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Original Research

Community Health Center Staff Perspectives on Financial Payments for Social Care

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Policy Points:

- State and federal payers are actively considering strategies to increase the adoption of social risk screening and interventions in health care settings, including through the use of financial incentives.
- Activities related to social care in Oregon community health centers (CHCs) provided a unique opportunity to explore whether and how fee-for-service payments for social risk screening and navigation influence CHC activities.
- CHC staff, clinicians, and administrative leaders were often unaware of existing financial payments for social risk screening and navigation services. As currently designed, fee-for-service payments are unlikely to strongly influence CHC social care practices.

Context: A growing crop of national policies has emerged to encourage health care delivery systems to ask about and try to address patients' social risks, e.g., food, housing, and transportation insecurity, in care delivery contexts. In this study, we explored how community health center (CHC) staff perceive the current and potential influence of fee-for-service payments on clinical teams' engagement in these activities.

Methods: We interviewed 42 clinicians, frontline staff, and administrative leaders from 12 Oregon CHC clinical sites about their social care initiatives, including about the role of existing or anticipated financial payments intended to promote social risk screening and referrals to social services. Data were analyzed using both inductive and deductive thematic analysis approaches.

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Findings: We grouped findings into three categories: participants' awareness of existing or anticipated financial incentives, uses for incentive dollars, and perceived impact of financial incentives on social care activities in clinical practices. Lack of awareness of existing incentives meant these incentives were not perceived to influence the behaviors of staff responsible for conducting screening and providing referrals. Current or anticipated meaningful uses for incentive dollars included paying for social care staff, providing social services, and supporting additional fundraising efforts. Frontline staff reported that the strongest motivator for clinic social care practices was the ability to provide responsive social services. Clinic leaders/managers noted that for financial incentives to substantively change CHC practices would require payments sizable enough to expand the social care workforce as well.

Conclusions: Small fee-for-service payments to CHCs for social risk screening and navigation services are unlikely to markedly influence CHC social care practices. Refining the design of financial incentives—e.g., by increasing clinical teams' awareness of incentives, linking screening to well-funded social services, and changing incentive amounts to support social care staffing needs—may increase the uptake of social care practices in CHCs.

Keywords: social risk screening, community health centers, community health workers, financial incentives.

A growing body of evidence indicates that social and economic conditions—including food, housing, and transportation insecurity—shape health care access and behaviors. This has led health care systems to ask about and increasingly attempt to address patients' social risks in the context of care delivery with the goal of improving health and reducing health care costs. Collectively, health care activities to identify and intervene on social risks or to otherwise mitigate the impacts of social risks on health and health care use are increasingly referred to as "social care" initiatives.[1]

Community health centers (CHCs) face unique facilitators and barriers to incorporating social care activities. The CHC movement was founded in the 1960s as part of the War on Poverty[2]; as such, many CHCs share a commitment to caring for socially and economically marginalized populations. This commitment and related federal mandates for CHCs have meant that many of these clinics were early adopters of social risk screening,[3,4] and most provide multiple enabling services (services such as transportation, translation services, food aid, and other social services).[5] CHCs also contend with high staff turnover, chronic understaffing, and budgetary constraints, however, barriers that were exacerbated during the COVID pandemic and together may make it difficult to sustainably provide well-integrated social and medical care services.[6]

Prior research on social care in CHCs and similar safety-net primary care settings has found that interdisciplinary teams [including social care staff such as social workers and community health workers (CHWs)] and technology tools [e.g., social screening tools embedded in electronic health records (EHRs)] facilitate social

risk screening and interventions.[7–11] Other research has shown that staff training, dedicated team workflows (e.g., assigning staff to perform screening activities), and quality improvement initiatives (e.g., plan-do-study-act cycles) also can influence uptake.[12–17] In parallel, several recent studies have underscored that lack of time and lack of adequate resources continue to be important obstacles to social care adoption in busy safety-net primary care clinics.[7,18–23] None of the existing research on social care implementation has explicitly examined the influence of fee-for-service payments on the adoption of social care practices in safety-net settings. Related research, however, has suggested that participation in value-based payment models (e.g., Accountable Care Organization participation) has not spurred investments in or uptake of social care as much as originally anticipated, even in settings serving low-income patients.[24,25]

Because financial incentives for social risk screening and navigation to social services are emerging in an increasingly wide array of state and federal initiatives—e.g., programs from the National Commission for Quality Assurance and the Centers for Medicare and Medicaid Services (CMS) that will affect health plans, hospitals, and other care delivery systems—it is an opportune time to explore the influence of financial incentives on social care practices. In this paper, we present the perspectives on fee-for-service payments as well as more generally on financial incentives for social care from CHC administrative leaders, clinicians, and frontline staff working in Oregon clinics participating in one or more social care implementation initiatives and all of which concurrently served patients potentially eligible for state Medicaid-funded social services.

Methods

Study Setting and Design

Beginning under a state Medicaid waiver in 2012 and extended in 2017 and 2022, the Oregon Health Authority (OHA, Oregon's Medicaid agency) granted flexibilities to the state's coordinated care organizations (CCOs, a novel blend of accountable care and managed care organizations) to fund a range of services to address beneficiaries' social needs. OHA's "Flexible Services" program enables CCOs to pay for services outside traditional health care services if such expenses could improve health outcomes and reduce spending growth. Both CHCs and other health care providers across Oregon can request that CCOs cover social services for CCO members, including services such as housing rental assistance, cell phones, nonmedical transportation, clothing, or employment services.[26] Although there is no guarantee that requests for services will be approved, a 2017 report on the waiver suggested that CCOs approve a high share of the total requests received.[26] Nonetheless, evaluations of the Medicaid waiver programs have indicated that the overall uptake of flexible services has been lower than anticipated; as of 2019, flexible services spending was only 0.36%

of total member spending.[27,28] In 2023, OHA also launched a new social risk screening incentive under its health plan pay-for-performance metrics that will be tied to payment in future years. Although the quality metric was not live at the time of the interviews conducted during this study and is specifically targeted to CCOs, the state metric development process spanned several years and included many different Medicaid-serving partners, including CHC leaders from around the state.

Against this backdrop, two large pragmatic initiatives focused on social care implementation were introduced in select Oregon CHCs between 2016 and 2018, each lasting 3 to 5 years. The concurrence of these efforts in the Oregon Medicaid context provided a unique opportunity to explore the impacts of financial incentives on the uptake of social care practices in CHCs.

