TEXAS
Health and Human Services

Texas Department of State Health Services

Care Plan Review

DSHS RW Part B Case Management

Reven Patlan Jr, MSSW - Training Specialist, DSHS HIV Care Services Group

Learning Objectives

- Review care plan requirements for Medical and Non-Medical Case Management per DSHS service standards
- Review the TCT Care Plan screen and process of creating a care plan
- Review FAQs for Case Management (+TCT Demo)

Case Management Standards

- Medical Case Management (including Treatment Adherence Services) | Texas DSHS
- Non-Medical Case Management | Texas DSHS

Requirements:

- Initial comprehensive assessment
- Acuity Screening (required for MCM only)
- Viral Suppression/Education (MCM)
- **Care Plan**
  - (Treatment adherence and Viral Suppression for MCM)
- Referral and follow-up
- Case Closure

Care Plans

Care Plan Review

A care plan is required for clients receiving services through Ryan White Part-B funded Medical and Non-Medical Case Management. A Care Plan is a mutually developed living document that assist both clients and case managers with tracking progress towards goals (with viral suppression being a primary goal of medical case management).

A care plan should be updated with outcomes of interventions and revised or amended in response to changes in the client's life circumstances or goals.

Regular "case notes" or "progress notes" should describe the progress toward meeting care plan goals by documenting progress in approved electronic health records OR by utilizing the "Case Notes" screen in Take Charge Texas.

Care Plan - Contents

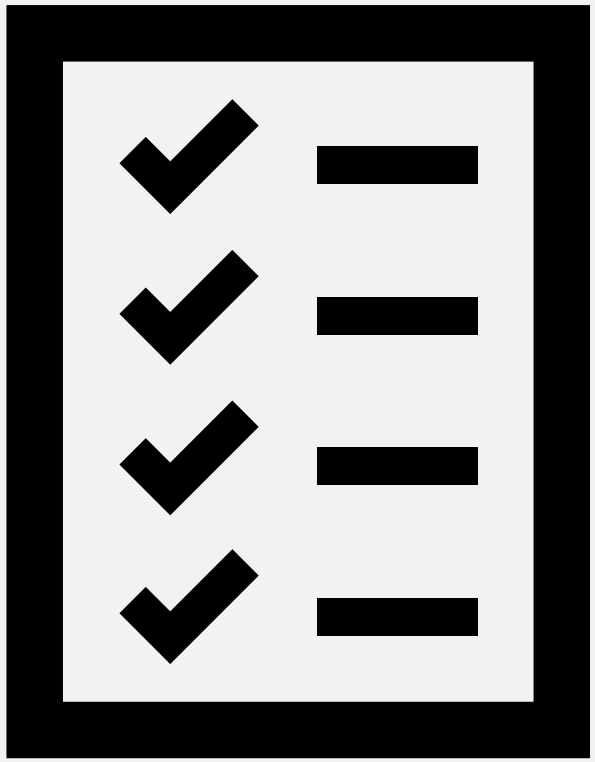
- Problem Statement (need)
- Goals (Case managers should focus on no more than three goals at a time in order to not overwhelm clients with tasks)

- Intervention
  - Tasks
  - Referrals
  - Service deliveries

- Individuals responsible for activity
- Anticipated time for each task

Care Plan Review

- The care plan is updated with outcomes and revised or amended in response to changes in client life circumstances or goals, at a minimum, **every six (6) months.**
- Again, tasks, referrals, and services should be updated as they are identified or completed – not only at set intervals.



Care Plan: Where Is It?

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

TEXAS
Department of
State Health Services

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.

Care Plan: Application

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

Care Plan Performance Measures

Percentage of clients with a care plan that contains all of the following:

a. Problem statement or need
b. Goal(s)
c. Intervention (tasks, referral, service delivery)
d. Responsible party for the activity
e. Timeframe for completion

