MODULE FIVE

Comprehensive Care Plan

POLICY

A comprehensive medical case management plan is to be developed, by the medical case manager and client, after the intake process and needs assessment have been completed. The needs assessment information and care plan are reported in ARIES and should describe and prioritize the client's medical concerns, treatment adherence issues, mental health and substance abuse needs, and other support service needs e.g. housing, food, transportation and the steps that will be taken to address and mitigate the impact of these issues.

The care plan should be developed with and agreed upon by the client and include realistic goals and tasks to be completed to address the problems named in the plan.

The Care Plan should be updated as goals are met and addressed with a full review at least once every 6 months.

MINIMUM REQUIREMENTS

At a minimum a Care Plan is to include the following:→

- Identifying client's issues, problems or concerns related to medical care, medication adherence and other issues, based upon the needs assessment. Priorities will be set to address the needs, e.g. making and keeping appointments, talking with doctors, following medication instructions, etc.
- Identifying services that the client is already receiving.
- Setting measurable and realistic objectives aimed at meeting the client's needs.
- Specifying the intended actions for meeting each goal.
- Identifying and documenting resources, other care providers, and/or agencies for referrals/linkage that will be accessed in order to meet objectives.
- Setting a timetable that will measure progress towards meeting the objective.
- Identifying potential problems and/or barriers to meeting goals.
- Assisting with implementing the plan through consultation, counseling, advocacy, coordination and referrals/linkage.
- Monitoring of the care plan followed by the implementation of any necessary modifications to the care plan. Documented in case notes and plan updates.
- Updating the care plan as goals are met with a full review at least once every six months. Care plans should be adjusted for the client's changing needs.

PROCEDURE

Care Plan Step 1 – Develop a care plan with the client

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Within two weeks of initial intake and needs assessment:

- Meet with client face-to-face.
- Begin developing care plan goals and tasks based on priorities set with the client during the intake and needs assessment process (see Appendix for sample goals and tasks).

Note: All clients at Contra Costa Regional Medical Center (CCRMC) should be enrolled in the appropriate early intervention program and may have an existing care plan. Coordination and case conferencing are important for implementing the medical treatment plan and coordination of care plan goals.

Care Plan Step 2 – Review the care Plan process with the client

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- Discuss and review the role of a care plan to assure client self-determination.
- Explain the Medical Case Manager and Client role in achieving goals and reducing barriers or obstacles to care plan achievement.
- Discuss what could happen if clients are not working towards the goals in their care plan, e.g. negative impact on health, limited access to Emergency Financial Assistance (EFA), etc.
- Create an understanding that the care plan serves as a guide and an agreement on what the client and medical case manager agree to work towards.
- Use the Care Plan Worksheet in the Appendix to capture the Care Plan information for ARIES.

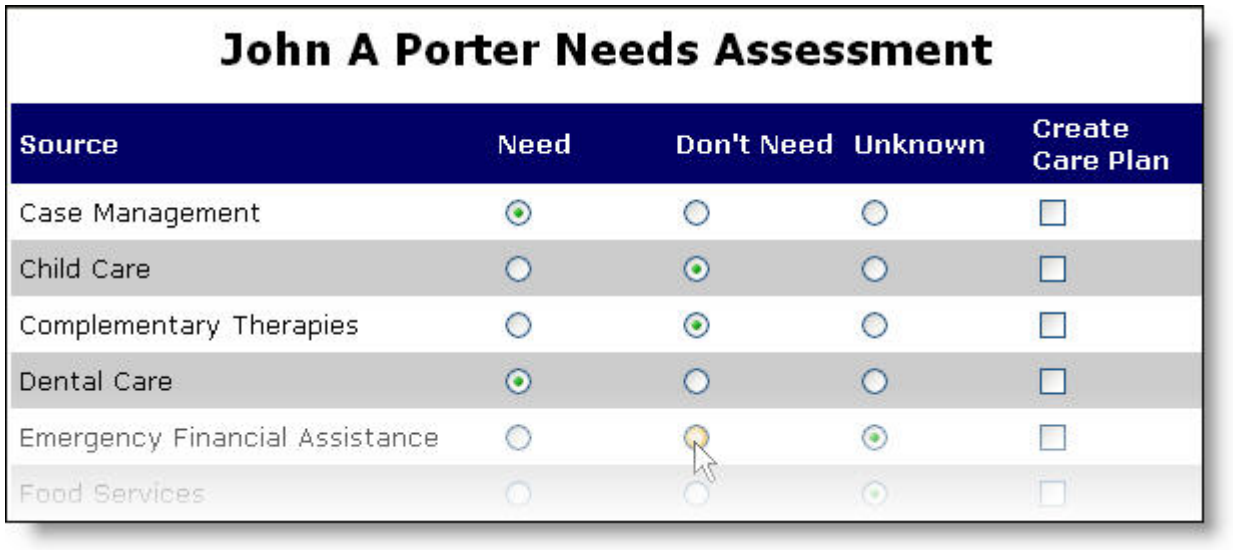
ARIES Care Plan Instructions

Medical Case Managers will use the needs assessment information to design the care plan goals and tasks to be accomplished to meet the client's identified needs.

