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Patient centered medical home helps assess social health determinants and promote health

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Physicians from the Departments of Pediatrics and Family Medicine at Boston Medical Center (BMC) and Boston University School of Medicine (BUSM) are proposing that current pediatric guidelines and practices could be implemented within a Patient Centered Medical Home model to address social determinants of health. The article, published in the *Journal of the American Medical Association* (*JAMA*), also suggests that these guidelines could reduce socioeconomic disparities in health care for all patients.

Arvin Garg, MD, MPH, assistant professor of pediatrics at BUSM and pediatrician at BMC, served as the study's first author. Barry Zuckerman, MD, professor of pediatrics at BUSM and a pediatrician at BMC, and Brian Jack, MD, Chief and Chair of Family Medicine at BMC and BUSM, were the article's co-authors.

A Patient Centered Medical Home (PCMH) is a comprehensive and coordinated health care model in which a team of providers coordinate all of the patient's health needs, including management of chronic health conditions, visits to specialists, hospital admissions and routine health screenings. Socioeconomic disparities continue to play a role in the health of children and families. Previous studies have shown that the environment in which a patient lives can impact their health, and these factors have historically been managed by public health and community organizations. However, a PCMH model allows for physicians to play a

role in examining the social determinants of health in order to assess and treat patients with a more holistic approach and improve population health.

The authors list five recommendations to help address social context of patient care within the PCMH model: making social determinants of health an important aspect of clinical guidelines; screening for particular social determinants at medical visits; helping patients and families access community based resources, such as Women, Infants, and Children (WIC), job training and food pantries; implementing "outside the box" multidisciplinary primary care interventions, such as programs like Reach out and Read, the Medical-Legal Partnership and Health Leads (developed at BMC); and integrating home visiting programs to better understand living conditions.

They suggest that the implementation of these guidelines will provide important data about the types of services necessary to improve population health. Additionally, the indicators related to social determinants of care may some day become part of pay for performance and quality evaluation metrics of the medical home model.

"Overall, implementing social determinants of health within the PCMH model will potentially reduce socioeconomic disparities in health that continue to exist today and ultimately improve the health care system, especially for PCMH's that serve low-income patient populations," said the authors.

The authors note that the "medical home" is not a novel concept in the world of pediatrics. Current guidelines and practices within pediatrics now address social risks of populations and these guidelines are adaptable to adult and elderly populations within the medical home as well.