PATH COLLABORATIVE PLANNING AND IMPLEMENTATION (CPI) REFERRAL BEST PRACTICES TOOLKIT

Toolkit Overview

This toolkit is designed to support Enhanced Care Management (ECM) and Community Supports providers in strengthening their referral systems. It includes practical tools, templates, and guidance to assess referral capacity, streamline referral workflows, and build effective partnerships. Each section offers actionable insights, real-world examples, and tips to avoid common pitfalls.

Components

This toolkit is organized into four key sections, each offering practical tools and guidance to support effective referral practices across Enhanced Care Management (ECM) and Community Supports. The table below provides an overview of each section and its purpose.

1. CalAIM Referral Self-Assessment	A structured tool to evaluate current referral sources, identify gaps, and plan for strategic growth.
2. Referral Cheat Sheets & 101 Guides	One-page reference tools that simplify the referral process with eligibility criteria, contact info, and step-by-step instructions.
3. Standardized Referral Forms	Templates that ensure consistent and complete referral information to improve processing and reduce delays.
4. Referral Process Maps	Visual flowcharts that clarify referral workflows, roles, and decision points to support training and process improvement.

Developed by PATH Collaborative Planning and Implementation (CPI) Facilitators

1. CalAIM Referral Self-Assessment

The CalAIM Referral Self-Assessment is a structured questionnaire that helps Enhanced Care Management (ECM) and Community Supports providers evaluate their current referral sources, capacity, processes, and strategic opportunities for expanding their referral network and improving referral workflows.

Purpose of this Tool

Enables providers to systematically analyze their referral ecosystems, identify gaps between current and desired referral sources, assess capacity for growth, and develop targeted strategies for strengthening community partnerships and referral pathways.

Primary Users

- ECM and Community Supports Providers
- Organizational Leadership
- Referral Coordinators
- Business development staff who want to strategically expand their referral network and improve referral processes

How to Use—Steps for Getting Started and Implementation

1. Gather referral data from the past 6-12 months (sources, volumes, conversion rates).
2. Complete the self-assessment questions about current state and desired future state.
3. Analyze gaps between current referral sources and desired referral sources.
4. Identify capacity constraints and process improvement opportunities.
5. Use results to develop targeted outreach and partnership strategies.

Template

The CalAIM Referral Self-Assessment is located in Appendix A and questions cover:

- Current Referral Sources
- Desired Referral Sources
- Referral Capacity Evaluation
- Referral Receipt Methods
- Organizational Readiness Assessment for Expanding Community Partnerships

Tips and Traps—Tips for Developing and Using this Tool and What to Avoid

Tips	Traps
» Use a data-driven approach when possible » Include both quantitative data and qualitative insights » Involve multiple staff perspectives » Re-visit assessment annually	» Don't rely solely on anecdotal information; gather actual referral data » Avoid making assessments overly lengthy or complex » Ensure assessment leads to actionable next steps

Related Resources

- Partner Identification Tools and Directories
  - Mendocino County CalAIM Collaborative Organizational Asset Map from Population Health Innovation Lab
- Capacity Planning Worksheets
  - Contracted Provider Lists by Service Type and County from Population Health Innovation Lab
- Utilization Data
  - PATH CPI County-Level Dashboard for Enhanced Care Management and Community Supports from Population Health Innovation Lab
- Referral Process Maps
  - Example Referral Process Journey Maps from HealthBegins

Where to Go for More Help

- Existing Referral Partners: Partnership HealthPlan Searchable Provider Directory
- PATH CPI Facilitators: Find Your Collaborative

2. Referral Cheat Sheets and 101 Guides

Referral Cheat Sheets are one-page reference guides that provide essential information for making CalAIM Enhanced Care Management (ECM) and Community Supports referrals, including eligibility criteria, contact information, and step-by-step referral processes.

Purpose

Streamlines the referral process by providing community partners and providers with at-a-glance information needed to connect eligible Medi-Cal members to appropriate ECM and Community Supports services. Reduces barriers and confusion in the referral pathway.

Primary Users

- Community-Based Organizations
- Healthcare Providers
- Social Service Agencies
- Referral Partners
- Community Members Who Need to Refer Individuals to CalAIM Services.

How to Use—Steps for Getting Started and Implementation

1. Identify potential eligible member using criteria checklist.
2. Reference contact information and preferred referral method.
3. Follow outlined steps for submission.
4. Use provided templates or forms as specified.

