

ORIGINAL RESEARCH

How High-Performing Community Health Clinics Accomplish Social Risk Screening

Sara L. Ackerman, PhD, MPH, Holly Wing, MA, Maura Pisciotto, MS, Danielle Hessler Jones, PhD, and Laura M. Gottlieb, MD, MPH

Purpose: Recent national policies encourage health care delivery systems to document patients' social risks (SR), for example, food, housing, and transportation insecurity, and provide referrals to community services. Under-resourced community health centers (CHCs) face challenges integrating SR screening into care delivery. We sought out CHCs with consistently higher-than-average SR screening rates to understand what drives sustained integration.

Methods: This qualitative study used semistructured interviews to collect data about strategies for implementing and sustaining SR screening, staff and patient experiences, and external influences. We recruited 5 CHCs in 3 states with SR screening rates in the top 20% of a large national CHC network. Clinic staff in a variety of roles were invited to participate. Thematic analysis was used for interpretation of interview transcripts.

Results: Interviews were conducted with 27 clinicians and other clinic staff. Responses highlighted both internal and external influences on SR screening. Internally, organization-wide investments in team-based care, longitudinal commitments to quality improvement activities, and capacity to coordinate social services were all cited as key drivers of staff commitment to screening. External influences included Accountable Care Organization incentives, Primary Care Medical Home certification requirements, and support from CHC consortia and external grants. Across interviews, SR screening was framed as a collective endeavor aligned with CHCs' collective mission to serve the whole patient.

Conclusion: CHCs with a sustained culture of team-based care, quality improvement, and care coordination may be more likely to integrate SR screening. Alongside enhanced external supports, investments in these well-characterized and mutually reinforcing building blocks of primary care are likely to translate to sustained SR screening in primary care clinical settings. (J Am Board Fam Med 2025;38:1064–1074.)

Keywords: Community Health Centers, Qualitative Research, Social Determinants of Health, Social Risk Factors, Primary Health Care

Introduction

Although the current federal administration has threatened a course change, a slate of national policies enacted over the last 5 years encourage health care delivery systems to document and address

adverse social conditions experienced by patients, or social risks (SR). In the Health care Effectiveness Data and Information Set (HEDIS), for instance, the National Committee for Quality Assurance (NCQA) has recommended large-scale implementation of SR screening and related interventions.¹ The Joint Commission has included social risk screening and interventions in hospital accreditation assessments, and multiple professional associations have issued guidelines recommending social risk screening and intervention.^{2–8} Though specific definitions of SR vary in different national policies, SR often include food and housing insecurity, social isolation, and other forms of adversity that contribute to poor health.^{9–13} SR are caused or exacerbated by poverty, systemic racism, and structural inequities.^{14,15} Efforts to assess and document whether patients are

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Corresponding author: Sara L. Ackerman, PhD, Department of Social and Behavioral Sciences, 490 Illinois St., Floor 12, Box 0612, San Francisco, CA, 94143 (E-mail: sara.ackerman@ucsf.edu).

experiencing SR include standardized, electronic health record (EHR)-integrated screening tools.^{16,17}

Despite ongoing implementation efforts and investments in SR screening, which is typically the entry point for related interventions, health system uptake of EHR-integrated SR screening tools has been uneven.^{18–21} Recent research points to challenges with uptake and integration that may be particularly acute at under-resourced community health centers (CHCs), despite the higher proportion of patients with SR seen in these facilities. Barriers to screening uptake that have been identified at CHC member clinics include staff concerns about discussing sensitive personal issues with patients, difficulties integrating standardized screening tools with patient-provider conversations about social needs, resource and staff time constraints, limited impact of external financial incentives, and administrative burden.^{22–27} To understand why some clinics are achieving sustained uptake of SR screening, we conducted semistructured interviews with clinicians and other staff at CHC member clinics with consistently higher SR screening rates than other clinics with access to the same EHR tools.

Methods

Our qualitative study design was guided by a pragmatic and flexible approach to aligning research questions and methods, rather than following a particular disciplinary tradition or methodological framework such as ethnography or grounded theory.

Study Setting

This study was conducted with a convenience sample of CHC-based clinics in the OCHIN network. OCHIN, Inc. is a nonprofit organization that provides a single, centrally managed instance of the Epic EHR platform to over 2000 clinics across the US. The OCHIN EHR includes multiple screening questions and standardized tools for clinical team members to document and review patients' social risk information (eg, housing, utilities, food, and transportation insecurity).

