

## **ARIES: Care Plans**

These instructions will assist in creating and updating care plans, as well as the corresponding referrals and service deliveries. Remember to refer to the F1-key ARIES manual for more assistance.

The first thing to know about care plans is how they are intended to be used.

**Care plans are an ongoing tool for planning and tracking client goals, tasks, and outcomes for specific needs.**

To use an ARIES client care plan effectively think of it as a living document instead of something that should be created and updated only every 6 months, which is the minimum for BVCOG-funded agencies. Each need noted in a client's needs assessment should have a corresponding care plan with tasks and, when applicable, referrals and service deliveries.

In general, care plans should follow these guidelines:

- Client centered – how does this benefit the client?
- Client driven – has the client expressed this as a need or have you assessed this as a need and the client agrees?
- Delineates responsible person(s) – who will make this appointment/decide on what is to be done?
- Outcome based – what need will this satisfy for the client?
- Action oriented – what does the case manager and/or client need to do in order to get this accomplished?
- Time specific – what period of time has been set to get this accomplished?

**How-To**

The editable screen of a care plan includes three main parts:

1. **Beginning** – the initial information entered to create a care plan.
2. **Interventions** – these are steps taken to achieve the client’s care plan goal and consist of 3 parts:
  - a. **Tasks** – the task to be performed. This could include coordinating appointments, transportation, completing applications, etc. Tasks can be used as internal reminders that can be assigned to staff members or the client.
  - b. **Referrals** –referrals made by the agency during the course of meeting the care plan goal.
  - c. **Service Deliveries** – service deliveries provided during the course of meeting the care plan goal.
3. **End** – After the intervention steps are completed (this will be after the goal is reached or another outcome occurs), the care plan is closed by entering the “completed date” and “outcome.”

The screenshot shows a software interface for creating a care plan. It includes the following elements:

- Form Fields:**
  - Date Need Identified:** 2/7/2006 (with a calendar icon)
  - Date Completed:** (empty) (with a calendar icon) **3**
  - Staff:** Griffith, Clarice (dropdown menu)
  - Outcome:** (dropdown menu)
  - 1 Program:** (dropdown menu)
  - Need:** (dropdown menu) if other (text input)
  - Subneed:** Select a Need (dropdown menu) if other (text input)
  - 2 Goal:** (text input)
- 2a Interventions Table:**

Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
- 2b Referrals Table:**

Referrals	Refer to	Referral Date	Target Date	Follow-up Date	PSC	Outcome	Outcome Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
- 2c Services Table:**

Services	Staff	Date	UOS	Total
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Buttons for **Save** and **Cancel** are located at the bottom right of the interface.

## 1. Beginning

Date Need Identified	<input type="text" value="2/7/2006"/>	
Staff	<input type="text" value="Griffith, Clarice"/>	
Program	<input type="text"/>	
Need	<input type="text"/>	if other <input type="text"/>
Subneed	<input type="text" value="Select a Need"/>	if other <input type="text"/>
Goal	<input type="text"/>	

When creating a care plan, first complete the initial information shown above. This is technically all of the information needed to create a care plan. Notice that "date completed" is not included here. The "date need identified" field indicates when the care plan is created and the "date completed" field is used only when no further tasks, referrals, or services will be entered for the care plan.

Entering this information is only the first step to creating a complete care plan – this conveys the area of need and the goal of the care plan, but does not say how the goal will be reached. The **goal** should be a specific outcome needed by the client. Examples of effective goals:

- Client will obtain HIV medication
- Client will attend medical appointments
- Client will access Medicaid transportation

After the information for this portion is entered, save the care plan by clicking the **Save** button at the bottom of the screen. The screen will then refresh to allow entry of the Interventions.

## 2. Interventions

After the goal of the care plan has been identified and the plan has been saved, the screen refreshes and you are able to create new tasks, referrals, and service deliveries from the care plan screen.

