

Integrating CCD Documents

A Way towards Effective Analysis of Patients' Health Documentation

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Abstract: Although the original purpose of the HL7's Continuity of Care Documents (CCD) was to deliver clinical summaries between healthcare organizations, nowadays they are increasingly used for collecting patients' health documentation from various healthcare providers. Usually the collected CCD documents are organized into hierarchical structures that simplify the search of documents, e.g., grouping together the documents by episode, clinical specialty or time period. Yet each clinical document is stored as a stand-alone artefact, meaning that each document is complete and whole in itself. Considering each document only as a complete and a whole in itself also has its drawback: the efficient usage of patients' health documentation often is data centric, meaning that data should be extracted from various documents and then integrated according to specific criteria. Processing such queries requires the integration of the data of the CCD documents. In this paper we present two methods for integrating CDD documents. In the first method an XML-database is developed and the content of the documents are stored in the database. So the content of clinical documentation can be effectively accessed by database query languages such as SQL. In the second method an OWL ontology for CDD documents is developed and the CCD documents are transformed in the format that is compliant with the ontology and then stored in the ontology. So the content of clinical documentation can be easily accessed by query languages such as RQL and SPARQL. Which integration method is appropriate depends on whether the CDD documents are based on CDA Level 2 or CDA Level 3.

1 INTRODUCTION

An *electronic medical record* (EMR) is a computerized medical record created in an organization that delivers care, such as a hospital or physician's office (Hartley and Jones, 2005).

Although the terms electronic medical record and *electronic health record* (EHR) are commonly used interchangeably, these terms describe completely different concepts. EHR relate to sharing patients health documentation (NEHTA, 2006). It relies on functional EMRs that allow care delivery organizations to exchange health documentation with other care delivery organization or stakeholders within the community, regionally, or nationally. That is, EMRs are data sources for EHRs.

EHRs are generally assumed to be summaries like ASTM's Continuity of Care Record (CCR) (CCR, 2011) or HL7's Continuity of Care Document (CCD) (HL7, 2007); (CCD, 2009). They may be

owned by patient or healthcare authorities. In the former case they are usually called as *personal health records*, and in the latter case they are also called as *electronic patient record archives* (Puustjärvi and Puustjärvi, 2010). Often such archives aim to capture patients' all health documentation.

As defined by the ISO 13606 Reference Model (ISO, 2012); (prEN13606, 2006), EHR systems usually organize clinical documents into hierarchical structures that simplify the search of documents, e.g., grouping together the documents by episode, clinical specialty or time period. Further, each clinical document is stored as a stand-alone artefact, meaning that each document is complete and whole in itself, including context information such as who created it, when and where and for what purposes (Boone, 2011). Without such contextual information in some cases it may be a risk to interpret some values of the data included on a document.

Considering each document only as a complete and a whole in itself also has its drawback. The problem here is that the efficient usage of patients' health documentation often is data centric, meaning that data should be extracted from various documents and then integrated according to specific criteria. Especially this is a common requirement in treating patients suffering from chronic diseases (Michie et al., 2003); (Fiandt, 2011).

For example, a physician may be interested to know the average blood pressure and/or cholesterol level during the time periods the patient was using Emconcor (a drug for blood pressure). Presenting the context information of each document stating the measured blood pressures is not necessary. Neither presenting the single values of each measurement is needed. Presenting such information may even frustrate the physician as the physician is overwhelmed with information.

Also the queries that access the documents of many patients may be of prime importance. For example, the healthcare authorities may be interested to know the average doses of drugs that the physicians have prescribed. Unfortunately, the computation required by such queries is not provided by the health information systems that are developed for managing hierarchically organized EHRs.

Nowadays EHR systems increasingly use HL7's CCD documents for collecting patients' health documentation although their original purpose was to deliver clinical summaries between healthcare organizations (Benson, 2010). Processing data centric queries on CDD documents would be of high importance. Yet, EHR systems do not provide this feature as it would require the integration of the data of the CDD documents.

In this paper we present two methods for integrating CDD documents. In the first method, an XML-database is developed and the content of the documents are stored in the database. In the second method, an ontology, called the CDD-ontology, for the CDD documents is developed. Also the CCD documents are transformed in the format that is compliant with the ontology, and finally they are stored in the ontology. Which method is appropriate depends on whether the CDD documents are based on CDA Level 2 or CDA Level 3.

