Virtual

C-CDA Implementation-A-Thon

Care Plan Document Track

June 22, noon - 5pm ET

Track Lead: Lisa Nelson

Step #1 – Get all Files from Dropbox (and wiki samples)
Step #2 – Send me an e-mail (Lisa@LisaRNelson.com)

Participants

Name	Company	E-mail
Jiong Mao	NextGen	
Marie Swall	US Dept of Veterans Affairs	
Jenna Norton	NIDDK	
Craig Lee	Intersystems	
Linda Michaelson	Optum	
Gordon Raup	Datuit	
Lisa Nelson (track lead)	Life Over Time Solutions, LLC	Lisa@LisaRNelson.com
Aditya Kandregula	ZeOmega	
Sean Muir		
Annette	ONC	
Emma Jones	Allsripts	
Evelyn Gallego		
Dave Carlson		

Virtual C-CDA Implementation-A-Thon Agenda (IAT #5) June 22, 2017 12:00pm – 5:00pm				
Host	**Track Content**	**Start**	**End**	**Skype Meeting link**
Dave Hamill / Dave Degandi	Introduction of track leaders	12:00pm	12:15pm	Join Skype Main Meeting Audio Only: (800) 406-9547 Conference ID: 74691216
	Break out into Tracks			
Track 1: Transition of Care Documents				Join Skype Track 1 Meeting Audio Only: (800) 406-9547 Conference ID: 8929239
Calvin Beebe	Exchange Documents	12:15pm	12:25pm	
Matt Blackmon	Referral Note	12:25pm	1:05pm	
	BREAK			
Ben Flessner	Continuity of Care	1:15pm	1:50pm	
Brett Marquard	Discharge Summary	1:50pm	2:15pm	
Calvin Beebe	Summary of Issues	2:15pm	2:25pm	
	BREAK			
Track 2: Care Plan Discussion & Documents				Join Skype Track 2 Meeting Audio Only: (800) 406-9547 Conference ID: 57869094
Lisa Nelson	Care Plan Discussion	12:15pm	1:05pm	
Lisa Nelson	Exchange Documents	1:05pm	1:15pm	
	BREAK			
Lisa Nelson	Care Plan	1:25pm	2:15pm	
Lisa Nelson	Summary of Issues	2:15pm	2:25pm	
	BREAK			
Report Out – General Discussion (All Attendees)				Rejoin Skype Main Meeting Audio Only: (800) 406-9547 Conference ID: 74691216
Calvin Beebe	Track 1 Issues Report Out	2:35pm	2:50pm	
Lisa Nelson	Track 2 Issues Report Out	2:50pm	3:05pm	
Calvin Beebe	Selected Issues for Discussion	2:05pm	3:45pm	
Ask the ONC – General Discussion (All Attendees)				
Matt Rahn	Scorecard Demo / Ask The ONC	3:55pm	4:30pm	
Wrap Up – General Discussion				
Dave Hamill / Dave Degandi	Wrap Up	4:30pm	4:40pm	

Track 2 Agenda

12:15 – 1:05 (10+40 minutes)
General
Creator: Datuit, 3 Samples (optional)
Consumers: Everyone Else
- Document overview – Gordon
- Everyone Consumes
  – Discuss results
- Talk through Discussion Questions

1:05 – 1:15 (10 minutes)
- Review Issues for Report Out

1:25 – 2:15 (50 minutes) Specialty
Creator: CKD, 2 samples (optional)
Consumers: Everyone Else
- Document overview – CKD team
- Everyone Consumes
  – Discuss results
- Talk through Discussion Questions

2:15 – 2:25 (10 minutes)
- Review Issues for Report Out

What is our success criteria (12:18)?

- Survive the technology
- Render a care plan document that looks clinically relevant
- Share more perspectives
- Understand how well the Care Plan C-CDA will aid providers, not just payers. How does the providers view get supported?

Specific questions we want to cover (12:22) ?

- What about the use of effectiveTime with the width attribute?
- Other clinicians – how can they interact with the care plan and share with physicians? How do we address/improve giving contradictory advice?

Approach (12:25)

- Scenario 1 (General Care Plans)
  - Datuit Sample
    - Overview of sample from Content Creator (10 mins) 12:35
    - Everyone Consume and Discuss Results+ScoreCard output (20 mins) 12:55
    - Talk through questions (10 mins) 1:05
  - Review report out points (10 mins) 1:15
- Break (10 mins) 1:25 [Discuss Jiva Care Plan]
- Scenario 2 (Specialty Care Plans)
  - CKD Sample
    - Overview of sample from CKD Cont (10 mins) 1:35
    - Everyone Consume and Discuss Results (20 mins) 1:55
    - Talk through questions (10 mins) 2:05
  - Review report out points (10 mins) 2:15
- Break (20 mins) 2:35 [Discuss other samples]

General Care Plan

Datuit Sample

Content Creator Discussion (10 mins, 12:35)

