

Declarative Health - cityEHR

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Declarative Health - cityEHR

- Electronic Health Records Using XML
- Open Source, Model-Driven, XML Health Records
- XML Health Records Using XForms







Patient Data in Healthcare

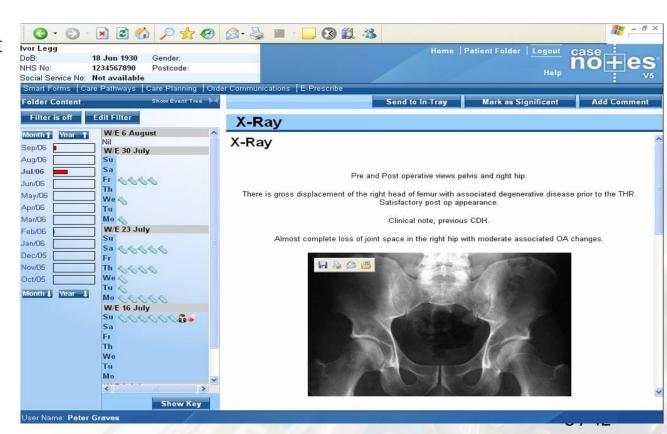
- Personalised medicine is revolutionizing treatments for
 - cancer
 - diabetes
 - rheumatoid arthritis
 - •
- Research requires (amongst other things) rich, structured data
 - ideally, gathered in routine clinical care
- XML provides an excellent mechanism for representing clinical data using standards such as HL7 CDA and ISO-13606





Case Notes

- Case Notes was an Enterprise Java application for Electronic Health Records (EHR)
- First live installation at Oxford Radcliffe Hospital in 1999 (still running there in 2019)
- Chosen as the base system for the Summary Care Records system in England in 2003
- Implemented using non-standard XML vocabularies, and a relational database
- > £5m investment
- > 100 person years effort







National Programme for IT

Case Notes was scaled up to 55 million patients

Systems integrators LogicCMG and BT

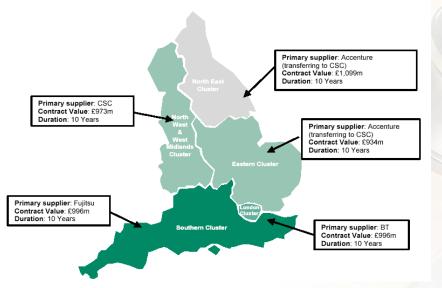
Clustered Oracle database and Java hardware accelerators

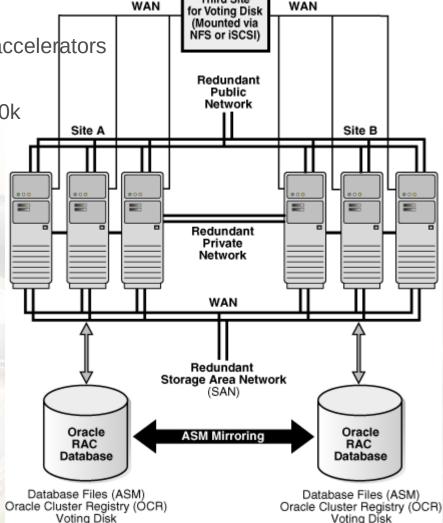
Estimated 90 – 100 Tb database

1Tb storage in BT's data centre cost approx £100k

Total budget was £100m's

Infrastructure cost was > £5 per patient





Third Site





Failure of EHR

- The National Programme for IT failed as a result of top-down design, poor quality products, feasting frenzy for systems integrators and consultants
- It failed to deliver its ambitious objectives, but also set the the whole UK Health Informatics industry back a decade
- We continue to spend £100m's on poor quality systems (not just in the UK)
- I dream of the day when we can offer an EHR system which is
 - Free (as in freedom of speech and free beer)
 - Completely based on open standards
 - Configured by clinicians to hold the information they need
 - Massively scalable
 - Deployable by a schoolboy



Raspberry Pi Beowulf Cluster



In 2018, my son (then aged 14) deployed the open source cityEHR On a cluster of 16 Raspberry Pi 3s

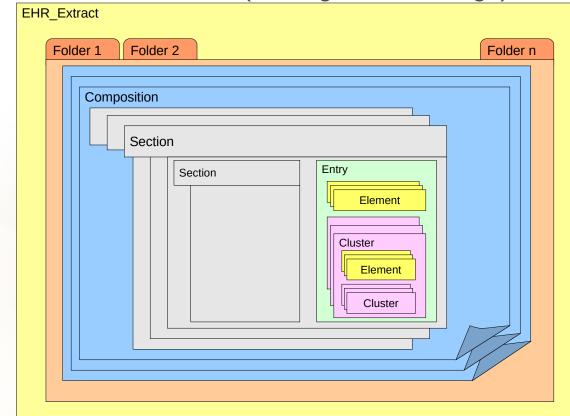
To demonstrate scalability of XML health records on commodity hardware





