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# Introduction AND SCOPE

Purpose of the Guide

The purpose of this guide is to ensure that HL7 Version 3 standards achieve their stated goal of semantic interoperability when used to communicate clinical information that is represented using concepts from SNOMED Clinical Terms®[[1]](#footnote-2) (SNOMED CT).

This version of the guide addresses use of SNOMED CT in the CDA Release 2 standard in particular. There are two primary reasons for this focus: (1) The current guidance in this ballot represents an incremental update from the prior DSTU (May 2009), as the CDA R2 standard (as a part of the HL7 V3 family) is based on versions of the RIM and Clinical Statement Pattern that are similar to those that were addressed in the prior DSTU; (2) CDA R2 represents a very important current use case of HL7 V3, as there is a great deal of CDA implementation activity occurring worldwide at present and likely for the foreseeable future (including Meaningful Use of Electronic Health Records in the US). Future guide versions are anticipated to expand the guidance related to other HL7 standards and terminologies.

Overview

This implementation guide has been developed by the HL7 TermInfo Project (a project of the HL7 Vocabulary Work Group) with significant contributions by the International Health Terminology Standards Development Organisation (IHTSDO). The guide is the result of a consensus process involving a wide range of interested parties who have contributed at various times over the span of the project.

* The HL7 Vocabulary and Structured Documents Work Groups
* The HL7 Clinical Statement Project
* Other current and past HL7 Technical Committees and Work Groups that have contributed to the project
* The SNOMED International Standards Board and Concept Model Working Group
* The IHTSDO, which took over ownership of SNOMED Clinical Terms in April 2007
* Vendors and providers actively implementing HL7 Version 3, including CDA R2, with SNOMED CT
* National Health Service (NHS) Connecting for Health in the United Kingdom
* A variety of other organizations and individuals who have contributed to the project or submitted ballot comments

The guide takes account of:

* The SNOMED CT Concept Model, including those elements concerned with the representation of context.
* The structure and semantics of the HL7 Reference Information Model (RIM).
* The particular features of CDA R2, to which the guidance in this version of the TermInfo implementation guide is specifically addressed.

Future Work

Future versions of this guide are anticipated to add guidance for:

* Use of both Clinical and Laboratory LOINC within HL7 V3 and CDA R2
* Use of SNOMED CT and LOINC with HL7 V3 features that are not available in CDA R2
* Use of both SNOMED CT and LOINC in FHIR
* Use of both SNOMED CT and LOINC in HL7 V2.x

Intended Audience – Who Should Read This Guide?

The guide can be used in various ways to assist the design, evaluation, operational implementation and use of various types of software applications that use SNOMED CT. The intended audience includes systems developers, health informatics specialists, purchasers, and system integrators.

**Software designers and developers**

Software designers and developers should use this guide:

• To enhance their technical understanding of SNOMED CT and the value it offers to their applications;

• As a point of reference when designing a SNOMED CT enabled application and when planning and undertaking the required development.

Designers and developers of fully integrated applications should use the guide:

• As a checklist of *SNOMED CT* services necessary to meet the needs of their users;

• For advice on how to implement the required services in ways that make the best use of *SNOMED CT* and which known pitfalls to avoid.

Designers and developers of *terminology servers* should use the guide:

• As a checklist when deciding which *SNOMED CT* services their server should offer;

• For advice on ways to implement the required services in ways that make the best use of *SNOMED CT* and avoid known pitfalls;

• As a point of reference when describing the functionality of their server.

Designers and developers of applications that use terminology services should use the guide:

• As a checklist of *SNOMED CT* services necessary to meet the needs of their users;

• To assist consideration of whether to use a *terminology server*;

• As a point of reference when reviewing the functionality of *terminology servers*.

**Health informatics specialists, analysts, purchasers and integrators**

Health informatics specialists, analysts, purchasers and integrators should use this guide:

• To enhance their technical understanding of SNOMED CT and the value it offers to their organization;

• As a point of reference when specifying, procuring and evaluating SNOMED CT enabled applications.

Health informatics specialists analyzing the needs of users and organizations should use this guide:

• As a checklist of *SNOMED CT* services necessary to meet the needs of their users;

• For advice on known pitfalls when implementing clinical terminologies;

• To assist decisions on technical approaches to design and implementation of applications that use *SNOMED CT*.

Purchasers of healthcare information systems should use this guide:

• As a checklist when specifying procurement requirements for applications that use *SNOMED CT*;

• As a starting point for the evaluation of the *SNOMED CT* related technical features of the available systems.

Healthcare information systems integrators should use this guide:

• As a checklist for confirming the claimed functionality of *SNOMED CT enabled applications*;

• For advice on alternative approaches to integration of *SNOMED CT* related services into a wider information system.

Information systems departments and project teams should use this guide:

• As a checklist for the *SNOMED CT* related functionality needed to meet the requirements of their users;

• For advice on alternative approaches to delivery

**Standards designers and developers**

Standards designers and developers should use this guide:

• To enhance their technical understanding of the described standards and their relationship when implemented together;

• As a point of reference when updating or designing new artifacts including implementation guides

Scope

The primary scope of this implementation guide is to provide guidance for the use of SNOMED CT in the HL7 V3 Clinical Statement Pattern, especially as used within the CDA R2 standard. The guide will be useful to those constructing content based on the Clinical Statement Pattern, representing clinical information from various HL7 domains including Structured Documents (CDA release 2), Patient Care, Orders and Observations and models using the Clinical Statement Common Message Element Types (CMET[[2]](#footnote-3)).

The guidance in this document should also be applied to the use of SNOMED CT in other HL7 V3 models that share features with the Clinical Statement Pattern, unless domain specific requirements prevent this.

While other code systems (such as LOINC, ICD-9 and ICD-10) may be preferred or even required in some situations, these situations are outside the scope of this current version of the guide. Where a particular constraint profile requires the use of other code systems, that profile should complement and not contradict recommendations stated here.

How to read this document

Following this introduction (Section 1) this guide contains both normative and informative sections.

Section 1 (informative) covers the background, suggested audience and describes the documentation conventions used in the remainder of the document.

Section 2 (normative) provides detailed guidance on dealing with specific overlaps between RIM and SNOMED CT semantics. It contains normative recommendations for use of SNOMED CT in relevant attributes of various RIM classes including Acts, ActRelationships and Participations. It also contains a subsection providing recommendations on Context conduction. Each subsection consists of:

* A brief introduction to the item;
* An explanation of the potential overlap;
* A statement of rules and guidance on usage;
* A supporting discussion and rationale.

Section 3 (informative) provides a set of examples and patterns for representing common clinical statements. The approaches taken are consistent with the normative statements in Sections 2 and 5, as well as work being done within HL7 domain committees.

Section 4 (informative) describes normal forms, including their use with SNOMED CT. It also discusses considerations for transformations between various common representations and SNOMED CT or HL7 RIM based normal forms.

Section 5 (normative) contains a number of constraints on SNOMED CT concepts applicable to relevant attributes in each of the major classes in the Clinical Statement Pattern. These normative constraints are presented as a series of tables in section 5.3. This section also summarizes the benefits and weaknesses of the constraints offered (see also Appendix D).

Appendix A (informative) provides a general discussion of the potential overlaps between an information model and a terminology model and the pros and cons of various possible approaches to managing these overlaps.

Appendix B (reference) provides references to relevant documents including SNOMED CT specifications and also outlines the compositional grammar used to express many of the examples in this document.

Appendix C (informative) notes the changes to this document since the last ballot draft.

Appendix D (informative) provides a more detailed discussion of approaches to normative constraints on SNOMED CT and identifies the need for further development of formal vocabulary rules to support this.

Appendix E

This document includes hyperlinks to external documents as well as to other sections within this document, which can be identified by the cited section number listed at the end of the reference, e.g. (§ B.3) for Appendix B Section 3.

In this document references to SNOMED CT concepts and expressions are represented using the SNOMED CT Compositional Grammar. An extension to this grammar is used in this document to represent constraints on use of SNOMED CT concepts and expressions.

It is recommended to review the material on the extended grammar, which is explained in [SNOMED CT Compositional Grammar - extended (§B.3)](file:///C:\\Users\\Lisa\\Documents\\05%20Professional\\90%20HL7\\00%20Standard%20-%20TermInfo\\TermInfo%20Course%2020130506\\html\\infrastructure\\terminfo\\terminfo.htm" \l "TerminfoAppendRefsGrammar), together with references to the SNOMED CT source material related to the underlying logical model before reading the main part of this guide. Reviewing **Table 12 (Compositional Grammar extension - Constraint symbols)** should be especially useful, as it provides the meaning of the symbols that are used in the compositional grammar examples that are provided throughout this document.

Conformance statements are identified in the normative sections using this convention:

Background

Semantic interoperability of clinical information

One of the primary goals of HL7 Version 3 is to deliver standards that enable semantic interoperability. Semantic interoperability is a step beyond the exchange of information between different applications that was demonstrated by earlier versions of HL7. The additional requirement is that a receiving application should be able to retrieve and process communicated information, in the same way that it is able to retrieve and process information that originated within its own application. To meet this requirement the meaning of the information communicated must be represented in an agreed upon, consistent and adequately expressive form.

Clinical information is information that is entered and used primarily for clinical purposes. The clinical purposes for which information may be used include care of the individual patient and support to population care. In both cases there are requirements for selective retrieval of information either from within a single patient record or from the set of records pertaining to the population being studied. Meeting these requirements depends on consistent interpretation of the meaning of stored and communicated information. This requires an understanding of the varied and potentially complex ways in which similar information may be represented. This complexity is apparent both in the range of clinical concepts that need to be expressed and the relationships between instances of these concepts. One way to organize information is in templates, which do not carry semantic meaning. The semantics must be communicated through the structure and vocabulary of the data itself.

Delivering semantic interoperability in this field presents a challenge for traditional methods of data processing and exchange. Addressing this challenge requires an established way to represent reusable clinical concepts and a way to express instances of those concepts within a standard clinical record, document or other communication.

Reference Information Model

The HL7 Version 3 Reference Information Model ([RIM](http://www.hl7.org/implement/standards/rim.cfm)) provides an abstract model for representing health related information. The RIM comprises classes which include sets of attributes and which are associated with one another by relationships.

Documentation of RIM classes, attributes and relationships and the concept domains specified for particular coded attributes provide standard ways to represent particular kinds of information. The RIM specifies internal vocabularies for some structurally essential coded attributes but also supports use of external terminologies to express more detailed information. SNOMED CT is one of the external terminologies that may be used in HL7 communications.

Clinical Statements

The RIM is an abstract model and leaves many degrees of freedom with regard to representing a specific item of clinical information. The HL7 Clinical Statement project has developed and is now maintaining a more refined model for representing discrete instances of clinical information and the context within which they are recorded.

The HL7 Clinical Statement Pattern is a refinement of the RIM, which provides a consistent structural approach to representation of clinical information across a range of different domains. However, neither the RIM nor the Clinical Statement Pattern place any limits on the level of clinical detail that may be expressed in a structured form. At the least structured extreme, an HL7 Clinical Document Architecture (CDA) document may express an entire encounter as text with presentational markup, without any coded clinical information. An intermediate level of structure might be applied when communicating a clinical summary with each diagnosis and operative procedure represented as a separate coded statement. Requirements for more comprehensive communication of electronic health records can be met by using the Clinical Statement Pattern to fully structure and encode each individual finding and/or each step in a procedure.

The Clinical Statement Pattern is the common foundation for the CDA Entries in HL7 Clinical Document Architecture release 2 and for the clinical information content of HL7 Care Provision messages. Details of the Clinical Statement Pattern can be found in the Universal Domains section of the HL7 Version 3 Normative Edition ([2013 version](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=306)). The clinical statement models used in CDA R2 are based on an early pre-publication version of the Clinical Statement Pattern (the closest available version is published in the [May 2005 ballot package](http://www.hl7.org/v3ballotarchive_temp_EAFE5005-1C23-BA17-0C14FAD30AD1332A/v3ballot2005MAY/html/welcome/environment/index.htm) under Common Domains – available to members).

Even within the constraints of the Clinical Statement Pattern, similar clinical information can be represented in different ways. One key variable is the nature of the code system chosen to represent the primary semantics of each statement. The other key variable is the way in which overlaps and gaps between the expressiveness of the information model (clinical statement) and the chosen terminology are reconciled.

Data Types

HL7 has defined “abstract” data types for use in HL7 models, and these definitions have been revised. The two versions are known as Release 1 (R1) and Release 2 (R2) – details can be found in the HL7 Version 3 Normative Edition ([2013 version](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=306)). While R2 addresses concerns some users have had with the original version (R1), the R1 data type is normative for many existing specifications, including CDA R2. Of particular interest for this implementation guide is the Concept Descriptor (CD) data type (present in both versions), which is used for the representation of coded data (in SNOMED CT or other terminologies), and is the most general coded data type. The CD data types provide for the representation of post-coordinated expressions, although by different mechanism in the two versions.   
  
The Data Types R1 specification, which is used by CDA R2 (and other earlier versions of V3), supports representation of post-coordination using “qualifier” elements (one or more) which encode attribute-value pairs that “qualify” (or modify) a primary concept (code) and are represented as an XML structure. Data Types R2 instead uses an arbitrary length string representation for the “code” attribute, which allows post-coordination to be represented by the grammar (if any) that is defined for that purpose by the terminology (code system) itself. In the case of SNOMED CT, this is the Compositional Grammar.  
  
In this guide examples will be showing the use of both Data Types R1 and R2, with the R1 examples being directly applicable to use in CDA R2. Both data types can support translation, though translation is not specifically in scope of TermInfo, as the translational mappings should be to the content represented in the respective data type, regardless of its representation.

Example of CD R1:

Example of CD R2:

Coding and Terminologies

The scope of clinical information is very broad, and this, together with the need to express similar concepts at different levels of detail (granularity), results in a requirement to support a large number of concepts and to recognize the relationships between them.

Several candidate terminologies have been identified at national and international levels. HL7 does not endorse or recommend a particular clinical terminology. However, HL7 is seeking to address the issues raised by combining particular widely-used terminologies with HL7 standards.

This guide focuses on the issues posed by using SNOMED Clinical Terms® (SNOMED CT) with HL7 clinical statements. It includes specific advice on how to specify communications that use SNOMED CT to provide the primary source of clinical meaning in each clinical statement.

Although this guide is specifically concerned with SNOMED CT, it is likely that similar issues will be encountered when considering the use of other code systems within HL7 clinical statements. Therefore some of the advice related to general approaches to gaps and overlaps is more widely applicable.

SNOMED CT

SNOMED CT is a clinical terminology which covers a broad scope of clinical concepts to a considerable level of detail. It is one of the external terminologies that can and will be used in HL7 Version 3 communications. SNOMED CT has various features that add flexibility to the range and detail of meanings that can be represented. These features summarized below are documented in detail in documents listed in SNOMED CT Reference materials (§ B.2 ). The OID value that identifies SNOMED CT when used in HL7 V3 models (in CD and additional coded data types) is "2.16.840.1.113883.6.96".

Logical concept definitions

Each SNOMED CT concept has an associated set of one or more relationships to other concepts, and may be fully defined by these relationships (if the set of relationships is insufficient to fully define the concept, the concept is considered to be primitive).. The following example illustrates the type of logical definitions that are distributed as part of SNOMED CT.

|  |
| --- |
| Example 1. SNOMED CT definition of 'fracture of femur' |
| [ 71620000 | fracture of femur |] is fully defined as...     116680003 | is a | = 46866001 | fracture of lower limb |,     116680003 | is a | = 7523003 | injury of thigh |,       {116676008 | associated morphology | = 72704001 | fracture |,       363698007 | finding site | = 71341001 | bone structure of femur |} |

**NOTE:** This example and many of the other illustrations in this document are expressed using the SNOMED CT compositional grammar. Where relevant this document also uses proposed extensions to this grammar to represent constraints on use of SNOMED CT concepts and expressions. The extended grammar is explained in [SNOMED CT Compositional Grammar - extended (§ B.3)](file:///C:\\Users\\Lisa\\Documents\\05%20Professional\\90%20HL7\\00%20Standard%20-%20TermInfo\\TermInfo%20Course%2020130506\\html\\infrastructure\\terminfo\\terminfo.htm" \l "TerminfoAppendRefsGrammar), together with references to the SNOMED CT source material.

Formal rules for post-coordinated expressions

When a SNOMED CT concept is used to record an instance of information, it can be refined in accordance with the SNOMED CT Concept Model to represent more precise meanings.

* For example, it might be necessary to record a "compression fracture of the neck of the femur".
  + SNOMED CT does not contain a concept identifier for this specific type of fracture at this precise location. However, the post-coordination rules allow refinement of the "finding site" and "associated morphology" attributes in the definition of the concept "fracture of femur" (see above example).
  + Therefore the required information can be recorded by refining the concept "fracture of femur" with the site "neck of femur" and the morphology "compression fracture".

The result of a refinement is referred to as a *post-coordinated expression*. A post-coordinated expression conforms to an abstract logical model specified in the "SNOMED CT Technical Implementation Guide" (see SNOMED CT Reference materials (§ B.2)). The same guide also specifies a compositional grammar for representing these expressions in a way that is both human-readable and computer-processable (see also SNOMED CT Compositional Grammar - extended (§ B.3)). The example below uses this grammar to represent a post-coordinated expression for "compression fracture of neck of femur".

|  |
| --- |
| Example 2. Expression representing 'Compression fracture of neck of femur' in SNOMED CT compositional grammar |
| 71620000 | fracture of femur |:     116676008 | associated morphology | =21947006 | compression fracture |     ,363698007 | finding site | =29627003 | structure of neck of femur | |

These expressions can also be accommodated within the HL7 Concept Descriptor (CD) data type which may be applied to various coded attributes in HL7 specification. For example, the SNOMED CT expression indicating a "compression fracture of neck of femur" can be represented as shown in the following example:

|  |
| --- |
| Example 3. Expression representing 'Compression fracture of neck of femur' in CD data type |
| **CDA R2 and R1 CD data type**  <code code="71620000" codeSystem="2.16.840.1.113883.6.96"  displayName="fracture of femur">  <originalText>  < Compression fracture of neck of femur>  </originalText>  <qualifier>  <name code="363698007" displayName="finding site"/>  <value code="29627003" displayName="structure of neck of femur"/>  </qualifier>  <qualifier>  <name code="116676008" displayName="associated morphology"/>  <value code="21947006" displayName="compression fracture"/>  </qualifier>  </code>    **R2 CD data type**  <code code="71620000 | fracture of femur |:116676008 | associated morphology | =21947006 | compression fracture |,363698007 | finding site | =29627003 | structure of neck of femur |"  codeSystem="2.16.840.1.113883.6.96"/>  <originalText>  < Compression fracture of neck of femur>  </originalText> |

A logical model for representation of semantic context

SNOMED CT "clinical finding" and "procedure" concepts have assumed (default) contexts which apply if they are used in a record without an explicit context.

1. Default Context:

The default context for a [ <<404684003 | **clinical finding** |] is that the finding is asserted to be present in the person who is the subject of the record at the current time (or at a specified time).

o E.g. When the concept [ 233604007 | pneumonia |] is used in a clinical record it is assumed to mean that pneumonia was found to be present in the subject of the record either at an explicitly stated effective time or at the current time when the statement was made.

The default context for a [ <<71388002 | **procedure** |] is that the procedure is asserted to have been done to the person who is the subject of the record, at the current time (or at a specified time).

o E.g. When the concept [ 80146002 | appendectomy |] is used in a clinical record it is assumed to mean that an appendectomy was done on the subject of the record either at an explicitly stated effective time or at the current time when the statement was made.

2. Overwriting default context:

The default context for a [ <<404684003 | **clinical finding** |] can be overridden by an explicit representation of context. Alternative contexts include:

* Finding contexts such as: present, absent, unknown, goal, risk, etc.
* Subject relationship contexts such as: family member, mother, father, sibling, contact, etc.
* Temporal contexts such as: past, current, recent, etc.

The default context for a [ <<71388002 | **procedure** |] can be overridden by an explicit representation of context. Alternative contexts include:

• Procedure contexts such as: requested, planned, in progress, done, not done, not to be done, etc.

• Subject relationship contexts: as above for findings

• Temporal contexts: as above for findings.

Explicit context may be represented either in a pre-coordinated form using a concept that is a subtype of [ <<243796009 | situation with explicit context | ] or by using a post-coordinated expression.

2.1 Using Pre-coordination to overwrite default context:

The following concepts provide examples of pre-coordinated concepts that include explicit context:

* [ 297243001 | family history of pernicious anemia | ]
* [ 399211009 | past history of myocardial infarction | ]
* [ 160274005 | no family history diabetes | ]
* [ 168748001 | mammography requested | ]

No pre-coordinated concept exists for “Patient has goal of being able to walk”

2.2 Using Post coordination to overwrite default context:

The following expressions illustrate ways in which in post-coordination can be applied to represent explicit context:

* [ 281666001 | family history of disorder |: 246090004 | associated finding | = 84027009 | pernicious anemia | ]
* [ 417662000 | past history of clinical finding |: 246090004 | associated finding | = 22298006 | myocardial infarction | ]
* [ 281666001 | family history of disorder |: 408729009| finding context | = 410516002 | known absent |, 246090004 | associated finding | = 73211009 | diabetes mellitus | ]
* [ 129125009 | procedure with explicit context | : 363589002 | associated procedure |= 71651007 | mammography |: 408730004 | procedure context | = 385644000 | requested | ]
* [ 413350009 | finding with explicit context |: 246090004 | associated finding | = 282144007 | able to walk |, 408729009 | finding context | = 410518001 | goal | ]

2.3 Example in CDA:

Family history of pernicious anemia

Mammography requested

Depending on how the information model is set up, selection of pre-coordination or post-coordination using the terminology or the information model is important. For example, where the information model supports the use of qualifiers, pre-coordination of concepts that overlap with said qualifiers should be disallowed.

Transformation and comparison of alternative representations

SNOMED CT expressions can be compared by applying "normal form" transformations that make use of logical concept definitions. These transformations generate the same normal form when applied to two expressions that logically have the same meaning. For more information on transformation to normal forms refer to [Normal Forms (§ **Error! Reference source not found.**)](file:///C:\Users\Lisa\Documents\05%20Professional\90%20HL7\00%20Standard%20-%20TermInfo\TermInfo%20Course%2020130506\html\infrastructure\terminfo\terminfo.htm#TerminfoAppendRefsGrammar)

* When the transformation rules are applied to either of the following two expressions:
  + [ 297243001 | family history of pernicious anemia |]
  + [ 281666001 | family history of disorder |: 246090004 | associated finding | = 84027009 | pernicious anemia |]

the following normal form is generated

* + 243796009 | situation with explicit context | :  
    { 246090004 | associated finding | = 84027009 | pernicious anemia |, 408729009 | finding context | = 410515003 | known present |,  
    408731000 | temporal context | = 410512000 | current or specified |,  
    408732007 | subject relationship context | = 303071001 | person in the family | }

This means that these two expressions are equivalent - they mean the same thing, and are computably equivalent, as they transform to the same normal form.

Potential conflicts when using SNOMED CT within HL7

The expressivity of SNOMED CT is one of its strengths. However this also leads to cases where overlaps may occur with semantics that may also be represented by an information model such as the HL7 RIM. For example:

* a single SNOMED CT coded expression can represent a meaning that the HL7 RIM could also represent using a combination of several coded attributes or related classes;
* HL7 RIM semantics may modify the default assumptions about the meaning of a SNOMED CT expression;
* HL7 RIM semantics may contradict the meaning expressed by a SNOMED CT expression.

There is a requirement for clear rules and guidance on these overlaps to minimize the risk that alternative representational forms, may lead to duplication, ambiguity and erroneous interpretation.

Guidance

This guide identifies gaps between the SNOMED CT terminology model and the HL7 RIM model and areas in which they overlapas a potential source of inconsistency and variablility in representation. Both overlaps and gaps will require identifying them and then either adjusting the information model or terminology model, but ideally not both at the same time to address them. Bridging gaps may require new functionality, while overlaps can be managed by adjusting how information and terminology model are used together to meet the common goal of semantic interoperability. Gaps will be identified as people implement the standards and are not specifically addressed further in the document. Identified gaps should be taken back to the appropriate standards organizations such as HL7 or IHTSDO.

The guide identifies options for use of SNOMED CT concepts, in both pre and post-coordinated forms in various attributes of HL7 RIM classes. The primary focus is on the RIM class clones used in the HL7 Clinical Statement Pattern. However, the general principles of the advice are also applicable to many RIM class clones used in constrained information models that form part of other HL7 specifications and standards.

In some situations, the features of HL7 Version 3 and SNOMED CT dictate a single way to utilize these two models together. Where this is true, the guide contains a single recommended approach which is normative, based on referenced pre-existing standards.

In other situations, there are several possible ways to combine HL7 and SNOMED CT to resolve a gap or an overlap. In these cases, the advantages and disadvantages of each option are evaluated. The next section explains the criteria used in this evaluation.

Requirements and Criteria

The intent of this section is to describe the requirements and criteria used to weigh various instance representations in order to arrive at the recommendations in this specification.

As discussed above, there are situations where there are several possible ways to combine HL7 and SNOMED CT to resolve a gap or an overlap. In these cases, the advantages and disadvantages of each option are evaluated using the criteria stated here. The guide recommends against approaches that have a disproportionate balance of disadvantages and are unlikely to deliver semantic interoperability. In some cases, the guide contains advice on several alternative approaches and the recommended approach may be based on prior implementation in accordance with criterion 4 below.

The following criteria have been identified to address these requirements:

1. Understandable, Reproducible, Useful: Normative statements and recommendations in this guide:

* Must be widely understandable by implementers who are familiar with the use of SNOMED CT and HL7 V3.
* Must be able to be applied consistently.
* Must cover common scenarios, but need not cover all conceivable cases of SNOMED CT/HL7 overlap.

1. Transformable into a common "Model of Meaning": Normative statements and recommendations in this guide should result in instance representations that can be converted, by following a set of computationally tractable rules, into a single normal form (known as the "Model of Meaning").[[3]](#footnote-4)

* Where this implementation guide supports multiple representations of the same meaning, they are all transformable (using appropriate procedures/tooling) to one another and/or into a single Model of Meaning.
* Representations that can be reused consistently in many contexts (problem list, family history, chief complaint, medical history, documentation of findings, final diagnosis, etc.) are preferred to representations that are specific to a particular context.
* Representation of data, precisely in the form in which it was captured in the application of origin (also referred to as the "Model of Use"), is not recommended unless the representation is transformable into a common Model of Meaning.

1. Practical: Tractable tooling/data manipulation requirements

* We can confirm with tools that an instance conforms to the recommendations.
* Existing tools and applications, either in their current form or with reasonable enhancements, can produce the recommended instances.
* Model does not require a combinatorial explosion of pre-coordinated concepts. For example, the model should not require the creation of the cross product of "Allergic to" and all drugs and substances.

1. Not superfluous: Where more than one approach appears to be viable and broadly equal in respect of the criteria above a single approach is recommended to avoid unnecessary divergence.

* Where one approach has already been successfully implemented and the other has not, the implemented approach is recommended.
* Optionality is restricted where possible to simplify the delivery of semantic interoperability.

Asserting Conformance to this Implementation Guide

This specification defines constraints on the use of SNOMED CT in an HL7 CDA R2 or other V3 instance. HL7 V3 provides a mechanism to reference a template or implementation guide that has been assigned a unique identifier, by referencing the guide's identifier in the InfrastructureRoot.templateId field. The formal identifier for this guide is **'2.16.840.1.113883.10.5'.**

The following example shows how to formally assert the use of this implementation guide. Use of the templateId indicates that the HL7 V3 instance not only conforms to the base specification, but in addition, conforms to constraints specified in this implementation guide.

|  |
| --- |
| Example 4. Use of the templateId element to assert conformance to this guide |
| <V3Instance>  <templateId root='2.16.840.1.113883.10.5'/>  ...  </V3Instance> |

**NOTE:** The normative constraints in this guide are expressed in a technology-neutral formalism. The key words **"SHALL"**, **"SHALL NOT"**, **"SHOULD"**, **"SHOULD NOT"**, **"MAY"**, and **"NEED NOT"** in this document are to be interpreted as described in the HL7 Version 3 Publishing Facilitator's Guide (available to members at the [HL7 ballot site](http://www.hl7.org/participate/onlineballoting.cfm?ref=common)). Various options for computable representations are under consideration and non-normative example implementations may be provided in the future.

# Guidance on Overlaps between RIM and SNOMED CT Semantics

Introduction

When used together, SNOMED CT and HL7 often offer multiple possible approaches to representing the same clinical information. This need not be a problem where clear rules can be specified that enable transformation between alternative forms. However, unambiguous interpretation and thus reliable transformation depends on understanding the semantics of both the RIM and SNOMED CT and having guidelines available to manage areas of overlap or apparent conflict.  
  
**Note:** See Appendix A (General Options for Dealing with Potential Overlaps) for further information on overlaps in semantics between an information model and a terminology model and discussion of the advantages and disadvantages of requiring, prohibiting or allowing either or both of two overlapping forms of representation. This discussion forms the basis for the rules and guidance provided in this chapter for the specific RIM attributes.

Table 1: Key to phrases used in this section

|  |  |  |
| --- | --- | --- |
| Phrase | Meaning | Examples |
| *[RimClass]* class | The HL7 Version 3 Reference Information Model class named *[RimClass]*. | "Act class" - refers to the RIM class Act as specified in the RIM. |
| *[RimClass]* class specialization | Any class in the RIM that is a specialization of the named *[RimClass]*. | "Act class specialization" - refers to any RIM class that is modeled as a specialization of Act in the RIM. For example, the "Observation class". |
| *[RimClass]* class clone | A class in a constrained information model (e.g. an DMIM, RMIM, HMD or template) that is derived from one of the following:   * the named *[RimClass]* * a *[RimClass]* class specialization. | "Observation class clone" - refers to any design time constraint on the Observation class.  This may be part of a domain model, a message design specification or a template. |
| *[RimClass]* class instance | An instance of information structured in accordance with one of the following:   * the named *[RimClass]* * a *[RimClass]* class specialization * a *[RimClass]* clone. | "Act class instance" - refers to an instance of run time information structured in accordance with either the Act class or any specialization or constraint applied to the Act class. |
| *[RimClass]*.*[Attribute]* | The named *[Attribute]* in any of the following:   * the named *[RimClass]* * a *[RimClass]* class specialization * a *[RimClass]* clone * a *[RimClass]* instance | "Act.code" refers the "code" attribute of either the Act class itself or of an Act class specialization (.e.g. Observation, Procedure). In contrast, "Observation.code" refers specifically to the "code" attribute of an Observation class. |
| SNOMED CT expression | One or more SNOMED CT concept identifiers used to represent meaning. | See the examples for "Pre-coordinated expression" and "Post-coordinated expression" in the following two rows. |
| Pre-coordinated expression | A SNOMED CT expression containing only one SNOMED identifier. In an HL7 attribute any of the coded data types can be used to represent a pre-coordinated expression. | <value code=195967001 displayName=”asthma" codeSystem="2.16.840.1.113883.6.96"/> |
| Post-coordinated expression | A SNOMED CT expression containing more than one SNOMED identifier. In an HL7 attribute the Concept Descriptor (CD) data type is used to represent a post-coordinated expression. | <value codeSystem="2.16.840.1.113883.6.96" code="195967001 | asthma |:246112005 | severity | =24484000 | severe |"/> |

Attributes

Act.classCode

The Act.classCode is a structural code which specifies the general nature of the Act. Its values are drawn from the HL7 ActClass code system.

Potential Overlap

The RIM definition of Act.classCode is “The major class of Acts to which an Act-instance belongs”. Accordingly, Act.classCode has the effect of specializing the Act class, and therefore it also necessarily constrains the concept domains that apply to other coded attributes of that class (particularly Act.code). If a SNOMED CT expression is used to encode the value of Act.code or any of the coded attributes of the class, the meaning of the expression must be appropriate to the constrained conceptual space that is established by the value of Act.classCode (which should also be consistent with the vocabulary binding to a particular concept domain or value set).

Rules and Guidance

The concept domain constraints applicable to specific SNOMED CT encoded attributes of different HL7 classes are specified in SNOMED CT Concept Domain Constraints (§ 5).

Discussion and Rationale

The rationale for the concept domain constraints applicable to particular HL7 classes are discussed in SNOMED CT Concept Domain Constraints (§ 5). This is supplemented by detailed aspects of issues with a vocabulary specification formalism (§ Appendix D), which discusses different ways in which constraints may need to be expressed to take account of the SNOMED CT terminology model.

Act.code (applicable to all Act class specializations)

The Act.code represents a refinement of the Act.classCode and expresses the specific nature of the Act.

Potential Overlap

A SNOMED CT expression can be used in the Act.code to represent the nature of the action (e.g. using concepts from the Procedure hierarchy).

Rules and Guidance

The following rules are intended to support validation and consistent interpretation of the Act.code attribute where SNOMED CT is used.

1. In a constrained information model or template that permits or requires the use of SNOMED CT to represent the nature of an Act class clone:

* the Act.code attribute SHOULD permit the use of the Concept Descriptor (CD) data type.
  + This is required to allow inclusion of post-coordination where appropriate (via qualifiers in CDA R2 using the R1 CD datatype, and full compositional grammar expressions with the R2 CD datatype).
* the Act.code attribute MAY be constrained to an HL7 data type that prohibits qualifiers, only if there is known to be no requirement for representation of meanings that might require the use of post-coordinated expressions.

1. In an Act class instance where the Act.code attribute is a SNOMED CT expression

* the expression SHOULD represent a type of [ <<363787002 | observable entity |] or [ << 71388002 | procedure |], with application of the SNOMED CT Context Model when appropriate.

Discussion and Rationale

The use of Act.code in Act class specializations other than Observation is generally straightforward, as described above.

**Note:** Additional guidance for the Observation class (a specialization of Act) is provided below in section 2.2.3.

Observation.code and Observation.value

Follow 2.2.2.2Rules and Guidance when using SNOMED CT in the Act.code attribute of Act class specializations other than Observation. This section 2.2.3 provides additional guidance for using SNOMED CT in the Observation.code and Observation.value attributes.

