstructure'?

The Infostructure is all that is needed, as a shared infrastructure, in a country or region to make semantic interoperability possible.

5.5. Introduction: What is the 'Semantic Stack'?

The Semantic Stack is all that is needed, as part of the INFOStructure, in a country or region to make semantic interoperability possible.

[4] http://www.iso.org

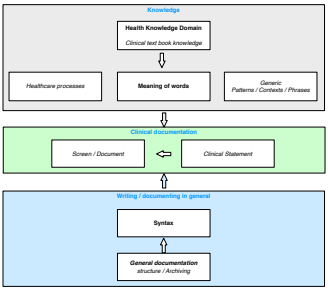
[5] http://www.ieee.org

[6] http://www.hl7.com

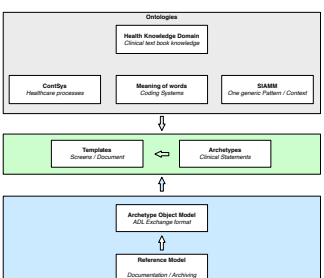
[7] http://www.ihtsdo.org

[8] http://www.loinc.org

In human written exchange of data several things need to be in place:



- agreements about how to produce and archive documents/screens
- agreements about the language specific syntax used in the document/ screen. (Observe that this allows the construction of syntactical correct nonsense)
- agreements about the context specific layout for a document/screen
- agreements how to construct meaningful sentences to be used as Clinical Statements in a specific context
- agreements about the use of words and their shared meaning
- agreements (implicit or explicit) about the back ground knowledge about the (specific aspects of) the world.
- In computer assisted interoperability the same components are necessary:
- agreements about a Reference Model that deals with the general structure of any document and archiving issues
- agreements a method to produce sentences, a kind of syntax using an Archetype Object Model
- agreements on the structure of specific documents (Templates) representing a specific data set
- agreements on the construction, structure, of Clinical Statements (SIAMM)
- agreements on the content of Clinical Statements (Archetype)



- agreements on the Meaning of all Words/concepts (Codes and Coding Systems) used in Clinical Statements and Documents
- agreements on the shared specific and general health knowledge (Ontologies)

Only a complete set of agreements, standards, and governing organisations at a regional or national level can realise flexible and safe exchange of patient data between IT-systems in health and care. Only a stack of standards that is used by all stakeholders will be able to create the Exchange Plane as described in the chapter on the Electronic Health Record. This stack of standards is depicted in figure XXX and is called the Semantic Stack.

When IT-systems in an interface now how to deal with data, that is exchanged according to the open International standards of the Semantic Stack, they can stay as they are and use company specific proprietary software inside their systems.

5.6. Introduction: Semantic Interoperability Artefacts: Structure and Codes

National or regional or local healthcare actors express their data needs in a data set. This what their systems must be able to collect and exchange.
As presented in the previous paragraph elements from the Semantic Stack are used.
This paragraph describes generically the principles behind semantic interoperability artefacts and the crucial role that codes play.

In the case of human communication we rely on many shared constructs (syntax, phrases, words and a shared knowledge about the world.
Equivalents in semantic interoperability between computer systems are:

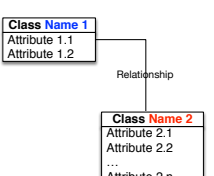
- Knowledge - Ontologies, defining knowledge
- Words - Codes from coding systems, defining meaning
- Phrases - Archetypes / Clinical Statements, defining structure
- Specific Document - Template, defining specific structure and meaning in a specific context
- Generic Document - Reference Model, defining a general structure

Archetypes are used to construct the specific Templates that represent a report or screen.
Codes are used to give meaning to specific parts of Archetypes.
Concepts from ontologies give meaning to codes.

In general communication amounts to agreements on shared Knowledge, Structures and Meaning/Codes.
And when the communication is digitally this Knowledge, Structure and Meaning/Codes need in addition internal technical representations that computers can manipulate.

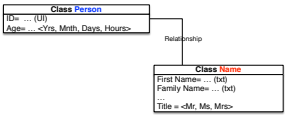
Archetypes as Structures based on a Reference Model and codes are the main atomic building blocks that are used.

The Reference Model and therefor all archetypes consist of UML classes with one or more Attributes per Class. The UML model allows the definition of the relationships between classes. The UML model provides the possibility to structure data.
Per UML CLASS the name of that class (Node) is specified and in addition each UML CLASS holds one or more Attributes that contain data values.



When modeling archetypes the structure, names of nodes, the attribute names but also the data values attached to these attributes can be specified.

In the example a Class named Person is connected with a sub-class named Name. About the Person and its Name things are specified in attributes that define what data can be captured.



Archetypes are constraints on the Reference Model and therefor always are conformant to this Reference model. Archetypes are built using UML classes that are named. UML Classes have Attributes that are named also. Data values associated with these Class Attributes can be of many kinds: numbers, texts, codes, dates, times, url, unique identifiers, etc.

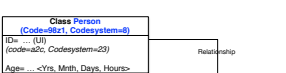
The names provided are arbitrary and have only meaning to humans. These names can be translated in any language. Inside the archetype and the systems that use it these names are represented by internal codes. Each internal code potentially can have any name. Names that have meaning for the user that provided that name. Each internal code does NOT carry a universally understood meaning of what it exactly is. The meaning attached to these names of Classes, Attributes and data values are derived from codes from one or more Reference Terminologies.

All these names and possibilities that are given to the Node names, Attribute names and data values can be for instance texts, numbers, dates, times, etc. or any combination. Data types specify the format of those data points.

Each author, each community potentially can specify its own structure, Node names, Attribute names and allowed content of the data points. Thereby not securing any general semantic interoperability.

For semantic Interoperability one basic structure (Reference Model), one way to construct and exchange artefacts, a set of common Node names, one set of common Attribute names, one set of common allowed Data types, one set of allowed or expected data values and one set of unique codes for all these names and data values are necessary.

Sometimes the codes are attached during design time. Sometime the codes for (for instance) possible Diagnosis must be selected from an available list of pre-selected codes to choose from at run-time. These lists are called: TermLists. These TermLists are stored outside the EHR and made available as catalogue to choose from.



An important benefit of the use of an international coding system is that while codes stay the same, the accompanying definitions and labels can be in any language. International coding system play an important role in cross border, cross language, semantic interoperability.

Archetype

Node 1= Name 1
Node 2= Name 2
Node 2.1= Name 3
Node 2,2= Name 4
etc..

Because there must not be too many competing coding systems to choose from, some coding systems are recognised as Reference Terminologies.
The Semantic Stack and therefor the INFOstructure plus tooling and libraries with defined artefacts are needed at a national level in order to secure patient safe semantic interoperability. For cross border exchanges International standards are essential.
Various standards define consensus agreements each at its own level in the semantic stack.

Archetype

Internal code	= Human text	= External Code
Node 1	= Name 1	= Code 1
Node 2	= Name 2	= Code 2
Node 2.1	= Name 3	= Code 3
Node 2,2	= Name 4	= Code 4
etc.		

5.7. Introduction: Two Level Model Paradigm

Archetype

Internal code	= Human text	= External Code
at0001	= XYZ	= 123456
at0002	= BloodPressure	= 2838586
at0003	= Systolic	= 321499
at0004	= Diastolic	= 254690
etc.		

The Two Model Paradigm (actually the multi model paradigm) is a relative recent development by CENtc251 and later ISOtc215. It is based on 20 years of European research and resulted in a CEN/ISO standard for EHR-Communication.

Two (or more) models are needed:

- A Reference Model that deals with the structure and archiving of documents
- An Archetype Object Model that allows the creation of Archetypes as constraints on the Reference Model. Each archetype always conforms to the Reference Model. Each archetype can fully specify the data needs of the users.

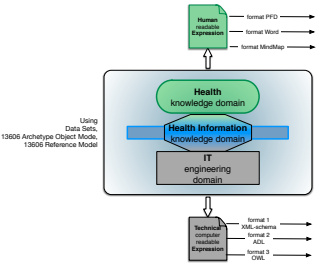
Based on local data needs by a community they can specify with great detail their local data requirements by grouping archetypes from a library in a structure (named Template). A Template defines for instance the data content of a report or screen or message.

This Two Level Model paradigm has substantial advantages over other paradigms:

- Models drive the archetypes enforcing that every archetype conform to both models
- It allows Model driven development and implementation
- Data bases using this Two Level Model paradigm do not need data base conversions when data requirements change
- Resulting in an agile, flexible, resource friendly solution for semantic interoperability

- Allows a complete separation of concerns between knowledge domain actors (healthcare providers and health organisations) and the IT-providers, while using the same paradigm and artefacts.

Editor tooling based on open international standards and the Two Level Model paradigm create the Archetypes. Archetypes can be exported such that healthcare providers and their organisations can read, comment and validate the archetypes. While at the same time IT-vendors are provided with technical artefacts based on the same archetype. Technical artefacts such as XML, they can use directly in the development of their systems or use t for integration (semantic interoperability) between systems.



5.8. Introduction: State of the Art Developments

Ireland is not the first or only country that makes plans for a National INFOstructure. Relevant and important recent developments in various countries are described.

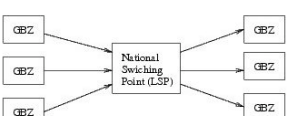
[to be added]

5.8.a. Introduction: Netherlands[9]

The Dutch Electronic Patient Record (EPD) System is a Dutch Nation-wide system for exchanging medical records, which is introduced in 2009-2010. The Dutch senate has decided not to accept a law that regulates and mandates the use of the EPD for exchanging patient information in the Netherlands.

An Association funded by the National Insurers together with Healthcare Provider organisations exploit the developed infrastructure using HL7v3 messages as technological solution.

The EPD is generally characterized as a decentralized system. Patient records are stored in the systems used by the care professional(s) - i.e., the responsibility for managing and storing these records remains with the care professionals; records are not stored a central database as in, for example, the SPINE system used by the U.K. National Health Service.



[9] Guido van 't Noordeinde (2012) University of Amsterdam - http://staff.science.uva.nl/~noordend/epd/index-start.html

The system's core is the National Switching Point (LSP in Dutch). This system contains a reference index which stores references (pointers) to patient records. Patient records are indexed using a unique identifier for patients (BSN, the former Dutch social security number) and an information type. Access control takes place centrally in the LSP, based on authorization of the care professional for a given information category (e.g., GP record or pharmacy record). The patient records in the EPD are most cases be professional summaries created by physicians for the purpose of sharing information with colleagues.

The de-central information systems that care professionals store their records in and which are connected to the LSP are termed well-managed care systems (GBZ systems). Only systems that adhere to the requirements for GBZ systems can connect to the LSP.

Above, a figure showing the LSP in relation to GBZ systems is shown. The central role of the LSP is clearly visible. To the right, GBZ systems (belonging to different organizations) are shown which registered patient information in the LSP. Clients (physicians or mandated employees in a GBZ, left) can access the central reference index in the LSP to find relevant records, or they can construct a query to let the LSP find and retrieve relevant records. All access is mediated by the LSP. In reality, GBZ systems will contain client as well as server functionality.

GBZ systems may be small (e.g., GP systems) or very large - including hospitals containing many different systems that contribute information to the EPD, or from which requests are made. For more details, please refer to the paper.

5.8.b. England

A few years ago, the NHS (National Health Service) launched a programme for centralising connected health in the UK called “Connecting for Health”. One of the first initiatives arising from this project was the creation of Summary Care Records (SCRs), the aim of which was to provide healthcare staff treating patients in an emergency with faster access to key clinical information. The NHS also set up HealthSpace, an online service whereby healthcare professionals could share and access medical data. The portal was however not as popular as expected and was closed down by the Department of Health in early 2013.

The NHS in England for many years maintains a data dictionary based on a subset of CEN/ISO 13606 and SNOMED codes using the Logical Record Architecture[10] (LRA).
[To be added]

5.8.c. Australia

[To be added]

[10] http://www.uktcregistration.nss.cfh.nhs.uk/trud3/user/guest/group/0/pack/12

5.8.d. New Zealand

Population is 4.5 million. The National Government has developed a National eHealth Strategy and Plan. Its goal is to achieve high quality healthcare and improve patient safety and by 2014 have a core set of personal health information available.

Technical aspects
National Patient, Healthcare Provider and Facility Identifiers are available.
Demographics information is stored centrally (name, address, date of birth, sex and ethnicity).

Standards used will rely on:

- IHE XDS messaging and document handling info structure
- Predefined semantic building blocks as extensible Core Health Content Models (archetypes) using openEHR (an CEN/ISO 13606 related proprietary specification)
- CCR, HL7 v3 CDA documents, HL7v2, HL7v3.
- ISO 13606 (EHR), 11179 (Data Elements/Dictionary) , 21090 (Data Types)
- SNOMED-CT, LOINC, ICD10, HSSP CTS2

5.8.e. Canada Infoway[11]

The last years Canada has gained much experience with health IT.
Canada is a federal state with a distribution of legal power between the National Government, ten Provinces and three Northern Territories. The Federal Government sets the framework and contributes to the financing arrangements are autonomous. Because of this regional differences are quite substantial.

EHR
In March 2001 Canada Health Infoway was started as an independent organisation owned by vice ministers for health of the fourteen Federal, Provincial and Territories. Infoway provides financial support for a common EHR framework. Best practices are shared. Infoway cooperates with various (local) governments, health organisations and IT-suppliers.

Projects
From 2001 more than 2200 projects have been subsidised: EHR, exchange of Lab reports, telehealth, patient access to the EHR data. In 2006-2007 350 million Euro was spent. (Canada has 32 million inhabitants.

Problems
The public at large does not support the Canadian vision. A lot of exchanges take place using paper. Support by local governments could be improved.

[11] https://www.infoway-inforoute.ca

Technology aspects

Developments in Canada are based on the messaging paradigm (HL7 v3 messages) and SNOMED-CT, LOINC.

Development of messages is supported by 'the Message Builder', Testing Environment, Terminology tools and tools for the localisation of the messages.

Plans for 2015

Deployment of the EHR nation wide, improved public support, better disease management, better tele-care, treatments of cancer patients and a reduction in waiting lists.

5.8.f. European Commission + Member States

epSOS is a European e-Health project executed by almost all (23) EU-Member States for the cross border exchange of digital exchange of relevant patient data for mobile citizens. The project is started in 2009.

epSOS develops solutions that do not need changes in national legal arrangements. All exchanged data is translated into the language used in the receiving country.

