Care Plan: What Is It?

Definition: A road map of goals and tasks developed for each unique client in order to facilitate retention in care and viral suppression. How do you and the client plan to tackle stated goals??

- Developed by the case manager AND the client
- Updated with outcomes and revised or amended in response to changes in circumstances or goals (minimum of every 6 mo)
- Tasks, referrals, and services should be updated as they are completed

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Care Plan: What Is It?

Common Terms..

- Definition: A plan of attack developed and agreed upon by a case manager and their client.
- Designed to help a client navigate their care and/or achieve and maintain viral suppression.
- Justification for putting a client under case management, receiving assistance from you specifically.

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Care Plan: Components

Common Terms..

- When you create a plan of attack it can't just state what your goal is. You need to know which specific steps to take in order to get where you want to be.

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SMART GOALS

Care Plan: Components

- Problem Statement (need)
- Goals (no more than three at a time)

- Intervention
  - Tasks
  - Referrals
  - Service deliveries

- Individuals responsible for activity
- Anticipated time for each task

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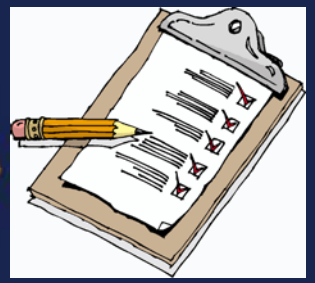
Referral and Follow-Up: Application

The creation of referrals for clients should be an organic, fluid process, informed by several sources:



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Care Plans=Case Notes?

What's the difference?

- *The progress of client and CM work done toward stated goals can be captured in case notes, updated and reflected to reflect progress made or challenges to work on. Case notes are the supporting documentation that you and the client are indeed making progress on the established care plan.

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CARE PLANS

CASE NOTES

Care Plan: Where Is It?

- The care plan should reside in the primary client record of choice at your agency.

The most important factor here is CONSITSENCY. Client care plans should be filed (and updated) in the same place for everyone and should be easily accessible.

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Care Plan: Application

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Client Name and/or **ID Number:** _____ **Care Plan Date:** _____

Case Manager Name: _____ **Program:** Ryan White

NOTE: To automatically fit row height to cell contents, locate the row heading for the cell and double click the bottom line of the heading.

Care Plan Goal: **Need:** 1 _____ **Subneed:** 1 _____

	Tasks	Priority	Assigned to	Start date	Target date	Check-in	Outcome	Out. date
1								
2								
3								
4								
5								

Care Plan Goal: **Need:** 2 Mental Health Services **Subneed:** 2 Mental Health Services

	Tasks	Priority	Assigned to	Start date	Target date	Check-in	Outcome	Out. date
1								
2								
3								
4								
5								

Care Plan Goal: **Need:** 3 _____ **Subneed:** 3 _____

	Tasks	Priority	Assigned to	Start date	Target date	Check-in	Outcome	Out. date
1								
2								
3								
4								
5								

Client Name: _____ Case Manager Name: _____

Client Signature Date: Case Manager Signature: Date:

https://www.dshs.texas.gov/hivstd/contractor/cm.shtm

Performance Measures

- Clients must have a care plan that is developed and/or updated a minimum of two times during measurement year (for both MCM and NMCM clients).
- Client records must have documented issues noted in care plans that have ongoing case notes to match stated needs and progress.
- Care plans must reside in primary client record.

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Critical Thinking Scenarios

What would you do?

- Afte raining, you
  real asn't been updated
  in q hed base regularly
  via once in a while. He
  ass going well and he
  was medical
  app ordinated.

  Wha alization?

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