

MODULE FIVE

APPENDIX

Care Plan Worksheet
And Example Goals and Steps

This worksheet (ARIES Master Data Collection Form) can be used to remind Medical Case Managers of the data elements required for the creation of a care plan in ARIES.

Demo-graphics	Eligibility	Programs	Medical	Medications	Risk & Assessments	Care Plan	Case Notes	Services
Care Plan				Needs Assessment	Care Plan	ARIES		

Date Need Identified: ___/___/___

Staff: _____

Program: _____

Need: _____ (See attached list of services)

If Other: _____

Sub Need: _____ (See attached list of services)

If Other: _____

Goal: _____

Date Completed: ___/___/___

Outcome:

- Completed
- Pending
- Some Progress
- Cancelled
- Unfunded
- Not Available in Area
- Completed Substance Abuse Program

Tasks

Tasks: _____

Assigned to: _____

Date Initiated: ___/___/___

Target Date: ___/___/___

Follow-Up Date: ___/___/___

PSC: _____

Outcome: _____

Outcome Date: ___/___/___

Sample Problems, Goals and Tasks for Care Plan Development

These are not meant to be used for all clients, but rather a menu of possible sample language for client problems, goals and tasks.

MEDICAL

Problems

Client currently out of medical treatment
Client not adherent to medication regimen
Client HIV/AIDS advancing
Client experiencing pain
Client experiencing medication side effects
Client lacks understanding of disease process

Goals:

Client will receive regular, adequate medical care that addresses both HIV-related issues and other health concerns
Client will be adherent to medication regimen that client and MD have agreed to
Client will experience the best possible health status given level of HIV-disease
Client will be informed and able to make decisions around treatment options

Tasks:

Client: Client will make appointment with medical provider
 Client will attend medical appointment set for (date)
 Client will report symptoms to medical provider
 Client will adhere to medication regimen
 Client will discuss pain/side effects with MD as well as medical case manager
 Client will bring a list of symptoms/questions to MD appt

Case Mgr: Provide client with referrals to medical providers in area
 Assist client in making medical appt and application process
 Determine barriers to appointment adherence (i.e. transportation, dementia, substance abuse, lack of insurance) and address
 Refer client to Nurse Case Management Program, if health is poor, declining or client pregnant.
 Confer with Nurse Case Manager, medical provider re: client medical issues
 Discuss psychosocial impact of illness, pain, and limitations with client
 Continue to monitor medication adherence
 Discuss disease process with client, assist client in formulating questions to ask medical provider at visit
 MCM will case conference client at medical rounds to ensure medical provider is up to date with client issues.

FUNCTIONAL LIMITATIONS

Problems

Client needs assistance with activities of daily living

Goals

Client will be able to live independently as long as safely possible through the provision of support services.

Client receives adequate assistance with activities of daily living

Tasks

Client: Apply for In-Home Supportive Services (Make/keep appointment to meet with IHSS Eligibility Worker, Social Worker, fills out paperwork, provides verifications, select provider, etc.)

Case Mgr: MCM will case conference client at medical rounds to ensure medical provider up to date with client's case
Refer to IHSS
Refer to Nurse Case Management Program for attendant care services
Discuss with client which friends/family can provide client assistance or respite to care giver
Refer client for volunteer support (i.e. Circle of Care)

MENTAL HEALTH

Problems

Client isolated, anxious, depressed, fearful, angry, and inappropriate (specify which)

Client exhibits poor impulse control (specify if violent or abusive)

Client experiencing delusions, hallucinations, other psychotic symptoms

Client developmentally delayed

Client experiencing memory problems, problems with concentration

Client does not show emotion

Client seems to lack motivation

Client experiencing problems with sleep or appetite (if related to mental health)

Client experiencing suicidal thoughts

Goals:

Stabilize immediate crisis

Client will receive regular, adequate medical care that addresses both HIV-related issues and other health concerns

Client's mental health symptoms will be controlled/have minimal impact on functioning

Client will receive necessary social, psychological, and emotional supports

Client will not be a danger to self or others

Client will be adherent to psychotropic medication regimen

Tasks

Client: Contract with case manager not to harm self or other, and to call crisis numbers if crisis arises.
Client agrees to meet (for initial visit, weekly, twice a week face to face or by phone with) Mental Health provider.
Client agrees to adhere to psychotropic medication regimen (antidepressants, anti-anxiety drugs, antipsychotic, etc) as prescribed.

