Pan-Canadian Health Data Content Framework

Data Content Standard: Open Review

March 2024

Canadian Institute for Health Information
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Canadian Institute for Health Information
495 Richmond Road, Suite 600
Ottawa, Ontario K2A 4H6
Phone: 613-241-7860
Fax: 613-241-8120
cihi.ca
copyright@cihi.ca

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Introduction

Canada's health data landscape is complex and fragmented. Historically, the digitization of health data has been a priority (having a way to capture the data electronically), but sharing this data (among facilities, organizations, health systems, etc.) has not been a focus. As such, the information that exists cannot be shared because it has not been captured in standardized ways and everyone is using different systems. To address this challenge, CIHI is developing the Pan-Canadian Health Data Content Framework, which defines, standardizes and models the health data required to enable connected care in Canada.

The purpose of the Pan-Canadian Health Data Content Framework is to lay the foundation for standard health data that can be used within and across various sectors and contexts. Unlike traditional data standards, the framework's standard is intended for primary and secondary use, and does not establish minimum requirements, as this will vary based on context and implementation requirements. Framework users can select the health data that is relevant to support their needs and that can be used to define data sets (e.g., e-Referral).

This data content standard is one of several products packaged in the Pan-Canadian Health Data Content Framework.

What is a data content standard?

Data content standards specify the data elements and value sets to be used to ensure accuracy, compatibility, uniformity and consistency in how health data is collected, interpreted and exchanged.

Scope

This data content standard intends to capture the data that is required for connected clinical practice and for patient access to their own records in a primary health care setting. While the initial scope of the standard is primary health care, future iterations will encompass data from hospitals, emergency departments, long-term care and other health domains.

This initial iteration of the data content standard lays the foundation for subsequent refinements and advancements for a modernized and interoperable health system.

Audience

The standard aims to incorporate a person-centred approach. The intended audiences include individuals with lived experience, people and communities, health care providers, governing bodies, organizational leaders, researchers, and technical users involved in health data management, as well as members of the public who would like to know more about the data content standard.

Help us shape the data content standard

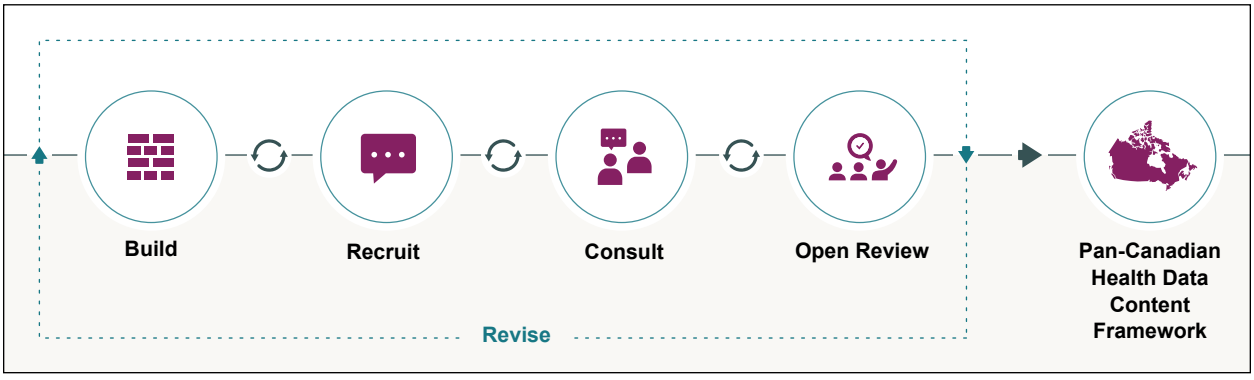
Your feedback is critical to the development of the data content standard. We are asking the public to help us identify and define the data that matters to you by providing feedback on the overall content, including definitions and value sets.

Please click the following link to start the feedback survey.

Development process

The data content standard was created through collaborative efforts, leveraging existing standards, conducting gap analyses and engaging stakeholders such as clinicians, researchers, Indigenous partners, policy-makers, government agencies and data architects (see Figure 1).

Figure 1 Pan-Canadian Health Data Content Framework development cycle



Build

Data elements

An environmental scan was conducted to identify source documents to inform the standard. This search involved identifying data content standards from around the world:

- **Canada** — Patient Summary Canada, CIHI's Primary Health Care Minimum Data Standard, Screening for Poverty And Related Social Determinants to Improve Knowledge of and Access to Resources (SPARK) tool, Alliance for Healthier Communities;
- **International** — International Patient Summary; and
- **Other jurisdictions** — United States' Core Data for Interoperability, United Kingdom's Professional Record Standards Body.

A mapping exercise was completed to identify common data categories, data elements and definitions across the literature. Gap analyses were then conducted to identify additional data elements within the scope of primary health care.

Value sets

The environmental scan, mapping exercises and gap analyses for the data elements also served as the foundation for developing the value sets. Value sets were selected based on domain-specific best practices and evaluated by terminology experts at CIHI and Canada Health Infoway. The framework includes the pan-Canadian value set recommendations and supporting alternate value sets where needed (e.g., for international data exchange). Generally, Systematized Nomenclature of Medicine — Clinical Terms (SNOMED CT) is the clinical terminology recommended for use in primary health care and in the data content standard, with additional recommendations of LOINC, ICD and HL7 standards where appropriate. The recommended value sets align with international and pan-Canadian standards, including the International Patient Summary, forthcoming National Vaccine Catalogue and PrescribeIT®. The Pan-Canadian Health Data Content Framework supports value set reuse in accordance with the "collect once, use many times" principle to ease the burden of data collection and facilitate data sharing within a person's care circle.

Recruit

A diverse group of co-contributors were recruited to provide initial feedback on the development of the data content standard: individuals with lived experience, clinicians, researchers, Indigenous partners and policy-makers representing various geographies and jurisdictions across Canada.

Consult

Feedback provided by expert co-contributors ensured that the group's diverse perspectives were considered. Their feedback also contributed to ensuring the standard's relevance and usability within the primary health care sector. The aim of this consultation process was to gather valuable input to enhance the data content standard prior to broader dissemination and open review.

Open review

The data content standard is posted for open review for a 60-day period, from March 7 to May 6, 2024. All content can be accessed and reviewed by any member of the public. Feedback obtained during the open review period will be considered for Version 1.0 of the Pan-Canadian Health Data Content Framework. Feedback obtained after the open review period will be considered for subsequent releases.

Release

Version 1.0 of the Pan-Canadian Health Data Content Framework will be released in September 2024 and will incorporate feedback received during the open review period.

Revise

The framework will undergo an iterative development process over time, where each release will go through the development cycle described above, with the aim of refining and enhancing the deliverables over multiple iterations. This cycle allows for flexibility and continuous improvement over time. Maturity levels are assigned to all framework deliverables to track their progression through iterations.

Maturity levels

A maturity model (Table 1) was designed to transparently document the readiness of artifacts within the framework, including data elements, value sets and data architecture components. The maturity model facilitates tracking the evolution of these artifacts over time, enabling continuous refinement and enhancement based on feedback and emerging needs. The maturity of the framework's deliverables will be re-evaluated with each release.

Table 1 Maturity model

Stage of maturity	Definition
Future development	Coming soon
0: In development	Artifact is a work in progress
1: Draft	Artifact incorporates input from experts
2: Proposed	Artifact has been through at least one round of open public review
3: Ready for use	Artifact is ready for implementation

Data content standard

About this standard

The data content standard includes the following:

- **Data element:** A distinct unit of information that represents a specific attribute or characteristic within a data set
- **Value set:** Defines a set of permitted values and their codes assigned to a data element

Guidance for the reader

The following tables provide a detailed list of data elements, definitions, value sets and recommended code systems for primary health care. The data content standard includes the information that may be collected in a primary health care setting, as well as the information that a primary health care provider may expect to receive from other providers in the system (e.g., pharmacist, specialist). Value set examples represent display names with further information on codes and concepts available through the value set hyperlink.

The table rows that are white (that do not contain an asterisk) indicate that the data may be entered by a person at the point of care (front end); the table rows that are colour-coded (and that do contain an asterisk) indicate that the data is derived from other sources at the back end (e.g., machine-generated).

- White rows without an asterisk represent front-end data
- Blue rows with an asterisk represent back-end data

Information that is entered at the front end may be entered by a patient (e.g., self-administered questionnaire), an administrator or a provider. Whether the data is front end or back end will vary depending on the administrative and clinical flows of the primary health care setting, as well as the technical solutions in use.

In the tables below, “n/a” means “not available.”

Administrative information

Person information

The following data elements pertain to administrative information about a person receiving care or other health-related services.

