Community Resource Specialist (CRS): Integration Playbook

Recommended practices for integrating the CRS role into primary care

ACT CENTER
Accelerating Care Transformation

KAISER PERMANENTE®

Clickable table of contents

How to navigate this playbook

From the menu pages, you can click directly to any best practice:

Assemble a local implementation team with representatives across the care team to better integrate the CRS role

Or you can scroll through the best practices page-by-page using the "next" and "back" buttons in the bottom corners:

◀▮ *Back*   ▮▶ *Next*

From any best practice page, you can also jump back to the menu of best practices using the "Back to menu" link at the top right.

If you have questions about how to use this playbook, please contact us at act-center@kp.org.

Introductory message: Why a playbook for CRS integration?

This playbook is for health systems, clinics, and providers who are exploring ways to improve patient health by integrating social health into primary care

Unmet social needs have a direct effect on peoples' health and quality of life. Issues like lack of transportation and nutritious food, financial strain, and social isolation can make it difficult for anyone to reach their health goals. Addressing social health is an increasingly important strategy to meet the quintuple aim: better patient experience, better health outcomes, lower costs, better clinician experience, and improved equity.

The Community Resource Specialist (CRS) role at Kaiser Permanente Washington was designed to help bridge this gap. CRSs work with patients to help address unmet social needs, so that they are better able to engage in their care plans and achieve their health goals.

- The CRS was co-designed with patients, a community advisory panel, providers, and staff with support from the Patient-Centered Outcomes Research Institute (PCORI) in 2013.

- After the PCORI-funded evaluation showed benefits for patients and primary care teams alike, Kaiser Permanente Washington prioritized systemwide implementation of the CRS role in 2017.

- The Center for Accelerating Care Transformation (ACT Center) then partnered with health system leaders and care teams in 2018 to optimize and evaluate the CRS role. We documented what we learned into a "CRS Integration Playbook" that recommends best practices for integrating the CRS role in primary care at Kaiser Permanente Washington.

We created this public version of the CRS Integration Playbook to help other health systems, clinics, and providers who are prioritizing social health and exploring ways to integrate it in primary care. The content is based on insights and best practices from our work to optimize the CRS role at Kaiser Permanente Washington. But whenever possible, we've tried to adapt our recommendations for variable settings. In some cases, we've included specific models or workflows from our health system that we hope will serve as helpful examples in different environments.

What's included in this playbook

- The **core competencies of the CRS role**, targets of their work, and expected benefits for patients.

- How to maximize CRSs' positive impact on patients by deploying **recommended best practices** for the CRS, primary care teams, clinic leaders, and organizational leaders.

- Ways to **standardize the CRS role** to ensure equitable patient access and experience — while still tailoring workflows and processes to fit different clinic environments.

A note about COVID-19 and the shift to virtual care: The best practices recommended for CRS integration were developed before the onset of COVID-19. We've made several adaptations to account for increases in virtual care, and we encourage care teams and leaders to further adapt the key principles in the playbook as needed to fit a virtual environment.

CRS job responsibilities

Resource referrals
Connecting patients to community resources

- Screening for social risk to identify specific needs and desire for assistance.
- Normalizing needs and reducing stigma.
- Sharing community resources that are customized to patient needs and actively supporting connection to those resources.
- Ensuring KP has up-to-date, high-quality information on local community resources.
- Developing organizational and individual contacts in the local community and cultivating personal and ongoing relationships with them.

Health and wellness support
Helping patients take steps to achieve care plan goals

- Supporting patients who are looking to make lifestyle changes by identifying health goals and removing barriers to meeting those goals.
- Working with patients around goal setting, problem solving, and follow up.
- Helping patients build self-efficacy skills to navigate social service systems.

System navigation
Helping patients find their way through the health system

- Interacting with other Kaiser Permanente departments to ensure coordination.
- Assisting with internal patient navigation needs.
- Advocating for and problem solving with the patient.
- Building trust with the care team by listening, expressing empathy, and following up.

The importance of CRS integration

- We know that our CRSs can be most effective when they are **fully integrated as members of the primary care team**.

- This playbook recommends best practices for CRSs – but also for, **primary care teams, clinic leaders, and organizational leaders**. When deployed collectively, these best practices will support CRS integration in primary care and the role's positive impact on patient health and experience of care.

- A **standardized approach to integrating CRSs** on the primary care team will help ensure that patients have effective, equitable access to services to help meet their social health needs.

