

# HL7 Working Group Meeting, Cleveland, April 2003

## HL7 Australia Report

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### ***Introduction***

A well-rounded Australian group of 12 attended the Cleveland Working Group Meeting consisting of 10 previous attendees.

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. The Australian group were seen to cover several committee areas yet there seem to be more than one Australian in the meetings with topics relevant to the Australian HL7 community including Methodology & Modelling (MnM), Control Query (CQ), Orders & Observations (OnO), Laboratory, Pharmacy, Patient Care (PC), Patient Administration (PA), Electronic Health Records, Clinical Document Architecture, Clinical Guidelines and Templates. Often it would be the Australians making a significant contribution to these committees and its committee work.

This was shown no better than by the extra-committee sessions held to progress work on V3 Referral messages and Archetype mapping to the RIM where the facilitators and at least 50% of the contributors were Australian.

This report includes a summary of my activities in various technical committees at the HL7 Working Group Meeting in Cleveland including Australian ballot response reconciliation outcomes. I have included several recommendations at the end of the document.

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 MnM, PA and OnO technical committees including Australian ballot response resolution, Facilitated Patient Care on Tuesday and Wednesday and attended the Facilitators Round Table on Thursday night. I was also heavily involved in the Referral and Archetype mapping extra-committee sessions.

### ***Summary of Meeting Activities***

#### **Modelling & Methodology**

One of the hottest topics in MnM this week from the Australian point of view was the Dynamic Model. Australia was successful in getting it back on the agenda after it was previously put on hold after it was lobbied to be important to a successful V3 ballot. The alternative use of Activity diagrams to the current Sequence diagrams to model storyboards was discussed.

The second RIM Ballot responses from Australia was reconciled with the 9 comments made, 2 were withdrawn, 3 accepted and the remaining 4 found Non Persuasive. Most of the non-persuasive dispositions related to this particular release of V3 and there resolution was deferred until a future release. This was accepted as long as there was a process in place, which would allow the RIM to evolve and be improved.

RIM and V3 versioning was discussed later in the week and guidelines were documented to indicate what can be changed without re-balloting the RIM and others that would require them to be approved via the balloting process. The RIM ballot had sufficient reconciled responses to pass committee ballot and the RIM is expected to be released as a membership ballot in July.

## **Patient care**

Significant work has been done in Patient Care Technical Committee to develop ballot content for a Patient Care domain in the next ballot release. This will include a message for a referral and a care event summary. This including developing a storyboard and referral workflow activity diagram. Significant amount of this work has been and will continue to be done by the Australian and New Zealand contingent outside of this meeting including a Monday night extra-committee session and a Standards Australia IT14-6-6 meeting.

Other storyboards were developed to support a proposal to change the Order mood code to Request. This was approved but an additional proposal to have Order remain as a specialisation of the Request mood to indicate a mandated request was rejected due to the subjective and realm specific business rules to decide if a request is mandated or not. This proposal was accepted at the Facilitators Round Table on Thursday night and later upgraded to improve the definition to ensure that both non-mandated and mandated requests are covered by the same mood code.

## **Patient Administration**

From two Australian ballot response comments made one was withdrawn and the other Accepted. The new section added to the Patient Administration DMIM to represent Primary Care Provider will be extracted to form a Healthcare Provider CMET, which will be used by Patient Care in the Referral and Event summary messages.

## **Orders and Observations**

Significant progress was made to advance the microbiology message dynamic model.

The Australian ballot response was reconciled with 8 of the 14 comments accepted, 3 referred, 2 withdrawn and 1 rejected. In accepting the committee agreed to work on providing more explanatory text and examples to help readers understand how to build messages from the generic structures in the message models.

## **Archetype Mapping**

A few extra-committee meetings were held to provide a mapping of OpenEHR archetypes to V3 RIM structures, which evolved towards a preliminary proposal. A series of RMIM extracts were developed to have a one to one mapping from the OpenEHR List\_s, Single\_S, Tree\_S, Table\_S and History structures. These can be used as a pattern to represent an instance of an Archetype such as a Full Blood Count. These structures are valid constrained models of a generic archetype RMIM extract that may be proposed as an alternative Observation message representation when the required lobbying is carried out. An outcome of this may be an Archetype CMET. Mixed responses were received from initial discussions. This may be a long and hard sell.

## **V3 Tools Training**

Sunday afternoon and evening included a tools training session, which took a room full of people from the writing of storyboards, drawing RMIM diagram, creating HMD's and

generating XML Schema's. This should improve the number of people who have the capability to produce the V3 artefacts including a group of Australians.

### **Next Ballot**

The fifth HL7 V3 ballot will open 21<sup>st</sup> July 2003 including the first Patient Care referral and event summary ballot.

### ***Recommendations***

#### **Travel as a Group**

A smaller group of Australians travelled together to Cleveland than to San Antonio and the trip was not as drawn out but it was still worthwhile having the opportunity to travel as a group. This gave the opportunity to discuss Australian hot topics and strategy while also providing company for the long trip. I recommend that this continue for subsequent meetings.

The Saturday morning and Monday night proved successful as an opportunity for a group of Australian experts to work on a couple of Australian projects with significant outputs. The earlier departure date allows this type of work, which is in preparation for the meeting, can 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. I had very few receipts to present this meeting as most of my meals were in a group where I paid cash.

A fair Per Diem rate (perhaps paid in advance) would ease this overhead without leaving the delegate out of pocket. From discussions with other delegates it seems that most do not bother claiming these expenses because the current system is too hard.

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 extra-committee meeting held Monday night by the Australians to continue the referral work done in San Antonio, and pursued by the New Zealand participant and a sub group of the Standards Australia IT14-6-6 working group. This work needs to have some support to allow its continuance rather than sparsely held and attended meetings as until now. The work done at the working group meetings is great but it becomes stagnant in between meetings. There are several projects underway around the country related to referral and event summaries but they are independently progressing and have no collaboration with the Standards Australia IT14-6-6 working group. I am sure it would benefit everyone if these projects can be coordinated to collaborate under the direction of IT14-6-6 which in turn may inject desperately needed human resources to the working group.

These projects may also be a way to provide funding to get these relevant people together for a couple of days, compensating for time and expenses. This work could be progressed much quicker, with more stakeholders involved and it would not be done when we are all in another country.

### **Continued Australian participation at Harmonisation meetings**

The experience gained from attending the November and March Harmonisation meetings has been significant. Without attending these meeting I would not be capable of supporting the Patient Care Technical Committee in their development of Patient Care messages and the IT14-6-6 V3/CDA sub group.

The informal discussions with the leading participants of HL7 outside the room paved the way for the new Patient Care Provision act class code and change to the Request/Order mood code. It has also helped in creating an impression of commitment to gain the respect to get these kinds of changes now and in the future approved.

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, Vocabulary and CMETs are ongoing topics at Harmonisation meetings and as the role of the harmonisation meeting change it covers more modelling & methodology hot topics and training including dynamic model and message wrappers.

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.

Unfortunately I am unable to attend the next few meetings including Harmonisation due to increased work and personal commitments so this second Australian facilitator and/or Harmonisation representative is even more important.

Along with the changing role of Harmonisation meetings, there has been some investigation into remote Harmonization processes and so far these seem to be working well. However these new harmonisation processes do not cover the additional areas of these Modelling & Methodology interim meetings and their other advantages of on-site participation.

### **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 Cleveland HL7 Working Group Meeting.