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HIV Prevention Referral Guide

HIV/AIDS Prevention Program

Division of Public Health

Nebraska Department of Health and Human Services

Draft

September 2007

Prepared by

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Acknowledgements

NDHHS-supported HIV Prevention Grantees; NDHHS HIV Prevention Program Staff; Nebraska HIV Care and Prevention Consortium (NHCPC) Intervention Committee.

A special note of appreciation to Jane Conklin, Michigan Department of Community Health, for sharing resources with Nebraska. This document is based largely on the Draft April 2007 HIV Prevention Referral Guidelines and Toolbox developed in Michigan.

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HIV Prevention Referral Guide

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Section I: Introduction

Why Refer?

Referral makes a lot of sense in HIV disease prevention. Prevention providers know that the risk of acquiring or transmitting HIV is influenced by both behavioral issues and physical health, and that prevention clients often have multiple, complex needs that fall outside the expertise of a single provider. Access to clean syringes, safe housing, or adequate employment are just a few psychosocial or access needs that can affect a client's risk behaviors. Additionally, addressing physical health issues—such as sexually transmitted infections (STI) screening and treatment for clients at sexual risk and appropriate primary medical care for HIV-positive clients—can have a significant impact on HIV acquisition and transmission. By working with clients and other agency partners, HIV-prevention service providers can support their clients and give them the best chance for maintaining the behaviors and physical health that can reduce the acquisition and spread of HIV.

Why this Guide?

The HIV/AIDS Prevention Program of the Nebraska Department of Health and Human Services (NDHHS) receives numerous requests from HIV-prevention providers for guidance and technical assistance around providing referrals. At the same time, quality assurance activities have revealed that prevention service providers diverge widely in their interpretation and implementation of referral services.

This guide is intended primarily for HIV-prevention providers and NDHHS staff. It was developed in response to requests for support and NDHHS experience with a range of referral practices. This document was created with two key goals:

- clarify the definition of and expectations for HIV-prevention related referrals; and
- provide tools to help agencies provide referrals to clients, expand agency referral networks, and monitor and evaluate referral processes.

What exactly is a Referral?

For such a simple and often used word, there are many opportunities for interpretation. The spectrum of definitions ranges from the relatively simple act of providing information to a more complex process that facilitates and ensures the client's receipt of additional services.

Referral for NDHHS HIV Prevention Providers

The specific definition for referral that will be used throughout this document and in the context of NDHHS HIV-prevention services implies an active role of prevention staff in ensuring clients receive appropriate services:

In the context of HIV prevention and counseling, referral is the process by which a client's immediate needs for care, prevention and supportive services are assessed and prioritized. Clients are provided with assistance (e.g., setting up appointments, providing transportation) in accessing referral services. Referral also includes reasonable follow-up efforts necessary to facilitate initial contact with prevention, care and psychosocial services and to solicit clients' feedback on satisfaction with services.

This definition is consistent with and largely derived from the definition for referral provided in the Centers for Disease Control and Prevention (CDC)'s "Revised Guidelines for HIV Counseling, Testing, and Referral."¹

Referral vs. Information Dissemination

For purposes of this document and as a guide for NDHHS prevention service providers, simply providing information—verbal or written—about where to access additional services does NOT constitute a referral. Referral is distinguished from information dissemination by the level of planning, facilitation, and follow-up. Both activities have important roles in prevention interventions, and providing information is an important part of a referral. However, with a referral, the referring provider takes an active role to ensure that the client will secure the additional services, and has a reasonable expectation that the client will receive the services.

Referral vs. Information Dissemination; an example



At the end of a Comprehensive Risk Counseling Services (CRCS) counseling session, a client asks about the availability of screening for sexually transmitted infections (STI). If the counselor only provides the client with the name and address of the local health department, then the counselor is only providing information dissemination. A referral to STI screening services would also include assistance in accessing the service (e.g., making an appointment and planning with the client on how he or she will get to and from the appointment) and developing a plan to follow up whether the client receives the STI screening services (e.g., asking the client at the post-test counseling session to see if he or she went for services and what his/her experiences were).

¹ "In the context of HIV prevention counseling and testing, referral is the process by which immediate client needs for care and supportive services are assessed and prioritized and clients are provided with assistance (e.g., setting up appointments, providing transportation) in accessing services. Referral should also include follow-up efforts necessary to facilitate initial contact with care and supportive service providers. CDC, *Revised Guidelines for HIV Counseling, Testing and Referral*, 36.

A Note for NDHHS HIV Care Providers

In contrast to the CDC and NDHHS prevention provider definitions, which encourage provider facilitation and support in the referral process, the Health Resources and Services Administration (HRSA), which funds the Ryan White HIV/AIDS Treatment Modernization Act, defines referral as the “act of directing a person to a service.”² While the HRSA definition would allow providers to take an active role and provide additional support for a referral, its primary focus is on the provision of information and therefore aligns more closely with what is defined here as information dissemination. Agencies that provide both care and prevention services need to attend closely to these distinctions.

