

IHE Work Item Proposal (Detailed)

# Proposed Work Item: Dynamic Care Planning

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**Summary**

HL7 and IHE have in the past produced standards for interchange of *documents* that are care plans or contain care plans. This profile will produce a means for a dynamic and shared “organizing care plan” which will facilitate aggregation and exchange of data resulting in consolidating of plans of care and treatment plans to support care coordination. This will be accomplished without violating the autonomies of the various types of care plans such as discipline specific care plans, disease management care plans, treatment plans, etc.

The profile will utilize HL7 Care Coordination Service (CCS) Functional Model Capabilities to define the needed aspects of care coordination and planning. CCS is based on HL7 Care Plan Domain Analysis Model (CP DAM).

The goal is to have a central Care Plan that meets the needs of many people (providers, patients, payers, etc). This central care plan will be dynamically updated as the patient interact with the health care system. FHIR resources (clinical, workflow, scheduling, etc) and infrastructure will be used as the back bone to provide the operational pieces needed for dynamic care planning.

# The Problem

Care plans have many different meanings to many different people. Each discipline has its own definition of what a care plan is and what it contains. This profile will use the term care plan for the framework created to solve the problems identified in the bulleted list below. We know that many bodies of work are ongoing related to this topic. Intentions are to build from that work and also to contribute.

As identified in the Nursing White Paper to Advocate the Uptake of Patient Plan of Care and eNursing Summary Profiles July 2012, each clinical discipline’s plan of care or treatment plan should be incorporated into one overarching central Care Plan for the patient. The issue we are trying to solve is to develop a Care Plan profile that will support one dynamic central care plan for the patient. This would expand the care plan from only being discipline specific to an interdisciplinary care plan where all disciplines that care for the patient are able to communicate their plan of care, treatment plan, health issues, interventions and goals/outcomes, for the patient.

The new profile will address many of the needs not met in many document based static use case specific care plans:

* A centralize dynamic care plan that meets the needs of many stakeholders (providers, patients, payers, etc);
* A method to consolidate the many care plans that can be attached to a patient;
* Provide a framework for centralized dynamic care planning.

Globally, the healthcare system is highly fragmented. Fragmentation can increase the number of hospital re-admissions. According to claims data reported for the Medicare beneficiaries in 2003-2004, 19.6% of re-hospitalizations occur within 30 days after discharge. This translated into $17.4 billion dollars in hospital payments from Medicare in 2004.[[1]](#footnote-1)

The numbers of service delivery encounters required by individuals, as well as, the failure to deliver and coordinate needed services, are significant sources of frustration and errors, and are drivers of health care expenditures. Providing person-centered care is particularly important for medically-complex and/or functionally impaired individuals given the complexity, range, and on-going and evolving nature of their health status and the services needed. Effective, collaborative partnerships between service providers and individuals are necessary to ensure that individuals have the ability to participate in planning their care and that their wants, needs, and preferences are respected in health care decision making.

The ability to target appropriate services and to coordinate care over time, across multiple clinicians and sites of service, with the engagement of the individual (i.e. longitudinal coordination of care) is essential to alleviating fragmented, duplicative and costly care for these medically-complex and/or functionally impaired persons.

# Use Cases

* 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 ensuring that needed clinical information is received (when authorized) by the multiple Providers involved in a patient’s care and supports safe and effective transitions in care from one care environment to another.

* Chronic Disease Management

The purpose of this use case is to illustrate the communication and 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.

# Standards & Systems

Standards

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

Systems

* EHR
* PHR
* Patient Portal
* HIE

# Technical Approach

Coordination Framework: Understand the HL7 CP DAM [[2]](#footnote-2)as a model framework supports the ability for Care Plans and fragments to be collected and sorted as an interleaved “deck” of Care Plan parts for collaboration purposes. Profiling FHIR resources will be used to support the CCS capabilities such as care plan management, care team membership and care team. communication.

**New actors**

Care Plan Manager

Possibly others depending on standards discovery

**Existing actors**

Content Creator

Content Consumer

Reconciling Agent

**New transactions (standards used)**

Content Creator

* New Transactions

Content Consumer

* New Transactions

**Impact on existing integration profiles**

As a coordinating framework, the Dynamic Care Plan could inform the care plan structures of future profiles and could be mapped to preexisting document based profiles such as the Patient Care Plan (PtCP). It could be leveraged relative to any other profile that includes care plans, plans of care, treatment plans, or instructions.

# 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 carePlan profiling.

# Open Issues

# Effort Estimates

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

1. Coleman, MD. MPH, Eric A. "Preparing Patients and Caregivers to Participate in Care Delivered Across Settings: The Care Transitions Intervention." *Journal of the American Geriatric Society* 52, (2004): 1817-1825. [↑](#footnote-ref-1)
2. See <http://wiki.hl7.org/images/1/1d/PCWG_Care_Plan_DAM_Specification_-_Part_1_-_Draft_2015-11-04.pdf>   [↑](#footnote-ref-2)