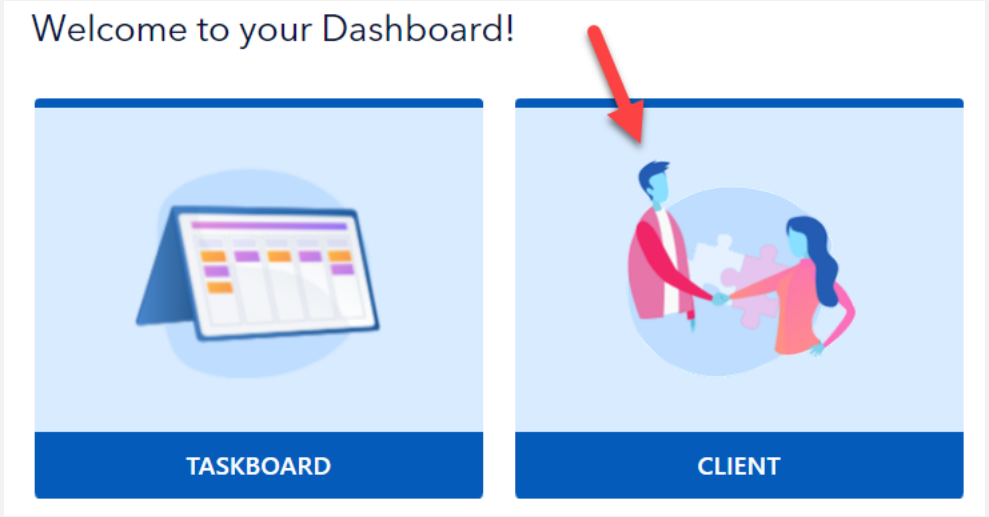
Percentage of clients with care plans that have been updated at least every 6 months.

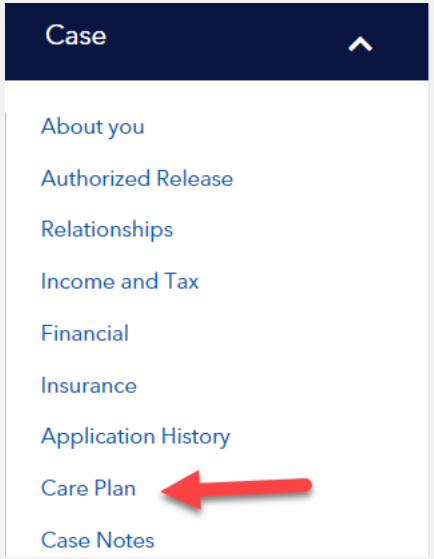
Percentage of client records with case notes that document the progress towards meeting goal(s) identified in the care plan.

Creating a Care Plan

Updates to TCT Care Plan Screen

Once logged in, select a client and navigate to the Care Plan screen under the “Case” column on the left navigation panel:





Care Plan

A care plan is required for clients receiving services through Ryan White Part-B funded Medical and Non-Medical Case Management. A care plan should be updated with outcomes of interventions and revised or amended in response to changes in the client's life circumstances or goals. Tasks, referrals, and services should be updated as they are identified or completed, and not at set intervals. Regular case notes or progress notes should describe the progress toward meeting care plan goals by utilizing the "Case Notes" screen in Take Charge Texas or other approved electronic health records. Case managers should focus on no more than three goals at a time in order to not overwhelm clients with tasks.

Care plans must be updated at minimum every 6 months, with documentation that all required elements (problem statement/need, goals, interventions, responsible party, and timeframe) have been reviewed and, if appropriate, revised.

Create a mutual goal with the client that addresses a need or barrier that is specific, measurable, achievable, relevant, and time-bound (SMART goals). Enter that goal into the care plan goal name and click "Add Care Plan Goal" (You can edit this later under the "Care Plan Actions" column)

Care Plan Goal Name

Add Care Plan Goal

Care Plan Goal Name	Problem Statement (Need)	Plan Details	Status	Care Plan Actions

