**2015-05-05 OHIE SHR Community Call**

**Attendees:**

    Carl Fourie

    Linda Taylor

    Ryan Crichton

    Tariro Mandevani

    Justin Fyfe (ecGroup)

    Derek Ritz (ecGroup)

    James Kariuki

    Larry Lemmon

    Jennifer Shivers (Regenstrief)

**Agenda:**

A consolidated CDA design discussion

* A single document to support 80% of basic Primary care and disease use cases for low resource settings
* A list of key use-cases

**Performance**

* Key benchmark tests and population figures to help us design our load and performance tests (i.e. population sizes and load examples)

**Implementation updates**

**AOB**

**Minutes:**

Call recording 79535401

<http://www.conferenceplayback.com/stream/92366024/79535401.mp3>

<https://notes.ohie.org/2015-05-05_SHR_Community_Call>

Implementation driven - a point where there is a single document - CDA document.  Huge amount of resources and support needed.

**RC** - Few domain visited - HIV and TB, Maternal, immunisation and Malaria, Referral and Discharge - areas that we are trying to look.  Implementation wanting more support – to focus on area without support.

**DR** - concept of reusable building blocks - set of 11 transactions that support a huge array of care scenarios

Common pattern of care for HIV, TB and maternal - managed as chronic disease, also true for cardiac disease, etc.

Immunisation is not repetitive but it is cyclic in as much as there are steps

PowerPoint used from may last year. As a set of transaction, in addition to the one that we have left. The immunisation can be managed.

From the CDA one of the thing noted are the CD plus.  This idea is a strong idea. We have the ability to support with a single document for key sections, this is a super-set document. Both referral and discharge are medical summary document.

There are sets of data needed to support guideline based care e.g. maternal care - mothers blood pressures, weight, etc. that drive the care guidelines

eg. If blood pressure is > x then escalate care, if temperature is > x then escalate care as indicative of issues

Document is part of the OHIE.  Bring clinical four cases.  Broader HIE would be facilitating.- Question to the community on super patterns - should we be designing some pre- loaded SHR configuration to support some of the big mdb’s - creating a data – to be leveraged in an implementation like (Maternal, TB etc.) on how we structure these together on a broader aspect.

**LL** - I like the guideline on where we should focus on.  We can support

The CDA pamphlet should be able to support the data.  Couple of documents showing guidelines - that would be helpful.  Tracking particular guideline - and how you will use that in CDA.

Certain data that you need to know on the guidelines - on maternal guideline, you need to know the care guidelines. There are specific elements that we need to capture on the guidelines.  If there is content that we are conveying on the CDA, we have to use that to get to reach a decision.

**DR:** There are things you need to know in certain data in order to support. There are specific data elements that we need to look at.

If there is particular content in the CDA SUPERSET e.g. CD4 counts, and how often CD4counts taken, then can use it to drive the decision points so can operationalise the guideline based care

The data elements become requirements because they drive the care. If we don’t have the data we cannot do the decision point.

Implementing a guideline using a CDA template.<http://www.healthit.gov/sites/default/files/c-cda_and_meaningfulusecertification.pdf> good stuff starts on slide 31

We have to have place to store CD4 count. Care plan is to do this every four month.

In terms backing into the data care guideline we are 100% on how to store.

Can start with care guidelines as starting requirement but will need to look at the required data to drive the ICP.

**CF** - need to be able to drive the discussion with clinicians and care providers and use WHO guidelines to show how we can instantiate the SHR to support it. Can include within implementation guide.

Would like consensus from this community as something we want to do - have the ability to solve a real world problem.

**CF** - As I see our community we technically understand the SHR.  What we need is a connection? If we can use the maternal guideline, to leverage the community.

**JF** - would recommend immunisation as an easier ICP to take on initially - how do we map the guidelines onto a CDA?

**RC** - Agree that immunisation seems more manageable then moving onto HIV seems to make sense.

**DR** - don't agree that HIV is harder than immunisation - also more in focus for one of our funders right now. We know there is a significant demand for this.  HIV is simpler.

**JF** - but some of HIV sections are not currently implemented in CDA sections i.e. LAB

CF: Is CCD+ an IHE balloted profile or should we be not looking at existing profile. How does that come in?

**JF** - The sections and entries are IHE defined but not all

**DR** - There is a medical summary CDA – XDS and that defines the whole satisfaction in MS that we have been using.

**Group agreed on 3 main areas:**

* HIV and TB
* maternal
* immunisations

How do we specify and agree which CDA sections that we want to support?

Draw info from guidelines and then map to the CDA?

Example: HIV guideline - e.g. what triggers stage 1 to stage 2 - can be shown as a flowchart g: CD4 < 500 do x

IHE profile - DEX - where in the CDA this data element is found

Need to read clinical guidelines and then look at the clinical framework

We will find gaps of sections not yet implemented

The HIV guideline stresses particular clinical terms, editorial comments etc. and those can be passed and as you read you see a flow chart.

We can follow a clinical guideline and come up with a clear mapping.  Immunisation guidelines are recommended.

**CF**: - We have immunisation that is using part of the IHE tool, second is maternal care and third is **HIV that have any implementation and has a white paper draft.**

**CF** - Have 3 H/L use cases to write up and prototype: real world experience in immunisation and maternal care already - HIV not an Open HE implementation but lots of opportunities for this.

As soon as you come up with a template on how a medication get represented in the CDA it is going to be similar to other medication and guidelines

**CF** - How ready are we technically with these in terms of the SHR tool readiness?

**JF** - We might be on 60-80% on some of them.

CF - Just the CDA doc spec or can the doc be persisted and stored etc.?

**RC** - Have the interface to get docs in - modules to extract data and process it. Work going forward is to add more handlers to new or existing modules as well as the CDA specification to handle semantics of the CDAs

The way the SHR document is structured? Adding more modules to CDA documents?.  We are pretty down the road at the moment.

**CF**: Do we have a mechanism to allow us to draft alerting rules e.g. if CD4 count drops below certain level triggers an alert?

**JF**- can reuse an OpenMRS module to do it or use the OpenHIE "module" to do this

If give users a CDA spec plus a list of OpenSHR modules to support it then it will facilitate a maternal care guideline.

**JF** - a separate actor is more suited to operationalise the guideline.

These cross multiple communities so next step would probably be say how to use these OpenHIE tools to do something.

Will raise on the Architecture Community Call.

Our mandate is to store and retrieve the data that supports these care guidelines not operationalise them.

DR: SHR needs to concentrate on data needed to support it.

**Action points**

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| **Action** | **Responsible**  | **Deadline** |
| Agreed selection of prioritised clinical area | SHR Community  | 12/05/15 |
| To circulate the IHE White paper  | DR | 12/05/15 |
| Raise with Architecture Community how to operationalise care guidelines ( since it is broader than the SHR community | CF | 12/05/15 |

**\*SELECTED A CLINICAL CARE GUIDELINE - when we meet in the next call.**