Draft Pan-Canadian Primary Health Care Electronic Medical Record Content Standard, Version 2.1—Implementation Guide

Primary Health Care

Canadian Institute for Health Information
Institut canadien d'information sur la santé

Our Vision

Better data. Better decisions.
Healthier Canadians.

Our Mandate

To lead the development and maintenance of comprehensive and integrated health information that enables sound policy and effective health system management that improve health and health care.

Our Values

Respect, Integrity, Collaboration, Excellence, Innovation

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Introduction

Purpose

This document provides technical teams with guidance on implementing the data elements that comprise the core of the *Draft Pan-Canadian Primary Health Care Electronic Medical Record Content Standard, Version 2.1* (PHC EMR CS). This guide provides general information that implementers need to know, regardless of their particular implementation or EMR application.

General implementation guidance in this document is divided into three main sections:

- **Special Instructions and Information**—provides overarching information about the data elements that implementers will need to consider in support of their system analysis and design efforts.
- **Logical Model**—provides a diagram that organizes the data elements into their logical groupings and associated relationships with each other. While the logical model is not specifically intended to support a particular implementation, it can guide the development of a physical database or data extract format.
- **Data Elements**—provides a complete description of each data element, including additional information specific to the particular data element that implementers may need to consider in support of system analysis and design efforts.

This document does not contain technology-specific implementation guidance, such as how to extract data from an EMR, how to load EMR data into a repository to support health system use or how to design EMR user interfaces to facilitate clinician capture of standardized data.

Audience

This document is written for a technical audience, which could include project managers, business analysts, systems analysts, data modellers and software programmers. The information contained in this guide may also be of interest to standards experts, researchers and clinicians who have an interest in capturing and using standardized PHC EMR data.

Background on the PHC EMR CS

The PHC EMR CS, when implemented in PHC EMRs, will yield data that enables EMR functionality and provides information that can be used to improve both the quality of patient care and the management of the broader health care system.

Once the PHC EMR CS has been implemented, PHC EMRs can make better use of comparable, standardized EMR data to drive application functionality, such as clinical decision-support tools that provide alerts when patients have an allergy to a prescribed medication, and to generate useful information back to the clinician, such as the percentage of diabetic patients who have had an HbA1C test in the last 15 months. The PHC EMR CS can also support the ability to extract data to support a variety of needs, ranging from interoperating with a jurisdictional electronic health record (EHR) to providing a data extract to a chronic disease management repository.

For more information on the history and benefits of the PHC EMR CS, please see the *Draft Pan-Canadian Primary Health Care Electronic Medical Record Content Standard, Version 2.0—Business View*, available at www.cihi.ca/phc.

Special Instructions and Information

Overarching Considerations

Multiple Potential Implementations

The data elements that form the core of the PHC EMR CS can be thought of as a data dictionary that defines the data elements regardless of precisely how they are implemented. As a result, the data elements may support both primary and health system uses of PHC EMR data within the same implementation. For example, the data elements can be implemented in an EMR to help drive decision-support algorithms, or they can help inform the core content of a PHC EMR data extract specification that focuses on health system uses of EMR data. Each implementation will require further specification of the use of the data elements and will need to apply additional constraints and information that support the specific implementation. For example, different implementations will need to define the conditions under which certain data elements are mandatory or optional and how and when to de-identify data.

Observations

Many complex concepts are represented in the data elements, and many of them take the form of observations about a patient's health profile. These concepts are expressed at varying levels of granularity. Best efforts have been made to align the data elements with pan-Canadian EHR standards and international standards wherever possible. However, more work may be required to determine the best means of representing all of the complex concepts and the required terminologies. For example, further work is required to determine the structures and terminologies that would facilitate the expression of a broad range of observations, such as diabetic foot assessments, clinical frailty scales and screening tools for unsafe drug use. In addition, more work is required to determine the best means to express orders and results for observations such as cardiac stress tests.

References to External Standards

The PHC EMR CS leverages other supporting standards where appropriate. In particular, the allowable value sets for most of the coded data elements are contained in supporting terminology standards. Each data element provides a reference to the external source terminology (SNOMED CT®, HL7 V3, LOINC, etc.). Where appropriate, it contains a link to the specific reference sets (ref sets) located on the Canada Health Infoway EMR and Integration Wiki (https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies). Each data element associated with a ref set also contains a Reference Set Name and Reference Set ID that uniquely bind the data element to a specific ref set used in the PHC EMR CS.

Canada Health Infoway led a project to develop the PHC Terminology Reference Sets (ref sets) that can be used by implementers of the PHC EMR CS. As part of that initiative, all of the coded data elements were reviewed; many required the creation of EMR-specific ref sets. These are effectively a constrained list of allowable values from the source code system(s) that are applicable to the delivery and administration of PHC as well as to other uses in the EMR, namely primary use data capture and coding. For more information on this project, please send an email to standards@infoway-inforoute.ca. If a data element required a specific PHC ref set, it is noted under the heading "Additional Information."

Implementers should be aware that there may be a lag time between the release of updates to a code system such as SNOMED CT® and the release of updated ref sets that are affected by any changes found in that release.

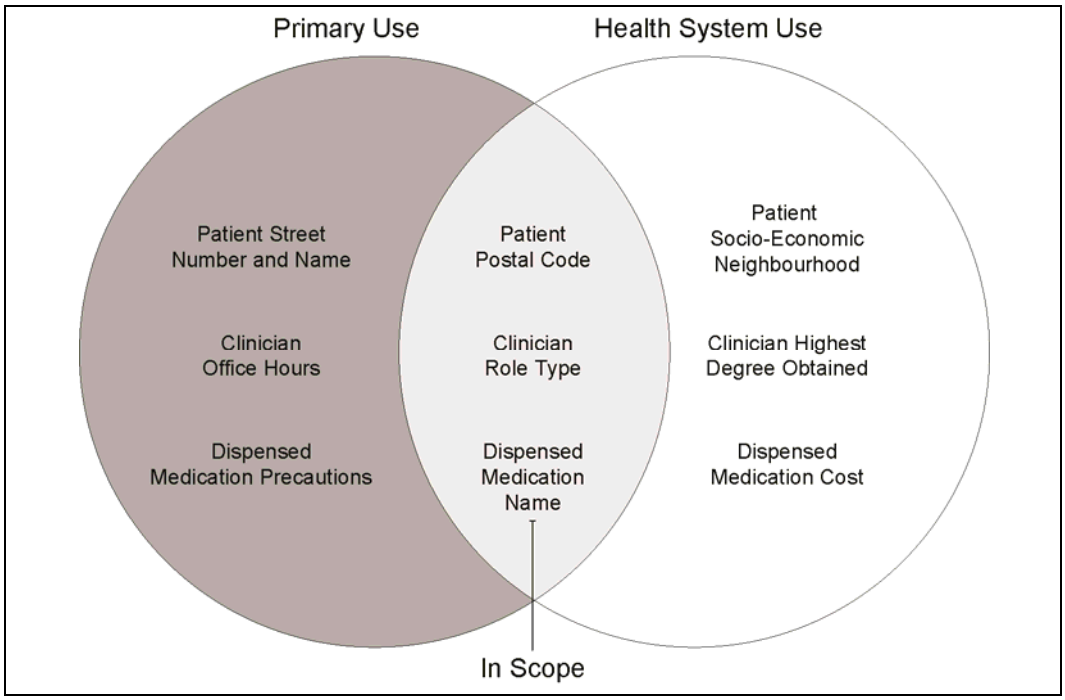
The ref sets may be implemented in a phased approach by adopting other code systems, such as ICD-9 and ICD-10, but the ultimate goal should be to implement the preferred code set to realize full benefits. As EMRs progress toward capturing more structured and coded data, it will be highly beneficial to use the ref sets to improve coding accuracy and usability. There will also be a benefit when extracting the codified data for analysis. The ref sets used within the PHC EMR CS are a key enabler for improving EMR functionality and ultimately achieving high-quality and comparable data for primary and secondary uses.

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca. It is expected that both guides will jointly facilitate implementation of the PHC EMR CS and associated ref sets.

Support for Primary and Health System Uses of EMR Data

- The main criterion for the inclusion of a data element in the PHC EMR CS was its ability to support both primary and health system uses of EMR data.
- Examples of data elements that support both primary and health system uses of EMR data are shown in Figure 1. Data elements that appear in the overlapping area of the two circles support both uses and are therefore deemed to be in scope for the PHC EMR CS.

Figure 1: PHC EMR CS Scope



Implementers should note that the value sets used to populate the data elements were chosen based on their ability to meet this scope criterion. In addition, the ref sets were also scoped to meet this criterion.

Privacy

Users of the PHC EMR Content Standard, Version 2.1, including the Data Extract Specification and the Implementation Guide, should comply with the 10 privacy principles established in the Canadian Standard Association's *Model Code for the Protection of Personal Information*, as well as the relevant jurisdictional privacy legislation and guidance provided by privacy oversight bodies.

Users of the PHC EMR Data Extract Specification need to ensure that they respect their organizations' privacy policies and practices, and meet the required standards in safeguarding the important and sensitive information they are trusted with.

Logical Model

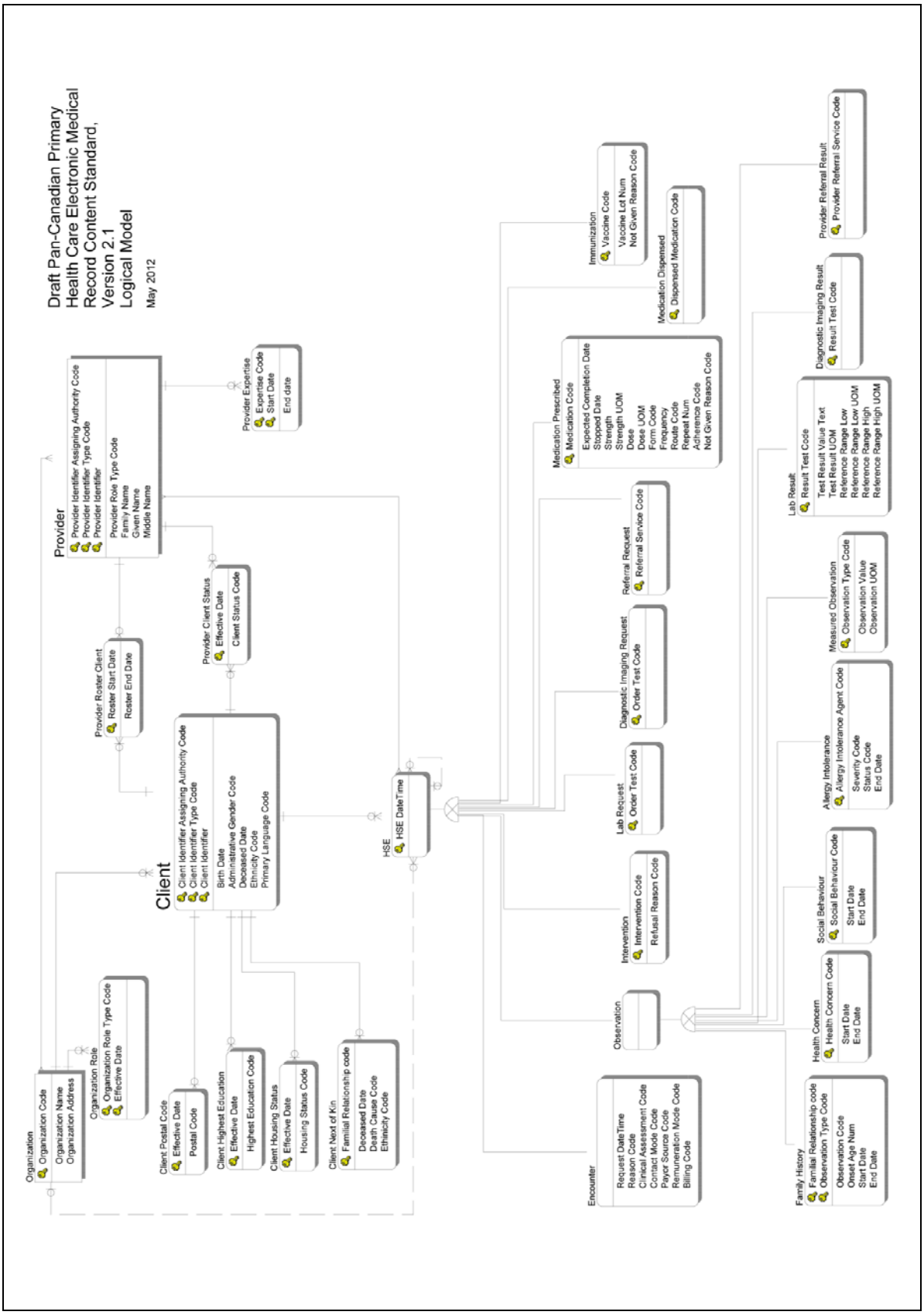
Draft Logical Model

A draft logical model was developed to provide an overview of primary health care business entities (for example, Clients and Health Service Events) and the relationships between these entities. The draft logical model is independent of technology (databases, files, etc.) and usage context. The draft logical model was structured with the Client at the centre to reflect the needs of patient-centric health care.

