Primary Care Network
CALGARY FOOTHILLS

Your Health, Your Team, Your Community

Pilot Project Overview
Community Resource Link: Helping People Connect to Social and Financial Resources

What is the project?

This project is grant funded by the Calgary Mental Health and Addiction Strategy. It aims to enhance coordination between clinics with member PCN physicians and 211, resulting in seamless connections between family physicians and community agencies. This will help patients meet basic needs, leaving them better able to benefit from medical care.

Reducing Impact Financial Strain was a similar partnership project between Alberta Health Services, Alberta Medical Association and 3 PCNs. This project has created helpful resources to spread the model. Most of the patients involved in this study were referred for financial strain and mental health resources. Watch Lacey's Story to hear about a patient experience with this project.

Why is this important?

Social Determinants of Health have a known impact on health outcomes. Gaps in social determinants of health such as food insecurity, housing, and financial strain create sometimes insurmountable barriers for people seeking health care and can result in higher risk of hospitalization (1). While resources often exist to help them, both within the healthcare system and among community agencies, patients may not be aware of which resources are available or how to access them. Family physicians can play an important role in identifying patients who would benefit from social determinant of health interventions and connect them to supports that will help patients navigate a complex web of social and community services (2).

What is the process?

Patients aged 50+ at selected clinics with member PCN physicians will be presented with a survey to assess their needs related to finances and other social determinants of health. When needs are identified, a referral to 211 is made by the physician. A 211 Community Resource Specialist (CRS) will make a follow-up call to the patient to further assess their needs. Following this assessment, the CRS will provide information and referrals to resources that may support the patient. Seven to 10 days later, the CRS will follow-up with the patient and review barriers and successes in connecting to the provided resources and reports back to the referring provider to indicate which resources were accessed.

Participating staff at clinics will receive supplementary education on the impact of social determinants of health gaps on patients' health as well as instruction on the project and its associated processes.
This pilot project will operate for 1 year.

What are the benefits to participating?

Benefit to patients: Improve access to community resources for those who are experiencing challenges across social determinants of health. Provide patient centered care and timely guidance and advice.

Benefits to physicians: Gaps in social determinants of health such as food security, housing, and financial strain can sometimes create barriers for people seeking health care. The project will work to build awareness of those patients who would benefit from social determinants of health interventions and connect them to supports that will help navigate a complex web of social and community services.

Benefits to the PCN: Build community partnerships and relationships to enhance patient care, reduce gaps, reduce duplication of services, and align and mobilize resources between primary care and community partners.

How does this project align with current similar services?

Our PCN Community Social Workers (CSW) also offer support with navigating social service resources. This project will identify patients who may benefit from support and may have otherwise been missed. The survey will identify those patients who are already connected with a CSW and for the purpose of continuation of care will suggest following up with their provider rather than connecting to a new service. The 211 Community Resource Specialist will also identify patients who need support navigating numerous resources or with chronic disease management and may be a good fit for a CSW referral.

Questions?

For more information about this pilot project please contact Kirbie Lewis, Program Manager, Calgary Foothills Primary Care Network
kirbie.lewis@cfpcn.ca.

References:

1. Association of Social Determinants of Health and their Cumulative Impact on Hospitalization Among National Sample of Community Dwelling US Adults
2. Implementing Social Interventions in Primary Care
3. Social Determinants of Health