Architecture/Technology

Based on the message paradigm using HL3 v3 CDA, Integrating the Health Enterprise (IHE) profiles, SNOMED and LOINC messages have been developed for the Patient Summary, eMedications and e-Prescribing. Services developed are: Identification Service, Patient Service, Order Service, eDispensation Service and theConsent Service.

Each country has one responsible National Contact Point that links with National users and other National Contact Points. Languages and codes are translated using the Taxonomy Manager and the Terminology Serviced Access Manager, when data is exchanged between the contact points.

In addition there are Auditing and Authentication services.

Status

In 2013 in a few countries the exchange was deployed and tested. epSOS is in the process to evaluate the technology choices. The CDA documents (messages) developed play a role in the collaboration between the EU and USA.

5.9. Introduction: Ireland - Workshops and Questionnaire: Results and Analysis

[To be added]

5.10. Introduction: Summary

6. Information Architecture Reference Model

6.1. IA-RM: Introduction

The Information Architecture Reference Model (IA-RM) is a high level abstract model that depicts how at the level of health semantics (messages, documents and objects, plus coding systems) Semantic Interoperability Artefacts (SIA's) are produced, published, maintained and published, including a set of supporting services.

The SIA's depict the data sets healthcare providers produce and validate. A collection of SIA's for a specific domain are called Subject Area Models (SAM's). The proposed HSE Tooling Environment will support all stakeholders to define SAM's in a coherent governed way.

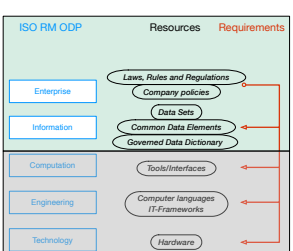
The IA-RM, SAM's and SIA's help create the open International standards based Exchange Plane in the general EHR architecture.

The ISO RM/ODP[12] standard provides a generic framework to describe the various aspects of IT-systems. It discerns 5 levels, called Viewpoints:

1. The **enterprise viewpoint**: A viewpoint on the system and its environment that focuses on the purpose, scope and policies for the system.
2. The **information viewpoint**: A viewpoint on the system and its environment that focuses on the semantics of the information and information processing performed.
3. The **computational viewpoint**: A viewpoint on the system and its environment that enables distribution through functional decomposition of the system into objects which interact at interfaces.
4. The **engineering viewpoint**: A viewpoint on the system and its environment that focuses on the mechanisms and functions required to support distributed interaction between objects in the system.
5. The **technology viewpoint**: A viewpoint on the system and its environment that focuses on the choice of technology in that system.

This document will focus on:

- the requirements from the environment, healthcare providers, etc. as expressed at the enterprise viewpoint level.
- the semantics (SAM's) that express the data needs healthcare providers, their organisations and authorities have, as expressed at the information viewpoint level.
- the behavior of IT-systems, applications and services, in casu the HSE Toolbox, will be



[12] ISO/IEC 10746 'Open Distributed Processing — Reference model'

described in the computational viewpoint.

- Engineering and technology requirements are out of scope for this document.

5.1. IA-RM: Why is an Information Architecture important

As long as each user in one IT-system uses their own software and locally defined codes the internal interoperability operability is 100%. The moment they start to communicate with other 'autonomous' IT-systems problems arise. Each IT-system has their own data base structure, define concepts and codes. They can not communicate. There is NO semantic interoperability.

An Information Architecture is needed. The Reference Model describes the architecture.

An IA-RM is needed when healthcare providers and their organisations need to report all to regional or national or international shared registries. An IA-RM is needed also when different health actors need to co-operate around the shared, joint, delivery of health and care to the same patient.
An IA-RM plus supporting tooling allows each user community to re-use building blocks for creating Subject Area Models (SAM's) that reflect a data set that is needed/prescribed by law.

An IA-RM can be defined as a collection of semantic interoperability artefacts (messages) with codes, as is the case in several countries (e.g. the Netherlands where an IA-RM is constructed by defining a 'static' set of HL7v3 messages).

An alternative is to construct a library of modules (based on a set of requirements) of re-usable semantic interoperability artefacts and supporting tooling that can be used flexibly to construct any message needed for reporting or shared care. Use this IA-RM to define data sets/SAM's and create SAM based exchange formats for communication between IT-systems as part of a procurement process for IT-systems and supporting tooling and services. All this is called the INFOstructure.
Over time the IA-RM and its SAM's will influence the continuous development of IT-systems because these systems internalise the prescribed standards inside their system architecture. IT-systems will be come more semantically interoperable and eventually will be federated.

5.2. IA-RM: Requirements

As a pre-amble New Zealand[13] published a set of general principles that in adopted form are relevant. The following high-level principles underpin the Reference Model Information Architecture for Ireland and will guide its development:

Align to national strategy. The Reference Model for the Information Architecture will align with national standards and business strategies, with priorities defined by national IT plans.

- **Invest in Information**. We will represent health data for exchange as detailed clinical models that can be represented in different ways independently of any particular information model

[13] HealthBase. Interoperability, Reference Architecture. Version1.0, December 2011

or serialized representation (structure) and derived directly from business requirements with clinical input. These models may be represented in different ways for different audiences.

- **Use single content model**. Information for exchange will be defined and represented in a single consistent way at the information model level. Where possible, it will align with national and international standards.
- **Work with sector**. The development of the Reference Model for the Information Architecture will be in partnership with the sector as represented core groups as relevant Irish stakeholders, such as: (1) Business and Strategy; (2) Clinical, Safety and Research; (3) Technical; (4) Allied Agencies of HSE and (5) Others, like industry, etc. ...
- **Align to business needs**. Development of the details of the Reference Model for the Information Architecture will be in conjunction with the prioritized business projects. Prioritization will be set by health and IT plans embodying those needs. The intent is to ensure clinical and other business engagement.
- **Use proven standards**. Where there is a relevant national or international standard that is compliant with the overall direction of the Reference Model for the Information Architecture, will meet a particular business/technology requirement and is used, we will use that standard. If modifications are required, we will work with the relevant SDO to make the modifications. This approach applies at all levels of the interoperability stack including workflow, payload, security, terminology and transport.
- **Adopt services approach**. To define the behavioral aspects of interoperability we will use a services approach, where a service can be thought of as a method of encapsulating business functionality behind a clearly defined interface that is technology agnostic and conforms to accepted practices.

In order to make choices that lead up to one National solution for Semantic Interoperability requirements need to be collected.
Based on meetings, discussions, a questionnaire, and desktop research the following list of requirements is produced.

5.3. IA-RM: Possible Solution Paradigms

There are several possible generic Information Architectures that provide semantic interoperability.

Without a firm foundation based on widely accepted standards a durable solution will be impossible. All solution paradigms can be based on open International standards.

Several solutions are presented:

- Data Dictionary paradigm;
- Message paradigm;
- Document paradigm;
- Two Level Model paradigm;
- Coding system paradigm / Ontologies

5.3.a. IA-RM possible solution: Data Dictionary paradigm

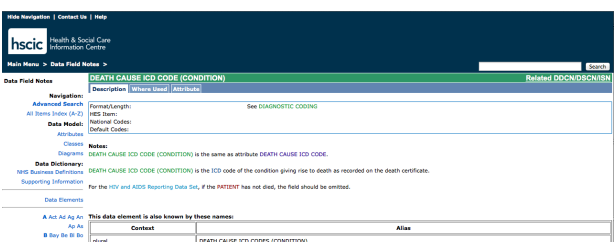
The Data Dictionary paradigm hinges on the need to map one field in a data base to an other field in an other data base. It is called a data base with meta-information about data bases, also.

A data dictionary[14], or metadata repository, as defined in the IBM Dictionary of Computing, is a "centralized repository of information about data such as meaning, relationships to other data, origin, usage, and format."[1] The term may have one of several closely related meanings pertaining to databases and database management systems (DBMS):

- *a document describing a database or collection of databases*
- *an integral component of a DBMS that is required to determine its structure*
- *a piece of middleware that extends or supplants the native data dictionary of a DBMS.*
- *ISO/IEC 11179[15] (formally known as the ISO/IEC 11179 Metadata Registry (MDR) standard) is an international standard for representing metadata for an organization in a metadata registry.*

A Data Dictionary allows (as in any normal dictionary) to define lemma's where an item (many times called concept) is described in detail, its label as presented and some relationships are defined.

A Data Dictionary allows an implementor to find corresponding fields in an other data base. Or it allows customers to define terms in a data set when they need to submit reports to a registry.



An example is the NHS eHealth Data Dictionary.16

The details about the lemma (Death Cause ICD Code) are defined. Observe that although no codes have been specified it is possible to do so.

---

14 http://en.wikipedia.org/wiki/Data_dictionary

15 http://en.wikipedia.org/wiki/ISO/IEC_11179

16 http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/d/dea/death_cause_icd_code_(condition)_de.asp?shownav=1

Observe that it is possible to create definitions using words, but computer processable output is impossible. And that it is impossible to define the structure of a data set. In other words how many times an item is allowed to occur.

Data Dictionaries can never represent a data set fully (structure, constraints and the meaning of its components, including codes). Data Dictionaries can represent a defined data set partially in the same way as a normal dictionary can define words but not a full document.

Well known data dictionaries in health care are:

- NHS (England)
- NHS (Scotland)
- METeOR (NEHTA-AU)
- 3M

NHS (England)

[to be added]

NHS (Scotland)

[to be added]

METeOR17

METeOR is Australia's repository for national metadata standards for health, housing and community services statistics and informationMETeOR is Australia's repository for national metadata standards for the health, community services and housing assistance sectors. The system was developed by the Australian Institute of Health and Welfare to replace the previous repository, the Knowledgebase.

METeOR provides users with a suite of features and tools. These include online access to a wide range of nationally endorsed data definitions and tools for creating new definitions based on existing already-endorsed components. It has a strong focus on providing comprehensive user support and assistance.

From a technical viewpoint METeOR operates as a metadata registry. This means METeOR is a system or application where metadata is stored, managed and disseminated. The registry aspects of METeOR have been based on the international standard for metadata registry - ISO/IEC 11179 - released in 2003.

Through METeOR you can find, view and download over 2,600 data standards. Using these standards will help you to:

- avoid wasting resources creating similar standards
- *base your information systems on nationally endorsed standards*
- *obtain data that is comparable across many different data collections*

METeOR provides powerful search facilities to help you find metadata quickly.

[17] http://meteor.aihw.gov.au/content/index.phtml/itemId/181414

When the metadata you need does not exist, METeOR's metadata creation tools mean that creating quality metadata and getting them endorsed has never been easier.

All these services are available free of charge.

The METeOR system can be used to create Performance Indicators as National standards.

The development of indicators in METeOR improves quality, relevance, consistency and the availability of national information about the health and welfare of Australians. The drivers for standard development arise from the need for better information - whether it is statistical, administrative, clinical or other information. This ensures the data used in statistics is compatible and it facilitates National and International interoperability.

Information management groups and committees in the community services, health and housing assistance sectors have endorsed the use of METeOR for Council of Australian Governments (COAG) performance indicators to ensure compliance with the intergovernmental agreements of a National registry of Performance Indicators.

What is the value of METeOR to PI development?

- *Nationally maintained registry for PIs – the only one of its kind in Australia.*
- *Functional and user friendly templates that provide users with differing PI 'views'.*
- *Items in the registry are ISO-11179 compliant, therefore items can be and are used for national and international comparability e.g. cancer registries.*
- *Established governance processes.*
- *Related indicator information*
- *Conceptual frameworks*
- *Indicator sets and related indicators*

Indicator metadata item types

Indicators are endorsed as standards by the relevant registration authority. There are a five metadata types that make up the suite of indicator templates.

- *Indicator set*
- *Outcome area*
- *Indicator*
- *Quality statement*
- *Data source*

The METeOR Data Dictionary allows the searching of defined concepts, data sets, associated code sets and exports to word and PDF formats.

3M18

[18] http://solutions.3m.com/wps/portal/3M/en_US/Health-Information-Systems/HIS/Products-and-Services/Products-List-A-Z/Healthcare-Data-Dictionary/

The 3M Healthcare Data Dictionary (HDD) is a controlled medical vocabulary server that has been continuously expanded and maintained for over 15 years. The 3M HDD makes it possible to map and manage medical terminologies, integrate content and standardize healthcare data. The technology allows organizations to transmit and receive accurate, actionable patient data across systems and applications, regardless of where data originates.

3M HDD is an integration tool that primarily focusses on interoperability of individual concepts and their codings. It is an 'active' Data Dictionary because it allows the run-time translation of codes when systems exchange data.

5.3.b. IA-RM possible solution: Message paradigm

Message passing[19] is a technique for invoking behavior (i.e., running a program) on a computer. In contrast to the traditional technique of calling a program by name message passing uses an object model to distinguish the general function from the specific implementations. The invoking program sends a message and relies on the object to select and execute the appropriate code.
The message paradigm is a specification that is designed to update data base fields of the receiving party with data sent by the sender. In healthcare examples of standards are: UN/Edifact messages based on European CEN message standard are deployed in Europe and HL7 v220 and v3 in the USA and elsewhere.
Edifact messages in healthcare are mostly based on CEN message standards they are widely used in Denmark, and the Netherlands.
HL7v2 are widely used in healthcare institutions.
Initially the exchange format of messages is position dependent. The place in the message provides the semantics.
HL7v3 messages more explicitly model the semantics because they use the Reference Information Model on which messages are based provide semantics.

A distinct feature of the messaging paradigm is the fact that the message standard encompasses several viewpoints as defined in the ISO RM/ODP standard: Enterprise, Informational, Computational and even the Engineering viewpoints.
In addition each of these methods allow too many degrees of freedom to model the same thing.
Each implementation of a message in an IT-system is a unique implementation.
All together this results in solutions that need a lot of engineering resources to create interoperability at all these RM/ODP layers before the message standard can be deployed in regions or countries. In fact an other organisation is needed to profile these standards and test the vendor engineered solutions. Integrating the Healthcare Enterprise (IHE21) develops these profiles and organises Connectathons.
Once in a region or country these profiles are implemented and tested in vendor systems any change needs to traverse the IHE process again.