² HRSA defines referral as “The act of directing a person to a service in-person or through telephone, written or other forms of communication. Referral may be made formally from one clinic provider to another, within a case-management system by professional case managers, informally through support staff or as part of an outreach services program. *Ryan White CARE Act Title II Manual*, Section X, Appendix B: Service Category Definitions, p. 19.

Section II: How to Make Referrals

A. Working with Clients

Referral in an HIV prevention context means working with the client to assess his or her service needs, developing a plan to access services, facilitating access to services and, if feasible, following up to determine whether the client has accessed the service. Each of these steps should be documented in client and/or program files.

Assess Client Referral Needs. Identify the key factors that are likely to influence the client's ability to adopt or sustain behaviors to reduce risk for HIV transmission or acquisition and/or promote health and prevent disease progression. Consider if these key factors might be addressed by other prevention, care and psychosocial service providers.

For HIV-infected clients; Referrals should be provided for appropriate medical care and partner counseling and referral services (PCRS). Client referral needs should also be assessed for prevention and support services aimed at reducing risk for further transmission of HIV. When a provider cannot make appropriate referrals for HIV-infected clients or client needs are complex, clients should be referred to case management.

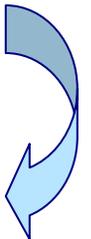


Best Practice: Assessment of referral needs should include an examination of client's willingness and ability to accept and complete a referral. Service referrals that match client's self-identified priority needs are more likely to be completed.

Plan the Referral. Identify strategies to facilitate a successful referral. Assess and address any barriers to completing the referral (e.g., lack of transportation or child care, work schedule, cost). Work with the client to identify strategies to overcome these barriers.

Best Practice: Referrals are more likely to be completed if easily accessible.

Referral services should be appropriate to a client's culture, language, gender, sexual orientation, age, and development levels. Prevention staff should be fully aware of the resources in their communities that would be most appropriate to the population they serve.



Facilitate Access to Services. Provide clients with both complete information and appropriate support to access referral services.

- Complete information will include agency name, address/location, telephone number, staff contact name, types of services, hours, eligibility requirements,

costs, time frame to get a ‘usual’ appointment, and process for making an appointment/securing services.

- Appropriate support can include individualized assistance, like setting an appointment, addressing transportation needs, or even taking the client directly to the appointment.

Referral forms of various types—appointment reminder cards, kick-back cards, or more formal referral forms—may help clients remember appointments and locations. All forms used in the referral process must respect client confidentiality.

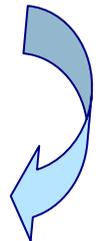
If client-identifying information is to be shared between providers, written consent must be obtained from the client. Any such forms, like all program materials, must be reviewed by the Nebraska HIV Materials Review Committee to assess appropriateness. See attachments for sample referral forms and authorization for release of information. The Material Review Request Form may be accessed at <http://www.dhhs.ne.gov>.

Follow Up. When feasible, assess whether the client receives referral services, if the client has difficulty accessing services, and whether the client was satisfied with the services. If the assessment reveals that the client did not access services, staff should determine why (if possible) and provide additional support (if appropriate). If the client received services, but found the services were unsatisfactory, the client should be provided with additional or different referrals. Additionally, the agency should review future referrals to the agency to determine if clients are consistently dissatisfied and find alternative service providers.

Document, Document, Document...

Proper documentation serves both individual clients and agency-wide needs. Having referral-related information included in the client’s file and in a referral log lets staff follow up with the client about the referral service and provide additional support if necessary. Documentation in client files and referral logs can also provide the foundation for quality assurance, monitoring and evaluation efforts.

See Appendix A, “Sample Referral Tools” for more information about documentation.



B. Working with Agency Partners

In addition to working with clients, HIV prevention providers must work within their own agency and with partners at other agencies to ensure that clients receive the most appropriate services. As with working with individual clients, implementing systems within and across agencies is a multi-part process; it includes assessment, planning, facilitation (implementing procedures and policies) and follow-up (monitoring and quality assurance).

Assess Referral Service Needs (What Services?). When determining which services to develop linkages to, consider client needs, funder requirements and internal service capacities.

Client Needs. Identify the most common key factors that are likely to influence the risk for HIV transmission or acquisition and/or promoting health and preventing disease progression. This process should include assessment of the client's expressed needs, agency perspectives, and guidance from other resources (other stakeholders interested in this population—e.g., Centers for Disease Control and Prevention (CDC), community planning or advocacy groups). Sources of information to consider when identifying services:

- Clients. What kinds of services do clients most frequently request?
- Agency staff. What kinds of services do staff believe clients need?
- Other Stakeholders. What kinds of services are suggested by other stakeholders serving the same client base?

