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"Beyond Clinical Care: Integrating Social Determinants of Health Screening into Community Nursing Practice for Equitable and Person-Centered Healthcare"

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Abstract: Health outcomes are significantly influenced by social, economic, environmental, and structural factors collectively known as the Social Determinants of Health (SDOH). Factors such as income, education, housing, food security, transportation, employment, social support, and access to healthcare contribute substantially to health disparities across populations. Community nurses are strategically positioned to identify and address these determinants because of their close engagement with individuals, families, and communities. Integrating SDOH screening into routine community nursing practice provides an opportunity to detect social risks early, facilitate timely referrals, improve care coordination, and promote health equity. This review examines the concept of SDOH, the rationale for integrating screening into community nursing practice, available screening tools, implementation strategies, benefits, challenges, ethical considerations, and future directions. Evidence suggests that systematic SDOH screening can improve health outcomes, enhance patient engagement, reduce healthcare costs, and strengthen population health management. However, successful implementation requires adequate training, organizational support, interprofessional collaboration, policy commitment, and the development of community resource networks. Community nurses play a pivotal role in translating SDOH screening findings into meaningful interventions that address social needs and reduce health inequities. The integration of SDOH screening into nursing practice represents a transformative approach toward holistic, person-centered, and equitable healthcare delivery.

Keywords: *Social Determinants of Health, Community Nursing, Health Equity, Population Health, Social Risk Screening, Public Health Nursing, Community Health Assessment, Nursing Practice, Health Disparities, Person-Centered Care*

Introduction

Health is influenced by much more than biological factors and medical interventions. Research consistently demonstrates that social, economic, and environmental conditions significantly affect individual and population health outcomes. The World Health Organization (WHO) defines Social Determinants of Health (SDOH) as the conditions in which people are born, grow, live, work, and age, as well as the broader systems shaping daily life, including economic policies, social norms, political systems, and institutional structures (WHO, 2023). These determinants influence access to resources, opportunities, and services necessary for maintaining health and well-being.

Despite remarkable advances in medical technology and healthcare delivery, health disparities continue to exist across communities worldwide. Individuals facing poverty, unstable housing, unemployment, food insecurity, limited education, social isolation, and discrimination experience poorer health outcomes and shorter life expectancy compared to socially advantaged populations (Braveman & Gottlieb, 2014). Traditional healthcare models often focus primarily on disease treatment rather than addressing the underlying social conditions contributing to illness. Community nursing has evolved beyond disease prevention and health promotion to encompass broader population health approaches. Community nurses frequently interact with vulnerable populations in homes, schools, workplaces, community centers, and primary healthcare settings. These interactions provide unique opportunities to identify social challenges affecting health and connect individuals with appropriate resources. Integrating SDOH screening into community nursing practice enables nurses to systematically identify social risks and develop interventions that address both medical and social needs.

The growing recognition of SDOH as critical determinants of health has prompted healthcare organizations, policymakers, and nursing professionals to advocate for routine screening practices. Such

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screening helps identify unmet social needs that may otherwise remain hidden during conventional health assessments. Consequently, integrating SDOH screening into community nursing practice has emerged as an essential strategy for advancing health equity, improving outcomes, and fostering comprehensive patient-centered care.

Understanding Social Determinants of Health

Social Determinants of Health encompass a wide range of non-medical factors that influence health outcomes. These determinants interact throughout an individual's life and significantly affect physical, mental, and social well-being. Research indicates that healthcare services contribute only a portion of overall health outcomes, while social and environmental factors account for a substantial share of health variations among populations (Hood et al., 2016).

The primary domains of SDOH include economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context. Economic stability influences individuals' ability to afford nutritious food, safe housing, healthcare services, and transportation. Education affects health literacy, employment opportunities, and income potential. Healthcare access determines the availability and utilization of preventive and therapeutic services. Neighborhood conditions influence exposure to environmental hazards, recreational opportunities, and community safety. Social relationships and community support systems affect mental health, resilience, and health behaviors.

These determinants often interact in complex ways. For example, low educational attainment may lead to unemployment or low-income employment, resulting in housing insecurity and limited healthcare access. Such cumulative disadvantages increase the risk of chronic diseases, mental health disorders, and adverse health outcomes. Therefore, addressing SDOH requires a comprehensive and multidisciplinary approach that extends beyond clinical treatment.

