

Glossary

The definitions in this Glossary are derived from the HL7 Glossary, SNOMED CT User Guide, 2008, CEN EN 13606, HIMSS Dictionary of Healthcare Information Technology Terms, Acronyms and Organizations, 2006 and other sources.

Abstract message

The basic level definition of an HL7 V2 message associated with a particular trigger event. It includes the data fields that will be sent within a message, the valid response messages and the treatment of application level errors.

Access control

Means of ensuring that the resources of a data processing system can be accessed only by authorised entities in authorised ways

Accountability

Property that ensures that the actions of an entity may be traced uniquely to that entity

ACK

Acknowledgement message

ACR

American College of Radiology

Acronym

An abbreviation formed by using the initial components in a phrase or name.

Act

Any action of interest. Something that has happened or may happen.

Actor

An abstraction for entities outside a system that interact directly with the system. An actor participates in a use case or a coherent set of use cases to accomplish an overall purpose.

ActRelationship

A relationship between two Acts

ADT

Admission Discharge and Transfer

AFNOR

Association Francaise de Normalisation

AMIA

American Medical Informatics Association

ANSI

American National Standards Institute. ANSI represents US interests on International standards organizations such as ISO.

ANSI accreditation

ANSI accreditation dictates that any standard submitted to ANSI for approval, be developed and ratified by a process that adheres to ANSI's procedures for open consensus and meets a balance of interest requirement by attaining near equal participation in the voting process by the various constituencies that are materially affected by the standard (e.g., vendors, providers, government agencies, consultants, non-profit organizations). This balance of interest goal ensures that a particular constituency is neither refused participation nor is it allowed to dominate the development and ratification of a proposed standard.

Anonymization

Removal of identifiable personal elements from the data, making it less sensitive and potentially not subject to stringent regulations governing privacy of personal data – while retaining its value for legitimate secondary uses like research and reporting

API

Application Program Interface

Application

A software program or set of related programs that provide some useful healthcare capability or functionality.

Application layer

The seventh and highest layer of the OSI model. Provides resources for the interaction that takes place between a user and an application.

Application role

An abstraction that expresses a portion of the messaging behaviour of an information system.

Archetype

Reusable, structured models of clinical information concepts that appear in EHRs, such as 'test result', 'physical examination' and 'medication order', and are expressed in terms of constraints on the reference model.

Artifact

Any deliverable resulting from the discovery, analysis and design activities leading to the creation of HL7 message specifications.

Architecture

A framework from which computer system components can be developed in a coherent manner and in which every part fits together without containing a mass of design detail

AS IS Model

Model of the present system as it is currently working

ASCII

American Standard Code for Information Interchange

Association

A reference from one class to another class or to itself, or a connection between two objects (instances of classes).

Association role name

A name for each end of an association. The name is a short verb phrase depicting the role of the class at the opposite end of the association from the perspective of the class adjacent to the role.

ASTM

American Society for the Testing of Materials

Attestation

Process of certifying and recording legal responsibility for a particular unit of information.

Attribute

Attributes express characteristics of concepts. SNOMED CT concepts form relationships to other SNOMED CT concepts through attributes. All of the attributes used in modelling SNOMED CT concepts are themselves SNOMED CT concepts and can be found in the Linkage concept hierarchy.

Attribute-value pair

The combination of an attribute with a value that is appropriate for that attribute. Example: FINDING SITE = Lung structure

Audit trail

Chronological record of activities of information system users which enables prior states of the information to be faithfully reconstructed

Authentication

Process of reliably identifying security subjects by securely associating an identifier and its authenticator.

Authorization

Authorization is the process of giving someone permission to do or have something. Authorization is sometimes seen as both the preliminary setting up of permissions by a system administrator and the actual checking of the permission values that have been set up when a user is getting access.

BCS

British Computer Society

Browser

A tool for exploring and searching the terminology content. A browser can display hierarchy sections and concept details (relationships between concepts, descriptions and Ids, etc).

BSI

British Standards Institute. BSI represents British interests on International standards organizations such as CEN and ISO.

caBIG

Cancer Biomedical Informatics Grid

Canonical equivalence

When two SNOMED-CT concepts or post-coordinated expressions have the same meaning. Equivalence can occur when a post-coordinated expression has the same meaning as a pre-coordinated concept; or when two different post-coordinated expressions have the same meaning.

CAP

College of American Pathologists

Cardinality

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).

Care Plan

A care plan is an ordered assembly of expected or planned activities, including observations, goals, services, appointments and procedures, usually organized in phases or sessions, which have the objective of organizing and managing health care activity for the patient, often focused upon one or more of the patient's health care problems. Care plans may include order sets as actionable elements, usually supporting a single session or phase. Also known as Treatment Plan.

CCD

Continuity of Care Document

CCITT

Comité Consultatif International Télégraphique et Téléphonique

CCOW

Clinical Context Object Workgroup; HL7 standard for single sign on.