Recommended Practices for Community Resource Specialists (CRSs)

Follow standard work with support from EHR-based dashboard for caseload management

Ensure consistent patient follow up with support from EHR-based dashboard

Increase "visibility" of the CRS as part of the primary care team

Use relationship-building, motivational interviewing, and other skills to engage patients

Share community resources that meet patients' needs and actively help them connect to those resources

Understand standard work on delivering high-quality care to patients with communication barriers

Foster regular communication with local community resource organizations

Contribute to a shared resource repository with up-to-date information

Recommended Practices for Primary Care Teams

Complete the CRS integration assessment individually and review as a team

Learn about the CRS role and scope

Complete the CRS workflow activity to understand gaps and refine workflow and communications for each care team role

Include CRSs in clinic meetings and communications

Utilize co-visits between CRS and other care team members

Assemble a local implementation team with representatives across the care team to better integrate the CRS role

Utilize referral data to ensure equitable access to the CRS

Recommended Practices for Clinic Leadership

Make sure the CRS has physical space to do their work well and support standardizing CRS "visibility"

Ensure all staff understand the CRS role and scope of work and support CRS with protecting time for finding/vetting resources

Clearly communicate workflows and policies related to the CRS role

Make space in daily huddles or team meetings for sharing patient stories

Lead the assembly of a representative local implementation team to better integrate the CRS role

Regularly share data on key CRS metrics guidance to monitor care and understand patient impact

Provide ongoing support to build a culture of improvement within the CRS team

Expand social needs screening and adapt CRS service to virtual care

Provide ongoing assessment of skills, training and support for CRS to be successful and grow in their role

Follow standard work with support from EHR-based dashboard for caseload management

Key recommendations

Standard work:

☐ CRS completes social needs screening (e.g., PRAPARE or an EHR-integrated social needs screening tool) for all referred patients and discusses the breadth of services that can be offered to the patient.

  ➢ Social needs screening can be done interview style (to build rapport) or the patient can fill out the screening tool on paper while the CRS completes other tasks (to improve efficiency).

☐ CRS enters screening data into the EHR.

☐ CRS uses EHR capabilities to track completion of screening and patient priority areas.

Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) is a screening tool designed to help health care organizations and their community partners understand and act on patients' social determinants of health (SDOH).

Nearly any social needs screening tool will work. Here are 2 websites that can help you learn more about the many social needs screening tools available:

• Social Needs Screening Tool Comparison Table, from the Social Interventions Research & Evaluation Network (SIREN)

• Systematic Review of Social Risk Screening Tools, from SIREN and Kaiser Permanente

Ensure consistent patient follow up with support from EHR-based dashboard

Key recommendations

Standard work:

☐ CRS makes a standardized number of outreach attempts (based on clinic protocol) followed by a letter if unable to reach patient.

☐ CRS follows up with all patients in person or by phone to see if they need support accessing resources provided.

☐ At follow-up contacts, CRS checks with patients to see if their goals and resource needs have been met, and whether they have additional needs.

☐ CRSs have EHR systems for tracking patients to ensure timely follow up.

➢ CRS manages referrals and active patients in the EHR using a dashboard.

➢ To reach a patient, CRS makes a standardized number of outreach attempts, followed by a letter if needed.

➢ When it's difficult to reach a patient, the CRS can look at the clinic schedule and try to meet with them when they are in the clinic.

☐ CRSs use EHR tools to effectively share work across clinics (e.g., coverage for CRSs who are out of office or support for CRSs with higher workloads).

☐ CRS follows up with providers and care team on patient outcomes, using EHR support tools (e.g., by forwarding a chart or using staff messaging).

"I can't make them go to the senior center, I can't make them join a church, I can't make them do anything, but I can follow up and say 'Hey, did you go and try this?' Just to follow up, for them to know that somebody cares enough to call back and say, 'Did you check up on this, how's this going for you?' benefits the patient." – CRS

Key recommendations

- ❑ CRS joins daily huddles and team meetings to give updates on their work, share new or interesting community resources, and describe patient stories that illustrate their breadth and impact of their work.

  - ➢ With providers, social workers, font desk staff, and other care team members

  - ➢ CRS is empowered to advocate for dedicated time during established huddles and meetings.

- ❑ CRS uses the social needs screener as a teaching tool by going through it with care teams (at huddles, provider meetings) and explaining how it is used to support patients.

- ❑ CRS shows teams where to find screening responses in the EHR and educates team on how to identify whether the patient is already working with CRS.

- ❑ CRS is physically embedded with the primary care team to encourage warm handoffs, referrals, and questions. Frequent daily rounding is recommended, especially if the CRS is not physically embedded with the primary care team.

  - ➢ CRS walks around the clinic once or twice per day and checks in with the care team.

- ❑ CRS maintains visibility by keeping their office door open when they aren't meeting with a patient.

- ❑ CRS makes sure their business cards and flyers (patient-facing and clinic-facing) are visible and available.

  - ➢ Patient-facing flyers are distributed with patient "after-visit" instructions and displayed in waiting rooms, clinic rooms, and other public spaces in the clinic.

- ❑ CRS uses multiple ways of indicating when they are on/off site, the best way to reach them, and who to contact if they aren't available.

