



HL7 Working Group Meeting May 2008
Meeting Report

HL7 Working Group Meeting May 08

Report prepared by Heather Grain and Elizabeth Hanley

1. The Working Group Meeting International Participation and Strategy

The May 2008 HL7 working group meeting in Phoenix, United States, was attended by one delegate from Australia, Heather Grain, who was funded by the Australian Government Department of Health and Ageing. Four other Australians attended the meeting with funding from vendor organisations or national E-Health programs: David Rowlands; Grahame Grieve; Matt Moores; and Andrew McIntyre. David Rowlands' meeting report is at Attachment 1.

This report provides an outline of the activities of HL7 Global, considers the capacity of Australia to engage in international HL7 activities and outlines the meeting mechanism, thereby highlighting the issues relevant to achieving the Standards Australia IT-014 objectives for international health informatics standards participation and influence at HL7. It should also be noted that decreased attendance at this meeting may have significant impact upon longer term influence on some projects, since return on investment requires ongoing contribution by a consistent delegation membership. Other international delegations take this long term approach and also include additional members from government initiatives to develop skills and understanding of both HL7 standards and processes.

An analysis of attendees pre-registered for the meeting demonstrates other national approaches to HL7 engagement. Attendees at this working group meeting represented a wide range of backgrounds and countries. Figure 1 indicates the investment being made by the international community to participate in, learn from and influence the development of standards at this HL7 working group meeting. These figures under represent the actual attendance as those people who had not registered 1 month in advance were not included in the official list of attendees. Figure 1 also indicates that Australia is falling far behind other countries with similar EHR agendas in its capacity to influence and learn from the standardisation activities at HL7. The current national attendance strategy of four to six funded delegates will put Australia well below the investment and influence of other countries with similar initiatives.

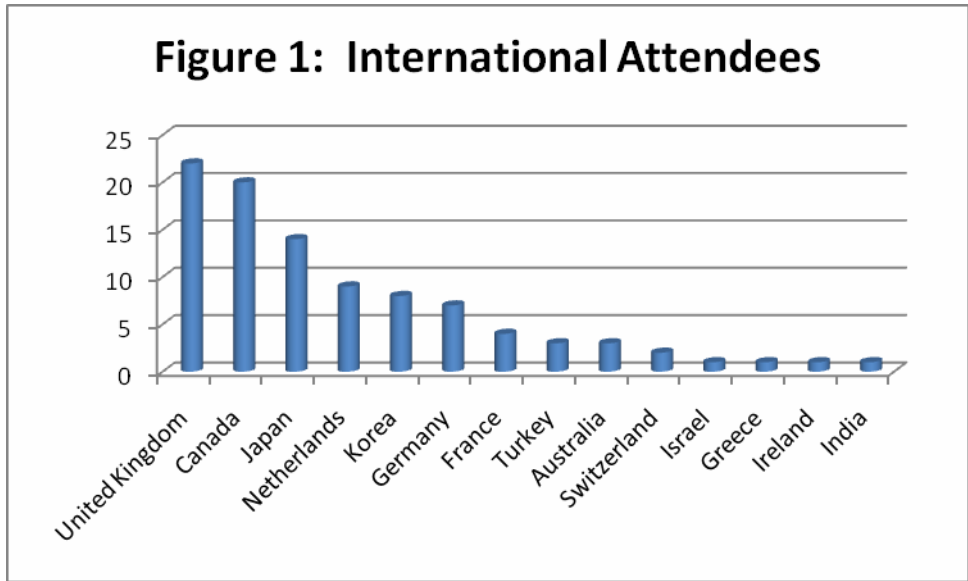
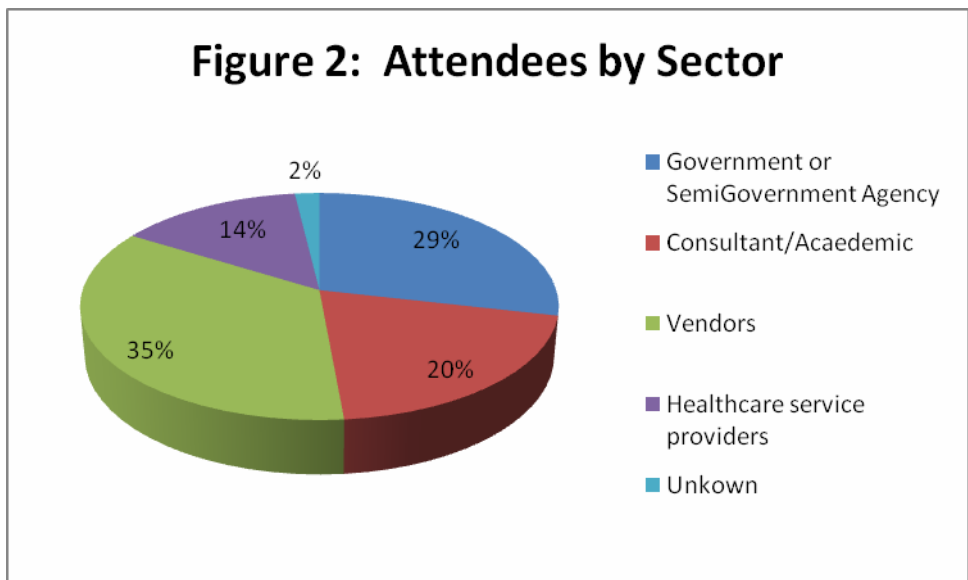


