



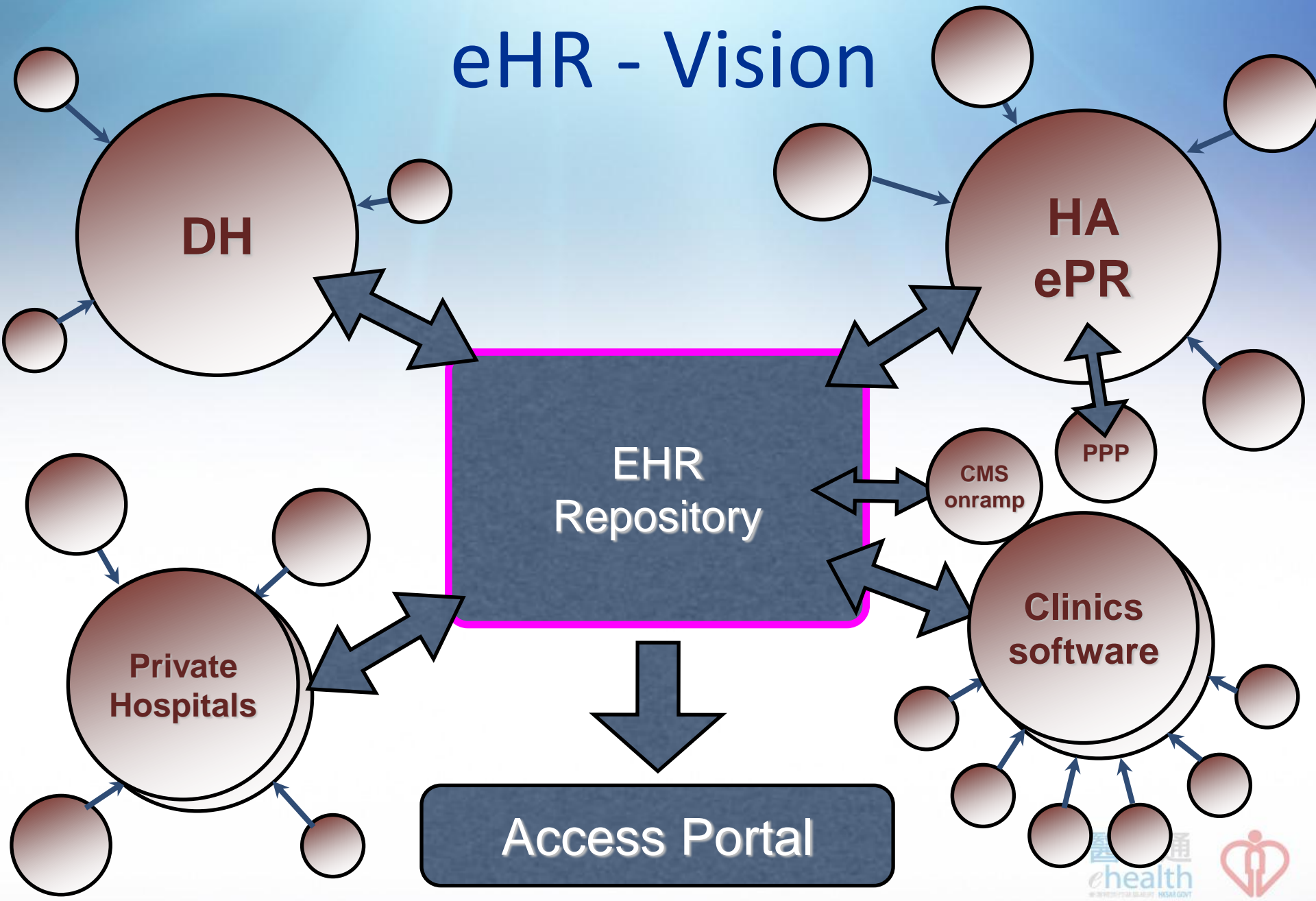
# eHR Sharable Data

Vicky Fung

Senior Health Informatician

eHR Information Standards Office

# eHR - Vision



# Standardisation for eHR

- Ensure accurate interpretation of health data by all parties
- Support reuse of data
- Reduce duplicated efforts in data entry
- Facilitate interoperability of systems for data captured at different platforms
- Improve efficiency of healthcare services
- Assist in protection of public health