  - ➢ Huddles, emails, daily briefs, rounding, sign at workspace, etc.

Use relationship-building, motivational interviewing, and other skills to engage patients

Key recommendations

❑ CRS has excellent relationship-building skills and easily establishes good rapport with patients from diverse backgrounds.

❑ CRS explains role to patients at first outreach to manage expectations (could include setting boundaries on scope of work).

❑ CRS has skills to engage in health and wellness support with patients and feels comfortable doing so.

❑ CRS uses motivational interviewing skills to help patients overcome stigma and to be responsive to their readiness to change and access resources.

❑ CRS uses goal-setting and action-planning with patients referred to resources (e.g., creating a plan for how and when patients will connect with resources and anticipating potential barriers).

❑ CRSs across the organization are connected for support and problem-solving (e.g., finding an appropriate resource or tips for successfully connecting with a patient).

> I don't know what I'd do, where I'd be without her [the CRS]. I'm very pleased, beyond satisfied. I'm encouraged because there is direction, there are people who can be part of the pursuit…and she has definitely opened doors. Not everybody does that. – KPWA patient

Share community resources that meet patients' needs and actively help them connect to those resources

Key recommendations

- CRS meets patient needs by offering the following help to personalize experience and honor preferences:

  - When possible, the CRS is prepared with resources when they meet with a patient (may need to do chart review if reason for referral unclear).

    - Even if reason for referral is known, the CRS gets information directly from the patient and asks about their priorities right away.

  - Guide patients through processes, forms, and warm handoffs for seamless transitions.

  - Walk patients to places (e.g., patient services, front desk) or call resources with them for virtual connection.

  - Aid patients in filling out forms on the spot to increase likelihood of completion.

  - Offer resources in multiple formats (electronic or paper copies, online or by mail).

- CRS is responsive to patient preferences (i.e., by asking patient when they should follow up).

- When appropriate, offer multiple resource options to choose from (balance this with not overwhelming the patient with too many options).

- Ask patients if they have already reached out to a resource to avoid referring them to a resource that didn't work out for them.

- If CRS is not aware of a helpful resource, they make a good effort to find a resource and follow up with the patient.

Understand standard work on delivering high-quality care to patients with communication barriers

Key recommendations

- CRS orders interpreter before visit/call.

- CRS lets patient know before visit/call that an interpreter will be present.

- CRS lets patient know when forms are available in patient's preferred language.

- For phone calls using an interpreter, CRS gives the interpreter the following before interpreter calls the patient (in case interpreter needs to leave message): their name, role, what clinic and PC provider they work with, and reason for phone call.

- CRS uses a simple and easy-to-understand definition of the CRS role (provided by CRS leadership) when speaking with interpreters, many of whom may not be familiar with the role and how it fits into a patient's health care needs.

- CRS anticipates a reduction in efficiency when working with an interpreter and prioritizes accordingly to deliver patient-centered care.

- To optimize communication, CRS offers interpretive services even for patients who speak some English.

- CRS explores virtual options (e.g., websites, video visits) to supplement verbal communication.

"Really having that connection with our interpreter service and having that dialogue, I think sometimes that can take a little bit longer than just a regular referral for someone who speaks English." – CRS

Foster regular communication with local community resource organizations

Key recommendations

❑ CRS visits or communicates with community resource organizations (outside of patient contacts) as part of their role to better connect patients to resources and help patients understand the program, how to access it, and staff who work there.

➤ Identifying contacts in the local community helps cultivate personal and ongoing relationships

➤ Community contacts can be sources of information for other local resources.

❑ CRSs vet resources by:

➤ Checking online and then verifying with a phone call or in-person visit to get an in-depth understanding of the resource.

➤ Regularly reaching back out to resources to ensure programs are still in place and to maintain relationships.

➤ Following up with patients about their experience with resources.

"I make sure to call [resources] once a month. I try to stay in contact with all the care coordinators in the nursing homes that we have and then Meals on Wheels. I check in with them…to make sure all the income limits and stuff haven't changed." – CRS

Contribute to a shared resource repository with up-to-date information

Key recommendations

❑ CRSs have extensive and up-to-date information on community resources in a shared resource repository. CRSs update the repository regularly and keep notes from what they learn through their connections with these community resources.

➢ This is helpful for CRS cross-coverage, for CRSs to support patients whose paneled clinics are outside their communities, and for CRSs to provide resources to clinic teams as needed.

❑ CRSs share helpful resources using a variety of methods: monthly CRS Consult Calls, ad hoc emails, Teams, etc.

❑ CRS uses listservs to get information about ad hoc community resources (e.g., subscribing to a senior listserv).