Figure 2 demonstrates the breakdown of attendees by their employment sector or type. The largest category are those employed by vendor companies who support their staff attendance and often effectively fund HL7 work by allowing their employees to spend x days per week on HL7 related activities in addition to weekends and evening time. The next largest group are the government/semi-government agencies such as the National Library of Medicine, national programs in Canada, UK and other countries. The third group are expert consultants and academics from a wide range of countries largely there on behalf of national programs or large government agencies. Healthcare service providers attending are often representatives of clinical professional groups or large health care organisations seeking implementation solutions. These attendees are largely paid to attend by their employer, or they are funded as employees or consultants to national programs to influence HL7 developments, and return expertise to their own country.



In the Vocabulary Working Group a straw poll indicated that attendees were paid to attend the meeting, either by their employer or their national body as part of consultancy arrangements. This fiscal support does not negate the voluntary nature of much of the standards development work which is done on weekends and evenings, outside work time, but does indicate the value attached to

the activities by employers and national programs. The current Australian approach to fiscal support of standards activities, and the volunteer community, is inconsistent with this fiscal model.

This HL7 Working Group meeting generated a number of activities requiring further progress, which are of significant concern to Australia. Consideration will need to be given to how these ongoing activities should be funded. There are very few true volunteers, attending without payment as is the case with the Australian delegation funded only for travel costs, despite the expertise and demonstrated capacity to influence shown by the Australian delegates in the last few years. This is a strong indication of the commitment of those volunteers and the value they offer from the perspective of the international community.

There is also an increasing correlation between ISO and HL7 attendees to enhance harmonisation of work across these two major standards development organisations.

HL7 meetings have a heavy schedule of activities extending from breakfast meetings to late night sessions. Table 1 shows the working group timetable. Shaded areas indicate groups where items of major Australian interest are being discussed. There are administrative and harmonisation meetings in addition to those shown in Table 1, that occur throughout the schedule. The number of concurrent sessions makes it impossible for a small delegation to effectively follow the issues and to influence meeting discussions. A small delegation also impacts Australia's capacity to influence voting for positions of influence, resulting at this meeting in the failure of a candidate with strong understanding of Australia's requirements and situation to gain a co-chair position. This review of the activities identified in the international objectives for international engagement highlights the need for a delegation of at least 12 – 13 people to cover all the concurrent meetings.

