

## Social Determinants of Health Assessment Tool for Pregnant Women

Today as part of your visit, I have some questions to learn more about you. If any of the questions make you feel uncomfortable, please let me know and we can skip that question.

Date: \_\_\_\_\_ ID #: \_\_\_\_\_

|  |   |
|--|---|
| <p><b>What best describes your race?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> African American</li> <li><input type="checkbox"/> Asian</li> <li><input type="checkbox"/> American Indian or Alaska Native</li> <li><input type="checkbox"/> White</li> <li><input type="checkbox"/> Hispanic/Latino (ethnicity)</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>What best describes how you are paying for this visit?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Private insurance</li> <li><input type="checkbox"/> Medicaid</li> <li><input type="checkbox"/> Self-pay</li> </ul> | <p><b>How many weeks pregnant are you?</b></p> <p><input type="checkbox"/> _____ weeks</p> <p><b>What language do you speak at home?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> English</li> <li><input type="checkbox"/> Spanish</li> <li><input type="checkbox"/> Chinese (Cantonese, Mandarin, etc.)</li> <li><input type="checkbox"/> French and/or French Creole</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>What is your zip code?</b></p> <p><input type="checkbox"/> _____</p> |
|--|---|

| <b>Transportation</b>   |  | <b>Need Identified<br/>(circle)<br/>Yes No</b> |
|---|--|--|
| <p><b>1. Do you have access to reliable transportation?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul> <p style="text-align: center;">↓</p> <p><b>2N. How did you get to this appointment today? (skip to housing)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Your own automobile</li> <li><input type="checkbox"/> Friend, relative or neighbor gave you a ride or loaned you their car</li> <li><input type="checkbox"/> Uber/Lyft/Taxi</li> <li><input type="checkbox"/> Walk/bike</li> <li><input type="checkbox"/> Public transportation</li> <li><input type="checkbox"/> Medical visit transport</li> <li><input type="checkbox"/> Other: _____</li> </ul> | <p><b>2Y. What is your primary mode of transportation?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Your own automobile</li> <li><input type="checkbox"/> Friend, relative or neighbor gives you a ride or loans you their car</li> <li><input type="checkbox"/> Uber/Lyft/Taxi</li> <li><input type="checkbox"/> Walk/bike</li> <li><input type="checkbox"/> Public transportation</li> <li><input type="checkbox"/> Other: _____</li> </ul> | <p>Notes:</p>                                  |

| <b>Housing</b>   |   | <b>Need Identified</b><br><i>(circle)</i><br><b>Yes No</b> |
|--|---|--|
| <p><b>1. What best describes the place where you live?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> A single family home</li> <li><input type="checkbox"/> Apartment, duplex, condo</li> <li><input type="checkbox"/> Mobile home</li> <li><input type="checkbox"/> Shelter</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>2. How long have you lived there?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> _____ months</li> </ul> <p><b>3. Including yourself, how many people (adults and children) live in your household?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> _____ adults</li> <li><input type="checkbox"/> _____ children</li> </ul> <p><b>4. How many bedrooms are there in the place where you live?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> _____ bedrooms</li> </ul> <p><b>5. Where you currently live, do you have access to... (check if yes, then go to 6)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> A working stove/oven</li> <li><input type="checkbox"/> A working refrigerator</li> <li><input type="checkbox"/> A working shower/toilet</li> <li><input type="checkbox"/> Heat</li> <li><input type="checkbox"/> Air conditioning</li> </ul> | <p><b>6. Do you feel safe in the place where you currently live?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes (<i>skip to food security section</i>)</li> <li><input type="checkbox"/> No</li> </ul> <p style="text-align: center;">↓</p> <p><b>6N. What factors make you feel unsafe in the place where you live?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Substance use in the home</li> <li><input type="checkbox"/> Fighting/violence in the home</li> <li><input type="checkbox"/> Guns/weapons in the home</li> <li><input type="checkbox"/> Crime in the area where you live</li> <li><input type="checkbox"/> Sanitation issues (e.g., insects, mold, etc.)</li> <li><input type="checkbox"/> Other: _____</li> </ul> | <p>Notes:</p>  |

