Community resource referral platforms - Lessons from early health care adopters

SIREN Webinar

April 18, 2019

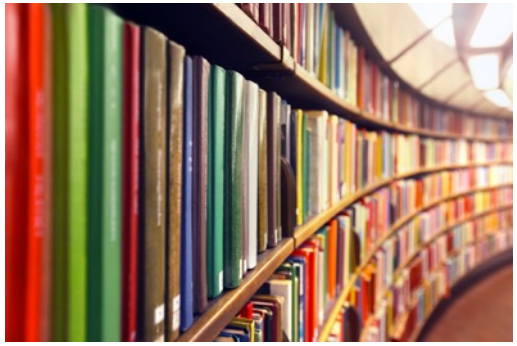
UCSF

Social Interventions Research & Evaluation Network

SIREN's mission is to catalyze and disseminate high quality research that advances health care sector efforts to improve health equity by addressing social risks.

Activities include:

Catalyzing and conducting high quality research



Collecting & disseminating research findings

Providing evaluation, research & analytics consultation services

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Evidence Library

This Evidence Library contains research articles, issue briefs, reports, and commentaries that either focus on or are relevant to evaluating health care-based interventions that address patients' social and economic needs. We prioritize for inclusion resources that carefully describe and evaluate the social needs components of these interventions, and to a lesser extent those where the social components are mentioned but are not the primary focus of the work. The library currently includes only papers published since the year 2000. If you are aware of a resource you think should be added to our Evidence Library, please let us know.

To receive monthly alerts of recent additions to the Evidence Library sign up to receive our newsletter.

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Community Resource Referral Platforms: A Guide for Health Care Organizations
Y. Cartier, C. Fichtenberg, L. Gottlieb
SIREN
Health care organizations are increasingly seeking to document patients' social and economic needs and facilitate relevant referrals to social service organizations.

PUBLICATION YEAR: 2019
RESOURCE TYPE: Issue Brief/Report
STUDY DESIGN: Qualitative

Automatically identifying social isolation from clinical narratives for patients with prostate cancer
V.J. Zhu, L.A. Lenert, B.E. Bunnell, J.S. Obeid, M. Jefferson, C.A. Hughes-Halbert
BMC Med Inform Decis Mak
Background: Social isolation is an important social determinant that impacts health outcomes and mortality among patients. The National Academy of Medicine recently recommended that social isolation be documented in electronic health records (EHR).

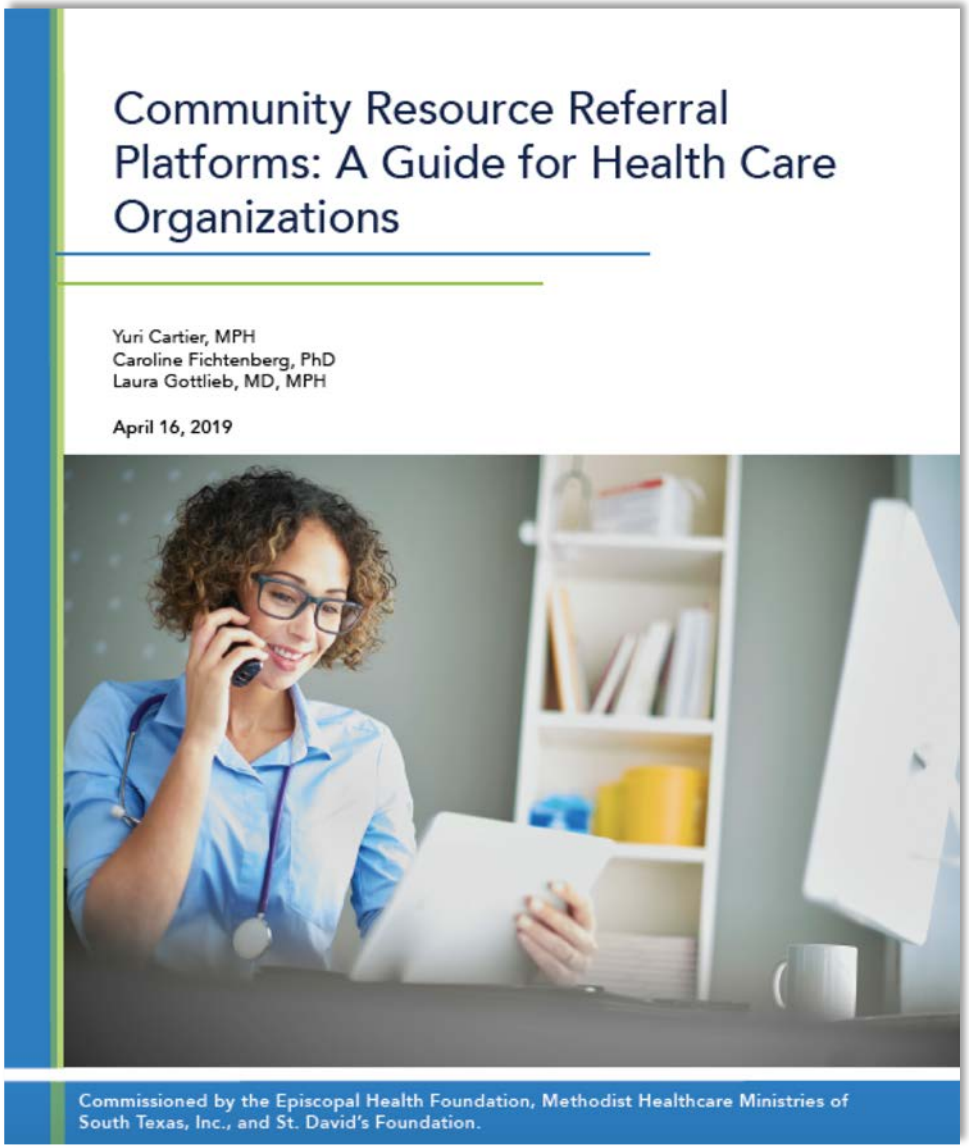
PUBLICATION YEAR: 2019
RESOURCE TYPE: Journal Article
STUDY DESIGN: Observational

Impact of risk stratification on referrals and uptake of wraparound

PUBLICATION YEAR:

How to use ReadyTalk to ask questions

This webinar will be recorded; the recording and slides will be made available in the coming days.



Thank you to our funders

Episcopal Health Foundation

Methodist Healthcare Ministries of South Texas, Inc.

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Our speakers today

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Managing Director
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Episcopal Health Foundation

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Research Associate
SIREN

Pat Schoenemann
Director
Brazos Health Resource Center
CHI St. Joseph Regional Health Center

Kristen Scholl
VP Population Health
Alliance for Better Health

Lori Petersen
Senior IT Business Analyst
Alliance for Better Health

Poll Question #1

Where do you work?

Safety net health care organization

Other (non-safety net) health care organization

Social service organization or community-based organization

Research institution

Capacity building and technical assistance organization

Technology company

Other

Disclaimer

This webinar does not constitute a product endorsement or recommendation by the University of California, San Francisco (UCSF), Social Interventions Research and Evaluation Network (SIREN), Episcopal Health Foundation, Methodist Healthcare Ministries of South Texas, Inc., or St. David's Foundation.

Community Resource Referral Platforms: A Guide for Health Care Organizations

Webinar
April 18, 2019

Yuri Cartier, MPH
Caroline Fichtenberg, PhD
Laura Gottlieb, MD, MPH

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Poll Question #2

Is your organization in the process of implementing a community resource referral platform?

