

Health Level 7 - Working Group Meeting Report

Cleveland, April 27 – May 2, 2003

Richard Harding

Introduction

I was selected by HL7 Australia to be an Australian delegate to the HL7 Working Group Meeting which was held in Cleveland, Ohio between the 27th April and 2nd of May 2003.

My travel and accommodation expenses were provided by HL7 Australia under an arrangement with the Commonwealth Department of Health and Ageing. I used accrued Recreation Leave entitlements to cover my absence from Queensland Health for the time involved.

This report is intended to fulfil the requirements of the travel grant guidelines of HL7 Australia to report on the meeting within 6 weeks of return including transferring information to the appropriate Standards Australia working groups.

Proposed Scope of Participation

My request to attend the Cleveland Working Group Meeting was based on the following main subject areas:

- V3 Dynamic Model
- V3 Pharmacy and Pathology
- V3 Discharge and Referrals
- V2 Items mainly Pharmacy and Pathology
- V2 and V3 Microbiology

Outcomes of Meeting

V3 Direction

As the consequence of discussions that started in Cleveland, an American colleague (Virginia Lorenzi of New York Presbyterian Hospital) and I jointly submitted a letter to the V3 Board. In general terms the letter raised concerns about the perceived lack of direction with V3 and the abandonment of some of its advertised goals.

Independently of this letter, two other threads appeared on the HL7 lists which voiced similar concerns. These were initiated by Mead Walker (USA) and Heath Frankel (Australia).

As a result of this letter and the abovementioned email threads, the HL7 Board retreat scheduled for late July has allocated one and a half days of its two day agenda for discussion of these matters. Virginia Lorenzi has been invited to attend as a visitor.

V2 and V3 Microbiology

Although only one two-hour session was originally allocated to this topic, discussion proved so fruitful that a further three sessions were allocated. There was also a lot of informal discussion taking place informally at breaks etc.

We now have consolidated on some considerable common ground concerning how microbiology might be represented in V3 messages. Several areas require some detail to be determined, but the general outlook for V3 Microbiology is extremely positive at least at this point in time.

I believe that the way forward is to contribute to these discussions for V3 until we can hopefully reach a consensus position. We should then look to see how we can transition the recommended Australian format for Microbiology (as described in the Handbook) towards the concepts inherent in our V3 model.

This is the most positive position that Microbiology messaging has been in for the past five years.

Dynamic model

The complexity of the V3 Dynamic Model has concerned me for several ballot cycles and I have been pivotal in getting some substantial changes made eg discontinuing the fine-grained Application Roles. At Cleveland I addressed the Modelling and Methodology Technical Committee about some of my concerns. This presentation seemed to be well received and I had four people approach me later to offer support.

There is now some widespread acceptance that considerable work is required on the dynamic model aspects of V3.

V3 Pharmacy and Pathology

There was very little discussion on these topics at Cleveland because most of the time of the Orders and Observations TC was taken up with resolving ballot responses to v3 Fourth Ballot.

This Technical Committee needs considerable support. Recent teleconferences have failed to raise sufficient interest to constitute a quorum and their work is languishing as a result.

V3 Discharge and Referrals

Continuing a practice started at San Antonio, a small group met on the Monday night and focussed on producing formal UML models for the data required for a Referral and to create a useful storyboard to help our design. The group mainly consisted of Australians but also included Stephen Chu (New Zealand), some UK and Dutch members.

This is a very significant body of work produced essentially by IF14/6/6 Working group members and forms a very firm basis on which the work of that group can proceed.

It is also very satisfying to see many of our International offering support to further this work.

Subsequent to Cleveland, a decision was made to progress this work for Fifth ballot, under the auspices of the Patient care committee.

V2 Items mainly Pharmacy and Pathology

This item was to progress several issues that Queensland Health has identified in specifying the interfaces for our Clinical Information Systems project. This involves changes to HL7 V2 and so must be targeted at V2.6. No work was done on V2.6 at San Antonio because the meeting was focussed on resolution of the V3 Fourth Ballot.

The value proposition for Australian Participation:

At the very least, we should consider the following attributes in our assessment of the value of Australian participation in HL7 Working Group Meetings:

Catering for Australian requirements

Traditionally this has been the only consideration for Australian participation. The value of Australian participation is to directly influence new developments to cater for Australian requirements and to change existing standards where Australian requirements are not currently adequately addressed.

Research and Development

Health Informatics is not a mature discipline and many of the concepts are currently still under development. Australians are often in the forefront of Research and Development thinking in various areas (consider the contribution of Thomas Beale, and Sam Heard in EHR theory for example. Other examples exist for Discharge and Referral modelling and messaging, Microbiology data representation, standardised data types etc etc).

HL7 Working Group meetings provide one of the few venues internationally, where such ideas can be discussed in open forum. Australia has a vested interest in progressing the maturity of these domains and could be seen to have an obligation to provide the resources to do this work.

Governance of International Standards

Australia also has an interest to preserve the integrity of the HL7 standard that we are using (V2) as it evolves. Therefore there is indirect value to be realised by contributing to the governance of V2.

The same values can also be realised from contributing to the governance of the V3 development.

Exposure to new ideas

Further value can be attributed to the ideas that attendees bring back from these meetings. Some of these are quite small, possibly inconsequential in themselves, but others such as the HDF (HL7 Development Framework) are likely to have an extensive impact on the way Australian health informatics presents its ideas and carries its normal business eg application development, enterprise architectures etc.

Another "idea" that should greatly affect Australian Health Informatics (Pharmacy coding specifically and Decision support generally) is the Drug database demonstrated in private sessions by Neil Jones (UK).

Recommendations and Actions

These are updated versions of the recommendations from San Antonio:

1. That the **Requirements Gathering and Analysis phase of the HDF** be promoted as a viable methodology for documenting business processes within Australian healthcare informatics. The diagrams produced from this process should also be promoted because they will simplify the task of explaining to a business expert (eg a Pathologist or pharmacist) precisely what HL7 attempts to do for them. The diagrams should be included into AS4700 documents.

For action by the IT14/6/x committees, possibly assisted by R Harding.

2. That the **Neil Jones drug database be demonstrated** to IT14/6/4 for its consideration. Peter Macisaac might be appropriate to do this. Purpose is to indicate the complexity of data necessary to have systematic Electronic Decision Support in Pharmacy.

For action by IT14/6/4 Chair (I Cheong).

That a coordinated effort be made within IT14/6/6 to **develop a Version 3 Referral message** in a constrained timeframe. This is being done, largely as the result of personal effort by Heath Frankel.

3. That HL7 Australia committee and the Department of Health and Ageing consider whether a **per diem allowance** be provided to attendees instead of the current reimbursement process. This idea was first raised by Heath Frankel.

For action by HL7 Australia executive (in the first instance).

Richard Harding, 30-Jun-2003