# 7.1.3 Point of Care Reporting

When it comes to reporting needs, the preference of most clinicians is to 'collect once and use many times'. SNOMED CT enables this goal to be achieved by allowing data to be captured at the appropriate level of detail and then queried at the same or less detailed level. SNOMED CT supports point of care reporting requirements using any (or all) of the SNOMED CT analytics techniques described in section 6 SNOMED CT Analytic Techniques, including subsets, subsumption, defining relationships and description logic. Examples of point of care reporting requirements may include:

- Helping clinicians remember preventative services (reminders)
- Identifying patients with care gaps and risk factors
- Monitoring patient compliance with prescribed treatments
- Reporting clinical data to registries, such as cancer, stroke, and infectious disease registries
- Billing and reimbursement[1]

When supporting a reporting requirement in which double counting must be avoided (such as statistical reporting, administrative reporting, billing, or reimbursement), SNOMED CT codes can be mapped to statistical classifications (such as ICD-9 and ICD-10) (see section 6.6 Using Statistical Classifications).

When the source data uses a coding system without the same reporting capabilities as SNOMED CT, or when a variety of coding systems are used, coded data can be mapped into SNOMED CT to support the reporting requirements (see section 5.2 Mapping Other Code Systems to SNOMED CT).

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[1] Note: In some healthcare environments this is a point of care activity, while in others it is not.