September 21, 2021

EHRA Submission to the Congressional Social Determinants of Health Caucus RFI

Experience with SDOH Challenges

1. What specific SDOH challenges have you seen to have the most impact on health? What areas have changed most during the COVID-19 pandemic?

The COVID-19 pandemic has brought to light health inequities that are unfortunately not new to the healthcare industry, and it has thankfully led to an increased focus on addressing the issue. We have seen clear demonstration of differing experiences during the pandemic for certain populations, particularly Black, Latinx and American Indian / Alaska Natives, but the underlying challenges that led to those disparities in outcomes -- ranging from a lack of electricity and running water to access to telemedicine, distance to testing facilities to more frequent inter-generational housing situations that put the elderly at greater risk of exposure -- have existed for decades. One positive change is that health IT companies played a critical role in rapidly developing and deploying enhanced reporting functionality to our clients (healthcare provider organizations) during this public health crisis to help public health organizations gain concrete visibility into the scope of this issue, facilitating this conversation now being had by the Social Determinants of Health Caucus.

Recognizing that the identified disparities are not new, we note that the use of screening tools for SDOH has increased substantially over the last several years and hear from our clients that utilization of various programs based on SDOH data availability has increased as well. In many cases, this increase in utilization is resulting in provider organizations and their partners in the community expending all currently available resources, indicating a need to increase capacity of these programs. As screening identifies the true scope of the need in the community, it is critical that funding for responsive programming and addressing root causes, where possible, is increased to match and that the capacity to bidirectionally exchange information between providers and community-based organizations be expanded.

Our clients also experience challenges with the different ways that common SDOH concepts are collected and exchanged absent good standards for semantic interoperability of the data. While ONC is already working with standards developers to strengthen support for standardized

AdvancedMD	CPSI	Experity Health	MEDHOST	Nextgen Healthcare
Allscripts	CureMD	Flatiron Health	MEDITECH, Inc.	Office Practicum
Athenahealth	eClinicalWorks	Foothold Technology	Medsphere	Sevocity - Division of Conceptual Mindworks, Inc.
BestNotes	eMDs	Greenway Health	Modernizing Medicine	STI Computer Services
Bizmatics	Endosoft	Harris Healthcare Group	Netsmart	Varian Medical Systems
Cerner Corporation	Epic	Lumeris	Nextech	

assessments and value sets for SDOH data through the adoption processes used for maintenance of the U.S. Core Data for Interoperability (USCDI), there is a risk here that well-intended work to address health inequities will lead to program launch or expansion that is not based on standardized data requirements. Doing so would make it very difficult to implement a standards-based data exchange approach to SDOH in the future, as we have seen in other public health efforts, such as Prescription Drug Monitoring Programs (PDMPs), so we recommend enhanced funding for standards development and promulgation at the earliest possible date so as to avoid standards being the reason for any serious delay in progress.

While much attention has been paid to health care delivery organizations, funding is critical for community based organizations and initiatives to connect and share information with healthcare providers to facilitate better coordination between health and social care. Standardized data sets across stakeholders would promote interoperability across the respective systems, helping to "close the loop" on necessary patient follow-up. Congress should create funding opportunities to enable these organizations to adopt the necessary IT infrastructure to do so.

We note that specific to the COVID-19 pandemic, barriers to care, such as lack of transportation and available time, were at least in part reduced thanks to the increased availability of telehealth services made possible through expanded authorization from Congress and special waivers. However, many of these tools require patients to have access to high-speed internet service, which is not the case in many rural and underserved populations. While much attention is paid to the availability of broadband internet, it is also important that programs be expanded that provide access to helpful technologies, such as tablets, that help patients stay connected to their providers, provide data through their personal health records / patient portals and participate in telehealth visits.

