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

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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.

PATIENT SNAPSHOT

- 27-year-old
- G2P0101
- 14 weeks gestation
- Mother to a 6-year-old son
- Currently staying with her cousin

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

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
Intimate partner violence
Safety concerns
Employment instability
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

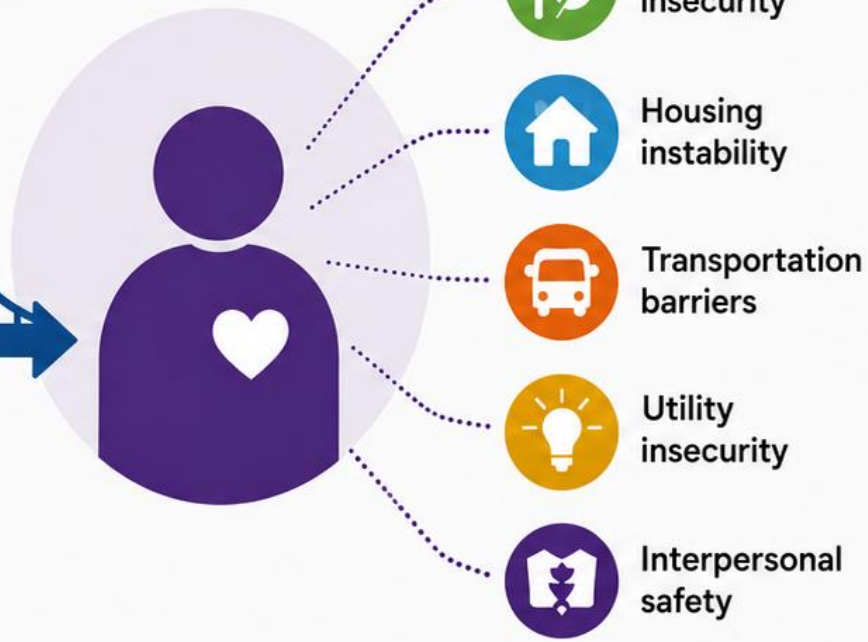
Population/Community level

- Education
- Economic Stability
- Neighborhood & Built Environment
- Social & Community Context
- Health Care System

Health-Related Social Needs (HRSNs)

Individual-level actionable needs presenting in healthcare settings

Individual level



- Food insecurity
- Housing instability
- Transportation barriers
- Utility insecurity
- Interpersonal safety

Milestones that shaped modern SDOH framework

1948

UK National Health Service

NHS

1974

Lalonde Report (Canada)

1980

Black Report (UK)

2008

WHO Commission on SDOH

World Health Organization

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

CMS
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

1

Not all patients agree to screening

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

2

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]

3

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]

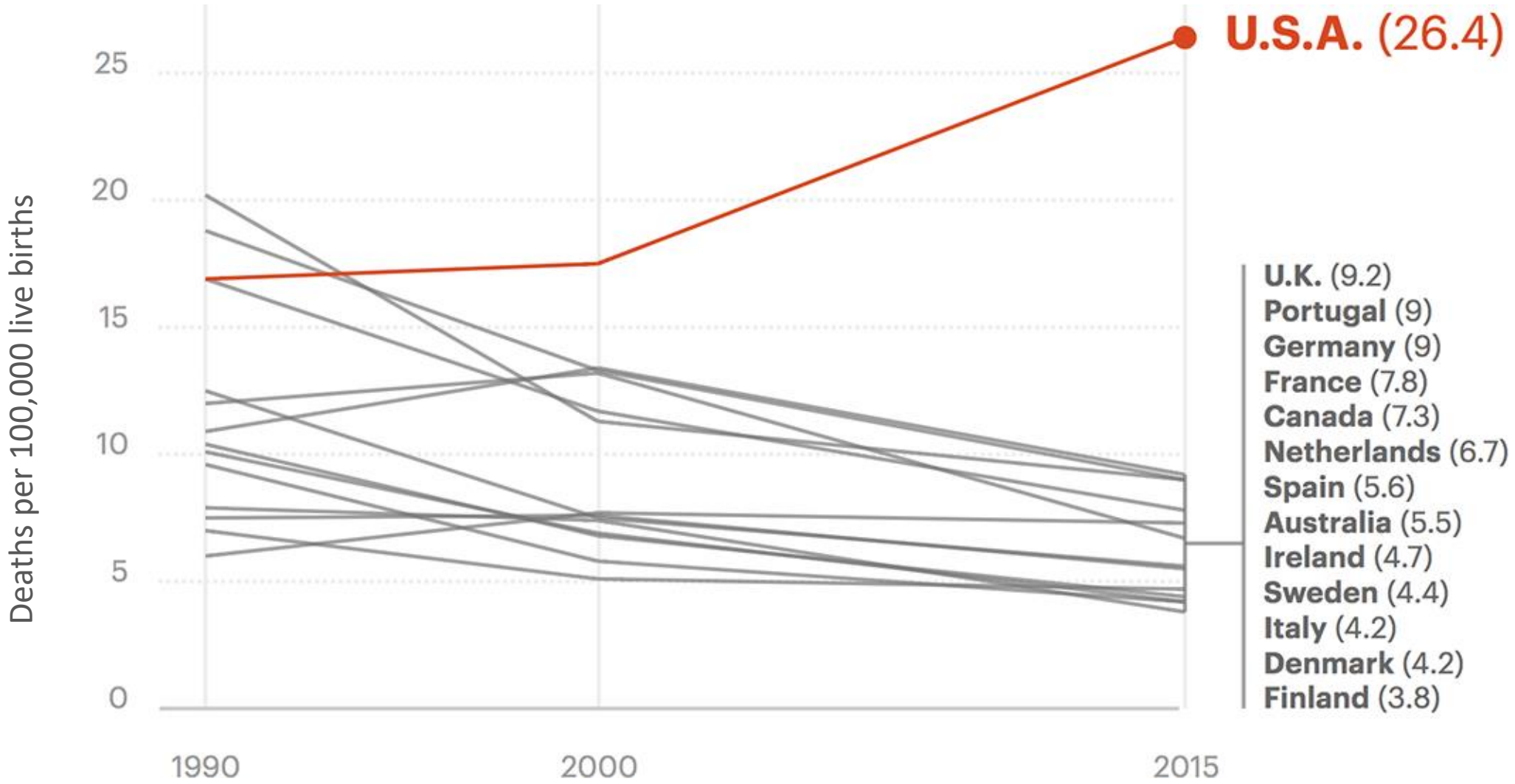
4

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

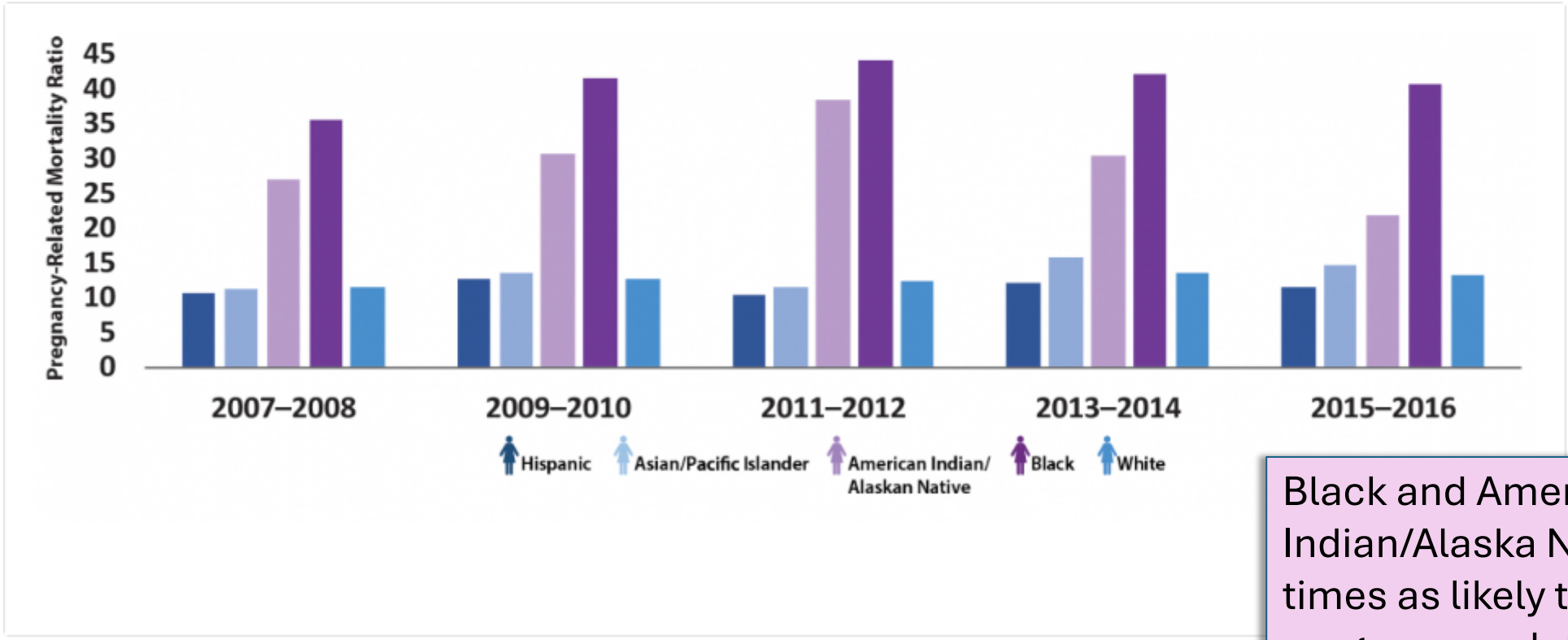
Why Social Determinants of Health (SDOH) Matter in Pregnancy & Postpartum