The Importance of Social Determinants of Health in Community Health

The impact of SDOH on population health has become increasingly evident through public health research. Studies estimate that social and environmental factors account for approximately 80% of health outcomes, whereas clinical care contributes only a smaller proportion (Magnan, 2017). Consequently, efforts to improve health outcomes must extend beyond healthcare settings to address broader social conditions.

Communities experiencing socioeconomic deprivation often face higher rates of chronic diseases, infectious diseases, maternal mortality, infant mortality, and mental health disorders. Food insecurity has been linked to obesity, diabetes, cardiovascular disease, and developmental problems among children. Housing instability increases the risk of respiratory illnesses, stress-related conditions, and poor mental health. Limited transportation can impede access to healthcare appointments, medications, and social services.

The COVID-19 pandemic further highlighted the profound influence of social determinants on health outcomes. Marginalized populations experienced disproportionately higher infection rates, hospitalization rates, and mortality due to factors such as overcrowded housing, occupational exposures, inadequate healthcare access, and economic insecurity (Tai et al., 2021). These disparities reinforced the need for healthcare systems to systematically identify and address social risks.

Community nurses are often among the first healthcare professionals to recognize social challenges affecting patients and families. Their close engagement with communities positions them uniquely to identify barriers, advocate for resources, and implement interventions that address social determinants. Integrating SDOH screening into nursing practice therefore represents a critical component of effective population health management.

The Role of Community Nurses in Addressing Social Determinants of Health

Community nurses play a fundamental role in promoting health, preventing disease, and reducing health disparities. Their practice extends beyond clinical care to include health education, advocacy, case management, community assessment, and intersectoral collaboration. Because they frequently work within communities rather than hospital settings, community nurses have direct exposure to the social and environmental factors influencing health.

Home visits provide valuable opportunities to observe living conditions, family dynamics, nutritional status, safety concerns, and access to resources. Through these observations, nurses can identify social risks that may not be apparent during clinic-based encounters. Community nurses also develop trusting relationships with individuals and families, facilitating open discussions about

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sensitive social challenges such as financial difficulties, housing insecurity, domestic violence, or food shortages.

In addition to identifying social needs, community nurses serve as care coordinators who connect patients with social services, community organizations, government assistance programs, and healthcare providers. They advocate for vulnerable populations, promote equitable access to resources, and support individuals in navigating complex healthcare and social service systems.

The integration of structured SDOH screening tools strengthens the ability of community nurses to identify social risks consistently and systematically. Rather than relying solely on informal observations, standardized screening approaches enable comprehensive assessments, documentation, monitoring, and evaluation of social needs.

Rationale for Integrating SDOH Screening into Community Nursing Practice

The integration of SDOH screening into community nursing practice is supported by several compelling factors. First, social needs often remain unidentified during traditional healthcare assessments. Patients may hesitate to discuss financial hardship, food insecurity, or housing instability unless specifically asked. Structured screening creates opportunities for meaningful conversations about social circumstances affecting health.

Second, early identification of social risks allows timely intervention. Addressing food insecurity, transportation barriers, or medication affordability issues before they worsen can prevent disease progression, hospital admissions, and emergency department utilization. Early intervention also improves treatment adherence and patient engagement.

Third, SDOH screening promotes person-centered care by recognizing the broader context of individuals' lives. Healthcare providers gain a more comprehensive understanding of factors influencing health behaviors, treatment adherence, and health outcomes. This understanding facilitates individualized care planning and shared decision-making.

Fourth, screening contributes to health equity by identifying populations experiencing social disadvantage. Healthcare organizations can use aggregated screening data to allocate resources, develop targeted interventions, and address disparities at the population level.

Finally, routine SDOH screening aligns with global public health priorities emphasizing prevention, equity, and integrated care. Organizations such as the WHO, the U.S. Centers for Disease Control and Prevention, and numerous professional nursing associations advocate for incorporating social determinants into healthcare assessments and interventions.

Social Determinants of Health Screening Tools Used in Community Nursing

Several validated screening tools have been developed to assess social determinants of health in healthcare settings. These tools vary in scope, complexity, and intended population but share the common goal of identifying social risks that may affect health outcomes.

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) is one of the most widely used tools. Developed by the National Association of Community Health Centers, PRAPARE assesses domains including housing, employment, education, insurance status, transportation, and social support. The tool facilitates standardized data collection and supports population health management initiatives.

The Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool, developed by the Centers for Medicare and Medicaid Services, evaluates housing instability, food insecurity, transportation needs, utility assistance requirements, and interpersonal safety concerns. The tool is designed to identify unmet social needs and facilitate referrals to community resources.

Other commonly used instruments include the Health Leads Screening Toolkit, SEEK (Safe Environment for Every Kid), and locally adapted community assessment tools. These instruments may be integrated into electronic health records to streamline documentation, data analysis, and referral processes.

Community nurses should select screening tools that align with organizational goals, population characteristics, available resources, and local community needs. Effective screening tools should be culturally sensitive, easy to administer, evidence-based, and capable of generating actionable information.

Implementation Strategies for Integrating SDOH Screening

Successful integration of SDOH screening into community nursing practice requires careful planning, organizational commitment, and interdisciplinary collaboration. Healthcare organizations must establish clear protocols that define screening procedures, documentation requirements, referral pathways, and follow-up responsibilities.

Education and training are essential components of implementation. Community nurses require knowledge regarding social determinants, screening methodologies, communication

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skills, cultural competence, trauma-informed care, and resource navigation. Training enhances confidence and competence in addressing sensitive social issues while maintaining patient dignity and trust.

Workflow integration is equally important. Screening processes should be incorporated into routine assessments without creating excessive burden for healthcare providers or patients. Electronic health record systems can facilitate screening administration, documentation, automated referrals, and outcome monitoring.

Strong partnerships with community organizations are critical for translating screening results into meaningful interventions. Identifying social needs without available resources may lead to frustration among patients and healthcare providers. Therefore, healthcare organizations should establish collaborative networks involving social service agencies, housing organizations, food assistance programs, transportation services, educational institutions, and community-based organizations.

Benefits of Social Determinants of Health Screening in Community Nursing Practice

Integrating Social Determinants of Health (SDOH) screening into community nursing practice offers numerous benefits for patients, healthcare organizations, and communities. One of the most significant advantages is the early identification of social risks that may negatively affect health outcomes. Many individuals experiencing food insecurity, housing instability, financial hardship, or transportation barriers may not voluntarily disclose these challenges during routine healthcare encounters. Structured screening enables nurses to identify such concerns proactively and implement timely interventions.

SDOH screening also enhances patient-centered care. By understanding the social circumstances influencing health behaviors and treatment adherence, nurses can develop individualized care plans that are realistic and responsive to patients' needs. For example, a patient with diabetes who struggles with food insecurity may require nutrition support services in addition to medication management. Similarly, a patient missing appointments due to transportation difficulties may benefit from transportation assistance programs or telehealth services. Such tailored interventions improve patient engagement and treatment outcomes.

Another important benefit is the reduction of healthcare utilization and costs. Unmet social needs often contribute to preventable hospitalizations, emergency department visits, and disease complications. Research suggests that addressing social determinants can improve chronic disease management and reduce unnecessary healthcare expenditures (Gottlieb et al., 2016). Community nurses who identify and address social barriers can help prevent health crises and support long-term disease prevention.

SDOH screening also strengthens population health management efforts. Aggregated screening data provide valuable insights into community needs, enabling healthcare organizations and policymakers to allocate resources strategically. Data on housing insecurity, food access, transportation challenges, and social isolation can guide community interventions and public health initiatives. Consequently, SDOH screening contributes to evidence-based planning and health equity promotion.

Furthermore, screening facilitates stronger collaboration between healthcare providers and community organizations. When social needs are systematically identified, referral pathways can be activated more efficiently, improving coordination of care and strengthening community support systems. Such collaborations create a more integrated healthcare ecosystem capable of addressing both medical and social determinants of health.

Ethical Considerations in SDOH Screening

While SDOH screening offers substantial benefits, ethical considerations must be carefully addressed to ensure respectful and equitable implementation. One primary concern is patient privacy and confidentiality. Information regarding income, housing status, food insecurity, immigration concerns, or interpersonal violence may be highly sensitive. Community nurses must ensure that collected information is handled securely and disclosed only to authorized personnel involved in care delivery.

Informed consent is another important ethical consideration. Patients should understand why screening is being conducted, how information will be used, and the potential benefits of participation. Screening should remain voluntary whenever possible, and patients should have the right to decline answering specific questions without fear of discrimination or compromised care.

