

MODULE EIGHT

Transferring/Referring Clients to Other Medical Case Managers

POLICY

Referrals (client transfers) between Medical Case Managers generally occur in the following situations:

- From **Nurse Case Management to community medical case manager** when the client's health dictates the need for less intensive monitoring and treatment.
- From **community medical case manager to Nurse Case Management** when the client's health dictates the need for greater monitoring and care.
- From **one medical case manager to another** when the client moves from one region of the county to another or when the medical case manager/client relationship is no longer cooperative and is detrimental to the client's progress.

All referrals between medical case managers require that the client be stable and agree to be transferred. The system of care strives to keep the transfer of clients to a minimum to encourage stability in their care.

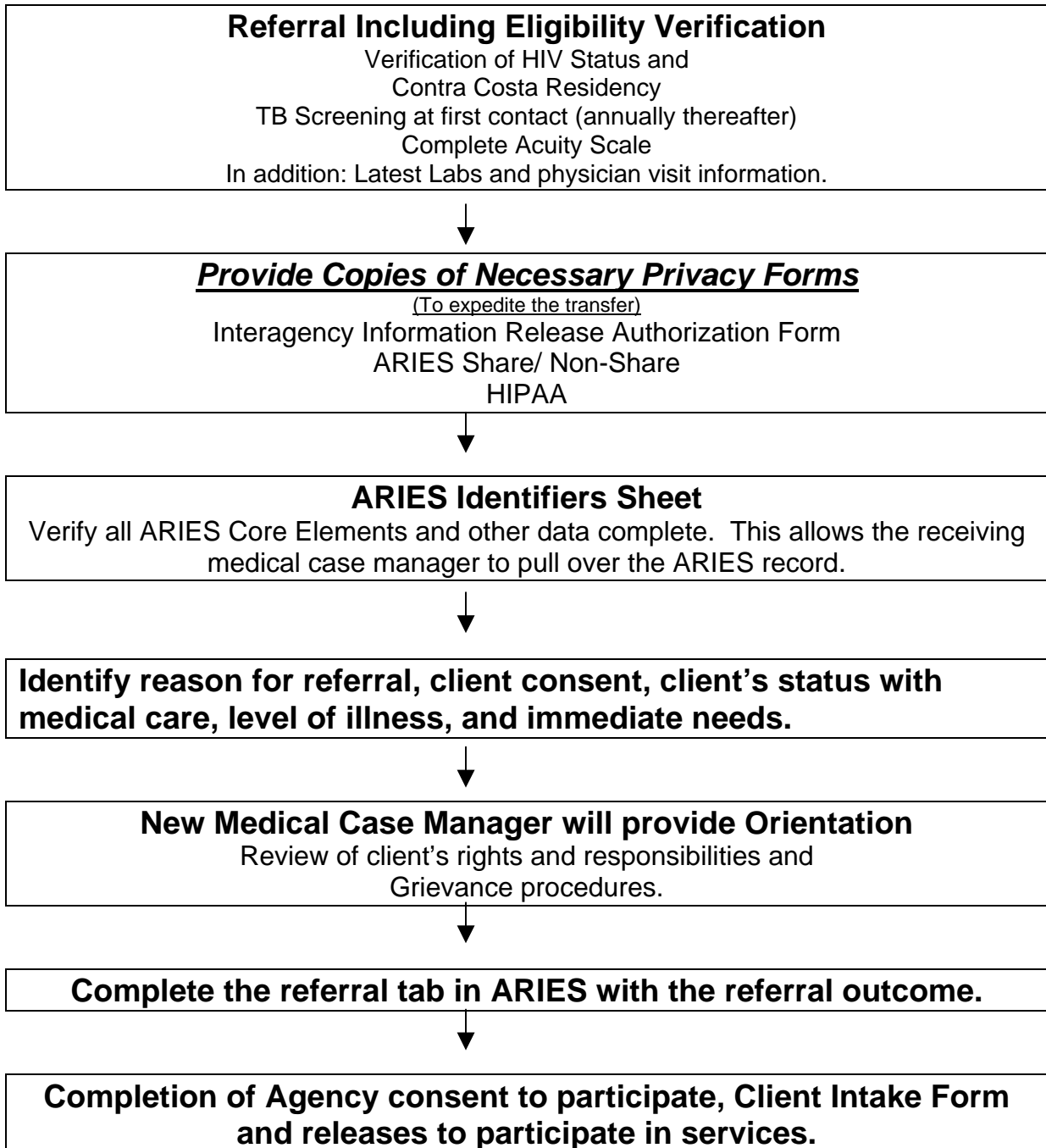
Transfers shall include all required minimum documentation for referrals, notation in ARIES referral tabs and dialogue between the medical case managers including an explanation of the reason for the transfer.

