Care Planning

OBJECTIVES

At the end of this unit, participants will be able to:

- Understand approaches/models to use in care planning
- Practice creating a care plan by using templates
- Discuss successes and challenges of care planning with colleagues
- Understand strategies to address challenges

INSTRUCTIONS

1. Before the session, review the PowerPoint slides and handouts.
2. Welcome participants and review objectives (slide 2).
3. Describe the components of a care plan (slides 3–4). Clarify that many agencies have their own format for care plans. Ask, "How many of you use a care plan at your agency? How similar or different is your agency care plan to the one on the slide?"
4. Distribute blank sample care plans (at least 2 per participant) and the Care Planning Case Scenarios (also on slides 5–6).
5. As a group, review the scenarios. Give participants time to create a care plan on their own or in pairs.
6. Distribute the handout RAP Documentation: Patient Case Notes and review the RAP model (slide 7).
7. Distribute the handout Gibbs Reflective Cycle. Walk through each step describing how these questions can help CHWs work with clients to identify and complete care plans (slide 8).
8. Wrap up. Review the questions and facilitate a brief group discussion (slide 9), encouraging the group to share additional points about care plan documentation.

Related C3 Roles

Care coordination, case management, and system navigation; providing coaching and social support; providing direct service; implementing individual and community assessments

Related C3 Skills

Interpersonal and relationship-building skills, communication skills, service coordination and navigation skills, capacity building skills, individual and community assessment skills, outreach skills

Method(s) of Instruction

Lecture, group discussion, demonstration

Facilitator's note: This session can also be conducted virtually as a webinar. It can easily be adapted if you have a platform such as Zoom or Skype and participants have access to a computer. If conducting as a webinar, allow 10 minutes to test the technology and aid participants in connecting.

Estimated time

60 minutes

Key Concepts

Care plans, documentation, consultations, team, client-centered care

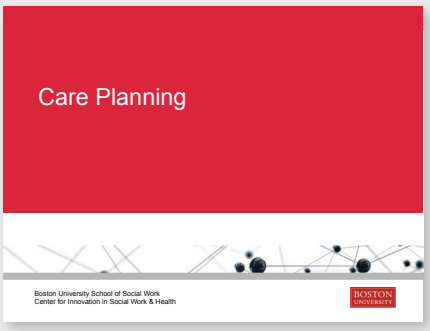
Materials

- Computer with internet access and projector
- PowerPoint slides

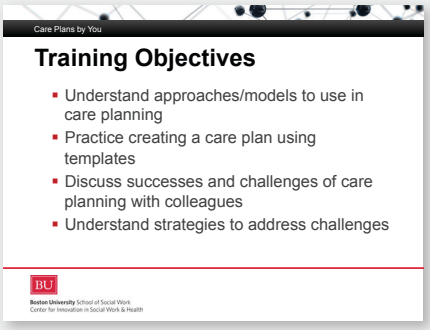
Handouts

- Sample Care Plan I
- Sample Care Plan II
- Care Planning Case Scenarios
- RAP Documentation: Patient Case Notes
- Gibbs Reflective Cycle

Care Planning

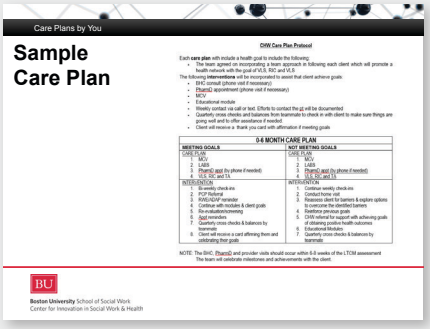


SLIDE 1



SLIDE 2

Review the slide.

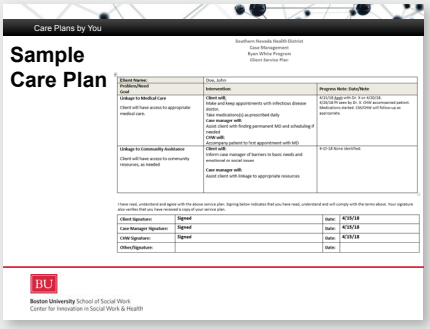


SLIDE 3

Review the slide and answer questions.

Ask, "How many of you use a care plan at your agency? How similar or different is your agency care plan to the one on the slide?"

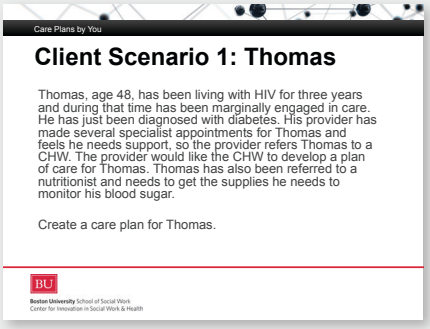
Facilitate a brief discussion.