Structure of a Health Record

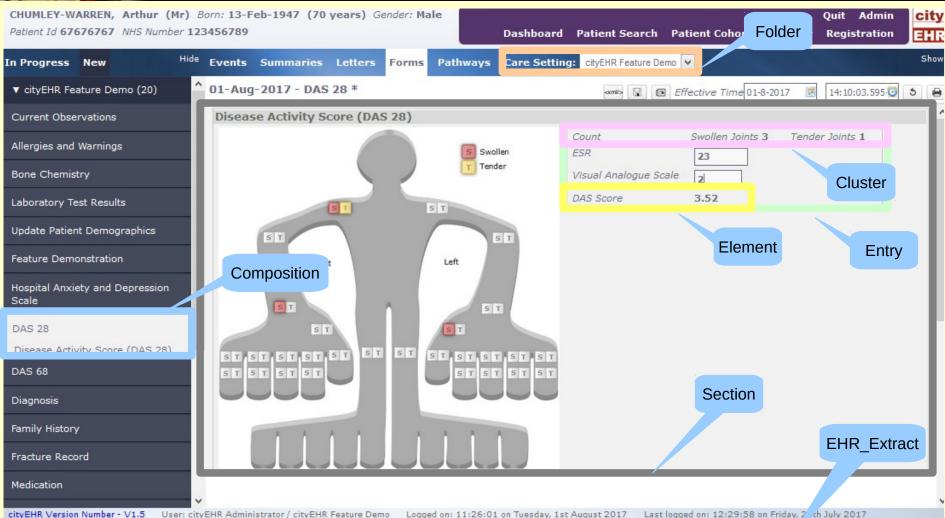
- ISO-13606 standard
- Started as a European standards activity, adopted by ISO
- Defines the general structure of a health record (amongst other things)







Structure of a Health Record







Clinical Statement

120 Normal 80

These data carry no meaning.

In ISO-13606, data items are modelled as Element, and grouped as Cluster



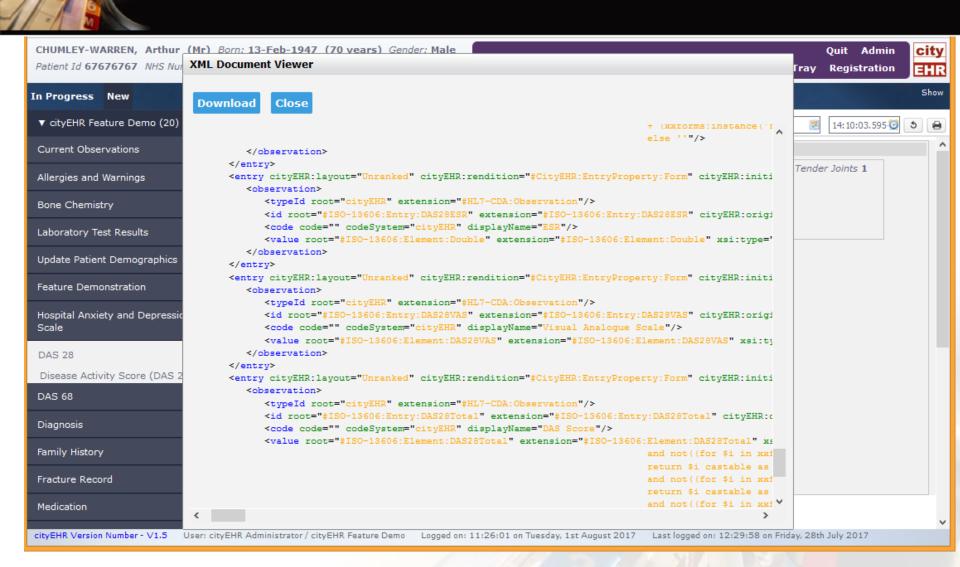
The Clinical Statement is the lowest level of modelling that carries useful clinical context.

It is the point in the model at which data becomes information.

In ISO-13606 the Clinical Statement is modelled as Entry.



HL7 Clinical Document Architecture







XML Health Record

	Quit Admin Registration	city
Dashboard Patient Search Patient Collors III-IIay	Registration	EHR
03-Aug-2018 - Patient Registration * Page load time: PT1.438S	exml/>	5 [i≡
Patient Demographics		^
NHS Number 1078288621 Hospital Number 12175731 Overseas Patient ☐ Find Demographics ☑		
Title Mr V Forename Corin Sumame Cale		
Gender Male Date of Birth 13-1-1991		
Address 13 Sandy Lane Town/City Colchester		
Postcode CO1 9DW		
GP Details		
Code Dr Practice Find GP		
Address Town/City Postcode		
2018-07-18 User: cityEHR Administrator / cityEHR Common Model Logged on: 07:34:41 on Friday, 3rd August 2018 Last logged on: 07:00:08 on Friday, 3rd August 2018		~





XML Health Record

```
<?xml version="1.0" encoding="UTF-8"?>
<ClinicalDocument xmlns:cityEHR="http://openhealthinformatics.org/ehr" xmlns:cda="urn:h17-org:v3" xmlns:owl="http://www.w3.org/2002/07/owl#"
    xmlns:mif="urn:h17-org:v3/mif" xmlns:cityEHRFunction="http://openhealthinformatics.org/ehr/functions" xmlns="urn:h17-org:v3"
   xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
    <typeId root="#CityEHR:Form" extension="#CityEHR:Form:BaseRegistration"/>
    <templateId root="#ISO-13606:EHR Extract:cityEHR" extension="#ISO-13606:Folder:FeatureDemo"/>
    <id root="cityEHR" extension="07-01-57.374*01-00-2017-02-23T08-15-25.865Z-CityEHR-Form-BaseRegistration-admin"/>
    <code code="134436002" codeSystem="2.16.840.1.113883.2.1.3.2.4.15" codeSystemName="SNOMED" displayName="Patient Registration"/>
    <effectiveTime value="2017-02-23T08:15:25.865Z"/>
    <recordTarget>
       <patientRole>
           <id extension="A47375107030" root="2.16.840.1.113883.2.1.4.1"/>
           <patient>
               <name>
                   <prefix/>
                   <given>Leicester</given>
                   <family>Jameson</family>
               </name>
               <administrativeGenderCode code="Male" codeSystem="" displayName="Male"/>
               <birthTime value="1980-02-04"/>
           </patient>
           cproviderOrganization>
               <id extension="NHS Hospital Code" root="#ISO-13606:EHR Extract:cityEHR"/>
               <name/>
           </patientRole>
    </recordTarget>
```





