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Beyond Clinical Boundaries: Medical Workers as Essential Partners in Addressing Social Determinants of Health Within Integrated Care Ecosystems

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Abstract

Healthcare systems increasingly recognize that addressing social determinants of health (SDOH) is essential for improving population health outcomes and reducing disparities. This study examines the evolving role of medical workers as key partners in identifying and addressing SDOH within integrated care ecosystems. Drawing on current research and implementation experiences, we explore how healthcare professionals across disciplines are expanding beyond traditional clinical boundaries to address the social factors that profoundly influence health. The Accountable Health Communities Screening Tool and similar instruments have standardized SDOH assessment in clinical settings, while various implementation patterns of integrated behavioral health demonstrate how practices incorporate SDOH into their workflows. Despite promising developments in screening tools, team-based approaches, and community partnerships, significant challenges remain, including workflow integration, sustainable financing, and ethical considerations in SDOH screening. We analyze how alternative payment models, policy developments, and workforce initiatives can support medical workers in addressing SDOH more effectively. The study concludes by outlining future directions for building sustainable ecosystems that support SDOH integration, including advancing technological solutions, strengthening multi-sector collaboratives, centering health equity, and enhancing interprofessional education. By embracing expanded roles in addressing social needs, medical workers can contribute to more effective, equitable healthcare systems

that improve outcomes for individuals and communities, particularly those experiencing social vulnerability.

Introduction

The United States healthcare system has traditionally operated on a predominantly biomedical model focused on diagnosing and treating illnesses rather than addressing the upstream factors that influence health outcomes. Despite significant healthcare expenditures, health outcomes in the United States lag behind those of many other high-income nations, with striking health disparities across socioeconomic, racial, and geographic lines (Adler et al., 2016). These disparities highlight a critical gap in our approach to healthcare: the insufficient attention to social determinants of health (SDOH)—the conditions in which people are born, grow, live, work, and age that shape health outcomes.

Research consistently demonstrates that social and behavioral factors account for a significant proportion of health outcomes, with some estimates suggesting they contribute to as much as 60% of premature deaths (Braveman & Gottlieb, 2014). Meanwhile, the United States continues to invest disproportionately in medical services while underinvesting in social services compared to other high-income countries. Nations with higher ratios of social services spending relative to healthcare spending tend to achieve better population health outcomes and longer life expectancies (Adler et al., 2016).

The recognition of this imbalance has catalyzed a paradigm shift toward integrated care models that bridge medical and social domains. As healthcare systems increasingly adopt integrated approaches, medical workers are being positioned at the frontlines of addressing SDOH. This shift transforms healthcare delivery from a siloed, disease-centered approach to a person-centered, holistic ecosystem that acknowledges the complex interplay between clinical and social factors affecting health.

This study examines the evolving role of medical workers as essential partners in addressing SDOH within integrated care ecosystems. Drawing on emerging research, policy frameworks, and implementation models, we explore how medical workers can effectively identify and address social needs, collaborate across sectors, and contribute to sustainable systems change. The discussion focuses on key challenges, promising practices, and future directions for enhancing the capacity of medical workers to address SDOH as part of a coordinated, integrated approach to healthcare.

Understanding Social Determinants of Health and Their Impact on Healthcare Delivery

The social determinants of health encompass a broad range of factors that influence health outcomes, including housing stability, food security, transportation access, education, employment, social support networks, and exposure to violence or discrimination. These factors are deeply interconnected and often have cumulative effects throughout the life course (Braveman & Gottlieb, 2014). For example, housing instability can exacerbate food insecurity, complicate medication adherence, and increase exposure to environmental hazards—all of which can contribute to poor health outcomes.

The impact of SDOH on healthcare delivery is profound and multifaceted. First, unaddressed social needs often manifest as complex clinical presentations that challenge traditional medical approaches. Patients experiencing homelessness, for instance, may present with multiple chronic conditions exacerbated by limited access to proper nutrition, medication storage, and hygiene facilities. Second, SDOH significantly influence healthcare utilization patterns, with socially vulnerable populations often experiencing barriers to preventive care while showing higher rates of emergency department use and preventable hospitalizations. Third, SDOH contribute to persistent health disparities, with socioeconomically disadvantaged populations experiencing disproportionately higher rates of chronic disease, disability, and premature mortality (Adler et al., 2016).

