Community Health Initiatives Tool

CAYUGA HEALTH SYSTEM

Community Health Resource Network

INITIATIVE DESCRIPTION AND GOALS

As Cayuga Health has worked to grow its population health efforts, it became obvious that health-related social needs were a main driver of health outcomes. Cayuga Health has begun to build partnerships between its providers, community-based organizations, academic partners and local government to address health-related social needs. Its intention is to move beyond simple coordination with community partners to collaboration, with a goal of health and social care integration.

Cayuga Health's providers know that unmet social needs are major drivers of adverse health outcomes. They want to connect their patients with community resources but had not had an effective way to do this. Through patient focus groups and conversations with a community advisory board, the health system learned that patients believe that their providers are not aware of the factors that are influencing their health. They want their providers to ask about their social needs, offer support and adjust how they provide care.

Having a better understanding of both provider and patient perspectives, Cayuga Health was able to establish a commitment to standardize its approach to addressing unmet social needs among all patients by screening for and responding to health-related social needs. This program started a multi-year process in 2021, working closely with the internal medicine residency program, several CBOs and Cornell's Center for Health Equity. They used Health Leads' social needs screening toolkit to customize the health system's first standardized social needs screening tool.

Cayuga's aim was for it to be short, with eight questions that cover food, utilities, housing, childcare, finances, transportation, health literacy and social support. Cayuga also selected questions written at a fifth-grade reading level whenever possible. This universal screening was given to all patients at their annual well visit. The team also created a community resource brochure so that when patients identified an unmet social need on the screening form they'd know what is available and had a number to call.

While this screening tool and brochure were a significant improvement, Cayuga Health recognized that self-referrals were not as effective as warm hand-offs and supportive contacts. However, the practices did not have sufficient staff resources to provide this necessary level of support. The team knew that to support patients and connect them with needed services, the health system had to expand the pilot to facilitate direct referrals to CBOs.

Partnering with CBOs to receive direct referrals enabled Cayuga to design a new process and approach to addressing unmet social needs. They brought all stakeholders to the table to co-design the screening and referral process, which includes a web-based closed-loop referral system. The goal is to treat social needs referrals the same as any referral coming out of a primary care office.

PARTNERS

Human Services Coalition, Cornell Center for Health Equity, Cornell University Department of Public and Ecosystem Health, Cayuga Health Partners, Tompkins Whole Health, Advocacy Center, Family & Children's Services, FoodNet Meals on Wheels, Visiting Nurse Services, Cayuga Addiction and Recovery Services, LawNY, Child Development Council, Opportunities Alternatives Resources, Finger Lakes Independent Center, YMCA and REACH.

OUTCOMES

Cayuga Health has screened over 44,000 patients for health-related social needs, with 20% of patients screened indicating at least one unmet social need. Patients who indicate having an unmet need are referred via a warm hand-off to CBO partners. The CBO partners have a 100% outreach rate, with every person being contacted to offer support or connection to resources to meet their needs.

LESSONS LEARNED

Increasing the rates of referrals for patients is a top priority area. This requires a streamlined, automated process at each site, which will be developed by the multidisciplinary project team.

Cayuga Health actively collects data around screening for social needs, population health/quality data and demographic data. Enhancing, expanding and leveraging these data is key to developing actionable steps to improve outcomes. This includes improving the use of ICD-10 coding for social needs and better understanding how referrals improve or eliminate unmet needs and if access to care is improved.

SUSTAINABILITY

To further sustainability of the program, Cayuga Health was awarded a state transformation grant, which is supporting the creation of an integrated health and social care network.

CONTACT

Amy Carver, MBA, Assistant Vice President, Clinical Integration and Population Health
acarver@cayugamed.org | 607.252.3695

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