IHE Work Item Proposal (Short)

# Proposed Work Item: Care Team Management

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Domain: Patient Care Coordination (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 care team management for the same patient between applicable care providers and the patient/caregiver to support dynamic, evolving and ongoing care coordination.

# Key Use Case

A 78 year old patient is admitted to hospital for planned right hip arthroscopic surgery. Upon discharge from the hospital, patient is transitioned to specialist care (orthopedic surgeon) and home health 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. This involves sharing information that supports care coordination between care providers that includes hospital discharge planning and transfer of care to the surgeon, the primary care provider, the Home Health Agency 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

Standards

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

Systems

* EHR
* PHR
* Patient Portal
* HIE

# 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 a Patient Care Coordination workflow profile that supports the ability to coordinate providers and caregivers that participate in the care of a patient in a comprehensive 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.