Terms for Terms: A Terminology Guide for e-HIM Professionals

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by **Marilyn D. Paterno**, MBI; **Sally J. Rynberg**, RHIA, MSA; and **Kathy Giannangelo**, MA, RHIA, CCS, CPHIMS

It can be a challenge to keep straight the many terms used in events, concepts, or data in clinical records. The following table provides definitions for some of the many terms to help HIM professionals differentiate among them.

The difference between terminologies and vocabularies included in this list is related to the domain that each is used to describe. If a terminology is a set of terms representing a system of concepts, and a vocabulary is a dictionary of those terms, those definitions hold true across various domains. The key to understanding the differences among the refined terms is in understanding the domain in which each is used:

> **Clinical**: pertains to the practice of medicine, particularly as it relates to patients.
>
> **Reference**: pertains to the terms of a field itself, such as medicine or disease; however, it is not limited to the medical field. An example in medicine of a reference terminology would be SNOMED CT, the Systematized Nomenclature of Medicine Clinical Terms.
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> **Interface**: refers to communication between two entities, one of which is usually an electronic system.
>
> **Controlled**: pertains to how the terms included in a vocabulary are bound or limited, such as ICD-9-CM (disease classification) and SNOMED CT (broader set of clinical terms).

The terms defined in electronic environments are not hierarchical to each other, nor are they mutually exclusive. This is what makes them difficult to describe and causes them to be used interchangeably, at times inappropriately. Which term to use depends on the context of its use. Knowing the correct term in a given situation improves communication and aids understanding.

Term	Definition	Example of Term in Use
Code set	Under HIPAA, a code set is any set of codes used for encoding data elements, such as tables of terms, medical concepts, medical diagnosis codes, or medical procedure codes.[1] Medical data code sets include coding systems for: • Diseases, impairments, other health-related problems, and their manifestations • Causes of injury, disease, impairment, or other health-related problems • Actions taken to prevent, diagnose, treat, or manage diseases, injuries, and impairment • Any substances, equipment, supplies, or other items used to perform these actions. Code sets for medical data are required for data elements in the administrative and financial	After a clinical coder assigns the codes based on the documentation, the healthcare provider submits an electronic transaction requesting payment for services to Medicare. The standard medical code set defined under HIPAA must be used to report the services. For example, diseases, injuries, impairments, other health-related problems and their manifestations, and causes of injury, disease, impairment, or other health-related problems are reported using ICD-9-CM codes.

	healthcare transaction standards adopted under HIPAA for diagnoses, procedures, and drugs.	
Concept	A concept is a "unit of knowledge or thought created by a unique combination of characteristics."[2] The term describes the most granular element in a reference terminology. If the terminology is a wall, concepts are the bricks that form the structure. Concepts are used as the building blocks for SNOMED CT.	At the time of the encounter, the problem list is encoded using SNOMED CT, a reference terminology that contains a clinical set of concepts, terms, and defined relationships. A terminology specialist working with the medical staff manages the problem list to ensure its accuracy so each problem can be traced to a specific agreed-to meaning that provides consistency in the way data are captured and shared.
Data content standard	Data content standards are "clear guidelines for the acceptable values for specified data fields."[3] Data structure, or the form in which data are stored (e.g., a file, database, a data repository), and content standards "create the framework for an optimal health record and effective information exchange between healthcare providers."[4] A data content standard often "leverages a terminology standard to simplify and unify the data presentation."[5] Data standards provide the ability to record a certain data item in accordance with the agreed-upon standard. Currently very few nationally agreed-upon data standards exist, but there is movement in this direction within the healthcare industry.	A medical claims analyst reports the data standards defined for quality measurement #49, Characterization of Urinary Incontinence in Women Aged 65 Years and Older, according to the 2008 Physician Quality Reporting Initiative specifications (percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months). A nurse stages and documents a patient's pressure ulcer using an industry-recognized standard staging system such as the one developed by the National Pressure Ulcer Advisory Panel.
Data element	A discrete unit of data such as patient birth date or principal diagnosis of interest to an organization. It is a unit of data for which the definition, identification, representation, and permissible values are specified by means of a set of attributes.[6]	An HIM director works with a research team to identify patients with myocardial infarction between the ages of 35 and 50 who died in the emergency room. The data elements of age (derived from birth date), principal diagnosis, and discharge disposition are used to retrieve the eligible cases for inclusion in the study.
Data exchange standard	Data exchange standards are protocols that help ensure that data transmitted from one system to another remain comparable. An example is the HL7 Clinical Document Architecture (CDA).[7]	A regional health information organization (RHIO) enables sharing of patient history between hospitals. A patient falls and fractures a hip while visiting his son in another city. The emergency room physician requests history records from the hospital and primary care clinic where this

