UNITE US

Leveraging Data to Advance Health Equity

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Introduction

Defining the Problem and Opportunity

The recognition that community conditions and social needs significantly influence health outcomes is not new. The pandemic has underscored this point and highlighted the known health disparities and structural inequities that exist between communities[1]. Unite Us data alone showcases a roughly 590-percent increase in demand for social care interventions since the pandemic began, a trend that has sustained well beyond the initial phases of the pandemic.

At Unite Us, we believe that evaluating social care data at scale can meaningfully contribute to health equity, and that analyzing the relationship between health and social care data can lead to valuable insights about how to improve overall health. Looking at the same two-year comparison (2018–2019 vs. 2020–2021) mentioned above, there has been a stark shift in the racial and ethnic breakdown of clients served in the Unite Us platform. Among clients with known race and ethnicity, data shows that the percentage of service episodes for Black/African American individuals has increased by 11 percent and for Hispanic/Latino individuals by 7 percent, whereas the percentage of service episodes has decreased during the same period for White individuals.

5 Principles for Using SDoH Data to Improve Health Equity

1. Ensure communities and individuals most impacted have power to make decisions.

2. Leverage the power of referral data to improve access to social care.

3. Measure and evaluate.

4. Remove barriers to data sharing.

5. Use data to drive action.

Effectively addressing social determinants of health (SDoH) will require dynamic sets of data that provide insight into local community needs and opportunities. We must address the SDoH by gaining a deeper understanding of individuals' lived experiences and health outcomes—not by disassociating them from the systems in which they exist, but by contextualizing them within the inequities that those systems create.[2] At Unite Us, our experience solving for gaps in coordination of care, reimbursement of community-based services, data analytics, and interoperability in social care is rooted in community-engaged practices. This puts Unite Us in a unique position to reduce health disparities and advance health equity through a hyper-local approach and with the ability to deliver at scale.

In this paper, we outline five principles of practice that are critical to reducing health inequity.

[1] https://www.policylink.org/sites/default/files/WHY_PLACE_AND_RACE%20MATTER_FULL%20REPORT_WEB.PDF

[2] Krieger N (2021) Structural Racism, Health Inequities, and the Two-Edged Sword of Data: Structural Problems Require Structural Solutions. Front. Public Health 9:655447. doi: 10.3389/fpubh.2021.655447

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Approaches that Ensure Communities and Individuals Most Impacted Have Power to Make Decisions

Strengths-based

To ensure communities and individuals most impacted by health inequities have the power to make decisions, we must start with a strengths-based approach.[3] A strengths-based framework engages the community as an equal partner to identify assets and resources, rather than focusing solely on unmet needs. At the same time, it gives organizations the tools to collaborate and enhances their ability to address unmet social needs. Together, this framework drives collective impact through a person-centered approach to care coordination.

Collaboration drives robust data

The collective action of community partners engaged in care coordination generates community-driven data. Social care data collected through this collaborative approach is grounded in the unique community context. This data can therefore offer a nuanced understanding of how health equity barriers and facilitators can be leveraged to drive change locally. Community investment decisions often rely on national datasets and local needs assessments, conducted through a healthcare lens.[4] A robust, locally reflective, social care dataset is critical to address the true needs and priorities of the communities they reflect and serve.

Community power and agency

Community partners who produce social care data should have open access to those data. When combined with community-based organizations' (CBOs) continually improving technology infrastructure for data documentation, analysis, and sharing, the opportunity to achieve parity in clinic-to-community partnerships becomes more attainable and less elusive than it has been historically. CBOs can gain power and agency through shared decision making driven by the data they produce. This is an important strategy for dismantling structural and institutional barriers to health equity and de-siloing the way community investment decisions are reached.[5]

Unite Us' local community engagement managers are a part of the communities with whom they partner. They have often been a part of the health and human service delivery system in the community before joining Unite Us. These existing relationships and understanding of their community help build networks with CBOs that offer a broad range of services. Large non-profits, barbershops, and churches participate in Unite Us-powered networks and create a no-wrong-door entry point for community members to access services.

[3] N. Kunnen, D. MacCallum, & S. Young (2013). Research Strategies for assets and strengths based community development In F. Moulaert (Ed), The International Handbook on Social Innovation: Collective Action, Social Learning and Transdisciplinary Research (pp. 285-298). Edward Elgar Publishing.

[4] Hacke, R., Wood, D., & Urquilla, M. (2015, March). Community Investment: Focusing on the System. (Working Paper No. 1). https://kresge.org/sites/default/files/Kresge-Community-Investment-Focusing-on-the%20System-March%202015.pdf

[5] Love, H., Thrash-Ntuk, T., Vey, J. (August 2020). No more status quo: A community-led action plan for addressing structural inequity during COVID-19 recovery. Anne T. and Robert M. Bass Center for Transformative Placemaking. https://www.brookings.edu/research/no-more-status-quo-a-community-led-action-plan-for-addressing-structural-inequity-during-covid-19-recovery/

03

Leverage the Power of Data to Improve Access to Social Care

Data on client journeys provide insights on their lived experiences.