Case Mgr: Refer to Mental Health Counselor
MCM will case conference client at medical rounds to ensure medical provider up to date with client's case
Refer for Psychiatric evaluation

- Refer for Psychological testing
- Refer to Regional Center of the East Bay
- Allow client to share problem issues
- Provide emotional support to client
- Help client to make connections between thoughts, feelings, impulses, behaviors, and consequences
- Discuss alternative coping strategies with client
- Determine the degree to which client is an imminent danger to self or others
- Make contract with client that client will not harm self or others
- Provide client with Crisis/Suicide Hotline, HIV Nightline, and other after-hours services
- Make mandatory report for involuntary hospitalization (if client is imminently suicidal) – consult with clinical supervisor regarding agency policy
- Inform police and intended victim (if client threatens a specific person) - consult with clinical supervisor regarding agency policy
- Work with client and family to develop ways of coping with dementia (how to talk with a person with memory impairment, ways to modify the home, etc)
- Refer client to appropriate emotional/illness-related support groups
- Confer with medical provider, Medical Social Worker, Nurse Case Manager, Mental Health Counselor, other professionals as appropriate about client mental health issues

SUBSTANCE USE

Problems

- Client is unable to keep medical appointments or stick to prescribed medication adherence.
- Client is actively using one or more substances.
- Client is sharing needles with others.
- Client is engaging in unsafe sex when using substances.
- Client is unable to maintain stable housing due to addiction issues.

Goals

- Client will receive regular, adequate medical care that addresses both HIV-related issues and other health concerns
- Client will make and keep appointment with Substance Abuse Coordinator for evaluation.
- Client will participate in substance abuse treatment or harm reduction activities to promote better health outcomes.
- Client will participate in risk reduction skills sessions.
- Client will become familiar and use needle exchange or syringe purchase sites.

Tasks

Client:

- Client will meet SA Coordinator, make and keep appointment for evaluation.
- Client will get schedule for NA/AA groups.
- Client will attend NA/AA groups.
- Client will define harm reduction steps with the SA Coordinator.

Case Mgr:

- MCM will case conference client at medical rounds to ensure medical provider up to date with client's case
- MCM will refer client to SA Coordinator and introduce client to SA Coordinator.
- MCM will refer client to physician/ medical provider for physical evaluation. MCM will assist client in making appointment for medical appointment.

FINANCIAL

Problems

Client lacks adequate income to purchase medical services, medications, food, housing, etc.
Client has difficulty meeting Medi-Cal Share of Cost
Client has not applied for/received all benefits for which he/she might be entitled
Client has difficulty managing his/her own finances (due to developmental delay dementia, addiction issues)

Goals

Promote a stable environment through stable housing
Client able to purchase adequate, nutritious food
Promote a stable environment through the client's ability to meet expenses
Client has adequate medical insurance to cover needs
Client receiving all benefits to which she/he is entitled, ensuring access to resources that support the client's receipt of needed health care
A stable environment with client financial affairs managed responsibly

Tasks

Client: Client will make and keep appointments with Social Services, Social Security, etc, and apply for all benefits to which he/she is entitled
Client will provide case manager with proof of income, insurance residency, etc
Client will meet with Housing Advocate
Client will meet with Substance Abuse Coordinator for Substance Abuse Evaluation, and will begin to implement recommendations as a condition of referral for housing assistance
Client will continue to look for work
Client will sign up with a food bank such as Extra Helpings
Client will sign up with and adhere to money management