2. **What types of gaps in care, programs, and services serve as a main barrier in addressing SDOH in the communities you serve? What approaches have your organization, community, Tribal organization, or state taken to address such challenges?**

Even where relationships exist between healthcare organizations and nearby community-based organizations (CBO), there is a lack of information sharing and coordination across programs. There is a distinct difference in the existing capability for information exchange between healthcare organizations, with tens of millions of record exchanges occurring daily, and the rudimentary levels of exchange between care providers and CBOs that they wish to refer patients to. While much of the information that would need to be shared would go from the clinical setting out to the social service agency, in some instances, there are also use cases in which the community professional might take note of information that would be beneficial for the doctor or other care provider to be aware of and incorporate into the patient's medical record. At a minimum, building the infrastructure for a closed-loop referral process would be very helpful to all involved, as well as enhancing funding for the CBOs to invest further in their own interoperable technologies outside of traditional health IT.

We note eHI's *Guiding Principles of Ethical Use of Social Determinants of Health Data* paper that provides further perspectives on appropriate use and sharing. A privacy and consent management framework that supports ethical use of SDOH also must consider considerations such as the following:

- Appropriately vs. inappropriately mixing of parental and children's SDOH – Even if "mixed," should it be shared under the same rules, or separated?
- Appropriately sharing identifiable, de-identified, or aggregate data – What must be shared, may be shared, or can never be shared at each level?

We suggest Congress enables HHS to work with all stakeholders to address these and other questions.

There are several states that have taken innovative approaches to SDOH and that can serve as models for coordination and collaboration, including Massachusetts, New York, Vermont, California and North Carolina. These states have invested in information exchange infrastructure, but even more importantly in regards to health inequities, they have built robust networks of community based organizations, care management agencies, and third-party SDOH experts (such as Unite Us and Aunt Bertha) to ease the process of connecting patients in need with those who can help address food insecurity, transportation and housing. Further, some have implemented innovative payment models and waiver structures.

3. Are there other federal policies that present challenges to addressing SDOH?

Policy makers need to assess where there are needs in local and regional IT infrastructures, needs assessment functionality, and a clearer understanding of a privacy and consent management framework (currently a mix of HIPAA, 42 CFR Part II, FERPA, and other state policies) that provides clear guidance on what data can be shared with whom and how. Congress should urge the HHS Office for Civil Rights to enhance guidance on what is permitted under the HIPAA Privacy rule for providers as covered entities to share information with non-medical providers and community resource entities who are not covered entities for the sake of improving coordination of care. Finalizing the HIPAA proposed rule should provide clarity in this area, especially as it is expected to explicitly address disclosures to non-covered entities.

4. Is there a unique role technology can play to alleviate specific challenges (e.g., referrals to community resources, telehealth consultations with community resource partners, etc.)? What are the barriers to using technology in this way?

Technology plays a vital role in enabling community and healthcare providers to create awareness and match patients with available resources, coordinate referrals between organizations, and provide insights into populations with specific needs. To continue to expand these capabilities in a meaningful way, standards must be developed regarding interoperability between healthcare and community organizations, as well as a consensus on the appropriate context for stakeholder access to SDOH data to reduce the risk of bias in its use. We reference the best practices embodied by the Gravity Project for sharing SDOH data with community organizations.

The EHR Association and its members are committed to supporting safe healthcare delivery and fostering continued innovation to connect communities in new ways for our users and their patients and families. Digital tools, such as telehealth and consumer applications, can provide care and resources at patients' fingertips. Telehealth can help identify and address SDOH. Additionally, consumer applications – available through smartphones, which a majority of Americans own – can provide patients self-management tools and access to resources that may not be available in their community. We reiterate the need for the HHS OCR to underscore how sharing of clinical information with community resource organizations and non-medical providers is critical to providing a whole context for what is enabled to be shared and accessed using technology.

Congress should act to provide for permanent Medicare telehealth reimbursement, free from artificial barriers on utilization, such as requirements for in-person visits prior to the use of telehealth and geographic and originating site restrictions. Telehealth is fundamental to many efforts to address health inequities, with utilization as relevant for a patient in an urban environment who can't navigate public transportation after a knee replacement as it is for someone living on an isolated Native American reservation 50 miles from the nearest care provider.

