# OHIE-SHR Call Notes

**Meeting purpose:** Community Call for OHIE Shared Health Record

**Date:** 07-05-2013

**Attendees:**

* Ryan Crichton (Jembi)
* Linda Taylor (Jembi)
* Hannes Venter (Jembi)
* Kari Schoonbee (Jembi)
* Chris Seebregts (Jembi)
* Larry Lemmon (Regenstrief)
* Mark Tucker (Regenstrief)
* Derek Ritz (ecGroup)
* Shahid Khokhar (Regenstrief)
* Evan Wheeler (Unicef)
* Chris Ford (ThoughtWorks)

**Agenda**

1. Planning and Deadlines
	1. [https://openhie.atlassian.net/wiki/display/resources/Shared+Health+Record+Community+Documentation](https://openhie.atlassian.net/wiki/display/resources/Shared%2BHealth%2BRecord%2BCommunity%2BDocumentation)
2. Feedback on Justin Fyfe's visit to Jembi
3. Discussion on separate calls (propose changing to a weekly basis, alternating the SHR and interoperability layer discussions)
4. Continue reviewing the SHR requirements
	1. <https://openhie.atlassian.net/wiki/pages/viewpage.action?pageId=4948134>

**Call Recording file** *#*67663101

<http://www.conferenceplayback.com/stream/62373355/67663101.mp3>

**Meeting Notes:**

***1. Planning and deadlines***

RC – The aim of this phase is whether to build a new tool, re-use an existing tool or some combination of both. Feel we are coming to a consensus on the use case and requirements - now have some deadlines:

1. Complete community discussion on SHR requirements document - then will send it out for a more formal review via email

2. First version 1 of document due 21st May (2 weeks time)

Does the community agree?

DR - Yes

LL - so this is the document that we are aiming to produce, not the tool?

RC - Yes, a first version - will not be the final document but will be a “snapshot” in time

DR - also a way to communicate with wider OpenHIE group and get wider review

DR - do you think we have a consensus?

RC - yes, is coming together quite nicely

DR - has been a useful discussion -- we have raised to the surface the appropriate issues

What are the open issues then?

DR - depending how you look at it answer varies (document paradigm? message paradigm?), so have to make ourselves comfortable with “it depends”

This is an honest approach

Very pleased to see a timeline and where initial prototypes start happening

RC- we hope to have a recommendation by the end of June i.e. modify existing tool, build new tool

***2. Feedback on JF’s visit:***

JF visited JHS from 22nd to 26th April - very useful visit. Did a full review of use case and requirements and shared knowledge - looked at Rwandan use case from H/L architecture to implementation, and also the Canada Health Infoway use case.

Discussed use of standards, etc.

Any there any powerpoints available? RC - can get some of the presentations from JF and we have also added information to the wiki - can share these with the group

The documentation on standards is on the OpenHIE wiki

[https://openhie.atlassian.net/wiki/display/resources/Research+various+standards+for+clinical+data](https://openhie.atlassian.net/wiki/display/resources/Research%2Bvarious%2Bstandards%2Bfor%2Bclinical%2Bdata)

ChrisF -Is there room to envisage who our customers are? Could this be part of this document?

What would the content be?

What sort of organisations would be implementing this software? What kind of users are we targeting ? Who would find it useful?

Would be a check for pragmatism.

e.g. for countries who do not have an SHR system but are considering using it, is it a national level only or could it be used by other NGOs/ organisations?

RC asked if CF could make a few points to start this via email and will talk about it on the next call and flesh out a bit more - agreed would be useful section to add to document

***3. Call schedule***

RC – Thinking it may now be time to have separate calls for the SHR and the HIM i.e. will have a call every week at same time, alternating topic - what do people think about that?

DR  - there is enough to discuss although is a “big footprint”

Think we should talk about the interoperability layer EVERY time we talk about anything above it: appreciate it is a personal bias but is key part of architecture that touches all components of HIE

RC - won’t preclude having it included in SHR call but the IL should also have its own call slot

Is there any difficulty in being able to attend every week?

MT asked if will consider having every 2nd weekly call on a Wed instead of a Tuesday

LL- The T/S has a call on a Wed at 9am so may overlap

DR - can’t commit to attend every call but there is enough content for discussion

***4. Continue reviewing the SHR requirements***

What data should a SHR store?

Some items have been crossed out as deemed redundant

What is the real world content for these observations?

History is NOT an observation: a clinical observation is different

e.g. Radiology is very different to some of the other things in the list

There is an opportunity to have a workflow engine based on BPMN expressed logic

if just view SHR as observations and documents then it is one thing, if can include executable care plans then is a “new beast”

Our ability to succeed in a low resource environment is based on our ability to operationalise care

RC - intention is a textual care plan , don’t think that is intended to be in the SHR but in a separate workflow engine

Can add “discrete” or “textual” to help with understanding what these items are

Also what do these observations mean - what are they used for?

Also need to reflect population indicators but should get these from collecting on personal basis and then aggregating them, rather than aggregate data and then trying to dis-aggregate them

If we are not storing enough data to generate common reporting indicators then we need to include these - should collect these at the time of care / should collect enough for the next level up

When we think about trending did not think this is something that a SHR does: although it can store and return data the actual representation of these should be left to the client system?

If we use example of workflow engine this may be the “client” that is requesting info from SHR

Information can be conveyed in different way but if returning it discretely then must store in such as way that can do this - SHR stores it at rest in coded ways i.e.

discrete (observation like) vs non-discrete (document)

maybe tweak points 3,4,5 - if send as discrete can be returned as discrete

Can’t return a discrete (not coded) data if not originally sent this way

Must be rigorous in terms of using “structured” vs. “non-structured”

Will replace “discrete” with “structured” and “document” with “non-structured” element

Is an approachable term for non-IT people

If have underlying data elements to do a calculation then shouldn’t also store that as could become inconsistent

e.g. have rules that compute  and store a value of “computed diabetic=True”

The requirements should provide examples of how to solve problems e.g.

a clinic can retrieve data from the SHR and a workflow engine / clinical decision support system can then calculate using these

Also narrows the scope of the SHR

Need to not be slavish about how things should be transferred

Should be stored in the SHR in a way that can returned in a query response

Information collected in many different ways can be returned in a care summary that includes all sort of data from different places

Can be stored and returned separately OR in the same way that it was collected

Example: can I get back the CDA (discharge summary) that I sent? Yes, will need to get it back in original form but should store as exploded data **and also** as original document

If a query is for a sub-set e.g. what drugs is patient on? Then should only include that piece of information and not unnecessary detail

RC - Will send out the SHR requirements document to iterate over via email ,either as word doc or keep as Google doc with comment rights to keep this conversation going before next call.