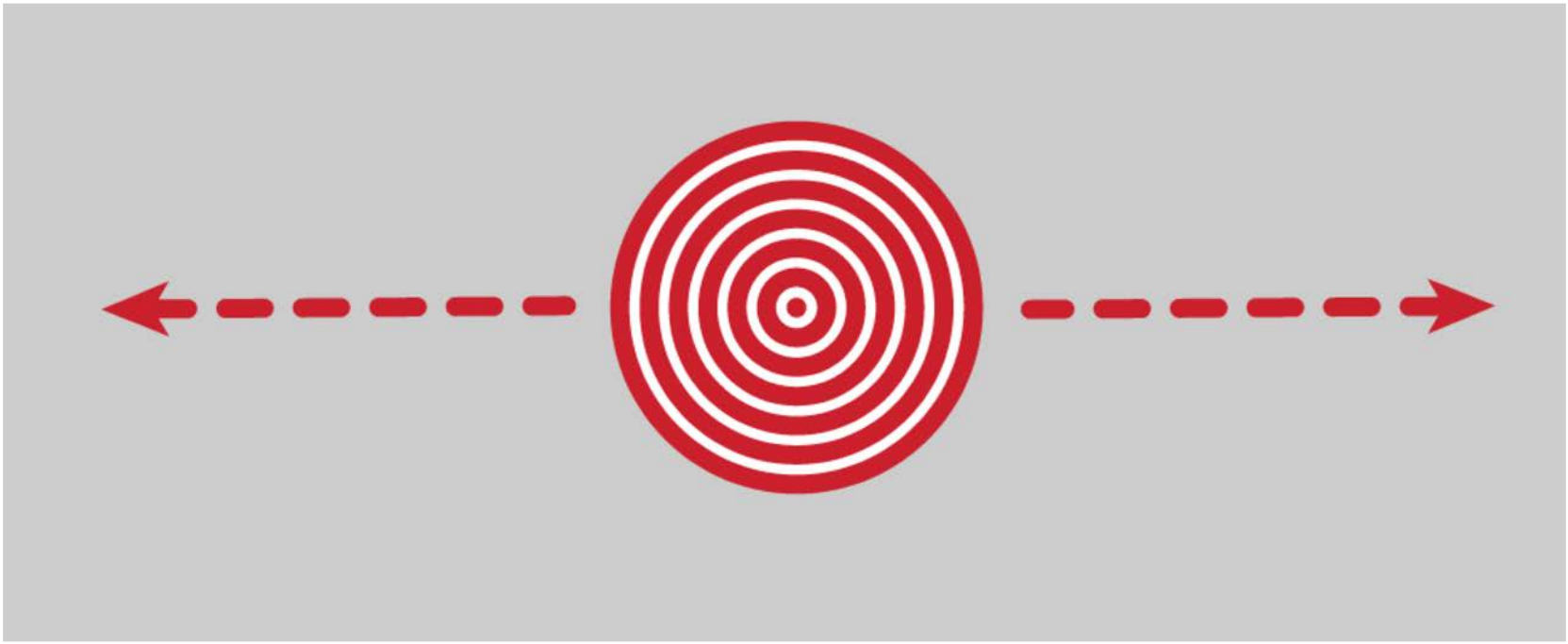
- Yes, we're currently using a platform
- No, but we may in the future
- Not applicable to our organization

Our Goal

To explore the market of community resource referral platforms and learn about the experiences of health care organizations implementing a platform.

Project Activities

1. Reviewed commonly used platforms
2. Interviewed users about their experiences using these platforms



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Nine platforms in our review

Key Functionalities

A searchable, regularly-updated resource directory

+

A referral management system that enables closed-loop referrals

Key Functionalities

+

A searchable, regularly-updated resource directory

A referral management system that enables closed-loop referrals

Other Functionalities and Characteristics:

Key Functionalities

A searchable, regularly-updated resource directory

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HIPAA/
Data security

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Key Functionalities

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+

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Other Functionalities and Characteristics:

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Systems integration

Social risk screening

Care coordination

Reporting & analytics

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Key Functionalities

A searchable, regularly-updated resource directory

+

A referral management system that enables closed-loop referrals

Other Functionalities and Characteristics:

HIPAA/ Data security

Systems integration

Social risk screening

Care coordination

Reporting & analytics

Vendor responsiveness

Key Functionalities

A seamless, regularly-updated resource directory

A referral management system that enables closed-loop referrals

$$$

Other Functionalities and Characteristics:

HIPAA/ Data security

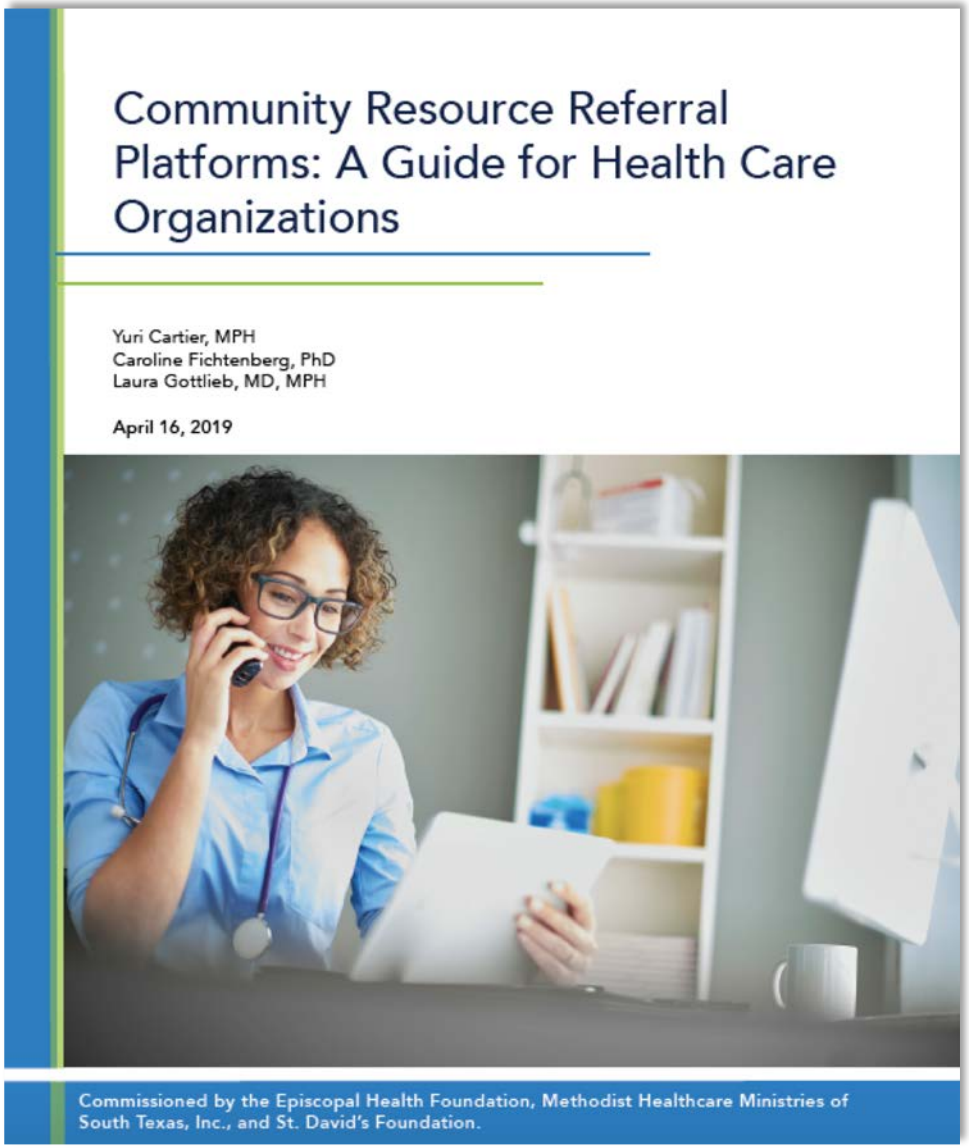
Systems integration

Social risk screening

Care coordination

Reporting & analytics

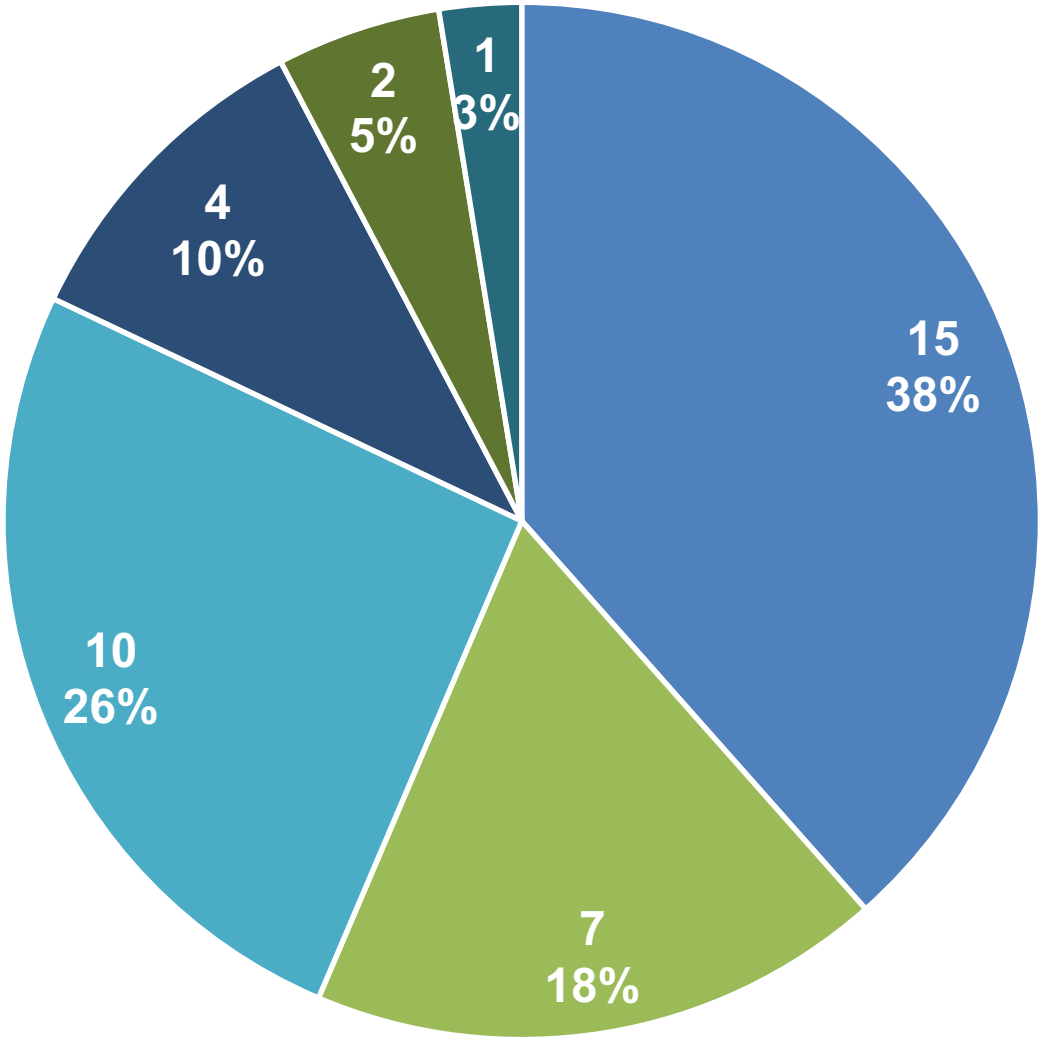
Vendor responsiveness



In our guide:

- Side-by-side comparison table of platform features and functionalities (pp.16-18)
- Platform profiles (pp.52-96)

Organization Type (N=39)



- Hospital/system
- Place-based care transformation or health improvement initiatives
- Health centers/health center networks
- Social service agencies
- Health information exchanges

Main takeaway from users

Implementation is slower and more complicated than anticipated, especially with community partners

Recommendations

1. Engage community partners from the beginning

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"Before you start, make sure your community partner is willing to actually be a recipient of that type of referral. If they're invited to the table early on, it helps them to understand really what's being asked of them. [...] Engage your partners early on and ask them what their concerns are before telling them what you want to do."

Recommendations

2. Examine what already exists in the community

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"If I were to do this all over again, I think I would bring key stakeholders from all hospitals across the state to the table, with our community stakeholders, and together figure out what collectively would be the best one, 'go slow to go fast' so that everybody is using that same thing."

Recommendations

3. Have a clear understanding of your goals and needs

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"The health centers that have really thought about their care model, and who on the care team is allocated to be addressing social and economic factors, have a better time adopting the tool, because they've thought through some of the larger system and workforce issues."

Recommendations

4. Don’t assume that if you build it they will use it

Recommendations

4. Don’t assume that if you build it they will use it
5. Evaluate the impact and share your learnings

Other approaches

- EHR vendors

Other approaches

- EHR vendors
- Community information exchanges

Other approaches

- EHR vendors
- Community information exchanges
- Pathways HUB Model

Other approaches

- EHR vendors
- Community information exchanges
- Pathways HUB Model
- Increasing interoperability


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considered
non-binding
decisions
analyses
design

Brazos Health Resource Center

COMMUNICATION, COORDINATION AND NETWORKING

Presented by: Patricia Schoenemann, Director

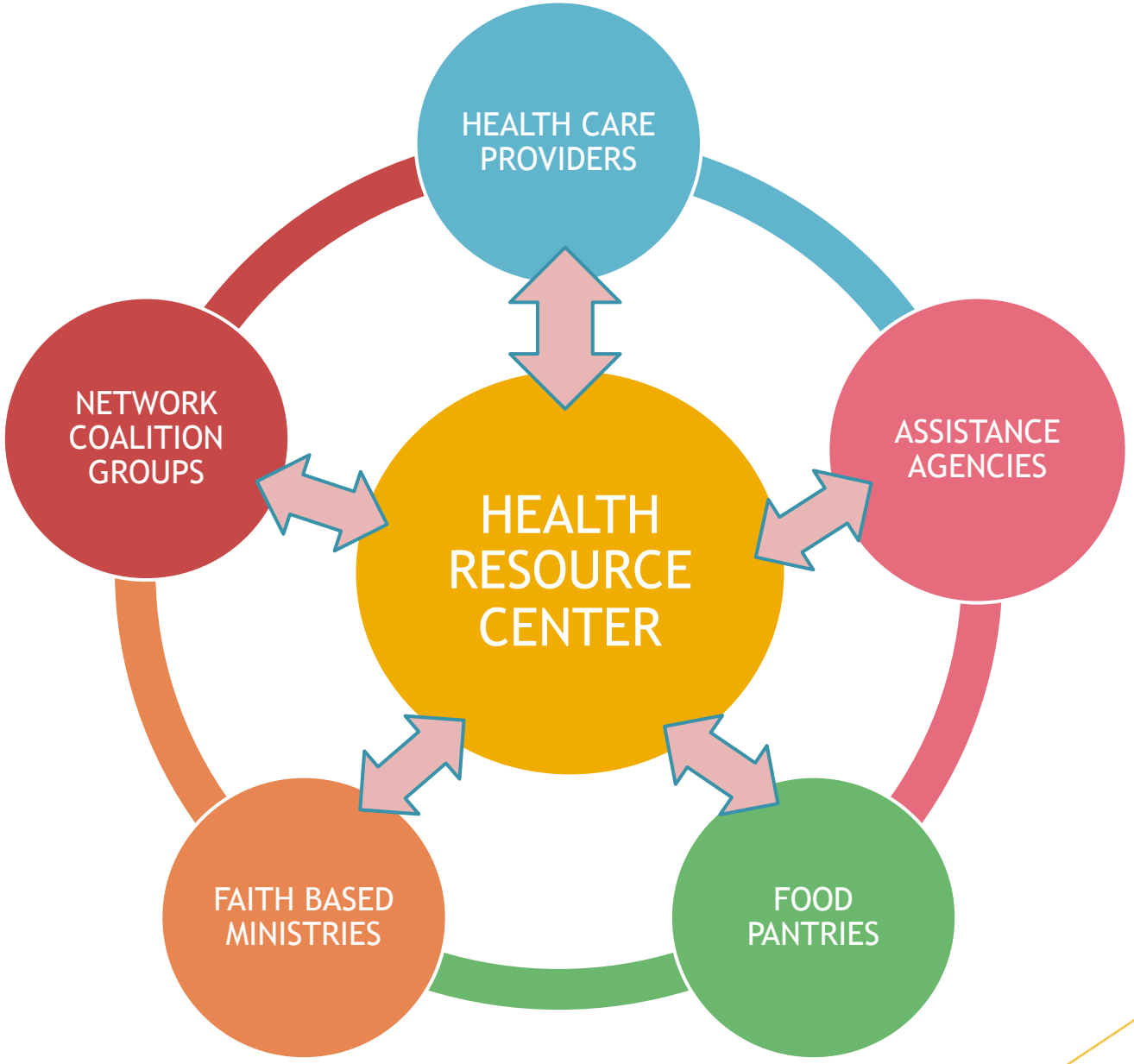
WHAT IS A HEALTH RESOURCE CENTER?

