



## Helping Plans Collect Enrollee Data on Social Determinants of Health and Health-Related Social Needs

Social determinants of health (SDOH) are “the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life.” SDOH include macro-level social constructs that affect health, like racism and institutional bias.<sup>1</sup> Relatedly, individual-level health-related social needs (HRSN) are the social and economic factors that affect an individual’s ability to maintain their health and well-being, like housing quality and instability, food insecurity, and employment status.<sup>2,3</sup> Health care leaders understand that identifying and quantifying key SDOH and HRSN variables can equip providers with insights that inform clinical decision making and enable nuanced interventions targeting individuals’ specific needs.<sup>4</sup> They also recognize that leveraging SDOH and HRSN data can help drive quality improvement, advance health equity, and deepen our understanding of how SDOH contributes to health outcomes.<sup>5</sup> Conversely, health care leaders know that when the system fails to fully capture and act upon SDOH and HRSN data, individuals and their communities may face gaps in access to care, increased health care costs, continued health inequities, and poor health outcomes.<sup>6</sup>

### Why Dual Eligible Special Needs Plans Can Benefit from SDOH and HRSN Data

Effective SDOH and HRSN data collection and analysis may hold opportunities to reduce health care disparities among individuals who are dually eligible for Medicare and Medicaid, a population that disproportionately experiences both higher social risk factors and poorer health than the Medicare-only population.<sup>7</sup> Regulators and health care accrediting organizations appreciate the potential of robust SDOH and HRSN information and, as a result, are increasingly directing health care organizations to collect individual-level data.<sup>8,9</sup>

### Inventory of SDOH and HRSN Collection Resources

Public and private data experts have created a broad library of products to help plans and providers amass information on SDOH and HRSN. However, busy professionals may struggle to differentiate between these resources and to quickly identify which would be most useful to meet their needs.

Resources for Integrated Care (RIC) developed this compendium to help organizations navigate the universe of SDOH and HRSN data collection tools and resources. In the table below, RIC summarized 18 such resources that offer either validated questions, established protocols, or promising strategies to leverage these tools in support of enrollees, including dually eligible individuals.

## Helping Plans Collect Member Data on Social Determinants of Health (SDOH)

### Key: Content Category Definitions

- **Data Sets and Maps:** Federally-produced SDOH-related data, with maps, that plans can leverage to develop a more robust picture of enrollee SDOH-related needs
- **Screening Tools:** Tools to help perform social need screening, including validated questions plans may wish to adopt for their SDOH data collection instruments
- **Guidance and Resource Compendiums:** Broad resources and guidance documents that plans can use to support SDOH data collection efforts, such as data collection standards, screening strategies, promising practices to improve reporting accuracy, training tools, and webinars
- **Z Codes:** Guidance and educational materials specific to using SDOH-related Z codes

### Inventory of SDOH and HRSN Resources by Content Category and Target Audience

Resource Type	Resource	Developer	Federally Funded	Audience				Summary
				General Public	Clinicians	Administrators	Programmers	
Data Sets and Maps	<a href="#">Mapping Medicare Disparities by Population</a>	CMS	X	X		X		This interactive mapping tool provides detailed SDOH disparity information at the county or census tract level. It includes information on a variety of SDOH data elements such as educational attainment and social context or health outcomes and associated costs. This tool provides disparity information at a geographic level, which may be helpful to health plan care coordinators supporting enrollees in specific communities. It can additionally serve as a strategic planning resource to support targeted SDOH interventions.
	<a href="#">SDOH and PLACES Data</a>	CDC	X			X	X	This resource explains the addition of SDOH data from the American Community Survey (ACS) into <a href="#">PLACES</a> , a Centers for Disease Control and Prevention (CDC) effort that shares local (e.g., county, census tract) population health data across the nation. This ACS data enables users to identify SDOH needs across nine measures in specific geographic areas, which can help a plan identify pertinent topics and tools. It can also help plans develop an overarching SDOH strategy, including partnerships with community-based organizations.

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Screening Tools	<a href="#">Accountable Health Communities Health-Related Social Needs Screening Tool</a>	CMS	X	X	X			This tool helps users in a clinical setting efficiently evaluate health-related social needs across five domains: housing, food, transportation, utilities, and interpersonal safety. It offers guidance to help clinicians administering the tool better understand unmet health needs. It offers a practical screening exercise applicable in various clinical settings.
	<a href="#">Identifying and Addressing Social Needs in Primary Care Settings</a>	AHRQ	X		X	X		This document supports practices seeking to screen patients for social needs. It includes a resource list to help find SDOH screening tools that best fit a practice's population, notes practical approaches for collecting SDOH data, and offers promising practices for connecting individuals with community resources. It also discusses uses for SDOH data in individual and population-level quality improvement efforts.
	<a href="#">Social Needs Screening Tool</a>	AAFP		X	X	X		Developed by AAFP, this tool helps providers assess patient needs across SDOH domains (e.g., housing, food, transportation, finances, personal safety). Health plans can share this tool with providers and internal staff to support SDOH data collection.
	<a href="#">PRAPARE Implementation and Action Toolkit</a>	NACHC, AAPCHO, and OPCA				X	X	Produced by the National Association of Community Health Centers (NACHC), Association of Asian Pacific Community Health Organizations (AAPCHO), and Oregon Primary Care Association (OPCA), the Protocol for Responding to & Assessing Patients' Assets, Risks & Experiences (PRAPARE) toolkit provides resources and promising practices to support SDOH data collection implementation. It helps users prepare for SDOH data collection, assess data, and respond to identified needs. It also offers supporting resources.