These care plan tasks can include instructions for caregivers, tasks for staff persons and/or clients, referrals, and services. Medical case managers can track a client's progress with care plans to ensure quality care.

Steps for Creating Care Plans in ARIES

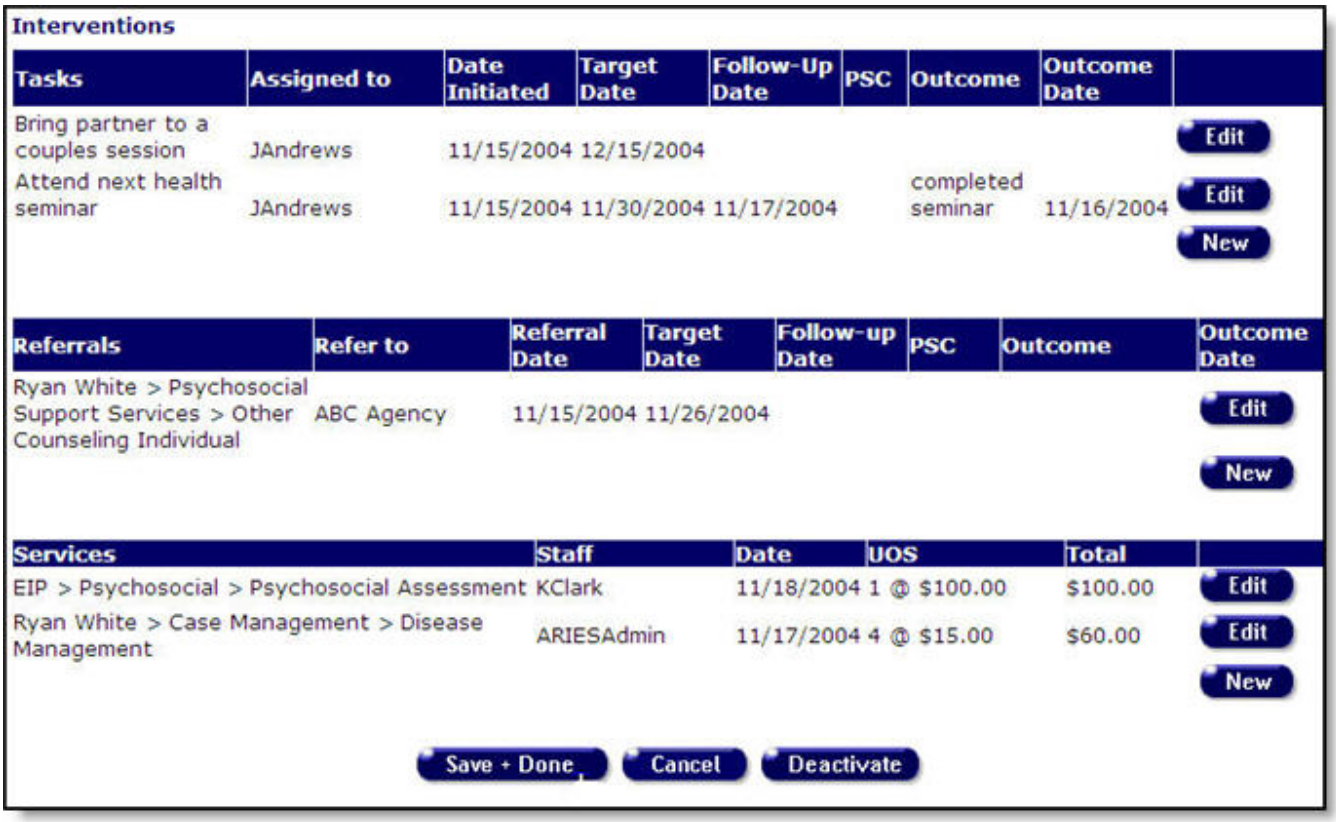
1. When selecting the care plan tab the needs assessment screen will appear. Click New button and you may start entering into ARIES the needs assessment information you gathered in Module 4. From this screen (see below), choose the needs for which you will develop care plans. ARIES will generate care plan templates for these needs.