We recruited OCHIN-member primary care clinics, prioritizing those with the highest average yearly adult screening rates between January 1, 2021 and March 31, 2022. This “positive deviance” approach enables the in-depth study and characterization of high performance and identification of

strategies for improvement.²⁸ The study team also considered location with the goal of enrolling clinics in multiple states and limiting enrollees to 1 clinic per multi-clinic CHC organization. CHCs were invited through e-mail by OCHIN author MP to participate in the research. Ten CHCs were approached for study participation. Three declined due to competing priorities and 2 did not respond. The study was approved by the home institution's IRB.

Participants

Five clinic sites from 5 different CHC organizations participated in this research. SR screening rates in these clinics were among the top 20% of OCHIN-member community-based clinics with embedded primary care from January 1, 2021 through December 2022. The average screening rate for every 100 adult encounter across similar OCHIN clinics during the same time period was 25.2 [SD = 13.8] for the top quintile, 3.81 [SD = 3.38] for the middle quintiles, and 0.05 [SD = 0.03] for the lowest quintile. At each clinic, the study team scheduled a meeting with a clinic leader to review study activities and identify staff involved directly or indirectly with social risk screening and/or navigation. Clinic leaders provided e-mail introductions between the identified staff and the study team. The study team reached out to each prospective participant by e-mail with an invitation to participate in an interview. See Table 1 for details of participating clinics and staff.

Approach

Semistructured 60-minute interviews were conducted between October 2022 and June 2023 over Zoom video conferencing by authors SA, HW, and LG. All 3 authors have extensive experience conducting qualitative research and leading semistructured interviews. Study team members all have expertise in social care delivery and research and several have lived experience with social adversity. These characteristics contribute to our interest in social determinants of health and ability to conduct in-depth, empathetic interviews on the subject. The interview guide included questions about clinic work processes, SR screening workflows, strategies for implementing and sustaining screening, staff and patient experiences, efforts to use screening results, barriers to screening and strategies used to address them, and external influences on screening.

Table 1. Participating Clinics and Staff

Clinic ID	State	Total Adult Patients during Study Period	Average Screening Rate per 100 Adult Encounters (2021)	Average Screening Rate per 100 Adult Encounters (2022)	Number of Interviews (N)
1	Massachusetts	4633 (2021) 5063 (2022)	70	75	1 Clinician 2 Frontline staff 2 Leadership
2	Wisconsin	4158 (2021) 4178 (2022)	26	37	1 Clinician 1 Frontline staff 3 Leadership
3	California	3737 (2021) 4245 (2022)	29	31	2 Frontline staff 3 Leadership
4	Massachusetts	2914 (2021) 2453 (2022)	22	27	4 Frontline staff 1 Leadership
5	Massachusetts	3623 (2021) 5598 (2022)	19	20	1 Clinician 3 Frontline staff 3 Leadership

All interviews were audio recorded and professionally transcribed.

Data Analysis

Interview transcripts were analyzed using Dedoose, a web-based qualitative data management and analysis application.²⁹ Our collaborative analytic process included both inductive and deductive interpretation and was based on thematic analysis as described by Braun and Clark (2021).³⁰ The first stage involved reading transcripts and developing a set of codes to reduce and organize the data. Codes were based on a priori subjects of interest developed by the research team and on topics that emerged spontaneously in interviews. Two authors (SA, HW) first coded a subset of 4 transcripts independently and then met to discuss differences in coding application. Next, an additional 3 transcripts were coded by

either SA or HW, who reviewed each other’s coding and met to discuss differences in code interpretation and application. Once consistency in coding was established, all transcripts were coded independently by SA or HW. During and after coding, the research team met regularly to discuss the coded data, identify patterns across transcripts, and develop themes. Differences in interpretation were resolved by revisiting and reviewing interview transcripts and discussion of trends and “negative cases.”³¹

Results

Three clinicians, 12 clinic staff, and 12 clinic leaders (n = 27) from 5 clinics in 3 US states participated in 24 individual interviews and 1 group interview with 3 participants from 1 clinic. See Table 2 for participant characteristics.

