Parent-Child Assistance Program (PCAP)

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Client File Protocol

The purpose of the client file is to hold and organize information the case manager collects and uses during the course of case management. Information in the client file should be kept up to date so that it is relevant and useful to the case manager and her supervisor at all times.

The office assistant assembles new files so case managers have a clean file ready to start with each new client assigned. Each client has a separate file.

Client files are never to be taken out of the office. When the case manager is not working with a file, it should be kept in the locked filing cabinet designated for that purpose. Files should not be kept in the case manager's desk. Supervisors should be able to locate any case manager's client files quickly and access information easily should a case manager not be available when action needs to be taken on a case.

Content of the Client File

1st section:	Client ID Sheet (on top), Tracing Information Update Log, Client Services Agreement
2nd section:	Services Coordination, Releases of Information
3rd section:	Mother and Target Child Medications Information
4th section:	Assessments and Goals (Difference Game, Strengths and Needs, Difficult Life Circumstance (DLC), Addiction Severity Index (ASI) last page of intake interview
5th section:	Case Notes
6th section:	Correspondence

1st Section, Contact Information and Client Services Agreement

Client ID Sheet

- Office assistant will enter new client ID information into the Access Client Tracing Database and print out the ID sheet to be put into the client file. Whenever the case manager learns updated contact information, she records this on the Tracing Information Update Log (see below) and will give the updated contact information to the office assistant, who will update the Access Client Tracing Database and print out a new ID sheet for the client file.

  Note: The Access client tracing database content should never be deleted. When a client graduates, the office assistant should move client information from the "mom/baby" table to the "graduated clients" table.
- Case managers should keep all former ID sheets filed in this section of the client file, never discarding old information as it may be valuable in tracing.

Tracing Information Update Log

- Throughout the intervention, whenever the case manager learns new contact information, she will record it on this form. This includes updated addresses, phone numbers, email addresses, social media names/IDs, references, drop off locations, etc. It may be helpful to ask the client who she would like you to contact in the case of an emergency with the target child. Then the case manager

gives a copy of the update sheet to the office assistant to enter into the Access Client Tracing Database.

Client Service Agreement

- The Client Service Agreement is reviewed and signed by the client and supervisor at the intake interview. Keep a copy of it in this section of the client file. Case managers may carry a blank laminated copy with her to remind clients of the Agreement and Ground Rules as often as necessary during the intervention.

2nd Section, Client Services Coordination

Services Coordination Form

Every client has an individualized case management plan. The Services Coordination form is used to document and organize information about the professionals and service providers with whom the client and case manager are working.

The Case Manager:

- Completes the form at client enrollment with input from the supervisor based on community services information obtained on the intake ASI interview, and with input from client about her present needs.
- Identifies additional professionals and providers whose skills and services will be necessary to help the client meet personal and program goals.
- Obtains signed Release of Information (ROI) forms from client and service providers involved (see ROI below), keeps ROIs up to date, and keeps ROIs in the Services Coordination section of the client file.
- Develops a tickler system to ensure ROIs haven't expired, and to get new ROIs signed as necessary.
- Contacts these service providers, introduces herself, explains PCAP and her role as a case manager, and asks how PCAP can help the provider to help the client meet her goals.
- Continually updates Service Coordination form and dates all new entries, so that another case manager or supervisor could pick up the Client File and make important contacts if necessary.
- As directed by the supervisor, may maintain a color-coded "dot" or other system to indicate provider status (e.g., green dot = current, or red dot = provider the client is no longer involved with).
- Retains all old Services Coordination pages in chronological order in this section of the file.

Strategies:

Number each service provider listed on the Services Coordination pages, and number the corresponding Releases of Information (ROI) with the same number. This process makes it easier for the case manager, supervisor, and DBHR auditor to verify that there are ROIs for each service provider. (See ROI information below regarding if a client refuses to sign a ROI.)

In consultation with the PCAP supervisor, the case manager determines whether it will be helpful to organize a case consultation or conference call with several providers in order to determine who can best assist with specific client goals. The case manager acts as a liaison for communication within this network in order to avoid duplication of services or working at cross-purposes, and to alleviate potential manipulation by the client. Supervisors are often involved in these case consultation conferences.

Clients' service networks usually change over time. Early in the intervention, services commonly include alcohol/ drug assessment and treatment, Child Protective Services (CPS), legal services, family healthcare, housing, family planning services, and basic needs. Later, clients in recovery often begin to utilize education and vocational training resources in the community.

