Academic Medicine's Fourth Mission: Building on Community-Oriented Primary Care to Achieve Community-Engaged Health Care

Courtney L. Savage Hoggard, MBE, Arthur Kaufman, MD, J. Lloyd Michener, MD, and Robert L. Phillips Jr, MD, MSPH

Abstract

A 2021 article, "Now is our time to act: Why academic medicine must embrace community collaboration as its fourth mission," by Association of American Medical Colleges (AAMC) authors, including AAMC president and CEO Dr. David J. Skorton, offers 2 aims that are highly related: community collaboration and health equity. The AAMC's call to prioritize community collaboration and health equity as pillars of the academic medicine mission echo earlier work on community-oriented primary care (COPC) and an even more robust model that builds on COPC, community-engaged health care (CEHC). COPC is a tested, systematic approach to health care by which a health clinic or system collaborates with a community to reshape priorities and services based on assessed health needs and determinants of health. COPC affirms health inequities' socioeconomic and political roots, emphasizing health care as a relationship, not a transaction or commodity. Communities where COPC is implemented often see reductions in health inequities, especially those related to socioeconomic, structural, and environmental factors. COPC was the foundation on which community health centers were built, and early models had demonstrable effects on community health and engagement. Several academic health centers build on COPC to achieve CEHC. In CEHC, primary care remains critical, but more of the academic health center's functions are pulled into community engagement and trust building. Thus, the AAMC has described and embraced a care and training model for which there are good, longitudinal examples among medical schools and teaching hospitals. Spreading CEHC and aligning the Community Health Needs Assessment requirements of academic health centers with the fourth mission could go a long way to improving equity, building trust, and repairing the social contract for health care.

A 2021 article, "Now is our time to act: Why academic medicine must embrace community collaboration as its fourth mission," by Association of American Medical Colleges (AAMC) authors, including AAMC president and CEO Dr. David J. Skorton, offers 2 aims that are highly related: community collaboration and health equity.[1] Community collaboration can be a path to health equity if it builds trust by using academic health center staff and resources to work with the community to identify and work on its priorities.[2–5] The AAMC's call to prioritize community collaboration and health equity as pillars of the academic medicine mission echo earlier work on community-oriented primary care (COPC) and an even more robust model that builds on COPC, community-engaged health care (CEHC).

The AAMC's call to make community collaboration the fourth mission also aligns with an existing Internal Revenue Service requirement, the Community Health Needs Assessment (CHNA), and is related to the social contract for health care. The CHNA requires nonprofit hospitals to engage with their community to identify health needs and commit resources to resolving them.[6,7] Hitching CHNA to a more robust commitment to community engagement could be powerful.[8] Making community collaboration the fourth mission also aligns with the social contract for health care, a set of commitments between the health professions and the public, which some say are currently damaged.[9,10] Both COPC and CEHC offer design and direction for the AAMC's intentions, and this article aims to clarify the opportunity to build on good existing models.

Overview of COPC

COPC is a tested, systematic approach to health care that combines epidemiology, primary care, public health, and community engagement.[11,12] COPC is a continuous process by which a health clinic collaborates with a community to reshape priorities and services based on assessed health needs and determinants of health. Several public health and medical schools use COPC as a training model, and George Washington University has a dedicated COPC graduate degree program.[13–18] The recommended steps of COPC are well tested (List 1),[11] and each step of the process includes community engagement. We emphasize the steps of this process as we believe that COPC has been watered down or misused as a label in some places. The partnership of health professionals and community organizations that COPC requires builds trust over time and has the added benefit of promoting community development and social change.[19]

Improving community health begins with community definition and characterization, which are

Please see the end of this article for information about the authors.

Correspondence should be addressed to Robert L. Phillips Jr, Center for Professionalism and Value in Health Care, 1016 16th St. NW, Ste 700, Washington, DC 20036; telephone: (202) 527-9993; email: bphillips@theabfm.org.

