

Screening for Social Determinants of Health in Arkansas

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Prepared By:



Faculty and Staff
Department of Health Policy and Management
College of Public Health
University of Arkansas for Medical Sciences



Faculty and Staff
University of Arkansas – Fayetteville



Faculty
University of Arkansas – Little Rock

List of Contributors

Moiz Bhai, PhD
J. Mick Tilford, PhD
Ben Amick, PhD
Melissa Quehanna Walker, MS
Michael Niño, PhD

Acronyms

(AHC) Accountable Health Communities
(API) Application Programming Interface
(CBOs) Community-Based Organizations
(CIE) Community Information Exchange
(CMS) Centers for Medicare & Medicaid Services
(EHR) Electronic Health Record
(EMR) Electronic Medical Record
(HCPCS) Healthcare Common Procedure Coding System
(HIT) Health Information Technology
(HIE) Health Information Exchange
(HRSN) Health-Related Social Needs
(ICD-10-CM) International Classification of Diseases 10th Revision Clinical Modification
(IHELP) Income Housing Education Legal Status Literacy Personal Safety
(IRB) Institutional Review Board
(IT) Information Technology
(MA) Medical Assistant
(MASQ) Medical-Legal Advocacy Screening Questionnaire
(MOUs) Memoranda of Understanding
(PRAPARE) Protocol for Responding to and Assessing Patient Assets Risks and Experiences
(SDOH) Social Determinants of Health
(SIPT) Social Determinants of Health in Pregnancy Tool
(QHP) Qualified Health Plans
(VBP) Value-Based Payment
(WE CARE) Welcome Engage Communicate Ask Reassure Exit

Executive Summary

A statewide survey of Arkansas healthcare providers was conducted to understand their use of social determinants of health (SDOH) screening tools. Social determinants of health—the underlying social, contextual, and environmental drivers of health—can affect individual health more than healthcare services. Surveying current practices, challenges, and opportunities for collecting and using SDOH data can inform state health policies to improve SDOH integration within the Arkansas healthcare ecosystem.

The survey instrument was developed by the Arkansas Department of Health with partners from the University of Arkansas for Medical Sciences, the University of Arkansas, Fayetteville, and the University of Arkansas at Little Rock. Completed surveys were obtained from 145 providers representing 1376 hospitals, clinics, and healthcare facilities statewide with a survey completion rate of 91.8%.

Most responding organizations (87.1%) reported screening patients for SDOH-related needs. Commonly addressed needs are Food Insecurity, Housing Issues, and Transportation Issues consistent with national priorities. While providers screen at a high rate, there is a gap in referring patients for services and providing services directly:

79.5% screen for food insecurity, 60.7% make referrals for it, and 18.9% provide direct food-related services.

77.9% screen for housing issues, 52.5% make referrals, and only 4.9% provide direct housing services.

77.0% screen for transportation issues, 56.6% make referrals, and 15.6% provide direct transportation services.

While providers demonstrate strong motivation and substantial adoption of SDOH screening, systemic infrastructure gaps and resource constraints limit the ability to translate screening into meaningful patient outcomes. Addressing these barriers will require a coordinated strategy emphasizing collaborative infrastructure, sustainable financing, and workforce capacity building.

Major policy recommendations to improve the ecosystem for screening and providing SDOH services in Arkansas include:

Strengthen community-based partnerships: Invest in social and community-service capacity to address social needs and to promote formal partnerships with healthcare providers.

Develop sustainable SDOH financing models: Integrate reimbursement mechanisms for screening, referrals, and coordination to ensure continuity of services.

Standardize SDOH tools and data exchange: Promote validated screening tools and data sharing through interoperable systems.

Arkansas healthcare providers are committed to improving population health. Realizing a coordinated system of SDOH screening and services to improve population health requires statewide leadership to build collaborations between providers and service organizations helping clients with SDOH issues. Implementation of infrastructure and reimbursement strategies in Arkansas is essential to translate policy into action.

Summary of Findings

Most of the respondents were primary care providers from small practices with the caveat that large organizations represented one observation and were not weighted to reflect the overall scope of practice in Arkansas. The providers used disparate electronic health record systems with the largest response category being "Other" at 36.2%. Analysis of the open-ended responses reveals dozens of distinct vendors, including eClinicalWorks, eMDs, Credible, Trubridge, and Office Practicum, among many others. When combining the pre-listed options with the open-ended responses, eClinicalWorks emerges as the most frequently named single system, yet it still represents only a fraction of the total market.

The majority of responding organizations (87.1%) reported that they screen patients for SDOH-related needs. This suggests a broad acknowledgment across the Arkansas healthcare landscape of the importance of identifying social risk factors. Following screening, a smaller majority of 66.4% report that they refer patients to external services that can address these needs. A much smaller group, just 27.9%, indicate that they provide services directly to patients. Only a small fraction (6.4%) report engaging in no SDOH activities at all.

An important question for health systems involves who to screen and when. The findings indicate that a large majority (70.6%) report routine screening of all patients for SDOH needs. This contrasts with 28.6% who selectively screen patients based on specific criteria like risk factors or clinical setting. The high rate of routine, universal screening is a positive development, as it aligns with best practices aimed at identifying needs across an entire patient population rather than relying on clinician intuition to target specific individuals. The findings indicate variation in approach to the frequency of screening. Based on a question with multiple selections, the most common approaches are "Annually" (50.0%) and "As needed" (45.8%). Screening at every patient encounter is less common, with 37.3% screening at the initial visit and only 22.0% screening at every appointment.

Responsibility for administering screenings also varies as Nurses (50.0%) are the most frequently cited personnel. However, the task is widely distributed across the care team and even delegated to patients themselves. Other common methods include self-administered paper forms (28.0%), administration by Physicians (22.0%), self-administered electronic forms (21.2%), and administration by Case Managers (19.5%).

A major concern in the SDOH literature is whether health systems use validated tools. The survey findings for Arkansas reveal a fragmented tool landscape dominated by custom-built solutions, which presents a significant barrier to data standardization and may limit the overall effectiveness of screening efforts. Among the organizations that screen for SDOH, a majority (72.0%) report using a specific, named tool, yet there is little consensus on *which* tool to use. The single largest category, identified by 35.0% of respondents, is "Other/Custom." A closer look at the open-ended responses for this question clarifies that this category encompasses a wide array of internally developed or "homegrown" tools, customized templates built within EHRs, and practice-specific questionnaires.

Survey findings also indicate that provider satisfaction with their current tools is lukewarm at best. Among the organizations that use a specific tool, the average satisfaction score was a moderate 3.59 on a 5-point scale. While a combined 57.6% were "Somewhat satisfied" or "Very satisfied," a substantial portion were "Neutral" (23.5%) or dissatisfied (a combined 18.8%). This middling satisfaction suggests that even organizations that have implemented a tool are not fully content with its functionality, its integration with their workflow, or its ability to lead to meaningful action. This dissatisfaction, coupled with the prevalence of non-standardized tools, points to a clear policy opportunity: promoting the adoption of a validated, user-friendly, and well-integrated screening tool could significantly advance the state's SDOH objectives.

Another concern among health systems is identifying appropriate domains of SDOH for screening. The survey asked about specific SDOH domains screened, whether the system referred patients based on the screening, and whether they provide services based on screening. The results show that providers are focusing on domains that align with national priorities, but the "Screening-Doing Gap" persists at the individual domain level.

The survey findings indicate the most commonly addressed domains are Food Insecurity, Housing Issues, and Transportation Issues where:

- 79.5% screen for food insecurity, 60.7% make referrals for it, and 18.9% provide direct food-related services.
- 77.9% screen for housing issues, 52.5% make referrals, and only 4.9% provide direct housing services.
- 77.0% screen for transportation issues, 56.6% make referrals, and 15.6% provide direct transportation services.

The SDOH focus in Arkansas is consistent with national frameworks. The technological reasons for the screening-doing gap become clear when querying screening organizations about the integration of their EMR/EHR system with external SDOH tools. A majority of organizations (51.3%) stated unequivocally that their EMR/EHR does not integrate with any such tools. Compounding this, a large portion (31.6%) answered "Don't Know," indicating a lack of awareness or clarity about their own system's capabilities. A very small fraction reported successful integration with established referral platforms like FindHelp (8.5%) or Unite Us (4.3%).

Beyond technology, systems need to rely on collaborative relationships and the ability to share data between healthcare providers and community-based organizations (CBOs). The survey data indicates there is a strong desire for collaboration, but the current state is one of informal, ad-hoc relationships rather than structured, data-driven partnerships. Systems were asked whether they share SDOH data electronically with external entities, such as the Arkansas Department of Health or CMS. Only 27.4% of systems reported doing so. A larger group, 42.7%, stated they do not share such data, while 29.9% did not know. This low level of external data sharing indicates that SDOH information largely remains siloed, preventing its use for population-level health planning, policy development, or system-wide quality improvement.

The nature of collaborative relationships was explored with the results showing that formal collaboration is rare. Only 6.1% of respondents reported being part of a formal network. Another 18.3% stated that they collaborate informally with community partners. There is evidence of untapped potential for collaboration as 33.0% of organizations reported that they are not currently in a network but are "interested in joining" one. In contrast, only 14.8% were not interested, and 27.8% were unsure.

Arkansas providers face a number of challenges in addressing SDOH. The most pressing challenge, cited by 62.3% of respondents is difficulty ensuring follow-up on identified needs. This confirms the "black box" referral problem where providers are successfully identifying needs but struggle to close the loop, leaving them uncertain about patient outcomes. This challenge is followed by a cluster of resource-related issues: time constraints during patient visits (50.0%), limited ability to track and monitor data over time (47.4%), and limited staff capacity to conduct screenings (40.4%).

A critical systemic barrier to SDOH screening and referral is the lack of a financial model for implementing systems and protocols. Systems were asked if they receive reimbursement for their efforts. The response was stark: a resounding 69.0% of respondents reported that they do not receive reimbursement with 12.1% being reimbursed and the remainder unsure. This finding positions SDOH screening as a largely unfunded mandate within the Arkansas healthcare system. The lack of resources from largely non-existent funding was evident: "Limited budget or resources" was cited by 41.6% of respondents as a primary impediment to implementation.

Another important barrier is the lack of clear and standardized processes. "Lack of clearly established processes" was the second-most-cited implementation barrier (36.3%) leading to a "Triad of Deficiencies" in screening for SDOH:

1. **Unfunded Mandates:** Providers are expected to perform SDOH screening and follow-up without a clear or consistent payment mechanism.
2. **Under-resourced Partners:** The community-based organizations essential for resolving identified needs are perceived as lacking the capacity to handle the volume of referrals.
3. **Unclear Processes:** The absence of standardized tools, workflows, and collaborative agreements creates inefficiency and uncertainty.

Addressing these deficiencies requires a successful statewide strategy to create sustainable financing models for providers, investment in capacity-building for CBOs, and facilitation and development of standardized, shared processes for collaboration.

Understanding why organizations choose to screen for SDOH is crucial for designing effective policies and support systems. The survey data indicates that screening adoption is driven more by commitment to improving health than by external pressure from regulators or payers, though awareness of such pressures is growing. The survey asked systems that screen to rate the importance of various rationales and found that the highest-rated rationale was the organization's "Population Health Mission," followed by "Patient Risk Stratification". In contrast, external motivators such as "Federal/State Regulations" and "Insurance Mandates" were rated lower. This

positive finding suggests that SDOH screening in Arkansas is authentic and deeply rooted in a professional commitment to patient well-being.

Providers are aware of the evolving policy landscape with a majority of respondents (59.5%) being aware of the CMS rules regarding SDOH data reporting. Furthermore, of the 40.5% who were unaware, Question 35 revealed that nearly half (45.3%) are actively in the process of learning about these new requirements.

The survey also asked about provider's willingness to commit their own internal resources to future SDOH efforts. One question asked about the likelihood of increasing resources for SDOH screening in the next year and the response was decidedly tentative with the largest group of respondents (37.9%) being "Neutral" while a combined 37.1% were "Somewhat likely" or "Extremely likely" to do so. A notable 25.0% were "Somewhat unlikely" or "Extremely unlikely" to increase resources in the coming year. Given the significant financial pressures and lack of reimbursement detailed earlier, it is logical that many organizations are hesitant to commit more of their own scarce resources to this largely unfunded work.

Summary Recommendations

The analysis of the 2025 Arkansas Provider SDOH Screening Survey offers a detailed and multi-faceted view of the state's progress and challenges in addressing the social determinants of health. This concluding section synthesizes the report's core findings into a cohesive narrative and translates those findings into a set of actionable, evidence-based recommendations for key stakeholders.

Based on this synthesis and informed by national best practices and policy models, the following strategic recommendations are proposed for key stakeholders.

For State Policymakers (e.g., Arkansas Department of Human Services, Arkansas Legislature, State Payers)

1. Develop a Sustainable Financing Model for SDOH. The lack of reimbursement is the most critical barrier. The state should lead the development of a multi-pronged financing strategy.
 - Action: Actively promote and provide technical assistance for the adoption of newly available reimbursement codes, such as HCPCS code G0136, which allows for payment for SDOH risk assessments under Medicare.
 - Action: Work with QHPs/Qualified Health plans to incorporate SDOH-related activities into value-based payment (VBP) arrangements. This can include using incentive payments or quality withhold arrangements to reward plans for screening, making effective referrals, and forming partnerships with CBOs, a strategy supported by CMS guidance and explored by other states.
 - Action: Frame SDOH investment not as a new cost, but as a long-term strategy for improving health outcomes and controlling costs, which is a key priority for Arkansas Medicaid sustainability. Evidence suggests addressing social needs can reduce high-cost utilization like emergency department visits and hospital readmissions.
2. Catalyze a Statewide Collaborative Infrastructure. Providers are interested in collaboration but lack the formal networks and technology to do so effectively.
 - Action: Fund the development and implementation of a statewide or regional Community Information Exchange (CIE) platform. A CIE is a shared technology infrastructure that enables standardized, closed-loop referrals between healthcare and social service organizations, directly addressing the "black box" referral problem.
 - Action: Provide grants and technical assistance to formalize regional collaborative networks, leveraging the 33% of providers who are interested in joining one. These networks should bring together providers, CBOs, and public health agencies to coordinate care and share resources.
3. Promote Standardization of Tools and Data. The fragmentation of screening tools and data practices hinders system-wide improvement.

- Action: Incentivize the adoption of a single, validated, nationally recognized screening tool, such as PRAPARE, which is evidence-based and designed for this purpose. Incentives could be tied to VBP models or grant funding.
- Action: Promote the consistent use of ICD-10-CM "Z codes" (Z55-Z65) to document identified social needs within the EHR. This aligns with CMS recommendations and is essential for creating standardized, analyzable data at the population level.

