EHRA
HIMSS ELECTRONIC HEALTH RECORD ASSOCIATION

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Chiquita Brooks-LaSure
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Brooks-LaSure,

On behalf of our 28 member companies, the HIMSS Electronic Health Record (EHR) Association appreciates the opportunity to provide feedback to CMS on the Medicare and Medicaid Programs and the Children's Health Insurance Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2025 Rates; Quality Programs Requirements; and Other Policy Changes Proposed Rule (CMS-1808-P).

The EHR Association is dedicated to improving the quality and efficiency of care through innovative, interoperable health information technology (IT) adoption and use. In doing so, we are committed to working toward a healthcare ecosystem that leverages the capabilities of EHR and other health IT to efficiently deliver higher-quality care to patients in a productive and sustainable way.

We appreciate this opportunity to provide CMS with the following detailed comments and look forward to continued collaboration toward improved patient care.

Sincerely,

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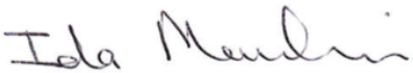

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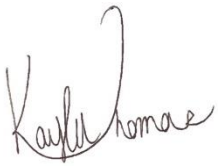

Kayla Thomas
Oracle Health

Established in 2004, the Electronic Health Record (EHR) Association is comprised of 28 companies that supply the vast majority of EHRs to physicians' practices and hospitals across the United States. The EHR Association operates on the premise that the rapid, widespread adoption of EHRs will help improve the quality of patient care as well as the productivity and sustainability of the healthcare system as a key enabler of healthcare transformation. The EHR Association and its members are committed to supporting safe healthcare delivery, fostering continued innovation, and operating with high integrity in the market for our users and their patients and families. The EHR Association is a partner of HIMSS. For more information, visit www.ehra.org.

The Patient Safety Structural Measure

Attestation Domains

Will be required starting in the CY2025 reporting period, impacting FY2027 payment. Requires a "Yes/No" response to attestation questions for each domain.

Five Patient Safety Domains:

1. *Leadership Commitment to Eliminating Harm*
2. *Strategic Planning and Organizational Policy*
3. *Culture of Safety and Learning Health Systems*
4. *Accountability and Transparency*
5. *Patient and Family Engagement*

The EHR Association broadly supports the domains of this measure and acknowledges their value for patient safety. In particular, we agree with the need for attention to and accountability for safety at all levels of an organization and recognize that hospitals must create the infrastructure to support a safety-driven culture. We note that the structure and focus of these domains align with those in the SAFER Guides. Consequently, many healthcare organizations may already be implementing aspects of these measures to some degree. Given this alignment, we recommend a staged rollout and adoption process similar to the approach used for the SAFER Guides to facilitate a smoother transition and allow organizations to integrate these measures into their existing patient safety frameworks.

Our members have raised concerns regarding the differences in attestation scoring between this measure, which is proposed to require attestation for each question, and SAFER Guides, which requires only an overall "yes" or "no" response. The EHR Association suggests adopting a similar requirement for the Patient Safety Structural Measure to ensure consistency and clarity in reporting. Organizations should be required to attest YES to indicate compliance with these safety measures, ensuring that patient safety remains a priority without negatively impacting the overall performance scores.

Domain 5 states "The effective and equitable engagement of patients, families, and caregivers is essential to safer, better care. Hospitals must embed patients, families, and caregivers as co-producers of safety and health through meaningful involvement in safety activities, quality improvement, and oversight." We agree that this is desirable, however, we recognize that there may be instances in which this is not appropriate. The EHR Association urges CMS to consider changing "must" to "should" to provide optionality when needed.

Measure Submission

We are proposing that hospitals would be required to submit information for the Patient Safety Structural measure once annually using the data submission and reporting standard procedures set forth by the CDC for the National Healthcare Safety Network (NHSN). We propose to adopt the Patient Safety Structural measure in the Hospital IQR Program beginning with the CY 2025 reporting period/FY 2027 payment determination and the PCHQR Program beginning with the CY 2025 reporting period/FY 2027 program year.

While we agree with CMS regarding the value of adopting these measures, the EHR Association recommends additional consideration be given to the adoption and attestation timelines. We are concerned the proposed requirements for the first year may be too demanding – without additional details on data submission and reporting standards, requiring more than a "Yes/No" attestation might not be feasible for many organizations. We propose a staged approach similar to the SAFER Guides, in which the first year involves only a "Yes/No" attestation without any impacts based on the organization's response. As with SAFER, requirements can be expanded in subsequent years, allowing for a gradual adoption and adjustment period.

