Care Management - Admin Guide

Description: In this guide, the user will learn about the Care Management Module. The DCI Care Management Module is designed to track the Individual Support Plan (ISP) of a client. An Individual Support Plan (ISP) is defined as documentation of the activities, resources, and supports that an individual, Personal Agent or Service Coordinator, and other designated caregivers agree are important to or for achieving and maintaining personal outcomes. The Individual Support Plan is referred to as the Plan of Care in DCI and is specific to the individual receiving care. The Plan of Care is where individual goals are tracked.

*Please note: Care Management is an instance-level setting and must be enabled by a DCI Project Manager or account representative. If Care Management is enabled, the Care Management tab will be visible on the main menu in DCI.

Roles Required: Super User, Supervisor

Permissions Required: Plan of Care Admin, Client Admin

- Setting Up Care Management for a Client
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- Care Management Overview
- Reports
- ICD-10 Codes
  - Access and Search the ICD-10 Code Library

Related articles

Setting Up Care Management for a Client

Description: In this topic, the user will learn how to set up Care Management for a client. Complete all steps in all sections below to finish the set-up which includes enabling care management for the client, creating the plan of care, adding goals, adding tasks, and linking goals to the funding account.

Enable Care Management for a Client

1. Log in with the appropriate profile
2. Click **Home** on the main menu
3. Click **Clients** on the submenu
4. Enter the client name into the search filter and click **Search**
5. Click **anywhere on the client's row** in the results table to open the Client Details page
6. Click **Actions**
7. Select **Edit Client** from the drop-down menu
8. Click the **Client Information tab** on the Edit Client Details page
9. Click the Enable Care Management **checkbox** at the bottom of the page
10. Click **Save** and **Yes** to confirm

Add a Plan of Care for a Client

1. Log in with the appropriate profile
2. Click **Care Management** on the main menu
3. Click **Plan of Care** on the submenu
4. Click **Actions**
5. Select **New Plan of Care** from the drop-down menu
6. Complete the Add Plan of Care form wizard
    a. Client - Type the client's name and select it from the list generated
        i. Please note: If the client's name does not appear in the list, Care Management is not enabled on the client profile.
    b. Assessment - Enter the assessment, a summary plan of care, progress, and status of goals.
        i. Assessment field is free text, data-based, or narrative, and can be edited throughout the life of a Plan of Care.
    c. Effective Date – Enter the date the Plan of Care starts
    d. End Date – Enter the date the Plan of Care ends
    e. Status – Select Active or Inactive from the drop-down
7. Click **Save** and **Yes** to confirm

Add Goals to the Plan of Care

1. Log in with the appropriate profile
2. Click **Care Management** on the main menu
3. Click **Plan of Care** on the submenu
4. Enter the client name into the search filter and click **Search**
5. Click **anywhere on the client's Plan of Care** in the results table to open the Plan of Care Details page
6. Click **Actions**
7. Select **Add Goal** from the drop-down menu
8. Complete the Add Goal form wizard
    a. Goal Name - Enter a general name for the goal
    b. Summary - Enter information specific to the individual and goals
    c. Target Outcome - Represents the target percentage of met outcomes for all completed tasks under this goal
    d. Effective date - Select a start date. Goals can start on any date within the plan of care dates and will display for the caregiver.
    e. End date - Select an end date. After this date, the caregiver will no longer see the goal.
    f. Status - Select Active or Inactive from the drop-down
9. Click **Save** and **Yes** to confirm
10. Repeat steps 6-9 to add additional goals for the client

Add Tasks to Goals

1. Log in with the appropriate profile
2. Click **Care Management** on the main menu
3. Click **Plan of Care** on the submenu
4. Enter the client name into the search filter and click **Search**
5. Click **anywhere on the client's Plan of Care** in the results table to open the Plan of Care Details page
6. Select the **Goals tab** on the Plan of Care details page
    a. The goal(s) for the client will be listed
    b. Optionally search for a specific goal or scroll down to view all goals for the client
7. Click **anywhere on the goal row** in the results table to open the Goal Details page
8. Click **Actions**
9. Click **Add Task** from the drop-down menu
10. Complete the Add New Task form wizard
    a. **Task Details tab:**
        i. Task Name - Tasks are a component of the overall goal
        ii. Summary - Enter the actions the caregiver must take for the task
        iii. Met Condition - Enter the condition(s) acceptable for the task to be marked as Met
        iv. Not Met Condition - Enter the condition(s) in which the caregiver should mark Not Met
        v. Additional information - Required field to ensure the task can be marked as met or not met
        vi. Required - Click Yes or No
            1. If Yes, the task must be resulted before a care note can be published.
                a. Please Note: Employees using the mobile app cannot clock out until the task is resulted if the Require Care Note setting is set to Yes on the service code.
            2. If No, the task is not required for the care note to be published.
        vii. Target Outcome - The target percentage of met outcomes of completed tasks
        viii. Effective date - The date the task starts. Can be any date within the goal dates. The task will be visible to the caregiver.
        ix. End date - After this date, the caregiver will no longer see the task.
        x. Status - Select Active or Inactive from the drop-down
        xi. Click **Next**
    b. **Tracking Option tab:**
        i. Allow Refusal - Select Yes to allow the caregiver to select that the client refused to participate
            1. If yes is selected, it will count towards the target outcome goal.
            2. If no is selected, it does not count towards the target outcome goal.
        ii. Allow Barrier - Select Yes to allow the caregiver to select Barrier as a task outcome
            1. Examples of barriers might include Client was sleeping, client was having a medical issue, etc.
        iii. Click **Next**
    c. **Additional Questions tab:**
        i. Additional Questions are questions the employee will document with their care note and can be either Canned or Custom question types
        ii. Question type - Click Canned or Custom
            1. Canned – This question type applies to more than one client. To add canned task questions, see the step-by-step instructions below for Create a Canned Task Question.
                a. Select Question - Click the Select Question drop-down and make a selection
                b. Required - Click Yes or No
                c. Status - Select Active or Inactive from the drop-down
                d. Click the **plus sign (+)** button to add a canned question
                e. Repeat as necessary
                f. Click **Save**
            2. Custom – This question type is specific to a client and the documented task
                a. Question - Enter Question text
                b. Required - Click Yes or No
                c. Click **Next**
                d. Answer - Enter the answer text and click the **plus sign (+)** button
                e. Repeat to add up to seven additional answer criteria
                f. Click **Save** to return to the Additional Question screen
            3. Repeat either the Canned or Custom process to add additional questions as needed
    d. Click **Save** and **Yes** to confirm

