NEWSLETTER 7

Screening Social Determinants of Health in CKM

Food insecurity, housing instability and financial strain as core clinical variables

Figure 7. Screening Social Determinants of Health in CKM — mechanism overview (illustrative; labels added for education).

The 2026 guideline elevates social context from background factor to core clinical pillar. It recommends routine assessment of social determinants of health (SDOH) closely linked with CKM development and complications, and treats addressing adverse SDOH as a key component of holistic CKM care.[1] This is a notable expansion of scope for a cardiometabolic guideline.

The document is specific about what to screen for: food insecurity, housing instability, and financial strain, each of which independently raises the risk of developing CKM syndrome and of poor outcomes once it is established.[2,3] Named social risk factors also include intimate partner violence, and the guideline explicitly calls for engaging social workers and community health workers as part of the care team.[4]

The rationale is grounded in the biology of the syndrome itself. Ndumele notes that obesity develops from "a complex array of social, behavioral and biological factors," and that addressing social risks, while "a very big challenge... [is] not one that I think we can afford to ignore."[4] With obesity and overweight affecting more than 70% of the U.S. population, the guideline frames CKM as a systemic challenge that cannot be solved by pharmacology alone.[4]

For clinicians, the practical implication is that a brief, validated SDOH screen belongs in the same encounter as the eGFR and UACR. Identifying a patient who cannot afford medication or reliably access food changes the treatment plan as much as any lab value—and points toward referral pathways rather than prescriptions alone.

Framing social risk as a clinical variable also has measurable downstream value. Food insecurity, housing instability, and financial strain each shape whether a patient can afford medication, attend follow-up, or maintain dietary change—so documenting them predicts adherence as reliably as many laboratory markers.[2] The guideline's inclusion of intimate partner violence and its call to embed social workers and community health workers acknowledge that CKM outcomes are shaped well outside the clinic, and that pharmacology alone cannot close the gap.[4]

Multidisciplinary teams extend this reach. Pharmacists and allied professionals have a defined role in addressing SDOH and bridging gaps across CKM care, from medication affordability counselling to adherence support.[5] In resource-constrained settings, systematically documenting social risk also supports population-health planning and equitable allocation of scarce specialist resources—making SDOH screening both a clinical and an administrative priority.

References

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