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Networks for Health

COLLABORATIVES IN ACTION

Building on Existing Infrastructure to Further Health Related Social Needs Screening

May 23, 2024

HOUSEKEEPING ITEMS

- This is a Zoom webinar.
- All webinar participants are automatically muted, and your video is not displayed.
- If you would like to ask a question, please use the Q&A function on the taskbar.
- Use the chat feature to introduce yourself (name, org, location), share resources, etc.
- We will share slides and the recording after today's event.
- For questions following the webinar, reach out to contact@civitasforhealth.org

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AGENDA

Civitas Welcome and Introduction

- **Jolie Ritzo**, *VP of Strategy and Network Engagement, Civitas Networks for Health*

Why Screen: National Landscape Insights from Civitas and Gravity Project

- **Jessica Little**, *Vice President, Business Development and Programs, Civitas Networks for Health*

Partnership Highlights:

- **Route 66 Consortium Accountable Health Communities**
  - **David Kendrick,** *CEO, MyHealth Access*
- **Leveraging NC HealthConnex to Exchange Data on Health-Related Social Needs**
  - **Jenell Stewart, DrBA,** *Assistant Director, Health Analytics & External Services, North Carolina Health Information Exchange*
  - **Kathryn Horneffer**, *MPH, Monitoring & Evaluation Lead – Program Evaluation NC Medicaid, NC Department of Health and Human Services*

Discussion/Q&A

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CIVITAS: OUR MISSION AND REACH

Civitas Networks for Health **convenes action-oriented leaders and implementers at the local, regional, state, and national level.** To achieve our mission, we drive cross-sector, multi-stakeholder, and data-informed initiatives by:

- **Increasing collaboration and shared learning** within and across communities that use data to ensure better health outcomes and drive health equity.
- **Educating public and private entities** regarding the benefits, functions, and roles of Regional Health Improvement Collaboratives (RHICs), Health Information Exchanges (HIEs), Quality Improvement Organizations (QIOs), All-Payer Claims Databases (APCDs), health data collaboratives, and combined organizations.

The largest network of its kind in the country with over 170 members, Civitas represents local health innovators moving data to improve outcomes that together cover more than 95% of the U.S. population.

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WHO WE SERVE

APCDs & Health Data Repositories

HIEs & CIES

Business & Tech Partners

Community Health Improvement Organizations

Payers/plans

Medicaid & Public Health

Health care Workers

Data Collaborations & Associations

All people

CIVITAS Networks for Health

Health Systems

QIOs

CBOs

Safety Net Providers & Systems

CIVITAS Networks for Health

CIVITAS IS THE BRIDGE BETWEEN…

DATA

DOING

CIVITAS
Networks for Health

InterSystems®
Creative data technology

#CIVITAS2024 UPDATES

The "Bridge Between Data and Doing" conference will be held October 15-17, 2024, in Detroit Michigan.

Registration is Open! Early Bird pricing through July 15.

Call for Proposals open until tomorrow May 24.

Thank you to our platinum sponsor, InterSystems!

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THANK YOU TO OUR CONFERENCE SPONSORS

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WHY SCREEN: NATIONAL LANDSCAPE INSIGHTS FROM CIVITAS AND GRAVITY PROJECT

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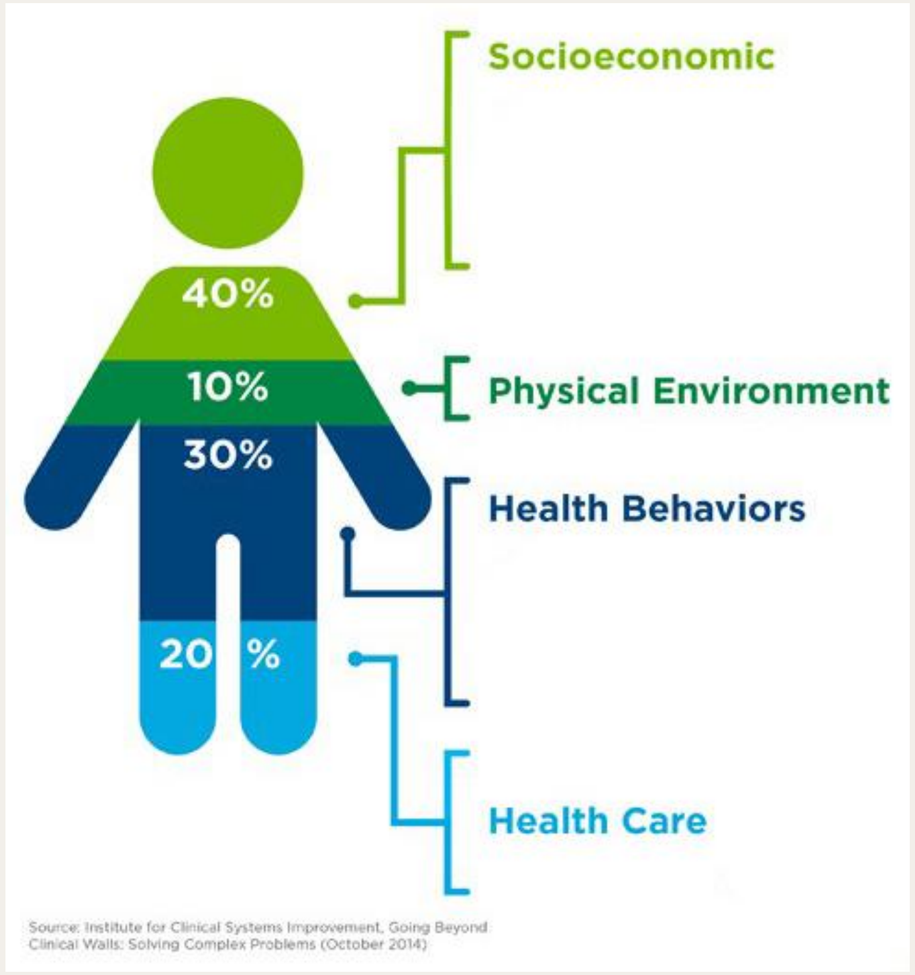

Why Screen for HRSN?

- HRSN screenings support multiple use cases: **treatment, payment, quality, population health, and public health.**
- Advancing the collection, use and exchange of social needs data is important to **improve the health and well-being of all individuals and communities**.
- Understanding social needs within communities helps **inform programs and policies** to meet the needs of the community.

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Current Landscape: National Policy, Guidance, & Strategy

ONC Office of the National Coordinator for Health Information Technology	• USCDI v2 (Jun. 2021) • HTI-1 Final Rule (Dec. 2023) • Interoperability Standards Advisory • SDOH Information Exchange Toolkit (Feb. 2023)
CMS CENTERS FOR MEDICARE & MEDICAID SERVICES CENTER FOR MEDICAID & CHIP SERVICES	• State Health Official (SHO) Letter: Opportunities in Medicaid and CHIP to Address SDOH (Jan. 2021) • State Medicaid Director (SMD): Additional Guidance in Use of In Lieu of Services (ILOS) and Settings in Medicaid Managed Care (Jan. 2023) • CMCS Information Bulletin: Coverage of Services and Supports to Address HRSN in Medicaid and the Children's Health Insurance Program (Nov. 2023) • CMCS Framework of services and supports to address HRSN (Nov. 2023)
CMS CENTERS FOR MEDICARE & MEDICAID SERVICES	• NEW* CMS Resource of Health Equity-related Data Definitions, Standards, & Stratification Practices (May 2024) • CMS Framework for Health Equity (2022) • CMS National Quality Strategy (2022) • CMS Quality in Motion: Action on the CMS National Quality Strategy (Apr 2024) • CMS The Path Forward: Improving Data to Advance Health Equity Solutions (2022) • CMS Innovation Center 2021 Strategy Refresh

Current Landscape: Federal Programs & Payment Models

- CMS Innovation Center NEW Model Health Equity Reporting Requirements: REACH and AHEAD
- CMS CY2024 Inpatient Prospective Payment System for Long-Term Hospitals Final Rule and Merit-based Incentive Payments (MIPS)
  - *Screening for Social Drivers of Health (SDOH-1) and Screen Positive Rate for Social Drivers of Health (SDOH-2)*
- CMS CY2024 Physician Fee Schedule (PFS) provides new benefits to address HRSN
- CMS CY2023 Medicare Advantage (MA) and Part D Final Rule
  - *Special Needs Plans (SNPs) must include standardized social risk questions in their Health Risk Assessments (HRAs)*

SDOH Screening Domains Required by CMS (as defined by Gravity Project)

Information compiled by EMI Advisors and shared with permission.

Why Standardize HRSN Screening Data

Standards allow the exchange of electronic messages between different systems and connects otherwise unaffiliated providers and care settings.

Benefits include:

- Whole person care – allowing integration of social risk data with other data sources
- Reduce provider and patient burden
- Reduces duplication of screenings
- Provider access to appropriate data at the point of care

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Gravity Overview

A collaborative initiative with the goal to develop consensus-driven data standards to support the collection, use, and exchange of data to address the social determinants of health (SDOH).

Gravity Conceptual Framework & Use Cases

Gather and aggregate SDOH data for uses beyond point of care.

3

Screening

Goals Setting

Treatment/ Interventions

2

Document and track SDOH related interventions to completion.

★ Gravity is AGNOSTIC to the systems and tools used to collect, exchange, aggregate, and analyze social care data.

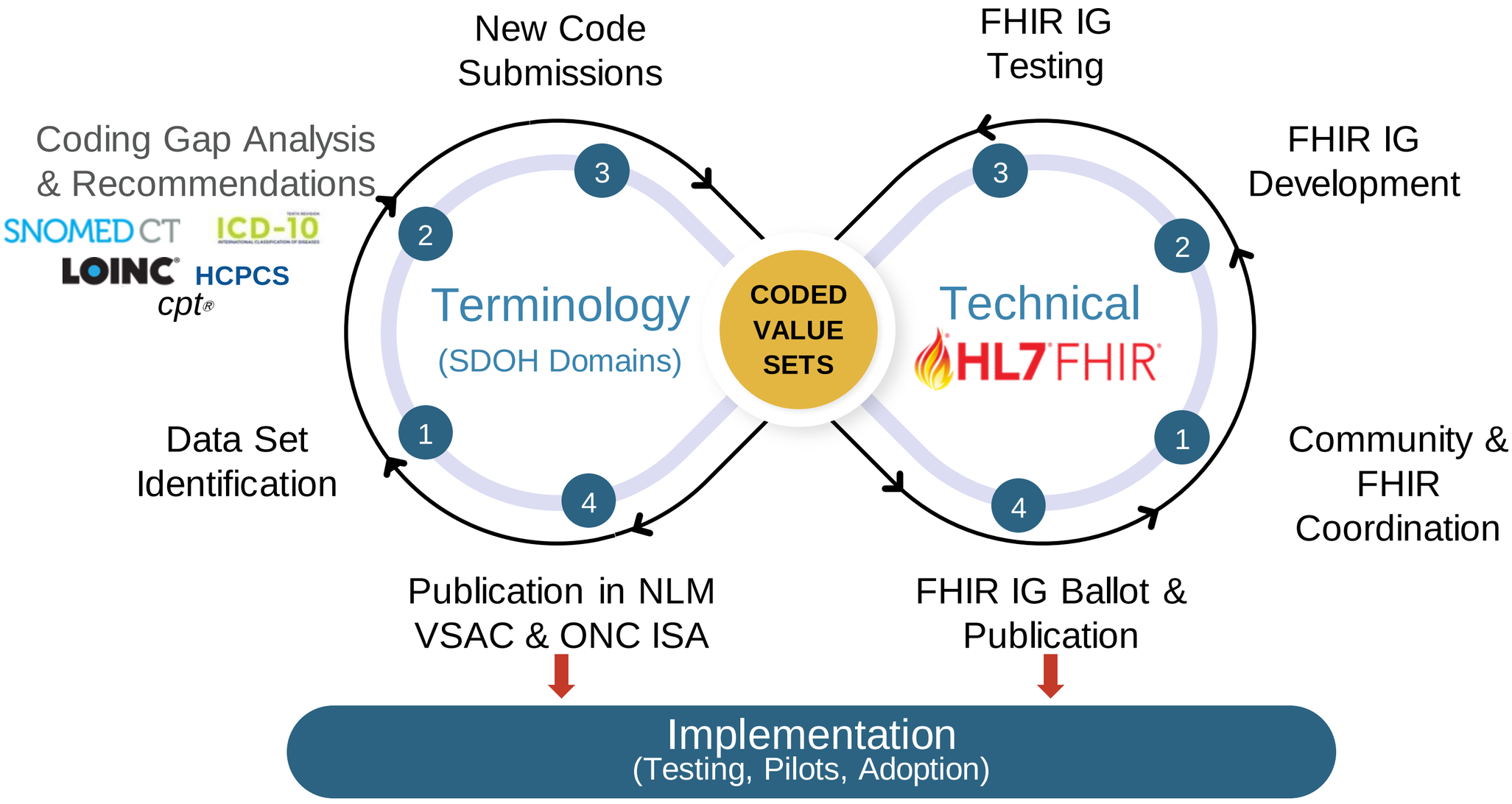
1

Assessment/ Diagnosis

Gather SDOH data in conjunction with a patient encounter.

Workstreams:

Terminology, Technical, Implementation



Gravity Implementation Across the Nation

This is a sample (not all-inclusive list) of organization locations that have participated in the Gravity Pilots Affinity Group. We are grateful to all organizations adopting the work of Gravity to advance SDOH standards.