The rest of the paper is organized as follows. First, in Section 2, we consider the characteristics of the clinical documents defined by the CDA standard. In Section 2, we first consider the RIM on which the CDA standard is based on, and then we present the structure of CCD documents. In Section 3, we

consider the suitability of XML databases for storing the content of CCD Level 2 documents, and in Section 4 we consider the suitability of OWL ontologies for storing CCD Level 3 documents. Finally, Section 5 concludes the paper.

2 HL7 CLINICAL DOCUMENT ARCHITECTURE

2.1 Reference Information Model

The HL7 Clinical Document Architecture (CDA) is an XML-based markup standard intended to specify the encoding, structure and semantics of clinical documents for exchange (Dolin, 2001); (Boone, 2011). It is based on the HL7 Reference Information Model (RIM) which is the UML model for healthcare information. The idea behind the RIM is that we can interpret the tags of the CDA documents by the RIM.

The RIM is based on two key ideas (Benson, 2010). The first idea is based on the consideration that most healthcare documentation is concerned with "happenings" and things (human or other) that participate in these happenings in various ways.

The second idea is the observation that the same people or things can perform different roles when participating in different types of happening, e.g., a person may be a care provider such a physician or the subject of care such as patient.

As a result of these ideas the RIM is based on a simple backbone structure, involving three main classes, *Act*, *Role*, and *Entity*, linked together using three association classes *Act-Relationship*, *Participation*, and *Role-Relationship* (Figure 1).

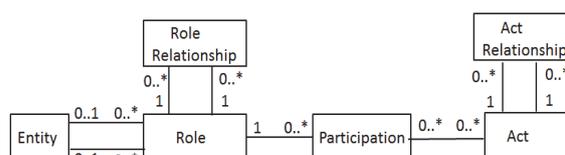


Figure 1: The RIM backbone structure.

Each happening is an Act, and it may have any number of Participations, which are Roles, played by Entities. An ACT may also be related to other Acts via Act Relationships. Act, Role and Entity classes have a number of specializations (subclasses), e.g., Entity has a specialization LivingSubject, which itself has a specialization Person.

The classes in the RIM have *structured attributes* which specify what each RIM class means when

used in a message (exchanged document). The idea behind structured attributes is to reduce the original RIM from over 100 classes to a simple backbone of six main classes.

Note that we cannot consider the RIM as the ontology of the CDA documents as CDA documents are not directly derived from the RIM but through the constrained information models RMIMs (Refined Message Information Model). As we will illustrate in section 5, each RMIM diagram is derived from the RIM by limiting its optionality such that it specifies the semantic of a whole CDA document or its portion.

2.2 Continuity of Care Document

The CCD (Continuity of Care Document) specification is a constraint on the HL7 CDA standard. The CCD standard has been endorsed by HIMMS (Healthcare Information and Management Systems Society Though) (HIMMS, 2013) and HITSP (Healthcare Information Technology Standards Panel) (HITSP, 2013) as the recommend standard for exchange of electronic exchange of components of health information.

Although the original purpose of the CCD documents was to deliver clinical summaries between healthcare organizations, nowadays it increasingly used for other types of messages: it is considered as set of templates because all its parts are optional, and it is practical to mix and match the sections that are needed (Benson, 2010). Hence, there is a RMIM behind each CCD document.

Each CCD document has one primary purpose (which is the reason for the generation of the document), such as patient admission, transfer, or inpatient discharge. A CCD document, as well as all CDA documents, is comprised of the *Header* and the *Body* (Benson, 2010). The *sections* that can appear in the Header and in the Body in a CCD document are presented in Figure 2.

Depending whether the header and body of the CDA documents are based on the RIM they are classified into three levels:

- *CDA Level 1*: Only the header is based on the RIM while the body is human readable text or image.
- *CDA Level 2*: Only the header of the document is based on the RIM while the body is comprised of XML coded sections.
- *CDA Level 3*: Both the header and the body are based on the RIM.

