THE Download

A monthly webinar diving into the intersection of healthcare and technology

MiHIN
MICHIGAN HEALTH INFORMATION NETWORK SHARED SERVICES

November 25, 2024

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** with the goals of:

- Better quality of care & health outcomes
- Optimized healthcare ecosystem with lower costs
- **Patient centered** personalized care

Shared Digital Infrastructure

Macro

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

Definition: Infrastructure refers to the foundational systems, frameworks, and technologies that enable tools to function effectively.

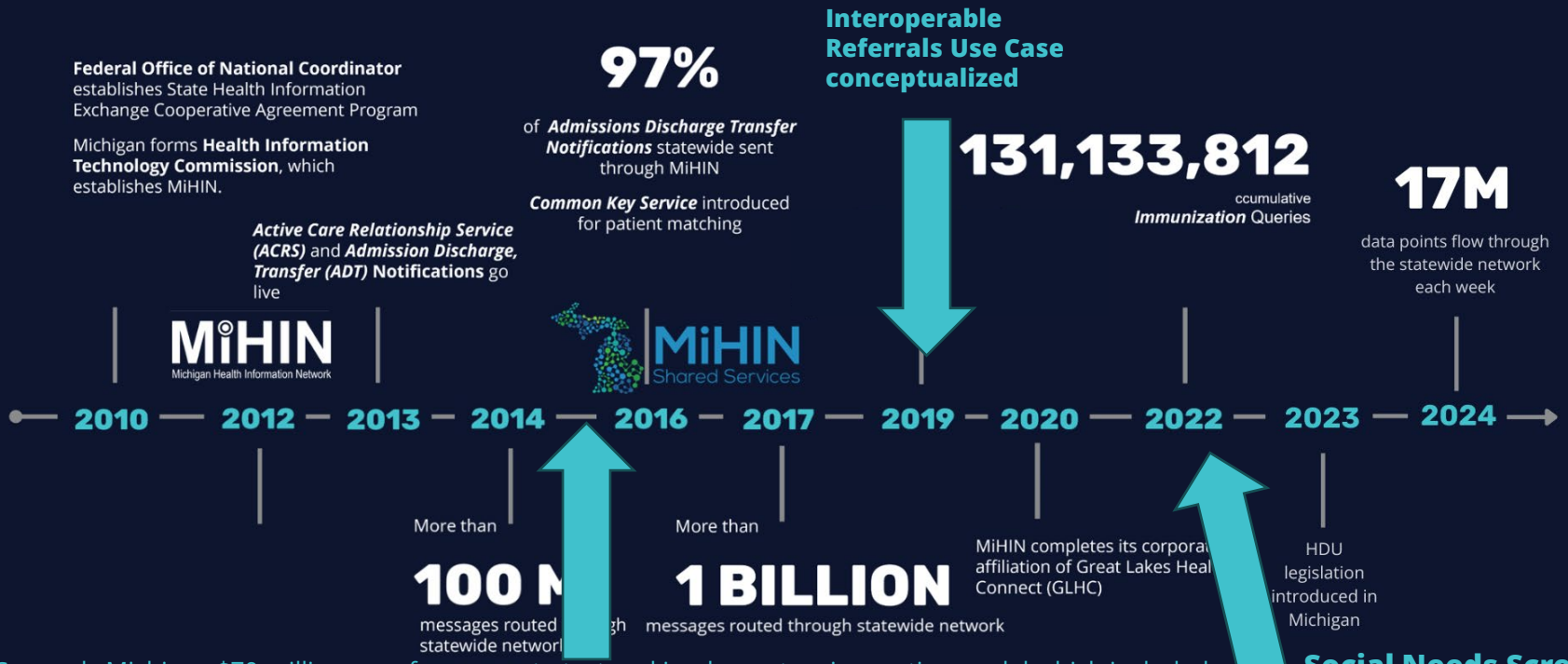
Meso

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

Micro

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

Brief History: Michigan Health Information Network Shared Services



CMS awards Michigan $70 million over four years to test and implement an innovative model which included **Community Health** Innovation Regions intended **to build community capacity** to drive improvements in population health.

Paving the Road to Health Equity, CDC, June 2024

Drivers	UPSTREAM	MIDSTREAM	DOWNSTREAM
	Social Determinants of Health	Social Risk	Health-Related Social Needs
What is this driver?	SDOH includes broad policies and systems at all levels that influence where people grow, live, work, and age.	Social risk includes living conditions and specific adverse scenarios that affect health.	Social needs includes individual situations and needs that affect one's ability to maintain health.
What factors influence it?	Macro-level conditions like racism, discrimination, environment, public policy and laws.	Specific risk factors like social isolation, healthcare access, economic opportunities, education level, area violence, food insecurity.	Individual factors like income, disability, ability to afford medications, access to transportation, family support or caregiver, personal behaviors like nutrition, physical activity, or smoking.
Where is the focus for action?	Public health programs, federal and state funding initiatives, legislative policies, advocacy and support for critical programs and regulations, wide-scale education and programs, including anti-racism policies.	Regional or local programs that address housing access, neighborhood safety, transportation access, including food banks, employment training, income stability, and grants to improve living conditions.	Individual and family-focused interventions and support focused on increasing stability, referrals to non-profits, and individualized risk programs.

