

# Experiences and Perspectives on Adopting New Practices for Social Needs-targeted Care in Safety-net Settings: A Qualitative Case Series Study

Journal of Primary Care & Community Health  
Volume 12: 1–7  
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DOI: 10.1177/21501327211017784  
journals.sagepub.com/home/jpc



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## Abstract

**Introduction:** Clinical settings are being encouraged to identify and address patients' social needs within the clinic or through partner organizations. The purpose of this qualitative study was to describe the current practice of social needs-targeted care in 3 Texas safety net clinics, and facilitators and barriers to adopting new social needs-targeted care tools and practices. **Methods:** Interviews were conducted with staff at 3 safety net clinics serving small and mid-sized communities. Analysis focused on perspectives and decisions around adopting new tools or practices related to social needs-targeted care, including standardized screening tools and community resource referral platforms. **Results:** Nine staff across 3 organizations were interviewed. Two organizations were currently using a standard social needs screening tool in their routine practice, and a third was considering doing so. One organization had adopted a community resource referral platform in partnership with a large community collaboration. Three case studies illustrate a range of facilitators, barriers, perceived benefits, and drawbacks influencing social needs-targeted practices. Benefits of systematic data collection on social needs included the generation of data for community action. Drawbacks include concerns about data privacy. Community resource referral platforms were seen as valuable for creating accountability, but required an influential community partner and adequate community resources. Concerns about disempowering clients and blurring roles were voiced, and potential to increase provider job satisfaction was identified. **Conclusions:** Benefits and drawbacks of adopting new tools and practices related to social needs-targeted care are strongly influenced by the community context. For the adoption of community resource referral platforms, the outer setting is particularly relevant; adoption readiness is best assessed at the community or regional level rather than the clinic system level. While screening tools are much easier than referral platforms for clinics to adopt, the ability to address identified needs remains heavily based on the outer setting.

## Keywords

primary care, underserved communities, access to care, community health, patient-centeredness, practice management

Dates received: 26 January 2021; revised: 31 March 2021; accepted: 23 April 2021.

## Background

Decades of observational epidemiological studies demonstrate relationships between social, economic, and environmental factors—often referred to as social determinants of health—and health outcomes.<sup>1</sup> Strategies to increase healthcare system engagement in the work of addressing social determinants of health are being developed and promoted in clinical care settings as “social needs-targeted care”—activities that identify and seek to address patients' social needs within the clinic or in partnership with community organizations.<sup>2</sup>

Addressing patients' social needs is not a fundamentally new practice, particularly for safety net clinics, which serve a

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substantial share of vulnerable patients.<sup>3</sup> The current movement calls for a more systematic, integrated approach to identifying and addressing patients' social needs, developed, and executed in close partnership with community organizations. To this end, new tools have emerged, including standardized social needs screeners, and technology platforms known as community resource referral platforms (referral platforms).<sup>4</sup>

A growing list of national health organizations, including the National Association of Community Health Centers<sup>5</sup> and the American Academy of Pediatrics,<sup>6</sup> recommend routine screening for social needs in patient populations. A large and growing number of standardized social needs screeners are now available. Topics most commonly included relate to the following 5 social needs: food, utilities, housing, transportation, and personal safety.<sup>7</sup> A 2019 nationally representative survey of US physician practices found that one-third did not screen for any of these 5, and nearly three-quarters screened only for interpersonal violence.<sup>8</sup> Evidence suggests that providers understand the value of social needs screening, but find it logistically and ethically challenging, particularly when unable to easily connect patients with needed assistance.<sup>9,10</sup>

To help address the issue of what to do once social needs are identified, a host of referral platforms are now available to facilitate connection between healthcare and social service organizations. Such technology platforms have the potential to solve some of the major challenges in addressing social needs; namely, keeping up with the details of an ever-changing landscape of social services, and facilitating connections with community partners in a bidirectional "closed-loop" manner. Bidirectional communications allow participating organizations to share client information and ensure that patients' social needs were addressed, thus "closing the loop" on referrals. Screening tools can be integrated into Electronic Health Records (EHR) systems, and EHRs can connect to referral platforms, reducing data entry needs and potentially time from screening to needs addressed. A study of referral platform early adopters identified 3 implementation challenges: engaging partners who can address social needs, managing the processes involved with adoption of new technology and practices, and ensuring necessary data security to ensure privacy.<sup>11</sup>

