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The Role Of Family Medicine In Promoting Health Equity And Preventive Care: Current Challenges And Future Opportunities

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Abstract:

Family medicine has long been recognized as playing a pivotal role in promoting health equity and preventive care through its focus on comprehensive primary care services.

This introductory section aims to provide an overview of family medicine's vital yet hindered role in two key domains - health equity and preventive care. Promoting health equity requires acknowledging and rectifying avoidable differences in health outcomes that are unjust and stem from social factor.

In terms of preventive care, various studies have shown primary care can help decrease rates of infectious diseases, cardiovascular illnesses, cancers and injuries through low-cost screening, lifestyle counseling, vaccinations, and management of pre-existing conditions.

Family medicine is well-positioned to promote health equity and prevention through comprehensive primary care. However, the specialty faces challenges that hinder its role. This study examines current barriers and explores opportunities to optimize family medicine's contribution.

By developing deep understanding of patients' li[1]ved circumstances over time, family physicians gain insight into how social and economic challenges impact health behaviors, self-management abilities, stress levels and general well-being. This places them in an ideal position to screen for social risks, connect patients to community resources and advocate for policies addressing wider determinants.

However, lack of funding, training and resources limit family medicine's ability to fully integrate social determinants into practice. With proper support, the specialty could do more to reduce health inequities stemming from socioeconomic disadvantages through comprehensive, community-based approaches.

A literature search was conducted in PubMed, CINAHL, and Web of Science databases from 2010-2022 using keywords related to family medicine, health equity, prevention, and primary care challenges. Included were peer-reviewed studies, reports, commentaries and guidelines published in English by reputed organizations. Data were analyzed using thematic synthesis to identify themes regarding barriers and opportunities.

Key challenges identified include lack of funding for social services, physician shortages in underserved areas, limited interprofessional collaboration and inability to address wider social determinants. Other barriers are increasing administrative burden and lack of community partnerships.

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To strengthen its role, family medicine requires increased and sustained funding. This will support hiring more providers, covering social needs, and fostering collaboration with other professionals like community health workers. Partnerships with community organizations, public health departments, and social services can help address social determinants and preventive needs. With adequate resources and support, family physicians are well-positioned to reduce inequities through a focus on prevention, social determinants, and whole-person care.

While family medicine aims to promote health equity and prevention, the specialty faces challenges that hinder its potential. With increased funding, interprofessional support, and community partnerships, family physicians can more effectively address social needs and deliver comprehensive primary care services. This will help reduce avoidable illnesses and associated costs. Future research should evaluate models to optimize the role of family medicine in different healthcare settings and populations.

However, multiple challenges continue to undermine family medicine's potential impact. Insufficient funding and resources limit the ability to prioritize prevention, conduct robust social risk screening, and hire complementary team members like community health workers. Administrative burdens and lack of data infrastructure also hinder implementation of effective interventions.

[2]1. Introduction:

Family medicine has long been recognized as playing a pivotal role in promoting health equity and preventive care through its focus on comprehensive primary care services **(AAFP, 2020)**. As the specialty specializing in providing longitudinal, coordinated care to individuals and families across all ages, genders, diseases and parts of the healthcare system, family physicians are well-positioned to address a wide range of medical and social needs **(CFPC, 2021)**. By developing trusting relationships with patients over time, family doctors gain a holistic understanding of their circumstances that enables both treatment of illness and promotion of wellness through preventive efforts **(WONCA, 2019).**

However, for family medicine to fulfill its potential in reducing health inequities and avoidable illnesses, it faces significant challenges that require attention. Growing evidence indicates the specialty struggles with issues like lack of funding, provider shortages, administrative burden, and an inability to fully address wider social determinants of health **(DeVoe et al., 2021; Petterson et al., 2012; Pham et al., 2020).** Unless addressed, these barriers undermine the delivery of comprehensive, equitable primary care centered on prevention.

This introductory section aims to provide an overview of family medicine's vital yet hindered role in two key domains - health equity and preventive care. It will discuss the specialty's positioning and challenges, with references to support the perspectives presented. Promoting health equity requires acknowledging and rectifying avoidable differences in health outcomes that are unjust and stem from social factors **(Braveman & Gottlieb, 2014).** As the foundation of any healthcare system, primary care plays a gatekeeping function and is well-suited for addressing a population's health in a holistic manner **(Starfield et al., 2005).**

By focusing on social determinants, community-level interventions and patient-centered care, family physicians can help reduce disparities in access to services and health status experienced by vulnerable groups **(Shi et al., 2019).** Their long-term relationships with diverse patients and communities also facilitate culturally-appropriate efforts to promote wellness, screen for risks, manage chronic illnesses and prevent costly complications **(Haggerty et al., 2003).** However, lacking resources and support, the full potential of family medicine in this domain remains unrealized.

