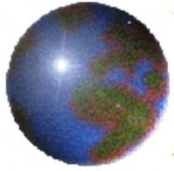


# ***Complex Medical Cases: Process and Role of the Medical Social Worker***

**LPH/VOLAG Forum  
January 24, 2012**

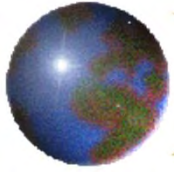
**Marge Higgins, LSW**  
***MDH Refugee Health Program***



## *It's happening!*

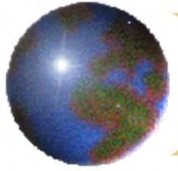
- ❖ VOLAGs, LPH, MDH, and others made this possible
- ❖ Position is 1 year, but structured to have lasting benefits
- ❖ Evolving process





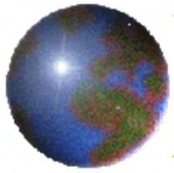
## *This presentation will review:*

- ⊕ Scope of the MSW position
- ⊕ The process
- ⊕ The forms
- ⊕ Discoveries, Developments & Ideas
- ⊕ Questions/Discussion



## *Purpose of the position:*

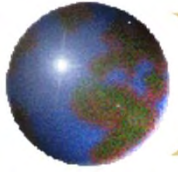
- ✦ A shared resource, with central access point for local VOLAGs to refer refugees with complex health concerns
- ✦ Assure referred refugees receive proper, adequate and timely treatment for identified health conditions
- ✦ Assure those with complex health needs are linked to necessary health services and able to access these services independently



## *MSW – Marge’s VOLAG Schedule*

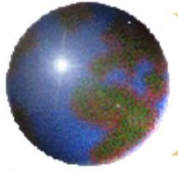
- ☉ Monday: CC am & WR pm
- ☉ Tuesday: MCC pm
- ☉ Wednesday: LSS am/pm alternate weeks
- ☉ Thursday: II am
- ☉ Available by phone:  
651-207-3529  
or email:  
[marge.higgins@state.mn.us](mailto:marge.higgins@state.mn.us)





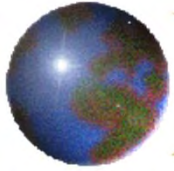
## *What is a complex medical case?*

- ✦ An arrival who needs health services outside of the routine health screening.
- ✦ Examples:
  - ▣ Persons arriving on medications
  - ▣ Persons with chronic health issues (e.g. diabetes, hypertension)
  - ▣ Persons with disabilities



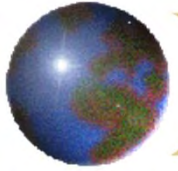
## *Issues raised in meetings with VOLAG staff:*

- ✦ Pressure from national office to accept cases with complex health issues
- ✦ Immediate access to prescription meds
- ✦ Dialysis upon arrival - adults and minors
- ✦ Accessible housing and transportation
- ✦ Medical terminology on SMC or other forms



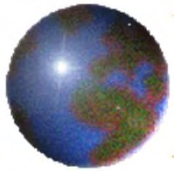
## *Wisdom from Kyaw: (paraphrased)*

- ✦ An arrival with physical health issues is like 5 arrivals.
- ✦ An arrival with mental health issues is like 10 arrivals.



## *How cases are determined*

- ✦ VOLAGs refer everyone who:
  - ✦ has complex medical condition indicated on pre-departure paperwork
  - ✦ presents with issues within 90 days of arrival
- ✦ MDH RHP Nurse Consultant (Sue Dicker )
  - ✦ reviews and “scores” referrals
- ✦ MDH MSW (Marge Higgins )
  - ✦ reviews referral
  - ✦ consults with Sue and VOLAG case mgr.
  - ✦ writes care plan & coordinates follow-up



# The Process – step 1 - Request

**VOLAG** completes a “Request for Referral to Medical Social Worker” form and faxes it to MDH, RHP Nurse Consultant (Sue Dicker)

