# Health Equity Quickinar Series
# Session 5

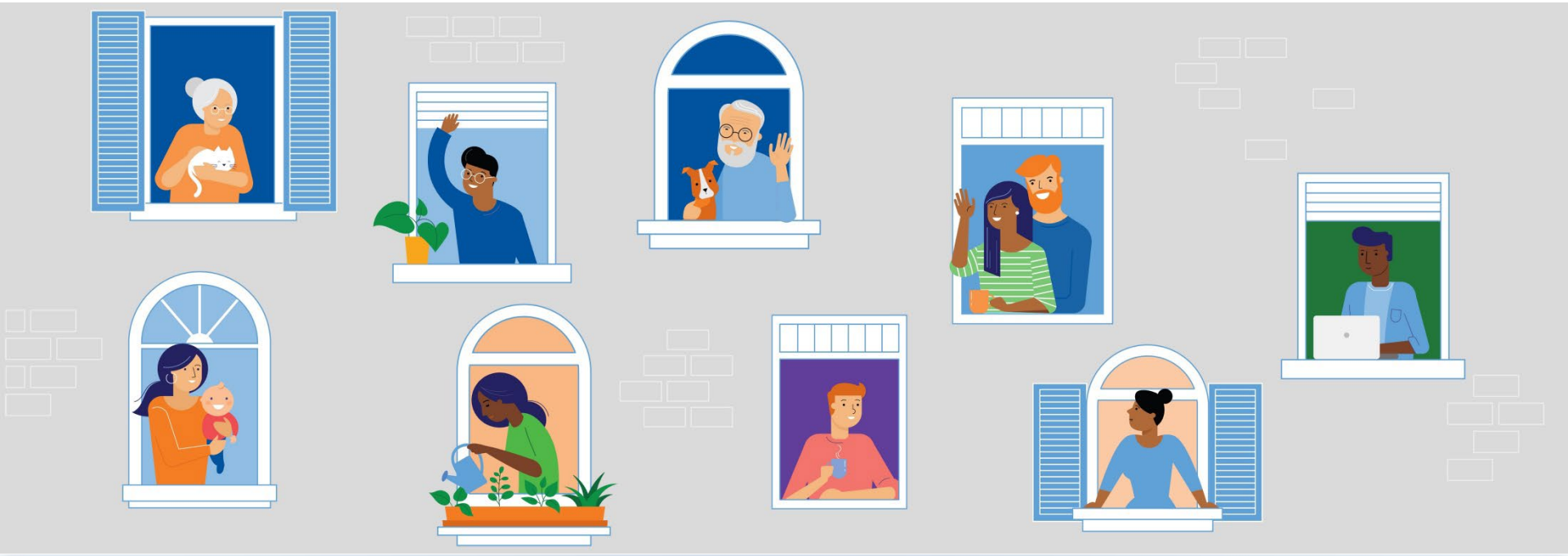
## Defining Terms: Social Determinants, Social Drivers, and Social Needs

# OBJECTIVES

- Identify the difference between social determinants of health (SDOH), social drivers, and social needs.
- Review screening strategies for data collection.
- Discuss interventions designed to address disparities related to social drivers.

# What Are SDOH?

Healthy People 2030 describes SDOH as the "conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."





https://health.gov/healthypeople/priority-areas/social-determinants-health
https://debeaumont.org/news/2019/meeting-individual-social-needs-falls-short-of-addressing-social-determinants-of-health

# What Are SDOH? (cont.)

- SDOH can be grouped into 5 primary categories.
  - Economic
  - Education access and quality
  - Healthcare access and quality
  - Neighborhood and built environment
  - Social and community context
- SDOH contribute significantly to health outcomes.
  - 80%–90% of modifiable contributors to health outcomes are social factors.
- SDOH contribute to health disparities and inequities.
  - Social factors can contribute to poor health outcomes and lower life expectancies.



https://health.gov/healthypeople/priority-areas/social-determinants-health

# Social Determinants vs. Social Drivers

- *Social determinants* and *social drivers* are terms that are used interchangeably.
  - They describe conditions impacting the health and well-being of communities.
- *Social drivers* is becoming the more used and acceptable term.
  - *Determinants* can have a sense of finality that implies access to food or housing is not changeable.