Table 2. Participant Characteristics

Clinic Role	Description	Number of Interviews (N)
Administrative leader	Chief executive officers, chief operating officers, quality improvement directors, team leads, clinician leaders, and individuals familiar with social risk screening at participating clinic and how screening and referrals were incorporated into practice.	12
Clinician	Physicians and advanced practice clinicians involved in social risk screening/referral and have no administrative leadership role.	3
Frontline staff	Clinical managers, medical assistants, community health workers, care coordinators, patient navigators, social workers, nurse case managers and registration staff.	12

SR screening at all clinics consisted of a clinic staff member presenting a patient with a set of questions either at check in or during a clinic visit. Questions were asked verbally by the staff member or on an article form that patients filled out. The SR-related questions asked varied across clinics but were all entered on the patient's electronic health record via a standardized form. All clinics reported offering screening questions in multiple languages and/or through an interpreter in the absence of language concordance between patient and clinic staff.

Our convenience sample enabled us to achieve thematic saturation through identification of influential internal and external factors shaping SR screening uptake and maintenance across clinics. We define "internal" and "external" based on the Consolidated Framework for Implementation Research's "inner setting" and "outer setting" domains.³² Inner setting refers to characteristics of an implementing organization, and outer setting encompasses external influences such as policies and pressure from peers in networked organizations. Internally, investments in team-based care, quality improvement (QI) efforts, and capacity to facilitate access to social services for patients reporting social risks were cited as key drivers of staff commitment to SR screening. External influences included primary care medical home certification requirements, accountable care organization incentives, and CHC consortia priorities. Across interviews, SR screening was framed as a collective endeavor undertaken in the service of addressing patients' needs. Below we describe each of these areas of influence in detail.

Internal Influences

Clinics Invested in Team-Based Care

All participating clinics operated with "team-based care" models, in which patient-care responsibilities are shared among clinicians, medical assistants (MAs), social workers, and other clinic staff. At some clinics, front desk staff participated in team meetings alongside clinicians and MAs. Interviewees reported that care teams met regularly to discuss both individual patients and practice change initiatives. SR screening was frequently discussed in care team meetings, with topics including the appropriate time and place for screening, strategies to ensure that screening did not interfere with other clinical activities, and how to integrate SR screening with efforts to respond to patient-reported hardships. A

physician and several MAs from one clinic reported that the participation of front desk staff in team meetings had enabled robust discussions about how to mitigate SR screening implementation barriers. Subsequent practice changes had contributed to consistent uptake of SR screening by front desk staff, whose perspectives were described as being "ingrained in [the clinic's] team culture..." (physician, Clinic 4).

Approaching social care as a collective, team-based activity was evident in clinics' approach to SR screening. Across participating clinics, responsibility for implementing SR screening was distributed among multiple members of a given care team, rather than being delegated by leadership to staff in particular roles, for example, MAs. "It is not necessarily from the top down, it is just the whole entire organization" (quality improvement coordinator, Clinic 3), said one participant. Another participant from the same CHC confirmed that implementing SR screening was a team endeavor: "...everybody's really aligned with it and sees the importance" (administrative leader, Clinic 3). This embrace of collaborative work was apparent in the social dynamics we observed during an interview with 3 staff from 1 clinic. In addition notable was the considerable variability across clinics in how and by whom SR screening was conducted during a patient's path through the clinic. The successful integration of screening appeared to hinge on the teams' ability to adapt screening workflows to clinic conditions and patient and staff preferences, rather than their ability to adopt standardized procedures and roles. (See Table 3 for additional quotes illustrating how an emphasis on team-based care contributed to SR screening uptake.)

Though MAs were not solely responsible for social risk screening in most clinics, they nonetheless played a central role in multiple aspects of social care. At several clinics, MAs were involved in decisions about SR screening implementation, including contributing to workflow revisions when screening rates flagged. At one clinic, MAs combined screening with direct assistance to patients, for example, providing information about local resources or making referrals to social workers or community health workers (CHWs). "We have a list of different grocery places that give out free groceries for people in need..." said an MA (Clinic 4). Giving MAs responsibility for SR screening and follow-up was often described as "empowering"

