**Care Plan / Plan of Care Redux**

**DV Summary of Current Issues**

1. The Document code from C-CDA 2.1 for Care Plan Document template ([52521-2](http://s.details.loinc.org/LOINC/52521-2.html?sections=Comprehensive)) is NOT a document code. It’s a panel from CARE!
	1. RI plan is to deprecate that term and point people to the generic Plan of Care term ([56447-6](https://loinc.org/56447-6)) or, if you are a CARE user, a new panel term. But that depends on…
2. Need to resolve naming or status of the infamous 18776-5 code
	1. I am tempted to model it just as “plan of care” (thus deprecating 56447-6 as a dupe), but the care plan document explicitly says it cannot contain the “Plan of Care” section template (which uses 18776-5). When I look at the expected information content, I’m hard pressed to see any conceptual difference.
3. We need to review/reconcile the Ontology, which has both “Plan of Care” and “Treatment Plan” as Type of Service entries
4. We have a whole queue of pending requests for “Plan of care note” terms from Canada (the local names all say {SMD} Care Plan)

**Prior Discussion and Decision**

PROPOSAL: Change “Care plan”, “Patient plan of care”, “Treatment plan”, and “Plan of treatment” terms to “Plan of Care” with a Scale of “Doc”

**Notes from 8/2012 Clinical LOINC Committee meeting:**

**Discuss with NQF care coordination group. SI Framework Care Coordination group.**

**[COMMITTEE DECISION]**

1. Change components to Plan of Care.
2. Laura to discuss with IHE whether to change the 61145-9 to include Nursing in the name (and Component of Plan of Care), or to use 64295-9 as the primary code. And deprecate the other. (per recent email correspondence with Laura– IHE will use 64295-9. Agreed to deprecating 61145-9)

**[RI Note]**

* There is a general need to add “note” as the Type of Document for these “Plan of care” terms, and some of this work has been done for those in the CLASS:DOC.CLINRPT as part of the production of the LOINC Document Ontology File

**Notes from 2/2013 Clinical LOINC Committee meeting:**

LOINC codes to be built, but the model is conceptual and has the potential of being not used or misused. The ‘uber’ Care Plan needs to be renamed within the model such as ‘consolidated multidisciplinary care plan’ in the HL7 workgroup. The new codes need to reference the HL7 model. It might be needed to discourage the use of the existing LOINC ‘plan of care’ codes. Regenstrief may want to draft a notice to stakeholders and put it on the website and list serve.

**Notes from 8/2013 Clinical LOINC Committee meeting:**

Extensive discussion on existing codes. Decision was to consult with Structured docs workgroup (Cambridge meeting) and get feedback.

64295-9 Care plan Find Pt {Setting} Doc Nursing

***v2.44: Plan of care note Find Pt {Setting} Doc Nurse***

(Created for HAIMS)

Description: A nursing care plan is a document that outlines the nursing care to be provided to an individual/family/community. It is a set of actions the nurse will implement to resolve/support nursing diagnoses identified by nursing assessment. The creation of the plan is an intermediate stage of the nursing process. It guides in the ongoing provision of nursing care and assists in the evaluation of that care. It includes a) nursing diagnosis including related and risk factors, b) expected outcomes (e.g. goals), and c) nursing interventions.

**[RI Done]**

* Changed Component to ‘Plan of Care’ based on CLC approval.
* 5/13 Added ‘note’ as Kind of document.

67853-2 Care plan Find Pt {Setting} Doc {Provider}

***v2.44: DEPRECATED***

(Created by RI for general care plan term)

**[RI Done]**

* Changed Component to ‘Plan of Care’ base on CLC approval.
* Upon further review, deprecated term and mapped to 56447-6 (duplicate – not needed since 56447-6 was meant to be general Plan of Care term)

56447-6 Treatment plan Find Pt ^Patient Doc

***v2.44: Plan of Care note Find Pt {Setting} Doc {Provider}***

Description: A document containing the (proposed) treatment plan for a patient. The purpose of this document is to inform the patient and other clinicians (therapists, etc) of the planned treatment.

