HL7 INTERNATIONAL®

NEWS

SEPTEMBER 2013

UNLOCKING THE POWER OF HEALTH INFORMATION

HL7 Mobile Health Work Group 101

By Gora Datta, Co-Chair, HL7 Mobile Health Work Group; Co-Lead, HL7 Interoperability EHR Work Group; HL7 Ambassador; Group Chairman & CEO, CAL2CAL Corporation

Gora Datta

The HL7 Mobile Health (MH) Work Group is now one year old! Over the past year, the work group (WG) has rapidly matured from loosely held interested individuals to a cohesive group of experts that meets regularly. We welcome one and all to join our Mobile Friday weekly calls every Friday at 11am ET.

The group's mission "The HL7 Mobile Health Work Group creates and promotes health information technology standards and frameworks for mobile health" captures the essence of its charter, as outlined:

- Identify (and develop, as applicable) data standards and functional requirements that are specific to the mobile health environment.
- Identify and promote mobile health concepts for interoperability as adopted and adapted for use in the mobile environment.
- Coordinate and cooperate with other groups interested in using mobile health to promote health, wellness, public health, clinical, social media, and other settings.
- Provide a forum where HL7 members and stakeholders collaborate in standardizing to enable the secure exchange, storage, analysis, and transmission of data and information for mobile applications and/or mobile devices.

One of the challenges the group has is that it is one of the few HL7 groups (like the EHR WG) that is not domain specific; and is more horizontal in nature. Therefore, its charter cuts across other vertical/domain oriented (work) groups.

Given the tremendous interest and participation not only in the US but also globally, the HL7 Mobile Health WG is rapidly stepping up to identify and fill the gaps in the mobile health standards space. But before we delve into the areas on which the WG can and is focusing, let's look at the various scenarios where mobile health is making its presence, scope and benefits felt:

- **Moving Around a Hospital:** EHR system services follow providers around a hospital

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In This Issue...

- **Independent Living:** Assisted living draws on a range of mobile services
- **Patient Empowerment:** Support for long-term conditions across a wide range of lifestyles
- **Individual Assistance:** Behavioral health support anytime, anywhere
- **Trusted Messages:** Leveraging simple messaging capability to provide critical services
- **Personal Health:** Taking charge of one's own health – wellness, healthy living, medication refill and reminders, fitness tracker, family member's health (child immunization etc.)

The use-cases/scenarios, the mobile healthcare activities, the benefits of mobile health, and the opportunities for innovation for each of the above scenarios will be covered in a subsequent article. However, what is clear from the above scenarios is that mobile health is NOT just a health app on a mobile device.

Another area where mobile health is making a big impact, even though it was not originally envisaged, is the US Meaningful Use program, colloquially referred to as "MU". As one reviews the various rules for Stage 1 (published in 2010-11), one will not note anything explicit pertaining to mobile health but there are subtle nudges toward it – in particular, encouraging patient involvement and engagement in the care process. MU Stage 2 (published in 2012-13) builds upon this and creates opportunities for mobile health – data integration and patient engagement is foundational to this stage. MU Stage 3 (slated for publication in 2013-14) rules are still evolving, but given the trend and the rapid rise in the use and proliferation of mobile devices by both consumers (i.e., patients) and caregivers, it is safe to predict that mobile health will become key and central to healthcare access and delivery by one and all.

Mobile health is making its impact felt and seen in the following areas:

- **Easy access** – Health information is just a tap/swipe away
- **Security** – Is health data safe and secure?
- **Usability** – Are senior citizens and younger generations using mobile devices the same way?
- **Affordability** – Is there parity among users from different income categories?
- **Social Media** – Is redefining what is private amongst friends
- **Low and Middle Income Countries (LMIC)** – Highest growth rate in adoption of mobile technology
- **Interoperability** – Many more devices, systems and users to connect

The HL7 Mobile Health WG is working on (or plans on) developing related standards to fulfill the gaps that exist today:

1. **MH Messaging Standards**
   a. Use of mobile devices to send short but structured chunks of information for rapid turnaround. Use of HL7 FHIR resource may be one answer or critically evaluate the need for a "mobile RIM"
2. **MH Related Functional Model/Profile**
   a. Mobile Health Functional Profile derived from the HL7 EHR System Functional Model
   b. Mobile Health Functional Profile derived from the HL7 PHR System Functional Model
   c. Mobile Health System Functional Model based upon a minimal data set paradigm
3. **MH Document Architecture**
   a. At a first glance this might seem too farfetched but think of this use case: you are on the road, in a foreign land, and out of your medicine(s). You go to the local pharmacy but you don't have your prescription, and even if you do the pharmacist is having difficulty understanding language. In addition, the medication may be branded with a different name in that country. You find that the pharmacy has a kiosk where you can "zap" your PHR device

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New HL7 Work Group Taking on Quality Information

By Crystal Kallem, Floyd Eisenberg, Patty Craig, Chris Millet and Walter Suarez, MD,
Co-Chairs of the Clinical Quality Information Work Group

Crystal Kallem

Floyd Eisenberg

Chris Millet

Walter Suarez, MD

With expanded emphasis on healthcare quality, HL7 formed the Clinical Quality Information Work Group (CQI WG) to provide a single point of entry for clinicians and others representing the quality community. The intent of the CQI WG is to work in concert with existing work groups to assure content of standards and templates is sufficient to enable secondary use for quality and measurement. The CQI WG will also coordinate with other work groups to complete active standards impacting quality measurement and reporting, provide required domain expertise to maintain and enhance these standards, and identify and develop new standards, as needed, in collaboration with other HL7 work groups.

The CQI WG has a variety of work efforts underway. Most recently, the group compiled comments in response to the Centers for Medicare and Medicaid Services (CMS) Fiscal Year 2014 Inpatient Prospective Payment System (IPPS) Notice of Proposed Rulemaking (NPRM). These comments were submitted to the HL7 Policy Committee for inclusion in HL7's public comment response to the proposed rule. The group is also collaborating with the Clinical Decision Support WG in an effort to harmonize the Quality Data Model (QDM) and Virtual Medical Record (vMR).

In addition to advancing important new projects, the CQI WG will soon coordinate with the Structured Documents WG to discuss transitioning the management and maintenance of various quality measurement and reporting standards to the CQI WG, including the Health Quality Measure Format (HQMF/eMeasure), QDM-based HQMF Implementation Guide, and Quality Reporting Document Architecture (QRDA) specifications.

The CQI WG co-chairs include Crystal Kallem, Floyd Eisenberg, Walter Suarez, Patty Craig, and Chris Millet. Those interested in participating in CQI WG activities should join the listserv and participate in weekly CQI WG meetings on Fridays from 1:00 – 3:00 pm ET US. For additional information, visit http://wiki.hl7.org/index.php?title=Clinical_Quality_Information_Work_Group.

HL7 Mobile Health Work Group 101, *continued from page 2*

(e.g. smart phone) onto the kiosk which in turn prints the prescription in the local language and the pharmacist refills the medication. This is not a science fiction story – just think of debit cards working in any country and producing a local currency at the ATM. This was not possible 20 years ago, but today we don't think about currency when we travel. Just ask the millennial generation – "What is a traveler's check?"

4. **MH Services**

   The advent of mobile devices and cloud computing will help focus on the need to develop MH services to be developed

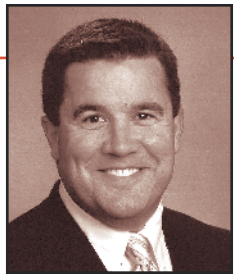
The MH WG is also looking into developing a Domain Analysis Model (DAM) for mobile health as well as a Domain Information Model (DIM) for mobile health or to leverage work that already exists.

In summary, as we transition to a digital record framework (access, capture, and dissemination of information) use of mobile health will continue to rise. The HL7 Mobile Health Work Group is poised to help fill the mobile health standards gap that exists today.

As mobile devices become more and more ubiquitous, accessing our Health Information is only a few taps/swipes away!