Many healthcare leaders are actively considering whether and how to enhance their social needs-targeted care, including through standardized social needs screening or utilization of referral platforms. Such work is particularly important in safety-net clinic settings, which care for underserved and vulnerable populations. Documentation of the experiences and perspectives of clinical decision-makers and care providers in safety-net settings is needed to help understand implementation contexts and develop appropriate and effective implementation efforts. The purpose of this qualitative study was to describe the current practice of social needs-targeted care in 3 Texas safety net clinics, and facilitators and barriers to adopting new social needs-targeted care tools and practices. This study builds on previous research by

focusing on smaller safety-net clinics that have not participated in an implementation initiative, and by considering the adoption of referral platforms.

## Methods

Data for this study came from interviews conducted for a larger project of the Texas Health Improvement Network on the current practice of social needs-targeted care in Texas. Interviews included in this analysis were conducted with staff at 3 safety net clinics. Clinics were identified with the help of project advisors, including leadership from the Texas Association of Community Health Centers and the Texas Medical Association. Clinics were selected to illustrate different approaches to social needs-targeted care and variation in adoption of new social needs-targeted care tools and practices. Semi-structured interview guides were based on the study aim and literature on social needs-targeted care implementation. They included questions related to the history and current social needs-targeted care practices, social needs screening tools, and referral platforms.<sup>12</sup> The interview guide is available in the Supplemental Material. Interviews were conducted between November 2019 and March 2020 via phone or video conferencing by the lead author plus one other member of the study team, and were professionally transcribed. Transcripts were analyzed by the lead author in NVivo 12 using a thematic approach that integrated deductive (driven by aims) and inductive (driven by data) analysis.<sup>13</sup> The initial codebook was co-created by the first and second authors, based on the study aim and interview questions, and inductive code development focused on perspectives and decisions around adopting new tools or practices related to social needs-targeted care, including standardized screening tools and referral platforms. Descriptive summaries and themes were reviewed among the authors and with project advisors as well as interview participants to check validity and ensure that they accurately reflected the perspectives and practices of the participating clinics. The study was classified as exempt by the University of Texas Health Science Center at Tyler Institutional Review Board (19-017).

## Results

Nine staff across the 3 institutions participated. Institution characteristics and participant roles are given in Table 1. Two institutions were multi-clinic Federally Qualified Health Centers, and 1 was an independent pediatric clinic. All 3 served patients regardless of their ability to pay. Results are presented as 3 case studies followed by a summary of barriers and facilitators related to adopting new social needs-targeted care tools and practices.

### Case Studies

*Organization A: Rural FQHC with 5 sites.* Organization A works to connect its patients with needed social services in

**Table 1.** Characteristics of Participating Clinics and Roles of Participants.

	Clinic/clinic system description	Interview participants
A	An FQHC* with 5 sites serving 2 rural counties with adult and pediatric primary care, maternity care, behavioral health, ophthalmology, gastroenterology, and dentistry services. The system serves 10 000 patients annually, one third of whom are covered through public insurance or are uninsured.	1. Chief executive officer 2. Director of nursing 3. Case manager/community outreach department lead
B	An independent pediatric clinic serving a mid-sized community with medical and dental care from birth to age 21. The clinic serves from 5000 to 10 000 patients annually, 85% of whom are covered through public insurance.	4. Pediatrician/community centered health home director
C	An FQHC* with 12 sites serving rural and mid-sized communities with pediatric and adult primary and maternity care, behavioral health, and dentistry. The system serves 19 000 patients annually, 75% of whom are covered through public insurance or are uninsured.	5. Chief executive officer (CEO) 6. Chief administrative officer (CAO) 7. Value-based care manager 8. Care coordinator 9. Patient eligibility specialist

\*Designated as a Federally Qualified Health Center by the Health Resources & Services Administration.

much the same way it has since its inception, albeit now with more staff. Social needs are identified through routine care interactions, without a standardized screening tool. Although any staff member may provide a referral, connecting patients to social services is primarily handled by the 4 community health workers. Staff do not use a referral platform, but are very familiar with the available community resources. Referrals are typically given to the patient directly, and patients are encouraged to follow up with the referral themselves, as the CEO describes:

*The majority of the time it's not a formal coded process. The provider, the MA [Medical Assistant], the front staff notifies someone in [community outreach] or elsewhere that someone's in need and we do our best to satisfy that need. There isn't a social service agency that we don't partner with in some way. . . . We know all of them and we work with all of them.*

