**Rwanda Health Enterprise Architecture (RHEA) Project Conference Call Minutes**

# Date and Time

July 3rd 2013, 2pm, GMT +2hrs

# Participants

Richard Gakuba (RG),Dawn Smith (DS), Rhonwyn Cornell (RHC), Carl Fourie (CF), Chris Seebregts (CS),Linda Taylor (LT), Emmanuel Rugomboka (ER), Desire Ruzigana (DRz), Michel Makolo (MM), Lorinne Banister (LB), Luke Duncan (LD), Derek Ritz (DR), Steffen Tengesdal (ST)

**STEFAN?**

**Call recording link**

<http://www.conferenceplayback.com/stream/74931725/17564801.mp3>

**Agenda**

* **Team Discussion Points**
  + RHIE Project Status Update - Dawn/Richard
  + NID Update: Next Steps for Access - Richard
  + Ubudehe Discussion: Setting Ubudehe and OpenMRS as Two Separate Systems - Richard
* **AOB**

**Apologies**

* Wayne Naidoo

***Key points of discussion:***

* Derek – are we aiming to include the private sector at some point – will they be connecting to our infrastructure in the future? RG – Health care about 90% public, and currently private companies do not have EMRs so although not practical now it is envisaged that they will connect to the HIE in the future

***RHIE Project Status Update***

* Training will start next week and continue over next 4 week. It will include IT skills training and training for IT managers and data managers, as well as clinic staff. Have reviewed and updated existing training materials. The meeting for the titulaires will be at JHS office on Friday.
* RG – we will have some contractors to assist with training and need to ensure logistics are in place. Please ask if clarity is needed as to what needs to happen next week
* Dawn – aiming for better communication within the team and have identified main objectives for each period in the status report. There will be a call with JHS team tomorrow to discuss details of activities planned.
* DR asked for the list if all RapidSMS messages to see if there are any we should consider capturing as well as those identified. RHC has asked Michel to source a full list of all messages from Pivot.
* The contract with Pivot for the RapidSMS work should be finalized by the end of the week

***NID update***

* There was a call with Jacques from NID last week. He will provide some details around the API and we will need to share details to figure out how we can connect to this database.
* DR – asked about the initiative to get the message to women to try and bring their NID cards to the clinics: have we been able to measure this? RG - We would need to have people in the clinic observing this. CF – this is not logged in the system currently.

***Ubudehe discussion***

* RG summarised the other option proposed as:
* Have the Ubudehe database running alongside the OpenMRS database at the healthcare facilities rather than pre-loading it into OpenMRS. At registration, when searching for a patient, if they not found in OpenMRS can then check in the Ubudehe database. Will be faster than using pre-loaded data which is currently slowing system down and making it difficult for staff. Desire noted that by separating them but residing on same server then this will make process faster and also limit unneccessary queries to the CR
* CF asked if this Ubudehe database is just a snapshot of data – we will not update it with new data?
* RG clarified that it will not be updated –this is static data
* CF – agreed this is technically feasible just need to consider time to link these databases and when to schedule this
* RG – asked about estimated time to do this work. Desire – estimate as one weeks’ work including testing with 2 JHS programmers (10 days effort)
* RG – thinks this should not be a pre-condition for going live unless we can do it in parallel? Will it affect activities related to going live?
* CF – Asked about other system features such as the changes to form entry and the various reports needed – are these a pre-conditions as well or should we aim to go live with existing system?
* RG – there are some things we can go live without as long as they are not on the critical path

Already have a list of tasks and will need to clarify which are mandatory and which are “nice to haves”

* CF – agree, just need to know explicitly which tasks are on critical path. Some are obvious i.e. internet infrastructure, training, but in terms of the software eg: is the OpenMRS 1.9 upgrade on the critical path or not
* DR – do we know what the level of effort is for some of these issues i.e. reports
* CF – yes, and we do have them listed (which RG referred to)
* Dawn –asked if RG will prioritise these listed activities?
* RG – Yes, there is a go-live checklist - Will work with local team to flag the activities as “must have” or “nice to have”
* DR – There is a subset of things to get system up and running in technical terms vs. the activities required to have the staff actually use and accept the system e.g. be aligned with workflow, be producing useful information. We should reflect the lessons learned from last go-live. Should we consider not going live with this 2nd wave until all of these are in place, otherwise as are setting ourselves up for an expensive and risky process
* RG – we have incorporated many things from past experience = e.g. reliable internet connectivity which has been dealt with. Also, producing reports the clinicians need, changing form entry to make it easier. Not just trying to connect computers, have learnt importance of engagement with people on the ground
* RG - will update list of tasks with priorities and will circulate the list for team to comment on but everyone should carry on with activities as planned in meantime

***Any Other Businesss***

The call ended at 2:51pm

The next call will be on Thursday 11th July.

|  |  |  |
| --- | --- | --- |
| **Action Items** | **Responsible** | **Due Date** |
| Update list of activities/tasks with priorities and circulate to the team for comment | Richard | As soon as updated |
|  |  |  |