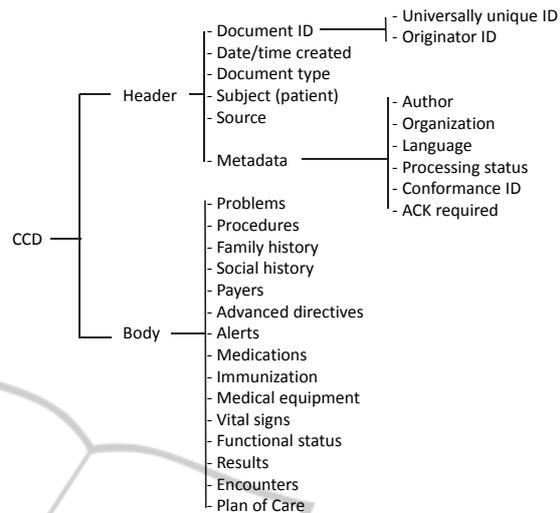


Figure 2: The components of the CCD.

3 INTEGRATING CCD LEVEL 2 DOCUMENTS

3.1 XML Databases

We have exploited XML database (Obasanjo, 2001) in integrating CCD Level 2 documents. However, in general there are other reasons why XML documents are stored in databases: the most common reason is to *publish* data stored in a database as an XML document. Its reverse process, i.e., extracting data from an XML document and storing it in the database is called *shredding* (Figure 3).

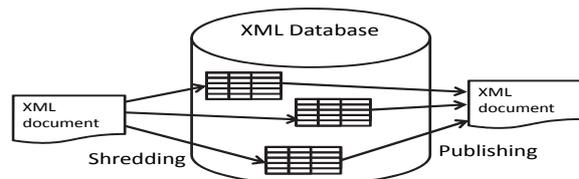


Figure 3: XML database.

In healthcare sector XML databases are suitable for archiving XML-formatted EHRs in the sense that databases are secure, and can be easily queried and retrieved. Further, as illustrated in Figure 4, an EHR system can be quite easily implemented by exploiting the functionalities provided by a document management system, which in turn exploits the functionalities of an XML database. Alternatively, an EHR system itself may also provide the functionalities of the document management system.

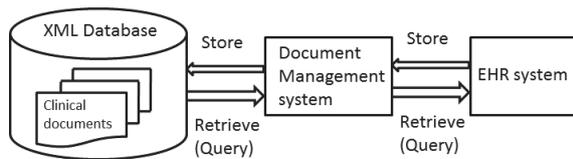


Figure 4: Archiving XML documents.

In principle, we have two choices to use XML with databases: *XML-enabled databases* and *native XML databases* (IBM, 2004). In the former XML is used only as a way to exchange data. The database schema matches the XML schema, but there is no “XML” visible inside the database. That is, the database includes the data items of the XML-documents but the original XML documents cannot be reconstructed by querying the database.

In contrast with native XML databases the document is itself stored in the database. Thus the structures of XML document are visible inside the database meaning that the database contains information such as element and attribute names. In other words, the database schema models XML documents, and so original XML documents can be reconstructed by querying the database.

In our case there is no need to reconstruct original XML-formatted CCD documents: according to the wholeness requirement it is enough that the content and the context of a CCD document can be put together. Aspects like the order of the elements in the original XML documents do not matter. This substantially simplifies the technical requirements of the database-based CCD archive: we just attach the identifier of each CCD document to each tuple in the database. Then by querying the instances by document identifier we can return the context and content of the CCD document. Thus the requirement of documents human readability is also easily met.

Further the requirement of persistence can be ensured by not allowing updates on the relations containing the data of clinical documents. The requirements of context and stewardship are met as the database includes all the data included in clinical documents. That is, if the clinical documents meet these requirements then the documents stored in databases also meet these requirements.

3.2 Storing CCD Documents in XML-enabled Databases

In order to illustrate how CDD documents can be stored in XML-enabled database consider the simplified CCD documents presented in Figures 5 and 6.