Update from Headquarters

HL7 Launches Educational Portal and Computer-based Certification Testing



Mark McDougall

By Mark McDougall, Executive Director, HL7

Online Education and Certification Testing

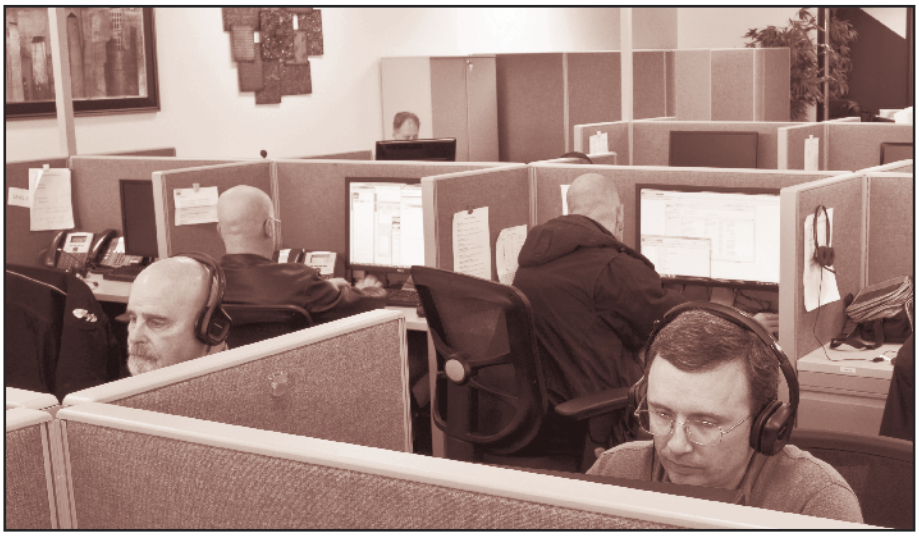
Under the leadership of HL7's Director of Education, Sharon Chaplock, PhD, we are pleased to be launching two significant new services that will help educate and certify individuals around the globe.

Sharon Chaplock, PhD

The HL7 Education Portal aims to be a comprehensive source of training and educational opportunities for the HL7 community. This dedicated space provides access to information about professional development and certification opportunities beneficial to project/product managers, implementers, software engineers, clinicians and business analysts working in the HL7 space. The HL7 Educational Portal will be the home to a library of webinars on various topics of interest to HL7 members. It will also provide resources for those interested in learning the skills needed to become HL7 certified specialists.

Certification testing now available online from the convenience of your own home

HL7 has also recently launched our computer-based certification testing service. This service will be provided by Kryterion, a leader in test development and delivery since 2001. Kryterion has certified proctors that monitor all online test takers as well as those taking tests at one of their over 400 testing centers around the world. It is important to note that those interested in taking the certification tests from their office or home will be required to have an external web camera that meets certain specifications. For more details on HL7's new eductional offerings, please see Sharon Chaplock's article on page 11.



One of over 400 Kryterion High Stakes Online Secure Testing (HOST) Centers

May Meeting

We served 369 attendees at our May Working Group meeting held in Atlanta, Georgia, May 5-10, 2013. Over 40 HL7 work groups convened meetings in Atlanta, of which 18 work groups conducted co-chair elections. Attendees also took advantage of 28 tutorials and three certification tests that week.

Meeting Sponsors

I am also pleased to recognize the following organizations that sponsored key components of our recent May Working Group meeting in Atlanta, Georgia:

- Beeler Consulting LLC
- Eastern Informatics
- Gordon Point Informatics
- iNTERFACEWARE
- Orion Health
- SPARX Systems

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

May 2013 Working Group Meeting Sponsors

27th Plenary Meeting

This year's Plenary meeting is focusing on the timely topic of Care Coordination and HL7's role in it. The slate of speakers and topics being covered is quite impressive. Highlights include:

The Next Generation of Interoperability, by John Halamka, MD, MS, Chief Information Officer of the Beth Israel Deaconess Medical Center; Chief Information Officer and Dean for Technology at Harvard Medical School; Chair of the ONC Standards Committee.

Evidence-Based Standards Development for Care Coordination, by Larry Garber, MD, Principal Investigator, IMPACT; Medical Director for Informatics, Reliant Medical Group

Importance of Interoperability and Workflow of Information Exchange for Transitions of Care, Planned and Unplanned, by Terry O'Malley, MD, Director, Non-Acute Care Services, Partners HealthCare System, Inc.

Lessons Learned from the Boston Marathon Bombing for IT, by Jim Noga, CIO, Partners HealthCare System, Inc.

Care Coordination Challenges in the Aftermath of Disaster, such as:

- Insights and Lessons Learned from the 2011 Tohoku Earthquake and Tsunami Tragedy, by Michio Kimura, MD, Chair, HL7 Japan, Medical Informatics, Hamamatsu University School of Medicine

- Lessons Learned from the Earthquake in Christchurch, New Zealand, by David Hay, MD, Chair, HL7 New Zealand; Product Strategist, Orion Healthcare

Post-Acute Care: Building Upon a Foundation and Current Synergy at CMS: Thinking Forward, by Stella Mandl, RN, BSN, BSW, PHN, Technical Advisor in the Division of Chronic and Post-Acute Care at the Centers for Medicare and Medicaid (CMS)

Consumer Priorities for Health & Care Planning in an Electronic Environment, by Erin Mackay, Associate Director, Health IT Programs, National Partnership for Women & Families

Benefactors and Supporters

We are thrilled to have attracted the all time highest number of HL7 benefactors and supporters, who are listed on page 19. Their support of HL7 is very much needed and sincerely appreciated. We are pleased to recognize our benefactors in all of our HL7 newsletters, on the HL7 website, in all of our HL7 press releases, and at all of our HL7 working group meetings. A special thank you is extended to the list of firms that represent our 2013 HL7 benefactors and supporters.

Organizational Member Firms

As listed on pages 19-21, HL7 is very proud to recognize the 711 organizations who are HL7 organizational member companies. We sincerely appreciate their ongoing support of HL7 via their organizational membership dues.

In Closing

I look forward to seeing many of you at our 27th Annual Plenary & Working Group Meeting in Cambridge, Massachusetts, September 22-27. Until then, may you and your loved ones be blessed with good health and happiness.

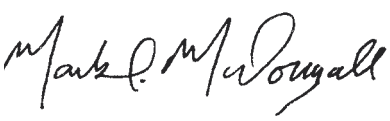


Photo above courtesy of Ken Rubin Photography

Pilot to Ballot IHE Profiles through HL7 Launched with the Healthy Weight Profile

Keith Boone

By Keith Boone, HL7 Liaison to Integrating the Enterprise, and Member of the HL7 International Board of Directors

In March of this year, HL7 and IHE announced an agreement to pilot joint balloting of IHE profiles through HL7. The organizations agreed to ballot an HL7 CDA®-based IHE profile through the HL7 ballot process. In July, shortly after the May Working Group Meeting, HL7 initiated this process and announced the formation of an out-of-cycle ballot pool on the IHE Healthy Weight Profile, overlapping with the IHE Public Comment Period. This HL7 ballot uses the least restrictive of our balloting forms, the ballot for public comment, to incur the least additional load on both HL7 and IHE members during this exploration.

We are still in the early stages of the pilot. The purpose of this first ballot is simply to explore the processes, workflows, and issues raised by jointly balloting IHE profiles through HL7. The Healthy Weight Profile will remain the intellectual property of IHE, and the HL7 feedback will be used to improve the feedback on this profile. The IHE comment process is very similar to the HL7 ballot process, and follows both HL7 and ANSI requirements that all comments must be addressed and responded to. HL7 agreed to allow the ballot feedback to be addressed during IHE meetings convened to resolve feedback on this profile. IHE agreed to coordinate with the HL7 work group sponsoring the ballot, and allow HL7 balloters to participate in that IHE meeting to resolve their comments.