How to Read the Model

For readability, the logical model has been broken up into two parts in the following diagrams (Figure 2: Client- and Provider-Related Entities and Figure 3: Health Service Event and Related Entities). The health service entity labelled “HSE DateTime” in the diagrams is the connecting entity between the two diagrams. A copy of the logical model, including a more detailed logical view, which can be easily scaled for printing on various page sizes, is available from www.cihi.ca/phc.

Figure 2: Client- and Provider-Related Entities



The logical model contains the following key entities and definitions:

Client: A person who has received, is receiving or is eligible to receive health care–related services or goods. A Client can have many Providers and can participate in zero, one or multiple Health Service Events. A Client is dependent on a Provider to receive a Health Service Event. A Client also has a relationship with an Organization, because Clients can be eligible to receive health services even though they may not have actually received any.

Provider: A person who has delivered, is delivering or has the potential to deliver health care–related services or goods. A Provider can have many Clients and can participate in many Health Service Events. A Provider can belong to many Organizations.

Organization: A formalized group of people with a common purpose or function. An Organization can have none, one or multiple Providers, Clients and Service Delivery Locations.

Service Delivery Location: A place, administered by an Organization, that assembles the resources required for the provision of health care–related services or goods. A Service Delivery Location can be the site of none, one or multiple Health Service Events. The Service Delivery Location entity currently does not exist in the logical model, as this is represented by the Organization and Organization Role entities, with the key attribute being organization address. Service Delivery Location may be proposed as a separate entity in future models.

Health Service Event: The act that is being done, has been done, can be done or is intended/requested to be done for a Client. This entity is effectively a "supertype" of the following business entities: Encounter, Observation, Intervention, Lab Request and Result, Diagnostic Imaging Request and Result, Referral Request and Result, Prescribed and Dispensed Medications, and Immunizations. A Health Service Event (and its subtypes) can have none, one or multiple relationships with other Health Service Events.

- ***Encounter:*** An interaction between a Client and one or more Providers for the purpose of providing one or more health care–related services or goods.
- ***Observation:*** Information derived from performing a health-related activity. This business entity is effectively a supertype of the following business entities: Coded Observation and Measured Observation.
  - *Coded Observations:* Information derived from performing a health-related activity that is represented by predefined symbols associated with a specific value or meaning. A coded recording of a Client's allergy to shellfish is an example of a Coded Observation.
    - Coded Observation entities include the following subtypes: family history, health concern, social behaviour, allergy intolerance, lab result, diagnostic imaging result and provider referral result.
  - *Measured Observation:* Information derived from performing a health-related activity that is represented by a numeric value. Recordings of a Client's height, weight and blood pressure are examples of Measured Observations (they can be expressed as numerical values).

- **Intervention:** An activity that is intended to assess and/or change the state of a Client's health.
- **Lab Request:** A request for analytical services, typically performed by medical laboratories in areas such as chemistry, serology, hematology, microbiology, histology, anatomic pathology, cytology and virology.
- **Diagnostic Imaging Request:** Requests for diagnostic imaging services to be performed on a Client.
- **Referral Request:** A request from one Provider to another Provider or Organization to deliver one or more health services to a Client. The scope of referrals includes requests for clinical care or evaluation, as well as requests for community services such as home care.
- **Medication Prescribed:** The medication ordered by a Provider for a Client.
- **Medication Dispensed:** The medication dispensed by a Provider to a Client.
- **Immunization:** The administration of vaccines to a Client for the purpose of preventing the spread of infectious disease.

Data Elements

This section contains complete details on each of the 106 data elements that form the core content of the PHC EMR CS. The data elements are arranged according to the business entities (for example, Client) as described in the Logical Model section. The description of each data element is broken out into several subsections. The table below describes the information in each of the subsections and provides an example from the Client Identifier Type Code data element to help illustrate the purpose of the subsection.

Data Element Subsection Label	Example Value	Description
Data Element Number	**A2**	A unique ID for each of the data elements.
Data Element Name	**Client Identifier Type Code**	The standard name of the data element that follows the ISO 11179 guidelines for naming data elements.
Common Data Element Name	**(Patient Identifier Type)**	The common or business name of the data element that may be better understood by a non-technical reader.
Specifications Table		A table containing the key information of primary importance to technical stakeholders and implementers.
Specifications Table—Data Type	**Code**	The high-level data type of the data element. The high-level data type values used are described below: • String—any alphanumeric characters (sometimes known as free text). • Number—numbers used to quantify something. • Date—the year, month and day expressed using their numerical representation in the form of YYYYMMDD. If partial dates are allowed, it is indicated by the notation YYYY[MM[DD]], where the brackets denote that the values are optional. • Code—defined lists of alphanumeric characters used to represent a concept. Data elements with the data type code can be populated only with a coded value. • Identifier—a list of alphanumeric characters used to identify an instance of an entity, such as a Client, Provider or Service Delivery Location.
Specifications Table—Valid Format	N/A	The valid format, if applicable. Currently limited to data elements that are dates or zip/postal codes for this iteration of the implementation guide.
Specifications Table—Example Values	Jurisdictional Health Number (Qualifier Value)	Example of a coded value that would be stored in the data field. The information in the brackets is an example of the corresponding name for the code.
Specifications Table—Code System	SNOMED CT®	Code system(s) adopted for PHC ref set.
Reference Set Name	Patient Identifier Type	A name that, in combination with the Reference Set ID, uniquely binds the data element to a specific PHC ref set.
Reference Set ID	2.16.840.1.113883.2.20.3.255	An identifier that, in combination with the Reference Set Name, uniquely binds the data element to a specific PHC ref set.
Definition	Represents the type of Client Identifier . . .	The definition of the data element.
Example of Primary Use	Used in the provision and administration of care . . .	Example of how the data element can be used in the delivery or administration of care (that is, Primary Use of the data element).

Data Element Subsection Label	Example Value	Description
PHC Indicator Mappings	13;36;39;40;41;42;43;44;48;49;50;51;52;53 . . .	A mapping to the pan-Canadian PHC indicators that require this data element. In some cases, data elements may not be directly used in an indicator definition but may be used for supplemental analysis and reporting. Refer to Appendix B for indicator definitions.
Example Use in EHR Messaging Standards	Found in REPC_MT500004CA - Care Composition Detail March 16, 2009	Example of a pan-Canadian EHR HL7 message that the data element supports. Please note the following caveats: • Only one example is provided, although the data element may support many other messages. • The data element may align with a field or component of an HL7 V3 data type. • The example does not imply that the data element is required for the HL7 V3 message.
Additional Information		Additional information that implementers may need to know about the data element and PHC ref set.

The following notation is used throughout the data element specification tables:

N/A: not applicable. This is used to indicate that a particular item in the specifications table does not apply to the data element.

TBD: to be determined. This is used to indicate that a particular item in the specifications table does apply to the data element and that a value will be supplied in a future iteration.

A1 Client Identifier (Patient Identifier)

Specifications	
Data Type	Identifier
Valid Format	N/A
Example Values	6611168070NN
Code System	N/A

Definition:

Represents a unique identifier assigned to the Client.

Example of Primary Use:

Used in the provision and administration of care. Can be used to associate administrative (for example, demographics) and health information (for example, lab results) with the Client.

PHC Indicator Mappings:

13;36;39;40;41;42;43;44;48;49;50;51;52;53;54;55;56;57;58;59;60;62;63

Example Use in EHR Messaging Standards:

Found in

REPC_MT500004CA - Care Composition Detail March 16, 2009

Additional Information:

None at this time.

A2 Client Identifier Type Code (Patient Identifier Type)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Jurisdictional health number (qualifier value)
Code System	SNOMED CT®
Reference Set Name	ClientIdentifierTypeCode
Reference Set ID	2.16.840.1.113883.2.20.3.255
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the type of Client Identifier (for example, jurisdictional health care identifier or passport).

Example of Primary Use:

Used in the provision and administration of care. Helps differentiate the type of identifier used to identify the Client. In conjunction with the Client Identifier, can be used to associate administrative (for example, demographics) and health information (for example, lab results) with the Client.

PHC Indicator Mappings:

13;36;39;40;41;42;43;44;48;49;50;51;52;53;54;55;56;57;58;59;60;62;63

Example Use in EHR Messaging Standards:

Found in

REPC_MT500004CA - Care Composition Detail March 16, 2009

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

A3 Client Identifier Assigning Authority Code (Patient Identifier Assigning Authority)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Ministry of Health Alberta (qualifier value)
Code System	SNOMED CT®
Reference Set Name	ClientIdentifierAssigningAuthorityCode
Reference Set ID	2.16.840.1.113883.2.20.3.256
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the legal entity/organization responsible for assigning the Client Identifier.

Example of Primary Use:

Used in the provision and administration of care. Helps identify the organization that issued the identifier when a Client can have multiple identifiers. In conjunction with the Client Identifier, can be used to associate administrative (for example, demographic) and health information (for example, lab results) with the Client.

PHC Indicator Mappings:

13;36;39;40;41;42;43;44;48;49;50;51;52;53;54;55;56;57;58;59;60;62;63

Example Use in EHR Messaging Standards:

Found in

PRPA_MT101101CA - Query by Client ID March 16, 2009

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

A4 Client Birth Date (Patient Date of Birth)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20101001
Code System	N/A

Definition:

Represents the Client's date of birth.

Example of Primary Use:

Used in both the provision and administration of care. Birth date is used to validate the identity of the Client. It is also used to ensure that the right drug and lab reference ranges are used for the Client.

PHC Indicator Mappings:

13;36;39;40;41;42;43;44;48;49;50;51;52;53;54;55;56;57;58;59;60;63

Example Use in EHR Messaging Standards:

Found in

REPC_MT500004CA - Care Composition Detail March 16, 2009

Additional Information:

None at this time.

A5 Client Administrative Gender Code (Patient Gender)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Male
Code System	HL7
Reference Set Name	AdministrativeGender
Reference Set ID	2.16.840.1.113883.1.11.1
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the reported gender category of the Client at a given time. Used for administrative purposes.

Example of Primary Use:

Used in both the provision and administration of care. Can be used for identification matching and confirmation.

PHC Indicator Mappings:

49;50;51;52;53

Example Use in EHR Messaging Standards:

Found in

REPC_MT500004CA - Care Composition Detail March 16, 2009

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

A6 Client Highest Education Code (Patient Highest Education)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	received university education (finding)
Code System	SNOMED CT®
Reference Set Name	HighestLevelEducationCode
Reference Set ID	2.16.840.1.113883.2.20.3.203
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the highest level of education completed by the Client.

Example of Primary Use:

Used in the administration of care. On average, the more education a person has, the more likely he or she is to understand health choices.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Not found in any of the pan-Canadian EHR messaging and terminology standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

A7 Client Housing Status Code (Patient Housing Status)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	32911000 homeless (finding)
Code System	SNOMED CT®
Reference Set Name	HousingStatusCode
Reference Set ID	2.16.840.1.113883.2.20.3.212
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the housing status of the Client.

Example of Primary Use:

Used in both the provision and administration of care. Housing status is important since it can also directly relate to health outcomes. Clients who are homeless or without a permanent address are much more likely to be depressed and unable to afford a healthy lifestyle.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Not found in any of the pan-Canadian EHR messaging and terminology standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

A8 Client Primary Language Code (Patient Primary Language)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	English
Code System	ISO639-3
Reference Set Name	LanguageCode
Reference Set ID	2.16.840.1.113883.2.20.3.190
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the preferred spoken language of the Client.

