NATIONAL QUALITY PARTNERS™ ACTION BRIEF:

Social Determinants of Health Data Integration Action Team

As much as 60 percent of health outcomes are driven by factors outside of the traditional healthcare system—by determinants such as food insecurity, access to stable housing and transportation, degree of social connectedness, level of education, and economic status.[1]

Social determinants of health (SDOH), as defined by the Centers for Disease Control and Prevention (CDC), are community-level conditions in the environments in which people live, learn, work, play, worship, and age that affect health and health outcomes.[2]

At the individual level, health-related social needs (HRSN) are nonmedical circumstances that impact individuals and their disease outcomes.[3] In recent years, there has been growing recognition that one's ZIP code may better predict health than one's genetic code.[4] Obtaining and incorporating data on social determinants and social needs are critical for improving the health of individuals and their communities. However, social determinants and social needs are not routinely identified, discussed, or addressed through clinical care pathways, and many community-based organizations (CBO) cannot systematically collect or share data with healthcare systems or with each other.

Despite recognition of the critical impact of SDOH on overall health, several factors have impeded efforts to identify and address individual, community, and population-level SDOH needs. These factors include fragmented data collection, influenced by disparate or limited data systems, siloed data infrastructure and capabilities, and the necessary prioritization of day-to-day service delivery over standardized data collection. Cross-sector collaboration, including engaging nontraditional partners, is necessary to advance our capacity to define, capture, and address social determinants to improve health and health outcomes.

Individual, family, caregiver, and community voices must speak at the core of this work to overcome institutional discrimination and eliminate health disparities.

To promote collaboration and partnerships that accelerate SDOH data integration into care and eliminate disparities, the National Quality Forum (NQF) convened the National Quality Partners™ (NQP™) SDOH Data Integration Action Team, bringing together 41 of NQF's member organizations from across the United States. This multistakeholder group included consumers and patients, caregivers, quality improvement organizations, clinicians, researchers, health systems, professional societies, payers, and federal agencies. They share a goal to improve health outcomes and eliminate disparities by overcoming challenges to integrating SDOH data into clinical practice and using data to prioritize local community-level prevention efforts.

The NQP™ Social Determinants of Health Data Integration Action Team

identified the following set of priority challenges:

- **the lack of standards** for collecting and documenting SDOH data, and addressing SDOH using captured data;[5]

- **ongoing definitional issues** complicate data collection and standardization efforts; terms such as food insecurity, social isolation, housing insecurity, etc. need to be consistently defined and a scale provided;

- **insufficient payment mechanisms, programs, and best practices** to identify and/or address needs;

- **need to build capacity** for adequate referral, resource, and service networks/providers;

- **potential burden to consumers and providers** in responding repeatedly to screening or assessment tools;

- **need to ensure consumers are protected**, avoiding potential harm from information sharing and guarding against inaccurate or "old" information being transferred;

- **need for a prioritization process** to identify which social determinants should be addressed first, by whom, and how; the interactive effects of specific social determinants; and the return on investment of screening for and addressing high-priority social determinants; and

- **lack of comparable data expertise, infrastructure, and workforce** to facilitate data integration between healthcare systems and CBOs.

With a growing commitment from communities, the private sector, and the public sector to collect, analyze, and respond to SDOH data, collaboration between communities and healthcare systems can ease data collection, sharing, and integration to drive improvements in health outcomes and reduce health disparities.[6] The relevant stakeholders can integrate community data with clinical information by using a multipronged strategy to address social determinants and social needs from the consumer, family, caregiver, payer, provider, state, and federal perspectives.

The NQP™ Social Determinants of Health Data Integration Action Team is calling for communities, healthcare providers, payers, federal agencies, and CBOs to collaborate on improving the collection and integration of top-down and bottom-up SDOH data, embedding a consumer perspective throughout the entire process.

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firmly believes that these recommended actions are timely and necessary to address the previously noted challenges. To improve person-centered care and health outcomes through SDOH data integration, healthcare and community organizations should:

1 Standardize and Share Data

- Capture meaningful, standardized, and locally actionable data

- Develop multidirectional data exchange, sharing, and consent processes

- Establish universal guidelines for social determinants and social needs data collection and exchange across settings and sectors to support coordination of care for individual patients

2 Demonstrate Collaboration and Partnerships Across Sectors

- Build community and clinical capacity for collaborative relationships across settings, sectors, and the continuum of care

- Advance policy change and innovative payment models that address SDOH across settings and sectors

- Invest in community and clinical workforce development—including frontline caregivers and community health workers—that promotes data collection and skill building to address social determinants and social needs

- Implement collective impact approaches to address community-wide social determinants and social needs

- Use data to understand and overcome barriers to person and family engagement in healthcare, community-based care, and community improvement initiatives outlined in local community health needs assessments

3 Evaluate Effectiveness

- Identify a standardized set of community and clinical outcome measures to monitor progress on social determinants of health data integration

- Perform continuous quality improvement activities to improve effectiveness of interventions that identify and address social determinants and social needs

Organizations, encompassing CBOs, primary and specialty medical care, and behavioral health, must establish partnerships and policies to standardize SDOH assessments, share data, and build a workforce to overcome SDOH barriers and achieve better health outcomes. Integrating SDOH and clinical/behavioral/long-term support services data to support meaningful action and respond to social needs at the organizational/community level is a necessary first step toward leveraging data to improve care, care delivery, health, and health outcomes.

With time and resources, collaboration and partnerships can advance interoperability of SDOH data so that regardless of the setting in which people receive services, clinicians and community organizations have access to data that will help them understand and address a person's needs, improve health, and eliminate health disparities.

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1   Office of Disease Prevention and Health Promotion. Healthy People 2020 website. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health. Last accessed May 2019.

2   Centers for Disease Control and Prevention. Social Determinants of Health: Know What Affects Health Frequently Asked Questions website. https://www.cdc.gov/socialdeterminants/faqs/index.htm. Last accessed June 2019.

3   Castrucci B, Auerbach J. Meeting Individual Social Needs Falls Short of Addressing Social Determinants of Health. Health Affairs Blog. January 16, 2019. https://www.healthaffairs.org/do/10.1377/hblog20190115.234942/full/. Last accessed June 2019.

4   Harvard School of Health. Zip code better predictor of health than genetic code. https://www.hsph.harvard.edu/news/features/zip-code-better-predictor-of-health-than-genetic-code/. Last accessed June 2019.

5   Cantor MN, Thorpe L. Integrating data on social determinants of health into electronic health records. Health Aff (Millwood). 2018;37(4):585-590. Last accessed June 2019.

6   Office of the Assistant Secretary for Planning and Evaluation (ASPE). Incorporating Social Determinants of Health in Electronic Health Records: A Qualitative Study of Perspectives on Current Practices among Top Vendors. Washington, DC: ASPE; 2018. https://aspe.hhs.gov/system/files/pdf/259901/NORCSDH.pdf. Last accessed June 2019.