**Refugee Health Program**  
Minnesota Department of Health

**Complex Case: Request for Referral to Medical Social Worker**

Request submitted by VOLAG to Medical Social Worker  
Fax to: 651-201-5501 Attention:  Sue Dicker, [sue.dicker@state.mn.us](mailto:sue.dicker@state.mn.us)

Date of request: \_\_\_\_\_

1. Request from:

<input type="checkbox"/> Catholic Charities	Case Manager	_____
<input type="checkbox"/> Immigration Institute	Office Phone	_____
<input type="checkbox"/> Lutheran Social Services	Cell phone	_____
<input type="checkbox"/> MN Council of Churches	Skype	_____
<input type="checkbox"/> World Relief	Fax #	_____

2. Name of person filling out referral form (if different than case manager)

Name \_\_\_\_\_ Job title \_\_\_\_\_  
Phone \_\_\_\_\_ e-mail \_\_\_\_\_

3. Attach copy of all available health information (check if attached)

SNIC form  yes  no  none  yes  no  
 Overseas list  yes  no  ICM Travel Form  yes  no  
 Assurance Form  yes  no

4. Client information

Family Case Number \_\_\_\_\_  
 Alien Number \_\_\_\_\_  
 Last Name \_\_\_\_\_  
 First Name, Middle Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 County of Residency \_\_\_\_\_  
 Other family members being referred to USIA?  yes, if yes, how many? \_\_\_\_\_  no

5. Local support  U.S. file  Free Case

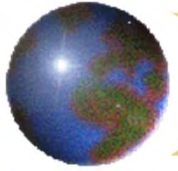
6. Notification of physical and/or mental health condition

Pre-arrival: Date notified \_\_\_\_\_ / Date of arrival \_\_\_\_\_  
 Post-arrival: Case identified \_\_\_\_\_ / Date of arrival \_\_\_\_\_

7. Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

12/2011





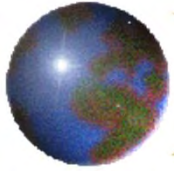
## *The Process – step 2 – Review & Refer*

- ☉ Sue reviews the request form and other faxed documents (SMC, assurance, biodata, pre-departure medical, IOM travel forms)

- ☉ Sue completes an MSW referral form including:

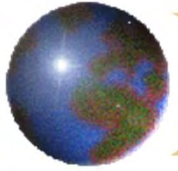
- ☒ Recommendation for referral (or denial)
- ☒ Level of need and urgency “ranking”
- ☒ Specific recommendations for follow-up

- ☉ Sue notifies Marge of referral



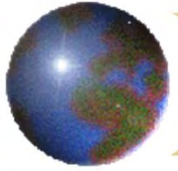
## *The Process – step 2b – “Level of Need/ Ranking Algorithm”*

HEALTH CONDITION	SEVERITY (Weight)	INDICATORS	LEVEL OF NEED/RANK
Developmentally Delayed/ Cerebral Palsy/	3	[ $\geq 1$ ] Multi-family members affected	Level 1: Mild/Moderate = 1-2 Level 2: Significant = 3-4 Level 3: Serious = 5-7 Level 4: Severe: = $\geq 8$
Mental Retardation/Brain injured	3	[ $\geq 0$ ] Disease Severity	
Infectious Disease (including HIV)	3	[0-5] Follow-up (F/U) Urgency	
Cancer	2	[1-21] Level of independence	
Mental Health Concern	2	[0-1] On medication	
Asthma	1	[0-3] Personal Care	
Cardiac / Hypertension	1	[0-1] Medical Escort	
Gastrointestinal (GI) disorders	0		
Gynecological condition	0	<b>TOTAL POINTS= HEALTH CONDITIONS(s) + INDICATOR (s)</b> <b>Assign “LEVEL OF NEED” based on “Total Points”</b>	



