# The “H” in SDOH Also Stands for “HIE”

**Presented By:**


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THE RISE ASSOCIATION

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We are a network of health care professionals addressing the challenges posed by the emerging landscape of value-based care and government health care reform.

## OUR MISSION

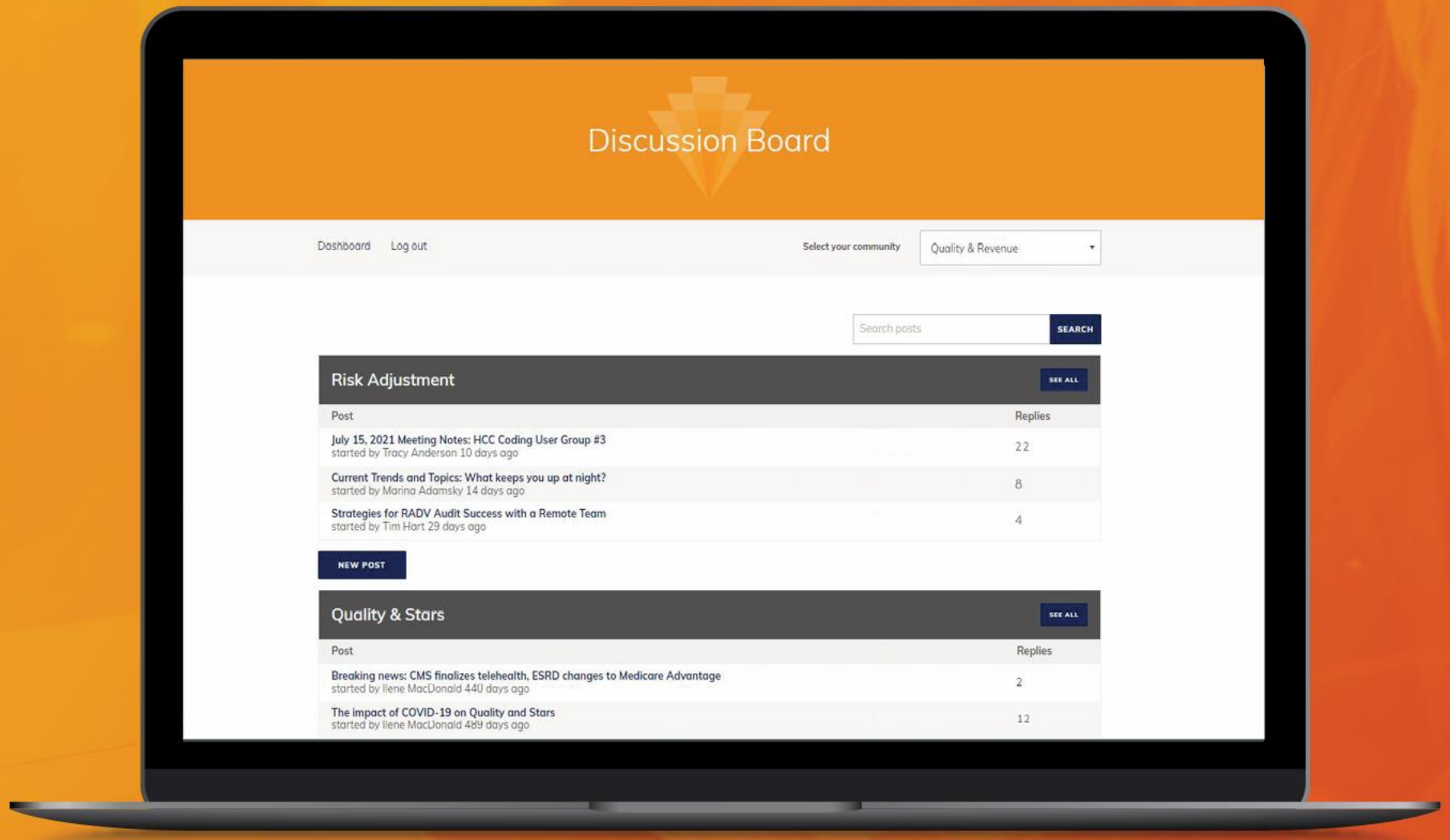
Our mission is to provide a community for like-minded professionals to come together for networking, education, and industry collaboration to stay ahead and advance their careers.

