SDOH Screening & Response in Perinatal Care: Reflections from the Field

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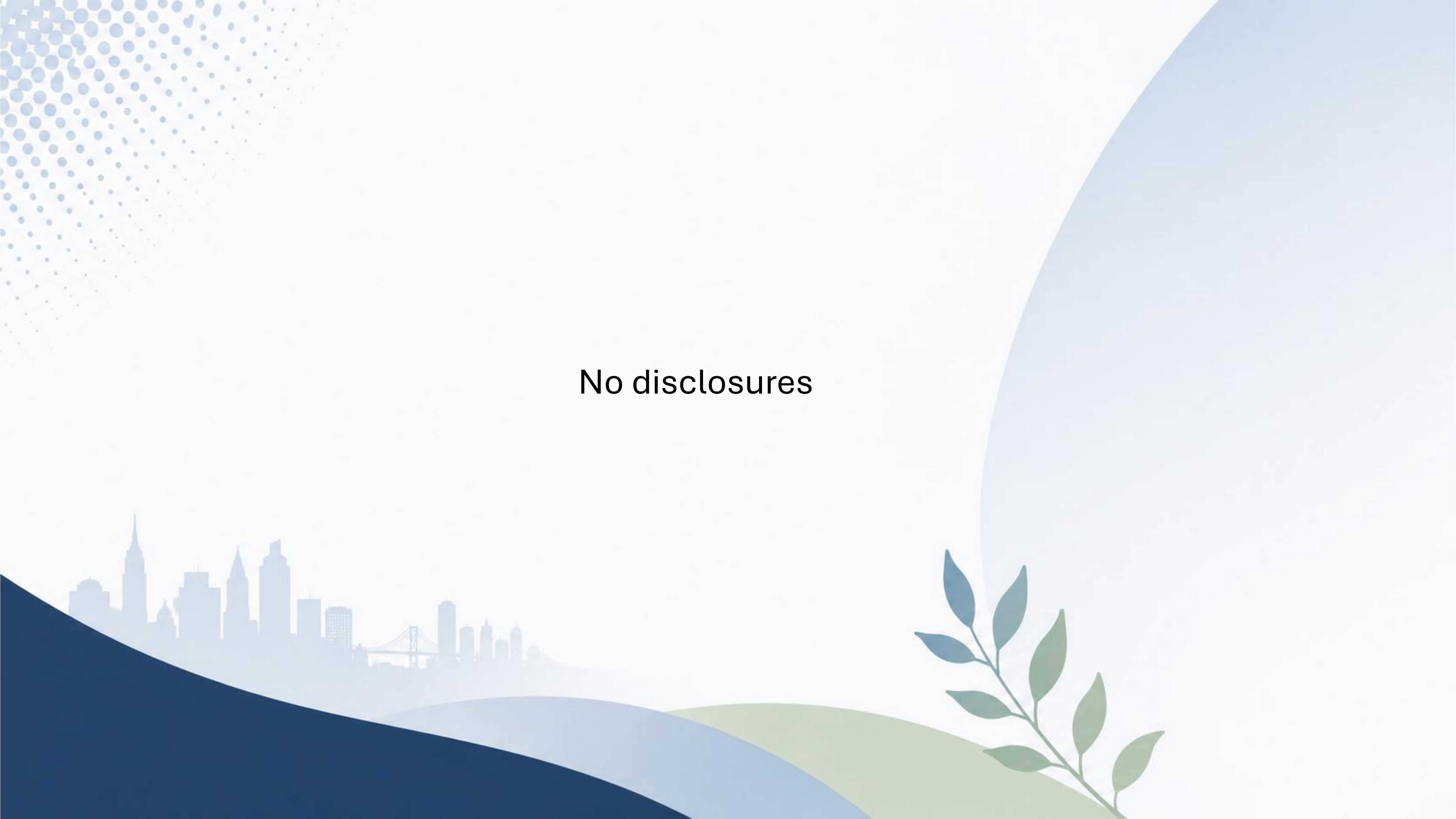
Sidney Kimmel Medical College at Thomas Jefferson University

PA Maternal Health Symposium, 5/19/2026

Blair County Convention Center, Altoona, PA


No disclosures

Jasmine’s story

Jasmine is a 27-year-old G2P0101 who presents for her initial prenatal visit at 14 weeks gestation.

She has a history of a prior spontaneous preterm birth at 36 weeks.

Her pregnancy is additionally complicated by obesity with a BMI of 35, depression, and anxiety.

OBSTETRIC & MEDICAL HISTORY

G2P0101

History of preterm birth after spontaneous labor at 36 weeks

Obesity (BMI 35)

History of depression and anxiety

SOCIAL & LIFE CONTEXT

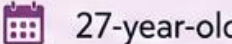
History of intimate partner violence with current FOB; they are not living together

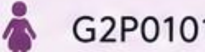
Housing instability – staying with cousin, uncertain how long

Temporary jobs with unpredictable hours and income

No reliable transportation – relies on public transit

PATIENT SNAPSHOT


- 27-year-old
- G2P0101


- 14 weeks gestation
- Mother to a 6-year-old son
- Currently staying with her cousin

IMPACT ON CARE & WELL-BEING

Late to appointments due to transportation barriers

Missed prior appointments due to work and transportation

Food insecurity – sometimes skips meals so her son can eat

Feels overwhelmed, worried about housing, providing for her son, and this pregnancy

Outline

1. What are SDOH / HRSNs?
2. The perinatal context
3. Intimate Partner Violence Screening & Response in Perinatal care - lessons from the ground
4. Reimagining perinatal support moving forward

Childcare needs

Employment instability

Intimate partner violence

Safety concerns

Housing instability

Missed healthcare appointments

Food insecurity

Financial insecurity

Social support needs

Unpredictable work schedule

Transportation barriers

Barriers to healthcare access

Single parenting stress

Risk of homelessness

Social Determinants of Health (SDOH)

"The conditions in which people are born, grow, live, work and age" - WHO

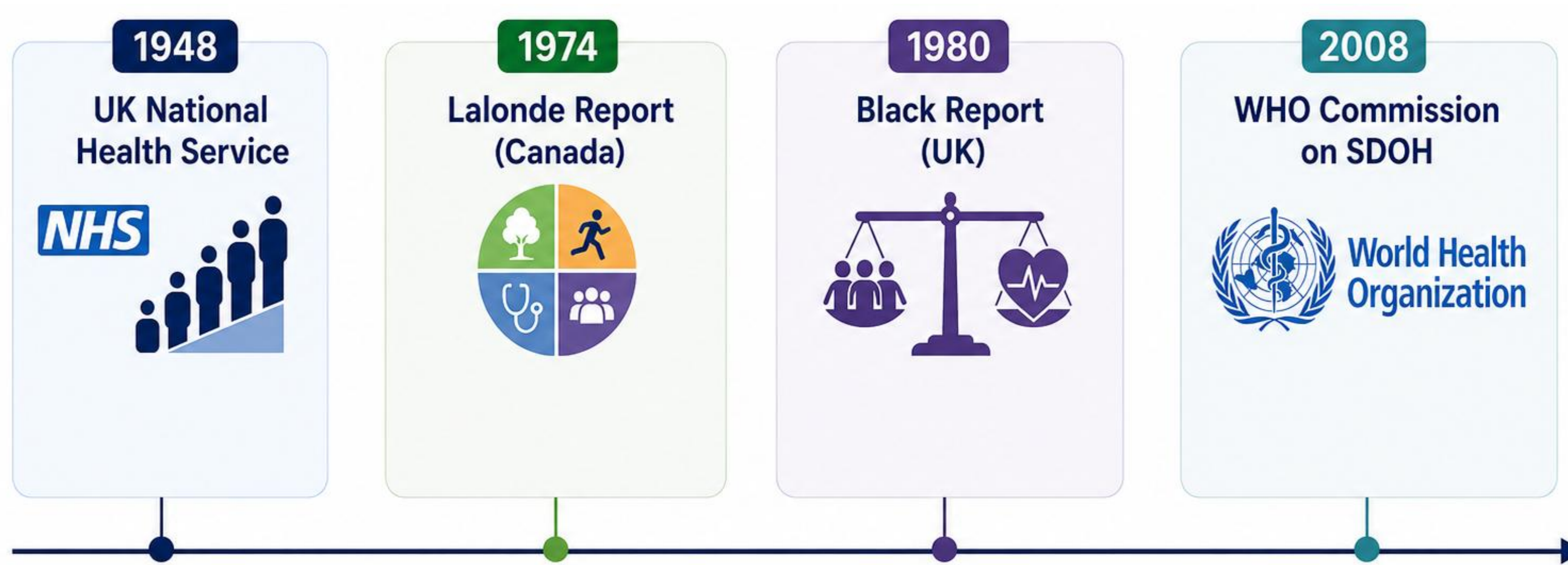
Population/Community level

Health-Related Social Needs (HRSNs)

Individual-level actionable needs presenting in healthcare settings

Individual level

Milestones that shaped modern SDOH framework



From Policy to Practice: How National Initiatives Led to More HRSN Screening in Hospitals