Acad Med. 2023;98:175–179.
First published online September 27, 2022
doi: 10.1097/ACM.0000000000004991

List 1

Recommended Steps in the Community-Oriented Primary Care (COPC) Process[11]

1. Community definition—Using health system patient data to geographically define the population served by the health clinic or system
2. Community characterization—Using quantitative and qualitative data about health status and identifying particular health problems as candidates for intervention
3. Prioritization—Selection of specific health problems as candidates for intervention with community participation
4. Detailed health problem assessment—Analyzing community factors related to the problem and strengths of the community and health clinic or system for intervening
5. Intervention—Working with community partners to develop a feasible and resource-practical intervention aimed to improve health
6. Evaluation—Measuring the results of interventions for reassessment of the priorities and the continuation of the COPC process in the defined community

essential to "community diagnosis" in COPC.[11,20] Community definition and characterization are also key to the AAMC's call for a fourth mission of community collaboration. These steps use quantitative data, public health data, and, increasingly, geospatial tools to turn collective electronic health record data into clinical service areas.[6,21–23] The geospatial approach also allows clinical data to be merged or layered with population health and equity data. Quantitative data are supplemented with qualitative data from the community to identify, discuss, and prioritize specific health problems as candidates for intervention with the community. Community engagement is key to prioritizing health issues. As a health problem emerges from the discussion and prioritization process, there can be many forms of intervention, such as targeting community factors like housing or food security, improving health care access, or developing needed policies. Academic health center staff and resources can be helpful in data gathering, data interpretation, and planning and evaluation of potential interventions, but to achieve sufficient and sustained implementation of an intervention, community and public health organizations need to be included as partners. Evaluation provides the basis for reassessing priorities and continuing the COPC process. Finally, COPC offers a roadmap to genuine community-led planning and evaluation, which builds trust and puts the community and academic health center on equal footing.

Brief History of COPC

Beginning in the 1940s, Drs. Sidney and Emily Kark organized the Pholela Community Health Centre in Pholela, South Africa. The Pholela Community Health Centre pioneered COPC, transforming the health status of a rural Zulu population that was impoverished and served as a worldwide model for integrating clinical medicine and public health approaches to help individuals and communities.[24,25] The Karks transplanted the COPC model to Israel developing clinics and training sites that continue to serve people there.[11] Dr. H. Jack Geiger's 6-month experience with the Karks in Pholela and experiences with Dr. Count Gibson Jr. during the Freedom Summer in Mississippi inspired the launch of the Tufts-Delta Health Center in northern Bolivar County, Mississippi, in 1965.[19] Jack Geiger knew that Delta families had marked socioeconomic inequities and were suffering from high levels of malnutrition, infant mortality, infectious and chronic diseases, and adult morbidity and mortality. The Tufts-Delta Health Center had a sister clinic, the Columbia Point Health Center (now the Geiger Gibson Health Center, Columbia Point), created simultaneously by Tufts University School of Medicine, where medical students were trained in COPC.[26] The Tufts-Delta Health Center established special medical service programs, legal services, transportation and outreach services, health education efforts, and environmental and other interventions involving housing, water supply, and sanitation. It also established community engagement programs, such as childhood enrichment, educational, and employment programs, and an agricultural cooperative.[26,27] The Tufts-associated Columbia Point Health Center was the university's more proximal effort to support community engagement. These first community health centers enhanced the health effects of traditional clinical and public health interventions—a core purpose of COPC.

In the early 1980s, the Institute of Medicine (IOM; now the National Academy of Medicine) refined the elements of COPC and documented 7 case studies of examples of COPC at academic health centers.[20,28] The report recommended widespread application of COPC to address health inequities' socioeconomic and political roots, emphasizing health care as a relationship, not a transaction or commodity. COPC has 5 essential elements (List 2), which are laid out in one of the chapters of the IOM report.[28] Communities where COPC is implemented often see reductions in health inequities, especially those related to socioeconomic, structural,

List 2

The 5 Essential Elements of Community-Oriented Primary Care (COPC)[28]

1. Use of epidemiologic and clinical skills as complementary functions; epidemiologic and clinical activities should both be of as high a standard as possible.
2. Definition of the population for which the health clinic or system is or feels responsible. This defined population is the target population for surveillance and care and is the denominator population for the measurement of health status and needs and the evaluation of the health clinic or system.
3. Defined programs to deal with the health problems of the community or its subgroups, within the framework of primary care. These community health programs may involve health promotion; primary or secondary prevention; curative, alleviative, or rehabilitative care; or any combination of these. The programs are based on the epidemiologic findings.
4. Involvement of the community in the promotion of its health. Community involvement may be seen as a prerequisite for the satisfactory and continued functioning of a COPC health clinic or system.
5. Accessibility that is not limited to geographic accessibility (the COPC health clinic or system should ideally be located in the community it serves) but that refers also to the absence of fiscal, social, cultural, communication, or other barriers. The full development of a COPC health clinic or system requires a synthesis of all of these barriers. Epidemiologic studies alone, or placement of the health clinic or system within the neighborhood it serves, are not enough to justify the use of the term COPC.