Example of Primary Use:

Used in both the provision and administration of care. Language is associated with health care access and compliance issues. If a Client can find a Provider that he or she can communicate with, it can reduce significant barriers that may prevent health problems and/or improve overall health.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

PRPA_MT101001CA - Add Client March 16, 2009

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

A9 Client Status Code (Patient Status)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	patient active (finding)
Code System	SNOMED CT®
Reference Set Name	ClientStatusCode
Reference Set ID	2.16.840.1.113883.2.20.3.191
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents whether or not the PHC Provider considers the Client to be actively seeking PHC services through him or her.

Example of Primary Use:

Used in both the provision and administration of care. Ensures that inappropriate reminders are not sent to Clients with who have a status of inactive with
the Provider.

PHC Indicator Mappings:

13;36;39;40;41;42;43;44;48;49;50;51;52;53;54;55;56;57;58;59;60;62;63

Example Use in EHR Messaging Standards:

Not found in any of the pan-Canadian EHR messaging and terminology standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

A10 Client Deceased Date (Patient Date of Death)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the Client's date of death.

Example of Primary Use:

Used in both the provision and administration of care. Records can be archived based on this date plus a number of days as determined by the Clinician/Organization. Ensures that the Client does not receive appointment reminders in the future.

PHC Indicator Mappings:

13;36;39;40;41;42;43;44;48;49;50;51;52;53;54;55;56;57;58;59;60;62;63

Example Use in EHR Messaging Standards:

Found in

PRPA_MT101001CA - Add Client March 16, 2009

Additional Information:

None at this time.

A11 Client Rostered Start Date (Patient Rostered Start Date)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the date the Client was included on the roster.

Example of Primary Use:

Used in the administration of care. Used by Providers to support pay-for-performance programs, physician billing quality checks and accuracy.

PHC Indicator Mappings:

36;39;40;41;49;52;54;55;56;57;58;59

Example Use in EHR Messaging Standards:

Not found in any of the pan-Canadian EHR messaging and terminology standards.

Additional Information:

It should be noted that there is a difference between the concepts of “Client status” and “Client rostering.” The concept of Client status is used to indicate whether the PHC Provider considers the Client to be actively seeking services, whereas the concept of Client rostering is used to indicate those Clients that are a part of the Provider’s roster as it pertains to the Provider’s billing practices. It is possible for a Client to be actively seeking services and not be on the Provider’s roster.

A12 Client Rostered End Date (Patient Rostered End Date)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the date the Client was removed from the roster.

Example of Primary Use:

Used in the administration of care. Used by Providers to support pay-for-performance programs, physician billing quality checks and accuracy.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Not found in any of the pan-Canadian EHR messaging and terminology standards.

Additional Information:

It should be noted that there is a difference between the concepts of “Client status” and “Client rostering.” The concept of Client status is used to indicate whether the PHC Provider considers the Client to be actively seeking services, whereas the concept of Client rostering is used to indicate those Clients that are a part of the Provider’s roster as it pertains to the Provider’s billing practices. It is possible for a Client to be actively seeking services and not be on the Provider’s roster.

A13 Client Administrative Ethnicity Code (Patient Ethnicity)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Inuit (ethnic group)
Code System	SNOMED CT®
Reference Set Name	EthnicityCode
Reference Set ID	2.16.840.1.113883.2.20.3.208
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the self-reported ethnic group to which the Client belongs. Used for administrative purposes. The ethnic origin refers to a person's roots and should not be confused with his or her citizenship or nationality.

Example of Primary Use:

Used in the administration of care to help understand the demographic profile of a Provider's Client base.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

An equivalent concept was not found in the pan-Canadian EHR messaging and terminology standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

A14 Client Residence Postal Code (Patient Postal/Zip Code)

Specifications	
Data Type	String
Valid Format	ANA NAN, NNNNN
Example Values	Example Canadian Postal Code: K0K 3R0 Example USA Zip Code: 20003
Code System	N/A

Definition:

Represents the postal code of the Client's permanent residence.

Example of Primary Use:

Used in both the provision and administration of care. Part of the Client's address, which can be used to help find service delivery locations that are close to the Client's home.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

REPC_MT500004CA - Care Composition Detail March 16, 2009

Additional Information:

None at this time.

B1 Provider Family Name Text (Clinician Last Name)

Specifications	
Data Type	String
Valid Format	N/A
Example Values	Doe
Code System	N/A

Definition:

Represents the Provider's legal family name.

Example of Primary Use:

Used in the provision of care. The family name of the Provider who assessed the Client during an encounter.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

SC-2003-EN - REPC_MT500004CA - Care Composition Detail – 20090316

Additional Information:

None at this time.

B2 Provider Given Name Text (Clinician First Name)

Specifications	
Data Type	String
Valid Format	N/A
Example Values	John
Code System	N/A

Definition:

Represents the Provider's legal given name.

Example of Primary Use:

Used in the provision of care. Name of the Provider used on referral requests.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

SC-2003-EN - REPC_MT500004CA - Care Composition Detail - 20090316
as Healthcare

Additional Information:

None at this time.

B3 Provider Middle Name Text (Clinician Middle Name)

Specifications	
Data Type	String
Valid Format	N/A
Example Values	Edward
Code System	N/A

Definition:

Represents the Provider's middle name.

Example of Primary Use:

Used in the provision of care. Name of the Provider used on referral requests.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

SC-2003-EN - REPC_MT500004CA - Care Composition Detail – 20090316

Additional Information:

None at this time.

B4 Provider Identifier (Clinician Identifier)

Specifications	
Data Type	Identifier
Valid Format	N/A
Example Values	82356743
Code System	N/A

Definition:

Represents a unique identifier assigned to the Provider.

Example of Primary Use:

Used in both the provision and administration of care. Can be used to link Client records and billing information to a specific Provider. Can be used to support authorization to access sensitive records.

PHC Indicator Mappings:

13;36;39;40;41;42;43;44;48;49;50;51;52;53;54;55;56;57;58;59;60;62;63

Example Use in EHR Messaging Standards:

Found in

SC-2003-EN - PRPM_MT301010CA - Add Provider - 20090316

Additional Information:

None at this time.

B5 Provider Identifier Type Code (Clinician Identifier Type)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Provider billing number (qualifier value)
Code System	SNOMED CT®
Reference Set Name	ProviderIdentifierTypeCode
Reference Set ID	2.16.840.1.113883.2.20.3.257
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the type of Provider identifier.

Example of Primary Use:

Used in both the administration and provision of care. In conjunction with the Provider Identifier, it can be used to link Client records and billing information to a specific Provider. Can be used to support authorization to access sensitive records.

PHC Indicator Mappings:

58

Example Use in EHR Messaging Standards:

Not found in any of the pan-Canadian EHR messaging and terminology standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

B6 Provider Identifier Assigning Authority Code (Clinician Identifier Assigning Authority)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Health regulatory body for physicians and surgeons (qualifier value)
Code System	SNOMED CT®
Reference Set Name	ProviderIdentifierAssigningAuthorityCode
Reference Set ID	2.16.840.1.113883.2.20.3.252
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the legal entity responsible for assigning the unique identifier to the Provider.

Example of Primary Use:

Used in both the administration and provision of care. In conjunction with the Provider Identifier, it can be used to link Client records and billing information to a specific Provider. Can be used to support authorization to access sensitive records.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

SC-2003-EN - REPC_MT500004CA - Care Composition Detail - 20090316

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

B7 Provider Role Type Code (Clinician Role)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Primary care physician (occupation)
Code System	SNOMED CT®
Reference Set Name	ProviderRoleCode
Reference Set ID	2.16.840.1.113883.2.20.3.265
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the role of the Provider in relation to his or her participation in a specific health care event.

Example of Primary Use:

Used in both the provision and administration of care. Used to distinguish roles within a health care setting. Can be used to restrict access to Client data by role type.

PHC Indicator Mappings:

13;36;39;40;41;42;43;44;48;49;50;51;52;53;54;55;56;57;58;59;60;62;63

Example Use in EHR Messaging Standards:

Found in

SC-2003-EN - REPC_MT500004CA - Care Composition Detail – 20090316

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

B8 Provider Expertise Code (Clinician Expertise)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	cardiology (qualifier value) general medicine (qualifier value)
Code System	SNOMED CT®
Reference Set Name	ProviderExpertiseCode
Reference Set ID	2.16.840.1.113883.2.20.3.267
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the expertise of the Provider.

Example of Primary Use:

Used in both the provision and administration of care. Used to identify expertise within a primary health care setting as well as expertise in other scenarios, including referrals.

PHC Indicator Mappings:

13;36;39;40;41;42;43;44;48;49;50;51;52;53;54;55;56;57;58;59;60;62;63

Example Use in EHR Messaging Standards:

Found in

PRPM_MT301010CA - Add Provider – 20090316

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

C1 Service Delivery Location Identifier (Service Delivery Identifier)

Specifications	
Data Type	Identifier
Valid Format	N/A
Example Values	897564RT
Code System	N/A

Definition:

Represents the unique identifier of the practice (Service Delivery Location) where the Client received care.

Example of Primary Use:

Used in both the provision and administration of care. Name of the Service Delivery Location is referenced on letters sent to Clients.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

PRLO_MT202015CA - Update Service Delivery

Additional Information:

None at this time.

C2 Service Delivery Location Name Text (Service Delivery Name)

Specifications	
Data Type	String
Valid Format	N/A
Example Values	Glendale Family Health Clinic
Code System	N/A

Definition:

Represents the name of the practice (Service Delivery Location) where the Client received care.

Example of Primary Use:

Used in both the provision and administration of care. Name of the Service Delivery Location is referenced in letters sent to Clients.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

SC-2003-EN - PRLO_MT000002CA - Service Delivery Location Detail - 20090316

Additional Information:

None at this time.

C3 Service Delivery Location Type Code (Service Delivery Type of Services)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	General practitioner (GP) practice site (environment) Allergy clinic (environment)
Code System	SNOMED CT®
Reference Set Name	ServiceDeliveryLocationCode
Reference Set ID	2.16.840.1.113883.2.20.3.268
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the type of location (Service Delivery Location) where the Client received care.

Example of Primary Use:

Used in the administration of care. Indicates the type of location where care is provided to a Client.

PHC Indicator Mappings:

13;36;39;40;41;42;43;44;48;49;50;51;52;53;54;55;56;57;58;59;60;62;63

Example Use in EHR Messaging Standards:

Found in

SC-2003-EN - PRLO_MT000002CA - Service Delivery Location Detail – 20090316

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

C4 Service Delivery Location Postal Code (Service Delivery Postal Code)

Specifications	
Data Type	String
Valid Format	ANA NAN, NNNNN
Example Values	Canadian Postal Code: K0K 3R0
Code System	N/A

Definition:

Represents the postal code where the Client received the PHC service.

Example of Primary Use:

Used in both the provision and administration of care. Part of the Service Delivery Location address, which helps Clients know where to go for service.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

REPC_MT610001CA - Professional Service Procedure Record May 8, 2007

Additional Information:

None at this time.

D1 Encounter Request Date (Appointment Creation Date)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the date on which an appointment was created for the Client by the Provider (or his or her staff).

Example of Primary Use:

Used in both the provision and administration of care. Helps identify wait times for specific Providers.

PHC Indicator Mappings:

55;56;57

Example Use in EHR Messaging Standards:

Not found in any of the pan-Canadian EHR messaging and terminology standards.

Additional Information:

None at this time.

D2 Client Encounter Reason Code (Reason for Visit)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Abdominal pain (finding) Wound care (regime/therapy)
Code System	SNOMED CT®
Reference Set Name	ClientReasonForEncounterCode
Reference Set ID	2.16.840.1.113883.2.20.3.280
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the reason for the encounter as conveyed by the Client.

Example of Primary Use:

Used in both the provision and administration of care. Can be used to give the Provider advance notice of information that may need to be addressed with the Client during the encounter. Can assist in scheduling the amount of time a Client may need with the Provider.

PHC Indicator Mappings:

63

Example Use in EHR Messaging Standards:

Note: While concept domains have been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

D3 Encounter Date (Visit Date)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the date the Client had an encounter with the Provider.