The first document includes data gathered from blood pressure measurements, and the second document includes information about patient’s medication.

```
<ContinuityOfCareDocument>
<CCDdocumentID> p3p5k </CCDdocumentID>
<PatientID> ABC-123 </PatientID>
<ExactDateTime>2012-06-02 </ExactDateTime>
<Body>
  <BloodPressureEvent>
    <EffectiveTime>2012-05-15T06:00:00 </EffectiveTime>
    <ActorId>DEF-56 </ActorId>
    <DiastolicBloodPressure>87 </DiastolicBloodPressure>
    <SystolicBloodPressure> 132</SystolicBloodPressure>
  </BloodPressureEvent>
  <BloodPressureEvent>
    <EffectiveTime> 2012-05-17T07</EffectiveTime>
    <ActorId>HJK-66 </ActorId>
    <DiastolicBloodPressure> 92 </DiastolicBloodPressure>
    <SystolicBloodPressure> 142 </SystolicBloodPressure>
  </BloodPressureEvent>
</Body>
</ContinuityOfCareDocument>
```

Figure 5: A CCD file of blood pressures.

```
<ContinuityOfCareDocument>
<CCDdocumentID> p7p5h </CCDdocumentID>
<PatientID> ABC-123 </PatientID>
<ExactDateTime>2012-06-07 </ExactDateTime>
<Body>
  <Medications>
    <Medication>
      <EffectiveTime>2012-05-15T08</EffectiveTime>
      <ActorId>DEF-56 </ActorId>
      <ProductName>Valsartan </ProductName>
      <StrenghtValue> 30</StrenghtValue>
      <StrenghtUnit> milligram</StrenghtUnit>
    </Medication>
    <Medication>
      <EffectiveTime>2012-05-18T08</EffectiveTime>
      <ActorId>RGF-54 </ActorId>
      <ProductName>Emconcor </ProductName>
      <StrenghtValue> 40</StrenghtValue>
      <StrenghtUnit> milligram</StrenghtUnit>
    </Medication>
  </Medications>
</Body>
</ContinuityOfCareDocument>
```

Figure 6: A CCD file of medication.

The representation formats of these documents in a relational XML-enabled database are presented in Figures 7 and 8. The basic idea behind transforming XML documents into relation schemas is that each complex element gives rise for a relation, and each attribute and simple element is represented by an attribute of the relation. Such relations are not necessary yet in BCNF (Boyce-Codd Normal Form) (Ullman and Widom, 1997), but their normalization can be easily carried out by splitting the non-normalized relations.

Relation: ContinuityOfCareDocument

CCDdocumentID	PatientID	ExactDateTime
p3p5k	ABC-123	2012-06-02
...		

Relation: BloodPressureEvent

CCDdocumentID	EffectiveTime	ActorId	DiastolicBloodPressure	SystolicBloodPressure
p3p5k	2012-05-15T06	DEF-56	87	132
p3p5k	2012-05-17T07	HJK-66	92	142
...				

Figure 7: Tuples generated from the document of Figure 5.

Relation: ContinuityOfCareDocument

CCDdocumentID	PatientID	ExactDateTime
p7p5h	ABC-123	2012-06-07
...		

Relation: Medications

CCDdocumentID	EffectiveTime	ActorId	ProductName	StrenghtValue	StrenghtUnit
p3p5k	2012-05-15T08	DEF-56	Valsartan	30	milligram
p3p5k	2012-05-17T07	RGF-54	92	40	milligram
...					

Figure 8: Tuples generated from the document of Figure 6.

Now, by SQL (Ullman and Widom, 1997), we can make many useful queries on patients' health information. Examples of such queries include:

- Patient's average blood pressures during January 2012.
- Patient's highest blood pressure during the time the patient was using Emconcor.

Queries that do not concern a single patient can be also easily presented. Examples of such queries include:

- List the physicians (attribute ActorId) in the order determined by the times they have prescribed Emconcor.
- The average blood pressures of the patients using Emconcor (Valsartan).

Note that these queries cannot be processed by EHR systems as they access documents by query languages, such as XPath or XQuery (Harold and Scott Means, 2002), which are designed for manipulating XML documents.

4 INTEGRATING CCD LEVEL 3 DOCUMENTS

We now illustrate the development of the CDD-ontology by integrating the RMIM ontologies, which are derived from the RMIM diagrams of the CCD Level 3 documents.

4.1 Developing RMIM Diagrams

The body and the header of a CDA Level 3 document are defined by RMIM diagrams. Further, according to the HL7 Version 3 Development Framework, the RMIM diagrams are transformer into XML schemas, which specify the structure of the exchanged CDA documents. In transformation classes map to complex elements, structured attributes map to attributes and other attributes map to simple elements. As a result, the tags of each CDA document represent the classes and attributes of the RMIM. Thus, we can interpret the semantics of the tags of the CDD documents by the RIM and RMIM.