Respect for autonomy and dignity is essential when discussing social challenges. Nurses should avoid stigmatizing language or assumptions regarding patients' circumstances. Instead, screening should be conducted using culturally sensitive, empathetic, and nonjudgmental approaches that foster trust and open communication.

Ethical concerns also arise when healthcare organizations identify social needs but lack adequate resources to address them. Screening without available interventions may create frustration,

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disappointment, or mistrust among patients. Therefore, healthcare systems have a responsibility to develop referral networks and support services before implementing large-scale screening programs. Ethical practice requires that screening be linked to meaningful action whenever possible.

Equity considerations are equally important. Screening tools should be culturally appropriate and validated for diverse populations. Failure to consider linguistic, cultural, socioeconomic, or disability-related factors may result in inaccurate assessments and unequal access to services. Community nurses must advocate for inclusive screening approaches that recognize the diversity of patient populations.

Barriers and Challenges to Implementation

Despite growing recognition of the importance of SDOH screening, several barriers hinder its widespread integration into community nursing practice. One of the most frequently reported challenges is time constraints. Community nurses often manage heavy workloads and multiple responsibilities, making it difficult to incorporate additional screening procedures into routine care.

Limited training and knowledge represent another significant barrier. Some nurses may feel inadequately prepared to discuss sensitive social issues or may lack confidence in identifying appropriate community resources. Without sufficient education and professional development, screening efforts may be inconsistent or ineffective.

Resource limitations pose additional challenges. Screening programs are most effective when healthcare organizations have access to referral networks and support services. However, many communities face shortages of affordable housing, food assistance programs, mental health services, transportation options, and social support resources. Identifying social needs without the ability to address them can undermine the effectiveness of screening initiatives.

Documentation and data management challenges also affect implementation. Integrating screening tools into electronic health records requires technological infrastructure, financial investment, and staff training. Inconsistent documentation practices may limit the usefulness of collected data for care planning and population health analysis.

Patient-related barriers must also be considered. Some individuals may be reluctant to disclose personal information due to fear of stigma, discrimination, loss of benefits, or mistrust of healthcare institutions. Language barriers, cultural differences, and health literacy limitations may further complicate screening processes.

Organizational culture can influence implementation success as well. Healthcare systems that prioritize acute medical care over social care may struggle to allocate resources and leadership support for SDOH initiatives. Sustainable implementation requires organizational commitment, policy support, and interdisciplinary collaboration.

Evidence from Current Research

An expanding body of research supports the integration of SDOH screening into healthcare settings, including community nursing practice. Numerous studies have demonstrated associations between social risk factors and adverse health outcomes, reinforcing the importance of identifying and addressing social determinants as part of comprehensive healthcare delivery.

A systematic review conducted by Gottlieb and colleagues (2017) found that interventions targeting social needs, particularly food insecurity, housing instability, and transportation barriers, were associated with improvements in health outcomes and healthcare utilization. The review highlighted the potential value of incorporating social risk screening into routine clinical care.

Research involving primary care and community health settings has shown that patients generally support SDOH screening when conducted respectfully and linked to available resources (Byhoff et al., 2019). Many patients recognize the connection between social circumstances and health and appreciate opportunities to discuss challenges affecting their well-being.

Studies examining community-based nursing interventions have reported positive outcomes related to chronic disease management, maternal and child health, mental health support, and healthcare access. Community nurses who assess social determinants and coordinate referrals contribute to improved treatment adherence, increased preventive service utilization, and enhanced patient satisfaction.

Evidence also supports the role of SDOH screening in reducing healthcare disparities. Programs targeting vulnerable populations have demonstrated improvements in access to care, disease control, and quality of life through integrated approaches that address both clinical and social needs (Alderwick & Gottlieb, 2019).

The COVID-19 pandemic further strengthened evidence regarding the significance of social determinants. Research conducted during the pandemic revealed that socioeconomic disadvantage, overcrowded housing, occupational exposures, and limited healthcare access contributed substantially to disparities in infection rates and health outcomes (Tai et al., 2021). These

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findings emphasized the necessity of incorporating social risk assessment into healthcare practice.

Although existing evidence is promising, researchers continue to emphasize the need for longitudinal studies evaluating long-term outcomes, cost-effectiveness, and best practices for implementing SDOH screening programs in diverse healthcare settings.

