

**Austin TGA**

# **Entering and Reporting on Needs Assessments, Care Plans, & Referrals in ARIES**

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*Information from by Brazos Valley Council of Governments (BVCOG) technical assistance documentation was incorporated into this manual*

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## Revision History

- **None at this time. This is the initial version of this document, dated December 13, 2010.**

## Introduction

### *Needs Assessments, Care Plans & Referrals*

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- **Conducting client Needs Assessments and Care Plans are important activities to help clients access and remain in care.**
- **The Needs Assessment, Care Plan, and Referrals modules in ARIES can be used to initiate and track a client's entire care plan process.**
- **This document covers the mechanics of entering these activities into ARIES.**
- **Although this document also contains some general guidelines and expectations regarding the care plan process, please consult your Standards of Care, Quality Management Plan, and related internal, EMA/TGA, and HRSA policies and procedures for additional information regarding the administration of these activities.**

# Introduction

## *General Guidelines for Care Plan Process*

- The following guidelines have been excerpted from documentation developed by BVCOG (<http://hiv.bvcoq.org>).
- The initial care plan should be conducted at intake and needs identified during this intake should be reflected on the Care Plan.
- The plan should be client-centered, client-driven, outcomes-based, action-oriented, and delineates responsible person(s)
- The care plan should reflect any new needs identified during reassessments.
- Care plans should be updated/reviewed at regular intervals, in addition to when changes in clients needs occur.
- A client's care plan information can be printed using your internet browser's *Print* option. For Internet Explorer, you can access the *Print* option by clicking on *File* in the IE *menubar*.
- Tasks or steps planned and undertaken in completing the plan should be documented.
- Any needed referrals should be documented, tracked, and the outcomes of the referrals should be indicated.

## Introduction

### *General Guidelines for Care Plan Process (cont'd)*

- **Below is an EXAMPLE of a needs assessment. Following this example will be a screen from the Care Plan module which illustrates how this plan could be entered into ARIES.**
  
- **A needs assessment was conducted for Sunny Daze on 1/1/2010:**
- **During the assessment, the client told her case manager, Dominic Toretto, that she was suffering from really bad anxiety attacks.**
- **Dominic identified that need on the assessment and began the process of getting Sunny referred for mental health assistance and medication for the attacks.**
- **The case manager...**
  - **Completed and gave the client a referral to see Dr. Monion.**
  - **Called Dr. Monion's intake specialist on 1/3/10 to see what documentation Sunny needed to have at her initial appointment.**
  - **Called Sunny on 1/6/10 to provide her with the needed information and to see if Sunny had called the doctor's office to make an appointment. Sunny had not called yet due to being sick.**

## Introduction

### *General Guidelines for Care Plan Process (cont'd)*

#### ■ EXAMPLE continued

- Called Sunny again on 1/9/10 to see if she had made an appointment. She has an appointment with Dr. Monion on 1/15/10.
- Dominic called Sunny on 1/15/10 to see how her appointment went. Sunny received some emergency medications and will see Dr. Munyon again on 1/21/10 to see how she is doing on her medications.
- Dominic called Sunny on 1/21/10 to make sure she attended her next appointment and to see if her medications were helping. She attended her appointment and she feels much better.
- Dominic will call her back in a month to check on her but told Sunny that if she needed anything else to call him back.
  
- *The following slide illustrates these steps entered into the ARIES Care Plan module.*

**Sunny I Daze**

Needs Assessment **New**

Date	Program	Needs
1/1/2010	Ryan White	Mental Health Services

SUNNY I DAZE

Care Plan **New**

Date	Staff	Program	Need/Subneed	Goal	Outcome	Completed	
1/1/2010	<a href="#">DOMTOR</a>	Ryan White	Mental Health Services (Psychiatric Evaluation)	To get the client help with the debilitating anxiety attacks she has been having		<b>Edit</b>	
Task	Assigned	Dt Init	Target Dt	F/U Dt	PSC	Outcome	Out. Dt
Call client to see how she is doing	<a href="#">DOMTOR</a>	2/21/2010	2/21/2010				
Follow up with client to see how appointment went	<a href="#">DOMTOR</a>	1/21/2010	1/21/2010	1/21/2010		client made it to her appt and is doing well	1/21/2010
Follow up with client to see how appointment went	<a href="#">DOMTOR</a>	1/15/2010	1/15/2010	1/15/2010		client made appointment and received emergency meds	1/15/2010
Client has appointment on 1/21/10	Client	1/15/2010	1/21/2010	1/21/2010		client made it to her appointment	1/21/2010
Follow up with client to see if she made appointment	<a href="#">DOMTOR</a>	1/9/2010	1/9/2010	1/9/2010		client has appointment on 1/15/10	1/9/2010
Check to see if Sunny made her appointment	<a href="#">DOMTOR</a>	1/6/2010	1/8/2010	1/6/2010		client had not made appt due to illness	1/6/2010
Provide client list of docs to take to appt	<a href="#">DOMTOR</a>	1/6/2010	1/8/2010	1/6/2010		read client list over the phone	1/6/2010
Get list of docs client needs to bring to doctor appointment	<a href="#">DOMTOR</a>	1/3/2010	1/4/2010	1/4/2010		doctor office	1/4/2010
Client needs to make appointment with Dr. Monion	Client						

**Sunny I Daze**

Referrals **New**

Date	Service	Referred to	Target Date	Outcome
1/1/2010	Ryan White > Mental Health Services > Psychiatric Evaluation	Dr. Monion	1/20/2010	Kept appointment

## Introduction

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### *General Guidelines for Care Plan Process (cont'd)*