One of these large implementation initiatives was the CMS Innovation Center's Accountable Health Communities (AHC) demonstration, which began in 2016 and initially supported 32 health systems across the United States to develop and test a model of social risk screening and navigation for Medicare and Medicaid beneficiaries.[29] In Oregon, the AHC grantee provided financial payments to all participating clinical sites (not all of which were CHCs) for each social screening completed with Medicare or Medicaid patients ($10 per screening during the first year of participation; $2 per screening for the subsequent 30 months of the demonstration). Screening questionnaires used in each AHC-participating site included a core set of questions provided by the funder to assess housing, food, transportation, utilities security, and interpersonal violence.[30] Participating sites also were eligible to receive an additional $100/client for providing up to 12 months of navigation services to clients endorsing social risks. Eight AHC clinical sites were CHCs that provided primary care. Seven of these CHCs agreed to participate in this study. All AHC CHCs developed internal lists of community resources. The Oregon AHC grantee additionally provided participants access to an online platform in which social risk screening data documentation prompted a report containing a list of community resources tailored to each patient's screening results.

A second pragmatic trial related to social care (Approaches to CHC Implementation of SDH Data Collection and Action [ASCEND]) was launched in 2018 by OCHIN (not an acronym). OCHIN is a nonprofit health care innovation center that offers a fully hosted, highly customized instance of Epic practice management and EHR solutions to over a thousand care delivery sites across the United States. The OCHIN ASCEND study provided 26 clinical sites (not all based in Oregon and not all providing primary care) 6 months of implementation supports to facilitate clinic uptake of relevant EHR tools that were also available to all OCHIN clinics. The EHR tools have been described in previous publications[31,32]; they included tools for identifying patients due for social risk screening, documenting and reviewing screening results, and ordering social service referrals.[33,34] The EHR infrastructure (including the screening tools but also patient social risk summaries and population-level

data dashboards) was available to all OCHIN member clinics and remained available after the ASCEND study ended. The implementation supports specific to the ASCEND trial included practice coaching in how to use or adapt these tools in clinic workflows. Participating clinics were encouraged to select from a range of social risk screening questions already available in the OCHIN EHR platform, including questions from the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool (Prapare.org)[35] and the AHC demonstration project's approved screening questions (see Appendix).[30] No financial payments were provided directly to clinics participating in the ASCEND trial based on the number or quality of social risk screenings conducted.

CHCs participating in the Oregon AHC and ASCEND projects incompletely overlapped, which enabled us to study the impacts of the two models and thereby better explore the array of supports needed for launching and sustaining social care activities. For this study, eligible clinics were Oregon-based OCHIN-member CHCs with embedded primary care and involvement in one or both of the two initiatives.

Participants

Fourteen OCHIN-member CHC clinic sites were eligible for this research. Participating clinics were targeted for study recruitment 9 to 12 months after the site's implementation of AHC or ASCEND in the case of clinic sites participating in only one initiative or 9 to 12 months after the implementation of the second initiative in the case of clinic sites participating in both initiatives. Clinic enrollment in each program also was staggered. AHC program implementation occurred gradually after the program's launch, and ASCEND implementation was conducted in several waves.

Twelve clinics agreed to participate. Five of the 12 clinics were involved in the ASCEND study only, three were involved in the AHC only, and four clinics were involved in both ASCEND and AHC. All participating clinics participated in either or both of the ASCEND and AHC programs between September 2018 and April 2022, although start and end dates varied based on the program. All clinics except one were part of larger, networked CHCs, which meant that 11 of 12 clinics acted under a network administrative leadership team located outside of the clinical delivery setting, although a clinic-specific leadership team also sat inside the delivery setting. Clinics were at various stages of implementation at the time of the staff interviews; clinics in the ASCEND project had already received 6 months of implementation supports through the trial's intervention. Those participating in AHC were still eligible to receive financial supports at the time of the interviews. All clinics used the OCHIN EHR Epic platform, which meant that at the time of the interviews, all had access to the EHR-based technology supports for social care that OCHIN had made available to all members, including EHR social risk screening summaries and dashboards.[32]

Table 1. Participant Characteristics

Clinic Role	Description	Number of Interviews (*N*)
Administrative leader	Practice managers, 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	17
Clinician	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	22

Additionally, all clinics could refer CCO-enrolled patients to the CCO to apply for support for social services under the OHA Flexible Services program.

After agreeing to be involved in this research study, clinic leaders were asked to identify a social care "clinical champion" (e.g., practice manager, quality improvement director, administrative leader) in their setting. The champion was interviewed in each participating clinic and then asked to suggest two to four additional informants involved directly or indirectly with social risk screening and/or navigation at their respective health center whom they thought should be approached as study key informants. Participants ultimately included both administrative and frontline clinical staff (e.g., clinical managers, medical assistants, CHWs, care coordinators, patient navigators, social workers, and registration staff) and clinicians (e.g., physicians and advanced practice providers). See Table 1 for detailed participant characteristics.

Data Collection

Semistructured interviews with all study participants were conducted between November 2020 and December 2021. Although key informant recruitment was delayed in six clinics secondary to the COVID pandemic and state wildfire emergencies, the AHC-participating clinics continued to be eligible to receive fee-for-social-care-services payments throughout the study period. An interview guide was developed to elicit participants' views of organizational efforts to understand and address patients'

social risks, understanding of processes related to social risk screening and referrals in their clinic settings, and experiences with the AHC and ASCEND programs—including specific questions related to financial and other incentives designed to increase uptake. Interviewees from clinics participating in AHC were asked about their understanding of current AHC-sponsored fee-for-service payments, other existing incentives for social care, and how any incentives influenced existing social care workflows. Interview guides also included a question about the participant's perception of the hypothetical role for social care incentives. Interviewees from ASCEND-only participating clinics were asked about any exposure to incentives for social care and their influence on current practices, as well as the same question about the hypothetical role for social care incentives. All participants provided informed consent. Interviews took place virtually using Zoom video conferencing, lasted approximately 60 minutes, and were audio recorded. All interviews were professionally transcribed. The research was approved by the University of California, San Francisco's Human Research Protection Program. Access to study data is limited because OCHIN research agreements are designed to protect clinic anonymity.

