

Purpose & Rationale

To implement system-level practice change to engage nurses in increasing referrals based on unmet **social drivers of health (SDOH)** and **improve patient/family experience** for older hospitalized adults transitioning from a **critical access hospital (CAH)** back into the community

- **SDOH contribute up to 80%** of health¹
- **Community Health Needs Assessment (CHNA)** identify needs²
- Hospitals report five domains of SDOH³
- **Joint Commission** National Performance Goal 4- Assess health-related social needs, share information on community resources⁴
- **American Nurses Association** Code of Ethics emphasizes nursing's role in social justice⁵
- **Nurses lack formal training** in SDOH and resources,⁶⁻⁸ leading to missed opportunities

EBP Model

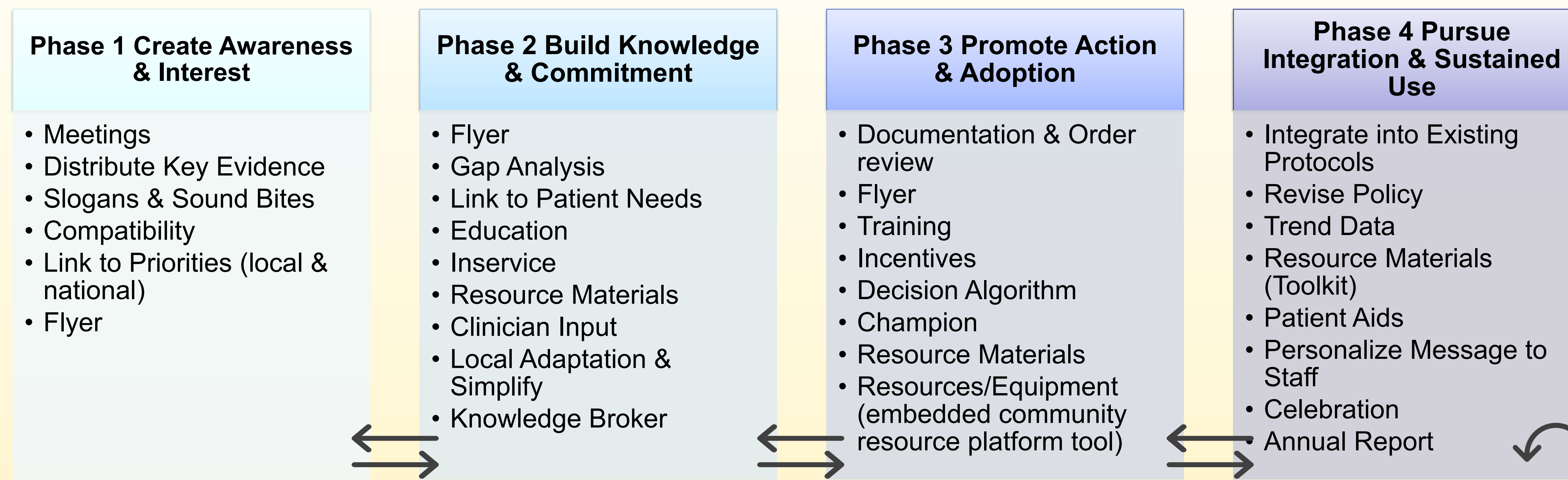
- **Iowa Implementation for Sustainability Framework⁹**

Synthesis of Evidence

- Most healthcare professionals believe unmet social needs impact health and screening should be standard in hospital⁶
- **Barriers-** limited/lack of knowledge of resources, lack of training/support to respond to needs⁶⁻⁸, lacking skills speaking about SDOH⁸, costs of referral platform, limitations of community resource programs, blurring of roles/responsibilities within healthcare¹⁰
- Those reporting **higher SDOH competence more likely to assess and address SDOH**¹¹
- Hospitals with **multiple management levels involved** in SDOH - higher odds of addressing patients' social needs¹²
- **Community partnerships** can help address SDOH^{2,13}
- **Facilitators-** standardized screening tools, referral platforms, social needs-informed care⁸, relationships within networks and organizations¹⁴
- **Education on community resources and effective communication** with socially at-risk patients may improve patient care and outcomes¹⁵

Practice Change & Implementation Strategies

- Med/surg unit, 20-bed CAH in west central Iowa
- System-level changes: Organized a task force involving key stakeholders, developed community partnerships, and engaged through feedback loops, implemented staff education with community presentations and resource fair
- Phased **evidence-based approach** to achieve objectives⁹