Affordable Care Act

Expanded coverage, prevention, and focus on population health

Centers for Medicare & Medicaid Services

Value-based payment, quality measures, and health equity

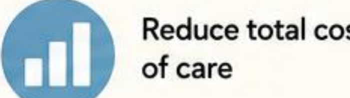
ACOs

Accountable Care Organizations

Coordinate care across providers and address social needs

New Incentives and Priorities

Payment tied to quality and outcomes



Reduce total cost of care

Address social drivers of health

Improve patient experience and health equity

Health Systems Take Action

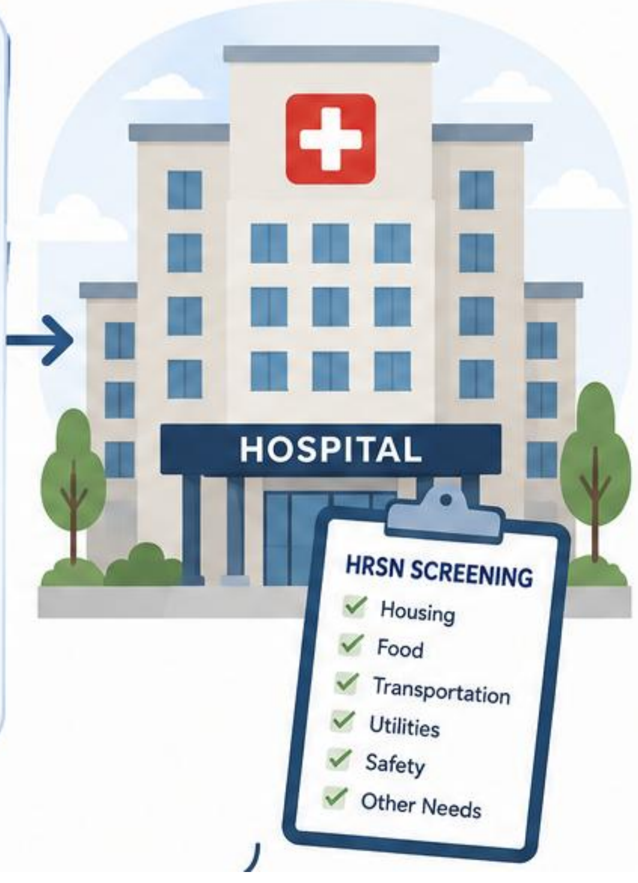
Identify patients' social needs

Connect to community resources

Track data and measure impact

Coordinate care across the continuum

Hospitals Increase HRSN Screening



AHC-HRSN Screening Tool

ORIGINAL TOOL: 5 CORE DOMAINS (10 QUESTIONS)		
HOUSING INSTABILITY	2 QUESTIONS	1. Housing situation "What is your housing situation today?" • I have housing • I do not have housing • I am worried about losing housing 2. Problems with housing "Think about the place you live. Do you have problems with any of the following?" • Pests • Mold • Lead paint • Lack of heat • Oven/stove not working • Smoke detectors missing • Water leaks • None of the above
FOOD INSECURITY	2 QUESTIONS	1. "Within the past 12 months, you worried that your food would run out before you got money to buy more." 2. "Within the past 12 months, the food you bought just didn't last and you didn't have money to get more."
TRANSPORTATION PROBLEMS	1 QUESTION	1. "In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or getting things needed for daily living?"
UTILITY HELP NEEDS	1 QUESTION	1. "In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?"
INTERPERSONAL SAFETY	4 QUESTIONS	1. "How often does anyone, including family and friends, physically hurt you?" 2. "How often does anyone insult or talk down to you?" 3. "How often does anyone threaten you with harm?" 4. "How often does anyone scream or curse at you?"
TOTAL: 10 QUESTIONS		

8 supplemental domains
Financial strain
Employment
Family and community support
Education
Physical activity
Substance use
Mental health
Disabilities

https://www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf

Even validated screening tools can introduce bias

Not all patients agree to screening

- Females>males, older> younger [Llamocca 2024]
- lower screening rates in Latino patients [Torres 2023]

Disclosure vary based on:

- Trust, language, stigma, fear of CPS involvement, prior experiences with healthcare systems
  - *"Nowadays, CPS likes to get involved in everything and anything. So that would scare me because I don't want them to be like, 'Oh, you're not able to be a right guardian for your kids, so we're going to take them out.' You really can't take a chance like that"* [Brown 2024]
- Asian patients are least likely to report any HRSN [Llamocca 2024]

There may also be biased in who gets offered resources

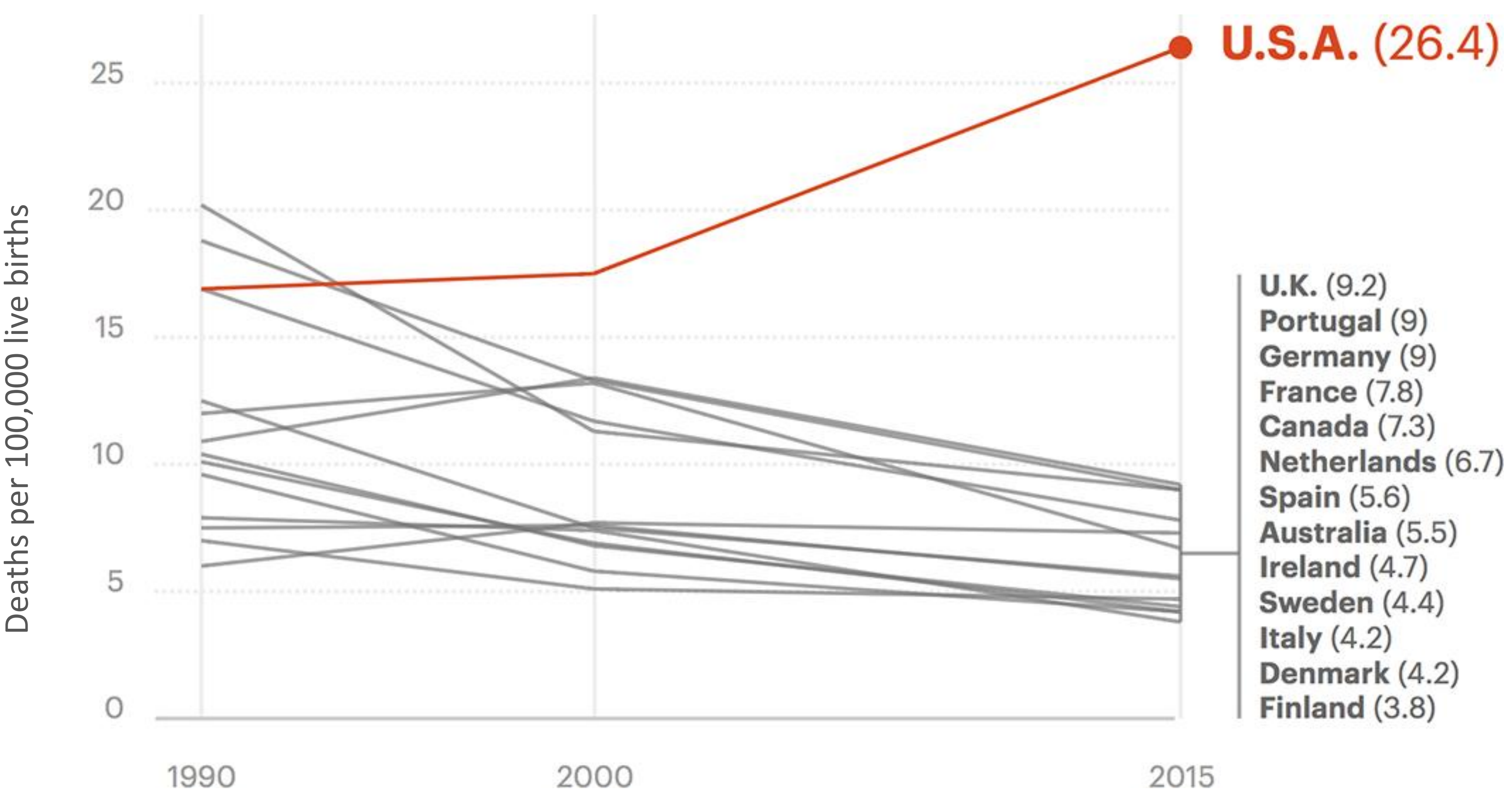
- Black patients were less likely to have documented offers of assistance but more likely to have documented assistance requests
- Older more likely to have documented offers of assistance [Llamocca 2025]

Screening does not = improved health outcomes

- Effective response systems and community resources are essential
- Screening should be tailored to the specific patient population and available local resources

Why Social Determinants of Health (SDOH) Matter in Pregnancy & Postpartum

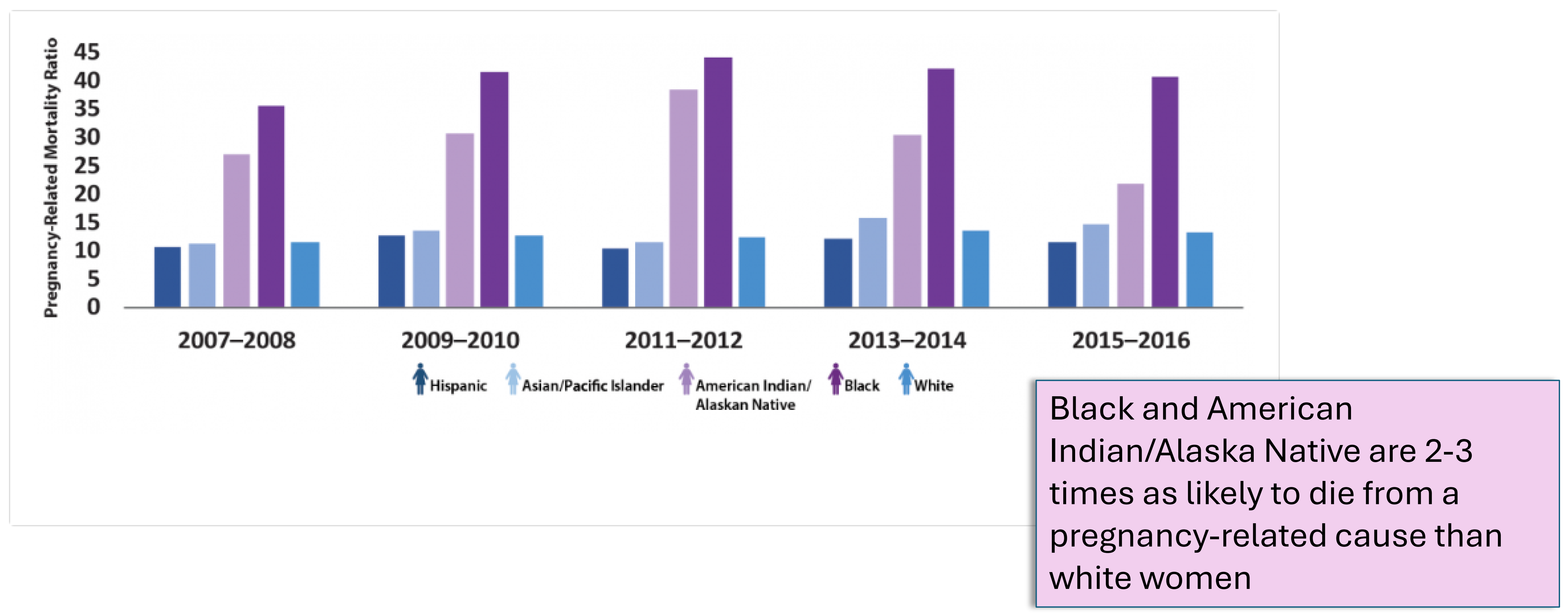
Maternal Mortality Is Rising in the U.S. As It Declines Elsewhere



["Global, regional, and national levels of maternal mortality, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015,"] *The Lancet*. Only data for 1990, 2000 and 2015 was made available in the journal.