Pilots Workstream 2023 - Phase 2

- Focus on public health and health equity in partnership with Civitas Networks for Health, with support from the Robert Wood Johnson Foundation*
- Pilot sites: Bronx (RHIO)/New York State, MyHealth Access Network/Oklahoma State; University of Colorado Hospital/Denver Metro Area; Pima County Department of Public Health & Southwest Tribe/Pima County Arizona
- Highlights: NY State 1115 waiver design and implementation TA for terminology and IG, learning about opportunities and barriers for health system terminology implementation
  - >2024 implementation planning!
- Monthly Gravity Pilots Affinity Group open implementation forums
- Significant advancement in implementation materials

*Support for this initiative was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

Standardizing HRSN Screening Data

New York State Pilot

OBJECTIVE:

To develop a standard set of functional and implementation requirements for the ingestion, handling and use of SDOH data across NY's Statewide Health Information Network (SHIN-NY) to support health equity efforts that will be implemented through a Medicaid 1115 Waiver CMS and the NYS Department of Health, Office of Health Insurance Programs.

Challenges with Translation of HRSN data to consistent standards

1. **The lack of health and social care ecosystem awareness** of the assessment data variability problem and the anticipated costs of not solving this problem and the opportunity associated with solving this problem.
2. **The lack of funding and champions to drive the initial development of a consistent set of interoperable rules** (e.g. HL7 FHIR StructureMaps) for high-priority HRSN assessment instruments.
3. **The lack of funding and champions to drive the ongoing maintenance and hosting** of a consistent set of interoperable rules for high-priority HRSN assessment instruments.
4. **The lack of clarity, and possibly funding, on which actors** (e.g. health information exchange (HIE), social care network (SCN), electronic health record systems (EHR), etc.) **is responsible for the execution of the assessment translation rules**.

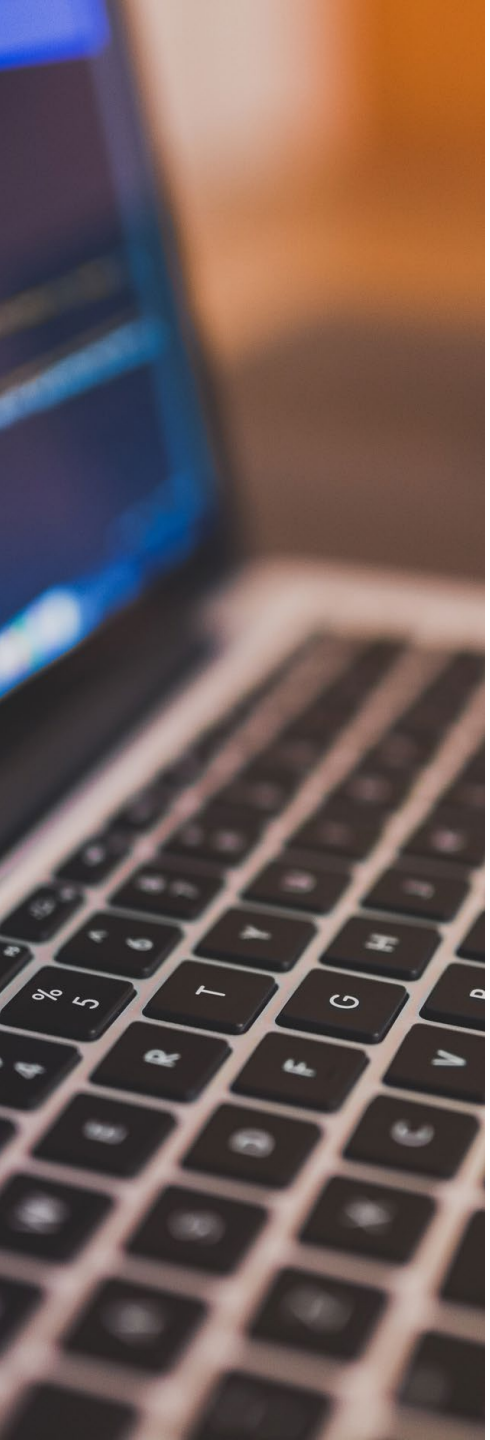
Source: Gravity Project Issue Brief

MyHealth® ACCESS NETWORK

Route 66 Consortium Accountable Health Communities

SOCIAL DETERMINANTS OF HEALTH DATA

2018-2024



MYHEALTH ACCESS NETWORK

right patient, right information, right time to the right provider

MyHealth® ACCESS NETWORK

MyHealth Access Network is the state designated nonprofit health information exchange created by a grassroots coalition of health care industry stakeholders across Oklahoma. Through this coalition, members securely share electronic health records to achieve better, safer, and lower cost care for all.

ACCOUNTABLE HEALTH COMMUNITES

Social Needs Screening and Referral Project

2018-2022

MyHealth® ACCESS NETWORK

CMMI INNOVATION

Study to determine if identifying and addressing health-related social needs impacts health care cost and reduce health care utilization

BRIDGING THE GAP

MyHealth served as a bridge connecting healthcare organizations and community service organizations.

SOCIAL NEEDS

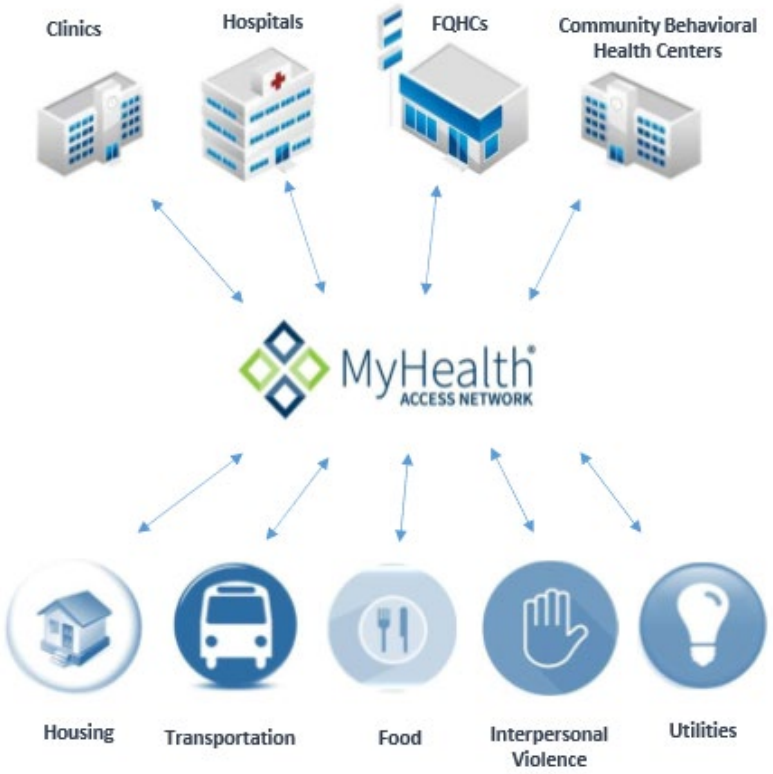
Housing Instability and Quality
Food Insecurity
Transportation Needs
Utility Needs
Interpersonal Violence

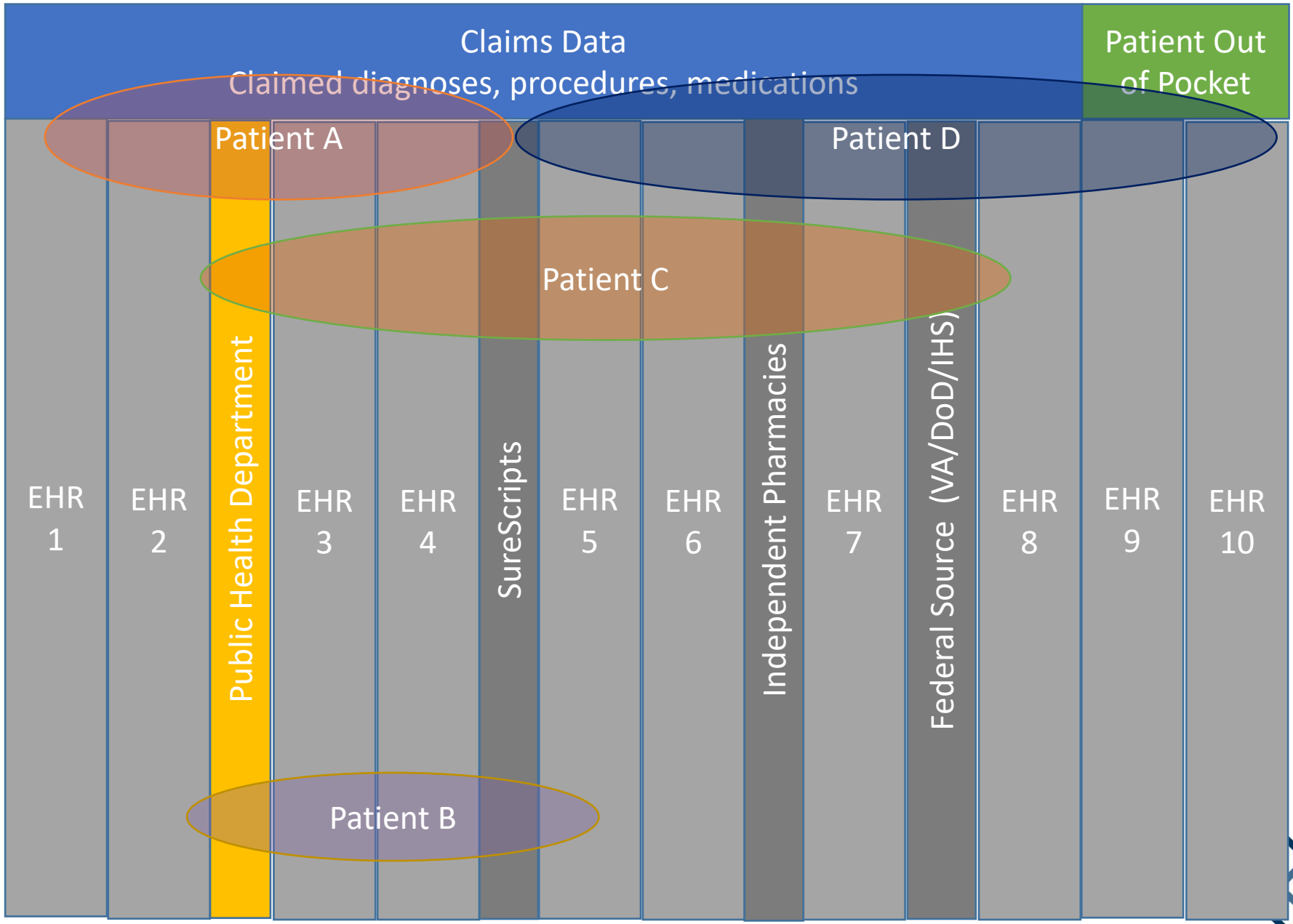
NOVEL SOLUTION

Screening sent to patient's mobile device. Screening completed and needs identified in real time.
An automate resource referral provided.

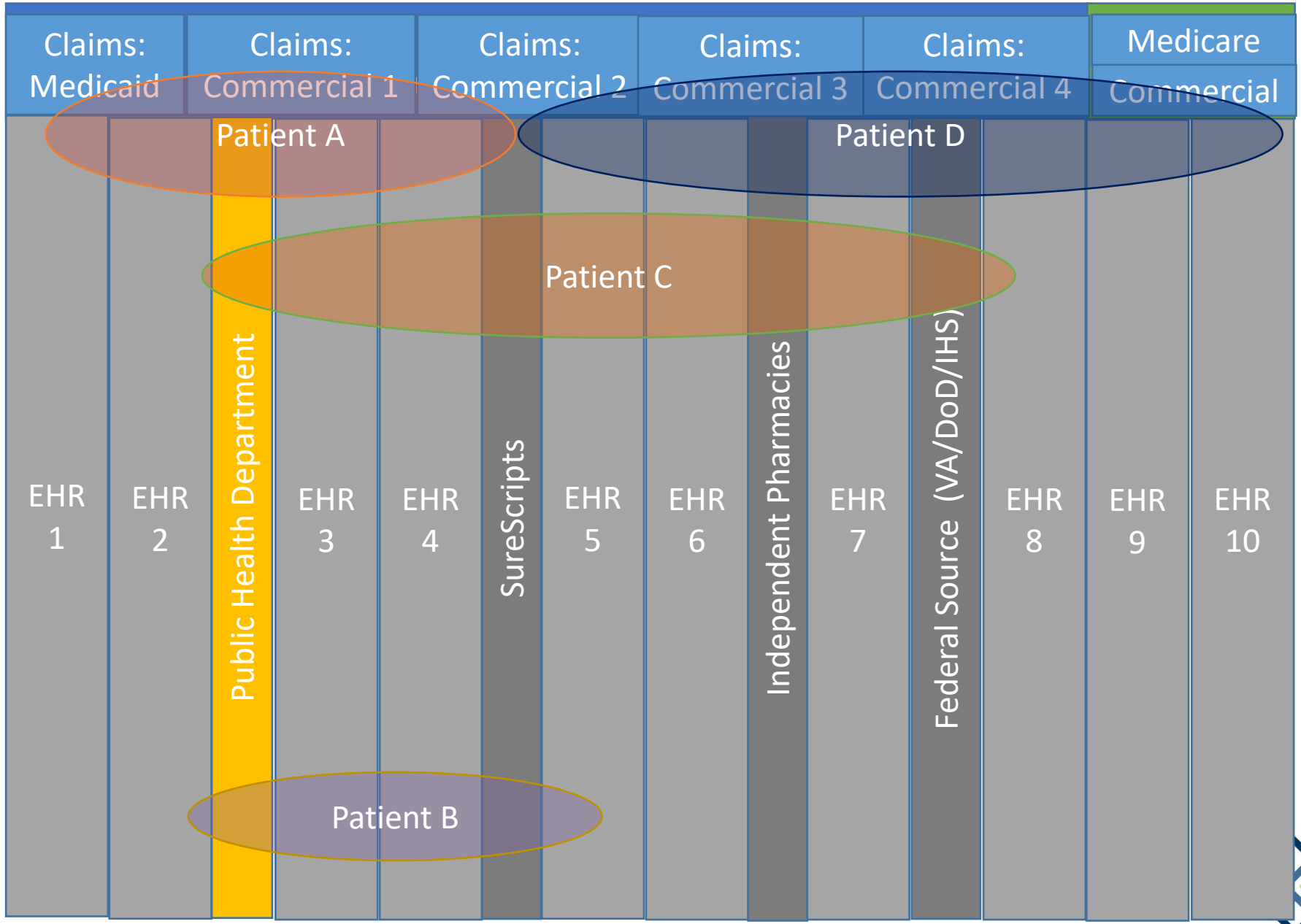
Bridge Organization Responsibilities

- Provide screening for patients to assess their social needs
- Minimize the burden of screening for clinics
- Use a standardized screening tool to measure study outcomes
- Provide an individualized Community Resource Summary to every patient with an identified social need
- Refer high-risk patients for navigation services provided by the Tulsa and Oklahoma County Health Departments
- Build relationships with community resource agencies to ensure a quality referral processes



