eCare Plan for People with Multiple Chronic Conditions (MCC)

PC-WG work plan for MCC eCare Plan

Joe Bormel, Lorraine Constable
Cognitive Medical Systems

Meeting Recorded 2021-06-23
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Technical Expert Panels; Advisors: Floyd Eisenberg, Bryn Rhodes, many others.

See Implementation Guide for comprehensive references to contributors.
Objectives-
here is what we want to get out of discussion today

"Computable Goals" for MCCs

What are the issues and options?
### Agenda

<table>
<thead>
<tr>
<th>June 21, 2021</th>
<th>Progress:</th>
</tr>
</thead>
</table>
| 5:00-6:00 PM  | Last session, 6/9  
**Issues around goal model in a variety of projects including MCC eCare Plan, The Gravity Project, FHIR Clinical Guidelines (CPG), PACIO, and Problem-based Charting/Provider Notes/Team Management** |
|               | prior sessions here:  
https://confluence.hl7.org/display/PC/MCC+Meeting+Minutes |

<table>
<thead>
<tr>
<th>5:10pm - 5:30pm</th>
<th>Plan:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1) <em>Problem Definition: Creation of ‘computable goals’ for MCCs</em></td>
</tr>
</tbody>
</table>
|                  | 2) *Available tools for*  
  a) Structuring the guideline  
  b) Formalizing the expression  
  c) Accessing the data |
| 5:30pm - 6pm     | 3) *Open Discussion* |

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Project Management: Katiya Shell, katiya.shell@emiadvisors.net, Gena Ford, gford@cognitivemedicine.com
Implications for Computable Goals for MCCs

Logical Sequence:

1. standardizing the goals data and data underlying display / evaluation
2. moving the standardized data (source-specific bi-directional mapping and translation)
3. change management
4. ultimate uses and related governance
Vision
the ability to think about or plan the future with imagination or wisdom.

Your plan

1 2 3 4

Reality

https://www.youtube.com/watch?v=9vJRopau0g0
Implications for MCC

standardizing the data
Content Model

moving the standardized data
Exchange Model

Gaining awareness, acceptance and commitment of stakeholders

Implied: Co-existence of CSCP with CDS and eCQMs (?improvement?) made explicit through computable IGs

doing cool things* with the data in practice

‘Cooperative’ artifacts (e.g. dictionary) raises the issue of the disposition of the stakeholders; h/o skipping 1,2,3

* manage cost, quality, access

How does the curation scale?

Requires curating the implied cooperative dictionary

https://www.youtube.com/watch?v=9vJRopau0g0
Computable Goals for MCCs
Pros and Cons of eCQMs cast as computable goals

1. PROs: eCQMs represent the closest artifacts to Computable Goals in that:
   a. The data definitions and exchange issues have a 10+ year history of VSAC support for value set definitions (NIH/NLM/VSAC launched December 2012)
   b. Over that time, $1.3B has been spent developing measures.
   c. Many measures can be cast as computable goals; and process measures often align well with Care Plan activities.
   d. Many measures should be expressed by competent professionals for indicated patients as computable goals
   e. Rich authoring tools including the VSAC, MAT and Bonnie exist and proven to develop and test measures
   f. Providers and Payers are familiar with eCQMs; there are 2,266 measures developed with 788 in use (see breakdown by type; >200 are outcome which are clinical goals)

2. CONs:
   a. MCC’s recognize that “multiple’ conditions is a distinct model
   b. Some quality improvement measures are just quality measures; they are population health focused vs person / individual goals of care plan
   c. Can be associated with non-value-add provider documentation burden
   d. CMS life cycle requirements for eCQMs are distinct from CSCP needs
   e. eCQMs are skewed to process measures at present
   f. eCQMs for a variety of reasons tend to billing codes designs
All eCQMs associated with: Management of Chronic Conditions

