

Addressing Social Determinants of Health in Primary Care

TEAM-BASED APPROACH FOR ADVANCING HEALTH EQUITY

“Health inequalities and the social determinants of health are not a footnote to the determinants of health. They are the main issue.”

– Sir Michael Marmot

The EveryONE Project™
Advancing health equity in every community





TABLE OF CONTENTS

Introduction 3
 Definitions of Key Terms 3

Section 1: Develop a Practice Culture that Values Health Equity 3
 Understand Your Patient’s Community 4
 Understand How Social Determinants of Health Impact Health Outcomes (Quickfacts)..... 4
 Addressing Implicit Bias 5
 Building Cultural Competence and Proficiency 5
 Health Literacy and Interpretation Services 5

Section 2: Develop a Team-based Approach for Addressing Social Determinants of Health ... 6
 Step 1: Identify Opportunities to Address Social Determinants of Health 7
 Step 2: Evaluate Patient and Workflow 7
 Step 3: Define a New System 8
 Step 4: Identify Barriers and Plan for Change 9
 Step 5: Measure and Celebrate Success 9
 Step 6: Finalize Your Team-based Implementation Plan 10

Conclusion 10

References 12

DISCLAIMER

Download these resources* for use in workplaces, health systems, and other places in your community.

*The EveryONE Project materials featured here are copyrighted by the American Academy of Family Physicians (AAFP). The EveryONE Project is a pending registered trademark of the AAFP. By downloading any of these materials, you agree that the AAFP is the owner of The EveryONE Project materials and that your use of The EveryONE Project materials will only be used for the purposes of education and advancing health equity in every community. The EveryONE Project materials may not be modified in any way and may not be used to state or imply the AAFP’s endorsement of any goods or services.

ACKNOWLEDGMENT

The AAFP would like to thank the following members for reviewing the Social Determinants of Health (SDOH) screening tool and guide:

Margot Savoy, MD, MPH, FAAFP | Venis T. Wilder, MD | David O’Gurek, MD, FAAFP

HOP18071112



Supported in part by a grant from the AAFP Foundation



INTRODUCTION

The American Academy of Family Physicians (AAFP) define social determinants of health (SDOH) as the conditions under which people are born, grow, live, work, and age.¹ SDOH factors include socioeconomic status; racism and discrimination; poverty and income inequality; and the lack of community resources, among others.² They account for as much as 55% of health outcomes.³ A substantial proportion of health care to America's underserved populations is provided by family physicians, who see the impact of SDOH every day. Family physicians and their health care teams are critical in addressing their patients' SDOH because primary care is a natural point of integration among clinical care, public health, behavioral health, and community-based services.^{4,5} You can incorporate information about patient's SDOH into the bio-psychosocial model to promote continuous healing relationships and comprehensive, whole-person care.

This implementation guide provides information and resources for family physicians and their practice teams to address their patients' SDOH and how to better advance health equity. Designed in two sections, the first section addresses how family physicians and their health care teams can develop a practice culture that values health equity. The second section provides resources to develop a planned, team-based approach to address SDOH. Work through this guide with your health care team to identify opportunities to improve how you and your team address patients' SDOH.

Definitions of Key Terms

Social determinants of health (SDOH): SDOH include the conditions under which people are born, grow, live, work, and age.¹ For the purposes of this implementation guide, the term refers to patients' individual level and immediate social needs.

Health equity: Health equity is the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."⁷ For the purposes of this implementation guide, the term refers to differences in health status between different population groups that are avoidable, unjust, and unfair.

Community-based resources: Community-based resources refer to organizations that provide programs and services that assist individuals with their social and economic needs. For the purposes of this implementation guide, the term is broad in scope and entails organizations that provide financial assistance, supplementary food assistance, and job placement and training, among a variety of other services.