For Healthcare Systems and Provider Groups

- Invest in Workflow Integration and Workforce Training. Move beyond the simple act of screening to build robust internal processes.
 - Action: Develop, document, and implement clear clinical workflows that specify *what* happens after a positive SDOH screen, including who is responsible for the referral, how it is documented, and what the follow-up procedure is.
 - Action: Invest in comprehensive training for all staff involved in the SDOH process from front desk personnel to nurses and physicians. Training should cover not only how to use the screening tool but also best practices for sensitive communication, cultural competency, and trauma-informed care.
- Forge Proactive and Formal Community Partnerships. Do not wait for a state-led system to build essential relationships.
 - Action: Proactively identify key CBOs in the service area that align with the most common patient needs (e.g., food, housing, transportation).
 - Action: Establish formal Memoranda of Understanding (MOUs) or partnership agreements that clearly define roles, responsibilities, communication channels, and protocols for sharing patient information securely and with consent. This formalizes relationships and builds a foundation for a more effective referral network.

For Community-Based Organizations (CBOs) and Philanthropic Foundations

- Advocate for and Invest in CBO Capacity. The healthcare system cannot solve this problem alone; the capacity of the social service sector is a critical limiting factor.
 - Action: CBOs should use the data from this report, particularly the finding that 63% of collaborating providers see limited CBO resources as a primary barrier, to advocate for increased funding from state, local, and philanthropic sources.
- Actively Participate in Network and System Design. CBOs must be at the table as new collaborative systems are designed.
 - Action: Engage actively in the formation of regional collaborative networks and the design of any statewide CIE. The perspective and expertise of CBOs are essential to ensure that the resulting systems are practical, effective, and truly meet the needs of the community.

- Action: Partner with healthcare organizations on joint grant applications and advocacy efforts to present a united front, demonstrating a shared commitment to building a more integrated system of care for all Arkansans.

Table of Content

List of Contributors.....	1
Acronyms.....	1
Executive Summary.....	2
Summary of Findings.....	3
Summary Recommendations	7
Section 1: Introduction.....	12
1.1: Organizational Scope and Clinical Focus	12
1.2: Provider Composition and Organizational Scale	14
1.3: Health Information Technology (HIT) Landscape.....	15
Section 2: The State of SDOH Screening Adoption and Practice.....	18
2.1: Prevalence and Nature of SDOH Activities	18
2.2: Screening Methodologies: Approach, Frequency, and Personnel.....	19
2.3: The SDOH Screening Toolkit: Tools and Satisfaction.....	21
2.4: Focus on Core SDOH Domains	23
Section 3: The Referral Ecosystem: Technology, Data Sharing, and Collaboration	25
3.1: Referral Technology and Tracking.....	25
3.2: Data Sharing and Community Partnerships	27
Section 4: Perceived Barriers and Systemic Challenges.....	31
4.1: The Non-Adopter's Perspective.....	31
4.2: The Adopter's Operational Hurdles	32
4.3: Overarching Systemic Barriers	33
Section 5: Motivations, Incentives, and Future Trajectory	36
5.1: Drivers of SDOH Screening.....	36
5.2: The Path Forward: Expressed Needs for Growth	38
5.3: Commitment to Future Investment	40
Section 6: Voices from the Field: Qualitative Insights from Provider Feedback.....	41
6.1: Affirming the Mission, Acknowledging the Hurdles	41
Subsection 6.2: The "Screening to Nowhere" Dilemma	41
6.3: The Financial Squeeze and Staffing Shortages	41
6.4: Patient Receptivity and a Call for Information	42
Section 7: Key findings and Strategic Recommendations.....	43
References.....	45

Appendices.....	46
Appendix A: Qualtrics Survey	46
Appendix B: Invitation Forms.....	84

Screening for Social Determinants of Health in Arkansas

Section 1: Introduction

The survey instrument was developed in collaboration with staff from the Arkansas Department of Health (SHARE), the project team, and external stakeholders building on information from both the published and gray literature. A review of the published literature indicated tools for assessing social determinants of health vary significantly in how they are used, which tool is used, and the domains considered.¹ Recent studies have highlighted tools used by US healthcare institutions and the domains included in each tool.² Most of the grey literature reported on tools assessed in the published literature.^{3,4}

There was limited published literature on barriers and facilitators to screening for social determinants of health. Thus, we relied primarily on grey literature for survey questions addressing factors influencing screening decisions. Based on the review of literature, a preliminary screening tool was developed and vetted by the research team. A draft version of the survey was then vetted with stakeholders from the hospital association, Arkansas Medicaid, and other organizations. The final survey was uploaded into Qualtrics.⁵ Finally, a letter was sent to the list of participating organizations to ask them to complete the survey online. After several mail outs, a team of research assistants called non-completing organizations to get surveys completed by phone or other means. The final sample of 145 represented a survey completion rate of 91.8%.

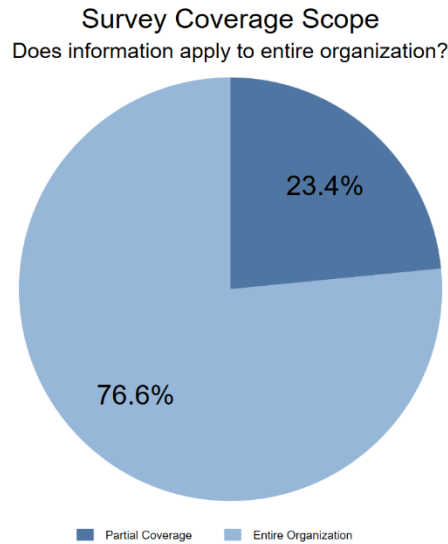
To accurately interpret the survey's findings on Social Determinants of Health (SDOH) practices, it is essential to first understand the characteristics of the responding healthcare organizations. This section provides a detailed profile of the survey respondents (N=145), examining their organizational scope, clinical focus, provider composition, scale of operations, and the technological landscape in which they operate. These foundational characteristics provide the necessary context for all subsequent analysis, revealing a respondent pool that is predominantly composed of small, primary care-focused practices operating within a fragmented health information technology environment.

1.1: Organizational Scope and Clinical Focus

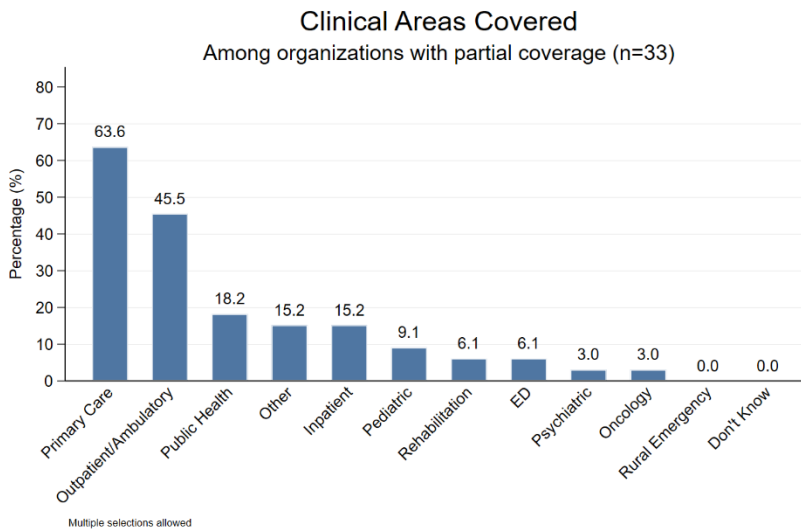
The survey first sought to establish the scope of the information being provided by each respondent. Participants were asked whether their responses applied to their entire organization or only to specific clinical areas. The results indicate that the data largely reflects a comprehensive organizational perspective.

Based on 145 total responses, an overwhelming majority, 76.6% (111 organizations), stated that the information provided covers their entire organization. In contrast, 23.4% (34 organizations) indicated their responses pertained to only a portion of their organization. This high rate of full-organizational reporting suggests that the survey findings are broadly representative of the policies and practices of the participating entities. This is important because

it suggests our findings are representative of system-level policies rather than departmental experiments.



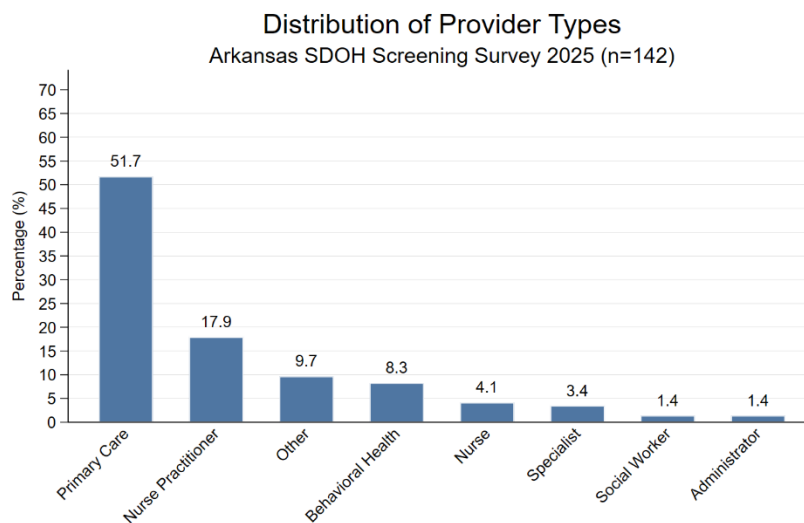
For the subset of 34 organizations providing information on only a portion of their operations, a follow-up question (Question 4) identified the specific clinical areas covered. This question allowed for multiple selections, and based on 33 valid responses, the focus is overwhelmingly concentrated in outpatient settings. The most frequently cited clinical area was Primary Care, identified by 63.6% of this subgroup. This was followed by Outpatient/Ambulatory Care at 45.5%. Other areas were significantly less common, including Public Health (18.2%), Inpatient settings (15.2%), and the Emergency Department (6.1%).



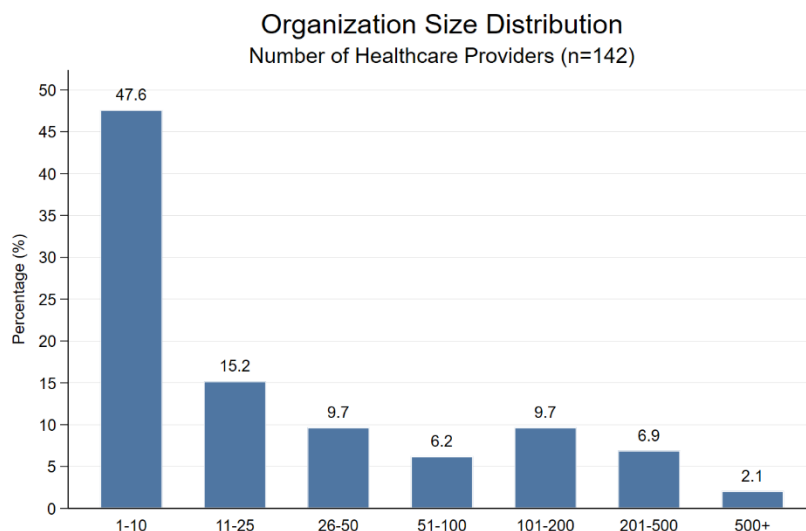
1.2: Provider Composition and Organizational Scale

The survey further profiled the respondent organizations by examining their primary provider type and overall size, revealing a landscape dominated by small, primary care-centric practices.

Question 5 asked respondents to describe the majority of providers in their organization. Out of 142 valid responses, over half, 51.7%, identified Primary Care Physicians as the predominant provider type. Nurse Practitioners were the next largest group at 17.9%. Other provider types were represented in much smaller proportions, including Behavioral Health Providers (8.3%), Registered Nurses (4.1%), and Specialist Physicians (3.5%). This finding reinforces the primary care orientation established in the previous subsection and confirms that the survey captures the viewpoint of those on the front lines of routine patient care.



Question 6 assessed organizational size by asking for the approximate number of healthcare providers. The results paint a clear picture of a system composed of many small entities. Based on 142 responses, nearly half of the organizations (47.6%) are small practices with just 1-10 providers. An additional 15.2% have 11-25 providers, meaning that over 60% of the respondent base consists of practices with 25 or fewer providers. Mid-sized organizations are less common, and very large organizations with over 500 providers are rare, constituting only 2.1% of the sample.

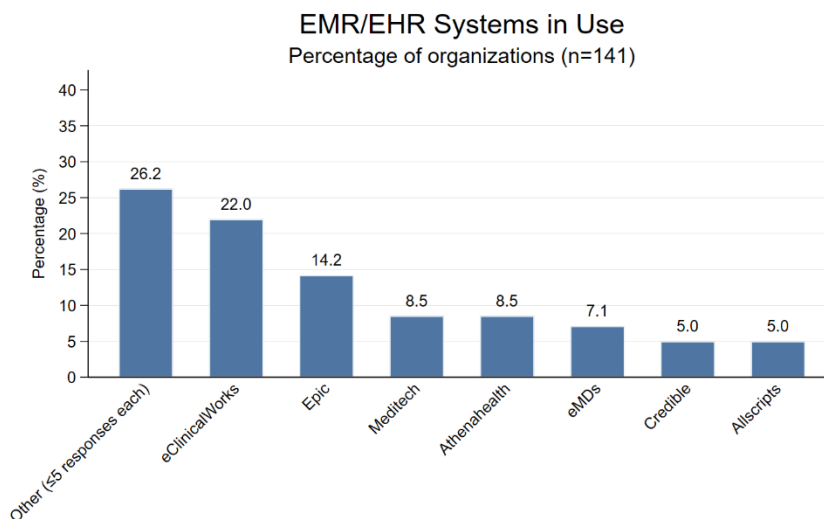


The predominance of small, primary care-focused practices is a crucial finding that foreshadows many of the challenges discussed later in this report. National research indicates that smaller facilities often lag behind larger health systems in the adoption of evidence-based practices and the implementation of significant workflow changes. This is typically due to fewer financial resources, a lack of dedicated administrative or IT support staff, and smaller economies of scale. Consequently, the barriers identified in this survey, such as limited staff capacity, budget constraints, and technological hurdles, are likely amplified within the context of Arkansas's healthcare ecosystem. Any proposed solutions or policy recommendations must be scalable and feasible for a small clinic setting, as strategies designed for large, well-resourced hospital systems may not be applicable to the majority of providers in the state.

1.3: Health Information Technology (HIT) Landscape

The final component of the organizational profile is an assessment of the Electronic Medical Record (EMR) or Electronic Health Record (EHR) systems in use. The data reveals a highly fragmented and non-standardized technological landscape, which poses a significant structural barrier to creating a cohesive, data-driven approach to SDOH across the state.

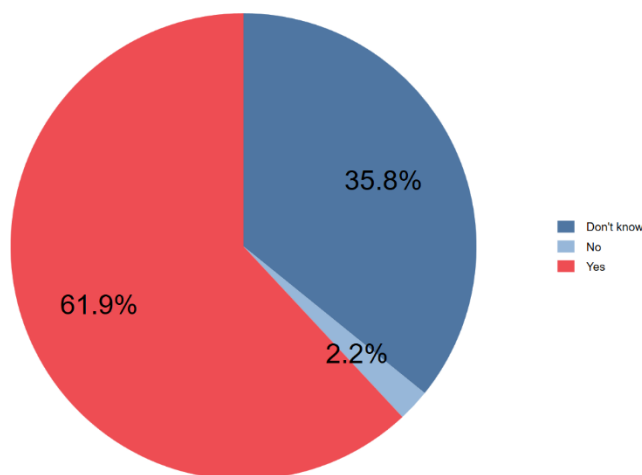
Question 7 asked organizations to identify their current EMR/EHR system. Based on 141 valid responses, no single vendor holds a majority market share. The largest response category was "Other" at 36.2%, indicating a long tail of numerous, less common systems. Analysis of the open-ended responses provided for this "Other" category confirms this fragmentation, revealing dozens of distinct vendors, including eClinicalWorks, eMDs, Credible, Trubridge, and Office Practicum, among many others. When combining the pre-listed options with the open-ended responses, eClinicalWorks emerges as the most frequently named single system, yet it still represents only a fraction of the total market.