Policy Implications and Health System Considerations

The successful integration of SDOH screening into community nursing practice requires supportive policies at organizational, regional, and national levels. Policymakers increasingly recognize that achieving health equity necessitates addressing social determinants alongside traditional healthcare services.

Healthcare accreditation bodies and professional organizations have begun encouraging the incorporation of social risk assessment into routine care. Policies supporting standardized screening practices can promote consistency, quality improvement, and data comparability across healthcare systems. Such standardization facilitates population health monitoring and informs evidence-based decision-making.

Funding mechanisms play a crucial role in supporting implementation. Reimbursement policies that recognize social care activities, care coordination, and community resource referrals can incentivize healthcare organizations to adopt SDOH screening programs. Without financial support, many organizations may struggle to sustain screening initiatives and associated interventions.

Data-sharing policies are also important. Effective management of social determinants often requires collaboration among healthcare providers, public health agencies, social service organizations, and community-based programs. Secure and ethical data-sharing systems can enhance coordination while protecting patient privacy and confidentiality.

Policy initiatives addressing broader social issues such as affordable housing, food security, transportation access, education, and employment opportunities are equally essential. While community nurses can identify and address individual social needs, sustainable improvements in population health require structural interventions targeting the root causes of health inequities.

Future Directions for Community Nursing Practice

The future of community nursing practice increasingly involves integrating social care with healthcare delivery. Advances in technology, data analytics, and population health management are creating new opportunities to identify and address social determinants more effectively.

Electronic health records are expected to play an increasingly important role in facilitating SDOH screening, documentation, referral tracking, and outcome evaluation. Automated alerts and decision-support systems may help nurses identify patients at risk and connect them with appropriate resources more efficiently.

Artificial intelligence and predictive analytics may further enhance the ability to identify populations vulnerable to adverse social determinants. By analyzing demographic, clinical, and social data, healthcare organizations can proactively target interventions toward high-risk groups and communities.

Interprofessional collaboration will remain central to future efforts. Community nurses will increasingly work alongside social workers, public health professionals, community health workers, mental health specialists, and policymakers to address complex social needs. Collaborative models of care can strengthen service integration and improve patient outcomes.

Educational institutions also have an important role in preparing future nurses. Nursing curricula should incorporate comprehensive content related to social determinants, health equity, cultural competence, advocacy, and community resource navigation. Such preparation will ensure that graduates possess the knowledge and skills necessary to address social factors influencing health.

Research efforts should continue to explore effective screening strategies, implementation models, patient experiences, and long-term outcomes. Evidence generated through rigorous research will guide policy development and strengthen the scientific foundation of SDOH-focused nursing practice.

Recommendations for Nursing Practice

Several recommendations can support the successful integration of SDOH screening into community nursing practice. First, healthcare organizations should adopt standardized and evidence-based screening tools appropriate for their patient populations. Consistent screening practices facilitate comprehensive assessments and improve data quality.

Second, ongoing education and training programs should be provided to community nurses. Training should address social determinants, communication skills, cultural competence, trauma-informed care, ethical considerations, and community resource navigation.

Third, healthcare organizations should establish strong partnerships with community agencies and social service providers. Effective referral networks ensure that identified social

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needs can be addressed through timely and coordinated interventions.

Fourth, screening should be integrated into routine workflows and supported by electronic documentation systems. Streamlined processes reduce administrative burden and facilitate monitoring of outcomes.

Fifth, nurses should actively advocate for policies that promote health equity and address structural determinants of health. Advocacy efforts may include participation in community initiatives, professional organizations, and policy development activities.

Finally, healthcare organizations should regularly evaluate screening programs to assess effectiveness, identify challenges, and implement quality improvement measures. Continuous evaluation supports sustainable and impactful implementation.

Conclusion

Social Determinants of Health exert profound influences on individual and population health outcomes, often contributing more significantly to health status than clinical care alone. Factors such as housing stability, food security, education, employment, transportation, and social support shape health trajectories throughout the lifespan and contribute substantially to health inequities. Community nurses, through their close engagement with individuals, families, and communities, are uniquely positioned to identify and address these determinants.