National Association of Community Health Centers. https://blog.nachc.org/social-drivers-vs-social-determinants-using-clear-terms

# Social Needs Versus SDOH

- *Social needs* describes individual-level factors impacting patients.
  - Are often the result of SDOH.
  - When impacting health, can also be called health-related social needs (HRSN).



https://www.champsoftware.com/2021/02/03/social-needs-vs-social-determinants-of-health-what-is-the-difference-and-how-to-document-them-at-the-local-level

# Social Needs Screening

- Social needs screening requires individual assessments.
  - Dependent on patient circumstances.
  - Can be impacted by community factors.
  - Social needs are fluid, so regular screening can be helpful.
- Multiple options for screening tools are available.
  - PRAPARE tool (prapare.org)
  - CMS tool (innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf)
  - HSAG Social Work Assessment (www.hsag.com/globalassets/hqic/hqic_socialworkassessment.pdf)
  - Screening tool comparison (sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison)



CMS = Centers for Medicare & Medicaid Services
PRARARE = Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences
https://www.champsoftware.com/2021/02/03/social-needs-vs-social-determinants-of-health-what-is-the-difference-and-how-to-document-them-at-the-local-level

# Social Drivers Screening

- Identification of social drivers occurs at the community level.
  - Collaboration with community partners can assist in identifying areas of need.
  - Requires hospitals to know the patient population they serve.
- Area Deprivation Index (ADI) can help with visualizing area-level deprivation.
- County Health Rankings website provides county-level information about social factors impacting population health.

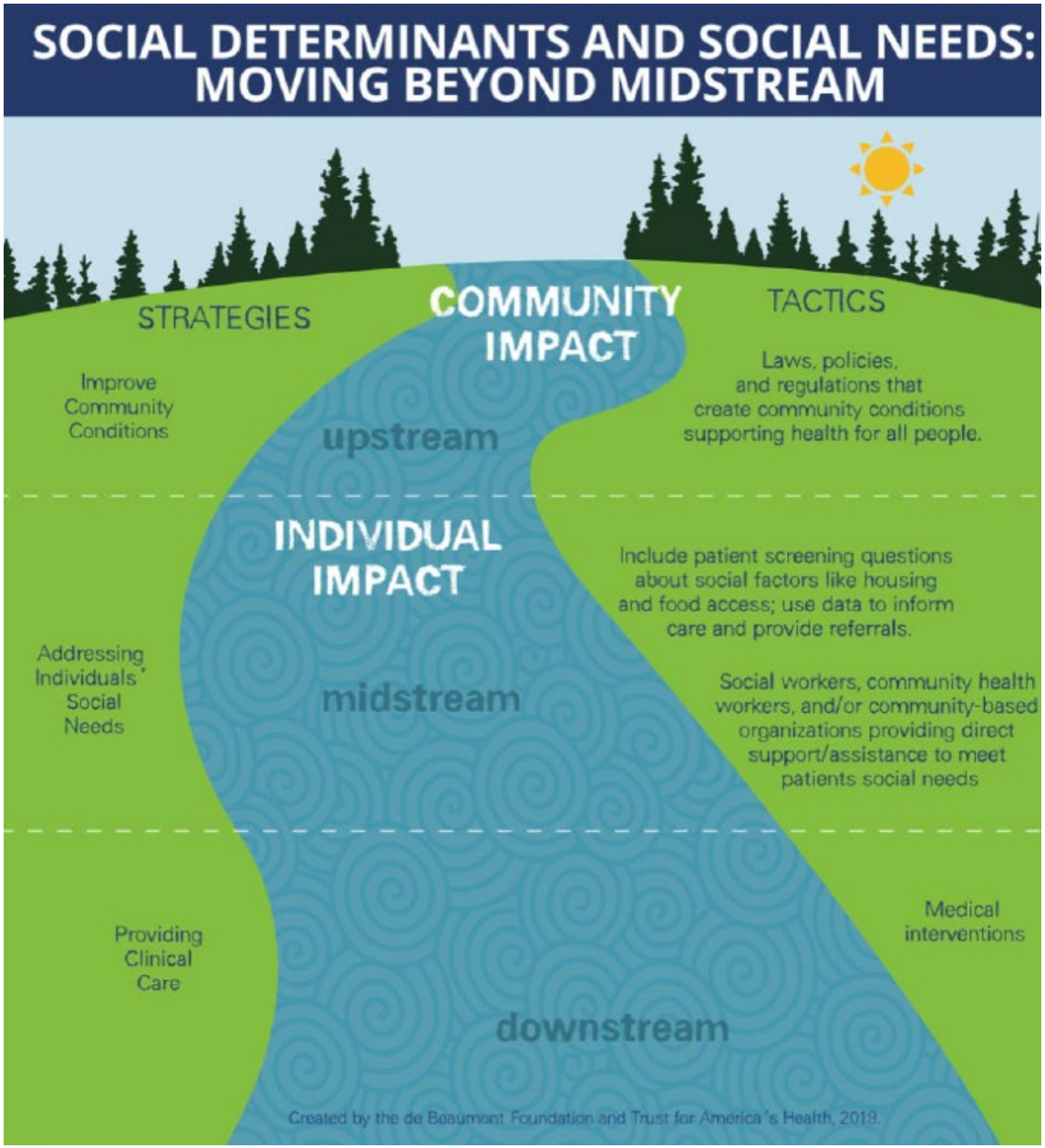


https://www.countyhealthrankings.org
https://www.neighborhoodatlas.medicine.wisc.edu

# Interventions

- Social needs require individual interventions.
  - Patient navigators, case managers, social workers
  - Transportation vouchers or consults
  - Patient education tools
    - HSAG Zone Tools www.hsag.com/hqic-zone-tools
- SDOH require community-level interventions.
  - Focus on preventing/addressing problems at the source rather than assisting individual patients.
  - Community Health Needs Assessment can be a good place to start.

