MEDINFO23

8 – 12 JULY 2023 | SYDNEY, AUSTRALIA

Panel: Standardized Representations of Systemic Anticancer Therapy Regimens

An Enabler of Real-World Evidence Synthesis

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Disclosures

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Consulting: Westat

Ownership: HemOnc.org LLC

Editorial: JCO CCI

Learning Objectives

Understand the complexities of systemic anticancer therapy (SACT) and name several approaches to standardly represent SACT.

Appreciate the challenges of coordinated representation of complex temporal events and discuss several complementary approaches to temporal resolution.

Learn about how patterns of SACT in real-world practice change over time, and how these changes relate to the understanding of the overall landscape of cancer treatment and prognosis.

Targeted therapy [edit | edit source]

- Rituximab (Rituxan) 375 mg/m^2 IV once on day 1, **given first**
  - Patients with peripheral blood involvement could have the cycle 1 dose of rituximab delayed or omitted by clinician discretion

Chemotherapy, Part A [edit | edit source]

- Cyclophosphamide (Cytoxan) as follows:
  - Cycles 1, 3, 5, 7: 300 mg/m^2 IV over 3 hours every 12 hours on days 2 to 4, **given second** (total dose per cycle: 1800 mg/m^2)
- Vincristine (Oncovin) as follows:
  - Cycles 1, 3, 5, 7: 1.4 mg/m^2 (maximum dose of 2 mg) IV once per day on days 5 & 12, **given 12 hours after the last dose of cyclophosphamide on day 5**
- Doxorubicin (Adriamycin) as follows:
  - Cycles 1, 3, 5, 7: 16.6 to 16.7 mg/m^2/day IV continuous infusion over 72 hours, started on day 5 (total dose per cycle: 49.8 to 50.1 mg/m^2)

Glucocorticoid therapy, Part A [edit | edit source]

- Dexamethasone (Decadron) as follows:
  - Cycles 1, 3, 5, 7: 40 mg IV or PO once per day on days 2 to 5, 12 to 15

Supportive therapy, Part A [edit | edit source]

- Mesna (Mesnex) as follows:
  - Cycles 1, 3, 5, 7: 600 mg/m^2/day IV continuous infusion over 76 hours, started on day 2, 1 hour prior to cyclophosphamide and completed 12 hours after the last dose of cyclophosphamide
    - "Over 76 hours" is not exactly specified in Romaguera et al. 2005; Wang et al. 2008. It is based on the assumption that "completed 12 hours after the last dose of cyclophosphamide" means that it would finish 12 hours after the last dose of cyclophosphamide completes.

Chemotherapy, Part B [edit | edit source]

- Methotrexate (MTX) as follows, by the following laboratory-based criteria:
  - Cycles 2, 4, 6, 8, patients with creatinine up to 1.5 mg/dL: 200 mg/m^2 IV over 2 hours once on day 2, then 800 mg/m^2 IV over 22 hours (total dose per cycle: 1000 mg/m^2)
  - Cycles 2, 4, 6, 8, patients with creatinine greater than 1.5 mg/dL: 100 mg/m^2 IV over 2 hours once on day 2, then 400 mg/m^2 IV over 22 hours (total dose per cycle: 500 mg/m^2)
    - Urine alkalinized to pH of 6.8 or more prior to the start of methotrexate and kept within that range until methotrexate is cleared
- Cytarabine (Ara-C) as follows, by the following age- and laboratory-based criteria:
  - Cycles 2, 4, 6, 8, patients up to age 60 and with creatinine up to 1.5 mg/dL: 3000 mg/m^2 IV over 2 hours every 12 hours on days 3 & 4 (total dose per cycle: 12,000 mg/m^2)
  - Cycles 2, 4, 6, 8, patients older than 60 or with creatinine greater than 1.5 mg/dL: 1000 mg/m^2 IV over 2 hours every 12 hours on days 3 & 4 (total dose per cycle: 4000 mg/m^2)

Supportive therapy, Part B [edit | edit source]

- Folinic acid (Leucovorin) as follows:
  - Cycles 2, 4, 6, 8: 50 mg PO once on day 3, 12 hours after methotrexate is complete, then 15 mg PO every 6 hours for 8 doses. If serum methotrexate level at 24 hours is greater than 1000 nmol/L or at 48 hours is greater than 100 nmol/L, dose is increased to 100 mg IV Q3H.
- Prednisolone as follows:
  - Cycles 2, 4, 6, 8: 1% ophthalmic solution 2 drops in each eye four times per day on days 3 to 9 was started on the day of the start of cytarabine infusion and was continued for 7 days to prevent chemical conjunctivitis.

Supportive therapy, all cycles [edit | edit source]

All growth factors and antibiotics given for 10 days, starting 24 to 36 hours after doxorubicin infusion is complete in A cycles and not specified in B cycles

- Filgrastim (Neupogen) 5 mcg/kg SC once per day
- Valacyclovir (Valtrex) 500 mg PO once per day
- Fluconazole (Diflucan) 100 mg PO once per day
- ONE of the following fluoroquinolones:
  - Levofloxacin (Levaquin) 500 mg PO once per day
  - Ciprofloxacin (Cipro) 500 mg PO twice per day
- Erythropoietin was permitted throughout therapy

21-day cycle for 8 cycles

Subsequent treatment [edit | edit source]

- Merli et al. 2012, responders: autologous HSCT (regimen not specified)

R-HyperCVAD/R-MA

State of the art, 1965-2011

MBC

Use:	Head and neck cancer	Cycle: 21 days		
Regimen:	Methotrexate	40 mg/m^2	IV	Days 1–15
	Bleomycin	10 units/m^2	IM	Days 1, 8, 15
	Cisplatin	50 mg/^{2}	IV	Day 4

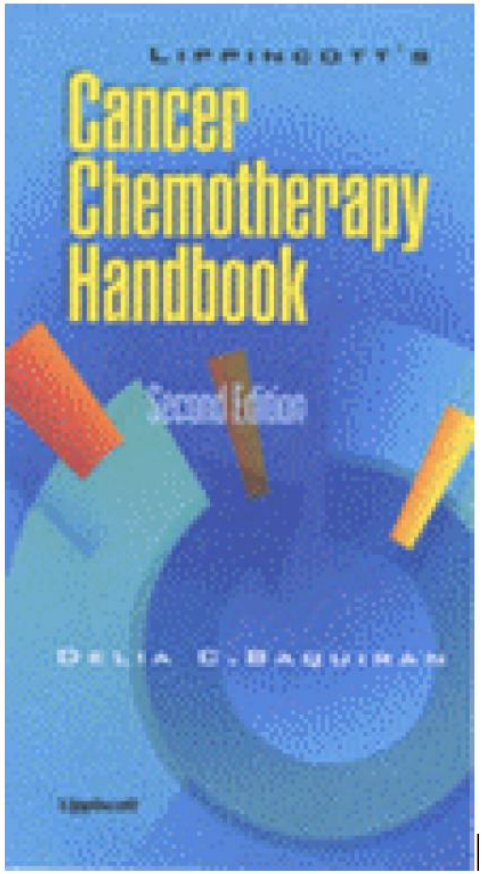
MC

Use:	Acute myelocytic leukemia (AML; adult induction)	Cycle: 28 days		
Regimen:	Mitoxantrone	12 mg/m^2	IV	Days 1–3
	Cytarabine	100–200 mg/m^2/day	CI	Days 1–7

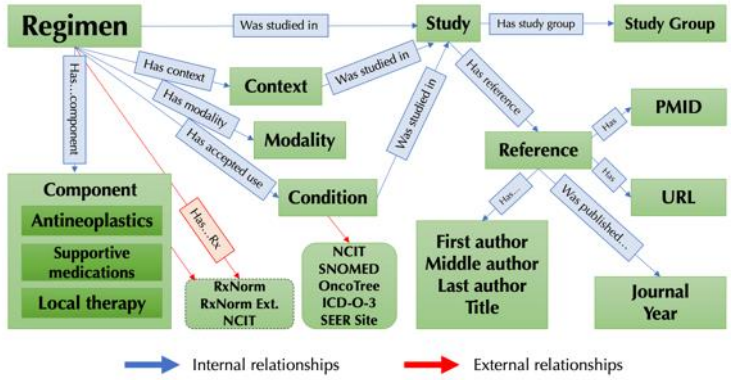
MF

Use:	Breast cancer	Cycle: 28 days		
Regimen:	Methotrexate	100 mg/m^2	IV	Days 1–8
	Fluorouracil	600 mg/m^2	IV	Days 1, 8, given 1 h after MTX
	Leucovorin	10 mg/m^2	IV or PO	Every 6 h for 6 doses, 24 h after MTX