MiHIN & Socially Determined

November 2024

63 minutes as a patient, 525 thousand as a person

63

Minutes per year seen by a provider

525,537

Minutes per year outside of a provider's care

There is so much more that influences patient outcomes than understanding the disease someone has or where they have gone for care. Leveraging SDOH data helps organizations understand the full healthcare equation for their members and quantifies and informs the path to an optimized healthcare journey.

Pervasive Challenges, Profound Impacts

45%
of US households have faced serious **financial problems**[1]

20%
of households reported being **housing insecure** during the pandemic[3]

36%
of Americans have **low health literacy** skills[5]

79%
of older adults are **using technology** to communicate with friends once a week or more[6]

NEARLY **25%**
of U.S. adults over 65 are considered **socially isolated**[7]


FINANCES


FOOD


HOUSING


TRANSPORTATION


HEALTH LITERACY


DIGITAL


SOCIAL CONNECTEDNESS

NEARLY **1 in 4**
U.S. households have experienced **food insecurity**[2]

45%
of Americans have no access to **public transportation**[4]

Patients with at least one social barrier are:

- **3.5x** more likely to have osteoporosis[8]
- **2.6x** more likely to be hospitalized[9]
- **2.0x** more likely report poor glycemic control[10]
- **4.2x** more likely to be unable to get medications on time[11]

Socially Determined partners with healthcare organizations to provide social risk insights so they can better understand the health-related social needs (HRSN) of their populations.

These insights enable them to make better community investments, identify strategic vendor and community partners, and provide proactive outreach to members that need it most.

COMMUNITY
SDOH
EXPOSURE

- Economic Climate
- Food Landscape
- Housing Environment
- Transportation Network
- Health Literacy
- Digital Landscape
- Social Connectedness

SDOH & Social Risk Domains

INDIVIDUAL
SOCIAL RISK
FACTORS

- Financial Strain
- Food Insecurity
- Housing Instability
- Transportation Barriers
- Health Literacy Challenges

ACCREDITATIONS

HIPAA COMPLIANT

HITRUST CSF Certified

How do we it...

We combine our social risk analytics with your data to provide you with a complete view of your membership and their environment

Raw Data Sources & Elements

- Fed, State & Local Open Data
- Commercial Business Data
- Commercial Consumer Data
- Alternative Risk Data

- Age
- Race
- Gender
- Education
- Income
- Profession
- Food options
- Car ownership
- Transit access
- Housing costs
- Housing crowding
- Address history
- Liens
- Bankruptcies
- Hundreds more...

Clinical Data

Claims Data

Curated Social Risk Analytics

Community SDOH risk exposure

- Economic Climate
- Food Landscape
- Housing Environment
- Transportation Network
- Health Literacy
- Digital Landscape
- Social Connectedness