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Guidance and Resource Compendiums	<a href="#">Inventory of Resources for Standardized Demographic and Language Data Collection</a>	CMS	X		X	X		This resource offers a collection of documents and summarizes minimum standards for race, ethnicity, and language (REaL) data collection in health care settings. It discusses REaL-related reports, guides, toolkits, and training tools. It also offers guidance to support training, documentation of standard updates, and promising provider network practices. It is applicable to a range of plan audiences, including care coordinators and administrative staff.
	<a href="#">SDOH &amp; Practice Improvement</a>	AHRQ	X		X	X		The Agency for Healthcare Research and Quality (AHRQ) highlights several SDOH screening tools, federal data sets, and other resources aimed at helping practices collect, analyze, and address individuals' SDOH. AHRQ features SDOH screeners that support data collection, as well as resources addressing SDOH and social needs through clinical-community linkages.
	<a href="#">SDOH in Rural Communities Toolkit</a>	HRSA	X	X		X		Developed by the Rural Information Hub and supported by the Health Resources and Services Administration (HRSA), health plans may wish to review the tools and resources located on the Hub to support assessments of rural individual or community-level SDOH.
	<a href="#">PhenX Social Determinants of Health Assessments Collection</a>	NIH	X		X		X	This collection includes SDOH screening tools across several domains that users can leverage to create a unique set of validated questions. It includes a collection of core and specialized tools addressing individual and structural SDOH. Data that plans gather using either core or specialty collections can measure multiple SDOH variables. While aimed at organizations that have begun their data collection journey, each collection also includes information on trainings needed to begin implementing included tools.

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Guidance and Resource Compendiums	<a href="#">SDOH Information Exchange Toolkit</a>	ONC	X			X		This 77-page report provides guidance on planning and implementing SDOH information exchange. It outlines challenges, promising practices, and additional resources.
	<a href="#">Screening for SDOH in Daily Practice</a>	AAFP			X	X		This American Academy of Family Physicians (AAFP) resource details the value-add of SDOH screening and provides screening tool suggestions for various organizations. AAFP also suggests potential SDOH workflows that could help reduce data collection burden and improve efficiencies.
	<a href="#">Social Determinants of Health</a>	HIMSS		X	X	X		The Healthcare Information and Management Systems Society (HIMSS) produced this guide to support practices with all aspects of SDOH screening and data analysis. It offers background on the connections between social and medical care, the impact of SDOH on population health, as well as resources from multiple screening tools and infrastructure standards.
	<a href="#">Adapting SDOH Data Collection Workflows during COVID-19</a>	NACHC, AAPCHO, and OPCA		X	X	X		Supported by NACHC, AAPHO, and OPCA, this presentation addresses how users adapted an existing protocol for responding to and assessing patients' assets, risks, and experience (PRAPARE) during the COVID-19 public health emergency. It provides extensive baseline information on SDOH screenings and can serve as an effective learning tool for plan staff.

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Z Codes	<a href="#">Improving the Collection of Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes</a>	CMS	X	X	X	X		This infographic provides information about ICD-10-CM Z codes, including what they are, how plans and providers use them to document SDOH data, and how SDOH collection can improve equity in health care delivery. It also links to other Centers for Medicare & Medicaid Services (CMS) resources and includes a detailed list of SDOH-related Z codes to help educate plan staff. It can be helpful to care coordinators, health plan staff, and providers.
	<a href="#">Using Z Codes</a>	CMS	X		X	X	X	This infographic, developed by the CMS Office of Minority Health, offers a general overview in five steps to help educate plans and providers about how to use Z codes.
	<a href="#">ICD-10-CM Coding for Social Determinants of Health</a>	American Hospital Association			X	X	X	Targeting hospitals, this resource provides educational materials and guidance specific to using Z codes. It also includes a useful table that defines individual Z code and identifies specific risk factors for each.
	<a href="#">Back to Basics: Social Drivers of Health: ICD-10-CM Z Codes and Documentation</a>	Superior Health Quality Alliance	X		X	X	X	This webinar can assist organizations collect SDOH ICD-10-CM Z codes specific to individuals with potential health hazards related to socioeconomic and psychosocial circumstances. Produced by Superior Health Quality Alliance, a CMS-funded Quality Improvement Organization (QIO), this webinar and its accompanying <a href="#">ICD-10-CM Z code guide</a> supports consistent Social Drivers of Health (SDOH) data collection by using standardized diagnosis codes while building a database for community-specific data mining. The guide also offers resources to connect patients with community and health care related supports – helping to reduce hospital readmissions.