Both IHE and HL7 have already learned a great deal about what it means to work together jointly on a project of this nature, and expect to learn more as it progresses. This project could not have been initiated if there had not already been close coordination by members involved across the two organizations.

FHIR® Connectathon 4 at the September Working Group Meeting

David Hay, MD

By David Hay, MD, Connectathon Planning Team Member

The fourth FHIR Connectathon will be held on Saturday, September 21, 2013 and the morning (9 am - 12:30 pm) of Sunday, September 22, 2013 in Cambridge, Massachusetts, prior to the HL7 Working Group Meeting.

This connectathon marks an important milestone for FHIR, as it will be the final connectathon before the DSTU publication. Feedback from the connectathon can still influence the contents of the Draft Standard for Trial Use (DSTU).

As the specification has matured considerably since the last connectathon, this time we have included scenarios that relate to the use of FHIR for Personal Health Records (PHR) as well as the more simple resource lookup scenarios that we have had previously. These PHR scenarios will require a system to be able to search for documents of varying types (similar functionality to the IHE XDS document query profiles – Registry Stored Query and Retrieve Document Set) and to search for some clinical resources associated with a patient.

The overall connectathon organization remains the same with Saturday for preparation, and Sunday morning being the actual testing against the scenarios.

We will be publishing the details of those who successfully complete the scenarios on the connectathon page (unless people wish otherwise).

Another change is that the registration process is integrated with the WGM registration process – it is an option when registering for the WGM, and there is a small charge ($50) to partially cover the costs of hosting the event. As always, the number of participants is limited, so please register early!

Connectathon details (including the scenarios) may be found at http://wiki.hl7.org/index.php?title=FHIR_Connectathon_4.

Trish Williams, PhD

14th International HL7 Interoperability Conference (IHIC 2013) *Achieving Reality in eHealth Interoperability – Today and Tomorrow*

By Dr. Trish Williams, Member, IHIC 2013 Program Executive Committee; and Member, HL7 Australia Board

HL7 Australia is honored to have been selected as the host for the 14th International HL7 Interoperability Conference 2013 (IHIC 2013), which will be held October 28-29, 2013 in Sydney, Australia. This event will also include a FHIR® Connectathon.

IHIC promotes world-wide engagement and thought provoking discussion in research and industry application of HL7. This annual two-day event brings together implementers, information architects, and researchers working on eHealth interoperability. IHIC provides a forum for implementers and researchers to present and discuss concepts, models, implementations and innovations for interoperable eHealth solutions. The conference also aims to play the role of an interface between research, science and the business of healthcare.

HL7 Australia invites implementers, academics and other researchers to submit papers to be presented at the conference and published in the conference proceedings as either industry contributions or research papers. The papers will be double blind peer reviewed by at least two reviewers. It has been proposed that selected research papers be published in a special issue of an appropriate internationally recognized health informatics "Electronic Journal of Health Informatics".

This year's conference topics include, but are not limited to:

- Emerging developments, in particular:
  - the semantic web
  - application of web services/SOA
  - clinical modelling
  - clinical decision support and knowledge resources
  - mobile health
- Convergence in standards implementation – HL7, IHE, Continua Alliance and other standards development organizations
- HL7/FHIR® (Fast Healthcare Interoperability Resources)
- CDA® implementation and innovation – particularly international use of Consolidated CDA
- Modelling business process and clinical workflow – models and impacts
- Future of HL7 Version 2

Important Dates:

- Notification to authors: September 15, 2013
- Camera-ready papers due: September 30, 2013
- IHIC: October 28–29, 2013

To promote engagement by younger HL7 enthusiasts, authors less than 35 years of age who are judged as submitting the best paper, will be awarded the Joachim W. Dudeck Award. This award distinguishes extraordinary achievements in developing and/or implementing HL7-based interoperability solutions, as well as promoting the use of HL7 and its harmonization with other specifications performed by young HL7 community members. It is awarded by the HL7 International Council at the annual International HL7 Interoperability Conference. The award was introduced in 2011 in memory and honour of the outstanding physician, scientist, lecturer and standards developer Joachim W. Dudeck (Giessen, Germany). Joachim Dudeck was the founder and long-term Chair of HL7 Germany, the first Affiliate Director at the HL7 International Board of Directors, and author or contributor of many specifications around HL7 and XML in health informatics.

This year's IHIC 2013 Program Executive Committee consists of Dr. Trish Williams (HL7 Security Co-Chair and HL7 Australia Board), Richard Dixon-Hughes (Chair of HL7 Australia and HL7 Advisory Council) and Amy Mayer (HL7 Australia Board).

Please join us in the city that boasts the most beautiful harbor in the world. Why not come to Sydney and whilst being inspired by its magnificent views, contribute your knowledge and expertise, and share experiences with like-minded healthcare interoperability experts and inspirational industry leaders?

More information can be found on the IHIC 2013 website http://ihic2013.org.au or email: ihic2013@hl7.org.au

Transitions of Care and Longitudinal Care Plans: The Need for Standards

Terrence O'Malley, MD

Larry Garber, MD

Russell Leftwich, MD

By Terrence O'Malley, MD, Medical Director, Non-Acute Care services, Partners HealthCare System, Inc.; Larry Garber, MD, Medical Director for Informatics, Reliant Medical Group; and Russell Leftwich, MD, Chair of HL7 Professional Engagement and Chief Medical Officer, Office of eHealth Initiatives

Why transitions? Why care plans? Why standards? The world of healthcare is changing and new tools are needed to meet new demands. The biggest change is the shift in payment methodology from fee-for-service (FFS) with volume driven payments, to new global, population based payments. The incentives shift from maximizing the volume of procedures, visits, admissions and tests to providing the patient with the appropriate amount of services in the least expensive appropriate setting to meet their needs in a timely manner.

Transitions of care are critical to this process because they are periods of high risk for the patient. If information that is essential to the patient's care fails to arrive on time, or at all, in a format that is useful, the likelihood of an adverse event increases. Adverse events include failure to continue appropriate treatments or medications, failure to act on pending tests, and inability to reach a "sender" for clarification. The more transitions that a patient experiences, the greater the risk for failure.

In the US, the shift in payment models is being driven by the fact that 14% of Medicare patients with six or more chronic conditions account for nearly 50% of total Medicare spending. The average annual expenditure for these patients is over $32,000 per person compared to an average expenditure of $2,000 for individuals with 0-1 chronic conditions. 70% of these patients have one or more emergency room (ER) visits, 27% have three or more ER visits per year, and 63% have one or more hospitalizations. In addition, 16% have three or more hospitalizations, and 41% of them have at least one encounter per year with post-acute care services (e.g. skilled nursing facility or home health agency). According to the 2012 Medicare Chartbook, the same 14% of Medicare patients account for 70% of all 30 day hospital readmissions.

This is the population that fuels the high volume of healthcare services. The average Medicare patient is cared for by more than seven healthcare providers. FFS payments neither encourage nor support the exchange of information across these sites, nor do they support the exchange of a care plan to coordinate care. This may be in part due to the fact that there are few adverse consequences to the provider, facility or network for a failed transition of care or a care plan that is not followed because failures are another driver of volume and increased revenue under FFS.

These patients require a much more elaborate process to define, update and reconcile the changing elements of their care. All patients have a treatment plan, which is usually condition-specific and defines the proposed interventions to address a specific health concern. The principle healthcare providers for patients who require several treatment plans for concurrent conditions will consolidate these treatment plans into a plan of care, thereby reconciling the potentially conflicting interventions and prioritizing the problems and interventions that are of the greatest importance to the patient. None of these tasks, treatment plans, or plans of care requires the exchange of information. However, the likelihood of conflicting interventions and misprioritization increases when patients received treatments from multiple providers. A more elaborate process is required for this group of patients: a care plan needs to be developed that consolidates all of the treatment plans and plans of care so they can be harmonized and reconciled.

