Community Resource Specialist (CRS) Integration Assessment

ACT CENTER
Accelerating Care Transformation

Thank you for filling out the CRS integration assessment!

We appreciate your participation in completing this CRS integration assessment. We are asking you to complete this assessment of your clinic's current integration of the CRS role into the Primary Care Team.

What is the assessment about?

The assessment walks through key components of the CRS role, how the CRS works with other care team members to improve patient care, and other structural components to support the CRS role. We will use the responses to guide discussions on where to focus efforts around the integration of the CRS role to improve care and services for our patients.

Who will see my answers?

<Insert site-specific language here> will see your answers when they review the assessments. The members of our implementation team will see clinic-level data when we discuss the assessment as a group.

What if I have questions?

If you have questions about the assessment, please contact _____ at PHONE and/or EMAIL.

How to fill out the assessment

1. Answer each question from your perspective and your role. Please answer all questions, giving your best estimate for questions that you are unsure about. There are no right or wrong answers. If you are unsure, you can leave us a comment.

2. The rows in this assessment represent key components of CRS implementation. Each component is divided into four levels (A through D) showing various stages in development toward a fully integrated CRS. The stages correspond to points that range from 1 to 12. The higher point values indicate CRS components that are more fully integrated.

3. For each component, circle the number (from 1 to 12) that best corresponds to the level of CRS integration in your clinic.

4. Feel free to jot notes about your answers, questions, or comments at the bottom of pages 3 to 5.

5. Please give your completed assessment to _____ by **DATE.**

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Your name: **What is your role in the clinic?**

Community Resource Specialist and Care Team Collaboration

Components	Level D			Level C			Level B			Level A		
1 Care team members have a clear understanding of the CRS role.	Many care team members do not know who the CRS is, or understand the CRS's role on the care team. Care teams do not know that a social needs screen is completed with patients who see the CRS.			The CRS role is not well understood or utilized across care teams. Care teams know that a social needs screen is completed with patients who see the CRS.			The CRS role is understood and utilized across care teams. The CRS sometimes attends clinic huddles and meetings to talk about their role. Care teams know about and understand the variety of social needs the CRS screens for.			Same as B, and the CRS regularly attends clinic huddles and meetings to clarify CRS scope/capacity, troubleshoot issues, exchange ideas, and share resources and patient stories.		
	1	2	3	4	5	6	7	8	9	10	11	12
2 Patients in need of support with community-based resources are linked to resources to meet their specific needs.	Care teams do not reliably refer patients in need of resources. Appropriate referral guidelines have not been established or are unknown. The care team is relatively unaware of available community resources that a CRS can assist with.			Care teams sometimes refer patients in need of resources. Appropriate referral guidelines have been established and communicated, but not well understood across teams. Whether the patient is successfully linked with resource is unknown by the care team.			Care teams consistently refer patients in need of resources. All care team members understand appropriate referral guidelines. The CRS actively links patients to resources, and care teams know when patients are successfully linked. CRS supports successful connections and fosters relationships with external community resources.			Same as level B, and: All members of care team help identify gap areas for needed community resources. CRS researches resources to help meet clinic-identified gaps. CRS actively seeks out and/or develops new partnerships for unmet patient needs. CRS educates care team members about new resources that are available to patients.		
	1	2	3	4	5	6	7	8	9	10	11	12