Major national vendors have a foothold but do not dominate. Epic is used by 14.2% of respondents, and Meditech is used by 8.5%. A small but important minority of organizations, 2.8%, report having no EMR/EHR system at all, relying instead on paper records. Later in the survey (Question 19), a strong majority of providers (61.9%) express interest in adopting a statewide SDOH system. However, the successful implementation of such a system is fundamentally dependent on data interoperability, the ability of different systems to seamlessly exchange and interpret information. Integrating a statewide platform with a single dominant EMR vendor is a significant undertaking; integrating it with dozens of disparate systems, many of which may lack robust Application Programming Interfaces (APIs) or technical support, presents a monumental challenge.

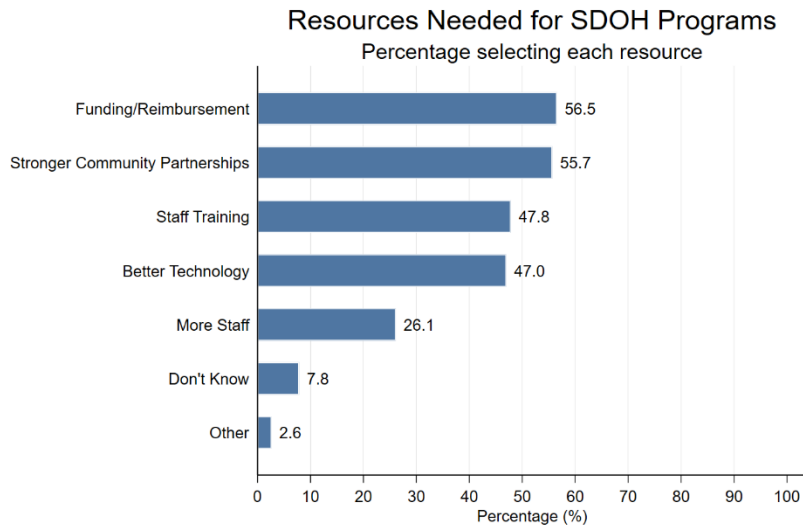
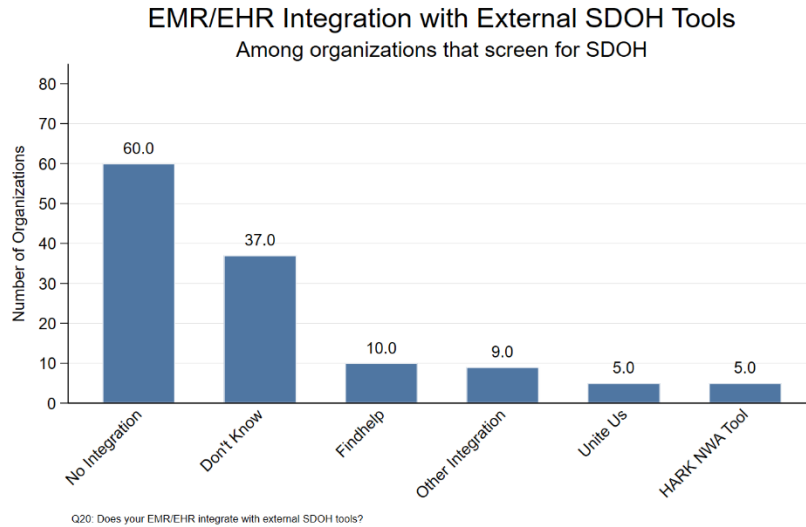
Interest in Adopting a Statewide SDOH System

If a statewide system were implemented



This technological reality directly explains the poor integration rates observed later in the survey. In Question 20, 60.0% of screening organizations report that their EMR does not integrate with any external SDOH tools, and another 37.0% do not know if it does. While

providers are willing to participate in a coordinated, statewide effort, the underlying technological infrastructure of Arkansas's healthcare system represents a primary structural barrier. Any policy aiming to create a unified SDOH data ecosystem must first confront the challenge of achieving interoperability across this diverse and fragmented EMR market. This will likely require substantial investment in technical assistance, the development of standardized data exchange protocols, and support for providers using less common or legacy systems. It also validates the finding from Question 30, where "Better technology integration" was identified as one of the most critical resources needed by providers accounting for 47.0% of responses.



Section 2: The State of SDOH Screening Adoption and Practice

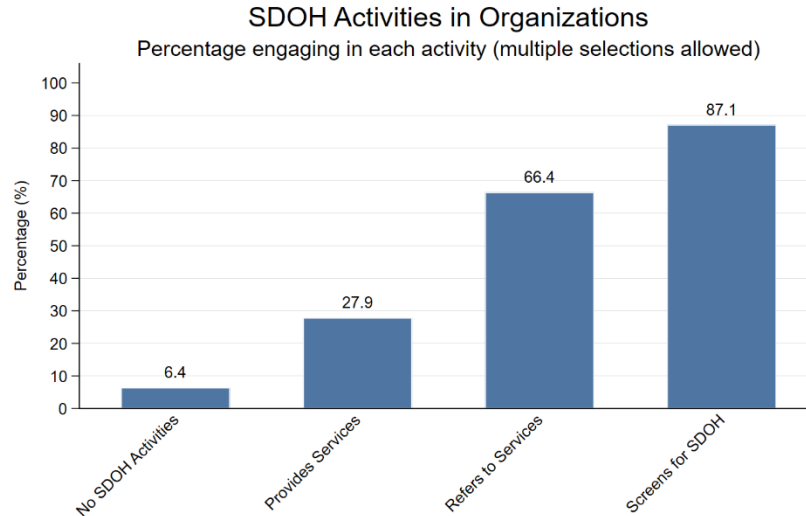
Having established the profile of responding organizations, this section transitions from *who* the providers are to *what* they are doing regarding Social Determinants of Health. It offers a detailed examination of the prevalence of SDOH-related activities, the specific methodologies employed for screening, the types of tools being used, and the primary SDOH domains being addressed. The findings indicate widespread adoption of screening in principle, but reveal significant variability in practice and a reliance on non-standardized, "homegrown" tools, signaling a system that is in an early stage of operational maturity.

2.1: Prevalence and Nature of SDOH Activities

Question 8 of the survey asked organizations to identify which SDOH-related activities they currently perform, allowing for multiple selections. The responses from 140 organizations show a high level of engagement in screening, but this engagement diminishes significantly when it comes to subsequent actions like referring to or providing services.

The "Screening-Doing Gap" in Arkansas

While a high percentage of Arkansas healthcare organizations (87.1%) screen patients for Social Determinants of Health (SDOH), this engagement drops significantly when it comes to taking action. A smaller majority (66.4%) refer patients to external services, and only 27.9% provide services directly. This pattern reveals a **"Screening-Doing Gap."** Although providers have embraced identifying social needs, the healthcare system is not structured or resourced to resolve them. This can lead to a phenomenon known as **"screening to nowhere,"** where patient needs are documented but not met, which can cause frustration and disillusionment for both patients and providers. The primary challenge for Arkansas is to strengthen the referral pathways and community partnerships that bridge the gap between identifying a need and resolving it



An impressive 87.1% of responding organizations report that they screen patients for SDOH-related needs. This suggests a broad acknowledgment across the Arkansas healthcare landscape of the importance of identifying social risk factors. Following screening, a smaller majority of 66.4% report that they refer patients to external services that can address these needs. A much smaller group, just 27.9%, indicate that they provide services directly to patients. Only a small fraction, 6.4%, report engaging in no SDOH activities at all.

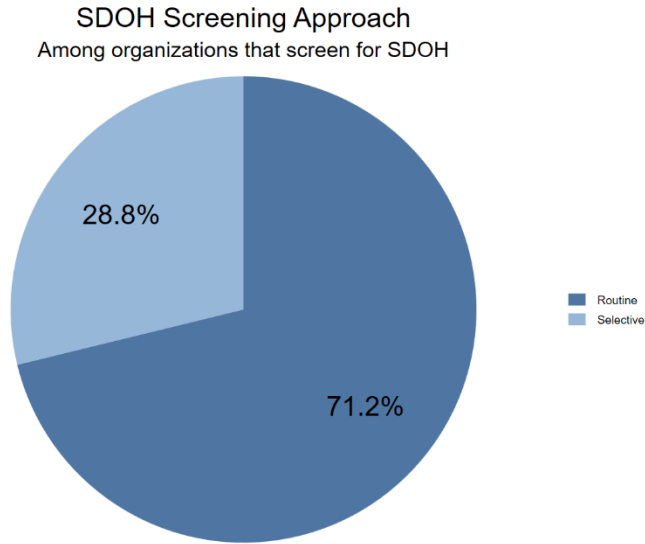
This pattern reveals what can be termed a "Screening-Doing Gap." The high adoption rate for screening is a positive indicator that the first step of the process, identification, is becoming a standard of care. However, the steep drop-off from screening (87.1%) to referring (66.4%), and the subsequent precipitous fall to directly providing services (27.9%), is a critical finding. This trend is consistent with national observations where healthcare organizations are often more equipped to identify social needs than they are to resolve them.⁴ This can lead to a phenomenon known as "screening to nowhere," where patient needs are documented but not met, potentially leading to frustration and disillusionment for both patients and providers.

The data strongly suggests that while Arkansas providers have embraced the identification of social needs, the healthcare system itself is neither structured nor resourced to be the primary provider of social services like housing, food, or transportation. This reality underscores the vital importance of a robust and functional referral ecosystem, which is explored in detail in the next section. The primary focus for system improvement should not necessarily be on encouraging more screening, as adoption is already high, but on strengthening the capacity for effective referral and follow-up to close the gap between identification and resolution.

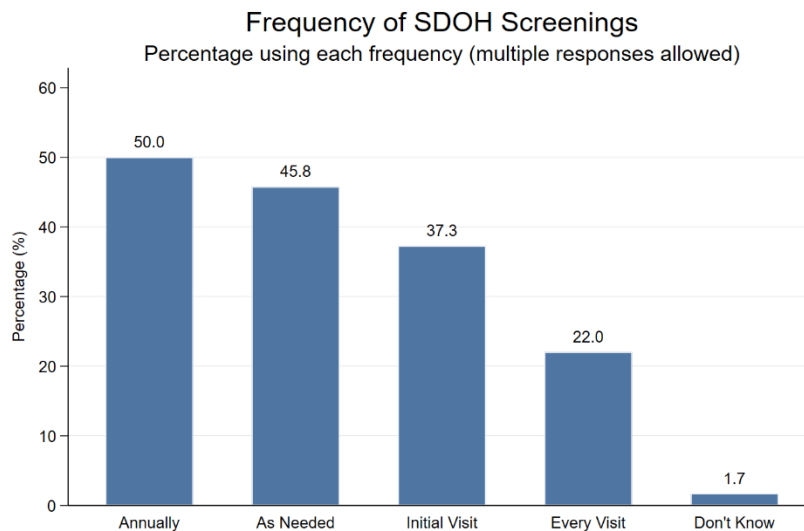
2.2: Screening Methodologies: Approach, Frequency, and Personnel

For the majority of organizations that do screen, the survey explored the specific methodologies they employ, including their overall approach, the frequency of screening, and the personnel responsible for administration. The results depict a system where screening is becoming a routine part of care but lacks a standardized, evidence-based workflow.

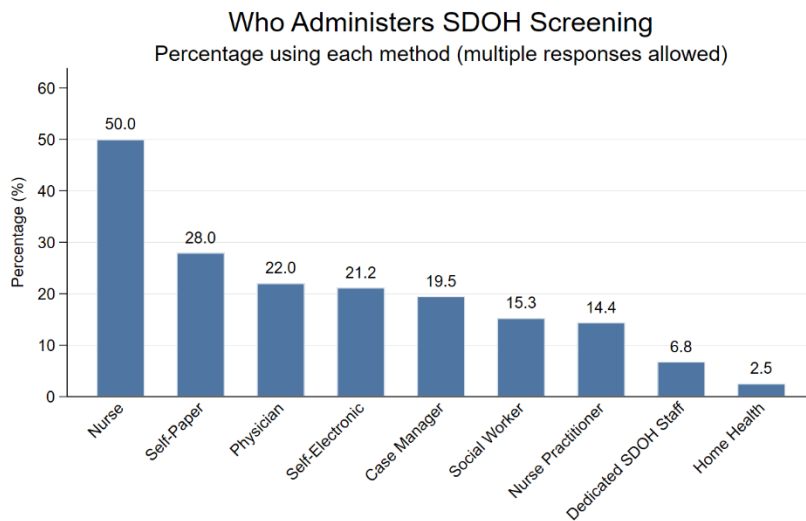
Among 119 screening organizations, Question 12 reveals that a large majority, 71.2%, report that they routinely screen all patients for SDOH needs. This contrasts with 28.8% who selectively screen patients based on specific criteria like risk factors or clinical setting. The high rate of routine, universal screening is a positive development, as it aligns with best practices aimed at identifying needs across an entire patient population rather than relying on clinician intuition to target specific individuals.



However, this consistency in approach does not extend to the frequency of screening. Question 13, which allowed for multiple selections, shows significant variation among 118 respondents. The most common frequencies are “Annually” (50.0%) and “As Needed” (45.8%). Screening at every patient encounter is less common, with 37.3% screening at the initial visit and only 22.0% screening at every appointment.



Responsibility for administering these screenings is also diffuse, as shown by the responses to Question 14. Among 118 screening organizations, Nurses (50.0%) are the most frequently cited personnel. However, the task is widely distributed across the care team and even delegated to patients themselves. Other common methods include self-administered paper forms (28.0%), administration by Physicians (22.0%), self-administered electronic forms (21.2%), and administration by Case Managers (19.5%). Open-ended responses further broaden this list to include roles such as "Care Coordinator," "Rooming Medical Assistant MA (MA)/Nurse," and "Front desk clerk," illustrating that screening is often a team-based or even an administrative task. This heavy reliance on nurses and MAs is an efficient strategy that avoids overburdening physicians. However, it underscores a critical point: to ensure that collected data is accurate and effectively integrated into care plans, **workforce training and investments should be specifically directed at the nursing and support staff who shoulder much of this work.**



Taken together, these data points suggest that while Arkansas providers have successfully integrated SDOH screening into routine care, the implementation itself is highly variable. The lack of a single, predominant workflow for frequency and administration indicates an opportunity for the state and healthcare leaders to promote best-practice models that could improve consistency and data quality. The heavy reliance on nurses, medical assistants, and self-administered forms is an efficient strategy that avoids overburdening physicians. However, this approach necessitates robust training and clear, standardized protocols to ensure that the collected data is accurate, complete, and effectively integrated into the patient's care plan, a challenge highlighted by findings on staff training (Question 24) and process clarity (Question 26) later in the survey.