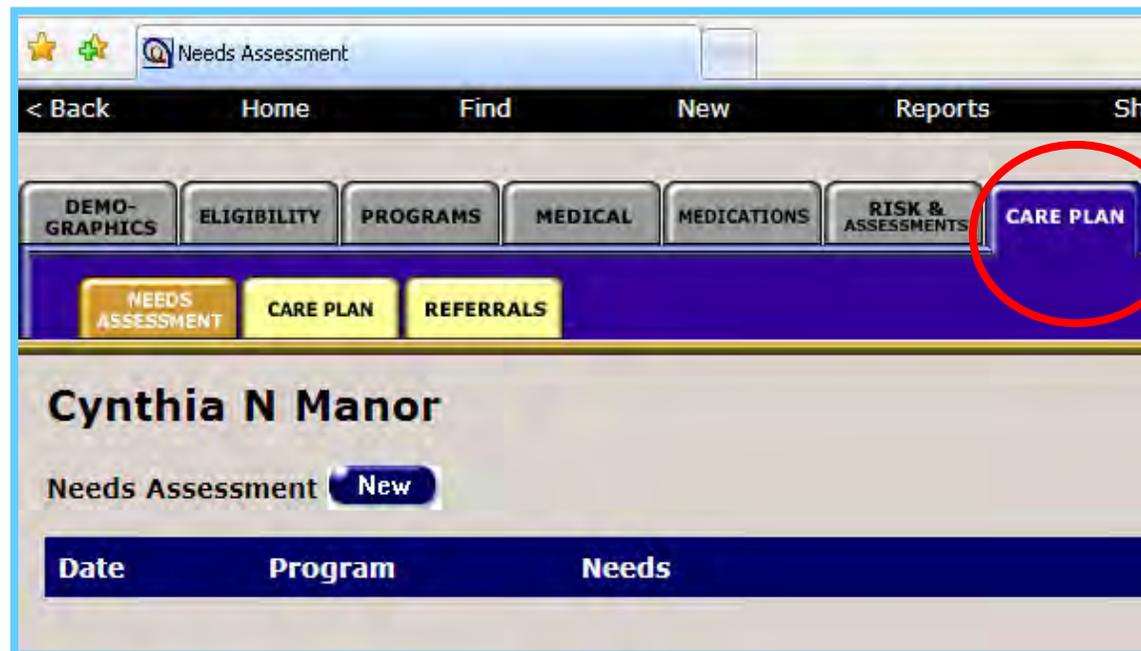
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- **The remainder of this document will illustrate the mechanics of entering Needs Assessments, Care Plans, and Referrals in ARIES.**

# Introduction

## *Needs Assessments, Care Plans & Referrals in ARIES (cont'd)*

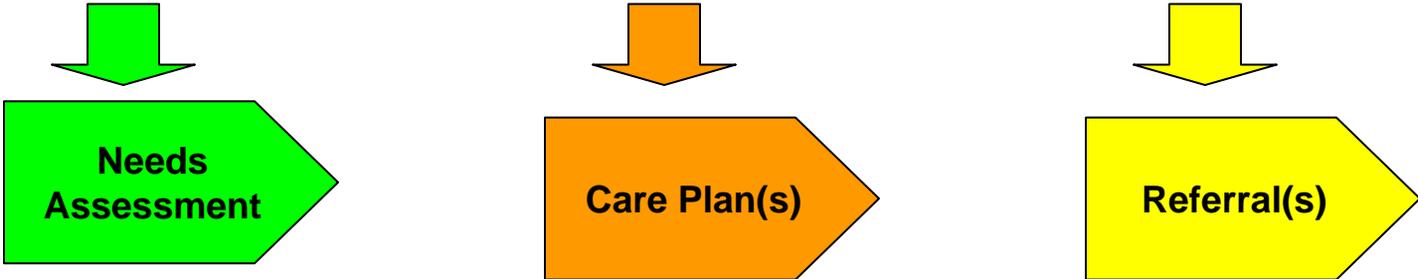
- ARIES makes it easy to initiate and track client care through its **Needs Assessment, Care Plan, and Referral** modules.
- These modules are located in ARIES under the **Care Plan major tab** at the top of the client record screen.



# Introduction

## *Needs Assessments, Care Plans & Referrals in ARIES (cont'd)*

- Each module can be accessed independently:



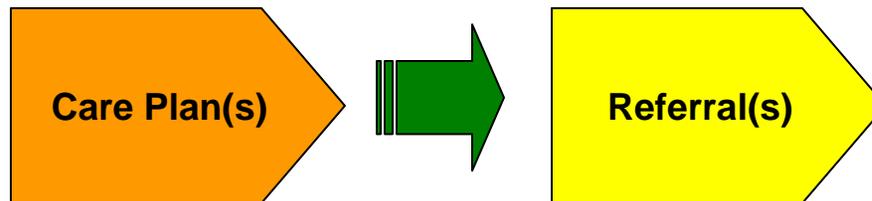
- You can complete the entire Needs Assessment, Care Plan, and Referrals process in sequence, starting with the Needs Assessment module:



## Introduction

### *Needs Assessments, Care Plans & Referrals in ARIES (cont'd)*

- You can access the Care Plan module then enter any needed Referrals.



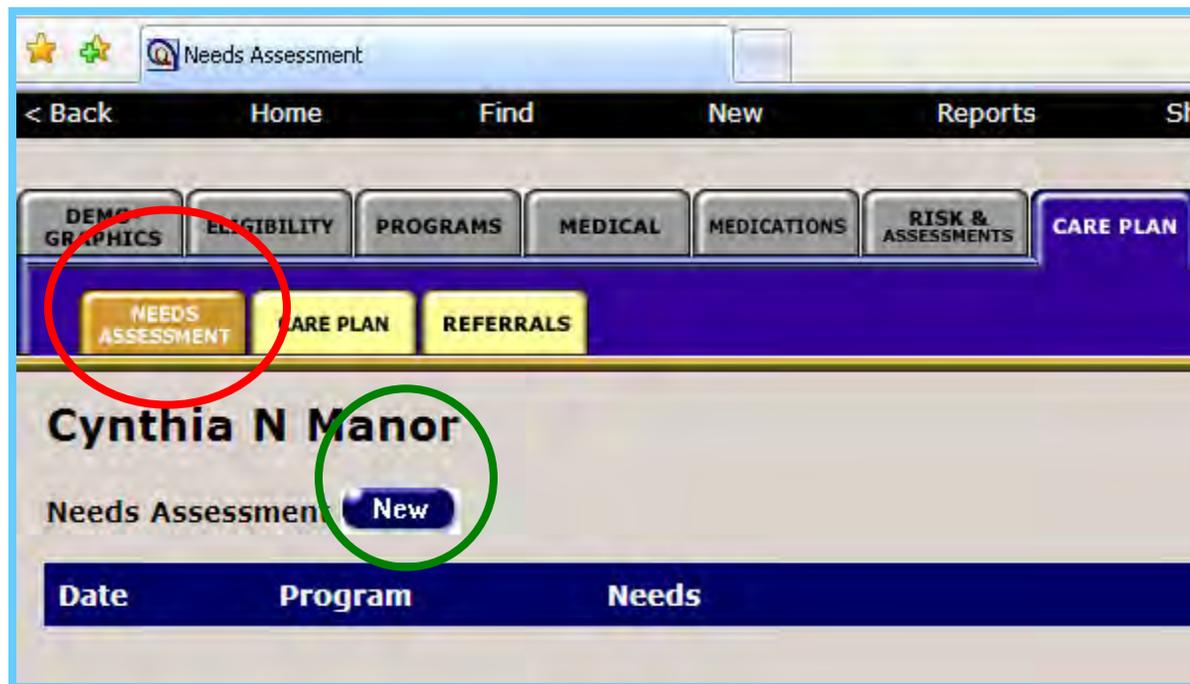
- If you conduct a Needs Assessment and determine that the client does not have any immediate needs that require a Care Plan or Referrals, *you can still document in ARIES that the Needs Assessment was conducted.*



