Lantana
CONSULTING GROUP

CM/DM CARE PLAN REQUIREMENTS

Review and Recommendations for Using the C-CDA R2.0 Care Plan Document

June 17th, 2015

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Commissioned by

BlueCross BlueShield Association

Agenda

Project Briefing for Patient Care WG (30 mins)

- Introduction
  - Historical perspective, goals and approach (5 mins)
    - C-CDA Care Plan Document
    - Identified missing requirements
    - Approach & collaboration
- Results
  - Review of Deliverables (3 mins)
    - Document Design Details
    - Style-sheet transformation – leveraging the design
  - Summary of Key "Gap" Findings (3 mins)
  - Summary of Recommendations (4 mins)
- Next Steps
  - Summary of Next Steps (5 mins)
  - Q/A (10 mins)

SEPTEMBER 2013 HL7 BALLOT COMMENT

CDAR2_IG_CCDA_CLINNOTES_R1_D1_2013SEP Ballot Comment
Supplemental Information

HL7 Implementation Guides for CDA Release 2: Consolidated CDA Templates for Clinical Notes, DSTU Release 2 - US Realm

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The issue

How to document and track patient enrollment in specific Care Management or Disease Management programs.

Background:

As part of providers and payers being in ACOs and the growth of Patient Centered Medical Home, there is a need to know and track which patients are in Care Management programs – to know what treatment protocol is expected, track any special patient/member co-pays or unique benefits, and to help insure it can be document and reported that the patient is in the program.

Historical Perspective

Standards development activities:

- **Consolidated CDA Release 2 (C-CDA R2.0)**
  - New Care Plan Document Template
  - Identified Missing Requirements
- **Pilot Lessons Learned**
  - S&I Framework Longitudinal Coordination of Care (LCC)
- **HL7 Patient Care**
  - Care Plan Domain Analysis Model
  - Added Story Board 8

ABOUT THE PROJECT

Goals and Objectives

Goal:

- Address 19 Requirements (Table 2)
- Demonstrate possible solutions
- Identify gaps

Objectives:

- Develop a generalized approach which could fit many different views of what a Care Plan is
- Educate about C-CDA R2 Care Plan templates
- Elevate CDA usage to a higher level
- Minimize differences between CDA and FHIR

Stakeholder Collaboration

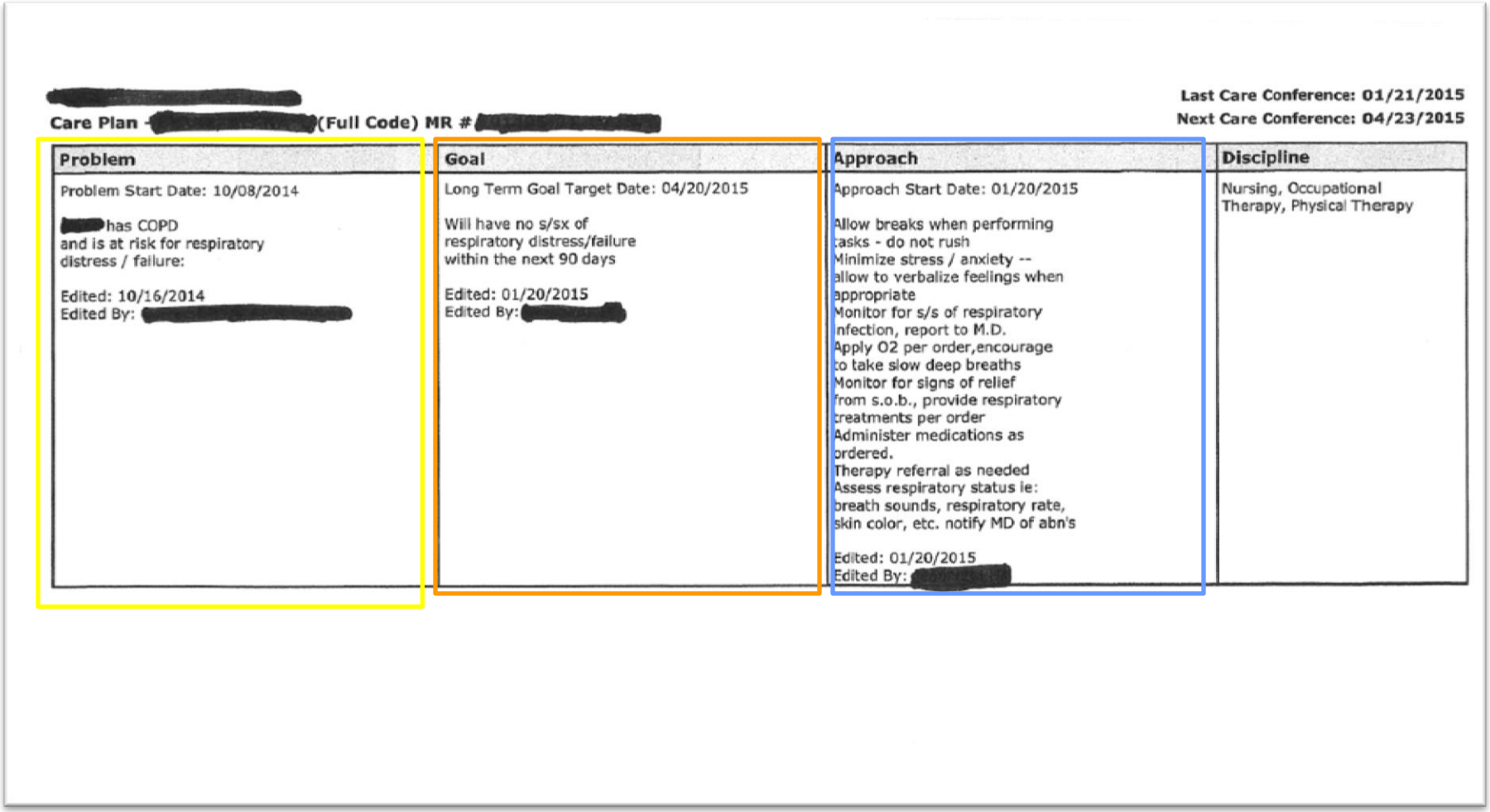
Requirements identification, project input:

