Social Determinants of Health

Improve Health Outcomes Beyond the Clinic Walls

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How Will This Toolkit Help Me?

Learning Objectives:

1. Define social determinants of health, social needs, and their impact on individual health
2. Identify methods to understand the unique health needs of your community and ways to engage community members to improve overall health
3. Formulate a plan to help your practice begin addressing social determinants of health
4. Explain the different tools available to screen patients, including how and when and to use these tools, and connecting patients to appropriate resources
Introduction

Social determinants of health (SDOH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems that shape the conditions of daily life.\(^1\)\(^2\) These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems. Also known as social and physical determinants of health, they impact a wide range of health, functioning, and quality-of-life outcomes.

Examples of a social determinant of health: number of grocery and food options in the area, local housing policies and availability of housing, quality of educational system, air quality, minimum wage standards.

Social needs refer to the immediate needs of an individual or family and often consist of real time connection of an individual to a resource, such as a food bank, ride-transportation services, or housing.\(^2\)

Examples of a social need: access to healthy meals, risk of eviction, transportation to doctor's appointment.

Social determinants of health focus on the social and economic conditions impacting health at a community-level, while social needs focus on the individual-level.\(^2\) Figure 1 describes the 5 common domains of SDOH.

![Figure 1. Five Common Domains of Social Determinants of Health](https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources)

Historically, the practice of medicine focused primarily on diagnosing and treating specific clinical conditions. As medical knowledge evolves and the health care system shifts to more value-based and population-focused medicine, the medical community is beginning to take a more comprehensive approach to patient care. Practices are looking beyond the clinic walls to understand how patients' social and physical environment impacts their health. Over 2 decades of research indicate that social determinants of health have up to a 6-fold greater impact on health than clinical care. Addressing social determinants of health requires collaboration across multiple sectors, including but not limited to medical care, public health, and social service providers.

**How Do SDOH Impact Health?**

Non-medical determinants such as the environment, health behaviors, and social factors are greater contributors to premature death than quality of health care (Figure 2). For example, poor air quality in the home due to mold, pest infestation, or pollution is detrimental to an individual's respiratory health. The resulting asthma, allergies, cough, and
headaches will impact the individual's overall quality of life. If the individual cannot remove him/herself from the housing condition, the health issue will likely persist despite medical treatment.

**Figure 2. Impact of Different Factors on Risk of Premature Death**

![Figure 2](https://www.goinvo.com/vision/determinants-of-health/)

Over the years, how key areas of social determinants of health are defined and the number of key areas identified by public health organizations and initiatives including the World Health Organization (WHO), Centers for Disease Control and Prevention (CDC), and Healthy People 2020, have evolved. It is less important for clinicians to define a discrete list of social determinants of health than to recognize that interactions among social determinants of health have a greater impact on health than any one social determinant alone. For example, people living in poverty-stricken areas experience more barriers and challenges with regard to education, housing, unemployment, and stress. This confluence of negative social determinants of health and its effect on health status is often reflected in life expectancy disparities based on zip code. The profound impact of these factors can persist across generations and drive health inequity based on race, ethnicity, and socioeconomic status—effects that can be visualized on a map of life expectancy. A few miles can translate into a significantly shortened lifespan as shown in Figure 3, which is an example of differences in life expectancy in Chicago neighborhoods.

**Figure 3. Mapping Life Expectancy**

![Figure 3](https://www.goinvo.com/vision/determinants-of-health/)
In addition to influencing health outcomes, social determinants impact a practice's clinical outcomes data, financial sustainability, resource allocation decisions, and the overall health of communities and the health care system. As the nation moves toward value-based care, expanding our health care focus to include SDOH is increasingly necessary to achieve improved outcomes.