2.3: The SDOH Screening Toolkit: Tools and Satisfaction

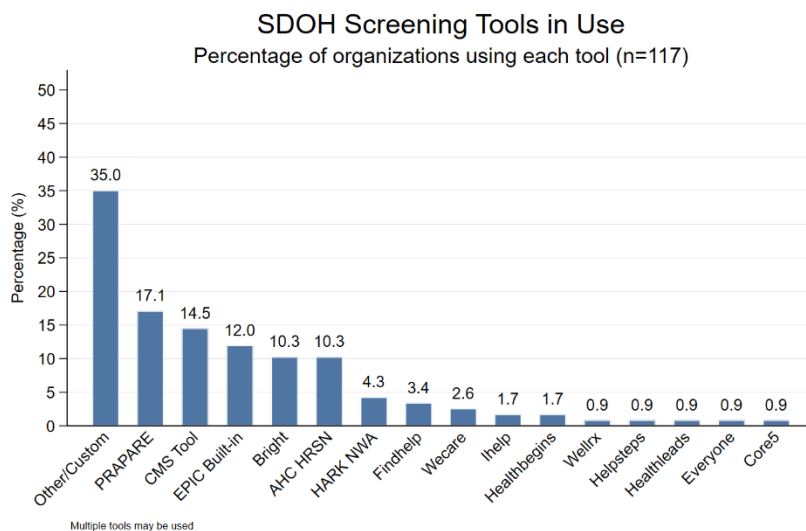
The effectiveness of SDOH screening is heavily dependent on the quality of the tools used to collect the data. The survey investigated whether organizations use a specific, named tool, which tools are most prevalent, and the level of satisfaction with these instruments. The findings reveal a fragmented tool landscape dominated by custom-built solutions, which presents

a significant barrier to data standardization and may limit the overall effectiveness of screening efforts.

Among the organizations that screen for SDOH, a majority (72.0%) report using a specific, named tool, according to responses from 118 organizations to Question 16. However, Question 17 reveals that there is little consensus on *which* tool to use. The single largest category, identified by 35.0% of 117 respondents, is "Other/Custom." A closer look at the open-ended responses for this question clarifies that this category encompasses a wide array of internally developed or "homegrown" tools, customized templates built within EHRs, and practice-specific questionnaires.

Standardized, nationally validated tools are in use but are not the dominant choice. The Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE), a tool specifically designed for and by community health centers, is used by 17.1% of respondents. The CMS Screening Tool (which often refers to the Accountable Health Communities Health-Related Social Needs Screening Tool) is used by 14.5%, and the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool is explicitly named by 10.3%. Built-in tools within the Epic EHR are used by 12.0% of organizations.

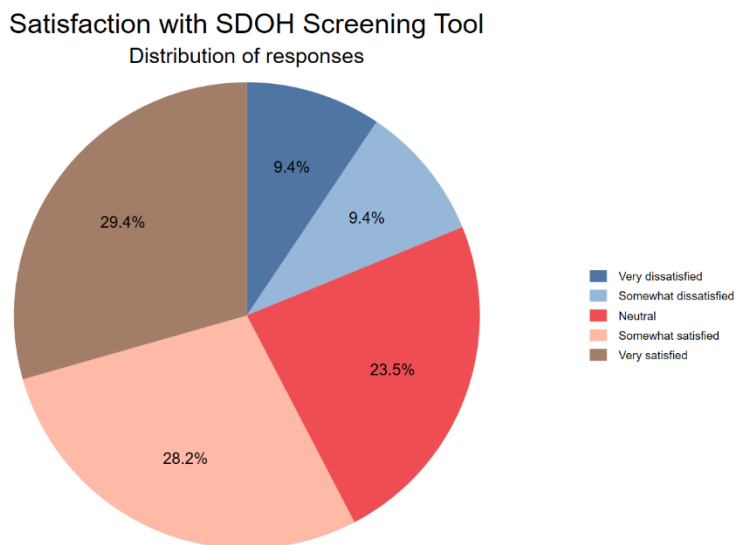
The graph below provides a clearer view of this fragmented landscape by separating the standardized tools from the large, amorphous custom category. Although the contents of homegrown tools vary, one example includes a large hospital implementing a social need screening tool covering food insecurity, housing instability, and special education, with integration into its Epic EHR to support workflows and referrals. Additionally, the state’s Health information exchange (HIE), also known as the State Health Alliance for Records Exchange (SHARE), is integrated with Hark to make SDOH information available to participating providers statewide, facilitating referrals and care coordination.



This proliferation of homegrown tools is a critical finding. National best practices and research emphasize the use of standardized, validated instruments like PRAPARE or the AHC

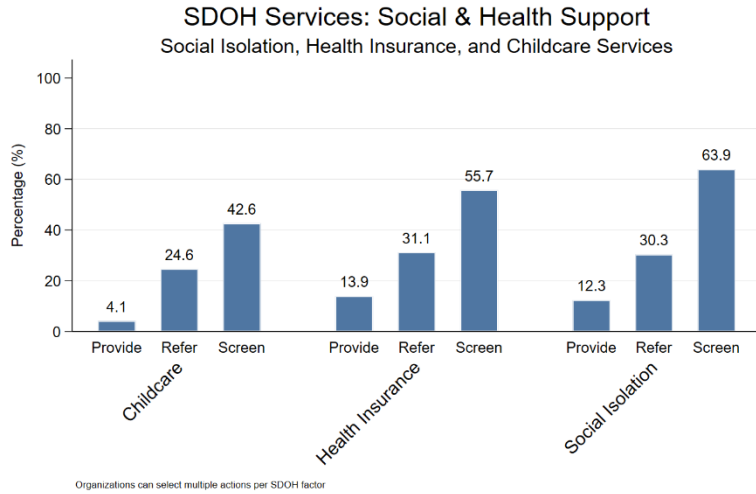
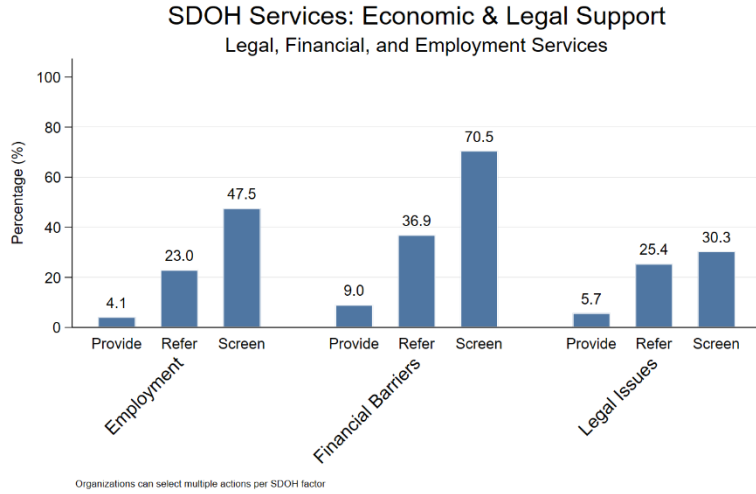
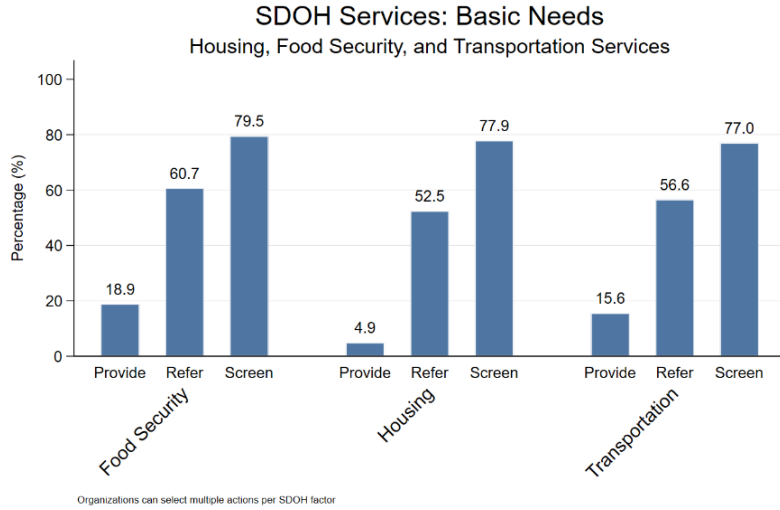
HRSN tool to ensure the collection of reliable, high-quality data that can be benchmarked, aggregated, and compared across different populations and settings. While custom tools may be well-tailored to a specific clinic's needs, they lack this external validation and inhibit the creation of a cohesive, interoperable SDOH data ecosystem for the state.

Furthermore, provider satisfaction with their current tools is inconsistent. Among 85 organizations that use a specific tool and answered Question 18, the average satisfaction score was a moderate 3.59 on a 5-point scale. While a combined 57.6% were "Somewhat satisfied" or "Very satisfied," a substantial portion were Neutral (23.5%) or dissatisfied (a combined 18.8%). This middling satisfaction suggests that even organizations that have implemented a tool are not fully content with its functionality, its integration with their workflow, or its ability to lead to meaningful action. The dissatisfaction with commercial tools, in conjunction with the widespread use of locally developed tools, creates a clear policy opening to adopt a validated, user-friendly, and well-integrated screening instrument statewide. Arkansas is positioned to act now because UAMS has already built the necessary data infrastructure: a repeatable pipeline that maps SDOH concepts using Healthy People 2030, links compiled consumer data to EHR patient records, persists the data in a SQL Server environment, and applies privacy/quality controls. In short, the state can pair standardized screening with existing data plumbing to accelerate actionable, interoperable SDOH use cases.⁶



2.4: Focus on Core SDOH Domains

To understand the substance of SDOH screening in Arkansas, Question 22 asked organizations to identify which specific social needs they screen for, refer for, or provide services for. The results show that providers are focusing on domains that align with national priorities, but the "Screening-Doing Gap" persists at the individual domain level.



Among the 122 organizations that screen for SDOH, the most addressed domains are Food Insecurity, Housing Issues, and Transportation Issues. Specifically:

- 79.5% screen for food insecurity, 60.7% make referrals for it, and 18.9% provide direct food-related services.
- 77.9% screen for housing issues, 52.5% make referrals, and only 4.9% provide direct housing services.
- 77.0% screen for transportation issues, 56.6% make referrals, and 15.6% provide direct transportation services.

This focus is highly consistent with national frameworks. The core domains of the influential CMS Accountable Health Communities (AHC) model are housing instability, food insecurity, transportation needs, utility difficulties, and interpersonal safety. The fact that Arkansas providers are prioritizing these same high-impact areas indicates that they are in step with the national dialogue regarding *what* to screen for. However, the data also powerfully illustrates the resource limitations of clinical settings at the domain level. The chasm between identifying a need and directly providing a service is stark, particularly for complex issues like housing. While nearly four out of five screening organizations identify housing instability, fewer than one in twenty are equipped to provide a direct solution. These results suggest that healthcare organizations most consistently contribute by identifying health-related social needs (HRSN) and connecting patients to community resources. Direct service delivery typically resides with CBOs and public agencies. For Arkansas, the priority is to build and strengthen referral pathways and community partnerships that reliably connect clinical settings with CBOs, enable closed-loop referrals, and support coordinated care.

Section 3: The Referral Ecosystem: Technology, Data Sharing, and Collaboration

Effective Social Determinants of Health (SDOH) initiatives depend on more than just screening; they require a robust ecosystem capable of connecting patients with the resources they need. This section evaluates the critical infrastructure that underpins the "refer" and "provide" components of SDOH work in Arkansas. The analysis assesses the state of referral technology, data sharing practices, and community collaboration, revealing an ecosystem characterized by a lack of closed-loop technological infrastructure and a reliance on informal, underdeveloped partnerships. This "infrastructure deficit" stands as a primary obstacle to translating screening efforts into measurable improvements in patient well-being.

3.1: Referral Technology and Tracking

For a referral to be more than a well-intentioned suggestion, systems must be in place to track its progress and confirm its completion. This is the function of a "closed loop" referral system, which provides feedback to the referring clinician about whether a patient successfully connected with a community service. The survey data indicates that such systems are largely absent in Arkansas, a failure rooted in a lack of integrated technology.

Question 15 asked organizations that refer patients if they have a system in place to track whether those referrals are successful. Of the total 145 survey respondents, only 91 provided a "Yes," "No," or "Don't Know" answer to this question, which was contingent on referring patients. Among those who did respond, only 50.5% (46 organizations) affirmed that they have a closed-loop system. Meanwhile, 36.3% (33 organizations) stated they do not, and a significant 13.2% (12 organizations) answered "Don't Know." Notably the don't know response suggest a lack of awareness of systems which suggests an information issue in addition to a technology issue. The large number of missing responses to this question suggests ambiguity and variability in practice across organization, and some may lack a formal tracking process. This uncertainty limits the ability to monitor referral closure and evaluate effectiveness.

The "Black Box" Referral: Providers Can Refer but Rarely Know if Needs Are Met

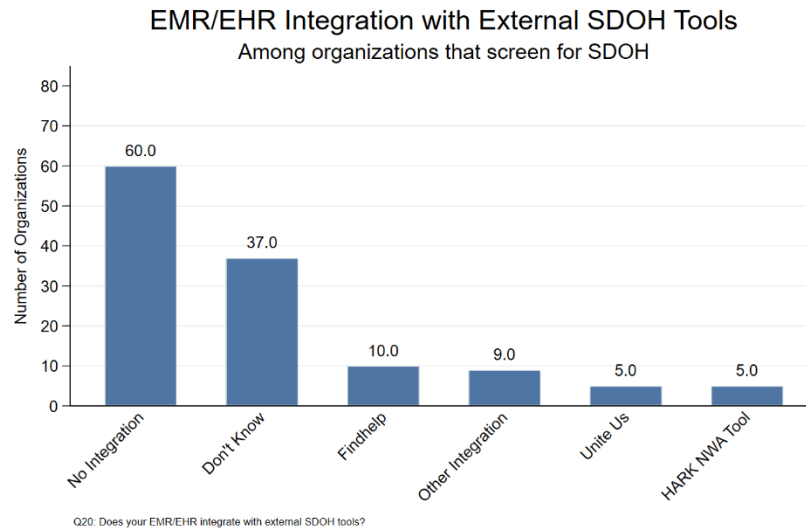
Arkansas providers have embraced screening for social needs, but the referral process often operates as a "black box". Clinicians can identify a need and provide a patient with a phone number or address, but they have no systematic way of knowing what happens next. This critical system failure severely limits the ability of healthcare organizations to ensure their patients' needs are being met.

The Top Challenge: The most pressing operational challenge for screening organizations is "Difficulty ensuring follow-up on identified needs," cited by 62.3% of respondents.

Lack of Tracking: Only 31.7% of organizations that refer patients have a "closed-loop" system in place to track whether those referrals are successful.

Technology Gap: This is largely a technological problem; a majority of providers (51.3%) report that their EMR/EHR does not integrate with any external referral platforms, making closed-loop tracking a manual and often impossible task.