CCR

ASTM E2369 - 05 Standard Specification for Continuity of Care Record.

CD

Concept descriptor data type

CDA

Clinical Document Architecture

CDC

Centers for Disease Control

CDISC

Clinical Data Interchange Standards Consortium. CDISC mission is to develop and support global, platform-independent data standards that enable information system interoperability to improve medical research and related areas of healthcare.

CEN

Comité Européen de Normalisation (European Committee for Standardization)

CENELEC

Comité Européen de Normalisation Electrotechnique

CEN/TC 251

CEN Technical Committee 251 responsible for standards within health informatics in Europe

Character Data

Text in a particular coding (e.g., ASCII), as distinguished from binary data.

Check-digit

SNOMED CT uses integers up to 18 digits in length as component identifiers known as SNOMED CT Identifiers (SCTIDs). The check-digit is the last digit of the SNOMED CT Identifier. It can be used to check the validity of SCTIDs. Clinical information systems can use the check-digit to identify SNOMED CT codes that have been entered incorrectly (typo errors, etc).

Choice

A message construct that includes alternative portions of the message. For a choice due to specialization, the sender picks one of the alternatives and sends it along with a flag.

CIM

Constrained Information Model

Class

An abstraction of a thing or concept in a particular application domain.

Class

A class represents a concept within the system being modelled.

Classification

Classification is the systematic placement of things or concepts into categories which share some common attribute, quality or property.

Clinical Decision Support (CDS)

Clinical Decision Support (CDS) refers broadly to providing clinicians or patients with clinical knowledge and patient-related information, intelligently filtered or presented at appropriate times, to enhance patient care. Clinical knowledge of interest could range from simple facts and relationships to best practices for managing patients with specific disease states, new medical knowledge from clinical research and other types of information.

Clinical Document

A Clinical Document is a documentation of clinical observations and services, with the following characteristics:

- Persistence – A clinical document continues to exist in an unaltered state, for a time period defined by local and regulatory requirements;
- Stewardship – A clinical document is maintained by a person or organization entrusted with its care;
- Potential for authentication – A clinical document is an assemblage of information that is intended to be legally authenticated;
- Wholeness – Authentication of a clinical document applies to the whole and does not apply to portions of the document without the full context of the document;
- Human readability – A clinical document is human readable.

Clinical information

Data/information related to the health and health care of an individual collected from or about an individual receiving health care services. It includes a caregiver's objective measurement or subjective evaluation of a patient's physical or mental state of health; descriptions of an individual's health history and family health history; diagnostic studies; decision rationale; descriptions of procedures performed; findings; therapeutic interventions; medications prescribed; description of responses to treatment; prognostic statements; and descriptions of socio-economic and environmental factors related to the patient's health.

Clone

A 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.

Cluster

The means of organising nested multi-part data structures such as time series, and to represent the columns of a table.

CMS

Centers for Medicare and Medicaid Services

CNE

Coded No Exceptions

CMET

Common message element type (CMET) is a specialised message type in a Hierarchical Message Description (HMD) that MAY be included by reference in other HMD's.

Code

A fixed sequence of signs or symbols, alphabetic or numeric characters, serving to designate an object or concept.

Coding Scheme

A system of classifying objects or entities such as diseases, procedures or symptoms, using a finite set of numeric or alphanumeric identifiers.

Component

An identifiable item in the main body of SNOMED CT, or in an authorized Extension. Each component is a uniquely identifiable instance of one of the following: Concept, Description, Relationship, Subset, Subset Member, Cross Map Set, Cross Map Target, History Component.

ComponentID

A general term used to refer to the primary identifier of any SNOMED CT Component. All ComponentIDs follow the form of the SCTID specification.

Composite data type

A data type assigned to a message element type that contains one or more components, each of which is represented by an assigned data type.

Composition

The set of information committed to one EHR by one agent, as a result of a single clinical encounter or record documentation session.

Concept

A clinical idea to which a unique ConceptID has been assigned in SNOMED CT. Each Concept is represented by a row in the Concepts Table.

Concept equivalence

When two SNOMED CT concepts or post-coordinated expressions have the same meaning. Concept equivalence can occur when a post-coordinated expression has the same meaning as a pre-coordinated Concept; or when two different post-coordinated expressions have the same meaning.

Concept Model

The SNOMED CT Concept Model is the complete set of rules that govern the ways in which concepts are permitted to be modelled using relationships to other concepts.

ConceptID

The unique identifier (code) for each SNOMED CT concept. Refer to the SNOMED Technical Reference Guide for a full explanation of how this identifier is structured.

Example: For the concept Pneumonia (disorder), the ConceptID is 233604007

Concepts Table

A table that includes all SNOMED CT concepts. Each concept is represented by a row.

Confidentiality

Property that information is not made available or disclosed to unauthorised individuals, entities, or processes.

