Referrals to Community Partners Toolkit

How to Use the Toolkit

This toolkit is designed to help build referral systems with community partners and create continuity of care for families.

Why is Referring Important?

There is a wealth of services and resources offered by organizations in your community that help new and expectant families prenatally throughout the post-partum period. However, many of these services are underutilized, as families may not know what is available to them.

That is why referrals are so important. When families are aware of and have access to community resources, they can get the support they need. Referring to your community partners will help families experience true continuity of care. By building and participating in a robust referral system, you can be a part of ensuring your community's health needs are met.

Getting Started

Identify services provided in your community.

It can be hard to keep track of all the resources in your community. The good news is that not everyone needs an in-depth understanding of everything – they just need to know what exists, a general idea of what the program does, and how to refer!

- **Work with the partners you have contacts with already.** Your partners may have contacts for other organizations in your community. Examples of organizations and partners that share similar goals include WIC agencies, home visiting programs, public health programs, hospitals, prenatal / outpatient clinics, community groups, doulas, midwives, lactation consultants, and breastfeeding coalitions.
- **Set up a collaborative meeting** with your community partners to discuss the services you each offer, and how others can make referrals. (See the Community Partner Leadership Meeting Toolkit)

Collaborate with the community

Referrals are ineffective if major barriers to care exist. Social determinants of health can greatly impact access to care. It's important to create a referral process that best supports the community's needs.

Get feedback from the populations being served about how services are (or are not) being utilized, what barriers to care exist, and how referrals can best support the individuals and families you serve.

Establishing a Referral Process

Aim for warm referrals.

A warm referral goes beyond handing a list of resources to a family. Warm referrals truly connect individuals and families with specific organizations that have been chosen based on the family's specific needs. A warm referral process is a three-pronged approach that includes the following components:

- **Information to the Family**: The family is given a complete list of trusted organizations, who have been engaged with and vetted by the referring organization.
- **Documentation**: The specific referrals chosen for the family, based on medical and social determinants, are documented in the electronic medical record (EMR) in an outward-facing location (i.e., the follow-up page in the discharge section of the EMR, after visit summary, etc.).
- **Notification to the Referral Organizations**: The specific referral organizations are notified of the referral so that they can facilitate the follow-up by reaching out to the family themselves and following up with the referring organization if the family is not engaged in a timely manner.

This bidirectional approach ensures that no family is lost to follow-up. A warm referral is a "gold standard" to work towards!

Create a referral list.

The list of referral organizations does not need to be long. The warm referral will need to include key contacts and a process for notification that is timely, reliable, and accurate.

If just starting, your organization should focus on meaningful connections with a small number of organizations that are vetted and engaged. To ensure that families have a comprehensive safety net of support, we recommend a list of programs that includes the following for every family:

- WIC referral
- Home visiting referral
- Community-based organization referral

Determine how referrals will be initiated.

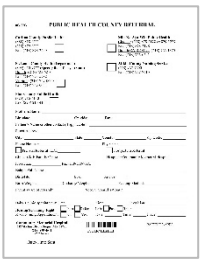
Below are suggestions to support systemic consistency regarding who will be referred and how to initiate referrals. These practices have been implemented and recommended as best practices in different communities throughout the Midwest.

- Refer all families regardless of assumed program income eligibility.
- Complete referrals early.
    - Consider completing referrals during the first prenatal appointment or first contact with a program.
- For hospitals, it is important to refer families by the time of discharge after a baby is born.
    - Include patients in conversations about services prior to referral and ask their permission prior to sending information to community partners. Examples could include:
        - Notify WIC program breastfeeding peer counselors when a WIC family has had a baby.
        - Fax discharge and follow-up information to community partner programs.
- Consider implementing systems where referral is completed in person. Examples could include:
    - Creating systems where WIC, home visiting, local health department nurses, etc. complete follow-up with a patient while attending a prenatal appointment or in the hospital prior to discharge.
        - View a local Ohio WIC agency's lesson learned on Integrating WIC Staff into Hospital Bedside Referral Process.
        - View local Michigan WIC agency and hospital's lessons learned for Integrating WIC Breastfeeding Peer Counselor into Birthing Center Night Shift and Infusing Peer-to-Peer Support & Traditional Lactation Care in the Prenatal Clinic.