Data Analysis

Interview transcripts were compiled and analyzed through Dedoose, an online qualitative data management and analysis application (https://www.dedoose.com/). The first phase of analysis involved reading transcripts and developing a set of codes to organize the data. Our "integrated approach" to coding focused on deriving deductive codes from a list of topics of interest to the research team a priori and developing inductive codes to capture topics that emerged spontaneously in interviews.[36] After developing a codebook, at least two members of the research team coded each transcript. Differences in coding were compared and discussed until consensus was reached.

The overarching findings from the qualitative analysis have been published elsewhere.[37] The current analysis examined a subset of codes and coded interview data identified during the original analysis related to "External Financial/Material Support" and/or "Recommendations for improving screening/referral"—including informants' comments about existing and ideal incentive scenarios. In this deep dive on financial incentives, two research team members reviewed the original data related to incentives and iteratively developed incentive-specific subcodes: knowledge of incentive, content of incentive, allocation of incentive, and impact of incentive. The research team met regularly to discuss the related subcodes and to resolve any differences in understanding and interpreting those subcodes. This collaborative process of data analysis involved both inductive and deductive interpretation and was based on thematic analysis as described by Boyatzis and further developed by Deterding and Waters.[38,39]

Results

A total of 42 CHC administrative leaders, clinicians, and frontline staff members from 12 CHC clinics participated in interviews. Nineteen interviews were conducted with participants from the seven clinics eligible to receive fee-for-service payments for social risk screening and navigation services provided as part of the AHC demonstration; 23 interviews were conducted with participants from 5 clinics that had received 6 months of implementation supports for social screening and navigation as part of the ASCEND program but no fee-for-service payments through the AHC program. Clinics ranged in size, serving 700 to greater than 12,000 patients annually; four clinics resided in rural areas. See Table 2 for other clinic and participant characteristics. All participating clinics served Medicaid beneficiaries who, under Oregon Medicaid waivers, could be eligible for social services support through their CCO.

Participants' comments about incentives were separated into three categories: awareness of financial incentives, uses for incentive dollars, and perceived impact of financial incentives on social care adoption. Findings related to each of these categories are detailed below, and illustrative quotes are presented in the Appendix Table. Although findings related to each section are presented separately, categories intersected; e.g., awareness of the financial incentives impacted the extent to which participants understood the incentive's influence on the clinical team's social care behaviors.

Participants' Awareness of Financial Incentives

Awareness of the AHC program's fee-for-service payments for screening and navigation services varied by the role of the interviewee in the CHC. Most (nine of ten) staff who had experience conducting screening (e.g., registration staff, patient navigators, CHWs, and clinicians) in either AHC or AHC + ASCEND demonstration clinics were not aware of the program's financial incentives. In cases across all clinic categories (AHC, AHC + ASCEND, ASCEND), frontline staff members participating in the study suggested that the research team discuss incentives instead with members of the CHC administrative leadership. Several frontline staff reported "feeling" as if there was a financial incentive but did not know program details. In these cases, staff sometimes noted that their health center had a pool of money from which the clinic provided direct aid to patients, but they were often unsure where the funding came from or how it was allocated.

Administrative leaders were more likely to be aware of financial incentives than frontline staff and clinicians, but awareness of the incentives among these leaders still varied even in clinics participating in the AHC demonstration. For instance, of the seven administrative leaders we spoke with in AHC clinics, five understood that there were fee-for-services payments in the AHC demonstration, but only two

Table 2. Participating Clinics[a]

Clinic ID	CHC	Screening/Navigation Program	ASCEND Launch	AHC Launch	Number of Interviews
1	System A	ASCEND	Fall 2019	n/a	2 administrative leaders 2 frontline staff
2	System B	ASCEND	Winter 2020	n/a	3 administrative leaders 3 frontline staff
3		ASCEND	Winter 2021	n/a	1 administrative leader 1 clinician 3 frontline staff
4	System C	ASCEND & AHC	Winter 2019	Spring 2019	1 administrative leader
5		ASCEND & AHC	Winter 2019	Fall 2018	3 administrative leaders 4 frontline staff
6		AHC	n/a	Winter 2019	1 administrative leader
7	System D	ASCEND & AHC	Winter 2020	Spring 2019	2 frontline staff
8		AHC	n/a	Spring 2019	1 frontline staff
9		AHC	n/a	Spring 2019	2 frontline staff
10		ASCEND & AHC	Winter 2021	Spring 2019	2 administrative leaders[b] 1 clinician 2 frontline staff
11	System E	ASCEND	Winter 2020	n/a	2 administrative leaders 2 frontline staff
12		ASCEND	Summer 2020	n/a	2 administrative leaders 1 clinician 1 frontline staff

Abbreviations: AHC, Accountable Health Communities; ASCEND, Approaches to CHC Implementation of SDH Data Collection and Action; CHC, community health center; n/a, not applicable.

[a] This table is modified from Ackerman and colleagues.[37]

[b] One administrative leader was affiliated with the CHC network and not the specific clinical site.

of those five were aware of the specific dollar amounts of those payments. In other words, not all administrators, even in clinics receiving money for conducting social risk screening and providing navigation services, were aware of the associated payments their clinic would receive. Only one staff member from one clinic (a clinic team supervisor) reported receiving training about the incentive. Across multiple clinics, administrative leaders were aware that quality measures related to both social screening and navigation to social services were on the state Medicaid program's horizon. One leader noted that they were participating in social care programs so that they would be prepared when those quality measures were finalized. Several participants also were aware that they could complete applications on behalf of their patients to solicit support for social services from the patient's CCO.

Uses for Incentive Dollars

In the AHC-participating clinics, when study participants were familiar with the demonstration's fee-for-service payments, they described how CHCs already allocated or planned to allocate the incentive dollars. They and participants from ASCEND-only clinics also described hypothetical use cases.

In some clinics, teams described that the funds would be used to pay for clinic-level resources, e.g., hiring more social care staff (including CHWs) or increasing staff hours. One frontline staff participant expressed hope that the incentives would go to "Employing more social care navigators because it's a lot of work, and with the size of the clinics that we have, with one person, it's not enough. I always felt like I wanted to split myself into 10, and I couldn't."

