

Resource Referral Guide & Template

Providing high quality, accurate referrals to community resources can help patients or clients successfully access the resources they need to be healthy – and build considerable trust along the way. From food, to housing, to transportation, clients know these resources are *essential* to their health and well-being, so it is critical that the information you provide is up-to-date and sets them up for success – just as you would approach medical referrals.

While providing accurate information on your community resources referrals is helpful, it is often not enough to successfully connect a client to needed resources. Gathering and tracking feedback from clients on the barriers they face when acting on a resource referral can help your organization establish more effective social needs screening and referral practices.

This guide is meant to help healthcare and community-based organizations create and maintain high-quality resource listings for clients –including the steps these organizations can take to better understand and proactively address barriers to access.

This resource was developed from a workshop (“Addressing social needs across the care continuum: Practical solutions for screening, referral, and navigation”) presented at the Camden Coalition of Healthcare Providers’ National Center for Complex Health and Social Needs conference Putting Care at the Center 2018. Learn more about the National Center and the annual conference at www.nationalcomplex.care.

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Referral Template

This template illustrates the core information that should be included in high-quality resource listings – whether for paper-based directories, home-grown resource databases, or in assessing resource database vendors.

Resource:	Identify the resource need that the referral intends to address. We recommend making this field searchable in your database so that resources can be quickly identified based on needs.
Organization Name:	Identify the entity or organization that provides the resource.
Phone Number & Address:	Provide the phone number and physical location of the resource organization. Include a map if possible.
Hours of Operation:	Indicate the hours when individuals or families can access the resource.
Languages Spoken:	List the languages that are spoken at the resource-providing organization and/or if translation services are available on-site.
Transportation:	Provide driving directions and instructions on how to use public transportation to get to the resource, where applicable.
Resource Description:	Provide a brief description of the resource. We recommend that this and all information in the referral be written from a first-person perspective (using I, we or us). Include details on what the organization offers and how those services or supports can be helpful in meeting a need.
Eligibility:	Describe who is able to receive this resource, including any requirements that must be met. Consider immigration status requirements, if applicable.
Referral Needed:	Indicate if a formal referral is needed and if it must be given by a specific provider.
How to Access this Service:	Describe steps the client must take to access the service (where to go, when, what to ask for, what to expect when there, etc.). A conversation with the service organization is often required to gather this level of detail, as it is usually not readily available online.
Materials to Bring:	Describe what the individual or family must bring to access the service (any required identification, referral documentation, proof of income status, doctor's note, proof of participation in a related program, etc.). The goal is to avoid multiple visits to access the resource.
Other Notes:	Include any other information that would be helpful to the individual or family as they attempt to access the resource.
Internal Notes:	These are not intended to be included in the individual or family referral, but can help case managers better support clients. This may include other resources related to the need or alternatives if the client has trouble accessing the referred resource.

Example Referral

Free Athletic Equipment Offered by: Youth Sports Help

Resource Description

This group gives free sports gear to kids who want to play sports. You can get baseball gloves, tennis rackets, or other sports equipment. This program can help if your child or a child in your care wants to join youth sports and cannot afford the equipment.

Target Population: Low income families, families with children

- Eligibility:**
1. Your child must qualify for the Free Lunch Program at school
 2. Each of your children is only allowed to take a piece of equipment once a year

Referral Needed? No

How to Access this Service: Go to 165 Center Street in Jamaica Plain on Saturday between 10:00 am and 5:00 pm

Once there, tell an employee what sport you need equipment for -- like baseball or hockey. They will help make sure your child gets the right size.

Materials to Bring: Materials to bring: You need to bring something that shows a youth sports league is about to have sign-ups, like a flyer or brochure. Anything that shows the date of the sign-ups will help.



(617) 872-3060 ; (773) 555-5555

[Website](#)

165 Center Street
Jamaica Plan, MA 02130

Directions: [Car](#) / [Transit](#)

Hours of Operation: Saturday 10:00 am - 5:00 pm

Languages Spoken: English

Contact Instructions: Call within hours of operation

Transportation: Take the Orange Line to Green Street

Other Notes: Your child has to sign-up for the sport that you said they would. The group does check if your child actually joined the sport.

Internal Notes: You might want to recommend families for year-round sports programs through the Park District or after-school programs.

Creating and Tracking Patient-Centered Referrals

These planning tools may help you establish more effective social needs screening and referral practices. Follow the steps below using the included worksheets to begin identifying small tests of change that you can try in your own setting!

Uncovering the most effective community resources and building collaborative partnerships can feel daunting! Consider the quality of your social need referral relationships rather than the quantity. A handful of strong relationships will likely lead to success for your patients.



Identify 1-3 Potential Resources

- Research community resource directories (Department of Aging, 211, etc.)
- Brainstorm with patient and staff
- Research to fill in gaps



Verify Resource Information

- Calls or visits to verify resource information
- Identify a contact person for practice and patients
- Discuss preferred referral processes and the goals of your social needs program



Collect Patient Feedback on Resources

- Continually assess accessibility of resources (hours, language access, eligibility requirements, etc.)
- Collect feedback through formal and informal channels



