April 2022

# Social Determinants of Health Data Issue Brief

BOLD GOAL
POPULATION HEALTH STRATEGY

This brief intends to increase knowledge and inform our stakeholders of opportunities to address social determinants of health, a core function of Humana's Bold Goal, Population Health Strategy. Our Bold Goal is dedicated to improving the health of the people and communities we serve by making it easier for everyone to achieve their best health.

Humana
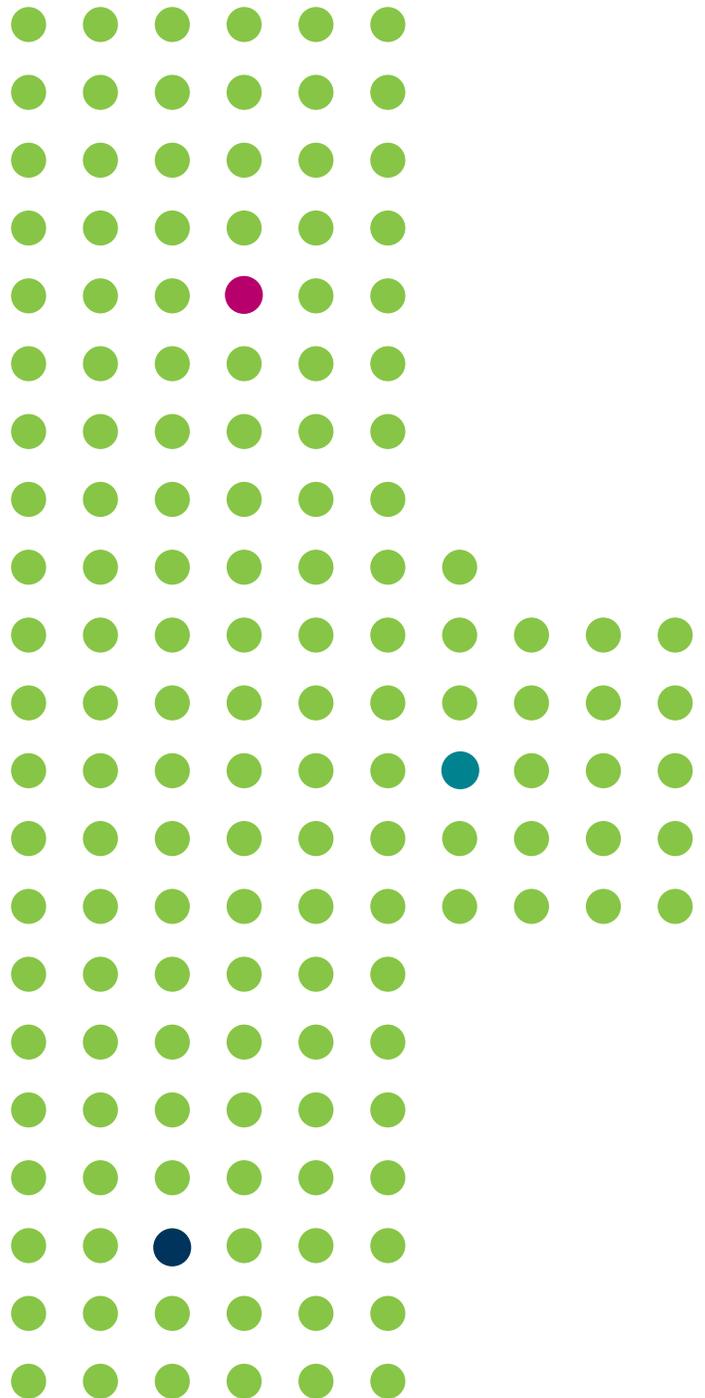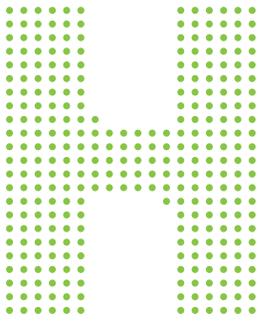
Introduction

In the wake of the coronavirus pandemic, questions about the role of social risk factors have shifted from "to what degree do they impact health?" to "how can the healthcare delivery system best identify and mitigate social risks?" This evolution has accelerated cross-sector collaboration in the drive toward enhanced social risk data generation, interoperability and analytics.