XML Health Record

```
<structuredBody>
    <component>
        <section cityEHR:layout="Ranked" cityEHR:labelWidth="17">
            <id root="cityEHR" extension="#ISO-13606:Section:Demographics"/>
            <title>Patient Demographics</title>
            <entry cityEHR:layout="Ranked" cityEHR:rendition="#CityEHR:EntryProperty:Form"</pre>
                cityEHR:initialValue="#CityEHR:EntryProperty:Pre-filled" cityEHR:labelWidth="17"
                cityEHR:entryScope="#CityEHR:EntryProperty:Defined" cityEHR:CRUD="#CityEHR:EntryProperty:UL"
                cityEHR:sortCriteria="#ISO-13606:Element:LookUpKey">
                <observation>
                    <typeId root="cityEHR" extension="#HL7-CDA:Observation"/>
                    <id root="#ISO-13606:Entry:Demographics" extension="#ISO-13606:Entry:Demographics" cityEHR:origin=""/>
                    <code code="" codeSystem="cityEHR" displayName=""/>
                    <value code="" codeSystem="" displayName="" root="#ISO-13606:Cluster:PatientIdentifiers" [28 lines]</pre>
                    <value code="" codeSystem="" displayName="" root="#ISO-13606:Cluster:BasicDemographics" [16 lines]</pre>
                    <value code="" codeSystem="" displayName="" root="#ISO-13606:Cluster:AgeAndGender"</pre>
                        extension="#ISO-13606:Cluster:AgeAndGender" cityEHR:elementDisplayName="">
                        <value root="#ISO-13606:Element:Gender" extension="#ISO-13606:Element:Gender" xsi:type="xs:string" value="Male"</pre>
                            units="" code="#CityEHR:Value:Gender3AMale" codeSystem="cityEHR" displayName="Male"
                            cityEHR:elementDisplayName="Gender" cityEHR:elementType="#CityEHR:ElementProperty:enumeratedValue"
                            cityEHR:valueRequired="#CityEHR:ElementProperty:Optional" cityEHR:elementScope="#CityEHR:ElementProperty:Defined"/>
                        <value root="#ISO-13606:Element:DateOfBirth" extension="#ISO-13606:Element:DateOfBirth" xsi:type="xs:date"</pre>
                            value="1980-02-04" units="" code="" codeSystem="" displayName="" cityEHR:elementDisplayName="Date of Birth"
                            cityEHR:elementType="#CityEHR:ElementProperty:simpleType"
                            cityEHR:valueRequired="#CityEHR:ElementProperty:Optional" cityEHR:elementScope="#CityEHR:ElementProperty:Defined"
                        />
                    </value>
                    <value code="" codeSystem="" displayName="" root="#ISO-13606:Cluster:AddressDetails" [15 lines]</pre>
                </observation>
```







Model-Driven EHR

- A base Information Architecture provides the building blocks
- Clinicians create clinical Information Models for their own systems
- The System Configuration is generated from the Information Model
- The runtime EHR system operates using the System Configuration
 - views of the patient record
 - search criteria
 - data collection forms
 - clinical messages
 - (pathways, orders, prescriptions)