MICE (ICE)



AA (ara-C, Adriamycin); AAF (2-acetylaminofluorene); AAFC (fiurocitabine); ABC (Adriamycin, BCNU, cyclophosphamide); ABCD (Adriamycm, bleomycin, CCNU and dacarbazine); ABCM (Adriamycin, bleomycin, cyclophosphamide, mitomycin-C); ABD (Adriamycin, bleomycin, DTIC); ABDIC (Adriamycin, bleomycin, dacarbazine, ll and prednisone); ABDV (Adriamycm, bleomycin, DTIC, vinblastine); ABLC (amphotericin B li); ABOS (doxorubicin, bleomycin sulfate e, streptozocin); ABP (Adriamycin, bleo); ABPP (bropirimine leomycin, vincristine); ABV (Adr nblasti vincristine, dacarbazine); ABVE in, vincr , bleomycin sulfate, teniposide Adriamycin nisone); ABVP (Adriamycin, bleo ne, predniso C (Adriamycin, CCNU); AC (Ad cuSite; Ac-D- mycin); ACe (Adriamycin, c E Adriamycin, c UCY (actinomycin phosphamide); A sphamide, imidazole, dactinomyci ; aclarubicin HCl; A iamycin, cyclophosphamide, methotrexa); ACOAP (Adriamycin, cyclophosphamide, Oncovin cytosine arabinoside, (Adriamycin, cyclophosphamide, Oncovin, pr); ACOPP (Adriamycin, cyclop e, Oncovin, prednisone, procarbazine); AC ACT (actinomycin); ACT-C (mycin-C); ACT-D (actino -D); Actin omcin-D (ACT-D); ACT-FU-Cy (actinomycin-D, 5-FU ide); bleomycin, CCNU); AD -C, daunorubicin, etopo inosi in, DTIC); ADOC (Ad cisplatin, vincristine, AdOA a-C, predniso iamycin, Oncovin, esin; AL (Adria ycin PFS; Ad -L-PAM ne must AF 1890 ((l driamycn te); AG nagrelic , ifosfamic M (L-aspar xate); (Proleukin alfacalcidol (; interfe n-N (interfer (vinblastine); A all trans-re); Allergan 2 ALOMAD (Adriamycin, Leuke methotrexate carbazine); A alpha tocopherol and beta ca Alpha Chymar); alpha interfe N-A); alpha1-antitrypsin; alpha-2 interfe IFN-alpha-2); 5-a itors; alpha-TGF (teroxirone); AlphaNine; ALTO (afterloading tandem and ovo lymphocyte-based treatment for renal cell carcinoma); altretamine (Hexalen, Hexastat) amethopterin (methotrexate); amiloride (Midamor); 9-aminocamptothecin; aminoglutethimide (Cytadren, AGT, Elipten); aminopterin; amiothiadiazole; AML-2-23 monoclonal antibody; AMMEN-OE5 monoclonal antibody; amonafide (nafidimide); amphotericin B colloidal dispersion (ABCD); amphotericin B lipid complex (ABLC); Ampligen (polyribonucleotide); AMSA (amsacrine); amsacrine (m-AMSA, AMSA, Amsidyl); Amsidyl (amsacrine); anakinra (Antril); anagrelide (Agrelin); ANAN (anandron); anandron (nilutamide); anastrozole (Arimidex);



HemOnc.org is a knowledge base aiming to capture all standard of care systemic anticancer treatment.