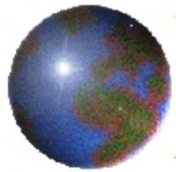
## *The Process – step 3 – Care Plan*

- ✦ Marge reviews case
- ✦ Consult with **LPH** re: county resources
  - ▣ Write and implement care plan
  - ▣ Review care plan with VOLAG case mgr. and/or designated complex case coordinator
    - Monitor care plan objectives weekly
    - Change care plan as needed
    - Follow-up with those involved



## *The Process – step 4 – Case Closure*

- ❖ **Marge** continues to “oversee” case until objectives are met or case is closed for another reason
  - ❖ Care plans are dynamic documents
    - Communication between LPH, VOLAG case mgr., MSW, & Clinicians is ongoing and will influence plan objectives
  - ❖ Goal: case completed/closed within 90 days of arrival



# The forms:

Request for referral to Medical Social Worker

(from VOLAG to Sue)

## Refugee Health Program Minnesota Department of Health



### Complex Case: Request for Referral to Medical Social Worker

Request submitted by VOLAG to Medical Social Worker

Fax to: 651-201-1501

Attention:  Sue Drake, [sue.drake@state.mn.us](mailto:sue.drake@state.mn.us)

Date of request: \_\_\_\_\_

#### 1. Request from:

- Catholic Charities
- International Institute
- Lutheran Social Services
- MN Council of Churches
- World Relief

Case Manager	_____
Office Phone	_____
Cell phone	_____
E-mail	_____
Fax #	_____

#### 2. Name of person filling out referral form (if different than case manager)

Name: \_\_\_\_\_ Job title: \_\_\_\_\_  
 Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

#### 3. Attach copy of all available health information (check if attached)

- SVC form:  yes  no      **Stodak**:  yes  no  
 Overseas Med:  yes  no      IOM Travel Form:  yes  no  
 Assurance Form:  yes  no

#### 4. Client information

Family Case Number: \_\_\_\_\_  
 Alien Number: \_\_\_\_\_  
 Last Name: \_\_\_\_\_  
 First Name, Middle Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_  
 County of Resettlement: \_\_\_\_\_

Other family members being referred to ASGAR:  yes, if yes, how many? \_\_\_\_\_  no

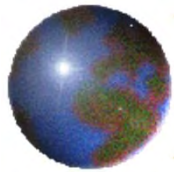
#### 5. Local support: U.S. Tie Free Case

#### 6. Notification of physical and/ or mental health condition

- Pre-arrival: Date notified \_\_\_\_\_ U-Expected date of arrival \_\_\_\_\_  
 Post-arrival: Date identified \_\_\_\_\_ / Date of arrival \_\_\_\_\_

#### 7. Comments

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



# The forms:

MSW  
referral  
form

(From Sue  
to Marge)

Case No. \_\_\_\_\_ Alien No. \_\_\_\_\_ Last Name: \_\_\_\_\_

## For Medical Social Worker Use

1. Initial Intake Date \_\_\_\_\_

### 2. Source of Health Information

SMC form:  yes  no

Biodata:  yes  no

Overseas Med:  yes  no

IOM Travel Form:  yes  no

### 3. Criteria for Referral (check all that apply; see attached form for Ranking Scale and details)

- Identified chronic disease requiring ongoing monitoring
- Medical condition requiring treatment by specialist
- Medical condition requiring:
  - multiple prescription medications
  - injectable or non-oral medication (ie insulin, oxygen)
- Mobility impairment requiring connection to specialized resources
  - adaptive equipment and/or housing
- Cognitive impairment, briefly describe: \_\_\_\_\_
- Mental health needs requiring treatment by a specialist
- More than one family member being referred