---

[19] http://en.wikipedia.org/wiki/Message_passing

[20] For examples see: http://www.ringholm.de/docs/04300_en.htm

[21] http://www. IHE.net

The consultancy firm Gartner over the years has analysed this paradigm and have declared this method not viable in the long run because of its problems. HL7v2 and Edifact will beused for considerable time for integration inside IT-systems. HL7v3 received the deprecated status because of the implementation problems as the result of inherent problems of the deployed Reference Information Model, modeling methods, the too many degrees of freedom that is allowed and the extensive problems and resources needed for the implementation.
Since CDA is predicated on HL7v3 this development will influence the future of HL7 CDA>

A recent development is FHIR22. Fast Health Interoperable Resources (FHIR) is on its way to become an HL7 (ANSI) standard. It is presented as:
'… 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 is work in progress.

5.3.c. IA-RM possible solution: Document paradigm

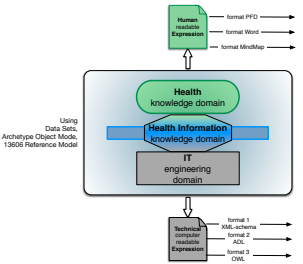
The document paradigm developed the notion to use the message paradigm to produce documents that contain data from an EHR and send it to an other EHR-system. HL7 CDA is such an example. Documents can be represented that are based on the HL7v3 Reference Information Model. The HL7v3 CDA document paradigm suffers from all negative aspects that the (HL7v3) message paradigm has.
Gartner[23] predicted that the document CDAR paradigm has proved itself and will be deployed for considerable time. While at the same time deprecated HL7v3 technology as 'obsolete before plateu'.

HL7 CDA is selected by the European Member States as one of the European Interoperability Framework base standards.

[22] http://www.hl7.org/implement/standards/fhir/summary.html

[23] Gartner Hypecycle published 2009

5.3.d. IA-RM possible solution: Two Level Model paradigm



This paradigm is designed as an EHR exchange standard and is based on the Two-Level-Modeling paradigm. This 13606 EHR-communication standard is developed by CEN/ISO. In this paradigm at least two models are needed to define artefacts. One model deals with all aspects of the structure of any document plus archiving facilities. A second model allows the production of artefacts as constraints on the first model. Any artefact will express what needs to be documented and exchanged according to user groups. Any artefact will be conformant to the first (Reference Model) and second model (Archetype Object Model). When the artefacts are produced based on a third model that defines how artefacts are structured the artefacts are very expressive and modeled with few degrees of freedom.
A substantial advantage of this paradigm is the fact that because of the precise models that guide the production of semantic interoperability artefacts these artefacts on one hand can be used by healthcare providers and at the same time can be used by IT-systems. This reduces the amount of resources needed to implement this paradigm and at the same time the model driven nature allows very fast change at local, regional and national levels.

The CEN/ISO 13606 EHR Communication standard fulfills the requirements of the ISO standard24 on requirements for EHR architectures and allows the expression of the Patient Mandate (ACL) that defines who has access to any data point.

In a recent development this 13606 EHR Communication standard is aligned with two other important standards in a process named Concurrent Use: CEN/ISO 13940: System of Concepts for Continuity of Care and CEN/ISO 12967.
The joint use of these three harmonised standards results in specifications that deal with the Enterprise, Information and Computation RM/ODP viewpoints and cover the domains of health care processes, service interfaces inside an EHR-system and the EHR data that is used.

5.3.e. IA-RM possible solution: Coding / ontology system paradigm

This paradigm hinges on the exclusive use of an ontology and codes such as SNOMED-CT for each datum in a message or data base. For this purpose SNOMED must be able to define codes for data in their complete context. IHTSDO has worked on a part of SNOMED where context informa-

24 ISO 18308: Requirements for an Electronic Health Record Architecture

tion can be combined with data. E.g. It allows to code for Systolic Blood pressure of the patient and a different code for the same measurement performed on a relative.
In the case of data sets that need a precise specification of all aspects of the context it must be possible to find all the needed SNOMED codes. In the course of the production of the epSOS data set it became clear that SNOMED is lacking concepts and codes.
In addition a precise specification of data sets can not be done without the possibilities to create a structure and define precise constraints on allowed numbers, letters, texts, etc.

In this context the NHS Logical Record Architecture 25 (LRA) must be mentioned. This solution uses a subset of CEN/ISO 13606 and makes extensively use of SNOMED. And will encounter the same problems that not the complete context can be specified.

5.3.f. Summary: Comparison of the paradigms

All presented solution paradigms have been analysed. The results are presented in the table below.

Paradigm	Scope	Degrees of freedom	Standards Conformance 18308, 13940, 12967 22220	Patient Mandate at the data item level	RM/ODP viewpoints	Data Expressivity	Human and computer processable artefacts	Resources Needed	Flexibility	EIF Base Standard
Data Dictionary	Define and manage data elements	+++	111179	-	Enterprise Information	-	+	+	-	-
Messages (1990-)	data base fields updating	+++	-	-	Enterprise, Information, Computation, Engineering	+++	-	+++	-	-
Documents (1996-)	document exchange between IT-systems	++	-	-	Enterprise, Information, Computation, Engineering	++	-	+++	-	+
Two Level Model (2001-)	EHR communication	-	+	+	Enterprise, Information, Computation,	++++	+	+	+	+
Coding Ontology	reference terminology and supporting ontology	± Managed by an ontology	-	-	Enterprise Information	-	±	+	±	-

The Two Level Modeling paradigm provides the best fit to the requirements for an IA-RM.

[25] http://www.uktcregistration.nss.cfh.nhs.uk/trud3/user/guest/group/0/pack/12

Requirement number	Requirement text	Comment	Data Dictionary	Messages	Documents	Two Level Model	Coding / Ontology	Remarks
1	The solution must be based on open International standards	The solution needs to be effective, efficient, be usable in the European market context of procurements and opportunities in other countries	+	+	+	+	+	
2	The solution must be able to facilitate the deployment of National and Regional policies	In Europe European standards play a formal role in the deployment of National policies for legal and ethical matters	±	+	+	+	±	Data dictionary and Codings only express part of what is needed
3	The solution must be usable in procurement processes	European standards play a formal role in the creation of a common market	+	+	+	+	+	
4	The solution must allow an evolutionary process from present systems to new systems in the future	Products and services have an economic life cycle. Occurred investments need to be recognized	+	+	+	+	+	
5	The solution must allow existing functional exchange/ interface formats to be supported	Groups of healthcare providers that exchange data using existing message based solutions will have a growing need to deal with the new National Exchange formats.	±	+	+	+	±	Data Dictionary and Ontology can not express all of that what is needed (see R3)
6	The solution will consist of a set of common and sharable services	The Irish ICT National Integrated Services Framework must have services can be used by all stakeholders	+	+	+	+	+	

7	The solution must be durable and affordable	Implementation experiences learn that generic interfaces that support both HISA as well as EHRCom standard are not more expensive to develop as proprietary one-to-one interfaces, but generate a considerable cost-efficiency by their re-usable nature and flexible deployment.	+	±	±	+	+	Messages and Documents need substantial resources (Time and €) to produce, implement and maintain
8	Components of the solution must be governed	Common and shared services that express components of agreements for exchange between stakeholders need to be trusted and be durable	+	+	+	±	+	Two Level Model is a model driven solution Technical conformance is automatically done by parsers at design time.
9	The solution must be able to define the components of the 'Semantic Stack' (data sets, codes from codings systems) as a common service.	Published agreements via a Data Dictionary and that include the agreed codes from coding systems fully normalize the data exchange between stakeholders	±	+	+	+	±	Data Dictionary and Codings only express part of what is needed
10	The solution must support the creation and maintenance of a Data Dictionary as a common and shared managed resource that helps unify data sets and the unified expression of these data sets	Published agreements via a Data Dictionary must be made available as a service users/ stakeholders can interface with.	+	-	-	+	+	Messages and Documents need Implementation guides and Profile documents. They do not function as Data Dictionary.
11	The solution must support the fact that EHR-data must be exchangeable fully or in part	Parts of the Patient Record must be exchangeable between stakeholders, but also complete records.	+	-	-	+	-	Messages, Documents have a scope smaller than the complete EHR.
12	The solution must allow groups of stakeholders to cooperate in the production of their data set and codes from coding systems		+	+	+	+	+	

13	The solution must be able to respond in a short time to new requirements	Solutions that need many months or years to get from expression of new requirements to the implementation stifle healthcare innovation and healthcare reforms	+	-	-	+	+	Messages and Documents are resource intensive.
14	The solution must support the use of clinical pathways, and protocols, for cooperating stakeholders	EHR data in IT-systems and in exchanges between stakeholders document the provision of healthcare. Healthcare is a complex interplay of many processes at various levels. The data that is documenting these processes and is reporting about it, must reflect the fact that the data is part of these processes.	+	±	±	+	+	Two Level is aligned with CEN/ISO System of Concepts. Others are not. Messages and Documents support processes to a degree, but are not aligned with ContSys
15	The common services will produce artefacts that at the same time must be readable and understandable by healthcare providers and be readable and usable by the IT-industry	One expression for the artefacts in the common and shared services that can be used in both the health and technical domain secure consistency and easy and fast implementation	H: +	H:+ T:+	H:+ T:+	H:+++ T:+++	H:+ T:+++	Two Level Model is capable of automatically generating: tree's, mind-maps, HTML screens, Excel, Schematrno, XML data instantiation, ADL

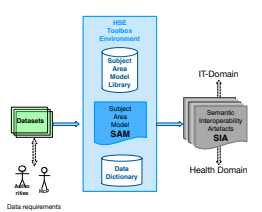
5.4. IA-RM: Description

The Reference Model Information Architecture will be a library of common, shared, re-usable, Subject Area Models (SAM's) and a tooling environment that will act as governed resource.

Subject Area Models (SAM's) and how they are defined will be described in detail in an other chapter of this document.

The Data Dictionary will be described in an other Deliverable.

The figure shows the high level picture of the proposed IA-RM architecture.



Stakeholders define their data requirements as 'data sets' that are transformed into Content Models in the HSE Toolbox Environment.
The HSE Toolbox Environment is a set of applications/services:

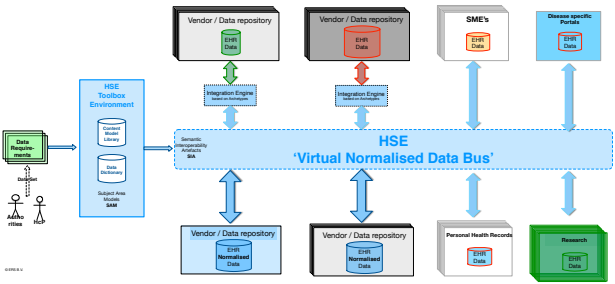
- Content Model Library that holds re-usable components of Content Models as Subject Area Models.
- Content Model Library holds the Subject Area Models, also.
- Data Dictionary an additional service to help maintain consistency between the Subject Area Models. It defines at any level of detail the definitions for the data points defined in the Subject Area Models including bindings to coding systems.
- The HSE Toolbox allows groups of users to cooperate on the production, validation of the Subject Area Models.

The HSE Toolbox can produce as validated and governed output various methods to display the Subject Area Models as re-usable Semantic Interoperability Artefacts in versions for use by health-care providers and in versions for use by IT-specialist.
[Add the references to the requirements and principles to the text below]

5.5. IA-RM and stakeholders

The IA-RM defines the HSE Toolkit that produces Semantic Interoperability Artefacts (SIA's) that the various stakeholders can use to express clinical data sets as Subject Content Models.
The SIA's can be viewed in an non-technical way as text or mind maps and at the same time the same SIA's can be viewed and used by IT-systems and the vendors.
A build in feature of the proposed solution allows fast and flexible maintenance of the SAM's and SIA's because of the fact that the tools are based on open International standards and the model driven tools architecture. The open International standards that will be used secure a HSE Toolbox that is based on a public specification without resorting to proprietary specifications.
The technical semantic interoperability artefacts that are made available to IT-vendors are expressed in a format that is conformant to an open International standard. All data could be exchanged in that neutral format.
Existing systems many times use other paradigms for their communications, such as HL7v2, and HL7v3 CDA R1 and R2 formats. Or use different methods to store and retrieve data in the systems. These systems will need an Integration Engine to transform their proprietary formats to and from the normalised format of the SIA's. System providers could build such Integration Engines that support IA-RM compliant artefacts.
Commercial tools exist that provide those transformation services. The Integration Engine is outside the scope of this project.
Integration Engines make it possible that these IT-systems can read and write data according to the normalised format in the 'Virtual Normalised Data Bus'. These Integration Engines use the SIA's to define the transformations, adapting to new data sets/ SAM's can take place in a very short period of time assuming that the Integration Engine is using a model driven architecture to provide functionalities.

Over time it can be expected that increasingly IT-systems of all stakeholders will be able to deal directly with the SIA's without any transformation as the result of requirements used in procurement processes. New small- and medium enterprises that produce health applications can from the beginning start to use the SIA's as way to format data that is exchanged.



The proposed IA-RM makes an evolutionary change process possible when deployed as a desired way forward. This IA-RM, with the SAM and SIA's plus the Data Dictionary are inline with the outcomes as expressed by the stakeholders in the Work Shop discussions and questionnaire.

5.5.a. IA-RM and Healthcare providers

Co-operating healthcare providers can produce and discuss their data requirements, also called (Clinical) Data Sets using the HSE Toolbox. They can use all kinds of methods (text, mind maps, excel spreadsheets, …) they prefer to define their data sets. Supported by Health-IT specialists, that most often are trained nurses that translate data sets into SAM's. These SAM's that are produced, need to be discussed and validated. After validation the SAM's will be published.
SAM's specify the data points but also their context and associated codes from Reference Terminologies plus Classifications and own local code lists. In this way SAM's are a resource where local codes can be mapped to Reference Terminologies and Classifications.
The open standard based, model driven architecture of the HSE Toolbox makes it possible that new requirements can be implemented in a short period of time.

The HSE Toolbox Environment holds the data requirements that can be used in procurement of systems. It indicates what, next to functional requirements, data points are expected that the next IT-system must be able to handle.
Integration Engines make it possible that these IT-systems can read and write data according to the normalised format in the 'Virtual Normalised Data Bus' and existing investments in IT-systems can be leveraged.
The above makes an evolutionary change process possible as a desired way forward to deploy the IA-RM and Data Dictionary outcomes as stated by stakeholders in the Work Shop discussions, which statements were overwhelmingly supported by the questionnaire outcomes.

