TIPS FOR SUCCESSFUL REFERRAL CONNECTIONS

A toolkit for Blueprint Recommendation 3

Transfer of care accountability and referral systems

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Tips for successful referral connections

Successful lactation care and referral coordination depend on timely and accurate workflows to inform effective clinical decision-making, but too often patient information remains siloed and fragmented in multiple formats among multiple care providers and organizations. This toolkit will help you think through a referral network flow and provide recommendations on navigating common concerns.

Addressing referral disconnections

Continuity of care with referral workflows already in place facilitate transitions of care that are coordinated and supportive of families. Therefore, it is important to know who to refer to and why.

1. Conduct a needs assessment to identify care continuity gaps, social, and cultural needs of the breastfeeding/chestfeeding families.
2. Identify key players or champions within the community that will be supportive in creating a bi-directional referral system.
3. Establish and create linkages with community organizations and lactation support professionals. See below for tips on how to link with other providers.

You can overcome local healthcare deserts by connecting breast/chest-feeding families to culturally congruent providers virtually in other areas of the country. If there is a lack of resources in your geographical area, consider looking for providers and allied health professionals who perform tele-health outside of your city and state. By expanding your search outside of your local area, you will find a diverse selection of resources to offer to families.

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Thinking through a bi-directional referral system

Bi-directional referral system is a communication loop between members of a patient's health care team and a referred community program or resource during transitions of care. Bi-directional communication improves care coordination by;

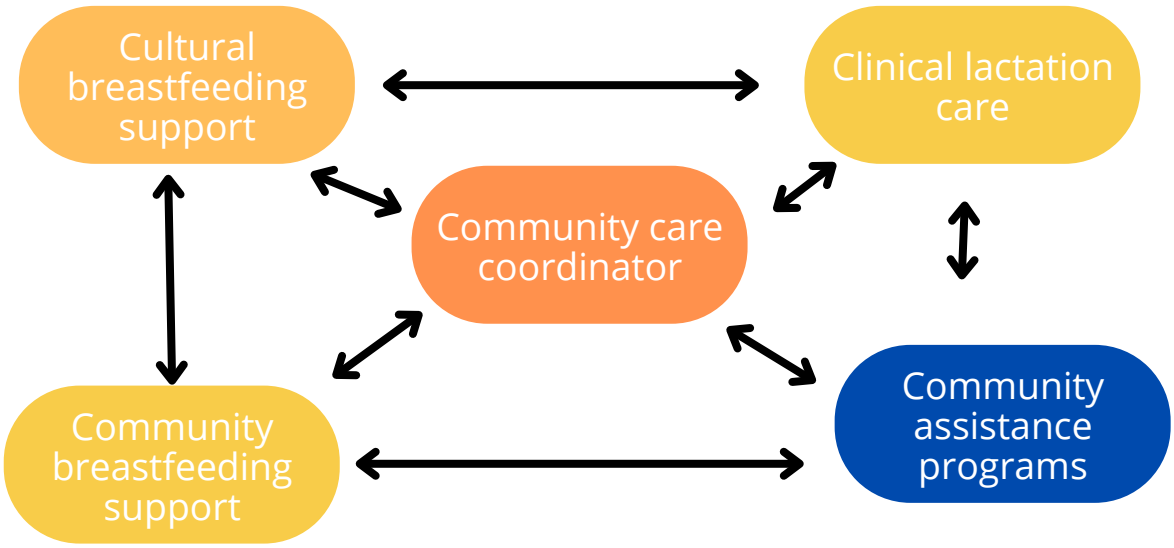
- establishing care accountability
- increasing patient compliance
- creating clinical-community linkages

A referral flowchart is a great tool to visually represent communication and care accountability between clinical settings and community support.

