Connecting Patients to Community Resources to Address Social Determinants of Health

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Objective

Social, behavioral, and economic factors all have a significant impact on health outcomes. Social determinants of health (SDoH) are the conditions in which people are born, live, learn, work, and age that affect health, functioning, quality-of-life outcomes, and risks.[12] While clinical care accounts for a minority (20-40%) of outcomes, social determinants account for nearly 60-80% of health outcomes. Addressing patient needs related to food insecurity, housing instability, inability to pay utility bills, and transportation can improve health outcomes and decrease healthcare utilization, thereby decreasing the cost of care. Organizational capacity and support to address SDoH has been linked to reduced self-reported provider burnout. The purpose of this project is to identify best practices for connecting patients to resources in the community
that help address social determinants of health, once the need
has been screened for and identified at a visit with a provider.

Methods

A thorough literature review was performed for this research project. The literature review involved: i) an electronic database searches; ii) a website search; iii) medical journals, and iv) a search of reference lists from literature reviews.

Results

The research shows that there is not one specific best practice for connecting patients to resources in the community that help address SDoH. Organizations across the country are utilizing different methods for connecting patients to resources in their community to address SDoH. The research shows that although there is not one best approach, data need to be utilized, and it is consistently necessary to be innovative and build strong partnerships with community organizations in order to ensure resources are there when the need is identified in a screening. A common theme across the research showed that the best way to be able to connect patients to resources in the community is first to have the information. Additionally, across the research there is a lack of consistency for how and if patients are getting screened in hospitals and clinics. Only 24% of hospitals screen for SDoH when treating patients.[1] Given this information, the organizations that are screening for SDoH needs use methods to connect patients to community resources that include: patient navigators, clinical integration, new technology, resource maps, and resource lists.

Patient Navigators

Several organizations report using patient navigators as a way to connect patients to resources in the surrounding community. Rural Health Information Hub defines the patient navigation role as someone who supports patients and families through treatment and care, connects them to community resources, provides education on health conditions, helps to follow-up with providers, and guides patients across the care continuum.[3] UC Davis, in Sacramento, California, utilizes patient navigators in their hospital emergency rooms to help patients enroll in insurance, get connected with a primary care provider (PCP), and find resources in the community that will be beneficial for their health.[2] One literature review that examined Patient Navigation programs linking primary care with community-based health and social services (CBHSS),

found that in 34 cases of using patient navigators, there were various positive outcomes reported for patients, providers, and the healthcare system.[4] The effectiveness of patient navigators has been studied for improving outcomes for specific illness such as cancer, diabetes, and childhood obesity.[9] In a study titled, "Patient Navigators Connecting Patients to Community Resources to Improve Diabetes Outcomes," it was found that "The patient navigator model is a promising and acceptable strategy to link patient, PCP, and community resources for promoting lifestyle modification in people living with or at risk for type 2 diabetes."[5]

Clinical Integration

Humana is another organization that has done a lot of work to address SDoH in the patient population they serve. Humana's Bold Goal initiative prioritizes the integration of SDoH into the "clinical, home health and pharmacy capabilities, allowing physicians, clinicians, and Humana care teams to address and impact an individual's whole-person health within the clinical setting."[11] Humana focuses on embedding social determinants into the patient care workflow so they can screen every patient that they see and refer them to community resources and support when necessary. This process and initiative allowed Humana to reach their goal of improving the health of the communities they serve by 20% by 2020.[11]

New Technology

New apps and technology have helped some organizations better connect their patients to community resources. A CMS Accountable Health Communities Model program grant helped Allina Health System, in Minnesota, better bridge the gap between clinical care and community resources for their patients. Allina implemented an app called NowPow, which provides a connection to community resources in a directory, after patients answer a few questions. The software's algorithm is maintained by NowPow and identifies the best community resources for each patient's individual needs and situation.[7]

OhioHealth, in Columbus, Ohio, implemented Docent Health in order to provide patient navigation services through technology. This form of technology will communicate with patients via "smart" text messaging and phone calls to help guide them through their care and help connect them to community resources to improve their overall health and wellness. Docent Health's technology requires integration into OhioHealth's electronic health record but utilizes both automatic messaging and patient navigators who work remotely.[8]

Resource Guides

The CDC performed a study to identify approach to "healthcare delivery that leverage community resources could improve outcomes for children at high risk for obesity."[10] After several parent interviews, interviewees indicated they wanted a community resource map that included free or low-cost physical activity resources, nutritional resources, social support programs, modes of transportation, and a street view so they could see the condition and safety of these locations. After creating both an online interactive map and a mailed community resource guide, it was found that there was no difference between the satisfaction of the two. The families utilizing these maps and guides reported feeling empowered by having access to these community resources that they otherwise may not have known about.

Conclusion/ Discussion

The research shows that there is not one single most effective way for connecting patients to community resources. Different organizations have had success using various methods, such as patient navigators, clinical integration into operational workflows, new technology and apps, and resource maps and guides. There was the most research on the effectiveness of patient navigators being utilized to connect patients to community resources, due to them being utilized for specific illnesses such as cancer, diabetes, and obesity. Across all of the research for best connecting patients to community resources, once a need has

been identified, there is a common theme on the utilization of data. Without data being collected both on the resources available in the community and screenings being performed on the patients coming into the healthcare organizations, there is not a way to know what patients are in need and what resources are available to meet their needs. In order to best address SDoH and connect patients to the resources they need to improve their health, there needs to be a uniform measurement of, or process to address, gaps in SDoH across the patient population. The ongoing failure to leverage social determinants screening and interventions with Electronic Health Record systems inhibits organizations' ability to track patients' needs, community-based resources provided, or the potential impact upon outcomes. SDoH gaps negatively impact the ability of patients to succeed at their prescribed plan of care because they compose 60-80% of the factors contributing to a patient's health quality outcomes, which is why it is essential to continue finding innovative ways to connect patients to community resources that address their needs.

Resources

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