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A Referral Partnership Framework for Accountable Home Healthcare Handoffs

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Abstract
A home healthcare referral is a sequence of decisions and transfers rather than a completed access outcome. This conceptual analysis uses selected literature published through 2024 to propose a partnership framework with explicit responsibility for referral preparation, transmission, receipt, agency decision, scheduling and first-visit confirmation. Evidence on service receipt and adjacent transitional care informs the problem, but does not validate the proposed process. The framework specifies an auditable event record, a clinically reviewed packet and an unresolved-case escalation route. It distinguishes closure of documentation from delivery of care and preserves appropriate decline, patient choice and alternative disposition. Proposed indicators address completion, delay, missing status and burden. A prospective pilot and comparative evaluation are outlined with clinical appropriateness assessed separately. The contribution is a handoff specification for participating organisations, not a marketing attribution system or a claim of improved clinical outcomes. Response windows and responsibilities require local agreement and adaptation to the clinical context.

Keywords: Home Healthcare, Referral, Care Transitions, Closed-loop Documentation, Partnership Framework, Health Equity, Nursing Informatics

1. Introduction
A referral written in one organisation's record does not establish that another organisation received it. Receipt does not establish acceptance, and acceptance does not establish a completed visit. A partnership that reports only referral volume misses these distinctions. It also obscures where a patient or household requires explanation, assistance or an alternative plan [1-21].

This paper specifies a referral partnership around documented handoffs. Its contribution is the distinction between process accountability and service delivery. Each partner records the event it controls, while reconciliation identifies unresolved cases. The framework includes clinical appropriateness and patient choice so a high conversion target does not encourage unnecessary or unwanted care [22-25].

The scope is a service process shared by referring teams, receiving agencies and support partners. Community workers assist within their defined roles; they do not replace clinical assessment or exercise authority the partnership has not assigned. The framework does not state a universal referral deadline or legal compliance standard [2, 26-39].

2. Research Method
2.1 Review question and source coverage
This paper addresses the following question. What must each partner record and own so a referral has an auditable disposition without confusing documentation closure with access to care?

The analysis draws on selected conceptual, measurement and empirical literature published no later than 2024. Sources are used according to their intervention, setting and outcome. Conceptual sources inform definitions and proposed relationships. Empirical studies inform the problem or an adjacent mechanism, with their findings kept within the evaluated intervention and

population. The synthesis is interpretive and does not follow a registered systematic review protocol or provide an exhaustive study census [2, 40-49].

The analytical procedure separates the target construct, the observation used to represent it and the claim supported by that observation. The resulting framework specifies process records, outcome boundaries and a prospective evaluation question. Design recommendations are identified as proposals. No participant dataset, new clinical results or validated composite score is reported, and no pooled effect is estimated from unlike interventions [2, 50-60].

The synthesis proceeds through three steps: define the communication or service task, identify the observation supported by each relevant source, and specify a comparison which would test the proposed relationship. Table 1 records construct boundaries; Table 2 operationalises a study or audit. Numerical illustrations demonstrate definitions and accounting only. They are not empirical results [1, 61-75].

2.2 Evidence handling and limits of transfer

Li *et al.* [76] examine receipt of a home health visit after discharge referral, supporting the distinction between referral and service receipt. Fashaw-Walters *et al.* [78] examine unequal use of high-quality agencies, adding a quality-sensitive access question. Neither study identifies the cause of every unresolved local referral or validates the proposed partnership workflow [2, 49, 76, 77, 79-98].

Transitional care research concerns interventions with several clinical and organisational components. Naylor *et al.* [100] test transitional care for older adults with heart failure; Feltner *et al.* [102] review interventions for heart failure readmissions; Tyler *et al.* [40] synthesise hospital-to-community transitional care. Balaban *et al.* [103] test navigation in safety-net patients. Their evidence informs the broader transition problem, but outcomes from those packages should not be attributed to referral documentation alone [2, 22, 42, 49, 51, 99, 100, 102-131, 216, 219, 222, 225, 228, 231, 234, 237, 240, 243, 246].