# Needs Assessments

## *Data Entry*

- To create a Needs Assessment, click on the Care Plan *major tab*, then click on the Needs Assessment *sub-tab*. This will take you to the Needs Assessment *home screen*.
- Click on the *New* control button to begin the process.



# Needs Assessments *Data Entry (cont'd)*

- The following Needs Assessment screen will appear with a listing of **Primary Service Categories**.
- The **Program** drop-down field contains the following choices:
  - “Ryan White”, “CARE-HIPP”, “HOPWA”, “State Services Insurance”, “State Services Only”

**Cynthia N Manor Needs Assessment**

Program: Ryan White

Category	Need	Don't Need	Unknown	Create Care Plan
Outpatient/Ambulatory Medical Care	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
AIDS Pharmaceutical Assistance (local)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
Oral Health Care	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
Early Intervention Services (Parts A and B)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
Health Insurance Premium and Cost Sharing Assistance	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
Home Health Care	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
Home and Community-Based Health Services	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
Hospice Services	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
Mental Health Services	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
Medical Nutrition Therapy	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
Medical Case Management (including Treatment Adherence)	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>

Ryan White

- Ryan White
- Care Services Program (RW Part B)
- Bridge Project
- MCWP
- CARE-HIPP
- HOPWA

## Needs Assessments

### *Data Entry (cont'd)*

- The list of **Primary Service Categories** listed on the screen is dependent on the **Program** you select. “Ryan White” is selected by default.
- For example, if you select “HOPWA” from the drop-down field, only the **Primary Service Categories** associated with “HOPWA” will appear on the screen.

**Cynthia N Manor Needs Assessment**

Program

Category	Need	Don't Need
Housing Subsidy Assistance	<input type="radio"/>	<input type="radio"/>
Housing Placement Assistance	<input type="radio"/>	<input type="radio"/>
Supportive Services	<input type="radio"/>	<input type="radio"/>

Dated  

# Needs Assessments

## *Data Entry (cont'd)*

- For each need in your assessment, you have the option of selecting “Need”, “Don’t Need”, or “Unknown” by clicking in the appropriate option field.
- If a client does **NOT** need a service in your assessment, **be sure to select “Don’t Need”**.
- For any need identified, select “Need” AND click in the ***Create Care Plan*** check box field.

Cynthia N Manor Needs Assessment				
Program <input type="text" value="Ryan White"/>				
Category	Need	Don't Need	Unknown	Create Care Plan
Outpatient/Ambulatory Medical Care	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="checkbox"/>
AIDS Pharmaceutical Assistance (local)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Oral Health Care	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Early Intervention Services (Parts A and B)	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Health Insurance Premium and Cost Sharing Assistance	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="checkbox"/>
Home Health Care	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>
Home and Community-Based Health Services	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="checkbox"/>

## Needs Assessments *Data Entry (cont'd)*

- To finish the Needs Assessment, scroll to the bottom of the screen, enter the date of your assessment in the **Dated** field, then click the **Save+Next** control button to proceed to the Care Plan module.
- If no Care Plan check box fields were checked, you will be taken back to the Needs Assessment **home screen** after clicking **Save+Next**.

The screenshot displays a mobile application interface for entering assessment data. It features a list of service categories, each with two radio button options. Below the list is a text input field for 'Other Services'. At the bottom, there is a 'Dated' field with a date picker set to 11/28/2010, and two buttons: 'Save + Next' and 'Cancel'.

Referral for Health Care/Supportive Services	<input type="radio"/>	<input type="radio"/>
Rehabilitation Services	<input type="radio"/>	<input type="radio"/>
Respite Care	<input type="radio"/>	<input type="radio"/>
Substance Abuse Services - Residential	<input type="radio"/>	<input type="radio"/>
Treatment Adherence Counseling	<input type="radio"/>	<input type="radio"/>
Other Services	<input type="radio"/>	<input type="radio"/>

Other Services:

Dated: 11/28/2010

# Needs Assessments

## *Data Entry (cont'd)*

- In the example illustrated on the previous screens, two needs were identified:
  - *Outpatient/Ambulatory Medical Care (OAMC)*
  - *Health Insurance Premium and Cost Sharing Assistance*
  
- Since the *Create Care Plan* check box field was selected for each need, two Care Plans were created – one for each service category.

## Needs Assessments

### *Data Entry (cont'd)*

- If you had **NOT** indicated any needs, OR if needs were identified but the ***Create Care Plan*** check box field was not checked, no Care Plans would have been created.
  - Clicking on the ***Create+Next*** control button would take you back to the Needs Assessment screen. The Needs Assessment would show the ***Date*** and the ***Program*** information you entered.
  - Any needs indicated (Oral Health) would be listed, but they would not have corresponding Care Plans.

