

Report on HL7 Working Group meeting - San Diego January 18-24th 2004

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Summary Report

In January 2004 I attended a HL7 international workgroup meeting and Integrating Healthcare Enterprise meeting in San Diego. HL7 workgroup meetings are held 4 monthly with teleconferences every 1-2 weeks between. The following summarises the key issues covered in my report and is hyperlinked to the equivalent section in the full report, which also contains references and document hyperlinks (where these documents have been provided)

Issues covered in this report include:

- Update on terminology and vocabulary issues including SNOMED, Drug terminology and US Government initiatives;
- Progress with HL7 version 3 messaging
- Standards for representation of medical certificates
- Security and role based access control
- Discharge summaries and referrals
- New approaches to implementation of standards
- An emerging standard to share health summaries and documents
- Software to support the design of the clinical desktop.

HL7 Vocabulary Technical Committee

NCVHS report on Patient Medical Record Information Terminologies

The US peak advisory body on health terminology (National Committee on Vital Health Statistics - NCHVS) has recommended the following terminologies and others to make up the standard core for US government health system use:

- SNOMED-CT (diagnosis, procedures and others)
- LOINC (Laboratory only)
- Rx-Norm and components of drug terminologies from the Veterans Affairs and Food and Drug Administration.

Additional recommendations cover integration of terminologies, mapping of the core set to important related terminologies, development of a coordinating entity and linkage with messaging standards. There are 3 key NCVHS reports recently delivered covering EHR vocabulary standards.

[Link to full report](#)

Update on SNOMED - CT and terminology implementation in Australia

SNOMED is due to release an update in January 04 and is continuing to explore avenues for internationalisation. The next SNOMED User Group meeting will be held in October 2004. The drug component of SNOMED, while not currently recommended as a US standard, is being updated with considerable input from the UK NHS.

Discussions were held regarding some of the preliminary issues raised by the GP vocabulary project review of SNOMED including the models used for some SNOMED concepts, the relative merit of

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different approaches to pre and post coordination, the use of terminology to represent context and SNOMED implementation issues. Overall our input was well received and key SNOMED figures presented a genuine interest in implementation issues in countries such as Australia.

I had an opportunity to discuss the Kaiser Permanente implementation of an enterprise wide terminology based on SNOMED-CT. Key features are the use of Kaiser term/concept identifiers which are mapped to the SNOMED identifiers, use of subsets to create value sets for specific data entry applications and non-use of most of the context dependent axis of SNOMED-CT. They have also prepared an allergy subset which is available via CAP. Considerable experience in implementation of SNOMED is being developed and would be worth following up further when Australia is considering this option.

[Link to full report](#)

Drug and Dose Form Terminology

Further progress was made on the analysis of drug terminology models used in UK/USA/Australia. A report on this is to be expected by the next HL7 meeting.

[Link to full report](#)

HL7 Pharmacy-Medication Information Special Interest Group

Pharmacy Messages in V3

The current pharmacy ballot was well received, however there were significant major negative ballots which once resolved will require at least one further committee level ballot prior to declaration of Draft Standard for Trial Use status. Requests for expansion of the current V3 message set were considered however the decision was made to finish the current set to completion for next ballot cycle and add in additional messages as time permits. V3 medication messages are to be implemented in the UK, Netherlands and Canada in 2004. An early adopters group is being formed to work with the various technical committees. A project is underway to compare the common V2 messages and segments with V3 to be sure that there is no key information missing. Likewise a workgroup is looking at the mapping of the CEN standard 13607 to HL7 and a closer working relationship between HL7 pharmacy and CEN related work. Gunner Klein, head of CEN TC 251 (health) attended several of the pharmacy group sessions. CEN have ceased independent production of health IT standards and are now collaborating with HL7. The drug dosage instruction standards paper was revised and is to be circulated to members of the vocabulary and terminology subcommittees.

[Link to full report](#)

Medical Certificate Forms (Structured Documents SIG)

I did a presentation to the Structured Documents Technical Committee on our requirements in Australia for a standard way of transporting medical certificates, potentially using the Clinical Document Architecture. **Recommendation: Australia explore the potential for CDA to be the standard for medical forms.**

[Link to full report](#)

Security and Role Based Access Control

Role based access control allows individuals to access information based on their role and permissions. Role definition has generally failed as each organisation varies and practical trials on role mapping between agencies has failed. - permissions are "bricks" which allows organisations to build their own customised roles. These need to be standardised across systems to allow inter-system communication.

