SIREN Webinar April 18, 2019: *Community resource referral platforms - Lessons from early health care adopters*

Remaining Q&A

Overall questions to co-presenters:
1. How do you vet the validity of each service agency's offerings? i.e., can they deliver what they say they do?
2. How do you keep the referred resource information updated?
3. How have different organizations done the initial outreach to potential clients? And what kind of uptake are you seeing?
4. What kind of technical assistance was offered to "network participants" who provide social services in order to implement these tools?
5. For community-based organizations, how do you address those who are not ready to engage in the platform?
6. How (or are) you gathering client satisfaction data from network participants to assess quality of services/experience?
7. Are either of you looking at health disparities using these systems?

Questions directed to Alliance for Better Health:
1. What were the key objectives, goals and tasks that the RFP wanted an applicant to respond to?
2. What kind of community-level data/reporting is happening?
3. In what ways were patients (/clients) involved in the design of the network and its policies? Can patients access the information, referrals, and communications related to them? Do community residents have access to information and data (in aggregate /
4. Are the hospitals providing the data necessary to prove ROI?
5. Are the community-based organizations receiving any reimbursement for services provided either by Medicaid billing and/or the hospitals from their DSRIP funding?

Questions directed to SIREN:
1. Are there plans to evaluate additional platforms?
2. What recommendations can you provide regarding how to integrate collection of SDoH data into clinic workflow in a way that is both efficient and respectful of our patients?
3. For recommendation 3, can you talk a bit more about how you help the health centers think through the ideal users for the tool? Did they need support figuring that out?
4. If the platforms were all to use common protocols for data exchange (like FHIR for personal information, and Open Referral for resource information) then why would a community need to reach collective consensus to all use one single platform?
5. For evaluating the impact, are CBOs gaining access through these systems to health outcome data to be able to measure their impact on health outcomes? or to better demonstrate how addressing SDOH needs impact health outcomes?

Overall questions to co-presenters:

1. How do you vet the validity of each service agency's offerings? i.e., can they deliver what they say they do?

   Alliance for Better Health:
   The organizations that participate in the Healthy Together referral program submit their program description, service offerings and program eligibility criteria using a standard registration template. Organizations must identify their point of contact, website, email and phone numbers which are used to validate the information submitted to create the organization profile. Referral rejections are monitored on an ongoing basis to ensure that program descriptions and eligibility information is accurate.

   Participant registration information includes:
   a. *Service type (based on a preset list of 20 types and several sub-types)*
   b. *Locations*
   c. *Geographical coverage*
   d. *Hours of operation*
   e. *Populations served*
   f. *Program eligibility criteria*
   g. *Required documentation for participation*

   Brazos:

   We only add information to the network for those who offer a "benevolence" service to benefit low income customers, whose information is published by the organization itself either in brochures or website or both. We meet with these representatives in person, discuss their organization listing, make adjustments, and then add that information to the network. Many of the non-profits periodically go through funding gaps where they are unable to serve. Most of the organizations on our network are well known and have offices in the local area, and have been operating for at least a year.

2. How do you keep the referred resource information updated?

Alliance for Better Health:
Healthy Together participating organizations are responsible for keeping their system profiles updated. The Solutions support teams send regular reminders to the participating members to validate their profiles. We routinely analyze the data and use this to identify unresolved or rejected referrals due to inaccurate services profiles. In that event, we contact the participating organization to update their information to mitigate any further discrepancies.

Brazos:
It is a continual process of collecting and updating as we acquire information. The members themselves can edit their own agency descriptions, or they call us at any time to make changes to the information in the services listed.

3. How have different organizations done the initial outreach to potential clients? And what kind of uptake are you seeing?

Alliance for Better Health:
The launch for Healthy Together was introduced to the Alliance for Better Health established partners in a series of community meetings and system demonstrations and educational sessions. Based on user feedback, the Healthy Together network was 'opened up' and additional social care organizations and clinical partners were added to the program. Additionally the network model was changed to permit direct organization to organization referrals. By permitting direct referrals, system utilization increased exponentially, and our existing partners started to introduce new participants to the network. Alliance and our Unite Us Account Manager work collaboratively to outreach and onboard new program participants.

To further expand the reach of the network, we partnered with the Adirondack Health Institute (AHI) to expand the network to an additional 9 counties in Northeastern New York State.

Alliance expanded the program to include Circulation (a transportation solution) and City Health Works (community health coaches) that stimulated additional user participation. Strategically, we removed the license restrictions and are actively recruiting new partners through targeted community outreach.

Brazos:
The organizations have their own methods for intake and outreach to people; in most cases the individuals themselves are seeking services. In the case of the Brazos Health Resource Center, we are in the center where many other services are also located, and we receive referrals from other organizations/members in the network all the time.