SLIDE 4

Review the slide.

Distribute two blank sample care plans and the handout Care Planning Case Scenarios.

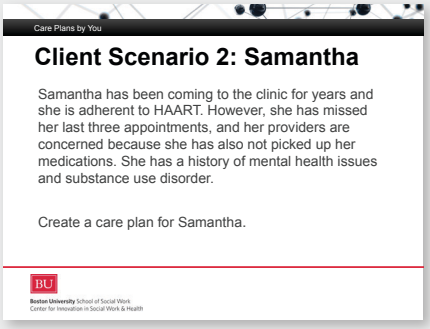


SLIDE 5

Tell the group we are going to review a few scenarios and practice filling out a care plan.

Ask for a volunteer to read the client scenario. Solicit input from the group for examples of what to include in the care plan.

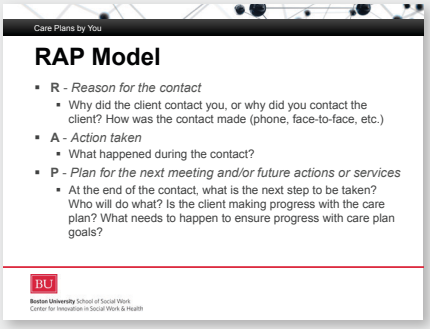
Give participants 10 minutes to complete their care plan for Thomas, then discuss as a group.



SLIDE 6

Ask for a volunteer to read the client scenario. Solicit input from the group for examples of what to include in the care plan.

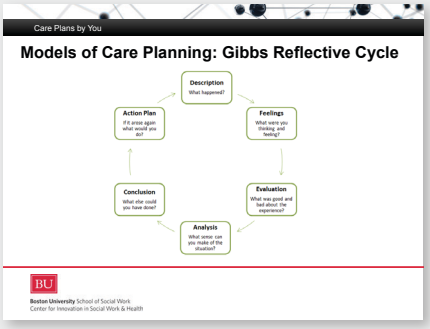
Give participants 10 minutes to complete their care plan for Samantha, then discuss as a group.



SLIDE 7

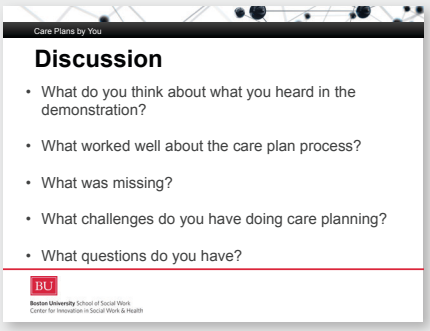
The RAP model is a simple way to structure a encounter note.

Review the slide and discuss as a group.



SLIDE 8

Review the steps in the graphic.



SLIDE 9

Review the questions and facilitate a group discussion.

Sample Care Plan I

CHW Care Plan Protocol

Each **care plan** with include a health goal to include the following:

- The team agreed on incorporating a team approach in following each client which will promote a health network with the goal of VLS, RIC and VLS

The following **interventions** will be incorporated to assist that client achieve goals:

- BHC consult (phone visit if necessary)
- PharmD appointment (phone visit if necessary)
- MCV
- Educational module
- Weekly contact via call or text. Efforts to contact the patient will be documented
- Quarterly cross checks and balances from teammate to check in with client to make sure things are going well and to offer assistance if needed.
- Client will receive a thank you card with affirmation if meeting goals

0-6 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC and TA	CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC and TA
INTERVENTION 1. Bi-weekly check-ins 2. PCP Referral 3. RWE/ADAP reminder 4. Continue with modules & client goals 5. Re-evaluation/screening 6. Appt reminders 7. Quarterly cross checks & balances by teammate 8. Client will receive a card affirming them and celebrating their goals	INTERVENTION 1. Continue weekly check-ins 2. Conduct home visit 3. Reassess client for barriers & explore options to overcome the identified barriers 4. Reinforce previous goals 5. CHW referral for support with achieving goals of obtaining positive health outcomes 6. Educational Modules 7. Quarterly cross checks & balances by teammate

NOTE: The BHC, PharmD and provider visits should occur within 6-8 weeks of the LTCM assessment

The team will celebrate milestones and achievements with the client.