Drafting a bi-directional referral system can be done in collaboration with champions, taking into consideration:

1. Needs of the community and breastfeeding/chestfeeding family
2. Indicators/risk factors for a referral
3. Ideal time of referral and method of communication
4. Identified gaps in coordination of care
5. Types of breastfeeding support and levels of care provided

(Fig. a) Example bi-directional referral flowchart



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Optimizing staff time

Use tele-health tools to provide care coordination. Many providers and organizations have implemented using some type of tele-health tool in response to the COVID-19 pandemic. Using tele-health for support, intakes, referrals, and coordination of services can eliminate the need for in-person appointments. Using a tele-health tool that allows for the sender, receiver, and breastfeeding family to be on video together to promote handoffs/ warm handoffs is optimal for continuity of care and accountability in referral systems.

Automation

Automating workflows with digital tools can shorten the time needed to seamlessly coordinate appropriate levels and types of care for breastfeeding/chestfeeding families. Some examples of automated forms include Typeform, Google Forms, and Jotform. Build pathways in your intake forms, needs assessments, and screening tools to direct the breastfeeding/chestfeeding family to appropriate resources, depending on the answers given.

Digital communication via texts. Download an SMS program from Google play and send automatic text messages to patients/clients for appointment confirmations and referral reminders.

Staff training

Have key documents in place that describe referral workflows and standard operating procedures. Having a 'source of truth' allows staff to self-onboard or get basic knowledge of the workflow. This will reduce the need to repeat training procedures due to staff turnover.

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Engagement

Patient engagement - It's impossible to implement a referral workflow with unengaged families or no families at all. If your organization is struggling with attracting people to services, consider the tips below. Once you've made a strong connection to a new family, it's then possible to facilitate that family's connection to other care.

- Survey patients to assess barriers and needs. This will help you get to the 'why' of patients not engaging with your services. Are they not attending support groups because they don't have child care? Would they be more likely to attend a support group if they received reminder emails or phone calls? Once you know, you can better address barriers to engagement.
- Partner with other organizations to spread the word about your work: local churches, gyms, etc.
- Digital advertising is great but don't forget about old fashioned flyers and print materials. Pass these materials out to local community organization and hang them up on local bulletin boards. Include a QR code so patients can access information online.

Provider engagement - You are only one part of the continuity of care equation! To make a successful referral, others must participate. Connecting with other care providers and aligning on a workflow sets the stage for care coordination.

- Identify pain points from other providers about their referral workflow and identify barriers. Then brainstorm solutions together to overcome the hurdles.
- Before asking them to help you, see how you can help them. You may be surprised to learn that you have something that other providers need! For instance, you may be able to offer them more referrals to their practice or a free offering for their patients.
- If budget allows, bring food to other offices or organizations. It's a good icebreaker! Consider planning a lunch and learn so that other community partners can learn more about your projects
- Attend local conferences, meetups, and continuing education events to get to know other providers
- Know you're not alone! It's difficult to be a change maker and organize your community to better support breastfeeding/chestfeeding families.

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Measure success

Data tells the story of the patient journey and identifies gaps in care continuity. Each organization may have different goals within their referral workflows. As a team, decide which data metrics are important to have, how that data is collected, and what data defines a successful referral workflow. Ensure that data collection includes key data points, like race and ethnicity, geographical location, socioeconomic status, etc. to identify gaps, prioritize, and improve equitable coordination of care.

Website analytics can measure core data such as: what times/days a website gets the most interaction, what pages are most visited, how viewers interact with the page, what links are clicked most, etc. This can become beneficial for organizations who have developed a lactation support resource guide including a compilation of services and LSPs available in a community.

A shared digital referral system can measure referral successes and drop offs by measuring: how many referrals where made, which party received the most referrals and how patients are accessing referrals and care.

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Journey mapping

A patient journey map helps identify and pinpoint all patient touchpoints within the current referral process. It visually represents the patients' experience receiving and accessing breastfeeding/chestfeeding support and reaching a desired outcome. With this visual map of the patient's journey, organizations can discover pain points, successes, barriers, and areas of improvement in the current referral/ hand-off process.

Journey maps help guide discussions with stakeholders, community contacts, and champions to improve existing workflows and hand-off/warm hand-off protocols.

