SDOH Screening Questionnaire Pilot

Purpose:

This pilot aims to improve the systematic identification, documentation and reporting of social drivers of health (SDOH) within the EHR using a standardized screening tool in order to support guideline-concordant blood pressure and cholesterol management, improve medication adherence, and inform individualized care planning.

Best Practice Recommendation:

The best practice recommendation is to incorporate routine screening for social drivers of health (SDOH) as part of cardiovascular risk assessment and management. AHA hypertension and cholesterol guidelines recognize that social and socioeconomic factors—including housing instability, food insecurity, transportation barriers, financial strain, health literacy, mental health conditions, stress, and safety concerns—are strong determinants of medication adherence, lifestyle modification, and long-term blood pressure and lipid control, and that failure to address these factors limits the effectiveness of proven prevention strategies. EHR tools should be used to systematically screen for, document, and track SDOH using standardized instruments, and to support patient-centered BP and cholesterol management by identifying barriers to adherence, informing treatment decisions, and applying population health and care coordination resources for patients requiring additional support.

Pilot Design & Implementation

- ***Pilot Duration:*** 2 months
- ***Preparation Period:*** January 13-February 14
- ***Pilot Go-Live:*** February 15
- ***Post-pilot Review:*** End of April

Pilot activities include:

- Baseline assessment of current SDOH documentation practices (completed via survey)
- Activation of the AHC HRSN SDOH screening tool within the Screening Questionnaire section of the EHR encounter note
- Customization of the below SOP for participating clinics, including standardized workflows for SDOH screening and documentation

- Training of MAs, nurses, and clinicians on SDOH screening and documentation workflows
- Consideration of follow up and resources needed to support patient SDOH barriers
- Feedback and modification for finalized grant best practice recommendation

Phase 1: Planning & Baseline Assessment January 14-January 19

1. **Define Pilot Scope**
    a. Define screening population (i.e. adults 18+) and visit types (i.e. annual physicals)
2. **Determine who needs to be involved**
    a. SDOH Questionnaire
        i. Specific clinical staff/volunteers vs all?
    b. Standard Operating Procedure (SOP) development
        i. Who needs to be involved in creating this?
        ii. Who needs to approve this SOP?
        iii. Who will this SOP impact (staff/volunteers)?
        iv. Do we have any internal documents that need to be reviewed related to this SOP?
        v. Who needs to access this SOP (consider clinic leadership, nurses, MAs, clinicians, volunteers, social work, behavioral health, community health workers)?
        vi. Where to store and how to access this SOP digital file (ex. SharePoint in Folder X)?

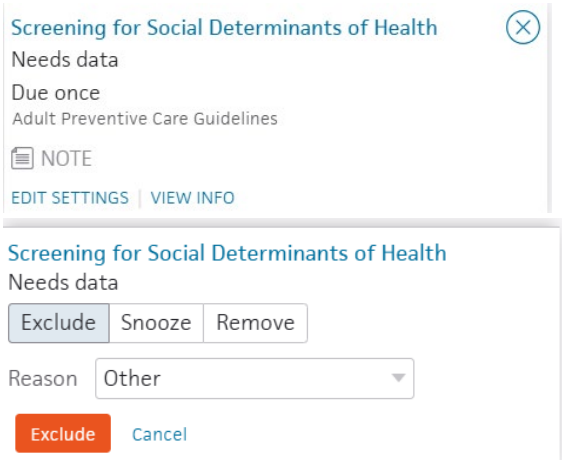
Deliverables by January 19:

- Define screening population and visit types
- Determine who needs to be involved for the SDOH questionnaire roll-out
- Determine who needs to be involved in the SDOH SOP development

Phase 2: EHR Build & Technical Activation January 20 - 28

3. Activate the AHC HRSN SDOH Screening Tool
    a. Add the suggested SDOH screening questionnaire to the system by following these steps: Gear > Clinicals > Exam > Screening Questionnaires > All Available Screening Questionnaires or My Practice's Screening Questionnaires > AHC-HRSN Core
    b. Review available screening questions within this tool
4. Select Screening Questions
    a. Review SDOH screening questionnaire and determine which questions the clinic will ask, taking into consideration the resources available, referral capacity, processes already in effect, and staffing support.
    b. Consider building a resource guide to address SDOH needs (example: list of housing or food resources, YWCA information, etc.)
5. Activate SDOH Quality Measure
    a. Quality tab: Turn on the "Screening for Social Determinants of Health" quality measure, which identifies patients 18yo and older who have had an encounter in the past 12 months that need to be screened for SDOH. The measure is satisfied when a patient is screened using one of the approved screening tools, including the AHC HRSN tool and/or CPT code M1207.
    b. Gear > Clinicals > Quality Management > Clinical Guidelines > Screening for Social Determinants of Health

An exception can be made if marking Patient refused/Not indicated/Not tolerated.



6. Optional Workflow Enhancements

a. Consider adding the screening questionnaire to an Encounter Plan template (if this is part of standard workflow). Use “Order Types and Procedure Template Mapping” to map screening questionnaires to procedure codes.

7. Test the workflow
    a. Create a mock encounter note in a Test patient chart. From the Intake section of the note under Screening Questionnaires, select the above SDOH questionnaire and complete the appropriate questions. Once marked complete, these questions can be reviewed within the note or under the Vitals section of the chart. You should also be able to determine if the SDOH Quality measure was completed by viewing the Quality Tab before and after submitting the questionnaire.