Improving Alignment

1. **Where do you see opportunities for better coordination and alignment between community organizations, public health entities, and health organizations? What role can Congress play in facilitating such coordination so that effective social determinant interventions can be developed?**

From a technology perspective, data sharing is the most critical area of focus. That starts with understanding the data to be shared; when and how it is collected; whether it should be identified, de-identified or aggregated only; how to maintain data privacy; and enabling individuals to manage who has access to their individual data. Within EHRs, which are the primary focus of our members, further clarity needs to be established at an industry level as to what data is relevant to decision making in different stages of health care delivery, what data can best be collected by EHRs vs. public health/community/population health/other sources, recognizing that EHRs are focused on supporting direct care delivery vs. population health analytics.

Interoperability between community organizations, public health entities, and health organizations would be ideal, but many are not yet automated. Standardized collection of SDOH variables with standardized nomenclature would support that interoperability, enabling analysis of the impact of interventions. ONC should accelerate their work with standards developers now to establish example SDOH assessments and associated standards, such as those that have been recommended by the USCDI Task Force of the Health Information Technology Advisory Committee (HITAC) that advises ONC on all matters related to health IT policy under the 21st Century Cures Act.

Intellectual property limitations related to the creators of the SDOH assessment methodologies present a challenge at times, even where EHR developers have made extensive efforts to date to support our healthcare provider clients in expanding them. All standards, whether vocabulary or otherwise, should be easily available for all stakeholders to enable frictionless data capture and exchange of SDOH across all parties, including consumers. In some cases currently, providers are required to purchase licenses for various standards, even where some code sets are only available through a single organization; in those cases, there is no competitive landscape providing reasonable alternatives. We suggest that respecting the intellectual property and maintenance of any such standards, the funding for related adoption should come from the government rather than be borne by the providers who are required to use it, and appropriate provisions should be put in place to make these publicly available. Addressing licensing and funding now, as health equity efforts ramp up, has the opportunity to reduce friction in obtaining and deploying the relevant, validated and necessary screening tools that then can be incorporated into documentation and clinical decision support workflows.

We suggest a three-pronged approach Congress can take:

- Lay the groundwork to address SDOH and health disparities - includes funding for development of consensus-based standards to represent and exchange SDOH data/assessment outcomes (and improved standards to represent race and ethnicity), funding for technology adoption by healthcare providers so they have the tools to consistently collect and exchange that data, funding for community based organizations and social care agencies to adopt technology that can receive referrals from clinical systems, and incentives for healthcare organizations to consistently collect race, ethnicity, SOGI, and SDOH data.
- Design and implement scalable social programs that address patients' SDOH. There is robust literature on the SDOH that most impact a patient's health. Federal/state/local coordination focused on designing and implementing programs to address those SDOH needs and building a technology infrastructure that can handle referrals across the healthcare/social care divide (and where appropriate, in administering social safety net programs) will be where the government can help most. Defer to clinical/social care stakeholders on the best way to design and implement the programs. Part of it must include reimbursement for healthcare providers if they are directly expected to address a patient's SDOH beyond evaluating/assessing them.
- Measure the impact by stratifying existing eCQMs. From a healthcare lens, the goal shouldn't necessarily be to measure whether the provider addressed the patient's SDOH problems themselves, but rather to measure whether the social care programs are working by evaluating whether disparities in quality are closed over time. This can be achieved by stratifying existing eCQMs that measure clinical best practices rather than creating new "SDOH Quality Measures."

2. **What potential do you see in pooling funding from different sources to achieve aligned goals in addressing SDOH? How could Congress and federal agencies provide states and communities with more guidance regarding how they can blend or braid funds?**

Pooling funding from different sources is a mechanism to address the 'wrong pocket problem'. Congress and federal agencies can promote interagency collaboration to solve a particular problem, such as housing instability or transportation barriers. They can promote flexibility through Medicaid 1115 waivers and demonstration projects to test innovation beyond what is traditionally covered by Medicaid. Furthermore, fostering interagency budget coordination can support braiding and blending of funds.

