HL7 NEWS
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In This Issue...

HIMSS 2008: Creating the Best and Most Widely Used Standards in Healthcare

The 2008 HIMSS Conference and Exhibition proved to be another success for Health Level Seven. HL7's exhibit attracted widespread attention on the showroom floor, where attendees could learn about how HL7 is creating the best and most widely used standards in healthcare today.

The HL7 HIMSS 2008 exhibit was made possible through the generous support of our sponsors. HL7 extends special thanks to Eli Lilly and Pfizer for sponsoring the Education Theater, Interfaceware for sponsoring the duplication of the Intro to HL7 CDs, and Language and Computing for sponsoring an educational session. These sponsors were also recognized in advertisements, the exhibit brochure and on-site signage, providing exceptional exposure and a rewarding experience.

Charles Jaffe, MD, PhD, presents the HL7 Roadmap to HIMSS attendees at the HL7 exhibit.

The HL7 Educational Theater showcased twenty-four well-attended sessions on compelling HL7 subjects such as Claims Attachments and HIPPA, Clinical Document Architecture (CDA), Clinical Genomics, the Continuity of Care Document (CCD), Electronic Health Record System Functional Model (EHR-S FM), Personal Health Record System Functional Model (PHR-S FM), Services Oriented Architecture (SOA), Version 2 and Version 3. HL7's CEO, Dr. Charles Jaffe and CTO, John Quinn also presented HL7's new Roadmap. Other sessions included talks by the Australian Healthcare Messaging Laboratory (AHML), the Electronic Health Record Vendors Association (EHRVA) and Integrating the Healthcare Enterprise (IHE).

HL7 would like to thank all of the speakers who volunteered as well as our exhibit sponsors for their help in making HIMSS 2008 a successful event for HL7. It is through their support, time and effort that HL7 is able to develop, test and gain wide acceptance of its standards.

Save the date for HIMSS 2009!

Please plan on visiting the HL7 exhibit at HIMSS 2009 in booth #2427. Mark your calendars now for HIMSS 2009 next April 4-8 at the McCormick Center in Chicago, IL.

The Joint Initiative Council

By W. Ed Hammond, PhD, Chair, Health Level Seven

W. Ed Hammond, PhD

Perhaps the most damning thing that can be said about standards is "The nicest thing about standards is that there are so many to choose from." Even worse, we have too many standards organizations, each with its inconsistent set of goals and internal conflicts.

In the healthcare arena, a number of Standards Developer Organizations (SDOs) emerged for a well-defined focused purpose, but, over time, evolved into producing broader-scoped standards. The participants in each of these organizations were friendly enough, and in many cases were the same people. In the early years, the leaders of HL7 and the European Committee for Standardization (CEN) shared ideas, documents and processes. We did not view ourselves in competition; we were more interested in becoming important in the vendor and provider communities. As the global market developed, these same SDOs began to produce competitive standards. Memoranda of Understanding supported cooperation, but each group still produced its own set of overlapping and competitive standards. Some of that competition was forced by the need for survival from sponsoring groups – whether members or governments.

Both the International Organization for Standardization (ISO) and CEN develop standards in a number of technical areas, with healthcare being a smaller component. Many nations mandate the use of ISO standards. An agreement for technical cooperation between ISO and CEN was approved by both groups in 1990. This agreement, called the Vienna Agreement, was published in 1991. It sets out two essential modes for collaborative development of standards: one mode under ISO lead and another mode under CEN lead, in which documents developed within one body are submitted for the simultaneous approval by the other. The transfer of work from CEN to ISO is the preferred direction and has been used for health data standards.

In 1998, encouraged by leaders in the U.S. and Europe, ISO created Technical Committee 215: Health Informatics. ANSI was named Secretariat of the TC. Individuals, representing their own countries, came together in TC 215 to create health data standards. Members of Working Group 2, Messaging and Communication, agreed that no existing standards would be fast tracked into the ISO process. After about a year, however, the WG2 activity shifted into the HL7 work space as HL7 international activity increased.

In 2002, following the lead of the Institute for Electrical and Electronic Engineers (IEEE), HL7, working through ANSI, negotiated an agreement with ISO to become an ISO Standards Partner. Under this agreement, HL7 may submit HL7 standards to become International Standards, subject to the agreement of TC 215, using the standard approval process. The HL7 RIM was the first standard to receive approval in 2006 and was published as the ISO/HL7 21731:2006 – Health Informatics – HL7 Version 3 – Reference Information Model. Three additional standards: HL7 Version 2.5 Messaging Standards; Common Data Architecture, Release 2; and Common Terminology Server, Release 1 are in Draft International Standard (DIS) ballot. The HL7 EHR-S Functional Model is also being prepared to move forward to a DIS ballot.

In late 2005, HL7 submitted four regulatory standards to ISO: Structured Product Labeling, Release 1; Individual Case Safety Report; Stability Study; and Annotated Electrocardiogram. TC 215 did not accept any of these standards (most nations abstained). In addition, the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH) was very concerned because they had standards in some of these areas. At the 2006 IHC meeting in Yokohama, Dr. Yun Sik Kwak, representing ISO; Ian Shepherd, representing CEN; and Ed Hammond, representing HL7 made presentations to the group about their respective organizations. As a result, ICH became a Class D Liaison with ISO and developed relationships with both CEN and HL7.

The ISO/CEN Vienna Agreement and the ISO/HL7 Standards Partner increased the productivity of ISO standards, but they did not solve the problem of overlapping standards. For example, the CEN standard 13606 overlaps with several HL7 standards. CEN and HL7 groups worked on harmonizing these two standards, but harmonization was essentially mapping the two standards to each other. It is obvious that this is not the most productive approach.

Presentations by Dr. Kwak, Chair, ISO/TC 215; Kees Molenaar, Chair, CEN TC 251; and Ed Hammond, Chair-elect HL7, at the Global Health Informatics Technology Standards Summit in Geneva, suggested the three SDOs might be able to work jointly to produce a single standard for a single purpose. An agreement was made to work together, and a charter for the agreement was written with Don Newsham of Canada taking the lead. This charter was later ratified by all three groups.

The charter establishes a Joint Initiative Council (JIC) which includes the chairs of the three participating organizations plus two additional representatives from each SDO. Any joint project must be agreed to by this group. A Joint Working Group (JWG) was also created, managed by ISO, which includes members from the participating SDOs. The purpose of the JWG is to work through the details of any joint initiative project, identify potential new projects, help develop policies and procedures, and support the work of the JIC. Each JIC project will be hosted by one of the participating SDOs, with that SDO providing a chair or lead for the project. Each of the other SDOs will provide a co-chair to ensure that the resulting work meets the needs of each participating SDO.

The work on any project will be done jointly by volunteer members from each participating SDO, working as a cohesive unit. The three SDOs will be considered equal in the work process. The resulting work product will be balloted simultaneously by each participating SDO, and the comments from each SDO will be aggregated and processed by the joint project team. The resulting standard will then be the joint property of each participating SDO and will carry a shared copyright along with the logo of each SDO.

There are currently four joint initiative projects. The first of these projects is data types – a standard that had been under development for five years, trying to bring together the requirements of ISO, CEN and HL7. Under the joint initiative, this standard is currently entering a second round of balloting in ISO, CEN and HL7. This progress is mainly a result of the dedicated effort of Graham Grieve and Tom Marley.

The other three joint initiative projects are:

- Individual Case Safety Report (ICSR), hosted by ISO/TC 215 (Working Group 6)
  HL7 Co-Chair, Lise Stevens
- Identification of Medical Products (IDMP), hosted by HL7
  Lead, Randy Levin
- Medical Product terminology, hosted by ISO/TC 215 (Working Group 6)
  HL7 Co-Chair, Julie James

Building Momentum

By Charles Jaffe, MD, PhD, HL7 CEO

Charles Jaffe, MD, PhD

If innovation is the heart of any organization, then education is its lifeblood. As HL7 reaches out to its members and stakeholders, we should take particular pride in our training and development programs. Throughout the year, HL7 provides exceptional instruction through its Educational Summits and the tutorial programs at the Working Group Meetings. Both the scope and audience are about to expand.

At every Working Group Meeting, more than two dozen tutorials are offered on a broad range of topics from the fundamentals of the Reference Information Model to special topics in messaging to implementation of the Clinical Document Architecture. There will also be short Ambassador presentations at the upcoming May and September Working Group Meetings on key HL7 standards including the Clinical Document Architecture, the Continuity of Care Document and the Electronic Health Record Functional Model.

In addition to the Educational Summits, such as the upcoming conference in Baltimore this July, HL7 offers on-site training focused on the specific needs of the host organization. International programs also take the spotlight in Canada and in the UK. For the first time, Argentina will also host an international forum in medical informatics.