In other cases, incentives were already or expected to be pooled with funds from other grants and/or from private donors and used to pay for social services for patients. For instance, staff from several clinics belonging to a group of networked clinics described that their network pooled funds into a "flex fund," which was a multisource pool of money that went toward assisting patients with needs such as food, rent, utility bills, and transportation. (This was distinct from flexible services available through the CCO.) Both administrative leaders and frontline staff described that flex fund and provided examples of direct patient uses. But several simultaneously reported lack of clarity about how the AHC incentive dollars reached the fund, and several participants expressed little confidence that the AHC dollars actually made it to the flex fund. For instance, another frontline staff participant noted the following:

> "So when the AHC program started, we were informed that there would be incentives and we asked where that money was going to go. We advocated it should go to the patients…for rental assistance. But when we signed up for this program, we didn't get an answer. I think it was around last year, when we heard that, if we did do a screening, it would go towards our patient flex funds, which is the program we used to help for food, rental assistance, utilities. It's hard to see if that's

> happening, I choose to believe that it is. Because we do get funding, but the majority of the funding comes from donors and grants. Due to the pandemic, there's been a rise of that. So we have funds, but I can't say whether a percentage came from the reimbursement, I just believe that it is occurring."

A third use case for the incentives was less direct but anticipated to lead to the same outcomes (increasing social care staff and providing social services). In this case, participants described that if the incentives for screening, particularly increased documentation of social needs, it might in turn support the clinic's future fundraising efforts. In other words, more documentation of their population's specific needs could help the staff demonstrate the clinic's eligibility for other, larger grants that could support them to hire social care staff, strengthen partnerships between clinics and community groups, or pay for more social services.

In no cases did the clinic staff report that financial incentives were passed on to clinic employees; one interviewee described county laws prohibiting the use of incentives for the purchase of employee gift cards.

Perceived Impact of Financial Incentives on Social Care Uptake

Whether participants worked in clinics receiving incentives or not, opinions varied regarding the current or potential impact of financial incentives on the uptake of social risk screening or navigation. Perceptions that incentives had relatively little impact on the clinical team's practices came in three distinct flavors. First, although a few participants hoped that the incentive programs would be an important part of more comprehensive strategies to fund new staff and/or to increase hours allotted to staff for social care–related activities, a more dominant sentiment was that incentives were unlikely to be large enough to overcome barriers to supporting the needed training, workflows, and workforce required to establish new or strengthen existing social care pathways. As one administrative leader framed it,

> "I mean, it's a lot of work every day. And, we often don't have time to stop and do everything we want to with the patients. It's unlikely that having a monetary incentive is really going to make a difference for us on the ground, I guess. They can tell us that, they often do with, 'Oh, we're going to get a grant if we do this,' and we still don't have enough motivation to do anything about it, because I just don't have time to put in an extra dot phrase, or ask every patient this particular question that I don't think is relevant to every single patient, or whatever the ask is."

A second group of participants that lacked confidence that financial incentives were or could be influential on social care practices shared a different perspective. These participants thought that social care was fundamentally part of CHCs' social mission. In these cases, participants indicated that the financial incentive was likely irrelevant

because their CHC would do this work regardless of financial reward. For example, one frontline staff participant commented,

> "I guess because everybody who is in this position is really passionate about the work that they do, there hasn't really been a need to incentivize. We're all pretty good about making sure we are screening our patients or making those connections, at least offering the services, even if the patients don't reach out or reach out at a later date."

Several participants from one AHC clinic location described a corollary rationale to explain why the fee-for-social-care-service payments did not directly influence their team's short-term behavior. This group flagged concerns about the design of the AHC program, which as a CMS Innovation Center program is designed for Medicare and/or Medicaid beneficiaries. Study participants from that particular CHC were disinclined to develop different care workflows for patients based on their health benefits, essentially underscoring the misalignment between the current benefit design and their clinic's social mission. As one administrative leader explained,

> "And the other part that I think we had to kind of work around, and we worked with AHC to figure out, is that a lot of our patients have Medicaid and some have Medicare. A lot of our patients are underinsured. And we didn't want to have a different process for patients based on insurance status. We didn't want to unintentionally prioritize screening for certain groups."

A third concern raised by participants who were not sure the incentives influenced or could influence clinical teams' behaviors was that the screening and navigation activities would not lead to changes in patients' social conditions. They described the tension between standardizing social care activities absent funding for meaningfully addressing identified social needs. They did not see that financial incentives paid to clinics could ever achieve a significant reduction in patients' experiences of social adversity. One frontline staff participant commented,

> "Partly that's because it comes back to that thing of you don't want to put yourself in a position where you're constantly asking people what they need and then not satisfying their need because the trust that I build with the people that walk up to my window, I hold in high value. No, I did not want to put myself in a position where I was constantly asking people what they need and then not providing any response to that."

In contrast, other participants across administrative leadership, clinical, and frontline staff roles endorsed the impact (or potential impact) of financial incentives on social care practices in CHC settings because they could envision that the incentive dollars to clinics would directly translate into funding to support social services that would reduce patients' needs. For instance, this was the case in clinics where participants indicated that the AHC money would be put into the clinic's flex funds or otherwise be given to patients. As one administrative leader stated,

> "[The incentive] definitely did [feel impactful] because it was like, oh, this is great. This is an ability for us to get programs going. So we were looking at using this money to buy cell phones for patients or prepaid cards or shoes, food, like do more food banks, go to wellness programs that we have here."

These and other participants indicated that bigger incentives (more money/incentive) would more strongly influence the clinical team's screening behaviors precisely because they would be more likely to affect patients' social conditions. For instance, one frontline staff participant commented,

> "So I feel like if we could have more money, it would be to be able to directly impact the patients. Because I know that right now we're only offering $250 just because of the amount of money that we received. But I know in the past they were covering whole rents, like I think $5,000, $2,000. I'm like, if we could do that again, that would be amazing. So I guess for me, it's just being able to impact them more directly is what I would want in a perfect world."

Multiple participants in this group that thought incentives could be influential believed that they would be motivated if incentive dollars were given directly to patients completing screening forms, although none of the CHCs in the study was doing this. Frontline staff—including CHWs—indicated that this shift alone would motivate them to increase social screening practices and then to make more referrals to social care staff. One participant indicated that $5/patient screening would be sufficient to motivate the staff member to encourage screening.