After improvements have been identified in the patient journey map, create a patient service map. Like a journey map, service maps communicate front and back-end players/processes in patient touchpoints within the current referral process. Services maps are more detailed and help to;

- create an ideal step-by-step flowchart for referrals
- promote hand-off/ warm hand-off between resources
- label parties responsible for care accountability.
- identify methods of communication between resources
- close communication loops between community and healthcare organizations.

Step 1: Map the patient's *current* journey

Identify and understand the details of all patient touchpoints within the current referral process. Look for areas of improvement, bottlenecks, and gaps in care.

1. List the first and last touchpoint in a patient's current journey of navigating breastfeeding/chestfeeding referrals. Leave space in between the first and last touchpoint.
2. List each additional touchpoint (or step) between the first and last touchpoint listed from step 1.
3. For each touchpoint listed, include the current workflows for;
   - Risk factors (clinical and social needs) of the patient
   - Referrals or hand-offs/ warm hand-offs,
   - How each touchpoint is communicated with patients (when and by whom).

Review the journey map to visualize existing gaps in care coordination, barriers, and care accountability.

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Step 2: Map an *ideal* patient journey

Now that you have identified areas of improvement with the patient's current experience, brainstorm about the patient's ideal experience. Re-write the patient journey map from above. Deep dive into what should happen at each touchpoint (or step). Each step should be able to answer;

- What happens at this step?
- When does this step occur?
- Where does this step take place (setting)?
- Who is present during this step?
- What needs are being met during this step?
- How are information and support delivered and communicated?
- What barriers exist for this touchpoint, and how do we accommodate?

From here, develop referral pathways to bridge each step together. Ensure that identified risk factors of the lactating parent and infant indicate the need for additional clinical care workflows or social support.

Create a bi-directional communication protocol and accountability for each step to ensure families receive the appropriate referral delivered at the appropriate time.

Sample journey maps *(fig. b and fig.c)* can be used to label patient touchpoints and identify gaps in care continuity. Every organization has its unique needs and barriers. Technical assistant consultants developed these tools for broad use cases to be adaptable to various organizations, focusing on maternal infant health. These tools aim to act as a template to guide lactation support professionals, health systems, and community based organizations in identifying gaps in care coordination and increasing continuity of care between the clinical and community settings.

To implement a referral workflow in a digital format, explore digital solutions that;

- Protect PHI/ HIPAA-compliant
- Allows breast/chestfeeding families to receive referrals via text/email
- Is utilized by both senders and receivers of referrals
- Allows communication between sender, receiver, and the breastfeeding family for bi-directional communication and handoffs/warm handoffs

Digital platforms offering referral management include but are not limited to;

- Iris - a community referral platform.
- Mahmee - An integrated care delivery platform for maternal and infant health. Mahmee provides the software to help care teams work together and offers a nurse-led care coordination team to facilitate continuity of care.
- FindHelp Social Care Technology - Makes it easy for organizations to connect people to social care services and allows them to follow up more quickly.
- UniteUs-Helps organizations connect patients to community resources.
- NowPow - A personalized community referral platform for every need and every person.