- A **local** community center
- Coordinates, communicates, and assesses situations for community residents in need
- Provides information, referral, application assistance, and material assistance to meet needs
- Offers meeting place for agencies headquartered outside of the county to hold appointments or meetings with county residents
- Hosts educational sessions available to local citizens
- A Community Resource Coordination Group (CRCG) facilitator and participant

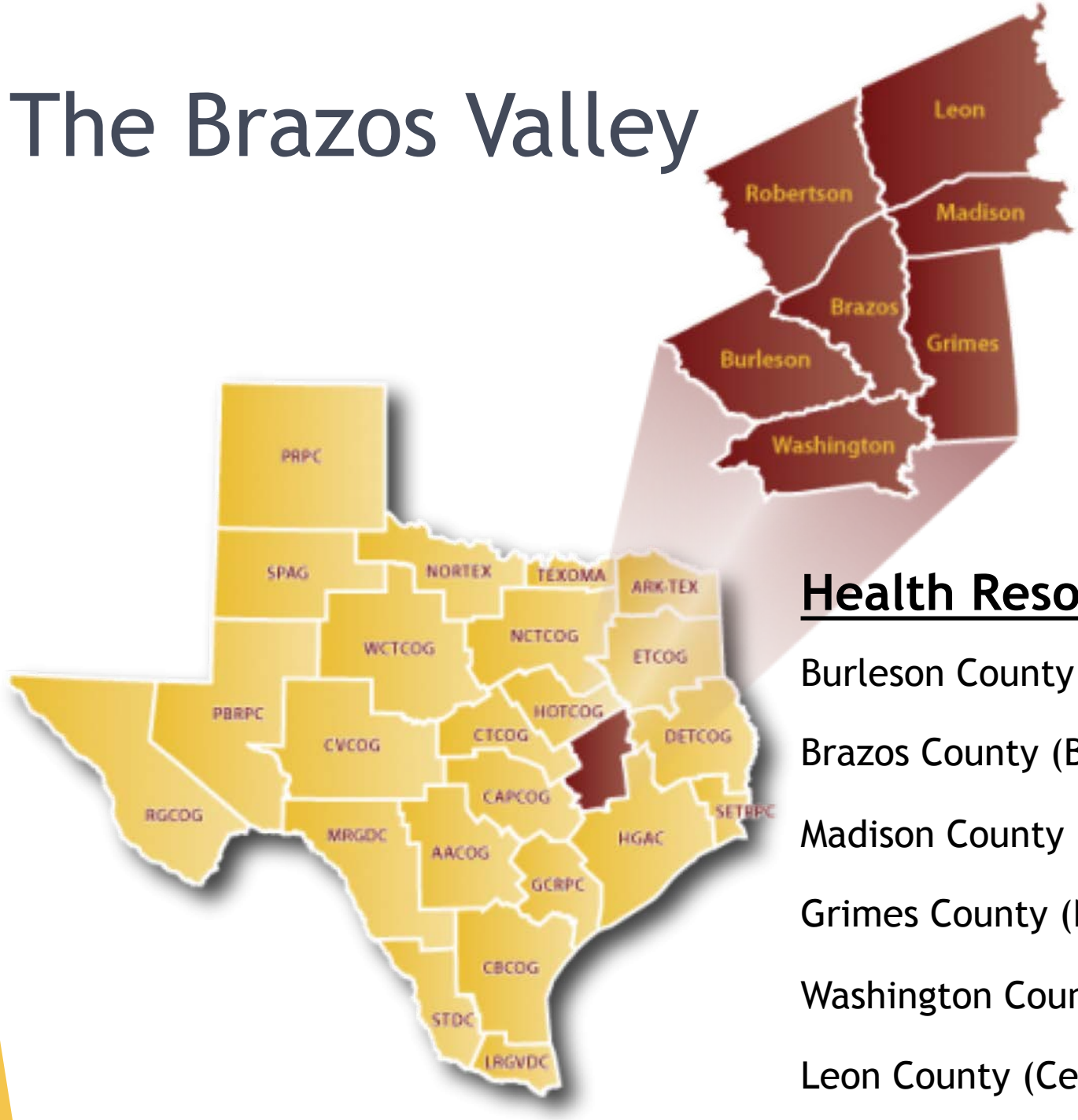
The attitude of the Health Resource Center when someone calls or comes in is always:

"You've come to the right place! If we don't know it, we will find out about it together!"

COMMUNITY ASSISTANCE NETWORK MATRIX



The Brazos Valley



Health Resource Center Locations:

Burleson County (Caldwell & Somerville)

Brazos County (Bryan & College Station)

Madison County (Madisonville)

Grimes County (Navasota)

Washington County (Brenham)

Leon County (Centerville)

Brazos Valley CharityTracker Network

Brazos Health Resource Center

Network Administrator

Brazos Valley CharityTracker Network

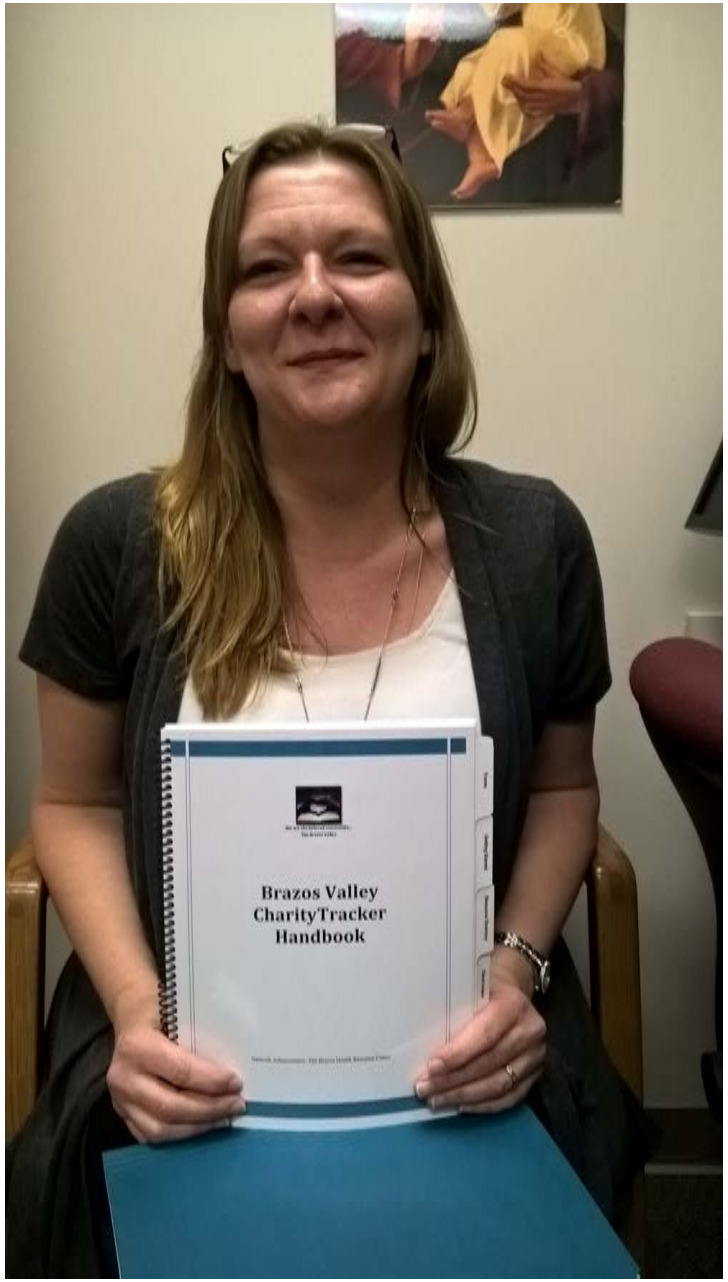
- Resource information pre-loaded on the service agencies, non-profits, churches in the 7-county Brazos Valley area
- Access provided to members at no cost
- Release of Information mandatory for client record to be entered
- Minimization of detail to maintain HIPAA compliance
- Continuous, ongoing updates of services and agency information

