

Brief Report

“What Do I Do About It?”: Perspectives about Conducting Health-Related Social Needs Screening and Response from Pediatricians Working at Federally Qualified Health Centers in the United States

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Background and Objectives

Adverse and structural drivers of health (SDOH) create conditions whereby health-related social needs (HRSNs) substantially influence child health outcomes in the U.S. Federally Qualified Health Centers (FQHCs) serve U.S. populations with high social need, yet pediatric HRSN screening and response models are not standardized. We aimed to gain some understanding from pediatricians about their perspectives on HRSN screening and response at FQHCs in the U.S.

Methods

We developed and conducted a qualitative interview study. Pediatricians practicing in FQHCs were recruited through convenience sampling via phone and email outreach to more than 100 FQHCs. Due to low response, recruitment efforts were expanded to include contacting state and county medical societies. After providing informed consent, study participants were interviewed and recorded virtually using a standardized script of questions developed and refined by our research team. Using a constructivist grounded theory approach, interview transcripts were iteratively coded to identify emerging themes. Findings were reported following the Consolidated criteria for REporting Qualitative research (COREQ).

Results

We conducted seven structured qualitative interviews between January 2023-March 2023 with pediatricians practicing in seven different states representing geographically and culturally diverse U.S.-based FQHCs. Despite a very small sample size, the coding team reached consensus that the analysis achieved thematic saturation. Three themes emerged after coding the interview transcripts: (1) perceived support for HRSN screening and response including dedicated staff, community partnerships, and funding; (2) barriers to effective implementation including time constraints, language barriers, and limited social services; and (3) perceived impact on patients including improving wellbeing and strengthening the physician-patient relationship, and on providers including moral distress when social needs could not be met.

Conclusions

Pediatricians working within FQHCs view HRSN screening as essential but insufficient without a robust response infrastructure. Investment in team-based response systems and partnerships with community organizations are critical in addressing HRSNs. These findings from a small sample of pediatric providers working at FQHCs in the U.S., though preliminary insights rather than generalizable conclusions, support the need for larger, more inclusive studies designed to understand patient, staff, and community perspectives to advance identification and response to social needs among patient families. This study highlights opportunities for advocacy by both health systems and pediatric providers to advance policies and practices to effectively address the adverse social and structural SDOH that influence HRSNs.

Advocacy Focus and Impact on Health

How this work impacts health: Pediatric health related social needs (HRSNs) screening and response has the potential to mitigate long-term health inequities. Understanding frontline pediatrician perspectives about the facilitators and barriers to effective HRSN screening highlights the need for investment in workforce, social services, and community partnerships, especially in Federally Qualified Health Centers (FQHCs).

How this paper addresses advocacy/action: Our preliminary findings inform the need to advocate at the local, state, and national level for sustainable staffing models and reimbursement for HRSN activities at FQHCs, and for greater investment in community-based social service providers—since these are the frontline professionals who work to meet these needs. These findings also illustrate the need to incorporate feedback and input from patients and healthcare workers involved in and impacted by HRSN screening.

What this work adds to the field: This brief report highlights pediatricians' voices from U.S.-based FQHCs about the moral and operational tensions inherent in screening for social needs without adequate response capacity. This work also adds valuable insights highlighting the importance physicians place on HRSN screening systems.

Next steps/needed action(s): Efforts to hear from a range of FQHC staff and community-based providers to inform best practices for screening and referral are greatly needed. Findings from expanded qualitative and mixed-methods research can then be used to inform scalable, policy-relevant HRSN screening and response models.

INTRODUCTION

Adverse social and structural factors—including housing shortages, food deserts, neighborhood disinvestment and community violence—are widely recognized as major drivers of health (SDOH) outcomes—or the conditions in which people are born, grow, live, work and age, as well as the systems that shape those conditions as experienced at the population level (Artiga and Hinton 2019; Centers for Disease Control and Prevention, n.d.). Children who experience unmet health-related social needs (HRSNs), or the symptoms of those conditions that are felt at the individual

and family level, such as a housing instability, food insecurity and an inability to afford medications, are at increased risk for adverse physical and mental health outcomes, with effects that can persist into adulthood (Pearce et al. 2019).