Templates and Examples

Templates

- CalAIM Overview- Editable Flyer for Providers from HC2 Strategies
- Bilingual ECM and Community Supports Guides from HIP of Santa Cruz

Examples

- Imperial County Referral Cheat Sheet from HC2 Strategies
- Kings & Tulare Counties Referral Cheat Sheets from HC2 Strategies
- King & Tulare Counties Community Knowledge Management Site from HC2 Strategies

Tips and Traps—Tips for Developing and Using this Tool and What to Avoid

Tips	Traps
» Include key service features that help match client needs (e.g., language, eligibility) » Clearly indicate date last updated » Use searchable format	» Avoid including contact information without permission » Do not make overly complex - keep practical and user-friendly

Related Resources—Essential Complementary Materials

- Provider Directories
  - San Francisco Provider Roster from Chapman Consulting
- Referral Forms and Templates
- Referral 101 Guide
  - San Francisco ECM/CS Referral Flyer from Chapman Consulting

Where to Go for More Help

- Contact Information for Managed Care Plan Referral Departments
- PATH CPI Facilitators: Find Your Collaborative

3. Standardized Referral Forms

Standardized Referral Forms capture essential member information, eligibility details, and referral context needed for Enhanced Care Management (ECM) and Community Supports enrollment and authorization processes.

Purpose

Ensures consistent information collection across referral sources, reduces back-and-forth communication, speeds up authorization processes, and improves referral completion rates by providing all necessary details upfront.

Primary Users

- ECM and Community Supports Providers
- Healthcare Providers Making Referrals
- Community-Based Organizations
- Managed Care Plan Staff Processing Referrals

How to Use—Steps for Getting Started and Implementation

1. Download appropriate form for ECM or Community Supports referral.
2. Complete all required sections with member information and eligibility details.
3. Submit via specified method (fax, email, portal) to designated recipient.
4. Follow up according to established timelines.

Examples

ECM Referral Forms Examples

- Sacramento County Universal, Adult ECM Referral Forms from Transform Health
- Health Plan of San Joaquin, Adult ECM Referral Forms
- Health Plan of San Joaquin, Child ECM Referral Forms
- CenCal Health, San Luis Obispo and Santa Barbara Counties ECM Referral Forms

Tips and Traps—Tips for Developing and Using this Tool and What to Avoid

Tips	Traps
» Standardize formatting across collaborative » Include screening checklist to confirm eligibility » Provide clear submission instructions	» Do not make forms overly lengthy - focus on essential information » Avoid creating forms without coordinating with MCPs on their requirements

Related Resources—Essential Complementary Materials

- Referral Cheat Sheets for Contact Information
- Eligibility Screening Tools
- MCP-Specific Authorization Guides
- Process Journey Maps

Where to Go for More Help

- Managed Care Plan Referral Departments
- PATH CPI Facilitators: Find Your Collaborative

4. Referral Process Maps

Referral Process Maps are visual flowcharts that map the end-to-end referral process from initial identification through service enrollment, showing decision points, timelines, roles, and hand-offs between different stakeholders.

Purpose

Provides transparency into complex referral workflows, helps identify potential bottlenecks or gaps, supports training and onboarding of new staff, and ensures all stakeholders understand their role in the referral ecosystem.

Primary Users

- Referral Coordinators
- Care Managers
- Provider Staff
- Community Partners
- Anyone involved in the referral process who needs to understand workflow steps and responsibilities.

How to Use—Steps for Getting Started and Implementation

1. Review process map relevant to your MCP and service type (ECM vs Community Supports).
2. Identify your role and responsibilities in the workflow.
3. Use the process map to define who communicates what, when, and how.
4. Use as reference during referral processes to ensure proper steps are followed.
5. Use as a reference for staff training and process improvement discussions.
6. Revisit the process map regularly to ensure it reflects real-time practice and evolves with program or policy changes.