Example of Primary Use:

Used in both the provision and administration of care. Can report on Client wait times for scheduled Clients and track the continuum of care provided to Clients.

PHC Indicator Mappings:

13;36;39;40;49;54;55;56;57;58;59;60;63

Example Use in EHR Messaging Standards:

Found in

REPC_MT500004CA - Care Composition Detail May 8, 2007

Additional Information:

None at this time.

D4 Encounter Mode Code (Visit Type)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Direct Encounter Client Alone (procedure) Telephone Client Alone (procedure)
Code System	SNOMED CT®
Reference Set Name	EncounterTypeCode
Reference Set ID	2.16.840.1.113883.2.20.3.207
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

A description of the type of contact between the Provider and the Client for a registered encounter or visit.

Example of Primary Use:

Used in the administration of care. Can be used to track services provided that may require special billing processes. Can be used to track percentage of Clients treated through various modes of visits.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

COCT_MT011001CA - Care Event identified - March 16, 2009

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

D5 Encounter Payor Source Code (Payment Source)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Provincial and/or territorial government health insurance plan—resident (qualifier value)
Code System	SNOMED CT®
Reference Set Name	EncounterPayorSourceCode
Reference Set ID	2.16.840.1.113883.2.20.3.253
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the source for Provider payment for the encounter.

Example of Primary Use:

Used in the administration of care for billing purposes. Determines the source of payment for the encounter.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Not found; likely point-of-service (POS)–specific due to administrative nature.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

D6 Encounter Remuneration Mode Code (Payment Type)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Fee for Service (finding)
Code System	SNOMED CT®
Reference Set Name	EncounterPaymentTypeCode
Reference Set ID	2.16.840.1.113883.2.20.3.254
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the type of reimbursement paid to the Provider for the encounter.

Example of Primary Use:

Used in the administration of care for billing purposes. Determines the type of payment to the Provider.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Not found; likely POS-specific due to administrative nature.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

D7 Encounter Billing (Fee) Code (Billing Code)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	A007 (Intermediate assessment or well baby care)
Code System	As per jurisdiction-specific set of values

Definition:

Represents the jurisdictional billing code.

Example of Primary Use:

Used in the administration of care for billing purposes.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Not found; likely point of service–specific due to administrative nature.

Additional Information:

Implementers are expected to support the jurisdictional billing (fee) codes for the jurisdictions covered by their implementation. A list of potential sources for more information on jurisdictional billing codes as of March 1, 2011, is provided below. Billing codes are sometimes published in documents that have titles such as “payment schedules,” “billing and remuneration codes,” “physician manuals” or “tariff of fees.”

Jurisdiction	Reference
Yukon	Yukon Health Care Insurance Program www.hss.gov.yk.ca/health_professionals.php
Northwest Territories	N.W.T. Health Care Plan www.hlthss.gov.nt.ca/english/services/health_care_plan/physician_services.htm
Nunavut	Nunavut Health Insurance Program General Inquiries Phone: 867-645-8002
British Columbia	Medical Services Plan of British Columbia www.health.gov.bc.ca/msp/infoprac/physbilling/payschedule/index.html
Alberta	Alberta Health Care Insurance Plan www.health.alberta.ca/professionals/fees.html
Saskatchewan	Saskatchewan Medical Care Insurance Plan www.health.gov.sk.ca/physician-information
Manitoba	Manitoba Health Services Insurance Plan www.gov.mb.ca/health/manual/
Ontario	Ontario Health Services Insurance Plan www.health.gov.on.ca/english/providers/program/ohip/sob/sob_mn.html
Quebec	Manuel de facturation – Médicins omnipraticiens http://www.ramq.gouv.qc.ca/fr/professionnels/medecins-omnipraticiens/manuels/Pages/facturation.aspx Manuel de facturation – Médicins spécialistes http://www.ramq.gouv.qc.ca/fr/professionnels/medecins-specialistes/manuels/Pages/facturation.aspx
New Brunswick	New Brunswick Medicare www.gnb.ca/0051/0394/index-e.asp
Nova Scotia	Nova Scotia Medical Services Insurance www.gov.ns.ca/health/reports/
Prince Edward Island	P.E.I. Medicare Services www.gov.pe.ca/publications/getpublication.php3?number=1415 (Published as part of the master agreement between the Medical Society of P.E.I. and the Government of P.E.I.)
Newfoundland and Labrador	Newfoundland and Labrador Medical Care Plan www.health.gov.nl.ca/health/mcp/providers/
Correctional Service of Canada	Correctional Service of Canada General Inquiries Phone: 613-992-5891
First Nations and Inuit Health Branch	First Nations and Inuit Health Branch General Inquiries Email: info@hc-sc.gc.ca Phone (toll-free): 1-866-225-0709

E1 Observation Family History Health Concern Code (Family Member Health Concern)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Malignant tumor of breast (disorder)
Code System	SNOMED CT®
Reference Set Name	HealthConcernCode HealthConcernCodeSubsetCommonlyUsed
Reference Set ID	2.16.840.1.113883.2.20.3.278 2.16.840.1.113883.2.20.3.209 (Commonly Used)
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the relevant health concerns of a person sharing common ancestry with the Client.

Example of Primary Use:

Used in the provision of care. Observation Family History Health Concern Code is often recorded to note Client risk factors for diseases. For example, a woman whose mother had breast cancer may be at higher risk of developing breast cancer.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Note: While a concept domain has been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E2 Observation Family History Social Behaviour Code (Family Member Social Behaviour(s))

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	cocaine misuse (finding) physically abusive behavior (finding)
Code System	SNOMED CT®
Reference Set Name	FamilyHistorySocialBehaviourCode
Reference Set ID	2.16.840.1.113883.2.20.3.259
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the relevant social behaviours of a person sharing common ancestry with the Client. This can include risk factors such as tobacco use, alcohol use, abuse of illicit or prescription drugs.

Example of Primary Use:

Used in the provision of care. Observation Family History Social Behaviour Code is often recorded to note that the Client may have a risk factor for social behaviours and/or diseases. For example, studies have shown that people whose parents were alcoholics have a higher risk of becoming alcoholics themselves.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Note: While a concept domain has been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E3 Observation Family History Intervention Code (Family Member Interventions (Treatments))

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Coronary artery bypass grafts x 4 (procedure)
Code System	SNOMED CT®
Reference Set Name	InterventionCode InterventionCodeSubsetNonLaboratoryNonDigitalImagingDiagnosticTest InterventionCodeSubsetOperatingRoomProcedure InterventionCodeSubsetPreventEducateCounseling InterventionCodeSubsetAssessmentTool InterventionCodeSubsetCare
Reference Set ID	2.16.840.1.113883.2.20.3.270 2.16.840.1.113883.2.20.3.273 (Non Digital Imaging Diagnostic Test) 2.16.840.1.113883.2.20.3.274 (Operating Room Procedure) 2.16.840.1.113883.2.20.3.275 (Prevention/Education/Counseling) 2.16.840.1.113883.2.20.3.272 (Assessment Tool) 2.16.840.1.113883.2.20.3.271 (Care)
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the relevant interventions performed on a person sharing common ancestry with the Client.

Example of Primary Use:

Used in the provision of care. Observation Family History Interventions Code is often recorded to note that the Client may have a risk factor for diseases. In some cases, Clients may know that the family member had a specific intervention but not know the health concern behind the intervention. For example, a Client might know that his or her father had triple bypass surgery but not know the exact underlying health concern that the surgery was attempting to treat.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Note: While a concept domain has been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E4 Observation Family History Familial Relationship Code (Family Member Relationship to Patient)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Father (person)
Code System	SNOMED CT®
Reference Set Name	FamilyMemberRelationshipCode
Reference Set ID	2.16.840.1.113883.2.20.3.192
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the relationship between the Client and a person who shares a common ancestry.

Example of Primary Use:

Used in the provision of care. Observation Family History Familial Relationship Code is often recorded to note that the Client may have a risk factor for diseases and social behaviours. For example, studies have shown that people whose parents were alcoholics have a higher risk of becoming alcoholics as well. Similarly, a woman whose mother had breast cancer may be at higher risk of developing it.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Note: While a concept domain has been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E5 Observation Family History Effective Onset Age Number (Family Member Health Concern, Intervention or Social Behaviour Age at Onset)

Specifications	
Data Type	Number
Valid Format	N/A
Example Values	82
Code System	N/A

Definition:

Represents the age of the family member (in years) when the health concern, intervention or social behaviour started.

Example of Primary Use:

Used in the provision of care. Observation Family History Effective Onset Age Number is often recorded to note that the Client may be at a higher risk of developing a health concern or social behaviour at a certain age.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Note: The pan-Canadian EHR messaging standards do not currently contain any messages that use this data element.

Additional Information:

None at this time.

E6 Observation Family History Effective Start Date (Family Member Health Concern, Intervention or Social Behaviour Start Date)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the date on which the health concern, intervention or social behaviour started for the family member.

Example of Primary Use:

Used in the provision of care. Observation Family History Effective Start Date is often recorded to note that the Client may be at a higher risk of developing a health concern or social behaviour at a certain age.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Note: The pan-Canadian EHR messaging standards do not currently contain any messages that use this data element.

Additional Information:

None at this time.

E7 Observation Family History Effective End Date (Family Member Health Concern, Intervention or Social Behaviour End Date)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the date on which the health concern, intervention or social behaviour ended for the family member.

Example of Primary Use:

Used in the provision of care. Observation Family History Effective End Date is often recorded to note that the Client may be at a higher risk of developing a health concern or social behaviour at a certain age.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Note: The pan-Canadian EHR messaging standards do not currently contain any messages that use this data element.

Additional Information:

None at this time.

E8 Observation Family History Effective Deceased Date (Family Member Deceased Date)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the date on which the family member died.

Example of Primary Use:

Used in the provision of care. Observation Family History Effective Deceased Date is often recorded to note that the Client may be at a higher risk of developing a health concern or social behaviour at a certain age.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Note: The pan-Canadian EHR messaging standards do not currently contain any messages that use this data element.

Additional Information:

It has been noted that the date of a family member's death is not as commonly known as his or her approximate age at death. A data element to represent a family member's age at death might be added in the next release of the PHC EMR CS. If you need a data element to represent a family member's age at death before the next release, please send an email to phc@cihi.ca.

E9 Observation Family History Death Cause Code (Family Member Cause of Death)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	57054005 acute myocardial infarction (disorder)
Code System	SNOMED CT®
Reference Set Name	HealthConcernCode HealthConcernCodeSubsetCommonlyUsed
Reference Set ID	2.16.840.1.113883.2.20.3.278 2.16.840.1.113883.2.20.3.209 (Commonly Used)
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the clinical cause of death for the family member.

Example of Primary Use:

Used in the provision of care. Observation Family History Death Cause Code is often recorded to note that the Client may have a risk factor for diseases. For example, a woman whose mother died of breast cancer may be at higher risk of developing it.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Note: While a concept domain has been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E10 Observation Family History Familial Ethnicity Code (Family Member Ethnicity)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Japanese (ethnic group)
Code System	SNOMED CT®
Reference Set Name	EthnicityCode
Reference Set ID	2.16.840.1.113883.2.20.3.208
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the ethnicity of the family member.

Example of Primary Use:

Used in the provision of care. Observation Family History Familial Ethnicity Code is often recorded to note that the Client may have a risk factor for diseases and social behaviours. For example, some health conditions are more prominent in certain ethnic groups, such as sickle cell anemia in people with African origins.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

An equivalent concept was not found in the pan-Canadian EHR messaging and terminology standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E11 Observation Health Concern Code (Health Concern)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Appendicitis (disorder) Abdominal pain (finding)
Code System	SNOMED CT®
Reference Set Name	HealthConcernCode HealthConcernCodeSubsetCommonlyUsed
Reference Set ID	2.16.840.1.113883.2.20.3.278 2.16.840.1.113883.2.20.3.209 (Commonly Used)
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the Client's relevant clinical problems, conditions, diagnoses, symptoms, findings and complaints.

Example of Primary Use:

Used in the provision of care. Provides a longitudinal record of problems or symptoms for a Client. Clinicians can use this information to monitor the health of their Clients, recommend treatments and assist in the formation of diagnoses.

