Improving Care for Seniors: Understanding Processes to Address Unmet Social Needs

A.M. Morris[1], J.K. Engelberg[1], S. Pashaee[2], M. Vincent[1], G. Corzo[3], S.R. Seghal[2], F. St-Onge[2], L.M. Gibbs[2]
1. West Health Institute, La Jolla, CA; 2. Division of Geriatrics, University of California, Irvine. Irvine, CA; 3. SeniorServ, Anaheim, CA

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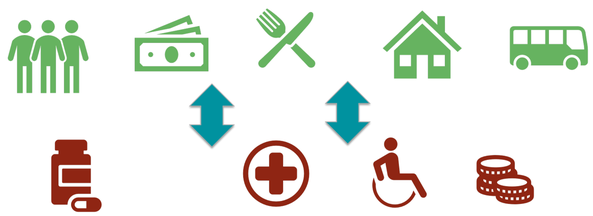
BACKGROUND

Social (non-clinical) factors significantly impact health outcomes and costs. To meet the full spectrum of senior patient needs (including both clinical and social), there is a need for person-centered care models that link clinical and community services.



This formative study examined processes for connecting seniors with community resources in a clinical and community setting. It was conducted as part of a multi-year quality improvement (QI) project to enhance senior care through comprehensive service navigation.

METHODS

Informational interviews were conducted with key personnel from an academic Senior Health Center (SHC) and a Community-Based Organization (CBO) to capture clinical and community perspectives on addressing social needs for seniors.

Informational Interview Key Informants:

- SHC (n=7)
  - Geriatrician, Pharmacist, Registered Nurse (RN), Licensed Clinical Social Worker (LCSW), Medical Assistant (MA), Physician Assistant (PA), Practice Manager
- CBO (n=6)
  - Management coordinator (n=1), Case Managers (CMs) from Home Delivered Meals (HDM) (n=2), Adult Day Health Care (ADHC) (n=2), Care Transitions (n=1)

Broader formative work included a 25-item survey to SHC clinical providers (n = 12) and a two-hour focus group with CBO staff (n = 14)

Across efforts, participants were asked to:

1. **Describe the process to identify and address social needs**
2. **Identify referral and communication practices**
3. **Discuss opportunities to improve coordination**

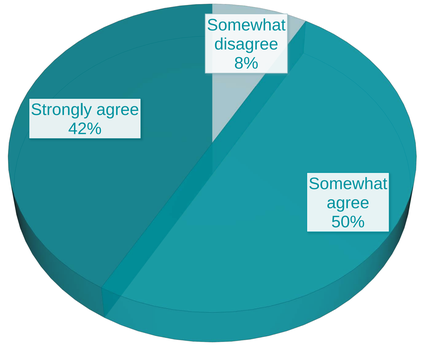
RESULTS

SHC Perspective

Key findings:

Opportunities	Challenges
1. Recognized the link between social needs and health 2. Approaches to address social needs varied o E.g. pamphlets, list of providers, calls 3. Saw the value in coordinated care	1. No systematic social needs screening 2. Limited knowledge of community-based service providers o Rely on referral to LCSW 3. Minimal communication with CBOs

"Patients express health concerns caused by unmet social needs that are beyond my control as a physician."



CBO Perspective

Key findings:

Opportunities	Challenges
1. Ongoing contact with patients o Frequency varied by program 2. Relationships with clinical staff help communication 3. Saw the value in improved coordination with clinical staff	1. Few standardized assessments 2. Often difficult to reach clinical staff o E.g. ADHCs delays for health records 3. HIPPA and patient privacy impede sharing patient data

Primary concern is the lack of available resources to meet ALL seniors unmet needs, especially:

Shared Findings: Opportunities & Challenges to Coordinate Care

1. **Identify and address social needs:**
   - Lack of systematic or standardized screeners to identify unmet social needs
2. **Referral and Communication:**
   - Understood potential value in sharing patient data across settings in real-time
     - Concerned with logistics
   - Current communication between settings is almost nonexistent and inefficient when present
3. **Improve coordination:**
   - Leverage CBOs ongoing contact with patients (e.g. communicate changes in patient's condition)
   - Utilize technology to facilitate communication and alerts across and within settings

CONCLUSIONS

Despite challenges, opportunities exist to improve clinical care to help seniors maintain their functional independence by addressing unmet social needs.

A SHC clinical provider described the ideal process to address patients' unmet needs as:

"Having all the available resources in the community, [a] point person, easy access to the person, good communication between team members and community based services."

QI opportunities at the SHC:

- Create a standardized process to identify social needs
- Designate a team with knowledge of community resources to help address unmet social needs
- Improve referrals, coordination and bilateral communication between clinical and community providers

Findings will inform a redesign of care delivery to include community service referral and navigation for senior patients.

NEXT STEPS

Next steps to achieve comprehensive care at the SHC:

- Develop and test a centralized care coordination 'hub'
  - Include a community-based social worker and technology-enabled communication platform
- The 'hub' will be designed to connect senior patients with community-based resources
  - Also will facilitate bilateral communication and information sharing across settings