Table 3. Exemplar Quotes

Themes	Quotations
Clinics invested in team-based care	<p>“We’ve been able to implement this more easily because we know who the front desk people are and they’re our friends and colleagues, and we can troubleshoot things in real time.” (Clinician Leader, Clinic 4)</p> <p>“I do think that the culture for the medical assistants (MAs) here has been really empowering. . . [. . .] . . . they’ve given them this ownership of, we need you guys to do the screenings. And you can tell. They take pride in making sure they’re getting the screenings done. [. . .] the MAs really are valued participants of care here. . .” (Clinician, Clinic 1)</p> <p>“ . . . anything that we try new. . . [. . .] . . . everybody sits down with MAs, nurses, providers. [. . .] We have a good teamwork, starting from the front desk to the end of the care coordinator. (MA, Clinic 4)</p> <p>“So everyone’s input and their opinion is heard.” (Registration staff, Clinic 4)</p> <p>“And I’m so happy because I have such an amazing team. We work so close together. . . once we do something we’re like, ‘Okay, what’s the next step to this thing?’” (Administrative Leader, Clinic 1)</p>
Clinics engaged in sustained quality improvement	<p>“ . . . we do a plan-do study act, is what we call it, lots of folks call it, just our typical quality improvement (QI) action. So we did all of our planning for those last four months. . . next week we’ll pull the big group back together again and talk about how’s it going, what’s working, what isn’t working. . . We have draft standard operating procedures (SOPs). And then at the end of that, hopefully about four months from now, we’ll finalize all those draft SOPs and say, okay, go.” (Administrative Leader, Clinic 2)</p> <p>“The way the EHR works is that if it [social risk screening] hasn’t been done in the previous 12 months, we added it to what’s called our health maintenance. . . it pops up and gives an alert saying that the patient is due for that item.” (Administrative Leader, Clinic 3)</p> <p>“Well, before we go into the patient, if I click on the patient’s chart, the popup comes up first because they need an SDOH [social determinants of health screening].” (MA, Clinic 4)</p> <p>“The teams are being asked to do a daily quality metric and set a goal and either have a red sticker if you didn’t meet the goal that day or a green sticker. . . I think some teams have done SDH screening as a quality metric that they’re following on a daily basis.” (Administrative Leader, Clinic 4)</p> <p>“So we do show that performance every month to the MAs, how our overall health center performance is performing, and then their individual performance, mainly just to see [if] they encounter any barriers. . .” (Administrative Leader, Clinic 1)</p>
Link between SR screening efforts and availability of resources for patients	<p>“I have to say, if you don’t have the resource at all, I would hold myself from asking. . . at the same time, if the resource does not exist I don’t want to say let’s not ask. . . I think asking the question and getting the data that we can then demonstrate to the state and the funders, ‘Hey, this is a need. . .’” (Administrative Leader, Clinic 5)</p> <p>“I think for us it’s helpful to only ask the questions we can address. I think we would maybe get pushback or maybe a negative response if we were asking something that we couldn’t help with. Like, maybe we were just being nosy.” (Care Coordinator, Clinic 2)</p>
Primary Care Medical Home certification requirements	<p>“I think [patient-centered medical home certification] it was a huge motivator. It was a really big project to get recognized, so the whole clinic was knowing that change was coming in regards to getting PCMH recognized. So, it was just a time of change in the clinic, and it worked out that people were willing to do the screenings.” (Administrative Leader, Clinic 2)</p> <p>“And the other thing is we’re a patient centered medical home certified. So they make sure too, that we’re doing it, the screenings. They look at certain charts to make sure that the screening is done and the follow up as well.” (Nursing Director, Clinic 1)</p>
ACO incentives and requirements	<p>“ . . . right now the SDOH is a quality measure that the accountable care organization (ACO) looks at. . . we get money if we screen a certain percentage of people. (Administrative Leader, Clinic 4)</p> <p>“ACO community health workers (CHWs) that focused on care management, they are tied to only be able to work with patients who have [type of health insurance]. So we were like, ‘As an organization, we cannot turn a patient away and say, ‘I’m sorry, I’m not going to give you resources, because you don’t have the insurance or the eligibility.’” [. . .] So regardless of the eligibility position for the patient, we will help the patient.” (Administrative Leader, Clinic 5)</p> <p>“ . . . SDOH is one of [the ACO] measures that we have to perform at a certain level, that’s only for ACO patients.” (Administrative Leader, Clinic 1)</p>
Support from participation in CHC consortia	<p>“It’s been huge in the sense that we were part of this SDOH work group with [name of health plan] and they’re really just having us come together, and even though the majority of the other health centers are not on the same EHR, our health record, we have been able to. . . hear out what are other people doing, what might be best practices as far as screening. . .” (Administrative Leader, Clinic 3)</p>
Support from external funding	<p>“ . . . our research and population health department is a grant-funded entity. . . It includes everything from our navigators. . . to community health workers, to our researchers, our pop health coordinators, our QI team, and a bunch of others.” (Administrative Leader, Clinic 5)</p> <p>“I believe we got a grant a little bit over a year ago. So that’s why we’re still working on implementing, on making sure that we’re doing the right thing. So we’re working on having a good workflow basically on this position.</p>

