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Closing the Gap Between Needs and Solutions

How Health Plans Can Support the Use of Data to Address Social Needs and Social Determinants of Health

Peter Long
Executive Vice President,
Strategy & Health Solutions
Blue Shield of California

Shruti Kothari
Director,
Industry Initiatives
Blue Shield of California

Joe Castiglione
Principal Program Manager,
Industry Initiatives
Blue Shield of California

Muriel LaMois
Program Manager,
Industry Initiatives
Blue Shield of California

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Organizations Interviewed

- AHIP
- Alameda Health Consortium
- Blue Cross Blue Shield Association
- California Department of Health Care Access and Information
- California Primary Care Association
- California State Assembly Health Committee
- CommonSpirit Health
- Community Clinic Association of Los Angeles County
- Community Health Center Network
- Covered California
- Findhelp
- Health Leads
- Hickman Strategies LLC
- Kaiser Permanente
- Kaiser Permanente Bernard J. Tyson School of Medicine
- L.A. Care Health Plan
- Los Angeles Department of Health Services
- Manatt Health Strategies
- Manifest Medex
- Savage & Savage LLC
- Social Interventions Research and Evaluation Network at the University of California San Francisco
- Stewards of Change Institute
- Unite Us

This table omits organizations that did not authorize acknowledgement.

Introduction

The communities in which we live have a tremendous impact on our health. Social determinants of health (SDoH), holistic health factors such as availability of affordable housing and healthy foods, or educational or employment opportunities, influence as much as 50 percent of health outcomes.[1] Unaddressed, SDoH and the resulting social needs people experience due to these SDoH factors adversely impact health equity through worse health outcomes, widened disparities, and increased health care costs for vulnerable communities. In communities where these basic needs are met, people experience better health outcomes.

There is increasing momentum in the health care ecosystem to address SDoH and unmet social needs through closer coordination of health and social care services.[2, 3, 4] In order to effectively address SDoH, health systems must be able to implement three critical components: adequate and sustainable funding; closed-loop referrals between health and social services; and accurate, robust data. Efforts to improve financing and referrals include value-based payment models that enable whole person care, and strong social needs intermediaries such as community health workers (CHWs), *promotores,* or peer support specialists who can serve as navigators between health and social services.[5, 6, 7]

The robust exchange of health and social data, the focus of this paper, is the other critical component to address SDoH. Effectively leveraging SDoH and social needs data is essential to supporting value-based payment models and care-team coordination across health and social services. When unlocked, shared, and used effectively, SDoH and social needs data become powerful tools with the potential to aid efforts to improve individual health outcomes, implement

DEFINITIONS

Social determinants of health: the conditions in which people are born and live, and the wider set of forces and systems shaping the conditions of daily life, including economic policies and systems, development agendas, social norms, social policies and political systems.[8]

Social needs: a person's perception of their own needs, based on the SDoH factors they face.[9]

Health equity: the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.[10]

population health initiatives, and reduce health inequities through upstream interventions that improve the condition of the communities in which individuals live.

However, significant barriers inhibit the collection, use, and sharing of SDoH and social needs data. As health care entities begin to partner more closely with community-based organizations (CBOs) providing social care services, tackling these data challenges will be key to growing and sustaining a system of care that can meet communities' social needs and address SDoH.

Health plans are in a unique position to assist in addressing the challenges to leveraging SDoH and social needs data. This paper explores challenges to the collection, use, and sharing of SDoH and social needs data, and highlights opportunities for health plans to help overcome these barriers in partnership with other stakeholders. The findings are compiled from interviews with over 40 stakeholders including subject matter experts, health plans, government, health information organizations, CBOs, providers, health analytics platforms, and referral platforms.

