Medical Home: Referrals is a component of Medical Home (a Universal Measure), one of twenty Maternal and Child Health (MCH) **National Performance Measures (NPMs)** for the Title V MCH Services Block Grant to States Program. This NPM subcomponent is focused on increasing the percent of children with and without special health care needs, ages 0 through 17, who receive needed referrals.

For Referrals, there are 19 evidence-based strategies from MCHbest and 11 field-based practices from Innovation Hub. Strategies for this subcomponent can be found on page 3.

The **What Works Evidence Accelerators** provide background information and a summary of effective strategies to advance each of the NPM topic areas. The strategies support increased access to referrals for preventive and specialty health care services and social needs as well as enhanced referral networks to improve access to care and care coordination for children and their families.

Overview. In a pediatric medical home, the primary health care professional helps the child and family access and coordinate care that is important to their overall health and well-being.[1,2] Referrals typically involve directing a child and family to specialists or services outside the primary care setting, such as medical sub-specialists, surgical specialists, therapists, early intervention, educational services, and community resources, to meet a child's health and social needs.[1,2] In many cases, referrals from approved providers are needed for health insurance to cover the cost of specialty care.[3] A provider's choice to refer may be affected by the severity and complexity of the child's health concerns, the family's desires, health insurance coverage, the availability of qualified specialists in the area, and local or regional variation in how therapies are delivered.[4]

Referrals is one of the components of the composite medical home measure.[5] Referral access is important for addressing unmet health and social needs. Communication and coordination are essential; all care providers need to collaborate to establish shared care plans in partnership with the child and family and develop a clear understanding of each other's roles to provide comprehensive care.[2] A strong cross-sector referral infrastructure is needed to improve child health through the integration of clinical and social care.[6]

Although referral to subspecialty care is an important task within primary care and occurs on average at least once annually for every 3 pediatric patients, the process of connecting children and families with subspecialists can be challenging.[7] Families without ready access to pediatric subspecialists are less likely to receive subspecialty care, more likely to receive care from specialists who are not trained in pediatrics, and more likely to report emergency department visits.[7] Access to referrals is often increased when a care coordinator, peer navigator, or community health worker is designated to assist children and families with obtaining and accessing needed specialty referrals in addition to helping them access equipment and services that may require referrals.[8]

Barriers to referrals include *barriers faced by families and/or communities*, such as difficulty leaving work, obtaining childcare, obtaining transportation, and inadequate health insurance; and *barriers related to the health care system*, such as workforce shortages, limited appointment availability, geographic location, communication challenges, and lack of access to interpreters.[9] Families experiencing many barriers had greater risk of incomplete referral.[9] It is critical to reduce barriers to referrals to improve rates of care usage among children who are underserved.[9]

Data. This NPM is measured through data collected from the National Survey of Children's Health (NSCH). In 2022, when parents and caregivers were asked how difficult it was for their child to get referrals to see any doctors or receive any services, 81.8% did not need referrals, 14.2% had no difficulty, 3.0% found it somewhat difficult, 0.9% found it very difficult, and 0.2% indicated that it was not possible to get a referral.[10] For children and youth with special health care needs (CYSHCN), 62.4% did not need referrals, 26.0% had no difficulty, 8.7% found it somewhat difficult, 2.6% found it very difficult, and 0.3% indicated that it was not possible to get a referral.[11]

Social Determinants of Health (SDOH).

SDOH can impact the ability of children and families to obtain referrals and subsequently access health care services.[12] This is the result of persistent structural and systemic barriers to health equity including racism, classism, ableism, and the like.[13] Efforts to improve socioeconomic conditions, enhance health literacy, expand access to health care resources, and understand cultural diversity can contribute to better access to referrals and receipt of heath care for children who are underserved.[14,15]

While barriers exist in providing effective community-based referrals for social service needs, such as lack of transportation, being unaware of eligibility, having difficulty navigating application and enrollment processes, and the stigma associated with accessing income-based eligibility services, a strong referral network of appropriate and qualified providers and effective coordination are critical to ensure children and their families receive services to address social needs.[16] Communities that offered a large range of public health supports and also had a large number of contributing organizations experienced a nearly 20% reduction in mortality rates across the life span.[16]