Continued

Table 3. Continued

Themes	Quotations
	<i>Interviewer: And is the grant specifically for a CHW to help with patients' social needs, like housing and food?</i>
	<i>Participant: Yes.</i> (CHW, Clinic 3)
	<i>"There used to be quality dollars that were tied to the frequency of us asking those questions. Those dollars are no longer specified in that way. Instead, they go to a larger pool of grant dollars that we get. So I think that's where it started, was the financial gain."</i> (Administrative Leader, Clinic 2)
	<i>"We hope to utilize the screenings to be able to have data to apply for grants. [...] It's a very well-encompassing form of data to let grant funders know that these are the struggles that our patient population deals with."</i> (Administrative Leader, Clinic 2)

Abbreviations: ACO, Accountable Care Organization; CHC, community health center; CHW, Community Health Worker; SDOH, Social Determinants of Health; SR, social risk.

both because it gave MAs a sense of “ownership” and pride and made them feel that the organization valued their work.

At clinics with less of an emphasis on MA involvement in social care decisions, care teams nonetheless served as an important mechanism for ensuring accountability with screening targets: “. . .we have huddle every morning. . .[the program lead] has told the MAs, ‘Hey, you need to be asking those questions again.’” (clinician, Clinic 2)

Clinics Engaged in Sustained Quality Improvement

Efforts to implement SR screening were also buoyed by organization-level QI efforts. These high performing clinics were already using QI activities to improve care across a range of clinic initiatives. They then harnessed that capacity to support social care practices, engaging in “plan-do-study-act cycles” aimed at improving SR screening rates. For example, all the clinics used screening data as a form of health center-, group- and individual-level performance feedback. Communicating performance metrics on a regular basis functioned as a type of report card or at least a means of initiating conversations among leaders and staff about reasons for lower-than-expected SR screening rates and strategies for improvement. Screening data were also used to prompt discussions about discrepancies in SR screening activities and screening rates represented in clinic records. For example, a [QI director] said: “. . .if the MA says, ‘Oh, well, we are asking everybody about this, but the numbers are not showing.’ It clearly means that there’s a workflow issue, then we have to address it. That is where I come in.” (Clinic 3)

Social care-focused QI activities varied across settings. For example, staff feedback about patient

outreach regularly led to adjustments to screening workflows at one clinic. At another, EHR alerts were employed to indicate to providers when a patient was due for SR screening. Across all participating clinics, both QI and care team commitments helped sustain attention to SR screening among busy providers and staff in a context of multiple competing demands. These structures and processes reinforced an ethos of mutual support and accountability, such that striving to improve screening rates became part of a group effort to support the clinic’s mission and maintain staff cohesion. (See Table 3 for additional quotes illustrating how QI practices contributed to SR screening uptake.)

Commitment to Screening Was Often Linked to Clinics' Capacity to Facilitate Access to Social Services for Patients in Need

Numerous interviewees across participating clinics reported that staff support for SR screening was contingent on the clinic’s ability to help patients with an identified social need, whether by directly providing assistance or by making referrals to community services. Some participants put this in stark terms, indicating that asking patients questions about their social risks felt like a form of moral injury to both patients and providers if a clinic does not have the capacity to provide assistance: “It does not do any good to ask somebody if they are food insecure, if you are not going to offer them resources to help meet that need. It just feels kind of hollow and empty,” said an administrative leader at Clinic 3. This participant explained that she had previously worked at clinics where staff were screening patients, or “checking the box,” without addressing identified social needs. By contrast, she

felt that Clinic 3 was more meaningfully addressing the “missing piece of the puzzle.” “That is the whole purpose” of social care, she said. A contrasting perspective was voiced by one interviewee, who indicated that asking about social needs, even in the absence of services, would produce data that could serve as an important advocacy tool with funders. Implicit in these discussions was the understanding that social care, like clinical care, is most effective when it involves comprehensive and coordinated services.