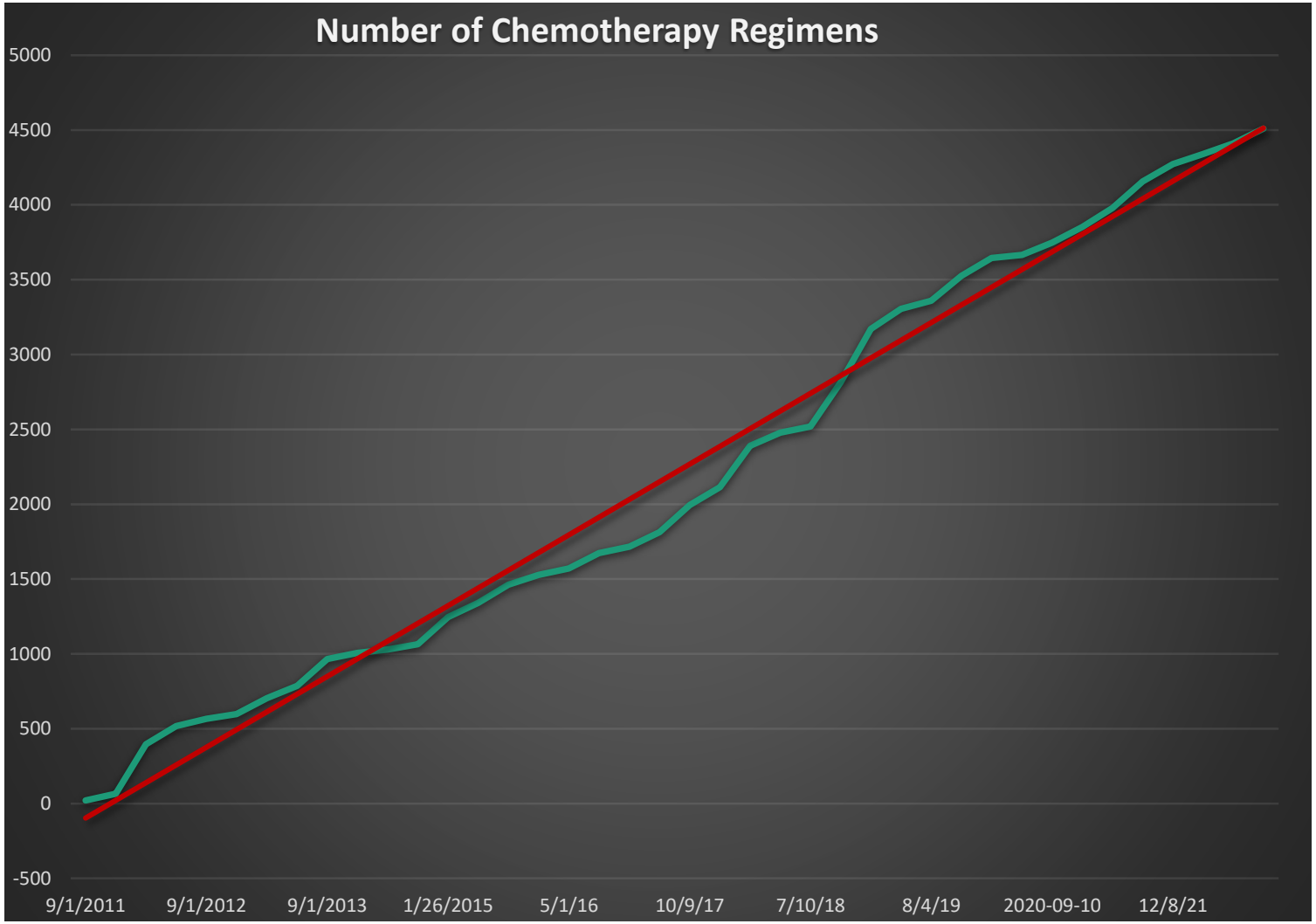
By the numbers

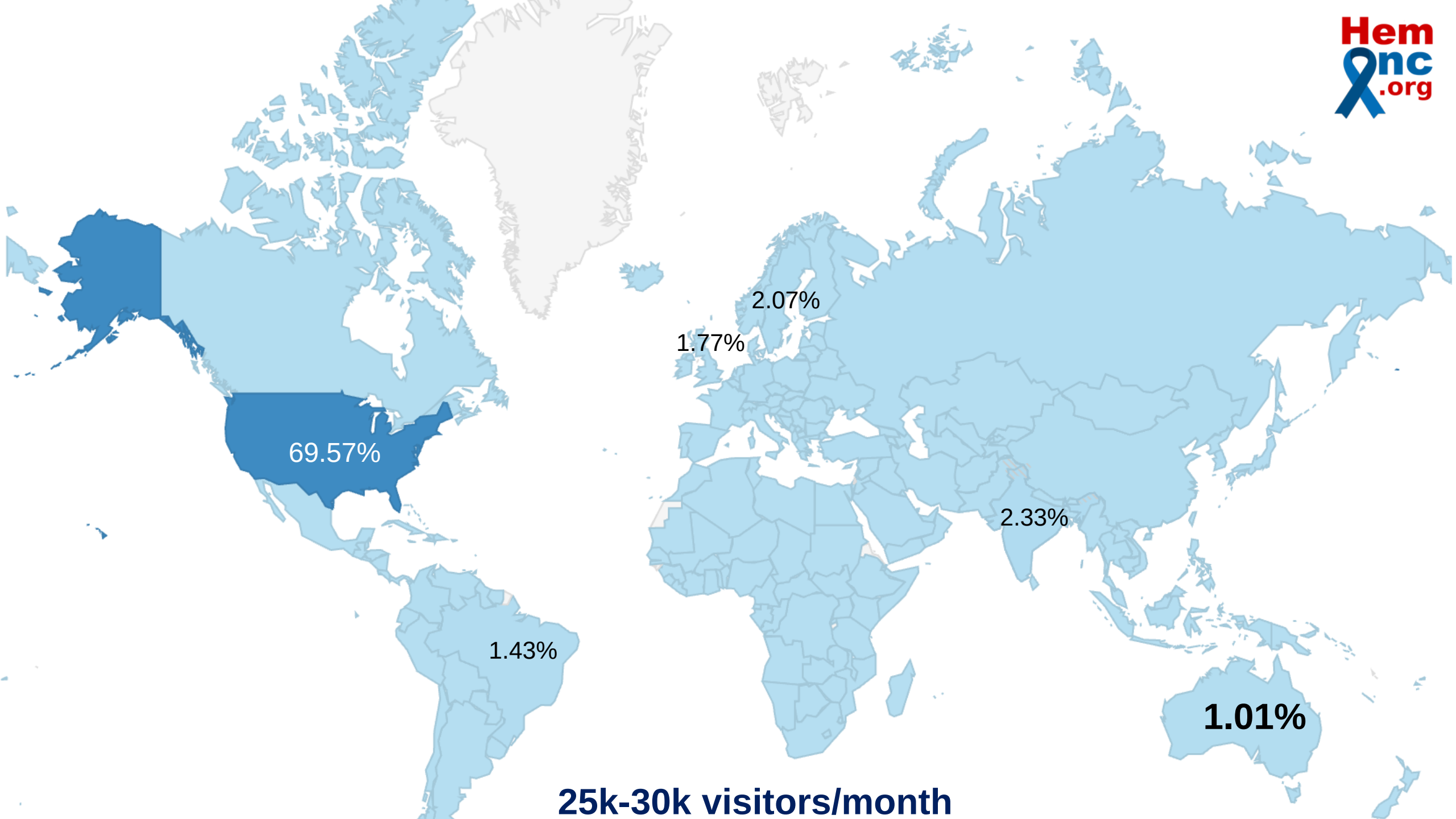
1037 primary content pages
310 disease-specific pages
>1,000,000 lines of content

