Pathology Result Reporting Package (v1.0 Draft)

Information Architecture v2.0

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Preface

Document Purpose

This document describes the Information Architecture for Pathology Result Reporting in Australia, between a Pathology Provider and a Pathology Report Recipient, in a manner which is independent of platform, technologies or messaging formats. As such, this document provides a reference for the information components involved in the implementation of any solution, which engages in the process of pathology reporting or receiving pathology reports as a key function.

This Information Architecture includes descriptions of the information components and their interrelations. It also includes references to other documents, which provide more detailed data specifications for each of these information components.

Intended Audience

This document is intended to be read by ICT managers, clinicians involved in Clinical Information System (CIS) specifications, software architects, software developers, and implementers of CISs in various healthcare settings. This document is reasonably technical in nature and assumes its audience will be familiar with the language of health data specifications and have some familiarity with health-related information standards.

Document Map

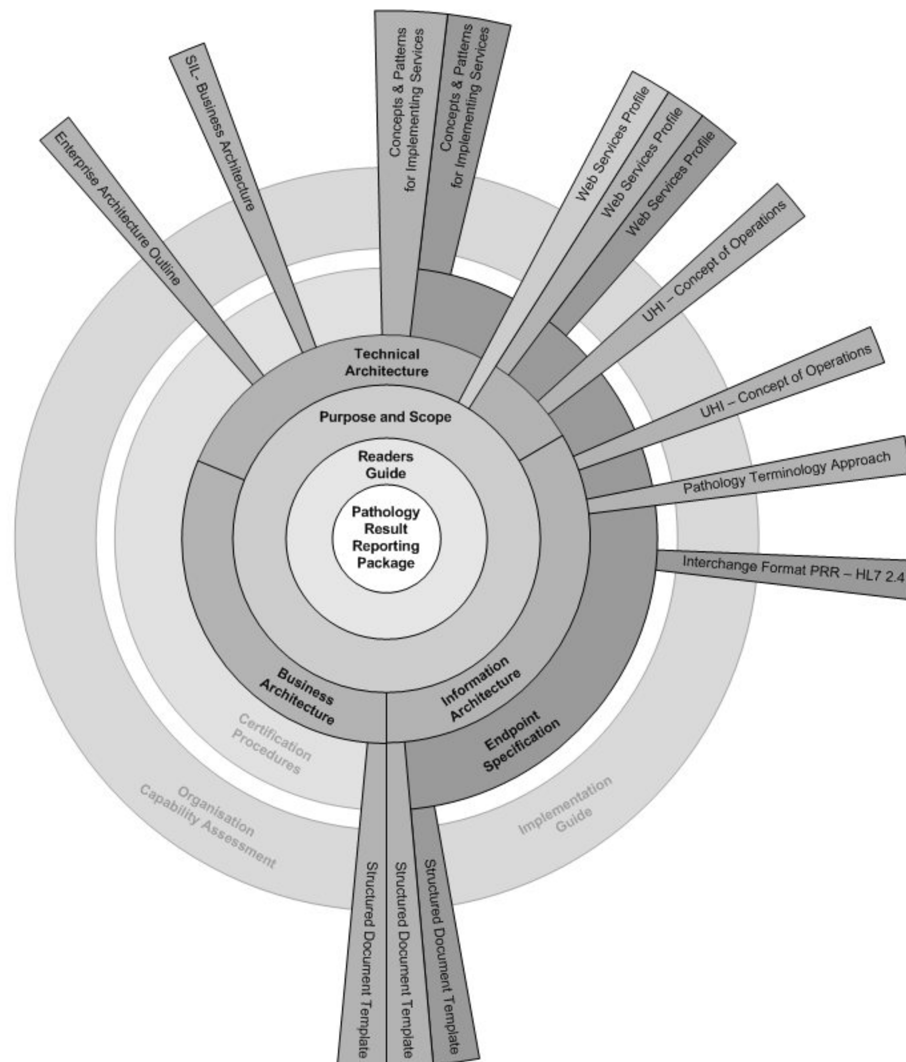

Figure 1 Pathology Result Reporting Package – Document Map

The Package Document Map is designed to show the hierarchy of core documents within the package, and their relationships to ancillary documents. Core package documents are represented as arcs, while ancillary documents (or references to such) appear as radiating spokes. Note that, due to the 'many-to-many' relationships within the package, some ancillary documents appear more than once, and have typically been grouped for clarity.

It is recommended that readers commence with documents at the centre of the map (i.e. the 'Readers' Guide', and 'Purpose and Scope'), working outwards to the detailed, technical documents as needed. Business sponsors may wish to focus upon core documentation, while technical implementers will also likely include ancillary documents.

Core documents are explained in the Readers' Guide [PATH-PRR-RG].

Definitions, Acronyms and Abbreviations

For a lists of abbreviations, acronyms and abbreviations, see the Definitions section at the end of the document, on page 27.

References and Related Documents

For a list of all referenced documents, see the References at the end of the document, on page 29.

1 Overview

1.1 Background

NEHTA is helping to establish an e-health environment that better enables the exchange of information between health service providers, and across the national healthcare community. To reach this goal of national information interoperability, NEHTA has proposed a service model, based on a service-orientated architecture. This service model provides coverage for specific business processes within the health domain, including pathology result reporting, medication management, discharge and referral. It builds upon a number of national e-health infrastructure services, including secure messaging, authentication, identification, and clinical terminology. It is also based on the privacy principles defined in NEHTA's *Privacy Management Framework*. [NPMF2008]

NEHTA's work program has involved the development of specifications for use by the e-health community to promote interoperability. As part of developing a solution roadmap for the e-health community, NEHTA aims to provide clear direction for stakeholders on these specifications through the delivery of a series of packages.

A NEHTA package is intended to provide guidance relating to NEHTA's service specifications, their adoption, and their implementation in the context of NEHTA's *Interoperability Framework* (IF) [INTER2007]. NEHTA packages also aim to provide sufficient supporting material to inform adoption and implementation across the e-health community.

The delivery of the Pathology Result Reporting package builds upon the electronic information currently being exchanged within the pathology reporting community, and provides implementation standards designed to enhance the quality and usefulness of this pathology information.