**[RI Done]**

* Changed Component to ‘Plan of Care’ based on CLC approval.
* Since this document term is meant to be “general” (not specific to setting or provider), this term has been edited (System= {Setting}, Method= {Provider}) to harmonize with existing Document Ontology model.
* 5/13 Added ‘note’ as Kind of document.

61145-9 Patient plan of care Find Pt ^Patient Doc

***v2.44: DEPRECATED***

Description: The Patient Plan of Care profile (PPOC) extends the description of the content structures for the plan of care in the current technical framework and is based on the data elements from the Nursing Process currently in common use.

**[RI Done]**

* Per approval by IHE and Clinical LOINC Committee, deprecated term and recommend users map to 56447-6 (Plan of Care) or 64295-9 (Nursing Plan of Care) based on their use-case.
* ***v2.46:*** New panel term ([74449-0](http://s.details.loinc.org/LOINC/74449-0.html?sections=Simple)) created to group together current IHE PPOC recommended sections (previously under 61145-9) based on corresponding LOINCs.



**Outstanding Issues**

**No decisions have been made for 18776-5 and other Treatment plan codes (see below).**

18776-5 Plan of treatment Find Pt Treatment plan Nar

*Used for Plan of Care section in CDA guide.*

Description from CDA: The Plan of Care section contains data that defines pending orders, interventions, encounters, services, and procedures for the patient. It is limited to prospective, unfulfilled, or incomplete orders and requests only, which are indicated by the @moodCode of the entries within this section. All active, incomplete, or pending orders, appointments, referrals, procedures, services, or any other pending event of clinical significance to the current care of the patient should be listed unless constrained due to privacy issues. The plan may also contain information about ongoing care of the patient and information regarding goals and clinical reminders. Clinical reminders are placed here to provide prompts for disease prevention and management, patient safety, and health-care quality improvements, including widely accepted performance measures. The plan may also indicate that patient education was given or will be provided.

18776-5 also used for Care Plan section/element within [IHE’s Patient Plan of Care document](http://www.ihe.net/Technical_Framework/upload/IHE_PCC_Suppl_PPOC_Rev1-3_TI_2011-09-09.pdf) (LOINC 34746-8, Nursing Note).

Description from IHE: A Patient Plan of Care (PPOC) is a care plan that is individualized and mutually agreed upon with the patient/advocate. The care plan includes problem issues (diagnoses), expected healthcare outcomes, implementable interventions, and evaluation of progress toward outcomes based on follow up assessment. It is a framework to document critical thinking necessary for progressive evidenced-based outcomes.

Other ‘plan of treatment’ codes:

27504-0 Plan of treatment Find Pt Alcohol-substance abuse rehabilitation treatment plan Nar

27446-4 Plan of treatment Find Pt Cardiac rehabilitation treatment plan Nar

27777-2 Plan of treatment Find Pt Medical social services treatment plan Nar

27624-6 Plan of treatment Find Pt Occupational therapy treatment plan Nar

27687-3 Plan of treatment Find Pt Physical therapy treatment plan Nar

18657-7 Plan of treatment Find Pt Psychiatric rehabilitation treatment plan Nar

52177-3 Plan of treatment Find Pt Pulmonary therapy treatment plan Nar

27726-9 Plan of treatment Find Pt Respiratory therapy treatment plan Nar

27573-5 Plan of treatment Find Pt Skilled nursing treatment plan Nar

29183-1 Plan of treatment Find Pt Speech therapy treatment plan Nar

**Extracted from CCDA 1.1 – July 2012**

***4.39 Plan of Care Section 18776-5***

[section: templateId 2.16.840.1.113883.10.20.22.2.10(open)]