3. **How could federal programs such as Medicaid, CHIP, SNAP, WIC, etc. better align to effectively address SDOH in a holistic way? Are there particular programmatic changes you recommend?**

This work must start with enabling the sharing of data and communication streams between healthcare delivery settings and community-based social services organizations and programs. We note that there are opportunities to extend the technologies that are currently widely deployed in the health care delivery space to community based health organizations without requiring investments into EHRs or other substantial health IT. Examples would be use of the Direct Messaging protocol using anything from pdf files to structured documentation (such as HL7 C-CDA), while emerging HL7 FHIR-based exchange reduce the technology requirements as well by further expanding on internet technology-based solutions. These technologies also would have the opportunity to facilitate effective referrals due in particular to the early adoption of HL7 FHIR based appointment and referral management capabilities between healthcare delivery and community health organizations. (Note that referral management capability within FHIR is still gaining traction; appointments are more widely adopted.)

We suggest tasking the Department of Labor and IRS with identifying programs for outreach, funding, and perhaps aggregated data sources to aid in identification of areas and populations of need. For example, the IRS could enhance the Community Health Needs Assessment elements that are part of the 501(r)(3) requirements of nonprofit hospitals and health systems to strengthen how providers speak to addressing SDOH related needs within their respective serviced communities. One may also further explore census data with general health status data (e.g., (cause of) [death by zip code](#)).

Considering the role of ONC is not limited to healthcare delivery and EHRs, we strongly urge that initiatives be coordinated with ONC to build on existing standards used in health care delivery to extend to the wider health management community around SDOH.

We also note that the use of Z-codes in the claims process is still nascent, but this presents a key opportunity for CMS to learn more about the current SDOH environment, do analysis to stratify by various demographic categories, and roll out responsive programming. Expanding the number of and capture of Z-codes may be among the easiest way to gather a larger pool of data

in this area without burdening providers with a new long list of quality measures. The reality is that there is already a tremendous amount of data on SDOH captured in EHRs, practice management and registration systems, so it is important that any efforts to measure and analyze data related to health equity not recreate the wheel but rather build on what is already being captured every day by care providers in their normal course of visit documentation.

4. **Are there any non-traditional partners that are critical to addressing SDOH that should be better aligned with the health sector to address SDOH across the continuum from birth through adulthood? What differences should be considered between non-health partners for adults' social needs vs children's social needs?**

To the extent that healthcare delivery systems will be expected to augment current social service programs, EHR developers need to be included in discussions to ensure that data models are aligned, reporting requirements are supported, and clinician burden is minimized.

We appreciate you asking about children's needs distinct from adults'. This is a delicate area when it comes to SDOH, as children are powerless to change any of the social determinants that are affecting their care and also entirely dependent on the adults in their lives taking advantage of any opportunities to address the circumstances even when care providers make them available. There are also issues of patient privacy that can be specific to pediatric patients, particularly teenagers when it comes to sexual activity and pregnancy, as well as sexual orientation and gender identity (SOGI), that can create challenging scenarios for both the patients and clinicians to navigate in trying to provide assistance. There is also an amplified need for building a trusted relationship between the care provider and the parents of pediatric patients, as those parents may be very hesitant to share issues with food insecurity or the ability to keep their home heated if they believe that sharing such information might result in their children being removed from their home.

There is a large volume of data captured by schools, housing authorities and other non-traditional partners that can be very informative to clinicians who see pediatric patients, but right now, there is very little link between the relevant entities. Facilitating a flow of information not only from care providers to those organizations but back again with follow-up to any referrals or new information gleaned from conversations with the patients outside the walls of the healthcare organization could be very helpful in addressing SDOH issues. We also note that during the COVID-19 pandemic, food and housing insecurity significantly worsened in the pediatric population, as many children lost access to free and reduced school lunches and their parents lost jobs. Necessary follow-up also became increasingly challenging as children were forced to stay in various locations in order to be safe while parents were ill, hospitalized or trying to hold down several jobs. Connecting the foster care system into the larger SDOH ecosystem of connected entities would be very helpful in ensuring that at-risk children don't suffer in their access to helpful programs during times of struggle.

