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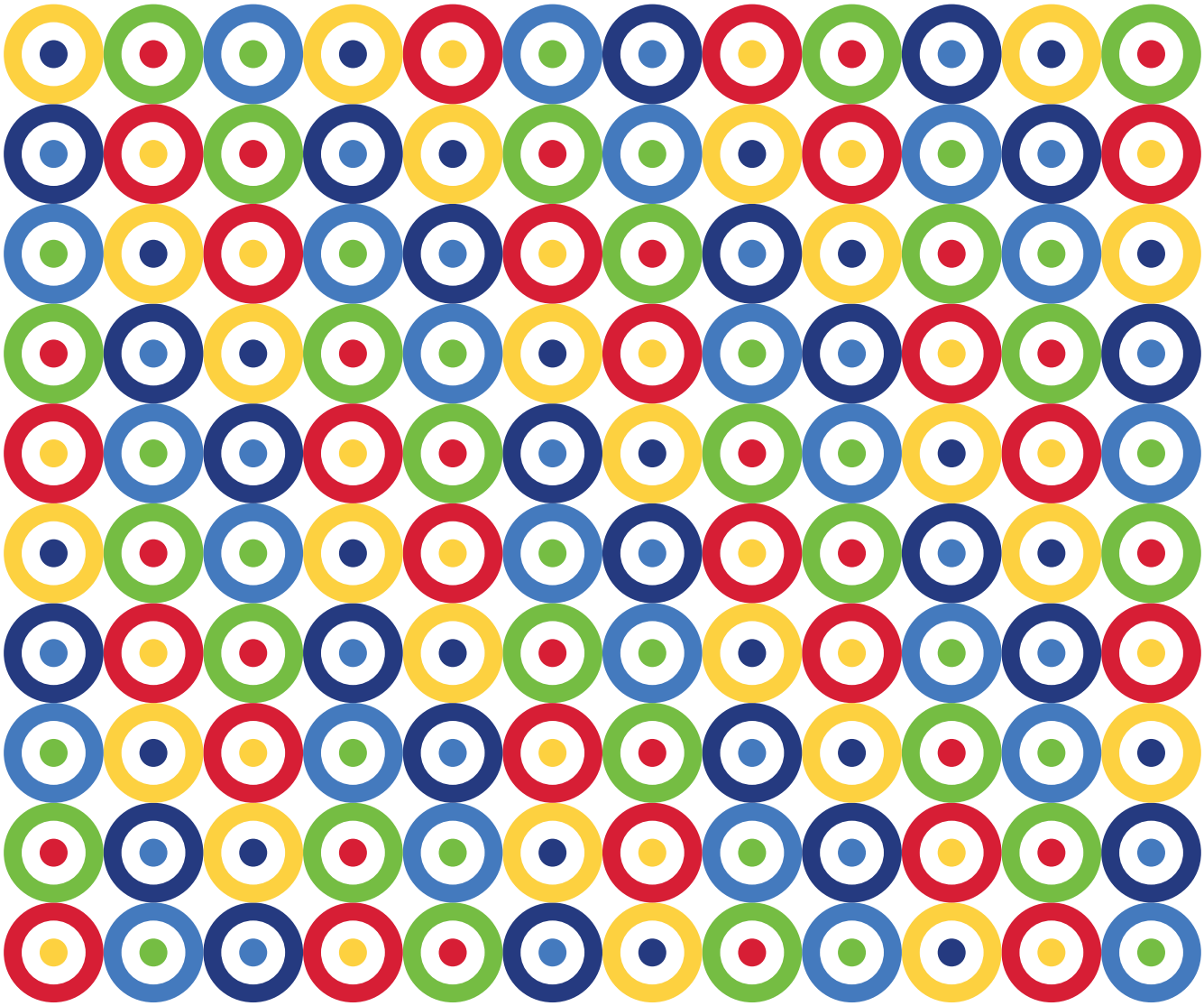
IFDHE
AHA Institute for Diversity and Health Equity

American Hospital Association™
Advancing Health in America

DEI Data Insights

Social Needs for Equitable Care



Introduction

As the leading national advocate for hospitals and health systems, the American Hospital Association (AHA) and its Institute for Diversity and Health Equity (IFDHE) support their member organizations' efforts to improve the health of the communities they serve.