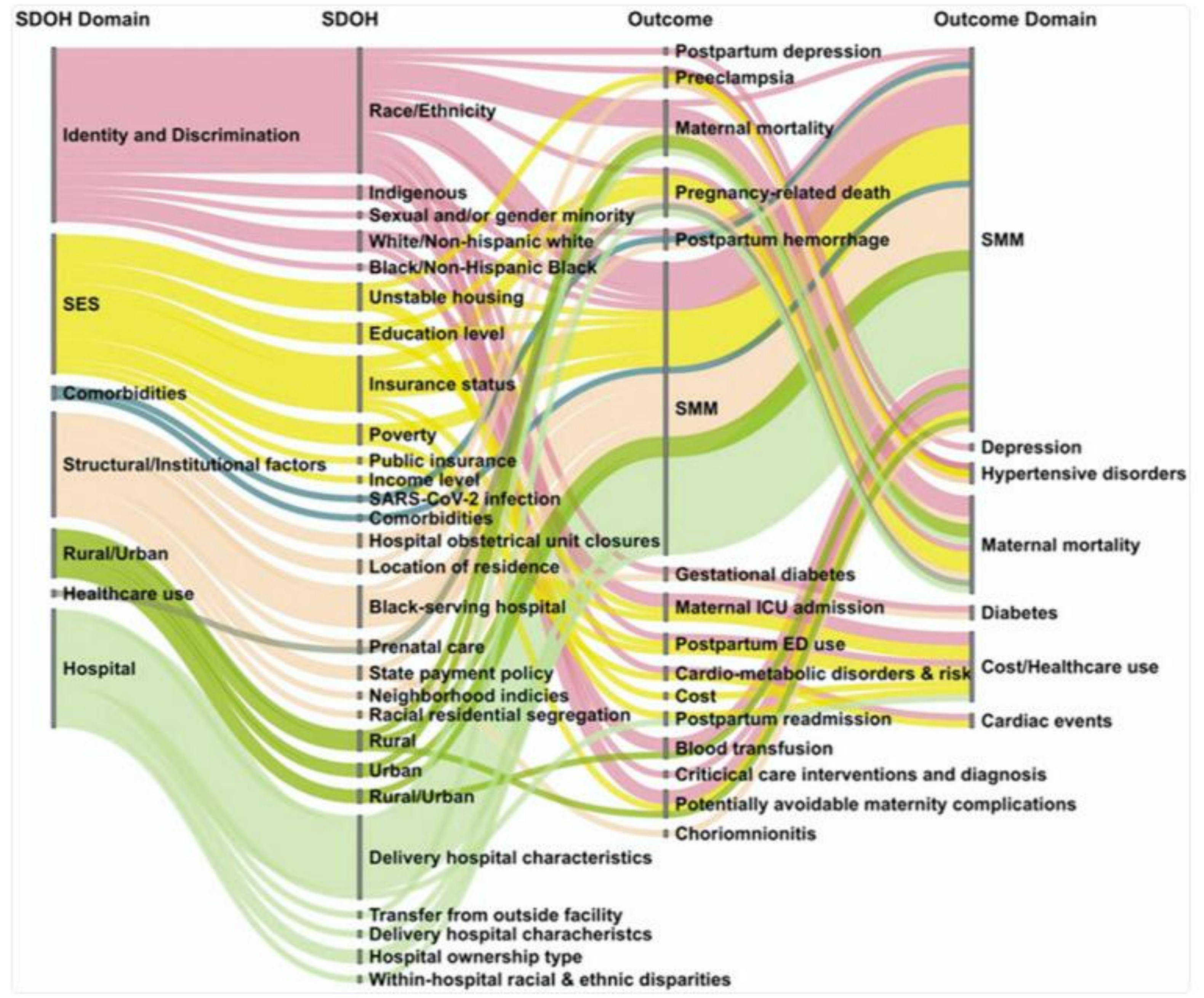
Source: The Lancet

Data confirms significantly higher pregnancy-related mortality ratios among Black and American Indian/Alaskan Native women. These gaps did not change over time.



Black and American Indian/Alaska Native are 2-3 times as likely to die from a pregnancy-related cause than white women

Centers for Disease Control and Prevention. *Disparities in Pregnancy-Related Deaths*. CDC; accessed May 18, 2026. [CDC infographic]



Neerland. Determinants for Maternal Morbidity and Mortality. Obstet Gynecol 2024.

Intimate partner violence during pregnancy

was connected to:

- Delaying or not getting prenatal care
- Depression
- Smoking, alcohol, and substance use
- Low infant birth weight

1 in 20

women experienced emotional, physical, and/or sexual violence during their pregnancy*

*survey in 9 U.S. jurisdictions of women who had a live birth

Preventing violence during pregnancy
supports maternal and infant health.

Prenatal Psychosocial Stressors and Blood Pressure Across 4 Years Postpartum

higher prenatal

Depressive Symptoms

Psychosocial Stress

→ GREATER

Neighborhood Social Cohesion → LOWER

Blood Pressure 1 Year After Birth

Associations diminished after the first year postpartum.

Pardo N, et al. *Hypertension*. 2025;82(5):849–858.

Why Social Determinants of Health (SDOH) Matter in Pregnancy & Postpartum

- The U.S. has the highest maternal mortality rate among developed nations

- Social conditions directly shape perinatal outcomes

- Certain risks increase during pregnancy and postpartum

- Pregnancy and postpartum are periods of heightened vulnerability

Why Perinatal Care Is a Unique Opportunity to Address SDOH

- Expanded healthcare coverage

- High patient engagement and motivation

- Existing support infrastructure already embedded in perinatal care

- Opportunity for early intervention with multigenerational impact

Current Landscape on Maternal Health and SDOH/HRSN

Federal Efforts to Improve Maternal Health Outcomes and Address Social Determinants of Health

Federal Agencies Driving Maternal Health Initiatives

HHS
(U.S. Department of Health and Human Services)

prioritizes maternal mortality reduction and health equity.

HRSA
Health Resources and Services Administration

funds maternal health programs, workforce development, rural maternal health initiatives, and community-based care models.

CDC
Centers for Disease Control and Prevention

supports maternal mortality review committees (MMRCs) and surveillance of pregnancy-related deaths.

CMS & Medicaid Policy Changes

CMS (Centers for Medicare & Medicaid Services) increasingly supports addressing Health-Related Social Needs (HRSNs) through Medicaid.

2021 CMS Guidance Expanded Allowable Services such as:

Housing-related supports

Non-emergency transportation

Home-delivered meals

Care coordination and community support services

2023 CMS HRSN Framework

- Clarified pathways for states to provide HRSN services through Medicaid and CHIP
- Encouraged "whole-person care" approaches

12-Month Postpartum Medicaid Coverage Expansion

- Adopted by most states
- Aims to improve continuity of postpartum care and reduce maternal morbidity/mortality

Ongoing Challenges in Perinatal HRSN Screening

Many HRSN tools are not tailored to pregnancy/postpartum needs

Positive screens often do not lead to meaningful support or follow-up

Providers may not know available resources or referral workflows

Disclosure is shaped by trust, language, stigma, and fear of CPS involvement

Standardized tools may oversimplify complex social realities and introduce bias

Response systems often depend on the knowledge of a single social worker

Key question:

Not just "Should we screen?" — but
"How do we build systems that truly respond?"

What Has Worked in HRSN Screening in Pregnancy and Postpartum?

1. Screening Must Be Paired with a Response System

2. Ongoing Support Works Better Than Screening Alone

3. Warm Handoffs Improve Connection to Resources

4. Integrated Healthcare–Community Partnerships Are Essential

5. Digital or Short-Form Tools Improve Feasibility

6. Patients Support Screening When It Feels Routine, Respectful, and Helpful

7. Staff Need Clear Workflows, Training, and Resources

8. Tailor to the Perinatal Period

Bottom Line: The literature supports screening only when it is embedded in a system that can respond.

Reyes et al. 2021; Peahl et al. 2023; Tully et al. 2022; ACOG 2024.

Jefferson Center for Connected Care

Jefferson Connected Care Services (CCS)

- Enhanced HRSN screening with follow-up questions
- Conducted by trained patient navigators
- Real-time support and resource connection
- Centralized referral specialists familiar with regional resources
- Longitudinal follow-up to ensure successful connection to services

1 in 4 women in the U.S. experience severe IPV in their lifetime

IPV often starts or **escalates in pregnancy** and postpartum

Philadelphia has one of the highest reported rates of **perinatal IPV 8.9%**

Black birthing persons 4x more than their White counterparts (11.4% vs 3.1%)