Case Mgr: Refer client to Extra Helpings, other food banks
Refer client to Housing Advocate for low-income housing
Refer client to Housing Advocate for rental subsidy/move-in monies
Advocate for client within social service and housing systems
Refer client to ADAP for assistance with prescription coverage
Assist client in applications for benefits
Refer client to money management services
Provide client with Emergency Funds including food, gas, and other vouchers, and Direct Emergency Assistance with Utilities and Telephone.
Review expenses and draw up a sample budget with client
Client referred to HEAP, Lifeline, and other discount programs
Client referred to Legal Services to execute Durable Power of Attorney for Finances

HOUSING

Problems:

Client homeless
Client unsafely housed
Client in temporary housing/ in need of permanent housing
Client housing is not handicapped-accessible

Client at risk for/being evicted (due to lack of income, money management problems, substance abuse problems, other landlord/tenant issues)

Client needs a higher level of care/no longer able to live independently

Goals:

Client benefits from a stable environment that is as unrestrictive as possible through the securing of stable, safe and affordable housing

Tasks

Client: Look for affordable housing
 Identify any family/friends with whom client may be able to live
 Meet with Housing Advocate
 Sign up for Section 8 when list is open
 Adhere to requirements for housing program applicants
 Provide case manager/housing advocate with necessary documentation
 Call Homeless Hotline
 Meet with Substance Abuse Coordinator for evaluation prior to Housing Referral
 and begin to implement plan
 Enter a substance abuse treatment program
 Sign up for money management services

Case Mgr.: Refer to Housing Advocate
 Advocate for Client with Housing Authority/other agencies
 Create a housing plan with client and Housing Advocate
 Assist client in locating a shelter bed
 Refer client to transitional housing programs
 Discuss with client barriers to permanent housing/conditions that led to
 homelessness or risk of eviction, and address these issues
 Confer with Housing Advocate/other providers
 Refer to money management
 Refer to a Board and Care Facility
 Refer to a Skilled Nursing Facility

LEGAL

Problems

Client lacks Durable Power of Attorney for Health care

Client lacks Durable Power of Attorney for Finances

Client in need of assistance with guardianship, divorce, custody, immigration, discrimination, bankruptcy issues (specify which issue)

Goals:

Client end-of-life plans in place

Permanency planning for client's children in place

Stabilization to maintain/achieve positive health outcomes through:

 Client's ability to protect remaining assets through bankruptcy filing

 Client's financial/legal affairs being in order

 Client's ability to redress discrimination issues

 Client's awareness of his/her legal rights and that these rights are protected

Tasks

Client: Client will call/meet with attorney or public defender
 Client will execute necessary documents with attorney

Client will identify family member/friend to be guardian of child, and discuss plans with them
Case Mgr: Refer client to pro bono legal services
Refer client to public defender
Confer with legal services or public defender as necessary
Advocate for client as necessary

SEX OFFENDER

Problems

Housing resources are limited.
Sex offenders unable to place in housing near schools or in buildings with families w/ children

Goal:

Client will obtain and retain affordable permanent housing.

Tasks

Client: Schedule and attend all appointments with parole officer.
Adhere to parole agents' instructions.

Case Mgr: Case conference with parole officer regarding housing options; source of housing funds
Referral to housing advocate for evaluation & assistance

RECENTLY RELEASED FROM INCARCERATION

Problems

Housing resources are limited

Goal:

Obtain and maintain safe affordable housing.

Tasks

Client: Schedule and attend all appointments with parole officer.
Schedule and attend all appointments with housing advocate.
Adhere to parole agent's instructions.

Case Mgr: Case conference with parole officer regarding housing options; source of housing funds
Case conference with the transitional case manager regarding housing, medical and employment options, if available
Referral to housing advocate for evaluation & assistance