Team-based Primary Care

Addressing social determinants of health (SDOH) requires a team-based approach. The instructions and suggestions outlined in this implementation guide are intended to be conducted by all the health care team members in your practice based on their role. Recognition of the unique skills of the members of your health care team is key to providing comprehensive care and identifying how all team members can contribute to addressing SDOH in your practice.⁶

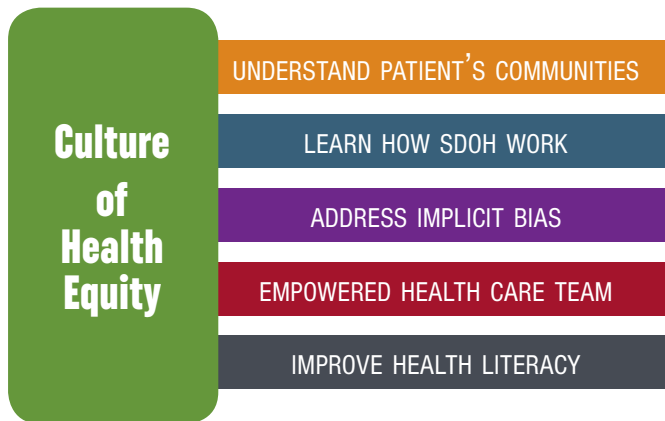
SECTION 1: DEVELOP A PRACTICE CULTURE THAT VALUES HEALTH EQUITY

Practices with a culture that values health equity strive to understand their patients' lives and context. These practices look for ways to help their patients overcome hurdles to their health and health care. While there are a variety of ways to establish and enrich a culture of health equity in your practice, key strategies include:

- **Understanding your patient's community.** What barriers do your patients face to living a healthy life? What resources do your patients have access to in their community? Demographic, environmental, and public health data can illuminate issues that your patients may not even know they face.
- **Learning about how social factors influence health.** Social factors influence health through a complex web of causation. Understanding the different mechanisms can help improve patient care.
- **Confronting implicit bias in your practice.** Everyone holds implicit biases. Work with your health care team to uncover these biases and identify opportunities to address them to improve patient care.
- **Empowering the whole health care team.** Addressing SDOH is complex. All members of the health care team have unique skills that can help to better address the social barriers to health that your patients face.
- **Developing processes that promote health literacy.** Improve how you present information to your patients so that they understand and can follow your instructions.



Each of these strategies is described in greater detail in this guide, with additional resources provided in the AAFP's SDOH Toolkit (www.aafp.org/EveryONE).



Understand Your Patient's Community

You have probably heard catch phrases like, “your zip code matters more than your genetic code,” or “place matters.” The reason for this is that poor health outcomes tend to cluster in disadvantaged neighborhoods. Some factors in disadvantaged neighborhoods, like living conditions, may be apparent to patients from these neighborhoods. Other factors, such as environmental hazards or discriminatory policies may go unnoticed by your patients. In these cases, patients will not be able to tell you or your practice team about these issues. There are a variety of databases and community efforts that can help fill this gap, including:

- **County Health Rankings & Roadmaps:** The annual county health rankings measure vital health factors, including high school graduation rates, obesity, smoking, unemployment, access to healthy foods, quality of air and water, income inequality, and teen births in nearly every county in the U.S. The annual rankings reveal a snapshot of how health is influenced by where we live, learn, work, and play. They provide a starting point of change in communities.⁸ (www.countyhealthrankings.org)
- **HealthLandscape:** HealthLandscape is an interactive, web-based mapping tool that allows you and your practice team to combine, analyze, and display information in ways that promote better understanding of health and the forces that affect it. (www.healthlandscape.org)
- **Local Health Department's Community Health Assessment:** City and county health departments are charged with developing health data profiles to help residents understand health concerns and drivers in their community. While community health assessments vary by how comprehensive they are, an ideal assessment includes

information on morbidity and mortality, risk factors, quality of life, community assets, and health inequities. Community health assessments are usually paired with a community health improvement plan, which lays out a collaborative, community-wide approach for advancing health priorities in the jurisdiction.⁹ Find your local health department's webpage at the National Association of County and City Health Officials' (NACCHO) directory. (www.naccho.org/membership/meet-our-members/lhd-directory)

- **Nonprofit Hospital's Community Health Needs Assessment:** Similar to the community health assessments conducted by local health departments, community health needs assessments provide information on a variety of community health-related data. Community health needs assessments are conducted by hospitals as a requirement for non-profit status. As such, they are often linked with the priorities for their community benefit program.¹⁰

Understand New Social Determinants of Health Impact Health Outcomes (Quickfacts)