Utilize a referral form.

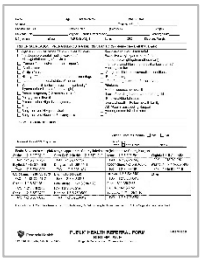
Below are resources that can help you create a warm referral network in your community. They have been created by agencies throughout the Midwest. The resources are focused on making referrals from a hospital or clinic to community organizations but can be modified and applied to other community partners as well.

SAMPLE REFERRAL FORMS



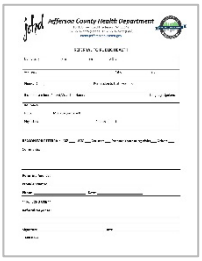
Public Health County Referral Form

This sample referral form from St. Louis County Health Department & Carlton County Public Health (MN) can be faxed to a general public health contact. Access the Public Health County Referral Form.



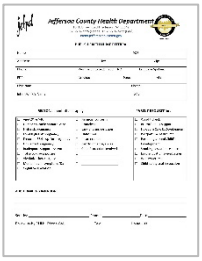
Public Health Referral Form

This customizable form from St. Louis County Health Department & Carlton County Public Health (MN) can be faxed to multiple county public health departments. It includes a referral reason section to indicate prenatal and postnatal risk factors. Access the Public Health Referral Form.



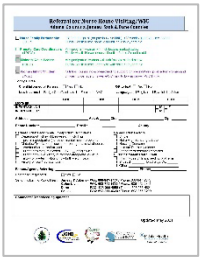
Referral to Public Health Form

This customizable form from Jefferson County Health Department (WI) includes a list of why referrals may be made. It can be faxed to the public health department and specific programs, such as immunizations, WIC, car seats, prenatal / parenting visits, and more. Access the Referral to Public Health Form.



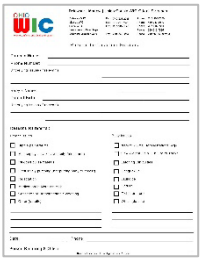
Public Health Nurse Referral Form

Customizable form from Jefferson County Health Department (WI) that can be used to refer to a public health nurse. The form includes a section to indicate potential parent requests. Access the Public Health Nurse Referral Form.



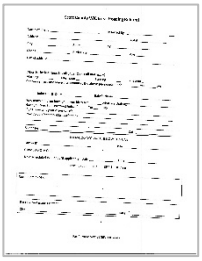
Referral Form for Nurse Home Visiting / WIC

Customizable form from Sauk County WIC (WI) for referring to public health programs, including Nurse-Family Partnership, Prenatal Care Coordination, Maternal Child Health, and WIC services located within public health. The form includes sections to indicate perinatal and postpartum conditions and general risk factors. Access the Referral Form for Nurse Home Visiting / WIC.



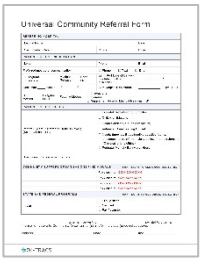
Referral Form for Lactation Services

Sample referral form from Delaware, Morrow, and Union County WIC (OH) that can be used to refer families to lactation services based on parent and/or baby issues. Access the Referral Form for Lactation Services.



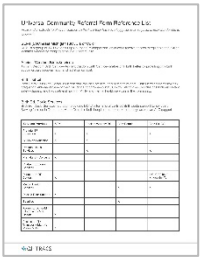
WIC Breastfeeding Referral Form

Sample referral form from Scott County WIC (IA) that can be used by hospitals to refer families to WIC breastfeeding services. The form includes a section to note breastfeeding concerns to be acknowledged and documented. Access the WIC Breastfeeding Referral Form.