The technological reasons for this deficiency become clear in the responses to Question 20, which queried screening organizations about the integration of their EMR/EHR with external SDOH tools. Among 117 screening organizations, a majority (60.0%) stated unequivocally that their EMR/EHR does not integrate with any such tools. Compounding this, a large portion (37.0%) answered "Don't Know," indicating a lack of awareness or clarity about their own system's capabilities which is reflected by the EMR fragmentation as demonstrated in Section 1. A very small fraction reported successful integration with established referral platforms like FindHelp (10.0%) or Unite Us (5.0%).



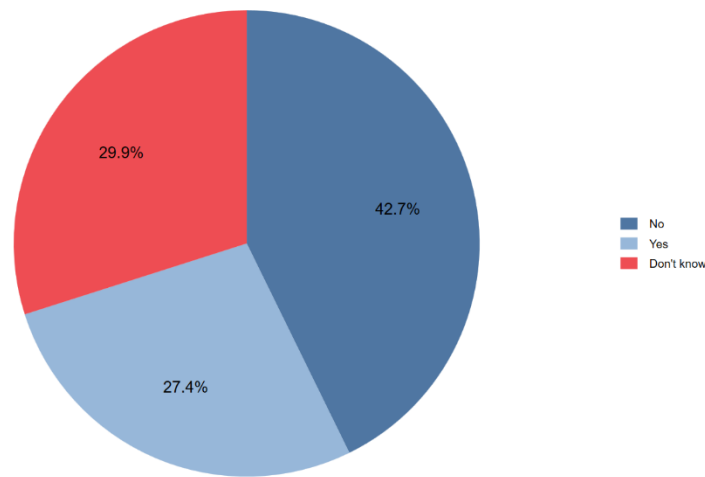
These two data points are inextricably linked. Without the technological integration of an EMR with a referral platform, creating and maintaining a closed-loop system is a manual, time-consuming, and often impossible task for busy clinical staff. The referral process in Arkansas, therefore, operates as a "black box." Providers can identify a need and provide a patient with a phone number or address, but they have no systematic way of knowing what happens next. This is a critical system failure that severely limits the ability of healthcare organizations to demonstrate the value of their SDOH programs, improve their referral processes based on outcomes, and ensure that their patients' needs are being met. This finding directly corroborates the top operational challenge cited by screening organizations in Question 23: "Difficulty ensuring follow-up on identified needs," reported by 62.3% of respondents. The lack of technological infrastructure is the root cause of this primary operational pain point.

3.2: Data Sharing and Community Partnerships

Beyond technology, a functional referral ecosystem relies on strong, collaborative relationships and the ability to share data between healthcare providers and community-based organizations (CBOs). Based on the survey responses, respondents expressed interest in deeper collaboration; however, current arrangements are often informal or ad hoc rather than formalized, data-driven partnerships.

Question 21 examined the practice of electronically sharing SDOH data with external entities, such as the Arkansas Department of Health or CMS. Among 117 respondents, only 27.4% reported doing so. A larger group, 42.7%, stated they do not share such data, while 29.9% did not know. This low level of external data sharing indicates that SDOH information largely remains siloed within the individual healthcare organizations that collect it, preventing its use for population-level health planning, policy development, or system-wide quality improvement.

SDOH Data Sharing to External Organizations
(e.g., ADH, CMS)



The nature of inter-organizational relationships was explored in Question 27, which asked about participation in collaborative networks to address SDOH. The results show that formal collaboration is rare. Only 6.1% of 115 respondents reported being part of a formal network. Another 18.3% stated that they collaborate informally with community partners. The most striking finding from this question, however, is the significant untapped potential for collaboration: **33.0% of organizations reported that they are not currently in a network but are "interested in joining" one.** In Arkansas, the Statewide Health Alliance for Records Exchange (SHARE) already works with Hark to provide a foundation on which a formal Community Information Exchange (CIE) could be built, connecting healthcare organizations and community partners for cross-sector data sharing. In contrast, only 14.8% were not interested, and 27.8% were unsure.

For the small subset of organizations (N=28) that do collaborate formally or informally, Question 28 identified their most common partners. The partnerships align logically with the most frequently screened-for needs, with Food Banks/Pantries (82.1%), Utility Assistance programs (64.3%), and Transportation Services (57.1%) being the most cited partners. This shows that providers are correctly identifying and attempting to connect with the types of CBOs that can address the primary needs of their patient populations.

Sample Community Information Exchange (CIE)

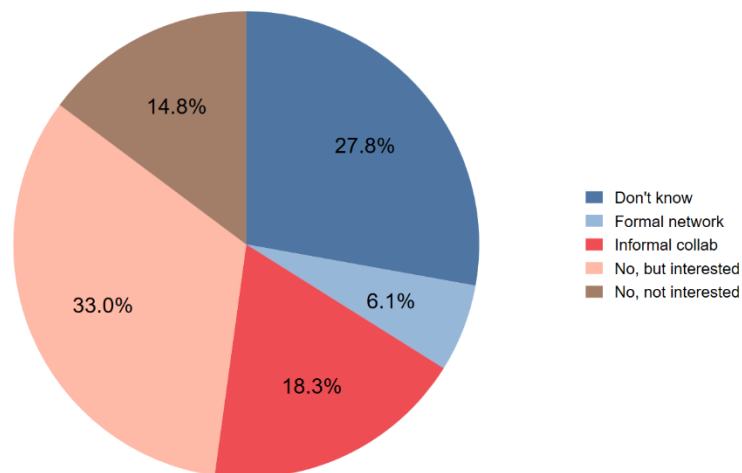
A rural primary care clinic in Arkansas screens an elderly patient for social determinants of health (SDOH) using a standardized tool like the Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (PRAPARE) integrated into their electronic health record (EHR) system. The screening reveals that the patient is experiencing food insecurity and has missed several appointments due to a lack of reliable transportation.

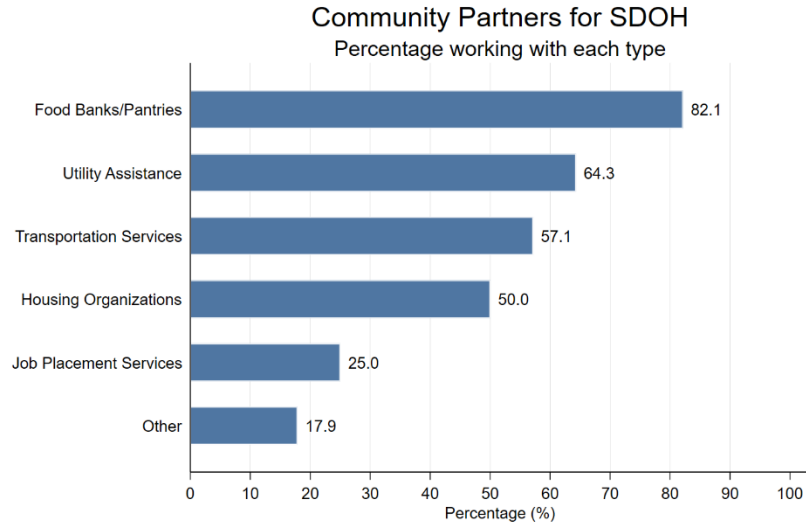
Instead of handing the patient a paper list of phone numbers, the clinic's nurse or case manager utilizes the statewide CIE platform. Through this secure, shared technology, the nurse can see a real-time directory of available services. They send an electronic referral directly to two specific organizations: a local food bank for immediate food assistance and a regional transportation service that partners with healthcare providers.

Both the food bank and the transportation service receive the referral instantly through the CIE. They can then accept the referral, contact the patient to arrange services, and update the patient's status within the system. The primary care clinic receives a notification back through their EHR, confirming that the patient has been successfully connected with both services, thus closing the referral loop.

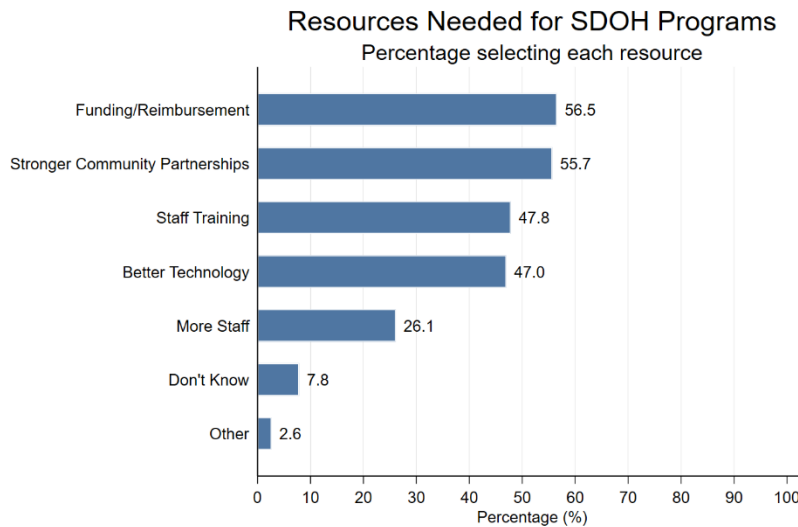
This CIE would be a collaborative effort involving healthcare providers, community-based organizations (CBOs), and public health agencies, potentially funded through a combination of state grants and technical assistance. By providing a shared infrastructure for standardized, closed-loop referrals, the CIE directly addresses the "black box" referral problem where providers are often uncertain about patient outcomes after making a referral.

Participation in Collaborative Networks
Networks to address SDOH in community





Collectively, these findings paint a picture of a collaborative landscape that is nascent and underdeveloped but holds significant promise. The system currently functions on informal, one-to-one relationships between individual clinics and local CBOs, with little in the way of formal governance, data-sharing agreements, or shared communication platforms. However, the high level of interest in joining such networks represents a crucial opportunity for state-level action. There is a clear and present desire among providers for a more organized, collaborative approach. Building the "connective tissue" or the formal networks and shared data infrastructure, that can transform this latent interest into a functional ecosystem is a major area for strategic intervention. This conclusion is further supported by the results of Question 30, where "Stronger community partnerships" was identified as one of the top three most-needed resources by providers seeking to improve their SDOH programs.



Section 4: Perceived Barriers and Systemic Challenges

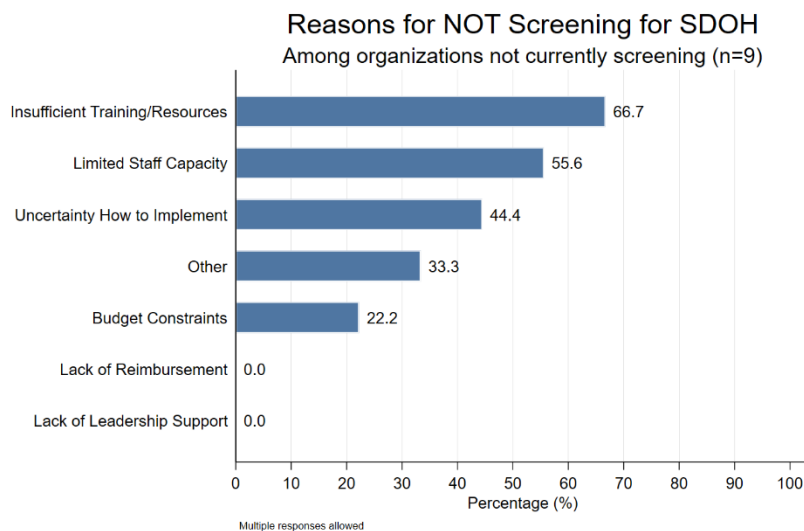
While the preceding sections detailed what Arkansas providers are doing to address SDOH, this section focuses on the obstacles they face. By synthesizing responses from multiple survey questions, a comprehensive model of barriers emerges. These challenges range from practical hurdles in knowledge and capacity for organizations just beginning their SDOH journey to more complex operational and systemic issues for those already engaged in screening. The analysis reveals a triad of interlocking deficiencies such as unfunded mandates, under-resourced partners, and unclear processes, that collectively stifle the progress of the entire SDOH ecosystem in the state.

4.1: The Non-Adopter's Perspective

A small minority of survey respondents (N=9) indicated that their organization does not currently screen for SDOH. While the sample size is too small for broad generalization, their reasons for non-adoption, captured in Question 9, provide valuable insight into the initial barriers to entry.

For this group, the primary challenges are not financial but are instead centered on knowledge and capacity. The most frequently cited reasons for not screening were Insufficient Training or Resources (66.7%), Limited Staff Capacity (55.6%), and Uncertainty about How to Implement Screening (44.4%). Notably, **Lack of Reimbursement** was cited by 0% of this specific subgroup, and Lack of Leadership Support was also cited by 0%. This suggests that for the few remaining non-adopters, the fundamental obstacle is a lack of practical know-how and the personnel to execute the task.

The future intentions of this group, as asked in Question 10, are split: 44.4% are considering integrating an SDOH screening tool, while an equal 44.4% are not. The open-ended responses to Question 9 provide some context for this hesitation, with one respondent noting their practice's focus on orthopedic surgery, implying a perceived lack of relevance. Another cited being "not a direct service provider," suggesting a belief that screening is only appropriate for those who also provide social services.



These findings indicate that efforts to bring the last remaining non-adopters into the fold should prioritize foundational implementation support. For example, concise toolkits, introductory training on screening and referral best practices, and specialty-specific guidance that clarifies the relevance of SDOH beyond primary care. Financial barriers were not a major concern with non-adopters; the barriers for this group are about the "how-to," not the "what's-in-it-for-me."

4.2: The Adopter's Operational Hurdles

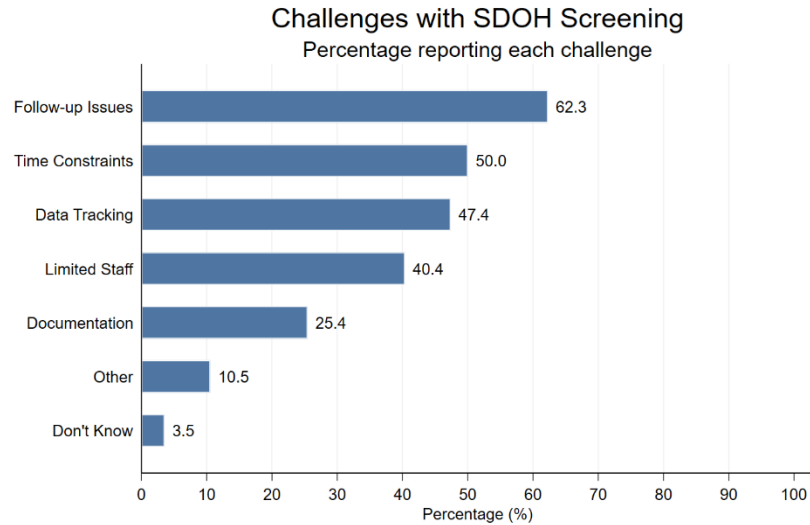
For most organizations (87.1%) that have already adopted SDOH screening, the nature of the challenges shifts from "how to start" to "how to manage and sustain" the work. Question 23 asked these screening organizations to identify their biggest operational challenges, revealing a set of significant post-implementation hurdles.