5.5.b. IA-RM and Organisations

Several organisations of stakeholders exist such as: hospitals, communities that use and exploit a communication platform, organisations that provide disease specific platforms and registries, and organisations that do research.

All of these organisations that need to use, re-use and exchange health data can use the HSE Tools to produce artefacts that express their data needs that can be used in the procurement of new IT-systems.

Integration Engines make it possible that these IT-systems can read and write data according to the normalised format in the 'Virtual Normalised Data Bus'.

5.5.c. IA-RM and Authorities

Authorities are one of the stakeholders that could use the possibilities that the HSE Toolbox and the 'Virtual Normalised Data Bus' will provide. When legislation or policies demand the reporting of prescribed data sets, then the proposed solution will allow them to define these data sets and how the data needs to be reported. The 'Virtual Normalised Data Bus' will enable the stakeholders to comply with the demands.

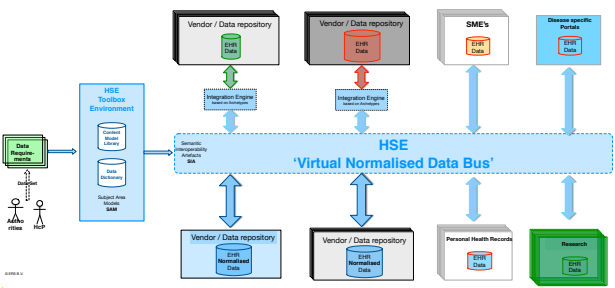
When the validated and published data sets, SAM's, and the different output files in various formats (SIA's) are made available for use in procurement and implementation will enhance the effectiveness of the National legal and policy requirements.

5.5.d. IA-RM and Research

5.5.e. IA-RM and IT-Systems

[To be added]

5.6. IA-RM: Summary



- The Information Architecture Reference Model is a high level, abstract, logical, model that serves as the point of departure - the basis- for developments in a region, in this case Ireland.
- The IA-RM guides the development of the Irish INFOstructure that supports all actors in healthcare when they want or need to exchange data about patients and the healthcare processes.
- The IA-RM has chosen to focus on the Information Viewpoint meaning on the specification of data sets, called Subject Area Models, that represent the data needs for healthcare actors.
- SAM's specify normalised the data exchanged, but increasingly, the data that will/can be stored and retrieved inside IT-systems.
- The technical SIA output will support flexible and cost effective implementation in IT-systems.
- SAM's will be produced in a central resource as governed environment.
- Output from that resource are called Semantic Interoperability Artefacts (SIA's) and represent SAM content in various human en computer processable formats.
- The IA-RM, SAM's and SIA's allow an 'HSE Virtual Normalised data Bus'.
- An evolutionary process is fostered where SAM's as part of procurement and remuneration processes will guide future developments of re-use of data for joint integrated care, reporting, audit registries, and research.
- The IA-RM creates a level playing field for small and large healthcare providers and organisations, plus small and large IT-vendors.

6. Subject Area Model

6.1. SAM: Introduction

A Subject Area Model (SAM) is a specification that reflects as the result of consensus the data requirements of a group of Healthcare Providers in their context and for a specific purpose.

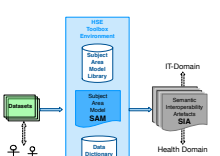
6.2. SAM: Why are SAM's important

Other names for SAM are Data Set or Data standard or Detailed Clinical Model or Semantic Interoperability Artefact.

Why use Subject Area Models (data standards)?[26]

- *Making data count*
- *Data standards promote the quality accuracy interpretability reliability relevance interchangeability transparency currency accessibility coherence and comparability of data and information.*
- *Without data standards there is the potential for data to be of poor quality. Data may fail to measure what it is supposed to measure or not be comparable across collections or over time. Decisions based on poor quality data affect us all whether it is hospital services or delivery of services in the community.*
- *Data standards enable consistent and comparable reporting of information about services and people including describing what services are available where services are located to whom they are delivered by whom are they delivered and when how much they cost and what happened as a result of delivering services.*
- *By making endorsed data standards readily available users are assured that they can use these standards with confidence and that they will enable the maximum re-use of their data for future research 'create once use often'.*

Subject Area Models (SAM's) are build according to data standards, and using other open International Standards.
SAM's are the translations of data sets defined by healthcare providers into a computer processable format. The SAM's have to be produced, validated by their stakeholder communities. A governing organisation needs to control the HSE Toolbox as managed common shared public resource.



SAM's define the data points that stakeholders need and the associated codes from coding systems. The SAM's, when exported, are called Semantic Interoperability Artefacts that can be presented in a healthcare friendly way. But also as a technical expression that can be used by IT-vendors and other IT-specialists.

[26] Text adopted from 'National data dictionaries', National Community Services Data Dictionary , version 5, Australia

In order to keep a consistency between the SAM's they are build from predefined shared building block from the library. This arrangement secures that all SAM's define the same things in the same consistent way. E.g. The demographics, date of births, what is documented about medication, lab tests, diagnosis, findings, etc.
The re-use of common building blocks helps to create uniform data in the 'HSE Virtual Normalised Data Bus'. In addition a Data Dictionary helps secure an overall consistency of the SAM's and resulting SIA's.

Individual healthcare providers, groups of providers, their organisations and governmental organisations have a need to re-use and share data about patients and their treatment. Data that is stored in their IT-systems.

Each vendor is using proprietary methods to deal with the data inside systems. Each user group has in a specific context a need for specific data. The context can be for instance:

- a digital prescription sent to the pharmacy
- an order for lab tests and the reporting of the results
- a referral or discharge letter
- obligatory of voluntary reporting to registries or for auditing purposes
- management reports
- research internal or external
- etc.
- When an IA-RM and supporting services are available they can be used to collect the data requirements for a Subject Area Model (SAM) also known as Data Set. Many times this data set is described in text and tables.
  Using the IA-RM supporting services the verbal specification is converted into a human and machine readable formats. After a validation phase the consensus is made available to the public.

6.2.a. Healthcare provider and their organisations

An individual Healthcare provider or group of providers can use the published SAM as a specification when selecting a new IT-system or demand updates for their present system.
Healthcare providers can use obligatory or voluntary SAM's for auditing or management reporting and they can use it to influence their vendor and the product developments.

Agreed general or ad-hoc SAM's when implemented can allow the provider to participate in research.

6.2.b. Health agencies

Governmental health agencies have a need for data from Patient EHR's for audit and policy reasons. SAM's will define their data needs that when published inform Healthcare Providers and their organisations to implement these requests for data.

6.3. SAM: International Developments

[Describe DCM, NHS, AU DD, epSOS, EU-USA developments)
[To be added]

6.4. SAM: Description

[Should it be named: Description?]

The SAM is the result of a consensus process and informed by the needs of healthcare actors.
The specification that describes the SAM in detail has two content related aspects:

- Health aspect and
- Technical aspect

Each of these aspects will be discussed.

6.4.a. SAM: Health content aspect

The collection of SIA's (artefacts that reflect the SAM's) contains formats that can be processed by humans.

DCM

This aspect is known under the name Detailed Clinical Model (DCM). A detailed clinical model is a standalone information model designed to express a clinical concept in a standardized and reusable manner. It documents clinical information as a discrete set of precise clinical knowledge for that concept.

The ISO 1397227 DCM specification describes the structure, its characteristics and production process. The output of that process is a text describing in detail the data needs.

Only groups of health experts can validate these structured documents. The DCM specification discusses the governance process.

For patient safe semantic interoperability it is essential that all DCM's are designed and produced in a standardised way as specified.
DCM's do not specify how technical expressions are made that can be used by system developers.

SAM

In the next step the DCM will have to be converted in a SAM. An health informatics experts with knowledge about DCM's, Archetypes, Coding systems and the described service processes will convert the data set (DCM) into one or more 13606 archetypes.

Groups of relevant experts will receive the SAM as Excell spreadsheet, as MindMap[28], or mock-up screen to inspect the translation of the DCM into the SAM.

---

27 ISO/DST 13972 Health informatics -- Detailed clinical models, characteristics and processes

[28] A mind map is a diagram used to visually outline information

For patient safe semantic interoperability it is essential that all SAM's are designed and produced in a standardised way as specified.
SAM's follow one prescribed pattern known as the Semantic Interoperability Artefact Modeling Method29 (SIAMM). SIAMM reduces the number of degrees of freedom and prescribes that each clinical fact can be documented including its full semantic rich context.

SAM's are constructed (re-)using predefined components, thereby guarantying that the same concepts are modeled in a uniform way. The general SIAMM pattern is annotated with relevant SNOMED codes.

SIA
When validated the output can be called Semantic Interoperability Artefacts (SIA's) that all together represent the SAM in various technical formats. The SIA's can be inspected by humans andcan be used immediately by the health IT industry for integration purposes.

6.4.b. SAM: technical content aspect

The collection of Semantic Interoperability Artefacts (SIA's) contain a series of artefacts that software engineers can use immediately in the process of creating messages for reporting or implementing it directly into their IT-system or use it to prepare for third party validation/certification.

Actors that validate, qualify or certify claims by IT-system vendors that they are conformant to specific SAM's need those technical artefacts such as : ADL1.4 Archetype and Template formats, XML instantiations of data, XML-Schematron formats.

6.5. SAM: Summary

[To be added]

- Subject Area Models (SAM's) describe the data needs of (groups of) Healthcare actors that need to store and exchange data.
- SAM's are produced as the result of consensus.
- SAM's are built using a series of supporting standards and codes from coding systems.
- SAM's are produced using a centrally governed resource consisting of an editor, a document manager, terminology servers/services, and acting as a collaboration tool.
- SAM's as usable output produce Semantic Interoperability Artefacts in various formats that humans and computers can process.
- SAM's need to be governed and validated before use.

[29] Developed by ERS B.V. and will be submitted for inclusion in the EN/ISO 13606 standard

7. Tools supporting the Subject Area Model

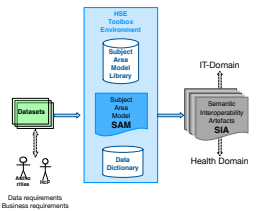
[Tooling. Replace by Services, Service Components?]

7.1. Tools: Introduction

This chapter will describe the HSE Tooling Environment and the artefacts that are produced.

The Subject Area Model describing the data needs / data set for a particular use case is produced using a SAM-Editor. The output of the SAM-editor is input for the SAM-Data Dictionary.
The SAM-Editor is using and producing artefacts (Semantic Interoperability Artefacts) that are maintained and governed in the SAM-Artefact-Library.

The Semantic Interoperability Artefacts (SIA's) are made available to the healthcare and IT-domains.



7.2. Tools: Why are Technical supporting Tools important

The Two Level Modeling paradigm that is model based supports the production of a SAM Editor to define in high detail and in a very structured way Subject Area Models. Without standards normalised human and computer processable output is impossible.
SAM's rely on many codes from coding systems. One localised environment where the codes and codings systems are made available is indispensable.
The re-usable building blocks to construct SAM's need a document manager tool. The collection of SAM's and SIA's in the various output formats need a document manager tool , also. Without such a document manager tool the complex collection of documents can not be governed.
All Healthcare actors that produce and make use of the SAM and SIA's need an environment, as service ,where they can search for documents they need to discuss, validate or use or make comments about. Around the document manager a controlled collaboration environment needs to be in place.
Without the described governed set of tools and services a functional centrally governed INFOstructure supporting semantic interoperability is impossible.

7.3. Tool: SAM- Artefact Editor

The SAM Artefact Editor is a tool that builds the specification for any Subject Area Model.

Requirements for the SAM Artefact Editor that have to be fulfilled are:

1. *standards based*
2. *must produce artefacts that can be understood by health domain experts and IT domain experts*
3. *must produce artefacts that must be computer processable by healthcare domain experts and IT-domain experts*

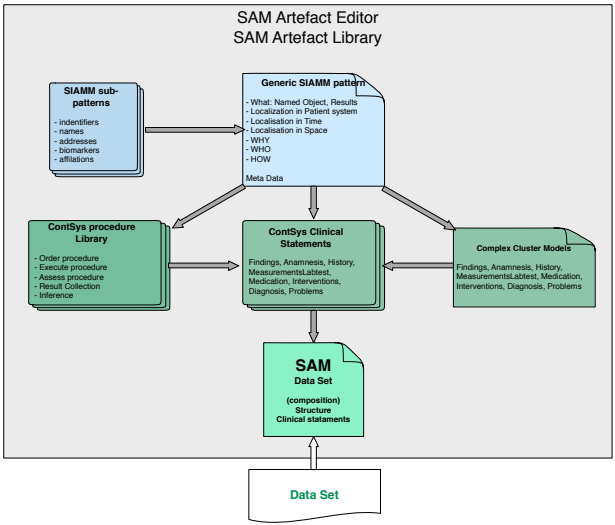
4. *allow the precise expression of any data structure*
5. *allow to attach one or more codes to nodes in the data structure*
6. *allow to attach to leaf nodes: components like: codes, multimedia, ordinal scales*
7. *allow to express in leaf nodes constraints on possible data values, data types, and code values*
8. *allow the expression of any clinical statement (quantitatively, semi-quantitatively and qualitatively) plus its complete context.*

On top of these tooling requirements additional requirements pertain to the artefacts produced. These requirements result in SAM artefact that allow the full context of any data point to be captured using one common set of basic patterns.

SAM Artefact Requirements:

1. *use one common pattern for any artefact reducing the degrees of freedom and allowing common shared basic patterns;*
2. *support concepts in the CEN/ISO System of Concepts for Continuity of Care, CEN General Purpose Information Components, CEN/ISO Health Information Service Architecture and ISO Subject of Care Identification.*

7.4. Tool: SAM-Artefact Library



[To be added]

7.5. Tool: SAM-Data Dictionary

Definitions

Passive / active Data Dictionaries

[To be added]

7.6. Tooling: Summary: Technical supporting systems

[To be added]

8. Deployment: Recommendations for implementation

Existing tooling solutions / options

[To be added]

8.1. Deployment: Why is deployment important

[To be added]

8.2. Deployment: Summary

[To be added]

9. Governance: Framework and Tooling

[See ANTILOPE, EuroRec, etc.]