Each RMIM diagram is derived from the RIM by limiting its optionality by omission and cloning (Benson, 2010). *Omission* means that the RIM classes or attributes can be left out. Note that all classes and attributed that are not structural attributes in the RIM are optional, and so the designer can take only the needed classes and attributes. *Cloning* means that the same RIM class can be used many times in different ways in various RMIMs. The classes selected for a RMIM are called *clones*.

The *multiplicities* of associations and attributes in a RMIM are constrained in terms of *repeatability* and *optionality*. Further, *code binding* is used for specifying the allowable values of the used attributes.

To illustrate the relationships of the CCD, RIM and RMIM consider the RMIM diagram of Figure 9.

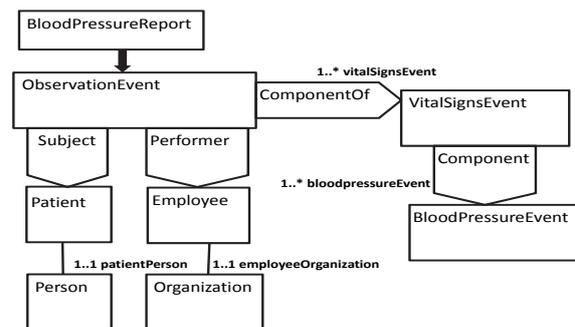


Figure 9: The RMIM of the blood pressure report.

Note that HL7 uses its own representation of UML in RMIM diagrams: each class has its own colour and shape to represent the stereotypes of these classes, and they only connect in certain ways.

The diagram specifies a blood pressure report. Its body includes the *Vital signs* section of the CCD. The use case behind this RMIM diagram is to

exchange and store patient’s blood pressures (SystolicBloodPressure and DiastolicBloodPressure) and the time of the measurement (EffectiveTime). These are the attributes of the clone BloodPressureEvent but we have omitted them, as well as other attributes, from the RMIM diagram.

The entry point of this diagram (BloodPressureReport) is ObservationEvent, which is specialization of the RIM class Act. Also classes VitalSignsEvent and BloodpressureEvent are specializations of the class Act. Classes Patient and Employee are specializations (subclasses) of the RIM class Role. Person and Organization are specializations of the RIM class Entity. Subject and Performer are specializations of the association class Participation. Component and ComponentOf are specializations of the association class ActRelationship.

4.2 Transforming RMIM Diagrams into OWL

Although the semantics of all CDA documents is tractable through a RMIM back to the RIM, we neither can use the RMIM nor the RIM in formulating queries. The reason is twofold: First, each RMIM diagram only models one type of document. Second, there are no query languages specified for the information model used in the RMIM and RIM schemas.

For these reasons we first transform RMIM diagrams into OWL (Web Ontology Language) (OWL, 2011), and then integrate these OWL-ontologies. The result of the integration is the CD-ontology. As it is OWL ontology we can define data centric queries by the query languages, such as RQL (RQL, 2002) and SPARQL (SPARQL, 2008), which are developed for OWL ontologies.

Transforming a RMIM diagram into OWL is straightforward in the sense that the both models are object-oriented although the notation used in RMIM diagrams slightly differs from the traditional UML notation. Yet their basic modelling primitives are the same, namely classes, subclasses, properties and values. The classes are also connected in a similar way through properties.

The RMIM diagram of Figure 9 is presented in OWL in a graphical way in Figure 10. In this graphical representation ellipses represent classes and subclasses while rectangles represent data type and object properties. Classes, subclasses, data properties and object properties are modeling primitives in OWL (Antoniou and Harmelen, 2004). Object properties relate objects to other objects

while datatype properties relate objects to datatype values. Note that, in Figure 10 we have attached datatype properties only to the class BloodPressureEvent.

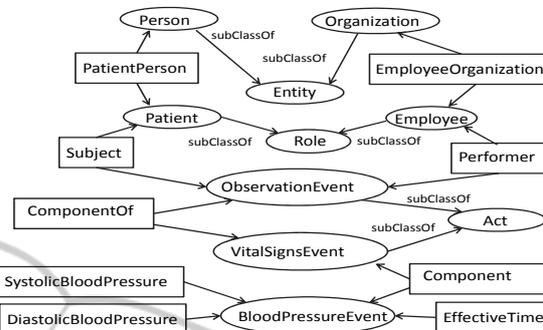


Figure 10: Graphical presentation of the RMIM ontology BloodPressureReport.