Health Equity. Children from families with limited incomes, of Black race/ethnicity, or uninsured use less specialty care, and those from minority backgrounds report more problems accessing specialty care.[9] A reason for low use of specialty care among children who are underserved may be an incomplete referral or not attending an appointment when referred,[9] due to implicit bias in health care and systemic barriers to health equity.[13] Families experiencing barriers to care also tend to report high levels of social risk and unmet needs, such as housing and food insecurity.[17]

Strategies to increase equity in referrals include:

- Patient and family navigation services to assist families in understanding the health care system, schedule appointments, and navigate insurance coverage to support referral completion.[18,19]
- Culturally tailored interventions with culturally competent providers to encourage families to seek needed referrals.[20]
- Telemedicine and technology-based solutions to reach children and families in underserved communities and facilitate consultations and referrals without the need for extensive travel.[21]

CYSHCN. Families of CYSHCN describe a fragmented health care system with significant unmet health and social needs.[22] Medicaid managed care contracting is a common strategy that Medicaid agencies are using to implement or expand systematic SDOH referral networks and ensure that high need populations, including CYSHCN, receive social services (see examples).[16] Medicaid and the Children's Health Insurance Program (CHIP) are well positioned to facilitate referrals to community-based organizations to address SDOH of CYSHCN.[16] Partnerships between Medicaid and Title V are critical for increasing and improving community referrals to support social needs and enhancing cross-agency referrals.[23]

Key Resources. Emerging interventions aimed at improving primary care referral decisions include referral guidelines and electronic consultations.[7] Strategies such as using electronic referrals, building subspecialist capacity, increasing reminders, utilizing telemedicine, and offering transportation assistance aim to bypass barriers and improve visit attendance.[7] Family navigation and peer support programs are promising for referral completion.[18,19]

Search the Established Evidence database for peer-reviewed research articles related to strategies for increasing needed referrals.

Find field-based resources focused on increasing needed referrals relevant to Title V programs in the MCH Digital Library.

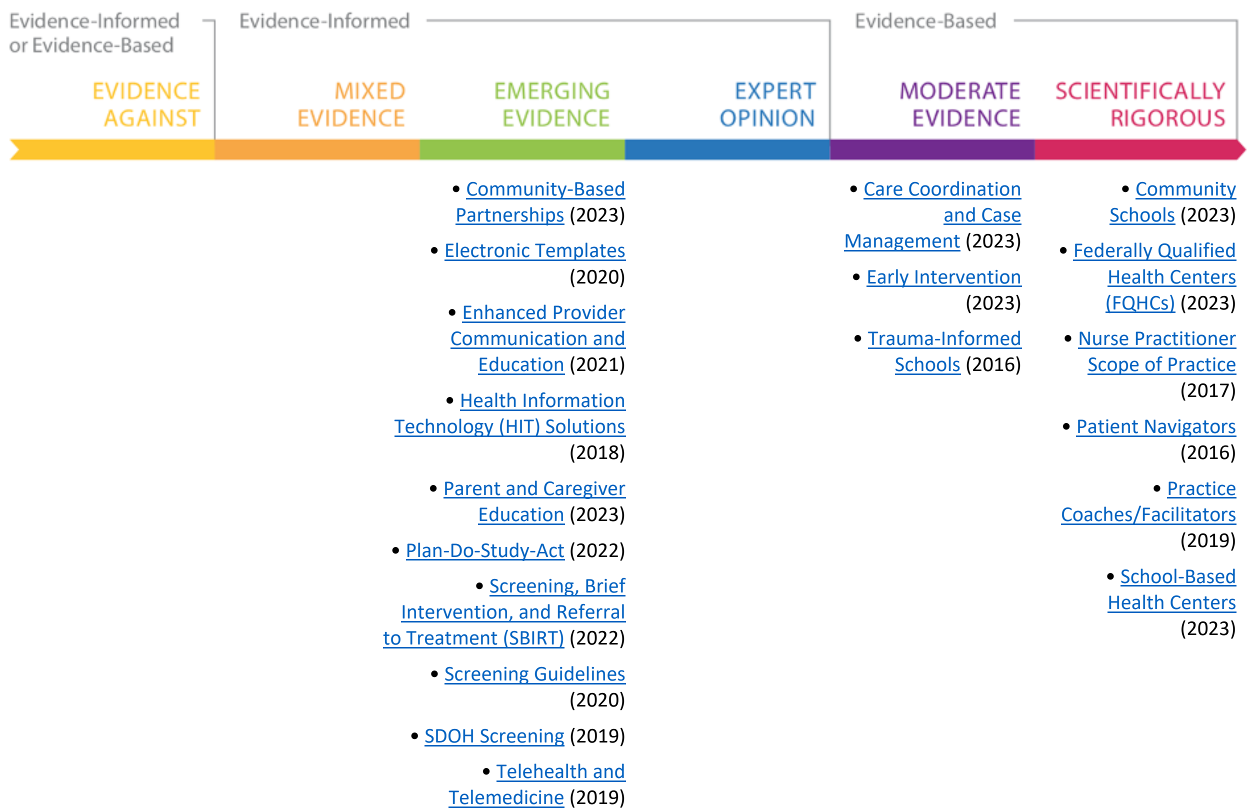
Partnership and the Role of Title V. Title V programs can help support a robust and high-functioning referral network by partnering with Medicaid, providers, health plans, and others to:

- Implement family-centered referral policies.[16]
- Designate dedicated and trained staff to make referrals and follow-ups to ensure completion.[16]
- Establish and promote registries of community-based providers and services.[16]
- Enhance referrals to and integration with other services, such as home visiting, family support, and early intervention, to advance high performing medical homes.[24]

Medical Home: Referrals Strategies.

This page summarizes the latest strategies and practices that have emerged as potential approaches for increasing the percent of children with and without special health care needs, ages 0 through 17, who receive needed referrals. It provides a framework to identify, understand, and implement "what works" in creating new or strengthening current Evidence-based/informed Strategy Measures (ESMs). Use the links below to access strategy and practice details, approaches, supporting evidence, outcomes, and examples of how Title V agencies are either using these strategies directly or adopting components of the intervention that address this NPM.

Evidence-Based/Informed Strategies. 19 strategies have emerged from studies in the scientific literature as being effective in advancing the NPM. They can be adopted or adapted to meet your program needs. More information on these strategies can be found in the MCH Evidence Center's MCHbest database.



Emerging Evidence

- Community-Based Partnerships (2023)
- Electronic Templates (2020)
- Enhanced Provider Communication and Education (2021)
- Health Information Technology (HIT) Solutions (2018)
- Parent and Caregiver Education (2023)
- Plan-Do-Study-Act (2022)
- Screening, Brief Intervention, and Referral to Treatment (SBIRT) (2022)
- Screening Guidelines (2020)
- SDOH Screening (2019)
- Telehealth and Telemedicine (2019)

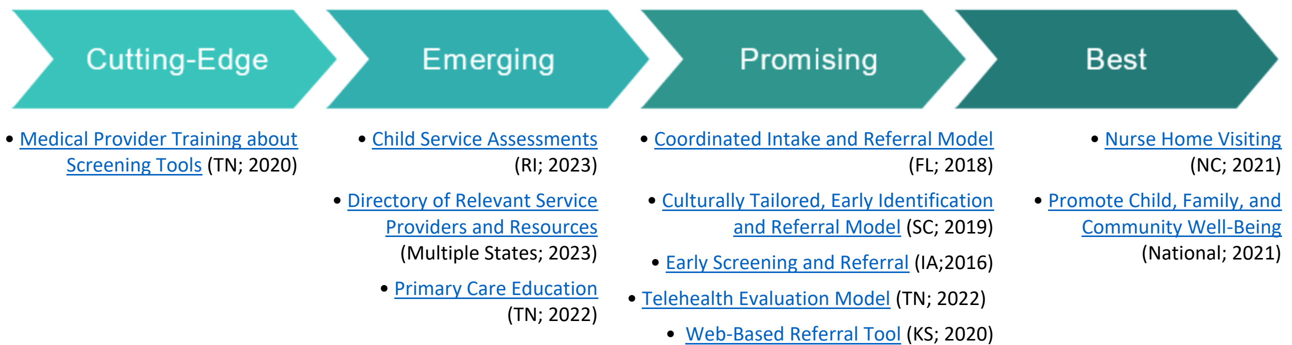
Moderate Evidence

- Care Coordination and Case Management (2023)
- Early Intervention (2023)
- Trauma-Informed Schools (2016)

Scientifically Rigorous

- Community Schools (2023)
- Federally Qualified Health Centers (FQHCs) (2023)
- Nurse Practitioner Scope of Practice (2017)
- Patient Navigators (2016)
- Practice Coaches/Facilitators (2019)
- School-Based Health Centers (2023)

Field-Based Practices. 11 practices from state-/community-based programs have emerged as potential approaches for advancing the NPM for specific communities or populations. They can be used as models to meet your program needs. More information can be found in the Association of Maternal and Child Health Program's (AMCHP's) Innovation Hub.