[To be added]

9.1. Governance: Why is governance important

[To be added]

9.2. Governance: Summary

[To be added]

10. Catalogue of Standards deployed

Standard name	Description	Comments
CEN/ISO 13606:2008	EHR Communication	5 part standard specifying the exchange of any partial or complete EHR
CEN/ISO-13940	System of concepts for continuity of care	Terminological standard about processes in health and care
CEN/ISO 12967	Health Information Service Architecture	Specification that defines the interfaces in an EHR-system
ISO 22220	Identification of Subjects of Care	Demographics (identification, names, addresses, other addresses, gender, etc.)
CEN 14822	General Information Components	3 part standard specifying the European information needs in healthcare based on 15 years of message production
CEN 14796	Data Types	To be replaced by a profile of ISO 21090:2011 Harmonized data types for information interchange
ISO 18308	Requirements for an Electronic Health Record Architecture	
ISO 3166	International Standard for country codes	
ISO 8601	Representation of dates and times	
ISO/IEC10746-1	Open Distributed Processing - Reference Model: Overview	
ISO/IEC 11179-3	Metadata registries (MD): Registry metamodel and basic attributes	Specifies the functioanlity of a data dictionary
IHTSDO - SNOMED-CT		
LOINC		
GS1		
ISO 639	Codes for the representation of names of languages	
ISO 21090: 2011	Health informatics -- Harmonized data types for information interchange	This specification is too complex to be used as is. A profile for specific use is necessary. For use as part of CEN/ISO 13606 a profile will be published in the present 13606 renewal phase.

APPENDIX

The appendix describes general topics that can be used as relevant background information for this project.

Introduction: Semantic Interoperability Artefacts in general

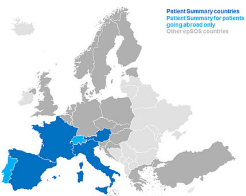
[To be added]

11. Appendix: SAM: epSOS data set

11.1. Introduction: epSOS30

epSOS aims to design, build and evaluate a service infrastructure that demonstrates cross-border interoperability between electronic health record systems in Europe.

epSOS in figures	
Time period	1st July 2008 - 31st December 2013
Duration	66 months (5 1/2 years)
Volume	€ 36,5 Million: co-funded by the European Commission Competitiveness and Innovation Programme (CIP) within the ICT Policy Support Programme
Number of Beneficiaries (formation of the consortium)	45 Beneficiaries: Consisting of national ministries of health, national/regional competence centers , a consortium of industry and the Project Management Team: • Technical Project Management Leader: gematik • Administrative Project Management: empirica • Project Coordination: SALAR
Number of countries	25 different European countries: 22 EU member states and 3 non-EU member states.



Cross-border eHealth Services

epSOS attempts to offer seamless healthcare to European citizens. Key goals are to improve the quality and safety of healthcare for citizens when travelling to another European country. Moreover, it concentrates on developing a practical eHealth framework and ICT infrastructure that enables secure access to patient health information among different European healthcare systems. epSOS can make a significant contribution to patient safety by reducing the frequency of medical errors and by providing quick access to documentation as well as by increasing accessibility of ones prescribed medicine also abroad. In emergency situations, this documentation provides the medical personnel with life-saving information and reduces the (sometimes needless) repetition of diagnostic procedures.

The technical, legal and organizational concepts developed within the framework of the project are subject to an extensive practical testing phase which will last until the end of the project. epSOS will tests cross-border eHealth services in the following areas.

In a first phase:

- *Patient Summary: access to important medical data for patient treatment.*
- *Cross-border use of electronic prescriptions ("ePrescription" - or "eMedication" systems)*

In the extended project phase - which started 2011- the epSOS project team consolidates, scales up and operationalizes the epSOS Services for ID management, security, semantics and standards. Additional epSOS Services like the access of patients to their data or the Medication Related Overview (MRO) are analyzed and will be tested if feasible.

For the first time, patients in Europe have the opportunity to use cross-border eHealth services when seeking healthcare in participating epSOS pilot countries - whether as tourists, business travelers, commuters or exchange students.

[30] http://www.epsos.eu/home/about-epsos.html This chapter is a copy from the epSOS home page.

11.2. epSOS developments

EpSOS is developed during two EU-projects and is the basis for an European Guideline on the Patient Summary[31].

Two Use Cases were used to guide developments:

- *USE CASE 1: The patient is an occasional visitor to the country of treatment, for example someone on holiday or attending a business meeting. The distinguishing characteristic is that this type of visit is irregular, infrequent and may not be repeated. This is a type of incidental encounter where the health professional will not normally have a previous record of the person seeking care and where the health professional does not know the patient.*
- *USE CASE 2: The patient is a regular visitor to another country from his or her country of origin, for example someone who lives in one country but works in another. The distinguishing characteristic is that this type of visit is regular, frequent and the person seeking care may be accustomed to using services in the country where he or she works as a matter of personal convenience. In this situation, the health professional may have some information available from previous encounters; the patient may therefore have a patient record locally stored in country B and possibly also a PS in country A, and both sources of information could be consulted.*

Three concepts were defined:

1. *The **Patient Summary** is an identifiable "dataset of essential and understandable health information" that is made available "at the point of care to deliver safe patient care during unscheduled care [and planned care] with its maximal impact in unscheduled care"; it can also be defined at a high level as: "the minimum set of information needed to assure healthcare coordination and the continuity of care".*
2. *The **basic dataset** is defined as a set of essential health information that needs to be sent from a clinical point of view in order to be able to deliver safe care to the patient (focused in unscheduled care). The information of the basic dataset must always be available.*
3. *The **extended dataset** is defined as the minimum amount of recommended health information from a clinical point of view that needs to be exchanged between Member States. These fields should be completed whenever possible.*

EU-Member States are fully free to use any technical standard to implement the data set or not using any technical standard according to this EU Recommendation/Guideline. Some will implement it using the HL7 CDA standard, others opt for a solution based on the CEN/ISO 13606 EHR-communication standard.

[31] Guidelines on minimum/non-exhautice patient summary data set for electronic exchange in accordance with the cross-border Directive 2011/24/EU Release 1.As adopted by the eHealth Network (19-11-2013)
http://ec.europa.eu/health/ehealth/docs/guidelines_patient_summary_en.pdf

Data sets use coding systems. Using a set of agreed requirements coding systems were selected for each data element in the Patient Summary. These coding systems are collected in the Master Value Sets Catalogue (MVC). Because Europe has 23 languages and that the Patient Summary must be used for cross-border exchanges a Master Translation/Transcoding Catalogue (MTC) is published.

[xxx References to these services]

11.3. epSOS infrastructure

The epSOS project developed a set of profiles in order to be able to request en send the needed Patient Summary. This infrastructural aspect is outside of the scope of this project but will be described briefly.

11.4. SAM: epSOS data set

The Subject Area Model chosen for this project is the epSOS data set. In this chapter this data set is presented.

It has three main components:

- epSOS Patient Data with data needed to identify the patient.
- epSOS Patient Summary data that defines data about the summary document
- epSOS Patient Clinical Data. This chapter reflects the consensus between European Member States in the epSOS project about the clinical content that is exchanged with the epSOS patient summary.

The epSOS data-set consist of two related aspects:

- Structure consisting of connected named and coded nodes;
- Per node coded named attributes and code sets;
- End nodes carry the results as data points. This recorded data can be numeric, text, but codes and code lists and value sets.

epSOS has defined its collection of codes, codes sets and value sets needed to populate the structure and give it common, shared, unique meaning.

11.5. SAM: epSOS coding systems

The Subject Area Model based on epSOS will have to describe the relevant codes and coding systems and value sets before it can be used for semantic interoperability.
epSOS describes the decision taken in the epSOS Master Value Set Catalogue (MCV[32]).
The next table defines the epSOS33 data set in detail.

The next chapter will describe the semantic interoperability artefacts that will be used in the Proof of Concept of this HSE project and that are based on this EU-Guideline for the Patient Summary.

[32] epSOS D3.5.2 Appendix D epSOS Master Value Set Catalogue v0.0.3 2010215.doc

[33] Guidelines on Minimum/Non-exhaustive Patient Summary Dataset for Electronic Exchange in Accordance with the Cross-Border Directive 2011/24EU. Release 1. DD 191-11-2013

PATIENT ADMINISTRATIVE DATA				
Variable (nesting level 1)	**Variables (nesting level 2)**	**Variables (nesting level 3)**	**DEFINITION AND COMMENTS**	**BASIC (Basic)/ EXTENDED (Ext) DATASET**
Identification [1]	National healthcare patient ID	National healthcare patient ID	Country ID, unique to the patient in that country. Example: ID for United Kingdom patient	Basic
Personal information	Full name	Given name	The first name of the patient (example: John). This field can contain more than one element.	Basic
		Family name/surname	This field can contain more than one element. Example: Español Smith Note: some countries require surnames to be the birth name [to avoid potential problems with married women's surnames).	Basic
	Date of birth	Date of birth	This field may contain only the year if the day and month are not available, e.g. 01/01/2009	Basic
	Gender	Gender code	This field must contain a recognized valid value.	Basic
Contact information	Address[2]	Street	Example: Oxford Street	Ext
		House number	Example: 221	Ext
		City	Example: London	Ext
		Post code	Example: W1W 8LG	Ext
		State or province	Example: London	Ext
		Country	Example: UK	Ext
	Telephone no.	Telephone no.	Example: +45 20 7025 6161	Ext
	e-mail	e-mail	Example: jens@hotmail.com	Ext
	Preferred HP/HPO to contact[3]	Name of the HP/HPO	Name of the HP/ HPO that has been treating the patient. If this is an HP, the structure of the name will be the same as described in 'Full name' (given name, family name/surname).	Basic
		Telephone no.	Example: +45 20 7025 6161	Basic
		e-mail	e-mail of the HP/legal organization	Basic
	Contact person/ legal guardian (if available)	Role of that person	Legal guardian or contact person	Ext
		Given name	The first name of the contact person/guardian (example: Peter). This field can contain more than one element.	Ext
		Family name/surname	This field can contain more than one element. Example: Español Smith	Ext
		Telephone no.	Example: +45 20 7025 6161	Ext
		e-mail	e-mail of the contact person/legal guardian	Ext
Insurance information	Insurance number	Insurance number	Example: QQ 12 34 56 A	Ext

[1] Dataset that enables the univocal identification of the patient
[2] May vary by country
[3] A health professional in country A may need a contact (health professional/healthcare provider) who knows the patient.

PATIENT CLINICAL DATA				
Variable (nesting level 1)	**Variables (nesting level 2)**	**Variables (nesting level 3)**	**DEFINITION AND COMMENTS**	**BASIC (Basic)/ EXTENDED (Ext) DATASET**
Alerts	Allergy	Allergy description	Description of the clinical manifestation of the allergic reaction. Example: anaphylactic shock, angioedema (the clinical manifestation also gives information about the severity of the observed reaction)	Basic
		Allergy description ID code	Normalized identifier	Basic
		Onset date	Date of the observation of the reaction	Ext
		Agent	Describes the agent (drug, food, chemical agent, etc.) that is responsible for the adverse reaction	Basic
		Agent ID code	Normalized identifier	Basic
	Medical alert information (other alerts not included in allergies)	Healthcare alert description	Medical alert information: any other clinical information that is essential to know so that the life or health of the patient does not come under threat. Example 1: Intolerance to aspirin due to gastrointestinal bleeding. Example 2: intolerance to captopril because of cough (the patient is not allergic but cannot tolerate it because of persistent cough).	Basic
		Healthcare alert ID code	Normalized identifier	Basic
Medical history	Vaccinations	Vaccinations	Contains each disease against which the patient has been immunized	Ext
		Brand name		Ext
		Vaccination ID code	Normalized identifier	Ext
		Vaccination date	Date when the immunization was given	Ext
	List of resolved, closed or inactive problems	Problem description	Problems or diagnoses not included in the definition of "current problems or diagnosis". Example: hepatic cyst (the patient has been treated with an hepatic cystectomy that solved the problem, which is therefore a closed problem)	Ext
		Problem ID code	Normalized identifier	Ext
		Onset time	Date of onset of problem	Ext
		End date	Problem resolution date	Ext
		Resolution circumstances	Describes the reason for which the status of the problem changed from current to inactive (e.g. surgical procedure, medical treatment, etc.). This field includes "free text" if the resolution circumstances are not already included in other fields such as surgical procedure, medical device, etc., e.g. hepatic cystectomy (this will be the resolution circumstances for the problem "hepatic cyst" and will be included in surgical procedures).	Ext
	Surgical procedures prior to the past six months	Procedure description	Describes the type of procedure	Basic
		Procedure ID (code)	Normalized identifier	Basic
		Procedure date	Date when procedure was performed	Basic

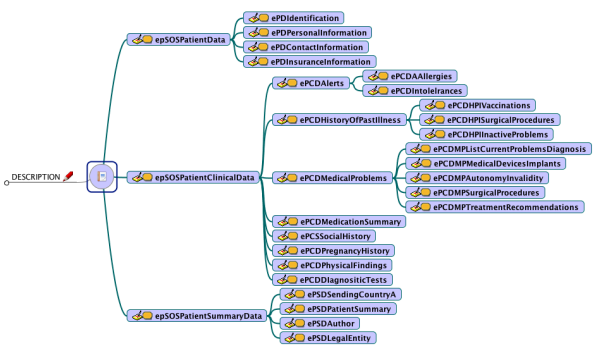
Variable (nesting level 1)	Variables (nesting level 2)	Variables (nesting level 3)	DEFINITION AND COMMENTS	BASIC (Basic)/ EXTENDED (Ext) DATASET
Social history	Social history observations	Social history observations related to smoking, alcohol and diet	Health-related "lifestyle factors" or "lifestyle observations" Example: cigarette smoker, alcohol consumption	Ext
		Reference date range	Example: from 1974 to 2004	Ext
Pregnancy history	Expected date of delivery	Expected date of delivery	Date on which the woman is due to give birth. Year, month and day are required (e.g. 01/01/2014).	Ext
Physical findings	Vital signs observations	Blood pressure	One blood pressure value, which includes systolic blood pressure and diastolic blood pressure	Ext
		Date when blood pressure was measured	Date when blood pressure was measured	Ext
Diagnostic tests	Blood group	Result of blood group	Result of blood group test performed on the patient	Ext
		Date	Date on which the blood group test was performed. This field may contain only the year if the day and month are not available (e.g. 01/01/2009).	Ext

PATIENT ADMINISTRATIVE DATA				
Variable (nesting level 1)	Variables (nesting level 2)	Variables (nesting level 3)	DEFINITION AND COMMENTS	BASIC (Basic)/ EXTENDED (Ext) DATASET
Country	Country	Country	Name of country A	Basic
Patient Summary	Date created	Date created	Date on which PS was generated	Basic
	Date of last update	Date of last update	Date on which PS was updated (date of most recent version)	Basic
Nature of the PS	Nature of the PS	Nature of the PS	Defines the context in which it was generated. Distinguishes between three methodological approaches for generating the PS: direct human intervention by an HP, automatically generated approach and mixed approach	Basic
Author organization	Author organization	Author organization	At least one author organization (HCP) shall be listed. If there is no HCP, at least one HP shall be listed.	Basic

11.6. SAM: epSOS: SIAMM Semantic Interoperability Artefacts

The epSOS data set will be represented in this project for the proof of concept using a method developed by ERS and published by the EN13606 Association for the production of semantic interoperability artefacts called archetypes. The name of this method is the Semantic Interoperability Artefact Modeling Method (SIAMM). This method is used in EU projects (SemanticHealthNet, SALUS, and soon in EXPAND), in addition it is a candidate for inclusion in the CEN/ISO 13606 EHR communication standard during its renewal process.
The goal of this method is to design archetype patterns that allow to record all of the semantics, the information around data points such that these data points describe fully all that is necessary to interpret the data safely.