Why Health Plans Are Critical to Improving the Use of SDoH Data

Both through direct engagement with their members and through contracts with their provider networks, health plans hold substantial influence over what kinds of data are collected. Health plans can bring much needed resources and infrastructure to support systematic and sustainable data collection and sharing between health and social care providers. Many health plans have also begun to partner with health care analytics platforms and health information organizations (HIOs) to collect, aggregate, and integrate non-clinical data with their clinical data to inform better whole person care.[11, 12, 13, 14] Health plans also have the ability to share aggregated data on populations that can help health care providers and CBOs make informed decisions that could drive improved outcomes.

Recent policy changes in California are mandating and accelerating these trends. Health plans are facing increased regulatory requirements to coordinate health and social care and to collect and report on SDoH and social needs data:

- As part of the California Advancing and Innovating Medi-Cal (CalAIM) implementation, managed care plans (MCPs) will be required to assess each enrollee's health-related social needs.[15]
- In February 2022, the California Department of Health Care Services (DHCS) issued an All Plan Letter outlining expectations that MCPs regularly document and code SDoH, listing 25 DHCS Priority SDoH Codes for MCPs and providers to use when coding for SDoH.[16]
- Covered California, the California Health Exchange, is implementing requirements for its participating health plans to screen their members for food and housing insecurity.[17] They plan to expand

requirements to include more social needs data and are coordinating efforts with other state purchasers such as DHCS and California Public Employee's Retirement System (CalPERS).

- In July 2022, the California Health and Human Services Agency (CHHSA), released a data exchange framework for the state, which requires that health care entities begin exchanging real-time health information including SDoH and social needs data elements with each other as well as with public health and social service entities.[18, 19]

As state and federal mandates relating to SDoH increase, health plans must develop or improve their own capabilities and may need to help their provider networks develop their infrastructure and achieve compliance. Beyond compliance, health plans should take a proactive stance in driving the improvement of social needs and SDoH data. As states and plans seek to implement value-based payment models, social needs data can play an important role in supporting accurate risk adjustment for patients and populations. Health plan involvement in the collection, use, and sharing of social needs and SDoH data has the potential to improve the health of their members, aid in improved quality of care and population health initiatives, and contribute to reducing health inequities by investing in upstream interventions that substantially improve the communities in which individuals live.

Challenges

A variety of barriers may limit the effective collection, use, and exchange of social needs and SDoH data. These include system limitations, lack of standards and consistent data sharing, a limited evidence base, and equity concerns. Each of these is described below.

System Limitations

- Many communities are limited in the extent to which resources are available to meet social needs. The shortage of affordable housing is one example, with about 160,000 people in California sleeping outside or in cars or shelters at night.[20] Providers may be reluctant to collect data on social needs if there are inadequate referral resources to meet identified social needs.[21]
- As health plans face increasing requirements to address social needs, CBOs may not be able to quickly scale up to meet the dramatic increase in referrals and resulting data reporting requirements due to limited staff and technology. Many CBOs are largely funded by grants and may not have the financial systems or trained staff that would allow them to bill health plans for their services. The piecemeal nature of this resourcing undermines long-term scale and sustainability of even the most effective organizations.

Lack of Standards and Consistent Data Sharing

- Lack of alignment on screening requirements and lack of standard codes for social needs, limited awareness of these codes, and limited interoperability across systems are all barriers to providers documenting social needs and sharing information effectively with referral partners.[22]

- Providers and CBOs can benefit from individual-level data shared by health plans, but business associate agreements and contracting processes can make it challenging to share these data.

- ICD-10 Z codes are an important source of social needs data that health plans receive from providers through claims data. However, providers cannot always include these codes as there are limits to how many codes providers can attach to a claim.

- Because social needs data are sensitive, issues regarding consent, data ownership, and data stewardship must be acknowledged and worked through in partnership with each community.

Limited Evidence Base

- Despite many pilot projects, research evidence about the effectiveness of interventions is limited. It is challenging to track when a social need has been met, making it difficult to measure impact. More work is needed to understand how referrals from health care providers impact individual social needs outcomes (e.g., food needs met for one month, permanent housing secured) and health outcomes (e.g., effective management of chronic conditions).