Proposed New Measures for the Hospital IQR Program Measure Set

We are proposing to adopt seven new measures.

The EHR Association supports the adoption of these measures generally but encourages CMS to consider the workflow and education impact of such a volume of new measures and to align adoption and attestation timelines accordingly.

Advancing Patient Safety and Outcomes Across the Hospital Quality Programs-Request for Comment

Hospital quality reporting and value-based purchasing programs encourage hospitals to address concerns about unplanned returns through existing measures. However, CMS is looking for public comment on how these programs could further encourage hospitals to improve discharge processes, such as by introducing measures currently in quality reporting programs into value-based purchasing to link outcomes to payment incentives. CMS is specifically interested in input on adopting measures which better represent the range of outcomes of interest to patients, including unplanned returns to the ED and receipt of observation services within 30 days of a patient's discharge from an inpatient stay.

The EHRA strongly agrees on the value of enhancing discharge processes to improve outcomes and supports the measures that will aid in related analytics and goals.

Request for Information Regarding Public Health Reporting and Data Exchange

Questions for Goal #1: Quality, Timeliness, and Completeness of Public Health Reporting

Should CMS shift to numerator/denominator reporting requirements for current and future measures in the public health and clinical data exchange objective? If so, should CMS prioritize only certain measures for numerator/denominator reporting?

The EHR Association does not recommend moving to a numerator/denominator reporting requirement, as this adds an unnecessary layer that requires additional measurement work and calculations, creating additional burden without adding value for those reporting or those receiving the reports.

New technical approaches such as the use of FHIR APIs to support information exchange with PHAs could enable PHAs to query healthcare provider systems directly, after an initial trigger, rather than solely relying on a healthcare provider to take action to share information. How could performance be measured under approaches such as the use of FHIR APIs to support information exchange with PHAs? Would numerator/denominator reporting be appropriate under such approaches?

The EHR Association is concerned that the focus on FHIR-based queries suggests a shift from push-based reporting upon the occurrence of a defined event to a model in which a notification of an event triggers a data query. This architectural change creates a less efficient reporting mechanism for providers and introduces unnecessary IT challenges, potentially impacting the performance of systems primarily designed to support clinical care. We recommend a mixed approach: use clearly defined trigger events with associated data requirements to push data at the appropriate time (using HL7 v2, CDA, and/or FHIR-based formats or transport), followed by FHIR-based queries for any additional data that was missed or found to be of additional interest for follow-up investigations.

Furthermore, how to quantify queries in a meaningful way is unclear. For example, are more queries better or worse? What would the denominator be—queries per eCR submitted? The EHR Association suggests that focusing on the ability to query for follow-up data is more suitable than simply counting the number of queries.

Should CMS continue to add measures under the PH and CDE objective to include additional system-specific requirements (for example, vital records)? If so, which ones and why?

The EHR Association supports including vital records as a valuable addition to the public health reporting requirements under the Public Health and Clinical Data Exchange objective.

Should CMS create a new measure for each new type of data or use case added to the PH and CDE objective? What are the risks of including too many measures under the objective?

The EHR Association supports addressing all relevant public health reporting and data-sharing requirements through practical and easy-to-calculate measures. As noted in our feedback above, the use of numerator/denominator measures is neither practical nor necessary to gain insight into adoption and to further advance it. Feedback from public health reporting can provide valuable insights to help focus incentives and increase adoption.

Alternatively, should CMS explore ways to group data types and use cases under a more limited set of PH and CDE objective measures? (anecdotal reports suggest that some healthcare providers are attesting to active engagement with PH for the eCase measure if they report cases for at least one notifiable condition (ex. COVID-19).

The EHR Association requests that CMS clarify the focus of grouping public health reports. Our response would differ if the intent is to group overall report types (e.g., syndromic surveillance plus lab reporting vs. case reporting vs. immunization reports and vital records), rather than if the grouping is intended to

be within each type of report (e.g., reportable condition grouping within case reporting and within lab results reporting, and grouping of registry reporting).

