Addressing Social Needs and Creating Community Linkage Pathways for Vulnerable Populations in Primary Care Practice Settings

Authors: Mindy Matthews, MSN, RN, CPHQ, Yale University School of Nursing
Mary Ann Camilleri, JD, RN, FACHE, Advisor, Yale University School of Nursing

INTRODUCTION

Addressing Social Determinants of Health (SDOH) is foundational to patient-centered, whole-person care. Social risk factors, the social determinants of health associated with *negative health outcomes, contribute to* ***health inequalities, high medical cost, overutilization of services, and have a greater impact on morbidity, mortality, and quality of life than chronic diseases***.[1]

- **Primary care is identified as a key setting** to introduce strategies around identifying at-risk patients with social needs.[2]
- Helping people resolve social needs has been demonstrated **to improve outcomes and reduce health care use and spending**.[3]

Frieden's framework (2010) addressing SDOH was used. This project sits at Friedan's clinical intervention tier with greatest individual level impact on health, and application for long-term prevention and health decision making. Standardized primary care practice protocols for SDOH can: improve the health of large, diverse patient groups; reduce cost and utilization. This novel project addresses these urgent needs.

OBJECTIVES

Project Goal: This DNP project developed a care delivery model to integrate social needs screening and navigational resources into the practices of primary care clinical teams.

Aims:

1. To develop standardized social needs screening processes and practice guidelines for community resource referral pathways.
2. To implement screening tools, workflows, and referrals pathways utilizing care navigators and evaluate the model's impact on care delivery.
3. To make recommendations to scale the process to all primary care practice sites across the organization.

METHODS

Standardized SDOH screening workflows were developed to identify needs and link patients to community resources using care navigational resources. This process improvement project employed a Plan-Do-Study-Act (PDSA) project management framework, using electronic medical record (EMR) resources to integrate resources supporting care navigators in creating referral pathways.

Plan:

- **Optimized EMR platform to support clinical processes, analytics, & reporting**
- **Adapted workflows to ensure consistent, standardized screening**
- **Developed education & resources: SDOH screening, care navigation**

Act:

- **Reviewed outcomes data & survey results to inform organizational expansion of SDOH screening & navigational resources**

Do:

- **Target population: Adults (18 and over) new to the practices**
- **Screening Domains: Financial, Food, Social, Transportation, and Housing**
- **10-week implementation at two pilot practice sites**

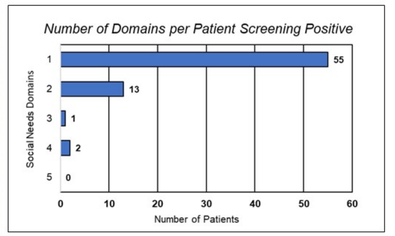
Study:

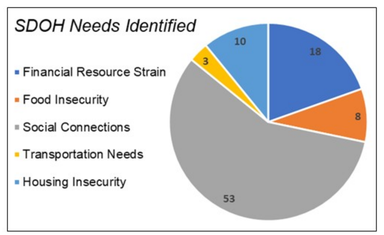
- **SDOH Task Force met weekly: reviewed process metrics & staff feedback to address barriers & adjust process**
- **Surveyed to assess clinician's experience with screening process/connecting patients with resources**

- Project was completed in March 2023 after a 10-week pilot at 2 practice sites.
- Findings support the use of screening and pathway protocols to facilitate linkages to community resource and the successful identification and management of SDOH in the provision of patient-centered care.

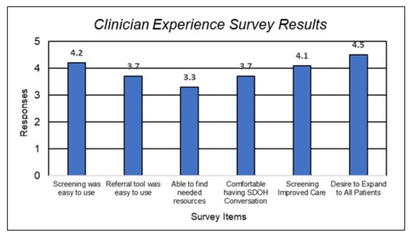
RESULTS

- 150 patients screened
- 71 patients identified needs (47.3% screened patients)
- 92 individual needs identified across all domains
- Avg 1.3 needs per patient screening positive
- 74 encounters with 57 positive patients
- Avg 1.4 encounter per patient screening positive
- 37 referrals made to community resources





- 11 clinician surveys collected (47.8% response rate)
- Providers reported that addressing SDOH and providing care navigational resources better supported them in addressing patient needs and improving patient health



REFERENCES

[1]Krist, A. H., O'Loughlin, K., Woolf, S. H., Woolf, S. H., Sabo, R. T., Sabo, R. T., Hinesley, Kuzel, A. J., Rybarczyk, B. D., Kashiri, P. L., Brooks, E. M., Glasgow, R. E., Huebschmann, A. G., & Liaw, W. R. (2020). Enhanced care planning and clinical-community linkages versus usual care to address basic needs of patients with multiple chronic conditions: A clinician-level randomized controlled trial. Trials, 21(1). https://10.1186/s13063-020-0446333

[2] Valaitis, R., Cleghorn, L., Ploeg, J., Risdon, C., Mangin, D., Dolovich, L., Agarwal, G., Oliver, D., Gaber, J., & Chung, H. (2020). Disconnected relationships between primary care and community-based health and social services and system navigation for older adults: A qualitative descriptive study. BMC Family Practice, 21(1). https://10.1186/s12875-020-01143-8

[3] Brewster, A. L., Fraze, T.K., Gottlieb, L M., Frehn, J., Murray, G. F., & Lewis, V. A. (2020). The role of value-based payment in promoting innovation to address social risks: A cross-sectional study of social risk screening by US physicians. Milbank Quarterly. https://doi-org/10.1111/1468-0009.12480

Contact mindy.matthews@yale.edu for Q&A