Community worker role studies and reviews inform assistance, coordination and role boundaries [2, 49, 132, 133]. Wallerstein and Duran [83] provide a participatory research perspective on partnership. These sources support attention to defined responsibilities and community involvement without assigning clinical duties to every support worker [2, 34, 135-142].

Te Loo *et al.* [143] examine referral implementation barriers and facilitators for hospital-to-community lifestyle interventions. The setting differs from skilled home health, so its relevance is to process questions and transfer boundaries. The proposed framework requires evaluation in the receiving service rather than assuming a workflow effective in one service will produce the same outcome in another [144-149].

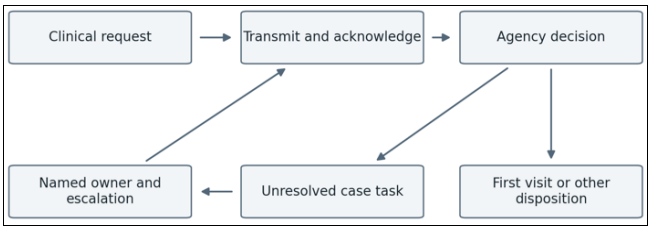
Parker *et al* [76]. describe participatory research partnership tools supporting reflection on collaboration. These tools inform how referral partners might review responsibilities together, rather than a claim that partnership meetings improve referral completion. In the proposed framework, such a review should result in a named owner for transmission, acknowledgement, unresolved cases and escalation [134, 151-156].

Scott *et al.* [49] review community health worker programmes, and Hartzler *et al.* [49] review roles and functions in primary care. This literature motivates task-specific descriptions of community assistance. For a home healthcare handoff, the locally agreed role should state whether the worker explains the process, contacts an agency or supports follow-up. These functions do not automatically confer clinical authority [2, 157].

Harrison *et al.* [76] report a stakeholder-informed hospital research agenda that includes transitions in care. Their approach supports asking patients and families which handoff problems deserve investigation. It does not validate the referral sequence proposed here. The sequence should be assessed using complete event records and the eventual disposition of the requested service [158-160].

3. Results and Discussion

3.1 Referral Accountability and Handoff Framework



Source: Author-developed conceptual framework. Arrows represent proposed relationships or process order, not estimated effects

Fig 1: Referral events responsibility and unresolved cases

Table 1: Referral events responsibility and unresolved cases measurement boundaries

Transition	Minimum record	Responsible function	Resolution measure
Decision to transmission	Clinical referral and destination	Referring team	Sent referral per documented decision
Transmission to acknowledgement	Send and receipt timestamps	Receiving intake function	Acknowledged per transmitted referral
Acknowledgement to disposition	Acceptance or decline with reason	Receiving clinical and intake functions	Recorded disposition per acknowledged referral
Disposition to patient agreement	Choice and explanation of next steps	Agency with referring team support	Documented agreement or refusal
Agreement to first visit	Scheduled and completed visit records	Receiving agency	Completed visit or reason for noncompletion

Table 1 provides an analytical specification. Its entries are proposed distinctions rather than empirical ratings or validated instrument properties.

3.1.1 Responsibilities and the referral event sequence

The referring clinical team identifies the intended service and prepares the clinically appropriate request. The receiving agency records receipt and its service decision. The scheduler records the agreed date and subsequent changes. A named coordinator or support partner tracks unresolved cases within the agreed role. Fig 1 presents the proposed sequence; Table 1 identifies the events and their interpretation boundaries [78, 161].

Use distinct event names for identification, order completion, transmission, acknowledgment, decision, scheduling and completed visit. Identification is not confirmation of eligibility. The agency's decision should

retain its reason where appropriate, such as service capacity, coverage, clinical fit or the patient's preference. Timestamp each event and preserve the source of the record. A retrospectively confirmed event should be distinguishable from one recorded at the time.

