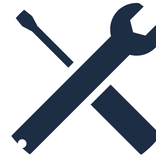
Leveraging the Potential of Social Determinants of Health Screening for Client Resource Connection

Erin Babbitt, BSN, RN - Program Manager

Objectives



Describe a tailored Social Determinants of Health (SDOH) screening tool, administration, and follow-up process

Analyze initial SDOH screening findings and outcomes

Discuss potential roadblocks to a successful implementation and identify strategies to overcome

Background & History

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Background & History

2020

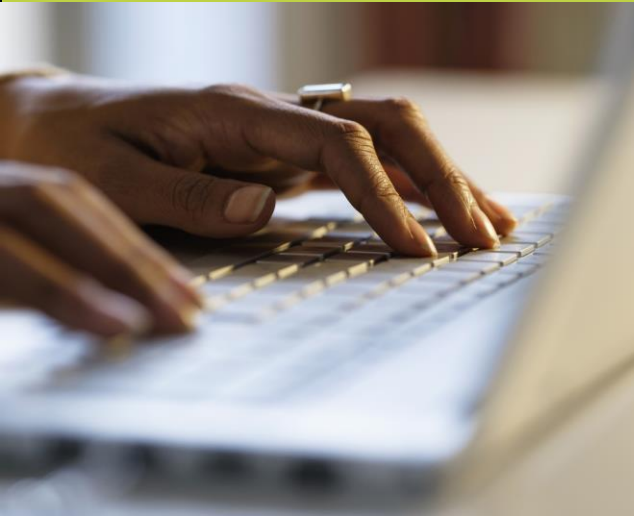
CHA first adopted the NCDHHS SDOH Screening questions and integrated them into the medical record

2022

CHA adopts a strategic goal to "implement an internal referral process to create a better patient experience"

2021

CureMD rolls out State Mandated Questions Template to collect SDOH data and automatically report to LHD-HSA



2023

Expanded to utilize tool across eight additional agency programs and paired with internal referral pilot

Integration beyond CureMD

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Agency leadership challenged the organization to:

- Enhance patient/client-centered care
- Align screening tools used throughout CHA
- Develop a process for tracking referrals for internal services
- Breakdown internal silos

Integration beyond CureMD

Participating Expansion Programs:

- Care Management for at Risk Children (CMARC)
- Care Management for High Risk Pregnancy (CMHRP)
- Communicable Disease (CD)
- Dental
- LiVe Well Counseling (Behavioral Health)
- Minority Diabetes Prevention Program (MDPP)
- Project MORE (Making Opportunities for Responsible Parenting and Education
- Syringe Services
- Women, Infants, and Children (WIC)

Integration beyond CureMD

Phase 1

Research (April 2021-November 2021) 8 months

- Research social determinants of health screening tool
- Identification of an external referral tool

Phase 2

Planning (November 2021-April 2022) 6 months

- Decide the program areas that will be implementing
- Discussions with program leads (designate leads as champions of this project)
- Partner with CHA Centralized Services team
- Microsoft Form and Power Automate logistics

Phase 3

Implementation (April 2022-January 2023) 10 months

- Orientation for champions (included phased approach timeline, standard of work, program specific Microsoft Form link)
- Opportunity to designate a front line staff as implementation champion

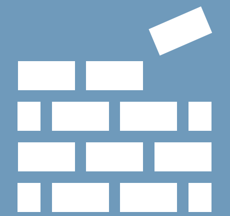
Phase 4

Evaluation (January 2023-Now) Ongoing

- Monthly data analysis
- Sharing finding with CHA leadership on gaps that have been discovered

Integration beyond CureMD

Implementation across CHA



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Expansion Strategy:

- SDOH Team developed agency-wide tools to capture screening data
- Automated workflows
- Standardized expectations across programs
- Developed alternative processes (paper options, alternative languages)
- Trained "champions" and program participants
- Plan or roll-out

Implementation across CHA

Supplemental Internal Referral Questions:

Do you need to be connected with any of the following:

1. Women's Health services
2. Pediatric services
3. Dental services
4. Behavioral Health Services
5. Chronic Disease Management
6. Immunization Services
7. WIC Services
8. Sexual Health Services

Implementation across CHA

Existing Clinical Workflow:

Client completes SDOH Screening Form *with supplemental internal questions*

Tool is reviewed by staff to assess for urgent needs to be addressed in real time

Screening data is transcribed into CureMD Custom Forms

Urgent need: CHA staff provides timely resources or connects to BH support team

Client indicates an internal need

Referral task is sent to our Centralized Services team

CS team follows up with patient and secures services for referral requested

Client indicates an external need

CHA staff utilizes talking points to meet clients where they are at and provides resource list

Client encouraged to visit external referral platform, or referral task sent to CHW team

Implementation across CHA

Expansion Workflow:

Client completes SDOH Screening Form with supplemental internal questions

Tool is reviewed by staff to assess for urgent needs to be addressed in real time

Urgent need: CHA staff provides timely resources or connects to BH support team

Screening data is transcribed into Microsoft Forms

Client indicates an internal need

Power-Automate (PA) triggers a referral email to our Centralized Services team

CS team follows up with patient and secures services for referral requested

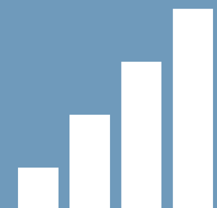
Client indicates an external need

CHA staff utilizes talking points to meet clients where they are at and provides resource list