Table 1: Meeting Schedule highlighting areas of major Australian interest

	Sun	Mon	Tue	Wed	Thur	Fri
Affiliates Council	X				X	
Anaesthesiology			X			
Architectural Review Board (ArB)	X		X	X	X	
Arden Syntax			X			
Attachments		X	X	X	X	
Cardiology				X		
Clinical Context Object Workgroup (CCOW)			X	X		
Clinical Decision Support		X		X	X	
Clinical Genomics				X	X	X
Clinical Interoperability Council					X	
Community Based Collaborative Care		X	X	X		
Electronic Health Records	X	X	X	X	X	
Electronic Services				X		
Emergency Care			X	X	X	
Financial Management	X	X	X	X	X	X
HL7/CEN/ISO	X					
Health Care Devices		X	X	X	X	X
Imaging Integration			X	X		
Implementation conformance		X	X	X	X	
Implementation Technology Specification				X	X	
Infrastructure and Messaging		X	X	X	X	X
Laboratory		X	X	X	X	
Modeling and Methodology	X	X	X	X	X	X
Orders and Observations		X	X	X	X	X
Patient Administration		X	X	X	X	X
Patient Care		X	X	X	X	X
Patient Safety		X	X	X	X	
Pharmacy		X	X	X	X	X
Public Health Emergency Response		X	X	X	X	X
Regulated Clinical Research Information Management		X	X	X	X	X
Security			X	X	X	
Services Oriented Architecture		X	X	X	X	
Structured Documents		X	X	X	X	

International representation is also increasing at the HL7 Board level, specifically with representatives from Canada and the UK now appointed as Board members. This international involvement is also reflected in working groups and administrative processes that affect the HL7 infrastructure. It must be recognised that Australia and its volunteers' major investment in international developments at HL7 is at severe risk due to lack of participation at this meeting. There were insufficient Australian members present to influence co-chair elections. This resulted in a UK candidate who has a strong understanding and sympathy with Australia's requirements not being elected as it was not possible to bring in enough voters to influence the vote.

2. Issue focused objectives

2.1 Monitoring and Influencing HL7's strategic position as a global SDO

The restructure of HL7 committees and processes are starting to positively impact upon harmonisation. Processes are changing. Care is being taken to manage the process of change and issues management. There is also an increasing willingness in some of the working groups to consider harmonisation and work done by other standards bodies. This is a significant change. However, it will take further effort to continue to influence this change in attitude within working groups and within the hierarchy of HL7.

There are significant issues in the management of vocabulary. Each new or changed standard must be reviewed for vocabulary consistency and quality prior to publication. This is a time consuming process. There are tools that have been designed to assist in this process, but vocabulary server and tooling need to be updated to make the management of new vocabulary easier. Currently the reconciliation of vocabulary updates is falling behind due to the size of this job and the lack of fiscal support for the activity. The Technical Steering Committee is looking into alternatives for the upgrade of the vocabulary tools and the management of the process. There is a need for an organisation to fund a real vocabulary governance process.

2.2 Negotiating the inclusion of Australian requirements into HL7 V2.x and V3 specifications

There was considerable discussion on the issue of vocabulary in V2. The National Library of Medicine is investigating the use of V3 concepts in V2 messages. This is a massive change to existing techniques. CDC and HITSP require want interoperability between V2.x and V3. This is based upon practical implementation issues where messages are coming in and going out in both forms.

A ballot for V2.7 will be released that includes some of these issues. The ballot will be re-opened as the changes are so significant.

Issue: Australia needs to consider the impact of these changes and how backwards compatibility will be managed.

2.3 Negotiating the inclusion of Australian requirements for EHR interoperability and function.

2.3.1 Privacy/Access Control

The requirement for a standardised approach to the management of information about access control and privacy requirements for all records, including electronic health records is recognised. However, HL7 has had a disparate approach to this issue. Though the Security Technical Committee is working to develop messaging requirements consistent with ISO requirements for role based access, there are other committees, Community Based Collaborative Care in particular where these efforts are less considered and coordinated. There are other working groups that have developed their own approaches to this material.