>7000 primary references
>4000 context-specific regimens

50 members of editorial board

2022 page views
1,428,842




HemOnc.org
69.57%
2.07%
1.77%
2.33%
1.43%
1.01%
25k-30k visitors/month

Going from Knowledge Base to Ontology

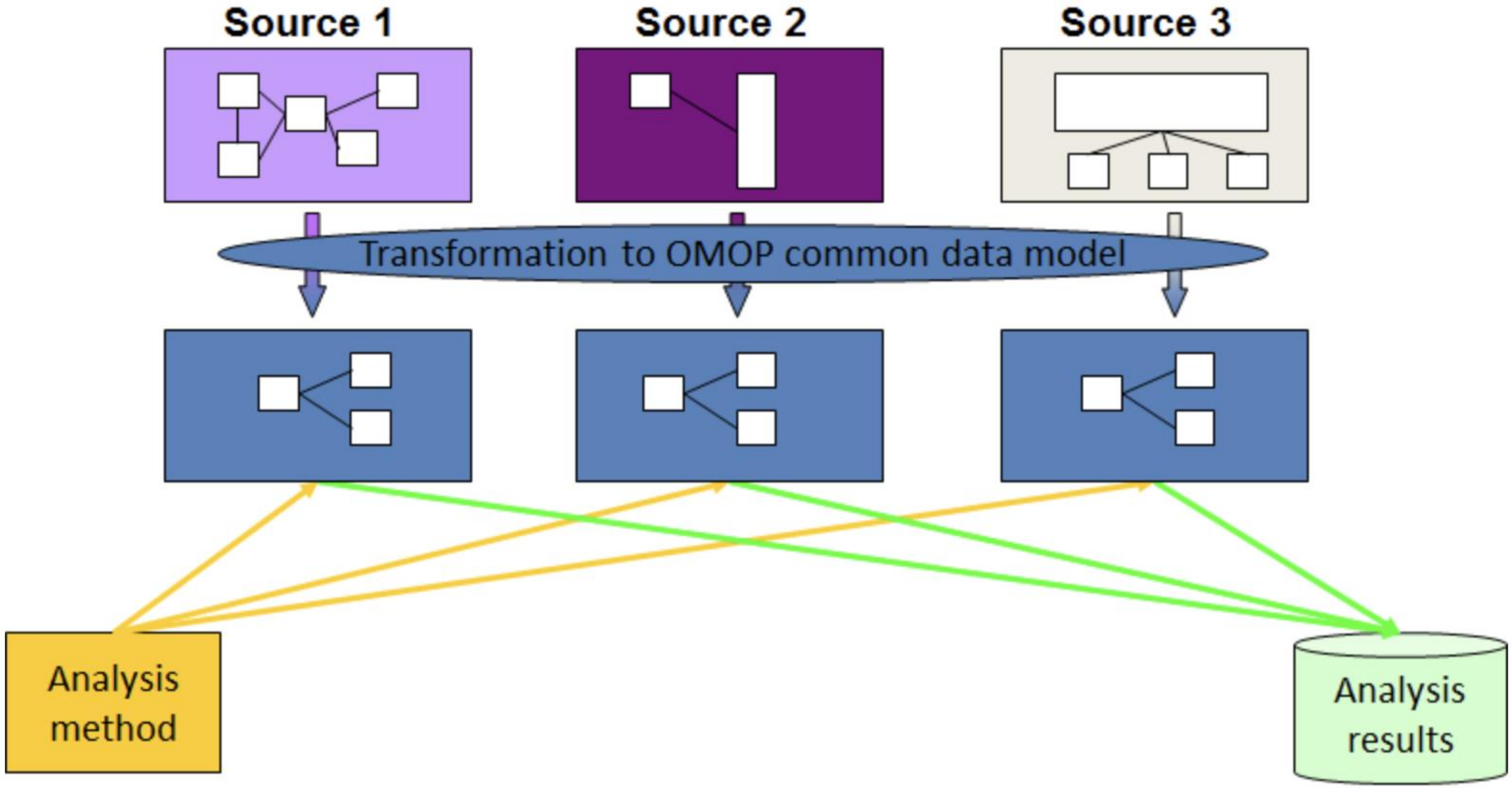
OHDSI

OBSERVATIONAL HEALTH DATA SCIENCES AND INFORMATICS

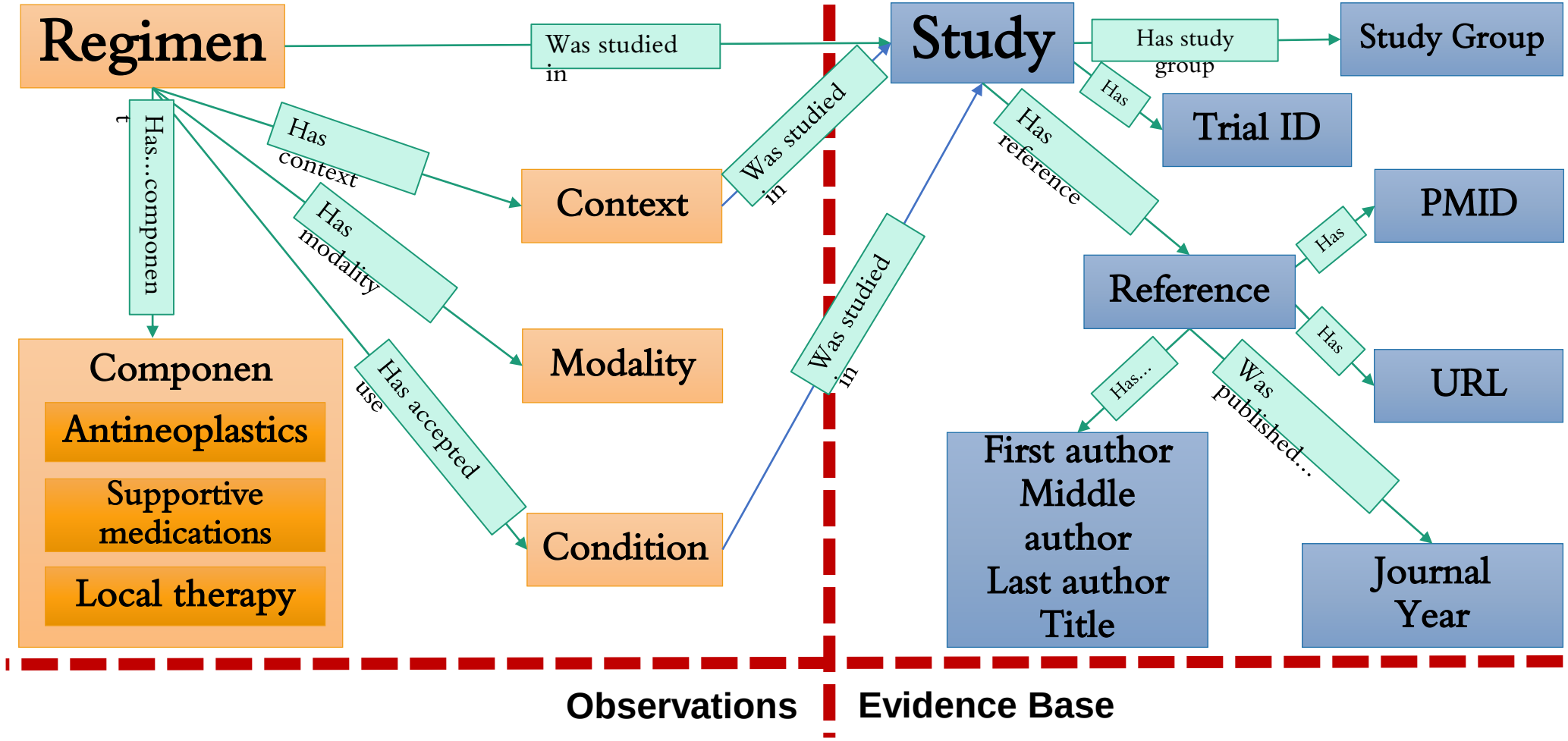
> The Observational Health Data Sciences and Informatics (or OHDSI, pronounced "Odyssey") program is a multi-stakeholder, interdisciplinary collaborative to bring out the value of health data through large-scale analytics. All our solutions are open-source.

IMAGE: FINE ART IMAGES/HERITAGE IMAGES/GETTY IMAGE

OMOP Common Data Model



HemOnc Regimen Model (simplified)



Concepts: 95,242 2023-06-07 **Relationships: 290,527**

Warner et al. *J Biomed Inform* 2019 https://doi.org/10.1016/j.jbi.2019.103239

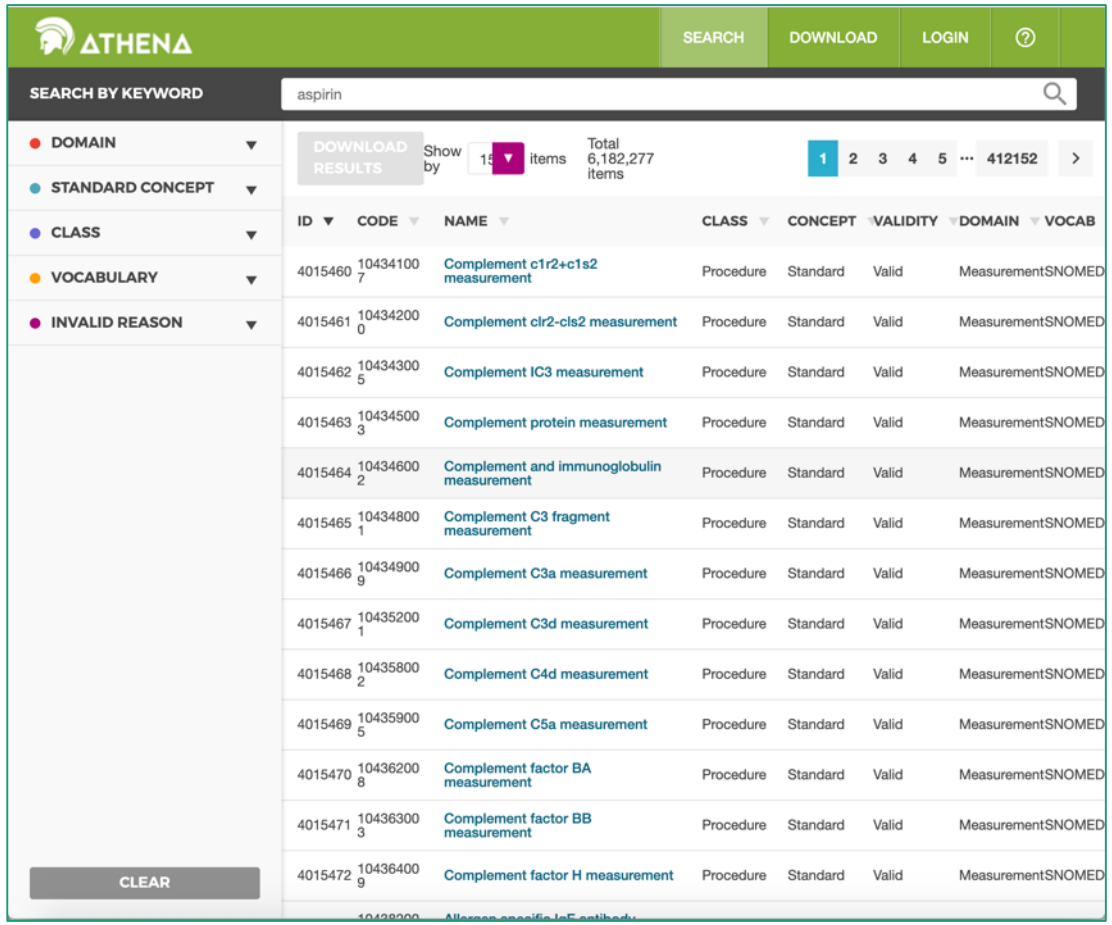
HemOnc has more content than other existing publicly available terminologies/ontologies.

Terminology	Maps to Drugs	Disease Context	Treatment Context	Modality	Link to Evidence	Number of regimens
SNOMED-CT	Yes[1]	No	No	No	No	6
SEER*Rx	Yes[1]	No	No	Yes	No	516
NCI Thesaurus	Yes[1]	Yes	No	No[2]	No	1021
HemOnc	Yes	Yes	Yes	Yes	Yes	3737*

[1]Antineoplastics; HemOnc also maps to supportive medications
[2]In some cases, modality can be inferred
*As of 2023-06-07; includes 1494 regimen “stubs” which are not yet completely defined

HemOnc is available to you!

Retrospective research (any user)



http://athena.ohdsi.org/vocabulary/list

Non-commercial user (any use)

Attribution-NonCommercial-ShareAlike 4.0 International (CC BY-NC-SA 4.0)

https://dataverse.harvard.edu/dataverse/HemOnc/

Any user (subset focused on drugs & diseases)

Attribution 4.0 International (CC BY 4.0)

https://dataverse.harvard.edu/dataverse/HemOnc/

Commercial user (full ontology)

Contact us for further details: *licensing@hemonc.org*

Lifespan
Delivering health with care®

HemOnc.org
10 YEARS

You can reach me at:

jeremy_warner@brown.edu

jwarner@hemonc.org

LEGORRETA CANCER CENTER
BROWN UNIVERSITY

Panelist Introductions

Asieh Golozar, MD, MPH, PhD
Global Head of Data Science at Odysseus Data Services, Inc.
Professor of the Practice & Director of Clinical Research at the OHDSI Center, Northeastern University

Travis Zack, MD, PhD
Hematology/Oncology Fellow
University of California, San Francisco

Georgina Kennedy, PhD
Maridulu Budyari Gumal (SPHERE) Cancer Clinical Academic Group
Ingham Institute for Applied Medical Research

Timothy Churches, MBBS, MPhil
University of New South Wales
Ingham Institute for Applied Medical Research