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



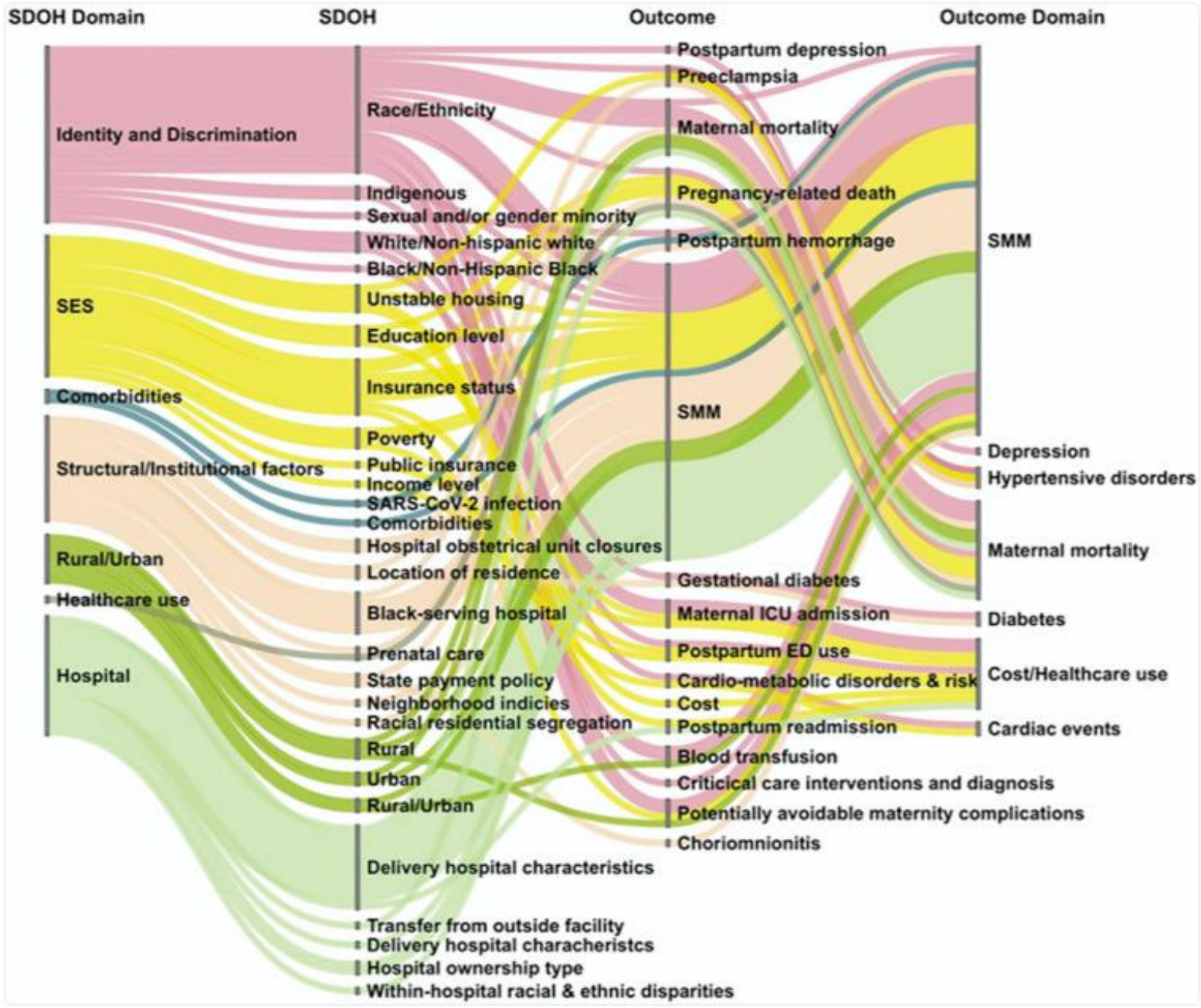
"Global, regional, and national levels of maternal mortality, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015," *The Lancet*. Only data for 1990, 2000 and 2015 was made available in the journal.
Source: The Lancet

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*

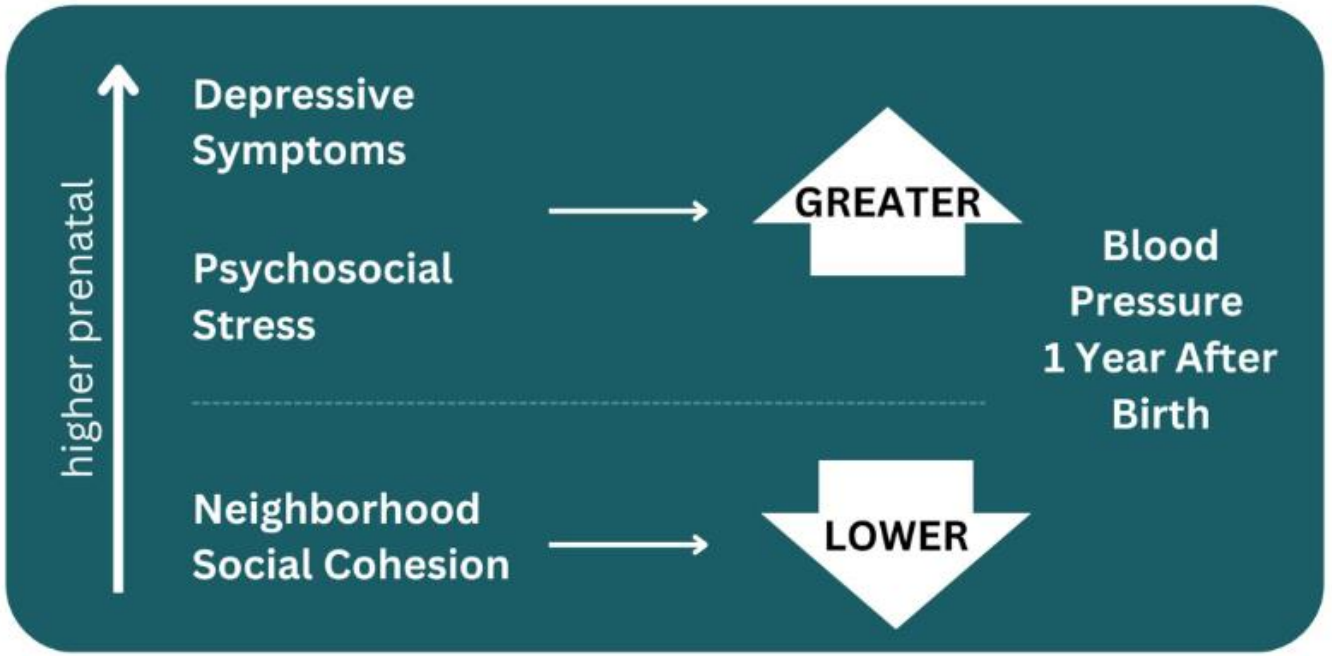
*survey in 9 U.S. jurisdictions of women who had a live birth

VetoViolence®

Preventing violence during pregnancy **supports maternal and infant health.**

CDC

Prenatal Psychosocial Stressors and Blood Pressure Across 4 Years Postpartum



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

The New York Times

OPINION

THE KILLINGS OF YOUNG MOTHERS

By Sara Chodosh
Illustrations by Angelica Alzona

Dec. 9, 2024

It's a startling statistic: In the United States, a woman's risk of being killed grows when she becomes pregnant and after giving birth — by about 20 percent, on average.