Artefact

Information Architecture

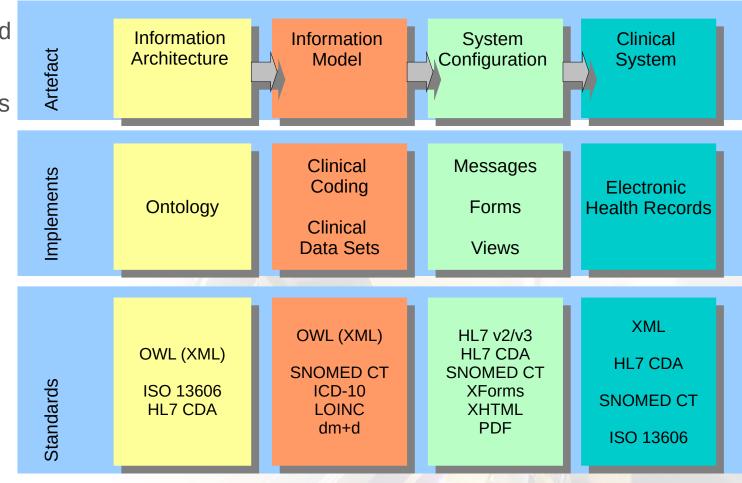
Information Model

System Configuration
System System
System



Standards/Clinician/Ontology-Driven EHR

- Standards based
- Clinician led
- Ontology models







EHR Ontology Model

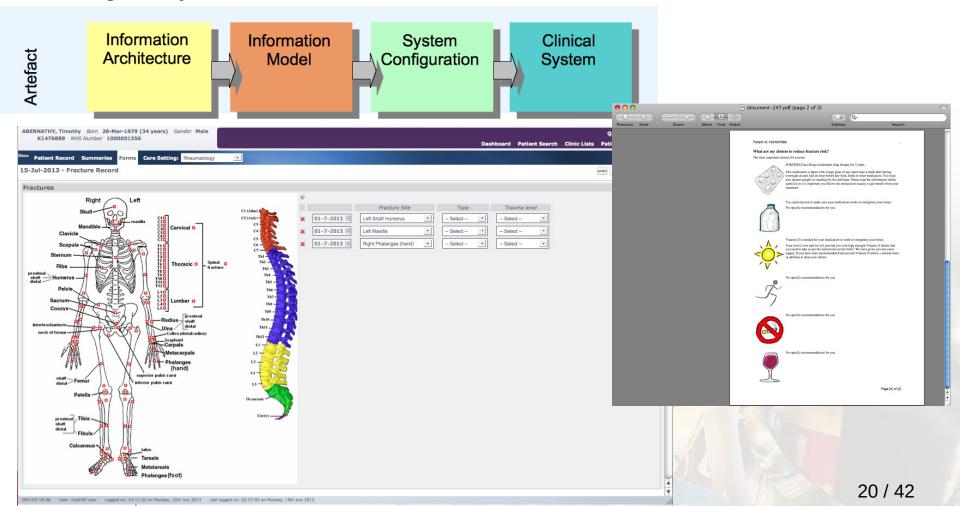
```
< D e claration >
                                                                        < 0 bjectProperty Assertion >
  < C lass IR I = " # IS O -1 3 6 0 6 : E n try " />
                                                                          < O b je c tP roperty IR I = " # h as C ontent" />
                                                                          < N am edIndividual IR I= "#IS 0 -1 3 6 0 6 : Entry : B M D D ata"/>
/D eclaration>
                                                                          < N am ed Individual IR I= "#ISO-3606:Element:BMDM easurement"/</pre>
< D e claration >
  < N am ed Individual IR I= "#ISO -13606:Entry:BMDD ata"/>
                                                                        /O bjectProperty Assertion>
/D eclaration>
                                                                        < 0 bjectProperty Assertion >
< Class Assertion>
                                                                          < O bjectProperty IR I = " # has Content"/>
  < C lass IR I = " # IS 0 -1 3 6 0 6 : E n try " />
                                                                          < N am edIndividual IR I= "#IS 0 -1 3 6 0 6 : Entry : B M D D ata"/>
  < N am ed In dividual IR I = "#ISO - 13606: Entry: BMDD ata"/>
                                                                          < N am edIndividual IR I= "#ISO -13606:E lement:T Score"/>
/O bjectProperty Assertion >
< D ataProperty A ssertion >
                                                                        < O bjectProperty A ssertion >
  < D ataProperty IR I = " # h as D is play N am e "/>
                                                                          < O bjectProperty IRI="#hasContent"/>
                                                                          < N am edIndividual IR I= "#ISO -13606:Entry:BMDD ata"/>
  < N am ed Individual IR I= "#ISO -13606:Entry:BMDD ata"/>
                                                                          < N am edIndividual IR I = "#ISO -13606; Element: Z Score"/>
  < L iteral x m l:lang = "en-gb" > D X A S can R esults < /L iteral>
/D ataPropertyAssertion>
                                                                        /O bjectProperty Assertion>
```





cityEHR - Clinician-led Development

- Clinicians create clinical models for their own systems
- Using the cityEHR architectural model

