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# A Practice Designed to Address Social Determinants of Health

**Leveraging a concierge model allows this practice to fund charity care and creatively address social determinants of health in underserved communities.**

**S**ocial determinants of health (SDOH) are widely known to have profound effects on overall health.<sup>1</sup> Variables such as wealth and income, educational attainment, dietary habits and food access, cultural influences, access to parks and sports, cleanliness of the local environment, number and quality of relationships, and the presence of meaningful spiritual expression



all affect a community's health in significant ways.<sup>2,3</sup> Certain SDOH may even have a greater impact on health than commonly performed clinical services such as cancer screenings.<sup>4</sup>

Yet most clinics don't address SDOH in a meaningful way. Doing so requires a major shift in the way we think about disease diagnosis and treatment, and the way we allocate resources. This article

## ABOUT THE AUTHORS

Dr. Bymaster is a family physician at Healing Grove Health Center in San Jose, Calif. Nicholas Fong is a pre-medical student who provided research assistance. Author disclosures: no relevant financial relationships.

describes an innovative practice model in which an outpatient clinic can creatively and effectively address SDOH in a primary care setting.

### THE PRACTICE MODEL

Healing Grove Health Center clinics are located in low-income neighborhoods and hire staff from the communities they serve. They are place-based clinics, focusing on the specific needs of the local community. Each population has a unique set of strengths

Each full-price patient funds their own primary care and that of two low-income patients.

and struggles, and our clinics leverage the strengths to tackle the struggles. Originally, we had one clinic in San Jose working with Spanish-speaking immigrants. This is the most mature site and will be the focus of this article, but we have since added three sites in other counties in California.

The clinics are concierge-direct primary care (DPC) hybrids, with concierge patients paying \$200 per month. Each full-price patient funds their own primary care and that of two low-income patients. The goal is to have 300 concierge patients plus 600 low-income patients per physician, resulting in a panel of 900 patients.

The concierge fees cover the clinic rent, supplies, and salaries for the physicians and a small staff consisting of a receptionist, patient navigator, and medical assistant. The clinics are organized as nonprofits and also receive donations and apply for

select grants. As funding allows, we employ staff who work full time addressing SDOH. We also have a network of volunteers. Our clinics can bill insurance (e.g., for certain procedures that aren't covered under the membership fee), though sometimes this requires more staff time than it is worth. The nature of the funding model allows our clinics to be creative and responsive to our patients' unique needs.

### HOW WE ADDRESS SDOH

Our clinics have developed a number of meaningful ways to address our patients' SDOH needs.

**Socioeconomic challenges.** Health is tied most closely to income, and when we work with a low-income population, lack of funds is a frequent barrier to ideal health. Our patients have multiple economic challenges: joblessness, insufficient funds to pay bills such as utilities or car repairs, and housing instability due to the inability to pay rent. Our staff make it clear to patients that we understand how these sorts of problems affect their health and we are willing to help. Each clinic site hosts trainings for food-handler certification, forklift endorsement, driver's licenses, resume creation, conflict resolution, CPR certification, and other workshops designed to help patients become more employable. We have built relationships with temporary job agencies, event staffing agencies, and employment training organizations, and we frequently refer patients to them. Our staff assist patients as they fill out job applications, and dozens of our patients have found jobs with the help of clinic staff.

**Educational challenges.** Our San Jose clinic has a target population of Spanish-speaking immigrants from Mexico and Central America, many of whom had only a few years of education in their country of origin because of a variety of factors related to poverty. In many medical practices today, patients are inundated with paper forms, which is a particularly negative experience for this population. Many have low literacy levels, and they come from a highly relational culture where in-person verbal communication is preferred over written communication. To stay community-centered, we decided to keep paperwork to a minimum. When we require

### KEY POINTS

- In the authors' concierge practice, each full-price patient funds their own primary care and that of two low-income patients.
- The funding model allows family medicine clinics to meaningfully address social determinants of health in a local, low-income community.
- Traditional practices can incorporate aspects of the model by focusing on a specific neighborhood and a specific SDOH to start.

forms, staff fill them out with patients. Parents also often need help navigating the U.S. educational system with their kids. We help them fill out school forms and negotiate challenges such as special education processes, school transfers, and college applications. We also connect highly motivated students with volunteer tutors.