3.1.2 Information packet and correction route

The partners should agree on the clinical and operational information needed to evaluate and act on a referral. Clinical staff determine the information required for the intended service. The packet should include usable contact details, preferred communication needs, the clinical request, relevant care information and a route for clarification. Record who will supply missing information and how an urgent request will proceed without waiting for nonessential fields [162-167].

Packet completeness is not the same as accuracy. An audit should compare the transmitted information with the source record and check for copied content that no longer describes the patient. Changes in the patient's condition or preference should produce an update and acknowledgment. The record should identify version and transmission time so partners do not act on conflicting packets. Collect and share information for the referral purpose, with access and retention governed by the participating organisations [42, 168].

3.1.3 Closure and disposition

At the reporting date, assign each referral a known disposition or an unresolved status. Served, declined, withdrawn, redirected and still awaiting action represent different results. A served disposition requires evidence of the first visit, rather than an acceptance message alone. A decline should retain the available reason. A patient withdrawal should record the decision respectfully without assuming an intervention failure [169-171].

Documentation closure is the proportion with a known disposition under the agreed definition. Service completion is the proportion reaching the defined service endpoint. These rates answer different questions. A partnership could improve documentation by recording more declines without increasing visits. It could also report more visits while leaving many cases unresolved. Present both rates with their original referral denominator and observation period.

3.1.4 Escalation and prospective evaluation

Partners should agree on response windows according to urgency, service conditions and the applicable clinical process. An unresolved event beyond its window generates a named task and an escalation contact. The trigger supports investigation; it does not establish blame. Keep cases open through correction or alternative planning where appropriate, and preserve a record of the final disposition [172-174].

A pilot should test record completeness, agreement between partner records and the staff time needed for reconciliation. A subsequent comparison should measure first-visit receipt in the defined cohort, clinical appropriateness and the time distribution. Hold the cohort definition stable and record changes in service supply. A comparison of documented cases alone excludes the very failures the partnership is intended to expose. Analysis should retain unresolved cases and show plausible bounds where their outcomes remain unknown.

3.1.5 Reconciliation workload and the interpretation of a known disposition

Reconciliation should begin with the original referral cohort, not only cases acknowledged by the receiving agency. Otherwise, requests lost before acknowledgment disappear from evaluation. Preserve a stable referral identifier through updates and redirection. Where several agencies consider the same referral, link their decisions to the episode so agency decisions do not become multiple patients.

The reporting period should distinguish open cases still within their expected window from overdue unresolved cases. An open case is not necessarily a failed handoff. The operational team should review overdue cases according to urgency and the task remaining. Clinical staff determine how a change in the patient's condition alters the care plan; the tracking system should record the resulting disposition rather than continue pursuing an obsolete request [175].

Partner record disagreement requires an evidence rule. An agency might record a completed visit while the referring record remains open. A household might report a visit absent from the agency extract. Record the source and time of confirmation, investigate discrepancies and retain corrections. A single source should not be declared authoritative for every event simply because it is easiest to access.

An audit should examine the accuracy of known dispositions as well as the share of unresolved cases. If the system classifies unanswered requests as withdrawals, apparent closure improves without better information. If redirection ends one record without tracking the receiving route, the partnership closes paperwork while losing the patient's journey. Each disposition should correspond to a documented event or decision [157].

Reconciliation consumes staff time. Record the number of follow-up attempts, organisations contacted and unresolved issues requiring clinical review. These measures describe workload and inform staffing; they should not become incentives for unnecessary contact. A programme should assess whether tracking reduces duplicated requests or shifts work to partners without resources to perform it.

The evaluation should retain the difference between documentation completeness, appropriate care and experience. A known disposition establishes traceability. Clinical assessment addresses whether the resulting care plan was appropriate. Patient and caregiver accounts address explanation, choice and burden. Reporting these separately protects the partnership from achieving a numerical closure target while leaving the underlying access problem unresolved [49, 56, 176-180].