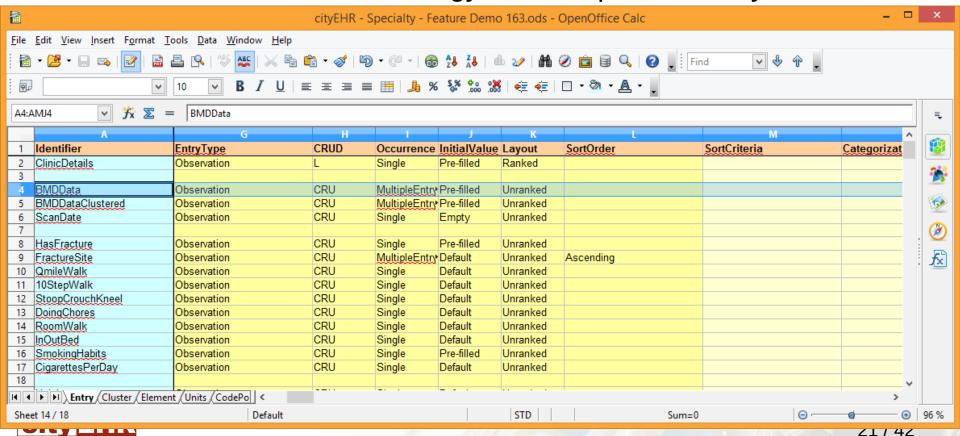




Information Model – Spreadsheet Input

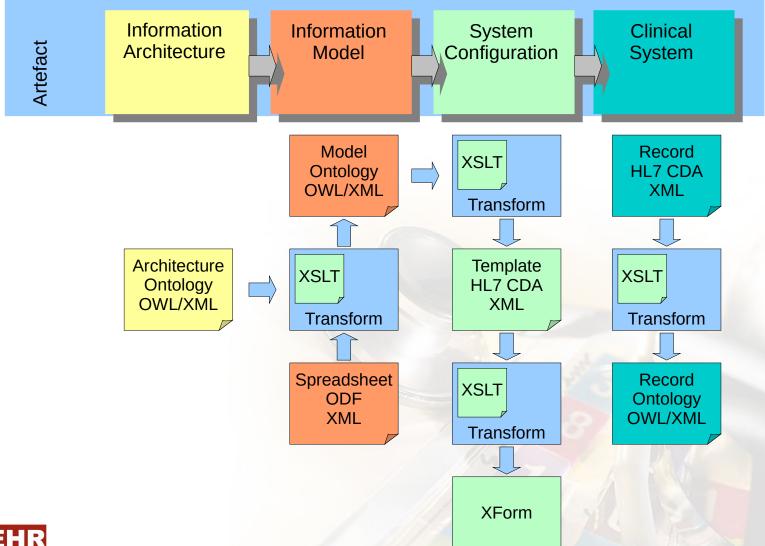
Clinicians can create their own information models using a spreadsheet

Converted to an OWL/XML ontology when imported to cityEHR





Generating XForms



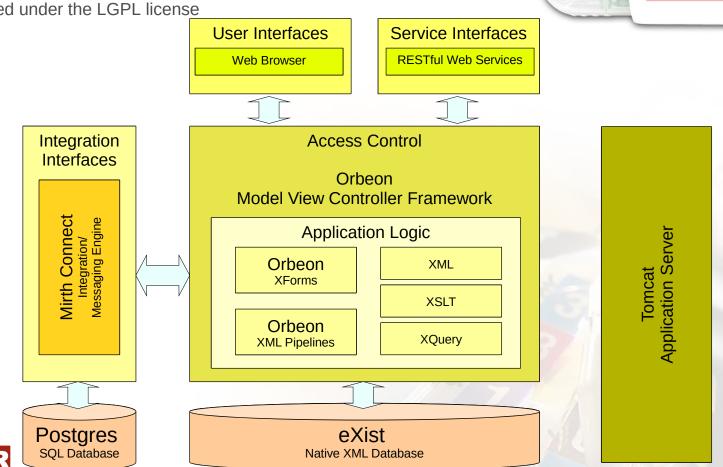






cityEHR Platform

- cityEHR is built using open source software
- An enterprise-scale health records system
- Following research at City University, London
- Distributed under the LGPL license



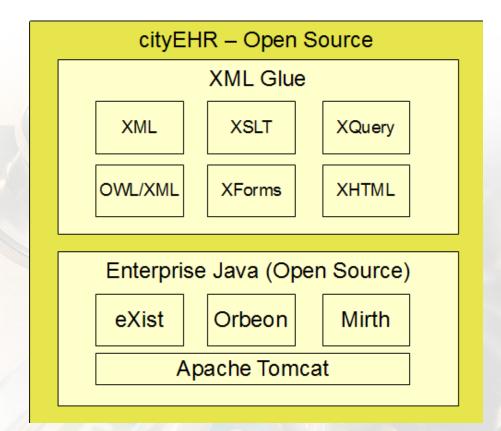




XForms – REST – XQuery

- An XRX application XForms REST XQuery
- Open source, Enterprise Java
- But no Java code
- 100% Declarative Application

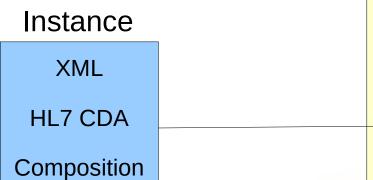








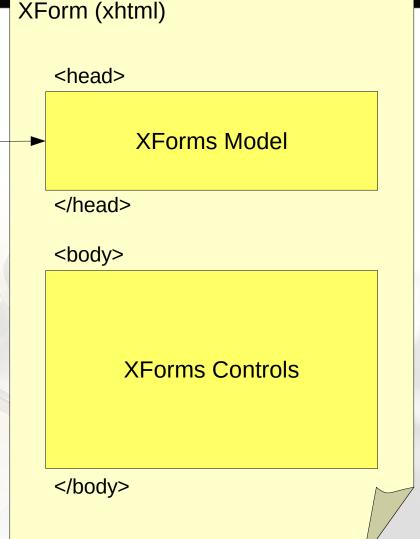
Dynamic XForms User Interface



Controls depend on the XML instance

Can create directly in XForms

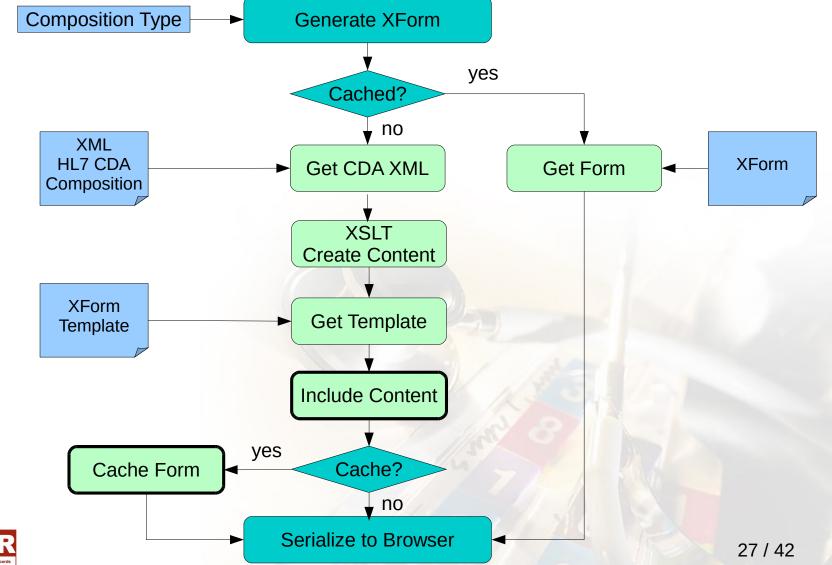
But cannot support arbitrary levels of nesting (for sections and clusters)