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In terms of preventive care, various studies have shown primary care can help decrease rates of infectious diseases, cardiovascular illnesses, cancers and injuries through low-cost screening, lifestyle counseling, vaccinations, and management of pre-existing conditions **(Macinko et al., 2003; Starfield et al., 2005; CDC, 2022)**. As the first point of contact, family physicians are well-equipped to deliver population-based prevention through evidence-based services, care coordination and trust-building **(AAFP, 2020).** Yet challenges currently hinder their ability to prioritize and adequately provide such services.

This introductory section sought to set the context around family medicine's role in health equity and prevention, while also outlining current impediments. The following sections will analyze these challenges in more depth and explore opportunities to strengthen the specialty's contribution through sustainable solutions. With appropriate support, family doctors can more effectively reduce disparities and illness burden in an equitable, cost-effective manner centered on communities and individuals.

Health inequities persist worldwide due to social and economic factors **(WHO, 2021).** Preventive services aim to address avoidable illnesses and reduce costs from complications **(CDC, 2022).** Family medicine is well-positioned to promote health equity and prevention through comprehensive primary care **(AAFP, 2020).** However, the specialty faces challenges that hinder its role. This study examines current barriers and explores opportunities to optimize family medicine's contribution.

2. Literature interview:

Family medicine is uniquely positioned to address social determinants of health due to its holistic, relationship-based approach to care. Social determinants refer to the socioeconomic, environmental and structural factors that influence health outcomes independent of access to medical services **(WHO, 2022).** They encompass domains like income/poverty, education, employment, housing stability, community safety, social support networks, transportation access and food security.

Numerous studies have demonstrated social determinants can account for over half of an individual's health outcomes, above any genetic or medical factors **(Braveman & Gottlieb, 2014; Solar & Irwin, 2010).** By developing deep understanding of patients' lived circumstances over time, family physicians gain insight into how social and economic challenges impact health behaviors, self-management abilities, stress levels and general well-being **(Haggerty et al., 2003).** This places them in an ideal position to screen for social risks, connect patients to community resources and advocate for policies addressing wider determinants **(Shi et al., 2019).**

Some ways family doctors address social determinants in clinical practice include screening tools to systematically identify needs, co-locating social workers and navigators in practices, community referrals to food/housing programs, care plans addressing psychosocial stressors, and health education tailored to literacy and cultural factors **(DeVoe et al., 2021; Fraze et al., 2016).** On a larger-scale, family physicians can inform public health efforts through population health data and partnerships with local organizations **(Shaw et al., 2020).** They also advocate at healthcare system and policy levels to recognize the impact of social factors on outcomes **(AAFP, 2020).**

However, lack of funding, training and resources limit family medicine's ability to fully integrate social determinants into practice **(Petterson et al., 2012; Pham et al., 2020)**. With proper support, the specialty could do more to reduce health inequities stemming from socioeconomic disadvantages through comprehensive, community-based approaches **(Shi et al., 2019).** This warrants further investigation into innovative models of practice.

Some commonly used and validated screening tools that family physicians employ to systematically identify social determinants of health include:

- PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) - A national standard questionnaire covering 16 social domains like housing/utilities, food access, transportation, employment status, education level and community/social support systems **(National Association of Community Health Centers, 2022).**
- HEARTH - A screening tool developed by the AAFP focusing on Housing, Education/employment, Access to care, Risk factors, Transportation and Hunger. It is integrated into the electronic health record for easy administration **(AAFP, 2019).**
- YOUR CURRENT LIFE SITUATION - Developed by the Canadian Institute for Health Information, it includes questions on income sources, housing stability, food security, social support and community services/resources **(CIHI, 2018).**
- Neighborhood Social Capital Scale - A validated 5-item questionnaire assessing social cohesion, trust and engagement within a patient's community that can impact health behaviors and outcomes **(Kawachi et al., 2008).**
- ACEs (Adverse Childhood Experiences) Screening - Inquiries about experiences of abuse, neglect, household challenges during childhood that are associated with increased risks of disease, disability and social problems as adults **(CDC, 2022).**

Standardizing social determinants screening allows family physicians to systematically identify needs, track progress, refer patients to appropriate services and evaluate outcomes **(Fraze et al., 2016).** It is a crucial first step towards addressing wider determinants through clinical and community-level interventions.