PHC Indicator Mappings:

36;39;40;50;55;56;57;58;59;60;62;63

Example Use in EHR Messaging Standards:

Found in

REPC_MT500004CA - Care Composition Detail May 8, 2007

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E12 Observation Health Concern Start Date (Health Concern Date of Onset)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the date on which the Client's health concern started.

Example of Primary Use:

Used in the provision of care. Provides a longitudinal record of problems or symptoms for a Client. Clinicians can use this information to monitor the health of their Clients, recommend treatments and assist in the formation of diagnoses.

PHC Indicator Mappings:

36;39;40;55;56;57;58;62;63

Example Use in EHR Messaging Standards:

Found in

SC-2003-EN - REPC_MT000003CA - Health Condition Record - 20090316.doc

Additional Information:

None at this time.

E13 Observation Health Concern End Date (Health Concern Date of Resolution)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the date on which the Client's health concern ended.

Example of Primary Use:

Used in the provision of care. Provides a longitudinal record of problems or symptoms for a Client. Clinicians can use this information to monitor the health of their Clients, recommend treatments and assist in the formation of diagnoses.

PHC Indicator Mappings:

36;39;40;55;56;57;58;63

Example Use in EHR Messaging Standards:

Found in

SC-2003-EN - REPC_MT000003CA - Health Condition Record - 20090316.doc

Additional Information:

None at this time.

E14 Observation Social Behaviour Code (Social Behaviour)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	heavy drinker: 7–9 u/day (finding) moderate cigarette smoker (10–19 cigs/day) (finding)
Code System	SNOMED CT®
Reference Set Name	ClientSocialBehaviourCode
Reference Set ID	2.16.840.1.113883.2.20.3.260
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents a type of Client social behaviour that increases the possibility of disease or injury for the Client. This can include risk factors such as tobacco use, alcohol use, abuse of illicit or prescription drugs.

Example of Primary Use:

Used in the provision of care. Can be used to identify Client behaviours that, if treated, could lead to improvements in the Client's health and wellness. For example, the identification and treatment of drug and alcohol problems can improve a Client's mental and physical health and social functioning.

PHC Indicator Mappings:

13;43

Example Use in EHR Messaging Standards:

Note: While a concept domain has been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E15 Observation Social Behaviour Start Date (Social Behaviour Date of Onset)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the effective date the Client started the social behaviour.

Example of Primary Use:

Used in the provision of care. Can be used to identify Client behaviours that, if treated, could lead to improvements in the Client's health and wellness. For example, the identification and treatment of drug and alcohol problems can improve a Client's mental and physical health and social functioning.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Note: While a data type has been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

None at this time.

E16 Observation Social Behaviour End Date (Social Behaviour Date of Resolution)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the effective date the Client ceased the social behaviour.

Example of Primary Use:

Used in the provision of care. Can be used to identify Client behaviours that, if treated, could lead to improvements in the Client's health and wellness. For example, the identification and treatment of drug and alcohol problems can improve a Client's mental and physical health and social functioning.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Note: While a data type has been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

None at this time.

E17 Observation Allergy/Intolerance Type Code (Allergy/Intolerance Type)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	food allergy (disorder)
Code System	SNOMED CT®
Reference Set Name	AllergyIntoleranceTypeCode
Reference Set ID	2.16.840.1.113883.2.20.3.210
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the type of allergy or intolerance a Client has.

Example of Primary Use:

Used in the provision of Care. Used to prevent adverse reactions and can be used for reminders and alerts.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

REPC_MT000001CA - Allergy Intolerance - 20090316

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E18 Observation Allergy Agent Code (Allergy Agent)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Mussels (substance)
Code System	SNOMED CT®
Reference Set Name	NonDrugAllergenCode
Reference Set ID	2.16.840.1.113883.2.20.3.269
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the specific allergen or other agent/substance to which the Client has an allergic reaction.

Example of Primary Use:

Used in the provision of care. Used to prevent adverse reactions and allergy to drug interactions and can be used for reminders and alerts.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

REPC_MT000001CA - Allergy Intolerance - 20090316

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E19 Observation Allergy/Intolerance Severity Code (Allergy/Intolerance Severity)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	severe (severity modifier) (qualifier value)
Code System	SNOMED CT®
Reference Set Name	AllergyIntoleranceSeverityCode
Reference Set ID	2.16.840.1.113883.2.20.3.213
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the level of severity a Client has in relation to an allergy or intolerance.

Example of Primary Use:

Used in the provision of care. Used to prevent adverse reactions and can be used for reminders and alerts.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

SC-2003-EN - REPC_MT000001CA - Allergy Intolerance - 20090316

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E20 Observation Allergy/Intolerance Status Code (Allergy/Intolerance Status)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Active (qualifier value)
Code System	SNOMED CT®
Reference Set Name	AllergyIntoleranceStatusCode
Reference Set ID	2.16.840.1.113883.2.20.3.211
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents whether an allergy/intolerance is active or inactive.

Example of Primary Use:

Used in the provision and administration of care. An EMR can be programmed to provide alerts for allergies/intolerances that are active.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

REPC_MT000001CA - Allergy Intolerance - March 16, 2009

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E21 Observation Allergy and or Intolerance Start Date (Allergy/Intolerance Date of Onset)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the date on which the recorded allergy/intolerance is considered active.

Example of Primary Use:

Used in the provision and administration of care. An EMR can be programmed to provide alerts for allergies/intolerances that are active.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

REPC_MT000001CA - Allergy Intolerance - March 16, 2009

Additional Information:

None at this time.

E22 Observation Allergy and or Intolerance End Date (Allergy/Intolerance Date of Resolution)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the date on which the recorded allergy/intolerance is no longer considered active.

Example of Primary Use:

Used in the provision and administration of care. An EMR can be programmed to provide alerts for allergies/intolerances that are active.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

REPC_MT000001CA - Allergy Intolerance - March 16, 2009

Additional Information:

None at this time.

E23 Observation Systolic Blood Pressure Number (Systolic Blood Pressure)

Specifications	
Data Type	Number
Valid Format	N/A
Example Values	120
Code System	N/A

Definition:

Represents the Client's systolic blood pressure value (in mmHg) as measured. The unit of measure (mmHg) is implied when representing the value.

Example of Primary Use:

Used in the provision of care. A discrete value provides the ability to graph and trend values over time. The measurement supports clinical decisions.

PHC Indicator Mappings:

40;54;55;56;57

Example Use in EHR Messaging Standards:

Found in

REPC_MT410001CA - Measured Observation Record March 16, 2009

Additional Information:

None at this time.

E24 Observation Diastolic Blood Pressure Number (Diastolic Blood Pressure)

Specifications	
Data Type	Number
Valid Format	N/A
Example Values	80
Code System	N/A

Definition:

Represents the Client's diastolic blood pressure value (in mmHg) as measured. The unit of measure (mmHg) is implied when representing the value.

Example of Primary Use:

Used in the provision of care. A discrete value provides the ability to graph and trend values over time. The measurement supports clinical decisions.

PHC Indicator Mappings:

40;54;55;56;57

Example Use in EHR Messaging Standards:

Found in

REPC_MT410001CA - Measured Observation Record March 16, 2009

Additional Information:

None at this time.

E25 Observation Blood Pressure Measurement Anatomical Location Code (Blood Pressure Body Location)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	right upper arm structure (body structure)
Code System	SNOMED CT®
Reference Set Name	BloodPressureAnatomicalLocationCode
Reference Set ID	2.16.840.1.113883.2.20.3.204
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the anatomical location on the Client's body where the blood pressure was measured.

Example of Primary Use:

Used in the provision of care. Identifies where the blood pressure was taken.

PHC Indicator Mappings:

40;55;56;57

Example Use in EHR Messaging Standards:

Found in

REPC_MT410001CA - Measured Observation Record - 20090316.doc

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E26 Observation Blood Pressure Measurement Body Position Code (Blood Pressure Body Position)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	sitting blood pressure (observable entity)
Code System	SNOMED CT®
Reference Set Name	BloodPressureBodyPositionCode
Reference Set ID	2.16.840.1.113883.2.20.3.205
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the position the Client's body was in when blood pressure was measured (for example, standing, sitting or lying).

Example of Primary Use:

Used in the provision of care. Identifies the position the Client was in when blood pressure was taken.

PHC Indicator Mappings:

40;55;56;57

Example Use in EHR Messaging Standards:

Found in

REPC_MT410001CA - Measured Observation Record - 20090316.doc

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E27 Observation Representative Blood Pressure Reading Code (Blood Pressure Representative Reading)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	True (qualifier value)
Code System	SNOMED CT®
Reference Set Name	RepresentativeBloodPressureReadingCode
Reference Set ID	2.16.840.1.113883.2.20.3.193
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents whether the Client's blood pressure reading is representative of the Client's current health condition.

Example of Primary Use:

Used in the provision of care. Identifies a blood pressure reading that appears to be non-representative at the time the reading was taken.

PHC Indicator Mappings:

40;55;56;57

Example Use in EHR Messaging Standards:

Found in

REPC_MT410001CA - Measured Observation Record – 20090316

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E28 Observation Height Number (Height)

Specifications	
Data Type	Number
Valid Format	N/A
Example Values	3.25
Code System	N/A

Definition:

Represents the height of the Client as measured.

Example of Primary Use:

Used in the provision of care. A decrease in female height could be an early sign of osteoporosis and trigger a need for a bone mineral density test.

PHC Indicator Mappings:

13;55;56;57

Example Use in EHR Messaging Standards:

Found in

REPC_MT410001CA - Measured Observation Record March 16, 2009

Additional Information:

None at this time.

E29 Observation Height Unit of Measure Code (Height Unit of Measure)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	centimeter
Code System	UCUM
Reference Set Name	HeightUnitofMeasureCode
Reference Set ID	2.16.840.1.113883.2.20.3.194
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the unit of measure used to capture the Client's height.

Example of Primary Use:

Used in the provision of care. A decrease in female height could be an early sign of osteoporosis and trigger a need for a bone mineral density test.

PHC Indicator Mappings:

13;55;56;57

Example Use in EHR Messaging Standards:

Found in

REPC_MT410001CA - Measured Observation Record March 16, 2009

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E30 Observation Weight Number (Weight)

Specifications	
Data Type	Number
Valid Format	N/A
Example Values	75.6
Code System	N/A

Definition:

Represents the weight of the Client as measured.

Example of Primary Use:

Used in the provision of care. Weight is used to calculate body mass index (BMI).

PHC Indicator Mappings:

13;55;56;57

Example Use in EHR Messaging Standards:

Found in

REPC_MT410001CA - Measured Observation Record March 16, 2009

Additional Information:

None at this time.

E31 Observation Weight Unit of Measure Code (Weight Unit of Measure)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	kilogram
Code System	UCUM
Reference Set Name	WeightUnitofMeasureCode
Reference Set ID	2.16.840.1.113883.2.20.3.195
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the unit of measure used to capture the Client's weight.

Example of Primary Use:

Used in the provision of care. Weight is used to calculate BMI.

PHC Indicator Mappings:

13;55;56;57

Example Use in EHR Messaging Standards:

Found in

REPC_MT410001CA - Measured Observation Record March 16, 2009

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E32 Observation Waist Circumference Number (Waist Circumference)

Specifications	
Data Type	Number
Valid Format	N/A
Example Values	70
Code System	N/A

Definition:

Represents the waist circumference of the Client as measured.

Example of Primary Use:

Used in the provision of care. Used to monitor and prevent onset of chronic diseases for Clients with a family health history of a specific chronic disease.

PHC Indicator Mappings:

13;55;56;57

Example Use in EHR Messaging Standards:

Found in

REPC_MT410001CA - Measured Observation Record March 16, 2009

Additional Information:

None at this time.

E33 Observation Waist Circumference Unit of Measure Code (Waist Circumference Unit of Measure)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	centimeter
Code System	UCUM
Reference Set Name	WaistCircumferenceUnitofMeasureCode
Reference Set ID	2.16.840.1.113883.2.20.3.196
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the unit of measure used to capture the Client's waist circumference.

Example of Primary Use:

Used in the provision of care. Used to monitor and prevent onset of chronic diseases for Clients with a family health history of a specific chronic disease.