Conformance Profile

A conformance profile is a constraint to either an underlying standard or another conformance profile. Normally, it specifies a single message or document.

Constraint

Narrowing down of the possible values for an attribute; 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.

Context Model

A model that specifies relationships relating to semantic context that has been defined outside of the SNOMED-CT Concept Model.

Continua Alliance

Continua Health Alliance is a non-profit, open industry coalition of healthcare and technology companies joining together in collaboration to improve the quality of personal healthcare, such as those used in the home.

Control event wrapper

A wrapper that contains domain specific administrative information related to the "controlled event" which is being communicated as a messaging interaction. The control event wrapper is used only in messages that convey status, or in commands for logical operations being coordinated between applications (e.g., the coordination of query specification/query response interactions).

Core

A SNOMED CT Component released by the IHTSDO.

CPT-4

Current Procedural Terminology. Coding system used in the US as a guide to services for which patients may be billed.

Cross Map

A Cross Map links a single SNOMED CT concept to one or more codes in a target classification (such as ICD-9-CM) or terminology. Each Cross Map is represented as a row in the Cross Maps Table.

CRE

Care record element

CRS

Care Record Service (NHS)

CTS

Common Terminology Services. The CTS defines the minimum set of functions required for terminology interoperability within the scope of HL7's messaging and vocabulary browsing requirements.

CTV3

Clinical Terms Version 3 (Read Codes)

CTV3ID

A five-character code allocated to a concept or term in CTV3. For data compatibility and mapping purposes, SNOMED CT concepts include a record of the corresponding concept codes from the Clinical Terms Version 3 (CTV3, previously known as Read Codes) and SNOMED RT.

CUI

Microsoft Health/NHS CFH Common User Interface (CUI) provides user interface design guidance and toolkit controls that address a wide range of patient safety concerns for healthcare organizations worldwide, enabling a new generation of safer, more usable and compelling health applications to be quickly and easily created [<http://www.mscai.net>]

CWE

Coded With Exceptions

DAM

Domain Analysis Model

Database

A collection of stored data typically organized into fields records and files and an associated description (schema)

Data type

The structural format of the data carried in an attribute. It MAY constrain the set of values an attribute may assume.

Delimiter

To mark or set off. For example the day, month and year in a string such as 2/5/2009 are delimited by the "/" symbol.

Description

A row in the Descriptions table. Each Description is assigned a unique DescriptionID and connects a Term and a Concept.

DescriptionID

An SCTID that uniquely identifies a Description. Refer to the SNOMED Technical Reference Guide for a full explanation of how this identifier is structured.

Diagnosis

The cause of a patient's problem. Various qualifiers such as provisional, working, primary, secondary, admitting, are applied to diagnosis. A differential diagnosis is a list of plausible possibilities as to the cause.

Dialect

A language modified by the vocabulary and grammatical conventions applied in a particular geographical or cultural environment.

DICOM

Digital Imaging and Communications in Medicine

Digital

Representation of an entity based on binary (on/off) signals.

DIN

Deutsches Institut für Normung – the German national standards organization.

DH

Department of Health (UK)

DMIM

Domain Message Information Model

Domain expert

Individual who is knowledgeable about the concepts in a particular problem area within the healthcare arena and/or is experienced with using or providing the functionality of that area.

Domain Message Information Model (D-MIM)

A form of Refined Message Information Model (R-MIM) constructed to represent the totality of concepts embodied in the individual R-MIMs needed to support the communication requirements of a particular HL7 domain.

DRG

Diagnosis Related Group

DSTU

Draft Standard for Trial Use

DTD

Document Type Definition (XML)

EAI

Enterprise Application Integration

ED

Encapsulated Data Type

EDI

Electronic Data Interchange – based on electronic sending and receiving of messages

EDIFACT

Electronic Data Interchange For Administration, Commerce, and Transport – a set of rules and syntax for EDI maintained by the UN.

EDM

Electronic Document Management

eGIF

Electronic Government Interoperability Framework

EHR

Electronic Health Record. A comprehensive, structured set of clinical, demographic, environmental, social, and financial data and information in electronic form, documenting the health care given to a single individual.

EHR-S FM

EHR System Functional Model (provides a reference list of over 160 functions that may be present in an Electronic Health Record System (EHR-S))

EHR System

The set of components that form the mechanism by which patient records are created, used, stored, and retrieved.

Element

The leaf node of the EHR hierarchy, containing a single data value

EN

Norme Europeene (European Standard) approved by CEN and which normally takes precedence over local or national standards.

Encounter

Encounter serves as a focal point linking clinical, administrative, and financial information. Encounters occur in many different settings - ambulatory care, inpatient care, emergency care, home health care, field and virtual (telemedicine).

Entity

A person, animal, organization or thing. Something that has separate and distinct existence and objective or conceptual reality. Something that exists as a particular and discrete unit. An organization (as a business or governmental unit) that has an identity separate from those of its members.