Healthcare systems are increasingly recognizing that effectively addressing SDOH requires moving beyond the traditional boundaries of clinical care. The Centers for Medicare & Medicaid Services (CMS) has acknowledged this through initiatives like the Accountable Health Communities Model, which tests whether systematically identifying and addressing health-related social needs impacts healthcare costs and improves health outcomes (Billioux et al., 2017). Similarly, the National Academy of Medicine has identified addressing SDOH as a "vital direction" for advancing health and healthcare in the United States (Adler et al., 2016).

As healthcare systems evolve to address SDOH, medical workers—including physicians, nurses, social workers, community health workers, and other allied health professionals—are increasingly being called upon to screen for social needs, connect patients with appropriate resources, and advocate for systems-level changes. This expansion of roles requires new competencies, workflows, and collaborative approaches that transcend traditional clinical boundaries.

The Rise of Integrated Care Models: Theoretical Frameworks and Implementation Patterns

Integrated care represents a comprehensive approach to healthcare delivery that brings together diverse professional disciplines and sectors to provide coordinated services addressing both medical and social needs. Several theoretical frameworks have emerged to guide the development and implementation of integrated care models, each emphasizing different aspects of integration.

The SAMHSA-HRSA Center for Integrated Health Solutions has developed a framework that outlines six levels of integration, ranging from minimal collaboration (Level 1) to full integration (Level 6). At higher levels of integration, behavioral health and primary care providers work together in a shared system with integrated records, unified treatment plans, and collaborative decision-making (Heath et al., 2013). Similarly, the Agency for Healthcare Research and Quality has developed a "Lexicon for Behavioral Health and Primary Care Integration," which defines integrated care as "the care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population" (Peek & The National Integration Academy Council, 2013, p. 2).

While these frameworks primarily focus on integrating behavioral health and primary care, they have evolved to encompass broader social determinants of health. The IBH Cross-Model Framework identifies core principles and structures that characterize effective integrated behavioral health across different implementation models, providing a foundation for understanding how healthcare systems can systematically address both clinical and social needs (Buchanan et al., 2022).

Implementation patterns of integrated care vary considerably across healthcare settings. Buchanan et al. (2022) used latent class analysis to identify distinct clusters of integrated behavioral health implementation in primary care settings, finding four implementation patterns: Low IBH (39.6% of clinics), Structural IBH (7.9%), Partial IBH (29.4%), and Strong IBH (23.1%). These patterns varied based on contextual factors such as urban/rural location, socioeconomic characteristics of the patient population, and organizational size. This research highlights that healthcare systems adopt different approaches to integration based on their specific contexts, resources, and patient populations.

Promising examples of integrated care models addressing SDOH include Hennepin Health, a safety-net accountable care organization (ACO) serving Medicaid expansion enrollees in Minnesota. Hennepin Health integrates medical, behavioral health, human services, and public health resources to address the comprehensive needs of its members, many of whom experience significant social challenges. The model includes interdisciplinary care coordination teams,

streamlined access to social services, and innovative payment mechanisms that support addressing social determinants (Sandberg et al., 2014).

These frameworks and implementation patterns provide valuable guidance for healthcare systems seeking to integrate attention to SDOH into clinical practice. However, successful integration requires not only structural and operational changes but also a fundamental shift in how medical workers conceptualize their roles and responsibilities.

Medical Workers as SDOH Champions: Evolving Roles and Competencies

As healthcare systems increasingly recognize the importance of addressing SDOH, medical workers across disciplines are expanding their roles to become champions for social determinants of health. This role expansion requires developing new competencies, adopting different mindsets, and engaging in collaborative practice that extends beyond traditional clinical boundaries.

Physicians and Nurses: From Clinical Experts to Holistic Care Advocates

Traditionally focused on diagnosing and treating medical conditions, physicians and nurses are increasingly incorporating screening for social needs and connecting patients with appropriate resources into their practice. The American College of Physicians has issued a position paper advocating for physicians to address social determinants to improve patient care and promote health equity (Daniel et al., 2018). This expanded role requires physicians to develop competencies in identifying social needs, understanding available community resources, and effectively coordinating care across medical and social service sectors.