We suggest that the Caucus particularly consult with the American Academy of Pediatrics to seek input as to their ideas specific to the differing factors they must consider.

5. **What opportunities exist to better collect, understand, leverage, and report SDOH data to link individuals to services to address their health and social needs and to empower communities to improve outcomes?**

While there are evidence-based screening tools that exist, there is variance among the domains and subdomains included, the timeframes of being able to address social needs, and response types (i.e., yes/no vs categorical responses). This results in inconsistencies among data collected for specific social needs. Further, comprehensive, standardized screening tools can be quite lengthy and time consuming, which can act as a barrier for successful implementation of such tools. In response, organizations frequently customize existing standardized screening tools, or they create a new screening tool allowing end users to focus on the top social needs of their communities and the social needs that can be intervened upon.

The time frame addressed by questions is also widely varied (i.e. have you experienced a need in the past two years vs. one year vs. six months vs. are you currently experiencing), making it difficult to understand the urgency of current needs vs. historical patterns. Exchange is then limited by differing workflows within each organization in terms of who documents the information (e.g. nurse doing an intake assessment, administrative staff during on-site registration, social worker or other clinician doing a direct consult interaction, self-reported data during the patient's registration process at home before they arrive, etc.), as well as how screenings are standardized, stored and scored/weighted. Additionally, there are differing definitions of domains & subdomains of SDOH data.

We suggest that there could be improved use of aggregated summary data at the population level to provide clinicians and CBOs with all necessary context, in addition to individual data available in the course of healthcare delivery that could indicate needs in other health programs and initiatives. These require a minimum standard vocabulary for SOGI-related data and other SDOH to enable improved consistency across stakeholders and quality of data collection.

We still see gaps in standardized and accurate reporting of race, ethnicity, and language demographics, and there is some concern that CMS may implement policy that could actually cause greater issues with data cleanliness, such as inferring race based on a patient's last name, as was proposed in the IPPS and PFS proposed rules, rather than waiting until the appropriate data collection and reporting functionality is available.

Such proposals are frequently driven by the fact that CMS systems are woefully outdated and need significant investment in order to be able to consume the wide array of data that is now captured by and reportable from EHRs.

We strongly encourage Congress to invest the necessary funds to allow CMS to upgrade their systems to be able to receive, consume and stratify data in order to be able to make the most informed decisions for healthcare providers and patients in this country. We also suggest that while those systems are upgraded, which we recognize would take time, that expanded requirements around the reporting of Z-codes would be a cost-efficient step, as CMS can already

receive and analyze that data, and that some effort be made by CMS to standardize what SDOH data is actually most necessary and can actually be used. Right now there, is significant variation in what data is requested to be reported by municipalities, states, and at the federal level, making it very difficult to do any "apples to apples" comparison of SDOH patterns or needs.

Ultimately narrowing the existing gaps will allow CMS and others responsible for quality to regularly stratify reports not only on quality measures but also on quality measures across race/ethnicity/language and other SDOH. In that context, it is important to consider how to collect the data and how it can be shared carefully; the healthcare delivery setting is not always the best place to collect certain data to achieve the desired level of completeness and accuracy. In some cases, it may make more sense for data to be captured and stored by payers, for example. This also emphasizes the need for a clear privacy and consent management framework to ensure the individual is aware and consents to how their data is used beyond the point of data collection.

We also must recognize the role of patient matching to ensure their data is correctly associated with the right record, and thus used correctly for analytics and decision making, while assuring a more complete record where appropriate.

It is important to respect the patient's right to share or not share such information about themselves, as virtually any socially determinative data has the risk of making patients feel vulnerable or exposed in some way. Patient privacy should still be considered the first priority, just as in any other health-related communication.