### Strategies to Successfully Implement SDOH and HRSN Data Collection Efforts

RIC explored the aforementioned resources and identified promising practices that can help plans successfully implement SDOH and HRSN data collection efforts. These strategies relate to three categories: obtaining buy-in, efficiently managing burden, and demonstrating the value of the effort to those involved in the data collection process.

#### Obtain Institutional Buy-In for SDOH and HRSN Data Collection

Collecting SDOH and HRSN data can be both challenging and time-consuming. Calling upon staff members or clinicians to ask enrollees to share personal information or answer sensitive questions may be awkward. Busy frontline staff and skeptical enrollees may respond with reluctance, particularly if they do not understand the impetus behind the request. To address these challenges, it is helpful to educate clinical and non-clinical team members, as well as the broader community, about the value and potential benefits of SDOH and HRSN data collection efforts.

Prior to implementation, plans may find it helpful to share with their teams, as well as the enrollees they serve, how the organization plans to use SDOH and HRSN data. Administrators can discuss how the organization will leverage this new information to support efforts to eliminate disparities in health and health care, address utilization gaps, identify opportunities for cost-effective care options, or even support value-based payment models that incentivize appropriate preventive care interventions. Plans may wish to explain to enrollees and community-based partners that, in addition to helping develop more comprehensive care plans for enrollees, SDOH and HRSN data offers insights into broader population trends,<sup>10</sup> which help state Medicaid agencies improve their health plan benefits, services, and programs.

It also can be helpful for plan administrators to discuss with both internal and external audiences how SDOH and HRSN data collection can bring to light challenges—like food insecurity, health care disparities, or workforce capacity needs—that can inform initiatives to improve the quality of care for enrollees with complex care needs.<sup>11</sup> For example, a Kaiser Permanente analysis of its SDOH data found that 29 percent of its most clinically complex members identified food insecurity as their greatest medical challenge, prompting Kaiser to spearhead an initiative (*Thrive Local*) that matches individuals with pressing social needs to community resources.<sup>12</sup> Similarly, as SCAN Health Plan's former chief medical officer described in a recent RIC [podcast](#), SCAN used the Healthcare Effectiveness Data and Information Set (HEDIS)—which includes a new “Social Need Screening and Intervention” measure—to identify and address disparities in disease management and prevention services among enrollee subpopulations.<sup>13,14</sup> Its analysis uncovered significant variation in flu vaccination rates by demographic groups, driving the plan to establish a multi-pronged intervention to reduce those disparities.

Plans may wish to offer information sessions that allow staff and enrollees alike to learn the potential benefits of collecting SDOH data and, critically, to ask questions and share their thoughts. Administrators can use these opportunities to learn about and directly address concerns from staff and enrollees, improving the implementation process and building trust with those individuals most closely involved in the data collection effort.

## Manage SDOH and HRSN Screening Burden

Health plans may wish to consider using self-administered screeners that decrease the onus on providers while simultaneously offering enrollees a more private experience to disclose social needs.<sup>15</sup> These screening tools allow the enrollee to input responses to SDOH and HRSN questions on their own, often on a tablet while in the waiting or exam room; some providers offer screeners through a patient portal so that the individual or caregiver can answer the questions and submit through a home computer or smartphone.<sup>16</sup> Plans may explore resources in the above table to refine or develop a workplan that operationalizes all aspects of the process—from pre-collection rollout through data storage considerations. The guidance helps support health care organizations' efficient and effective SDOH data strategy implementation, reducing the burden associated with data collection.

## Follow Up Data Collection Efforts with Action

Collecting data is about both creating *and maintaining* new workflows. To keep clinical and administrative staff engaged in the ongoing efforts, plans can help connect the dots by publicly sharing how they are using SDOH and HRSN data and how insights from that data are positively affecting the communities they serve.

## Closing Thoughts

Creating new data collection mechanisms requires a commitment from everyone—plan administrators, frontline staff, providers, data analysts, and of course, the enrollees themselves. However, doing so offers significant promise for public health.

Given the regulatory and accreditation landscape's evolution, researchers, policy makers, regulators, and health care industry leaders all recognize that leveraging SDOH and HRSN data is key to improving health care quality and equity for populations most at risk to experience poor health outcomes. Fortunately, as this Tip Sheet illustrates, health plans have a wide range of resources at their disposal that can help them initiate successful and efficient data collection processes.

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The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. This tip sheet is intended to support health plans and providers in integrating and coordinating care for dually eligible beneficiaries. It does not convey current or anticipated health plan or provider requirements. For additional information, please go to <https://www.resourcesforintegratedcare.com/>. Please submit feedback to [RIC@Lewin.com](mailto:RIC@Lewin.com).

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