Releases of Information

IMPORTANT INFORMATION ABOUT RECORDS FROM OTHER AGENCIES:

- DO NOT PUT RECORDS FROM TREATMENT, MENTAL HEALTH, MEDICAL, etc. in PCAP client files - there is no such thing as a "dummy file."
- All PCAP files can be subpoenaed. Paperwork from other agencies should only exist in a client file if there is a valid release for it. Otherwise, do not keep outside agency records in any PCAP files. Doing so has the potential to put PCAP at legal risk. Instead, in client case notes, record relevant information from the outside agency document (e.g. a monthly report from the treatment provider). Then shred the outside agency document or return it to the owner. Do not assume the document or report belongs to the client.
- Whoever created the document is the only one who can authorize its release and re-release. For documents from treatment agencies (e.g., monthly or other regular reports, discharge summaries) or from hospitals, doctors, or clinics, do the following: Document that you received the report; include relevant information, e.g., diagnoses, recommendations (including medications prescribed), and facts such as admission date and discharge date.
- You may keep copies of dependency court orders. These are public record and you are working with DCFS, the courts, and the client to work toward compliance. You need a signed Release of Information for this paperwork and any other reports, correspondence, or letters in your file.

3rd Section, Mother and Target Child Medications

Ask client for medication information beginning at enrollment, and if possible, look at actual medication containers to determine name and dosage. Record this information on the medications form. Include medications for physical problems and mental health issues, and for birth control methods. Medication-Assisted Treatment (MAT) should be documented on this form, including dates, changes that occur in medication, dosage, and providers.

Update information as necessary. You may need to complete more than one medications form over the course of the clients' three years. Keep all previous forms in chronological order in the client file.

Ask client or foster parent for information about medications the target child (TC) is taking or that have been prescribed for the child, (for physical and/or mental health problems). Note any allergies the child has. Record immunizations the target child has received and when received, using the immunization schedule on the back of the TC Medications form. In Washington State, this information can be requested from the Washington State Immunization Information System using their authorization form. See:
http://www.doh.wa.gov/Portals/1/Documents/Pubs/348-367-IISAuthorizationForm.pdf

- or call the WA State Immunization Information System at **1-866-397-0337**
- or email: WAIISRecords@doh.wa.gov

4th Section, Assessments and Goals

Assessment Instruments

- Difference Game data entry form
- Goals
- Family Strengths and Needs
- Difficult Life Circumstances (DLC)
- Last page of ASI intake interview
- Biological Children at Enrollment

The case manager:

- Completes assessments with client within six weeks after enrollment.
- Reviews assessments as soon as possible in supervision.

Copies of the following assessment instruments may be kept in the client file: the Difference Game data entry form, Difficult Life Circumstances (DLC), and Biological Children at Enrollment*; originals are kept in a separate Data file for each client (filed by ID number, not name).*

Goals

Goals are established with the client within six weeks after enrollment. They are evaluated and reestablished every four months because this amount of time allows clients to (a) accomplish short-term, concrete tasks (e.g., complete paperwork for housing waiting lists or enroll in a parenting class), and (b) make progress on long-term goals requiring fundamental, gradual life changes (e.g., staying in recovery or avoiding contact with former abusive partner).

SMART Goals are Specific, Measurable, Attainable, Relevant, and Time-Based.

The case manager:

- First administers the Difference Game card sort assessment to help client think about and identify issues that would "make a difference" in her life, and that she may want to consider as goals.
- Talks with client about what they learned from the Difference Game.
- Helps client identify one or two goals that are realistic, manageable.
- Writes these goals down on the Goals form using client's own words.
- Identifies and records "baby steps" she and the client will each take to reach the goals.
- Makes sure at least some of these "baby steps" are attainable in the 4-month period.
- Translates "baby steps" into Weekly Goals that they can refer to at the end of each home visit. Gives a copy of Weekly Goals to the client, or takes a photo with her phone and sends it to the client.
- Makes a plan for their next home visit. Do they each have their homework assignments? How will the visit relate to client goals and "baby steps"?
- Reviews Goals and "baby steps" as soon as possible in supervision every time goals are set.
- Makes a copy to keep in client file.
- Can give a copy to the client so she is reminded of goals she set.

Helping clients increase self-efficacy is all about helping them to identify reasonable goals and steps and helping them to accomplish these successfully.

It is critical to recognize and reinforce every step in the right direction.

The client MUST observe herself succeeding in order for her to move along to new stages of change.

Reminders:

- Sometimes the first baby steps may inform what needs to be done next.
- Be flexible. Modify/add goals and steps as client's needs change.
- Review and evaluate goals as needed, and every 4 months.
- Clients may not understand the word "Goal". Here are ways case managers use to describe the concept:

  What do you want your life to look like?
  What would you like your life to look like in the next few months, in the next year?

Ask the client, "What has held you back from doing that goal, or that baby step?"
Then help her take steps to resolve those barriers so they won't hold her back.

5th Section, Case Notes

The Importance of Documentation

1. Case notes serve as a narrative version of case management activity and client progress.
2. Your files are not strictly for the case manager. If an auditor, other case manager, or supervisor picks up a file, they need to be able to get a clear picture of who the client is, what has been done, what is working, what areas need attention. Without good, clear case notes, it can be next to impossible for successful client transition should the case manager be absent.
3. Case notes could be important in an investigation. You want an accurate, truthful record of what has happened. You do not want a file that reads as if you did next to nothing with a client or with a service provider. *All attempts at contact need to be documented. If a client refuses services, or is a no-show, it needs to be recorded. Record all attempts to contact service providers, and their no-shows.* This documentation may be needed later to strengthen a case.
4. Case notes help to tell the complete story of the client's experience in PCAP. The case manager's work with clients is reflected in: Case notes, Time Summaries, Goals, and Biannual Assessments. *Information is expected to be consistent across forms.*

Supervisors are required to read and sign off on case notes and review file content, using the PCAP Client File Review form every four months.

