**OpenHIE SHR Community Call 25 March 2014**

Please login below

**Attendees:**

Ryan Crichton

Bruce Mc Cleod

Larry Lemmon

Derek Ritz

Joan

Linda

Suranga

Jeremy Keiper

Meeting recording available online here for 30days <http://www.conferenceplayback.com/stream/84855406/95491001.mp3>

**Agenda:**

* Vision mission and values
* What processing the SHR and what processing should the IL do
* The uses of discrete data and their workflows
* [https://wiki.ohie.org/display/SUB/The+uses+of+discrete+data+in+the+SHR](https://wiki.ohie.org/display/SUB/The%2Buses%2Bof%2Bdiscrete%2Bdata%2Bin%2Bthe%2BSHR)
* SHR development update
* Other community topics

**Minutes:**

Vision Mission and Values

LT - thanks to everyone who replied. Very close to something we can all agree on hopefully can circulate for final agreement by the end of the week.

RC - Is there another topic that the community would like to discuss. Is the agenda okay or more pressing topics?

DR - an issue for us to get our arms around, what processing do we think the SHR is going to do and what the orchestrator is going to do

DR may have the EMR set up as a repository. There are other standard compliant options out there. We must keep our options open. OpenMRS plug ins can be written

RC - thought we had consensus but maybe we should talk about it. What to support the XDS.b interface and everything that the IL would do would be processing on the XDS.b in the CDA doc and pass on that to the IL

Gives us the option of swopping out our SHR to other repositories that are out there.

DR - same understanding expect the SHR to give us the opportunity to do the things that we want to do, there are profiles for fetching discrete data and if the SHR can't do those transactions then it is not what we need.

Is discrete fetching data transaction that we should be able to send to the SHR regardless of the profile that the message is relayed in.

Clinical decision support you don't find in the SHR and aggregating info to send to the HEMR.

DR - use as a data cube for analysis that we could be able to do

RC - when it comes to saving and querying doc we are agreed but the questions are around discrete data and whether that should be part of the SHR.

DR - it should be in the SHR but operating on it as a rules engine. Better served to expect the SHR to be a dumb repositiory

RC - Look at the link included above. Looks at processing for the SHR discrete data

Haven’t discussed this much.

Need to nail down an agreement.

DR - must decide on the schemer for discrete data, will need a bit of evolution to serve the purposes we want from the SHR.

DR - not required to have the database become an EMR to store discrete data. XML is the simplest and then understanding the RIM is the other end of the spectrum

RC - look at the three workflows from the previous discussion

LL - two more that should go on the use case 1. trending over time of a number of discrete data, the ability for the data points to do trending over a time window, 2. partial medical summary for a patient the ability not to do a total summary but a partial summary of certain items.

LL - talking about a shortlist of items you want for a patient a defined list but a partial list summary. A regular request for the work LL does. Sent back as discrete data not report

DR - not full medical history but the defined minimum summary of what the full history would be, every Canadian province has gone through this definition - data elements that you have to be able to return

RC - process of number 2 could be something useful

RC - decide on the top priority use of discrete data in the SHR

Start with creation of the medical care summary record for patients workflow

JK - is it CCD?

LL - talking about a subset of discrete items that is needed many times but is a partial medical summary

DR - CCD can be expressed as a CDA

LL - talking about requests for only certain items from the medical summary not all of it

**Medical summary for a patient**

RC- docs for each patient each time they have an encounter multiple docs over a time. Certain CDAs that is supported like XTS MS medical summary standard (??)

RC - As docs come into the SHR an internal process in the SHR that takes those docs and converts them to a med summary and then registers it as such

DR worth looking at the concept of a virtual med record, a summary is a point in time summary query each time you query you may get a different response

DR virtual med record doesn't get persisted back just because you made the query. Request is not saved to the database. It is a saved query executed to the extent at the time of the query.

RC - how does this fit in with the XDS.b because it has to be registered in the registry and be able to be queried for again.

DR - what's the value of keeping the queries stored can create clutter not so with the virtual medical record

DR - Virtual medical record is what is the current summary for a patient

DR - argument is that each time a query is made a CDA is saved, while the virtual will give a response to the person who queries but doesn't save a record but a result of the current information is returned with the current information

DR - can use a time stamp to replicate what you got as a result at a date

DR - it is a debate that is ongoing if the record is saved it doesn't have to be recreated. DR - favours the virtual one but this may be a challenge if the query is changed. Can be challenging when you need to prove the information given to a doctor for a decision he made

DR - requires you to do version control of the stored queries, need to do a time stamped journaling for the query statement as for something else. Can win with both sides. We need to decide on the path to take and then decide how we will manage for the approach we decide on

RC - favour the virtual medical record then have to decide if we send to user and save the query. Could evolve to easily save the queries and then plan to have the structure in place if we need to store it.

DR - could store it in the IL as well as part of the logs without having to do any work.

LL - favour it too but it does mean the SHR needs to be able to go back to a time and recall the value that was there at the time.

DR need to look at how strict the journaling of the database is. RC yes OpenMRS is a journaling database that saves all changes so it should work.

RC - mentioned the SHR should be fairly simple and only store and retrieve, something that can be replicated by an off the shelf product. How does this fit in with that? Is this a value added service or a requirement?

DR - it is up to us to request a medical summary from the SHR. THe job of the SHR is to generate the response and return it to the IL and then return it to the user or the IL Could prepare the summary and return it to the user.

DR in the Canadian example of the HIAL works with discrete data as opposed to documents, when a summary is requested you can go to all the repositories and build the message and returns it.

JK - level of complexity that the IL requires sounds like a level of complexity higher than what the IL is able to perform.

DR - somebody must be able to piece it together need to answer where all the content is going to be. The SHR could be the holder of all the information but there are specific needs that need a separate repository. Are we expecting all the information to be in the SHR or it must be smart enough to fetch all the information from other repositories.

RC - where should the logic be housed, reasonable argument to have it in the IL in case of more repositories in future.

LL - in Indiana the SHR has everything in its grasp and it can generate everything you need or would you have numerous SHRs and the IL would go and get it from there. Would the robust SHR have everything?

DR - need to decide if all the content is in one place or someone knows where all the content is

LL - having it all in a single place is the function of the SHR

DR - different repositories but they are not federated but there may be different schemers for the different types of information and have the different repositories.

RC - OpenMRS only suited for clinical encounters not suited to the other and may need to be able to have them in the future.

DR - if we had something that is a CDA repository it might be possible but the internal schemers in the CDA may not find a happy home in the OpenMRS as it is currently.

**SHR Development Update**

SK - was away from the office not much progress. Been focusing on a small number of profiles. Need to get profiles more suited to our needs. May not need all the complex CDA template that was received.

DR - difference between template and example of a CDA. Templates are broken out into sub components and has a XML schemer for it APS will determine the mandatory elements and optional ones should be. Need to generate an example with mandatory elements and decide what is most appropriate for us. DR sent SK links to where the templates can be found.

DR - there may be CDA examples that we are able to use. Mohawk could create some for us as examples.

SK - need a draft document that he could work with

DR - to get the CDA instance you want to work with you must work with the CDA template and indicate that these are what I want to work with. No readymade CDA examples for us to work with need to look at elements and then have it generated for us.

DR - recommend that Hannes make a buddy call to Justin at Mohawk and make a request for example CDAs but must get our heads around CDA instances and templates.

RC - take data from Rwanda and then build a CDA of our own using data we already use. Will communicate to SK offline.

JK - need to make a decision together

RC - could schedule a call with JK, and SK to discuss further.