Unlocking the Power of Health Information

2010 ANNUAL REPORT

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HL7® Vision

To create the best and most widely used standards in healthcare.

HL7® Mission

HL7 provides standards for interoperability that improve care delivery, optimize workflow, reduce ambiguity and enhance knowledge transfer among all of our stakeholders, including healthcare providers, government agencies, the vendor community, fellow SDOs and patients. In all of our processes we exhibit timeliness, scientific rigor and technical expertise without compromising transparency, accountability, practicality, or our willingness to put the needs of our stakeholders first.

2010

To create the best and most widely used standards in healthcare.

2010 Chair Report

Robert Dolin, MD
HL7 International
2010 Chair

In 2010, we achieved a major milestone for the organization — we achieved a shared sense of HL7 International's priorities.

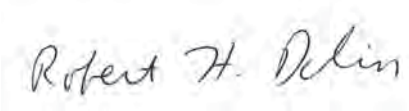
We did this by fleshing out our Strategic Initiatives, by refining the process for keeping the Strategic Initiatives fresh, and by "operationalizing" them.

As we move from HL7's Vision, to HL7's Mission, to HL7's Strategic Initiatives, we're essentially going from an abstract ideal to an operational and measureable set of objectives. Actual projects build upon these objectives — they are literally the concrete projects we embark upon with the intent of progressing one or more of our objectives. This relationship might be characterized something like this:

The 2011 Strategic Initiatives and Strategic Initiative Criteria were approved by the Board of Directors toward the end of 2010. These are the objectives we will operate against in 2011. This most recent January ballot cycle saw the first annual Strategic Initiative "ballot" — which is open to all stakeholders regardless of HL7 membership status, and which sets in motion a process that will culminate in approval of the 2012 Strategic Initiatives and Strategic Initiative Criteria toward the end of this year. Our Governance and Operations Manual defines this process in detail, including the role of the Strategic Initiative Committee, the Technical Steering Committee, and the Board of Directors.

Operationalizing the Strategic Initiatives means finding ways to insert them into our decision making; it means making them real. We're using them now to help ensure TSC and Board alignment, to help ensure that HL7 is working effectively with external stakeholders, as part of budget and resource prioritization, etc. We still have some learning to do surrounding how best to operationalize the Strategic Initiatives, but for now, I'm glad that we've achieved a shared sense of priorities and that we can speak in terms of HL7 International's priorities. I suspect this will take on increasing significance as we get better at putting our Strategic Initiatives into practice.

We welcome your thoughts and input on HL7 International's priorities for 2011 and beyond!



2010

In 2010, we achieved a major milestone for the organization – we achieved a shared sense of HL7 International's priorities.

2010 CEO Report

Charles Jaffe,
MD, PhD
HL7 International
Chief Executive Officer

The first year of the decade was a remarkable time for healthcare IT, both in the United States and around the globe. Healthcare providers, as well as the developers that helped to create electronic health records and the international standards community, have witnessed many changes in the management of healthcare, its governance and its rapidly evolving technology. The process was slow and deliberate at times and nearly revolutionary at others. Governments demanded more solutions for interoperability, better practices for security and privacy, and greater collaboration among stakeholders. The impact of these changes was not lost on Health Level Seven.

Adapting to a Changing Healthcare Landscape

In the United States, the promise of universal healthcare was made but not realized; governments struggled to pay for the soaring costs of healthcare while healthcare delivery quality was failing to keep pace. As the notion of accountable care became the newest paradigm to drive improvements in chronic disease management, the technology to support the evaluation of care delivery lagged behind. At the same time, the European community was making plans to share clinical summaries and provide electronic prescribing technologies across borders. HL7 has been asked to respond, both as a technology innovator and as a successful collaborator.

