

# Implementing social interventions in primary care

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Most family physicians now report that they engage in some degree of social intervention in the management of patients.<sup>1</sup> However, outside of community health centres, social interventions are still not a routine part of primary care practice and are not yet considered “standard of care.” Traditional primary care seldom included interventions such as social prescribing and health–legal partnerships until the early 1990s,<sup>2</sup> and some practitioners still question whether social intervention is part of the primary care provider’s role.<sup>3</sup> A small cadre of practitioners in high-income countries, including Canada, Australia, the United Kingdom and the United States, has been at the forefront of developing and evaluating interventions into social risks to health, which has led to a few social interventions being widely adopted, with positive impacts on broad markers of health.

Producing high-quality, clinically actionable research on social interventions in primary care is challenging. The effects of living with social pressures such as poverty, racism or trauma are difficult to evaluate over the duration of a typical study using traditional markers of change in physical or mental health. For this reason, the literature on social interventions in primary care often focuses on process rather than outcome measures, and on self-reported indicators of health and well-being.<sup>31</sup> Despite these limitations, the literature points to a positive general impact on health of social interventions.

## Box 1: Evidence used in this review

In October 2018, we conducted an extensive, nonsystematic review of the literature with the aid of a medical librarian, which we updated in November 2020. We searched MEDLINE, Embase, CINAHL and Sociological Abstracts. Search terms, which varied slightly by database, included “primary health care/or patient-centered care,” “primary care,” “physicians, family,” “general pract\*,” “family pract\*,” “family physician\*,” “social determinants of health,” “social equit\*,” “social screening,” “social prescribing,” “social determinant\*” and “social barrier\*.” We limited the search to English language articles. We identified grey literature through discussion with experts, scanning reference lists and Google searches. In an attempt to maintain a focus on interventions replicable across practice settings, we limited our search to high-income countries. This search yielded 895 unique abstracts, which we both reviewed for relevance. We selected 177 articles for full review.

## Key points

- Primary care–based social interventions offer an important means to mitigate threats to individual and community health posed by adverse social conditions.
- Effective interventions include those that target individual-level determinants, connections with community resources, community-focused partnerships and structures within health teams that affect equity.
- Accumulating evidence points to the positive impacts of social interventions on broad markers of health; however, most research in this area has focused on implementation and process measures, rather than outcomes.
- Some interventions require large, interdisciplinary health care resources to implement, but many are accessible to small group practices or individual providers.

We discuss accumulated evidence (Box 1) on social interventions and provide an overview of common primary care–based interventions (Table 1), highlighting their strengths, limitations and feasibility of implementation in different practice settings. We discuss levels of practice resources that would facilitate their implementation, and also suggest those interventions that could be led by an external community partner, which may provide an alternate avenue for less well-resourced practices. Although the incorporation of new interventions may seem daunting, especially to community-based health care providers without an interdisciplinary team, we have been involved in change processes with practices of all sizes to incorporate social interventions.

## How can patients’ social needs be identified?

The first step in addressing social risk factors for poor health is to identify an individual’s needs in relation to social factors that may be affecting their health, such as income, housing, literacy, education and employment, or socially defining life experiences, such as trauma, racism, homophobia or domestic violence. Questions related to social needs also enable identification of individual and community assets that could be leveraged in building a program of care, such as support networks or neighbourhood associations.

**Table 1: Social interventions in primary care by type, setting, infrastructure requirements and ability to be led by a community partner**

| Intervention                                   | Infrastructure required  | Solo practitioner | Small group | Large interdisciplinary group | Community partner |
|--|--|-------------------|-------------|-------------------------------|-------------------|
| Social needs screening                         | Front-line provider or support staff willing to engage   | X                 | X           | X                             |                   |
| Literacy                                       | Front-line providers willing to engage; financial resources to purchase books  | X                 | X           | X                             |                   |
| Income security specialists                    | Social needs screening, and funded in-team income security specialist or partnership with outside specialized agency   |                   | X           | X                             | X                 |
| Social prescribing                             | Social needs screening, link worker (funded by practice or partnership with external organization), and practice lead to coordinate and supervise  |                   | X           | X                             | X                 |
| Equity-oriented practice change                | Front-line providers and team members willing to explore structural inequities, and engage in team training and ongoing discussion; external consultant or guide to facilitate practice exploration and change |                   | X           | X                             |                   |
| Health-legal partnership                       | Legal needs screening and partnership with legal agency; office and supplies for legal staff; practice lead to coordinate  |                   |             | X                             | X                 |
| Social data collection                         | Access to data (in electronic health record or external database); data processing and analysis expert   |                   |             | X                             | X                 |
| Community partnership or community development | Front-line providers and team leadership willing to engage in community meetings and adjust team infrastructure; specialized community health or development workers   |                   |             | X                             | X                 |

### Screening tools

Routinely recording a patient’s social pressures at health visits enables providers to adjust assessments of need and to determine the resources required to address them. Social needs screening is also often a prerequisite to patients accessing benefit programs and the services of community-based organizations.