This increase is entirely driven by the murders of America's youngest mothers. When women under age 25 get pregnant, their odds of death by homicide more than double.

This is just one of their stories.

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%)

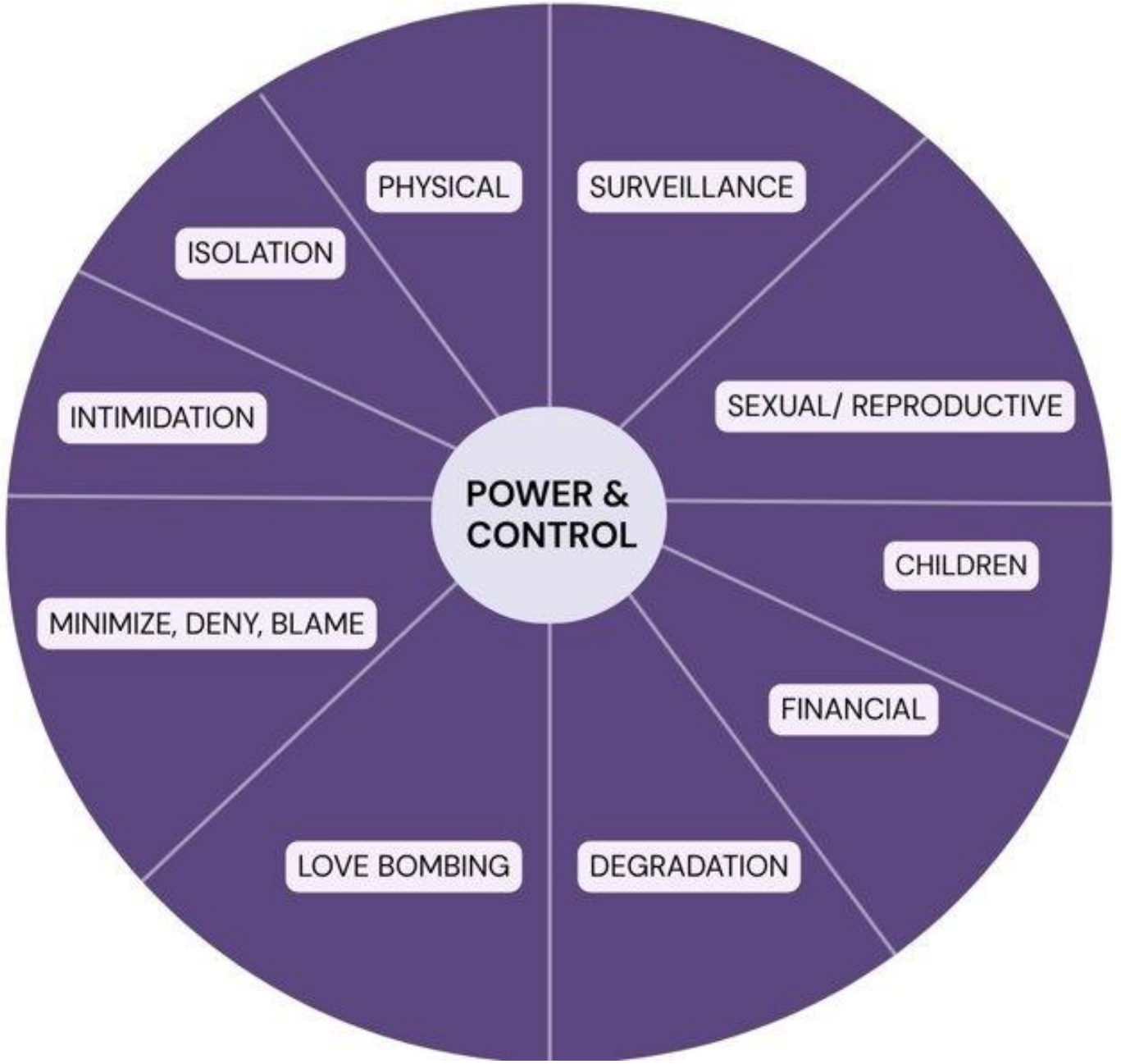
Homicide is a leading cause of maternal mortality in the U.S. most often perpetrated by an intimate partner.

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

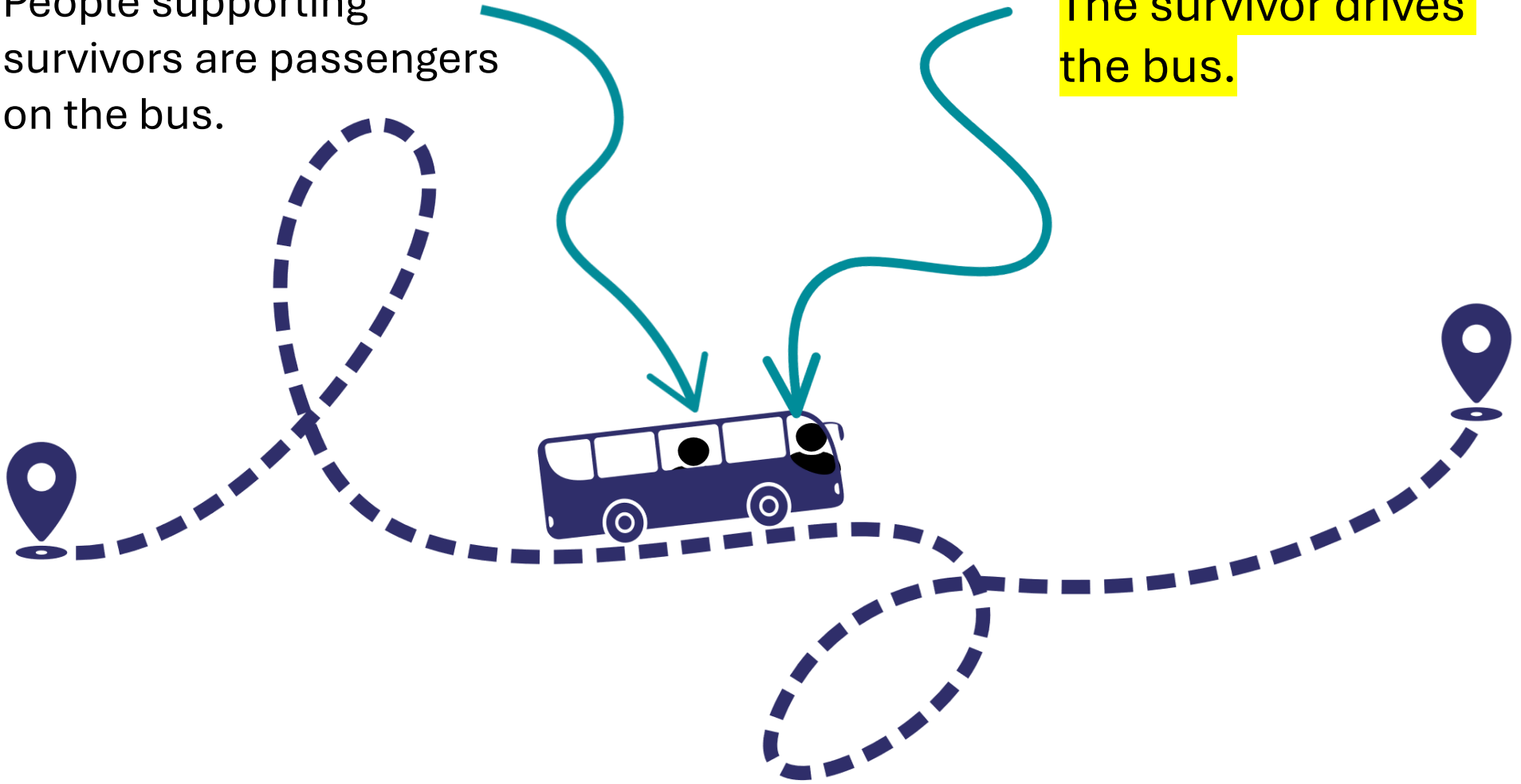
- **Leaving is the most dangerous time for survivors.**
- Leaving does not always end the abuse.
- Abusers can be a source of both love and harm.
- Survivors may not realize they are being abused or may blame themselves for the violence.
- "Betrayal blindness"
- Intermittent reinforcement
- Isolation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

People supporting survivors are passengers on the bus.

The survivor drives the bus.



