COMMUNITY HEALTH CENTRES OF NORTHUMBERLAND

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Improving Data Quality & Collaboration Through Standardized Social Prescribing Pathways

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From Fragmented Work to Connected Care

Today's Focus

- The previous documentation challenge
- Why it impacted care and outcomes
- How social needs are identified and supported
- A standardized approach to improve care
- What this means for practice and data

The Challenge: Work Happens, But Isn't Captured

- No consistent approach to documenting social supports
- Heavy reliance on informal communication:
  - Emails,
  - Sticky notes
  - Hallway conversations
- Client records were often incomplete or fragmented
- Limited visibility across teams

Key Issue: Important work was happening – but it was not being consistently recorded or shared.

Why This Matters for Client Care

- Incomplete understanding of client needs
- Missed or delayed follow-ups
- Reduced coordination across providers
- Limited ability to track outcomes and trends

Impact: We lost opportunities to deliver fully coordinated, client-centred care.

Understanding Socially Driven Needs

Common needs we **see** in clients:

- Housing instability
- Food insecurity
- Social isolation
- Financial challenges
- Access to community resources

How we **identify** them:

- Screening tools
- Targeted conversations
- Client disclosure
- Ongoing provider insight

How We Support Clients Today

Support can include:

- Referrals to community connectors or link workers
- Connecting clients with community organizations
- Providing resources and information (e.g., pamphlets, contacts)
- Supporting access to programs (e.g., food, classes)
- Addressing barriers (e.g., transportation, technology, forms)

Key Point: Support is already happening – across many roles and touchpoints.

The Missing Link:
Consistent Documentation

When to Document

- When a need is identified **and** support is provided or facilitated (e.g., providing program info, referring to community agencies)

What to Document

- Actions taken
- Referrals made
- Follow-up plans

How to Document

- Use standardized encodes
- Select "**Social Prescription**" under services
- Record follow-up clearly

Goal: Capture meaningful actions – not just conversations.

Our Approach:
From Informal to Standardized

Making existing work visible and trackable.

We introduced:

- A standardized referral pathway
- A consistent documentation workflow
- A structured EMR (PSS) custom form
- Integrated internal communication

This is not extra work – it's better visibility of the work already happening.

The Referral Pathway:
Clear and Consistent

How it works:

1. Provider identifies a social need
2. Referral pathway is activated
3. Support is provided directly by the provider **OR** a referral is initiative to the Social Prescribing Team
4. Connection to a Community Connector
5. Follow-up is documented

Built collaboratively across teams

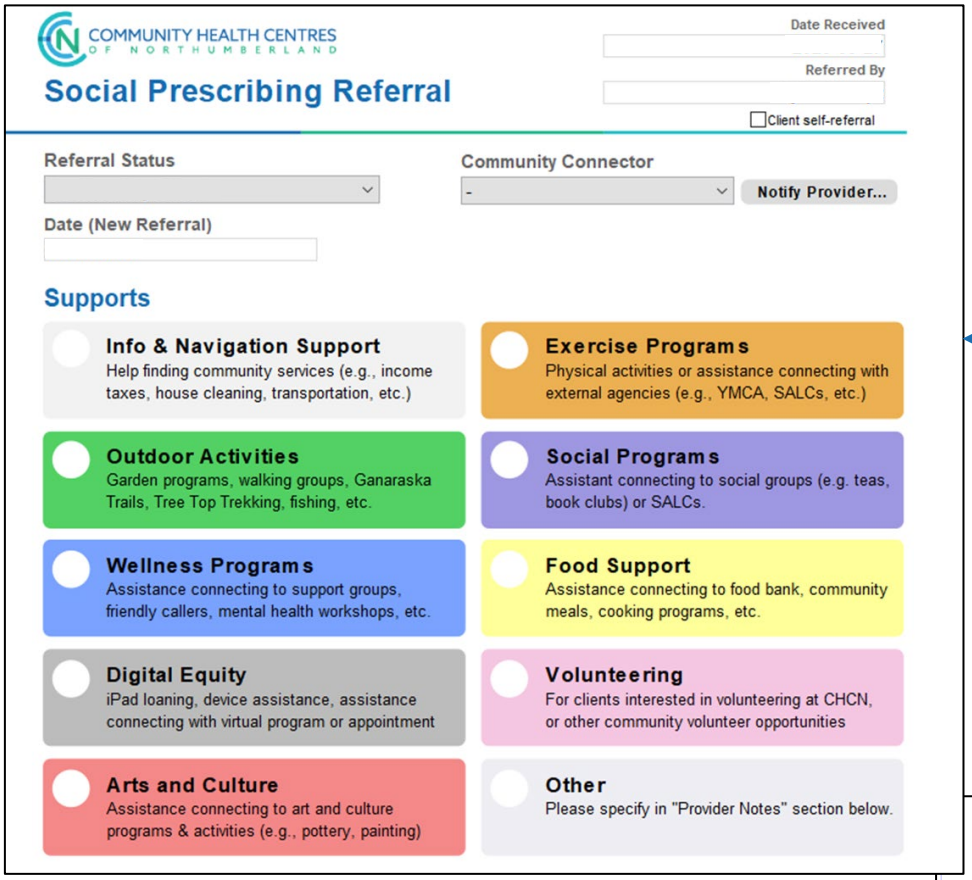
- Provider input, feedback, training, committee work