Currently available tools range from those that support targeted screening approaches for single determinants, such as income or adverse childhood experiences, to those that provide a more comprehensive assessment of social need. The Clinical Tool on Poverty offers a single question screen for income security: “Do you ever have trouble making ends meet at the end of the month?” Simple to use, this question has a sensitivity of 98% and a specificity of 40% for identifying people living below the poverty line.<sup>4,5</sup> More comprehensive social needs screening tools, such as HealthBegins and the Protocol for Responding to and Assessing Patients’ Assets, Risks and Experiences (PRAPARE), explore multiple domains of social risk that range from housing to childcare to neighbourhood safety.<sup>6</sup> Evaluation of multifaceted tools has shown that many individuals have multiple, intersecting social needs.<sup>7</sup> The Siren Network has published a comparison table of social screening tools used in the US.<sup>8</sup>

Implementation of screening requires training and buy-in from front-line health providers. It also requires sustained commitment and the allocation of time and resources.<sup>9-11</sup> However, neither the training nor the resource demands are onerous. Some screening tools can be implemented by office staff or by using electronic interfaces, such as tablets handed to patients for self-completion of simple questionnaires.<sup>12,13</sup>

### Local research

Although the focus of clinical screening tools is the identification of individual need, practice- and population-level data can enable higher-level efforts to engage in social interventions. Data from electronic health records can be used to build a picture of social need within a practice population<sup>14</sup> and to guide quality improvement initiatives.<sup>15</sup> As such, social needs screening can form a foundation for further action on social risks to health and inform the design, monitoring and evaluation of interventions.

The HealthRx project in Chicago and the Ontario Health Profiles website translate community-level social data for the use of health teams and other social services.<sup>16,17</sup> The University of Toronto Practice-Based Research Network (UTOPIAN) project allows researchers to access anonymized data from electronic health records from 1700 family physicians.<sup>18</sup> Large databases are also being used to incorporate social data into predictive, artificial intelligence algorithms to identify and target services to high-needs individuals and groups.<sup>19,20</sup>

Identifying people with higher social and health needs and, by extension, higher health system costs can be harmful if those data are used to restrict services.<sup>21,22</sup> Moreover, the identification of social needs does not always translate into uptake of social interventions, which may point to a disconnect between identification and ability to address need.<sup>23</sup>

### How can physicians connect patients with effective social supports?

Social prescribing leverages individual and community assets with a view to improving individual well-being, self-management and empowerment.<sup>24,25</sup> As such, it uses a structured approach to refer

patients to community supports. Along with a focus on lifestyle factors, such as exercise, many social prescribing programs seek to directly address social determinants, such as income and housing.

Social prescribing typically requires a health professional to make a referral to a community resource and engagement specialist, known as a link worker. The link worker meets with clients to explore their circumstances and codetermine their needs, then connects clients to appropriate local services, accompanying them and supporting them through their journey as required. Link workers may be embedded in primary care practices or based in the community. They provide expertise, capacity and sustained support in a way that is seldom possible for primary care providers.

Social prescribing is widely implemented in the UK, now supported by the National Health Service; its Social Prescribing Network organizes practices nationally and regionally.<sup>26</sup> In the US, the Health Leads program relies on volunteer university students to facilitate links to support programs.<sup>27</sup> In Canada, the Alliance for Healthier Communities recently completed a pilot program to build community-designed social prescribing programs into community health centres.<sup>24</sup> In Winnipeg, the government-funded model, My Health Team, supplies multidisciplinary health providers, including income specialists and community navigators, to small group and solo family practices. Services are mobilized by primary care providers through an electronic medical record-integrated interface that facilitates team communication.<sup>28,29</sup> In the absence of such external support, social prescribing requires financial and human resources, and is most easily implemented by a well-resourced interdisciplinary team.<sup>30</sup>

Social prescribing has shown promising outcomes, including improvements in broad markers of health and well-being.<sup>32-35</sup> Research from the UK has reported improved resilience, mental health, quality of life and successful modification of lifestyle factors, as well as stronger links between health and community-based services, a reduction in drug prescribing, an increase in preventive management and a reduction in primary care use by patients seeking help for unmet social needs.<sup>25</sup> A strong case management role for link workers has been associated with improved outcomes and health team satisfaction.<sup>36</sup>

## How can individual social determinants of health be addressed directly?

### Income security

Primary care-based programs for income intervention have emerged in some settings over the last 30 years and largely focus on helping low-income individuals access benefits, consolidate and reduce debt, and increase their financial literacy.

