Addressing Individual Social Needs in Primary Care: A Government Assistance Navigation Tool

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on behalf of the Basics for Health Board of Directors

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HEALTH CONNECTION

1. BACKGROUND

Social determinants of health - including income inequities - are the largest upstream determinants of health outcomes. However, systemic changes are slow, and may not meet individuals' health related social needs.

Primary care is an ideal setting to help meet social needs through the integration of clinical care, public and behavioural health, and community services.

The Canadian Medical Association and the College of Family Physicians of Canada recommend screening for and addressing the social needs of patients.[1,2]

Currently, this work is difficult for various reasons[3]:

- Time constraints,
- Inadequate information about local resources,
- Varying eligibility criteria, and,
- Complicated and inaccessible applications.

Screening tools can help with these challenges. There are a growing number of interventions, programs and tools for primary care.[4,5]

2. ENVIRONMENTAL SCAN

Purpose:

1. Identify and summarize best practices, barriers and facilitators of social needs screening and interventions in primary care.
2. Understand how social needs information is charted.

Methodology:

- Review of academic and grey literature,
- Consultations with 6 key informants, and
- Review of 11 social needs screening tools.

Findings:

- Focus on a navigation tool to help navigate income benefits,
- Use validated screening questions,
- Consider data privacy.

	Barriers to SDOH screening & intervention	Facilitators of SDOH screening & intervention
Individual (Micro)	• Subjectivity of answers to questions, • Survey fatigue of patient populations, • Patients have limited access to resources, • Efficiency is dependent on provider awareness.	• Screening facilitates conversations about social needs and overall increases comprehensiveness of care, • Screening contributes to assessment of overall risk while identifying opportunities for intervention and SDOH-informed actions plans.
Community (Meso)	• Inadequate workflow resources to follow-up, • Integration into clinical records is challenging.	• Volunteers and students help to increase capacity, • Team-based care, including community social workers, help workflow, • Online and web-based applications can help teams track outcomes.
Systemic (Macro)	• Difficult systems to understand and navigate, • Fee-for-service payment models, • Lack of recognition that social needs screening and interventions improve health outcomes.	• Poverty screening can act as a measure of complexity of care and could secure appropriate funding, • Alternate payment plan structures can help to support this work.

3. www.BCbenefitsnavigator.ca

Purpose:

1. Help address unmet social needs of patients in primary care, focusing on those who require income support.
2. Empower patients and physicians to discuss social needs.

Relevance:

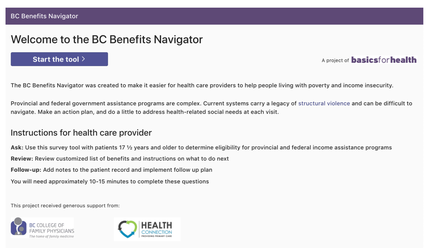
- Social needs screening can lead to improvements in health and a reduction in health disparities.[6]
- Provincial and federal government assistance systems are difficult to navigate even for healthcare professionals.
- Current systems carry a legacy of "structural violence."

Objectives:

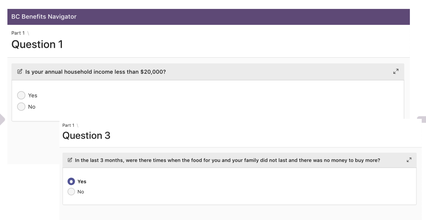
1. Create a standardized assessment tool that is:
   - Practical and easy-to-use,
   - Able to be completed by any team member,
   - Can be completed during a primary care visit,
   - Can be integrated as part of the patient record, and,
   - Able to provide information to users.
2. Provide information about next steps and local resources for healthcare providers and patients.

4. TOOL OVERVIEW

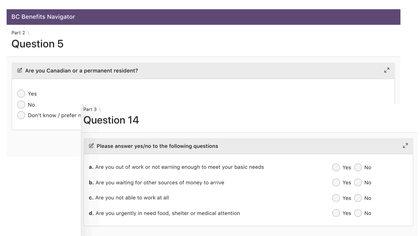
Homepage



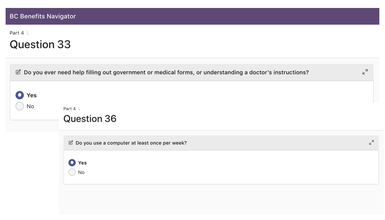
Part 1: Poverty screening



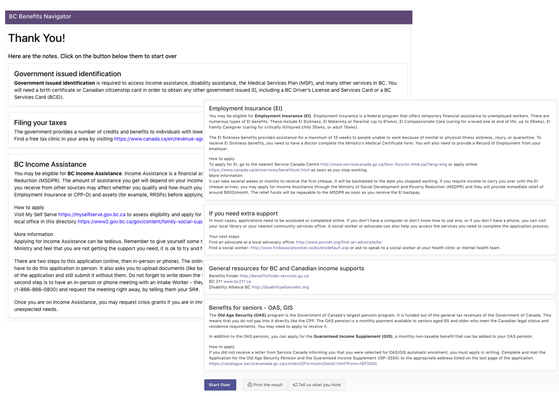
Part 2-3: Income assistance eligibility



Part 4: Health and literacy access



Completion page: Next steps and support



Design: A series of 36 binary screening questions which a team member can answer with patients to determine eligibility for various BC and/or Canadian government income assistance programs.

Questions adapted from:

- Income Security Health Promotion study
- Validated food, literacy, housing screening measures
- CEP and Divisions poverty tools
- SPARK initiative SDOH screening content areas

Content and Eligibility Criteria developed from:

- Collaboration with content expert Sandra Vasquez (Health Connections)
- Government of British Columbia - Family and Social Supports - Gov.bc.ca
- Government of Canada - Benefits - Canada.ca
- Checked for accuracy by three content experts (BC-based social workers)

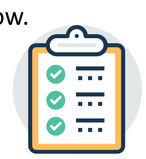
5. PILOT TEST

Methodology:

- 3 physicians and 2 social workers piloted the tool,
- 6 question feedback questionnaire completed (revised and integrated at the end of the tool),
- Additional user feedback was solicited.

Results:

- **Feasibility:** 8-10 minutes to complete, but was an added task during the clinic visit. Challenging to find time. Solutions: Schedule separate appointments? Workflow? Billing?
- **Usability**: Relatively easy to use, overall good flow.
- **Acceptability:** Patients were willing to use it.
- **Content**: Revision, simplification, adaptation.



Discussion:

- The tool is acceptable to patients and physicians, if:
  - Content is improved, simplified & other benefits/info provided,
  - User interface improved: simplification, streamlined design.
  - Guidelines for use provided: which patients, recommended timing?

6. NEXT STEPS

Continued tool development

- Ongoing technology & maintenance support confirmed,
- Content review with additional social workers complete,
- Integration of feedback survey in tool complete,
- Anonymized data collection approach in progress,
- Testing with FPs at Vancouver Division workshop in progress.

Knowledge translation and implementation

- Potential adaptation and testing of the tool for new families through the UBC Clinician Scholar Program,
- Add content for specific populations.

Dissemination and continuous evaluation

- Research, quality improvement projects.

The BC Benefits Navigator facilitates discussions between health providers and patients about poverty and income supports. This intervention shows promise to address health-related social needs, especially in settings where learners and allied health can support follow-up.

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[6]Williams et al. (2008) Moving upstream: how interventions that address the social determinants of health can improve health and reduce disparities, Journal of Public Health Management and Practice.