**OPENHIE Provider Registry Community Call: February 20th**

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**MINUTES:**

1. Background on Provider Registry (PR) (**SEE POWER POINT**)
	1. Motivating Example: RHEA Provider Registry-driving current work
	2. Goal: Register providers from multiple sources and validate provider data from POC applications before they enter the shared health record (use case).
	3. Technology: LDAP (data store), MySQL (database and search for user interface, based on same framework of iHRIS Manage software (iHRIS provides HRH business & interface logic)
	4. Achieved through IntraHealth/CapacityPlus effort with partnership and RHEA collaborative
	5. Rwanda Health Enterprise Architecture: Provider Data and Clinical data fed by two sources: public sector IHRIS system and RapidSMS (excel spreadsheets). **How can we make this more programmatic through API?**
	6. Interoperability layer (IL): Sending HL7 applications through shared health record. The interoperability layer is validating messages to ensure that the coding is correct and the providers/clients are present. Once validated, data gets put into shared health record which is queriable from any clinical location.
		1. iHRIS does not pass through the IL to get to PR—future plans to make services available to make this happen. iHRIS would be data source so we wouldn’t need to validate HL7 applications.

**Please see attached list of links for additional resources/training**

RL: So if given country wanted to deploy PR, they wouldn’t need IL?

CL: Yes, PR is supposed to be a stand-alone system—the IL is just pulling other systems together

1. Zimbabwe: 2nd Use Case:

5 different Councils and Public Sector HR system. Using PR as intermediary to ensure info from Councils is passed into PS HR and vice versa, they are looking to use PR—health worker system, not clinical as mentioned previously

1. OpenMRS: 3rd Use Case:

Open MRS PR Module (Point of Care application). Users are providers and those providers are validated against PR through HIM (Rwanda). Before messages are sent from OpenMRS, administrator can validate the provider and take next steps.

1. Q&A

BO: Why was LDAP selected? You have built web-services on top of within the HIM? Are you accessing LDAP or web-service?

CL: There is only one web-service currently in Rwanda that is sitting on top of LDAP query (enterprise ID).

BO: They don’t access with LDAP query directly?

CL: Correct, but as another example, the Provider Directory Profile does access LDAP directly—self architecture

BO: The line between facility and provider can be a bit blurred, where facility is almost a subset of the provider as seen in Australia. Need to make an effort to standardize the definition of each.

CL: Yes, that is certainly present within the Botswana as well

DS: Should be taken on Country to Country basis to be navigated together. Continuing conversations with Facility Registry will help.

RL: For PR, what kind of flexibility makes sense to build in at the community health worker level? Most information that is available is informal. What are the validation points and who has access?

DS: The quasi formal provider is handled many different ways. RapidSMS can be helpful. It will be up to each individual country how to capture and maintain community health worker data. At the global level, we need to provide all possible support for use cases.

RL: It may be beneficial to select 3 or so different countries with different approaches to community health workers to represent use cases.

1. **Going forward: proposed goals of Provider Registry Community**
	1. **Build towards Interlinked Registry Profile/standards development (most important!)**
		1. **Health Provider Directory (HPD) standard (already published)**
		2. **Interlinked registry (in development through OpenHIE)**
	2. **Develop state-of-the-art open source provider registry that functions independently and as part of larger OpenHIE to be adapted to country specific implementations**
	3. **Support country customizations and implementations of Provider Registry**
	4. **Develop client system use cases and reference implementations**
2. Next Steps: How can we work together?
	1. Define area of work
	2. Build roadmap/ prioritize
	3. What will it take to resource?
	4. Take proposal to OpenHIE/PEPFAR for possible resourcing
3. Next Call: March 6th, continuing every other Wednesday at 10:00am

**Preliminary TOPICS for next call:**

1. Review HPD to see if it meets the needs of proposed use cases

2. Define parameters for collaborative approach