Decades of research demonstrate that improving social conditions — such as access to stable income and housing, nutritious and sufficient food, appropriate health care, and reliable transportation — is critical to improving overall health across the United States and reducing disparities in health outcomes. Integrating social care into health care delivery can help achieve this goal.

Taking social risk factors into account is critical to improving the prevention and treatment of acute and chronic illness, which requires effective interprofessional teams that include experts in social care, such as social workers. Social care providers understand that the conditions in which people live, work, and play influence their mental and physical health, their ability to access health care, and individuals’ health-related behaviors. They provide interventions to address social needs and maximize the success of health care plans.

Others who provide social care include:

- **Community health workers**, who are often recruited from the communities they serve, and provide linkages among health care, social services, and the community.

- **Social service navigators**, aides, and assistants, who assist patients and families on a wide range of activities and often help them find and access services in the community.

- **Nurses**, who may serve within acute care settings, as care managers, as home care nurses, in community health centers, or in in-home visitation programs, and may address social needs directly or make referrals.

- **Home health aides and personal care aides**, who provide extensive in-home support services to older adults, individuals with disabilities, and patients after a hospitalization.

- **Case managers**, who coordinate the health and social care of patients and often focus on benefit enrollment.

- **Gerontologists**, who are trained to support the aging process and aging populations.

- **Lawyers**, who may assist patients and families with legal matters that can compromise health, such as inadequate housing.

- **Family caregivers**, who often provide social care and have a valuable perspective on the social needs of patients.
Integrating Social Care Into the Delivery of Health Care

Social workers and others who provide social care often play a lead role within interprofessional efforts to develop, implement, and scale social care integration activities. Social care integration activities include awareness of social risks and social needs, adjustment of clinical care, assistance to address needs, alignment with community partners, and advocacy to minimize social risks and increase social care resources.

To promote better health for all, social care providers should be integrated into health care through various strategies:

**Include social care providers on health care teams.** All team members should have clearly defined roles and be trained to work well together within the complex and shifting landscape of health-related social care.

**Align financing mechanisms to support team members who provide social care.** Social workers and other social care providers should be considered eligible for reimbursement for their social care integration activities by health care payers, including Medicare and Medicaid.

**Engage social workers in interprofessional education efforts.** Social workers should educate other disciplines about the social determinants of health and health disparities, and about effective models that integrate social care and health care delivery.

**Conduct further research.** Study workforce issues related to integrating social care and health care, including the impact of various social care activities and staffing configurations on health and financial outcomes.

**Examples of innovative interventions with specialized roles for social care providers on the team:**

**The Care Neighborhood program’s medical home** teams address the social, medical, and behavioral health care needs of those most at risk, and clinic-based community health workers focus on building relationships with patients and identifying their needs. With support from a nurse and a social worker, a community health worker determines next steps, which may include connecting patients to basic benefits and community resources; connecting them to clinic resources and primary care visits; or providing full case management support, integrated behavioral health, or housing support services.

**Geisinger Health System** uses teams of community health assistants, social workers, physicians, nurses, and pharmacists to identify and address care gaps. Community health assistants take referrals from care team members and local community-based organizations, and assess for care gaps in patients’ home environments in order to tailor care access and supports.

Read more recommendations for integrating social care into the delivery of health care at nationalacademies.org/SocialCare.