- Numerous studies suggest that SDOH account for between 30-55% of health outcomes.³ Other research points to specific SDOH factors attributed to deaths, including low neighborhood socioeconomic status (18-25%), poverty (2-6%), and income inequality (9-25%).¹¹
- There are vast differences in the health status of individuals based on socioeconomic status, income, race, ethnicity, educational status, and geographic location, among a variety of other factors.¹²⁻¹⁴
- There is up to a 20-year gap in life expectancy between the counties with the lowest and highest life expectancy in the U.S.¹⁴
- Health risk factors, such as poor diet, inadequate exercise, and smoking, are more common in groups with lower socioeconomic status.¹⁵ Social epidemiologists attribute this to social patterning, obstacles to healthy behaviors, and targeted marketing by the tobacco, alcohol, and fast-food industries, rather than to individual shortcomings.
- SDOH primarily influence health outcomes by constraining opportunities to live a healthy lifestyle, and through chronic stress.^{16,17}
- SDOH lead to health inequities through social stratification and reduced political and social influence, which ultimately results in an imbalance of power between groups based on socioeconomic situation, race, ethnicity, and other characteristics.¹⁸



Addressing Implicit Bias

Implicit bias refers to the underlying attitudes and stereotypes that people hold toward members of other groups. As opposed to explicit bias or prejudice, implicit bias is unconscious and can affect people's reflexive behavior towards members of other groups.¹⁹ Implicit bias is common in society and in health care, and can impact the quality of health care provided.²⁰

Acknowledging and responding to implicit bias can be difficult, but it needs attention to best address your patients' SDOH and to advance health equity. Addressing implicit bias is a conscious decision, and there are proven ways to approach this in your practice. Implicit bias cannot be measured through self reporting. Instruments have been created to measure implicit bias, with the most common being the Implicit Association Test (www.implicit.harvard.edu/implicit).¹⁹

Consider incorporating the following strategies for identifying and addressing implicit bias in your practice:

- Remember that everyone has implicit biases. By working to reveal your practice team's implicit biases, you have made a positive acknowledgement that should be commended.
- Develop an understanding of health disparities and bias in medicine to help lay a foundation of the effect of implicit bias.
- Avoid categorizing specific groups of patients and treating them differently based on their social group.
- Take stock of your practice team's implicit biases. Implicit Association Tests are available online (www.implicit.harvard.edu/implicit) to help assess biases.
- Address implicit biases to practice better medicine. For example, "physicians can address their biases by paying attention to their gut reactions to different patients and pausing, when possible, to ask themselves if the reaction may be stemming from an implicit bias. If it is, the physician can consider how they might react to the same situation if it involved a different patient."²¹ This is important for all clinicians to better understand how implicit biases may affect patient care.

Building Cultural Competence and Proficiency

The AAFP defines cultural proficiency as "the knowledge, skills, attitudes, and beliefs that enable people to work well with, respond effectively to, and be supportive of people in cross-cultural settings. Family physicians care for a wide variety of patients and need these skills to offer better patient care. Today's health care environment is increasingly diverse, and physicians interact with patients from an ever-widening range of ethnic and sociocultural backgrounds."²²

Family physicians and their teams strive to provide the best experience for every patient in their practice. The following resources can help you and your practice team better understand and provide culturally-proficient and linguistically-appropriate care:

- Cultural Proficiency: The Importance of Cultural Proficiency in Providing Effective Care for Diverse Populations (Position Paper) (www.aafp.org/about/policies/all/cultural-diverse-populations.html)
- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (www.thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf)

Health Literacy and Interpretation Services

Health literacy can be defined as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."²³ Nearly nine out of 10 adults may not possess the skills they need to assist them in managing their health and preventing disease.²⁴ It might be helpful to assume that some of your patients have limited health literacy. Patients with low health literacy may not comprehend drug labeling or medical instructions, with the result that they appear unwilling to follow recommendations.

Patients may have difficulty with understanding health publications, giving adequate history or comprehending content, and completing medical and insurance forms.

To assist your patients, consider the following recommendations:

- Use plain language instead of medical jargon or technical language.
- Sit down to achieve eye-level communication.
- Use visual models to illustrate a procedure or condition.
- Have patients explain back to you the care instructions you gave them or demonstrate procedures you explained.