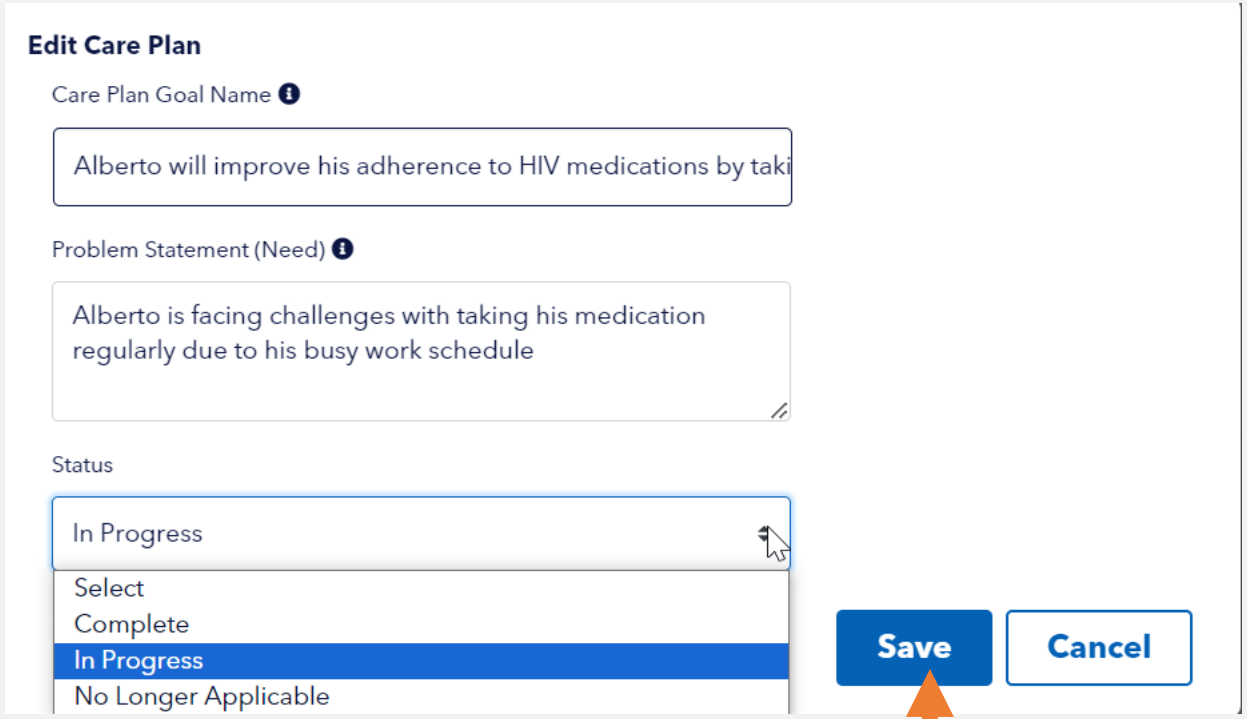
Save Changes

For this example, we will create a goal to address medication adherence challenges the client and case manager have identified.

TEXAS Health and Human Services

Texas Department of State Health Services

Clicking on the "Add Care Plan Goal" button will present this pop up where you can edit the Care Plan Goal Name and add the Problem Statement (need). Once you have added the Goal and Problem statement, you can use this screen to update the status of this goal, as shown below.



Click "Save" once completed and you will see a confirmation banner at the top of the Care Plan Screen

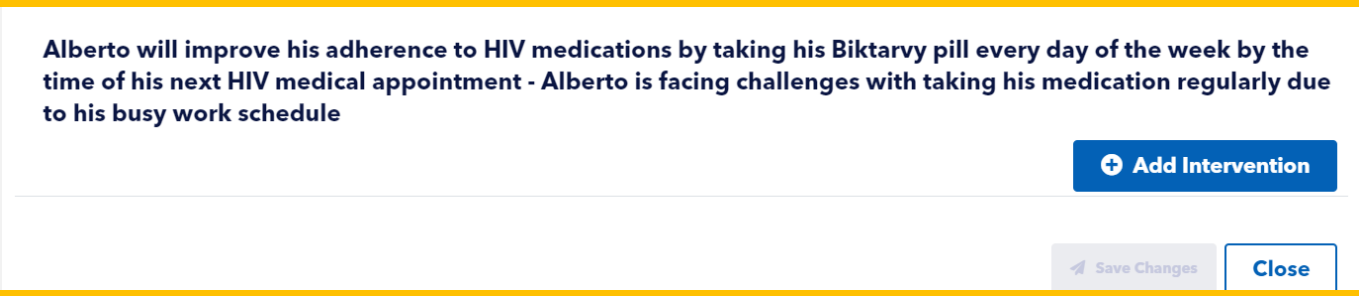
Once your changes are saved, you will see the Goal and Problem Statement as shown below. Adding additional goals will be displayed as in the below example
Click on "Plan Intervention Details" to add interventions and tasks to address the stated goals and needs.

Care Plan Goal Name	Problem Statement (Need)	Plan Details	Status	Care Plan Actions
Demo Goal 2	Demo Problem 2	Plan Intervention Details	In Progress	Edit Plan Delete Plan
Demo Goal 1	Demo Example 1	Plan Intervention Details	In Progress	Edit Plan Delete Plan
Alberto will improve his adherence to HIV medications by taking his Biktarvy pill every day of the week by the time of his next HIV medical appointment	Alberto is facing challenges with taking his medication regularly due to his busy work schedule	Plan Intervention Details	In Progress	Edit Plan Delete Plan