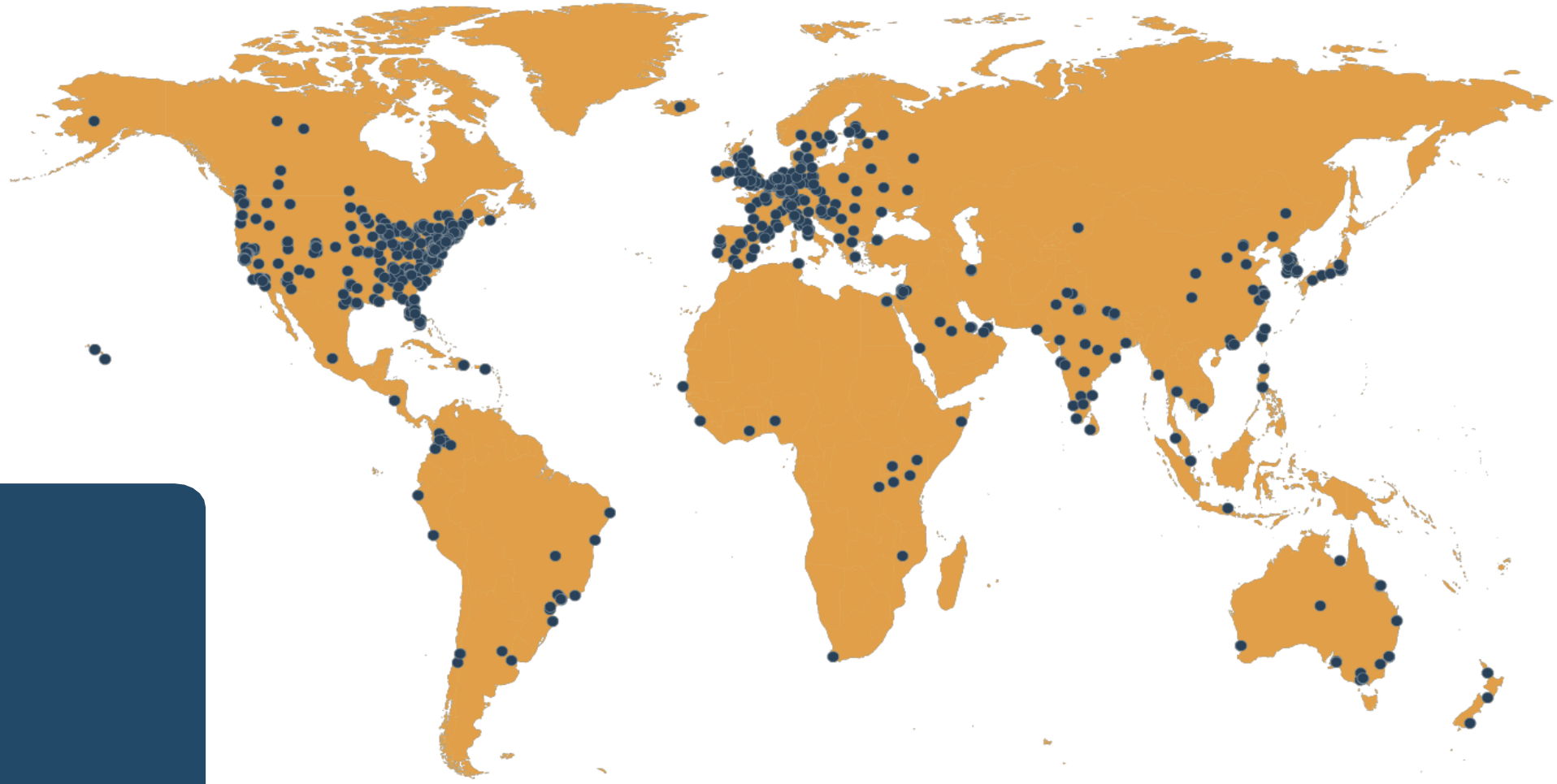
Detecting Systemic Anticancer Therapy Regimens from temporal drug exposures – the OHDSI experience

OHDSI community

We're all in this journey together…

OHDSI Collaborators

- 3,266 collaborators
- 80 countries
- 21 time zones
- 6 continents



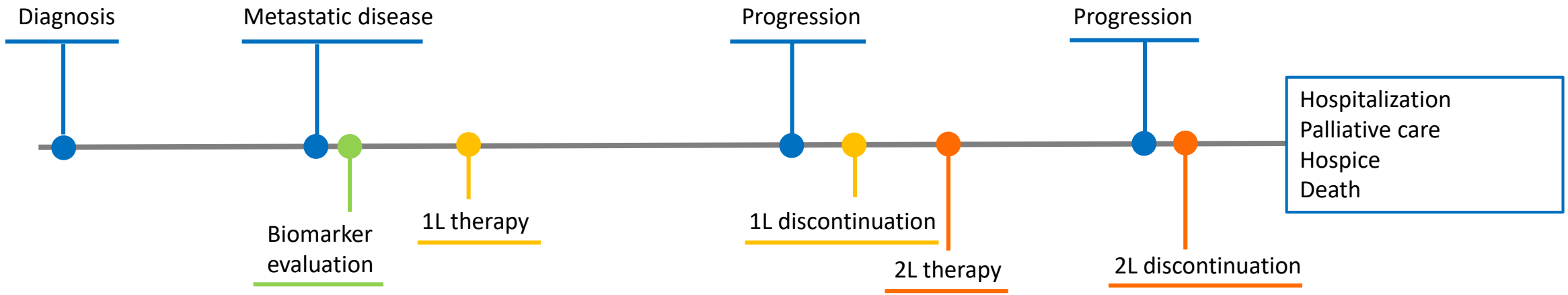
OHDSI Data Network

- 435 data sources
  - 347 EHRs
  - 34 registries
  - 30 administrative claims
- 41 countries
- 928 million unique patient records (12% of the world's population)

Open community data standards (OMOP CDM) ↔ Methodological research ↔ Open-source development (OHDSI tools) ↔ Clinical evidence generation

Why is oncology any different than the rest of medicine?

Schematic Cancer Patient Journey



Clinical Trial Endpoints for the Approval of Cancer Drugs and Biologics

Guidance for Industry

- Overall Survival
- Symptom Endpoints
- Disease-Free Survival/Event-Free Survival
- Objective Response Rate
- Complete Response
- Progression Free Survival/Time to Progression

Cancer is Complicated

HIGHLIGHTS OF PRESCRIBING INFORMATION
These highlights do not include all the information needed to use TABRECTA safely and effectively. See full prescribing information for TABRECTA.

TABRECTA™ (capmatinib) tablets, for oral use
Initial U.S. Approval: 2020

----------INDICATIONS AND USAGE----------
TABRECTA is a kinase inhibitor indicated for the treatment of adult patients with metastatic non-small cell lung cancer (NSCLC) whose tumors have a mutation that leads to mesenchymal-epithelial transition (MET) exon 14 skipping as detected by an FDA-approved test.

This indication is approved under accelerated approval based on overall response rate and duration of response. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s). (1)

----------DOSAGE AND ADMINISTRATION----------
- Select patients for treatment with TABRECTA based on presence of a mutation that leads to MET exon 14 skipping. (2.1)
- Recommended dosage: 400 mg orally twice daily with or without food. (2.2)

----------DOSAGE FORMS AND STRENGTHS----------
Tablets: 150 mg and 200 mg (3)

----------CONTRAINDICATIONS----------
None. (4)

----------WARNINGS AND PRECAUTIONS----------
- Interstitial Lung Disease (ILD)/Pneumonitis: Monitor for new or worsening pulmonary symptoms indicative of ILD/pneumonitis. Permanently discontinue TABRECTA in patients with ILD/pneumonitis. (2.3, 5.1)
- Hepatotoxicity: Monitor liver function tests. Withhold, dose reduce, or permanently discontinue TABRECTA based on severity. (2.3, 5.2)
- Risk of Photosensitivity: May cause photosensitivity reactions. Advise patients to limit direct ultraviolet exposure. (5.3)
- Embryo-Fetal Toxicity: Can cause fetal harm. Advise patients of the potential risk to a fetus and to use effective contraception. (5.4, 8.1, 8.3)

----------ADVERSE REACTIONS----------
The most common adverse reactions (≥ 20%) are peripheral edema, nausea, fatigue, vomiting, dyspnea, and decreased appetite. (6)

To report SUSPECTED ADVERSE REACTIONS, contact Novartis Pharmaceuticals Corporation at 1-888-669-6682 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch.

----------DRUG INTERACTIONS----------
Strong and Moderate CYP3A Inducers: Avoi

----------USE IN SPECIFIC POP
Lactation: Advise not to breastfeed. (8.2)

See 17 for PATIENT COUNSELING INF
approved patient labeling.