and environmental factors; reductions in avoidable hospitalizations; and reductions in infant mortality.[28] Early COPC models had demonstrable effects on community health and engagement.[11] COPC was the foundation on which community health centers, such as Federally Qualified Health Centers, were built, and the Indian Health Service was an early adopter of COPC.[11,28]

Exemplars of COPC and CEHC in Academic Medicine

In the 1970s and 1980s, dozens of academic health centers used COPC as a training model.[20,26,28] Recognizing the value of COPC, these academic health centers built on COPC as they moved toward achieving CEHC—in which primary care remains critical, but more of the academic health center's functions are pulled into community engagement and trust building.

More recent examples include the National Center for Rural Health Professions at the University of Illinois College Health Sciences Campus-Rockford, which began including COPC in interprofessional student scholarly projects in 1997.[14] Another example, the University of New Mexico Health Sciences Center designed its Office for Community Health to embrace CEHC and to coordinate 7 institutional programs to fulfill this mission.[2,3,29] These programs include the Health Extension Regional Offices, where university staff and community health workers address the underlying social determinants of disease.[2] The Health Extension Regional Offices have community-based health extension agents who draw on academic health center resources to help address the underlying social determinants of disease. National measures that compare states based on health determinants and outcomes were adopted by the University of New Mexico Health Sciences Center in 2013 as Vision 2020, and these measures are now used to track progress toward improved health and health care in New Mexico.[3] These measures have helped the University of New Mexico Health Sciences Center to recognize that it would be more successful in meeting communities' health priorities if it better aligned its educational, research, and clinical missions with their needs.

Montefiore Medical Center and Albert Einstein College of Medicine also have a long history of community partnership in the Bronx,[30,31] which includes their residency program in social medicine, which has a 50-year history of interdisciplinary training in primary care, population health, and social medicine.[5] The residency explicitly uses COPC as its clinical and training model in all of the Federally Qualified Health Centers that are part of the Bronx Community Health Network.[5]

Morehouse School of Medicine describes its CEHC approach in the publication *The Morehouse Model: How One School of Medicine Revolutionized Community Engagement and Health Equity*.[32] Its CEHC model combines social accountability, medical education, and public health with the goal of narrowing health equity gaps in their community. The publication also details Morehouse School of Medicine's inclusion of community-based participatory research and the importance of community coalitions, which taken together touch 159 counties.

The recent National Academies of Sciences, Engineering, and Medicine (NASEM) report, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, highlights the role of primary care in achieving population health outcomes and health equity goals and reiterates COPC as the best model for accomplishing these goals.[33] The NASEM report emphasizes how changing demographics and primary care needs must be met with a model that is able to adjust to different patient populations, including rural and other underserved populations. One of the objectives of the NASEM report, to train primary care teams where people live and work, points to COPC clinical models as being ideal for training primary care teams.

Challenges to COPC and CEHC for Academic Medicine

Implementing COPC and CEHC can be challenging for academic health centers. Some of the key issues include:

- Mission: Whether the mission includes improving the health of the local community (as opposed to providing care for those in need).[34]
- Metrics: Whether metrics include outcomes that the community cares about (or is even aware of), and which metrics can be accomplished by the academic health center in partnership with its communities.[35]
- Trust: Cultivating and achieving trust with the community that their interests and needs will be valued and prioritized, and that results will be shared and lead to change.[34,35]
- Funds flow: Whether resources are allocated, at least in part, to measurably improved local health outcomes.[36]
- Rewards: Whether efforts to engage, partner, support, implement, and evaluate community health improvement are recognized as important elements for promotion and tenure.[36]

The Fourth Mission and the Social Contract

The social contract for health care is a set of commitments between the health professions and the public that specify the health professions' obligations in return for the privileges afforded to it by society (e.g., self-regulation).[37,38] Unfortunately, the social contract is fraying and there is a lack of agreement in academic medicine about what it means and who the stakeholders are.[9,10] An important source of this fraying relates to the existing incentives and rewards in the medical service system, which favor downstream interventions (e.g., hospitalizations, procedures) instead of upstream preventions, including addressing adverse social determinants (e.g., housing, income, education, food, transportation). Further, despite evidence of the benefit of broadening the scope of clinical care to include these determinants, their inclusion threatens to introduce challenges for which current health systems and academic health centers are unprepared.[39] One result of this contractual fraying and not embracing the community as a primary stakeholder is that the public's faith in the health professions and its institutions has eroded.[9] COPC is a viable solution to this fraying, as it offers a systematic process for defining, characterizing, and collaborating with the community to address community determinants of health. CEHC builds on COPC to include academic health center capacity for social accountability and public benefit, community-based participatory research, and workforce training and production. By combining all of these, CEHC facilitates collaboration with public health and community-based organizations to address community priorities and build trust.