"I visit local food banks, I go to the senior centers, I go into the community so that I know - follow the news, follow Facebook, follow those things so I find out where HUD housings listings open up, I have that information so I can share that with patients." - CRS

Complete the CRS integration assessment individually and review as a team

Key recommendations

☐ Care teams use the **CRS integration assessment** to rate the level of integration of the CRS into primary care across different domains. Based on the data, care teams assess their strengths and areas for improvement and use the data and discussions to guide next steps for better integration.

➢ Team members should complete the CRS integration assessment independently before engaging in group discussion: clinic managers, primary care providers, MAs, RNs, social workers, pharmacy staff, CRSs, front desk staff, customer service staff, and other team members, as relevant.

☐ Care teams can use this **data template and discussion guide** to review the results.

☐ Care teams repeat the CRS integration assessment about 3 months later to review improvements made, celebrate successes, and identify next steps for change.

Example data from CRS integration assessment

First Assessment

Second Assessment (3 mos. later)

■ Level A: Full Integration
■ Leval C: Little Integration
■ Level B: Moderate Integration
■ Level D: No Integration
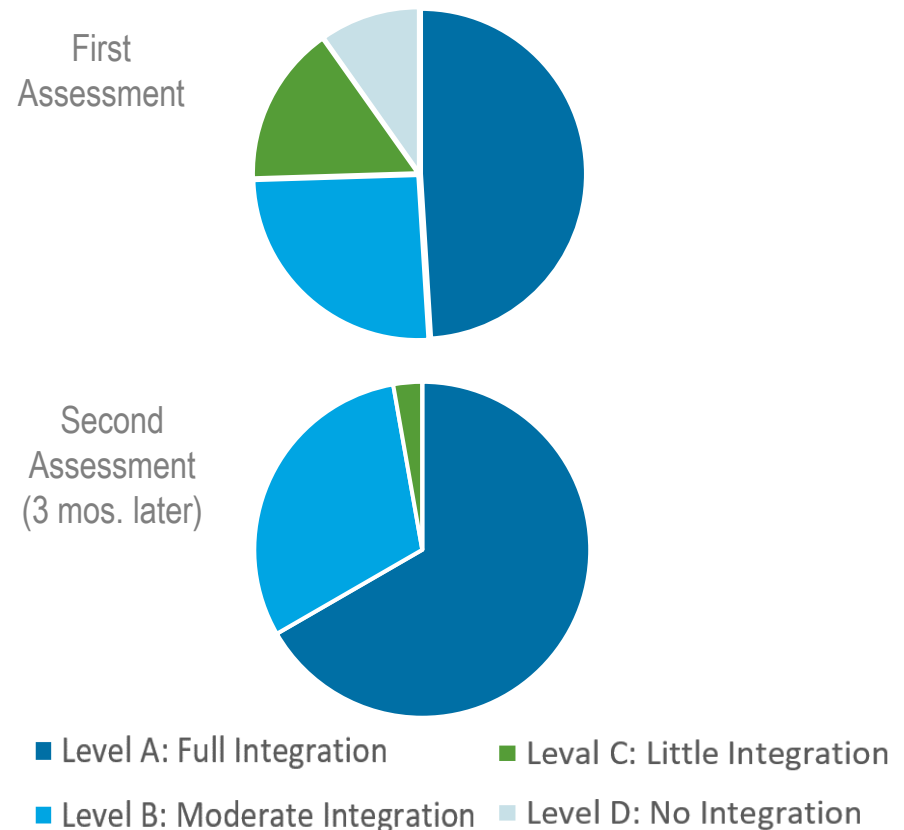
Key recommendations

- ☐ Care teams complete the **roles clarification activity** as a group to learn the differences between the scopes of work for the CRS, social workers, and other staff so they can better provide whole-person care and seamless transitions to these different roles.

- ☐ Care teams discuss the differences between the CRS, social worker and other staff roles with a focus on communication, job aids, and referral workflows to better understand the niche and full scope of the CRS role. This is especially important when patient concerns are in a "grey area" and different roles could be utilized.

  - ➢ Some clinics may decide there is a "go-to" person to help triage concerns when team members are not sure who could best support a patient.

- ☐ Care teams utilize social health screening tool, code cards, cheat sheets, and flyers to understand when to refer to the CRS.

CRS helps patients with...

- Transportation
- Food Insecurity
- Connection to low/no cost gyms, community and senior centers
- Low to No Cost Dental and Mental Health Services
- Employment and Education Resources
- Referrals for culturally specific agencies /community health workers
- Housing Assistance, Resources for Homeless/At Risk of Homelessness
- Utility Assistance/Bill Pay/Debt
- Kaiser Permanente systems navigation
- Work with patients around goal setting, action planning, problem solving, and follow up (health coaching)
- Actively link patients to community resources to meet the patient's specific needs
- Referrals to legal aid services
- Referral coordination with social services agencies
- Social programs and support groups
- Assist with internal patient navigation needs
- Medicaid apps

Complete the CRS workflow activity to understand gaps and refine workflow and communications for each care team role

Key recommendations

- ☐ Primary care teams complete a **workflow activity** to map out the current state of referral workflow from each primary care role to the CRS.