1. Cancer is rare
2. Cancer is complicated
3. No Terminologies

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The OHDSI Oncology Working Group Has Worked on the **Solution**

- Oncology Network
- OMOP Oncology Module

OMOP CDM: Oncology Module

Solves all problems of oncology research

1. **Cancer Disease Model**
   - Cancer Diagnosis: Base Diagnosis + Diagnostic Modifiers
   - (One-to-many connection between them)

2. **Cancer Treatment Model**
   - Composite Level (Treatment Episodes) or Individual Level (standard OMOP)

3. **Cancer Episode Model**
   - Continuous periods of disease or treatment with distinct clinical meaning
   - Composed of multiple events
   - Essential for conducting cancer research

Cancer Disease Model: Terminologies

Solves all problems of oncology research

1 **Cancer Disease Model**

Cancer Diagnosis: Base Diagnosis + Diagnostic Modifiers

ICD-O | Cancer Modifiers + OMOP Genomics

2 **Cancer Treatment Model**

Composite Level (Treatment Episodes) or Individual Level (standard OMOP)

HemOnc

3 **Cancer Episode Model**

Overarching disease episode

Disease dynamic (remission, stable, progression)

Disease extent (confined, invasive, metastatic)

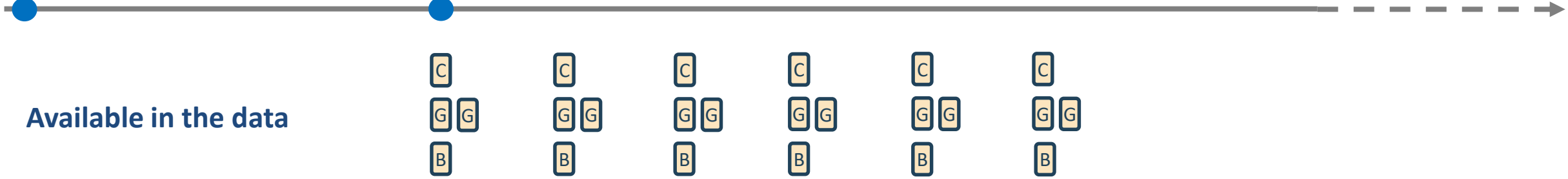
De novo vocabularies

2 OMOP Oncology: Cancer Treatment Model

Abstracted **chemotherapy** regimens rarely available

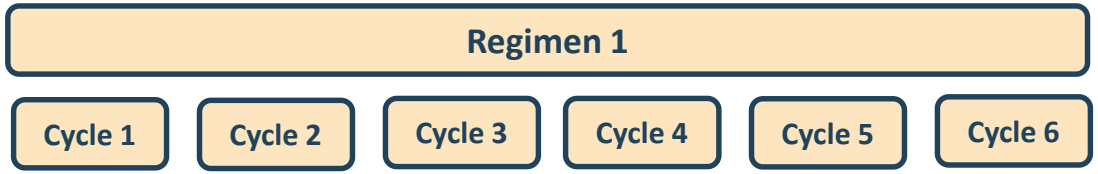
Metastatic non-squamous NSCLC

Cisplatin+Gemcitabine (GC)
21-day cycle for up to 6 cycles



Available in the data

Needed for research but mostly not available



A patient's medical record can be treated as a temporal sequence of events

- Apply sequence alignment methodologies to infer regimens from discrete events
- Sequence alignment:
  - Standard for assessing biological sequence homology.
  - Established approach in bioinformatics and has been applied to other domains, including sequences of temporal events.
  - A combination of recursive dynamic programming and a scoring matrix guarantees optimal alignment

- Two classic algorithms for sequence alignments:
  1. Needleman-Wunsch (NW)
  2. Smith-Waterman (SW)

- Traditional NW and SW **do not incorporate missing events, treatment delays, protocol deviation and relative time between events**
- Extensions of both NW and SW incorporates relative timing information have been used to extract chemotherapy regimens with high accuracy

ARTEMIS: A Modified Smith-Waterman algorithm

accounts for missing events, treatment delays, protocol deviation and relative time between events

User input:

Alignment parameters: $\begin{bmatrix} \text{gap penalty (g)} \\ \text{maximum temporal penalty} \\ \text{loss function} \end{bmatrix}$

Substitution matrix $S(x_i + yj) = \begin{Bmatrix} +1, xi = yj \\ -1.1, xi \neq yj \end{Bmatrix}$

$$TR_{i,j} = \begin{Bmatrix} 0, & if\ D(i,j) = 0 \\ TR_{i,j-1}, & if\ D(i,j) = 1 \\ Tr_{i-1,j} + txi, & if\ D(i,j) = -1 \end{Bmatrix}$$

$$TC_{i,j} = \begin{Bmatrix} 0, & if\ D(i,j) = 0 \\ TR_{i,j-1+}t_{yi}, & if\ D(i,j) = 1 \\ Tr_{i-1,j}, & if\ D(i,j) = -1 \end{Bmatrix}$$

$$D_{i,j} = \begin{Bmatrix} 0, & if\ H(i,j) = 0 \\ -1, if\ H(i,j) = H(i-1,j) - g \\ 1, if\ H(i,j) = H(i,j-1) - g \end{Bmatrix}$$

$$H_{i,j} = \max \begin{Bmatrix} 0 \\ H_{i-1,j-1} + S(x_i + yj) - f(txi + TRi_{\_1,j\_1} + TCi_{\_1,j\_1}) \\ H_{i\_1,j} - g \\ H_{i,j\_1\_} g \end{Bmatrix}$$

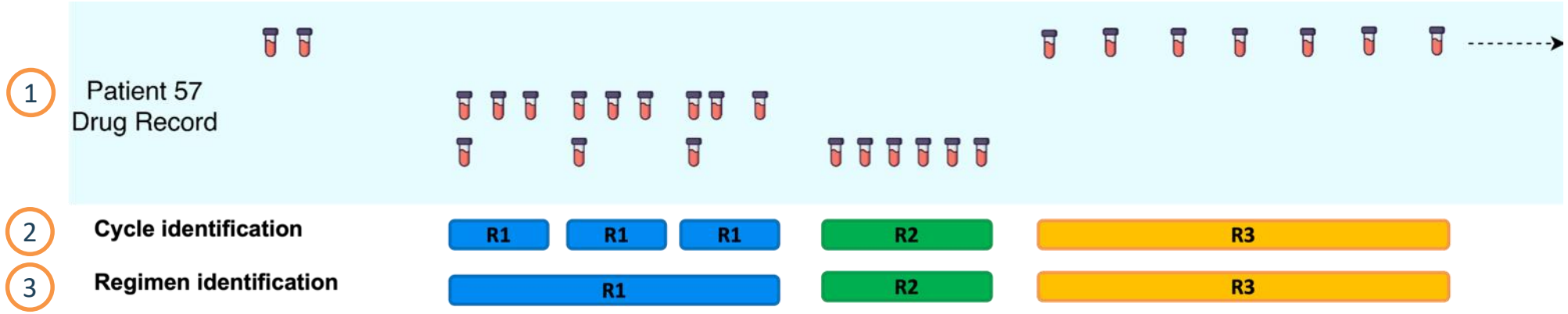
$$\forall\ i\epsilon\ [1,m], j\epsilon\ [1,n]$$

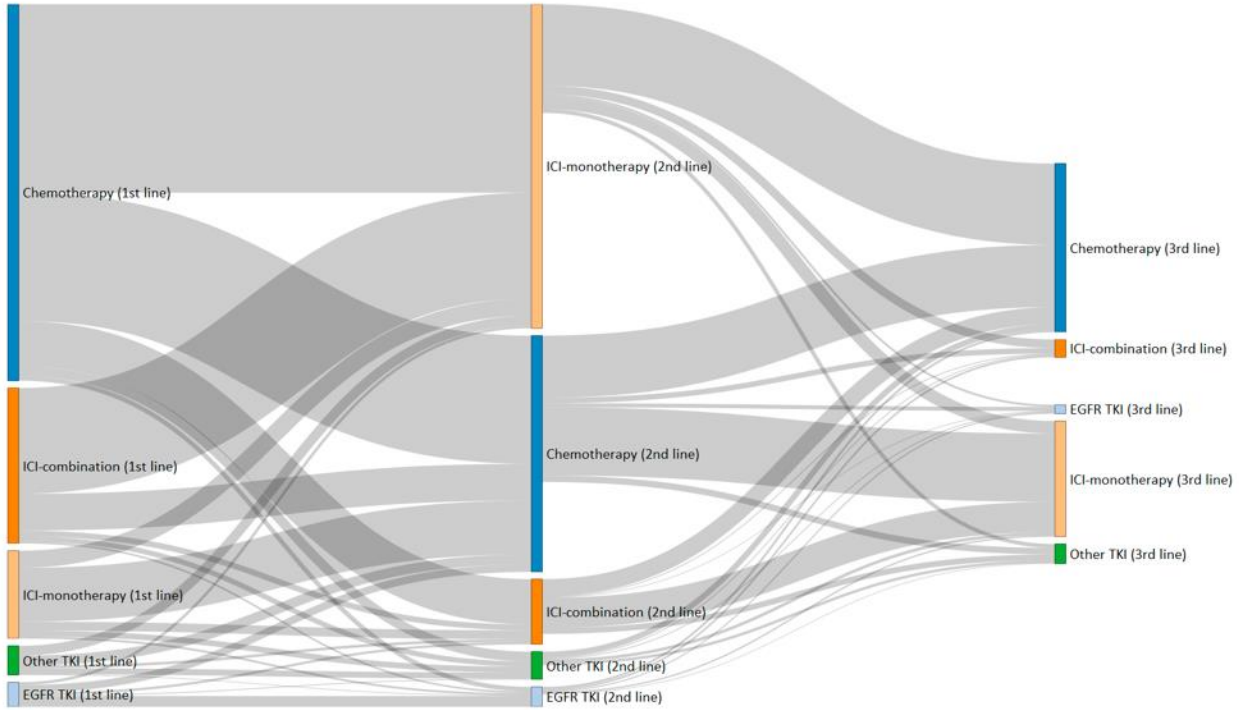
H		7.A	0.B	0.C	7.A	7.D
	0	0	0			
0.C	0					
7.D	0					
15.C	0					
7.A	0					
0.B	0					
0.C	0					
7.A	0					
7.D	0					
7.E	0					
7.E	0					

