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Transitions from primary care to specialty mental health: Understanding characteristics of successful referrals in the public mental health system
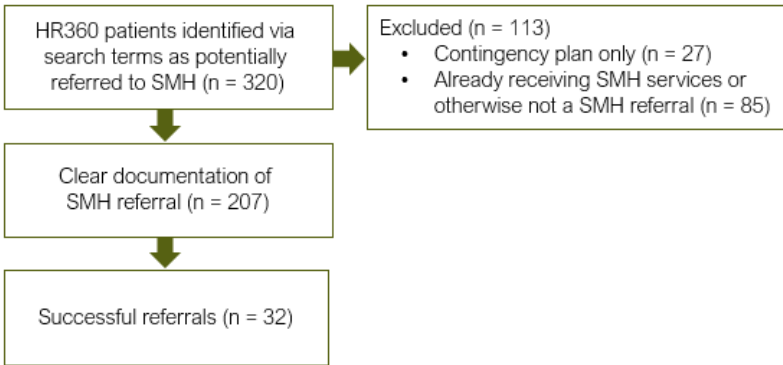
Background
- Specialty medical referral from primary care (PC) has frequent breakdowns and inefficiencies[1, 2]
- Referral coordinators and warm hand-offs are commonly used in other specialties to assist in the referral process [3]
- Specialty mental health (SMH) referrals often depend on a patient's ability to navigate this process independently[4]
- Limited research on referral patterns for behavioral health conditions[5]

Objectives
- Assess the success of SFDPH specialty mental health referrals from HealthRIGHT 360 (HR360) to improve coordination of care and address disparities

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│ HR360 patients         │        │ Excluded (n = 113)             │
│ identified via search  │───────>│ • Contingency plan only        │
│ terms as potentially   │        │   (n = 27)                     │
│ referred to SMH        │        │ • Already receiving SMH        │
│ (n = 320)              │        │   services or otherwise not a  │
└────────────────────────┘        │   SMH referral (n = 85)        │
            │                     └────────────────────────────────┘
            v
┌────────────────────────┐
│ Clear documentation of │
│ SMH referral (n = 207) │
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│ Successful referrals   │
│ (n = 32)               │
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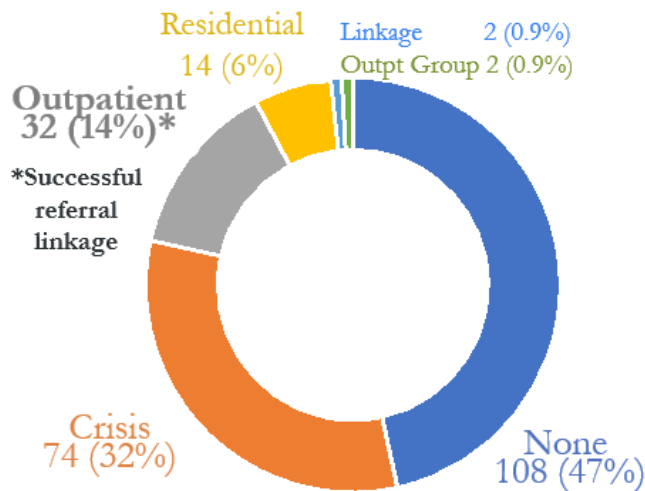
Methods
- Design: Retrospective cohort study
- Setting: HR360 Integrated Care Clinic (ICC) is a community-based FQHC in San Francisco for underserved and otherwise marginalized low-income individuals, many of whom have substance use disorders and/or housing instability
- Data Source #1: HR360 eClinicalWorks
  - Free text chart review using search terms including "specialty mental health" from Jan 2019 through Dec 2020. Reviewed to determine if a referral to SMH was made.
- Data Source #2: SFDPH Avatar
  - Link HR360 data to SFDPH data to determine which patients received MH services through SFDPH within 6 months of their referral date. We coded this data by type of service and time from referral date.

Results

First service type received after referral

Residential 14 (6%)
Linkage 2 (0.9%)
Outpt Group 2 (0.9%)
Outpatient 32 (14%)*
*Successful referral linkage
Crisis 74 (32%)
None 108 (47%)

	Successful	P-value
Total, N (%)	32 (15.53)	
Race/Ethnicity		
American Indian/Alaska Native	0	0.3317
Asian/Asian-American	2 (28.57)	0.3326
Black/African-American	2 (3.92)	0.0083
Native Hawaiian/Pacific Islander	0	-
Hispanic/Latinx	1 (6.67)	0.3248
White	22 (28.95)	0.0000
Other	5 (15.15)	0.9472
Declined/Missing	0	0.0498

- Mean days from referral to outpatient appt: 20.4 +/-27.6 days
- Successful referrals seen for medication management: 14 (44%)

Limitations
- Ambiguity in referral status due to lack of formalized referral process at PC and SMH clinics
- Difficulty exchanging patient information with outside clinics: Unclear how many "successful referrals" were already receiving outpatient SMH services prior to their referral date

Discussion
- Low rates of successful linkages, high rates of crisis service utilization
- Lack of parity with other medical specialty referrals
- Marked racial disparities

Recommendations
- Formalize SMH referral process, ideally with an integrated electronic system (like eConsult Mental Health in LA[6])
- Use referral coordinator to give parity with other specialties and help SMI patients most in need
- Build close relationship with a nearby "sister" clinic to facilitate increased communication
- Better understand root causes of racial disparities; implement more culturally competent care to address

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3. Greenwood-Lee J, Jewett L, Woodhouse L, et al. A categorisation of problems and solutions to improve patient referrals from primary to specialty care. BMC Health Serv Res. 2018;18:986.
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