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**Eight STEPS to Engage Your Practice in Addressing Social Determinants of Health**

1. Understand and Engage Your Community
2. Engage Key Leadership
3. Assess Your Readiness
Understand and Engage Your Community

Begin by understanding the health needs of the communities you serve. Likely, you have already seen the impact of SDOH among your patients. A good place to start is by reviewing your local Community Health Needs Assessment (CHNA). Federally tax-exempt hospitals are required to conduct a CHNA every 3 years. Hospitals typically collaborate with local public health departments and seek community input to conduct a CHNA. The CHNA report is posted on each hospital’s website and includes information about the population the hospital serves, identifies disparities, and prioritizes health issues of concern. If you are in a community practice with patients seeking care across multiple hospitals, we recommend sampling a few CHNA reports to further define your patient population’s needs. The assessment can be easily accessed online by typing your organization’s name and “Community Health Needs Assessment” into a search engine.
Q&A

What is a Community Health Needs Assessment (CHNA)?

According to the CDC, a CHNA “refers to a state, tribal, local, or territorial health assessment that identifies key health needs and issues of a particular community through systematic, comprehensive data collection and analysis.”

How are community health assessments performed?

According to the CDC, “community health assessments use such principles as”:

- Multisector collaborations that support shared ownership of all phases of community health improvement, including assessment, planning, investment, implementation, and evaluation
- Proactive, broad, and diverse community engagement to improve results
- A definition of community that encompasses a significant enough area to allow for population-wide interventions and measurable results and also includes a targeted focus to address disparities among subpopulations
- Maximum transparency to improve community engagement and accountability
- Evidence-based interventions and encouragement of innovative practices with thorough evaluation
- Evaluation to inform a continuous improvement process
- The highest quality data pooled from and shared among diverse public and private sources”

What specific questions should I explore regarding SDOH?

Look for specific data on community demographics, health trends, services, and resources.

1. **Incidence of chronic illness**—understand the prevalence of obesity, diabetes, asthma, and other chronic diseases within your service area and pay close attention to disparities that exist for different subpopulations or different locations
2. **Hardship Index**—review hardship indices by community and understand the impact of crowded housing, households below poverty, unemployment for those over age 16, lack of high school diploma, population under 18 and over 64, and per-capita income
3. **Health coverage profiles**—understand the percentage of insured and uninsured patients in your community by age and ethnicity
4. **Find sources of information for SDOH** such as unemployment, graduation rates, poverty, food insecurity, etc.

Where can I locate important population health data besides our CHNA?

Local and state public health departments, as well as the Community Guide from the US Department of Health and Human Services, provide information by county on health outcomes, behaviors, access to care, social factors, and the physical environment through resources such as The University of Wisconsin Population Health Institute’s County Health Rankings and Roadmaps.

Community Commons is another resource that provides a wealth of data in easily generated maps of specific, self-defined communities. Population-level data can be shared with faculty, staff, and leaders.
throughout the institution. Understanding the needs of your particular patient population will better equip your organization to meet the community's needs.

2 Engage Key Leadership

Addressing SDOH is an essential strategy to maintain or improve the health of a population. Support from key leadership, such as a Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Medical Officer (CMO), and Chief Medical Information Officer (CMIO), is recommended. Executive leadership provides the necessary financial and staffing resources to implement programs and initiatives. They can also assist in removing any administrative or logistical barriers. For a smaller scope of intervention, such as an individual department within a larger institution, secure the support of the department chair; for an individual practice, seek the practice manager’s buy-in.

Many practices and health systems have seen the positive impact of addressing SDOH, both financially and in terms of patient health outcomes. Calculating the return on investment (ROI) for your specific intervention can enhance key leadership support and provide a sustainable, data-driven approach. One such resource to help evaluate impact is the Return on Investment (ROI) Calculator for Partnerships to Address the Social Determinants of Health created by The Commonwealth Fund.

Real-World Case

Houston’s Patient Care Intervention Center (PCIC) focused on 39 patients who had at least 10 emergency room visits or 4 hospital admissions over the previous year. With an emphasis on care coordination, these patients received social assistance, a chaperone at primary care appointments, and additional focused interventions. Over the course of 6 months, the total health care costs of the 39 patients were reduced by $1.3 million (Table 1).³

Table 1. Analysis of Health Care Utilization, Cost, and Patient Functioning Among 39 Patients Enrolled in PCIC Intervention