  - ➤ Clear, standardized workflows help to ensure equitable access to the CRS and adequate, timely follow up by the CRS.

- ☐ Each care team member understands they have a referral pathway to the CRS.
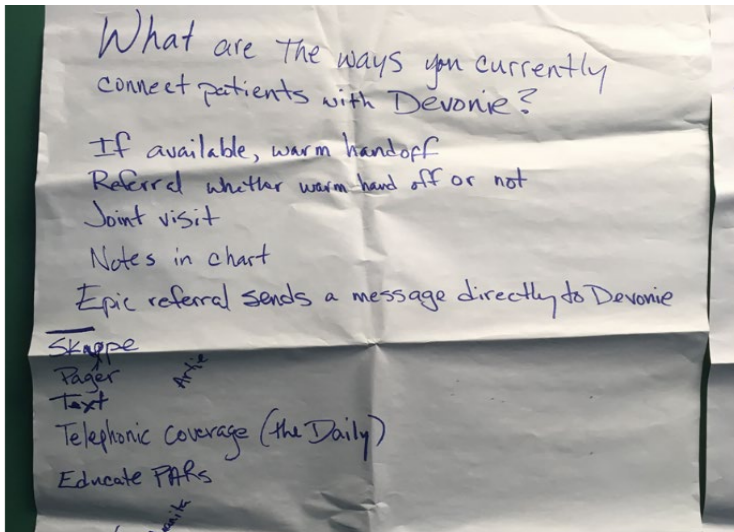
- ☐ Care teams refine workflows by:

  - ➤ Communicating the reason for the referral

  - ➤ Prioritizing warm handoffs first. If a warm handoff not possible, then:
    - • Team members with access to EHR referrals should make referrals through the EHR using a specified referral type
    - • Team members who can't make EHR referrals use staff messaging apps or email
    - • Make sure patients know when they are being referred to the CRS and knows to expect a call.

- ☐ Care teams prioritize connecting patients with social needs to the CRS over establishing rigid workflows.

  - ➤ Care teams should try not to let process interfere with CRS connections and can tailor processes to what works best for their clinic culture.

Key recommendations

☐ CRS and care teams have multiple opportunities to connect and communicate (1:1 meetings, team meetings, all-staff meetings, etc.).

☐ Care teams include the CRS in scheduling announcements, daily schedules, newsletters, and daily announcements.

☐ Care teams reserve agenda time during huddles for:

➢ The CRS to share patient stories and other information about helpful community resources

➢ Other care team members to share stories about CRS-related encounters to demonstrate the impact of the CRS role and to help care teams (especially providers) understand why addressing social needs is relevant to patients' health

"We do huddles here, so Mondays, Wednesdays and Fridays we meet as a staff. We each have time where we can share. I'm generally pushing resources in the community just because if the providers or the MAs don't know those resources are out there and they hear the patient say something, how are they going to know I have a resource for it." – CRS

"CRS is a wonderful program. I would definitely 100% recommend it, support it, advocate for it, because I think that a lot of people are in need of it, they just don't know the program exists, how there is this service that can help." – Patient

Key recommendations

☐ Care teams use co-visits with patients, the CRS, and other care team members (e.g., RN, social worker, patient service representatives) to streamline patient care and better address patient care needs.

➢ Patients have expressed gratitude for these co-visits because they do not need to repeat their needs in separate appointments. Co-visits are also a way to show value for patient time and help patients feel they are being supported by a team.

➢ Co-visits help reduce stigma and legitimize social needs as important for overall health and well-being.

➢ Co-visits help integrate the CRS as a vital member of the care team.

➢ Co-visits can be pre-scheduled or can happen spontaneously depending on CRS availability.

"We're doing a joint thing generally. While they're taking care of my wounds, I've got lots of time to talk." – Patient

Assemble a local implementation team with representatives across the care team to better integrate the CRS role

Key recommendations

☐ Create a clinic-specific local implementation team, with representation from all primary care team roles to help move CRS integration work forward.

  ➤ This smaller workgroup can implement recommended practices (from this playbook and the linked activities and materials), identify priorities for improvement, test changes, and roll out/explain best practices to their primary care teams.

☐ Consider the following roles: clinic chief, clinic manager, administrative coordinator, primary care provider, MA (who may be dyad partner of the primary care provider), RN, patient service representative, social worker, pharmacy lead, CRS, and others.

  ➤ The administrative coordinator for the clinic is most likely to have clear channels of communication with all departments and often knows the best way to share information across staff in different roles.