Date Need Identified  \*      Date Completed    
 Staff       Outcome   
 Program   
 Need  if other   
 Subneed  if other   
 Goal

**Interventions**

Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date	
								<a href="#">New</a>

  

Referrals	Refer to	Referral Date	Target Date	Follow-up Date	PSC	Outcome	Outcome Date	
								<a href="#">New</a>

  

Services	Staff	Date	UOS	Total	
					<a href="#">New</a>

[Save + Done](#)   [Cancel](#)   [Deactivate](#)

### a. Tasks

To create a new task, click on the **new** button in the tasks section (see above). This will open a new task:

Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<a href="#">Save</a> <a href="#">Cancel</a>

Each task is a step in reaching the goal set for the client. They should be specific things that need to be done, such as making appointments or referrals. Tasks can be assigned to any staff member with an ARIES profile or the client.

### Example:

Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date	
Assess CL's willingness to receive counseling	ws	3/1/2006	3/8/2006					<a href="#">Edit</a>

**The task table includes:**

**Tasks:** The task to be performed. This could include coordinating appointments, transportation, completing applications, etc. Tasks can be used as internal reminders that can be assigned to staff members or the client.

**Assigned to:** To whom the task is assigned. This will usually be the case manager or other agency staff, but tasks can also be assigned to the client. Tasks assigned to staff members will appear as their initials when the task is saved.

**Date Initiated:** The date the task was first assigned.

**Target Date:** The date the task is to be completed.

**Follow-Up Date:** The date when a task's status is revisited. This field will be completed with the date of when the case manager updates the task or follows up to see if the task was completed.

**PSC:** This stands for Payment Source Code – leave this field blank unless specifically instructed to complete it.

**Outcome:** Enter the outcome of the task in this text field. For instance, if the task is coordinating a meal delivery, you might enter "2 weeks of meal delivered."

**Outcome Date:** This is the date that the outcome was achieved.

In other words, these fields should be completed when the task is created:

Task  
Assigned to  
Date Initiated  
Target Date

And these fields will be completed when the plan is updated:

Follow-Up Date  
Outcome  
Outcome Date

**b. Referrals**  
**c. Services**

Referrals	Refer to	Referral Date	Target Date	Follow-up Date	PSC	Outcome	Outcome Date
-----------	----------	---------------	-------------	----------------	-----	---------	--------------

[New](#)

Services	Staff	Date	UOS	Total
----------	-------	------	-----	-------

[New](#)

Referrals and service deliveries completed in the course of meeting the care plan goal can be entered from the care plan screen. Clicking on **new** in the referral or services section will bring up the standard referral or service delivery entry screen. Once the information is entered for the referral or service, clicking **save** will bring back the care plan screen and show the entry:

Referrals	Refer to	Referral Date	Target Date	Follow-up Date	PSC	Outcome	Outcome Date
-----------	----------	---------------	-------------	----------------	-----	---------	--------------

Ryan White >  
 Ambulatory/Outpatient Medical  
 Care > Ambulatory Outpatient  
 Medical Care

Physician

3/1/2006

3/14/2006

[Edit](#)

[New](#)

Services	Staff	Date	UOS	Total
----------	-------	------	-----	-------

Ryan White > Case Management Services > Social Case  
 Management

ws

3/1/2006

8 @ \$10.00

\$80.00

[Edit](#)

[New](#)

These referral and service deliveries will also appear on the separate Referral and Service Delivery screens for the client and in all reports. They will not, however, appear on the care plan summary screen.

### 3. End

After the care plan goal is reached, or if the goal is updated due to a change, the care plan is closed with an outcome. This should occur after the completion of tasks.

Date Completed	<input type="text"/>	
Outcome	<input type="text"/>	

To close a care plan, which will prevent future editing of the plan, enter the completion date and an outcome. The following outcomes are available from the drop-down list:

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

**Note:** Referrals and services entered through the care plan will not be visible on the care plan summary screen after an outcome date is entered for the plan. Print the completed care plan with the outcome before pressing the save button to have a print-out with these details.