<table>
<thead>
<tr>
<th>Year</th>
<th>Type</th>
<th>CMS eCQM ID</th>
<th>Measure Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022</td>
<td>EP/EC</td>
<td>CMS529v10</td>
<td>Diabetes: Hemoglobin A1c (HbA1c) Poor Control (&gt; 9%)</td>
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<tr>
<td>2022</td>
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<td>CMS532v10</td>
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<td>EP/EC</td>
<td>CMS534v10</td>
<td>Diabetes: Medical Attention for Nephropathy</td>
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<td>2022</td>
<td>EP/EC</td>
<td>CMS535v10</td>
<td>Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) or Angiotensin Receptor-Neprilysin Inhibitor (ARNI) Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
</tr>
<tr>
<td>2022</td>
<td>EP/EC</td>
<td>CMS544v10</td>
<td>Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
</tr>
<tr>
<td>2022</td>
<td>EP/EC</td>
<td>CMS545v10</td>
<td>Coronary Artery Disease (CAD): Beta-Blocker Therapy-Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF &lt;40%)</td>
</tr>
<tr>
<td>2022</td>
<td>EP/EC</td>
<td>CMS557v10</td>
<td>Oncology: Medical and Radiation - Pain Intensity Quantified</td>
</tr>
<tr>
<td>2022</td>
<td>EP/EC</td>
<td>CMS565v10</td>
<td>Controlling High Blood Pressure</td>
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<tr>
<td>2022</td>
<td>EP/EC</td>
<td>CMS567v6</td>
<td>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease</td>
</tr>
<tr>
<td>2022</td>
<td>EP/EC</td>
<td>CMS634v6</td>
<td>Bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy</td>
</tr>
</tbody>
</table>
Data standardization - Objective estimate of scope

COVID diagnosis

Overall Cohort
Patients with COVID-19 diagnosis

COVID-19 Patients:
N = 629,144

Diagnosis only in EHR
N = 131,336 (21%)

Diagnosis in both
N = 45,423

Diagnosis only in claims
N = 452,385 (72%)
Goal may have anticipatable tasks
Use Case:
Goal: Maintain Therapeutic Warfarin Dose

https://www.ncbi.nlm.nih.gov/books/NBK470313/
Applying this 35 page, L1 evidence-base presupposed assured terminology conformance into Care Plan

**Health Concerns** represented with:
- CorePlan.addresses
- CorePlan.supportingInfo
- CorePlan.addresses (from within referenced goal)
- Goal.addresses
- activity.reason.reference

**Goals** represented with:
- CorePlan.goal (for entire plan)
- resource-pertainsToGoal

**Interventions** represented with:
- CorePlan.plannedActivityReference (aka activity.reference)
- CorePlan.performedActivityReference (aka activity.outcome.reference)

**Outcomes** represented with:
- CorePlan.ActivityOutcome
- Goal.outcome.reference

Current State:
Receive INR result; if it's within therapeutic range, Continue same dose

Future State with Comprehensive Shared Care Plan with computable goals:
1. find/retrieve relevant diagnosis (active problem) and specific INR target
2. review trend of prior INRs (lab) and prior prescribed dosages (through means - medication statement, admin record, other resources)
3. retrieve specific indication for warfarin {strong adherence to content model}
   a. Deep Vein Thrombosis, (first occurrence)
   b. Heart Attacks
   c. Strokes or Transient Ischemic Attacks
   d. Pulmonary Embolism
4. scan for adverse event CBC, asking about bleeding, etc
5. look up how they want to be notified? (patient.contact.telecom [sliced for rank])
6. … any other information accessing steps …
## 11.4 Resource MedicationStatement - Content

<table>
<thead>
<tr>
<th>Name</th>
<th>Flags</th>
<th>Card.</th>
<th>Type</th>
<th>Description &amp; Constraints</th>
</tr>
</thead>
<tbody>
<tr>
<td>MedicationStatement</td>
<td>TU</td>
<td>0.*</td>
<td>DomainResource</td>
<td>Record of medication being taken by a patient. Elements defined in Ancestors: id, meta, implicitRules, language, text, contained, extension, modifierExtension</td>
</tr>
<tr>
<td>identifier</td>
<td>Σ</td>
<td>0.*</td>
<td>Identifier</td>
<td>External identifier</td>
</tr>
<tr>
<td>basedOn</td>
<td>Σ</td>
<td>0.*</td>
<td>Reference(MedicationRequest</td>
<td>CarePlan</td>
</tr>
<tr>
<td>partOf</td>
<td></td>
<td></td>
<td></td>
<td>Information</td>
</tr>
<tr>
<td>reasonCode</td>
<td>0.*</td>
<td>CodeableConcept</td>
<td>Reason for why the medication is being/was taken</td>
<td></td>
</tr>
<tr>
<td>reasonReference</td>
<td>0.*</td>
<td>Reference(Condition</td>
<td>Observation</td>
<td>DiagnosticReport)</td>
</tr>
<tr>
<td>note</td>
<td>0.*</td>
<td>Annotation</td>
<td>Further information about the statement</td>
<td></td>
</tr>
<tr>
<td>dosage</td>
<td>0.*</td>
<td>Dosage</td>
<td>Details of how medication is/was taken or should be taken</td>
<td></td>
</tr>
</tbody>
</table>
Formal alignment with approved uses and issues