The demands placed upon HL7 and its role in the international community has been growing. Many factors accelerated these demands. Medical knowledge, previously thought to double every 18 months, is now expanding exponentially. New technologies and disciples, like genomics and epigenetics, are adding new concepts and terms. The population is aging, which adds pressure to deliver better care to more people without adding to the growing fiscal burden. Medical images are requiring greater storage, archiving and retrieval; and these files are on a trajectory to consume 20% of the world's data storage space by 2020. The medical delivery system is now clearly a broken model. HL7 is trying to answer this challenge through collaboration.

Physicians alone cannot meet the demands for care delivery in a system far too resource-limited. New modes of care are rapidly emerging. Patients' demands and the extended support infrastructure are expanding, but medical literacy is not keeping pace. If patients are to become the epicenter of their own care, they need better access to reliable healthcare information and their own medical data. Stand-alone personal health records have mushroomed, but sufficient completeness of these records to support patient-centeredness and improve caregiver acceptance cannot always be assured. Perhaps more importantly, maintaining the accuracy of data transport while ensuring data security and patient privacy are often competing values. HL7 continues to collaborate with government agencies and other standards development organizations to deliver on these requirements.

Accelerating Innovation

Some solutions require the redistribution of manpower or creative approaches to resource management. No one believes that simply training more doctors will solve these problems. Traditions surrounding the workflow of caregivers must be reevaluated. We can no longer expect to engineer information systems to satisfy a faulty work engine. Some technologies will help. Mobile computing has already delivered on some of the promise of rapid delivery and integration of patient data. However, that technology brings with it the unrealistic expectation that physicians should be able, or even required, to remember all of practice guidelines and evidence-based medicine that is essential for quality care. The success of medical records systems requires more than accurate and timely sharing of information between caregivers. Decision support, well-documented and well-implemented, is at the heart of successful accountable care. HL7 continues to lead the way, but collaboration with other organizations and other standards developers is required for this process to be truly transformative.

Interoperability is more than accurately and seamlessly sharing data between two systems (and two caregivers); interoperability is being able to reuse the data that the systems exchanged. The the success of the BRIDG (Biomedical Research Integrated Domain Group) model to provide data interchange between patient care and clinical research environments is a landmark

Interoperability is more than accurately and seamlessly sharing data between two systems (and two caregivers); interoperability is being able to reuse the data that the systems exchanged.

in both technology and collaboration. More importantly, it addresses the fundamental requirements for the reuse of this data. Some aspects of the US Department of Health & Human Services' Final Rule require the reuse of data for public health to enable comparative effectiveness and quality measurement. This development process is progressing at an ever increasing pace.

While HL7 has accelerated the time lines for standards development, the complexity of healthcare information has increased exponentially. Moreover, the inter-relationship between healthcare domains demands that data exchange is seamless and secure. In many realms, the complexity of our healthcare data is often underestimated. While there are only 300,000 words in the English language, the National Library of Medicine informs us that there are 600,000 unique medical concepts, and the number is growing. In some circles, delays in creating new standards are attributed to the requirements that HL7's process be open, transparent, and consensus-driven. However, we have come to realize that to resolve this conundrum we need more than technical simplification, flexibility and universality. Our resources are strained. The leadership of HL7 has spent nearly two years redefining the process by which our mission can be achieved and the demands for accelerated development can be met.

Implementing the Business Plan

The Business Plan Taskforce has undertaken an ambitious plan for reevaluating the business model and creating a sustainable solution for our increased requirements and ambitious goals. The changes in the healthcare landscape have demanded this action. Last fall, the Board of Directors approved the new Business Plan Framework, which has been structured around four supporting elements: membership, governance, intellectual property (IP) and services. Clearly, they are not independent components, but rather are intimately entwined. In order for any one component of the plan to be successfully implemented, the interdependencies must be addressed.

Intellectual property and its management lie at the heart of this framework. The procedures for management must be kept simple to understand and straight-forward to administer. At the same time, the rules must adhere to the legal structures that define IP. We have begun to develop both the policies and tools to achieve these goals, without putting an undue burden on the systems developers or on the broad community of end-users. In doing so, we have strived to comply with international law and have borrowed liberally from other organizations that have implemented successful IP management strategies. Peter Kay, a British pundit, has said that "Knowledge is knowing that a tomato is a fruit. Wisdom is knowing not to put a tomato in a fruit salad." We strive daily to keep this in mind.