Generating XForms in a Pipeline





cityEHR <u>Electronic Health Records System</u>

- Web-based EHR
- Open standards
- Clinician led
- One click deployment
- Enterprise scale

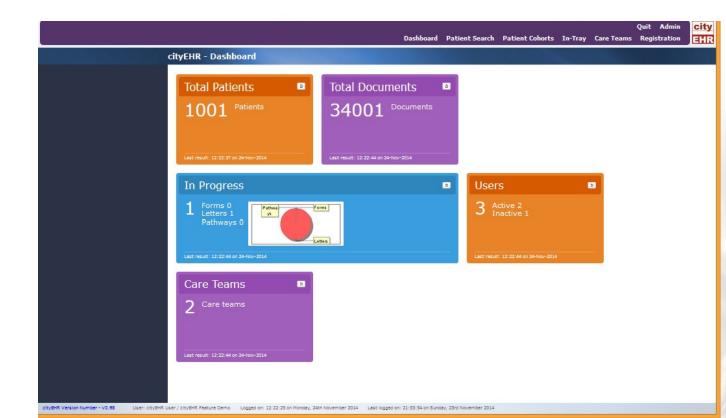






Dashboard – Cross Patient Information

- Execute any database query (configurable)
- Summary of results
- Charts (Bar, Pie, Dial)

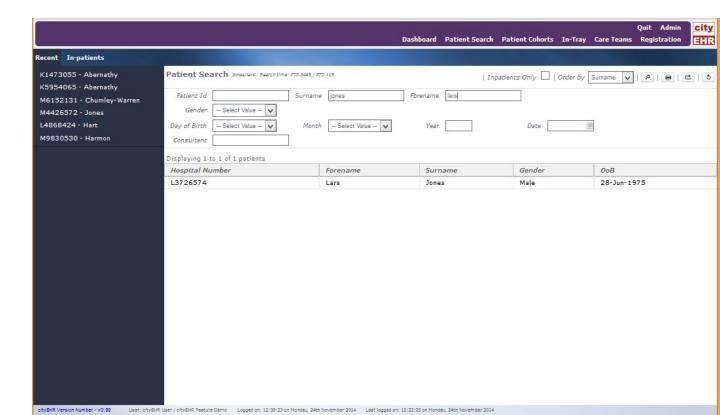






Finding Patients

- Patient search
- Linked to entries in designated CDA registration documents
- Completely configurable
- Recently accessed (from audit log)
- From clinic lists
- From in-patient lists

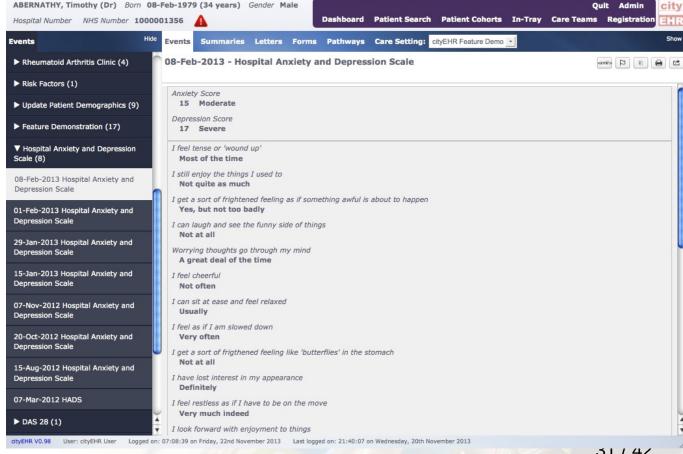






Full Historic Record

- Full list of stored CDA documents
- From migrated data
- From messages
- Or from input data

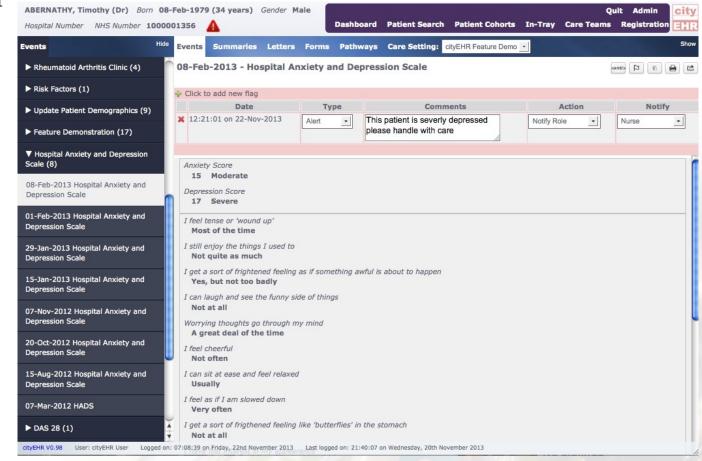






Annotating the Historic Record

- Add annotations to historic data
- Configurable structure of annotations
- Stored as HL7 CDA
- Linked to subject document
- With notification to InTray

