

MODULE SIX

Client Reassessment & Follow-Up

POLICY

At a minimum, Medical Case Managers and Medical Social Workers (Short Term Assistance Providers) must follow-up and have contact with their clients on a monthly basis. Contact can occur in face-to-face and non-face to face formats, with at least one face to face each month for most clients. In addition, a more extensive follow-up must occur face-to-face every six months.

Information must be collected and recorded in ARIES for each client contact captured in the units of service (UOS). In addition, case notes, care plans, and referral tabs must also be updated. A client's Care Plan will be updated at each visit, as goals are accomplished and new ones established. At a minimum, a thorough assessment and care plan update will be done every six months.

The purpose of client follow-up is:

- To ensure adequate support for optimal health outcomes and implementation of the clinical treatment plan.
- To ensure that clients are monitored and afforded services, referrals and linkage to meet their needs for optimal health.
- To assess regularly the client's level of functioning to ensure enrollment in the correct level of care (e.g. nurse case management if ill, mental health, supportive housing, etc.).
- To keep client motivated in their overall care.
- To ensure that the care plan remains relevant and appropriate to the client's changing needs or situations, and to monitor the step-by-step completion of the goals outlined in the Client Care Plan.
- To update key client information and ensure client still meets the eligibility criteria for services.
- To ensure coordinated care with system providers.
- To reduce duplication of service.
- To maintain accurate records for reporting.

MINIMUM REQUIREMENTS

At a minimum, client follow-up should include:

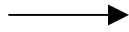
Monthly contact

- At a minimum the Case Manager or Medical Social Worker should have contact (face-to-face meeting) with the client based upon their level of function.
- A monthly re-assessment of how the client is doing in terms of health and accessing services, medication adherence, appointments, lab tests, etc.
- Troubleshoot navigation of the medical care system
- Provide counseling on medication appointment and treatment adherence
- Conduct risk reduction counseling and partner counseling and referral services (PCRS) with all clients to prevent HIV transmission.
- Evaluate the effectiveness of services based upon client outcomes in the scope of work and record information as required.
- Screen emergency assistance requests. Provide access to emergency financial assistance (EFA) e.g. food vouchers, transportation vouchers, utility payment assistance or special needs as necessary.

Monthly Follow-up Needs Assessment/ARIES Intake

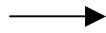
- Record any changes in the clients situation and needs over time on the Intake form and highlight.
- Refer to Nurse Case Management (NCM) any client whose health status has declined. Ensure client was successfully linked with NCM. If referred to NCM, and the Medical Case Manager later comes to know something regarding the client the Medical Case Manager should contact the social worker or nurse to pass on the information. Do not contact the client directly, as it may cause confusion.
- Nurse Case Managers will refer to community based medical case management those clients who are stabilized but have chronic medical needs and are at a higher functioning level appropriate for community based medical case managers.

Monthly Care Plan Follow-up



- Follow-up on goals and tasks as outlined in Care Plan (see Module #5).
- Follow-up on referrals made and ensure outcomes are recorded.
- Recording of changes/additions to the client's care plan as new goals are added.

Six-month Needs Assessment/ ARIES Intake Follow-up

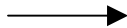


Six months after intake and at 6-month intervals from then forward:

- Complete reassessment of client needs in a face-to-face visit.
- Record changes to client needs on the ARIES Intake Form and highlight for data entry (see Module 3 Intake/Needs Assessment).
- Update the care plan based on the client's changing needs and progress toward achieving medical treatment plan and care plan goals.
- Verify enrollment in medical care and support enrollment or re-certification of the uninsured in Basic Health Care (BHC) if eligible.
- Ensure client has been case conferenced at medical rounds at least twice per year and documentation is complete.