For background information relating to the Pathology Result Reporting package, please refer to '*Pathology Result Reporting Package v1.0 – Purpose and Scope*' [PATH-PRR-PS].

1.2 Pathology Reporting Community

The Pathology Reporting Community is the collection of entities (e.g. individuals, organisations and information systems) established to manage the process of transferring Pathology Reports between a Pathology Provider and the intended Pathology Report Recipient(s). This process is described in more detail in '*Pathology Result Reporting Package v1.0 – Business Architecture*' [PATH-PRR-BA].

As shown in Figure 2, the Pathology Reporting Community is comprised of four main community roles, and one main information component.

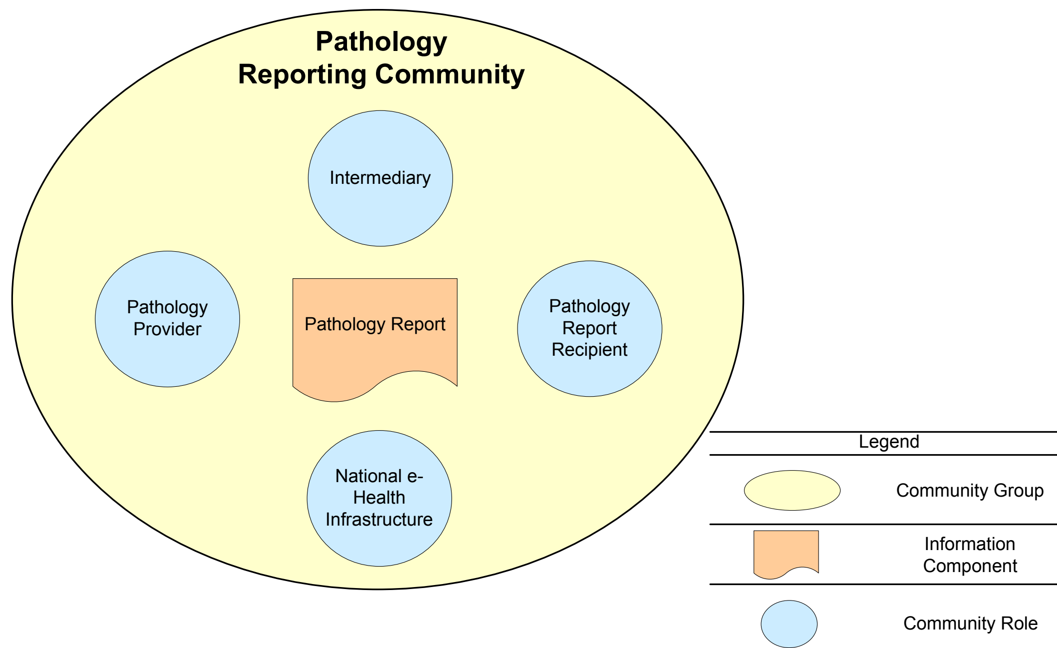

Figure 2: Pathology Reporting Community

The Pathology Report, which is the main information component in this community, also plays a corresponding 'artefact role' [PATH-PRR-BA].

The four main community roles are:

- The *Pathology Provider*, responsible for performing pathology services
- The *Pathology Report Recipient*, the person, group, system or place intended to receive a specific Pathology Report instance
- The *Intermediary*, which (when present) mediates between a Pathology Provider and the Pathology Report Recipient to facilitate the communication process, providing;
  - a storage facility for disconnected parties and/or
  - a method for the aggregation of Pathology Reports from multiple Pathology Report Providers
- The *National E-Health Infrastructure*, which is designed to support a common approach across the Australian e-health community for processes such as authentication, identification and service location. The proposed National E-Health Infrastructure includes:
  - The *Unique Healthcare Identification Servic*e, enabling the unique identification of individuals (healthcare consumers) and healthcare providers (individual or organisations)
  - The *National Authentication Service for Health* (NASH), which will provide strongly-authenticated credentials to individuals and organisations across the health community
  - The *Service Instance Locator* (SIL), used by applications to locate the correct service endpoint, when attempting to establish communications with a service instance.

Please note that these infrastructure components will not be available during the initial implementation of the Pathology Result Reporting Package. [PATH-PRR-TA]

2 Information Components

2.1 Overview

The key information components used in a Pathology Result Reporting solution are shown in the high-level class diagram below in Figure 3.

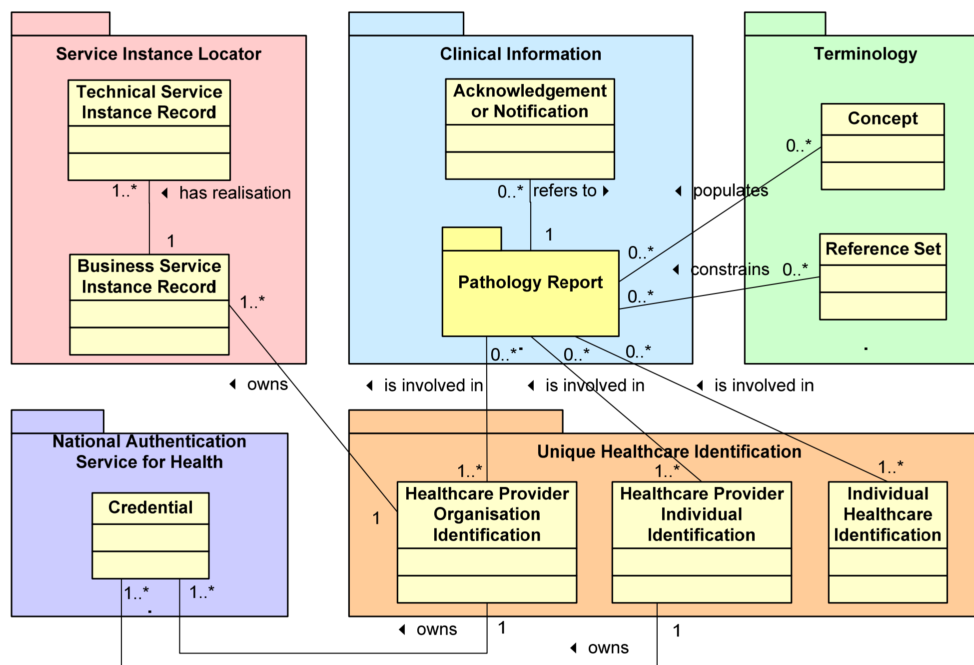

Figure 3: Information Component Overview

This diagram groups the key information components into logical categories (represented as separate UML 'packages'), and shows the relationships between these components. The key information components shown in Figure 3 include:

- The Pathology Report (Clinical Information)
- Acknowledgement and Notifications (Messaging Information)
- Concepts and Reference Sets (Terminology)
- Healthcare Provider Individual Identification, Healthcare Provider Organisation Identification and Individual Healthcare Identification (Unique Healthcare Identification)
- Business and Technical Service Instance Records (Service Instance Locator) and
- Credentials (National Authentication Service for Health).