Brazos Valley CharityTracker Network

- Demonstrations at Brazos Health Resource Center or at the prospective member's location
- Immediate response from our in-house expert to answer questions, solve issues, correct errors or add information
- Each agent receives a handbook created specifically for the Brazos Valley CharityTracker network as a user guide

I wrote a book!

Shawndel Blakemore



Example Bulletins

Connected to Miracles

BACKGROUND

- 6 weeks of daily outpatient treatment needed after weeks in hospital
- No financial support, no insurance, no car, no family nearby, no in-town friends, no money, no income, no benefits of any kind

PLEASE FIND

- Free or Cheap room and board for 6 weeks plus daily transportation to the hospital for therapy to successfully complete her treatment plan

SOLUTION:

- Local shelter consented to accept her 6-wk stay; local St. Vincent de Paul funded the weekly $55 Fair Share Rent ($330); local Baptist Church funded the weekend taxi transportation cost (public transit buses run M-F) ($300); bus passes for six weeks of M-F round trips ($90) funded by an Episcopal Church; oral prescription med also covered ($25)
- Total funding required to complete treatment as outpatient: $715

LESSONS LEARNED

Initially there were limits to the number of members covered under the subscription fee: the membership costs beyond that slowed the join up process;

Covering a large geographic area is challenging to reach out to remote organizations to join as members;

Switching or adding a new data process is a hurdle for most established resource organizations.

Alliance
FOR BETTER HEALTH

Healthy Together powered by Unite Us

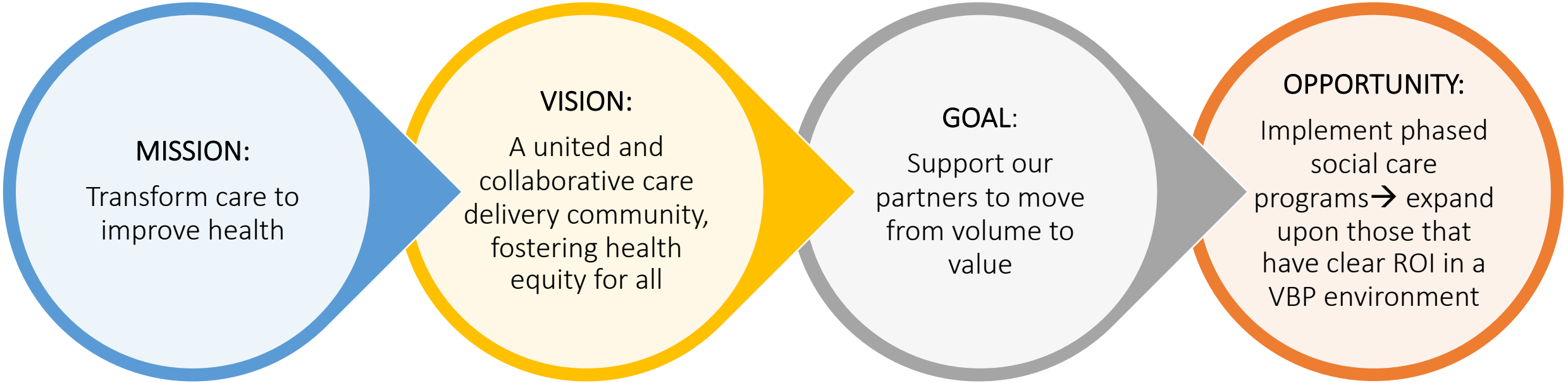
SIREN Webinar

April 18, 2019

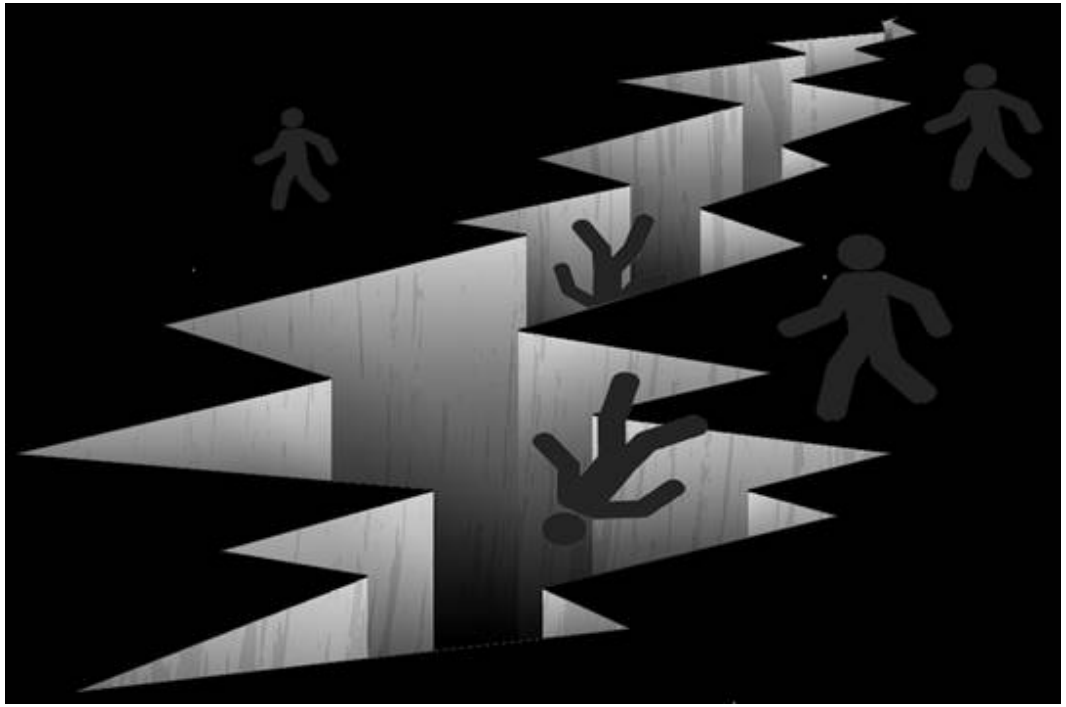
Agenda:

- Who we are
- Why Unite Us
- Overview of Healthy Together
- Post Launch Optimization
- Use Case
- What's working

ALLIANCE FOR BETTER HEALTH



The Opportunity:



The Process:

Identify the problem

- Absence of infrastructure to manage referrals
- No shared documentation tool, poor communication, no data collection
- Time consuming, cumbersome referral processes
- No accountability for referral outcomes – clients are falling through the cracks in the system

Issue an RFP

- Buy versus Build
- Issued an RFP – analyzed results
- Hosted an Innovation Summit

Select a vendor

- Review options with Alliance IT Committee and Board
- Selected Unite Us!
- Technology platform and Coordination Center model met our needs
- Includes basic elements of a care coordination platform for agencies that need it

Why Unite Us?