***Table 85: Plan of Care Section Contexts***

**Used By:**

Progress Note (optional)

Consultation Note (optional)

Discharge Summary (required)

History and Physical (optional)

Procedure Note (optional)

Operative Note (optional)

Continuity of Care Document (CCD) (optional)

**Contains Entries:**

Instructions

Plan of Care Activity Act

Plan of Care Activity Encounter

Plan of Care Activity Observation

Plan of Care Activity Procedure

Plan of Care Activity Substance Administration

Plan of Care Activity Supply

The Plan of Care section contains data that defines pending orders, interventions, encounters, services, and procedures for the patient. It is limited to prospective, unfulfilled, or incomplete orders and requests only, which are indicated by the @moodCode of the entries within this section. All active, incomplete, or pending orders, appointments, referrals, procedures, services, or any other pending event of clinical significance to the current care of the patient should be listed unless constrained due to privacy issues. The plan may also contain information about ongoing care of the patient and information regarding goals and clinical reminders. Clinical reminders are placed here to provide prompts for disease prevention and management, patient safety, and health-care quality improvements, including widely accepted performance measures. The plan may also indicate that patient education will be provided.

1. **SHALL** contain exactly one [1..1] **templateId** (CONF:7723) such that it

a. **SHALL** contain exactly one [1..1] **@root**="2.16.840.1.113883.10.20.22.2.10" (CONF:10435).

2. **SHALL** contain exactly one [1..1] **code** (CONF:14749).

a. This code **SHALL** contain exactly one [1..1] **@code**="18776-5" Plan of Care (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:14750).

3. **SHALL** contain exactly one [1..1] **title** (CONF:16986).

4. **SHALL** contain exactly one [1..1] **text** (CONF:7725).

5. **MAY** contain zero or more [0..\*] **entry** (CONF:7726) such that it

a. **SHALL** contain exactly one [1..1] **Plan of Care Activity Act** (2.16.840.1.113883.10.20.22.4.39) (CONF:8804).

6. **MAY** contain zero or more [0..\*] **entry** (CONF:8805) such that it

a. **SHALL** contain exactly one [1..1] **Plan of Care Activity Encounter** (2.16.840.1.113883.10.20.22.4.40) (CONF:8806).

7. **MAY** contain zero or more [0..\*] **entry** (CONF:8807) such that it

a. **SHALL** contain exactly one [1..1] **Plan of Care Activity Observation** (2.16.840.1.113883.10.20.22.4.44) (CONF:8808).

8. **MAY** contain zero or more [0..\*] **entry** (CONF:8809) such that it

a. **SHALL** contain exactly one [1..1] **Plan of Care Activity Procedure** (2.16.840.1.113883.10.20.22.4.41) (CONF:8810).

9. **MAY** contain zero or more [0..\*] **entry** (CONF:8811) such that it

a. **SHALL** contain exactly one [1..1] **Plan of Care Activity Substance Administration** (2.16.840.1.113883.10.20.22.4.42) (CONF:8812).

10. **MAY** contain zero or more [0..\*] **entry** (CONF:8813) such that it

a. **SHALL** contain exactly one [1..1] (templateId:2.16.840.1.113883.10.20.22.4.43) (CONF:14756).

11. **MAY** contain zero or more [0..\*] **entry** (CONF:14695) such that it

a. **SHALL** contain exactly one [1..1] (templateId:2.16.840.1.113883.10.20.22.4.20) (CONF:16751).

***Figure 125: Plan of care section example***

<section>

<templateId root="2.16.840.1.113883.10.20.22.2.10" />

<!-- \*\*\*\* Plan of Care section template \*\*\*\* -->

<code code="18776-5" codeSystem="2.16.840.1.113883.6.1"

codeSystemName="LOINC" displayName="Treatment plan"/>

<title>Plan of Care</title>

<text>

...

