Rwanda Health Enterprise Architecture (RHEA) Project Conference Call Minutes

# Date and Time

January 10th 2013, 3pm, GMT +2hrs

# Participants

Rhonwyn Cornell (RhC), Linda Taylor (LT),Carl Fourie( CF), Michel Makolo (MM), Emmanuel Rugomboka (ER), Liz Peloso (LP), Yvonne Hong (YH), Hannes Venter (HV), Kari Schoonbee(KS), Ryan Crichton (RC), Carl Leitner (CL) , Tiffany Jager (TJ) , Wayne Naidoo (WN), Luke Duncan (LD),

Shaun Grannis (SG), Dykki Settle (DS), Odysseas Pentakalos (OP), Chris Seebregts (CS), Mead Walker (MW), Yvonne Hong (YH), Dawn, Gilbert Uwayezu (GU), Richard Gakuba (RG), Hamish Fraser (HF)

**Call recording link**

Call Recording File # 49774001

**Agenda**

1.        Track 1 updates (by registry)   
2.        Track 2 planning  
3.        Any other business – Meeting schedule

***Key points of discussion:***

***Track 1***

WN gave an update on technical teams’ work over December period:

* Team has been finalizing the updates based on issues raised at Ruhunda and Musha – that development work is completed – working with MOH to fix internet issues at those sites – will be doing updates next week
* Upgrades to 7 modules developed are now complete and working with MOH team to collaboratively test ALL OpenMRS modules
* Also done some documentation and collating the various workflows into one place to manage use cases at the POC – will send out a notification to group to review and feedback
* One of the servers was down for a short period earlier this week but worked with NDC to get this up and running again – affected the interoperability layer which did not re-start when server was re-started – must ensure that both Jembi in-country team and MOH must be informed by NDC should this recur, as per the SLA. The message transactions not affected just the user interface needed to be re-started. CF asked if there are plans to monitor the POC systems at clinics from MOH side? GU and JHS working on this.

Error messages mainly due to invalid NIDs – the PR was failing those messages – caused by two providers on site not being registered. Need to ensure that clinic staff know how to deal with this as part of the ongoing monitoring and training process. LP wrote up some instructions on how to do this and was concerned that there have been 0 messages from Musha at end of December. WN thinks that this may be due to lack of internet connectivity on site Must develop a checklist for daily / weekly monitoring of registries to catch this. SG – in their system have to run 3 hourly reports in their system to monitor continually to ensure a fully functioning HIE.

LP asked who was the person who was going to be taking over the interoperability layer? WN said that GU was going to identify the new point person in the MOH.

PR – set up waiting to be tested with HIM then will put into production. Still defining the deliverables for Track 2.

CR – SG said that have implemented some security fixes prior to December break. Still need clarification re: OpenMRS and HIM related to patient search function. OP confirmed that have set up a backup for CR on the MOH server and periodically monitoring the server.

Also, for track 2, for training, testing and further enhancements will need a (de-identified?) data set so will need to speak to RG and LP about this.

CF – Two major changes to Track 1 is that the implementation has been moved to the MOH and now JHS providing financial and some technical support – Also the M&E component has been moved to the MOH as well. RhC will be working with GU to ensure a smooth handover of the implementation and also working on the handover of the M&E work package to InSTEDD and MOH.

RHC asked partners to share what each partner will now be doing under track 1 to ensure we have the full picture:

SG referred to Google document where the CR Track 1 information is stored. The WPs have remained largely the same i.e. record matching, security, etc. RHC would like clarification regarding the deliverables due so can be compiled into an overall project plan, especially regarding the mentoring and training.

LP - Dawn is taking over some of the activities and specifics to be discussed with RG but main activities are the same. CF asked that this be clarified to ensure the correct people are communicated with.

DS said that the Track 1 activities for the PR were very light so have completed the security work needed and are now essentially waiting to respond to any requests and working on Track 2 plans.

***Track 2***

RG said still need to cut budgets. Need to clarify the SOW for Track2 for each organization and discuss the document sent out prior to the call.

CF said these are not set in stone but open to negotiation, but must be aware of September deadline Two key objectives identified at Sept 2012 meeting were:

1 – CR patient identification – this WP to be led by Regenstrief and Sysnet

2 – The data warehousing integration

Other WPs are about expanding the HIE into additional areas of primary health to ensure a broader range of services. In WP1 we are looking to a more configurable module-based approach so any new system is able to synchronise concepts. RG asked how much of an overlap there is here with the Track 3? CF said that first 4 modules are all envisaged to be installed at the POC system so asked if this is the right approach and what are the priorities?