Role of the provider- ACT

1. **A**SK THE QUESTIONS
2. **C**ONNECT ON AN EMOTIONAL LEVEL
3. **T**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

Lutheran Settlement House

WOMEN IN TRANSITION

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:

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

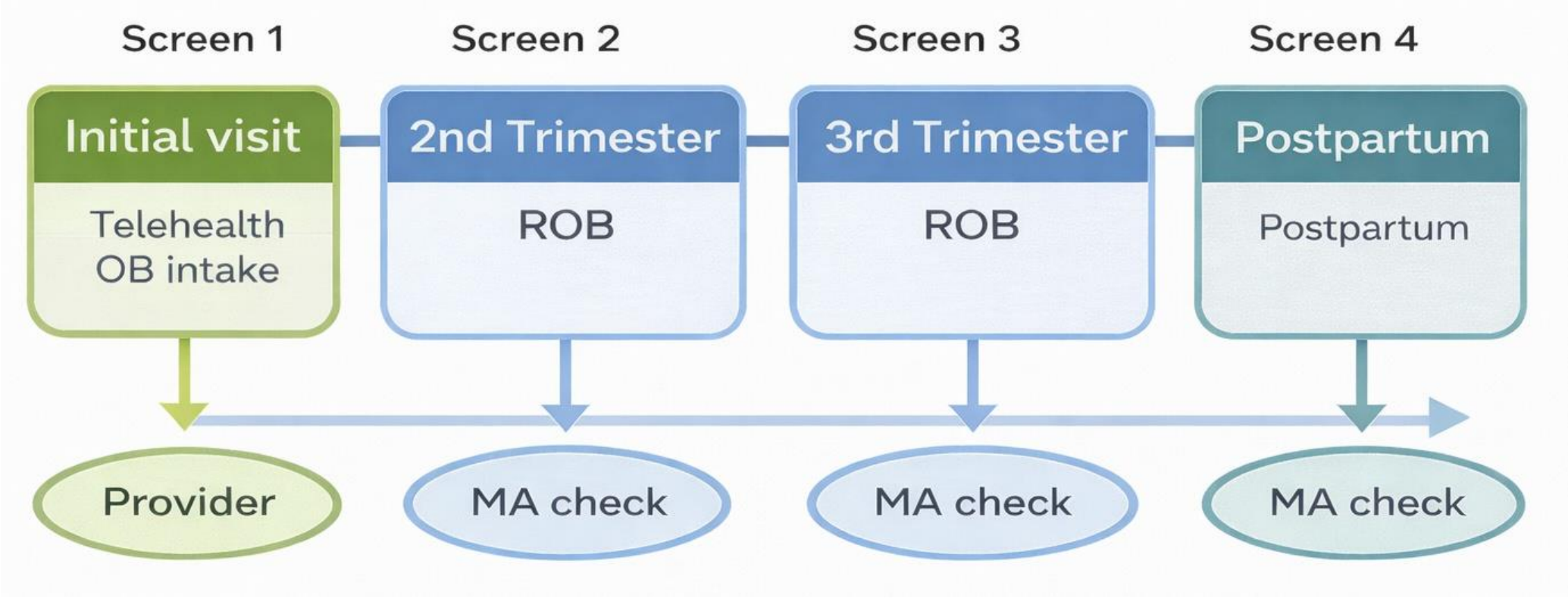
3. Response Pathway

- 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:



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?
Yes No

In the last year, have you been kicked, hit, slapped, or physically hurt by partner/ex-partner?
Yes No

In the last year, have you been afraid of your partner/ex-partner?
Yes No

In the last year, has your partner forced you to do sexual acts that you are not comfortable with?
Yes No

Would you like to speak with someone about your answers to any of those questions?
Yes No

Continue

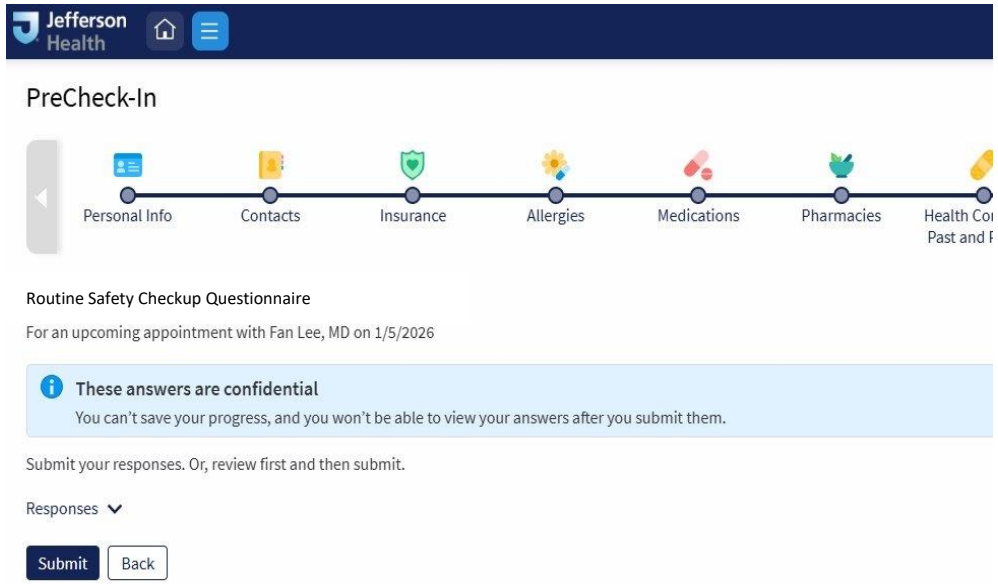
We are here for you.
Someone from our clinic team will reach out within 5-7 business days.

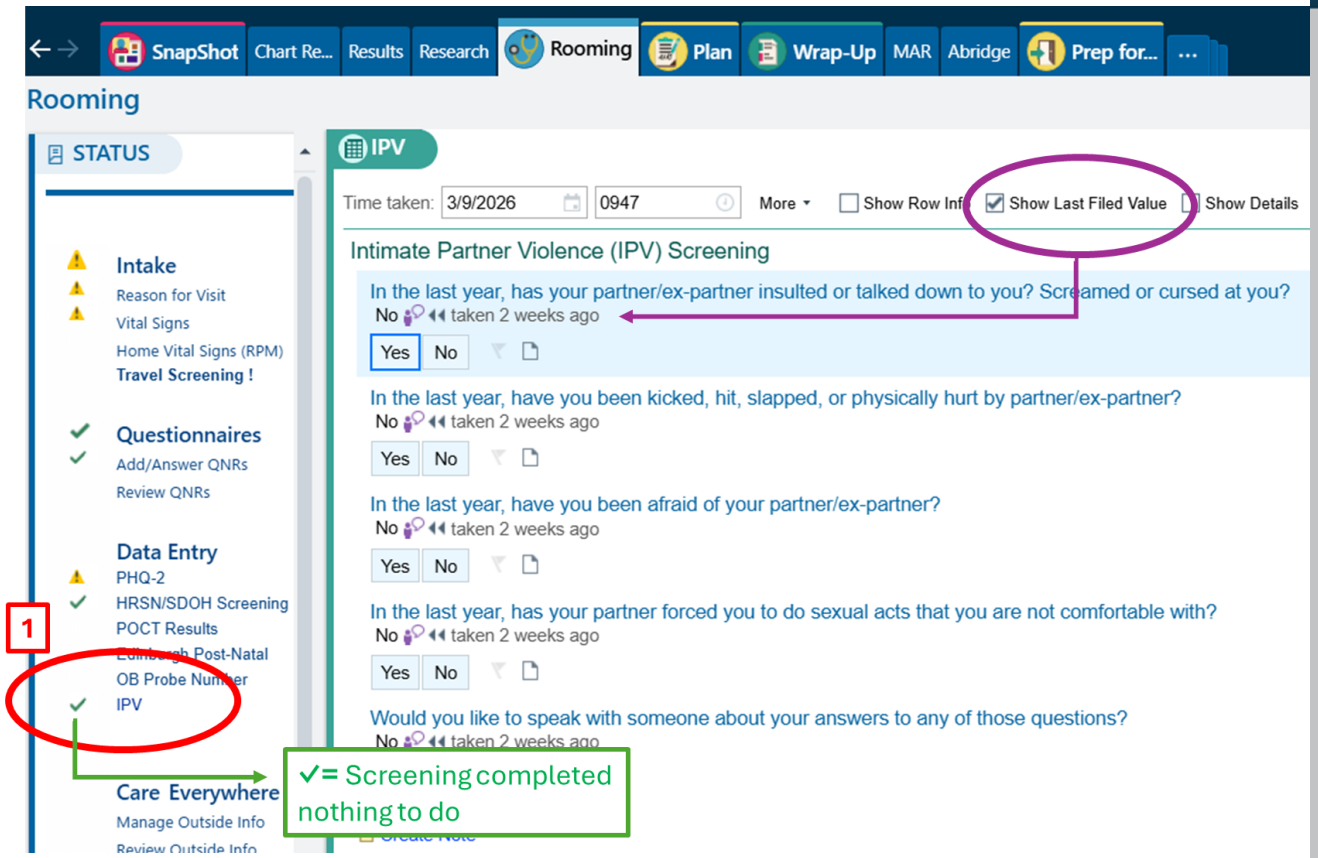
For immediate confidential support call **Philadelphia Domestic Violence Hotline: 1-866-723-3014 (24/7)**
Please call 911 if emergency

