SDOH: What’s data got to do with it?

Health Care Provider Teams

AGENDA

10:00 – 10:25 a.m.
Presentation of Background and Purpose

10:30 – 11:30 a.m.
Break Out Rooms and Facilitated Discussion/Discovery/Feedback

11:30 – 12:00 a.m.
Regroup: Next Steps?

HOUSEKEEPING

This session, and each breakout room, is being recorded.

Please feel free to ask questions and make comments by unmuting or by using the chat function.

Please take a moment to type into the chat the main reason you are attending today.
MiHIN SDOH Program Team

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In Partnership With:
Workshop Purpose:

• A series of conversations to identify barriers to cross-sector care and data exchange that impacts
  • Community based organizations and social care providers
  • Healthcare organizations
  • Government entities

• A concentrated opportunity to provide feedback towards a statewide social care data exchange strategy
Michigan Health Information Network Shared Services (MiHIN) is a non-profit organization that provides technology and services to connect disparate sectors, our stakeholders, to securely share health information.

An unbiased data trustee, MiHIN does not provide health care services, produce health care data or compete in the marketplace.

Instead, we help convene to share vital health information to advance better care, better outcomes and lower costs.

Technology is a tool. Humans are the energy. Technology allows humans to connect, communicate, and collaborate.
Who is attending: Summary of attendees

AAA3C
ACL
Aetna Better Health of MI
Alcona Citizens for Health, Inc.
Alcona Health Center
Altarum
American Advantage Home Care, Inc.
AmeriCorps MI - Southeastern Michigan Health Association
Area Agencies on Aging Association of MI
Area Agency on Aging of Western Michigan
Ascension
Ascension Medical Group
Ascension Medical Group Genesys
Ascension Providence Medical Center South Lyon
Authority Health
Avalon Housing
Blue Cross Blue Shield of Michigan
Business Men & Women Social Club of Detroit
Cadillac Family Physicians
Cadillac Family Physicians PC
Center for Health & Research Transformation
Cherry Health
CHRT
CHTN/HFHS
Community Service
Community Development Corp
Complex Care - Michigan Medicine
Development Centers
District Health Department #10
East Jordan Family Health Center
Genesys PHO
Genesys PHO
GLPO
GMP Network
Great Lakes PO
Greater Flint Health Coalition
Greater Flint Health Coalition Inc.
Hastings Internal & Family Medicine
Health Project HUB
HealthShare Exchange
HealthWest
Henry Ford Allegiance Health
Henry Ford Health System
Henry Ford Health System
Henry Ford Macomb Faith Community Nursing Network
HFHS
Holland Hospital
Holland PHO
HOM
Homewatch
Hope Clinic
HVPA
Integrated Health Partners
Lake Huron PHO
Lakeshore Regional Entity
Lakewood Family Medicine
MCA
McLaren Physician Partners
MDHHS
MDHHS-MCPD QIPD
Medical Advantage
Medical Advantage Group
Medical Network One
MedNetOne
MedNetOne Health Solutions
Melissa Kirshner
Michigan Dept of Health and Human Services
Michigan Medicine
Michigan Medicine
Michigan Primary Care Association
Michigan Works!
MidMichigan Collaborative Care Organization
Mid-State Health Network
MIHIN
Molina Healthcare
Montcalm Care Network
Mott Children's Health Center
MPHI
MSHIELD
MSU
MSU HCI
MSU Health Care
MSU Institute for Health Policy
Muson Healthcare
MyMichigan Collaborative Care Organization
MyMichigan Health
National Council on Aging
National Interoperability Collaborative
NMHSI
Northern Michigan Care Partners
Northern Michigan Community Connections
Oakland Physician Network Services
Oakland Southfield Physicians
Olympia Medical
Olympia Medical LLC and Compliance Medical Services
TPA LLC
ONC
OPNS
Ortele LLC
Packard Health
Partners in Care
Portage Health Foundation
Professional Medical Corporation
Red Maple Resources, Inc.
Region IV Area Agency on Aging
Reliance PO of Michigan
SEMHIE
Senior Resources of West Michigan
Silver pine Medical Group
SJMH
Sparrow Health System
Spectrum Health
Spectrum Health Hospitals
St Mary’s PHO
St. Joe’s
St. Joseph Mercy Health System
St. Mary’s PHO
The Physician Alliance
What goes into your health?