Community Resource Specialist and Care Team Collaboration

Components	Level D	Level C	Level B	Level A
3 The CRS is integrated as an active and critical member of the primary care team.	Appropriate work flows for referral to the CRS and connecting patients back to care teams have not been established and communicated and/or are different for each person or team.	Appropriate work flows for referral to the CRS (e.g. warm hand-offs, use of Epic referrals, & what to do when the CRS is off site) and back to care teams have been established and communicated. However, these processes are not well understood and utilized across care teams.	Appropriate work flows for referral to the CRS are utilized in a standardized way and understood across the care teams. Providers and other care team members actively and successfully connect patients with CRS. However, referrals are not regularly received from all care teams. The CRS is able to actively connect patients back to care teams for clinical needs.	Same as B, and these processes are evaluated and modified on a regular basis between care teams and the CRS. Warm handoffs are prioritized and received from all care teams. The CRS actively connects patients back to care teams for clinical needs and co-visits with other care team members may occur to address social, behavioral, and medical health needs simultaneously.
	1 2 3	4 5 6	7 8 9	10 11 12
4 Patients who can benefit from health coaching, goal-setting, and action-planning are connected to the CRS.	Patients struggling to follow care plans are rarely referred for health coaching, goal-setting, and action-planning.	Care team sometimes refers patients struggling to follow care plans for health coaching, goal-setting, and action-planning, but the care team is sometimes unsure how the CRS can support patients.	Care team regularly refers patients struggling to follow care plans to CRS for health coaching, with clear understanding of how the CRS can support patients.	Same as B, and care teams know when patients are successfully supported by the CRS.
	1 2 3	4 5 6	7 8 9	10 11 12

Your notes and comments about components 1 – 4 (optional):

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Leadership at the Clinic Level												
Components	**Level D**			**Level C**			**Level B**			**Level A**		
5 Clinic leadership is committed to the success and integration of the CRS role into the care team.	Clinic leadership does not provide resources, physical space, and/or time with care teams to fully integrate the CRS role into the primary care team. Communication about the CRS role is largely absent.			Clinic leadership provides some resources, physical space, and time with care teams to integrate the CRS role into the primary care team. Communication about the CRS role is done on an ad hoc or CRS-driven basis.			Clinic leadership provides resources, physical space, and time with care teams to integrate the CRS role into the primary care team. Communication about the CRS role is visible, and the CRS role is prioritized and highlighted by being given opportunities to share about community resources and updates about the role on the care team on a regular cadence.			Same as level B, and commitment to the CRS role is clear and communicated consistently during huddles and other team meetings. Leadership makes time for CRS to educate staff, clarify appropriate referrals, and share patient stories. CRS manager and local leadership work together to define best practices for support of the CRS, with local leadership providing guidance to the CRS for urgent or in-the-moment clinic needs.		
	1	2	3	4	5	6	7	8	9	10	11	12

Your notes and comments about component 5 (optional):

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Leadership at the Organizational Level												
Components	**Level D**			**Level C**			**Level B**			**Level A**		
6 Leadership at the organizational level are committed to supporting CRS skills and professional development.	Support and/or training opportunities are not routinely available to the CRS.			Support and/or training opportunities are available on a limited basis when CRS coverage is available.			Support and/or training opportunities are routinely available to the CRS. These opportunities are prioritized.			Same as level B, with regular assessment of skills and CRS training needs and progress on professional development goals.		
	1	2	3	4	5	6	7	8	9	10	11	12
7 There is leadership commitment to understanding the population impact of the CRS role and dedication to monitoring care.	Leadership commitment to monitoring of the CRS population impact is not evident. Data on key CRS metrics are not defined and there is no commitment to monitor care to ensure fidelity to the CRS role.			Leadership commitment to monitoring of the CRS population impact is evident to some extent. Some metrics around the CRS role exist, but not routinely shared with organizational and clinic-level leadership.			Leadership commitment to monitoring the CRS population impact is evident with defined metrics, and data are shared with organizational and clinic-level leadership; discussions/actions are taken occasionally to address gaps and monitor care to ensure fidelity to the defined role.			Same as level B, and resources are dedicated to organizational and clinic-level quality improvement using data and IT resources, including the Epic EHR, to support CRS work. Leadership is responsive to advance clinics' capacity to screen for and address social needs at a population level.		
	1	2	3	4	5	6	7	8	9	10	11	12

Your notes and comments about components 6 – 7 (optional):

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