Making It Visible:
The PSS Custom Form

Captures:

- Client needs and priorities
- Actions taken by providers or teams
- Referrals (internal & external)
- Wraparound supports provided
- Barriers and how they're addressed
- Follow-up actions and ongoing engagement

Outcome: A complete, structured view of the client journey.

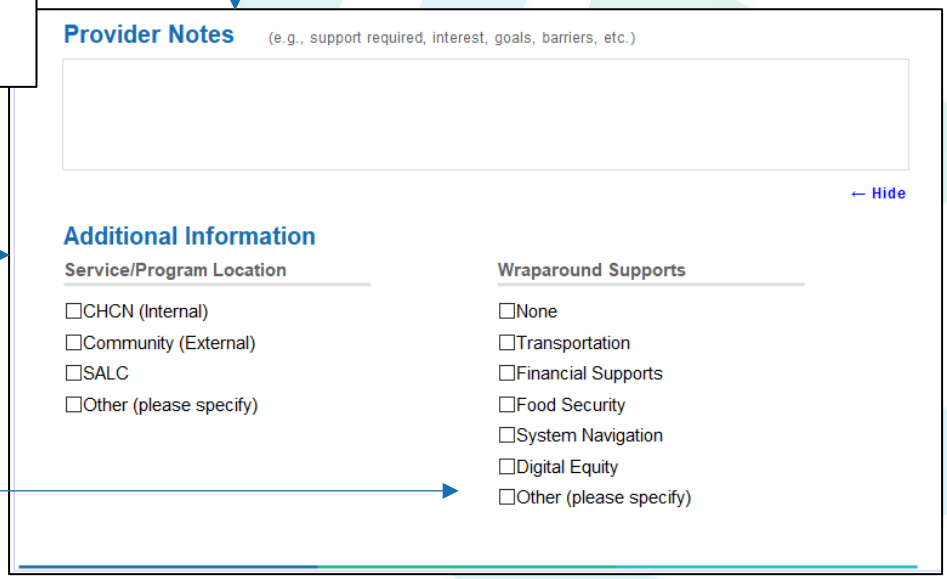


Client needs and priorities

Actions taken by providers or teams

Referrals *(internal & external)*

Wraparound supports provided



Why Standardization Matters

- Creates a shared language across teams
- Reduces gaps and miscommunication
- Improves continuity of care
- Enables real-time collaboration through EMR messaging