For more than two decades, HL7 has relied on its members for support. The fundamental principles will not be changed in the new business plan. At the same time, use of the intellectual property is a key component in the implementation of this plan. As HL7 has grown to become a truly international organization, use of our IP must reflect the needs of the user community around the globe. In addition, we will continue to recognize the social and economic diversity of our membership as the benefit and rights of membership become better defined. This is equally true for governments, multi-national organizations and individuals.

Finally, services have become a growing part of the value which HL7 brings. This is true for our technical products as well as our outreach and educational offerings. For nearly two years, HL7 has provided a highly-acclaimed and ever-growing eLearning program, which provides technical training in multiple languages around the globe. As our services grow to include other requested benefits, such as conformance testing, we will continue to rely upon consensus and collaboration.

Early in 2011, the taskforce will recommend the complete details to implement this business plan. It promises to take into account, and attempt to balance, many factors. These include the fiscal requirements of the organization, the growing diversity of the membership, the needs and the contributions of governments, and the effective maintenance of our intellectual property. Many of the components of the plan will be implemented early this year. Some will require changes in the governance process and perhaps even key alliances. If preliminary discussions with a very diverse community of our stakeholders are born out, the process will be transformative. Throughout the year, I look forward to sharing the principles of the plan with many of you. As always, a collaborative environment will help drive the plan's success.

2010

While HL7 has accelerated the time lines for standards development, the complexity of healthcare information has increased exponentially.

2010 CTO Report

John Quinn
HL7 International
Chief Technology
Officer

2010 Tooling Report

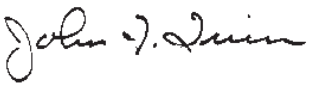
During 2010, HL7 made significant progress in developing and improving tools for (1) standards ballot preparation and publication and (2) using Version 3 RIM-based standards:

- In 2010, we updated and implemented the HL7 Version 3 publishing methodology and tools to use and support the features of the HL7 Model Interchange Format (MIF 2.0). As a result, we streamlined our publishing process and fixed a number of technical problems that had reduced quality and required significant manual intervention. The HL7 membership received the HL7 Version 3 2010 Normative Edition in August 2010 on-time and with far less direct manual intervention in the publishing process than in any other year since the first Version 3 Normative Edition.
- Updates were created by the NHS for their Static Model Designer (SMD) in the Open Health Tools (OHT) Organization. They were developed by the NHS as an Open Health Tools Project to incorporate changes needed to support full development cycle of Universal level artifacts, as well as realm-specific artifacts (e.g., UK, Canada, US, etc.). The SMD is an Eclipse Platform based tool that can be acquired through the OHT website. It is populated by the user with a licensed copy of the Version 3 Normative Standard in MIF format and then used to create constrained user models.
- The US Department of Veteran Affairs Veteran's Health Administration (VHA) has continued development and new publications of tooling API plug-in modules that work with the IBM Rational UML-based modeling products. These tooling modules also enable users to create UML and XML/XMI representations of user required constraints on the HL7 Version 3 RIM. The plug-in modules are also available through OHT and apply a similar process of enabling a user to take a licensed machine-readable form of the HL7 Version 3 RIM and import it into the VA's Model Driven Health Tools (MDHT) Project. For more information, please visit https://www.projects.openhealthtools.org/sf/projects/mdht/cda/presentations/20101029/ONC_MDHT_Overview.pdf.

- Both of these tools have demonstrated an ability to enable a particularly useful and powerful templating process for use with the HL7 Version 3 based Clinical Document Architecture (CDA™) product. This enables a user to create new valid constrained CDA compliant templates. An example of such a template is the Continuity of Care Document (CCD™). The NHS tool is based on an NHS-developed Static Model Designer which is used by the NHS to support the UK's use of Version 3 and is not available in Open Source through OHT. The VHA's MDHT project requires IBM's Rational tools as a foundation. However, this enables a much higher level of off-the-shelf documentation, education and support.

