Social Determinants of Health for the ED Provider

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Objectives

Describe the influence of social determinants of health on outcomes for individuals, communities, and populations.

Identify factors affecting the health of individuals, communities, and populations within the context of the emergency department.

Discuss the implications of social determinants of health in the management and disposition of patients in the emergency department.

Social Determinants of Health (AACN, 2021)

"Determinants of health include personal, social, economic, and environmental factors that interrelate to determine individual and population health."

Social determinants of health, more specifically, are "the conditions in the environment 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."

Healthy People 2030 Social Determinants of Health Framework

Photo credit: https://www.cdc.gov/visionhealth/images/social-determinants/SDoH.png?_=73171

Social Ecological Model

Photo credit: https://www.cdc.gov/violenceprevention/about/social - ecologicalmodel.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Fpublichealthissue%2Fsocial-ecologicalmodel.html

Individual (e.g., age, education, income, substance use, history of abuse)

Relationship (e.g., close peers, partners, family members)

Community (e.g., schools, workplaces, neighborhoods)

Societal (e.g., social and cultural norms, policies)

Elements of a Healthy Community

Photo credit: https://nccollaborative.org/wp -content/uploads/2018/11/elements-of-healthy-community.png

Case study

A 62-year-old male is transported by helicopter to your facility from his residence 112 miles away after experiencing sensory deficits. His symptoms resolve enroute and his NIH score is 0. A non-contrasted CT at your emergency department is interpreted as negative. Neurology recommends starting the patient on aspirin and outpatient follow-up in the clinic.

What social determinants of health are likely to impact this patient?

Rural versus Urban Health

Approximately 15% of Americans live in rural areas.

In comparison to residents in urban areas, rural Americans are more likely to die from

- heart disease,
- cancer
- unintentional injury
- chronic lower respiratory disease
- stroke

Rural residents have

- higher rates of poverty
- lower access to healthcare
- are less likely to have health insurance

Rural versus Urban Health

Rural barriers to healthcare include

- distance to care
- transportation
- workforce shortages
- health insurance coverage
- broadband internet access
- poor health literacy
- social stigma
- privacy issues

Case study

A 72-year-old female is transported by ground ambulance to your facility with complaints of generalized weakness and chronic cough. It is the middle of July in an inner-city area of the southeastern U.S. Evaluation and management includes the administration of IV fluids for dehydration. When offered admission, the patient reports she would like to go home to her cat but admits that her apartment is without air conditioning.

What is the primary social determinant of health that is most likely impacting this patient?

Planetary Health and the Environment

Planetary health is a solutions-oriented, transdisciplinary field and social movement focused on analyzing and addressing the impacts of human disruptions to Earth's natural systems on human health and all life on Earth.

Climate justice is a concept that addresses the just division, fair sharing, and equitable distribution of the benefits and burdens of climate change and the responsibilities to deal with climate change.

Environmental justice is a concept that addresses the just division, fair sharing, and equitable distribution of the benefits and burdens of pollutants that enter water, soil, and air.

Case study

A 49-year-old male with a past medical history of schizophrenia is brought to the emergency department with complaints of foot pain. It is the middle of winter and temperatures have consistently been around freezing. The patient is diagnosed with trench foot and responds well to treatment. The hospitalist is not eager to admit the patient and you are concerned with follow-up.

What is a social determinant of health that may affect this patient?

Housing

Risk factors for being unhoused include

- substance abuse
- severe mental illness
- chronic medical illness

Simple issues and conditions among unhoused persons are often managed in the ED instead of primary care.

Healthcare costs among persons who are unhoused are higher due to

- more frequent and longer hospitalizations
- frequency of admissions for psychiatric reasons
- more frequent use of the ED

Housing

Clinical considerations include

- risk of incorrect diagnoses and polypharmacy due to unstable care and environment
- prioritization of basic necessities
- barriers to follow-up
- differing styles of communication
- difficulty obtaining healthcare coverage

Case study

A 1-year-old female is referred to the ED by a primary care provider with concerns of failure to thrive. The patient does not meet expected developmental milestones and is underweight.

What social determinant of health is most likely affecting this patient?

Food Security

Food insecurity is defined as a household-level economic and social condition of limited or uncertain access to food.

Hunger is a consequence of food insecurity that results in discomfort, illness, weakness, or pain that exceeds the usual uneasy sensation.

8.4% of U.S. households have low food security and 5.1% have very low food security.

Food insecurity disproportionately affects African American and Hispanic households and is associated with negative health outcomes and an increased use of healthcare.

Drivers of food insecurity include unemployment, poverty, and income shocks.

Interprofessional Practice

A collaborative and integrated approach to healthcare that is patient-centered and driven by outcomes and competencies.

Improves patient safety, quality of patient care, efficiency of resource utilization, length of hospital admissions, and overall patient satisfaction.

Supports community health, greater access to care, increased cultural competence, and health equity.

Promotes professional satisfaction and professional development while reducing burnout and improving retention.