</text>

<entry typeCode="DRIV">

<observation classCode="OBS" moodCode="RQO">

<templateId root="2.16.840.1.113883.10.20.22.4.44"/>

<!-- \*\*\*\* Plan of Care Activity Observation template \*\*\*\* -->

...

</observation>

</entry>

*HL7 Implementation Guide for CDA R2: IHE Health Story Consolidation, DSTU R1.1 Page 261*

*July 2012 © 2012 Health Level Seven, Inc. All rights reserved.*

<entry>

<act moodCode="RQO" classCode="ACT">

<templateId root="2.16.840.1.113883.10.20.22.4.39"/>

<!-- \*\*\*\* Plan of Care Activity Act template \*\*\*\* -->

...

</act>

</entry>

<entry>

<encounter moodCode="INT" classCode="ENC">

<templateId root="2.16.840.1.113883.10.20.22.4.40"/>

<!-- \*\*\*\* Plan of Care Activity Encounter template \*\*\*\* -->

...

</encounter>

</entry>

<entry>

<procedure moodCode="RQO" classCode="PROC">

<templateId root="2.16.840.1.113883.10.20.22.4.41"/>

<!-- \*\*\*\* Plan of Care Activity Procedure Template \*\*\*\* -->

...

</procedure>

</entry>

<entry>

<substanceAdministration moodCode="RQO" classCode="SBADM">

<templateId root="2.16.840.1.113883.10.20.22.4.42"/>

<!-- \*\*\*\* Plan of Care Activity Substance Administration \*\*\*\* -->

...

</substanceAdministration>

</entry>

<entry>

<supply moodCode="INT" classCode="SPLY">

<templateId root="2.16.840.1.113883.10.20.22.4.43"/>

<!-- \*\* Plan of Care Activity Supply \*\* -->

...

</supply>

</entry>

</section>

**Extracted from CCDA 2.0 – Nov. 2014**

* 1. Plan of Treatment Section (V2)

[section: identifier urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09 (open)]

Table 168: Plan of Treatment Section (V2) Contexts

| Contained By: | Contains: |
| --- | --- |
| [Transfer Summary](#D_Transfer_Summary) (optional)[Consultation Note (V2)](#Consultation_Note_V2) (optional)[Referral Note](#D_Referral_Note) (optional)[Continuity of Care Document (CCD) (V2)](#D_Continuity_of_Care_Document_CCD_V2) (optional)[Discharge Summary (V2)](#D_Discharge_Summary_V2) (required)[History and Physical (V2)](#D_History_and_Physical_V2) (optional)[Operative Note (V2)](#D_Operative_Note_V2) (optional)[Procedure Note (V2)](#D_Procedure_Note_V2) (optional)[Progress Note (V2)](#D_Progress_Note_V2) (optional) | [Goal Observation](#E_Goal_Observation)[Handoff Communication Participants](#E_Handoff_Communication_Participants)[Instruction (V2)](#Instruction_V2)[Nutrition Recommendation](#E_Nutrition_Recommendation)[Planned Act (V2)](#E_Planned_Act_V2)[Planned Encounter (V2)](#E_Planned_Encounter_V2)[Planned Immunization Activity](#E_Planned_Immunization_Activity)[Planned Medication Activity (V2)](#E_Planned_Medication_Activity_V2)[Planned Observation (V2)](#E_Planned_Observation_V2)[Planned Procedure (V2)](#E_Planned_Procedure_V2)[Planned Supply (V2)](#E_Planned_Supply_V2) |

This section, formerly known as "Plan of Care", contains data that define pending orders, interventions, encounters, services, and procedures for the patient. It is limited to prospective, unfulfilled, or incomplete orders and requests only. These are indicated by the @moodCode of the entries within this section. All active, incomplete, or pending orders, appointments, referrals, procedures, services, or any other pending event of clinical significance to the current care of the patient should be listed. This section may also contain information about ongoing care of the patient, clinical reminders, patient’s values, beliefs, preferences, care expectations, and overarching care goals.