2011 Tooling Strategy

- HL7 will continue to ensure that our tooling meets the foundational needs of our standards. We will spend the necessary funds to keep our tooling current so that we can reliably produce and process the HL7 ballots and publish HL7 standards and other products.
- Moving forward in 2011, we have the opportunity to shift from a focus of remediating and updating the current tooling environment to one of looking at new opportunities for external collaboration and long-term strategy. HL7's immediate challenge will be in finalizing and implementing MIF 2.2 in our balloting and publication (i.e., non-user) environment. It also presents the challenge of developing a self-documenting and broad shared artifact repository for all useful artifacts, such as models (data, behavior and more), constrained elements of models, template models, and others that can be easily searched and provide a point for download that goes beyond our current environment of downloadable document sets (e.g., ballots, products, etc.). We are working with Open Health Tools on our shared needs for such a repository. This will be an ideal place for the Open Source community to work with HL7 and for HL7 to adopt concepts and benefits that can be found in Open Source.



2010

During 2010, HL7 made significant progress in developing and improving tools...

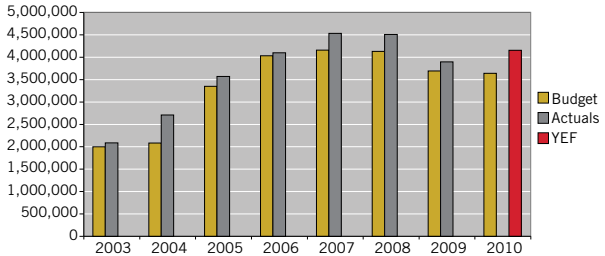
2010 Treasurer Report

Hans Buitendijk
HL7 International
Board Treasurer

During 2010, HL7 International stayed financially healthy and was unexpectedly able to avoid dipping into its reserves. However, looking to 2011 and beyond, we continue to be concerned about the revenue stream as critical tooling projects require substantial funding that is currently not available.

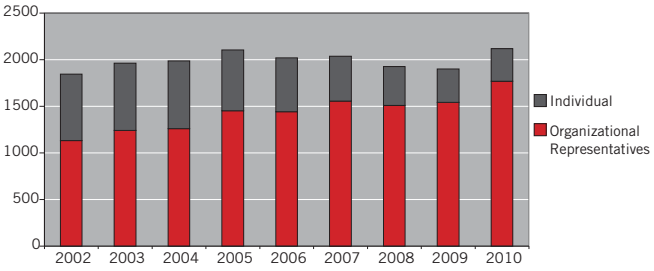
Revenues

2010 Revenues were budgeted at $3,639,445. Stronger than expected organizational memberships and affiliate contributions are expected to help us reach $4,151,827[1].



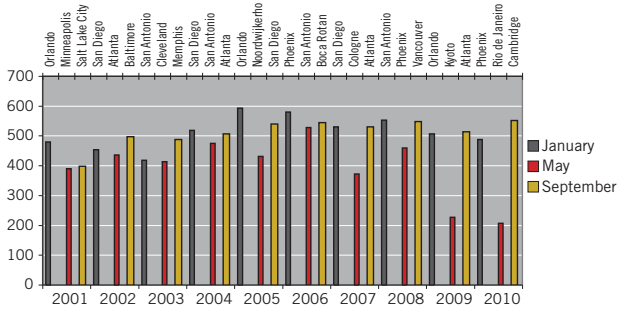
Memberships

The number of organizational members saw a robust growth, while the number of individual members has leveled off in 2010. The net effect on the number of voting members (organizational representatives and individual members), is a substantial increase to 2117 voters at the close of 2010[2].

