

Editorials

Social Determinants of Health: Family Physicians' Leadership Role

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Family physicians have a leadership role in identifying and addressing issues that affect patients beyond the clinical setting. A previous editorial in *American Family Physician* explained how community vital signs can be used in patient care to address social determinants of health (SDOH).¹ SDOH are contextual environmental factors that can give rise to health inequity; they include poverty, educational quality, food insecurity, access to transportation, affordable housing, unemployment, maintenance of basic utilities, violence, and public safety.² Data show that most family physicians agree they should identify key SDOH that trigger interventions; engage and empower communities to address health disparities; and advocate for public policies.³ Incorporating an assessment tool for SDOH into patient care is an important first step.

In traditional medical care, screening promotes health by allowing for earlier diagnosis of diseases so that treatment can begin promptly to prevent poor outcomes.⁴ Similarly, screening for SDOH may improve the overall health of patients because SDOH can influence a patient's access to medical care and treatment.⁵ As the Centers for Medicare and Medicaid Services collects data on the development of a payment model addressing social needs (Accountable Health Communities),⁶ evidence for the effectiveness of SDOH screening in clinical practice will accumulate at the national level. One key reason is the emphasis on the Quadruple Aim approach for patient care, which is profoundly affected by SDOH. The Quadruple Aim focuses on cost reduction; improvement of the patient experience, health outcomes, and physician satisfaction; and the need for physicians to address the health of their communities.⁷

As family physicians and the organizations in which they work begin to incorporate SDOH screening into the clinic visit, they should take a proactive approach to address vulnerabilities and barriers, and implement timely referral and follow-up. The EveryONE Project toolkit (<https://www.aafp.org/patient-care/social-determinants-of-health/everyone-project/eop-tools.html>) was launched in 2018 by the American Academy of Family Physicians to provide

clinicians with education and resources to advance health equity.⁸ The toolkit includes resources for implementing SDOH screening, creating a practice culture of health equity, and helping patients access services within their communities. The SDOH screening tool includes questions about personal safety and access to housing, food, transportation, and utilities, and can be self-administered or administered by staff in English or Spanish. The initiation of any type of screening into the medical practice involves a team-based approach integrated into the workflow.⁵ In addition, SDOH screening requires appropriate referrals or linkages to community resources. The EveryONE Project toolkit aligns with efforts for the community to work together to improve housing, food access, and transit.⁹ The Neighborhood Navigator within the EveryONE Project toolkit facilitates this effort by identifying community assets and resources for patients.¹⁰ For example, if screening indicates food insecurity or inadequate housing, physicians can use this interactive platform to connect patients to food and housing services within their zip codes. In addition, the Neighborhood Navigator can help cultivate future partnerships to advance health equity as physicians gain a better understanding of the resources available in their communities. It may also reveal a shortage of resources within the community, which may spur physician advocacy for increased services.

Family physicians can be early adopters of SDOH tools and models for practice, and they can advocate for use of these tools across systems of care. We can also develop programs and initiatives in partnership with medical organizations such as the American College of Physicians and the American Academy of Pediatrics, which have endorsed similar frameworks for addressing SDOH,^{11,12} and with organizations in sectors relevant to SDOH (e.g., school, transportation, or housing systems). Finally, we can engage in research on the effectiveness of these models in real-world settings. Although the demands on physicians' time are indisputable, as patient advocates we have a duty to provide the most effective care for our patients by integrating community factors that influence health.¹³

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

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