Improved Transitions of Care through Enhanced Referral Relationships

Table of Contents

Overview of Improved Transitions of Care Through Enhanced Referral Relationships 3
Steps in Enhanced Referral 3
Understand Partner Services and Expertise 3
Agree on the Patient Population 3
Communication 3
Workflow 4
Care Compact 4
Referral Tracking 5
Monitoring Performance 5
Tools 6
Enhanced Referral Worksheet #1: Assess Network 6
Enhanced Referral Worksheet #2: Identifying Network and Referral Programming 7
Referral Form Sample 9
Enhanced Referral Worksheet #3: Communication Considerations 10
Enhanced Referral Worksheet #4: Workflow Considerations 12
Sample Workflow 13
Essential Elements for Patient Engagement in Enhanced Referral Process 14
Care Compact Worksheet 17
Referral Tracking Spreadsheet Example 22
Referral Tracking Example 1 22
Enhanced Referral Worksheet #5: Sample Measures 23

Overview of Improved Transitions of Care Through Enhanced Referral Relationships

Enhanced referral is developing a focused and planned partnership with a referral source. The expressed purpose of the partnership is to collaborate on shared patients to improve care and for health care practices to provide each other access to needed services with a guarantee to work together on referrals to improve timeliness and quality. This brief will offer specific steps and tools for optimal design of the referral process to drive improved patient experience, more consistent communication with referral partners, and a higher rate of referral success.

in prioritizing additional components of enhanced referral with each referral partner.

Tips:

- See Enhanced Referral Worksheet #1: Assess your network.

Steps in Enhanced Referral

The following section describes the steps of enhanced referral in detail.

Understand Partner Services and Expertise

In the selection of partners and in the early stages of partnership, the focus is on understanding the services offered by each provider organization to support more specific and tailored referrals. This process of programmatic clarity allows each practice to understand what each partner offers and how to leverage expertise and consultation to fill treatment gaps. This phase will often expand partners' understanding of how to leverage each other's skills and knowledge and expand bidirectional referral.

- See Enhanced Referral Worksheet # 2 : Discuss Services and Expertise.

Agree on the Patient Population

Often the partners have knowledge of shared patients which initiates a partnership discussion. As providers share more about their services, they often recognize a broader base of patients that can benefit from each other's services and expertise. The best partnerships offer bidirectional referral opportunities.

Communication

One of the explicit value propositions of an enhanced referral relationship is that practices get more than simply a referral source. Instead, practices can craft communication and consultation opportunities for shared patients. Specific elements of discussion on shared communication include:

- **Shared Referral Form—**Time is invested in developing clear parameters on shared patient information that is meaningful to both partners so that referrals are efficient and effective.

Tips:

- See Sample Referral Form

- **Consultation—**Partners consult with one another via phone to discuss patients, to discuss questions that arise on either physical health or behavioral health conditions, and to foster a collaborative relationship that moves beyond simply referral.
- **Shared Treatment Planning—**Coordination and shared treatment planning around the shared patients with discussion of specific interventions, data on improvement and other factors impacting patient care.
- **Outcome Measurement—**For practices engaged in measurement-based care, sharing updates on patient progress can improve treatment decisions and inform both providers when individuals are not improving, and treatment adaptation is needed.

Tips:

- See Enhanced Referral Worksheet #3: Communication Considerations

Workflow

Spending time designing workflow can be pivotal to improving success in the handoff of patients. The workflow design should entail each partner's internal workflow process around the referral (referral forms, education, and engagement of the patient, and addressing administrative functions particularly with insurance) as well as the external workflow between providers (e.g., identified contact, agreed upon shared information in the referral, determination of which practice will do what elements of the administrative approvals, etc.). Mapping out the workflow is an important step in ensuring that the process is complete.

Tips:

- See Enhanced Referral Worksheet #4: Workflow Considerations
- See Sample Workflow

Engaging the Individual

Engaging the patient and obtaining consent that supports shared treatment planning is central to the workflow. Referrals often leave the patient out of the process—consider methods for enhanced engagement and keeping the person at the center of the process.