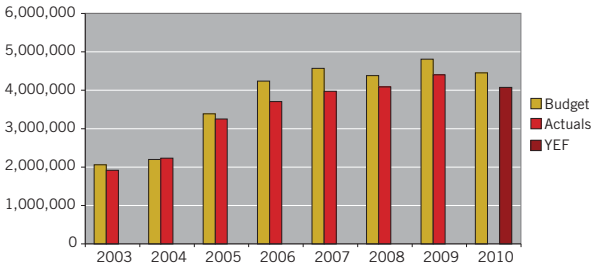


Work Group Meeting Attendance

Attracting standards developers at venues outside North America again proved difficult with lower than expected participation during the May meeting, while the October meeting saw record attendance for a Plenary meeting.

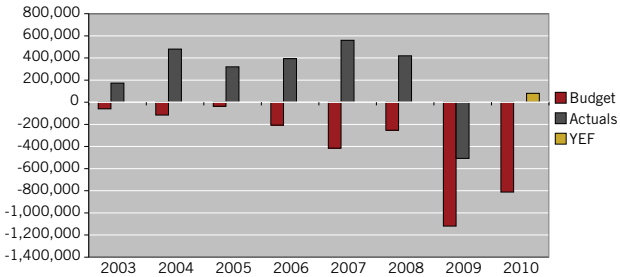


[1] All 2010 numbers are unaudited
[2] As of December 31



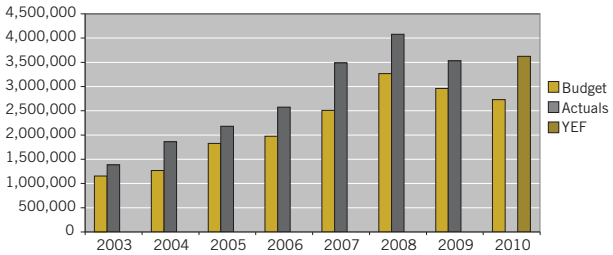
Expenses

Expenses were well managed during 2010 and are expected to be $4,071,6881, which is lower than budgeted. Starting in August, we began to pay for our CEO's compensation.



Income

The combination of better then expected revenues, expense controls, and projects running below budget, allowed us to improve on our income over budget. This is expected to add $80,139[1] to the reserves.



Reserves

The reserves are expected to reach $3,620,745.

2010

The number of organizational members saw a robust growth...

[1] All 2010 numbers are unaudited

2010 Executive Director Report

Mark McDougall
HL7 International Executive Director

Membership Report

HL7 had 2,261 members on December 30, 2010, as compared to 2,019 one year earlier. We currently have 30 Benefactors and 10 Supporters. We had one new Benefactor and five new Supporters in 2010. New memberships for both individual and organizational memberships remained higher than 2009.

Individual Memberships

As of December 30, 2010, HL7 had a total of 426 individual members. This total reflects 269 new members joining or being re-instated during 2010, as compared to 227 new members joining during 2009. For the 2010 year, there was a net gain of three members, which is better than the loss of four in 2009.

Organizational Memberships

There were a total of 590 organizational members as of December 30, 2010. For organizational members in 2010, we had 288 new organizations joining or being re-instated as opposed to 213 in 2009. For the year, there was a net increase in organizational memberships of 93. This is an an increase from the additional 69 organizational members that joined in 2009.

International Council Memberships

During 2010, there were 33 countries with active HL7 affiliates, including Argentina, Australia, Austria, Brazil, Canada, Chile, China, Colombia, Croatia, Czech Republic, Finland, France, Germany, Greece, Hong Kong, India, Italy, Japan, Korea, The Netherlands, New Zealand, Norway, Pakistan, Romania, Russia, Singapore, Spain, Sweden, Switzerland, Taiwan, Turkey, United Kingdom, and Uruguay.

Membership Outreach Efforts

As part of our marketing efforts, HL7 conducted an outreach to our old and non-members through email and mail to generate interest in HL7 membership. We contacted approximately 3,024 old members and non-members. The campaign directly produced $45,545 in membership dues revenues.