The most pressing challenge, cited by 62.3% of 114 respondents, is Difficulty ensuring follow-up on identified needs. This powerfully confirms the "black box" referral problem identified in Section 3. Providers are successfully identifying needs but struggle to close the loop, leaving them uncertain about patient outcomes. This is followed by a cluster of resource-related issues: Time constraints during patient visits (50.0%), Limited ability to track and monitor data over time (47.4%), and Limited staff capacity to conduct screenings (40.4%).

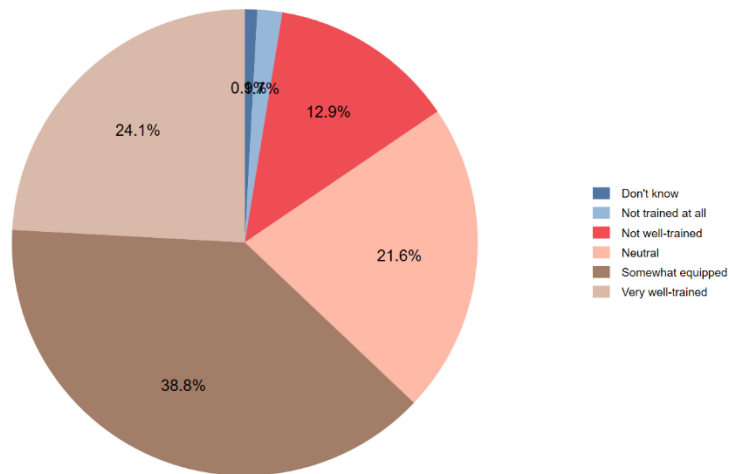
These are not abstract problems; they are the day-to-day operational consequences of adding a new, complex workflow into an already strained clinical environment. Simply adding a screening questionnaire to the intake process creates significant downstream work, documentation, referral management, data analysis, and follow-up, that existing systems and staffing models are often not equipped to handle.

The state of staff preparedness, as measured by Question 24, is a direct contributor to these operational difficulties. While a combined 62.9% of 116 respondents feel their staff are "Somewhat equipped" or "Very well-trained," a substantial minority (36.2%) feel "Neutral," "Not

well-trained," or "Not trained at all". Staff who are poorly trained or lack confidence will inevitably struggle with the sensitive conversations, complex documentation, and diligent follow-up required for effective SDOH work. For most Arkansas providers, the near-term need is less persuasion to screen and more practical support including the implementation resource, workflow-aligned tools, and workforce training, to manage the downstream needs that screening uncovers efficiently and effectively.



Staff Training Levels for SDOH Screening
Self-reported preparedness

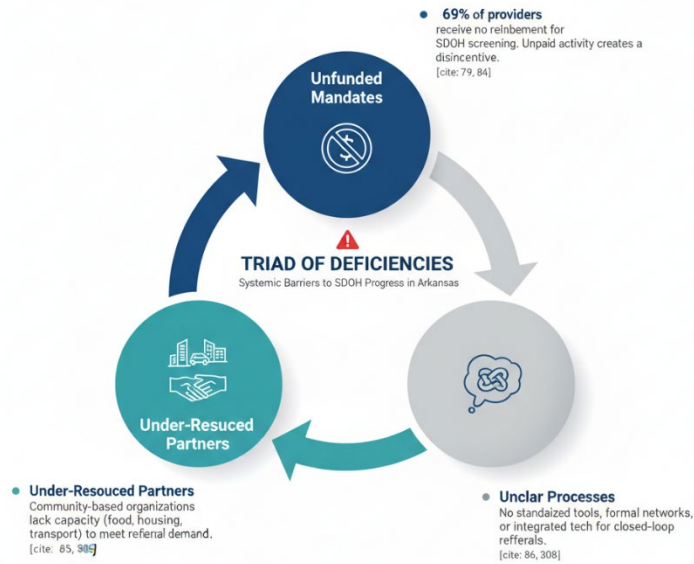


4.3: Overarching Systemic Barriers

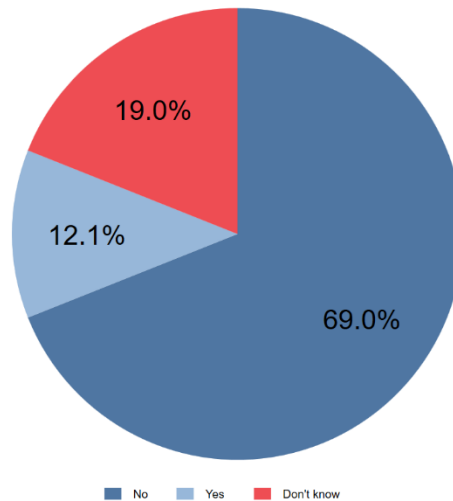
Beyond the perspectives of non-adopters and the operational hurdles of adopters, the survey reveals a set of overarching systemic barriers that affect the entire SDOH ecosystem. These challenges, related to funding, processes, and partner capacity, are deeply interconnected and represent the most significant obstacles to progress as shown in the figure below.

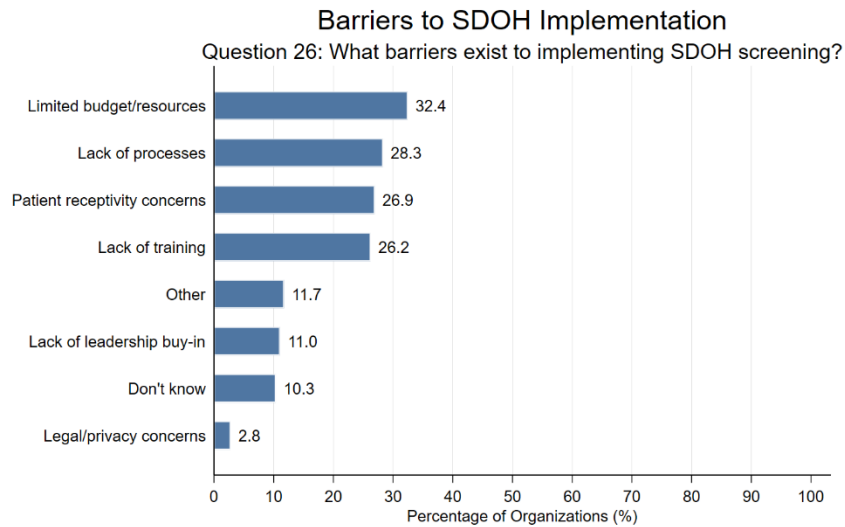
A critical systemic barrier is the financial model, or lack thereof, for SDOH work. Question 25 asked screening organizations if they receive reimbursement for their efforts. The response was stark: a resounding 69.0% of 116 respondents reported that they do not receive reimbursement. Only 12.1% do, with the remainder unsure. This finding positions SDOH screening as a largely unfunded mandate within the Arkansas healthcare system. This lack of a sustainable payment model is the root cause of the

Figure 1: The Triad of Deficiencies in Arkansas's SDOH Ecosystem



Reimbursement for SDOH Screening





"Limited budget or resources" barrier was cited by 32.4% of respondents in Question 26 as a common impediment to implementation. Even if screening were fully funded, the referral process faces a critical bottleneck on the supply side. Question 29 surveyed the small group of providers who collaborate with CBOs about the primary barriers to that collaboration. The most cited barrier, by 63.0% of 27 respondents, was "Limited community organization resources." The second most common was "Lack of formal partnerships" (59.3%). This reveals a crucial perception among healthcare providers: even if they could perfect their screening and referral process, the CBOs they refer to are seen as under-resourced and unable to meet the demand. This sentiment is echoed in open-ended responses, with one provider noting the primary barrier is that "if positive, no local resources to refer to" and is a salient reminder that the health system cannot act alone.

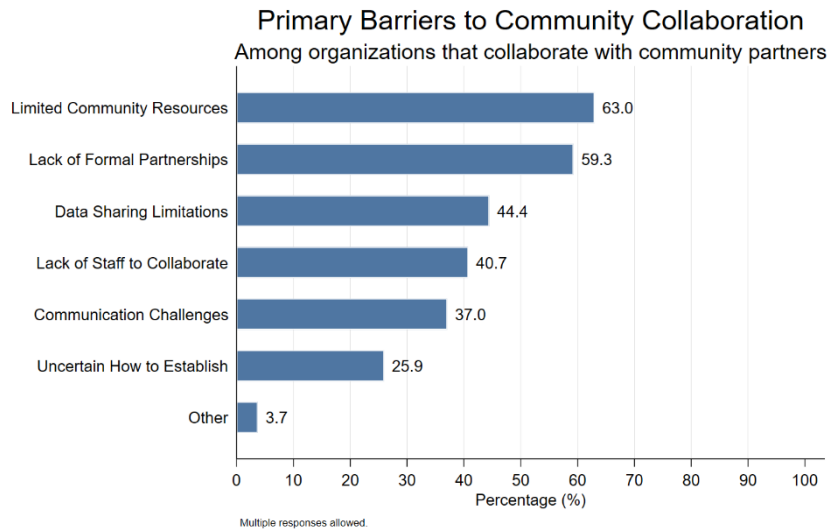
The third major systemic barrier is an absence of clear, standardized processes. In Question 26, "Lack of clearly established processes" was the second-most-cited implementation barrier (28.3%). This aligns with earlier results indicating nonstandard workflows (Section 2.2), fragmentation of screening tools (Section 2.3), lack of formal partnerships (Question 29), and the absence of a shared data and referral infrastructure (Section 3.1).

The figure above synthesizes the barriers identified across multiple survey questions, illustrating how they manifest at different stages of SDOH implementation. This synthesis reveals a "Triad of Deficiencies":

1. **Unfunded Mandates:** Providers are expected to perform SDOH screening and follow-up without a clear or consistent payment mechanism.
2. **Under-resourced Partners:** The community-based organizations essential for resolving identified needs are perceived as lacking the capacity to handle the volume of referrals.
3. **Unclear Processes:** The absence of standardized tools, workflows, and collaborative agreements creates inefficiency and uncertainty.

Addressing any one of these deficiencies in isolation will likely prove insufficient. A successful statewide strategy must simultaneously create sustainable financing models for

providers, invest in capacity-building for CBOs, and facilitate the development of standardized, shared processes for collaboration.



Section 5: Motivations, Incentives, and Future Trajectory

After a thorough examination of the barriers and challenges, this final analytical section shifts focus to the drivers of SDOH work and the potential pathways for future growth. It explores the core motivations that compel providers to engage in screening, the specific resources and incentives they believe would be most helpful, and their overall commitment to future investment. The findings suggest that while providers are intrinsically motivated and have a clear vision for what they need, the future expansion of SDOH initiatives in Arkansas is largely contingent on external support and systemic change.

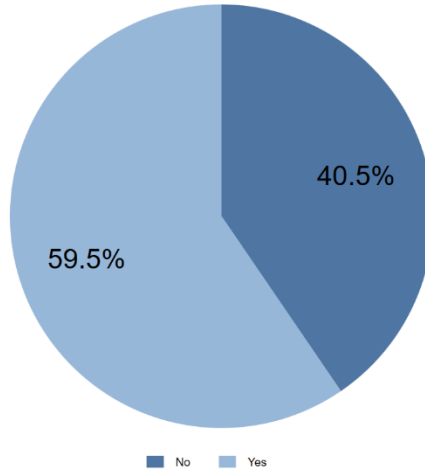
5.1: Drivers of SDOH Screening

Understanding why organizations implement SDOH screening is crucial for policy design and implementation supports. Survey responses suggest that motivations are primarily mission- and patient-care oriented, with regulatory or payer requirements cited less frequently. Question 11 asked screening organizations to rate the importance of various rationales on a scale of 1-5 (1 = Least Important; 5 = Most Important). "Population Health Mission," had the highest mean (4.14), followed by "Patient Risk Stratification" (3.88). External motivators were rated lower: "Federal/State Regulations" (3.64), and "Insurance Mandates" (3.39). Taken together, these findings indicate that, in this sample, mission and patient-care considerations were more salient than regulatory or payer pressures. This pattern suggests that SDOH efforts are more value driven than compliance driven, which policymakers can leverage.

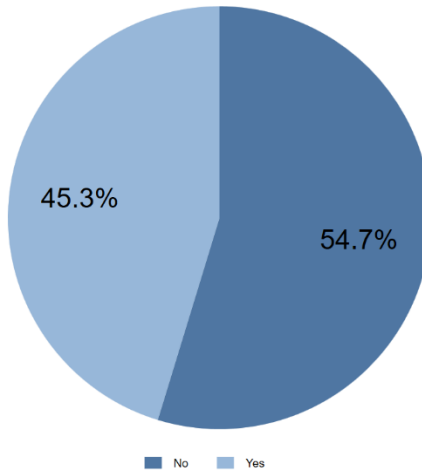
At the same time, awareness of the evolving policy landscape is significant. Question 34 found that a solid majority of respondents (59.5%) are aware of the CMS rules regarding SDOH

data reporting. Furthermore, of the 40.5% who were unaware, Question 35 revealed that nearly half (45.3%) are actively in the process of learning about these new requirements.

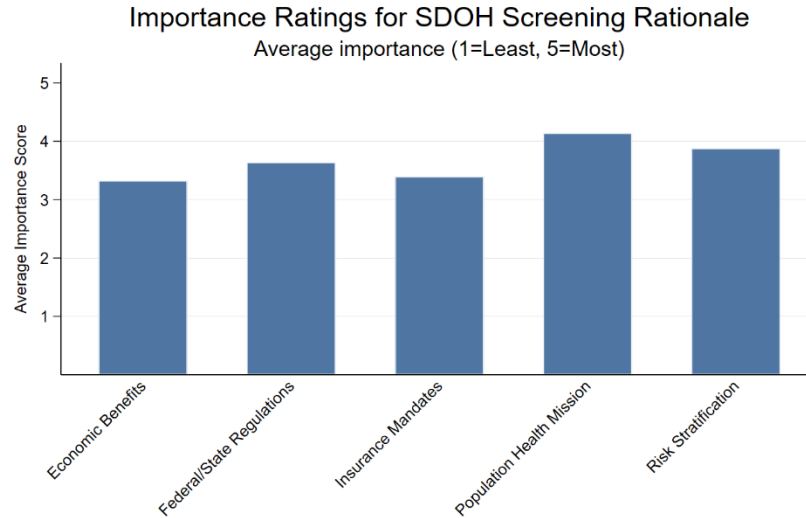
Awareness of CMS SDOH Reporting Rules
Centers for Medicare & Medicaid Services requirements



Currently Learning About CMS Requirements
Among those unaware of CMS SDOH rules



This combination of intrinsic motivation and growing policy awareness creates a fertile ground for state-level action. The primary driver for SDOH adoption is a shared mission, which policymakers can support and enable. The increasing attention to external rules from bodies like CMS indicates that providers are a receptive audience for state-level policies and payment reforms that align with these national trends, such as the introduction of new reimbursement codes like HCPCS code G0136 for SDOH risk assessments. Policies that are framed as supporting the core mission of improving population health are likely to be met with greater uptake than those perceived primarily as compliance requirements.