A critical requirement of a care plan is that it can be exchanged among many different providers in multiple sites of care. Care plans and compre-

hensive care transition documents are the technology-enabled tools that the new healthcare systems require. They rest on the capability to exchange standardized information among different care providers in order to achieve the high level of coordination that is necessary. Tight transitions of care and the exchange of care plans become the glue that joins the various pieces of this complex healthcare system. Because very few organizations have deployed a common health information platform, this information will be exchanged between platforms rather than just within one platform. This is why standards are important.

It is the growth of global payment models, such as accountable care organizations (ACOs) with population health management, that is propelling the development of exchangeable plans of care and a longitudinal care plan for these complex patients who receive care from multiple providers in different sites of care. Under global payments, a failed transition or care provided outside of a care plan represents not only a patient quality and safety issue, but also potentially avoidable costs with lost revenue. As such, the priority for transitions and care plans is now much higher. Without the capabilities to electronically exchange essential clinical data at the time of transitions of care, and the ability to share interoperable care plans among the expanding list of providers of healthcare service for this population, the ACOs will have difficulty meeting their twin goals of reducing costs of care while improving quality.

But what standards? Aren't the current HL7 standards sufficient to meet the needs of the modern healthcare system? The US Office of the National Coordinator for Health Information Technology (ONC) funded the IMPACT (Improving Massachusetts Post-Acute Care Transfers) project to answer that question. IMPACT surveyed numerous healthcare team members including physicians, nurses, social workers, therapists, and patients from hospitals, nursing facilities, physician practices, home health agencies, community based organizations and others, asking what healthcare information they needed. Over 1,000 survey responses were evaluated and the findings were remarkable. First, IMPACT found that out of all healthcare providers, home health nurses had the broadest information requirements, amounting to almost 500 data elements. In retrospect, this makes sense. When a patient is sent from a hospital to a nursing facility where they will need oxygen, wound dressing supplies and a wheelchair, the nursing facility has one vendor that supplies each of these. In contrast, when a patient is sent home and needs these, dozens of vendors could potentially supply these, based on the patient's location and insurance. The home health nurse needs to know which vendors were contacted to deliver these so they know who to call if the supplies don't arrive at the patient's home.

IMPACT also compared these ~500 data elements to those in the HL7 Consolidated CDA® Implementation Guide (C-CDA) and discovered that nearly 20% of the data elements did not have a template that could adequately convey the information. What are the parameters for the patient's Total Parenteral Nutrition? What are the patient's pertinent religious beliefs and practices (which is different than "religion")? What are the expected milestones for the patient's physical therapy plan?

The findings of the IMPACT study have subsequently been vetted through ONC's S&I Framework Longitudinal Coordination of Care Workgroup as well as by numerous state, national and international organizations. Based on the feedback from this process, refined data sets have been developed, focusing on the full Transfer of Care Summary (e.g. transfer from one care setting and care team to an entirely new setting and team, including home health), the Request for Consultation (e.g. to a specialist or ER), the Consult Note (e.g. from a specialist or ER), the Care Plan, and the Home Health Plan of Care (AKA CMS-485). There was also the recognition that the Home Health Plan of Care will require an electronic or digital signature. Multiple US organizations such as ONC, Centers for Medicare & Medicaid Services (CMS), Assistant Secretary for Planning and Evaluation (ASPE), New York eHealth Collaborative (NYeC), Healthix, and Continuum of Care Improvement Through Information New York (CCITINY), have provided financial support to the S&I Framework and Lantana Consulting Group to facilitate the HL7 balloting process for updating the C-CDA with updated and new document types to accommodate these data sets in September. ONC's Health Information Technology Policy Committee is considering specifying support for these new C-CDA documents as part of their 2016 EHR certification criteria.

With these new evidence-based standards in place and EHRs capable of utilizing them, there will finally be hope for truly coordinated care. The winners will not only be providers who receive global payments in ACOs or the US taxpayers that fund the cost of Medicare, but more importantly, the patients who will receive higher quality and safer care.

PBS Metrics Update

By the PBS Metrics Team composed of HL7 International Staff Members Dave Hamill, Director, Project Management Office; Lynn Laakso, TSC Project Manager; Don Lloyd, PhD, Director of Technical Publications; and Karen Van Hentenryck, Associate Executive Director

Dave Hamill

Lynn Laakso

Don Lloyd, PhD

Karen Van Hentenryck

How to Use the PBS Metrics Excel File

Are you puzzled when presented with the PBS Metrics Excel spreadsheet (Projects, Ballots and Standards)? The best place to start is to review the "Helpful Hints" tab within the spreadsheet. This tab provides details about all of the data within the file.

Next, review your work group's "Report Card". Identify which areas are marked yellow or red. For those areas, either click on the respective tab or refer back to the "Helpful Hints" to determine where to find more information on those infractions.

Project Health is the one column in the Report Card that is a combination of values from other Report Card data. Unlike the other figures within the Report Card, there is no separate tab associated with Project Health.

Project Health is based on the infractions listed below. Project Health is red when two or more of the following are designated red; Project Health is yellow when one of the following is red. The cell containing the name of the work group will match the Project Health color.

- Recirculation (items which have passed Normative ballot but have outstanding negatives that will require a recirculation ballot to be published)
- Unpublished Ballots (items that are "finished" (passed by numbers and reconciliation is complete) but unpublished (not in the Normative Edition or on the HL7 Standards page))
- Missing 3-Year Plan Items (i.e. there are no 3YP items in Project Insight for the work group)
- % of Project Insight Items Behind > 120 Days is greater than 33%

Creating a 3-Year Plan

3-Year Plan items can be submitted to the HL7 PMO (pmo@HL7.org) however a work group chooses. Most work groups email an Excel spreadsheet as that provides an easy way to review, maintain and update the plan going forward. Each item needs a title, start date and end date. That's it. A Project Scope Statement does not have to be filled out, nor do 3-Year Plan items need Steering Division or TSC approval. Note that work groups need to notify the PMO about any updates made to their 3-Year Plan.

Three-year plans are used in the preparation and evaluation of organizational strategies as well as to assess the alignment of proposed work group projects with the published strategies of the working group. Thus, proposed projects that do not fit into any of the currently accepted strategies would be deemed out of scope for the organization, but could be considered for inclusion in future strategic initiatives when the roadmap is updated.

PBS Metrics Reports and Dashboard

The PBS Metrics reporting and dashboards are easily accessible via the Reports link on your work group's HL7.org page. The Excel report resides on GForge within the TSC's File area (http://gforge.hl7.org/gf/project/tsc/frs/?action=FrsReleaseBrowse&frs_package_id=169).

The PBS Metrics Report was created to support the HL7 Strategic Initiative to "streamline the HL7 standards development process". It is intended to be a tool to assist work groups with managing ballots in addition to cleaning up projects and old data. By reviewing the reports, work groups can identify potential issues before they get out of hand as well as move items through balloting to a final document or standard state.

If you have any questions or comments, please direct them to any PBS Metrics team member: Dave Hamill (dhamill@HL7.org), Lynn Laakso (lynn@HL7.org), Don Lloyd (dlloyd@HL7.org) and Karen Van Hentenryck (karenvan@HL7.org).

Sharon Chaplock, PhD

Education Department Corner

By Sharon Chaplock, PhD, HL7 Director of Education

Computer-based Testing

Until recently, individuals seeking HL7 certification had only one option to take HL7 certification exams – by paper and pencil at scheduled events, such as HL7 educational summits, working group meetings; company-sponsored onsite testing or at an HL7 affiliate site outside the US. In response to its stakeholder's requests to provide computer based testing (CBT) and testing at testing centers, HL7 has worked diligently in recent months in order to offer this option to its stakeholders. Effective July 1, HL7 is pleased to announce that, in addition to the traditional paper and pencil exams currently offered, individuals may opt for computer based testing from their home or workplace, or at an exam testing center. As a result, test-takers can schedule exams according to their personal availability and at a location of their choice.

HL7 has chosen Kryterion to partner with to administer its certification exams at over 400 High Stakes Online Secure Testing Centers (HOST) world-wide. For a list of HOST locations, please click here: http://www.kryteriononline.com/test_centers/.