According to the CEO, one social need that Organization A has worked to address more directly over years is food insecurity:

*We had things like we partnered for a while with an institution where you could purchase food at a very low price. That institution went out of business. We had a community garden that we planted here and gave food out for many years until we just got frustrated because people weren't taking the food.*

The organization had recently incorporated a social needs screening tool into their Electronic Health Records (EHR) system, although the CEO is not sure if or how they will use it:

*We know it's coming, so we went ahead and reached out. Our electronic health record provider had already made the decision [on the specific tool]. So we simply asked them to upload it into our system.*

Recently, the CEO learned that a local Health Information Exchange was looking into organizing community partners to use a referral platform. The CEO was not sure this would be a good use of resources in their community:

*If we're going to get money, that's just not the way to invest it. You're talking about working with people in a rural community. . . hardly any of the social service agencies here have the technology or the capacity to do this. The majority of all those [community organizations] have none of that [technology], and at best are keeping track by paper, if they keep track at all.*

**Organization B: Independent pediatric clinic in a mid-sized community.** Organization B's work to address social needs pre-dates its clinical services, but had recently adopted a more systematic approach to providing social needs-targeted care. According to the clinic pediatrician interviewed:

*We had a food pantry and a clothes closet before we had a medical clinic. . . approximately three years ago we started screening formally for food insecurity using the Hunger Vital Sign. We had previously been asking families whether they were participating in WIC or SNAP or school lunch and breakfast as part of our yearly checkups, but we weren't formally screening for food insecurity. And then about twelve months later we started doing a broader social determinants of health screen.*

Parents are asked to complete the social needs screener at new patient and annual visits while in the waiting room. The provider reviews the results with the family, and shares needs-specific resource sheets with patients. Providers will refer families with urgent needs to the clinic's licensed clinical social worker (LCSW) or social work intern, who may provide counseling and more hands-on help connecting with services.

Organization B's biggest focus for their social needs-targeted care has been to address food insecurity.

*Food insecurity is the easiest loop for us to close internally in that we A, can know if our food pantry served the family. B, we also have a partnership with the food bank where we can actually enroll families in a program where they come to clinic, and for 12 weeks they can get a box of healthy foods and a bag of produce, and receive motivational interviewing-based nutrition education. If they are SNAP eligible, we help enroll them in SNAP. And then our next plan is to have a WIC staff member embedded in our clinic. So we really could feel like we were closing that food loop pretty much as tightly as I think possible.*

The pediatrician knows that food insecurity is not the only social need facing her patients' families, but she sees addressing food insecurity as 1 step toward addressing other social needs.

*If I can get a family who has housing insecurity and food insecurity enrolled in WIC and SNAP, and have them know where they can go consistently to get healthy food at a food pantry, then my hope is this that that relieves some of that strain and they're able to utilize more of their own personal family resources towards one of those other needs that I don't have as great of community-based organization resources for, like housing.*

Organization B does not have access to a referral platform. While the pediatrician saw potential benefits of such a tool, she believed that establishing a referral platform would require leadership of a large, regional institution.

*My small clinic isn't a big enough player. To get a bunch of nonprofits and social service agencies to uptake an electronic platform and to change their workflow? I think it would require buy-in of [one of the regional hospital systems].*

She also expressed concerns about costs and the for-profit status of the companies providing the platforms.

*Maybe this is because I've lived in the world of nonprofit health clinics for a long time, I am really skeptical of platforms like some of the for-profit platforms that charge for organizations to use them. Because I just think how do we get uptake of that when we've got nonprofits that are working on this shoestring budget and clinics that are working on a shoestring?*

**Organization C: FQHC with 12 sites serving rural and mid-sized communities.** In 2017, leadership of Organization C began looking for ways to more systematically address its patients' social needs. According to the CAO:

*We know that our patients have these issues. We've known for a long time and when we started truly investing in trying to find*

*a way, other than sending patients to the food bank, kind of a little helter-skelter way, we decided that we wanted to do an organizational approach.*

The CAO began assessing options for standardized screening tools and referral platforms. A grant for information technology improvements from the Health Resources and Services Administration (HRSA) in 2018 and a partnership with a local United Way were 2 critical catalysts. The clinic system worked with the United Way to vet referral platform options, cover startup costs, and build the referral network. As the CAO described:

*[After receiving the HRSA grant] we thought 'Okay, this is where we're going to really start to address the social determinants.' That's when we reached out to United Way. We just happened to reach out to them when they were looking to replace their 211 system to address community needs. They invited some of their United Way grantee partners to come in and look at them [referral platforms]. We put up all the implementation costs. They put up the training costs. It's been a great partnership. We would not have been able to create a network without the United Way.*

By the fall of 2019, the referral platform was operational, and all the partners had been trained on using the screening tools and the platform. At the time of the interview, Organization C was in the process of integrating use of the new tools into their workflow. Interviewees felt that this new system was a great improvement over the previous method of providing referrals, particularly for accountability.

*In the past, we would refer patients, but we would never hear back whether they actually got the assistance. Now we can actually track it in the system, and everyone's accountable. (CAO)*

We know that these people are in partnership with us. So it's not like we're blindly Googling. (Value-Based Care Manager)

According to the CAO, achieving the goal of all patients being routinely screened, and enough referral options to address identified needs will take time, further investments, and additional partnerships.

*I can't dedicate as much of my time to making sure it's pushed through as I would like. So it's all about staffing. It's all about money to pay another employee the amount of money that we need to really make the process happen. [We are planning to] hire a social determinants of health manager who will not only ensure everybody is being screened, but also work. . .with the community organizations to keep building this network. If there's a way to spread this or duplicate this in [County X]. . .I would like to do that because our patients are coming from a wider area, and the United Way is only committed as the United Way of [County Y].*



**Table 2.** Facilitators/Benefits and Barriers/Drawbacks to Providing Social Needs-Targeted Care and Adopting Standardized Screening Tools and Community Resource Referral Platforms to Support Such Care.

Potential facilitators/perceived benefits	Potential barriers/perceived drawbacks
<p>Screening tools</p> <ul style="list-style-type: none"> <li>Using standardized screening tools generates data for community action</li> <li>Screening tools are triable and adaptable based on experiences and needs</li> <li>Availability through EHR vendor facilitates triability of screening tools</li> </ul> <p>Community resource referral platforms</p> <ul style="list-style-type: none"> <li>Influential/powerful community partner (e.g., United Way, large hospital system)</li> <li>Feedback and accountability of referral platforms</li> <li>Funds to cover referral platform start-up costs</li> </ul> <p>Social needs-informed care</p> <ul style="list-style-type: none"> <li>Helping to address one social need (e.g., food insecurity) can relieve pressure on patients</li> <li>“Burnout prevention”—being able to help address patients’ social needs may lead to greater job satisfaction</li> </ul>	<ul style="list-style-type: none"> <li>Concerns about data privacy/confidentiality</li> <li>Limited staff time/lack of reimbursement for care coordination</li> </ul> <ul style="list-style-type: none"> <li>Limitations of social service organizations (technology, availability, and quality of services provided)</li> <li>Costs (startup and ongoing) of using a referral platform</li> <li>For profit referral platform providers may be perceived as profit-driven and exploitative</li> </ul> <ul style="list-style-type: none"> <li>Concern about potential to disempower clients by doing too much on their behalf</li> <li>Blurring of appropriate roles and responsibilities of healthcare</li> </ul>

### Facilitators and Barriers to Adopting Social Needs-Targeted Care Tools

Table 2 lists all identified facilitators/perceived benefits and barriers/perceived drawbacks of adopting either tool or implementing social needs-targeted care generally. The most salient factors are further described in the text.

**Standardized screening tools.** All 3 organizations had taken action toward adopting a standardized screening tool to varying degrees. Beyond the potential usefulness of such tools to help facilitate social needs-targeted care, interviewees from all 3 organizations mentioned the potential value of aggregating social needs data to understand community problems.

*One of the challenges we have had is for local government to openly admit that there are problems in the community. So any opportunity to collect valid data and present that is going to be invaluable to the people that live here. (CEO, Organization A)*

*We are getting data that we can take to the broader community and say, ‘look how many of our families are struggling with this particular issue.’ (Pediatrician, Organization B)*

One barrier to adoption of systematic screening, specifically the encoding of results into the EHR, was identified by Organization A’s CEO, who expressed concern about the potential for misuse of collected data.