Entry

The information recorded in an EHR as a result of one clinical action, one observation, one clinical interpretation, or an intention. This is also known as a clinical statement.

ENV

Europäische Vornorm (European Pre-standard) – a standard that has yet to be put into a final and definitive form for approval as an EN.

EOM

End of Message

Eponym

The use of a person's name to describe an entity.

EPR

Electronic Patient Record (owned by the patient)

ESC

Escape

ETP

Electronic Transfer of Prescriptions

Expression

A collection of references to one or more concepts used to express an instance of a clinical idea. 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 with rules expressed in the SNOMED CT Concept Model.

Extension

Extensions are complements to a released version of SNOMED CT. Extensions are components that are created in accordance with the data structures and authoring guidelines applicable to SNOMED CT.

FCE

Finished Consultant Episode (NHS)

Field

The smallest named unit of data in a database. Fields are grouped together to form records.

File

A collection of electronic data. A file has a name by which it is known to the computer and may contain, for example, data, records, text, image etc.

Folder

The high level organisation within an EHR, dividing it into compartments relating to care provided for a single condition, by a clinical team or institution, or over a fixed time period such as an episode of care.

FTP

File Transfer Protocol

Fully defined concept

SNOMED CT concepts are either primitive or fully defined. Fully defined concepts can be differentiated from their parent and sibling concepts by virtue of their relationships. Primitive concepts do not have the unique relationships needed to distinguish them from their parent or sibling concepts. A concept is primitive when its modelling (attributes and parents) does not fully express its meaning.

Fully Specified Name (FSN)

A phrase that describes a concept uniquely and in a manner that is intended to be unambiguous.

Generalization

An association between two classes, referred to as superclass and subclass, in which the subclass is derived from the superclass. The subclass inherits all properties from the superclass, including attributes, relationships, and states, but also adds new ones to extend the capabilities of the parent class. Essentially, a specialization from the point-of-view of the subclass.

GOSIP

Government OSI Profile

GP

General Medical Practitioner

GP2GP

GP to GP record transfer service (NHS)

Graphical expression

A visual representation of a model that uses graphic symbols to represent the components of the model and the relationships that exist between those components.

HDF

HL7 Development Framework

HES
Hospital Episode Statistics (NHS)

Health care agent
Person, device, or software that performs a role in a health care activity

Health care organization
Organisation involved in the direct or indirect provision of health care services to an individual or to a population. NOTE Groupings or subdivisions of an organisation, such as departments, may also be considered as organisations where there is a need to identify them.

Health Care Party
Person involved in the direct or indirect provision of health care services to an individual or to a population.

Health Care Professional.
A person who is authorized by a nationally recognized body to be qualified to perform certain health duties.

Health Care Provider
A Health Care Provider is a person licensed, certified or otherwise authorized or permitted to administer health care in the ordinary course of business or practice of a profession, including a health care facility.

Health Care Service
Service provided with the intention of directly or indirectly improving the health of the person or populations to whom it is provided.

Hierarchical Message Description
A 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.

Hierarchy
An ordered organization of concepts. General concepts are at the top of the hierarchy; at each level down the hierarchy, concepts become increasingly specialized. SNOMED CT concepts are arranged into Top-level hierarchies. Each of these hierarchies subdivides into smaller sub-hierarchies. Concepts are related by IS_A relationships to their more general parent concepts directly above them in a hierarchy. There is one concept from which the Top-level hierarchies descend called SNOMED CT concept or the "Root concept."

HIMSS
Healthcare Information and Management Systems Society

HIPAA
Health Insurance Portability and Accountability Act, 1996

HIS
Health (or Hospital) Information System

HITECH

Health Information Technology for Economic and Clinical Health Act

History Mechanism

SNOMED CT includes some information about the history of changes to concepts and descriptions.

HITSP

Health Information Technology Planning Panel

HL7

Health Level Seven (HL7) is an American National Standards Institute (ANSI) accredited, not-for-profit standards-development organization, whose mission is to provide standards for the exchange, integration, sharing, and retrieval of electronic health information; support clinical practice; and support the management, delivery and evaluation of health services.

HMD

Hierarchical Message Description

Homonym

One term having two or more independent meanings

HTML

Hypertext Markup Language

HTTP

Hypertext Transfer Protocol

ICD

International Classification of Diseases

ICP

Integrated Care Pathway

ICPC

International Classification of Primary Care

ICPM

International Classification of Procedures in Medicine

ICT

Information and Communication Technology

Identifier

A piece of data that uniquely identifies an item, information, or a person as the subject of this identity within a given context.

IEC

International Electrotechnical Commission

IEEE

Institute of Electrical and Electronics Engineers

IHE

Integrating the Health Environment.

IHE (Integrating the Healthcare Enterprise) is an industry-led initiative to improve the way computer systems in healthcare share information. IHE promotes the coordinates use of established standards such as HL7 and DICOM to address specific clinical needs.