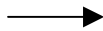
PROCEDURE

Monthly Contact ARIES Needs Assessment Update



- Schedule and conduct a monthly contact (face-to-face or non-face to face) meeting with the client (based upon their level of function).
 - Record any attempts to schedule appointments and any missed appointments in the case notes section of ARIES.
- When face-to-face contact is not possible, schedule and conduct an extensive telephone follow-up (15 to 30 minutes) with the client.
 - Record in the notes section in ARIES, the reason why a phone conversation took place instead of a face-to-face meeting.
 - Monthly telephone follow-up should only replace face-to-face contact as is indicated by level of function/acuity.
 - If you do not succeed in reaching the client, try at least one more time that month and record all attempts to contact the clients

ARIES Intake Update



- Update the ARIES Intake and Needs Assessment Form highlighting any new or changed information and enter it into ARIES.
- Conduct ongoing reassessment of client needs with each contact.
- Additional information gathered during the reassessment process can be recorded in the case notes.

Care Plan Follow-Up



- At each meeting with the client, discuss any changes/progress with the care plan.
 - Add any new problems and update/rewrite any modified problems, goals, and tasks.
 - For Updates to the care plan, use the ARIES instructions in Module 5.
 - Print the care plan from ARIES and have the client sign along with the Medical Case Manager. The signed copy should be kept in the client file.
 - Record the completion of any care plan steps and/or goals by placing a date in the appropriate column next to those goals.
- See an example of care plan updating below.

John A Porter Needs Assessment				
Source	Need	Don't Need	Unknown	Create Care Plan
Case Management	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Child Care	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Complementary Therapies	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Dental Care	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Emergency Financial Assistance	<input type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
Food Services	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>

NEEDS ASSESSMENT		CARE PLAN		REFERRALS		CARE PLAN			ARIES	
John A Porter										
Care Plan New										
Date	Staff	Program	Need/Subneed	Goal	Outcome	Completed				
11/15/2004	ARIESAdmin	HOPWA	Housing Assistance (Housing Assistance)	Lease an apartment			Edit			
Task		Assigned	Dt Init.	Target Dt	F/U Dt	PSC	Outcome	Out. Dt		
Fill out housing paperwork		JAndrews	11/15/2004	12/1/2004						
11/15/2004	ARIESAdmin	Ryan White	Health Education (Health Education)	Explore how to keep negative partner safe	Pending	11/24/2004				
Task		Assigned	Dt Init.	Target Dt	F/U Dt	PSC	Outcome	Out. Dt		
Bring partner to a couples session		JAndrews	11/15/2004	12/15/2004						
Purchase condoms		JAndrews	11/24/2004	11/29/2004						
Attend next health seminar		JAndrews	11/15/2004	11/30/2004	11/17/2004		completed seminar	11/16/2004		

Follow-up every **Six months** following initial intake →

- Verify proof of County residency (annually).
- Recertify for ADAP (annually)
- Conduct a thorough reassessment of client needs based on the needs assessment areas outline on the needs assessment form/ARIES Intake Form and in the protocol. Discuss any current concerns the client has and any progress made toward addressing needs identified in the past.
- Acuity scale assessment should be completed at least twice during the year with some clients needing more frequent re-assessment.
- At a minimum, the content of the reassessment must include information about changes to the client's:
 - a. Current medical, mental and emotional health
 - b. Insurance coverage including Low Income Health Plan (LIHP), Basic Health Care (BHC) eligibility
 - c. Benefits
 - d. Current living and/or support situation
 - e. Financial status
- Record any changes in needs on the reassessment form/worksheet as well as in ARIES.
- Discuss new/modified steps needed to address the client's changing needs.
- Update the care plan based on changes in client needs and progress made toward meeting care plan goals.
- At each six-month reassessment only, complete the last box of the latest reassessment form. This health care utilization information must be gathered and recorded

Client Reassessment Form

Client ID: _____ Date of Initial Assessment _____

Medical, Health & Nutrition Status	Update HAART Meds and Adherence Changes in Medical Treatment Plan	Date
Mental, Psychological or Emotional Status	Update	Date
Substance Abuse Issues	Update	Date
Insurance, Benefits and Legal	Update	Date
Risk Reduction/ Partner Disclosure Assistance	Update	Date
Financial Status	Update	Date
Social Support System & Living Situation	Update	Date
Other Needs or Concerns	Update	Date

Case Manager Signature: _____ Date: _____

* Should be updated at least every six month.

Contra Costa AIDS Program
Final June 2009

VI/8