Individuals may also choose online proctored testing from the comfort of their own computers anywhere in the world, as long as they have Internet access and an external webcam that meets Kryterion's specifications (http://shopping.netsuite.com/kryterion). Software is downloaded from Kryterion's website to enable secure exam delivery and each individual's identity is authenticated during the registration process. Testing occurs via webcam by a remote online proctor.

Results from either testing method are displayed immediately upon submittal of the completed test and certificates will be emailed directly to successful individuals; thus individuals will no longer have to wait weeks for their results and/or certificates! Please check the HL7 website for more details and registration information at http://www.hl7.org/implement/certification.cfm

Education Portal

HL7 is launching an education portal that will provide a gateway to information about professional development resources related to the standards and to specialist certifications. The web-based portal is designed to serve as a highly accessible central repository for both paid and free training and education materials for HL7 constituents worldwide. Webinar recordings, self-paced courses and online certification information will be easily accessed and beneficial to project and product managers, implementers, software engineers, clinicians and business analysts working within the HL7 space who wish to deepen their knowledge.

From the webinar library in the portal, HL7 stakeholders will be able to view webinar recordings on-demand from anywhere in the world. Expert instructors who are practicing professionals address a wide-range of topics, including core competencies for certification, industry best practices, and trends in the field. Each webinar includes a combination of lectures, demonstrations, question and answer sessions and often, student engagement activities, all designed to enhance the learning experience.

The education portal will have the following items available in the Webinar Library when it launches:

- Meaningful Use Stage 2 Series (8 webinars)
- Skill Building for Certification Preparation series, including:
  - Introduction to Version 2 (4 webinars)
  - Introduction to Version 3 RIM (4 webinars)
  - Introduction to Clinical Data Architecture (CDA®)
  - Advanced CDA
  - V3 RIM Specialist Exam Review (2 webinars)
- How to Design & Deliver an HL7 Tutorial (1 webinar) FREE
- Link to Ambassador and other free webinars

The HL7 Education Portal is coming soon. Please watch the HL7 website for more details.

Is HL7 Relevant to Clinicians?

Adam Chee, PhD

By Dr. Adam Chee, PhD, Chair, HL7 Singapore

As part of our ongoing quest *"To create a Singapore Healthcare Standards Community where users, providers and suppliers can build consensus on healthcare standards to enable IT systems technical, semantic and process interoperability of healthcare information to improve patient-centric care delivery across the healthcare continuum,"* HL7 Singapore established several goals for the year 2013, with outreach ranking on top.

This translates to the engagement of educational institutions, eHealth solution providers, healthcare providers, and basically anyone who would listen. This includes traditional IT professionals, biomedical engineers, conference organizers, etc.

To be perfectly honest, I had the impression that we were making great progress, that is until I met a particular Chief Medical Information Officer (CMIO). To explain the context, this particular CMIO wields not only considerable respect from fellow CMIOs, but also the entire eHealth community in Singapore. Hence, I initiated a meeting with him, hoping to gain his 'seal of approval' for HL7 Singapore (as I was also trying to attract more corporate sponsors to ensure financial sustainability).

Decorum-wise, the meeting went very well; objective-wise, it was downright pitiful for me (as the Chairperson of HL7 Singapore). The CMIO expressed that while he has heard of the term 'HL7' on countless occasions, he has no clue what HL7 really translates to in terms of its intended purposes, what roles it plays, and how it fulfills these roles. All he knows (and cares about) is that all eHealth solutions be 'HL7 compliant' and that's that.

I was dumbfounded; never in my wildest imagination ever did I expect this. To express the level of shock I went into – a 'flying kangaroo' would have been deemed to be normal.

After recomposing myself, I thought I would seize the opportunity to bridge the information gap and impress upon the CMIO all the good work done by HL7 as an international organiztion, including the various standards developed, activities of the local affiliate and how some of these standards are currently supporting the eHealth initiatives in Singapore.

I ended the conversation segment by seeking the CMIO's opinion on how HL7 Singapore can be more effective in reaching out to clinicians.

The answer was a brutal one – "Don't bother because clinicians will not be interested in complicated technical standards like HL7; they are more familiar with ICD or SNOMED, which are **relevant** to their profession."

To be honest, after my conversation with the CMIO, the question "is HL7 relevant to clinicians?" lingered on my mind for days. Hence, I sought to reaffirm my thoughts on the subject by speaking with clinicians who switched careers to eHealth, hoping to gain some insights on how to best advocate to clinicians. The opinions I gathered varied, but there was one message in common – HL7 shouldn't be just about IT, it is about enabling interoperability that helps improve the overall care delivery process.

So is HL7 Relevant to Clinicians?

So is HL7 relevant to clinicians? I personally think so and I take comfort in knowing that HL7 International thinks so too.

HL7 International launched a health professional membership category about a year ago and the objective is to provide a direct channel for health professionals to participate and ensure that the standards developed through HL7 offers practical value for real world adoption though;

- Active sharing of clinical requirements for standards needed to support an increasingly patient-centered healthcare system
- Provision of feedback, particularly to those concerning usability and workflow

On reflection, while the goals of HL7 Singapore (to build a Singapore healthcare standards community where all stakeholders – including clinicians, can make a difference) pales slightly in comparison to the objectives mentioned above, the general direction are the same –seeking the domain expertise and opinions of health professionals to ensure the work we do at HL7 remains contextually relevant!

Outreach

As I pen this article, the question that lingers in my mind is not if HL7 is relevant; rather, I am mulling over the best advocacy approach to the CMIO. Perhaps I will not be successful in reaching out to clinicians this year but there is always next year! To quote Thomas A. Edison, "I have not failed. I've just found 10,000 ways that won't work" and I take comfort in knowing that I am not alone in my outreach efforts.

To my fellow colleagues in HL7 International, let us persevere as a community and move forward together in this journey.

John Quinn

The HL7 Terminology Authority

By John Quinn, HL7 CTO

The HL7 Board of Directors, at the request of the International Health Terminologies Standards Development Organization (IHTSDO) Terminology Work Group, has created The HL7 Terminology Authority. HL7 has an existing Statement of Understanding (SOU) with IHTSDO and is in need of a formal governance group to manage not only this relationship but our relationship with other terminology development organizations.

The HL7 Terminology Authority (HTA) is responsible for developing and managing the HL7 organizational processes that are necessary for external terminology management. The HTA will work with the existing HL7 Vocabulary Work Group and, in as much as possible, the process that already exists around terminologies and HL7. The HTA is intended, at this point, to also complement our existing HL7 harmonization procedures.

The Purpose of the HTA

The HTA will be a representative body of HL7 International that will provide timely and high quality terminology products and services to meet HL7's and its customer's business needs. The HTA will also provide a single point of contact and communication with external terminology SDOs that have an existing formal Statement of Understanding

continued on page 18

Member Spotlight on Frank Oemig, PhD

Frank Oemig, PhD, has been involved with HL7 for 20 years and became a member of the HL7 Germany affiliate shortly after its inception in 1993. He is a "standards geek," as others would call it, who has worked in programming for 33 years and in the healthcare information technology industry for 22 years. For the past seven years, he has worked for Agfa Healthcare. Prior to that, he was a freelance consultant for five years. Frank received a degree in computer science with medicine from University in Dortmund in 1989. In 2011, he completed his PhD in communication standards ontology (CSO) from the University in Regensburg. Additionally, he holds a certificate for medical informatics from the GMDS/GI association.

As a long-time member of HL7, Frank has been a key contributor to several HL7 initiatives. He has served as a originator and co-chair of the Personnel Management Work Group (1998-2003) and co-chair of the Conformance & Guidance for Implementation/Testing Work Group since 2005. He is also a facilitator for the Publishing Work Group, where he has helped add an international perspective. Frank is the author of the Access Database for the Version 2.x suite of messaging standards, which helps users implement the standard more easily and efficiently. In addition, Frank was awarded the HL7 Volunteer of the Year Award in 2002 and was accepted as an HL7 Fellow in 2012.