Unfortunately, it is common for learning and developmental disabilities, including autism spectrum disorders, to go undiagnosed in low-income populations.<sup>5</sup> We focus great effort on helping children with special needs to get a proper diagnosis and treatment plan. Physicians at our clinics have diagnosed children as old as 11 with major developmental disabilities, which had previously been missed.

**Cultural celebrations.** Loving and embracing one's culture of origin is foundational to health. Emerging research is uncovering ways that positive childhood experiences, such as community-wide cultural traditions, promote resilience among people who experience adversity.<sup>6</sup> To strengthen the sense of culture, our San Jose clinic celebrates multiple traditional holidays throughout the year with hundreds of people from the neighborhood. We make traditional artwork, play games, sing songs, eat traditional foods, and wear traditional clothes, celebrating with entire families, from grandparents to young children.

**Legal assistance.** When patients are arrested, it affects their health and the health of their families. Sometimes their health improves with incarceration, such as with severe addiction or certain mental health disorders. But many times their health worsens, as they experience extreme anxiety or depression related to legal problems.<sup>7</sup> Even when legal problems do not result in arrest, they still affect families in significant ways. We have seen patients struggle with a loved one being threatened with deportation, domestic violence situations, a landlord bullying a tenant, a worker whose company refused to pay her for a month's work, and much more. We partner with private lawyers, local police, and the district attorney's office to bring help, clarity, justice, and healing to individuals and their families when these situations occur.

**Ecological challenges.** Our clinics are planted in low-income communities where

the local ecology can be detrimental to health.<sup>8</sup> Because of this, we engage in political advocacy to try to improve the built environment in our local communities. For example, the San Jose site is in a population-dense, inner-city neighborhood with insufficient green space and one public pool with limited hours. The area's one community center has been almost entirely closed to the public for more than a decade due to mismanagement. The average low-income patient in our practice does not have sufficient funds to pay for gym memberships or recreational sports opportunities for their children. Many families are densely packed into small apartments devoid of safe open spaces for exercise. It is not surprising that this community suffers with high rates of obesity, diabetes, hypertension, hyperlipidemia, and other chronic diseases.<sup>9</sup>

To address this, our clinics hired an athletic coach and engaged in political advocacy alongside hundreds of our patients to convince politicians to fund and construct an enormous park and to increase public use of the community center and the public pool. In the summer of 2021, we piloted a sports program, and the 50 children who participated saw an average weight loss of six pounds over two months.

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(One middle-school boy lost 45 pounds!) Several of those children also made their middle school athletic teams the following year. Research has repeatedly shown that engagement in school athletics improves grades, decreases high-risk behaviors, and often results in lifelong exercise habits.<sup>10</sup>

**Sociorelational challenges.** Loneliness is a root cause of many health problems in the U.S.<sup>11</sup> We found that churches do good work addressing this problem through gatherings that facilitate healthy friendships and increase social capital. At the San Jose site, we hired three pastoral staff

tasked with building community and getting isolated people involved in local events. These clergy, all Spanish-speaking and Latino, have created different kinds of groups that bring people together and foster relational health. Through these groups, we have identified vulnerable persons who were not seeking medical care anywhere at the time but have since benefited significantly from a therapeutic intervention. The social groups have also improved the well-being of many patients who were suffering with anxiety, depression, somatization, domestic violence, and other conditions related to loneliness and isolation. Now, many of the previously isolated families visit each other on weekends to celebrate birthdays or eat dinner together.

**Spirituality.** Many U.S. hospitals were founded by faith-based organizations, and it used to be common to treat the spiritual aspects of suffering through modalities such as prayer, meditation, forgiveness, community, and words of hope.<sup>12</sup> Our clinics incorporate spiritual practices in the clinic setting as well as in the larger community. The vast majority of people we encounter in all of our clinics desire faith conversations. We remain patient-centered by entering into spiritual spaces with them. We also offer opportunities to grow spiritually when patients desire this, through pastoral counseling, prayer, scrip-

Any primary care clinic could incorporate aspects of our model to meaningfully address SDOH by following these steps.

ture, large-group gatherings, and spiritual celebrations. Participation in religious gatherings is strongly associated with lower rates of depression, suicide, and substance use,<sup>13-16</sup> and regular church attendance is associated with a greater sense of purpose and a longer life expectancy.<sup>17,18</sup>

#### **INCORPORATING SDOH INTO AN ESTABLISHED CLINIC**

This model for addressing SDOH is easiest

to replicate in a concierge or DPC practice, where physicians have more flexibility and time because of the lack of insurance requirements and other administrative burdens. That said, any primary care clinic could incorporate aspects of our model to meaningfully address SDOH by following these steps.