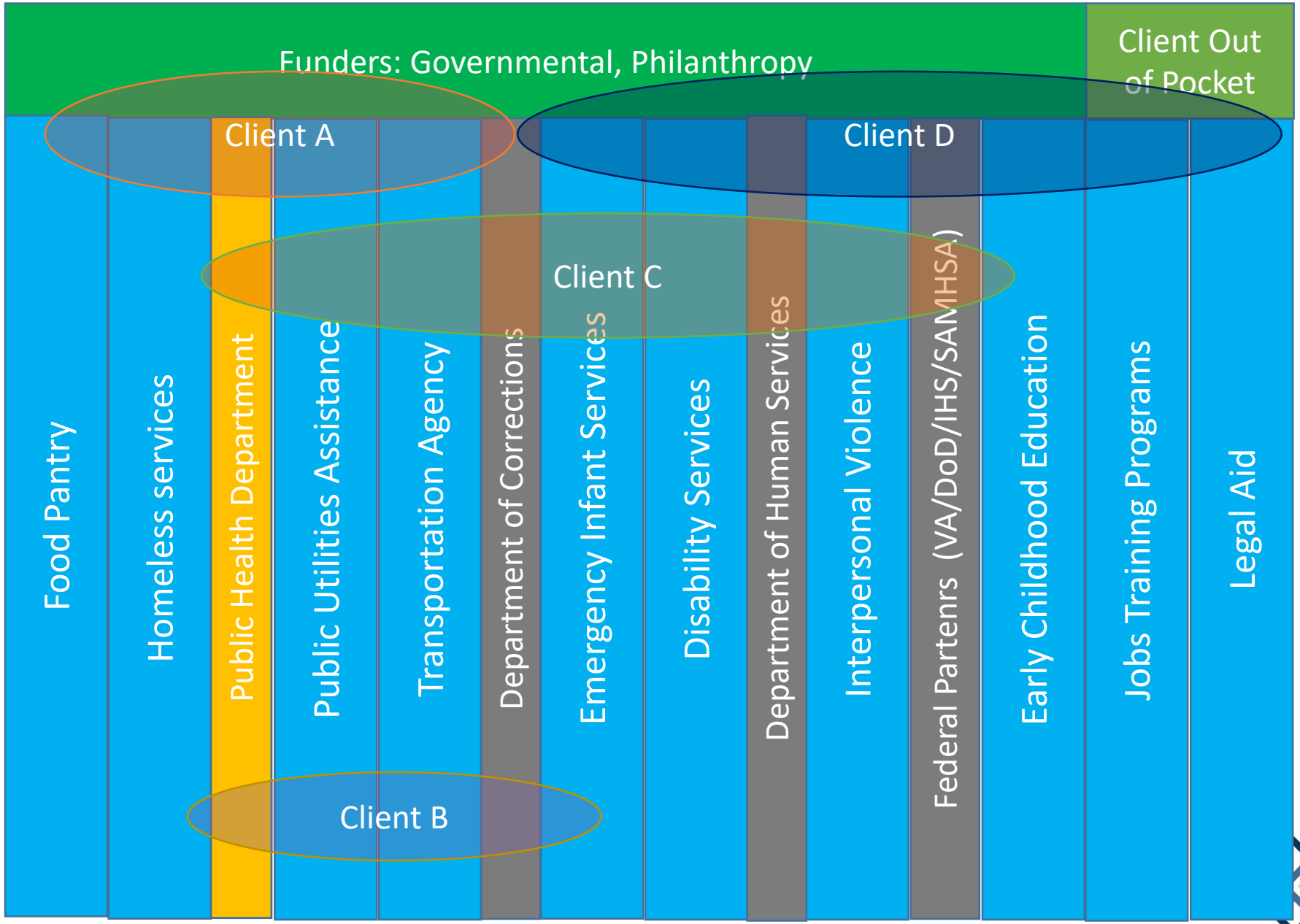


MyHealth ACCESS NETWORK



MyHealth ACCESS NETWORK

MyHealth now working with social needs and early childhood programs, where data is even more fragmented . . .



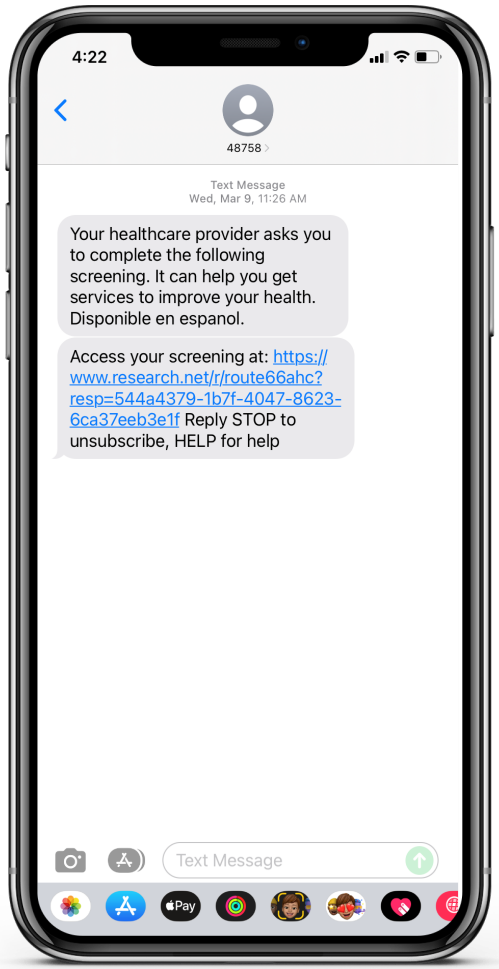
MyHealth ACCESS NETWORK

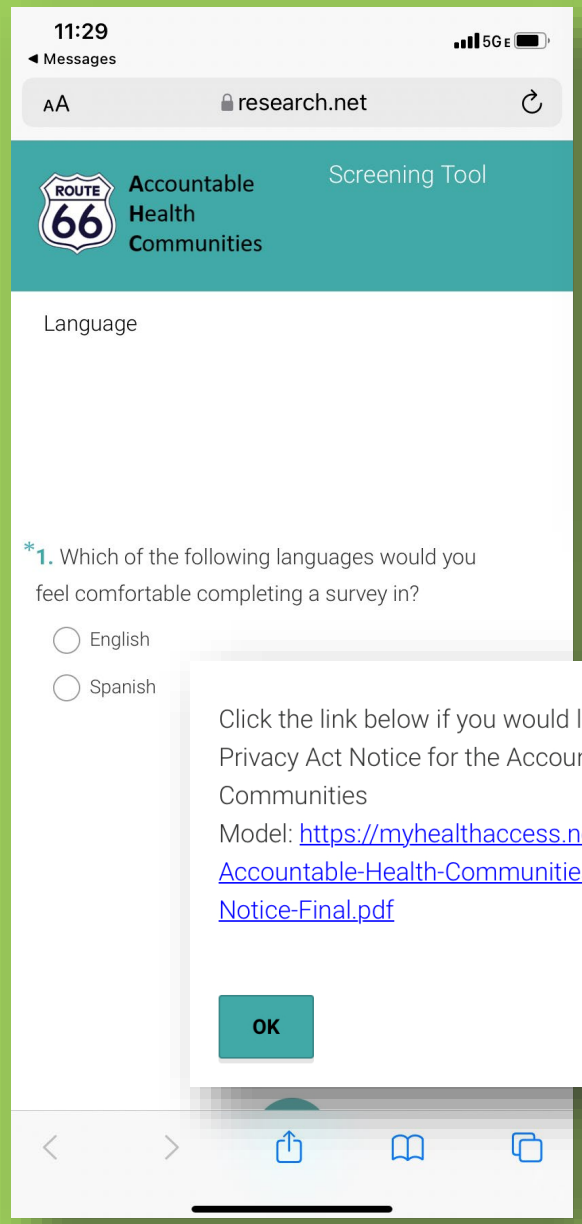
Screening & Referral Efforts Are Expensive

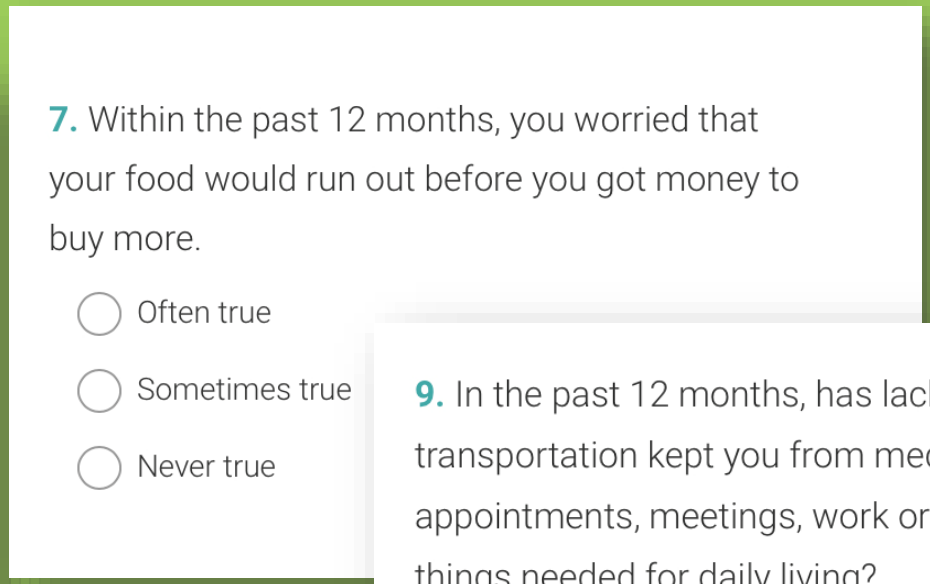
- AHC Instrument Time & Motion Study:
  - Screening: 12-15 minutes per patient
  - Tailored Referral: 5-10 minutes per patient
  - + EHR documentation

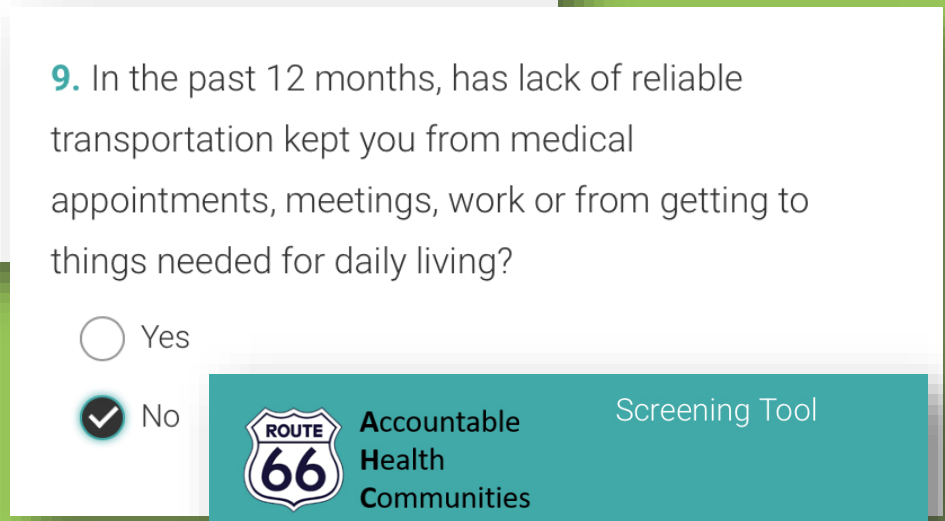
- Providers (inpatient, outpatient, ER) willing to take on added burden: ZERO

