

HL7 Working Meeting - Summary Report

Note: This summary report was sent out to the HL7 Australia and the IT14-06-xx lists on January 16, 2003. It was written by the team of experts "in situ" during the Working meeting and has not been edited.

The work on the HL7 V2.5 ballot results review was completed and it is expected that V2.5 will be published in the next few months.

Work on V2.6 has commenced and some of the Australian requirements (eg. for AS4700.1, etc.) have already been included.

Routing of pathology reports to an individual within an institution: v2.5 resolves that MSH-23 and MSH-24 be used for receiving and sending organisation responsible for action (taking it up to 3 sending and 3 receiving identifiers). MSH-23 would be used for the specific receiving practitioner. The path forward will be to specify this in the V2.3.1 Aus standard and user guide despite not being part of v2.3.1.

LOINC has released 2.08, which features more "batteries" but is still somewhat immature and incomplete for ordering. It was noted in the meeting that LOINC are moving toward implementing hierarchies and that there will be more generic codes introduced. Segment 6 the method is now optional and should only be specified where it is clinically relevant. It will take a year for the changes to appear. There has been an undertaking to provide, and a keen interest to receive, the output of the Australian work on request and report codes. There is every indication that an all of country deal has been done between SNOMED and the US Government. Announcement awaits voting of funds from Congress.

The Global Profile Repository has been released onto the HL7 website for uploading of message conformance profiles as produced in the Messaging Workbench. IHE have been working on a number of message conformance profiles that should appear on the website soon (mostly related to message within Imaging). It is envisaged that profiles appearing in the repository will be reused by multiple vendors, not just the vendor that posted it. In this way, there will be standardised usage of messages within the flexible HL7 environment.

Australia and New Zealand have joined forces for further development of the discharge-referral message specification and supporting models. We now have a combined stakeholder requirements document, data set and a high-level class diagram, which will continue to be refined. This will become one of the first projects here to be brought into the robust HL7 Development Framework (HDF). The data elements/class diagrams were analysed against the Clinical Document Architecture (CDA) Release 2 specification and gaps identified. We have proposed to the Structured Document Technical Committee (STDC) an enhancement request for the CDA Release 2 spec. This proposal has full support of the STDC co-chair and key members all of whom have helped us with the work. It is considered as a very important initiative to help tighten up the CDA development and refinement processes. The version 2.6 Referral specification has been presented to the Patient Care

TC and Community Health SIG. Our proposed segment extensions have in principle acceptance. The difficulties arising from the complexity of the clinical care components of the message were presented and two possible but very different ways forward have been suggested with committee support for further testing. The Australian presence in the Community Health SIG was increased with an out of sessions meeting to discuss the current status of Victorian developments around Community & Mental messaging developments & requirements. This has developed into several action items to be carried out in both Australia & USA to raise the profiles of these programs prior to the April Meeting.

The Clinical Decision Support group is developing an object version of Arden Syntax. Its recent version (2.1) has recently been adopted as an ANSI standard (the only such standard in existence for decision support). The decision support work continues to be hampered by conflicting approaches using low-level implementations rather than a disciplined approach involving requirements, and abstract domain modelling. We have been arguing for the adoption the HDF (similarly to our approach to Discharge Referral) and there is now a strong prospect for this.

Version 3 work is progressing very well with many of the issues raised by Dick Harding in recent listserver discussions being addressed. There has been considerable enhancements to the presentation formats for the version 3 ballots, some of these enhancements being developed by Australians. Expect the next ballot of Version 3 to be released about February 12th.

No progress on Microbiology this meeting owing to the non-attendance of the other two prime movers in the Microbiology discussions. Hopefully, they will be able to attend next meeting. Similarly and not unexpectedly, the major effort this meeting has been on Version 2.5 Ballot resolution so very little discussion on new V2.6 proposals has occurred.

Most of the work of the Vocab Committee happens later in the week however the key developments so far are discussion about the development of a terminology tool (service) to support HL7 internal vocabulary management. This has direct value in that similar terminology management tools or modules or functionality will be required in clinical software.

There are very strong opinion that the US Government and the College of American Pathologists have agreed on a model for public licence of SNOMED-CT in the US. The HL7 vocabulary co-chairs (who have been the backbone of the Open Terminology Project) are supportive of this direction and have committed to keeping the needs and interests of the international members of HL7 to the fore in joint discussions with the key parties planned for March 2003.

On the medication terminology front, further work has been done on a potential international standard terminology for dose forms (in which each country eg. our TGA can find their own standard codes represented).

There has been further work done on drug terminology models with agreement to get US, UK and Australian, and potentially European interests together to discuss a common approach to drug term modelling and identification of drugs and devices.

HL7 vocabulary and medication groups have supported a strong FDA proposal for a common drug identifier in the US which meets several key requirements. One of these is compatibility with the EAN/UCC numbering and barcoding system. This leaves the way open for a common approach in both the US and Australia (which would be scalable to other countries, if they wished to adopt it and potentially to use the same approach for identification of devices).

The HL7 Board is moving towards submitting HL7 V2.4 for approval by ISO TC215 as a global standard.

The HL7 Board has endorsed the 4th International Affiliates Meeting in Daego, Sth. Korea, on Oct. 13+14, 2003.

The planning to hold the first regular HL7 Working Meeting in Europe in May 2004 is also progressing well. A formal announcement will be made in the next few months.

We have received verbal advice that the New Zealand HL7 User Group will be able to take over the HL7 Affiliateship for New Zealand.

The first introductory book on HL7 V3 has been published and will be available to HL7ers in Australia next week (cost A\$40 or A\$35 for HL7 Australia members).

We feel it has been a very successful Australian participation at the Working Meeting and we believe that we have achieved more than we expected.

The Australian team in San Antonio: Heath Frankel, Grahame Grieve, Dick Harding, Sam Heard, Michael Legg, Peter MacIsaac, Mike Rochow, David Rowed, Klaus Veil, Max Walker and Stephen Chu (New Zealand)