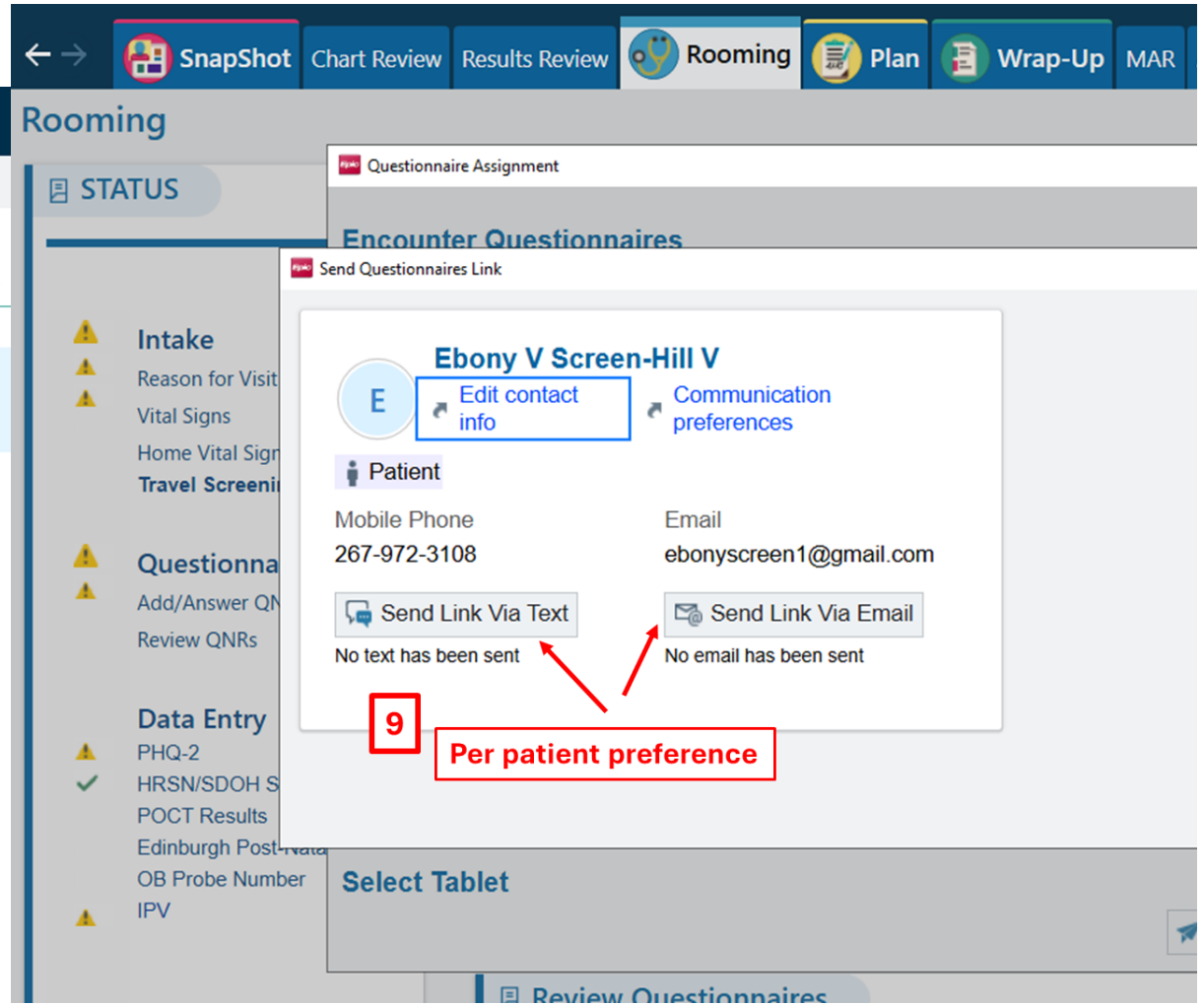
You can also visit local advocacy agencies during walk-in hours of 10AM-4PM:
Lutheran Settlement House: 1340 Frankford Avenue 215-426-8610
Congreso de Latinos: 216 W Somerset Avenue 215-763-8870
Women in Transition: 718 Arch Street, Suite 401N 215-564-5301

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

Cancel




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
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Ebony V Screen-Hill V
E
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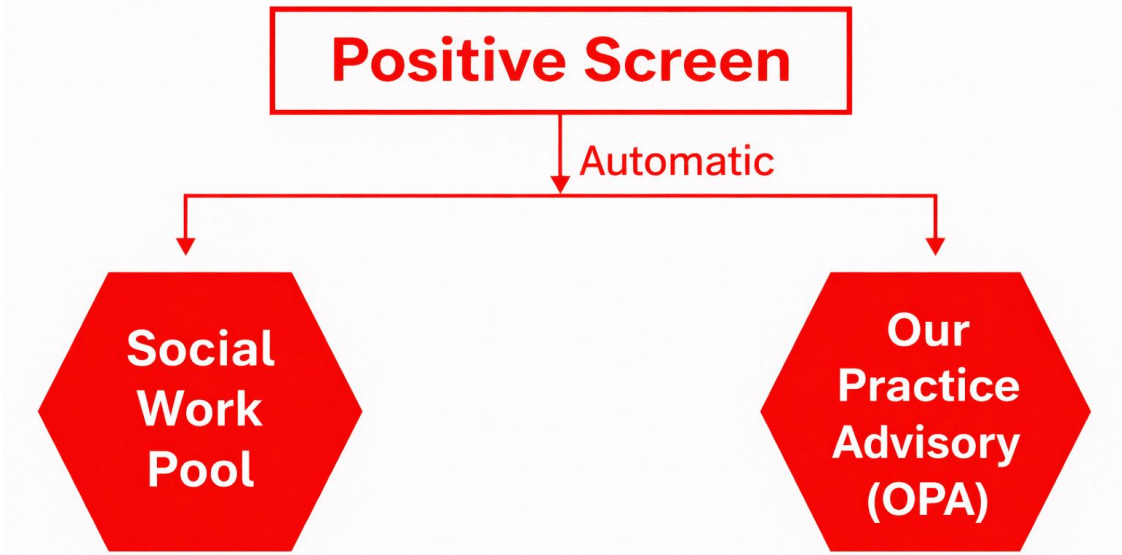
Communication preferences
Patient
Mobile Phone
267-972-3108
Email
ebonyscreen1@gmail.com
Send Link Via Text
No text has been sent
Send Link Via Email
No email has been sent
9
Per patient preference
Select Tablet
Review Questionnaires

RESPONSE WORKFLOW:

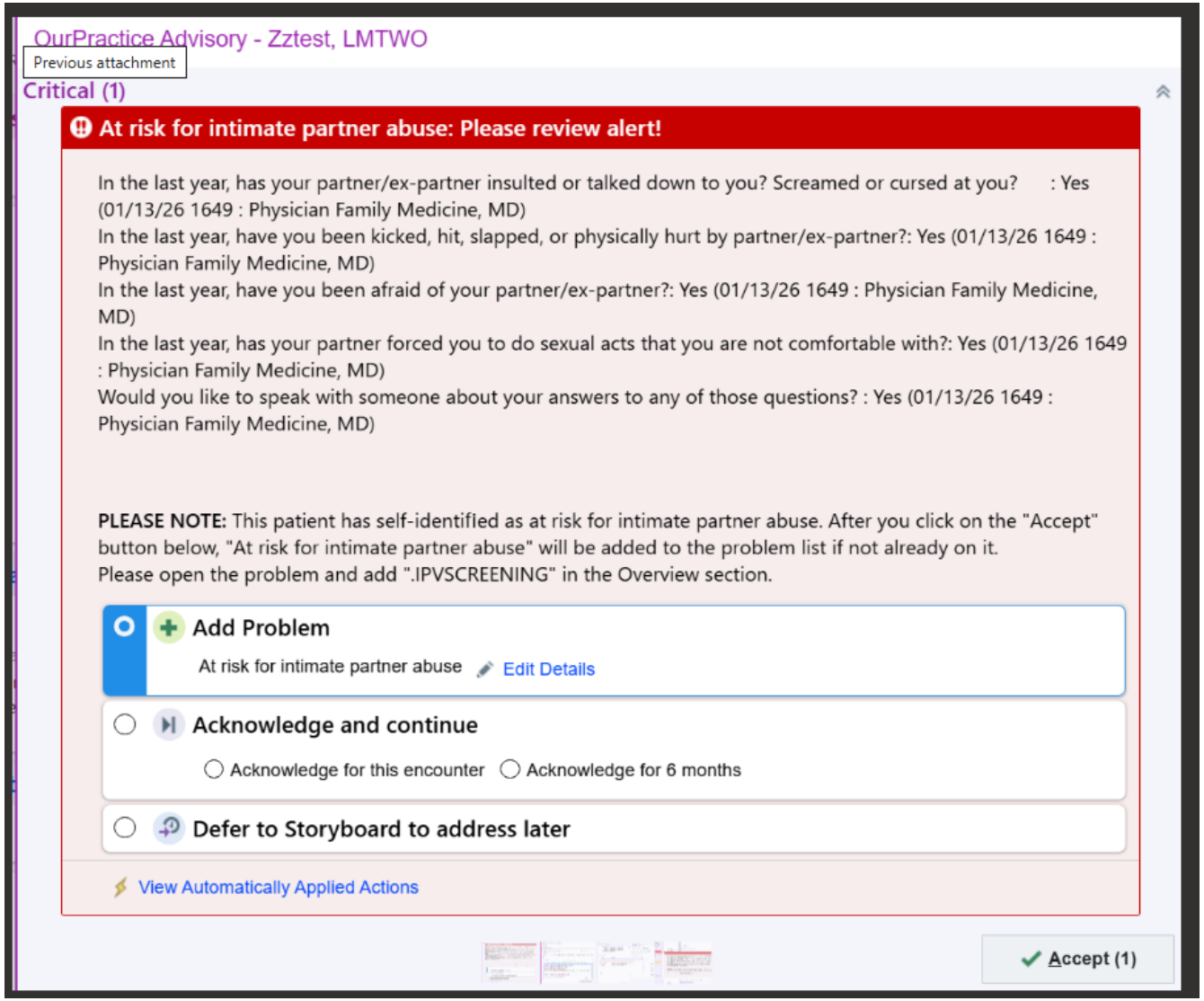


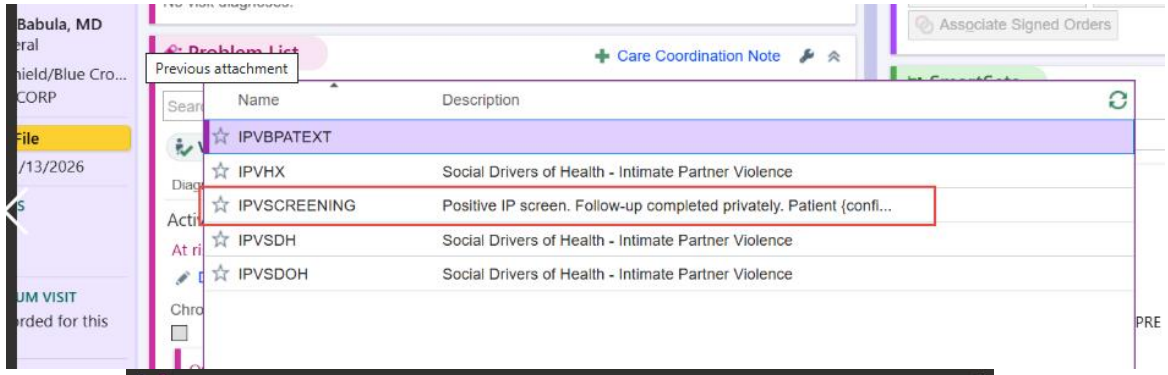
Social Work:

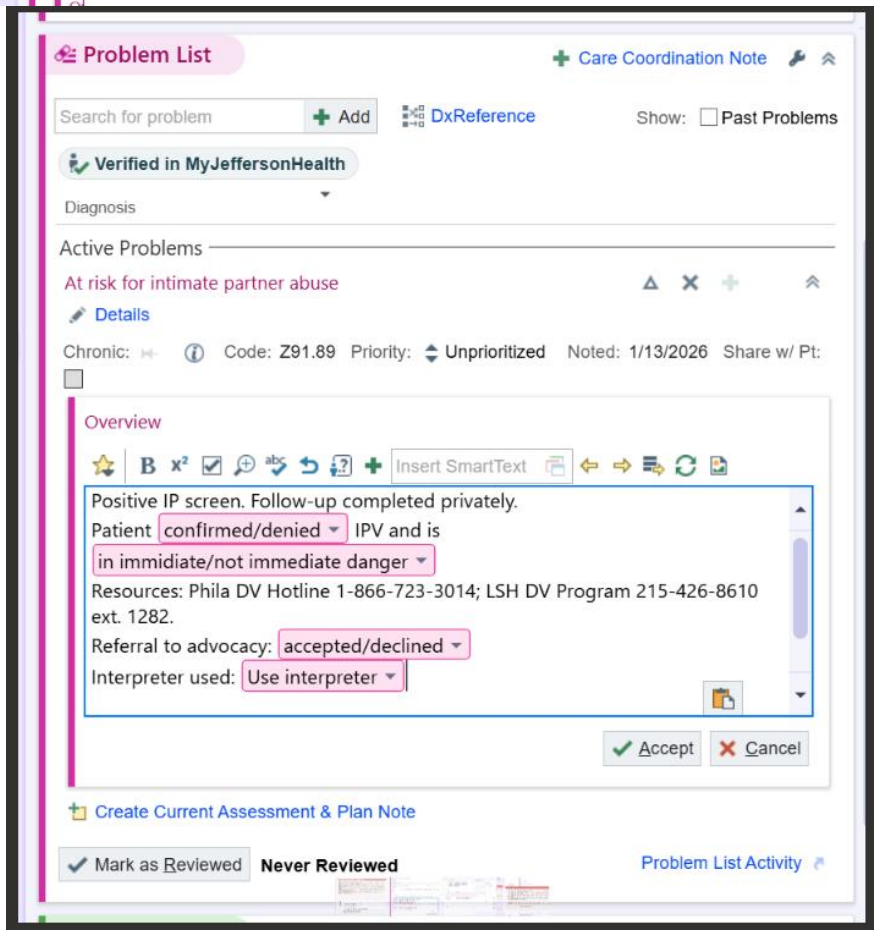
- Follow-up within 7 days
- Warm handoff to LSH if accepted
- Arrange provider continuity
- Ongoing support and check-ins

Providers:

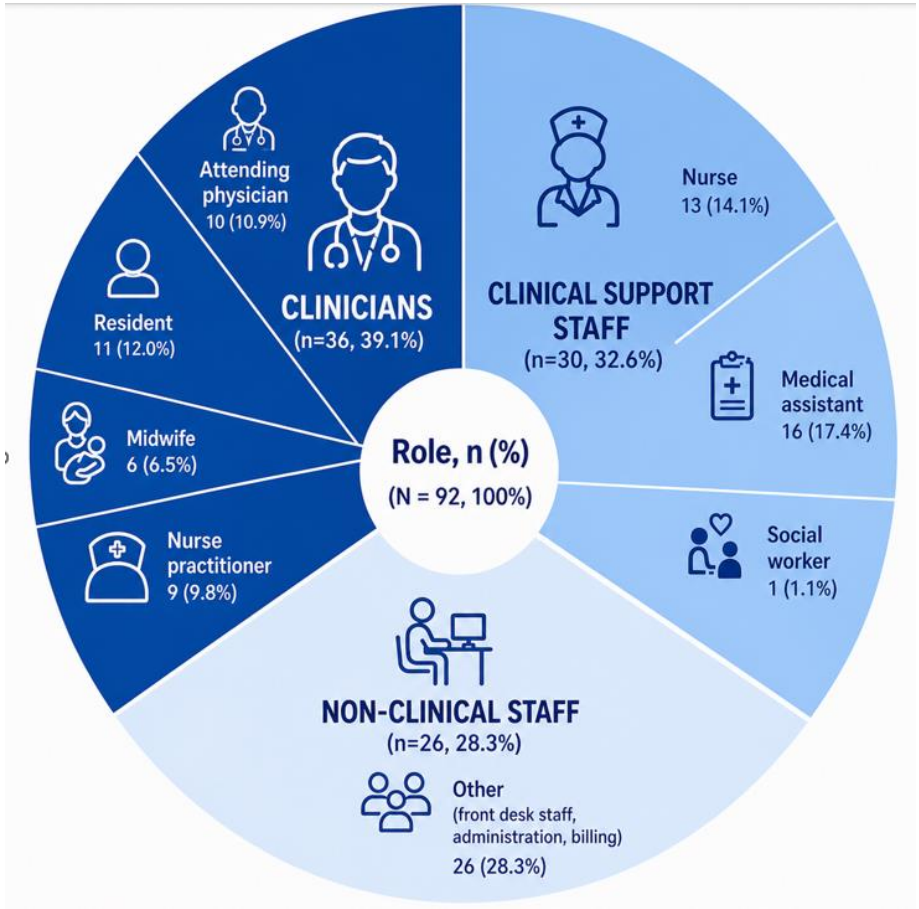
- Add “At risk for IPV” Problem List
- **.IPVSCREEN** – guided safety assessment
- Offers referral to LSH
- Initiates IPV-specific birth planning (.IPVPREGNANCY)

