Care Plan Data Element Review for HITAC Interoperability Standards Work Group

March 5, 2024

Jenna Norton, NIH
Arlene Bierman, AHRQ
Elizabeth Palena Hall, CMS
Evelyn Gallego, EMI Advisors

AHRQ

National Institute of Diabetes and Digestive and Kidney Diseases

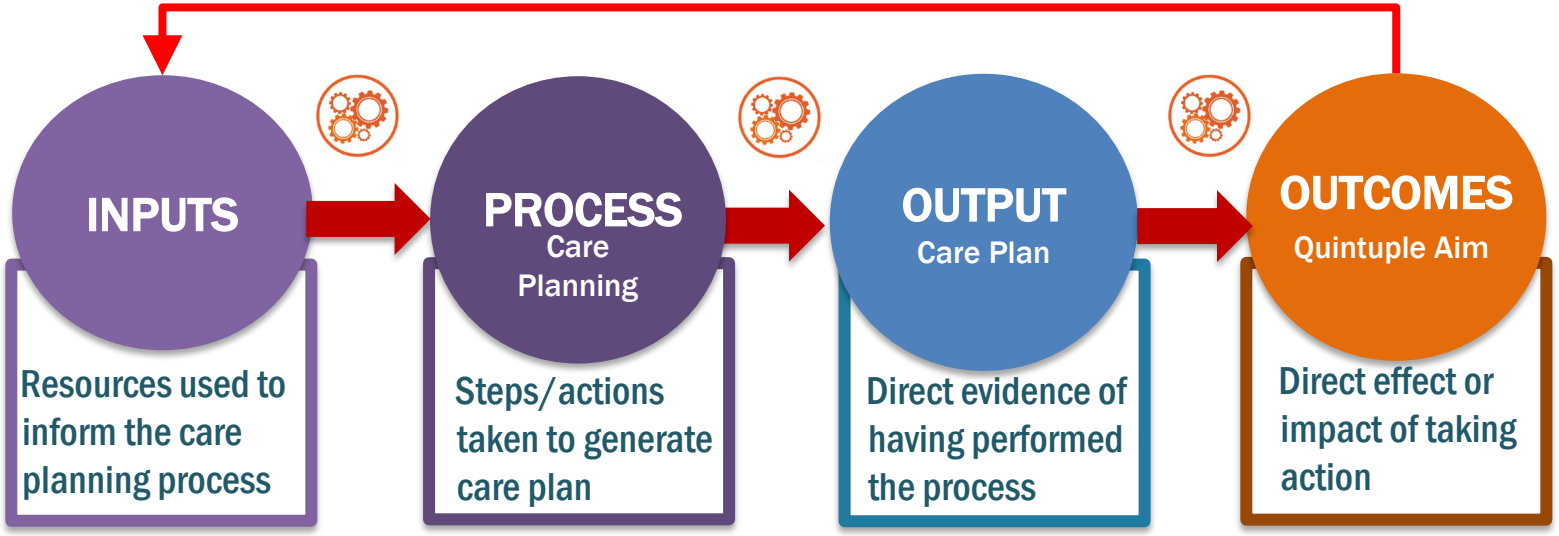
Agenda

Topic	Time	Presenter(s)
Care Plan Terms, Definition, and Components	5 min	Jenna Norton
Care Plan Importance to Clinical Care	5 min	Jenna Norton
MCC eCare Plan FHIR IG Crosswalk to USCDI	5 min	Evelyn Gallego
Recommendations	10 min	Liz Palena Hall
Q&A	5 min	

AHRQ

NIH National Institute of Diabetes and Digestive and Kidney Diseases

Care Planning vs. Care Plan



USCDI incorporates data elements that represent INPUTS for the care planning process. There is an opportunity to better define the OUTPUT of the process with a Care Plan data element.

