IHE Work Item Proposal (Short)

# Proposed Work Item: Dynamic Care Planning Definition

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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 plan care for patients that isn’t derived directly from clinical relevant order sets, protocols, clinical practice guidelines, etc. This is needed to inform providers and patients of the care needed in real time which would assist in care provision. There need to be a means of defining how care planning interventions can be derived from clinical relevant order sets, protocols, clinical practice guidelines, etc. as part of the clinical workflow.

FHIR may provide a solution to the solution. However, there is not enough guidance provided by HL7 FHIR resources on the use of FHIR PlanDefinition resource to create CarePlan activities.

<Describe the Value Statement: What is the underlying cost incurred by the problem and what is to be gained by solving it? If possible provide quantifiable costs, or data to demonstrate the scale of the problem.>

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 exchange and aggregate information needed to create care plans for patients from applicable order sets, protocols and/or clinical practice guidelines to support dynamic, evolving and ongoing care.

# 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. 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 create care planning information that supports the following interactions:

1. Acute care hospital discharge planning and transfer of care information with the surgeon’s post hip arthroscopic surgery order set.
2. Acute care hospital discharge planning and transfer of care information with the Home Health Agency admission protocol.

After the patient is referred for home health services, the specialist and the PCP is contacted for approval of the initial assessment and plan of care orders. These transactions results in sharing of care planning information that supports the following interactions:

1. Home Health Agency initial assessment with plan of care orders with the surgeon’s hip arthroscopic surgery protocol
2. Home Health Agency with the PCP diabetes and rheumatoid arthritis care protocol

# 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 a Patient Care Coordination workflow profile that supports the ability to dynamically create and update patient care plan information 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 content issues as well as functional workflows. This profile differs from XDW in that it is not limited to sharing of documents although sharing of documents will be supported. This profile is a workflow profile that streamlines the ability to create and share information that will enhance clinical workflow by focusing on the data that is created and shared and how it’s shared and updated.