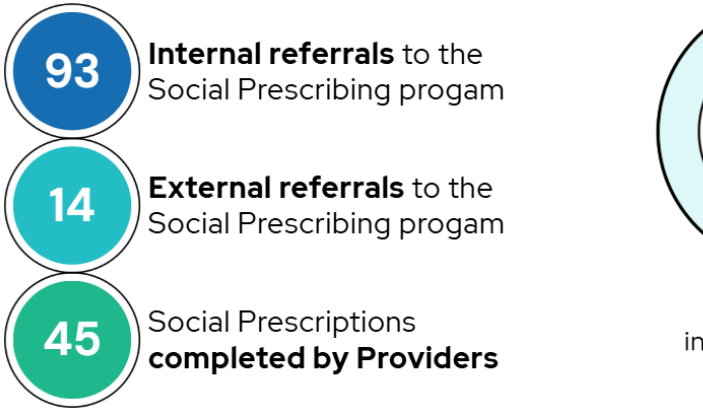
Result: Stronger coordination and more efficient care delivery.

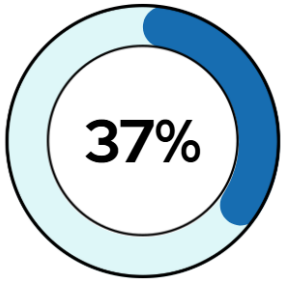
From Documentation to Insight

What better data enables:

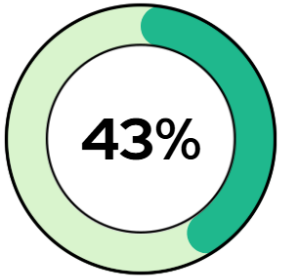
- Tracking client needs and service use
- Identifying trends across populations
- Measuring program impact
- Strengthening reporting and funding applications

From Documentation to Insight





connected to internal programs or service



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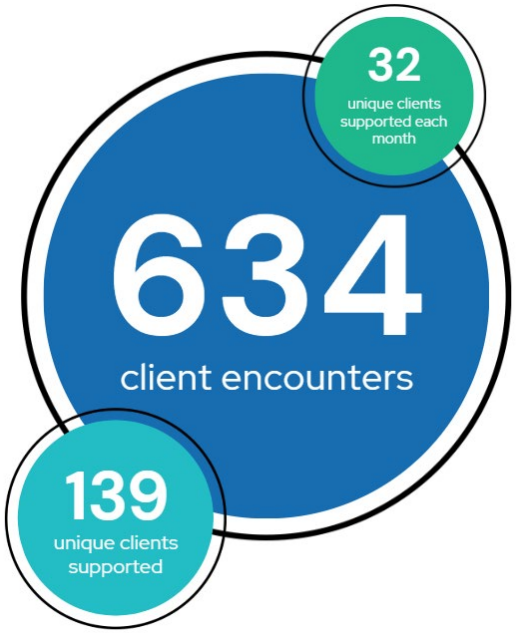
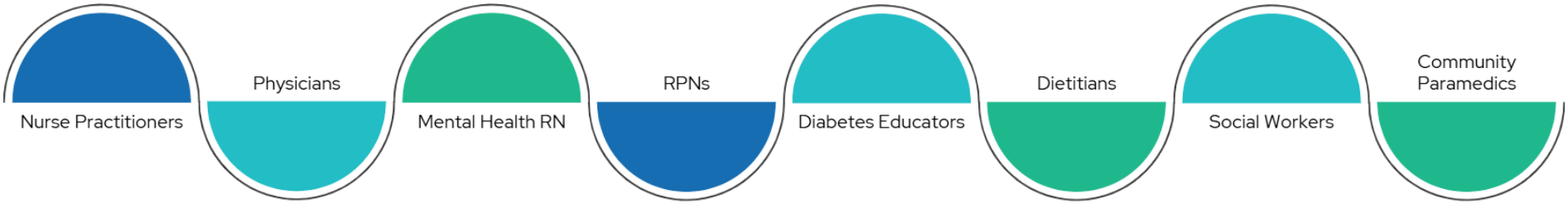


55% of referrals are for Information & Navigation Support



Key Takeaways

- Social needs are already being addressed across teams
- Inconsistent documentation limits impact and visibility
- Standardization improves care coordination and outcomes
- Better data leads to better decisions and stronger programs

Thank You

Questions?