Client encouraged to visit external referral platform, or PA referral sent to CHW team

Implementation across CHA

Data Collection



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SDOH Screeners Completed in CureMD

Since implementation in 2020

SDOH Screener Questions	2020 (launched mid-year only in Peds)	2021	2022	2023 (to date)
Total # of screeners entered into Microsoft Form	109	3035	3103	1454
Food need identified	13	468	367	177
Housing/Utilities need identified	16	325	252	115
Transportation need identified	3	117	91	38
Interpersonal Safety need identified	2	327	308	129
Would like help with identified need(s)	14	192	184	83

2023 SDOH Data To-Date

Collected since January '23 Launch

SDOH Screener Questions	JAN 23	FEB 23	MAR 23	APR 23	MAY 23	JUN 23	JUL 23	AUG 23	SEP 23	Total
Total # of screeners entered into Microsoft Form	149	344	314	154	147	118	129	57	29	**1441**
Food need identified	39	93	82	37	42	34	51	18	10	**406**
Housing/Utilities need identified	42	46	56	24	17	11	24	15	5	**240**
Transportation need identified	30	30	23	15	9	13	18	10	6	**154**
Interpersonal Safety need identified	14	21	15	9	12	14	14	8	4	**111**
Would like help with identified need(s)	34	52	58	26	28	19	28	15	9	**269**

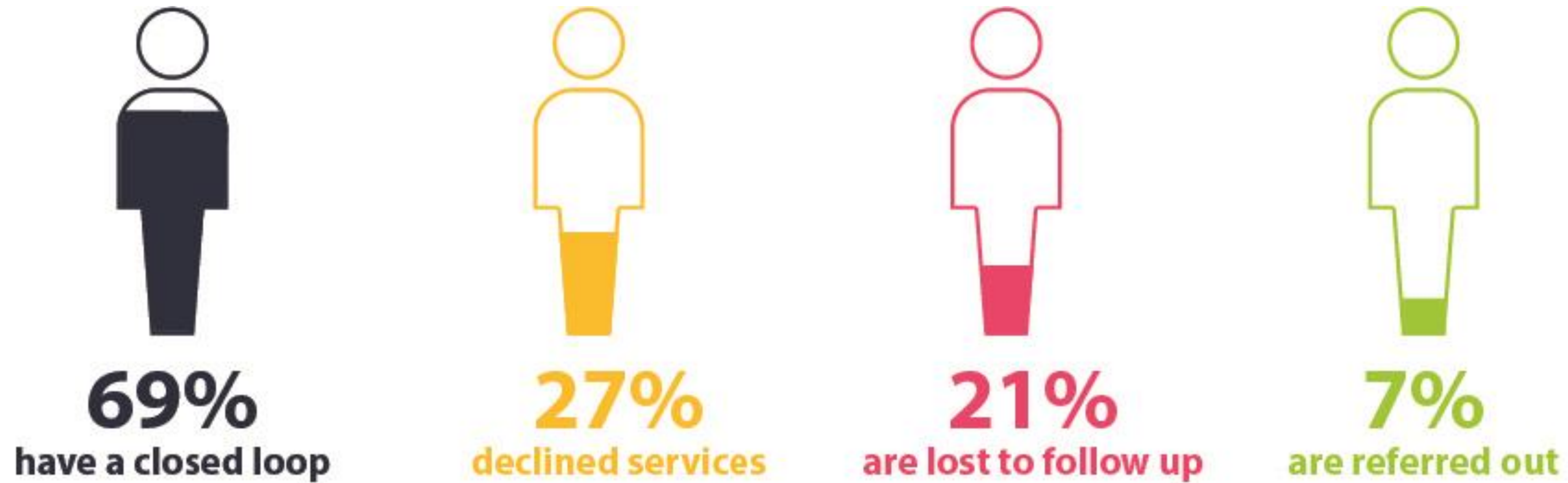
2023 Internal Referral Data To-Date

Collected since January '23 Launch

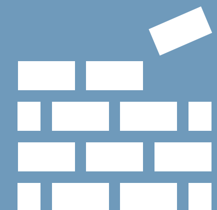
SDOH Screener Questions	JAN 23	FEB 23	MAR 23	APR 23	MAY 23	JUN 23	JUL 23	AUG 23	SEP 23	Total
Total # of screeners entered into Microsoft Form	141	234	253	140	181	222	175	189	151	**1,686**
% with Appointments Scheduled/Completed	24%	19%	23%	18%	22%	21%	27%	33%	33%	**24%**
% with Closed Loop	78%	69%	74%	71%	76%	76%	65%	73%	79%	**73%**
Highest Referral Source	Syringe Services	WIC	WIC	WIC	WIC	Womens Health	Womens Health	Womens Health	Womens Health	**Womens Health**
Highest Referral Need	Dental	Dental	Dental	Dental	Dental	Dental	Dental	Dental	Dental	**Dental**

2023 Internal Referral Data

January–August 2023



Next Steps & Lessons Learned



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Opportunities & Sustainability:

- Partner with Community Health Worker (CHW) program to mirror internal referral processes to support food/utilities, transportation, and interpersonal safety needs to ensure wraparound care
- Organizational commitment to connect patients/clients to internal and external services
- Use screener data to inform strategic growth opportunities and close service gaps
- Share data with community partners to support investment in opportunities outside of LHD scope
- Continuous quality improvement

Next Steps and Lessons Learned

Let's Connect...

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(pursuing MHA, projected completion Summer 2026)

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