Defining Terms: Social Determinants, Social Drivers, and Social Needs
• 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.”

[Sources: Health.gov/HealthyPeople/priority-areas/social-determinants-health](https://health.gov/healthypeople/priority-areas/social-determinants-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.

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).

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)
  – Screening tool comparison (sirenetwork.ucsf.edu/tools-resources/resources/screening-tools-tools-comparison)
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
    o 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

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.
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.

6. Screening for Social Drivers

**Thursday, March 23, 2023 | 1 p.m. ET | 12 noon CT | 11 a.m. MT | 10 a.m. PT**

**Objectives:**
- Identify new Centers for Medicare & Medicaid Services (CMS) metrics for social drivers.
- Identify how the social drivers of health are calculated for submission to CMS.
- Define Z Codes and how they can be implemented to document social drivers in the patient medical record.

1. Health Equity, Hospitals, and CMS Reporting
2. Engagement and Culturally Competent Data Training
3. Health Equity as a Strategic Priority
4. Collection and Validating REaL Data
5. Social Determinants and Social Drivers of Health
6. Screening for Social Drivers
7. Culturally Competent Data Training
8. Analysis and Stratification of Health Equity Data
9. Health Equity Interventions
10. Best Practices in Health Equity Interventions
11. Community Paramedicine
12. Identifying Community Health Disparities
13. Community Engagement—Health Equity

[www.hsag.com/health-equity-quickinars](http://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.

4. PFE to Prepare for Hospital Admission

Engaging the Patient and Care Partner to Prepare for Hospital Admission

Thursday, March 16, 2023 | 1 p.m. ET | 12 noon CT | 11 a.m. MT | 10 a.m. PT

Objectives:

- Discuss planning checklists for planned admissions.
- Identify opportunities to collaborate and engage members of the healthcare team.
- Describe how to involve the patient/care partner in the plan of care.
- Review a PFE pamphlet to prepare a patient and care partner for their hospital stay.

1. Intro to PFE

2. Achieving Meaningful Outcomes

3. Preparing for PFE Programs

5. PFE to Prepare for Hospital Discharge

7. Bedside Hand Off to Improve Patient Outcomes

9. Role of the PFE Advisor

11. PFE in Critical Access & Small Rural Hospitals

4. PFE to Prepare for Hospital Admission

6. Role of PFE in Readmission Prevention

8. Adverse Event Transparency

10. Selecting/Training/Engaging Advisors

12. PFE in Acute Care Hospitals

www.hsag.com/pfe-quickinars
QUESTIONS?
Thank you!

Questions: hospitalquality@hsag.com