AHRQ

National Institute of Diabetes and Digestive and Kidney Diseases

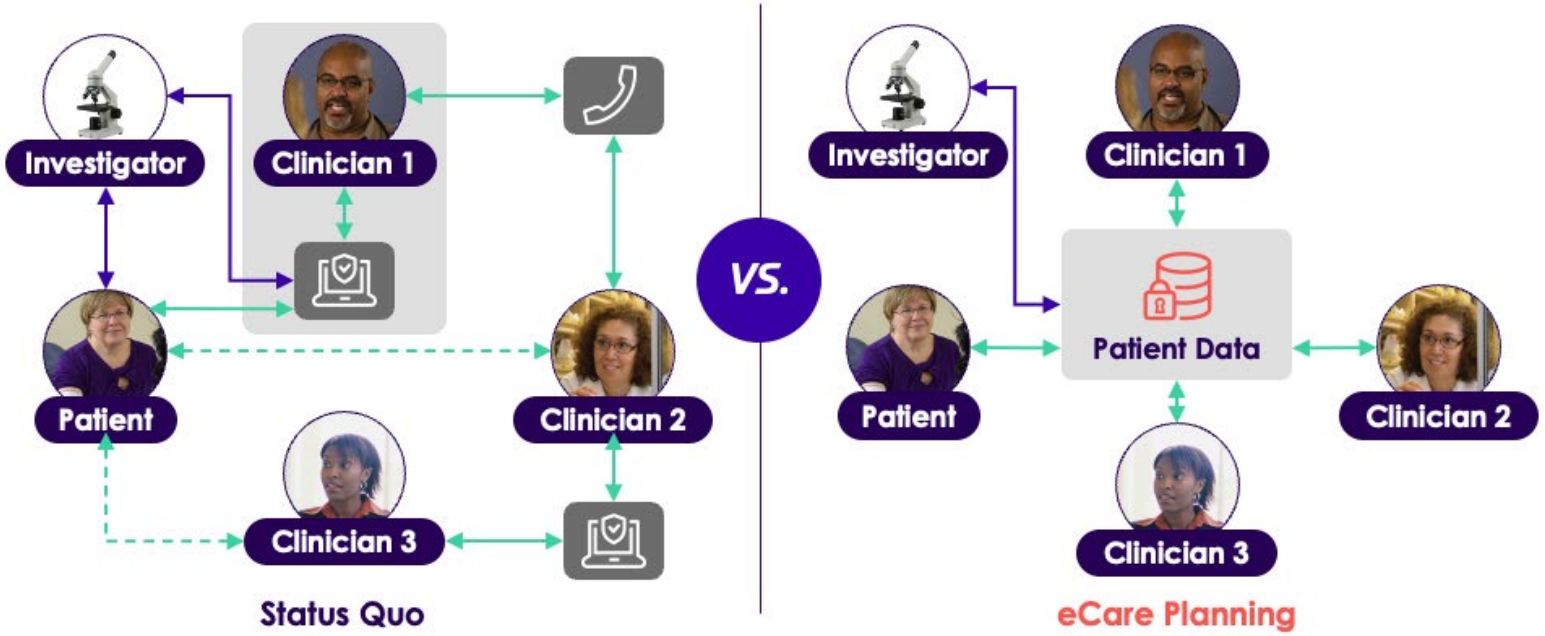
Care Plan Lexicon

Terms "Plan of Care" and "Care Plan" used interchangeably within the healthcare industry

Initial standardization efforts focused on the agreement of components of each rather than when to use which term

Type of Plan	Description
Treatment Plan	**Domain-specific plan** managed by a single discipline focusing on a specific treatment or intervention.
Plan of Care	**Clinician driven plan** that focuses on a specific health concern or closely related concern. It represents a specific set of related conditions that are managed or authorized by a clinician or provider.
Care Plan	**Shared dynamic longitudinal plan** representing all Care Team Members (including patient/caregiver) prioritized concerns, goals, interventions, and evaluation/outcomes across all health and social services settings.

Comprehensive Standards-Based eCare Planning



National Institute of Diabetes and Digestive and Kidney Diseases

The Challenge of Multiple Chronic Conditions (MCC)

- **Disease-specific vs. person-centered approaches.** Disease-specific approach to care delivery and research is misaligned with the **whole person-centered needs** of patients and caregivers.
- **Interoperability obstacles in complex care.** People with MCC require care in multiple settings, from multiple providers. **Data do not easily move across settings of care**.
- **Health equity.** People from low-income backgrounds and under-represented racial or ethnic groups develop MCC at **higher rates and earlier ages**.

