

# Data, Coding & Information Exchange 101

## *Sharing Care*

# Webinar Instructions

## Audio Options

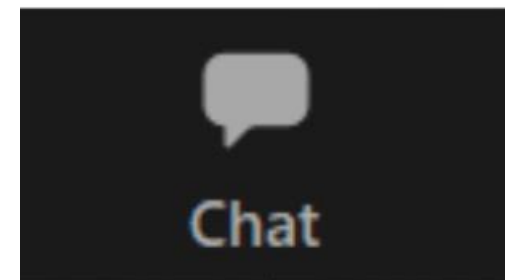
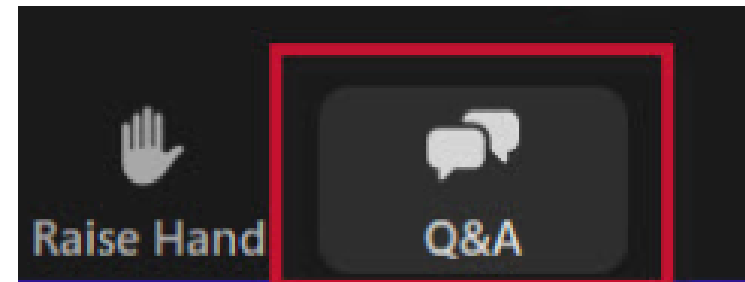
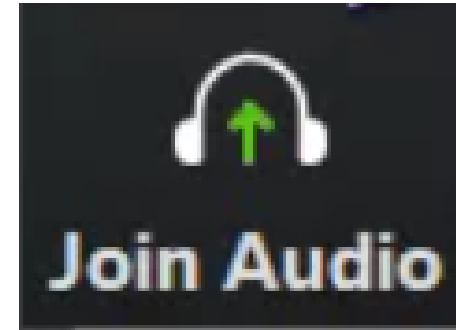
- Use your computer speakers, **OR** dial in using the phone number in your registration email.
- All participants are muted.

## Questions and Answers (Q&A)

- You can submit questions for the panelists at any time during this presentation. On the Zoom module on the bottom of your screen, click the Q&A icon, type your question in the box and submit.

## Chat Feature

- The Chat feature allows webinar attendees, the host, co-hosts and panelists to communicate for the duration of the webinar.



# Accessibility

- **Screen Reader Users: Reduce unwanted chatter**
  - Request speech on demand: Insert, Spacebar, “S”
- **To get our attention if you need tech assistance:**
  - Raise or Lower Hand: Alt + Y

# Speakers

Michael S. Klinkman, MD, MS

Professor, Departments of Family Medicine and Learning Health Sciences  
University of Michigan Medical School

Medical Director, Cross Sector Data Sharing Program, MiHIN

Courtney Baldrige

Business Strategy & Health Systems Integration

USAging

# Session agenda

- **What's currently happening in the social care landscape?**
  - SDOH (and HRSN) are the highest priority issues for health care
  - What is driving changes and social care integration efforts?
  - Who are the players in this space?
- **How can social care organizations engage in these efforts?**
  - The complementary workflow of medical and social care
  - A shared care model for social care
  - What needs to be done to support shared care?
- **What will it take to build equitable shared care?**
  - Data standards (codes)
  - Data exchange between medical and social care providers and payors

# What's happening?

# SDOH/HRSN are ‘all the rage’

[Social Determinants of Health/Health Related Social Needs]

## There is growing recognition that:

- “Health” mainly happens outside of the medical care setting
- Evidence-based outcomes confirm the value of HCB services and supports to a person’s health
- Services and supports can improve outcomes AND provide cost savings to the health system
- Populations without access to meals and rides via Older Americans Act (or other funding sources) would benefit from access to these services
- The effort to modernize SDOH offerings, drive a reduction in health care spend, and rethink how we best manage a broader population with significant HRSN is changing the landscape.

**These realities have driven changes in states approaches to Medicaid, CMS’s and MCO’s approach to Supplemental Benefits, and the creation of new programs and healthcare and socialcare integrated opportunities to leverage HCBS.**

# What (who) are the drivers of social care integration?



# Stakeholders:

## Standards Bodies, Governmental Entities, Data Exchanges, Payors

- **National (technical) collaboratives for standards development**
  - Gravity Project
  - HL7, Direct Trust, InformUSA
  - Project Unify
- **Federal agencies [ONC, NCVHS, White House....] and now state agencies**
  - Guides and “Playbooks”
  - Standards recommendations and acceptance (binding for medical orgs)
- **Health Information Exchanges [+ Community Information Exchanges]**
  - Develop and implement data sharing/exchange protocols and policies
  - CIVITAS as a national convenor
  - TEFCA and QHINs
- **Payors – (Big P and little p) -- CMS, States, plans, health systems**