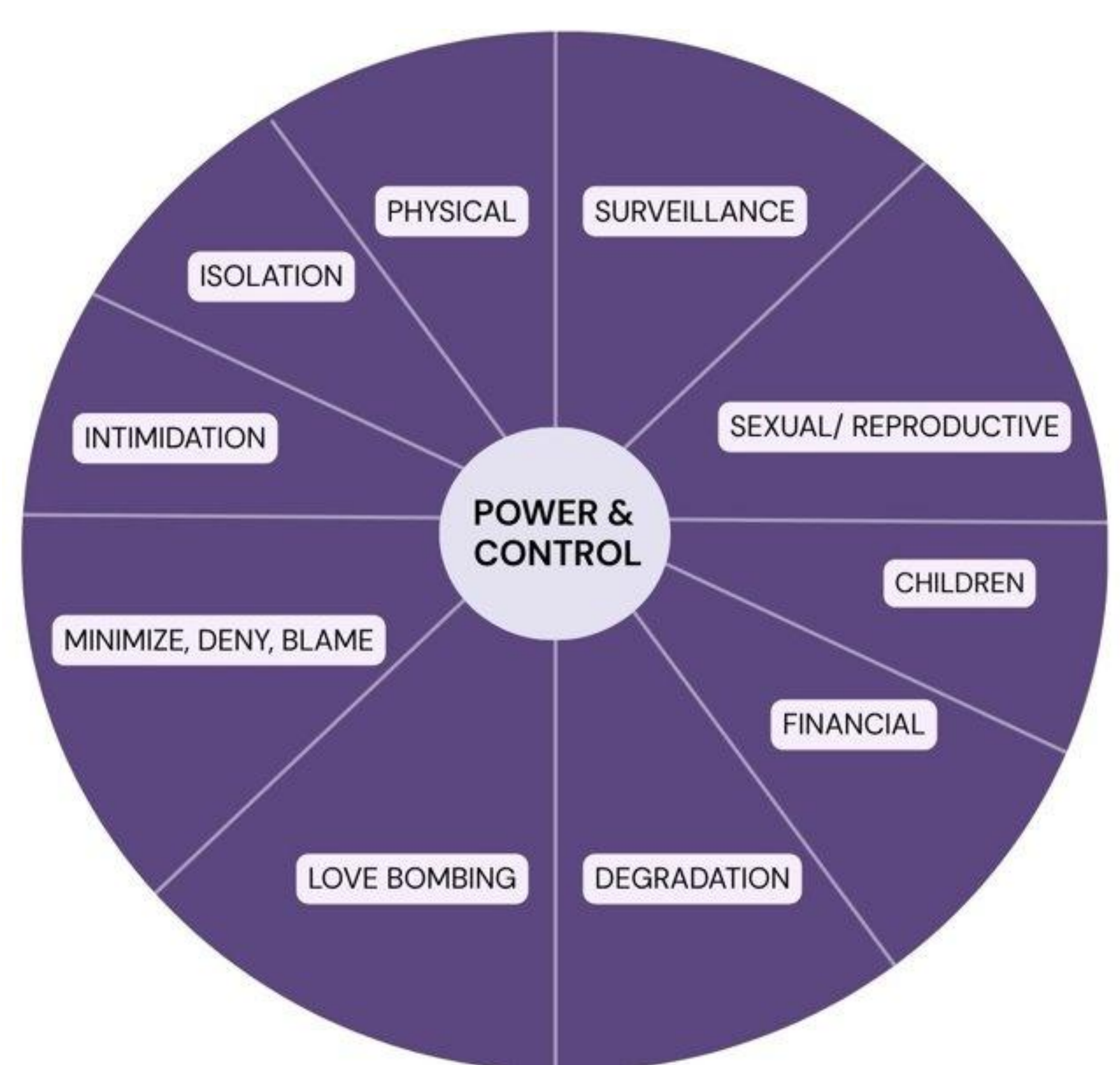
Homicide is a leading cause of maternal mortality in the U.S. most often perpetrated by an intimate partner.

Understanding IPV: Power & Control

IPV: A pattern of coercive behavior used by one person to gain power and control over another in a relationship

Pregnancy can escalate domestic abuse as:

- Abusers feel threatened by the shift in priorities
- Pregnancy challenges isolation

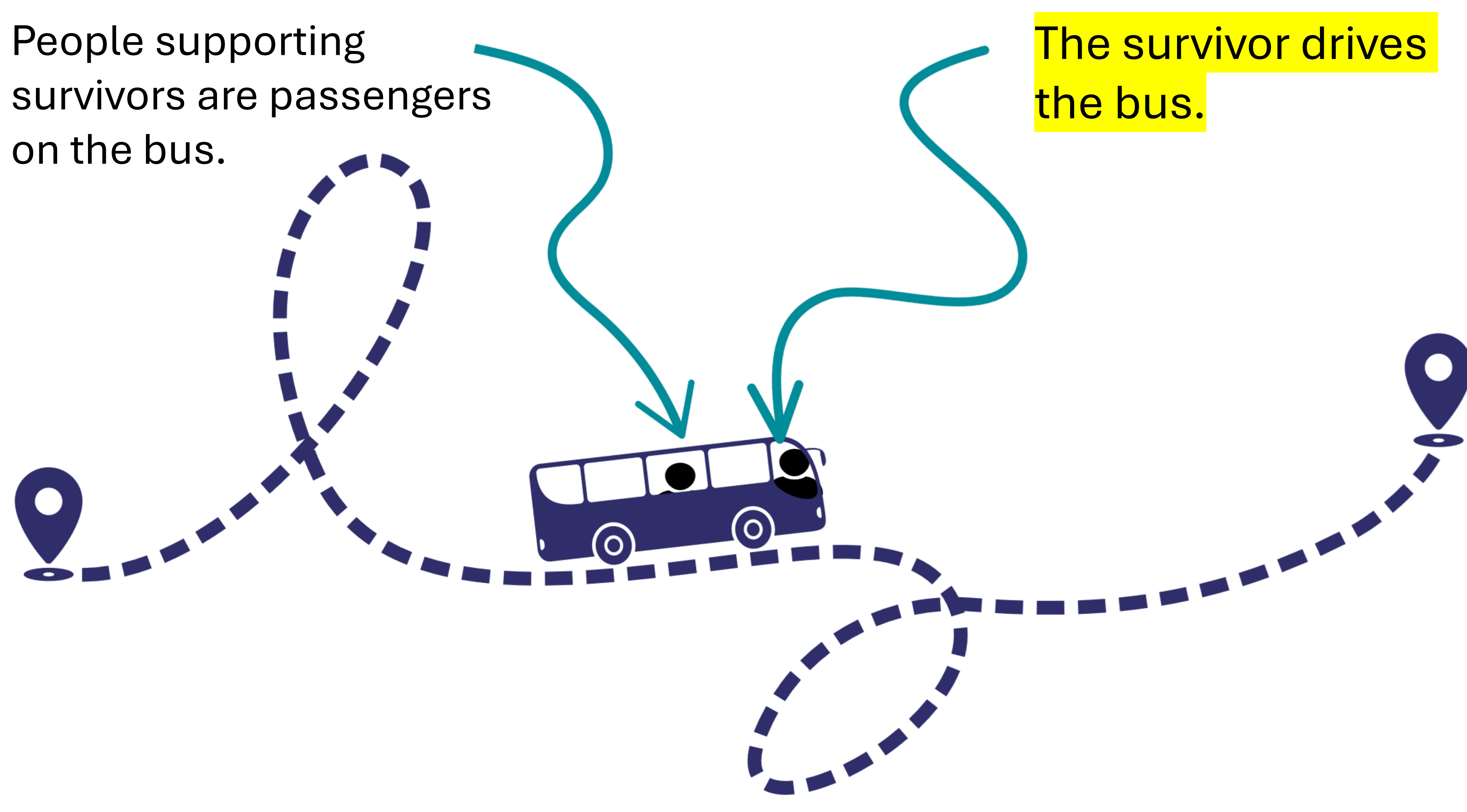


Barriers to leaving

- **Leaving is the most dangerous time for survivors.**
- Leaving does not always end the abuse.
- Abusers can be a source of both love and harm.
- Survivors may not realize they are being abused or may blame themselves for the violence.
- "Betrayal blindness"
- Intermittent reinforcement
- Isolation from social supports
- Children/Pets
- Economic Realities

On average, it takes a survivor 7-10 times to leave an abusive relationship for good.

The Empowerment Model



Role of the provider- ACT

1. <u>A</u>SK THE QUESTIONS
2. <u>C</u>ONNECT ON AN EMOTIONAL LEVEL
3. <u>T</u>RANSITION THEM TO EXPERT CARE

Because of IPV dynamics, especially isolation and surveillance, providers and clinic staff have a unique opportunity for intervention, harm reduction, and connecting patients with safety planning

Integrating Intimate Partner Violence Screening and Response into Prenatal care:

A Survivor-Centered Workflow-Integrated Community-Partnered Pilot

6/2025-6/2026

SKMC Dean's Jump-Start Pilot Grant

Philadelphia Maternal and Infant Health Mini-Grant

PILOT PROJECT AIMS:

1. Assess current practices and provider readiness
2. Develop and implement a tailored IPV screening protocol
3. Pilot and iteratively refine the workflow
4. Evaluate using RE-AIM (acceptability, uptake, scalability)

WHERE WE STARTED:

Inconsistent Screening

SDOH (not IPV-specific)

Reactive Care

Provider-Dependent

Triage / ED / L&D

Identification

Crisis-Driven

Limited Follow-Up

Social Work Referral

No Longitudinal Support

Recurrent Presentations

Minimal Safety Planning

Minimal Community Linkage

WHAT WE FOUND:

Evidence

- Limited data in prenatal care
- Repeated screening disclosure (ACOG)
- Trauma-informed care

+

Clinic Barriers

- Low provider comfort/knowelege
- Unclear resources
- Time + unclear ownership
- Weak community linkage
- No warm handoffs

→

Design Goals

- Workflow-integrated
- Low burden, high reach
- Timely, low-barrier access to advocacy and support
- Longitudinal support

WHAT WE BUILT:

1. Training

- Clinic-wide IPV education
- Trauma-informed care in pregnancy

2. Automated Screening

- MyChart-based automated screening per trimester and postpartum
- In-clinic completion if not done prior