# Information Architecture

*Every medical fact has a concept*

*What the data means*

*Every medical fact has a context*

*How data should be interpreted*

*Every medical fact has a presentation*

*How data are organized & presented*

Analyze

Reuse



Display

Store

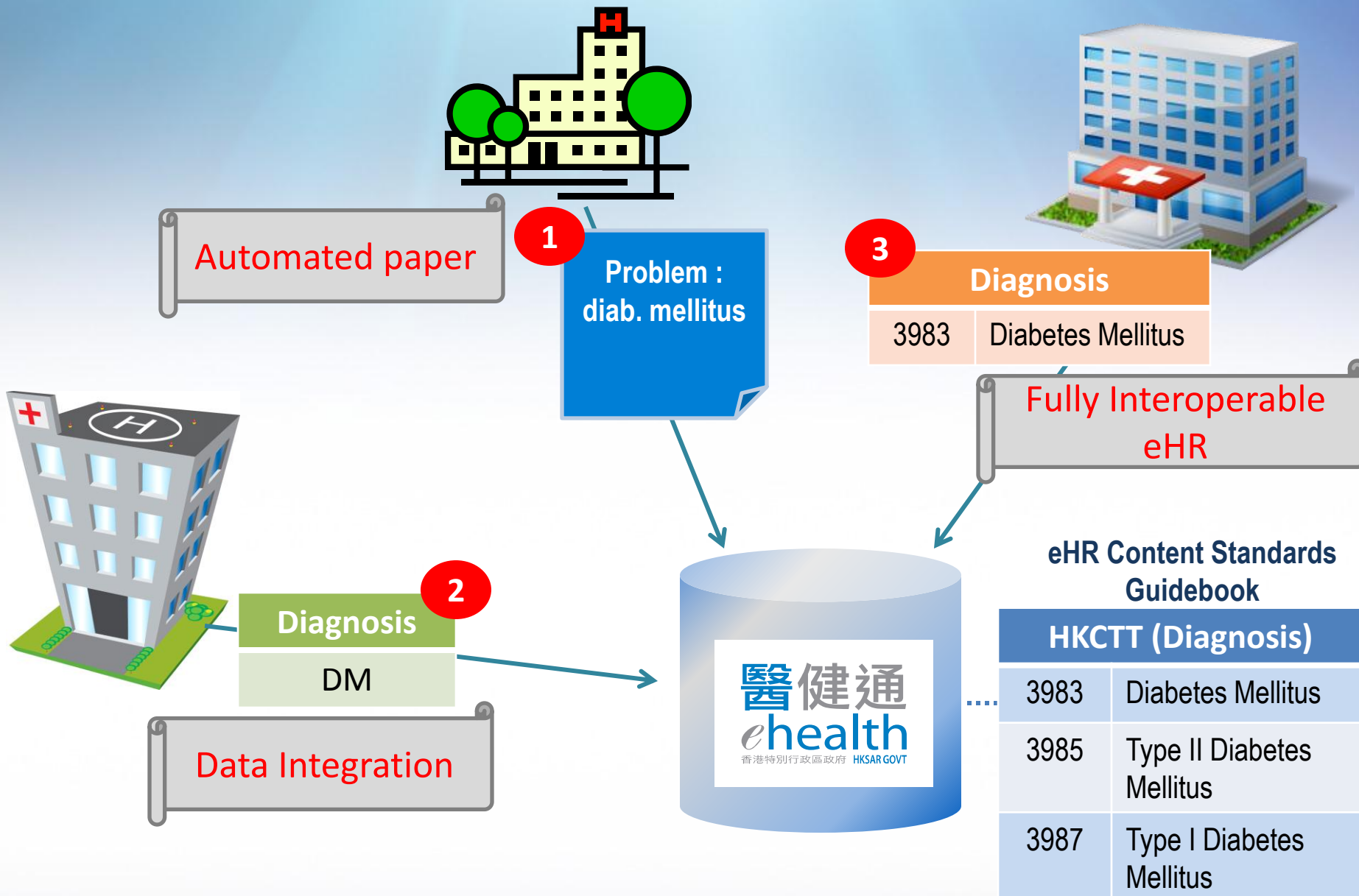
Capture

Design

# Standards for eHR

- Identification
  - Registry
  - Healthcare provider
  - Healthcare staff
- eHR content 
- Terminology 
- Message standard

# Standards Compliance



Automated paper

1

Problem :  
diab. mellitus

3

Diagnosis

3983 Diabetes Mellitus

Fully Interoperable  
eHR

2

Diagnosis

DM

Data Integration

eHR Content Standards  
Guidebook

HKCTT (Diagnosis)

3983 Diabetes Mellitus

3985 Type II Diabetes  
Mellitus

3987 Type I Diabetes  
Mellitus

醫健通  
ehealth  
香港特別行政區政府 HKSAR GOVT

# Phased Approach – A Proposal

eHR Section	Level 1	Level 2	Level 3
Healthcare Recipient			
Encounter			
Referral			
Clinical note / summary			
Adverse reaction / allergy			
Clinical alert			
Problem			
Procedure			
Birth record			
Assessment / physical exam			
Social history			
Past medical history			
Family history			
Drug – prescription record			
Drug – dispensary record			
Immunization			
Clinical request			
Diagnostic test result – Laboratory			
Diagnostic test result – Radiology			
Diagnostic test result – Other investigation			
Care & treatment plan			

Key :

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
---------	---------	---------	---------	---------