5.2: The Path Forward: Expressed Needs for Growth

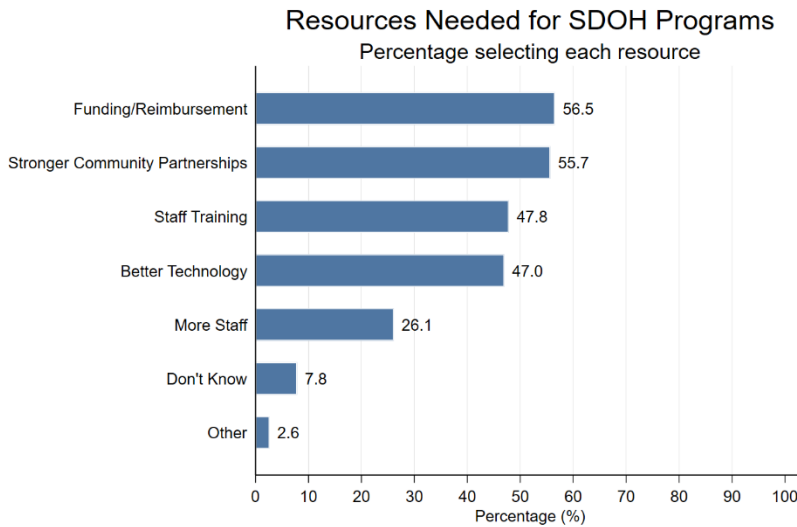
The survey not only identified barriers but also asked providers directly what they need to improve and expand their SDOH programs. The responses across several questions are remarkably consistent, painting a clear picture of the resources, incentives, and system-level changes that providers believe are necessary for success.

Question 30 asked what additional resources are needed to improve SDOH screenings and interventions. Among 115 respondents, the top needs were:

- Funding/Reimbursement Models (56.5%)
- Stronger Community Partnerships (55.7%)
- Training for Staff (47.8%)
- Better Technology Integration (47.0%)

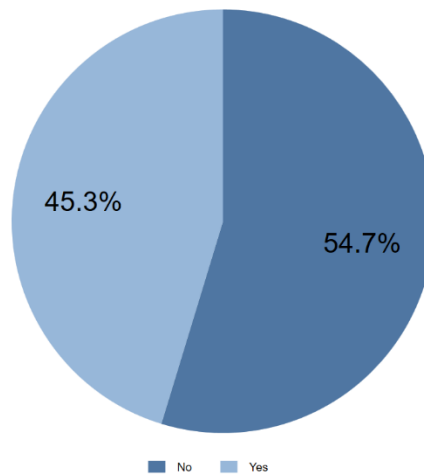
This list was mirrored in Question 32, which asked about the most helpful resources or incentives. Among 105 respondents, the most desired were:

- Community Partnership Opportunities (63.8%)
- Enhanced Community Collaboration (57.1%)
- Improved Health Outcomes (53.3%)
- Staff Availability and Training (55.2%)
- Payment Model Incentives (52.4%)



Currently Learning About CMS Requirements

Among those unaware of CMS SDOH rules



The consistency is clear: providers need partners, money, and better technology and training. These expressed needs are a direct reflection of the primary barriers identified in Section 4. The call for "Funding/Reimbursement" addresses the significant reimbursement gap (Question 25). The desire for "Stronger Community Partnerships" and "Enhanced Collaboration" speaks to the informal and underdeveloped nature of the current collaborative landscape (Question 27). The need for "Staff Training" and "Better Technology" directly corresponds to the findings on mediocre staff preparedness (Question 24) and the fragmented, non-integrated EMR environment (Question 7 and 20).

Crucially, providers are not just identifying problems; they are open to system-level solutions. Question 33 found that a majority (51.9%) would be interested in receiving training on SDOH screening best practices. **Even more significantly, Question 19 revealed that a strong majority (61.9%) would consider adopting a statewide SDOH system if one were implemented.** This demonstrates a clear appetite for statewide guidance, standardization, and

infrastructure support. Arkansas providers have effectively provided a roadmap for policymakers. A successful statewide strategy should focus on a three-pronged investment in:

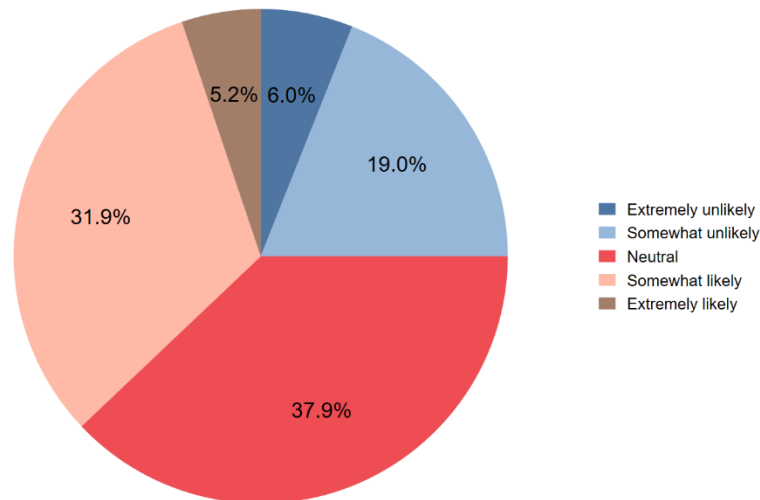
- (1) **Collaborative infrastructure:** develop of networks and shared data platforms.
- (2) **Workforce development:** provided standardized training and technical assistance.
- (3) **Financial sustainability:** implement payment reforms that support screening, referral, and follow-up.

5.3: Commitment to Future Investment

While providers have a clear vision for what external support they need, the final piece of the puzzle is their willingness to commit their own internal resources to future SDOH efforts. Question 31 asked about the likelihood of increasing resources for SDOH screening in the next year. The response was decidedly tentative, suggesting that without external support, internal investment is likely to stagnate.

Among 116 respondents, the largest group (37.9%) was "Neutral" on the prospect of increasing resources. While a combined 37.1% were "Somewhat likely" or "Extremely likely" to do so, a notable 25.0% were "Somewhat unlikely" or "Extremely unlikely". This high rate of neutrality suggests a "wait-and-see" attitude. Given the significant financial pressures and lack of reimbursement detailed earlier, it is logical that many organizations are hesitant to commit more of their own scarce resources to this largely unfunded work.

Likelihood to Increase SDOH Resources Next Year



This finding serves as a crucial capstone to the financial and resource arguments made throughout this report. It indicates that providers, driven by their mission to improve population health, have likely stretched their internal resources as far as they can. They are doing what they can do within their current constraints, but they have reached the limit of their ability to self-fund and expand these initiatives. The future growth of SDOH programs in Arkansas is therefore contingent on external investment and policy change. The state, along with private payers and foundations, must provide the incentives, resources, and collaboration identified by providers in

Questions 30 and 32 to unlock further progress and move the system from its current state of nascent adoption to one of mature, effective implementation.

Section 6: Voices from the Field: Qualitative Insights from Provider Feedback

While the quantitative data provides a broad overview of the SDOH landscape in Arkansas, the open-ended comments from survey respondents offer a rich, qualitative layer of understanding. These voices from the front lines of healthcare add nuance and a human dimension to the statistics, powerfully illustrating the day-to-day realities of implementing SDOH screening. The feedback coalesces around several key themes that reinforce and expand upon the report's primary findings.

6.1: Affirming the Mission, Acknowledging the Hurdles

Across the feedback, there is a strong and clear affirmation of the importance of SDOH screening. Providers are not questioning the "why"; they are grappling with the "how." One respondent stated plainly, "SDOH screening is essential because they have significant impact in health outcomes". This sentiment is echoed by others who see the value in the work, with one noting, "Yes, I believe that SDOH screening is essential for identifying social factors that directly impact the health of our clients".

However, this belief is almost always paired with a call for better implementation support. Multiple providers pointed to the need for improved operational processes. One commented, "it would be helpful to provide more hands-on training for the teams involved and to improve the integration between the systems used. This would make the process more efficient and accurate". This highlights a recurring theme: the concept is sound, but the execution is hampered by practical challenges in training and technology.

Subsection 6.2: The "Screening to Nowhere" Dilemma

Perhaps the most powerful theme to emerge from the qualitative data is the deep frustration with identifying patient needs that cannot be met due to a lack of community resources. This gives a voice to the "Screening-Doing Gap" identified in the quantitative analysis. As one provider articulated, "Screening is not really the issue in my organization. We can screen patients. Our issue is that we have only limited resources in our rural area to refer patients to".

This problem is particularly acute in rural settings and for complex needs like housing. Another respondent detailed this challenge: "We are working on implementing this, but one barrier is the lack of local resources to provide to patients who screen with a need (beyond food banks). For instance, there are no local shelters in our immediate area". These comments underscore a critical system failure: without a robust and well-resourced network of community partners, the act of screening can feel futile, identifying problems that the healthcare system is unequipped to solve and for which community solutions are scarce.

6.3: The Financial Squeeze and Staffing Shortages

The financial strain of performing this work without adequate compensation comes through clearly in the provider comments. This feedback personalizes the stark finding that 69%

of screening organizations receive no reimbursement. One primary care provider offered a blunt assessment of the financial reality: "Need funding for it. We already are paid too little as primary care providers to be able to add additional documentation/time for no pay. We have not had an increase in pay from the state of Arkansas in over a decade and our pay was cut by Medicare this year, even with our overhead increasing and employees needing raises".

This financial pressure directly contributes to staffing shortages, another frequently mentioned barrier. Providers explicitly stated the need for more personnel to manage the workload associated with SDOH. "Need social work staff in order to connect identified needs with community resources," one wrote. Another from a small clinic added, "We are a small clinic and struggle with staffing, so it may be that we also just don't have enough time to research properly". These comments connect the dots between the lack of a sustainable payment model and the "limited staff capacity" cited as a major operational hurdle.

6.4: Patient Receptivity and a Call for Information

Finally, a smaller but important theme relates to challenges at the patient level. One provider noted the issue of patient pushback, stating, "Patients complain constantly about filling them out and states that's personal information! We always get complaints". This aligns with the survey data showing that "concern about patient receptivity" is a barrier for over a third of organizations and highlights the need for staff training on how to frame these sensitive questions.

Amidst these challenges, there is also a clear desire for more information and guidance. One respondent's request, "please send information about the CMS (Centers for Medicare & Medicaid Services) rules regarding the reporting and collection of patients' Social Determinants of Health (SDOH) data," demonstrates a proactive interest in aligning with evolving national standards. This suggests that providers are not just waiting for solutions but are actively seeking the knowledge needed to improve their practices, reinforcing the finding that the provider community is a willing and receptive partner for system-wide improvement efforts.

challenges. A significant "Screening-Doing Gap" exists, with a steep drop-off from screening to referring (66.4%) and providing services (27.9%). The referral process itself is a "black box," with most organizations lacking the closed-loop tracking systems needed to ensure follow-up. This indicates that while the first step of identification is common, the infrastructure to act on that information is largely missing.

2. **The Small Practice Problem:** The respondent pool is dominated by small (47.6% have 1-10 providers), primary care-focused organizations. This is a critical contextual factor, as small practices typically have fewer financial, technological, and administrative resources than large health systems. The prevalence of barriers such as limited staff, budget constraints, and technological hurdles is amplified in this environment. Solutions must be scalable and affordable for the small clinics that form the backbone of Arkansas's healthcare delivery system.
3. **The Infrastructure Deficit:** The ecosystem is defined by fragmentation at multiple levels. The technology is fragmented, with a diverse EMR market that lacks a dominant vendor, hindering interoperability. The tools are fragmented, with most providers using non-standardized, "homegrown" screening instruments instead of validated national tools like PRAPARE. The relationships are fragmented, characterized by informal, ad-hoc collaboration rather than structured networks with formal data-sharing agreements. This lack of standardized infrastructure prevents the development of a cohesive, efficient, and data-driven ecosystem.
4. **The Triad of Deficiencies:** Progress is fundamentally stifled by a vicious cycle of three interlocking systemic barriers. First, SDOH work is largely an unfunded mandate, with 69% of screening organizations receiving no reimbursement. Second, the crucial community-based partners are perceived as under-resourced, creating a supply-side bottleneck where there are not enough services to meet the demand uncovered by screening. Third, there is a lack of unclear processes, with providers citing the absence of established workflows and formal partnerships as a major impediment. These three issues reinforce one another, creating a system where no single actor has the resources or clarity to drive comprehensive change.
5. **The Willing but Waiting:** Despite these significant challenges, the provider community is not apathetic. The primary motivation for screening is an intrinsic "Population Health Mission," not external mandates. There is a clear and strong appetite for system-level solutions, with majorities expressing interest in adopting a statewide SDOH system (61.9%) and receiving best-practice training (51.9%). Providers have a consistent vision of what they need, funding, partnerships, technology, and training, but are hesitant to increase their own internal investment without external support. They are willing partners, but they are waiting for a catalyst for change.

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Appendices

Appendix A: Qualtrics Survey

Arkansas Provider SDOH Screening Survey

Start of Block: Introduction

Q1 Dear Provider, To better serve communities across Arkansas, the University of Arkansas, Fayetteville, in collaboration with the University of Arkansas for Medical Sciences, is conducting a statewide survey of healthcare providers. This survey aims to understand how providers and healthcare practices screen for social determinants of health in Arkansas. The findings from the survey will help researchers and policymakers better understand and address gaps in screening. As a provider in the state, you have been selected to participate in this study. The survey should take approximately 10 to 15 minutes to complete. If you choose to participate, you should only take the survey once. Every participant who completes the survey will receive an electronic gift card worth \$10. Your responses will be kept confidential to the extent allowed by the law and University. Your participation is voluntary, and you may choose to skip questions or stop responding at any point. There are no anticipated risks to participate greater than those experienced in daily life. Please note that once data collection is completed, your address will be removed from the dataset and deleted, leaving your responses anonymous. The Institutional Review Board at the University of Arkansas, Fayetteville has determined that this study meets the ethical obligations required by federal law and University policies. If you have questions or concerns regarding this study, please contact Dr. Michael Niño at mnino@uark.edu. If you have any questions about your rights as a research study participant, you may call Ro Windwalker, IRB Coordinator. Ro Windwalker's telephone number is 479-575-2208 and can be reached weekdays from 8:00 a.m. to 5:00 p.m. CST.

- Yes - I have read the above information and voluntarily agree to participate. (1)
- No – I do not wish to participate in the research study or I am not 18 years of age (2)

Page Break

Q2 Prior to beginning the survey, we first need to confirm your eligibility. Below, please provide your name and provider address. Note: All identifiable information, including your name, will be removed at the end of the study. This information will only be used to confirm eligibility.

Name (5) _____

Street Address (1) _____

Address Line 2 (2) _____

City (3) _____

Zip Code (4) _____

End of Block: Introduction

Start of Block: Organization, Provider Type, Size

Q3 Would the information you provide today apply to your entire organization or only to some clinical areas (e.g. ED, inpatient)?

Yes, covers entire organization (1)

No, only covers a portion of my organization (2)

Page Break _____

Display this question:

If Would the information you provide today apply to your entire organization or only to some clinica... =
No, only covers a portion of my organization

Q4 What areas would your information cover? Select all that apply.

- Inpatient (1)
- Outpatient/Ambulatory care (2)
- ED (3)
- Public health (4)
- Pediatric (5)
- Oncology (6)
- Primary care (7)
- Rural emergency hospital (8)
- Rehabilitation hospital (9)
- Psychiatric hospital (10)
- Other (11) _____
- Don't know (12)

Page Break

Q5 Would you describe the majority of the providers in your organization as_____?