<http://www.ihe.net/>

IHTSDO

International Health Terminology Standards Development Organization

IM&T

Information Management and Technology

IMIA

International Medical Informatics Association

Implementation Technology

A technology selected for use in encoding and sending HL7 messages. For example, XML is being used as an implementation technology for Version 3.

Implementation Technology Specification (ITS)

A specification that describes how HL7 messages are sent using a specific implementation technology . It includes, but is not limited to, specifications of the method of encoding the messages, rules for the establishment of connections and transmission timing and procedures for dealing with errors.

Information Model

A structured specification, expressed graphically and/or in narrative, of the information requirements of a domain. An information model describes the classes of information required and the properties of those classes, including attributes, relationships, and states. Examples in HL7 are the Domain Reference Information Model, Reference Information Model, and Refined Message Information Model.

Integration Profile

An integration profile describes the workflow for a specific use case. It combines actors and interactions.

Interaction

A single, one-way information flow that supports a communication requirement expressed in a scenario.

Interface

A common boundary between two associated systems across which information may flow. The interface may filter or modify data as it passes across the boundary.

Interface Terminology

Interface terminologies are used to mediate between a user's colloquial conceptualizations of concept descriptions and an underlying reference terminology.

International Release

The required international components of the SNOMED CT terminology, along with related works and resources, maintained and distributed by the IHTSDO.

Internet

The International network of computers providing support for data exchange, Email and the World-wide Web.

IOM

Institute of Medicine

ISB

Information Standards Board (NHS)

ISO

International Organization for Standardization – the body overseeing endorsement and publication of international standards.

ISP

International Standardized Profile

IT

Information Technology

ITS

Implementation Technology Specification

ITU

International Telecommunications Union

IVR

Interactive Voice Response

LAN

Local Area Network

Language

For purposes of SNOMED CT translations, a language is a vocabulary and grammatical form that has been allocated an ISO639-1 language code. See also Dialect.

Language Subset

SNOMED CT can be translated into any language or dialect. These translations use existing SNOMED CT concepts, along with new language-specific descriptions. A language subset is a set of references to the descriptions that are members of a language edition of SNOMED CT. Additionally, this subset specifies the type of description (FSN, Preferred Term or synonym).

LOINC

Logical Observation Identifiers Names and Codes

LR

Legitimate Relationship

LSP

Local Service Provider (NHS)

Mandatory

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.

Mandatory association

An association with a multiplicity minimum greater than zero on one end. A fully mandatory association is one with a multiplicity minimum greater than zero on both ends.

Mapping Mechanism

SNOMED CT provides a mechanism for mapping concepts to other terminologies and classifications. This mapping mechanism consists of three tables: Cross Map Sets Table, Cross Maps Table and Cross Map Targets Table

Markup

Computer-processable annotations within a document. 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.

Master file

Common lookup table used by one or more application systems.

May

The conformance verb MAY is used to indicate a possibility.

MBDS

Minimum Basic Data Set

MeSH

Medical Subject Headings

Message

A package of information communicated from one application to another. See also message type and message instance.

Message element

A unit of structure within a message type.

Message element type

A portion of a message type that describes one of the elements of the message.

Message instance

A message, populated with data values, and formatted for a specific transmission based on a particular message type.

Message payload

Data carried in a message.

Message type

A set of rules for constructing a message given a specific set of instance data. As such, it also serves as a guide for parsing a message to recover the instance data.

Meta-model

A model used to specify other models. For example, the meta-model for a relational database system might specify elements of type 'Table', 'Record', and 'Field'.

MIB

Medical Information Bus

MIM

Message Implementation Manual published by NHS Connecting for Health.

MIME

Multipurpose Internet Mail Extension

MPI

Master Patient Index

MT

Message Type

Model

A semantically complete abstraction of a system

Multiplicity

In the information model, multiplicity is a specification of the minimum and maximum number of objects from each class that can participate in an association. Multiplicity is specified for each end of the association.

N3

National network for the NHS

Namespace or Namespace-identifier

When an organization creates an extension to SNOMED CT, the new components in the extension need to be identified as part of that particular organization's extension. SNOMED CT does this by allocating an identifier to the organization (the Namespace-identifier). The organization would include its namespace-identifiers as part of the identifiers originated in its namespace. The Namespace identifier is part of the SCTID. If no namespace is identified in a SCTID, it is assumed that the component is part of the International Release of SNOMED CT. In these cases, SCTIDs can be used in an abbreviated form, without the seven-digit namespace identifier.

Navigability

Direction in which an association can be navigated (either one way or both ways).

NCPDC

National Council for Prescription Drug Program

NDC
National Drug Code

Nested qualifiers
Where the value of a qualifier is a refinement of a refined concept.

NHS
National Health Service

NHSCR
NHS Central Register

NHS CFH
NHS Connecting For Health

NIST
National Institute for Science and Technology

NLM
National Library of Medicine

Node
One of the interconnected computers or devices linked in a communications network.