		patient normally receives care. This helps inform care and treatment and to avoid duplicating laboratory tests. The RHIO receives the request, confirms the identity of the person and records needed, then retrieves the information and sends it to the requesting facility. The data exchange standard provides necessary information for medical decision making by ensuring information integrity is maintained between sender and receiver.
Data set	A data set is a "list of recommended data elements with uniform definitions that are relevant for a particular use."[8] It may also be defined as a "named collection of logically related data items arranged in a prescribed manner."[9] Data sets are frequently used in healthcare transactions to facilitate health information exchange. Use of data sets ensures a uniform data model that enables software applications and routine reports. Examples of data sets used today include the Minimum Data Set (MDS) for post-acute care reporting, Outcomes and Assessment Information Set (OASIS) for home care agencies, Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI), the Data Elements for Emergency Department Systems (DEEDS), and the National Electronic Disease Surveillance System (NEDSS). There are also data sets used for statistical analysis, such as the Uniform Hospital Discharge Data Sets (UHDDS) and the National Hospital Ambulatory Medical Care Survey (NHAMCS).	A reimbursement specialist in a short-term acute care hospital provides codes for an electronic transaction requesting payment under the Inpatient Prospective Payment System (IPPS) for services to a Medicare beneficiary. To do so, the hospital must report a set of common, uniform data elements from the Uniform Hospital Discharge Data Set. For example, the definition of principal diagnosis is used in the IPPS's MS-DRG algorithm.

Lexicon	Lexicon has two meanings. A lexicon can be a list of words with additional word-specific information (i.e., a dictionary).[10] In linguistics, the term more commonly refers to a language's inventory of lexemes (i.e., its vocabulary). This vocabulary is used in a language or subject area by a particular speaker or group of speakers or is a collection of words or terms and their meanings for a particular domain.[11]	A medical coder refers to an English medical dictionary to determine the meaning of a term found in the documentation of a medical record in order to select the most accurate code for the term. A health information system applications support manager works with a linguist to identify how the vocabulary in a medicine report or note is structured, how healthcare providers use and store words, and the types of relationships between words to develop a natural language processing application for an EHR system.
Relationship	Relationships are the connections between concepts.[12] The relationships characterize concepts and give them their meaning.	A clinical mapping specialist reviews the relationships between concepts in SNOMED CT (a terminology) and ICD-10 (a classification) to develop a map between the two.
Taxonomy	A taxonomy is a method of classifying things according to ordered groups.[13] It may also be described as an intellectual structure that arranges items into groups and subgroups based on predetermined rules.[14] Used in relation to classification, taxonomy describes both the study of the principles and rules for classifying a given set of things into ordered groups and the end results of the process.	For taxonomy as product: (1) A clinical research associate in the state health department organizes and tags content against a public health taxonomy. (2) Providers, in applying for a National Provider Identifier number, must select a taxonomy code that describes provider type, classification, and area of specialization. For taxonomy as process: The ICD-9-CM taxonomy includes the grouping of diseases in body systems or by etiology, subdividing the main disease or etiological categories into three-digit classes (category).
Terminology	A terminology is a set of terms, expressions, designations, or symbols used to represent concepts that are specific to a particular science, discipline, or specialized subject area.[15] Different fields of study require the use of different terminologies. For instance, in medical (clinical) terminology, "evacuation" usually refers to the emptying of bowels. In military terminology, "evacuation" means withdrawal from a military occupation.	An educator teaches a medical terminology course to health information technology students. A health information coder uses CPT to assign billing codes for procedures documented in a patient record.

