
**Health informatics — Electronic health
record communication —**

**Part 3:
Reference archetypes and term lists**

*Informatique de santé — Communication du dossier de santé
informatisé —*

Partie 3: Archétypes de référence et listes de termes



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Published in Switzerland

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Foreword

ISO (the International Organization for Standardization) is a worldwide federation of national standards bodies (ISO member bodies). The work of preparing International Standards is normally carried out through ISO technical committees. Each member body interested in a subject for which a technical committee has been established has the right to be represented on that committee. International organizations, governmental and non-governmental, in liaison with ISO, also take part in the work. ISO collaborates closely with the International Electrotechnical Commission (IEC) on all matters of electrotechnical standardization.

International Standards are drafted in accordance with the rules given in the ISO/IEC Directives, Part 2.

The main task of technical committees is to prepare International Standards. Draft International Standards adopted by the technical committees are circulated to the member bodies for voting. Publication as an International Standard requires approval by at least 75 % of the member bodies casting a vote.

Attention is drawn to the possibility that some of the elements of this document may be the subject of patent rights. ISO shall not be held responsible for identifying any or all such patent rights.

ISO 13606-3 was prepared by Technical Committee ISO/TC 215, *Health informatics*.

ISO 13606 consists of the following parts, under the general title *Health informatics — Electronic health record communication*:

- *Part 1: Reference model*
- *Part 2: Archetype interchange specification*
- *Part 3: Reference archetypes and term lists*
- *Part 5: Interface specification*

The following part is in preparation:

- *Part 4: Security*

Introduction

0.1 Summary

This part of ISO 13606 contains two kinds of specification:

- 1) a normative set of (coded) term lists that each define a controlled vocabulary for a Reference Model attribute that is defined in ISO 13606-1;
- 2) an informative set of reference archetypes, expressed as mappings that each specify how the Reference Model in ISO 13606-1 should be used to represent information originating from
 - the set of HL7 Version 3 Acts that form part of the Clinical Statement Pattern (Draft Standard for Trial Use), and
 - the specializations of ENTRY that are defined in the *openEHR* Reference Model.

0.2 Term lists

Each term list is referenced by its corresponding attribute as an invariant constraint in ISO 13606-1, by referring to its term list name. For each term list, every code value is accompanied by a phrase and description; however, in each case it is the code that is to be used as the Reference Model attribute value. Language translations of the phrase and description will therefore not affect the instances of RECORD_COMPONENT that are communicated using this part of ISO 13606.

Should any revision to these term lists prove necessary in the future, a technical revision to this part of ISO 13606 will be required. Such a revised version must specify an updated Reference Model identifier that shall then be used as the value of the *rm_id* of an EHR_EXTRACT, to inform the recipient of the version of this part of ISO 13606 that was used in its creation.

A cross-mapping of the term list for LINK.role to HL7 actRelationship typecodes is also provided, for the convenience of those wishing to adopt or interface this part of ISO 13606 with HL7 Version 3. This is part of a longer-term vocabulary harmonization project between the health informatics standards development organizations (SDOs), and might therefore be extended in the future via other publications, such as the planned HL7-13606 Implementation Guide (see below). It is therefore informative in this document.

0.3 Reference archetypes

Each reference archetype is represented in this part of ISO 13606 as a mapping correspondence table to indicate the way in which the ITEM structure within an ISO 13606-1 ENTRY is to be used to represent the classes and attributes of relevant HL7 v3 and *openEHR* classes. These two external models have been chosen for inclusion as these are the most likely internationally used source models from which fine-grained clinical data may need to be transformed into this document for communication.

These reference archetypes are included as an aid to those adopting this part of ISO 13606 and wishing to transform Electronic Health Record (EHR) data from existing HL7 v3 or *openEHR* instances or messages. It is recognised that full two-way interoperability between these various representations requires more detail, including rich vocabulary and data type harmonization, and a corresponding set of technical artefacts such as eXtensible Markup Language (XML) Schemata and Extensible Stylesheet Language Transformation (XSLT) scripts. Such interoperability is very much the goal of current SDO harmonization efforts, and will be published as an HL7-13606 Implementation Guide, possibly as an open-access and regularly updated resource. However, the outstanding work required to achieve this level of interoperability might take up to another year after publication of this part of ISO 13606. It has therefore been decided to offer what does exist towards harmonization in an informative form within this part of ISO 13606, as an aid to those already needing to make such data transformations. A worked example of the HL7 v3 to ISO 13606 mapping is given in Annex B.

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Health informatics — Electronic health record communication —

Part 3: Reference archetypes and term lists

1 Scope

This part of ISO 13606 is for the communication of part or all of the electronic health record (EHR) of a single identified subject of care between EHR systems, or between EHR systems and a centralized EHR data repository. It may also be used for EHR communication between an EHR system or repository and clinical applications or middleware components (such as decision support components) that need to access or provide EHR data, or as the representation of EHR data within a distributed (federated) record system.

This part of ISO 13606 (EHR Communications Standard Series), defines term lists that each specify the set of values that particular attributes of the Reference Model defined in ISO 13606-1 may take. It also defines informative reference archetypes that correspond to ENTRY-level compound data structures within the Reference Models of *openEHR* and HL7 Version 3, to enable those instances to be represented within a consistent structure when communicated using this part of ISO 13606.

2 Terms and definitions

For the purposes of this document, the following terms and definitions apply.

2.1

archetype instance

individual metadata class instance of an Archetype Model, specifying the clinical concept and the value constraints that apply to one class of Record Component instance in an electronic health record extract

2.2

clinical information

information about a person, relevant to his or her health or health care

2.3

committed

information that has been persisted within an electronic health record system and which constitutes part of the electronic health record for a subject of care

2.4

committer

agent (party, device or software) whose direct actions have resulted in data being committed to an electronic health record

2.5

composer

agent (party, device or software) responsible for creating, synthesising or organizing information that is committed to an electronic health record

2.6

electronic health record extract

part or all of the electronic health record for a subject of care, communicated in compliance with the ISO 13606 series of International Standards

2.7

electronic health record system

system for recording, retrieving and manipulating information in electronic health records

2.8

entries

health record data in general (clinical observations, statements, reasoning, intentions, plans or actions) without particular specification of their formal representation, hierarchical organization or of the particular Record Component class(es) that might be used to represent them

2.9

Record Component

part of the electronic health record extract of a single subject of care, represented as a node within a hierarchical data structure conforming to the ISO 13606 series of International Standards

2.10

state (of a process)

condition or situation during the lifecycle of an object during which it satisfies some condition, performs some activity or waits for some event

[ISO/TS 18308:2004, definition 3.39]

2.11

subject of care

patient

person scheduled to receive, receiving, or having received health care

3 Abbreviations

CEN	Comité Européen de Normalisation (European Committee for Standardization)
CEN/TC 251	CEN Technical Committee 251, <i>Health informatics</i>
EHR	electronic health record
EU	European Union
HISA	Health Information Systems Architecture
HL7	Health Level Seven
ISO	International Organization for Standardization
UML	Unified Modeling Language
XML	Extensible Mark-up Language

4 Conformance

When electronic health record information is to be communicated using the ISO 13606 series of International Standards and where an attribute of the Reference Model defined in ISO 13606-1 requires a value to be taken from a bounded set of codes from a named term list, the code shall be one of those defined in Clause 5 of this part of ISO 13606 for the correspondingly named term list.

5 Term lists

5.1 Introduction

The Reference Model defined in ISO 13606-1 defines several attributes whose values are to be selected from a fixed list of values. This clause defines those value lists (term lists) for each of those attributes. Attributes not included in this clause may take any value that conforms to the data type and invariant specifications defined in ISO 13606-1.

5.2 Term list **SUBJECT_CATEGORY**, Class **ENTRY**, attribute **subject_of_information_category**

This attribute provides a coarse-grained definition of the person who is the subject of an ENTRY. The default value is DS00 (the patient, or subject of care). A more fine-grained definition of the information subject (such as the precise relative with a family history) can be specified through the ENTRY.subject_of_information.relationship attribute.

Code	Meaning	Description
DS00	subject of care	the subject of care
DS01	relative of subject of care	any human relative, without limitation to biological or adoptive relatives
DS02	foetus or neonate or infant	the baby or babies being described by an ENTRY in the EHR of the mother
DS03	mother	the mother of a foetus or neonate, if being described in the EHR of a baby (e.g. during pregnancy)
DS04	donor	The donor of an organ or body specimen being described by an ENTRY in the EHR of the recipient
DS05	unrelated person	any other person not related to the subject of care, such as an employer, friend, carer

NOTE If ENTRY.subject_of_information_category is null, the value DS00 is assumed.

5.3 Term list ITEM_CATEGORY, Class ITEM, attribute item_category

Some kinds of ENTRY might have a complex internal data structure, comprising the main values of interest and other kinds of context. This optional attribute in the Reference Model permits the communication of the category of information for each ELEMENT or CLUSTER. This may be of value to a receiving EHR system, to enable easier processing of the data.

Code	Meaning	Description
IC01	Principal or "core" value	The CLUSTERS or ELEMENTS that contain the main values that are the subject of the ENTRY
IC02	Supplementary/complementary details about the value	Contextual information that most users would regard as necessary to interpret the core values
IC03	Patient state/circumstances	Contextual information about the subject of care's circumstances when an observation is made, e.g. fasting, standing
IC04	Method details	Contextual information about the method of an observation, such as the technique or device used
IC05	Clinical reasoning	Any explanatory information provided by the author to explain a clinical decision or interpretation, other than a specific reference to a protocol or guideline or knowledge source
IC06	Protocol/guideline	A description, reference or explanation of any protocol or guideline that informed the ENTRY (e.g. to perform an observation, or initiate a plan of care)
IC07	Knowledge source	A reference to any external knowledge source, such as a web site or medical text, that explains or amplifies a clinical decision
IC08	Presentation	Any information about how the values in the ENTRY should be presented; image rendering information is one example
IC09	Assertion status	To indicate that the ELEMENT contains a value that indicates the presence/absence, normality/abnormality of the core values (e.g. if the core value is a questionnaire question, and the ELEMENT contains the yes/no answer)

5.4 Term list VERSION_STATUS, Class AUDIT_INFO, attribute version_status

This attribute is used to indicate the status of a particular version of a RECORD_COMPONENT. This attribute is optional, and if no value is provided it is to be assumed that the RECORD_COMPONENT is the first definitive version corresponding to code value VER01. **In all cases, the new version of a RECORD_COMPONENT shall replace the former version, as specified in ISO 13606-1.**

Code	Meaning	Description
VER00	Draft	The version is known at the time of committal to be incomplete (because additional information is expected later) or the necessary authorizations have not been made: VER00 implies that the EHR_recipient might in future expect to receive a more definitive updated version of this RECORD_COMPONENT.
VER01	Finished	The version is committed with the intention of being a final version, with no anticipated reason for revision.
VER02	Update	The version is an update of the previous version, usually by adding supplementary information that was not available at the time of committal. NOTE Revision is intended for additions usually to be made by the original author within a short time frame, and not for recoding an evolving clinical story.
VER03	Correction	The version corrects errors made in the recording of the previous version.
VER04	Deletion	The version logically deletes the previous version (e.g. if the RECORD_COMPONENT had been placed in the wrong patient's EHR).