Clinical reminders are placed here to provide prompts for disease prevention and management, patient safety, and healthcare quality improvements, including widely accepted performance measures.

Values may include the importance of quality of life over longevity. These values are taken into account when prioritizing all problems and their treatments.

Beliefs may include comfort with dying or the refusal of blood transfusions because of the patient’s religious convictions.

Preferences may include liquid medicines over tablets, or treatment via secure email instead of in person.

Care expectations may range from being treated only by female clinicians, to expecting all calls to be returned within 24 hours.

Overarching goals described in this section are not tied to a specific condition, problem, health concern, or intervention. Examples of overarching goals could be to minimize pain or dependence on others, or to walk a daughter down the aisle for her marriage.

The plan may also indicate that patient education will be provided.

Table 169: Plan of Treatment Section (V2) Constraints Overview

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| XPath | Card. | Verb | Data Type | CONF# | Value |
| section (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) |
|  templateId | 1..1 | SHALL |  | [1098-7723](#C_1098-7723) |  |
|  @root | 1..1 | SHALL |  | [1098-10435](#C_1098-10435) | 2.16.840.1.113883.10.20.22.2.10 |
|  @extension | 1..1 | SHALL |  | [1098-32501](#C_1098-32501) | 2014-06-09 |
|  code | 1..1 | SHALL |  | [1098-14749](#C_1098-14749) |  |
|  @code | 1..1 | SHALL |  | [1098-14750](#C_1098-14750) | 18776-5 |
|  @codeSystem | 1..1 | SHALL |  | [1098-30813](#C_1098-30813) | 2.16.840.1.113883.6.1 (LOINC) = 2.16.840.1.113883.6.1 |
|  title | 1..1 | SHALL |  | [1098-16986](#C_1098-16986) |  |
|  text | 1..1 | SHALL |  | [1098-7725](#C_1098-7725) |  |
|  entry | 0..\* | MAY |  | [1098-7726](#C_1098-7726) |  |
|  observation | 1..1 | SHALL |  | [1098-14751](#C_1098-14751) | [Planned Observation (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.44:2014-06-09](#E_Planned_Observation_V2) |
|  entry | 0..\* | MAY |  | [1098-8805](#C_1098-8805) |  |
|  encounter | 1..1 | SHALL |  | [1098-30472](#C_1098-30472) | [Planned Encounter (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.40:2014-06-09](#E_Planned_Encounter_V2) |
|  entry | 0..\* | MAY |  | [1098-8807](#C_1098-8807) |  |
|  act | 1..1 | SHALL |  | [1098-30473](#C_1098-30473) | [Planned Act (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09](#E_Planned_Act_V2) |
|  entry | 0..\* | MAY |  | [1098-8809](#C_1098-8809) |  |
|  procedure | 1..1 | SHALL |  | [1098-30474](#C_1098-30474) | [Planned Procedure (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09](#E_Planned_Procedure_V2) |
|  entry | 0..\* | MAY |  | [1098-8811](#C_1098-8811) |  |
|  substanceAdministration | 1..1 | SHALL |  | [1098-30475](#C_1098-30475) | [Planned Medication Activity (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.42:2014-06-09](#E_Planned_Medication_Activity_V2) |
|  entry | 0..\* | MAY |  | [1098-8813](#C_1098-8813) |  |
|  supply | 1..1 | SHALL |  | [1098-30476](#C_1098-30476) | [Planned Supply (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.43:2014-06-09](#E_Planned_Supply_V2) |
|  entry | 0..\* | MAY |  | [1098-14695](#C_1098-14695) |  |
|  act | 1..1 | SHALL |  | [1098-31397](#C_1098-31397) | [Instruction (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09](#Instruction_V2) |
|  entry | 0..\* | MAY |  | [1098-29621](#C_1098-29621) |  |
|  act | 1..1 | SHALL |  | [1098-30868](#C_1098-30868) | [Handoff Communication Participants (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.141](#E_Handoff_Communication_Participants) |
|  entry | 0..\* | MAY |  | [1098-31841](#C_1098-31841) |  |
|  act | 1..1 | SHALL |  | [1098-31864](#C_1098-31864) | [Nutrition Recommendation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.130](#E_Nutrition_Recommendation) |
|  entry | 0..\* | MAY |  | [1098-32353](#C_1098-32353) |  |
|  substanceAdministration | 1..1 | SHALL |  | [1098-32354](#C_1098-32354) | [Planned Immunization Activity (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.120](#E_Planned_Immunization_Activity) |
|  entry | 0..\* | MAY |  | [1098-32887](#C_1098-32887) |  |
|  observation | 1..1 | SHALL |  | [1098-32888](#C_1098-32888) | [Goal Observation (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.121](#E_Goal_Observation) |