A portion of the graphical RMIM ontology of Figure 10 is presented in OWL in Figure 11.

```
<rdf:RDF
  xmlns:rdf=http://www.w3.org/1999/02/22-rdf-syntax-ns#
  xmlns:rdfs=http://www.w3.org/2000/01/rdf-schema#
  xmlns:owl=http://www.w3.org/2002/07/owl#>
  <owl:Ontology rdf:about="ccdOntology"/>
  <owl:Class rdf:ID="act"/>
  <owl:Class rdf:ID="role"/>
  <owl:Class rdf:ID="entity"/>
  <owl:Class rdf:ID="observationEvent"/>
    <rdfs:subClassOf rdf:resource="#act"/>
  </owl: class>
  <owl:Class rdf:ID="vitalSignsEvent"/>
    <rdfs:subClassOf rdf:resource="#vitalSignsEvent"/>
  </owl: class>
  <owl:Class rdf:ID="bloodPressureEvent"/>
    <rdfs:subClassOf rdf:resource="#act"/>
  </owl: class>
  <owl:ObjectProperty rdf:ID="component"/>
    <rdfs:domain rdf:resource="#vitalSignsEvent"/>
    <rdfs:range rdf:resource="#bloodPressureEvent"/>
  </owl:ObjectProperty>
  <owl:DatatypeProperty rdf:ID="systolicBloodPressure"/>
    <rdfs:domain rdf:resource="#bloodPressureEvent"/>
    <rdfs:range rdf:resource="xsd:integer"/>
  </owl:DatatypeProperty>
  <owl:DatatypeProperty rdf:ID="diastolicBloodPressure"/>
    <rdfs:domain rdf:resource="#bloodPressureEvent"/>
    <rdfs:range rdf:resource="xsd:integer"/>
  </owl:DatatypeProperty>
  <owl:DatatypeProperty rdf:ID="effectiveTime"/>
    <rdfs:domain rdf:resource="#bloodPressureEvent"/>
    <rdfs:range rdf:resource="xsd:time"/>
  </owl:DatatypeProperty>
  .
  .
</rdf:RDF>
```

Figure 11: The RMIM BloodPressureReport ontology.

4.3 Integrating RMIM Ontologies

In the development of the CDD-ontology we have first translated a RMIM ontology into OWL. Then this ontology (the CCD ontology) is extended step by step by integrating other RMIM ontologies with the ontology. Hence the CDD ontology is incremental: when a new CDD document type (RMIM) is introduced, the CDD-ontology is extended accordingly.

Each integration step is comprised of two successive phases: First, the CDD-ontology is merged with the CDD-ontology, and then potential conflicts are detected and resolved.

To illustrate the merging phase, consider the CDD document (named MedicationReport), which RMIM diagram is presented in Figure 12, and the graphical OWL ontology derived from this RMIM diagram is presented in Figure 13.

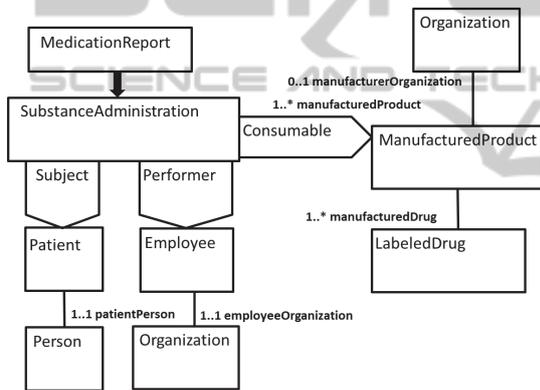


Figure 12: The RMIM of the medication report.

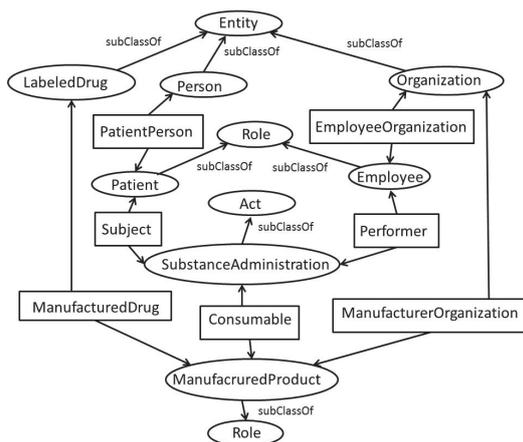


Figure 13: Graphical presentation of the RMIM ontology MedicationReport.

