# Meeting/Call Notes

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

**Date:** 25-03-2013

**Attendees:**

Carl Fourie (CF), Ryan Crichton (RC), Linda Taylor (LT), Mead Walker (MW), Derek Ritz (DR), Paul Biondich (PB), Lorinne Banister (LB), Shaun Grannis (SG), Larry Lemmon (LL), Shahid Khokar (SK), Mark Tucker (MT), Justin Fyfe (JF), Bruce McLeod (BM), Chris Ford (CF)

**Agenda:**

1. Review comments and feedback on documents

[OpenSHR Discussion](https://docs.google.com/document/d/1Vv_2QPr5nfVWmAp3YuT__8l3zect1ZLvzRKvivxkvls/edit)  
[Interoperability Layer Discussion](https://docs.google.com/document/d/1doz07xPGcta_1lu1f_9xgNuveN8d70dU0hgz7P6tJtk/edit)

2. Share and get comments on the initial draft of the evaluation tool for the HIM and SHR

**Call Recording file** *#* **92871601**

[**http://www.conferenceplayback.com/stream/58588590/92871601.mp3**](http://www.conferenceplayback.com/stream/58588590/92871601.mp3)

**Meeting Notes:**

* RC gave an overview of what the SHR and HIM are intended to do in the context of the OpenHIE. Aim is to define some of the use cases and requirements as a community to come to a common agreement as to what these should be and then evaluate both the current tools used in the Rwanda implementation under RHEA as well as other possible tools and technologies
* Have two Google docs which are collaborative documents in progress (see links listed under agenda)
* Have now converted the use case and requirements into an evaluation tool (spreadsheet) that ask a number of questions about the technologies. Would like feedback and input from the group around this tool.
* The RHEA implementation is based on the HIAL work done by the Mohawk team: the interoperability layer aims to lessen the burden on the edge systems (at the clinic) to enable connection to the HIE, performing orchestration and transformation of messages.
* Something like monitoring can be done in other ways than an interoperability layer – how specifically are we tied to the idea of an interoperability layer?
* The basic premise is that the system will have to support a wide number of interfaces to allow creation of a national system and having an interoperability layer is not considered as absolutely essential but is one appropriate solution.
* Seems like a central component managing the transactions is the most viable solution although could also look at a more distributed architecture
* Seems easier to have a centralised federated health exchange
* Would like to see another example of an architecture to compare
* Would the edge nodes even know the difference between these different architectures?
* How can software be developed for both paradigms but be configured to work in either?
* We thought it was a good model to follow for RHEA, with a central component that keeps the edge systems as dumb as possible. Can deal with a limited interface and allow some logic/orchestration to happen within the OpenHIM that makes it easier for edge nodes
* Open ESB are easier for integration for the use cases we have been working with but in other use cases can customize i.e. not every jurisdiction will actually need that
* OpenSHR and other community registries should be developed to be stood up either as a stand-alone or with interfaces which will connect with an interoperability layer if needed
* For RHEA, we have defined a fairly generic set of transactions
* SHR could be a standalone, a point to point or in an ESB environment and could configure as appropriate
* If it is easy to exchange data with dumb edge systems, then more sophisticated systems can also use this – would be a great service from the central core
* Do you accept some orchestration is required and therefore someone needs to be smart?
* Stand alone registries will need to discover and orchestrate with peers or there needs to be a central layer. The US now moving to a more brokered model
* Should not have to apologies for embracing a particular architecture that is appropriate for the low resource settings where we work
* Should champion a centralized architecture unless it hinders adoption
* Must be careful to not introduce additional complexity if not required
* We are talking about orchestration from an IT point but must also consider that from the human workflow standpoint it is also very important. Can have significant health outcomes impact if we can operationalize standard care guidelines
* People don’t do what you expect them to do, we must think about breaking our technical ideals to accommodate humans. What is the ideal architecture given real life scenarios? Idealised architectures are often over-engineered because we forget about the human factor.
* This should be simpler and less sophisticated than we would like but are capable of being managed and used by people. Should also consider the people who have to maintain these systems in resource-constrained settings and be able to set up and validate that it is doing what is intended

*Evaluation tool*

* RC showed the evaluation tool that has been developed (insert link) and described the intent behind it: should treat it as a stickman and would like people to review and see if the questions are the right questions. Would appreciate every ones views: please make notes and comments or additional questions and send these to RC. Will also update requirements with this information.
* Is the impact to be accepted?

RC – if you think these don’t reflect what is correct, feel free to change and comment. This is intended to drive discussion in the community

* A combination of different technologies could be the final solution
* Does it make use of standards seems to be ranked a bit low
* Also the ability to link to aggregate systems should be ranked very high
* We are expecting a wide range of views and could even average these rankings to get a final ranking. If there is a lot of divergence on an issue / ranking then we can discuss on a call
* Should add comments to support rankings / assessments

*Administration*

* RC has sent out separate excel spreadsheets to groups and asked them to fill in and send back to RC to collate including comments
* Will send out a doodle poll to group to find better time to schedule this call
* Are also considering using Google hangout instead of the conference line
* Justin and Dwayne may be visiting Jembi in Cape Town at the end of April to go over what we have discussed and focus on this work
* What is the trajectory of what is planned?

Our aim is to get the evaluation tool finished: this will be an iterative process to get community driven consensus

Have compiled a list of tools to evaluate

The next activity will be to perform evaluations

Then consider what would be best solution (could be a combination of things)

And will document the best options going forward to support a final recommendation

*Expected Timeframe*

* 2 weeks to get evaluation tool completed
* Start to evaluate in middle of April
* Creating options by May
* Final recommendations by the end of May
* Are we focused on more concrete software rather than abstract interoperability standards?
* PB – a chicken and egg scenario in that countries want solutions. The reality is to create a set of standards but in the short term to validate that by a reference implementation in a real world setting. Sometimes think the aim is to “Build one technology to rule them all” but this is not our goal

***Next Community Call***

The next call will be on Monday 8th April.

***Community Wiki***

All links to working documents and call information are available here:

[**https://openhie.atlassian.net/wiki/display/resources/OpenHIM+Community+Call**](https://openhie.atlassian.net/wiki/display/resources/OpenHIM+Community+Call)