Research on clinician experiences with screening for social needs in primary care indicates both enthusiasm for addressing SDOH and significant challenges. Tong et al. (2018) found that while many clinicians recognize the importance of addressing social determinants, they often feel unprepared to do so effectively, citing constraints related to time, workflow integration, knowledge of community resources, and follow-up systems. These findings highlight the need for targeted training, resource support, and workflow redesign to enable physicians and nurses to effectively address SDOH.

Social Workers: Essential Partners in Integrated Care

Social workers bring unique expertise in addressing SDOH and have increasingly become integral members of healthcare teams. With their training in person-in-environment perspective, systems theory, and resource navigation, social workers are well-positioned to bridge the gap between medical and social domains. Fraser et al. (2018) conducted a systematic review of integrated primary care and social work, finding that social workers in primary care settings contribute to improved patient outcomes, increased access to services, enhanced patient satisfaction, and reduced healthcare costs.

The role of social workers in integrated care settings encompasses multiple functions: conducting comprehensive psychosocial assessments, facilitating connections to community resources, providing brief interventions for behavioral health concerns, advocating for patients, and contributing to interprofessional team-based care (de Saxe Zerden et al., 2018). Fraher et al. (2018) identified specific roles that social workers fulfill in integrated care settings, including behavioral health specialist, care manager, community resource specialist, patient navigator, and health educator.

Despite their crucial role, social workers in healthcare settings often face challenges related to role clarity, professional identity, and sustainable financing models. Zerden et al. (2021) highlight the need for greater recognition of social work's contributions to addressing SDOH and integrating social care into healthcare, calling for policy changes that support the sustainable inclusion of social workers in healthcare teams.

Community Health Workers: Bridging Clinical and Community Contexts

Community health workers (CHWs) serve as vital links between healthcare systems and communities, particularly for underserved populations. With their deep understanding of local contexts, cultural nuances, and community resources, CHWs play a crucial role in addressing SDOH. Their functions include conducting outreach, providing culturally responsive health education, supporting navigation of healthcare and social service systems, offering informal counseling and social support, and advocating for individual and community needs.

The integration of CHWs into healthcare teams enhances the capacity to address SDOH in several ways. First, CHWs often share cultural, linguistic, and experiential backgrounds with the communities they serve, enabling them to build trust and effectively engage patients who may be disconnected from traditional healthcare systems. Second, their knowledge of community resources and social service systems allows for more effective referrals and care coordination. Third, CHWs can provide insights about community-level factors affecting health, informing more contextually appropriate interventions.

Interprofessional Collaboration: The Foundation for Addressing SDOH

Effectively addressing SDOH requires collaboration across disciplines, sectors, and systems. The Interprofessional Education Collaborative has identified four core competency domains for collaborative practice: values/ethics for interprofessional practice, roles/responsibilities, interprofessional communication, and teams/teamwork (IPEC, 2023). These competencies are essential for medical workers engaging in integrated approaches to SDOH.

Successful interprofessional collaboration for addressing SDOH involves several key elements: shared understanding of team members' roles and expertise, effective communication systems, mutual respect for diverse professional perspectives, joint decision-making processes, and commitment to patient-centered care. When these elements are in place, healthcare teams can develop comprehensive approaches that address both medical and social needs.

Implementing SDOH Screening and Intervention in Clinical Settings: Challenges and Promising Practices

As healthcare systems increasingly recognize the importance of addressing SDOH, many have begun implementing screening and intervention protocols in clinical settings. These implementations face numerous challenges but have also yielded promising practices that can guide future efforts.

Screening Tools and Approaches

The development of standardized screening tools has been a crucial step in systematizing SDOH assessment in clinical settings. The Accountable Health Communities (AHC) Screening Tool, developed by the Centers for Medicare & Medicaid Services, screens for needs across five core domains: housing instability, food insecurity, transportation difficulties, utility assistance needs, and interpersonal safety (Billioux et al., 2017). This 10-item tool was designed to be brief enough for integration into clinical workflows while comprehensive enough to identify significant needs that can be addressed through community services.

Other widely used screening tools include the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) and the Health Leads Screening Toolkit. These tools vary in length, domains covered, and implementation approach, allowing healthcare systems to select instruments that best fit their patient populations and clinical contexts.