Funder Requirements. Review contracts and program guidance to confirm funder requirements. Some funders may require the programs they support to have specific kinds of referral relationships to serve particular populations. NDHHS requires that grantees have a process in place to monitor and report all referrals made to program clients.

Internal Agency Capacity. Consider if any other services offered internally are appropriate for HIV-prevention clients. The guiding principles of referrals—assessing client need and addressing key factors to reduce risk of acquisition or transmission of HIV—must inform the decision to refer internally to other agency programs. Clients should NOT be referred just for the sake of ease and proximity.

Plan the Referrals (Which Providers?). Once service linkage needs are identified, identify appropriate service providers to address these needs.

Identifying Providers.

Client Acceptability. In addition to the services offered by potential referral partners, consider key factors that make the service appropriate for clients:

- cultural and linguistic competence
- accessibility (location/transportation, costs, availability of appointments/wait time)
- confidentiality/anonymity (perceived and actual)



Depending on the needs of the clients and the capacity of partner providers, more than one partner may need to be identified for some services.

Quality Assurance Tip: Understand the Receiving Agency. *Prevention staff should visit prospective referral receiving agencies to better understand where they are sending clients. Ideally, prevention staff should talk with agency counterparts who will be providing services to referred clients. Prevention staff can also ask their clients who receive services to comment on their experiences with receiving agencies. Client feedback—both good and bad—should be shared among prevention staff.*

Receiving Agency Support. Assess potential referral partners for the availability of services, their ability to facilitate referrals and willingness to support the linkage relationship. Prior to setting up a linkage relationship, agencies should verify that the receiving agency can handle the additional caseload. Referral partners should also be active participants in accepting referrals (e.g., accept appointments or referral forms). Additionally, they should be willing to monitor and maintain the relationship as appropriate (e.g., provide information about the numbers of clients received, discuss how services are provided and how they could be improved).

Developing Linkages & Partnerships.

Communication. Whether a service is to be provided by an internal referral or to an external referral to another agency, it is important to articulate the process and expectations for everyone involved. Clear discussion about the expectations, along with a written referral agreement, such as a Memorandum of Agreement (MOA), can help keep the relationships on track and clients flowing smoothly between service providers. The following topics should be addressed in a referral agreement: what services will be provided by each agency, how these services will be provided, what kind of information sharing is required (i.e., data collection, referral tracking, feedback loop).

Memorandum of Agreement. A Memorandum of Agreement (MOA) is a formal statement of commitment between organizations to collaborate or coordinate on a

program or services. Some funders require relationships be documented with a MOA or other written documentation. Agencies should refer to their contracts or funders for specific guidance. Appendix A provides additional information on MOA, along with a sample MOA.

Facilitate Referrals. Develop and implement mechanisms to assist clients in accessing services. Some of these include specific policies and procedures, tools, and staff training that address and support referrals.

- **Agency Policies and Procedures.** Define the service (What is a referral?), establish standards (What are agency expectations around providing referrals?), and develop policies and procedures on referrals (How to provide referrals to clients). Agency policies and procedures should outline how to work with clients to make referrals, how to document and monitor referrals, and how the agency will assure the quality of referrals.
- **Tools.** Develop tools to support client referrals and internal management of referrals. Potential tools include referral forms, referral logs, and a referral resource guide. Refer to Appendix A for more detailed information and sample referral tools.
- **Prevention Staff Knowledge and Skill.** Train prevention staff on policies and procedures, monitor staff compliance with policies and procedures, and regularly update staff about community referral resources.

Follow Up. At an agency level, following up on referrals includes monitoring agency-wide provision of referrals and clients' receipt of referral services. Additionally at the agency level, quality assurance activities measure adherence to policies, procedures and standards as well as exploration of whether clients are receiving appropriate services. These components are described in more detail in the following sections.

C. Practical Tools & Tips

As indicated in the previous section, providing referrals requires procedures and tools to record information. More information about three key areas—referral documentation, referral resource guides, and referral forms—is provided below.

Documentation of Referrals

Individual referrals should be documented, at minimum, in client and/or program files. Complimenting client files with a referral log can prompt staff to follow up with individual referrals and to understand the number and types of referrals generated.

Client files. Individual client files may be maintained for interventions where counselors have extended or multiple contacts with clients (e.g., multi-session CRCS or skills building workshops). All referral components—specific service referrals, facilitation efforts, whether services were accessed, and client feedback—should be documented in client files. Specific components include:

- Date referral made
- Counselor making the referral
- Type of service
- Agency/program referred to and specific contact name, if provided
- Assistance provided to the client to help access the referral, if applicable (e.g., provision of transportation, scheduling of appointment).
- Copy of release of information for each specific referral issued, if client identifying information is to be shared across providers.
- If available:
 - Whether referral was completed and date completed.
 - Client feedback about barriers to accessing service and perceived quality of services.