To fulfill this mission, AHA periodically surveys the field's efforts, successes and challenges in diversity, equity and inclusion (DEI). IFDHE's biennial DEI Benchmark Survey provides a snapshot of member and non-member hospitals' attitudes and practices regarding diversity in the workforce; leadership and governance; equity; and inclusive policies and behavior. The survey provides insights into hospitals' progress and highlights opportunities for improvement.

This is the fifth and final installment in a series of Insight Reports that highlight results from the 2022 DEI Benchmark Survey. In these reports, we discuss the survey data and share case studies and resources that can aid hospitals in taking actions to accelerate their health equity, diversity and inclusion journey.

This set of data insights addresses **Social Needs for Equitable Care**.

The other four topics in this series include:

- DEI Strategy
- Workforce Diversity
- DEI Leadership and Governance
- Data

Key Terms

Diversity, Equity and Inclusion (DEI):
the values, practices and policies that support the representation of individuals from all backgrounds

Health Equity:
different from DEI, the fair and just opportunity for all individuals to achieve their highest level of health

Diversity:
the presence of individual differences that may include race, gender, sexual orientation, religion, gender identity, age, disability, etc.

Equity:
promoting fair, just and unbiased treatment for all people, regardless of background or social status

Inclusion:
ensuring that all populations feel safe, respected, heard and valued

About the Survey

The survey was administered from Jan. 19-June 3, 2022, to 6,234 AHA member and non-member hospitals in the U.S. and its territories. Of these, 1,356 completed the survey, a 22% response rate. While the sample offers valuable insights, there were statistical differences in characteristics between respondents and nonrespondents. Survey responses were not necessarily reflective of the entire hospital field. The data establishes a baseline for future surveys.

About this Topic

Data show that 80 percent of health outcomes can be attributed to the conditions into which people are born, grow, work, live and age. These factors include safe and stable housing, access to food and transportation, access to quality education, social connectivity, community and interpersonal safety, and a clean environment. These societal factors that influence health are non-medical needs that contribute to health inequities and drive health outcomes.

Hospitals are uniquely positioned to identify and address societal factors that influence health within their patient population and community. By tailoring their approach and working with community stakeholders, they can make an impact at the personal, community and systemic level. Addressing these societal factors not only enhances patient care and aligns with the missions of many hospitals but also supports strategic objectives such as improving quality and outcomes, reducing costs, advancing equity, and fostering community engagement and trust.

Many health care organizations screen their patients for health-related social needs. When patients seek health care services, their provider may identify issues such as lack of stable housing or limited access to healthy food. Providers can help mitigate these social and economic challenges by connecting patients and their families with resources offered by the hospital or referring them to community partners or social service agencies that can assist. Screening patients in multiple domains enhances medical care and contributes to better health and overall well-being.

Screening, documenting and addressing social needs can:

- Provide more holistic patient care that can address the root causes of illness.
- Allow organizations to collect and stratify data to better understand the needs of their patient population.
- Enable health care organizations to strategically design initiatives around the prevalent social needs of their patient population.