Fred E Sanford Needs Assessment				
	Program <input type="text" value="Ryan White"/>			
Category	Need	Don't Need	Unknown	Create Care Plan
Outpatient/Ambulatory Medical Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
AIDS Pharmaceutical Assistance (local)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Oral Health Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Early Intervention Services (Dental and B)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Health Insurance Premium and Cost Sharing Assistance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>
Home Health Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/>

Fred E Sanford		
Needs Assessment <input type="button" value="New"/>		
Date	Program	Needs
12/1/2010	Ryan White	Oral Health Care
5/13/2009	Ryan White	AIDS Pharmaceutical Assistance (local); Health Insurance Premium and Cost Sharing Assistance

# Needs Assessments

## Associated Care Plans

- Below is the Care Plan screen for OAMC. To view the Health Insurance Assistance Care Plan, click on the **Save+Next** control button. You can go back and edit/delete a Care Plan as long as you have not entered information in the **Date Completed** and **Outcome** fields.
- If you need to delete the Care Plan you started, click on the **Deactivate** control button.

### Cynthia N Manor Care Plan

Date Need Identified:  calendar icon

Staff:  dropdown icon

Program:  dropdown icon

Need:  dropdown icon

Subneed:  dropdown icon

Goal:

Date Completed:  calendar icon

Outcome:  dropdown icon

if other:

if other:

**Interventions**

Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date	
								<input type="button" value="New"/>

Referrals	Refer to	Referral Date	Target Date	Follow-up Date	PSC	Outcome	Outcome Date	
								<input type="button" value="New"/>

Services	Staff	Date	UOS	Total	
					<input type="button" value="New"/>

## Needs Assessments

### *Associated Care Plans (cont'd)*

- The Care Plan for Health Insurance Assistance is below.
- Since this is the last Care Plan you created under the current Needs Assessment, the **Save+Done** control button appears for you to save the data. As previously noted, Care Plans can be edited as long as you have not entered a **Date Completed** and an **Outcome**.

#### Cynthia N Manor Care Plan

Date Need Identified:  
 Date Completed:

Staff:  
 Outcome:

Program:

Need:  
 if other:

Subneed:  
 if other:

Goal:

Interventions

Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date	
								<input type="button" value="New"/>
Referrals	Refer to	Referral Date	Target Date	Follow-up Date	PSC	Outcome	Outcome Date	
								<input type="button" value="New"/>
Services		Staff	Date	UOS		Total		
								<input type="button" value="New"/>

# Needs Assessments

## *Conclusion*

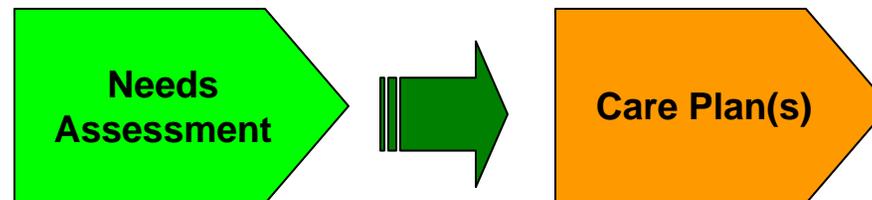
- This concludes the section on *Needs Assessment*.
- The following section focuses on *Care Plans*.



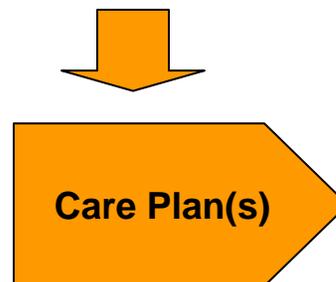
# Care Plans

## *Introduction*

- The Care Plan process can be initiated via the Needs Assessment module by identifying needs and specifying those needs that require corresponding Care Plans.



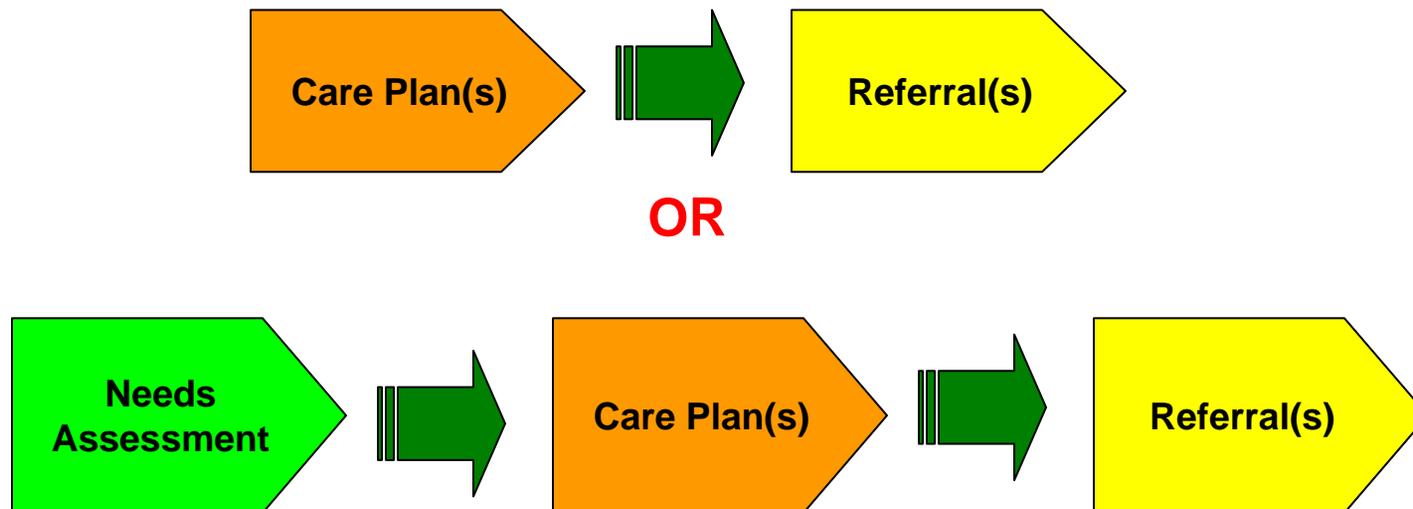
- Care Plans can be accessed directly from the Care Plans *major tab*.