We are unconvinced the first approach – the grouping of overall report types – would significantly encourage adoption. However, for certain reports like case reporting, accelerating the adoption of more trigger events, conditions, or other criteria may help encourage step-wise adoption of higher priority events. This would be more applicable for reports with lower electronic reporting adoption rates, such as electronic case reporting, compared to those with higher adoption rates, such as electronic laboratory reporting.

Questions for Goal #2, Flexibility and Adaptability of the Public Health Reporting Enterprise

How can the Medicare Promoting Interoperability Program support or incentivize response ready reporting capabilities for healthcare providers? What, if any, challenges exist around sharing data with PHAs?

The most important challenges the Medicare PI program can address to support and incentivize response-ready reporting capabilities for healthcare providers are those associated with jurisdiction-specific requirements. While our members provide certified reporting and make the configuration of physical connections simpler, out-of-the-box reports cannot be universally used due to these variations. Therefore, the EHR Association recommends:

- **Standardizing Reporting Requirements**: Encourage the standardization of reporting requirements across jurisdictions to minimize the need for customized adjustments.
- **Providing Technical Assistance**: Offer technical assistance and resources to help healthcare providers adapt their reporting systems to meet specific local requirements efficiently.
- **Incentives for Compliance**: Create incentives for healthcare providers who successfully implement and maintain response-ready reporting capabilities.
- **Facilitating Collaboration**: Promote collaboration between healthcare providers and public health agencies to streamline the reporting process and ensure data is shared effectively.

How can CMS and ONC work with vendors to ensure that provider systems are being continually updated to meet new data needs, such as those in rural areas?

The EHR Association suggests CMS and ONC can create a more efficient and up-to-date reporting process using USCDI/USCDI+ as a mechanism to set expectations for data relevant to public health while advancing the use of computable reporting knowledge definitions to specify data requirements by trigger event. For example, sharing electronic case reporting (eCR) knowledge would enable source systems to quickly adjust to new data content, especially when the data is already recognized and adopted through USCDI and USCDI+. This approach will help ensure that the data needs of all areas, including rural ones, are met effectively.

Questions for Goal #3, Increasing Bi-Directional Exchange with Public Health Agencies

Both CDC's ACD and ONC's HITAC have recommended that CDC and ONC work together to establish certification criteria for public health technologies used by PHAs and implement a coordinated, phased approach to incentivize and eventually require their adoption. How, if at

all, could the Medicare Promoting Interoperability Program support or incentivize PHA adoption of certified systems and technologies?

The EHR Association suggests that CMS, CDC, and ONC collaborate to advance the consistent, standards-based adoption of reporting and data sharing/query capabilities using a certification approach. For reporting, certification creates alignment between senders and receivers on the same format and content. For queries, certification ensures that data sources are consistent and requesters support certified formats and content.

For PHAs, certification would focus on capabilities where other parties query PHA data, such as immunization histories. Ensuring that queries are properly defined and aligned with authorized purposes is crucial to stakeholders across the healthcare continuum. Therefore, certifying PHAs for their ability to handle such requests effectively adds value. The EHR Association recommends appropriate funding be allocated to PHAs to build infrastructure that supports these capabilities, including standardized tools and algorithms. The availability of implementation centers to support PHAs can further advance improvements in their infrastructure.

While we are not familiar with other specific CMS programs that can incentivize PHAs to adopt these capabilities, the Medicare Promoting Interoperability Program could play a role by providing incentives for PHAs to adopt certified systems and technologies.

How can CMS use the Public Health and Clinical Data Exchange objective to incentivize early adoption of FHIR-based APIs for public health data exchange?

The EHR Association suggests that CMS focus on new "green field" opportunities that benefit from FHIR-based data sharing techniques rather than solely replacing existing HL7 v2 and HL7 CDA-based reporting mechanisms. Replacing existing systems may require investments greater than the benefits it yields at this time. Instead, targeted enhancements that address missing data and improve data quality can immediately provide substantial benefits in those areas.

We suggest that meaningful data-sharing advancements can be achieved without requiring comprehensive system replacements by:

- **Targeted Enhancements:** Focus on areas where FHIR-based data sharing can address gaps in data quality and completeness.
- **Investigative Queries:** Encourage the use of FHIR for investigative queries to enhance data accessibility and usability.
- **Bulk Data Support:** Support the use of FHIR for bulk data queries by PHAs where needed, allowing large data set queries by providers.
- **FHIR-Based Payloads:** Promote the adoption of FHIR-based payloads, as demonstrated with electronic case reporting (eCR).