# Health sector policy changes and funding incentives to address HRSNs

- **Medical care organizations and payors**
  - Next wave of primary care transformation
  - Provider and PO incentives for SDOH screening, use of ‘Z-codes’
- **CMS & CMS Innovation Center**
  - Medicaid HCBS program/1115 waiver program expansion
  - eLTSS extension, D-SNP, C-SNP
  - **Medicare 2023-24 IQR reporting (In patient Hospital Screening)**
  - **Medicare 2024 Physician Fee Schedule**
  - Innovation Center: Making Care Primary, AHEAD
- **ONC & NCVHS**
  - Community Information Exchange ‘playbook’
  - New coding standards for social care (LOINC, ICD-10-CM, etc)
- ***On the horizon – State initiatives (CalAIM, others)***

# CMS Hospital Inpatient Quality Reporting (IQR) Program, 2023-2024

- **SDOH-1: Screening for Social Drivers of Health**  
% of inpatients 18 years or older who are screened for: food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety
- **SDOH-2: Screen Positive Rate for Social Drivers of Health**  
% of inpatients 18 years or older who screen positive for: food insecurity, housing instability, transportation needs, utility difficulties or interpersonal safety
- **Required as of January 1, 2024**

CMS.gov

Centers for Medicare & Medicaid Services

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## FY 2024 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule – CMS-1785-F and CMS-1788-F Fact Sheet

Aug 01, 2023 | Billing & payments, Hospitals, Policy

# CMS: 2024 Medicare Physician Fee Schedule

**Reimbursement for ‘SDOH risk assessment’**  
[aka SDOH screening] (GXXX5)

**Reimbursement for  
Community Health Integration services –**  
care coordination for social problems (GXXX1 and GXXX2)

*Documentation in patient’s medical record (not fully specified)*

*Not available if patient also receiving home health services*

52262

Federal Register / Vol

DEPARTMENT OF HEALTH AND  
HUMAN SERVICES

Centers for Medicare & Medicaid  
Services

42 CFR Parts 405, 410, 411, 414, 415,  
418, 422, 423, 424, 425, 455, 489, 491,  
495, 498, and 600

[CMS–1784–P]

RIN 0938–AV07

**Medicare and Medicaid Programs; CY  
2024 Payment Policies Under the  
Physician Fee Schedule and Other  
Changes to Part B Payment and  
Coverage Policies; Medicare Shared  
Savings Program Requirements;  
Medicare Advantage; Medicare and  
Medicaid Provider and Supplier  
Enrollment Policies; and Basic Health  
Program**

**AGENCY:** Centers for Medicare &  
Medicaid Services (CMS), Health and  
Human Services (HHS).

**ACTION:** Proposed rule.



Office of the National Coordinator  
for Health Information Technology

# Social Determinants of Health Information Exchange Toolkit

**FOUNDATIONAL ELEMENTS FOR COMMUNITIES**

February 2023

[https://www.healthit.gov/sites/default/files/2023-02/Social%20Determinants%20of%20Health%20Information%20Exchange%20Toolkit%202023\\_508.pdf](https://www.healthit.gov/sites/default/files/2023-02/Social%20Determinants%20of%20Health%20Information%20Exchange%20Toolkit%202023_508.pdf)