These information components will be discussed in more detail in the following sections.

2.2 Pathology Report

2.2.1 Overview

A Pathology Report is a series of Pathology episodes, which are grouped together for a specific reporting purpose. Each Pathology Report is unique although the information contained may reside in other Pathology Reports. A Pathology Report may have many different instances which are created when the act of reporting takes place.

2.2.2 Pathology Report Instance

A Pathology Report Instance represents a single version of a pathology report, which is created and circulated to recipients. Each uniquely identified Report Instance references a specific Pathology Report and includes the status of the instance from a reporting perspective. An Instance can exist in different stages, such as an interim report, adjusted report, etc.

A Pathology Episode is an atomic item of information that is obtained when a Pathology Test is performed on a specimen. The structure, format and unit of measure, which are used to define a Pathology Episode, can vary based on a number of factors, such as the specific test performed.

2.2.3 Pathology Report Components

The diagram below in Figure 4 illustrates the major component classes that comprise a standard Pathology Report. Pathology communications involving non-standard data formats (i.e. non-standard report formats, cumulative report types, commercially unique transmissions) are currently out of scope for this community.

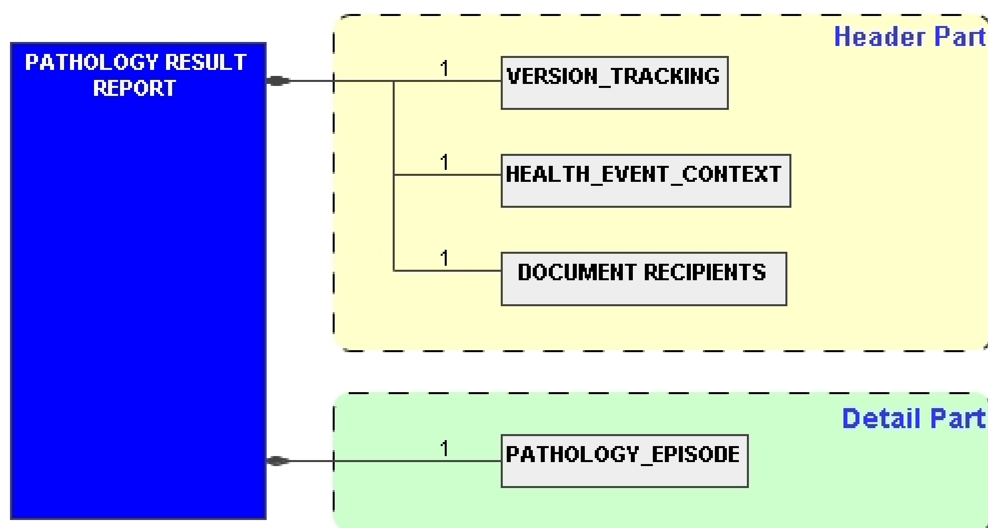

Figure 4: Pathology Result Report Overview

The diagram is split into two parts:

- the **Header Part**, containing the component classes of the report heading, and
- the **Detail Part**, containing the component classes of the Pathology Episode (i.e. the actual pathology test results).

Further information about these component classes can be found in the Structured Document Template – Pathology Result Reporting Package v1.0 [PATH-PRR-SDT], which describes the structure of and constraints on a Pathology Report. More specifically, this document names the data elements in a valid Pathology Report Instance, together with their structure, definition, datatype and constraints (including occurrence frequency, value domains and conditions of use).

2.3 Acknowledgements and Notifications

2.3.1 Overview

The diagram below in Figure 5 shows the business-level acknowledgements and notifications, which are relevant to the Pathology Result Reporting

Community. These messages are required for each Pathology Report instance distributed.

