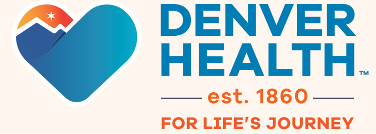
SOCIAL DETERMINANTS OF HEALTH



Growing evidence shows that if we deal with unmet Health Related Social Needs (HRSN) like homelessness, hunger, and exposure to violence, we can help undo harm and improve health outcomes. Denver Health is embarking on a concerted effort to screen for HRSN to help inform patients' treatment plans and make referrals to community services.

Current State: Summer 2022

Tableau Dashboard

To track screening and geographic metrics

Partnering with FindHelp

To promote free access to this online platform that provides information to free and reduced-cost community programs

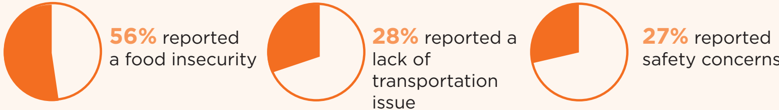
Current screening rates for targeted population for HRSN:

Patients/families during well visits for children/infants:	57.8%
Medically complex adult patients during an in person visit, annually; and additional outreach completed by integrated care teams.	44%

PROJECT OUTCOME MEASURES

Outreach and care plans successfully created by central care navigators when referrals were received by clinics via the HRSN flowsheet are measured on the SDOH Care Plan Tableau report.

The ACS HRSN dashboard contains information gathered from patients as they completed the HRSN screening, including screening status, screening responses, demographics, geographics, resources needed and number of patients screened. As of July 2022, of those patients who identified at least one need on their screening:



Future State: Goals 2022-2023

Automate screening through MyChart outreach for high-risk adults.

Increase screening and referrals to inpatient hospital care as part of the Hospital Transformation Program.

Add two care navigator positions and define additional resources needed.

Increase collaboration with the Office of Health Equity to support Denver Health's Anchor Institution framework.