We also urge Congress to encourage the HHS OCR to finalize their HIPAA Privacy rulemaking that would improve clarity around the ability of provider covered entities to share information with community resource organizations and non-medical providers for the sake of coordination of both population level care planning and patient level care delivery.

6. **What are the key challenges related to the exchange of SDOH data between healthcare and public health organizations and social service organizations? How do these challenges vary across social needs (i.e., housing, food, etc.)? What tools, resources, or policies might assist in addressing such challenges?**

The lack of technology adoption by agencies hinders effective patient referrals for community services or resources. The Social Security Administration offers a good counterexample - they have demonstrated success in reducing benefits determination evaluation time by adopting interoperable technology. Similar outcomes could be achieved by implementing proper technology infrastructure for service organizations to receive referrals from healthcare providers.

As previously discussed, a lack of data standardization is a major barrier to the collection, exchange, and use of SDOH data. While foundational standards exist, much work is still needed to have use case specific implementation guidance to allow all stakeholders to implement those

standards consistently. Work is progressing on various approaches, such as HL7 where SDOH and referral focused guidance is emerging, but these only cover initial use cases, not yet a comprehensive set across all relevant use cases and needs.

Best Practices and Opportunities

1. **What are some programs/emergency flexibilities your organization leveraged to better address SDOH during the pandemic (i.e., emergency funding, emergency waivers, etc.)? Of the changes made, which would you like to see continued post-COVID?**

During emergencies and pandemics, individuals are often forced to leave the area where they otherwise live. This has highlighted the importance of the portability of patient data, which can follow the patient and be interpreted and used consistently across jurisdictions. The COVID pandemic created challenges for IT suppliers, including EHR developers, to support a quickly changing infrastructure. Earlier engagement and collaboration would enable a faster and smoother response when quick updates are needed to meet newly identified needs.

We have also learned that incomplete and non-standard data still has value; allowing for some flexibility in accepting data for expanded or new reporting requirements can encourage quick adoption and yield early insights. When implementing new reporting programs, we must strike a balance between being perfect from the start vs. building alignment and convergence over time. We must also realize that technology moves rapidly and learning is ongoing, so there is a need to have funding not only to start, but also to maintain and advance initiatives.

Relaxed reimbursement policies for telehealth implemented during the COVID-19 pandemic allowed more vulnerable and underserved communities to access health care services. Utilization rates of telehealth services were consistent across race and ethnicity and provided healthcare providers a greater opportunity to address SDOH. The EHR Association strongly recommends the permanent continuation of Medicare telehealth reimbursement, free from artificial barriers on utilization such as requirements for in-person visits prior to the use of telehealth and geographic and originating site restrictions.

2. **Which innovative state, local, and/or private sector programs or practices addressing SDOH should Congress look into further that could potentially be leveraged more widely across other settings? Are there particular models or pilots that seek to address SDOH that could be successful in other areas, particularly rural, tribal or underserved communities?**

The San Francisco Department of Public Health works with the Department of Homelessness and Supportive Housing to share data and technology to better facilitate the coordination of care for people experiencing homelessness, and the city of San Antonio launched a robust, connected SDOH effort several years ago. As previously noted, there are also innovative approaches being taken by MA, NC, VT and NY that should be investigated as best practices.

3. **Given the evidence base about the importance of the early years in influencing lifelong health trajectories, what are the most promising opportunities for addressing SDOH and promoting equity for children and families? What could Congress do to accelerate progress in addressing SDOH for the pediatric population?**

Again, we strongly encourage consultation with the AAP on this topic, given the unique factors of caring for pediatric patients.

Transformative Actions

1. **Alternative payment models help to measure health care based on its outcomes, rather than its services. What opportunities exist to expand SDOH interventions in outcome-based alternative payment models and bundled payment models?**

We suggest that CMS should focus first on a more complete and accurate reporting of patient race, ethnicity, and language, which as described above, requires a modernization of CMS' own systems and could also be done at least in part through an expansion of requirements associated with Z-codes. Once that is in progress, CMS could then stratify APM measures based on these divisions to understand how existing alternative payment models are affecting disparities in care. Right now, that is unclear because data analysis has been rudimentary to date.