NOTE If AUDIT_INFO.version_status is null, the value VER01 is assumed.

5.5 Term list MODE, Class FUNCTIONAL_ROLE, attribute mode

This attribute is used to describe the physical or electronic means by which an entity has participated in the provision or documentation of health care. This term list is taken from the corresponding code set in EN 14822-2 except that codes have been added for use within an EHR extract.

Code	Meaning	Description	EN14822-2 term
MOD01	electronic data	Participation by non-human-language-based electronic signal.	ELECTRONIC
MOD02	verbal	Participation by voice communication.	VERBAL
MOD03	dictated	Participation by pre-recorded voice. Communication is limited to one direction (from the recorder to recipient).	DICTATED
MOD04	face-to-face	Participation by voice communication where parties speak to each other directly.	FACE
MOD05	telephone	Participation by voice communication where the voices of the communicating parties are transported over an electronic medium.	PHONE
MOD06	videoconferencing	Participation by voice and visual communication where the voices and images of the communicating parties are transported over an electronic medium.	VIDEOCONF
MOD07	written	Participation by human language recorded on a physical material.	WRITTEN
MOD08	e-mail	Participation by text or diagrams transmitted over an electronic mail system.	EMAIL
MOD09	telefax	Participation by text or diagrams printed on paper that have been transmitted over a fax device.	FAX
MOD10	handwritten	Participation by text or diagrams printed on paper or other recording medium.	HANDWRITTEN
MOD11	typewritten	Participation by text or diagrams printed on paper or other recording medium where the recording was performed using a typewriter, typesetter, computer or similar mechanism.	TYPEWRITTEN
MOD12	physical presence	Participation by direct action where subject and actor are in the same location. (The participation involves more than communication.)	PHYSICAL
MOD13	remote presence	Participation by direct action where subject and actor are in separate locations, and the actions of the actor are transmitted by electronic or mechanical means. (The participation involves more than communication.)	REMOTE

NOTE If FUNCTIONAL_ROLE.mode is null, the value MOD04 is assumed.

5.6 Term list ACT_STATUS, Class ENTRY, attribute act_status

This term list is identical to the act status values in EN 12967-3 except that codes have been added for use within an EHR extract.

Code	Meaning	Definition from EN 12967-3
ACT01	Foreseen	The activity to be done has been identified by the requestor, but a formal request or planning has not been issued yet.
ACT02	Requested	A formal request has been sent to the provider supposed to deliver the service(s).
ACT03	Accepted	The providing unit has formally accepted to provide the service.
ACT04	Booked	The actual activities to be executed have been identified and a date, shift and time for execution has been agreed between the involved agents (i.e. requestor, provider and other involved units).
ACT05	Planned	The act has been assigned to one (set of) Service Point, which will be in charge for its execution.
ACT06	Ready	All preliminary activities have been completed and the execution of the act may actually start.
ACT07	In progress	The execution of the act has actually started.
ACT08	Completed	The provider has completed the actual execution of the act.
ACT09	Reported	The provider has delivered the final report on the act.
ACT10	Terminated	The final report has been received and accepted by the original requester.
ACT11	Forwarded	The request of delivering the service has been transferred by the initially envisaged provider to a different provider.
ACT12	Suspended	The processing of the act (in any moment of its life-cycle) has been temporarily interrupted for various reasons.
ACT13	Annulled-Cancelled	The act has been annulled by the requestor (who cancels the request).
ACT14	Annulled-Rejected	The act has been annulled by the envisaged provider (who rejects the request received).
ACT15	Substituted	The act has been substituted with another one.

5.7 Term list LINK_NATURE, Class LINK, attribute nature

The LINK class contains two coded-value attributes to communicate the semantics of the relationship between the source and target RECORD_COMPONENTS. The nature attribute, which is mandatory in ISO 13606-1, is intended to be a coarse-grained category that can be used to enable interoperability between sender and receiver. The role attribute, which is optional in ISO 13606-1, provides for a more specific description of the actual role played by the target in relation to the source. This latter attribute may be populated from any suitable terminology, and therefore might support human readership better than interoperable automated processing. This part of ISO 13606 requires that the nature attribute be a value taken from the mandatory term list defined in this subclause. This part of ISO 13606 offers a term list for the role attribute, in 5.8, but it is not required that this be used.

Code	Meaning	Description
LINK-A0	is related to	A generic category for any link, the details of which will be given by the value of LINK.role.
LINK-B0	is confirmed by or authorized by	The target link contains a COMPOSITION, SECTION or ENTRY that acts as the legal or authoritative basis for the activity documented in the source RECORD_COMPONENT, or is a declaration of intent to provide (or not to provide) requested care. This Link shall be used to connect two RECORD_COMPONENTS, as opposed to the inclusion of a corroborating or authorizing participant as an identified party within a single COMPOSITION or ENTRY.
LINK-C0	is related to the same problem or health issue	The target RECORD_COMPONENT documents health or health care that pertains to the same clinical situation as the source component. One of the two might be defining a problem for which the other is a manifestation, or the relationship might, for example, be cause and effect, stages in an evolving clinical history, a different interpretation of an observation, a clinical indication or contra-indication.
LINK-D0	is related to the same plan of care, act or episode	The source and the target RECORD_COMPONENTs each document parts of the same plan of care, act or episode. One or the other might be defining the same plan of care, act or episode, or both might be related milestones.
LINK-E0	is a related documentation	The target RECORD_COMPONENT is an alternative documentary form of the source component, such as re-expression of the same clinical information or additional supplementary explanatory information.

NOTE A further understanding of each of these categories may be obtained by reviewing the detailed terms proposed for each, as values of LINK.role in 5.8.

5.8 Term list LINK_ROLE, Optional term list for LINK attribute role (informative)

5.8.1 Introduction

Each of the link terms in the list is a sub-category of a corresponding term in the table of 5.7, where that correspondence is indicated by the first letter after the code string "LINK-", e.g. the term LINK-A1 is a subcategory of term LINK-A0. If a term in the list is used for the LINK.role attribute, the appropriate corresponding LINK.nature attribute value from 5.7 must be used.

5.8.2 Optional term list for LINK attribute role (informative)

Code	Meaning	Description
LINK-A1	unspecified link	The term is used when no semantic information is available for the Link in the EHR system from which the EXTRACT has been created.
LINK-A2	suggests (tentatively related to)	The interpretation expressed in the target component is a possible cause or outcome of the findings documented in the source component.
LINK-A2i	is suggested by	The inverse relationship of LINK-A2.
LINK-A3	re-occurrence or repeat of	The source component documents a clinical situation which, in the opinion of the composer, is a repeat occurrence of the clinical situation documented in the target. This is intended for re-occurrences of real world situations, not repeated documentation of the same real-world event.
LINK-B1	endorses (agrees with, confirms, verifies)	The interpretation expressed in the source component provides confirmatory evidence or a confirmatory opinion of the interpretation expressed in the target component.
LINK-B2	disagrees with (e.g. another opinion)	The interpretation expressed in the source component disproves or disagrees with the interpretation expressed in the target component.
LINK-B3	permits (sanctions, authorises)	The source component documents a permission or an authorisation of an action documented in the target component.
LINK-B3i	permitted by	The inverse relationship of LINK-B3.
LINK-B4	assumes responsibility for	The participant (e.g. composer) identified in the source component is taking responsibility for the care acts documented in the target component.
LINK-B5	declines (refuses, cancels)	The participant (e.g. composer) identified in the source component is declining or withdrawing consent to take responsibility for the care acts documented in the target component.
LINK-B6	consents to	The participant identified in the source component is proof of consent to care actions documented in the target component.
LINK-B6i	consented by	The inverse relationship of LINK-B6.
LINK-C1	cause (interpretation)	The clinical situation documented in the source component is considered by the author to be the cause of the clinical situation documented in the target component.
LINK-C1i	caused by	The inverse relationship of LINK-C1.

Code	Meaning	Description
LINK-C2	revised interpretation	The interpretation documented in the source component is a revision of, or difference in, clinical thinking compared to that documented in the target component.
LINK-C3	evidence for	The observation or interpretation documented in the source component provides confirmatory evidence of the interpretation expressed in the target component.
LINK-C3i	justified by	The inverse relationship of LINK-C3.
LINK-C4	evidence against	The observation or interpretation documented in the source component provides evidence against the interpretation expressed in the target component.
LINK-C4i	countered by	The inverse relationship of LINK-C4.
LINK-C5	indicated by	The target component documents a clinical indication for the care action documented in the source component.
LINK-C5i	indication for	The inverse relationship of LINK-C5.
LINK-C6	contra-indicated by	The target component documents an observation or interpretation that is a contra-indication for a care action documented in the source component.
LINK-C6i	contra-indication for	The inverse relationship of LINK-C6.
LINK-C7	trigger for	The source component is the trigger event or situation for the clinical situation documented in the target component.
LINK-C7i	triggered by	The inverse relationship of LINK-C7.
LINK-C8	manifestation of	The source component documents a clinical manifestation of the phenomenon documented in the target component.
LINK-C8i	manifested by	The inverse relationship of LINK-C8.
LINK-C9	sequel (consequence, progression)	The source component documents a clinical situation that is a temporal successor to the target component (expected or unexpected, intended or unintended).
LINK-C10	intended (aim, goal, target, hoped for, desired)	The clinical situation documented in the target component is an intended consequence, sequel or outcome of the situation documented in the source component.
LINK-C11	anticipated (predicted)	The clinical situation documented in the target component is an anticipated consequence, sequel or outcome of the situation documented in the source component (desirable or undesirable).
LINK-C12	to be avoided (at risk of, fear of, prophylaxis against)	The clinical situation documented in the target component is an undesirable but possible consequence, sequel or outcome of the situation documented in the source component.
LINK-D1	outcome	The clinical situation documented in the target component is the direct outcome of the situation documented in the source component.
LINK-D2	has pre-condition	The clinical situation (possibly an objective or criterion) documented in the target component is a pre-condition of the situation or intended action documented in the source component.