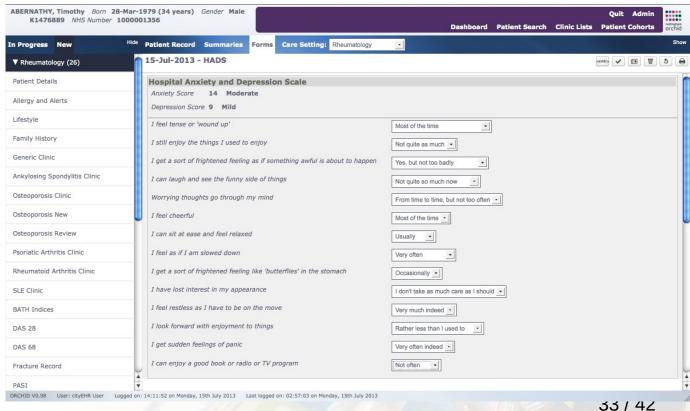






Clinical Data Entry

- All data relationships and behaviour are defined in the information model
- Conditional sections, entries, clusters, elements
- Calculated values (elements)
- Multiple entries
- Pre-filled entries
- Default values
- Constraints
- Hints
- Supporting information
- Required values
- Layout
- Rendition
- Reference data look-up

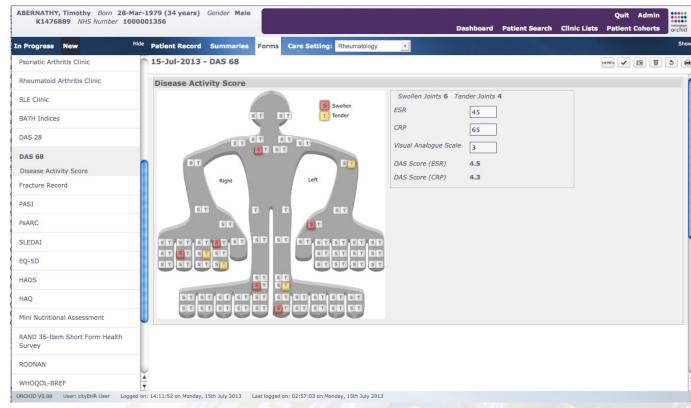






Graphical Input of ISO-13606 Entry

- Link any image with an ISO-13606 entry
- Define an image map, linking to ISO-13606 elements
- Data input is though click on the image
- Only affects the rendition of the entry
 - All other aspects of the data are identical to formbased renditions





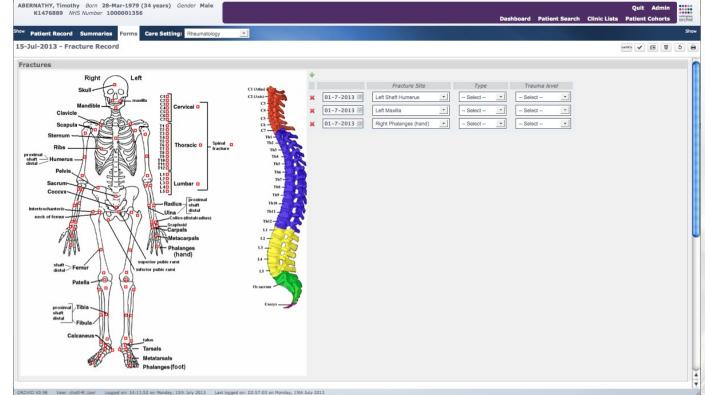


Graphical Input of Multiple Entries

- Link any image with an ISO-13606 entry
- Define an image map, linking to one ISO-13606 element
- Data input is though click on the image
- Each click adds a new entry to the record
- Only affects the rendition of the entry

All other aspects of the data are identical to form-

based renditions

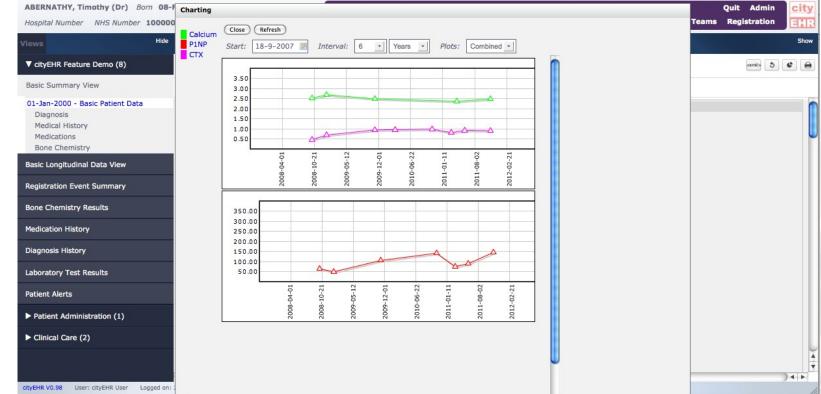






Charts of Historic Data

- Available for recognised data patterns
- For an longitudinal data sets
- Generated as SVG graphics
- As trends or interval plots
 - Laboratory test results
 - Start and stop dates for medications