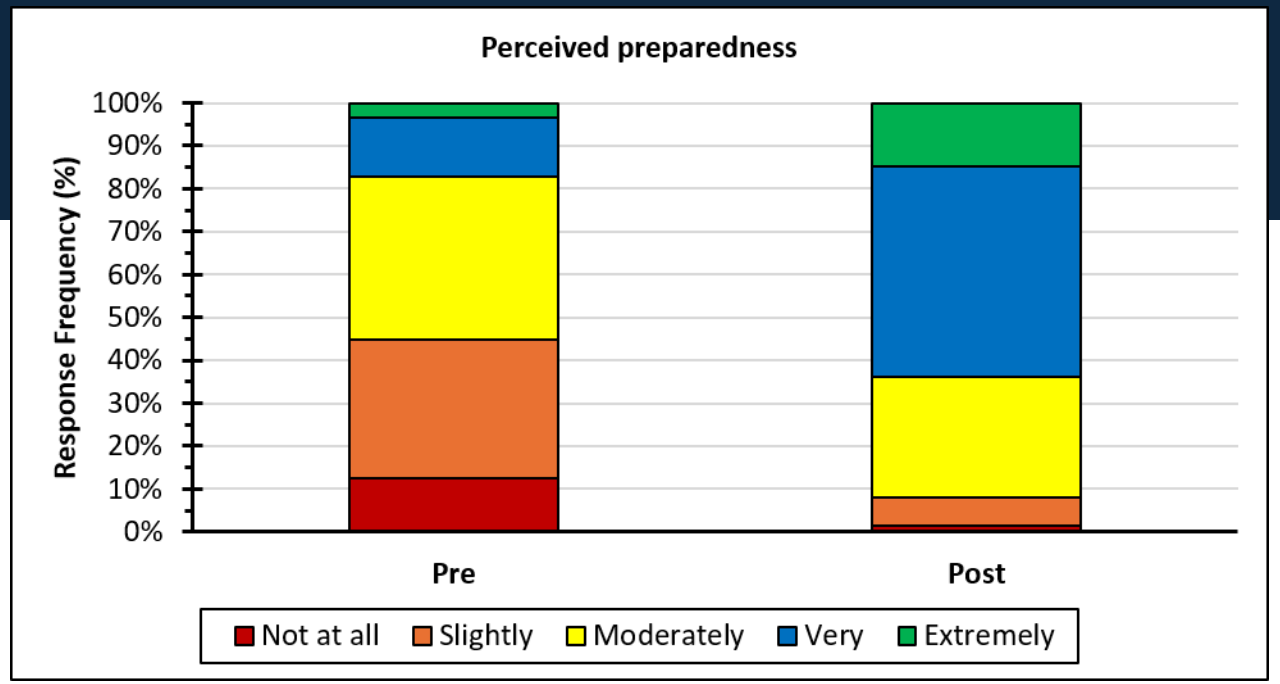

OurPractice Advisory - Zztest, LMTWO
Previous attachment
Critical (1)
At risk for intimate partner abuse: Please review alert!
In the last year, has your partner/ex-partner insulted or talked down to you? Screamed or cursed at you? : Yes (01/13/26 1649 : Physician Family Medicine, MD)
In the last year, 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-identifled 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)

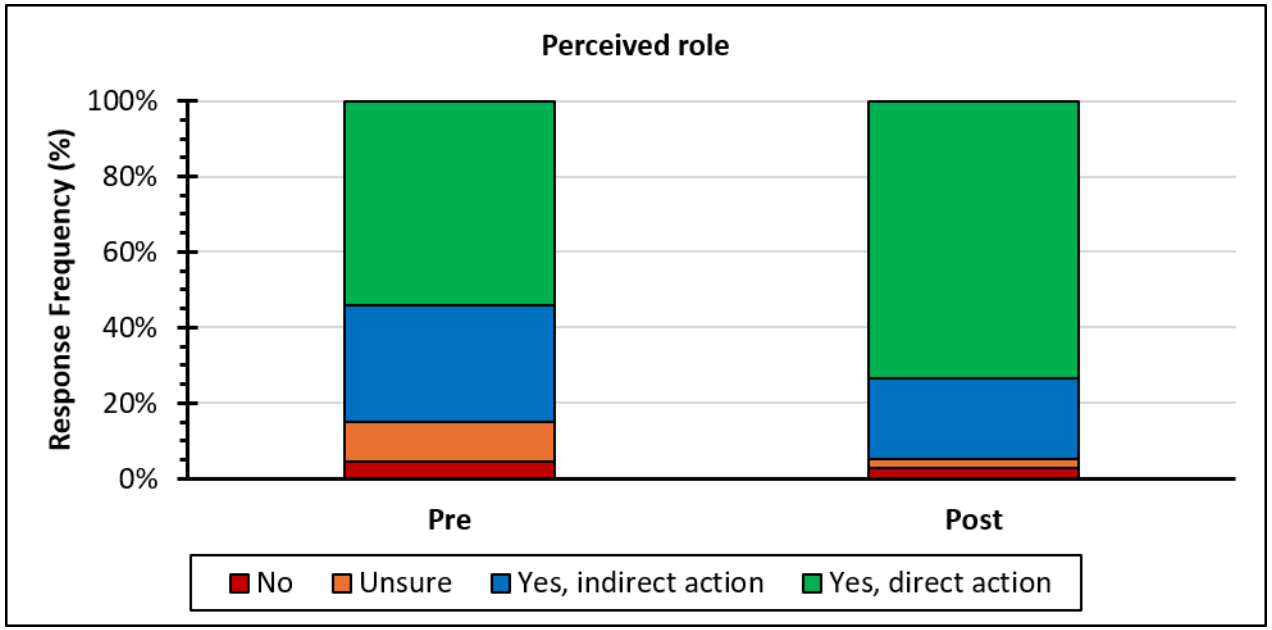

Babula, MD
Previous attachment
Care Coordination Note
Associate Signed Orders
Name
Description
IPVBPATEXT
IPVHX
Social Drivers of Health - Intimate Partner Violence
IPVSCREENING
Positive IP screen. Follow-up completed privately. Patient {confi...
IPVSDH
Social Drivers of Health - Intimate Partner Violence
IPVSDOH
Social Drivers of Health - Intimate Partner Violence