- Discuss the Health Concerns Section
  - Present
  - Diagnoses came from discharge Summary
- Discuss the Goals Section
  - Present
  - Care Coordinator added the goals
- Discuss the Interventions
  - Present
  - Medications came from Discharge Summary; Care Plan Manager added other intervensions
  - Each intervention only could reference goal.
- Discuss the Health Status Evaluations and Outcomes
  - Not done
- Linkages – simple to add in the xml. Hard to render with these linkages revealed.
  - Are the id's only internal to the CDA document?
  - Allscripts – supports internal id's (imported ids are also stored to the element can be recognized later)
  - NextGen – internal ids are used (imported ids from other vendors are converted into local ids. External id's will not be saved//used)
  - Intersystems – supports external ids for data elements; we try to resolve the OID in the ID. Both are captured into the internal ID. External IDs are adopted as the internal id if possible.
  - ZeOmega – How are OIDs resolved? Datuit uses HL7.
  - Challenge - spec only mentions unique within the document not explicit
- Discuss other sections of content that may be present in the document
  - No additional sections added.
  - No indicator if people got educational materials
  - How do we see what education the person had received and from whom.
  - Allscripts – would expect to use the instructions template, and link to the actual education was. Both for planned and completed interventions.
  - Ziva – in Interventions

More discussion

- Health Concern section is explicit about where the Problem is
- Goal is not clear about where the goal would be.
  - Allscripts – uses the value element in the goal observation to record the actual goal
  - PACP – uses the value element in the goal observation

Content Consumer Discussion (20 mins,12:55)

- What issue were relevant to expected uses of the Care Plan Document information?
- Dave Carlson – MIE – Sees the three sections. Seeing a medication section also – they are part of the Interventions section.
  - Should there be subheaders in the Intervention section?
  - Stylesheet throws up unknown identifiers.
  - Data would not be imported into the intervention section. Document would be associated with the patients chart and viewable from the chart. Reconcile tool would try to work on demographic and medication info, but medication information wasn't found.
- Emma – viewing with the Allscripts style sheet. Systems would view, attach to record, working on data import (section or entry level). Care Plan import is on their roadmap.
  - Multiple goals can be linked to multiple interventions. Interventions can only reference one goal. Going from Intervention to Goal – need to check on this.
- Aditya – ZeOmega – can recieve a C-CDA Care Plan when pushed to them. Working on how to consume the information. How do other vendors match information? Use of SNOMED CT? If no match, the item is presented to the user and they can add a mapping.

Content Consumer Discussion (20 mins, 12:55)

- What issue were relevant to expected uses of the Care Plan Document information?
- How are completed interventions represented versus planned versus current.
  - Uses moodcode and effective time
  - When to use planned intervention verses Intervention
  - How do you represent and intervention that
  - Status code for planned intervention has a stateModel

Assessment (10 mins, 1:05)

- In what ways does the Care Plan show patient health concerns?
- In what ways does the Care Plan show patient goals?
- In what ways does the Care Plan show the patient's goals for care?
- In what ways does the Care Plan show the patient's treatment preferences for care?
- In what way does the Care Plan show planned actions for specific goals or specific conditions?
- In what way does the Care Plan show the progress or completion status associated with interventions or goals?
- In what way does the Care Plan show or address a patient's self-management care plan?
    - We also reviewed three other sample care plans to see other options
        - Datuit just showed the information for the 3 main section (no info for the Assessment section)
            - No infor for patient's goals or patient's treatment preferences
            - Linkages not exposed
        - Jiva showed the information in a "linked view" using the care plan "container design"
            - Showed only the 3 main sections (no info for the Assessment section)
        - Lisa showed 2 other samples that demonstrated a way to use the container design to show linkages and to expose gaps in care
            - Other samples also are not clear on how to show the Assessment section (Health Status Evaluation and Outcomes)

ZeOmega Example

- Offers a different view showing the linkages.
  - Challenges in how to code the problems, how to code the goals
  - Not clear how to move to machine processed coded entries.
  - Question from other consumers – what is the problem, what is the goal?
    - These are not always framed the same way.
  - Non-medical problems don't have codes but medical Problem codes come from the Problem value set.
- How to make care plans reconcilable for physicians. They will go with their medical diagnosis as what to look for.
  - Should their be a relationship between items on the problem list in a CCD or Discharge Summary
    - Should the medical problems in the Health Concern section match the issues in the Problem List?
    - Other non-medical problems – would they be coded differently, if not from the value set, then becomes a "non-medical problem"

- How do you get codes for non-medical needs (social determinants for health)
  - There are other codes from other sources
  - Does the care plan need to list other needs/issues? Patient goals and Preferences. These could be ‘barriers” to care.
  - How/where do you list these other issues?
- How do you separate the non-medical problem in the care plan from the medical problem?
- How do you reference Patient’s needs/goals or Patient Preferences?
- How do you find gaps in care?