FDA-approved clinical uses for warfarin:

- Prophylaxis and treatment of venous thrombosis and arising pulmonary embolisms
- Prophylaxis and treatment of thromboembolic complications from atrial fibrillation or cardiac valve replacement
- Reduction in the risk of death, recurrent myocardial infarction, and thromboembolic events (e.g., stroke, systemic embolization) after myocardial infarction

Adverse Effects

Serious adverse effects of warfarin include bleeding and significant hemorrhage. A major hemorrhage (e.g., intracranial hemorrhage, gastrointestinal (GI) bleed, hematomas, intraocular bleeding, hemorrhoids) can occur at virtually any site on the body. Patients should receive education about the easy bleeding or bruising that is a common adverse effect. A clinician should also counsel patients about the proper management of cuts, bruises, and nosebleeds.

The risk of bleeding and hemorrhage is dependent on multiple variables, including the intensity of anticoagulation and patient susceptibility. Individuals should undergo an assessment for their risk, with appropriate adjustments to their treatment plan made accordingly.

Other adverse effects include nausea, vomiting, abdominal pain, bloating, flatulence, and an altered sense of taste.

FDA-Approved uses:

- Prophylaxis and treatment of venous thrombosis and arising pulmonary embolisms
- Prophylaxis and treatment of thromboembolic complications from atrial fibrillation or cardiac valve replacement
- Reduction in the risk of death, recurrent myocardial infarction, and thromboembolic events (e.g., stroke, systemic embolization) after myocardial infarction

Continuing Education Activity

Warfarin is a medication used in the prophylaxis and treatment of venous in the anticoagulant class of drugs. This activity reviews the indications, a speakable, point in the speakable, point in the treatment of myocardial infarction.
Use Case: CKD in MCC eCare Plan, **computable goals** will need to be stated and valid against the IG (... and Evidence Resources, and anointed CPGs)

**Health Concerns** represented with:
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- CarePlan.supportingInfo
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- activity.reason.reference

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Goal: Evaluate for Renal Transplant or Dialysis

Problem Definition: Creation of ‘computable goals’
Available tools for
a) Structuring the guideline
b) Formalizing the expression
c) Accessing the data

Consensus Guidelines on Treatment of CKD/Preparation for Dialysis:
- Clinic follow-up, including modality education, dietary instruction, and comprehensive clinical management for at least 6 months prior to initiation
- CVD risk reduction: physical activity, smoking, lipids
- Blood pressure
- Mineral and bone disorders: control of calcium, phosphorus, PTH
- Anemia management
- Hepatitis B immunization
- Renoprotection: angiotensin II antagonists (ACE inhibitor, ARB)
- Assessment for transplant and referral prior to initiation
- Access: functioning fistula or PD catheter at initiation of dialysis

Ways to achieve information access for computable goals in FHIR

1. Structuring the guidelines (PlanDefinition)
2. Formalizing the computation/expressions e.g. CQL and data sources
3. Accessing the data
   a. server-side bulk
   b. server-side piece
   c. client-side methods
      i. {std FHIR query, use of FHIRpath, FHIR filter search operations}
PlanDefinition

https://www.hl7.org/fhir/plandefinition.html
# PlanDefinition - relationship to computable goals