- There is a growing body of literature that seeks to measure the return on investment (ROI) for addressing SDoH and considers different ways of thinking about returns, such as the return on quality or return on equity.[23, 24, 25, 26, 27] However, more evidence is needed to better understand the ROI for SDoH and social needs interventions.

Equity Concerns

- Historical and ongoing marginalization and exploitation of communities such as people of color and sexual and gender minorities has resulted in legitimate skepticism about divulging social needs and demographic information to their health care providers. Institutions can and have used data for harm (e.g., redlining, profiling).

- Consideration is needed on when, how, and by whom social needs information is collected to not exacerbate existing inequities. For example, screening individuals via telehealth may increase inequities for those without unlimited cell phone minutes, reliable internet access, or a private place to talk with a provider.

- As organizations seek to identify members' social needs and address SDoH, it should be done as part of a larger strategy to advance health equity. Addressing SDoH without a specific focus on equity can inadvertently increase disparities.

Recommendations: Closing the Gap Between Needs and Solutions

Health plans have an essential role to play in efforts to collect, code, integrate, aggregate, and report data related to social needs and SDoH. Key partnerships with organizations embedded in the community that have connections to individuals with social needs will help advance these efforts, as these organizations already have established trusted relationships with community members. Below are some specific recommendations for how health plans can meaningfully engage with their communities and partner organizations to have the greatest impact:

Supporting Providers and CBOs to Address SDoH and Social Needs

- Many providers will struggle to update their infrastructure to meet social needs data collection and sharing requirements. Health plans can play an important role in building capacity and strengthening their provider network and their CBO partners with funding, technical assistance, and education, thereby reducing their partners' burden in meeting new requirements. Health plans should regularly evaluate whether their approaches accomplish these goals and modify as needed to make them as effective as possible.

- Health plans can leverage their administrative resources to collaborate with providers and CBOs to draw down available federal and state funds to support capacity and infrastructure building that will improve their ability to collect and share data, such as DHCS's CalAIM Providing Access and Transforming Health (PATH) Initiative.

- Health plans can provide support for pilot projects, including funding, access to software, and technical assistance, so that stakeholders can identify and scale effective solutions more quickly.

- Providers face many competing priorities for their limited time with patients. Health plans can support providers' documentation of social needs data through value-based payment models, as well as education and financial incentives for the documentation of social needs through ICD-10 Z codes.

Using Data to Drive Improved Care

- Sharing data that has been aggregated and analyzed can be helpful to provider and community partners. Health plans can share aggregated social needs data as well as community-level SDoH data that providers and CBO partners can use to help them better understand and meet the needs of their patients and community.

- While building an evidence base on the impact of social needs and SDoH interventions, it may be necessary for health plans to reevaluate the timeframe and data used to measure success. Community-level SDoH interventions and individual-level social needs may require a longer horizon to adequately assess outcomes and may also have a broader impact across the community that expands beyond a health plan's members.

- It is important to remember that data and the technology used to collect and share data are tools to improve care and health outcomes. As health plans seek to address SDoH and social needs, technology and data must be part of the solution, but they should proceed with a community-first mindset that centers meeting individual and community needs as the end goal.

Improving Interoperability and Technology Infrastructure

- Health plans can encourage electronic health record (EHR) vendors to integrate modules on social needs into their systems in both health care and community settings and reduce the cost for adding on the module to an already existing system.

- Health plans can encourage standards-based data exchange that focuses on domains, as recommended by the Gravity Project, which allows health care and social care providers to achieve a level of interoperability without imposing requirements on them to use the same assessment tool or infrastructure. Bidirectional and/or multidirectional exchange is essential for ensuring initiatives meet individual health and social care needs.

