THE Download

A monthly webinar diving into the intersection of healthcare and technology

MiHIN
MICHIGAN HEALTH INFORMATION NETWORK SHARED SERVICES

October 18, 2023

Michigan Health Information Network Shared Services (MiHIN)

MiHIN is **a non-profit organization** that provides technology and services to connect disparate sectors to securely, legally, technically and privately share health information.

An **unbiased data trustee**, MiHIN does not provide health care services or produce health care data.

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

44,582

Michigan care providers with Active Care Relationships® through MiHIN, working within

5,637

Michigan care entities

13.1M

Unique Patient Records

Federal Gov't
State Gov't
Health Department
Health Payers
Health Systems
PIHPs

Hospitals
Clinics
Practices
CMHs
Hospices
FQHCs
Pharmacies
Physician Orgs
Physician Hospital Orgs

Doctors
Nurses
Clinicians
Care Managers
Social Workers
Dentists
Pharmacists
CARE SEEKERS!

Social Determinants of Health (SDOH) Use Case V4.0: Evolution, Reasoning and Rollout

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Agenda

Review of Current State

- What data does the SDOH use case represent?
- Why does everyone talk about SDOH and why is this important to MiHIN
- Evolution of MiHIN's SDOH Use Case

Why are we moving to v4.0 and why now?

- National regulatory changes point towards standards
- Legal data sharing agreement changes
- Direction of the use case

Social Needs Screening (SDOH) Use Case v4.0:

- What changes are coming
- Review of the Timeline
- How does this impact submitting organizations
- What are the next steps

Discussion

Why Share Social Care data?

What's the purpose? Where is the value?

To improve the care of individuals:

- Care coordination
- As individuals move between care teams in health and social care sectors, data is available from which to understand the whole individual and their circumstance.

To assist payers and policy-makers:

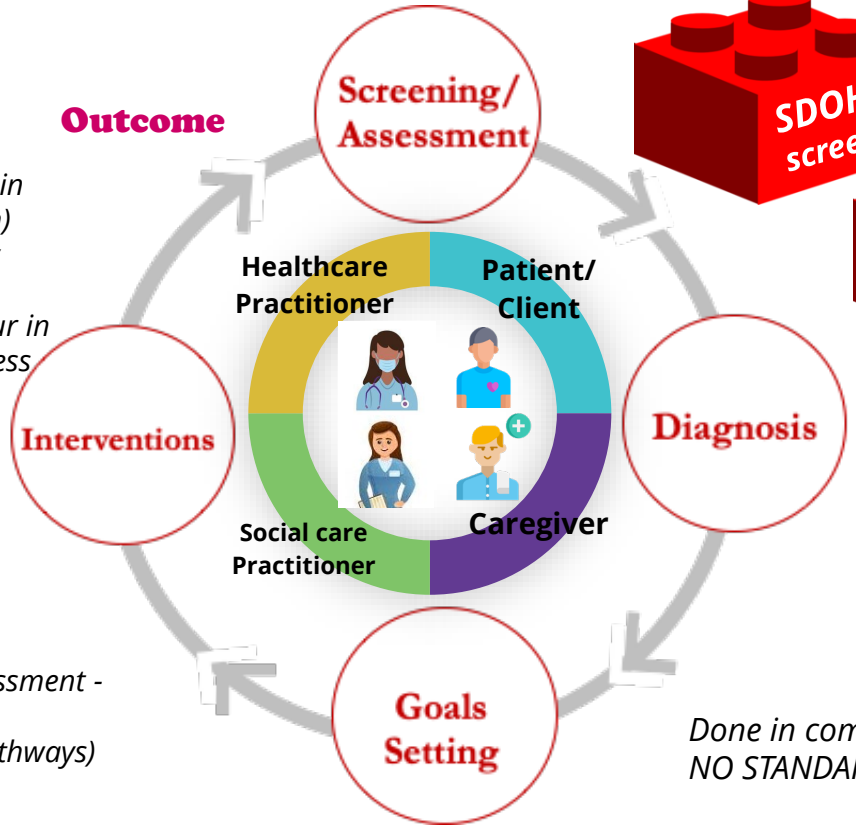
- The US spends more than any other developed country on healthcare
- Outcomes like infant mortality rates which rival 3rd world nations when stratified for socioeconomic status
- Health Equity is primarily impacted by the distribution of power, wealth and resources
- Decisions about where to spend scarce resources

MiHIN SDOH Use Case: What data does it represent?

- Social Determinants of Health is a broad subject
- The MiHIN SDOH use case moves Social Needs Screening data and identifies if an intervention is initiated
  - Aligns with HEDIS measures
- A foundation from which to build on other data sets/ use cases
  - Screening
  - Referral
  - Interventions
  - Outcomes

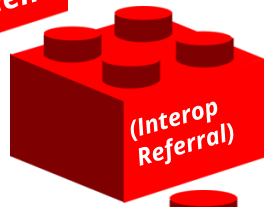
alignment with the gravity projects evolving data models which are evolving based on co-designed care models

Data exchange building blocks



Screening mostly done in health care
Assessment mostly done in community (CBOs)

Some general referrals sent from health care to community (ex: Jackson 211, AAA)



Health care: assigns ICD Z-codes
Community: multiple approaches

Some interventions carried out in health care setting (ex: dietician)
Most carried out by community (CBOs)
Multiple interventions may occur in sequence or in parallel to address one problem

Specific referrals sent after assessment - directed to individual CBO OR directed to 'narrow network' (Pathways) requesting intervention

Done in community as part of care plan
NO STANDARDS YET

Drivers of Cross Sector Data Movement:

- **Changed disease burden**
- **Quadruple Aim in Health Care:**
  - Increased health outcomes for patients
  - Lower costs of care
  - Increased satisfaction of patients
  - Increased satisfaction of care team
- **Payment model reform**
- **COVID**
- **Measurement drivers**
  - NCQA
  - Promoting Interoperability – Meaningful Use
- **Persistent health equity gaps**

Evolution of the MiHIN SDOH Use Case

- **First use case attempt started with the State Innovation Model (SIM)**
  - Homegrown Michigan screening tool – mandated
  - Many early adopters hard coded that tool into systems of record
  - Community Health Innovation Regions (CHIRs)
    - Community Clinical Linkages
    - Use data to move upstream

***Question**: How are health care organizations capturing SDOH data and what data elements are requested.*

Post SIM recognition that one size fits all tool not likely to be adopted

- No guidance by state or federal agencies
- Refined based on end user feedback to allow choices in screening questions while still capturing domain level data
- Attempting to move towards standardized and codified tools – little uptake

- **January 2023 – HEDIS SNS-e measures go into place**
  - Provides clear guidance on use of codified/ validated questions and answers
  - Social needs screening data generated in community creates a comparison to data generated only in healthcare settings; **Valuable data**

- **Summer 2023**
  - Consensus building to transition to codified/ validated questions/ answers.

Why are these changes important to make:

- **Michigan adopted this work early – before standards**
  - Standards are now available, we need to align
- **Post COVID – increased attention on health equity**
  - Significant opportunity to highlight the value that social care entities bring
  - Sustainability and resources to meet demand

If it is important to identify when individuals have unmet social care needs, then…

It is important to ensure the data coming from this work is useable, aggregable, machine readable and interoperable

Data From Healthcare and Community Sources

- Identifying social related health needs is **not just a healthcare activity**

- Some community sources of screening data exist
  - Community Information Exchanges (CIE's as a noun) are good examples
  - Community Health Innovation Regions

- Much screening happening, but only identifying the individuals that *eventually* cross paths with healthcare
  - What about those who are at highest risk but may abstain from healthcare until a problem exists; sicker individuals – treated in more costly spaces
  - Moving upstream through the community

- MiHIN is meeting community where they are
  - Simplified our legal data sharing agreements
  - 2 implementation Guides (Community and Healthcare)
  - Healthcare follows a full TPO pathway
  - Community treatment only with data moving up through the Health Equity project to CQI's
    - Community pilot to test the capacity to engage in data sharing agreements

Gravity Project: Where is MiHIN in the Gravity Project Tiered Evaluation?

Tier-Level Self-Assessment Tool Overview

- **Tier I**: Social risk data (including screening, diagnoses, goals, and interventions) is documented in a simple method designed to evaluate the structure and value of the data, as well as the impact that collecting information in this format will have when compared to legacy systems.
- **Tier II**: Gravity-vetted terminology and value sets are exchanged within established content and transport standards.
  - Includes HL7 CDA, HL7 V2, and Direct Transport.
- **Tier III**: Gravity-vetted terminology is exchanged using the HL7 SDOH Clinical Care FHIR Implementation Guide (IG).

Levels	Color Key
Planning - Not at Pilot Testing Level, but preparing	
Tier I - using Gravity-vetted terminology	
Tier II - exchanging Gravity-vetted terminology using any content and exchange standards	
Tier III - using Gravity-vetted terminology and exchanging via the SDOH CC IG	

Access the tool here: https://bit.ly/3ChPspl

- Moving into Tier 1
- LOINC code screening
- Screening intervention

MiHIN SDOH Use Case File Spec V4.0 Changes

- Refine fields to simplify and clarify data requirements which will make validation easier
- **Only allow codified/ validated and approved screening tools/ questions**
- Additional fields to increase matching capabilities
  - at least one of the following is required in addition to base 4 (first name, last name, DOB, sex)
    - Phone Number
    - SSN4
    - Address_1
    - *If it is important to collect, we **have** to be able to ensure identity match*
- Elimination of elements that were hold overs from SIM demonstration
- Elimination of z-codes

These align with HEDIS measurement standards.

Approved Screening Instruments (Documented via LOINC):

- Accountable Health Communities
- AAFP Social Needs Screening Tool
- Health Leads Screening Panel®1
- Hunger Vital Sign™
- PRAPARE
- Safe Environment for Every Kid (SEEK)
- We Care Survey • WellRx Questionnaire
- Housing Stability Vital Signs™
- Comprehensive Universal Behavior Screen (CUBS)
- PROMIS
- USDA Food Security Survey
- https://mihin.org/wp-content/uploads/2022/12/MIHIN-Slides.pdf (presentation by NCQA hosted by MiHIN 12/2022

As more domains are added it is expected that this list will grow and change

Codified and Validated Screening Tools: An example

The tool is codified

LOINC CODE	LONG COMMON NAME	LOINC STATUS
96777-8	Accountable health communities (AHC) health-related social needs screening (HRSN) tool	Active

Term Description

The Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool is designed to assess the the health-related social needs of Medicare and Medicaid beneficiaries, in an effort to determine impact on health care costs and health outcomes. Five specific domains are addressed: housing instability, food insecurity, transportation problems, utility help needs, and interpersonal safety.

Source: Regenstrief LOINC

Panel Hierarchy

Details for each LOINC in Panel | LHC-Forms

The individual questions are codified

LOINC	Name	R/O/C	Cardinality	Example UCUM Units
96777-8	Accountable health communities (AHC) health-related social needs screening (HRSN) tool			
71802-3	What is your living situation today?			
96778-6	Think about the place you live. Do you have problems with any of the following?		1..7	
88122-7	Within the past 12 months, you worried that your food would run out before you got money to buy more.			
88123-5	Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.			
93030-5	In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work			

Example **Continued**

Survey Question

Text	(I/We) worried whether (my/our) food would run out before (I/we) got money to buy more.
Source	U.S. Household Food Security Survey Module.HH2

Normative Answer List LL5890-0

Answer	Code	Score	Answer ID
Often true			LA28397-0
Sometimes true			LA6729-3
Never true			LA28398-8

The answers are codified

Member of these Panels

Key MiHIN SDOH Use Case Timeline Dates:

- **October 2023**:
  - Outward campaign to inform about v4.0
  - Increased coordination with Account Managers and the CSDS team
  - No additional onboardings to anything but v3.0 2022
- **January 2024:**
  - Finalized v4.0
- **July 2024:**
  - V4.0 starts to be accepted
  - Many organizations to transition to v4.0 **before December 15th 2024.**
- **January 2025:**
  - No other file specification will be accepted

How does this impact submitting organizations?

- Significant technical and human investment already – Change is hard
- MIHIN needs to be able to guide and minimize the work to understand what changes are needed
- Value based payments are dependent on this use case
- High priority

What are the next steps:

- **Bits and Bytes – October 30th, 11am – 12pm**
  - More specifics on technical rollout
  - Tools to assist in the transition
- **Start evaluating your screening questions now**
  - Are the questions you use from a validated tool already?
  - If questions are close to but not exact…switch to the validated version
  - Use Gravity tools to assist
  - Identify the codes
  - Map codes to questions – these can be submitted using v3.0 of the use case
  - Compare what you submit now to the DRAFT v4.0 spec

Questions and Discussion:

THANK YOU

LET'S CONNECT

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