## Terminology Bindings

<table>
<thead>
<tr>
<th>Path</th>
<th>Definition</th>
<th>Type</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>PlanDefinition.type</td>
<td>The type of PlanDefinition.</td>
<td>Extensible</td>
<td>PlanDefinitionType</td>
</tr>
<tr>
<td>PlanDefinition.status</td>
<td>The lifecycle status of an artifact.</td>
<td>Required</td>
<td>PublicationStatus</td>
</tr>
<tr>
<td>PlanDefinition.subject[x]</td>
<td>The possible types of subjects for a plan definition (E.g. Patient, Practitioner, Organization, Location, etc.).</td>
<td>Extensible</td>
<td>SubjectType</td>
</tr>
<tr>
<td>PlanDefinition.action.subject[x]</td>
<td>High-level categorization of the definition, used for searching, sorting, and filtering.</td>
<td>Example</td>
<td>DefinitionTopic</td>
</tr>
<tr>
<td>PlanDefinition.jurisdiction</td>
<td>Countries and regions within which this artifact is targeted for use.</td>
<td>Extensible</td>
<td>Jurisdiction ValueSet</td>
</tr>
<tr>
<td>PlanDefinition.topic</td>
<td>Example codes for grouping goals for filtering or presentation.</td>
<td>Example</td>
<td>GoalCategory</td>
</tr>
<tr>
<td>PlanDefinition.goal.category</td>
<td>Describes goals that can be achieved.</td>
<td>Example</td>
<td>SNOMEDCTClinicalFindings</td>
</tr>
<tr>
<td>PlanDefinition.goal.pRIORITY</td>
<td>Indicates the level of importance associated with reaching or sustaining a goal.</td>
<td>Preferred</td>
<td>GoalPriority</td>
</tr>
<tr>
<td>PlanDefinition.goal.start</td>
<td>Identifies the types of events that might trigger the start of a goal.</td>
<td>Example</td>
<td>GoalStartEvent</td>
</tr>
<tr>
<td>PlanDefinition.goal.addresses</td>
<td>Identifies problems, conditions, issues, or concerns that goals may address.</td>
<td>Example</td>
<td>Condition/Problem/DiagnosisCodes</td>
</tr>
<tr>
<td>PlanDefinition.goal.target.measure</td>
<td>Identifies types of parameters that can be tracked to determine goal achievement.</td>
<td>Example</td>
<td>LOINC-Codes</td>
</tr>
<tr>
<td>PlanDefinition.action.priority</td>
<td>Identifies the level of importance to be assigned to actioning the request</td>
<td>Required</td>
<td>RequestPriority</td>
</tr>
</tbody>
</table>

[https://www.hl7.org/fhir/plandefinition.html](https://www.hl7.org/fhir/plandefinition.html)
Examples of computable goals in FHIR Guidelines

Should this “Goal: CHF cardiology consult” be an example in the Goal Resource, AND identically in the iteration of the MCC eCare Plan that covers CHF?

[IG Style guide issue?]
GraphQL - one part of a pathway to the data

Problem Definition: Creation of ‘computable goals’
Available tools for
a) Structuring the guideline
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Problem Statement

- Well described modular schema + CRUD Operations
- Client applications built against the API
- User interface applications require a set of resources
- To build a view e.g. List of encounters
  - For each encounter, fetch the patient to get their name
  - For each encounter, fetch the consulting physician to get their name
  - For each encounter, fetch the ward location to get it’s name
  - etc
- Similar for almost every operation

GraphQL and GraphDefinition

- Both are concerned with scanning across resources
- GraphQL
  - Select a subset of information across a graph of resources
  - Return content is not actually resources
- GraphDefinition
  - Specify a set of rules about relationships between resources
  - May be used to retrieve a set of resources

Getting a set of resources: ideal

- Just fetch what you want to display:
- Fetch the elements from encounter that you want to display
- Get the server to replace the links to the other resources with your choice of display for them

- No work on the client...

- Price: bandwidth (down), latency * 1

https://www.youtube.com/watch?v=_1alqp_3e24
3.1.2.4 Field Selection

Any FHIR defined field can be used directly e.g. this graphql against the Patient resource (r3):

```json

{  
  name (text, given, family)  
}
```

Example: `http://test.fhir.org/r3/Patient/example?graphql?query={name(text,given,family)} (note: examples are only informative).

Polymorphic fields are represented by their JSON property name e.g. for Observation.value[x]:

```json

{  
  valueQuantity (value, unit)  
}
```

Example: `http://test.fhir.org/r3/Observation/example?graphql?query={valueQuantity(value,unit)} (note: examples are only informative).

Note: This is because the leaf names have to correspond to scalar types, so there is no use selecting all the variants at once.