The timing, frequency, and modality of screening also vary across implementations. Some healthcare systems conduct universal screening at every visit, while others screen at specific intervals or trigger points. Screening may be conducted through paper forms, electronic tablets, patient portals, or verbally by clinical staff. Each approach has advantages and limitations related to workflow integration, patient comfort, data capture, and resource requirements.

Workflow Integration and Team Roles

Successfully implementing SDOH screening and intervention requires thoughtful integration into clinical workflows and clear delineation of team roles. Key considerations include who administers the screening (e.g., front desk staff, medical assistants, nurses, social workers), how results are documented and communicated, who is responsible for follow-up, and how referrals and care coordination are managed.

Kostelanetz et al. (2022) conducted a mixed-methods study of healthcare professionals' perspectives on universal SDOH screening, finding that successful implementation depends on several factors: leadership support, dedicated staffing, integrated electronic health record (EHR) documentation, clear workflows, and established community partnerships. Respondents emphasized the importance of building staff capacity through training, resource guides, and protected time for addressing identified needs.

Hudon et al. (2022) explored stakeholder perspectives on integrating SDOH into primary healthcare, identifying several enablers of successful integration: continuity of care, data sharing, collaborative care approaches, adequate resources, and supportive organizational cultures. They also highlighted the importance of engaging patients as partners in the process and considering socioeconomic contexts when developing interventions.

Referral Systems and Community Partnerships

Identifying social needs through screening is only valuable if effective systems exist for connecting patients to appropriate resources. Healthcare systems have developed various approaches to resource referral and community partnership, ranging from simple resource lists to sophisticated closed-loop referral platforms that track referral outcomes.

Effective referral systems typically include several components: comprehensive, up-to-date resource directories; clear protocols for making referrals; mechanisms for tracking referral status and outcomes; and feedback loops to inform quality improvement. These systems require ongoing maintenance and relationship-building with community partners to ensure accuracy and effectiveness.

Strong community partnerships are essential for addressing SDOH effectively. Healthcare systems have established various partnership models, including formal contracts with community-based organizations, participation in multi-sector coalitions, co-location of services, and shared governance structures. These partnerships enable coordinated approaches to addressing complex social needs and facilitate more seamless transitions between medical and social service systems.

Data Integration and Measurement

Integrating SDOH data into healthcare information systems presents both challenges and opportunities. On one hand, capturing social needs data in electronic health records (EHRs) can enhance clinical decision-making, facilitate care coordination, and support population health management. On the other hand, concerns about privacy, stigma, and potential misuse of sensitive information must be carefully addressed.

Gottlieb et al. (2016) explored opportunities and barriers related to integrating social and medical data, highlighting several considerations: developing standardized SDOH data elements, establishing appropriate consent processes, ensuring data security, creating interoperable systems across sectors, and addressing workforce capacity for data collection and use. They emphasized that successful data integration requires attention to both technical infrastructure and social factors such as trust, privacy concerns, and power dynamics.

Measuring the impact of SDOH interventions presents additional challenges. Healthcare systems must determine what outcomes to measure (e.g., resolution of social needs, healthcare utilization, clinical outcomes, patient experience), how frequently to collect data, and how to attribute changes to specific interventions. Despite these challenges, robust measurement

systems are essential for demonstrating value, informing improvement, and securing sustainable funding for SDOH initiatives.

Ethical Considerations and Potential Unintended Consequences

Implementing SDOH screening and intervention in clinical settings raises important ethical considerations. Garg et al. (2016) highlighted potential unintended consequences of screening for social determinants, including increased stigmatization of patients, inappropriate diversion of clinical attention from medical issues, breached patient confidentiality, and inadequate follow-up for identified needs. They advocated for careful implementation that considers these potential harms and establishes safeguards to mitigate them.

Additional ethical considerations include ensuring that screening is conducted with cultural sensitivity and linguistic appropriateness, respecting patient autonomy in deciding whether to disclose social needs, avoiding assumptions based on demographic characteristics, and addressing implicit biases that may influence how healthcare providers respond to identified needs. Healthcare systems must also consider issues of equity in resource allocation, ensuring that SDOH initiatives do not inadvertently exacerbate existing disparities.