At this meeting The Domain Experts Steering Division meeting (held in the evening of the 5th of May) considered this issue. Australia called for a consistent and harmonised approach to this issue. Investigation and lobbying after this meeting has resulted in acceptance of the need for an 'environmental scan' of HL7 standards and current work items, in conjunction with ISO/CEN documents to scope and quantify the problems. This activity also requires consideration of the ontological clarity of the concepts used in the current message standards. The environmental scan will be used to inform a purpose specific taskforce.

Issue: The development of an access control/privacy environmental scan of standards documents and activities is a task likely to take some weeks of work. This work must be undertaken by people with a sound knowledge both of HL7 and ISO. It is unlikely that this task would be able to be achieved before the next HL7 meeting in September 2008.

Role Based Access Control is being progressed in the Security Technical Committee. A V3 Role Based Access Control (RBAC) permission catalogue has been developed which allows for interoperable access control among healthcare business partners. This work has been developed using five interactive use cases that demonstrate how healthcare security and privacy policy is enforced. These use cases include patient consent directives, clinical roles and permissions, emergency access, HIS security policy and Patient-Directed Data Filtering. These are all expressed as XACML Policies. A full interoperability demonstration is planned for the HIMSS meeting in April 2009.

2.3.2 Terminology Services

Common Terminology Services (CTS) – This work item is defining the use cases and functionality required of a clinical terminology server. The initial version of this standard CTS1 only considered the reading of terminology, the current work item CTS2 is extending this to the management of terminology and terminology servers, including mapping processes. The inclusion of the ISO specifications for best practice in terminology to the definitions and use case in this document is a strong harmonisation activity. It is important that those involved with the implementation of SNOMED in Australia and at IHTSDO, as well as those determining strategic directions for the processes of management of SNOMED contribute to the use cases in this document to ensure that their requirements are met, and that the development of SNOMED can take advantage of any initiatives that might simplify the processes of terminology service management.

2.2.3 TermInfo

TermInfo is the short name for the SNOMED CT implementation guide for HL7 V3. The document includes a general approach to resolving issues related to the interface between HL7 information models and terminologies or code systems using SNOMED and semantics for the representation of SNOMED in messages. The document emphasises how to communicate clinical information and preserve the semantic integrity of the statement. At this stage this work does not consider how to communicate the point in the workflow associated with the terminological concept. The document currently specifies how to communicate semantically reliable clinical concepts, but there is a recognised need to include context (the information in the model). This can be achieved through archetypes, but this is not covered in the document. The focus of this current version of the implementation guide has adhered tightly to semantic interoperability. There is a need to consider additional work that will cover the problems of workflow and process communication that as yet do

not fit clearly and it is not known where these are to be addressed. The extension of the work to cover terminology more generically, for example to include LOINC concepts is being considered.

2.4 Negotiating the harmonisation of ISO, HL7 and CEN standards.

The objective is to negotiate the harmonisation of ISO, HL7 and CEN Standards (in particular CEN/ISO 13606 and HL7 V3), to achieve progressive inter-SDO eHealth standards harmonisation with the goal of a unified set of global health informatics standards.

Specific issues of harmonisation that have been progressed at this meeting include identification, privacy and the glossary.

2.4.1 Identification

The Patient Administration working group have accepted that project proposals for harmonisation of identification in V2 and V3 be prepared for HL7 consideration at the next meeting. This is an action item for Heather Grain. Discussion of identifier vocabulary issues and harmonisation of datatypes was also initiated. Grahame Grieve and Heather Grain are to consider the requirements and identify a potential solution. The objective of this activity is to harmonise the ISO/Standards Australia standards that identify data components to meet the functional requirement of the identification process, and the metadata identified in HL7 to communicate the identification of an individual between systems.

