Social Determinants of Health (SDH) Screening Sample Workflow

Steps for Non-Clinical Staff After the Clinical Visit

Non-clinical staff includes patient navigators, patient advocates, and community health workers, among others.

Take-Aways:
- Non-clinical staff are often employed from the community, so they can more easily relate to patients, understand their needs, and build trusting relationships.
- Ensures that the staff person administering SDH screening also addresses the needs identified by referring the patient to resources.
- Non-clinical staff have more time to administer and respond to assessments.
- Allows the patient to become familiar and comfortable with the clinical setting.
- Information is not available during the time of the visit.
- Contact information for follow up can be a barrier.
- Increases the patient’s time at the clinic.

The Steps:

#1 Clinical Visit w/Provider  
Provider conducts clinical visit.  
Provider will refer patient to non-clinical staff (Patient Navigator) on an annual basis.

#2 Referral to Patient Navigator  
Patient navigator explains why they will ask SDH questions and how it can help the patient’s care plan, either in person or by phone.

#3 Ask SDH Questions  
Patient navigator asks the patient to answer all of the questions in whichever form they like (i.e. with assistance or on their own).  
If patient has already answered questions in the past, ask if they would answer these differently.

#4 Document Responses  
Patient navigator records and dates the patient's answers in electronic health record, using z codes where possible.  
If patient has answered the questions in the past and answers differently, Patient Navigator records and dates changes.

#5 Connect Patient to Resources  
The Patient navigator will connect the patient to community resources, if those resources are available.

#6 Follow Up  
Patient navigator follow up by phone to determine if resources were utilized.  
Document in electronic health record.

Within 24 hours  
Within one week  
In person or w/in a week of visit  
If social needs are identified  
If no needs are identified