Keep in Mind Special Circumstances:

Referral from Community-based Medical Case Management to Nurse Case Management is communicated to the System of Care Intake Coordinator 925-313-6781. The referring medical case manager may maintain contact with the client to provide non EFA-related support; however, the Medical Social Worker from the nurse case management team becomes the client's primary case manager, unless there is a special agreement to do otherwise.

Minimum Requirements

The referring medical case manager should help broker the initial meeting and provide the **warm handoff** to the new medical case manager or nurse case manager. This can ensure that the client transitions well to the new provider.



**Procedures for transfers from:
Medical Social Workers providing Short-Term Assistance (STA) to Community
Medical Case Managers (MCM)**

This type of referral will occur when an STA has served a client that needs and desires long-term MCM after their medical crisis or condition has improved. STAs should encourage all clients who do not imminently require nurse case management to transition to being served by a community medical case manager.

**STA
Procedures →**

1. When the client has stabilized, refer to community-based medical case management with client consent.
2. Explain the differences & similarities between STA services & community-based medical case management e.g.
 - a. MCMs may meet in office, home or other settings.
 - b. Home visits may be arranged depending on circumstances.
 - c. The STA will no longer be the client's Case Manager.
 - d. All EFA requests & other services will be provided or coordinated by the MCM they are being referred to.
3. Intake Coordinator will identify community agency to receive STA referral.
 - a. Intake Coordinator will contact the Community Medical Case Manager (MCM) or supervisor and discuss referral/transfer.
 - b. Intake Coordinator will document referral/transfer in ARIES referral tab.
 - c. Community Medical Case Manager will complete the referral outcome
 - d. Intake Coordinator will send to the receiving community MCM the following:
 - ARIES Identifier Sheet
 - ARIES Share/Non-Share Form
 - Verification of HIV status
 - Client ID and proof of residency
 - Intake form, care plan and other documents to assume care of client.
 - Last Clinical visit, labs, medications, and adherence information, and next scheduled appointment.

**STA
Procedures →
(Cont'd)**

4. Receiving Community MCM will establish contact with the client by the next business day and to offer an intake appointment within three business days. STA will review file to see that MCM completed the referral outcome tab to close out the transfer/referral.

**Receiving MCM
Procedures →**

1. Respond to the referral as quickly as possible (no later than the next business day).
 - a. Call both the referring Intake Coordinator and the client.
2. Record all initial attempts to contact the client in the Case Notes in ARIES.
3. After meeting the client face-to-face for the first time:
 - a. Communicate to the Intake Coordinator that the referral/transfer is complete.
 - b. Complete the referral tab outcome in ARIES related to this referral.
 - c. Open the client in ARIES and complete the units of service.
4. Begin the client intake, orientation to services, needs assessment and care plan development process.
5. Continue to serve client and recording services in ARIES.

**Procedures for:
*Medical Case Manager transfer to Nurse Case Management***

(This type of referral occurs when a MCM client progresses in his/her HIV disease to fluctuating between severe episodes and functioning (Level III) or being severely ill (Level IV) and is at the point that he/she is best served by a nurse case management team. The Acuity Scale can be used to assess the need for this type of referral/transfer.

MCM Procedures →

1. If there is any doubt as to whether the client is in need of nurse case management contact the client's primary care physician and/or the intake coordinator and request an assessment of the client's health and functionality.
2. If it is determined that the client should be transitioned to nurse case management, obtain the client's consent to be transitioned to nurse case management. Before obtaining consent:
 - a. Explain to the client that you will no longer be their primary Case Manager, unless special circumstances require it.
 - b. Explain that all EFA and most supportive services will be provided or coordinated by the Medical Social Worker (MSW) and public health nurse they are being referred to.
 - c. Obtain signed consent from the client to release their eligibility documents, recent needs assessment form and recent care plan to the nurse case management team (Use the Authorization for Disclosure of HIV/AIDS Information Client Consent Form to obtain consent).
3. If the client does not want to be transitioned, continue to serve the client and revisit the subject of nurse case management when possible. Scheduling a case conference and discussing at rounds to facilitate the transfer can be helpful. Conducting a warm hand off also facilitates the transfer.
 - **NOTE:** If the client does not consent to the transfer, consult with the physician and case conference to support the client.
4. If the client does consent to the transfer/ referral:
 - a. Contact the intake coordinator at the County AIDS Program who will determine which nurse will serve the client.
 - b. MSW of the assigned nurse case management team will contact the MCM to begin transferring the client to medical case management.

