Adapting an In-Clinic Resource Navigator Program to a Virtual Referral Model

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THE INNOVATION

Awareness and understanding of social determinants of health, such as socioeconomic status and social support, are fundamental in successful management of chronic diseases.[1] Since 2016, our clinic has worked with the Community Resource Navigator Program (CRNP), an innovative model that uses student navigators to connect patients with community resources. With the sudden shift toward telehealth in spring 2020 due to the COVID-19 pandemic, we used a plan-do-study-act cycle to adapt our CRNP social prescribing[2] to a more flexible virtual referral process. By developing a multifaceted social screening and referral process for both in-person and telehealth visits we have continued connecting our patients with much needed social supports and services.

WHO & WHERE

University of Wisconsin (UW) Health Northeast Family Medical Center is an academic primary care clinic in Madison, Wisconsin. The CRNP is led by a social worker and community health worker who train undergraduate student "navigators" to mobilize an extensive knowledge of social, financial, and legal resources. Navigators previously worked onsite in the clinic. Patients identified social needs using a paper survey handed out at check-in for all appointments. Our clinicians frequently referred patients to an in-person intake or provided personal introductions to the navigators before patients left the clinic (see **Supplemental Table 1** for workflow details at different stages of quality improvement).

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HOW

With new infection control guidelines in March 2020, the navigators began working remotely, connecting with clinicians and patients by telephone. We conducted interviews with clinicians and staff to identify barriers and opportunities for screening and referring patients to the CRNP. These interviews yielded key themes—communication, opportunities to improve original workflow, and new barriers with off-site navigators. We identified clear communication, easy access to navigator contact information for referrals, and increased frequency of reminders to screen for social needs as specific targets for quality improvement.

We have now developed multiple opportunities for patients to screen into and be connected to the CRNP. This multifaceted screening/referral process involves sharing updated contact information for the navigators with all staff through an electronic health record "smartphrase." Navigators join our daily clinic huddle every Monday to provide updates and reminders to clinic staff about how to connect with navigators off-site. We established a "universal screening" protocol, providing all patients at office visits with a brief handout about how to contact navigators directly.

Survey results evaluating these updated workflows suggest that most clinicians are contacting the navigators for patients, with their consent. In other cases, clinicians discuss how to contact the navigators with patients, enabling patients to make the connection directly. Based on feedback from this survey we are continuing to improve 2-way communication between clinicians and navigators.

LEARNING

Despite an increase in telehealth and a shift to new workflows that limited physical interactions in our clinic, we were able to use virtual workflows to continue connecting patients with resources to address their unmet social needs. We achieved this by integrating off-site community partners into telephone huddles, shared health record reminders, and telephone/e-mail connections. Other clinics can connect patients with similar social prescribing programs by providing team members and patients with multiple pathways for screening and referrals and involving community partners in regular telephone "huddles." These strategies can help reinforce meaningful community-clinic partnerships that support patients to surmount structural and systemic barriers to health.

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Supplemental materials, including references, prior presentations, funding support, and acknowledgments

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