Both SDOH and HRSN are considered to have a larger impact on health outcomes as compared to medical care (Woolf 2017); however, the health care system can play a critical role by identifying needs and linking patients and families to services and resources to meet their immediate needs, as well as partnering with community-based service providers to advocate for policy changes that can have a long-term impact on the drivers of adverse health across the lifespan. As a result, identification of unmet social needs among children and families within the health care system represents a critical upstream intervention that can help to prevent and overcome poor health outcomes and health disparities.

Federally Qualified Health Centers (FQHCs), which provide care to populations disproportionately affected by HRSN—largely due to being strategically located in under-resourced communities—have increasingly adopted HRSN screening practices, particularly following the COVID-19 pandemic (Sharac et al. 2022; Cole et al. 2022; McKoy 2022). While pediatric HRSN screening is not mandated in FQHCs, the majority of pediatric practices are screening for HRSNs following recommendations from the American Academy of Pediatrics (AAP) (Coker et al. 2024), since evidence suggests that the presence of children in the home is itself associated with higher rates of household-level HRSNs (Vest and Mendonca 2025). Standardization around HRSN screening varies and is largely dependent on state policy, organizational resources, and reimbursement models (Shah et al. 2025), although the clinical landscape is shifting toward such requirements (Centers for Medicare & Medicaid Services 2021; Hinton and Diana 2024). Nonetheless, variability creates uncertainty for clinicians, particularly those working within FQHCs, who are challenged to implement HRSN screening while navigating limited time, staffing, and community resources (Rudisill et al. 2023).

While professional organizations such as the AAP advocate for pediatric HRSN screening and referral (Gitterman et al. 2016) and the landscape is shifting towards screening requirements, this work is still occurring in clinics—and because it is—robust evidence about what this work entails and how these efforts and their downstream effects are perceived by pediatricians practicing in FQHCs across the U.S. is needed. This exploratory interview study aimed to capture this information to inform future research, practice, and advocacy.

METHODS

We designed a qualitative interview study using a constructivist grounded theory approach (Chun Tie et al. 2019; Delve 2021). The study team, which included an expert in qualitative research methods and analysis, developed, refined, and standardized the interview questions (Table 1). Interviews were designed to be conducted virtually by two researchers and last 15–30 minutes.

Table 1. Health Related Social Needs (HRSNs) Screening Practices at Federally Qualified Health Centers (FQHCs) in the U.S.: Demographic and Interview Questions to Assess Perceptions of and Capacity to Identify and Respond to Unmet Social Needs