Integrating SDOH screening into community nursing practice represents a transformative approach to healthcare delivery that extends beyond disease treatment to address the broader conditions influencing health. Evidence suggests that systematic screening can improve patient outcomes, enhance care coordination, reduce healthcare costs, and promote health equity. However, successful implementation requires adequate training, organizational commitment, technological support, community partnerships, and policy alignment.

As healthcare systems increasingly embrace population health and person-centered care models, community nurses will play an essential role in bridging the gap between clinical services and social support systems. By identifying social risks, advocating for vulnerable populations, and facilitating access to resources, community nurses contribute significantly to the creation of healthier and more equitable communities. The integration of SDOH screening into routine nursing practice is therefore not merely an innovation but a necessary evolution toward comprehensive, equitable, and sustainable healthcare.

References

1. World Health Organization. Social determinants of health. Geneva: WHO; 2023.
2. Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. Public Health Rep. 2014;129(Suppl 2):19–31.
3. Hood CM, Gennuso KP, Swain GR, Catlin BB. County health rankings: relationships between determinant factors and health outcomes. Am J Prev Med. 2016;50(2):129–35.
4. Magnan S. Social determinants of health 101 for health care: five plus five. NAM Perspectives. 2017;7(10):1–9.
5. Gottlieb LM, Hessler D, Long D, Amaya A, Adler N. A randomized trial on screening for social determinants of health. Am J Prev Med. 2016;53(1):1–10.
6. Gottlieb LM, Wing H, Adler NE. A systematic review of interventions on patients' social and economic needs. Am J Prev Med. 2017;53(5):719–29.
7. Alderwick H, Gottlieb LM. Meanings and misunderstandings: a social determinants of health lexicon for health care systems. Milbank Q. 2019;97(2):407–19.
8. Byhoff E, De Marchis EH, Hessler D, Fichtenberg C, Adler N, Cohen AJ, et al. Part II: a qualitative study of social risk screening acceptability in patients and caregivers. Am J Prev Med. 2019;57(6):S38–46.
9. Centers for Medicare & Medicaid Services. Accountable Health Communities Health-Related Social Needs Screening Tool. Baltimore: CMS; 2022.
10. National Association of Community Health Centers. PRAPARE: Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences. Bethesda: NACHC; 2021.
11. Artiga S, Hinton E. Beyond health care: the role of social determinants in promoting health and health equity. Health Affairs. 2018;37(1):1–10.
12. Taylor LA, Tan AX, Coyle CE, Ndumele C, Rogan E, Canavan M, et al. Leveraging the social determinants of health: what works? PLoS One. 2016;11(8):e0160217.
13. Thornton RLJ, Glover CM, Cené CW, Glik DC, Henderson JA, Williams DR. Evaluating strategies for reducing health disparities. Health Aff. 2016;35(8):1416–23.
14. National Academies of Sciences, Engineering, and Medicine. Integrating social care into the delivery of

SCIENTIFIC JOURNAL
www.scientificjournal.in
JOURNAL PUBLICATIONS INDEXED IN
www.scientificjournal.in YEAR: 2025 VOLUME: 3 ISSUE: 2 ISSN: 3107-4162

health care: moving upstream to improve the nation's health. Washington DC: National Academies Press; 2019.
15. Tai DBG, Shah A, Doubeni CA, Sia IG, Wieland ML. The disproportionate impact of COVID-19 on racial and ethnic minorities in the United States. Clin Infect Dis. 2021;72(4):703–6.
16. De Marchis EH, Hessler D, Fichtenberg C, Fleegler EW, Huebschmann AG, Clark CR, et al. Assessment of social risk factors and interest in receiving health care-based social assistance among adult patients. JAMA Netw Open. 2020;3(10):e2021201.
17. Andermann A. Taking action on the social determinants of health in clinical practice: a framework for health professionals. CMAJ. 2016;188(17-18):E474–83.
18. Fraze TK, Brewster AL, Lewis VA, Beidler LB, Murray GF, Colla CH. Prevalence of screening for food insecurity, housing instability, utility needs, transportation needs, and interpersonal violence by US physician practices and hospitals. JAMA Netw Open. 2019;2(9):e1911514.
19. Fichtenberg CM, Delva J, Minyard K, Gottlieb LM. Health and social services integration: a review of implementation and outcomes. Health Aff. 2020;39(11):1943–50.
20. American Nurses Association. Public health nursing: scope and standards of practice. 3rd ed. Silver Spring, MD: ANA; 2022.