3.1.6 A referral reconciliation audit and competing endpoints

A reconciliation audit should use the referral episode as its unit. Sending the same request to two agencies produces two agency decisions within one episode, rather than two patients or two referrals requiring independent success claims. The audit should retain successive clinical plans and distinguish a correction from a new episode. Research on first-visit receipt makes clear why an order and a delivered visit require separate observations [1]. Qualitative referral research supplies adjacent evidence about implementation barriers, not proof of the proposed home health workflow [143]. [181-184].

Table 2 presents a hypothetical cohort of 100 referral episodes. Suppose 50 end in a confirmed first visit, 15 in an agency decline, 10 in an informed withdrawal, five in documented alternative care, and 20 remain unresolved. Documentation closure is 80 percent because 80 dispositions are known. First-visit receipt is 50 percent. Alternative care

should receive a separate appropriateness assessment rather than be added automatically to the first-visit numerator. These calculations illustrate endpoint definitions and do not describe observed programme results.

Table 2: Hypothetical referral dispositions and documentation closure

Disposition	Illustrative count	Included in closure	Included in first visit receipt
Confirmed first visit	50	Yes	Yes
Agency decline	15	Yes	No
Informed withdrawal	10	Yes	No
Documented alternative care	5	Yes	No
Unresolved	20	No	Unknown
Total	100	80 percent closed	50 percent confirmed visits

Source: Author-developed analytical example. Numerical values, where shown, are hypothetical and do not represent study observations

Now suppose reconciliation establishes that eight unresolved episodes received a visit and seven ended in a decline. Recorded closure rises to 95 percent and recorded first visits rise to 58 percent, although no additional care was delivered during reconciliation. This example identifies a measurement effect. A prospective comparison should distinguish newly documented historical events from newly delivered care. Otherwise, a successful record audit becomes an unsupported claim that the partnership increased service receipt.

Unknown outcomes require a sensitivity account. Before reconciliation, the first-visit proportion in the illustrative cohort lies between 50 and 70 percent if every unresolved episode is either a visit or a nonvisit. This is an outcome bound, not a confidence interval. After resolving 15 cases, the analogous bound narrows to 58 through 63 percent. Clinical appropriateness, timing and experience remain separate. The audit should therefore retain a record of what became known, the confirming source and the original uncertainty.

Time measures should share a starting event. Order-to-acknowledgment describes transmission and receipt; acknowledgment-to-decision describes agency assessment; acceptance-to-first-visit describes scheduling and delivery. An overall time from the original order preserves the cumulative experience. Reporting only the last interval among served patients excludes people who never reached acceptance. Transitional care syntheses concern broader interventions and downstream outcomes, so their results should not be assigned to any one of these documentation intervals [2, 101]. [185-188].

The proposed mechanism is that named responsibility exposes and resolves handoff uncertainty. The first test concerns record agreement and unresolved tasks; the next concerns timely, appropriate service receipt under a controlled comparison. Community workforce and partnership research inform the responsibilities and resources needed for assistance [49, 150]. The partnership should assess whether tracking work reduces repeated requests or merely shifts burden to households and smaller organisations. Success requires a documented improvement in the chosen endpoint, not attainment of an arbitrary closure target [49, 189-204, 217, 220, 223, 226, 229, 232, 235, 238, 241, 244].

A referral between organisations is often described as a single event, but in practice it is a sequence of decisions and transfers, each of which can fail independently. The sequence typically begins when a clinician or care coordinator decides that a patient needs a service that another organisation provides. It continues with the preparation and transmission of the referral, the receiving organisation's decision to accept, the scheduling of an appointment or visit, the patient's attendance and, ideally, the confirmation that the visit occurred. Failure at any point breaks the chain, and the point of failure determines the remedy. A referral that is never generated reflects a gap in recognition; one that is generated but not accepted reflects a mismatch between the referral and the receiving organisation's criteria; one that is accepted but not attended reflects a logistical or motivational obstacle; and one that is attended but not confirmed leaves the referring clinician uncertain. Distinguishing these failures is the first step in improving the pathway, and it requires that the sequence be mapped and measured at each stage.