# Push for inclusion of “SDOH data” in Health Information Exchanges



*SDOH screening  
Social problems  
Social interventions  
'closed loops'*

# How can social care engage? *The shared care model*

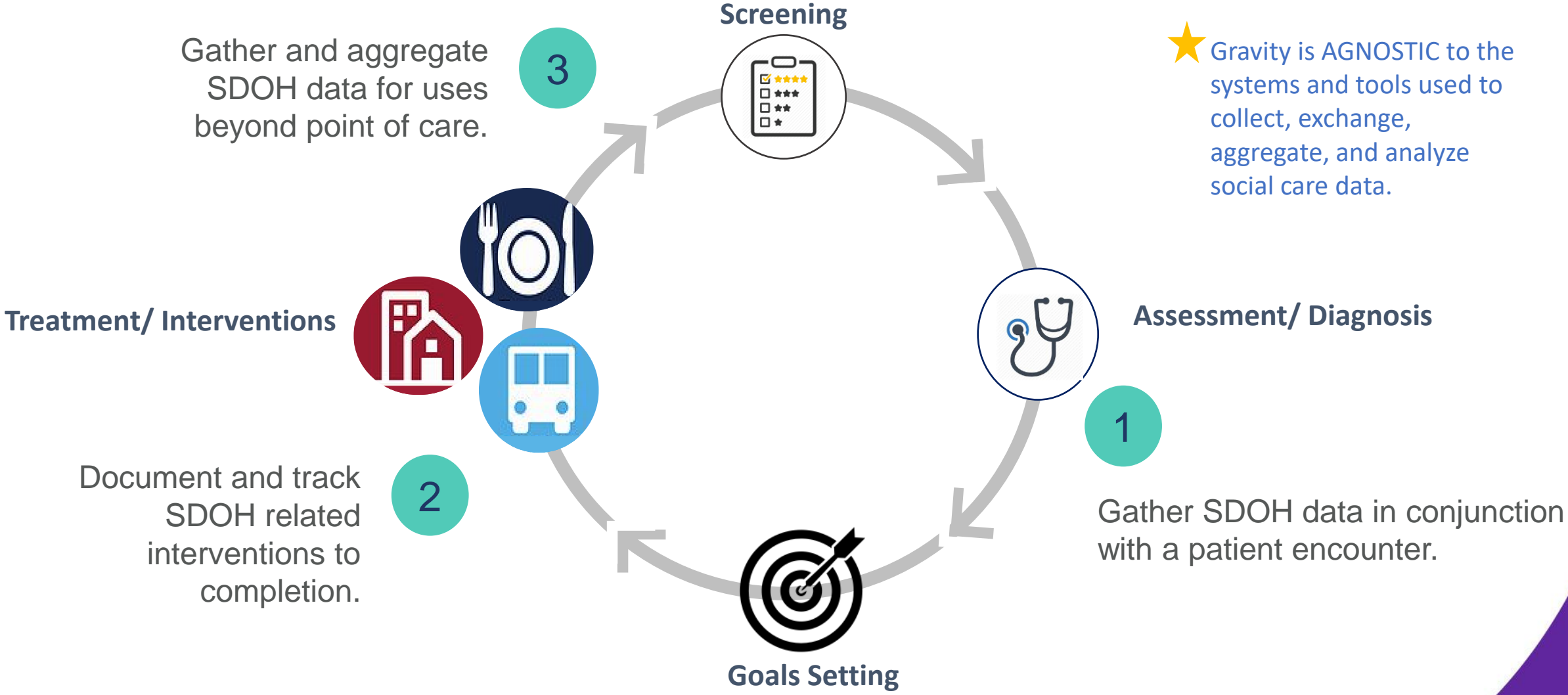
Important note:

Shared care is not the same thing as the data-centric “social care integration” or “health system integration” currently envisioned and implemented in most medical care settings.

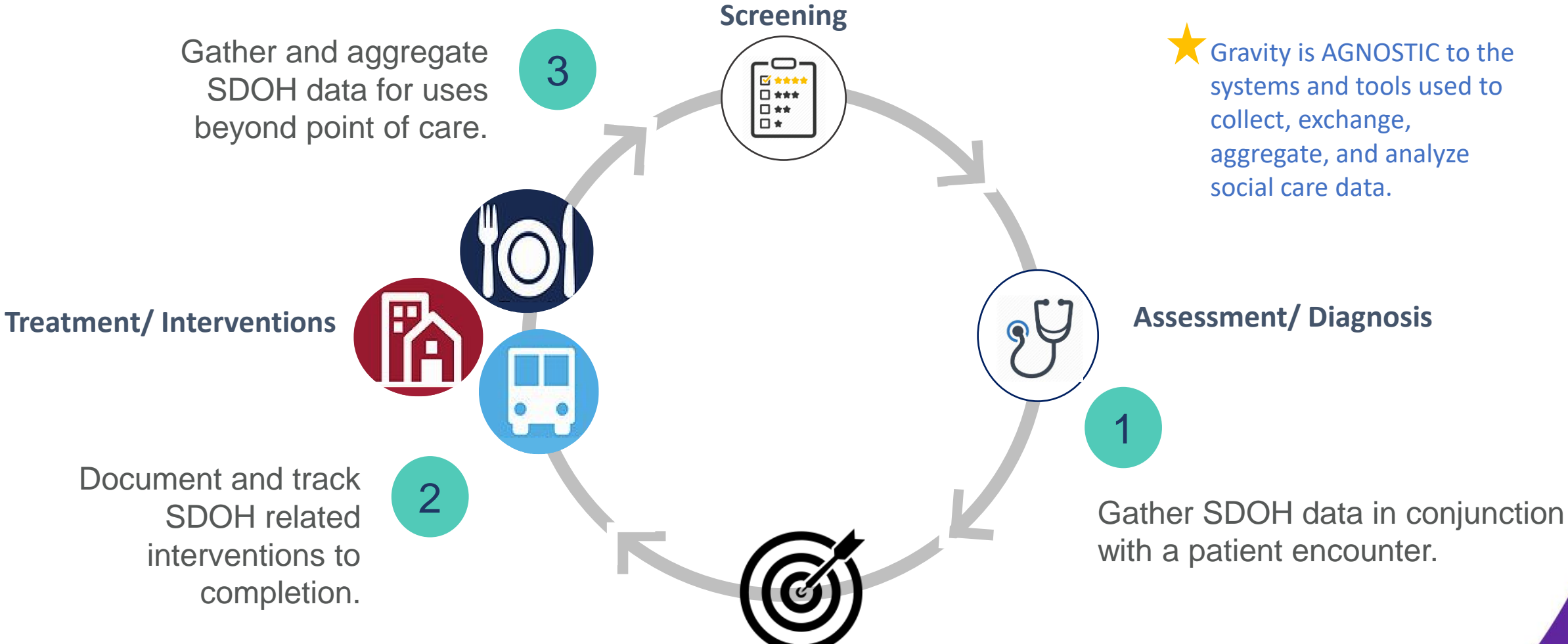
Shared care focuses on providing person-centered care that engages providers from more than one domain in effectively sharing the information necessary to support care.