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Person Identifier information					
Person Identifier Type	A coded type for the identifier that can be used to determine which identifier to use for a specific purpose	1: Draft	To be developed	n/a	n/a
Person Identifier Value	The alphanumeric value and/or number of the health identifier (e.g., medical record number, jurisdictional health number)	1: Draft	n/a	n/a	n/a
Person Identifier System*	The namespace for the identifier value — a URI that describes a set value that is unique	1: Draft	n/a	n/a	n/a
Person Identifier Assigner*	Represents the legal entity/organization responsible for assigning the Person Identifier	1: Draft	ClientIdentifierAssigningAuthorityCode (SNOMED CT CA)	• Veterans Affairs Canada • Saskatchewan Ministry of Health • Quebec Health Insurance Authority • Nova Scotia Department of Health and Wellness • Nunavut Department of Health and Social Services • Correctional Service Canada • Indigenous and Northern Affairs Canada • Alberta Health • Canadian Armed Forces • British Columbia Ministry of Health	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Person Identifier information (continued)					
Person Identifier Period*	The start and end date (e.g., expiry date) for the unique identifier	1: Draft	n/a	n/a	n/a
Person Name information					
Given Name	The person's first name as indicated on their government-issued identification (e.g., health card, driver's licence, passport)	1: Draft	n/a	n/a	n/a
Middle Name	The person's middle name as indicated on their government-issued identification (e.g., health card, driver's licence, passport)	1: Draft	n/a	n/a	n/a
Family Name	The person's family name as indicated on their government-issued identification (e.g., health card, driver's licence, passport)	1: Draft	n/a	n/a	n/a
Pronouns	The pronouns by which a person prefers to be referred **Note:** Pronouns, while part of the GSSO standard, are captured under Person Information.	1: Draft	Personal pronouns - Reported (LOINC) NullFlavor (HL7)	• He/him/his/his/himself • She/her/her/hers/herself • They/them/their/theirs/themselves • Ze/zir/zir/zirs/zirself • Xie/hir ("here")/hir/hirs/hirself • Co/co/cos/cos/coself • En/en/ens/ens/enself • Ey/em/eir/eirs/emself • Yo/yo/yos/yos/yoself • Ve/vis/ver/ver/verself • Prefer not to answer • Unknown • Unable to ask • Unsure	0: In development

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Person Name information (continued)					
Name Used	The name specified by the person that should be used in the context of health care, including nicknames, middle names, language-specific alternatives (e.g., Bill, William, Guillaume, Guillermo) or names that affirm gender identity. **Note:** It is important to capture this data element. When implemented, Name Used will be a name with Name Type = *usual*. **Note:** Name Used, while part of the GSSO standard, is captured under Person Information.	1: Draft	n/a	n/a	n/a
Previous Given Name	The first name by which the person formerly went **Note:** Previous Given Name is a name with Name Type = *old*.	1: Draft	n/a	n/a	n/a
Previous Family Name	The family name by which the person formerly went **Note:** Previous Surname is a name with Name Type = *old*.	1: Draft	n/a	n/a	n/a
Birth Date	The year, month and day on which the person was born	1: Draft	n/a	n/a	n/a
Name Type*	Indicates the use of the person's name (e.g., official name, nickname)	1: Draft	NameUse (HL7)	• Usual • Official • Temp • Nickname • Anonymous • Old • Name changed for marriage	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Person Name information (continued)					
Name Text*	A text representation of the full name	1: Draft	n/a	n/a	n/a
Name Period*	Indicates the period of time when this name was valid for the named person	1: Draft	n/a	n/a	1: Draft
Person Address information					
Person Address Street	The person's street address	1: Draft	n/a	n/a	n/a
Person Address City	The person's city	1: Draft	n/a	n/a	n/a
Person Address Province	The person's province or territory	1: Draft	To be confirmed	0: In development	1: Draft
Person Address Postal Code	The person's postal code	1: Draft	n/a	n/a	n/a
Person Address Country	The person's country	1: Draft	Standard Classification of Countries and Areas of Interest (SCCAI) 2022 (ISO)	• Algeria • Australia • Belgium • Canada • France • Haiti • Italy • Norway • United Kingdom • United States of America	1: Draft
Person No Fixed Address Flag	Indicates whether the person has no fixed address (i.e., experiencing homelessness, living in a shelter)	1: Draft	n/a	n/a	n/a

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Person Address information (continued)					
Person Address Use*	The use for a given address (e.g., home, work, temporary, old/incorrect)	1: Draft	AddressUse (HL7)	• Home • Work • Temporary • Old/incorrect • Billing	1: Draft
Person Address Type*	The type for a given address (e.g., physical, postal or both)	1: Draft	AddressType (HL7)	• Postal • Physical • Postal and physical	1: Draft
Person Address Period*	The period of time in which the person's address is in use	1: Draft	n/a	n/a	n/a
Person Telecom information					
Person Telecom Value	The actual value of the telecom (e.g., phone number, email address)	1: Draft	n/a	n/a	n/a
Person Telecom System*	The type of telecom system	1: Draft	ContactPointSystem (HL7)	• Phone • Fax • Email • Pager • URL • SMS • Other	1: Draft
Person Telecom Use*	Indicates whether the telecom value is a home number, work number, etc.	1: Draft	ContactPointUse (HL7)	• Home • Work • Temp • Old • Mobile	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Person Telecom information (continued)					
Person Telecom Rank*	The order of priority for the telecom list (e.g., use home number first)	1: Draft	n/a	n/a	n/a
Person Telecom Period*	The period of time in which the person's communication method is in use	1: Draft	n/a	n/a	n/a
Medical record status					
Person Active Status	Indicates whether the person's record is in active use	1: Draft	n/a	n/a	n/a
Date of Death	The date that the person passed away	1: Draft	n/a	n/a	n/a
Contact person name information					
Contact Given Name	The contact's first name as indicated on their government-issued identification (e.g., health card, driver's licence, passport)	1: Draft	n/a	n/a	n/a
Contact Family Name	The contact's family name as indicated on their government-issued identification (e.g., health card, driver's licence, passport)	1: Draft	n/a	n/a	n/a
Contact Relationship Type	The contact's relationship to the person (e.g., emergency contact, mother, spouse, step-sibling)	1: Draft	v3-PersonalRelationshipRoleType (HL7)	• Family member • Adopted daughter • Stepson • Aunt • Maternal cousin • Paternal grandfather • Brother • Mother • Spouse • Unrelated friend	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Contact person name information (continued)					
Contact Relationship Role	The contact's role within the circle of care (e.g., next of kin, caregiver, emergency contact)	1: Draft	relatedperson-relationshiptype (HL7)	• Emergency contact • Next of kin • Guardian • Dependant • Guarantor • Caregiver • Employer • Other • Interpreter • Health care power of attorney	1: Draft
Contact Name Type*	Indicates the use of the contact's name (e.g., official name, nickname)	1: Draft	NameUse (HL7)	• Usual • Official • Temp • Nickname • Anonymous • Old • Name changed for marriage	1: Draft
Contact Period*	The period of time in which the contact is active	1: Draft	n/a	n/a	n/a
Contact person address information					
Contact Address Street	The contact's street address	1: Draft	n/a	n/a	n/a
Contact Address City	The contact's city	1: Draft	n/a	n/a	n/a
Contact Address Province	The contact's province/territory	1: Draft	To be confirmed	0: In development	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Contact person address information (continued)					
Contact Address Postal Code	The contact's postal code	1: Draft	n/a	n/a	n/a
Contact Address Country	The contact's country	1: Draft	Standard Classification of Countries and Areas of Interest (SCCAI) 2022 (ISO)	• Algeria • Australia • Belgium • Canada • France • Haiti • Italy • Norway • United Kingdom • United States of America	1: Draft
Contact Address Use*	The use for a given address (e.g., home, work, temporary, old/incorrect)	1: Draft	AddressUse (HL7)	• Home • Work • Temporary • Old/incorrect • Billing	1: Draft
Contact Address Type*	The type for a given address (e.g., physical, postal or both)	1: Draft	AddressType (HL7)	• Postal • Physical • Postal and physical	1: Draft
Contact Address Period*	The period of time in which the person's address is in use	1: Draft	n/a	n/a	n/a

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Contact person telecom information					
Contact Telecom Value	The actual value of the telecom (e.g., phone number, email address)	1: Draft	n/a	n/a	n/a
Contact Telecom System*	The type of telecom system (e.g., email, phone)	1: Draft	ContactPointSystem (HL7)	• Phone • Fax • Email • Pager • URL • SMS • Other	1: Draft
Contact Telecom Use*	Indicates whether the telecom value is a home number, work number, etc.	1: Draft	ContactPointUse (HL7)	• Home • Work • Temp • Old • Mobile	1: Draft
Contact Telecom Rank*	The order of priority for the telecom list (e.g., use home number first)	1: Draft	n/a	n/a	n/a
Contact Telecom Period*	The period of time in which the contact's communication method is in use	1: Draft	n/a	n/a	n/a
Most Responsible Provider information					
Most Responsible Provider Status	Indicates the person's status to a regular primary health care provider where they receive ongoing care	1: Draft	n/a	n/a	n/a
Most Responsible Provider Given Name	The most responsible provider's first name	1: Draft	n/a	n/a	n/a

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Most Responsible Provider information (continued)					
Most Responsible Provider Family Name	The most responsible provider's family name.	1: Draft	n/a	n/a	n/a
Most Responsible Provider Period*	The approximate date that the person started receiving ongoing care from their most responsible provider	1: Draft	n/a	n/a	n/a

Health coverage information

The following data elements pertain to information about a person's coverage for health care.