NPfIT
National Programme for Information Technology (NHS)

Null
A value for a data element which indicates the absence of data. A number of “flavors” of null are possible.

Object
An instance of a class. 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

Object identifier
A scheme to provide globally unique identifiers. This object identifier (OID) scheme is an ISO standard (ISO 8824:1990).

ODA
Open Document Architecture

ODP
Open Distributed Processing (ISO/IEC 10746, used for describing distributed systems)

OHT
Open Health Tools is a community of open source developers, health professionals, and an ecosystem that brings together members from the health and IT professions to create a common health interoperability framework, exemplary tools and reference applications to support health information interoperability. The fact that this software framework is available under a commercially-friendly open source license means that anyone, any

company, any hospital, whether or not they are a member, can build applications using this framework – without any payment required for the software.

OID
Object Identifier

OMG
Object Management Group

ONCHIT
Office of the National Coordinator for Health Information Technology

OpenEHR
OpenEHR is a not-for-profit foundation to make EHRs “adaptable and future-proof” through the use of a technology independent architecture.

OSI
Open Systems Interconnection

OWL
Web Ontology Language

PACS
Picture Archiving and Communication System

Participation
The involvement of a Role in an Act

Partition-identifier
The partition identifier is a two-digit number just to the left of the check digit in the SCTID. The first of these two digits indicates whether the SCTID refers to a SNOMED CT Component in the International Release (indicated by a 0 as the first digit in the partition identifier), or a Component in an extension (indicated by a 1 as the first digit in the partition identifier). The second of the two digits in the partition identifier indicates which of the partitions of SNOMED CT the SCTID is identifying.

PAS
Patient Administration System

Patient
One who is suffering from any disease or behavioral disorder and is under treatment for it.

PC
Personal Computer

PDF
Portable Document Format

PDS
Personal Demographics Service (NHS)

PICS
Protocol Implementation Conformance Statement

PIM
Platform Independent Model

PIN
Personal Identification Number

PKI
Public Key Infrastructure

PN
Person Name data type

POC
Point of Care

POMR
Problem oriented medical record, originally developed by Dr Larry Weed.

Post-coordination
Representation of a clinical idea using a combination of two or more concept identifiers. A combination of concept identifiers used to represent a single clinical idea is referred to as a post-coordinated expression (see expression). Many clinical ideas can also be represented using a single SNOMED CT concept identifier (see pre-coordination). Some clinical ideas may be represented in several different ways. SNOMED CT technical specifications include guidance of logical transformations that reduce equivalent expressions to a common canonical form.

Pre-coordination
Representation of a clinical idea using a single concept identifier. A single concept identifier used to represent a specific meaning is referred to as a pre-coordinated expression (see expression). SNOMED CT also allows the use of post-coordinated expressions (see post-coordination) to represent a meaning using a combination of two or more concept identifiers. However, including commonly used concepts in a pre-coordinated form makes the terminology easier to use.

Preferred Term
The Term that is deemed to be the most clinically appropriate way of expressing a Concept in a clinical record. Preferred Term is one of the three types of terms that can be indicated by the DescriptionType field in SNOMED.

Primitive Concept
A concept is primitive when its modelling (attributes and parents) does not fully express its meaning. A concept definition is the list of its relationships to other concepts. Primitive concepts do not have the unique relationships needed to distinguish them from their parent or sibling concepts.

Privacy

Freedom from intrusion into the private life or affairs of an individual when that intrusion results from undue or illegal gathering and use of data about that individual.

Problem List

The problem list of a given individual can be described by formal diagnosis coding systems (such as ICD-10) or by other professional descriptions of health care issues affecting an individual. Problems can be short or long term in nature, chronic or acute, and have a status. In a longitudinal record, all problems may be of importance in the overall long term care of an individual, and may undergo changes in status repeatedly. Problems are identified during patient visits, and may span multiple visits, encounters, or episodes of care.

Profile

A set of functions required in a particular setting or available as part of a particular system or component

PSIS

Personal Spine Information Service (NHS)

PSM

Platform Specific Model

QMAS

Quality Management and Analysis System (NHS)

QMR

Quick Medical Reference

QOF

Quality and Outcomes Framework (NHS)

QoS

Quality of Service

Qualifying attribute

Some SNOMED CT concepts can have Qualifying attributes, which are optional non-defining relationships that may be applied by a user or implementer in post-coordination. The qualifier value mechanism in SNOMED CT constrains the possible values an implementer can select in assigning a qualifying characteristic to a concept.

Query

Queries are the primary mechanism for retrieving information from computer systems. Many database management systems use the Structured Query Language (SQL) standard query format.

Realization

The relationship between a specification and its implementation.

Realm

A sphere of authority, expertise, or preference that influences the range of Components required, or the frequency with which they are used. A Realm may be a nation, an organization, a professional discipline, a specialty, or an individual user.