Services offering advice on welfare rights have been implemented across the UK since the mid-1990s. Often colocated with health teams, they focus on maximizing client access to social assistance supports. Evaluations have shown that service access is associated with an improvement in income, as well as in indices of well-being.<sup>37</sup>

In Canada, income specialists are embedded in several primary care teams. They focus on individual income security assessments, as well as health provider education and social policy advocacy.

Early implementation analyses and administrative data are promising, but the results of outcomes studies, including a randomized controlled trial, have not yet been released.<sup>38</sup>

Other promising approaches include peer-led financial coaching, partnerships between medical and financial agencies, and the colocation of tax return services at clinical sites. Evaluations have shown a positive impact on well-being, as well as a strong return on investment.<sup>39-41</sup>

The establishment of income support programs requires funding for embedded specialists or partnership with community organizations that have the expertise and capacity to carry out this work. Practices with fewer resources can establish and maintain lists of income benefits programs and local, free tax clinics to which patients may be referred.

### Legal needs

Programs that offer legal services directly to clients of health teams first emerged in the US in 1993. By 2010, more than 200 American hospitals and community health centres were engaged in such partnerships.<sup>42</sup> Health-legal partnerships have now also emerged in Canada, the UK and Australia.<sup>43</sup>

Legal providers may be embedded directly in primary care teams, colocated or accessed through a referral process. In addition to providing legal assistance to individual clients, they may engage in health provider and client education and advocacy for systemic change through law reform. They are supported by government or private funding, and through partnerships with private and public legal service organizations.<sup>42</sup>

A high-functioning health-legal partnership in Cincinnati, Child HelP, paired a pediatric primary care service with a legal community agency with expertise in serving populations that are socially marginalized. An evaluation of the program showed positive legal outcomes, focused heavily on income and housing concerns for children with chronic illness.<sup>44</sup>

Implementation and outcome studies of health-legal partnerships point to a feasible, high-impact model with strong potential for improving health outcomes.<sup>45</sup> However, they require substantial health team, legal and community partnership resources, and are most easily implemented in larger team settings or with strong community partner or government support.

### Literacy

Literacy is a marker of educational attainment, and low education may be associated with poverty. Literacy is also often a prerequisite for accessing employment and navigating health and social supports. The American Academy of Pediatrics, among other organizations, promotes literacy awareness as an essential part of primary care practice.<sup>46</sup>

A health-based literacy intervention, Reach Out and Read, was created in Boston in 1989, and has been implemented in more than 6400 sites in North America. It trains health practitioners to provide literacy counselling, free books and referral to literacy organizations to families with young children. Evaluations show positive literacy outcomes, with a particularly strong impact on children from low-income families.<sup>47</sup>

This intervention can be established in practices with limited resources. It requires some initial training and sponsorship for books, but ultimately relies on front-line providers devoting a few minutes to discussing literacy with parents at child health visits.

### Social isolation

Social isolation and loneliness have been shown to be risk factors for poor health and increased risk of death, especially among people older than 50 years.<sup>48</sup> The prevalence and health impacts of social isolation are magnified among people living at low incomes or without adequate housing.<sup>49</sup>

Interventions may tackle social isolation from many angles, including improving mobility and hearing, building social skills, reducing lack of access to transportation, and addressing cognitive and psychological challenges through targeted psychotherapy. Evidence is mostly of low quality, with the greatest impact to date associated with interventions that increase physical activity.<sup>50</sup>

### Employment, housing, transportation and food security

The evidence base for other primary care-based, individual-focused, social interventions is growing, but remains relatively sparse. A systematic review found few primary care-based interventions that targeted employment, with most focused on patients with severe mental illness. It did, however, point to the potential for embedded employment specialists or partnerships with community agencies to improve employment outcomes for patients.<sup>51</sup> Housing interventions, although impactful, have almost exclusively been studied in specialized health care settings that provide services to people experiencing homelessness.<sup>52</sup> Transportation to medical appointments has been identified as a determinant of access to care, and interventions may enable clients to connect with health care services.<sup>53</sup> Food insecurity is often screened for in primary care, but since food insecurity is a proxy for inadequate income, the utility of interventions that are limited to food provision are questionable.<sup>54–56</sup>