Cutting-Edge

- Medical Provider Training about Screening Tools (TN; 2020)

Emerging

- Child Service Assessments (RI; 2023)
- Directory of Relevant Service Providers and Resources (Multiple States; 2023)
- Primary Care Education (TN; 2022)

Promising

- Coordinated Intake and Referral Model (FL; 2018)
- Culturally Tailored, Early Identification and Referral Model (SC; 2019)
- Early Screening and Referral (IA;2016)
- Telehealth Evaluation Model (TN; 2022)
- Web-Based Referral Tool (KS; 2020)

Best

- Nurse Home Visiting (NC; 2021)
- Promote Child, Family, and Community Well-Being (National; 2021)

Key Findings.

The following are key findings emerging from the literature:

1. Telehealth can facilitate warm handoffs[25] and access to patient navigators.[26] Children using telehealth referrals are three times more likely to complete screening; parents report higher satisfaction with overall care.[27,28]
2. Electronic referral trackers have proven effective at increasing referrals and ensuring appropriate follow-up care.[29,30,31] Providing automated alerts to physicians increases the likelihood of patients receiving a specialty referral.[32] Studies show promising results for integration of technology (e.g., mobile apps).[33]
3. Combining services to incorporate specialty consultation referrals or care in primary care has proven effective.[34] Nurse practitioner subspeciality programs are efficient and cost effective.[35] On-site community health workers,[36] mental healthcare specialists,[37] and embedded psychiatric consultations[38] all increase successful referrals.
4. Care coordinators are effective in connecting families with needed referrals to community-based health programs,[36] social services,[26] vision care,[39] and transportation services.[40] Other methods that have proven effective include coordinated discharge instructions.[41] Warm handoffs also lead to significant improvement in access to referrals and increase the likelihood that patients will access follow-up care.[1,42,37]
5. A cost-effective method of improving access to needed referrals is to provide enhanced screening practices with direct referral pathways. Many models have shown effectiveness: the roadmap model supporting families awaiting consultation after a referral;[34] Screen-Refer-Treat, Plan-Do-Study-Act, Early Screening for Autism and Communication Disorders, and Get SET (Screening, Evaluation, and Treatment) Early models, which aim to improve early access to autism spectrum disorder screening, treatment, and referral;[29,30,43,44,45] checklists for families receiving the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC);[46] early intervention programs;[36] pain management programs;[47] screening, brief intervention, and referral to treatment;[48] and broader screening during well-child visits.[49]

Discussion: Research, Practice, Partnership.

Research. Multiple strategies are emerging as potential approaches to advance this NPM, but they have not been studied with enough rigor to be included in the evidence-based continuum. Additional research is needed to verify outcomes, but initial studies have shown promise of these strategies in MCH settings:

- Providing training to physicians and caregivers to improve understanding of screening methods and accessing needed referrals.[50,51,52]
- Providing school-based options to facilitate care coordination and referral access to mental health and community services.[53,54]

Practice. The following tools can be used to translate evidence to action to advance this NPM:

- LINK-KID Lifeline for Kids (UMass Chan Medical School). A centralized referral system to streamline access to care.
- Developmental Concern? Next Steps for Families and Caregivers (AAP). A referral resource from Learn the Signs Act Early.

Partnership. The following organizations focus efforts on improving referrals:

- AAP provides an Interventions and Referrals Portal of early childhood programs that enhance referral communication and utilization.
- NICHQ provides The Act of Making a Referral is Not Enough, a checklist for the referral process.

Frameworks and Tools for "What Works."

Use this accelerator to strengthen current or new programs that align with multiple MCH frameworks across domains and settings. Access toolkits related to these frameworks for additional resources:

- MCH Evidence Framework
- Blueprint for Change for CYSHCN
- Maternal Health Toolkit
- Life Course and Social Determinants Brief

Need More Help?

Contact us for training and technical assistance customized to your needs.

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