

Patient Perspectives Resource 10:

What Patients Want Health Care Teams to Know

# Strengthening Community Resource Pathways and Patient Engagement

Developed December 2025 with input from members of the NEO QI Hub Patient Advisory Council to help health care teams provide more patient-centered diabetes care.

## Access to Community Resources

### Try This:

- Recognizing that social drivers of health (SDOH)—including food, housing, transportation, utilities, and social support—strongly influence diabetes outcomes
- Routinely screening for SDOH as part of standard clinical workflows, especially for Medicaid patients with chronic conditions
- Pairing screenings with warm handoffs to community-based resources
- Providing follow-up support to confirm patients were able to access services
- Maintaining a centralized, regularly updated community resource directory
- Vetting resources for:
  - Eligibility requirements
  - Availability and capacity
  - Accuracy of contact information
- Partnering with local government, community organizations, and faith-based groups to validate and maintain resource accuracy



### Instead of This:

- Treating social needs as separate from medical care
- Giving patients a list of resources without guidance or follow-up
- Relying on outdated, fragmented, or inaccurate directories
- Assuming online searches or 2-1-1 services alone will meet patient needs



## Trust, Communication, and Health Literacy

### Try This:

- Using plain language in all patient-facing materials and conversations
- Meeting patients where they are, without judgment
- Building trust through consistent, respectful communication
- Creating a safe and supportive environment for patients to share social needs
- Training staff and advocates in:
  - Health literacy best practices
  - Cultural humility
  - Patient-centered communication
- Reinforcing that patients are active partners in their care



### Instead of This:

- Using jargon or complex eligibility language
- Rushing conversations about social needs
- Expecting patients to disclose barriers without trust
- Overestimating patients' familiarity with health care or community systems



## Systems, Staffing, and Ongoing Support

### Try This:

- Embedding health care advocates in both clinic and community settings
- Using advocates to:
  - Screen for social needs
  - Navigate community resources
  - Support ongoing patient engagement
- Strengthening coordination across:
  - Clinics and health systems
  - Insurers
  - Community-based organizations
  - Local government
- Establishing clear referral pathways with defined roles and expectations
- Using accountability structures for grant-funded and community programs
- Tracking outcomes and continuously updating systems to reduce patient burden



### Instead of This:

- Expecting patients to navigate complex systems on their own
- Leaving follow-through solely to community partners without coordination
- Operating in silos across health care, insurance, and community services
- Funding programs without monitoring accessibility, effectiveness, or equity



This resource is part of the AHEAD Initiative Diabetes QI Clinical Toolkit. For access to this toolkit and additional resources, please visit [NEOQIHub.org](https://NEOQIHub.org).

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The Northeast Ohio Quality Improvement Hub is funded by the Ohio Department of Medicaid and administered by the Ohio Colleges of Medicine Government Resource Center. The views expressed in this website are solely those of the authors and do not represent the views of the state of Ohio or federal Medicaid programs.