Receiver

The application fulfilling the Receiving Application role in an interaction

Receiver responsibility

An obligation on an application role that receives an interaction as defined in the interaction model.

Record

A writing by which some act or event, or a number of acts or events, is recorded;

Recursion

An association that leads from a class directly or indirectly back to that class.

Reference Information Model (RIM)

The HL7 information model from which all other V3 information models (e.g., R-MIMs) and messages are derived.

Reference Terminology

A reference terminology is a terminology in which every concept designation has a formal, machine-usable definition supporting data aggregation and retrieval.

Refined Message Information Model (R-MIM)

An information structure that represents the requirements for a set of messages. 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.

Relationship

An association between two Concepts. The nature of the association is indicated by a Relationship Type. Each Relationship is represented by a row in the Relationships Table.

Relationship Type

The nature of a Relationship between two Concepts. The RelationshipType field indicates the ConceptID for the concept in SNOMED that forms the relationship between two other concepts (ConceptID1 and ConceptID2)

RelationshipID

A SCTID that uniquely identifies a Relationship between three concepts: a source concept (ConceptID1), a target concept (ConceptID2), and a relationship type. Each row in the Relationships Table represents a relationship “triplet” (ConceptID1 – RelationshipType - ConceptID2) identified by a RelationshipID.

Relationships Table

A table consisting of rows, each of which represents a Relationship.

Release Version

A version of SNOMED CT released on a particular date. Except for the initial release of SNOMED CT that was called “SNOMED CT First Release,” subsequent releases use the release data. Example: “SNOMED CT July 2008 Release”

Required

One of the allowed values in conformance requirements, 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 null value MAY be sent.

Requirement

A desired feature, property or behaviour of a system.

RFID

Radio frequency identification (RFID) is a generic term that is used to describe a system that transmits the identity (in the form of a unique serial number) of an object or person wirelessly, using radio waves.

RIM

HL7 Reference Information Model

RHIO

Regional Health Information Organization

RMIM

HL7 Refined Message Information Model

Role

A part played by or the responsibility of an Entity

RoleLink

A relationship between two Roles.

Root Concept

The single Concept “SNOMED CT Concept” that is at the top of the entire SNOMED CT hierarchy of concepts.

SAEF

Services Aware Enterprise Architecture Framework. HL7’s SAEAF defines the artifacts and specification semantics needed to support interoperability in healthcare, life sciences, and clinical research.

Sanctioned relationships

Relationships between SNOMED-CT concepts that are sanctioned by the SNOMED-CT Concept Model. Sanctioned relationships are specified in a row in the SNOMED-CT Relationships table, as opposed to ‘Allowable’ relationships, which are a pattern in the Concept Model.

Scenario

A sequence of actions that illustrates behaviour. A scenario may be used to illustrate an interaction or the execution of a use case instance.

Schematron

Schematron is an XML structure validation language for making assertions about the presence or absence of patterns in trees. It is a simple and powerful structural schema language.

SCR

Summary Care Record

SCT

SNOMED Clinical Terms

SCT Enabled Application

A software application designed to support the use of SNOMED CT.

SCTID

SNOMED Clinical Terms Identifier

SDO

Standards Development Organization

SDS

Spine Directory Service (NHS)

Section

EHR data within a composition that belongs under one clinical heading, usually reflecting the flow of information gathering during a clinical encounter, or structured for the benefit of future human readership.

Semantics

Meaning of symbols and codes

Semantic interoperability

Ability for data shared by systems to be understood at the level of fully defined domain concepts.

Sender

The application fulfilling the Sending Application role in an interaction.

Service

A consultation, diagnosis, treatment or intervention performed for a person and/or other activity performed for a person. Includes health, goods and support services.

Set

A form of collection which contains an unordered list of unique elements of a single type.

SGML

Standardized General Markup Language

Shall

The conformance verb SHALL is used to indicate a requirement.

Should

The conformance verb SHOULD is used to indicate a recommendation.

SIG

Special Interest Group

SMTP

Simple Mail Transport Protocol

SNOMED

An acronym for the Systematized Nomenclature of Human and Veterinary Medicine originally developed by the College of American Pathologists.

SNOMED Clinical Terms (SNOMED CT)

The clinical terminology maintained and distributed by the IHTSDO. The First Release of SNOMED Clinical Terms was the result of the merger of the CTV3 and SNOMED RT.

SNOMED Clinical Terms Identifier (SCTID)

A unique identifier applied to each SNOMED CT component (Concept, Description, Relationship, Subset, etc.). The SCTID can include an item identifier, namespace identifier, a check-digit and a partition identifier. It doesn't always include a namespace identifier.

SOA

Service Oriented Architecture provides methods for systems development and integration where systems package functionality as interoperable services. A SOA infrastructure allows different applications to exchange data with one another. Service-orientation aims at a loose coupling of services with operating systems, programming languages and other technologies that underlie applications. SOA separates functions into distinct units, or services, which developers make accessible over a network in order that users can combine and reuse them in the production of applications. These services communicate with each other by passing data from one service to another, or by coordinating an activity between two or more services.

