Minutes, IHC, TC
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**Agenda**

- SNOMED inside OASIS
- Health Indicators (from ISO to OASIS)

**Health Indicators**

Health indicators are often crafted in response to not what is best but what is easily measured. You report on the metrics and by changing the standards for what is measured and then report globally. All countries are different and this leads to inequities of care throughout the world. This leads to things like poor cueing and misguided resource allocation.

In ISO there were packages and models created that could be implemented. Globally in health, providing for a standard way in the quality of healthcare could create tremendous opportunities in healthcare.

The initiative failed at ISO because the American Dental Association voted it down. Could these be passed in the OASIS space and then be taken back to the ISO as a better defined standard?

So as related to the DRGs, CPTs, LOINC, etc. These are models and must take into account social and cultural aspects of care. So instead of measuring just numbers of cases we are also measuring satisfaction, days of hospitalization etc. that related to the quality of care.

The entire idea is egalitarian and improves healthcare throughout the world.

Rex: If this hasn’t made it through ISO once, how can we make this “not in conflict” with ISO.

Peter: This is coordinate with the “indicators framework” process from ISO. This is a UML model driven model that can be computable and implementable.
Peter’s group did the modeling and are welcoming the changes to the model as necessary. They should be consistent and have flexible cardinalities. The attempt is to be comprehensive.

Fulton: So in the personal health record is there going be fields where patients can enter their own indicators?

Peter: Yes. The healthcare system can do a better job of monitoring the health indicators by engaging patients.

Rex: From the clinical EHR/PHR perspective will patients be able to access the information they need to be healthy?

Peter: These should be fueled back and forth as necessary to make healthcare work. There should be a multiplayer PHR fueled by the EHR with the ability to create communities of diagnosis and/or treatments. A change in this generation has occurred – not only in the old model were patients less educated and knowledgeable – today this is different and patients are well educated can be a partner in the delivery of healthcare.

SNOMED will be a part of the process of feeding these models from PHRs and EHRs.

**SNOMED inside IHC**

Duke and Mayo are working on the “go forward” work in SNOMED.

So the SNOMED will account for all medical disciplines and in the future it is hoped that it will be free of charged (public domain) – anyone who has federal reporting requirements to the government.

So, what will happen when the CAP sells the intellectual property to the governments we are not sure how the entire thing will be managed going forward. It is in OASIS’ best interest to obtain the rights to.

Rex: We just completed HAVE and with SNOMED we will need to get buy in by individuals who can ensure interoperability. We must have a mechanism (SDO) to continue to manage the process of change and improvement.

Can someone step up and propose to the consortium that we take the SDO piece of the SNOMED consortium efforts?

**Other**

In the context of the long term goals for the IHC we should create a liaison with the Emergency messaging sub committee. Peter chairs the Biosurveillance technical committee at HITSP and we need to be sure that the committee knows and understands the work done by Rex’s group.
Situational awareness work being done in OASIS.

Peter: We need to look more deeply into the data for biosurveillance to work well. We are not really sure how resources are currently used in performing state and local public health functions is currently being performed.