

HL7 Working Group Meeting, San Antonio, January 2002

HL7 Australia Report

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Introduction

A well-organised Australian group of 10 attended the San Antonio Working Group Meeting. This group consisted of 7 previous attendees with the remaining 3 being their first time to a Working Group Meeting. 6 of the group travelled together on the same long haul to San Antonio providing the opportunity to develop a good team connection and morale whilst discussing hot topics.

With this large group of people familiar to the working group meeting experience and this experience getting stronger each meeting, there was a great sense of purpose and strategy. Quite often there would be more than one Australian in the key meetings where topics were important to the Australian HL7 community. When things need to be done the Australians were seen putting their hands up to help with the work.

Additionally a large group of the Australian contingent in conjunction with a New Zealand and a United Kingdom colleague, worked together on the Wednesday night to develop a high level domain model for Referral including the development of use cases and a storyboard. The opportunity to do this kind of work face to face with this kind of experienced attendance does not come very often. It's a shame we had to travel 12000 kilometres to do so.

Most of the major committees were covered including Methodology & Modelling (MM), Control Query (CQ), Laboratory, Pharmacy, Patient Care (PC) including its Community Health special interest group, Patient Administration, Electronic Health Records, Clinical Document Architecture, Clinical Guidelines and Templates.

This report includes a brief summary of the important issues discussed at the HL7 Working Group Meeting in San Antonio. I have also included some recommendations.

My goals for this meeting were to follow the progress of the HL7 V3 standard development and to continue providing Methodology & Modelling Facilitation to the Patient Care Technical Committee. This experience can be used to help the Australian HL7 community in future.

To fulfil these goals I spent some time in the Modelling and Methodology technical committee while attending Control Query for discussions on data types and Patient Care on Tuesday and Wednesday.

Summary

The first RIM Ballot opened on 3rd December 2002. Unfortunately the Australian HL7 User Group did not get notified of this release. The Ballot responses comprised of 14 affirmatives, 9 negatives and 4 abstentions. Most of the responses were in response to descriptive text and misunderstanding of the RIM's purpose. The RIM structure was not a widely criticised issue.

The HL7 Definition Framework (HDF) draft was going through a peer review. Different authors currently manage the chapters and hence consistency between them is lacking however it is a long way towards being complete. The HDF project manager has been reappointed with the goal to complete the project by the end of the year.

The HDF is being used Patient Care Technical Committee for 2-3 projects in varying degrees as test cases for the new message development methodology.

Significant amount of work was done in the Patient Care TC including redefining definitions of Act class codes and Act Relationship type codes related to conditions, episodes and goal variance. A goal Refined Message Information Model (RMIM) was started along with a Patient Referral and Care Plan RMIM.

A new Care Provision Act class code was successful proposed by Patient Care at the Fast Track Harmonization meeting held on the Thursday night. The Care Provision act will be used to associate a patient with a care provider for a particular type of care by the Patient Administration committee while also being used to represent a referral in Patient Care and insurance coverage for a particular type of care in Financial Management.

Discussions related to data types have resulted in a few outcomes. The inheritance by restriction relationships will be remodelled using a UML compliant representation while maintaining the current semantics. This will be done with significant Australian input. Secondly, using the new concept of constraining HL7 data types a taskforce was initiated to provide mapping rules between the following items:

- 1) templates equivalent to OpenEHR archetypes
- 2) constraints of HL7 data types equivalent to OpenEHR data types
- 3) constraints of HL7 AD and NM data types equivalent to OpenEHR Address & Name archetypes.

Note that these OpenEHR archetypes will be samples only as archetypes are by design user defined. Address for example could be based on an Australian address standard and we can select a few representative clinical archetypes already developed during OpenEHR requirements analysis.

This work could grow into an OpenEHR ITS for HL7 V3 messaging.

Guidelines were agreed to for standardising the RIM class attribute encoding in the XML ITS to ensure that attributes are represented as XML elements or attributes in a consistent manner.

Implementation guidelines are being developed to show how HL7 messages can be transported using Web services. The HL7 message may be passed in the SOAP body or as an ebXML style attachment. Rules will also provide what information should go in the SOAP header.

The 4th HL7 V3 committee ballot will open 10th March 2003 including the second RIM ballot.

Recommendations

Travel as a Group

I believe that it was worthwhile having the opportunity to travel as a group on the way to San Antonio. This gave the opportunity to get to know each other, discuss hot topics and strategy while also providing company on such an extended trip with long stopovers. I recommend that this continue for subsequent meetings.

The Wednesday night proved successful as an opportunity for a group of Australian experts to work on an Australian project with significant outputs. Perhaps an earlier departure date could allow this type of work, which may also be in preparation for the meeting, to be done prior to the meeting without overloading the already full week of meeting activities.

Per Diem allowance

The overhead required to record and gather receipts for out of pocket expenses for such things as food, drinks & phone calls is significant for a delegate. Most casual eating facilities do not provide receipts such as a deli or café. Restaurants provide receipts but these type of meals are usually attended as a group and each person is not going to get a copy of the receipt or one may pay another some cash who may then cover the whole meal using a credit card.

A fair Per Diem rate (perhaps paid in advance) would ease this overhead without leaving the delegate out of pocket. Most meals are supplied as part of the meeting, leaving only one meal a day to be covered by a Per Diem Allowance with a little for work related phone calls, checking email etc. An AUS\$40-45 allowance would convert into approx. US\$21-25 which should cover a reasonable meal and a phone call or two.

CDA/V3 Workshop/SIG to develop a Referral/Discharge message

A significant amount of work was done at the informal meeting held Wednesday by the Australians to produce a high level model for Referral based on work done in New Zealand, IT14-6-6 and GPCG. This work needs to have some support to allow its continuance rather than sparsely held and attended meetings as until now. It showed on the Wednesday night just how much work can be done if you get enough of the right people in the one place wanting to get something done. The thing is, what happens now? We wait until the next Working Group Meeting in April?

If funding could be made available to get these same people together for a couple of days to compensate for time and expenses, this work would not need to be done when we are all in another country. It may also allow and possibly attract personnel from the wider Health Informatics community in Australia to contribute.

Continued Australian participation at Harmonisation meetings

The experience gained from attending the November Harmonisation meeting was immense. The day of training in the use of the HL7 message development tools allowed me to support the Patient Care Technical Committee in their development of Patient Care messages in San Antonio. The knowledge of the Harmonisation process also allowed me to propose further changes at the Fast Track Harmonisation meeting on the Thursday night. Above all, the informal discussions with the leading participants of HL7 outside the room paved the way for the new Care Provision act class code in San Antonio. The benefits of having a person with these skills, knowledge of the process and access to the process can be gained by Australian groups when the need arises.

Continued Australian participation at Harmonisation will continue building on these skills & knowledge while building the relationships to have help influence the direction of HL7 standards development. HDF is a topic for discussion at the next Harmonisation meeting, which will provide an Australian participant detailed access to the HDF principles.

As a HL7 approved facilitator to the Patient Care technical committee, I am entitled to attend the Harmonisation meetings and HL7 helps by providing financial assistance to attend. I would recommend that a second Australian investigate the opportunity to become either a vocabulary or modelling facilitator to spread this experience across more than one Australian and lighten the travel requirements by taking turns in attending Harmonisation meetings.

Conclusion

I would like to thank IT14-6-3 for nominating me and both the Department of Health and Aged Care and HL7 Australia Users Group for their financial and administrative support to attend the San Antonio HL7 Working Group Meeting.