It is also clear that CMS and commercial payers will need to provide reimbursement related to the documentation of social needs and interventions. This could be accomplished by determining reimbursement based on the severity of social needs (i.e., homelessness) as indicated through ICD-10 Z-codes, and for interventions to address the patient's unmet social need (i.e., case management and social work engagement for identifying long-term housing). A per member per month model has proven successful when matched with corresponding quality measurement to assure compliance with the extra effort required of providers.

We also note that while it would be necessary for social services agencies and other CBOs to invest in technologies that can receive and share information relevant to addressing the patient's SDOH, most of those organizations are frequently not identified as part of the patient's care team or reimbursed as such for delivery of interventions and thus do not have funds available to modernize their information exchange capabilities. Where organizations such as the YMCA, housing authorities, and food pantries – and health systems themselves who take it upon themselves to address challenges associated with transportation and food access -- are already providing critical support to tackle SDOH, they are almost never paid under the structure of health payments and thus remain underfunded. We suggest that CMS should assess where their Medicare and Medicaid program funding structures should recognize and pay for health-related activities that are taking place outside of the walls of a traditional healthcare provider.

2. **A critical element of transformation, particularly for new models of care, is measurement and evaluation. With SDOH in mind, which are the most critical elements to measure in a**

model, and what differences should be considered when measuring SDOH outcomes for adults vs children?

We suggest to continue the use of existing eCQMs since they represent best practices for clinical care, and stratify those eCQMs to measure SDOH outcomes by evaluating whether disparities across race, ethnicity, and other vulnerable groups are reduced over time. Further, Z-codes can be a useful source of additional information in data gathering and analytics.

We do note that CMS currently cannot consume all of the information requested in current quality measure programs. This is a short-coming that affects not just SDOH efforts but larger attempts to move to outcomes-driven reimbursement models. Their systems simply cannot receive or analyze the numerous data classes and segmentation that already exists in EHRs. Until this is addressed, efforts around quality measurement will remain limited, and patients will not receive the services they need as it relates to SDOH.

3. **How can Congress best address the factors related to SDOH that influence overall health outcomes in rural, tribal and/or underserved areas to improve health outcomes in these communities?**

Many of the SDOH-related needs (e.g., secure housing, internet access, food stability) to improve outcomes in rural, tribal, and underserved communities are similar to those of other communities but seen at dramatically higher rates. There are also some challenges, such as access to reliable electricity and running water that are more common in certain areas, and these are systemic challenges that must be addressed across the entirety of the federal government, ranging from Interior to Commerce to HHS. Further, higher funding and support may be needed to address those needs because it can be challenging to sustain a community-based organization or make social services readily accessible in certain geographies where the population is very spread out, so ensuring that those citizens have access to high-speed internet and modern technologies can make a huge difference in their ability to access telehealth, online schooling, and other helpful support.

4. **What are the main barriers to programs addressing SDOH and promoting in the communities you serve? What should Congress consider when developing legislative solutions to address these challenges?**

Congress must recognize that addressing SDOH is not solely a healthcare issue; challenges and barriers to leading a healthy, productive life can be found in every part of an individual's life. Congress should consider the CDC's Health in All Policies approach to the integration of health considerations in community planning decisions. These health impact assessments are used to anticipate and prevent triggers of negative social determinants and allow policy makers at federal, state and local levels to integrate health considerations into government-implemented policies like transportation, infrastructure and urban planning.

Open Forum

1. **Is there any other information you would like to share?**

22% of the population of the US is children, but standards to code for the SDOH for children are lacking even more than other categories. For example, children may not have employment difficulties, but their caregivers do, which directly impacts child health. There are also no good risk adjustment models for children that include caregiver/parental SDOH. It is necessary to identify gaps and work toward standards to impact this significant population.