- Pilot experimentation and feedback

- **Input from various groups and individuals**
  - Vocabulary and structural design work
  - Collaboration with HL7 Patient Care
  - Report, sketch review and feedback
  - Experimentation with sample plan

- **Sample care plans provided as informative examples**
  - Shelly Spiro – Pharmacy HealthIT Collaborative

Sample Care Plan – 20 pages



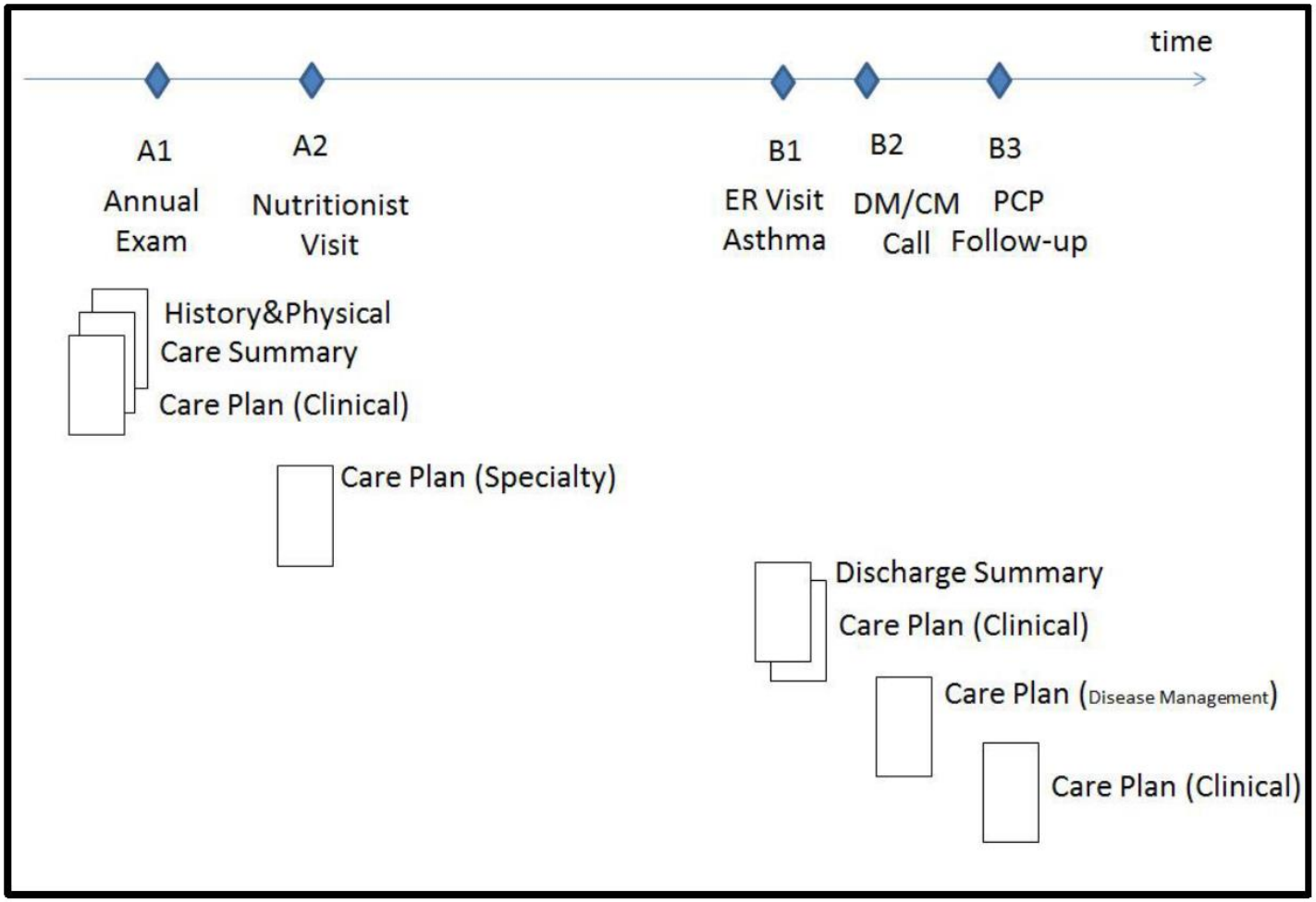
[redacted]