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

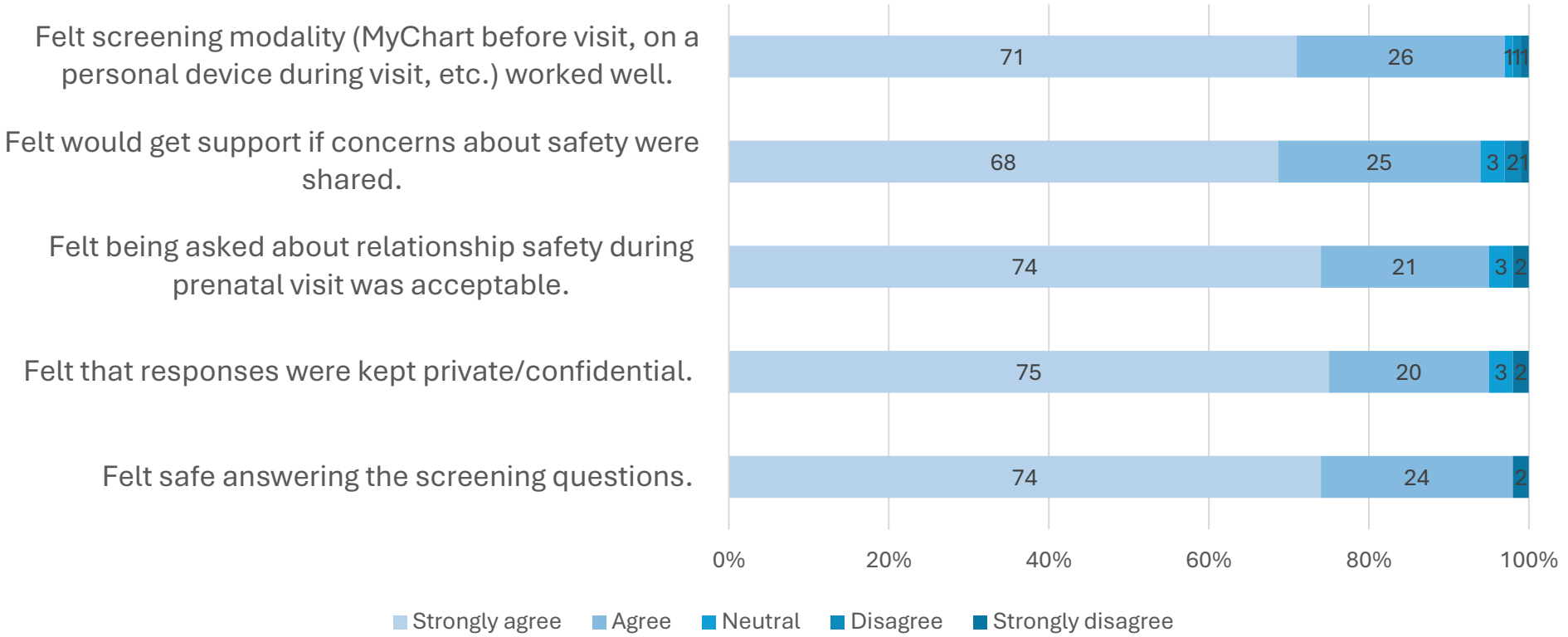
77%
Eligible Patients Screened

79%
Completed via **MyChart**

High screening uptake with meaningful connection to community support.

PATIENT SATISFACTION

Patient Perceptions of Intimate Partner Violence Screening



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.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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
- Limited access to advocates
- Time constraints in clinic
- 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

It matters what they see around them:

The environment itself can communicate safety.

Non-verbal signs of support matter.

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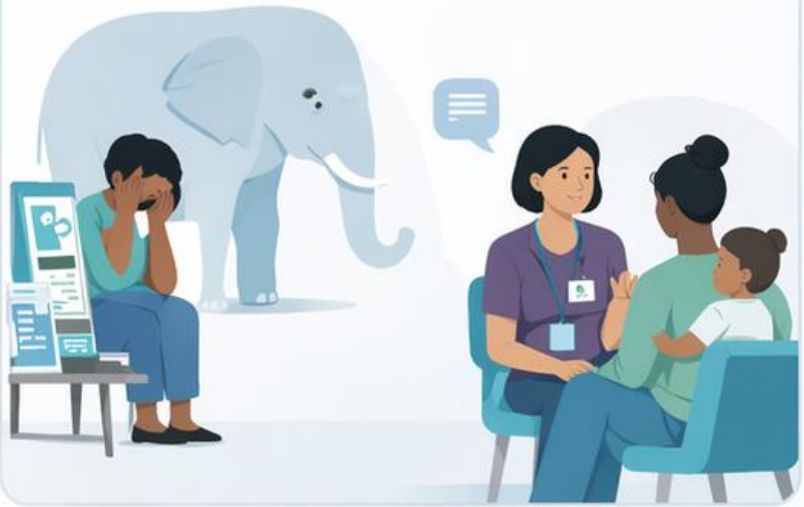

It matters who talks to them:

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

Gaps We're Recognizing

Screening Limitations

- MyChart: unclear who completes screening
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- 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)
- ✓ In partnership with LSH & WIT (Shared Safety Philadelphia grant)
- ✓ Ongoing design + evaluation in our clinic

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- ✓ **Expanding into postpartum + pediatric settings**

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3. Low-Barrier Access to Support

- ✓ Resource-led **model** (no disclosure required)
- ✓ Bringing advocates to patients
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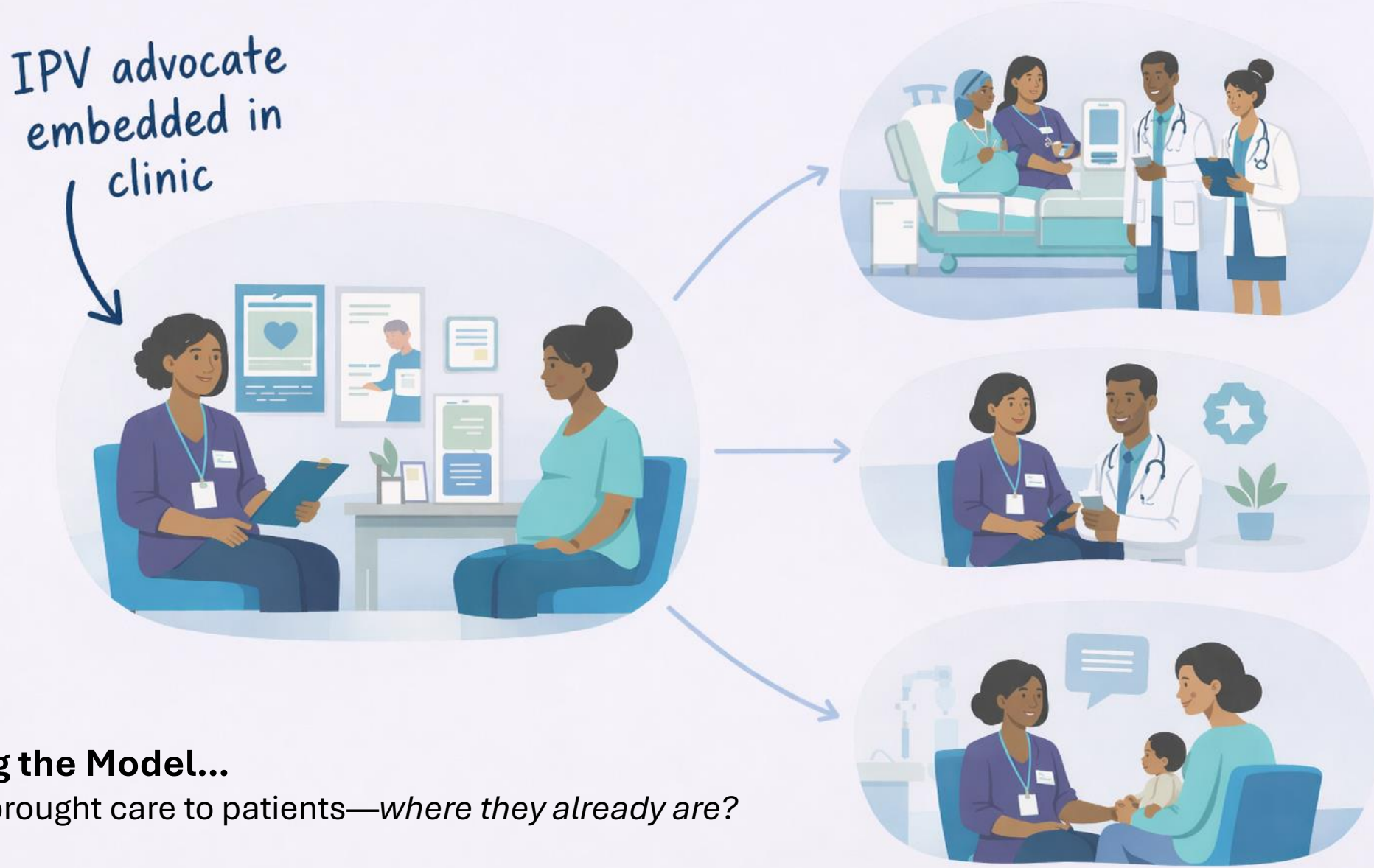
4. Sustainability & Culture Change

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

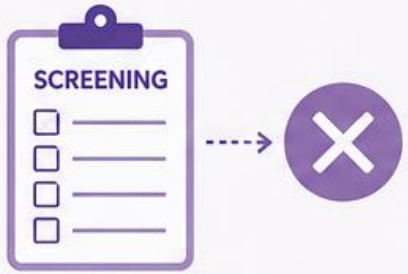


Rethinking the Model…

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?

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Jefferson Epic Team

Elon Kotler, MD

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Questions?

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