**Supplemental Table 1.** Examples of possible interventions used to address SDoH.

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| --- | --- |
| **Study** | **Intervention** |
| Elsborg et al 1 | Engage people in sports-based recreation activities. These activities should be free of charge, based on no or few facilities, locally available, and be tailored to the target groups. |
| Gurewich et al 2 | Identify unmet social needs and refer to social services to address unmet social needs |
| Hale et al 3 | considering improving sleep health a necessary step toward achieving health equity as sleep is a key indicator of overall health |
| Hassan et al 4 | Researchers developed a web-based tool for patients to assess health-related social domains, offering feedback and assistance in choosing appropriate agencies. Telephone follow-ups were conducted after 1-2 months to ensure patients had addressed their issues. |
| Hatef et al 5 | Proposing to develop an EHR\*-derived CHR\* which has the potential to significantly enhance the scope, accuracy, and timeliness of data accessible for designing interventions aimed at addressing SDoH at both individual and local or even national levels. |
| Henwood et al 6 | Developing a national agenda on homelessness and health disparities |
| Yaun et al 7 | Identify the most pressing need and work to meet that need directly through clinic resources, Methodist Le Bonheur Community Outreach services, or a network of community partners. |
| de Ramirez et al 8 | Patients were asked whether they would be willing to accept assistance if they screened positive for 1 or more SDoH categories, and results from the SDoH screening were incorporated into the patient's EHR |
| Roebuck et al 9 | A patient with positive SDoH results receives a community resource guide and discusses options. If needed, a nurse or medical assistant can initiate a referral for the patient to be connected with a patient navigator. |
| Mullen et al 10 | If the user has indicated "YES" for any of the options in the survey, it would be asked whether they wish to receive support for any of these identified needs to address them and refer patients to appropriate community services |
| Harriett et al 11 | Patients who screened positive for any section of SIPT were contacted to assess the linkage of services depending on each positive domain (mostly includes, counseling, referral, and handouts offer) |
| Hao et al 12 | The social work team addresses SDOH needs upon referral |
| Gupta et al 13 | Patients receive referrals based on the positive domain |
| Friedman et al 14 | Specific interventions and referrals for each positive domain |
| Bradywood et al 15 | Refer to social work by a registered nurse, social work connects with patients for individualized resource support and additional needs |
| Page-Reeves et al 16 | Refer to community health workers |
| Fleegler et al 17 | In the web-based context, patients could explore and choose the domain that needs to be addressed |
| Sokol et al 18 | Patients were asked whether they needed any assistance/ referral program for help on any of their responses/ domains |

\*Abbreviations: EHR (Electronic Health Records), CHR (Community health records).

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