As the U.S. population becomes more diverse, family physicians are more likely to encounter patients with limited English proficiency. This can be challenging.

Disabilities, such as hearing or visual impairments should also be considered. These can lead to communication challenges.



Steps that practices can take to develop a strategy to overcome language barriers and improve the quality of care include:²⁵

- Determine the need for services in your practice.
- Develop a policy.
- Determine the method of communication to be used during the patient encounter.
- Seek financial support for medical interpretation.
- Provide language-appropriate patient forms and educational resources.²⁵

For more information about health literacy and medical interpretation, see:

- Health Literacy in Primary Care Practice (www.aafp.org/afp/2015/0715/p118.html)
- Incorporating Medical Interpretation into Your Practice (www.aafp.org/fpm/2014/0300/p16.pdf)

SECTION 2: DEVELOP A TEAM-BASED APPROACH FOR ADDRESSING SOCIAL DETERMINANTS OF HEALTH

This section will help you and your health care team identify, plan, and implement small changes to address SDOH in your practice.

The AAFP's framework for addressing SDOH in primary care (Figure 1) is based on a three-phased process (Ask, Identify, Act) that encourages family physicians and their health care teams to:

1. **Ask** patients about their SDOH.
2. **Identify** resources in patients' communities that can help address SDOH.
3. **Act** to help connect patients with resources to help address patients' SDOH.

Other efforts, such as speaking out, advocating, providing testimony, and collaborating with organizations to address SDOH are ways to advance health equity. The AAFP suggests starting small and fitting these efforts into your practice as time and resources allow.

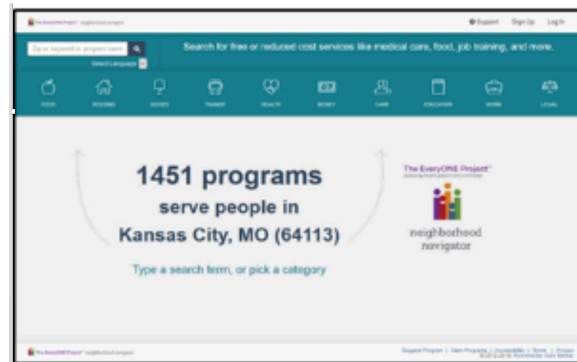
Figure 1: AAFP's Framework for Addressing SDOH in Primary Care and SDOH Resources

Step 1 Screen Every Patient for Social Determinants of Health

AAFP's Guide to Social Needs Screening



Step 2 Identify Community-based Resources Matched to Your Patient's Social Determinants of Health



AAFP's Neighborhood Navigator Search Page



Step 3 Connect Your Patients to Community-based Resources

AAFP's Neighborhood Navigator Resource Page



Step 1: Identify Opportunities to Address Social Determinants of Health

Conduct a brief, informal assessment of your practice with your health care team to identify opportunities to address SDOH. This will help you determine the actions you would like to take. Answer the following questions to help with this.

1. How does your practice currently identify and document SDOH, if at all? Whose responsibility is this?
2. In what ways does your practice currently help address patient's SDOH? (Select all that apply.)
 - Screen for SDOH
 - Maintain up-to-date records of community-based resources
 - Refer patients to community-based resources
 - Engage patients about how to overcome their SDOH
 - Other: _____
3. What systems do you have in place to ensure SDOH are addressed at patient visits?
 - Reviewing prompts in the electronic health record (EHR) system
 - Identifying SDOH as part of a patient's vital signs
 - Maintaining a registry of patients by categories of SDOH
 - Using flags or stickers on paper charts
 - Other: _____

4. What resources are available in your patients' communities that they could use to address SDOH?
5. What initiatives are occurring in your patients' communities to address the drivers of SDOH? How could your practice engage in these?
6. Imagine that your practice is successfully doing everything possible to help address SDOH. What would that look like?
7. Taking your health care team's unique strengths and needs, what can your practice do differently to address the SDOH?

Step 2: Evaluate Patient and Workflow

Take a moment to examine how patients flow through your office. This will help you identify opportunities to incorporate the actions you identified in Step 1. Work through the following questions and create a simple document that shows how patients advance through your system from the time they enter until the time they leave. Also, document actions that can be taken at each step to address the SDOH.