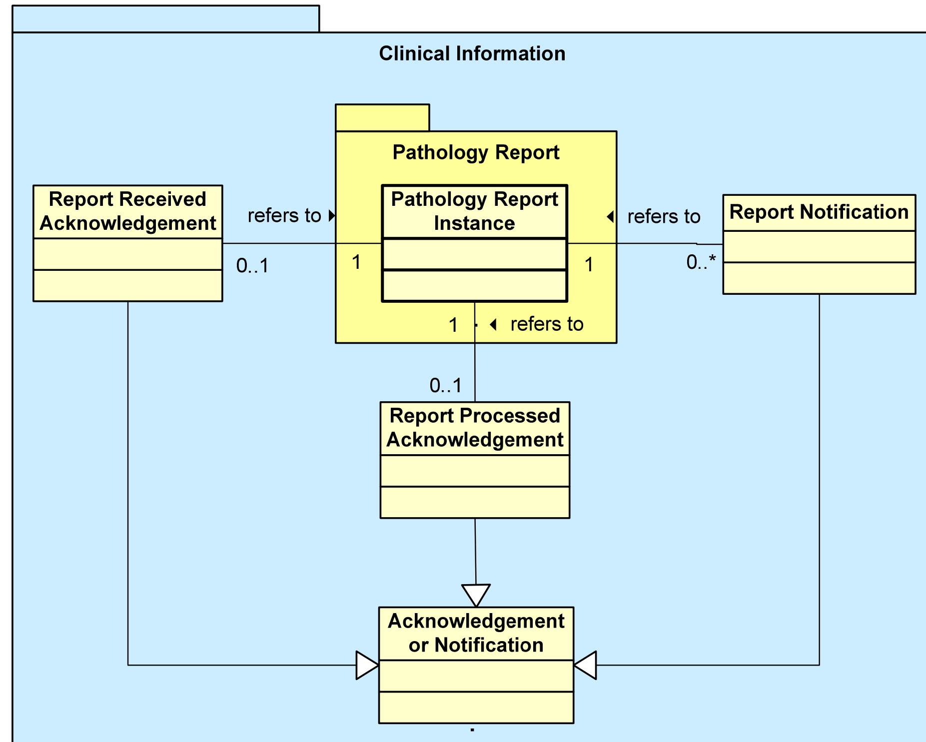

Figure 5: Acknowledgements and Notifications

For more information about these acknowledgements and notifications, please refer to the Community Policy section in the *Pathology Result Reporting Package v1.0 – Business Architecture* document [PATH-PRR-BA]. Please note that additional acknowledgements and notifications may be required if an Intermediary is required between the Pathology Provider and the Pathology Report Recipients.

2.3.2 Report Notification

When a report is ready for collection (or is distributed to an Intermediary), the *Pathology Provider* will compile a notification message that includes the report identifier and the location where the report is stored. This message is for the end use of the *Pathology Report Recipient*.

For each Pathology Report Instance, a Report Notification must be sent in a timely manner. However, as there may be a short delay between the creation of the report and the sending of the Report Notification, the cardinality of this relationship indicates that the Report Notification is optional, to allow for this short delay.

In cases where the test results require quick action from the *Pathology Report Recipient* (the entity that requested the report) the *Pathology Provider* may notify the Pathology Report Recipient, through additional means (e.g. a phone call). This additional report notification is only applicable to certain test results.

2.3.3 Report Received Acknowledgement

When the report instance is received by the *Pathology Report Recipient*, the *Pathology Provider* requires that a 'Report Received Acknowledgement' be sent by that recipient. This acknowledgement is required for audit and 'Chain of Information' custody purposes, and will include the Pathology Report Instance identifier.

2.3.4 Report Processed Acknowledgement

Once the *Pathology Report Recipient* has received the report, it must be uploaded into the Clinical Information System (CIS) system of the *Pathology Report Recipient*. The outcome of this upload process is represented in the 'Report Processed Acknowledgment'. This acknowledgement is provided by the *Pathology Report Recipien*t to the *Pathology Provider* to allow for status tracking and to allow for reports that are found to be faulty to be resent. This acknowledgement will include the Pathology Report Instance identifier.

2.4 Terminology

2.4.1 Background

One prerequisite to the safe exchange of clinical information between healthcare providers is the establishment of a common, coded clinical language (clinical terminology). The concepts and terms used in clinical communications that describe diagnoses, procedures, therapies, medications, and other clinical ideas must be accurately and consistently interpreted by all participating health IT systems and the clinicians that interact with them.

2.4.2 SNOMED CT

SNOMED Clinical Terms® (SNOMED CT), the internationally pre-eminent clinical terminology, has been identified by NEHTA as the preferred terminology for Australia. SNOMED CT is now freely available for use in Australia, under NEHTA's licensing arrangements with the International Health Terminology Standards Development Organisation (IHTSDO). As SNOMED CT does not provide total coverage of all concepts and descriptions used in the Australian healthcare environment, NEHTA will supplement SNOMED CT by developing specific extensions and derivatives to cover local clinical information requirements. The extensions and derivatives are anticipated to cover an increasing number of terminology domains over time. However, initial priorities have been defined to cover areas such as medicines, allergies, adverse reactions, pathology, diagnosis and procedures. Ongoing priorities will be defined through stakeholder consultation and NEHTA's assessment of benefits and capacity to support ongoing releases.

With this in mind, SCT-AU (SNOMED CT with Australian-specific extensions) will be used, wherever suitable, to define coded terms used within a Pathology Report sent by a *Pathology Provider* to a *Pathology Report Recipient*.

2.4.3 Terminology Binding

The specification document, Structured Document Template – Pathology Result Reporting Package v1.0 [PATH-PRR-SDT], describes and constrains the contents of a Pathology Report sent by a *Pathology Provider* to a *Pathology Report Recipient*. This specification also identifies those data elements which either can, or should, use terminology values to populate them. Data elements of this kind are identified by the data type 'CodeableText' or 'CodedText'.

Each of these 'codeable' data elements has a value domain, which will be bound (or restricted,) to specific terminology value sets, called 'reference sets'. These reference sets define the possible set of concepts that may be used to populate the associated data element.

The diagram in Figure 6 shows the common structure of all Event Summaries (e.g. Pathology Report), and the relationship of its component with those of Terminology. In particular, it shows the relationship between the Data Elements and the Concepts which populate them, and the relationship between the Value Domains and the Reference Sets which constrain their

valid values. The dashed arrow, between these two relationships, represents the constraint that Concepts populating a particular Data Element must be referenced by the Reference Set that constrains that Data Element's Value Domain.