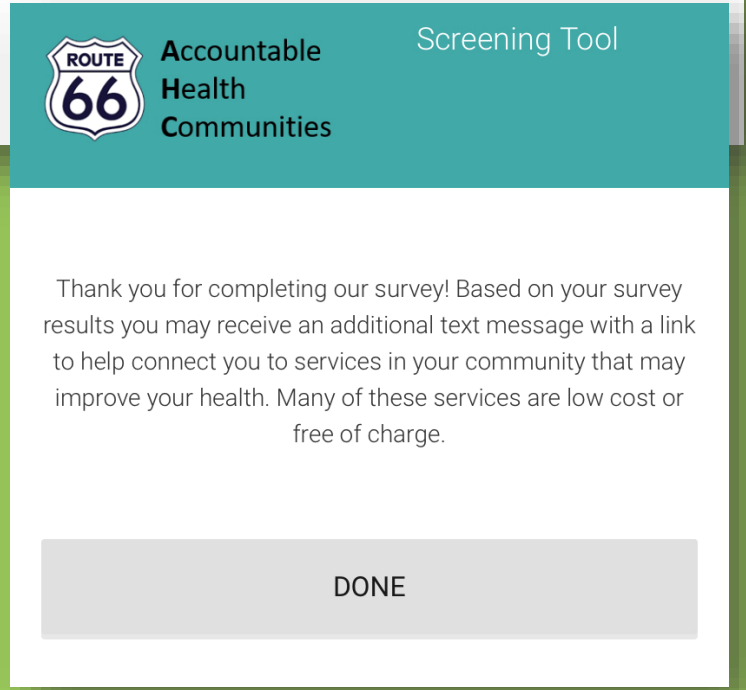
Mobile Screening





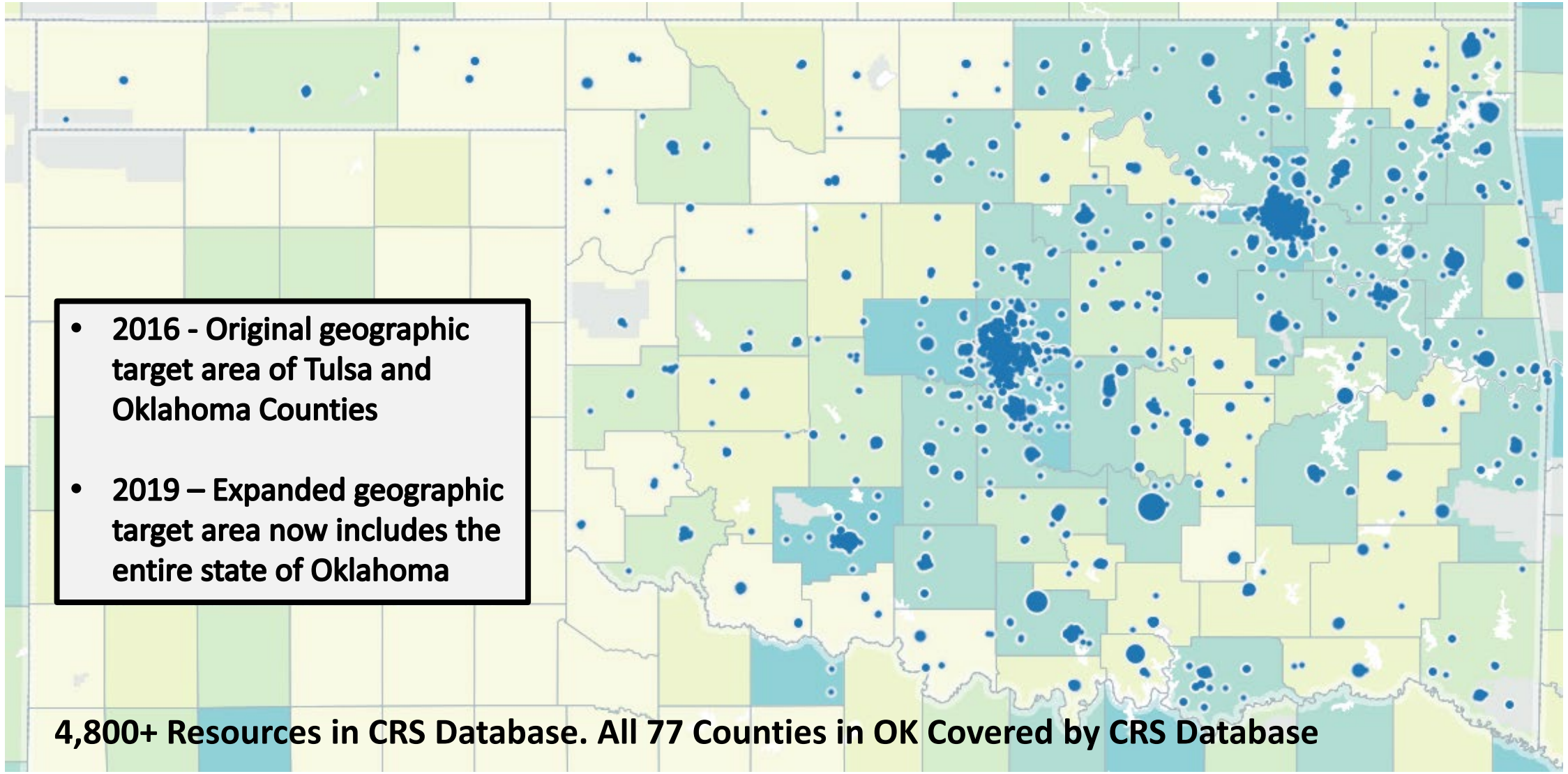




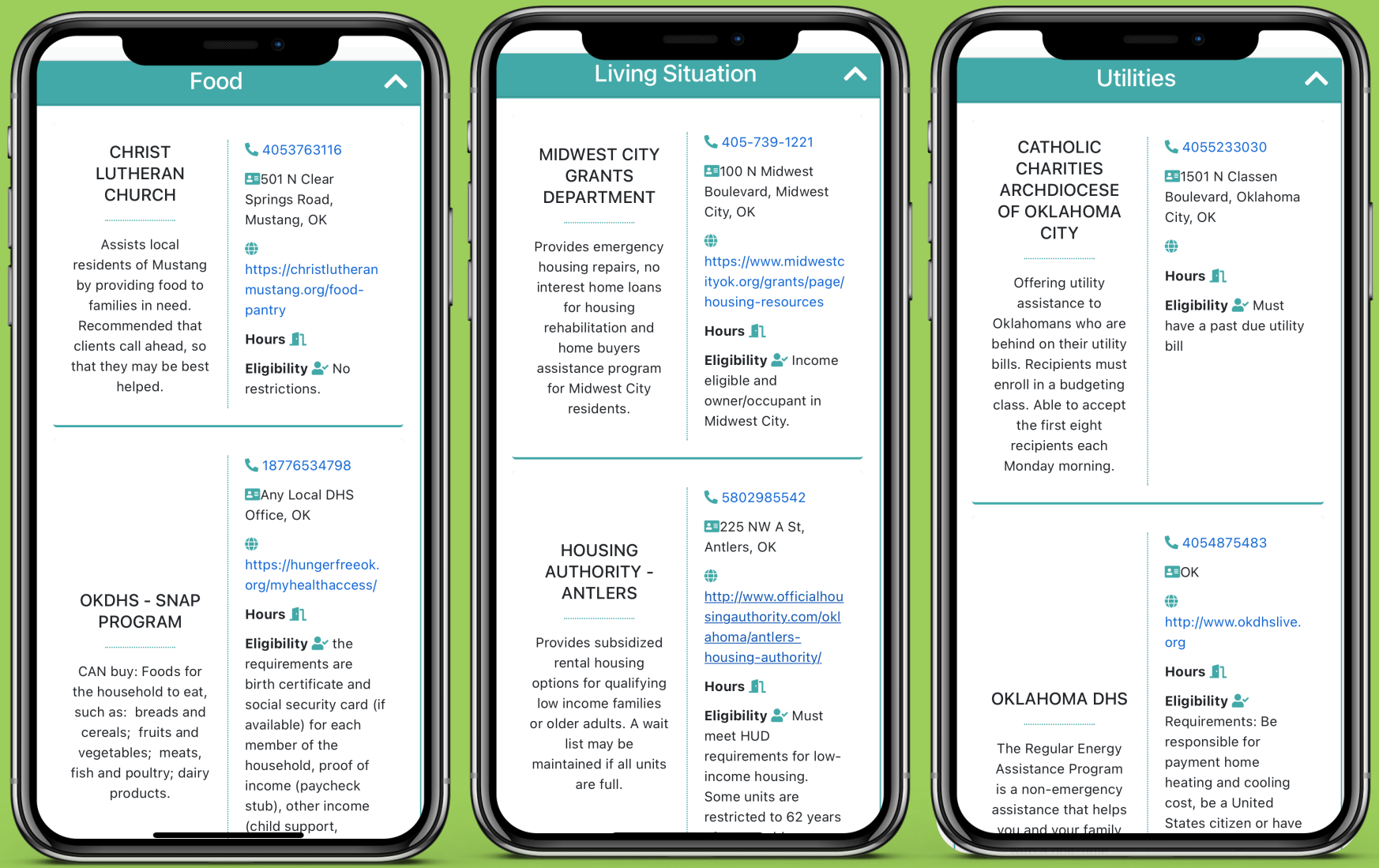


MyHealth® ACCESS NETWORK

Community Resources in Oklahoma



Community Resource Inventory



Every community resource summary includes information for 211

Community Resource Summary

Texted back to patient after completion of the screening

MyHealth ACCESS NETWORK

LOINC CODE
96777-8

LONG COMMON NAME
Accountable health communities (AHC) health-related social needs screening (HRSN) tool

LOINC STATUS
Active

MyHealth ACCESS NETWORK

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

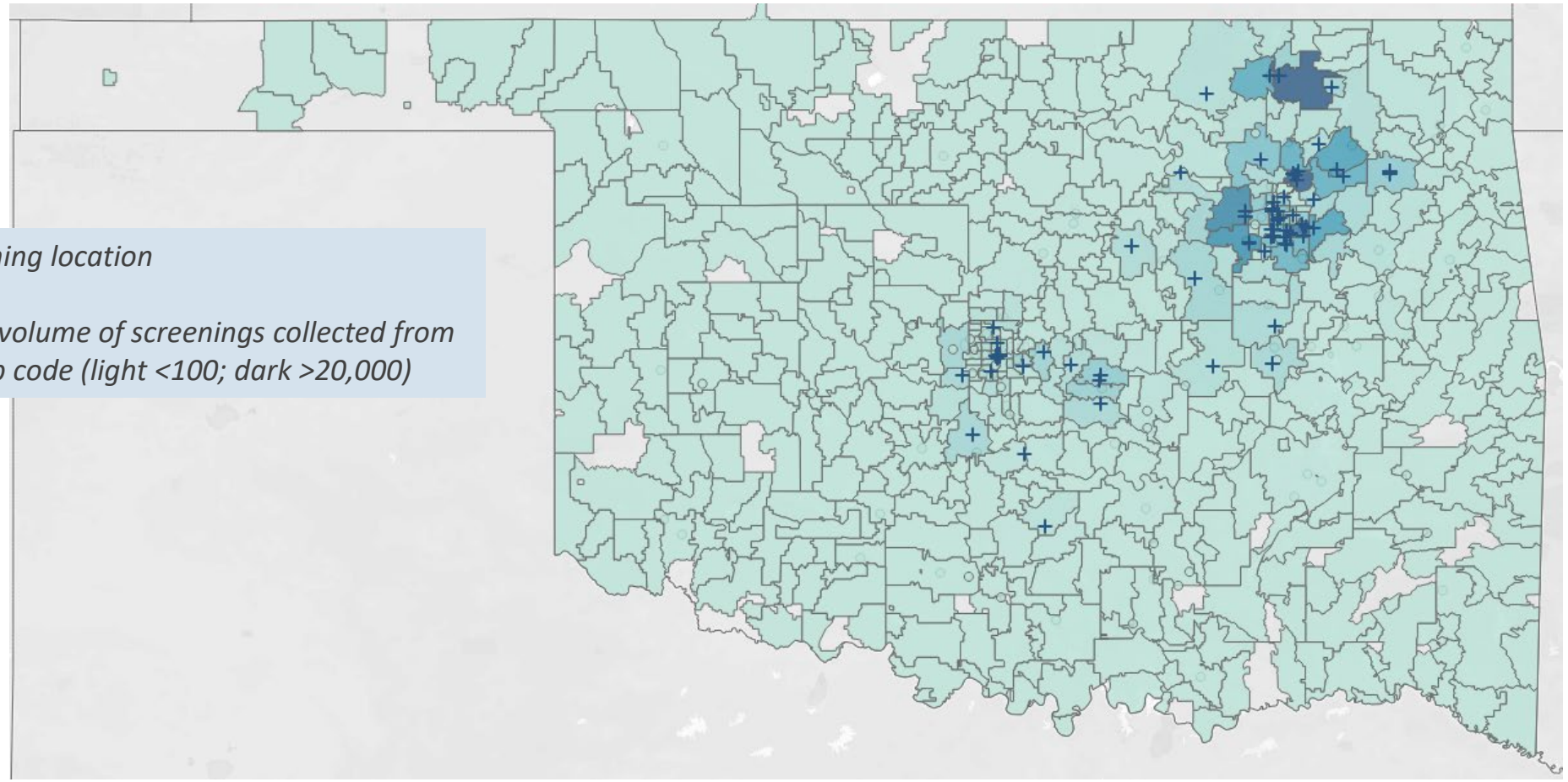
LOINC	Name	R/O/C	Cardinality	Example UCUM Units
96777-8	Accountable health communities (AHC) health-related social needs screening (HRSN) tool			
71802-3	What is your living situation today?			
96778-6	Think about the place you live. Do you have problems with any of the following?		1..7	
88122-7	Within 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 or from getting things needed for daily living?			
96779-4	In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?			
95618-5	How often does anyone, including family and friends, physically hurt you?			
95617-7	How often does anyone, including family and friends, insult or talk down to you?			
95616-9	How often does anyone, including family and friends, threaten you with harm?			
95615-1	How often does anyone, including family and friends, scream or curse at you?			
95614-4	Safety total score			{score}