2.4.2 Health Informatics Glossary

There is a need to harmonise health informatics terms and have the resultant glossary readily available through the web. The Vocabulary Technical Committee have agreed that the use of the ISO glossary process and tool be trialled with the inclusion of the current HL7 glossary and that this be a project put forward to the SDO Harmonization Joint Working Group as a joint activity. The objective of this activity is to:

- a) Provide a web based, open tool to lookup terms and their definitions, and to identify the context and documents within which the term is used. Thereby simplifying the development of standards, and encouraging consistent use of terms.
- b) Maintain the terms in the tool to identify a single preferred definition of each term and, where there is a need for variation, to clearly identify the context in which the different definition applies. The tool also includes the concept of synonyms.
- c) Develop a process for cleansing the existing terms used, to harmonise and make consistent the terms used in health informatics standards.

Vocabulary Technical Committee intend to include the definitions from the core principles document in this activity once the site and process have been trialled at ISO. The implication of this is that IHTSDO, NEHTA and DOHA etc should attempt to use consistent definitions for health informatics concepts in an effort to improve the understanding of the numerous issues in this area and reduce confusion and cross purpose discussion.

Issue: There will need to be discussion on how access to the information in the glossary will be made available. Access needs to be free of charge if it is going to meet the intended objectives. At this point ISO are processing the specification and process as a standard, rather than the actual glossary. The tool development has been sponsored by Canada Health Infoway. There has been no

funding for the management of the glossary content which is currently being undertaken on a volunteer basis.

2.4.3 IHTSDO

There is considerable ongoing concern amongst some of the attendees at the HL7 Working Group Meeting with the perceived failure of IHTSDO to engage with the terminology community. This problem is more severe in some countries than others. There has been discussion in Australia and internationally about the establishment of a formal user group to inform and assist IHTSDO development. The most significant issues raised include:

- a) Lack of knowledge of independent developments in the community and in IHTSDO, leading to incapacity to leverage the power of sharing and joint development.
- b) Lack of coordinated development activities and involvement of harmonised input, appropriately resourced.
- c) Major SNOMED related activities.
- d) Relationship between IHTSDO and HL7 – this is informal. There was attendance by people actively involved in IHTSDO core activities for 7 of the 20 quarters. The other issue is that an understanding of terminology services by NEHTA, and the ontological clarity of expressed at these meetings would be highly informative to any person working on the detail of SNOMED – HL7 considers the practical issues of implementation of SNOMED and as such offers the potential to greatly assist the development of SNOMED itself.

2.5 Monitoring and influencing new initiatives to standardise clinical data content

There is a significant problem with Vocabulary documentation. Most of the documents produced are understood by those actively involved, but not clear to others, and are at times inconsistent when implemented. For this reason, with the support of Canada, Heather Grain achieved agreement that the new document being developed to explain the core principles of Vocabulary (and modelling) will include diagrammatic explanations, examples and the rationale for the processes described. This approach requires editorial input from a wider group of authors than those originally intended. This approach is required to support greater consistency of process and decision making in the vocabulary technical committee, a problem for which the committee has been criticized in the past.

Heather Grain has also started to document the processes for access to and contribution to Vocabulary information (because it is not currently clear nor is it a simple/straight forward process). She anticipates completing this document in the next few weeks.

Issue: Consider if Australia should establish liaison responsibilities for individual working groups and provide to the relevant agencies similar access and contribution information.

2.6 Assessing and influencing HL7's work on service oriented architectures (SOA)

There was considerable energy at this meeting surrounding the management and control of SOA work. HL7 leadership desire to take over much of this work from the HSSP project and make it HL7 oriented. This issue is ongoing. Though this is largely a power issue there are implications for

Australia and a need to ensure that the process of SOA development is ongoing and does not lose momentum.

The Architecture Review Board (ArB) is one of the factors behind the power play. The Arb is the tool that the HL7 leadership are using to enforce change. ArB works to the Technical Steering Committee and this committee needs to deliver improvements. Some of these difficulties arise from issues of power, and some from the consequence of technical issues related to the size of the task.