In merging, we add those elements (classes, object properties and datatype properties) from the

Medication report ontology to the Blood pressure report ontology that do not include in both ontologies. Such classes are SubstanceAdministration, ManufacturedProduct, and LabeledDrug. Correspondingly such object properties are Consumable, ManufacturedProduct and ManufacturedOrganization.

Note that in graphical OWL representations (for simplicity) we have specified only a few datatype properties (only the class BloodPressureEvent has attached datatype properties in Figure 10), and so our used examples do not reveal the datatype properties that we should insert in the integrated ontology (CDD ontology).

However, assuming that clone (class) Person has the datatype property JobTitleName in the Medication report ontology but not in the Blood Pressure report ontology, then the datatype property JobTitleName should be inserted into the integrated ontology. So, in the merging phase we have to insert the OWL code of Figure 14 to the ontology presented in Figure 11.

```

<owl:Class rdf:ID="labeledDrug">
  <rdfs:subClassOf rdf:resource="#entity"/>
</owl:Class>
<owl:Class rdf:ID="substanceAdministration">
  <rdfs:subClassOf rdf:resource="#act"/>
</owl:Class>
<owl:Class rdf:ID="manufacturedProduct">
  <rdfs:subClassOf rdf:resource="#role"/>
</owl:Class>
<owl:ObjectProperty rdf:ID="manufacturedDrug">
  <rdfs:domain rdf:resource="#manufacturedProduct"/>
  <rdfs:range rdf:resource="#labeledDrug"/>
</owl:ObjectProperty>
<owl:ObjectProperty rdf:ID="manufactureeOrganization">
  <rdfs:domain rdf:resource="#manufacturedProduct"/>
  <rdfs:range rdf:resource="#organization"/>
</owl:ObjectProperty>
<owl:ObjectProperty rdf:ID="consumable">
  <rdfs:domain rdf:resource="#substanceAdministration"/>
  <rdfs:range rdf:resource="#manufacturedProduct"/>
</owl:ObjectProperty>
<owl:DatatypeProperty rdf:ID="jobTitleName">
  <rdfs:domain rdf:resource="#person"/>
  <rdfs:range rdf:resource="&xsd:string"/>
</owl:DatatypeProperty>

```

Figure 14: The OWL code to be inserted in merging the Blood pressure report and Medication report ontologies.

After this we have to detect and resolve conflicts. However, in the context of RMIM ontologies detecting and resolving conflicts is not as complex as in general: the “backbone structure” of the RIM ensures that the same concept has the same semantics in all RMIM ontologies. The only sources of heterogeneity arise from constraining the classes (clones) in different ways.

4.4 CCD Level 3 Documents

Storing CCD Level 3 documents into the CDD-ontology requires that they are first transformed (by an XSLT-based style sheet engine (Harold and Scott, 2002) into RDF/XML format that is compliant with the CDD-ontology. The transformation requires that we have to define a stylesheet for each type of CDD document (Figure 15).

Reconstructing the content of original documents (or representing queries) by RQL and SPARQL on the CDD-ontology is rather easy. For example, in RQL to retrieve all instances of the class `BloodPressureEvent` (i.e., all measured blood pressures) we only have to write “`BloodPressureEvent`”. However, the physicians do not have to be familiarized with query languages in order to retrieve data from the CDD-ontology as user-friendly interfaces can be easily developed.

5 CONCLUSIONS

The Clinical Document Architecture (CDA) is proven to be a valuable and powerful standard for a structured exchange of clinical documents between healthcare information systems.

What is still missing is the conceptual model of patient’s health data. Without a conceptual schema we can neither query health data nor can we store health data in a way which allows data centric queries, and therefore we have focused on this problem. We have shown how the integration can be carried out by exploiting XML-enabled relational databases if the CCD documents are based on the CDA Level 2. Further, we have shown how ontology-based integration can be carried out if the CCD documents are based on the CDA Level 3. Still an open problem is how to integrate CCD Level 2 and CCD Level 3 documents among themselves. This is an issue of our future work.

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