Standards in Proper Sequence

1. Screening Instrument
   - Questions & Answers: Observations coded in **LOINC**
2. Scoring of Screening Instrument
   - Conclusions about needs: **SNOMED** (Chronic food need, houselessness, etc.)
   - "Preliminary results"
3. Selection of social services category for referral: **SNOMED** codes
4. Delivery of Results to Provider
   - Review and sign-off on results
   - Assignment of **ICD-10 Z code** if appropriate

AHC: *Screening by Zip Code*

(August 2018 –July 2022)



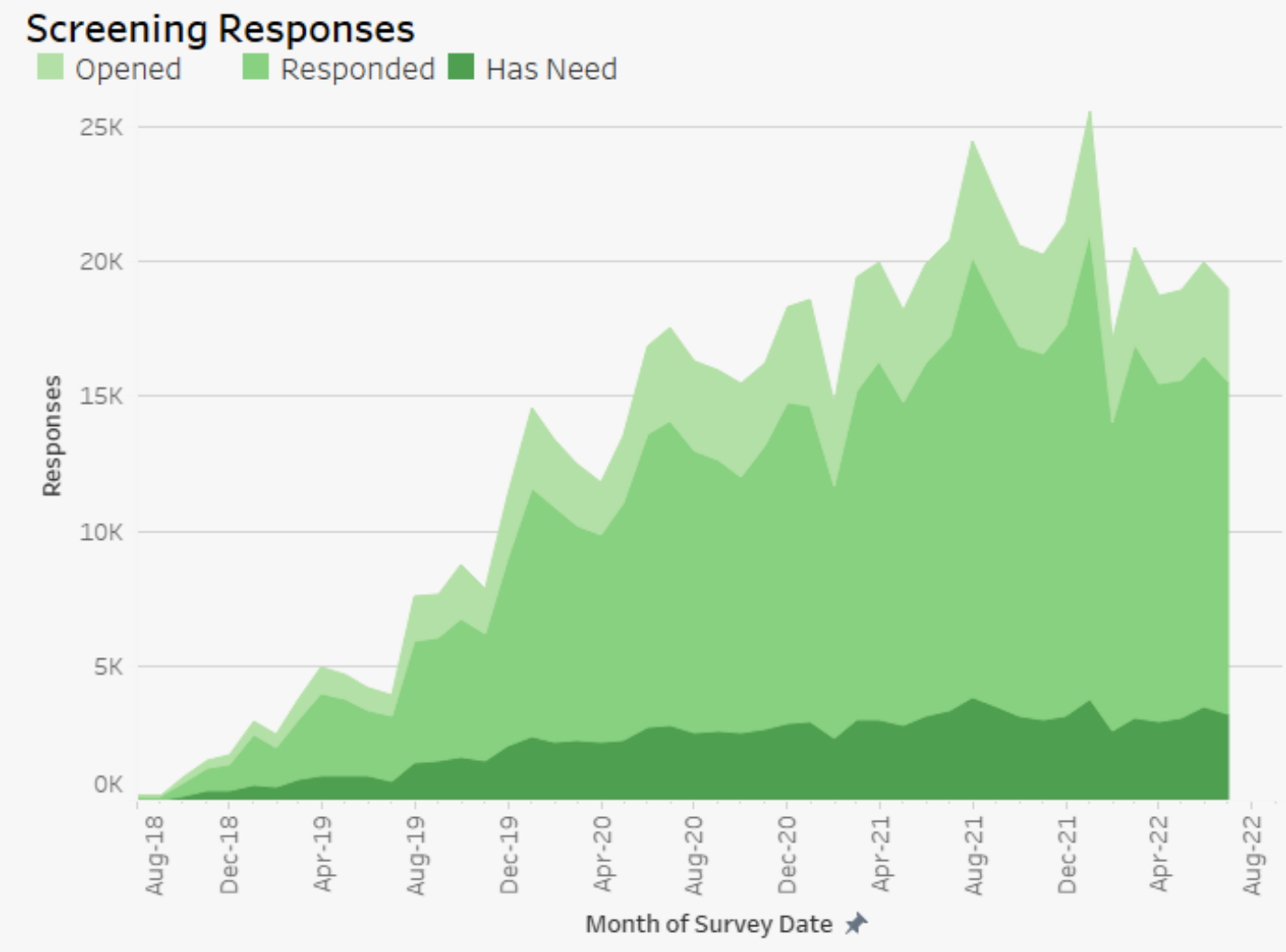
+ *indicates a screening location*

Color indicates the volume of screenings collected from residents of that zip code (light <100; dark >20,000)

Accountable Health Communities

Final Screening Data

(August 2018 – July 2022) *AHC screening ended as of July 31, 2022

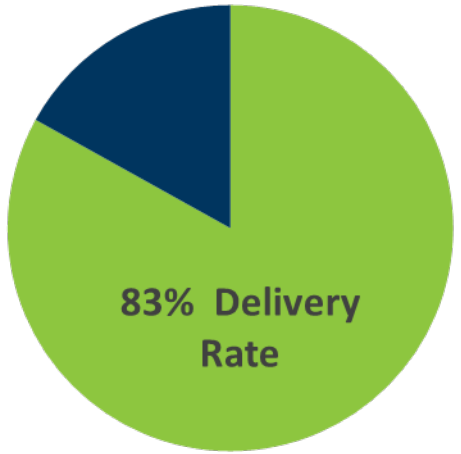


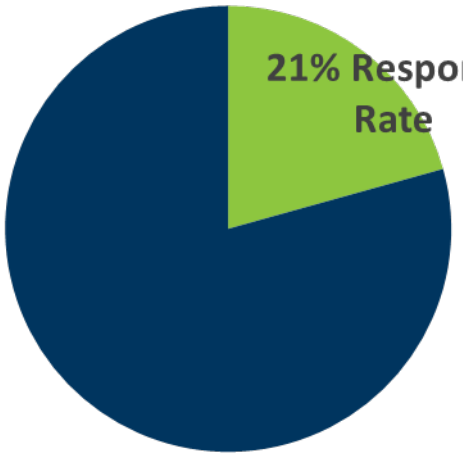
***2,988,078** Offers to Screen*

***515,146** Responses*

***102,304** Responses with a Need*

***165,020** Individual Needs Reported*

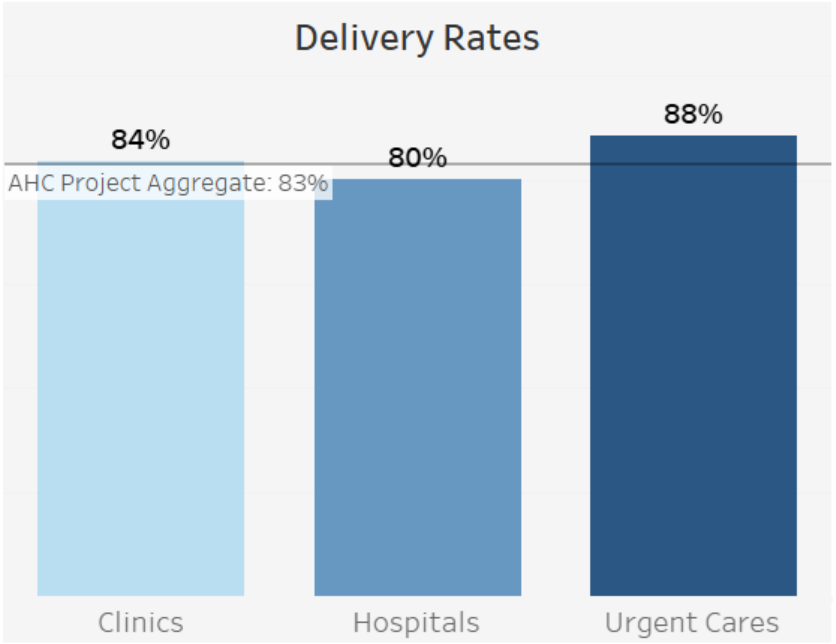


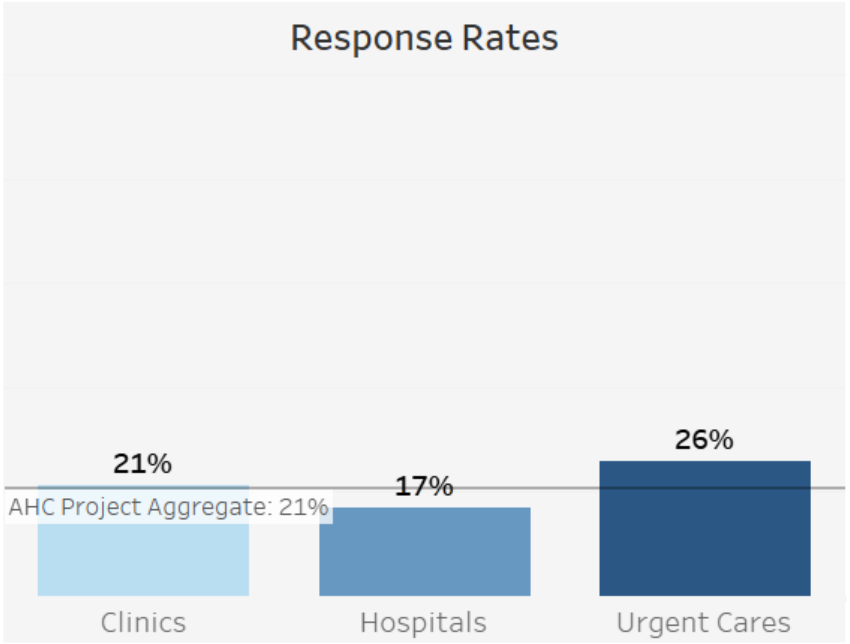


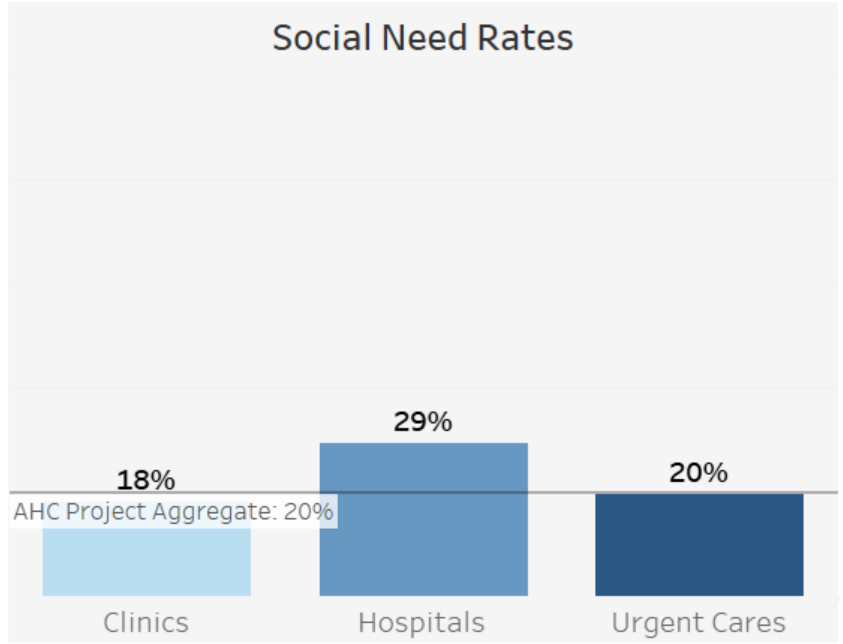
Note: These patients include Medicare, Medicaid, uninsured and commercially insured patients.