Referral Logs. Many agencies also use a referral log or another centralized system that lists dates and types of referrals provided by staff. Logs can be in paper or electronic forms (e.g., internal database or shared network). They should contain the following information:

- Client Identification Number/Unique Identification Number (UIN) – (to ensure confidentiality client names or identifying information should not be recorded in the log)
- Date referral initiated
- Counselor making the referral
- Type of service
- Agency/program referred to
- Date referral service provided, if available

- If the referral service was not provided, if known (e.g., client did not get service).
- Client feedback on quality—brief description—if available.

Samples of referral logs and client file tools can be found in Appendix A.

Referral Resource Guide

A referral resource guide is one tool to capture and maintain the essential information about referral partner agencies. The information contained in the referral resource guide should be relevant to the needs of the agency's clients and to interagency agreements. The guide can be in paper or electronic form. The listings should be dated, with an annual review, verification and update of listed referral resources.

For each agency included, the guide should indicate:

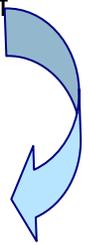
- Name of provider or agency.
- Types of services provided.
- Populations served by the provider/agency.
- Service area.
- Name of primary contact person, with telephone, fax and email address.
- Hours of operation.
- Location.
- Cultural, linguistic and developmental competence.
- Costs of services.
- Eligibility Requirements.
- Appointment policies and procedures.
- Directions, transportation information and accessibility to public transportation.

A good referral guide is centralized to the organization and not to individual staff. Accurate, updated information on referrals is shared and accessible to all staff who make referrals, regardless of where the agency program or physical site staff is located. Case conferences and regular meetings are useful tools to share information about referrals and partner agencies; however, agencies need to ensure that information shared in these settings is recorded and available to all staff for future reference.

Referral Forms

Forms of various kinds can support referral efforts. Examples include reminder cards for clients, forms to share information between agencies and/or track referrals, and release of information forms for when client-specific information is shared across agencies. See Appendix A for sample forms and Section III “Tracking Referrals” for more information.

Best Practice: Any materials used to support referral services should be piloted and tested with clients for acceptability and preference. For example, do clients prefer wallet-sized reminder cards or does a larger, more formal-appearing form lend more value to the referral service? Is the language in the release of information form clear and understandable to clients?



Section III: Tracking Referrals

Always follow-up on a referral you've made for a client. If the referral is unsuccessful in some way, find out why. For example, in some cases, clients need help obtaining childcare, translation services, transportation to the service provider, or someone to accompany them to the referral. When evaluating referral needs for a client, consider the following;

- You and your client should prioritize referrals together
- Make sure referrals are made when your client's' needs are identified
- However, it may be helpful to space out referrals over time to keep clients from feeling overwhelmed
- Remember that making referrals is a partnership between you and your client

You may need to balance these two competing needs.



Referral tracking focuses on determining whether the client has completed the referral and received the intended services. In some cases, referral tracking may also include an opportunity for client feedback on the accessibility and quality of services accessed. Referral tracking can allow agencies to follow up to ensure clients receive services and to understand more fully the types and quality of referral services received by clients.

When to Track Referrals

In HIV-prevention settings, tracking whether the client completes a referral is not always feasible. Prevention staff often have single or relatively short interactions with clients. Lack of systems within or between agencies to share and track information as well as confidentiality concerns also make referral tracking challenging.

However, in some cases, referral tracking *is* possible. It usually occurs in the following circumstances:

- when an agency provides an *internal referral* (where a client receives multiple services within the same agency).
- when an agency provides an *active referral* (where the counselor escorts a client to another service). This can be either internal (escorting to another service within the agency) or external (escorting to another service at a different agency).
- when an agency has ongoing contact with a client (such as a comprehensive risk counseling services (CRCS) intervention).
- when an agency sets up a separate tracking system with other service providers to confirm that a client has received a service.

In some specific situations, receipt of the referral service may be required by agency or funder policy.

How to Track Referrals

Multiple methods are available to track referrals. They include directly observing whether a client goes to an appointment with a referral service provider, asking the client whether or not they received a service, or confirming with a partner agency whether clients received referral services. All information should be documented in client files and/or referral logs as appropriate. Information about barriers and perceived quality of referral services should also be documented in client files and shared via case conferencing or with other staff as appropriate.

Direct Observation

In some cases—either internal referrals or those active referrals where staff escorts the client to another agency—it is fairly straightforward for staff to document that the client received the referral service. In these situations, the counselor may also be able to assess to some degree any barriers or the quality of the services received.

Client Self-Report

For interventions with on-going contacts with clients such as CRCS, clients can be asked at the next contact whether they received the referral services, if they had any barriers accessing services, and their perception of the quality of the services received.