- Primary care physician (1)
- Nurse practitioner (2)
- Specialist physician (3)
- Behavioral healthcare provider (4)
- Physician assistant (5)
- Registered nurse (6)
- Social worker (7)
- Administrator (8)
- Outreach staff (9)
- Home health/home visit personnel (10)
- Other (please specify) (11) _____
- Don't know (12)

Page Break

Q6 Considering all types of healthcare providers, approximately how many work in your organization (Select response closest to your answer)?

- 1-10 providers (1)
- 11-25 providers (2)
- 26-50 providers (3)
- 51-100 providers (4)
- 51-100 providers (5)
- 101-200 providers (6)
- 201-500 providers (7)
- Over 500 providers (8)
- Don't know (9)

Page Break

Q7 What EMR/EHR system is your organization currently using?

- Center (1)
- Epic (2)
- Meditech (3)
- Allscripts (4)
- NextGen (5)
- Greenway (6)
- Athenahealth (7)
- Other (please specify) (8) _____
- None (9)
- Don't know (10)

End of Block: Organization, Provider Type, Size

Start of Block: SDOH

Q8 The next set of questions focus on capturing information on Social Determinants of Health (SDOH) within your patient population. SDOH are non-medical factors that influence health, well-being, and quality of life. These factors include the conditions in which people are born, grow, live, work, and age. Does your organization currently screen/refer or provide patients

services associated with social determinants of health (SDOH) such as food insecurity, housing issues, social support or other needs that affect patient health (select all that apply)?

- Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers). (1)
- Yes, we refer patients to external services that address SDOH-related needs. (2)
- Yes, we provide services directly to patients to address SDOH-related needs. (3)
- No, our organization does not currently engage in screening, referring, or providing SDOH services. (4)
- Don't know (5)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDoH)... = No, our organization does not currently engage in screening, referring, or providing SDOH services.

Q9 What are the primary challenges preventing your organization from using an SDOH screening tool? (Please select all that apply.)

- Lack of reimbursement for SDOH screenings (1)
- Limited staff capacity to conduct screenings (2)
- Insufficient training or resources (3)
- Budget constraints for tools and technology (4)
- Lack of leadership or executive support (5)
- Uncertainty about how to implement screening (6)
- Other (Please specify) (7) _____
- Don't know (8)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = No, our organization does not currently engage in screening, referring, or providing SDOH services.

Q10 Is your organization currently considering integrating an SDOH screening tool with your EMR/EHR system?

- Yes (1)
- No (2)
- Don't know (3)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q11 Which of the following best describes your organization's commitment/rationale to screening for SDOH?

	1 (Least Important) (1)	2 (2)	3 (3)	4 (4)	5 (Most Important) (5)
Federal/state regulations (1)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Population health mission (2)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Insurance mandates (3)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Economic benefits (4)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Patient Risk Stratification (5)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (Please specify) (6)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q12 Which statement best describes your organization's approach to screening patients for social determinants of health (SDOH)?

- We routinely screen all patients for SDOH needs. (1)
- We selectively screen certain patients based on specific criteria (e.g., risk factors, clinical setting). (2)
- Don't know (3)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q13 How often does your organization screen patients for social determinants of health (SDOH)? Please select all that apply.

- At the initial appointment (1)
- At every appointment (2)
- Annually (3)
- As needed, based on patient circumstances (4)
- Don't know (5)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q14 Who in your organization is responsible for administering SDOH screenings? (Please select all that apply).

- Physician (1)
- Nurse (2)
- Nurse Practitioner (3)
- Social Worker (4)
- Case Manager (5)
- Dedicated SDOH staff (6)
- Self-administered electronically (e.g., tablet, online form) (7)
- Self-administered on paper (e.g., survey form) (8)
- Home health/home visit personnel (9)
- Other (Please specify) (10) _____
- Don't know (11)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we refer patients to external services that address SDOH-related needs.

Q15 Does your organization have a system in place to track whether referred patients successfully access the services (e.g., closed-loop referral)?"

- Yes (1)
- No (2)
- Don't know (3)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q16 Does your organization uses a specific SDOH tool to screen patients?

- Yes (1)
- No (2)
- Don't know (3)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH) ... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q17 Which SDOH screening tool(s) does your organization use? (Select all that apply.)

- PRAPARE – Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (1)
- AHC HRSN – Accountable Health Communities (HRSN = Health-Related Social Needs) (2)
- WE CARE – Welcome, Engage, Communicate, Ask, Reassure, Exit (3)
- CMS Screening Tool (4)
- FindHelp (5)
- Hark NWA Tool (6)
- Health Leads (7)
- SIPT – Social Determinants of Health in Pregnancy Tool (8)
- Health system’s EPIC EHR screening tool (9)
- Core 5 Social Risk Screening (10)
- I-Screen (11)
- WellRx (12)
- Health Begins (13)
- Help Steps (14)
- The EveryONE Screening Tool (15)
- IHELP – Income, Housing, Education, Legal Status, Literacy, Personal Safety (16)
- MASQ – Medical-Legal Advocacy Screening Questionnaire (17)
- Bright Futures (18)
- Montefiore SDOH Screening Tool (19)
- Other (Please specify) (20) _____



Don't know (21)



Page Break



Display this question:

If Does your organization uses a specific SDOH tool to screen patients? = Yes

Q18 In general, how satisfied in your organization with your current SDOH screen tool?

- Extremely dissatisfied (1)
- Somewhat dissatisfied (2)
- Neither satisfied nor dissatisfied (3)
- Somewhat satisfied (4)
- Extremely satisfied (5)

Page Break

Q19 If a statewide SDOH system were implemented, would your organization consider adopting it?

- Yes (1)
- No (2)
- Don't know (3)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q20 Does your organization's EMR/EHR system integrate with any external SDOH tools? (Please select all that applies)

- Unite Us (1)
- FindHelp (2)
- Hark NWA Tool (3)
- Other (Please specify) (4) _____
- No, our EMR/EHR does not integrate with external SDOH tools (5)
- Don't know (6)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q21 Does your organization electronically share SDOH data with external organizations (e.g., Arkansas Department of Health, Centers for Medicare & Medicaid Services)?

- Yes (1)
- No (2)
- Don't know (3)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q22 Which of the following social determinants of health (SDOH) does your organization currently screen, refer, or provide services? Please check all that apply and indicate the approach used (screen, refer, provide)

	Yes, Screen (1)	Yes, Refers (2)	Yes, Provides (3)	Don't know (4)
Housing issues (1)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food insecurity (2)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation issues (3)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Legal issues (4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial barriers (5)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social isolation (6)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health insurance challenges (7)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childcare availability/affordability concerns (8)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employment issues (9)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

End of Block: SDOH

Start of Block: Challenges

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q23 What are the biggest challenges your organization faces in conducting SDOH screenings?
(Please select all that apply.)

- Time constraints during patient visits (1)
- Limited staff capacity to conduct screenings (2)
- Difficulty ensuring follow-up on identified needs (3)
- Challenges with documentation and data entry (4)
- Limited ability to track and monitor data over time (5)
- Other (Please specify) (6) _____
- Don't know (7)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q24 How well do you feel your staff is trained to screen for and address SDOH?

- Very well-trained (1)
- Somewhat equipped (2)
- Neutral (3)
- Not well-trained (4)
- Not trained at all (5)
- Don't know (6)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q25 Do you receive reimbursement for SDOH screenings?

- Yes (1)
- No (2)
- Don't know (3)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q26 What are the primary barriers your organization faces in implementing SDOH screenings?
(Please select all that apply)

- Lack of clearly established processes (1)
- Limited budget or resources (2)
- Lack of training (3)
- Lack of leadership buy-in (4)
- Concern about patient receptivity (5)
- Legal or privacy concerns (6)
- Other (Please specify) (7) _____
- Don't know (8)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q27 Is your organization part of a collaborative network to address SDOH in your community?

- Yes, my organization is part of a formal network (Please specify) (1)

 - Yes, we collaborate informally (2)
 - No, but interested in joining (3)
 - No, not interested in joining (4)
 - Don't know (5)
-

Page Break

Display this question:

If Is your organization part of a collaborative network to address SDOH in your community? = Yes, my organization is part of a formal network (Please specify)

Or Is your organization part of a collaborative network to address SDOH in your community? = Yes, we collaborate informally

Q28 What types of community organizations or community partners does your organization work with? (Please select all that apply)

- Food banks/pantries (1)
- Housing organizations (2)
- Transportation services (3)
- Utility assistance programs (4)
- Job placement services (5)
- Other (please specify) (6)

Page Break

Display this question:

If Is your organization part of a collaborative network to address SDOH in your community? = Yes, my organization is part of a formal network (Please specify)

Or Is your organization part of a collaborative network to address SDOH in your community? = Yes, we collaborate informally

Q29 What are the primary barriers to collaborating with community organizations? (Select all that apply)

- Lack of formal partnerships (1)
- Communication challenges (2)
- Data sharing limitations (3)
- Uncertain of how to establish partnerships (4)
- Lack of staff to collaborate with (5)
- Limited community organization resources (e.g., funding to hire staff) (6)
- Other (Please specify) (7) _____

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q30 What additional resources would you need to improve SDOH screenings and interventions?
(Select all that apply)

- More staff (1)
- Funding/reimbursement models (2)
- Training for staff (3)
- Better technology integration (4)
- Stronger community partnerships (5)
- Other (6) _____
- Don't know (7)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q31 How likely are you to increase resources for SDOH screening efforts in the next year?

- Extremely unlikely (1)
- Somewhat unlikely (2)
- Neither likely nor unlikely (3)
- Somewhat likely (4)
- Extremely likely (5)

Page Break

Display this question:

If The next set of questions focus on capturing information on Social Determinants of Health (SDOH)... = Yes, we screen patients for SDOH-related needs (e.g., food insecurity, housing instability, transportation barriers).

Q32 What resources or incentives would help your organization with screening for SDOH? (Select all that apply)

- Staff availability and training (1)
- Improved technology integration (2)
- Community partnership opportunities (3)
- Improved patient health outcomes (4)
- Reduced emergency department visits (5)
- Stronger patient-provider relationships (6)
- Enhanced community collaboration (7)
- Payment model incentives (8)
- Other (Please specify) (9) _____
- Don't know (10)

Page Break

Q33 Would your organization be interested in training for SDOH screening best practices?

- Yes (1)
- No (2)
- Don't know (3)

Page Break

Q34 Are you aware of the CMS (Centers for Medicare & Medicaid Services) rules regarding the reporting and collection of patients' Social Determinants of Health (SDOH) data?

Yes (1)

No (2)

Page Break

Display this question:

If Are you aware of the CMS (Centers for Medicare & Medicaid Services) rules regarding the reportin... =
No

Q35 Are you currently in the process of learning about or preparing for these reporting requirements?

Yes (1)

No (2)

Page Break

Q36 Any additional comments or suggestions regarding SDOH screening implementation in your organization?

Page Break

Q37

Thank you for participating in the survey. Your input is greatly appreciated!

Would you like to receive an electronic gift card for participating in this survey? If yes, please provide your first name and preferred email address in the box below. We process all gift cards through a secured site to ensure you receive your card. Please allow 10-14 business days for us to process and send your electronic gift card.

Name (1) _____

Email address (2) _____

End of Block: Challenges

Appendix B: Invitation Forms



J. William Fulbright College of Arts and Sciences
Sociology and Criminology

Dear Provider,

You have been selected to participate in this year's healthcare provider survey.

To better serve communities across Arkansas, the University of Arkansas, Fayetteville, in collaboration with the University of Arkansas for Medical Sciences, is conducting a statewide survey of healthcare providers. This survey aims to understand how providers and healthcare practices screen for social determinants of health in Arkansas. The findings from the survey will help researchers and policymakers better understand and address gaps in screening.

The survey should take approximately 10 to 15 minutes to complete. If you agree to participate, please go to the website below or use the QR Code to complete the survey.

<https://uaheal.uark.edu/take-the-hps/>



We are not selling anything or asking for money. If you complete the survey, you will receive a \$10 electronic gift card.

If you do not have access to the internet or would prefer to complete the survey over the phone, please call (479-575-3205).

Your participation is important to the success of this study. You will provide vital information on the state of health and healthcare access in Arkansas. We greatly appreciate your cooperation.

Sincerely,

Dr. Michael Niño
Associate Professor
Director, Arkansas Health Equity and Access Lab



Dear Provider,

You have been selected to participate in the 2025 healthcare provider survey.

To better serve communities across Arkansas, the University of Arkansas, Fayetteville, in collaboration with the University of Arkansas for Medical Sciences, is conducting a statewide survey of healthcare providers. This survey aims to describe how providers and healthcare practices screen for social determinants of health in Arkansas. Your participation is vital to study success.

The survey should take approximately 10 minutes to complete. If you agree to participate, please go to the website below or use the QR Code to complete the survey.

<https://uaheal.uark.edu/take-the-hps/>



We are not selling anything or asking for money. If you complete the survey, you will receive a \$10 electronic gift card as a token of our appreciation.

If you do not have access to the internet or would prefer to complete the survey over the phone, please call (479-575-3205).

We greatly appreciate your cooperation.

Sincerely,

Dr. Michael Niño

Associate Professor

Director, Arkansas Health Equity and Access Lab



Dear Provider,

We recently mailed you a letter asking for help with this year's healthcare provider survey. This study is conducted by the University of Arkansas and the University of Arkansas for Medical Sciences and will provide important information on how providers and healthcare practices screen for social determinants of health.

If you or someone in your organization has already completed the survey, we are grateful for your participation. If you have not responded yet, we invite you to participate. Please go to the website below or use the QR code to complete the survey. The survey should only take 10 minutes to complete.

<https://uaheal.uark.edu/take-the-hps/>



We are not selling anything or asking for money. If you complete the survey, you will receive a \$10 electronic gift card as a token of our appreciation.

If you do not have internet access or would prefer to complete the survey over the phone, please call (479-575-3205).

Your participation is important to study success. We greatly appreciate your cooperation.

Sincerely,

Dr. Michael Niño
Associate Professor
Director, Arkansas Health Equity and Access Lab



UNIVERSITY OF
ARKANSAS

J. William Fulbright College of Arts and Sciences
Sociology and Criminology

Dear Provider,

This is our final reminder about the Healthcare Provider Survey conducted by the University of Arkansas and the University of Arkansas for Medical Sciences. If you have already completed the survey, we sincerely appreciate your time and contribution. If not, this is your last opportunity to share your insights. The survey takes only 10 minutes. Your participation is essential in helping describe how healthcare providers in Arkansas screen for social determinants of health.

Please take a moment to complete the survey using the website below or the QR code.

<https://uaheal.uark.edu/take-the-hps/>



We are not selling anything or asking for money. If you complete the survey, you will receive a \$10 electronic gift card as a token of our appreciation.

If you do not have internet access or would prefer to complete the survey over the phone, please call (479-575-3205).

We greatly appreciate your cooperation.

Sincerely,

Dr. Michael Niño
Associate Professor
Director, Arkansas Health Equity and Access Lab

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