# ONE ASSOCIATION

# THREE COMMUNITIES




## LEARN MORE AT THE RISEHEALTH.ORG/MEMBERSHIP




# ASK YOUR QUESTIONS IN OUR DISCUSSION BOARD

# Learning Objectives

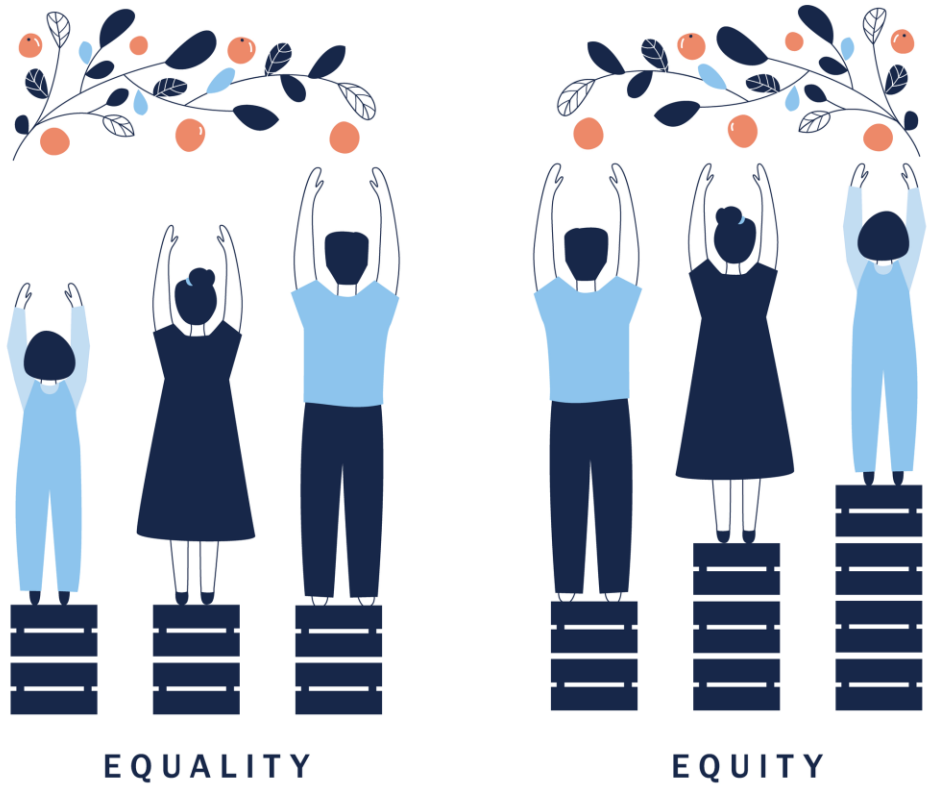
- **Learn how clinical data delivered in the right way improves health equity** and supports business activities, such as care/case management, quality reporting, care coordination, population-based analytics, and predictive risk assessments.
- **Discuss the role of technology solutions** in improving multi-stakeholder collaboration across the clinical, non-clinical, and community resources to close care gaps, improve health outcomes, and better address SDoH to advance overall population health equity.
- **Understand the tools and strategies** needed for accessing and using population data when implementing SDoH programs and risk and quality care gap closure activities.
- **Learn how to acquire and effectively use the clinical data** you have to improve SDoH outcomes and realize a return on investment.

# Domains of SDoH

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighborhood  and Built Environment
- Social and Community Context

# Whose Responsibility is Health Equity?

- Health equity is not the responsibility of any one entity, which is what makes it complex:
  - Government (policy, accountability)
  - Payer (benefits, care management, risk, quality)
  - Provider (engagement, clinical documentation)
  - Community and culture (support systems)



# CY 2023 Medicare Advantage Advance Notice

- Plans to enhance current CMS efforts to report stratified Part C and D Star Ratings measures by social risk factors to help MA and Part D sponsors identify opportunities for improvement.
- The development of a Health Equity Index as an enhancement to the Part C and D Star Ratings program.
- The development of a measure to assess whether plans are screening their enrollees for health-related social needs such as food, housing, and transportation.
- How MA organizations are transforming care and driving quality through value-based models with providers to use in the potential development of a Part C Star Ratings measure.