1. SHALL contain exactly one [1..1] templateId (CONF:1098-7723) such that it
	1. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.2.10" (CONF:1098-10435).
	2. SHALL contain exactly one [1..1] @extension="2014-06-09" (CONF:1098-32501).
2. SHALL contain exactly one [1..1] code (CONF:1098-14749).
	1. This code SHALL contain exactly one [1..1] @code="18776-5" Plan of Treatment (CONF:1098-14750).
	2. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem: LOINC 2.16.840.1.113883.6.1) (CONF:1098-30813).
3. SHALL contain exactly one [1..1] title (CONF:1098-16986).
4. SHALL contain exactly one [1..1] text (CONF:1098-7725).
5. MAY contain zero or more [0..\*] entry (CONF:1098-7726) such that it
	1. SHALL contain exactly one [1..1] [Planned Observation (V2)](#E_Planned_Observation_V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.44:2014-06-09) (CONF:1098-14751).
6. MAY contain zero or more [0..\*] entry (CONF:1098-8805) such that it
	1. SHALL contain exactly one [1..1] [Planned Encounter (V2)](#E_Planned_Encounter_V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.40:2014-06-09) (CONF:1098-30472).
7. MAY contain zero or more [0..\*] entry (CONF:1098-8807) such that it
	1. SHALL contain exactly one [1..1] [Planned Act (V2)](#E_Planned_Act_V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.39:2014-06-09) (CONF:1098-30473).
8. MAY contain zero or more [0..\*] entry (CONF:1098-8809) such that it
	1. SHALL contain exactly one [1..1] [Planned Procedure (V2)](#E_Planned_Procedure_V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.41:2014-06-09) (CONF:1098-30474).
9. MAY contain zero or more [0..\*] entry (CONF:1098-8811) such that it
	1. SHALL contain exactly one [1..1] [Planned Medication Activity (V2)](#E_Planned_Medication_Activity_V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.42:2014-06-09) (CONF:1098-30475).
10. MAY contain zero or more [0..\*] entry (CONF:1098-8813) such that it
	1. SHALL contain exactly one [1..1] [Planned Supply (V2)](#E_Planned_Supply_V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.43:2014-06-09) (CONF:1098-30476).
11. MAY contain zero or more [0..\*] entry (CONF:1098-14695) such that it
	1. SHALL contain exactly one [1..1] [Instruction (V2)](#Instruction_V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.4.20:2014-06-09) (CONF:1098-31397).
12. MAY contain zero or more [0..\*] entry (CONF:1098-29621) such that it
	1. SHALL contain exactly one [1..1] [Handoff Communication Participants](#E_Handoff_Communication_Participants) (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.141) (CONF:1098-30868).
13. MAY contain zero or more [0..\*] entry (CONF:1098-31841) such that it
	1. SHALL contain exactly one [1..1] [Nutrition Recommendation](#E_Nutrition_Recommendation) (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.130) (CONF:1098-31864).
14. MAY contain zero or more [0..\*] entry (CONF:1098-32353) such that it
	1. SHALL contain exactly one [1..1] [Planned Immunization Activity](#E_Planned_Immunization_Activity) (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.120) (CONF:1098-32354).
15. MAY contain zero or more [0..\*] entry (CONF:1098-32887) such that it
	1. SHALL contain exactly one [1..1] [Goal Observation](#E_Goal_Observation) (identifier: urn:oid:2.16.840.1.113883.10.20.22.4.121) (CONF:1098-32888).

