Patient Care WG
Thursday Q1

Care Plan DAM 2.0
Progress report

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Assessment & Evaluation in Cycle of Care Planning and Care

https://docs.google.com/document/d/1OJxtJiQMTVqRa5DtGrlZDd52gV5P8OR7x5suDvdYq4E/edit#heading=h.3c03cjrb5rok
Social determinants of health and Care Planning

Positive and negative SDoH factors impact on health

Negative SDoH factors

Health Outcomes

Quality of life
- No health insurance
- Did not receive needed health care
- Did not get required health checks/screening
- Did not have required vaccination

Length of life
- Poor housing quality
- Poor air, water quality
- Inadequate/no public transportation
- Unsafe/high crime neighbourhood

Geographical/population level factors impacting Individual’s health
- Leave school without graduating
- Low literacy and numeracy
- Household poverty
- Lack/no personal transportation
- Poor/no family support
- Poor/no community support

Health care

Physical Environment

Economic & social factors

Individual factors & health behaviours

Policies & Programs
Representing SDoH factors in Care Plan

High level examples

Social Determinants of Health Factors/Issues

- Social Determinants of Health Issues
  - Health Services Issues
  - Personal & Behavioural Issues
  - Socio-economic Issues
  - Physical & Environmental Issues

Low income, poverty issues
- Example: Low literacy/language problem: reduced capability to read, understand health and care information

Education, literacy, language issues

Housing security/instability issues
- Example: Homelessness: very difficult/impossible to locate patient and provide home care services

Housing quality issues

Care Plan

- Assessment/Observation
  - Example:
    - Over-crowdedness, inadequate heating: impacts negatively on physical & mental health (concern/problem)
    - Poor lighting affects readability of medication instruction (risk)

- Health Concern (includes Concern or Risks)
  - Barrier
  - Preference
Gaps in care – Scope
How care plan contributes to addressing gaps in care, in particularly in transition of care

Examples:
- Individual does not get the care his/she should have received
- Care planned or delivered is inappropriate to (or wasteful care) /inadequate for the needs of the individual
- Care planned or delivered is not culturally appropriate to the individual
- Patient “falls through the crack” when patient is transferred between care providers

Two approaches:
- Prospective aspect/approach
- Reactive/retrospective/approach
Care activities – order sets and orders

- Care activities in care plan are planned interventions
  - Intended outcomes: to achieve health goals and targets
  - Evidence-based: driven by clinical guidelines and protocols
  - Instantiated in EMR/EHRS as order sets and/or orders
  - Outcomes: determined by ongoing assessment/evaluation

- Development work:
  - In progress
Care coordination

- Synonym for Care “Planning” which provides ongoing support for
  - Continuously “Assessing” and Provision of Assessments
    - Use of Assessment tools, determining assessment results, setting goals, etc
  - Preventing, Identifying and Fixing Gaps in Care
  - Identifying, Evaluating and Resolving SDOH
  - Identifying, Evaluating and Completing Care Activities
    - Utilizing Guidelines/Protocols
  - Integrating Payer support with clinical needs
  - Care Team Management
    - Utilizing collaborative process of evaluating and planning appropriate actions
  - Identifying and Supporting Patient Preferences
Multiple Chronic Conditions (MCC) eCare Plan Project

- Joint U.S. AHRQ-NIDDK Project
- Objective: To develop an **interoperable electronic care plan** to facilitate aggregation and sharing of critical patient-centered data across home-, community-, clinic- and research-based settings for people with MCC
- Deliverables:
  - open-source clinician facing SMART on FHIR eCare Plan application
  - HL7® Fast Health Interoperability Resource (FHIR®) Implementation Guide

More info see [here](#)
# Multiple Chronic Condition (MCC) eCare Plan

## 2019 – 2023 Roadmap

<table>
<thead>
<tr>
<th>Track 1</th>
<th>Track 2</th>
<th>Track 3</th>
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<tr>
<td><strong>Months 1-6</strong></td>
<td><strong>Develop CIMS, e-care plan app &amp; IG for CKD</strong></td>
<td><strong>Develop repository &amp; app development collaborative</strong></td>
<td><strong>Expand e-care plan data elements &amp; standards: CVD, T2D, Pain</strong></td>
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<td><strong>Track 2</strong></td>
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<td><strong>Expand CIMs &amp; revise e-care plan app &amp; IG</strong></td>
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*Developed by Health Level Seven (HL7)*
MCC eCare Plan Roadmap Sept 2019 to Sept 2020