AHC: *Screening Metrics*

(August 2018 –August 2022)



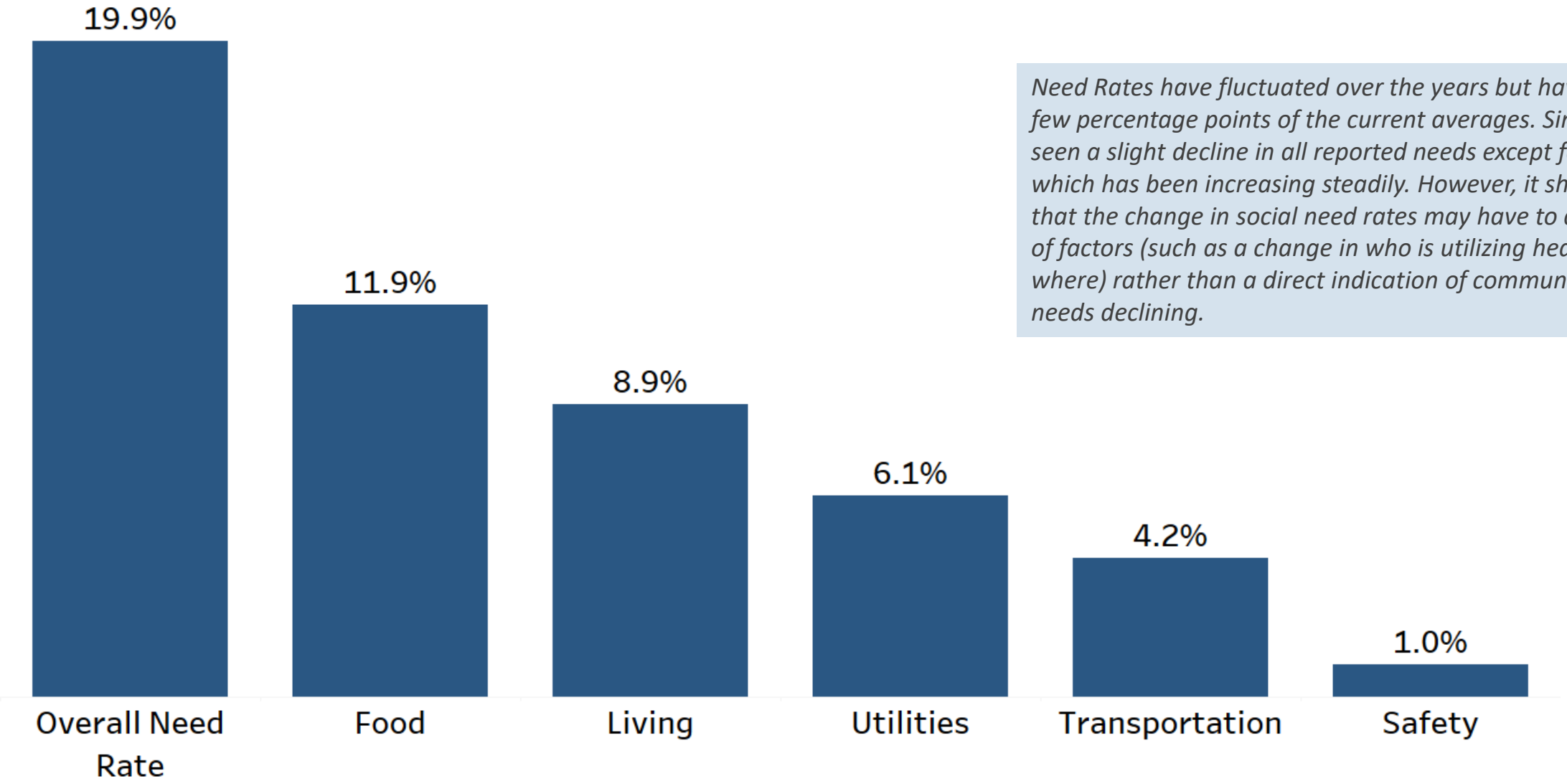




We see different delivery and response rates based on the location of the screening. Generally, clinics see a higher response rate than ERs/hospitals. Even within the clinic grouping, there are types of clinics that see a consistently higher engagement rate with the screening than others (e.g. OBGYN clinics have a much higher delivery and response rate than many primary care clinics.)

AHC: Needs Rates for 5 Core Needs

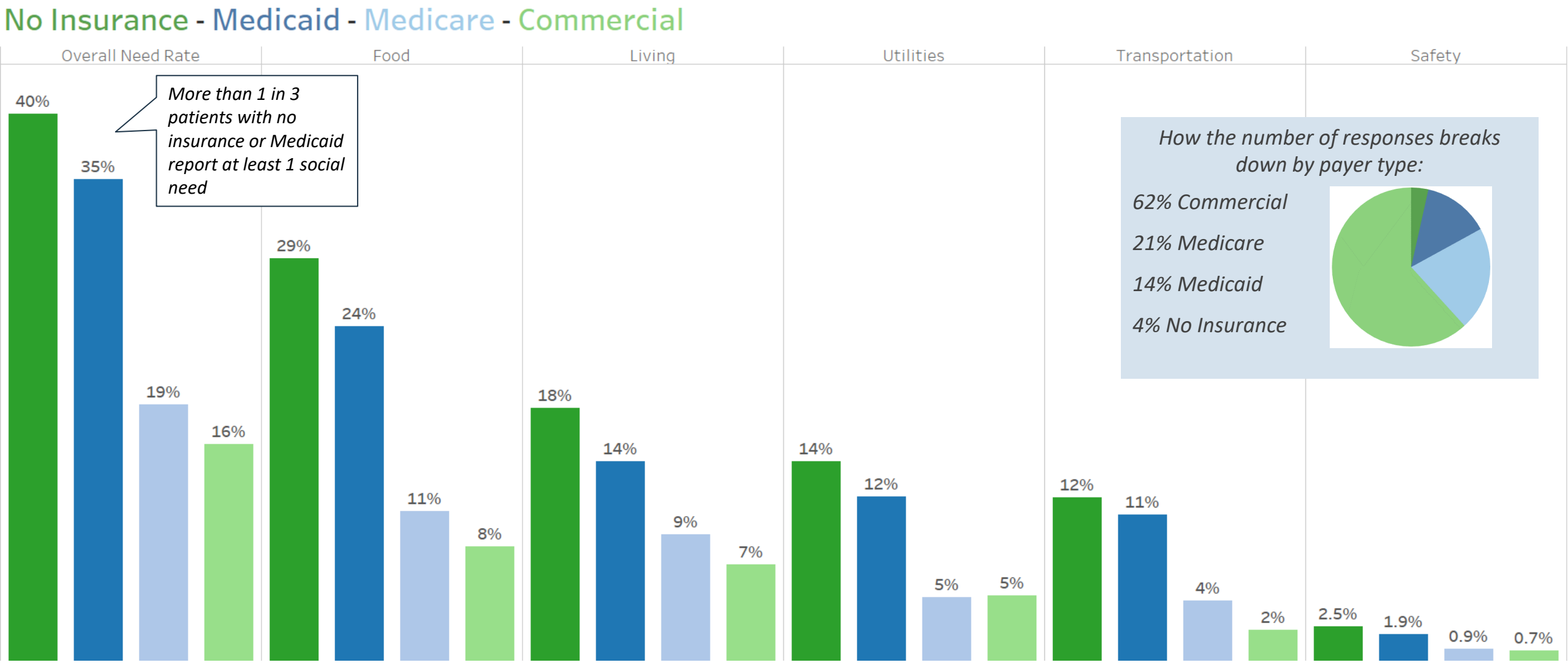
(August 2018 –August 2022)



Need Rates have fluctuated over the years but have stayed within a few percentage points of the current averages. Since 2020, we have seen a slight decline in all reported needs except for transportation, which has been increasing steadily. However, it should be noted that the change in social need rates may have to do with a variety of factors (such as a change in who is utilizing health care and where) rather than a direct indication of community social needs declining.

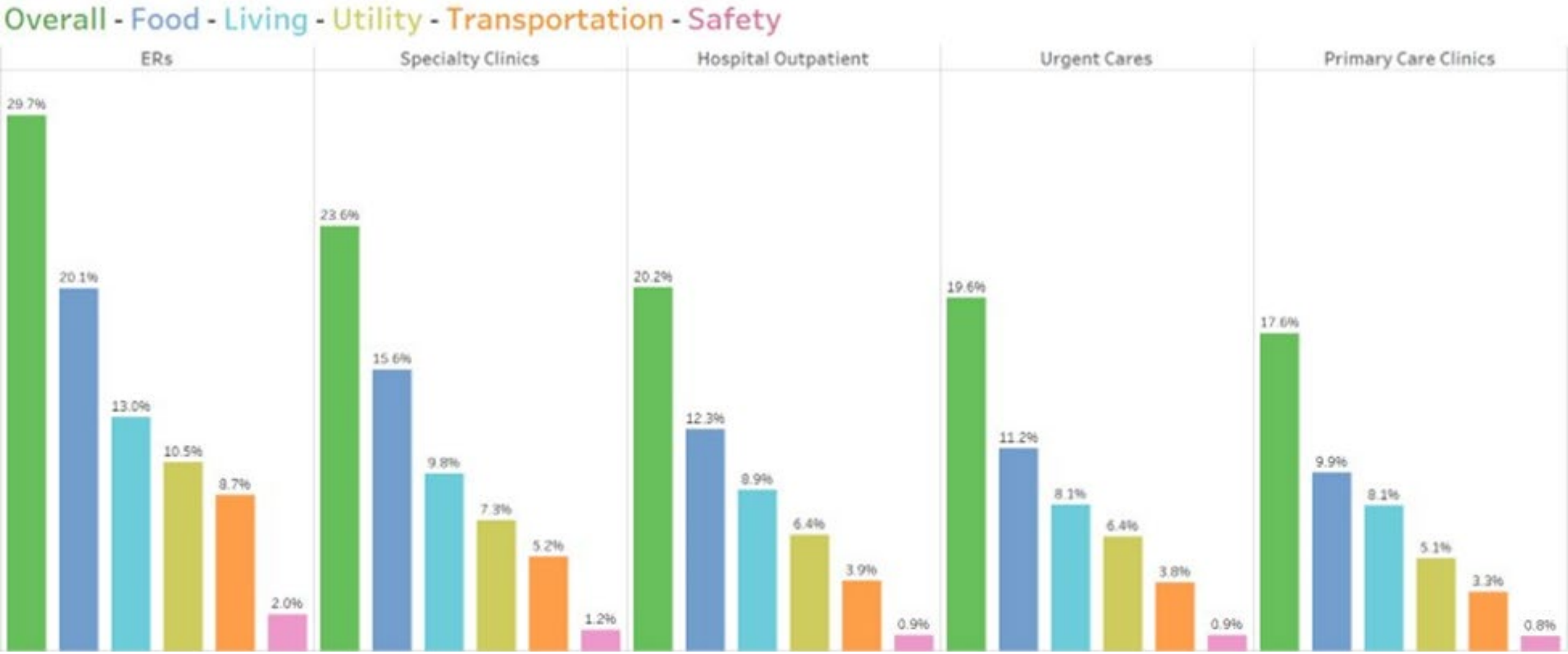
Needs Rates by Payer Type

(August 2018 –August 2022)



Needs Rates by Clinical Delivery Site Type

(August 2018 –August 2022)



PRELIMINARY AHC OUTCOMES

Outcomes reported by CMS evaluation team

Medicaid Beneficiaries

Medicare Beneficiaries

TOTAL EXPENDITURE

INPATIENT ADMISSIONS

READMISSIONS

ED VISITS

CMMI's Accountable Health Communities Model
MyHealth HIE Mobile SDoH Screenings & Referrals

	Time	Hourly Rate
Time & Motion Study of Manual Screening & Referral Process		
Provider Administration of AHC Screening (minutes)	12	$30
Provider Generation of Tailored Resource Referral for Needs (minutes)	20	$30

Total Number of Screenings offered	3,700,000	
Total Number of Screenings completed	850,000	
Total Number of Screenings with at least 1 need	250,000	

Total Human Screener Time Saved (hours)	170,000	$5,100,000
Total Human Tailored Resource Referral Time Saved (hours)	83,333	$2,500,000
Total Cost of MyHealth HIE SDoH Screening and Referral	0	$ 3,145,000

Net Savings Based on Staff Time and Cost Alone (hours)	253,333	$4,455,000

SDOH Mobile Screening & Referral

1
Clinical Encounter

Patient checks into clinic.

2
SDoH Screening

SDoH Screening text from MyHealth is triggered to patient's cell phone while they are in the waiting room.

3
Process Results

MyHealth processes the results to determine social needs reported.

4
CRS Returned

If a need is reported, a community resource summary is returned via text with information for 3 resources per need identified.

5
Closed Loop Referral Partner

Referral sent to partner for closed loop coordination.

SDOH Program Metrics

August 2018– November 30, 2023

By the numbers:

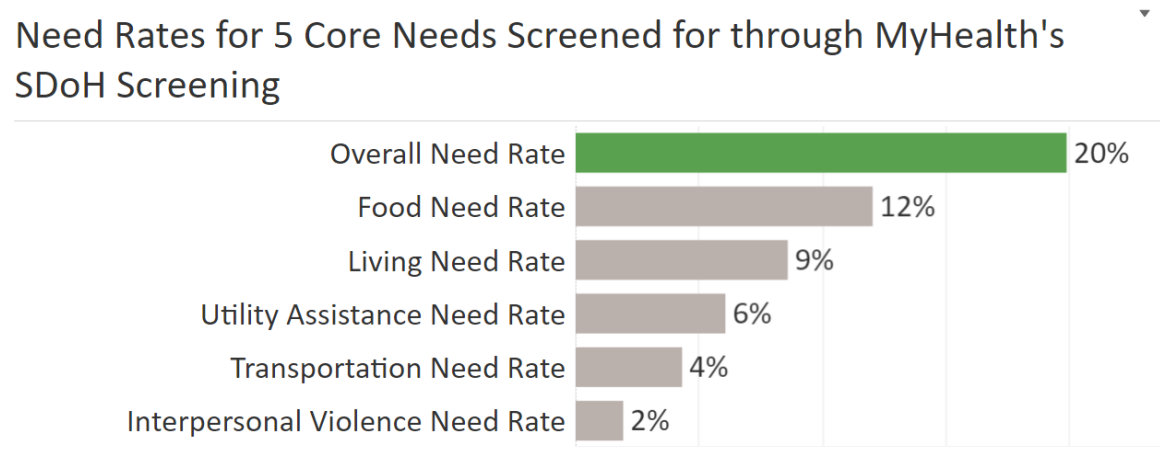
- ✓ **4.2+** million offers to screen
- ✓ **739,000+** responses
- ✓ **150,000+** responses with needs
- ✓ **250,000+** individual needs reported

