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

Process

Purpose

While social determinants of health play a significant role in one's health and well-being, it can be overwhelming to navigate social service resources in the city. The Distress Centre Calgary/211 maintains a comprehensive database of community resources, after vetting each resource through inclusion and exclusion criteria to ensure that every resource in their database is trustworthy. The 211-service delivery model includes an individual assessment of needs, clarification of the situation, information, referrals, and warm transfers, as required advocacy, when warranted; and follow-up, as necessary. This project aims to enhance coordination and communication between Primary Care Network clinics and 211 resulting in seamless connections between family physicians and community agencies towards a continuum of care that are holistic, human-centered, and appropriate for patient needs in a timely manner.

Objectives

Improve access to community resources for patients aged 50+ who are experiencing challenges across the social determinants of health by screening them at selected primary care clinics and referring them to 211.

Eligible patients

Any PCN patient aged 50+

Eligible physicians

Have the following:

- Data Sharing Agreement between member physician and PCN
- Privacy Impact Assessment and Information Management Agreement with Brightsquid and a live Brightsquid account

Detailed Process Map

Please refer to the *Detailed Process Flow Map*

Simplified Written Process

Clinic Admin or Physician

1. Inform the patient that their physician is participating in a project to help identify people who may need help with social health factors like finances, housing, and social services; and get them connected to community supports through 211 or a PCN social worker.
2. If the patient consents to participate in the project, provide the *Patient Survey and Patient Handout*. Note in EMR consent obtained to participate in the Community Resource Link Project.
3. If the patient declines, please record in the declined tracking document, and please chart in EMR patient declined to participate in Community Resource Link Project (or send EMR message to physician as applicable). Send aggregate number of declines to PCN evaluations via Brightsquid weekly.
4. If the patient answers yes to any of the first 5 questions, they have screened positive.

5. Upload survey response to clinic EMR for physician to review and discuss outcome with patient as required.

Next Steps for Each Survey Outcome

6. If the patient screens positive and answers:
    - YES to Question 6 on the survey tool, send the referral to their PCN CSW as usual. Include the completed survey tool and any additional information as required.
    - YES to Question 7 on the survey tool, send a referral to 211
        - Send the completed screening tool to 211Calgary@distresscentre.com via Brightsquid
        - In the subject line, include "Referral to Community Resource Link – *insert clinic name*" For example: Referral to Community Resource Link - Coordinated Attachments Clinic
        - In the body of the email message, include "Please ensure all return communication is sent to this email address via Brightsquid [insert clinic Brightsquid email]"
    - NO to Question 6 and 7, no referral is made
7. Charting: In addition to uploading the completed survey, include the following in the EMR:
   Community Resource Link
   Referral to PCN Social Worker: Yes/No
   Referral to 211: Yes/No
8. Send completed survey as an attachment to CFPCN evaluations via Brightsquid evaluation@cfpcn.ca
9. Secure survey paper copy and dispose in secure shredding at end of pilot

Reference:

- https://actt.albertadoctors.org/health-system-integration/keeping-care-in-the-community/Reducing-Impact-of-Financial-Strain/Documents/Questionnaire%20Samples%20Rv1.pdf