Utilize referral data to ensure equitable access to the CRS

Key recommendations

☐ Care teams utilize referral data to help inform integration efforts and equitable access to the CRS. Useful data may range from 2-week or 6-month intervals and should highlight information to fit team needs. Examples include:

➢ Total number of referrals and referrals adjusted by FTE for better comparison

➢ Referrals by team/clusters and/or referrer

➢ Number and proportion of referrals that are warm handoffs

➢ Number and proportion of referrals that are sent via the EHR vs. other mechanisms

➢ Referral data broken down by demographics to better understand equity and referrals

➢ Care teams can use this **Excel template to help visualize referral data**

Example data visualization
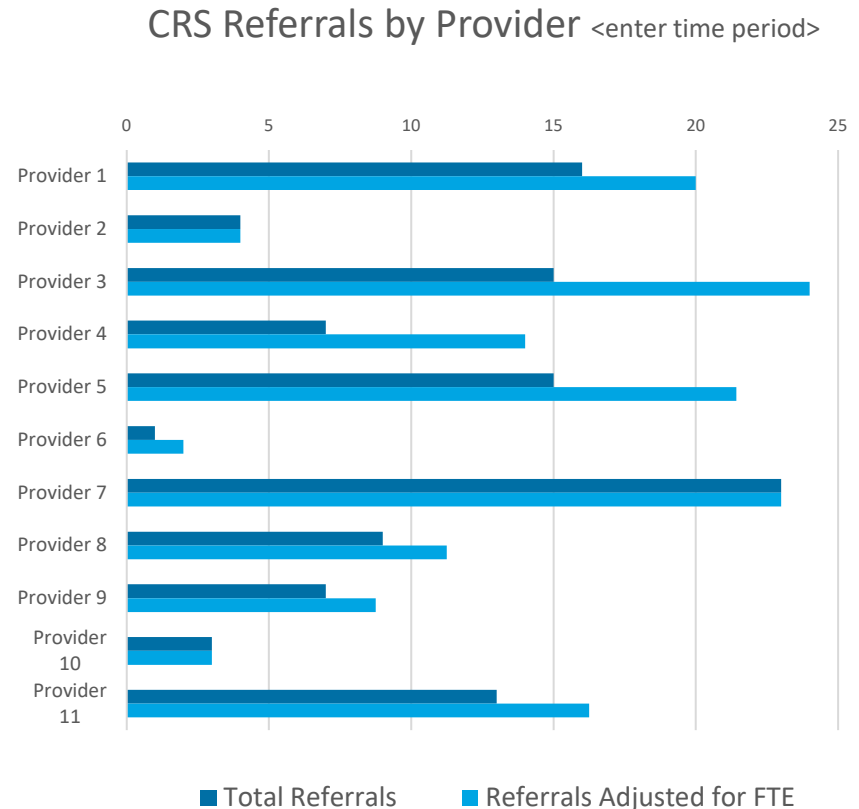
CRS Referrals by Provider <enter time period>

CRS Integration Playbook – March 2022

Key recommendations

❑ Clinic leadership ensures the CRS has a workspace that balances CRS visibility in the primary care team with the need for private space for the CRS to meet patients.

➢ This may be two separate spaces: a CRS desk with high visibility and access to a private room for visits with patients.

❑ Clinic leaders provide opportunities for CRS "visibility" (i.e., time at huddles, space in newsletters, etc.)

Recommended Practices for Clinic Leadership

Ensure all staff understand the CRS role and scope of work and support CRS with protecting time for finding/vetting resources

Key recommendations

☐ Clinic leadership introduces new care team staff (especially providers) to the CRS and provides a **description of the CRS scope (view example)**.

☐ Clinic leadership provides training on workflows for CRS referral during onboarding/orientation for new staff and providers.

    ➢ Consider having new providers and staff shadow the CRS.

☐ Clinic leadership identifies a "CRS champion" in each care team role to facilitate communication and educate peers about the CRS role.

☐ Clinic leadership ensures all staff know how to refer to the CRS and understand any copays or other patient fees thar are charged for a CRS visit, if any.

☐ Clinic leadership supports CRS with protecting time for finding community resources and either visiting them or communicating with them first-hand.

"We get a lot of new providers and I think in their training they must be really talking about the CRS's role, because when they come in, they know about it."
– CRS

Clearly communicate workflows and policies related to the CRS role

Key recommendations

❑ Clinic leadership ensures staff receive consistent training and communication about payment policies that affect CRS work.

❑ Clinic leadership provides scripting and training so that all clinic staff feel comfortable discussing social needs and referring patients to the CRS. Special scripting may be needed for staff who work in public spaces, to help maintain patient confidentiality.

❑ Clinic leadership creates standard workflow plan for how to manage room flow when a CRS is called in to work with a patient as part of a warm handoff (e.g., when the CRS should be in the exam room and when they should move to another location, like their office).