Potential Overlap

A SNOMED CT expression (a single concept identifier, or, when required, a post-coordinated exppression) can be used in Observation.code to represent the nature of the observation (using concepts from the Observable entity or Procedure hierarchy). For specific implementations it is often preferred to constrain the Observation.code value set to a predefined set of pre-coordinated concepts.

In cases where an observation results in a non-numeric result this can also be represented using a SNOMED CT expression. Actions involving measurement of a quantity or observation of a specified quality can readily be represented using this pair of attributes. The SNOMED CT context model may be applied to Clinical findings.

Some kinds of observation are typically expressed in a way that does not specify the observation action but merely asserts a result (or finding). In these cases the asserted result is fully specified and does not require a detailed indication of the action taken (e.g. "abdomen tender", "past history of renal colic", etc.). SNOMED CT supports representation of these assertions in a single expression using concepts from the [ <<404684003 | clinical finding |] and [ 413350009 | finding with explicit context |] hierarchies.

Several different ways of representing the same information exist using different combinations of the Observation.code and Observation.value. Unconstrained use of the alternatives presents a major challenge for computation of semantic equivalence and for safe interpretation of observations origination from different applications and users. For example the following instances could reasonably represent the same case:

* <observation>  
   <code code=[Examination]/>  
   <value code=[Abdomen tender]/>  
   ...  
  </observation>
* <observation>  
   <code code=[Abdominal examination]/>  
   <value code=[Tenderness]/>  
   ...  
  </observation>
* <observation>  
   <code code=[Abdominal tenderness]/>  
   <value code=[found]/>  
   ...  
  </observation> (Note: this last example is violating TermInfo recommendations)

Rules and Guidance

The following rules are intended to support validation and consistent interpretation of particular combinations of the Observation.code and Observation.value attributes where SNOMED CT is used. The general rules and guidance for the use of Act.code also apply, as described above in section 2.2.2.2.

##### Recommended (normative) rules

1. In a constrained information model or template that permits or requires the use of SNOMED CT to represent the result of an Observation class clone:

* The vocabulary constraint contained in the vocabulary declaration of the Observation.code attribute SHALL permit the use of the code "[ASSERTION](#Observation_code_ASSERTION)" (from the HL7 ActCode code system [2.16.840.1.113883.5.4]).
* the Observation.value attribute SHOULD permit the use of the Concept Descriptor (CD) data type.
  + This is required to allow inclusion of post-coordination where appropriate (via qualifiers in CDA R2 using the R1 CD datatype, and full compositional grammar expressions with the R2 CD datatype).
* the Observation.code and Observation.value attributes MAY be constrained to a data type that prohibits qualifiers, only if there is known to be no requirement for representation of meanings that might require the use of post-coordinated expressions.

1. In an Observation class instance where the Observation.code attribute is a SNOMED CT expression:

* the expression SHOULD represent a type of [ <<363787002 | observable entity |] or [<<386053000 | evaluation procedure |],   
  with application of the SNOMED CT Context Model when appropriate.

1. In an Observation class instance where the Observation.code is the HL7 code "ASSERTION" and the Observation.value is represented by a SNOMED CT expression:

* the concept represented SHALL be a type of [ <<404684003 | clinical finding |], [ <<413350009 | finding with explicit context |] or [ <<272379006 | event |], with application of the SNOMED CT Context Model when appropriate.

1. An Observation class instance in which the Observation.value is a SNOMED CT expression representing a [ <<404684003 | clinical finding |] or a [ <<413350009 | finding with explicit context |] SHALL NOT contain an Observation.code which when interpreted with the Observation.value yields a meaning that is substantially different from the meaning implied if the Observation.code was "ASSERTION".

* For example, an Observation.code meaning "Past history" or "Family history" may substantially alter the interpretation of a [ <<404684003 | clinical finding |] and should not be used in this way. Instead the SNOMED CT context model should be used to capture these significant differences in meaning.

##### Deprecated or non-recommended forms

1. In an Observation class instance where the Observation.code attribute is a SNOMED CT expression representing a [ <<404684003 | clinical finding |] or [ <<413350009 | finding with explicit context |], if the Observation.value is omitted, the Observation SHALL be interpreted as semantically equivalent to the same SNOMED CT expression in the Observation.value attribute with the Observation.code "ASSERTION" (see point 3 above).

* This deprecated form of representation is permitted to support backward compatibility with existing implementations.
* For example:
  + <observation><code code=[ 195967001 | asthma |]/>...</observation>
  + *is treated as equivalent to*
  + <observation><code code="ASSERTION"/><value code=[ 195967001 | asthma |]/>...</observation>

1. An Observation class instance in which the Observation.code is a SNOMED CT expression representing a [ <<404684003 | clinical finding |] or [ <<413350009 | finding with explicit context |] SHALL NOT contain an Observation.value attribute.

* If a value attribute is applied to a [ <<404684003 | clinical finding |] there are multiple possible interpretations of what that value means. For example, the possible meanings of a value applied to a clinical finding such as [ 195967001 | asthma |], [ 195114002 | acute left ventricular failure |] or [ 254838004 | carcinoma of breast |] might include severity, stage, duration, certainty, presence or absence. Thus in this context, the meaning of the value is ambiguous and open to misinterpretation. Further more, such misinterpretation might fundamentally alter the intended meaning. The SNOMED CT Concept Model and HL7 attributes provide ways to explicitly state these nuances of meaning. Therefore use of the non-specific value attribute is not appropriate.
* In contrast, a value applied to an [ <<363787002 | observable entity |] clearly represents the observed quantitative or qualitative value of the specified entity. Similarly a value applied to a [ <<386053000 | evaluation procedure |] clearly represents the quantitative or qualitative result of that measurement.

1. An Observation class instance in which the Observation.value is a SNOMED CT expression representing a [ <<404684003 | clinical finding |] or a [ <<413350009 | finding with explicit context |] MAY contain an Observation.code other than "ASSERTION" provided that the interpretation of the Observation.code together with the Observation.value does not yield a meaning that is substantially different from the meaning implied if the Observation.code was "ASSERTION". Observations of this type SHOULD be interpreted as having a meaning that is equivalent to the meaning of the same Observation.value when used with the Observation.code "ASSERTION".

* This deprecated form of representation is permitted to support backward compatibility with existing implementations.
* For example:
  + <observation><code code=[Abdominal examination]/><value code=[Abdomen tender]/>...</observation>
  + *does not differ significantly from the asserted observation ...*
  + <observation><code code="ASSERTION"/><value code=[Abdomen tender]/>...</observation>
* In addition, the same Observation class instance can separately be interpreted to determine that an "abdominal examination" was carried out.
  + In the preferred representation this information would be expressed in a separate Observation class instance because it relates to a general examination procedure which may have resulted in several distinct assertions.

Discussion and Rationale

In some cases the way that the Observation.code and Observation.value attributes are populated and interpreted has led to extensive discussions which are summarized below.

A clinical record consists of statements related directly or indirectly to the health of a patient. Some statements relate to actions taken or requested as part of the provision of care. These actions may include procedures, investigations, referrals, encounters, supply and administration of medication. In the case of these statements, SNOMED CT expressions representing [ <<71388002 | procedure |] concepts provide appropriate content for the Observation.code attribute of the relevant Observation class specialization.

Other statements in a clinical record relate to information found or derived in a variety of ways during the delivery of care. These statements can be referred to as “statements about clinical findings”. The way in which “statements about clinical findings” are represented has been a source of considerable discussion within HL7. This discussion focuses on the way in which the coded representation of such statements is expressed in the Observation.code and Observation.value attributes of the Observation class.

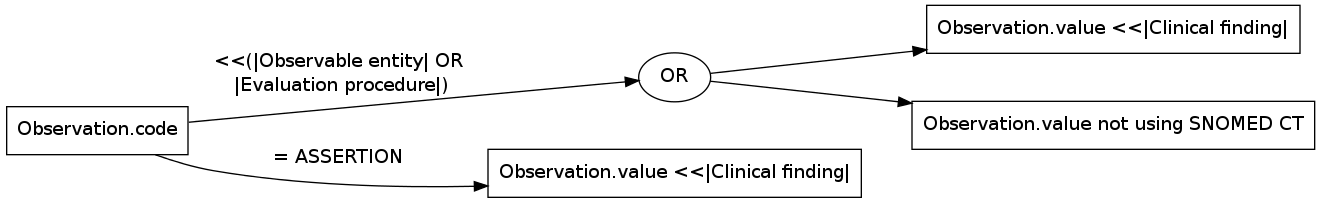


Figure 1: Options for Observation.code

Statements about clinical findings can be divided into two categories.

*A) Statements about findings in which two facets are clearly distinct*

* (1) The action taken to make the finding (and/or the property about which the property was observed)
* (2) The result of the observation

Examples:

* *Measurement of blood hemoglobin (1)* = 14 g/dl (2)
  + This example follows the formal RIM semantics.
* *Body weight (1)* = 75 Kg (2)
  + This example is not in line with strict interpretation of the formal RIM definition in which the Observation.code is the action taken to make the observation. However, it is a more familiar form in real-world clinical statements about many observations. A possible bridge between these two views is to regard the name of the property observed (e.g. [ 27113001 | body weight |]) as implying the action to measure or observe that property (e.g. [ 39857003 | weighing patient |]).

*B) Statements about findings that are often captured as a single “nominalized” expression*

* The term "nominalized" is used to indicate a statement reduced to a single name (or term) which can then be coded as a single expression.
* The fact that a statement is often nominalized does not mean it consists of a single atomic item of information. Many such statements can be readily divided into several identifiable facets. However, unlike statements of type A, there are different views on how the semantics of the facets of these statements might be divided between the “code” and/or “value” attributes of the observation class.

Examples: The following examples are statements that might appear in clinical records. In each case they assert a finding in relation to the “record target”. Each of these examples illustrates a particular aspect of the potential for nominalizing a statement.

*Record target …*

* has a fracture of her left femur
* is complaining of pain in his right knee for the last two days
* reports that she had a heart attack in January 2001
* may have pernicious anemia
* has an aortic ejection murmur
* has normal visual acuity

Type (A) statements can be readily represented using the Observation class as documented in the RIM. However, a variety of options have been considered for type (B) "nominalized" statements. These options vary in the use they make of the Observation.code and Observation.value attributes.

In summary the options considered included

* Using only one of the attributes to represent the nominalized meaning of the statement and omitting the other attribute.
* Applying a fixed value to one of the attributes and using the other one to represent the nominalized meaning of the statement.
* Using the value to represent the nominalized meaning of the statement while allowing the other code to operate independently to track the question or process without affecting the meaning of the result to the observation.
* Creating a separate class for nominalized statement rather than using the Observation class.

A joint meeting of the HL7 Modeling and Methodology and Vocabulary Technical Committees was asked to rule on the validity of these options. The discussions of these committees led to a decision to clarify the RIM definition of the Observation class. The clarification made clear that both Observation.code and Observation.value should be present and should be interpreted together rather than independently.

As a result the preferred option is for a fixed Observation.code value "ASSERTION" to be used and for the meaning of the nominalized statement to be conveyed in the Observation.value. All other options are deprecated but some of these are permitted for backward compatibility.

The options permitted for backward compatibility are those that are known to be in use and these are supported as far as possible with transformation rules to allow the preferred form to be derived for comparison. There is a practical limitation to the transformation rules where code and value are used independently because it may not be possible to confirm computationally whether the code was intended to significantly modify the meaning of the value.

Act.moodCode

The Act.moodCode is a structural code which is defined as "a code distinguishing whether an Act is conceived of as a factual statement or in some other manner as a command, possibility, goal, etc.". Its values are drawn from the HL7 ActMood vocabulary table.

Potential Overlap

The values specified in the ActMood vocabulary partially overlap with SNOMED CT representations of [ 408729009 | finding context |] and [ 408730004 | procedure context |].

* SNOMED CT [ 408729009 | finding context |]:
  + Represents an assertion that the [ 246090004 | associated finding |] is: present, absent, a goal, a risk or an expectation.
  + May also represent an assertion that the presence or absence of a finding is unknown, possible or probable.
  + Applies to:
    - any SNOMED CT expression that represents a [ <<404684003 | clinical finding |].
    - any SNOMED CT expression that represents either a [ <<71388002 | procedure |] or an [ <<363787002 | observable entity |] provided that the expression is combined with a relevant result or value.
  + Is relevant to instances of HL7 Observation classes expressed in "event", "goal", "expectation" and "risk" moods.
* SNOMED CT [ 408730004 | procedure context |]
  + Represents an assertion that the [ 363589002 | associated procedure |] is: "requested", "planned", "started", "done", "cancelled", "not done", "not to be done" or one of several more specific [ <<408730004 | procedure context |] values.
  + May also represent an assertion that it is not known whether the procedure has been done.
  + Applies to any SNOMED CT expression that represents a [ <<71388002 | procedure |] (except where that expression is combined with a relevant result value).
  + Is relevant to:
    - instances of various HL7 Act classes including Procedure, SubstanceAdministration and Supply.
    - instances of the HL7 Observation class except in "intent" moods (including "request" and other subtype of "intent").

#### Rules and Guidance

The following rules ensure validation and consistent interpretation of particular combinations of moodCode and SNOMED CT context. They also specify the context a particular moodCode value applies to a SNOMED CT expression that does not include an explicit representation of context (explicit representations of context can be made either in pre-coordinated concepts or post-coordinated expressions).

1. The moodCode SHALL be present in all Act class instances[4](file:///C:\\Users\\Lisa\\Documents\\05%20Professional\\90%20HL7\\00%20Standard%20-%20TermInfo\\TermInfo%20Course%2020130506\\html\\infrastructure\\terminfo\\terminfo.htm" \l "fn4)
2. If the *code* attribute of an instance of the Observation class, with a moodCode that is neither "intent" (INT) nor a subtype of "intent", is populated with a SNOMED CT expression, this expression MAY include an explicit representation of [ 408729009 | finding context |].

* If the expression does not include an explicit [ 408729009 | finding context |], it SHALL be interpreted as having the default context specified for the relevant moodCode in Table 2.
* If the expression includes an explicit [ 408729009 | finding context |], the context SHALL be compatible with the constraints specified for the relevant moodCode in [Table 3](file:///C:\\Users\\Lisa\\Documents\\05%20Professional\\90%20HL7\\00%20Standard%20-%20TermInfo\\TermInfo%20Course%2020130506\\html\\infrastructure\\terminfo\\terminfo.htm" \l "TableHl7ActMoodFindingContextConstraint). Any Act class instance that does not conform to these constraints SHALL be regarded as an error.

1. If the *value* attribute of an instance of the Observation class is populated with a SNOMED CT expression, this expression MAY include an explicit representation of [ 408729009 | finding context |].

* If the expression does not include an explicit [ 408729009 | finding context |], it SHALL be interpreted as having the default context specified for the relevant moodCode in [Table 2](file:///C:\Users\Lisa\Documents\05%20Professional\90%20HL7\00%20Standard%20-%20TermInfo\TermInfo%20Course%2020130506\html\infrastructure\terminfo\terminfo.htm#TableHl7ActMoodFindingContextDefault).
* If the expression includes an explicit [ 408729009 | finding context |], the context SHALL be compatible with the constraints specified for the relevant moodCode in [Table 3](file:///C:\Users\Lisa\Documents\05%20Professional\90%20HL7\00%20Standard%20-%20TermInfo\TermInfo%20Course%2020130506\html\infrastructure\terminfo\terminfo.htm#TableHl7ActMoodFindingContextConstraint). Any Act class instance that does not conform to these constraints SHALL be regarded as an error.

1. If the *code* attribute of an instance of any Act class (except Observations included in points 2 or 3 above) is populated with a SNOMED CT expression, this expression MAY include an explicit representation of [ 408730004 | procedure context |].

* If the expression does not include an explicit [ 408730004 | procedure context |], it SHALL be interpreted as having the default context specified for the relevant moodCode in [Table 4](file:///C:\Users\Lisa\Documents\05%20Professional\90%20HL7\00%20Standard%20-%20TermInfo\TermInfo%20Course%2020130506\html\infrastructure\terminfo\terminfo.htm#TableHl7ActMoodProcedureContextDefault).
* If the expression includes an explicit [ 408730004 | procedure context |], the context SHALL be compatible with the constraints specified for the relevant moodCode in [Table 5](file:///C:\Users\Lisa\Documents\05%20Professional\90%20HL7\00%20Standard%20-%20TermInfo\TermInfo%20Course%2020130506\html\infrastructure\terminfo\terminfo.htm#TableHl7ActMoodProcedureContextConstraint). Any Act class instance that does not conform to these constraints SHALL be regarded as an error.

1. If a SNOMED CT expression includes an explicit statement of context, this SHALL be validated by the rules stated above and SHALL be interpreted as a restatement or refinement of the meaning specified by the moodCode. The meaning of the SNOMED CT context SHALL NOT be interpreted as an independent compounding semantic modifier.

*For example*  
moodCode="RQO" and Act.code <<129125009 | procedure with explicit contect (situation) |:[ 408730004 | procedure context | = 385644000 | requested | ]  
This means "requested". It does not mean a "request to request".

moodCode="INT" and code=[ 408730004 | procedure context | = 385650005 | organised ]  
This means "organized". It does not mean an "intention to organize".

moodCode="INT" and value=[ 408729009 | finding context | = 410518001 | goal ]  
This is an error. It does not mean an "intention to set a goal".

moodCode="GOL" and value=[ 408729009 | finding context | = 410518001 | goal ]  
This means that a goal is set. It does not mean a "goal to set a goal".

[Table 2](file:///C:\\Users\\Lisa\\Documents\\05%20Professional\\90%20HL7\\00%20Standard%20-%20TermInfo\\TermInfo%20Course%2020130506\\html\\infrastructure\\terminfo\\terminfo.htm" \l "TableHl7ActMoodFindingContextDefault) shows the mapping from moodCode to the default [ 408729009 | finding context |] for concepts that are subtypes of [ 404684003 | clinical finding |]. Table 4shows the mapping from moodCode to default [ 408730004 | procedure context |] for concepts that are subtypes of [ <<71388002 | procedure |].

Table 3 shows the [ 408729009 | finding context |] validation constraints for SNOMED CT expressions based on the moodCode of the containing Act class instance. Table 5 shows the [ 408730004 | procedure context |] validation constraints for SNOMED CT expressions based on the moodCode of the containing Act class instance.

In these tables the symbol "<<" preceding a value indicates that either the value or any subtype of the value is permitted.

The context values in these tables are based on the following assumptions about other attributes in the same Act class instance:

* the HL7 negationInd is omitted from the Act class instance (see Act.negationInd (§ 2.2.10))
* the HL7 uncertaintyCode is omitted from the Act class instance (see Act.uncertaintyCode (§ 2.2.11))
* the HL7 statusCode in the Act class instance has a value that does not influence the context (see Act.statusCode (§ 2.2.5))

If any of these assumptions do not apply then refer to the referenced sections for further information.

Table 2: HL7 Act.moodCode mapping to default context for SNOMED CT findings

|  |  |  |
| --- | --- | --- |
| moodCode | Mood Name | Finding context |
| EVN | Event | [ 410515003 | known present |] |
| GOL | Goal | [ 410518001 | goal |] |
| RSK | Risk | [ 410519009 | at risk |] |
| EXPEC | Expectation | [ 410517006 | expectation |] |

Table 3: HL7 Act.moodCode constraints on explicit context for SNOMED CT findings

|  |  |  |
| --- | --- | --- |
| moodCode | Mood name | Finding context |
| EVN | Event | [(<<36692007 | known |) OR (<<261665006 | unknown |)] |
| GOL | Goal | [ <<410518001 | goal |] |
| RSK | Risk | [ <<410519009 | at risk |] |
| EXPEC | Expectation | [ <<410517006 | expectation |] |

Table 4: HL7 Act.moodCode mapping to default context for SNOMED CT procedures

|  |  |  |
| --- | --- | --- |
| moodCode | Mood name | Procedure context |
| EVN | Event | [ 385658003 | done ) OR (*values dependent of Act.statusCode - see note* )] |
| INT | Intent | [ 410522006 | pre-starting action status |] |
| RQO | Request | [ 385644000 | requested |] |
| PRP | Proposal | [ 385643006 | to be done |] |
| PRMS | Promise | [ 385645004 | accepted |] |
| ARQ | Appointment request | [ 385644000 | requested |] |
| APT | Appointment | [ 416151008 | scheduled |] |

**NOTE:** For more information on statusCode dependent values see [Table 7](file:///C:\\Users\\Lisa\\Documents\\05%20Professional\\90%20HL7\\00%20Standard%20-%20TermInfo\\TermInfo%20Course%2020130506\\html\\infrastructure\\terminfo\\terminfo.htm" \l "TableHl7ActStatusProcedureContext)

Table 5: HL7 Act.moodCode constraints on explicit context for SNOMED CT procedures

|  |  |  |
| --- | --- | --- |
| moodCode | Mood name | Procedure context |
| EVN | Event | [ (<<410523001 | post-starting action status) OR *(values dependent of Act.statusCode - see note )* ] |
| INT | Intent | [ << 410522006 | pre-starting action status |] |
| RQO | Request | [ << 385644000 | requested |] |
| PRP | Proposal | [ (<< 385649005 | being organized |) OR (<< 385643006 | to be done |) ] |
| PRMS | Promise | [ <<385649005 | being organized |] |
| ARQ | Appointment request | [ << 385644000 | requested |] |
| APT | Appointment | [ << 385649005 | being organized |] |

**NOTE:** For more information on statusCode dependent values see Table 7

[Table 6](file:///C:\Users\Lisa\Documents\05%20Professional\90%20HL7\00%20Standard%20-%20TermInfo\TermInfo%20Course%2020130506\html\infrastructure\terminfo\terminfo.htm#TableHl7ActMoodNoSnomedContext) lists Act.moodCodes that have no direct relationship to SNOMED CT context attributes. This assertion is made based on knowledge of the definitions in the HL7 RIM for these mood codes and of the SNOMED CT qualifier values for context model attributes. Based on those definitions (in both standards) there are, in fact, no SNOMED CT concepts which directly correspond to the meaning of these specific mood codes. While no constraints are specified for these moodCodes, some combinations may be irrational or open to misinterpretation. Therefore, caution should be used when combining these moodCodes with explicit representations of SNOMED CT context.

Table 6: HL7 MoodCodes that have no direct relationship to finding or procedure context

|  |  |
| --- | --- |
| moodCode | Name |
| DEF | Definition |
| SLOT | Resource slot |
| EVN.CRT | Event criterion |
| OPT | Option |

Discussion and Rationale

The Act.moodCode is a mandatory component of all HL7 Act classes. Therefore this HL7 representation is required irrespective of whether SNOMED CT context representations are used.

SNOMED CT [ 408729009 | finding context |] and [ 408730004 | procedure context |] value hierarchies include more specific meanings than those associated with the Act.moodCode. Therefore, the SNOMED CT representation cannot be prohibited without resulting in loss of information.

For example, Act.moodCode cannot be used to express various:

* SNOMED CT [ 408730004 | procedure context |] values, including [ 410536001 | contraindicated |] and [ 385661002 | considered and not done |].
* SNOMED CT [ 408729009 | finding context |] values, including [ 410596003 | likely outcome |] and [410605003 | confirmed present |].

The SNOMED CT context model permits default context values to be applied, based on the surrounding information model. Therefore, inclusion of SNOMED CT context can be specified as optional, provided there are explicit rules (such as those in [Table 2](file:///C:\Users\Lisa\Documents\05%20Professional\90%20HL7\00%20Standard%20-%20TermInfo\TermInfo%20Course%2020130506\html\infrastructure\terminfo\terminfo.htm#TableHl7ActMoodFindingContextDefault) and [Table 4](file:///C:\Users\Lisa\Documents\05%20Professional\90%20HL7\00%20Standard%20-%20TermInfo\TermInfo%20Course%2020130506\html\infrastructure\terminfo\terminfo.htm#TableHl7ActMoodProcedureContextDefault)) for deriving default context values from the moodCode and, where relevant, from other HL7 Act class attributes.

Act.statusCode

The Act.statusCode is defined "a code specifying the state of the Act". This definition is further elaborated by the state-machine diagram for the Act class in the RIM documentation and the ActStatus vocabulary.

Potential Overlap

The interaction between statusCode and SNOMED CT semantics varies according to the nature of the statusCode and the value of the Act.moodCode.

* The most general HL7 Act.statusCode values ("normal", "obsolete" and "nullified") relate to whether the Act class instance is currently valid. These states do not result in any overlaps with SNOMED CT semantics.
* Other states overlap with aspects of SNOMED CT semantics in a manner that is to some extent dependent on the mood of the Act.

Unlike the other attributes discussed in this section the value of the statusCode may progress over time. Thus the fact that a "request" was aborted implies that a request was made, as well as indicating that the request was not acted upon. Therefore, the impact of an Act.statusCode on SNOMED CT semantics depends on whether the concern is to know what steps were taken or to know whether a step was completed.

The relevance of statusCode is fairly clear cut when the Act.moodCode value is "EVN", since this implies an actual occurrence. In these cases, the statusCode pertains to whether the event is complete and thus directly to the SNOMED CT [ 408730004 | procedure context |].

In other moods, this relationship is less clear. For example, the Act.statusCode applies to an Act with moodCode "RQO" refers to the status of the request, whereas the [ 408730004 | procedure context |] refers to the progress of the concept specified by the [ 363589002 | associated procedure |].

Rules and Guidance

The following rules deal only with cases where the Act.statusCode has a clear effect on the meaning of an Act class instance in a particular mood. Other rules or guidelines, based on similar principles, may be added in the future.

1. Act class instances SHALL be interpreted taking account of the Act.statusCode and the way particular values of this attribute when combined with the Act.moodCode may alter the default or permitted [ 408730004 | procedure context |] values.
2. In the case of an Act in "event" mood the defaults and constraints specified in Act.code (§ 1.2.2) and Act.moodCode (§ 1.2.4) should be modified in accordance with statusCode as shown in [Table 7](file:///C:\Users\Lisa\Documents\05%20Professional\90%20HL7\00%20Standard%20-%20TermInfo\TermInfo%20Course%2020130506\html\infrastructure\terminfo\terminfo.htm#TableHl7ActStatusProcedureContext).

Table 7: HL7 statusCode impact of defaults and constraints applicable to procedure context for Acts in "event" mood

|  |  |  |
| --- | --- | --- |
| statusCode | Default procedure context | Procedure context constraints |
| new | [ 410522006 | pre-starting action status |] | [ <<410522006 | pre-starting action status |] |
| active | [ 410523001 | post-starting action status |] | [ <<410523001 | post-starting action status |] |
| complete | [ 385658003 | done |] | [ <<385658003 | done |] |
| held | [ 385642001 | under consideration |] | [ <<385642001 | under consideration |] |
| cancelled | [ 89925002 | cancelled |] | [ <<89925002 | cancelled |] |
| suspended | [ 385655000 | suspended |] | [ <<385655000 | suspended |] |
| aborted | [ 385657008 | abandoned |] | [ <<385657008 | abandoned |] |

Discussion and Rationale

The HL7 statusCode changes throughout the life cycle of an Act in its specified mood, until it reaches an end-state. Consideration of the impact of a statusCode on aspects of semantics depends on whether the requirement is to know 'what steps were taken' or 'whether a step was completed'. Thus the fact that a "request" was aborted implies that a request was made, as well as indicating that the request was not taken through to normal completion.

The statusCode values "new", "active", "held", "completed", "cancelled", "suspended", "nullified" and "obsolete" track the progress of the Act in its specified mood. The semantic relevance of statusCode in "event" mood is more clear cut than in other moods.

* For example, statusCode="completed"
  + when applied to an Act with moodCode="ENV" implies [ 408730004 | procedure context | = 385658003 | done |]
  + when applied to an Act with moodCode="RQO" implies that the act of request has been completed. It does *not* mean that the requested action has been completed.

The statusCode values "normal", "obsolete" and "nullified" relate to the validity of a particular representation of an Act class instance. These states do not result in any overlaps with SNOMED CT semantics because the meaning of an Act class instance is no longer relevant if it has been "nullified" or marked as "obsolete".

Procedure.targetSiteCode and Observation.targetSiteCode

The Procedure.targetSiteCode is defined by HL7 as “the anatomical site or system that is the focus of the procedure.” The Observation.targetSiteCode is defined as "a code specifying detail about the anatomical site or system that is the focus of the observation if this information is not already implied by the observation definition or Act.code."

Potential Overlap

SNOMED CT finding concepts have a defining attribute that specifies the [ 363698007 | finding site |] and similarly SNOMED CT procedure concepts have a defining attribute that specifies the "procedure site". The post-coordination rules that apply to SNOMED CT permit refinement of these defining attributes. The resulting post-coordinated expressions can be represented in a single coded attribute using the HL7 Concept Descriptor (CD) data type.

The result of this is that there are two completely overlapping approaches to the representation of sites associated with observations and procedures.

Rules and Guidance

The following rules avoid redundancy and the risk of misinterpretation by restricting the use of targetSiteCode in Act class instances. There are two sections dealing with information models which 1) contain only SNOMED content and 2) allow multiple terminologies to be used.

If an Act.code or Observation.value contains only SNOMED CT content then the following shall apply:

1. The targetSiteCode attribute SHOULD be omitted from any Act instance.
2. If necessary the specific applicable site SHOULD be represented (in Act.code or Observation.value) as a refined relevant site attribute, either as part of a SNOMED CT pre-coordinated concept or a post-coordinated expression.

If an Act.code or Observation.value contains SNOMED CT content as one permitted code system then the following shall apply:

1. The targetSiteCode attribute SHALL be optional in any Act instance.
2. If the targetSiteCode attribute is present in an Observation or Procedure class instance in which the Act.code or Observation.value is expressed using SNOMED CT then:
   * The targetSiteCode SHALL also be represented using SNOMED CT
   * The targetSiteCode SHALL be the same as, or a subtype of, the value of the relevant site attribute as specified in the SNOMED CT expression
   * The targetSiteCode SHALL be treated as equivalent to a restatement or refinement of the relevant site attribute in the SNOMED CT expression
   * If the value of the targetSiteCode attribute is incompatible with the above rules then this SHALL be interpreted as an error

**NOTE:** The *relevant site attribute* depends on the SNOMED CT Concept Model for the type of procedure or finding. It may be one of the following: [ 363698007 | finding site |], [ <<363704007 | procedure site |], [ 405813007 | procedure site - Direct |] or [ 405814001 | procedure site - Indirect |]. In some cases, "procedure morphology", "direct morphology" or "indirect morphology" may also provide more specific site related information.

Discussion and Rationale

The notes following the definition of Observation.targetSiteCode make it clear that the intent is not to repeat a site implied by the Act.code.

Most observation target sites are implied by the observation definition and Act.code, or Observation.value. For example, "heart murmur" always has the heart as target. This attribute is used only when the observation target site needs to be refined, to distinguish right and left etc.

The notes following the Procedure.targetSiteCode definition are perhaps a little less clear cut. However, they convey a similar general sense.

Some target sites can also be "pre-coordinated" in the Act definition, so that there is never an option to select different body sites. The same information structure can handle both the pre-coordinated and the post-coordinated approach.

Therefore, if the Procedure.code or Observation.code specifies the site to a sufficient level of detail, there is no requirement to include a separate targetSiteCode attribute. When using SNOMED CT post-coordination to refine the site, the Act.code specifies the site to the same level of detail as can be achieved using the targetSiteCode.

SNOMED CT offers additional features which make it significantly more expressive than the targetSiteCode:

* Specific subtypes of the [ <<363704007 | procedure site |] attribute distinguish between the direct and indirect targets of a procedure. One use of this is to ensure that removal of a something from an organ does not classify as a type of removal of that organ.
  + For example:
    - [ 287742007|ureter calculus removal ]  
      is defined as a procedure with  
      {260686004|method|=129303008|removal - action|  
      ,363700003|direct morphology|=56381008|calculus|  
      ,405814001|procedure site - Indirect|=87953007|ureteric structure|}
    - [ 51607004|total ureterectomy | ]  
      is defined as a procedure with ...  
      {260686004|method|=129304002|excision - action|   
      ,405813007|procedure site - Direct|=302511008|entire ureter|}
* Explicit grouping of attributes allows representation of multiple sites to be associated with different actions in a single procedure.
  + For example
    - The procedure [ 11401008 | dilation and curettage of uterus |] involves dilatation of one site (cervix uteri) and curettage of another (endometrium) so it is defined as a procedure with the following two relationship groups ...
    - {260686004 | method | = 129319001 | curettage - action |   
      ,405813007 | procedure site - Direct | = 2739003 | endometrial structure | }   
      {260686004 | method | = 129419002 | dilation - action |   
      ,405813007 | procedure site - Direct | = 71252005 | cervix uteri structure | }

The recommendation to use the SNOMED CT representation of site is based on its added expressivity. Omission of the HL7 targetSiteCode attribute is recommended to avoid the redundancy and the potential for conflicts between the two forms of representation of site. However, while the use of these HL7 attributes is deprecated, it is permitted to support use in environments that do not support SNOMED CT post-coordination. In this case, requiring these attributes to be encoded using SNOMED CT and interpreted as refinements of the relevant SNOMED CT attributes enables a simple transformation to the recommended form.

Procedure.approachSiteCode and SubstanceAdministration.approachSiteCode

The Procedure.approachSiteCode is defined by HL7 as "the anatomical site or system through which the procedure reaches its target (see targetSiteCode)." The SubstanceAdministration.approachSiteCode works simular to the Procedure.approachSiteCode.

Potential Overlap

SNOMED CT procedure concepts have a defining attribute that specifies the [ 424876005 | surgical approach | ] which has a comparable meaning to the HL7 approachSiteCode. The post-coordination rules that apply to SNOMED CT permit refinement of this defining attribute. The resulting post-coordinated expressions can be represented in a single coded attribute using the HL7 Concept Descriptor (CD) data type.

The result of this is that there are two completely overlapping methods for representing approaches associated with procedures.

While HL7 models SubstanceAdministration as a separate class from Procedure, the SNOMED CT concept [ 432102000 | administration of substance | ] is a subtype of procedure. Therefore the [ 424876005 | surgical approach | ] attribute can also be applied to refine SNOMED expressions that encode the action associated with SubstanceAdministration. Therefore, this overlap also applies to that class.