Demographic Questions
1. In what state are you located?
2. What is your role in the FQHC where you work?
3. How many years have you practiced pediatrics at your FQHC?
4. Approximately how many pediatricians or pediatric providers (Nurse Practitioner, etc.) does your organization employ?
5. Can you give me a sense of the average volume of pediatric patients at this practice site in terms of visits per year?
6. Would you consider your organization serves a rural population, urban population, or a combination of both?
Interview Questions and Prompts
1. Does your organization have a standardized screening process for addressing drivers of health or health related social needs for pediatric patients seen at your clinic? These needs can include housing, food insecurity, utilities, transportation, and interpersonal safety, to name a few. a. If YES, please describe the process (Who is screened? What screening tool is used?, Is there a standard workflow?, What response/referral is initiated?) b. If NO, does your clinic have a process for assisting pediatric patient families with such needs (housing, food insecurity, utilities, transportation, and interpersonal safety) if information of such needs is disclosed to a provider? For example, a process can include referral, connection with community resources, planned follow-up, etc. c. If NO, is your organization considering adopting a standardized screening process for pediatric visits for addressing drivers of health or health-related social needs?
2. Is a specific member of the care team responsible for responding to a patient's drivers of health or health related social needs? a. If so, who? This can include a Physician, Nurse Practitioner or Physician's Assistant, Nurse, Community Health Worker, Social Worker, or other.
3. To what degree do you think it is beneficial to screen for pediatric patient drivers of health or health-related social needs? 1- Not at all beneficial, 2- slightly beneficial, 3- moderately beneficial, 4- quite beneficial, 5- extremely beneficial. Please explain your response.
4. What barriers exist to successfully screen for and address drivers of health or health-related social needs in the pediatric patient population you serve? a. Are there organizational, local, or state-wide barriers to addressing drivers of health? Explain.
5. Are you aware if your organization receives any additional resource support for responding to individual pediatric patient drivers of health or health-related social needs? This can include state funding, insurance funding, grants, staff funding, dedicated staffing, etc. Please explain your response.
6. Do any relationships between your organization and community organizations exist to address pediatric patient needs related to drivers of health or health-related social needs? a. If YES, what types of community organizations do you work with? b. If YES (i.e., relationships with community organizations exist), how are they structured into the workflow or patient navigation process? c. If YES, how do patients access these resources and does any follow up with the care team exist?
7. Is there anything I did not ask today which you feel would be helpful for me to know?

Pediatricians practicing in FQHCs were recruited through convenience sampling via phone and email outreach to more than 100 FQHCs identified through the Health Resources and Services Administration database (Find a Health Center, n.d.). After low initial response, recruitment efforts were expanded to include contacting state and county medical societies to connect with FQHC leadership within their geographic areas.

Individuals who agreed to be contacted were scheduled for a phone or Google Meet interview. Before completing the interview, potential participants were asked to provide verbal informed consent for recording the interview responses and analyzing the transcripts. The Institutional Review Board (IRB) at The University of Texas, Austin, deter-

mined the study to be exempt from IRB oversight due to this being a survey study in which the identity of the participants could not be readily identified, and their responses would not pose any additional risk to their daily lives.

For data analysis, responses to Yes/No and Likert Scale questions were analyzed and reported. Interviews were transcribed using Transcripts with Google Meet and anonymized. Interviewees were not sent their transcripts for review and verification. Transcripts were coded independently by two team members using an iterative process. Coding discrepancies were resolved through discussion, with input from a designated content expert when needed. Themes were identified through team consensus. For re-

Table 2. Health Related Social Needs (HRSNs) Screening Practices at Federally Qualified Health Centers (FQHCs) in the U.S.: Participant Demographics and Site Characteristics

Participant and Site Characteristics	n (%)
Role in pediatric FQHC	5 (71%) Pediatrician 2 (29%) Pediatrician/Medical Director
Years practiced in pediatric FQHC	3 (43%) 5 to 10 years 3 (43%) > 10 years 1 (14%) No Response
Fluency in another language	2 (29%) Yes, Spanish 4 (57%) No 1 (14%) No Response
Trainees (medical students and residents) practicing in FQHC	6 (86%) Yes 1 (14%) No Response
Number of pediatricians employed in FQHC	4 (57%) < 10 3 (43%) > 10
Number of pediatric patients per year	5,000-9,999 (28.5%) 10,000-19,999 (43%) 20,000 + (28.5%)
Location of FQHC	1 (14%) Rural 3 (43%) Urban 3 (43%) Combination
FQHC located in a state with Medicaid expansion	5 (71%) Yes 2 (29%) No

porting the findings, we adhered to the Consolidated criteria for REporting Qualitative research (COREQ).

RESULTS

PARTICIPANTS AND SETTINGS

Interviews were conducted with seven pediatricians representing FQHCs in Alabama, Arizona, Hawaii, Michigan, Nebraska, Texas, and Virginia, respectively. Interviewees varied in terms of their years in practice, the clinic size and geographic setting of the FQHC where they practice, and the Medicaid expansion status of the state in which the FQHC is located ([Table 2](#)).