Code	Meaning	Description
LINK-D3	evaluation (assessment, milestone)	The source component documents a clinical assessment or milestone of the care activity, objective or clinical condition documented in the target component.
LINK-D4	contributes to or fulfils goal, plan or act	The source component documents a care activity or clinical situation that makes some positive contribution towards the achievement of a plan of care or objective.
LINK-D5	revised state of the same act	The source component is a revised status of a care activity documented in the target component; e.g. the source might be a completed or cancelled state of a planned health care activity documented in the target.
LINK-D6	sub-task of	The health care activity documented in the source is a part of, or sub-routine of, an activity (e.g. a planned activity) documented in the target.
LINK-E1	documented by (is documented within)	A clinical situation documented in the source component is more formally documented in the target component.
LINK-E1i	documents (describes, reports)	The inverse relationship of LINK-E1.
LINK-E2	summarises	The source component documents in summary form the clinical situation documented by the target component.
LINK-E3	supplements	The source component provides supplementary information to the situation documented by the target.
LINK-E4	excerpts	The source component is an extract (copy) of part or all of the information contained within the target component.
LINK-E5	derived from	The source component contains information that has been derived (e.g. calculated) from information documented in the target component.
LINK-E6	has reference ranges	The target component provides a reference basis for the interpretation of the values in the source component.
LINK-E7	identified within (study product)	The source component is an observation or interpretation taken directly from information contained within the target component.

5.8.3 Mapping of extended term list to ISO 13606-2 categories of Link (informative)

Part 2 of the 1999 CEN pre-standard for EHCR Communication defined a set of Link item categories that have been referred to in drawing up the present LINK term lists. Some of those were no longer considered appropriate to retain. A mapping table below indicates the closest match between the pre-standard link terms and the ones defined in this part of ISO 13606.

Code	Meaning	Corresponding term(s) from ISO 13606-2:2007, Annex C
LINK-A0	is related to	DTL01- is related to; DTL09- is compared to
LINK-A1	suggests (tentatively related to)	DTL16- is assigned to (thought to be caused by)
LINK-A1i	is suggested by	(none)
LINK-A2	re-occurrence or repeat of	(none)
LINK-B0	confirmed by or authorized by	(none)
LINK-B1	endorses (agrees with, confirms, verifies)	(none)
LINK-B2	disagrees with (e.g. another opinion)	DTL10- is recorded against (disagrees with)
LINK-B3	permits (sanctions, authorizes)	(none)
LINK-B3i	is permitted by	(none)
LINK-B4	assumes responsibility for	(none)
LINK-B5	declines (refuses, cancels)	(none)
LINK-B6	consents to	(none)
LINK-B6i	is consented to by	(none)
LINK-C0	related to the same problem or health issue	(none)
LINK-C1	is cause (interpretation)	DTL19- has cause; DTL17- is interpretation of (finding); DTL24- has motivation
LINK-C1i	is caused by	(none)
LINK-C2	revised interpretation	DTL11- supersedes
LINK-C3	evidence for	DTL21-(finding) is evidence for (diagnosis)
LINK-C3i	is justified by	(none)
LINK-C4	evidence against	(none)
LINK-C4i	is countered by	(none)
LINK-C5	is indicated by	(none)
LINK-C5i	is indication for	(none)
LINK-C6	is contra-indicated by	(none)
LINK-C6i	is contra-indication for	(none)
LINK-C7	is trigger for	DTL22- triggers
LINK-C7i	is triggered by	(none)
LINK-C8	manifestation of	(none)
LINK-C8i	is manifested by	(none)
LINK-C9	is sequel (consequence, progression)	DTL18- has progress; DTL25- has consequence
LINK-C10	intended (aim, goal, target, hoped for, desired)	DTL23- has goal
LINK-C11	anticipated (predicted, prognosis)	(none)

Code	Meaning	Corresponding term(s) from ISO 13606-2:2007, Annex C
LINK-C12	to be avoided (at risk of, fear of, prophylaxis against)	(none)
LINK-D0	related to the same plan of care, act or episode	DTL12-(contact) is framework for (condition)
LINK-D1	outcome	(none)
LINK-D2	has pre-condition	(none)
LINK-D3	evaluation (assessment, milestone)	(none)
LINK-D4	contributes to or fulfils goal, plan or act	DTL13- has phase (sub-activity)
LINK-D5	revised state of the same act	DTL14- is next phase with respect to (sibling activity)
LINK-D6	is sub-task of	DTL13- has phase (sub-activity)
LINK-E0	documentation relationship	(none)
LINK-E1	is documented by (is documented within)	DTL05- is reported within; DTL04- is documented by
LINK-E1i	documents (describes, reports)	DTL06- describes; DTL03- produces (report)
LINK-E2	summarises	(none)
LINK-E3	supplements	(none)
LINK-E4	excerpts	(none)
LINK-E5	is derived from	DTL08- is derived from
LINK-E6	has reference ranges	(none)
LINK-E7	is identified within (study product)	DTL07- is identified within (study product)

5.8.4 Mapping of extended term list to HL7 actRelationship typeCodes values (informative)

HL7 defines a vocabulary (term list) for the typeCode property of actRelationship, which is the closest equivalent to the ISO 13606-1 LINK. A review of those codes has been helpful in defining the LINK.nature term list, and a mapping to relevant members of that HL7 vocabulary is given below.

This subclause is informative because of ongoing harmonization work which might result in additional mappings to new HL7 terms in the future: it is offered as an informal guide, as an aid to those already needing to make data transformations between these standards. A more detailed mapping is to be published in the future in the Implementation Guide referred to in the Introduction.

For some values, the inversionInd property of the actRelationship class is set to "True" in order to represent the inverse relationship direction of a LINK. For some values, more than one corresponding typeCode mapping is provided: in these situations the specific context of use may indicate which value is more appropriate to use, but further work is planned to provide more precise mapping guidance. In some situations, the semantic equivalent for the LINK.nature label is provided by the classCode (and/or moodCode) of the target Act (as specified under Additional information in the table below) rather than by the actRelationship typeCode.

Code	Meaning	Corresponding term from HL7 actRelationship typeCode	Value of HL7 inversionInd property	Additional information
LINK-A0	is related to	REFR: refers to PERT: has pertinent information	False False	
LINK-A1	suggests (tentatively related to)	RSON: has reason	True	
LINK-A1i	is suggested by	RSON: has reason	False	
LINK-A2	re-occurrence or repeat of	PREV: has previous instance OCCR: occurrence	False False	
LINK-B0	confirmed by or authorized by	AUTH: authorized by	False	
LINK-B1	endorses (agrees with, confirms, verifies)	EVID: provides evidence for SPRT: has support DOC: documents	True	
LINK-B2	disagrees with (e.g. another opinion)	REV: reverses	False	
LINK-B3	permits (sanctions, authorizes)	AUTH: authorized by	False	
LINK-B3i	is permitted by	AUTH: authorized by	True	
LINK-B4	assumes responsibility for	FLFS: fulfils	False	Target of the LINK must be an Act with Act.classCode=PCPR
LINK-B5	declines (refuses, cancels)	FLFS: fulfils	True	Target of the LINK must be an Act with Act.classCode=PCPR Additional refinement may be provided by the Act.statusCode
LINK-B6	consents to	COVBY: covered by	True	Target of the LINK must be an Act with Act.classCode=CONS
LINK-B6i	is consented to by	COVBY: covered by	False	Target of the LINK must be an Act with Act.classCode=CONS The "consented to by" is the "person in role, participating in this act" as subject.
LINK-C0	related to the same problem or health issue	ELNK: episodelink	False	
LINK-C1	is cause (interpretation)	EXPL: has explanation RSON: has reason CAUS: is aetiology for	False False False	
LINK-C1i	is caused by	EXPL: has explanation RSON: has reason CAUS: is aetiology for	True True True	
LINK-C2	revised interpretation	APND: is appendage RPLC: replaces		
LINK-C3	evidence for	EVID: provides evidence for EXPL: has explanation SPRT: has support	False True False	

Code	Meaning	Corresponding term from HL7 actRelationship typeCode	Value of HL7 inversionInd property	Additional information
LINK-C3i	is justified by	EVID: provides evidence for EXPL: has explanation SPRT: has support	True False True	
LINK-C4	evidence against	BLOCK: blocks MITGT: mitigates MITG.AD: adjunct mitigation	False True True	
LINK-C4i	is countered by	BLOCK: blocks MITGT: mitigates MITG.AD: adjunct mitigation	False False False	
LINK-C5	is indicated by	CURE: curative indication CURE.AD: adjunct curative indication	True True	
LINK-C5i	is indication for	CURE: curative indication CURE.AD: adjunct curative indication	False False	
LINK-C6	is contra-indicated by	CIND: has contra-indication	False	
LINK-C6i	is contra-indication for	CIND: has contra-indication	True	
LINK-C7	is trigger for	TRIG: has trigger	True	
LINK-C7i	is triggered by	TRIG: has trigger	False	
LINK-C8	manifestation of	MFST: is manifestation of OCCR: is occurrence of	False False	
LINK-C8i	is manifested by	MFST: is manifestation of OCCR: is occurrence of	True True	
LINK-C9	is sequel (consequence, progression)	SEQL: is sequel	False	
LINK-C10	intended (aim, goal, target, hoped for, desired)	GOAL: has goal OBJC: has continuing objective OBJF: has final objective	False False False	Additional refinement is provided by the Act.moodCode
LINK-C11	anticipated (predicted, prognosis)	GOAL: has goal OBJC: has continuing objective OBJF: has final objective	False False False	Additional refinement is provided by the Act.moodCode
LINK-C12	to be avoided (at risk of, fear of, prophylaxis against)	RISK: has risk	False	
LINK-D0	related to the same plan of care, act or episode	ELNK: episodelink	False	
LINK-D1	outcome	OUTC: has outcome	False	
LINK-D2	has pre-condition	PRCN: has pre-condition	False	
LINK-D3	evaluation (assessment, milestone)	GEVL: evaluates (goal)	False	
LINK-D4	contributes to or fulfils goal, plan or act	FLFS: fulfils	False	
LINK-D5	revised state of the same act	RPLC: replaces SUCC: succeeds UPDT: updates	False False False	
LINK-D6	is sub-task of	COMP: has component	False	
LINK-E0	documentation relationship	DOC: documents	False	

Code	Meaning	Corresponding term from HL7 actRelationship typeCode	Value of HL7 inversionInd property	Additional information
LINK-E1	is documented by (is documented within)	XCRPT: excerpts	False	
LINK-E1i	documents (describes, reports)	DOC: documents	False	
LINK-E2	summarises	SUMM: summarised by	True	
LINK-E3	supplements	APND: is appendage	False	
LINK-E4	excerpts	VRXCRPT: excerpt verbatim	False	
LINK-E5	is derived from	DRIV: is derived from	False	
LINK-E6	has reference ranges	REFV: has reference values	False	
LINK-E7	is identified within (study product)	SPRTBND: has bounded support	False	

5.9 Term list STRUCTURE_TYPE, Class CLUSTER, attribute structure_type

This attribute is used to define the structural organization of a CLUSTER and its contained CLUSTERs and/or ELEMENTs.