Social determinants of health have tremendous affect on an individual’s health regardless of age, race, or ethnicity.

**Socioeconomic Factors**

- Education
- Job Status
- Family/Social Support
- Income
- Community Safety

**Physical Environment**

- 40%
- 10%

**Health Behaviors**

- Tobacco Use
- Diet & Exercise
- Alcohol Use
- Sexual Activity

**Health Care**

- 30%
- 20%

**SDOH Impact**

- **20 percent** of a person’s health and well-being is related to access to care and quality of services.
- The **physical environment**, **social determinants** and **behavioral factors** drive **80 percent** of health outcomes.

Environments in which people live, work, play that impact their health; Data of social care can help to identify important disparities that impact health and how to improve environments.

Social Determinants of Health:

- **Social Care Data**
  - Social Need Screenings
  - Social Care Outcomes

- **Social Care Data**
  - Social Care Goals
  - Social Intervention History
  - Social Problem Diagnosis
MiHIN’s Goals for the SDoH Program

To enable the collection and exchange of social data at the point of care
to support cross-sector care coordination and to provide comprehensive data for population health improvement

by developing and implementing content and exchange standards for
- Social needs screening
- Social problems (diagnoses)
- Social interventions
Social Data and Care in Michigan
2005-present

BCBSM Value Partnerships
PGIP  PCMH  PCMH+  OSC  PDCM  BH int  VB reimb  SDoH initiative

2005  2010  2015  2020

CMS Multipayer Advanced Primary Care
CMS CPC+ [>400]
CMS Michigan SIM Demo [5 CHIRs]
CMS Accountable Health Community
CMS Primary Care First [>40]

MDHHS – MiHIN
SDOH Collaboration
Health Equity funding
BCBSM CQI initiative

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Pandemic Impact
MiHIN’s Strategy to Support Cross-Sector Data Exchange

✔ Build on the foundation of a common care model to support cross-sector care coordination

✔ Work with the national Gravity Project to develop standards for social care data exchange

✔ Use MiHIN’s existing tools and services wherever possible

✔ Work with IT vendors willing to employ Gravity and MiHIN standards
Gravity Project: overall social care model

Conceptual Framework

GOAL: **data-level interoperability** by enabling electronic documentation and exchange of SDOH data among all relevant users of data.
Role of health care providers in social care

Conceptual Framework

Researchers
Social Services
Payers

Intervention

Screening
Diagnosis
Referral

Goals Setting

Digital App
Person (Patient)

Clinic System
Care Team


GOAL: data-level interoperability by enabling electronic documentation and exchange of SDOH data among all relevant users of data.
Role of social service providers (CBOs) in social care

Conceptual Framework

Social services: [screening] [referral] Diagnosis Interventions [Outcomes]

GOAL: data-level interoperability by enabling electronic documentation and exchange of SDOH data among all relevant users of data.

Value of social care data in population health

Conceptual Framework

Second-level users:
- Risk adjustment
- Benefits adjustment
- Resource allocation
- Effectiveness

GOAL: data-level interoperability by enabling electronic documentation and exchange of SDOH data among all relevant users of data.

Standardized language to support social care data exchange

Conceptual Framework

Social Service Navigation apps
- Community Hubs
  - Standards TBD – options include:
    - ICD-10-CM
    - CPT
    - LA-211 [AIRS] taxonomy
    - [SNOMED-CT]

Care Coordination apps
- Standards TBD
  - [SNOMED-CT]

Goals Setting

GOAL: data-level interoperability by enabling electronic documentation and exchange of SDOH data among all relevant users of data.

Cross-Sector Care in social care

Medical care sector:
• Screening
• Diagnosis
• some follow-up

Community sector:
• Problem ID
• Intervention
• Follow-up
• some screening

Screening → Diagnosis → Problem ID → Treatment → Intervention

Monitoring → Follow-up
Where are we now in Michigan?
Community Integrated Health Networks (CIHNs)

a model for cross-sector care partnerships

Source:

STRATEGIC FRAMEWORK FOR ACTION: State Opportunities to Integrate Services and Improve Outcomes for Older Adults and People with Disabilities

Administration for Community Living

June 2020
West Michigan Community Integrated Health Network

Current technology:
- Epic [3 health systems]
- findhelp
- Signify Health
- 211 resource directory
- TBD [Health Net]
- Healthify [? CBOs]

Governance:
- Still working out - Steering Committee includes 3 health systems, Health Net, UW/211, Public Health, Payors (through MiCCSI)