Create Patient-Centered Referral Processes

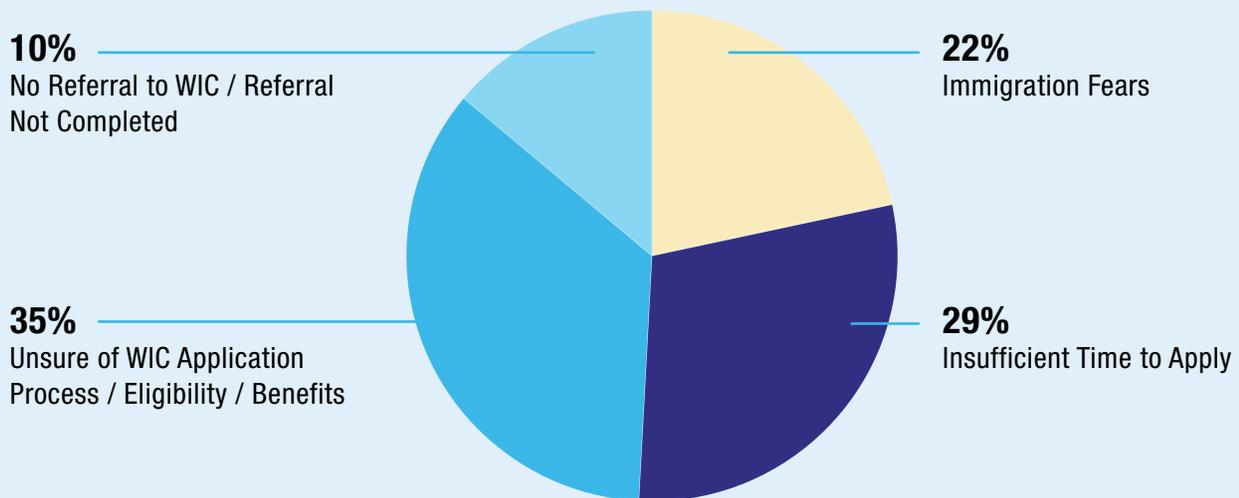
- Decide on paper or electronic format
- Consider and plan for all eligibility and accessibility factors
- Translate to top languages
- Train staff on making referrals

Example: Gathering and Using Client Feedback to Improve Resource Connections

As shared in our case study with New York Health + Hospitals and New York State WIC — [Community Health Workers, Localized Data, and the Path to Healthier Families](#) — a major part of the community health worker (CHW) role was to gather feedback from patients on their experiences accessing services and compile this qualitative information in a simple spreadsheet. Common experiences or barriers were coded and tracked to quantify how frequently patients encountered similar challenges. This feedback was shared with WIC site directors to drive discussions on what system-level changes could be adopted to better ensure that families in need are able to access services. Maintaining an open dialogue also helped CHWs and WIC staff effectively address patient access issues in real time.

Patient-Reported Barriers to WIC Access

10/16/17 to 8/31/18



Worksheet #1:

Uncovering and Verifying Community Resource Information

(Fill in these fields directly in the form or feel free to print and expand with additional text.)

Think about what information a client may need when referred to a community resource for the first time:

- Eligibility Information
- Immigration Status
- Address of Location
- Detailed Description of the Service
- Reason for Referral
- Materials Needed to Apply
- Languages Spoken by Organization
- Populations Served by Organization
- Contact Person (name, number and email)
- Transportation Information (Is there parking? Closest bus or train lines?)

<p>What other information might be relevant?</p>	
<p>How might you engage your clients directly in helping identify what information feels most relevant?</p>	
<p>Do ALL of your current social need referrals include this information?</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> I'M NOT SURE</p>
<p>Has someone verified this information by calling / visiting / emailing the community resource within the last 6-12 months? (Tip: Don't rely solely on community resource guides!)</p>	<p><input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> I'M NOT SURE</p>
<p>How might your practice gather all of the information needed for a client centered referral?</p>	
<p>How might you train staff on making health-related social needs referrals more client centered?</p>	
<p>What action could you try NEXT WEEK to make improvements? (Think small tests: one patient, one phone call, one referral sheet, etc.) See Page 8 for a PDSA worksheet!</p>	

Worksheet #2:

Tracking Health-Related Social Needs Referrals

(Fill in these fields directly in the form or feel free to print and expand with additional text.)

Tracking referral outcomes provides valuable information that allows organizations to understand and proactively address barriers that clients face when acting on a resource referral.

Does your practice have definitions of successful outcomes for resource referrals?	
How might your practice engage clients to define what successful referrals look like?	
How could you track that a successful referral has been made?	
How will you track barriers your clients experienced when connecting to a community resource?	
How can your practice address those barriers?	
How will your full care team understand resource needs and barriers clients experience?	
Where can your practice track the outcome of a referral?	
What action could you try NEXT WEEK to make improvements? (Think small tests of change: one patient follow-up, one conversation, one barrier addressed, etc.) See Page 8 for a PDSA worksheet!	

Worksheet #3: Plan-Do-Study-Act Cycles

(Fill in these fields directly in the form or feel free to print and expand with additional text.)

Team:	Start Date:	End Date:
Plan		
Objective of this Cycle The idea or change to be tested:		
Questions – What questions do you want to answer? 1. 2. 3.	Predictions – What do you predict are the answers? 1. 2. 3.	
Testing Strategy What will be tested: Who is responsible: Where will it be done: When will it be done:		
Data Collection Plan How data will be collected (check all that apply): <input type="checkbox"/> Data Collection Form <input type="checkbox"/> Interviews <input type="checkbox"/> Run Charts <input type="checkbox"/> Check Sheet <input type="checkbox"/> Flowcharts <input type="checkbox"/> Other: <input type="checkbox"/> Written Surveys <input type="checkbox"/> Swim Lane Maps		

Do

Observations in Carrying Out the Plan

General Observations:

Problems/Challenges:

Unintended Outcomes:

Study

Data Analysis & Interpretation

How do your findings compare with your predictions? What does the data show?

What are the implications of any problems, challenges, or unintended outcomes?

Based on your findings, did the change lead to improvement? Why or why not?

Act

Conclusions from this Cycle

- Adapt** – We will modify the change strategy and/or widen the test conditions based on our learnings.
- Adopt** – We will implement and spread the change strategy across our program.
- Abandon** – We will stop testing and move on to a new change strategy.

Plan for Next Cycle