Rules and Guidance

The following rules avoid redundancy and the risk of misinterpretation by restricting the use of the approachSiteCode in Procedure and SubstanceAdministration class instances. There are two sections dealing with information models which 1) contain only SNOMED content and 2) allow multiple terminologies to be used.

If a Procedure.code or SubstanceAdministration.code contains only SNOMED CT content then the following shall apply:

1. The approachSiteCode attribute SHOULD be omitted from any Act instance.
2. If necessary the specific applicable site SHOULD be represented as part of the SNOMED CT expression (in Procedure.code or SubstanceAdministration.code) by refining the relevant site attribute as part of a pre or post-coordinated expression.

If a Procedure.code or SubstanceAdministration.code contains SNOMED CT content as one permitted code system then the following shall apply:

1. The approachSiteCode SHALL be optional in any Act instance.
2. If the approachSiteCode attribute is present in a SubstanceAdministration or Procedure class instance in which the Act.code is expressed using SNOMED-CT then:

* The approachSiteCode SHALL also be represented using SNOMED CT
* The approachSiteCode SHALL be the same as, or a subtype of, the value of the relevant site attribute as specified in the SNOMED CT expression
* The approachSiteCode SHALL be treated as equivalent to a restatement or refinement of the relevant site attribute in the SNOMED CT expression
* If the value of the approachSiteCode attribute is incompatible with the above rules then this SHALL be interpreted as an error

Discussion and Rationale

The notes following the Procedure.approachSiteCode definition suggest that the intent is not to repeat the approach if it is fixed by the nature of the procedure specified by the Act.code.

Some [ 424876005 | surgical approach | ] sites can also be "pre-coordinated" in the Act definition, so that there is never an option to select different body sites. The same information structure can handle both the pre-coordinated and the post-coordinated approach.

Therefore, if the Procedure.code or SubstanceAdministration.code specifies the [ 424876005 | surgical approach | ] to a sufficient level of detail, there is no requirement to include a separate approachSiteCode attribute. When using SNOMED CT post-coordination to refine the [ 424876005 | surgical approach | ] , the Act.code can specify the approach to the same level of detail as can be achieved using the approachSiteCode attribute.

The concept domain specified for approachSiteCode is ActSite which is the same as the concept domain for targetSiteCode. In contrast SNOMED CT uses a specific value hierarchy for approaches which is different from the one used for [ 363698007 | finding site |] or [ <<363704007 | procedure site |]. The distinction is that an approach is a route used to reach a target site rather than a specific structural landmark that represents a point on or part of that route.

The example values in the approachSiteCode include a mixture of approaches (e.g. "trans-abdominal approach" and "retroperitoneal approach") which fit the idea of approach as used by SNOMED CT. However, references to the punctured area of skin or structural landmarks have a significantly different semantic quality. Many sites are never the names of routes, several routes may pass through a single site and a route may pass through several sites. Therefore attempts to combine SNOMED CT and HL7 representations of approach may result in confusion rather than clarity.

The recommendation to use the SNOMED CT representation of [ 424876005 | surgical approach | ] is based on the more appropriate range of values available for this attribute, and on the fact that many procedure concepts pre-coordinate an implied or explicitly stated approach. Omission of the HL7 approachSiteCode attribute is recommended to avoid the redundancy and the potential for conflicts between the two forms of representation of site. However, while the use of these HL7 attributes is deprecated, it is permitted to support use in environments that do not support SNOMED CT post-coordination. In this case, requiring the approachSiteCode attributes to be encoded using SNOMED CT and interpreted as refinements of the SNOMED CT [ 424876005 | surgical approach | ] , enables a simple transformation to the recommended form.

Procedure.methodCode and Observation.methodCode

The Procedure.methodCode is defined by HL7 as “identifies the means or technique used to perform the procedure”. The Observation.methodCode is defined as “a code that provides additional detail about the means or technique used to ascertain the observation.”

Potential Overlap

SNOMED CT Procedure concepts have a defining attribute that specifies the [ 260686004 | method |] used. SNOMED CT "evaluation procedure" concepts, which may be used to specify the nature of an observation, have a defining attribute that specifies the [ 370129005 | measurement method |]. SNOMED CT [ 404684003 | clinical finding |] concepts, which may be used as values of a nominalized observation or assertion, have a defining attribute that specifies the [ 418775008 | finding method |]. The post-coordination rules that apply to SNOMED CT permit refinement of this defining attribute. The resulting post-coordinated expressions can be represented in a single coded attribute using the HL7 Concept Descriptor (CD) data type.

The result of this is that there are two overlapping approaches to the representation of methods associated with observations and procedures.

Rules and Guidance

The following rules avoid redundancy and the risk of misinterpretation by restricting the use of the methodCode in Procedure and Observation class instances. There are two sections dealing with information models which 1) contain only SNOMED content and 2) allow multiple terminologies to be used.

If an Act.code or Observation.value contains only SNOMED CT content then the following shall apply:

1. The methodCode attribute SHOULD be omitted from any Act instance.
2. If necessary the method applicable SHOULD be represented as part of the SNOMED CT expression (in Act.code or Observation.value) by refining the relevant method attribute as part of a post-coordinated expression.

If an Act.code or Observation.value contains SNOMED CT content as one permitted code system then the following shall apply:

1. The methodCode attribute SHALL be optional in any Act instance.
2. If the methodCode attribute is present in an Observation or Procedure class instance in which the Act.code or Observation.value is expressed using SNOMED CT then:

* The methodCode SHALL also be represented using SNOMED CT
* The methodCode SHALL be the same as, or a subtype of, the value of the relevant method attribute as specified in the SNOMED CT expression
* The methodCode SHALL be treated as equivalent to a restatement or refinement of the relevant method attribute in the SNOMED CT expression
* If the value of the methodCode attribute is incompatible with the above rules then this SHALL be interpreted as an error

**NOTE:** The *relevant method attribute* depends on the SNOMED Concept Model in respect of the type of procedure or finding. It may be one of the following: [ 260686004 | method |], [ 418775008 | finding method |] or [ 370129005 | measurement method |].

Discussion and Rationale

The notes following the definition of Observation.methodCode make it clear that the intent is not to repeat a method implied by the Act.code.

In all observations the method is already partially specified by simply knowing the kind of observation (observation definition, Act.code) and this implicit information about the method does not need to be specified in Observation.methodCode.

The notes following the Procedure.methodCode are less explicit about avoidance of duplication. However, they do suggest that code systems might be designed with relationships between procedures and possible method – which is exactly how SNOMED CT is designed. What the note does not take into account is that the terminology may also specify a way to represent a specific method with the procedure in a single code or expression.

'… a code system might be designed such that it specifies a set of available methods for each defined Procedure concept'

Therefore, if the Act.code or Observation.value specifies the method to a sufficient level of detail, there is no requirement to include a separate methodCode attribute. When using SNOMED CT post-coordination to refine the method, the Act.code or Observation.value specifies the method to the same level of detail as can be achieved using the methodCode.

The notes on methodCode use "open" and "laparoscopic" procedures as examples of differences in method. SNOMED CT makes this same differentiation using another defining attribute [ 260507000 | access |]. This highlights the potential for confusion from using both SNOMED and HL7 representations of method.

### Act.priorityCode

The Act.priorityCode is defined by HL7 as “a code or set of codes (e.g., for routine, emergency), specifying the urgency under which the Act happened, can happen, is happening, is intended to happen, or is requested/demanded to happen.”

#### Potential Overlap

The semantics of this attribute potentially overlaps with SNOMED CT “[ 260870009 | priority |]” attribute which "... refers to the priority assigned to a procedure".

#### Rules and Guidance

The following rules recommend specific uses for the HL7 and SNOMED CT representations of priority. There are two sections dealing with information models which 1) contain SNOMED content and 2) allow multiple terminologies to be used.

In all cases:

1. Act class clones SHALL include the priorityCode attribute if there is a requirement for expressing the urgency of a request, tracking and auditing services based on requested prioritization or any other aspects of workflow management related to priority.
2. Act class clones *need not* include the priorityCode attribute if the only requirement for indicating priority relates to distinguishing differences between the nature of the procedure itself based on priority (see example below).
3. In Act class instances the Act.priorityCode attribute SHALL be used where it has a specific functional role in relation to the purpose of a communication.

* For example, to prioritize a request for a service or to track the priority under which a service was scheduled and carried out.

In cases where SNOMED CT is used.:

1. In Act class instances, the relevant SNOMED CT priority attribute SHOULD be included in the expression in the Act.code or Observation.value if the priority significantly alters the nature of the statement.

* The priorityCode SHALL be the same as, or a subtype of, the value of the relevant priority attribute as specified in the SNOMED CT expression
* For example, an [ 274130007 | emergency cesarean section |] is a significantly different procedure when compared with an [ 177141003 | elective caesarean delivery |].

#### Discussion and Rationale

At face value the Act.priorityCode and the SNOMED CT [ 260870009 | priority |] attribute appear to have similar meanings. However, the way in which these are used appears to differ significantly.

* The SNOMED CT attribute is used to specify the defining characteristic that distinguishes an elective procedure from an emergency procedure. Like any defining attribute it can also be used to refine or qualify a procedure that is specified without references to its urgency.
* The HL7 priorityCode is generally used to communicate priority in relation to workflow management and audit. One obvious use case for this is to allow request for a service to indicate the priority assigned to it by the requester.

These aspects of priority can vary independently of one another. Two requests for the same procedure can assert different priorities for processing them based on perceived clinical need or other factors. On the other hand, some emergency procedures are carried out directly without a specific request and thus without the normal workflow associated with prioritization.

The use of a distinct information model attribute (i.e. Act.priorityCode), which is applicable to all services, makes the priority more readily accessible to workflow management. It does not require the SNOMED CT expression to be parsed to determine the priority of a request or action. In addition, it allows consistent handling of priority when some services are represented using SNOMED CT while others are represented using different code systems.

The use of a representation of priority that is integrated with the definition model of the associated concept is more useful from the perspective of clinical record retrieval. The description logic model of SNOMED CT ensures the computational equivalence of a procedure concept defined as an emergency and a post-coordinated expression in which [ 260870009 | priority | = 25876001 | emergency |] is added to the more general procedure concept.

### Act.negationInd

The Act.negationInd is defined by HL7 as “An indicator specifying that the Act statement is a negation of the Act as described by the descriptive attributes”.

**NOTE:** The Act.negationInd attribute has been deprecated in recent releases of the RIM (since Sept. 2008) and has been replaced by the two new attributes of Act.actionNegationInd and Observation.valueNegationInd (see *Core Principles and Properties of V3 Models* for details). However, the original Act.negationInd has not been deprecated and continues to be in use in CDA R2 (RIM v 2.07). It is anticipated that a future release of CDA will update this to be consistent with the current RIM, but at present the following guidance is applicable for the use of Act.negationInd in CDA R2.

#### Potential Overlap

The semantics of this attribute overlaps with:

* SNOMED “[ 408729009 | finding context |]” values indicating absence of a specified finding.
* SNOMED CT “[ 408730004 | procedure context |]” values indicating that a specified procedure was not done.

This overlap must be avoided. If not avoided, it leads to ambiguity. For example, a combination of negationInd with a contextual representation of absence in SNOMED CT results in different interpretations based on the approach taken, as:

* double negation (i.e. "not finding X is absent" - which may mean "finding X is present") [Note: Interpretations based on formal logic may not always be intuitive for humans, and using machine reasoning in this way may have patient safety implications.]
* restatement or emphasis of the negative resulting from a mapping between the two ways to indicate negation or absence (i.e. "negative observation: finding X is absent" - which still means that "finding X is absent").

#### Rules and Guidance

The following rules avoid the risk of misinterpretation by prohibiting use of the negationInd in Act class instances that are encoded using SNOMED CT.

1. In a constrained information model or template the negationInd attribute SHOULD be omitted from:

* any Act class clone in which SNOMED CT is the only permitted code system for the Act.code attribute.
* any Observation class clone in which SNOMED CT is the only permitted code system for the Observation.value attribute.

1. In a constrained information model or template, the negationInd attribute SHALL be optional if it is included in:

* an Act class clone in which SNOMED CT is one of the permitted code systems for the Act.code attribute.
* any Observation class clone in which SNOMED CT is one of the permitted code systems for the Observation.value attribute.

1. The negationInd attribute SHOULD be omitted from any Act class instance in which the Act.code attribute is expressed using SNOMED CT.

* Negative assertions about an Act (e.g. "procedure not done", "substance not to be administered" ) SHOULD be represented, as part of the SNOMED CT expression in the Act.code attribute, by including the appropriate explicit [ 408730004 | procedure context |] (e.g. [ 385660001 | not done |] or [410521004 | not to be done |]).

1. The negationInd attribute SHOULD be omitted from any Observation class instance in which the Observation.value attribute is expressed using SNOMED CT.

* Assertions of negative Observations (e.g. absence of a specified finding) SHOULD be represented, as part of the SNOMED CT expression in the Observation.value attribute, by including the appropriate explicit [ 408729009 | finding context |].

1. The negationInd attribute MAY be included in an Act class instance where the SNOMED CT expression represents a [ <<71388002 | procedure |] with no explicit [ 408730004 | procedure context |] or a [ <<129125009 | procedure with explicit context |] with [ 408730004 | procedure context | = 385658003 | done |]

* This approach is not recommended but is permitted to allow simple negation in systems that do not support the SNOMED CT context model. If it is used, it SHALL be interpreted as equivalent to the specified [ 363589002 | associated procedure |] with [ 408730004 | procedure context | = 385660001 | not done |].

1. The negationInd attribute MAY be included in an Observation class instance where the SNOMED CT expression represents a [ <<404684003 | clinical finding |] with no explicit [ 408729009 | finding context |] or a [ <<413350009 | finding with explicit context |] with the [ 408729009 | finding context | = 410515003 | known present |].

* This approach is not recommended but is permitted to allow simple negation in systems that do not support the SNOMED CT context model. If it is used, it SHALL be interpreted as equivalent to the specified [ 246090004 | associated finding |] with a [ 408729009 | finding context | = 410516002 | known absent |].

1. If the negationInd attribute is present in an Act class instance in which either the Act.code or Observation.value is expressed using SNOMED CT, it SHALL be interpreted as an error unless the conditions noted in points 5 and 6 above apply.

#### Discussion and Rationale

The Act.negationInd is an optional RIM attribute which negates the meaning of an Act. This negation is unnecessary in cases where SNOMED CT is used because the context attributes can be used to specify the absence of a finding or the fact that a procedure has not been done. Including both representations introduces potential for serious misinterpretation of combinations including the following:

* Double negative
  + If negationInd is true and the SNOMED CT [ 408729009 | finding context | = 410516002 | known absent |] the double negative would be “not known absent” (i.e. “present”).
  + If negationInd is true and the SNOMED CT [ 408730004 | procedure context | = 385660001 | not done |] the double negative would be “not not done” (i.e. “done”).
  + For the avoidance of potential ambiguity this option is explicitly prohibited by rules in this document.
* Indication or emphasis of negation
  + HL7 negationInd indicates the presence of negation and the SNOMED CT context provides more details of the nature of the negation.
  + Implies that if negationInd is true and the Act is coded with SNOMED CT an appropriate negated SNOMED CT finding or procedure context value (e.g. [ 410516002 | known absent |] or [ 385660001 | not done |]) should also apply.
  + Might imply that if a negated SNOMED CT finding or procedure context value (e.g. [ 410516002 | known absent |] or [ 385660001 | not done |]) is applied the negationInd should be true.
* Restatement of negation
  + HL7 negationInd and SNOMED CT negative contexts apply as alternatives and when combined serve to restate the negation
  + Implies that if only negationInd is present a mapping table is required to the relevant SNOMED CT context to enable consistent interpretation. This mapping table would need to specify combinations of moodCode and negationInd. For example, negationInd=true with moodCode=“EVN” the would imply [ 408730004 | procedure context | = 385660001 | not done |], whereas negationInd=true with moodCode=“RQO” might imply [ 408730004 | procedure context | = 410521004 | not to be done |].

To meet requirements to support some simple negation in systems that do not support the SNOMED CT context model, use of negationInd is permitted where it cannot be misinterpreted. The only cases where no risk of misinterpretation are where the SNOMED CT context is either unspecified or explicitly states the default values [ 410515003 | known present |] or [ 385658003 | done |]. The negationInd can be used to switch these defaults to the appropriate negated values such as [ 410516002 | known absent |] and [ 385660001 | not done |].

### Act.uncertaintyCode

Act.uncertaintyCode is not used in CDA R2.

The Act.uncertaintyCode is defined by HL7 as “a code indicating whether the Act statement as a whole, with its subordinate components has been asserted to be uncertain in any way.” The values of this attribute in the HL7 vocabulary are "stated with no assertion of uncertainty" (N) and "stated with uncertainty" (U).

#### Potential Overlap

The semantics of this attribute overlaps with SNOMED CT [ 408729009 | finding context |] values [ <<410590009 | known possible |] and its subtypes including [ 410592001 | probably present |] and [ 410593006 | probably not present |]. This provides different ways to express the uncertainty of a finding and ambiguity about the impact of combining these two representations in a single Act class instance.

#### Rules and Guidance

The following rules avoid the risk of misinterpretation by prohibiting use of the uncertaintyCode in Act class instances that are encoded using SNOMED CT. There are two sections dealing with information models which 1) contain only SNOMED content and 2) allow multiple terminologies to be used.

If an Act.code or Observation.value contains only SNOMED CT content then the following shall apply:

1. The uncertaintyCode attribute SHOULD be omitted from any Act instance.
2. If necessary the uncertainty applicable SHOULD be represented as part of the SNOMED CT expression by refining the relevant context attribute as part of a post-coordinated expression.

If an Act.code or Observation.value contains SNOMED CT content as one permitted code system then the following shall apply:

1. The uncertaintyCode attribute SHALL be optional in any Act instance.
2. If the uncertaintyCode attribute is present in an Act class instance in which the Act.code or Observation.value is expressed using SNOMED CT then:

* The uncertaintyCode SHALL also be represented using SNOMED CT
* The uncertaintyCode SHALL be the same as, or a subtype of, the value of the relevant context attribute as specified in the SNOMED CT expression
* The uncertaintyCode SHALL be treated as equivalent to a restatement or refinement of the relevant context attribute in the SNOMED CT expression
* If the value of the uncertaintyCode attribute is incompatible with the above rules then this SHALL be interpreted as an error

#### Discussion and Rationale

The SNOMED CT [ 408729009 | finding context |] values provide a more specific way to express uncertainty about the presence or absence of a finding. This is therefore preferred over the use of the optional uncertaintyCode attribute.

The SNOMED CT [ 408730004 | procedure context |] does not contain values to represent "possibly done" or "probably done". As a result there is no obvious way to express uncertainty about whether a procedure has been done. This may be relevant if an informer reports something like "I think I had a tetanus vaccination but I am not sure". The current advice is to treat such information as an Observation about past history, rather than adding uncertainty value to the [ 408730004 | procedure context |] value hierarchy. However, this issue has been raised with the SNOMED Concept Model Working Group and the advice may be revised if after further consideration the [ 408730004 | procedure context |] value set is expanded.

The HL7 UVP (Uncertain Value - Probabilistic) data type was considered as this is another HL7 approach to representation of uncertainty. The UVP data type is defined as "A generic data type extension used to specify a probability expressing the information producer's belief that the given value holds." The data types specification adds that "How the probability number was arrived at is outside the scope of this specification." There is some potential for overlap as the UVP data type is a "generic data type extension". This means it can be applied to any other data type, and hence to any HL7 attribute. This data type may be applied to attribute values associated with a SNOMED CT code (for example, to express uncertainty associated with the value of a particular measurement). However, use of UVP to apply a specific level of uncertainty to a SNOMED CT concept in an Act should be avoided.

### Observation.interpretationCode

The HL7 RIM defines Observation.interpretationCode as:

A qualitative interpretation of the observation.  
Examples: Normal, abnormal, below normal, change up, resistant.  
Usage Notes: These interpretation codes are sometimes called "abnormal flags," however, the judgment of normalcy is just one of the interpretations, and is often not relevant. For example, the susceptibility interpretations are not about "normalcy," and for any observation of a pathologic condition, it does not make sense to state the normalcy, since pathologic conditions are never considered "normal."

The value of including an observation interpretation is to be able to say:

(a) “The hemoglobin measurement is 18g/dl and this is abnormally high (when compared with the reference range).”  
or  
(b) “This Streptococcus pneumoniae isolate has been tested for susceptibility to Penicillin G and has been found to be resistant.”

#### Potential Overlap

There are multiple scenarios that may result in overlap, particularly with data recorded in Observation.code or Observation.value.

1. Within HL7 V3

* From a modeling perspective, the “interpretation” of a value (i.e. laboratory test result, etc.) is an additional “higher level” observation that is made on the results (raw data) from a particular investigation. This additional observation can, and likely in some cases does, carry the full semantics of an “observation” (including author, author time, etc.), and thus may be represented by an additional instance of an Observation class. Alternatively, and more commonly, the result of this additional observation is represented using the interpretationCode attribute within the original Observation class (which is essentially a lightweight or “shortcut” method for representing this data). There is the potential for conflict and/or ambiguity between these two approaches.
* In some situations, current practice in V3 laboratory messaging (parallel to the common usage in V2) has been to use the Observation.interpretationCode in place of, rather than in conjunction with Observation.value. This typically occurs in laboratory antimicrobial susceptibility messaging (see the Streptococcus susceptibility to Penicillin G example above).

1. Between HL7 V3 and SNOMED CT

* The SNOMED CT concept model for Clinical Findings provides the [ 363714003 | Interprets ] and [ 363713009 | Has interpretation ] attributes[[4]](#footnote-5). The latter represents similar notions to those intended for use by the HL7 Observation.interpretationCode attribute. An example of the use of these attributes is:   
    
  [ 165558001 | Platelet count abnormal ]   
    
  Includes, in its reference definition:   
    
  363714003 | Interprets |=61928009 | Platelet count |,  
  363713009 | Has interpretation |=263654008 | Abnormal |
* Whether primitively represented or defined according to the above scheme, SNOMED CT contains many pre-coordinated ‘Finding’ concepts, that include notions similar to those expressed as ‘interpretations’, for example:   
    
  [ 110368006 | Decreased estrogen level]  
  [ 102659003 | Normal glucose level ]  
    
  It is therefore possible to represent, using a SNOMED CT ‘Finding’ in Observation.value, notions such as ‘normality’, ‘abnormality’, ‘resistance’.

#### Rules and Guidance

Given the complexities described in ‘discussion and rationale’, it is not currently possible to provide normative guidance on the use of Observation.interpretationCode. In particular, it is not possible to provide guidance on the prohibition of Observation.interpretationCode where SNOMED CT is the only permitted code system for the Act.code.

However, the following guidance (with caveats) can be provided:

* In a constrained information model or template that permits or requires the use of SNOMED CT to represent the nature of an Observation class clone, or in which SNOMED CT is one of the permitted code systems for the Observation.value attribute, Observation.interpretationCode SHALL be optional.
* In any Observation class instance in which the Act.code or Observation.value attribute is expressed using SNOMED CT, and if Observation.interpretationCode is present and also is expressed using SNOMED CT, then Observation.interpretationCode SHALL take its value from the following range in SNOMED CT:  
    
  <<260245000 | findings values |
* Unless explicitly specified by model designers or communicating parties, SNOMED CT findings that represent ‘interpretation’ notions are not prohibited from use. It is possible, therefore, that receiving systems and analytic queries that wish to detect ‘interpretation’ notions may also need to test the SNOMED CT concept carried as Observation.value.

#### Discussion and Rationale

Relevant to this topic, an HL7 Observation will currently support the representation of three notions:

* The thing being observed (in Observation.code)
* The result of the observation (in Observation.value)
* The interpretation of the result of the observation (in Observation.interpretationCode)

Either primitively represented or modeled using the ‘has interpretation’ attribute, SNOMED CT will support the representation of the following notions:

* The thing being observed (in Observation.code)
* The thing being observed and interpretation of the result of the observation (in Observation.value)

There is therefore incomplete overlap in ‘interpretation’ representation, and incomplete expressivity of SNOMED CT to support all aspects of representation (a SNOMED CT expression cannot exhaustively communicate the result of an observation and its interpretation).

Evidence suggests that Observation.interpretationCode is currently used, and it is not possible currently to provide a SNOMED CT-only representation to allow its prohibition.

Neither is it possible, currently, to enhance normalization rules to support equivalence detection between ‘interpretations’ communicated in Observation.value or in Observation.interpretationCode.

### Representation of Units

The HL7 Observation.value attribute allows units to be applied to a physical quantity, range or ratio. The HL7 datatypes specification requires the use of UCUM (Unified Code for Units of Measure[[5]](#footnote-6)) to express units in the PQ (physical quantity) datatype.

#### Potential Overlap

SNOMED CT contains concepts that represent most of the widely used units and these overlap with the UCUM representation. These SNOMED CT concepts could be represented in the translation element of the PQ datatype. However, this would introduce redundancy and the potential for conflict between the alternative representations.

#### Rules and Guidance

The following guidance is intended to reduce the need for redundant representation of units and maximize the opportunity for automated unit conversion.

1. Consistent with the Data Types: Abstract specification (both the R1 release, as used in CDA R2, and the R2 release), the unit attribute of the HL7 PQ (physical quantity) data type SHALL be encoded using the appropriate UCUM representation and not using a SNOMED CT concept identifier.
   1. If a SNOMED CT concept identifier is used to populate the unit attribute of the PQ data type, this is a non-standard use which will result in an invalid CDA R2 or V3 instance.
   2. It is valid in CDA R2 and V3 to use a SNOMED CT concept identifier to populate the translation element of the PQ data type, but this is not recommended in cases where a standard UCUM representation exists, in order to avoid introducing redundancy and the potential for conflict between the alternative representations.
2. In the case of “informal units", which have no standard UCUM representation, a SNOMED CT concept identifier MAY be used in the translation element of the PQ data type.

#### Examples of “informal units" may include counted items (such as tablets or capsules). Items such as these are frequently encountered in the role of a "unit", but are not true units at all (as they include dose form or other information). The use of these “informal units", although common, is discouraged. The nature of the counted items should be captured in the appropriate information model or terminology structures. In these cases the unit "1" (the UCUM symbol meaning "the unity") or the "informal unit" enclosed in curly braces ({}) SHALL be used and the SNOMED CT representation of the nature of the counted unit MAY then be used in the translation element.Discussion and Rationale

Use of UCUM representation simplifies interoperability using HL7 messages. The UCUM specification also supports translation between different types of units. It is possible to map from SNOMED CT concepts to UCUM in all cases except those where an informal unit is specified. On the other hand, since the UCUM representation is an expression syntax it can be used to represent an almost unlimited range of complex units in a formal mathematical manner. Many of the units that can potentially be represented in UCUM have no pre-coordinated equivalent in SNOMED CT. SNOMED post-coordination does not currently support the type of mathematical formalism that UCUM offers.

### Dates and Times

In the RIM the HL7 Act class includes two attributes related to the temporal situation of an action (Act.effectiveTime, Act.activityTime). In CDA R2 this has been constrained to allow only the effectiveTime attribute.Each participation in an Act may also have an associated time (for example, author.time or performed.time). Each of these times can be expressed either as a point-in-time or a period of time.

#### Potential Overlap

The SNOMED CT [ 408731000 | temporal context |] distinguishes between findings or procedures that are recorded as part of "past" history and those that are recorded as [ 15240007 | current |]. It also allows a distinction to be made between a specified point or period in time (e.g. and a more general unspecified time (e.g. [ 410588008 | past - unspecified |]). The [ 408731000 | temporal context |] potentially affects the interpretation HL7 date and time attributes.

When a SNOMED CT expression (or concept definition) includes an explicit representation of [ 408731000 | temporal context |], the effectiveTime might be interpreted either as "the time at which the *situation* applied" or "the time at which the *focus concept* applied". Guidance is needed to avoid this potentially misleading ambiguity.

* For example, the definition of the concept [407553003 | history of - glandular fever |] includes:
  + [ 246090004 | associated finding | = 271558008 | glandular fever |, 408731000 | temporal context | = 410513005 | past |]
  + The concept [407553003 | history of - glandular fever |] represents a *situation.*
  + The value of the associated finding attribute is the *focus concept* (i.e. the concept [ 271558008 | glandular fever |]).
  + When an Observation asserts the value [407553003 | history of - glandular fever |], the effectiveTime might be interpreted as:
  + The time when the *focus concept* applied (i.e. the time in the past when they actually had glandular fever);
  + The period of time during which the *situation* applied (i.e. the period of time during which they had a "history of glandular fever" (i.e. a period of time from when they first had glandular fever with no upper bound or extending until death);
  + The time during an episode of care when the *situation* was recognized (i.e. a period starting when "history of glandular fever" was first recorded as part of the record of this episode of care);
  + The time during which the *situation* was considered clinically relevant (i.e. a period of time based on a clinical judgment of the significance of a past history of glandular fever to the currents longer term health).

#### Rules and Guidance

The following rules clarify the impact of [ 408731000 | temporal context |] on interpretation of HL7 date and time attributes associated with an Act class instance.

1. If a SNOMED CT expression includes an explicit [ 408731000 | temporal context |] value, the effectiveTime SHALL be interpreted as applying to the time at which the focus concept applied.

* The focus concept is the value of the [ 246090004 | associated finding |] or [ 363589002 | associated procedure |] in the SNOMED CT expression or concept definition.
  + For example, the Act.effectiveTime for [ 407553003 | history of - glandular fever |] is the time, in the past, when they had glandular fever.
* If the [ 408729009 | finding context |] indicates negation (e.g. [ 408729009 | finding context | = 410516002 | known absent |]), the Act.effectiveTime refers to the point in time or period or time during which the focus concept was known to be absent
* Similarly, if the [ 408730004 | procedure context |] has a negative value such as [ 385660001 | not done |] the Act.effectiveTime refers to the point in time or period or time during which the focus concept was not done.
  + For example, the Act.effectiveTime for [ 165139002 | endoscopy not carried out |] represents the time at which, or period during which, an endoscopy was not done.

1. If the SNOMED CT expression in an Act class instance specifies [ 408731000 | temporal context | = ([ 410584005 | current - specified |) OR ( 410587003 | past - specified |)]:

* the Act.effectiveTime attribute SHALL be present and its value SHALL be interpreted as the clinically relevant point or period in time at which the focus concept applied or is intended to apply.

1. If the SNOMED CT expression in an Act class instance does not explicitly specify [ 408731000 | temporal context |] or explicitly specifies [ 408731000 | temporal context | = ( 410512000 | current or specified |) OR ( 15240007 | current |) OR ([ 410585006 | current - unspecified |)]:

* the Act.effectiveTime attribute SHOULD be included and, if present, its value SHALL be interpreted as the clinically relevant point in time or period during which the associated finding procedure applied or is intended to apply.
  + If the Act.effectiveTime represents a period of time with an upper bound either set in the future or omitted, this indicates that the focus concept continues (or is expected to continue) to apply beyond the time when it was recorded.
* If the Act.effectiveTime attribute is omitted (or contains a null flavor), the Participation.time value stated for a performer MAY be regarded as an approximation to the clinically relevant time.

1. If the SNOMED CT expression in an Act class explicitly specifies [ 408731000 | temporal context | = ((410513005 | past |) OR ( 6493001 | recent |))]:

* the Act.effectiveTime attribute MAY be included and, if present, its value SHALL be interpreted as the clinically relevant point or period in time to which the focus concept applied or is intended to apply.
* the Participation.time value stated for an author SHALL be regarded as the time at which it was asserted that this procedure or observation was carried out in the past.

1. If the SNOMED CT expression in an Act class instance explicitly specifies [ 408731000 | temporal context | = 410588008 | past - unspecified |]:

* the Act.effectiveTime attribute SHALL NOT be included as this would contradict the asserted [ 408731000 | temporal context |].
* the Participation.time value stated for an author SHALL be interpreted as the time at which it was asserted that this procedure or observation was carried out in the past.

1. If the SNOMED CT expression in an Act class explicitly specifies [ 408731000 | temporal context | = 410589000 | all times past |]:

* the Act.effectiveTime attribute SHOULD NOT be included but, if present, it SHALL only specify the upper bound of a period of time.
  + **Note:** The [ 408731000 | temporal context | = 410589000 | all times past |] is used with [ 408729009 | finding context | = 410516002 | known absent |] to assert a negative past history or a negative family history (e.g. [ 266882009 | no family history of ischemic heart disease |]). Negative assertions of this type imply that at [ 410589000 | all times past |] the focus concept did not apply. It is reasonable to combine this with the upper bound of a period of time, as the finding may be true at some future point in time (e.g. the patient may now be diagnosed as having asthma, although they have no past history of asthma). However, it would be contradictory to specify a point in time value or a lower bound for a period of time.
* the Participation.time value stated for an author SHALL be interpreted as the time at which it was asserted that at all times past this Observation applied.

#### Discussion and Rationale

In most cases, following the general rules specified by the HL7 RIM allow unequivocal interpretation of the meaning of the Act.effectiveTime and associated Participation.time values. However, there are several possible interpretations of Act.effectiveTime, in relation to a SNOMED CT expression which includes an explicit past history temporal context (i.e. [ 408731000 | temporal context |<< 410513005 | past |]). Therefore, the rules specified above require that the relative time as specified by the SNOMED CT [ 408731000 | temporal context |] and any specific point or period of time expressed in Act.effectiveTime should be consistent with one another. The rules do not permit the effectiveTime and [ 408731000 | temporal context |] to be interpreted in a combinatorially manner. Thus if the [ 408731000 | temporal context | = 410513005 | past |] the Act.effectiveTime, if stated, must be the point or period in the past when the finding applied.

## ActRelationships

### Observation Qualification Using ActRelationships

Constrained information models specified by some Domain committees use an ActRelationship to allow one Observation to qualify the meaning of another Observation. For example, to specify the severity of an abnormal observation.

#### Potential Overlap

SNOMED CT includes qualifiers that allow refinement of meaning using post-coordinated expressions. As a result, the use of an additional Observation class is unnecessary and introduces alternative ways to represent the same meaning.

#### Rules and Guidance

The following rules are specified to simplify interpretation by minimizing unnecessary variability in representation.