Code	Meaning	Description
STRC01	List	The CLUSTER contains a set of CLUSTERs and/or ELEMENTs that is intended to be represented as an ordered or unordered list, or a set of ELEMENTs that are intended to represent a single row in a table.
STRC02	Table	The CLUSTER contains a set of CLUSTERs that are intended to each represent a column in a table.

NOTE A tree of ITEMS can be represented by using the code STRC01 for all CLUSTERs, since a tree is equivalent to a list of lists.

Annex A (informative)

Reference archetypes

A.1 Introduction to the *openEHR* and HL7 mapping archetypes

This set of reference archetypes corresponds to the compound classes defined within the *openEHR* Reference Model and the HL7 Version 3 Clinical Statement Pattern (Draft Standard for Trial Use), and which map to the ITEM class within this part of ISO 13606. These archetypes constrain the ISO 13606-1 Reference Model, which defines a more basic ITEM aggregation structure, to enable instances of data that conform to one of those compound classes to be represented consistently within this part of ISO 13606.

Archetypes or templates that further constrain any of those compound classes can be represented as specializations of one of the archetypes listed in this annex.

In this annex, the archetypes are represented as a table of correspondence. Indentation to the right is used to indicate containment. The meaning attribute of RECORD_COMPONENT is used to label the correspondence of each node to the source model. A code set for these is defined in Clause A.4, and must be used if this informative annex is adopted.

A.2 openEHR ENTRY archetypes

A.2.1 Introduction

The following information model diagrams are taken from the *openEHR* Reference Model, version 1.0.1 (May 2007), and are included as an aid to the reader in understanding this section. The formal documentation of this model may be obtained from www.openEHR.org.

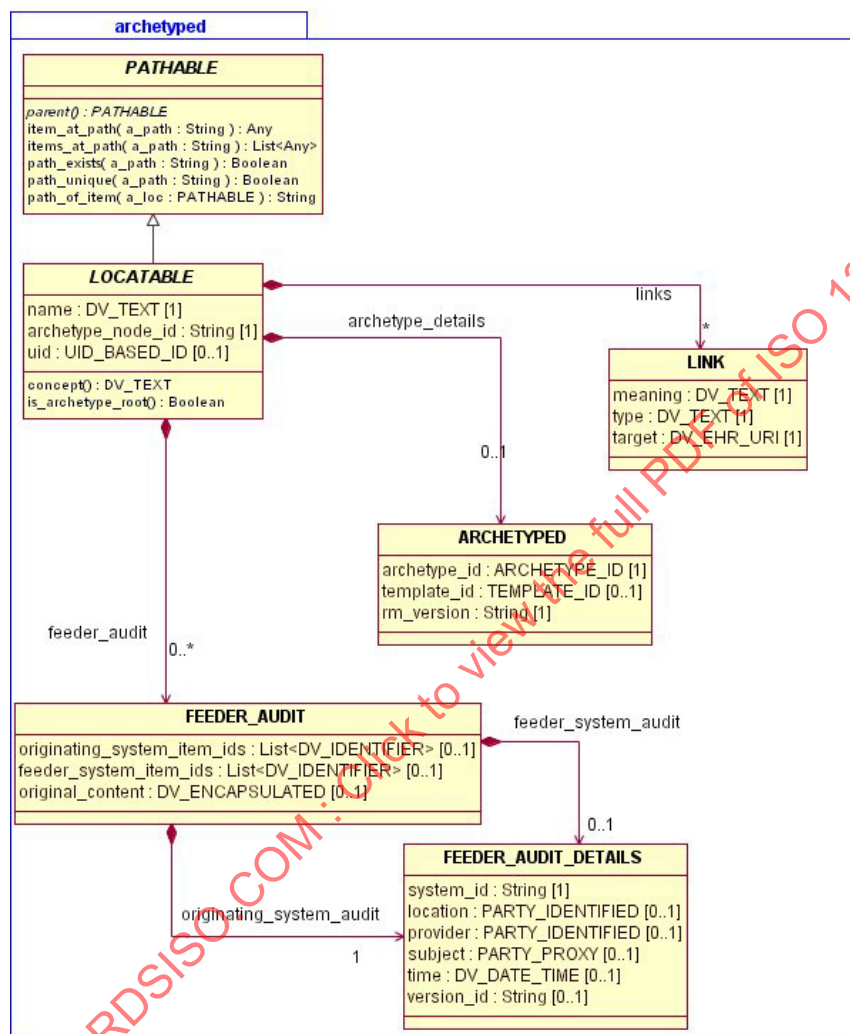


Figure A.1 — *openEHR* archetyped package

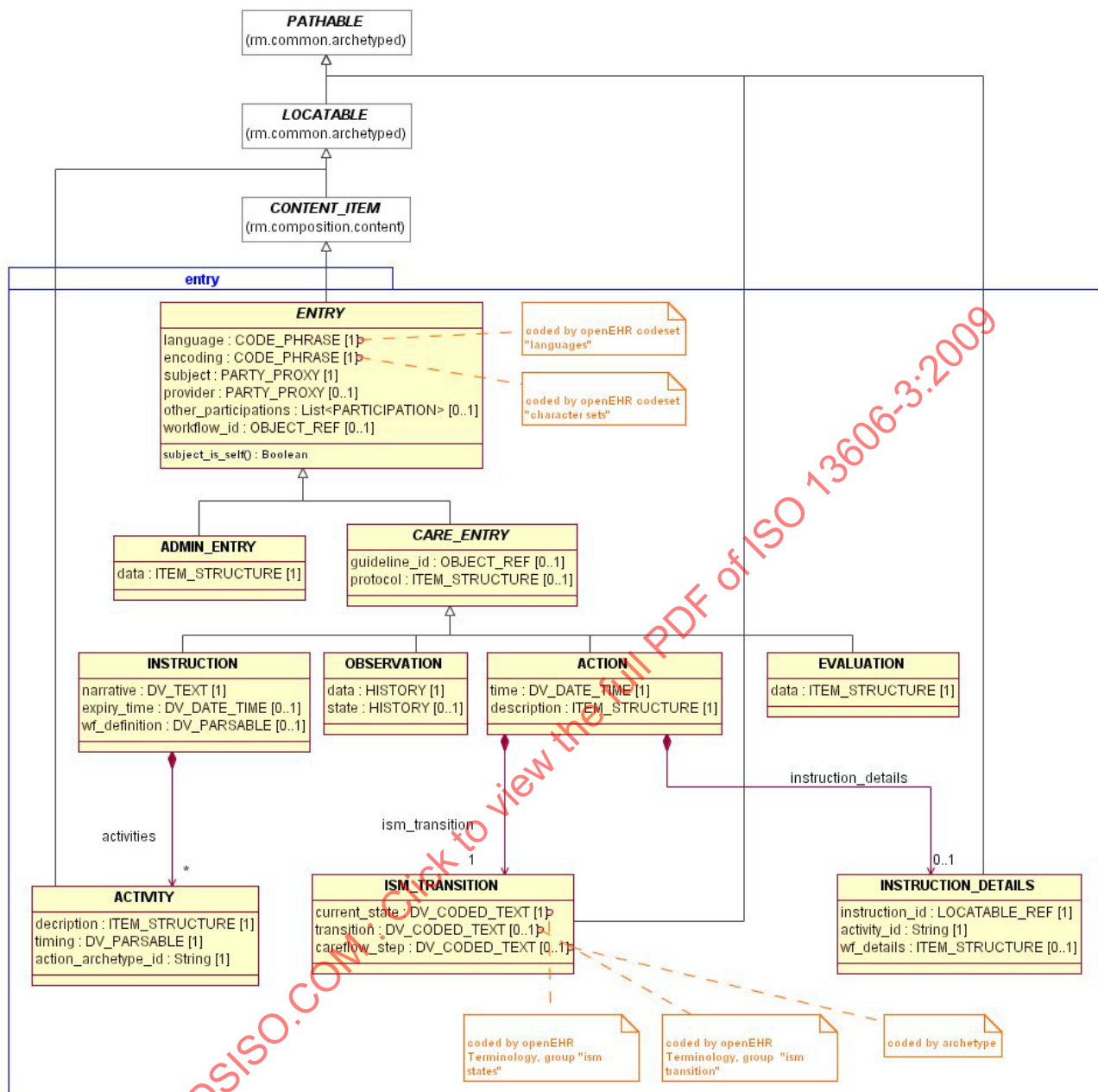


Figure A.2 — openEHR entry package

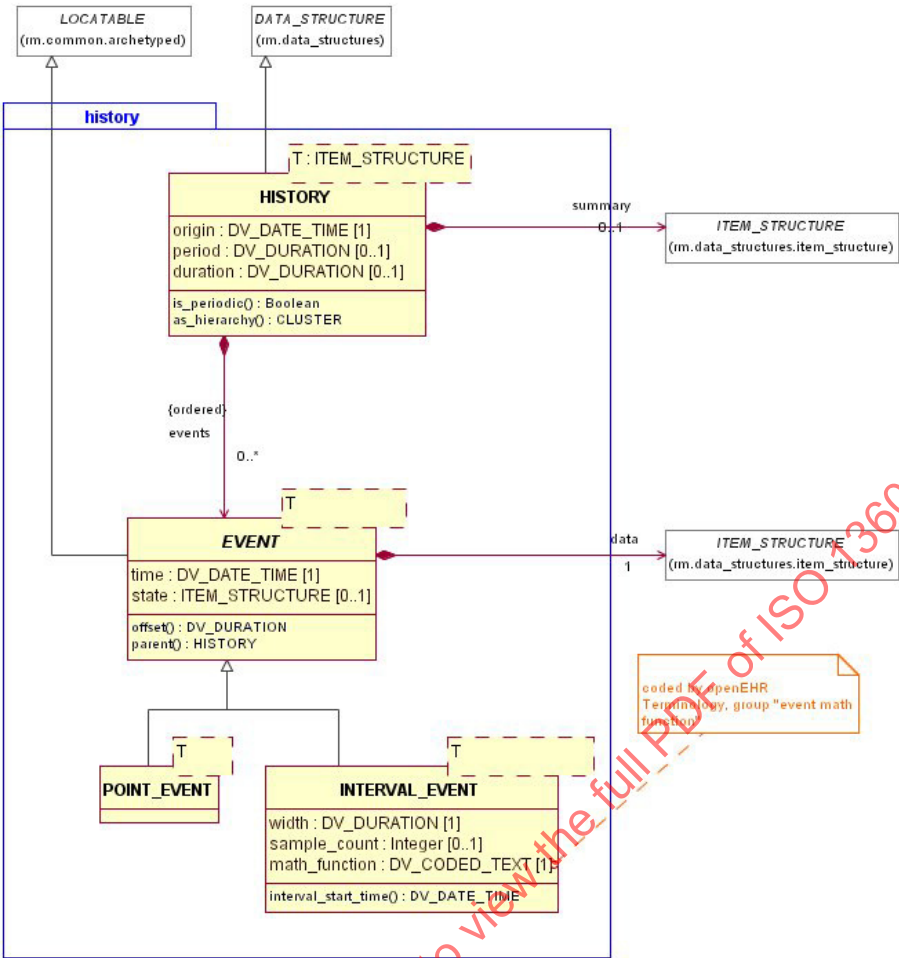


Figure A.3 — openEHR history package

A.2.2 openEHR ENTRY

The openEHR ENTRY class originates from LOCATABLE and ARCHETYPED. The following attribute correspondence is to be used.