H		7.A	0.B	0.C	7.A	7.D
	0	0	0	0	0	0
0.C	0	0	0	0.125	0	0
7.D	0	0	0	0	0	1
15.C	0	0	0	0.0625	0	0.6
7.A	0	1	0.6	0.2	1.0625	0
0.B	0	0.6	2	1.6	1.2	0
0.C	0	0.2	1.6	3	2.6	2.2
7.A	0	1	1.2	2.6	4	3.6
7.D	0	0.6	0.8	2.2	3.6	5
7.E	0	0.2	0.4	1.8	3.2	4.6
7.E	0	0	0	1.4	2.8	4.2

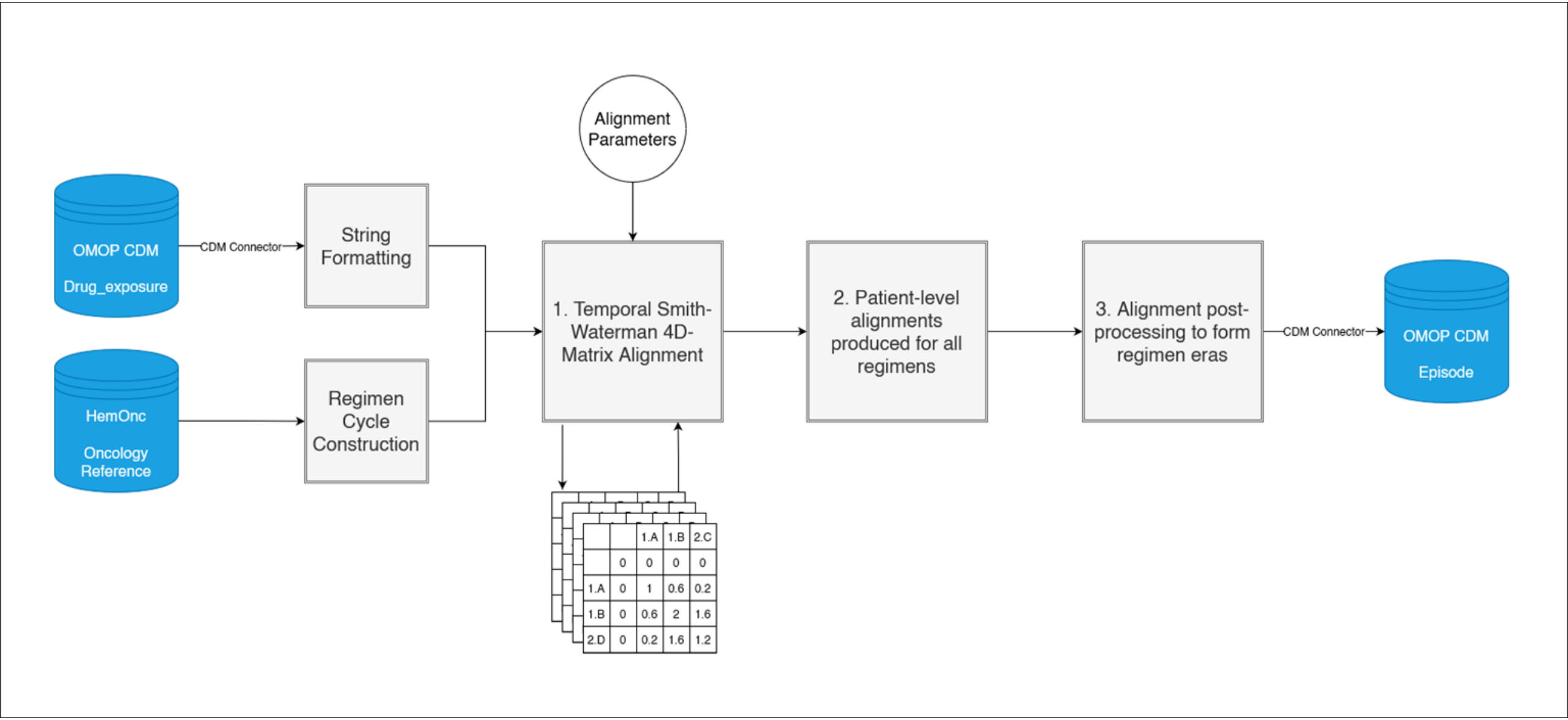
Alignment Result: 0.C-7.C-15.C-7.A-0.B-0.C-7.A-7.D-7.E-7.E
_._-__-__-__-7.A-0.B-0.C-7.A-7.D

Modified Temporal Smith-Waterman





ARTEMIS - Method Flow Chart



Placeholder for Travis Zack slides

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Mapping and semantic harmonization of Australian and US SACT protocol definitions

Meg Stevens, Timothy Churches, Leo Coleman, Shelley Rushton,
Julia Shingleton, Aisling Kelly, Huai-Hsuan Tseng, Georgina Kennedy

Georgina Kennedy

Senior Research Fellow

Maridulu Budyari Gumal (SPHERE) Cancer Clinical Academic Group

Ingham Institute for Applied Medical Research

@gkenno

MEDINFO23

8 – 12 JULY 2023 | SYDNEY, AUSTRALIA

UNSW SYDNEY

Ingham Institute
Applied Medical Research

ACDN
Australian Cancer Data Network

NSW GOVERNMENT
Health
South Western Sydney
Local Health District

QaVa

NSW GOVERNMENT
Cancer Institute NSW

Maridulu Budyari Gumal
Cancer
Clinical Academic Group

@TheInstituteDH #MEDINFO23

Australian context: eviQ

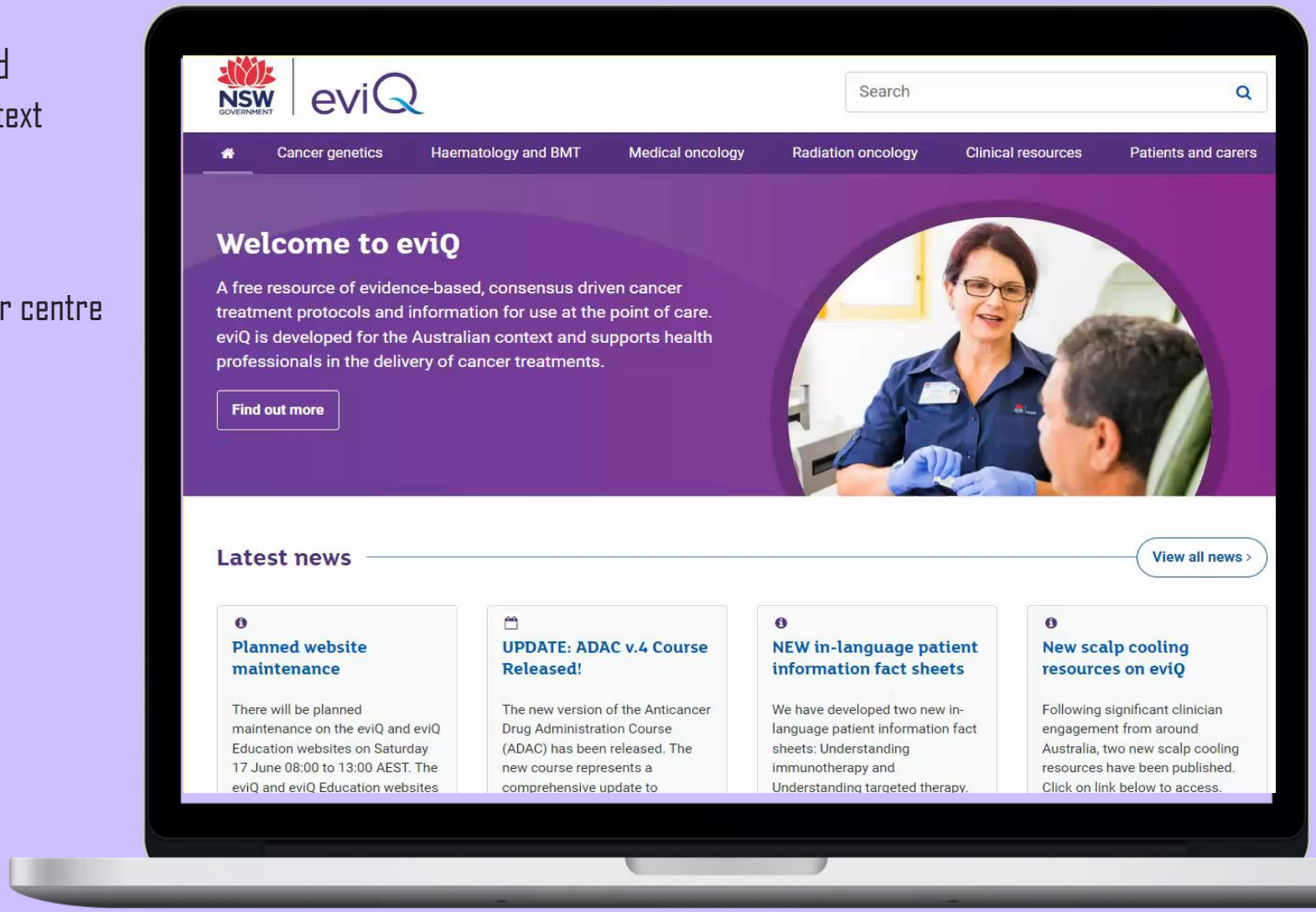
Free, online resource of cancer treatment protocols and treatment information developed for the Australian context

