Freed Associates
CAHP seminar on data
Transcript

What are the latest health inequity challenges for health plans in complying with new data collection and reporting requirements? How can data analysis be improved to support health equity efforts?

These and other data-related questions were the focal points of "Health Equity and Quality Data: Going Beyond Regulatory Compliance," a panel discussion at a May 2023 seminar on data sharing and exchange hosted by the California Association of Health Plans (CAHP). **Shanti Wilson**, Vice President of Client Solutions for Freed, hosted guests **Genia Fick**, Vice President of Quality for Inland Empire Health Plan (Rancho Cucamonga, Calif.), and **Timshel Tarbet**, Vice President of Business Excellence and Diversity Strategy for SCAN Health Plan (Long Beach, Calif.). Below is a summary of how their health plans are tackling data practices overcome health inequity challenges.

Shanti: Many of our firm's clients are addressing how to collect and understand the unique differences among members and patients. As health equity focused regulation increases at the state and federal levels, and your organization works to comply, what are some of the challenges you're facing?

Timshel: We face a few things as we're trying to comply with the new (data collection) requirements, such as: How do we get this data? What is it? Where does it come from? What is our source of truth? There are so many different ways to pull in the data and we have to think about what the best single source of truth is.

All of this requires more communication with membership and providers. And it requires us to frankly, wrap our arms around our providers a little bit more, because sometimes they don't have the ability to capture and report out information we need.

Genia: With Medicare, we have the benefit of a lot more data, so I think we're in a place where we can actually assess what we have and where are the gaps. For example, we have race, ethnicity and language data that comes through for MediCal members. It's not 100% complete, but it is a good start.

We're just starting to figure out ways of capturing data from provider-reported sources. So, we're moving into a next step of ingesting and enriching our data with some non-standard sources that we haven't traditionally had (such as from Community Based Organizations).

Shanti: Looking beyond regulation, basic member data needed to improve health equity can be very difficult to obtain. How are you addressing data collection to really understand a 360-degree view of your members' health?

Genia: We're starting with educating our providers on Z codes; the diagnosis codes that they can capture and record in their billing systems when they screen for Social Determinants of Health (SDOH). We have started encouraging our providers to screen and then report any sort of identified concerns.

Providers have a lot of hesitancy to screen because they're concerned about what do if a member has a

need; what's the pathway for support? That's where I think the CalAIM program, with some of those community support services that are now live for MediCal health plans, is a nice pathway.

It's really been about educating our providers on those resources and reinforcing and reminding them of the pathways of where they can route members. We started with primary care, and included basic screening for social determinants of health in our incentive program as a performance quality measure.

Timshel: We have a program called "Independence at Home" where we're trying to keep seniors healthy and independent. Leveraging this program, we're able to determine what options we might have, from a SDOH standpoint, to help take care of our membership.

We work fairly closely with our providers, bringing them in quarterly to talk about how we might be able to partner with them. We also send out our provider services teams to providers that have more indicators on the SDOH level and try and bring those providers along.

Shanti: Some providers aren't trained to collect SDOH data, and some members are reluctant to share. What are some of the best practices in data collection you've seen from both a provider and member perspective?

Timshel: From a provider standpoint, one of the things we have spent a fair amount of time on is training them on how, and the why behind it. It's not just asking for this data or sharing this data, but also the why behind it. That gives them the knowledge to be able to connect with the members, and they can then share with the member why we're collecting this.

Genia: We've learned that partnering with quality professionals at the medical group level is a really powerful way to introduce these new screening processes into the provider workflow. Because a lot of our providers want to do the screenings but they just don't have mechanisms or the workflow defined. It isn't something that they can just start doing overnight, there are things to think through such as the mechanisms and the resources available for referring members when they have a need identified.

Shanti: Many of the health plan clients we work with pull data from disparate sources both internally and externally. And we work a lot with our clients on data governance to understand how to intake and analyze their data. Can you describe SCAN's data governance that's been put in place?

Timshel: We have a data governance council made up of a cross-functional team. We are really working to look at data from different areas and understand what it means. And then we start to figure out ways to address disparities and how to prioritize opportunities.

In aggregate, you can look at data, and it can look kind of good, but you have to start to slice it and compare it, and that's what we've done. We've started to look at it based on age, race, ethnicity, zip code and provider group. Do we see differences, what are the differences and how might we address them? And we did. We saw differences and instead of saying, "Hey, this is something that healthcare services and health equity should work on," we've actually made it an organizational goal.

Shanti: Once you have data, how are you analyzing the data to support impactful interventions to address inequities?

Timshel: As we look at our data, we have to get out of our own way. We all make assumptions on data, like, this group isn't going to get this because of that, right? I've seen it in our organization many times, and we push back and say, "What is the data telling us? What are we looking at here?"

There's probably going to be something else that you can find, as you segment and understand the data better, to be able to find other interventions that might help.

Genia: We want to always look at arch trends over time. So, when we look at the race, ethnicity, language for breakdown of our populations and our performance on these quality measures, we have started to track them over time.

For example, we saw in our data that our controlling high blood pressure measure was consistently showing us that our black population was having significantly lower rates than our overall population. We saw that repeating over multiple years, and so informed our health services teams to directly work with that sub-population. We defined a very specific care management intervention to educate partner providers, along with proper medication management to help reduce this disparity that we found.

Shanti: How is data informing your initiatives to address disparities?

Genia: It's about looking at the data and understanding where the opportunities are, such as perhaps we partner with providers differently, or maybe we want to incentivize providers in a different way.

It's important for us to think about the way data flows between plans and providers to inform action at the point of care. For example part of the challenge we've seen with IEHP is that a lot of our obstetrician contracts are set up to make it easy for OBs to get paid. But it gives us very little information on the progress throughout the journey of the pregnancy. The most basic challenge around data is just knowing that a member is pregnant, and then linking that information to their risks. If we see that there are other risk factors in place, it's about the timing of the information flowing.

Shanti: Across government and health plans and their approach to data, what is your advice to help break down barriers to work more cross-functionally? Because if we're not working together, we're not going to be able to really achieve the health equity we are looking to achieve.

Timshel: We need to not be afraid. We have this sense of fear. We don't want to say the wrong thing. We don't want to do the wrong thing. We don't want to offend anybody. We are trying to do the right thing ultimately, nothing is ever going to be perfect, but we try, I think that matters.

We need to trust each other. We need to know that we're not working against each other here. This system has done a great job of playing people off each other and playing the different ways we do health care off of each other. It would be so much more helpful if we all took a step back and said, "You know

what, let's work together because ultimately, we all care about people here and we care about people's health. We care about their outcomes, and that's really what we're working towards."