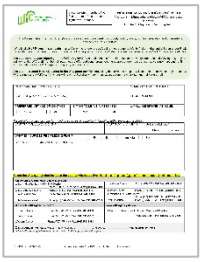
Universal Community Referral Form

This referral form, developed through the QI-TRACS initiative in Michigan, was co-created with community organizations to provide families with timely perinatal support. Hospitals can use this form to refer patients to community organizations and individuals as well as federal and state programs such as WIC. Access the Universal Community Referral Form.



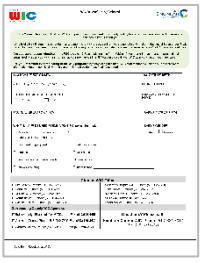
Detroit Universal Community Referral Form

Customized version of the Universal Community Referral Form (above) that includes contact information for Detroit-based organizations as well as a reference list of services. Access the Detroit Universal Community Referral Form.



Birth Notification Form

Birth notification and referral form that helps families and hospitals notify WIC of births and provide timely follow-up. The customizable form was created as a collaborative cross-border effort between 12 WIC agencies covering 20 counties in the Midwest (IA, MN, WI) and their two shared birthing hospitals. Access the Birth Notification Form.



WIC Breastfeeding Referral Form

Customized version of the Birth Notification Form for Hamilton County WIC (OH). Access the WIC Breastfeeding Referral Form.

The form was made electronic through Google Forms and made available to patients by adding the WIC Breastfeeding Referral Form QR Code Stickers to materials.

LESSONS LEARNED

- View the Cross-Border, Multi-Agency Notification of Birth and Referral in IA, MN & WI lesson learned to learn more about the process of using a shared notification of birth and referral process that facilitates timely support by WIC after discharge from the hospital.
- Notification of Birth Form: Hospital + WIC Referral Process: View this lesson learned from Defiance County WIC Program (OH) to see how they coordinate care from WIC to the local birthing hospital.

Document referrals in the Electronic Medical Record.

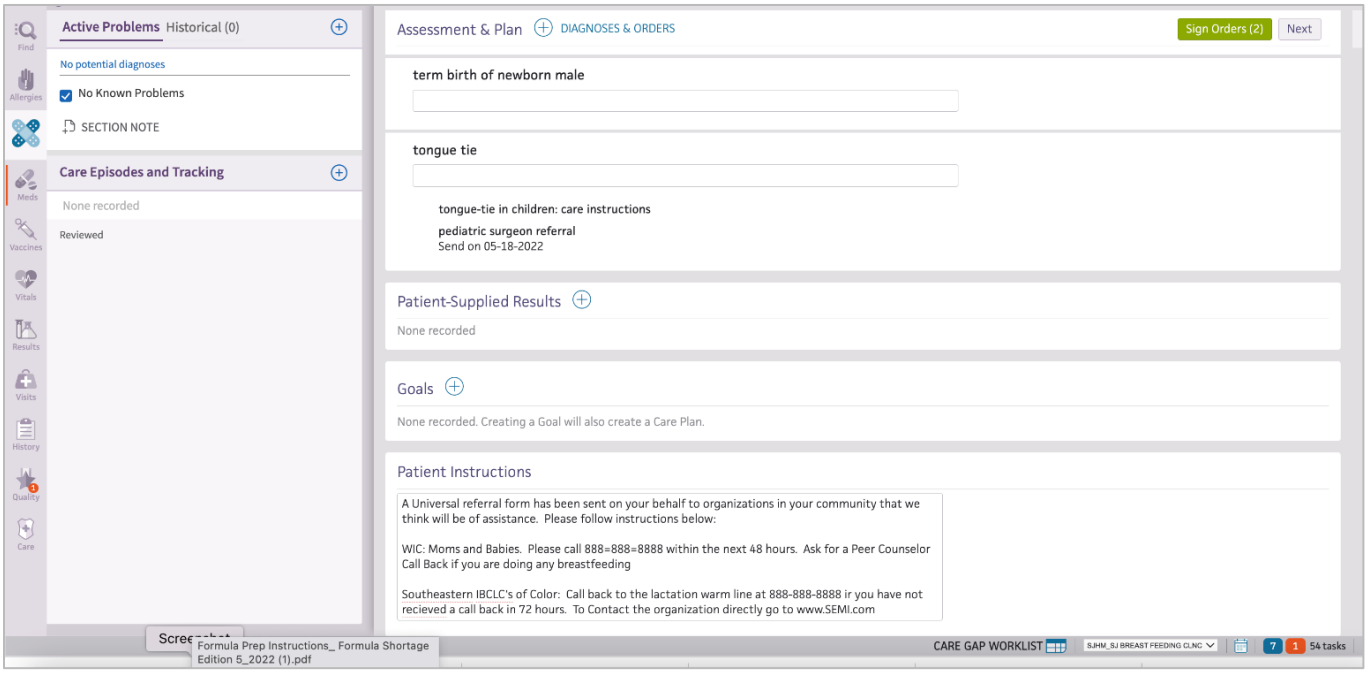
For most hospitals, changing the EMR to accommodate specific documents and processes is an arduous, complicated, and expensive task. This following paragraph is designed to be saved as a Smart Phrase, (some examples of Smart Phrases include “macros”, “dot phrases”, or “shortcuts”) by staff (likely nurses or providers) to document referrals into the hospital or clinic’s EMR. It can be inserted into the discharge follow-up page in the EMR. Staff refer to their chosen referral form to customize the macro per patient. This process does not require EMR customization.