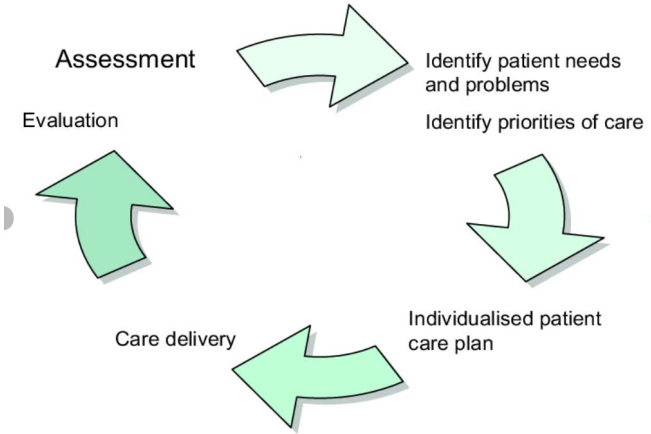
People with MCC account for:

64%	70%	83%	71%	93%
OF ALL **Clinician Visits**	OF ALL **In-Patient Stays**	OF ALL **Prescriptions**	OF ALL **Healthcare Spending**	OF ALL **Medicare Spending**

CMS 2018: *https://www.cms.gov/data-research/statistics-trends-and-reports/chronic-conditions/chartbook-and-charts;*
AHRQ 2010: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/prevention-chronic-care/decision/mcc/mccchartbook.pdf;
Quiñones, et al. Racial/ethnic differences in multimorbidity development and chronic disease accumulation for middle-aged adults. *PLoS One*, 2019;14(6), PMID: 31206556.

Elevate Care Plan Level 2 to Align with Clinical Workflow

Previous Careplan Recommendations Level 2	Current draft USCDI v5	Revised Careplan Recommendations
• Health Concerns • Patient Goals • Problems [e.g., diagnoses] • Procedures [e.g., interventions] • Care Team Member(s) • Care Plan Summary	**Patient Summary and Plan** • Assessment and Plan of Treatment	• Care Plan Information • Assessment • Health Concerns • Goals • Interventions • Outcomes/ Evaluation • Care team



e-Care Plan: Potential Benefits for Clinical Care

- **Improved communication & care coordination** across the care team leading to increased caregiver and patient **experience**
  - Person/patient
  - Paid & unpaid caregivers
  - Home & community-based providers
  - Diverse clinicians – primary care, specialists, hospitalists, etc.
- Access to **patient/caregiver-reported** and **patient/caregiver-centered** data
  - Patient & caregiver goals, preferences & priorities
  - Social determinants of health
- **Improved patient safety**/reduced medical errors
- Reduced redundancy/duplication of orders → **reduced costs**

Care Planning Components

Care Plan Information	Assessment/ Health Concerns	Goals	Interventions	Outcomes/ Evaluation
Plan type, demographic, administrative and care team information including unpaid caregivers.	Existing or potential health states, conditions, social issues, and risks.	Desired outcomes or conditions to be achieved as a result of the interventions provided for health concerns.	Actions taken to treat health concerns and achieve goals.	Observations about or related to the health concerns with respect to interventions performed and progress towards goals.

Care Coordination

The deliberate organization of patient care activities between two or more participants (including the patient) involved in patient care to facilitate and ensure that the delivery of healthcare services is appropriate, safe, and efficient. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities, and often is managed by the exchange of information among participants responsible for different aspects of care.

MCC eCare Plan FHIR Implementation Guide (IG)

The HL7® MCC eCare Plan FHIR Implementation Guide (IG) defines FHIR R4 profiles, structures, extensions, transactions, and value sets needed to represent, query for, and exchange Care Plan information to support care planning for people with multiple chronic conditions (MCC).

The IG supports the following use cases:

1. Generate and update comprehensive e-care plan in clinical setting.
2. Expose (Share) e-care plan to clinical care team, patient, or caregiver.
3. Identify care team members.