RG asked if the same team are working on the Track 3 work as some of this work could be generic for many countries so could be done for Track 2 but could be re-used for Track 3

JHS are now involved in the SHR and OpenHIM components and these are primarily focused on review and standards compliance with connectathon at end of January. No development in this phase but a detailed review of the architecture and technologies in use and alternative solutions as part of due diligence. CF can send the 2 page concept notes for Track 3 to RG, so no overlap of deliverables at this stage.

SG agreed that main goal of Track 3 is a technology assessment and description of ay forward – are we using optimal technologies and strategies – if not, what should the alternative be – so more assessment not code development. Confirmed there is no overlap of deliverables.

LP asked if generic development work could come out of the Track 3 budget instead, while specific activities related to training etc. be part of Track 2 e.g. connection btw data warehouse and FR? RG said that PIH will be assisting MOH with the POC work that was cut from Track 1, so PIH staff will be joining the calls from now on. HF said that have been in discussions to see where PIH can collaborate.

LP said OpenHIE direction was that Rwanda should not be charged for any work that could be re-used elsewhere. CF said we need a firm commitment from Track 3 management and see if Track 3 would like to take these ideas forward.

SG said need more detailed conversations need to take place but the general notion is that focus on Track 3 is on core infrastructure – the Track 2 proposal suggest an improved way to implement new features so not sure if these should these improvements take place in the core or at the “fringe”

WP 2 is requirements gathering: we do have some documented requirements in place but these are outdated and require further detail based on what we have learnt for each area of primary health care

WP 3 - Instantiation of a health profile specification template a set of XML files that define how the components link together using concepts

WP 6 – Have lifted the meetings out of the technical WPs – proposed 2 meetings (March and August) but now feel that should rather have only 1 meeting in July/August.

Additional WP – technical support package to allocate additional resources to supplement the MOH team.

Contractual WP – have lifted out the contractual aspect e.g. consultants, outside contractors, hosting services etc. rather than tying these into technical WPs

LP asked where the M&E component is? RhC confirmed there is no M&E in Track 2 and is now in Track 1 for MOH and InSTEDD

RG asked to see how partners represented – asked that they add their thoughts about what work needs to be done for the registries to address the new use cases

SG said his understanding is that Track2 are new enhancements driven by MOH needs. CF confirmed that this is the case. SG said WP5 for the CR needs to be clarified further.

LP asked where the specific areas are shown e.g. TB, Malaria, which hospital systems?

MW noted that the list of primary care needs is a very long list and is a many year project

RHC will share the longer document for Track 2 which has more detail but cautioned we need to make sure we do as much as we can with the limited resources we have e.g. how do you make a workable HIE without forcing a re-build of existing or new systems so there is no need for external partners to extend the HIE in the long term but will be able to be done fully in-country.

CF said that all implementation forms and reports are not in scope as can be done by the MOH’s EMR teams e.g. gathering reqs for TB but not developing the forms and reports for Track 2.

CF said there is no rollout and implementation as has been moved to the MOH – very ambitious to try and do a rollout in this timeframe.

Requirements need to be detailed: e.g.all forms documented, defined reports, data elements, additional module functionality, confidentiality and regulatory needs, etc.

GU thought that the requirements were to be done by MOH team - RHC said that this was for the Track 1 bar code functionality etc. but not Track 2 requirements however can re-look at this.

MW – Should first agree on what can actually be done and what can be done globally? Then should consider who does what.

RG not sure what JHS vs. MOH are actually doing from this plan – RHC has another call planned with GU tomorrow to ensure no confusion. Asked all partners to send through plans to RHC by Tuesday by next week to collate into 1 plan.

*Any Other Business – Meeting Schedule*

Agreed to have only 1 meeting rather than 2 and thought July better than September to give more time rather than at the end of the grant/contract period.

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| **Action Item – THIS CALL** | **Responsible** | **Due Date** |
| JHS to follow up with in-country team re: Gilbert and monitoring at the clinics | **RHC** | **Friday 11th** |
| CF will re-send the track 1 revised activities to the group | **CF** | **Friday 11th** |
| LP will send out communication re: Dawn’s role | **LP** | **Wednesday 16th** |
| RHC to set up a call with Hamish, CF, RHC and JHS team | **RHC** | **Friday 11th** |
| All partmers to contribute to document reviewed using Track Changes and send back to RHC by Tuesday | **ALL** | **Tuesday15th** |
| RHC to send out detailed Track 2 plan to all to review prior to next call | **RHC** | **Friday 11th** |
| Send the 2 page concept notes for Track 3 to RG | **CF** | **Friday 11th** |