John A Porter Needs Assessment

Source	Need	Don't Need	Unknown	Create Care Plan
Case Management	◉	○	○	☐
Child Care	○	◉	○	☐
Complementary Therapies	○	◉	○	☐
Dental Care	◉	○	○	☐
Emergency Financial Assistance	○	◉	○	☐
Food Services	○	○	○	☐

2. By selecting save and next at the bottom of the screen above, you will be sent to the care plan edit screen. At this screen you can input intervention tasks, referrals and services. The first table lists the tasks to be performed. To edit a current task, click the Edit button to the right of a task. To create a new task, click the new button. When you edit referrals and services through this screen, you will be directed to the referrals and services screen with each entry being linked to this care plan. (See Module 9: Referrals to Other Services for additional information).



Interventions

Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date	
Bring partner to a couples session	JAndrews	11/15/2004	12/15/2004					Edit
Attend next health seminar	JAndrews	11/15/2004	11/30/2004	11/17/2004		completed seminar	11/16/2004	Edit
								New

Referrals	Refer to	Referral Date	Target Date	Follow-up Date	PSC	Outcome	Outcome Date	
Ryan White > Psychosocial Support Services > Other Counseling Individual	ABC Agency	11/15/2004	11/26/2004					Edit
								New

Services	Staff	Date	UOS	Total	
EIP > Psychosocial > Psychosocial Assessment	KClark	11/18/2004	1 @ $100.00	$100.00	Edit
Ryan White > Case Management > Disease Management	ARIESAdmin	11/17/2004	4 @ $15.00	$60.00	Edit
					New

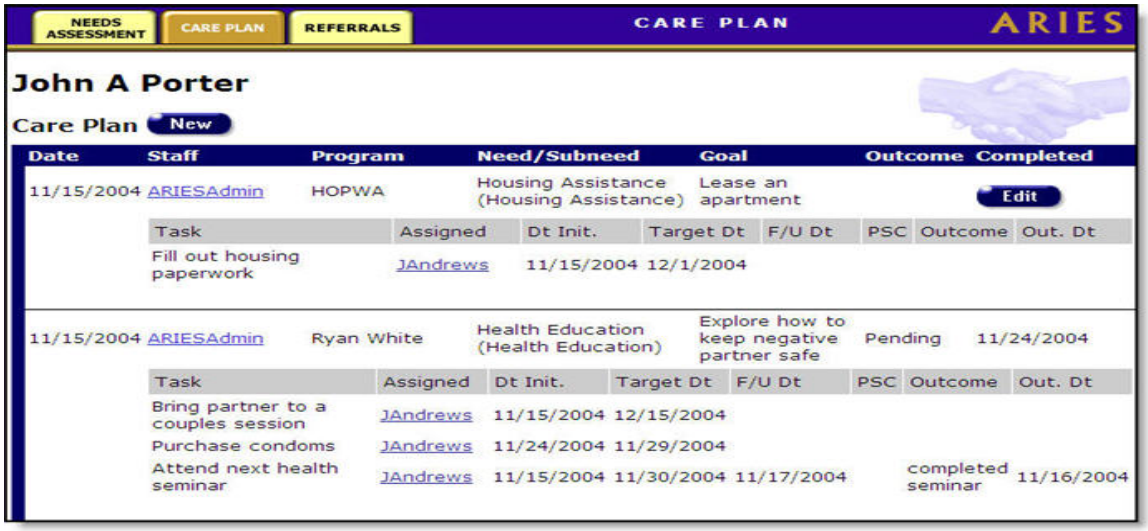
Save + Done Cancel Deactivate

The tasks table includes:

Task	The task related to the care plan. This includes any individual tasks assigned to staff persons and/or clients. Also, it includes referrals and services for the client.
Assigned	The person the task is assigned to (staff, client or other, e.g., care giver).
Date Initiated	The date the task was initiated.
Target Date	The target date of the task's completion.
F/U Date	If the case manager has entered follow-up information, when this information was entered.
PSC	Payment source code.
Outcome	The outcome of the given task. If this task has not yet been completed, this entry will be blank.
Outcome Date	When the outcome was achieved. If the outcome has not yet been achieved, the Edit button displays.

3. You can also access and create a care plan directly from the care plan tab by selecting new.

4. The Care Plan screen lists the client's existing care plans in a table. Each care plan includes the date it was created and who created it in the first two columns.