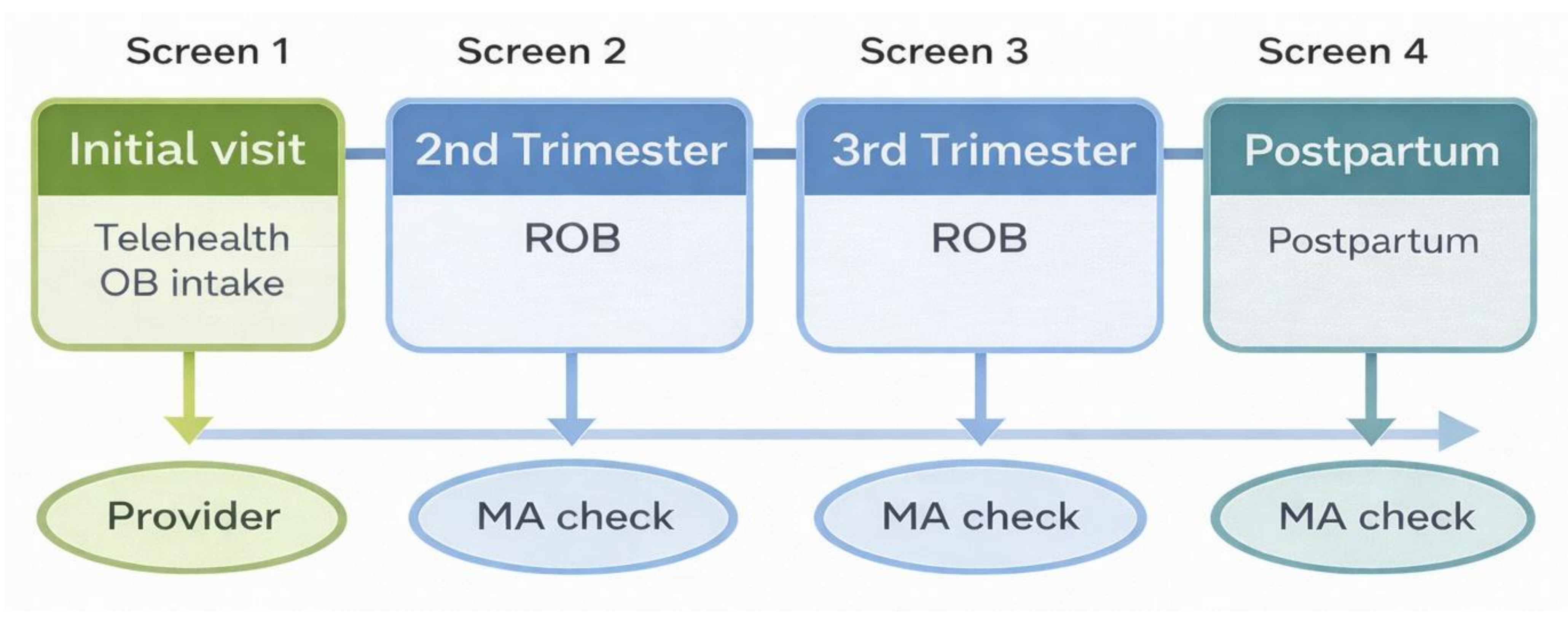
3. Response Pathway

- Automated alerts to social work for positive screens
- Standardized provider workflow (OPA with dot phrase–guided evaluation
- Confidential documentation via Problem List

4. Community Integration

- Embedded referral in EPIC
- Warm handoffs
- LSH outreach to patients
- Longitudinal IPV support

SCREENING WORKFLOW:



PreCheck-In

Routine Safety Checkup Questionnaire

For an upcoming appointment with Fan Lee, MD on 1/5/2026

These answers are confidential
You can't save your progress, and you won't be able to view your answers after you submit them.

In the last year, has your partner/ex-partner insulted or talked down to you? Screamed or cursed at you?

In the last year, have you been kicked, hit, slapped, or physically hurt by partner/ex-partner?

In the last year, have you been afraid of your partner/ex-partner?

In the last year, has your partner forced you to do sexual acts that you are not comfortable with?

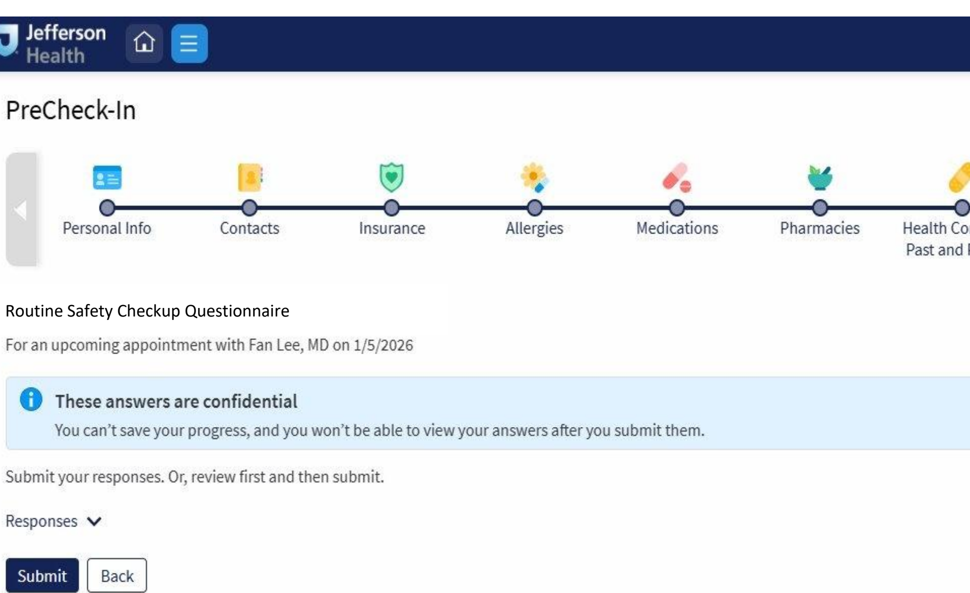
Would you like to speak with someone about your answers to any of those questions?

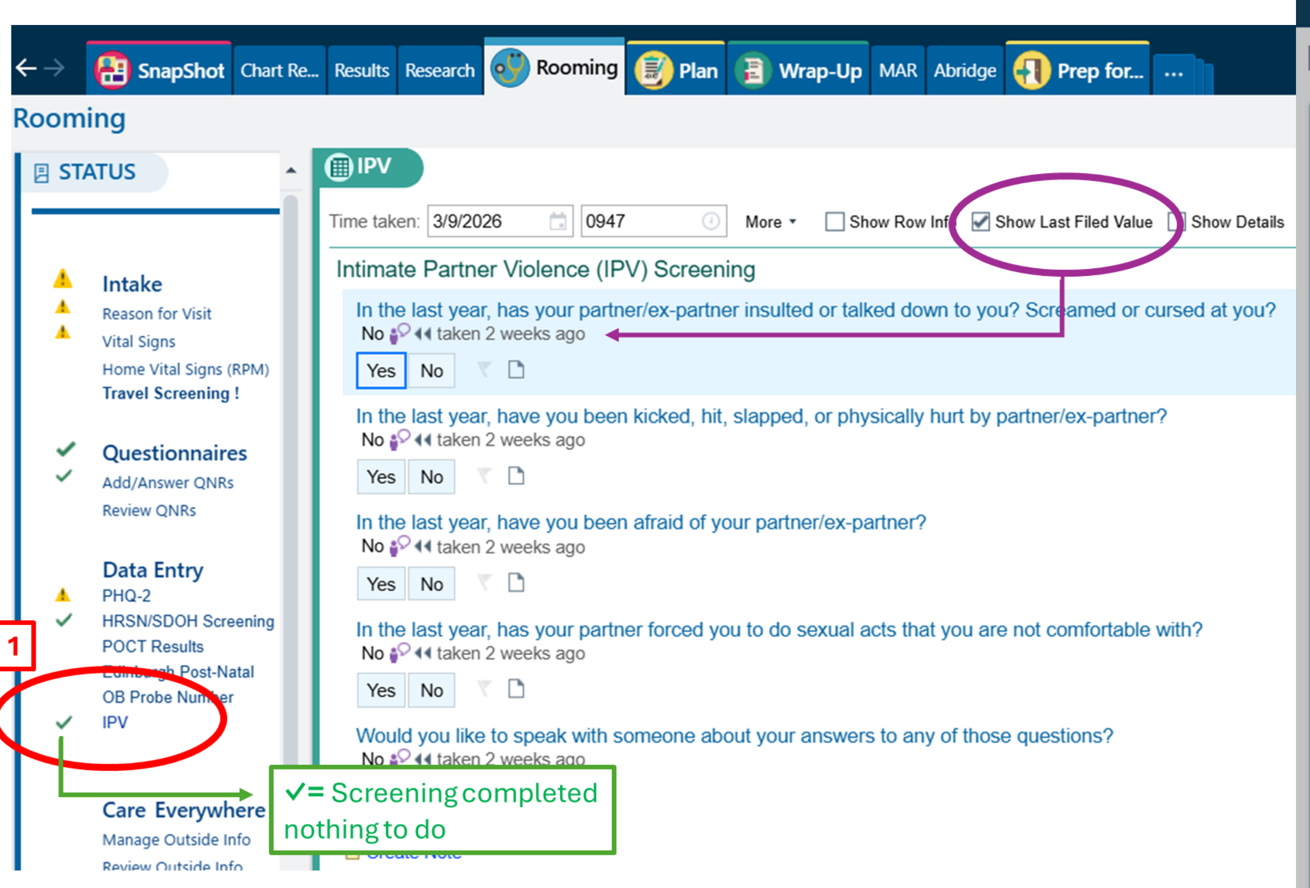
We are here for you.
Someone from our clinic team will reach out within 5-7 business days.

For immediate confidential support call **Philadelphia Domestic Violence Hotline: 1-866-723-3014 (24/7)**
Please call 911 if emergency