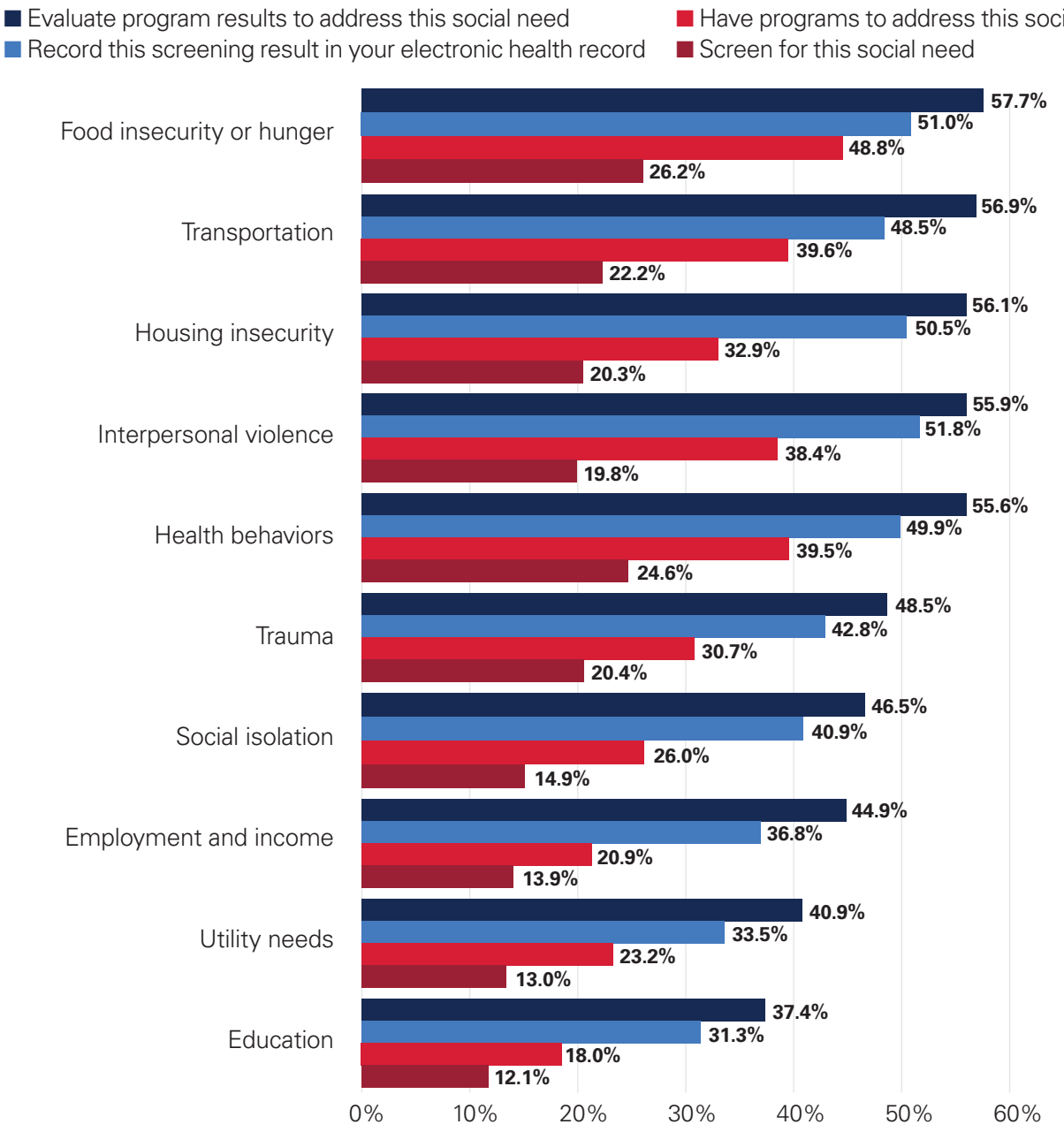
The AHA supports hospitals and health systems in addressing patients' social needs and providing comprehensive care to their communities. This holistic approach can enhance community health and promote equity.

Identifying and Addressing Patients' Social Needs

The figure below illustrates how survey respondents are addressing their patients' health-related social needs across four dimensions:

1. Screening for certain social needs.
2. Recording the screening result in the electronic health record (EHR).
3. Having programs to address the social need.
4. Evaluating program results to address the social need.

Which of the following does your hospital or health system do to address patients' social needs? (Check all that apply) (N=1,356)



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Screening and Documenting Social Needs

When it comes to identifying social needs, the top five most frequently screened-for areas were food insecurity or hunger (57.7%), transportation (56.9%), housing insecurity (56.1%), interpersonal violence (55.9%) and health behaviors (55.6%). While a majority of respondents reported screening patients for some social needs, there is room for growth. Screening patients at the point of care is a crucial first step in addressing non-medical needs. Without a comprehensive understanding of their patients' unique set of circumstances, providers lack the necessary data to provide holistic care.

