**Helpful Hints to Improve the Referral Process**

Referrals from primary care practices to community resources are often needed to help families access services. Ideally, practices have an effective approach to facilitate referrals. Optimizing the referral process enhances the likelihood that it will occur and thus the care provided to children and their families. However, referrals frequently do not pan out, for several reasons.

First, primary care professionals (PCPs) may focus on what they perceive to be the problem(s) and elicit little input from the parent,[[1]](#footnote-1)\* instead telling them what to do.1 This may not fit with a parent’s view of the issue, as well as interest in whether and how to address the problem. Without the parent at least partly owning the plan, it’s less likely that the plan will be implemented.1 Second, PCPs may not convey the importance of the referral and confidence in it being helpful. A ‘warm handoff’ to a social worker, for example, may be missing.2 (e.g., “we have an excellent social worker. Would you like to talk with him?”). Other barriers include logistical challenges that may impede a parent’s ability to follow through with the referral, such as work schedule conflicts and limited availability of convenient time slots with long wait times.3 Transportation too may be a barrier; families requiring Medicaid-funded transportation may need a few days for authorization. Bureaucratic challenges with insurers may also obstruct care. Limited monthly phone minutes or hesitancy to answer the phone from an unknown number may limit communication.3 Additionally, the complexity of referral systems and availability of specialists may impede easy access to care. Agencies or professionals may have specific requirements before offering services; these may be cumbersome and confusing.4 Finally, the type of insurance coverage may be a barrier for families to access needed referrals.4

What is known about optimizing the referral process? A few factors have been found to help, such as utilizing a family-centered risk or needs assessment, such as the [SEEK Parent Questionnaire-R (PQ-R)](https://seekwellbeing.org/seek-materials/), to identify family needs.5 If possible, have the assessment results sent directly to the electronic health record (EHR) to be readily accessible to PCPs.5 Additionally, having referral contact information readily available, the institutionalization of formal written protocols on when referrals should be made, a tracking system for monitoring referral completion and formal agreements with community resources.6 As mentioned above, we’ve learned from clinical experience that a warm hand-off helps instill confidence in someone ambivalent about a referral.2 Further, parent handouts customized with local resources and highlighting the best options and when possible, calling a resource with the parent should help.

Helpful hints for **bolstering your referral process**:

1. Consider creating formal **written protocols** on when referrals should be made for specific problems

* Include when and how to make referrals
* Protocols should be easily accessible for practice personnel
* Train PCPs, residents, behavioral health professionals (BHPs) and other frontline staff on screening and briefly assessing for psychosocial problems. The [SEEK training videos](https://seekwellbeing.org/introduction-to-training-videos/) and [SEEK Algorithms and Barriers](https://seekwellbeing.org/seek-materials/) should be useful for this5

1. Have **parent handouts** for targeted, common problems like food insecurity, such as the [SEEK Parent Handouts](https://seekwellbeing.org/seek-materials/)

* Customize with info on local and perhaps national resources. Specify:
* Service(s) provided
* Address
* Contact information
* Hours of operation
* Cost, fees
* Eligibility criteria7
* Update the information periodically, at least annually7
* Use clear and simple language – not higher than an 8th grade reading level
* Have versions in commonly used languages in the community served
* Identify specific people at community resources that can serve as the main point of contact for referred parents7
* Have the handouts easily accessible for practice personnel
* Encourage personnel to use the handouts
* Personnel can plan with the family optimal resource(s) (e.g., location, insurance accepted), and encourage them to contact the resource

1. Have **community resource information** for targeted, common problems in the waiting room for families to easily access5

* Down time during primary care visits is common, especially when waiting.5 Having resource information readily available in the waiting area could help families learn about local resources
* The [SEEK posters and video](https://seekwellbeing.org/seek-materials/) may be useful to help parents understand why they’re being asked sensitive questions on the SEEK PQ-R about such things as domestic violence and substance use