Data element name	Data element definition
Private Health Coverage Status	The presence or absence of private health care insurance coverage
Private Health Plan Name	The name of the private health insurance company
Private Health Plan Group Name	The name of the employer or group that purchased the private health insurance
Private Health Plan Policy Number	The person's health coverage policy unique identifier
Private Health Plan Coverage Period	The time frame in which the private health care coverage policy is in force

Cross border overview

The following data elements pertain to the provenance detail necessary for cross-border transactions.

Data element name	Data element definition
Country of Affiliation	The designated source country where the person and their health care information are based
Country-Specific Requirements	The information used to describe unique facts, cultural and legal details, and jurisdictional matters that need stating as part of the agreement to interchange

Health status

Allergies and intolerances

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Allergy or Intolerance overall status					
Allergy or Intolerance Status	Information about the known absence of an allergy, or whether there is no allergy information available	1: Draft	AbsentOrUnknownAllergiesUvIps (HL7)	• No information about allergies • No known allergies • No known medication allergies • No known environmental allergies • No known food allergies	1: Draft
Allergy or Intolerance Code	The pharmaceutical or biologic product or substance (e.g., peanut) to which the person has an allergy or intolerance	1: Draft	PharmaceuticalBiologicProductAndSubstanceCode (SNOMED CT CA)	• Bee venom • Dairy sauce • Dog dander • Gluten • Grass pollen • Latex • Morphine • Peanut • Penicillin • Perfume	1: Draft
Allergy or Intolerance Criticality	Estimate of the potential clinical harm or of the seriousness of the reaction to the identified substance (i.e., low risk, high risk, unable to assess risk)	1: Draft	AllergyIntoleranceCriticality (HL7)	• Low risk • High risk • Unable to assess risk	1: Draft
Allergy or Intolerance Clinical Status	The status of the allergy or intolerance (i.e., active, inactive, resolved)	1: Draft	AllergyIntoleranceClinicalStatusCodes (HL7)	• Active • Inactive • Resolved	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Allergy or Intolerance overall status (continued)					
Allergy or Intolerance Date of Resolution*	The date that the allergy or intolerance resolved or went into remission	1: Draft	n/a	n/a	n/a
Allergy or Intolerance Category*	The allergy or intolerance exposure category (i.e., food, medication, environmental, biologic)	1: Draft	AllergyIntolerance Category (HL7)	• Food • Medication • Environment • Biologic	1: Draft
Allergy or Intolerance detailed information					
Allergy or Intolerance Substance	The specific substance (e.g., Ara h 2) considered to be responsible for the allergy or intolerance event	1: Draft	SubstanceCode (SNOMED CT CA)	• 1,1,-dichloropropane • 1-naththylamine • Blood group antibody Fy5 • Volatile agent • Whole milk • White sugar • Willow pollen • Vismodegib • Vinegar • Rye	1: Draft
Allergy or Intolerance Type	Identification of the underlying physiological mechanism for the reaction risk (e.g., allergy, intolerance)	1: Draft	AllergyIntoleranceType (HL7)	• Allergy • Intolerance	1: Draft
Allergy or Intolerance Onset	The estimated or actual date when the allergy or intolerance was identified	1: Draft	n/a	n/a	n/a

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Allergy or Intolerance detailed information (continued)					
Allergy or Intolerance Exposure Route	Information about the route by which the person was exposed to the substance	1: Draft	RouteOfAdministration (SNOMED CT CA)	• Cutaneous route • Dental route • Gastrostomy route • Nasal route • Oral route • Orogastric route • Suborbital route • Surgical cavity route • Topical route • Transmucosal route	1: Draft
Allergy or Intolerance Verification Status	The confirmation status of the risk of reaction to the identified product or substance	1: Draft	AllergyIntoleranceVerificationStatus (HL7)	• Unconfirmed • Presumed • Confirmed • Refuted • Entered in error	1: Draft
Allergy or Intolerance Reaction information					
Allergy or Intolerance Reaction	Information about the person's reaction as a result of exposure to identified substances	1: Draft	Pan-Canadian Health Concern Value Set (PHCVS) (SNOMED CT CA)	• Acute photoallergic dermatitis • Allergic bronchitis • Acute allergic otitis externa • Allergic contact dermatitis • Allergic cough • Allergic fungal sinusitis • Allergic reaction to drug • Seasonal allergic rhinitis • Anaphylaxis caused by fruit • Peanut-induced anaphylaxis	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Allergy or Intolerance Reaction information (continued)					
Allergy or Intolerance Reaction Description	A text description of the reaction, including details of the manifestation	1: Draft	n/a	n/a	n/a
Allergy or Intolerance Reaction Severity	The provider's subjective assessment of the severity of the reaction, potentially considering multiple different manifestations (e.g., mild, moderate, severe)	1: Draft	AllergyIntolerance Severity (HL7)	• Mild • Moderate • Severe	1: Draft
Allergy or Intolerance Reaction Date of Onset	The date when a reaction event and associated clinical symptoms started	1: Draft	n/a	n/a	n/a
Allergy or Intolerance Reaction Date of Last Occurrence	The date of the last known occurrence of a reaction event	1: Draft	n/a	n/a	n/a

Immunizations

The following data elements pertain to information about the record of vaccine administration.

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Immunization Protocol details					
Immunization Protocol Authority*	The authority responsible for publishing the recommendations	1: Draft	n/a	n/a	n/a
Immunization Protocol Target Disease*	The immunization-preventable disease being targeted	1: Draft	VaccinePreventable DiseaseCode (SNOMED CT CA)	• Measles • Lyme disease • Typhoid fever • Influenza • Tetanus • Human papilloma virus infection • Hepatitis A • Shingles • Tuberculosis • COVID-19	1: Draft
Immunization Protocol Series*	The name of the vaccine series	1: Draft	n/a	n/a	n/a
Immunization Series Doses*	The recommended number of doses for immunity	1: Draft	n/a	n/a	n/a
Immunization Dose Number	Dose number within a series (e.g., dose 1 of 2 for Shingles immunization)	1: Draft	n/a	n/a	n/a

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Immunization product details					
Immunization name	The trade name and its associated DIN, or the generic name of the immunization product	1: Draft	VaccineAdministeredTradeNameCode (SNOMED CT CA)	• Inf Xanaflu API • Zos ZOSTAVAX II MC • MMR-Var ProQuad MC • Men-C-ACYW-135 NIMENRIX GSK • HPV-9 GARDASIL 9 MC • DTaP-Hib ACTacel SP • COVID-19 COVOVAX • Pneu-C-13 Prevnar 13 Pfiz • Rab Imovax Rabies SP • Td-IPV Td Polio Adsorbed SP	1: Draft
	The trade name and its associated DIN, or the generic name of the immunization product	1: Draft	VaccineHistoricalNameCode (SNOMED CT CA)	• Pneu-C-7 pneumococcal conjugate 7-valent unspecified • COVID-19 whole inactivated virus unspecified • Inf influenza unspecified • HPV-9 human papillomavirus 9-valent unspecified • Varicella-zoster live attenuated vaccine • HA hepatitis A regular strength unspecified • Var varicella unspecified • Pertussis acellular unspecified • Mu mumps live unspecified • Td tetanus + diphtheria adult unspecified	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Immunization product details (continued)					
Immunization name (continued)	The trade name and its associated DIN, or the generic name of the immunization product	1: Draft	AbsentOrUnknown ImmunizationUvIps (HL7)	• No information about immunizations • No known immunizations	1: Draft
	The trade name and its associated DIN, or the generic name of the immunization product	1: Draft	Alternate value sets: PassiveAdministered ImmunizingAgentCode (SNOMED CT CA)	• BAtx BAT Cang • CMVIg Cytogam STR • DAtx Diphtheria Antitoxin (DAT) IBB • Ig GamaSTAN Grif • HBIg HepaGam B STR • RabIg HyperRAB Grif • RSVAc SYn/aGIS BI • TIg HyperTET Grif • VarIg VariZIG STR	1: Draft
	The trade name and its associated DIN, or the generic name of the immunization product	1: Draft	PassiveHistorical ImmunizingAgentCode (SNOMED CT CA)	• CMVIg Cytogam CSL • DAtx Diphtheria antitoxin IOI • HBIg HepaGam B Cang • BAtx botulism antitoxin unspecified • Ig immune globulin unspecified • TIg tetanus immunoglobulin unspecified • RSVAb respiratory syncytial virus monoclonal antibody unspecified • RabIg rabies immunoglobulin unspecified • VIG vaccinia immune globulin unspecified • VarIg VariZIG Cang	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Immunization product details (continued)					
Immunization Lot Number	The lot number (identification number) of the immunization product	1: Draft	n/a	n/a	n/a
Immunization Expiration Date*	The date of expiration of the immunization product	1: Draft	n/a	n/a	n/a
Immunization Manufacturer*	The name of the immunization manufacturer	1: Draft	n/a	n/a	n/a
Immunization encounter details					
Immunization Status	The indication of the current status of the immunization event (i.e., completed, entered in error, not done)	1: Draft	ImmunizationStatus Codes (HL7)	• Completed • Entered in error • Not done	1: Draft
Immunization Reason	The reason why the immunization product was administered (e.g., routine immunization, travel)	1: Draft	ActImmunizationReason (SNOMED CT CA)	• High risk immunization • Routine immunization	1: Draft
Immunization Route of Administration	The path by which the immunization product is taken into or makes contact with the body (e.g., oral, intramuscular)	1: Draft	To be developed	n/a	0: In development
Immunization Site	The anatomical site where the immunization product was administered (e.g., right deltoid)	1: Draft	To be developed	n/a	0: In development
Immunization Dose Volume	The volume of immunization product being administered	1: Draft	n/a	n/a	n/a
Immunization Education Note	The documentation of education and/ or resources provided to the person or guardian at the time of immunization administration	1: Draft	n/a	n/a	n/a
Immunization Supporting Documents	Additional documents that provide further information about a person's immunization record (e.g., a record from a previous provider or public health unit)	1: Draft	n/a	n/a	n/a

