



# Case Management Plan Common Contents

This fact sheet is to assist in the preparation of management plans for people with HIV and complex needs.

**Name:**

**Case Co-ordinator:**

**Date:**

**Review Date:**

Needs to be targeted	Strategies (what needs to be done - where possible detail small achievable and measurable tasks for client)	Resources and Action (who works on client needs, their contact details – and by when)	Outcomes (can add a column for performance indicators or be more specific about outcome measures)
<p><b>Case Management / Care co-ordination</b></p> <p><b>Ensure care is coordinated by a case management/care coordinator</b></p>	<ul style="list-style-type: none"> <li>➤ Case Manager / Care Coordinator identified. Can be a local HCW. (eg. a community nurse, a social worker, OT or an NGO worker. A mental health worker if persons main problem is a mental illness.</li> <li>➤ Case Manager organises case management meeting with key health care workers, key carers and the client to establish client needs. (Note: literature suggests case manager needs to have a clinical role).</li> <li>➤ Establish ADAHPT involvement (eg. consultancy, assessment, co case management, paid carer support)</li> <li>➤ Case Manager coordinates the implementation of the case plan.</li> <li>➤ Case Manager organises regular case plan reviews and ensures all parties involved are clear about the various roles and the timetable for review.</li> </ul>	<p>Name, position, institution, contact details and timetable for all strategies.</p>	<ul style="list-style-type: none"> <li>➤ Client participates in all stages of the care planning process.</li> <li>➤ Clients' care is efficiently co-ordinated.</li> <li>➤ Client is aware and agrees with case management arrangements.</li> <li>➤ Communication between all involved in client's care is understood and acted upon by all parties as per the case management plan.</li> <li>➤ Client's significant others are sufficiently informed and are aware of what is going on (with consent).</li> <li>➤ Case management meeting seeks agreement on the case management plan to meet these needs, the roles of staff, carers, guardian and protective office if they are involved, volunteers involved, establishes review times and communication arrangements between all parties.</li> </ul>



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<p><b>Health Monitoring and Health Maintenance</b></p> <p><b>Ensure health monitoring and health maintenance is planned</b></p>	<p>Identify who is to be involved in assessment, development of treatment plan and is to implement the plan and monitor health. What is their role?</p> <p>Regular visits to: (examples)</p> <ul style="list-style-type: none"> <li>➤ Specialist is to (detail)</li> <li>➤ HIV prescriber is to (detail)</li> <li>➤ General Practitioner is to (detail)</li> <li>➤ Psychiatrist is to (detail)</li> <li>➤ Social Worker is to (detail)</li> <li>➤ Community Nurse is to (detail)</li> <li>➤ Clinical/Neuropsychologist is to (detail)</li> <li>➤ Physiotherapist is to (detail)</li> <li>➤ Occupational Therapist is to (detail)</li> <li>➤ Dietitian is to assess, develop a dietary plan and to review (how often).</li> <li>➤ Case Manager to note changes.</li> <li>➤ Case Manager may need to establish whether a full assessment has been completed and if not, who should do this, whether D&amp;A assessments and monitoring should happen.</li> <li>➤ HACC services</li> <li>➤ Ensure support is culturally relevant – refer to, for example Aboriginal or multicultural HIV services, youth services, etc.</li> </ul>	<p>Name, position, institution, contact details – and by when for all strategies.</p>	<ul style="list-style-type: none"> <li>➤ Client attends appointments.</li> <li>➤ Client obtains adequate feedback to make informed decisions.</li> <li>➤ Client's health is adequately monitored.</li> <li>➤ Client has access to high quality treatment care and support.</li> <li>➤ Maximum attention is given to the client's case management plan.</li> </ul>



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<p><b>Medication Compliance</b></p>	<p>Examples;</p> <ul style="list-style-type: none"> <li>➤ Who is to load dosette box, or organise blister pack? Who is to monitor, check medications, maintain liaison with medical staff?</li> <li>➤ Provide phone prompts daily.</li> <li>➤ Write a sign prompt.</li> <li>➤ Provide support (describe strategies) to encourage client to take responsibility for medications.</li> <li>➤ Regular medication reviews (describe).</li> <li>➤ Communication between prescriber and case management team.</li> </ul>	<p>Community Nurse.</p> <p>Community Nurse.</p> <p>Volunteer / Care workers.</p> <p>Case Manager or Nurse.</p>	<ul style="list-style-type: none"> <li>➤ Client is stable on medications.</li> <li>➤ No reported symptoms due to lack of compliance. adverse (eg. resistance, psychiatric disturbance, etc)</li> <li>➤ Blister pack emptied at appropriate times.</li> </ul>
<p><b>Emotional Support</b></p> <p><b>Ensure adequate emotional support</b></p> <p><b>Active learning of own coping strategies</b></p> <p><b>Emotional Support continued.</b></p>	<ul style="list-style-type: none"> <li>➤ Need to establish strategies for support.</li> <li>➤ What support can carers / friends provide, how often.</li> <li>➤ eg: counselling to deal with losses</li> <li>➤ Day to day counselling support.</li> <li>➤ Who is to provide support to carer – see below.</li> <li>➤ Volunteer support- what are they to do and when.</li> <li>➤ Who is to provide training, supervision, debriefing of volunteers.</li> </ul>	<p>Name, position, institution, contact details – and by when.</p> <p>As above</p>	<p>Client / Carer is emotionally supported.</p> <p>As above</p>



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<b>Social and Daily Activities</b>	<ul style="list-style-type: none"> <li>➤ Develop strategies with carer (eg. local HIV social activities and non HIV).</li> <li>➤ Need to establish whether escorts are required, who can do this. With severe dementia this may require funded carers with ADAHPS assistance. (eg. Dial-An-Angel / HACC services)</li> <li>➤ May need OT training to use public transport, physio for mobility training, CBT for behaviour plan.</li> </ul>	Who / when.	<ul style="list-style-type: none"> <li>➤ Client is not bored.</li> <li>➤ Client gives feedback.</li> <li>➤ Activity program is stimulating and relevant to the client's stated needs.</li> </ul>
<b>Ensure Carers are Supported</b>  <b>Ensure carers are adequately informed (with consent of client)</b>	<ul style="list-style-type: none"> <li>➤ Assess carers needs.</li> <li>➤ Referral to carer's group, counsellor, etc</li> </ul>	Case Manager.	Minimise stress to carers.