PHC Indicator Mappings:

13;55;56;57

Example Use in EHR Messaging Standards:

Found in

REPC_MT410001CA - Measured Observation Record March 16, 2009

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

E34 Observation Encounter Clinical Assessment Code (Clinician Assessment)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Acute bronchitis (disorder) Abdominal distension (finding)
Code System	SNOMED CT®
Reference Set Name	HealthConcernCode HealthConcernCodeSubsetCommonlyUsed
Reference Set ID	2.16.840.1.113883.2.20.3.278 2.16.840.1.113883.2.20.3.209 (Commonly Used)
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the Provider's professional opinion of the most relevant clinical findings related to the Client's encounter. The most relevant clinical finding for the encounter can include diagnoses and symptoms.

Example of Primary Use:

Used in the provision and administration of care. The clinical assessment of the encounter can be used to help track episodes of care. Can also support the automatic creation of billing information.

PHC Indicator Mappings:

13;36;39;40;43;49;55;56;57;58;59;60;63

Example Use in EHR Messaging Standards:

Note: While concept domains have been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

F1 Intervention Code (Intervention (Treatment))

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Smoking cessation education (procedure) Appendectomy (procedure)
Code System	SNOMED CT®
Reference Set Name	InterventionCode InterventionCodeSubsetNonLaboratoryNonDigitalImagingDiagnosticTest InterventionCodeSubsetOperatingRoomProcedure InterventionCodeSubsetPreventEducateCounseling InterventionCodeSubsetAssessmentTool InterventionCodeSubsetCare
Reference Set ID	2.16.840.1.113883.2.20.3.270 2.16.840.1.113883.2.20.3.273 (Non Digital Imaging Diagnostic Test) 2.16.840.1.113883.2.20.3.274 (Operating Room Procedure) 2.16.840.1.113883.2.20.3.275 (Prevention/Education/Counseling) 2.16.840.1.113883.2.20.3.272 (Assessment Tool) 2.16.840.1.113883.2.20.3.271 (Care)
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the services/activities performed or intended to be performed by the PHC Provider as well as interventions performed by other Providers for the Client (referral).

Example of Primary Use:

Used in the provision of care. Tracked interventions performed on a Client can help guide future interventions. Used to track Client's progressive improvement on the continuum of care timeline (for example, counselling for smoking cessation delivered in 2008, blood pressure and drug administered show positive improvement today).

PHC Indicator Mappings:

13;43;49;50

Example Use in EHR Messaging Standards:

Found in

REPC_MT610001CA - Professional Service

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

F2 Intervention Date (Intervention (Treatment) Date)

Specifications	
Data Type	Date
Valid Format	YYYY[MM[DD]]
Example Values	20100430
Code System	N/A

Definition:

Represents the date the intervention was performed or intended to be performed by the Provider for the Client.

Example of Primary Use:

Used in the provision of care to track the date a particular intervention was performed by the Provider.

PHC Indicator Mappings:

13;49;50

Example Use in EHR Messaging Standards:

Found in

REPC_MT610001CA - Professional Service

Additional Information:

None at this time.

F3 Intervention Refusal Reason Code (Intervention (Treatment) Refusal Reason)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	has religious belief (finding)
Code System	SNOMED CT®
Reference Set Name	ReasonInterventionRefusedCode
Reference Set ID	2.16.840.1.113883.2.20.3.263
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the reason the Client refused an intervention.

Example of Primary Use:

Used in the provision of care. Can be used to ensure an intervention already refused by a Client is not repeatedly offered to the Client.

PHC Indicator Mappings:

13;43;49;50

Example Use in EHR Messaging Standards:

Not found in any of the pan-Canadian EHR messaging and terminology standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

G1 Laboratory Test Name Ordered Code (Lab Test Ordered)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Hemoglobin A1c in Blood
Code System	LOINC®, pCLOCD
Reference Set Name	ObservationOrderableLabType ObservationOrderableLabTypeSubsetCommonlyUsed
Reference Set ID	2.16.840.1.113883.2.20.3.164 2.16.840.1.113883.2.20.3.276 (Commonly Used)
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the lab test ordered by the Provider for the Client.

Example of Primary Use:

Used in the provision of care. Lab tests are ordered in the provision of care for many reasons, including confirmation of suspected diagnoses. The lab test name is required to know what test is being ordered. Clear identification of lab test name and value.

PHC Indicator Mappings:

48;52;53;55;56;57

Example Use in EHR Messaging Standards:

Found in

POLB_MT001000CA - Laboratory Placer Order – 20090316

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

G2 Laboratory Test Order Date (Lab Test Ordered Date)

Specifications	
Data Type	Date
Valid Format	YYYYMMDD
Example Values	20100430
Code System	N/A

Definition:

Represents the date the lab test was ordered by the Provider.

Example of Primary Use:

Used in both the provision and administration of care. Schedule future appointments based on the tracked turnaround time of lab tests.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

SC-2003-EN - POLB_MT001000CA - Laboratory Placer Order – 20090316

Additional Information:

None at this time.

H1 Laboratory Test Performed Date (Lab Test Performed Date)

Specifications	
Data Type	date
Valid Format	YYYYMMDD
Example Values	20100430
Code System	N/A

Definition:

Represents the date the lab test was performed.

Example of Primary Use:

Used in both the provision and administration of care. Schedule future appointments based on the tracked turnaround time of laboratory tests.

PHC Indicator Mappings:

39;48;52;53;55;56;57

Example Use in EHR Messaging Standards:

Found in

POLB_MT004000CA - Laboratory Result Event - 20090316

1.6.3 Result Observation Date/Time

Additional Information:

None at this time.

H2 Laboratory Test Result Name Code (Lab Test Name)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Hemoglobin [Mass/volume] in Blood
Code System (OID)	LOINC®, pCLOCD
Reference Set Name	ObservationResultableLabType ObservationResultableLabTypeSubsetCommonlyUsed
Reference Set ID	2.16.840.1.113883.2.20.3.105 2.16.840.1.113883.2.20.3.210 (Commonly Used)
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the name of the lab test performed.

Example of Primary Use:

Used in both the provision and administration of care to ensure that the name of the test performed is understood by the Provider, researcher, etc.

PHC Indicator Mappings:

39

Example Use in EHR Messaging Standards:

Found in

POLB_MT004000CA - Laboratory Result Event – 20090316

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

H3 Laboratory Test Result Value Text (Number, Code) (Lab Test Result Value)

Specifications	
Data Type	String (Number, Text)
Valid Format	N/A
Example Values	Sickle cell trait
Code System	N/A

Definition:

Represents the result of the lab test.

Example of Primary Use:

Used in the provision of care. Lab tests are ordered in the provision of care for many reasons, including confirmation of suspected diagnoses. Blood sugar monitoring (Accu-Chek) values are tracked over time and compared with yearly Hb1Ac test results at a central lab.

PHC Indicator Mappings:

39

Example Use in EHR Messaging Standards:

Found in

POLB_MT004000CA - Laboratory Result Event – 20090316

Additional Information:

None at this time.

H4 Laboratory Test Result Value Unit of Measure Code (Lab Test Result Unit of Measure)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	mg/mmol (milligram per millimole)
Code System	UCUM
Reference Set Name	LaboratoryTestResultUnitofMeasureCode
Reference Set ID	2.16.840.1.113883.2.20.3.206
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the unit of measure of the lab result for the lab test performed.

Example of Primary Use:

Used in the provision of care. Ensures that the unit of measure associated with the value is provided.

PHC Indicator Mappings:

39

Example Use in EHR Messaging Standards:

Found in

POLB_MT004000CA - Laboratory Result Event – 20090316

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

H5 Laboratory Test Result Reference Range Low Number (Lab Test Result Low Range)

Specifications	
Data Type	Number
Valid Format	N/A
Example Values	0.5
Code System	N/A

Definition:

Represents the low end of a normal reference range lab result for a particular test performed in a particular lab.

Example of Primary Use:

Used in the provision of care. Lab tests are ordered in the provision of care for many reasons, including confirmation of suspected diagnoses. The reference range is required to determine whether the lab test result is normal and can be used to flag and alert the Provider to potential issues. For example, if the HbA1c is 6.5 but the Client has a family history of diabetes, preventive measures should be initiated.

PHC Indicator Mappings:

39

Example Use in EHR Messaging Standards:

Found in

SC-2003-EN - POLB_MT004000CA - Laboratory Result Event – 20090316

Additional Information:

None at this time.

H6 Laboratory Test Result Reference Range Low Unit of Measure Code (Lab Test Result Unit of Measure)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	mg (milligram)
Code System	UCUM
Reference Set Name	LaboratoryTestResultUnitofMeasureCode
Reference Set ID	2.16.840.1.113883.2.20.3.206
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the unit of measure associated with the Lab Test Result Reference Range Low Number.

Example of Primary Use:

Used in the provision of care. Ensures that the unit of measure is associated with the value as provided.

PHC Indicator Mappings:

39

Example Use in EHR Messaging Standards:

Found in

POLB_MT004000CA - Laboratory Result Event – 20090316

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

H7 Laboratory Test Result Reference Range High Number (Lab Test Result High Range)

Specifications	
Data Type	Number
Valid Format	N/A
Example Values	2.5
Code System	N/A

Definition:

Represents the high end of a normal reference range lab result for a particular test performed in a particular lab.

Example of Primary Use:

Used in the provision of care. Lab tests are ordered in the provision of care for many reasons, including confirmation of suspected diagnoses. The reference range is required to determine whether the lab test result is normal and can be used to flag and alert the Provider to potential issues. For example, if the HbA1c is 6.5 but the Client has a family history of diabetes, preventive measures should be initiated.

PHC Indicator Mappings:

39

Example Use in EHR Messaging Standards:

Found in

SC-2003-EN - POLB_MT004000CA - Laboratory Result Event – 20090316

Additional Information:

None at this time.

H8 Laboratory Test Result Reference Range High Unit of Measure Code (Lab Test Result Range Unit of Measure)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	mg (milligram)
Code System	UCUM
Reference Set Name	LaboratoryTestResultUnitofMeasureCode
Reference Set ID	2.16.840.1.113883.2.20.3.206
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the unit of measure associated with the Lab Test Result Reference Range High Number.

Example of Primary Use:

Used in the provision of care. Ensures that the unit of measure is associated with the value as provided.

PHC Indicator Mappings:

39

Example Use in EHR Messaging Standards:

Found in

POLB_MT004000CA - Laboratory Result Event – 20090316

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

I1 Diagnostic Imaging Test Ordered Code (Diagnostic Imaging Test Ordered)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	cardiovascular diagnostic imaging procedure
Code System	TBD

Definition:

Represents the type of diagnostic imaging test ordered by the Provider for the Client.

Example of Primary Use:

Used in the provision of care. Diagnostic images can be used to assist in the confirmation of suspected diagnoses.

PHC Indicator Mappings:

49;51

Example Use in EHR Messaging Standards:

Note: While concept domains have been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

This data element requires a PHC reference set, but one has not yet been developed.
For additional information, send an email to standards@infoway-inforoute.ca.

I2 Diagnostic Imaging Test Ordered Date (Diagnostic Imaging Test Ordered Date)

Specifications	
Data Type	Date
Valid Format	YYYYMMDD
Example Values	20100430
Code System	N/A

Definition:

Represents the date the diagnostic imaging test was ordered by the Provider.

Example of Primary Use:

Used in both the provision and administration of care. Schedule future appointments based on the tracked turnaround time of diagnostic imaging tests.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Note: While a data type has been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

None at this time.

J1 Diagnostic Imaging Test Performed Date (DI Test Performed Date)

Specifications	
Data Type	Date
Valid Format	YYYYMMDD
Example Values	20100430
Code System	N/A

Definition:

Represents the date the diagnostic imaging test was performed.

Example of Primary Use:

Used in both the provision and administration of care. Schedule future appointment based on the tracked turnaround time of diagnostic imaging tests.

PHC Indicator Mappings:

49

Example Use in EHR Messaging Standards:

Note: While a data type has been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

None at this time.