Each step of a referral pathway provides insights about individuals' lived experiences

1 Systematically screen for health-related social needs.

2 Identify services to provide in community settings.

3 Refer individuals to identified services.

4 Coordinate care delivery.

5 Track outcomes.

Coordinated social care platforms provide closed-loop, bi-directional, and HIPAA-secure communication so that healthcare and health and human service providers can refer individuals with social needs to local services. It's important that these platforms close the referral loop so stakeholders can collect data reflecting the end-to-end referral journey and lived experience of individuals accessing services. In practice, this means that we need to be clear on what we should measure, how often, and why. Data-collection practices, such as client interview questions, should be person-centered and avoid asking clients to retell traumatic stories across different service providers. And data analysis should account for biases that could lead to inaccuracies, uninformed conclusions, or exacerbated disparities. It's also critical that outcomes data indicate whether organizations connect a client to services, and whether their social need is addressed. **Without it, their story is not complete.**

Data from unresolved referrals should be analyzed to understand why the referral could not be completed, identify potential gaps in local services, and other barriers to care delivery. These end-to-end referral journey data can inform improvements in the client experience and upstream barriers to social care that may exist.

Complete referral-journey data provide insights on communities.
Complete referral data positions stakeholders to analyze community-level data in combination with client and public data to highlight the needs of a population, and expose gaps in services available to meet those needs. This can help identify high-impact areas for targeted interventions. It also helps stakeholders shape the direction of local investments from healthcare, government, or philanthropy to maximize more equitable distribution of resources. Service providers like CBOs can independently and collaboratively review data trends to indicate the need to expand or diversify services to better meet the needs of the community.

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Measure and Evaluate Data

Disparities measurement: Stakeholders must align on how health and healthcare disparities will be measured and tracked to understand whether any progress is achieved. Effective measurement and tracking requires:

1 Agreement on common definitions and methods for measuring disparities;

2 A conceptual framework on how disparities arise and how progress towards reducing disparities over time is assessed;

3 Accurate and complete collection of key sociodemographic data (e.g. age, education, race/ethnicity), as well as non-sociodemographic data (e.g. access to food, health outcomes such as blood pressure) across those key sociodemographics; and

4 The establishment of data-reporting mechanisms that can answer the key questions under consideration.

To begin with, implementing common definitions of health and healthcare disparities requires statistical tools that match the concepts underlying the definition. However, stakeholders should recognize that even common definitions have implicit value judgements; therefore, it's important to consider and discuss the judgements on which those common definitions or measurements may be based.[6]

Stakeholders collecting and/or analyzing health disparities data must ensure racial/ethnic subgroups are sufficiently represented in the data. Adequate representation will support narratives centered around the presence of racial/ethnic subgroup data, rather than their absence. In cases where not enough data is available on a particular subgroup, provision of sufficient justification as to why a subgroup was chosen as the referent group should be standard practice.

Actionable evaluation and effective reporting

Health equity-oriented evaluations should be designed to understand what works, for whom, and under what conditions. They should also reveal whether health inequities have changed over time or remained the same. **Achieving this level of understanding can be challenging.** A good first step is to incorporate health equity activities, goals, and expected outcomes into a program or intiative's conceptual framework, or logic model (Figure 1). Doing so will help clarify the intended effects of the initiative or program on health equity outcomes.

Stakeholders should also think about how their findings will be applied. A utilization-focused evaluation approach is a principle that can be applied across multiple evaluation designs and helps stakeholders apply their evaluation findings in real-world settings. Applying this principle in the evaluation approach is important for ensuring the evaluation generates meaningful results, avoids collection of information that does not have a specific use, and respects the time constraints of participants. It also encourages stakeholders to disseminate insights from their evaluations in a manner that is easily understood and memorable for their target audience, which increases the likelihood that the findings are applied by different stakeholders.

[6] Harper, S., King, N.B., Meersman, S.C., Reichman, M.E., Breen, N., & Lynch, J. (2010). Implicit Value Judgments in the Measurement of Health Inequalities. Milbank Quarterly, 88(1), 4–29. https://doi.org/10.1111/j.1468-0009.2010.00587.

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Remove Barriers to Data Sharing

Appropriately addressing SDoH requires removing barriers to data sharing across the systems with which individuals interact regularly—education, healthcare, and transportation to name a few. The health, social needs, and situations of the clients served by healthcare and community organizations continuously change. As those clients move across sectors and through referral pathways, their changing situations should be accurately reflected wherever and whenever an individual accesses social care. They should also receive person-centered and trauma-informed care that eliminates the need to recount traumatic experiences each time they access services. To do this, health and social care providers need a way to ensure that they can effectively manage the care journey of an individual across historically siloed systems of record.