Health Equity

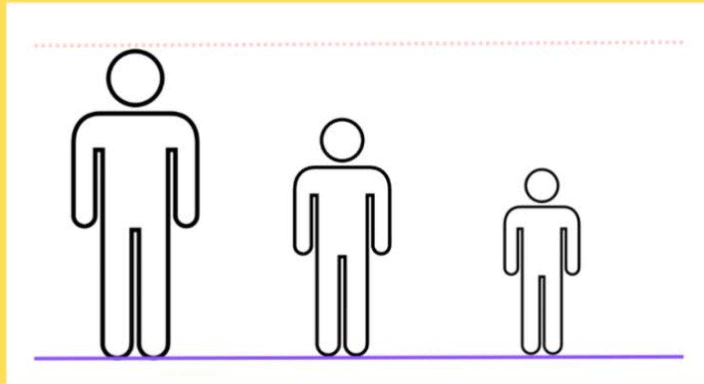
"Health refers to health status, that is, physical and mental health and well-being, distinguished from health care" (RWJF, 2017).

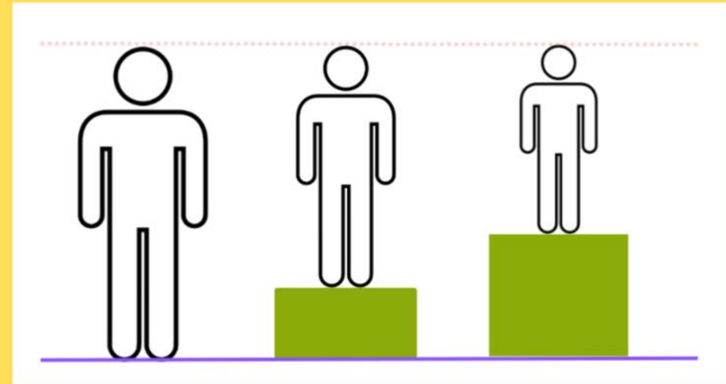
"Health equity means that everyone has a fair and just opportunity to be as healthy as possible" (RWJF, 2017).

- Requires societal action to remove obstacles to health and increase opportunities to be healthier for everyone, focusing particularly on those who face the greatest social obstacles and have worse health.
- Requires engaging excluded or marginalized groups in identifying and addressing their health equity goals.

Health disparities/inequalities are closely linked with economic, social, or environmental disadvantage and are "how we measure progress toward health equity" (RWJF, 2017).

Equality vs. Equity





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Key Steps to Advancing Health Equity (RWJF, 2017)

Identify important disparities in health (including disparities known to be inequities and disparities whose causes are unknown or contested) that are of concern to key stakeholders, especially those affected.

Identify social inequities in access to the resources and opportunities needed to be healthier that are likely to contribute to health disparities.

Change and implement policies, laws, systems, environments, and practices to reduce inequities in access to the opportunities and resources needed to be as healthy as possible.

Evaluate and monitor effects using short-, intermediate-, and long-term measures.

Reassess strategies to plan the next steps.

Core 5 SDH Screening Checklist

Is the patient or their family currently experiencing:

(1) housing instability: *Are you worried about losing your housing, or are you homeless?*

(2) food insecurity: *Do you/your family worry about whether your food will run out and you won't be able to get more?*

(3) utility needs: *Are you currently having issues at home with your utilities, such as your heat, electric, natural gas or water?*

(4) transportation barriers: *Has a lack of transportation kept you from attending medical appointments, or from work, or from getting things you need for daily living?*

and/or (5) interpersonal violence: *Are you worried that someone may hurt you or your family?*

Identifying social determinant of health needs with referral for community resources was found to likely decrease visits to the ED (Bechtel et al., 2021).

Documentation

Z codes are related to social determinants of health and are used to document related data.

Factors influencing the patient's health status or reasons for contact with health services that are not related to disease, injuries, or other external causes (CMS, n.d.).

Documentation of SDoH codes may improve health equity

- Identification of needs of communities and populations
- Empowerment of providers to identify and address disparities in health
- Support planning and implementation of interventions
- Advocating for policy change and/or creation
- Monitoring effectiveness of interventions in promoting favorable patient outcomes.

Documentation

Social Z codes (ICD 10)

- Access to health care
- Clothing
- Education
- Employment
- Finances
- Access to food
- Housing status
- Immigration/migration
- Incarceration
- Primary language
- Race/ethnicity
- Social connections
- Transportation
- Utilities
- Veteran status

Social Z codes examples

- Z55.6 – Problems related to health literacy
- Z58.6 – Inadequate drinking water supply
- Z57 – Occupational exposure to risk factors
- Z59.00 – Homelessness unspecified
- Z59.82 – Transportation insecurity
- Z59.86 – Financial insecurity
- Z62.24 – Child in custody of non-relative guardian
- Z62.82 – Parent-child conflict (CMS, n.d.)
- Z64 – Problems related to certain psychosocial circumstances

Documentation

A review of all ED visits from a 2018 sample of nearly 36 million revealed that 1.21% had one or more documented Z codes.

Z codes were most often documented with primary diagnoses that were related to mental, behavioral, and neurodevelopmental illnesses.

Increased use of Z codes in documentation is needed to support the implementation of social interventions, social risk payment adjustments, and future reforms in health policy (Molina et al., 2022).

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