Paper Forms

Paper forms can be used so partner providers can confirm that clients received services. In this situation, the prevention staff initiating the process documents the referral in the client file and completes the appropriate paper form. If any client-identifying information is to be shared between agencies, confidentiality must be observed and a written release of information obtained from the client. A copy of this release should also be included in the client file (see Appendix A, page 25).

The paper form itself can be relatively detailed or as simple as a kickback card or self-mailing form (see Appendix A, 23).

Partner agencies can confirm if the service has been provided by returning the forms or notifying the agency initiating the referral (either electronically or via phone). Upon confirmation of the service, the client file and any logs or databases are updated as appropriate.

Advantages to paper forms. Paper forms provide a physical reminder that can include easily accessible information of the time and location of appointments. Paper forms—particularly with postage provided—may make it easier for the referral partner to verify that services were provided to the client.

Drawbacks to paper forms. Forms or cards can get misplaced by clients prior to the appointment. Some agencies encourage client use of the referral forms by working with the provider of the referral service to provide an incentive for submission of the form.

Referral Network System

Some agencies have developed formal referral networks that rely on client identification cards or identification numbers to track referrals across agencies and services. These systems have specific policies and procedures for making and tracking referrals. As with paper forms, client-identifying information must be protected and managed with appropriate signed releases.

Section IV: Process Monitoring and Evaluation

Both process monitoring—understanding what services were provided to whom—and process evaluation—understanding how the services provided conformed to standards—can be helpful to understanding the kinds of referrals provided and the success of those referrals.

Process Monitoring. Process monitoring related to referrals can explore the following factors:

- Number of total referrals made
- Number of referrals made to different services or different service providers
- Number/percent of referrals completed
- Number/percent of clients satisfied with referral services received, if available

Process monitoring can be refined to focus on different subsets of the data. For example, the agency may look at referrals provided for particular populations, in conjunction with particular interventions, to specific agencies, or by individual staff.

Process evaluation. Process evaluation allows the agency to determine if referrals are meeting expectations and whether program refinements need to be made. For example, the agency may have a standard that all newly-diagnosed HIV-positive clients will be referred into care. Process evaluation would assess how many of the newly diagnosed clients were successfully referred into care. If the number did not meet standards, the agency may need to identify new care providers, refine policies and procedures, or (re)train staff on policies and procedures.

Process monitoring and evaluation should be built into the referral process and occur on a regular basis.

See Appendix B, page 29 for a sample process monitoring tool.

Section V: Quality Assurance

“Quality Assurance (QA) is a planned and systematic set of activities designed to ensure that requirements are clearly established, standards and procedures are adhered to, and the work products fulfill requirements or expectations.”³ Quality assurance of referrals may be incorporated into routine agency quality assurance as appropriate. The following are examples of quality assurance activities:

- ◆ chart reviews
- ◆ client interviews
- ◆ team meetings
- ◆ Referral resource guide review
- ◆ case conferencing
- ◆ role-played counseling sessions
- ◆ case debriefing
- ◆ directly-observed counseling sessions
- ◆ client surveys

Several of these activities—client interview, chart review and case conferencing—are explored in more detail below.

Chart reviews. Chart reviews are a relatively unobtrusive way to get a sense that referrals have been provided according to standards. In the technical review component of chart review, charts are checked to ensure that documentation is complete and appropriate. For referrals, this would include verification that referrals have been provided and documented according to standards, and that any required forms are completed, including written release of information forms if required. Additionally, the technical review would confirm that procedures for particular populations have been adhered to and documented. An example of a population-specific referral requirement would be whether an HIV-positive client received referral to PCRS services.

Chart reviews can also explore qualitative issues, asking not just if referrals were provided, but also how well they were provided. For referrals, this means looking for clues about the quality of the staff-client interaction, particularly if the referral appears client-centered and also adheres to agency and program funders requirements. Qualitative reviews can also assess the quality of the documentation itself. Questions might include whether documentation is legible or if the information is complete enough so that another counselor can follow up with a client at subsequent interactions.

See Appendix B, page 30 for sample chart review tools that address referrals.

Client Interviews. As indicated previously, the referral process should include routine follow up with clients (where feasible) to assess the client’s perspective on the quality of the referral made and services received. Clients should be asked about the ease of completing the referral and any barriers to completing the referral. Clients should also be asked about the quality of the services received. For individual clients, if problems are identified, then alternative referrals or additional support should be provided. If repeated problems are identified with particular service providers, then an alternative partner agency may need to be identified to provide the service(s).

Client responses should be noted in client files. Additionally, mechanisms for reviewing client feedback—chart review, client surveys, case conferencing— should be in place and used to refine service network and procedures as appropriate.

Case Conferences. Case Conferences are an important method to ensure that information about referrals is shared between staff. Regular case conferencing and routine updates to the agency Referral Resource Guide can be ways to make sure staff maintain full and current knowledge of local services.

