Care Plan and Referral Expectations

Care Planning

- Initial care plan is done at intake.

- The needs identified during the initial intake and assessment should be reflected on the care plan; therefore, every time the client is reassessed the care plan should reflect this (i.e., there are new needs updated or the care plan is reviewed for accuracy.)

- Expect Care Plan to be updated/ reviewed if there is a change in case manager, at least every six months and any time there is a change in client status (completed item, new need).

- Care plan needs to be printed off of AIRES anytime it is reviewed or updated and filed in the client chart. It needs to be noted that the care plan was reviewed

- Need to include tasks (steps) in completing the care plan. The tasks should be ongoing and updated often, not just every 6 months.

- Clients should be aware of their care plan and agree to it. The clients do not have to sign the actual care plan, but there should be documentation (i.e., in the case notes) that the client participated in the development of the care plan and agree to it.

- Plan of Care Development Standard**:**
  A written plan of care will be developed through a collaborative process between the case manager and each individual HIV+ person that may include their families/significant others and should include these conditions:

  > Client centered – how does this benefit the client?
  >
  > Client driven – has the client expressed this as a need or have you assessed this as need and the client agrees?
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  > Delineates responsible person(s) – who will make this appointment/ decide on what is to be done?
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  > Outcome based – what need will this satisfy for the client? The outcomes should tie into the outcomes in the Performance Measures/QM Plan. This is a good way to assess and document whether you achieved your stated outcome measures.
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  > 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? Include a date to follow up on goals/tasks.

Referrals

- A new referral should be made for each need that a client has. Referrals should *always* be made at intake.

- Referrals will be reviewed to ensure that funds are used as payor of last resort. If the client is not eligible for the referred service, note that in the outcome. If the client does not want the referral, that needs to be documented as well.

- They need to be followed up on regularly to track completion; pre-establish a schedule to review open referrals (weekly, monthly)

- No-show by a client for referral should automatically trigger a call to the client to assess the reason for not going to the appointment. A new referral should be made or it should be documented why the client does not want to or cannot follow through with the referral.

- Need to assess the quality of the service from client perspective. Did it meet his or her need?

Example

Referring client for mental health counseling.

1. Fill out or give client referral to mental health counselor for 4/2/06.
2. Discuss barriers that the client may have in accessing the referral (i.e., transportation, stigma regarding mental health treatment, getting time off work, etc.) and address the barriers/work with client to overcome the barriers to the extent that it's possible.
3. Fill out the referral screen in ARIES and document in the case note that the referral was made and on what day? Call the client to remind them of referral before 4/2/06.
4. Call client on 4/4/06 to follow-up on services received. If client missed the appointment, why – what barriers need to be overcome? Was the client satisfied with the referral? Did it meet his or her needs?
5. Retrieve any pertinent notes, bills from referral source for client chart/ review. Does the client require additional appointments? When does the counselor need to see client again? Make a new referral.