❑ Clinic leadership consistently communicates messages of empowerment for CRS referrals, so everyone knows they are authorized to refer patients to the CRS (not just providers).

➢ Clinic leadership can emphasize referral empowerment for providers and MAs.

• Provide a list of cues that might signal that patient could benefit from meeting with the CRS.

• Provide scripting to help staff discuss social needs with patients.

• At team huddles, share stories about how MAs, patient representatives, and other staff members have referred patients to the CRS to encourage and normalize the practice.

➢ Clinic leadership can also share common reasons for specific departments to refer to the CRS, for example front desk staff or pharmacy staff may notice when patients are having trouble with medical expenses.

Make space in daily huddles or team meetings for sharing patient stories

Key recommendations

- ❑ Clinic leadership communicates strategically about the CRS role and demonstrates support for CRS integration into the primary care team. This can be done in huddles, provider meetings, nursing meetings, etc.

- ❑ Clinic leaders provide opportunities for the CRS and other care team members to share stories with care team members, especially providers (huddles, provider meetings, nursing meetings).

- ❑ Clinic leaders educate care teams on how socio-economic issues can directly affect patient health.

  - ➢ Ask the CRS to share stories about how working with patients to address their social needs ultimately improved their health.

  - ➢ Referrals to the CRS often hinge on the CRS's relationship with the care team. Encourage care teams to refer to the CRS as part of standard work and help them understand how care "outside of these 4 walls" directly affects patient health.

- ❑ Clinic leaders encourage providers to "dig deeper" with patients and discuss social needs that may affect patient health (i.e., social determinants of health) in order to raise issues that a CRS could help with. Providers won't know to refer to the CRS if they do not connect with patients on topics beyond standard medical care.

> "I worked with a woman who was a mother and had a young kid, like one year old. She was staying in the car, and I gave her the resource to call for housing and she did, and she got housing within that week. So that was helpful. I could hear it in her voice, the follow-up call. She was like, 'I got in, we're moving in!'" – CRS

Lead the assembly of a representative local implementation team to better integrate the CRS role

Key recommendations

- ❑ Clinic leaders establish a local implementation team (composed of staff in various roles) engaged in improving CRS implementation/integration.

  - ➢ Identify team members and ensure they have permission and time to attend

  - ➢ Appoint a facilitator if you don't have an external practice coach

What practice coaching can help with

Determining best practices for engaging CRSs in team-based patient care

Standardizing workflows to improve Primary Care team efficiency and impact

Supporting practices as they better integrate the CRS into care teams

Identifying useful metrics and developing a follow-up plan for sharing and monitoring

- ❑ The local implementation team's work is best done with support from an external practice coach.

  - ➢ Practice coaches help guide implementation efforts to make them the most effective and provide extra support to teams with project management. An engaged team member interested in guiding and managing the work could also lead the CRS integration work.

  - ➢ Ideally practice coaching is in person, involving multiple meetings spanning months of time.

  - ➢ If it's not possible to bring in an external practice coach, designate time for someone in the clinic to lead implementation efforts and support change over time.

- ❑ Clinic leadership distributes the **CRS Integration Assessment** to all clinic staff to identify opportunities for improvement.

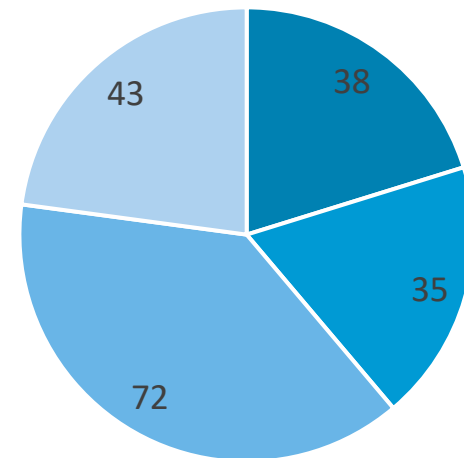# Regularly share data on key CRS metrics guidance to monitor care and understand patient impact

Key recommendations

❑ Clinic leaders monitor data and develop plans to share data with care teams regularly.

➢ Attention to data demonstrates support for CRS work and helps ensure adequate access to the CRS.

❑ Clinic leaders monitor and share CRS referral data. Useful data may range from 2-week or 6-month intervals, and should highlight information to fit team needs. Examples include:

➢ Total number of referrals, referrals adjusted by FTE for better comparison

➢ Referrals by team/clusters and/or referrer

➢ Number and proportion of referrals that are warm handoffs

➢ Number and proportion of referrals that are sent via Epic vs. other mechanisms

➢ Here is a **template for visualizing referral data**

❑ Clinic leaders share CRS referral rates by provider as a teaching tool to encourage all providers to engage with the CRS.