Tips:

- See Essential elements for patient engagement

Care Compact

The care compact becomes the document formalizing the partnership and other elements of enhanced referral described above. It is also an avenue for addressing legal issues such as HIPAA and often incorporates a memorandum of understanding (MOU) or a business associates' agreement (BAA) for sharing of data and other information. Care compacts may address other operational elements of a partnership such as information technology requirements or payment considerations. This could include establishing formal time to review more complex patient needs.

Tips:

- See Care Compact Worksheet
- Example of a Care Compact from the CMS Innovation Center website https://innovation.cms.gov/files/x/cpcipsl-rc1.pdf

Referral Tracking

Tracking referrals together is important to determine what is working and where the referral process needs to be adapted or further enhanced. This data may inform the practices on specific populations that need different approaches or where elements of the process are not working as intended. A referral is considered successful or "closed" when there is documentation of at least one kept appointment. This is different than the typical approach of just making sure the patient has a referral name and number or the practice has made an appointment for the patient. This method tracks appointment attendance to make sure the patient did not "no show." Either notification from the referral partner of a kept and appointment and, better yet, actual clinical documentation of the encounter allows the referring practice to deem the referral process completed.

Tips:

- See Examples of Referral Tracking

Monitoring Performance

Develop a consistent process to monitor and improve upon the process internally and with the referral partner. It takes some time to hone the referral process and using a Plan Do Study Act (PDSA) performance cycle can help quickly find problems and try next step solutions.

Tips:

- See Enhanced Referral Worksheet #5: Sample Measures

Tools

Enhanced Referral Worksheet #1: Assess Network

What are the types of needs that you commonly need a referral partner to address (e.g., mental health or substance use, primary care/medical needs, housing, food, or clothing)?

Do you have existing relationships for referrals – for these needs?

Do you know the sources of referrals (in) to your practice/agency (e.g., who are your prime referral sources and who else should be referring to you)?

What new referral relationships would you like to develop and why? (i.e., how will this relationship improve care for your patients? how will this relationship create opportunities to provide your services to other patients that need them?)

Enhanced Referral Worksheet #2: Identifying Network and Referral Programming

What services does your agency provide that may fill needed gaps in services for the system of care?

In evaluating your current service delivery options, where do you excel?

What steps do you take to assure that the people you serve are engaged in the referral process?

How do you make your organization available to receive referrals? Are their barriers to your receiving referrals? How can you improve this process?

Do you have a formal process for measuring and reporting your outcomes for people with SUD/OUD? What outcomes are you measuring?

Do you have a communication plan to share your strengths with potential referral partners?

For referrals you receive, do you get information back to the referring agency that the referral was successful; information regarding treatment or treatment recommendations?

Do you provide this type of information to providers/agencies who send referrals to you?

What new referral relationships would you like to develop and why? (i.e., how will this relationship improve care for the people you serve? How will this relationship create opportunities to provide your services to people who need them?)

What can you do to develop additional relationships?

Referral Form Sample

Referring Agency:	Receiving Agency:
Key Contact:	Key Contact:
Contact Info:	Contact Info:

<table>
<tr><th colspan="2">Client Information</th></tr>
<tr><td>Name:</td><td>DOB:</td></tr>
<tr><td>Address:</td><td>Preferred Contact Info:</td></tr>
<tr><td>Phone:</td><td>Preferred Language:</td></tr>
<tr><td>Insurance Status:</td><td>Caregiver/Parent Info:</td></tr>
<tr><th colspan="2">Referral Details</th></tr>
<tr><td colspan="2">Reason for Referral (details of current problem and specific needs for receiving agency services):</td></tr>
<tr><td>Lab Tests/Screening Tools Given:
☐ PHQ-9 (Score__________)
☐ GAD-7 (Score_________)
☐ Brief Addiction Monitor (Score________)
☐ Recent crisis contact related to BH:
    ☐ Crisis service
    ☐ Emergency Department
    ☐ Inpatient Hospital stay
☐ Other Relevant information (please specify)</td><td>Client Engagement of Referral (check all that apply):
☐ Yes and consented for referral (see attached)
☐ Yes and anticipates outreach
☐ Yes and wants more information about receiving agency
☐ Yes needs more engagement to follow-through
☐ No (reason for not telling them):

Client stated needs/goals:</td></tr>
<tr><td>Urgency of Referral:
☐ Crisis
☐ Urgent
☐ Routine
Additional Details:</td><td>Assessment and Other Data to be Shared:
☐ Treatment history
☐ Diagnostic information
☐ Formal assessments
☐ Medication list
☐ Other (please specify)</td></tr>
</table>

Enhanced Referral Worksheet #3: Communication Considerations

How do you receive and send referrals? (letters, email, phone, fax, other)

How are referrals acknowledged? (By you upon receipt of a referral; by the provider/practice receiving your referral)

Is each referral tracked (in and out)?

