IHE Work Item Proposal (Short)

# Proposed Work Item: Dynamic Care Planning

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Date: October 7, 2015

Version: 1

Domain: PCC

# The Problem

The ability to provide coordinated services and patient care over time is currently fragmented, often duplicative, and costly. Providing dynamic care planning, thus allowing plans, goals, interventions, and requests for services across multiple care settings has the potential to improve care at reduced costs.

The World Health Organization (WHO) stipulates approximately 63% of all annual deaths are due to non-communicable or chronic diseases[[1]](#endnote-1). US Medicare claims data reports $17.4 billion dollars was spent on re-admissions to hospital within 30 days of discharge in 2004[[2]](#endnote-2). 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 exchange and aggregate data for the same patient to/from applicable care providers and the patient/caregiver team to support dynamic, evolving and ongoing care.

# 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 share care planning information that supports the following interactions:

1. Acute care hospital discharge planning and transfer of care information with the surgeon
2. Acute care hospital discharge planning and transfer of care information with the Home Health Agency

The hospital shares the discharge summary with post discharge and transfer of care information. After the information is shared, the hospital may need to

* Amend original information in the discharge summary (including patient-specific orders – e.g., a change in medication, addition of more orders, update clinical findings, etc)
* Provide additional information about the patient such as a summary of the hospital course.

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 with the surgeon
2. Home Health Agency with the PCP

After the initial assessment and plan of care orders is sent, the home health agency may need to

* Amend original information in the assessment and plan of care documents (including patient-specific orders and observations – e.g., a change in medication, change in nursing care, change in observation details, etc).
* Provide additional information about the patient during the care period.
* Provide additional information about the patient when the care period has ended.

The current attempt to share static documents which represents a point in time can be improved only by new approaches where care teams and granular content for a patient may be dynamically shared.

# 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
* PIX
* ATNA

Systems

* EHR
* PHR
* Patient Portal
* HIE

# Discussion

This profile should be a Patient Care Coordination profile that supports the ability to dynamically share 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 as well as technical issues. This profile differs from XDW in that it is not limited to sharing of documents although sharing of documents will be supported. This profile will use HL7 Care Coordination Services as a basis for profiling well identified requirements for dynamic care planning. It streamlines the ability to share information that will enhance clinical care.

1. http://www.who.int/features/factfiles/noncommunicable\_diseases/facts/en/ [↑](#endnote-ref-1)
2. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3771544/ [↑](#endnote-ref-2)