# Interventions: Upstream vs. Downstream



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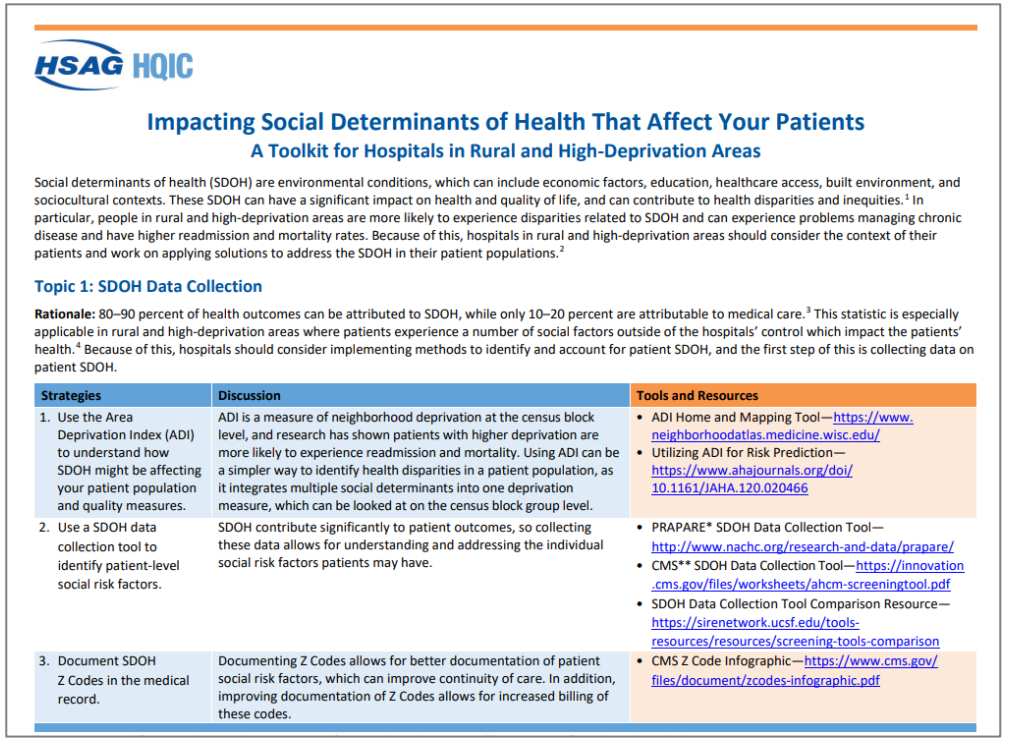
https://debeaumont.org/news/2019/meeting-individual-social-needs-falls-short-of-addressing-social-determinants-of-health

# HSAG SDOH Toolkit

HSAG developed an SDOH toolkit for hospitals in rural and high-deprivation areas.

- Focuses on common social drivers of health.
- Provides strategies, tools, and resources to assist hospitals in addressing community-level drivers, as well as individual social needs.



HSAG HQIC

**Impacting Social Determinants of Health That Affect Your Patients**

**A Toolkit for Hospitals in Rural and High-Deprivation Areas**

Social determinants of health (SDOH) are environmental conditions, which can include economic factors, education, healthcare access, built environment, and sociocultural contexts. These SDOH can have a significant impact on health and quality of life, and can contribute to health disparities and inequities.[1] In particular, people in rural and high-deprivation areas are more likely to experience disparities related to SDOH and can experience problems managing chronic disease and have higher readmission and mortality rates. Because of this, hospitals in rural and high-deprivation areas should consider the context of their patients and work on applying solutions to address the SDOH in their patient populations.[2]

**Topic 1: SDOH Data Collection**

**Rationale:** 80–90 percent of health outcomes can be attributed to SDOH, while only 10–20 percent are attributable to medical care.[3] This statistic is especially applicable in rural and high-deprivation areas where patients experience a number of social factors outside of the hospitals' control which impact the patients' health.[4] Because of this, hospitals should consider implementing methods to identify and account for patient SDOH, and the first step of this is collecting data on patient SDOH.

