The Social Vulnerability Index Toolkit

Overview

What is the Social Vulnerability Index?

Social vulnerability refers to several external factors that can negatively impact a community's health, such as poor housing conditions, lack of access to transportation and disability. Certain populations need additional support before, during and after a public health event, such as natural disasters and infectious disease outbreaks. The Social Vulnerability Index (SVI) measures the extent to which a community is vulnerable to hazardous events. The index provides a way to plan for challenges related to a community's vulnerabilities and give community members the resources they need.

What is the Data Source for the SVI?

The SVI is based on the American Community Survey (ACS), administered by the U.S. Census Bureau. The ACS obtains information on the changes taking place in various communities' populations, collecting information on social factors (e.g., ancestry, citizenship status), housing (e.g., occupants per room, owner or renter) and economic factors (e.g., class of worker, poverty status and demographics (e.g., race, age). The SVI is updated every two years, based on when the U.S. Census Bureau releases data.

How are SVI Scores Developed?

The SVI considers 15 measures from the ACS and groups them into four distinct themes, as outlined below:

Overall Vulnerability

Socioeconomic Status	Household Composition & Disability	Minority Status & Language	Housing & Transportation
• Below poverty • Unemployed • Income • No high school diploma	• Aged 65 or older • Aged 17 or younger • Civilian with a disability • Single-parent household	• Minority • Speak English "less than well"	• Multi-unit structures • Mobile homes • Crowding • No vehicle • Group quarters

The SVI combines and ranks these 15 measures at the census tract level. Census tracts are small, relatively permanent subdivisions of a county or geographic area, typically encompassing a population of about 4,000 people (but can range from 1,200 – 8,000 people). Using

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the census tracts, estimated counts are made for the different measures, such as the estimated number of people living in poverty in a geographic area.

Within each measure, communities are assigned a percentile ranking, ranging from 0 (least vulnerable) to 1 (most vulnerable). For example, a tract with a percentile rank of 0.8 for any variable is more vulnerable for that variable than 80% of all tracts against which it is ranked. The relative vulnerability of each tract is scored at three levels: by each variable, each theme and an overall score.

The SVI is categorized as follows:

Very Low (0.0-0.19)	Low (0.20-0.39)	Moderate (0.40-0.59)	High (0.60-0.79)	Very High (0.80-1.0)

Using the SVI

Because the SVI allows users to identify high vulnerabilities in specific social needs categories, it can be particularly useful in designing and implementing health equity interventions.

Identify Priority Areas and Current Gaps. Review your hospital's SVI data provided in the quarterly disparities report. Begin by focusing on the top three counties that your hospital receives beneficiaries from. Within those counties, note which ones have a high overall SVI ranking, and the specific categories where higher vulnerabilities persist (e.g., socioeconomic status, household composition and disability, minority status and language and/or housing and transportation).

Once you have noted the vulnerabilities that are of high priority for your hospital's catchment area, review the resources and social services your hospital currently provides to patients, if any. Assess whether the current resources are sufficient to meet the needs of patients and where there may be room for improvement.

Assessment questions can include:
- How are we identifying patients in need? (e.g., using screening tools)
- What resources are being provided to patients? In what format? (e.g., pamphlet, flyer, patient portal, etc.)
- Who is sharing these resources with patients? (e.g., clinician, community health worker, social worker, etc.)
- Is resource sharing built into our workflow?

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Gather Resources and Create Targeted Interventions. Once your organization has identified priority areas and any gaps in current needs, the SVI data can be used to create initiatives and provide resources that target patients' specific needs.

Screening for the Social Determinants of Health (SDOH)

Use the SVI to select social needs domains to focus on for screening. Be sure to customize screening tools based on the characteristics that are prevalent in your community and patient population (i.e., housing, transportation, unemployment). Flag when patients are coming from areas with high vulnerability. Screening is necessary to be able to identify patients in need of specific resources and subsequently assist them. Reference the following screening information and resources for additional information.

- The **Quick Start Guide: Screening for the Social Determinants of Health** provides an overview of the social determinants of health, provides key tips on successfully integrating screenings and shares additional resources.
- The **Social Determinants of Health: Guide to Social Needs Screening** tool provides the resources necessary for hospitals to customize screening for individual practice, population and community needs.

Once patients in need have been identified, the next step is to gather appropriate resources and develop targeted interventions that will address those needs.

Evidence-Based Intervention Libraries

Use evidence-based intervention libraries to brainstorm and discover interventions that can be applied at your hospital. The libraries provide examples that can guide you in creating your own interventions.

- **What Works for Health | County Health Rankings & Roadmaps**
- **Healthy People 2030**
- **CDC Community Health Improvement Navigator**
- **SIREN Evidence & Resource Library**

Resources & Interventions

The resources and interventions your organization provides should be specific to the social needs category a patient is experiencing: socioeconomic status, household composition and disability, minority status and language and/or housing and transportation. The following examples of evidence-based interventions may be helpful in meeting your patient's needs.