Issue: HL7 Australia, Standards Australia and NEHTA need to track what the ArB is doing. Grahame Grieve sits on the ArB and will be able to monitor and provide feedback.

2.7 Assessing, exploring and proposing approaches to the embedding and transportation of archetypes in HL7 V2.x messages

Heather Grain was not able to pursue this issue at this meeting, however the development of documentation in the Vocabulary Technical Committee on terminology binding, will include generic approaches, including archetype concepts in V2 messages.

2.8 International harmonisation of common data types and terminologies

2.8.1 Data Types

This meeting established a purpose specific task between InM and Vocabulary to harmonise entity identifiers between datatypes V2.x, V3 and ISO. This task is to be completed before the harmonisation phase for HL7. The results will be taken back to ISO, and will be reflected in the revised Australian Standards on identification when resolved. Abstract data types has passed ballot with removal of qualifier which has made this more effective. This approach relies on IHTSDO to cover this issue however there is no progress on this from IHTSDO.

Issue: There is no current process for identification of IHTSDO work items generated from HL7 activities.

2.8.2 Core Principles Document

This is a document being prepared by the Vocabulary TC and MnM. The document is designed to explain the general principles and processes of HL7 modelling and vocabulary for people who are new to HL7 concepts. It is intended as a first stop for implementers and for those wishing to understand HL7. The meeting determined that the document must include more examples and diagrams to make issues clearer as the current status of the document, though certainly a draft, is generally understandable only to those who already know exactly how everything works. To this end the document will have a major review. The next draft is likely to be a worthwhile document to forward to IHTSDO representatives in Australia for comment and input both to inform the document, and to educate the relevant representatives.

2.9 HL7 Development Framework and Conformance Profiles

This issue was not pursued at the May 2008 HL7 meeting.

3. Achieving Objectives

The general objectives of Australian engagement in HL7 meetings are:

- improving Australian capacity to apply health informatics and develop health informatics standards by expanding domestic knowledge and expertise based on international best practice.
- promoting free trade and its benefits to health ICT (by lowering the cost of integrating and implementing health information systems, many of which are imported, and by reducing costs to Australian exporters) – both these outcomes require Australian requirements to be embedded into global standards so that they can be adopted in Australia, rather than having different standards across domestic and international markets, and
- improving Australian health information systems by facilitating a standards-based approach to development and implementation, and achieving interoperability between systems.

Although a written report of attendance at the HL7 meeting is regularly provided by the funded delegates, this report does not, in and of itself, educate and develop skills in the Australian health informatics and infrastructure development community. The current reporting process does not support active learning, mentoring or information exchange that enhances domestic knowledge. A specific strategy to achieve this objective should be considered. This could include:

1. Information exchange workshop upon return of the delegation with an open invitation to attend and contribute to further discussion that advances Australian knowledge and identifies more clearly Australia's position on important issues.
2. Identification of task specific liaisons (contact people) to allow the delegate/s to directly inform and gain opinion from national and state activities in a given topic. This approach requires the identification of individual liaisons for each major topic area. For this strategy to be effective communication must be direct and informed. This has not been the approach in the past and opportunities to develop understanding and skills have been lost. Relevant documents could be made available to these liaisons to ensure that awareness of issues is high and that Australia has a truly harmonised response considering the needs of all stakeholders. The current situation, where there is minimal involvement from the government agencies relies upon individuals finding out about documents and being able to access them, which can be difficult.

Any such approach needs to recognise the cost to the volunteer delegate of reporting time, and feedback time. This time, in addition to the time taken to prepare for and contribute to standards development activities is often more than twice the time taken to attend the meeting itself.

Promotion of free trade requires more active implementation of standards in system requirements, where health care system purchasers become more demanding of the software vendors. This strategy would have been an expensive and potentially high risk strategy in the past; however, with the increasing requirement for vendors to meet international standards (particularly in the European Union) the application of this approach is consistent with those of other nations with E-health initiatives.