Frank currently resides in Mülheim, a small town north east of Düsseldorf, where he has lived since his childhood. He has been married to his wife Anja for 20 years and has two children — a ten year-old son named Fabian and a twelve year-old daughter named Alina. Aside from spending time with his family, Frank enjoys kite flying, scuba diving and photography. He has been diving in the Maldives, Florida and the Mediterranean Sea and is certified in cave and shipwreck diving. His family is his favorite photography subject, but he is also partial to shooting scenes from nature and architecture. Another hobby that Frank participates in during business trips is geocaching, which is a modern day treasure hunt with GPS devices. He released the HL7 Affiliate World Traveler at the January 2012 Working Group Meeting in San Antonio, which is now lost near Vienna, Austria. The second one was started at the January 2013 Working Group Meeting in Phoenix. It is is currently close to Quebec, Canada.

HL7 Version 3 Tools on 64 bit Windows

Andy Stechishin

By Andy Stechishin, Co-Chair, HL7 Tooling and Publishing Work Groups, and Co-Chair, Technical and Support Services Steering Division—HL7 Technical Steering Committee; and George "Woody" Beeler, PhD, Co-Chair, HL7 Modeling and Methodology and Publishing Work Groups, and Co-Chair, Foundation and Technology Steering Division—HL7 Technical Steering Committee

George "Woody" Beeler, PhD

With the increased acceptance and use of the 64 bit Windows operating system by HL7 members, the Tooling Work Group has noticed that certain issues and problems are occurring more frequently in the tool suite that supports Version 3 standards development. Woody Beeler invested considerable effort researching the issue on the web and via Microsoft's knowledge base and brought the results of the research back to the Tooling Work Group for consideration.

The Tooling Work Group has managed, with the aid of our corporate members and the efforts of volunteers, to provide a reasonably comprehensive set of tools to support the processes of HL7 in the development of high-quality healthcare standards. However, these resources are not limitless and sometimes compromises are necessary. The source of the issues limits the environments that can support the RMIM Designer for the immediate future.

In short, Microsoft does not support a set of software pieces (controls for dialog boxes to be exact) that were commonly used in the 32 bit versions of Windows and/or Office in the 64 bit versions. The RMIM Designer will not run with 64 bit Visio 2010 (Visio is a member of the "Office Suite"). Furthermore, because these software components are shared across a release of the Office suite, it is not possible to install 32 bit Visio 2010 when running 64 bit Office 2010. (The only solution to enable the RMIM Designer to run with 64 bit Visio 2010 would entail a substantial rewrite of the RMIM Designer.)

The Tooling Work Group carefully considered the implications of both initiating the rewrite and maintaining status quo. Tooling was unable to justify proceeding with a rewrite of the RMIM Designer at the current time, leaving HL7 members with the following options:

1. Install 32-bit Office 2010 in order to use Visio 2010 on a 64-bit operating system; or
2. Install a different, 32-bit release of Visio (such as 2007) alongside 64-bit Office 2010.

Both of these options have been verified to work under Windows 7, as well as Windows 8, and the pre-release of Visio 2013.

Given suitable interest, a rewrite of RMIM Designer could be possible in the future. The Tooling Work Group felt that the RMIM Designer would be usable by almost the entire current user base. However, we (the Tooling Work Group) would like to hear your opinion. Please either join our teleconferences or post a message to our list server (tooling@lists.hl7.org). And of course, we are always looking for volunteers to help create interesting and useful software tools for the HL7 community.

The Tooling Work Group has managed, with the aid of our corporate members and the efforts of volunteers, to provide a reasonably comprehensive set of tools to support the processes of HL7 in the development of high-quality healthcare standards.

Terrie Reed

Erin Fields

Linda Tompkins

FDA Presents Unique Device Identification

to the HL7 Community at the 27th Annual Plenary & September Working Group Meeting

By Terrie Reed, MSIE, Associate Director of Informatics, FDA/CDRH; Erin Fields and Leslie Thompkins, Informatics Staff, FDA

In 2007, the US Food and Drug Administration Amendments Act (FDAAA) gave the FDA the authority to establish a Unique Device Identification (UDI) system for medical devices. The FDA published the proposed rule, "Unique Device Identification System," in the Federal Register on July 10, 2012, and a final rule is expected to be published soon. This rule would require all medical devices, unless excepted, to bear a unique identifier on its label and device companies to enter a standard set of associated device identification data to the FDA-administered Global Unique Device Identification Database (GUDID).

The UDI identifier itself and its associated attributes are modeled within the Common Product Model (CPM) and we intend to accept GUDID submissions in HL7 Structured Product Labeling (SPL) format. The informatics team, within FDA's Center for Devices and Radiological Health (CDRH), has been actively participating in SPL ballots, as well as CPM and Regulated Product Submission (RPS) ballots. At the September Annual Plenary & Working Group Meeting (WGM) the FDA CDRH team will request support from HL7 work groups and the broader HL7 community to achieve UDI incorporation into appropriate HL7 standards associated with clinical, administrative and interoperable healthcare device messages in the US realm. The UDI system has the potential to positively impact medical device identification, resulting in better device documentation in electronic health records (EHRs), medical billing, inventory, adverse event reporting, and medical device recalls. Incorporation of UDI and its associated attributes into HL7 standards for the US realm is one important step toward realizing those benefits.

The UDI system has the potential to positively impact medical device identification, resulting in better device documentation in electronic health records (EHRs), medical billing, inventory, adverse event reporting, and medical device recalls.

At HL7's September & Plenary Working Group Meeting, Terrie Reed, Associate Director Informatics with the FDA, will be giving presentations to help the HL7 community understand what the UDI is and how the UDI implementation of the Common Product Model will impact the standards/implementation guides of a number of HL7 work groups, including Fast Healthcare Interoperability Resources (FHIR®), Infrastructure and Messaging, Orders and Observations, Health Care Devices, and Structured Documents. We will be reaching out to them, and others as needed, to determine how to best enable all relevant standards/implementation guides to support the transmission of UDI data as soon as possible.

Congratulations

To the following people who recently passed the HL7 Certification Exams

Certified HL7 Version 2.7 Chapter 2 Control Specialist

May 9, 2013
Eric M. Haas
David W. Harris
Alexander Henket
Vamsi Konduru
Ulrike G.Merrick
Elba G. Peralta-Cole
Brian Scheller

June 8, 2013
Patricia E. Barbe
Christopher D. Duskin
Robert A. Paden
Elisa A. Samuels
David K. Thomas

June 19, 2013
Mohammed S. Alhassen
Christopher R. Ecijan
Geri L. Mertz
Lokendra Uppuluri
Curt L. Webb
Yonghong Xue
Paul Yi

HL7 Australia

March 15, 2013
Michael R. Demark
Kyaw K. Htat
Anthony Wilson

HL7 Canada

June 18, 2013
Manpreet Bhinder

July 7, 2013
Milagros Lopez

HL7 India

April 13, 2013
H G Devanand
Zeeta D'Souza
Pooja Radhakrishna
Thilak Raj
Usha Sekhar
Rahul Sharma
Namitha V A
Anita Upare

April 27, 2013
Thejaswini. C.N
C. Navya Kumari
Vijayaprabha
Nalubolupapaiah
Vijaya Bhaskar R
Saira Firdose Rahemulla

May 25, 2013
Santosh Anantha Ramu
Ilango Chandrasekaran
Harish Kumar
Kumar Rangaraj

HL7 Spain

June 19, 2013
Francisco Albarracín Pascual
Adriana Brenlla Calvo
Antonio Cámara Valero
Oswaldo Crespo Pérez
Mª Carmen Ezquerra
Ángel Gutiérrez Peinado
Carlos Hervás Jiménez
Fernando Igual Novella
Víctor Martínez Sánchez
Carlos Peces Mateos
Graciela Poceiro Rey
Francisco Javier Sáez Hernández
Cristina Sanz de Ayala
Manuel Suárez Taboada