# CY 2023 HHS Notice of Payment and Benefit Parameters Proposed Rule – ACA

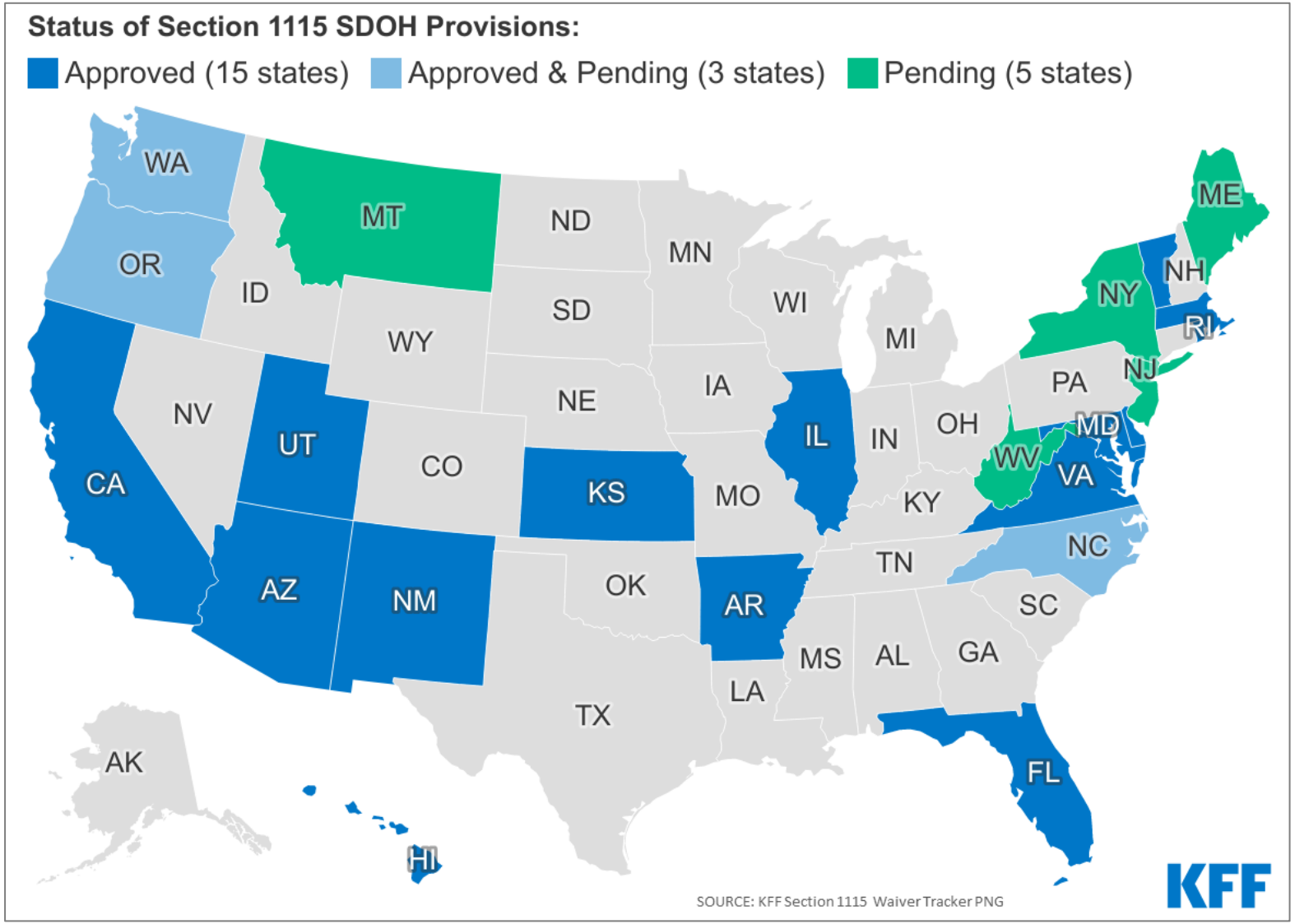
CMS proposes to collect and extract through issuers' EDGE servers five new data elements, including:

- ZIP code
- Race
- Ethnicity
- Individual coverage health reimbursement arrangement (ICHRA) indicator
- Subsidy indicator

# Medicaid News

Medicaid Section 1115 Waiver Approvals to Address Health-Related Social Needs

- **18 states approved**
- **8 states pending**




SOURCE: https://www.kff.org/medicaid/issue-brief/section-1115-waiver-watch-approvals-to-address-health-related-social-needs/ KFF Section 1115 Waiver Tracker PNG

# Accountable Care Organization (ACO) Realizing Equity, Access, and Community Health (REACH) Model

- Encourages health care providers to coordinate care to improve the care offered to people with Medicare and to achieve equitable outcomes.
- The new cohort will begin participation in the ACO REACH Model on January 1, 2023.