Unite Us has developed its platform to address the challenge that health and social care providers face when managing an individual's care journey. The Unite Us Platform utilizes a single, unified record for each client that enables secure, longitudinal tracking of and visibility into a client's journey across the different systems of record used by health and social service providers. It positions stakeholders to understand the relationship between access to services and health outcomes, and to use this information to better serve individuals. Ultimately, this enables significant advancement and scaling of systems of care.

There are also several regulatory and policy opportunities to accelerate data sharing across sectors and systems. Recent changes proposed to the HIPAA Privacy Rule by the Department of Health and Human Services' (HHS) Office of Civil Rights (OCR) would represent a step forward in enabling information sharing between health and social care providers, which is essential to positively impacting care delivery. In addition, policymakers can advance federal policies that promote shared data standards across federal agencies and sectors, support interagency efforts to reduce variability in data collection, and develop consensus-based data standards related to social determinants data. **Collectively, these efforts strengthen the infrastructure and standards that currently fail individuals who are most in need of cross-sector support.**

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Use Data to Drive Action

Actionable insights can readily be distilled from SDoH analytics to target critical community needs and address disparities. For example, Unite Us data show that since the onset of the pandemic, emergency food and rent/mortgage payment assistance have been the top two requested service needs. In particular, these two service needs account for a larger percentage of total service episodes for Black/African American and Hispanic/Latino people than their White counterparts, suggesting potential varied levels of need for services across these different racial and ethnic groups.

| Race/Ethnicity	Emergency Food (Percent of Total Service Episodes)	Rent/Mortgage (Percent of Total Service Episodes)
Black/African American	20%	14%
Hispanic/Latino	15%	9%
White	9%	8%

The complexity and persistence of health disparities requires an approach grounded in public and political will for change, combined with cross-system collaboration. Across sectors, stakeholders should consider how enhanced technology and data infrastructure can help advance health-related policies. In doing so, stakeholders can strive to meet community members' social needs and develop policies that redistribute resources equitably to prevent those needs from occuring in the first place. **On the following page are key areas in which stakeholders can support the creation of health-related policies and more equitable communities.**

Policymakers must use more robust data to guide equitable investments in public health and healthcare infrastructure. They should advocate for and use data to: 1) Inform legislative and budgeting decisions; and 2) Bring health into healthcare.

Inform legislative and budgeting decisions: As local, state, and federal officials look to address upstream costs in their legislative and budgeting efforts, they will need data to inform where investments should be made first, and how to monitor and evaluate the impact of those investments. This applies to both emergency funding decisions, like the CARES Act Provider Relief Fund and the American Rescue Plan to help local governments and communities respond to the COVID-19 pandemic, as well as more predictable government budgeting cycles. To do this effectively, it will be important to use data-informed approaches that identify top social needs and capacity to deliver services (e.g. housing, food distribution, etc.) at a localized level. These data are already more robust and available than in the past and can be applied to guide and support policy decisions. Yet opportunities still exist for policy makers to pass legislation that create standards across the collection, recording, and reporting of sociodemographic data, which would enable policymakers to better understand inequities across different constituencies, and drive investments where they are most needed. **Leveraging existing data through technology partners like Unite Us, while also advocating for standards across these data, will improve the ability of communities to generate and use rich SDoH data through digital infrastructure.** In turn, this can inform legislation to direct resources and investments to communities that would benefit most, and position future statewide innovation opportunities, such as Medicaid Section 1115 waivers, to build off of an infrastructure of social care data that is already reliable and valid.
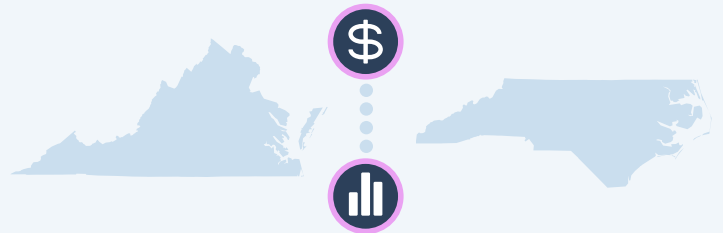
> States like Virginia and North Carolina have allocated initial funding to develop coordinated social care solutions that generate measurable, standard data, and which can inform the impact of future state government investments in social services.

Bring health into healthcare: The current healthcare payment and delivery mechanisms do not sufficiently incentivize healthcare organizations to address patients' non-clinical needs. Social care activities still count primarily against the administrative portion of a health plan's medical loss ratio calculation rather than the cost of services, and therefore disincentivize fully embedding social care strategies into business operations. For healthcare providers, reimbursement methodologies do not sufficiently account for social risk factors that patients may have, and therefore make it harder for providers to receive appropriate reimbursement for spending time on patients' non-clinical needs. Yet with health plans, providers, and community organizations increasingly using SDoH technologies, it is more possible to accurately assess social risk and incorporate it into reimbursement methodologies.

