The Big Picture: IDNT in Electronic Records
Glossary

TERM	DEFINITION
CCI	Canadian Classification of Interventions is the Canadian standard for classifying health care procedures, and was developed for use with ICD-10-CA in Canada by CIHI. • Used to classify health interventions for clinical, epidemiological, quality and population purposes • Intervention code system • Therapeutic interventions: inpatient/day surgeries, surgical and non-surgical • Diagnostic interventions: diagnostic imaging, test, measurements, biopsies and explorations • Cognitive, psychosocial and sensory therapeutic interventions • Other healthcare interventions: assisted living, environmental assessments, therapeutic, and counseling http://www.cihi.ca/CIHI-ext-portal/internet/EN/TabbedContent/standards+and+data+submission/standards/classification+and+coding/cihi010689
Canada Health Infoway	The organization within Canada charged with the overall responsibility for development of a national plan and standards for electronic health records for Canadians. https://www.infoway-inforoute.ca/index.php/about-infoway/what-we-do
Canadian Institute for Health Information	The organization within Canada with the overall responsibility for development and maintenance of national health care reporting standards, systems and databases. http://www.cihi.ca/CIHI-ext-portal/internet/EN/Theme/about+cihi/cihi010702
EHR	Electronic Health Record is defined as computer-based clinical data for an individual across multiple locations. This longitudinal health record includes data form a number of different interoperable EMRs, and EPRs and is shared across multiple jurisdictions.[1]
EMR	Electronic Medical Record is defined as computer-based data for an individual that are kept by a single physician office or practice or community health centre.[2]
EPR	Electronic Patient Record is defined as computer-based clinical data for an individual that are kept by a single health care organization (e.g. hospital, acute care facility, regional health authority).[3]
H L 7 International (HL7)®	• The global authority on standards for interoperability of health information technology with members in over 55 countries, including Canada. • A not-for-profit, ANSI-accredited standards developing organization dedicated to providing a comprehensive framework and related standards for the exchange, integration, sharing, and retrieval of electronic health information that supports clinical practice and the management, delivery and evaluation of health services. • Provides standards for interoperability that improve care delivery, optimize workflow, reduce ambiguity and enhance knowledge transfer among healthcare providers, government agencies, the vendor community, fellow SDOs and patients. • "Level Seven" refers to the seventh level of the seven-layer communications model for Open Systems Interconnection (OSI) - the application level. • Canada Health Infoway Standards Collaborative holds the HL7 licensing for Canada, and is the link to the HL7 Canada Constituency for voting on and contributing to standards. http://www.hl7.org/about/ https://www.infoway-inforoute.ca/index.php/programs-services/standards-collaborative/international-standards-organizations
ICD 10-CA	ICD -10-CA is an enhanced version of the 10th revision of the International Classification of Diseases and Related Health Problems, developed by Canadian Institute for Health Information (CIHI) for morbidity classification in Canada based on the World Health Organization ICD-10. • Morbidity and mortality code system • Classify disease and health status for clinical, epidemiological, quality and population health purposes • The encoding of diagnoses for submission to CIHI, and use in funding and hospital management to understand the type of diagnoses receiving care • "U" codes section supports research and temporary codes for new diseases

[1] Abrams, K.J., & Gibson, C.J. (Eds.). (2013). Fundamentals of health information management (2nd ed.). Ottawa, ON; Canadian Healthcare Association. Page 394.
[2] Ibid.
[3] Ibid.

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	http://www.cihi.ca/CIHI-ext-portal/internet/EN/TabbedContent/standards+and+data+submission/standards/classification+and+coding/cihi010689

Infoway InfoCentral	This Canada Health Infoway Standards Collaborative site serves to help connect knowledge, standards, tools and solutions with potential and existing users and enables collaboration for communities of practice.
	Access to the following is now available on InfoCentral:
	• International and pan-Canadian Standards including:
	  o SNOMED CT
	  o pan-Canadian LOINC Observation Code Database (pCLOCD)
	  o pan-Canadian MTW and Messaging Artifacts
	  o pan-Canadian Messaging Standards
	  o HL7 International Standards
	• Standards implementation guides
	• pan-Canadian and jurisdictional EMR specifications
	• downloads and other tools and solutions to help you get up-and-running as quickly as possible when it comes to implementation
	• other materials, such as ePrescribing specifications, Health System Use Data Extract specifications, and documentation regarding the jurisdictional EMR Upgrade Programs
	As much of the information in InfoCentral is covered by various agreements, access is carefully controlled, and certain areas are limited to members of specific groups.
	https://infocentral.infoway-inforoute.ca/

International Dietetics and Nutrition Terminology (IDNT)	International Dietetics and Nutrition terminology (IDNT) is the standardized language published by the Academy of Nutrition and Dietetics used to support the nutrition care process. International Dietetics and Nutrition Terminology (IDNT) Reference Manual: Standardized Language for the Nutrition Care Process. Fourth Edition. 2013 https://andevidencelibrary.com/store.cfm?category=9 https://www.eatright.org/Shop/Product.aspx?id=6442471676
International Health Terminology Standard Development Organisation (IHTSDO) ®	• A not-for-profit association which owns and maintains SNOMED CT. In May 2013 twenty- two countries were Members of IHTSDO, including Canada. • Purpose is to develop, maintain, promote and enable the uptake and correct use of its terminology products in health systems, services and products around the world. • The focus is on enabling the implementation of semantically accurate health records that are interoperable. http://www.ihtsdo.org/members/ca00/
LOINC ®	Logical Observation Identifiers Names and Codes. A universal code system that includes 6 parameters: 1. Component (what is measured or observed (food provided, food intake) 2. Characteristic of what is measured evaluated (volume, time stamp) 3. Time aspect – interval (1 hour, 24 hour) 4. System (food, fluid, blood, urine) 5. Type of Scale of measure (kilograms, pounds, centimeters, inches) 6. Type of method – procedure to measure or observe (blood draw, food weight) Regenstrief Institute's informatics group developed the LOINC (Logical Observation Identifiers Names and Codes) terminology coding system to standardize laboratory test result names, clinical observations and test requests. Regenstrief Institute remains the overall steward or Standards Development Organization responsible for LOINC, including its distribution, development and maintenance. https://www.infoway-inforoute.ca/index.php/programs-services/standards-collaborative/international-standards-organizations/regenstrief-institute
pCLOCD	Pan-Canadian LOINC Observation Code Database is the Canadian LOINC available through the CHI Standards Collaborative that meets the needs of Canada with the inclusion of metric units of measure and French display names. In Canada, the LOINC database has been constrained to include only observables applicable to Canadian implementers. This adapted standard, referred to as the pan-Canadian LOINC Observation Code Database (pCLOCD), is maintained and distributed by the Standards Collaborative. • Provides standardization for disparate lab tests across multiple organizations and platforms allowing

