HIV Care Services Fundamentals Call #3
Q & A
HIV Care Plans

Facilitators: **Desty Muturi, DSHS, Trainer, Care Services Group**
Desty.Muturi@dshs.texas.gov

Anthony Lee, DSHS, Consultant, Care Services Group
Anthony.Lee@dshs.texas.gov

Liza Hinojosa, Project Coordinator, UT-Austin
Liza.hinojosa@austin.utexas.edu

Presentation Overview

Definition: Care plans are a road map of goals and tasks developed for each unique client in order to facilitate retention in care and viral suppression

- 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
- Designed to help a client navigate their care and/or achieve and maintain viral suppression.
- Care plan template – in an effort to eliminate barriers a client signature is no longer required.
- Care plans should reside in your agency's primary record of choice (e.g., paper file, EMS, ARIES) – client files should be updated and stored in the same place – consistency is key.
- Care plans should be in place for both MCM and NMCM clients.
- Case notes are not a substitute for a Care Plan.
- Care plans should be updated to reflect client's progress and new goals if applicable.
- If a client has accomplished all goals that require a case manager's assistance you should begin reviewing clients for graduation.
- Care plan performance measures:
    - Percentage of medically case managed clients who had a care plan developed to or more times in the measurement year

- Percentage of client records with documented issues noted in care plans that have ongoing case notes matching the stated needs and meeting the progress goals

Questions

1) If a client accomplishes a task before the anticipated time agreed on in the care plan, there is no need to review the care plan during next scheduled client visit? True of False

   Answer: Respondents correctly answered **False**

2) After a year with your client, you have both realized that the goals for the previous care plans are now accomplished and there is no real need to keep meeting to update them. Your client is now confident in navigating their HIV care alone. However, they have requested to keep working with you for the occasional help they might need (making a referral to an unknown physician, getting bus passes, etc.). What do you do? Responses received included:

   a. Close care plan, graduate from CM and refer to a PN.
   b. Clients can graduate from case management yet still access referral services as needed.
   c. Graduate from MCM and assist with NMCM (for example provide a needed referral).
   d. Provide referrals as needed...change to NMCM or graduate to case management not indicated.
   e. Explain CM services to the client and further explain that graduation does not mean they wouldn't have access to staff to review needs and assist with needs as appropriate.
   f. At our agency in these situations we would do a stepping stone process and graduate them to NMCM first, then to a referral as needed.
   g. Case management not indicated.
   h. We as case managers have to complete all eligibility, ADAP, medical and non-medical referrals so most of the time we cannot graduate any clients.
   i. You can graduate people from case management even if you have to help them out occasionally.

ALL OF THE ABOVE ARE CORRECT ANSWERS. USE YOUR KNOWLEDGE OF THE CLIENT SITUATION TO CHOOSE FROM THE ABOVE IN THIS SCENARIO

3) Does a client need to be graduated annually?

   Answer: There is nothing that says a client should be graduated annually. Instead, clients should be graduated whenever they have achieved all goals in their care plans *and* can navigate their HIV care/maintain viral suppression by themselves.

4) We scan our care plans into an electronic record system and shred the original document. Other than case notes, how do we document when a goal has been met as we do not have a paper form to hand write goal completion dates?

   Answer: You can always transfer your paper case notes into the ERS you use as a primary client record, after you have performed the service in your day to day work. The same goes for any case notes typed up in your computers.

5) Does the Acuity Tool need to be completed to graduate them?

   Answer: Acuity tools should be regularly updated as a course of MCM specific clients (a minimum of every three months). As the tool should be updated frequently, it can help indicate when case closure is necessary.

6) During our recent site visit, Germain indicated to us that even a client who is graduated from all CM services must have a care plan. Is this correct?

   Answer: This is a misunderstanding. Germane is consistent with DSHS standards of care, which state that care plans are case management specific requirements.

7) We talked extensively with Germain about the need for a care plan in order graduated people. What we were told that was true, however, if we labeled those folks as referral for health services then they don't need it?

   Answer: This is correct. Clients who qualified to graduate case management, but still need assistance with referrals can be assisted with Referral for Healthcare service category. These clients do not require care plans.

8) What are the populations that are automatically qualified for case management? Answer:

   a. pregnant women
   b. medically fragile clients (acute?)
   c. clients with active untreated mental health

9) One question I hear is care plans and on-going referrals. Do all referrals have to be in the care plan? Especially referrals such as transportation (bus passes, etc.), food bank (voucher, card).

   Answer: Yes. The care plan is a living document that should be updated and changed as case management progress and client goals are achieved. Referrals are part of this process and should be reflected and updated/tracked in the care plan and/or attached case notes.

Next Call: Tuesday, October 30th
1:00 p.m. – 2:00 p.m.