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Immunization encounter details (continued)					
Immunization Reason Not Performed	The reason the immunization event was not performed	1: Draft	ActNoImmunization Reason (SNOMED CT CA) DataAbsent Reason (HL7)	• Anaphylaxis to previous dose or a constituent of this vaccine • Guillain-Barré syndrome developed within 0-8 weeks of previous immunization • Known immunity confirmed by lab result • Known immunity reported • Patient immunocompromised • Pregnancy • Procedure contraindicated • Procedure refused for religious reason • Vaccine refused due to general objection non-religious and/or non-philosophical • Vaccine refused due to philosophical objection • Unknown • Asked But Unknown • Not Asked • Asked But Declined • Not performed	1: Draft
Immunization Subpotent Reason	The reason why the dose is considered to be subpotent	1: Draft	To be developed	n/a	Future development

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Immunization encounter details (continued)					
Immunization Date*	The date the immunization was administered	1: Draft	n/a	n/a	n/a
Immunization Reason Not Performed Date*	The date of an immunization refusal or deferral	1: Draft	n/a	n/a	n/a
Immunization Reaction details					
Immunization Reaction	The type of immunization reaction (e.g., rash, fever, anaphylaxis)	1: Draft	n/a	n/a	n/a
Immunization Reaction Date	The date of the reaction to the immunization	1: Draft	n/a	n/a	n/a
Immunization Reaction Time	The time of the reaction to the immunization	1: Draft	n/a	n/a	n/a
Immunization Reaction Reporter*	The individual who reported a reaction to an immunization (e.g., provider, person)	1: Draft	n/a	n/a	n/a

Medication

The following data elements pertain to information about prescribed and non-prescribed medications, vitamins, herbal preparations and over-the-counter medications consumed.

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Medication Code	The code (e.g., DIN) of the medication that was administered or was to be administered	1: Draft	PrescriptionMedicinal Product (CCDD)	• Acetaminophen • acetaminophen 160 mg chewable tablet • CHILDREN'S TYLENOL CHEWABLES (acetaminophen 160 mg chewable tablet) MCNEIL CONSUMER HEALTHCARE DIVISION OF JOHNSON & JOHNSON INC • INFANTS' TYLENOL (acetaminophen 80 mg per mL oral drops) MCNEIL CONSUMER HEALTHCARE DIVISION OF JOHNSON & JOHNSON INC • acetaminophen 80 mg per mL oral drops • GRAVOL LIQUID GELS (dimenhydrinate 50 mg oral capsule) CHURCH & DWIGHT CANADA CORP • Oxycodone • SANDOZ FOLIC ACID (folic acid 5 mg oral tablet) SANDOZ CANADA INCORPORATED	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Medication Code (continued)	The code (e.g., DIN) of the medication that was administered or was to be administered	1: Draft	PrescriptionMedicinal Product (CCDD) (continued)	• sodium nitrite 300 mg per 10 mL solution for injection vial • INDAYO (ethinyl estradiol 30 mcg and levonorgestrel 150 mcg oral tablet with lactose oral tablet) MYLAN PHARMACEUTICALS ULC	1: Draft
	The code (e.g., DIN) of the medication that was administered or was to be administered	1: Draft	HealthCanadaNatural ProductNumber (HCNPN)	• Melatonin 3 Mg • Cod Liver Oil Gummy • Cyctek Shan Zhu Yu Powder • Herbal Magic -Green Coffee Plus • Echinacea • Whey Protein Isolate • Moringa • Milk Thistle • Calcium Magnesium With Vitamin D • Omega 3 Formula	1: Draft
	The code (e.g., DIN) of the medication that was administered or was to be administered	1: Draft	Alternate value set: WhoAtcUvIps (ATC)	• Epinephrine • Oxyquinoline • magnesium oxide • calcium carbonate • Antacids with sodium bicarbonate • Naloxone • Prednisone • Metformin • potassium citrate • thrombin	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Medication Brand Name	The brand name of medication that was administered or was to be administered	1: Draft	Manufactured Product (CCDD)	• DEPO-PROVERA (medroxyprogesterone acetate 150 mg per 1 mL suspension for injection syringe) PFIZER CANADA ULC • DEXIRON (iron (iron dextran) 100 mg per 2 mL solution for injection vial) AMERICAN REGENT, INC • DIAZEPAM (diazepam 5 mg oral tablet) AA PHARMA INC • GLUCOPHAGE (metformin hydrochloride 500 mg oral tablet) SANOFI-AVENTIS CANADA INC • GRAVOL TABLETS (dimenhydrinate 50 mg oral tablet) CHURCH & DWIGHT CANADA CORP • HEPARIN SODIUM INJECTION USP (heparin sodium 5000 unit per 0.5 mL solution for injection syringe) STERINOVA INC. • IBUPROFEN EXTRA STRENGTH CAPLETS (ibuprofen 400 mg oral tablet) VITA HEALTH PRODUCTS INC • INDAYO (ethinyl estradiol 30 mcg and levonorgestrel 150 mcg oral tablet with lactose oral tablet) MYLAN PHARMACEUTICALS ULC	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Medication Brand Name (continued)	The brand name of medication that was administered or was to be administered	1: Draft	Manufactured Product (CCDD) (continued)	• PROACTIV TREAT (benzoyl peroxide 2.5 % cutaneous gel) ALCHEMEE, LLC • TYLENOL LIQUID GELS (acetaminophen 325 mg oral capsule) MCNEIL CONSUMER HEALTHCARE DIVISION OF JOHNSON & JOHNSON INC	1: Draft
Medication Generic Name	The generic name of medication that was administered or was to be administered	1: Draft	Non-proprietary Therapeutic Product (CCDD)	• budesonide 100 mcg per actuation nasal powder • chloral hydrate 500 mg per 5 mL syrup • clindamycin (clindamycin phosphate) 900 mg per 50 mL solution for injection bag • diazepam 10 mg oral tablet • epinephrine 0.3 mg per 0.3 mL solution for injection syringe • glucagon 1 mg per vial powder for solution for injection with diluent solution • heparin sodium 5000 unit per 0.5 mL solution for injection syringe • insulin human 100 unit per mL solution for injection 10 mL vial • lidocaine 5 % cutaneous cream • penicillin G (penicillin G sodium) 1000000 unit per vial powder for solution for injection	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Medication Generic Name (continued)	The generic name of medication that was administered or was to be administered	1: Draft	Device Non-proprietary Therapeutic Product (CCDD)	• glucose meter • glucose strips • lancets • valved holding chamber with adult mask • valved holding chamber with child mask • valved holding chamber with infant mask • valved holding chamber with mouthpiece	1: Draft
	The generic name of medication that was administered or was to be administered	1: Draft	Alternate value set: PharmaceuticalBiologic ProductCode (SNOMED CT CA)	• Tdap ADACEL SP • Dapsone-containing product • Ethyl chloride-containing product • Nitrogen-containing product • Coagulation factor V only product • Codeine only product • Acetaminophen and codeine only product • Glucosamine only product • Nitroglycerin only product in transdermal dose form • Hydrocortisone only product	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Medication Active Ingredient	A list of substances that alone or in combination with one or more other ingredients produces the intended activity of a medicinal product	1: Draft	Therapeutic Moiety (CCDD)	• acetaminophen and caffeine • acetylsalicylic acid • amoxicillin • calcium chloride • doxycycline • epinephrine • fentanyl • glucagon • heparin • insulin human	1: Draft
	A list of substances that alone or in combination with one or more other ingredients produces the intended activity of a medicinal product	1: Draft	Alternate value set: DrugOrMedicament SubstanceCode (SNOMED CT CA)	• Coagulation factor IX • Epinephrin • Fentanyl • Heparin calcium • Human insulin • Hydrocortisone • Long acting metabolite of methadone • Magnesium carbonate hydrate • Metformin • Sodium bicarbonate	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Medication Status	A code to indicate whether the medication is in active use	1: Draft	MedicationStatusCodes (HL7)	• active • on-hold • cancelled • completed • entered-in-error • stopped • draft • unknown	1: Draft
Medication Reason	The reason why the medication is being prescribed or used	1: Draft	Pan-Canadian Health Concern Value Set (SNOMED CT CA)	• Bacterial sepsis • Pneumonia and influenza • Pain of joint of knee • Allergy to Hevea brasiliensis latex protein • Edema of foot • Abnormal urine • Gestational diabetes mellitus • Sensory integration disorder • Myxoma of heart • Mild persistent asthma	1: Draft
Medication Dose	A measured portion of medicine taken at any one time	1: Draft	n/a	n/a	n/a