HL7 FHIR

Improve care coordination without increasing clinician burden

AHRQ

National Institute of Diabetes and Digestive and Kidney Diseases

Most Care Plan Components Already in USCDI

eCare Plan FHIR IG components

- Care Plan Information
- Health Concerns
- Goals
- Interventions
- Outcomes/ Evaluation

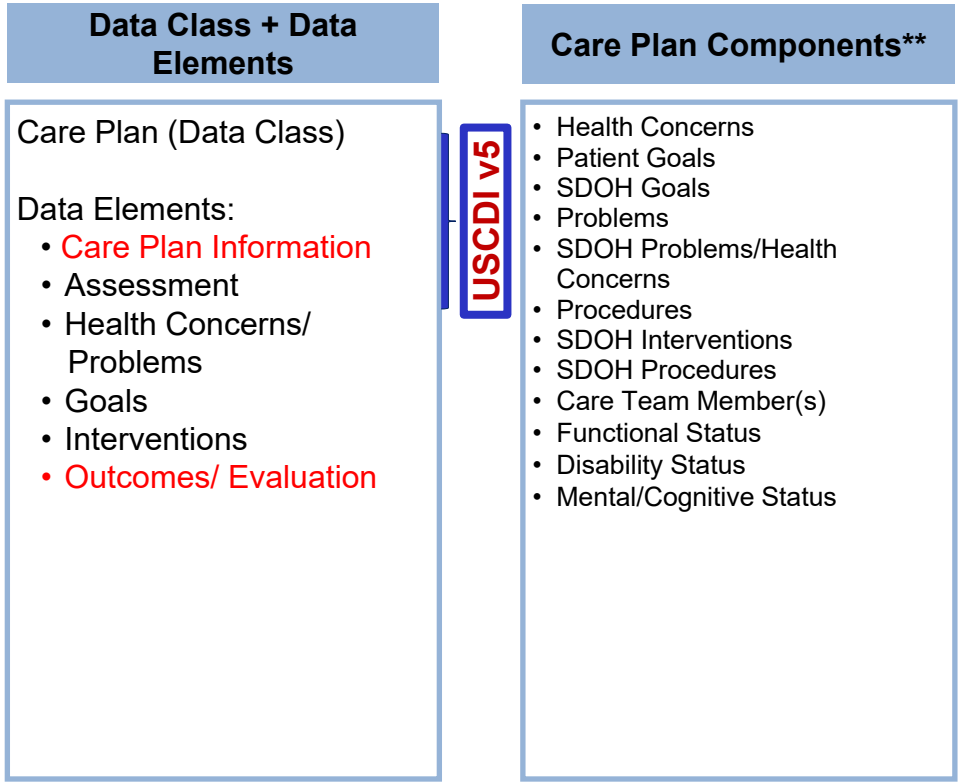
USCDI United States Core Data for Interoperability

Data Class	Example Data Element(s)
Patient Demographics/ Information	Name, Name to Use, DOB, Preferred Language
Care Team Member(s)	Name, Role, Telecom
Health Insurance Information	Coverage status, Type, payer Identifier
Health Status Assessment	Health Concerns, Physical Activity, Assessments (SDOH, Functional, Cognitive, Disability)
Problems	Problems, SDOH Problems/ Health Concerns
Goals & Preferences	Patient Goals, SDOH Goals, Treatment Intervention Preference, Care Experience Preference
Procedures	Procedures, SDOH Interventions, Reason for Referral
Medications	Medication, dose, route, instructions

Recommendation for Care Plan in USCDI v5

Data Class + Data Elements
Data Class: Care Plan Data Elements: • Care Plan Information • Assessment • Health Concerns/ Problems • Goals • Interventions • Outcomes/ Evaluation