openEHR LOCATABLE attribute	ISO 13606-1 RECORD_COMPONENT attribute
name	name
archetype_node_id	meaning
uid	rc_id

openEHR ARCHETYPED attribute	ISO 13606-1 RECORD_COMPONENT attribute
rm_version	(not applicable)
archetype_id	meaning
template_id	(not applicable)

A.2.3 openEHR Evaluation

openEHR attribute				ISO 13606 representation
EVALUATION				ENTRY
				meaning = Evaluation "OE-30"
inherited ENTRY.language				(property of CV data type)
inherited ENTRY.encoding				(property of CV data type)
inherited ENTRY.subject				subject_of_information association
inherited ENTRY.provider				information_provider association
inherited ENTRY.other_participations				other_participations association
inherited ENTRY.workflow_id				act_id attribute
inherited CARE_ENTRY.protocol				0..1 CLUSTER
				meaning = <Protocol> "OE-02"
				item_category = "IC04"
				obs_time = (constrained to null)
				1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)
inherited CARE_ENTRY.guideline_id				0..1 ELEMENT
				meaning = <Guideline_id> "OE-03"
				item_category = "IC04"
				obs_time = (constrained to null)
	EVALUATION.data			1..1 CLUSTER
				meaning = <Data> "OE-04"
				item_category = "IC01" or "IC02" or "IC05" or "IC06" or "IC07" or "IC08"
				obs_time = (constrained to null)
				1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)

A.2.4 openEHR Observation

openEHR attribute			ISO 13606 representation		
OBSERVATION			ENTRY		
			meaning = <Observation> "OE-01"		
inherited ENTRY.language			(property of CV data type)		
inherited ENTRY.encoding			(property of CV data type)		
inherited ENTRY.subject			subject_of information association		
inherited ENTRY.provider			information_provider association		
inherited ENTRY.other_participations			other_participations association		
inherited ENTRY.workflow_id			act_id attribute		
inherited CARE_ENTRY.protocol			0..1 CLUSTER		
			meaning = <Protocol> "OE-02"		
			item_category = "IC04"		
			obs_time = (constrained to null)		
			1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)		
inherited CARE_ENTRY.guideline_id			0..1 ELEMENT		
			meaning = <Guideline_id> "OE-03"		
			item_category = "IC04"		
			obs_time = (constrained to null)		
OBSERVATION.data			1..1 CLUSTER		
			meaning = <Data> "OE-04"		
			item_category = "IC01" or "IC02" or "IC05" or "IC06" or "IC07" or "IC08"		
			obs_time = (mandatory, constrained from interval to single date-time)		
OBSERVATION.data.HISTORY.origin			0..1 ELEMENT		
OBSERVATION.data.HISTORY.period			meaning = <Period> "OE-05"		
			item_category = "IC02"		
			obs_time = (constrained to null)		
			value = IVL<TS>		
OBSERVATION.data.HISTORY.duration			0..1 ELEMENT		
			meaning = <Duration> "OE-06"		
			item_category = "IC02"		
			obs_time = (constrained to null)		
			value = IVL<TS>		
OBSERVATION.data.HISTORY.events.POINT_EVENT			0..* CLUSTER		
			meaning = <Point_event> "OE-07"		
			item_category = "IC01" or "IC02" or "IC05" or "IC06" or "IC07" or "IC08"		
			obs_time = (mandatory, constrained from interval to single date-time)		
OBSERVATION.data.HISTORY.events.POINT_EVENT.time			1..1 CLUSTER		
OBSERVATION.data.HISTORY.events.POINT_EVENT.data			meaning = <Event_data> "OE-08"		
			item_category = "IC01" or "IC02" or "IC05" or "IC06" or "IC07" or "IC08"		
			obs_time = (constrained to null)		
			1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)		
OBSERVATION.data.HISTORY.events.POINT_EVENT.state			0..1 CLUSTER		
			meaning = <Event_state> "OE-09"		
			item_category = "IC03"		
			obs_time = (constrained to null)		
			1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)		
OBSERVATION.data.HISTORY.events.INTERVAL_EVENT			0..* CLUSTER		
			meaning = <Interval_event> "OE-10"		
			item_category = "IC01" or "IC02" or "IC05" or "IC06" or "IC07" or "IC08"		
			obs_time = (mandatory, constrained from interval to single date-time)		
			1..1 ELEMENT		
			meaning = <Width> "OE-11"		
			item_category = "IC02"		
			obs_time = (constrained to be null)		
			value = IVL<TS>		
			0..1 ELEMENT		
			meaning = <Sample_count> "OE-12"		
			item_category = "IC02"		
			obs_time = (constrained to be null)		
			value = Integer		
			1..1 ELEMENT		
			meaning = <Math_function> "OE-13"		
			item_category = "IC02"		
			obs_time = (constrained to be null)		
			value = CV		
OBSERVATION.data.HISTORY.events.INTERVAL_EVENT.data			1..1 CLUSTER		
			meaning = <Event_data> "OE-08"		
			item_category = "IC01" or "IC02" or "IC05" or "IC06" or "IC07" or "IC08"		
			obs_time = (constrained to null)		
			1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)		
OBSERVATION.data.HISTORY.events.INTERVAL_EVENT.state			0..1 CLUSTER		
			meaning = <Event_state> "OE-09"		
			item_category = "IC03"		
			obs_time = (constrained to null)		
			1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)		

openEHR attribute				ISO 13606 representation			
	OBSERVATION.state			0..1	CLUSTER		
						meaning = <State> "OE-14"	
						item_category = "IC03"	
	OBSERVATION.state.HISTORY.origin					obs_time = (mandatory, constrained from interval to single date-time)	
	OBSERVATION.state.HISTORY.period			0..1	ELEMENT		
						meaning = <Period> "OE-05"	
						item_category = "IC02"	
						obs_time = (constrained to null)	
						value = IVL<TS>	
	OBSERVATION.state.HISTORY.duration			0..1	ELEMENT		
						meaning = <Duration> = "OE-06"	
						item_category = "IC02"	
						obs_time = (constrained to null)	
						value = IVL<TS>	
	OBSERVATION.state.HISTORY.events.POINT_EVENT			0..*	CLUSTER		
						meaning = <Point_event> "OE-07"	
						item_category = "IC01" or "IC02" or "IC05" or "IC06" or "IC07" or "IC08"	
	OBSERVATION.state.HISTORY.events.POINT_EVENT.time					obs_time = (mandatory, constrained from interval to single date-time)	
	OBSERVATION.state.HISTORY.events.POINT_EVENT.data			1..1	CLUSTER		
						meaning = <Event_data> "OE-08"	
						item_category = "IC01" or "IC02" or "IC05" or "IC06" or "IC07" or "IC08"	
						obs_time = (constrained to null)	
						1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)	
	OBSERVATION.state.HISTORY.events.POINT_EVENT.state			0..1	CLUSTER		
						meaning = <Event_state> "OE-09"	
						item_category = "IC03"	
						obs_time = (constrained to null)	
						1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)	
	OBSERVATION.state.HISTORY.events.INTERVAL_EVENT			0..*	CLUSTER		
						meaning = <Interval_event> "OE-10"	
						item_category = "IC01" or "IC02" or "IC05" or "IC06" or "IC07" or "IC08"	
	OBSERVATION.state.HISTORY.events.INTERVAL_EVENT.time					obs_time = (mandatory, constrained from interval to single date-time)	
				1..1	ELEMENT		
						meaning = <Width> "OE-11"	
						item_category = "IC02"	
						obs_time = (constrained to be null)	
						value = IVL<TS>	
				0..1	ELEMENT		
						meaning = <Sample_count> "OE-12"	
						item_category = "IC02"	
						obs_time = (constrained to be null)	
						value = Integer	
				1..1	ELEMENT		
						meaning = <Math_function> "OE-13"	
						item_category = "IC02"	
						obs_time = (constrained to be null)	
						value = CV	
	OBSERVATION.state.HISTORY.events.INTERVAL_EVENT.data			1..1	CLUSTER		
						meaning = <Event_data> "OE-08"	
						item_category = "IC01" or "IC02" or "IC05" or "IC06" or "IC07" or "IC08"	
						obs_time = (constrained to null)	
						1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)	
	OBSERVATION.state.HISTORY.events.INTERVAL_EVENT.state			0..1	CLUSTER		
						meaning = <Event_state> "OE-09"	
						item_category = "IC03"	
						obs_time = (constrained to null)	
						1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)	

A.2.5 openEHR Instruction

openEHR attribute				ISO 13606 representation			
INSTRUCTION				ENTRY			
				meaning = Instruction "OE-31"			
inherited ENTRY.language				(property of CV data type)			
inherited ENTRY.encoding				(property of CV data type)			
inherited ENTRY.subject				subject_of_information association			
inherited ENTRY.provider				information_provider association			
inherited ENTRY.other_participations				other_participations association			
inherited ENTRY.workflow_id				act_id attribute			
inherited CARE_ENTRY.protocol				0..1 CLUSTER			
				meaning = <Protocol> "OE-02"			
				item_category = "IC04"			
				obs_time = (constrained to null)			
				1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)			
inherited CARE_ENTRY.guideline_id				0..1 ELEMENT			
				meaning = <Guideline_id> "OE-03"			
				item_category = "IC04"			
				obs_time = (constrained to null)			
INSTRUCTION.narrative				1..1 ELEMENT			
				meaning = <Instruction_narrative> "OE-15"			
				item_category = "IC01"			
				obs_time = (constrained to null)			
				value = TEXT			
INSTRUCTION.expiry_time				0..1 ELEMENT			
				meaning = <Instruction_expiry_time> "OE-16"			
				item_category = "IC02"			
				obs_time = (constrained to null)			
				value = IVL<TS>			
INSTRUCTION.wf_definition				0..1 ELEMENT			
				meaning = <Instruction_wf_definition> "OE-17"			
				item_category = "IC02"			
				obs_time = (constrained to null)			
				value = TEXT			
INSTRUCTION.activities.ACTIVITY				0..* CLUSTER			
				meaning = <Activity> "OE-18"			
				item_category = "IC01" or "IC02"			
				obs_time = (constrained to null)			
INSTRUCTION.activities.ACTIVITY.timing				1..1 ELEMENT			
				meaning = <Activity_timing> "OE-19"			
				item_category = "IC01"			
				obs_time = (constrained to null)			
				value = TEXT			
INSTRUCTION.activities.ACTIVITY.description				1..1 CLUSTER			
				meaning = <Activity_description> "OE-20"			
				item_category = "IC01" or "IC02" or "IC05" or "IC06" or "IC07" or "IC08"			
				obs_time = (constrained to null)			
INSTRUCTION.activities.ACTIVITY.action_archetype_id				1..1 CLUSTER			
				meaning = <Activity_action_archetype_id> "OE-33"			
				item_category = "IC01" or "IC02" or "IC05" or "IC06" or "IC07" or "IC08"			
				obs_time = (constrained to null)			
				1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)			