The handoff between organisations is frequently the weakest link in this sequence because it is where responsibility is least clear. Within an organisation, roles and processes are defined and accountability is established, but between organisations there may be no shared understanding of who is responsible for what, no common definition of a completed referral, and no means of confirming that a patient arrived. The result is a gap in which patients can be lost without anyone noticing, because each organisation believes the other is handling the next step. Closed-loop documentation addresses this gap by requiring that the referring party be informed when the referral is received, accepted and completed, and that the receiving party understand the context in which the referral was made. Closing the loop converts an ambiguous transfer into an accountable handoff and makes it possible to detect failures that would otherwise be invisible.

The information exchanged during a referral shapes whether the receiving organisation can act effectively. A referral that conveys the clinical reason, the relevant history, the patient's circumstances and any practical considerations enables the receiving organisation to plan and to prepare the patient. A referral that conveys only a diagnosis or a service code may be technically sufficient but practically inadequate, particularly where the service involves care in the home and must account for the patient's environment, support and preferences. The framework recommends that partners agree on the information a referral should contain, that the agreement reflect the receiving organisation's actual needs rather than the referring organisation's convenience, and that the exchange be reviewed periodically as services change. Information exchange of this kind is not merely administrative; it determines whether the receiving organisation can deliver appropriate care and whether the patient experiences the transition as continuous.

Shared accountability is the mechanism by which partners sustain coordination over time. Referral networks frequently involve organisations with different mandates, funding sources and performance measures, and a patient transferred between them can fall between separate accountabilities. Agreement on a small number of shared outcome measures, such as the proportion of referrals reaching a first visit within a defined window, gives partners a common objective that transcends their individual metrics. It also creates a basis for constructive review when performance

falls short, because the discussion concerns a shared target rather than one organisation's failure. The framework recommends that shared measures be few, clearly defined and jointly owned, and that they be reviewed on a regular cycle with participation from all partners. Accountability of this kind is more durable than contractual obligation because it aligns partners' interests rather than merely specifying their duties.

Data infrastructure is a practical precondition for accountable referral, and it is frequently the constraint that limits what partners can achieve. Where organisations use systems that do not interoperate, information must be transferred manually, which is slow and error-prone. Where privacy rules restrict the sharing of information, partners may be unable to confirm that a patient arrived even when both wish to. Where data are held in systems that cannot report on referral status, monitoring the pathway becomes a manual exercise that consumes staff time. The framework recommends that partners invest in the capability to exchange and track referrals as an early priority, and that they design their processes around the information they can actually share rather than assuming a level of interoperability they do not have. Addressing these constraints is less exciting than redesigning clinical pathways, but it determines whether redesign is possible.

Patient and family experience deserves measurement alongside process indicators because a referral that is administratively complete may still leave the patient confused, anxious or unsupported. The sequence of decisions and transfers that constitutes a referral is experienced by the patient as an episode of uncertainty, and the quality of communication during that episode shapes their confidence in the service they are about to receive. Patients who do not understand why they are being referred, where they are going or what to expect may fail to attend or may attend without the information the receiving organisation needs. Measuring experience, and using what is learned to improve communication at each stage, addresses a dimension that process metrics cannot capture. It also provides an early warning of problems that have not yet appeared in referral volumes or completion rates, since patient dissatisfaction often precedes measurable failure.