### 4. LPH Contact Information

County \_\_\_\_\_

Name \_\_\_\_\_

Phone# \_\_\_\_\_ Fax # \_\_\_\_\_

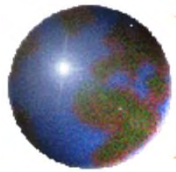
Email \_\_\_\_\_

### 5. Intake Outcome

- Request for referral to Medical Social Worker approved on \_\_\_\_\_ (date)  
(for specifics, see above, Criteria for Referral and attached form, Ranking Scale)
- Request for referral to MSW denied. If not approved, why not?
  - Does not meet criteria / specify: \_\_\_\_\_
- Meet with:
  - VOLAG Case Manager \_\_\_\_\_ (date)
  - LPH \_\_\_\_\_ (date)
  - MDH Refugee Health Nurse \_\_\_\_\_ (date)
- Initial Care Plan established on \_\_\_\_\_ (date)
- Assigned to SW Intern \_\_\_\_\_ (date)
- Refer to Health Care Home on \_\_\_\_\_ (date)
- Refer to Community Health Worker on \_\_\_\_\_ (date)

6. Date Case Closed: \_\_\_\_\_

(see next page for additional notes)



# The forms:

MSW  
referral  
form

"denial"

Case No. \_\_\_\_\_ Alien No. \_\_\_\_\_ Last Name: \_\_\_\_\_

## For Medical Social Worker Use

1. Initial Intake Date \_\_\_\_\_

### 2. Source of Health Information

SMC form:  yes  no

Biodata:  yes  no

Overseas Med:  yes  no

IOM Travel Form:  yes  no

### 3. Criteria for Referral (check all that apply; see attached form for Ranking Scale and details)

- Identified chronic disease requiring ongoing monitoring
- Medical condition requiring treatment by specialist
- Medical condition requiring:
  - multiple prescription medications
  - injectable or non-oral medication (ie insulin, oxygen)
- Mobility impairment requiring connection to specialized resources
  - adaptive equipment and/or housing
- Cognitive impairment, briefly describe: \_\_\_\_\_
- Mental health needs requiring treatment by a specialist
- More than one family member being referred

### 4. LPH Contact Information

County \_\_\_\_\_

Name \_\_\_\_\_

Phone# \_\_\_\_\_ Fax # \_\_\_\_\_

Email \_\_\_\_\_

### 5. Intake Outcome

Request for referral to Medical Social Worker approved on \_\_\_\_\_ (date)

## 5. Intake Outcome

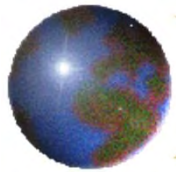
Request for referral to Medical Social Worker approved on \_\_\_\_\_ (date)

(for specifics, see above, *Criteria for Referral* and attached form, *Ranking Scale*)

Request for referral to MSW denied. If not approved, why not?

Does not meet criteria / specify: Refugee Health Screening referral

adequate for assessing status of medical condition.



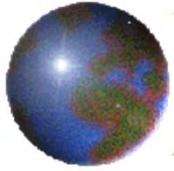
# The forms: MSW referral form "ranking"

Case No. \_\_\_\_\_ Alien No. \_\_\_\_\_ Last Name: \_\_\_\_\_

MEDICAL FOLLOW-UP AFTER ARRIVAL / URGENCY:												
Follow up urgency :	<input type="checkbox"/>	<b>[5]</b>	Immediately	<input type="checkbox"/>	<b>[3]</b>	W/in one week	<input type="checkbox"/>	<b>[1]</b>	W/in one mo.	<input type="checkbox"/>	<b>[0]</b>	W/in 60 days
By:	<input type="checkbox"/>	Surgery		<input type="checkbox"/>	Hospitalization		<input type="checkbox"/>	General medicine to refer to specialist, specify: _____				
Duration:	<input type="checkbox"/>	Initial only		<input type="checkbox"/>	Ongoing treatment (specify if necessary):							
											<b>[ ]</b>	sub-total