June 21, 2013
Albert Font Valverde
Ivan Labajos Rodríguez
Cristina Mollá García
Martí Pàmies Solà
Iryna Perih
David Rodríguez Cocinero

Certified HL7 CDA Specialist

May 9, 2013
Marcin S. Grudzien
George Koromia
Russell Ott
Toril O. Reite
Alan J. Vitale

HL7 Canada

March 22, 2013
Frederic Laroche

April 25, 2013
Abhishek Pandey

May 13, 2013
Minli Yang

HL7 China

June 9, 2013
Yihui Fan
Yang Gao
Limei Han
Xinting Huang
Dujuan Jiao
Jinghua Li
ZhiBiao Ou
Chaoren Sun
Hongxia Tan
Haisheng Wang
Yanbo Xue
Dejun Yang
Jian Yang
Lele Yang
Fan Zeng
Lin Zhang
Ben Zhang
Lin Zheng
Qin Zhu
Nan Zhou

HL7 India

May 25, 2013
Dinesh Cheluvegal Balasundara

HL7 Spain

June 19, 2013
Santiago Borrás Natividad

June 21, 2013
María Cecilia Costantini
Marc Górriz Marcelino

Certified HL7 Version 3 RIM Specialist

May 9, 2013
Dirk Donker
Sireerat Srisiriratanakul

HL7 Canada

June 18, 2013
Balraj Sandhu

HL7 India

May 25, 2013
Dr. Satish Khune

Upcoming INTERNATIONAL EVENTS

ICHI 2013 – IEEE International Conference on Healthcare Informatics
Philadelphia, PA
September 9-11, 2013
For more information, please visit
http://www.cvent.com/events/2013-ieee-international-conference-on-health-care-informatics-ichi-/event-summary-18aa6e46c40f4cab940040c16e2181b3.aspx

eChallenges e-2013 Conference
Dublin, Ireland
October 9-11, 2013
For more information, please visit
http://www.echallenges.org/e2013//

ISO/TC 215 Health Informatics Working Group Meeting
Sydney, Australia
October 21-25, 2013
For more information, please visit
http://www.iso.org/iso/iso_technical_committee?commid=54960

International HL7 Interoperability Conference (IHIC2013)
Sydney, Australia
October 28-30, 2013
For more information, please visit
http://www.HL7.org.au

HIMSS Europe CIO Summit
Mallorca, Spain
November 18-20, 2013
For more information, please visit
http://hitleadershipsummit.eu/

Health 2.0 Europe
London, England
November 18-19, 2013
For more information, please visit
http://www.health2con.com/events/conferences/europe-fall-2013/

mHealth Summit
Washington, DC
December 9-11, 2013
For more information, please visit
http://www.mhealthsummit.org/

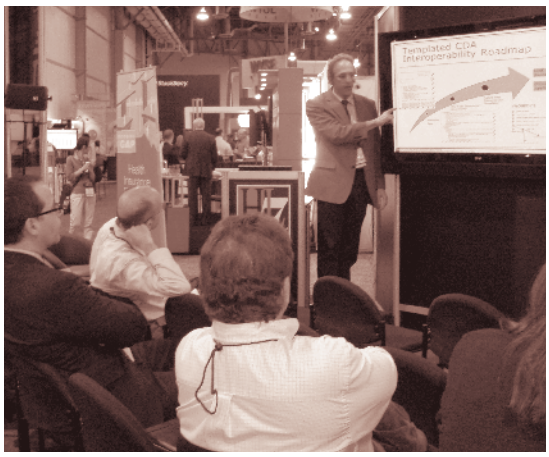
HEalthINF 2014 – 7th International Conference on Health Informatics
Eseo, Angers, Loire Valley, France
March 3-6, 2014
For more information, please visit
http://www.healthinf.biostec.org/

SAVE THE DATE FOR HIMSS 2014

February 23 – 27, 2014
Orlando, FL

Join us in the HL7 Booth (#1265) at the HIMSS 2014 Exhibit

HL7 will once again offer a variety of education sessions covering HL7 standards and current industry topics such as Meaningful Use. Visit our booth to learn more about how HL7 and HL7 standards contribute to meaningful use and are helping change the face of healthcare IT.



HL7 Chair-Elect Dr. Bob Dolin presents at the HL7 Exhibit at the annual HIMSS conference

www.himssconference.org

HL7 Terminology Authority, *continued from page 13*

(SOU) relationship with HL7 (e.g., IHTSDO, Logical Observation Identifiers Names and Codes (LOINC), National Council for Prescription Drug Programs (NCPD) and others).

The HTA is exclusively concerned with content of Value Set Expansions that are derived from external terminology SDO code systems. The scope includes:

1. Developing and maintaining HL7 quality processes and measures related to HL7 terminology derived from external technology SDOs.
2. Providing advice, where needed, on the acceptability of vocabulary proposed for inclusion in HL7 vocabulary.
3. Maintaining relationships with external terminology providers to ensure legal use of their products.

The HTA is expected to work with the Technical Steering Committee (TSC) and the CTO to implement any process or policy changes that would impact the Working Group. It will also serve in an advisory capacity to the existing harmonization process. All final terminology decisions will be made as a part of the harmonization process.

The HTA may become involved in the harmonization process at these times:

- When development of vocabulary is proposed;
- During harmonization where proposals for external terminologies are being considered and;
- Following harmonization to review the results of the process for actions assigned to harmonization.

Next Steps

As CTO I am charged with facilitating a call for nominations (which has already occurred). The HTA will be comprised of five individuals, including one of the HL7 Vocabulary co-chairs and at least two representatives from the affiliate community. Nomination can come from any HL7 member in good standing and self-nominations are allowed. I will then make recommendations to the Board regarding the composition of the HTA based on the qualifications of the nominations we receive (as they fit the specific requirements in the HL7 Board Approved action creating the HTA) and the five positions that we need to fill on the HTA.

HL7 ORGANIZATIONAL MEMBERS

Benefactors

Accenture
Allscripts
Booz Allen Hamilton
Centers for Disease Control and Prevention/ CDC
Duke Translational Medicine Institute
Epic
Food and Drug Administration
GE Healthcare
GlaxoSmithKline
IBM
Intel Corporation, Digital Health Group
InterSystems
Kaiser Permanente
McKesson Provider Technologies
Microsoft Corporation
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Oracle Corporation - Healthcare
Partners HealthCare System, Inc.
Philips Healthcare
Quest Diagnostics, Incorporated
Siemens Healthcare
U.S. Department of Defense, Military Health System
U.S. Department of Veterans Affairs

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7 Delta, Inc.
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Gamma-Dynacare Medical Laboratories
GEMMS
healthbridge
Holston Medical Group
Info World
Inofile
iNTERFACEWARE, Inc.
Knowtion
Liaison Technologies Inc.,
Mediture
Notable Solutions
Panacea Healthcare, LLC
Pitney Bowes Software
Shimadzu Scientific Instruments, Inc.
Standing Stone, Inc.
Varian Medical Systems
WellPoint, Inc.