| <b>Food Security</b>  |   | <b>Need Identified</b><br><i>(circle)</i><br><b>Yes    No</b> |
|---|---|---|
| <p><b>1. Which of the following best describes the food eaten in your household in the last 12 months?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Enough of the kinds of food you want to eat</li> <li><input type="checkbox"/> Enough, but not always the kinds of food you want to eat</li> <li><input type="checkbox"/> Sometimes there's not enough to eat</li> <li><input type="checkbox"/> Often, there's not enough to eat</li> </ul> <p><b>2. Are you currently participating in WIC and/or FoodShare Wisconsin?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> WIC</li> <li><input type="checkbox"/> FoodShare Wisconsin</li> <li><input type="checkbox"/> No</li> </ul> | <p><b>3. Where do you typically get your food?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Grocery store</li> <li><input type="checkbox"/> Convenience store</li> <li><input type="checkbox"/> Grow own food</li> <li><input type="checkbox"/> Food pantry/food bank</li> <li><input type="checkbox"/> Other _____</li> </ul> | <p>Notes:</p>   |

| <b>Childcare</b>  |   | <b>Need Identified</b><br><i>(circle)</i><br><b>Yes    No</b> |
|---|---|---|
| <p><b>1. Do you have a plan in place for who will help you with childcare once the new baby is born?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul>  |   | <p>Notes:</p>   |
| <p><b>2. Do you have reliable childcare for your children?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Don't have any other children at present (<i>skip to social support</i>)</li> </ul> <p><b>2N. What are the barriers you experience when trying to find reliable childcare?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cost</li> <li><input type="checkbox"/> Availability of childcare provider(s)</li> <li><input type="checkbox"/> Transportation issues</li> <li><input type="checkbox"/> Work schedule</li> <li><input type="checkbox"/> Other: _____</li> </ul> | <p><b>2Y. What best describes your primary childcare provider?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Self/parental care</li> <li><input type="checkbox"/> Grandparents</li> <li><input type="checkbox"/> Babysitter comes to your home</li> <li><input type="checkbox"/> Childcare in someone else's home</li> <li><input type="checkbox"/> Day care center</li> <li><input type="checkbox"/> Preschool</li> <li><input type="checkbox"/> Kindergarten</li> <li><input type="checkbox"/> School K-12</li> </ul> |   |

| <b>Social Support</b>  |   | <b>Need Identified</b><br><i>(circle)</i><br><b>Yes    No</b> |
|--|---|---|
| <p><b>1. Currently, do you feel like you are receiving an adequate amount of social support?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p style="text-align: center;">↓</p> <p><b>2N. In what areas could you benefit from more social support? (check all that apply)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Emotional support</li> <li><input type="checkbox"/> Help making decisions</li> <li><input type="checkbox"/> Providing childcare</li> <li><input type="checkbox"/> Transportation</li> <li><input type="checkbox"/> Housing</li> <li><input type="checkbox"/> Meal preparation/grocery shopping</li> <li><input type="checkbox"/> Help with paying the bills</li> <li><input type="checkbox"/> Eating healthy/exercise</li> <li><input type="checkbox"/> Substance abuse support</li> <li><input type="checkbox"/> Religious/spiritual support</li> <li><input type="checkbox"/> Educational support</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p style="text-align: center;">↓</p> <p><b>3N. Who would you like to provide you with this support? (check all that apply, then skip to medical care)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Parent(s)</li> <li><input type="checkbox"/> Sibling(s)</li> <li><input type="checkbox"/> Spouse/significant other</li> <li><input type="checkbox"/> Other relatives</li> <li><input type="checkbox"/> Friends</li> <li><input type="checkbox"/> Boss/co-workers</li> <li><input type="checkbox"/> Medical providers</li> <li><input type="checkbox"/> Religious/spiritual leaders</li> <li><input type="checkbox"/> Peer support group members</li> <li><input type="checkbox"/> Other: _____</li> </ul> | <p><b>2Y. Who provides you with social support? (check all that apply)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Parent(s)</li> <li><input type="checkbox"/> Sibling(s)</li> <li><input type="checkbox"/> Spouse/significant other</li> <li><input type="checkbox"/> Other relatives</li> <li><input type="checkbox"/> Friends</li> <li><input type="checkbox"/> Boss/co-workers</li> <li><input type="checkbox"/> Medical providers</li> <li><input type="checkbox"/> Religious/spiritual leaders</li> <li><input type="checkbox"/> Peer support group members</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p style="text-align: center;">↓</p> <p><b>3Y. In what ways do they provide you with social support? (check all that apply)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Emotional support</li> <li><input type="checkbox"/> Help making decisions</li> <li><input type="checkbox"/> Providing childcare</li> <li><input type="checkbox"/> Transportation</li> <li><input type="checkbox"/> Housing</li> <li><input type="checkbox"/> Meal preparation/grocery shopping</li> <li><input type="checkbox"/> Help with paying the bills</li> <li><input type="checkbox"/> Eating healthy/exercise</li> <li><input type="checkbox"/> Substance abuse support</li> <li><input type="checkbox"/> Religious/spiritual support</li> <li><input type="checkbox"/> Educational support</li> <li><input type="checkbox"/> Other: _____</li> </ul> | <p>Notes:</p>   |

| <b>Medical Care (access/bias)</b>  |  | <b>Need Identified</b><br><i>(circle)</i><br><b>Yes    No</b> |
|--|--|---|
| <p><b>1. Are you able to see a doctor/nurse practitioner when you need to?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p style="text-align: center;">↓</p> <p><b>2N. What are the barriers to obtaining medical care? (then go to 2Y/3)</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cost of appointment/medical care</li> <li><input type="checkbox"/> Transportation to appointment</li> <li><input type="checkbox"/> Cannot get time off work</li> <li><input type="checkbox"/> Medical provider does not have availability</li> <li><input type="checkbox"/> Nervous/anxious to see provider due to substance use</li> <li><input type="checkbox"/> Other: _____</li> </ul> | <p><b>2Y/3. How do you like medical providers to show you respect?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Listening carefully to your needs and answering your questions</li> <li><input type="checkbox"/> Spending enough time with you</li> <li><input type="checkbox"/> Involving you in decisions about your care</li> <li><input type="checkbox"/> Keeping your information confidential</li> <li><input type="checkbox"/> Calling you by your preferred name</li> <li><input type="checkbox"/> Not making assumptions about you</li> <li><input type="checkbox"/> Communicating with you in a language that you understand</li> <li><input type="checkbox"/> Clearly explaining medical conditions/concerns with you</li> <li><input type="checkbox"/> Providing you with health-related resources in a format you understand</li> <li><input type="checkbox"/> Showing an understanding and appreciation for your culture/religion               <ul style="list-style-type: none"> <li><input type="checkbox"/> In what way can medical providers show respect for your culture/religion?<br/>_____</li> <li>_____</li> </ul> </li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>3a. Do you feel like your medical providers treat you with respect?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes, all of them</li> <li><input type="checkbox"/> Yes, some of them</li> <li><input type="checkbox"/> No, none of them</li> </ul> <p><b>4. Since becoming pregnant, have you ever felt stigmatized or discriminated against by a medical provider?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No <i>(skip to substance use care)</i></li> </ul> <p><b>4a. In what ways have you felt stigmatized/discriminated against by a medical provider since becoming pregnant?</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Based on your race</li> <li><input type="checkbox"/> Based on your education level</li> <li><input type="checkbox"/> Based on your substance use</li> <li><input type="checkbox"/> Based on appearance</li> <li><input type="checkbox"/> Other: _____</li> </ul> | <p>Notes:</p>   |

| <b>Substance Use Care</b>  |  | <b>Need Identified</b><br><i>(circle)</i><br><b>Yes    No</b> |
|--|--|---|
| <p><b>1. Are you currently seeking treatment or support for substance use?</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p style="text-align: center;">↓</p> <p><b>2N. What are the barriers to seeking treatment/support?</b></p> <p><input type="checkbox"/> Feel shame/guilt<br/> <input type="checkbox"/> Worry about legal ramifications<br/> <input type="checkbox"/> Cost of treatment<br/> <input type="checkbox"/> Not ready yet<br/> <input type="checkbox"/> Other: _____</p> <p style="text-align: center;">↓</p> <p><b>3N. Would you like to receive treatment or support for substance abuse?</b></p> <p><input type="checkbox"/> Yes<br/> <input type="checkbox"/> No</p> | <p><b>2Y. What type of treatment or support are you currently receiving?</b></p> <p><input type="checkbox"/> Substance abuse counseling<br/> <input type="checkbox"/> Mental health counseling<br/> <input type="checkbox"/> Religious/spiritual counseling<br/> <input type="checkbox"/> Peer-support group<br/> <input type="checkbox"/> Opioid replacement therapy</p> <p style="margin-left: 20px;"> <input type="radio"/> Buprenorphine<br/> <input type="radio"/> Methadone<br/> <input type="radio"/> Other: _____         </p> <p style="text-align: center;">↓</p> <p><b>3. Do you feel that your substance use support team members respect you as a person and your cultural background?</b></p> <p><input type="checkbox"/> Yes<br/> <input type="checkbox"/> No</p> | <p>Notes:</p>   |
| <p><b>Thank you for talking with me today. Is there anything else you think that I should know about your preferences and priorities that can help you experience the best possible pregnancy?</b></p>   |  |   |

**Care Planning Summary:**

**Transportation:**

**Housing:**

**Food Security:**

**Childcare:**

**Social Support:**

**Medical Care (access/bias)**

**Substance Use Care:**