Funding:
- CMS – AHC [Health Net]
- MHEF planning grant
- CDC -Health Equity
Flint/Genesee County: 2016-
Greater Flint Health Coalition
3 health systems + CBO hublets
SDoH screening / CBO referral
eReferrals [Holon]

Northern MI: 2016-
Public Health/PO coalition
SDoH screening
Homegrown IT support

Jackson County: 2016-
Jackson Collaborative Network
Single health system + 211 + 37 CBOs
SDoH screening / CBO referral
Jackson Care Hub [RiverStar]
MiHIN tools/Epic exchange in place
140K screens, 40K referrals

Muskegon: 2016-2018?
CBO coalition
SDoH screening / Pathways
Minimal IT capacity

Kent County: 2019-
Health care - CBO coalition
3 health systems + Health Net (CBO)
Planning complex
+ Housing subnetwork [Signify] 2019
+ findhelp [2022?]

BCBSM and Priority Health: 2020-
SDoH screening incentive program
ICD-10-CM diagnosis incentive program

MDHHS: 2015-
Multiple Medicaid health plans
MiHealthLink
Medical-BH-social care coordination

BCBSM: 2021
Michigan Community Network [Healthify]

Washtenaw County: 2016-
WHI/CHRT coalition
2 health systems + CBO hublets
Pred / SDoH screen / CBO referral
Care Coord IT [PCE]
+ Wash Care Hub [RiverStar] 2020
+ findhelp [2022?]

SE Michigan: 2020-
DCCN - Care Hub [RiverStar]
+ United Way/211 – developing IT
+ telehealth, mobile, CHCs
+ city/county government
+ findhelp [2022?]
Facilitated Discussions:

1. Collection and sharing of social care data
2. Referring individuals in need. Workflow and process
3. Organizational capacity
Breakout Room Instructions

• PLEASE use this opportunity to BE HEARD and SPEAK UP
• 5 Facilitated Breakout Rooms
• Transferred Automatically
• If you have any problems with connectivity, please contact: Katy Lewis Katelyn.lewis@mihin.org or 734-626-4375
Questions:
1. Do you understand why there has been greater emphasis on screening for social care needs in your practice?
2. How has your practice implemented social care needs screening?
3. What value is there for you in working with social care problems?
4. Do you ever assign z-code diagnoses when you’re working with patients?
Questions:
1. How does collecting social care needs screening and follow up activities affect your practice workflow?
2. How do you refer people to other services in the community? What are the challenges in doing so?
3. When you work with referrals--Does your organization work with or receive referrals through other systems?
4. Are you submitting social needs screening data to MiHIN thorough the SDoH use case?
Organizational Capacity

Questions:
1. Have you thought about how you might be able to use your own social needs screening information to improve your organization?
2. Do you have the ability to work with the social care data that you collect?
3. Are there organizational capacity issues that keep you from being able to engage in more advanced data collection?
Summary and Next Steps:

Where does the work need to go next?

What is the next best step from your perspective?
Overview of ICD z-codes - with some examples

- Other problems related to housing and economic circumstances
  - Housing instability, housed
  - Housing instability, housed, with risk of homelessness
  - Housing instability, housed, homelessness in past 12 months
  - Housing instability, housed unspecified
  - Other problems related to housing and economic circumstances

Diagnosing social problems

• A YES answer to a screening question is NOT THE SAME as an active social problem

• Ask additional questions to clarify whether problem is active and whether patient wants assistance

• If no time to clarify, ask patient to return - or follow up after visit by portal/phone

• If problem is active – and if patient wants assistance - assign a diagnosis

• Use best ICD-10-CM code available

• THE NEXT STEP is just being worked out in many health care settings – REFERRAL or MANAGEMENT
SDOH Interactions & Workflow

Coordination Platform (CP) — Typically CPs are based on referral platforms such as UniteUs, Aunt Bertha, NowPow, 211 (this is not an exhaustive list)

Community Based Organizations (CBO) — Typically CBOs provide the services to address social risk and need (e.g. food pantry)

Both CPs and CBOs may provide a number of services that overlap and differ substantially by community.

Note: Where two FHIR APIs are shown, it is for drawing simplicity and not a technical requirement

Interaction with a patient or caregiver may require alternative methods if internet access is not available

Source: Gravity Project
Thank you!

The MiHIN SDOH Team
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