# TEAM = SDOH Success

- Health equity, population health and SDoH is not the responsibility of any one entity. Government, payers, providers and communities all have shared responsibility and these do not operate in silos
- Integrating SDoH into population health requires a multifaceted approach focused on data management AND care management – and these do not operate in silos


# SHARE HIE Extending Patient Care Beyond Traditional Healthcare

The Arkansas **State Health Alliance for Records Exchange (SHARE)** is a state-wide health information exchange (HIE), overseen by the **Office of Health Information Technology (OHIT)**, a division of the **Arkansas Department of Health (ADH)**.

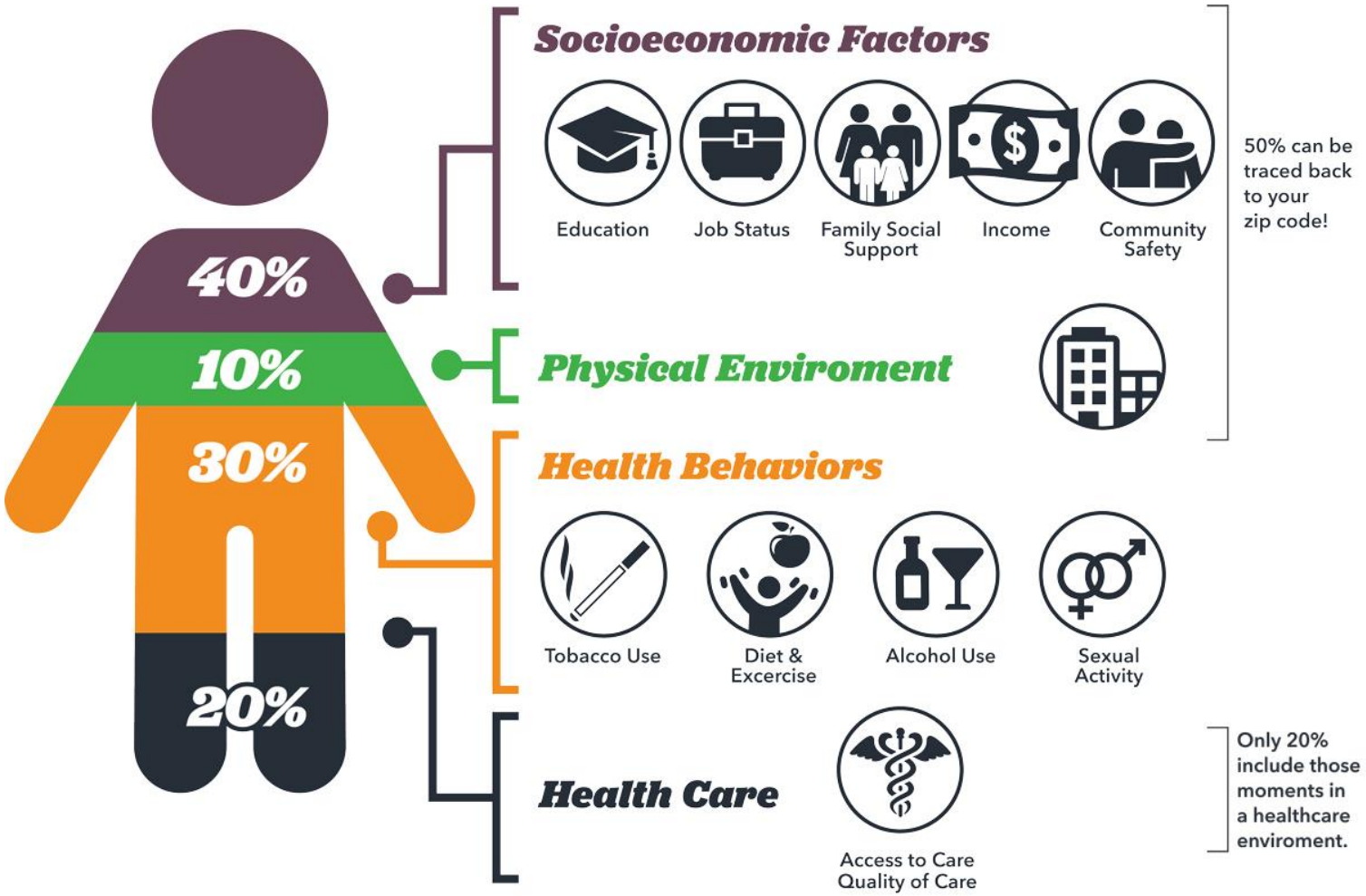
SHARE
State Health Alliance FOR Records Exchange