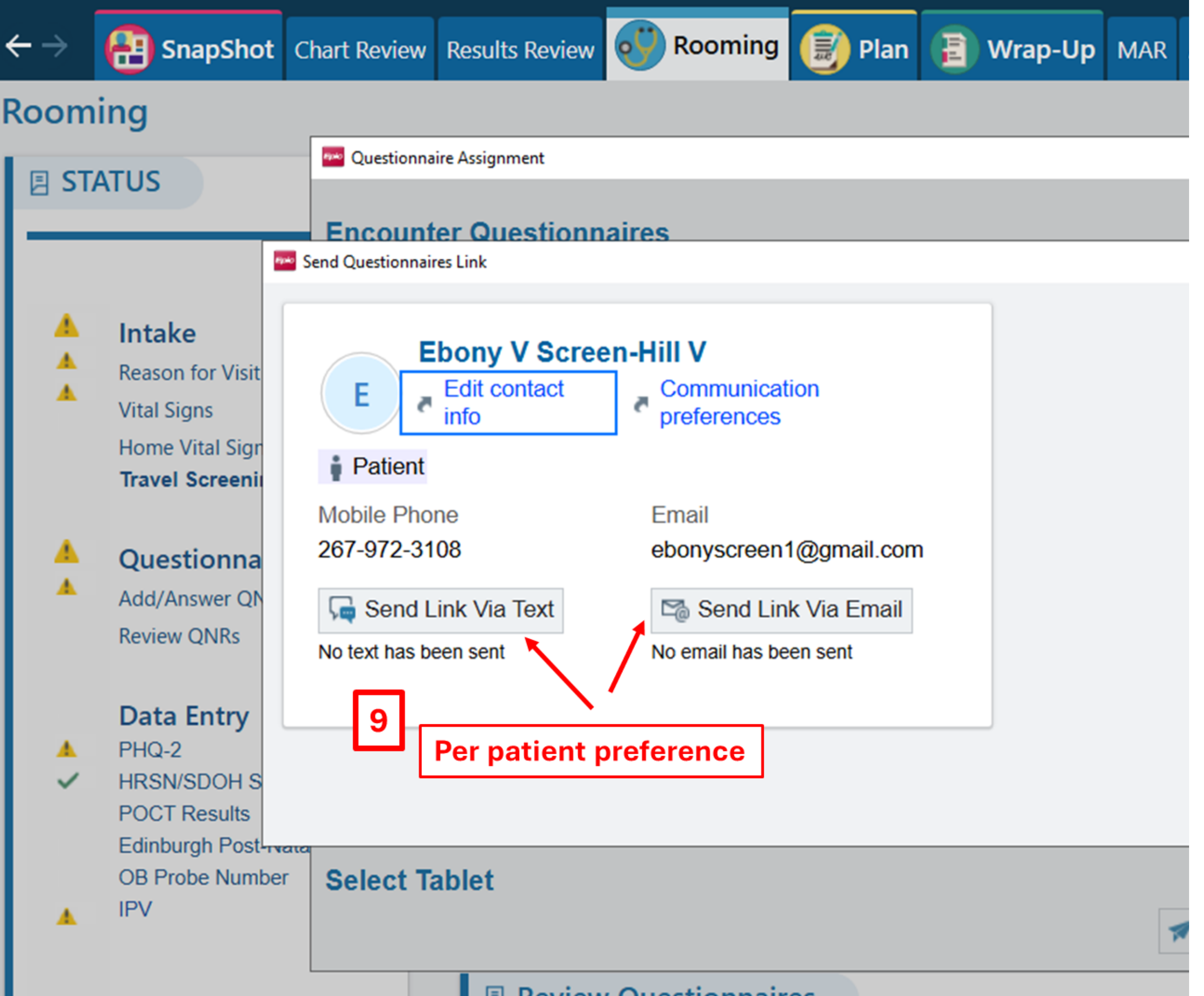
You can also visit local advocacy agencies during walk-in hours of 10AM-4PM:
Lutheran Settlement House: 1340 Frankford Avenue 215-426-8610
Congreso de Latinos: 216 W Somerset Avenue 215-763-8870
Women in Transition: 718 Arch Street, Suite 401N 215-564-5301

This questionnaire has not yet been submitted. Please click Continue to submit.



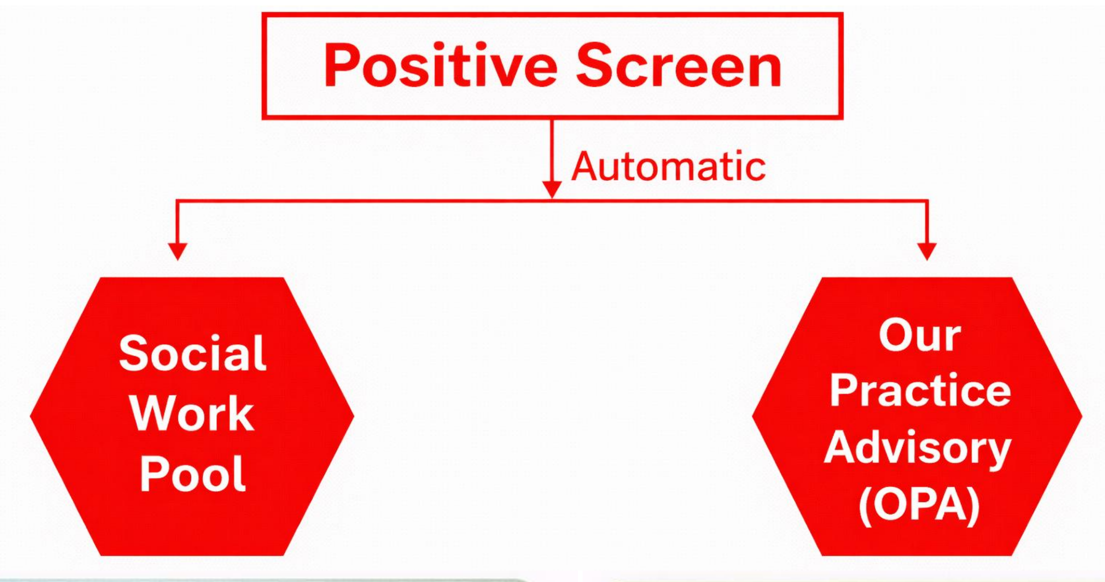


SnapShot
Chart Re...
Results
Research
Rooming
Plan
Wrap-Up
MAR
Abridge
Prep for...
Rooming
STATUS
Intake
Reason for Visit
Vital Signs
Home Vital Signs (RPM)
Travel Screening !
Questionnaires
Add/Answer QNRs
Review QNRs
Data Entry
PHQ-2
HRSN/SDOH Screening
POCT Results
Edinburgh Post-Natal
OB Probe Number
IPV
Care Everywhere
Manage Outside Info
Review Outside Info
1
IPV
Time taken: 3/9/2026 0947
More
Show Row Info
Show Last Filed Value
Show Details
Intimate Partner Violence (IPV) Screening
In the last year, has your partner/ex-partner insulted or talked down to you? Screamed or cursed at you?
No taken 2 weeks ago
Yes No
In the last year, have you been kicked, hit, slapped, or physically hurt by partner/ex-partner?
No taken 2 weeks ago
Yes No
In the last year, have you been afraid of your partner/ex-partner?
No taken 2 weeks ago
Yes No
In the last year, has your partner forced you to do sexual acts that you are not comfortable with?
No taken 2 weeks ago
Yes No
Would you like to speak with someone about your answers to any of those questions?
No taken 2 weeks ago
✓= Screening completed nothing to do



SnapShot
Chart Review
Results Review
Rooming
Plan
Wrap-Up
MAR
Rooming
STATUS
Intake
Reason for Visit
Vital Signs
Home Vital Signs
Travel Screening
Questionnaires
Add/Answer QNRs
Review QNRs
Data Entry
PHQ-2
HRSN/SDOH S
POCT Results
Edinburgh Post-Natal
OB Probe Number
IPV
Questionnaire Assignment
Encounter Questionnaires
Send Questionnaires Link
Ebony V Screen-Hill V
E
Edit contact info
Communication preferences
Patient
Mobile Phone
267-972-3108
Email
ebonyscreen1@gmail.com
Send Link Via Text
No text has been sent
Send Link Via Email
No email has been sent
9
Per patient preference
Select Tablet
Review Questionnaires

RESPONSE WORKFLOW:



- Follow-up within 7 days
- Warm handoff to LSH if accepted
- Arrange provider continuity
- Ongoing support and check-ins

Providers:

- Add "At risk for IPV" Problem List
- .IPVSCREEN – guided safety assessment
- Offers referral to LSH
- Initiates IPV-specific birth planning (.IPVPREGNANCY)

OurPractice Advisory - Zztest, LMTWO

Previous attachment

Critical (1)

At risk for intimate partner abuse: Please review alert!

In the last year, has your partner/ex-partner insulted or talked down to you? Screamed or cursed at you? : Yes (01/13/26 1649 : Physician Family Medicine, MD)
In the last year, have you been kicked, hit, slapped, or physically hurt by partner/ex-partner?: Yes (01/13/26 1649 : Physician Family Medicine, MD)
In the last year, have you been afraid of your partner/ex-partner?: Yes (01/13/26 1649 : Physician Family Medicine, MD)
In the last year, has your partner forced you to do sexual acts that you are not comfortable with?: Yes (01/13/26 1649 : Physician Family Medicine, MD)
Would you like to speak with someone about your answers to any of those questions? : Yes (01/13/26 1649 : Physician Family Medicine, MD)

PLEASE NOTE: This patient has self-identified as at risk for intimate partner abuse. After you click on the "Accept" button below, "At risk for intimate partner abuse" will be added to the problem list if not already on it.
Please open the problem and add ".IPVSCREENING" in the Overview section.

- Add Problem
  At risk for intimate partner abuse Edit Details
- Acknowledge and continue
  - Acknowledge for this encounter
  - Acknowledge for 6 months
- Defer to Storyboard to address later

View Automatically Applied Actions

Accept (1)

Babula, MD
eral
ield/Blue Cro...
CORP
File
/13/2026
UM VISIT
rded for this

Problem List Care Coordination Note

Previous attachment

Name	Description
IPVBPATEXT	
IPVHX	Social Drivers of Health - Intimate Partner Violence
IPVSCREENING	Positive IP screen. Follow-up completed privately. Patient {confi...
IPVSDH	Social Drivers of Health - Intimate Partner Violence
IPVSDOH	Social Drivers of Health - Intimate Partner Violence

Associate Signed Orders

Problem List Care Coordination Note

Search for problem Add DxReference Show: Past Problems

Verified in MyJeffersonHealth

Diagnosis

Active Problems

At risk for intimate partner abuse

Details

Chronic: Code: Z91.89 Priority: Unprioritized Noted: 1/13/2026 Share w/ Pt:

Overview

Insert SmartText

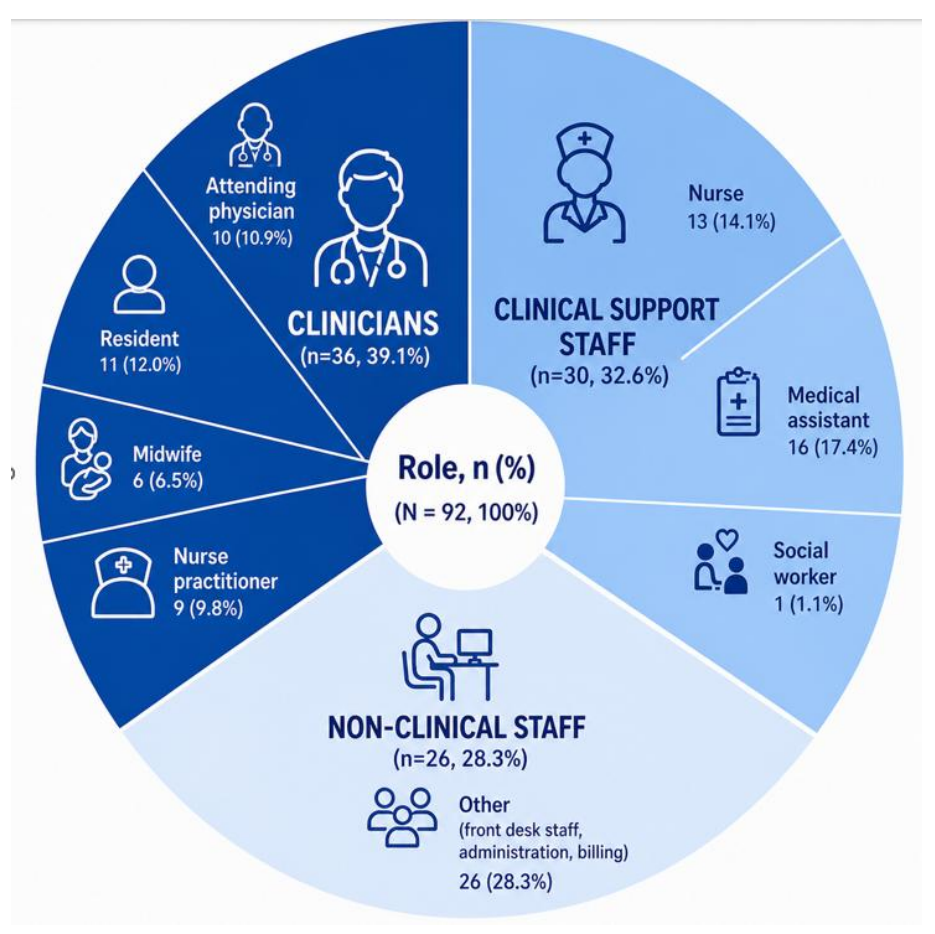
Positive IP screen. Follow-up completed privately.
Patient confirmed/denied IPV and is in immidiate/not immediate danger
Resources: Phila DV Hotline 1-866-723-3014; LSH DV Program 215-426-8610 ext. 1282.
Referral to advocacy: accepted/declined
Interpreter used: Use interpreter

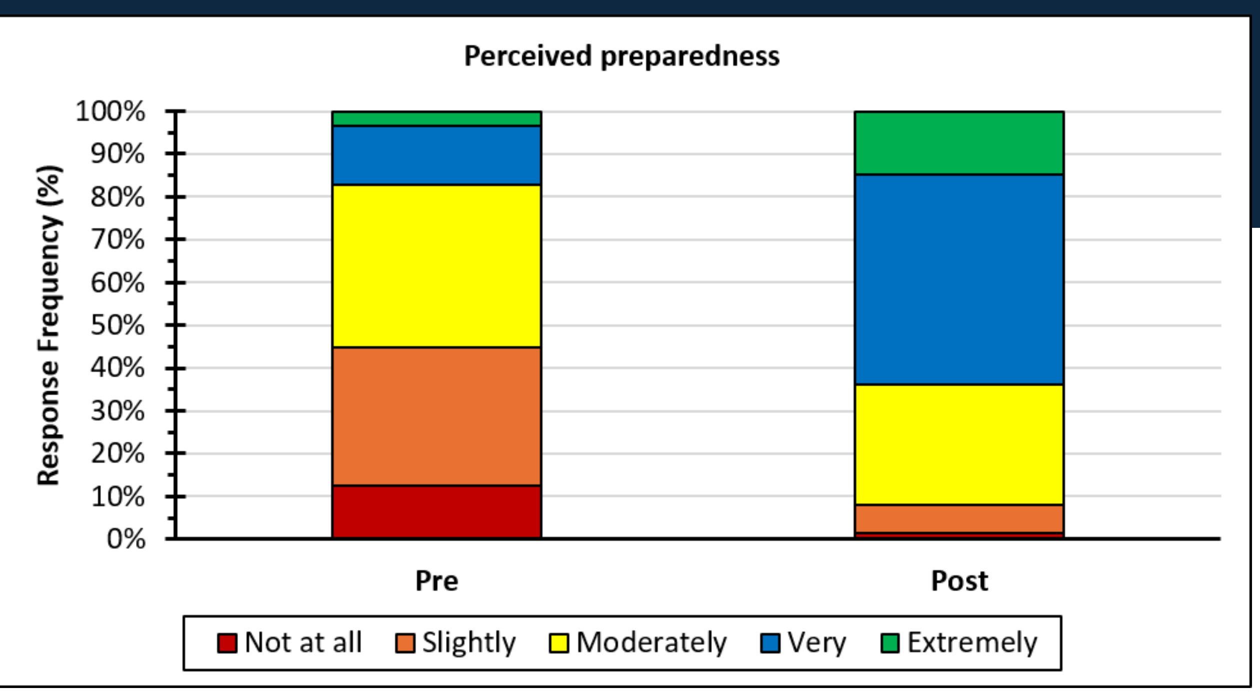
Accept Cancel

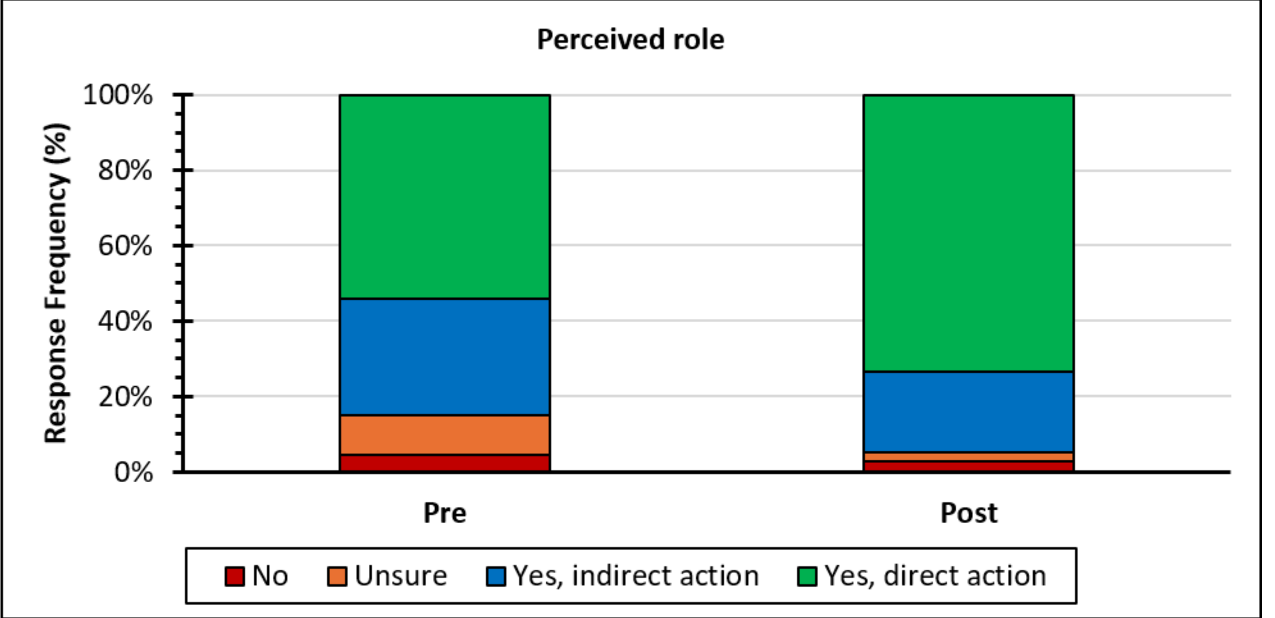
Create Current Assessment & Plan Note

Mark as Reviewed Never Reviewed Problem List Activity

PRELIMINARY RESULTS







Preliminary Screening Results (First 12 Weeks)

1123
Patients Screened

77%
Eligible Patients Screened

79%
Completed via **MyChart**

High screening uptake with meaningful connection to community support.

PATIENT SATISFACTION

Patient Perceptions of Intimate Partner Violence Screening

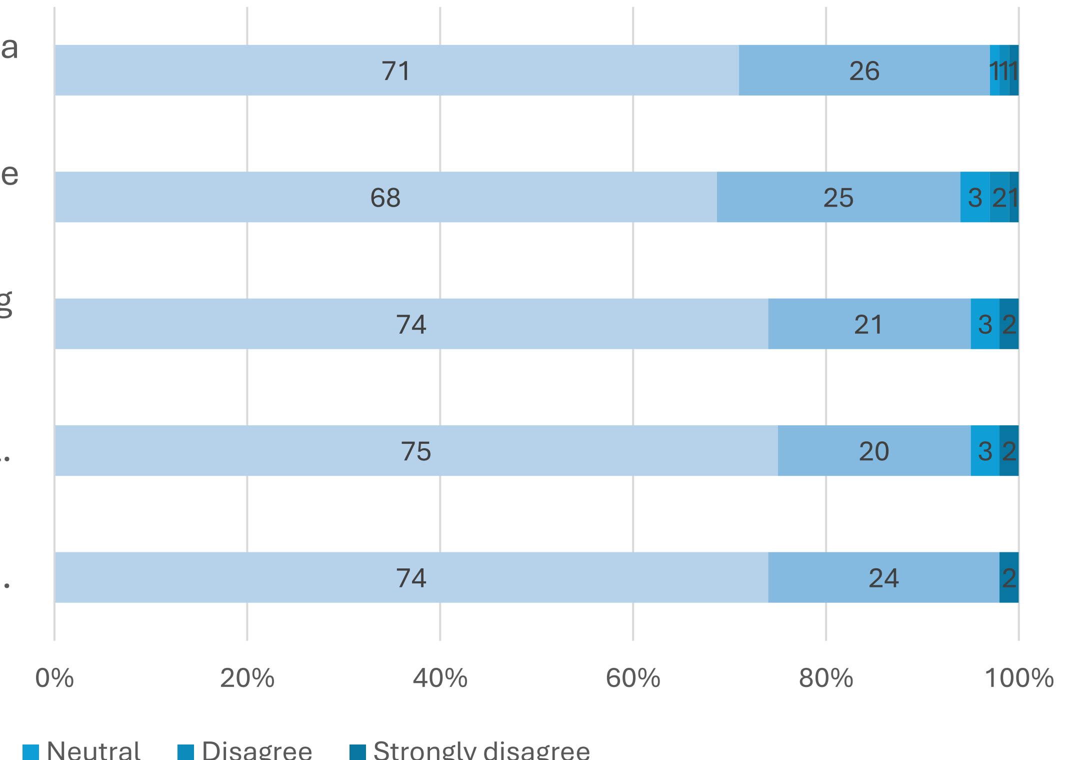
Felt screening modality (MyChart before visit, on a personal device during visit, etc.) worked well.