Discussion

This is the first study of which we are aware to explore the perspectives of CHC clinical teams on how financial incentives might influence the uptake and sustainability of social risk screening and navigation services in CHC settings, which serve many patients experiencing social and economic barriers to health promotion and disease management. Almost half of our study participants worked in clinics participating in a program already offering fee-for-service payments for social risk screening and social services navigation. All of the clinical teams we spoke with in this study could refer patients to the Oregon Medicaid CCO Flexible Services program, in which there was a high likelihood that requests to cover select social services would be granted.[26]

Clinic staff and clinicians that had been participating in the AHC demonstration for over 1 year were rarely aware of the program's fee-for-services payments for social risk screening and navigation services, although several participants were aware that the state of Oregon was considering quality measures related to social risk screening. Because the AHC program was time limited and not all patients served by the CHCs were eligible for reimbursements, it is possible that clinic leaders who initially

committed the clinic to participating in the program did not invest substantial resources in either the initial or ongoing training and education about them; the administrative leaders making decisions about participation also sometimes were physically removed from networked clinics that were responsible for providing services. These together may have led to a lack of awareness of the AHC fee-for-service payments for social care. Awareness of incentives, not surprisingly, has been shown in other studies to affect the uptake of desired practice changes. For instance, a study on incentives for specific care changes in accountable care organizations showed that few care providers were aware of incentives at all, fewer were aware of the specific components of those incentives, and furthermore, lack of awareness of the incentives was associated with difficulty adopting new care recommendations.[40] Across Oregon clinic teams we spoke with, interestingly, few participants even mentioned the opportunity to support patients with social needs to apply for the state-sponsored and CCO-mediated program that could help to pay for select social services. That finding is consistent with a 2017 report to the state suggesting that low uptake of CCO Flexible Services benefits was in part due to difficulty spreading the word about the program to clinical teams.[26] Although the CCO benefit is not a financial incentive provided to the clinic, the finding similarly underscores the challenges associated with communicating information about available social care programs.

A logical next question, however, is whether increasing awareness of financial incentives would then lead clinical teams to adopt social care practices. In fact, there already is mixed evidence about the effectiveness—and sustained effectiveness—of financial incentives on the uptake of more common clinical practices, such as alcohol screening,[41] diabetes management,[42] immunization administration,[43–45] and colorectal screening.[46–48] One study on pay-for-performance incentives, specifically, noted that they also can have a wide range of unintended consequences, including leading to "box-ticking" or rote activities that do not contribute to meaningful changes in the quality of care.[49]

In our interviews, despite believing that social care was consistent with their overarching organizational mission, staff described multiple, deeply embedded barriers to social care, which together suggest that financial incentives are likely to be less impactful for social care than for other clinical care activities. These reasons included that the staff and workflows for social care differ markedly from other clinical pathways and therefore require more resources. This is consistent with the related literature on social risk screening that has not explored financial incentives but has identified other key clinical barriers to social care practice adoption.[7,18–23] In our study, multiple participants noted that financial incentives would have to be either sizable enough to overcome those clinical staff and workflow barriers or, alternatively, directly benefit patients by paying for social services. Both pathways would eventually lead to what participants believed could be meaningful changes in patients' social conditions. Importantly, the availability of the CCO-mediated program that would pay for CCO

patients' social services did not seem sufficient, perhaps because the teams were not aware of it or because CCO-level funding for social services was too distal to influence CHC staff practices.

Multiple frontline staff, clinicians, and administrative leaders in the study indicated interest in paying patients directly for completing social risk screenings. This idea is similar to the desire to provide social services through the clinic but could be a less resource-intensive approach to overcoming the concern that the clinic is unable to offer adequate and responsive social supports.[18,50–61] That said, other research has shown that patient-directed incentives do not consistently lead to improvements in the delivery of all clinical preventive services. For instance, in one recent study, fecal immunochemical test completion did not increase significantly with patient-directed incentives.[62] But there are other cases in which patient-directed incentives can be impactful. In one large review, the Community Preventive Services Task Force found sufficient evidence for client or family incentive rewards for vaccinations, for example.[63] Patient-directed incentives may be worth testing in the case of social risk screening because, in our study, it appeared that they would reduce staff discomfort around assessing social risks without subsequently having something to offer patients who endorse specific needs.

Limitations

Our findings should be interpreted in light of several study limitations. The biggest limitation to consider is perhaps simultaneously the study's biggest strength. Oregon's Medicaid program has long been and continues to be a champion for the integration of social and medical services. That context helped the Oregon AHC applicant win the AHC award under the federal demonstration project and explains why many ASCEND project clinical sites are based in Oregon. In parallel, however, this context also means that the interest in social care may be higher in Oregon than in other areas of the country, and participants may require fewer financial incentives for adopting social care than in other settings, which together limit the generalizability of our study findings. It is also possible that the Oregon context meant that CHC staff believed that patients' social needs were being met through the CCOs. This explanation seems unlikely because the uptake of the CCO Flexible Services program at the time of our study interviews was so low.[26,27] In future work, it may be worth asking more directly about the influence of the CCO funding for social services on social care practices. CHC teams' awareness that the state would soon be offering other forms of financial payments for social care also might have diminished enthusiasm for the relatively small dollar amounts involved in the AHC demonstration. That said, even non–AHC-involved clinic participants were skeptical about the influence of financial incentives—however structured—for social care in CHC settings.

An additional limitation is that although we recruited clinics serving diverse populations of patients in both urban and rural areas, we spoke with staff from a relatively small number of CHCs that provide primary care. This limits the generalizability of our findings to other health care contexts. It is likely that fee-for-service payments work differently in settings that do not provide safety-net primary care. Furthermore, about half of our study CHCs were not receiving fee-for-service incentives for social risk screening and navigation services. Although we asked participants in these clinics about the hypothetical influence of incentives, hypothetical versus actual influence of financial incentives may not be congruent. Finally, although we intentionally aimed to interview staff involved in different roles in social screening and intervention programs, ultimately, we conducted interviews based on staff availability, and therefore, the sample may not fully represent the environment or culture even of a participating CHC. It is important to note, however, that we were able to interview many frontline staff responsible for screening and navigation program delivery, who often are not available to participate in and therefore not represented in other qualitative research.