# Original Gravity Project social care model

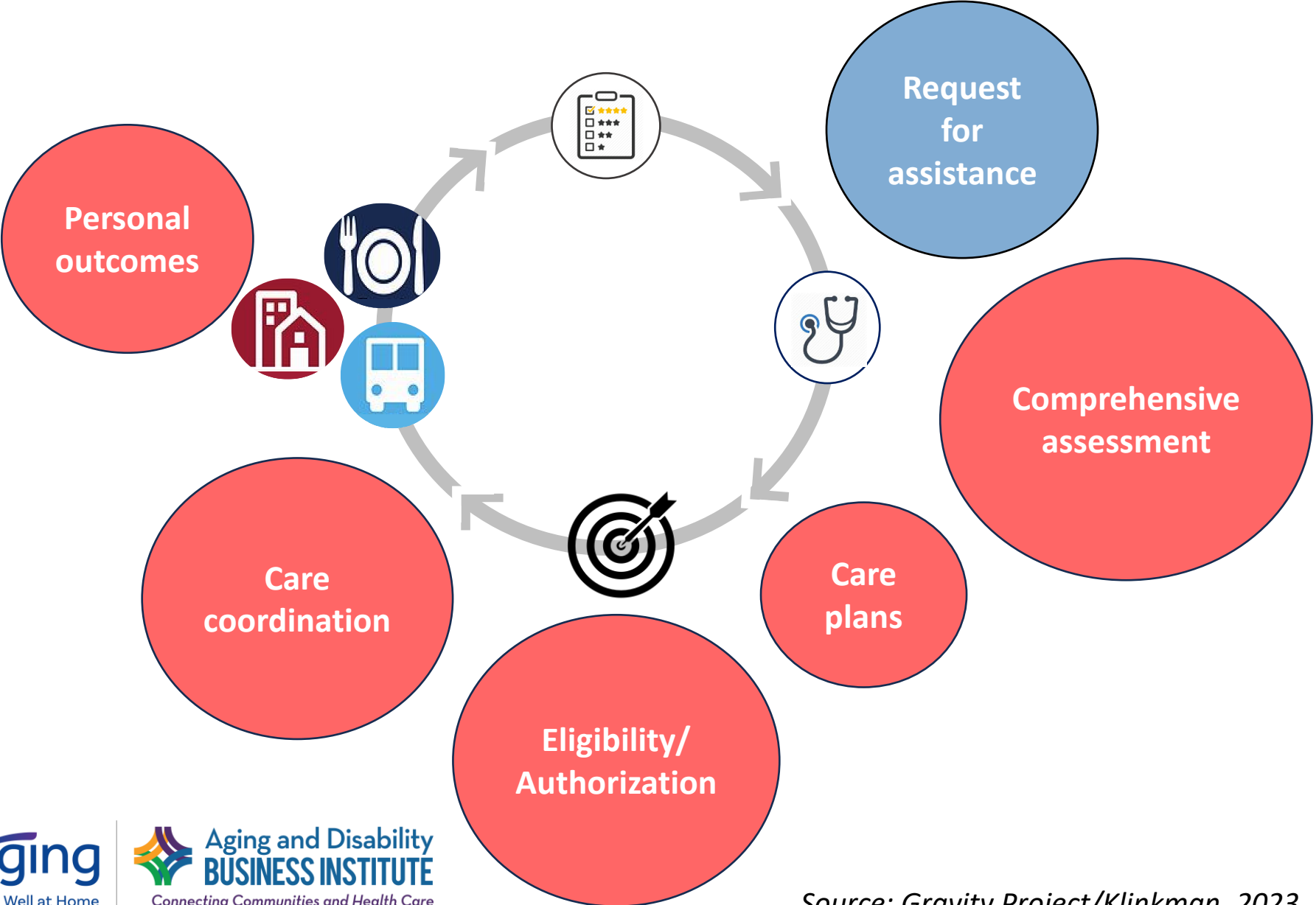


# Original Gravity Project social care model



***They send you patients. You give them data.***

# Expanded social care model: accounting for shared care



# Some important shared care issues to address

## Request for assistance

- Need to develop standards for referrals to social care - what type of assistance or service is requested
- Need for identity-matching across sectors

## Comprehensive assessment

- Need to advocate for comprehensive assessment of referred patients with 'SDOH' needs
- Need means to assess the quality of incoming referrals
- Need ability to redirect or decline referrals
- Need for bidirectional communication regarding steps after assessment

## Eligibility/ Authorization

- Need for means to determine eligibility for services
- Need for bidirectional communication regarding authorization (ex: CMS Community Health Integration codes)

# Pressing problems to solve before implementing shared care / Health System Integration models

- Screening versus Assessment
- Low quality referrals
- Payments are adequate to cover staff costs, payments are needed for services
- Socialcare is a complicated landscape for eligibility and consent
- MANY redundant and incompatible datasets, systems and platforms, reporting requirements, training and credentialing requirements, etc.

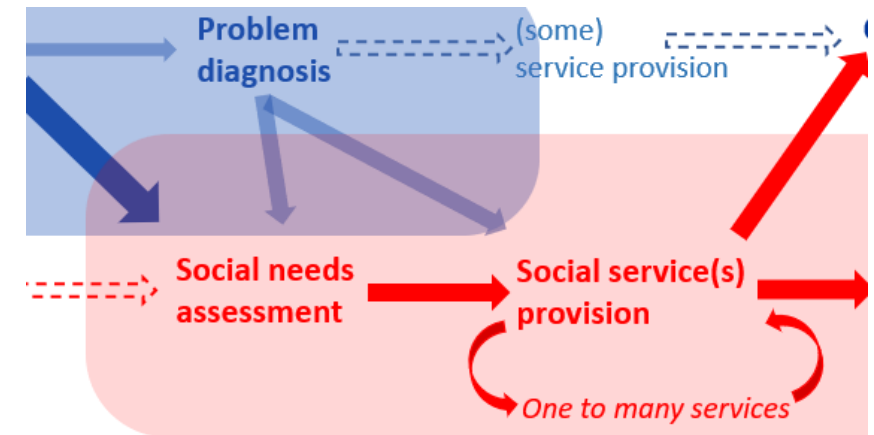
**Data!**  
**Coding!**  
**Information exchange!**

# Data, coding and information exchange tasks ahead...

- **Map common workflows (ex: assessment, referral, care plans, service provision, care coordination)**