1. Where do patients go when they enter the office? What do they see and do before they are called back for their visit?
2. Who do patients see before meeting the clinician?
3. What questions are asked when vital signs are measured?
4. What information is exchanged with patients before the patient-clinician encounter?

Sample Patient Visit Flowchart	
Step	Actions and Considerations
Patient checks in ↓	Posters are available in the waiting room that prompt patients to discuss their social needs.
Patient sits in waiting room ↓	Social determinants of health (SDOH) screening tool is distributed to patients at check-in to be completed in the waiting room.
Height and weight checked in hallway ↓	Nurse or medical assistant confirm social needs with patient and provides information to office clerk to cross reference social needs with available community resources.
Remaining vital signs checked in exam room ↓	Posters are available in the waiting room that prompt patients to discuss their social needs.
Patient meets with clinician ↓	Clinician discusses social needs with patient and available resources and works to develop a plan to address the patient's SDOH.
Patient meets with counselor ↓	Nurse or medical assistant finalizes plan to address patient's SDOH and referrals to community resources.
Patient stops at billing/scheduling station ↓	Office staff schedules follow-up appointment.
Patient leaves ↓	



If SDOH are currently being addressed in your practice:

5. How do clinicians address SDOH during the encounter?
6. How are counseling or other interventions for SDOH documented?
7. What reminder systems and prompts are in place to alert clinicians of opportunities to discuss SDOH?
8. What path do patients take as they exit the office? Do they make any stops to speak with non-clinical staff (social workers, navigators, reception, etc.)?

Draw out your patient and workflow as shown in the sample patient visit flowchart shown on the previous page. See the worksheet available here: www.aafp.org/dam/AAFP/documents/patient_care/everyone_project/patient-workflow-print.pdf.

Step 3: Define a New System

Now that you have identified what actions you want to take to address SDOH and evaluated your current system for opportunities to incorporate these actions, it is time to define more clearly how these actions will be implemented.

The AAFP's framework (Ask, Identify, and Act) for addressing SDOH in primary care is an easy-to-remember approach, which provides the opportunity for every member of the practice team to intervene at every visit, and allows interventions to be tailored to a specific patient based on his or her needs, as well as to the structure of the practice. The AAFP provides resources to help with each of these processes, which are described below.

Ask Patients About Social Determinants of Health

SDOH should be assessed and documented for every patient at every office visit. The AAFP has developed a Guide for Social Needs Screening (www.aafp.org/social-needs-screening) to help facilitate this process. This screening tool is based on the National Academy of Medicine's 11 SDOH domains and can be used to develop a systematic approach for inquiring about patients' SDOH.²⁶

Screening for SDOH is important because:

- Patients may not know to discuss non-medical issues with their physician—this will prompt them to discuss their needs.
- SDOH status of a patient can change. For example, opportunities for good health can be constrained after a job loss.
- Validated questions exist for inquiring about SDOH.

Steps you can take to incorporate screening for SDOH include:

- Expanding the vital signs to include SDOH.
- Including prompts on face sheets or summary screens to help identify patients with SDOH.
- Using electronic health records (EHRs) to integrate SDOH screening into the practice workflow by:
 - o Integrating SDOH screening questions.
 - o Documenting arrangements made for patients to visit community-based resources.
 - o At follow-up, documenting the results of the referral.

Identify Community-based Resources

As with any screening program, it is essential to address problems as they are identified. Family physicians and their health care teams need a way to identify community-based resources. Historically, this has been challenging, but the AAFP and other organizations now provide the following tools to help with this:

- **AAFP's Neighborhood Navigator:** Neighborhood Navigator is a free, easy-to-use database that provides instant access to a comprehensive local listing of community-based resources in every ZIP code in the U.S. These resources are kept up-to-date by a dedicated team. The Neighborhood Navigator also includes tools to make and manage referrals, tag favorite programs, and receive information about how your patients use resources. (www.aafp.org/neighborhood-navigator)*
- **2-1-1:** 2-1-1 is a free and confidential service that helps people across the U.S. (and in many parts of Canada) find the local resources they need. 2-1-1 can be accessed 24 hours a day, seven days a week by phone, text, or the web. (www.211.org)*
- **Local Health Departments:** Local health departments often have strong relationships with community-based resources, and may be able to provide you and your practice team with an up-to-date list of these resources. You can find your county or city health department at the National Association of County and City Health Officials' (NACCHO's) directory (www.naccho.org/membership/meet-our-members/lhd-directory).