Policy and Payment Models to Support SDOH Integration

The sustainability and scalability of efforts to address SDOH in healthcare settings depend significantly on supportive policy and payment models. Recent years have seen notable policy developments and payment innovations that facilitate greater attention to social determinants, though significant gaps remain.

Policy Developments at Federal, State, and Local Levels

At the federal level, the Centers for Medicare & Medicaid Services (CMS) has implemented several initiatives supporting SDOH integration, including the Accountable Health Communities Model, which tests whether systematically identifying and addressing health-related social needs impacts healthcare costs and improves health outcomes (Billioux et al., 2017). Additionally, the Medicaid program has expanded flexibility for states to address SDOH through Section 1115 demonstration waivers, which allow states to test innovative approaches to Medicaid delivery and financing.

State Medicaid programs have increasingly incorporated SDOH-related requirements and incentives into managed care contracts, requiring plans to screen for social needs, develop partnerships with community-based organizations, and implement strategies to address identified needs. Some states have also established Medicaid Health Homes or Accountable Care Organizations with explicit focus on addressing social determinants.

Local governments have implemented various policies supporting SDOH integration, including zoning changes to promote healthy food access, transportation investments to enhance healthcare accessibility, and housing initiatives that incorporate healthcare supports. Many localities have also established multi-sector collaboratives that bring together healthcare, public health, social services, education, and other sectors to address SDOH through coordinated action.

Alternative Payment Models and Value-Based Care

The shift toward value-based care creates incentives for healthcare systems to address SDOH as a strategy for improving outcomes and reducing costs. Alternative payment models such as global budgets, shared savings arrangements, and capitated payments provide financial flexibility to invest in addressing social needs that impact health outcomes.

Accountable Care Organizations (ACOs) like Hennepin Health demonstrate how alternative payment models can support comprehensive approaches to SDOH. Hennepin Health uses a total cost of care model that combines funding streams from Medicaid, human services, public

health, and corrections to provide integrated care addressing both medical and social needs. This approach has yielded reductions in emergency department visits and inpatient admissions, along with improvements in preventive care measures (Sandberg et al., 2014).

Despite these innovations, significant challenges remain in financing SDOH interventions through healthcare payment systems. Current healthcare financing mechanisms often do not adequately account for the additional resources required to address complex social needs, particularly for safety-net providers serving populations with high social vulnerability. Additionally, siloed funding streams across healthcare, social services, and public health create barriers to coordinated, holistic approaches.

Workforce Development and Education Policies

Effectively addressing SDOH requires a workforce equipped with appropriate knowledge, skills, and attitudes. Policy changes to support workforce development include revisions to educational accreditation standards incorporating SDOH competencies, loan forgiveness programs for professionals working in underserved areas, and funding for interprofessional education initiatives.

The Interprofessional Education Collaborative (IPEC) has developed core competencies for collaborative practice that include addressing social determinants of health. These competencies are increasingly being incorporated into health professions education, preparing future medical workers to engage effectively in integrated approaches to SDOH (IPEC, 2023).

Policies supporting the community health worker (CHW) workforce are particularly important for SDOH integration. Many states have implemented CHW certification programs, established reimbursement mechanisms for CHW services, and developed training standards that include SDOH-related competencies. These policies enhance the capacity of healthcare systems to bridge clinical and community contexts in addressing social needs.

Future Directions: Building Sustainable Ecosystems for Addressing SDOH

As healthcare systems continue to evolve toward more integrated, holistic approaches, several future directions emerge for strengthening the role of medical workers in addressing SDOH within sustainable care ecosystems.

Advancing Technology Solutions

Technological innovations offer promising opportunities for enhancing SDOH integration. These include artificial intelligence applications for predicting social needs based on clinical and demographic data, machine learning algorithms to match patients with appropriate resources, telehealth platforms that reduce access barriers, and mobile applications that support patient self-management of both clinical and social factors affecting health.

Interoperable data systems that facilitate secure information exchange between healthcare and social service sectors represent another crucial technological frontier. Such systems can enable more coordinated care, reduce duplication of assessments, facilitate warm handoffs between providers, and support comprehensive outcome measurement. However, successful implementation requires addressing challenges related to data standards, privacy regulations, technical infrastructure, and organizational boundaries.