	A set of terms representing the system of concepts of a particular subject field.	
Terminology, clinical	A clinical terminology represents the terms, expressions, designations, or symbols used in the field of medicine (e.g., SNOMED CT). It is used to record patient findings, circumstances, events, and interventions with sufficient detail to support clinical care, decision support, outcomes research, and quality improvement.[16] A set of standardized terms and their synonyms that record patient findings, circumstances, events, and interventions.	A documentation specialist works with physicians to develop a standard set of data values, using SNOMED CT, to populate a patient problem list, which promotes interoperability of this data.
Terminology, controlled	Frequently used interchangeably with "controlled vocabulary," a controlled terminology is an established list of standardized terminology for use in indexing and retrieval of information. An example of a controlled vocabulary is subject headings used to describe library resources.[17] A controlled vocabulary is a list of standard terms used to index information. It usually includes a list of cross-references that link other commonly used terms to the controlled vocabulary term. The creators of most bibliographic databases assign controlled vocabulary terms to journal articles, books, dissertations, and other publications. Users of bibliographic databases use controlled vocabulary terms to find information that addresses their research needs.	A systems analyst helping to install a laboratory system creates one display for the results of a blood glucose test regardless of its collection method, which could be via a serum glucose test, plasma glucose test, or fingerstick glucose test. An applied health informatics researcher assigns terms from the controlled and hierarchical MeSH terminology used by the National Library of Medicine to index all the articles cited in MEDLINE to an article for publication in a professional journal.
Terminology, interface	An interface defines the communication boundary between two entities, such as a piece of software, a hardware device, or a user.[18] An interface terminology contains the terms used for the communication type being referenced. Within an electronic health record system, it involves the capture of structured data elements that can be mapped to another reference terminology, usually mapping local terms to a broader reference terminology, with the goal of making the broader reference terminology more useful in the clinical workplace.[19] An interface terminology is a "systematic collection of health care–related phrases (terms) that supports clinicians' entry of patient-related information into computer programs, such as clinical 'note capture' and decision support tools. Interface terminologies	A provider selects from a prepopulated list a value that describes a patient's condition, such as "mild fatigue secondary to sleep deprivation" or "work-related stress." Each item on the list has already been mapped by a clinical data collection and reporting specialist to a concept in a reference terminology, such as SNOMED CT. A health data resource manager develops a continuity of care record template that uses the familiar concepts of the interface terminology to identify the patient's problems.

	also facilitate display of computer-stored patient information to clinician-users as simple human-readable text. The 'interface' of interface terminologies (which have also been called colloquial terminologies, application terminologies, and entry terminologies) links health care providers' own free text patient descriptors to structured, coded internal data elements used by specific clinical computer programs. These terminologies generally embody a rich set of flexible, user-friendly phrases displayed in the graphical or text interfaces of specific computer programs."[20] "Interface terminologies bridge the gap between information that is in the physician's mind and information that can be interpreted by computer applications. They interface between the users and the standard reference terminologies required by clinical information systems. Interface terminologies provide clinically relevant language which can describe patient characteristics such as problems, history, procedures, allergies, and medications with the desired level of specificity. The maps from interface terminologies to appropriate reference terminologies enable advanced functionality available in clinical information systems."[21]	
Terminology, reference	A set of concepts and relationships that provide a common reference point for the comparison and aggregation of data about the entire healthcare process, recorded by multiple individuals, systems, or institutions.[22] By creating computable definitions, a reference terminology supports reproducible transmission of patient data between information systems. It supports consistent and understandable coding of clinical concepts and so is a central feature for the function of computerized patient records.	A terminology standards manager oversees the work of clinical mapping specialists responsible for the maintenance of a map from SNOMED CT to ICD-9-CM. A data integrity specialist takes a list of synonyms and abbreviations familiar to clinicians working for the same hospital or clinic and maps it to SNOMED CT concepts for efficient lookup to identify the desired concept quickly, easily, and accurately for their EHR system. The list of synonyms and abbreviations is an example of an interface terminology (see above entry).
Vocabulary	A list or collection of words or phrases with their meanings. Examples include terms specific to sports, photography, informatics, or medicine.[23] A vocabulary is also defined as a dictionary containing the terminology of a particular field.[24]	Practitioners in complementary medicine use a different vocabulary specific to the discipline. The vocabulary of an accupuncturist includes the terms qi, meridians, and acupoints.

Vocabulary, clinical	A clinical vocabulary is one specific to the clinical realm in the field of medicine; a list or collection of clinical words or phrases with their meaning. It is also called a medical vocabulary.[25]	A clinical data systems analyst uses a clinical vocabulary specific to orthopedics when developing a template for an electronic progress note for orthopedic surgery.

Notes

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Marilyn D. Paterno (mdpaterno@partners.org) is a senior medical informatics specialist at Partners Healthcare System. **Sally J. Rynberg** is a revenue management consultant at Trinity Health. **Kathy Giannangelo** is a medical informaticist at Language and Computing.

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