National program

Embedded into clinical practice and used in every cancer centre across Australia

Primary audience: health professionals

Secondary audience: patients and carers



eviQ.org.au

eviQ Program History

2000 - 2004	2005	2009	2010	2013
Intranet cancer treatment protocol resource developed by Professor Robyn Ward, used across 3 Sydney hospitals	Cancer Institute NSW assumed responsibility. Website built and launched as CI-SCaT*	Rebranded as eviQ **eviQ.org.au** Increased functionality and content	Nationally endorsed as the preferred source of evidence-based cancer treatment information in Australia	National eviQ program MOU with each state and territory

*Cancer Institute's Standard Cancer Treatments Program (CI-SCaT)

eviQ usage and reach 2022

- Guidance not a guideline
- Not mandated
- Editorially independent
- Complies with Australia's regulatory and reimbursement process i.e., TGA/PBS
- Variation may be appropriate

448, 084 Australian users

166% increase in total monthly users since 2018

331, 437

International users

2018 = 22%

2022 = 44%

202 countries

1. Australia
2. United States
3. New Zealand
4. Brazil
5. United Kingdom

- Oncology
- Haematology
- BMT
- Radiation oncology
- Cancer genetics

1064

Treatment protocols

162

Clinical resources

123

Patient information sheet

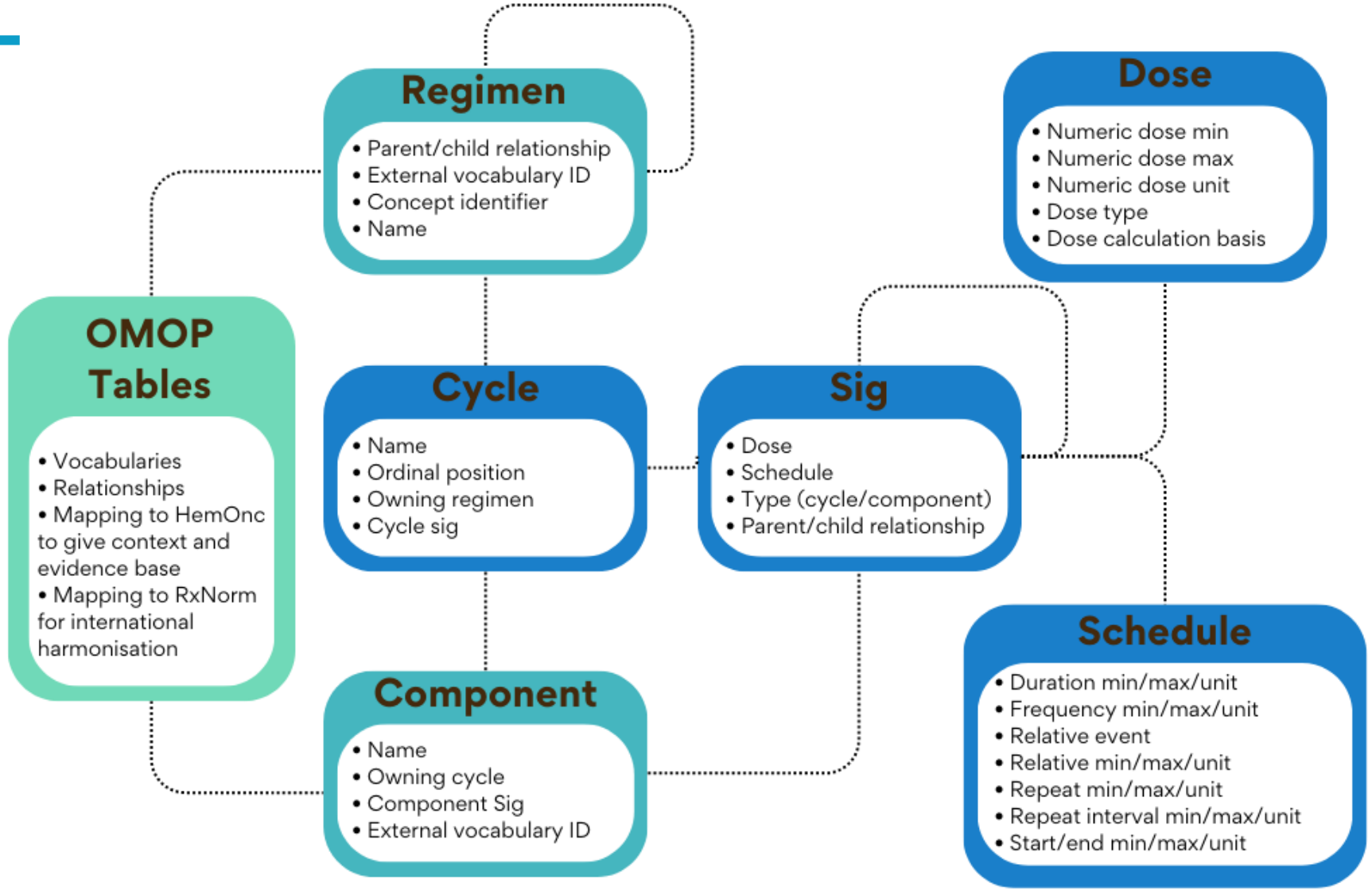
6 calculators

Why is it important to identify lines of therapy?

- Assess real-world treatment effectiveness
- Quality indicators to assess appropriateness of treatment patterns
- Determine future treatments

Why is it hard to identify SACT regimens in RWD?

CaVa Regimen Model: Computable Baselines



CaVa Regimen Model: Computable Baselines

Regimen

ID: 123
Name: Breast adjuvant Paclitaxel dose dense
Status: approved
Create date: 2005-01-12
Status date: 2019-10-01
Regimen code: 160

Cycle

ID:	999
Regimen ID:	123
Sequence:	1
SigID:	1

Cycle Component

CompID	CycID	Type	Component
1	999	Supportive therapy	Dexamethasone
2	999	Supportive therapy	Loratadine
3	999	Cytotoxic chemotherapy	PACLitaxel
4	999	Growth factor support	Pegfilgrastim

Dose

DoseID	NumMin	NumMax	NumUnits	DoseBasis	Route
1	20	20	mg		PO
2	10	10	mg		PO
3	20	20	mg		PO
4	175	175	mg/m2	BSA	IV
5	6	6	mg		SC

Sig

Sig ID	Source Type	Source ID	Dose ID	Schedule ID
1	Cycle	999	None	1
2	Component	1	1	2
3	Component	2	2	3
4	Component	1	3	4
5	Component	3	4	5
6	Component	4	5	6

Schedule

SchedID	FreqMin	FreqMax	FreqUnit	RepeatMin	RepeatMax	StartOffset	StartUnit
1	14	14	Days	4	4	0	Days
2				1	1	-1	Days
3				1	1	-60	Minutes
4				1	1	-60	Minutes
5				1	1	0	Days
6				1	1	1	Days

Computable Baselines: Detect & Measure Variation

Harmonisation

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