MODULE NINE

Referrals
To
Other Services

Policy

One of the primary roles of Medical Case Managers is to ensure implementation of the clinical treatment plan and care plans by facilitating referrals to services not provided on site. Referrals should meet the client needs identified and prioritized by the physician and other service providers during the intake and needs assessment process and integrated into the clinical treatment plan and care plan development processes. Services to which clients are referred must be appropriate to the needs of the client, be accessible to the client in terms of culture, physical location, and cost. Following the referral of a client, the provider must follow up with the client and the service provider to whom the client was referred to ensure that services were accessed. It is the medical case manager's role to assist the client with mediating any barriers to accessing services (e.g. travel, scheduling, etc.) as well as any perceived stigma in seeking assistance from core service providers e.g. mental health and substance abuse. In many cases the medical case manager will need to use motivational interviewing, case conferencing, warm hand-offs or other client centered techniques to successfully link a client with necessary services for improved health outcomes.

All referrals are to be reported and tracked in the ARIES database following the process outlined in the procedure of this module.

Minimum Requirements

Referrals must be appropriate to the client's identified and prioritized needs.

Referred services must be accessible to client.

Referrals must be documented in ARIES.

Medical Case Managers should contact referral provider to coordinate the referral ***and*** ensure greater likelihood that the client will be successful in accessing services. The referral should be discussed with the client.

Medical Case Managers must follow up on urgent referrals (i.e. emergency shelter and health care) with the receiving agency/provider ***and*** the client immediately. For all other referrals, follow up with client as part of your monthly client contact and review of their care plan.

Referral follow-up must be documented in the ARIES Case Notes, including any barriers to accessing services ***and*** steps to overcome those barriers. The receiving provider should enter referral outcomes in the ARIES referral tabs.

Referral discussions must be included in case conferences at least twice during the program year recorded on the *Referral Case Coordination Log* (See sample attached).

Units of Services should be entered for all referrals.

Procedure

In consultation with clinical providers in rounds and in clinical supervision, determine which referrals are necessary for the client to address his/her needs identified during intake and assessment. ➔

Services the client is referred to must be:

- ❖ Accessible in terms of physical location, transportation, culture/language, and cost.
- ❖ Appropriate to the client's needs.
- ❖ Presented to the client in a manner that lends itself to completion.

For each referral:

Provide the client with a description of the service you are referring them to and the reason for the referral, e.g. "Your Doctor has asked …" ➔

The description should include:

- ❖ any eligibility criteria
- ❖ any time-sensitive aspects to the service (i.e. application deadlines, appointment schedules, etc.).
- ❖ phone number and contact person. (The Medical Case Manager and client may call during the session to arrange the appointment)
- ❖ arrangement for warm hand-off to ensure referral completion.

Make an initial call on behalf of the client to the agency/provider you are referring the client to ➔

This is to ensure that:

- ❖ the service is still available
- ❖ that the receiving provider has the current capacity to serve the client.

Clinic Social Workers and Physicians should complete the County MR 191 referral form to link clients with other services. ➔

The MR 191 ensures Core Services (e.g. Mental Health, Substance Abuse, Medical Case Management, and Dental Services as well as Outreach) are:

- ❖ documented in the client's medical file.

Referral recipient completes the bottom portion of the MR 191 and returns form to the issuing provider.

The MCM will complete the community agency referral form ➔

The agency referral form ensures:

- ❖ the service is documented in the client's file and ARIES Referral Tabs.
- ❖ Client is eligible for service and all necessary data is in the ARIES to receive non-MCM services e.g. legal services, food services , etc.

Provide the client with the necessary contact information to follow up on the appointment. ➔

This should include, at a minimum:

- ❖ The appointment ***date and time***
- ❖ The ***location*** of the agency where the appointment is to be held and any information needed on ***how to get there*** (i.e. directions, public transportation information, voucher, etc.)
- ❖ The receiving provider's ***name***
- ❖ The receiving provider's ***telephone number***

Record all of the referrals you make for the client **in the client's ARIES care plan** and print for the file. In addition, the Referral Case Coordination Log should be completed for each client. A sample of this form is at the end of this module.

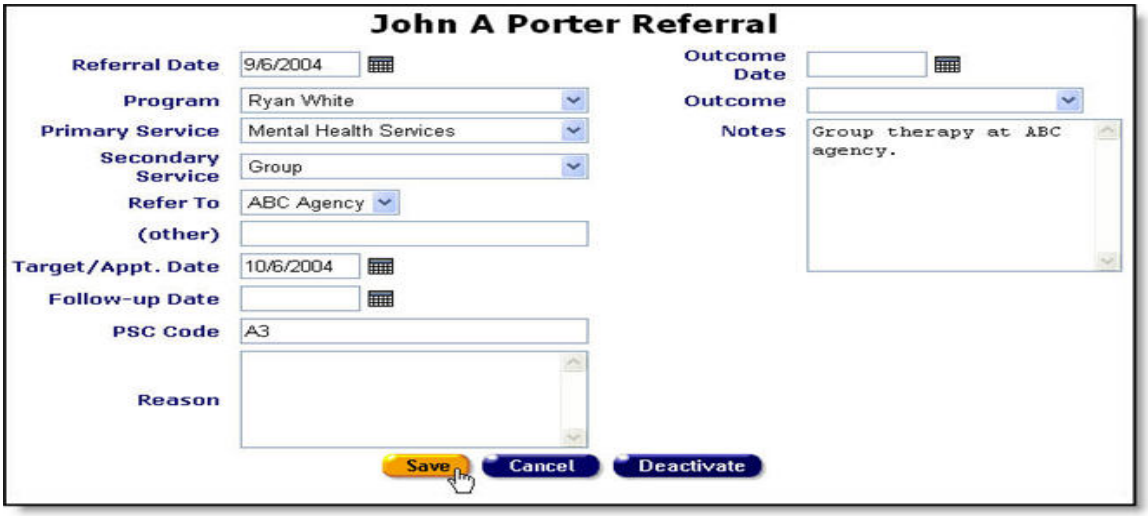
Steps for Entering Referral Information in ARIES

To access the Referrals screen, from a client's information screen, click the Care Plan tab from the top tier of tabs. Then, from the second tier of tabs, click the Referrals tab.