[Link to full report](#)

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Referral and Continuity of Care Records

Further development of the Massachusetts Medical Society- Continuity of Care Record is occurring with overlaps with Australian Discharge Referral and General Referral. This is a standard for CDA document covering referral from physician to hospital and physician.

[Link to full report](#)

Integrating Healthcare Enterprise (IHE): new approach to standards implementation -

IHE is an organisation, sponsored by health user representative groups and supported by vendors which aims to implement existing standards to tackle current healthcare informatics issues. IHE is concerned with solving key current connectivity problems by agreeing on the integration profile to use multiple standards required to complete complex tasks or workflow.

There are a range of profiles based Radiology, Cardiology, General Information Technology, and Laboratory. Website with details of profiles in radiology, laboratory and infra-structure (described as IT). **IHE appears to be a powerful new force in the health informatics scene and may have direct relevance to dealing with complex user and vendor issues in Australia.**

This year IHE and HL7 have joined forces for the traditional HIMSS demonstration which covers 4 scenarios relating to:

- Bio-terrorism (public health reporting)
- Patient Safety
- Drug trials
- Cancer Registry reporting.

Multiple systems are connected in a virtual electronic healthcare system to follow a patient(s) through various scenarios.

[Link to full report](#)

Document Registry - Open Source model (National Institute of Standards and Technology (NIST))

The National Institute of Standards and Technology is a US Federal Government funded agency for the development of testing methods for standards. NIST has been a collaborator in the building of an open source software to implement the OASIS standard for document registry. The goal of the project is to deliver a functionally complete reference implementation for the OASIS ebXML Registry specifications. Such a register may be considered for this role in a *HealthConnect* implementation.

[Link to full report](#)

Longitudinal Electronic Health Record (EHR-LR)

Integrating Healthcare Enterprise (IHE) has identified the longitudinal EHR as a potential subject for profile development in 2004. This is known as the **Cross-enterprise Document System (XDS)**. The EHR model is based on a central or distributed XML document repository, with a document registry managing the query and pointer functions. IHE takes a layered approach to development with this first years proposal covering much of the basic functionality consistent with the basic elements of the *HealthConnect* systems architecture. In the present proposal the document registry will return a list of documents relating to an individual patient (in a Web-search like format) indicating the source and type of document. The current profile does not have capacity to extract structured information and represent it in various user appropriate views. Documentation on the EHR model will be available in June 2004 and vendor implementations by February 2005.

[Link to full report](#)

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Clinical Desktop

The use of internet type solutions to integrate information from various systems into a view able format has driven the need to manage the user desktop. The General Electric health information system was to create the doctors desktop from the perspective of a workstation screen that would be used in direct patient care as well as an alternative format which would be used when between patients. The Opentext software allowed the user to allocate the internet browser screen "real-estate" to various applications, with coordination of user login (no more multiple passwords) and patient synchronisation.

[Link to full report](#)

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Complete Report on HL7 Working Group and IHE meeting - January 2004

Background and meeting objectives:

For further information about HL7 see

www.hl7.org

www.hl7.org.au

HL7 roles - Peter MacIsaac:

- Medication Information/Pharmacy (Committee Co-Chair)
- Vocabulary (Facilitator - International Committee)
- Board Member HL7 (Australia)
- Liaison with Australian Department of Health and Ageing

Specific meeting objectives:

- Further consideration of international approaches to Clinical Terminology including obtaining updates on implementation of SNOMED CT;
- The drug terminology collaboration (US/UK/Australia) continues to look at standards for how this information is structured to facilitate international sharing of drug terminology and drug information resources. This has direct applicability to the medicines coding work undertaken within the Department of Health and Ageing;
- HL7 version 3 is due to be released in part in 2004. I am one of the primary authors of the current version 3 pharmacy ballot for prescription messaging. Although health messaging has been developed in HL7 version 2 in Australia, it is likely that we will eventually move to the new standard, especially to handle more complex clinical messages relating to medication management. I will be working with Australian colleagues to ensure that current (Australian) version 2 functionality is included in version 3 draft standard.
- The medication group also has a workgroup developing standardisation of dosage instructions for use in computer prescribing systems. I am a key member of this group. Such standards or the consistent application of implementation guidelines do not exist or and prevent the use of computer decision support to check safe dosage ranges and calculate the expected duration of supply of a particular medication.

