**Care Plan Minutes**

 **August 3, 2016**

**Attendees:**

 Laura Heermann Langford

 Lisa Nelson

 Stephen Chu

 Evelyn Gallegos

 Emma Jones

**Agenda/Minutes**

Review of the spreadsheet comparing the CP DAM to FHIR resources that could be used to instantiate the DAM.

The following topics were discussed and need further discussion in future meetings.

1. Need to clarify distinction between FHIR Care Plan Resource and C-CDA Care Plan Document. Is the intent of FHIR resource to capture and share 'snippets' of dynamic data needed to support care planning 'process' not care plan document exchange? While C-CDA document template is focused on capturing and exchange care plan data within 'container' or document as a static or snapshot of time. C-CDA Care Plan document serves as an 'output' of the care planning process. Care Plan DAM is the underlying information model both FHIR and C-CDA Care Plan support.
2. We need to understand how the definition of the Care Plan resource compares to the view that Evelyn was discussing regarding this question.  This definition does not seem consistent with the understanding that the Care Plan resource just represents “snippets” of the care plan.  More clarity is needed to develop a common shared understanding.

Resource CarePlan - Content 

|  |  |  |
| --- | --- | --- |
| [Patient Care](http://www.hl7.org/Special/committees/patientcare/index.cfm) Work Group | [Maturity Level](http://hl7-fhir.github.io/resource.html#maturity): 1 | [Compartments](http://hl7-fhir.github.io/compartmentdefinition.html): [Patient](http://hl7-fhir.github.io/compartment-patient.html), [Practitioner](http://hl7-fhir.github.io/compartment-practitioner.html), [RelatedPerson](http://hl7-fhir.github.io/compartment-relatedPerson.html) |

Describes the intention of how one or more practitioners intend to deliver care for a particular patient, group or community for a period of time, possibly limited to care for a specific condition or set of conditions.

9.3.1 Scope and Usage 

Care Plans are used in many of areas of healthcare with a variety of scopes. They can be as simple as a general practitioner keeping track of when their patient is next due for a tetanus immunization through to a detailed plan for an oncology patient covering diet, chemotherapy, radiation, lab work and counseling with detailed timing relationships, pre-conditions and goals. They may be used in veterinary care or clinical research to describe the care of a herd or other collection of animals. In public health, they may describe education or immunization campaigns.

This resource takes an intermediate approach to complexity. It captures basic details about who is involved and what actions are intended without dealing in discrete data about dependencies and timing relationships. These can be supported where necessary using the extension mechanism.

The scope of care plans may vary widely. Examples include:

* Multi-disciplinary cross-organizational care plans; e.g. An oncology plan including the oncologist, home nursing staff, pharmacy and others
* Plans to manage specific disease/condition(s) (e.g. nutritional plan for a patient post bowel resection, neurological plan post head injury, pre-natal plan, post-partum plan, grief management plan, etc.)
* Decision support-generated plans following specific practice guidelines (e.g. stroke care plan, diabetes plan, falls prevention, etc.)
* Definition and management of a care team, including roles associated with a particular condition or set of conditions.
* Self-maintained patient or care-giver authored plans identifying their goals and an integrated understanding of actions to be taken

Note that this resource represents a specific plan instance for a particular patient or group. It is not intended to be used to define generic plans or protocols that are independent of a specific individual or group. I.e. It represents a specific intent, not a general definition. Protocols and order sets will be supported through future resources.

This resource can be used to represent both proposed plans (for example, recommendations from a decision support engine or returned as part of a consult report) as well as active plans. The nature of the plan is communicated by the status. Some systems may need to filter CarePlans to ensure that only appropriate plans are exposed via a given user interface.