Summary Schedule

- LEE, CHINAN
  - Allergy and Adverse Drug Reaction
  - Diagnosis
  - Procedure
  - Birth Record
  - Summaries
    - Discharge Summary
    - Nursing Discharge Summary
  - Clinical Note
    - Cataract - PPI
    - FM Note
  - Assessment / Findings
    - Investigation
      - Pulmonary Function Test
      - Echo
      - GRR
  - Laboratory Result
    - Recent Result
      - QMH 01/01/10 YFC
      - NDH 27/02/08 Biochem
      - TMH 27/02/08 Biochem
      - TMH 27/02/08 Biochem
      - TMH 27/02/08 Biochem
      - TMH 27/02/08 Biochem
      - PWH 01/02/08 BGS
      - PWH 01/02/08 OSM
      - PWH 01/02/08 SUK, SU
      - PWH 01/02/08 BPR, LF
      - PWH 01/02/08 CBCU
      - PWH 01/02/08 SC1
      - PWH 31/01/08 POCT BC

- Biochemistry Result
- Cumulative Common
- Haematology Result
- Microbiology Result
- Virology Result
- Immunology Result
- Anatomical Path Result
- Toxicology
- Specialty Profile
  - Medical
  - DM
  - Immunology
  - Liver
  - Renal
  - Thyroid
  - Anaesthetic
  - TBCU
- Abnormal Result
  - Numerical Result
  - Non-numerical Result
- Radiology Record
  - Radiology Result
  - Radiology Appointment
- Medication
  - Prescribing History
    - By Order
    - By Drug Items
    - Formulary Management
  - Dispensing History
    - By Order
    - By Drug Items

# eHR Phase 1

Based on PPI-ePR





# eHR Implementation – Phase 1

eHR Section	Level 1	Level 2	Level 3
Healthcare Recipient			
Encounter			
Referral			
Clinical note / summary			
Adverse reaction / allergy			
Clinical alert			
Problem			
Procedure			
Birth record			
Assessment / physical exam			
Social history			
Past medical history			
Family history			
Drug – prescription record			
Drug – dispensary record			
Immunization			
Clinical request			
Diagnostic test result – Laboratory			
Diagnostic test result – Radiology			
Diagnostic test result – Other investigation			
Care & treatment plan			



# Workflow to Prepare Domain Dataset

Develop initial set of eHR content standards based on local / international standards



Gap analysis: HA-ePR, eHR on-ramp, eHR adaptation, proposed eHR viewer

Consult Domain Groups, Expert advisory group

Briefing & consult local healthcare providers

Endorsement : Working Group on eHR Content & Information Standards (early 2013)



# Hong Kong eHR Standards



## eHR Standards Guide

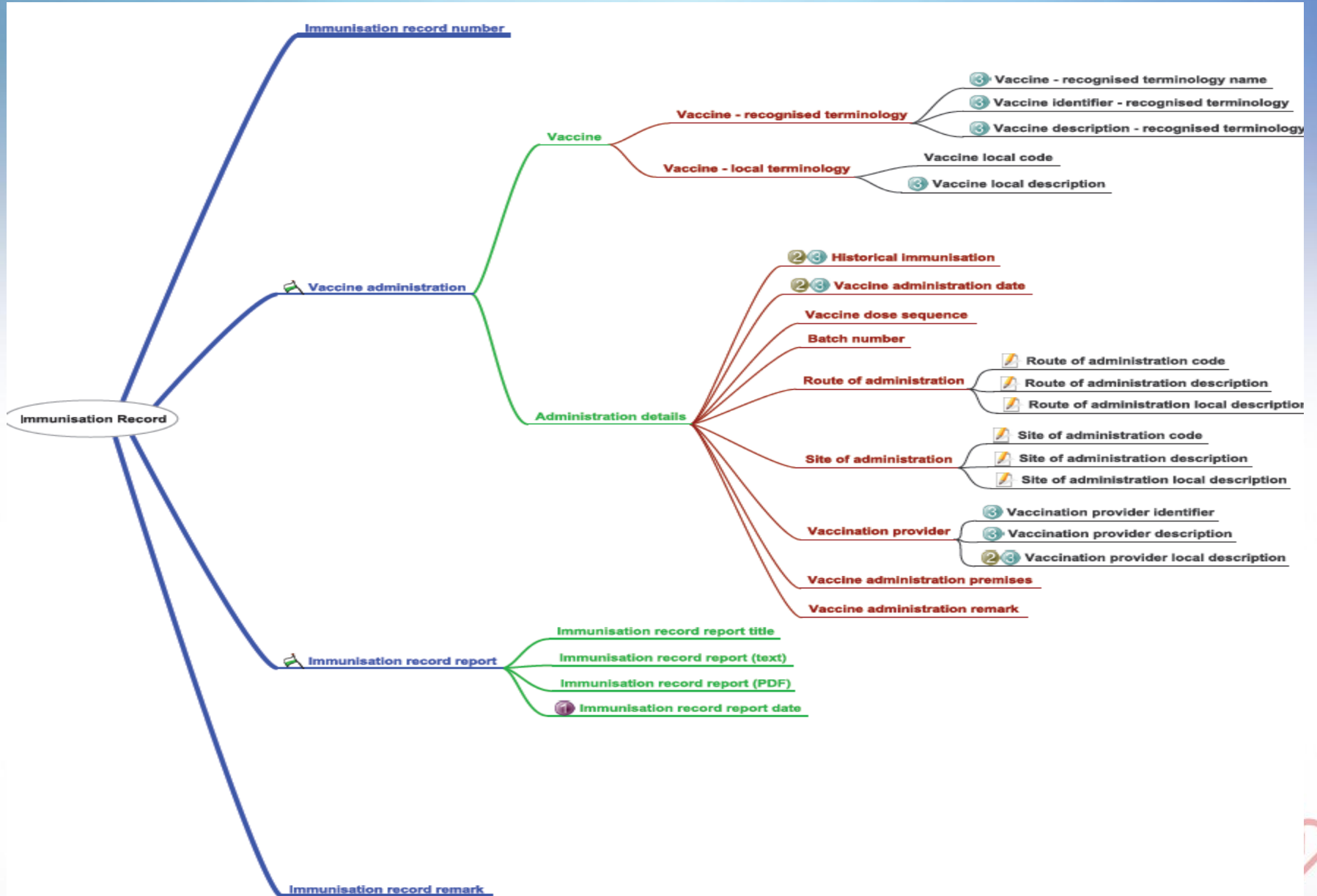
- eHR Content Standards Guidebook
- eHR Data Interoperability Standards