11.6.a. SIAMM General Pattern



One generic SIAMM archetype pattern is used to derive in a structured way all other re-usable patterns. In addition SIAMM is aligned with two other important standards: CEN/ISO System of Concepts for Continuity of Care and CEN/ISO Health Information Service Architecture.

The generic SIAMM pattern describes for each clinical data point (clinical statement) the complete context:

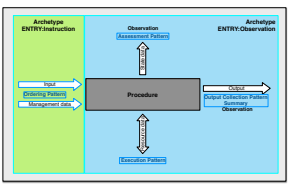
WHAT: The name of the subject of the clinical statement and the associated result(s). E.g. ‘Diagnosis is Diabetes with code XYZ’, ‘Blood Glucose measurement result = 7.4 mM/L’, ‘Order the execution of procedure ZYX’.

- WHERE: features to locate the topic in time, place and when relevant the patient system.

- WHO: The items, persons, or organisations that participate in the clinical statement.
- WHY: The reasons why this clinical statement is documented in the EHR.
- HOW: The circumstances that are necessary to interpret the clinical statement correctly and safely. E.g. 'Body Weight measured without clothing'.' Systolic Blood Pressure measured while in rest'.

11.6.b. SIAMM Specialised Sub-Patterns

In contrast to other methods of archetype modeling, SIAMM is aligned with the CEN/ISO Standard Concepts for Continuity of Care. One of the consequences is that what is modeled is modeled from the perspective of processes (Pathways, Protocols, Tasks).



One single general SIAMM pattern is specialised into sub-patterns that define what is documented about:

Ordering,

- Execution,
- Assessment and
- Summary after completion plus
- Inferences.

In the case of the epSOS patient summary production in an EHR-system a Procedure to create the epSOS Patient Summary is ordered, executed and when finished there is an epSOS Patient summary.

The data in the Patient Summary in the sending system is re-use of existing data and not de novo data generated by the author during a patient contact. The SIAMM artefacts will reflect this because one of the attributes in the MetaData of the Artefact indicates that it is not de novo data -as the result of a diagnostic or therapeutic process- but an administrative process.
The epSOS Patient Summary that will be created by the Procedure is a Composition with attributes that this is according to ContSys not 'non-ratified clinical data', since it is duplicated data for the purpose of reporting. Observe that the document/message itself can and must be signed (ratified) as document.
The data in the Composition will not be searched since it is 'not-ratified', not active.

In the receiving system a choice by the receiving Healthcare Provider must be made to designate the data from the epSOS Patient Summary as data that will or will not become searchable in his EHR-system by inserting it in the health record as non-ratified clinical data or 'normal' clinical data.

The table XXX lists the mapping of the epSOS data set on the epSOS Template and what SIAMM archetypes will be used to build this Template. The SIAMM archetypes that will be used to populate the epSOS Template will be ENTRY archetypes that use one of the sub-patterns that model one of the stages in the life-cycle of any Procedure.
E.g.

- ENTRY:ReportingItemProcedure:Allergies, or
- *ENTRY:ReportingItemProcedure:MedicinalProduct, etc*.

All examples using the SIAMM Summary sub-pattern in order to indicate that it is the result after the execution of a Procedure that will query the existing data and insert it into the epSOS Patient Summary Template (Composition).

These SIAMM archetypes will be enriched by SNOMED-CT codes and used to populate the HSE SAM Library and HSE Data Dictionary.

Layer 1	Layer 2	Layer 3	Mapping to 13606 and ContSys	Specialisation hierargy	Specialisation hierargy	Specialisation hierargy
epSOS exchange artefact - Template			13606: EHR-extract ContSys:electronic patient summary	electronic health record extract		
epSOS Data Set			13606: Composition ContSys:electronic record compo-nent (s)			
epSOSPatientData			13606: Section ContSys: subject of care specialisation of: healthcare actor and person role			
	ePDIdentification		13606: ENTRY: via NamedObject	healthcare actor		
	ePDPersonalInformation					
	ePDContactInformation					
	ePDInsuranceInforma-tion					
epSOSPatientClini-calData			13606: Section ContSys: observed condition (s)			
	ePCDAlerts		13606: Section ContSys: risk condition (s)	potential health condition	health condi-tion	health issue
		ePCDAAllergies	13606: ENTRY ContSys: risk condition (s)	potential health condition	health condi-tion	health issue
		ePCDAIntoller-ances	13606: ENTRY ContSys: risk condition (s)	potential health condition	health condi-tion	health issue
	ePCDIHistoryOfPastIll-ness		13606: Section ContSys:health condition (s) Specialisation of: health issue			
		ePCDHPIVaccina-tions	13606: ENTRY ContSys: healthcare treatment	(healthcare activity element)	healthcare activity	
		ePCDHPISurgical-Procedures	13606: ENTRY ContSys: healthcare treatment	(healthcare activity element)	healthcare activity	
		epCDHPIInac-tiveProblems	13606: ENTRY ContSys: health problem	potential health state	health condi-tion	health issue
	ePCDMedicalProblems		13606: Section ContSys: health problem list Specialisation of health condition			
		ePCDMPListCur-rentProblemsDiag-nosis	13606: ENTRY ContSys: health problem	health condition	health state	
		epPCDMPMedi-calDevicesImplants	13606: ENTRY ContSys: healthcare treatment (medical device)	(healthcare activity element)	healthcare activity	
		epPCDMPAutono-myInvalidity	13606: ENTRY ContSys: observed condition		health condi-tion	health issue
		ePCDMPSurgical-Procedures	13606: ENTRY ContSys:healthcare treatment (surgery procedure)	(healthcare activity element)	healthcare activity	
		epCDMPTreatmen-tRecommendations	13606: Section (or Folder) Contsys: care plan Generalisation of: uniprofesional care plan, or multi-professional care plan Aggregation of: care plan, healthcare activity, healthcare activities bundle			care plan
			13606:ENTRY Any: healthcare activity, other sub-plan	(healthcare activity element)	healthcare activity	

Layer 1	Layer 2	Layer 3	Mapping to 13606 and ContSys	Specialisation hierargy	Specialisation hierargy	Specialisation hierargy
	epSOSPatientClinicalData (continued)			13606: Section ContSys: observed condition(s)		
		epCDMedical-Summary	13606: ENTRY ContSys: observed condition	health condition	**health issue**	
		epCDSocialHistory	13606: ENTRY ContSys: observed condition	health condition	**health issue**	
		epCDPregnancy-History	13606: ENTRY ContSys: observed condition	health condition	**health issue**	
		epCDPhysicalFind-ings	13606: ENTRY ContSys: observed condition	health condition	**health issue**	
		epCDDiagnosticT-ests	13606: ENTRY ContSys: healthcare investigation	health activity element	**healthcare activity**	
	epSOSPatientSumma-ryData			13505: Section		
		epPSDPatient-Summary	DateCreated Date Last Update	13606: ENTRY: ??? ContSys: ???		
		epPSDAuthor		13606: ENTRY		
		epPSDLegalEntity		associated with ContSys: healthcare provider, healthcare organisation		
		epPSDSCountry		sending country A 13606: ENTRY		

11.7. SAM: Semantic Interoperability Artefacts and Coding Systems

This chapter describes coding systems that can be used as part of the Subject Area Models (SAM's).

11.8. Codes, Code sets and value sets

11.8.a. Introduction

Human text is many time arbitrary and fuzzy. In order to reduce fuzziness in communication eHealth systems make use of agreed code sets. These codes are like words in a dictionary and describe in detail the meaning of the word, its preferred spelling, etc.

A code is a combination of a unique number, a label used for presentation and a description. Together with the Coding System it stems from the code and its meaning can be described fully.

E.g.

Coding System =	QCODE, version 2008
Unique Number (code) =	12xyz12
Label =	Aorta
Description:	The aorta (/eɪˈɔrtə/) is the largest artery in the human body, originating from the left ventricle of the heart and extending down to the abdomen, where it bifurcates into two smaller arteries (the common iliac arteries).

Sometimes only selected (Non-coded) text or numbers are allowed in a data point. These are expressed as Value-sets.

E.g.
Allowed text that can be entered in a data point is: Male, Female, Unresolved.
Allowed numbers in a data point are: 1, 2, 3, 4, and 5. or 1940, 1950 or 1960.

11.8.b. Why are coding systems important

User groups documenting the provision of healthcare in one location and/or in one clinical domain share the meaning of words easily because of many years of education and training.
IT-systems can deal with words/text.
When communication with the 'outside' world is necessary, and certainly across borders, but also when several groups need to report to a central facility, then the needs arises to create a reference list with words, descriptions and, in order to process it in IT-systems, attach meaningless unique codes to these words.
In other words a Reference Terminology is necessary for safe semantic interoperability for nation wide reporting and cross-border exchange of data.

Description of coding systems used in epSOS[34]

epSOS has investigated many coding systems used in Europe and made choices. Choices that had to fulfill a list of criteria.

11.8.c. SNOMED-CT

- SNOMED: Systematized Nomenclature of Medicine-Clinical Terms
- Copyright & Issuer: IHTSDO – International Health Terminology Standards Development Organization, a non-for-profit association based in Denmark. Products are open for researchers but for clinical coding it is restricted to its twelve country licensees and some companies/hospitals paying the license fee.
- Languages & Localization: English (US, UK), Spanish, Danish. Translations into French and Swedish are currently taking place. Translation into Lithuanian are also taking place but only on a small-scale.
- Fields of application: SNOMED CT is a comprehensive terminology, created to cover the whole patient record and medical documentation.
- Number of entries: 310.000 active concepts
- Structure: There are almost 800,000 descriptions in SNOMED CT, including synonyms that can be used to refer to a concept. In addition, there are approximately 1,360,000 links or semantic relationships between the SNOMED CT concepts. These relationships provide formal definitions and other characteristics of the concept. One type of link is the "IS_A" relationship.
- Cross-map to other international standards is not officially available.
- It has been announced the creation of a join working group between IHTSDO and WHO to develop an official cross-reference between SNOMED-CT and ICD-10 (ICD-11).

[34] This chapter is largely based on:
epSOS D3.5.2 Appendix D epSOS Master Value Set Catalogue v0.0.3 20100215.doc

11.8.d. ICD.X

- ICD: International Statistical Classification of Diseases and Related Health Problems
- Copyright & Issuer: WHO
- Languages & Localization: ICD-10 is available in the six official languages of WHO (Arabic, Chinese, English, French, Russian and Spanish) as well as in 36 other languages.
- ICD-9 CM coding system and the application guidelines are available in Italian.
- Localizations have been made mainly for reimbursement purposes:
- Various manifestations: ICD-10-GM Version 2009 [1.2.276.0.76.5.356] icd10gm2009
- ICD-10-CM [2.16.840.1.113883.6.90]
- ICD-9-CM [2.16.840.1.113883.6.2]
- The Official Updates to the published volumes of ICD-10 are available as annual lists of changes and new versions with slight differences.
- Fields of application: The ICD is the international standard diagnostic classification of diseases (signs, symptoms, conditions) for all general epidemiological, health management and statistics (death) and clinical use (health records). These include monitoring of the incidence and prevalence of diseases and other health problems.
- Number of entries: ca. 13.000 classes
- Structure: 22 chapters, its nodes denote classes of diseases and related problems. ICD classes are arranged into up to five levels. There is one terminal class for each entity. Attributes of ICD are inclusions and exclusions and glossary-like text.

11.8.e. LOINC

- LOINC: Logical Observation Identifiers names and codes.
- Copyright & Issuer: Regenstrief Institute, Indiana
- Languages & Localization: English, Spanish, Chinese, German (Users guide), Estonia Italian
- Fields of application: The scope of the LOINC effort includes laboratory and other clir ical observations. The laboratory portion of the LOINC database contains the usual cat- egories of chemistry, hematology, serology, microbiology, toxicology; as well as categ ries for drugs and the cell counts and antibiotic susceptibilities. The clinical portion of the LOINC database includes entries for vital signs, hemodynamics, intake/output, elec trocardiogram (EKG), obstetric ultrasound, cardiac echo, urologic imaging, gastroen- doscopic procedures, pulmonary ventilator management, selected survey instruments (e.g. Glascow Coma Score, PHQ-9 depression scale, CMS-required patient assessment instruments), other clinical observations and document sections.
- Number of entries: 53,344
- Structure: Each LOINC record corresponds to a single test result or panel. The record includes fields for specifying:
    - Component (analyte) - e.g., potassium, hemoglobin, hepatitis C antigen.
    - Property measured - e.g., a mass concentration, enzyme activity (catalytic rate).
    - Timing - i.e., whether the measurement is an observation at a moment of time, or a observation integrated over an extended duration of time - e.g., 24-hour urine.
    - The type of sample - e.g., urine, blood.
    - The type of scale - e.g., whether the measurement is quantitative (a true measure- ment) ordinal (a ranked set of options), nominal (e.g., E. coli; Staphylococcus au- reus), or narrative (e.g., dictation results from x-rays).
    - Where relevant, the method used to produce the result or other observation

LOINC is also used for the CDA (Clinical Document Architecture) sections

11.8.f. HL7

[To be added]

11.8.g. UCUM

- UCUM: Unified Code for Units of Measure.[Datatype PQ]
- Copyright & Issuer: Regenstrief Institute, Indiana
- Languages & Localisation: English
- Fields of application: UCUM is a system of codes for unambiguously representing measurement units to both humans and machines.
- Number of entries: 556
- Structure: Each unit is defined relative to a system of base units by a numeric factor and a vector of exponents by which the base units contribute to the unit to be defined. Although we can reflect all the meaning of units covered by dimensional analysis with this vector notation, UCUM does not show vectors. Proposed definition from Regenstrief: The Unified Code for Units of Measure is a code system intended to include all units of measures being contemporarily used in international science, engineering, and business. The purpose is to facilitate unambiguous electronic communication of quantities together with their units.