Government funding and policy decisions can accelerate progress in addressing social needs and advancing health equity. Potential actions include:

① Updating quality measures to incentivize or require efforts to address health disparities and inequities

② Allowing investments in SDoH infrastructure to count as a quality improvement activity when calculating medical loss ratios (MLR)

③ Permitting Medicaid managed care plans and Medicare Advantage plans to cover a broader array of social service interventions

④ Incorporating social risk into risk adjustments for Medicare and Medicaid

Community-based partners' data is often fragmented and limited. Community-based partners will benefit from the tools that thread together the data they collect and manage, and from support in driving the internal change management necessary for adopting new technology tools. This enhanced data infrastructure allows local organizations to improve operations, better serve their communities, and align local public and private resources to address marginalized populations.

Community-based organizations: Technology that accommodates many current CBO needs (e.g. screening forms, workflow changes, reporting capabilities, etc.) is available. As these technology solutions evolve to better meet the needs of communities, CBOs should embrace the innovation and choose solutions that provide tools to deliver person-centered care in an efficient and data-informed manner.

Foundations: A missing piece to cross-sector collaborations has been a lack of visibility into an individual's journey as they access services across the community. This solution is now available. As such, foundations have an opportunity to influence and promote the adoption of SDoH technologies to enhance the collective infrastructure for service delivery, tracking of outcomes, and distribution of grant-based funding.

Case study

Unite Us and Metro United Way provided a combined $1 million in funding to Greater Louisville, Kentucky to provide longer-term housing and wraparound support for those struggling with the continued effects of the pandemic. The funds supported housing-related costs to help Greater Louisville residents impacted both by the COVID-19 pandemic and persistent, historical inequities. The funds were distributed and tracked through community-based organizations (CBOs) in the United Community network using Unite Us Payments.

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Conclusion

Partnering with Unite Us to Advance Health Equity

Our mission is to connect health and social care. We understand that determinants of health and health disparities are mostly behavioral, social, and economic. **As the only end-to-end solution for addressing SDoH, we are uniquely positioned to be a partner in solutions that equitably improve the health of communities.** With our mission rooted in community capacity building, we've formed partnerships with a diverse range of stakeholders, including CBOs, health plans, health systems, hospitals, and government entities. Though each partnership is unique, the highest-performing ones share common characteristics. They proactively use data to deploy social needs services where inequities are the greatest. They use real-time data to drive continuous improvement of services. They invest additional resources into the community where gaps exist. Finally, they partner to evaluate the effectiveness of these interventions to inform future improvements to the partnership, and to advance practices in the industry as a whole.

Partnerships that share these characteristics are not an elusive vision for Unite Us. With our end-to-end capabilities and committed partners, we've been fortunate to institute these types of partnerships. We also understand that growing these partnerships will require Unite Us' continued commitment to implementing internal checkpoints that mitigate the risk of biases in network data or our other end-to-end solutions leading to unintended consequences.

Unite Us' end-to-end solutions

> **Identify needs:** We provide a dynamic, data-powered toolkit to proactively identify social needs.

> **Enroll in services:** Our networks provide a robust support system ensuring accountable care coordination.

> **Serve the individual:** Our community-wide infrastructure connecting healthcare and social services provides on-the-ground expertise and a flexible technology platform.

> **Measure network impact:** Real-time social care data analytics empower network efficiency and drive efficacy.

> **Invest in social care:** Our comprehensive solution enables social care funding at scale by paying for interventions that drive outcomes.

We work hard to build an infrastructure that offers the size and scale necessary to address the magnitude of the challenge, and accelerate and ultimately advance health equity. We look forward to continuing this work alongside industry partners and the individuals we collectively strive to serve.

To learn more about partnering with Unite Us, please visit our **solutions page.**

About the Authors

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She has nearly 20 years of experience in program evaluation, and social and behavioral health research working with local, state, and a number of federal government clients, including the Centers for Medicare & Medicaid Services (CMS); the Centers for Disease Control and Prevention (CDC); the National Institutes of Health (NIH); The Department of Labor (DoL); the U.S. Department of Defense (DoD); and the Veterans Health Administration (VHA).

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Prior to Unite Us, Marc served as the Director of Healthcare Integration at YMCA of the USA, where he led innovation models that integrated CBOs into healthcare payment and delivery systems and assisted local Ys across the country in advancing their local partnerships with healthcare provider and payor organizations. Marc has direct service and technical assistance experience in diabetes prevention and management, asthma management, smoking cessation, COPD, and falls prevention interventions.

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