Suitability of LOINC Document Ontology as a reference terminology for clinical document types: A case report of a research-oriented EHR

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Abstract
A detailed electronic record of delivered clinical care is important for providing clinical decision support and for conducting research using existing clinical data. Knowing the type of document filed within an EHR (e.g., bronchoscopy report), helps to derive important procedural or phenotypic information that may not be obtainable from other sources. A comprehensive document ontology can also greatly facilitate review of clinical documents integrated from multiple sources within a health information exchange (HIE) platform. The Clinical LOINC (Logical Observation Identifiers Names and Codes) terminology includes a Document Ontology (DO) that is intended to provide a standardized set of document types. We analyzed the frequency of clinical document types from the National Institute of Health’s (NIH) Clinical Center as mapped to LOINC DO. Our work complements prior work with results from a research-oriented healthcare institution, and has implications for LOINC developers as well as EHR system administrators.

Methods
We used clinical documents data from the NIH Biomedical Translational Research Information System (BTRIS), which contains documents from several systems. Using the RELMA mapping tool, two experts mapped the most frequent document types to LOINC DO (v2.36, containing 661 document types). A consensus process was used to resolve any mapping differences and produce a single mapping for each document type.

Preliminary Results
The current BTRIS repository has a total of 174 different document types, with 18 document types accounting for 80% of all documents and 67 document types accounting for 99% of all documents. The two mappers agreed eight times that there is no corresponding term within LOINC DO and agreed on the mapped term in 6 cases; they agreed on LOINC mapping for the four remaining document types after subsequent discussion. Therefore, the mappers identified a corresponding LOINC code for 56% of NIH document types (10 out of 18 types; see Fig. 2).

Discussion and Conclusion
Our result of 56% LOINC DO coverage of document types is comparable to findings by Chen. The mapping revealed a possibility to use LOINC DO as a way of linking retired, view-only, legacy document types (e.g., legacy code C114110, respiratory observations) to the current active types at the integrated data repository (IDR) level. In order to improve DO coverage, we are in the process of submitting a request for new terms to the clinical LOINC committee as we have done in the past. To expand our initial mapping and improve our analysis of LOINC DO, we have also created a draft mapping of all 174 NIH document types (single mapper only).

To fully utilize LOINC DO as a reference ontology, mapping of standardized document types would ideally occur during introduction of new document types within the EHR rather than during import to the IDR. Unfortunately, most EHR vendors do not support mapping of internal document types to a common reference terminology. Moreover, the current hierarchy within LOINC DO is undergoing revisions and it was not originally developed to support a clinician picking the most relevant document type to view or author within an EHR system (see Fig. 2 and 3). Our future work includes creating a subset of commonly used document types from LOINC DO which would be similar to the “best of” Lab LOINC subset to facilitate adoption of LOINC DO and mapping efforts at other institutions. We also want to explore the use and possible roles for LOINC parts concepts within LOINC DO.