A.2.6 openEHR Action

openEHR attribute			ISO 13606 representation		
ACTION			ENTRY		
			meaning = <Action> "OE-32"		
inherited ENTRY.language			(property of CV data type)		
inherited ENTRY.encoding			(property of CV data type)		
inherited ENTRY.subject			subject_of_information association		
inherited ENTRY.provider			information_provider association		
inherited ENTRY.other_participations			other_participations association		
inherited ENTRY.workflow_id			act_id attribute		
inherited CARE_ENTRY.protocol			0..1 CLUSTER		
			meaning = <Protocol> "OE-02"		
			item_category = "IC04"		
			obs_time = (constrained to null)		
			1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)		
inherited CARE_ENTRY.guideline_id			0..1 ELEMENT		
			meaning = <Guideline_id> "OE-03"		
			item_category = "IC04"		
			obs_time = (constrained to null)		
	ACTION.description		0..1 CLUSTER		
			meaning = <Action_description> "OE-21"		
			item_category = "IC01"		
	ACTION.time		obs_time = (mandatory, constrained from interval to single date-time)		
			1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)		
	ISM_TRANSITION.current_state		1..1 ELEMENT		
			meaning = <Current_state> "OE-22"		
			item_category = "IC02"		
			obs_time = (constrained to null)		
			value = CV		
	ISM_TRANSITION.transition		0..1 ELEMENT		
			meaning = <Transition> "OE-23"		
			item_category = "IC02"		
			obs_time = (constrained to null)		
			value = CV		
	ISM_TRANSITION.careflow_step		0..1 ELEMENT		
			meaning = <Careflow_step> "OE-24"		
			item_category = "IC02"		
			obs_time = (constrained to null)		
			value = CV		
	INSTRUCTION_DETAILS		0..1 CLUSTER		
			meaning = <Instruction_details> "OE-25"		
			item_category = "IC02"		
			obs_time = (constrained to null)		
	INSTRUCTION_DETAILS.instruction_id		1..1 ELEMENT		
			meaning = <Instruction_id> "OE-26"		
			item_category = "IC02"		
			obs_time = (constrained to null)		
			value = URI		
	INSTRUCTION_DETAILS.activity_id		0..1 ELEMENT		
			meaning = <Activity_id> "OE-27"		
			item_category = "IC02"		
			obs_time = (constrained to null)		
			value = String		
	INSTRUCTION_DETAILS.wf_details		0..1 CLUSTER		
			meaning = <Workflow_details> "OE-28"		
			item_category = "IC02"		
			obs_time = (constrained to null)		
			1..* (Further CLUSTERS and ELEMENTS, as openEHR ITEM_STRUCTURE)		

A.3 HL7 Version 3 entry archetypes

A.3.1 Introduction

The information model diagrams in this clause which accompany the mapping tables are taken from the HL7 Version 3 Clinical Statement Pattern (Draft Standard for Trial Use), and are included as an aid to the reader in understanding this clause. The formal documentation of this model may be obtained from www.hl7.org.

This set of mapping tables focuses only on the Act classes that may form part of an Entry within the Clinical Statement. It does not include the specific vocabulary harmonization. The Organizer class has not been included specifically through a mapping table: its representation in ISO 13606-1 will either be through a CLUSTER or a SECTION, depending upon the precise clinical data being represented. The ActReference class has not been included as a separate mapping table: its representation in ISO 13606-1 will normally be as a LINK instance to another RECORD_COMPONENT.

A more complete representation for this part of ISO 13606, along with ISO 13606-1, using the HL7 Clinical Statement Pattern, is being developed and will be published in the Implementation Guide referred to in the Introduction of this part of ISO 13606.

A.3.2 HL7 Observation Act

```

Observation
classCode*: <= OBS
moodCode*: < x_ClinicalStatementObservationMood
id: SET<I> [0..1]
code*: CD CWE [1..1] < ObservationType
negationInd: BL [0..1]
derivationExpr: ST [0..1]
text: ED [0..1]
statusCode*: CS CNE [0..1] < ActStatus
effectiveTime: GTS [0..1]
availabilityTime: TS [0..1]
priorityCode: CE CWE [0..1] < ActPriority
confidentialityCode: SET<CE> CWE [0..1] < Confidentiality
repeatNumber: IVL<INT> [0..1]
uncertaintyCode: CE CNE [0..1] < ActUncertainty
languageCode: CE CNE [0..1] < HumanLanguage
value: ANY CWE [0..1] < ObservationValue
interpretationCode: SET<CE> CWE [0..1] < ObservationInterpretation
methodCode: SET<CE> CWE [0..1] < ObservationMethod
targetSiteCode: SET<CD> CWE [0..1] < ActSite

```

HL7 v3 attribute	ISO 13606 representation
Class Observation	ENTRY
	meaning = <Act_Observation_root> "HL7-01"
	1..1 CLUSTER
	meaning = <Act_Observation> "HL7-02"
	item_category = "IC01"
classCode = OBS	(fixed value, need not be mapped)
languageCode	(represented within each textual data value)
confidentialityCode	sensitivity
	policy_ids
text	attestation,attested_view
availabilityTime	feeder_audit,time_committed
effectiveTime	obs_time
id	rc_id
	feeder_audit,version_set_id
	0..* ELEMENT
	meaning = <Act_id> "HL7-03"
	item_category = "IC02"
	obs_time = (constrained to null)
code	1..1 ELEMENT
	meaning = <Act_code> "HL7-04"
	item_category = "IC01"
	obs_time = (constrained to null)
value	0..1 DATA_VALUE
moodCode	1..1 ELEMENT
	meaning = <Act_moodCode> "HL7-05"
	item_category = "IC02"
	obs_time = (constrained to null)
text	0..1 ELEMENT
(if an accompanying narrative)	meaning = <Act_text> "HL7-06"
	item_category = "IC02"
	obs_time = (constrained to null)

HL7 v3 attribute	ISO 13606 representation		
negationInd	0..1	ELEMENT	meaning = <Act_negationInd> "HL7-07" item_category = "IC09" obs_time = (constrained to null)
uncertaintyCode	0..1	ELEMENT	meaning = <Act_uncertaintyCode> "HL7-08" item_category = "IC02" obs_time = (constrained to null)
derivationExpr	0..1	ELEMENT	meaning = <Act_derivationExpr> "HL7-09" item_category = "IC02" obs_time = (constrained to null)
statusCode	0..1	ELEMENT	meaning = <Act_statusCode> "HL7-10" item_category = "IC02" obs_time = (constrained to null)
priorityCode	0..1	ELEMENT	meaning = <Act_priorityCode> "HL7-11" item_category = "IC02" obs_time = (constrained to null)
repeatNumber	0..1	ELEMENT	meaning = <Act_repeatNumber> "HL7-12" item_category = "IC02" obs_time = (constrained to null)
interpretationCode	0..*	ELEMENT	meaning = <Act_interpretationCode> "HL7-13" item_category = "IC02" obs_time = (constrained to null)
targetSiteCode	0..*	ELEMENT	meaning = <Act_targetSiteCode> "HL7-14" item_category = "IC02" obs_time = (constrained to null)
methodCode	0..*	ELEMENT	meaning = <Act_methodCode> "HL7-15" item_category = "IC04" obs_time = (constrained to null)
If a container (via actRelationship)			
	0..*	CLUSTER	(Further CLUSTERS where meaning = "HL7-02")

A.3.3 HL7 Procedure Act

Procedure

```

classCode*: <= PROC
moodCode*: < x_ClinicalStatementProcedureMood
id*: SET<ID> [0..*]
code: CD CWE [0..1] < ActCode
negationInd: BL [0..1]
text: ED [0..1]
statusCode*: CS CNE [0..1] < ActStatus
effectiveTime*: GTS [0..1]
availabilityTime: TS [0..1]
priorityCode: CE CWE [0..1] < ActPriority
confidentialityCode: SET<CE> CWE [0..*] < Confidentiality
interruptibleInd: BL [0..1]
uncertaintyCode: CE CNE [0..1] < ActUncertainty
languageCode: CE CNE [0..1] < HumanLanguage
methodCode: SET<CE> CWE [0..*] < ProcedureMethod
approachSiteCode: SET<CD> CWE [0..*] < ActSite
targetSiteCode: SET<CD> CWE [0..*] < ActSite

```

HL7 v3 attribute	ISO 13606 representation
Class Procedure	ENTRY
	meaning = <Act_Procedure_root> "HL7-41"
	1..1 CLUSTER
	meaning = <Act_Procedure> "HL7-42"
	item_category = "IC01"
classCode = PROC	(fixed value, need not be mapped)
languageCode	(represented within each textual data value)
confidentialityCode	sensitivity
	policy_ids
text	attestation.attested_view
availabilityTime	feeder_audit.time_committed
effectiveTime	obs_time
id	rc_id
	feeder_audit.version_set_id
	0..* ELEMENT
	meaning = <Act_id> "HL7-03"
	item_category = "IC02"
	obs_time = (constrained to null)
code	1..1 ELEMENT
	meaning = <Act_code> "HL7-04"
	item_category = "IC01"
	obs_time = (constrained to null)
moodCode	1..1 ELEMENT
	meaning = <Act_moodCode> "HL7-05"
	item_category = "IC02"
	obs_time = (constrained to null)
text	0..1 ELEMENT
	meaning = <Act_text> "HL7-06"
	item_category = "IC02"
	obs_time = (constrained to null)
negationInd	0..1 ELEMENT
	meaning = <Act_negationInd> "HL7-07"
	item_category = "IC09"
	obs_time = (constrained to null)
uncertaintyCode	0..1 ELEMENT
	meaning = <Act_uncertaintyCode> "HL7-08"
	item_category = "IC02"
	obs_time = (constrained to null)
statusCode	0..1 ELEMENT
	meaning = <Act_statusCode> "HL7-10"
	item_category = "IC02"
	obs_time = (constrained to null)
priorityCode	0..1 ELEMENT
	meaning = <Act_priorityCode> "HL7-11"
	item_category = "IC02"
	obs_time = (constrained to null)
targetSiteCode	0..* ELEMENT
	meaning = <Act_targetSiteCode> "HL7-14"
	item_category = "IC02"
	obs_time = (constrained to null)
methodCode	0..* ELEMENT
	meaning = <Act_methodCode> "HL7-15"
	item_category = "IC04"
	obs_time = (constrained to null)
approachSiteCode	0..* ELEMENT
	meaning = <Act_approachSiteCode> "HL7-24"
	item_category = "IC04"
	obs_time = (constrained to null)
If a container (via actRelationship)	0..* CLUSTER
	(Further CLUSTERS where meaning = "HL7-42")