SIGNIFICANT MEDICAL CONDITIONS/LEVEL OF OVERALL INDEPENDENCE: <i>Check as many boxes as appropriate</i>												
1	Learning/ Development:	<input type="checkbox"/>	<b>[3]</b>	Dependent	<input type="checkbox"/>	<b>[2]</b>	Moderately dependent	<input type="checkbox"/>	<b>[1]</b>	Minimal assistance		
2	Communicating:	<input type="checkbox"/>	<b>[3]</b>	Dependent	<input type="checkbox"/>	<b>[2]</b>	Moderately dependent	<input type="checkbox"/>	<b>[1]</b>	Understood with difficulty		
3	Mobility:	<input type="checkbox"/>	<b>[3]</b>	Dependent	<input type="checkbox"/>	<b>[2]</b>	Moderately dependent	<input type="checkbox"/>	<b>[1]</b>	Can move with difficulty		
4	Trauma/Injury:	<input type="checkbox"/>	<b>[3]</b>	Dependent	<input type="checkbox"/>	<b>[2]</b>	Moderately dependent	<input type="checkbox"/>	<b>[1]</b>	Minimal assistance		
5	Psychiatric Condition:	<input type="checkbox"/>	<b>[3]</b>	Dependent	<input type="checkbox"/>	<b>[2]</b>	Moderately dependent	<input type="checkbox"/>	<b>[1]</b>	Minimal assistance		
Other Disability (list) :												
6		<input type="checkbox"/>	<b>[3]</b>	Dependent	<input type="checkbox"/>	<b>[2]</b>	Moderately dependent	<input type="checkbox"/>	<b>[1]</b>	Minimal assistance		
7		<input type="checkbox"/>	<b>[3]</b>	Dependent	<input type="checkbox"/>	<b>[2]</b>	Moderately dependent	<input type="checkbox"/>	<b>[1]</b>	Minimal assistance		
			<b>[ ]</b>	sub-total			<b>[ ]</b>	sub-total			<b>[ ]</b>	sub-total



# The forms: MSW referral form "ranking" (cont'd)

MEDICATION NEEDS:		
Comments:	<input type="checkbox"/> Ongoing medication	<input type="checkbox"/> Multiple medications
	Name of medication:	Supply upon arrival:
	[1]	[4] <input type="checkbox"/> 1 week    [3] <input type="checkbox"/> 2 weeks    [2] <input type="checkbox"/> 4 weeks    [1] <input type="checkbox"/> 8 weeks
	[1]	
	[1]	
	[1]	
	sub-total	sub-total



ASSISTANCE REQUIRED FOR PERSONAL CARE:		TRAVEL REQUIREMENTS:		
<input type="checkbox"/>	[3] Needs full time caregiver	Escort:	<input type="checkbox"/> Individual	<input type="checkbox"/> Nurse
<input type="checkbox"/>	[2] Needs part-time caregiver	[1] Yes	<input type="checkbox"/> Group	<input type="checkbox"/> Specialist
<input type="checkbox"/>	[1] Minimal supervision for self-care required	[0] No	<input type="checkbox"/> Doctor	<input type="checkbox"/> Non-medical
<input type="checkbox"/>	[0] Fully independent, no assistance required	sub-total		
	sub-total			

URGENCY \_\_\_\_\_  
 OVERALL INDEPENDENCE \_\_\_\_\_  
 MEDICATION NEEDS \_\_\_\_\_  
 ASSISTANCE \_\_\_\_\_  
 TRAVEL REQUIREMENTS \_\_\_\_\_  
TOTAL \_\_\_\_\_

Level of Need Ranking	Total Score
Level 1: Mild/Moderate	1-2
Level 2: Significant	3-4
Level 3: Serious	5-7
Level 4: Severe	≥8



# Example from World Relief:

Case No. \_\_\_\_\_ Alien No. \_\_\_\_\_ Last Name: \_\_\_\_\_

MEDICAL FOLLOW-UP AFTER ARRIVAL / URGENCY:			
Follow up urgency :	<input type="checkbox"/> [5] Immediately	<input type="checkbox"/> [3] W/in one week	<input type="checkbox"/> [1] W/in one mo. <input checked="" type="checkbox"/> [0] W/in 60 days
By:	<input type="checkbox"/> Surgery	<input type="checkbox"/> Hospitalization	<input type="checkbox"/> General medicine to refer to specialist, specify: _____
Duration:	<input type="checkbox"/> Initial only	<input type="checkbox"/> Ongoing treatment (specify if necessary): _____	
			0 sub-total