During the HL7 conference the US President in his weekly [national address](#) increased the focus on information management within the healthcare system and doubled the budget from \$50million to \$100million.

Vocabulary Technical Committee

In HL7 standards there is a major reliance on vocabulary to constrain or specialise the general models to meet specific message specifications. This is particularly true of version 3 messages. The vocabulary TC spent some time reviewing the processes for managing internal HL7 vocabularies and is in the process of producing an implementation guide to vocabulary issues covering the full range of activities expected of a vocabulary facilitator (liaison) supporting the content based technical committees and special interest groups.

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[Committee agenda attached:](#)

NCVHS report on Patient Medical Record Information Terminologies

A group known as the National Committee on Vital Health Statistics has been charged with making recommendations to the US Government on terminology issues under the HIPAA and to advise the Department of Health and Human Services. This group has also been working with a US Government process to determine appropriate health informatics standards for use in government systems (known as Consolidated Health Information or CHI). NCVHS have established a formal and open evaluation process and have recommended the establishment of a core set of terminologies for use in US healthcare. There is a process of review of options for key functional areas. The major findings support the

- SNOMED-CT (diagnosis, procedures and others)
- LOINC (Laboratory only)
- Rx-Norm and components of drug terminologies from the Veterans Affairs and Food and Drug Administration.

Additional recommendations cover integration of terminologies, mapping of the core set to important related terminologies, development of a coordinating entity and linkage with messaging standards.

Mapping priorities are to the current HIPAA code sets (procedures, ICD-9 and National Drug Codes (NDC) and to a range of other enabling terminologies (DSM-IV, private sector drug knowledge bases, Medcin, MedDRA, nursing terminologies).

The full report is available at www.ncvhs.hhs.gov. Powerpoint presentation available on request.

There are 3 key NCVHS reports recently delivered covering EHR vocabulary standards:

[Report 1](#) covers the recommendations for the following domains:

Anatomy & Physiology, Billing, Medical Devices and Supplies, Nursing, History & Physical, Disability, Genes & Proteins

[Report 2](#) covers:

Interventions and Procedures: Part B, Laboratory Test Order Names, Medication, and Immunization

[Report 3](#) covers:

The general strategy to develop a core set of health terminologies based on SNOMED-CT. The core set to be investigated is recommended and strategies for implementation. Background to the major recommendations is contained in a [separate report](#).

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Update on SNOMED - CT and terminology implementation in Australia

Ellen Ryske (eryske@cap.org) from SNOMED participates in the vocabulary TC. SNOMED is due to release an update in January 04 and is continuing to explore avenues for internationalisation and this issue was discussed at the recent SNOMED Authority meeting. There has been no change in direction since the preliminary discussions held with the College of American Pathologists last October. The next SNOMED User Group meeting will be held in October 2004. The drug component of SNOMED is being updated with considerable input from the UK NHS.

Discussions were held with Kent Spackman, David Markwell, Bob Dolin and Jim Cimino regarding some of the preliminary issues raised by the GP vocabulary project review of SNOMED including the models used for some SNOMED concepts eg. pain and impact of modelling decisions on use of the terminology for decision support, the relative merit of different approaches to pre and post coordination, the use of terminology to represent context and SNOMED implementation issues. Overall our issues were well received and Kent Spackman (the intellectual leader of the SNOMED-CT project) presented a genuine interest in implementation issues in countries such as Australia.

In essence the comments relating to pain model and use of locality in pre-coordinated concepts will be reviewed by CAP, perhaps with allocation of more appropriate parent concepts, however the practical significance of the issues identified is not regarded as an impediment to the continued use and evolution of SNOMED, subject to further discussion with Don Walker to identify more specific issues. With regard to pre and post coordination there was a strong view that both modalities are required and that a means of reconciling the same concepts in both modes is required. There was some support for the notion of excluding context dependent pre-coordinated concepts if Australia is able to centrally manage the terminology implementation.