ATTACHMENT 1

Meeting Report prepared by David Rowlands

(Note: David Rowlands was funded by NEHTA to attend the HL7 Working Group Meeting)

There were 439 registered attendees from 16 countries, including 15 International Affiliates, at the Phoenix meeting. About 25% of the overall attendance was from outside the US.

Australia was relatively lightly represented at the Phoenix WGM.

Clinical Document Architecture (CDA)

HL7 has no comprehensive register of CDA implementations, and the number of actual, currently working implementations is still thought to be relatively limited. However, a series of substantial pilots are also underway or imminent and an increasing number of (US) EHRVA vendors have indicated that they either currently have or intend to have US-released products that handle CDA.

A range of international e-health programs are also thought to be using CDA, but HL7's list includes countries considering as well as those who might have actually implemented CDA. For example, the list includes Australia.

HL7's CDA standards development activities are focussing on Implementation Guides for specific applications. The Continuity of Care Document (CCD) Guide (see below) has already been published, and Guides are currently being developed and/or balloted for History and Physical Exams; Consultations; Operational Notes; and Healthcare Acquired Infections.

A Structured Document Architecture is being developed to, among other things, provide a framework for a range of order set documents; there is work underway in paediatrics; and a clinical document related to home monitoring is nearing ballot, having been developed jointly with the Continua Alliance.

Other next steps will be to assimilate requirements for CDA R3 over the next 18 months or so, and develop a project plan for revising the CCD to incorporate international requirements and address implementation feedback. The CCD was developed primarily for the US realm.

An external group, CDA for Common Document Types, is also developing CDA implementation specifications and then submitting them to HL7. A range of IHE profiles are closely aligned with the HL7 clinical document specifications.

CDA Implementation Forum

The 9th International HL7 interoperability Conference, to be held in Crete in early October, will focus on CDA implementations. CDA implementers globally are being encouraged to register their use of CDA and share implementation learnings in a "CDA show and tell". This will be complemented by an IHE workshop.

Service Oriented Architecture (SOA)

HL7's senior management has now recognised the strategic importance of SOA in healthcare ICT and is looking to both refine HSSP's modus operandi and supplement the HSSP with a broader SOA program. The content of the latter is still to be determined,

but the highest priority is to develop an "HL7 architecture" view of SOA. The precise meaning of this is still unclear, but it appears to embrace:

- Clear articulation of an HL7 position on and principles for involvement in SOA-related activities;
- Clarification of the way in which HL7 manages its SOA related activities, and the boundaries between HL7 and other organisations such as the Object Management Group (OMG). This includes articulating the roles of HL7's Architecture Review Board vis a vis the SOA special Interest Group and the HSSP;
- Articulation of the relationships between SOA, HL7-SOA products and other HL7 products (such as the RIM)

HSSP

To date, the HSSP has produced a methodology and has the production of several services in process:

- Requirements for the Entity Identification Service (handling identity management interfaces such as patient master indexes) and the Record Location and Use Service have been published by HL7 as Draft Standards for Trial Use (DSTUs). These will expire as DSTUs in September 2008 and will need to be progressed to normative standards.

Initial technical submissions have been developed under the OMG processes, and these are currently being revised. This should be completed by about September.

- Decision Support Service requirements have been published and an initial technical submission is due via OMG in about September.
- The Common Terminology Service (CTS2) requirements are due for HL7 balloting in September, after which an RFP will be issued (around December). Technical submissions will be developed thereafter.
- Requirements for the Privacy Access and Security Service are expected to go to HL7 ballot in January 2009.
- The Human Services Directory (HSD) project appears to be at risk due to lack of broad support in developing requirements.
- The HSSP project is also developing a Practitioners Guide to service specification, an initial draft of which should be ready in the third quarter this calendar year. This will include a "samplehealth" provider's architecture that incorporates legacy applications and illustrates how SOA components can be incorporated. It will work down through layers of architecture. Reviewers have been requested for this work stream.