Humana's commitment to whole-person health has guided investments in an advanced data ecosystem to understand its beneficiaries' social needs and an infrastructure to facilitate personalized outreach and care. Humana has also been a vocal advocate and thought leader for improved social risk data collection and sharing and accounting for social risk in payment models and quality measurement.

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> **Given that social, economic, and environmental determinants explain substantial variance in health and health-related outcomes, more widely adopted and consistent documentation of them is needed to comprehensively identify non-medical factors affecting health and to track progress toward addressing them; doing so could aid in work toward achieving health equity and ensuring highest quality and best-value care for all beneficiaries**
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> Centers for Medicare and Medicaid Services (CMS)

The following brief will examine the types of social risk data available to healthcare providers and policymakers, efforts to operationalize this data and opportunities to facilitate greater integration.

By the Numbers

32%   **Of Humana's Medicare Advantage (MA) beneficiaries screened for health-related social needs (HSRNs) in 2021, an increase from 15% in 2019. The most prevalent HSRN is Financial Strain.**

1.59%   **Of Medicare Fee-For-Service (FFS) beneficiaries with "Z code" claims. The most common Z code claim is Z59.0, Homelessness.**
"Z codes" refer to International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) psychosocial risk and economic determinant-related code.

83%   **Of Family Physicians agree they should identify and help address patients' Social Determinants of Health (SDOH), according to a survey by the American Academy of Family Physicians. However, only 16% of physician practices report screening.**

Political and Regulatory Landscape

CMS | Promoting SDOH Data Collection
2023 Medicare Advantage and Part D Proposed Rule and Rate Notice

The Centers for Medicare and Medicaid Services (CMS) sees Medicare Advantage (MA) as a key lever in addressing health inequity and included a number of proposals in the 2023 Proposed Rule and Rate Notice to incentivize social needs screening and intervention. These include:

- Special Needs Plans (SNPs) to add standardized screening questions for food insecurity, housing stability and transportation barriers to Health Risk Assessments (HRAs). While it will not be required immediately, CMS made it clear that they are interested in having SNPs report these data to CMS to help policymakers "better understand the prevalence and trends in certain social risk factors across SNPs and further consider ways to support SNPs in promoting better outcomes for their enrollees," as well as facilitating better data exchange among SNPs.

- Proposing a potential new Star Ratings measure that assesses whether a contract's enrollees have had their health-related social needs (HRSNs) assessed using a standardized screening tool. Such measure would initially be introduced as a display measure. CMS also requests feedback on the National Committee for Quality Assurance (NCQA) proposed HEDIS measure for Social Need Screening and Intervention.

Humana applauds CMS's acknowledgment of the important influence of HRSNs on health outcomes and health-related quality of life and supports these and other steps taken by CMS to promote health equity. We agree that it is only by understanding an enrollee's physical, mental and social health status and risk factors that health plans can help them achieve optimal health. Humana is already screening for a number of social needs using standardized questions as part of our SNP HRA and other member health assessments in our commitment to whole-person healthcare.

Proposed New Measure for HEDIS® Measurement Year (MY) 2023
SOCIAL NEED SCREENING AND INTERVENTION (SNS-E)

The percentage of members who were screened, using pre-specified instruments, at least once during the measurement period for unmet food, housing and transportation needs and received a corresponding intervention if they screened positive.

Source: **National Committee for Quality Assurance (NCQA)**

With the expectation that screening data from different plans and care settings may be aggregated and that positive screening rates will ultimately be reported publically and used for comparison between plans, we support the requirement for standardized screening questions for HRSNs. In 2019, Humana conducted a study to test and compare two comprehensive assessments – the **Accountable Health Communities (AHC) HRSN Screening Tool** and the **Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)**. Using multi-channel outreach, we surveyed nationally representative matched samples of Humana's MA membership. On their face, the screening tools assess each HRSN in different ways, and consequently, they produce different positivity rates. While data interoperability standards are in development, these will not address the underlying variability in screening methods.