I had a meeting with Bob Dolin, Chief Terminologist, at Kaiser Permanente regarding their implementation of an enterprise wide terminology based on SNOMED-CT. Key features are the use of Kaiser term/concept identifiers which are mapped to the SNOMED identifiers, use of subsets to create value sets for specific data entry applications and non-use of most of the context dependent axis of SNOMED-CT. They have also prepared an allergy subset which is available via CAP. Considerable experience in implementation of SNOMED is being developed and would be worth following up further when Australia is considering this option.

Drug and Dose Form Terminology

Further progress was made on the analysis of drug terminology models used in UK/USA/Australia. A report on this is to be expected by the next HL7 meeting. The drug model was also discussed in the context of a review of drug CMETs which are to be modified to cover all required messages.

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The dose form terminology progressed. A presentation from the US Pharmacopeia, one of the US agencies describing dose forms, was made indicating a keenness to work with HL7. A draft terminology is expected to be released by next HL7 meeting.

Pharmacy-Medication Information Special Interest Group

[Committee agenda attached:](#)

Pharmacy Messages in V3

The current pharmacy ballot was well received, however there were significant major negative ballots which once resolved will require at least one further committee level ballot prior to declaration of Draft Standard for Trial Use status.

There was pressure to extend the current message set to include a message confirming what the pharmacy dispense intends to dispense (in the "promise mood") and a range of messages covering the state of the order (abort, cancel, modify). It was agreed that these would be required to have a reasonably full set of messages (mirroring the current Version 2 group). A decision was made to finish the current set to completion for next ballot cycle and add in additional messages as time permits.

V3 medication messages are to be implemented in the UK, Netherlands and Canada in 2004. An early adopters group is being formed to work with the various technical committees.

The HL7 development process now calls for use of UML activity diagrams to formalise the storyboard representation and a simplification of application roles to reflect these systems as "black boxes". Pharmacy domain had already been moving in this direction.

The HL7 tooling to generate XML message schema from the diagrams is being enhanced by the UK NHS fast track project and is expected to be available for training at the next meeting.

A project is underway to compare the common V2 messages and segments with V3 to be sure that there is no key information missing.

Likewise a workgroup is looking at the mapping of the CEN standard 13607 to HL7 and a closer working relationship between HL7 pharmacy and CEN related work. Gunner Klein, head of CEN TC 251 (health) attended several of the pharmacy group sessions.

The newly formed ISO TC 215 Working Group 6 (pharmacy) met in Toronto prior to HL7. They agreed to look at the overall strategy for international standards in medication, however to leave practical standards development to HL7. CEN have ceased independent production of health IT standards and are now collaborating with HL7.

The drug dosage instruction standards [scoping paper](#) was revised and is to be circulated to members of the vocabulary and terminology subcommittees. Paul Frostdick (UK NHS) suggested that they may be willing to lead a fast track project on this early in 2004.

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Medical Certificate Forms (Structured Documents SIG)

I made a [presentation](#) to the Structured Documents Technical Committee on our requirements in Australia for a standard way of transporting medical certificates, potentially using the Clinical Document Architecture. There was considerable interest as the committee has not actively considered the use of CDA in electronic forms

One areas where the use of CDA in forms may stretch the standard is in the ability of the XML documents to be rendered into a human readable form. CDA has a standard transform, however forms will most likely require a specific transformation to present the data in a form specified by the form "owner".

Links have been created with related work such s the Discharge Referral, with special interest from Calvin Bebe (MAYO), Amnon Shabo (IBM), Stephen Chu, Bob Dolin.

The advice given to progress this include:

1. Formal Modelling of Document data
2. Creation of data analysis table (extension of work already undertaken)
3. Modification of CDA DMIM

Recommendation: Australia explore the potential for CDA to be the standard for medical forms.

Security and Role Based Access Control

[Presentation attached](#) - Mike Davis. - DVA Security Consultant.

Role based access control allows individuals to access information based on their role and permissions. VA has to implement role based access control, must have interoperability with DOD, and finally contribute to standards via creation of a healthcare standard for permissions.