HL7 will also partner with other standards development organizations later this year to highlight the cooperative programs we have initiated. In April, the Clinical Data Interchange Standards Consortium (CDISC) will host a joint educational program at its European Interchange in Copenhagen in April and during its Japanese Interchange in Tokyo in June. In addition, the healthcare arm of GS1, the barcode and RFID standards organization, will sponsor an international program to be held in Toronto in June.

For the first time this year, the Object Management Group (OMG), and HL7 will co-sponsor the Service Oriented Architecture in Healthcare Workshop, which will take place in Chicago this April. Later this fall, HL7 will sponsor its annual International Interoperability Conference, hosted by Crete in mid-October.

Two other exceptional new educational initiatives are planned. Under the auspices of the HL7 Ambassador program, HL7 educators and leaders will present a broad perspective of our technology and services to institutions and educational forums around the globe. Notably, during the Rockefeller Foundation conference on Healthcare in the Global South, HL7 will lead a week-long program for bringing interoperability to developing nations.

Many of the HL7 work group chairs and other members will be encouraged to share the message of interoperability to new audiences and our evolving stakeholder community. We are also encouraged by the new opportunities in distance e-learning programs, jointly sponsored by our affiliates on four continents.

2008 promises to be an exciting year for educational outreach. To learn more about these conferences or opportunities to participate in specific HL7 training, please review the Calendar of Events on the HL7 website, or contact the HL7 office in Ann Arbor for more details. I encourage you to take this opportunity to make a real difference.

Sincerely,

Charles Jaffe, MD, PhD

Continued from previous page

Projects will be assigned a project number and will have a project description whose contents are specified in a template. All of the JIC projects will carry an identity within each SDO. In HL7, the projects will come to the TSC via the CTO John Quinn. In discussion with the TSC and the Structure Domain, leads and co-chairs will be identified and the appropriate working groups will be invited to participate in the projects.

There are barriers that must be overcome for the JIC process to work. The balloting scenario differs among the three SDOs as well as the length of balloting periods. In addition, the publication process and form differ.

Policies are still being worked out with both the JWG and the JIC. Hopefully, the confusion will soon disappear, and the work will progress. In my opinion, this process and these agreements are some of the most exciting things since we began to develop health data standards. This effort needs your understanding and support.

W. Edward Hammond, PhD
Chair, HL7

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A Thousand Thanks

Update from Headquarters

By Mark McDougall, HL7 Executive Director

January Meeting

A near record 553 attendees participated in our January 2008 Working Group Meeting held in San Antonio, Texas. This total includes 134 attendees from outside of the USA, which represents an impressive 24% of all attendees. More than 40 HL7 work groups met in San Antonio. Attendees also took advantage of the 30 tutorials that were offered during the meeting.

Board Changes

After two years at the helm, Chuck Meyer's term as Board Chair came to a close at the end of 2007. Representing the official passing of the gavel, pictured to the right, is the new Board Chair, W. Ed Hammond, PhD, presenting Chuck with his gavel plaque.

New Health Level Board Chair Ed Hammond, PhD, presents past Chair Chuck Meyer, his gavel plaque.

I would like to personally thank Chuck for his tremendous contributions to our organization. I believe that Chuck's most visible contribution was his effective management of the strategic reorganization of HL7 that was funded by a grant from the Robert Wood Johnson Foundation. Chuck also devoted hundreds of hours on both our organization's Bylaws and the Policy and Procedure Manual, which transitioned to the recently published HL7 Governance and Operations Manual. His contributions will be appreciated for years to come. Fortunately for HL7, Chuck will continue to serve on the Board in 2008 as the Vice Chair.

We also recognized two outgoing Board members who served lengthy terms on the HL7 Board of Directors: Bill Braithwaite, MD, PhD, and Klaus Veil.

Bill Braithwaite was actively engaged in many areas of the organization. Most recently, he served two terms as the Treasurer of the Board. He was a treat to work with and oversaw significant increases to the HL7 budget and our reserves. Bill also served as an HL7 co-lead for a $2.3M and multi year project for the National Library of Medicine. In addition to being involved in several work groups, Bill also served as the HL7 project lead with the California HealthCare Foundation on the development of an ELINCS implementation guide.

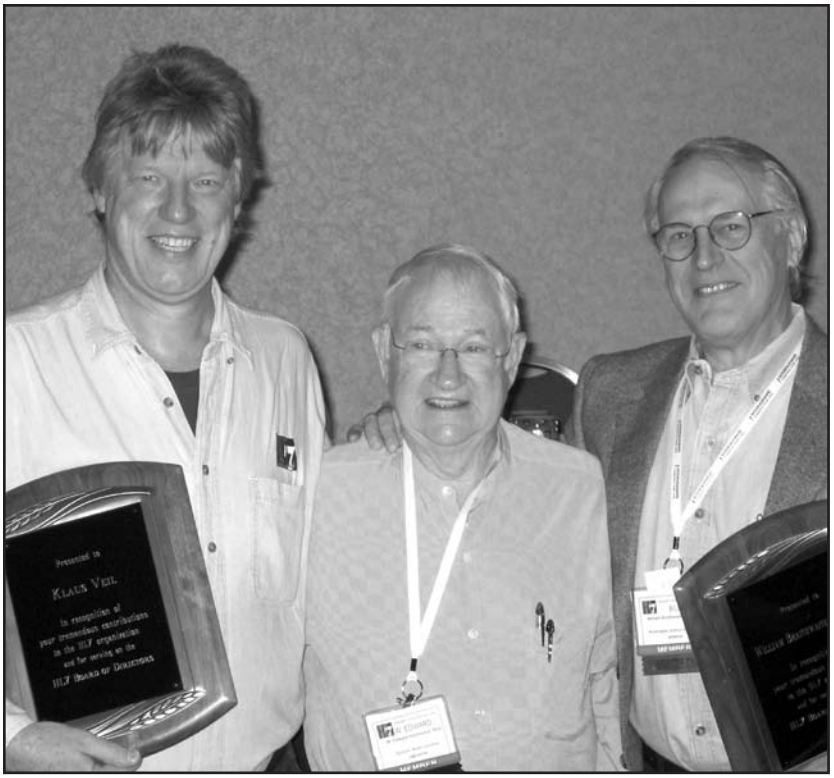
Klaus Veil has also greatly contributed to HL7 over the years. He not only served as a spokesman for our 30 affiliates, but also served as an effective evangelist for HL7 around the globe. For example, Klaus was very involved with an HL7 "road show" of outreach activities and tutorials in many countries in Eastern Europe, Asia and the South Pacific.

We are extremely grateful for the many contributions made by Chuck, Bill and Klaus. Likewise, we are hopeful that they will continue to stay involved with HL7 in the years to come.

We are pleased to welcome seven new members of the HL7 Board of Directors. These individuals bring a wealth of experience and international perspective to the HL7 Board. We look forward to working with them and are pleased to list them below:

- Charlie McCay, Ramsey Systems Ltd
- Dennis Giokas, Canada Health Infoway, Inc.
- Kenneth Lunn, PhD, NHS Connecting for Health
- Donald Simborg, MD, Co-Founder, HL7
- Michael van Campen, HL7 Canada and Gordon Point Informatics Ltd.
- Sam Brandt, MD, Siemens Healthcare
- Nina Schwenk, MD, Mayo Clinic

Provided on page 5 is the group photo of the 2008 HL7 Board of Directors. On behalf of the entire HL7 organization, I welcome the new members of the Board and thank them for their ongoing leadership and contributions to HL7.



HL7 Chair Ed Hammond, PhD, presents plaques to outgoing Board members Klaus Veil and Bill Braithwaite, MD, PhD.

Meeting Sponsors

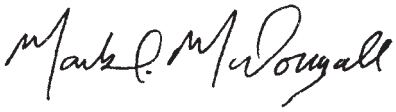
I am also pleased to recognize the following organizations that sponsored key components of our recent January Working Group meeting in wonderful San Antonio:

- THOMSON – Morning Coffee Breaks
- iNTERFACEWARE – Lanyards
- LINKMED – Afternoon Snack Breaks
- Orion Health – Monday's Continental Breakfast
- Gordon Point Informatics – Tuesday's Continental Breakfast

The additional sponsorship support provided by these organizations greatly contributes to HL7's meeting budget and is greatly appreciated.

In Closing

On behalf of the HL7 staff, we extend to you our best wishes for good health, rewarding days, and plenty of laughter in your life. Despite the challenges we face each day, let's try to view our glasses as half full, and not half empty. Thanks again and take care.



The 2008 Board of Directors

Back row standing from left: Daniel Russler, MD; Kai Heitmann, MD; Michael van Campen; Charlie McCay; Hans Buitendijk; and Robert Dolin, MD. Middle row standing from left: Mark McDougall; Ken Lunn, PhD; W. "Ed" Hammond, PhD; Liora Alschuler; Chuck Meyer; and Sam Brandt, MD. Bottom row seated from left: John Quinn; Linda Fischetti, RN, MS; Charles Jaffe, MD, PhD; Dennis Giokas; Jill Kaufman; Don Simborg, MD; and Freida Hall. Missing: Wes Rishel and Nina Schwenk, MD.