**MCM Procedures →
(Cont'd)**

5. MCM will:
 - a. Complete the referral tab in ARIES
 - b. Include the reason for the referral to Nurse Case Management and other required information.
 - c. Highlight the client's current needs.
 - d. Make contact with the Intake Coordinator to verify receipt of referral/transfer.

6. Transmit to the receiving MCM a copy of the:
 - a. Signed Authorization for Disclosure of HIV/AIDS Information Client Consent Form.
 - b. ARIES Identifiers Sheet
 - c. ARIES Share/Non-Share Form
 - d. Verification of HIV status
 - e. Client identification and/or other proof of county residency
 - f. Intake Form, care plan and other documents as necessary to assume care of client.
 - g. Needs Assessment and Reassessment Forms (if consent is given) should include complete and current medical information including current medications & TB clearance.
 - h. Updated client care plan (if consent given).
 - i. Last medical visit, labs, medication, and other relevant information.

Receiving STA Procedures



1. The nurse case management team will respond to the MCM within 3 days and indicate that the referral was accepted or requires addition information. They will discuss next actions.
2. Record all initial attempts to contact client on the Case Notes in ARIES.
3. Once the initial visit is conducted the new Medical Case Manager will contact the prior community MCM so that both sides can complete the referral tab in ARIES and record the information in ARIES case notes.
4. Following initial client face-to-face visit:
 - a. Communicate to the MCM in writing that the referral/transfer is complete.
 - b. Complete the referral tab outcome in ARIES related to this referral.
 - c. Open the client in ARIES and complete the units of service.
5. During the initial visit begin the client intake, needs assessment and care plan development process.
6. Continue to serve client and recording services in ARIES.

Procedures for a Transfer from one Community Medical Case Manager to another Community MCM.

This is a referral that occurs in rare situation such as:

1. When a client moves from one region of the county to another.
2. When staffing changes occur at a MCM's agency such that the MCM is no longer able to serve a client.
3. When a MCM's relationship with his/her client becomes unproductive or negative and the client's transfer to another MCM is the only solution. Refer to the policy on "Dealing with Abusive Behavior and Difficult Situations" for further guidance (Module 12).

Referring MCM →

1. Assess the need to refer the client to another provider:
 - a. If the client is not satisfied with the services you are providing, ask the client the reason for their dissatisfaction and review the client grievance procedure to familiarize them with their right to file a grievance.
 - b. If the client is angry, you may suggest to the client a cooling off period of no more than two weeks before engaging the client in further discussion about your working relationship. Client should have access to the case manager's supervisor at any point in time. Having a cooling off period is not a punitive measure and does not necessarily mean the client will not have access to EFA assistance during this time period, as appropriate.
 - c. The fact that a client is not adhering to their care plan is not an adequate reason for a transfer, unless it is specifically causing difficulty working with the case manager.
 - d. If the client becomes abusive, refer to the policy on "Dealing with Abusive Behavior and Difficult Situations" for more guidance on this matter.
2. Assess the client's desire to transfer to another medical case manager.
3. Assess whether a transfer to another MCM could be a solution to the issues contributing to the difficulties in the working relationship. The MCM should review the situation with the Clinical Supervisor to determine the best course of action for the client.

Referring MCM (cont'd)



4. When it is clear that there is a need to refer a client to another MCM:
 - a. Obtain the client's consent for the transfer and explain the limitations of transferring that client to another MCM:
 - b. Explain that the client may not be able to return to you if the new MCM situation does not work out, as your caseload may be at maximum at the time the client may want to return.
 - c. Explain that, once they have transferred over, you will no longer be their medical case manager and that all EFA and supportive services they need will have to be provided or coordinated by the new MCM.
5. Obtain a written statement (i.e. a letter) from the client that:
 - a. Ends their provider/client relationship with the current MCM.
 - b. Authorizes the client transfer to another MCM.
 - c. This statement is required and must be filed in the client's file at your agency. If client refuses, MCM will document the information for the file.
Note: If client is terminating the relationship with the medical case manager based on their own choice, they **must** write a letter formally ending the relationship.
6. MCM contacts the Intake Coordinator for re-assignment and completes the ARIES referral tab for transfer.
7. Obtain signed consent from the client to release their records as listed below. (Use the Authorization for Disclosure of HIV/AIDS Information Client Consent Form to obtain consent).
8. Transmit to the Intake Coordinator or new MCM:
 - a. Signed Authorization for Disclosure of HIV/AIDS Information Client Consent Form.
 - b. ARIES Face Sheet
 - c. ARIES Share/Non-Share Form
 - d. Verification of HIV status
 - e. Client identification and/or other proof of county residency