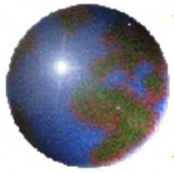
SIGNIFICANT MEDICAL CONDITIONS/LEVEL OF OVERALL INDEPENDENCE: <i>Check as many boxes as appropriate</i>								
1	Learning/Development:	<input type="checkbox"/> [3] Dependent	<input checked="" type="checkbox"/> [2] Moderately dependent	<input type="checkbox"/> [1] Minimal assistance				
2	Communicating:	<input type="checkbox"/> [3] Dependent	<input type="checkbox"/> [2] Moderately dependent	<input checked="" type="checkbox"/> [1] Understood with difficulty				
3	Mobility:	<input type="checkbox"/> [3] Dependent	<input type="checkbox"/> [2] Moderately dependent	<input checked="" type="checkbox"/> [1] Can move with difficulty				
4	Trauma/Injury:	<input type="checkbox"/> [3] Dependent	<input type="checkbox"/> [2] Moderately dependent	<input type="checkbox"/> [1] Minimal assistance				
5	Psychiatric Condition:	<input type="checkbox"/> [3] Dependent	<input type="checkbox"/> [2] Moderately dependent	<input type="checkbox"/> [1] Minimal assistance				
Other Disability (list) :								
6		<input type="checkbox"/> [3] Dependent	<input type="checkbox"/> [2] Moderately dependent	<input type="checkbox"/> [1] Minimal assistance				
7		<input type="checkbox"/> [3] Dependent	<input type="checkbox"/> [2] Moderately dependent	<input type="checkbox"/> [1] Minimal assistance				
		sub-total	2 sub-total	2 sub-total				

MEDICATION NEEDS:		
Comments:	<input type="checkbox"/> Ongoing medication	<input type="checkbox"/> Multiple medications
	Name of medication:	Supply upon arrival:
	[1] _____	[4] <input type="checkbox"/> 1 week [3] <input type="checkbox"/> 2 weeks [2] <input type="checkbox"/> 4 weeks [1] <input type="checkbox"/> 8 weeks
	[1] _____	
	[1] _____	
	[1] _____	
	sub-total	sub-total

ASSISTANCE REQUIRED FOR PERSONAL CARE:	TRAVEL REQUIREMENTS:
<input type="checkbox"/> [3] Needs full time caregiver	Escort: <input type="checkbox"/> Individual <input type="checkbox"/> Nurse
<input type="checkbox"/> [2] Needs part-time caregiver	[1] Yes <input type="checkbox"/> Group <input type="checkbox"/> Specialist
<input type="checkbox"/> [1] Minimal supervision for self-care required	[0] No <input type="checkbox"/> Doctor <input type="checkbox"/> Non-medical
<input type="checkbox"/> [0] Fully independent, no assistance required	1 sub-total
sub-total	

URGENCY 0  
 OVERALL INDEPENDENCE 4  
 MEDICATION NEEDS \_\_\_\_\_  
 ASSISTANCE \_\_\_\_\_  
 TRAVEL REQUIREMENTS 1  
**TOTAL 5**

Level of Need Ranking	Total Score
Level 1: Mild/Moderate	1-2
Level 2: Significant	3-4
Level 3: Serious	<b>5-7</b>
Level 4: Severe	≥8




# The forms:

MSW care plan = who, does what, by when.