1. Helpful tips for **finding local resources**

* National resource hotlines or websites often help find local resources
* Many state governments have websites on specific problems (e.g., substance use)
* County health departments or general county government websites may have information on resources for certain problems (e.g., food banks, smoke alarms, mental health)
* City websites may have information on resources for certain problems
* [Benefits.gov](https://www.benefits.gov/) has information on government programs, eligibility criteria, how to apply
* 2-1-1 helps find nearby resources for many problems, like food assistance, housing, substance use, domestic violence, employment, health care and counseling
* The [Supplemental Nutrition Assistance Program (SNAP](https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program)) provides nutrition benefits to low-income individuals and families through its nationwide network of field offices
* The [Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)](https://www.fns.usda.gov/wic) helps women and children, up to age 5, with free healthy foods, advice on healthy eating and referrals to health, welfare and social services
* [www.foodpantries.org](https://www.foodpantries.org/) has food assistance info for many states
* Legal Aid Clinics helps those that are financially eligible with civil legal problems, such as partner violence, employment and housing
* The American Red Cross provides free smoke alarms; check local or statewide website
* Most states have smoking quit lines; search ‘(state) smoking quit line’
* Most states have a Poison Control website; search ‘(state) poison control’
* [Aunt Bertha](https://www.findhelp.org/) finds resources for problems, such as finding food, help paying bills; enter zip code and targeted problem
* The [Help Me Grow National Center](https://helpmegrownational.org/) has affiliates in many states which link community resources, such as education, healthcare and family services
* Social media accounts (e.g., Facebook or Twitter) for agencies or programs may have information on events, news, up to date contact info

1. Have a formal or informal **agreement** with local resources. This may include:

* Identifying specific people at community resources to serve as the main point of contact7
* Establishing how referrals are to be made (e.g., phone, email)
* Clarifying necessary documentation
* Exchanging information among service providers and practice personnel. This does not need to include sensitive, detailed information; rather there can simply be general indication of engagement and progress. This may require parental ‘release of information’
* For additional information on collaborating with community resources, this [AAP article](https://pediatrics.aappublications.org/content/136/4/e993) is useful

1. Use **Motivational Interviewing (MI)** when assessing and developing the plan with a parent or patient. MI is a patient-centered approach to motivate someone who is ambivalent about changing their behavior or accepting an intervention.8 MI involves parents or youth in a way that makes it more likely they’ll ‘own’ the plan and implement it. MI helps engage children beyond age 6 in the referral process. The SEEK website has helpful [MI articles](https://seekwellbeing.org/seek-materials/). MI involves:

* Gauging a person’s readiness for or interest in addressing a problem
* Encouraging the person to take the lead in developing a plan by asking what they think about the issue, and what they are interested in doing about it
* Changing the PCP mindset to be consistent with the patient-centered spirit of MI, and using specific communication techniques, such as open-ended questions, affirmations, reflections and summary statements3

1. Identify and incorporate individuals’ or families’ **strengths or protective factors;** these can buffer the impact of risk factors and help develop resilience

* Identify and incorporate these factors when developing a plan to strengthen a PCP’s relationship with a family, and to develop a more effective plan
* These may be ‘internal’ or ‘external’ to a patient and family
* Internal protective factors involve individual’s and family’s attributes that help cope with problems, such as a parent’s wish for their child to be healthy
* External protective factors are those outside the family, such as the care provided by a PCP, therapy for a depressed father or a food pantry

1. Provide a **“warm hand-off”** when recommending and introducing a parent or patient to another professional (e.g., “we have an excellent social worker. He’s been able to help lots of families. Would you like to talk with him?”)
2. PCPs and BHPs should, with the family, **prioritize what problem(s) to address first**, explaining “we’ll get to the other issues ASAP.”

* One may be tempted to try to address all presenting problems. That good intention may be unrealistic, and risks overwhelming a family
* One may also wish to quickly fix a problem, but thoughtful assessment and planning are key and an additional visit(s) may be needed

1. Help address **logistical challenges**

* Plan with the parent what’s needed for the referral (e.g., insurance coverage, what to expect)
* Provide contact information for the resource (e.g., parent handout)
* Offer to help set up an appointment
* Follow-up with the family to ensure barriers didn’t block the referral from panning out

1. **Follow-up** with the parent and perhaps the resource (with permission) to assess progress

* Decide when to follow-up
* Set reminders to follow-up
* Document follow-up attempts and contacts
* Contacting outside agencies and professionals may require parental ‘release of information’
* Ask parents about their experiences with community resources7

1. **Document** information related to referrals

* Document referrals in the patient’s medical record
* Document follow-up attempts and contacts, such as the date, nature of f/u (e.g., phone call, email, letter) and summarize what transpired
* Implement a tracking system for monitoring referrals, ideally in the EHR5

**References**

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1. \* Also pertains to other primary caregivers. [↑](#footnote-ref-1)