Deliverables by January 28:

- AHC HRSN SDOH screening tool activated and questions reviewed
- SDOH quality measure turned on
- Workflow tested in EHR

Phase 3: SOP Customization January 29 – February 14

8. Customize the SDOH SOP
    a. The goal is to create a rough draft at this stage, with plans to finalize at the pilot's completion.
9. Determine SOP location and access
    a. Determine where to store the SOP digital file, with the hope that similar SOP will be built in the future for other clinical workflows
    b. Determine who needs access to the file for ongoing reference

Deliverables by February 14

- Draft of SDOH SOP
- Plan for SOP storage location, access and communication to staff

Phase 4: Staff Training & Go-Live Preparation February 2-14

10. Assess training needs:
    a. Who needs to be trained (in SDOH questionnaire and/or SOP)?
        i. Suggest MAs and nurses on administration and documentation, Clinicians on review, care planning and referrals, additional clinical staff if available (behavioral health, social work, community health workers)
    b. When can training be completed?
    c. What resources do staff need for SDOH needs (based on questionnaire results)?
    d. Confirm: when screening occurs, who conducts screening, how results are communicated
    e. Resources to support training:
        i. AHC Health Related Social Needs Screening Tool article
        ii. AHC HRSN Core Questionnaire
11. Train staff utilizing a training guide (to be provided by TCCN) that covers:
    a. SDOH concepts and relevance to BP/Cholesterol as well as impact on patient health outcomes (the *why*)
    b. How to administer the AHC HRSN tool
    c. How to document and review results in the EHR
        i. Ensure all screening tools are reviewed and addressed at time of completion
    d. Interpreting results and addressing patient needs
        i. Take into consideration resources available and needed to address SDOH needs including staff, volunteers, community connections and handouts
    e. Reviewing SOP and providing access (prefer digitally)

Deliverables by February 14:

- Clear screening workflow confirmed
- Training materials distributed
- Completed staff training
- SOP reviewed and access granted

Phase 5: Go Live February 15 – April 15

12. Conduct SDOH Screening
13. Clinical Review & Care Integration
    a. Incorporate findings into assessment & plan, referrals and follow-up actions
14. Consider building a SDOH Report based on questionnaire results
    a. Refer to athena O-Help article "Screening Questionnaires Report" or run to the report by following these steps: Reports > General > Report Library > Other > Standard Reports > Screening Questionnaires Report > Run

Deliverables by April 15:

- Conduct SDOH screening questionnaire during appropriate clinic visits

Phase 6: Monitoring, Feedback & Refinement

15. Post-implementation feedback
    a. Consider a brief post-implementation survey for clinical staff such as:
        i. Do you find having a standard SOP for SDOH screening helpful?
        ii. Has the use of the AHC HRSN screening tool changed how you identify barriers to BP or cholesterol management?
        iii. Do you feel SDOH information is accessible and actionable within the EHR during clinical decision-making?
        iv. Are you able to capture SDOH information via reports?
16. Refinement & Final Recommendations
    a. Modify SOP, workflows, or training as needed
    b. Incorporate lessons learned into final grant best-practice recommendation and long-term SOP maintenance plan
    c. Consider ongoing impact of SDOH results on clinic model & patient care

Social Drivers of Health SOP

Effective Date / Review Date

- Effective: 1/2026
- Next Review: 7/2026 (suggesting a 6-month review process for a new SOP and annual for established SOPs)

Version History

Version 1 **Date** 1/2026 **Description** Clinical Workflow **Author** TCCN

1. Purpose

To support high-quality, patient-centered care by systematically identifying and documenting social drivers of health that may affect a patient's ability to access care, follow treatment plans, and achieve optimal health outcomes.

2. Scope

Applies to all Medical Assistants, Nurses, and Clinicians involved in patient intake, screening and management. Consider adding social work, community health workers and behavioral health consultants if staff includes these.

3. Definitions & Abbreviations

Clarify any essential terms, preferably only using approved abbreviations.
Examples:

- **SDOH** – Social Drivers of Health
- **AHC HRSN** – Accountable Health Communities Health-Related Social Needs Screening Tool
- **EHR** – Electronic Health Record

4. Responsibilities

- **Medical Assistants and Nurses:**
    - Administer the AHC HRSN SDOH screening tool during intake or rooming
    - Document responses in the Screening Questionnaire section of the EHR
    - Notify clinicians of urgent or high-risk social needs per clinic protocol

- **Clinicians:**
    - Review SDOH screening results
    - Incorporate identified social needs into patient evaluation and treatment
    - Document assessment and plan, including referrals or adjustments to care
- **Other staff: Behavioral Health, Social Work, Community Health Workers**

5. Required Equipment & Supplies

- EHR workstation with access to Screening Questionnaire tools
- Patient-facing devices or paper backup (if applicable)
- Staff and resources to support SDOH needs

6. Procedure (Step-by-Step Instructions)

1. Administer the AHC HRSN SDOH screening tool during the *adult annual physical* encounter
2. Enter responses directly into the Screening Questionnaire section of the Encounter Note (Intake > Screening Questionnaires)
3. Review SDOH screening results to identify and address patient needs. (Review from within the Encounter Note or under the Vitals tab)
4. Compare to previous results if applicable (Vitals tab > Screening Questionnaires)
5. Document clinical considerations and referrals in the EHR. Provide appropriate resources.

7. Safety & Infection Control Considerations

- Ensure patient confidentiality and trauma-informed screening practices
- Inform patients that screening is voluntary and used to improve care
- Follow clinic protocols for urgent social needs

8. Documentation Requirements

- SDOH screening responses must be documented as structured data
- Relevant social needs should be referenced in the assessment and plan, including diagnosis codes and referrals as needed

9. Quality Assurance & Compliance Metrics

- **Process Measures:**
  - Percentage of eligible patients screened for SDOH
  - Completion rates of the AHC HRSN screening tool
- **Reporting:**
  - List applicable EHR reports

10. References & Attachments

AHC HRSN Core Screening Questionnaire