

Provider Organisations

Provider organisations have a number of basic priorities with respect to health information:

- being able to share the information across systems *within* the enterprise
- being able to share some of the enterprise information, including at least discharge summaries and referrals with *other providers*, e.g. GPs, within a community of care
- being able to *compute* with the health information they create, e.g. to support:
 - care pathway management
 - business process improvement
 - decision support including preventative risk assessment
 - medical research
- being able to integrate multiple software applications and packages without losing meaning - preferably avoiding vendor lock-in
- being able to evolve their information systems to deal with new kinds of procedure, management approach or workflows
- In some countries, provider enterprises may be required to connect with a national e-health framework, using national or international standards or specifications.

In the majority of medium to large enterprises, the existing computing infrastructure must continue to function, and any change made gradually.

openEHR offers various advantages to health provider organisations. Firstly, it provides a health computing platform for creating, storing, querying and sharing clinical, demographic and some administrative information ([specifications](#)¹). Implementations ([commercial](#)², [open source](#)³) of the *openEHR* platform can provide a high-performance, high-volume health record for use by any number of applications. Applications interface via the published virtual EHR (vEHR) API (coming end 2008). Initially, most provider organisations will have a number of existing systems, many of which do not communicate or for which only expensive one-off integrations are made. The *openEHR* platform provides a disciplined way to integrate such data, using *openEHR* Templates ([FAQ](#)⁴) to model the legacy data structures, while using normal *openEHR* archetypes ([FAQ](#)⁵) to define the data points. This approach means that data from e.g. laboratory, radiology, cardiology, patient administration, and many others can be brought together in a patient-centric fashion. This shared data can then be reflected back to existing systems. It can also be queried via the vEHR interface, and new applications can start to use it directly.

This approach has a number of advantages. Firstly, it allows the enterprise to start supporting a true patient-centric longitudinal health record that is technology-independent and will support all manner of other systems and applications for many years to come. Secondly, because the clinical semantics of the data are defined by archetypes rather than in the software, the back-end system can evolve without costly and risky downtime, upgrading, testing and redeployment.

Over time, as uptake of the *openEHR* platform increases, the cost of managing clinical information

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1. <http://www.openehr.org/svn/specification/TAGS/Release-1.0.1/publishing/roadmap.html>
 2. daisy:65-OE (Commercial products and systems based on openEHR)
 3. daisy:88-OE (The openEHR Java Reference Implementation Project)
 4. daisy:130-OE (Template FAQs)
 5. daisy:92-OE (Archetypes FAQs)

should decrease, while its utilisation and quality increase. Procurement is likely to have more freedom to purchase applications, since any application that is compliant to openEHR, CEN EN13606, HL7 CDA rel 2, HL7v2.x can easily be integrated. Larger enterprises that write their own applications will be able to use Template tools for building GUI forms, and Query building tools to build reusable queries. Because of its support for these standards, the *openEHR* platform will enhance the capability of the enterprise to connect to a national health information infrastructure.