## References

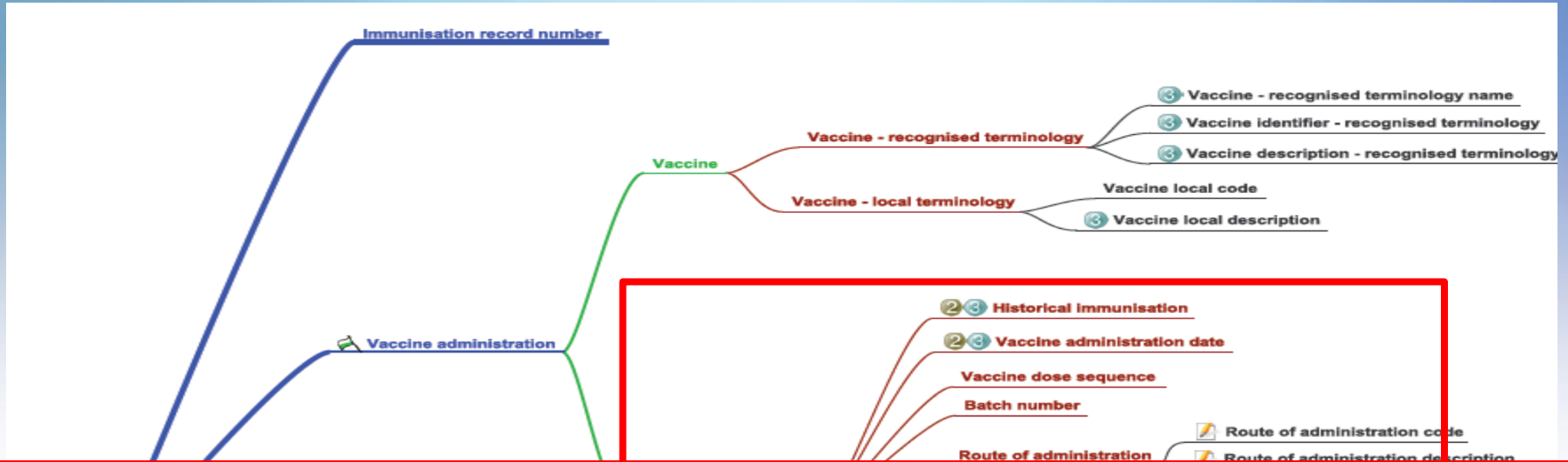
- ASTM
  - E1384 Content & structure of electronic health record
  - E2369 Continuity of care record (CCR)
- HL7 standards
- SNOMED CT
- HA data structure for electronic patient record (ePR)



