

Appendix C - Glossary of Terms

The following terms appear throughout the information presented in these guides:

Term	Definition
Canadian Classification of Health Interventions (CCI)	CCI is the national standard for classifying health care procedures. It is a classification system for describing a broad spectrum of health interventions from various types of providers across the continuum of health care. (Source: https://www.cihi.ca/en/data-and-standards/standards/classification-and-coding/canadian-classification-of-health)
Commercial Off The Shelf (COTS)	Commercial Off-The-Shelf is a term for goods available in the commercial marketplace that can be bought and used under government contract. COTS purchases are alternatives to in-house developments or one-off government-funded developments. (Source: http://en.wikipedia.org/wiki/Commercial_off-the-shelf)
Digital Imaging and Communication in Medicine (DICOM)	Standard for handling, storing, printing, and transmitting information in medical imaging. It includes a file format definition and a network communications protocol. The communication protocol is an application protocol using TCP/IP to communicate between systems. DICOM files can be exchanged between two entities capable of receiving image and patient data in DICOM format. (Source: http://medical.nema.org/Dicom/about-DICOM.html)
Electronic Health Record (EHR)	Provides each individual in Canada with a secure and private lifetime record of their key health history and care within the health system. The record is available electronically to authorized health care providers and the individual anywhere, anytime in support of high quality care. (Source: https://www.infoway-inforoute.ca/index.php/resources/technical-documents/architecture/doc_download/283-ehrs-blueprint-v2-summary ; Page.32)
Health Information Access Layer (HIAL)	An interface specification for the EHR infostructure that defines service components, service roles, information model and messaging standards required for the exchange of EHR data and execution of interoperability profiles between EHR services. . (Source: https://www.infoway-inforoute.ca/index.php/resources/technical-documents/architecture/doc_download/283-ehrs-blueprint-v2-summary ; Page.33)
Health Level 7 (HL7)	Founded in 1987, HL7 is a not-for-profit standards developing organization dedicated to providing a comprehensive framework and related standards for the exchange, integration, sharing, and retrieval of electronic health information that supports clinical practice and the management, delivery and evaluation of health services. (Source: http://www.hl7.org/about/index.cfm?ref=nav)
Health Level 7 Clinical Document Architecture (HL7 CDA)	The HL7 CDA is a document markup standard that specifies the structure and semantics of "clinical documents" for the purpose of exchange between health care providers and patients. It defines a clinical document as having the following six characteristics: 1) Persistence, 2) Stewardship, 3) Potential for authentication, 4) Context, 5) Wholeness and 6) Human readability. (Source: http://www.hl7.org/implement/standards/product_brief.cfm?product_id=7h)
Health Level 7 version 2 (HL7 v2)	Standard supporting hospital workflows. Created in 1987, it defines electronic messages to support administrative, logistical, financial and clinical processes. (Source: http://www.hl7.org/implement/standards/product_brief.cfm?product_id=185)
Health Level 7 version 3 (HL7 v2)	Standard supporting health care workflows. Development started in 1995, resulting in an initial standard publication in 2005. HL7 v3 is based on a formal methodology (the HDF – HL7 Development Framework) and object oriented principles. (Source: http://www.hl7.org/implement/standards/product_brief.cfm?product_id=186)
HL7 Fast Healthcare Interoperability Resources (FHIR)	Expected to be a next generation standards framework created by HL7. FHIR combines the best features of HL7's Version 2, Version 3 and product lines while leveraging the latest web standards and applying a tight focus on implementability (Source: http://www.hl7.org/implement/standards/fhir/)
Hypertext Transfer Protocol (HTTP)	HTTP is a protocol with the lightness and speed necessary for a distributed collaborative hypermedia information system. It is a generic stateless object-oriented protocol, which may be used for many similar tasks such as name servers, and distributed object-oriented systems, by extending the commands, or methods used. A feature of HTTP is the negotiation of data representation, allowing systems to be built independently of the development of new advanced representations. (Source: http://www.hl7.org/documentcenter/public_temp_B48207D3-1C23-BA17-0CD09DA0F7B11184/calendarofevents/FirstTime/Glossary%20of%20terms.pdf)
Integrating the Healthcare Enterprise (IHE) - Cross Enterprise Document Sharing (XDS)	IHE XDS is focused on providing a standards-based specification for managing the sharing of documents between any health care enterprise, ranging from a private physician office to a clinic to an acute care in-patient facility and personal health record systems. This is managed through federated document repositories and a document registry to create a longitudinal record of information about a patient within a given clinical affinity domain. (Source: http://wiki.ihe.net/index.php?title=Cross-Enterprise_Document_Sharing). It's worth noting that there are specializations of the IHE XDS profile, such as IHE XDS-I, which provides a solution for publishing, finding and retrieving imaging documents across a group of affiliated enterprises. (Source: http://wiki.ihe.net/index.php?title=Cross-enterprise_Document_Sharing_for_Imaging)
International Classification of Diseases (ICD)	ICD is the standard diagnostic tool for epidemiology, health management and clinical purposes. It is used to monitor the incidence and prevalence of diseases and other health problems. It is used to classify diseases and other health problems recorded on many types of health and vital records including death certificates and health records.(Source: http://www.who.int/classifications/icd/en/)