| Strategies | Discussion | Tools and Resources |
|---|---|---|
| 1. Use the Area Deprivation Index (ADI) to understand how SDOH might be affecting your patient population and quality measures. | ADI is a measure of neighborhood deprivation at the census block level, and research has shown patients with higher deprivation are more likely to experience readmission and mortality. Using ADI can be a simpler way to identify health disparities in a patient population, as it integrates multiple social determinants into one deprivation measure, which can be looked at on the census block group level. | • ADI Home and Mapping Tool—https://www.neighborhoodatlas.medicine.wisc.edu/<br>• Utilizing ADI for Risk Prediction—https://www.ahajournals.org/doi/10.1161/JAHA.120.020466 |
| 2. Use a SDOH data collection tool to identify patient-level social risk factors. | SDOH contribute significantly to patient outcomes, so collecting these data allows for understanding and addressing the individual social risk factors patients may have. | • PRAPARE* SDOH Data Collection Tool—http://www.nachc.org/research-and-data/prapare/<br>• CMS** SDOH Data Collection Tool—https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf<br>• SDOH Data Collection Tool Comparison Resource—https://sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-comparison |
| 3. Document SDOH Z Codes in the medical record. | Documenting Z Codes allows for better documentation of patient social risk factors, which can improve continuity of care. In addition, improving documentation of Z Codes allows for increased billing of these codes. | • CMS Z Code Infographic—https://www.cms.gov/files/document/zcodes-infographic.pdf |



www.hsag.com/globalassets/hqic/hqic_sdoh_toolkit_508.pdf

# Key Concepts

- Social determinants and social drivers are interchangeable terms referring to community-level factors impacting health.
- Social needs are individual-level factors impacting health.
- Hospitals should use different strategies to screen for and identify SDOH and individual-level social needs.
- Social needs require personalized interventions, while addressing SDOH requires broader, community-level action.

# Join Us for the Entire Health Equity Quickinar Series: 2nd and 4th Thursdays

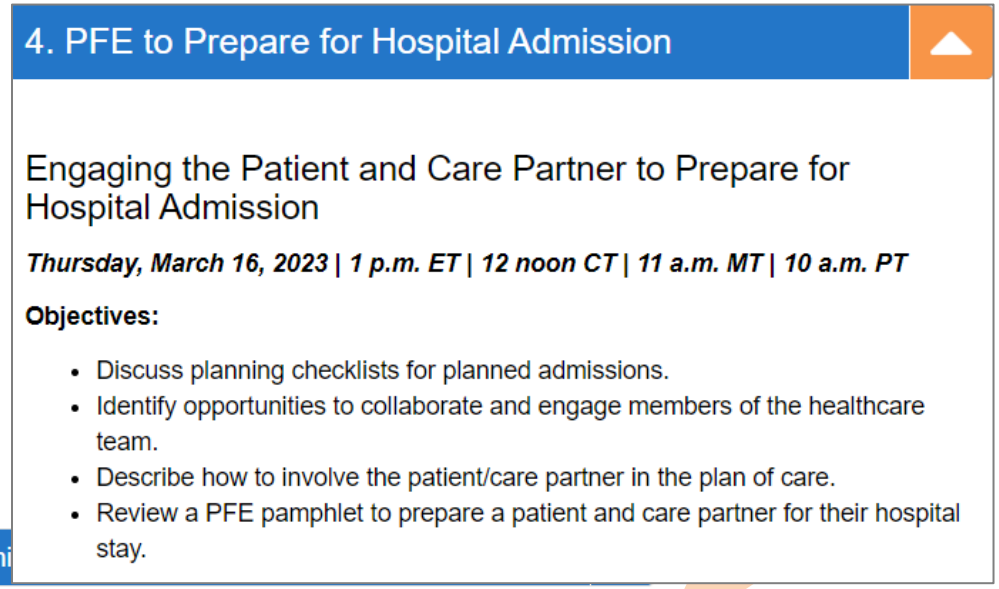
Recordings, slides, and resource links are posted for on-demand access after every session.




**www.hsag.com/health-equity-quickinars**

# Check out the Patient and Family Engagement (PFE) Quickinars: 1st and 3rd Thursdays

Recordings, slides, and resource links are posted for on-demand access after every session.




1. Intro to PFE
2. Achi
3. Preparing for PFE Programs
4. PFE to Prepare for Hospital Admission
5. PFE to Prepare for Hospital Discharge
6. Role of PFE in Readmission Prevention
7. Bedside Hand Off to Improve Patient Outcomes
8. Adverse Event Transparency
9. Role of the PFE Advisor
10. Selecting/Training/Engaging Advisors
11. PFE in Critical Access & Small Rural Hospitals
12. PFE in Acute Care Hospitals



**www.hsag.com/pfe-quickinars**


QUESTIONS?

# Thank you!

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