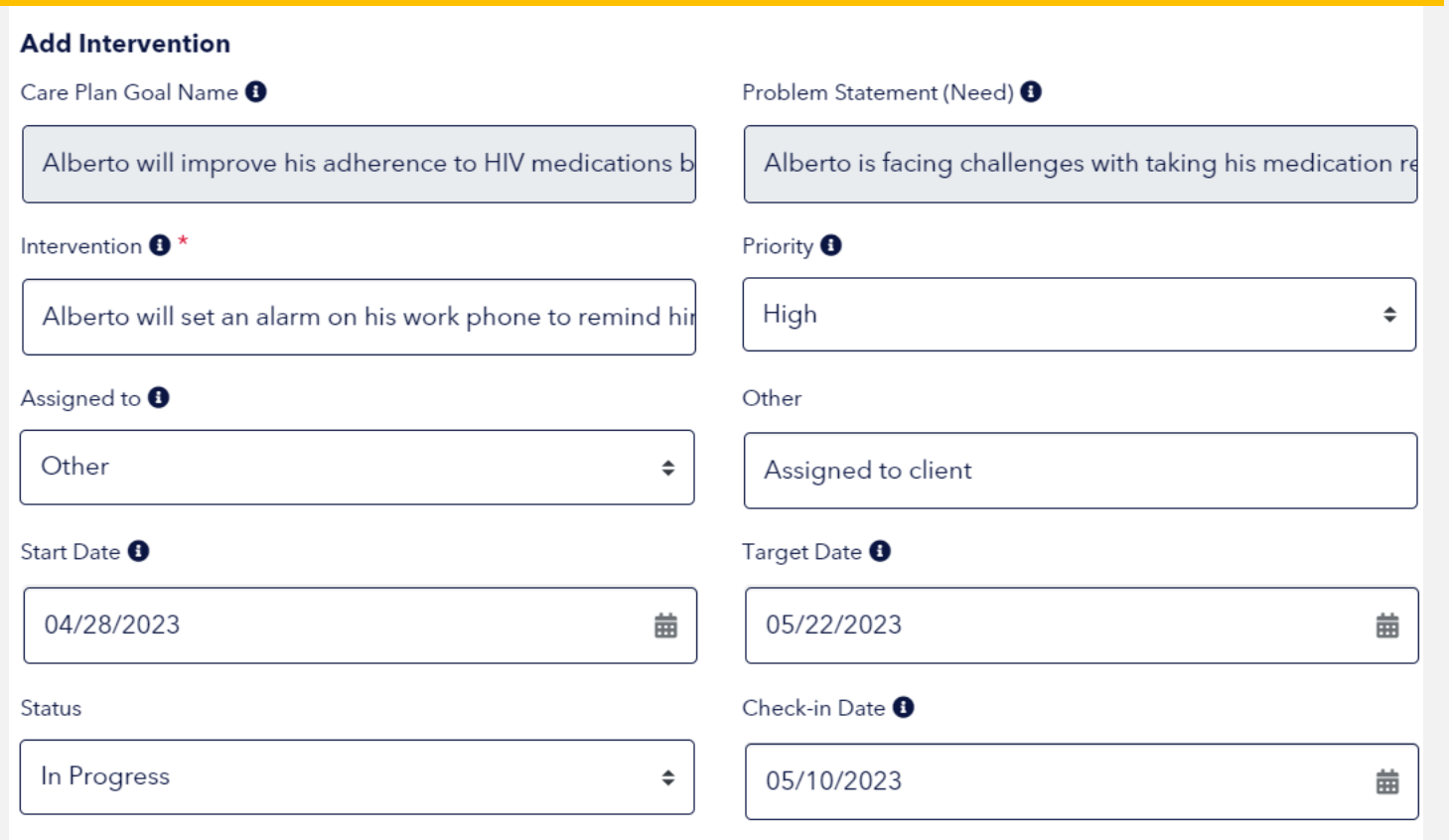
Note: Adding a fourth goal while there are three goals "In Progress" will result in the error message below

TEXAS Health and Human Services
Texas Department of State Health Services

Clicking on "Plan Intervention Details" will display the below pop-up. Click on "Add Intervention" to list out tasks or activities to be completed to achieve the goal.



Begin filling out the fields to both identify the intervention and reflect the status and outcome



TEXAS Health and Human Services

Texas Department of State Health Services

Once there has been an outcome or check-in, you can document this in the "Outcome" fields below. Add any additional information in the "Notes" section that could be helpful with tracking. A "last updated" filed will display the last time the record was edited by a TCT user. Click "Save" to update the intervention/task.