Figure 107: Plan of Treatment Section (V2) Example

<component>

 <section>

 <templateId root="2.16.840.1.113883.10.20.22.2.10" extension="2014-06-09" />

 <!-- \*\*\*\* Plan of Treatment Section V2 template \*\*\*\* -->

 <code code="18776-5" codeSystem="2.16.840.1.113883.6.1" codeSystemName="LOINC" displayName="Treatment plan" />

 <title>TREATMENT PLAN</title>

 <text>

 ...

 </text>

 <entry>

 <act classCode="ACT" moodCode="EVN">

 <!-- Handoff Communication template -->

 <templateId root="2.16.840.1.113883.10.20.22.4.141" />

 ...

 </act>

 </entry>

 <entry>

 <encounter moodCode="INT" classCode="ENC">

 <templateId root="2.16.840.1.113883.10.20.22.4.40" extension="2014-06-09" />

 <!-- Plan Activity Encounter V2 template -->

 ...

 </encounter>

 </entry>

 </section>

</component>

**Extracted from CCDA 2.1 – Aug. 2015**

**CARE PLAN FRAMEWORK**

A Care Plan (including Home Health Plan of Care (HHPoC)) is a consensus-driven dynamic plan that represents a patient’s and Care Team Members’ prioritized concerns, goals, and planned interventions. It serves as a blueprint shared by all Care Team Members (including the patient, their caregivers and providers), to guide the patient’s care. A Care Plan integrates multiple interventions proposed by multiple providers and disciplines for multiple conditions.

A Care Plan represents one or more Plan(s) of Care and serves to reconcile and resolve conflicts between the various Plans of Care developed for a specific patient by different providers. While both a plan of care and a care plan include the patient’s life goals and require Care Team Members (including patients) to prioritize goals and interventions, the reconciliation process becomes more complex as the number of plans of care increases. The Care Plan also serves to enable longitudinal coordination of care.

The CDA Care Plan represents an instance of this dynamic Care Plan at a point in time. The CDA document itself is NOT dynamic.

Key differentiators between a Care Plan CDA and CCD (another “snapshot in time” document):

Requires relationships between various acts:

o Health Concerns

o Problems

o Interventions

o Goals

o Outcomes

• Provides the ability to identify patient and provider priorities with each act

• Provides a header participant to indicate occurrences of Care Plan review

Please see Volume 1 of this guide to view a Care Plan Relationship diagram and story board.

**Gory details…**

1. Conforms to US Realm Header (V3) template (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.1.1:2015-08-01).

2. SHALL contain exactly one [1..1] templateId (CONF:1198-28741) such that it

a. SHALL contain exactly one [1..1] @root="2.16.840.1.113883.10.20.22.1.15" (CONF:1198-28742).

b. SHALL contain exactly one [1..1] @extension="2015-08-01" (CONF:1198-32877).

3. SHALL contain exactly one [1..1] code (CONF:1198-28745).

a. This code SHALL contain exactly one [1..1] @code="52521-2" Overall Plan of Care/Advance Care Directives (CONF:1198-28746).

b. This code SHALL contain exactly one [1..1] @codeSystem="2.16.840.1.113883.6.1" (CodeSystem:

This structuredBody **SHALL NOT** contain a Plan of Treatment Section (V2) (identifier: urn:hl7ii:2.16.840.1.113883.10.20.22.2.10:2014-06-09) (CONF:1198-31044).