# Meeting/Call Notes

**Meeting purpose:** Community Call for OpenHIM and OpenSHR

**Date:** 18-02-2013

**Attendees:** CF, CS, LT, HV, RC, KS, LB, JRT, CC, SK, Larry, Mead Walker,

**Agenda:**

* Discussion of next steps for evaluation of OpenHIM
* What is an interoperability layer – use case and functions?

**Notes:**

CF provided a brief introduction to the first official community call for OpenSHR and OpenHIM projects. Based on the work undertaken for RHEA and now evolving into a more generalized approach

Explained that will have a combined call for the SHR and Interoperability layer work for now, but will probably split into two separate calls as the work progresses.

There are 2 mailing lists – openhim-dev and openhie-shr - which will be used for general communications .

RC introduced the approach and described the aim of the collaborative documents available on Google docs for anyone to add contributons to. Intended to be used to capture ideas and thoughts around the best approach and the use case and requirements for both the SHR and the interoperability layer.

The Trello boards will be a place where people can add topics for the agenda for these calls. Also pointed people to the etherpad which was used to capture the earlier discussions when the Jebi team visited Regenstrief I early February.

The Github wikis contain the technical documentation and code.

**Overall objective**

***To look at both the SHR and the IOL and critically review these , based on the RHEA implementation experiences, and then decide which is the best strategy to take forward for the broader OpenHIE***

**Planned approach for the SHR**

RC described the methodology

MW – is it possible to see how well the SHR is actually working in Rwanda currently?

RC – will add a point for this as a task

CF asked how are we going to stress test the existing SHR? How to do performance testing?

RC – Will discuss this but need to define use cases first

RC- Will need to also define What transactional load is indicative of the national level?

HV – stressed that we must look at the functional requirements first i.e.

What do we want the SHR to do and does OpenMRS meet these needs?

RC – Will also evaluate other tools at a later stage and will need to define an evaluation tool (excel) similar to risk assessment that Derek Ritz did

Use it to evaluate both performance and functionality: will be an empirical way to assess these technologies

HV asked: OpenMRS stores the patient encounters but what else should it be doing?

MW – OpenMRS has the advantage in Rwanda that it was already there and in use and may find that same situation in other places i.e. existing tools already implemented. Thinks that there may be issues when volumes are large but this is just a feeling. Also thinks that the encounter based tool is fine

May change technology as the system grows

What we have now is not broken

HV and RC have been working on the documentation – What is a SHR?

Asked people to review and add comments or additional notes in the Google doc – ask RC for edit permissions if you would like to contribute

**Next Steps for the Interoperability layer**

By talking about the SHR we have implied certain aspects within the IOL

Have another document for the IOL to define the use case and define what is an IOL – What are the requirements, functional and non-functional?

Aim to follow a very similar methodology to SHR evaluation

Asked: is it an Interface engine vs. a mediator

RC asked for opinions

MW – an application that has the ability to receive transactions from local systems and route them to intended destination and return responses as received from the destination = most fundamental feature

SK – interfacing requires processing as well – is a different approach

Fundamental difference is we do not expect pristine messages and we have pre-processing in place . Underneath MirTh (used for interfacing) we use Mule – easy to plug in new technology and replace if needed

If we use a standard on receiving messages then can get away with this

CC – have to ensure normalization of coding system – use a standard like LOINC

LL asked: are we going to allow only access via IOL or can u go to Client Registry directly? Or the Facility Registry? For something not related to the HIE?

CF – not channelling everyone through the IOL introduces complexity to other registry services. It provides a central point of authorization and authentication, and a single point of security . It is also a single point of failure that needs to be mitigated against

MW – have always has the notion that everything should go through the IOL – if there is a very strong reason to do something different then consider, but shouldn’t worry about it prematurely

RC – must be aware we are looking at it from different level to RHEA – a more conceptual level

MW – feels same at conceptual level

Login and access control are centrally managed at the IOL? Should these be a requirement?

MW – thinks this is centralized login is a useful feature as removes burden from local system But NOT centralized access control

RC – What is the drawback of decentralized access control?

Mw – OK if you have centralized system with a single access point BUT trying to administer access control with a decentralised system will be difficult to manage

RC – there are 2 separate aspects:

* physical control ie. Who can log into what?
* What systems can submit transactions to the HIE?

MW – should be able to deal with transactions btw systems e.g. Lab to a clinical system – not simply handling transactions from the periphery to the centre

Have transactions designed around sending messages to SHR and query SHR but what if hospital send info to another hospital – should the IOL be a mediator for those transactions as well? i.e. inter-facility communication

RC – Is a good idea to have centralized management of access to the HIE i.e. services like CR, FR managed by the IOL but not having individual user rights : these should be managed by single systems

If info coming from a trusted system then will receive transaction and deal with it securely therefore security is on a system by system basis

This is how it has been implemented in RHEA – any thoughts?

MW agrees with this perspective – cannot allow central system to worry about individual logins of each system – absolutely out of the question

Individual user rights should NOT be part of a IOL

RC asked how security is handled by the Regenstrief team ?

SK – is handled on an interface basis and this works well in practice

LL – is handled as a trusted connection

A federated model -

MW – trust that the hospital manages is staff access and is a trusted source –

MW – thinks there are good reasons why this is why we go this route

Central system trusts the local system – local system must live up to that trust

RC will create a stick man to poke at on next call and he asked all team members to review the Google docs and add their contributions to ensure a robust debate

**LINKS**

All links are available here:

**https://openhie.atlassian.net/wiki/display/resources/OpenHIM+Community+Call**