1. A constrained information model or template that permits use of SNOMED CT as one of the permitted ways to represent the result of an Observation, MAY include related Observation classes included to permit qualification of the meaning of an Observation but inclusion of these qualifying class SHALL NOT be required.
2. A constrained information model or template that requires use of SNOMED CT to represent the result of an Observation SHALL NOT include any related Observation classes included to permit qualification of the meaning of an Observation.
3. An Observation class instance in which the Observation.value is represented by a SNOMED CT expression SHALL NOT include any related qualifying classes but SHOULD encode the relevant qualifications as part of the expression.

#### Discussion and Rationale

It is important to reduce the scope for unnecessary alternative representation of the same information. Tight coupling of the qualification to the primary result of the observation is likely to reduce the risk of misinterpretation.

### Representing Compound Statements and Relationships between Statements

In the HL7 Clinical Statement Pattern the ActRelationship class is used to express links or associations between different clinical statements. These linkages may be of different types expressed using the typeCode attribute. Examples of typeCode values include "contains", "pertain to", "caused by", and "reason for".

#### Potential Overlap

SNOMED CT provides a variety of attributes that can be used to represent relationships between different concepts in a post-coordinated expression. These post-coordinated expressions have the potential to represent some association that might alternatively be represented using ActRelationships. For example, the attributes [ 42752001 | due to |] could be used to construct expressions such as [ 49218002 | hip pain |: 42752001 | due to | = 396275006 | osteoarthritis |], which could also be represented using two separate Observations linked by an ActRelationship with the typeCode "caused by".

#### Rules and Guidance

There is no absolute rule about when to express linkage in the terminology and when to use linkage mechanisms in the RIM (e.g. ActRelationships). However, the following guidance should be followed:

* A single identifiable observation, assertion or procedure SHOULD usually be represented by a single Act class instance containing an appropriate SNOMED CT expression.
* A single Act class instance SHOULD be used to represent an integral combination of facets applicable to a single identifiable observation, assertion or procedure. Some examples of integral combination are shown below. The common feature of these is that together they represent a finding with a distinct pattern and a shared life history.
* A combination of findings is a part of a single recognizable condition
  + E.g. "Headache preceded by visual disturbance".
* A disorder is specialized by a specific cause
  + E.g. "Pneumonia due to streptococcus pneumoniae".
* The nature of a disorder is determined by another condition
  + E.g. [ 4855003 | diabetic retinopathy |].
* A temporal or causative relationship between two concepts in which one is a specific symptom or diagnostic criterion for the other.
  + E.g. [ 51771007 | postviral fatigue syndrome |].
* A single recognized procedure involves two or more distinct but related actions:
  + E.g. [86477000 | total hysterectomy with removal of both tubes and ovaries |].
  + E.g. [118468006 | open reduction of fracture with fixation |].
* Post-coordinated SNOMED CT expressions SHOULD NOT be used to artificially combine distinct observations, assertions and procedures into a single Act class instance.
* The line between integral combinations of items and distinct items is not clear-cut. However, as a general rule two items SHOULD be considered to be distinct if
  + they are capable of being independently validated (i.e. the accuracy of one statement is not dependent on the accuracy of the other)
  + their life histories differ and are independent of one another
  + the relationship between them is a matter of judgment rather than fact
* Distinct observations, assertions and procedures SHOULD be represented by separate Act class instances related to one another by appropriate ActRelationships.
  + Multiple distinct findings in a patient that may or may not be associated with one another or with some more general problem.
    - * E.g. A collection such as "chest pain" with "shortness of breath" finding of "tachycardia" and "ECG abnormality" interpreted as "Myocardial infarction".
  + Multiple conditions occur contemporaneously (or in sequence) where the nature of individual conditions is specific to the presence of the other condition.
    - * E.g. "AIDS" and "gastro-enteritis"
  + Multiple distinct procedures incidentally performed at the same time or during the same hospital stay.

#### Discussion and Rationale

In general SNOMED CT expressions (whether pre-coordinated or post-coordinated) are most appropriate for expressing multiple facets of a single logical concept. On the other hand, HL7 ActRelationships are more appropriate for making associations between multiple distinct observations or procedures. However, this boundary is fuzzy and there are many situations in which either approach may have equal merit.

The use of SNOMED CT attributes may result in arbitrarily complex statements that wrap multiple distinct findings within a single terminological expression. In these cases, the use of separate coded statements linked by Act Relationships is preferable. On the other hand, use of multiple statements linked by ActRelationships to represent a single composite finding or procedure may result in loss of the natural clinical term used by a clinician within a collection or linked classes.

Even when the guidelines above are followed, there will be grey areas. In an ideal world a rule would be devised to compute equivalence between single Act class instances containing a post-coordinated SNOMED CT expression and multiple Act class instances. While this is theoretically possible, there are several practical obstacles. The HL7 vocabulary for the ActRelationship.typeCode attribute differs from the range of values for linkage attributes in SNOMED CT. Simple precise or close mappings exist for some values but more work is needed before we can assert full semantic interoperability between the two representations. In addition, while a single instance of a post-coordinated representation has a single life-history, the individual instances in a multiple class representation may have separate life histories and separate associations with other contextual information.

## Participations

### Subject Participation and Subject Relationship Context

The HL7 participation type “subject” relates a finding or procedure to a subject who may or may not be the subject of the record. This allows specific named individuals to be identified as the subject of an Act. It can also be used to associate a related person by specifying their relationship rather than by identifying them. For example [ 303071001 | person in the family |], [ 72705000 | mother |], [ 70862002 | contact person |], etc.

#### Potential Overlap

The SNOMED CT [ 408732007 | subject relationship context |] attribute provides a mechanism for indicating that the subject of a procedure or finding is a person (or other entity) related to the subject of the record. This facility is used to define some SNOMED CT concepts (e.g. "family history of asthma" has [ 408732007 | subject relationship context |] = [ 303071001 | person in the family |]). The same attribute can also be used to create post-coordinated expressions. For example, it can be used to express a family history of a disorder without requiring a pre-coordinated concept that expresses a family history of that particular disorder. Unlike the HL7 "subject" participation, the SNOMED CT mechanism does not directly support reference to an identified person.

#### Rules and Guidance

The following rules are specified to encourage explicit recording of the [ 408732007 | subject relationship context |] in order to minimize risks of overlooking this aspect of the information.

1. When using SNOMED CT to represent an observation or procedure that applies to a subject other than the record target, the appropriate [ 408732007 | subject relationship context |] SHOULD be specified in the SNOMED CT expression.

* For example "family history" should be represented using an expression that specifies the [ 408732007 | subject relationship context |] as [ 303071001 | person in the family |].

1. The HL7 subject participation MAY also be used and SHALL be used if there is a requirement to specifically identify an individual subject.
2. If the HL7 subject participation is used in addition to the SNOMED CT representation of [ 408732007 | subject relationship context |], the Role.code of the role that is the target of the subject SHOULD be represented using SNOMED CT with the value applied to the [ 408732007 | subject relationship context |] or with a subtype of that value.

#### Discussion and Rationale

These recommendations leave some situations in which either approach may be used. Therefore, to compute equivalence, a map between the values used in the code attribute of the associated subject role is required. The simplest option would be to specify that when the classCode attribute of the HL7 Role specifies "personal relationship" the code attribute should have a value from the SNOMED CT [ 408732007 | subject relationship context |] hierarchy.

Ambiguity may be introduced if the information is coded using a concept with explicit [ 408732007 | subject relationship context |] and also has an association to a specific subject. For example, if the concept [ 160303001 | FH: Diabetes mellitus | ] is stated in an observation linked to a person other than the subject of the record, this could mean either (a) "the patient has a family history of diabetes, in the named family member" or (b) "the identified subject has a family history of diabetes".

Specific recommendations on this should be included in communication specifications. Where a communication pertains to an individual patient interpretation (a) is recommended. However, specific instances of the subject participation in a communication about a group of patients may need to specify interpretation (b).

### Specimen Participation in Observations

The HL7 participation type “specimen” relates an observation to the specimen on which an observation was made (or is to be made). The specimen participation allows type of specimen or an actual identifiable specimen to be specified.

#### Potential Overlap

Some SNOMED CT [ <<386053000 | evaluation procedure |] and [ <<363787002 | observable entity |] concepts indicate the type of specimen that is the subject of the measurement or observed property. Refinement is possible using the [ 116686009 | has specimen |] attribute to specify particular specimen types for any relevant procedure. Therefore, there is a potential overlap between two approaches to representation of the nature of the specimen.

#### Rules and Guidance

1. When using SNOMED CT to record an observation that applies to a specimen the nature of the specimen MAY be expressed separately using the Entity.code of the entity playing the role that is the target of the specimen participation

* This type of representation may be appropriate in cases where it is also necessary to identify the specimen and where a single specimen is the subject of multiple different observations.
* When using this form of representation:
  + The type of specimen SHOULD be expressed using an appropriate SNOMED CT concept in the Entity.code attribute.
  + If the SNOMED CT expression used in Observation.code specifies a value for the [ 116686009 | has specimen |] attribute, the value of this attribute SHALL be either the same as or less specific than the value used in the Entity.code.

1. Alternatively, a specific SNOMED CT concept or expression MAY be used to specify the nature of the observation including the type of specimen.

* This form MAY be appropriate to simple recording of result in a clinical record but does not allow the specific instance of the specimen to be identified.

#### Discussion and Rationale

The recommendations on representation of specimen take into account the current incomplete set of investigation codes available. Recent experience in the UK suggests that the first approach above, using the Entity.code is a more flexible basis for requesting and reporting laboratory investigation using SNOMED CT.

The guidance on use of SNOMED CT in the Entity.code attribute is intended to avoid conflicts or ambiguity that may result from representing the values of [ 116686009 | has specimen |] and Entity.code using different coding systems.

### Product and Consumable Participations in Supply and SubstanceAdministration

The HL7 *product* Participation associates a specified material (via an appropriate Role) with the instance of the Supply class instance that delivers this material to a subject. Similarly the "consumable" associates a specified material (via an appropriate Role) with the instance of the SubstanceAdministration class instance that delivers this material to a subject. In both these cases, the relevant Act class instance itself only needs to specify the action involved and does not need to indicate the nature of the material supplied or administered.

#### Potential Overlap

In SNOMED CT concepts that are subtypes of [ 432102000 | administration of substance |] can also specify the nature of the substance administered. Refinement of any particular type of administration is possible by applying values to the "direct substance" attribute to represent administration of any pharmaceutical product. Therefore, there is a potential overlap between two approaches to representation of the nature of the substance administered.

#### Rules and Guidance

1. When using SNOMED CT to communicate about the supply or administration of a substance the nature of the substance SHOULD be specified in the Entity.code of the Entity associated with the Role that is the target of the relevant *product* or *consumable* Participation. When using this form of representation:

* the Act.code of the SubstanceAdministration class instance SHOULD be coded using a SNOMED CT concept that is a subtype of [ <<432102000 | administration of substance | ], but which does not specify a [ 363701004 | direct substance |].
* the nature of the substance administered SHOULD be expressed using an appropriate SNOMED CT concept in the Entity.code attribute of Entity playing the Role that is the target of the relevant participation.

Example: SubstanceAdministration.code= [ 36673005 | intradermal injection |] with associated Entity (via a *consumable* Participation and an appropriate *Role*), in which Entity.code=[ <<82573000 | lidocaine |] OR

1. When using SNOMED CT to summarize information about a particular type of medication (e.g. use of a local anesthetic during a procedure), a SNOMED CT expression that includes information about the nature of the substance administered MAY be used. However, this form SHOULD NOT be used for communicating about the prescription, supply or personal administration of medication.

Example: SubstanceAdministration.code=[ 36673005 | intradermal injection | 363701004 | direct substance |<< 82573000 | lidocaine |]

#### Discussion and Rationale

The first approach follows the form recommended by the Pharmacy TC and endorsed by the Clinical Statement Pattern and other domain committees. The alternative approach may be relevant for summary notes related to certain types of treatment but is not appropriate for prescribing or medication management as it does not provide a reference to a specific quantifiable amount of the substances administered nor does it allow reference to batch numbers and detailed product information.

## Context Conduction

### Structures which propagate context in HL7 models

CDA R2 includes specific attributes, which indicate whether context propagates across Participation and ActRelationship associations. The rules associated with these attributes determine whether the target Act of an ActRelationship shares the participations and other contextual attributes of the source Act and whether these can be substituted by alternative explicit values within the target Act.

**NOTE:** The context conduction model used in earlier versions of the RIM and currently in CDA R2 has been deprecated and replaced in later versions of the RIM by a new “vocabulary-based” context conduction model (as of March 2010 – see *Core Principles and Properties of V3 Models* for details). It is anticipated that a future release of CDA will update this to be consistent with the current RIM, but at present the following guidance is applicable for use in CDA R2.

#### Potential Overlap

Propagation of context is valuable and in some cases almost essential, as it reduces the need to duplicate contextual information. However, it is not entirely clear whether, and if so how, this propagation of context applies to coded information in each Act instance. Safe interpretation of clinical information requires a common understanding of where contextual information is represented using SNOMED CT, if either Act.code or Observation.value propagates to related Acts based on the context propagation rules. For example, several Observations coded using SNOMED CT disorder concepts might be related as component parts of an Organizer labeled with the SNOMED CT code "family history of disorder". If the coded context propagated it might seem to express a family history, if not these might be part of the personal medical history of the subject of record.

#### Rules and Guidance

The following rules are specified to minimize the risk of ambiguity due to loss of contextual information.

1. SNOMED CT contextual information SHOULD NOT be assumed to propagate between Acts and SHOULD therefore be restated in each expression.

* For example, each SNOMED CT expression in a collection of statements representing family history, SHOULD represent the relevant [ 408732007 | subject relationship context |]. This context SHOULD NOT be assumed to propagate from an Organizer (or other containing Act) to its constituent Observations or from one Observation to another.

1. In specific cases where there is clear advantage in allowing specific aspects of SNOMED CT context to conduct, this behavior SHALL be explicitly documented in a manner that ensures reproducible interpretation.

#### Discussion and Rationale

It is not clear how context conduction is intended to apply to contextual information that is represented in concepts within an Act. If this type of context is assumed to propagate it would mean that the meaning of a single Observation might be fundamentally altered by a related Act (or potentially by a chain of several different related Acts). This type of dependency presents significant risks, since different systems may be unable to reproducibly determine the composite meaning. Therefore, it seems safest to recommend restatement of the essential aspects of context as defined by the SNOMED CT context model rather than permitting this context to conduct.

There may be some specific cases, where a tightly coupled set of Acts are expected to behave as a block with regard to the surrounding context and where some or all aspects of context represented using SNOMED CT also need to be conducted. In these cases the potential for misinterpretation needs to be considered and appropriately documented.

# common patterns

* 1. Introduction

Common patterns are clinical statements that are used frequently, often in many different specifications, for a wide variety of communication use cases. The patterns shown here are based upon the Principles and Guidelines defined above, and represent informative examples, unless otherwise stated.[[6]](#footnote-7)

**NOTE:** The approach taken in the development of these patterns is to build upon the modeling work being done within HL7 domain committees. In many cases, the patterns presented here are small subsets of more complete domain models, often greatly simplified so as to illustrate certain principles. Actual instances must conform to the particular HL7 V3 specification being communicated.

* 1. Observations vs. Organizers

The RIM defines the abstract ActClass "ActClassRecordOrganizer" as a navigational structure or heading used to group a set of acts sharing a common context. Record organizers include such structures as folders, documents, document sections, and batteries. The Clinical Statement Pattern includes an Organizer class, whose class code can be valued with an ActClassRecordOrganizer subtype. Where the Organizer class is used, the value of Organizer.code **MAY** be drawn from the SNOMED CT [ (<<419891008 | Record artifact |) OR (<<386053000 | Evaluation procedure |) ] hierarchies.[[7]](#footnote-8) .

It is often the case that there is a close correspondence between a particular kind of clinical statement (e.g. a blood pressure reading) and the organizer where the clinical statement is commonly found (e.g. a vital signs section). The patterns presented here are irrespective of and not dependent on the organizer in which they are found. Thus, the pattern for allergies and adverse reactions should be used regardless of any organizers they may or may not be contained in; and any distinction between a finding vs. disorder vs. diagnosis needs to be made explicit in the clinical statement itself, without reliance on the containing organizer. Stated in another way, a clinical statement needs to be a correct assertion by itself, when viewed outside the organizer.[[8]](#footnote-9)

* 1. Observation code and value (in event mood)

A recurring issue for many observation events, regardless of the particular pattern, is determining how to populate observation.code and observation.value. While this is typically straight-forward for laboratory observations, it can get blurry for other types of observations, such as findings and disorders, family history observations, etc.

The intent of this section is to illustrate the acceptable patterns. Subsequent sections do not include all possible permutations of code/value split, and it should be assumed that any of the acceptable patterns described here would be equally applicable.

* + - 1. Acceptable patterns for Observation code/value

Based on these guiding principles come the following acceptable patterns:

**PATTERN ONE:** Observation.code [ (<<363787002 | Observable entity |) OR (<<386053000 | Evaluation procedure |) ] ; Observation.value = not null (e.g. numeric, nominal, ordinal, coded result).

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| Example 5. Observation code/value: observable entity with result |
| **CDA R2 and R1 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="50373000"  codeSystem="2.16.840.1.113883.6.96"  displayName="Height"/>  <text>Height: 177 cm</text>  <value xsi:type="PQ" value="1.77" unit="m"/>  </observation>  <observation classCode="OBS" moodCode="EVN">  <code code="247030006"  codeSystem="2.16.840.1.113883.6.96"  displayName="Eye color"/>  <text>Green eyes</text>  <value xsi:type="CD" code="371246006"  codeSystem="2.16.840.1.113883.6.96"  displayName="Green"/>  </observation>  **R2 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="50373000|body height|" codeSystemName=”SNOMED CT” codeSystem="2.16.840.1.113883.6.96">  <displayName value="Height"/>  </code>  <text>Height: 177 cm</text>  <value xsi:type="PQ" value="1.77" unit="m"/>  </observation>  <observation classCode="OBS" moodCode="EVN">  <code code="247030006|Color of iris|" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Eye color"/>  </code>  <text>Green eyes</text>  <value xsi:type="CD" code="371246006|Green|" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Green"/>  </value>  </observation> |

**PATTERN TWO:** Observation.code = "ASSERTION" (codeSystem="2.16.840.1.113883.5.4"); Observation.value [ (<<413350009 | Finding with explicit context |) OR (<<404684003 | Clinical finding |) ] .

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| Example 6. Observation code/value: assertion of a clinical finding |

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| **CDA R2 and R1 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <text>Headache</text>  <value xsi:type="CD" code="25064002"  codeSystem="2.16.840.1.113883.6.96"  displayName="Headache"/>  </observation>  **R2 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <text>Headache</text>  <value xsi:type="CD" code="25064002 | Headache |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Headache"/>  </value>  </observation> |

In this example, the observation is simply the assertion of a "headache". If there is a need to distinguish between, say, a patient-reported symptom vs. a clinician-asserted diagnosis, more information would need to be present. Thus, while an acceptable pattern is to assert a clinical finding, that may not convey sufficient context for all communication use cases. Likewise, an assertion of a procedure.code (such as for an appendectomy performed 5 years ago) doesn't distinguish between a patient's reported past surgical history vs. information gleaned from chart review, and additional contextual information will be needed in some cases.

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| Example 7. Observation code/value: assertion of a clinical finding with explicit context |
| **CDA R2 and R1 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <text>Presence of headache</text>  <value xsi:type="CD" code="373573001"  codeSystem="2.16.840.1.113883.6.96"  displayName="Clinical finding present">  <qualifier>  <name code="246090004" displayName="Associated finding"/>  <value code="25064002" displayName="Headache"/>  </qualifier>  </value>  </observation>  **R2 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <text>Presence of headache</text>  <value xsi:type="CD" code="373573001 | Clinical finding present |:246090004 | Associated finding | =25064002 | Headache |" codeSystem="2.16.840.1.113883.6.96"/>  </observation> |

In this example, a finding with explicit context is used to assert the presence of a headache.

An HL7 Observation in event mood is analogous to a SNOMED CT [ 404684003 | Clinical finding | ], and an HL7 Observation in event mood with explicit context (such as presence or absence, subject, past or present) is analogous to a SNOMED CT [ 413350009 | Finding with explicit context |]. Noting this, and drawing from section "Codes and Values" above, come the following guiding principles for populating observation.code and observation.value:

* Acceptable patterns shall be fully transformable amongst each other (by a machine, with no loss of semantics).
* Acceptable patterns shall not conflict with SNOMED CT's definitions, where only certain hierarchies (e.g. [ 363787002 | Observable entity |], [ 386053000 | Evaluation procedure |]) are defined as being able to take on values (i.e. have an associated observation.value).
* Acceptable patterns shall not conflict with the RIM, which defines the Act class as "a record of something that is being done, has been done, can be done, or is intended or requested to be done", and defines the Act.code attribute as "a code specifying the particular kind of Act that the Act-instance represents within its class".
  1. Source of information

Another recurring issue for many clinical statements is the representation of how the information in that statement was obtained (e.g. patient-reported symptom, gleaned from chart review, physical exam finding). Whether or not the source of information needs to be included in a particular communication is outside the scope of this guide, but in some cases, such as the recording of patient medications, knowing the source of the information can have significant clinical implications, and since there are overlaps in HL7 and SNOMED CT representations, the topic is addressed in this guide.

Common sources include: [1] Previously recorded information (e.g. a patient-authored questionnaire, a problem list entry, a lab report); [2] Informant (e.g. the patient, a witness); [3] Direct examination (e.g. a physical examination finding, a radiographic finding, an automated specimen analysis).

Various ways by which the source of information can be represented include:

* SNOMED CT defining attributes (whether pre- or post-coordinated)
  + [ 418775008 | Finding method |]: Used to indicate the method by which a finding was ascertained.
  + [ 419066007 | Finding informer |]: Used to indicate the informant of a finding.
  + [ 260686004 | Method | ]: Used to indicate the method by which a procedure is performed.
  + [ 370129005 | Measurement method |]: Used to indicate the method by which an observable entity or evaluation procedure is performed.
* RIM attributes
  + Procedure.methodCode: Identifies the means or technique used to perform the procedure.
  + Observation.methodCode: A code that provides additional detail about the means or technique used to ascertain the observation.
* RIM participants
  + Informant (INF): A source of reported information.
* RIM act relationships
  + Excerpt (XCRPT): The source is an excerpt from the target.
  + Verbatim excerpt (VRXCRPT): The source is a direct quote from the target.
    - 1. Acceptable patterns for source of information

Patterns for the common sources listed above include:

**PATTERN ONE:** Source is previously recorded information.

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| Example 8. Current observation is directly referenced from something previously recorded. |
| **CDA R2 and R1 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <id root="3568dbe1-8f49-11da-a72b-0800200c9a66"/>  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <text>Headache, per problem list</text>  <value xsi:type="CD" code="25064002"  codeSystem="2.16.840.1.113883.6.96"  displayName="Headache"/>  <actRelationship typeCode="XCRPT"  contextConductionInd="false">  <actReference classCode="OBS" moodCode="EVN">  <id root="201877f1-8f49-11da-a72b-0800200c9a66"/>  </actReference>  </actRelationship>  </observation>  **R2 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <id root="3568dbe1-8f49-11da-a72b-0800200c9a66"/>  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <text>Headache, per problem list</text>  <value xsi:type="CD" code=" 25064002 | Headache |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Headache"/>  </value>  <actRelationship typeCode="XCRPT"  contextConductionInd="false">  <actReference classCode="OBS" moodCode="EVN">  <id root="201877f1-8f49-11da-a72b-0800200c9a66"/>  </actReference>  </actRelationship>  </observation> |

This pattern uses an actRelationshipType of "XCRPT" to indicate that there is a new observation which represents an excerpt of previously recorded information. The ActReference class is used here as the target, but other clinical statement act choices could also be used. Context conduction to the ActReference class is blocked by setting contextConductionInd to "false".

**PATTERN TWO: Source is informant.**

The distinction between the excerpt relationship in the prior figure and an informant participant discussed here can be blurry, such as when a clinician is drawing upon the patient's recollection and a prior record of medication use to determine the current medication usage. An informant (or source of information) is a person who provides relevant information, whereas an excerpt is a sub portion of some other act.

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| Example 9. Informant is the father |
| **CDA R2 and R1 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <text>  Father says that the patient has a headache  </text>  <value xsi:type="CD" code="25064002"  codeSystem="2.16.840.1.113883.6.96"  displayName="Headache"/>  <informant typeCode="INF">  <relatedEntity classCode="PRS">  <code code="66839005"  codeSystem="2.16.840.1.113883.6.96"  displayName="Father"/>  </relatedEntity>  </informant>  </observation>  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <text>  Father says that the patient has a headache  </text>  <value xsi:type="CD" code="25064002"  codeSystem="2.16.840.1.113883.6.96"  displayName="Headache">  <qualifier>  <name code="419066007"  displayName="Finding informer"/>  <value code="66839005" displayName="Father"/>  </qualifier>  </value>  </observation>  **R2 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <text>Father says that the patient has a headache.</text>  <value xsi:type="CD" code="25064002 | Headache |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Headache"/>  </value>  <informant typeCode="INF">  <relatedEntity classCode="PRS">  <code code="66839005 | Father |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Father"/>  </code>  </relatedEntity>  </informant>  </observation>  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <text>Father says that the patient has a headache.</text>  <value xsi:type="CD" code="25064002 | Headache |:419066007 | Finding informer | =66839005 | Father |" codeSystem="2.16.840.1.113883.6.96"/>  </observation> |

The first example uses an Informant participant to indicate that the observation is gleaned through the record subject's father, and the second example expresses the same thing using the finding informer attribute in a post-coordinated expression.

The first example is particularly useful where there is a need to identify or provide additional specifics about the informant participant. Where both informant participant and finding informer are present, the former should be the same as or a specialization of the latter.

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| Example 10. Source is patient-reported symptom |
| **CDA R2 and R1 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <text>Patient states he has a headache</text>  <value xsi:type="CD" code="25064002"  codeSystem="2.16.840.1.113883.6.96"  displayName="Headache">  <qualifier>  <name code="419066007"  displayName="Finding informer"/>  <value code="116154003" displayName="Patient"/>  </qualifier>  </value>  </observation>  **R2 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <text>Patient states he has a headache</text>  <value xsi:type="CD" code="25064002 | Headache |:419066007 | Finding informer | =116154003 | Patient |" codeSystem="2.16.840.1.113883.6.96"/>  </observation> |

This example shows the use of the finding informer attribute to indicate that the patient is the source of the information. It will commonly be the case that a V3 instance will assert an informant participant, which will propagate to nested observations. Therefore it won't often be necessary to directly assert a finding informer of patient.

**PATTERN THREE:** Source is direct examination.

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| Example 11. Source is direct examination of patient |
| **CDA R2 and R1 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="77989009"  codeSystem="2.16.840.1.113883.6.96"  displayName="Measurement of skin fold thickness">  <qualifier>  <name code="370129005"  displayName="Measurement method"/>  <value code="5880005" displayName="Physical exam"/>  </qualifier>  </code>  <text>Skin fold thickness is 7cm</text>  <value xsi:type="PQ" value="7" unit="cm"/>  </observation>  **R2 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="77989009 | Measurement of skin fold thickness |:370129005 | Measurement method | =5880005 | Physical examination procedure |" codeSystem="2.16.840.1.113883.6.96"/>  <text>Skin fold thickness is 7cm</text>  <value xsi:type="PQ" value="7" unit="cm"/>  </observation> |

This pattern uses the SNOMED CT measurement method attribute to qualify a measurement procedure concept, indicating that the observation was determined via physical exam.

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| Example 12. Source is direct examination of radiograph |
| **CDA R2 and R1 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <text>Hilar mass on chest CT</text>  <value xsi:type="CD" code="309530007"  codeSystem="2.16.840.1.113883.6.96"  displayName="Hilar mass">  <qualifier>  <name code="418775008"  displayName="Finding method"/>  <value code="169069000" displayName="CT chest"/>  </qualifier>  </value>  <actRelationship typeCode="SUBJ"  contextConductionInd="false">  <observation classCode="DGIMG" moodCode="EVN">  <id root="9cc8b460-8f47-11da-a72b-0800200c9a66"/>  <code code="169069000"  codeSystem="2.16.840.1.113883.6.96"  displayName="CT chest"/>  </observation>  </actRelationship>  </observation>  **R2 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <text>Hilar mass on chest CT</text>  <value xsi:type="CD" code="309530007 | Hilar mass |:418775008 | Finding method | =169069000 | CT of chest |" codeSystem="2.16.840.1.113883.6.96"/>  <actRelationship typeCode="SUBJ" contextConductionInd="false">  <observation classCode="DGIMG" moodCode="EVN">  <id root="9cc8b460-8f47-11da-a72b-0800200c9a66"/>  <code code="169069000 | CT of chest |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="CT chest"/>  </code>  </observation>  </actRelationship>  </observation> |

This pattern uses the SNOMED CT finding method attribute to qualify a finding concept, indicating that the finding was determined via CT chest. To relate the finding to the actual CT scan being observed, the example uses an act relationship of type "SUBJ", with blocked context conduction (using the original “conduction-indicator-based” context conduction style in both the R1 and R2 examples).

* 1. Allergies, Intolerances and Adverse Reactions

Both SNOMED CT and HL7 differentiate an isolated reaction event from the condition of being allergic or intolerant. For instance, the following hierarchy is present in SNOMED CT:

* [ 404684003 | Clinical finding |]
  + [ 420134006 | Propensity to adverse reactions |]
    - [ 106190000 | Allergy |]
    - [ 416098002 | Drug allergy |]
  + [ 281647001 | Adverse reaction |]
    - [ 416093006 | Allergic reaction to drug |]

Different SNOMED CT value sets may apply, depending on the application context. Potential value sets include:

* **Substance/Product value set:**[[9]](#footnote-10) Values drawn from [ 105590001 | Substance |] and/or [ 373873005 | Pharmaceutical / biologic product | ] hierarchies, might be used where the context is the recording of substances to which the patient is allergic (e.g. a data entry box labeled "ALLERGIES").[[10]](#footnote-11)
* **Findings value set:** Values drawn from [ 413350009 | Finding with explicit context |] and/or [ 404684003 | Clinical finding |] hierarchies, might be used where the context is an encounter diagnosis or a problem list.

**NOTE:** The HL7 Patient Care Work Group is continuing to develop a formal model for allergy tracking, which supports the representation of the sequential determination of primary and secondary observations relating to discovery and analysis of adverse reactions. The examples provided here are greatly simplified so as to illustrate certain aspects of SNOMED CT implementation.

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| Example 13. Allergies coded with Substance/Product value set |
| **CDA R2 and R1 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <text>Allergy to PCN manifesting as hives</text>  <value xsi:type="CD" code="106190000"  codeSystem="2.16.840.1.113883.6.96"  displayName="Allergy">  <qualifier>  <name code="246075003"  displayName="Causative agent"/>  <value code="373270004"  displayName="Penicillin -class of antibiotic- (substance)"/>  </qualifier>  </value>  <actRelationship typeCode="MFST"  inversionInd="true" contextConductionInd="true">  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <value xsi:type="CD" code="247472004"  codeSystem="2.16.840.1.113883.6.96"  displayName="Hives"/>  </observation>  </actRelationship>  </observation>  **R2 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <text>Allergy to PCN manifesting as hives</text> | |  <value xsi:type="CD" code="106190000 | Allergy |:246075003 | Causative agent |=373270004|Penicillin - class of antibiotic - (substance)" codeSystem="2.16.840.1.113883.6.96"/>  <actRelationship typeCode="MFST" inversionInd="true" contextConductionInd="true">  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <value xsi:type="CD" code="247472004 | Hives |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Hives"/>  </value>  </observation>  </actRelationship>  </observation> |

Where the clinician fills in both the substance/product and the reaction, context can propagate across the “is manifestation of” (MFST) relationship. The manifestation should not be post-coordinated with the allergic disorder (i.e. this guide recommends against a single post-coordinated expression such as "penicillin allergy manifesting as hives").

|  |
| --- |
| Example 14. Allergies coded with Findings value set |
| **CDA R2 and R1 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <value xsi:type="CD" code="91936005"  codeSystem="2.16.840.1.113883.6.96"  displayName="Allergy to penicillin"/>  <text>Allergy to PCN</text>  </observation>  **R2 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <value xsi:type="CD" code="91936005 | Allergy to penicillin |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Allergy to penicillin"/>  </value>  <text>Allergy to PCN</text>  </observation> |

In this case, the selected finding indicates the condition of being allergic.

* 1. Assessment Scale Results

An assessment scale is a collection of observations that together yield a summary evaluation of a particular condition. Examples include the Braden Scale (used for assessing pressure ulcer risk), APACHE Score (used for estimating mortality in critically ill patients), Mini-Mental Status Exam (used to assess cognitive function), APGAR Score (used to assess the health of a newborn), and Glasgow Coma Scale (used for assessment of coma and impaired consciousness.)

Assessment scales share certain features, which are described here as part of a recommended pattern:

1. Assessment scales have one or more component observations that can be taken in aggregate to provide an overall score (e.g. [ 248241002 | Glasgow coma score | ]).
2. Assessment scale component observations can be represented as a question and answer (e.g. [ 248240001 | Response to pain | ] = "3") or as a finding (e.g. [ 85157005 | Decorticate posture |]). Either or both of these representations may need to be communicated, depending on the use case.

The following Table 8 shows a sample Glasgow Coma Scale and result. A score is given for each of three types of neurological responses. A Coma Score of 13 or higher indicates a mild brain injury, 9 to 12 is a moderate injury and 8 or less a severe brain injury.