Screening Delivery Rate

83%

Screening Response Rate

21%



24% of responses report 2+ needs

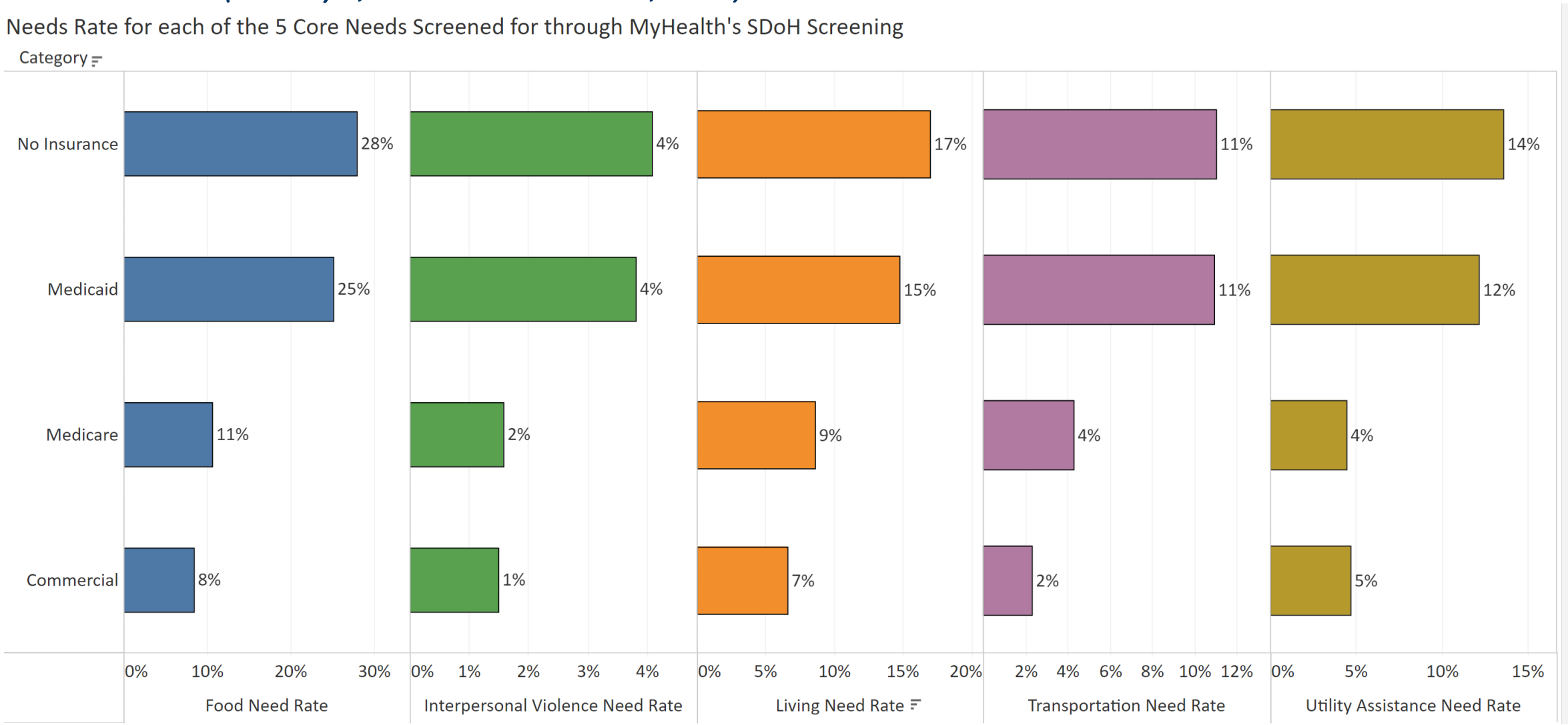
average of **1.7** needs are reported per need positive screening

85% of responses with a living need is due to living conditions* rather having a place to stay

**Living condition issues include lack of heating, lead paint or pipes, mold, oven or stove not working, pests, missing or not working smoke detectors, and water leaks*

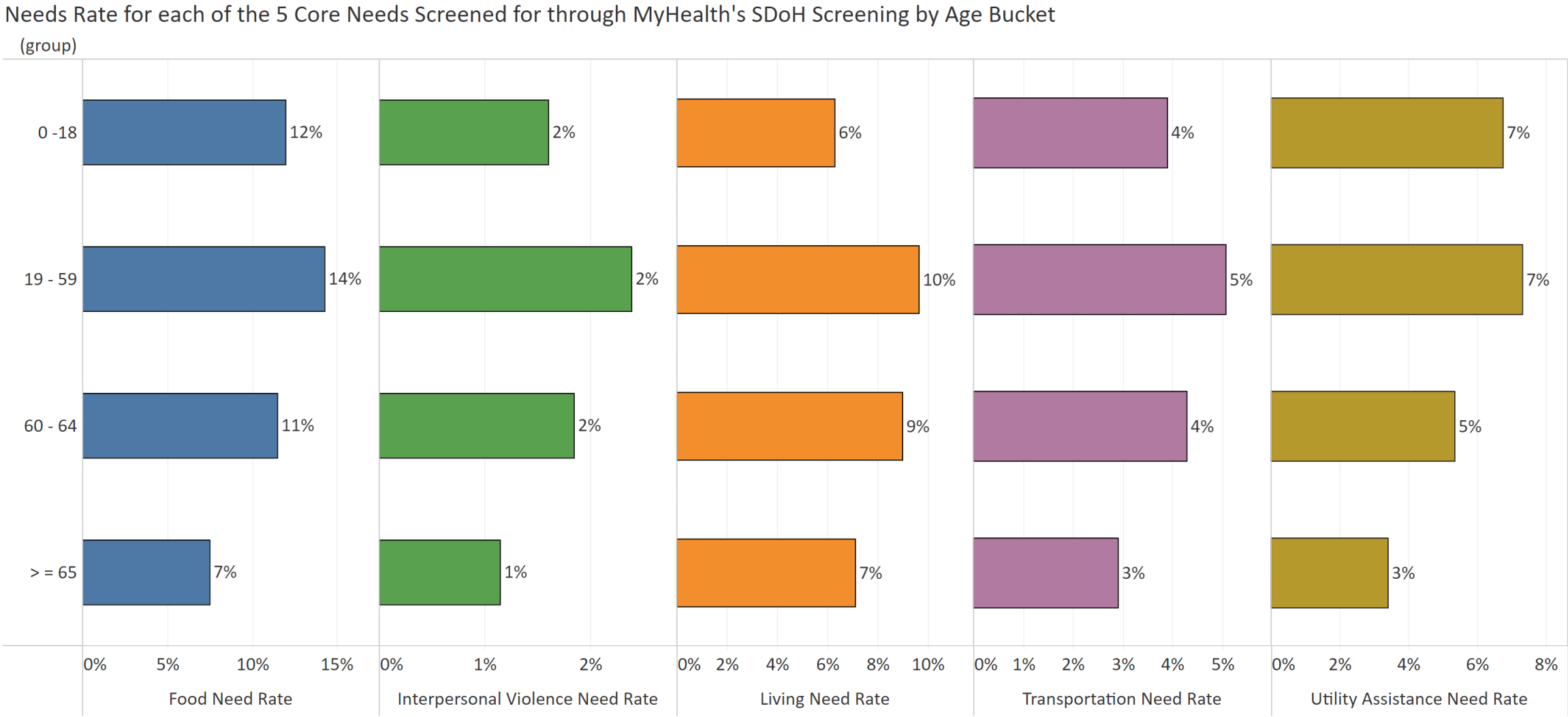
SDOH Screening Metrics

Year to Date (January 1, 2023 – November 30, 2023)



SDOH Screening Metrics

Year to Date (January 1, 2023 – November 30, 2023)



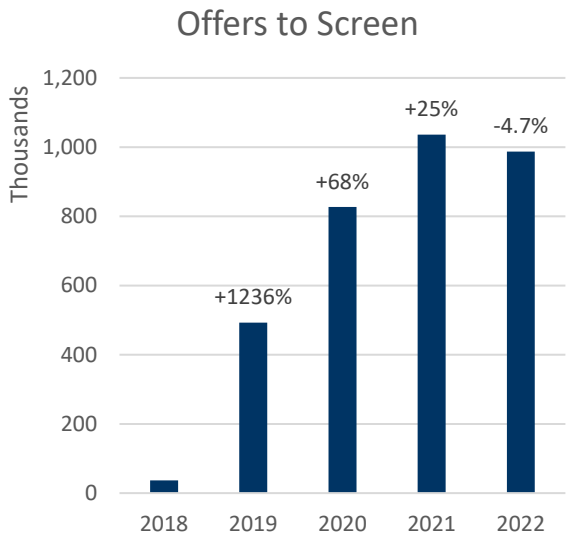
MyHealth Social Determinants of Health Screening Metrics

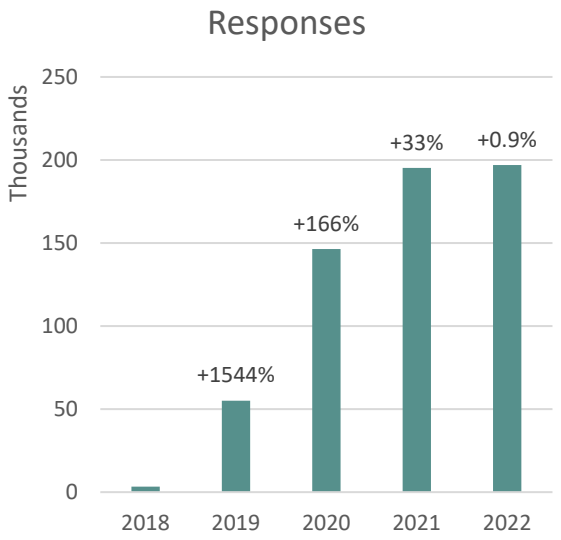
2-Year Trends in Screenings

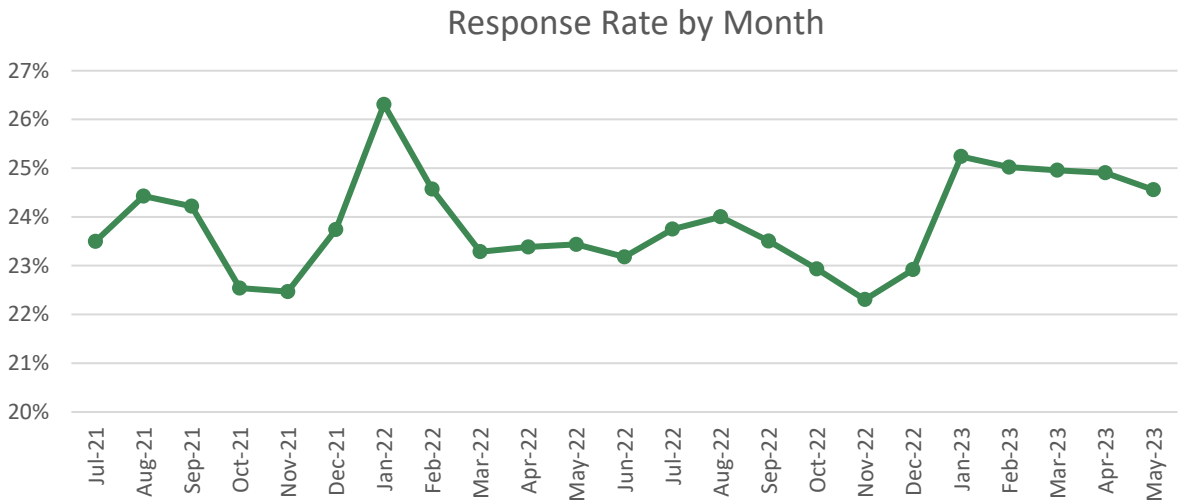
YTD over YTD (Jan-May2023 v Jan-May 2022):

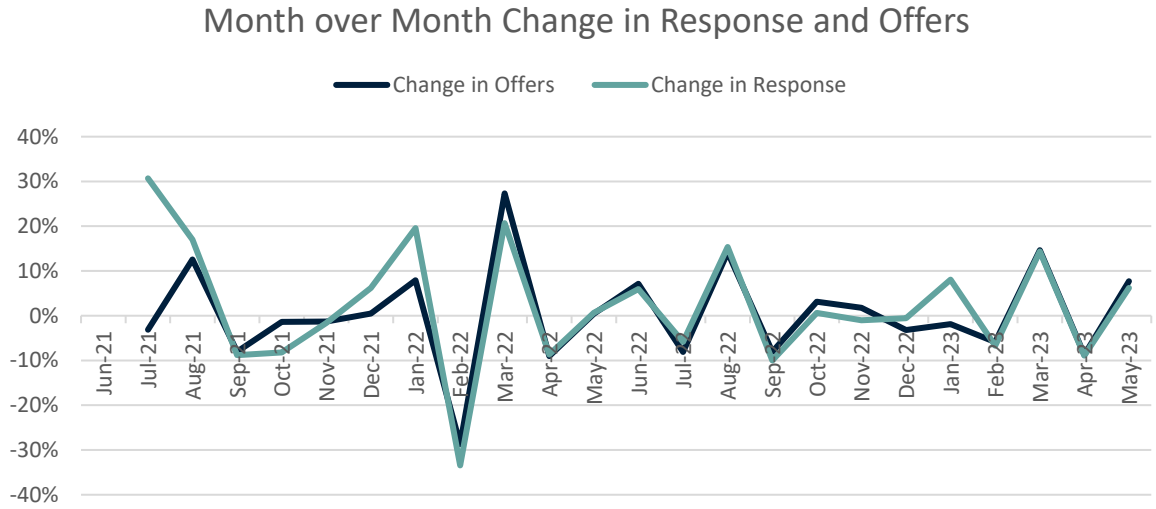
- **1.1%** increase in offers to screen (i.e. clinical visits with a valid phone #)
- **3.8%** increase in responses
- **2.7%** increase in response rate (24.3% to 24.9%)

Takeaway:
Number of responses seems to be trending slightly upwards despite small changes in the offers to screen. The last 5 months in particular has shown a sustained increase in response rate compared to last year's trend.