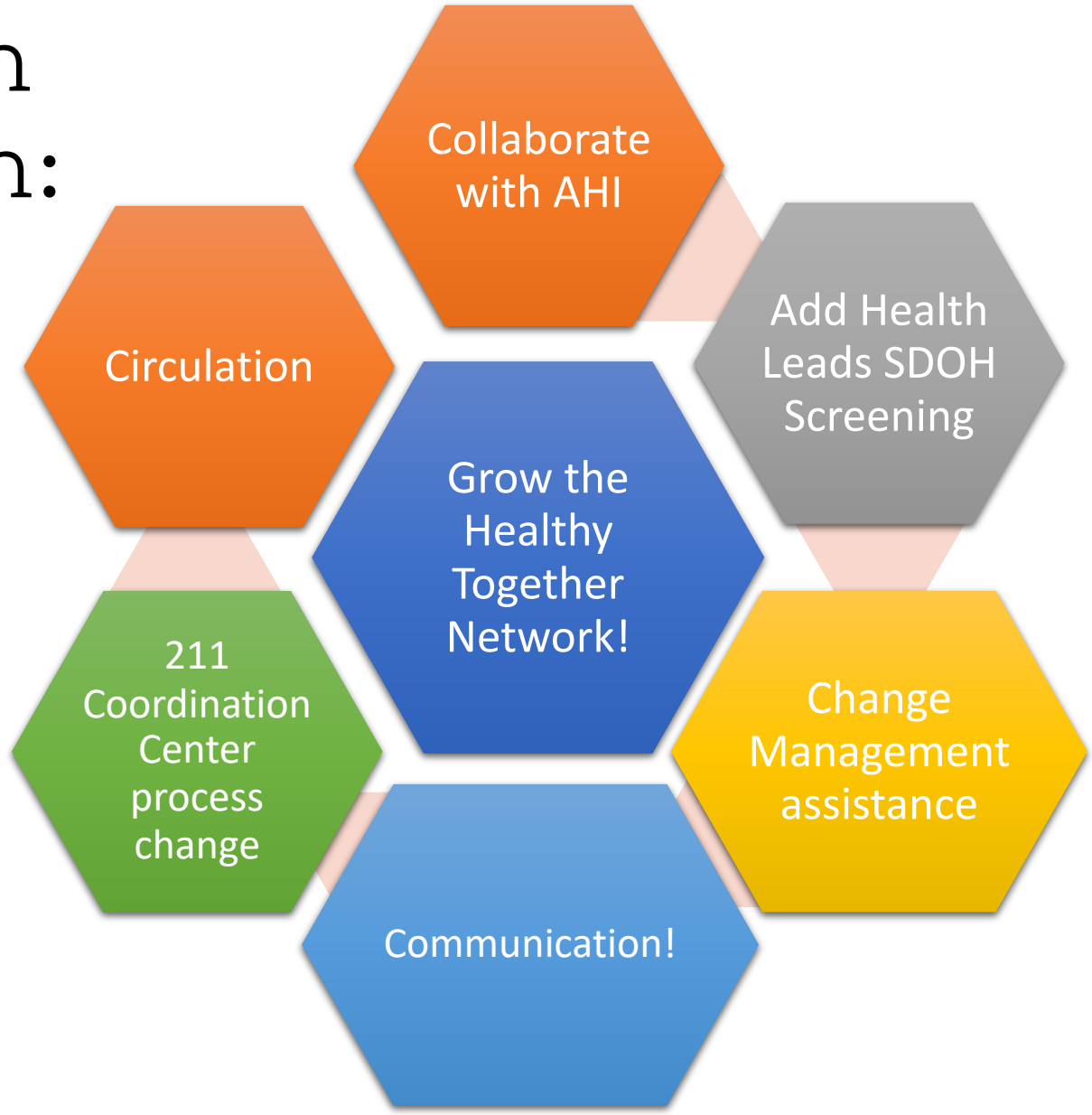
Technology infrastructure powering a coordinated network of health and social care providers

- ✔ Secure HIPAA compliant platform
- ✔ Client matched with eligible providers and programs
- ✔ Accountability around every referral sent
- ✔ Client's information is captured once and shared on their behalf to recipient organizations through electronic referrals.
- ✔ Service providers have insight into the entire client's entire journey
- ✔ Community-wide data is tracked to allow for informed decision making by community partners to address needs.

Introducing Healthy Together!

Remember when we used to send referrals by fax or phone……

Post Launch Optimization:

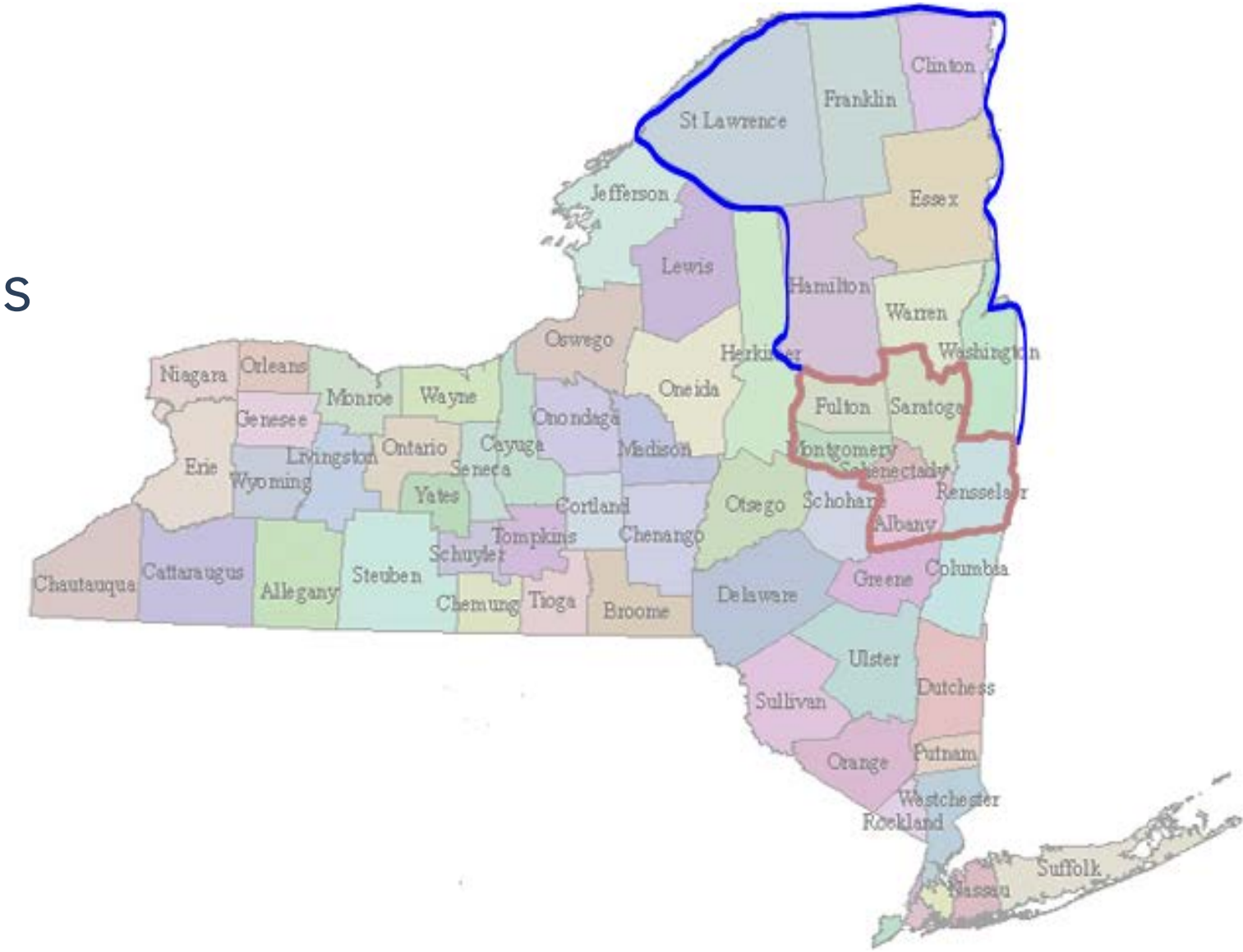


Combined Network:

Healthy Together &
ADK Wellness Connections

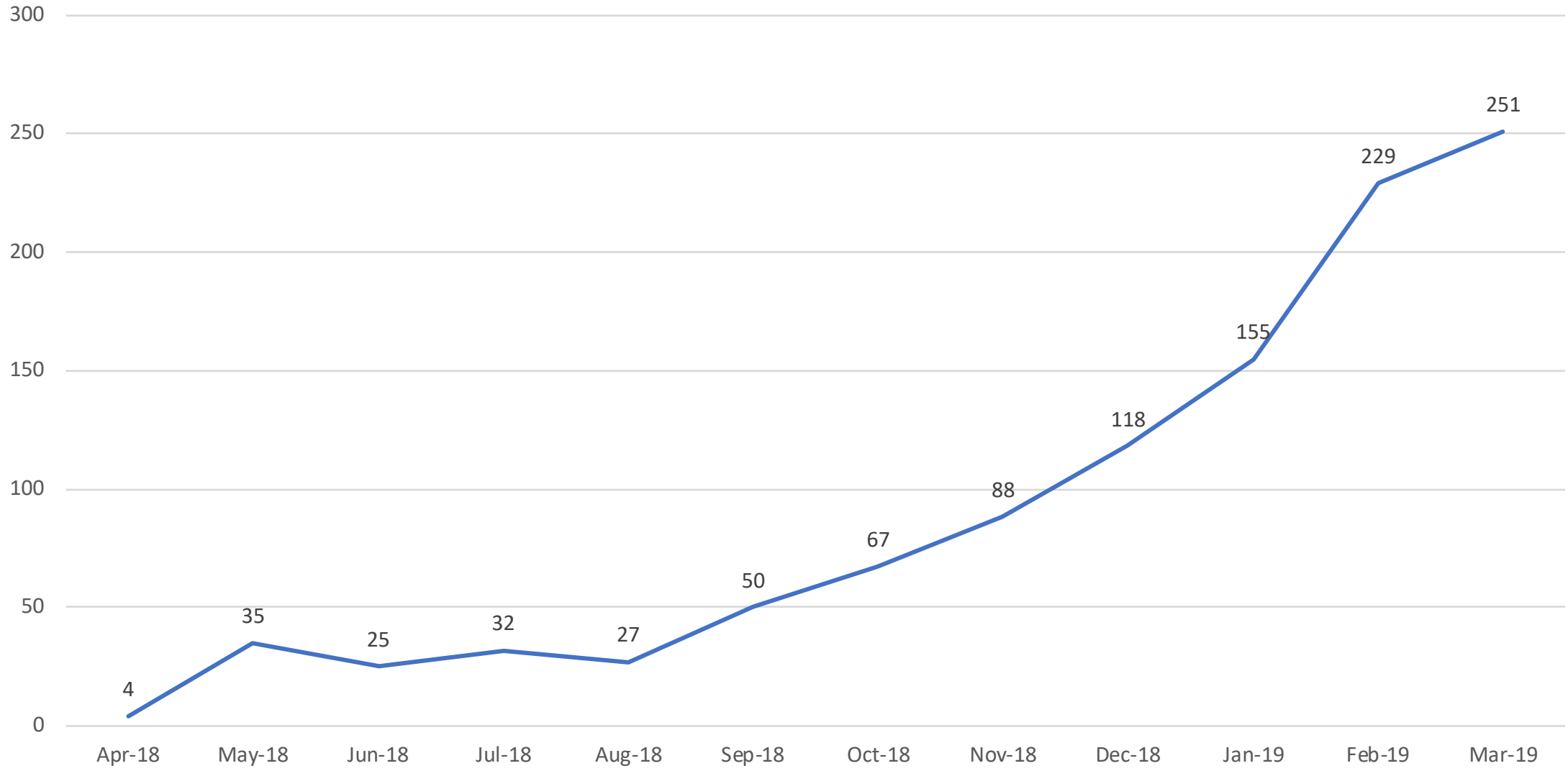
200 Organizations across
13 counties

And growing!!



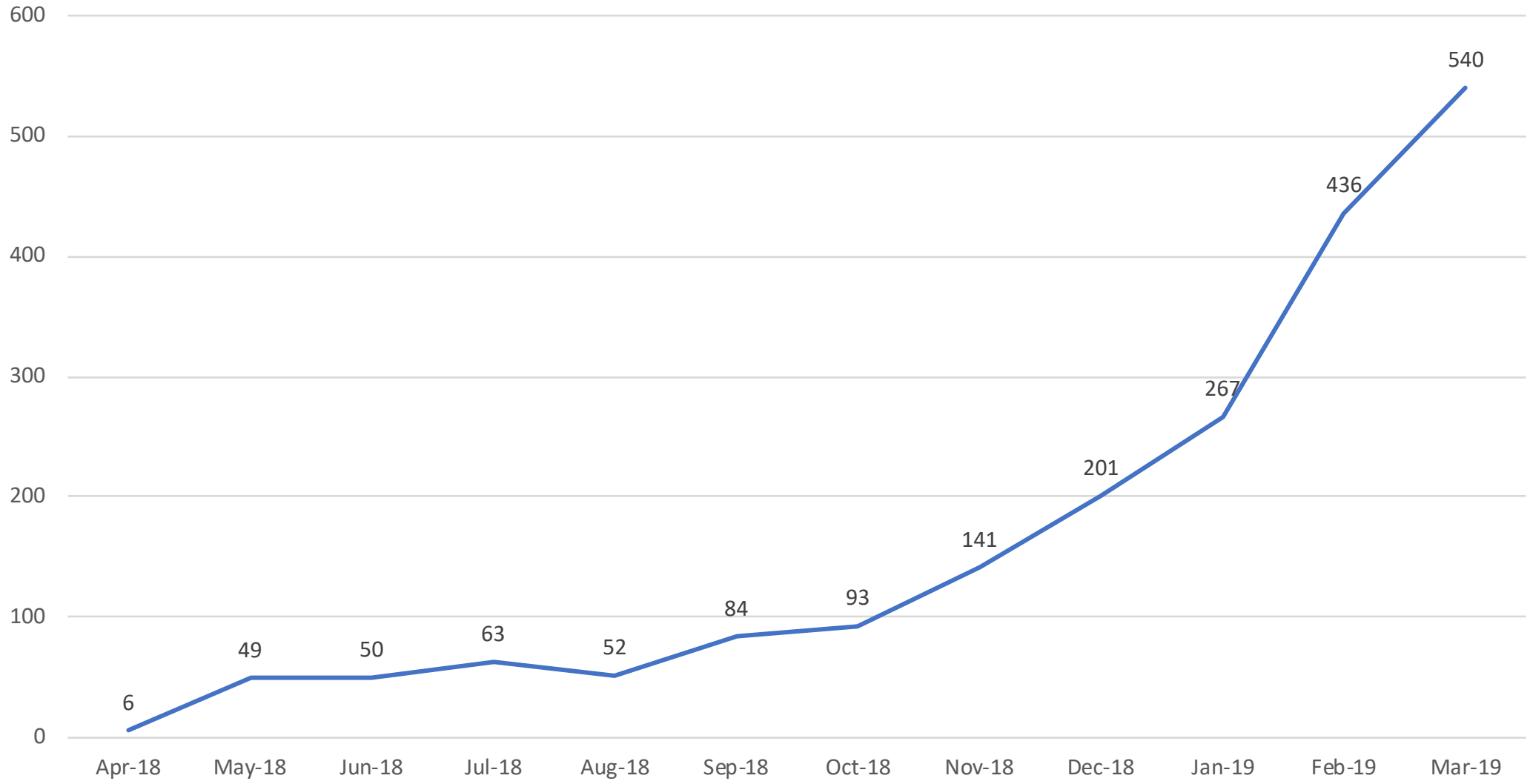
Clients Served by Month (1,265 Clients Served)

