Despite strong evidence linking patients’ social circumstances to their health, little guidance exists for health care practitioners and institutions on addressing social needs in clinical settings. Current approaches to social determinants generally focus on population-level and policy interventions; these overlook individual and clinical innovations within health care that can address patients’ social circumstances. This article proposes a framework for how social determinants interventions in the health care system can be construed across 3 tiers—patient, institution, and broader population—and describes ways to collect data and target interventions at these levels.

Exponential growth in research on social determinants of health over the past 2 decades has fueled interest in the possibility that intervening on environmental and social exposures could improve health and reduce health care spending. Many health care professionals have equated addressing social determinants of health with acting on “fundamental” upstream causes of disease that lie outside the health care system. But upstream efforts, while important, largely ignore the potential for medical professionals to address social determinants within the health care delivery system. Modifiable social problems such as housing and food insecurity, which have been linked to health status and health care utilization, can be addressed in clinical settings as well as at a policy level. Yet, little serious discussion has occurred about the multiple roles that health care organizations can play in directly acting on social determinants of patients’ health. Articulating these roles is increasingly relevant to hospitals given the emergence of accountable care organizations and related financial incentives to keep patients healthy, in addition to the 2012 tax code from the Internal Revenue Service requiring nonprofit hospitals to report regular community needs assessments and to establish plans for addressing identified needs.

### Intervention Tiers for Social Determinants of Health

Reflecting lessons from early community health center pioneer Dr H. Jack Geiger and the National Center for Medical-Legal Partnership (http://www.medical-legalpartnership.org/), we propose the concept map presented in the Table as a guide for health care organizations and practitioners to act on individual, health care institution, and population levels to affect health. The framework includes (1) individual-level interventions that may immediately and directly affect patients’ social situations; (2) system or institutional interventions affecting populations over which health care organizations have responsibility, including patients and employees; and (3) community- or societal-level interventions, including social and political advocacy and research.

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Below, we suggest strategies for integrating these levels of social interventions into traditional health care delivery.

USING SOCIAL DETERMINANTS OF HEALTH DATA IN CLINICAL SETTINGS

Several key steps are needed to address social determinants of health within the clinical arena.

Screening for Social Needs

Improving collection of social data inside clinical settings is a necessary step toward translating the proposed intervention levels into practice. The vast majority of medical providers working in underserved settings believe social needs screening is effective for improving health.4 Just as data on symptoms and medical and family history are routinely collected to inform diagnosis and treatment, data on patients’ social circumstances need to be collected and tracked. Evidence to date suggests that the criteria of sensitivity, feasibility, and “actionability” can be met for specific social screening measures and interventions, and recommendations have been made regarding potential social data domains and the appropriate frequency of data collection.5

Applying Social Needs Data

Patient social data, once collected, can be used to affect medical risk and treatment decisions and to inform interventions to improve vulnerable patients’ social circumstances.

Adjust Individual Disease Risk. Patient social data can influence clinical care decisions. Fiscella et al,6 for instance, treated poverty as an independent risk factor for heart disease and incorporated patient income into 10-year Framingham Risk Score calculations. Doing so better identified patients at risk of developing cardiovascular disease than did traditional calculators. Socioeconomic indicators also can enhance the utility of specific screening recommendations and algorithms. For example, adjusting for education improves the accuracy of the Mini-Mental State Examination in predicting disease likelihood.7

Address Social Determinants of Health. Beyond improving risk assessment and informing the use of conventional medical treatment, social data can be used to guide on- or off-site referrals in an effort to improve patients’ modify social circumstances.

Co-Locate Health and Social Services. Some health care settings have co-located on-site emergency food boxes, farmers markets, or Special Supplementation Nutrition Program for Women, Infants, and Children offices to address hunger and nutrition. Others have co-located health and legal services through medical-legal partnerships, which address health-related legal needs—such as unsafe housing or denial of insurance—within the scope of clinical services. Health and social service co-location can provide increased consumer utilization and program efficiencies.8

Tools to address social needs may be incorporated into standard clinical protocols at the organizational level. For instance, Boston Medical Center’s electronic health record includes a legally formatted letter template to protect utility services (eg, heating or air conditioning)9 (Table). Such a letter can help a patient with cold-induced asthma from worsening symptoms in winter or enable medication refrigeration. Access to a common template improves clinical efficiency by lowering provider time demands.

Improve Referral Capacity. Despite the aforementioned examples, most social services reside outside the health care system, and social workers are used to link patients with these services.8 However, social work provider short-
ages, lack of standardization, and poor geographical and racial/ethnic diversity may limit their effectiveness. Alternative models are being developed that expand the capacity of providers and systems to link patients to needed services at lower costs. These range from improving resource information availability (https://www.helpsteps.com/home.html and http://cap4kids.org/philadelphia/) through use of technology to training college student volunteers to connect patients with community-based resources (http://www.healthleadsusa.org/).

**OPPORTUNITIES AND BARRIERS**

Existing guidelines for patient-centered medical home standards and meaningful use of health information technology focus on integration of medical services and data within and across health care providers and sites. Recommendations here capitalize on federal mandates for service integration to include data collection on social determinants and resource integration within and across health care and non–health care agencies. These highlight a key difference between a “medical home” and a “health neighborhood.”

Health care and non–health care agencies could overcome barriers posed by separate funding streams by creating shared funding and reimbursement agreements. Electronic health records could facilitate these intersectoral partnerships, particularly if they capture some of the social and behavioral factors that shape health. Initiatives supporting clinical transformation in the American Recovery and Reinvestment Act of 2009 and the Affordable Care Act of 2010 expand the potential for piloting and scaling these collaborations. Reimbursement opportunities for these activities may emerge in Medicaid Administrative Activities and Reimbursement opportunities for Medicaid enrollees.

As social and health services integration diffuses, issues of privacy and effectiveness will require particular attention. Despite the recent surge in social determinants research, little analysis of ethical challenges surrounding routine data collection has occurred, and interventions have been inadequately studied for their effectiveness. Incorporating social data and interventions into health care settings should result in improved health status and lower health care costs and utilization; achieving this will require documenting expected benefits while addressing privacy concerns and other barriers to collaboration.

**CONCLUSIONS**

As implementation of the Affordable Care Act proceeds, 32 million previously uninsured Americans will enter the health care system, most of whom will be low-income or otherwise socially vulnerable patients. The overlap and distinctions between social determinants of health interventions and population health approaches are relevant to help meet these patients’ needs and to alleviate worsening societal cost burdens. Health systems must now take the critical next steps, tracking and addressing social factors at individual and institutional levels. Doing so can improve care for such high-risk patients and inform policy and advocacy actions that influence population health.

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Images From Our Readers

São Paulo, Brazil.

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