**Open SHR Community Call**

**Date: 12 August 2014**

**Attendees:**

Ryan, Justin, Linda, Joan, Hannes, Larry, Derek

Meeting recording available on line for 30 days here: <http://www.conferenceplayback.com/stream/37558946/38940601.mp3>

**Agenda:**

* Development updates
* XDS.b module
* CDA processors and QED interface
* Discuss On-demand documents - IHE supplement
* Discuss OpenHIE version 1 - what does this mean for the SHR

Minutes:

RC - any other business to add or any other topics to discuss?

* **Development updates**
* **XDS.b module**
* **CDA processors and QED interface**

RC - been working on the XDS.b module for OpenMRS work has been going fairly well had help from JF to bootstrap the project to get the initial web servers end points up and running pretty rapidly. Since then been trying to integrate that into some of the modules we already had. We already had such modules for the SHR already such as the content handler and various modules like that. Just wanted to integrate that in, get patients created and providers created as messages come in. Basically deal with the meta data in the message so that we can then pass on the content in the message. At the moment we are able to receive Provider register documents as a SOPE request Each document is processed and any patient associated with the document is created, now working on providers to be created and some of the other meta data created in OpenMRS before it can be passed on to the content handler. Pretty much where we sit with that now looking ahead what we are going to be doing is trying to get the providers registry transactions working fully, then try and concentrate on, there's an extra step where we have to ship off meta data to the XDS registry as well. That is the next logical piece that needs to be worked on and then also ensuring that all the APNA logging takes place. And what we have been able to do is actually leverage quite a lot of code from the DCM42 project that is an open source project on Github, it is an open source XDS registry and repository and we've been able to pull in a few modules from there to provide some of the base Java classes for working with XDS.b messages and also processing messages. So that helped quite a bit and has cut off the development time so it is good that we can get some reuse out of that. This is where we are sitting with the XDS.b module.

JF - been struggling with the substance admin section, the issues that I am running into are code based in the OpenMRS versions 1.97 to 1.10, and there is quite a bit of discussion on the forum that I started about activating orders in the past. Currently there is an issue where OpenMRS refuses to record an order activated in the past but it is still ongoing. Trying to find a way around that. Also started to integrate the CDA parsing into the CDA content handler module that HV wrote. Added the necessary handler for the APS now OpenMRS can understand an APS minus the medications section which is the current issue. Talking about doing a basic end to end test through from receiving XDS to the content handler into the CDA processer, should be able to do that soon.

RC - what we want to try to do is where we can get to the stage to set up a preproduction environment for the SHR so that we have something to actually play around with and then we will start getting all the modules together and see if we can get transactions flowing through the whole system.

RC - in terms of the QED interface is it on hold for now concentrating mainly on the CDA generation?

JF - trying to put substance admin into OpenMRS. Issue in OpenMRS where you can't activate an order in the past it rejects storing it, trying to work around it so did things around the meds importing.

LL - does OpenMRS expect you to close the order and then reopen it? What is the rationale?

JF - the rationale is you can't activate an order before the encounter takes place. some of the prescribe actions or the rationale is a prescription that happened in the past and is still on going, in CDA you can say that the order was done and is still active it is open not closed.

RC - any response from the OpenMRS community

JF - we keep coming back to what may be a misunderstanding on how the encounter is used. ........ It is a debate on how to handle a historical order, can create an order just for the substance but it doesn't give the concept of the visit as to where it fits in the visit. Could store it as an OID with a to do. We could store it that way.

RC - will have a look through the message and see to add anything to the discussion.

JF - additional input would help.

RC - things have changed recently

JF - it worked in the earlier version but not working now.

RC - wonder if in OpenMRS there is a way to change the validator maybe use a custom or the one from the older version.

JF - suggest for the order in the past to have it marked as not being done in the encounter.

JF - doing the integration of the models

* Discuss On-demand documents - IHE supplement

RC - DR has put out a nice deck on the mailing list that covers what we want to do for OpenHIE version 1 using the Rwanda use case. Has put together what an OpenHIE version 1 could look like.

Part of what DR described we already know also included generating documents on demand and this is a supplement to the IHE requirements. Start a discussion if this is what we would be looking to support in the SHR. Could be a static document or an on demand document, the first way is simpler and doesn't require understanding all the content in the CDA and would be quicker, on Demand we would have to understand all the elements of the CDA longer time to create. We would be aiming toward on demand.

JF - it has moved to final text which means it is stable. what happens is the repository receives a provide a register for a patient for the first time it will store the document it can then create an on demand document that is created on the fly the repository marks it as an on demand document and knows it has to fill it as an on demand doc. The good news is we are doing QED and the QED docs are the same as CDA and may not require as much work. It is the document created from a retrieve request that it knows is an on demand doc it creates the document from information in the discrete data source.