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Medication Dose Unit of Measure	The unit of measure of a drug dose taken at any one time	1: Draft	PrescriptionDose QuantityUnit (UCUM, SNOMED CT CA)	• mcL • mcmol • meq • mg • ml • mmol • milliUnit(s) • mol • ng • nL	1: Draft
Medication Form	The physical form (e.g., liquid, tablet) of a dose of the medication	1: Draft	PrescriptionDrugForm (HL7, SNOMED CT CA)	• Aerosol • Chewable Tablet • Cream • Drops • Oral Solution • Rectal Cream • Sublingual tablet • Tablet • Transdermal patch • Vaginal Tablet	1: Draft
Medication Frequency	The number of occurrences within a given time period that a dose of a drug is to be administered	1: Draft	n/a	n/a	n/a

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Medication Route of Administration	The path by which the pharmaceutical product is taken into or makes contact with the body (e.g., oral, intramuscular)	1: Draft	PrescriptionRouteOf Administration (HL7)	• Sublingual • Epidural • Intravenous • Inhalation, oral • Intramuscular • Subcutaneous • Rectal • Nasogastri • Otic • Oral	1: Draft
	The path by which the pharmaceutical product is taken into or makes contact with the body (e.g., oral, intramuscular)	1: Draft	Alternate value set: RouteOfAdministration (SNOMED CT CA)	• Buccal route • Epidural route • Ileostomy route • Intravenous route • Nasal route • Oral route • Subcutaneous route • Topical route • Urethral route	1: Draft
Medication Response	The documented response after the administration of a medication	1: Draft	To be confirmed	n/a	n/a
Medication Stop Date	The last date the prescribed medication was taken	1: Draft	n/a	n/a	n/a
Medication Adherence	Information about whether the medication is consumed according to instructions	1: Draft	To be confirmed	n/a	n/a

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Medication Incident	A description of a preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient or consumer	1: Draft	n/a	n/a	n/a
Medication Summary Status	Indicates whether there is no information about a medication history or whether there is no medication in the patient's history; the reason for no medication data has to be stated	1: Draft	To be confirmed	n/a	n/a

Medical devices and equipment

The following data elements pertain to information about tools, apparatus, machines or implants used to prevent, diagnose, cure and alleviate illness or to build structures and improve body functions.

Data element name	Data element definition
Device Status	A code indicating whether the person has a medical device or not
Device Name	The name of the device as provided by the manufacturer
Device Type	The kind or type of medical device
Device Expiration Date	The date of expiry of the device
Device Manufacturer	The name of the device manufacturer
Device Serial Number	The serial number of the device as assigned by the manufacturer
Device Lot Number	The lot number of the device as assigned by the manufacturer
Device Use Date	The date when the device was implanted in the person or the external device was first in use

Assessments and screening

Social history

The following data elements pertain to information about health behaviours that influence the risk of developing chronic disease (e.g., smoking, alcohol consumption).

Data element name	Data element definition
Type of Social Behaviour	The type of social behaviour that the person is engaging in that increases the possibility of disease or injury, including risk factors such as tobacco use, alcohol use and problematic use of illicit or prescription drugs
Social Behaviour Observation Date	The date that the social behaviour was recorded
Social Behaviour Value	The measured number of times a person engages in a social behavioural activity (e.g., number of alcoholic beverages consumed per week)
Number of Sexual Partners	The number of sexual partners in the last year
Gender of Sexual Partners	The genders of the person's sexual partner(s)
Safer Sex Practices	The method(s) the person uses to prevent the transmission of sexually transmitted and blood borne infections
Type of Sexual Contact	The type of sexual contact (e.g., oral, vaginal, anal)

Family history

The following data elements pertain to information about the health conditions of a person's biological family members that influence the risk of developing chronic disease.

Data element name	Data element definition
Family Member History Status	A code indicating the presence or record of diseases and/or health conditions of an individual and their biological family members, both living and deceased, that can contribute to the development of chronic illnesses
Family Member History Date	The date when the family history was recorded or last updated
Family Member Relationship	The nature of the relationship between the person and the related individual being described in the family member history
Family Member History Condition	A code indicating the condition that the family member has or had
Family Member Condition Onset	The date or age of onset that the condition first manifested

Social determinants of health

The following data elements pertain to a detailed assessment of a person's needs related to the social determinants of health, including social and demographic information.

Data element name	Data element definition	Data element maturity	Value set (Code System)	Value set examples	Value set maturity
Sociodemographic Information and Equity Stratifiers					
Language	The person's preferred language of service	0: In development	To be confirmed	n/a	n/a
Education Level	The person's highest level of education obtained	0: In development	To be confirmed	n/a	n/a
Relationship Status	The person's legal marital, common-law or union status	0: In development	To be confirmed	n/a	n/a
Born in Canada Status	An indication of whether or not the person was born in Canada	0: In development	To be confirmed	n/a	n/a
Time since Arrival in Canada	The timeframe since arrival in Canada	0: In development	To be confirmed	n/a	n/a
Race	The person's self-identified racial background	0: In development	RacializedGroupCode (SNOMED CT CA, HL7)	• East Asian • Indigenous • Latin • American • Middle Eastern • Southeast Asian • South Asian • Black • White • Do not know • Another race category	1: Draft

Data element name	Data element definition	Data element maturity	Value set (Code System)	Value set examples	Value set maturity
Sociodemographic Information and Equity Stratifiers (continued)					
Indigenous Self-Identification	The person's self-identification as either First Nations, Métis and/or Inuk/Inuit	0: In development	IndigenousIdentityCode (SNOMED CT CA, HL7)	• First Nations • Inuk/Inuit • Métis • Do not know • Not applicable • Asked but declined	1: Draft
Ethnicity	The person's ethnic or cultural background	0: In development	To be confirmed	n/a	n/a
Religious or Spiritual Affiliations	The person's religious or spiritual affiliations	0: In development	To be confirmed	n/a	n/a
Gender, Sex and Sexual Orientation (GSSO)					
Gender Identity	An individual's personal experience of being a woman, a man, non-binary or something else. People may identify with more than one gender identity or use different gender identities in different settings.	0: In development	Gender identity (LOINC)	• Woman / Girl • Man / Boy • Non-binary	0: In development
	An individual's personal experience of being a woman, a man, non-binary or something else. People may identify with more than one gender identity or use different gender identities in different settings.	0: In development	NullFlavor (HL7)	• Prefer not to answer • Unknown • Unable to ask • Unsure	0: In development

Data element name	Data element definition	Data element maturity	Value set (Code System)	Value set examples	Value set maturity
Gender, Sex and Sexual Orientation (GSSO) (continued)					
Sex Assigned at Birth*	The assignment of the sex of a person at birth based on biological characteristics including chromosomes, anatomy and hormones	0: In development	Sex Assigned at Birth (LOINC)	• Male • Female • Intersex / Indeterminate	0: In development
	The assignment of the sex of a person at birth based on biological characteristics including chromosomes, anatomy and hormones	0: In development	NullFlavor (HL7)	• Unknown • Not asked • Asked but unknown	0: In development
Administrative Gender	Represents the gender identity that a person wishes to have recorded on legal documents or the gender identity that a person identifies with for the purposes of interactions with official agencies.	0: In development	AdministrativeGender (HL7)	• Woman / Girl • Man / Boy • Non-binary	0: In development
	Represents the gender identity that a person wishes to have recorded on legal documents or the gender identity that a person identifies with for the purposes of interactions with official agencies.	0: In development	NullFlavor (HL7)	• Unknown	0: In development
Sex Parameter for Clinical Use	A parameter that provides guidance on how a recipient should apply settings or reference ranges that are derived from observable information, such as an organ inventory, recent hormone lab tests, genetic testing, menstrual status or obstetric history. This property is intended for use in clinical decision-making and indicates that treatment or diagnostic tests should consider best practices associated with the relevant reference population.	0 – In development	Sex Parameter for Clinical Use (HL7)	• Apply female-typical setting or reference range • Apply male-typical setting or reference range • Apply specified setting or reference range • Unknown	0: In development

Data element name	Data element definition	Data element maturity	Value set (Code System)	Value set examples	Value set maturity
Gender, Sex and Sexual Orientation (GSSO) (continued)					
Sexual Orientation	How a person describes their sexuality	0: In development	Action Plan to Modernize GSSO Information Practices in Canadian EHRs (SNOMED CT)	• Heterosexual • Lesbian • Gay • Bisexual • Asexual • Pansexual • Unsure	0: In development
	How a person describes their sexuality	0: In development	NullFlavor (HL7)	• Choose not to disclose • Something else • Unknown	0: In development
Recorded Sex or Gender	Refers to the documented sex or gender of an individual used for clinical, official or legal purposes where only one data field for sex and gender is available, and where it is the value found in the local system and/or historical documentation	0: In development	Recorded Sex or Gender (LOINC)	• Female / Woman • Male / Man • Non-binary / Intersex	0: In development
	Refers to the documented sex or gender of an individual used for clinical, official or legal purposes where only one data field for sex and gender is available, and where it is the value found in the local system and/or historical documentation	0: In development	NullFlavor (HL7)	• Unknown	0: In development