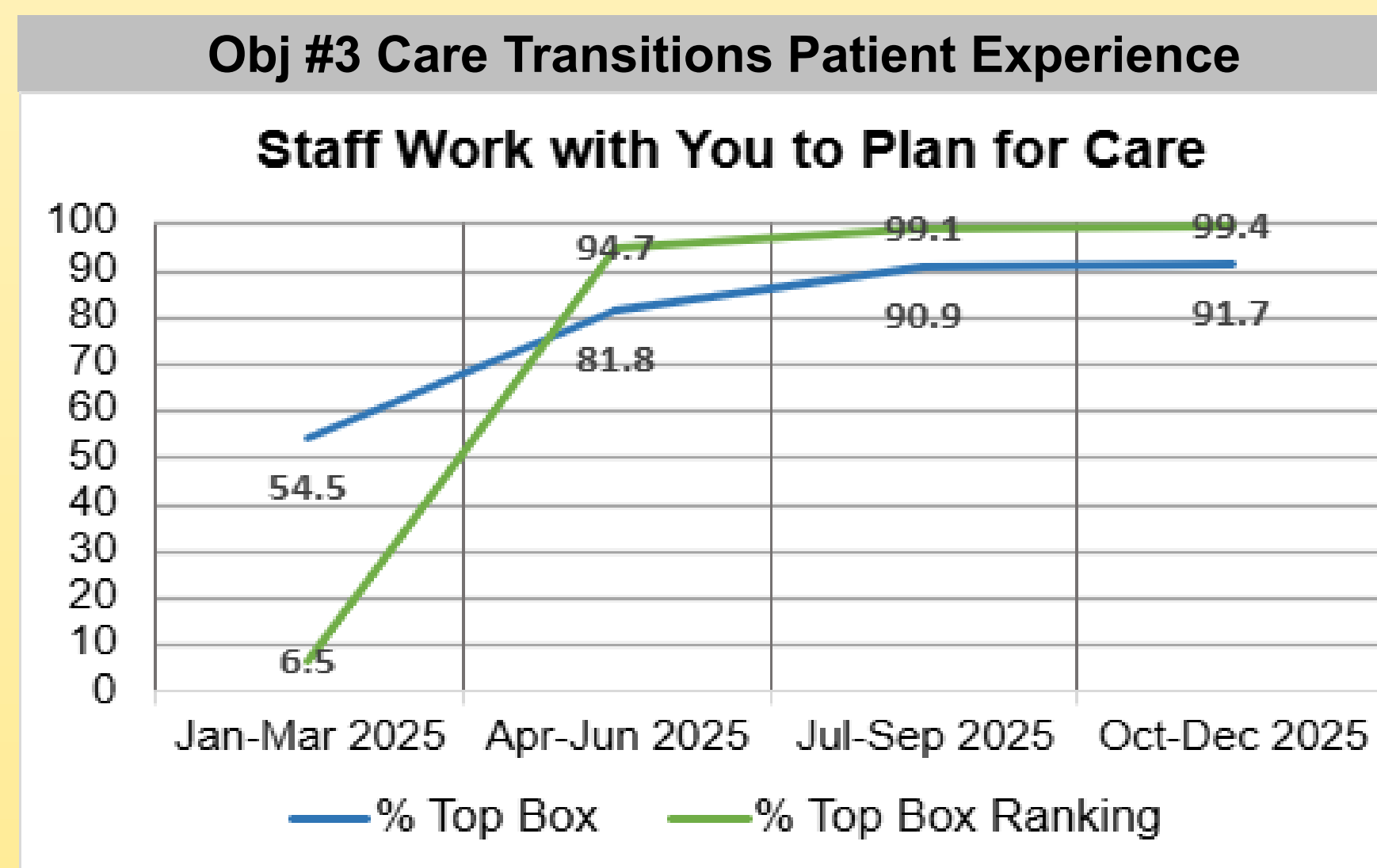
Evaluation

- ✓ Obj #1 Outcome: **Met** Task force created, addressed gaps and implementation plan, met 9 times throughout project
- ✓ Obj #2 Outcome: **Met** Referrals to identified community partners (local AAA and regional transportation) initiated
- ✓ Obj #3 Outcome: **Met** The targeted Care Transitions survey item "Did doctors, nurses, and hospital staff work with you and your family or your caregiver in making plans for your care after you left the hospital?" improved from baseline by 12/31/25
- ✓ **All objectives met, plus unanticipated favorable outcomes**

| Obj #1 Nurse Leader Task Force | |
|--------------------------------|----------------------|
| Core Members | Ad Hoc Members |
| Project Director | Frontline Nurses |
| Chief Nursing Officer | Education Nurse |
| Quality Director | Public Health Nurse |
| Inpatient Director | Marketing Director |
| RN Case Manager | Staffing Coordinator |

| Obj #2 Referrals | |
|-----------------------------|-----------------------------|
| Before Intervention | After Intervention |
| AAA referrals: 0 | AAA referrals: 1 |
| Transportation referrals: 0 | Transportation referrals: 1 |

While volumes were small, system & behavior changes demonstrated feasibility



Referral Platform

Hosted by community organization

HIPAA-compliant, no-cost

Embedded into hospital website Fall 2025

Video tutorial with flyer

- Distributed organization-wide

Referrals initiated showing system level impact

- Hospital-affiliated clinic made 2 referrals by end of this project data collection period (12/31/25)