The Attachment Capsule

A Way to Exchange Supplemental Information Within Electronic Data Interchange (EDI) Transactions

By Craig Gabron, Reimbursable Manager, Blue Cross Blue Shield of South Carolina

Craig Gabron

Background

Standard electronic healthcare attachments, to either the claim or other healthcare transactions, are a means of electronically exchanging additional information to augment those transactions. Examples of such information include the clinical and administrative information often necessary to adjudicate claims for ambulance trips, rehabilitation therapy, and a wide variety of clinical procedures. Either trading partner may initiate the transmission of a standard electronic healthcare attachment, by using either the solicited model (payer first sends a standard query to the provider, provider responds with the attachment) or the unsolicited model (provider sends the attachment with the initial claim). The goal of standard electronic healthcare attachments is to make the process of providers submitting and payers adjudicating healthcare claims (and other transactions if desired) more efficient by providing structured, standardized electronic data to payers. By using standardized electronic healthcare attachments, payers will see significant benefits:

- Potential increase in automated adjudication through the availability of coded supportive data.
- Reduction in administrative overhead necessary to process claim loads through decreased need for human intervention.
- Potential reduction of turnaround time on claims payment.
- Reduction of denials and improvement of the appeals process, which is costly to both the payer and the provider.

As the rate of automated adjudication increases and human intervention decreases, providers will be able to better predict the successful adjudication and payment of their claims. When providers are aware in advance of the need to provide the information included in standardized electronic healthcare attachments, the provider may, at their discretion, submit the attachments with their initial claims (referred to as "unsolicited" claims attachments). This will result in a much shorter and more predictable turnaround of claims, and will reduce the amount of time and effort necessary to respond to payer requests for additional information via healthcare attachments (referred to as "solicited" claims attachments). Please see below for the full description.

Another significant benefit to the provider community is the reduction of a manual, paper-driven process that exists today. If this data can be gathered and submitted electronically, providers will no longer need to retrieve, photocopy, and mail paper (sometimes many pages of paper) records to the payer. Standard electronic healthcare attachments will help to reduce costs of people, paper, postage, and storage, for both payers and providers. Also, as electronic claims transactions become more prevalent, the time and cost associated with simply delivering the information (via standardized electronic transaction instead of by copying from the health record and faxing or mailing) will diminish.

Standard electronic healthcare attachments are part of the Health Insurance Portability and Accountability Act (HIPAA) suite of standards. Adoption of standard electronic healthcare attachments gives the healthcare industry a consistent platform to convey solicited and/or unsolicited data via a Clinical Document Architecture (CDA) document encapsulated within the Binary Data Segment (BIN) of the ASC X12 275 transaction, hereafter referred to as the "attachment capsule".

How does the attachment capsule work?

Solicited Attachments

During the process of claim adjudication, additional data needs are identified and the payer sends an ASC X12 277 Request for Additional Information transaction. Upon receipt of the transaction, the provider responds with the ASC X12 275 Additional Information in Support of the Healthcare or Encounter transaction. The requested data, in the form of readable text, scanned document images or structured data within a CDA document is loaded into the attachment capsule and electronically sent back to the payer.

Unsolicited Attachments

Payers may notify providers in advance of their requirements for additional information needs. When this occurs, the provider may choose to send the additional information at the same time they submit the claim using the ASC X12 275 Additional Information in Support of the Healthcare or Encounter transaction. As with solicited attachments, the requested data, in the form of readable text, scanned document images or structured data within a CDA document is loaded into the attachment capsule and electronically submitted to the payer.

Data extracted from the attachment capsule can then be engineered into ex-

isting software workflows or routed to a browser for human review. Implementation of the standard electronic healthcare attachment standard under HIPAA provides the healthcare industry with the infrastructure to exchange solicited and unsolicited clinical data in support of a healthcare encounter, helping to achieve the goal of minimizing administrative overhead and improving return on investment.

How can the attachment capsule augment the claims attachment standard?

Under the Notice of Proposed Rulemaking (NPRM), six attachment types were identified and documented in the Additional Information Specifications (AIS) developed by HL7 (Ambulance, Emergency Department, Rehabilitation Services, Clinical Reports, Laboratory Results, and Medications). Please note that HL7 recommended that only five of the six specifications move forward to the final rule for claims attachments. The Emergency Department specification is not being recommended for inclusion into the final rule since all the data necessary to augment Emergency Department claims can be captured in one of the other five recommended attachment types. The attachment capsule augments these attachment types by allowing the specified clinical data to be codified or inserted into the capsule in a human readable format utilizing the HL7 CDA standard. Adoption of the attachment standard and development of the supporting software/hardware infrastructure, either by federal regulation, or by widespread voluntary industry implementation, provides the healthcare industry with a standard platform to exchange data between trading partners in support of current and future business needs.

The healthcare industry may require additional data not available in the HL7 developed attachment specifications. To accommodate these additional needs, HL7 has created a specification called the Patient Information Unspecified Content (PIUC) that provides a way for trading partners to exchange additional data using the same method of exchange (the ASC X12 275 plus the HL7 CDA) as they do for attachment types that have developed content specifications. For example, a claims review team may require additional data to support the billing of a wheelchair. At this time, HL7 has not developed a specific content specification for any type of durable medical equipment. In this scenario, trading partners can agree to exchange the data they need to support the billing of the wheelchair using the ASC X12 275 Additional Information to Support a Healthcare Claim or Encounter with the PIUC specification in the binary data segment of the 275. The attachment capsule can provide trading partners with a standard method of exchanging clinical encounter data that is derived from non-standard personal or electronic health records. The attachment standard will accommodate many current Multipurpose Internet Mail Extension (MIME) types (including rich text format documents (.rtf), scanned images (e.g., .GIF, .JPG, and .TIF), and text (.txt).

In conclusion:

With the adoption of the claims attachment standard, the attachment capsule can reduce administrative overhead and alleviate the manual paper process of handling claims encounter data. For more information on the proposed claims attachment standard, including a copy of the proposed rule and our own Frequently Asked Questions (FAQs) document, please navigate to the Attachments Special Interest Group (ASIG) page at www.HL7.org.

Upcoming Co-Chair Elections

The following HL7 Work Groups will conduct co-chair elections at the May Working Group Meeting in Phoenix, AZ:

- **Attachments**—electing two co-chairs
- **Cardiology**—electing one co-chair
- **Clinical Genomics**—electing one co-chair
- **Clinical Interoperability Council**—electing one co-chair
- **Community Based Collaborative Care**—electing one co-chair
- **Financial Management**—electing three co-chairs
- **Implementation/Conformance**—electing two co-chairs
- **Java**—electing one co-chair
- **Laboratory**—electing one co-chair
- **Modeling & Methodology**—electing one co-chair
- **Patient Administration**—electing one co-chair
- **Patient Care**—electing one co-chair
- **Security**—electing one co-chair
- **Services Oriented Architecture**—electing two co-chairs
- **Templates**—electing two co-chairs

CCOW Protection Package Passes Ballot

By Robert Seliger, CCOW Co-Chair

Robert Seliger

The CCOW Work Group, in conjunction with the HL7 Security Work Group, is proud to announce that their recent jointly-sponsored ballot for a CCOW Protection Package was unanimously ratified by the HL7 Membership in January. Ballots were cast for three related documents, which taken together presents a complete protection package for CCOW-related security capabilities. A protection package is a subset of an overall protection profile. According to the National Information Assurance Partnership (NIAP) website (http://www.niap-ccevs.org), a protection profile is described as follows:

- A Protection Profile (PP) is an implementation-independent specification of information assurance security requirements. Protection profiles are a complete combination of security objectives, security related functional requirements, information assurance requirements, assumptions, and rationale.

- The purpose of a PP is to state a security problem rigorously for a given collection of system or products - known as the Target of Evaluation (TOE) - and to specify security requirements to address that problem without dictating how these requirements will be implemented.

- Product vendors may respond to the security concerns defined by a PP by producing a Security Target (ST), which is similar to a PP except that it contains implementation-specific information that demonstrate how their product addresses those security concerns.

This description may sound rather arcane, but the ratification of a CCOW protection package is an important step in enabling healthcare organizations that use CCOW-compliant applications and system components to have a methodical way to validate the security strength of their systems. The need to do this exists because while the HL7 CCOW standard is generally known for its ability to enable applications to share clinical context, such as synchronizing data displays for the same underlying patient, the standard also supports security capabilities that may be used to achieve features such as single sign-on (SSO). In fact, CCOW may very well be the first SSO standard for any industry, pre-dating more recent standards such as Security Assertion Markup Language (SAML) for Web-based SSO by more than a decade.