4. What kind of technical assistance was offered to "network participants" who provide social services in order to implement these tools?

Alliance for Better Health:

The Healthy Together platform is cloud-based and can be accessed from any browser. Training is available in group classes, on-line, and in-person. The Alliance for Better Health provides one-on-one training through a dedicated care coordinator that will work with the social care organizations to ensure system access. If a technical issue arises, the Alliance for Better Health information services team will assist with troubleshooting as needed.

Brazos:

Network members are offered a demonstration, a user guide which was custom-written for our network, and help loading their agency descriptions into the network. As administrators, we are able to customize several aspects of the software to accommodate special service descriptions, including service categories. Our office manager makes herself available to users at any time to answer questions. Beyond that, the software company, Simon Solutions, has to take care of it.

5. For community-based organizations, how do you address those who are not ready to engage in the platform?

Alliance for Better Health:

The Alliance for Better Health has dedicated community relations specialists that meet monthly with our social care organizations and participate in various community events. Barriers to adoption are addressed collaboratively until such time that the organization is positioned and comfortable participating in the Healthy Together Program. Once on-boarded to the system, a dedicated care coordinator provides one-on-one training to ensure a successful integration of the program into the organization's workflows. The Healthy Together Program also includes a Coordination Center to help remove some of the administrative burden from organizations.

Brazos:

We continue periodically to offer membership to those who are not yet in the network, via direct contact or via community network meeting opportunities to issue invitations.

6. How (or are) you gathering client satisfaction data from network participants to assess quality of services/experience?

Alliance for Better Health:

The Alliance for Better Health hosts monthly Healthy Together Community user meetings and has assigned partner success managers to obtain feedback during monthly check-in visits. Our Unite Us account specialist participates in these interactive sessions to address system specific questions. Our Healthy Together Solutions team provides best practices and collects feedback directly from the user community. The feedback is aggregated and disseminated into the product roadmap, user communications and training.

Brazos:
At this time, we are not polling on the satisfaction / quality /experience.

7. Are either of you looking at health disparities using these systems?

Alliance for Better Health:
The Alliance for Better Health uses the data from their Healthy Together referral program in conjunction with clinical encounter and medical claims data to develop risk stratification models and determine the value of the social intervention on overall health outcomes.

Brazos:
At this point, HIPAA compliance in our network does not allow us to enter information which is related to diagnoses. We are able to connect and refer people to other organizations who are network members. Most entities have their own intake process, and are resistant to additional data collection processes being added. Our network is geared toward meeting social determinant needs.

Back to top

Questions directed to Alliance for Better Health:

1. What were the key objectives, goals and tasks that the RFP wanted an applicant to respond to?
   - *Security*
     - *HIPAA compliant platform*
     - *Integrated consent*
     - *Roles based permissions*
     - *Audit capabilities*
   - *Cloud-based solution*
   - *Care Coordination functions*
     - *Closed loop referrals*
     - *Pre-defined assessments*
     - *Standard data capture for client demographics*
     - *Workflow management*
   - *Accountability*
     - *Consistent Data collection,*
     - *Network performance reporting*
     - *Data extraction*
     - *User dashboards*
   - *Support*
     - *Network development assistance*
     - *Partner on-boarding support*
     - *Online and in-person training options*

- *Disaster recovery*
- *System maintenance administration*
- *Auditing and performance reporting*

2. What kind of community-level data/reporting is happening?

   Healthy Together provides a robust set of user dashboards at the network and organizational level. These dashboards include the aggregate number of referrals by organization, status breakdown to facilitate follow-ups, services profiles, geographical map for all participating organizations, network services profiles, and care coordination case load at individual level.

   The Alliance for Better Health is also able to extract the data and perform analytics across disparate data sets to identify gaps in care and develop key performance indicators (KPI's) to foster network growth an organizational success for our partners.

3. In what ways were patients (/clients) involved in the design of the network and its policies? Can patients access the information, referrals, and communications related to them? Do community residents have access to information and data (in aggregate / deidentified) from the network?

   The Alliance for Better Health held a series of informational meetings with our established partners to gather input on their organizational needs based on the populations served. Due to confidentiality considerations, we developed needs profiles based on the individuals served by our partners rather than speak directly with the individuals receiving services. Under the initial implementation, all referrals went through a coordination center to track the types of services available and the individual's needs. From this data, we were able to modify the network model to support direct provider to provider referrals that has effectively reduced the gaps in care and increased network utilization.

   We do not provide reports on the individual level. Individuals work with their care coordination team to facilitate access to services and communicate referral status.

   Participating organizations can access dashboards and generate reports directly from the network platform. The Alliance for Better Health tracks network performance and provides communications back to the community through various public events as well as directly to the partners via our Community Relations and Care Coordination teams.

