Workflow Activity: Primary care team workflows for interacting with the CRS

Purpose

The purpose of this activity is to help primary care teams map out their current state of workflows from each primary care role to the CRS. This activity helps teams identify:

- Best practices across the different roles
- Gaps in care; redundancy; inefficiencies
- Ways to streamline workflow processes

While standard workflows should be encouraged, the top priority is to connect patients with social needs to a CRS. Teams are encouraged to prioritize successful connections over process and to tailor processes that align well with clinic culture.

Lead

This activity should be facilitated by someone engaging with primary care improvement at the clinic level.

Audience

This activity should be completed by at least one representative from every primary care team role (e.g., providers, MAs, RNS, CRS, pharmacy, patient representatives, admin, etc.)

Instructions

Set-Up

Label three large flip-chart pages or whiteboards as:

1. How do you identify patients who can benefit from working with the CRS?
2. What are the ways you currently connect patients to the CRS?
3. How do you want the CRS to update you on services and resources provided to patients?

Delivery

1. The focus of this activity is to identify the best processes for prioritizing warm handoffs to the CRS, streamlining other referral methods, and closing the loop on communication from the CRS back to the referring care team member.
2. Gather representatives from each care team role in a space with the 3 flip-chart pages or whiteboards.
3. Describe workflow considerations:
    - Where is the CRS workstation physically located in relation to other primary care team members?
    - What is the CRS staffing model (e.g., one full-time CRS, multiple CRS, CRS splitting time between clinics

- What communications are well used by staff (e.g., EHR, staff messaging apps, text paging, daily communications/newsletters, huddles, all-staff meetings, etc.)?

4. Explain: "We're going to talk through how each primary care team role interacts with the CRS to provide referrals, communicate the social needs of patients, and follow up on what services and resources have been provided. I'll be asking each of you to reflect on how you identify patients who could benefit from working with the CRS, the ways you currently connect patients to the CRS, and how you want the CRS to provide you with updates on services and resources provided to patients.
5. Walk through each of the three questions with each care team role representative. Be sure to ask whether their responses reflect standard practice for others who share their role. The facilitator or a designated note taker should record responses on the flip-chart pages or whiteboard.
6. Discuss:
    - Are current practices sufficient?
    - What referral mechanisms could increase connections between patients with social needs and CRS services?
    - What can each role do to prioritize warm handoffs and standardize referral mechanisms?
    - What will be most efficient and effective for care team roles to make referrals? What will be most efficient and effective for the CRS?
7. Disseminate: Make a plan for each role representative to share results with their colleagues or for clinic leadership to disseminate results to the care team and implement identified best practices for each role.

Examples from a Kaiser Permanente Washington medical center

Practice Coaches led the workflow activity with a Local Implementation Team at a KP medical center in October 2019.

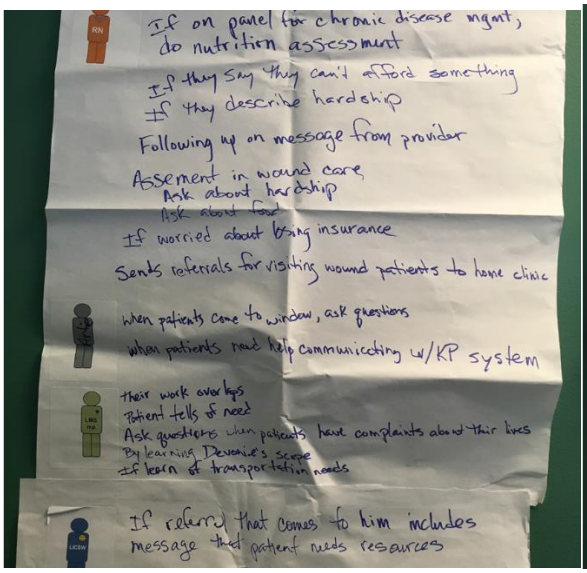
Some clinic teams have implemented:

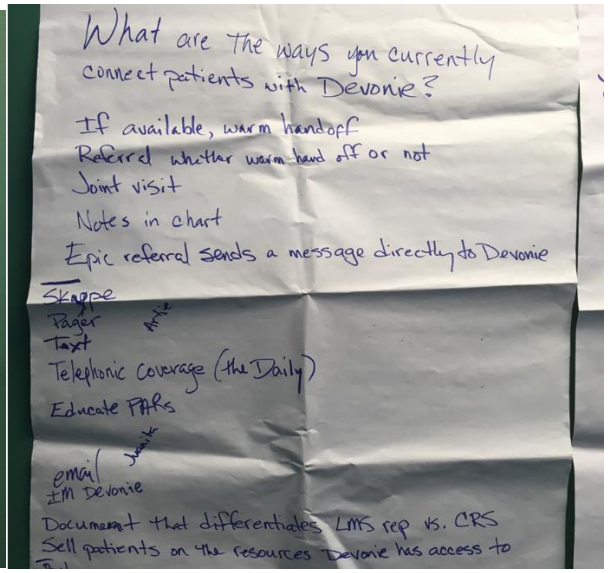
- Giving CRS business cards and flyers to patients who could benefit from CRS services (have a clear plan to keep business cards and flyers stocked in different areas—know who is responsible for stocking these)
- Laminated CRS referral flyers in waiting areas and clinic rooms
- Develop a standardized EHR SmartPhrase to use in the printed after visit summary for patients referred to the CRS
- Empowerment of MAs, patient representatives, and pharmacy staff to refer patients to the CRS (It's helpful to facilitate collaboration between the CRS and MA, patient rep, and pharmacy leads to establish patient-facing messages, scripting, and CRS referral pathways.)
- Pharmacy and PAR staff have financial assistance applications available and know when to provide them to patients