ARKANSAS DEPARTMENT OF HEALTH

*SHARE allows participating doctors, nurses, specialists, health services professionals and public health authorities to access and securely exchange with each other real-time, electronic patient information that is protected by federal and state privacy and security laws.*

# Did You Know…

**…that 80% of what makes up someone's health is determined by what happens outside of the hospital and health clinic?**



# Data NO Longer Siloed via HIE

- ❑ Clinical Care Summaries
- ❑ Discharge Summaries
- ❑ Lab Results
- ❑ Radiology Reports
- ❑ Medication Histories
- ❑ Immunizations
- ❑ Vitals
- ❑ SDOH (Social History)
- ❑ Allergies
- ❑ CCDs
- ❑ Problem Lists / Diagnoses
- ❑ Referrals
- ❑ Transcribed Documents
- ❑ Demographics

**HL-7 Messages, CCDs and Unstructured Documents**

# Population Health and SDO(H) = HIE Arkansas

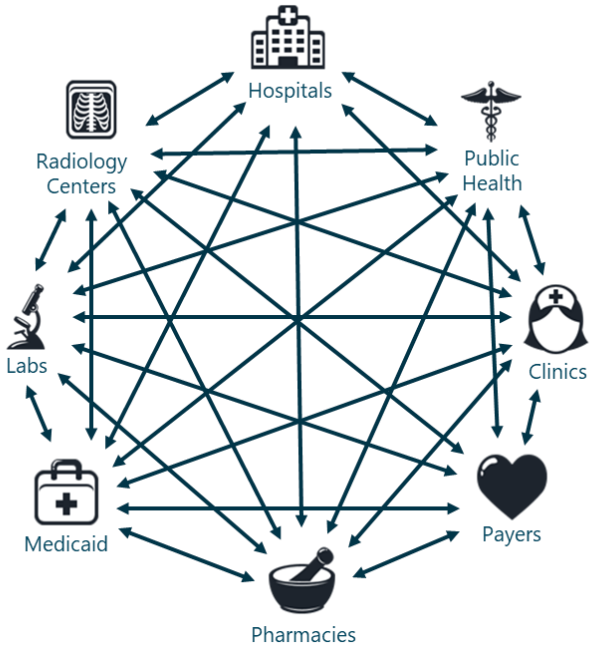
## Connecting health to social care

With SHARE, SDOH data is shared seamlessly, privately, and securely through the statewide health information exchange

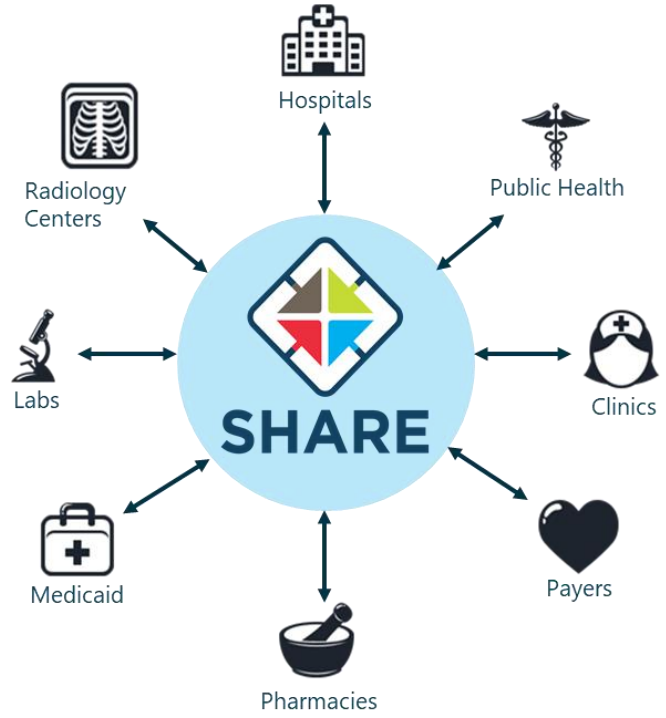
- Enhancing care coordination and delivery
- Allows participants to better serve the most vulnerable patients.