Interoperability Standards	Documented rules and guidelines that describe data structure, format and exchange mechanism between two or more software applications. (Source: http://www.himss.org/library/interoperability-standards/what-is?navItemNumber=17333)
Logical Observation Identifiers Names and Codes (LOINC)	A universal code system for identifying laboratory and clinical observations. The purpose of the database is to facilitate the exchange and pooling of results for clinical care, outcomes management, and research. (Source: http://loinc.org/background)
Message Interchange Format (MIF)	MIF is a set of XML formats used to support the storage and exchange of HL7 version 3 artefacts as part of the HL7 Development Framework. It is the pre-publication format of HL7 v3 artefacts used by tooling. The formats are defined by a set of inter-related schemas. (Source: http://wiki.hl7.org/index.php?title=Model_Interchange_Format)
Minimal Lower Layer Protocol (MLLP)	The MLLP protocol is a minimalistic OSI-session layer framing protocol. It is assumed that the MLLP protocol will be used only in a network environment. Most of the details of error detection and correction are handled by the lower levels of any reasonable network protocol (e.g. TCP/ IP, SNA) and do not require any supplementation (Source: http://www.hl7.org/documentcenter/public_temp_B48207D3-1C23-BA17-0CD09DA0F7B11184/calendarofevents/FirstTime/Glossary%20of%20terms.pdf)
Pan-Canadian Lab Observations Codes Database (pCLOCD)	Nomenclature standard that allow access, management and storage of patient laboratory orders and results across the continuum of care through a jurisdictional Laboratory Information System. (Source: https://www.infoway-inforoute.ca/index.php/programs-services/standards-collaborative/pan-canadian-standards/pan-canadian-loinc-observation-code-database-pclood- nomenclature-standard)
Radiology Lexicon (RADLEX)	A comprehensive lexicon—a unified language of radiology terms—for standardized indexing and retrieval of radiology information resources. (Source: https://www.rsna.org/RadLex.aspx)
Representational State Transfer (REST)	Architectural style consisting of clients and servers. Clients initiate requests to servers; servers process requests and return appropriate responses. Requests and responses are built around the transfer of representations of resources. A resource can be essentially any coherent and meaningful concept addressed. A representation of a resource is typically a document capturing the current or intended state of a resource. (Source: http://www.ics.uci.edu/~taylor/documents/2002-REST- TOIT.pdf)
Security Assertion Markup Language (SAML)	An XML-based open standard data format for exchanging authentication and authorization data between parties, in particular, between an identity provider and a service provider. (Source: http://en.wikipedia.org/wiki/Security_Assertion_Markup_Language)
Simple Object Access Protocol (SOAP)	Lightweight protocol intended for exchanging structured information in a decentralized, distributed environment. It uses XML technologies to define an extensible messaging framework providing a message construct that can be exchanged over a variety of underlying protocols. The framework has been designed to be independent of any particular programming model and other implementation specific semantics. (Source: http://www.w3.org/TR/2000/NOTE-SOAP-20000508/)
Standards Analyst	A generic role title used to describe a person with expertise in one or more standards (e.g. SNOMED- CT, HL7 CDA, etc.) who is typically responsible for reviewing, comparing, constraining or extending standards documentation to help inform IT system or software design and implementation. (Source: COACH HIP® Role Profiles. Page 77. https://ams.coachorg.com/inventory/PurchaseDetails.aspx?Id=529927ef-0e5d-4f0e-81e2-5b2968501fd9)
Standard Development Organization (SDO)	Organization responsible to develop, support and maintain Standards (sometimes called Specifications, Products or Protocols) for a particular domain such as messaging (such Health Level 7), terminology (such as International Health Terminology Standards Development Organization for SNOMED CT) or technology (such as XML). (Source: http://en.wikipedia.org/wiki/Standards_organization#Standards_developing_organizations_.28SDOs.29)
Systemized Nomenclature of Medicine Clinical Terms (SNOMED CT)	SNOMED CT is the most comprehensive, multilingual clinical health care terminology in the world. It is an internationally recognized terminology standard to capture, retrieve, aggregate and share relevant clinical information across health care settings and providers in a consistent, safe, and reliable manner. It contains more than 300, 000 active components with unique meanings, ranging from diagnoses and therapies, to medications, results and orders. (Source: https://www.infoway-inforoute.ca/index.php/programs-services/standards-collaborative/pan-canadian-standards/systematized-nomenclature-of-medicine-clinical-terms-snomed-ct)
XML	eXtensible Markup Language (XML) is markup language that defines a set of rules for encoding documents in a format that is both human-readable and machine-readable (Source: http://www.w3.org/XML/)
XML Schema	An XML schema describes a set of rules to which an XML document must conform in order to be considered 'valid'. (Source http://www.w3.org/XML/Schema)