#### **Decide which neighborhood to focus on.**

Focusing on an entire city or town would be impossible, unless it's a community of 1,000 people or fewer. Instead, start with one low-income apartment, trailer park, or small neighborhood. We chose a specific 10-block neighborhood in San Jose based on the U.S. Census Bureau's statistics on the lowest-income census block in the county. This allows our public health specialist/receptionist to determine whether a patient falls within our scope. We see all patients who join our practice, but by focusing on the SDOH of a specific area, our impact is more directed and efficient.

**Decide which aspects of SDOH to address.** This starts by building trust and actively listening to members of the target population. But this is often where organizations make the biggest mistake. People from outside the neighborhood should not decide what the principal problems of the neighborhood are. Ideally, strong leaders from within the neighborhood should join the clinic as outreach staff and lead the process of discerning the greatest strengths and weaknesses of the community. Finding the right community leader is its own process, deserving of its own article; suffice it to say that the loudest voice is not always the best leader.

Once you identify a community leader, you can begin to assess what is possible based on the individual community's strengths and the broader community's assets. For example, our San Jose community leader identified two excellent coaches who live in the community and previously coached at the YMCA. They have allowed us to build a thriving sports program in this neighborhood even though many of the kids have not played sports previously, some have high-trauma backgrounds and behavioral challenges, and many are overweight. The coaches' mentorship of these kids is resulting in positive changes beyond simply weight loss.

**Address SDOH little by little, when the community is ready.** For example, our community wanted to have a big party to celebrate the International Day of Peace, encouraging families to turn away from domestic and gang violence. We were not able to afford this until a large church in the area offered to sponsor the event. It now runs every year, is planned by community members and clinic staff in partnership with that church, and is attended by more than 1,000 people from the neighborhood.

A small clinic could start with something as basic as throwing a “back to school” party in the summer for a particular neighborhood. The event could include wellness checks and vaccinations for kids — as well as bouncy houses, a popcorn machine, and music. The clinic could then throw a Halloween party in the fall with scary snacks, a costume parade, and a picture booth, allowing clinic staff to get to know the families better. With time, staff could identify community leaders, learn the strengths and weaknesses of the people living in the neighborhood, and work on solutions together.

**Find community partners.** Physicians and clinic staff play a critical role in identifying SDOH in their patients, but they can’t solve every problem and should instead aim to connect patients with community resources. Partnering with healthy local churches has been the secret sauce to our clinic’s success in addressing SDOH. Healthy churches often have volunteers and money they are willing to give to benefit the poor. They also are skilled at planning large events, have access to sound equipment, have large gathering spaces, and have lots of social capital. The key is to be open to relationships with the faith community while helping local leaders spearhead the process. For example, a Spanish-speaking church member in our area started volunteering with our weekly homeless outreach event, wherein low-income patients make a homemade Mexican meal for people at a nearby homeless encampment. This particular man was a Mexican immigrant and entrepreneur

who had recently started two popular ice cream stores. He ended up hiring two of the homeless people he met, helped them break free from drug and alcohol use, and helped them find housing. No clinic staff were involved in this positive outcome; the church simply provided social capital, which improved the lives of two homeless men significantly. Through the social capital in churches, we have also been able to connect our patients with free attorneys,

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political lobbyists, dentists, optometrists, babysitters, employment opportunities, housing, social workers, pastoral counselors, summer enrichment camps, and more.

### THE OPPOSITE OF BURNOUT

Addressing SDOH in a local, low-income, immigrant community from the home base of a family medicine clinic is immensely gratifying, and it is our hope that more doctors will give this a try. It has been said that fun is the opposite of trauma. To us, there is nothing more satisfying than participating in healing the traumatized and oppressed through holiday parties, soccer tournaments, and art nights. Being able to creatively work with a low-income community and play a minor role in their lives has been the opposite of burnout. It has been fun and healing, even for us. **FPM**

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