# Social Determinants of Health Screening

## Background

Social Determinants of Health refers to the structural conditions in which people are born, grow, live, work and age. They are factors that can have drastic impacts on a person's health and their ability to care for themselves. Research indicates that social determinants can account for 20% of a person's health status while health care accounts for just 10%. At Health Care for the Homeless we know that our clients have complex lives and complex health conditions. Social determinants are factors that we have long considered when determining the best care and treatment plans for our clients. Understanding and addressing social determinants of health is critical to our efforts to achieve our strategic goals of providing quality, whole-person health care and affordable housing, and meaningfully improving client health outcomes.

Our next step, which we began implementing in January of this year, was standardizing how we collect and document these important factors. Standardization is necessary for us to be able to assess, report on, and improve the social determinants of our clients. To do this, we implemented a standardized tool (PRAPARE) being used by health centers across the country to screen for SDH. The tool consists of 21 questions that capture a wide variety of social determinants that impact a person's health and wellbeing.

## Questions and Frequency

The PRAPARE tool has a total of 21 questions, some of which remain stable throughout a person's life while others have answers that may change every time the question is asked. Because of this, we chose to stagger the frequency each question is asked based on where in the workflow the questions would be asked and the likelihood that the information would change. We grouped questions into three categories:

1. Episodic –questions are asked during every clinical visit
2. Quarterly – questions are asked a minimum of 1x every 3 months during a clinic visit
3. Annual – questions are asked a minimum of 1x per year through the completion of an annual baseline form completed during registration/check-in

| **Episodic** | **Quarterly** | **Annual** |
|---|---|---|
| Housing status | Social Support | Race |
| Housing stability | Stress | Migrant farm work history |
| Transportation | Intimate partner violence | Language |
| Insurance | | Education |
| Safety | | Material Security |
| | | Ethnicity |
| | | Veteran Status |
| | | Neighborhood |
| | | Employment |
| | | Income |

## Data Collection and Analysis

Our goal is to have 100% of all clients seen each year screened for social determinants at least once during the calendar year with a particular focus on housing status and family income.

Data for these metrics come in two forms: completion rates for each question and the answers clients provide to the questions. Completion rate dashboards have been developed using Tableau which is reviewed monthly to monitor how we are doing asking each questions. The second set of data looks at the answer clients are providing to the question. Last month we combined these two data sets to best reflect our data and the gaps therein.

Once we reach a 90% question completion rate we will distribute data semiannually since we do not expect the aggregate data to change much over time unless we are actively working to change a particular measure. This data will be used to help us focus interventions designed to minimize the impact of the social determinants a person is facing in efforts to improve their overall health outcomes.

## Next Steps

Our strategic focus this year is to implement the SDH screening and to know the housing and family income status for 100% of our clients. Currently, we have housing statuses on 91% of people and federal poverty level status on 65% of people seen in 2018. While it is nearly impossible to get to 100% for 2018, our goal is to get to 100% for the month of December which will set us up for a successful year in 2019.

In addition to data completion rates for income, housing status, and family size, we will start the conversation at Management Team for how else to use Social Determinants of Health data across the agency with a goal of determining which 1 or 2 measures we want to focus on improving in 2019. Finally, we will present the results to All Staff to demonstrate the impact of their efforts.