- Health plans should collaborate with CBOs to ensure they are adopting interoperable data systems capable of sending and receiving information from other platforms. This can facilitate data exchange and reduce CBO burden caused by having to work across multiple platforms or make duplicate data entries.

Ensuring Authentic Community Engagement

- Many CBOs use assessment and screening tools that have been adapted specifically for the populations they serve. Rather than requiring CBOs implement a new tool or method of data collection, health plans should engage with individuals and CBOs from the outset of community engagement and program development. Taking the time to learn from and build trust with the community will help ensure a program collects relevant data and effectively meets the community's needs.

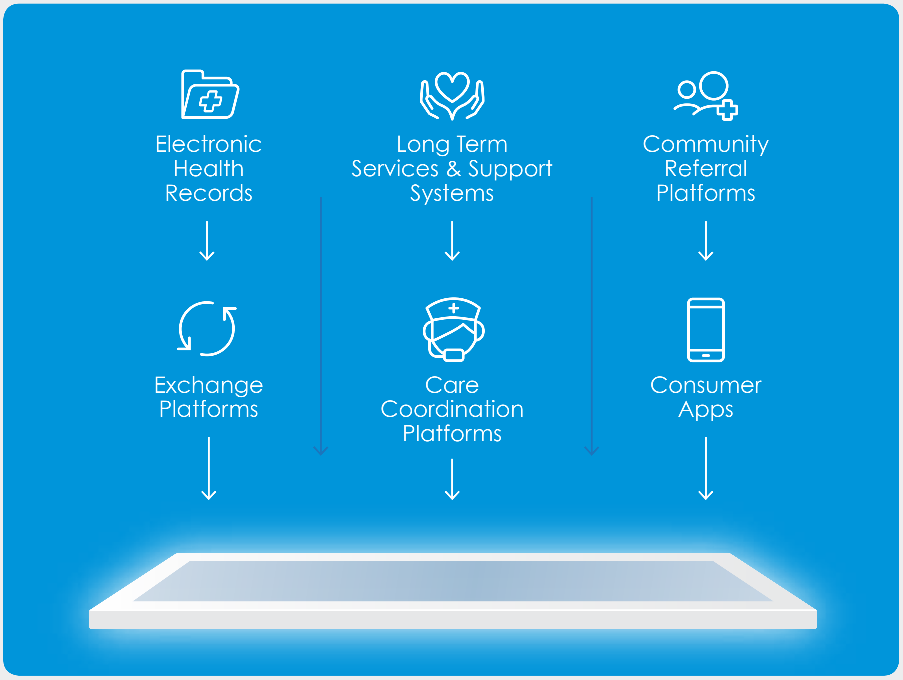
- Health plans can make the greatest impact on addressing social needs when they seek and maintain a partner role rather than leading with a top-down approach. Supporting CBOs and staff, such as CHWs, *promotores,* or peer support specialists who have deeply established connections in their communities and act as intermediaries between health and social services, can enhance social needs data collection and closed-loop referrals. Individuals may be more willing to share sensitive information with organizations and staff who already have established credibility and trust with the communities they serve.

- Health plans should clearly articulate how sharing social needs information can benefit its members. Demonstrating how this data can enable better care can help build trust and encourage members to share sensitive social needs information. As part of demonstrating value to members, plans could help with auto enrollment into certain programs if a member is eligible for a service or program (e.g., Medi-Cal and Special Supplemental Nutrition Program for Women, Infants and Children/WIC).

CASE STUDY

The Gravity Project: Advancing equitable health and social care through SDoH interoperability standards[28]

The Gravity Project is a convening of stakeholders from across the health and human services ecosystem that seeks to develop consensus-based data standards to improve the use and sharing of SDoH information. They develop data standards to represent individual-level SDoH information that can be documented in and exchanged across disparate digital service platforms. These national standards support the consistent use of SDoH data across organizations, providers, and caregivers, and help to facilitate payment for social risk data collection and intervention activities such as referrals, counseling, and care coordination.