A permission is an operation on protected objects. Role definition has generally failed as each organisation varies and practical trials on role mapping between agencies has failed. - permissions are "bricks" which allows organisations to build their own customised roles.

These need to be standardised across systems to allow inter-system communication. HL7 Security Working Group is very active in progressing this but has not yet produced public documents (in a ballot). HL7 and other SDOs eg ISO, ASTM are involved.

Taskforce (Dept Defense, DVA, Indian health Service, Kaiser Permanente.

Advisors: HL7, American Society for Testing and materials (ASTM) and National Institute of Standards and Technology (NIST)

Outcome will be a set of standard permissions (standard vocabulary) which can be used by organisations to develop local roles which are transferable.

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Development of permissions is a general issue, however application in health settings requires considerable health-care domain expertise (rather than a generic model).

This has relevance to EHR (*HealthConnect*) as these permissions may allow consumers to customise access to their health information.

This work is being done by workflow, task analysis, object identification and creation of permission catalogues. It is proposed that each HL7 TC would look at their own workflows to create a distributed workforce.

Major potential for IHE to profile permissions. Suggested that this model start with an intra-enterprise model.

There are some existing work eg [SAML \(Security Assertion Markup Language\)](http://www.oasis-open.org/committees/tc_home.php?wg_abbrev=security) (http://www.oasis-open.org/committees/tc_home.php?wg_abbrev=security).

Further information: www.va.gov/rbac. A copy of a report on Role-Based Access Control (RBAC) Role Engineering Process; Version 1.2 (DRAFT) is [attached](#).

Referral and Continuity of Care Records

Further development of the Massachusetts Medical Society- Continuity of Care Record is occurring with overlaps with Australian Discharge Referral and General Referral http://www.massmed.org/pages/081403pr_AAFP.asp.

This is a standard for CDA document covering referral from physician to hospital and physician. There is considerable overlap with Discharge Referral messaging.

Attached is a [data analysis form](#) representing the data from the CCR.

Using Microsoft Infopath the local XML schema created for the CCR have been covered to CDA format demonstrating the flexibility of XML and the capacity to require transmission in a standard format were such forms to be sent to *HealthConnect*.

Integrating Healthcare Enterprise (IHE)- Standards Implementation

[Presentation link](#) - what is IHE

IHE is an organisation, sponsored by health user representative groups and supported by vendors which aims to implement existing standards to tackle current healthcare informatics issues. IHE is concerned with solving key current connectivity problems by agreeing on the integration profile to use multiple standards required to complete complex tasks or workflow.

Following HL7 meeting I attended the Integrating Healthcare Enterprise Information Technology group - technical committee. IHE is concerned with the interactions/communication between systems, using current standards (from a range of

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sources). It does not tend to influence internal application functionality or business model. The technical committee takes the broad problem definitions created by the planning group and develops the integration profiles to provide the integration required.

The final result of the IHE process is:

- End users define their requirements for connectivity;
- the development of one or many integration profiles by industry based on existing standards;
- vendors demonstrate their conformance with these standards integration profiles in a "connectathon" and are able to advertise their participation and outcomes;
- vendors participate in trade show demonstrations (HIMSS, RSNA, UK, France, Germany, Italy, Japan);
- users can then reference conformance with IHE profiles in Requests for Tender/Purchase

A current IHE Fact Sheet developed for this years HIMSS is [available](#).

There are a range of profiles based Radiology, Cardiology, General Information Technology, and Laboratory. Website with details of profiles in radiology, laboratory and infra-structure (described as IT). http://www.rsna.org/IHE/ff/ihe_tf_index.shtml.

Attached is the [agenda](#) for this meeting: Issues covered included:

- Provider registry (White Pages)
- Security options
- Patient Identifier exchange
- Longitudinal electronic health record based on document registry and repository.

In a parallel process to the technical committee designing next years profiles, vendors gathered to test their applications against the profiles in the IHE Connectathon and prepare for the connectivity demonstration at the HIMSS demonstration.

The HIMSS demonstration which is a joint IHE/HL7 venture covers 4 scenarios relating to:

- Bio-terrorism (public health reporting)
- Patient Safety
- Drug trials
- Cancer Registry reporting.