Community Organization Engagement

14 Total Engaged
(5 invited + 9 requested participation)

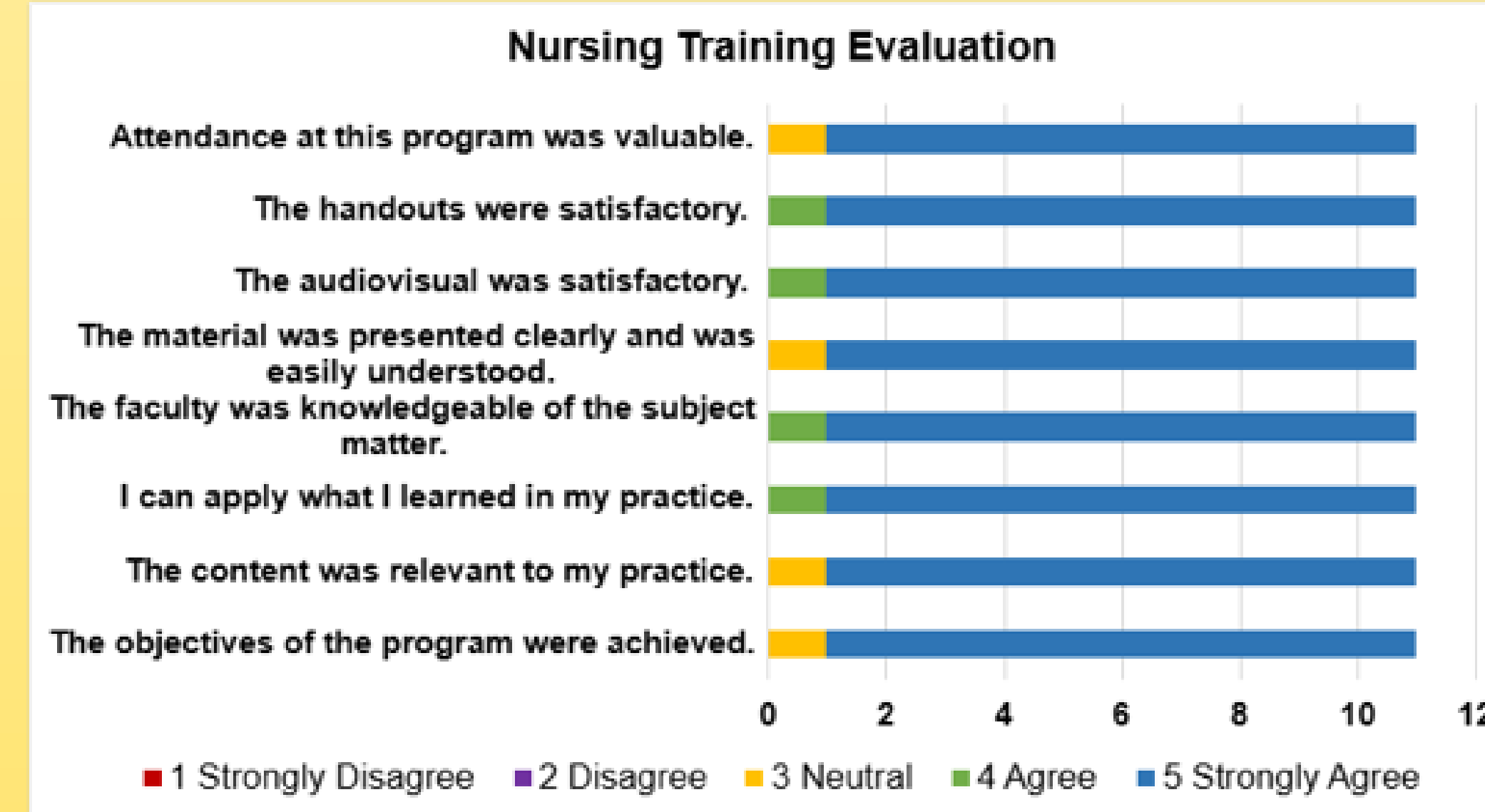
100% would participate again

Overall Value

★★★★★

Community Organization Representation at Fair

Housing, Food, Utilities, General Assistance
Mental/Behavioral Health
Older Adult & Caregiver Support
Smoking Cessation
Interpersonal Safety/Trauma/Violence
Rehabilitation (PT/OT/ST)
Foster/Adoption
Family Planning, Maternity, Child Health
Public Health
Transportation



Conclusions

- **Systems-level leadership imperative**, built awareness of resources and community partnerships
- Demonstrates the **value and positive impact** of targeted training and partnership
- Equips and empowers nurses to assess SDOH and connect to resources
- Highlights critical role of nurses in **bridging hospital and community care**
- **Advances CHNA** implementation plan and goals²
- Demonstrates feasibility for **scalability**
- Limitations: single, rural hospital; short timeframe and time to advertise for resource fair; evolving SDOH reporting requirements
- Lessons learned: public health also stakeholder, marketing is key, keep incentives simple

Next Steps

- Staff training and community organization presentations recorded, **shared hospital-wide**
- Repeat resource fair with community organization partners annually
- Poster presentations, journal publication
- Submit education for wider audience
- Consult with other CAHs to implement

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The author reports no conflicts of interest.

References



Project Materials



"Healing doesn't end at discharge"
"Better Transitions, Better Outcomes"
"Advancing Patient Outcomes – One Referral at a Time"