	for comparability and analysis of consolidated lab data • Provides options for standardizing laboratory test names and reporting units across disparate lab systems for use in a consolidated system • Facilitates semantic interoperability between disparate lab systems • Supports all commonly used lab tests and the majority of tests done in specialty areas • Supports both ordering and reporting lab tests https://www.infoway-inforoute.ca/index.php/programs-services/standards-collaborative/pan-canadian-standards/pan-canadian-loinc-observation-code-database-pclocd-nomenclature-standard
PHR	Personal Health Record is defined as an individual's longitudinal health record, maintained by the individual, encompassing a complete record of their health (e.g. immunizations, allergies, health encounters, lifestyle choices); may contain links to health information held by a health care provider or health care facility. The PHR continues to evolve with added electronic information, and linkages through applications and websites are also possible.[4]
Reference Set	A work consisting of a set of references to SNOMED CT components which may associate additional properties with components that are members of the set and/or which may indicate associations between members of the set or between members of the set and content of another nomenclature, classification or knowledge structure. The uses of *Reference sets* include identification of subsets of SNOMED CT content, representation of alternative hierarchical structures and *cross maps* to classifications. http://www.ihtsdo.org/fileadmin/user_upload/doc/en_us/gl.html
SDO	Standards Development Organization in context of health information standards is a private or government agency charged with the development of health care information standards at a national or international level.[5]
SKMT	Standards Knowledge Management Tool is the Joint Initiative for Global Standards Harmonization Health Informatics Document Registry and Glossary is a source for glossary terms of interest to health informatics, and is contributed to globally. SKMT is sponsored by a number of organizations, and is evolving to continue to be populated with glossary terms from many countries and people. Sponsors •CRED (Collaborative Research for Effective Diagnosis) •Llewelyn Grain Informatics •CIHI (Canadian Institute for Health Information) •Canada Health Infoway •Université de Sherbrooke http://www.skmtglossary.org/
SNOMED CT®	Systemized Nomenclature of Medicine Clinical Terms. The most comprehensive, multilingual clinical healthcare terminology in the world. SNOMED CT is owned, maintained and distributed by the International Health Terminology Standard Development Organisation (IHTSDO). Canada Health Infoway Standards Collaborative is the national release organization for Canada and holds the licensing rights for use in Canada. https://www.infoway-inforoute.ca/index.php/programs-services/standards-collaborative/pan-canadian-standards/systematized-nomenclature-of-medicine-clinical-terms-snomed-ct
Standard Protocol	Approved model or template for a set of procedures; e.g., nutrition assessment incorporates patient history of food intake and activity, blood laboratory reports, medical diagnosis in a previously tested and accepted format.
Standardized Language	Systematically defined body of words developed to ensure effective communication within a profession or group.
Standards Collaborative	In 2006, Canada Health Infoway and the Canadian Institute for Health Information (CIHI) agreed to launch a new pan-Canadian coordination function to support and sustain health information standards on a national scale. The objective of the Standards Collaborative was to integrate the Canadian health information standards community into a single, cohesive, coordinated forum and provide a single point of contact for health information standards in Canada. That Standards Collaborative was borne through extensive engagement and consultations with *Infoway* and CIHI Boards; federal provincial and territorial Deputy Ministers of Health; as well as domestic and international health information standards stakeholders. SC Mandate: • To establish standards to support *Infoway's* mandate in fostering and accelerating the deployment and

[4] Ibid. Page 403.
[5] Ibid. Page 82.

	use of eHealth solutions • To provide services to support and maintain these standards • To act in a formal liaison role to international Standards Organizations https://www.infoway-inforoute.ca/index.php/programs-services/standards-collaborative
Structured Data	The term structured data refers to *data that is identifiable* because it is organized in a structure. The most common form of structured data -- or structured data records (SDR) -- is a database where specific information is stored based on a methodology of columns and rows. Structured data is also searchable by data type within content. Structured data is understood by computers and is also efficiently organized for human readers. http://www.webopedia.com/TERM/S/structured_data.html
Unstructured Data	**Unstructured Data** (or **unstructured information**) refers to information that either does not have a pre-defined data model and/or does not fit well into relational tables. Unstructured information is typically text-heavy, but may contain data such as dates, numbers, and facts as well. This results in irregularities and ambiguities that make it difficult to understand using traditional computer programs as compared to data stored in fielded form in databases or annotated (semantically tagged) in documents. http://en.wikipedia.org/wiki/Unstructured_data
Value Set	HL7 uses value sets to define lists of values derived used to define clinical and administrative concepts to support effective exchange of health information; includes formal or informal code systems. http://www.hl7.org