A.3.4 HL7 Substance Administration Act

SubstanceAdministration
classCode: <= SBADM
moodCode: < x_ClinicalStatementSubstanceMood
id: SET<I> [0..1]
code: CD CWE [0..1] < ActCode
negationInd: BL [0..1]
text: ED [0..1]
statusCode: CS CNE [0..1] < ActStatus
effectiveTime: GTS [0..1]
availabilityTime: TS [0..1]
priorityCode: CE CWE [0..1] < ActPriority
confidentialityCode: SET<CE> CWE [0..1] < Confidentiality
repeatNumber: IVL<INT> [0..1]
languageCode: CE CNE [0..1] < HumanLanguage
routeCode: CE CWE [0..1] < RouteOfAdministration
approachSiteCode: SET<CD> CWE [0..1] < ActSite
doseQuantity: IVL<PQ> [0..1]
rateQuantity: IVL<PQ> [0..1]
doseCheckQuantity: SET<RTO<QTY, QTY>> [0..1]
maxDoseQuantity: RTO<PQ, PQ> [0..1]
administrationUnitCode: CE CWE [0..1] < AdministrableDrugForm

HL7 v3 attribute	ISO 13606 representation
Class SubstanceAdministration	ENTRY meaning = <Act_SubstanceAdministration_root> "HL7-21"
	1..1 CLUSTER meaning = <Act_SubstanceAdministration> "HL7-22"
	item_category = "IC01"
classCode = SBADM	(fixed value, need not be mapped)
confidentialityCode	sensitivity
text	policy_ids
availabilityTime	attestation.attested_view
effectiveTime	feeder_audit.time_committed
id	obs_time
(if version specific id)	rc_id
(if cross-version id)	feeder_audit.version_set_id
(others)	0..* ELEMENT meaning = <Act_id> "HL7-03"
	item_category = "IC02"
	obs_time = (constrained to null)
code	1..1 ELEMENT meaning = <Act_code> "HL7-04"
	item_category = "IC01"
	obs_time = (constrained to null)
moodCode	1..1 ELEMENT meaning = <Act_moodCode> "HL7-05"
	item_category = "IC02"
	obs_time = (constrained to null)
text	0..1 ELEMENT meaning = <Act_text> "HL7-06"
	item_category = "IC02"
	obs_time = (constrained to null)
negationInd	0..1 ELEMENT meaning = <Act_negationInd> "HL7-07"
	item_category = "IC09"
	obs_time = (constrained to null)
statusCode	0..1 ELEMENT meaning = <Act_statusCode> "HL7-10"
	item_category = "IC02"
	obs_time = (constrained to null)
priorityCode	0..1 ELEMENT meaning = <Act_priorityCode> "HL7-11"
	item_category = "IC02"
	obs_time = (constrained to null)
repeatNumber	0..1 ELEMENT meaning = <Act_repeatNumber> "HL7-12"
	item_category = "IC02"
	obs_time = (constrained to null)
routeCode	0..1 ELEMENT meaning = <Act_routeCode> "HL7-23"
	item_category = "IC04"
	obs_time = (constrained to null)
approachSiteCode	0..* ELEMENT meaning = <Act_approachSiteCode> "HL7-24"
	item_category = "IC02"
	obs_time = (constrained to null)
doseQuantity	0..1 ELEMENT meaning = <Act_doseQuantity> "HL7-25"
	item_category = "IC02"
	obs_time = (constrained to null)

HL7 v3 attribute	ISO 13606 representation	
rateQuantity	0..1 ELEMENT	meaning = <Act_rateQuantity> "HL7-26"
		item_category = "IC02"
		obs_time = (constrained to null)
maxDoseQuantity	0..1 ELEMENT	meaning = <Act_maxDoseQuantity> "HL7-27"
		item_category = "IC02"
		obs_time = (constrained to null)
administrationUnitCode	0..1 ELEMENT	meaning = <Act_administrationUnitCode> "HL7-28"
		item_category = "IC02"
		obs_time = (constrained to null)
Consumable	1..1 CLUSTER	(Further ITEM structures, as necessary)
If a container (via actRelationship)	0..* CLUSTER	(Further CLUSTERS where meaning = "HL7-22")

A.3.5 HL7 Supply Act

Supply
classCode*: <= SPLY
moodCode*: < x_ClinicalStatementSupplyMood
id: SET<II> [0..*]
code: CD CWE [0..1] < ActCode
text: ED [0..1]
statusCode*: CS CNE [0..1] < ActStatus
effectiveTime: GTS [0..1]
availabilityTime: TS [0..1]
priorityCode: SET<CE> CNE [0..*] < ActPriority
confidentialityCode: SET<CE> CWE [0..*] < Confidentiality
repeatNumber: IVL<INT> [0..1]
independentInd: BL [0..1]
languageCode: CE CNE [0..1] < HumanLanguage
quantity: PQ [0..1]
expectedUseTime: IVL<TS> [0..1]

HL7 v3 attribute	ISO 13606 representation	
Class Supply	ENTRY	meaning = <Act_Supply_root> "HL7-31"
	1..1 CLUSTER	meaning = <Act_Supply> "HL7-32"
		item_category = "IC01"
		(fixed value, need not be mapped)
classCode = SPLY		sensitivity
confidentialityCode		policy_ids
text (if a legal rendering)		attestation.attested_view
availabilityTime		feeder_audit.time_committed
effectiveTime		obs_time
id (if version specific id)		rc_id
(if cross-version id)		feeder_audit.version_set_id
(others)	0..* ELEMENT	meaning = <Act_id> "HL7-03"
		item_category = "IC02"
		obs_time = (constrained to null)
code	1..1 ELEMENT	meaning = <Act_code> "HL7-04"
		item_category = "IC01"
		obs_time = (constrained to null)
moodCode	1..1 ELEMENT	meaning = <Act_moodCode> "HL7-05"
		item_category = "IC02"
		obs_time = (constrained to null)
text (if an accompanying narrative)	0..1 ELEMENT	meaning = <Act_text> "HL7-06"
		item_category = "IC02"
		obs_time = (constrained to null)
statusCode	0..1 ELEMENT	meaning = <Act_statusCode> "HL7-10"
		item_category = "IC02"
		obs_time = (constrained to null)
priorityCode	0..1 ELEMENT	meaning = <Act_priorityCode> "HL7-11"
		item_category = "IC02"
		obs_time = (constrained to null)

HL7 v3 attribute	ISO 13606 representation		
repeatNumber	0..1	ELEMENT	meaning = <Act_repeatNumber> "HL7-12" item_category = "IC02" obs_time = (constrained to null)
independentInd	0..1	ELEMENT	meaning = <Act_independentInd> "HL7-33" item_category = "IC04" obs_time = (constrained to null)
quantity	0..1	ELEMENT	meaning = <Act_quantity> "HL7-34" item_category = "IC02" obs_time = (constrained to null)
expectedUseTime	0..1	ELEMENT	meaning = <Act_expectedUseTime> "HL7-35" item_category = "IC02" obs_time = (constrained to null)
Product	1..1	CLUSTER	(Further ITEM structures, as necessary)
If a container (via actRelationship)			
	0..*	CLUSTER	(Further CLUSTERS where meaning = "HL7-32")

A.3.6 HL7 Act

Act

```

classCode*: <= ACT
moodCode*: < x_ClinicalStatementActMood
id*: SET<I> [0..*]
code*: CD CWE [1..1] < ActCode
negationInd: BL [0..1]
text*: ED [0..1]
statusCode*: CS CNE [0..1] < ActStatus
effectiveTime*: IVL<TS> [0..1]
availabilityTime: TS [0..1]
priorityCode: CE CWE [0..1] < ActPriority
confidentialityCode: SET<CE> CWE [0..*] < Confidentiality
uncertaintyCode: CE CNE [0..1] < ActUncertainty
languageCode: CE CNE [0..1] < HumanLanguage

```

HL7 v3 attribute	ISO 13606 representation		
Class Act	ENTRY		meaning = <Act_Act_root> "HL7-51"
	1..1	CLUSTER	meaning = <Act_Act> "HL7-52" item_category = "IC01" (fixed value, need not be mapped) (represented within each textual data value)
classCode = ACT			
languageCode			sensitivity
confidentialityCode			policy_ids
text	(if a legal rendering)		attestation.attested_view
availabilityTime			feeder_audit.time_committed
effectiveTime			obs_time
id	(if version specific id)		rc_id
	(if cross-version id)		feeder_audit.version_set_id
	(others)	0..*	ELEMENT
			meaning = <Act_id> "HL7-03" item_category = "IC02" obs_time = (constrained to null)
code		1..1	ELEMENT
			meaning = <Act_code> "HL7-04" item_category = "IC01" obs_time = (constrained to null)
moodCode		1..1	ELEMENT
			meaning = <Act_moodCode> "HL7-05" item_category = "IC02" obs_time = (constrained to null)
text	(if an accompanying narrative)	0..1	ELEMENT
			meaning = <Act_text> "HL7-06" item_category = "IC02" obs_time = (constrained to null)
negationInd		0..1	ELEMENT
			meaning = <Act_negationInd> "HL7-07" item_category = "IC09" obs_time = (constrained to null)

HL7 v3 attribute		ISO 13606 representation	
uncertaintyCode		0..1	ELEMENT
			meaning = <Act_uncertaintyCode> "HL7-08"
			item_category = "IC02"
			obs_time = (constrained to null)
statusCode		0..1	ELEMENT
			meaning = <Act_statusCode> "HL7-10"
			item_category = "IC02"
			obs_time = (constrained to null)
priorityCode		0..1	ELEMENT
			meaning = <Act_priorityCode> "HL7-11"
			item_category = "IC02"
			obs_time = (constrained to null)
If a container (via actRelationship)		0..*	CLUSTER
			(Further CLUSTERS where meaning = "HL7-52")