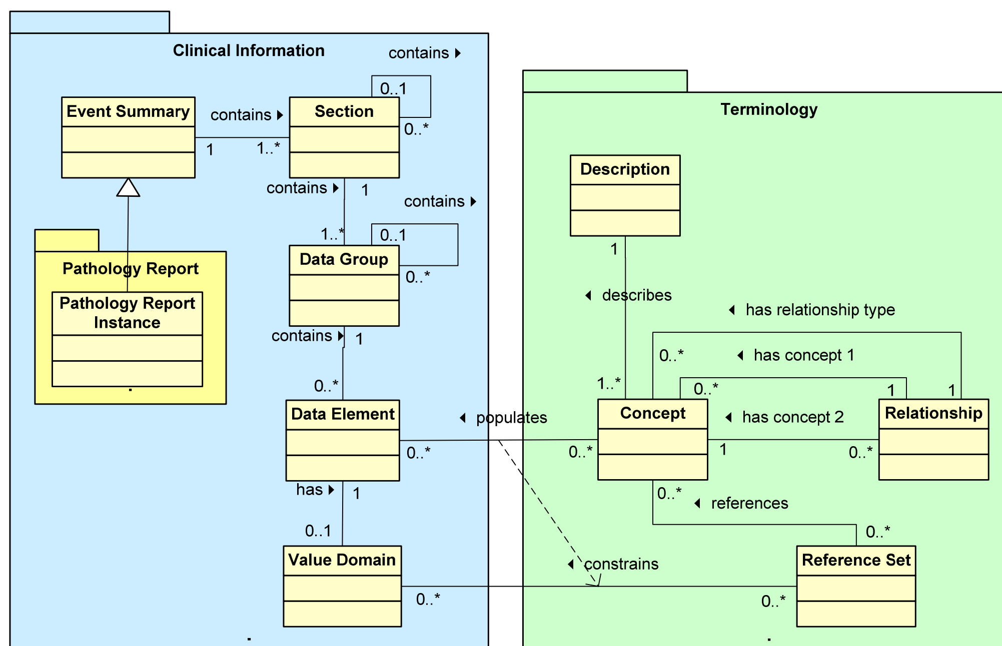

Figure 6: Pathology Report Terminology Binding

2.4.4 Terminology Bindings for Pathology Reports

In the current version of the *Structured Document Template* [PATH-PRR-SDT], six of the data elements have value domains, which have been bound to SNOMED CT – namely:

- Specimen Type (DE-11008)
- Specimen Qualifier (DE-11009)
- Specimen Anatomical Site (DE-11010)
- Request Test Name (DE-11017)
- Result Test Name (DE-32001)
- Testing Method (DE-11025)

For a summary of the terminology bindings defined in the *Structured Document Template*, please refer to Appendix A:.

For a more detailed description of the terminology approach taken for Pathology Result Reporting, please refer to the *Pathology Terminology Approach Document* [NEHTA_0198_2008]. Please note that to access this, and other SNOMED CT related documents, a free SNOMED licence is required. This licence can be obtained by going to: https://nehta.org.au/aht.

2.5 Unique Healthcare Identification

2.5.1 Overview

The healthcare system relies heavily on the ability to uniquely and accurately identify a healthcare individual so as to relate current patient status to previous care, and to support the communication between healthcare providers in either manual or computer-based information environments.

Within the healthcare service delivery community, the process of positively identifying healthcare consumers involves matching data supplied by those individuals against data held by healthcare providers.

In order to support this identification process, NEHTA has secured the services of Medicare Australia to design and build Australia's first national healthcare identification service. The resulting Unique Healthcare Identifiers (UHI) Service will provide the requisite identification service for the people and organisations involved in healthcare across Australia, by way of:

- *Individual Healthcare Identifiers* (IHIs) to identify all Australian healthcare consumers
- *Healthcare Provider Identifiers - Individual* (HPI-Is), to identify individual healthcare providers, such as general practitioners, clinicians, nurses and pharmacists
- *Healthcare Provider Identifiers – Organisation* (HPI-Os), to identify healthcare organisations such as hospitals and clinics.

Initially, it is assumed that the Unique Healthcare Identifiers (UHIs) and jurisdictional and local system identifiers (including Medical Record Numbers [MRNs] and Unique Patient Identifiers [UPIs]) will coexist. However, in the longer term, IHIs and HPIs are expected to replace these existing, localised identifiers, providing a more interoperable approach to identification.

2.5.2 Healthcare Identifiers in Pathology

A *Pathology Report* uses healthcare identifiers (and other identification data) for a number of purposes, including the identification of:

- The subject of care (IHI)
- The facility involved in the delivery of healthcare to the subject of care (HPI-O)
- The individual healthcare provider who requested the pathology investigations be performed (HPI-I)
- The recipient(s) of the pathology report instance (HPI-I)
- The primary laboratory that performed the pathology investigation (HPI-O)
- The secondary laboratory that performed the pathology investigation (HPI-O); and
- The reporting pathologist (HPI-I).

Three distinct types of information components are required to support these identification requirements, namely: Individual Healthcare Identification, Healthcare Provider Individual Identification, and Healthcare Provider Organisation Identification. These information components are shown in Figure 7.

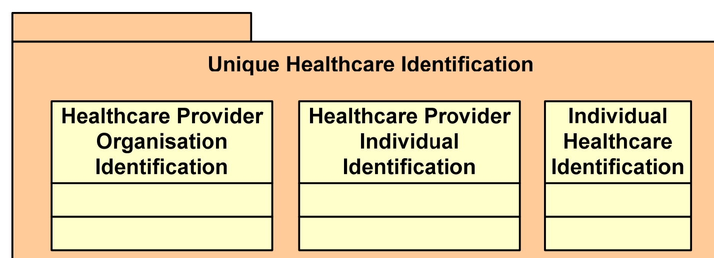

Figure 7: Healthcare Identifiers

For more information about IHIs, HPIs and the planned UHI service, please refer to Unique Healthcare Identification - Concept of Operations [UHI-CO].

2.6 NASH Credentials

2.6.1 Overview

The authentication of healthcare providers is an important foundation service in the e-health community. For this reason, NEHTA plans to build and operate a new national service, called the *National Authentication Service for Health* (NASH). Its goals are to:

- Establish a single authoritative source providing strong authentication credentials for use in the Australian health sector
- Create a number of credential issuers across the sector, each able to create and issue local credentials using the central source
- Establish and operate an authentication service adoption program, intended to support both health software vendors and health jurisdictions in their own programs to:
  - incorporate strong authentication credentials into their applications and environments
  - create a service to assist end users with the adoption and deployment of authentication tokens.

2.6.2 Credentials

As shown in Figure 8, the NASH information components that are relevant to Pathology Result Reporting implementations include:

- **Credential** – A trusted digital certificate made of public and private components, used to assert the identity of the certificate owner
- **Digital Signing Credential** – A trusted digital certificate used for digitally signing messages, which enables detection of changes of information in transit, and also enables non-repudiation of the sender
- **Authentication Credentia**l – A trusted digital certificate used to authenticate individuals or organisations
- **Encryption Credential** – A trusted digital certificate used to encrypt and decrypt messages.