# Care Plans

## *Introduction (cont'd)*

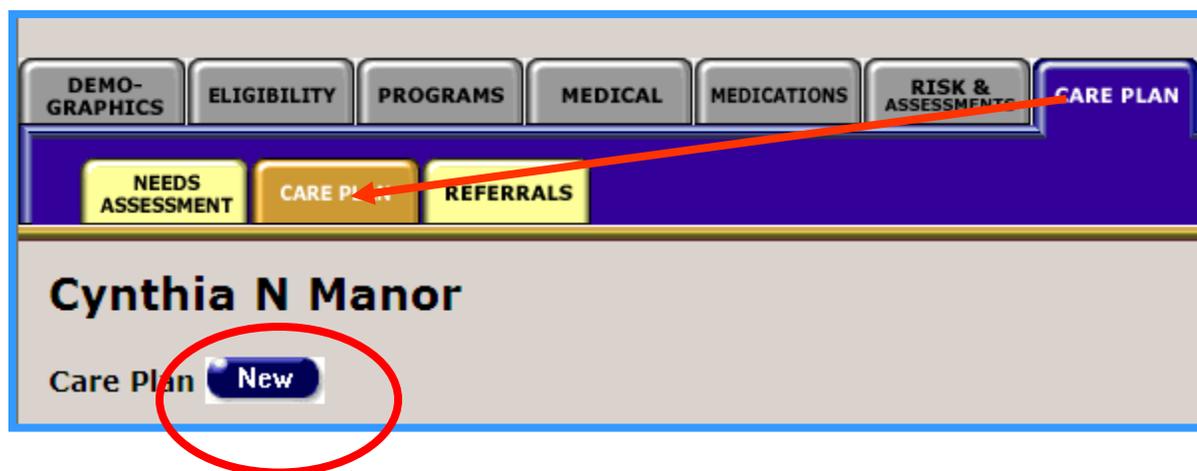
- In addition, at any point in the aforementioned Care Plan data entry process, you have the option of creating Referrals, which will be covered in detail in the Referrals chapter.



## Care Plans

### *Data Entry*

- The following instructions will illustrate Care Plan data entry via directly accessing the module. However, the data entry steps are basically the same regardless of how you access the module.
- Click on the **New** control button on the Care Plan *sub-tab*. This will take you to the Care Plan *home screen*.



## Care Plans

### *Data Entry (cont'd)*

■ Below is the data entry screen:

Initially enter data for the following fields:

***Date Need Identified*** – For example, at intake.

***Staff*** – Select a staff member from the drop down field, such as the client’s case manager or counselor. If one of your staff does not appear in the list, contact Betsy.

***Program*** – This is the program being referred TO.

The choices include: “Ryan White”, “CARE-HIPP”, “HOPWA”, “State Services Insurance”, and “State Services Only”.

### Cynthia N Manor Care Plan

Date Need Identified  Date Completed

Staff  Outcome

Program

Need  if other

Subneed  if other

Goal

Interventions

Referrals	Refer to	Referral Date	Target Date	Follow-up Date	PSC	Outcome	Outcome Date

Services	Staff	Date	UOS	Total

## Care Plans

### *Data Entry (cont'd)*

#### ■ Entry of initial data continued:

**Need** – This drop-down field contains a list of primary service categories set up in ARIES. The choices available in this field depend on the selection you make in the **Program** field. If the desired service is not on the list, select “Other Services”.

**Sub-need** – This drop-down field is populated with sub-services based on the selection you make in the **Need** field.

**If Other** – If you selected Other Services in the Need and Sub-need drop-down fields, you can enter the specific needs in these corresponding text fields.

### Cynthia N Manor Care Plan

Date Need Identified

Date Completed

Staff

Outcome

Program

Need  if other

Subneed  if other

Goal

Interventions

Referrals	Refer to	Referral Date	Target Date	Follow-up Date	PSC	Outcome	Outcome Date
Services	Staff	Date	UOS	Total			

# Care Plans

## Data Entry (cont'd)

### ■ Entry of initial data continued:

**Goal** – Describe the goal of this Care Plan entry in this field.

**DO NOT ENTER and save any information for the Date Completed and Outcome fields at this time.**

**Once you enter these data points, you cannot edit the Care Plan!**

**Wait until AFTER the outcome of the client’s Care Plan has been determined to enter and save this data.**

**Cynthia N Manor Care Plan**

Date Need Identified   Date Completed  

Staff  Outcome

Program

Need  if other

Subneed  if other

Goal

Interventions

Referrals	Refer to	Referral Date	Target Date	Follow-up Date	PSC	Outcome	Outcome Date

Services	Staff	Date	UOS	Total

# Care Plans

## *Data Entry (cont'd)*

- The following is an initially completed Care Plan.
- Note that the **Date Completed** and **Outcome** fields have been left blank.
- Click on the **Save** control button to save the information. This will take you back to the Care Plan **home screen**.

### Cynthia N Manor Care Plan

Date Need Identified	<input type="text" value="12/1/2010"/>	Date Completed	<input type="text"/>
Staff	<input type="text" value="Goodnight, Betsy"/>	Outcome	<input type="text"/>
Program	<input type="text" value="HOPWA"/>		
Need	<input type="text" value="Housing Placement Assistance"/>	if other	<input type="text"/>
Subneed	<input type="text" value="Permanent Housing Placement"/>	if other	<input type="text"/>
Goal	<input type="text" value="To get the client into a more stable housing situation to improve health outcomes"/>		

**Interventions**

Referrals	Refer to	Referral Date	Target Date	Follow-up Date	PSC	Outcome

Services	Staff	Date	UOS	Total

# Care Plans

## *Interventions – Tasks, Referrals & Services*

- Once you have saved your new Care Plan, you can enter **Interventions** made on behalf of the client to assist her with successfully completing the plan.
- These **Interventions** include **Tasks, Referrals, and Services.**
- To enter these **Interventions** later, click on the **Save+Done** control button.
- The following screens show how to enter **Tasks.** Referrals are covered in the next chapter.