1. Identify Candidate CIMS
   - Conduct CIM Gap Analysis
   - Modify and Develop new CIMS

2. eCare Plan APP
   - Create Development and Testing Environment
   - Develop SMART on FHIR Application
   - Continuous integration and testing

3. eCare Plan FHIR IG
   - Identify Use Cases
   - Develop Draft FHIR Implementation Guide for testing
   - AHRQ ACTION III Pilot Coordination
   - Technical Expert Panel Coordination

Timeline:
- Sep - Oct 19: Identify Candidate CIMS
- Nov - Dec 19: Create Development and Testing Environment
- Jan - Feb 20: Develop SMART on FHIR Application
- Mar - Apr 20: HL7 May San Antonio WGM
- May - Jun 20: HL7 PSS Due JAN 2020
- Jul - Sep 20: Modify and Develop new CIMS

Additional Milestones:
- Project Kick-Off 20190923
- HL7 Sept Baltimore WGM
- APP & IG Ready for Testing at HL7 FHIR Connectathon SEP 2020
<table>
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<tr>
<th>Deliverables</th>
<th>Timeline</th>
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<tr>
<td>Clinical Information Model (FHIR Profile) Gap Analysis Mapping and definition</td>
<td>March 2020</td>
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<tr>
<td>Value Set Definitions</td>
<td>June 2020</td>
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<tr>
<td>Care Planning, Plan Definition, and Clinical Guidelines Framework for MCC eCare Plan</td>
<td>June 2020</td>
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<tr>
<td>Draft IG (non-balloted)</td>
<td>Sept 2020</td>
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<tr>
<td>SMART on FHIR App v1.0 (ready for testing)</td>
<td>Sept 2020</td>
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<td>Connectathons</td>
<td>Sept 2021 – May 2022</td>
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<td>Submit for STU ballot</td>
<td>Sept 2022</td>
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<td>Complete STU reconciliation</td>
<td>Feb 2023</td>
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<tr>
<td>Request STU publication</td>
<td>Feb 2023</td>
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<tr>
<td>Submit for Normative Ballot</td>
<td>Sept 2023</td>
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<tr>
<td>Complete Normative Reconciliation</td>
<td>Feb 2024</td>
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Patient Care Workgroup

Care Plan topics

- **Essential Information for Children with Special Healthcare Needs**
  - For communicating patient preferences/plans in settings including urgent or emergent care
  - Initially envisioned as a possible distinct CDA template
  - Transitioned to rendering of use-cases among FHIR resources including the Care Plan resource
  - Have created multiple use-cases for complex patients with unique features, such as
    - 1 month-old with metabolic disorder (OTC deficiency) presenting to emergency department
    - 18 year-old with cystic fibrosis transitioning care providers
    - 7 year-old with autism and seizure disorder on a ketogenic diet
    - More details available: [https://confluence.hl7.org/display/PC/Essential+Information+for+Children+with+Special+Health+Care+Needs](https://confluence.hl7.org/display/PC/Essential+Information+for+Children+with+Special+Health+Care+Needs)
- Also rendering these scenarios via resources in Clinicians of FHIR (CoF) tracks/meetings
- May be relevant for the Multiple Chronic Condition (MCC) eCare Plan, as well
Child health record projects

**US Realm**

- HL7 EHRS-FM Release 2 Functional Profile: Child Health Functional Profile Release 1; Developmental Screening and Reporting Services Derived Profile, Release 1 - US Realm
  - Identifies the critical EHR capabilities for Pediatric Developmental Screening and Reporting services
  - Provides a documentation standard for the development of pediatric developmental screening and follow-up functions in EHR systems that align with existing regulatory and clinical care standards
  - Facilitates documentation and information exchange for clinical decision making
  - Facilitates aggregate reporting to relevant entities including public health agencies 

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What’s Next?

- Patient/Caregiver
  - Participation
  - Preferences
- Care Coordination/Care Team
- Planning Ballot – Sept 2020

- Ongoing meetings – Wednesdays 5pm EST (Join us!)
  - Care Plan DAM 2.0 and MCC eCare Plan (alternate Wednesdays)
  - https://join.freeconferencecall.com/patientcare

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