Table 8: Glasgow Coma Scale

|  |  |  |
| --- | --- | --- |
| Glasgow Coma Scale | Value | Score |
| **Eye Opening** | | |
| spontaneous | 4 |  |
| to speech | 3 |  |
| to pain | 2 | 2 |
| no response | 1 |  |
| **Motor Response** | | |
| obeys verbal command | 6 |  |
| localizes pain | 5 |  |
| flexion-withdrawal | 4 |  |
| flexion-abnormal | 3 | 3 |
| extension | 2 |  |
| no response | 1 |  |
| **Verbal Response** | | |
| oriented and converses | 5 |  |
| disoriented and converses | 4 |  |
| inappropriate words | 3 |  |
| incomprehensible sounds | 2 | 2 |
| no response | 1 |  |
| **Glasgow Coma Score** | | 7 |

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| --- |
| Example 15. Glasgow Coma Score assessment scale result pattern |
| **CDA R2 and R1 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="248241002"  codeSystem="2.16.840.1.113883.6.96"  displayName="Glasgow coma score"/>  <derivationExpr/>  <value xsi:type="INT" value="7"/>  <actRelationship typeCode="DRIV">  <observation classCode="OBS" moodCode="EVN">  <code code="288598006"  codeSystem="2.16.840.1.113883.6.96"  displayName="verbal response"/>  <value xsi:type="INT" value="2"/>  </observation>  </actRelationship>  <actRelationship typeCode="DRIV">  <observation classCode="OBS" moodCode="EVN">  <code code="248240001"  codeSystem="2.16.840.1.113883.6.96"  displayName="Motor Response"/>  <value xsi:type="INT" value="3"/>  <actRelationship typeCode="XFRM">  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <value xsi:type="CD" code="85157005"  codeSystem="2.16.840.1.113883.6.96"  displayName="Decorticate posture"/>  </observation>  </actRelationship>  </observation>  </actRelationship>  </observation>  **R2 CD datatype**  <observation classCode="OBS" moodCode="EVN"> | |  <code code="248241002|Glasgow coma score" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Glasgow coma score"/>  </code>  <derivationExpr/>  <value xsi:type="INT" value="7"/>  <actRelationship typeCode="DRIV">  <observation classCode="OBS" moodCode="EVN">  <code code="288598006 | ability to use verbal communication |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="verbal response"/>  </code>  <value xsi:type="INT" value="2"/>  </observation>  </actRelationship>  <actRelationship typeCode="DRIV">  <observation classCode="OBS" moodCode="EVN">  <code code="248240001 | Response to pain |" codeSystem="2.16.840.1.113883.6.96"gt;  <displayName value="Motor Response"/>  </code>  <value xsi:type="INT" value="3"/>  <actRelationship typeCode="XFRM">  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <value xsi:type="CD" code="85157005 | Decorticate posture |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Decorticate posture"/>  </value>  </observation>  </actRelationship>  </observation>  </actRelationship>  </observation> |

The aggregate score is modeled as the value of the assessment procedure (outer) observation. The <derivationExpr> can contain a formal language expression specifying how the value is computed. Component observations are nested under the aggregate observation, linked with a "DRIV" (is derived from) relationship. Where a component observation needs to be communicated in different formats, each format is a discrete observation, linked by a "XFRM" (is a transformation of) relationship.

* 1. Observation, Condition, Diagnosis, Concern

**NOTE:** The HL7 Patient Care Work Group is continuing to develop a formal model for condition tracking. The examples provided here are greatly simplified so as to illustrate certain aspects of SNOMED CT implementation.

Observations, Conditions, Diagnoses, and Concerns are often confused, but in fact have distinct definitions and patterns.

* "Observation" and "Condition": An HL7 observation is something noted and recorded as an isolated event, whereas an HL7 condition is an ongoing event. Symptoms and findings (also know as signs) are observations. The distinction between "seizure" and "epilepsy" or between "allergic reaction" and "allergy" is that the former is an observation, and the latter is a condition.  
    
  SNOMED CT distinguishes between "Clinical Findings" and "Diseases", where a SNOMED CT disease is a kind of SNOMED CT clinical finding that is necessarily abnormal:
  + [ 404684003 | Clinical finding |]
    - [ 64572001 | Disease |]

The SNOMED CT finding/disease distinction is orthogonal to the HL7 observation/condition distinction, thus a SNOMED CT finding or disease can be an HL7 observation or condition.

* "Diagnosis": The term "diagnosis" has many clinical and administrative meanings in healthcare
  + A diagnosis is the result of a cognitive process whereby signs, symptoms, test results, and other relevant data are evaluated to determine the condition afflicting a patient.
  + A diagnosis often directs administrative and clinical workflow, where for instance the assertion of an admission diagnosis establishes care paths, order sets, etc.
  + A diagnosis is often something that is billed for in a clinical encounter. In such a scenario, an application typically has a defined context where the billable object gets entered.
* "Concern": A concern is something that a clinician is particularly interested in and wants to track. It has important patient management use cases (e.g. health records often present the problem list or list of concerns as a way of summarizing a patient's medical history).

Differentiation of Observation, Condition, Diagnosis, and Concern in common patterns:

* "Observation" and "Condition": The distinction between an HL7 Observation and HL7 Condition is made by setting the Act.classCode to "OBS" or "COND", respectively. The distinction between a SNOMED finding and SNOMED disease is based on the location of the concept in the SNOMED CT hierarchy. There is no flag in a clinical statement instance for distinguishing between a SNOMED CT finding vs. disease.
* "Diagnosis":
  + Result of a cognitive process: Could potentially be Indicated by post-coordinating a SNOMED CT finding method attribute with a procedure such as "cognitive process".
  + Directs administrative and clinical workflow: These use cases typically rely more on the context in which the diagnoses are entered (e.g. where an order set has a field designated for the admission diagnosis). In such a case, the distinction of a (particular kind of) diagnosis is that it occurs within a particular organizer (e.g. a condition within an Admission Diagnosis section is an admission diagnosis from an administrative perspective).
    - Something that is billed for: The fact that something was billed for would be expressed in another HL7 message. There is nothing in the pattern for a diagnosis that says whether or not it was or can be billed for.
* "Concern": The HL7 Patient Care Work Group is developing a formal model for condition tracking. In that model, a problem (which may be an Observation, a Procedure, or some other type of Act) is wrapped in an Act with a new Act.classCode “CONCERN”. The focus in this guide is on the use of SNOMED CT, whereas the Patient Care condition tracking model is the definitive source for the overall structure of a problem list.

It should be noted that the administrative representation of a diagnosis and the representation of a concern break the rules from section ‎3.1.1 Observations vs. Organizers, in that these designations are based on context, whereas the designation of something as an Observation vs. Condition is inherent in the clinical statement itself.

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| Example 16. Assertion of a clinical finding |
| **CDA R2 and R1 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <text>Headache</text>  <value xsi:type="CD" code="25064002"  codeSystem="2.16.840.1.113883.6.96"  displayName="Headache"/>  </observation>  **R2 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <text>Headache</text>  <value xsi:type="CD" code="25064002 | Headache |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Headache"/>  </value>  </observation> |

The observation is asserting a clinical finding of "headache".

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| Example 17. Context-dependent (administrative) assertion of a diagnosis |
| **CDA R2 and R1 CD datatype**  <act classCode="DOCSECT" moodCode="EVN">  <code code="8646-2"  codeSystem="2.16.840.1.113883.6.1"  codeSystemName="LOINC"/>  <title>Hospital Admission Diagnosis</title>  <text>Hospital admission diagnosis of headache</text>  <actRelationship typeCode="COMP">  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <value xsi:type="CD" code="25064002"  codeSystem="2.16.840.1.113883.6.96"  displayName="Headache"/>  </observation>  </actRelationship>  </act>  **R2 CD datatype**  <section classCode="DOCSECT" moodCode="EVN">  <code code="8646-2" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>  <title>Hospital Admission Diagnosis</title>  <text>Hospital admission diagnosis of headache</text>  <entry typeCode="COMP">  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <value xsi:type="CD" code="25064002 " codeSystem="2.16.840.1.113883.6.96">  <displayName="Headache"/>  </value>  </observation>  </ entry>  </section> |

That a given diagnosis is, for instance, an Admission Diagnosis, can be asserted by wrapping the Observation within a particular Organizer (or other applicable Act or Act subtype).

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| --- |
| Example 18. Example of a problem list containing concerns |
| **CDA R2 and R1 CD datatype**  <act classCode="DOCSECT" moodCode="EVN">  <code code="11450-4"  codeSystem="2.16.840.1.113883.6.1"  codeSystemName="LOINC"/>  <title>Problem List</title>  <text>  <list>  <item>Headache</item>  <item>Osteoarthritis of knee</item>  </list>  </text>  <actRelationship typeCode="COMP">  <act classCode="CONCERN" moodCode="EVN">  <actRelationship typeCode="SUBJ">  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <value xsi:type="CD" code="25064002"  codeSystem="2.16.840.1.113883.6.96"  displayName="Headache"/>  </observation>  </actRelationship>  </act>  </actRelationship>  <actRelationship typeCode="COMP">  <act classCode="CONCERN" moodCode="EVN">  <actRelationship typeCode="SUBJ">  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <value xsi:type="CD" code="239873007"  codeSystem="2.16.840.1.113883.6.96"  displayName="Osteoarthritis of knee"/>  </observation>  </actRelationship>  </act>  </actRelationship>  </act>  **R2 CD datatype**  <act classCode="DOCSECT" moodCode="EVN">  <code code="11450-4" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC"/>  <title>Problem List</title>  <text>  <list>  <item>Headache</item>  <item>Osteoarthritis of knee</item>  </list>  </text>  <actRelationship typeCode="COMP">  <act classCode="CONCERN" moodCode="EVN">  <actRelationship typeCode="SUBJ">  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <value xsi:type="CD" code="25064002 | Headache |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Headache"/>  </value>  </observation>  </actRelationship>  </act>  </actRelationship>  <actRelationship typeCode="COMP">  <act classCode="CONCERN" moodCode="EVN">  <actRelationship typeCode="SUBJ">  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <value xsi:type="CD" code="239873007 | Osteoarthritis of knee |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Osteoarthritis of knee"/>  </value>  </observation>  </actRelationship>  </act>  </actRelationship>  </act> |

That a given clinical statement is a part of a condition tracking structure can be asserted by containing the clinical statement within the concern act, using the mechanism defined by the HL7 Patient Care Work Group, as shown here.

* 1. Family History

As noted above (see section 2.2.5 Participations), the HL7 "subject" participant overlaps in meaning with the SNOMED CT Subject Relationship Context.

Where a family member has a condition, regardless of whether the observation code contains an explicit Subject Relationship Context, the subject of the observation is the family member, and not the patient. Where the observation code does include an explicit Subject Relationship Context, the subject participant can also be used where needed to provide further information about the subject.

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| Example 19. Family history, with explicit Subject Relationship Context |
| **CDA R2 and R1 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <text>Family history of cancer in father</text>  <value xsi:type="CD" code="275937001"  codeSystem="2.16.840.1.113883.6.96"  displayName="Family history of cancer">  <qualifier>  <name code="408732007" displayName="Subject relationship context"/>  <value code="9947008" displayName="Biological father"/>  </qualifier>  </value>  </observation>  **R2 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <text>Family history of cancer in father</text>  <value xsi:type="CD" code="275937001 | Family history of cancer |:408732007 | Subject relationship context | =9947008 | Biological father |" codeSystem="2.16.840.1.113883.6.96"/>  </observation> |

This observation uses an explicit SNOMED CT Subject relationship context attribute to represent the fact that the subject of the observation is the father.

|  |
| --- |
| Example 20. Family history, without explicit Subject Relationship Context |
| **CDA R2 and R1 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION"  codeSystem="2.16.840.1.113883.5.4"/>  <text>Family history of cancer in father</text>  <value xsi:type="CD" code="363346000"  codeSystem="2.16.840.1.113883.6.96"  displayName="Cancer"/>  <subject typeCode="SBJ">  <relatedEntity classCode="PRS">  <code code="9947008"  codeSystem="2.16.840.1.113883.6.96"  displayName="Biological father"/>  </relatedEntity>  </subject>  </observation>  **R2 CD datatype**  <observation classCode="OBS" moodCode="EVN">  <code code="ASSERTION" codeSystem="2.16.840.1.113883.5.4"/>  <text>Family history of cancer in father</text>  <value xsi:type="CD" code="363346000 | Cancer |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Cancer"/>  </value>  <subject typeCode="SBJ">  <relatedEntity classCode="PRS">  <code code="9947008 | Biological father |" codeSystem="2.16.840.1.113883.6.96">  <displayName="Biological father"/>  </code>  </relatedEntity>  </subject>  </observation> |

This example is equivalent to the preceding example, using the subject participant rather than the SNOMED CT Subject relationship context attribute to represent the fact that the subject of the observation is the father.

* 1. Medications and Immunizations

Areas of overlap between HL7 and SNOMED CT include the source of information, as described above (§ 3.4). This is particularly important for medications, where one needs to differentiate what a patient is actually having administered vs. what is being dispensed. The former is typically gleaned from the patient, family member, or the medication administration record for an inpatient. The latter is often gleaned from a pharmacy application.

Another area of overlap between HL7 and SNOMED CT includes the method and route by which a substance is administered. Various ways by which this information can be represented include:

* SNOMED CT defining attributes (whether pre- or post-coordinated)
  + [ 260686004 | Method | ]: Used to indicate the method by which a procedure is performed.
  + [ 410675002 | Route of administration |]: Used to indicate the route by which a substance is administered.
* RIM attributes
  + SubstanceAdministration.code: A code further describing the type of administration.
  + SubstanceAdministration.routeCode: The method of introducing the therapeutic material into or onto the subject.

The following patterns post-coordinate within SubstanceAdministration.code to represent the route of administration. Within a particular realm, or as required by a particular implementation, there may also be a need to populate SubstanceAdministration.routeCode, possibly with values drawn from a required and non-SNOMED CT value set.

The level of detail by which an administered substance is known can vary greatly, particularly when dealing with patient recollection. SNOMED CT has both a [ 105590001 | Substance |] hierarchy and a [ 373873005 | Pharmaceutical / biologic product | ] hierarchy, and may have realm-specific drug extensions that include manufacturer-specific product codes. Concepts from the Substance hierarchy **SHOULD NOT** be used to code an administered substance.

In the following examples, the pharmacy is dispensing atenolol 50mg tablets with instructions to take one tablet per day, whereas the patient's daughter says that only a half-tablet per day is being ingested.

|  |
| --- |
| Example 21. Pharmacy: Atenolol 50mg tablet, take 1 per day. |
| **CDA R2 and R1 CD datatype**  <substanceAdministration classCode="SBADM" moodCode="INT">  <code code="225426007"  codeSystem="2.16.840.1.113883.6.96"  displayName="Administration of therapeutic substance">  <qualifier>  <name code="410675002"  displayName="Route of administration"/>  <value code="26643006" displayName="Oral route"/>  </qualifier>  </code>  <text>Atenolol 50mg tablet, take 1 per day</text>  <effectiveTime xsi:type="PIVL\_TS">  <period value="24" unit="h"/>  </effectiveTime>  <doseQuantity value="1"/>  <consumable typeCode="CSM">  <manufacturedProduct classCode="MANU">  <manufacturedLabeledDrug classCode="MMAT"  determinerCode="KIND">  <code code="318420003"  codeSystem="2.16.840.1.113883.6.96"  displayName="Atenolol 50mg tablet"/>  </manufacturedLabeledDrug>  </manufacturedProduct>  </consumable>  <actRelationship typeCode="XCRPT"  contextConductionInd="false">  <actReference classCode="SBADM" moodCode="EVN">  <id root="b3440e50-8f48-11da-a72b-0800200c9a66"/>  </actReference>  </actRelationship>  </substanceAdministration>  **R2 CD datatype**  <substanceAdministration classCode="SBADM" moodCode="INT">  <code code="432102000 | Administration of substance |:410675002 | Route of administration | =26643006 | Oral route |" codeSystem="2.16.840.1.113883.6.96"/>  <text>Atenolol 50mg tablet, take 1 per day</text>  <effectiveTime xsi:type="PIVL\_TS">  <period value="24" unit="h"/>  </effectiveTime>  <doseQuantity value="1"/>  <consumable typeCode="CSM">  <manufacturedProduct classCode="MANU">  <manufacturedLabeledDrug classCode="MMAT" determinerCode="KIND">  <code code="318420003 | Atenolol 50mg tablet |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Atenolol 50mg tablet"/>  </code>  </manufacturedLabeledDrug>  </manufacturedProduct>  </consumable>  <actRelationship typeCode="XCRPT" contextConductionInd="false">  <actReference classCode="SBADM" moodCode="EVN">  <id root="b3440e50-8f48-11da-a72b-0800200c9a66"/>  </actReference>  </actRelationship>  </substanceAdministration> |

This act represents an excerpt from a pharmacy application.

|  |
| --- |
| Example 22. Informant: Atenolol 50mg tablet, taking 1/2 per day. |
| **CDA R2 and R1 CD datatype**  <substanceAdministration classCode="SBADM" moodCode="EVN">  <code code="225426007"  codeSystem="2.16.840.1.113883.6.96"  displayName="Administration of therapeutic substance">  <qualifier>  <name code="410675002"  displayName="Route of administration"/>  <value code="26643006" displayName="Oral route"/>  </qualifier>  </code>  <text>Atenolol 50mg tablet, taking 1/2 per day</text>  <effectiveTime xsi:type="PIVL\_TS">  <period value="24" unit="h"/>  </effectiveTime>  <doseQuantity value="0.5"/>  <consumable typeCode="CSM">  <manufacturedProduct classCode="MANU">  <manufacturedLabeledDrug classCode="MMAT"  determinerCode="KIND">  <code code="318420003"  codeSystem="2.16.840.1.113883.6.96"  displayName="Atenolol 50mg tablet"/>  </manufacturedLabeledDrug>  </manufacturedProduct>  </consumable>  <informant typeCode="INF">  <relatedEntity classCode="PRS">  <code code="66089001"  codeSystem="2.16.840.1.113883.6.96"  displayName="Daughter"/>  </relatedEntity>  </informant>  </substanceAdministration>  **R2 CD datatype**  <substanceAdministration classCode="SBADM" moodCode="EVN">  <code code="432102000 | Administration of substance |:410675002 | Route of administration | =26643006 | Oral route |" codeSystem="2.16.840.1.113883.6.96"/>  <text>Atenolol 50mg tablet, taking 1/2 per day</text>  <effectiveTime xsi:type="PIVL\_TS">  <period value="24" unit="h"/>  </effectiveTime>  <doseQuantity value="0.5"/>  <consumable typeCode="CSM">  <manufacturedProduct classCode="MANU">  <manufacturedLabeledDrug classCode="MMAT" determinerCode="KIND">  <code code="318420003 | Atenolol 50mg tablet |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Atenolol 50mg tablet"/>  </code>  </manufacturedLabeledDrug>  </manufacturedProduct>  </consumable>  <informant typeCode="INF">  <relatedEntity classCode="PRS">  <code code="66089001 | Daughter |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="Daughter"/>  </code>  </relatedEntity>  </informant>  </substanceAdministration> |

This act represents information gleaned from the patient's daughter.

# Normal forms

Every application has its own data entry screens, workflow, internal database design, and other nuances, and yet despite this, we talk of semantic interoperability. In order to achieve interoperability, and enable a receiver to aggregate data coming from any number of applications, it must be possible to compare data generated on any of these applications. In order to compare data, it helps to imagine a canonical or normal form. [A canonical form is defined as a serialized representation of a SNOMED CT expression which follows the normal form and in which the refinements, attributes and attribute groups are arranged in a standard order.] If all data, regardless of how it was captured, can be converted into a common representation, it becomes possible to compare.

To that end, we differentiate the "model of use" from the "model of meaning", where the former represents the way in which the data was captured, and the latter represents a common representation. All representations recommended in this guide can be converted into a common model of meaning. This common model of meaning can be expressed in a SNOMED CT normal form and/or a RIM Normal Form, thereby enabling data comparisons.

There is no attempt in this section to comprehensively address "HL7/RIM Normal Forms", but rather to suggest why they may be desirable and useful. An "agreed upon comprehensive reference normal form" is declared as out of scope for this document. A normal form for Clinical Statements would likely be very useful and desirable and it certainly could be considered for inclusion in a future version of this document.

* 1. SNOMED CT Normal Forms

The text below is taken from the introduction to the document 'SNOMED CT Transformations to Normal Forms', and outlines the purpose of transformations and the general method of transformation. Related information can be found in the Technical Implementation Guide ([TIG](http://www.ihtsdo.org/fileadmin/user_upload/doc/en_us/tig.html)). From the perspective of integration of SNOMED CT expressions in HL7 communications the assumption is that in most cases a "close to user" form will be stored and communicated. The normal form transformation provides a method that enables consistent comparison of these expressions with one another and with retrieval queries.

The purpose of generating normal forms is to facilitate complete and accurate retrieval of pre- and post-coordinated SNOMED CT expressions from clinical records or other resources.

The approach described is based on the description logic definitions of SNOMED CT concepts which are used when recording clinical statements in an electronic records system. Using this approach, expressions that are authored, stored and/or communicated in a relatively informal close-to-user form are logically transformed into a common normalized form. In this normalized form it is possible to apply simple rules to test subsumption between expressions.

The simplest case of a valid close-to-user expression is a single conceptId, and the approach described can be applied to these simple pre-coordinated expressions, as well as to more complex expressions that include multiple conceptIds and refinements (qualifiers).

Likewise, transformations and normalisations can be both simple and complex, however the general principle is that the normalisation process will restate a SNOMED CT expression in terms of the 'primitive' concepts with which it is associated in the reference data. By example, the SNOMED CT concept [ 80146002 | appendectomy |] would, in essence, transform under normalisation to [ 71388002 | procedure |: { 260686004 | method | = 129304002 | excision - action |, 405813007 | procedure site - Direct | = 66754008 | appendix structure |} ] ("a procedure that consists of excising an appendix").

The approach to normalization may be applied to the specific SNOMED CT expressions but may also be extended to take account of contextual information derived from the information model in which the expression is situated. Therefore, the normal form may include SNOMED CT context information, even if this is not present in the initial SNOMED CT expression. As such the result of transformation of [ 80146002 | appendectomy |] is a simplification (the additional contextual/situation information is missing), but it is hoped that the example sufficiently illustrates the principle of normalisation.

The algorithm extends earlier work on normal forms as follows:

* Normalizes fully-defined values within definitions or expressions producing nested expressions that are fully normalized.
* Merges refinements stated in an expression with definitional relationships present in the definitions of the concepts referenced by the expression.
* The merge process takes account of refinements that may not be grouped or nested in a manner that precisely reflects the structure of a current (or future) concept definition.
* This avoids the need to add, store and communicate potentially spurious detail from current definitions to the expression recorded by a user or software application.
* Takes account of context rules including soft default context and a preliminary approach to moodCode mapping and handling of procedures with values (present in algorithm but not yet easily visible in test environment).
  1. Transformations to Normal Forms

The requirements for full normalization of alternative representations using different combinations of SNOMED CT and HL7 RIM artifacts requires an agreed upon comprehensive reference normal form. This is beyond the scope of this document. However, the rules and guidance in Guidance on Overlaps between RIM and SNOMED CT Semantics (§ 2 ) provide the foundations for specifying some of the more common transformation requirements.

In particular the following types of transformation may be required

* Transforming deprecated patterns using the Observation.code and Observation.value to the preferred pattern. See Act.code (§ 2.2.2) and Observation.value (§ 2.2.3) and Observation code and value (in event mood) (§ 3.3)
* Transforming based on moodCode and statusCode to apply specified contexts to SNOMED CT expressions, where these expressions do not state an explicit context. See Act.moodCode (§ **Error! Reference source not found.**) and Act.statusCode (§ **Error! Reference source not found.**).
* Transforming any deprecated uses of the negationInd attribute to an appropriate SNOMED CT expression that explicitly state appropriate "finding context" or "procedure context". See Act.negationInd (§ **Error! Reference source not found.**).
* Transforming any information in specific HL7 methodCode, targetSiteCode and approachSiteCode attributes into the appropriate refinements of the associated SNOMED CT expression. See Procedure.methodCode and Observation.methodCode (§ **Error! Reference source not found.**), Procedure.targetSiteCode and Observation.targetSiteCode (§ **Error! Reference source not found.**) and Procedure.approachSiteCode and SubstanceAdministration.approachSiteCode (§ **Error! Reference source not found.**).
* Transforming the representation of "subject" participation and SNOMED CT "subject relationship context" into a single coherent form. See Subject Participation and Subject Relationship Context (§ **Error! Reference source not found.**).

Additional documentation on this topic will be added based on experience with use of this specification.

# SNOMED CT concept domain constraints

* 1. Introduction

This section presents general guidance regarding which SNOMED CT concepts are suitable for use as values for specific attributes of the main classes of the Clinical Statement pattern. These value set constraints are presented at a fairly high level, by partitioning of SNOMED CT into a number of major concept classes that relate to the concept domains that apply to the relevant HL7 attributes.

In most cases, these value sets are supersets of the values used in the constrained models in Common Patterns (§ **Error! Reference source not found.**) (any exceptions to this are indicated).

For reasons introduced in this section and explored in greater detail in Detailed aspects of issues with a vocabulary specification formalism (§ **Error! Reference source not found.**), a complete solution to value set representation is not presented in this Guide. The nature of and rationale for the approach taken is given in the following sections.

* 1. Approach to Value Set Constraint Specifications

* + 1. How the Value Sets are Presented

The value set specifications are presented as tables in the following general structure:

|  |  |
| --- | --- |
| **Class Name:** The Clinical Statement pattern class is identified here | **Class Code:** If relevant, distinct classCodes are identified here |
| **Attribute Name:** The relevant attribute(s) is/are identified here | |
| **Narrative description of concept domain:** The relevant narrative description of the concept domain is identified here. | |
| **Value set representation:** Value sets are identified here, using the SNOMED CT compositional grammar extended for the purpose of this Implementation Guide as described in SNOMED CT Compositional Grammar - extended (§ **Error! Reference source not found.**) | |
| **Notes:** Any notes relevant to this className+classCode+attributeName value set specification are made here. | |

* + 1. Why these Value Set Constraints are Useful

Specifications of the "simple" form provided in this section have some limitations but they serve two important purposes described in the following sub-sections.

* + - 1. General Partitioning of SNOMED CT

A large clinical terminology such as SNOMED CT represents a number of lexically similar concepts which are grammatically, linguistically or semantically distinct. This phenomenon is particularly pronounced if the terminology is considered without any kind of partitioning. The coarse-grained partitioning specified by these constraints simplifies and clarifies decisions about which of a set of superficially similar SNOMED CT concepts are appropriate to particular HL7 concept domains.

For example, consider a concept domain defined as representing "an adverse event in reaction to a drug".

The most suitable SNOMED CT concepts to represent such an event would be those subsumed by [ <<62014003 | adverse reaction to drug |].

However from a lexical perspective other less appropriate concepts may appear to be suitable. For example

The reference to "adverse drugs reaction" may suggest use of subtypes of the procedure concept [ <<396079007 | assessment of adverse drug reactions |].

The reference to "drug" may suggest concepts in the use of subtypes of [ <<373873005 | pharmaceutical / biologic product |] or [ <<410942007 | drug or medicament |].

The simple value set constraints in these specifications exclude these inappropriate alternatives and thus provide a helpful guide for value set developers.

* + - 1. Starting Point for SNOMED CT Model-based Value Set Specifications

The Schematic Illustrations of SNOMED CT Expressions (**Error! Reference source not found.**) identify the "clinical kernel" or primary clinical "focus concept" that may exist alone or as part of a contextualized expression. In most cases, the simple value set constraints in these specifications apply to this clinical focus concept. In combination with the SNOMED CT concept model these constraints form a foundation for more detailed "complete" value set specification (as explored in Detailed aspects of issues with a vocabulary specification formalism (§ **Error! Reference source not found.**)).

Simple value set constraints can be regarded as a set of subsumption clauses related by OR logic. Each clause permits the inclusion of a focus concept that is subsumed by a specified concept. In contrast, a more complete specification would check normal form transformations of candidate expressions against a variety of subsumption and role-based restrictions. In addition a complete specification requires support of a full set of logical operators between clauses (i.e. OR, AND, NOT).

For example, consider a value-set constraint which indicates that the "focus concept" must be a kind of [ <<404684003 | clinical finding |].

* The concept model indicates that a [ 404684003 | clinical finding |] concept
  + can be refined by name/value pairs with attribute names such as [ 363698007 | finding site |], [ 246112005 | severity |], [ 116676008 | associated morphology |] etc.,
  + can be the value to the attribute name [ 246090004 | associated finding |]
    - as part of the definition or refinement of a [ 413350009 | finding with explicit context |]
    - as part of post-coordinated expression that includes the [ 404684003 | clinical finding |] within a context wrapper.
* A comprehensive notation for value sets that allow subtypes of [ 404684003 | clinical finding |] may therefore also need to indicate whether any limitations apply either to the refinement or situation in which the concepts are used.
  + The context wrapper may, for instance, be used to communicate negation and uncertainty and may thus be required to support some types of information. However, it may also be necessary to constrain the use of context in a manner that is relevant to the Act.moodCode or other attributes and association in the HL7 representation.
    1. Why the Value Set Constraints are Incomplete

A simple approach to value set constraints is inevitably incomplete when applied to SNOMED CT as a result of two features supported by SNOMED CT.

1. The ability to create, and the requirement to communicate, post-coordinated SNOMED CT expressions.
2. The ability to use pre-coordinated expressions referring to concepts that are subtypes of [ 243796009 | situation with explicit context |][[11]](#footnote-12).

Both these SNOMED CT features are useful for the detailed coded capture of clinical data. However, they create a challenge for value set representation that cannot be fully met by the simple approach used in this specification. As outlined in the following sections, the inadequacy of the simple approach introduces the risks of false-positive and false-negative results.

* + - 1. False Negatives - Rejection of Valid Expressions

Two different aspects of SNOMED CT post-coordination ("attribute refinement" and "context/situation wrapping") may result in valid expressions being rejected by "simple" value sets tests.

*Example of "attribute refinement" false negative:*

The concept [ 82764005 | operation on duodenum |] could be refined by applying more specific values to its [ 260686004 | method |] and [ 363704007 | procedure site |] attributes.

If the value for [ 260686004 | method |] is refined to [ 129304002 | excision - action |] and the value for [ 363704007 | procedure site |] to [ 181247007 | entire duodenum |], the resulting expression means "excision of the entire duodenum" and we would expect this to mean the same as "total excision of duodenum". This expression would be inappropriately rejected by a "simple" value set test of the instruction [ <<173848007 | total excision of duodenum |] (i.e. "include 'total excision of duodenum' and any sub-types").

* This false negative arises because [ 82764005 | operation on duodenum |] is not a subtype of [ 173848007 | total excision of duodenum |].
* In order to obtain the appropriate result, a more complex test must be performed. This involves comparison of the normal forms of the two expressions.

*Example of "context/situation wrapping" false negative:*

The concept [ 373573001 | clinical finding present |] can be refined by applying a more specific value to its attribute [ 246090004 | associated finding |].

If the value for [ 246090004 | associated finding |] is refined to [ 404640003 | dizziness |], the resulting post-coordinated expression means "dizziness present". This expression would be inappropriately rejected by a "simple" value set test of the instruction [ <<404640003 | dizziness |] (i.e. "include 'dizziness' and any sub-types").

* This false negative outcome is because [ 373573001 | clinical finding present |] is not a subtype of [ 404640003 | dizziness |].
* In order to obtain the appropriate result, a more complex test must be performed. This involves comparison of the normal forms of the two expressions, taking into account the default context of a SNOMED CT 'finding'.
  + - 1. False Positives - Acceptance of Invalid Expressions

A potential pattern of false positive value set testing would result from attempts to augment the "simple" value set specifications to include corresponding "context/situation" concepts. The absence (by design) of an exhaustive set of "context/situation" concepts corresponding to each "finding" or "procedure" concept means that on many occasions only the specification of a more general "situation" concept will guarantee that desirable concepts will be included, but at the expense of allowing multiple false positives.

*Example of pre-coordinated "situation" false positive:*

Consider a value set designed to include "respiratory disorders". To avoid rejecting concepts which include explicit context, a simple value set might include [ <<413350009 | finding with explicit context |] as well as [ <<50043002 | disorder of respiratory system |]. Such a clause would include the relevant respiratory findings, including those with explicit context. However, it would also inappropriately include other findings with explicit context (i.e. non-respiratory finding with explicit context).

Failure to include [ <<413350009 | finding with explicit context |] would result in false negatives as illustrated in the previous section.

When including findings with explicit context one MUST restrict the context to the respective subset that matches the more simple value set definition for findings/disorders. References: the HL7 VSD standard and SNOMED CT reference set, compositional grammar and constraint language (and other "family of language") specifications for obtaining additional guidance in this area.

* In order to obtain the appropriate result, a more complex test must be performed. This involves restricting the inclusion of subtypes of [ 413350009 | finding with explicit context |] to those with a value for [ 246090004 | associated finding |] that are in the set specified by [ <<50043002 | disorder of respiratory system |].
  1. Constraint Specifications

The "simple" value set constraints are provided as a set of tables, covering the major classes of the Act and Entity Choice boxes.