*Neighborhood Navigator and 2-1-1 include information about: supplemental food and nutrition program; shelter and housing options and utilities assistance; emergency information and disaster relief; employment and education opportunities; services for veterans; health care, vaccinations, and health epidemic information; addiction prevention and rehabilitation programs; re-entry help for ex-offenders; support groups for individuals with mental illnesses or special needs; and a safe, confidential path out of physical and/or emotional domestic abuse.



Act to Connect to Patients with Community-Based Resources

After a patient's social needs have been identified and matched to community-based resources, it is important to work with your patients to determine a plan of action and connect them with the resources. Talk with your patients about getting help. If the patient is unsure about getting help, explore why. If patients are unsure how community-based resources can help, you could provide comfort with statements like, "I have referred many of my patients to this service, and they have found it helpful." If the patient is not interested, offer a printout of the resources available, and provide information about the Neighborhood Navigator or 211. If the patient is interested, provide a referral and have your health care team set this up. Neighborhood Navigator has a "connect" feature to help with this, which allows you to send a message to the community-based resource, informing them that your patient will be seeking their services.

It is also important to formulate an action plan with your patients and follow-up with them. Use AAFP's Social Needs Patient Action Plan (www.aafp.org/sdoh-patient-action-plan) to document the plan, share it with your patient, and use for follow up.

Step 4: Identify Barriers and Plan for Change

Change can be difficult. Identify challenges you expect to face as you make these changes to address your patients' SDOH. This could be done by yourself or through a group meeting with your health care team. Start by making a list. Common barriers may include:²⁷

- Perceived lack of payment for SDOH
- Staff expertise and capacity
- Implicit bias and cultural proficiency
- Lack of resources in patients' communities
- Ensuring that patients know what to do and how to follow up with you
- Engaging the health care team and building momentum.²⁷

Inappropriate expectations about what success looks like when addressing SDOH may be another barrier. By their nature, SDOH are complicated and often require changes in social, environmental, and economic systems that are outside of the practice's and patient's immediate control. Advancing health equity is not a linear process. To stay positive, remember that cause and effect are not always closely related. Family physicians and their health care teams may not be able to address each social need of their patients, but patients should be encouraged by the help you and your practice team can provide.

Step 5 : Measure and Celebrate Success

To promote sustainability and increase motivation, it is essential to understand how successful your initiative to address your patients' SDOH has been.²⁸ Define a set of measures that can be easily monitored to determine how effective your work has been. Early measures of success may focus on process and implementation.

Measures may include things like:

- Percent of staff trained
- Processes established
- Percent of staff engaged

As you and your health care team become proficient in your new process for addressing patients' SDOH, more outcome-based measures of success may be appropriate.

Outcome-based measures of success may include:

- Percent of patients with specific SDOH
- Percent of patients screened for SDOH
- Percent of patients with positive screen being referred to community-based resources
- Percent of patients that receive follow up
- Percent of patients that have successfully addressed an identified SDOH challenge

Set goals and use these measures to monitor progress. Bring attention to early wins and major breakthroughs. Celebrate as a team when goals are achieved and make sure that people are publicly recognized when they have gone above and beyond. Celebrating your health care team and their successes will help team members remain engaged and motivated to ensure that these changes become part of your practice culture.



Step 6 : Finalize Your Team-based Implementation Plan

Now that you know what you want to do, how to incorporate this into your practice, and potential barriers, it is time to assign responsibilities for implementing the plan. You and your health care team need to determine who is responsible for which duties, as well as for deadlines and tracking progress. See the sample implementation plans below as a guide and use the template provided here: www.aafp.org/sdoh-implementation-plan.

Roles of Multidisciplinary Team Members

Systematizing processes requires very clear guidelines on roles and responsibilities. Assignments may vary based on practice size and structure. As you and your practice team define who will assume various roles in your practice, consider the following options:

Physicians

- Discuss with your patients their SDOH and available community-based resources.
- Deliver strong, personalized messages about preferred community-based resources.
- Refer your patients to other team members for supplemental counseling and referral.
- Follow up with your patients about their use of community-based resources and the quality of their experience.
- Keep current on research.