# Population Health and SDO(H) = HIE

## Appropriate, timely sharing of vital patient information through HIE can better inform decision-making at the point of care and allow care teams to:



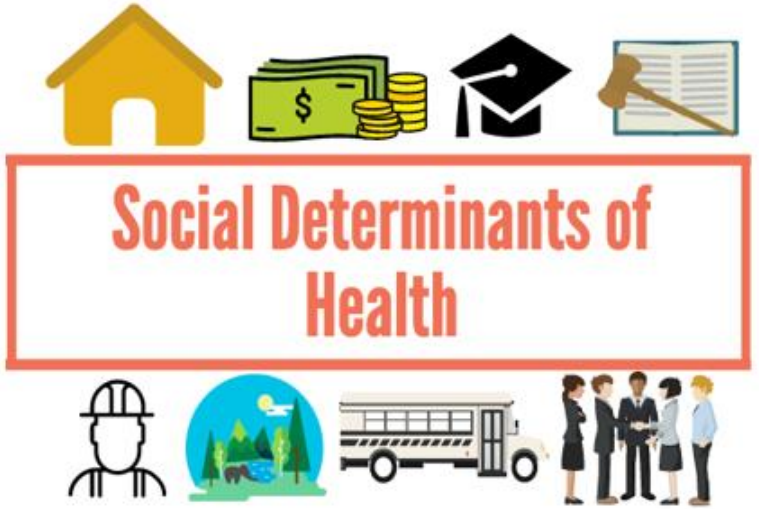

- Improve well-being of patient
- Avoid hospital readmissions
- Improve patient care coordination
- Promote improved management of chronic diseases
- Assists Health Plans, ACO, CIN in management of patient panels



# Impacting the Lives of Patients

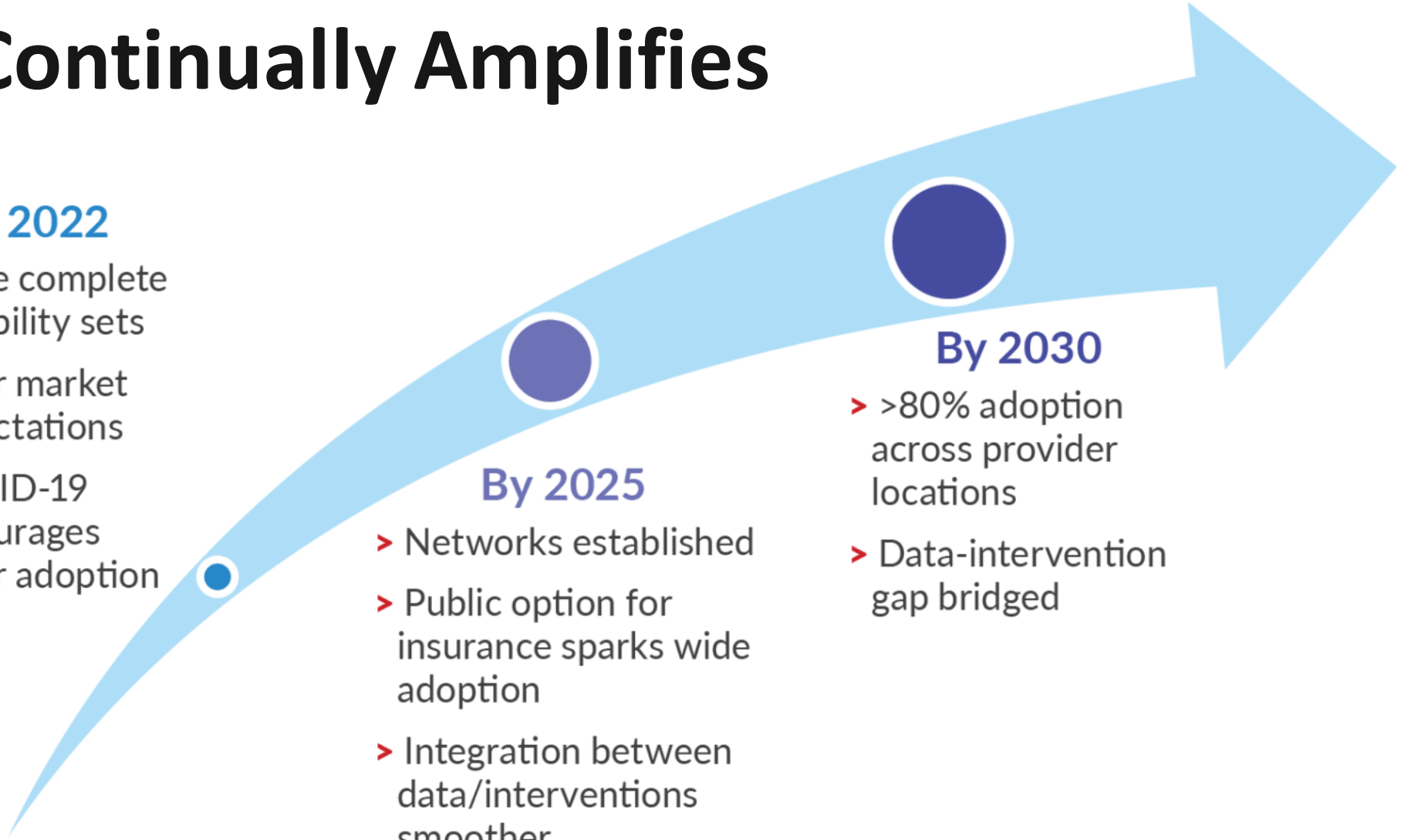
- Caring for patients and supporting the best health outcomes goes beyond the medical services.
- HIEs offer a powerful platform to help address the social determinants that **directly** and **indirectly** impact patients' health every day.