Membership Recognition

HL7 has been very fortunate to repeatedly attract incredibly talented and dedicated volunteers. In an attempt to recognize some of these dedicated individuals, during the October 2010 Plenary and Working Group Meeting, the 14th Annual W. Edward Hammond, PhD, HL7 Volunteer of the Year Awards were presented to:

Hugh Glover
Stan Huff, MD
Julie James
Charlie Mead, MD
Mark Shafarman
Pat Van Dyke
Mead Walker

HL7 also announced a new recognition program during this meeting: HL7 Fellowship. This program recognizes individuals who have contributed significantly to HL7 and have held at least 15 years of continuous HL7 membership. HL7 is pleased to recognize and congratulate the following 25 individuals as the inaugural 2010 class of HL7 Fellows:

Woody Beeler, PhD
Bernd Blobel, PhD
William Braithwaite, MD, PhD
Hans Buitendijk
Jane Curry
Norman Daoust
Gary Dickinson
Bob Dolin, MD
Jean Ferraro
Freida Hall
W. Edward Hammond, PhD
Stan Huff, MD
Bert Kabbes
Ted Klein
Virginia Lorenzi
Ken McCaslin
Clement McDonald, MD
Charlie Mead, MD
Chuck Meyer
John Quinn
Wes Rishel
Robert Seliger
Gregg Seppala
Mark Shafarman
D. Mead Walker

Meetings Report

January Meeting in Phoenix, Arizona

At least 515 attendees participated in our January 2010 Working Group Meeting held in Phoenix, Arizona. This total includes 149 attendees from outside of the USA, which represents an impressive 29% of all attendees. Over 40 HL7 work groups met in Orlando. Attendees also took advantage of 26 tutorials that week.

2010

HL7 has been very fortunate to repeatedly attract incredibly talented and dedicated volunteers.

This meeting marked the end of Ed Hammond's unprecedented third term as Chair of the HL7 Board of Directors (1990, 1996-1997, and 2008-2009). Dr. Hammond has dedicated two decades to serving HL7 in leadership positions and has become the face of HL7 around the globe.

May Meeting in Rio de Janeiro, Brazil

HL7 convened the May 2010 Working Group Meeting in the world-famous Rio de Janeiro. The meeting was business as usual with 210 attendees, 19 tutorials and 36 work groups meeting. Attendees also enjoyed the many beautiful and fun attractions that Rio has to offer. HL7 extends sincere appreciation to Marivan Santiago Abrahão, MD, Chair of HL7 Brazil, for his invaluable guidance and the hundreds of hours of effort he put forth to help us plan this meeting.

October Meeting in Cambridge, Massachusetts

HL7 hosted its 24th Annual Plenary and Working Group Meeting at the Hyatt Regency Cambridge Hotel in Cambridge, Massachusetts across the Charles River from Boston. This meeting attracted over 560 attendees from 25 countries. This total includes 132 attendees from outside of the USA, which represents 24% of all attendees. The meeting also featured 27 tutorials, three certification exams, and 55 HL7 work groups convened meetings.

The theme of HL7's 24th Annual Plenary Meeting was the future of healthcare using genomics as a key tool. Kicking off the program as our first keynote speaker was Raju Kucherlapati, MD – Paul C. Cabot Professor of Genetics, Professor of Medicine at Harvard Medical School. His spell-binding keynote address focused on the implementation of personalized medicine and set the stage for several timely and well-received presentations.

Immediately following the morning Plenary meeting, HL7 produced an HL7 Ambassador program on HL7 and the Final Rule: Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology. This very popular session attracted more than 100 attendees and presented an overview of how HL7 will be used to achieve Meaningful Use and then provided high-level tutorials on HL7's Clinical Document Architecture (CDA™), Continuity of Care Document (CCD™) and our Version 2 standards, which are named in the Final Rule referenced in the session title. The HL7 Ambassador program was one of many HL7 sessions during 2010 that provided physicians with opportunities for earning CMEs.