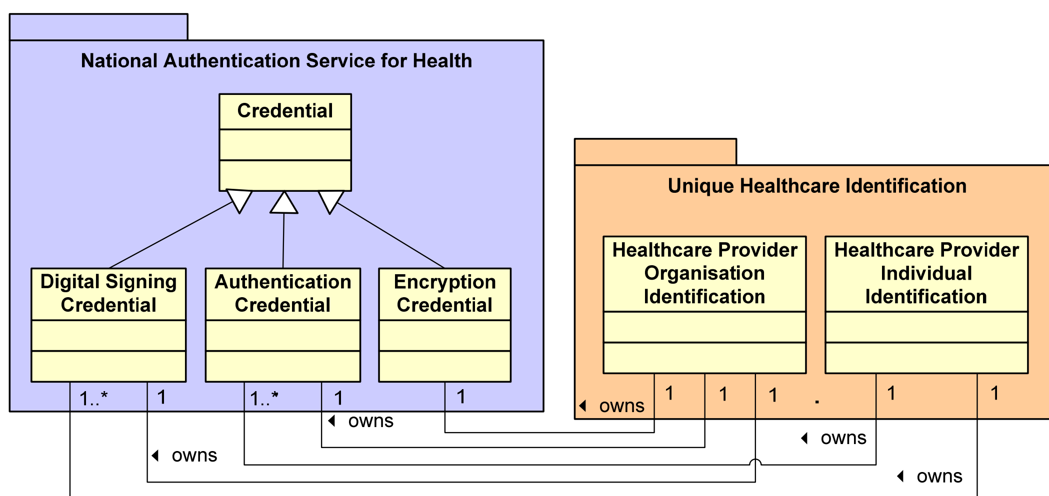

Figure 8: NASH Credentials

For more information about the NASH and about NASH credentials, please refer to the National Authentication Service for Health – High Level Technical Requirements [NASH-TR].

2.7 Service Instance Locator

2.7.1 Overview

The requirement for a *Service Instance Locator* (SIL) has been identified as a key piece of National E-Health Infrastructure. Applications that attempt to establish communications with a service (e.g. report receipt and processing service at a Reporting Recipient) will use a SIL to locate the correct service endpoint.

The only data stored in a SIL repository is a set of *Business Service Instance Records* (BSIRs) and a set of *Technical Service Instance Records* (TSIRs). BSIRs include enough information for a client to choose between possible technical realisations of a business service.

The TSIRs subsequently identify the technical type and endpoint of the service, its owner and host, and metadata to facilitate caching. The owner is the organisation, which is the identified target of the business service (e.g. a GP practice), and the host is the organisation which runs the technical service (e.g. a middleware hub). The technical type of the service is information about the technical communication protocols of the service.

2.7.2 SIL in the Pathology Reporting Community

In the Pathology Reporting Community, each Pathology Report Provider and each Pathology Report Recipient will have a SIL repository, upon which it owns a set of BSIRs and TSIRs. The Pathology Provider will be able to use the Pathology Report Recipient's SIL to determine the technical details required to deliver the Pathology Result Report securely to the appropriate location.

The diagram in Figure 9 shows the main information components involved in this process.

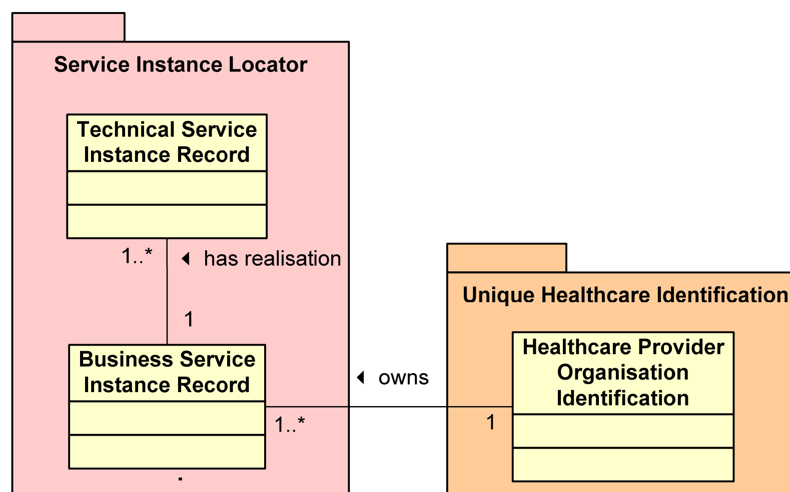

Figure 9: Service Instance Directory

For more information about the SIL's information architecture, please refer to the *Service Instance Locator – Business and Information Architecture* document [SIL2008].

3 Data Capture Requirements

3.1 Overview

This section summarises the key information requirements of the components described in Chapter 2, which apply within the Pathology Result Reporting community (as shown in Figure 3: Information Component Overview).

For each information component, a table is shown, which includes the name of the business process in which the component's data capture occurs, a definition of the information component, the data capture requirement being documented, a list of business processes which use the given information component in some way, and any other relevant notes.

Please note that the Business Processes referred to in this table are defined in the *Business Architecture* document [PATH-PRR-BA].

3.2 Pathology Report

Information Component	Pathology Report Instance
Business Process	1.0 Compile Report
Definition	A Pathology Report Instance is a series of Pathology Test results which are grouped together for a specific reporting purpose. Each Pathology Report Instance is unique, although the information it contains may reside in other Pathology Reports. A Pathology Report may have many different instances which are created when the act of reporting takes place.
Data Capture Requirements	The data capture requirements are consolidated in the Pathology Result Report Structured Document Template [PATH-PRR-SDT]
Related Business Processes	1.0 Compile Report
Notes	

3.3 Acknowledgements and Notifications

3.3.1 Report Notification

Information Component	Report Notification
Business Process	6.0 Acknowledgement Management
Definition	When a report is ready for collection or is distributed to an *Intermediary*, the *Pathology Provider* will compile a notification message that outlines the report identifier and where the report is stored. This message is for the end use of the *Pathology Report Recipient*.
Data Capture Requirements	• *Sending Party ID* – The notification must allow for identifying the sending party. • *Receiving party ID* – The notification must allow for identifying the receiving party. • *Unique Community Identifier for the Payload Instance* – The payload (i.e. the Pathology Report Instance) must be uniquely identifiable within the