³ Michigan Department of Community Health. HIV/AIDS Prevention and Intervention Section. *Quality Assurance of HIV Prevention Counseling: A Toolbox for Supervisors and Monitors.* Draft: June 2006. Section 1,1.

Appendix A: Sample Referral Tools

Sample Client Referral Form

Agency Address
Agency Phone Number

Date: _____

Client Name * (or ID #) _____

Birth Date: _____ Gender: _____

Release of Information: Attached: _____ In Client File: _____

Referred to:

Agency Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____

Contact Name: _____

Services Requested/Reason for Referral: _____

Referred by staff : _____

Services Received:

Services Provided: _____

Staff Providing Services: _____ Date Provided: _____

Comments: _____

Our client has requested services provided by your agency. In order to provide the best possible services to our client, please verify the service has been provided and return this card. Thank you!

* If client identifying information is to be shared with another agency, a signed consent must be obtained.

Kick Back Cards

Kick Back cards are simple mailers that can be folded in half and mailed back (postage prepaid) to the referring agency. The client takes the kick back card with him/her when seeking services, and receiving agency staff initials the card, seals it and mails it back to the referring agency. The outside of the card can be addressed via program initials (or some other non-HIV-identifying name) and a PO Box (to preserve confidentiality). The inside of the card can contain the receiving agency name, address and telephone and appropriate notes. Some sort of client identification code or unique identifier should be included on the card, so client files and referral logs can be updated once the receipt of the service is confirmed. Some agencies find providing a small incentive for when the client provides the card to the receiving agency may increase the likelihood the client will take the card to the receiving agency.

Side A

Referral to Requested Services
Client ID _____ Date _____
Your Agency Referring Staff: _____
Referral
Agency Name: _____
Contact Person: _____
Address: _____
Telephone: _____
-----f-o-l-d-----
Service Desired: _____
Notes: _____
Date Given: _____
Staff Initials: _____
<p>Our client has requested services provided by your agency. In order to provide the best possible services to our client, please verify that the service has been provided and return this card. Thank you!</p>

Side B

Referral Coordinator PO Box 222 Your Town, NE 68502	Prepaid Postage
Referral Coordinator PO Box 222 Your Town, NE 68112	
-----f-o-l-d-----	

Sample Referral Log

Date of Referral	Client ID / UIN	Staff making referral	Service Type	Location/Agency	Outcome	Close Date
09/29/06	Lm9zwD4	Davis	CM	APM	Lost to F U	11/30/06
10/05/06	7y+lfu*9z	Smith	HIV Care	WSU	Confirmed--accessed	10/05/06
12/26/06	Cd45ft8Y	Davis	STD	DHD		

Service Type Abbreviations:

CM:	HIV Case Management	Prenatal:	Prenatal Care
PCM:	HIV Prevention Case Management	Repro:	Reproductive Health Services
CTR:	HIV Counseling, Testing and Referral	STD:	STD screening and treatment
HIV Prev:	HIV Prevention Services (other)	Sub/Ab:	Substance Abuse Prevention and Treatment
Housing:	Housing Assistance	SEP:	Syringe Exchange Program
Med:	Medical Care (general)	TB:	Tuberculosis Testing and Treatment
HIV Med:	Medical Care (HIV)	Hep:	Viral Hepatitis screening and treatment
Mental:	Mental Health Services		
PCRS:	Partner Counseling and Referral Services	Other:	Other support services

Outcomes:

- **Confirmed – Accessed:** Agency providing referral service confirmed that the client received the service, or the client confirmed that she/he has received the service.
- **Confirmed – Did not access services:** Agency providing referral service has confirmed that the client did not receive the service, or the client confirmed that she/he did not received the service.
- **Lost to follow-up:** Client receipt of the service cannot be confirmed or denied. Outcome automatically becomes “Lost to follow-up” if a receipt of services cannot be verified within 60 days of the date of the referral.

Close Date:

- **Confirmed – Accessed:** Date the client received the service.
- **Confirmed – Did not access services:** Date the client or agency provided confirmation that the client did not receive the service.
- **Lost to follow-up:** Date 60 days after the referral was initiated and the receipt of services cannot be verified.

Key Elements of Memoranda of Agreement

Memoranda of Agreement are formal statements of commitment between organizations to collaborate or coordinate on a program. This agreement delineates specific roles and responsibilities of all organizations involved in the proposed project. When writing a Memorandum of Agreement, including the following:

- ❑ **A clear goal stating what will be achieved through the collaborative effort.**

Example: To strengthen and improve the quality of prevention services provided to MSM.

- ❑ **An objective(s) that states how the collaborating agencies will achieve the stated goal.**

Example: Agency A and Agency B will provide integrated HIV and substance abuse prevention risk assessment/reduction and education activities.