4. Are the hospitals providing the data necessary to prove ROI?

   The Alliance for Better Health as a Participating Provider System under DSRIP has access to the adjudicated Medicaid claims for member organizations in their network. This data can be used in conjunction with the Healthy Together referral data to develop algorithms that

quantify the value of the interventions to meet social needs and reduce overall emergency room utilization and preventable admissions/ readmissions.

5. Are the community-based organizations receiving any reimbursement for services provided either by Medicaid billing and/or the hospitals from their DSRIP funding?

   Alliance for Better Health participating community-based organizations qualify for incentive funds under DSRIP if they meet the prescribed quality metrics based on their services and populations served. Key objectives under DSRIP include an overall reduction in emergency room visits and preventable admissions/readmissions. The Healthy Together referral program facilitates coordination across social care organizations to identify and address underlying social needs that impact an individual's health. These interventions have been shown to meet the DSRIP goals of overall reduced emergency room utilization, increase access to primary care, and improve the outcomes for individuals with asthma, diabetes, and hypertension.

[Back to top](#)

Questions directed to SIREN:

1. Are there plans to evaluate additional platforms?

   Not at this time. We would love to but don't have the resources to keep up with the field.

2. What recommendations can you provide regarding how to integrate collection of SDoH data into clinic workflow in a way that is both efficient and respectful of our patients?

   There is no one size fits all approach. There are a number of studies that have examined different social risk screening processes ([1](#), [2](#), [3](#), [4](#), [5](#), [6](#)). The National Association of Community Health Centers (NACHC) has [an implementation toolkit](#) for their social risk screening tool (PRAPARE) which includes steps you can take to determine what kind of workflow integration might best in your setting. We also want to highlight one patient-centered approach called Empathic Inquiry ([OPCA resource](#)). See our collection of [implementation resources](#) for more implementation guidance, especially on food insecurity screening.

3. For recommendation 3, can you talk a bit more about how you help the health centers think through the ideal users for the tool? Did they need support figuring that out?

   The ideal users for the platform will depend on what intervention(s) the tool is intended to support. If the intervention is already being implemented, that determination is fairly straightforward, but if this represents a new area of

activity for the health center, our informants' experiences would suggest that the intervention should be designed first.

4. If the platforms were all to use common protocols for data exchange (like FHIR for personal information, and Open Referral for resource information) then why would a community need to reach collective consensus to all use one single platform? Why couldn't key outcomes still be achieved when different stakeholders select different platforms if those platforms can share data through interoperability?

    We agree wholeheartedly that there is a great potential for improved interoperability to mitigate many of the problems emerging from the use of multiple platforms in a given geographical area (see p. 39 of our report). The conversations around interoperability between platforms have grown exponentially in the months since we interviewed our informants and so we are hopeful that we may reach a point when easy exchange of information between platforms facilitates use of different platforms in the same geographic area. That being said, interoperability between EHRs has been much harder to implement than desired, despite years of effort so we may not get to full interoperability. And there are other benefits to organizations in a given area reaching consensus on a platform. For example, there may be financial benefits derived from being able to negotiate network pricing. The collaboration process for a platform may strengthen an existing partnership or it may be the first opportunity for typically competing organizations to work together. The search for a community-wide solution may also allow other non-health care sectors to emerge as major stakeholders.

5. For evaluating the impact, are CBOs gaining access through these systems to health outcome data to be able to measure their impact on health outcomes? or to better demonstrate how addressing SDOH needs impact health outcomes?

    We didn't specifically ask our informants about CBOs' access to health data. We agree that that would likely be very helpful to CBOs and would encourage health care organizations to provide that access. That might be one way to make using the platform valuable for CBOs.

6. Can you speak to security? Was it something that you asked about for each company or service provider? How good are these systems are in being prepared for hacking?

    We asked each vendor about data security and confidentiality as these often go together. See the vendor profiles in Appendix F of our guide (pp.53-96).

7. How are organizations funding platforms?

Among our informants, most were funding through grants, internal funds, and/or value-based initiatives (see p.31 of our guide). Many also hoped that value-based initiatives or incentives would help fund the platforms more sustainably in the future.

8. What is the typical payment model for these platforms?

    We asked each vendor about their cost structure. See p.18 of our guide for the side-by-side comparison. Note that there can be flexibility offered by the vendor for per member per month (PMPM) vs per user licenses vs network pricing.

9. What is the current thinking of how EMRs are involved?

    The platform vendors in our guide are developing ways of exchanging data and creating seamless interfaces with EMRs (pp.25-26 of our guide) but EMR vendors are also building out their own functionalities in this space (p.37 of our guide).

10. Which SDoH screening tools are being used?

    Among our informants, no one screening tool predominated. Many had built their own tools by combining questions from several tools. See the SIREN [screening tool comparison tables](#) to learn more about commonly used social risk screening tools.

[Back to top](#)