K1 Referral Service Code (Referral)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	ear, nose and throat service (qualifier value)
Code System	SNOMED CT®
Reference Set Name(s)	ReferralServiceCode ReferralServiceCodeSubsetService ReferralServiceCodeSubsetPhysician ReferralServiceCodeSubsetNurse ReferralServiceCodeSubsetOtherProvider
Reference Set ID	2.16.840.1.113883.2.20.3.197 2.16.840.1.113883.2.20.3.198 (Service) 2.16.840.1.113883.2.20.3.199 (Physician) 2.16.840.1.113883.2.20.3.200 (Nurse) 2.16.840.1.113883.2.20.3.201 (Other)
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the type of service required for the Client.

Example of Primary Use:

Codes that identify different types of referral requests. Identifies the general type of care or category of services requested. Not used to represent the indication or diagnosis that triggered the need for the referral.

PHC Indicator Mappings:

58

Example Use in EHR Messaging Standards:

Found in

REPC_MT210001CA - Referral Record - March 16, 2009

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

K2 Referral Requested Date (Referral Requested Date)

Specifications	
Data Type	Date
Valid Format	YYYYMMDD
Example Values	20100430
Code System	N/A

Definition:

Represents the date the referral request was created by the primary health care Provider.

Example of Primary Use:

Used in provision of care and administration of care. Assists Providers in tracking when a request to obtain a consult was first requested.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Note: While a data type has been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

None at this time.

L1 Referral Occurred Date (Referral Occurred Date)

Specifications	
Data Type	Date
Valid Format	YYYYMMDD
Example Values	20100430
Code System	N/A

Definition:

Represents the actual date the Client had the encounter with the referred-to Provider.

Example of Primary Use:

Used in both the provision and administration of care. Assists Providers in understanding which referral partners have longer wait times. Determine the wait time of Clients and develop accurate future scheduling times for selected reasons for visit and referrals.

PHC Indicator Mappings:

58

Example Use in EHR Messaging Standards:

To be determined. The date of the referral encounter could show in several messages, depending on what the referral is for.

REPC_MT500004CA - Care Composition Detail May 8, 2007

Additional Information:

None at this time.

M1 Medication Prescribed Name Code (Prescribed Medication)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	Amoxicillin
Code System	TBD

Definition:

Represents the medications prescribed (or intended to be prescribed) to the Client.

Example of Primary Use:

Used in the provision of care. Can be used to create a longitudinal medication record to support the provision of care.

PHC Indicator Mappings:

59;60;62;63

Example Use in EHR Messaging Standards:

Found in

PORX_MT010120CA - Rx Drug Order – 20090316

Additional Information:

This data element requires a PHC reference set, but one has not yet been developed. For additional information, send an email to standards@infoway-inforoute.ca.

M2 Medication Prescribed Date (Prescription Date)

Specifications	
Data Type	Date
Valid Format	YYYYMMDD
Example Values	20100430
Code System	N/A

Definition:

Represents the date the prescription for the medication was created for the Client.

Example of Primary Use:

Used in the provision of care. Can be used to create a longitudinal medication record to support the provision of care.

PHC Indicator Mappings:

59;60;62;63

Example Use in EHR Messaging Standards:

Represents the first date in the interval defined by the “dispensing allowed period” found in

PORX_MT010120CA - Rx Drug Order – 20090316

Additional Information:

None at this time.

M3 Medication Prescribed Expected Completion Date (Prescription Expected Completion Date)

Specifications	
Data Type	Date
Valid Format	YYYYMMDD
Example Values	20100430
Code System	N/A

Definition:

Represents the date the prescribed medication is expected to be finished on.

Example of Primary Use:

Used in the provision of care. Can be used to create a longitudinal medication record to support the provision of care.

PHC Indicator Mappings:

62

Example Use in EHR Messaging Standards:

Represents the last date in the interval defined by the “dispensing allowed period” found in

PORX_MT010120CA - Rx Drug Order – 20090316

Additional Information:

None at this time.

M4 Medication Prescribed Stopped Date (Prescription Stop Date)

Specifications	
Data Type	Date
Valid Format	YYYYMMDD
Example Values	20100430
Code System	N/A

Definition:

Represents the last date the Client took the prescribed medication.

Example of Primary Use:

Used in both the provision and administration of care. Provides historical and current medication profile for the Client.

PHC Indicator Mappings:

59;60;62;63

Example Use in EHR Messaging Standards:

Not found in any of the pan-Canadian EHR messaging and terminology standards.

Additional Information:

None at this time.

M5 Medication Prescribed Strength Number (Medication Strength)

Specifications	
Data Type	Number
Valid Format	N/A
Example Values	100
Code System	N/A

Definition:

Represents the potency of the drug/chemical, usually measured in metric weight (for example, micrograms, milligrams or grams) and described as the strength of the product's active (medicinal) ingredient.

Example of Primary Use:

Used in both the provision and administration of care. Conveys the potency of the drug to be dispensed for the Client's treatment.

PHC Indicator Mappings:

59

Example Use in EHR Messaging Standards:

Represents the numeric component of the "drug ingredient quantity" found in

COCT_MT220200CA - Medication administrable – 20090316

Additional Information:

None at this time.

M6 Medication Prescribed Strength Unit of Measure Code (Medication Strength Unit of Measure)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	mg
Code System	TBD

Definition:

Represents the units of measure for the Medication Prescribed Strength Number.

Example of Primary Use:

Used in both the provision and administration of care. Conveys the unit of measure for the strength (potency) of the drug to be dispensed for the Client's treatment.

PHC Indicator Mappings:

59

Example Use in EHR Messaging Standards:

Represents the unit of measure component of the "drug ingredient quantity" found in

COCT_MT220200CA - Medication administrable – 20090316

Additional Information:

This data element requires a PHC reference set, but one has not yet been developed. For additional information, send an email to standards@infoway-inforoute.ca.

M7 Medication Prescribed Dose Number (Medication Dosage)

Specifications	
Data Type	Number
Valid Format	N/A
Example Values	100
Code System	N/A

Definition:

Represents the measured portion of a drug to be taken at any one time that pertains to the drug prescribed.

Example of Primary Use:

Used in the provision of care. Used with Client weight and age to determine ideal dose for the Client.

PHC Indicator Mappings:

59

Example Use in EHR Messaging Standards:

Found in

PORX_MT010120CA - Rx Drug Order – 20090316

Additional Information:

None at this time.

M8 Medication Prescribed Dose Unit of Measure Code (Medication Dose Unit of Measure)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	mg (milligram)
Code System	UCUM
Reference Set Name	MedicationPrescribedDoseUnitofMeasureCode
Reference Set ID	2.16.840.1.113883.2.20.3.202
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the unit of measure of a drug dose taken at any one time.

Example of Primary Use:

Used in the provision of care. Used with Client weight and age to determine ideal dose for the Client.

PHC Indicator Mappings:

59

Example Use in EHR Messaging Standards:

Found in

PORX_MT010120CA - Rx Drug Order – 20090316

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

M9 Medication Prescribed Form Code (Medication Form)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	NDROP (Nasal Drops)
Code System	TBD

Definition:

The physical configuration or presentation of state of matter of any given drug product. The dosage form in which the medication is administered (such as tablet, liquid, suppository or solution).

Example of Primary Use:

Used in both the provision and administration of care. Ensures that the right form of the prescribed medication is provided to the Client as required for treatment.

PHC Indicator Mappings:

59

Example Use in EHR Messaging Standards:

Found in

PORX_MT010120CA - Rx Drug Order – 20090316

Additional Information:

This data element requires a PHC reference set, but one has not yet been developed. For additional information, send an email to standards@infoway-inforoute.ca.

M10 Medication Prescribed Frequency Text (Medication Frequency)

Specifications	
Data Type	String/General Timing Specification
Valid Format	N/A
Example Values	2 tablets/24 hours
Code System	N/A

Definition:

Represents the number of occurrences within a given time period that a dose of a drug is to be administered.

Example of Primary Use:

Used in the provision of care to ensure that the Client takes the medication as required during a specified period of time, helping to ensure the efficiency of the treatment and to prevent any unintended medication overdose.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

PORX_MT010120CA - Rx Drug Order – 20090316

Additional Information:

None at this time.

M11 Medication Prescribed Route Code (Medication Route)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	NASINHL (nasal inhalant)
Code System	TBD

Definition:

Represents the part of the body on which, through which or into which a drug product is to be introduced. A drug product can have more than one route of administration.

Example of Primary Use:

Used in the provision of care. Provides instructions to the Client regarding how the medication is to be taken (for example, as a suppository versus orally).

PHC Indicator Mappings:

59

Example Use in EHR Messaging Standards:

Found in

PORX_MT010120CA - Rx Drug Order – 20090316

Additional Information:

This data element requires a PHC reference set, but one has not yet been developed. For additional information, send an email to standards@infoway-inforoute.ca.

M12 Medication Prescribed Repeat Number (Medication Number of Repeat/Refill(s))

Specifications	
Data Type	Number
Valid Format	N/A
Example Values	2
Code System	N/A

Definition:

Represents the number of times the prescription can be used to refill the prescribed medication.

Example of Primary Use:

Used in the provision of care. Provides instructions on how often a particular prescription can be refilled and the potential need for a follow-up reminder to the Provider for this Client.

PHC Indicator Mappings:

59

Example Use in EHR Messaging Standards:

Found in

PORX_MT010120CA - Rx Drug Order – 20090316

Additional Information:

None at this time.

M13 Medication Prescribed Not Given Reason Code (Medication Not Prescribed Reason)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	PATINELIG (patient not eligible) AGE (Age Alert)
Code System	TBD

Definition:

Represents the reason why a preferred medication was not prescribed to a Client.

Example of Primary Use:

Used in both the provision and administration of care. Explains why a Provider was not able to prescribe a medication at the time of an encounter. Can serve as a reminder for future provision of care as to why a particular medication may not be suitable for an individual.

PHC Indicator Mappings:

62

Example Use in EHR Messaging Standards:

Note: While concept domains have been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

This data element requires a PHC reference set, but one has not yet been developed. For additional information, send an email to standards@infoway-inforoute.ca.

M14 Medication Prescribed Adherence Code (Medication Compliance)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	true (qualifier value) false (qualifier value)
Code System	SNOMED CT®
Reference Set Name	MedicationPrescribedAdherenceCode
Reference Set ID	2.16.840.1.113883.2.20.3.258
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents whether or not the Client has been administering the prescribed medication(s) as instructed.

Example of Primary Use:

Used in both the provision and administration of care. Documents that a Client did not take the prescribed drug and can be used to inform subsequent provision of care. For example, upon taking Prevacid, a Client developed diarrhea and discontinued use of the drug.

PHC Indicator Mappings:

60;63

Example Use in EHR Messaging Standards:

Note: While a data type has been referenced, this exact data element does not currently exist in the pan-Canadian EHR messaging standards.

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

N1 Medication Dispensed Code (Medication Dispensed)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	gen-acebutolol 200 mg
Code System	TBD

Definition:

Represents the medication that was dispensed to the Client.

Example of Primary Use:

Used in the provision of care. Can be used to create a longitudinal medication record to support the provision of care.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

PORX_MT020070CA - Drug Dispense – 20090316

Additional Information:

This data element requires a PHC reference set, but one has not yet been developed. For additional information, send an email to standards@infoway-inforoute.ca.

N2 Medication Dispensed Date (Medication Dispensed Date)

Specifications	
Data Type	Date
Valid Format	YYYYMMDD
Example Values	20100430
Code System	N/A

Definition:

Represents the date the medication was dispensed to the Client.

Example of Primary Use:

Used in the provision of care. Can be used to create a longitudinal medication record to support the provision of care.

PHC Indicator Mappings:

59;60;63

Example Use in EHR Messaging Standards:

Found in

PORX_MT020070CA - Drug Dispense – 20090316

Additional Information:

None at this time.

O1 Vaccine Administered Name Code (Vaccine Administered)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	influenza virus vaccine (product)
Code System	SNOMED CT®
Reference Set Name	VaccineAdministeredNameCode
Reference Set ID	2.16.840.1.113883.2.20.3.264
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the name of the vaccine that was administered to the Client.

Example of Primary Use:

Used in the provision of care. Can be used to create reminders to offer a vaccine or to flag that a vaccine has already been given and does not need to be re-administered until a specific future date.

PHC Indicator Mappings:

41;42;44

Example Use in EHR Messaging Standards:

Found in

POIZ_MT030050CA - Immunization – February 7, 2008

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

O2 Vaccine Administered Date (Vaccine Administered Date)

Specifications	
Data Type	Date
Valid Format	YYYYMMDD
Example Values	20100430
Code System	N/A

Definition:

Represents the date the vaccine was administered to the Client.