Information Component	Report Notification
	Pathology Community.
Related Business Processes	• 4.0 Construct Message • 5.0 Sourcing Reports • 6.0 Acknowledgement Management • 7.0 Report Monitoring
Notes	

3.3.2 Report Received Acknowledgement

Information Component	Report Received Acknowledgement
Business Process	6.0 Acknowledge Management
Definition	When the report instance is received by the *Pathology Report Recipient,* the *Pathology Provider* requires that a 'Report Received Acknowledgement' be sent. This acknowledgement is required for audit and 'Chain of Information' custody purposes.
Data Capture Requirements	Report Identifier
Related Business Processes	• 5.0 Sourcing Reports • 6.0 Acknowledgement Management • 7.0 Report Monitoring
Notes	

3.3.3 Report Processed Acknowledgement

Information Component	Report Processed Acknowledgement
Business Process	6.0 Acknowledge Management
Definition	Once the *Pathology Report Recipient* has received the report, it must be uploaded into the Clinical Information System (CIS) system of the *Pathology Report Recipien*t. The outcome of this upload process is represented in the 'Report Processed Acknowledgment'. This acknowledgement is provided by the *Pathology Report Recipient* to the *Pathology Provider* to allow for status tracking, and to allow for reports that are found to be 'faulty' to be resent.
Data Capture Requirements	Report Identifier
Related Business Processes	• 5.0 Sourcing Reports • 6.0 Acknowledgement Management 7.0 Report Monitoring
Notes	

3.4 Terminology

3.4.1 Concept

Information Component	Description
Business Process	1.0 Compile Report
Definition	A concept is a valid SNOMED CT concept.
Data Capture Requirements	See Terminology Specification [NEHTA_0198_2008].
Related Business Processes	1.0 Compile Report
Notes	More details can be found in the Pathology Result Reporting SDT [PATH-PRR-SDT]

3.4.2 Reference Set

Information Component	Reference Set
Business Process	1.0 Compile Report
Definition	The associated (bound) reference sets restrict the valid set of concepts that may be used to populate the Pathology Report.
Data Capture Requirements	See Terminology Specification [NEHTA_0198_2008].
Related Business Processes	1.0 Compile Report
Notes	More details can be found in the Pathology Report SDT [PATH-PRR-SDT]

3.5 Unique Healthcare Identification

3.5.1 Healthcare Provider Organisation Identification

Information Component	HPIO
Business Process	3.0 Distribute Report
Definition	Healthcare Provider Identifiers – Organisation (HPI-Os) uniquely identify healthcare organisations, such as hospitals and clinics (HPI-Os).
Data Capture Requirements	As per UHI specification [UHI-CO]
Related Business Processes	3.0 Distribute Report 6.0 Acknowledge Management
Notes	

3.5.2 Healthcare Provider Individual Identification

Information Component	HPI
Business Process	3.0 Distribute Report
Definition	Healthcare Provider Identifiers - Individual (HPI-Is) uniquely identify individual healthcare providers (HPI-Is), such as general practitioners, clinicians, nurses and pharmacists.
Data Capture Requirements	As per UHI specification [UHI-CO]
Related Business Processes	3.0 Distribute Report 6.0 Acknowledge Management
Notes	

3.5.3 Individual Healthcare Identification

Information Component	IHI
Business Process	3.0 Distribute Report
Definition	Individual Healthcare Identifiers (IHIs) uniquely identify all Australian healthcare consumers.
Data Capture Requirements	As per UHI specification [UHI-CO]
Related Business Processes	3.0 Distribute Report 6.0 Acknowledge Management
Notes	

3.6 NASH Credentials

3.6.1 Digital Signing Credential

Information Component	Digital Signing Credentials
Business Process	4.0 Construct Message
Definition	This component contains the trusted digital certificate used for digitally signing messages and required for non-repudiation of the sender.
Data Capture Requirements	As per NASH specification [NASH-TR]
Related Business Processes	4.0 Construct Message 5.0 Sourcing Report 6.0 Acknowledge Management 8.0 Manage Report Storage
Notes	

3.6.2 Authentication Credential

Information Component	Authentication Credential
Business Process	4.0 Construct Message
Definition	This component contains the trusted digital certificate used to authenticate individuals or organisations.
Data Capture Requirements	As per NASH specification [NASH-TR]
Related Business Processes	4.0 Construct Message 5.0 Sourcing Report 6.0 Acknowledge Management 8.0 Manage Report Storage
Notes	

3.6.3 Encryption Credential

Information Component	Encryption Credential
Business Process	4.0 Construct Message
Definition	This component contains the trusted digital certificate used to encrypt and decrypt messages.
Data Capture Requirements	As per NASH specification [NASH-TR]
Related Business Processes	4.0 Construct Message 5.0 Sourcing Report 6.0 Acknowledge Management 8.0 Manage Report Storage
Notes	

3.7 Service Instance Locator (SIL)

3.7.1 Business Service Instance Record

Information Component	Business Service Instance Record
Business Process	2.0 Determine Receiver 5.0 Sourcing Report
Definition	Business Service Instance Records include enough information for a client to choose between the possible technical realisations of a business service.
Data Capture Requirements	As per SIL specification [SIL2008]
Related Business Processes	2.0 Determine Receiver 5.0 Sourcing Report
Notes	

3.7.2 Technical Service Instance Record

Information Component	Technical Service Instance Record
Business Process	2.0 Determine Receiver 5.0 Sourcing Report
Definition	Technical Service Instance Records identify the technical type and endpoint of the service, its owner and host, and metadata to facilitate caching.
Data Capture Requirements	As per SIL specification [SIL2008]
Related Business Processes	2.0 Determine Receiver 5.0 Sourcing Report
Notes	

Definitions

This section explains the specialised terminology used in this document.

Shortened Terms

This table lists abbreviations and acronyms in alphabetical order.

