Use Case Summary

Use Case Name:	Social Determinants of Health
Sponsor:	Michigan Department of Health and Human Services
Date:	August 15, 2022

Executive Summary

The executive summary gives a description of the use case's importance while highlighting expected positive impact.

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. These conditions are impacted by the distribution of power and wealth.[1] As the quest to improve health outcomes, lower the cost of healthcare, and preserve the care teams that serve the population continues, organizations must factor in social and environmental conditions.

Traditionally however, the health and social care sectors have not shared data or aligned business models. A lack of standards or scalable methods to connect at-risk populations with available social service resources in communities exists due to differences in existing infrastructure, funding models and core differences in mission alignment. Despite these differences, most recognize the potential transformative value that sharing data between sectors of care for the purposes of social need identification and resolution may have on more than just health and social services. There is a need to create data sharing pathways to connect clinical and social health care for the purposes of direct care coordination efficiency and to provide policy and decision makers with quality data from which to determine where to spend scarce human and financial resources.

The SDOH use case is a first step in building the data sharing pathways between these disparate sectors of care. The use case intakes social related health needs screening data and will redistribute that data to legally eligible care team members. Data submitted through this use case will also be available in aggregate to participating organizations to support population health. The value of this use case comes from the ability to share this data with care teams across sectors of care.

[1] Healthy People. "Social Determinants of Health". (N.d.) https://health.gov/healthypeople/priority-areas/social-determinants-health

Purpose of Use Case: This use case begins documenting the social care process within healthcare with social needs screening data. Participating organizations screen patients in the healthcare setting for social need identification. This data is submitted to the Health Information Network (HIN), integrated with Active Care Relationship Services (ACRS)™ to allow for accurate person-care team relationships to be identified. This creates individual social need identifiers which can be shared among care team members, and for a holistic understanding of the individual receiving care. Access to this data allows care teams to assess and intervene as driven by the individual. Social needs screening data will pair with Interoperable Referral (IR) Use Case data to support a vendor agnostic cross sector data sharing pathway for social care.

Overview

This overview goes into more details about the use case.

Identifying and addressing SDOH needs has traditionally been a challenging and siloed process, making coordination of social and health care complicative, duplicative, and expensive; without clear metrics for quality improvement or payment. Individuals with numerous social related health needs may be cared for by multiple social support organizations. These organizations all may operate with different missions, funders, data needs, and processes. Creating connections with each organization individually creates an excessive administrative burden on care teams.

Healthcare is well supported with Information Technology (IT) infrastructure that provides tools for social need identification. Awareness of an individual's social needs allows healthcare team members the widest possible view of an individual from which to base the development of patient-centric medical treatment plans. Despite Community Based Organization's (CBOs) lack of infrastructure and challenges related to language, regulatory, consent, and financial considerations that differ from physical and behavioral health care teams, there is belief that coordination with healthcare holds transformational potential and is therefore willing to begin a partnership towards data sharing.

By implementing the SDOH use case, health and social care organizations gain access to social needs screening data distributed through the HIN. Using a Hub and Spoke model, organizations connect once to the HIN, which facilitates connections to all other participating organizations across sectors of care.

Social needs screening data is only a small piece of enabling effective solutions to address a person's social health needs. The screening process is a very healthcare-centric approach that is meant to be the first step in identifying an individual's social health need.

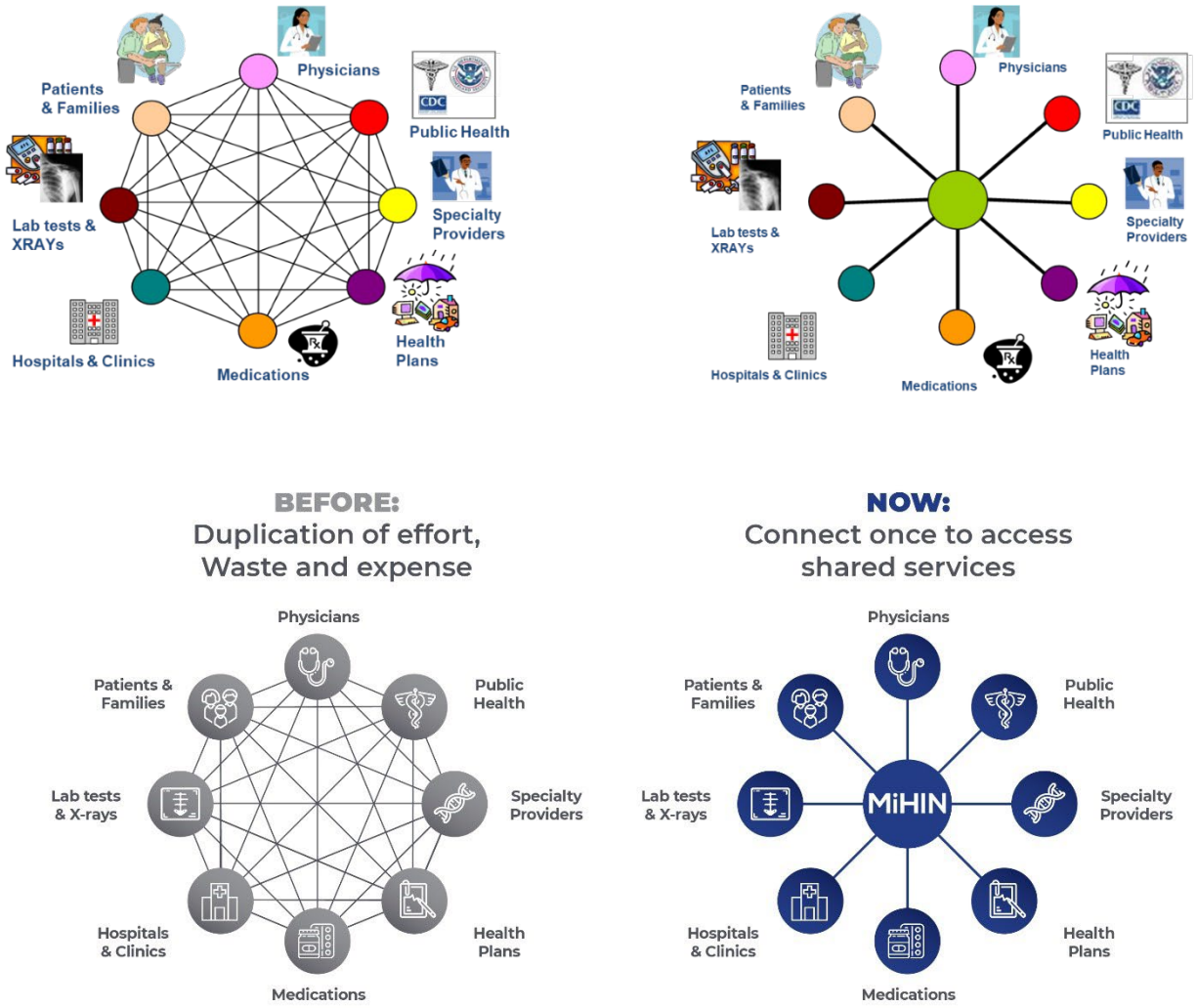

Figure 2. Hub and Spoke Data Sharing Approach

The SDOH use case, partnered with the Interoperable Referral use case, provides the following essential information to those delivering care:

- Health related social needs identified in the health care screening process can be made available to care team members across health and social services through legally permissible and standard data sharing agreements
- When and where the screening was performed
- If a referral was made to an organization to meet the health-related social need and the status of that referral

The SDOH use case will provide essential information to health care providers and CBOs in a timely and accessible manner. Each type of health-related social need, such as housing or food insecurity, is called a domain.

Persona Story

To explain this use case, this section follows a persona example from start to finish.

Hannah Gibson

Hannah and her husband had big dreams when they first married. Life was perfect when their third child arrived, she felt their family was finally complete. Their idyllic life came to a screeching halt when her husband died suddenly in a car accident. Hannah has had a hard time staying positive since she lost her husband, and every day feels like an uphill battle. They had never planned on what to do if something happened to one of them. While the pay-out from his life insurance helped support the family for a while, eventually it wasn't enough. Hanna had to take on a night job as a janitor to support her three children and still have time to spend with them. She relies heavily on her mother to watch the children since she is unable to afford professional child-care. Hannah is trying to stretch her paychecks, but it never seems like enough. Some weeks she needs to choose between buying food for her family and paying for her asthma medication. She knows that she needs to keep her asthma under control so that she can continue to work, but it's hard to prioritize medication when her landlord has told her that she'll be evicted if she misses another rent payment.

When Hannah lost her husband, she also lost a co-parent. She never imagined she would face life and raising their children alone. She feels guilty for not being able to spend more time with her children, and she wants to try to do something special. She's hoping to save enough money to be able to take a day off and go on a family camping trip, even though she knows that this dream probably won't happen for a while.

Joyce Smith

Joyce Smith got into healthcare to make a difference. Joyce's first job was as a social worker helping low-income residents of Grand Rapids. She did everything she could to help; counseling, paperwork and sometimes even helping with daily needs. When she began grocery shopping with some clients, even her supervisor felt she may have finally taken on too much.

Joyce liked working closely with her clients, but it also could be quite stressful; not because of her patients, but because of the healthcare system. Joyce saw first-hand the impact of healthcare's bureaucracy on her clients, from difficulties with prescriptions to insurance challenges to massive amounts of paperwork. After one too many times being frustrated by the system, Joyce became convinced that she could make an impact from the inside.

Now Joyce is a care coordinator for a managed care plan. She looks at each call she receives like one of her old clients, a frustrated individual who just wants a solution to a problem. When Hannah was referred to Joyce for assistance, Joyce was able to quickly identify Hannah's needs for housing and food assistance. This information was easy to find in MiHIN's MI Gateway and due to the data flowing through MiHIN's Interoperable Referral use case, she was also able to make a referral to local services that can support Hannah's needs

Diagram

This diagram shows the information flow for this use case.

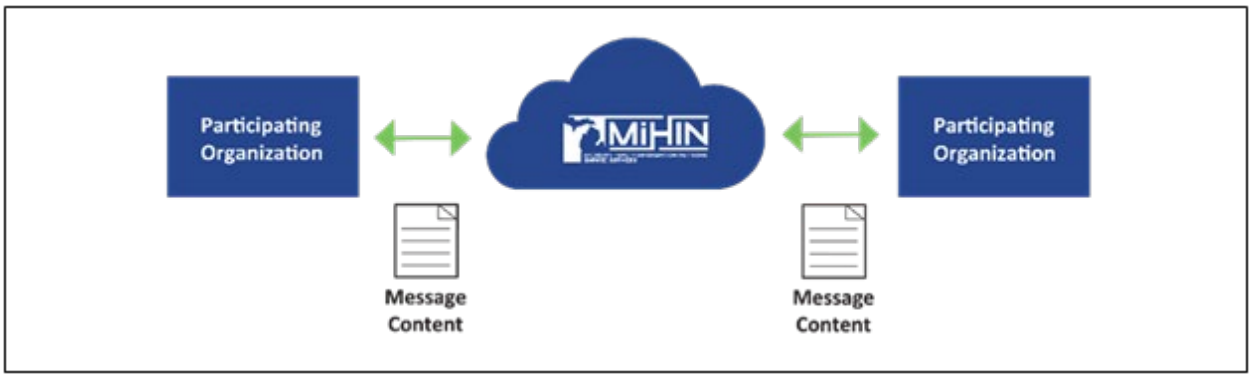

Figure 2. SDOH Use Case Data

1. The Participating Organization sends an SDOH file [social needs screening data] to the HIN.
2. The HIN receives the SDOH message [social needs screening data] and stores the data.
3. The HIN provides the SDOH data [social needs screening data] to Participating Organizations with an Active Care Relationship in one of two ways:
    a. Delivery of batch file for participating organization's population
    b. Through MIGateway

Regulation

This section describes whether this use case is being developed in response to a federal regulation, state legislation or state level administrative rule or directive.

Legislation/Administrative Rule/Directive:

☐ Yes
☒ No
☐ Unknown

Meaningful Use:

☒ Yes
☐ No
☐ Unknown

Cost and Revenue

This section provides an estimate of the investment of time and money needed or currently secured for this use case.

Costs

The project financially covers the following components:

- Extensive File review and data normalization and mapping
- Development and maintenance of the implementation and user guides
- Technical development and maintenance at MiHIN
- Training
- Participant development and implementation to onboard for this use case
- Implementation of both the screening and referral systems/workflow
- Development and delivery of file systems of the participating organization to deliver the data

Revenue

- Enhanced information of patient status via MiHIN services and tools
- MDHHS support for planning and development

Implementation Challenges

This section describes the challenges that may be faced to implement this use case.

Organizations participating in this use case require onboarding the following use cases: Active Care Relationship Service® (ACRS®), Common Key Service®(CKS) and Health Directory.

The implementation challenges associated with the Social Determinants of Health Use Case include the variation of screening domains and questions, mapping to standard and reportable data formats, proliferation of EMR, screening and referral vendor technologies and community collaboration and investment in the work of creating systems to support their work and clientele. Lack of standardization throughout the HIE (health information exchange) ecosystem as it pertains to the results of social needs screenings is also a challenge. While suggested data standards do exist, adoption of those standards is sporadic. The value of social needs screening data being brought into a clinical care team system has yet to be determined and needs to be investigated.

Vendor Community Preparedness

This section addresses the vendor community preparedness to readily participate in the implementation of this use case.

Social Care Referral vendors and Electronic Health Systems will need to be able to develop and implement a standardized file format for screening data, payload delivery, and updates in real-time as transactions.

Support Information

This section provides known information on this support for this use case.

Support can come from multiple levels (Governor, Federal or State Legislature, Michigan HIT Commission, Michigan State Departments, CMS/ONC/CDC, MiHIN Board, Participating Organizations, payer community, interest groups [e.g. MSMS, MHA], or citizen support).

Political Support:

☐ Governor
☐ Michigan Legislature
☐ Health Information Technology Commission
☒ Michigan Department of Health and Human Services or other State of Michigan department
☐ CMS/ONC
☐ CDC
☒ MiHIN Board

Other: Comprehensive Primary Care Plus (CPC+) track 2 requires collection of social, psychological and behavioral observations

Concerns/Oppositions:

None

Sponsor(s) of Use Case

This section lists the sponsor(s) of the use case.

- Michigan Department of Health and Human Services

Metrics of Use Case

This section defines the target metrics identified to track the success of the use case.

This use case will be measured by:

- Percentage of organizations sending SDOH information to MiHIN
- Percentage of organizations receiving SDOH information through MiHIN
- Percentage of organizations providing intervention data