# SDOH Tools Connecting to HIEs




- **Screen for social needs** to address barriers to care and increase health equity.
- **Easily refer and connect** patients to local services they need, and the data is **NOT** siloed.
- **Improve collaboration** with a wide array of community partners (Health Plans, Hospitals, NGOs, Provider Practices, Behavioral Health)
- **Track the outcomes** of all referrals and services delivered.
- **Connect people** in need with resources including food, housing, transportation, mental health support, state benefits, and employment services and SHARE data to network.

# Steady March to Value-Based Care (VBC) Continually Amplifies



# Arkansas Population Health and SDoH Workgroup

**Justin Villines** , Arkansas Department of Health, OHIT/SHARE – Chair

**Team Members**

- Arkansas Behavioral Health Integrated Network (ABIN)
- Arkansas Children's
- Arkansas Children's Care Network (ACCN) (CIN)
- Arkansas Foundation for Medical Care (AFMC)
- Arkansas Department of Health
- Arkansas Pediatric Clinic
- Arkansas Chapter, American Academy of Pediatrics
- Baptist Health
- Central Arkansas Pediatric Clinic
- CHI St. Vincent (CommonSpirit)
- University of Arkansas for Medical Sciences

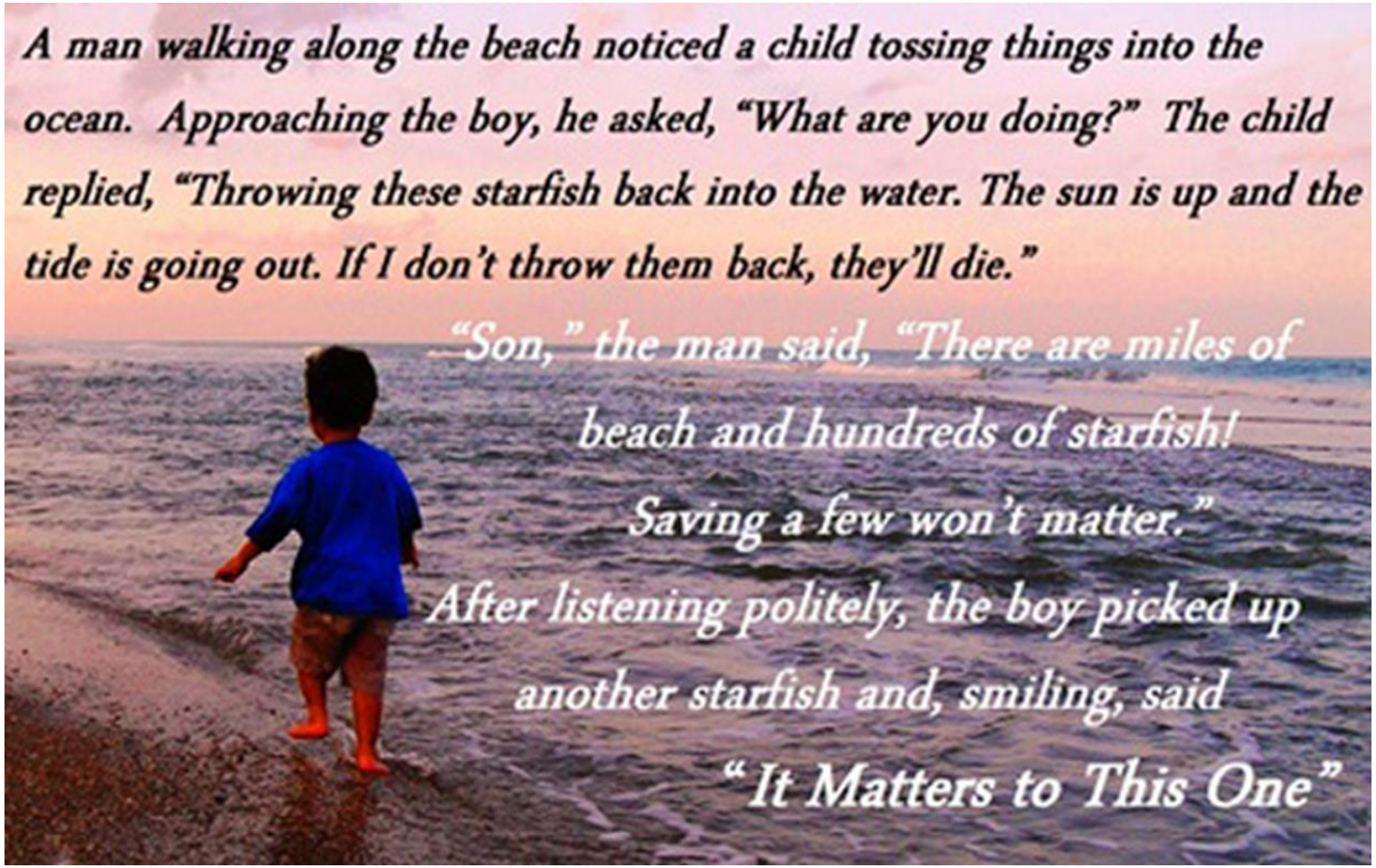
# SDoH…….  NOW What?

- **Z55** Problems related to education and literacy
- **Z56** Problems related to employment and unemployment
- **Z57** Occupational exposure to risk factors
- **Z59** Problems related to housing and economic circumstances
- **Z60** Problems related to social environment
