

The Value of Social Determinants of Health Needs Assessments in Primary Care

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Abstract

Social determinants of health (SDOH) such as income, housing, food security, education, transportation, and healthcare access, exert a far greater influence on health outcomes compared with traditional clinical care alone. This policy commentary argues for the routine integration of SDOH needs assessments into primary care to enable more comprehensive, equitable, and effective patient care. By screening for social drivers, providers can identify non-medical obstacles to treatment adherence, connect patients with community resources, and develop realistic care plans tailored to individual circumstances. Additionally, understanding patients' social environments can help clinicians consider alternative or differential diagnoses associated with specific social exposures. For example, housing instability or poor housing conditions may contribute to respiratory illnesses such as asthma due to mold or environmental exposures, while food insecurity may increase risk for malnutrition or poor control of chronic diseases such as diabetes. Incorporating SDOH information into clinical decision-making therefore not only improves care coordination but also supports more accurate and context-informed diagnostic assessments. A real-world needs assessment conducted with a Delaware State University professor living with a neuromuscular disorder illustrates how even insured, employed, highly educated individuals can face critical gaps in medical device coverage, underscoring the intersection of social and economic factors with clinical care. The commentary further highlights how aggregated SDOH data can inform community-wide public health planning, policy advocacy, and resource allocation. Practical implementation strategies, including digital screening tools embedded in electronic health records, are proposed to minimize workflow disruption while ensuring consistent data collection. Ultimately, embedding SDOH assessments into routine primary care represents an essential step toward holistic, value-based healthcare that addresses root causes of health disparities and improves long-term patient outcomes.

Commentary/Narrative

There is significant value in primary care providers completing social determinants of health needs assessments (SDOH) in their practices for patient needs evaluations. Social drivers such as income, housing, food security, education, transportation, and access to healthcare can have a major impact on health outcomes. Traditional clinical care focuses primarily on diagnosing and treating medical conditions, but research consistently shows that social and environmental factors account for a much larger share of what influences overall health.¹ By assessing these social needs, providers gain a more comprehensive understanding of their patients' lives out of a medical setting, which allows for more personalized and effective care delivery.

One of the key benefits of integrating SDOH assessments into primary care is the ability to identify and address barriers that interfere with health management. For example, patients who experience housing instability or food insecurity may struggle to follow treatment plans, not out of noncompliance, but because they lack the necessary resources for survival. When providers screen for these issues, they can connect patients with social workers or community organizations that provide targeted support for what holds them back. This process would allow patients to access assistance such as food pantries, housing aid, or even utility benefits; resources that will in turn improve their ability to maintain health. Anderman highlights that physicians often avoid addressing SDOH issues because they feel helpless when faced with complex challenges their patients experience.² However, she emphasizes that health professionals have a crucial role in identifying these factors and helping patients access community and social support services. By doing so, providers can bridge the gap between clinical care and the social realities influencing health outcomes.

In addition, SDOH needs assessments help promote health equity by ensuring that care is tailored to each patient's unique social context. Many individuals, particularly those from marginalized or low-income communities, face systemic barriers that impact their access to care and overall health. When providers are aware of and understand these factors, they can create more realistic and sustainable care plans that coincide with a patient's financial or social limitations. Drake et al. conducted a qualitative study using semi-structured focus groups with front-line clinicians to explore how collected SDOH data could inform implementation factors and best practices for responding to patients' social needs.³ Clinicians involved in the study noted "how the different parts of a person's life impact them because... one area influences the other." This not only leads to better health outcomes but can also build trust between patients and providers, as patients feel understood and supported beyond their medical diagnoses.

As part of our exploration of the SDOH, a needs assessment was conducted with a faculty member at Delaware State University, living with a neuromuscular degenerative disorder characterized by progressive muscle weakness, stiffness, and pain that limits upper arm mobility.⁴ Through the assessment process, financial and insurance-related barriers to assistive technology were identified as significant challenges affecting daily functioning. Although the individual maintains employment and health insurance coverage, medically beneficial adaptive equipment remains inaccessible due to lack of insurance reimbursement. For example, an arm elevation assist device costing approximately \$2,000, which would substantially improve the ability to perform activities of daily living such as dressing, cleaning, lifting objects, and conducting academic work with students, is not covered under the current insurance plan. This example illustrates how SDOH assessments can reveal economic and structural barriers that may not be apparent through a traditional clinical evaluation alone. Even individuals with stable employment, education, and insurance coverage may encounter gaps between medical necessity and coverage policies, demonstrating the broader importance of integrating social needs assessments into routine care to identify and address these barriers

Furthermore, collecting needs assessment data of SDOH in primary care settings supports broader public health initiatives and policy development. By analyzing the gathered data, health systems can identify community-wide trends, such as areas with high rates of food insecurity, crime rates or lack of transportation. This information can guide community health planning, funding, and advocacy efforts aimed at addressing the root causes of poor community health outcomes.

One effective way to implement SDOH needs assessments into primary care visits could be through the use of digital or electronic screening tools and patient surveys.⁵ Integrating brief, SDOH questionnaires into electronic health record (EHR) systems would allow patients to complete assessments before or during appointments, without the hassle of the doctors or nurses having to conduct them orally during each patient visit. These can be done either through individual patient portals, mobile check-in systems, or paper form. This digital approach would minimize the burden on providers while ensuring consistent data collection across patient populations. For example, an electronic survey might include questions on food access, transportation, or housing stability, with automatic prompts linking positive responses to referral resources or community-based services. By streamlining the process and embedding it into routine care, healthcare organizations can efficiently capture essential social data without disrupting clinical workflow. This not only enhances individualized care planning but also generates valuable population-level insights that support health equity initiatives and value-based care models.

In summary, incorporating SDOH needs assessments into primary care adds substantial value by allowing providers to identify social barriers, enhance patient care, promote health equity, and inform public health strategies. By recognizing and addressing the social and environmental factors that influence health, providers can deliver more holistic and compassionate care that meets patients where they are. These assessments not only uncover hidden barriers to treatment adherence but also empower clinicians to connect patients with vital community resources. As the healthcare system continues to shift toward value-based care, integrating SDOH needs assessments into routine practice is essential for improving outcomes, reducing disparities, and ultimately creating a more responsive healthcare environment.

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