- ❑ **A statement concerning the extent to which the collaborating agencies will collaborate.**

Example: Under the terms of this affiliation, the agencies agree to provide cross training in HIV prevention and substance abuse risk assessment/reduction and education to agency staff. Further, the agencies will conduct bi-monthly joint staff meetings to ensure linkage of programming appropriate referrals and to address skills/training needs of staff.

- ❑ **A statement designating responsibility for coordination of the agreement.**

Example: Responsibility for coordination of this affiliation rests with the respective Executive Directors of the collaborating agencies.

- ❑ **A specific period of time during which the collaboration is in place, or a set period of time after which the collaborative relationship will be reviewed.**

Example: This agreement will remain in place throughout the contract period.

Memorandum of Agreement

**Between
ACME AIDS Services
And
STOP AIDS Clinic**

Effective October 1, 2006 through September 30, 2007, ACME AIDS Services (ACME) agrees to collaborate and coordinate with the STOP AIDS Clinics to ensure provision of medical services for eligible clients in Anytown, Nebraska.

Under terms of this agreement, STOP AIDS Clinic agrees to:

1. Accept ACME referral forms to set appointments for eligible ACME clients.
2. Return ACME referral cards on a monthly basis to the ACME Referral Coordinator.
3. Meet with ACME on a quarterly basis to review the collaboration and coordination of services.

Under terms of this agreement, ACME agrees to:

1. Refer clients who test positive for HIV to STOP AIDS Clinic for HIV medical services.
2. Contact STOP AIDS Clinic staff to coordinate appointments for newly diagnosed clients.
3. Provide referred clients with referral forms and copies of their confidential lab results.
4. Meet with STOP AIDS Clinic on a quarterly basis to review the collaboration and coordination of services.

Both agencies agree to secure appropriate authorization for Release of Information from clients prior to sharing client-identifying information.

This agreement does not require financial obligations from either party at this time. Responsibility for coordination of this agreement shall be the parties signed below or her/his designee. This agreement will terminate September 30, 2007 and may be renewed for an additional 12 months upon mutual agreement. Either party may make earlier termination of this agreement with a thirty day written notice.

Mr. Byron Wigg
Chief Executive Officer
ACME Services

Ms. Delores Honchette
Executive Director
STOP AIDS Clinic

Date

Date

November, 2007

Appendix B: Quality Assurance Tools

Sample Process Monitoring Worksheet

Date of Review: Feb 07, 2007 Reviewer Name/Initial: KSM

Period of Review: Oct 1 – Dec 31, 2006 Client Subpopulation (if applicable): All and HIV+

Other criteria: (staff reviewed, site reviewed, etc): none – all staff, all sites included in review

Data Source(s): HIV Event System CTR module: testing summary & client characteristics reports

Total Clients Served	Referral Services Provided/ completed	Comments	Follow Up
79 Clients	STD = 22/unknown Hep = 15/15 HIV Med = 1/1 Med = 1/0 Mental = 2/unknown HIV Prev = 15/10	HES data show 74 clients indicated sexual risk; only 22 STD referrals provided	Follow up w/staff regarding STD referral policies and procedures, and client receptiveness. Any feedback on STD providers?
2 HIV+ clients (both confidential)	1 client = HIV Med, STD, Hep 1 client = 0 referrals	No PCRS referrals documented in referral log or client files	Verify PCRS not completed, follow up w/staff re PCRS policies. Consider staff meeting or re-training?

Service Type Abbreviations:

- | | |
|--|--|
| CM: HIV Case Management | Prenatal: Prenatal Care |
| PCM: HIV Prevention Case Management | Repro: Reproductive Health Services |
| CTR: HIV Counseling, Testing and Referral | STD: STD screening and treatment |
| HIV Prev: HIV Prevention Services (other) | Sub/Ab: Substance Abuse Prevention and Treatment |
| Housing: Housing Assistance | SEP: Syringe Exchange Program |
| Med: Medical Care (general) | TB: Tuberculosis Testing and Treatment |
| HIV Med: Medical Care (HIV) | Hep: Viral Hepatitis screening and treatment |
| Mental: Mental Health Services | |
| PCRS: Partner Counseling and Referral Services | Other: Other support services |

Sample Chart Review Components for Counseling, Testing and Referral (CTR):

Individual Chart Review Criteria for Referrals:

REQUIRED CONTENTS	Yes	No	N/A	Comments
Referrals documented, including signed releases and disposition, as appropriate				

INITIAL SESSION: Referrals and Support	Rating 0 -3, N/A	Comments
Provide and document referrals to support action plan		
Referral needs assessment and plan documented		
STD referral made, if applicable		
Sub/ab referral made, if applicable		
Referral is client-specific		

