IHE Work Item Proposal (Detailed)

# Proposed Work Item: Care Team Management

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**Summary**

In the past, HL7 and IHE have produced standards that support the exchange of documents that contain information about the patient care team(s). This profile will provide the ability to organize and share data that will result in consolidated and updated care team information to support care coordination.

The profile will utilize HL7 Care Coordination Service (CCS) Functional Model Capabilities to define the needed aspects of care team management. CCS is based on HL7 Care Plan Domain Analysis Model (CP DAM)[[1]](#endnote-1).

The goal is to have a means of identifying providers and care givers who are providing or have provided care for the patient. This information can be dynamically updated as the patient interacts with the healthcare system. FHIR resources infrastructure and other specifications to support clinical, workflow, scheduling, etc, will be used as the back bone to provide the operational pieces needed for managing care team membership.

# The Problem

Patients are suffering from an increasing number of complex or chronic health conditions which require frequent episodes of care involving multiple providers. With this complexity, it is difficult to identify and coordinate care amongst providers and caregivers. Being able to inform providers and patients with care team information and the functions to support improving care provision is needed.

The World Health Organization (WHO) stipulates approximately 63% of all annual deaths are due to non-communicable or chronic diseases. US Medicare claims data reports $17.4 billion dollars was spent on re-admissions to hospital within 30 days of discharge in 2004. Effective collaboration and communication is needed to support the provision of patient-centered care. This would enable the provision of efficient health information needed for effective care planning and collaboration between applicable providers, participants and the patient.

The purpose of this profile: Provide a mechanism to facilitate programmatic care team management for the same patient between applicable care providers and the patient/caregiver to support dynamic, evolving and ongoing care coordination.

The new profile will address many of the needs not met in many document based static list of care team members:

* A centralized means of aggregating and managing care team members that meet the needs of many stakeholders (providers, patients, payers, etc);
* A method of consolidating the many care team members that can be associated with a patient;
* Provide a framework for centralized care team management

# Use Cases

**Care Plan Driven Care Teams**: As providers are involved in ongoing care planning for the patient, the need to communicate who the providers are, the role they play and their involvement in the care of the patient is paramount to support care coordination

* Transitions in care – Discharge form Acute Care to Post Acute Care

Provider to Provider Transitions of Care focus on the sharing of patient information between multi-disciplinary teams of Providers across acute and post-acute care sites to support care coordination, management, and service delivery by the multiple providers involved in a patient’s care. During these situations, care provision and coordination is based on care planning.

* Chronic Disease Management

The purpose of this use case is to illustrate the coordination of care between a patient, the primary care provider, specialist and allied health care providers involved in the management and treatment of one or more chronic health issues. This Use Case includes referrals for the purpose of consultation. Here again, care provision and coordination is based on care planning.

**Non-Care Plan Driven Care Teams**:

Provides the opportunity to engage care teams that provides supportive care for the persons in at-risk or underserved populations. For example, elderly persons who may or may not be in direct contact with the health care system; persons with behavioral health issues; low-income women and their minor children with limited access to health services. Non-Care plan driven care teams supports the implications for quality of care, quality of life, and healthcare financing. These care teams provide ability to maximize independence, improve quality of care and life, support professional and family caregivers, increase providers’ efficiency, and reduce the nation’s healthcare expenditures. Examples of these types of care team include:

* A homeless person who may interact with the healthcare system intermittently but need social services interventions on an ongoing basis
* Community based service agency teams need to coordinate services with each other (e.g. social services team with behavioral care services team)
* Caregiver need to coordinate non-health care services involving teams for an elderly parent (e.g. church members who prepares meals and provide personal care services with meals-on-wheels team and community services team.

# Standards & Systems

Standards

* HL7 [Care Coordination Service Functional Model](http://wiki.hl7.org/index.php?title=Coordination_of_Care_Services_Specification_Project)[[2]](#endnote-2)
* FHIR Resources and RESTFul transport – including FHIR messaging and potential workflow
* PIX
* ATNA
* Existing group membership standards (need further exploration)
* HPD (need further exploration)

Systems

* EHR
* PHR
* Patient Portal
* HIE
* Community-Based Social Service Agency Systems
* Payer systems

# Technical Approach

The use of a coordination framework is needed to support the ability to identify and collect care team members for the purpose of collaboration. Profiling FHIR resources will be used to support the CCS capabilities such as care team membership and care team communication.

**New actors**

Care Team Contributor

Care Team Service

Possibly others depending on standards discovery

**Existing actors**

Content Creator

Content Consumer

Reconciling Agent

Care Plan Contributor

Care Plan Service

**New transactions (standards used)**

Content Creator

* New Transactions

Content Consumer

* New Transactions

**Impact on existing integration profiles**

Care Team Management could inform the structures of future profiles that could be mapped to preexisting FHIR based profiles such as Dynamic Care Planning and document based profiles such as the Patient Care Plan (PtCP). It could be leveraged relative to any other profile that includes care teams or care team members.

# Risks

Some FHIR Resources are still in a state where further modifications will be made. Will need to keep up with FHIR resource changes.

Identifying and re-use of appropriate technology.

Redundancy – many groups are working on FHIR care team profiling.

# Open Issues

# Effort Estimates

<The technical committee will use this area to record details of the effort estimation.>

1. See <http://www.hl7.org/implement/standards/product_brief.cfm?product_id=435> [↑](#endnote-ref-1)
2. See <http://www.hl7.org/Special/committees/patientcare/index.cfm> [↑](#endnote-ref-2)