<table>
<thead>
<tr>
<th></th>
<th>12 months before intervention</th>
<th>12 months after intervention</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care utilization</td>
<td>360</td>
<td>131</td>
<td>Almost 64% decrease</td>
</tr>
<tr>
<td>(measured number of by emergency room visits)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health care costs</td>
<td>$2.32M</td>
<td>$1.04M</td>
<td>55% decrease</td>
</tr>
<tr>
<td>($ millions)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient functioning</td>
<td>43</td>
<td>51</td>
<td>17% increase</td>
</tr>
<tr>
<td>(measured using the 20-item Daily Living Activities [DLA-20] Functional assessment tool)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

By sharing success stories from other practices and linking your community’s needs to the health of the organization, you will be better equipped to make the business case for addressing SDOH to leadership.
Assess Your Readiness

Before selecting a specific initiative, assess your organization's readiness to implement.

Begin by engaging your team and fostering a supportive culture to address SDOH. Understanding your own internal biases is a necessary first step in fostering a supportive patient–clinician relationship and practice culture. We are all human and are all shaped by our unique experiences and circumstances. As a result, we may form judgments and perceptions about which we may not be consciously aware.

Consider having your team take the Project Implicit® tests. This resource offers 14 different implicit association task (IAT) tests that identify potential biases related to attributes such as gender, skin tone, and religion.

By acknowledging and exploring individual biases, individuals are better equipped to create and be a member of an engaged and empathetic team, which ultimately results in a high level of cultural competency.

By understanding the available resources within your organization, you will be able to select an appropriate SDOH initiative. An assessment can help you identify:

- **Gaps in processes**—Does your practice or organization have the infrastructure to implement a specific program?
- **Financial needs**—What financial resources are available from your practice, organization, community, or state to support SDOH initiatives? The amount of available funds often determines the size and scope of the SDOH project you select.
- **Staffing needs**—Does your practice or organization have the necessary personnel? Or will you need to engage community health workers or recruit a pharmacist or social worker? Is there a champion who can help spearhead the project and sustain the effort?
- **Existing supportive resources**—Does your community, region, state, or federal government have existing guidelines or resources specifically targeted for your project of interest?

**How Can I Tell If My Organization Is Ready to Address SDOH?**

- **Focus**—Think about one priority patient population your organization serves and one health-related social need that impacts that population; for example, adults with diabetes and food insecurity, children with asthma and substandard housing, or elders with cognitive impairment and social isolation.
- **Assess**—Keeping a specific population and a specific social need in mind, assess your capability as an organization. For example, HealthBegins recommends a review of readiness across these 10 domains:
  1. **The external environment**—Assess the favorability of external environment for your organization to address social determinants of health
  2. **Perceived value of moving upstream**—Identify the perceived value of change to assess and address social determinants of health
  3. **Executive sponsorship**—Assess the quality and degree of executive sponsorship to advance social determinants interventions
  4. **Non-clinical and clinical team roles**—Identify if non-clinical and clinical team roles have been clearly defined and integrated into upstream work
  5. **Scope of work of upstream interventions**—Consider if the scope of the proposed or current upstream intervention has been defined
  6. **Project management of upstream interventions**—Assess the maturity and style of project management for social determinants interventions
  7. **Workflow integration**—Assess the degree to which your social determinant intervention is integrated in care delivery workflows
  8. **Quality improvement**—Assess your organization's quality improvement culture and processes as they relate to social determinants interventions
  9. **Organizational infrastructure**—Consider the organizational infrastructure and supports for your social determinants intervention
10. Financial readiness—Identify the degree to which financial risks and rewards and payment models have been optimized for your intervention
   • Review—Reflect on your assessment and your areas of strength and opportunities for improvement.

Conducting a readiness assessment can help your practice determine where to begin. For example, suppose your CHNA identified obesity as an area of need, and your state is already focusing on healthy lifestyle initiatives to reduce the incidence of obesity. In that case, a readiness assessment might determine that an intervention focusing on obesity is an optimal place to start due to existing resources and support.

Select and Define Your Plan

There are many social determinants of health, and each can influence another. However, it is best to begin by selecting just 1 need in your patient population as the area of focus for your SDOH initiative.