The screen lists a table of the client's referrals to other agencies. The first column indicates when the referral was made. The Service column indicates what type of service the client needed. The "Referred To" column lists the agency to which the client was referred. The Target Date column lists the estimated date of when the client was to receive the referred services (generally 2 weeks from the referral date).

The Outcome column lists the outcome of the referral; whether the client attended their appointment with the other agency or not. It does not tell whether or not the client successfully received services. If the outcome has not been achieved, the **Edit** button appears. The receiving provider should complete the outcome button. The Medical Case Manager can record detailed information about the activity related to the referral e.g. challenges to keeping appointment and steps taken to assist client, etc. in the case notes and the units of service sections of ARIES.

To create a new referral, click the **New** button or click the Edit button to change an existing referral. Either action takes you to the Referrals Edit screen. This screen allows for the details about the referral to be recorded. See below for guidance on the steps for completion of the edit screen.



Referrals Edit

"**Referral Date**": Date referral was conducted.

"**Program**": Select from the pull-down menu that accurately describes the Program. For example, if you select "Ryan White," only services covered by the Ryan White program will display in the Primary Service drop-down list.

"**Primary Service**": Select from the pull-down menu the service that accurately describes the service that you are referring the client to. If the service is not listed, select "Other Services" and type the information into the blank space. ***Once the selection is made, the next drop-down menu adjusts accordingly.****

"Secondary Service": Select from the pull-down menu that accurately describes the secondary service. If the service is not listed, select "Other Services". ***Once the selection is made, the next drop-down menu adjusts accordingly.****

"**Refer to**": The person assigned the referral and completion of the service. If the agency/person assigned is not listed, select "Other" and fill in the information.

"(other)": Enter the appropriate agency/person receiving the referral in the text field.

"**Target/Appt. Date**": The planned completion/appointment date of service referred to. This is generally within 2 weeks of the referral date.

"**Follow up Date**": The date the MCM will follow-up on the referral to ensure that it had been completed successfully.

"**PSC Code**": Payment Source Code. (Currently not used by our agency at this time.)

"**Reason**": In this text field, enter why the client was referred to another agency. For example, if the client's service need is Medical Case Management for ADAP, the reason might be "Help the client receive medications and treatment adherence."

"**Notes**": In this text field, enter the overall objective that addresses the referral outcome. For example, if the client attended appointment with Medical Case Management for ADAP, the note might be "Client kept appointment with MCM for ADAP and treatment adherence, completing the referral."

When you have finished entering referral information, click the Save button to return to the Referral screen. To return to the Referral screen without saving changes, click the Cancel button. Click the Deactivate button to remove the referral from view.

"**Outcome Date**": ***Leave blank when making the referral.*** This will be completed by the receiving provider who will enter the date the referral was completed.

"**Outcome**": Outcome of the specific referral. Use the pull-down menu to select the term most nearly describing the progress made towards achieving the goal. This section will be completed by the receiving provider and reviewed by the MCM to ensure completeness. ****Do not select an option from the drop-down list until the referral is completed. Once you select an outcome, the referral cannot be edited further.**** The drop down list includes the following options as outcomes:

Kept Appointment	The client attended the scheduled appointment for services resulting in the completion of the referral.
No Show	The client didn't attend the scheduled appointment without any notice for rescheduling.
Rescheduled Appointment	The client didn't attend the scheduled appointment for services and made arrangements for the appointment to be rescheduled.

Following ARIES Referral Tab Data Entry ➔

- Contact the provider MCM is referring to make a warm hand off.
- Review referral tab at target date to ensure outcome has been completed by referral recipient agency.
- Case conference with the provider to ensure client progress, etc.

Complete Units of Service Data Entry for All referrals. ➔

See Module 11 for Units of Service Data Entry Procedures.

Referral Case Coordination Log

Client: _____ MD: _____

Referral to:	Yes	No	Status/Notes/Other
Mental Health _____ date			Referred to:
Has the client kept appointments			
Is the client taking medications			
Has the client established goals			
Is there other progress to report			
Substance Abuse _____ date			Referred to:
Has the client kept appointments			
Is the client taking medications			
Has the client established goals			
Is there other progress to report			
Risk Reduction _____ date			Referred to:
Has the client kept appointments			
Is the client taking medications			
Has the client established goals			
Is there other progress to report			
Nurse Case Mgt _____ date			Referred to:
Was the client assessed			
Has client been enrolled in NCM			
Did CBO dis-enroll client in ARIES			
Is there other progress to report			
Other_____ date			Referred to:
Has the client kept appointments			
Is the client taking medications			
Has the client established goals			
Is there other progress to report			
Other_____ date			Referred to:
Has the client kept appointments			
Is the client taking medications			
Has the client established goals			
Is there other progress to report			

Other Comments:

Medical Case Manager: _____ Date: _____