Specialization

An association between two classes (designated superclass and subclass), in which the subclass is derived from the superclass. 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

A detailed description of the required characteristics of a product.

Standard

A document, established by consensus and approved by a recognized body, that provides, for common and repeated use, rules, guidelines or characteristics for activities or their results, aimed at the achievement of the optimum degree of order in a given context.

Storyboard

Defines what happens from the users point of view. A narrative of relevant events defined using interaction or activity diagrams or use cases. The storyboard provides one set of interactions that will typically occur in the domain.

String

A sequence of text characters.

Stylesheet

A file that describes how to display an XML document of a given type.

Subclass

A class that is the specialization of another class (superclass).

Subset

A group of Components (e.g. Concepts, Descriptions or Relationships) that share a specified common characteristic or common type of characteristic. Example: UK English Subset

Superclass

A class that is the generalization of one or more other classes (subclasses).

Swimlane

A partition on activity graphs for organizing responsibilities for activities, often corresponding to the organizational units in a business model.

Synonym

A term that is an acceptable alternative to the Preferred Term as a way of expressing a Concept. Synonyms allow representations of the various ways a concept may be described. Synonyms and Preferred Terms (unlike FSNs) are not necessarily unique. More than one concept might share the same Preferred term or Synonym.

Syntax

Rules for structuring words into sentences or computer commands or electronic messages.

System

A collection of connected units organized to accomplish a purpose.

Table view

An expression of the Hierarchical Message Description (HMD) common and message type definition condensed in size to fit on a printed page.

TC

Technical Committee

TCP/IP

Transmission Control; Protocol / Internet Protocol. A protocol for communication between computers, used as a standard for transmitting data over networks and as the basis for standard Internet protocols.

Template

A template is an RMIM which is used to constrain another model

Term

A text string represents the Concept. The Term is part of the Description. There are multiple descriptions per Concept.

Terminology

A terminology is a set of concepts designated by terms belonging to a special domain of knowledge, or subject field.

Terminology Binding

An instance of a link between a terminology component and an information model artefact.

Terminology server

Software that provides access to SNOMED CT (and/or to other terminologies). A Terminology server typically supports searches and Navigation through Concepts. A server may provide a user interface (e.g. a browser or set of screen controls) or may provide low-level software services to support access to the terminology by other applications.

Top-Level Concept

A Concept that is an immediate child of the root concept "SNOMED CT Concept" which is at the top of the entire SNOMED CT hierarchy of concepts.

Transaction

A complete set of messages for a particular trigger event, e.g. a message and a response.

Transport wrapper

A wrapper that contains information needed by a sending application or message handling service to route the message payload to the designated receiver. All HL7 Version 3 messages require an appropriately configured transport wrapper.

Trigger Event

Defines what causes a message to be sent. An 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.

TRUD

Terminology Reference Data Update Distribution Service (NHS)

TSC

Technical Steering Committee (HL7)

UML

Unified Modeling Language

UMLS

Unified Medical Language System

UN/CEFACT

United Nations Centre for Trade Facilitation and Electronic Business

UKTC

UK Terminology Centre (NHS)

UPI

Unique Patient Identifier

Use case

The specification of sequences of actions, including variant sequences and error sequences, that a system can perform by interacting with outside actors.

VA

Veterans Administration

Valid document

A document which meets all of the validity constraints in the XML specification.

Value set

A vocabulary domain that has been constrained to a particular realm and coding system.

View

Specific information displayed on a computer monitor after it has been filtered for a different user or purpose.

Vocabulary

The set of all concepts that can be taken as valid values in an instance of a coded attribute or field.

W3C

World Wide Web Consortium

WAN

Wide Area Network

WEDI

Workgroup on Electronic data Interchange

WHO

World Health Organization

Wrapper

The control or envelope information in which the message payload resides.

WWW

World Wide Web

XDS

Cross-enterprise Document Sharing

XML

Extensible Mark-up Language

XSL

Extensible Style sheet Language. The XSL family comprises three languages:

- XSL Transformations (XSLT): an XML language for transforming XML documents
- XSL Formatting Objects (XSL-FO): an XML language for specifying the visual formatting of an XML document

- XML Path Language (XPath): used to address the parts of an XML document.

XSLT

Extensible Stylesheet Language Transformations (XSLT) is an XML-based language used for the transformation of XML documents into other XML or "human-readable" documents. The original document is not changed; rather, a new document is created based on the content of an existing one. The new document may be serialized (output) by the processor in standard XML syntax or in another format, such as HTML or plain text. XSLT is most often used to convert data between different XML schemas or to convert XML data into HTML or XHTML documents for web pages, creating a dynamic web page, or into an intermediate XML format that can be converted to PDF documents.