In response to the initial interview questions, interviewees indicated that HRSN screening is currently being conducted at their FQHCs (100%), HRSN screening is beneficial (100%), providers are aware of resources to support HRSN screening (100%), and their FQHCs have relationships with local organizations that can provide support services (86%) ([Table 3](#)).

EMERGENT THEMES FROM INTERVIEWS WITH PEDIATRIC PROVIDERS

Even with a very small sample size, our analysis of the interviews achieved thematic saturation based on the lack of new code emergence from the first to the last interview. These findings are presented as preliminary.

Interview transcript analysis revealed three major themes: 1) perceptions of support for HRSN screening and response; 2) barriers to successful HRSNs screening; and 3) impact of screening for HRSN on patients and providers.

SUPPORT FOR HRSN SCREENING AND RESPONSE

Participants emphasized that screening was most meaningful when paired with dedicated staffing—particularly community health workers, case managers, and care coordinators—and strong community partnerships. Co-located services, such as food pantries, were viewed as especially impactful. Stable funding was seen as foundational to sustaining these support systems. Overall, interviewees saw the need and value of HRSN screening and did implement some screening and referral practices, though not all locations had dedicated staff or funding.

“Our current model [...] varies a bit... But there are clinics where the community health worker would definitely be that person [...] But then there’s other places where that wouldn’t be, and so maybe the provider takes the lead on it.”

“We have a child advocacy center co-located within our office, so they address any children who are victims of child sexual abuse. [...] We also have behavioral health staff on site, so when it’s a behavioral health issue, we can refer directly to our own behavioral health staff as well as a pediatric psychiatrist on staff.”

“I believe we do get some reimbursement from insurance companies if we meet certain measures of screening a certain number of patients, so that helps us to be able to afford the staff that manages them.”

BARRIERS TO EFFECTIVE IMPLEMENTATION OF HRSN SCREENING

Time constraints were the most frequently cited barrier, affecting both clinic workflows and patient experience. Participants also identified language barriers, inadequate interpretation services, and limited availability of culturally

Table 3. Health Related Social Needs (HRSNs) Screening Practices at Federally Qualified Health Centers (FQHCs) in the U.S.: Presence of Screening Process and Supports

Health Related Social Needs (HRSNs) Screening and Referral Process	
Question	Response
Screening process for HRSN, Y/N	7 (100%) Yes
If Y, Who Screens Tool Used	Who: Community Health Workers, Social Worker, Physician, Volunteer, Behavioral Health Specialist Tool: Unknown, Food Insecurity Screener, Adverse Childhood Experiences (ACE) Questionnaire
Beneficial to screen (scale: 1-5; 1- Not at all beneficial, 2- slightly beneficial, 3- moderately beneficial, 4- quite beneficial, 5- extremely beneficial)	6 (86%) Extremely beneficial 1 (14%) Quite beneficial
Awareness of resources to support response to HRSN, Y/N	7 (100 %) Yes
Relationships with local organization who can address HRSN, Y/N	6 (86%) Yes 1 (14%) No

appropriate screening tools. Language barriers highlight a discrepancy between physician language fluency and a wide range of spoken languages among local populations (Table 2). Further, local structural shortages in housing and social services constrained clinicians' ability to effectively refer patients and families to meet their identified needs.

"We don't have the time to give the additional help we need plus the screenings we do."
 "The amount of different dialects and languages that are spoken is very hard to keep up with. We're up to having our forms available in something like 18 languages, but it's not enough."
 "If you had to ask at a statewide level, housing is the biggest problem [...] Some of my patients are sleeping 24 people to one bedroom."

IMPORTANCE AND IMPACT OF HRSN SCREENING ON PATIENTS AND PROVIDERS

Pediatricians were well versed on the impact of HRSNs on the overall health and poor health outcomes of their patient populations. They described the importance of addressing the health drivers that are impacting their well-being, including systemic and structural factors. Their responses reflect a deeper understanding that the physician-patient relationship cannot be understated as creating an environment where families can feel heard in their concerns and needs.