### How can health providers engage with communities to address social needs?

Targeting social determinants in communities rather than for the individual, through community-collaborative, primary care-based interventions, also offers strong potential to expand the integration and impact of primary health care teams.<sup>57</sup>

The Keeping Infants Nourished and Developing (KIND) program in Cincinnati leveraged a strong community partnership to address food insecurity and other social needs for children living in poverty.<sup>54</sup> A review of the evidence showed a positive return on investment for health-community partnerships focused on housing, nutrition, transportation, home modification and navigation of health and social care.<sup>58</sup>

Specialized community health workers, who are often also community members, contribute local knowledge to health teams. In addition to identifying social needs, they can lead outreach and engagement for health teams, with a focus on health education, care coordination and health literacy. A program at

the Mayo Clinic placed community health workers in practices under the cosupervision of health teams and community groups. The workers were often from similar socioeconomic and cultural backgrounds to clients and helped individual patients navigate health and social needs. The program resulted in decreased outpatient visits, emergency department use and health costs.<sup>59</sup>

A community development model takes this approach one step further by focusing on organization, empowerment and community leadership of program development. Specialized community development workers lead community members in identifying needs and leveraging local and external assets to develop programs to address those needs. One group in the UK estimated a 380% return on investment for their health-focused community development initiative.<sup>60</sup> Encouragement of democratic engagement by health care providers may support marginalized communities to increase their impact on community structures and social policy.<sup>61</sup>

A community focus requires deep involvement with, and assessment of, community needs, and support for community-led efforts to address those needs. Community-focused interventions are most easily implemented by larger interdisciplinary teams. Any practitioner, however, can begin to forge partnerships with community agencies. In the US, the Health Extension program provided 1500 small primary care practices with government funding to hire workers to engage with community needs, modelling how a large funder can empower small health practices to deepen their community ties.<sup>62</sup>

### How can health teams actively address structural drivers of inequity within their services?

An emerging area of inquiry evaluates drivers of inequity, such as racism and colonialism, and how they manifest in the operations of health teams. Those involved in addressing these determinants of health look to techniques such as cultural safety, critical reflection and antioppressive approaches to help providers understand how inequities manifest throughout health care interactions, as well as through the core structures of our society.<sup>63</sup>

In Vancouver, the EQUIP project explored the effects of an intervention on the structural determinants of health in 5 community health centres that serve socially marginalized populations in western Canada. The intervention reported perceived improvement in the ability of staff to recognize inequity and to address the needs of clients facing complex medical and social issues.<sup>64</sup> A subsequent evaluation showed that patients reported improved health outcomes postintervention.<sup>65</sup>

A Canada-wide initiative on Indigenous cultural safety has offered Web-based training to thousands of health care providers.<sup>66</sup> Its impact is currently being studied in a primary care setting.<sup>67</sup>

Health team engagement with equity-oriented practice change requires resources to hire embedded equity specialists or to engage external expertise to guide the process. It also requires willingness to tackle subjects that are often personally uncomfortable, such as individual and social group privilege.

## What are the challenges?

Despite the encouraging evidence presented herein, barriers to implementation of social prescribing remain. Conventional approaches to health program evaluation are, arguably, ill-suited to assessing the effects of interventions that are expected to produce improvements in health over many years. In addition, practitioners are understandably concerned about the time and resources these interventions require, both to initiate and to maintain.<sup>68</sup> However, recent research has suggested that engagement with social needs reduces physician burnout, and improves job satisfaction and perceived quality of care.<sup>69–71</sup> Moreover, the important contribution of social conditions in determining health dictates the imperative to act to address these conditions. This is an emerging area of practice and health providers, researchers and health program designers share responsibility for the continued establishment and evaluation of social interventions.

Health-harming social factors, such as economic inequality, misogyny, homophobia, systemic racism and colonialism, require action beyond the medical office, and some stakeholders caution that attempting to address social needs through medical care may misdirect resources and responsibility away from the need to advance policy and dismantle harmful societal structures.<sup>72,73</sup>

## Conclusion

Interventions to improve the social situation of patients in primary care can lead to improvements in health and sensitize providers to their responsibility to address health-harming social conditions. Any primary care provider can engage in some degree of social intervention. The extent and success of these interventions will depend on a desire to prioritize them, dedicate resources, and engage with community partners and interdisciplinary supports. Social interventions offer an important step toward offering more holistic primary care.

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