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<b>Safety and Security</b>	Examples:- <ul style="list-style-type: none"> <li>➤ Supported with harm minimisation practices.</li> <li>➤ Food delivered instead of cooking.</li> <li>➤ OT assessment to establish whether client can manage hot plates/cooking/ mobility etc.</li> <li>➤ OT develops ADL training.</li> <li>➤ Roster developed for carers, friends, community workers, to ensure supervision.</li> <li>➤ HACC organised.</li> <li>➤ ADAHPT care packages.</li> </ul>	Community Nurse. Occupational Therapist. Carers.	Client is safe from harm or harm is minimised.
<b>Drug and Alcohol</b>	Support harm minimisation by providing condoms/safe injecting equipment. <ul style="list-style-type: none"> <li>➤ Assessment.</li> <li>➤ Develop strategies to assist client to manage drug/alcohol intake.</li> </ul>	Who / when. Drug and alcohol workers.	Drug or alcohol intake does not adversely effect health and daily living.
<b>Legal</b>	<ul style="list-style-type: none"> <li>➤ Does the client require a substitute decision maker – and in which areas (eg. Medical, dental, placement, etc).</li> <li>➤ May require psychiatrist and neuropsychologist assessment.</li> <li>➤ Who is to prepare documents for the Guardianship Tribunal. Note importance of Enduring Guardianship arrangements as early as possible.</li> <li>➤ Ensure guardian’s views are sought.</li> <li>➤ Consult with client / carers to establish whether a public guardian is required and who should make the application. Capacity to consent.</li> </ul>	Who / when.	<ul style="list-style-type: none"> <li>➤ Maximise client’s involvement in consent issues.</li> <li>➤ Ensure a substitute decision maker acts on client’s behalf (if required).</li> <li>➤ Consent Guidelines followed.</li> <li>➤ Guardianship Act followed as required.</li> </ul>



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<b>Legal (continued)</b>	<ul style="list-style-type: none"> <li>➤ In what areas does the client have capacity to consent and what is the history of his beliefs regarding advanced directives and future treatment and what are his current wishes. Detail a full history.</li> <li>➤ Are there other legal issues such as a need for a living will, power of attorney, legal advice.</li> </ul>		
<b>Accommodation</b>	<p>Assist client to determine and arrange adequate accommodation based on needs.</p> <ul style="list-style-type: none"> <li>➤ Bridge</li> <li>➤ Floating Care</li> <li>➤ DOH</li> <li>➤ Supportive housing</li> <li>➤ Rental Assistance</li> <li>➤ Care packages/HACC</li> </ul>	Who / When Case Manager or other identified worker	Safely accommodated.  Client's supported to ensure they can maintain living in the community.
<b>Management of Difficult Behaviours</b>  <b>Ensure staff are educated in implementing behavioural management plan and principles of behaviour management.</b>	<ul style="list-style-type: none"> <li>➤ Assist client to identify psychosocial triggers for difficult behaviours.</li> <li>➤ Psychosocial triggers are identified including internal ones (eg. pain, boredom, anxiety).</li> <li>➤ Consider preventative strategies.</li> <li>➤ Develop strategies for difficult behaviour, if the behaviour persists following the implementation of prevention strategies.</li> <li>➤ Behaviour plans developed and monitored.</li> </ul>	Clinical Psychologist. Mental Health Nurse. Social Worker.	Unwanted behaviours are prevented and / or alleviated.  Client learns alternate means of having his / her needs met.



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<p><b>Separation Planning</b></p> <p>Planning the process of linking the client with primary and secondary services whilst reducing ADAHPT's involvement at these levels</p>	<p>Assist the client in accessing services to meet needs</p> <p>Support the client to work toward his/her independence and autonomy</p> <p>Support the client in meeting his/her needs</p>	<p>Case Managers and others involved in the client's care</p>	<p>Client's needs have been met to the extent that ADAHPT's role is minimal</p> <p>Client is linked in with a Case Manager and continuity of care is ensured</p> <p>The client has adequate independence/assistance</p>
<p><b>Consumer Education</b></p>	<ul style="list-style-type: none"> <li>➤ Information Packages (upon entry to the service)</li> <li>➤ Reinforcement of illness knowledge and the importance of safe practices as required</li> <li>➤ Continuous feedback / information giving to clients and professionals involved in care</li> </ul>	<p>Case Managers to ensure new clients and all existing clients have access to the information package</p> <p>Case Managers to reinforce clients knowledge of illness/illnesses and the importance of safe practices i.e., safe sex, needle exchange</p>	<p>To allow the client more independence / knowledge of what to do/expect when accessing service</p> <p>To ensure clients have access to condoms, clean needles, disposal of same</p> <p>Client has knowledge of their <b>rights</b> and <b>responsibilities</b> as a consumer</p>