Conclusion

In this qualitative study, participants indicated that as designed, fee-for-service payments for social screening had—and if scaled, would have—relatively little impact on more systematic uptake of social screening and navigation services in CHCs. It is relevant that an ongoing dialogue about financial incentives in medicine has raised the possibility that financial incentives for medical care practices may undermine professionalism[64,65] or health care professionals' "unique training and intrinsic concern for their patients."[66] This point resonates in our findings that the CHC staff felt like social care was already part and parcel of their daily activities—and study participants felt that financial incentives as designed were at times incongruent with those activities, whether because the recommended practices were not applicable to all their patients or were unlikely to lead to meaningful changes in patients' social conditions. That said, changing clinical norms often requires more than reliance on professionalism, even when the new practices are consistent with an organization's mission. Even those scholars who have raised reasonable concerns about incentives, e.g., performance measures, recognize that health care systems are likely to continue to need some extrinsic incentives to improve care. One way to ensure that financial incentives for social care augment rather than undermine the professionalism of CHC teams would be to design them specifically based on the needs and priorities of those organizations. Design changes for CHCs might include providing payments directly to patients and increasing incentive payments either explicitly to better support the CHCs' social care workforce or to provide resources that CHCs could use to directly

provide social supports. Future research should leverage the emerging federal social care quality measures[67,68] to better evaluate how incentive design in different health care settings can influence both implementation and effectiveness of these initiatives.

References

1. Alderwick H, Gottlieb LM. Meanings and misunderstandings: a social determinants of health lexicon health care systems. *Milbank Q*. 2019;97(2):407-419. https://doi.org/10.1111/1468-0009.12390
2. Reynolds PP. Commentary: the teaching community health center: an idea whose time has come. *Acad Med*. 2012;87(12):1648-1650. https://doi.org/10.1097/ACM.0b013e318272cbc8
3. Cottrell EK, Dambrun K, Cowburn S, et al. Variation in electronic health record documentation of social determinants of health across a national network of community health centers. *Am J Prev Med*. 2019;57(6):S65-S73. https://doi.org/10.1016/j.amepre.2019.07.014
4. Cartier Y, Gottlieb L. The prevalence of social care in US health care settings depends on how and whom you ask. *BMC Health Serv Res*. 2020;20(1):481. https://doi.org/10.1186/s12913-020-05338-8
5. What is a community health center? National Association of Community Health Centers. Accessed November 6, 2022. https://www.nachc.org/about/about-our-health-centers/what-is-a-health-center/
6. Sharac J, Stolyar L, Corallo B, Tolbert J, Shin P, Rosenbaum S. How community health centers are serving low-income communities during the COVID-19 pandemic amid new and continuing challenges. Kaiser Family Foundation. June 3, 2022. Accessed July 31, 2023. https://www.kff.org/medicaid/issue-brief/how-community-health-centers-are-serving-low-income-communities-during-the-covid-19-pandemic-amid-new-and-continuing-challenges/
7. Broaddus-Shea ET, Fife Duarte K, Jantz K, Reno J, Connelly L, Nederveld A. Implementing health-related social needs screening in western Colorado primary care practices: qualitative research to inform improved communication with patients. *Health Social Care Comm*. 2022;30(5):e3075-e3085. https://doi.org/10.1111/hsc.13752
8. O'Toole TP, Roberts CB, Johnson EE. Screening for food insecurity in six Veterans Administration clinics for the homeless, June-December 2015. *Prev Chronic Dis*. 2017;14:E04. https://doi.org/10.5888/pcd14.160375
9. Pettignano R, Caley SB, McLaren S. The Health Law Partnership: adding a lawyer to the health care team reduces system costs and improves provider satisfaction. *J Public Health Manag Pract*. 2012;18(4):E1-E3. https://doi.org/10.1097/PHH.0b013e31823991a9
10. Beck AF, Henize AW, Kahn RS, Reiber KL, Young JJ, Klein MD. Forging a pediatric primary care–community partnership to support food-insecure families. *Pediatrics*. 2014;134(2):e564-e571. https://doi.org/10.1542/peds.2013-3845

11. Gold R, Bunce A, Cowburn S, et al. Adoption of social determinants of health EHR tools by community health centers. *Ann Fam Med*. 2018;16(5):399-407. https://doi.org/10.1370/afm.2275
12. Sand KA. Linking underserved patients to social services using the SScAR Tool. *J Doct Nurs Pract*. 2021;14(2):139-145. https://doi.org/10.1891/JDNP-D-20-00033
13. Colvin JD, Bettenhausen JL, Anderson-Carpenter KD, et al. Multiple behavior change intervention to improve detection of unmet social needs and resulting resource referrals. *Acad Pediatr*. 2016;16(2):168-174. https://doi.org/10.1016/j.acap.2015.06.001
14. Patel M, Bathory E, Scholnick J, White-Davis T, Choi J, Braganza S. Resident documentation of social determinants of health: effects of a teaching tool in the outpatient setting. *Clin Pediatr (Phila)*. 2018;57(4):451-456. https://doi.org/10.1177/0009922817728697
15. Higginbotham K, Davis Crutcher T, Karp SM. Screening for social determinants of health at well-child appointments. *Nurs Clin North Am*. 2019;54(1):141-148. https://doi.org/10.1016/j.cnur.2018.10.009
16. Power-Hays A, Li S, Mensah A, Sobota A. Universal screening for social determinants of health in pediatric sickle cell disease: a quality-improvement initiative. *Pediatr Blood Cancer*. 2020;67(1):e28006. https://doi.org/10.1002/pbc.28006
17. O'Toole JK, Solan LG, Burkhardt MC, Klein MD. Watch and Learn: an innovative video trigger curriculum to increase resident screening for social determinants of health. *Clin Pediatr (Phila)*. 2013;52(4):344-350. https://doi.org/10.1177/0009922813475702
18. Schickedanz A, Hamity C, Rogers A, Sharp AL, Jackson A. Clinician experiences and attitudes regarding screening for social determinants of health in a large integrated health system. *Med Care*. 2019;57(Suppl 6 2):S197-S201. https://doi.org/10.1097/MLR.0000000000001051
19. Hamity C, Jackson A, Peralta L, Bellows J. Perceptions and experience of patients, staff, and clinicians with social needs assessment. *Perm J*. 2018;22(4S):18-105. https://doi.org/10.7812/TPP/18-105
20. Purnell TS, Marshall JK, Olorundare I, et al. Provider perceptions of the organization's cultural competence climate and their skills and behaviors targeting patient-centered care for socially at-risk populations. *J Health Care Poor Underserved*. 2018;29(1):481-496. https://doi.org/10.1353/hpu.2018.0032
21. Schwartz B, Herrmann LE, Librizzi J, et al. Screening for social determinants of health in hospitalized children. *Hosp Pediatr*. 2020;10(1):29-36. https://doi.org/10.1542/hpeds.2019-0092
22. Berry C, Paul M, Massar R, Marcello RK, Krauskopf M. Social needs screening and referral program at a large US public hospital system, 2017. *Am J Public Health*. 2020;110(S2):S211-S214. https://doi.org/10.2105/AJPH.2020.305642
23. Sokol RL, Mehdipanah R, Bess K, Mohammed L, Miller AL. When families do not request help: assessing a social determinants of health screening tool in

practice. *J Pediatr Health Care*. 2021;35(5):471-478. https://doi.org/10.1016/j.pedhc.2021.05.002