# Immunisation Dataset



# Immunisation Dataset



Administration details

2 3 Historical immunisation

2 3 Vaccine administration date

Vaccine dose sequence

Batch number

Route of administration

Route of administration code

Route of administration description

Route of administration local code

Immunisation record remark

## Legend



Mandatory for all Levels



Mandatory for Level 1



Mandatory for Level 2



Mandatory for Level 3



Conditional mandatory



Repeated data



Encrypted eHR storage



Code table



Recognised terminology



# Data Schema

Entity Name	Entity ID	Definition	Data Type (code)	Data Type (description)	Validation Rule	Repeated Data	Code Table	Remark	Data Requirement (Certified Level 1)	Data Requirement (Certified Level 2)	Data Requirement (Certified Level 3)	Example (Certified Level 1)	Example (Certified Level 2)	Example (Certified Level 3)
Immunisation record number	1001804	A unique Identifier for each vaccine administration record defined by Individual Institution	ST	String					O	O	O	5805 0000 XXXX	5805 0000 XXXX	5805 0000 XXXX
Vaccine - recognised terminology name	1001808	Terminology name that is recognised by the eHR Information Standards Office for vaccine	CE	Coded Element		y	Vaccine - recognised terminology name		N/A	N/A	M	N/A	N/A	CPP
Vaccine Identifier - recognised terminology	1001809	A unique Identifier of Individual vaccine in the "Vaccine list"	CE	Coded Element		y	Vaccine list		N/A	N/A	M	N/A	N/A	01891
Vaccine description - recognised terminology	1001810	Name of Individual vaccine in the "Vaccine list"	CE	Coded Element		y	Vaccine list		N/A	N/A	M	N/A	N/A	MMR II
Vaccine local code	1001806	A unique Identifier issued to the vaccine defined by Individual Institution	ST	String		y			N/A	O	O	N/A	MMR	MMR II
Vaccine local description	1001807	The description of the vaccine defined by Individual Institution	ST	String		y			N/A	M	M	N/A	MMR	MMR II
Historical Immunisation	1001814	Immunisation administered previously by other providers. All historical Immunisation data should be based on the Immunisation record documented by previous healthcare providers who gave the vaccine to the person.	CE	Coded Element		y	Yes No Unspecified		N/A	M	M	N/A	No	Unspecified
Vaccine administration date	1001805	The date on which the vaccine is given	TS	Time Stamp		y			N/A	M	M	N/A	1/11/2009	1/11/2009
Vaccine dose sequence	1001812	Immunisation dose in series, booster	ST	String		y			N/A	O	O	N/A	1st dose	2nd dose
Batch number	1001811	Batch number for drug product as assigned by the drug manufacturer	ST	String		y			N/A	O	O	N/A	09-33344-XX098	09-33355-XX099
Route of administration code	1001816	The path by which a drug / substance is taken into the body	CE	Coded Element		y	Route of drug administration table		N/A	N/A	N/A or M if [Route of administration description] is given	N/A	N/A	IM
Route of administration description		Description of the path by which a drug / substance is taken into the body, defined by eHR	ST	String		y			N/A	N/A	N/A or M if [Route of administration code]	N/A	N/A	intramuscular
Route of administration local description		Description of the path by which a drug / substance is taken into the body, defined by Individual Institution	ST	String		y			N/A	O	O or M if [Route of administration code] is given	N/A	IM	Intramuscular
Site of administration code	1001817	Code of the body site where the drug / substance is given	CE	Coded Element		y	Site of drug administration		N/A	N/A	N/A or M if [Site of administration description] is given	N/A	N/A	LT
Site of administration description		Description of the body site where the drug / substance is given, defined by eHR	ST	String		y			N/A	N/A	N/A or M if [Site of administration code] is given	N/A	N/A	Left Thigh
Site of administration local description		Local description of the body site where the drug / substance is given, defined by Individual	ST	String		y			N/A	O	O or M if [Site of administration code]	N/A	L Thigh	Lt Thigh

# Data Schema

Entity Name	Entity ID	Definition	Data type (code)	Data Type (description)	Validation Rule	Repeated Data	Code Table	Remark	Data Requirement (Certified Level 1)	Data Requirement (Certified Level 2)	Data Requirement (Certified Level 3)	Example (Certified Level 1)	Example (Certified Level 2)	Example (Certified Level 3)
Immunisation record number	1001804	A unique identifier for each vaccine administration record defined by Individual Institution	ST	String					O	O	O	5805 0000 XXXX	5805 0000 XXXX	5805 0000 XXXX
Vaccine - recognised terminology	1001808	Terminology that is recognised by the Information Standard for vaccine	CE	Coded Element			Vaccine terminology name		N/A	N/A	N/A			
Vaccine identified terminology	1001809	A unique identifier of Individual vaccine in the "Vaccine list"	CE	Coded Element		y	Vaccine list		N/A	N/A	N/A			
Vaccine described terminology	1001810	Name of Individual vaccine in the "Vaccine list"	CE	Coded Element					N/A	N/A	N/A			
Vaccine local	1001806	A unique identifier issued to the vaccine defined by Individual Institution	ST	String					O	O	O			
Vaccine local description		The description of the vaccine defined by Individual Institution	ST	String					M	M	M			FR II
Historical Immunisation		Immunisation administered previously by other providers. All historical immunisation data should be based on the	CE	Coded Element					M	M	M	N/A	No	Unspecified
Vaccine administration						y			N/A	M	M	N/A	1/11/2009	1/11/2009
Vaccine second						y			N/A	O	O	N/A	1st dose	2nd dose
Bat						y			N/A	O	O	N/A	09-33344-XX098	09-33355-XX099
Route of administration						y	Route of drug administration table		N/A	N/A	N/A or M if [Route of administration description] is given	N/A	N/A	IM
Route of administration description		(the body, defined by eHR)				y			N/A	N/A	N/A or M if [Route of administration code] is given	N/A	N/A	intramuscular
Route of administration local description		Description of the path by which a drug / substance is taken into the body, defined by Individual Institution	ST	String		y			N/A	O	O or M if [Route of administration code] is given	N/A	IM	Intramuscular
Site of administration code	1001817	Code of the body site where the drug / substance is given	CE	Coded Element		y	Site of drug administration		N/A	N/A	N/A or M if [Site of administration description] is given	N/A	N/A	LT
Site of administration description		Description of the body site where the drug / substance is given, defined by eHR	ST	String		y			N/A	N/A	N/A or M if [Site of administration code] is given	N/A	N/A	Left Thigh
Site of administration local description		Local description of the body site where the drug / substance is given, defined by Individual	ST	String		y			N/A	O	O or M if [Site of administration code] is given	N/A	L Thigh	Lt Thigh

## Entity Name

Name of data field, e.g.