11.8.h. EDQM

EDQM: Standard Terms of European Directorate of Quality in Medicine.

- Copyright & Issuer: EDQM
- Languages & Localization: Albanian, Bulgarian, Chinese, Croatian, Czech, Danish, Dutch, English, Estonian, Finnish, French, German, Greek, Hungarian, Icelandic, Italian, Latvian, Lithuanian, Macedonian, Maltese, Norwegian, Polish, Portuguese, Romanian, Russian, Serbian, Slovak, Slovenian, Spanish, Swedish and Turkish.
- Fields of application: The List of Standard Terms covers dosage forms, routes of administration and containers used for medicines for human and veterinary use.
- Number of entries: ~ 450
- Structure: Part 1: Pharmaceutical dosage forms and short terms; Part 2: Routes of administration; Part 3: Containers.

11.8.i. ATC

- ATC: Anatomical Therapeutic Chemical (ATC) classification system
- Copyright & Issuer: WHO Collaborating Centre for Drug Statistics Methodology, Norwegian Institute of Public Health
- Languages & Localization: English, Spanish, German, Italian
- Various manifestations: ATC-WHO, ATC-GM (Germany), ATC-WIDO (Germany), ATC Vet, ATC Herbal
- International non-proprietary names (INN) are used. If INN names are not assigned, USAN (United States Adopted Name) or BAN (British Approved Name) names are usually chosen.
- Fields of application: In the ATC-classification pharmacological substances are divided into different groups according to the organ or organ system which they affect and their chemical, pharmacological and therapeutic properties.
  A defined daily dose is assigned to each active substance. Defined daily doses (DDD) are the assumed average daily maintenance dose for the main indication of each substance in adults. The ATC-Classification with defined daily doses serves as an easing of comparisons between drugs and guarantees a standardized reference for the specification of daily treatment expenses. The purpose of the ATC/DDD system is to serve as a tool for drug utilization research in order to improve quality of drug use.
- Number of entries: 4067 Codes (2006)
- Structure: In the Anatomical Therapeutic Chemical (ATC) classification system, the drugs are divided into different groups according to the organ or system on which they act and their chemical, pharmacological and therapeutic properties. Drugs are classified in groups at five different levels. The drugs are divided into fourteen main groups (1st level), with one pharmacological/therapeutic subgroup (2nd level). The 3rd and 4th levels are chemical/pharmacological/therapeutic subgroups and the 5th level is the chemical substance. The 2nd, 3rd and 4th levels are often used to identify pharmacological subgroups when that is considered more appropriate than therapeutic or chemical subgroups.

  ATC assures the unified coding of active components registered. This feature, coupled with strength (dosage) and pharmaceutical form) assures the possibility to transfer the full information on a medication from Country to Country, regardless the brand name of the medication. A medicinal product can be given more than one ATC code if it is available in two or more strengths or formulations with clearly different therapeutic uses. The existence of multiple codes reduces the risk of mistakes in the specification of strength and prescription / dispensation of different medication for the two pathologies.

11.8.j. Coding systems: Choices made by epSOS[35]

epSOS has investigated several potential coding systems.
The next table shows choices made for coding system that are used at present in epSOS. These coding systems have been described in the previous chapter.

Snomed codes are used in place where no license-free alternative was present.

epSoS CDA R2	
Field	**Terminology Binding**
Field Labels	LOINC
Problem list	ICD 10
Medication list	ATC + EDQM + UCUM
Allergies	Allergen: SNOMED Active ingredient, medicaments: ATC
Surgical procedures	SNOMED
Medical devices	SNOMED
Country and languages	ISO 639
Professional role	ISCO
Vaccinations	tbd
SNOMED CT is not licensed in all countries.	

[35] This chapter is largely based on:
epSOS D3.5.2 Appendix D epSOS Master Value Set Catalogue v0.0.3 20100215.doc

12. Appendix: Glossary

Term	Description	Source	Comment
SAM	Semantic Area Model		A formal specification of a collection of data points for a specific purpose and users (both healthcare providers, authorities and IT-specialists
epSOS	European Patient Smart Open Services		a project by EU-Member states for cross border exchange of the Patient summary and Prescriptions.
INFOstructure			
IA-RM			
Reference Model			
CEN			
ISO			
IHTSDO			
HL7			
LOINC			
IHE			
CDA			
Patient Summary	electronic health record extract that provides an electronic patient health data set applicable both for unexpected, as well as expected, healthcare contact	ContSys	electronic health record extract that provides an electronic patient health data set applicable both for unexpected, as well as expected, healthcare contact
health record extract	part or a health record grouped for the purpose of communication	ContSys	

13. Appendix: Questionnaire

COMPLETE ICT INFO ARCHITECTURE REF MODEL

Generated on 21/11/2013 15:14:14

[To be updated]

1. General Questions
Please indicate whether you agree with the following general statements?

- Data Integrity including its validity, structure, standardisation and shareability are critical characteristics for the data associated with my function.

	Answer Percent	Answer Total
Yes	100%	17
No	0%	0
Total answers		17
Unique Respondents		17
Respondent Reach		94.44%
Mean		1

1. General Questions
Please indicate whether you agree with the following general statements?

- Consistency and equivalence of related information stored or used in various data systems is critical to my work function.

	Answer Percent	Answer Total
Yes	100%	17
No	0%	0
Total answers		17
Unique Respondents		17
Respondent Reach		94.44%
Mean		1

1. General Questions
Please indicate whether you agree with the following general statements?

- I need an authoritative source of reference to assure the correctness of the content of the data I use in my daily work.

	Answer Percent	Answer Total
Yes	87.5%	14
No	12.5%	2
Total answers		16
Unique Respondents		16
Respondent Reach		88.89%

Mean	1.13

1. General Questions
Please indicate whether you agree with the following general statements?

- Data standards and structure are important dimensions in ensuring my data is usable and fit for purpose.

	Answer Percent	Answer Total
Yes	94.12%	16
No	5.88%	1
Total answers		17
Unique Respondents		17
Respondent Reach		94.44%
Mean		1.06

1. General Questions
Please indicate whether you agree with the following general statements?

- Common data standards and structure with shared governance must be applied to all of our ICT systems and technologies.

	Answer Percent	Answer Total
Yes	88.24%	15
No	11.76%	2
Total answers		17
Unique Respondents		17
Respondent Reach		94.44%
Mean		1.12

2. Additional Comments

Each single bullet represents one respondent' opinion:
This is a key research interest of mine as opposed to clinical practice

- These are very important and I agree with all of the statements.
- I do not agree with shared governance for ALL ICT data standards. Some data is sectoral. The common standards and structures need to apply to shared data only.
- Cannot disagree with all of this
- As the regulator of medicinal procucts, my organisation is required to receive/distribute data using standards established under EU legislation & guidance.
- As a GP I interact with HSE systems but control my own data. I feel standardisation is critical but would be slow to share governence.
- As a GP I can manage most patient care without much systems interoperability but the administrative functions and many clinical functions would be much improved by standardised systems

3. DATA DICTIONARY
Please indicate whether you agree with the following statements about a common Data Dictionary?

- I need better availability and greater comprehensiveness of data compared to that currently available.

	Answer Percent	Answer Total
Yes	81.25%	13

No	18.75%	3
Total answers		16
Unique Respondents		16
Respondent Reach		88.89%
Mean		1.19

3. DATA DICTIONARY
Please indicate whether you agree with the following statements about a common Data Dictionary?

- In my work role, I need structured data that is defined unambiguously using a central point of reference.

	Answer Percent	Answer Total
Yes	87.5%	14
No	12.5%	2
Total answers		16
Unique Respondents		16
Respondent Reach		88.89%
Mean		1.13

3. DATA DICTIONARY
Please indicate whether you agree with the following statements about a common Data Dictionary?

- A Data Dictionary providing me with standardised, shareable and unambiguously defined data is critical to my role.

	Answer Percent	Answer Total
Yes	87.5%	14
No	12.5%	2
Total answers		16
Unique Respondents		16
Respondent Reach		88.89%
Mean		1.13

3. DATA DICTIONARY
Please indicate whether you agree with the following statements about a common Data Dictionary?

- The Data Dictionary must be able to facilitate standardised and structured data exchange both internally and with external agencies.

	Answer Percent	Answer Total
Yes	100%	17
No	0%	0
Total answers		17
Unique Respondents		17
Respondent Reach		94.44%
Mean		1

4. Additional comments

Each single bullet represents one respondent' opinion:
The development of data dictionaries in Ireland is a key priority

- These are very important and I agree with all of the statements.
- My organisation uses data dictionaries extensively. We have our own medicinal product data dictionary based on the ISO IDMP standard(s)
- I would like all of the above but do not necessarily "need" them or find them "critical"
- I am unsure whether you are referring to metadata or actual data.
- For instance, the second question, are you referring to data structure or the contents.
  Dictionary must be active i.e accessible by developers / applications to check conformance to definitions etc.

5. Please tick the boxes which apply;

	Answer Percent	Answer Total
The HSE ICT Systems and technologies occasionally limit my ability to enter the data that I need	28.57%	4
I regularly encounter data entry problems with HSE ICT Systems and technologies	50%	7
I am satisfied with the current data input capability of HSE ICT systems and technologies	21.43%	3
Total answers		14
Unique Respondents		12
Respondent Reach		66.67%
Mean		1.93

6. With respect to the HSE ICT systems that you are familiar with, please outline below your most pressing data entry requirements for these systems.

Each single bullet represents one respondent' opinion:
Unique Health Identifier is most pressing need
Agreed standard for geocoding local areas also urgently needed- this supports epidemiological mapping but is also essential for correct return of results to responsible authority (e.g. newborn screening results) to avoid missed cases etc and support failsafe processes

- Translational research completed last year
  With community care encountered a number of data entry problems
- There is a great need to share data - which is consistent and coherent. At present this can generally only be achieved by once off work arounds.
- Most of the limitations/issues are identified but have more to do with inertia on the HSE side
- I operate outside the HSE
- I do not use |HS|E ICT systems directly at present
- At present the IMB has no direct access to HSE systems, though we would wish to have greater automation of adverse reaction reports, or quality defect notifications from the HSE systems. Additonaly access to HSE contact/distribution lists or communication channels would be extremely valuable.
- I'm not engaged personally in data entry
  We have one ICT system which our department uses all the time called CIDR (computerised infectious disease reporting) It needs a major revision in my view in relation to data entry as it is far too cumbersome
- ~There are no data entry issues other than lack of staffing resources and an overdependence on drop down lists and a lack of use of bar code scanning and electronic signature scanning

7. Please tick the box below which best represents the restrictions you encounter with data search and presentation using HSE ICT Systems.

	Answer Percent	Answer Total
I encounter significant limitations in searching and viewing relevant data already entered in the system	28.57%	4
I encounter some limitations in searching and viewing relevant data already entered in the system	57.14%	8
I have no problem searching and viewing relevant data already entered in the system	14.29%	2
Total answers		14
Unique Respondents		12
Respondent Reach		66.67%
Mean		1.86

8. Please list in the box below your most pressing challenges with respect to data search and presentation capabilities when using HSE ICT Systems. (Please list these in order of priority).

Each single bullet represents one respondent' opinion:
Searches are generally system specific- so not that had to do. But it's very difficult to search for data e.g. patient specific over multiple systems.

- One of the most obvious difficulties is the variation in practice and standards of ICT statems used in child health information systems - in certain areas data is easily accessible to the general user but in most it is not available without expert ICT request
- Most systems in HSE ICT have been established as closed systems and do not accommodate homogenous searches to present views or summaries of health records.
  Network infrastructure whilst well established in some organisations is limited to this organisation so shared record views and summaries across and between institutions is not possible with the exception of Healthlink
- Includes the incident data on the State Claims Agency's system
- IMB has no access to HSE ICT Systems. IMB is a data provider to HSE (licensed medicines and generic interchangeability data)
- I work outside the HSE
- I use Hospital INpatient Enquiry data (HIPE system)
  This is one of the better HSE ICT systems - my limitations in finding what I want are more related to the infrequency with which I use it
- I find the PCRS system difficult to use for some functions such as new GMS registrations for babies
- Lack of structured discharge prescriptions from the HSE hospitals and clinics
  Lack of detailed electronic returns from PCRS arm of HSE

9. The purpose of this question is to establish the usage and type of data processing requirements undertaken by the HSE ICT Systems and technologies that you use. In the boxes below please tick all that apply.

	Answer Percent	Answer Total
Finding the data needed	16.88%	13
Documenting healthcare delivery	15.58%	12
Reporting to management	12.99%	10

Reporting to National registries	10.39%	8
Clinical Audits	11.69%	9
Own research/analysis	15.58%	12
Research/analysis for third parties	11.69%	9
Billing	5.19%	4
Total answers		77
Unique Respondents		15
Respondent Reach		83.33%
Mean		4.04

10. Other (Please Specify)

Each single bullet represents one respondent' opinion:
There is an urgent need to devise systems for integrated care particularly for documenting clinical referral and discharge

- Providing data on medication.
- Prescriptions
- Approval to supply
- No relevance to me
- I work outside the HSE but have ticked the boxes that are relevant to my work. I interact with referrals from within the HSE
- I am my own boss but do need to generate data for internal analysis and management purposes.
- all of above + maintaining patient owned/focused data repository

11. Please tick the boxes below that are relevant to your data exchange requirements. - I need capabilities for importing (without problems) data from other internal systems:		
	Answer Percent	Answer Total
Patient Records	14.29%	8
Patient Summary	16.07%	9
Patient Medication List	16.07%	9
Patient Prescription	16.07%	9
Referral Letter	12.5%	7
Discharge Letter	12.5%	7
Research data	12.5%	7
Total answers		56
Unique Respondents		13
Respondent Reach		72.22%
Mean		3.84

Other

Each single bullet represents one respondent' opinion:
Problem summary.

