

Lesson 2: Strategies to Obtain Information about Local Community Resources

Identifying and Connecting with Community Resources

Successful lifestyle medicine practice requires knowledge of and connections to community resources that can support patients' lifestyle changes. Healthcare settings alone cannot provide all the resources patients need to make and sustain lifestyle changes. Community partnerships extend the reach and impact of clinical interventions.

Conducting a Community Asset Mapping Exercise

Systematically identifying resources available in your community provides a foundation for effective referrals. Creating a comprehensive inventory of local organizations, facilities, and programs requires dedicated effort but yields valuable information. Categorizing resources by type, such as nutrition, physical activity, and stress management, makes the information more accessible and useful. Documenting details such as location, cost, eligibility requirements, and contact information enables efficient referrals. Considering both formal resources like YMCA programs and informal resources like walking groups captures the full range of community assets that can support patients.

Establishing Relationships with Community Organizations

Building partnerships with local resources enhances referral processes and creates opportunities for collaboration. Scheduling meetings with program directors to learn about their services provides firsthand knowledge that improves referral quality. Inviting community partners to give presentations to your healthcare team educates staff about available resources and builds relationships. Creating formal referral agreements with key organizations streamlines the referral process and may enable bidirectional communication about patient progress. Co-developing programs that address gaps in community resources can fill important needs while strengthening partnerships.

Utilizing Existing Resource Directories

Taking advantage of established databases and referral systems saves time and provides access to comprehensive information. Contacting your local public health department for community resource information taps into their knowledge and connections. Exploring online directories such as 211 Information and Referral Systems provides searchable databases of community resources. Connecting with local hospitals that may maintain community benefit programs and resource lists leverages their

community engagement efforts. Reviewing resources compiled by disease-specific organizations like the American Diabetes Association provides specialized information relevant to particular patient populations.

Engaging in Community Outreach and Networking

Actively participating in community events and professional networks builds relationships and keeps you informed about community resources. Attending health fairs and community events provides opportunities to meet representatives from local organizations face-to-face. Joining local professional associations and coalitions focused on health promotion connects you with others working toward similar goals. Participating in community health needs assessments conducted by hospitals provides insight into community priorities and gaps in services. Speaking at community venues such as libraries, places of worship, and schools raises awareness of lifestyle medicine while building community connections.

Implementing a Systematic Approach to Resource Management

Creating systems to maintain up-to-date information on community resources ensures that referrals are current and accurate. Designating a team member responsible for maintaining the resource database ensures accountability for this important function. Establishing a schedule for regular updates of resource information keeps the database current as programs change. Creating a feedback mechanism for patients and providers to report on resource quality provides valuable information about the effectiveness of community partners. Developing a rating system to help identify the most effective community partners guides referral decisions and strengthens relationships with high-quality resources.

Implementing Social Connection Interventions in Clinical Practice

Addressing social isolation and loneliness as part of clinical lifestyle medicine practice requires systematic approaches to screening, intervention, and connection to community resources. Implementing routine screening for social isolation should be integrated into standard intake procedures alongside other lifestyle factors, using brief validated instruments such as single-item loneliness questions or the 3-item UCLA Loneliness Scale. Electronic health record systems can be configured to include social connection as a lifestyle vital sign, with documentation templates prompting assessment of relationship quality, social support, and community engagement. Positive screens for loneliness or social isolation should trigger clinical protocols that include further

assessment, brief counseling, and referral to appropriate resources. Tracking social isolation as a clinical variable enables population health management approaches that identify at-risk patients and target interventions to those most in need.

Social prescribing programs formalize the process of connecting patients to community-based social activities and support services. Implementing social prescribing requires several components: designated link workers or health coaches who have time and expertise to conduct detailed social assessments and connect patients with resources; comprehensive community resource directories that catalog local opportunities for social connection including volunteer programs, classes, clubs, support groups, and recreational activities; established referral relationships with community organizations that facilitate smooth transitions and may enable feedback about patient engagement; and systems for tracking referral completion and outcomes. Social prescribing works best when integrated into team-based care models, with link workers collaborating closely with clinicians to ensure that social interventions complement medical treatment. Some healthcare systems have developed formal partnerships with community organizations, creating preferred referral pathways and even embedding community organization staff within healthcare settings.

Group medical visits represent a clinical intervention that simultaneously addresses medical needs and social connection. Shared medical appointments bring together patients with similar conditions for extended visits that include both individual medical attention and group education and support. The group format creates opportunities for peer connection, with patients often reporting that learning from others with similar experiences and feeling less alone are among the most valuable aspects of group visits. Implementing group visits requires developing appropriate patient selection criteria, creating structured agendas that balance medical and social components, training clinicians in group facilitation skills, and establishing billing procedures that ensure financial sustainability. Group visits are particularly effective for chronic conditions where ongoing support and behavior change are essential, such as diabetes, obesity, and chronic pain. Beyond formal group visits, practices can facilitate patient connection through support groups, walking clubs, cooking classes, and other activities that bring patients together around shared health goals.

Measuring the impact of social connection interventions provides data to demonstrate value and guide quality improvement. Process measures such as screening completion rates, referral rates to social resources, and patient participation in group activities assess implementation fidelity. Outcome measures should include changes in loneliness scores, patient-reported quality of life, mental health symptoms, and

engagement in health behaviors. Some practices track healthcare utilization, hypothesizing that improved social connection may reduce emergency department visits and hospitalizations by providing support that prevents crises. Qualitative feedback from patients about their experiences with social interventions provides rich information about what works and what needs improvement. Using quality improvement methodologies such as PDSA cycles enables practices to test social connection interventions, evaluate results, and refine approaches based on data. As evidence grows that addressing social isolation improves health outcomes and potentially reduces costs, documenting these impacts strengthens the case for sustained investment in social connection interventions as part of comprehensive lifestyle medicine practice.

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