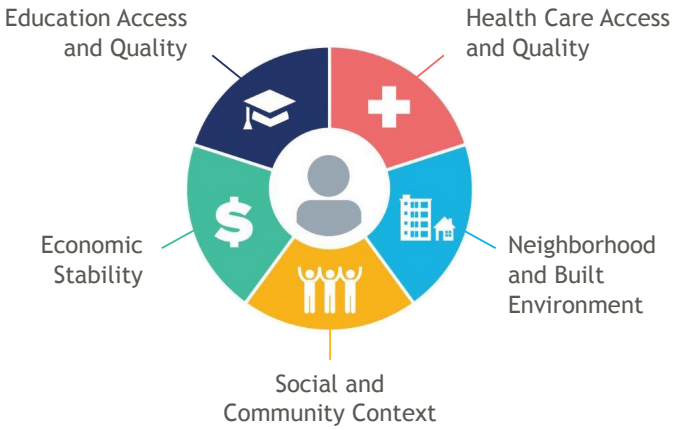
CONNECT2BMS

Social Determinants of Health (SDOH)

Social determinants of health (SDOH) are the conditions in the places where people live, learn, work, and play, affecting a wide range of health risks and outcomes. Health-related social needs (HRSN) refer to an individual's unmet social and economic needs contributing to poor health and can be the result of underlying SDOH.[1,2]

Health-Related Social Needs (HRSN) Screener



Adapted from HealthyPeople 2030[1]

In a 2018 survey of 500 consumers from the U.S. ≥27 years old, and had a healthcare encounter within the past 12 months:[3]

68% of consumers face some SDOH challenges in their lifetime, of which:

16% of consumers face a low risk

25% of consumers face a moderate risk

27% of consumers face a high risk

According to the CDC, addressing SDOH is a primary approach to achieving health equity.[4]

In a retrospective cross-sectional, observational study (2013-2017), individuals[a] with self-identified social service needs[b] (n = 13,708) vs. those without these needs (n = 6109) experienced:[5]

68% higher odds of a 30-day readmission

2 x the odds of a 180-day readmission

Among 2718 participants[c] in a retrospective secondary analysis (2015-2016), those who reported all their social needs[d] were met (n = 1521) experienced:[6]

11% reduction in total healthcare expenditures in the 12 months following a social services referral

[a]Insured by Medicaid or Medicare Advantage across 13 states who were readmitted to hospitals. [b]Financial assistance for utilities, food programs, housing support, transportation, and medication assistance. [c]Insured through Medicare Advantage or Medicaid managed care in 14 states. [d]Homelessness, transportation barriers, and food insecurity.

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Health-related social needs (HRSNs) are often identified as the root causes of health disparities and outcomes for individuals. HRSN is frequently used instead of SDOH to indicate that HRSNs are a cause of poor health outcomes for individual patients, while SDOH describes populations.[7]

Identification and screening for HRSN is highlighted in recently launched Enhancing Oncology Model, a five-year, voluntary payment and delivery care model developed by Center for Medicaid and Medicare services (CMS) for patients with certain cancer types. Developing plans for health equity and collecting sociodemographic and HRSN data using appropriate screening tools are important aspects of EOM.[8] EOM participants are required to screen across a minimum of three HRSN domains: transportation, food insecurity, and housing instability.[8]

Examples of HRSN screening tools include the ***American Academy of Family Physicians (AAFP) Social Needs Screening Tool, the Accountable Health Communities (AHC) HRSN Screening Tool, Boston Medical Center (BMC)-Thrive, Health Leads Social Needs Screening Toolkit, and the Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences (PRAPARE) Tool***.[9]

Although there is no consensus on SDOH coding, International Classification of Diseases Tenth Revision (ICD-10) offers an expanded set of codes related to SDOH in the form of Z codes.[10]

ICD-10 code for SDOH[10,11]

Social Determinant	ICD-10 Code/Description
Difficult/Unstable housing or housing support services instability	**Z59.0** Lack of housing **Z59.1** Inadequate housing **Z59.8** Other problems related to housing and economic circumstances
Food insecurity	**Z59.4** Lack of adequate food and safe drinking water **Z59.41** Food insecurity
Transportation challenges	**Z91.89** Other specified personal risk factors, not elsewhere classified
Interpersonal safety	**Z91.41** Personal history of adult abuse

The accurate completion of reimbursement or coverage-related documentation is the responsibility of the healthcare provider and patient.

Key considerations for a screener

- Position the process as a conversation
- Respect the patient's autonomy and privacy
- Engage compassionately and reflectively
- Understand patient goals and priorities
- Providers to regroup and share lessons learned

Bristol Myers Squibb (BMS) has adapted the CMS Center for Medicare and Medicaid Innovation's Accountable Health Communities HRSN Screening Tool.[12] This screening tool is an option for identifying patients with SDOH needs. The screener is based on the five core domains of HRSN (housing, food insecurity, transportation, utility needs, and interpersonal safety) and may be used by providers to inform patients' treatment plans and make referrals to community services.

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