Educational Summits

HL7 also produces intensive training via our educational summits, where our expert instructors provide high quality training in a small classroom setting. This concentrated two-day format provides maximum training with minimal time

investment. During 2010, HL7 provided such intensive training to 180 individuals from three educational summits that were held in Raleigh, NC; Bloomington, MN; and Portland, OR. Several customized HL7 on-site training programs also provided HL7 training to many others during 2010.

Remote/Distance e-Learning

The HL7 e-Learning Course is a web-based workshop which includes a set of guided exercises that teach by practice and example, not by exposition. The HL7 e-Learning course focuses on learning by doing. During 2010, HL7 produced six e-Learning courses around the world that served 342 students. These courses were produced by HL7 International, HL7 Argentina and HL7 India. The courses are so effective and popular that they often sell out within days of being announced. In fact, HL7 has 1,016 people on the waiting list for these courses.

Certification Testing Report for 2010

HL7's popular certification program continues to attract hundreds of individuals from around the globe each year. The worldwide number of certified HL7 specialists by type of exam is provided below.

CERTIFICATION TESTING REPORT FOR 2010

CERTIFICATION EXAM	NUMBER CERTIFIED IN 2010	TOTAL NUMBER CERTIFIED
Version 2	273	2,309
Clinical Document Architecture	69	224
Version 3 Reference Information Model (RIM)	86	235
Total Certified	428	2,768

HL7 International 2010 Board of Directors

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Robert Dolin, MD
Lantana Consulting Group

Vice Chair
W. Edward Hammond, PhD
Duke University

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Hans Buitendijk
Siemens Healthcare

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Affiliate Director
Catherine Chronaki
FORTH-Institute of Computer Science/ HL7 Hellas

Affiliate Director
Michael van Campen
Gordon Point Informatics Ltd.

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Charles Jaffe, MD, PhD
Health Level Seven International

Executive Director (Non-Voting)
Mark McDougall
Health Level Seven International

Chief Technology Officer (Non-Voting)
John Quinn
Health Level Seven International

Advisory Council Chair (Non-Voting)
Richard Dixon Hughes
DH4 Pty Ltd

HL7 Affiliates

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Australia
Austria
Brazil
Canada
Chile
China
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Croatia
Czech Republic
Finland
France
Germany
Greece
Hong Kong
India
Italy
Japan
Korea
New Zealand
Norway
Pakistan
Romania
Russia
Singapore
Spain
Sweden
Switzerland
Taiwan
The Netherlands
Turkey
UK
Uruguay

2010

Argentina
Australia
Austria
Brazil
Canada
Chile
China
Colombia
Croatia
Czech Republic
Finland
France
Germany
Greece
Hong Kong
India
Italy

HL7 2010 Standards Snapshot

HL7 Standards Receiving ANSI Approval in 2010

- ***HL7 Version 3 Standard: Shared Messages, Release 3***
  Designation: ANSI/HL7 V3 COMT, R3-2010
  Date Approved: 1/5/2010
  Information: This is a revision of ANSI/HL7 V3 COMT, R2-2005

- ***HL7 Version 3 Standard: Healthcare, Community Services and Provider Directory, Release 1***
  Designation: ANSI/HL7 V3 SPDIR, R1-2010
  Date Approved: 2/18/2010

- ***HL7 Version 3 Standard: Role-based Access Control Healthcare Permission Catalog, Release 2***
  Designation: ANSI/HL7 V3 RBAC, R2-2010
  Date Approved: 2/18/2010
  Information: This is a revision of ANSI/HL7 V3 RBAC, R1-2008

- ***HL7 Version 3 Standard: Reference Information Model, Release 2***
  Designation: ANSI/HL7 V3 RIM, R2-2010
  Date Approved: 4/20/2010
  Information: This is a revision of ANSI/HL7 V3 RIM, R1-2003