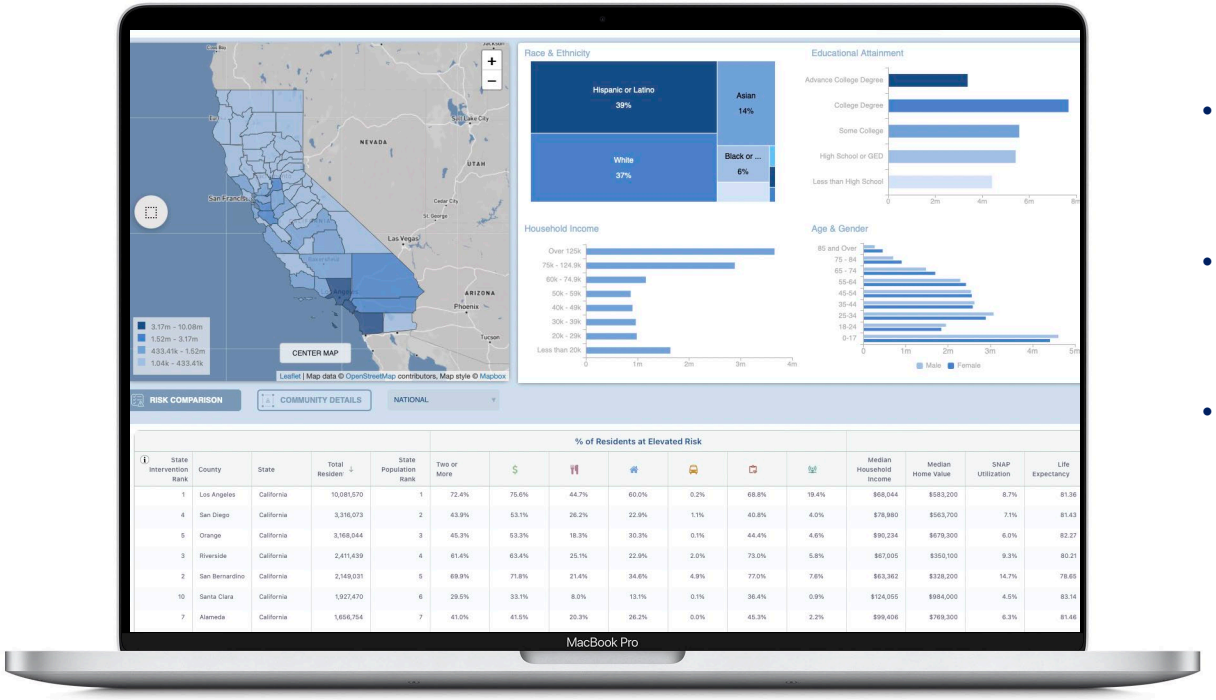
Individual social risk factors

- Financial Strain
- Food Insecurity
- Housing Instability
- Transportation Barriers
- Health Literacy Challenges

Secure Cloud Infrastructure – HIPAA Compliant – HITRUST Certified

Our approach

View your communities with clarity

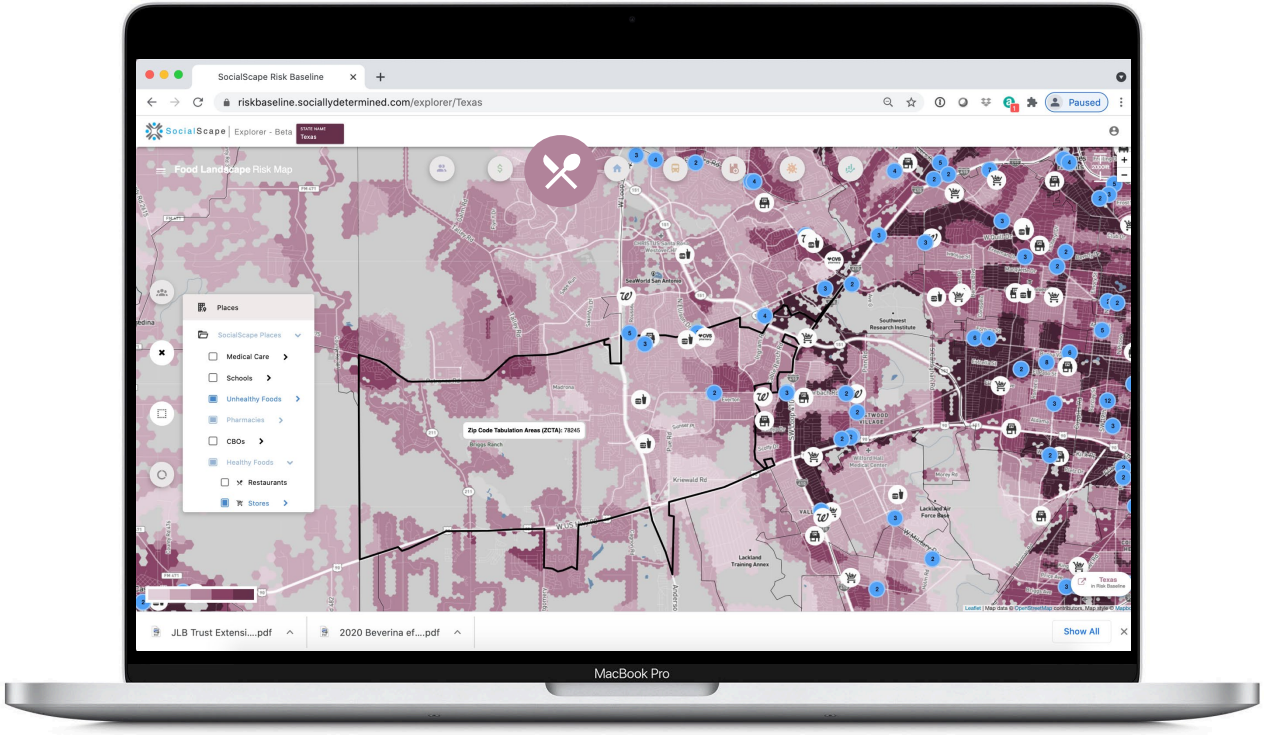


- **Drill down** for a granular view of every county in the U.S. (down to a 200-meter level)
- **Identify** high concentrations of social risk across **seven domains**
- **View** business, healthcare provider, and community resource overlays