Template & Examples of Successful Use

Template

- "Referral" Mapping Template Tool from HealthBegins

Example

- San Joaquin/Stanislaus MCP referral process journey maps for Kaiser Permanente, Health Plan of San Joaquin, and Health Net from HealthBegins

Tips and Traps—Tips for Developing and Using this Tool and What to Avoid

Tips	Traps

» Update regularly as MCP processes change
» Include specific contact information and timelines
» Use consistent symbols and formatting
» Understand what each symbol means in the referral/workflow process
  ○ Oval (Start/End): This symbol marks the beginning or end of the referral process. It signifies where the process starts and finishes.
  ○ Rectangle (Process/Action): This represents a specific task, activity, or operation within the referral process.
  ○ Arrow (Flow): Arrows connect the different symbols and indicate the direction of the process flow.
  ○ Diamond (Decision): This symbol indicates a decision point in the process (like Yes/No).
	» Avoid creating overly complex visuals that are hard to follow
	» Do not assume processes are identical across MCPs—verify MCP-specific requirements

Related Resources—Essential Complementary Materials

- Contact Directories for Referral Departments
- Managed Care Plan-Specific Referral Forms
  - Example: HealthNet End-To-End Referral Process
- Closed Loop Referral Implementation Guidance

Where to Go for More Help

Visit the statewide MCP directory to identify the contact information for your designated MCP referral department here or contact your local collaborative facilitator to determine if a tailored copy exists for your region.

Appendices

Appendix A: CalAIM Referral Self-Assessment

The following questions are intended to support you and your organization in assessing your current system of receiving referrals for CalAIM services and considering options for increasing referral volume. A glossary of terms is included at the end of this document.

Referral Sources and Intake Overview

Using the table below, list all sources from which your organization currently receives referrals. This may include Member Information File (MIF) referrals from your Managed Care Plan(s) (MCP), referrals from partner organizations, or internal referrals from other programs within your organization. For each source, complete the table to understand how those referrals are received, the number of referrals per month, the proportion of those referrals that ultimately result in authorization, and any additional notes you would like to include. Feel free to use estimates if needed. Add additional rows as necessary.

Referral Source	Referral Method	Average Monthly Volume	Average Conversion to Authorization Rate	Notes
1.				
2.				
3.				
4.				
5.				
6.				

Current Referral Processes and Capabilities Analysis

1. Using the table below, analyze your current referral processes and capabilities.

Capability	Yes/No
Are referrals tracked?	
Are referrals tracked uniformly across referral sources?	
Does your organization have a standardized intake protocol for newly referred clients?	
Does your organization have capacity to accept more referrals for your CalAIM program?	If yes, what is that capacity in members per month:_____

2. From what new or existing source would you like to receive additional referrals?_____
3. What are your current barriers to achieving this? _____
4. Identify one strategy to increase referrals from the source identified above, given the barriers noted. _____
5. Identify one first step toward implementing that strategy. _____

Glossary of Terms

Average Monthly Volume: The typical number of referrals received per month from a specific source. This figure helps assess referral flow, capacity planning, and the contribution of each source to overall program intake.

Desired Referral Source: A potential or existing referral source that aligns with your organization's Populations of Focus and outreach strategy, and from whom the provider organization may want to start receiving referrals/more referrals.

Referral Capacity: The number of referrals a provider organization can reasonably accept and process within a monthly period, based on staffing levels and current caseloads.

Referral Conversion to Authorization Rate: The percentage of received referrals that result in an approved authorization from the MCP for the service. This rate can help show how much an increase in referrals will result in increases in client volume.

Formula: (Number of Referrals Resulting in Member Enrollment or Service Authorization ÷ Total Number of Referrals Received from the Referral Source) × 100

Referral Method: The way in which a provider organization receives the names and contact information for members who may be interested in and/or eligible for ECM or Community Supports services. Methods may include health plan referral portals, secure electronic health records (EHR) interfaces, secure email, fax, phone call, or in-person visits.

Referral Source: An individual or organization that initiates a referral to an Enhanced Care Management (ECM) or Community Supports service. Most providers receive referrals from their contracted Managed Care Plan(s) via a Member Information File (MIF). Other common sources include primary care providers, hospitals, emergency departments, county behavioral health departments, community-based organizations (CBOs), community partners (such as churches or libraries), and self-referrals by Medi-Cal members.

Referral Tracking: A standardized process or system for recording, updating, and managing the status of each referral from initial receipt through to authorization or resolution. Tracking tools may include spreadsheets, EHRs, case management software, Customer Relationship Management (CRMs), or other tools.

Standardized Intake Protocol: A uniform set of procedures for processing and assessing newly referred members. Protocols typically include eligibility checks, outreach attempts, engagement scripts, documentation requirements, and timeframes for follow-up.