- **Z62** Problems related to upbringing
- **Z63** Other problems related to primary support group, incuding family circumstances
- **Z64** Problems related to certain psychological circumstances
- **Z65** Problems related to other psychological circumstances

# In Summary

- Health equity, population health and SDoH is not the responsibility of any one entity. Government, payers, providers and communities all have shared responsibility.
- Integrating SDoH into population health requires a multifaceted approach focused on data management AND care management.

# It Matters to This One



# Additional Resources

- **Beyond the Z-Codes:** https://www.centaurihs.com/beyond-the-z-codes/
- The Accountable Health Communities Health-Related Social Needs Screening Tool: https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf
- Protocol for Responding To and Assessing Patients' Assets, Risks and Experiences: The PRAPARE Screening Tool – PRAPARE
- National Alliance to Impact the Social Determinants of Health:https://nasdoh.org/screening-tools-and-tool-kits/
- Developing and Testing Risk Adjustment Models for Social and Functional Status-Related Risk Within Healthcare Performance Measurement - Final Technical Guidance: NQF: Developing and Testing Risk Adjustment Models for Social and Functional Status-Related Risk Within Healthcare Performance Measurement - Final Technical Guidance (qualityforum.org)
- 3 Steps for Building an SDoH Business Case (LexisNexis): Building an SDOH Business Case | LexisNexis Risk Solutions

# THANK YOU