The CCOW standard provides detailed specifications for its security architecture and the requisite behaviors for applications and system components that support the standard. However, CCOW is not an implementation, and so design decisions and correct implementations remain the responsibility of the application developer. This means that healthcare organizations are on their own when it comes to determining whether an application or component that purports to implement CCOW has in fact done so properly, especially when it comes to security.

The challenge of validating the implementation of a security protocol or standard is an age-old issue. Most security systems require thorough implementations of all of the necessary mechanisms and policies in order to provide the intended level of security. A weak link can compromise an entire system. The challenge for the consumer is determining whether a thorough implementation has been achieved. The challenge is exacerbated when the determination is constrained to be via a "black box" verification, meaning that it is not possible to actually inspect the implementation to determine correctness. For software, such as a CCOW-compliant application, this means that the consumer is not going to have access to source code and design documents in order to verify the security correctness of an application or component.

In order to make it feasible for customers of CCOW applications and components to assess their security compliance, the CCOW Work Group embarked on the process of creating a series of protection packages. Modeled on the concept of a Protection Profile, each CCOW Protection Package document identifies a set of related security capabilities, per the CCOW standard, that a CCOW-compliant application or component must properly implement. The Protection Package documents have been structured and written in accordance with the NIAP guidelines for Protection Profiles.

The result is a cohesive series of assertions that describe the security behaviors that a CCOW-compliant application must achieve. Further, by structuring these assertions in the form of a Protection Package it is possible to conduct black box verification. While such an undertaking may be a formidable task for a healthcare organization to conduct on its own, it is now a practical undertaking for experienced third-party organizations. The addition of the CCOW Protection Package to the CCOW set of specifications has once again raised the bar for CCOW as a pre-eminent healthcare security standard.

HL7 and CDISC Renew Associate Charter Agreement

Joint Worldwide Clinical Research Standards Educational Events Planned for 2008

Health Level Seven (HL7) and The Clinical Data Interchange Standards Consortium (CDISC) recently renewed their associate charter agreement, which was initiated in 2001. As a new key objective of the renewed agreement, HL7 and CDISC will develop joint educational programs in areas around the world.

At present, there are several opportunities scheduled or in the planning stages that are designed to educate on the collaborative activities of HL7 and CDISC. A half-day CDISC-HL7 tutorial titled "Harmonizing Standards Initiatives: An Overview of Collaborative Standards Initiatives for Clinical Research and Healthcare" will be offered in Copenhagen, Denmark in April, as well as other regions of the globe throughout the year. CDISC and HL7 are also exploring holding a one-day joint event "Improving Patient Safety and Clinical Research through Standards" in China and India in the fall.

The initial charter agreement expanded HL7's focus to include the domain of clinical research, and an HL7 work group was formed to lead this initiative. As the relevance of CDISC to the research community has grown, so has the adoption of CDISC standards to improve clinical research processes and for clinical research and submission of that data to the FDA. The harmonization between healthcare and clinical research standards, which is at the core of the CDISC-HL7 collaboration, will further facilitate the conduct of research by physicians by integrating research into their patient care workflow.

"Recognizing that interoperability of patient care and research data is critical, HL7 and CDISC began a joint effort in 2004 to map the research domain into the HL7 Reference Information Model (RIM)," said Charles Jaffe, MD, PhD, and CEO of HL7. "The National Cancer Institute (NCI) and the FDA have joined this unprecedented collaborative effort. The BRIDG (Biomedical Research Integrated Domain Group) model is now paving the way for more effective collaboration among clinical investigators and is helping to integrate other knowledge resources into clinical care, including genomic and proteomic data."

Edward Helton, PhD, Chairman of the CDISC Board of Directors and Co-Chair of the HL7 RCRIM Work Group stated, "The charter agreement between CDISC and HL7 continues to support the important efforts to build the interface between healthcare and research, not only through education but through the continuation of the very critical work for both content and transport data standards so badly needed to accelerate the timely evaluation of patient safety and efficacy."

For those interested in learning more about the joint CDISC and HL7 educational opportunities, stay tuned to the CDISC eNewsletter, the HL7 eNewsletter, and the respective websites (www.cdisc.org) and (www.HL7.org) for updated information.

EHRVA Offers Online CCD Training to Its Members

By Don Schoen, EHRVA Chair and CEO and President, MediNotes Corporation

Don Schoen

When the HIMSS Electronic Health Record Vendors Association (EHRVA), a trade association of EHR vendors that represents the majority of installed EHR systems in the US, was first created, we made a commitment to collaborate on accelerating the adoption of electronic health records. Since that time, we have become the "go to" organization for guidance to the health information technology industry from the EHR perspective. I would credit this to the dedication of our membership and our steadfast pursuit of ongoing member education. Most recently, we published the Quick Start Guide for the ASTM/HL7 Continuity of Care Document (CCD) and made it available to the entire industry at no charge (You can find this document at http://www.himssehrva.org/ASP/CCD_QSG_20071112.asp).

The EHRVA is also reinforcing the value of this guide by providing a series of four CCD training sessions to our member organizations, held in February and early March 2008. The training sessions, offered in a webinar format, were very well attended and provided CCD education to over 300 individuals from EHRVA member organizations. The webinar training sessions are provided at no cost and are recorded to allow other members and their staff to review the course materials. The EHRVA is currently investigating opportunities to provide this important educational series to the industry at large, based on the great interest shown from individuals and organizations around the world on HL7 CDA and the CCD implementation guide.

News from the PMO

By Dave Hamill, Director, HL7 Project Management Office

Dave Hamill

HL7 Project List

Do you ever wonder what projects are being worked on by HL7 members? You can now view them on GForge, via the TSC's File page at http://hl7projects.hl7.nscee.edu/frs/?group_id=52.

This list originates from HL7's primary project repository, Project Insight, which currently contains projects submitted to the PMO since 2006. The PMO plans to upload all projects dating back to 2005 to Project Insight by the May Working Group Meeting in Phoenix, providing HL7 members with a searchable database of projects submitted over the past three years. The PMO will work with each work group to ensure that this list reflects all active projects.

HL7 Project List

The pilot period for the new Project Scope Statement (PSS) has come to an end and the PMO and Project Services Committee (PSC) are completing revisions for it to support Project Insight, and transition changes resulting from the Strategic Initiative's recommendations.

The first thing users will notice is that the directions have been moved out of the template to an appendix at the end of the document. Hyperlinks have been added to assist in quickly moving back and forth from the template to the appendix.

In addition, clarification was added on how the PSS differs when used for infrastructure projects (i.e. projects pertaining to the RIM, HL7 maintained vocabulary, wrappers, methodology, etc) versus standard ballotable projects.

The following section changes were made:

- Project Name, ID and Products – this section was expanded to add check boxes for the associated HL7 product type for the project. The product line list was established by the Products and Services Task Force to help HL7 track our standards development and includes categories such as V2 Messages-Clinical, V3 Documents-Clinical, and V3 Messages-Clinical.

- Sponsoring Groups – this section was expanded to identify not only the work group (e.g. TC/SIG(s)) supporting the project, but also the project team (for example, project modeling, publishing, and vocabulary facilitators) as well as two individuals who agree to implement a DSTU prior to normative ballot for projects anticipating publication as a normative standard. While this is a non-binding agreement, the intent is to focus on developing standards the healthcare industry plans to implement. Infrastructure projects are not required to name implementers.

- Project Objectives and Deliverables – the bulleted list of deliverables was revised.

- Project Intent / Project Collaboration and Interested Parties – This section was split into two sections with check boxes added for normative and informative standards, as well as other categories.

- Project Approval Date – This is a new section to track approvals by the respective work group, steering division, and the TSC.

- Project Plan – This is a new section that includes general project planning information, such as project schedule, ballot strategy, and budget.

- Realm – This is a new section that indicates whether the project is applicable globally (universal), or is intended for a specific country or region (realm) The realm must be indicated if the project is realm-specific.

Rolling out the New Project Scope Statement

The current ballot cycle gave project facilitators, steering divisions and the TSC their first opportunity to follow, from start to finish, the project approval process unveiled at last September's Working Group Meeting in Atlanta. The purpose of the new approval process is to engage the steering divisions and TSC early in a project's life.

The PMO would like to extend a heartfelt thanks to the project facilitators, steering divisions, and TSC members who participated in the process during the past few months.

Based on feedback provided by each of these groups, the PMO and PSC are working to establish the easiest and most efficient method to achieving each approval step. In fact, the TSC has already implemented GForge's Tracker functionality for their review and approval of Project Scope Statements.

Project Insight Presentations Will Continue at the May Working Group Meeting in Phoenix, Arizona.

The PMO will again demonstrate Project Insight and provide free tutorials to all interested parties at the Phoenix Working Group Meeting in May. Sessions are planned for Q4 Sunday and Q3 Thursday. This training will help project facilitators assist their work groups in project development and facilitation by utilizing an online tool. Look for more details under the 'Tutorials' section in the WGM Brochure and in the On-Site Meeting Schedule and Resort Guide.