Felt would get support if concerns about safety were shared.

Felt being asked about relationship safety during prenatal visit was acceptable.

Felt that responses were kept private/confidential.

Felt safe answering the screening questions.



Demographics (N=100)	n(%)
Age	
18-24	18
25-34	54
35-44	28
Race/Ethnicity	
White	42
Black or African American	34
Hispanic or Latino	15
Asian	7
Bi-racial	2
Primary Language	
English	98
French	2
Route of Screening	
MyChart	80
In-person during visit	14
Private device during visit	6

Main Themes from open response:

- Patients felt **comfortable** completing screening
- Appreciated being **asked about safety**
- Questions were **clear and appropriate**
- Valued ability to complete screening **privately** (without partner present)
- Some patients who screened negative still **wanted in-person discussion**

PILOT PROJECT AIMS:

1. Assess current practices and provider readiness
2. Develop and implement a tailored IPV screening protocol
3. **Pilot and iteratively refine the workflow**
4. Evaluate using RE-AIM (acceptability, uptake, scalability)

We are screening.

We have a response.

We have community partnerships.

We are screening.
We have a response.
We have community partnerships.

We are screening.
We have a response.
We have community partnerships.
Stigma & Silence
Shame
Normalization of violence
Cultural stigma
Fear & Safety
Fear of retaliation
CPS & children
Privacy concerns / partner presence
Barriers to Access
Transportation, childcare
Financial dependence
Housing instability
Language barriers
Gaps in Education
What is IPV?
What happens if I disclose?
Available resources
Structural & System Challenges
• Fragmented care
• Time constraints in clinic
• Limited access to advocates
• Lack of longitudinal support

- *It matters what they see around them*
- *It matters to address the elephant in the room*
- *It matters who talks to them*

What Matters

The environment itself can communicate safety.

Non-verbal signs of support matter.

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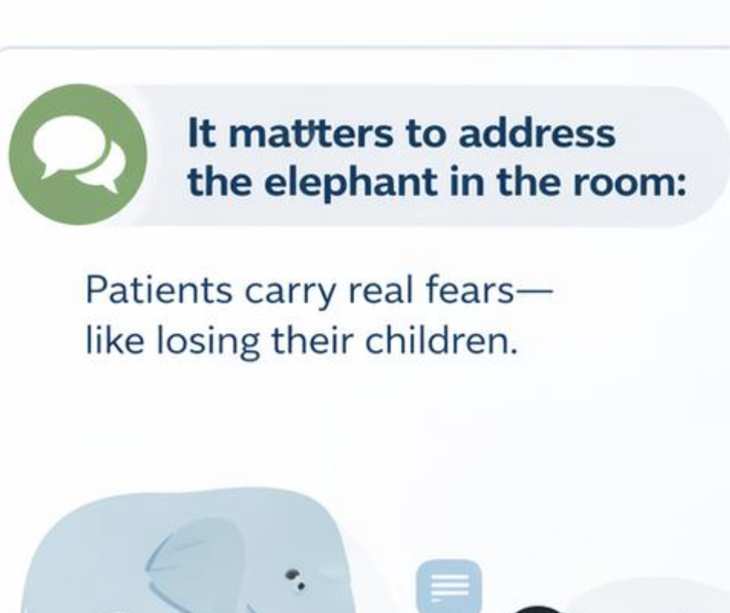

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Patients carry real fears—like losing their children.

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Patients carry real fears—like losing their children.

It matters who talks to them:

Survivors shared they felt more comfortable speaking with advocates or social workers.

Gaps We're Recognizing

- MyChart:
  unclear who
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Screening Limitations

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Care Gaps After Disclosure

- Disclosure ≴ support
- Need for:
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Practical Barriers

- Limited phone/ technology access
- IPV control dynamics limit follow-up

Centering the Survivor: Next Steps

1. Environment & Messaging

- ✓ Posters + discreet resource cards (perinatal-specific)
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- ✓ Resource-led **model** (no disclosure required)
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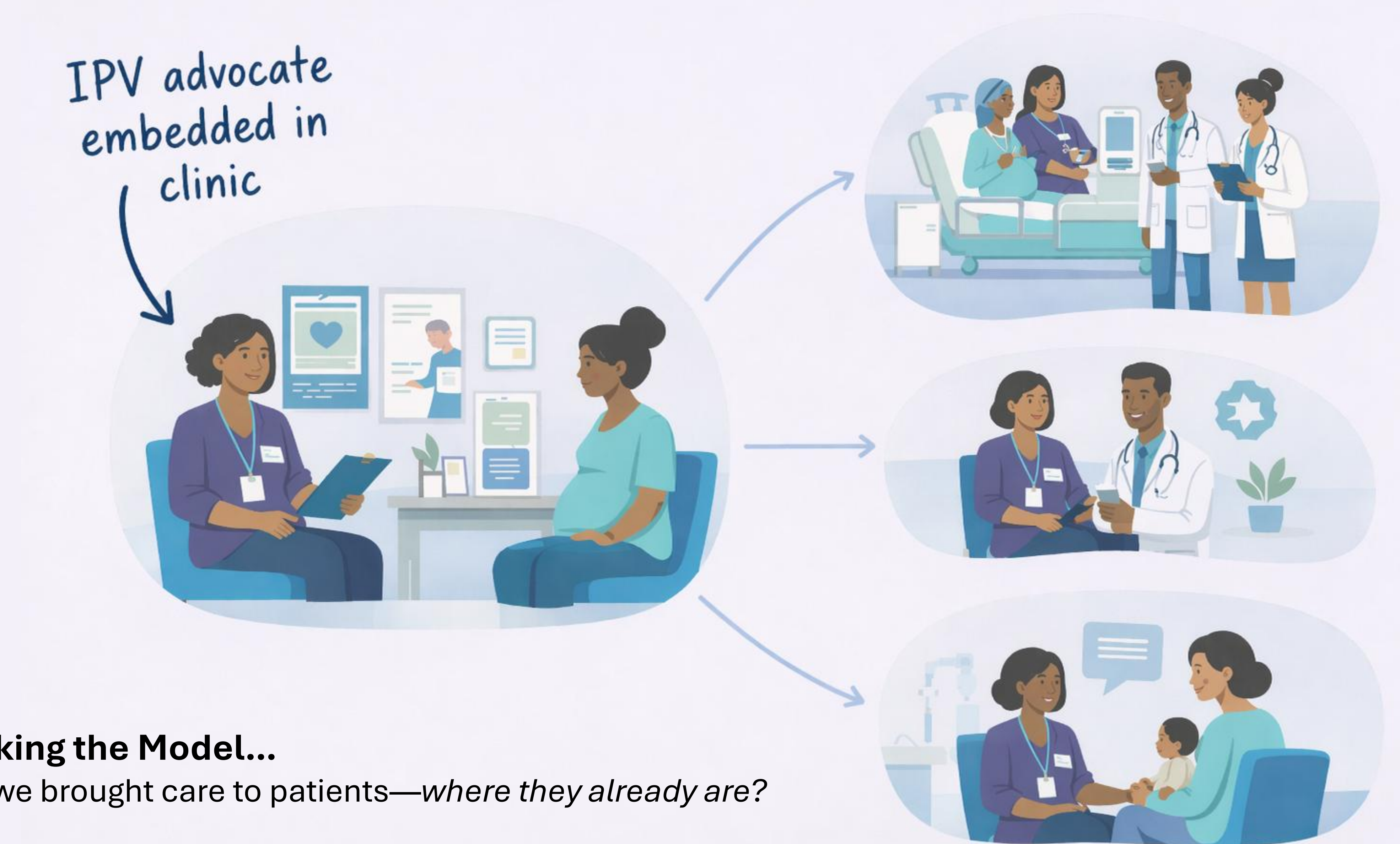
4. Sustainability & Culture Change

- Leadership buy-in
- IPV training as required **for all staff**
- Onboarding + ongoing refreshers

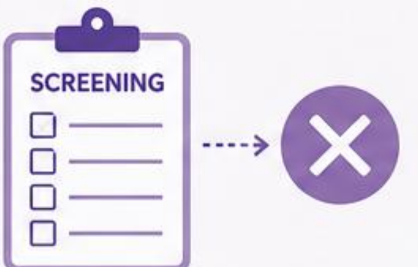


Rethinking the Model...

What if we brought care to patients—*where they already are?*

Key Takeaways Applicable to HRSN Screening

1 Screening alone is insufficient



Identification without response can feel performative or even harmful.

2 Trust and relationship-building matter

Patients disclose more when they feel seen, respected, and supported.

3 Real-time response is critical

Needs are often immediate and dynamic during pregnancy.

4 Embedded support works better than fragmented referral systems

Warm handoffs outperform handing patients a phone number or resource sheet.

5 Longitudinal engagement matters

Social needs evolve across pregnancy, delivery, and postpartum.

6 Care should extend across settings

Prenatal clinic, triage, labor and delivery, postpartum, NICU, and outpatient care should not function as isolated silos.

7 Dedicated personnel matter

Community health workers, navigators, doulas, social workers, and advocates can operationalize support in ways physicians alone often cannot.

8 Universal education can reduce stigma

Not every patient will disclose a need today, but every patient can leave knowing resources exist.

If Jasmine presented to your hospital tomorrow:

What would happen next?
What is the patient experience from disclosure to response?

Who would respond?
Who is involved at each step of the process?

Where are the gaps?
Where do patients fall through the cracks?

What resources already exist but are disconnected?
What do we have that we could better connect?

What would it take to build a more trusted, coordinated, and longitudinal model of support?
What changes—big or small—could make a meaningful difference?

Questions?

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