5. The Need/Subneed column lists the reason for the care plan. For example, if a client needs dental health services for a root canal, the need would be listed as Dental Care, and the subneed might be Oral Surgery. The Goal column lists the anticipated outcome of the care plan. For example, if a client needs employment assistance, their goal would be, "Find client a full-time job." The Completed column lists when the care plan ended and the Outcome lists whether or not the goal was achieved. The example above includes a Housing Goal with the need defined as Housing Assistance and the Goal: to lease an apartment.

6. Each care plan includes a list of tasks and services listed in a gray table underneath each care plan row. In the example above, the task for the housing goal is to fill out the housing paperwork. For the second goal: Explore how to keep negative partner safe to address the Health Education need, the defined tasks include bringing the partner in for risk reduction counseling, purchasing condoms, and attending health seminar. Tasks would be listed under one single care plan as they relate to the goal and each task can be assigned to a specific person.

7. Once a care plan outcome has been entered, whether the goal was reached or not, it cannot be edited further in this screen.

8. To edit a care plan, click the Edit button to the right of the care plan entry. To enter a new care plan, click the New button. Both actions take you to the *Care Plan Edit* screen. From the edit screen you can enter specific information about task assignments, dates, outcomes, etc. See below for specific guidance for these ARIES fields.

Care Plan Edit Instructions / Definitions

"**Date Need Identified**": The date the client's need was identified. (MM/DD/YYYY)

"**Date Completed**": field empty until the care plan has been completed. This should be entered in a subsequent follow-up.

"**Staff**": select the staff person who will be managing this care plan.

"**Outcome**": Use the pull-down menu within the care plan edit screen to select the term most nearly describing the progress made towards achieving the goal. ***Do not select an option from the drop-down list until the referral is completed. Once you select an outcome, the referral cannot be edited further.*** The Outcome drop down menu includes the following options:

Completed	The goal was achieved.
Pending	The goal has not yet been achieved and the client's services have not been administered.
Some Progress	The client has partially achieved the goal and is no longer continuing services.
Cancelled	The client's services have been halted and their care plan has been cancelled.
Unfunded	The client's services have ended due to lack of funding of the contract or because the contract has expired.
Not available in area	Services necessary to achieve the goal were not available.
Completed Substance Abuse Program	If the client's needs are related to substance abuse and the client has completed a treatment program.

"**Program**": select the program from which the services of the care plan will be covered. For example, if the client is receiving mental health services under a contract funded by Ryan White funds, select "Ryan White."

"**Need**": (If you are accessing this screen after performing a needs assessment, the drop-down list will already be prefilled). Otherwise, select which need most accurately addresses the care plan. **"if other":** Enter the appropriate agency/person receiving the referral in the text field.

"**Subneeds**": needs related to the primary need. Example: If a client needs dental health services for a root canal, the need would be listed as Dental Care and the sub-need might be oral surgery.

"if other": Enter the appropriate agency/person receiving the referral in the text field. Some needs and sub-needs require assistance from outside agencies and specialists. Indicate in this field: the person or agency the client was referred to for further assistance.

"**Goal**": enter the overall objective that addresses the client's need. For example, if the client's need is housing, the goal might be "Get the client an apartment."

9. As clients complete care plan goals, return to the "edit" screen and complete the "Date Completed" field and the "Outcome" from the drop down menu below.

Completed	The goal was achieved.
Pending	The goal has not yet been achieved and the client's services have not been administered.
Some Progress	The client has partially achieved the goal and is no longer continuing services.
Cancelled	The client's services have been halted and their care plan has been cancelled.
Unfunded	The client's services have ended due to lack of funding of the contract or because the contract has expired.
Not available in area	Services necessary to achieve the goal were not available.
Completed Substance Abuse Program	If the client's needs are related to substance abuse and the client has completed a treatment program.

10. To create new ARIES Care Plans, return to step 3 on page 6.

Care Plan Step 3 – After ARIES Care Plan Entry - Finalize the Care Plan with the Client →

- Print the care plan from ARIES and have the client and Medical Case Manager sign and date the agreed upon care plan.
- File the signed and dated paper Care Plan in the physical client file.
- Additional detail about the work with the client should be recorded in the case notes.
- Service units should be entered in ARIES for this activity.

Care Plan Step 4 – Follow-up Regularly with the Client →

- Record progress toward achieving the tasks and goals in ARIES during each client contact as appropriate.
- A full review of the Care Plan must be completed at least every six months.
- Ensure that all referrals made have outcomes recorded. Consult with providers if the outcome is unclear. (See Module 9: Referrals for Other Services for more information).