Congratulations to the following people who passed the HL7 Certification Exam

Certified HL7 V2.5 Chapter 2 Control Specialist

October 15, 2007
James F. Boyd
Fraser B. Crow
Kevin C. Decker
Kent L. King
Rovshanak Sedghi
Michael L. Stillwagner
Joseph W. Zabel

November 7, 2007
Joseph R. Birsa
Justin D. Campbell
Kim Wai Michael Cheung
Jack Chung
Reginald A. Flynn
Sridhara R. Guda
Siva L. Kudithipudi
Sridhar Mandalapu
Michael P. McNamara
Aaron R. Paquette
Timothy J. Ramirez
Forrest H. Schiesler
Susan V. Shive

January 17, 2008
Ugur Bilge
Karl J. Waitz
Ergin Soysal

HL7 Canada

November 1, 2007
Peter Hoyle
Vincent Tran
Greg P. Violette

February 14, 2008
Norman A. Ramirez

HL7 India

November 27, 2007
Neha Agarwal
Rohit A. Chitnis
Aarti Iyer
Deepak Kumar
Ramesh K. Mendiratta
Ameeta S. Mohata
Preeti P. Nair
Geetha K. Rajan
Snigdhadev Roy
Hemendra Singh Patel
Shikha Valsalan
Prajakta S. Varde

December 15, 2007
Rayilla Chandra Shekhar
Ganesan Chandrasekaran
Upasna Raina

December 29, 2007
Zaheer Abbas Sheik
Meena C. S.
Maruthi Kiranmayee Palakodety
Chandra Prakash
Lakshmi K. Prasanna
Jyothi P. Priya

January 19, 2008
Rahul D. Aimera
Deepak A. Chainani
Abhishek Choubey
Ruchi B. Damani
Mahesh R. Dedhia
Elza Prithu George
Dhiraj B. Jain
Jyoti P. Khetan
Kunal Kumar
Ajay V. Kumrah
Thomas Linson
Kanan Mani
Manish Nagar
Soubhagya R. Nayak
Mayank D. Parikh
Santosh S. Patil
Smita R. Satam
Dhaval D. Shah
Ketan M. Shah
Ashutosh Sharma
Arti C. Shivankar
Harpreet H. Singh
Upendra Singh Sisodia
Sampat M. Somani
Sajirama Subramanian Sowmyaraman

February 2, 2008
Jithesh Gopal
Prabhu Sriramulu
Joseph M. Thottungal

Certified HL7 CDA Specialist

November 7, 2007
Virginia Lorenzi
Tao Wang

January 15, 2008
Steven T. Baranowski
Skirmantas Kligys
Jennifer Puyenbroek

HL7 Canada

January 25, 2008
Farzaneh Ashrafi

Continued from previous page

Project Insight is a 100% web-based project management software application with tools that offer many strategic benefits to HL7, such as:

- Intelligent project scheduling, including cross project dependency capability
- Flexible reporting
- Project templates and project methodologies
- Microsoft Outlook and Office integration
- Options for customization

Project Insight is HL7's primary project repository. It will function as the foundation for project data and reporting, and will assist the PMO, steering divisions and TSC in the execution of HL7's project methodology and processes. The tool will be made available to each work group through its respective co-chairs or project facilitators.

A prime element of Project Insight is its ability to assist project teams in organizing project documents and providing a roadmap for them to follow. Templates have been created to ensure consistent use of folder hierarchies, project schedules, and project documents.

The initial project schedule template created by the PMO is based on the HL7 Project Lifecycle and has been built for a 'standards project' whose goal is to be submitted for balloting. The schedule template is accompanied by a folder structure to house project deliverables, documents, issues, status reports, as well as to provide document templates and examples.

Health Level Seven Healthcare Quality Reporting Initiative Gains Momentum

Broad coalition seeks to advance Quality Reporting Document Architecture (QRDA), submit HL7 Draft Standard for Trial Use (DSTU)

The HL7 Quality Reporting Document Architecture (QRDA) initiative and a broad coalition to advance the quality reporting standard is gaining support and momentum in the industry.

Representatives of the American College of Physicians, American Health Information Management Association (AHIMA), Iowa Foundation for Medical Care, MedAllies for the Hudson Valley Health Information Exchange, among others, have agreed to work together on the QRDA initiative. The group intends to submit QRDA as an HL7 Draft Standard for Trial Use (DSTU), develop a QRDA Implementation Guide and gain consensus to formalize and publish the standard. The coalition also hopes to expand the number of participating organizations and will continue collaborating with other groups developing related standards.

"The QRDA initiative is driven by a cadre of industry leaders and has gained significant momentum," said Crystal Kallem, AHIMA practice leadership director. "By bringing together experts in healthcare quality and health IT, we believe the QRDA standard will benefit healthcare providers, requesters and analyzers of quality measurement data and EMR [electronic medical record] system vendors."

Quality reporting can be a fragmented and challenging process. Healthcare providers are tasked with mining quality data from various sources – such as handwritten medical charts and EMRs – to satisfy a growing number of requests from local agencies, healthcare payers, Centers for Medicare & Medicaid Services (CMS) and accrediting organizations, among others. Accordingly, these requesters collect, reconcile and analyze data that is often incongruous and incomplete. Across the board, these efforts are costly, time-consuming and technically complex. The industry needs technology specifications that standardize and facilitate the reporting of healthcare quality data, which must be pulled from diverse provider systems and sent to multiple requesters.

"We believe the QRDA initiative is the first to undertake electronic standardization of quality measure reporting. It's an important step that should make it easier for healthcare providers to use their EMR systems to participate in performance improvement work," said Feliciano Yu, MD, a medical informaticist at the Children's Hospital of Alabama. "As a clinician, I am eager to see the QRDA work progress through the HL7 standardization process and am hopeful about its benefits."

Phase I complete

Healthcare institutions routinely collect and report performance measure data to improve the quality of care provided to patients. This data conforms to the requirements of defined "quality measures," which are written and maintained by institutions concerned about healthcare quality. Current data collection and reporting activities rely on a variety of mechanisms that range from structured paper to electronic data entry formats – usually derived from claims-based data sets or manual data abstraction.

To make it easier for providers to report quality data, the HL7 Pediatric Data Standards Work Data Standards Special Interest Group (PeDSSIG) pioneered the QRDA initiative with funding for Phase I from the Alliance for Pediatric Quality. The initiative is aimed at developing an EMR-compatible standard for distributing data related to patient-level quality measures across disparate healthcare IT systems. Participating organizations are dedicated to the belief that such a standard will make it easier to support the analysis and tracking of healthcare quality, decrease the reporting burden for providers and improve the quality of data used for measurement.

In the first phase of the QRDA initiative, participating organizations confirmed the feasibility of using the HL7 Clinical Document Architecture (CDA) as the foundation for the QRDA specification. It was concluded that CDA, a document markup standard that defines the structure and semantics of clinically-relevant documents for healthcare information exchange across EMRs, can provide the technical underpinnings for communicating pediatric and adult quality measures for both inpatient and ambulatory care settings. The project team developed sample QRDA instances from an adult use case developed for the CMS Doctor Office Quality–Information Technology (DOQ-IT) initiative (defined as an HL7 Version 2.4 messaging specification), and a sample pediatric quality measure from the Joint Commission Pediatric Asthma Measures.

The coalition is now focused on developing a QRDA Implementation Guide and other materials needed for the September 2008 HL7 ballot that could make QRDA a DSTU.

The QRDA initiative is compatible with parallel industry efforts and organizations that are addressing the quality landscape, including the American Health Information Community (AHIC), Healthcare Information Technology Standards Panel (HITSP) and Integrating the Healthcare Enterprise (IHE).

For More Information

To participate in the QRDA initiative, please contact Joy Kuhl, HL7 Pediatric Data Standards Work Group Administrative Co-Chair, joy.kuhl@chca.com, or Crystal Kallem, Clinical Interoperability Council Co-Chair, crystal.kallem@ahima.org.

To see the "QRDA Initiative Phase I Final Report," please visit http://www.hl7.org/Library/Committees/pedsdata/QRDA%20Phase%20I%20Public%20Report.pdf.

'Guide to Use of SNOMED CT in HL7 Version 3' DSTU Published

By Dr. Edward Cheetham, Chief Quality Assurance Officer, IHTSDO & Principal Clinical Terminology Specialist, NHS Connecting for Health

Dr. Edward Cheetham

The Draft Standard for Trial Use (DSTU) 'Guide to Use of SNOMED CT in HL7 Version 3' is now available as part of the Version 3 ballot, having been accepted in September 2007. The 'TermInfo' group is actively soliciting feedback on the DSTU, and would welcome all comments, questions or results of in-use experience during the trial period.