Term	Description
BSIR	Business Service Instance Record
CIS	Clinical Information System
HL7	Health Level Seven
HPI	Healthcare Provider Identifier
HPI-I	Healthcare Provider Identifier – Individual
HPI-O	Healthcare Provider Identifier - Organisation
ICT	Information & Communications Technology
IHI	Individual Healthcare Identifier
IHTSDO	International Health Terminology Standards Development Organisation
MRN	Medical Record Number
NASH	National Authentication Service for Health
SIL	Service Instance Locator
TSIR	Technical Service Instance Record
UHI	Unique Healthcare Identifier
UML	Unified Modelling Language
UPI	Unique Patient Identifier

Glossary

This table lists specialised terminology in alphabetical order.

Term	Description
Business Architect	A Business Architect is anyone looks at the way work is being directed and accomplished, and then identifies, designs and oversees the implementation of improvements that are harmonious with the nature and strategy of the organisation. Source: http://www.businessarchitects.org
Information Architect	The information architect is responsible for: 1. Creating the structural design of shared information environments. 2. Organising and labelling web sites, intranets, online communities and software to support usability. Source: http://www.iainstitute.org/
Interoperability	The ability of software and hardware on multiple machines from multiple vendors to communicate. Source: The Free On-line Dictionary of Computing. Denis Howe. 21 Apr. 2008. From: Dictionary.com - http://dictionary.reference.com/browse/Interoperability

Term	Description
Solutions Architect	The Solutions Architect is typically responsible for matching technologies to the problem being solved. Source: http://www.developer.com
Technical Architect	The technical architect is responsible for transforming the requirements into a set of architecture and design documents that can be used by the rest of the team to actually create the solution. Source: http://www.developer.com

References

This section lists NEHTA specifications and other documents that provide information for or about this document.

At the time of publication, the document versions indicated are valid. However, as all documents listed below are subject to revision, readers are encouraged to use the most recent versions of these documents.

Package Documents

The documents listed below are part of the suite delivered in the Pathology Result Reporting Package.

Pathology Result Reporting Package Documents			
[REF]	Document Name	Publisher	Link
[PATH-PRR-BA]	Pathology Result Reporting Package v1.0 – Business Architecture v2.0	NEHTA 2008	http://www.nehta.gov.au/ (Home > Publications)
[PATH-PRR-CP]	Pathology Result Reporting Package v1.0 – Certification Procedures v1.0	NEHTA 2008	Reference in preparation for future release.
[PATH-PRR-EPS]	Pathology Result Reporting Package v1.0 – Endpoint Specification v2.0	NEHTA 2008	http://www.nehta.gov.au/ (Home > Publications)
[PATH-PRR-IG]	Pathology Result Reporting Package v1.0 – Implementation Guide	NEHTA 2008	Reference in preparation for future release.
[PATH-PRR-OCA]	Pathology Result Reporting Package v1.0 – Organisation Capability Assessment	NEHTA 2008	Reference in preparation for future release.
[PATH-PRR-PS]	Pathology Result Reporting Package v1.0 – Purpose and Scope v3.0	NEHTA 2008	http://www.nehta.gov.au/ (Home > Publications)
[PATH-PRR-RG]	Pathology Result Reporting Package v1.0 – Readers' Guide v3.0	NEHTA 2008	http://www.nehta.gov.au/ (Home > Publications)
[PATH-PRR-TA]	Pathology Result Reporting Package v1.0 – Technical Architecture v2.0	NEHTA 2008	http://www.nehta.gov.au/ (Home > Publications)

References

The documents listed below are non-package documents that have been cited in this document.

Reference Documents			
[REF]	Document Name	Publisher	Link
[INTER2007]	Interoperability Framework, version 2.0, NEHTA, 2007.	NEHTA 2007	http://www.nehta.gov.au/ (Home > Publications)
[NPMF2008]	NEHTA's Privacy Management Framework.	NEHTA 2007	
[PATH-PRR-IFHL7]	Interchange Format - Pathology Result Report and AS4700.2 (HL7 v2.4)	NEHTA 2008	http://www.nehta.gov.au/ (Home > Publications)

Reference Documents			
[PATH-PRR-SDT]	Structured Document Template – Pathology Result Reporting Package v0.4	NEHTA 2008	http://www.nehta.gov.au/ (Home > Publications)
[NEHTA_0198_2008]	Pathology Terminology Approach Document - Draft 20080829	NEHTA 2008	Reference in preparation for future release.
[UHI-CO]	Unique Healthcare Identification – Concept of Operations	NEHTA 2007	http://www.nehta.gov.au/ (Home > Publications)
[NASH-TR]	National Authentication Service for Health – High Level Technical Requirements	NEHTA 2008	Reference in preparation for future release.
[SIL2008]	Service Instance Locator – Business and Information Architecture	NEHTA 2008	Reference in preparation for future release.

Related Reading

The documents listed below may provide further information about the issues discussed in this document.

Related Documents			
[REF]	Document Name	Publisher	Link
[NEHTAWEB]	NEHTA Web Site	NEHTA 2008	http://www.nehta.gov.au/ (Home > Publications)

Appendix A: Summary of Terminology Bindings

Pathology Result Reports that conform to the NEHTA-defined Pathology Result Reporting Package v1.0 - Structured Document Template [PATH-PRR-SDT] use the following terminology-bound value domains. The terminology reference sets associated with these value domains are listed below.

Please note that SCT-AU refers to SNOMED CT with Australian extensions, and SCTID is an abbreviation for *SNOMED CT Identifier*.

A.1 Pathology Episode

Value Domain	Reference Set (SCTID) [Type]	Source Terminology
Specimen Type Values	Pathology specimen type reference set (SCTID: 4021000036102)	SCT-AU draft 20080829
Specimen Qualifier Values	Pathology specimen qualifier reference set (SCTID: 5021000036101)	SCT-AU draft 20080829
Specimen Anatomical Values	Pathology specimen anatomical site reference set (SCTID: 6021000036108)	SCT-AU draft 20080829
Request Test Name Values	Pathology request test name reference set (SCTID: 1021000036104)	SCT-AU draft 20080829
Result Test Name Values	Pathology result test name reference set (SCTID: 2021000036107)	SCT-AU draft 20080829
Testing Method Values	Pathology testing method reference set (SCTID: 3021000036100)	SCT-AU draft 20080829