IHE Work Item Proposal (Short)

# Proposed Work Item: Dynamic Care Team Management

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Version: 1

Domain: PCC

# The Problem

<Summarize the integration problem. What doesn’t work, or what needs to work?>

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 workflow profile: Provide a mechanism to facilitate programmatic creation and updates of care teams to support care team management as part of the care coordination process.

# Key Use Case

<Describe a short use case scenario from the user perspective. The use case should demonstrate the integration/workflow problem. Feel free to add a second use case scenario demonstrating how it “should” work. Try to indicate the people/systems, the tasks they are doing, the information they need, and where the information should come from.>

A 78 year old patient is admitted to hospital for planned right hip arthroscopic surgery. The plan is that upon discharge from the hospital, the patient will be transitioned to specialist care (orthopedic surgeon) then eventually discharged to home with home health services for skilled nursing and rehab services. The patient is also diabetic and suffers from rheumatoid arthritis. Her diabetes and rheumatoid arthritis are being managed by her primary care physician.

Her discharge from the hospital results in the need to transition to the next level of care to the appropriate care providers and care settings. In order to support care coordination between the patient’s care providers and caregivers, the hospital’s discharge planner will need to create new care teams and/or update existing care teams with the appropriate care team members that will provide the needed care. This will include identifying the rehabilitation facility and eventually the post discharge providers, teams that will provide skilled services and the patient caregivers.

As providers become involved in ongoing care of the patient, the ability 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.

# Standards & Systems

<List existing systems that are/could be involved in the problem/solution.>

<If known, list specific components of standards which might be relevant to the solution.>

Standards

* FHIR Constructs
* Mobile Device
* CDA Documents
* XDR (for Direct exports and inbound documents)
* Audit Logging
* Error Handling
* Secure Transport

Systems

* EHR
* PHR
* Patient Portal
* HIE
* CPOE

# Discussion

<If possible, indicate why IHE would be a good venue to solve the problem and what you think IHE should do to solve it.>

This profile should be an update to the Patient Care Coordination Dynamic Care Team Management (DCTM) workflow profile that currently supports the ability to coordinate providers and caregivers that participate in the care of a patient. The proposed update would include the ability to create/update care teams in a dynamic way. IHE would be a good venue to solve this problem because it involves developing a profile across several existing standards. It has the necessary expertise in PCC to address functional workflows. This profile differs from XDW in that it is not limited to sharing of documents. This profile is a workflow profile that streamlines the ability to share information that will enhance clinical workflow by focusing on information that is used to support care coordination.

<A one page proposal is preferred. Please do not exceed two pages.>