Link Goals to Funding Account

1. Log in with the appropriate profile
2. Click **Authorization** on the main menu
3. Click **Funding Accounts** on the submenu
4. Enter the search criteria in the filter (i.e., client, cost center) and click **Search**
5. Click **anywhere on the Service Account row** in the results table to open the Account Details page
6. Click **Actions**
7. Select **Add/Remove Goals** from the drop-down menu
8. The Add/Remove Goals wizard will open
9. Select a goal(s) in the Available Goals column
    a. Click the right triangle button to add a goal to the Selected Goals column
    b. Click the double right triangle >> button to add all goals to the Selected Goals column
    c. Click the left triangle button to remove the goal from the Selected Goals column
    d. Click the double left triangle << button to remove all goals from the Selected Goals column
10. Click **Save** and **Yes** to confirm

Create a Canned Task Question

1. Log in with the appropriate profile
2. Click **Settings** on the main menu
3. Click **Task Question** on the submenu
4. Click **Actions**
5. Select **Add New Task Question** from the drop-down menu
6. Complete the form wizard
    a. Question - Enter question text
    b. Status - Select Active or Inactive from the drop-down
    c. Click **Next**
    d. Answer - Enter the answer. Click the **plus sign (+)** to add additional answers to be available for the question.
    e. Click **Save** underneath the answers to add more questions to this task if applicable
7. Click **Save** and **Yes** to confirm
8. The task question is now available for use when adding tasks to goals in the Add New Task form under the Additional Questions tab, Question Type Canned.

Care Management Overview

Description: In this topic, the user will learn about the Care Management Overview page, how to search for and select a client who has a Plan of Care and view their progress toward goals and care notes.

1. Log in with the appropriate profile
2. Click **Care Management** on the main menu
3. Click **Overview** on the submenu
4. Enter the search criteria in the filter (i.e., client, employee, cost center) and click **Search**
5. Click **anywhere on the row** to select and open the Care Management Overview Detail page
6. On the Care Management Overview Detail page:
    a. View the Trends widget by selecting a tab
        i. Task Outcomes Over Time tab
        ii. Task Submissions By Task tab
        iii. Use the radio buttons to change the days displayed in the Trends widget
    b. The Plan of Care widget provides Goal details including goal name, number of tasks, outcome, target outcome, last tracked, effective date, end date, status, and added by.
        i. Select the goal by clicking anywhere in the row to open the Goals Details page
    c. Select a tab i.e., Care Notes, Task Results, Notes, Attachments, or Events to view. Select an entry in the results table to view the details page.

Reports

Description: In this topic, you will learn about care management reports. The Care Management Reports are accessible in the Reports Module.

1. Log in to personal profile
2. Click **Reports** on the main menu
3. Click **Care Management Reports** on the submenu
4. The available reports are listed on the flyout menu:
    a. Pending Care Notes Report
    b. Task Result Details Report
    c. Raw Data Dump Report
    d. Client Diagnosis Report
    e. Diagnosis Code Usage Report
5. Select the **Report** to run
6. Enter desired criteria into the filters and click **Search**
7. The records will display in the table below the filters
8. Organize the results as needed by dragging and dropping the column headers
9. Optionally, click the **Download** button and select the columns and the format in which to download the report.

For more information on how to download reports, please see the Reports - Run and Download article.

ICD-10 Codes

The user has access to advanced functionality for storing client diagnosis codes, including:

- A library of all current ICD-10 Codes
- The ability to add multiple diagnosis codes to a single client profile

Access and Search the ICD-10 Code Library

1. Log in with the appropriate profile
2. Click **Settings** on the main menu
3. Click **Diagnosis Code** on the submenu
4. Use the filters to view available codes

Related articles

- Import Formats - Admin Guide
- Case Workers Guide
- System Set-Up - Admin Guide
- Care Notes - Mobile App
- January 2024 Release Notes