Health care organizations seeking to enhance their approach to social needs should consider how to integrate screening into their existing workflows, train team members to administer screening tools empathetically, and develop processes for responding to positive screens. When social needs are identified, hospitals need established procedures to connect patients with hospital programs or community-based services.

Regulatory Requirements

Collecting social needs data also aligns with new regulatory requirements from governmant agencies like the Centers for Medicare & Medicaid Services (CMS) and accreditors like The Joint Commission (TJC). Starting in 2024, CMS requires hospitals participating in the CMS Inpatient Quality Reporting program to report on the proportion of inpatients screened for five health-related social needs: food insecurity, housing instability, transportation needs, interpersonal safety and utility difficulties. In addition, hospitals accredited by TJC must assess patients' health-related social needs. More information and a crosswalk of these requirements with AHA's Health Equity Roadmap can be found on the IFDHE's website.

Across all categories, the survey data show a gap between screening for social needs and documenting them in the EHR. Consistent documentation in the EHR would enable providers to understand their patients' social needs better, avoiding duplicative and invasive questions. Additionally, documenting social needs in the EHR would allow health care organizations to stratify their data, gain insights into health inequities, and design targeted programs to address these needs. Most EHR systems can document social needs, and hospitals should consider integrating these features into their processes. Making these data actionable to drive improvements in health outcomes for all patient populations is essential to creating a high-performing health system.

Addressing Patients' Social Needs and Evaluating Programs

The survey data reveal a gap between screening for social needs and having programs to address those needs, suggesting that many health care organizations rely on referrals to community-based organizations. Despite this, a notable percentage of survey respondents reported having programs that address common social needs: food insecurity (44.8%), transportation (39.6%), health behaviors (39.5%) and interpersonal violence (38.4%).

Addressing patients' social needs often falls outside of the scope of traditional medical care, and hospitals may lack the necessary tools or resources to provide social services. While hospitals are not expected to solve these issues alone, they are key stakeholders in the community and should consider partnering with multi-sector organizations to jointly address these challenges.

Another notable gap illuminated by the data is in program evaluation. Even hospitals with programs to address certain social needs do not necessarily evaluate the impact of those programs. Robust program evaluation is crucial for initiatives that address health-related social needs. As more health care organizations adopt strategies to improve the societal factors that influence health, building a solid evidence base is essential to demonstrate its value and secure investment. Researchers and providers need comprehensive evidence to design effective programs that meet patient's social needs and eliminate health disparities. Evaluation data helps health care organizations improve their initiatives and can be used to support further investment in similar efforts.

Conclusion

Hospitals' ability to identify and respond to their patients' social needs is a crucial component of any health equity strategy. Societal factors and their influence on health are complex, requiring efforts to be programmatically aligned from screening through providing resources. Clinical and support staff should be educated about the importance of screening patients and probing around potentially sensitive topics. Health care organizations should establish systematic approaches to address cases where patients screen positive for social needs and form long-term partnerships with community stakeholders to collaboratively address these identified needs through closed-loop referrals and other supportive programs. Finally, program leaders should document and rigorously evaluate program outcomes to assess impact, refine strategies as needed and add to the evidence base demonstrating the importance of addressing societal factors in promoting health equity.

AHA Resources

- **Societal Factors that Influence Health — A Framework for Hospitals**
- **Screening for Social Needs: Guiding Care Teams to Engage Patients**
- **Z Codes for Social Determinants of Health**
- **Community Health Assessment Toolkit**
- **Crosswalk of AHA Health Equity Roadmap with Selected National Health Equity Quality Measures and Standards for Hospitals and Health Systems**
- **ACHI Resources and Guides**
- **Social Determinants of Health Guides**
- **Podcast: A Portfolio of Community Investment with Advocate Health**
- **Podcast: Aligning Health Equity and Community Health Goals**
- **Blog: Community Health as a Strategic Asset for Redesigning Care Delivery and Accelerating Health Equity**