**Referring
MCM Procedures →
(Cont'd)**

- f. Most recent clinical labs, visits, medications, TB Clearance, etc.
 - g. Intake Form and Needs Assessment updated in ARIES.
 - h. Care plan and other documents updated in ARIES as necessary to assume care of client.
9. Complete file shall be provided to new MCM (with current Share/Non-Share Form granting permission to share form) and the original file retained with the original MCM for audit purposes. If the client refuses, at minimum items in #8 above must be provided.

**Receiving MCM
→**

1. Respond to referral/transfer as quickly as possible (no later than 3 days following referral):
 - a. Call the referring provider.
2. Record all initial attempts to contact client In ARIES case notes.
3. When meeting the client face-to-face for the first time:
 - a. Communicate to the MCM in writing that the referral/transfer is complete.
 - b. Complete the referral tab outcome in ARIES related to this referral within 2 weeks. (See ARIES Referral Entry later in this Module).
 - c. Open the client in ARIES and complete the units of service.
4. Begin the client intake, needs assessment and care plan development process.
5. Continue to serve client and recording services in ARIES.

Procedures for Inactive or Out of Care Clients

Verify previous Medical Case Manager →

Ask the client who they worked with before. Verify in ARIES who the previous Medical Case Manager was and link the client back with that provider. If unable to determine, contact the AIDS Program for assistance.

Determining Case Management Assignment →

1. If the client wishes to continue with their former medical case manager, provide them with the contact information.
2. If they would like to be served by you:
 - a. Have the client provide a written statement (i.e. a letter) to the previous medical case manager closing their services with them.
 - b. Keep a copy of the written statement in your file and provide to the previous medical case manager.
 - c. This will allow the current case manager to take the client off of their caseload and list them as inactive to their agency.

Client Files

1. To receive copies of the client file content from a current/former MCM:
 - a. Obtain written authorization (ARIES Share/Non-Share form electing to share) from the client. This will provide access to the previous files for the client.
 - b. If the client refuses (elects to not share, do not request any information on that client from the former case manager/agency).
 - c. Begin intake process as if a new client.

Instructions for Documenting Transfers In ARIES

In this instance, the referral tabs are used to document movement from one MCM to another or to Nurse Case Management. 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.



Date	Service	Referred to	Target Date	Outcome
2/1/2005	Ryan White > Oral Health Care > Oral Health Care	Dental	2/28/2005	Kept appointment
3/1/2005	HOPWA > Housing Assistance > Utility Assistance	Section 8	3/15/2005	Edit
3/31/2005	Ryan White > Case Management Services > Disease Management	Public hospital	4/15/2005	Edit

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 to which agency the client was referred. The Target Date column lists the estimated date of when the client was to receive the referred services.

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. 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.

John A Porter Referral

Referral Date: 9/6/2004

Program: Ryan White

Primary Service: Mental Health Services

Secondary Service: Group

Refer To: ABC Agency

(other):

Target/Appt. Date: 10/6/2004

Follow-up Date:

PSC Code: A3

Reason:

Outcome Date:

Outcome:

Notes: Group therapy at ABC agency.

Save Cancel Deactivate

Referrals Edit

Below is an explanation of the fields in the edit screen.

“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. For a program not listed e.g. Genard, use “Other” and explain.

“Primary Service”: Select from the pull-down menu that accurately describes the primary service. If the service is not listed, select “Other Services”. ****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”.

“(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.

“Follow up Date”: The date the MCM was to follow-up on the referral to ensure that it had been completed successfully.

“PSC Code”: Payment Source Code. (currently not used by our system of care at this time.)

“Reason”: In this text field, enter the 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.”

“Outcome Date”: Date the referral was completed.

“Outcome”: Outcome of the specific referral. The receiving provider will use the pull-down menu to select the term most nearly describing the progress made towards achieving the goal. ****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:

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.

“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.” For a referral to another provider, this is where the attempts at contact are recorded for both the referring and receiving party to view and track progress on the completion of 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. This function is not available for all ARIES users.

Units of service should be completed for all services provided in the transfer of a client from one provider to another.