- [Date of birth]
- [Report title]

## Entity ID

- Unique identifier for each Entity
- Issued by eHRISO

## Definition

- Definition of the entity





# Data Schema

Entity Name	Entity ID	Definition	Data Type (code)	Data Type (description)	Validation Rule	Repeated Data	Code Table	Remark	Data Requirement (Certified Level 1)	Data Requirement (Certified Level 2)	Data Requirement (Certified Level 3)	Example (Certified Level 1)	Example (Certified Level 2)	Example (Certified Level 3)
Immunisation record number	1001804	A unique identifier for each vaccine administration record defined by Individual Institution	ST	String					O	O	O	5805 0000 XXXX	5805 0000 XXXX	5805 0000 XXXX
Vaccine - recognised terminology name	1001808	Terminology name that is recognised by the eHR Information Standards Office for	CE			y	Vaccine - recognised terminology name		N/A	M		N/A	N/A	CPP
Vaccine - recognised terminology name						y	Vaccine list		N/A	M		N/A	N/A	01891
Vaccine - recognised terminology name						y	Vaccine list							
Vaccine - recognised terminology name						y								
Vaccine - recognised terminology name						y	Yes No Unspecified							
Vaccine administration date	1001805	The date on which the vaccine is given	TS	Time Stamp		y								
Vaccine dose sequence	1001812	Immunisation dose in series, booster	ST	String		y								
Batch number	1001811	Batch number for drug product as assigned by the drug manufacturer	ST	String		y								
Route of administration code	1001816	The path by which a drug / substance is taken into the body	CE	Coded Element		y	Route of drug administration table							
Route of administration description		Description of the path by which a drug / substance is taken into the body, defined by eHR	ST	String		y								
Route of administration local description		Description of the path by which a drug / substance is taken into the body, defined by Individual Institution	ST	String		y								
Site of administration code	1001817	Code of the body site where the drug / substance is given	CE	Coded Element		y	Site of drug administration		N/A	N/A	N/A or M if [Site of administration description] is given	N/A	N/A	LT
Site of administration description		Description of the body site where the drug / substance is given, defined by eHR	ST	String		y			N/A	N/A	N/A or M if [Site of administration code] is given	N/A	N/A	Left Thigh
Site of administration local description		Local description of the body site where the drug / substance is given, defined by Individual	ST	String		y			N/A	O	O or M if [Site of administration code]	N/A	L Thigh	Lt Thigh

## Validation Rules

For data quality, e.g.

- Section : Birth Record
- Entity : [Apgar Score ]
- Validation : value is 0 to 10

## Code Table

- Name of the code table from which the data value for a particular entity is referenced to
- In Codex – around 50 tables

Section	Entity	Code Table
Healthcare Recipient	Sex	Sex
Encounter	Specialty	Specialty

# Code Tables



Laboratory Category

Laboratory Category Code

Laboratory Category Description

Laboratory Category Local Description

## Laboratory Category Table

TermID	eHR Value	eHR Description
	CHEM	Chemical Pathology Laboratory
	HAEM	Haematology Laboratory
	IMMUN	Immunology Laboratory
	MICRO	Microbiology Laboratory
	VIRO	Virology Laboratory
	PATH	Anatomical Pathology Laboratory
	TRL	Toxicology Reference Laboratory
	BLDBK	Blood Bank
	T&I	Transplantation & Immunogenetic Laboratory
	MOLPATH	Molecular Pathology Laboratory
	LAB	Clinical Laboratory