* + 1. Specifications
       1. Observation

|  |  |
| --- | --- |
| **Class Name:** Observation | **Class Code: OBS** |
| **Attribute Name:** Observation.value | |
| **Narrative description of concept domain:** An act that is intended to result in new information about a subject. The main difference between observations and other acts is that it has a value attribute that is used to state the result of the assessment action described in Act.code. | |
| **Simple representation:** ((<<404684003 | clinical finding |) OR (<<413350009 | finding with explicit context |) OR (<<272379006 | event |)) | |
| **Notes:** Where Observation.code = ASSERTION.   As indicated in section 2.2.3.2 subheading 3 under "Deprecated or non-recommended forms", the situation may arise in which Observation.value is a SNOMED CT expression from the set specified in the 'simple representation' field of this table and Act.code is represented by a code other than "ASSERTION". Such an approach can only be safely used if interpretation of the Act.code together with the Observation.value does not yield a meaning that is substantially different from the meaning implied if the Act.code was "ASSERTION". Without exhaustive scrutiny of SNOMED CT's content it is not possible to identify that set of codes that can safely be used in this way in Act.code. | |

A further alternative representation is needed to communicate record entries where SNOMED CT content has been used to represent both Observation.code and a coded Observation.value. Observation.value may be numeric, or it may be a coded nominal or ordinal result and so itself may also be drawn from SNOMED CT:

|  |  |
| --- | --- |
| **Class Name:** Observation | **Class Code: OBS** |
| **Attribute Name:** Observation.code  **Attribute Name:** Observation.value | |
| **Narrative description of concept domain:** An act that is intended to result in new information about a subject. The main difference between observations and other acts is that it has a value attribute that is used to state the result of the assessment action described in Act.code. | |
| **Simple representation for Observation.code:** ((<<386053000 | evaluation procedure |) OR (<<363787002 | observable entity |))  **Simple representation for Observation.value:**  When Observation.value is datatype CD, the Observation.value needs to correspond with the Observation.code, as a valid result of the Observation and needs to be in alignment with the IHTSDO work on Observation Result, which is ongoing.. | |
| **Note:** Observation.code need not be a SNOMED CT code - i.e., could be LOINC. | |

* + - 1. Procedure

|  |  |
| --- | --- |
| **Class Name:** Procedure | **Class Code: PROC** |
| **Attribute Name:** Procedure.code | |
| **Narrative description of concept domain:** An Act whose immediate and primary outcome (post-condition) is the alteration of the physical condition of the subject. | |
| **Simple representation:** ((<<71388002 | procedure |) OR (<<129125009 | procedure with explicit context|)) AND (!432102000 | Administration of substance|) AND (!<243704004 | provision of appliances|) AND (!<183253002 | provision of medical equipment |) AND (!<404919001 | wheat-free diet) AND (!<223456000 | provision of a special diet) AND (!<440298008 | Dispensing of pharmaceutical/biologic product |)) | |
| **Notes:** in order to prevent overlap, this specification includes the negated clauses to exclude the value sets of "Substance administration" and "Supply". | |

* + - 1. Substance Administration

|  |  |
| --- | --- |
| **Class Name:** SubstanceAdministration | **Class Code:** SBADM |
| **Attribute Name:** SubstanceAdministration.code | |
| **Narrative description of concept domain:** Introducing or otherwise applying a substance to the subject | |
| **Simple representation:** (416118004 | administration |) optionally: <<432102000 | administration of therapeutic substance | | |
| **Notes:** In Release 1 of this guide, and in order to support a tighter standardization of this class and ensure that the "substance" administered was only represented in the related Material Entity, SNOMED CT content that explicitly referred to substances (for example 39543009|administration of insulin (procedure)|) was excluded (by a specification that limits the codes offered and disallows any of the subtypes.)  In response to examples that have been identified where specific subtypes of 432102000 | Administration of substance (procedure) | are required for use in SubstanceAdministration.code, the looser optional constraint is offered to provide access. Nevertheless, the intent of the guide (to ensure that the "substance" administered was only represented in a related Material Entity) still holds to enable consistent analysis. | |

* + - 1. Supply

|  |  |
| --- | --- |
| **Class Name:** Supply | **Class Code:** SPLY |
| **Attribute Name:** Supply.code | |
| **Narrative description of concept domain:** The provision of a material by one entity to another | |
| **Simple representation:** ((<<243704004 | provision of appliances|) OR (<<183253002 | provision of medical equipment |) OR (<<404919001 | wheat-free diet|) OR (<<223456000 | provision of a special diet|) OR (<<440298008 | Dispensing of pharmaceutical/biologic product |)) | |
| **Notes:** Possibly incomplete. Currently SNOMED CT has no abstract notion of the "supply/provision of material", so whilst diet and appliances, equipment and pharmaceutical/biologics are supported, it is still possible that some cases are not supported. | |

* + - 1. Organizer

|  |  |
| --- | --- |
| **Class Name:** Organizer | **Class Code:** ORGANIZER |
| **Attribute Name:** Organizer.code | |
| **Narrative description of concept domain:** Organizer of entries. Navigational. No semantic content. Knowledge of the section code is not required to interpret contained observations. Represents a heading in a heading structure, or "organizer tree". | |
| **Simple representation:** ((<<419891008 | record artifact |) OR (<<386053000 | evaluation procedure |)) | |
| **Notes:** [<<386053000 | evaluation procedure |] is included to allow the naming of batteries with Laboratory procedure terms. | |

* + - 1. Entity

The following very general SNOMED CT value set for using the Entity.code attribute is outlined below. In any specific model this set should be appropriately constrained.

|  |  |
| --- | --- |
| **Class Name:** Entity | **Class Code:** ENT |
| **Attribute Name:** Entity.code | |
| **Narrative description of concept domain:** A physical thing, group of physical things or an organization capable of participating in Acts, while in a role. | |
| **Simple representation:** ((<<410607006 | organism |) OR (<<373873005 | pharmaceutical / biologic product |) OR (<<260787004 | physical object |) OR (<<105590001 | substance |) OR (<<123038009 | specimen |) OR (<<308916002 | environment or geographical location |)). | |
| **Notes:** (1) A more sophisticated division of SNOMED CT Entities is needed to reconcile with the coarse-grained specializations of Entity within the HL7 V3 Specification (e.g. LivingSubject, Place, Manufactured Material...).  (2) the SNOMED CT class [ 123038009 | specimen ] could be viewed as merging both the Entity and the specimen "role"; however, it is included in this specification on the understanding that the "specimen" role would be restated within the Clinical Statement pattern-conformant specification. | |

* + 1. Notes

* + - 1. moodCode influences

A comprehensive notation for all SNOMED CT ‘findings and procedures" value sets is logically ‘wrapped" in the SNOMED CT context/situation wrapper, and indeed the context/situation wrapper would be used to communicate negation and uncertainty in message designs where SNOMED CT is the only permitted code system. In more "complete" value set constraint specifications, therefore, it can be expected that the moodCode values found in message instances should influence the corresponding valid "finding and procedure context" values. Details of the recommended mappings are provided in Act.moodCode (§ **Error! Reference source not found.**)

* + - 1. Translations

A value set constraint can be applied to any coded content where the codeSystem is SNOMED CT. This includes cases where original encoding is SNOMED CT or where the SNOMED CT encoding is based on a translation from another codeSystem. Thus the value set constraints may be tested against the original encoding or translation sub-element in an instance of the HL7 Concept Descriptor (CD) data type.

* + - 1. Inactive SNOMED CT concepts

New record entries should be made using SNOMED CT concepts with an active status. However it is possible that communications may contain SNOMED CT content that, while active at the time of entry, has subsequently been rendered inactive in the reference data (e.g. as a result of recognition of errors such as duplication or ambiguity). In these cases value set testing SHOULD include analysis of information contained in the SNOMED CT history data. Such data will assist in establishing the relationship(s) between inactive concepts and active concepts. If it can be demonstrated that an inactive concept has an appropriate historical relationship to a value set valid active concept, and if the specification does not explicitly exclude inactive concepts, then the inactive concept should be regarded as valid for communication.

For example, consider the concept [ 274638001 | asthenia |], which is now marked as an inactive duplicate in SNOMED CT. This concept may have been active in the past, and may thus have been used in the creation a record entry. This historical record entry may subsequently be communicated (perhaps as part of a record extract), by which time the concept has been marked as inactive. If this is encountered it is possible (by analysis of the SNOMED CT history data) to identify the [ 168666000 | SAME AS |] relationship to the active concept [ 13791008 | asthenia |]. Assuming the message specification does not explicitly exclude inactive concepts it is then possible to test the (active) concept for suitability in the message instance and accept it as valid.

# General Options for Dealing with Potential Overlaps

* 1. Introduction

This section outlines the general options for dealing with overlaps in semantics between an information model and a terminology model. It considers the advantages and disadvantages of requiring, prohibiting or allowing either or both of two overlapping forms of representation.

The discussion in this section is applicable to the potential overlaps between any information model and any terminology. It was used as the basis for the consideration of specific overlaps between HL7 and SNOMED CT semantics in Guidance on Overlaps between RIM and SNOMED CT Semantics (§ **Error! Reference source not found.**).

* 1. Classification of Options

Table 9considers the interplay between three rules (required, optional and prohibited) that might in theory be applied to the use of an HL7 and a terminology representation in each case where there is an overlap. For each optional rule two potential instances are considered – presence and absence of the optional element. The intersection of the rules and instances result in a total of sixteen potential cases. In half of these cases there is no difficulty because there is no actual overlap. The remaining cases create either a requirement to manage duplication or a requirement to enforce a prohibition imposed by the relevant rule. The general issues related to different types of prohibition or duplicate management are considered below. These general considerations are then applied to specific areas of overlap.

Table 9: General approach to options for dealing with overlaps

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | ***Terminology representation Required*** | ***Terminology representation Optional and is Included*** | ***Terminology representation Optional but is Omitted*** | ***Terminology representation Prohibited*** |
| HR HL7 representation Required | Generate, validate and combine dual representations | Generate HL7 representation (if not present). Validate and combine dual representations | No overlap | Manage unconditional prohibition of Terminology representation |
| HO(I) HL7 representation Optional and is Included | Generate Terminology representation (if not present). Validate and combine dual representations | Validate and combine dual representations | No overlap | Manage conditional prohibition of Terminology representation |
| HO(O) HL7 representation Optional but is Omitted | No overlap | No overlap | No information | No information |
| HP HL7 representation Prohibited | Manage unconditional prohibition of HL7 attribute/structure | Manage conditional prohibition of HL7 attribute/structure | No information | No information |

* 1. Prohibiting overlapping HL7 representations

Any prohibition of an HL7 representation that overlaps with a terminology representation is unconditional if the corresponding Terminology representation is required. However, if the terminology representation is optional, then the prohibition of the HL7 representation becomes conditional and is only applied in cases where the corresponding terminology representation is actually present.

Some unconditional prohibitions may be sufficiently generalized to be modeled by excluding a particular attribute or association from the relevant model. A conditional prohibition may require additional constraints (e.g. a restricted concept domain) or implementation guidelines (e.g. textual supporting material).

Any prohibition needs to be expressed in a way that does not undermine support for any required communications of data encoded using other code systems. In most cases, the universal HL7 standards for a domain should support conditional prohibition. This allows some realms or communities to enforce prohibition, while allowing others to use alternative code systems.

* 1. Prohibiting overlapping Terminology representations

A prohibition of a terminology representation that overlaps with an HL7 representation is unconditional if the corresponding HL7 representation is required. However, if the HL7 representation is optional, the prohibition is conditional and does not apply unless the HL7 representation is present.

Prohibition of a terminology representation is fraught with difficulties. If a particular terminology representation is recorded in a sending system, prohibiting the inclusion of that expression in an HL7 message prevents faithful communication of original structured clinical information. Transformation of a terminology representation into an HL7 syntactic form such as the Concept Descriptor (CD) data type should be possible for most if not all terminologies. It has been argued that disaggregating a post-coordinated Terminology representation across multiple HL7 attributes (e.g. assigning SNOMED "procedure site" to the HL7 Procedure.targetSiteCode) is a similar kind of transformation. However, this presumes a one-to-one match between the semantics of the Terminology representation and the specific HL7 attribute. In cases where the terminology has more finely grained attributes than those present in the RIM (e.g. SNOMED CT includes ʺprocedure site – directʺ and ʺprocedure site – indirectʺ), a mapping to RIM attributes will be less precise and will result in some degree of information loss. As a terminology continues to evolve, more finely grained attributes are expected to be added, thus increasing the likelihood of information loss from transforms of this type.

A general prohibition of use of valid terminology representations is likely to form an obstacle to communication rather than encouraging semantic interoperability. However, guidelines on specific topics within a domain may recommend use of HL7 representations rather than or in addition to terminology representations. These guidelines will be most effective if implemented in the design of data entry and storage rather than restricted by communication specifications.

* 1. Generating required representations

If either form of representation is required, any sending system that does not store that required representation must generate it to populate a valid message. In any case where a particular representation is required, clear mapping rules from the other representation(s) are needed, unless the communicating applications also use the required representation for storage.

* 1. Validating and combining dual representations

If HL7 and terminology representations of a similar characteristic are permitted to co-exist, there is a requirement for rules that determine how duplicate, refined and different meanings are validated or combined. ***Table 10***outlines the general types of rules that might be applied. The rules in this table form a framework for discussion of specific recommendations related to the overlaps between HL7 and particular terminology representation.

Note that different rules that appear superficially rational can result in profoundly different interpretations of the same data. While it is possible for different rules to apply to different overlaps it is essential that the rules for each given overlap are clear and unambiguous. Applying different rules based on convenience of a particular representational form in a particular environment, domain or use case can lead to serious misinterpretation of information flows between environments. Furthermore, every variation in the rules will require additional processing overhead and implementer understanding.

***Table 10: Outline of possible rules for interpretation of dual representations***

| Overlap condition | Examples | Possible rules for interpretation | Interpretation |
| --- | --- | --- | --- |
| General form used for examples | HL7:(HL7 representation) TMR:(Terminology model representation) | - | - |
| The meanings of both the HL7 and Terminology representations are equivalent | HL7:negationInd="true" TMR:presence="not present"  '' | Apply meaning ignoring repetition | NOT PRESENT |
| Apply HL7 as combinatorial revision of TMR | PRESENT (i.e. double negative "not not present") |
| The meaning of one of the two representations is a subtype of the meaning of the other representation | HL7:moodCode=" intention" TMR:stage="requested" | Apply more specific meaning (ignoring more general meaning) | REQUESTED |
| Apply HL7 as combinatorial revision of TMR | INTENTION TO REQUEST |
| The meaning of the two representations differs and neither meaning is a subtype of the other | HL7:moodCode=" intention" TMR:stage="goal" | Apply HL7 as combinatorial revision of TMR | INTENTION TO SET A GOAL |
| Apply HL7 as addition to TMR | INTENTION AND A GOAL |
| Apply HL7 and ignore terminology representation | INTENTION |
| Ignore HL7 and apply TMR | GOAL |
| Treat as an error | - |
| HL7:targetSiteCode="ovary" TMR:site="cyst" | Apply HL7 as combinatorial revision of TMR | CYST OF OVARY |
| Apply HL7 as an addition to TMR | CYST AND OVARY |
| Apply HL7 and ignore TMR | OVARY |
| Ignore HL7 and apply TMR | CYST |
| Treat as an error | - |

1. References
   1. HL7 V3 References

[Clinical Statement Pattern](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=40)  
[Version 3 Datatypes](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=264)

[Reference Information Model](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=77)

[CDA Release 2](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=7)

* 1. SNOMED CT Reference materials

The following SNOMED CT reference materials (or their successors) are available at <http://ihtsdo.org/fileadmin/user_upload/doc/>. Most of the previously referenced materials (or equivalent) are now included in the SNOMED CT Technical Implementation Guide ([TIG](http://www.ihtsdo.org/fileadmin/user_upload/doc/en_us/tig.html)):

* **SNOMED CT Reference Set Specification** - includes information about:
  + Representation and use of sets of SNOMED CT components using the Reference Set mechanism (and its predecessor the Subset mechanism).
* **SNOMED CT User Guide** - includes information about:
  + Defining relationships in the SNOMED CT concept model.
* **SNOMED CT Guide to Abstract Models and Representational Forms** - includes information about:
  + SNOMED CT concept definitions;
  + Representation of context in the SNOMED CT concept model;
  + Pre-coordinated and post-coordinated SNOMED CT expressions;
  + Alternative representation of SNOMED CT expressions, including HL7 Concept Descriptor (CD) datatype and the SNOMED CT compositional grammar.
* **SNOMED CT Guide to Transformation and Normal Forms** - includes information about:
  + Transformation between close-to-user representation of SNOMED CT expressions and normal forms that can be used for comparison and computation;
  + Comparison of normal forms to determine equivalence and subsumption;
  + Optimization of the process of normal form comparison.
* Compositional Grammar for SNOMED CT Expressions in HL7 Version 3
  + Makes available, as a DSTU, the SNOMED CT Compositional Grammar.

All efforts have been made to ensure that the SNOMED CT identifiers used in this version of the guide are currently active in the SNOMED CT International Release.

* 1. SNOMED CT Compositional Grammar - extended

This document uses the SNOMED CT Compositional Grammar to refer to SNOMED CT concepts and expressions. Table 11provides an overview of this grammar which is intended to meet the needs of readers of this document. However, those with a more detailed interest in this topic should read the relevant section in the Technical Implementation Guide (TIG), which explains the underlying abstract model and includes a full Backus-Naur Form (BNF) definition of the grammar.

The abstract model of expressions and definitions is at the heart of SNOMED CT. In contrast, the grammar is just one way of representing instances of concepts, definitions and expressions. As noted in the Formal rules for post-coordinated expressions (§ 1.8.6.2), there are other ways to represent expressions, including the HL7 Concept Descriptor data type. The reason for using the compositional grammar in this document is that it offers a terse representation which is both human-readable and computer-processable.

The grammar used in this document extends the SNOMED CT Compositional Grammar in two respects:

To improve the clarity and processability of references to SNOMED CT concepts and expressions within blocks of narrative text:

Compositional grammar expressions are separated from the text of the document by square brackets (“[]”);

To enable a simple representation of constrained value-sets of concepts and expressions based on post-coordinated refinement:

To support clear documentation of relatively simple constraints, an informal extension has been made to the compositional grammar. This extended grammar is used in this document for pragmatic reasons. It is not proposed as a formal extension to the SNOMED CT Compositional Grammar and has neither been discussed or approved by the IHTSDO (http://www.ihtsdo.org) or the wider SNOMED community.

This extension includes:

Additional symbols specified in Table 12 to represent different types of constraints.

Specification of the elements that can be constrained as documented in Table 13.

Logical 'AND' and 'OR' operations as described in Table 14.

Table 11: Summary of SNOMED CT Compositional Grammar

|  |  |  |
| --- | --- | --- |
| Symbol | Notes | Examples |
| digits | ConceptId | A sequence of digits in an expression represents a SNOMED CT concept identifier. The only exception to this is where digits occur between a pair of pipe symbols, in which case the digits are part of the display name (see next row of this table).  The simplest expression is a concept identifier on its own. For example:     87628006 |
| **|** text **|** | Display name delimiter | A pair of pipe ("|") symbols are used to delimit an optional display name for the immediately preceding concept identifier. For example:     87628006 | bacterial infectious disease |  The display name may be the term string of any of the descriptions associated with the concept in a current version of SNOMED CT. For example any the following are a sample of valid representations of the same concept:     87628006 | bacterial infectious disease (disorder) |     87628006 | disease caused by bacteria |     87628006 | enfermedad infecciosa bacteriana |     87628006 | infección bacteriana |  Note: In this document all expressions include display names to aid understanding. Although the Fully Specified Name is more precise, use of the Preferred Term makes the document easier to read and full details can be found by looking up the concept identifier. Except where otherwise specified, the display name used in this document is the Preferred Term in US English in the SNOMED CT International Edition. |
| space tab linefeed return | Whitespace characters | Whitespace characters are ignored and can thus be used to format the appearance of an expression where this aids clarity. The only exception to this rule is that spaces are not ignored within a display name.  Note: Spaces before or after the last non whitespace character of a display name are ignored. The text between the pair of pipe characters is trimmed of any surrounding whitespace but spaces within the enclosed text are treated as part of the display name. |
| **:** | Refinement prefix | A colon (":") precedes a refinement of meaning of the concept to the left of the colon. A refinement consists of one or more attributes and/or attributes groups and these are illustrated by examples in subsequent rows of this table. |
| **=** | Attribute value prefix | Each of the attributes that make up a refinement consists of an attribute name and an attribute value. The attribute name precedes the value and is separated from it by an equals sign ("=").  The attribute name is represented by a concept identifier and the attribute value. The attribute value may be represented by a concept identifier as in the following example or by a nested expression (see example later in this table).  The following example specifies a bacterial infectious disease caused by streptococcus pneumoniae.  87628006 | bacterial infectious disease | :      246075003 | causative agent | = 9861002 | streptococcus pneumoniae | |
| **,** | Attribute separator | A refinement may includes more than one attribute. In this case, a comma (",") is used to separate attributes from one another.  The following example specifies a bacterial infectious disease affecting the lung and caused by streptococcus pneumoniae.  87628006 | bacterial infectious disease | :      246075003 | causative agent | = 9861002 | streptococcus pneumoniae | ,      363698007 | finding site | = 39607008 | lung structure | |
| **(** exp **)** | Nested expression | The value of an attribute may be represented by a nested expression rather than a single concept identifier. In this case, the nested expression is enclosed in parentheses.  The following example specifies a bacterial infectious disease affecting the left upper lobe of the lung and caused by streptococcus pneumoniae. The nested expression localizes (upper lobe of the lung) and lateralizes (left) the site of the disease.  87628006 | bacterial infectious disease | :      246075003 | causative agent | = 9861002 | streptococcus pneumoniae | ,      363698007 | finding site | = (45653009 | structure of upper lobe of lung | :           272741003 | laterality | = 7771000 | left | ) |
| **{** group **}** | Attribute group | In some cases different sets of attributes apply to different facets of the same concept. For example, some common fractures involve two adjacent bones and the nature of the fracture of each bone may differ. Similarly, some procedures involve removal of one structure and repair of another and different refinements of these actions may be required.  In SNOMED CT concepts that have multiple facets are defined with each facet represented by a separate relationship group. When these concepts are refined it may be necessary to specify which group is being refined. In these cases, curly braces are used to group together sets of attributes that act together.  The following example represents a fracture of the shaft of the tibia and fibula. The tibia has a spiral fracture while the nature of the fracture of the fibula is incomplete.  271577005 | fracture of shaft of tibia and fibula | :      {116676008 | associated morphology | = 73737008 | fracture, spiral |        ,363698007 | finding site | = 52687003 | bone structure of shaft of tibia | }       {116676008 | associated morphology | = 30543000 | fracture, incomplete |        ,363698007 | finding site | = 113224005 | bone structure of shaft of fibula | } |
| **+** | Combination | A disorder that is both a bacterial disease and disorder of the respiratory systems. For example "bacterial pneumonia".  87628006 | bacterial infectious disease | + 50043002 | disorder of respiratory system |  It does not mean two separate disorders that for some reasons are being linked. For example, this use of the plus sign is not the appropriate way to represent that someone has both a separate respiratory disorder (e.g. allergic asthma) and a separate bacterial disease (e.g. impetigo). |

Table 12: Compositional Grammar extension - Constraint symbols

|  |  |  |
| --- | --- | --- |
| Symbol | Notes | Examples |
|  | This specific concept  (No symbol prefix) | 71388002 | procedure |  The concept "procedure" SHALL be used. Note: By default, unless the surrounding context states otherwise, this implies this precise concept (i.e. not one of its subtypes) shall be used. However, the context within a sentence or parsable expression may imply a less specific requirement. For example, if the concept is followed by any options for addition of refinements these implicitly permit refinement of the concept. |
| **<<** | This concept or any subtype permitted | <<71388002 | procedure |  Either the concept "procedure" or one of its subtypes SHALL be used. Note: this differs from the "<=" symbol used to indicate the same constraint in other HL7 specifications. The reason for the difference is to limit the use of "=" as the operator that joins an attribute name and an attribute value in the un-extended compositional grammar.  Supersedes “<=”. |
| **<=** | **Deprecated symbol**  Has same meaning as **<<** (see above) | In HL7 Version 3 information models the symbol "<=" is used to indicated a concept domain consisting of the specified concept or one of its subtypes. This symbol may be confused with the use of the "=" symbol between the attribute name and value in a post-coordinated expression. Therefore, it SHOULD be replaced by "<<" in the extended SNOMED CT compositional grammar. |
| **<** | Any subtype of this concept (but not the concept itself) | | procedure | :   363704007 | procedure site |     = ( 29836001 | hip region structure | :             272741003 | laterality | = <182353008 | side | )  The procedure site SHALL be the value "hip region structure" and SHALL include the attribute "laterality" The value of "laterality" SHALL be a subtype of "side" but SHALL NOT be "side" itself. |
| **~** | Optional attribute (only applicable as a prefix to AttributeName) | 71388002 | procedure | :   <<363704007 | procedure site |     = ( <<29836001 | hip region structure | :              ~272741003 | laterality | = <182353008 | side | )  The attribute "procedure site" or one of its subtypes (e.g. "procedure site – direct") SHALL be applied and its value SHALL be "hip region structure" or one of its subtypes. The attribute "laterality" MAY BE applied and if present its value SHALL be a subtype of "side" but SHALL NOT be "side" itself. |
| **!** | This concept is prohibited and SHALL NOT be used. | 71388002 | procedure | :   363704007 | procedure site |     = ( 29836001 | hip region structure | :             !272741003 | laterality | )  The procedure site SHALL be the value "hip region structure" and SHALL NOT include the attribute "laterality". Note: This example conflicts with the SNOMED CT compositional grammar as no value is supplied for the laterality attribute. Since the laterality attribute is not permitted, it makes no sense to provide a value. Alternatively a dummy value could be provided but it has been omitted here and in the examples in this document as it would decrease rather than enhance clarity. |
| **!<** | This concept and all its subtypes are prohibited and SHALL NOT be used. | 71388002 | procedure | :   363704007 | procedure site |     = ( 29836001 | hip region structure | :           ~272741003 | laterality | = !<66459002 | unilateral |)  The procedure site SHALL be the value "hip region structure" and MAY include the attribute "laterality" The value of "laterality" SHALL NOT be "unilateral" or a subtype of "unilateral". |

Table 13: Compositional Grammar Extension - Constrainable elements

|  |  |
| --- | --- |
| Element | Notes and examples |
| ConceptId | A constraint symbol MAY directly precede a ConceptId. In this case, it requires, allows, or prohibits use of the referenced concept (and/or subtypes of that concept) in that logical position in the expression.  Unless otherwise stated, the comparison between an instance expression and a constraint assumes both are transformed to normal forms before testing.  For example, the following constraint:    [ 71388002 | procedure | :         260686004 | method | << 129304002 | excision – action ]. Permits expressions such as    [ 38102005 | cholecystectomy ] or [ 80146002 | appendectomy ] because the concepts "cholecystectomy" and "appendectomy" are defined in SNOMED CT release data as subtypes of "procedure" and have [ 260686004 | method | = 129304002 | excision – action ]. |
| Attribute Name | A constraint symbol MAY directly precede the concept id that specifies the name of an attribute. In this case it requires, allows or prohibits use of that attribute (or a subtype of that attribute). Unless the use of the attribute is prohibited, the value of that attribute MAY be separately constrained.  The following example asserts that the attribute "procedure site" or one of its subtypes (e.g. "procedure site – direct") SHALL be applied and its value SHALL be "hip region structure" or one of its subtypes.  [ 71388002 | procedure | :      <<363704007 | procedure site |           = <<29836001 | hip region structure ] |
| Nested *Expression* | A constraint symbol may directly precede an expression enclosed in parentheses. In this case, it requires, allows or prohibits inclusion of the parenthesized expression (and/or subtypes of that expression) in that logical position in the expression.  Note: It is generally clearer to specify the individual constraints on the elements within the nested expression rather than to apply a constraint to the nested expression as a whole. However, this form is also included. |
| Attribute Group | A constraint symbol MAY directly precede an attribute group. In this case, it requires, allows or prohibits inclusion of the specified group (and/or refinements of that group) in that logical position in the expression.  The following example asserts that the group shown or a refinement of that group must be present. [ 71388002 | procedure | :      <<{260686004 | method |= 129304002 | excision - action | ,          ,405813007 | procedure site - Direct | = 113345001 | abdominal structure | } ] |
| Other | The constraints cannot be used elsewhere in the expression. In particular a constraint cannot be applied to a refinement as whole or to a display name. Therefore, the constraint symbols cannot immediately follow the concept identifier, nor can they precede the pipe ("|") or colon (":") symbols. |

**Note:** According to the HL7 TermInfo [Requirements and Criteria (§ 1.9.2)](file:///C:\Users\Lisa\Documents\05%20Professional\90%20HL7\00%20Standard%20-%20TermInfo\TermInfo%20DSTU%201.5%2020130506\html\infrastructure\terminfo\terminfo.htm#TermRandC) and the SNOMED CT Technical Implementation Guide chapter 4.3, when alternative representations are semantically equivalent either representation may be used. Therefore, the constraints defined in this document specify the range of possible representations, rather than the precise way a meaning is represented. From an operational perspective it may sometimes be desirable to constrain the forms of representation permitted within a given community or realm. In these cases, additional constraints may be stated in an implementation profile.

Table 14: Compositional Grammar Extension - Logical constrain combinations

|  |  |  |
| --- | --- | --- |
| Symbol | Notes | Examples |
| OR | Where two or more values are permitted the set of conditions and the individual expressions SHALL both be enclosed in standard curved brackets () and the word "OR" SHALL be placed between the expressions. | [ 71388002 | procedure |: 363704007 | procedure site | = (29836001 | hip region structure |: ~ 272741003 | laterality | =(7771000 | left |) OR (24028007 | right |)) ]  The procedure site SHALL be the value "hip region structure" and MAY include the attribute "laterality" The value of "laterality" SHALL be either "left" or "right". |
| AND | Where two or more conditions are both required to apply the individual expression SHALL be enclosed in standard curved brackets and the word "AND" shall be placed between the expressions. ((exp1) AND (exp2)) | [ 71388002 | procedure |: 363704007 | procedure site | = ( 29836001 | hip region structure |: ~272741003 | laterality | =((<182353008 | side |) AND (!<66459002 | unilateral |))) ]  The procedure site SHALL be the value "hip region structure" and MAY include the attribute "laterality" The value of "laterality" SHALL be a subtype of "side" AND SHALL NOT be either "unilateral" or a subtype of "unilateral". |

* 1. Guidance on using SNOMED CT Compositional Grammar in CD R2 Datatype

**NOTE:** The material in this section is provided for reference, as it is likely to be incorporated in a future version of CDA. However, it does not apply currently to CDA R2, which is based on the R1 datatypes.

B.4.1 Introduction

The HL7 V3 “Data Types – Abstract Specification, Release 2” defines what can be carried in the Concept Descriptor (CD) data type as “the plain code symbol defined by the code system, or an expression in a syntax defined by the code system which describes the concept.”

In response to the requirement for “syntax defined by the code system” The IHTSDO has published a section on the SNOMED CT compositional grammar in the Technical Implementation Guide (TIG). The serialization syntax (SNOMED Compositional Grammar, SCG) defined is the same as the ‘unextended’ syntax described in this document.

This section describes the recommended way for communicating SNOMED CT expressions using the HL7 V3 Concept Descriptor (CD) datatype.

B.4.2 Rules and guidance on usage

B.4.2.1 Minimal representation

Where communicating parties agree that only ConceptId’s are required for communication, whether single ID’s or compositional code phrases, these SHALL be communicated using CD.code, with expressions structured according to the SCG.

|  |
| --- |
| Example 23. Minimal CD representation of single code (pre-coordinated) Fracture of humerus |
| <value code="66308002" codeSystem="2.16.840.1.113883.6.96"/> |

|  |
| --- |
| Example 24. Minimal CD representation of one pattern of compositional (post-coordinated) Fracture of humerus |
| <value code="127278005:363698007=85050009,116676008=72704001" codeSystem="2.16.840.1.113883.6.96"/> |

It is, however, likely that good recording/communication practice between communicating parties will require the communication of associated human readable elements. Guidance is therefore provided for the following circumstances:

B.4.2.2 Single code SNOMED CT expression associated with a valid SNOMED CT description

Where a term of a valid description for the communicated SNOMED CT ConceptId has been selected to make the originating record entry, or where communicating parties wish to communicate a valid description for a code it may be communicated as:

CD.displayName - subject to the rules of the terminology, e.g. by use of a designated reference set that specifies the term to be selected for each code:

|  |
| --- |
| Example 25. valid description “Fracture of humerus” communicated as displayName |
| <value code="66308002" codeSystem="2.16.840.1.113883.6.96">  <displayName value="fracture of humerus"/>  </value> |

CD.code, using the SCG rules:

|  |
| --- |
| Example 26. Minimal CD representation of single code (pre-coordinated) Fracture of humerus |
| <value code="66308002 | fracture of humerus |" codeSystem="2.16.840.1.113883.6.96"/> |

Both CD.code and CD.displayName:

|  |
| --- |
| Example 27. Valid description “Fracture of humerus” communicated as displayName |
| <value code="66308002 | fracture of humerus |" codeSystem="2.16.840.1.113883.6.96">  <displayName value="fracture of humerus"/>  </value> |

Where both CD.code and CD.displayName are used, the terms must be the same.

CD.originalText may, of course, also be communicated - subject to the rules of the data type specification:

|  |
| --- |
| Example 28. Valid description “Fracture of humerus” communicated as originalText and displayName |
| <value code="66308002" codeSystem="2.16.840.1.113883.6.96">  <displayName value="fracture of humerus"/>  <originalText mediaType="text/plain" value="fracture of the humerus"/>  </value> |

B.4.2.3 Single code or compositional SNOMED CT expression with an associated human-readable string

Where either a pre-crafted human-readable string or a relevant fragment from analysed narrative text is associated with a single code or compositional SNOMED CT expression, this string SHALL be communicated as CD.originalText:

|  |
| --- |
| Example 29. Text string “Open repair of outlet of muscular interventricular septum” communicated with associated code-only compositional code phrase |
| <code code="387713003:363704007=264116001,260507000=129236007,260686004=257903006" codeSystem="2.16.840.1.113883.6.96">  <originalText mediaType="text/plain" value="Open repair of outlet of muscular interventricular septum"/>  </code> |

Where the recording process also presents a valid SNOMED CT description (or descriptions) to assist in the selection/creation of the communicated SNOMED CT expression, or where communicating parties wish to communicate a valid description for a code (or each code in a compositional expression) the associated term (or set of terms) MAY be communicated as follows:

|  |
| --- |
| Example 30. Concept representing “Open repair of outlet of muscular interventricular septum” communicated with SCG structured code and term phrase in CD.code |
| <code code="387713003 | Surgical procedure |:363704007 | Procedure site | =264116001 | Outlet muscular septum |,260507000 | Access | =129236007 | Open approach - access |"  codeSystem="2.16.840.1.113883.6.96">  <originalText mediaType="text/plain" value="Open repair of outlet of muscular interventricular septum"/>  </code> |

If communicating parties agree that CD.code will only convey ConceptIds, then there is no current support, according to the rules of the datatype specification and the SCG rules, for unambiguously communicating descriptions using available CD attributes.

In the future, if alternative standard term-phrase composition rules become part of the SNOMED CT standard (and are regarded as such by relevant communicating parties) then the value of displayName could be generated according to these to be specified rules.