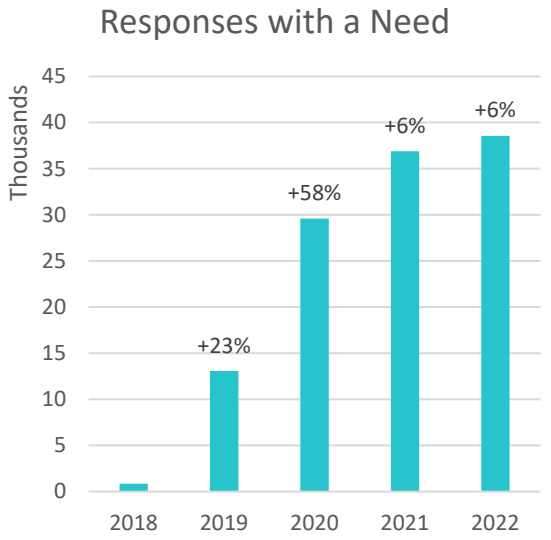
MyHealth Social Determinants of Health Screening Metrics

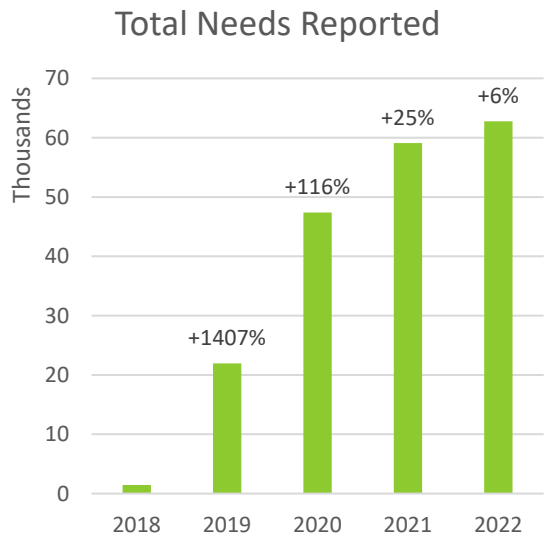
2-Year Trends in Needs Reported

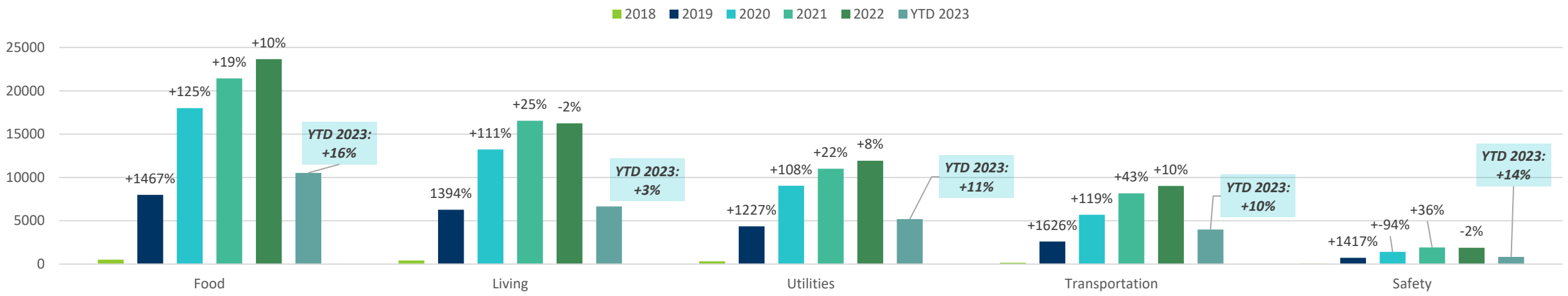
YTD over YTD (Jan-May2023 v Jan-May 2022):

- **9.4%** increase in responses with at least 1 reported need
- **9.7%** increase in total reported individual needs
- **1.1%** increase in need rate (18.4% to 19.5%)

Takeaway:
*Year over Year trends suggest an **increasing reporting of needs** at a higher rate than responses are increasing (10% versus 4%) with the areas of greatest increase in **Food, Safety, and Utility Assistance**.*







Next up:

- Financial support for Community Based Organizations
  - Sustainability model and fee schedule for CBO’s
  - Supported by MyHealth SDoH Workflow

Thank you!

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MyHealth® ACCESS NETWORK

LEVERAGING NC HEALTHCONNEX TO EXCHANGE DATA ON HEALTH REALTED SOCIAL NEEDS

CIVITAS
Networks for Health

Leveraging NC HealthConnex to Exchange Data on Health-Related Social Needs

May 2024

Context: Health-Related Social Needs as an NC Medicaid Priority

Landscape of Health-Related Social Needs Efforts

Understanding and addressing health-related social needs (HRSN) is a top priority for NC DHHS and a key focus for NC Medicaid under managed care

NC Medicaid's HRSN-related efforts include:

1. Healthy Opportunities Pilots: Nation's first comprehensive program to test and evaluate the impact of providing select evidence-based, non-medical interventions related to housing, food, transportation, and interpersonal safety/toxic stress to high-needs Medicaid enrollees
2. Requirements for managed care organizations to screen for HRSN and provide services to address those needs
3. Focus on whole-person health embedded throughout care management programs

NC Medicaid's HRSN Data Sources

Good data on Medicaid beneficiaries' HRSN needs can:

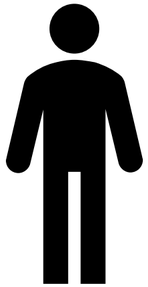
1. Help individuals get the support they need
2. Improve clinical decision-making
3. Facilitate program and policy design based on population-level trends
4. Evaluate the effectiveness of Medicaid programs and policies focused on HRSN

NC Medicaid collects HRSN screening information from many sources, each of which has their own limitations

- Current focus: Tapping into HRRN screening data collected at the provider level

HRSN Screening Data Exchange (Current State)

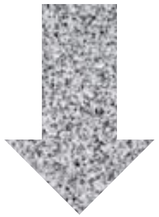
MCO attempts to screen John for unmet resources needs but can't reach him.

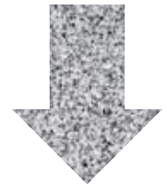


John's PCP conducts an HRSN screen and finds John is struggling with food insecurity and housing instability. John's PCP provides him with some helpful resources.

MCO records that the screen is incomplete

John's PCP records his unmet resource needs and the referrals provided in the EHR





Medicaid, John's MCO, and John's care manager at his MCO don't have any information on unmet resource needs

Information is only seen by providers in the same health system

HRSN Screening Data Exchange (Future State)

MCO attempts to screen John for unmet resources needs but can't reach him.

John's PCP conducts an HRSN screen and finds John is struggling with food insecurity and housing instability. John's PCP provides him with some helpful resources.

MCO records that the screen is incomplete

NC Health Connex

John's PCP records his unmet resource needs and the interventions provided in the EHR

Linked screening and intervention information can be seen by DHB, John's MCO, John's care manager, any provider permissioned to see John's data

Initial Data Exchange Pilot

NC's Health Information Exchange: NC HealthConnex

- 60,000+ providers with contributed records
- 10,000+ health care facilities submitting data, including 140 hospitals and connection with commercial labs (e.g., Quest and LabCorp)
- 6,000+ health care facilities in onboarding
- 14 million+ unique patient records with clinical documents
- 80 EHR vendors live

Initial Data Exchange Pilot: Overview

Pilot goal: Support the exchange of HRSN screening data via NCHealthConnex by developing standards across participating hospitals

- Partnership between NC DHHS Data Office, NC Health Information Exchange Authority, and NC Medicaid
- 3 participating hospital systems
- 6 questions – covering Food, Housing, Transportation, and Utilities
- Identified standard LOINC codes across each hospital's screening questions
- Hospitals to translate screening results into LOINC codes and transmit to NC HealthConnex via HL7 ADT (may include CDA or flat file in the future)

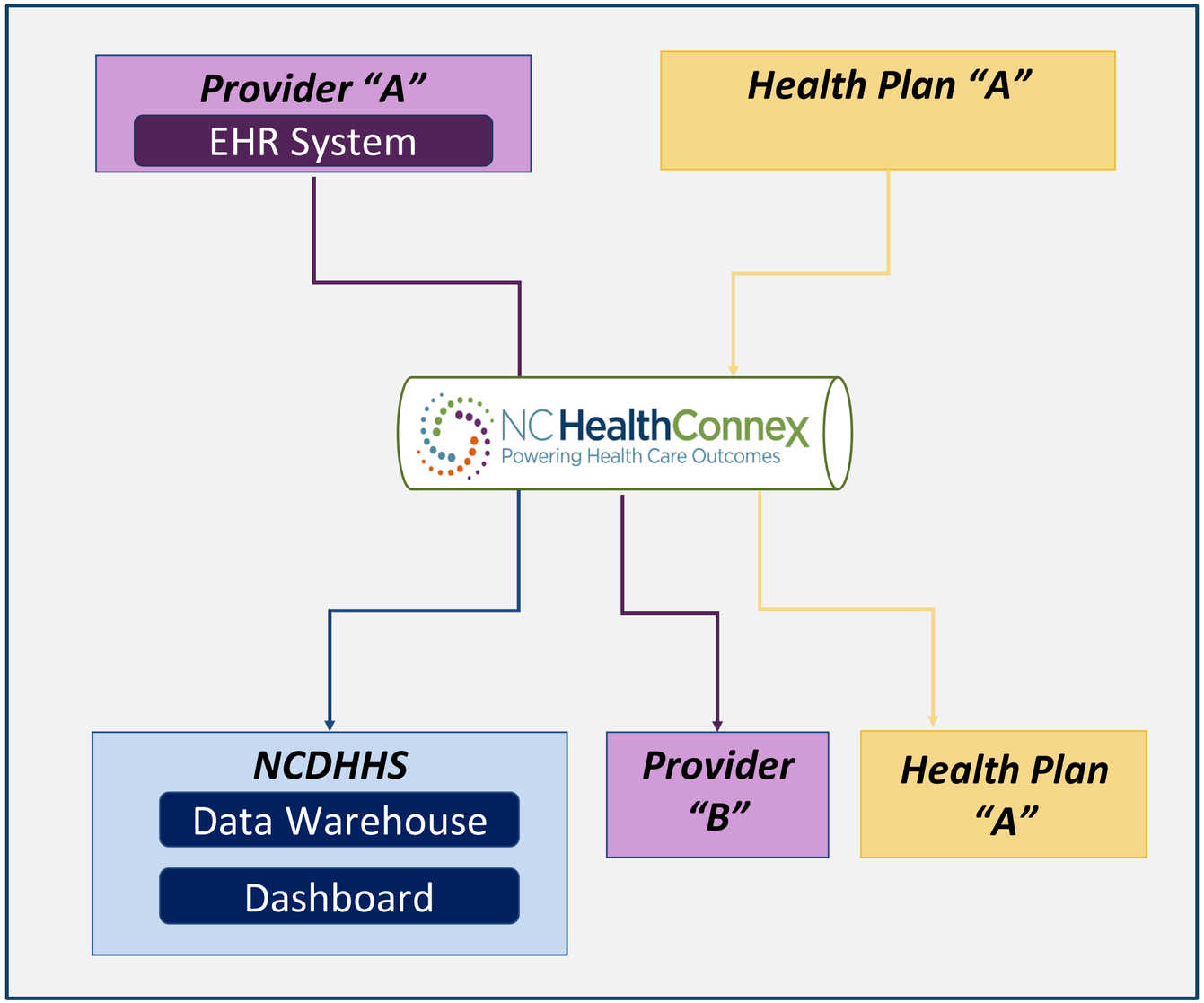
Mapping Screening Questions

Variation Types	SDOH Domain	High-level Question	Version 1 of Question	Version 2 of Question
1. No Variation Questions Are Exactly The Same	**Food**	**Worry about food**	Within the past 12 months, did you worry that your food would run out before you got money to buy more?	Within the past 12 months, did you worry that your food would run out before you got money to buy more?
2. Moderate Variation Meanings Are Essentially The Same	**Housing**	**Been homeless**	Within the past 12 months, have you ever stayed: outside, in a car, in a tent, in an overnight shelter, or temporarily in someone else's home (i.e., couch-surfing)?	In the last 12 months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?
3. Significant Variation Questions Address Different Topics	**Transportation**	**Lack transport**	Within the past 12 months, has a lack of transportation kept you from medical appointments?	In the past 12 months, have you been unable to get somewhere because you didn't have a ride?

Moving Forward…

Future Vision

- NC Medicaid recently received approval from CMS for an Advanced Planning Document (APD) that provides enhanced federal match to build on this work
- Goal: Expand and scale the HRSN screening data exchange infrastructure, including to primary care practices and Medicaid health plans



Next Steps

Next steps in 2024 & 2025:

1. Scale up solutions developed in the initial pilot to more providers
2. Build out necessary infrastructure to share outbound HRSN screening data with NC Medicaid, health plans, and permissioned providers
3. Develop and implement technical and operational supports for providers

In the future, we hope to integrate additional HRSN screening data sources and add information on referrals and interventions—ultimately creating holistic, linked data on each beneficiary's unmet resource needs

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