# Glossary

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 all 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.

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* | |  |  |