B.4.2.4 Compositional SNOMED CT expression without an associated human-readable string

If neither a pre-crafted human-readable string, nor a relevant fragment from analysed narrative text is associated with a single code or compositional SNOMED CT expression, then:

1. The minimal representation pattern MAY be used (if this is regarded as satisfactory for recording/communication purposes between communicating parties) – see ‘Minimal representation’ above.
2. If recording process also presents a valid SNOMED CT description (or descriptions) to assist in the selection/creation of the communicated SNOMED CT expression, the associated term (or set of terms) must be communicated in CD.code, structured according to the SCG rules, as has been the convention used in examples elsewhere in this implementation guide.

|  |
| --- |
| Example 31. Compositional code phrase corresponding to one representation of “Open repair of outlet of muscular interventricular septum” communicated with SCG structured code and term phrase in CD.code |
| <code code="387713003 | Surgical procedure |:363704007 | Procedure site | =264116001 | Outlet muscular septum |,260507000 | Access | =129236007 | Open approach - access |"  codeSystem="2.16.840.1.113883.6.96"/> |

B.4.3 Supporting discussion and rationale

The approach described is based on the following principles:

* CD.code should only be used to communicate expressions in a syntax defined by the code system | |
* Equality – “The equality of two CD values is determined solely based upon code and codeSystem”. From the perspective of HL7 datatypes, "66308002" is not equivalent to "66308002 | Fracture of humerus |” – however according to SNOMED CT and the rules of the SCG it is.
  + Users wishing to test for true equality of concepts should therefore refer to SCG guidance from the IHTSDO.
* For the simple case of a single SNOMED CT code and corresponding description, use of CD.code and CD.displayName is allowed.

1. Revision changes

Significant changes in the January 2014 ballot include:

* All sections
  + Applied the ballot comment resolutions from the May 2009 ballot cycle
  + Further specified the focus (for the current ballot cycle) to applications in CDA R2 models
  + Restored R1 CD datatype pattern examples for use with CDA R2
  + Updated to reflect changes to SNOMED CT (Concept Model, Compositional Grammar, etc.)
  + Re-organized some material for better accessibility and flow
  + Updated references to reflect newer tools and definitions
  + Converted from HTML to Word document format
* Section 1
  + Added new "Audience" and “Data Types” sections
* Section 2
  + Created separate sections for Act.code (general Acts) and Observation code and value attributes
* Glossary
  + Updated and added entries

Changes in the May 2009 balloted version include:

* All sections
  + Alignment of examples with R2 CD datatype pattern
* Section 2
  + Addition of discussion/guidance on use of Observation.interpretationCode
  + Clarification of use of targetSiteCode, methodCode and approachSiteCode, uncertaintyCode, priorityCode
* Section5
  + Updates to domain and range constraints for Procedure, SBADM and Supply
* Annex B
  + Addition of guidance on the use of the SNOMED compositional grammar in R2 CD datatype

Major changes in the January 2007 balloted version include:

* All Sections
  + Use of a common grammar for referencing SNOMED CT concepts, expressions and constraints within the text of the document. This approach is based on an extended version of SNOMED CT compositional grammar. The intention is to ensure that human readable references to SNOMED CT concepts can also be computer parsed and validated. See also changes to Annex B.
* Section 1. Introduction and Scope
  + Section 1.5, SNOMED CT: Restructured and expanded with examples.
  + Section 1.6, Asserting Conformance to this Implementation Guide: New subsection.
* Section 2. Guidance on Overlaps between RIM and SNOMED CT Semantics
  + Section 2.2.2, Removed redundant references to temporal content and subject relationship context in the moodCode default mapping and constraint tables.
  + Section 2.2.5, More consistent representation of relevant site attributes by reference rather than repetition.
  + Section 2.2.12, Significant corrections to inconsistent handling of time temporal context.
* Section 3. Common Patterns
  + Section 3.1, Introduction: Describes the approach used to build examples that are both consistent with the SNOMED recommendations presented here, and are consistent with the source technical committee domain models.
  + Section 3.1.1, Observations vs. Organizers: Reference to ActContainer changed to now reference ActClassRecordOrganizer, based on RIM harmonization.
  + Section 3.4, Observation, Condition, Diagnosis, Problem: Updated to be consistent with Patient Care TC model
* Annex B. References
  + New section B.3 describing the extended version of SNOMED CT compositional grammar used in the text of the document.
* Annex D. SNOMED CT Open Issues
  + New SNOMED CT open issue in relation to 'Events and Conditions'
  + New SNOMED CT open issue in relation to identifying those SNOMED CT codes suitable for Act.code where Observation.value is a SNOMED CT finding.
* Annex E. Detailed aspects of issues with a vocabulary specification formalism
  + Clarification of the definition of 'subsumption'.

1. Detailed aspects of issues with a vocabulary specification formalism
   1. Introduction

SNOMED CT Concept Domain Constraints (§ **Error! Reference source not found.**) specifies SNOMED CT value sets using a ‘simple notation'. As noted in Approach to Value Set Constraint Specifications (§ **Error! Reference source not found.**) this simple notation may result in certain error patterns in membership testing.

Two related requirements for value set specification need to be considered. These, and the dominant error patterns that will be encountered if they are not addressed, are as follows:

1. The ability to specify post-coordination-accommodating ‘implicit Expression’ value sets. It is already a common convention in HL7 V3 messaging specifications to exploit the hierarchical nature of certain terminologies by referring to a value set member and indicating that this member and the members that it subsumes should constitute an allowable value set. An extended requirement refers to the ability to define value sets that will test the suitability of candidate SNOMED CT expressions which may have become valid as a result of post-coordinated attribute refinement, but would fail ‘simple implicit’ validity testing against ‘node’ subsumption ('simple subsumption'). Failure to satisfy this requirement will principally result in false negative (erroneous rejections) treatment of suitable post-coordinated expressions.
2. The ability of value set specifications to allow the communication of 'Finding/Procedure/Observable entity'-based expressions as well as their post-coordinated ‘situation/context wrapped’ and pre-coordinated 'context-dependent' or 'situation' counterparts [SNOMED CT has recently renamed the top-level concept of 'context-dependent categories' (where can be found 'finding' and 'procedure' concepts where nuances of status and state are explicit in the reference data) - the top-level concept in this chapter is now named 243796009 | situation with explicit context (situation |)|]. Failure to satisfy this requirement will commonly result in false negative (erroneous rejection) treatment of suitable post-coordinated expressions and either false positive (erroneous inclusion) or false negative treatment of pre-coordinated expressions (depending on the value set specification strategy adopted).

Neither of the above requirements can be satisfactorily supported by value set specifications that either simply enumerate ‘valid codes’ or ‘valid subsumption nodes’ ('codes and logical descendants').

These requirements are now explored in more detail, and are followed by (1) an enumeration of the desirable features of a specification formalism and (2) an explanation for the inclusion of a normalization step in value set testing.

* 1. ‘Implicit Expression’ value sets

Whilst ‘simple implicit’ (subtype testing) value set specifications are suitable for ‘Primitive’ SNOMED CT concepts (even if post-coordination is allowed), in those situations where value sets are specified by reference to ‘Fully Defined’ concepts, a ‘simple’ solution is inadequate.

E.2.1 Requirements for ‘abstract or Primitive SNOMED CT concepts’

As with (presumably) all vocabularies organized by subsumption hierarchies, SNOMED CT includes a number of abstract[[12]](#footnote-13) ‘high-level’ concepts that can be thought of as organizing the content into coherent ‘chapters.’ By example, SNOMED CT has high-level concepts such as [ 404684003 | clinical finding |], [ 71388002 | procedure |] and [ 105590001 | substance |], each correspondingly subsuming thousands of pre-coordinated concepts that are deemed to be ‘Findings’, ‘Procedures’ or ‘Substances.’

It is a property/requirement of the SNOMED CT classification process that a distinction is made between ‘Primitive’ and ‘Defined’ concepts (put simply, only Defined [in terms of other concepts] Concepts can acquire new, inferred sub-types as a result of the classification process), and whilst including a high number of Defined Concepts is desirable for more complete classification, it is an inevitable feature of SNOMED CT that a number of concepts need to be regarded as Primitive (to introduce nuances of the world against which ‘Defined’ content can be formally differentiated).

For this guide, the importance of the Primitive/Defined[[13]](#footnote-14) distinction is that as long as value sets are defined by reference only to Primitive Concepts, we can be confident that, even where post-coordination is allowed[[14]](#footnote-15), expressions cannot logically be ‘made’ members of the value set (§ Figure 2). This suggests that for many coarse-grained ‘universal’ value set specifications there is little need for a specification form of greater sophistication than:

“this field may communicate concepts subsumed by [SNOMED CT Primitive]a OR subsumed by [SNOMED CT Primitive]b OR subsumed by [SNOMED CT Primitive]…n”

which would appear to be satisfactorily supported by a notation similar to the current HL7 documentation convention of:

|  |
| --- |
| Example 32. |
| Act.code <= [SNOMED CT Primitive]a OR [SNOMED CT Primitive]b OR [SNOMED CT Primitive]…n |

E.2.2 Requirements for ‘detailed or fully-defined SNOMED CT categories’

Whilst many ‘universal’ value sets can be specified by the mechanism above, as concept domains are progressively constrained we may reach a point where a detailed SNOMED CT-derived value set is specified by reference to one or more Fully-Defined Concepts[[15]](#footnote-16). In this setting, where post-coordination is allowed, it will be possible to 'create' expressions that are now members of the value set but whose ‘focus concepts’ would not be members according to ‘simple’ subsumption testing (Figure 3). The '(clinical) focus concept' (often singular but strictly-speaking a set of 'focus concepts') is the concept that to a large degree characterizes the type of expression being documented or communicated. Reference to the SNOMED CT concept model when the nature of the 'focus concept' is known will indicate which types of refinement and which axes of 'context modification' can be applied. For example, if the 'focus concept' is a member of the set specified by [ <<404684003 | clinical finding |], inspection of the concept model will tell us that the concept can be modified by selecting/refining values for defining characteristics with attribute names such as [ 363698007 | finding site |], [ 246112005 | severity |], [ 116676008 | associated morphology |] etc., and that the focus concept can serve as the value of an [ 246090004 | associated finding |] attribute of a 'context/situation' wrapped post-coordinated expression. Additional information which may influence appropriate aspects of model application are (1) whether a concept chosen from the sets specified by [ ((<<363787002 | observable entity |) OR (<<386053000 | evaluation procedure |)) ] is accompanied by a value (determining whether it should be treated by the concept model as a 'finding' or a 'procedure') and (2) the moodCode value of the relevant HL7 V3 class (as this will determine the detailed value applied to the respective attribute names [ 408729009 | finding context |] or [ 408730004 | procedure context |]).

In order to avoid false rejection of valid ‘post-coordination by refinement’ expressions, value set specifications need to be modified to allow their inclusion. Consistent with the guidance that is currently offered for normal form generation for data retrieval, the following general modifications to each specification (and, for comparison purposes, each 'candidate' expression) should be considered:

* A ‘relaxing’ of each ‘Focus Concept’ to its proximal primitive supertype(s)
* Explicit reference to the required attributes of valid expressions

By example, such a transformation would result in the 'simple' value set ‘predicate’

33149006 | Pancreatectomy |

being rephrased as

71388002 | procedure |:  
{ 260686004 | method |= 129304002 | excision - action |,  
363704007 | procedure site |= 15776009 | pancreatic structure |}

and the value set ‘candidate’

9524002 | Total pancreatectomy |

being rephrased as

71388002 | procedure |:  
{ 260686004 | method |= 129304002 | excision - action |,  
363704007 | procedure site |= 181277001 | entire pancreas |}

As indicated in Figure 3, failure to include this transformation step would result in inappropriate rejection of a valid post-coordinated representation of 'total pancreatectomy'.

The tests performed to determine value set membership against 'complex' value set predicates are still 'subsumption' tests, but here might be regarded as 'complex subsumption', insofar as testing will include steps such as candidate expression normalisation, structural predicate/candidate comparison (or the equivalent) and multiple 'simple subsumption' tests for focus concept, attribute name and attribute value comparisons.

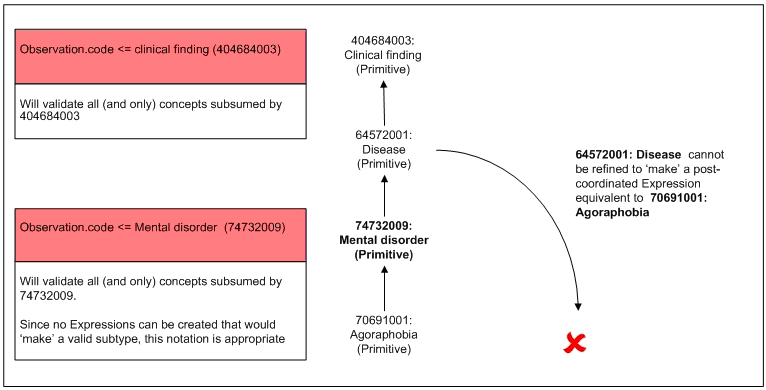


Figure 2: The consequences of refinement post-coordination on valid value set membership for sets defined by reference to Primitive Concepts

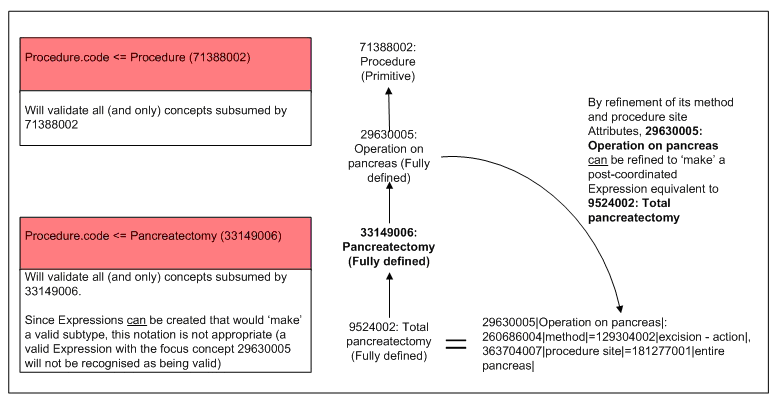


Figure 3: The consequences of refinement post-coordination on valid value set membership by reference to Fully Defined or 'Definable’ Concepts

* 1. Pre- and Post-Coordinated Concepts and Expressions

For many 'universal' specifications it will be possible to anticipate and provide a set of appropriate value set clauses that would adequately accommodate, in a general sense, paired 'plain' pre-coordinated (concepts specified in the sets [ <<404684003 | clinical finding |] and [ <<71388002 | procedure |]) and 'context/situation' ([ <<413350009 | finding with explicit context |] and [ <<129125009 | procedure with explicit context |]) pre-coordinated concepts. It may well be desirable to do this, as there are many concepts in the set specified by [ <<243796009 | situation with explicit context |] that represent useful clinical notions, and also happen to represent some nuance of status or state (e.g. 'dizziness' is a 'finding' and 'dizziness present' is an 'explicit situation' - the latter represented in SNOMED CT by [ 162260006 | dizziness present |]).

For example we may wish to specify that both 'plain' clinical findings or their 'context/situation' counterparts are valid value set members:

|  |
| --- |
| Example 33. |
| Observation.code ((<<404684003 | clinical finding |) OR (<<413350009 | finding with explicit context |)) |

Whilst not worrying about the details of moodCode/context bindings (not all pre-coordinated 'context/situation' concepts would be valid for all moodCode values), this notation would appear to suffice (specifying the paired ‘clinical finding’ and the ‘explicit situation' finding). However, consider the following more precise/refined 'simple' value set, consisting of a set of 'plain' concept clauses:

* ((<<50043002 | disorder of respiratory system |) OR
* (<<49601007 | disorder of cardiovascular system |) OR
* (<<119292006 | disorder of gastrointestinal tract |))

To reproduce the paired ‘simple & situation’ pattern here we also need pre-coordinated concepts of the form:

* Respiratory system disorder with explicit context OR
* Cardiovascular system disorder with explicit context OR
* Gastrointestinal tract disorder with explicit context

Even if these did exist as pre-coordinated concepts (currently they do not) we may well run into the same pattern of problem as in ‘Implicit Expression’ value sets, since it will be possible to ‘make’ a ‘Cardiovascular system disorder with explicit context’ expression by post-coordinated refinement of a suitable 'context/situation' supertype.

The second pattern of 'context/situation' representation (for example stating in a SNOMED CT expression that a finding is 'present', or that a procedure was 'performed in the past on a family member') is the use of SNOMED CT's 'context/situation' wrapper in the creation of expressions. This has the effect of introducing a 'focus concept' from the set specified by [ <<243796009 | situation with explicit context |] and the nesting (as the value of the respective attributes [ 246090004 | associated finding |] or [ 363589002 | associated procedure |]) of the 'clinical kernel' expression.

Re-using the 'dizziness' example, it is possible to document 'dizziness present' by both the use of the existing pre-coordinated 'context/situation' concept ([ 162260006 | dizziness present |]) and by the following expression [ 373573001 | clinical finding present |: 246090004 | associated finding | = 404640003 | dizziness |]). A value set specification that is looking for subtypes of 'dizziness' (the 'finding') and 'dizziness present' (the 'situation') (by the specification [ ((<<404640003 | dizziness |) OR (<<162260006 | dizziness present |))] ) would inappropriately reject this expression if only the 'focus concept' [ 373573001 | clinical finding present |] was tested.

E.3.1 Context or situation wrapping, refinement and normal forms

We therefore have two patterns of problem:

1. For pre-coordinated content, where explicit context/situation variants should also be allowed, we will need pre-coordinated 'situation with explicit context' concepts that may well not exist
2. Where post-coordination is allowed we also need specifications to accommodate content that has 'become valid' as a result of

* refinement of 'plain' concepts
* refinement of 'context/situation' concepts
* 'context/situation wrapping' of 'plain' concepts

It therefore seems reasonable to regard value set specifications where post-coordination (by sub-type refinement or context/situation wrapping) is taking place as similar to predicate specification for post-coordinated data retrieval.

With some modifications and additional tuning (see below) such ‘value set predicates’ can be generated by processing pre-coordinated ‘simple’ concepts according to the published rules for SNOMED CT expression transformation to normal forms. Without loss of precision this will result in specifications that will appropriately allow the communication of expressions that would have been missed by simple subsumption testing.

* 1. End Result

Taking the above suggestions to their conclusion, it is recommended that even for the most abstract value set specification, an inclusive value set representation will need to be modified from:

|  |
| --- |
| Example 34. |
| Observation.code ((<<404684003 | clinical finding |) OR (<<413350009 | finding with explicit context |)) |

To a form that states 'following value set normalization, valid expressions will be those with a focus concept in the descent of Finding with explicit context ( [ <<413350009 | finding with explicit context |] ) and a value for the attribute [ 246090004 | associated finding |] from the descent of Clinical finding ([ <<404684003 | clinical finding |]). For example:

|  |
| --- |
| Example 35. |
| Observation.code << [Following ‘value set’ normal form transformation]:  413350009 | Finding with explicit context |: 246090004 | associated finding | = <<404684003 | clinical finding | |

For more refined/precise value sets the change would be from:

|  |
| --- |
| Example 36. |
| Observation.code (( <<50043002 | disorder of respiratory system |) OR  ( <<NO CODE | respiratory system disorder with explicit context |) OR  ( <<49601007 | disorder of cardiovascular system |) OR  ( <<NO CODE | cardiovascular system disorder with explicit context |) OR  ( <<119292006 | disorder of gastrointestinal tract |) OR  ( <<NO CODE | gastrointestinal system disorder with explicit context |)) |

To a form more like

|  |
| --- |
| Example 37. |
| Observation.code [Following ‘value set’ normal form transformation]:  <<413350009 | Finding with explicit context |:  246090004 | associated finding | = ( <<64572001 | disease |: 363698007 | finding site | =  <<(( 20139000 | respiratory system structure |) OR  (113257007 | cardiovascular structure |) OR  (122865005 | gastrointestinal tract structure |)) |

* 1. Transformation rules.

General purpose SNOMED CT expression transformation rules published by IHTSDO apply default context values to un-specified axes e.g. the full transformation of ‘Disorder of cardiovascular system’ is:

243796009 | situation with explicit context|:  
{ 246090004 | associated finding | = ( 64572001 | disease |:  
363698007 | finding site |= 113257007 | cardiovascular structure |)  
,408729009 | finding context |= 410515003 | known present |  
,408731000 | temporal context |= 410512000 | current or specified |  
,408732007 | subject relationship context |= 410604004 | subject of record |}

The use of these defaults is appropriate for retrieving and analyzing data that does not include any explicit indication of context. However, within HL7 artefacts, context may be denoted by other attributes or by associated classes in the model. The SNOMED CT expression transformation rules described a process for recombining information model contextual information to provide accurate values for unspecified attributes. Explicit context attribute values, such as those shown in the expression below, are considered prior to merging information model context. The defaults only apply to missing context information after explicit context information provided by the information model has been taken into account.

243796009 | situation with explicit context |:  
{ 246090004 | associated finding |= ( 64572001 | disease |:  
363698007 | finding site |= 113257007 | cardiovascular structure | )}

* 1. Representation concept model constraints

The IHTSDO publishes human and machine-readable representations of the main elements of the SNOMED CT Concept Model. Further work is continuing to formalize an extended expression constraint syntax which is closely related to the constraint representation in this document. Enhancements to constraint representation arising from that work will be applied to future releases of this guide.

* 1. Schematic Illustrations of SNOMED CT Expressions

These following informal representations of expression help to explain some of the language used elsewhere in this guide. In November 2013, IHTSDO adopted a set more fomal diagramming guidelines for SNOMED CT definitions and expression and this will be used in future versions of this document.

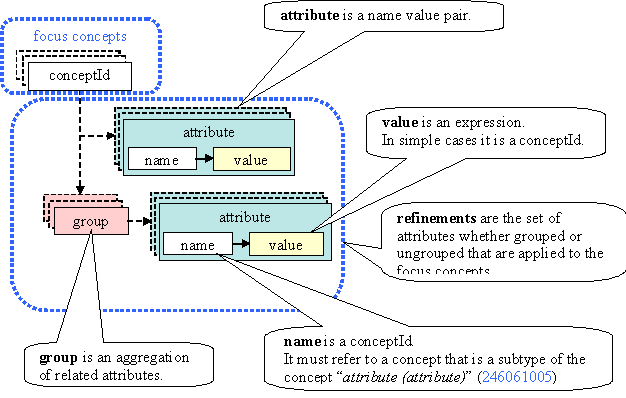


Figure 4: Illustration of names used to refer to general elements of an expression

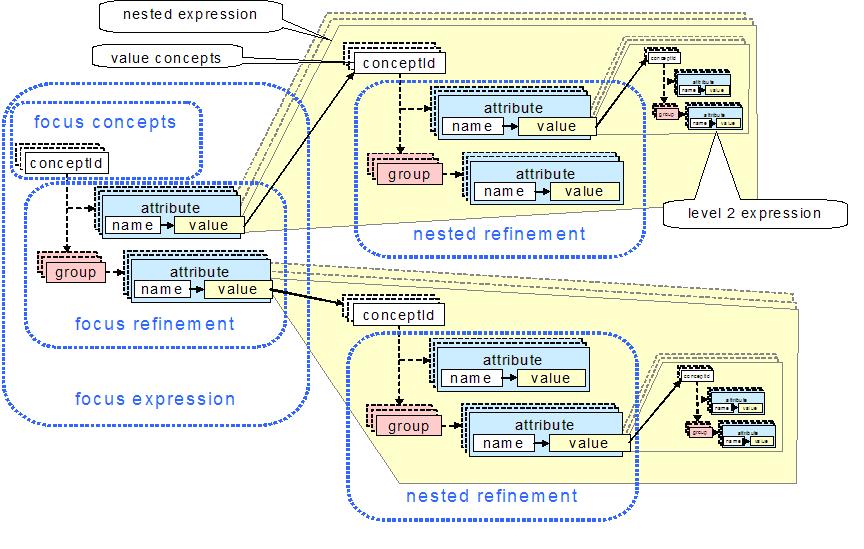


Figure 5: Illustration of the names used to refer to parts of a nested expression

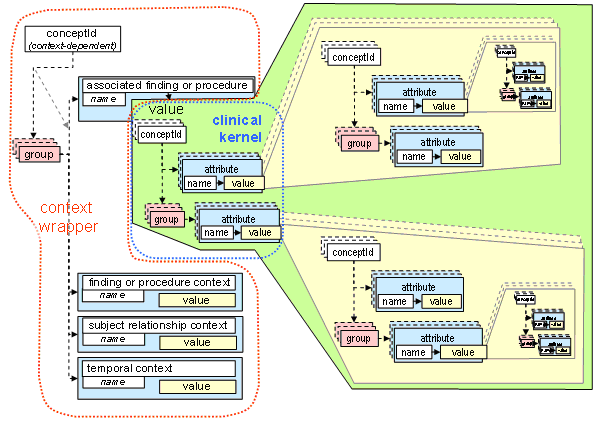


Figure 6: Illustration of the names used to refer to parts of an expression that represent context

1. Glossary
   1. Introduction to the Glossary

###### The HL7 Glossary provides "core" definitions of words and terms used throughout HL7 standards and documents. These definitions are maintained by the Modeling and Methodology (MnM) and Publishing Technical Committees (TC) and are identified in the glossary as "Core Glossary".

###### It should be noted that while the Modeling and Methodology and Publishing Technical Committees maintain the glossary definitions, the definitions themselves originate from within the various technical committees and special interest groups and are not constrained or vetted in any way by the MnM or Publishing TCs. It is expected that each committee and its balloters know their business best and that, should an imprecise or incorrect definition be put forward, it will be corrected through the domain balloting process.

###### It should further be noted that this glossary does not include all the definitions from the Reference Information Model (RIM) as the RIM definitions are already available in the RIM publication and are in context there.

###### Readers may also note that "core" definitions may be constrained or narrowed within the context of specific domains. For instance, the PM domain includes a definition for Person that is constrained from the RIM definition of Person. In these cases, the PM:Person is perfectly consistent with the RIM:Person, albeit as a specialized subset of the larger group. So while all instances of a PM:Person will also be members of RIM:Persons, not all instances of RIM:Person will fall within the group of PM:Persons.

###### The MnM and Publishing TCs encourage all members to review the definitions put forward by committees as part of the balloting process with an eye towards correcting and refining them as necessary and appropriate.

###### This glossary attempts to include terms used in this guide - it draws the definitions from various resources, which are listed in the source column of this table. References are drawn primarily from HL7 V3 (core glossary or Core princliples), where available. When the term could not be found there, TermInfo is listed as the source.