*Anybody could come in, the federal government, the state, whomever could come in and extract that data out of all these individual’s charts. . . at the touch of a hand you’re going to know a lot about people. (CEO, Organization A)*

**Community resource referral platforms.** The most salient theme related to referral platform adoption was the importance of the community context, or outer setting. Clinics can play a leadership role, but cannot establish a referral platform without a larger community coalition or organizing force and well-resourced community partners. The CAO of Organization C succinctly stated, “we could not have done this without the United Way.” The CEO of Organization A did not think their community organizations had the technological or staffing capacity to participate in a referral platform. The pediatrician interviewed from Organization B said her “clinic isn’t a big enough player” to get the needed buy-in from all the community partners.

### Discussion

This study provided a snapshot of social needs-targeted care practice in 3 safety net clinics in Texas and described practice evolution and decision processes. Importantly, these practices have evolved in the absence of an externally led dissemination initiative. Nearly all prior studies have described implementation in clinics that engaged in a funded, researcher-driven implementation study<sup>14-17</sup> or were part of a larger healthcare system initiative.<sup>18</sup> Our study offers a window into the unfacilitated diffusion—or lack thereof—of new social-needs targeted tools and practices into small and mid-sized safety-net clinics, and contributes to the understanding of the adoption of referral platforms, which in comparison to social needs screening has received less attention.

This study extends prior research on barriers and facilitators to the diffusion of social needs screening. A 2021 study of the adoption without external implementation

support of social needs screening among community health clinics identified 3 factors that facilitated implementation: external motivators, an internal advocate, and flexibility.<sup>19</sup> In the 3 clinics included in the current study, the 2 with established social needs screening had strong internal advocates. The third clinic, which only recently had integrated a social needs screening tool into their EHF, did so primarily because of external factors (action by their EHR provider and perception that it was inevitable), and lacked a strong internal champion. This clinic also did not have clear plans to use the screening tool. These findings suggest that an internal champion may be more essential to adoption than the existence of external motivators.

Our study also adds to the literature by illustrating 3 different perspectives on community resource referral platforms. Clearly, and not surprisingly, while referral platforms can greatly enhance the ability of clinics to address identified needs, they are much more difficult than systematic screening to put into place. Only one of the clinics in this study had adopted such a platform and was only able to do so because of a strong community partner and adequate community resources. In fact, this was the only clinic in the state that we were able to identify that had fully adopted a referral platform at the time the study began in 2019. One of the clinics interviewed for this study was clear that their community lacked the necessary capacity to meet identified needs and a referral platform would not be a useful or appropriate investment.

Fortunately, the issue of community capacity to address social needs is beginning to get more attention. A recent study of physician burnout related to addressing social needs found that clinic-level resources were necessary but not sufficient to address burnout.<sup>20</sup> Meanwhile, another recent study on the capacity of community-based organizations (CBO) to absorb health system referrals concluded that a lack of consideration of CBO capacity undermines the success of clinical and social care integration.<sup>21</sup> These studies together with the current study strongly indicate that the limitations of clinics to provide social needs-targeted care independent of adequately resourced community partners and strong collaboration should be given more attention. They also suggest that in many cases community capacity to address social needs must be expanded, particularly in smaller communities.

There are several limitations to this study. First the small number of clinics precluded thematic saturation. Authors were unable to assess how variation in participant roles may have impacted results. Finally, all interviews were completed prior to COVID, and therefore no information about how COVID impacted the work of addressing social needs is available. Subsequent conversations with 2 study participants suggested that COVID increased patients' social needs and use of referrals.

This study demonstrates that systematic social needs-informed care is diffusing into small and mid-sized community clinics, and that the adoption of new tools and practices is strongly influenced by the community context. For the adoption of community resource referral platforms, the outer setting is particularly relevant; adoption readiness is best assessed at the community or regional level rather than the clinic system level. While screening tools are much easier than referral platforms to adopt, the ability of a clinic to address identified needs remains heavily based on the outer setting. These findings suggest that interventions designed to facilitate community partnerships and the adoption of referral platforms and interventions designed to strengthen community capacity to address social needs may be of value. Future studies should explore barriers and facilitators of referral platform adoption and use, the ability of the community organizations to partner with healthcare and to address identified needs, and strategies to support community-wide adoption of referral platforms.

### Acknowledgments

The authors wish to thank the study participants and the Texas Health Improvement Network advisory council for their time and insights.

### Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Episcopal Health Foundation [grant number 3978].

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### Supplemental Material

Supplemental material for this article is available online.

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