Data element name	Data element definition	Data element maturity	Value set (Code System)	Value set examples	Value set maturity
Employment and Finance Information					
Employment Status	The person's current job status	0: In development	To be confirmed	n/a	n/a
Household Income	The sum of the total incomes of all members of a household	0: In development	To be confirmed	n/a	n/a
Financial Stability	Information about a person's ability to pay for their household's basic needs, including food, water, housing and clothing	0: In development	To be confirmed	n/a	n/a
Housing Information					
Housing Stability	The person's current housing situation, including whether they are housed or unhoused	0: In development	To be confirmed	n/a	n/a
Housing Condition	The physical infrastructure of the residence, including overcrowding, a leaking roof, no bath/shower and no flushing toilet, or a dwelling considered too dark	0: In development	To be confirmed	n/a	n/a
Household Composition	Information about who the person lives with, such as parents, children, spouse or roommates	0: In development	To be confirmed	n/a	n/a
Accessibility Information					
Access to Food	The person's ability or inability to access food over the past 12 months	0: In development	To be confirmed	n/a	n/a
Access to Medication	The person's ability to access or afford medicine	0: In development	To be confirmed	n/a	n/a
Access to Internet	The person's ability to access or afford internet over the past 12 months	0: In development	To be confirmed	n/a	n/a
Access to a Phone	The person's ability to access or afford a telephone over the past 12 months	0: In development	To be confirmed	n/a	n/a

Data element name	Data element definition	Data element maturity	Value set (Code System)	Value set examples	Value set maturity
Accessibility Information (continued)					
Access to Transportation	The person's access to public or private transportation over the past 12 months	0: In development	To be confirmed	n/a	n/a
Access to Utilities	The person's ability to access and afford utilities, such as heat, electricity, water, sewage and waste services over the past 12 months	0: In development	To be confirmed	n/a	n/a
Access to Child Care	The person's ability to access or afford child care in the past year over the past 12 months	0: In development	To be confirmed	n/a	n/a
Social Needs					
Social Supports	The actual or perceived availability of family, friends, neighbours and/or community that a person can confide in or rely on to feel more socially connected and secure	0: In development	To be confirmed	n/a	n/a
Incarceration History	The person's experiences with the judicial system such as spending time in a jail, prison, detention centre or juvenile correctional facility	0: In development	To be confirmed	n/a	n/a

Vital signs

The following data elements pertain to physiologic measurements of a person that indicate the status of the body's life-sustaining functions.

Data element name	Data element definition
Date of Observation	The date when the vital sign was recorded
Weight	The measured weight of the person
Weight Unit of Measure	The unit of measure used to capture the person's weight
Height	The measured height of the person
Height Unit of Measure	The unit of measure used to capture the person's height
Body Mass Index (BMI)	An indicator of body density as determined by the relationship of body weight to body height
Waist Circumference	The measured waist circumference of the person
Waist Circumference Unit of Measure	The unit of measure used to capture the person's waist circumference
Body Temperature	The measurement of body temperature
Temperature Unit of Measure	The unit of measure used to capture the person's temperature
Systolic Blood Pressure	The measured systolic blood pressure value (in mmHg)
Diastolic Blood Pressure	The measured diastolic blood pressure value (in mmHg)
Blood Pressure Body Location	The anatomical location on the body where the blood pressure was taken
Blood Pressure Body Position	The position the body was in when the person's blood pressure was taken
Heart Rate	The measurement of the person's heart rate in beats per minute
Heart Rhythm	The rhythm of the heart (e.g., regular, skipped beats, irregular)
Respiratory Rate	The respiration rate measured in breaths per minute
Pulse Oximetry	The measurement of oxygen saturation levels

Functional status and disability

The following data elements pertain to information about a person's abilities to perform activities of daily living and maintain health.

Data element name	Data element definition
Functional Assessment Screening Tool	The type of screening or assessment tool used to screen for a certain condition
Date of Assessment	The date the screening or assessment tool was completed
Functional Assessment Result	The outcome or result of the completed screening or assessment
Mobility	The person's ability to roll over, transfer and walk short distances independently
Balance	The person's ability to control their body positions while standing or moving
Hearing	The person's hearing status or information about significant changes in level of hearing
Vision	The person's vision status or information about significant changes in level of seeing
Self-Care	Information about the person's ability to perform self-care activities such as bathing, dressing, grooming and toileting
Feeding	The person's ability to feed themselves.
Cognitive Abilities	The person's ability and actual performance in remembering, concentrating and making everyday decisions
Communication	The person's ability to communicate
Leisure Activities	The person's ability to participate in leisure activities
Activities of Daily Living	The person's ability to complete day-to-day activities independently
Instrumental Activities of Daily Living	The person's need for assistance with the following instrumental activities of daily living: meal preparation, medication administration, telephone use, housekeeping, shopping, managing finances and transportation use (drive car/use taxi/bus)
Environmental Factors	The environmental conditions within which the person is living, including any home accommodations that help the person function independently at home
Terminal Illness Status	Information about the person's advanced disease state from which there is no expectation of recovery
Onset Date	The date of first clinical symptoms or signs of a particular condition
Accommodation Notes	Information or details regarding modifications, tools, technologies and/or other supports needed to address barriers to care for a person living with a disability(ies) in order to improve their care and quality of life
Disability Name	A code identifying the disability of the person

Obstetrics and gynecology

The following data elements pertain to information about a person's obstetrical status and history, including their gynecological health.

Data element name	Data element definition
Gynecological Exam	An examination of the reproductive organs, including the uterus, cervix, ovaries and vagina, as well as addressing various aspects of a person's reproductive health
Age of First Menstrual Period	The approximate age of the person's first menstrual period
Menstrual Period Start Date	The start date of a person's most recent menstrual period
Menstrual Period End Date	The end date of a person's most recent menstrual period
Menstrual Period Length	The average duration of the person's menstrual cycle
Menstrual Period Flow	Describes the amount of menstrual blood a person discharges on their heaviest day of their cycle
Menstrual Cycle Length	The time from the first day of a person's period to the day before their next period
Pregnancy Confirmation Status	The state or condition of being pregnant or intent to become pregnant (e.g., pregnant, not pregnant, intent to become pregnant, unknown)
Pregnancy Status Date	The date when the pregnancy status was confirmed
Pregnancy Intent	Information about whether the pregnancy is planned or unplanned
Estimated Delivery Date	The approximate date of delivery
Pregnancy Expected Outcome Method	The expected pregnancy outcome method (e.g., planned pregnancy termination, vaginal birth, Caesarean section)
Pregnancy Outcome Date	The date of the outcome of the pregnancy
Pregnancy Specialist Contact	Information about an optional health care provider with obstetrical expertise who can provide resources and/or treatment
Number of Unexpected Pregnancy Loss(es)	The number of unexpected pregnancy loss event(s) the person has experienced
Number of Previous Planned Pregnancy Termination(s)	The number of planned pregnancy termination(s) the person has experienced
Number of Total Pregnancies	The total number of times a person has been pregnant, present or past, regardless of the period of gestation, including live births, unplanned pregnancy loss(es), planned pregnancy termination, ectopic, etc.
Number of Deliveries	The number of times the person has delivered greater than 20 weeks gestation
Number of Living Children	The number of living children the person has

Diagnostic information

Clinical tests

The following data elements pertain to information about non-imaging and non-laboratory tests performed.

Data element name	Data element definition
Clinical Test	The name of the non-imaging or non-laboratory test performed on the person
Clinical Test Result	The results or findings of the clinical test
Clinical Test Result Unit of Measure	The unit of measurement of the clinical test result
Clinical Test Date	The date the clinical test was performed
Clinical Test Time	The time the clinical test was performed

Medical imaging

The following data elements pertain to information about visual imaging tests used to diagnose, monitor or treat medical conditions.

Data element name	Data element definition
Medical Imaging Test Modality	The type of imaging service requested (e.g., X-ray, CT scan, ultrasound)
Medical Imaging Test	The medical imaging test code and test description
Medical Imaging Body Site	The name of the anatomical structure(s) examined
Medical Imaging Test Ordered Date	The date the medical imaging test was ordered by the provider
Medical Imaging Test Performed Date	The date the medical imaging test was performed
Medical Imaging Test Performer First Name	The first name of the provider responsible for performing the imaging service
Medical Imaging Test Performer Last Name	The last name of the provider responsible for performing the imaging service
Medical Imaging Test Performer ID	The numerical identifier of the provider responsible for performing the imaging service
Medical Imaging Study Status	The status of the imaging study

Data element name	Data element definition
Medical Imaging Report Status	The status of the imaging report
Medical Imaging Report Result	The result of the imaging test
Medical Imaging Report Recommendation	A text description of the suggested follow-up/next steps (e.g., repeat in 3 months, MRI recommended for further detail)
Medical Imaging Report Author First Name	The first name of the provider who authored the imaging report
Medical Imaging Report Author Last Name	The last name of the provider who authored the imaging report
Medical Imaging Report Author ID	The numerical identifier of the provider who authored the imaging report
Medical Imaging Location Name	The name of the location or site where the imaging test took place
Medical Imaging Organization Identifier	The facility code where the imaging test took place
Medical Imaging Location Postal Code	The postal code where the imaging test took place

Laboratory

The following data elements pertain to the analysis of clinical specimens to obtain information about the health of a person.