Building a functioning referral partnership requires attention to the sequence in which capabilities are developed, because attempting improvement before the foundations are in place often produces frustration and erodes commitment. Data infrastructure and agreed definitions must precede joint measurement, joint measurement must precede shared accountability, and shared accountability provides the basis on which process improvement can be sustained. The framework therefore recommends that partners invest first in a common process map and in the capacity to exchange confirmation of referral receipt, and that they add outcome measures and review cycles once these basics function reliably. It also recommends that early successes be made visible, because partnership depends on confidence that cooperation produces results. Starting with a small number of high-volume pathways where the benefits of coordination are clearest allows partners to demonstrate value before extending the arrangement, and it reduces the risk that the partnership collapses under the weight of its own ambition.

The evidence on care transitions supports the framework's emphasis on handoffs as the point of greatest vulnerability. Studies of hospital-to-home transitions consistently find that gaps in communication and follow-up are associated with adverse events, readmissions and patient dissatisfaction, and that structured transition programmes which address these gaps improve outcomes. The mechanisms identified in this literature include timely information transfer, confirmed receipt, patient preparation and follow-up, all of which correspond to elements of the framework advanced here. The evidence also indicates that the benefits of transition programmes depend on implementation quality, and that programmes which adopt the structure without the supporting capability achieve less. This pattern reinforces the framework's recommendation that referral partnership be built through a sequence of capability development rather than by adopting a process map alone.

Measurement in referral partnership is complicated by the fact that the relevant outcomes are distributed across organisations that may not share data. The referring organisation can observe that a referral was made but not necessarily that it was completed; the receiving organisation can observe that a patient arrived but not necessarily the circumstances that preceded the referral. Where the two can be linked, the pathway can be measured end to end; where they cannot, each organisation sees part of the picture and the shared outcome is invisible to both. This is precisely the situation the framework aims to address, and it explains why data infrastructure figures among the foundational capabilities rather than among the refinements. Partnerships that invest in linkage early are able to observe the outcomes they share, while those that defer it may continue to measure components and mistake activity for completion.

Incentives shape whether partnership persists, and they are often misaligned with the outcomes that matter. Referral volume is frequently rewarded, while completion of the transition is not, which encourages the generation of referrals without regard to whether they are accepted or attended. Organisations may be accountable for their own patients rather than for the pathway, so that a failure at the boundary falls between them. Where funding rewards the transfer rather than the outcome, partners may have limited incentive to invest in the coordination that improves outcomes. The framework recommends that incentives be examined as part of the design of a partnership, that shared outcomes be reflected in how performance is assessed, and that partners consider how their separate accountabilities could be aligned with the outcome they jointly seek. Alignment of incentives is a condition for the durability of partnership, because goodwill alone is difficult to sustain when rewards point elsewhere.

Implementation science offers guidance on how such partnerships can be developed and sustained, emphasising the importance of readiness, adaptation to context, leadership support and iterative learning. Readiness includes the capacity of organisations to change their processes and the willingness of staff to adopt new ways of working. Context includes the local service landscape, the populations served and the relationships among organisations. Leadership support matters because partnership requires decisions that cut across organisational boundaries and cannot be made by front-line staff alone. Iterative learning allows partnerships to adjust as problems emerge rather than being fixed in an initial design. The framework advanced here is consistent with these principles and locates them within a specific focus on the referral pathway, so that implementation effort is directed at the transitions where it

is most needed.

Equity considerations apply to referral partnership because transitions can fail disproportionately for populations that experience barriers. Patients with limited English, unstable housing, cognitive impairment or limited support may be less able to navigate a referral and more likely to be lost during it, and a partnership that measures only average completion may not notice. The framework recommends that completion be monitored by population segment, that transitions be examined for the groups that experience the greatest difficulty, and that support be designed for those groups specifically. It also recommends that the reasons for non-completion be recorded where possible, because they indicate whether the obstacle lies in communication, logistics, service capacity or the patient's circumstances. Monitoring equity at the transition level is more actionable than monitoring it in aggregate, because it identifies where the pathway fails particular populations and directs attention to that point.

