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Bidirectional SSRL Implementation

Aliados Health
Promising Practice

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PROMISING PRACTICE OVERVIEW

In a continued effort to connect patients in need of services identified during SDOH screening tools like PRAPARE, Alliance implemented OCHIN Epic's bi-directional social service resource locator (SSRL) to improve follow-up and closed loop referrals on social risk factor screenings. In November 2022, Alliance began a pilot implementation of findhelp Native+ to enable EHR integrated bidirectional communication between its providers and the community-based organizations they partner with. After identifying barriers and adapting workflows to optimize the tool, Alliance found that findhelp Native+ resulted in increased staff ability to connect patients to community resources and understand patient needs and barriers to care. Along with improving patient's quality of care, this can be beneficial for clinic resource allocation and community advocacy.

AIM

- Facilitate timely closure of social service referral loops
- Improve documentation of social service referrals and actions taken
- Eliminate the need for patients to share their story multiple times
- Document and easily track every contact with patient

BARRIERS & RESPONSE

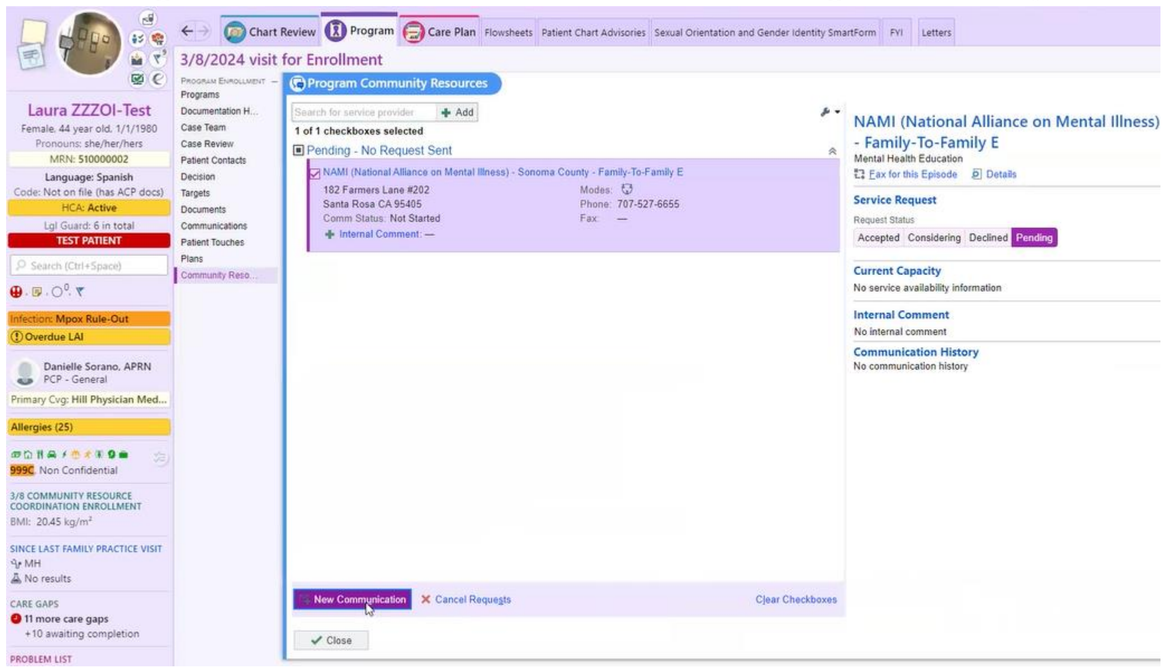
Main barriers to implementation included:

- **Buy-in / Interoperability**: Reluctance among CBO's to sign up with findhelp and accept communications from partners. Many CBOs are small and lack the capacity or willingness to engage with multiple SSRLs.
- **Technology**: Technical difficulties and user issues loading findhelp through Compass Rose. Extended support time and more frequent check-ins from OCHIN may be needed.
- **Knowledge Gaps**: Staff need clarity around workflows, processes, and practices to operationalize findhelp.

Alliance responded to barriers though:

- **Training**: 1:1 elbow training with identified staff is crucial. Address the specific training needs of CHW's.
- **Building Relationships**: Connect with CBO's directly and provide resources for them to learn more about the benefits of findhelp and how to claim their program and enlist them as a partner.
- **Maintaining a Community Engagement Strategy**: Work with a Community Engagement Manager from findhelp to create a community engagement schedule.

Sending Communications to CBO's Through Findhelp



ACTIONS TAKEN

Facing a lack of adequate staffing to screen all their patients and to follow up on social service referrals, staff at Alliance wanted to optimize closed loop referrals for the patients they were able to screen. After its rollout in the behavioral health department, Alliance began 1:1 staff trainings with community health workers, who were the primary users of the tool. Once the tool is ready, CHW's document the patient's referral in Compass Rose within Epic, then utilize the findhelp tool integrated in the E.H.R. to send the patient's summary of care and referral to a participating CBO. Next, the health center waits for an accepted or denied response from the CBO that goes directly into the patient's chart. Finally, Epic's workbench reports can pull data on the status of the program referral per patient, when the communication was made, outcome of the referral, and if the targets were addressed. Currently, there are only a handful of CBO's that are using findhelp, and Alliance is working on adding other CBO's to be able to directly communicate with them.