To mitigate staff concerns about potential harms resulting from asking about difficult life circumstances without the capacity to help, several participating clinics had adjusted standardized SR screening forms to include only questions pertaining to social risks that team members felt could be addressed by the clinic. “We want to be able to have resources in place if we’re asking them,” said one clinic leader (Clinic 2). On the other hand, one interviewee in our study sample reported that it felt useful to ask patients about all SRs even if clinic staff are not able to provide social services immediately. Resources to address the identified need may become available later, said that participant, such that “. . .not asking is missing that opportunity to get something that we might not know (care coordinator, Clinic 4).”

Most participants agreed that the primary goal of SR screening is connecting patients with services. To bolster their social care efforts, and ensure that SR screening led to meaningful assistance and referrals to local organizations, all the participating clinics had actively sought – and often secured – external funding to support their capacity to refer patients to community services and/or provide direct assistance, for example, clothing, transportation, and food.

External Influences

Our findings indicate that SR screening efforts were also shaped by influences originating outside of the clinic. Those mentioned most often were Accountable Care Organization (ACO) incentives, Primary Care Medical Home (PCMH) certification requirements, support from grants and other *ad hoc* sources of funding, and participation in CHC consortia. These activities enabled and supported social care activities, but they also created additional work for staff in some cases.

Accountable Care Organization Requirements and Incentives Influenced Screening

Most participating CHCs were members of ACOs, which are groups of health care providers and organizations that collectively agree to be held financially accountable for the quality of clinic services provided. Three of the 5 participating clinics reported being members of ACOs that prioritized social care. ACO financial incentives rewarded clinics for reaching predetermined SR screening benchmarks, and peer institutions within ACOs provided mutual aid: “We share experiences with each other within [the] ACO. . .whenever we talk, I feel like a lot of clinics [are] try[ing] to move to doing the screenings more often than once a year.” (population health manager, Clinic 1)

Despite its largely positive influence, ACO participation could be a source of tension. ACO financial incentives for screening applied only to patients with select insurance coverage. This forced clinics to choose between sorting patients into screen/do not screen categories or screening all patients while only receiving financial incentives for a subset.

Primary Care Medical Home Certification Requirements Motivated Screening

Staff at 2 participating clinics reported that their CHC was certified as a PCMH. To meet certification requirements, clinics are expected to achieve both required and elective criteria; SR screening was one of the elective criteria selected by one clinic. A patient care coordinator at that clinic described the PCMH certification process as a “huge motivator” to integrate SR screening into clinic workflows (see Table 3 for full quote). (Clinic 2)

Support from CHC Consortia, Grants, and External Partnerships Was Influential

Interviewees at 4 of the participating clinics indicated that their organization was a member of a state-wide CHC consortium. The consortia provide a forum for troubleshooting challenges with SR screening, learning about the social care activities at other CHCs, and “getting feedback not only from health centers, but also other community organizations and ideas of how to better reach and connect to folks. . .” (administrative leader, Clinic 3).

Some clinics also received financial support from the CHC consortia and/or other external grants. Departments of public health and the US Health Resources and Services Administration were most

often mentioned as sources of funding. These funds often enabled clinics to hire CHWs tasked with helping patients access community resources. An externally-funded CHW was able to serve “any patient, regardless of insurance coverage. . .”, a clinic leader told us (Clinic 5), thereby bridging the gap created by their ACO’s selective reimbursement criteria.

Discussion

Staff from 5 clinics with SR screening rates in the top quintile of a national CHC network described both internal and external factors supporting their efforts to integrate social risk (SR) screening into clinical practices. Internal drivers of SR screening in these settings included organization-wide investments in team-based care, longitudinal commitments to quality improvement activities, and capacity to assist patients with identified needs. These 3 key drivers of social care align closely with the seminal work from Bodenheimer et. al on the “10 building blocks of high-performing primary care”³³ (eg, engaged leadership; data-driven quality improvement; team-based care; and comprehensiveness and care coordination), which has been used to explain variations in primary care quality across the US and internationally.

