Meeting Name	IHE Eye Care Planning Committee
Meeting Date and Time	October 15 2010
Next Meeting Scheduled	December 16-17, 2010, San Francisco CA
Location / Dial-in Numbers	1 800 605-5167 use passcode 724635
Gotomeeting	989659922

Agenda

I. Welcome and Introductions

II. Goals for Meeting and Review of Agenda — All

III. Proposals for IHE Eye Care Year 5 — All

IV. New business

V. Next Steps/Next Meeting

Decisions and Actions

Decisions and Action Items	Person responsible	Timeline
1. The group reviewed the IHE technical and planning committee functions for the new participants. This explanation of terms was performed with real world examples- integration profile, actors, transactions. The group discussed the overview documents available this year explaining to clinicians in non-technical terms what IHE does and how it does it. The group also discussed an extensive handbook for next year for implementers that is being developed for next year, and invited vendors to contribute to make it maximally useful.	Vendors	
2. The group discussed reporting, highlighting the importance of terminology for clinical data and reports and looking at current trends to establish proper approach for future IHE efforts. Reporting is generally felt to be something we must do; there was extensive discussion of possible technical solutions for interoperable reports: DICOM SR vs HL7 CDA done within the HL7 organization vs HL7 CDA done by an IHE Eye Care Committee. Pros and cons of each approach discussed from the vendor and clinical vantage. o DICOM is generally viewed as something we can do now with our existing expertise, and therefore is more familiar to us. It would be faster than working within the HL7 organization but slower than doing CDA within an IHE committee. The quality of our product would likely be better in DICOM due to the extensive oversight that occurs in the approval	Planning Committee	12/16-17/10

process. Some of the data points in a report would be expected to be machine output, and DICOM has a long record of proven interoperability for machine output. o Do both at the same time? We may want to cover part of what is needed in DICOM, and part in CDA. • What is CDA (Clinical Document Architecture o A tool for capturing interpretations in a persistent and exchangeable format based on XML o Encoded data o CCD- Continuity of Care Document ▪ Templates for various modules- medications, order, immunizations, etc ▪ No ophthalmic specific templates at this time ▪ C32- personal health record component • Patient summary document • HL7 solution is integral to current meaningful use trend, and for this reason we may want to provide a CDA solution whether or not we eventually come up with a DICOM SR solution. • Report ownership- PACS or EHR o A clear point of controversy that was defended in each direction with equal passion and validity o Clinical use cases o Technical use cases o Best practices use cases o Jim Riggi pointed out that in real life he can always get data from a PACS vendor but very infrequently can he get data from an EHR vendor. For this reason he favors the PACS owning the report. o Some believe that we should not even consider who is going to own the data in our decision making about what data structure we use. Query for Don – will PACS be able/willing to deal with CDA's? • How do we decide? – Do a test use case o DR may be the best choice o Work through it to determine empirically which approach is preferable or if some combination will be needed		
3. Don introduced the issue of the minimum requirements for IHE performance to create two levels of Clinical work flow to maximize participation • Basic workflow without MPPS and Storage Commitment • Strict requirement for native IOD vs use of DICOM PDF There is a potential downside to a second level IHE conformance, namely it disincentivizes the other vendors that conform to the more rigid legacy standards. Rich Amador says it is easy to sell the idea to clinicians that we ultimately want native IOD's rather than PDF data output– he has experience with that in radiology and clinicians do understand the difference Does this allow clinical workflow and openness of data? –	Planning Committee	10/29/10

our most important goals, and it was agreed that modality worklist and storage do this very well, while the additional contribution of MPPS and storage commitment is smaller. This should not be considered IHE "lite", but rather another profile that is Clinical Workflow with/without certain functionality. Many people also believed that we should just make MPPS, native IOD's, and storage commitment optional in our current profile while putting a lot of emphasis on the benefits of full implementation in our marketing strategies in fairness to those vendors who have already implemented the full workflow as planned. This creates new marketing requirements for IHE that provide transparency and unbiased distinction between various levels of conformance. There was not a quorum when this issue was called so this will need to be voted upon later by e-mail. The options are to delay the decision until our next meeting in December or vote by tcon or e-mail- the decision was made to vote on this by e-mail. In any case, both levels of conformance will be allowed to participate in the AAO demonstration as they are this year.		
4. The next face-to-face meeting is scheduled for December 16-17 at the Academy Headquarters in San Francisco. The intent will be to discuss in-depth proposals for Year 6.	Planning Committee	

General Notes

Prepared by Linda Wedemeyer and Mark Horton

Documents Discussed

Meeting Minutes

Scheduled Calls & Meetings

December 16-17, Academy Headquarters, San Francisco

Participants

The following members participated in person or by phone in the meeting.

Attendee, Project Role	*Org.*	*E-mail Address*	*IHE Member*	*Present*
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Linda Wedemeyer, Co-Chair	Veterans Health Administration	linophth@cox.net	Y	X

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Attendees included:

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Michael Chiang, MD
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