Recommendation for Care Plan in USCDI v5



**Components and existing data elements in USCDI.

Recommendation for Care Plan in USCDI v5

Data Class + Data Elements		Care Plan Components**	Code Systems / Value Sets
Care Plan (Data Class) Data Elements: • Care Plan Information • Assessment • Health Concerns/ Problems • Goals • Interventions • Outcomes/ Evaluation	USCDI v5	• Health Concerns • Patient Goals • SDOH Goals • Problems • SDOH Problems/Health Concerns • Procedures • SDOH Interventions • SDOH Procedures • Care Team Member(s) • Functional Status • Disability Status • Mental/Cognitive Status	• LOINC ▪ Screening data elements (functional status, disability status, cognitive status, SDOH assessment) ▪ Patient Goals ▪ SDOH Goals ▪ Treatment Intervention Preference ▪ Care Experience Preference • SNOMED-CT ▪ SDOH Goals ▪ Problems ▪ Procedures ▪ SDOH Interventions ▪ Health Concerns • ICD-10-CM ▪ Problems ▪ Health Concerns ▪ CPT/ HCPCS, ICD-10-PCS ▪ Interventions

**Components and existing data elements in USCDI.

Recommendation for Care Plan in USCDI v5

FHIR Implementation Guides (IG) / Use Cases (UC)	Data Class + Data Elements		Care Plan Components**	Code Systems / Value Sets
• Multiple Chronic Condition eCare Plan IG STU1 • Pharmacist Care Plan Document IG • eLTSS IG STU2 • Advance Directive Interoperability IG STU1	Care Plan (Data Class) Data Elements: • Care Plan Information • Assessment • Health Concerns/ Problems • Goals • Interventions • Outcomes/ Evaluation	USCDI v5	• Health Concerns • Patient Goals • SDOH Goals • Problems • SDOH Problems/Health Concerns • Procedures • SDOH Interventions • SDOH Procedures • Care Team Member(s) • Functional Status • Disability Status • Mental/Cognitive Status	• LOINC ▪ Screening data elements (functional status, disability status, cognitive status, SDOH assessment) ▪ Patient Goals ▪ SDOH Goals ▪ Treatment Intervention Preference ▪ Care Experience Preference • SNOMED-CT ▪ SDOH Goals ▪ Problems ▪ Procedures ▪ SDOH Interventions ▪ Health Concerns • ICD-10-CM ▪ Problems ▪ Health Concerns ▪ CPT/ HCPCS, ICD-10-PCS ▪ Interventions

**Components and existing data elements in USCDI.

Recommendations

1. Repurpose ‘Patient Summary and Plan’ to NEW ‘Care Plan’ Data Class (similar to Medications).

Include data elements: Care Plan Information, Assessment (SDOH assessments, Functional Status, Cognitive Status, etc.), Health Concerns, Goals, Interventions, and Outcomes/Evaluation

Rationale: Patient Summary is already included in Clinical Notes, and US CORE Careplan IG includes ‘Narrative Summary and Plan of Treatment’.

Recommendations

2. Refine the definition for Care Plan

Shared dynamic longitudinal plan *representing all Care Team Members (including patient/caregiver) prioritized concerns, goals, interventions, and evaluation/outcomes across all health and social services settings.*

Usage Notes: Must contain identified goals for the patient/person and provider, as well as assessments, health concerns, interventions, and outcomes/evaluations.

Examples include but are not limited to multiple chronic conditions eCare Plan and electronic Long-Term Services & Supports (LTSS) Plan.

Recommendations

3. Revise ‘Health Status Assessments’ definition to incorporate outcomes/evaluation:
   - Assessments of a health-related matter of interest, importance, or worry to a patient, patient’s family, or patient’s healthcare provider that could identify a need, problem, or condition and/or progress toward goals.

4. Establish bare minimum for components and add as more data elements become available (e.g., MCC expands to include new domains like dementia).

Questions?

- Arlene Bierman- arlene.bierman@ahrq.hhs.gov
- Jenna Norton- jenna.norton@nih.gov
- Liz Palena Hall- elizabeth.palenahall@cms.hhs.gov
- Evelyn Gallego- evelyn.gallego@emiadvisors.net

National Institute of Diabetes and Digestive and Kidney Diseases

Additional MCC eCare Plan Project Links

- AHRQ and NIDDK Confluence Page for MCC eCare: https://cmext.ahrq.gov/confluence/display/EC//

- HL7 Patient Care Work Group – MCC eCare Project Page: https://confluence.hl7.org/display/PC/Multiple+Chronic+Conditions+%28MCC%29+eCare+Plan

National Institute of Diabetes and Digestive and Kidney Diseases