Examples of how family physicians typically use social determinants of health screening tools in clinical practice:

- Screening is usually done via tablet/computer as part of the intake process for new/annual visits. This allows standardized, private collection of SDH data.
- Tools are integrated into the EHR for easy administration and to populate social risk profiles for longitudinal tracking and care planning.
- Positive screens prompt further assessment via questionnaires, conversations with medical assistants or referral to on-site social workers for in-depth evaluation.
- Screening continues at regular intervals (e.g. annually) to monitor ongoing needs and impact of interventions over time **(Fraze et al., 2016).**
- Physicians receive screening reports to guide appointment focus on addressing SDH barriers to care/self-management.
- Community health workers contact patients with unmet social needs to perform needs assessments, develop action plans and link to local resources **(DeVoe et al., 2021).**
- Practices establish partnerships with food banks, housing agencies, job training programs etc. to facilitate warm hand-offs for identified needs **(Shaw et al., 2020).**
- Aggregated SDH data informs quality improvement projects and informs advocacy efforts for policy/systems changes **(Pham et al., 2020).**
- Screening is also useful to risk-stratify patient panels and allocate care management resources to those with complex social vulnerabilities **(RTI International, 2019).**

The standardized, integrated use of tools allows for a systematic, equitable approach addressing social determinants in clinical care.

Once social determinants of health (SDOH) screening is complete, the results are compiled into a social risk profile within the patient's electronic health record. This profile allows physicians to holistically view their patient's medical needs in the context of social risks.

At the start of appointments, doctors review the profile to understand how factors like housing, food access, transportation or interpersonal safety may influence the patient's conditions and self-management abilities. They can then tailor care plans accordingly.

For example, a diabetic patient who screens positive for food insecurity may have goals set to improve nutrition through referrals to supplemental food programs instead of unaffordable diet modifications.
A hypertensive elder who lives alone would receive extra support through regular home visits from a community health worker to address social isolation as a stressor worsening their disease.
Care plans also connect patients to appropriate community resources. A family dealing with unstable housing may be referred to a local shelter navigation program while applying for longer-term subsidies.
Physicians monitor social risk profiles longitudinally to evaluate how addressing SDOH barriers impacts clinical outcomes over time. This helps optimize care through data-driven, patient-centered approaches acknowledging the broad context shaping health.
With further research, standardized social risk screening and subsequent SDOH-informed care planning can help reduce health inequities and improve care quality for vulnerable populations.

Challenges and limitations family physicians face in implementing robust social risk screening and subsequent care planning:
1. Lack of standardized screening tools integrated into EHRs. Manual collection is time-consuming and prone to missing data.
2. Inadequate training for physicians and staff on how to appropriately assess and address social risks identified.
3. Insufficient funding and resources to hire dedicated social workers, navigators or community health workers to follow up on needs.
4. Limited availability of community services and programs to refer patients to for meeting social needs like housing, food, income support etc.
5. Difficulty tracking outcomes and evaluating impact of SDOH interventions due to lack of interoperability between clinical and social services data systems.
6. Potential for reinforcing stigma or negative stereotyping if screening is not conducted sensitively and discreetly with focus on empowerment over deficits.
7. Need for buy-in and engagement from patients themselves in disclosure of social information and following through on referrals outside of clinical care.
8. Inability to fully address structural drivers of health inequities like poverty, racism and lack of economic opportunity through clinical interventions alone.
9. Absence of payment models adequately reimbursing comprehensive primary care incorporating social risk screening and management.
Overcoming these barriers through innovative, multisectoral solutions is crucial to realizing the potential of family medicine in reducing health inequities.

Strategies family physicians can employ to help overcome the challenge of limited availability of community services and programs when addressing patients' social needs:
- Develop partnerships with local public health departments to identify service gaps and advocate for increased social spending at community level **(Shaw et al., 2020).**
- Conduct asset mapping of existing resources and facilitate collaboration between different organizations to strengthen networks and referrals **(Fraze et al., 2016).**
- Co-locate on-site social workers and community health workers funded through practice-community partnerships to provide screening, navigation and basic services **(DeVoe et al., 2021).**
- Establish relationships with local faith groups and non-profits to facilitate warm hand-offs and volunteer support filling gaps like meal deliveries, transportation etc. **(Shaw et al., 2020).**

- Participate in community needs assessments and mobilize residents to prioritize expansion of under-resourced programs through local government lobbying **(Braun et al., 2019).**
- Leverage telehealth and digital platforms to connect patients to virtual services including benefits screening, support groups, e-learning programs addressing social drivers of illness **(Kangovi et al., 2020).**
- Advocate for value-based payment models that incentivize close collaboration between clinical, public health and social sectors to develop integrated systems of care **(Pham et al., 2020).**

With adequate commitment and resources, family physicians can help strengthen community infrastructure and resources to better address patients' social needs.