Nurses, physician assistants, and/or health educators

- Assess your patients' SDOH and their readiness to find help.
- Provide counseling, with a focus on identifying strategies to overcome obstacles and reduce stress.
- Perform follow-up counseling.

Receptionists/medical assistants

- Distribute the SDOH questionnaire to your patients.
- Ensure that information about preferred community-based resources is available in waiting areas.
- Schedule or arrange for appointments with community-based resources.
- Follow up with your patients to remind them of their appointments with community-based resources.

Administrators

- Ensure adequate human resource support for staff addressing patients' SDOH.
- Support integration of SDOH tools into the EHR.
- Arrange for training on SDOH and health equity, implicit bias, and cultural proficiency.
- Implement quality audits and monitor key implementation activities.
- Ensure data are tracked for program evaluation.
- Communicate outcomes to other members of the health care team.

Be sure to communicate to each staff member about his or her responsibilities for addressing SDOH. Incorporate a discussion of these staff responsibilities into training of new staff.

CONCLUSION

Thank you for reading this implementation guide. We hope that you and your practice team members have found it useful. As you and your practice team work toward addressing SDOH and advancing health equity, please check back with the AAFP for new resources at www.aafp.org/everyone. We welcome feedback about this guide and you can reach us at healthequity@aaafp.org.

SAMPLE SDOH IMPLEMENTATION PLAN

TASK	PERSON RESPONSIBLE	DATE TO BE COMPLETED	CHECK WHEN COMPLETED
Planning Tasks			
Conduct initial meeting with staff to introduce them to the initiative			
Identify opportunities to address SDOH			
Evaluate patient and workflow			
Define the new system			
Identify barriers and plan for change			
Make assignments and complete the team-based implementation plan			
Establish a Culture of Health Equity			
Provide training to understand your patient's communities			
Provide training about how social factors influence health			
Provide training about implicit bias and cultural proficiency			
Develop strategies for health literacy and interpretation			
Implementation Tasks			
Formalize a protocol for addressing SDOH			
Provide staff training on new protocols			
Incorporate SDOH screening tool into workflow			
Create prompts for electronic health records or paper charts			
Update billing process to ensure payment			
Create a list of community-based resources, or use of Neighborhood Navigator, 211, etc.			
Create and implement a system to track and communicate success			
Ongoing Tasks			
Provide patients' with SDOH screening form		N/A	N/A
Identify community-based resources matched to patient's SDOH screening form		N/A	N/A
Work with patients to develop a plan of action to address their SDOH		N/A	N/A
Work with patients to make referral to community-based resources		N/A	N/A
Follow up with patients about SDOH		N/A	N/A
Monitor measures of success and communicate with practice members			