IMPLEMENTATION WORKFLOW

Launch

- Integration of findhelp Native+ with Epic Compass Rose
- Identify multi-disciplinary team and stakeholders
- Complete findhelp consent form to begin contacting CBO's

Training

- Identify internal "champion" to oversee and assist with staff training
- Create training materials in partnership with E.H.R and findhelp
- Set aside time for training to alleviate the burden on providers and CHW's of learning a new system

Expansion

- Adjustments made to screening and documentation workflows
- Utilization of Epic's workbench reports to analyze referral outcomes
- Identifying additional CBO partners and communicating benefits of bi-directional SSRL

LESSONS LEARNED & NEXT STEPS

Top Tips:

1. Make sure the implementation team has understanding in navigating their EHR and findhelp.
2. Many CHW's acted as champions for findhelp Native+ adoption. Their involvement was key to project success.
3. After making the first few referrals, connect with the CBO to ensure they are receiving and acting on referrals as anticipated.

Next Steps:

1. Increasing CBO participation: Alliance is working on connecting with more CBO's to set them up on findhelp to be able to utilize the bi-directional message feature.
2. Measuring quantitative results: Workbench reports will be utilized to measure quantitative results on referrals sent directly to CBO's through this method.

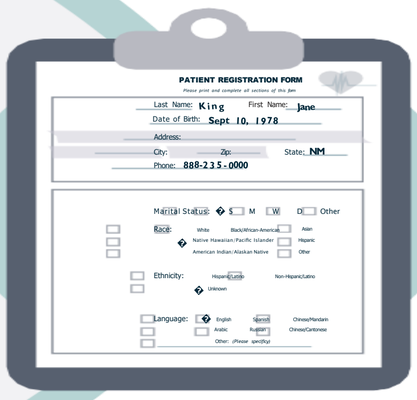
JANE'S PATIENT JOURNEY:
SDoH Screening and Referral with a Bidirectional SSRL

Jane wakes up tired. She had tossed and turned all night at a temporary housing shelter and hopes she can find the right bus to take her to a medical appointment for her persistent cough.

While sitting down for breakfast at the shelter, Jane thinks about her life situation and worries about being embarrassed when she is asked for her address. She heads to the bus stop.

Jane arrives at the community health clinic.

At the clinic, she looks down at her clothes and hopes no one will notice that they have not been laundered recently. She feels lost but hopeful she will get help for her persistent cough and for her housing needs.



Jane checks in for her appointment and is handed registration forms. She begins to fill them out, but leaves "address" blank.

Jane gets called by the medical assistant, David, for her appointment.

Patient-centered screening approaches, including empathic inquiry, motivational interviewing and trauma-informed care, can reduce feelings of embarrassment, shame, or reluctance to share.

During the rooming process, David screens Jane for social risk factors.

David is trained in patient-centered screening approaches and takes a conversational approach to the screening, demonstrates active listening, and uses language that makes Jane feel comfortable and supported. Jane tells him of her housing need.

Screening for SDoH can help providers adjust care plans to best meet patient's needs.

Jane's primary care provider, Dr. Cruz, reads Jane's history, enters the exam room, and examines Jane.

She prescribes medication for Jane's cough, carefully considering Jane's living situation and taking extra time to discuss treatment recommendations.

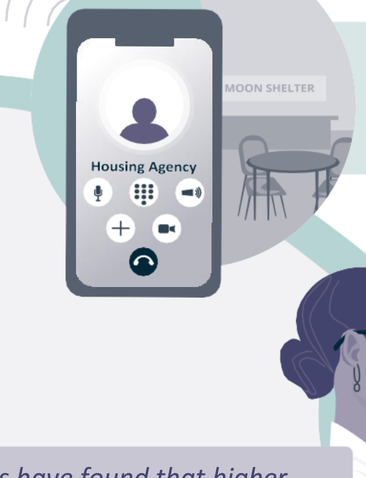
Warm handoffs from providers have been shown to increase patient trust and engagement.

After the medical appointment is completed, she gives Jane a warm handoff to the community health worker (CHW) on duty, Luis, so that Jane's housing needs can be addressed.

Luis accesses the bidirectional SSRL and finds a housing agency that is accepting new clients. He makes the referral, including information about Jane's situation. The housing agency accepts the referral, Jane receives a message notifying her of the referral, and it is recorded in the EHR.

After her appointment, Jane picks up her medication and returns to the temporary shelter. She is feeling relieved that she only had to tell her story once and comforted that her care team is addressing her housing need. Jane settles in for another night knowing that permanent housing options could be on the horizon.

EHR documentation and SSRL referrals help prevent retraumatizing patients by limiting the number of times they have to repeat their stories.



The following day, a representative from the housing agency contacts Jane to arrange an appointment and complete an application. Jane will be placed on a waitlist for a housing program.

Jane sees Dr. Cruz two weeks later for a follow-up appointment.

Because the referral for housing assistance was made through the EHR-integrated SSRL, Dr. Cruz can see that Jane has had contact with the housing agency. She is relieved to hear that Jane submitted an application and is on a waitlist for permanent housing.

Recent studies have found that higher perceived clinic capacity to address patients' social needs is associated with lower burnout in primary care providers.