RHEA Project Meeting Minutes – March 2012

Date and Time

March 27th, 2012

Agenda | Day Two AM Session

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Key points of discussion:

Introduction by Rhonwyn Cornell

Discussion around agenda and aims for today – need decisions to be able to plan way forward as have only 26 weeks until deadline. On very tight timeline so need right not perfect decision.

1. Terminology Service Discussion

DR said Apelon WILL meet the RHEA requirements – already meets very similar requirements for other systems. Not all of its components are open-source and free.

PB: Job of T S is usually to bring together disparate systems. Initially a terminology servicewas part of the design and needs to be a part and will ultimately be necessary but not a fundamental part of the system for now.
Should agree how
JC: A terminology service sually only needed during configuration or for updates when new terminology code updates are released.
RG: Only want a very simplified terminology service with a defined set of standard codes. Concentrate on minimum scope for now.
CF: Choice to use Apelon has been made, need to define capacity development long-term maintainability. For now want to define how download export - what hardware is needed, where will it be hosted, what is the full list of codes, who will load and maintain these.
HV – How to get terminologies in is a big issue – Apelon can provide as a service – some are standard paid—for service, can also request specific code list to be set up and updated when new versions become available.
DR – Recommends against using Apelon to do this: should use their expertise to get started but not to maintain in the long-term.
CF – Need decision as to what terminologies must be loaded now.

RG – Already have a full list if these – ICD10 maternity and morbidity codes, laboratory (LOINC), procedures and medication codes.
HV – Can use DTS Editor to do the importing using freely available import wizard plug-in. Other way is to use the API's
WN – Can develop the import ourselves, but will be valuable to get help from Apelon to train on the curatorship aspect.
HV – Training by Apelon on how to use the Apelon tools would be good for people in-country.

WN asked for feedback on functionality of UI as demonstrated. General consensus is that the UI

RG have selected about 100 most common ICD10 codes – would like to be able to view these as a group. HV said can make a sub-set of a name space.

LP asked about timeline and would like to see it live in 3 weeks. CF said possible but is dependant on getting required code-sets from MoH in format as needed.

RG – Decisions to be made

1. Must decide on list of terminology needed – have agreement on this with exception of procedure codes.(Australian vs Canadian ones) Have the Australian ones already so will use these and move forward – use DM+D which includes ATC. For Lab use LOINC.
   MW – Will need list of local codes e.g. administrative units.
   RW – would be better to NOT replicate facility codes in two systems but would like a list of common key indicator codes/ defintions. Should the list of HR terms (provider role) also be stored in the TS?
   CF –suggested codes such as admin unit codes in FR and provider role codes in PR but can use the terminology service web interface for people to browse these terms.
   RG – Agreed but said that indicator list should be stored in the terminology service as will be used across many systems. For local indicators will use local codes, for international codes use ICD-10.
   RC – What about use of Maternal Concept Lab codes? PB – how do you want to communicate externally from RapidSMS and OpenMRS – a local code OR an MCL code? LP – Have mapped to MCL and many match already – some map to ICD-10 codes, some don't, etc. so cannot do it without local code set. MW suggest a hybrid approach with some mapped to ICD10 and some local ones.

   Decision:

   a. RG – Terminology codes needed are: procedure codes (Autralian codes), ICD10 maternity and morbidity codes, laboratory codes (LOINC) and medication codes, and local codes such as key indicators codes.

   b. RG – Decision to use a hybrid approach to map codes to ICD10 where can be mapped and extend to include local extension code set OR MCL codes.

2. Who will contact Apelon about training and costs for training on curatorship?

Action Items	**Responsible**	**Due Date**
Get full list of all terminology codes to be imported into the terminology service from the MoH.	Michel Makolo	

Decide on whether to use local Rwandan code sets OR MCL codes	Richard Gakuba	
Who will contact Apelon about training and costs for training on curatorship		

2. **Client and Provider Registry Discussion**

Possible Technology choices: OpenEMPI and MirthMatch.

SG gave a brief overview of the technical requirements for the Client Registry.

Both OpenEMPI and MirthMatch have said open source versions will not be able to meet these transaction loads for long term but may be able to do so in short term.

MirthMatch has a version no longer supported.

OpenEMPI has open source version but lead developer said not suitable for RHEA needs - currently providing a quote to do development work to meet the RHEA requirements. Supports limited set of data elements. To support addtional demographics will need to be extended. Cannot handle the volume of transactions expected but did not clarify. Do have an open community but not very active.

SG – Need to make strategic decisions:

We can take code-base and extend to meet our needs?

DR said if choose interface well can "plug and play" solutions so critical for risk mitigation.
JC – Choosing interface is on crtical path, choosing the engine is not. Can do with some manual work-arounds initially. More sophisticated processes can come later. Both of these products cannot be stood up in this timeframe.

SG – Can mock up a simple system for now but are proposing an answer in about 4 weeks

SG – Patient matching is a core expertise in this group so proposing decide on technology and costings.

CF – What are the interfaces? Allows for "rip & replace" of a true service-oriented architecture.

DR – What is the best instinctive choice? Either is the right choice : a greenfields approach is the wrong one.

SG-Still need more information, but MirthMatch has more features currently as per their description. MirthMatch ver is NOT open-source.

CS asked if they have a simple patient lookup and progress to fuzzy matching later? Is fuzzy matching a critical capability?

DR said when searching by name can be very difficult to get an exact match.

RG – for now national ID not used for healthcare and children under 16 do not have an ID. This project was intended to introduce an identifier for under-16s.

MW – Missing requirements – are they all around matching or are their others?

SG – No 1 lack was the performance requirements. For immediate use, OpenEMPI has the most functionality and version 2.2 is downloadable now. A gap analysis is being written this week and a budgetary proposal. Still propose that performance testing must go ahead as this is a critical part of the requirements.

DR – Are their interfaces ones we can use – believe that they will be suitable.

SG – Fixed PDQ of native web interface calls are two options.

PB – Both organisations are aware of both bigger and short-term view of this project. Will need to sub-contract with them, and believes OpenEMPI is better organizational fit.

CF – Which organization will work best with the government of Rwanda. As long as we have the standard interface , technical solution is swappable - what about the admininstrative interfaces? Using open source solution will give us an indication of how this will work in long-term.

RC- Asked if developer team should start to work or wait for proposal? CF suggested using our own resources immeadiately while still working with OpenEMPI, but local capacity development is very important.

SG – asked if we should also continue with the MirthMatch evaluation?

RG – Said continue to evaluate both as a risk-mitigation strategy.

PB – Jembi team should work with OpenEMPI rather than working independently. Should be ready to pay for their expertise as will make process much more efficient.

DR – Should do independent load testing and look at interfaces. Do not have capacity to start opening up code base. CF agreed that this is exactly the level we are intending to work, just as HV has done with Apelon.

RG – Concerned about costs of engaging with OpenEMPI – will much work will they do pro-bono?

RG – Main item of next weeks' call should be to discuss the OpenEMPI proposal if expected to be delivered by end of this week.

SG – is built on Java using Spring Hibernate JWT stack.

Decision made- To use OpenEMPI for the Client Registry.

Will action a developer to look at this, and on separate stream will continue to evaluate MirthMatch.

Action Items	**Responsible**	**Due Date**
Assign a developer to look at the OpenEMPI instance	Carl Fourie	
Continue to evaluate MirthMatch	Shaun Grannis	
Discuss OpenEMPI gap analysis proposal on next week's project call		

3. **Facility Registry Discussion**