Use Case Summary

Use Case Name:	Social Determinants of Health (Social Needs Screening)
Sponsor:	Michigan Department of Health and Human Services
Date:	July 29th, 2024

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] Each type of health-related social need, such as housing or food insecurity, is called a domain. 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.

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 [Social Needs Screening] Use Case is a first step in building that data sharing pathway 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. The data holds value in direct care coordination to ensure care teams see the individual's full health picture when developing care plans. Data submitted through this use case will also be available 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 and begin the process of understanding more completely how those sectors will work together.

[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 to identify social needs. 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 with those with the legal right to access this data in a timely and accessible manner. 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 to coordinate and intervene as driven by the individual.

Overview

This overview goes into more details about the use case.

Identifying and addressing SDOH needs has traditionally been challenging and siloed, making coordination between health and social 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 that don't have communication pathways to other care teams. These organizations all may operate with different missions, technology platforms, funders, data needs, and processes. Creating connections with each organization individually creates an excessive administrative burden on care teams.

Screening data is the beginning data set to enable effective solutions that address a person's health related social needs but does not represent a solution in itself. It is a first step in building that data sharing pathway between these disparate sectors of care.

By implementing the SDOH [Social Needs Screening] use case, healthcare providers and payers 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. Additionally, the aggregation of screening data can support policy and program administrators' to better understand the prevalence of needs in communities. When changes are then applied, understanding if that change is having a positive, negative or neutral effect can allow change to happen in a control and directed way.

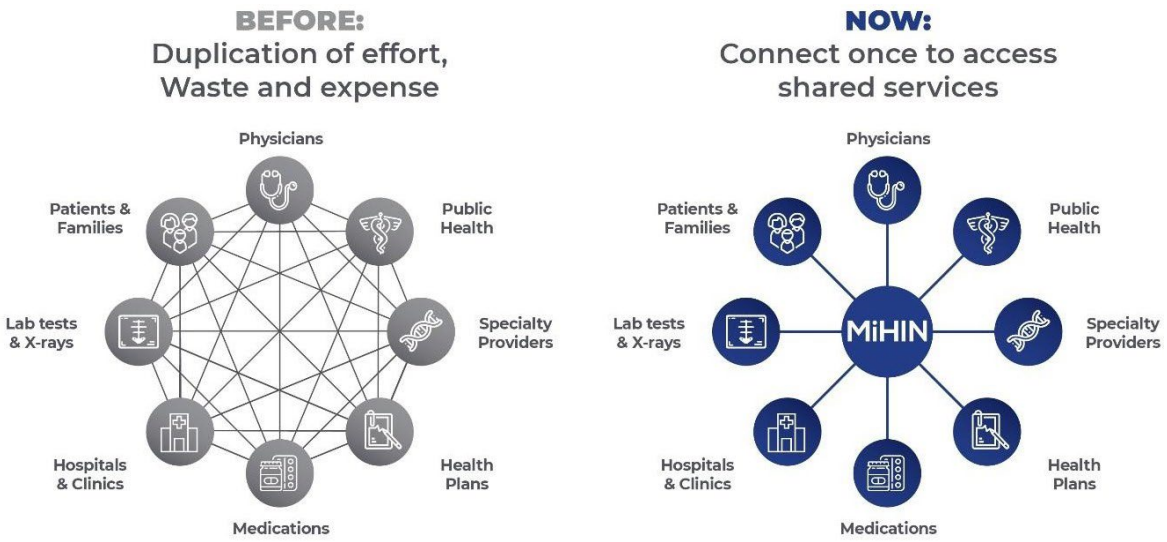

Figure 1 Hub and Spoke Data Sharing Approach

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 identify Hannah's needs for housing and food assistance.

Diagram

This diagram shows the information flow for this use case.

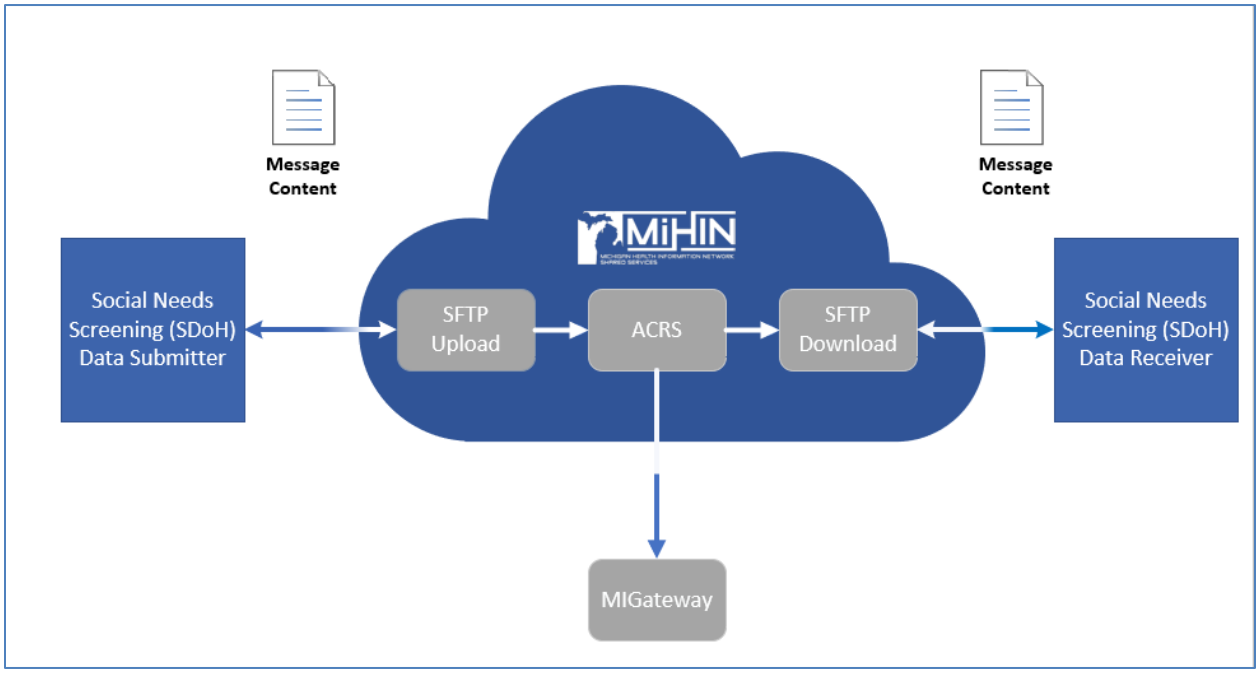

Figure 2. Data flow to send and receive Social Needs Screening Data

1. The Organization submitting the social needs screening (SDOH) data sends a .CSV file to MiHIN via Secure File Transfer Protocol (SFTP). **Note:** Data submitters may also receive data and vice versa.
2. MiHIN validates the file and triggers an email to the submitter detailing rows with errors.
3. MiHIN stores the data in the HIE SDOH Sender Database
4. MiHIN filters the patient social needs screening (SDOH) data through ACRS and creates a list of ACRS populations that list the patient.
5. MiHIN sends an SDOH .csv file to organizations with at least 1 matching patient in their ACRS population

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 the screening 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.

- ACRS Use Case
- Health Directory
- Common Key Service Use Case

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 technologies. 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