**Meeting/Call Notes - OpenHIE Interoperability Layer**

**Meeting purpose: Community Call for OpenHIE IL**

**Date: 10-12-2013**

 **Please sign yourself in below.**

**Attendees:**

* Ryan Crichton
* Linda Taylor
* Hannes Venter
* Derek Ritz
* Larry Lemmon
* Carl Fourie
* James Kariuki

**Agenda**

1. Call schedule for December
2. Update an architecture call
3. Vision mission and values and the implementation guide
4. CSD Work update
5. The interoperability layer work in RSA
6. Feedback from previous call
7. Technologies and standards to use for the OpenHIM reference implementation

*Please feel free to add any other items you would like to discuss to the agenda.*

**Call Recording file #**  83251901

**Meeting Notes:**

Last SHR call for 2013 = 17th December 2013

First Interoperability Layer call for 2014 = 7th January 2014

Jembi office closure from end of day Friday 20th December 2013, re-openIng on Thursday 2nd January 2014.

***2. Feedback from architecture call***

Key point of discussion: Should everything travel through the IL?

Some instances where an IL may not be required initially if only using a single registry but becomes inc valuable to have Interoperability Layer in place when any form of interaction between registries occurs. Does not preclude us from putting IT in place before a single registry i.e. the PR team preferred this to have security, user management, auditing etc done so don’t have to do themselves.

Generally useful but not mandated for single registry.

DR - without an IL there is no OpenHIE - product rather than platform strategy. Value proposition not do-able without platform strategy. We should have no qualms about saying that if someone embraces this for their national health infrastructure, then these are the pieces within that infrastructure.

LL asked:how much dev time needed for it to be implemented like this?

RC:There is already enough functionality to make it useful. For a full HIE implementation using new IHE profiles there is still work to do, but for standing up in front of a single registry we can do that now. Have the core il component that does generic tasks but adaptors and mediators are specific for RHIE implementation, so will need to be configured alongside core components of IL.

DR- Our face to the world should be the IHE profile.

***3. Vision,mission and values and the implementation guide***

CF: Spent a lot of time looking at the tool and business case. Now we should focus on what we as a community stand for - would like to look at this pre-architecture meeting and have an initial version ready by end of March. Will aim to have something out on email list soon, by early in new year if not by end of this week.

DR: Agree. Some of points discussed above will probably form part of this.

RC: Should draft a TOC for the implementation guide. Will start on this early in new year based on Rwanda imp and some RSA initial implementations but don’t have a lot of implementations.

***4. CSD Work update for the Connectathon***

HV: adding support to act as CSD service finder actor - make use of services in InfoManager. Validate Providers and Facilities using CSD rather than existing APIs.

Have a pre-production server up and running and have added most support in OpenHIM. Have 2 issues o/s:

* Working closely with Carl Leitner to fix issue that was working
* Facility validation spec missing other ID spec so cannot cross-reference with other ID (other than OID)

DR: OIDs very complex to use. Being able to query by other IDs needed for all registries not just FR

HV:Other ID is implemented for the PR currently

RC: Will now need to test with partners pre-connectathon.

***5. The interoperability layer work in RSA***

CF - a great deal of interest in HIM / HIE from DHIS group led by HISP and the mobile providers (mobile app providers such as Cellife etc) to facilitate data exchange.

Looking at data exchange using standards such as CDA and CSD

HV will be doing some of these implementations and pushed back into the community versions

40MB stack quite heavy so a lot of push to trim that and make it more lightweight component

DR: What stack of std will SA be using?

CF:The draft version of normative stds is available and is very comprehensive

RC: All of the XDS stds included as well as PIX PDQ PAM - A lot of core IHE stds being prescribed

CF: Will be looking at aggregate data standards in particular

DR: Not a lot of momentum behind SDMX-HD

CF: Yes, looking at that and seeing how we should handle it going forward

DR: Patient Care Coord and Quality for Health probably main areas

JK: I am currently conducting testing with aggregate data exchange and will be happy to share this information when done

DR: In future don’t know who much aggregate data will be exchanged as focus shifts to patient-centric

Hope to see another community around data warehouse and analytics

CF: In immediate future there is heavy need in SA for agg data but looking forward to seeing shift to patient-centric

DR: Analytics should be in the data warehouse not SHR

CF: Agree - agg data will be coming from SHR not client systems

Each province here can have diff instantiations of DHIS in SA

Also seeing different roles e.g. DHIS playing role of FR , using DHIS patient tracker rather than SHR for initial phase

DR: If have IHE facade in place doesn’t matter what is behind it

RC: Aiming to drive as many standards into architecture as possible and be able to swop out tools as needed to allow for arch to grow and expand - hopefully into a full HIE

***6. Feedback from previous call***

Have been wanting core to be more lightweight / easier to stand up. Split core from orchestrators and adaptors which are implementation-specific (for RHEA)

Have used Mule ESB so far -

For core proxy component which needs to be configurable dynamically Mule is awkward - a static framework - so thinking of changing to Node JS (http handling, etc)

Will use Mule for the mediation functions