Extensions on primitives: the JSON convention for primitives is observed, e.g. use `[name]` for accessing extensions on primitives. So

```json

{  
  birthDate birthDate (extension (valueDateTime)  
}
```

results in

```json

{  
  "birthDate" : "2016-05-18",  
  "_birthDate": {  
    "extension": [  
      {"valueDateTime": "2016-05-18T10:28:42"}  
    ]  
  }  
}
```

Example: `http://test.fhir.org/r3/Patient/example?graphql?query={birthDate,birthDate(extension(valueDateTime))} (note: examples are only informative).

https://www.hl7.org/fhir/graphql.html
Options for accessing data for computable goals

SERVER: (2 steps)
1 define: Create Profiles on Plan Definition the way CPG-on-FHIR does
2 use the definitions:plan definition.apply operation results in a CarePlan
   result depends on what put in expression library {what clinician is often doing manually today}

SERVER: using GraphQL to comb through resources for a sparse result set

CLIENT: Client could go back and forth, gather the data, and make the decisions on client
   (using search, _include, FHIRpath, )

CLIENT: could use application-specific tool e.g. Warfarin calculator (eg SoF)

External Orchestration: Decision Modeling getting coordination with FHIR and BPM+
   could be done in BPM+/DM and returned across a cleavage plane

Other models?

Problem Definition: Creation of ‘computable goals’
Available tools for
a) Structuring the guideline
b) Formalizing the expression
c) Accessing the data
Examples of potential computable goals

**Qualitative**
non-computable
(typically with narrative text)

**Quantitative**
computable from fully codified elements
(no narrative text)
e.g. eCQMs when cast as goals

**Reasoning/Synthesis**
complex-computable
(inference, AI/ML potentially with bias)
## Reasoning/Synthesis Axis

Complex statements (questions), when evaluated from EHR sourced information, for the Quality and Safety Review System, identified 7 classes which map into 3 levels of Relative Complexity Value (RCV)

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Examples</th>
<th>RCV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence of a concept/entity</td>
<td>“Did the patient have a urinary tract catheter inserted during the stay?”</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>“Was an opioid administered to the patient?”</td>
<td></td>
</tr>
<tr>
<td>Numeric value extraction</td>
<td>“During this hospitalization, did the patient have a PTT value greater than 100 seconds?”</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>“What was the birth weight of the neonate?”</td>
<td></td>
</tr>
<tr>
<td>Multiple concept detection</td>
<td>“Which secondary morbidities developed?”</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td>“Which combination of anesthesia and sedation was used?”</td>
<td></td>
</tr>
<tr>
<td>Temporal occurrence of a concept</td>
<td>“On or within the first 24 hours of admission, was a history of allergies and/or sensitivities documented?”</td>
<td>Medium</td>
</tr>
<tr>
<td></td>
<td>“What was the baby's Apgar score 5 minutes after birth?”</td>
<td></td>
</tr>
<tr>
<td>Conditional</td>
<td>“Did bleeding develop more than 24 hours after admission and within 1 day of (’PTT’ &gt; 100 seconds) OR (’Protamine administration’) OR …?”</td>
<td>Medium</td>
</tr>
<tr>
<td></td>
<td>“On any day that the blood glucose was less than 50 mg/dl, which of the following were noted?”</td>
<td></td>
</tr>
<tr>
<td>“Fuzzy” concepts</td>
<td>“Did the patient undergo an unplanned transfer to a higher level care area within the facility or to another facility?”</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>“Was the OR procedure done emergently?”</td>
<td></td>
</tr>
<tr>
<td>Open-ended responses</td>
<td>“If at all, describe how the device harmed the patient.”</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>“Describe the adverse event(s).”</td>
<td></td>
</tr>
</tbody>
</table>
Examples of potential computable goals

**Qualitative**
non-computable  
(typically with narrative text)

**Quantitative**
computable from fully codified elements  
(no narrative text)

e.g. eCQMs when cast as goals

**Reasoning/Synthesis**
complex-computable  
(human and/or machine)  
(inference, potentially with bias)

Goal: Maintain Therapeutic Warfarin Dose 
(synthetic: time in therapeutic range)