To be assigned

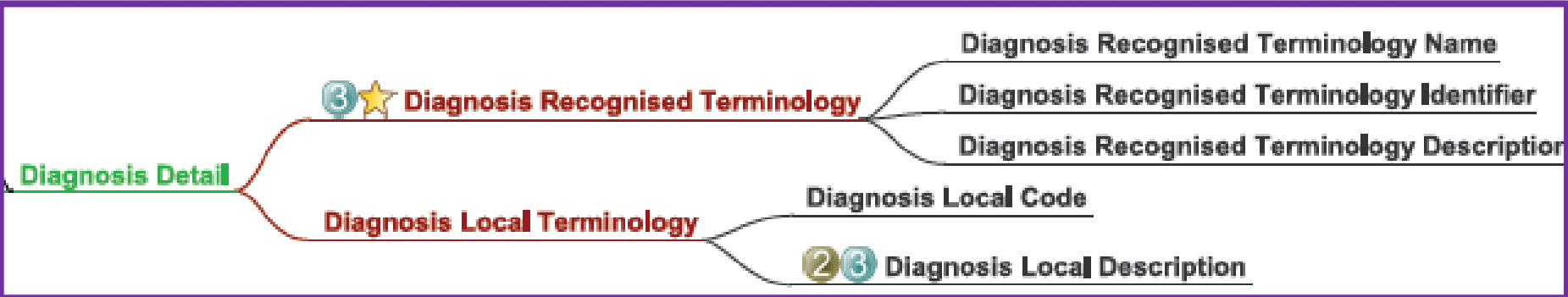
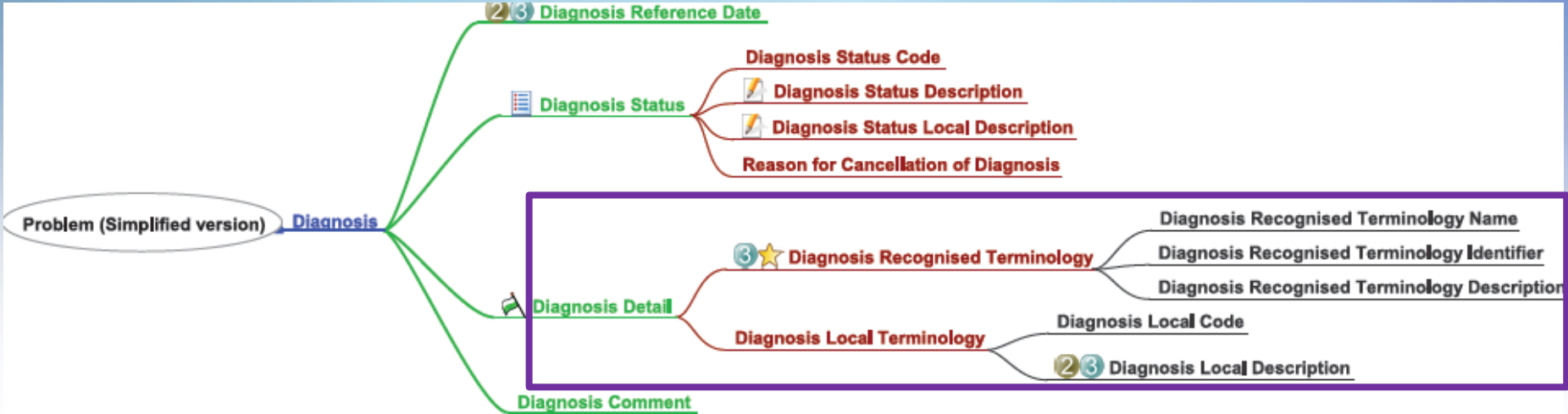
Laboratory	Certified Level	Laboratory Category Code	Laboratory Category Description	Laboratory Category Local Description
A	Level 2	---	---	Chem
B	Level 3	Chem	Chemical Pathology Laboratory	ChemPath
C	Level 3	HAEM	Haematology Laboratory	Haematology Laboratory



# Recognised Terminologies for eHR

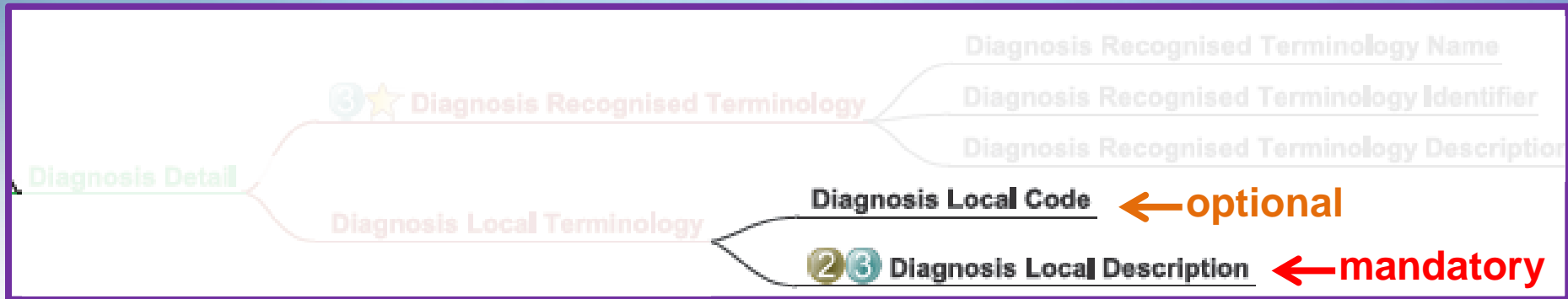
- Registered Pharmaceutical Products
- Hong Kong Clinical Terminology Table (HKCTT)
- International Classification of Diseases, 10th Revision (ICD 10)
- International Classification for Primary Care, 2<sup>nd</sup> Edition (ICPC2)
- Logical Observations, Identifiers Names and Codes (LOINC)
- Systematized Nomenclature of Medicine, Clinical Terms (SNOMED CT)