COPC, CEHC, and Academic Medicine in the Future

Much has changed since the 1940s when the Karks organized a community health care delivery system in Pholela. Awareness of health inequities and their roots in structural racism is higher; community willingness for others to define their boundaries and goals is greatly reduced; and technology and data availability now make community definition, assessment, and interventions easier. New tools that help screen for social needs and link people with local services are proliferating.[40–42] Improving community health equity now requires a much greater degree of partnership and is no longer something that is necessarily lead by a practice or an academic group.

While COPC was once a common topic across primary care, other than the exemplar programs listed above, few schools or primary care residency programs have regular curricular elements for training in the COPC skills of community engagement, community diagnosis, and partnered intervention and evaluation.[43] More recent calls for such training tend to focus on community engagement, health equity, social determinants, and structural competency.[8,44–46] New departments of population health sciences have capacities far beyond the aspirations of early COPC leaders and their community partners, and new funding streams from the National Institutes of Health, such as the Clinical and Translational Science Awards (CTSA), have increased research skills and training that is community-engaged and data-driven.[8] Despite these advancements, there is a need to align academic health care with community health (i.e., CEHC).

If COPC did not flourish before because it was out of step with academic values, the fourth mission is an important shift. CEHC will require real leadership, new resource commitment to primary care and population health sciences divisions, engagement of other clinical specialties and help understanding their roles in community collaboration, alignment with institutional CTSA and CHNA resources, and direction to information technology and data managers. Existing CEHC models offer guidance for this important call from AAMC leaders, but its capacity for improving health equity and increasing community trust depends on resource allocation and leadership.

Now Is the Time to Act

In "Now is our time to act: Why academic medicine must embrace community collaboration as its fourth mission," AAMC authors say that the fourth mission of community collaboration:

> … means working with community-based organizations in true partnership to identify and address needs, and jointly develop, test, and implement solutions … [building] a strong network of collaborators across public and population health, government, community groups, and the private sector … [and] weaving community collaborations consistently throughout the mission areas of clinical care, research, and education.[1]

These design elements look very much like current CEHC models, which could be potent for fulfilling the goal of:

> … [approaching] community collaborations with a posture of humility and [seeking] to value and appreciate the lived experiences of our patients and their families, our colleagues, and our communities [to] create space for meaningful partnerships to achieve health equity.[1]

The intentionality of this goal is rooted in COPC. The AAMC has described and embraced a care and training model for which there are good, longitudinal examples among medical schools and teaching hospitals. These schools and hospitals could serve their peers well in the goal of advancing health equity in the United States by helping them implement a new vision of COPC—namely, CEHC. The recognition of health inequities, which was widened by the global pandemic; commitment to community collaboration and health equity as a fourth mission; a recent NASEM report full of supportive evidence[7]; and peer institutions able to offer guidance make for a good recipe for establishing more successful CEHC programs and potentially for successfully rehabilitating the social contract.

Acknowledgments: The authors thank Dr. Crystal Cash, associate dean, Office of Diversity, Equity, and Inclusion, Loyola University Chicago Stritch School of Medicine, for developing the concept of community-oriented medical care as an expansion of community-oriented primary care within academic health centers.

Funding/Support: None reported.

Other disclosures: C.L. Savage Hoggard was a visiting scholar with the Center for Professionalism and Value in Health Care when she drafted this article.

Ethical approval: Reported as not applicable.

C.L. Savage Hoggard is a medical student, Loyola University Chicago Stritch School of Medicine, Maywood, Illinois.

A. Kaufman is vice president for community health, University of New Mexico Health Sciences, Albuquerque, New Mexico.

J.L. Michener is professor emeritus, Department of Family Medicine and Community Health, Duke School of Medicine, Durham, North Carolina.

R.L. Phillips Jr is founding executive director, Center for Professionalism and Value in Health Care, Washington, DC.