RESULTS SESSION: General	Rating 0 -3, N/A	Comments
Documentation of status of referrals, if applicable/available		
RESULTS SESSION: HIV +		
PCRS elicitation/referral documented (DCH 1221)		
Referral to case management documented, CARF used if organization policy.		
Additional referrals assessed, given, facilitated, documented		
If confidential test and client no-shows, referral made to LHD (DCH 1221)		

Rating: 0 = missing

1 = does not meet expectations (incomplete, another counselor would not be able provide client-specific follow up)

2 = meets expectations

3 = exceed expectations

N/A = not applicable

Summary of Chart Reviews (referral components only):

Required Contents	Total number charts with element
Referrals documented, including signed releases and disposition, as appropriate	

Initial Session: Prevention Counseling: # of charts receiving scores:

Referrals and Support Score: 0 ___ 1 ___ 2 ___ 3 ___ N/A ___

Results Session Score: 0 ___ 1 ___ 2 ___ 3 ___ N/A ___

Overall Comments:

Strengths of documentation:

Items consistently missing or incompletely documented:

Areas requiring development or improvement:

Follow Up Plans:

List of Acronyms

CDC = Centers for Disease Control and Prevention

CTR = Counseling, Testing and Referral Services

CRCS = Comprehensive Risk Counseling Services

HRSA = Health Resources and Services Administration

MOA = Memorandum of Agreement (singular) or Memoranda of Agreement (plural)

NDHHS = Nebraska Department of Health and Human Services

PCRS = Partner Counseling and Referral Services

QA = Quality Assurance

STD/STI = Sexually Transmitted Disease/Sexually Transmitted Infection

UIN = Unique Identification Number

Glossary

Evaluation “The process of determining whether programs—or certain aspects of programs—are appropriate, adequate, effective, and efficient.”⁴

Process Evaluation “A descriptive assessment of the implementation of intervention activities; what was done, to whom, and how, when and where (e.g., assessing such things as an intervention’s conformity to program design, how it was implemented, and the extent to which it reaches the intended audience.)”⁵

Information Dissemination Provision of information, written or verbal, about where and how to access additional services. In contrast to referral, information dissemination does NOT include assistance/support in accessing services or developing a plan to follow up with whether or not a client accessed a particular service.

Kick Back Card Simple mailers that can be folded in half and mailed back (postage prepaid) to the originating agency to confirm that the client has received services.

Linkage “Can indicate either 1) the process of successfully connecting an individual to needed services or 2) the relationships and systems connecting service providers with each other.”⁶

Monitoring “Routine documentation of characteristics of the people served, the services that were provided, and the resources used to provide those services.”⁷

Process Monitoring “The collection of data to describe and assess intervention implementation; for example routine documentation of characteristics describing the target population served, the services that were provided, and the resources used to deliver those services.”⁸

Quality Assurance “a planned and systematic set of activities designed to ensure that requirements are clearly established, standards and procedures are adhered to, and the work products fulfill requirements or expectations”⁹

Receiving Agency The agency/service provider where the client is referred for additional needed services.

Referral “In the context of HIV prevention and counseling, referral is the process by which a client’s immediate needs for care, prevention and supportive services are assessed and prioritized. Clients are provided with assistance (e.g., setting up appointments, providing transportation) in accessing referral services. Referral also includes reasonable follow-up efforts necessary to facilitate initial contact with prevention, care and psychosocial services and to solicit clients’ feedback on satisfaction with services.”¹⁰

Active Referral Escorting the client directly to the additional needed referral service, either within the initiating agency or at another service provider.

External Referral Client receives additional needed services at another agency.

Internal Referral Client receives another service within the initiating agency (i.e., the client receives multiple services within a single agency. For example, a client who tests positive for HIV at Agency A is referred for case management services at Agency A).

Referral Log A centralized tool—either in paper or electronic form—that lists the dates and types of referrals provided by the agency.

Referral Network Different organizations that participate in making and receiving referrals with one another. Networks can be loosely or informally structured or can be formally established groups of providers.

Referral Tracking Determining whether or not a client has completed the referral and received the intended services.

Referring Agency The agency/service provider which initiates the referral process with the client.

Release of Information A document that secures the client's written consent that identifying information may be shared.

⁴CDC/ASPH, *Steps to Success in Community-Based HIV/AIDS Prevention: Module 3*, 109.

⁵Ibid. 112.

⁶Program Expert Panel Meeting April 2001, cover letter definition.

⁷CDC//ASPH, *Steps to Success in Community-Based HIV/AIDS Prevention: Module 2*, 111.

⁸Ibid. 111.

⁹MDCH/HAPIS. *Quality Assurance of HIV Prevention Counseling: A Toolbox*, section 1.1.

¹⁰Adapted from CDC, *Revised Guidelines for HIV Counseling, Testing and Referral*, 36; HAPIS, *Quality Assurance Standards*, 18; and FHI, *Establishing Referral Networks*, 4.