Here is a sequence for developing your SDOH initiative:

A. Select a social need
B. Choose a health outcome to track
C. Define your target patient population
D. Consider what type of practice setting best describes your clinical practice:
   • Physician practice
   • Federally qualified health center (FQHC)
   • Hospital/health system

The practice setting will play a key role in determining the size and scope of project implementation. For example, will you deploy a system-wide initiative or begin with a subset of your patient population? Table 2 is an example of a plan that a FQHC might implement.

<table>
<thead>
<tr>
<th>Plan component</th>
<th>Selected definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social determinant of health</td>
<td>Food insecurity</td>
</tr>
<tr>
<td>Health screening metric</td>
<td>Percent of patients reporting food insecurity</td>
</tr>
<tr>
<td>Target patient population</td>
<td>Dual-eligible patients</td>
</tr>
</tbody>
</table>

There are many ways to address a social determinant of health depending on an organization's size and capacity. For example, a small practice might screen for select SDOH and refer patients to community organizations for assistance. A larger practice might employ a social worker or community health workers to navigate the community referrals with their patients. A next-level-larger organization, such as a hospital or academic medical center, might screen, refer, navigate, develop new services if there are gaps in the community (eg, patient education activities and farmer’s markets for access to fruits and vegetables), and contribute to community policy considerations (eg, supporting neighborhood park creation to promote physical activity throughout the community).
Below is an example of a quality matrix, which can help you identify different potential initiatives for a specific population and social determinant of health based on intervention and prevention levels (Table 2).

Table 3. HealthBegins Upstream Strategy Matrix™

<table>
<thead>
<tr>
<th>Primary prevention</th>
<th>Patient level</th>
<th>Health care organization population level</th>
<th>General population level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coordinate financial literacy, support, and nutrition programs for low-income families with a strong family history of diabetes</td>
<td>Provide on-site Farmer’s Market, gym, walking trails, or financial counseling for families at risk for diabetes</td>
<td>Advocate for local increase in minimum wage and supports for low-income families, particularly those at risk for diabetes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary prevention</th>
<th>Patient level</th>
<th>Health care organization population level</th>
<th>General population level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coordinate poverty screening and financial assistance for patients with diabetes at risk of end-of-month hypoglycemia</td>
<td>Subsidize vouchers to local Farmer’s Market or hire a financial counselor for low-income patients with diabetes</td>
<td>Change timing and content of Women, Infants, and Children (WIC) and school food programs to avoid insecurity among patients with diabetes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tertiary prevention</th>
<th>Patient level</th>
<th>Health care organization population level</th>
<th>General population level</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reduce emergency department use among high-utilizer patients with severe diabetes using food and income support referrals</td>
<td>Coordinate with local banks, collectors, and lenders to reduce debt burden for utilizer patients with diabetes</td>
<td>Support legislation or regulations to provide financial and “hotspotter” services to patients with severe diabetes</td>
</tr>
</tbody>
</table>

As you define your plan, leverage quality improvement methods, such as Plan-Do-Study-Act (PDSA) or Lean concepts.

- Identify who will be on your SDOH team
- Map out your workflows and what roles each team member will play
- Orient practice staff to metrics and goals
- Identify and communicate your plan with your community partners and resources

Q&A

Who should be a part of the SDOH team?

Include all members of your health care team as you address social determinants of health in your practice.

Once a need is identified, empower a team member to provide or refer resources to meet that need automatically. Try to avoid adding another step, such as a physician-generated order or referral, to existing processes.

Team members involved and their responsibilities will depend on your practice size and structure, and may include team additions if current team members are already overburdened. Consider including patient navigators, social workers, care coordinators, and community health workers to help with this effort. Those assisting with SDOH work and referrals should add this directly to the patient chart as an action plan.
Assess SDOH at the Patient Level

Once you have resources to address needs, start to assess a portion of your patient population for the selected SDOH at an individual patient level. This process is recommended regardless of the practice setting or social determinant selected. By incorporating screening into your workflow, you will quickly begin to understand what is important to the patient and identify social determinants that may be impacting their health status.