Scaling a referral partnership from an initial pathway to broader coverage raises challenges that differ from those of establishing it. What works in a high-volume pathway with motivated partners may not transfer to a pathway with less frequent referrals, weaker relationships or different information requirements. Scaling requires attention to the capability of new partners, the volume of referrals that will flow through the pathway and the support that will be needed to sustain the interfaces. The framework recommends that scaling be undertaken deliberately, that new pathways be introduced with the capability and infrastructure they require rather than being added to an existing process, and that the performance of each pathway be monitored separately. Scaling too quickly risks eroding the quality that made the initial partnership effective, while scaling too slowly leaves patients in other pathways without the benefit of coordination.

The framework's central practical message is that a referral is not complete until the patient is known to have been received. That assurance is produced by partnership, and it depends on the elements the framework identifies: A shared understanding of the sequence of steps, closed-loop information exchange, joint measurement of the outcomes partners share, and the investment in data infrastructure on which all of these depend.

Programmes that adopt the framework should expect to build capability in a deliberate order, to start with the pathways where coordination is most obviously valuable and to extend the arrangement only when the foundations are in place. Attempting to improve outcomes without the supporting capability tends to produce frustration rather than results, and it can erode the commitment on which partnership depends. Building in sequence, and making early successes visible, sustains the effort that accountable handoffs require.

The framework also implies that patients and families should be involved in how the pathway is evaluated, because a referral that is administratively complete may still leave people confused or unsupported. Measuring experience alongside process metrics captures a dimension that completion counts cannot, and it provides early warning of problems that have not yet appeared in referral volumes. Combining process and experience measures produces an account of accountability that corresponds to what patients actually experience as they move between organisations.

3.2 Interpretation and Constrained Evaluation

The framework makes the referral's status reviewable without equating traceability with clinical quality. Knowing that a referral ended in a decline is useful because it identifies a result requiring explanation or an alternative plan. It does not establish that the decline was appropriate. Conversely, a completed first visit does not establish that the original request represented the best care option [205, 247-266].

A comparative evaluation should investigate both service outcomes and reporting changes. If partner reconciliation reveals previously unrecorded visits, a rise in recorded completion might reflect better measurement. If additional agency capacity arrives during the pilot, improvement might reflect supply. The evaluation must distinguish these explanations before attributing the result to the partnership [206].

The framework is a proposed workflow, not a validated referral standard. It assumes partners have a workable agreement and some ability to exchange or reconcile status. Smaller organisations might need a simpler record and explicit resources for tracking. Clinical appropriateness, patient experience and staff burden require separate assessment. Future evaluation should report unintended effects, including delayed urgent referrals, excessive documentation and pressure to accept a service [207-212].

The framework treats a home healthcare referral as a sequence of decisions and transfers rather than a single event, and this shift in perspective has direct implications for how partnerships are designed and evaluated. Each step in the sequence, from the decision to refer through acceptance, scheduling and first visit, can fail independently, and the most common failure points are the handoffs between organisations rather than the activities within them. A partnership that measures only referral volume cannot distinguish a system that transfers patients smoothly from one that generates referrals no one accepts. The framework therefore recommends that partners adopt a shared process map and that they measure progress at each transition. This common language is a precondition for accountable partnership, because organisations cannot improve a handoff they do not jointly observe, and they cannot assign responsibility for a failure they cannot locate.

Closed-loop documentation emerges from the framework as a central requirement. A referral is only genuinely complete when the referring clinician knows that the patient was accepted and seen, and when the receiving organisation knows the clinical and social context that accompanied the referral. Where this loop is open, responsibility for the patient becomes ambiguous precisely at the moment when continuity matters most. The framework recommends that partners agree in advance on what constitutes confirmation, how it will be transmitted and how long it should take. It also recommends that the loop close in both directions, so that receiving organisations can return information that improves future referrals. This two-way flow transforms documentation from a compliance burden into a quality mechanism, and it allows partners to learn from the referrals that do not succeed as well as those that do. Without it, partnership is coordination in name only.