References

1 Alberti P, Fair M, Skorton DJ. Now is our time to act: Why academic medicine must embrace community collaboration as its fourth mission. Acad Med. 2021;96:1503–1506.
2 Kaufman A, Powell W, Alfero C, et al. Health extension in New Mexico: An academic health center and the social determinants of disease. Ann Fam Med. 2010;8:73–81.
3 Kaufman A, Roth PB, Larson RS, et al. Vision 2020 measures University of New Mexico's success by health of its state. Am J Prev Med. 2015;48:108–115.
4 Cashman SB, Stenger J. Healthy communities: A natural ally for community-oriented primary care. Am J Public Health. 2003;93:1379–1380.
5 Strelnick AH, Swiderski D, Fornari A, et al. The residency program in social medicine of Montefiore Medical Center: 37 years of mission-driven, interdisciplinary training in primary care, population health, and social medicine. Acad Med. 2008;83:378–389.
6 Phillips RL, Bazemore AW. Essay: Shared space: Using geography to identify relationships and increase understanding in primary care and public health. In: Michener JL, Koo D, Castrucci BC, Sprague JB. The Practical Playbook: Public Health and Primary Care Together. 1st ed. Oxford, UK: Oxford University Press; 2015:297–304.
7 Weinstein JN, Geller A, Negussie Y, Baciu A. National Academies of Sciences, Engineering, and Medicine Committee on Community-Based Solutions to Promote Health Equity in the United States. Communities in Action: Pathways to Health Equity. Washington, DC: National Academies Press; 2017.
8 Wilkins CH, Alberti PM. Shifting academic health centers from a culture of community service to community engagement and integration. Acad Med. 2019;94:763–767.
9 Wynia MK. The short history and tenuous future of medical professionalism: The erosion of medicine's social contract. Perspect Biol Med. 2008;51:565–578.
10 McCurdy L, Goode LD, Inui TS, et al. Fulfilling the social contract between medical schools and the public. Acad Med. 1997;72:1063–1070.
11 Mullan F, Epstein L. Community-oriented primary care: New relevance in