"If we don't first ensure that the patient has a healthy, safe lifestyle, we can't expect to have any impact on their health."
 "Creating a space where people feel comfortable sharing that they have a need, whatever that need is [...] creating that space and giving people the opportunity to share what is happening in their life that's impacting them, which therefore is impacting their health and their children's health is important. And even if you don't have an answer for them [...] that's meaningful."
 "We don't live in a society where there's structure for [screening] to be happening regularly in other places, and so we are [...] needing to step into that space, and it's necessary."

Pediatricians also expressed a strong sense of responsibility to address social needs and viewed HRSN screening as an essential component of holistic care. However, they emphasized that screening without adequate response capacity contributed to moral distress and burnout, particularly when clinicians repeatedly identified needs that could not be resolved.

"Then you get to, you know, the proverbial "What do you do?" So, I'm asking all these [screening] questions and now what do I do about it."
 "I think it adds to [...] people's feeling of burning out, and moral injury, and all of that, when you are uncovering all of these hardships and difficulties, and you don't have anything to offer. [...] It's really hard to do that day in and day out. Like ask all these questions, find out all this information, and not really have anything to give people."

DISCUSSION

This brief report presents preliminary findings of a qualitative interview study to gather insights from pediatricians about their experiences with and perspectives about HRSN screening and response at FQHCs in the U.S. Although the study's sample size was small, these preliminary findings should raise new questions for future studies that could look to assess differences in interviewee responses from those working at rural vs. urban sites, providing care in states with/without Medicaid expansion, and/or by size, patient population and staffing ratios, language fluency of providers and availability of interpretation services, and whether sites have trainees who can be integrated into the HRSN screening process. As HRSN screening is starting to become mandatory (Centers for Medicare & Medicaid Services 2021; Hinton and Diana 2024), this data could help to support larger studies to build an even stronger case for pediatric HRSN screening since it will be important to understand not only the effectiveness of different implementation models but also the perspectives of those who implement and engage in them.

Interviewees uniformly endorsed the importance of identifying social needs among their pediatric patients and

families, yet emphasized that screening alone is insufficient and potentially harmful when unaccompanied by meaningful interventions. Consistent with prior literature (Sokol and Miller 2023; National Association of Community Health Centers 2023; Kangovi et al. 2020; 2017; Beidler et al. 2023), respondents highlighted the value of team-based care models and community partnerships. Community health workers were repeatedly identified as critical to bridging clinical and social care, aligning with evidence demonstrating their effectiveness and return on investment (Kangovi et al. 2020; 2017).

Interviewees agreed about the importance of conducting HRSN screening and providing on-site response and/or referrals based on the findings, and the majority of interviewees reported conducting screening and having some staff support and community partners who they can refer to, though this was limited by time and funding for this work. These pediatricians did not need to be convinced about the value of HRSN screening, but without time, resources, staff and places to refer for needed services and support, a key question that emerged was—what can they be expected to do?

While our interview questions were primarily focused on gaining the perspectives of the interviewees themselves, interviewees often responded to our questions in terms of how they felt the screening process impacted patient families. This included taking too much time during the clinic visit, and language and cultural issues. This focus on patient families emphasized that systematic changes are needed to make screening easier and understandable in multiple languages and ensure that screening is worthwhile for them—meaning that if needs are identified, resources are provided and accessible. These responses further highlight the importance of hearing directly from patients and families about how providers can achieve these aims, which can be explored in future studies.

