Moodle H5P Drag and Drop

Interoperability in electronic medical record environment

Drag the words in correct boxes.

Before all vendors were using their own *storage format* for images. *DICOM* standard made it possible to exchange images between different vendors. Standard for exchanging text between systems and facilities is called *HL7*. The message consists of *segments* with pre-defined order (metadata, other segments depended on the message's purpose). The version 3 is *object oriented* and *XML* based.

The syntax and full semantics of a clinical document are defined by *CDA* which is abbreviation for *Clinical Document Architecture*. These documents can contain any kind of clinical notes such as reports, *unstructured text* and links to other documents. Document has *textual part* readable for humans and *structured parts* for software processing. For *transportation* of the document different HL7 or IHE protocols can be used.

The most recent HL7 evolvement has been with *FHIR* which is abbreviation for *Fast Healtcare Interoperability Resources*. It combines best features of HL7 v2 and v3, and CDA.

IHE, which stands for *Integrating the healthcare enterprise*, creates paths to seamless movement of clinical patient data *internationally*. IHE creates so called *profiles* so that people can choose which standard to use in which case. Annual IHE Connectathon is arranged for *testing* the interoperability of health information systems.