24. Murray GF, Rodriguez HP, Lewis VA. Upstream with a small paddle: how ACOs are working against the current to meet patients' social needs. *Health Aff (Millwood)*. 2020;39(2):199-206. https://doi.org/10.1377/hlthaff.2019.01266
25. Brewster AL, Fraze TK, Gottlieb LM, Frehn J, Murray GF, Lewis VA. The role of value-based payment in promoting innovation to address social risks: a cross-sectional study of social risk screening by US physicians. *Milbank Q*. 2020;98(4):1114-1133. https://doi.org/10.1111/1468-0009.12480
26. Kushner J, Tracy K, Lind B, Renfro S, Rowland R, McConnell J. Evaluation of Oregon's 2012–2017 Medicaid waiver. Oregon Health & Sciences University, Center for Health Systems Effectiveness. December 29, 2017. Accessed July 31, 2023. https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Summative%20Medicaid%20Waiver%20Evaluation%20-%20Final%20Report.pdf
27. Grunditz J, McConnell J, Daly A, et al. Evaluation of Oregon's 2017–2022 Medicaid waiver. Oregon Health & Sciences University, Center for Health Systems Effectiveness. October 15, 2021. Accessed July 31, 2023. https://www.oregon.gov/oha/HPA/ANALYTICS/Evaluation%20docs/Final%20Evaluation%20of%20Oregon's%202017-2022%20Medicaid%20Waiver%20-%20Interim%20Report%20-%20October%2015%202021.pdf
28. Oregon leverages Medicaid to address social determinants of health and health equity. Oregon Health & Sciences University, Center for Health Systems Effectiveness. June 2021. Accessed July 31, 2023. https://www.ohsu.edu/sites/default/files/2021-06/Oregon%20Medicaid%20addresses%20SDOH%20and%20health%20equity1.pdf
29. Accountable Health Communities model. Centers for Medicare & Medicaid Services. Accessed August 16, 2022. https://innovation.cms.gov/innovation-models/ahcm
30. Billioux A, Verlander K, Anthony S, Alley D. Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. Washington,DC: National Academy of Medicine Perspectives, 1–9; 2017. Accessed July 31, 2023. https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf
31. Gold R, Bunce A, Cowburn S, et al. Adoption of social determinants of health EHR tools by community health centers. *Ann Fam Med*. 2018;16(5):399-407. https://doi.org/10.1370/afm.2275
32. Gold R, Cottrell E, Bunce A, et al. Developing electronic health record (EHR) strategies related to health center patients' social determinants of health. *J Am Board Fam Med*. 2017;30(4):428-447. https://doi.org/10.3122/jabfm.2017.04.170046
33. Gold R, Kaufmann J, Cottrell EK, et al. Implementation support for a social risk screening and referral process in community health centers. *NEJM Catalyst*. 2023;4(4):CAT.23.0034. https://doi.org/10.1056/CAT.23.0034

34. Guide to implementing social risk screening and referral-making. Kaiser Permanente and OCHIN, Inc. 2021. Accessed July 31, 2023. https://sirenetwork.ucsf.edu/guide-implementing-social-risk-screening-and-referral-making
35. The PRAPARE screening tool. PRAPARE - Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences. 2022. Accessed August 16, 2022. https://prapare.org/the-prapare-screening-tool/
36. Bradley EH, Curry LA, Devers KJ. Qualitative data analysis for health services research: developing taxonomy, themes, and theory. *Health Serv Res*. 2007;42(4):1758-1772. https://doi.org/10.1111/j.1475-6773.2006.00684.x
37. Ackerman SL, Wing H, Aceves B, Pisciotta M, Hessler D, Gottlieb LM. "We were trying to do quality versus quantity": challenges and opportunities at the intersection of standardized and personalized social care in community health centers. *SSM Qual Res Health*. 2023;3:100267. https://doi.org/10.1016/j.ssmqr.2023.100267
38. Deterding NM, Waters MC. Flexible coding of in-depth interviews: a twenty-first-century approach. *Sociol Methods Res*. 2021;50(2):708-739. https://doi.org/10.1177/0049124118799377
39. Boyatzis RE. *Transforming Qualitative Information: Thematic Analysis and Code Development*. Sage Publications; 1998.
40. Markovitz AA, Rozier MD, Ryan AM, et al. Low-value care and clinician engagement in a large Medicare shared savings program ACO: a survey of frontline clinicians. *J Gen Intern Med*. 2020;35(1):133-141. https://doi.org/10.1007/s11606-019-05511-8
41. Anderson P, Bendtsen P, Spak F, et al. Improving the delivery of brief interventions for heavy drinking in primary health care: outcome results of the Optimizing Delivery of Health Care Intervention (ODHIN) five-country cluster randomized factorial trial. *Addiction*. 2016;111(11):1935-1945. https://doi.org/10.1111/add.13476
42. Egede LE, Walker RJ, Linde S, et al. Nonmedical interventions for type 2 diabetes: evidence, actionable strategies, and policy opportunities. *Health Aff (Millwood)*. 2022 Jul;41(7):963-970. https://doi.org/10.1377/hlthaff.2022.00236.
43. Abdullahi LH, Kagina BM, Ndze VN, Hussey GD, Wiysonge CS. Improving vaccination uptake among adolescents. *Cochrane Database Syst Rev*. 2020;1(1):CD011895. https://doi.org/10.1002/14651858.CD011895.pub2
44. Fairbrother G, Siegel MJ, Friedman S, Kory PD, Butts GC. Impact of financial incentives on documented immunization rates in the inner city: results of a randomized controlled trial. *Ambul Pediatr*. 2001;1(4):206-212. https://doi.org/10.1367/1539-4409(2001)001<0206:IOFIOD>2.0.CO;2
45. Guttmann A, Saunders NR, Kumar M, et al. Implementation of a physician incentive program for 18-month developmental screening in Ontario, Canada. *J Pediatr*. 2020;226:213-220.e1. https://doi.org/10.1016/j.jpeds.2020.03.016
46. Issaka RB, Dominitz JA. Financial incentives to improve colorectal cancer screening—time to cut our losses. *JAMA Netw Open*. 2021;4(8):e2122661. https://doi.org/10.1001/jamanetworkopen.2021.22661