Figure a; Sample Patient Journey Map

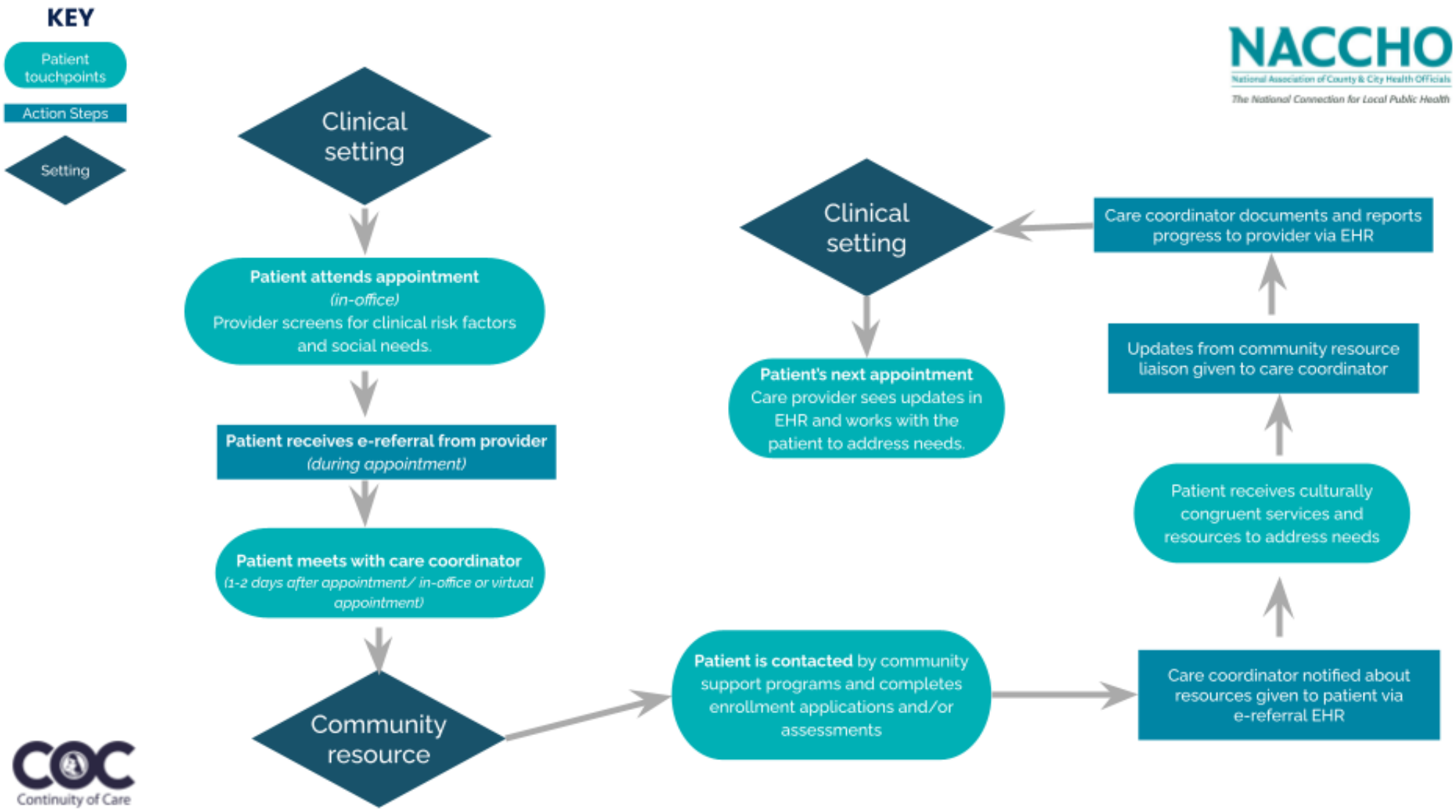

Figure b; Sample Patient Service Map

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Stage	**Prenatal**				**Postpartum**				**Desired outcome**
Journey steps *What steps do patient's take to navigate their care? What is the goal?*	Patient has appointment	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6	Step 7	Step 8
Setting *When and where does this touchpoint take place?*	3rd trimester, in-office								
Touchpoint *What part of your organization does the patient interact with?*	Clinical appointment (questions answered, care plan reviewed)								
Whom *Whow does the patient engage with*	Office staff, Midwife								
Needs identified *What resources, referrals, or support would the patient like to receive? What barriers exist?*	Clinical risk factors and social needs identified								
Patient Communication *How are information and referrals communicated to the patient?*	Paper of local breastfeeding resources, office tells patient about referrals to care coordinator								
Internal Communication *What steps are taken internally? How is the communiation loop closed? ex sending an e-referral to a resource*	A note is lefft on care coordinators desk. *PAINPOINT*								
Process Ownership *Who is responsible fo ensuring this journey step closes the communcation loop?*	N/A *GAP*								

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