Background

In recent years, there has been growing international interest in the use of the clinical terminology SNOMED Clinical Terms (SNOMED CT) in the HL7 community—in particular how to integrate SNOMED CT with the HL7 Version 3 standard. In response to this interest, the HL7 Vocabulary Work Group (supported by SNOMED International) launched the 'TermInfo Project', conceived with two initial work packages:

1. Specification of a general approach to resolving issues related to the interface between HL7 information models and terminologies or code systems.
2. A guide on use of SNOMED Clinical Terms (SNOMED CT) concepts in the HL7 Version 3 communication standards.

After several rounds of revision and review, the 'Guide to Use of SNOMED CT in HL7 Version 3' (as the realization of the work package 2) was accepted as a DSTU. More information about SNOMED CT is available through the International Health Terminology Standards Development Organization, the new SNOMED SDO (http://www.ihtsdo.org/).

The guide itself contains both normative and informative sections. The normative sections cover:

- Guidance on dealing with specific overlaps between RIM and SNOMED CT semantics and recommendations for use of SNOMED CT in relevant attributes of various RIM classes.
- Constraints on SNOMED CT Concepts applicable to relevant attributes in each of the major classes in the Clinical Statement pattern.

The informative sections cover:

- Examples and patterns for representing common clinical statements.
- A general discussion of the potential overlaps between an information model and a terminology model and the pros and cons of various possible approaches to their management.
- References to relevant documents and known open issues.

Next steps

The TermInfo group is now keen for the DSTU to receive as wide an audience as possible and would value all feedback. Feedback may be made in the following ways:

1. Entered after following the 'HL7 Version 3 Implementation Guide: Using SNOMED CT' link at http://www.hl7.org/dstucomments/index.cfm. In order to capture the identity of the submitter (so that advice and resolution can be given), please log on to the HL7 website at www.HL7.org. This site is monitored by TermInfo participants and comments left will be discussed on TermInfo conference calls.
2. By subscribing to the TermInfo list (http://www.hl7.org/special/committees/list_sub.cfm?list=hl7terminfo) and posting the issue as a message.

For both methods, if it is felt that extended discussion and resolution is required, the issue will be moved to the TermInfo site at http://hl7projects.hl7nscee.edu/projects/terminfo. Non-registered users can view issues as they are discussed. Registered members will be able to contribute to the resolution process.

Additional notes

The guide itself (v 1.4) can be found in the 'Foundation' folder of the HL7 Version 3 Ballot (January 2008 and May 2008 Preview sites), under the DSTU heading 'Using SNOMED CT.' Details of the TermInfo project (including contact details of the project leads) can be found at http://www.hl7.org/Special/committees/terminfo/index.cfm. The DSTU is planned for an 18 month trial period (closing in May 2009).

Co-Chair Election Results from the January Working Group Meeting

Congratulations to the following individuals elected as co-chairs at the January Working Group Meeting in San Antonio, Texas:

- **Attachments –** Durwin Day and Rob Root
- **Cardiology –** Brian McCourt
- **CCOW –** Barry Royer and David Staggs
- **Clinical Genomics –** Phil Pochon
- **Clinical Interoperability Council –** Crystal Kallem
- **Community Based Collaborative Care –** Suzanne Gonzales-Webb and Max Walker
- **Electronic Health Records –** Corey Spears and Patricia Van Dyke
- **Emergency Care –** Laura Hermann-Langford and Dan Pollock
- **Generation of Anesthesia Standards –** Martin Hurrell
- **Government Projects –** Randy Levin and Jim McCain
- **Healthcare Devices –** Todd Cooper and Melvin Reynolds
- **Infrastructure & Messaging –** Tony Julian
- **Java –** Gunther Schadow
- **Laboratory –** Rob Hausam
- **Patient Safety –** Lise Stevens
- **Pediatric Data Standards –** Andy Spooner and Feliciano Yu
- **Public Health Emergency Response –** Alean Kirnak
- **Regulated Clinical Research Information Management –** Randy Levin, John Speakman and Edward Tripp
- **Security –** Mike Davis and Glen Marshall
- **Structured Documents –** Bob Dolin
- **Vocabulary –** Heather Grain and Beverly Knight

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Quest Diagnostics

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sunquest

Thomson

U.S. Department of Defense Military Health System

Department of Veterans Affairs

Wyeth

UPCOMING WORKING GROUP MEETINGS

September 14–19, 2008

22nd Annual Plenary & Working Group Meeting

Sheraton Wall Centre Hotel
Vancouver, BC, Canada

January 11–16, 2009

Working Group Meeting

Hilton in the Walt Disney World Resort
Orlando, FL

May 10–15, 2009

Working Group Meeting

Kyoto International Conference Center
Kyoto, Japan

PLEASE BOOK YOUR ROOM AT THE HL7 MEETING HOTEL

HL7 urges all meeting attendees to secure their hotel reservations at the HL7 Working Group Meeting Host Hotel. In order to secure the required meeting space, HL7 has a contractual obligation to fill our sleeping room block. If you make reservations at a different hotel, HL7 risks falling short on our obligation and will incur additional costs in the form of penalties. Should this occur, HL7 will likely be forced to pass these costs on to our attendees through increased meeting registration fees.

Thank you for your cooperation!

HL7 EDUCATIONAL SUMMITS

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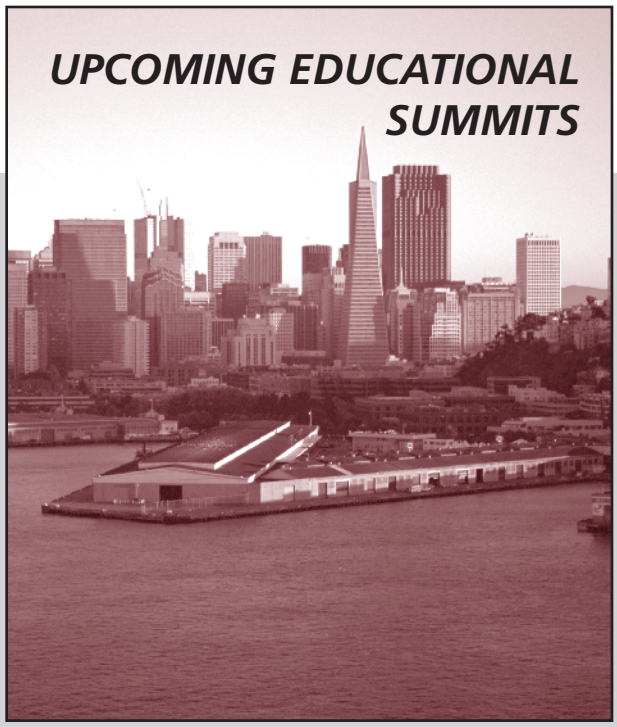
What is an Educational Summit?

The HL7 Educational Summit is a a three-day schedule of tutorials focused on HL7-specific topics such as Version 2, Version 3 and Clinical Document Architecture. Educational sessions also cover general interest industry topics such as HIPAA Claims Attachments.



July 29–31, 2008
Sheraton Inner Harbor Hotel
Baltimore, MD

November 4–6, 2008
Embassy Suites Hotel
Salt Lake City, UT

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- **Efficiency**
  Concentrated three-day format provides maximum training with minimal time investment
- **Learn Today, Apply Tomorrow**
  A focused curriculum featuring real-world HL7 knowledge that you can apply immediately
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  High-quality training in a "small classroom" setting promotes more one-on-one learning
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- **Economical**
  A more economical alternative for companies who want the benefits of HL7's on-site training but have fewer employees to train

Ireland Leverages the EHR-S Functional Model to Certify Family Practice Software

By Dr. Brian O'Mahony, Project Manager, General Practice Information Technology (GPIT) Group
Email: bom@iol.ie

Dr. Brian O'Mahony

The HL7 Electronic Health Record System Functional Model, Release 1 is currently being used to certify family practice information systems in Ireland.

Family doctors, known as general practitioners, play a key role in healthcare in Ireland and have been at the forefront of information system development over the last 10 years. More than 80% of the 2,400 general practitioners (GPs) in Ireland use information systems for managing their practice and supporting electronic health records. The Health Service Executive (http://www.hse.ie) and the Irish College of General Practitioners (http://www.icgp.ie) came together to form the General Practice Information Technology (GPIT) Group with the aim of promoting and sustaining computerization in general practice. One of the functions of the GPIT Group is the certification of information systems used by GPs.

There are four main software vendors in the Irish market. Certification of GP software systems is necessary to:

- Ensure that practice management software systems support the requirements of general practice;
- Help to coordinate the development of GP systems with health service information systems; and
- Provide a roadmap for further development of the Electronic Health Record.