### Cynthia N Manor Care Plan

Date Need Identified:  
 Date Completed:

Staff:  
 Outcome:

Program:

Need:   if other:

Subneed:   if other:

Goal:

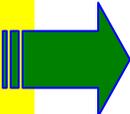
**Interventions**

Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date	<input type="button" value="New"/>
Referrals	Refer to	Referral Date	Target Date	Follow-up Date	PSC	Outcome	Outcome Date	<input type="button" value="New"/>
Services	Staff	Date	UOS	Total	<input type="button" value="New"/>			

## Care Plans

### *Interventions – Tasks Data Entry*

- To enter a **Task**, click on the corresponding **New** control button for the desired data. If you do not have any Interventions to enter, you can save your Care Plan by clicking on the **Save** control button at the bottom of the screen.
  - *Services data entry is covered in a separate technical assistance document.*



Interventions								
Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date	New
Referrals	Refer to	Referral Date	Target Date	Follow-up Date	PSC	Outcome	Outcome Date	New
Services	Staff	Date	UOS	Total				New

## Care Plans

### *Interventions – Tasks Data Entry (cont'd)*

- Complete the **Tasks** field with the tasks that need to be accomplished.
- The **Assigned To** drop-down field contains a list of staff members at your agency that you can select from. If a staff member is not on the list contact Betsy so she can add the individual as a “non-user” staff.
- The **Date Initiated** is the date you or the assigned staff member started working on this task.
- The **Target Date** is the goal date to have the task completed by.
- Enter into the **Follow-Up Date** field any staff follow-up activity, including your own. If multiple follow-ups were made, this date will be the most recent one.
- **DO NOT ENTER any outcome information in the Outcome and Outcome Date fields until after you are completely finished with the task.**
- **After you enter outcome information, YOU CANNOT EDIT THE TASKS ANY FURTHER!**

Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date	
<input type="text"/>	<input type="text" value="▼"/>	<input type="text" value=""/>	<input type="button" value="Save"/> <input type="button" value="Cancel"/>					

## Care Plans

### *Interventions – Tasks Data Entry (cont'd)*

- The following example shows that the task was assigned to the same individual who is associated with the Care Plan and was initiated on December 1<sup>st</sup>. The goal of the task was to send some paperwork to ASA by the 8<sup>th</sup>. A follow up was conducted on the 6<sup>th</sup>.
- Outcome information is not available so it has not yet been entered.
- Save the Task by clicking on the *Save* control button.

Interventions								
Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date	
Send paperwork to ASA	Goodnight Betsy	12/1/2010	12/8/2010	12/6/2010				<input type="button" value="Save"/> <input type="button" value="Cancel"/>

## Care Plans

### *Interventions – Tasks Data Entry (cont'd)*

- Click on the **Edit** control button to update the task, including adding outcome information.

Interventions							
Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date
Send paperwork to ASA	bg1	12/1/2010	12/8/2010	12/6/2010			
							<input type="button" value="Edit"/> <input type="button" value="New"/>

- The screen below shows the **Outcome** and **Outcome Date** information that was added to the task.
- Note that the **Edit** button is no longer visible after adding the outcome data.

Interventions							
Tasks	Assigned to	Date Initiated	Target Date	Follow-Up Date	PSC	Outcome	Outcome Date
Send paperwork to ASA	bg1	12/1/2010	12/8/2010	12/6/2010		Paperwork received by ASA	12/7/2010
							<input type="button" value="New"/>

## Care Plans

### *Conclusion*

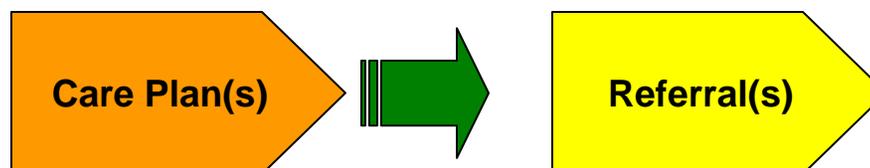
- If the care plan contains any associated referrals, they can be entered while initially creating the Care Plan OR while updating the Care Plan if it was previously created. Note again that Care Plans for which outcome information has been entered and saved cannot be updated.
- Referrals are covered in the next chapter.



# Referrals

## *Introduction*

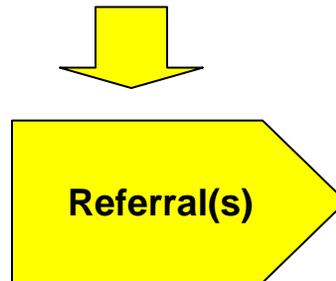
- The Referrals data entry process can be initiated via the Care Plan module while creating a new Care Plan when updating a pre-existing Care Plan for which outcome information has NOT been entered.



# Referrals

## *Introduction (cont'd)*

- Referrals can be accessed directly from the Care Plans *major tab*.