Importantly, the findings from this study also underscore the emotional toll of this work on pediatricians. Interviewees shared that moral distress emerged when clinicians felt compelled to ask about social needs without the resources to respond, an experience that may contribute to workforce burnout and retention challenges particularly in these safety-net settings (Henrich et al. 2017; Gottlieb et al. 2024). Beyond screening, FQHCs could look to track data on HRSNs. For example, high rates of food insecurity should inspire clinics to partner with—not just refer to—community-based service providers or state and national coalitions to leverage this data to advocate for better food access policies, resulting in longer lasting structural change. While some sites do create onsite food pantries, more of this work could help to relieve more of the moral distress that providers feel because it can increase linkages to services for their patients and improve the underlying SDOH that lead to HRSNs, which could thereby lead to long-term improvements in the lives of their patients, families, and the communities in which they live and work.

This study had several limitations. The very small sample size and low response rate limit the representativeness and generalizability of the findings and indicate an inability

to draw conclusions about a national perspective on HRSN screening and response amongst pediatric providers working in FQHCs. Incentives and compensation were not offered, which likely contributed to a small sample size. While interview analysis reflected thematic saturation, this may have been due to participants being more engaged or interested in HRSN screening than non-respondents; however, the published literature on this topic reflects similar perceptions and challenges (Rudisill et al. 2023). Accordingly, these findings should be interpreted as exploratory and hypothesis generating rather than definitive.

In addition, we only interviewed pediatricians; patients, families, and staff voices are needed to gain a more comprehensive understanding of the need for and impact of HRSN screening and referral at FQHCs in the U.S. Because interviewees' responses frequently mentioned community health workers, social workers, case managers, care coordinators, and community partners, their perspective should be sought and included in future studies. Overall, future studies should aim to incorporate larger sample sizes and diverse stakeholder perspectives, examine state-level policy variation, and evaluate specific screening-response models to better understand which are most effective and feasible in what settings. Despite these limitations, this study represents an initial step to bring attention to key considerations for future research, policy, and advocacy related to efforts to conduct HRSN screening in FQHCs.

IMPLICATIONS FOR HEALTH ADVOCACY AND FUTURE DIRECTIONS

By centering frontline pediatrician experiences, the preliminary findings from this study contribute to ongoing conversations about how health systems can more effectively—and ethically—identify and work to address the drivers of child health. Based on our findings, efforts to advocate for mandatory HRSN screening in FQHCs should focus on prioritizing sustainable funding, workforce support, and investment in social services alongside a clinical screening mandate, which might be expected to be paired with funding that supports dedicated staff and time.

When time, resources and funding are available, screening patients for HRSNs during a clinic visit can lead to immediate responses to problems affecting care and health outcomes through referrals to community-based service providers. However, these are most often short-term fixes that do not lead to the type of systemic change needed to address SDOH. In addition to partnership with local community-based organizations, health care systems including FQHCs can work to address these by partnering with local governments on community development and affordable housing projects, conduct and use community health needs assessments (CHNAs) to guide investments, and advocate for policy change at various levels. This type of advocacy could change the environments that create high levels of social need for their patients and families.

While the original impetus for this study was to understand provider perspectives about HRSN screening at FQHCs in the U.S. that could be applied to improve patient and family health outcomes and provider wellbeing, both

the process and the findings support further multi-sector research to determine optimal ways to increase pediatric HRSN screening and response. A natural next step would lead to an increase in advocacy for action on the SDOH to decrease HRSNs.

We encourage continued efforts to incorporate diverse voices in HRSN research and to highlight innovative models that improve systems to effectively address HRSNs.

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AUTHOR CONTRIBUTIONS

RL conceptualized and developed the study design. RL and RP participated in data acquisition. LW provided expertise in data analysis and qualitative methodology. MG contributed to study design and provided additional qualitative resources. All members of the study team contributed to the development of the interview script, data analysis, and thematic analysis and interpretation. All authors participated in preparing the initial manuscript and its first revisions. RP and RL critically revised the final version. All authors approved the final version to be submitted for publication and are responsible for the accuracy and integrity of the content.

DECLARATION OF COMPETING INTERESTS

The authors have no competing interests to declare. The funder had no role in the study design; in the collection, analysis, and interpretation of data; in the writing of the report; or in the decision to submit the article for publication.

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