The framework also emphasises the role of shared accountability in sustaining partnership over time. Referral networks frequently involve organisations with different mandates, funding sources and incentives, and a patient transferred between them can fall into the gap between

separate accountabilities. Agreement on shared outcome measures, such as the proportion of referrals reaching a first visit within a defined window, gives partners a joint objective that transcends their individual metrics. It also creates a basis for honest review when performance falls short, because the discussion concerns a shared target rather than one organisation's failure. The framework recommends that such measures be few, clearly defined and jointly owned, and that they be reviewed on a regular cycle. Accountability of this kind is more durable than contractual obligation because it aligns partners' interests rather than merely specifying their duties.

Finally, the framework acknowledges the obstacles that make referral partnership difficult to implement. Data systems may not interoperate, privacy rules may limit information sharing, and organisations may lack the staff to monitor referrals across boundaries. Financial incentives may reward volume rather than continuity, and leadership attention may shift before the partnership matures. The framework therefore recommends that partnerships be built incrementally, starting with a small number of high-volume referral pathways where the benefits of coordination are clearest, and that they invest early in the data and communication infrastructure on which closed-loop processes depend. It also recommends that patient and family experience be measured alongside process metrics, since a referral that is administratively complete may still leave the patient confused or unsupported. Attending to these practical and human dimensions is what distinguishes a functioning partnership from a formal agreement.

Building a functioning referral partnership in practice requires attention to the sequence in which capabilities are developed. Data infrastructure and agreed definitions must precede joint measurement, joint measurement must precede shared accountability, and shared accountability provides the foundation on which process improvement can be sustained. Attempting improvement before the underlying information systems and agreements are in place often produces frustration and erodes commitment. The framework therefore recommends that partners invest first in a common process map and in the capacity to exchange confirmation of referral receipt, and that they add outcome measures and review cycles only once these basics function reliably. It also recommends that early successes be made visible, because partnership depends on confidence that cooperation produces results. Starting with a small number of high-volume pathways where the benefits of coordination are clearest allows partners to demonstrate value before extending the arrangement to more complex cases, and it reduces the risk that the partnership collapses under the weight of its own ambition.

The framework's central message is that a referral is not complete until the patient is known to have been received, and that partnership is the mechanism by which that assurance is produced. Mapping the referral sequence, closing the information loop in both directions, agreeing a small set of jointly owned measures and building capability in a deliberate order together create the conditions under which handoffs become accountable. Where these conditions are met, gaps in the pathway become visible and correctable rather than invisible and tolerated. Where they are not, partners may believe they are coordinating while patients continue to fall between organisations. Adopting the framework is therefore a means of making accountability observable, and of turning a formal partnership into one that can demonstrate that patients actually arrive.

4. Conclusion

This paper has developed a framework that treats a home healthcare referral as a sequence of decisions and transfers whose weakest links are the handoffs between organisations. By mapping the sequence and measuring progress at each transition, partners can locate the points at which patients are lost and assign responsibility for improvement, something that referral volume statistics alone cannot reveal. The framework makes closed-loop documentation a central requirement, arguing that a referral is complete only when the referring clinician knows the patient was accepted and seen and when the receiving organisation understands the context of the transfer. It recommends that partners agree in advance on what constitutes confirmation and how it will be exchanged in both directions, turning documentation into a quality mechanism rather than a compliance task. It further proposes a small set of jointly owned outcome measures that give partners a shared objective and a basis for honest review. Finally, it recognises the data, privacy, capacity and incentive obstacles to partnership and recommends incremental implementation supported by patient and family experience measurement, which together distinguish genuine accountable handoffs from formal agreements. Sequencing capability development, and demonstrating value early, will determine whether partnership matures into accountable handoffs or remains a formal agreement.

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