6-9 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC, and TA 5. Goals identified by the client	CARE PLAN 1. MCV 2. LABS 3. PharmD visit (by phone if needed) 4. VLS, RIC and TA 5. Goals identified by the client
INTERVENTION 1. Monthly check-ins 2. PCP Referral 3. RWE/ADAP reminder 4. Continue with modules & client goals 5. Re-evaluation/screening 6. Appt reminders 7. Quarterly cross checks & balances by teammate 8. Client will receive a card affirming them and celebrating their goals	INTERVENTION 1. Continue weekly check-ins 2. Home visit from LTCM and CHW 3. Reassess client for barriers & make referral to community agency 4. Call from provider w/concerns re: NVLS & NRIC 5. CHW referral for support with achieving goals of obtaining positive health outcomes 6. Educational Modules 7. Quarterly cross checks & balances by teammate to include interventional assessment
9-12 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC, and TA 5. Goals identified by the client	CARE PLAN 6. MCV 1. LABS 2. PharmD visit (by phone if needed) 3. VLS, RIC and TA 4. Goals identified by the client
INTERVENTION 1. Monthly check-ins 2. PCP Referral 3. RWE/ADAP reminder 4. Continue with modules & client goals 5. Re-evaluation/screening 6. Appt reminders 7. Quarterly cross checks & balances by teammate 8. Client will receive a certificate and gift bag to CELEBRATE this milestone and affirming them.	INTERVENTION 1. Readiness for change assessment 2. Monthly check-ins 3. Educational Modules if it is determined that the client is ready 4. Quarterly cross checks & balances by teammate to include interventional assessment 5. Place client on an inactive list if it is determined that the client is not ready

12-18 MONTH CARE PLAN	
MEETING GOALS	**NOT MEETING GOALS**
CARE PLAN 1. MCV 2. LABS 3. PharmD appt (by phone if needed) 4. VLS, RIC, and TA 5. Goals identified by the client	CARE PLAN 1. MCV 2. LABS 3. PharmD visit (by phone if needed) 4. VLS, RIC and TA 5. Goals identified by the client
INTERVENTION 1. Monthly check-ins for 12-18 months. At the 18 month mark the client will be contacted bi-monthly. 2. RWE/ADAP reminder 3. Continue with modules & client goals 4. Re-evaluation/screening 5. Appt reminders 6. Quarterly cross checks & balances by teammate 7. Client will receive a card celebrating milestones with affirmations.	INTERVENTION 1. Continue monthly check-ins 2. Place client on an inactive list if it is determined that the client is not ready

Source: East Caroline University Adult Specialty Care Clinic

Sample Care Plan II

Southern Nevada Health District
Case Management
Ryan White Program
Client Service Plan

Client Name:		
Problem/Need Goal:	Intervention:	Progress Note: Date/Note
Linkage to Medical Care	Client will: Case manager will: CHW will:	
Linkage to Community Assistance	Client will: Case manager will: CHW will:	

I have read, understand and agree with the above service plan. Signing below indicates that you have read, understand and will comply with the terms above. Your signature also verifies that you have received a copy of your service plan.

Client Signature:		**Date:**	
Case Manager Signature:		**Date:**	
CHW Signature:		**Date:**	
Other/Signature:		**Date:**	

Care Planning Case Scenarios

Thomas

Thomas, age 48, has been living with HIV for three years and during that time has been marginally engaged in care. He has just been diagnosed with diabetes. His provider has made several specialist appointments for Thomas and feels he needs support, so the provider refers Thomas to a CHW. The provider would like the CHW to develop a plan of care for Thomas. Thomas has also been referred to a nutritionist and needs to get the supplies he needs to monitor his blood sugar.

Create a care plan for Thomas.

Samantha

Samantha has been coming to the clinic for years and she is adherent to HAART. However, she has missed her last three appointments, and her providers are concerned because she has also not picked up her medications. She has a history of mental health issues and substance use disorder.

Create a care plan for Samantha.

RAP Documentation: Patient Case Notes

Various entities (HRSA, ADPH, United Way, etc.) require program staff to compose case notes to record actions taken in a patient's treatment plan. Case note entries are used to reflect significant contacts related to a patient's care. Entries should be written in a manner in which an auditor or surveyor would be able to obtain a running history and general overview of the patient, their needs, services provided, the staff person's observations, and progress with the case or a lack of progress.

Below you will find a general guide for practical record keeping.

Minimum Requirements for Documentation

- Patient/client's full name
- Date
- Time
- Outside agency (if applicable)
- Title
- Author's signature if possible