Data element name	Data element definition
Laboratory Test	The name of the laboratory test performed
Laboratory Test Ordered Date	The date the laboratory test was ordered
Laboratory Request Type	The type of laboratory service being requested (e.g., chemistry, serology, hematology, microbiology, histology, anatomic pathology, cytology, virology)
Laboratory Specimen Type	The substance being sampled or tested (e.g., nasopharyngeal swab, whole blood, serum, urine, wound swab)
Laboratory Specimen Source Site	The body location from where the specimen was obtained (e.g., right internal jugular, left arm, right eye)
Laboratory Specimen Collection Date	The date the specimen was collected
Laboratory Test Performed Date	The date the laboratory test was performed
Laboratory Test Observer First Name	The first name of the author of the observation (e.g., the person who interpreted the results)
Laboratory Test Observer Last Name	The last name of the author of the observation (e.g., the person who interpreted the results)
Laboratory Test Observer ID	The registration number, or suitable alternative, that uniquely identifies the observer
Laboratory Result Status	The state or condition of a laboratory test
Laboratory Test Result Value	The result of the laboratory test
Laboratory Test Result Unit of Measure	The unit of measurement to report laboratory test results so that they can be compared
Laboratory Test Reference Range	The upper and lower limit of test values expected for a designated population of individuals
Laboratory Specimen Status	The codes providing the status/availability of a specimen
Laboratory Result Trigger	A code indicating a laboratory result that triggers the need for additional tests (e.g., reflex, repeat, re-run)

Care and services

Health concerns

The following data elements pertain to the identification of the nature, cause or manifestation of a person's condition, situation or problem.

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Health Concern overall status					
Health Concern(s)	A broad classification of active and historical health-related conditions or issues requiring attention, typically encompassing various health complaints or challenges	1: Draft	Pan-Canadian Health Concern Value Set (PHCVS) (SNOMED CT CA) AbsentOrUnknownProblemsUvIps (HL7) Alternate value sets: ICD-9CM ICD-10-CA	• Bacterial sepsis • Pneumonia and influenza • Pain of joint of knee • Allergy to Hevea brasiliensis latex protein • Edema of foot • Abnormal urine • Gestational diabetes mellitus • Sensory integration disorder • Myxoma of heart • Mild persistent asthma • No information about current problems • No known problems	1: Draft
Health Concern Category	Indicates whether the health concern is a problem list item or an encounter diagnosis	1: Draft	ConditionCategoryCodes (HL7)	• Problem List Item • Encounter Diagnosis	1: Draft

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Health Concern overall status (continued)					
Health Concern Body Site	Information about the location on the body of the health concern	1: Draft	AnatomicalOrAcquiredBodyStructureCode (SNOMED CT CA)	• Abdominal aorta structure • Abnormal cell • Acquired body structure • Entire salpingopharyngeal fold • Structure of intraabdominal region • Lumbosacral region structure • Structure of permanent maxillary left third molar tooth • Sagittal sinus • Tendon structure • Terminal aorta structure	1: Draft
Health Concern Severity	The subjective assessment of the severity of the condition	1: Draft	SeverityCode (SNOMED CT CA)	• Fatal • Life-threatening severity • Mild • Mild to moderate • Moderate severity • Moderate to severe • Severe • Severe to life-threatening severity	1: Draft
Health Concern Date of Onset	Information about the estimated or actual date of onset of the health concern	1: Draft	n/a	n/a	n/a
Health Concern Date of Resolution	The date the health concern or condition subsided or resolved	1: Draft	n/a	n/a	n/a
Health Concern Evidence Code*	A code indicating a manifestation or a symptom that led to the reporting of this health concern	1: Draft	To be confirmed	To be confirmed	Future development

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Health Concern overall status					
Health Concern Clinical Status	The current status of the health concern or the condition (e.g., active, resolved)	1: Draft	ConditionClinical StatusCodes (HL7)	• Active • Recurrence • Relapse • Inactive • Remission • Resolved • Unknown	1: Draft
Health Concern Date of Diagnosis	The date of diagnosis of the health concern	n/a	n/a	n/a	n/a
Health Concern Verification Status	Information about the status of the condition (e.g., confirmed, differential)	1: Draft	ConditionVerification Status (HL7)	• Unconfirmed • Provisional • Differential • Confirmed • Refuted • Entered in error	1: Draft
Health Concern Stage Type	The type of stages for a condition or disease (e.g., pathological or clinical staging)	1: Draft	To be developed	n/a	Future development
Health Concern Stage Summary	A summary of the stage of the condition or disease (e.g., stage 3)	1: Draft	To be developed	n/a	Future development
Health Concern Stage Assessment	Reference to a formal record of evidence on which the staging assessment is based	1: Draft	n/a	n/a	n/a
Health Concern Supporting Documents	Other documents that provide context and/or supporting evidence related to a health concern or diagnosis (e.g., scan results)	1: Draft	n/a	n/a	n/a

Data element name	Data element definition	Data element maturity	Value set (code system)	Value set examples	Value set maturity
Health Concern Specialist information					
Health Concern Specialist First Name	The first name of an optional health care provider who may have expertise related to a particular health concern	1: Draft	n/a	n/a	n/a
Health Concern Specialist Last Name	The last name of an optional care provider who may have expertise related to a particular health concern	1: Draft	n/a	n/a	n/a
Health Concern Specialist ID*	The numerical identifier of an optional care provider who may have expertise related to a particular health concern	1: Draft	n/a	n/a	n/a

Procedures

The following data elements pertain to information about interventions performed for or on a person as part of the provision of care.

Data element name	Data element definition
Procedure Performed	The code and name of the procedure performed on the person
Procedure Status	Information about the state of a procedure (e.g., in progress, completed)
Procedure Date	The date the procedure was performed
Procedure Body Site	The anatomical location of the procedure
Procedure Reason	The justification of why the procedure was performed
Procedure Outcome	Information about whether the procedure resolved the issue it was trying to address
Procedure Performer First Name	The first name of the provider performing the procedure
Procedure Performer Last Name	The last name of the provider performing the procedure
Procedure Performer ID	The numerical identifier of the provider performing the procedure
Procedure Refusal Reason	The reason the person refused a procedure
Procedure Complication	A textual description of any complications that occurred during the procedure or in the immediate post-performance period
Procedure Notes	A textual description of the procedure

Medication request

The following data elements pertain to information about a prescribed medication, including the instructions for administration of the medicine to a person.

Data element name	Data element definition
Medication Brand Name	The brand name of the medication that is being prescribed
Medication Generic Name	The generic name of medication that is being prescribed
Medication Prescribed Dose	The measured portion of a drug to be taken at any one time that pertains to the drug prescribed
Medication Administration Dose	The amount of the medication given at 1 administration event
Medication Administration Dose Units	The unit of measure of a drug dose taken at any one time
Medication Strength	The potency of the drug/chemical, usually measured in metric weight and described as the strength of the product's active (medicinal) ingredient
Medication Strength Unit of Measure	The unit of measure for the medication prescribed strength number
Medication Frequency	The number of occurrences within a given time period that a dose of a drug is to be administered
Medication Amount	The specific amount of the drug in the packaged product, when specifying a product that has the same strength
Medication Route of Administration	The path by which the pharmaceutical product is taken into or makes contact with the body (e.g., oral, intramuscular)
Medication Period of Use	The relevant duration for the medication
Medication Form Description	The medication form text description
Medication Refills	The number of refills or repeats authorized
Medication Request Date	The date that the medication request was made
Medication Request Status	A code specifying the current state of the order (e.g., active, completed)
Medication Request Priority	An Indication of how quickly the medication request should be addressed with respect to other requests
Medication Administration Instruction	The administration instructions for the medication
Medication Administration Instruction Time	Instructions about when medication should be administered
Medication Reason Preferred Product Not Prescribed	The reason why a preferred medication was not prescribed
Medication Prescriber First Name	The first name of the provider prescribing the medication
Medication Prescriber Last Name	The last name of the provider prescribing the medication

Data element name	Data element definition
Medication Prescriber ID	The jurisdictional registration number of the provider prescribing the medication
Preferred Pharmacy Name	The name of the preferred pharmacy
Preferred Pharmacy Identifier	The location code of the preferred pharmacy
Preferred Pharmacy Postal Code	The postal code of the preferred pharmacy
Preferred Pharmacy Phone Number	The telephone phone number of the preferred pharmacy
Preferred Pharmacy Fax Number	The fax number of the preferred pharmacy

Integrated care plan

The following data elements pertain to the plan to meet the health, wellness, care and service needs and objectives of a person.