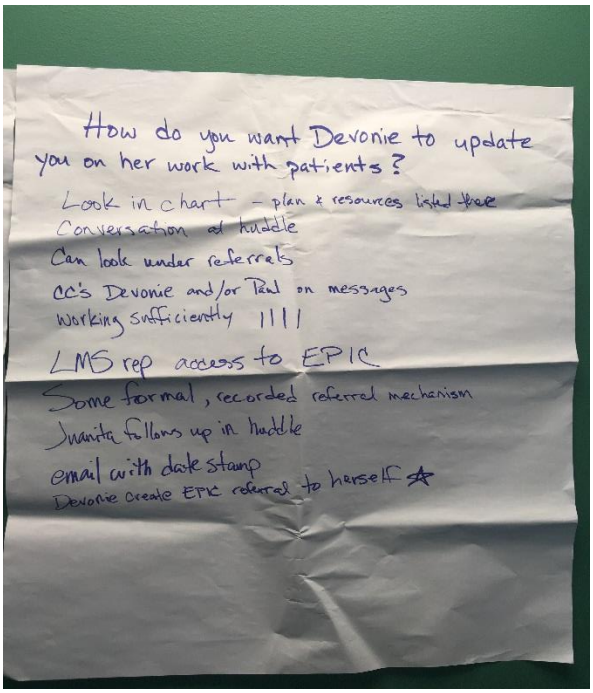
- PARs trained on how to schedule on the CRS template, scheduling phone or in-person appointments per patient preference
- For clinics that have a sheet to indicate other services a patient needs to get done (e.g., future scheduling, labs, pharmacy) after the primary care visit, include the CRS and social worker as fields

Below are photos of some of the responses collected during the activity:

Photos from the activity







How do you identify patients who can benefit from working with the CRS?	What are the ways you currently connect patients to the CRS?	How do you want Devonie to update you on her work with patients?
Pharmacy: Patients present at the window and can't afford medication; if patient not taking med will ask about barriers	Some staff know about CRS and others don't. Most go through PFS (pt financial services) to see if pt has pending MFA account. If not, give pt # to call. Pt signs emergent form and med is released w/o payment (if pt pays, can't be reimbursed). Devonie: if MFA is pending, don't need to call PFS. - **Opportunities:** More training on "believe me" policy; scripting; strengthen workflow for pharmacy to CRS	Devonie currently goes to pharmacy to let them know of patient's MFA status - **Challenges:** pharmacy can only see MFA status when approved; also due to shared computers don't have access to emails
PARs: Have long-term relationships with pts so often know when: - pts are struggling - have transportation issues - can't afford copays	Call Devonie. - In office: warm handoffs; if not available, schedule onto Devonie's schedule; phone vs. in person = pt preference - Out of office: give pt info to Devonie who calls pt or leave post-it note for Devonie - **Opportunities:** Not sure if consistent with other PARs; more education with what Devonie does; scripting.	Currently: - Ask patient or family member - Check in with Devonie
Providers: - Pt or visit-specific: asking ques when hint of non-compliance, challenging social situation, overdue for medications, pt clues, pt brings up - Purple form: screening tool during well-visits w/non-judgmental prompts - **Opportunities**: Press-Ganey comments: if pts note financial issues ("too expensive")	- Ask MA to reach out to Devonie - Will Skype/Teams message Devonie themselves - Referral in Epic - Less now because asking pts if they want to see Devonie today (warm handoff) - Many pts recently have already seen Devonie – will give them a handout/flyer again but sometimes re-refer if pts need	- Devonie updates PCPs/care teams verbally - Sometimes route encounters - If need provider input, will staff msg or route encounter - **Next step:** Amy will ask providers to opt-in to Devonie routing encounters (Devonie will keep list) - **Decision:** If need provider action, staff message provider (better than routing since providers may clear without seeing)
MAs: PCP instruction; if hear something from pt will do best to tell PCP or put on pre-visit but time is challenging; purple forms left for PCPs - **Opportunities:** expanding purple form to problem visits when issues come up; empowering MAs to refer to CRS	- Call - Skype/Teams message - Walk over - Will try to alert provider verbally or on pre-visit and PCP decides if CRS needed	- ??

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Example from another Kaiser Permanente Washington medical center

How do you identify patients who could benefit from working with the CRS?

- Patient complaints re: deductibles, copays, difficulty affording meds, difficulty affording specialty or home care
- Patient reports problems with MFA
- Patient missed and/or cancels appointments
- Difficulty contacting patients (patient doesn't call back)
- Patient brigs up other life challenges: falls, housing issues, needing support (e.g. grief, mental health, caregiver resources)
- Inappropriate referral to social work
- Patient looses insurance or expresses concerns about maintaining coverage (patients may not be upfront about this, but may request longer med supplies or attempt to schedule lots of visits in a short period of time)

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How do you connect patients to the CRS? (current workflow)

- Phone call or Teams message to CRS to determine availability for warm handoff
- CRS available: warm handoffs; (could also include MRN sticker printed from Epic). Don't need Epic referral for warm handoff
- CRS not available: **Epic referral (best)**, staff/in-basket messages, PAR schedules directly on CRS schedule
- Can give flier to patient with non-urgent need (ideally would also pass on patient info to CRS for follow-up)
- Opportunity: could expand pager use. Staff can message CRS directly using Amion. This could be useful if Vera is with another patient and away from Teams

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How do you get updates on CRS work with patients?

- Informal follow-up between CRS and referring staff; this could be in-person during rounding or huddles
- Can get info from CRS Encounter notes in Epic
- Cc'd chart in Epic (only if requested)