Measuring health-related social needs at a population level
PRESENTED AT ACADEMYHEALTH 2020 ANNUAL RESEARCH MEETING

HSRN Domain	AHC % Positive	PREPARE % Positive
Food Insecurity	20%	16%
Housing Insecurity	6%	5%
Transportation	8%	8%

Social Risk Adjustment

In the 2023 MA and Part D Rate Notice, CMS requests comments on if and how to make enhancements to the CMS-HCC risk adjustment model to address the impacts of social determinants of health (SDOH) on beneficiary health status. CMS asks for comments on what data they should focus on collecting more completely to provide more complete information when calibrating the risk adjustment model.

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> **Adopting methods that account for all factors that influence patients' risk, and those factors' interdependence, could help create a more equitable healthcare payment system that better serves patients, including the most disadvantaged members of society.**
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> Shantanu K. Agrawal, M.D., then-President and CEO of National Quality Forum, and
> William H. Shrank, M.D., M.S.H.S., Humana's Chief Medical Officer in The New England Journal of Medicine

Humana shares CMS's concern that the lack of social risk adjustment may exacerbate inequities and believes that adopting methods that account for all factors, including social risk factors, that influence enrollees' risk could help create a more equitable healthcare payment system that better serves patients. Several studies have shown how incorporating select individual-level social risk factors can improve the prediction of **utilization** and **costs.** Humana's internal analyses have reached similar conclusions. We have found that self-reported HRSNs are strongly and positively associated with spending when added to the current risk adjustment model. Consequently, researchers and policymakers, as well as Humana's **Chief Medical Officer,** have raised the possibility that individual-level social risk could be used for **more accurate MA risk adjustment.**

These findings point to the necessity of collecting standardized HRSN data from MA enrollees. **Humana has demonstrated our commitment to screening our members for their comprehensive needs to provide whole-person care.** However, we must be thoughtful in regards to the member and provider experience as we seek to expand HRSN data collection to avoid exacerbating both distrust in the healthcare system and clinician burnout. Standardization and interoperability of SDOH and HRSN data are key enablers. Humana looks forward to continuing working with CMS to address the important need.
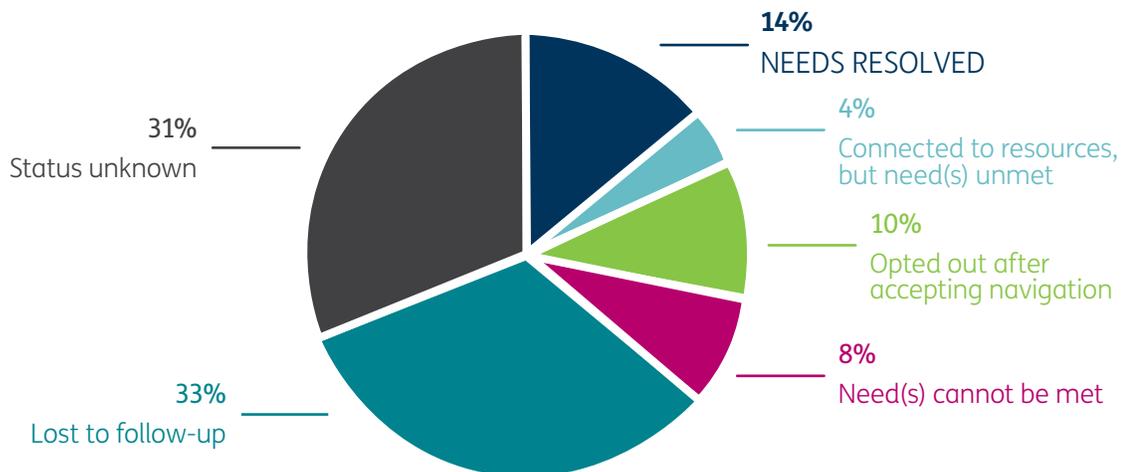
Accountable Health Communities Model

The Center for Medicare and Medicaid Innovation (CMMI) launched the **Accountable Health Communities (AHC) Model** in 2016 to test whether systematically identifying and addressing HRSNs of Medicare and Medicaid beneficiaries' through universal screening, referral and community navigation services will impact healthcare costs and reduce healthcare utilization. The participant performance period began in May 2017, and the **first evaluation report** was released in December 2020. Key findings of this report include:

- High acceptance of screening and navigation services (74%) by the targeted patient population.

- Food insecurity was the most commonly reported HSRN (median prevalence of 69%).

- Nearly one-third of beneficiaries reported having three or more needs, including 19% who reported all three of the most frequently reported needs - food, housing and transportation.

- Medicare Fee-For-Service (FFS) beneficiaries in the intervention group had 9% fewer emergency department (ED) visits than those in the control group in the first year after screening.

The report also reported that **only 14% of those patients who completed a full year of navigation had any HRSNs documented as resolved.** A number of factors were identified as contributing to the low documented resolution rates, including "difficulties with data reporting, loss of contact with beneficiaries, difficulty managing large caseloads, a lack of transportation to needed services and insufficient community resources."

HRSN Resolution Among AHC Beneficiaries with a Closed Navigation Case

14% NEEDS RESOLVED
4% Connected to resources, but need(s) unmet
10% Opted out after accepting navigation
8% Need(s) cannot be met
8% Need(s) cannot be met
33% Lost to follow-up
31% Status unknown

Source: **Accountable Health Communities Model - First Evaluation - At-A-Glance Report**

The Gravity Project | Accelerating National SDOH Data Standards

Humana is proud to sponsor the **Gravity Project,** a national, multi-sector collaborative that defines SDOH and HRSN information so it can be documented in and exchanged across disparate digital platforms. The Gravity Project is also an official HL7 FHIR Accelerator Project. After defining domains, terminology and data sets, the Technical Team develops and tests the health IT interoperability standards and implementation guide. These data standards will help reduce barriers to care coordination within and across health and social service providers.

Since it was launched in May 2019 by the Social Interventions Research and Evaluation Network **(SIREN)** with funding from the Robert Wood Johnson Foundation, the Gravity Project has already led to several advancements:

- Development of standardized data sets for 14 SDOH domains, including food insecurity, housing instability, inadequate housing, transportation insecurity and social connectedness.

- Inclusion of the **SDOH data class** to the **United States Core for Data Interoperability (USCD) V2** by the Office of the National Coordinator (ONC). This allows providers to systematically capture HRSN and SDOH patient information and provides health IT stakeholders clear direction toward its standardized electronic exchange.

- Approval of new and updated **ICD-10 CM codes** for education, food insecurity and housing for implementation beginning October 1, 2021.

- Publication of the first SDOH value sets in the National Library of Medicine's **Value Set Authority Center** (VSAC), making them available for implementation and reference for US quality measure development, such as the proposed Social Need Screening and Intervention HEDIS measure, and policymaking, such as federal grant programs.

- Submission of the first **HL7 SDOH Clinical Care FHIR Implementation Guide (IG)** for ballot. An updated IG is targeted for publication in June 2022.

- The Gravity Project Technical Team regularly participates in HL7 FHIR Connectathons and hosted an SDOH FHIR Track at the July 2021 CMS Connectathon.

In the future, the Gravity Project will work on additional domains such as health literacy, neighborhood safety and measures of discrimination and bias and begin pilots of the SDOH FHIR IG.

Resources from Humana to Support Physicians

Physician Guide to Address SDOH in Patients
This guide discusses the health impacts of SDOH, screening patients for SDOH and connecting them with resources for help, along with tracking and documenting patients' results in the electronic health record (EHR).

SDOH Provider Coding Guide
This guide helps physicians and other healthcare providers to document patient screening results using ICD-10-CM SDOH codes, or "z-codes" to track patient progress over time and communicate screening results to the patient's health plan.

State Policy | Data-Driven Medicaid Programs

Because of Medicaid's important role in serving people with complex physical, mental and social health needs, many states are driving innovation in SDOH data collection and utilization including in value-based payment models with providers and managed care organizations (MCOs). A study conducted by the **Center for Health Care Strategies** funded by the Commonwealth Fund found that states are collecting data, as well as requiring their MCOs to collect data, at both the population and individual levels for such purposes as informing:

- Member care plans and care coordination

- Program evaluation

- Provider quality improvement

- MCO population health management programs

- MCO risk adjustment models

- Rate-setting

- State investment in community resources

States Reporting SDOH Data-Related Policies Required in Medicaid Managed Care Contracts

(STATE FISCAL YEAR 2021)

State	Screen for HRSNs	Use of Standardized Screening Questions	Track Outcome of Social Service Referrals	Provider Use of Z Codes
United States	24 Yes	11 Yes	5 Yes	7 Yes
Arizona	Yes	No	No	Yes
Arkansas	Yes	No	Yes	Yes
California	No	No	No	No
Colorado	No	No	No	No
Delaware	NR	NR	NR	NR
District of Columbia	Yes	Yes	No	No
Florida	Yes	No	No	No
Georgia	No	No	No	No
Hawaii	Yes	No	No	Yes
Illinois	Yes	No	No	No
Indiana	Yes	Yes	No	No
Iowa	Yes	Yes	No	No
Kansas	Yes	Yes	No	No
Kentucky	Yes	No	No	No
Louisana	Yes	No	Yes	No
Maryland	No	No	No	No
Massachusetts	Yes	No	No	No
Michigan	Yes	No	Yes	Yes
Minnesota	NR	NR	NR	NR
Mississippi	No	No	No	No
Missouri	No	No	No	No
Nebraska	Yes	No	No	No

State	Screen for HRSNs	Use of Standardized Screening Questions	Track Outcome of Social Service Referrals	Provider Use of Z Codes
Nevada	Yes	No	No	No
New Hampshire	Yes	Yes	No	No
New Jersey	Yes	Yes	No	No
New Mexico	NR	NR	NR	NR
New York	No	No	No	No
North Carolina	No	No	No	No
North Dakota	No	No	No	No
Ohio	Yes	Yes	No	No
Oregon	Yes	No	No	No
Pennsylvania	Yes	Yes	Yes	Yes
Rhode Island	NR	NR	NR	NR
South Carolina	No	No	No	No
Tennessee	Yes	No	Yes	Yes
Texas	Yes	No	No	Yes
Utah	No	No	No	No
Virginia	Yes	Yes	No	No
Washington	Yes	Yes	No	No
West Virginia	Yes	Yes	No	No
Wisconsin	No	No	No	No

Source: **Kaiser Family Foundation Survey** of Medicaid Officials in 50 states and DC conducted by Health Management Associates, October 2021.

Notes: Only states with Medicaid Managed Care were surveyed. Four states (DE, MN, NM, and RI) did not provide survey responses to the 2021 survey and therefore are reported as No Response ("NR").

Social Risk Adjustment in Massachusetts

Massachusetts incorporates SDOH and HRSN data into payment and quality programs to direct additional funding to address the needs of the most vulnerable. The state incorporates a "neighborhood stress" measure into its model for making **risk-adjusted global capitated payments** to Medicaid MCOs. The Neighborhood Stress Score (NSS7) is a composite measure of economic stress encompassing seven Census variables, including income, employment, education and transportation. The payment **model** also includes individual factors of unstable housing (three or more addresses within a year) and homelessness (by ICD-10 CM code).

MassHealth also has a federal 1115 waiver to implement its **Delivery System Reform Incentive Payment (DSRIP) program,** which will support the state's transition to Accountable Care Organizations (ACOs). ACOs are networks of primary care providers who are financially responsible for healthcare costs and outcomes of a member population, including identifying innovative ways to address HRSNs by integrating community-based social services into healthcare delivery. The DSRIP program also includes a Flexible Services Program to help ACOs pay for health-related nutrition and housing supports for members.

Massachusetts has also established an **HRSN Screening quality measure** for its Medicaid ACOs. The measure requires ACO-attributed members to be screened annually for four core domains (food, housing, transportation and utility) and at least one of the supplemental domains (employment/education, experience of violence and social supports). While the screening may be completed by any member of the ACO care team and may be completed over the phone, electronically, in-person, by mail or by other means, the results must be present in the member's health record and be readily accessible to the primary care provider. Other **states** such as North Carolina, Oregon and Rhode Island have also developed screening measures.

SDOH Data and Privacy

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule regulates the use and disclosure of Protected Health Information (PHI) by covered entities (generally, health plans, payers and healthcare providers). However, HIPAA, enacted in 1996, did not anticipate the digitization of healthcare, the subsequent explosion of health and SDOH data and analytics, and the incorporation of social health and services into care coordination, trends that the opiod crisis and coronavirus pandemic have accelerated.

The U.S. Department of Health and Human Services (HHS) Office of Civil Rights (OCR), charged with enforcing the Privacy Rule, has been considering how to potentially modify this and other rules to promote coordinated, value-based healthcare. (continued)
In response to a 2018 Request for Information (RFI), Humana highlighted our partnerships with community-based organizations (CBOs) to call on HHS to clarify and simplify regulations to facilitate care coordination, including via community referral platforms.

In 2021, HHS issued a **Proposed Rule** that would add a new subsection expressly permitting covered entities (i.e. health plans or providers) to disclose PHI to social services agencies, CBOs and other similar third parties that provide health-related services to individuals for individual-level care coordination and case management. In most cases, under the proposal, this could occur without express consent from the individual and without a Business Associate Agreement. A Final Rule is anticipated in 2022.

To inform healthcare and social service providers and policymakers, Executives for Health Innovation (formerly the eHealth Initiative) convened experts and released a document, **Guiding Principles for Ethical Use of Social Determinants of Health Data.**

The guide provides an ethical framework for the use of SDOH data in:
- Care coordination
- Recognizing risk through SDOH analytics
- Mapping community resources and identifying gaps
- Service and impact assessment
- Customizing health services and interventions

What Humana is doing

COLLECT

Collecting member- or patient-level HRSN data is the first step to intervening and providing social risk-informed care, as well as to measuring progress in addressing these needs. Humana collects and incorporates three types of HRSN data into our Enterprise Data Platform:

> **Screening Data** consists of self-reported HRSN information collected using validated assessment tools such as the **Accountable Health Communities (AHC) Health-Related Social Need Screening Tool** developed by the CMMI. Humana screens our members for HRSNs through health risk assessments, care management programs and other member interactions. We partner with health systems and clinicians to integrate HRSN screenings into their practice and share data with the health plan.

Health Affairs   **Health-Related Social Needs Among Older Adults Enrolled In Medicare Advantage**

What it means:
This research provides Medicare Advantage plans with actionable insights that will influence and drive member health and engagement. Humana has been ahead of this curve through it's Bold Goal strategy and associated actions with members and in communities. This research confirms we must:
- Continue to address unmet social needs (Our Bold Goal)
- Design benefits that help address unmet social needs
- Influence Point of Care through partnership with providers and enabling value-based care
- Prioritize within care coordination

> Humana can ensure members receive individualized care and benefits by screening for HRSNs using standardized and validated screening tools. For example, **Humana has partnered with Meals on Wheels to offer a Special Supplemental Benefit for the Chronically Ill (SSBCI) on select MA plans**. This benefit provides twice-daily meals for chronically ill or post-acute members who are also food insecure for thirteen weeks. Members are also screened for loneliness using the **UCLA Three-Item Loneliness Scale.** Individuals who screen positive are also eligible for a weekly Friendly Visitor service, where a Meals on Wheels volunteer spends time with them to provide social connection.

+ Financial Strain
+ Food Insecurity
+ Housing Insecurity
+ Loneliness
+ Transportation Barriers
———————————————
= SOCIAL RISK INDEX

Derived Data leverages advanced analytics, such as predictive modeling and natural language processing, to understand social risk at an individual level. Proprietary predictive models developed with machine learning identify members at risk of experiencing specific HRSNs. The Social Risk Index, an indicator of member social need burden that includes financial strain, food insecurity, housing insecurity, loneliness and transportation barriers, provides insight into the cumulative burden of HRSNs a member may be experiencing. We also employ natural language processing techniques with clinical notes and member interactions to identify HRSN risks.
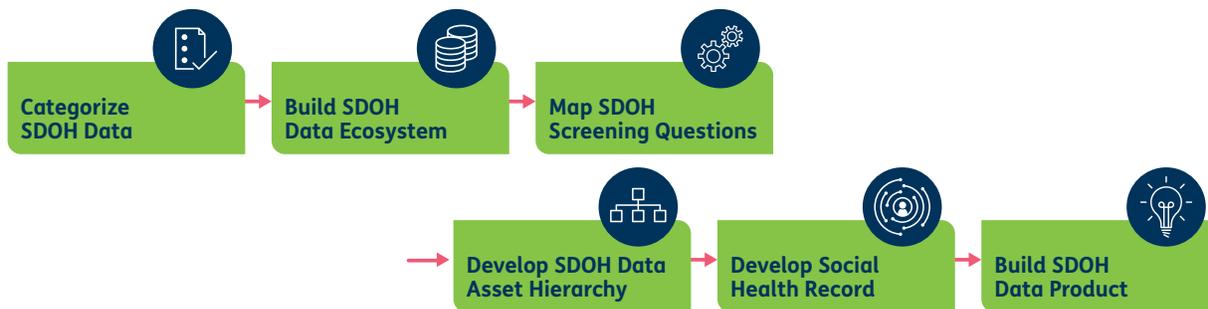
Inferred Data provides insight into SDOH, community-level factors that may be causing a member to experience HRSNs and poor health outcomes. Relevant data are collected by the U.S. Census Bureau, the Centers for Disease Control and Prevention (CDC) and other government institutions and integrated into Humana's data ecosystem. Humana uses individual indicators, as well as the **Social Vulnerability Index (SVI)** and an internally-developed **Neighborhood Stress Score (NSS),** to identify members and communities in need. Humana's NSS is a composite measure of economic stress that is based on the Massachusetts NSS7 and derived from eight Census variables.

By geocoding a member's address to a Census block group, we can assess social risk factors in their neighborhood. While we do not know for certain that an individual living in an under-resourced area is experiencing food insecurity, for example, we do know that they are at elevated risk of experiencing HRSNs. Screening a member or patient for HRSNs is still the best way to understand their individual social and economic barriers to health.

COMPILE

Individual HRSN and SDOH data elements are only actionable when standardized and put into context. Standardization is the process of making a uniform dataset, irrespective of its source of origin. Humana follows a six-step process to standardize HRSN and SDOH data elements. Then various tools are leveraged to enable whole-person healthcare and population health management, including assembling clinical and social health data in the **Longitudinal Human Record (LHR)** to show a holistic view of a member over time.

SDOH Data Standardization Process

Categorize SDOH Data → Build SDOH Data Ecosystem → Map SDOH Screening Questions → Develop SDOH Data Asset Hierarchy → Develop Social Health Record → Build SDOH Data Product

Powered by the Microsoft Azure cloud computing service, the LHR populates a variety of population health platforms utilized by all stakeholders in the care delivery ecosystem to empower point-of-care insights, care management and proactive interventions. For example, when **Humana partnered with Mom's Meals to evaluate the feasibility of providing a year-long, [medically tailored, home-delivered meals program](#) to food insecure individuals with diabetes,** the LHR made it possible to identify eligible members most likely to benefit from the intervention. Participants expressed a high degree of satisfaction with the program and experienced improved food security and health-related quality of life.
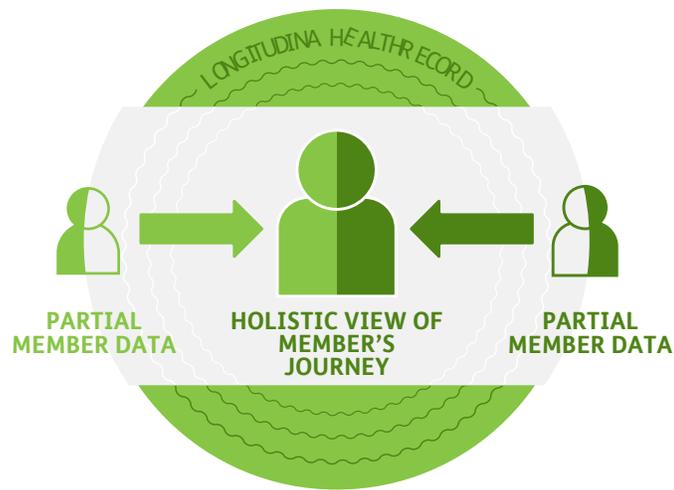
Humana's **Population Health Analytics Suite** is a suite of data, reporting and machine learning products built for population health analysis at Humana. It includes an innovative informatics tool that empowers "citizen data scientists" by combining more than 80 data sets to aggregate and stratify business, clinical, social needs and community metrics for Humana's membership. Its hot-spotting capabilities allow clinical and population health teams to identify opportunities to improve health at a hyper-local level. Population Health Analytics Suite is also where Humana monitors the extent to which we are screening members for HRSNs. We strive to assess member social needs at least annually, particularly for our most vulnerable members.

SHARE

Incorporating social needs and risks into the member LHR enables point-of-care insights and coordination among a multidisciplinary care team. These data empower clinical and non-clinical providers to address member basic needs that create barriers to health while setting goals related to chronic condition management and preventative care. Social risk data may also be shared with primary care providers in value-based relationships with Humana to provide care insights.

Humana frequently connects members to community-based organizations (CBOs) to help address their HRSNs. CBOs can often act as extended care teams for socially vulnerable members. However, we want to ensure that we do not refer an individual to a CBO that may have moved, does not have capacity to meet the need, or is otherwise unable to serve the member. That is why Humana has invested in community referral platforms to create feedback loops between Humana care teams and CBOs. These networks exist to proactively identify and address social needs and risks with community members and consist of a range of social care providers, including non-profit and faith-based organizations, local governments, foundations and healthcare providers. They also:

- Identify patterns in community member needs and gaps in services
- Increase collaboration between organizations
- Reduce duplication of efforts
- Gather evidence for cross-sector collaboration

COMMUNITY RESOURCE REFERRAL POWERED BY Humana-findhelp

1 What Do You Need?
2 Identify Resources
3 Provide Referral
4 Making The Connection
5 Using The Service
6 Measure Impact

Humana-findhelp is a network of social programs across the United States and an online platform for finding and connecting to these resources. All programs listed are direct services that are free or reduced cost. **Findhelp** is an ideal partner social care platform because of its broad, national network, including a strategic partnership with United Way/211, and **integration** with Epic, Cerner and other electronic health record (EHR) services. For the past two years, KLAS Research, a healthcare IT evaluator who provides 'accurate, honest and impartial' analysis based on extensive reviews with healthcare users, has awarded findhelp the **Best in KLAS** designation for SDOH networks.

Humana-findhelp is integrated into Humana's internal network, allowing for collaboration between Humana teams and facilitating reporting and analytics. There is also a public version of **Humana-findhelp** for self-navigation or provider use. Local social health networks have also been built to meet specific community needs. In San Antonio, Humana and Signify Health have partnered with more than 70 organizations in the **Alamo Area Community Network (AACN)** to improve the health of individuals while strengthening community connections.

First Quality Measures Related to Food Insecurity

Humana partnered with the **National Quality Forum (NQF)** through the NQF Measure Incubator project to develop, test and refine the first healthcare **quality measures** related to food insecurity. At each phase of the review, multi-stakeholder feedback and measure testing information and results were incorporated, resulting in three fully specified and tested electronic clinical quality measures (eCQMs).

Screening for Food Insecurity:
The percentage of patients that have been screened for food insecurity

Appropriate Clinical Action After Screening:
Percentage of patients that screened positive for food insecurity (from the screening measure), where appropriate clinical action is taken

A Change in Severity of Food Insecurity:
Ratio of change in patient-reported food insecurity

An implementation guide - **Food Insecurity and Health: Overcoming Food Insecurity Through Healthcare-Based Interventions** - was published in 2020.

Humana Priorities to Pursue

Maintain and invest in Humana's SDOH and HRSN data ecoystem
As CMS, accrediting bodies, and state Medicaid agencies both incentivize and mandate HRSN screenings and interventions, Humana will need to maintain our ability to document and report these data. This will also require the use of standardized screening and intervention documentation as HRSN assessments are expanded to new use cases.

Support healthcare providers to effectively and efficiently integrate social needs care
New quality measures will likely require healthcare providers and hospitals to demonstrate that they are identifying and addressing the HRSNs of their patients. Humana can deepen our partnership with value-based care and CenterWell providers by leveraging our expertise and analytics resources to support the adoption of HRSN screening and referral to services.

Promote SDOH data interoperability
As the Gravity Project publishes and pilots SDOH Interoperability Guides, Humana can be an advocate by participating in testing and engaging our partners in piloting and adopting the standards. Humana will also continue to advocate for policies that facilitate interoperability in Washington, DC.

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