Building Multi-Sector Collaboratives

Addressing SDOH effectively requires collaboration beyond the healthcare system. Future directions include developing more robust multi-sector collaboratives that bring together healthcare, public health, social services, education, housing, transportation, and other sectors to address social determinants through coordinated action.

Successful multi-sector collaboratives typically include several key components: shared governance structures, aligned incentives across sectors, data-sharing agreements, joint planning processes, and sustainable financing mechanisms. These collaboratives enable more comprehensive approaches to complex social needs and facilitate system-level changes that address root causes of health disparities.

Advancing Health Equity Through SDOH Integration

Efforts to address SDOH present significant opportunities to advance health equity—the attainment of the highest level of health for all people. Future directions include developing more nuanced approaches to SDOH that explicitly address structural racism, historical injustices, and other systemic factors contributing to health disparities.

Zerden et al. (2021) emphasize the importance of centering equity in approaches to SDOH, advocating for strategies that empower marginalized communities, address structural barriers to health, and promote social justice. This includes ensuring that SDOH initiatives are culturally responsive, linguistically appropriate, and designed with meaningful input from the communities they serve.

Enhancing Education and Training

Preparing the healthcare workforce to effectively address SDOH requires significant enhancements to education and training. Future directions include developing more robust interprofessional education models that bring together students from medicine, nursing, social work, public health, and other disciplines to learn collaboratively about addressing social determinants.

Curriculum innovations might include community-based learning experiences, simulation scenarios involving complex social needs, training in trauma-informed care approaches, and education about structural determinants of health such as racism, sexism, and classism. These educational enhancements would equip future medical workers with the knowledge, skills, and attitudes needed to address SDOH effectively within integrated care ecosystems.

Conclusion

The evolution of healthcare toward more integrated, holistic approaches presents both opportunities and challenges for medical workers engaged in addressing social determinants of health. As boundaries between clinical and community contexts become increasingly permeable, medical workers across disciplines are expanding their roles, developing new competencies, and engaging in collaborative practices that transcend traditional professional silos.

Evidence suggests that when properly implemented, integrated approaches addressing both medical and social needs can improve health outcomes, enhance patient experience, reduce healthcare costs, and advance health equity. However, successful implementation requires attention to multiple dimensions: workflow integration, team roles, community partnerships, data systems, payment models, and workforce development.

The path forward involves building sustainable ecosystems that support medical workers as essential partners in addressing SDOH—ecosystems characterized by interprofessional collaboration, technological innovation, multi-sector partnerships, and unwavering commitment to health equity. By moving beyond clinical boundaries to address the social factors that profoundly influence health, medical workers can contribute to more effective, equitable healthcare systems that truly improve population health.

As Adler et al. (2016) observed, "Overcoming our national health disadvantage will require rebalancing our priorities to focus more on preventing or ameliorating health-damaging social conditions and behavioral choices" (p. 15). Medical workers, as frontline participants in healthcare delivery, have a crucial role to play in this rebalancing—serving not only as

clinicians but as advocates, partners, and champions for addressing the social determinants that shape health and wellbeing for individuals and communities.

