

DPROV Glossary

Data Provenance Glossary

Use Case Terminology

Draft Use Case Role Definitions:

Term	Definition
Data Source	A role played by a system that creates data (acting as the true source).
Endpoint	A role played by a system that receives the data.
Transmitter	A role played by a system that serves as a pass through, transporting data from a data source and transmitting that data (unchanged) to an end point.
Assembler	A role played by a system that extracts data from one or more data sources and compiles all of the data so that the output equals the sum of the data source inputs in aggregate. There is neither less nor more data available in the output of an assembler than what can be created by joining all data from the input data sources. The provenance of the output data is no different than the provenance of the input data (with the exception of the provenance information added to indicate the role of the system responsible for assembling the information). (NOTE: this implies machine logic)
Composer	A role played by a system that extracts data from one or more data sources and compiles the data so that the output is less or more than just the sum of the inputs from the data source. A system playing the role of a composer takes an active role in picking and interacting with the source data. It may even interact with a human use to incorporate additional data or update the available information before creating the output data which it dispatches to an end point. The provenance of any data created, updated or omitted by during the interaction is attributed to system playing the role of the Composer or the human operator using the system playing the role of the Composer. (NOTE: this implies human logic is involved where there is a human system operator and machine logic may being applied depending on the functionality of the system acting as the Composer)

Term	Definition	Source
CDA Standard	<p>The HL7 Version 3 Clinical Document Architecture (CDA®) is a document markup standard that specifies the structure and semantics of "clinical documents" for the purpose of exchange between healthcare providers and patients. It defines a clinical document as having the following six characteristics: 1) Persistence, 2) Stewardship, 3) Potential for authentication, 4) Context, 5) Wholeness and 6) Human readability.</p> <p>A CDA can contain any type of clinical content -- typical CDA documents would be a Discharge Summary, Imaging Report, Admission & Physical, Pathology Report and more. The most popular use is for inter-enterprise information exchange, such as is envisioned for a US Health Information Exchange (HIE).</p>	CDA Release 2 Description
Custodian	Responsible for maintaining the record/care plan	HL7 Care Plan Definition

Data Provenance	The term “data provenance” in the context of Health IT refers to evidence and attributes describing the origin of health information as it is captured in a health system.	Data Provenance Charter
EHR	An electronic health record (EHR) is a digital version of a patient’s paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users.	HealthIT.gov
Health IT	Health IT, shorthand for “health information technology,” is a broad concept that encompasses an array of technologies. Health IT is the use of computer hardware, software, or infrastructure to record, store, protect, and retrieve clinical, administrative, or financial information.	HealthIT.gov
HIE	Health Information Exchange	
Life Cycle (Record Entry)	Lifecycle occurs over time and at one or more Events during the Entry Lifespan, starting with the Entry creation/origination Event and ending with the Entry destruction/erasure Event. Intervening Lifecycle Events may include Entry amendment, attestation, access/view, translation, disclosure/transmission, de-identification, encryption, archival.	ISO/HL7 10781 EHR System Functional Model Release 2
Lifespan (Record Entry)	Lifespan is the period starting when the Entry (instance) is created/originated and ending when that Entry (instance) is destroyed/permanently erased - typically after a retention period specified according to scope of practice, organizational policy and/or jurisdictional law.	ISO/HL7 10781 EHR System Functional Model Release 2
PHR	Personal Health Record	
W3C	World Wide Web Consortium	