

RHEA Project Meeting Minutes – March 2012

Date and Time

March 28th, 2012

Agenda | Day Three AM Session

9:00 - 9:10	Introduction and Agenda for the day	Emmanuel Rugomboka Rhonwyn Cornell
9:10 - 10:30	Interoperability Layer	Ryan Crichton
10:30 - 11:00	COFFEE BREAK	
11:00 - 12:00	Shared Health Record - requirements overview, technologies reviewed, development plan and capacity development needs	Wayne Naidoo
12:00 - 13:30	LUNCH	
13:30 - 15:00	Work done to date on Point of Care Systems - OpenMRS and RapidSMS	Wayne Naidoo
15:00 - 15:30	TEA BREAK	
15:30 - 16:30	Infrastructure Discussion	TBA
	HEART Breakout	OHT
16:30 - 16:45	After Action Review	Carl Fourie

Key points of discussion:

Messaging Specifications by Ryan Crichton

Terminology Service transaction mockups have been defined and have decided on a single end point.

Client Registry message specs

4 major message types:

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1=register a new client in CR

2=query for clients

3=get client

4= update client

RC thinks should also use RSS or Atom for a list of messages rather than a concatenation of HL7 messages, and asked for feedback. Agreed that RSS will be used for APIs throughout system when returning lists. RC proposed 2 ways of doing this:

Within RSS feed have HL7 XML based schema OR wrap EDI version of HL7 in a CDA element tag ie: a text string in XML.

EJ recommends XML even though compression not as good, DR says CDA allows it to be rendered as well as more human-readable. PB suggested parameterizing existing way of doing it.

RC asked if PIXPDQ should be used as a standard? MW this is not part of HL7 – is part of another std for querying patient information, more object-oriented spec. Can define different calls in the interoperability layer. Agreed that should stay with current specification for now.

Shared Health Record message specs

1=save patient encounter

2=query for previous encounters

3=get encounter

SG – Different types of data can be suitable for different types of message formats, sometimes atomical sometimes clinical document. (CDA). PB – CDA is a significantly larger message so not always best choice for single transaction. HL7 V2 message type not as good with richer data across multiple encounters.

LP – Hospital use case – almost every SHR query will look for a full record for each patient.

RC-Thinks CCD making more sense. MW concern is asking people to support multiple ways of doing things, so first step it o use XML encoding for version 2, so recommends using messages as currently defined. DR recommends CCD with a template approach. PB there is a trade-off between an older, broadly adopted approach and a new, richer but less well-known approach. JC recommends future-proofing by taking advantage of template structure of CCD. PB said OpenMRS development is heading towards CCD. PB cautioned about using larger message when bandwidth so low.

Dennis – Interop conference 26/27th april in Geneva.

Decision: Continue using HL7 V2 XML and will plan CCD for later phase

Shared Health Record discussion led by Wayne Naidoo

Alternative technologies for the SHR :

WN explained advantages of using OpenMRS for the SHR component – skills already available, in use in Rwanda, capacity development will be much simpler, etc. Already have all expertise in-house to work on this. WN highlighted some points in the evaluation:

1. **Security requirements** – need role-based secure access, to view and display different data dependant on the role. DR said that using the HIE as the place to put security in is a better option. Do we want a web-based view of the SHR that does NOT go thru the interoperability layer. For example: in the hospital, should they run an instance of OpenMRS to be able to access the SHR thru interop layer or go direct via a web view? SG asked if the viewer supports the use case. MW said should explore option of adding role-based access to OpenMRS. RG asked if rollout includes hospital in Ramugwana? Gilbert said existing system in use already. RG said they do have a hospital level OpenMRS version – just how ready is it to be deployed? RG also noted that not all POC systems will be OpenMRS – this is only true for this first pilot phase. CF said that the interoperability layer will provide that secure access – can have a limited cloud-based OpenMRS interface that enables much wider access to SHR, as that is what the architecture is designed to do. RG says the MoH responsibilities are to roll out OpenMRS. Agreed there will be no direct access to SHR – will only go through the interoperability layer.
2. **Load Testing** - PB there are some Ampath implementations with over 200 million clinical observations and other large implementations. Difficult to say if it can handle a national load as has not been implemented as a SHR but there is active community support. RG asked Cheryl about existing PIH sites. CA synchronisation of data btw sites – all data – would like to be able to only send subsets but not in use yet – also sync content eg: forms, modules etc. working over slow connections. Have 2 databases with 25-30 000 in one and 3000 in the other.

CF asked what does the SHR store? LP answered: sub-sets of data as defined and approved.

EJ would like to review role-based access restrictions to the facility registry.

RW basic foundational issue needs to be defined – to what extent is the SHR pointer to data in another system? LP answered: Have data defined for the maternal use case only: a maternal summary.

No other technologies have been investigated yet. WN asked if there any other alternatives known of? DR said OpenMRS is a good solution and only other good alternatives are expensive commercial solutions. Does not think another evaluation of open-source products would be necessary as OpenMRS was selected as best option in CHP evaluation. DR said main risk is if it can handle traffic above the HIE? Can test and mitigate that.

Decision: RG and group agreed that OpenMRS is the selected choice of technology for the SHR.

Decision: RG and group agreed there will be no direct access to SHR – access will only be through the interoperability layer.