Data element name	Data element definition
Reviewer First Name	The first name of the individual who has the responsibility for reviewing, maintaining or updating this information
Reviewer Last Name	The last name of the individual who has the responsibility for reviewing, maintaining or updating this information
Entry Date	The date that the care plan entry was made
Identified Needs	Information about the health needs, problems or concerns that the integrated care plan aims to address
Person Strengths	The person's strengths and assets relating to their goals and hopes about their health and well-being
Person Goals and Wishes	A description of a person's desired outcomes of their care
Social Determinant of Health Goals	A description of the person's goals and wishes regarding social determinants of health-related concerns, conditions or diagnoses (e.g., food security)
Person Treatment Preferences	A description of a person's goals, preferences and priorities for care and treatment in case that person is unable to make medical decisions because of a serious illness or injury (e.g., cardiopulmonary resuscitation)
Safety Considerations	Information about specific safety measures that are required to ensure the safety of the person (e.g., home safety features, maintenance of equipment and furnishings)
Other Required Services	Information about the specific services and programs that are required to address physical, psychosocial and/or cultural needs
Person Responsibilities	The person's responsibilities regarding their care and health (e.g., taking medications, informing the team of changes in their health status)

Data element name	Data element definition
Team Responsibilities	The team members' responsibilities, including those of caregivers, in the delivery of care or services
Caregiver Involvement	An indication of whether a member of the person's family or social circle is currently involved in the person's care plan
Timeframe for Goals	The time frame required to achieve the goals and wishes identified within the care plan, as determined by the person
Agreement With Care Plan	Indicates whether the plan was discussed with and agreed to by the person or legitimate representative
Treatment Recommendation	A treatment recommendation that aligns with the person's goals and wishes
Given Recommendation Date	The date of each recommendation included in the care plan; however, it may be that the plan is given on a single date with multiple recommendations in the same plan
Other Care Planning Documents	References to other care-planning documents, including the type, location and date
Integrated Care Plan Summary	Indicates which parts of the medical record are used to inform the integrated care plan (e.g., immunizations, procedures, encounter)
Next Planned Review Date	The date when the care plan will be reviewed next
Care Plan Evaluation	An assessment of whether the person is achieving their goals and wishes related to their care plan

Care team members

The following data elements pertain to information about the person(s) who care(s) for a person.

Data element name	Data element definition
Provider First Name	The first name of the provider
Provider Last Name	The last name of the provider
Provider Phone Number	The provider's phone number
Provider Email	The provider's email address
Provider Type	A code used to categorize the type of person providing care, including registered service provider (e.g., physician, registered nurses) and non-registered providers (e.g., family caregiver, peer support worker, volunteer)
Provider Role	The role of the provider in relation to their participation in a specific health care event
Provider Expertise	The expertise of the provider

Data element name	Data element definition
Provider Registration Status	The class of licence/registration issued to a provider by a regulatory body or other professional association at the time of registration or renewal
Provider Registration Date	The month/year in which the provider registered (or renewed) with a Canadian provincial/territorial health care provider regulatory body or professional association
Provider National Unique Identifier	The registration number, or suitable alternative, that uniquely identifies a provider who may register in more than one province or territory
Provider Provincial/Territorial Registration Number	The registration number, or suitable alternative, that uniquely identifies a provider in a particular jurisdiction; assigned by the submitting jurisdiction for administrative purposes
Provider Registration Province/Territory	The Canadian province or territory of registration, based on the jurisdiction or organization that submits provider data
Provider Concurrent Registration Province/Territory	Any other Canadian province or territory that a provider is licensed in (for the same profession) at the time of registration or renewal
Provider Concurrent Registration Country	Any other country that a provider is licensed in (for the same profession) at the time of registration or renewal
Provider Billing Province/Territory	The jurisdiction issuing the provider's billing number
Provider Province/Territory Billing Number	The unique number assigned to a provider by a jurisdiction that allows the calculation of and direct payment for claims submitted under the number

Care coordination and referrals

The following data elements pertain to information about the coordination of care and engagement with various service providers through referral and consultation.

Data element name	Data element definition
Service Request Organization	The name of the organization where the service request is being sent
Service Request Date	The date the referral and/or consult request was created by the provider
Service Request Reason	An explanation or justification for why this service is being requested
Service Request Type	Documents whether the referral and/or consult is internal or external
Service Request ID	A code that classifies the type of service being requested (e.g., hematology, medical imaging)

Data element name	Data element definition
Service Request Urgency	Indicates how quickly the service request should be addressed with respect to other requests (e.g., routine, urgent, ASAP, STAT)
Service Requestor First Name	The first name of the provider who initiated the request
Service Requestor Last Name	The last name of the provider who initiated the request
Service Requestor ID	The Canadian provincial or territorial registration number of the sending provider
Provider Receiving the Service Request First Name	The first name of the provider receiving the referral and/or consult
Provider Receiving the Service Request Last Name	The last name of the provider receiving the referral and/or consult
Provider Receiving Service Request ID	The Canadian provincial or territorial registration number of the receiving provider
Service Request Status	Information about the status of the referral and/or consult (e.g., accepted, rejected, redirected), including the reason why the referral was rejected
Service Request Accepted Date	The date the referral and/or consult was accepted by the service provider
Service Request Appointment Date Provided	The date the person was provided with an appointment
Service Request Appointment Date	The actual date of the encounter with the referred provider or service
Appointment Status	The status of an appointment (e.g., free, busy)
Service Request Completion Date	The date the referral and/or consult is considered complete (i.e., from a transition in care perspective)
Service Request Summary Notes	Documentation sent to a consultant by a primary health care provider that summarizes the person's clinical history and reason for consult
Service Request Outcome	The treatment plan that was determined as part of the consultation (e.g., surgical, medical, return for follow up)
Service Request Date Occurred	The date that the provider consulted with another provider or service
Service Request Supporting Document	Additional documents such as reports or images that accompany the service request and provide additional information

Organization information

The following data elements pertain to information about the facility that is providing health care services.

Data element name	Data element definition
Organization Identifier	The unique numeric or alphanumeric entry identifier of the practice (organization) where the person received care
Organization Name	The name of the practice (organization) where the person received care
Organization Type	The type of organization (e.g., location, service) where the person received care
Organization Role	The function, responsibility or competency that an organization may play, perform or be assigned
Organization Relationship	The association between 2 or more organizations
Organization Street Address	The address of the practice (organization) where the person received care
Organization City	The city of the organization where the person received care
Organization Province	The province of the organization where the person received care
Organization Postal Code	The postal code of the organization where the person received care
Organization Phone Number	The contact phone number of the organization where the person received care
Organization Email	The contact email of the organization where the person received care

Directives and consent

Advanced directives

The following data elements pertain to information about treatment preferences, consent or refusal of treatment, and contact information of authorized decision-makers.

Data element name	Data element definition
Advanced Directives	A list of provisions for health care decisions in the event that, in the future, a person is unable to make those decisions
Advanced Directive Category	A list of directives related to decisions prior to, or after, death
Advanced Directive Description	A textual description of the advanced directive
Advanced Directive Name	The name of the advanced directive
Person Authorizing Advanced Directive First Name	The first name of the person who is authorizing the advanced directive
Person Authorizing Advanced Directive Last Name	The last name of the person who is authorizing the advanced directive
Advanced Directive Reference Document	A reference to a legal document (e.g., living will) or an external textual description
Advanced Directives Role	The role of the person who is authorizing the advanced directive (e.g., patient, substitute decision-maker)

Health records management

Provenance

The following data elements pertain to the source and context of the information supplied. Data to afford trust in the communication and the data being interchanged.

Data element name	Data element definition
Asserter	The source of information, usually the person
Authoring Health Care Provider First Name	The first name of the health care provider who is entering information in the medical record, which provides both a means of verifying the origin and a measure of confidence/trust about the information being entered
Authoring Health Care Provider Last Name	The last name of health care provider who is entering information in the medical record, which provides both a means of verifying the origin and a measure of confidence/trust about the information being entered
Authoring Health Care Provider ID	The numerical identifier of the health care provider who is entering information into the medical record, which provides both a means of verifying the origin and a measure of confidence/trust about the information being entered
Date of Document Creation	The date that the medical record or medical entry was created
Language of Document	The language used in the medical record
Legal Authenticator First Name	The first name of the responsible author and/or the health care provider who is attesting or signing the person's medical record or parts of it that may be required, dependent on jurisdiction
Legal Authenticator Last Name	The last name of the responsible author and/or the health care provider who is attesting or signing the person's medical record or parts of it that may be required, dependent on jurisdiction

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help@cihi.ca

CIHI Ottawa
495 Richmond Road
Suite 600
Ottawa, Ont.
K2A 4H6
613-241-7860

CIHI Toronto
4110 Yonge Street
Suite 300
Toronto, Ont.
M2P 2B7
416-481-2002

CIHI Victoria
880 Douglas Street
Suite 600
Victoria, B.C.
V8W 2B7
250-220-4100

CIHI Montréal
1010 Sherbrooke Street West
Suite 511
Montréal, Que.
H3A 2R7
514-842-2226

cihi.ca

47822-0324