Data standards

There are two current initiatives within HL7 that are focussing on data standards and which may be of interest to NEHTA's clinical information initiative:

- The Detailed Clinical Models project aims to represent standardized clinical content in ways that can be implemented in different standards paradigms and technologies; and to build a repository of such models.

- The Clinical Interoperability Council is endeavouring to strongly engage clinicians in standardising the data elements they require in those areas where cross organisational information exchange is abundant.

Neither of these initiatives is currently well advanced – despite significant interest, they are still largely shaping their agendas.

Tooling and Implementation Support

Effective tooling for HL7 v3 has been a major topic for the HL7 Board which has now recognised that:

- Effective tooling is critical to successful and consistent HL7 deployment;
- HL7 does not have the resources that would be required to develop a comprehensive, high quality toolset; and
- It must therefore support opportunities to leverage HL7's tooling efforts by building on substantial investments being made in the wider stakeholder community, including the Open Health Tools Community.

Accordingly, key focus areas for tooling within HL7 are:

- Having tooling that is consistently able to support both internal HL7 standards development and external users seeking to implement HL7
- Aiding the consistent publishing of Standards, Implementation Guides and specific-use instance specifications
- Supporting all HL7 products – CDA, v3, v2 and others (where appropriate)
- Resolving existing problems with publication, schemas and CDA templates
- Producing implementation guides that people actually use or need for implementation
- Making best use of the Eclipse open source platform and potentially useful donations of existing tools that might be adapted to HL7's particular needs.

HL7/CEN/ISO Joint Meeting

The next formal meetings of the Joint Initiative (for which Standards Australia provides the Secretariat) are in:

- Early June - Gothenburg Sweden (in conjunction with joint ISO TC215 and CEN TC251 meetings).
- September 2008 - Vancouver Canada (in conjunction with the HL7 Plenary WGM).

However, a meeting of the ad hoc group promoting HL7-ISO-CEN Collaboration was held and was attended by well over 50 people.

Relevant ISO activities include:

- V2.5 DIS ballot closes June 10; same with CDA R2;
- EHRS FM ballot closes 24 September; also CTS R1;

- ISO13606-1 was published in 2008; Part 2 is due for FDIS ballot soon; DIS ballot results have been distributed for Part 3; the Part 4 DTS ballot closes 28 Jun; and Part 5 has been submitted for DIS preparation. Connecting for Health has undertaken an investigation of the feasibility of interchanging EHR extracts (bi-directionally) between 13606 and HL7 based systems. Recommendations include:
 - Interchange is possible but it is preferable to adopt a single interoperability framework;
 - The Detailed Clinical Models (see above) or something similar that abstracts data standards is worthwhile;
 - OpenEHR/13606's constraint mechanisms are very useful because they hide technical detail from clinicians/end users;
 - Alignment of vocabularies is needed.
- The Data Types DIS ballot closes 24 September;
- Laboratory reporting is at Committee Draft stage, as is the Drug Dictionary and the Identification of Medicinal Products (product IDs, ingredients, units of measure, etc);
- ISO 21091, Directory Services, is currently a TS but is moving to full standard. It will be important to ensure that the HSSP HSD project is aligned with this;
- Re Data Types - joint balloting processes across the 3 SDOs had been scheduled between March and August, to enable joint reconciliation processes at HL7 in Vancouver and beyond. However, this deadline was not met. The ISO ballot was passed, with a small number of technical issues to be resolved. Contingency plans for continuing synchronization efforts were identified, and there will be significant discussion on data types in Vancouver in September.
- ISO 18308 (Requirements for EHR Architecture) is being redrafted in light of subsequent publications including the Definition, Scope and Context of EHRs, The HL7 EHR-S FM and Interoperability Model, 13606 etc. The aim is greater coherence. A draft will be discussed in Sweden.