TEXAS Health and Human Services

Texas Department of State Health Services

Note: "Interventions" are actions taken to address a need or barrier the client is facing related to their health and wellbeing. This may look like a referral, a check-in, a reminder, etc. Evidence based "interventions" should be used when appropriate but are not exclusively the interventions listed in a care plan.

Your intervention will now be shown under the related goal on the Intervention Screen as shown below. Collaborate with the client to identify additional interventions that will help achieve the identified goal. Click on "Add Intervention" to add additional tasks and interventions. You can edit each intervention by clicking "Edit Intervention" in the "Intervention Actions" column. Click "Save Changes" to ensure your work is saved in TCT.

Alberto will improve his adherence to HIV medications by taking his Biktarvy pill every day of the week by the time of his next HIV medical appointment - Alberto is facing challenges with taking his medication regularly due to his busy work schedule

Add Intervention

Intervention	Priority	Assigned To	Start Date	Target Date	Check-in Date	Outcome	Outcome Date	Updated By	Last Updated	Status	Notes	Intervention Actions
Alberto will set an alarm on his work phone to remind him to take his medication.	High	Assigned to client	04/28/2023	05/22/2023	05/10/2023	In progress		00000337509	08/29/2023 10:47 AM	In Progress		Edit Intervention Delete Intervention

Save Changes Close

TEXAS Health and Human Services

Texas Department of State Health Services

Export to a File (PDF, Excel, Word)

Care Plan Goal Name	Problem Statement (Need)	Plan Details	Status	Care Plan Actions
Demo Goal 2	Demo Problem 2		In Progress	
Demo Goal 1	Demo Example 1		In Progress	
Alberto will improve his adherence to HIV medications by taking his Biktarvy pill every day of the week by the time of his next HIV medical appointment	Alberto is facing challenges with taking his medication regularly due to his busy work schedule		In Progress	

FAQ – Case Management

Are care plans only updated and reviewed every 6 months?

No.

Care plans should ideally be reviewed and updated as progress towards goals and interventions are met. ***At minimum*** care plans should be updated every six months.

Note for MCM: Acuity screening is required for clients in **Medical Case Management**, and frequency of contact and updates to care plans should match the client's acuity score and need.

Are case/progress notes and the care plan the same thing?

No.

The Care Plan is a living document to help keep track of progress towards specific goals and needs that impact the client's care and well-being. Care plans should be updated as progress towards goals and interventions are met.

Progress notes document the ongoing work you are doing with your clients and contain much more information. Case/progress notes supplement the care plan, and a progress note should be completed for each meeting with you client (depending on your agency procedures).

It is encouraged to reduce duplication of case managers documentation when possible. A care plan note indicating a need for follow up may state: "see case note for additional details" vs. documenting the details in both the care plan and case notes. Case notes and Care Plans should be kept in the Primary Client Record.

I already complete a care plan using my agency EHR. Do I still have to input the care plan into TCT?

No.

The care plan should exist in the Primary Client Record. If your agency uses an approved care plan document or electronic record, then you do not need to use TCT for your care plan. However, **all clients in case management MUST have a care plan.** Ensure that any care plan documents or electronic records capture the required information as indicated by the DSHS Standards of Care.

TCT can be used by agencies that do not have electronic health systems and would like to have a centralized system of documentation. The same is true for case/progress notes.

Do clients have to be case managed to receive HIV medical care?

No.

Medical Case Management is a service based on need and is not appropriate or necessary for every client accessing services. Medical Case Management is designed to **only** serve individuals who have complex needs related to their ability to access and maintain HIV medical care.

Medical Case Management should NOT be used as the only access point for medical care and other agency services.

When clients can maintain their medical care, clients should be graduated. Clients with ongoing existing need for Treatment Adherence support due to mental illness or other documented behavioral disorders meet the criteria for Medical Case Management services.

Can a client receive referrals through both RFHC and MCM/NMCM?

Technically yes, however:

Referrals for health care and support services **provided during a case management visit** (medical and non-medical) should be reported in the appropriate case management service category (i.e., Medical Case Management or Non-Medical Case Management)

Referrals are a natural part of case management; the **Referral for Healthcare** service category should **not** be used for referrals that occur through case management services.

Funds cannot be used to duplicate referral services provided through other service categories. "*Double dipping*" or billing twice for the same service must be avoided!

Q&A

Any additional questions?

Thank you!

Care Plan Review

Reven Patlan, MSSW

Training Specialist, HIV Care Services Group

Ruben.Patlan@dshs.Texas.gov