Format for Writing PCAP Case Notes
Charting good notes requires discipline. Keep case notes up to date. It is critical that to get in the habit of jotting down a few notes after every action or interaction. Then complete case notes by the end of each week. Notes can be brief, but they need to use the DAP system (explained below).

For each case note form entry:
Fill in the ACTUAL DATE contact happened in the left column: month, day, and YEAR.
Check the checkboxes as appropriate:

- Was it a face-to-face visit (in the home or elsewhere)?
- Was Target Child present?
- Was it a phone call?
- Were you transporting the client or anyone else?

The "DAP" System:

***DESCRIPTION:* An objective description of pertinent information**

WHEN Note time of day if it was outside normal work hours.
WHERE Note location where contact occurred. Note the specific address if it is a new location.

WHO	Note EVERYONE who was present. If it is a new provider, add to Services Coordination form. It’s okay to use acronyms (e.g., FOB for Father of Baby) or abbreviations (e.g. clt. for client) or initials of people. When charting service provider information use the name of the provider.
WHAT	Note what happened (client, child's caregiver, service provider). Note purpose of visit, topics discussed, reactions, and outcome.

***ASSESSMENT*:**
How is the client doing? Describe status, progress. Is she working toward her goals?

***PLAN*:**
Case notes should include a plan for next step; a date for next visit. What needs to be done? When and by whom? Note any upcoming major changes/issues.

Case Notes: Some Do’s

- Write case notes neatly, in ink. If you type case notes, they must be kept up to date, printed out weekly, signed, and put in client file. (See Electronic Case Note Security, below.)
- Sign each case note entry with full signature (not just initials), and put in client file.
- Use direct quotes from client, service provider, or others to portray and illustrate the person’s attitude or opinion (e.g., “I’m so angry about this I don’t want to see my social worker”).
- Report the facts, e.g., what you saw and heard, not your subjective opinion about what you think happened or what you think someone might have meant.
- Use plain English. Avoid technical terms, jargon (e.g. “slippery”), and unusual acronyms. If you use a new or unusual acronym, define it the first time you use it (e.g. SO = significant other).
- Keep case notes up to date. Have at least some notes jotted down each day, and complete case notes by the end of the week. Some case managers, while in the field, speak into their smart phones to record a case note, email it to themselves, and then cut and paste later into a written case note.
- Write notes that are useful to you.
- If you make a mistake, strike through and write above. No white-out.
- Record volatile situations, but also notify your supervisor immediately (e.g., report made to CPS, client threat to self or others).

And Don’ts
- Avoid speculation. Do not discuss what you think the client or provider’s actions mean. Instead use direct quotes, or describe actual behavior you observed (it is helpful to use the phrase “…as evidenced by….”).
- Avoid subjective, judgmental statements.
- Do not get behind on your notes.

Electronic Case Note Security
Case managers may write their case notes on the computer. If they do they should follow these security protocols:
- Client and target child names or other identifiable information are never put into an electronic case note; instead, use the client ID # at the top of the page. Full names of others should not be in the case notes. Use initials or descriptor (e.g., “landlord” or “older sister”).
- Case notes must be printed out weekly, signed, and filed in the chart.
- The computer used or the case note file should be password protected, and may temporarily be saved

on a thumb drive, and should never be saved to the hard drive.

- Case notes should be deleted from the computer or thumb drive after they are printed out and filed.
- Because deleted files can easily be recovered, it is more secure to delete the text from the file before the final save (i.e., save an empty file). Then delete the file. The data is still on the hard drive but it is harder to recover.
- Thumb drives should ideally have the capacity to be password protected and to have the data encrypted in case the thumb drive is lost. Not all drives can do this ("Cruzer" thumb drives, for example, do come with software that can do this.)

6th Section, Correspondence

- In the front of this section, file Permission for Transport and any other permissions.
- Following these, file other correspondence in chronological order.

Client File Tips

Case Manager Best Practice for Updating Client Files

Create a "Carry File" containing blank pages of the forms you usually need in the field:

- ROIs
- Service Coordination forms
- Tracing Information Update form
- Goals forms
- Case Note pages
- Medications Information forms
- CRSQ
- Weekly Goals sheet
- Laminated Client Services Agreement (to remind clients what they agreed to)

Biannual time is a good time to update everything in that client's file.

Supervisor Lessons Learned about Client Files

- Supervisor is ultimately responsible for content and quality of client files.
- Supervisors do client file audits every four months.
- Client file audit results have been be used in personnel actions.