Following consultation with all parties, a document entitled "Requirements for Certification 2007" version 1.3, was created. The document is available at http://www.icgp.ie/gpit. Stakeholders who helped developed this document included GPs, software vendors, the Health Service Executive, the Department of Health and Children (http://www.dohc.ie) and the Health Information and Quality Authority (http://www.hiqa.ie). The process of drafting, discussion and feedback took seven months.

The certification document uses 78 of the 136 functions detailed in the EHR System Functional Model. It also includes eight additional functions necessary for the Irish environment, including: Manage Display of Electronic Results, Manage Appointments, Manage Ante-Natal and Post-Natal Care, and Data Backup.

The use of keywords: SHALL, SHOULD, MAY and priorities: Essential Now, Essential Future, Optional allows a roadmap of present mandatory requirements and developments necessary for the future to be laid out.

Using the EHR System Functional Model as a basis for the certification document was brilliant. There is a sense that the model contains the wisdom of the bazaar. Many intelligent people have looked at this model and have contributed their experience and insights. For out part, we added our own ingredients to the stone soup. Our certification document is localized to a fine level of granularity. It includes details on the process of certification and the service level agreement required between the vendor and the general practitioner.

We have developed a certification test plan to help vendors prepare for the certification process. This clarifies for them how the mandatory functions will be tested. The certification will take place between June and October 2008. We are grateful to HL7 for allowing us to use the EHR System Functional Model as the basis for our Requirements for Certification.

For more information, please visit www.icgp.ie/gpit.

HL7 Welcomes its Newest Affiliate: HL7 Colombia

Fernando A. Portilla

Fernando A. Portilla, Chair

Fernando is the Director of the Informatics Department at the Hospital Universitario del Valle Colombia, one of the biggest of this country (700 beds). He has approximately 12 years experience in projects related to the implementation of health information systems in different government agency and private entities. He also works as a consultant and supports health information systems in the fields of public health, insurance, clinical laboratory, billing in health process, and RIS and PACS systems. He participates in projects at the local, regional and national levels. In addition, he teaches health sciences and informatics at Lbre University, Satniago de Cali University and IECSI University.

The Board of HL7 Colombia consists of:

Co-Chair: Lyda Peña Paz, Systems Engineer, MSc. Universidad Autonoma de Occidente

Technical Director: Gabriel Tamura, Computing Systems Engineer, MSc., Universidad ICESI

Secretary: Mary Yulieth Moreno, Nurse, MSc., Comfenalco Valle

Lilia Edith Aparicio, Systems Engineer, PhD., Universidad Distrital, Francisco Jose de Caldas, Speaker

Hernando Garcia, Systems Engineer, Clinica Valle de Lili, Speaker

Mario Enrique Cortes, Industrial Engineer, Datasalud IT Ltda., Speaker

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RIM-Based Application Architectures

By Tom de Jong, HL7 The Netherlands

Tom de Jong

"HL7 is a messaging standard"...this statement has historically been used to limit the scope associated with HL7. This made it clear that HL7 was intended to standardize electronic communications interfaces and not database or application design. For Version 2, I don't think anyone would disagree with this statement, but since the introduction of Version 3, and more specifically the RIM, this may not tell the whole story.

First of all, it has become clear that interfacing is more than just messaging. HL7 Version 3 is still used to send messages, but also to structure CDA documents, and to specify exchanges in service oriented architectures. But why stop there? If the Version 3 Reference Information Model (RIM is the basis for consistent semantic modeling of messages and documents, why not use it to structure a database, or an application's internal data representation? Obviously, this is not a must for using HL7 interface standards, but that doesn't mean it has no merit.

Last year, a group of early adopters of Version 3 in the Netherlands concluded that they had all drawn Version 3 into their application design in one way or another. Some had based their physical database design on the RIM, others at least their internal data representation. Some even used Version 3 on the user interface side, by supporting custom-made data entry forms, that were basically templates built from RIM components. Almost all made use of code generation, based on Version 3 XML Schema Definitions.

Since then, a RIM-based Application Architectures special interest group (SIG) has periodically met in the Netherlands, exchanging ideas for current and future developments, as well as sharing implementation do's-and-don'ts in the spirit that HL7 has always been known for. At the last Working Group Meeting in San Antonio, there was a meeting with several like-minded implementers from all over the world. It became clear that the HL7 Java Work Group would be a natural home for such discussions, since that group's scope had really always been RIM-based architectures, and not just the use of Java for that purpose.

We encourage all of you who are interested in applying the HL7 RIM outside of just data interfaces to send a note to the Java Work Group list service. By the way, the Java Work Group is considering a name change to better reflect this wider scope. We shouldn't forget that being a clear, consistent and complete standard for semantic interoperability is still our main focus. However, it doesn't hurt to look at other ways to put the RIM to good use, especially if implementation results are fed back to ensure a more robust standard!

Upcoming International Events

MIE 2008—Medical informatics Europe 2008 Conference and Exhibition
Göteborg, Sweden
May 25-28, 2008.
For more information, please visit
http://www.sfmi.org/home/index.asp?sid=63&mid=1

ISO TC215 Health Informatics Working Group Meeting
Göteborg, Sweden
May 30 – June 2, 2008.

22nd Annual Plenary & Working Group Meeting
Vancouver, B.C., Canada
September 14 – 19, 2008

9th International HL7 Interoperability Conference
Crete, Greece
October 8 – 11, 2008
For more information, please visit
http://www.hl7.org.gr/ihic2008/

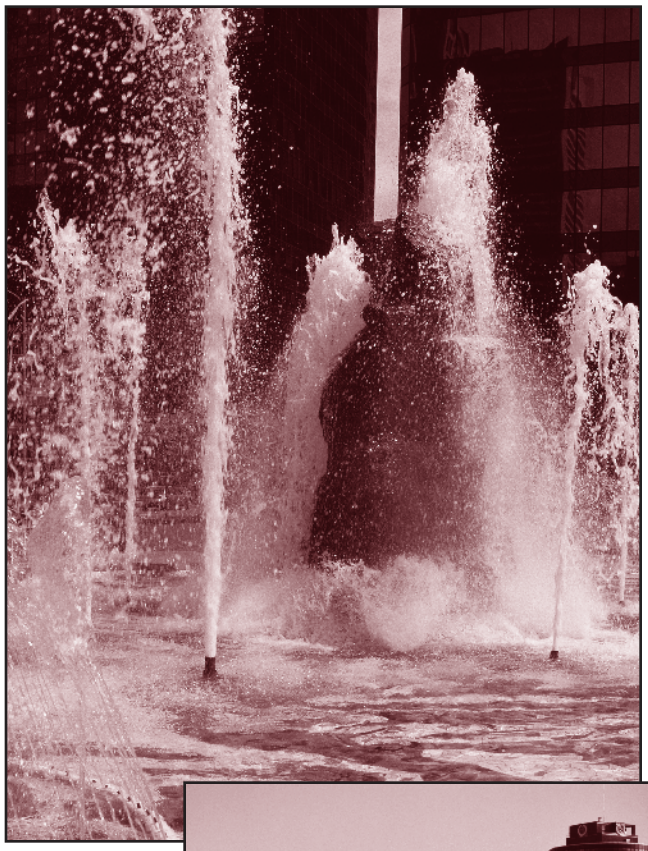
HL7 UK 2008 Conference
London, England
October 22 – 23, 2008
For more information, please visit
http://www.hl7.org.uk/hl7ukconferencesite/2008.asp

1st Medical Informatics Argentinian Congress
Buenos Aires, Argentina
October 29 – 31, 2008

HL7 22nd Plenary & Working Group Meeting Heads to Vancouver!

By the HL7 Canada Secretariat

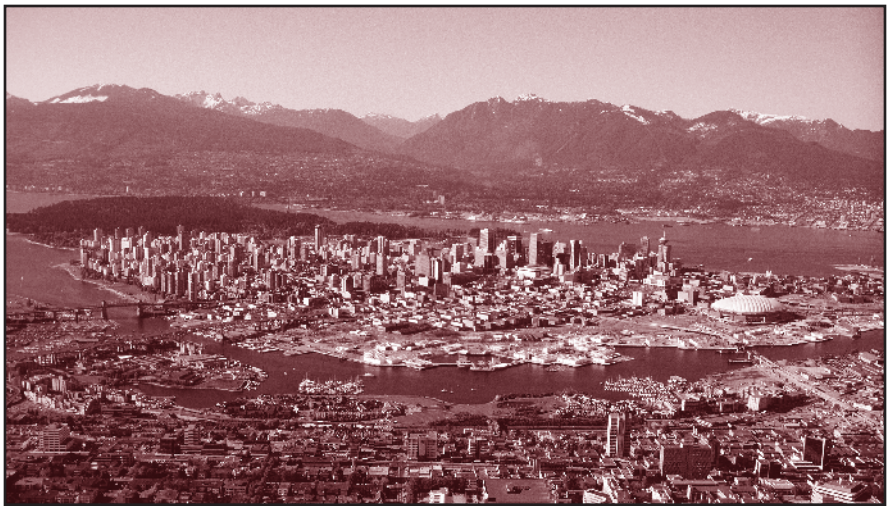
Canada Health Infoway and HL7 Canada take great pleasure in welcoming colleagues and friends to the Sheraton Wall Centre Hotel in beautiful Vancouver, British Columbia, for the 22nd HL7 Plenary & Working Group Meeting!