RC - how much effort is required to get the on demand documents.

JF - DIff between QED and CCD is it will require some work on how the QED and the on demand production could share the same code base. Once you have the .......................

RC - would we be able to represent the documents we are sending in completely in a on demand document. What we are getting in and then mapped to data models that we would not get an identical document back do you feel that may be a problem.

JF - it is a problem but it is shared by all. The on demand is more about are you representing what is in your data model. Is the information represented properly in the data model. I believe you can generate it from EMR. Technically you should have the data pop out in an on demand document. Not have to reproduce it exactly like what was in the CDA.

JF - QED is a test of can you produce what is in your data model onto the QED form. May have challenges with testing because there aren't many implementers yet.

RC - if the PoC wanted the document it entered they could use the static doc and the on demnad would be created when requested.

LL - are we gonna have anything like a hybrid of that two eg. What CDA docs do you have on the patient and pick the most relevant one. Is it a onetime ask or an ask off a document list and pick one.

JF - the on demand doc entry in the registry so when you query the registry and you will get a list of document including the on demand doc as an option. ..........list of files created on the query.

RC - the query would produce all the documents and we need to have the user decide what document it needs.

LL - the registry would be an indication of what is available only

JF - when the SHR registers a doc with the registry it must tell the registry if it is on demand or stable to differentiate between the two. Some registries will store and not care but some don't.

LL - you're saying the CR would record all the docs it receives for the patient

JF - it would be an XDS document, from this standpoint it is storing a blob, the document registry is the master index of this patient has this document in this registry.

LL - isn't it all part of the SHR

JF - we are using a third party registry so we have to understand that.

RC - both would sit in the box for a shared health record.

RC - sounds like something we spoke about for our requirements and it doesn't seem like to much effort if we are using the QED.

LL - it is essential that we have it for any clinical decision support.

JF - if we support on demand document do we need to support QED?

JF - if we do both which will be more important for version 1

LL - where is it going to be implemented?

RC - if they are so similar we should focus efforts on one of them for now. How can we figure out what which one would suit our needs.

JF - an on demand doc doesn’t' have to be a CDA when doing clinician support need to have a CDA.... with QED you can choose what you want.

RC - a good way to get to that decision is to go back to our use case for QED and CDA. Our use case would be the ICP and then immunizations think about how they best fit either of those.

RC - put on our agenda for the next call, which we need to prioritise

LL - in version one where do we stand on storing discrete data? Are we committing to discrete data in version 1?

JF - think we are

RC - we can commit to discrete data what we are saying we would have discrete data just not sure in what form.

JF - need to know what the priority is for version 1

DR - would the underlying things we would have to do on the OpenMRS database be the same

JF - basically want to know, the basic things are the same just different wrappers, need to assign importance to QED or OED.

DR - the V1 as described would require the on demand documents not the QED, expectation we could piggy back on the GSOC work

RC - projects are finishing up this week and will start submitting to OpenMRS talk and see if there is a presentation, it should be complete at the end of the week.

DR - at the least we will get a running start or it should be close to complete....

JF - is there a public repository to look at the code to see how we could integrate that. IF we are generating a CDA as our on demand doc we should choose a template that suits our use case.

DR - we could get almost all the mileage out of the APS not sure if all of the APHP goes into APS

GSoC Presentation: <https://talk.openmrs.org/t/gsoc-2014-openmrs-cda-generator-final-presentation/493>

[https://wiki.openmrs.org/display/projects/OpenMRS+CDA+Generator](https://wiki.openmrs.org/display/projects/OpenMRS%2BCDA%2BGenerator)

DR - if we are testing at the connectathon we will have to have a list of profiles we support

RC - using on demand docs gives PoC access to the information

JF - on demand docs should be higher priority than QED

Decision was made to use the creation of documents on the fly and recreate the document if needed.

DR - if this is too difficult to do we would reconsider the use of not saving or registering. if it is hard to roll the clock back.

* Discuss OpenHIE version 1 - what does this mean for the SHR

RC - at SHR level 1 we would have .....

DR - is the ITI 8 merge command is it just the registry

JF - yes

DR - if that is the case then we can have that in our scope if we use a third party registry

JF if we use a third party registry it must understand on demand docs as well.

DR - the IL and SHR community are going to have to make the most effort before December

RC - seems on the demand is the document to go for and we can discuss this again at the next meeting.

DR - architecture call is before the next SHR call. We will use the Google group to discuss any issues related to the architecture