POLICY BRIEF

Rural Family Physicians Are More Likely to Collaborate with Multisector Community Organizations

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Based on our analysis of data from 10,802 family physicians, we found significant variation in collaboration with local social service agencies by rurality. This variation highlights the need for tailored strategies that address disparities in health care resource utilization and collaboration, particularly improving service access and delivery. (J Am Board Fam Med 2024;37:1167–1169.)

Keywords: **Community Medicine, Family Physicians, Health Services, Primary Health Care, Public Health, Social Determinants of Health, Social Service**

Collaboration between primary care and community organizations is essential for addressing social determinants of health (SDOH) and improving health care outcomes.[1–3] Primary care is critical in this effort, taking an active role in identifying social risks, coordinating with community-based resources, advocating for policy reform, and striving toward health equity.[2] Integrating primary care with public health and other sectors requires collective action from all stakeholders involved in health care, with a specific focus on disparities in rural versus urban systems.[3,4] While a recent study found that 55.6% of family physicians felt their practices were well equipped to address patient's SDOH needs, there is a limited detailed understanding of how collaboration with other sectors may fulfill these needs.[5] Significant variation exists in population health networks, with emerging research suggesting urban systems typically engage more partners than their rural counterparts.[6,7] Our objective was to examine the connections between primary care practices and multisector community organizations -encompassing health care, education, social services, and local government - with a particular focus on differences with rurality. These organizations play key roles in driving multisector approaches to address social determinants of health creating comprehensive strategies that bridge diverse sectors.

We utilized data from the 2023 American Board of Family Medicine (ABFM) Continuing Certification Questionnaire completed by practicing family physicians whose examination requirement was due in 2023.[8] Family physicians who practiced outpatient continuity care were asked if their practice collaborated with a number of community organizations. We used the 2023 Rural Urban Continuum Codes (RUCC) to assign metropolitan, micropolitan, small rural, and frontier status based on county population. We tested for the association between rurality and collaboration with each type of community organization. This study was approved by the American Academy of Family Physician Institutional Review Board.

Among 10,802 family physicians, we found significant variation in collaboration with community organizations overall, with rates generally increasing with rurality. Bivariate tests were significant for all variables, indicating strong associations between rurality and the extent of collaboration across different sectors. Overall, 22% of physicians reported collaborating with transit and

This article was externally peer reviewed.
Submitted 4 March 2024; revised 10 May 2024; accepted 20 May 2024.
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Funding: None.
Conflict of interest: Dr. Peterson and Ms. Fleischer are employees of the American Board of Family Medicine.
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J Am Board Fam Med: first published as 10.3122/jabfm.2024.240104R1 on 21 March 2025. Downloaded from http://www.jabfm.org/ on 9 November 2026 by guest. Protected by copyright.

Table 1. Practice Collaboration with Local Multisector Organizations as Reported by Family Physicians Registering for the American Board of Family Medicine Certification Examination in 2023 by County Level Rurality*

	Rural Urban Continuum				
Collaborative Partners	Metropolitan (n = 9,210)	Micropolitan (n = 673)	Small Rural (n = 781)	Frontier (n = 138)	Total (n = 10,802)
Local public health	52.0	66.4	72.2	80.7	54.8
Local government	39.3	50.8	50.6	67.4	41.2
Faith based organization	21.8	26.7	28.4	39.3	22.9
Drug treatment facilities	26.9	36.2	35.6	37.0	28.3
Behavioral health agencies	51.3	62.1	67.1	74.8	53.5
Schools	31.5	44.4	53.2	74.8	34.5
Neighborhood organizations	28.1	28.3	25.8	38.5	28.1
Law enforcement	22.8	39.7	51.3	68.9	26.6
Emergency medical services	45.1	59.8	69.8	82.2	48.3
Transit	20.5	28.3	32.3	44.4	22.1

*Numbers are column percentages.
All bivariate tests for associations were significant at $P < .05$.

faith-based organizations whereas more than half collaborated with local public health and behavioral health agencies. The highest collaboration rates for family physicians in metropolitan areas were with local public health departments (52.0%), followed by behavioral health agencies (51.3%), and emergency medical services (45.1%). In smaller rural areas, collaboration rates were higher, for example, in local public health agencies (72.2%), schools (53.2%), and emergency medical services (69.8%). However, in frontier counties, family physicians reported the highest collaboration rates across all types of organizations, with emergency medical services being the highest level of collaboration (82.2%) (Table 1).

Our research revealed significant variations and diverse collaboration patterns between family physician practices and community organizations, both by sector and by rurality. These patterns suggest that rural family physicians might collaborate with other organizations at a higher rate to meet the multifaceted needs of their patients. This collaboration could include activities such as screening for social risks, referring to appropriate services, and actively following up on these referrals to ensure ongoing support and seamless care coordination. By fostering collaborative partnerships between family physicians and multisector community organizations, communities can enhance the sharing of resources, further strengthen care coordination, and improve community-level health outcomes.[4] These findings have important implications for policy makers and health care administrators. They underscore the necessity of designing interventions that prioritize clinical collaborations involving health professionals, community stakeholders, and social services. This holistic approach is essential for enhancing health care delivery and effectively addressing SDOH, with the potential to inform policy reforms aimed at reducing health disparities across different geographic locales.

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