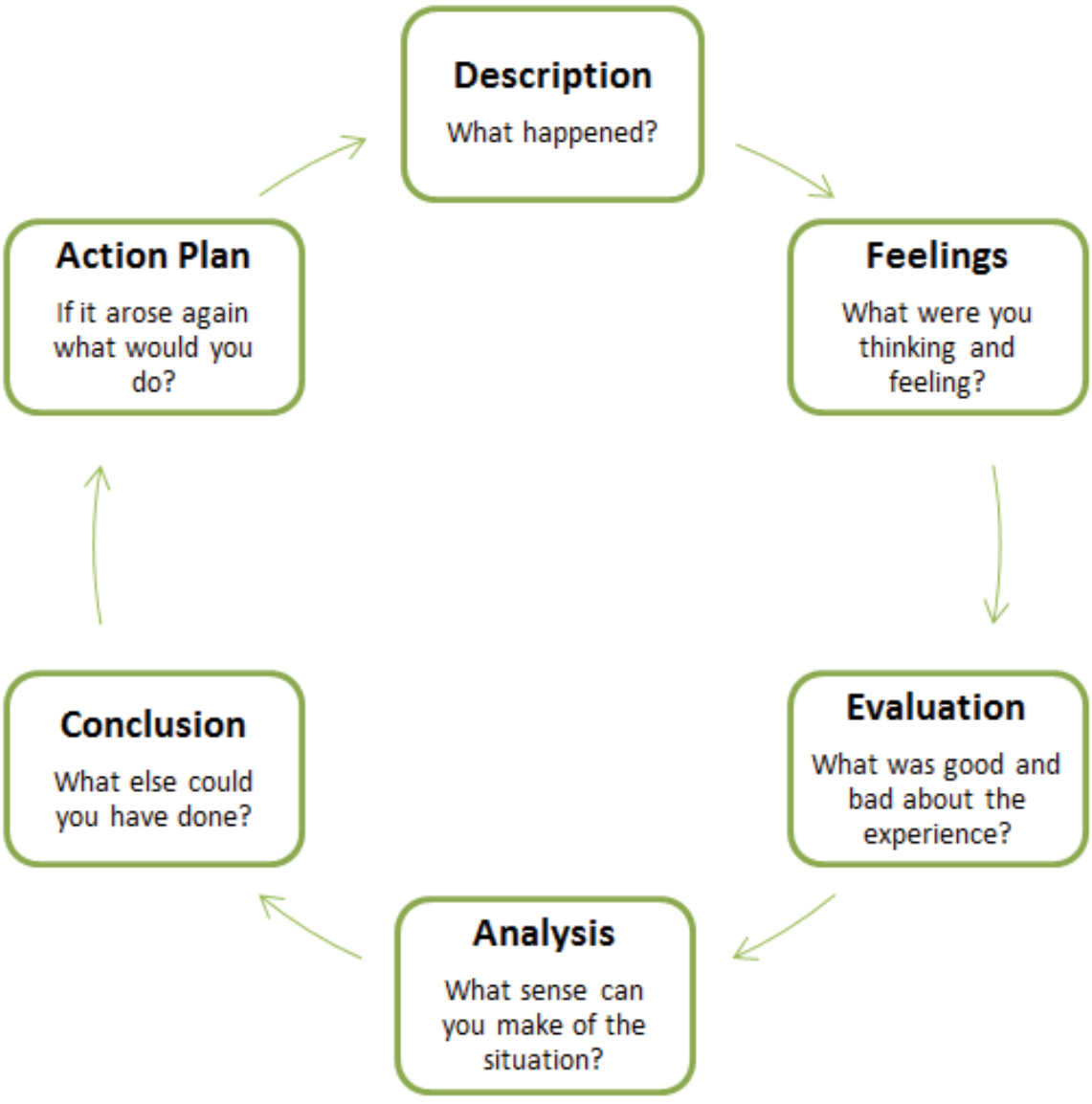
The SOAP (Subjective, Objective, Assessment and Plan) format is one that is sometimes used in documentation. Another common format is RAP. RAP stands for

R - Reason for the contact
- Why did the client contact you or why did you contact the client? How was the contact made (phone, face-to-face, etc.)?

A - Action taken
- What happened during the contact?

P - Plan for the next meeting and/or future actions or services
- At the end of the contact, what is the next step to be taken? Who will do what? Is the client making progress with the care plan? What needs to happen to ensure progress with care plan goals?

Gibbs Reflective Cycle



Source: Gibbs, G. (1988). *Learning by Doing: A Guide to Teaching and Learning Methods*. Further Educational Unit, Oxford Polytechnic, Oxford.

Acknowlegements

This curricula draws from and is adapted from other training curricula for peer educators and community health workers, such as the Building Blocks to Peer Success (https://ciswh.org/resources/HIV-peer-training-toolkit) and the Community Capacitation Center, Multnomah County Health Department (https://multco.us/health/community-health/community-capacitation-center)

Team

Serena Rajabiun
Alicia Downes
LaTrischa Miles
Beth Poteet
Precious Jackson
Simone Phillips
Maurice Evans
Jodi Davich
Rosalia Guerrero
Maria Campos Rojo

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U69HA30462 "Improving Access to Care: Using Community Health Workers to Improve Linkage and Retention in HIV Care" ($2,000,000 for federal funding). This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Suggested Citation:

Boston University Center for Innovation in Social Work & Health. (2019). A Training Curriculum for Using Community Health Workers to Improve Linkage and Retention in HIV Care. Retrieved from: http://ciswh.org/chw-curriculum

BOSTON UNIVERSITY

Boston University School of Social Work
Center for Innovation in Social Work & Health