Example of Primary Use:

Used in the provision of care. Can be used to ensure that only Clients who have not received an offer to vaccinate receive reminders or to flag that a vaccine has already been given and does not need to be re-administered until a specific future date.

PHC Indicator Mappings:

41;42;44

Example Use in EHR Messaging Standards:

Found in

POIZ_MT030050CA - Immunization – February 7, 2008

Additional Information:

None at this time.

O3 Vaccine Administered Lot Number (Vaccine Administered Lot Number)

Specifications	
Data Type	Identifier
Valid Format	N/A
Example Values	89765
Code System	N/A

Definition:

Represents the batch identification number of the vaccine.

Example of Primary Use:

Used in the provision of care. Can be used to contact Clients who received a particular lot number of a vaccine substance.

PHC Indicator Mappings:

Used for supplementary analysis and reporting.

Example Use in EHR Messaging Standards:

Found in

POIZ_MT030050CA – Immunization

Additional Information:

None at this time.

O4 Vaccine Not Given Reason Code (Reason Vaccine Not Given)

Specifications	
Data Type	Code
Valid Format	N/A
Example Values	patient currently pregnant
Code System	SNOMED CT®
Reference Set Name	ReasonVaccineNotAdministeredCode
Reference Set ID	2.16.840.1.113883.2.20.3.261
PHC Ref Set Location	https://infocentral.infoway-inforoute.ca/2_Standards/1_pan-Canadian_Standards/Terminology/4_SNOMED_CT_Terminologies

Definition:

Represents the reason a vaccine was not administered to a Client.

Example of Primary Use:

Used in the provision of care. Explains why a Client may have been offered a vaccination but refused or why the vaccine was not given for other reasons. Can be required for physicians who participate in pay-for-performance programs.

PHC Indicator Mappings:

41;42;44

Example Use in EHR Messaging Standards:

Found in

POIZ_MT030050CA - Immunization – February 7, 2008

Additional Information:

For additional information on the ref sets, refer to the *Reference Set Implementation Guide—Primary Health Care* or send an email to standards@infoway-inforoute.ca.

Contact Information

For more information on the PHC EMR CS or to learn more about PHC in Canada, please contact CIHI's Primary Health Care Information program via email at phc@cihi.ca or visit the website at www.cihi.ca/phc. This online resource provides easy access to important pan-Canadian PHC information, including the *Primary Health Care Indicators Chartbook*, the *Draft Pan-Canadian Primary Health Care Electronic Medical Record Content Standard, Version 2.0—Business View*, the *Primary Health Care Electronic Medical Record Content Standard Expected Benefits Information Sheet,* and supporting materials such as a project information sheet, frequently asked questions and a simplified view of the 106 data elements.

Appendix A: Glossary of Terms

Term	Acronym (if Applicable)	Description
Canadian Institute for Health Information	CIHI	The Canadian Institute for Health Information is an independent, not-for-profit organization that provides essential data and analysis on Canada's health system and the health of Canadians.
Clinical Data Warehouse	CDW	An overarching term for health information data warehouse. This is an enterprise-level system to facilitate query and analysis of health care data.
Clinical Program Management		Use of data for direct management of health services and programs, including quality improvement and decision support (at the program level).
Electronic Health Record	EHR	An electronic health record (commonly known as an EHR) is a secure and private lifetime record of an individual's health and care history, available electronically to authorized health care providers.
Electronic Medical Record	EMR	The electronic medical record is provider-centric, focuses on medical or physician-specific information and is configured to reflect the needs of individual physicians or groups of physicians who are directly caring for a patient. The EMR is a record of each and every patient encounter and contains detailed encounter information. This is also the system where patient results (such as laboratory, diagnostic imaging and other reports ordered by a provider) are delivered to that provider's electronic inbox (that is, this information is pushed to the provider, negating the need for the provider to go out and seek it).
Health Level 7	HL7	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. For more information on HL7, please visit https://sl.infoway-inforoute.ca/content/dispPage.asp?cw_page=infostand_hl7can_e.
Health System Use	HSU	Health system use of information refers to the use of health information to monitor, manage and improve the health of Canadians and the health care system. Health system use of information also supports the delivery of care and patient outcomes.
International Organization for Standardization	ISO	ISO is an international developer and publisher of standards. It consists of a network of national standards institutes in 163 countries. For more information on ISO, please visit www.iso.org.

Term	Acronym (if Applicable)	Description
Master Terminology Worksheet	MTW	An Excel file developed and maintained by Canada Health Infoway's Standards Collaborative that provides the classification and status for all coded concept domains and value sets for the following pan-Canadian EHR HL7 V3 messaging domains: Infrastructure, Shared Interactions, Client Registry, Provider Registry, Location Registry, Shared Health Record, Pharmacy, Laboratory, Immunization, Claims and Record Access (includes Consent).
Object Identifier	OID	An OID is a set of numbers used to precisely identify an object or concept.
Pan-Canadian Laboratory Observation Code Database	pCLOCD	The pan-Canadian Laboratory Observation Code Database (pCLOCD) Nomenclature Standard was created using the LOINC® records and attributes that specifically meet Canadian laboratory ordering and reporting requirements. For more information on pCLOCD, please visit https://sl.infoway-inforoute.ca/content/disppage.asp?cw_page=standards_maintenance_e.
Physician Office System Requirements	POSR	The purpose of the pan-Canadian physician office system requirements (POSR) exercise was to collaboratively identify core requirements based on experiences from across the country to assist jurisdictions in the management of EMR specifications. Stakeholders for this initiative include individual physicians and jurisdictions that are preparing for or are in the midst of the procurement process. The Standards Collaborative Strategic Committee recommended that, due to known POSR limitations, stakeholders should be aware of these limitations and exercise diligence in use of POSR. For more information, contact the Standards Collaborative Infodesk by email at standards@infoway-inforoute.ca or by phone at 1-877-595-3417 (toll-free) or 416-595-3417 (local).
Point of Service	POS	Refers to clinical systems used by a clinical provider at the point of care.
Primary Health Care Reference Sets	PHC Ref Sets	PHC reference sets are effectively a constrained list of allowable values from the source code system(s) that are applicable to the delivery and administration of PHC. They support the implementation of the PHC EMR CS by facilitating standardization of PHC data for primary and health system use.
Secondary Use		Expression sometimes employed to describe the use of data for purposes other than the primary reason for its collection, adding value to this data. Secondary use of data is increasingly described as health system use of data.
Statistics Canada		Statistics Canada is a federal organization responsible for producing statistics that help Canadians better understand characteristics of Canada's population, resources, economy, society and culture. For more information on Statistics Canada, please visit www.statcan.gc.ca/.

Term	Acronym (if Applicable)	Description
Surveillance		The ongoing, systematic collection, analysis and interpretation of data essential to the planning, implementation and evaluation of public health practice, closely integrated with the timely dissemination of this data to those responsible for prevention and control.
Systematized Nomenclature of Medicine—Clinical Terms	SNOMED CT®	SNOMED CT® provides the core general terminology for the EHR and contains more than 311,000 concepts with unique meanings and formal logic-based definitions organized into hierarchies. When implemented in software applications, SNOMED CT® can be used to represent clinically relevant information consistently, reliably and comprehensively as an integral part of producing electronic health records. For more information on SNOMED CT®, please visit https://sl.infoway-inforoute.ca/content/dispPage.asp?cw_page=snomedct_e.
Unified Code for Units of Measure	UCUM	A code system intended to include all units of measure currently in use in international science. For more information on UCUM, please visit www.unitsofmeasure.org/.

Appendix B: Pan-Canadian Primary Health Care Indicators

This information comes from the *Pan-Canadian Primary Health Care Indicators Report 1, Volume 2*, which is available from www.cihi.ca/phc.

Indicator Number	Indicator Definition
13	Percentage of PHC clients/patients, age 12 and older, who were screened by their PHC provider for the following common health risks over the past 12 months: • Tobacco use; • Unhealthy eating habits; • Problem drug use; • Physical inactivity; • Overweight status; • Problem alcohol drinking; • Unintentional injuries (home risk factors); • Unsafe sexual practices; and • Unmanaged psychosocial stress and/or depression.
36	Percentage of PHC clients/patients, age 18 to 64, with established diabetes mellitus (type 1 and type 2) who have had an acute myocardial infarction or an above- or below-knee amputation or who began chronic dialysis within the past 12 months.
39	Percentage of PHC clients/patients, age 18 and older, with diabetes mellitus in whom the last HbA1c was 7.0% or less (or equivalent test/reference range depending on local laboratory) in the last 15 months.
40	Percentage of PHC clients/patients, age 18 and older, with hypertension for a duration of at least one year, who have blood pressure measurement control (that is, less than 140/90 mmHg).
41	Percentage of PHC clients/patients, age 65 and older, who received an influenza immunization within the past 12 months.
42	Percentage of PHC clients/patients, age 65 and older, who have received a pneumococcal immunization.
43	Percentage of PHC clients/patients who received screenings for congenital hip displacement, eye problems and hearing problems by age 3.
44	Percentage of PHC clients/patients who received required primary childhood immunizations by age 7.
48	Percentage of PHC clients/patients, age 50 and older, who received screening for colon cancer with Hemoccult test within the past 24 months.
49	Percentage of female PHC clients/patients, age 50 to 69, who received mammography and clinical breast examination within the past 24 months.
50	Percentage of female PHC clients/patients, age 18 to 69, who received a Papanicolaou smear within the past three years.
51	Percentage of female PHC clients/patients, age 65 and older, who received screening for low bone mineral density at least once.
52	Percentage of female PHC clients/patients, age 55 and older, who had a full fasting lipid profile measured within the past 24 months.
53	Percentage of male PHC clients/patients, age 40 and older, who had a full fasting lipid profile measured within the past 24 months.
54	Percentage of PHC clients/patients, age 18 and older, who had their blood pressure measured within the past 24 months.

Indicator Number	Indicator Definition
55	Percentage of PHC clients/patients, age 18 and older, with coronary artery disease who received annual testing, within the past 12 months, for all of the following: • Fasting blood sugar; • Full fasting lipid profile screening; • Blood pressure measurement; and • Obesity/overweight screening.
56	Percentage of PHC clients/patients, age 18 and older, with hypertension who received annual testing, within the past 12 months, for all of the following: • Fasting blood sugar; • Full fasting lipid profile screening; • Test to detect renal dysfunction (for example, serum creatinine); • Blood pressure measurement; and • Obesity/overweight screening.
57	Percentage of PHC clients/patients, age 18 and older, with diabetes mellitus who received annual testing, within the past 12 months, for all of the following: • Hemoglobin A1c testing (HbA1c); • Full fasting lipid profile screening; • Nephropathy screening (for example, albumin/creatinine ratio, microalbuminuria); • Blood pressure measurement; and • Obesity/overweight screening.
58	Percentage of PHC clients/patients, age 18 to 75, with diabetes mellitus who saw an optometrist or ophthalmologist within the past 24 months.
59	Percentage of PHC clients/patients, age 6 to 55, with asthma, who were dispensed high amounts (more than four canisters) of short-acting beta2-agonist within the past 12 months **and** who received a prescription for preventer/controller medication (for example, inhaled corticosteroid).
60	Percentage of PHC clients/patients, age 18 and older, with congestive heart failure, who are using ACE inhibitors or angiotensin receptor blockers.
62	Percentage of PHC clients/patients who have had an acute myocardial infarction and are currently prescribed a beta-blocking drug.
63	Percentage of PHC clients/patients with depression who are taking antidepressant drug treatment under the supervision of a PHC provider and who had follow-up contact by a PHC provider for review within two weeks of initiating antidepressant drug treatment.

Production of this report is made possible by financial contributions from Health Canada and provincial and territorial governments. The views expressed herein do not necessarily represent the views of Health Canada or any provincial or territorial government.

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ISBN 978-1-77109-087-2 (PDF)

How to cite this document:
Canadian Institute for Health Information, *Draft Pan-Canadian Primary Health Care Electronic Medical Record Content Standard, Version 2.1—Implementation Guide* (Ottawa, Ont.: CIHI, 2012).

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