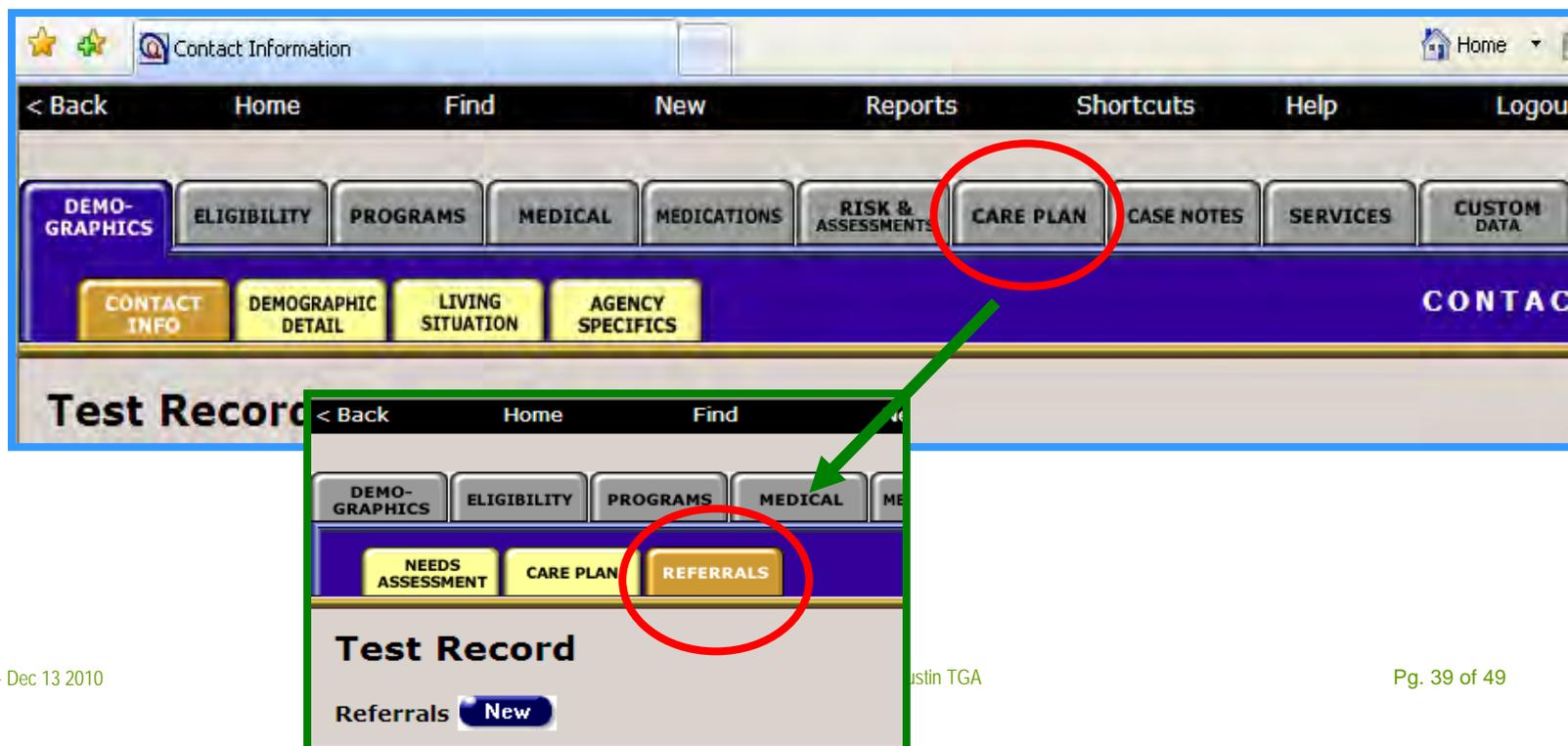
- Or you can access Referrals when you enter Needs Assessments and any subsequent, associated Care Plans.



# Referrals

## Data Entry

- The following instructions show how to enter Referrals directly. However, the same basic steps will apply if you access the module via Needs Assessments and/or Care Plans.
- To enter a Referral, click on the **Care Plan** tab then click on **Referrals**. This will take you to the Referrals **home screen**.
- Click on the **new** control button.



# Referrals

## *Data Entry (cont'd)*

- The client's Referral data entry screen appears below.

**Program** being referred to - Ryan White, CARE-HIP, HOPWA, State Services Insurance, State Services Only

**Primary & Secondary Service** being referred TO – includes all ARIES primary and secondary service categories.

The **Primary Service** selection options depend on the **Program** selected. Accordingly, the **Secondary Service** options depend on the **Primary Service** selected.

For example, if you select “Ryan White” for **Program**, and “Outpatient Ambulatory Medical Care” for **Primary Service**, only those Secondary Services relevant to OAMC will populate this field, such as CD-4 and Viral Load tests.

**Refer To** – Pre-populated by DSHS. If the category you need is not in the list, enter it in the **Other** field.

The screenshot shows a web-based form titled "Test Record Referral". The form is organized into two columns. The left column contains: "Referral Date" (calendar icon), "Program" (dropdown), "Primary Service" (dropdown), "Secondary Service" (dropdown), "Refer To" (dropdown) with an "Other" text field below it, "Target/Appt. Date" (calendar icon), "Follow-up Date" (calendar icon), "PSC Code" (text field), and "Reason" (text area). The right column contains: "Outcome Date" (calendar icon), "Outcome" (dropdown), and "Notes" (text area). At the bottom right, there are "Save" and "Cancel" buttons.

# Referrals

## *Data Entry (cont'd)*

### ■ Referrals data entry continued:

**Target/Appt. Date** – This is the date you are trying to get the client into services at the agency you are referring the client to.

**Follow-up Date** - If you change information in the referral, plan a follow-up date in advance, or enter outcome information, enter the date here. You do not have to enter a date when creating the referral record.

**PSC Code** –Payment Source Code . This field can be left blank.

**Reason** – Enter a reason for the referral. The reason does not have to be lengthy but should contain enough information to describe the purpose of the referral.

**Notes** – Use this field to enter any pertinent notations while the referral is still active, i.e., no outcome information has been entered and saved.

### Test Record Referral

Referral Date	<input type="text" value=""/>	Outcome Date	<input type="text" value=""/>
Program	<input type="text" value=""/>	Outcome	<input type="text" value=""/>
Primary Service	<input type="text" value=""/>	Notes	<div style="border: 1px solid gray; height: 100px; width: 100%;"></div>
Secondary Service	<input type="text" value=""/>		
Refer To	<input type="text" value=""/>		
(other)	<input type="text" value=""/>		
Target/Appt. Date	<input type="text" value=""/>		
Follow-up Date	<input type="text" value=""/>		
PSC Code	<input type="text" value=""/>		
Reason	<div style="border: 1px solid gray; height: 80px; width: 100%;"></div>		

# Referrals

## *Data Entry (cont'd)*

### ■ Referral data entry continued:

#### *Outcome Date & Outcome –*

**DO NOT ENTER AND SAVE DATA FOR THESE FIELDS UNTIL you have determined the appropriate outcome for the referral.**

Once outcome information is entered and the referral is saved, the referral **CANNOT BE EDITED!!** The referral ceases to be “active”.