  - Workflows needed to acknowledge & accommodate the many steps in social care
  - Once workflows are known, data needs can be determined
- **Determine core data requirements (these are evolving!)**
  - Need to capture what socialcare does in a standard, reproducible way
  - Need to use common language accepted by health care (or be able to map codes and terms)
    - *Medical – LOINC, ICD, SNOMED, CPT.*
    - *Social – multiple, InformUSA as repository*
- **Develop Information Exchange capacity to share data with health care**
  - *Medical – HL7, now FHIR*
  - *Social – multiple conflicting requirements*
  - *One possible goal: FHIR-enabled Direct Secure Messaging*
- **Determine roles of social care professionals: CHWs, LSCWs, 211 navigators, SWs, others**
  - Who does what? What task(s) is/are appropriate for which professional?

# Example: data exchange capabilities needed for contracting

- **Receive and accept referrals from medical clinicians and health care systems**
  - *What does the referral look like, is it complete?*
- **Receive authorization for service**
- **Participate in ‘closing the loop’**
  - *What constitutes closing the loop?*
  - *What flexibility do socialcare clinicians have to identify additional service needs?*
- **Document the care provided (& follow funders’ requirements)**
- **Bill for services provided (using funders’ codes)**
- **PLUS - Connect to your own network of social service providers (‘social-to-social’ connections).**





# Questions? Comments?

# Thank you!