Below are some common, free screening tools for care teams:

- **PRAPARE**—Protocol for Responding to and Assessing Patients’ Assets, Risks, and Experiences Implementation and Action Toolkit—Sponsored by the National Association of Community Health Centers, PRAPARE is a national standardized patient risk assessment protocol. The PRAPARE assessment tools are designed to assess, address, and respond to patients’ SDOH data. PRAPARE consists of a set of national core measures as well as a set of optional measures for community priorities, and it aligns with national initiatives. PRAPARE templates can be used with a variety of electronic health record (EHR) systems.

- **SIREN**—Social Interventions Research and Evaluation Network—Supported by Kaiser Permanente and the Robert Wood Johnson Foundation and housed at the Center for Health and Community at The University of California, San Francisco. The SIREN team developed a table that compares the most widely used social health screening tools from a variety of aspects, ranging from number of social needs questions, patient population, reading level, education and beyond.

- **The EveryONE Project™**—Developed by the American Academy of Family Physicians (AAFP). This initial screening toolkit can help physicians recognize and respond to various social factors that affect their patients’ health. The toolkit includes screening questions that have been tested, validated, and purposefully assembled to reveal the health hurdles patients face. The screening toolkit also includes a description of a team-based approach to screening for SDOH, along with supporting resources and tools to help family physicians plan next steps to address deficiencies.

- **AHCM**—Accountable Health Communities Health-Related Social Needs Screening Tool—The Centers for Medicare & Medicaid Services (CMS) developed a screening tool to identify patient needs in 5 different domains that can be addressed through community services (housing instability, food insecurity, transportation difficulties, utility assistance needs, and interpersonal safety). Clinicians and their teams can use this short tool across a spectrum of patient ages, backgrounds, and settings, and it is sufficiently streamlined to be incorporated into busy clinical workflows. As with clinical assessment tools, results from this screening tool can inform a patient’s treatment plan as well as make referrals to community services.

- **OCHIN**—Oregon Community Health Information Network—This nonprofit health information and innovation network developed a method to collect and utilize SDOH in community health centers with the
The SDOH health flowsheet OCHIN created facilitates the entry of patient-reported SDOH information in the EHR that is not already collected in other places, such as demographics or social history. Additionally, the data collection tools are designed to be flexible so that anyone on the care team can enter data.

**Q&A**

Should I start by screening all patients who have an appointment?

No; we recommend beginning by screening a smaller population, such as dual-eligible patients; a particular age group; or those with a specific diagnosis, such as asthma, diabetes, chronic pain, or obesity.

As you begin to screen and accumulate important information about your patients and their social determinants of health, it can be valuable to incorporate this data into the patient's electronic health record (EHR). Many EHR vendors provide the functionality to embed a screening tool into the clinical workflow. Incorporating an SDOH screening tool during the pre-visit planning process or patient visit is a great way to gather patient information and connect the patient with his/her needs and wishes. By understanding what matters to the patient, you can be more effective in designing and linking that patient to a care plan.

**Link Patients to SDOH Resources**

Once you have identified patients who have unmet needs for your selected SDOH need, your next step is to link individual patients to appropriate resources. Providing individual patients with a list of resources can be beneficial; however, taking a more active role in arranging a resource alongside each patient and following up to ensure each patient accessed the resource successfully is likely to have a much larger impact.
Examples of resource connections might include:

- Referrals to local food banks and food pharmacies
- Vouchers for bus and subway transportation
- Providing a mobile food pantry at a clinic location

It is important to think about how this “navigation” could be accomplished in the practice setting. There are models using students (e.g., Health Leads and Case Western Reserve University’s Patient Navigator Program) and community health workers as parts of the medical team to extend the reach of physicians and nurses.

Take advantage of the 211—Essential Community Services Program. By simply dialing “211”, callers are routed to referral specialists who can match them to available resources and oftentimes will make a direct referral to an organization that can provide assistance. This resource is available throughout the US.

Q&A

What types of referrals may be offered by 211?