For referrals you send, do you get information back that the referral was successful; information regarding treatment or treatment recommendations?

Do you provide these to providers/agencies who send referrals to you?

Are referrals made routinely as part of a standardized process?

If not, what triggers sending a referral?

For referrals you receive, do you have standards for timeliness of access to service?

☐ Yes ☐ No

If yes, how do you monitor adherence to this standard?

Do you have management processes and structure in place to address deviations from the standard or identified gaps? How do you respond when deviations or gaps are identified?

In establishing standards for referral processes, focus on your value proposition. What do you want from a referral? What do you want to provide to referral partners? Use that as a guide for establishing standards and what to measure.

Enhanced Referral Worksheet #4: Workflow Considerations

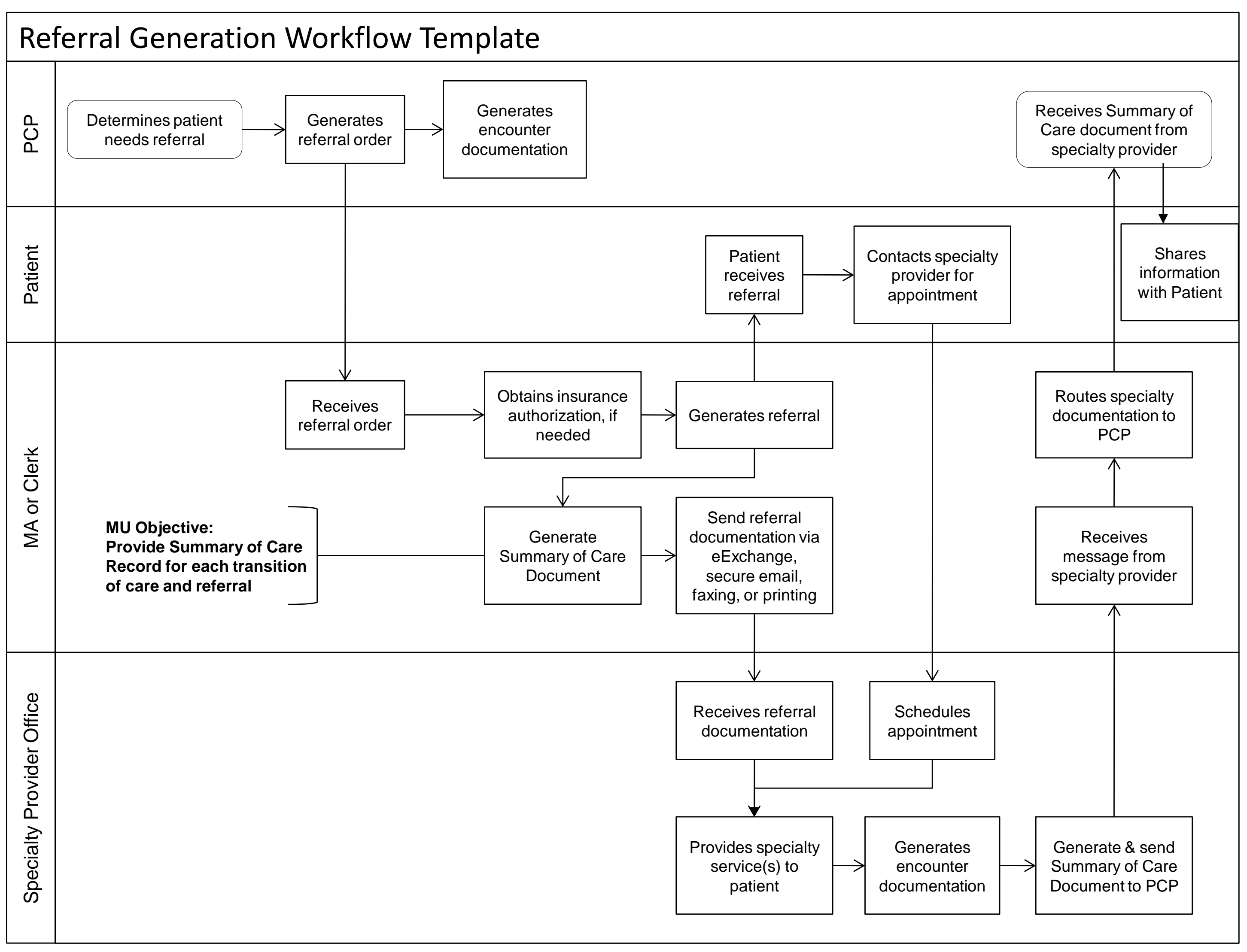
Do you know how well your referral process works?