Multiple systems are connected in a virtual electronic healthcare system to follow a patient(s) through various scenarios. This year the demonstration will include an EHR based on a document registry and retrieval system developed by the NIST which contains many of the features consistent with the *HealthConnects* systems architecture..

Further information on Connectathon/HIMSS demonstration:

<http://rome.wustl.edu/hl7ihe/scenarios/>

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Document Registry - Open Source model (National Institute of Standards and Technology (NIST))

The National Institute of Standards and Technology is a US Federal Government funded agency for the development of testing methods for standards. They do not conduct and publicise test results, however provide other organisations with such capacity.

NIST has been a collaborator in the building of an open source software to implement the OASIS standard <http://www.oasis-open.org/home/index.php>, for document registry. <http://hcxw2k1.nist.gov:8080/hl7services/index.jsp>. The goal of the project is to deliver a functionally complete reference implementation for the [OASIS ebXML Registry specifications](#) as defined by the [OASIS ebXML Registry Technical Committee](#)

Demo site for a demonstration registry based on HL7 Documents
<http://hcxw2k1.nist.gov:8080/hl7services/index.jsp>.

The current NIST download is a local server using PKI access. A web interface being used at the 2004 HIMSS demonstration and available later in 2004.

Such a register may be considered for this role in a *HealthConnect* implementation.

Contacts:

Bill Majruski, Computer Scientist, NIST bill@nist.gov
Len Gallagher, HL7 site manager, NIST

Longitudinal Electronic Health Record (EHR-LR)

Integrating Healthcare Enterprise (IHE) has identified the longitudinal EHR as a potential subject for profile development in 2004. This is known as the **Cross-enterprise Document System (XDS)**.

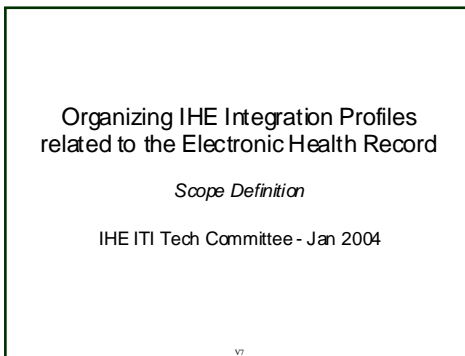
The EHR model is based on a central or distributed XML document repository, with a document registry managing the query and pointer functions. IHE takes a layered approach to development with this first year's proposal covering much of the basic functionality consistent with the basic elements of the *HealthConnect* systems architecture.

In the present proposal the document registry will return a list of documents relating to an individual patient (in a Web-search like format) indicating the source and type of document. This uses a range of existing profiles such as IHE Retrieve Information for Display (RID) profile. This can return document pointers, documents and summary documents for pharmacy and laboratory

The current profile does not have capacity to extract structured information and represent it in various user appropriate views.

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The following [presentation](#) describes the usecases and high level architecture:



The scope of the XDS has been set by the IHE planning committee and the meeting I attended was of the technical committee consisting of systems engineers and technical experts from a range of large IT companies, consultancies and a representative of the French hospital IT users society, the major sponsor of IHE France.

The TC reviewed the use cases, identified the interactions of interest and workshopped the key requirements and data transfer required. These specifications were then compared with available candidate standards (HL7v2, CDAv1, DiCOM) and pre-standards (HL7v3, CDA v2)

A discussion paper will emerge and be published for comment by June 2004. The TC will continue to meet by TCON (their abbreviation for Teleconference) and Australia is welcome to continue participation.

Clinical Desktop

The use of internet type solutions to integrate information from various systems into a viewable format has driven the need to manage the user desktop. One application which I reviewed at the HL7/IHE interconnectivity demo aimed to take the information feed from multiple systems and construct a user defined screen format. Using software from OpenText Corporation (Andre Vandenberg, avandenberg@opentext.com, www.opentext.com) the General Electric health information system was to create the doctors desktop from the perspective of a workstation screen that would be used in direct patient care as well as an alternative format which would be used when between patients. The Opentext project allowed the user to allocate the internet browser screen real-estate to various applications, with coordination of user login (no more multiple passwords) and patient synchronisation. In a way this is an enhancement of the basic functionality obtainable via the windows or apple desktops

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