References

1. Adler, N. E., Cutler, D. M., Fielding, J. E., Galea, S., Glymour, M. M., Koh, H. K., & Satcher, D. (2016). Addressing social determinants of health and health disparities: A vital direction for health and health care. NAM Perspectives, 6(9). https://doi.org/10.31478/201609t
2. Billioux, A., Verlander, K., Anthony, S., & Alley, D. (2017). Standardized screening for health-related social needs in clinical settings: The accountable health communities screening tool. NAM Perspectives, 7(5), 1–9. https://doi.org/10.31478/201705b
3. Braveman, P., & Gottlieb, L. (2014). The social determinants of health: It's time to consider the causes of the causes. Public Health Reports, 129(1_suppl2), 19–31. https://doi.org/10.1177/00333549141291S206
4. Buchanan, G. J. R., Piehler, T., Berge, J., Hansen, A., & Stephens, K. A. (2022). Integrated behavioral health implementation patterns in primary care using the cross-model framework: A latent class analysis. Administration and Policy in Mental Health and Mental Health Services Research, 49(2), 312–325. https://doi.org/10.1007/s10488-021-01165-z
5. Daniel, H., Bornstein, S. S., & Kane, G. C. (2018). Health and public policy committee of the American college of physicians. Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper. Annals of Internal Medicine, 168(8), 577–578. https://doi.org/10.7326/M17-2441
6. de Saxe Zerden, L., Lombardi, B. M., Fraser, M. W., Jones, A., & Rico, Y. G. (2018). Social work: Integral to interprofessional education and integrated practice. Journal of Interprofessional Education & Practice, 10, 67–75. https://doi.org/10.1016/j.xjep.2017.12.011
7. Fraher, E. P., Richman, E. L., de Saxe Zerden, L., & Lombardi, B. (2018). Social work student and practitioner roles in integrated care settings. American Journal of Preventive Medicine, 54(6), S281–S289. https://doi.org/10.1016/j.amepre.2018.01.046
8. Fraser, M. W., Lombardi, B. M., Wu, S., de Saxe Zerden, L., Richman, E. L., & Fraher, E. P. (2018). Integrated primary care and social work: A systematic review. Journal of the Society for Social Work and Research, 9(2), 175–215. https://doi.org/10.1086/697567
9. Garg, A., Boynton-Jarrett, R., & Dworkin, P. H. (2016). Avoiding the unintended consequences of screening for social determinants of health. JAMA, 316(8), 813–814. https://doi.org/10.1001/jama.2016.9282
10. Gottlieb, L., Tobey, R., Cantor, J., Hessler, D., & Adler, N. E. (2016). Integrating social and medical data to improve population health: Opportunities and barriers. Health Affairs, 35(11), 2116–2123. https://doi.org/10.1377/hlthaff.2016.0723
11. Heath, B., Wise Romero, P., & Reynolds, K. (2013). A review and proposed standard framework for levels of integrated healthcare. SAMHSA-HRSA Center for Integrated Health Solutions.
12. Hudon, C., Dumont-Samson, O., Breton, M., Bourgueil, Y., Cohidon, C., Falcoff, H., Senn, N., Van Durme, T., Angrignon-Girouard, É., & Ouadfel, S. (2022). How to better integrate social determinants of health into primary healthcare: Various stakeholders' perspectives. International Journal of Environmental Research and Public Health, 19(23), 15495. https://doi.org/10.3390/ijerph192315495
13. Interprofessional Education Collaborative [IPEC]. (2023). IPEC core competencies for interprofessional collaborative practice: Version 3. https://www.ipecollaborative.org/ipec-core-competencies
14. Kostelanetz, S., Pettapiece-Phillips, M., Weems, J., Spalding, T., Roumie, C., Wilkins, C. H., & Kripalani, S. (2022). Health care professionals' perspectives on universal screening of social determinants of health: A mixed-methods study. Population Health Management, 25(3), 367–374. https://doi.org/10.1089/pop.2021.0176

15. Peek, C. J., & The National Integration Academy Council. (2013). Lexicon for behavioral health and primary care integration: Concepts and definitions developed by expert consensus. Agency for Healthcare Research and Quality. http://integrationacademy.ahrq.gov/sites/default/files/Lexicon.pdf
16. Sandberg, S. F., Erikson, C., Owen, R., Vickery, K. D., Shimotsu, S. T., Linzer, M., Garrett, N. A., Johnsrud, K. A., Soderlund, D. M., & DeCubellis, J. (2014). Hennepin health: A safety-net accountable care organization for the expanded Medicaid population. Health Affairs, 33(11), 1975–1984. https://doi.org/10.1377/hlthaff.2014.0648
17. Tong, S. T., Liaw, W. R., Kashiri, P. L., Pecsok, J., Rozman, J., Bazemore, A. W., & Krist, A. H. (2018). Clinician experiences with screening for social needs in primary care. Journal of the American Board of Family Medicine, 31(3), 351–363. https://doi.org/10.3122/jabfm.2018.03.170419
18. Zerden, L. D., Cadet, T. J., Galambos, C., & Jones, B. (2021). Social work's commitment and leadership to address social determinants of health and integrate social care into health care. Journal of Health & Human Services Administration, 43(3), 309–323. https://doi.org/10.37808/jhhsa.43.3.5