What information (data) do you need to have to evaluate how well your referral process is working?

For patients that are referred to you?

For patients you refer to other providers/agencies?

Sample Workflow (Below):



Essential Elements for Patient Engagement in Enhanced Referral Process[1]

Activity	Element of Workflow	Outcome Tracking (process and outcome metrics)
Provide education to patient about need or rationale for referral and how information will inform treatment approach. ✓ Utilize motivational interviewing to connect need to referral to patient goals and autonomy in decision making process ✓ Provide patient with quantitative in addition to additional information on the reason for referral. For example, share the PHQ9 score with a patient being referred for depression.	Identification of need for referral; Communication about the referral	✓ Patient can repeat reason for referral and indicate interest in the referral. ✓ Patient asks questions about the referral indicating interest or is presenting honest assessment for provider to support referral. ✓ Patient engages in referral process
Provide warm-handoff or cool handoff or even co-located "intake/appointment" to referral contact to enhance engagement if available. ✓ Can this be done immediately at the point of referral education? ✓ Provider leverages patient trust to the new provider/referral to enhance engagement (can be a minute or two of shared conversation or using terms as "extended team members" to demonstrate trust and relationship). ✓ If you are engaged with shared treatment planning with referral partner, explain this to patient to demonstrate coordination of care as well as relationship as extended team.	Communication about the referral	✓ Patient engages with contact from referral partner ✓ # of warm handoffs ✓ # of cool handoffs ✓ Appointment scheduled following handoff

[1] Adapted from Berta, W., Barnsley, J., Bloom, J., Cockerill, R., David, D. et al. (2008). Enhancing continuity of information: Essential components of a referral document. *Canadian Family Physician, 54*.

Activity	Element of Workflow	Outcome Tracking (process and outcome metrics)
Explore barriers or challenges to completing referral with the patient. ✓ Open the conversation and explore concerns or challenges patient perceives in completing referral. ✓ Focus on *guiding* patient to engagement rather than *lecturing* when barriers are presented. ✓ Engage in problem solving with patient to address barriers. ✓ Leverage additional team members who can provide resources or problem-solving therapy to explore solutions. ✓ Share decision making with the patient—be open. ✓ When possible, engage the referral warm handoff for this discussion.	Communication about the referral	✓ Track the common types of challenges/barriers ✓ # that complete referral by barrier/challenge to identify what barriers present significant problems to referral process.
Identify administrative tasks that need to be accomplished to support referral and minimize reliance on patient for completing tasks. ✓ Obtain insurance authorization (if needed); ✓ Schedule first appointment; ✓ When necessary, identify or schedule transportation supports; ✓ Share information on potential co-pay; ✓ Provide location information—address and information for contact at referral partner as well as any brochure or information on partner organization and services; ✓ Obtain ROI or other documentation to support information sharing.	Communication and Care Compact	✓ Track number of patients with ROI with specific referral partner
Provide training and regular review of patient engagement and interaction. ✓ Train team members on patient engagement; ✓ Remind team members of importance of engagement of patient during referral;	Monitoring performance	✓ Track number of trainings provided to staff on engagement ✓ Set routine review of referral process with partner.