According to the Federal Communications Commission’s 211 Consumer Guide, connections to appropriate agencies and community resources include:

- **Basic human needs resources**—including food and clothing banks, shelters, rent assistance, and utility assistance
- **Physical and mental health resources**—including health insurance programs, Medicaid and Medicare, maternal health resources, health insurance programs for children, and medical information lines, crisis intervention services, support groups, counseling, and drug and alcohol intervention and rehabilitation
- **Work support**—including financial assistance, job training, transportation assistance, and education programs
- **Access to services in non-English languages**—including language translation and interpretation services to help non-English-speaking people find public resources (foreign language services vary by location)
- **Support for older Americans and persons with disabilities**—including adult day care, community meals, respite care, home health care, transportation, and homemaker services
- **Children, youth, and family support**—including childcare, after-school programs, educational programs for low-income families, family resource centers, summer camps, and recreation programs, mentoring, tutoring, and protective services
- **Suicide prevention**—referrals to suicide prevention help organizations. Callers can also dial the following National Suicide Prevention Hotline numbers, which are operated by the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services:
  - 1-800-SUICIDE (1-800-784-2433)
  - 1-888-SUICIDE (1-888-784-2433)
  - 1-877-SUICIDE (1-877-784-2432) (Spanish)

Are there resources to find local treatment facilities, support groups, and community-based organizations for individuals and family members facing mental and/or substance use disorders other than suicide?

Yes, the Substance Abuse and Mental Health Services Administration (SAMHSA) operates a free, confidential National Helpline **1-800-662-HELP (4357)**, also known as the Treatment Referral Routing Service. This service is available 24 hours a day, 7 days a week, and 365 days a year to help with treatment referral and information (in English and Spanish) for individuals and families facing mental and/or
substance use disorders. This service provides referrals to local treatment facilities, support groups, and community-based organizations. Callers can also order free publications and other information.

Are there other products or services that specialize in linking patients with SDOH needs to resources?

Yes. As technology and digital health applications continue to evolve, organizations are creating social referral platforms to assist clinicians and patients.¹⁴ Many of these platforms are in early phases of implementation and range in cost from free services to more comprehensive EHR solutions.

Commercial services that link patients to community resources are available, such as NowPow, Purple Binder, and Pieces.* A great free resource is Aunt Bertha, a search engine specializing in locating local resources and services.

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Evaluate and Refine

Throughout the implementation phase of your SDOH initiative, it is important to refine and enhance your workflows. Discuss with your team and patients to learn what is working and what needs to change. If you discover that your screening method isn't occurring as consistently as it should, examine the process to see if you can identify a better way to screen more patients. The solution may be as simple as training one extra staff member on administering the questionnaire during rooming.

Celebrate Your Success

As you continue to refine your workflow, celebrate your successes. Share patient stories and best practices with colleagues across your organization and community. By sharing your stories, you may inspire other practices to implement your model, which will help to scale and sustain the initiative and improve the health outcomes of many more patients across the community.

Conclusion

With a step-wise approach, health care professionals and systems can address social determinants of health to improve health outcomes, improve care quality, lower costs, and enhance joy at work for health care providers across the organization. As hospitals and clinics expand their roles in creating healthy communities, it will be essential to address the social determinants of health for their patients where they live, work, and play.
AMA Pearls

Be thoughtful in determining your target population for intervention.

Trying to address too large of a patient population or including too many SDOH initiatives at one time could dampen the impact of your initiative. Targeted, specific, and focused is best.

Take the time to adequately develop and train team members to address SDOH initiatives.

Understanding implicit bias and assumptions is critical to ensuring open and productive communication with patients from all backgrounds.

Build and sustain strong partnerships with external stakeholders.

It is far more important to partner with expert, community-based organizations than to build new services that may be redundant and competitive.

Further Reading

Journal Articles and Other Publications


Websites

- Community Commons. https://www.communitycommons.org/
Article Information

AMA CME Accreditation Information

Credit Designation Statement: The American Medical Association designates this enduring material activity for a maximum of 0.50 AMA PRA Category 1 Credit(s)™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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The AMA Professional Satisfaction and Practice Sustainability group has been tasked with developing and promoting innovative strategies that create sustainable practices. Leveraging findings from the 2013 AMA/RAND Health study, “Factors affecting physician professional satisfaction and their implications for patient care, health systems and health policy,” and other research sources, the group developed a series of practice transformation strategies. Each has the potential to reduce or eliminate inefficiency in broader office-based physician practices and improve health outcomes, increase operational productivity, and reduce health care costs.

References: