# Social Drivers of Health (SDOH): Aspirus' Mission to Support Health Equity

Passion for excellence. Compassion for people.

ASPIRUS® HEALTH

# Learning Objectives

- By the end of this course, learners will understand:
  - How health equity aligns with the Aspirus Mission and Vision.
  - The terms health equity, social drivers of health (SDOH), and health disparities.
  - How social drivers of health contribute to patient health outcomes.
  - The requirements from CMS and Joint Commission to focus on health equity by screening patients for SDOH and referring to community resources.
  - How the SDOH data will be used to create action plans that aim to improve the quality of life for our patient population.
  - The availability of the Find Help Community Resource platform as a referrals source to community-based organizations.

# Aspirus Health's Mission

## Health equity aligns with the Aspirus mission and vision by improving the quality of life for our patients.

- At Aspirus Health, our mission is to heal people, promote health and strengthen communities.

# Our Vision

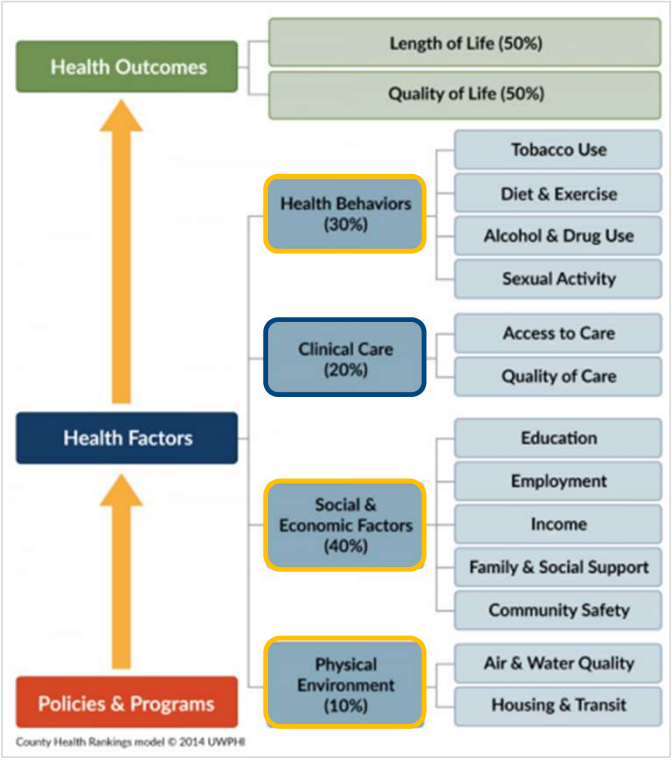
We commit to helping the communities we serve thrive by reaching outside the hospital walls and building trusting partnerships with community-based organizations.

- At Aspirus Health, we are a catalyst for creating healthy, thriving communities, trusted and engaged above all others.

# What Makes a Person Healthy?

## Social determinants (or drivers) are 80% of the modifiable contributors to health.

- Social drivers of health (SDOH) include health behaviors, social and economic factors and the physical environment. Examples:
  - Safe housing, transportation and neighborhoods
  - Education, job opportunities and income
  - Access to nutritious foods and physical activity
  - Polluted air and water
- Social drivers of health contribute to health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. This raises their risk of health conditions like heart disease, diabetes and obesity.



# What is Health Equity?

## Health equity is the state in which everyone has a fair and just opportunity to attain their highest level of health.

- If a person wants to go on a bicycle ride with their friends and family, each person needs a different bicycle solution to enjoy the ride. This parallels the work in health equity. Knowing what solution(s) work best for each individual patient helps focus the provision of the appropriate resources.
- Achieving health equity requires identifying and addressing the social drivers of health and health care disparities.

# Understanding Health Equity Terms and Definitions

## Defining these terms helps us build a common understanding when taking care of our patients

- A **disparity** exists when groups of people have different levels of health outcomes (e.g., infant mortality, length of life, cancer rates).
- An **inequity** is when groups of people are more or less healthy than others because of their income, neighborhood, gender, race, ethnicity, and additional variables.
- Pursuing **health equity** means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions.
- Collecting **Social Drivers of Health (SDOH)** data will help inform the needs of target populations and interventions in effort to remove barriers to health, reduce healthcare disparities, and improve health outcomes for patients.

# Why is Health Equity Important?

## Together, we can improve the quality of life for our patients

- Envision a place where everyone has a chance to lead the healthiest life possible regardless of where we live or the circumstances we were born into; this is the prospect of equity. However, that is not always our reality. More often the choices we make depend on the opportunities we have, such as access to quality education, healthy foods, and safe, affordable housing in crime-free neighborhoods. The opportunities are not the same for everyone.
- To improve the health of the community, particularly for individuals and communities with the poorest health, we need to improve the social conditions in which we live. We can pair that long-term goal with responding to individual needs.
- By screening our patients for social needs, we can start treating the whole person and we can improve the health of our patients.

# Understanding Why Health Equity is Important

By intervening early, we can identify needs and get them connected to community resources to improve their quality of life.

- We don't always know what is going on in someone's life that could impact their health and well-being.
- Because we care about our patients, taking the time to complete the Social Drivers of Health screener will help us better understand the social issues that affect their health and well-being.
- ***Did you know?*** Of the patients screened for SDOH across the Aspirus system, the top drivers of health are housing instability, food insecurity, transportation needs, and financial constraints.

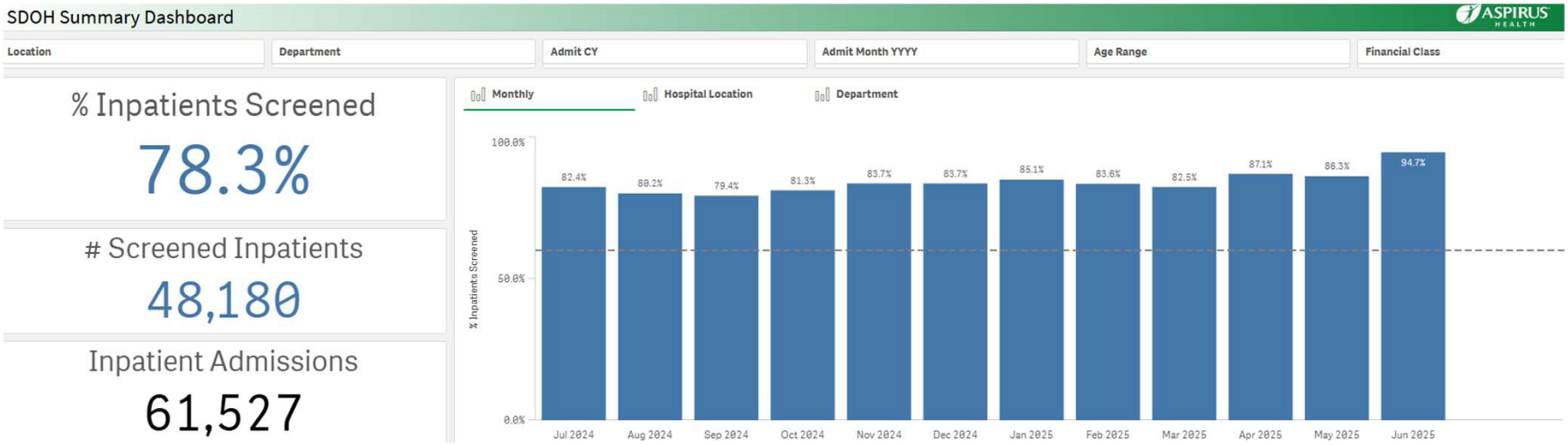
# Why are we doing health equity?

## This work aligns with the Aspirus mission and vision and is a requirement of Centers for Medicare & Medicaid Services (CMS) and Joint Commission

- The focus on health equity and SDOH screening is a new requirement from CMS and Joint Commission:
  - CMS Commitment to Health Equity:
    - Assesses the hospital commitment to health equity.
  - CMS Screening for Social Drivers of Health:
    - Assesses whether a hospital implements social drivers of health (SDOH) screening for all patients that are 18 years or older. Screening is for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.
    - Joint commission adds access to transportation, difficulty paying for prescriptions and medical bills, and education and literacy.
    - Patients need to be screened during every inpatient admission and at least yearly in the outpatient.
  - Joint Commission Requirements (in addition to CMS requirements):
    - Assess patient's SDOH needs and provide information about community resources and support services.
    - Identifies health care disparities in its patient population by stratifying quality and safety data.
    - Develops a written action plans that describes how the organization will address at least one health care disparity identified.
    - The organization acts when it does not achieve the goal(s) in its action plan.

# Once we screen patients and collect data, how will this data be used?

## The data collected is available in Qlik and can be stratified to help us understand disparities and develop focused interventions



# My patient has a social need; how do I know what resources are available in the community?

## Find community resources and make referrals to community-based organizations through the Find Help platform

- Aspirus Community Resources, powered by Find Help, is your source for connecting your patients with community-based organizations and following up to ensure they get the help they need.
- ***Did you know?*** The top 3 searches for Aspirus patients and community members are food, housing, and health-related resources.


**The Find Help community resource platform is accessible through Epic, the Intranet, and the Aspirus Website.*

# Healthier Patients and Communities through Social Needs Screening and Referral

## Connecting the clinical with the community

**Clinical:**

**Nurses will screen patients upon admission and document SDOH data in Epic**

Asking the questions, we will identify any social need risks

Refer to community resources using the Find Help platform

Refer to Care Coordination for patients with complex needs


**Data:**

**SDOH data collected will be pulled from Epic into the SDOH dashboard**

Data analysis and stratification will identify health disparities

Identified health disparities will inform health equity action plan to be used at the clinical and community level

**Community:**

**Patient SDOH data collected along with data from the community health needs assessment will inform:**

Community Partnerships

Community Investment

Community Programming

Goal: Improve Patient and Community Health Outcomes

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