Note: This process is to document in the EMR that a referral has been made, it does not take the place of a referral.

SAMPLE LANGUAGE FOR PATIENT DISCHARGE FOLLOW-UP IN EMR

A referral has been sent on your behalf and with your permission to an organization in the community for additional services. Please know that the organization will be contacting you. Follow the instructions below if you are not contacted within 72 hours by the organizations listed. At any time, call back the birthing center referral specialist at XXX-XXX-XXXX and leave a message to request assistance.

1) ORGANIZATION ONE: Please call XXX-XXX-XXXX if you do not receive a call in 72 hours from this {WIC} agency.
2) ORGANIZATION TWO: Please call XXX-XXX-XXXX if you do not receive a call in 72 hours from this {home visiting} agency.
3) ORGANIZATION THREE: Please call XXX-XXX-XXXX if you do not receive a call in 72 hours from this {community-based} agency.



Keep the Momentum Going

Continue to learn about each other's organizations and strengthen partnerships. Below are additional suggestions for keeping your momentum going.

- ☐ Arrange for your community partners to take a tour of your organization to learn more about the services you provide (See the Hospital Tour Toolkit).
- ☐ Identify a point-person to contact regarding the referral process. Set up on-going meetings or check-in dates to discuss referral process efficiencies and share updates on program services. We recommend checking-in with referral organizations weekly or bi-weekly when new referrals processes are implemented to ensure processes are working effectively. Once referral processes have been established communities usually connect with contacts monthly, bi-monthly, or at a minimum quarterly.
- ☐ Include the community in discussions for referral processes and how to decrease barriers to care once a referral has been made.
- ☐ Provide outreach materials, applications, and/or sign-up information that can be provided to all families / clients.
- ☐ Display community program posters in waiting rooms and exam rooms.

ABOUT TOOLKITS

Toolkits provide guidance to local organizations in their efforts to drive systemic change in their communities. Toolkits are developed based on local organization experiences and include curated examples to complete an initiative. Local organizations have provided permission to share the available resources.

If you would like to contribute a resource to this toolkit or have questions about this toolkit, please contact solutions@coffective.com.

To access more examples of projects completed at the local level and supporting resources, sign up or log in to the Coffective dashboard.