Report out issues (10 mins, 1:15)

- How id’s work and can be used across exchange scenarios
- Where the goal is recorded
- How to address the status of Interventions, Planned Interventions
  - MoodCode; effectiveTime; statusCode
- Representation of information
  - Use of headings
  - How to show the linkages across information (entries)
- The web of relationship between concerns, goals, and interventions

Break (10 mins, 1:25)

Option to discuss other general samples – Used this time to show the other samples

Specialty Care Plan

CKD Sample

Content Creator Discussion (10 mins, 1:35)

- Discuss the Health Concerns Section
- Discuss the Goals Section
- Discuss the Interventions
- Discuss the Health Status Evaluations and Outcomes
- Discuss other sections of content that may be present in the document

- The care plan is a set of pointers into information in a patient's chart. It doesn't introduce new information, it is just a set of linkages. We don't include the information into the health concern, we just reference to the other entry in the other sections. Then, it is very easy to adopt any linkages. (NextGen)
  - They offer several ways to make the linkages. The User is free to describe what ever issue they want, the User Interface allows the person to pick the Health Concern from the Problem List. The concern has to first be listed into the Problem List.

Content Consumer Discussion (20 mins, 1:55)

- What issue were relevant to expected uses of the Care Plan Document information?
- The Care Plan “interface” utilizes the “Problem Section” in the EHR. This becomes the issues in the “Problem Area”, but this makes an issue about how to decide what “problems” below on the “Problem List”.
- Would all data need to move from setting to setting, then allow others to decide how to show the information based on the linkages.
- Need to see the whole patient’s chart to Procedures, Medical Equipment, Medications
  - Immunization, Nutrition Education, etc.
  - What about Edcuation interventions?

- How do specialty plan fit together with broader plans
  - We do see specialty plans fitting together eventually
  - Smaller plans get brought together into one larger plan
    - No way to separate them back out into individual plans
    - Not sure how to keep the sub-plans entact.
  - CKD was mostly concerned with having the right information present rather than keeping it “separate”?
  - Several different contexts may be relevant.
  - Producer of the document isn’t necessarily the actor who will be operating on the information.
    - Document is static – in the real world, may provider groups will be working on this information in different settings and belonging to different organizations.
  - What does the actual output of the care plan need to look like.
  - Can there be a single care plan document that can be shared across a very broad team? Everyone is looking for a single care plan document?
    - Very Com

Assessment (5 mins, 2:10)

- In what ways does the Care Plan show patient health concerns?
- In what ways does the Care Plan show patient goals?
- In what ways does the Care Plan show the patient's goals for care?
- In what ways does the Care Plan show the patient's treatment preferences for care?
- In what way does the Care Plan show planned actions for specific goals or specific conditions?
- In what way does the Care Plan show the progress or completion status associated with interventions or goals?
- In what way does the Care Plan show or address a patient's self-management care plan?
  - Discussed how Specialty care plans are really no different from “general care plans” They are just being created to make sure the relevant information content is included in these types of plans.
  - How will different types of Care Plans be identified. DSTU comment against C-CDA R2.1 is addressing this to allow a value set to be bound to the clinicalDocument.code element of the Care Plan Document.

Report out issues (10 mins, 2:15)

- Added them on the other slide to save time.

Break (20 mins, 2:35)

Option to discuss other specialty samples – used this time to discuss the Specialty Sample and other issues.

Report Out

Track 2: C-CDA Care Plan Documents

Report out Care Plan Track

- How id's work and can be used across exchange scenarios
- Where the goal is recorded? Agree about the use of the value element.
- How to address the status of Interventions, Planned Interventions
  - MoodCode; effectiveTime; statusCode – more analysis and guidance needed
- Representation of information
  - Use of headings may be needed and needs to be clearer guidance on this
  - How to "show" the linkages across information (entries) when rendering the info
- The web of relationship between concerns, goals, and interventions
  - Lots of discussion about use of linkages
  - View – Care Plan as just a set of linkages between information that exists in other "sections" of the patient's chart
  - Questions on the allowed cardinalities of the number of relationships

Report Out (continued)

- Discussion of the relationship between different care plans
  - What happens when a person's "care plan" includes a variety of plans – maybe some specialty care plans and an broader plan?
    - Key is to make sure all the right information is captured/present
    - Not sure if there is a need for plans to be "separateable" after being joined together.
- View of the human readable plans seemed very doable
- Attaching the document to the patient's chart was doable
- How the available data will be processed was less well developed
- Representation of information as coded data is a challenge.
- What is the clinically relevant way of showing the care plan information?
  - More concensus needed on how to "present" the information , ie render it in a relevant way
  - Could agreement at this higher level help inform ways to share and exchange info under "shared rules" about whose information goes where in the exchange document?

Report Out (continued)

- Viewing the care plans was the key criteria for success
- Including the “right” information seems to be the focus at this point for many working on specific types of care plans.

- Time seemed very short for all we needed to discuss
- Took no breaks
- Technology was “fair”
  - Sharing worked pretty well for most
  - Sound quality was problematic, may have made it hard to participate
  - I got dropped at about 3:55 and could not get back on

ASK the ONC

- Suggestion: The one-click Scorecard tool needs better rules for scoring Care Plan documents.
  - We may need to convene a group to look at what rules are needed specifically for Care Plan documents.
  - There seems to be agreement that Care Plan documents are very different from other document types.

Insight on the Roles needed:

- Coordinator/facilitator -
- Note taker
- Validation checker
- Spec Researcher
- Meeting Technology Support
- 1st Timer Support