REFERENCES

- American Academy of Family Physicians. Social determinants of health policy. www.aafp.org/about/policies/all/social-determinants.html. Accessed August 14, 2018.
- O'Campo P, Dunn JR, eds. *Rethinking social epidemiology: towards a science of change*. New York, NY: Springer; 2012.
- Booske BC, Athens JK, Kindig DA, Park H, Remington PL. County health rankings working paper. Different perspectives for assigning weights to determinants of health. University of Wisconsin Population Health Institute. www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf. Accessed March 6, 2018.
- Shim R, Rust G. Primary care, behavioral health, and public health: partners in reducing mental health stigma. *Am J Public Health*. 2013;103(5):774-776.
- Krist A, Shenson D, Woolf S, Bradley C, Liaw W, Rothemich S. A framework for integration of community and clinical care to improve the delivery of clinical preventive services among older adults. National Association of Chronic Disease Directors. Michigan Public Health Institute. Healthy Aging Program, Division of Population Health. Centers for Disease Control and Prevention. www.cdc.gov/aging/pdf/cps-integration-framework.pdf. Accessed August 14, 2018.
- Schottenfeld L, Petersen D, Peikes D, Ricciardi R, Burak H, McNellis R, et al. Creating patient-centered team-based primary care. Agency for Healthcare Research and Quality. 2016. www.pcmh.ahrq.gov/sites/default/files/attachments/creating-patient-centered-teambased-primary-care-white-paper.pdf. Accessed August 14, 2018.
- Healthy People 2020. Disparities. Office of Disease Prevention and Health Promotion. www.healthypeople.gov/2020/about/foundation-health-measures/Disparities. Accessed August 14, 2018.
- County Health Rankings & Roadmaps. www.countyhealthrankings.org/. Accessed August 14, 2018.
- National Association of County & City Health Officials. Definitions of Community Health Assessments (CHA) and Community Health Improvement Plans (CHIPs). Community health assessment. www.archived.naccho.org/topics/infrastructure/community-healthassessment-and-improvement-planning/upload/Definitions.pdf. Accessed August 14, 2018.
- Wilson KD, Mohr LB, Beatty KE, Ciecior A. Describing the continuum of collaboration among local health departments with hospitals around the community health assessments. *J Public Health Manag Pract*. 2014;20(6):617-625.
- Galea S, Tracy M, Hoggatt KJ, DiMaggio C, Karpati A. Estimated deaths attributable to social factors in the United States. *Am J Public Health*. 2011;101(8):1456-1465.
- Marmot M, Wilkinson RG, eds. *Social determinants of health*. 2nd ed. Oxford, United Kingdom: Oxford University Press; 2005.
- Olshansky SJ, Antonucci T, Berkman L, et al. Differences in life expectancy due to race and educational differences are widening, and many may not catch up. *Health Aff*. 2012;31(8):1803-1813.
- Dwyer-Lindgren L, Bertozzi-Villa A, Stubbs RW, et al. Inequalities in life expectancy among US counties, 1980 to 2014: temporal trends and key drivers. *JAMA Intern Med*. 2017;177(7):1003-1011.
- Phelan JC, Link BG, Tehranifar P. Social conditions as fundamental causes of health inequalities: theory, evidence, and policy implications. *J Health Soc Behav*. 2010;51(Suppl):S28-S40.
- Glass TA, McAtee MJ. Behavioral science at the crossroads in public health: extending horizons, envisioning the future. *Soc Sci Med*. 2006;62(7):1650-1671.
- McEwen BS. Protective and damaging effects of stress mediators. *N Engl J Med*. 1998;338(3):171-179.
- World Health Organization. A conceptual framework for action on the social determinants of health. Social determinants of health discussion paper 2. www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf. Accessed August 14, 2018.
- Blair I V, Steiner JF, Havranek EP. Unconscious (implicit) bias and health disparities: where do we go from here? *Perm J*. 2011;15(2):71-78.
- FitzGerald C, Hurst S. Implicit bias in healthcare professionals: a systematic review. *BMC Med Ethics*. 2017;18(1):19.
- Altus A. 4 steps physicians can take to address implicit biases. <https://thedo.osteopathic.org/2017/04/4-steps-physicians-can-take-to-address-implicit-biases/>. Accessed August 14, 2018.
- American Academy of Family Physicians. Cultural proficiency. www.aafp.org/patient-care/social-determinants-of-health/cultural-proficiency.html. Accessed August 14, 2018.
- Office of Disease Prevention and Health Promotion. National action plan to improve health literacy. U.S. Department of Health and Human Services. www.health.gov/communication/HLActionPlan/pdf/Health_Literacy_Action_Plan.pdf. Accessed August 14, 2018.
- National Center for Education Statistics. The health literacy of America's adults. Results from the 2003 National Assessment of Adult Literacy. Institute of Education Sciences. U.S. Department of Education. www.nces.ed.gov/pubs2006/2006483.pdf. Accessed August 14, 2018.
- Moch R, Nassery HG, Fareed MT. Incorporating medical interpretation into your practice. *Fam Pract Manag*. 2014;21(2):16-21.
- The National Academies of Sciences, Engineering, and Medicine. Recommended social and behavioral domains and measures for electronic health records. www.nationalacademies.org/hmd/Activities/PublicHealth/SocialDeterminantsEHR.aspx. Accessed August 14, 2018.
- American Academy of Family Physicians. 2017 social determinants of health survey.
- Kotter JP. *Leading change*. Boston, Mass. Harvard Business Review Press; 1996.