Our approach

Instantly analyze conditions on the ground

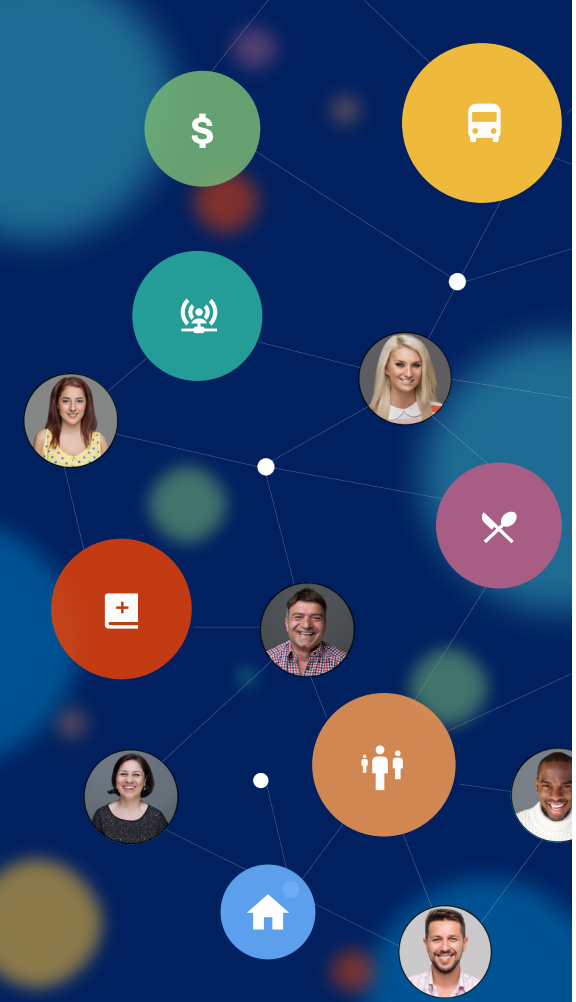
- **Local resources** mapped and analyzed for availability and density
- **Visualize data points of interest as overlays** in the context of social risk, e.g. disease prevalence



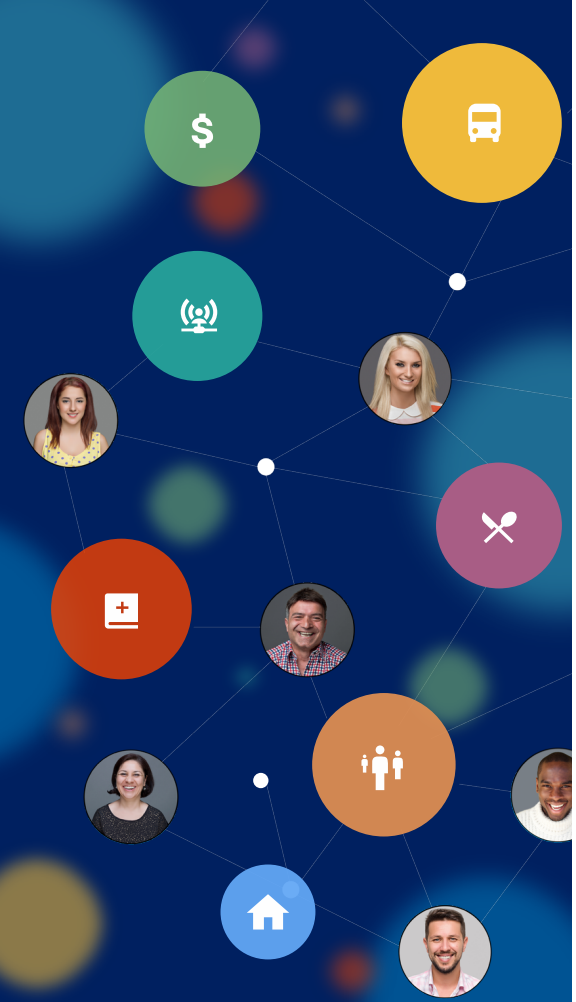
Our approach

View individual risk

- **Preload your patient roster** to see how social risk is impacting your people at the aggregate or individual level
- Get precise insights into what's driving social risk across **five domains**
- Tap into **robust features** through our SocialScape® platform and/or as a data extract



SocialScape Demo



Thank You

Chris Talley, MBA, HSM, PMP, CSM, CSPO
Sr. Director, Customer Strategy & Experience
703-489-0472
christalley@sociallydetermined.com

Eli Brick
Vice President, Payer & Provider Solutions
339-223-6928
elibrick@sociallydetermined.com

Health Information Exchange with Michigan's Skilled Nursing Facilities (SNF)

THE DOWNLOAD (why? who?): January 23, 11-12

BITS & BYTES (how, technically? what)? : February 6, 11-12