Care Plan - [redacted] (Full Code) MR # [redacted]

Last Care Conference: 01/21/2015
Next Care Conference: 04/23/2015

Problem	Goal	Approach	Discipline
Problem Start Date: 10/08/2014 [redacted] has COPD and is at risk for respiratory distress / failure: Edited: 10/16/2014 Edited By: [redacted]	Long Term Goal Target Date: 04/20/2015 Will have no s/sx of respiratory distress/failure within the next 90 days Edited: 01/20/2015 Edited By: [redacted]	Approach Start Date: 01/20/2015 Allow breaks when performing tasks - do not rush Minimize stress / anxiety -- allow to verbalize feelings when appropriate Monitor for s/s of respiratory infection, report to M.D. Apply O2 per order,encourage to take slow deep breaths Monitor for signs of relief from s.o.b., provide respiratory treatments per order Administer medications as ordered. Therapy referral as needed Assess respiratory status ie: breath sounds, respiratory rate, skin color, etc. notify MD of abn's Edited: 01/20/2015 Edited By: [redacted]	Nursing, Occupational Therapy, Physical Therapy

PC – Care Plan DAM: Story Board 8



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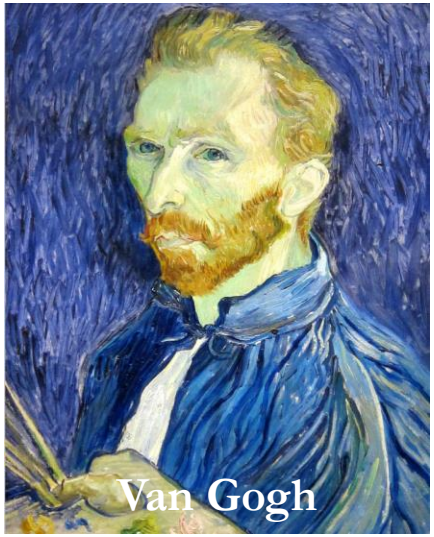
RESULTS



Summary of Deliverables

Deliverables:

- **Report (50+ pages)**
  - 19 CM/DM care plan requirements addressed
- **Context for sketches (Chapter 3.1)**
  - Visualizations of the "longitudinal view"
- **Summarized C-CDA R2.0 care plan document sections and entries**
  - (Appendix A, Table 5)
- **Novel care plan document design (Chapter 3.2)**
  - Care plan "containers" organize human readable content
  - Care plan standard "core sections" organize machine readable entries
  - Multidimensional "linkages" to aid information processing
- **9 CDA Care Plan Documents**
  - (Table 1 (over time), Table 4 (requirements met)
  - Reinforce longitudinal context
  - Demonstrate a way to address CM/DM requirements
  - Identify potential new templates, and current gaps
- **Stylesheet to illustrate processing possibilities that leverage the proposed design (Chapter 3.3)**

Summary of Requirements Addressed (Tables 2,4)

Priority: A B B/C C S=Sketched G=Guidance X=Gap

	Requirement Characterization	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Structure	Care Plan structure – Containers	S	S	S			S	S	S	S	S		S							
Acceptance	Metadata – Acceptance/status				S	S									S	S				
Linking	Linking – internal and external										S	S					S			
Linking	Linking of Outcome Observaction																		G	
Linking	Linking Supplied Edu materials																			G
Uncharted	Types of interventions, barriers, etc.													X						
Uncharted	Goal not met																	X		

TO BE CONTINUED ...

As part 2