A.3.7 HL7 Encounter Act

Encounter
classCode*: <= ENC
moodCode*: < x_ClinicalStatementEncounterMood
id: SET<I> [0..*]
code: CD CWE [0..1] < ActEncounterCode
text: ED [0..1]
statusCode*: CS CNE [0..1] < ActStatus
effectiveTime: GTS [0..1]
availabilityTime: TS [0..1]
priorityCode: CE CWE [0..1] < ActPriority
confidentialityCode: SET<CE> CWE [0..*] < Confidentiality
languageCode: CE CNE [0..1] < HumanLanguage
admissionReferralSourceCode: CE CWE [0..1] < EncounterReferralSource
lengthOfStayQuantity: PQ [0..1]
dischargeDispositionCode: CE CWE [0..1] < EncounterDischargeDisposition
preAdmitTestInd: BL [0..1]
specialCourtesiesCode: SET<CE> CWE [0..*] < EncounterSpecialCourtesies
specialArrangementCode: SET<CE> CWE [0..*] < SpecialArrangement

HL7 v3 attribute		ISO 13606 representation	
Class Encounter		ENTRY	
			meaning = <Act_Encounter_root> "HL7-61"
		1..1	CLUSTER
			meaning = <Act_Encounter> "HL7-62"
			item_category = "IC01"
			(fixed value, need not be mapped)
classCode = ENC			sensitivity
confidentialityCode			policy_ids
text	(if a legal rendering)		attestation.attested_view
availabilityTime			feeder_audit.time_committed
effectiveTime			obs_time
id	(if version specific id)		rc_id
	(if cross-version id)		feeder_audit.version_set_id
	(others)	0..*	ELEMENT
			meaning = <Act_id> "HL7-03"
			item_category = "IC02"
			obs_time = (constrained to null)
code		1..1	ELEMENT
			meaning = <Act_code> "HL7-04"
			item_category = "IC01"
			obs_time = (constrained to null)
moodCode		1..1	ELEMENT
			meaning = <Act_moodCode> "HL7-05"
			item_category = "IC02"
			obs_time = (constrained to null)
text	(if an accompanying narrative)	0..1	ELEMENT
			meaning = <Act_text> "HL7-06"
			item_category = "IC02"
			obs_time = (constrained to null)
statusCode		0..1	ELEMENT
			meaning = <Act_statusCode> "HL7-10"
			item_category = "IC02"
			obs_time = (constrained to null)
priorityCode		0..1	ELEMENT
			meaning = <Act_priorityCode> "HL7-11"
			item_category = "IC02"
			obs_time = (constrained to null)
admissionReferralSourceCode		0..1	ELEMENT
			meaning = <Act_admissionReferralSourceCode> "HL7-63"
			item_category = "IC02"
			obs_time = (constrained to null)

HL7 v3 attribute	ISO 13606 representation	
lengthOfStayQuantity	0..1	ELEMENT
		meaning = <Act_lengthOfStayQuantity> "HL7-64"
		item_category = "IC02"
		obs_time = (constrained to null)
dischargeDispositionCode	0..1	ELEMENT
		meaning = <Act_dischargeDispositionCode> "HL7-65"
		item_category = "IC02"
		obs_time = (constrained to null)
preAdmitTestInd	0..1	ELEMENT
		meaning = <Act_preAdmitTestInd> "HL7-66"
		item_category = "IC02"
		obs_time = (constrained to null)
specialCourtesiesCode	0..1	ELEMENT
		meaning = <Act_specialCourtesiesCode> "HL7-67"
		item_category = "IC02"
		obs_time = (constrained to null)
specialArrangementCode	0..1	ELEMENT
		meaning = <Act_specialArrangementCode> "HL7-68"
		item_category = "IC02"
		obs_time = (constrained to null)
If a container (via actRelationship)	0..*	CLUSTER
		(Further CLUSTERS where meaning = "HL7-62")

A.4 Code set for RECORD_COMPONENT.meaning attribute

Code	Term
OE-01	Observation
OE-02	Protocol
OE-03	Guideline_id
OE-04	Data
OE-05	Period
OE-06	Duration
OE-07	Point_event
OE-08	Event_data
OE-09	Event_state
OE-10	Interval_event
OE-11	Width
OE-12	Sample_count
OE-13	Math_function
OE-14	State
OE-15	Instruction_narrative
OE-16	Instruction_expiry_time
OE-17	Instruction_wf_definition
OE-18	Activity
OE-19	Activity_timing
OE-20	Activity_description
OE-21	Action_description
OE-22	Current_state
OE-23	Transition
OE-24	Careflow_step

Code	Term
OE-25	Instruction_details
OE-26	Instruction_id
OE-27	Activity_id
OE-28	Workflow_details
OE-30	Evaluation
OE-31	Instruction
OE-32	Action
OE-33	Activity_action_archetype_id
HL7-01	Act_Observation_root
HL7-02	Act_Observation
HL7-03	Act_id
HL7-04	Act_code
HL7-05	Act_moodCode
HL7-06	Act_text
HL7-07	Act_negationInd
HL7-08	Act_uncertaintyCode
HL7-09	Act_derivationExpr
HL7-10	Act_statusCode
HL7-11	Act_priorityCode
HL7-12	Act_repeatNumber
HL7-13	Act_interpretationCode
HL7-14	Act_targetSiteCode
HL7-15	Act_methodCode
HL7-21	Act_SubstanceAdministration_root
HL7-22	Act_SubstanceAdministration
HL7-23	Act_routeCode
HL7-24	Act_approachSiteCode
HL7-25	Act_doseQuantity
HL7-26	Act_rateQuantity
HL7-27	Act_maxDoseQuantity
HL7-28	Act_administrationUnitCode
HL7-31	Act_Supply_root
HL7-32	Act_Supply
HL7-33	Act_independentInd
HL7-34	Act_quantity
HL7-35	Act_expectedUseTime
HL7-41	Act_Procedure_root
HL7-42	Act_Procedure

Code	Term
HL7-51	Act_Act_root
HL7-52	Act_Act
HL7-61	Act_Encounter_root
HL7-62	Act_Encounter
HL7-63	Act_admissionReferralSourceCode
HL7-64	Act_lengthOfStayQuantity
HL7-65	Act_dischargeDispositionCode
HL7-66	Act_preAdmitTestInd
HL7-67	Act_specialCourtesiesCode
HL7-68	Act_specialArrangementCode

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Annex B (informative)

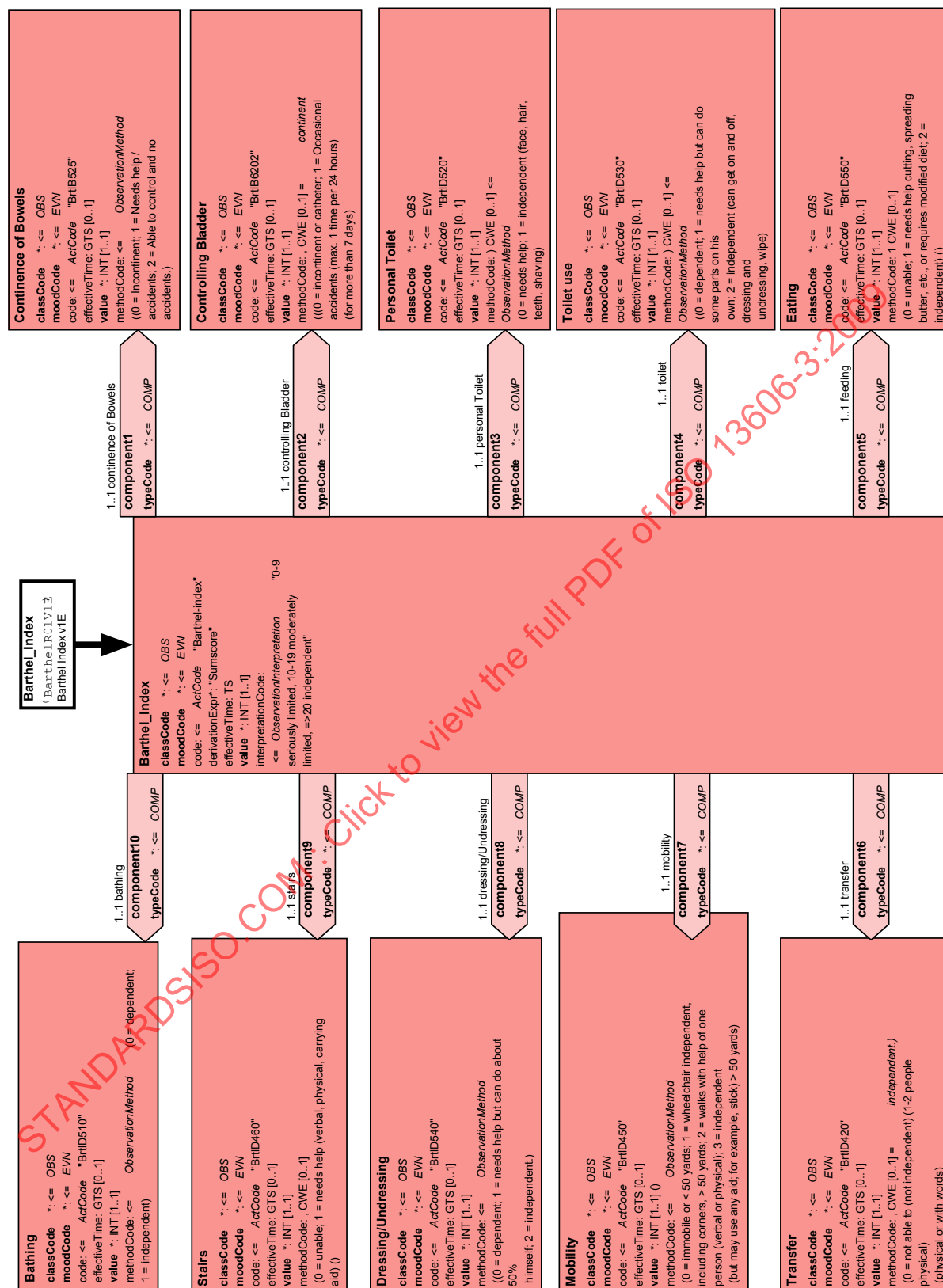
Clinical example of the mapping between HL7 v3 and the ISO 13606 series

B.1 Introduction

It is recognised that the HL7 v3 Reference Information Model (RIM) is primarily used as an abstract model basis from which to define specific message models. It is these latter models that are more likely to be the source models for mapping to ISO 13606. For this reason, although Annex A defines the broad points of correspondence between version HL7 v3 Act classes and attributes, the following worked clinical example may be more representative of the mapping that will more often be required.

B.2 HL7 v3 representation of the Barthel Index

The Barthel Index is a scoring assessment used as the basis for assessing the functional capability of a patient following, for example, a cerebrovascular accident (stroke). This model, shown below, focuses on the attributes holding key clinical values, and omits data management attributes such as instance identifiers. Further details about this model may be obtained from the Patient Care Technical Committee of HL7.



B.3 Table of correspondence between HL7 v3 and ISO 13606 for the Barthel Index

The table over the following eight pages shows the points of correspondence between the HL7 v3 and ISO 13606 representations of the Barthel Index.