Goal: Evaluate for Renal Transplant or Dialysis

Goal: Dance at daughter’s wedding

Goal Class: (simple)
Observation achievement  
e.g. Diabetes control HgA1c <7

goal,target,measure

Goal Class: eCQM attainment as goal

Goal Class: (combo)
Examples of MCV specific eCQMs cast as goals

All eCQMs associated with: Management of Chronic Conditions

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<tr>
<td>2022</td>
<td>EP/EC</td>
<td>CMS143v10</td>
<td>Primary Open–Angle Glaucoma [POAG]: Optic Nerve Evaluation</td>
</tr>
<tr>
<td>2022</td>
<td>EP/EC</td>
<td>CMS144v10</td>
<td>Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)</td>
</tr>
<tr>
<td>2022</td>
<td>EP/EC</td>
<td>CMS145v10</td>
<td>Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF &lt;40%)</td>
</tr>
<tr>
<td>2022</td>
<td>EP/EC</td>
<td>CMS157v10</td>
<td>Oncology: Medical and Radiation – Pain Intensity Quantified</td>
</tr>
<tr>
<td>2022</td>
<td>EP/EC</td>
<td>CMS165v10</td>
<td>Controlling High Blood Pressure</td>
</tr>
<tr>
<td>2022</td>
<td>EP/EC</td>
<td>CMS347v6</td>
<td>Statin Therapy for the Prevention and Treatment of Cardiovascular Disease</td>
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<tr>
<td>2022</td>
<td>EP/EC</td>
<td>CMS445v6</td>
<td>Bone density evaluation for patients with prostate cancer and receiving androgen deprivation therapy</td>
</tr>
</tbody>
</table>

https://ecqi.healthit.gov/mcw/list/meaningful-measure/management-chronic-conditions?field_year_tax_target_id=2316&field_measure_type_target_id=2
## Exemplary Table of computable goals

<table>
<thead>
<tr>
<th>Goals:</th>
<th>Category</th>
<th>Note</th>
<th>Relative Complexity Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapeutic Target</td>
<td>clinical observation</td>
<td></td>
<td>low</td>
</tr>
<tr>
<td>- Warfarin, HgA1C, Weight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interim milestone</td>
<td>diagnostic/therapeutic</td>
<td>Could be captured through a survey workflow</td>
<td>medium</td>
</tr>
<tr>
<td>- approve for dialysis</td>
<td>milestone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Well-being</td>
<td>Quality of Life</td>
<td>Implies a generic translation from free-text goal to Questionnaire</td>
<td>low</td>
</tr>
<tr>
<td>- dance at daughters wedding</td>
<td></td>
<td>Response through some workflow</td>
<td></td>
</tr>
<tr>
<td>Combo</td>
<td>Management Effectiveness</td>
<td>? Dynamically calculated?</td>
<td>high</td>
</tr>
<tr>
<td>- Time in therapeutic Range</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Upcoming Topics

<table>
<thead>
<tr>
<th>Topic</th>
<th>Completed / Potential Available Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Element Review: Provide Project Update and Goal Review</td>
<td>2021-03-03</td>
</tr>
<tr>
<td>Data Element Review: Discuss recognized issues/concerns with T2D</td>
<td>2021-03-17</td>
</tr>
<tr>
<td>Data Element Review: Discuss recognized issues/concerns with CVD</td>
<td>2021-03-31</td>
</tr>
<tr>
<td>Data Element Review: Discuss recognized issues/concerns with Pain</td>
<td>2021-04-21</td>
</tr>
<tr>
<td>Data Element Review: Social Concerns</td>
<td>2021-04-28</td>
</tr>
<tr>
<td>Patient Administration and Value Set Contexts of Use</td>
<td>2021-05-12</td>
</tr>
<tr>
<td>Data Element Review: Goals (+/- use FHIR Goals Resource)</td>
<td>2021-06-09</td>
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<tr>
<td><strong>Computable Goals roles and boundaries</strong></td>
<td>2021-06-23</td>
</tr>
<tr>
<td>Data Element Review: Health Status / Eval</td>
<td>2021-07-07</td>
</tr>
<tr>
<td>Update: experience/progress at OHSU</td>
<td>2021-07-21</td>
</tr>
<tr>
<td>Data Element Review: Interventions</td>
<td>TBD or Deferred</td>
</tr>
<tr>
<td>... more to come through July and August ...</td>
<td>...</td>
</tr>
</tbody>
</table>
Discussion

"Computable Goals - what are the issues and options?"

Specific Questions:

1) Is computable goals as described necessary to usable care plans for MCC? 80/20

2) Can and should there be a layering to support ‘separation of [architectural] concerns’?

3) Does this analysis imply piloting computable goals sooner…?