Improving Health Outcomes of Older Adults by Family Medicine Residency Coordination with a Local Social Service Agency

Andrew Collins, DO
Deaconess Family Medicine Residency, Evansville, IN

BACKGROUND

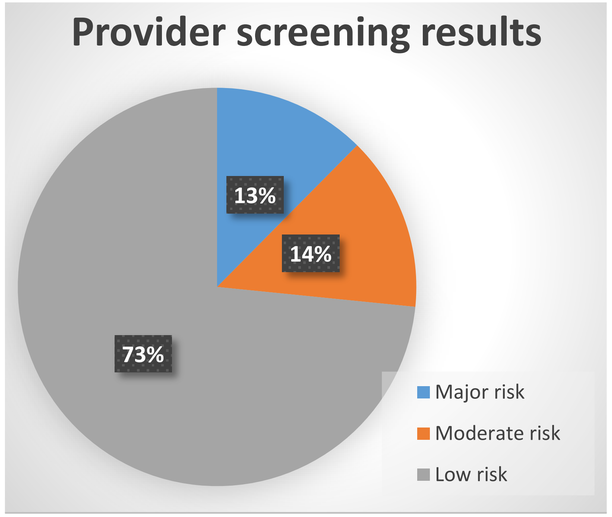
- Research has demonstrated that the social determinants of health, such as poverty and inadequate housing, place the geriatric population at significant risk of poor health outcomes. [1]
- A partnership between the Deaconess Family Medicine Residency (DFMR) and the Southwest Indiana Regional Council on Aging (SWIRCA) seeks to improve the healthcare and health outcomes of older adults through a pilot program to strengthen referral linkages between primary care clinics and community resources for our senior adults that is funded as part of a five year HRSA grant through the University of Southern Indiana.

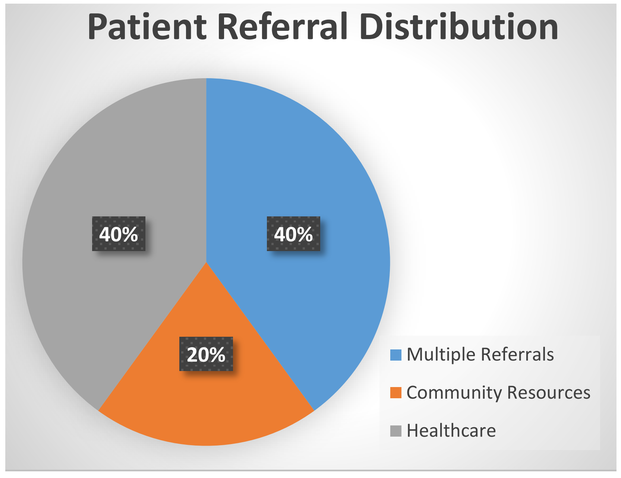
OBJECTIVES

- Identify the most at risk geriatric populations (>60) and increase access to adjunct geriatric services in their area through coordination with their primary care provider.

METHODS

- Through use of screening questionnaire, resident PCPs identified patients based on risk for not having food/medications, social support and/or proper shelter. Patients who demonstrated moderate to major concern were then contacted by PCP and then referred to a dedicated SWIRCA case manager.
- Upon Referral, SWIRCA utilizes a screening instrument that assesses things such as advanced care planning, adequate supplies of medication and toiletries, access to regular meals, and regular activity. Referral resources and/or actions were then allocated once need identified.





RESULTS

- Of the 322 patients at DFMR, 282 had risk assessment completed. The remaining patients were unable to be screened due to PCP not being familiar with patient situation.
- 45 patients were scored to be of moderate to major risk.
- At time of poster presentation only 15 have completed social work assessment. Thus far, 40% have been referred for healthcare resources, 20% for community resources and 40% have needed multiple referrals including healthcare needs, community resources, and socialization.
- 66% of our major to moderate risk group had barriers to prevent social work intervention (inconsistent phone access).

CONCLUSIONS

- If successfully connected with social work, high-risk patients were provided with additional community resources.
- EMR referral to a community social service agency can be used.
- Resident PCPs have become more familiar with the use of a local community agency as a referral resource. Resident physicians at our practice previously identified social determinants as an area of frustration and burnout.
- There are several limitations in this pilot study
  - Screening also took place in June, and some patients were unable to be screened due to loss of provider continuity.
  - Social work was not embedded onsite.
  - Screening process could limit patient engagement.

REFERENCES/ACKNOWLEDGEMENTS

1. Ish P. Bhalla et al, Social determinants of mental health care systems: intensive community based Care in the Veterans Health Administration, BMC Public Health, 10.1186/s12889-020-09402-0, **20**, 1, (2020).

2. The University of Southern Indiana's (USI) was awarded a five-year cooperative agreement from the Health Resources and Services Administration (HRSA) Geriatrics Workforce Enhancement Program (GWEP).