- Outcome measures, Incident and risk data, Performance reporting including Quality indicators

11. Please tick the boxes below that are relevant to your data exchange requirements. - I need capabilities for importing (without problems) data from other external systems:		
	Answer Percent	Answer Total
Patient Records	18.52%	10
Patient Summary	18.52%	10

Patient Medication List	14.81%	8
Patient Prescription	14.81%	8
Referral Letter	11.11%	6
Discharge Letter	11.11%	6
Research data	11.11%	6
Total answers		54
Unique Respondents		13
Respondent Reach		72.22%
Mean		3.59

Other

Each single bullet represents one respondent' opinion:
Vaccines

- Outcome measures, Incident and risk data, Performance reporting including Quality indicators
- Ideally reports of Adverse Drug Reactions could be sent automatically from HSE systems.
-

I1. Please tick the boxes below that are relevant to your data exchange requirements. - I need capabilities for exporting (without problems) data to other internal systems:

	Answer Percent	Answer Total
Patient Records	14.71%	5
Patient Summary	17.65%	6
Patient Medication List	14.71%	5
Patient Prescription	8.82%	3
Referral Letter	8.82%	3
Discharge Letter	8.82%	3
Research data	26.47%	9
Total answers		34
Unique Respondents		10
Respondent Reach		55.56%
Mean		4.12

Other

Each single bullet represents one respondent' opinion:
Outcome measures, Incident and risk data, Performance reporting including Quality indicators

I1. Please tick the boxes below that are relevant to your data exchange requirements. - I need capabilities for exporting (without problems) data to other external systems:

	Answer Percent	Answer Total
Patient Records	16.22%	6
Patient Summary	18.92%	7
Patient Medication List	13.51%	5
Patient Prescription	10.81%	4
Referral Letter	13.51%	5
Discharge Letter	13.51%	5
Research data	13.51%	5
Total answers		37

Unique Respondents	10
Respondent Reach	55.56%
Mean	3.81

Other

Each single bullet represents one respondent' opinion:
Vaccines

- Outcome measures, Incident and risk data, Performance reporting including Quality indicators
- Note I operate outside HSE so I need to send info into HSE system. For me, external = HSE

11. Please tick the boxes below that are relevant to your data exchange requirements. - I need capabilities to find view and use the data:

	Answer Percent	Answer Total
Patient Records	22.22%	12
Patient Summary	16.67%	9
Patient Medication List	14.81%	8
Patient Prescription	11.11%	6
Referral Letter	9.26%	5
Discharge Letter	11.11%	6
Research data	14.81%	8
Total answers		54
Unique Respondents		14
Respondent Reach		77.78%
Mean		3.61

Other

Each single bullet represents one respondent' opinion:
Outcome measures, Incident and risk data, Performance reporting including Quality indicators

- Ideally we could review this information in the context of assessing medication safety issues.
-

12. Other (please Specify).

Each single bullet represents one respondent' opinion:
Please note that my organisation is a data provider to HSE. We provide HSE with the listing of licensed medicines (ISO std) together with the interchangeability indicators for generic medication. Ideally we could also receive quality defect reports; adverse events with medical devices; etc. directly from the HSE systems.

- Patient summary records as opposed to patient records are more urgent at this time
- Currently GP computerised records are usually the most extensive up to date and accurate patient record thus we end up providing information for multiple agencies such as daycare, nursing homes, social workers, PHNs, PCT members, hospitals etc - this should really be the HSEs responsibility and creates huge workload for GPs - a central repository which could be automatically updated might eliminate this.
-

13. Please tick the boxes below that best identify the problems you encounter with the import and export of digital data from the HSE Health ICT systems that you regularly use - My IT-system is not capable of importing data from other internal systems:

	Answer Percent	Answer Total
Patient Records	20.45%	9
Patient Summary	15.91%	7
Patient Medication list	13.64%	6

Patient Prescription	13.64%	6
Referral Letter	11.36%	5
Discharge letter	11.36%	5
Research data	13.64%	6
Total answers		44
Unique Respondents		11
Respondent Reach		61.11%
Mean		3.68

Other

Each single bullet represents one respondent' opinion:
Outcome measures, Incident and risk data, Performance reporting including Quality indicators.

- I don't yet have an IT system for patient records.
- As described, I am commenting at a national level on child health systems and this capacity is only available in pockets.
-

13. Please tick the boxes below that best identify the problems you encounter with the import and export of digital data from the HSE Health ICT systems that you regularly use - My IT-system is not capable of importing data from other external systems:

	Answer Percent	Answer Total
Patient Records	19.57%	9
Patient Summary	17.39%	8
Patient Medication list	15.22%	7
Patient Prescription	10.87%	5
Referral Letter	13.04%	6
Discharge letter	13.04%	6
Research data	10.87%	5
Total answers		46
Unique Respondents		11
Respondent Reach		61.11%
Mean		3.63

Other

Each single bullet represents one respondent' opinion:
Outcome measures, Incident and risk data, Performance reporting including Quality indicators

- As described, I am commenting at a national level on child health systems and this capacity is only available in pockets.
-

13. Please tick the boxes below that best identify the problems you encounter with the import and export of digital data from the HSE Health ICT systems that you regularly use - My IT-system is not capable of exporting data from other internal systems:

	Answer Percent	Answer Total
Patient Records	22.86%	8
Patient Summary	17.14%	6
Patient Medication list	14.29%	5
Patient Prescription	11.43%	4
Referral Letter	11.43%	4

Discharge letter	14.29%	5
Research data	8.57%	3
Total answers		35
Unique Respondents		9
Respondent Reach		50%
Mean		3.49

Other

Each single bullet represents one respondent' opinion:
Outcome measures, Incident and risk data, Performance reporting including Quality indicators

- As described, I am commenting at a national level on child health systems and this capacity is only available in pockets.
-

13. Please tick the boxes below that best identify the problems you encounter with the import and export of digital data from the HSE Health ICT systems that you regularly use - My IT-system is not capable of exporting data to external systems:

	Answer Percent	Answer Total
Patient Records	24.24%	8
Patient Summary	15.15%	5
Patient Medication list	15.15%	5
Patient Prescription	12.12%	4
Referral Letter	12.12%	4
Discharge letter	12.12%	4
Research data	9.09%	3
Total answers		33
Unique Respondents		9
Respondent Reach		50%
Mean		3.45

Other

Each single bullet represents one respondent' opinion:
Outcome measures, Incident and risk data, Performance reporting including Quality indicators

- As described, I am commenting at a national level on child health systems and this capacity is only available in pockets.
-

14. Other (Please Indicate)

Each single bullet represents one respondent' opinion:
Yes

- With the exception of established registries, GP systems and Health link there is little opportunity to export or import data across the HSE. Nursing and midwifery records are primarily paper based.
- Note I am external to HSE and do not yet have an electronic patient record system
- No relevance to me
- Internal Practice management system very capable of importing and exporting extracted data as a PDF or Word document but limited capability in exporting data that can be directly integrate in to other systems.
- Importing/ exporting can only be done via HL:7 in the most part
- I do not directly use any HSE ICT system. I exchange data with them.
- GP systems are capable of importing multiple structured messages in HL7 v2.4 format and also capable of generating electronic referrals in HL7 v2.4.

15. What are your most pressing problems with respect to data import and export capabilities? Please list your

problem below in order of priority.

Each single bullet represents one respondent' opinion:
We need secure e-mail to allow secure transfer of patient information to/from HSE and in the longer term need structured messages and interrogation facilities so that the information we obtain can be integrated directly in to the patient record and so that referrals can be made from within the PMS for all specialities and community resources.

- Sharing patient data between on-site system silos e.g. lab data to diabetes system etc.
- Patient Demographics, Referrals, and Medications import. Patient Summary export.
- Organisation structure constantly changing so comparisons and aggregation of data a constant problem.
- Note I am external to HSE and do not yet have an electronic patient record system.
- Lack of uniformity and a national standard.
- I have done a lot of work on patients with diabetes over the years, no clinical management IT system in hospital. Need integrated IT systems which link all services required by these complex patients, similarly need these IT systems for all patients with chronic disease. Need to move towards Electronic Health Records for patients
- Electronic transfer /referral of core patient data on discharge across and between services.
  View patient health outcome status data to inform care planning which is patient centred to manage/ target effective use of existing resources and services.
  Import prescriptions
  Import payment information for drugs supplied
  Export vaccination records

16. Please tick the boxes below which you deem are of importance to your future business and systems requirements.

	Answer Percent	Answer Total
Flexible arrangements so that healthcare providers and other users of the IT Systems can define and change information needs quickly	14.61%	13
Adoption of a 'Big Bang' revolutionary scenario to Information Architecture development	2.25%	2
Adoption of a stepwise evolutionary approach to Information Architecture development	15.73%	14
Structured standardised data for information exchange between systems	17.98%	16
The adoption of ICT and Information Standards early in the procurement process to ensure data alignment across all core systems and technologies	15.73%	14
Data Standards for faster and cheaper integration time for Information systems	15.73%	14
Improved Data Quality	17.98%	16
	Total answers	89
	Unique Respondents	17
	Respondent Reach	94.44%

Mean	4.37

17. If you regularly use systems outside of the HSE ICT portfolio please provide a list of these systems and any standards you are aware of that they use.
These may include:

	Answer Percent	Answer Total
Message standards such as: Edifact, HL7v2, HL7 v3 etc.	43.48%	10
Coding systems such as: SNOMED, ICD, ICPC, national, local classifications, etc.	56.52%	13
Total answers		23
Unique Respondents		13
Respondent Reach		72.22%
Mean		1.57

18. Other Technical Standards

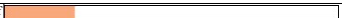
Each single bullet represents one respondent' opinion:
Recommending uptake and use of HISA for nursing and midwifery service delivery reporting

- Note I am external to HSE and do not yet have an electronic patient record system
- MedDRA; HL7 E2B; ISO IDMP;
  WHO ATC/DDD; WHO INN;

  Please find attached document outlining details of standard utilised by the Irish Medicines Board
- Loinc (Lab) and ICPC2
- I have been involved with GP It systems which use ICPC or Snomed
- Healthlink messaging -HL7v2, XML
  ICPC 2 and ICD10 and LOINC and Health One dictionary
- Community Pharmacists/HSE: Message standards based on PICNIC, a child of the PCRS and a few other EU based bodies. This is loosely based on HL7 V1.
- We also use a derived Edifact message for ordering, which is in the process of being replaced by ebXML. Drug coding based three separate codes: IPU codes/ATC/GMS -IPU product file is drug/product file used in 90% community pharmacies and many hospitals. ATC codes are only international standard but the file is normalised and could readily incorporate Snomed CT coding.
  CIS data in State Claims Agency.
- Data in funded organisations

19. Please tick as appropriate

	Answer Percent	Answer Total
I am an employee of the HSE and use HSE ICT systems	42.11%	8
I am not an employee of the HSE but I use HSE ICT systems	15.79%	3
I am not an employee of the HSE but my agency's ICT systems interface with the HSE's ICT systems	21.05%	4

I am not an employee of the HSE but I am familiar with HSE ICT systems		21.05%	4
		Total answers	19
		Unique Respondents	17
		Respondent Reach	94.44%
		Mean	2.21

20. Optional

Your name:
Tony Kenny
Tessa Greally
Suzanne McDonald
Sarah Craig
Pamela Hussey
Mai Mannix
Lesley Smith
John Kenny
Jack Shanahan
Frank Hill
Dr. Kieran Murphy
Dr Noel McCaffrey
Brian O'Mahony

Organisation:
Irish Pharmacy Union
Irish Medicines Board
HSE - Health and Well Being Division
HSE
HSE
HRB
GPIT
GP IT ICGP
DCU HISINM
DCU
Connolly Hospital

Email Address:
tmpkenny@gmail.com
tessa.greally@hse.ie
suzanne.mcdonald@imb.ie
shanahan.jack@gmail.com
scraig@hrb.ie
pamela.hussey@dcu.ie
omahonyb@gmail.com
noel.mccaffrey@dcu.ie
mai.mannix@hse.ie
lesley.smith@live.ie
john.kenny@hse.ie
info@westburymc.com
drfrankhill@gmail.com

21. General Comments

Each single bullet represents one respondent' opinion:
We need a revolution in ICT in HSE to bring us up to speed. Really need to include clinicians in the design of the systems. We also need unique identifier straight away. Data protection need to be won around on this. The current situation is completely crazy

PS some of this questionnaire tricky for non ICT people like myself - was it piloted? Many thanks good to see some movement anyway

- This survey is a good example of what can happen when data integrity is not designed in from the beginning. Systems must be constructed to make sure quality data input. Many times in this survey you can enter contradictory information. This is just like the ICT systems we use. It was clever for you to think of doing this in this survey.
- One of the biggest advantages of a nationwide technology solution is to enable rapid communication between health stakeholders. It is currently very difficult to contact the correct individuals or logical groupings quickly. Thank you.
- I am the project manager for the planned HSE National Immunisation and Childhealth Information System and the system administrator for the current National HPV Immunisation System. I am also responsible for all the local immunisation systems in use in the HSE and for the interfaces with them to the Primary Care Reimbursement Services (PCRS). A lot of these system require integration with birth information, birth registrations, schools, department of education, practice management systems to name but a few. If further workshops are taking place I would appreciate being informed and invited.
- Delighted to see progress in Standards and national Information Architecture.
- Brian O'Mahoney asked us to comment on this survey and is the direct representative of GP IT at the meetings.
- Best wishes for this work. It's important.
- Personal opinions expressed only - not that of organisation.
- A key issue for pharmacists will be some type of electronic prescription repository or hub where prescriptions will be temporarily stored prior to retrieval/cancellation/return. We have reached this position because trials with direct to pharmacy transmission have been largely unviable, presenting major deficiencies. The introduction of national identifiers for patients, professionals and locations are also important issues.
- A IHTSDO national license and institution to manage data is I believe a priority for 2014
- A workshop on the requirement to integrate Child Health Information Systems in the HSE and linked partner organisations was held on February 18 2013. The proceedings and recommendations are available.
-