We Continue to Grow Healthy Together

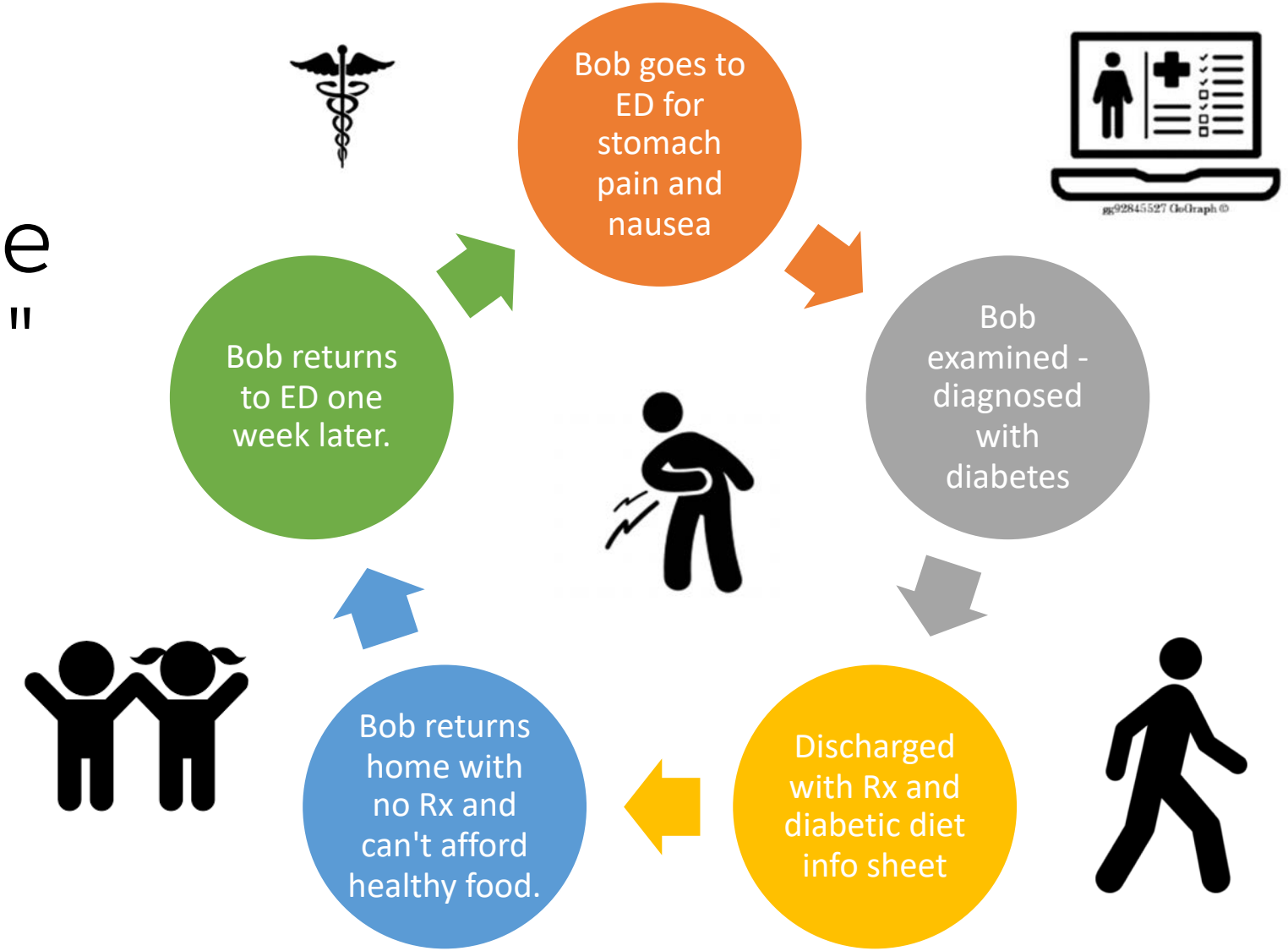


We Continue to Grow Healthy Together

Referrals by Month (2,110 Total Referrals)



A Day in the Life....."Bob"



A Day in the Life.....SDOH Interventions

Health Leads

FQHC conducts SDOH screen.
Bob has food insecurity.
Code Z59.4 entered in EHR.

Bob referred to local food pharmacy.

Healthy Together
Referral Network of Alliance for Better Health

Bob receives transportation to pick up his medicine.

CIRCULATION

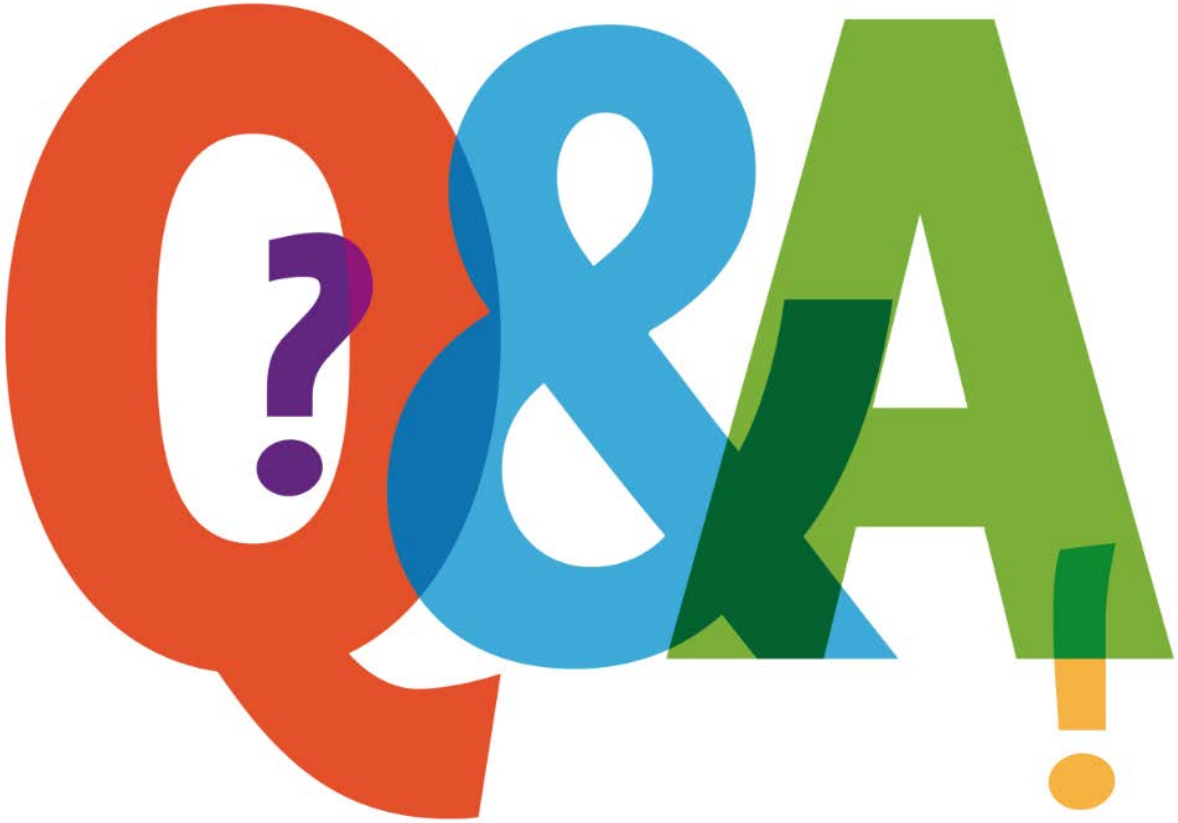
Referred to City Health Works

city HEALTH WORKS

Bob no longer suffers symptoms of diabetes.
No more ED visits

What is working:

- Integrating the referral platform into a larger social care program
- Customized training for each agency by an experienced Care Coordinator
- Program adjustments based on community feedback
- Provider accountability – network standards
- Case conferences for high volume referral agencies
- No cost to Healthy Together Program providers
- Providing a clear understanding of the sustainability of the program


Q?&A!