# Set of 5



# Set of 5

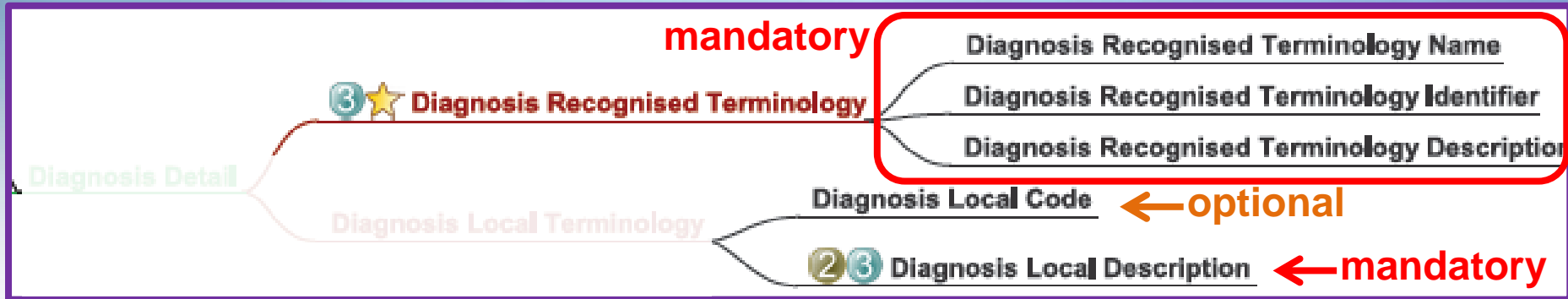
## Diagnosis – Level 2 Compliance



Example	Diagnosis Local Code	Diagnosis Local Description
1	----	Haemorrhoid
2	HM	Hemorrhoid
3	123	Piles

# Set of 5

## Diagnosis – Level 3 Compliance



Example	Rcg T Name	Rcg T ID	Rcg T Des	Local Code	Local Description
1	SNOMED CT	233604007	Pneumonia	----	Pneumonia
2	ICD 10	J18.9	Pneumonia	PN	Pneumonia
3	HKCTT	8471	Pneumonia	123	Chest infection
4	HKCTT	8471	Pneumonia	---	Pneumonia

# Data to eHR

For displaying data in eHR viewer

For grouping data in eHR viewer / secondary use of eHR data

Declared Standard Level	Unstructured data	Local structured data		Recognised structured data			
	PDF, Free Text	Local Code	Local Description	Types	Recognised Terminology Name	Recognised Code	Recognised Description
1	Mandatory	NA	NA	---	NA	NA	NA
2	Optional	Optional	Mandatory	---	NA	NA	NA
3	Optional	Optional	Mandatory	Recognised Terminology	Mandatory	Mandatory	Mandatory
			Code Tables	---	Mandatory	Mandatory	

If data is required, local description must be sent to eHR, but local code is optional.

When sending local description to eHR :

- Send local term if map local table to standard one
- Send term of the recognised terminology if adopt recognised terminology in local system directly



# Data Schema

Entity Name	Entity ID	Definition	Data Type (code)	Data Type (description)	Validation Rule	Repeated Data	Code Table	Remark	Data Requirement (Certified Level 1)	Data Requirement (Certified Level 2)	Data Requirement (Certified Level 3)	Example (Certified Level 1)	Example (Certified Level 2)	Example (Certified Level 3)
Immunisation record number	1001804	A unique identifier for each vaccine administration record defined by Individual Institution	ST	String					O	O	O	5805 0000 XXXX	5805 0000 XXXX	5805 0000 XXXX
Vaccine - recognised terminology name	1001808	Terminology name that is recognised by the eHR Information Standards Office for vaccine	CE	Coded Element		y	Vaccine - recognised terminology				M	N/A	N/A	CPP
Vaccine identifier - recognised terminology	1001809	A unique identifier for vaccine										N/A	N/A	01891
Vaccine description - recognised terminology	1001810	Name of vaccine										N/A	N/A	MMR II
Vaccine local code	1001806	A unique identifier for vaccine										N/A	MMR	MMR II
Vaccine local description	1001807	Description of vaccine										N/A	MMR	MMR II
Historical immunisation	1001814	Immunisation history										N/A	No	Unspecified
Vaccine administration date	1001805	Date of vaccine administration										N/A	1/11/2009	1/11/2009
Vaccine dose sequence	1001812	Sequence of vaccine doses										N/A	1st dose	2nd dose
Batch number	1001811	Batch number of vaccine										N/A	09-33344-XX098	09-33355-XX099
Route of administration code	1001816	Code for route of administration										N/A	N/A	IM
Route of administration description		Description of route of administration										N/A	N/A	intramuscular
Route of administration local description		Local description of route of administration										N/A	IM	intramuscular
Site of administration code	1001817	Code for site of administration										N/A	N/A	LT
Site of administration description		Description of the body site where the drug / substance is given, defined by eHR	ST	String		y			N/A	N/A	N/A or M if (Site of administration code) is given	N/A	N/A	Left Thigh
Site of administration local description		Local description of the body site where the drug / substance is given, defined by Individual Institution	ST	String		y			N/A	O	O or M if (Site of administration code) is given	N/A	L Thigh	Lt Thigh

## Data Requirement

Whether data is required for the certified level as indicated by the healthcare provider

- M – mandatory
- O – optional
- NA – not applicable



Section	Entity Name	Certified Level	Data Requirement
Healthcare Recipient	Sex	3	Mandatory
Birth Record	Apgar Score	2	Optional
Immunisation Record	Vaccine Name	1	Not applicable

# Thank You

