

Building an Evidence Base for Integration of Social Care Into Health Care: Our Collective Path Ahead

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As adverse social determinants of health are increasingly recognized for their role in perpetuating health inequities and poor health outcomes, there are growing efforts to integrate social care (ie, activities to identify, assist with, and adjust for social risk factors) into health care.¹⁻⁵ Numerous professional societies have called for screening and intervening on patients' social risks.⁶⁻¹⁰ The COVID-19 pandemic has increased the urgency of social care as many patients face new or intensified socioeconomic hardship.¹¹⁻¹⁵ Amidst accelerating social care integration efforts, collaboration among researchers, policy makers, payers, and health care systems is needed as the drive to implement outpaces the evidence.

This issue of *Annals of Family Medicine* includes 3 articles highlighting both how far we have come in advancing the integration of social and medical care, and how much work lies ahead. In their qualitative case study of Michigan federally qualified health centers (FQHCs), Greenwood-Ericksen et al examine the implementation of social risk screening and drivers of variation in social care activities.¹⁶ In their special report, Hoeft et al translate lessons learned from behavioral health integration to the social care realm.¹⁷ And finally, in a narrative piece, Fessler et al poignantly reflect on the importance of human connection, and how stepping away from formal training

into community volunteering when medical school clerkships were halted due to COVID-19 enabled a reconnection with why they went into medicine.¹⁸

Taken together, these 3 articles serve as a timely call to action, reminding readers of the work still needed to meet patients' needs. This work includes improved training and education for all members of the clinical care team around social risk and social care activities, as well as best-practice guidelines, evidence-based interventions, and sustainable funding streams. Commitment to patients and social care integration starts with critically appraising all levels of training and education. Fessler et al speak to how medical training can distance students from their humanity by distilling medically and socially complex patients down to a few "key" descriptors, and how these practices often implicitly blame patients for adverse circumstances.¹⁸ Both Hoeft et al and Greenwood-Ericksen et al discuss the role of interdisciplinary team-based care in social care integration, and the importance of context-appropriate adaptation. Hoeft et al examine how embracing adaptation as a core implementation strategy has been essential to scaling and disseminating behavioral health integration across clinical settings.¹⁷ Although the social care integration evidence base is more nascent, an example of such "real world" adaptation is Greenwood-Ericksen et al's finding that community health workers played a critical and often evolving role in FQHC integration efforts.¹⁶

It is crucial to remember that screening for social risks is not the end goal, as acknowledged by both Hoeft et al¹⁷ and Greenwood-Ericksen et al.¹⁶ Screening is a necessary input to enable health care team identification of patients who may be experiencing social risks. Yet similar to the patient health questionnaire 2 (PHQ-2), screening for social risks is not

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diagnostic, and when not followed-up, has the potential for harm.^{19,20} Screening may not always result in patient disclosure of their social risks or interest in assistance,²¹⁻²⁴ and resources may be limited and vary by setting (not dissimilar to behavioral health). But this does not mean that screening—when done sensitively and appropriately—is not worth pursuing. Conversations around patients' social contexts can build relationships,²⁵ guide treatment and follow-up that is accessible and acceptable to patients,²⁶ and can empower patients to be active agents in their own care.¹⁶ Furthermore, social risk data can aid advocacy and policy efforts to expand community-based resources, efforts to address health inequities, and population health-level interventions more broadly.²⁶ Without adequate preparation to integrate social care activities into practice, however, health care teams may be ill-equipped to handle implementation challenges.

These articles further highlight the importance of the sustainability of social care activities. An obstacle to social care integration is the funding stream itself, often relying on temporary grants from funders with their own priorities and agendas, which—as Greenwood-Ericksen et al found—can drive local implementation decisions.¹⁶ Both greater flexibility in use of Center for Medicare & Medicaid Services dollars²⁷⁻²⁹ and the new 2021 Evaluation & Management (E/M) coding guidelines for social determinants³⁰ may facilitate more consistent funding for social care activities. Such funding mechanisms will be critical to support meaningful and sustainable social care integration into medical care.

Central to building the case for sustainable funding streams is a robust evidence base around implementation best practices and outcomes. Learning collaboratives—such as the Texas Managed Care Organization Social Determinants of Health Learning Collaborative³¹—and online repositories—such as the Social Interventions Research & Evaluation Network's Evidence & Resource Library³²—can assist in these efforts. Hybrid design implementation studies can enable simultaneous evaluation of both efficacy and implementation.³³ While high-quality evidence is necessary to guide the field and inform future guidelines,^{34,35} Hoeft et al remind us that we may not have to reinvent the wheel.¹⁷

Hoeft et al identify specific next steps to advance and scale social care integration, including developing and prioritizing a set of core social risk measures that are appropriate to patients and across multiple contexts.¹⁷ Consistent and shared coding and metrics can aid population health efforts, increase the ease of social risk documentation, and improve monitoring and actionability of social risk information.³⁶ Efforts to facilitate social determinants data capture such as the Gravity Project are actively working toward that goal.³⁷

While there is urgency to implement social care activities *now*, we must also ensure we are learning from on-the-ground efforts and building the evidence base to inform uptake and sustainability of future social care integration. The 3 articles included in this issue are a step in that direction,¹⁶⁻¹⁸ each highlighting areas for continued progress. The path ahead requires working together and sharing learnings to advance our common goal of achieving health equity and wellness—for patients and the health care workforce alike.

To read or post commentaries in response to this article, go to <https://www.AnnFamMed.org/content/19/4/290/tab-e-letters>.

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CORRECTIONS

Ann Fam Med 2021;19:292. <https://doi.org/10.1370/afm.2692>.

In: Ebell MH, Bentivegna M, Hulme C. Cancer-Specific mortality, all-cause mortality, and overdiagnosis in lung cancer screening trials: a meta-analysis. *Ann Fam Med.* 2020;18(6):545-552, the x-axis in Figure 1 was labeled incorrectly and the scale was incorrect. The author regrets the error and the figure has been corrected online; therefore the online version of record differs from the print publication.

In Newton WP, Baxley E, Magill MK. Learning from COVID-19: system blindness to primary care. *Ann Fam Med.* 2021;19(3):282-284, there was a typo on p. 282. The number of primary care office visits annually is over 4,000,000, not 400,00 as originally published. The online version has been corrected; therefore it differs from the print publication.

In both cases, the authors regret the errors.