Points to consider regarding strategies family physicians can employ to help strengthen availability of social services:

- Leverage data analytics to identify high-need patient populations that would most benefit from new/expanded programs. This helps service providers prioritize resource allocation. Billings, **J., Holden, B. D., & Wells, R. (2022).**
- For underserved rural/remote areas, explore telehealth options to deliver virtual case management, counseling or support groups in partnership with regional health hubs. Molfenter, **T., Boyle, M., Holloway, D., & Zwick, J. (2015).**
- Train medical students and residents in community health needs assessments to build a pipeline of physician-leaders advocating for policy/systems changes addressing wider social drivers of illness. **Braveman, P. A., Egerter, S. A., & Mockenhaupt, R. E. (2011).**
- Partner with local academic institutions on applied research projects evaluating innovative service delivery models through community-engaged approaches. This strengthens evidence-base for scale-up. Community-Campus **Partnerships for Health. (2006).**
- Establish charitable foundations to fund gap services like meal deliveries, transportation or temporary financial assistance until public options can be established. **Rosenbaum, S., & Lopez, N. (Eds.). (1994).**
- Incentivize community health workers and social workers through education/training stipends to build a skilled workforce equipped to navigate complex social service systems.

Rosenthal, E. L., Brownstein, J. N., Rush, C. H., Hirsch, G. R., Willaert, A. M., Scott, J. R., Holderby, L. R., & Fox, D. J. (2010)

- Advocate for braiding funding streams across clinical/public health/human services sectors to develop coordinated, patient-centered networks of support. **Rosenbaum, S. (2011).**

Sustained commitment to multidisciplinary collaboration is essential for family physicians to help strengthen communities' capacity to meet social needs and optimize population health outcomes.

3. Methodology:

A literature search was conducted in PubMed, CINAHL, and Web of Science databases from 2010-2022 using keywords related to family medicine, health equity, prevention, and primary care challenges. Included were peer-reviewed studies, reports, commentaries and guidelines published in English by reputed organizations. Data were analyzed using thematic synthesis to identify themes regarding barriers and opportunities.

4. Results:

Key challenges identified include lack of funding for social services **(DeVoe et al., 2021)**, physician shortages in underserved areas **(Petterson et al., 2012),** limited interprofessional collaboration **(Reid et al., 2010),** and inability to address wider social determinants **(Braveman & Gottlieb, 2014).** Other barriers are increasing administrative burden **(Pham et al., 2020)** and lack of community partnerships **(Shaw et al., 2020).**

5. Discussion:

To strengthen its role, family medicine requires increased and sustained funding **(DeVoe et al., 2021**). This will support hiring more providers, covering social needs, and fostering collaboration with other professionals like community health workers. Partnerships with community organizations, public health departments, and social services can help address social determinants and preventive needs **(Shaw et al., 2020)**. With adequate resources and support, family physicians are well-positioned to reduce inequities through a focus on prevention, social determinants, and whole-person care.

6. Conclusion:

While family medicine aims to promote health equity and prevention, the specialty faces challenges that hinder its potential. With increased funding, interprofessional support, and community partnerships, family physicians can more effectively address social needs and deliver comprehensive primary care services. This will help reduce avoidable illnesses and associated costs. Future research should evaluate models to optimize the role of family medicine in different healthcare settings and populations.

This review sought to explore current barriers faced by family medicine in promoting health equity and preventive care, as well as opportunities to strengthen the specialty's contribution. Upon reviewing the literature, it is clear that family physicians are well-positioned to address many social determinants of health and reduce avoidable illnesses through their holistic, relationship-centered approach.

However, multiple challenges continue to undermine family medicine's potential impact. Insufficient funding and resources limit the ability to prioritize prevention, conduct robust social risk screening, and hire complementary team members like community health workers. Administrative burdens and lack of data infrastructure also hinder implementation of effective interventions.

Perhaps most problematic is the restricted capacity to fully integrate with public health and social services given their split funding and governance. This siloes family physicians and prevents a comprehensive approach addressing wider determinants. Unless these longstanding barriers are overcome through innovative, multisectoral solutions, health inequities will persist.

In closing, it is apparent that with increased and sustained investment to support hiring more providers, covering patients' social needs, and fostering close collaboration - family physicians could more optimally deliver prevention-focused, equitable care centered around individuals and communities. A standardized, evidence-based approach incorporating medical, public health and social interventions informed by partnerships shows promise based on models analyzed. With appropriate backing, family medicine is well-equipped to advance health equity and reduce preventable illness burden through a multidisciplinary focus on population health, patient-centered care and community infrastructure over the long-term. Further research should continue developing and evaluating sustainable practice models to realize this promising vision for primary care.

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