Standardizing Social Determinants of Health Screening to Improve Identification of Social Needs and Care Coordination

Liberty Erfe, DNP, RN, EBP-CH, Aidan Butz, BSN, RN, AMB-BC, Mellody McDonald, BS, ADN, RN, CNOR (E), Amy Hornbuckle MSN, RN, CNL, CCRP
Riverside Healthcare, Kankakee, Illinois

Background

According to Centers for Medicare & Medicaid Services (CMS), Social Determinants of Health (SDOH) screening questions are essential to delivering high-quality, equitable, and patient-centered care. Social determinants of health (SDOH) significantly influences 80 percent of health outcomes, yet inconsistent screening practices across healthcare settings limits the systematic identification of social needs and hinders effective care coordination. CMS recognizes that clinical care alone accounts for only a portion of health outcomes, while social and environmental factors such as housing stability, food access, transportation, and financial security play a critical role in a patient's ability to achieve and maintain health. Standardizing SDOH screening may improve detection, referral, and integration of social care into clinical workflows. Accurate and complete screening supports compliance with CMS requirements, strengthens performance on quality measures, and contributes to data-driven strategies to address disparities in care (CMS, 2023). Equally important, SDOH screening facilitates effective care coordination by connecting patients to internal resources and community-based services.

Project Goal

This evidence-based quality improvement project initiative aimed to develop, implement and evaluate a standardized SDOH screening process to improve identification of patients' social needs and enhance care coordination across clinical and community-based services. A standardized, evidence-based SDOH screening tool called Accountable Health Communities Health-Related Social Needs Screening Tool (AHC-HRSN) was integrated into routine clinical workflows in Epic EMR across inpatient units on patient's admission and outpatient clinics while patients are being roomed.

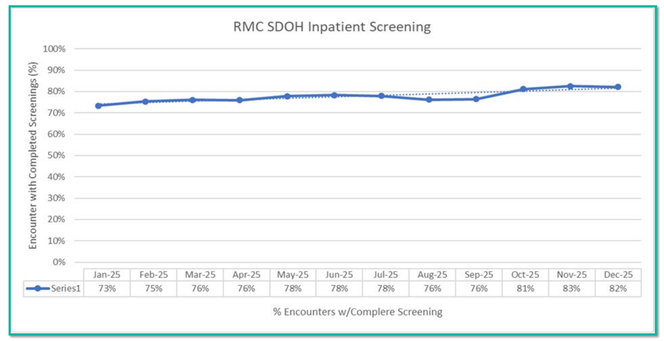
Methods

- Clinical staff received training on screening administration, documentation, and referral pathways.
- Training started on November of 2023 for the Inpatient Nursing Staff for a go-live date of January, 2024.
- Phase I implementation in Riverside Medical Group (RMG) Primary Care Clinics, staff training started on September of 2024 for a go-live date of November, 2024.
- Phase II implementation in RMG Specialty Clinics, staff were reeducated again on March of 2025 for a go-live date of May, 2025.
- Data was collected pre- and post-implementation to assess knowledge base of Outpatient clinic staff, SDOH screening completion rates, prevalence of identified social needs, referral rates to Population Health Care Coordination, and follow-up outcomes.
- Positive screening rate on all five core domains of SDOH were monitored by Population Health Care Coordination Team.
- Ambulatory referral to Population Health Care Coordination team are completed as part of the process flow and intervention.
- Situation, background, assessment, and recommendation (SBAR) method of educating staff was completed and distributed to Riverside Leaders to optimize education of the importance of completing the SDOH screening tool.
- Qualitative feedback from staff sparked the need for continuing education for workflow refinement and sustainability.
- The Plan-Do-Check-Act (PDCA) model was also utilized as a method in process improvement and implementing change.

Results

Following implementation, inpatient SDOH screening completion rates increased substantially, from 0 percent to 82 percent, month over month and 0 percent to 28 percent across RMG clinics in 2025. These results improved identification of key social needs, including food insecurity, housing instability, transportation barriers, and financial strain. Referrals to community resources and care coordination services increased, with improved documentation and tracking of social care interventions. Staff reported greater confidence and consistency in addressing social needs as part of routine care.

SDOH IP Data 2025



Transportation: 55% Housing Instability: 40%
Utility Difficulties: 23.35% Interpersonal Safety: 9.48%
Food Insecurity: 49%

SDOH OP Data 2025

Conclusions

Standardizing SDOH screening is a feasible and effective approach to improving identification of social needs and strengthening care coordination. By integrating standardized tools in completion of SDOH screening, as well as following the correct referral workflow processes and care coordination interventions, patient-centered care supports a more equitable foundation for addressing social risk factors that impact health outcomes.