#### Outcome selections include:

***“Kept Appointment”, “No Show”, “Rescheduled Appointment”.***

### Test Record Referral

Referral Date	<input type="text" value=""/>	Outcome Date	<input type="text" value=""/>
Program	<input type="text" value=""/>	Outcome	<input type="text" value=""/>
Primary Service	<input type="text" value=""/>	Notes	<div style="border: 1px solid gray; height: 100px; width: 100%;"></div>
Secondary Service	<input type="text" value=""/>		
Refer To	<input type="text" value=""/>		
(other)	<input type="text" value=""/>		
Target/Appt. Date	<input type="text" value=""/>		
Follow-up Date	<input type="text" value=""/>		
PSC Code	<input type="text" value=""/>		
Reason	<div style="border: 1px solid gray; height: 80px; width: 100%;"></div>		

## Referrals

### *Data Entry (cont'd)*

- Below is a screen of an initially completed Referral.
- Click on the **Save** control button at the bottom of the screen to save the information.

The screenshot displays a web-based form titled "Test Record Referral". The form contains several fields for data entry:

- Referral Date:** 10/1/2010 (with a calendar icon)
- Program:** Ryan White (dropdown menu)
- Primary Service:** Outpatient/Ambulatory Medical Care (dropdown menu)
- Secondary Service:** Outpatient/Ambulatory Medical Care (dropdown menu)
- Refer To:** Clinic public (dropdown menu)
- (other):** (empty text field)
- Target/Appt. Date:** 10/15/2010 (with a calendar icon)
- Follow-up Date:** (empty text field with a calendar icon)
- PSC Code:** (empty text field)
- Reason:** Newly identified with HIV. Not sure where to go to get medical care. Referring to DPC. (text area)

At the bottom right of the form, there are three buttons: "Save" (yellow), "Cancel" (blue), and "Deactivate" (red). The "Save" button is circled in green.

# Referrals

## *Data Entry (cont'd)*

- The saved Referral will be listed on the Referrals *home screen*. To edit the referral, click on the *Edit* control button.

The screenshot displays a web application interface with a navigation menu at the top: < Back, Home, Find, New, Reports, Shortcuts, Help, Logout. Below the menu is a row of buttons: DEMO-GRAPHICS, ELIGIBILITY, PROGRAMS, MEDICAL, MEDICATIONS, RISK & ASSESSMENTS, CARE PLAN (highlighted), CASE NOTES, SERVICES, CUSTOM DATA. A secondary row of buttons includes NEEDS ASSESSMENT, CARE PLAN, REFERRALS, and REFERRALS. The main content area is titled 'Test Record' and contains a 'Referrals' section with a 'New' button. Below this is a table with the following data:

Date	Service	Referred to	Target Date	Outcome
10/1/2010	Ryan White > Outpatient/Ambulatory Medical Care > Outpatient/Ambulatory Medical Care	Clinic public	10/15/2010	Edit

# Referrals *Updates*

- To add notes to the Referral, click on the *Edit* control button, as described in the previous slide.
- In the example below, the case manager followed up with the client on October 10<sup>th</sup>.

**Test Record Referral**

Referral Date	10/1/2010	Outcome Date	
Program	Ryan White	Outcome	
Primary Service	Outpatient/Ambulatory Medical Care	Notes	Followed up with client to see if he made an appointment at DPC yet - client has not called yet - 10/10/10.
Secondary Service	Outpatient/Ambulatory Medical Care		
Refer To	Clinic public		
(other)			
Target/Appt. Date	10/15/2010		
Follow-up Date	10/10/2010		
PSC Code			
Reason	Newly identified with HIV. Not sure where to go to get medical care. Referring to DPC.		

Buttons: Save, Cancel, Deactivate

# Referrals

## Updates (cont'd)

- On October 18<sup>th</sup>, the case manager followed up with David Powell to see if the client made his appointment. The client did make his appointment. So, the case manager entered “10/18/2010” for the **Outcome Date** and “Kept Appointment” for the **Outcome**.

### Test Record Referral

<p>Referral Date: <input type="text" value="10/1/2010"/> </p> <p>Program: <input type="text" value="Ryan White"/> </p> <p>Primary Service: <input type="text" value="Outpatient/Ambulatory Medical Care"/> </p> <p>Secondary Service: <input type="text" value="Outpatient/Ambulatory Medical Care"/> </p> <p>Refer To (other): <input type="text" value="Clinic public"/> </p> <p>Target/Appt. Date: <input type="text" value="10/15/2010"/> </p> <p>Follow-up Date: <input type="text" value="10/18/2010"/> </p> <p>PSC Code: <input type="text"/></p> <p>Reason: <input type="text" value="Newly identified with HIV. Not sure where to go to get medical care. Referring to DPC."/></p>	<p>Outcome Date: <input type="text" value="10/18/10"/> </p> <p>Outcome: <input type="text" value="Kept appointment"/> </p> <p>Notes: <input type="text" value="Client made his appointment :)&lt;br/&gt;Followed up with client to see if he made an appointment at DPC yet - client has not called yet - 10/10/10."/></p>
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## Referrals

### *Updates (cont'd)*

- Since an **Outcome Date** and an **Outcome** were entered and saved, the referral is no longer editable; hence, the referral is no longer “active.”
- Note that the **Edit** control button no longer appears on the screen.



NEEDS ASSESSMENT CARE PLAN REFERRALS REFERRALS AR

### Test Record

Referrals **New**

Date	Service	Referred to	Target Date	Outcome
10/1/2010	Ryan White > Outpatient/Ambulatory Medical Care > Outpatient/Ambulatory Medical Care	Clinic public	10/15/2010	Kept appointment

## Referrals

### *Conclusion*

- **When entering referrals, it is important to remember not to enter and save any outcome information prematurely, since you cannot go back and edit such entries.**



## Contact Information for Assistance

**For assistance with entering, updating or reporting on Needs Assessments, Care Plans, and Referrals, you may contact ~~**



**Cynthia Manor, Data Manager**  
Austin TGA  
City of Austin Health and Human Services HIV Resources Unit  
(512) 972-5076 – [cynthia.manor@ci.austin.tx.us](mailto:cynthia.manor@ci.austin.tx.us)  
T.A Website: <http://austinaries.tech.officelive.com/default.aspx>

**Betsy Goodnight, Data Manager**  
Brazos Valley Council of Governments (BVCOG)  
(979) 595-2801 ext 2227 – [bgoodnight@bvco.org](mailto:bgoodnight@bvco.org)  
HIV Provider site: <http://hiv.bvcog.org>