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Theme 1:   *Socioeconomic Status*

- **Health Literacy Interventions:** Low socioeconomic status, and low educational attainment in particular, is considered to be a determinant of one's health literacy level. Health literacy interventions and resources include:
  - Providing written and print-based materials designed to be easy to read and understand, with language written at no higher than a fifth grade reading level. eHealth interventions, such as using PCs and tablets with video tutorials and interactive self-help tools, can also assist in understanding.
  - The **AHRQ Health Universal Precautions Literacy Toolkit** provides evidence-based guidance to increase patient understanding of health information and enhance support for patients of all health literacy levels. The toolkit includes a quick start guide (on page 7) and a variety of tools that address spoken and written communication.

- **Health Insurance Enrollment & Outreach Support:** Access to health insurance is often tied to employment status, and other times, employers may not offer affordable coverage. Evidence shows that inadequate health insurance is a barrier to health care access. Interventions and resources to address health insurance challenges can include:
  - Providing person-to-person assistance to enroll patients in health insurance, where a **CMS Navigator organization** or a designated staff member (e.g., community health worker or navigator) provides education to eligible individuals about their coverage options and supports individuals through the application process.
  - Engaging in community outreach such as organizing events to make community members aware of their coverage options (e.g., at community centers, non-profit offices, churches, etc.)
  - The **Enrollment Toolkit: Help Consumers Choose the Right Plan** provides community partners, assisters and others a guide to aid in enrolling individuals into health insurance coverage, from choosing a plan to next steps after enrolling.
  - The **National Association of Free & Charitable Clinics**, for those who may not be eligible for enrollment or cannot afford health insurance, is a resource providers can use to help patients locate affordable quality healthcare services.

Theme 2:   *Household Composition & Disability*

- **Household Composition**
  - The **Eldercare Locator** is a nationwide service that connects older Americans and their caregivers with local support resources, such as state and local agencies on aging, as well as community-based organizations that serve both older adults and

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their caregivers. Resources include services related to meals, home care, and transportation as well as training and education for caregivers.

- **ChildCare.gov** helps parents access safe and quality childcare services in their community that best suits their family's needs. It provides websites that parents can use to search for childcare, licensing information, education and information on financial assistance.

- **Disability**
  - The **ARCH National Respite Network and Resource Center** provides caregivers and professionals assistance in locating quality respite and crisis care programs in their communities and across the U.S.
  - The **ADA Checklist: Health Care Facilities and Service Providers** guides providers in ensuring that their healthcare facilities and services are accessible for patients who are blind, deaf-blind, or visually impaired.
  - The **Improving Access to Care for People with Disabilities** library provides a compendium of resources aimed to improve healthcare access for those with physical disabilities, those who are blind or deaf and those with visual impairments. Key resources in this library include:
    - The **How to Improve Physical Accessibility at Your Health Care Facility** resource is geared to assist those in outpatient settings improve the accessibility of their facility. It outlines physical barriers people may face, highlights actions healthcare facilities can take to assess accessibility and describes ways to design and implement programs and policies that eliminate barriers for people with disabilities.
    - The **Modernizing Health Care to Improve Physical Accessibility Primer for Providers** assists staff in removing accessibility barriers in order to deliver high-quality, patient-centered care for individuals with disabilities.
    - Guidance on improving communication accessibility for individuals who are **blind or have low vision** or those who are **deaf or hard of hearing** by assessing practices, developing communication plans and implementing accessible services.

Theme 3:	Minority Status & Language

- An **Implementation Checklist for the National CLAS Standards** provides practices that organizations can implement to meet each theme of the CLAS standards. This will help your organization assess where you currently are and create a CLAS implementation action plan.
- The **Improving Patient Safety Systems for Patients with Limited English Proficiency Guide** identifies the role of language and cultural barriers on patient safety

events, documents how hospitals are addressing the safety of limited English proficiency (LEP) and culturally diverse patients and provides guidance and tools for how hospitals can address these issues. Pages 22-28 provide key strategies to improve patient safety for LEP patients.

Theme 4: *Housing & Transportation*

- **Housing**
  - The **AHA's Housing and the Role of Hospitals Guide** provides key strategies for improving housing stability (on page 9), steps to develop housing programs (on page 10) and relevant case studies (on pages 12-26).
  - **What To Do If You're Facing Eviction** is a resource that can be shared with housing unstable patients, as it provides information on housing rights, rental assistance and eviction protections.

- **Transportation**
  - The **AHA's Transportation and the Role of Hospitals Guide** provides information on how hospitals can implement strategies to increase patients access to healthcare services. Key strategies are listed on pages 10-12 with case studies provided on pages 14-24.
  - Medicaid provides non-emergency medical transportation (NEMT) to eligible beneficiaries, serving as a resource to assist patients in getting to and from medical appointments. The two resources listed below provide important guidelines on accepted types of transportation, qualifications for an NEMT and types of service delivery systems.
    - **Non-Emergency Medical Transportation Fact Sheet for Beneficiaries**
    - **Non-Emergency Medical Transportation Booklet for Providers**

Other Resources

- The **Benefit Finder** is a government resource that increases access to general benefit information while reducing the expense and difficulty of interacting with the government.