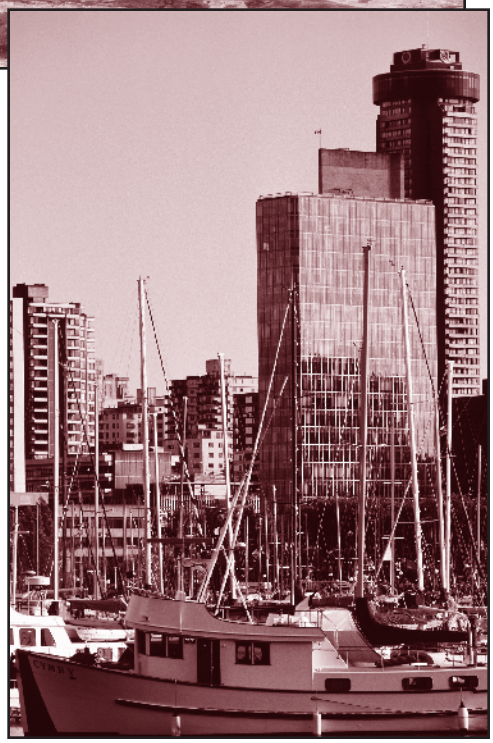


Situated along British Columbia's coastline, lying between the Coast Mountain range and the Pacific Ocean, Vancouver is one of the most scenic cities in the world. A quintessential West Coast metropolis, Vancouver appeals to visitors who bask in all it has to offer, including soothing beaches, vibrant streets and breathtaking mountain vistas.

The HL7 Plenary Planning Task Force is well under way to setting the stage for the meeting. The Monday Plenary Program will feature Canadian, U.S. and other international leaders and experts who will discuss the latest HL7 success stories and achievements, as well as the growing momentum for Version 3. This meeting will also be an excellent opportunity to network with your colleagues and share experiences of facilitating the implementation of HL7-based e-health solutions. Enjoy all that Vancouver has to offer with session activities including a spousal program and the traditional Wednesday night reception.

Look for more information at the May Working Group Meeting in Phoenix, AZ. Registration for the Plenary & Working Group Meeting will be available in July. Please stay tuned for more details to come!





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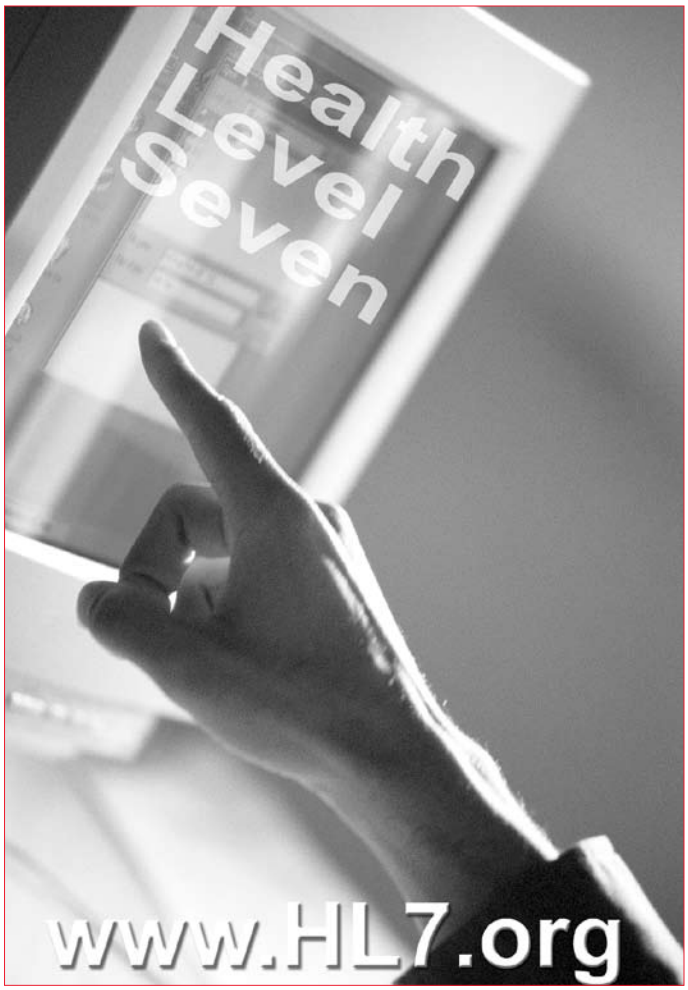

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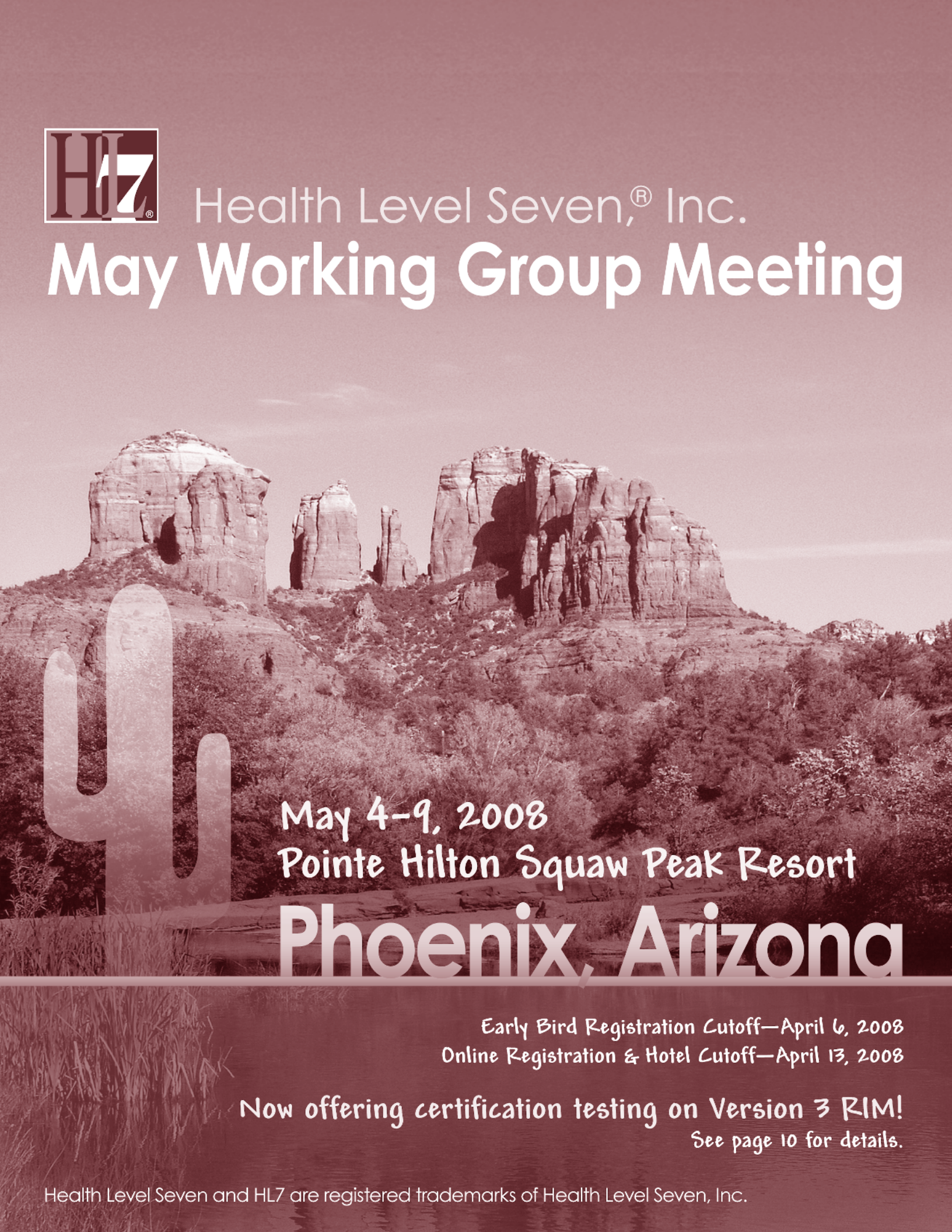

Health Level Seven,® Inc.

May Working Group Meeting

May 4–9, 2008
Pointe Hilton Squaw Peak Resort

Phoenix, Arizona

Early Bird Registration Cutoff—April 6, 2008
Online Registration & Hotel Cutoff—April 13, 2008

Now offering certification testing on Version 3 RIM!
See page 10 for details.