The Gravity Project focuses its activities on three workstreams:

1. **Terminology:** Creates words and respective meanings for social risk and social needs so they can be applied and understood across the health and human services ecosystem.
2. **Technical:** Expands available SDoH data within electronic systems for interoperability and accelerates standards-based information exchange.
3. **Pilots:** Validates terminology and data exchange standards through real-world testing across clinical, social services, payer, and government electronic systems.

Partnering to Scale Investment and Impact

- Health plans should jointly fund SDoH systems and infrastructure, including community information exchanges, social service resource locators, and social need referral platforms. These upstream supports are vital to SDoH and social needs interventions but are expensive to implement and difficult to capture the ROI since the benefits extend to the entire community. By working together, health plans can lower the cost for each plan, while eliminating the competitive disadvantage and ensuring adequate resourcing for SDoH and social needs.[29]

- Health plans can collaborate with each other to conduct a joint needs assessment with key stakeholders in a community, including relevant CBOs, to determine how plans can best support a given community's specific needs. Health plans could additionally align with local health departments, hospitals, and health centers that are required to conduct community health needs assessments to reduce the burden on participating organizations.

- While health plans work to address the social needs of their members, they should also identify opportunities to partner with a wider variety of organizations in the community to address SDoH. This may mean building public-private partnerships or identifying a coalition in the community that is working on broader issues such as expanding the stock of affordable housing, bringing in more farmers' markets, growing the workforce through new programs at community colleges, or expanding transportation options. Improvements in areas such as these will improve upstream conditions in the overall community.

- Health plans can work together to advocate for policy changes at the state or federal level that would facilitate improvements in the collection, use, and exchange of social needs and SDoH data. Advocacy efforts could focus on appropriate state funding and resources to address social needs, barriers related to accessing public benefits, and on the inclusion of health-related social services as health care costs in the plan's medical loss ratio rather than as administrative expenses.

CASE STUDY
The Community Bank: An innovative model to address SDoH through community collaboration[30]

With a shared goal of improving community health outcomes while reducing health inequities, a Community Bank is a locally controlled pool of funds contributed by stakeholders who work together to support community well-being and prevention initiatives. The Community Bank creates a sustainable funding mechanism for public-private partnership through braiding and blending of resources. Funding partners such as health providers, health care payers, government agencies, and foundations make financial contributions to the Bank, and they share a common vision and agenda, with a commitment to meaningful community engagement and partnership. A neutral third party Convener acts as the fiscal agent for the Community Bank, providing governance, establishing commitments from funding partners, and disseminating funds.

To quantify the impact of the funds and ensure sustainability, the Community Bank model requires funding partners to agree on success metrics and follow data-driven decision-making for process improvement and addressing need gaps.

Concluding Thoughts

Data are the single most important tool that health plans have to improve the health of individuals and communities. The collection, use, and sharing of health and social data is essential to address social needs and SDoH. Health plans have a critical role to play in improving our collective ability to effectively leverage social needs and SDoH data to meet individual needs and strengthen communities.

Health plans should proactively identify and engage in strategies to bolster communities' capabilities to address SDoH. These strategies can include partnering with other organizations in a community, providing funding and technical assistance to providers and CBOs to help them meet new requirements regarding social needs data collection and sharing, involving the community in crafting solutions, and advancing interoperability and the use of standards.

Health plans and the communities they serve need to move beyond piecemeal approaches to resourcing SDoH initiatives. To effectively address SDoH in a community, instead of working individually, health plans must work collaboratively towards the shared goal of a healthier member population, whose health and social needs are being met. Collaborative investments in upstream infrastructure are necessary to adequately resource SDoH interventions and can improve provider and CBO ability to collect and share data. Strengthening community efforts through intentional alignment between institutions like health plans will help build a system capable of meeting individual social needs and developing thriving and equitable communities.

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