It is perhaps not surprising that primary care clinics successfully adopting and sustaining new practices would already have laid a foundation for high quality primary health care delivery. That said, we believe this is the first study to explicitly link the building blocks of high quality primary care to specific *social care* practices, requirements for which are increasing in both primary and non-primary care settings yet which have not traditionally been well integrated into health care delivery. Though prior work has not directly linked primary care building blocks to social care activities, our findings are nonetheless consistent with other research on social care. For example, recent studies have indicated that QI efforts can increase uptake^{21,34–37} and that implementation is influenced by the ability of the team to both respect and adjust activities based on the opinions of staff at all levels.³⁸ Moreover, commitment to SR screening increases when staff experience the task as aligned with patient-centered care.^{23,39–43} A key takeaway from these collective findings is

that efforts to strengthen high quality primary care generally are likely to influence clinic capacity to implement and maintain social risk screening and related interventions, more specifically. Focusing solely on social care EHR functions (eg, documentation tools) is less likely to increase or sustain screening rates in the context of busy primary care clinical settings.

Though external factors are not described in detail in the essential building blocks model, Bodenheimer et. al³³ nonetheless acknowledge that external factors such as payment reform will also be essential for ensuring high quality primary care in the future. Our findings similarly suggest that internal supports were necessary but insufficient for motivating and sustaining SR screening in the clinics included in our study. External supports that facilitate accountability – such as membership in ACOs, PCMHs, CHC consortia, and external grants – were also essential. The reliance on both internal and external supports resonates with recent research on social care efforts at federally qualified health centers.⁴¹ One study demonstrated that external funding bolstered the availability of social care staff and the perception that their work could meaningfully impact patients’ conditions; at the same time, however, uncertain external funding also undermined sustainability in SR screening.²⁷

Notably, 3 of the 5 participating clinics were located in 1 state, Massachusetts, which had the third highest public welfare expenditures among US states in 2021.⁴⁴ Publicly available information also indicates that 2 of these clinics had engaged in long-term social care research collaborations with academic institutional partners, although these partnerships were not discussed by participants. It is likely that SR screening practices at these clinics have been influenced by collaboration with academic institutions and by state and local policies, funding allocations, and commitments to social welfare, but we are unable to confirm this hypothesis beyond our reported findings.

Limitations

Our findings should be interpreted in light of several study limitations. First, we defined high performing clinics based on average SR screening rates over 2 years. It is possible that SR screening rates would not be sustained over a longer time period in

these clinics. Future work might explore the consistency of SR screening rates as well as the relative impacts of internal and external drivers on sustainability. For instance, the influence of new policies providing financial incentives for screening may vary across clinics that differ in their internal capacity for screening. Moreover, all participating clinics used the Epic EHR platform, which has relatively advanced tools for SR screening compared with other EHRs. It is possible that our findings are less transferable to clinics without comparable technological capability. On the other hand, the variability in SR screening uptake across EPIC-supported clinics suggests that EHR technology is not the only – or even the greatest – influence on screening activities. In addition, both the national and local context for SR screening, and for primary care more generally, is dynamic. The role of internal and external factors today is likely to change over time, which means it will be important to regularly assess the evolving needs of CHCs as they consider additional investments in social care practices. Finally, SR screening is not the end goal of social care, though new standards are often designed around this step in the workflow. Instead, the intent of social care integration is to improve care for people experiencing social barriers to health and well-being. Future research might start by identifying clinics where social care practices have optimized ways to improve patients' social conditions rather than identifying clinics where SR screening has been successfully implemented.

Conclusion

In response to growing policy-level enthusiasm for attending to adverse socioeconomic conditions that interfere with patient health and wellbeing, many CHCs are attempting to standardize social risk screening. Teams from the high performing clinics in our study suggested that factors influencing their success include both internal characteristics as well as a variety of external drivers, such as the national and state policy environment and pressure from peer organizations. Participants underscored that the internal characteristics associated with high adoption are not specific to social care, but instead reflect the same capacities that facilitate high quality primary care more generally. These include capacity for team based care, quality improvement and care coordination. Infrastructure investments in these areas may

therefore have multiplier effects by strengthening both medical and social care delivery.

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