47. Green BB, Anderson ML, Cook AJ, et al. Financial incentives to increase colorectal cancer screening uptake and decrease disparities: a randomized clinical trial. *JAMA Netw Open*. 2019;2(7):e196570. https://doi.org/10.1001/jamanetworkopen.2019.6570
48. Rose L. Financial incentives for at-home colorectal cancer screening tests. *JAMA Netw Open*. 2019;2(3):e191168. https://doi.org/10.1001/jamanetworkopen.2019.1168
49. Hackett J, Glidewell L, West R, Carder P, Doran T, Foy R. 'Just another incentive scheme': a qualitative interview study of a local pay-for-performance scheme for primary care. *BMC Fam Pract*. 2014;15(1):168. https://doi.org/10.1186/s12875-014-0168-7
50. Hoeft TJ, Hessler D, Francis D, Gottlieb LM. Applying lessons from behavioral health integration to social care integration in primary care. *Ann Fam Med*. 2021;19(4):356-361. https://doi.org/10.1370/afm.2688
51. Tong ST, Liaw WR, Kashiri PL, et al. Clinician experiences with screening for social needs in primary care. *J Am Board Fam Med*. 2018;31(3):351-363. https://doi.org/10.3122/jabfm.2018.03.170419
52. Garg A, Cull W, Olson L, et al. Screening and referral for low-income families' social determinants of health by US pediatricians. *Acad Pediatr*. 2019;19(8):875-883. https://doi.org/10.1016/j.acap.2019.05.125
53. Eismann EA, Theuerling J, Maguire S, Hente EA, Shapiro RA. Integration of the Safe Environment for Every Kid (SEEK) Model across primary care settings. *Clin Pediatr (Phila)*. 2019;58(2):166-176. https://doi.org/10.1177/0009922818809481
54. Palakshappa D, Benefield AJ, Furgurson KF, et al. Feasibility of mobile technology to identify and address patients' unmet social needs in a primary care clinic. *Popul Health Manag*. 2021;24(3):385-392. https://doi.org/10.1089/pop.2020.0059
55. Browne J, Mccurley JL, Fung V, Levy DE, Clark CR, Thorndike AN. Addressing social determinants of health identified by systematic screening in a Medicaid Accountable Care Organization: a qualitative study. *J Prim Care Community Health*. 2021;12:215013272199365. https://doi.org/10.1177/2150132721993651
56. Adams E, Hargunani D, Hoffmann L, Blaschke G, Helm J, Koehler A. Screening for food insecurity in pediatric primary care: a clinic's positive implementation experiences. *J Health Care Poor Underserved*. 2017;28(1):24-29. https://doi.org/10.1353/hpu.2017.0004
57. Zielinski S, Paradis HA, Herendeen P, Barbel P. The identification of psychosocial risk factors associated with child neglect using the WE-CARE screening tool in a high-risk population. *J Pediatr Health Care*. 2017;31(4):470-475. https://doi.org/10.1016/j.pedhc.2016.12.005
58. Nehme E, Castedo de Martell S, Matthews H, Lakey D. Experiences and perspectives on adopting new practices for social needs-targeted care in safety-net settings: a qualitative case series study. *J Prim Care Community Health*. 2021;12:21501327211017784. https://doi.org/10.1177/21501327211017784

59. LaForge K, Gold R, Cottrell E, et al. How 6 organizations developed tools and processes for social determinants of health screening in primary care: an overview. *J Ambul Care Manage*. 2018;41(1):2-14. https://doi.org/10.1097/JAC.0000000000000221
60. Lax Y, Bathory E, Braganza S. Pediatric primary care and subspecialist providers' comfort, attitudes and practices screening and referring for social determinants of health. *BMC Health Serv Res*. 2021;21(1):956. https://doi.org/10.1186/s12913-021-06975-3
61. Palakshappa D, Scheerer M, Semelka CT, Foley KL. Screening for social determinants of health in free and charitable clinics in North Carolina. *J Health Care Poor Underserved*. 2020;31(1):382-397. https://doi.org/10.1353/hpu.2020.0029
62. McDermott L, Cornelius V, Wright AJ, et al. Enhanced invitations using the question-behavior effect and financial incentives to promote health check uptake in primary care. *Ann Behav Med*. 2018;52(7):594-605. https://doi.org/10.1093/abm/kax048
63. Increasing appropriate vaccination: client or family incentive rewards. Community Preventive Services Task Force. May 2015. Accessed July 31, 2023. https://www.thecommunityguide.org/media/pdf/Vaccination-Incentive-Rewards.pdf
64. Casalino LP. The unintended consequences of measuring quality on the quality of medical care. *N Engl J Med*. 1999;341(15):1147-1150. https://doi.org/10.1056/NEJM199910073411511
65. McWilliams JM. Pay for performance: when slogans overtake science in health policy. *JAMA*. 2022;328(21):2114-2116. https://doi.org/10.1001/jama.2022.20945
66. McWilliams JM. Professionalism revealed: rethinking quality improvement in the wake of a pandemic. *NEJM Catalyst*. 2020;1(5). https://doi.org/10.1056/CAT.20.0226
67. NCQA updates & releases new quality measures for HEDIS® 2023 with a focus on health equity. National Committee for Quality Assurance. August 1, 2022. Accessed August 16, 2022. https://www.ncqa.org/news/ncqa-updates-releases-new-quality-measures-for-hedis-2023-with-a-focus-on-health-equity-stratifying-measures-by-race-ethnicity-and-affirming-gender-identity-helps-tackle-health-disparities/
68. Gottlieb LM, DeSilvey SC, Fichtenberg C, Bernheim S, Peltz A. Developing national social care standards. *Health Aff Forefront*. https://doi.org/10.1377/forefront.20230221.857308

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Supplementary Material

Additional supporting information may be found in the online version of this article at http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)1468-0009:

Appendix Table. Illustrative Quotes by Category