

## Link Patients to Non-Medical Support

## Tool 18

### Overview

Limited health literacy affects not only patients' health care but also other aspects of their lives. Linking patients with available community resources, such as assistance with transportation, food, employment, budgeting, and housing, helps patients attend to and maintain their health. Supporting patients in this way involves developing knowledge of the resources available in the community, directing patients to relevant resources, and following up to ensure that the connections were actually made. Attending to patients' non-medical needs, critical for patients to achieve optimal health, is time well spent.

### Actions

#### Assess each patient's needs and support system.

- **Ask patients** about things that may affect their ability to manage their health.
  - You could ask a general question:
    - “Is there anything in your daily life that makes it hard to take care of your health?”
    - “What matters to you?”
  - Or, you could ask questions addressing specific needs:
    - “Healthy foods can be hard to find and expensive. Do you have any trouble getting healthy foods?”
    - “Was it easy to get here today?”
- Ask about and involve the patient's current support systems, such as family, friends, and social workers.
  - Find out and record what role each member of the support system plays in the patient's care.
- **Listen to what patients tell you** about the challenges in their lives.
- **Note patients' non-medical challenges** in their medical records.

#### Identify your community resources.

- 2-1-1– Information & Referral Search: In many parts of the country, the United Way and AIRS (Alliance of Information and Referral Systems) can provide you with a phone number to call for information about the social services in your area. You can press 2-1-1 on your phone or access this resource on the Internet.
  - The following AHRQ Toolkit describes a process for establishing linkages with community partners: Linking Primary Care Patients to Local Resources for Better Management of Obesity.
  - The Chamber of Commerce in your area can provide a list of community services.
  - Ask specific agencies to send pamphlets or to give a presentation at your practice. This provides staff with an opportunity to meet a contact person as well as learn more about the agency's services and the referral process.

- **Create a system for organizing resources.** Have one person take responsibility for organizing and updating resources, and helping patients get connected.
- **Keep resources up to date.** Ask patients to let you know if they cannot reach a community resource. Establish a schedule for verifying whether resource information is still accurate.

**Connect patients with resources.**

- **Use a Community Referral Form** to provide patients with essential information about recommended services.
- **Follow up.** Find out if the referral was completed by contacting the patient or the service provider. (See Tool 6: Follow Up with Patients.)
- **Certify a Notary Public.** Select one person in the practice to become a Notary Public. This can help expedite completion of certain forms and eliminate an additional step for patients. The following link provides access to a Notary Public training course.
- See Tool 21: Make Referrals Easy for information on supporting and following up on referrals.

[Practice Name]  
Community Referral Form

Reason for Referral: \_\_\_\_\_

Name of Program: \_\_\_\_\_

Name of Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_

Location: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Track Your Progress

Test whether your resource list is up to date. Call four randomly chosen service providers and verify their information.

Conduct a spot check of your medical records. Choose 10 medical records at random to see if they record information about patients' non-medical challenges and support systems. Repeat again in 2, 6, and 12 months to see if the medical records are more complete.

Track how many referrals are made in a month and then again 2, 6, and 12 months after implementation. To track referrals, develop regular reports of referrals made from your medical record system. Alternately, collect completed Community Referral Forms to track when staff make community referrals.

Make note of five referrals you have made. Check the patients' charts 1 month later to see if the outcome of the referral is documented.

If you field questions from the Health Literacy Patient Survey, calculate what percentage of patients responded "Yes" to question #32

## Resources

Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment summarizes the evidence regarding the value of addressing patient's non-medical needs.