- ***HL7 Version 3 Standard: GELLO; A Common Expression Language, Release 2***
  Designation: ANSI/HL7 V3 GELLO, R2-2010
  Date Approved: 4/28/2010
  Information: This is a revision of ANSI/HL7 V3 GELLO, R1-2005

- ***HL7 Version 3 Standard: Context-Aware Retrieval Application (Infobutton); Knowledge Request, Release 1***
  Designation: ANSI/HL7 V3 INFOB, R1-2010
  Date Approved: 7/21/2010

- ***HL7 EHR System Records Management and Evidentiary Support Functional Model, Release 1***
  Designation: ANSI/HL7 EHR RMESFP R1-2010
  Date Approved: 8/16/2010

- ***HL7 EHR System Long Term Care Functional Profile, Release 1 - US Realm***
  Designation: ANSI/HL7 EHR LTCFP, R1-2010
  Date Approved: 9/3/2010

International Organization for Standardization approved standards

Currently five HL7 standards are also approved as ISO standards. They include the following:

- Health Informatics – HL7 Version 3 – Reference Information Model – Release 1 – 2006-08-03
- Data Exchange Standards – HL7 Clinical Document Architecture – Release 2 – 2009-11-24
- Electronic health Record-System Functional Model, Release 1 – 2009-11-13
- Health Informatics – Common Terminology Service, Release 1 – 2009-11-05
- Data Exchange Standards – Health Level Seven Version 2.5 – An Application Protocol for Electronic Data Exchange in Healthcare Environments – 2009-06-17

HL7 Draft Standards for Trial Use (DSTUs) published in 2010

- HL7 Implementation Guide for Clinical Document Architecture, Release 2: Healthcare Associated Infection (HAI) Reports, Release 4
- HL7 Version 3 Domain Analysis Model: Medical Records; Composite Privacy Consent Directive, DSTU Release 2
- HL7 Version 3 Standard: Representation of the Health Quality Measures Format (eMeasure), Release 1
- HL7 Version 3 Standard: Patient Administration, DSTU Release 2; Encounter Topics, Release 1
- HL7 Implementation Guide for Clinical Document Architecture, Release 2 – Level 3: Neonatal Care Report, DSTU Release 1
- HL7 Implementation Guide for Clinical Document Architecture, Release 2: Procedure Note, Release 1
- HL7 Implementation Guide for Clinical Document Architecture, Release 2: Healthcare Associated Infection (HAI) Reports, DSTU Release 5
- HL7 Implementation Guide for Clinical Document Architecture, Release 2: Unstructured Documents, DSTU Release 1
- HL7 Implementation Guide for Clinical Document Architecture, Release 2: Personal Healthcare Monitoring Report, DSTU Release 1.1

Informative Documents Published in 2010

- HL7 Version 2.5.1 Implementation Guide: Electronic Laboratory Reporting to Public Health, Release 1 (US Realm)

HL7 International Work Groups

Anatomic Pathology

Architectural review Board

Arden Syntax

Attachments

Child Health

Clinical Context Object Workgroup

Clinical Decision Support

Clinical Genomics

Clinical Interoperability Council

Clinical Statement

Community Based Collaborative Care

Education

Electronic Health Records

Electronic Services

Emergency Care

Financial Management

Generation of Anesthesia Standards

Governance and Operations

Government Projects

Health Care Devices

Imaging Integration

Implementable Technology Specifications

Implementation / Conformance

Infrastructure and Messaging

International Council

International Mentoring Committee

Marketing

Modeling and Methodology

Orders and Observations

Organizational Relations

Outreach Committee for Clinical Research

Patient Administration

Patient Care

Patient Safety

Pharmacy

Policy Advisory Committee

Process Improvement Committee

Project Services

Public Health and Emergency Response

Publishing

Regulated Clinical Research Information Management

RIMBAA

Roadmap Committee

Security

Services Oriented Architecture

Structured Documents

Technical Steering Committee

Templates

Tooling

Vocabulary

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