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CCO Oregon Conference:

# Strengthening Pathways to Social Support in Primary Care



# Objectives

- Explore different referral and resource navigation pathways in primary care
- Understand common challenges clinics face in connecting patients to social supports
- Identify opportunities to strengthen connections across clinics, CCOs, and community partners

# Social Needs in Primary Care

Primary care is an important access point for identifying and responding to social needs.

- How clinics approach social needs varies based on staffing, workflows, technology, reporting requirements, and community resources
- Federal and state metrics and initiatives also shape clinic approaches to screening, referral, and documentation
- **Bottom line:** There is no single model that works for every clinic or community



# Connecting Patients to Support

## Internal Referral Approaches

- Connect to an in-house CHW, care manager, social worker, or other navigator
- Provide clinic-based assistance or facilitate connection to external resources

## External Referral Approaches

- Facilitate direct outreach to social services (e.g., phone call, fax, online portal, or form)
- Community Information Exchange (CIE) platforms such as UniteUs/Connect Oregon or findhelp
- Tailored resource information when a patient prefers to connect independently

## Common Resource Providers:

- Community-based Organizations (e.g., local food pantry)
- Community Care Organizations / Health-Related Social Need (HRSN) Providers
- State programs (e.g., SNAP or WIC)
- Federal programs (e.g., Supplemental Security Income (SSI) or Section 8 housing vouchers)

# Common Challenges for Clinics

**Creating a pathway that patients and staff can realistically navigate**

- Staff knowledge of available resources and how to access them
- Limited staffing and navigation capacity
- Changing eligibility requirements, availability, and waitlists
- Different systems and communication methods across organizations
- Patient preferences, trust, and previous experiences seeking assistance
- Technology that can add rather than reduce workflow burden

# Types Clinic-Community Relationships

## Informal Connections

- Awareness of local organizations
- Inclusion in clinic resource lists or directories
- Information provided to patients (e.g., pamphlets, cards, website)

## Active Coordination

- Direct referrals (e.g., phone call, community information exchange platform, website portal)
- Shared communication about patient needs

## Formal Partnerships

- Established agreements or workflows
- Shared referral system or data tracking
- Ongoing coordination between organizations

## Collaborative Initiatives

- Joint planning, shared goals, addressing broader community health needs.
- Community coalitions, networks, and hubs
- Participation in community health needs assessments (CHNA/CHIP)

# What Strengthens the Pathway?

- **Clinic capacity**
  - Sustainable navigation/CHW/care coordination roles
  - Clear ownership and workflows
- **Clinic–community connections**
  - Direct relationships with key community partners
  - Clear referral and communication expectations
  - Processes that reflect CBO capacity
- **System infrastructure**
  - Coordinated navigation and referral hubs
  - Interoperable or streamlined referral mechanisms
  - Sustainable funding for navigation and community capacity



Thank you!

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