Activity	Element of Workflow	Outcome Tracking (process and outcome metrics)
✓ Review engagement process with referral partner routinely to explore methods for enhancement.		
Ask patients for feedback/satisfaction. ✓ Explore referral experience with patients; ✓ Ask about satisfaction of referral; ✓ Explore patient experience of shared treatment planning or case coordination.	Communication and Monitoring performance	✓ Review patient feedback as partners ✓ Discuss challenges/barriers in process between partners; and ✓ Set quantitative outcomes for patient population (e.g., 50% reduction in symptoms) ✓ Set process measures with partner to evaluate referral process (e.g., no show rates, patient engagement in at least 2 sessions with referral partner, number of patients with shared treatment plans, etc.)

Care Compact Worksheet

Developing care compacts that define processes and shared expectations between provider organizations is an important step to increase integration of behavioral health and primary care. Achieving effective care compacts requires a deliberate process to assure the integration is valuable and feasible and addresses cultural differences and operational workflows of the two organizations. Use the below questions to start the process of developing a care compact with organizations that you refer to.

Although the specific content of the care compact is up to the discretion of the two organizations involved, many care compacts address some of or all the following four concepts as a part of the expectations:

- Access to Care
- Timeliness
- Communication
- Results

PART I: DEFINING THE SCOPE

Part I: Defining the Scope

1. How would you describe your value proposition to partner organizations? What do you have to offer in the relationship that will increase integration and improve patient/ client/ member care?:

____
____
____
____

2. What are your expectations from your partner organization? What are you asking for that will increase integration and improve patient/ client/ member care?

____
____
____
____

3. What do you expect your partner organization to ask of you? Which of these elements will you be able to provide and which will be challenging for you? Is there anything that is not possible? (Use the sample care compacts as a guide if helpful)

____
____
____
____

4. Consistent performance on any expectation is an important factor in the success of a referral relationship and a care compact. What processes do you have in place or can you develop to assure that your organization is able to consistently meet the expectations outlined in the care compact?

____
____
____
____

5. What ideas do you have for processes or other elements that may support maintenance of the commitment and communication between organizations in your care compact over time?

____
____
____
____

PART II: NEGOTIATION

Sit with representatives of another organization who may be a potential partner, or not. Review your expectations of the referral relationship. Do the expectations align?

____
____
____

Are there any cultural differences between the two organizations apparent in the negotiation of the care compact? If yes, how can these differences be addressed in the care compact?

____
____
____
____

WORKING WITH THE PARTNER, SPECIFY THE EXPECTATIONS FOR EACH ORGANIZATION:

Topic #1: ______________________________

Organization 1 will do:

Organization 2 will do:

Topic #2: ______________________________

Organization 1 will do:

Organization 2 will do:

Topic #3: ___________________________________

Organization 1 will do:

Organization 2 will do:

OTHER CONSIDERATIONS FOR THE CARE COMPACT:

Referral Tracking Spreadsheet Example

Referral Tracking Example 1

EXAMPLE OF REFERRAL TRACKING TEMPLATE

Use: create a simple tool to monitor the completion of referrals for all patients/ clients. This tool can be used to track performance of a specific referral relationship/ organization, track performance by provider, and to any measures of success defined by the organizations.

Patient Identifier	Provider	Organization/ Provider Referred To	Date Referral Sent	Referral Received	Patient No-Showed Appointment	Return Communication Received	Medications and Care Plan Updated

Weekly totals:

Number of referrals [by organization, by provider] successfully completed: ___________________

Number of referrals [by organization, by provider] not successfully completed in expected timelines: ________________

Number of referrals [by organization] still outstanding: ________________________

Enhanced Referral Worksheet #5: Sample Measures

1. Referral source and subsets of referrals received:
   (a) new or repeat referral? (b) Type of referral (develop “groups” to track based on business needs, i.e., what you need to report and/or service line(s) you are trying to build)
2. Date referral received; date referred patient contacted or number of attempts made if not contacted; date service provided
3. Date referral source contacted regarding disposition of service requested, i.e., completed appointment (date), unable to contact (closing the loop)
4. Date clinical follow up/disposition information provided to referral source.
5. Others?

Once you identify what you need to measure, how will you measure? (i.e., tools, data, reporting processes, management observations)