Consultants

CDA PRO
Accenture
Anakam Identity Services, Equifax
Andy McKenna
Blackbird Solutions, Inc.
Booz Allen Hamilton
Canon Information & Imaging Solutions, Inc.
CentriHealth
Champ IT Solutions Inc.
CSG Government Solutions
Dapasoft Inc.
Dent Technical Consulting Services
Eastern Informatics, Inc.
Edifecs, Inc.
Emergint Technologies, Inc.
EnableCare LLC
ESAC Inc
FEI.com
Frank McKinney Group LLC
Gartner
General Dynamics Information Technology
Genoa Healthcare Clinical Laboratory
Goodmark Medical (International) Ltd
Haas Consulting
Health Konnekt
Healthcare Data Assets
Healthcare Integration Technologies
Healthcentric Advisors
HLN Consulting, LLC
Hubbert Systems Consulting
iConnect Consulting
iEHR.eu
Just Associates, Inc.
Keiper & Associates Inc
Lantana Consulting Group
Life Technologies
Logimethods
LOTS, LLC
M*Modal, Inc.
Matricis Informatique Inc.
MCNA Dental
Michael Keevican, LLC
Netsoft USA
newMentor
Ockham Information Services LLC
Octagon Research Solutions, Inc.
OMKT LLC
OTech, Inc.
Professional Laboratory Management, Inc.
RedGranite, LLC
River Rock Associates
Rob Savage Consulting
Shafarman Consulting
SLI Global Solutions
Stat! Tech-Time, Inc.
The Audigy Group, LLC
Travers Consulting
United Laboratory Network IPA, LLC
Virginia Riehl
Westat

General Interest

ASIP SANTE
ACLA
Agency for Healthcare Research and Quality
Alabama Department of Public Health
American Assoc. of Veterinary Lab Diagnosticians
American College of Physicians
American College of Surgeons, NTDB
American Dental Association
American Dietetic Association
American Health Information Management Association
American Immunization Registry Association (AIRA)
American Medical Association
American Society of Clinical Oncology
Arizona Department of Health Services
Arkansas Department of Health
Blue Cross Blue Shield Association
CA Department of Public Health
California Correctional Health Services
California Department of Health Care Services
California HealthCare Foundation
CalOptima
Cancer Care Ontario
CDISC
CEI Community Mental Health Authority
Centers for Disease Control and Prevention/ CDC
Centers for Medicare & Medicaid Services
City of Houston
College of American Pathologists
College of Healthcare Information Mgmt. Executives
Colorado Regional Health Information Organization
Columbia University
Community Mental Health Center of Crawford County
Comprehensive Medical and Dental Program
Connecticut Department of Public Health
Contra Costa County Health Services
Council of Cooperative Health Insurance
Delaware Division of Public Health
Delta Dental Plans Association
Department of Developmental Services
Department of Health
DGS, Commonwealth of Virginia
District of Columbia Department of Health
Duke Translational Medicine Institute
ECRI Institute
Electronic Transactions Development Agency
Estonian eHealth Foundation
Florida Department of Health
Food and Drug Administration
Georgia Medical Care Foundation
Health Sciences South Carolina
ICCBBA, Inc.
IFPMA (as trustee for ICH)
Illinois Department of Public Health
Indian Health Service
Indiana Health Information Exchange
Iowa Department of Public Health
Japan Pharmaceutical Manufacturers Association
L.A. County Dept of Public Health
LA County Department of Mental Health
LCF Research
Louisiana Public Health Institute
Medical University of South Carolina
Michigan Health Connect
Michigan Health Information Network
Ministry of Health - Slovenia
Minnesota Department of Health
Missouri Department of Health & Senior Services
NAACCR
National Association of Dental Plans
National Cancer Institute
National Center for Health Statistics/CDC
National Council for Prescription Drug Programs
National eHealth Transition Authority (NEHTA)
National Institute of Standards and Technology
National Library of Medicine
National Marrow Donor Program
National Quality Forum
NCQA
New Mexico Department of Health
New York State Department of Health
NICTIZ Nat.ICT.Inst.Healthc.Netherlands
NIH/Department of Clinical Research Informatics
OA-ITSD - Department of Mental Health
Oak Ridge Associated Universities
Office of the National Coordinator for Health IT
OFMQ
Oklahoma State Department of Health
Oregon Public Health Division
Pharmaceuticals & Medical Devices Agency
Phast
Primary Care Information Project, NYC Dept Health
Qatar Science & Technology Park
Ramsey County Public Health
Region Sjaelland
Region Syddanmark
RTI International
SAMHSA
SC Dept. of Health & Environmental Control HS
Social Security Administration
Technological University of Panama, CIDITIC
Telligen
Tennessee Department of Health
Texas Department of State Health Services
Texas Health Services Authority
The Joint Commission
The MITRE Corporation
The National Council for BehavioralHealth
UC Davis School of Medicine
University HealthSystem Consortium
University of AL at Birmingham
University of Kansas Medical Center
University of Miami
University of Minnesota
University of Szeged, Institute of Informatics
University of Texas Medical Branch at Galveston
University of Utah Pediatric Critical Care/ IICRC
UT Austin Health Information Technology Program
Utah Health Information Network
Virginia Department of Health
Virginia Information Technologies Agency
Washington State Department of Health
West Health Institute
Wisconsin State Laboratory of Hygiene
WNY HEALTHeLINK
WorldVistA

Payers

AIM Specialty Health
Blue Cross and Blue Shield of Alabama
Blue Cross Blue Shield of Arizona
Blue Cross Blue Shield of South Carolina
CIGNA
Community Health Group
Coventry Health Care
Florida Blue
Healthspring
Meridian Health Plan
MetLife, Inc.
National Government Services
Neighborhood Health Plan
Premera Blue Cross
UnitedHealth Group
Valence Health
Wisconsin Physicians Service Ins. Corp.

HL7 ORGANIZATIONAL MEMBERS, continued

Pharmacy

Bristol-Myers Squibb
GlaxoSmithKline
Merck & Co. Inc.
Sanofi-Aventis R&D

Providers

Advanced Biological Laboratories (ABL) SA
Advantage Dental
Akron General Medical Center
Alaska Native Tribal Health Consortium
Albany Medical Center
Albany Medical Center Hospital
ARUP Laboratories, Inc.
Ascension Health Information Services
Avalon Health Care
BHR - Behavioral Health Response
BJC HealthCare
Blessing Hospital
Bloomington Hospital & Healthcare Systems
Blount Memorial Hospital
Boston Children's Hospital
Butler Healthcare Providers
Carilion Services, Inc.
Cedars-Sinai Medical Center
Center for Life Management
Central Illinois Radiological Associates
CentraState Healthcare System
CHI
Childrens Mercy Hospitals and Clinics
Children's of Alabama
Cincinnati Children's Hospital
City of Hope National Medical Center
Cleveland Clinic Health System
Clinical Reference Laboratory, Inc.
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Clinical Genomics
Clinical Interoperability Council
Clinical Quality Information
Community Based Collaborative Care
Emergency Care
Health Care Devices
Patient Care
Pharmacy
Public Health & Emergency Response
Regulated Clinical Research
Information Management

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Implementation/Testing
Implementable Technology Specifications
Infrastructure & Messaging
Modeling & Methodology
RIM Based Application Architecture
Security
Service Oriented Architecture
Templates
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Electronic Services
International Mentoring Committee
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Project Services
Publishing
Tooling

STRUCTURE & SEMANTIC DESIGN
Arden Syntax
Clinical Decision Support
Clinical Statement
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Financial Management
Imaging Integration
Mobile Health
Orders & Observations
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  You'll get HL7 training straight from the source: Our instructors. They are not only HL7 experts; they are the people who help produce the HL7 standards
- **Certification Testing**
  Become HL7 Certified: HL7 is the sole source for HL7 certification testing, now offering testing on Version 2.7, Clinical Document Architecture, and Version 3 RIM
- **Economical**
  A more economical alternative for companies who want the benefits of HL7's on-site training but have fewer employees to train

Upcoming WORKING GROUP MEETINGS

January 12 – 17, 2014

Working Group Meeting

Hyatt Regency Baltimore
Baltimore, MD

May 4 – 9, 2014

Working Group Meeting

Pointe Hilton Squaw Peak Resort
Phoenix, AZ

September 14 – 19, 2014

28th Annual Plenary & Working Group Meeting

Hilton Chicago Hotel, Chicago, IL

January 18 – 23, 2015

Working Group Meeting

Hyatt Regency on the Riverwalk
San Antonio, TX

May 10 – 15, 2015

Working Group Meeting

Hyatt Regency Paris – Charles de Gaulle Hotel, Paris, France

October 4 – 9, 2015

29th Annual Plenary & Working Group Meeting

Sheraton Atlanta Hotel
Atlanta, GA