a changing world. Am J Public Health. 2002;92:1748–1755.
12 Gofin J, Gofin R, Stimpson JP. Community-oriented primary care (COPC) and the Affordable Care Act: An opportunity to meet the demands of an evolving health care system. J Prim Care Commun Health. 2015;6:128–133.
13 Robert Graham Center. Community Oriented Primary Care (COPC) Curriculum. https://www.graham-center.org/maps-data-tools/copc-curriculum.html. Accessed August 12, 2022.
14 The University of Illinois College of Medicine. Community-Oriented Primary Care (COPC) Projects. https://rockford.medicine.uic.edu/research/national-center-rural-health-professionals/community-oriented-primary-care-copc-projects. Accessed August 12, 2022.
15 McGill Faculty of Medicine and Health Sciences Department of Family Medicine. Community Oriented Primary Care (COPC) at McGill. https://www.mcgill.ca/familymed/education/postgrad/curriculum-overview/clinical-curriculum/copc. Accessed August 12, 2022.
16 PCORE Primary Care Online Resources and Education. Prevention—Community Oriented Primary Care. https://edblogs.columbia.edu/pcore/prevention/prevention-putting-prevention-in-practice-community-and-public-health-dimensions/prevention-community-oriented-primary-care. Accessed August 12, 2022.
17 Creighton University. Community Oriented Primary Care (COPC). https://healthsciences.creighton.edu/diversity/community-oriented-primary-care-copc. Accessed August 12, 2022.
18 GW Public Health. Community Oriented Primary Care - MPH. https://publichealth.gwu.edu/programs/community-oriented-primary-care-mph. Accessed August 12, 2022.
19 Geiger HJ. Community-oriented primary care: A path to community development. Am J Public Health. 2002;92:1713–1716.
20 Institute of Medicine Division of Health Care Services. Community Oriented Primary Care: A Practical Assessment, Vol 2: Case Studies. Washington, DC: National Academies Press; 1984.
21 Heitgerd JL, Dent AL, Elmore KA, et al. Community health status indicators: Adding a geospatial component. Prev Chronic Dis. 2008;5:A96.
22 Bazemore A, Phillips RL, Miyoshi T. Harnessing Geographic Information Systems (GIS) to enable community-oriented primary care. J Am Board Fam Med. 2010;23:22–31.
23 Kind AJH, Buckingham WR. Making neighborhood-disadvantage metrics accessible—The Neighborhood Atlas. N Engl J Med. 2018;378:2456–2458.
24 Geiger HJ. Community-oriented primary care: The legacy of Sidney Kark. Am J Public Health. 1993;83:946–947.
25 [No author listed.] Meet our featured guest columnist: Dr. Jeremy Kark. Against the Odds. https://www.nlm.nih.gov/exhibition/againsttheodds/guest_column/2009/09/index.html. Published September 2009. Accessed August 12, 2022.
26 Longlett SK, Kruse JE, Wesley RM. Community-oriented primary care: Historical perspective. J Am Board Fam Pract. 2001;14:54–63.
27 Primary Care Development Corporation. In conversation with a pioneer: Dr. Jack Geiger. https://www.pcdc.org/public-health-pioneer-conversation-dr-jack-geiger. Published November 13, 2017. Accessed August 12, 2022.
28 Institute of Medicine Division of Health Care Services. Community Oriented Primary Care: A Practical Assessment: Volume I, Committee Report: A Practical Assessment. Washington, DC: National Academies Press; 1984.
29 University of New Mexico Health Sciences. OCH Programs. https://hsc.unm.edu/about/administrative-departments/community-health/programs. Accessed August 12, 2022.
30 Montefiore Medical Center. Community & Population Health Dashboards. https://www.montefiore.org/population-health-dashboards. Accessed August 12, 2022.
31 Montefiore Medical Center. Community Development. https://www.montefiore.org/communitydevelopment. Accessed August 12, 2022.
32 Braithwaite RL, Akintobi TH, Blumenthal DS, Langley WM. The Morehouse Model: How One School of Medicine Revolutionized Community Engagement and Health Equity. Baltimore, MD: Johns Hopkins University Press; 2020.
33 McCauley L, Phillips RL Jr., Meisnere M, Robinson SK. National Academies of Sciences, Engineering, and Medicine Committee on Implementing High-Quality Primary Care. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: National Academies Press; 2021.
34 Stewart EC, Erves JC, Hargreaves MK, et al. Developing an infrastructure to cultivate equitable and sustainable community-academic research partnerships: Meharry community engagement core. J Natl Med Assoc. 2020;112:423–427.
35 Wallerstein N, Duran B. Community-based participatory research contributions to intervention research: The intersection of science and practice to improve health equity. Am J Public Health. 2010;100:S40–S46.
36 Michener L, Cook J, Ahmed SM, Yonas MA, Coyne-Beasley T, Aguilar-Gaxiola S. Aligning the goals of community-engaged research: Why and how academic health centers can successfully engage with communities to improve health. Acad Med. 2012;87:285–291.
37 Phillips RL Jr, Bazemore AW, Newton WP. Medical professionalism: A contract with society. The Pharos. 2019;Autumn:2–7.
38 Cruess RL, Cruess SR. Professionalism, communities of practice, and medicine's social contract. J Am Board Fam Med. 2020;33:S50–S56.
39 Robert Wood Johnson Foundation. Health Care's Blind Side: The Overlooked Connection Between Social Needs and Good Health—Summary of Findings From a Survey of America's Physicians. Princeton, NJ: Robert Wood Johnson Foundation; 2011.
40 Wortman Z, Tilson EC, Cohen MK. Buying health for North Carolinians: Addressing nonmedical drivers of health at scale. Health Aff (Millwood). 2020;39:649–654.
41 Eder M, Henninger M, Durbin S, et al. Screening and interventions for social risk factors: Technical brief to support the US Preventive Services Task Force. JAMA. 2021;326:1416–1428.
42 Page-Reeves J, Kaufman W, Bleecker M, et al. Addressing social determinants of health in a clinic setting: The WellRx Pilot in Albuquerque, New Mexico. J Am Board Fam Med. 2016;29:4141–4418.
43 Doobay-Persaud A, Adler MD, Bartell TR, et al. Teaching the social determinants of health in undergraduate medical education: A scoping review. J Gen Intern Med. 2019;34:720–730.
44 Park B, Frank B, Likumahuwa-Ackman S, et al. Health equity and the Tripartite Mission: Moving from academic health centers to academic–community health systems. Acad Med. 2019;94:1276–1282.
45 Hansen H, Metzl JM. New medicine for the U.S. health care system: Training physicians for structural interventions. Acad Med. 2017;92:279–281.
46 Alicea-Alvarez N, Reeves K, Lucas MS, et al. Impacting health disparities in urban communities: Preparing future healthcare providers for "neighborhood-engaged care" through a community engagement course intervention. J Urban Health. 2016;93:732–743.