* 1. Alphabetic Index

| Term | | Source | Definition |
| --- | --- | --- | --- |
| **A** | |  |  |
| ANSI | | HL7 V3 Core Glossary | American National Standards Institute |
| application | | HL7 V3 Core Glossary | Software program or set of related programs that provide some useful healthcare capability or functionality. |
| artifact | | HL7 V3 Core Glossary | Any deliverable resulting from the discovery, analysis, and design activities leading to the creation of message specifications. |
| Assessment scale | | TermInfo | Collection of observations that together yield a summary evaluation of a particular condition.  Note: Examples include the Braden Scale (used for assessing pressure ulcer risk), APGAR Score (used to assess the health of a newborn). |
| association | | HL7 V3 Core Glossary | Reference from one class to another class or to itself, or a connection between two objects (instances of classes). For more information refer to the Relationships section of the Version 3 Guide. |
| Attribute in the context of HL7 | | HL7 V3 Core Glossary | Abstraction of a particular aspect of a class. Attributes become the data values that are passed in HL7 messages. |
|  | |  |  |
| Attribute in the context of SCT | | TermInfo | Abstraction of a particular aspect of a class.  Note: Attributes express characteristics of SNOMED CT concepts. Example: Concept Arthritis IS-A Arthropathy IS-A Inflammatory disorder FINDING-SITE Joint structure ASSOCIATED-MORPHOLOGY Inflammation In this example, Arthritis has two attributes: FINDING-SITE and ASSOCIATED-MORPHOLOGY. The value of the attribute FINDING-SITE is Joint structure. SNOMED CTconcepts form relationships to each other through attributes. |
| Attribute in the context of XML | | TermInfo | Characteristic of an object or entity  Attributes are used to associate name-value pairs with elements. |
| **B** | |  |  |
| bag | | HL7 V3 Core Glossary | Form of collection whose members are unordered, and need not be unique. |
| Binding realm | | Core Principles and Properties of V3 Models | Named interoperability conformance space  Note: All information models within a particular Binding Realm share the same conformance bindings. In non-technical terms, it can be considered a dialect where speakers use the semantics of the language but agree to use certain terms that are specific to their community; it is a context of use for terminology in HL7 models. Binding Realms may be defined by jurisdictional boundaries and are often HL7 Affiliates, or sub-national jurisdictional entities within the Affiliate purview. Binding Realms may also be based on other factors such as type of patient (e.g. human vs. veterinary, pediatric vs. geriatric), type of medicine (e.g. dentistry vs. psychiatry), etc.. |
| blank | | HL7 V3 Core Glossary | One of the allowed values for conformance requirements. Blank means that conformance for this element is to be negotiated on a site-specific basis. |
| **C** | |  |  |
| Canonical form | | TermInfo | Standard or basic structure of a post coordinated expression, a set of linked concepts |
| cardinality | | HL7 V3 Core Glossary | Property of a data element (the number of times a data element MAY repeat within an individual occurrence of an object view) or column in the Hierarchical Message Description (the minimum and maximum number of occurrences of the message element). |
| Choice in the context of HL7 | | HL7 V3 Core Glossary | Message construct that includes alternative portions of the message.  Note: For a choice due to specialization, the sender picks one of the alternatives and sends it along with a flag. |
| choice due to specialization | | HL7 V3 Core Glossary | Choice that arises when a Hierarchical Message Description includes (a) an object view which is associated with a class that is a superclass of two or more object views, or (b) an object view which is a superclass of one or more object views and MAY itself be instantiated. Under this circumstance different message instances MAY contain different object views. The choice structure is used to accommodate the alternatives. |
| class | | HL7 V3 Core Glossary | Abstraction of a thing or concept in a particular application domain. For more information refer to the Classes section of the Version 3 Guide. |
| Clinical Statement Pattern in the context of HL7 | | TermInfo | A refinement of the RIM to represent discrete instances of clinical information and the context within which they are recorded.  Note: The RIM is an abstract model and leaves many degrees of freedom with regard to representing a specific item of clinical information. The HL7 Clinical Statement project has developed and is now maintaining a more refined model for representing discrete instances of clinical information and the context within which they are recorded.  The HL7 Clinical Statement Pattern is a refinement of the RIM, which provides a consistent structural approach to representation of clinical information across a range of different domains aand may addtionally include the attribute “context”. However, neither the RIM nor the Clinical Statement Pattern place any limits on the level of clinical detail that may be expressed in a structured form. At the least structured extreme, an HL7 Clinical Document Architecture (CDA) document may express an entire encounter as text with presentational markup, without any coded clinical information. An intermediate level of structure might be applied when communicating a clinical summary with each diagnosis and operative procedure represented as a separate coded statement. Requirements for more comprehensive communication of electronic health records can be met by using the Clinical Statement Pattern to fully structure and encode each individual finding and/or each step in a procedure.  The Clinical Statement Pattern is the common foundation for the CDA Entries in HL7 Clinical Document Architecture release 2 and for the clinical information content of HL7 Care Provision messages. Details of the Clinical Statement Pattern can be found in the Universal Domains section of the HL7 Version 3 Normative Edition ([2013 version](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=306)). The clinical statement models used in CDA R2 are based on an early pre-publication version of the Clinical Statement Pattern (the closest available version is published in the [May 2005 ballot package](http://www.hl7.org/v3ballotarchive_temp_EAFE5005-1C23-BA17-0C14FAD30AD1332A/v3ballot2005MAY/html/welcome/environment/index.htm) under Common Domains – available to members).  Even within the constraints of the Clinical Statement Pattern, similar clinical information can be represented in different ways. One key variable is the nature of the code system chosen to represent the primary semantics of each statement. The other key variable is the way in which overlaps and gaps between the expressiveness of the information model (clinical statement) and the chosen terminology are reconciled. |
| Clinical finding | | TermInfo | Concepts that represent the result of a clinical observation, assessment or judgment.  These concepts are used for documenting clinical disorders and symptoms and examination findings. Within the “clinical finding” hierarchy is the sub-hierarchy of “disease”. Concepts that are descendants of “disease” are always and necessarily abnormal. Note: As expected, this definition includes concepts that would be used to represent HL7 Observations. However, it is worth noting that the definition of a finding in SNOMED CT is that it combines the question (see Observable entity) with the answering value. |
| clone | | HL7 V3 Core Glossary | Class from the Reference Information Model (RIM) that has been used in a specialized context and whose name differs from the RIM class from which it was replicated. This makes it possible to represent specialized uses of more general classes to support the needs of messaging. |
| CMET | | HL7 V3 Core Glossary | See Common Message Element Type. |
| code | | Oxford Dictionary 2014 | A series of letters, numbers, or symbols assigned to something for the purposes ofclassification or identification |
| code system | | HL7 V3 Core Glossary | Collection of coded concepts, each having associated designations and meanings  Note: This term is used to describe any and all such systems, whether authoratively managed or not. |
| coded attribute | | HL7 V3 Core Glossary | Attribute in the Reference Information Model (RIM) with a base data type of CD, CE, CS, or CV. |
| coding and terminologies | | HL7 V3 Core Glossary | Note:The scope of clinical information is very broad, and this, together with the need to express similar concepts at different levels of detail (granularity), results in a requirement to support a large number of concepts and to recognize the relationships between them.  Several candidate terminologies have been identified at national and international levels. HL7 does not endorse or recommend a particular clinical terminology. However, HL7 is seeking to address the issues raised by combining particular widely-used terminologies with HL7 standards.  This guide focuses on the issues posed by using SNOMED Clinical Terms® (SNOMED CT) with HL7 clinical statements. It includes specific advice on how to specify communications that use SNOMED CT to provide the primary source of clinical meaning in each clinical statement.  Although this guide is specifically concerned with SNOMED CT, it is likely that similar issues will be encountered when considering the use of other code systems within HL7 clinical statements. Therefore some of the advice related to general approaches to gaps and overlaps is more widely applicable. |
| coding system | HL7 V3 Core Glossary | | Schema for representing concepts.  Note: The schema usually usiuses short concept identifiers to denote the concepts that are members of the system; defines a set of unique concept codes. Examples of coding systems are ICD-9, LOINC and SNOMED. |
| collection | | HL7 V3 Core Glossary | Aggregation of similar objects. The forms of collection used by HL7 are set, bag, and list. Objects which MAY be found in collections include data types and message element types. |
| common message element type in the context of CMET | | HL7 V3 Core Glossary | Message type in a Hierarchical Message Description (HMD) that MAY be included by reference in other HMD's. For more information refer to the Common Message Element Types section of the Version 3 Guide. |
| concept identifier | | HL7 V3 Core Glossary | Unique identification assigned to a concept by the HL7 organization. |
| Concept | |  | A member of a terminology.  Note: Examples of terminologies: ICD, SNOMED, LOINC. |
| Concept in the context of SCT | | IHTSDO | Clinical concept to which a unique ConceptId has been assigned.  Note: The term concept may also be used informally with the following meanings:  • The concept Identifier, which is the key of the Concept file (in this case it is less ambiguous to use the  term "conceptId" or "concept code");  • The real-world referent(s) of the Concept Identifier, that is, the class of entities in reality that the Concept  Identifier represents (in this case it is less ambiguous to use the term "meaning" or "code meaning"). |
| concept domain | | Core Principles and Properties of V3 Models | Set of all concepts that can be taken as valid codes in an instance of a coded attribute or field; a constraint applicable to coded elements  Note: An HL7 Concept Domain is a named category of like concepts (a semantic type) that is specified in the Vocabulary Declaration of an attribute in a information model or property in a data type, whose data types are coded or potentially coded, and may be used in a Context Binding. Concept Domains exist to constrain the intent of the coded element while deferring the binding of the element to a specific set of codes until later in the specification development process. Thus, Concept Domains are independent of any specific vocabulary or Code System. Concept Domains are hierarchical in nature, and each hierarchy represents a constraint path from a broader to a narrower semantic category. In HL7's base models – the RIM and the Abstract Data Types specification – all coded elements are tied to these abstract definitions of the allowed types of concepts. |
| conformance verb | | HL7 V3 Core Glossary | Verb used to indicate the level or type of conformance required.  Note: In HL7 Version 3 Specifications, the correct verb form for indicating a requirement is "SHALL." The correct verb form for indicating a recommendation is "SHOULD." The correct verb form for an option is "MAY." Universally accepted standardization terminology does not recognize "must". Use "SHALL" to indicate a mandatory aspect or an aspect on which there is no option. The negatives are SHALL NOT, SHOULD NOT, MAY NOT. The Publishing Facilitator's Guide requires the Conformance Verbs to be capitalized when they are used to indicate conformance criteria, to differentiate from common usage of the words. The source for this usage is ANSI. |
| Connection in the context of an information model | | HL7 V3 Core Glossary | Specified relationship between two classes in and information model. |
| constraint | | HL7 V3 Core Glossary | Narrowing down of the possible values for an attribute.  Note: A suggestion of legal values for an attribute (by indicating the data type that applies, by restriction of the data type, or by definition of the domain of an attribute as a subset of the domain of its data type). MAY also include providing restrictions on data types. A constraint imposed on an association MAY limit the cardinality of the association or alter the navigability of the association (direction in which the association can be navigated). A Refined Message Information Model (R-MIM) class MAY be constrained by choosing a subset of its Reference Information Model (RIM) properties (i.e., classes and attributes) or by cloning, in which the class’ name is changed. For more information refer to the Constraints section of the Version 3 Guide. |
| Context model in the context of SNOMED CT | | TermInfo | Establishing relationships of concepts to different attributes in the hierarchy of “Situation with explicit context”.  Note: Concepts can be placed in defined or refined in specific contexts related to subject (e.g. subject of record, family member, disease contact, etc.), time, finding (e.g. unknown, present, absent, goal, expectation, risk, etc.) or procedure (e.g. not done, not to be done, planned, requested, etc) |
| Context Wrapper | | IHTSDO | Part of a SNOMED CT expression that specifies the context that applies to the focus concept that it contains.  Note: An example: "Family history of asthma" can be represented by an expression in which the concept "asthma" is nested within an context wrapper that indicates that this is "family history" - rather than a current condition affecting the patient. |
| coupling | | HL7 V3 Core Glossary | Interaction between systems or between properties of a system.  Note: With regard to application roles, refers to whether or not additional information about the subject classes participating in a message may be commonly available to system components outside of the specific message. |
| **D** | |  |  |
| data type | | HL7 V3 Core Glossary | Structural format of the data carried in an attribute.  Note: It MAY constrain the set of values an attribute may assume. For more information refer to the Data Types section of the Version 3 Guide.  HL7 has defined two sets of “abstract” data types for use in HL7 models, including CDA. The two versions are known as Release 1 (R1) and Release 2 (R2) – details can be found in the HL7 Version 3 Normative Edition ([2013 version](http://www.hl7.org/implement/standards/product_brief.cfm?product_id=306)). Of particular interest for this implementation guide is the Concept Descriptor (CD) data type (present in both versions), which is used for the representation of coded data (in SNOMED CT or other terminologies), and is the most general coded data type. The CD data types provides for the representation of post-coordinated expressions, although by different mechanism in the two versions.  The Data Types R1 specification, which is used by CDA R2 (and other earlier versions of V3), represents post-coordination using “qualifier” elements (one or more) which encode attribute-value pairs that “qualify” (or modify) a primary concept (code) and are represented as an XML structure. Datypes R2 instead uses an arbitrary length string representation for the “code” attribute, which allows post-coordination to be represented by the grammar (if any) that is defined for that purpose by the terminology (code system) itself. In the case of SNOMED CT, this is the Compositional Grammar.  In this guide examples will be shown of the use of both Data Types R1 and R2, with the R1 examples being directly applicable to use in CDA R2. |
| Diagnosis | | TermInfo | Result of a cognitive process whereby signs, symptoms, test results, and other relevant data are evaluated to determine the condition afflicting a patient.  Note: Diagnosis directs administrative and clinical workflow, where for instance the assertion of an admission diagnosis establishes care paths, order sets, etc., something that is billed for in a clinical encounter. In such a scenario, an application typically has a defined context where the billable object gets entered. |
| domain | | HL7 V3 Core Glossary | Particular area of interest.  Note: For example, the domain for HL7 is healthcare. |
| domain in the context of HL7 | | TermInfo | Set of possible values of a data type, attribute, or data type component.  Note: See also concept domain.  A special interest group within HL7, such as Pharmacy, Laboratory, or Patient Administration |
| **E** | |  |  |
| event | | HL7 V3 Core Glossary | Stimulus that causes a noteworthy change in the state of an object, or a signal that invokes the behavior of an object.  Note: See also trigger event. |
| event in the context of HL7 | | HL7 V3 Core Glossary | Concept in the ActMood code system (universally bound for use with the Act.moodCode attribute) representing “An act that actually happens (may be an ongoing act or a documentation of a past act).” |
| Expression in the context of SCT | | TermInfo | Collection of references to one or more concepts used to express an instance of an idea.  Note: An expression containing a single concept identifier is referred to as a pre-coordinated expression. An expression that contains two or more concept identifiers is a post-coordinated expression. The concept identifiers within a post-coordinated expression are related to one another in accordance rules expressed in the SNOMED CT Concept Model. These rules allow concepts to be:  • combined to represent clinical ideas which are subtypes of all the referenced concepts • E.g. “tuberculosis” + “lung infection”  • applied as refinements to specified attributes of a more general concept.  • E.g. “asthma” : “severity” = “severe” Notes: The SNOMED CT compositional grammar provides one way to represent an expression. The HL7 messaging standard supports communication of SNOMED CT expressions using the “concept descriptor” (CD) data type. |
| Extensible Markup Language | | HL7 V3 Core Glossary | A meta-language that defines a syntax used to define other domain -specific, semantic, structured markup languages. Based on SGML (Standard Generalized Markup Language), it consists of a set of rules for defining semantic tags used to mark up the content of documents. Abbreviated as XML. |
| **F** | |  |  |
| *no words starting with F in this list* | |  |  |
| **G** | |  |  |
| *no words starting with G in this list* | |  |  |
| **H** | |  |  |
| Hierarchical Message Description | | HL7 V3 Core Glossary | Specification of the exact fields of a message and their grouping, sequence, optionality, and cardinality. This specification contains message types for one or more interactions, or that represent one or more common message element types. This is the primary normative structure for HL7 messages. |
| HL7 | | HL7 V3 Core Glossary | Health Level 7 |
| HMD | | HL7 V3 Core Glossary | See Hierarchical Message Description. |
| HTML | | HL7 V3 Core Glossary | Hypertext Markup Language, a specification of the W3C that provides markup of documents for display in a web browser |
| **I** | |  |  |
| ICD(9 or 10) | | TermInfo | International Statistical Classification of Diseases and Related Health Problems (version 9 or 10) is a classification published by the National Center for Health Statistics which is a branch of the Centers for Disease Control and Prevention. |
| IHTSDO | | TermInfo | The International Health Terminology Standards Development Organisation  Note: An international organisation established as an association under Danish Law. It has responsibility for the ongoing maintenance, development, quality assurance, and distribution of SNOMED CT |
| inclusion | | HL7 V3 Core Glossary | The specification in the Hierarchical Message Description indicating whether an element of a message type MAY be null in some message instances.  Note: Contrast this with conformance. |
| information model | | HL7 V3 Core Glossary | A structured specification, expressed graphically and/or narratively, of the information requirements of a domain.  Explanation:  An information model describes the classes of information required and the properties of those classes, including attributes, relationships, and states. Examples in HL7 are Domain Reference Information, Model (DMIM), Reference Information Model (RIM), and Refined Message Information Model (RMIM) |
|  | |  |  |
| instance | | HL7 V3 Core Glossary | Case or occurrence.  Note: For example, an instance of a class is an object. |
| interaction | | HL7 V3 Core Glossary | Single, one-way information flow that supports a communication requirement expressed in a scenario. |
| interoperability | | IEEE Standard Computer Dictionary: A Compilation of IEEE Standard Computer Glossaries, IEEE, 1990 | Ability of two or more systems or components to exchange information and to use the information that has been exchanged.Note: “Functional” interoperability is the capability to reliably exchange information without error “Semantic" interoperability is the ability to interpret, and, therefore, to make effective use of the information so exchanged. In our context, "effective use" means that the information can be used in any type of computable algorithm (appropriate) to that information |
| **J** | |  |  |
| *no words starting with J in this list* | |  |  |
| **K** | |  |  |
| *no words starting with K in this list* | |  |  |
| **L** | |  |  |
| life cycle | | HL7 V3 Core Glossary | See state machine. |
| list | | HL7 V3 Core Glossary | Form of collection whose members are ordered, and need not be unique. |
| Logical concept definition | | TermInfo | Relationships between concepts which define a concept  Note: Each SNOMED CT concept is defined by relationships to one or more other concepts. The following example illustrates the type of logical definitions that are distributed as part of SNOMED CT.  Example 1. SNOMED CT definition of 'fracture of femur'  [ 71620000 | fracture of femur |] is fully defined as...  116680003 | is a | = 46866001 | fracture of lower limb |,  116680003 | is a | = 7523003 | injury of thigh |,  {116676008 | associated morphology | = 72704001 | fracture |,  363698007 | finding site | = 71341001 | bone structure of femur |}  This example and many of the other illustrations in this document are expressed using the SNOMED CT compositional grammar. Where relevant this document also uses proposed extensions to this grammar to represent constraints on use of SNOMED CT concepts and expressions. The extended grammar is explained in SNOMED CT Compositional Grammar - extended (§ Error! Reference source not found.), together with references to the SNOMED CT source material. |
| LOINC | | The Regenstrief Institute | Logical Observations, Identifiers, Names, and Codes is terminology with a focus on clinical and laboratory observtions maintained by The Regenstrief Institute (www.regenstrief.org) |
| **M** | |  |  |
| mandatory | | HL7 V3 Core Glossary | Requirement for non-null content in a value  Note: If an attribute is designated as mandatory, all message elements which make use of this attribute SHALL contain a non-null value or they SHALL have a default that is not null. This requirement is indicated in the "mandatory" column in the Hierarchical Message Description. |
| markup | | HL7 V3 Core Glossary | Computer-processable annotations within a document. Note: Markup encodes a description of a document’s storage layout and logical structure. In the context of HL7 Version 3, markup syntax is according to the XML Recommendation. |
| MAY | | HL7 V3 Core Glossary | The conformance verb MAY is used to indicate a possibility. See the conformance verb definition for more information. |
| Message in the context of HL7 | | HL7 V3 Core Glossary | Package of information communicated from one application to another.  Note: See also message type and message instance. |
| message element in the context of HL7 | | HL7 V3 Core Glossary | Unit of structure within a message type. |
| message element type in the context of HL7 | | HL7 V3 Core Glossary | Portion of a message type that describes one of the elements of the message. |
| message instance | | HL7 V3 Core Glossary | Message, populated with data values, and formatted for a specific transmission based on a particular message type. |
| message type | | HL7 V3 Core Glossary | Set of rules for constructing a message given a specific set of instance data.  Note: As such, it also serves as a guide for parsing a message to recover the instance data. |
| model | | HL7 V3 Core Glossary | Representation of a domain that uses abstraction to express the relevant concepts.  Note: In HL7, the model consists of a collection of schema and other documentation. |
| model of meaning | | TermInfo | Universal sematic representation of an expression  Note: This differs from the “model of use” which may have local interpretations or context, for example an application my place some clincial statements in a “Negative” column meaning “ruled out”. Those statements would have to be modified (transformed into a cannonical form) to be correctly understood when transmitted to a third party. This would be the representation regardless of how it was colelcted / shared with the user. |
| Model of use | | TermInfo | Local interpretations or context of the model of meaning.  Note: For example an application my place some clincial statements in a “Negative” column meaning “ruled out”. Those statements would have to be transformed into a cannonical form to be correctly understood when transmitted to a third party. Distinguished from the “model of meaning” which stand on its own, which can be universally understood. |
| moodCode | | TermInfo | Acode distinguishing whether an Act is conceived of as a factual statement or in some other manner as a command, possibility, goal, etc”.  Note: This s one attribute of a HL7 Act. |
| **N** | |  |  |
| navigability | | HL7 V3 Core Glossary | Direction in which an association can be navigated (either one way or both ways). |
| negationInd | | TermInfo | IA marker declaring that the Act statement of the Act as described by the descriptive attributeswas annulled.  Note: Negation Ind = Negation Indicator is applicable to all Act subtypes, including observations. In the current version of the RIM there are two types of Negation Indicators: The Act.negationInd – applicable to procedures etc and the ObservationValue.NegationInd, applicable to clinical findings. CDA is using an older version of the RIM, where that distinction was not explicitly stated, so when using the NegationInd in CDA, it is important to conceptualize if it applies to the act or the observation value. For example when a negationIndicator is set to true on an observation value, it means that observation did not occur. |
| NHS | | TermInfo | United Kingdom’s National Health Service |
| normal form in the context of SNOMED | | IHTSDO | A representation of a SNOMED CT expression in which none of the referenced concepts are fully defined.  Note: Normal forms can be used to determine equivalence and subsumption between expressions and thus assist with selective retrieval.  Any SNOMED CT expression can be transformed to its normal form by replacing each reference to a fully defined concept with a nested expression representing the definition of that concept.  Transformation rules then resolve redundancies, which may arise from expanding fully defined concepts, by removing less specific attribute values. Normal forms can be used to determine equivalence and subsumption between expressions and thus assist with selective retrieval. |
| not permitted | | HL7 V3 Core Glossary | Allowed value in conformance requriementns meaning that the message element is never sent for that message type  Note: One of the allowed values in conformance requirements. Abbreviated as NP, it means that the message element is never sent for that message type. |
| null | | HL7 V3 Core Glossary | Value for a data element which indicates the absence of data. A number of “flavors” of null are possible and are enumerated in the domain NullFlavor. |
| **O** | |  |  |
| object | | HL7 V3 Core Glossary | Instance of a class.  Note: A part of an information system containing a collection of related data (in the form of attributes) and procedures (methods) for operating on that data. For more information refer to the Classes section of the Version 3 Guide. |
| Observable entity in the context of SCT | | TermInfo | Hierarchy in SNOMED CT which represents a question about something which may be observed or measure.  Note: An observable entity combined with a result, constitutes a finding. For instance, the concept Left ventricular end-diastolic pressure (observable entity) in effect represent the question “What is the value of the left ventricular end diastolic pressure?” When Left ventricular end-diastolic pressure (observable entity) is given a value it represents a finding. For example: Increased left ventricular end-diastolic pressure is a finding with the value Increased. Left ventricular end-diastolic pressure combined with a separately expressed value such as 95 mmHg also behaves as a finding. Note: This definition includes concepts that would be used to represent the code attribute of HL7 Observations. |
| Observation | | HL7 V3 Core Glossary | measurement of a single variable or single value derived logically and/or algebraically from other measured or derived values  Note: An Act of recognizing and noting information about the subject, and whose immediate and primary outcome (post-condition) is new data about a subject. Observations often involve measurement or other elaborate methods of investigation, but may also be simply assertive statements. Discussion: Structurally, many observations are name-value-pairs, where the Observation.code (inherited from Act) is the name and the Observation.value is the value of the property. Such a construct is also known as a “variable” (a named feature that can assume a value); hence, the Observation class is always used to hold generic name-value-pairs or variables, even though the variable valuation may not be the result of an elaborate observation method. It may be a simple answer to a question or it may be an assertion or setting of a parameter. As with all Act statements, Observation statements describe what was done, and in the case of Observations, this includes a description of what was actually observed (“results” or “answers”); and those “results” or “answers” are part of the observation and not split off into other objects. Note: This definition refers to the action rather than the outcome of the observation but in the discussion continues to refer to the “results” or “answers” as being a part of the observation. The general idea of an HL7 Observation therefore includes three distinct types of concept from a SNOMED CT perspection “Observable entities” (things that can be measured), “Measurement procedures” (a type of procedure used to make a measurement or observation) and “Clinical finding” (expressing both the name of the observation and its value). |
| optional | | HL7 V3 Core Glossary | See inclusion. |
| Organizer | | TermInfo | Navigational structure or heading an object class in the HL7 Clinical Statement Pattern, which can be an ActContainer.  Note: Organizersare used to group a set of acts sharing a common context, include such structures as folders, documents, document sections, and batteries. Values may be drawn from the SNOMED CT Care Record Elements hierarchy. |
| **P** | |  |  |
| Pattern | | TermInfo | An object model that is generally effective for a type of problem and can be easily adapted to aparticular instance of the problem. |
| Post-Coordinated expression | |  | Representation of a clinical meaning using a combination of two or more concept identifiers  Synonym: postcoordinated expression  Note: Post-coordinated expressions define a concept using semantics and linking of pre-coordinated concepts.  Some clinical meanings may be represented in several different ways. SNOMED CT technical specifications include guidance for transforming logical expressions to a common canonical form.  Source: IHTSDO Glossary 2014 modified to meet SKMT metadata specifications.  Each SNOMED CT concept is defined by relationships to one or more other concepts. The following example illustrates the type of logical definitions that are distributed as part of SNOMED CT.  Example 1. SNOMED CT definition of 'fracture of femur'  [ 71620000 | fracture of femur |] is fully defined as...  116680003 | is a | = 46866001 | fracture of lower limb |,  116680003 | is a | = 7523003 | injury of thigh |,  {116676008 | associated morphology | = 72704001 | fracture |,  363698007 | finding site | = 71341001 | bone structure of femur |}  This example and many of the other illustrations in this document are expressed using the SNOMED CT compositional grammar. Where relevant this document also uses proposed extensions to this grammar to represent constraints on use of SNOMED CT concepts and expressions. The extended grammar is explained in SNOMED CT Compositional Grammar - extended (§ Error! Reference source not found.), together with references to the SNOMED CT source material. |
|  | |  |  |
| Pre-coordination | | TermInfo | Representation of an idea by a single attribute.  Synonym: Precoordination  Note: In HL7 documents the idea is the meaning of a class, though not clearly stated, but inferred from usage in relation to particular attributes like Procedure.methodCode and Procedure.targetSiteCode. Contrast this with the definition of pre-coordination in SNOMED CT documentation which implies a single concept identifier is used to represent a meaning.  For examples of use in SNOMED CT see post-coordinated expression. |
| Problem | |  | Clinical statement that a clinician chooses to add to a problem list. |
| Procedure in the context of HL7 | | TermInfo | Act whose immediate and primary outcome (post-condition) is the alteration of the physical condition of the subject.  Note: Applied to clinical medicine, procedure is but one among several types of clinical activities such as observation, substance-administrations, and communicative interactions (e.g. teaching, advice, psychotherapy, represented simply as Acts without special attributes). Procedure does not subsume those other activities nor is procedure subsumed by them. Notably Procedure does not comprise all acts of whose intent is intervention or treatment. Whether the bodily alteration is appreciated or intended as beneficial to the subject is likewise irrelevant, what counts is that the act is essentially an alteration of the physical condition of the subject. Note: This definition and the associated discussion exclude many activities which are subsumed by the more general sense of the word “procedure” which is used in the SNOMED CT definition. |
| Procedure in the contextof SCT | | TermInfo | Concepts and hierachry that represent the purposeful activities performed in the provision of health care.  Note: This hierarchy includes a broad variety of activities, including but not limited to invasive procedures (Excision of intracranial artery), administration of medicines (Pertussis vaccination), imaging procedures (Radiography of chest), education procedures (Instruction in use of inhaler), and administrative procedures (Medical records transfer). Note: As expected, this definition includes concepts that would be used to represent HL7 Procedures. However, it also includes measurement procedures and actions that involve administration of a substance. Therefore, the code attribute of many HL7 Observations and SubstanceAdministration Acts may also be expressed using concepts from the SNOMED procedures hierarchy. |
| property | | HL7 V3 Core Glossary | Any attribute, association, method, or state model defined for a class or object. |
| Q | |  |  |
| *no words starting with Q in this list* | |  |  |
| **R** | |  |  |
| Realm | | The free dictionary | An area of knowledge or activity.  Note: See “Binding realm” |
| Reference Information Model in the context of HL7 | | HL7 V3 Core Glossary | The model from which all other information models and messages are derived  Note: The HL7 Version 3 Reference Information Model (RIM) provides an abstract model for representing health related information. The RIM comprises classes which include sets of attributes and which are associated with one another by relationships.  Documentation of RIM classes, attributes and relationships and the concept domains specified for particular coded attributes provide standard ways to represent particular kinds of information. The RIM specifies internal vocabularies for some structurally essential coded attributes but also supports use of external terminologies to express more detailed information. SNOMED CT is one of the external terminologies that may be used in HL7 communications. |
| Refined Message Information Model | | HL7 V3 Core Glossary | An information structure that represents the requirements for a set of messages.  Note: A constrained subset of the Reference Information Model (RIM) which MAY contain additional classes that are cloned from RIM classes. Contains those classes, attributes, associations, and data types that are needed to support one or more Hierarchical Message Descriptions (HMD). A single message can be shown as a particular pathway through the classes within an R-MIM. For more information refer to the Information Model section of the Version 3 Guide. |
| required | | HL7 V3 Core Glossary | One of the allowed values in conformance requirements. Note: Abbreviated as R, it means that the message elements SHALL appear every time that particular message type is used for an interaction. If the data is available, the element SHALL carry the data, otherwise a blank MAY be sent. |
| RIM | | TermInfo | See Reference Information Model.   Defined in Using SNOMED CT in HL7 Version 3; Implementation Guide, Release 1.5 |
| R-MIM | | HL7 V3 Core Glossary | See Refined Message Information Model. |
| role | | HL7 V3 Core Glossary | A Reference Information Modelclass that defines the competency of an Entity class. Note: Each role is played by one Entity (the Entity that is in the role) and is usually scoped by another. In UML, each end of an association is designated as a role to reflect the function that class plays in the association. |
| **S** | |  |  |
| schema | | HL7 V3 Core Glossary | Diagrammatic presentation, a structured framework, or a plan.  Note: A schema documents the set of requirements that need to be met in order for a document or set of data to be a valid expression within the context of a particular grammar. |
| Scope (noun) | | HL7 V3 Core Glossary | Definition of the range or extent of a project undertaken by a Technical Committee. |
| SCT | | TermInfo | Systematic Nomenclature of Medicine Clinical Term (SNOMED CT) |
| Section in the context of HL7 version 3 guide | | HL7 V3 Core Glossary | Method of grouping related information into domains.  Note: These domains include Infrastructure Management, Administrative Management, and Health & Clinical Management. |
| Semantic in the context of technical specification | | HL7 V3 Core Glossary | Meaning of something as distinct from its exchange representation.  Note: Syntax can change without affecting semantics. |
| semantic interoperability | | TermInfo | Capability of two or more systems to communicate and exchange information, and for each system to be able to interpret the meaning of received information and to use it seamlessly with other data held by that system.  Note: A receiving application should be able to retrieve and process communicated information, in the same way that it is able to retrieve and process information that originated within that application.  One of the primary goals of HL7 Version 3 is to deliver standards that enable semantic interoperability. Semantic interoperability is a step beyond the exchange of information between different applications that was demonstrated by earlier versions of HL7. The additional requirement is that a receiving application should be able to retrieve and process communicated information, in the same way that it is able to retrieve and process information that originated within its own application. To meet this requirement the meaning of the information communicated must be represented in an agreed upon, consistent and adequately expressive form.  Clinical information is information that is entered and used primarily for clinical purposes. The clinical purposes for which information may be used include care of the individual patient and support to population care. In both cases there are requirements for selective retrieval of information either from within a single patient record or from the set of records pertaining to the population being studied. Meeting these requirements depends on consistent interpretation of the meaning of stored and communicated information. This requires an understanding of the varied and potentially complex ways in which similar information may be represented. This complexity is apparent both in the range of clinical concepts that need to be expressed and the relationships between instances of these concepts.  Delivering semantic interoperability in this field presents a challenge for traditional methods of data processing and exchange. Addressing this challenge requires an established way to represent reusable clinical concepts and a way to express instances of those concepts within a standard clinical record, document or other communication. |
| set | | HL7 V3 Core Glossary | Form of collection which contains an unordered list of unique elements of a single type. |
| SHALL | | HL7 V3 Core Glossary | The conformance verb SHALL is used to indicate a requirement.  Note: See the conformance verb definition for more information. |
| SHOULD | | HL7 V3 Core Glossary | The conformance verb SHOULD is used to indicate a recommendation.  Note: See the conformance verb definition for more information. |
| SNOMED CT | | IHTSDO Glossary 2014 | Clinical terminology maintained and distributed by the IHTSDO.  Note: It is considered to be the most comprehensive, multilingual healthcare terminology in the world. It was created as a result of the merger of SNOMED RT and NHS Clinical Terms Version 3.  SNOMED CT is a clinical terminology which covers a broad scope of clinical concepts to a considerable level of detail. It is one of the external terminologies that can and will be used in HL7 Version 3 communications. SNOMED CT has various features that add flexibility to the range and detail of meanings that can be represented. These features summarized below are documented in detail in documents listed in SNOMED CT Reference materials (§ Error! Reference source not found. ). The OID value that identifies SNOMED CT when used in HL7 V3 models (in CD and additional coded datatypes) is "2.16.840.1.113883.6.96".  Preferred Synonym: SNOMED CT |
| specialization | | HL7 V3 Core Glossary | Association between two classes (designated superclass and subclass), in which the subclass is derived from the superclass.  Note: The subclass inherits all properties from the superclass, including attributes, relationships, and states, but also adds new ones to extend the capabilities of the superclass. |
| specification | | HL7 V3 Core Glossary | Detailed description of the required characteristics of a product. |
| state | | HL7 V3 Core Glossary | Named condition of a classinstance (object) that can be tested by examination of the instance's attributes and associations.  Note: For more information refer to the Dynamic Behavior section of the Version 3 Guide. |
| state machine | | HL7 V3 Core Glossary | Description of the life cycle for instances of a class, defined by a state transition model. |
| state transition model | | HL7 V3 Core Glossary | Graphical representation of the life cycle of a class.  Note: The model depicts all of the relevant states of a class, and the valid transitions from state to state. |
| system | | HL7 V3 Core Glossary | End user application |
| System in the context of RIM | | The free dictionary | A group of interacting, interrelated, or interdependent elements forming a complex whole.  Note: In this context sytem refers to the group of physiologically or anatomically related organs or parts |
| **T** | |  |  |
| TermInfo | | TermInfo | Project started by NASA and adopted by HL7 Vocabulary Committee to define how to use SNOMED CT in HL7 RIM record transfers. |
| Terminology | | TermInfo - Adapted from ISO 17115:2007 | terminology; a defined or limited vocabulary of terms or concepts Structured, human and machine-readable representation of concepts  Note: This includes the relationship of the terminology to the specifications for organizing, communicating and interpreting such a set of concepts. The use of the term terminology in healthcare implies a terminology that is designed for use in computer systems. The term Vocabulary or health or medical language is used to indicate the idea of linguistic representation without the specification of computability. |
| Terminology server | | wikipedia | Piece of software providing a range of terminology-related software services through an applications programming interface to its client applications.  Note: A subscription service that allows real time access to terminology look up tables for example. |
| Terms | | TermInfo | Linguistic representation of a concept  Note: Terms are members of a terminology; a defined or limited vocabulary of terms or concepts, for example: ICD, SNOMED CT, LOINC. |
| tight coupling | | HL7 V3 Core Glossary | ADD DEFINITION!  Note: Tightly coupled application roles assume that common information about the subject classes participating in a message is available to system components outside of the specific message. |
| trigger event | | HL7 V3 Core Glossary | Event which, when recorded or recognized by an application, indicates the need for an information flow to one or more other applications, resulting in one or more interactions. |
| **U** | |  |  |
| uncertaintyCode | | TermInfo | Code indicating whether the Act statement as a whole, with its subordinate components has been asserted to be uncertain in any way.  Synonym of Act.uncertaintyCode |
| **V** | |  |  |
| Version 3 Guide | | HL7 V3 Core Glossary | A companion to the Version 3 Standard which contains the methodological information an HL7 member needs to understand the Version 3 standard. |
| value set | | Core Principles and Properties of V3 Models | Uniquely identifiable set of values consisting of concept representations drawn from one or more code systems, which can be resolved at a given point in time to an exact set of codes.  Note: A Value Set represents a uniquely identifiable set of valid concept identifiers, where any concept identifier in a coded element can be tested to determine whether it is a member of the Value Set at a specific point in time. A concept identifier in a Value Set may be a single concept code or a post-coordinated expression of a combination of codes. |
| vocabulary | | Merriam-Webster's Dictionary | Sum or stock of words employed by a language, group, individual work or in a field of knowledge.  Note: In health informatics computable vocabularies, including terms concept identifiers etc are referred to as terminologies. |
| Vocabulary binding in the context of HL7 version 3 | | Core Principles | Mechanism of identifying specific codes to be used to express the semantics of coded model elements in HL7 information models or coded data type properties.  Note: Vocabulary Binding may bind the coded element or data type property to a single fixed value code, or may bind it to a Value Set Assertion. The description of the collection that is bound, along with parameters controlling other aspects of the use and stability of the collection, are called a Value Set Assertion. Vocabulary binding is required to specify Vocabulary Conformance. ( |
| vocabulary declaration | | Core Principles and Properties of V3 Models | The Vocabulary Declaration identifies the constraints on the coded expressions that can be used as well as the vocabulary conformance expectations for implementers of the data element.  Note: A Vocabulary Declaration is the semantic constraint for a coded model element or data type property. |
| **W** | |  |  |
| W3C | | HL7 V3 Core Glossary | The World Wide Web Consortium, an international industry consortium |
|  | |  |  |
| **X** | |  |  |
| XML | | HL7 V3 Core Glossary | See Extensible Markup Language. |
| **Y** | |  |  |
| *no words starting with Y in this list* | |  |  |
| **Z** | |  |  |
| *no words starting with Z in this list* | |  |  |

1. More information: <http://ihtsdo.org/snomed-ct/> [↑](#footnote-ref-2)
2. The Clinical Statement CMET is a proposed replacement for the Supporting Clinical Information CMET which is based on the Clinical Statement pattern. [↑](#footnote-ref-3)
3. Text TBD [↑](#footnote-ref-4)
4. www.snomed.org/eg?t=att\_findings\_has\_interpretation [↑](#footnote-ref-5)
5. http://aurora.rg.iupui.edu/UCUM [↑](#footnote-ref-6)
6. These patterns assume the use of SNOMED CT. While other code systems (such as LOINC or ICD9) may be required or even preferable in some situations, these situations are outside the scope of this guide. [↑](#footnote-ref-7)
7. The Organizer class can be used to communicate batteries. Therefore measurement procedures representing batteries can be used. [↑](#footnote-ref-8)
8. The organizer may have contextual components (e.g. participants or act relationships) which propagate to nested observations. [↑](#footnote-ref-9)
9. SNOMED distributes an allergen subset, drawn from Substance and Product hierarchies. [↑](#footnote-ref-10)
10. Note that it may not be possible in this context to differentiate an allergic reaction from the condition of being allergic, since the data entry field only accepts substance and product values. [↑](#footnote-ref-11)
11. Note that the naming in SNOMED CT"s documentation/data has recently been updated - "context-dependent categories" in the data have been renamed "situation with explicit context". In this guide these concepts are referred to as [ <<243796009 | situation with explicit context |] or the more specific [ <<413350009 | finding with explicit context |] and [ <<129125009 | procedure with explicit context |]. [↑](#footnote-ref-12)
12. The distinction between ‘abstract’ and ‘detailed’ (e.g. between ‘procedure’ and ‘total pancreatectomy’) might be better articulated in alternative ways (e.g. ‘narrow’ and ‘broad intension’), but it is hoped that the point is clear. [↑](#footnote-ref-13)
13. Whilst it is fair to say that many ‘abstract’ SNOMED CT Concepts are ‘Primitive’, it should also be noted that many ‘detailed’ Concepts – such as the vast majority of concepts in the descent of [ <<105590001 | substance |] are also Primitive. [↑](#footnote-ref-14)
14. With the exception of ‘context/situation wrapping.’ [↑](#footnote-ref-15)
15. Or ‘potentially’ Fully Defined – that is, Concepts that could be modeled as Fully Defined within the published SCT concept model, but where either the modelling is insufficient, or where the modelling is sufficient but the 'Fully Defined' assertion has not been made by the editors of the terminology. [↑](#footnote-ref-16)