## Common objectives:

- *Assure adequate medication supply*
- *Schedule expedited health screening*
- *Establish primary care*
- *Ensure PMAP choice is compatible with primary care*



Refugee Health Program  
Minnesota Department of Health

### Complex Medical Case - Care Plan

---

Name \_\_\_\_\_ DOB \_\_\_\_\_  
Last First Middle

A-number \_\_\_\_\_ File number \_\_\_\_\_ VOLAG \_\_\_\_\_

Other family members with complex medical issues: \_\_\_\_\_ yes (how many? \_\_\_\_\_) \_\_\_\_\_ no

Date of referral/request: \_\_\_\_\_ VOLAG Case Worker: \_\_\_\_\_  
 Care Plan updated on: \_\_\_\_\_ Phone # \_\_\_\_\_ Cell# \_\_\_\_\_  
(change whenever plan changes)

County of Resettlement \_\_\_\_\_

---

Identified Health needs/issues:

Strengths/Resources:

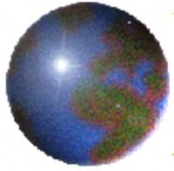
Other related immediate needs/issues:

Questions/Concerns raised:

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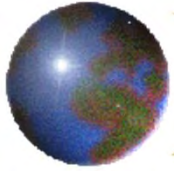
**CARE PLAN – review and update on a weekly basis until other timeline is set.**

Objective	Person Responsible	Due Date	Follow-up logistics	Outcome



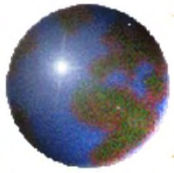
## *This is a flexible process -*

- ⊕ Decision is informed by available information and is negotiable
  - ⊞ Information on pre-departure forms may be incomplete or inaccurate
  - ⊞ New information will be clear upon/after the person arrives
- ⊕ Care plans will be reviewed & changed as new information becomes available



## *Discoveries:*

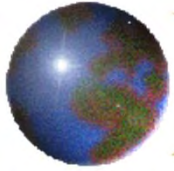
- ✦ Email security – use file number and individual's initials or family role (dad)
- ✦ Tuberculosis (TB) Class follow-up will be addressed through routine health screening
- ✦ VOLAG request form - fax to Sue Dicker at MDH 651-201-5501



## *In development:*

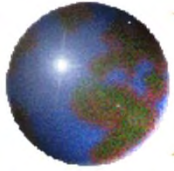
- ✦ MDH Access database to house case referrals and care plans
- ✦ Resource list of county services, emergency health and mental health services
- ✦ Release of information to use between: **MSW / VOLAG / LPH / Health care provider**





## *Ideas:*

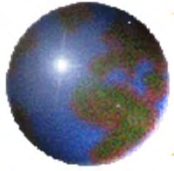
- ❖ PMAP choice – how to make this a seamless process for refugees
- ❖ Expedited MA – county specific process opportunity for clarity
- ❖ Primary Care / Health Care Homes / Community Health Workers / Mental Health – optimal access for those with immediate needs



## *Ideas:*

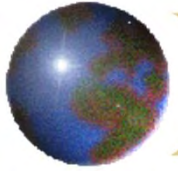
- ✦ VOLAGs “flag” charts of arrivals with health issues
- ✦ Anna Carpenter, MSW intern at World Relief – resource to ALL VOLAGs:
  - ✦ Chart review/system
  - ✦ Health Education for arrivals
  - ✦ Develop resource directory
  - ✦ Other?





## *Ideas: Will Wilson, DHS*

- ❖ Access Community Health Workers
  - ❖ CHW receives certificate of completion from MNSCU
  - ❖ CHW enrolls with DHS (free) and receives a “UMPI” number (for billing)
  - ❖ MD, LPN, NP, and LPH can “prescribe” CHW for up to 8 hrs. per month for Health Ed.
  - ❖ MA and all health plans reimburse for CHW



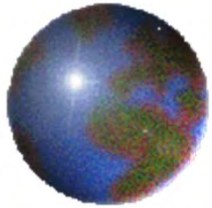
## *Questions & Comments*

- ❖ *A prudent question is one-half of wisdom.*
- ❖ *Who questions much, shall learn much, and retain much.*

*Francis Bacon (1561-1626)*



## *THANK YOU -*



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