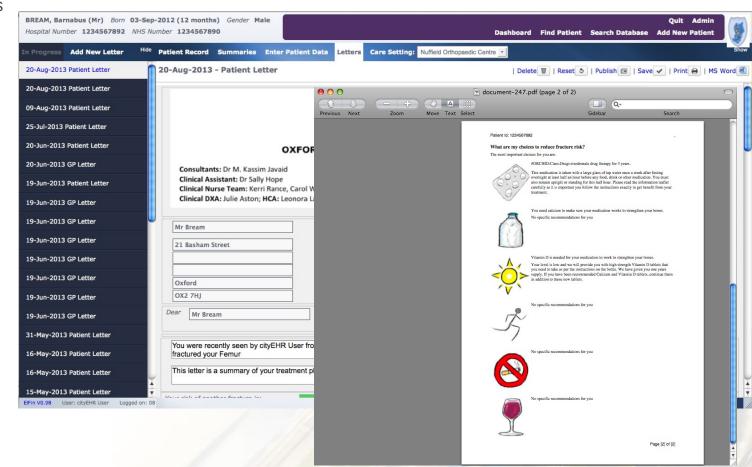






Letters – Integrated Part of the Record

- Created as CDA documents
- Using same modelling tools as other documents
- Stored as HL7 CDA
- Printed (exported) as
 - PDF
 - MS Word

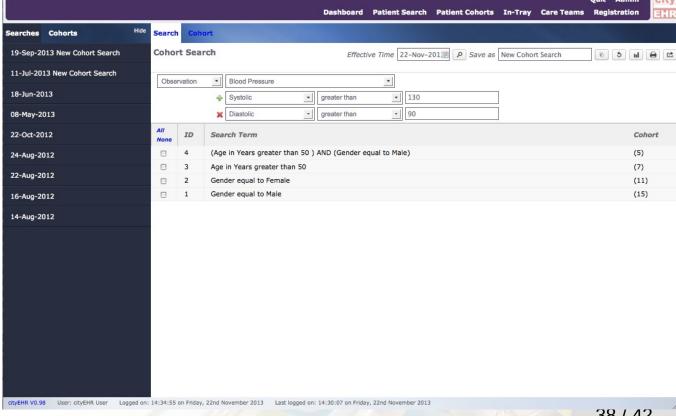






Secondary Uses of Clinical Data

- Cohort search using terms built from the data dictionary
- Use entry/element in clinical context
- Combine cohorts
- Export cohorts, with specified data sets
- as HL7 CDA
- as spreadsheet
- (anonymised)

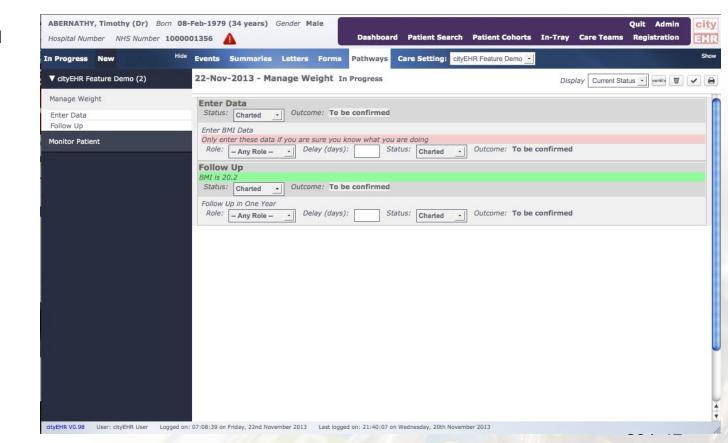






Care Pathways as CDA Documents

- Pathways modelled as CDA documents
- Using same modelling tools as other documents
- Stored as HL7 CDA
- In progress
- and when complete
- forms part of the record

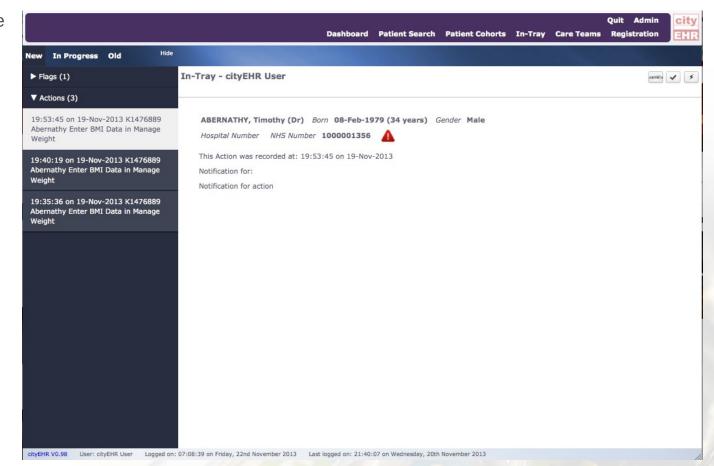






In-Tray — Collaboration for Care Teams

- List of notifications for the user
- Can be actions in pathways
- Or annotations on events
- Click directly through to the patient record

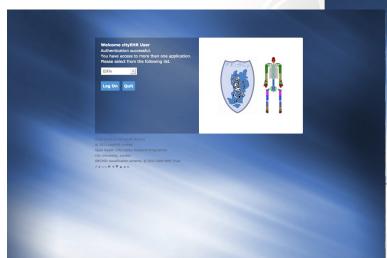






NHS Implementations

- Ponseti database club foot clinics
 - Chelsea and Westminster
 - Manchester Children's Hospital
- ORCHID clinical data for biobank
 - Nottingham University Hospital
- Elfin pathways for fracture prevention
 - Nuffield Orthopaedic Centre, Oxford









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