Example data visualization

CRS Referrals by Cluster, Aug 2019- Jan 2020

Pie chart values: 38, 35, 72, 43

■ A ■ B ■ C ■ D

Provide ongoing support to build a culture of improvement within the CRS team

Key observations from the field

❑ Continue facilitating opportunities for CRSs to connect and share resources and best practices by taking advantage of:

- ➢ Monthly team meetings

- ➢ Specific meetings for CRSs to learn, share, and provide support to each other

- ➢ Technology and shared online tools as a resource for CRSs to learn, share, and provide support to each other

❑ Provide the following support to CRSs:

- ➢ Ensuring they have protected time for finding and vetting resources

- ➢ Be responsive and regularly connect with CRSs individually

- ➢ Recognize individual milestones and accomplishments (i.e., birthdays, work anniversaries, successful projects)

- ➢ Ask CRSs for their feedback and adjusting processes, as needed

- ➢ Check in on CRS workloads and facilitate spreading work across the CRS team as needed

Expand social needs screening and adapt CRS service to virtual care

Key recommendations

❑ Implement universal screening for social needs

❑ Ensure you have enough CRSs to accommodate the number of eligible patients prior to and after universal screening in primary care

❑ Consider how the CRS can integrate with new roles and pathways your organization is developing for virtual care and social needs—for example, video visits make it easier to do co-visits with a care team member or to have a community resource dial in.

Other considerations:

❑ CRSs provide a social connection and humanizing element in a virtual-first world. How do we leverage video visits with the CRS to create a personal connection with patients?

❑ What IT equipment will CRSs need to be effective in a virtual environment?

❑ Warm handoffs to the CRS are ideal—but what do warm handoffs look like virtually?

Provide ongoing assessment of skills, training, and support for CRS to be successful and grow in their role

Key recommendations

❑ Provide ongoing assessment of CRS competencies to help prevent drift post-training.

➢ Opportunities for role play with feedback can ensure CRS skill are maintained, drive patient outcomes, and ensure fidelity to the CRS role.

❑ Consider the key competencies that may need more training and support:

➢ Action planning and health coaching (including assessing patient readiness)

➢ Motivational interviewing

➢ Trauma informed care

➢ De-escalation

➢ Cultural competency

➢ Managing secondary trauma

➢ EHR dashboards and other tools to track and monitor patient care

❑ Commit to ongoing discussions around training and scope, including determining which departments and workflows CRSs can support.

➢ Be clear with clinic providers and staff about who should refer to the CRS and who should not.

➢ Organizational leadership must provide adequate training for CRSs around health and wellness support and communicate the purpose the purpose of this support to primary care teams.

➢ If considering universal social needs screening, need to have adequate support with FTE and workflow redesign within care teams and in the health system.

List of linked resources and team activities

Social needs screening tools

- Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE)

- Social Needs Screening Tool Comparison Table, from the Social Interventions Research & Evaluation Network (SIREN)

- Systematic Review of Social Risk Screening Tools, from SIREN and Kaiser Permanente

CRS integration assessment: A tool to help clinics and care teams rate the level of integration of the CRS into primary care.

Integration data template and discussion guide: A tool to help clinics and care teams interpret data from the integration assessment, assess their strengths and areas for improvement, and discuss next steps for better integration. Care teams can use this to review the results.

Roles clarification activity: Care teams do this activity as a group to learn the differences between the scopes of work for the CRS, social worker, and other staff roles.

Workflow activity: Care teams complete this activity to map out the current state referral workflow from each primary care role to the CRS.

Excel template for visualizing referral data: Care teams can use this template share data that to inform integration efforts and equitable access to the CRS

Example description of CRS scope: A summary to help clinic leadership introduce new care team staff to the CRS role.

Acknowledgements

The CRS Integration Playbook was developed at Kaiser Permanente Washington as a joint project involving our **Center for Accelerating Care Transformation, Mental Health and Wellness department, and Primary Care teams.** Over 18 months, we worked together to:

- Provide practice coaching in a subset of clinics to identify best practices for standardizing CRS integration and services

- Build EHR tools to support caseload management for the CRS team

- Evaluate the CRS role to learn about its impact on patients and care teams and areas for growth and improvement

- Distill what we learned into the best practices recommended in this playbook.

Thank you to our **Local Implementation Teams** at the following Kaiser Permanente Washington Steele Street, Renton, and Northgate Medical Centers.

We are also grateful for our EHR analyst, EHR trainer, and **the many CRSs** who helped us develop and pilot our EHR-based decision support tools.

And finally, we are grateful for **dedicated partnership and support** from Kaiser Permanente Washington leaders in Mental Health and Wellness and Primary Care.

ACT CENTER
act-center.org

If you have questions about using this resource, please contact us at act-center@kp.org.

Suggested citation: Amy Lee, Jess Mogk, Cindee DeWitt, Rebecca Parish, Cara Lewis, and Clarissa Hsu. Community Resource Specialist Integration Playbook, March 2022.