Additionally, we note that the collaboration between ONC and CDC through the HL7 HELIOS Accelerator offers a holistic approach to integrating FHIR-based capabilities. This approach focuses on complementing and advancing current capabilities, thereby minimizing the need for costly and immediate replacements of existing systems.

CMS previously finalized the Enabling Exchange under TEFCA measure under the HIE objective for eligible hospitals and CAHs to attest to engaging in health information exchange. Should CMS introduce a similar measure to allow providers to receive credit for the HIE objective by exchanging public health data through participation in TEFCA?

The EHR Association supports the adoption of the Public Health purpose of use in TEFCA, leveraging a common agreement and trust framework to minimize connection configurations and point-to-point data-sharing agreements. However, we have some concerns about the current use cases being considered using FHIR, as they may involve unnecessary architectural changes or be ahead of the FHIR adoption pace under TEFCA and HL7 HELIOS.

Ensuring that FHIR-based exchanges are firmly established and thoroughly tested is crucial for the success of any PHA use cases. This does not mean slowing down pilot activities, but rather setting realistic timelines for scaling these initiatives to a national level. Focusing on investigative follow-up queries by PHAs upon receipt and analysis of lab reports, case reports, etc., would be a beneficial area to introduce FHIR-based access.

However, requiring case reporting to shift from XDR and Direct-based communication directly with APHL or PHAs to QHIN-brokered reporting should not be necessary, as this would involve like-for-like capability investments rather than introducing new capabilities. Enabling exchange should not be limited to QHIN-brokered communication or restricted to IHE Document Exchange and FHIR-based APIs.

The EHR Association suggests utilizing the full set of available capabilities, all under the TEFCA common agreement and trust framework, to support the exchange of public health data. This approach will ensure a more flexible and efficient integration while maintaining a high standard of interoperability and data sharing.

Questions for Goal #4, Eliminating Reporting Burden for Healthcare Providers

Under the current Public Health and Clinical Data Exchange objective, which measures, or other requirements result in the most administrative burden for eligible hospitals and CAHs?

Measures that require data not captured in routine care documentation, or that add new data requirements unrelated to the current data flow, result in the most significant administrative burden for eligible hospitals and CAHs. These measures create significant challenges for health IT developers, who must develop additional data collection processes, and for providers, who must collect this data and adjust their workflows accordingly. Simplifying these measures to align with existing documentation practices and data flows would help reduce this administrative burden.

How can the Medicare Promoting Interoperability Program balance robust Public Health and Clinical Data Exchange objective requirements with our desire to reduce burden on eligible hospitals and CAHs?

To balance robust Public Health and Clinical Data Exchange objective requirements with the desire to reduce the burden on eligible hospitals and CAHs, the EHR Association suggests ensuring consistency between ONC certification requirements and PHA requirements. Implementing a PHA-focused certification program that aligns with the standards referenced by ONC can substantially reduce unnecessary variations.

How can new technical approaches to data exchange with PHAs, such as the use of FHIR APIs, reduce burden for health care providers? What are potential barriers to achieving burden reduction as these new approaches are implemented?

The increased availability of FHIR-based APIs for querying data presents tremendous opportunities for more efficient data access. However, it's important to balance this with the appropriate use of query-based approaches and avoid moving everything to this model. Focusing on suitable use cases, such as investigative follow-up queries upon receipt and analysis of ongoing reports, will be key to achieving this balance. One of the main challenges will be ensuring the appropriate use of these APIs and identifying the use cases that can now be effectively addressed, such as the investigative queries mentioned. The participation of PHAs in TEFCA will be critical to supporting these use cases at scale.

Additionally, the rapid expansion of case reporting, facilitated by common agreements through APHL, eHealth Exchange, and Carequality, highlights the power of a national network in accelerating adoption. Flexibility will be essential, and we urge CMS to work with ONC to provide the necessary flexibility to determine when to use the common agreement and trust framework versus when data should flow through QHINs.

With the opportunity to use TEFCA to rapidly expand PHA access to relevant data, variations across jurisdictions, particularly in privacy rules, present a critical challenge. Deciding when to share or not to share data will be complex, not only for provider-PHA data sharing to include any data exchange involving different privacy rules across jurisdictions of the source and the recipient of the data.

Request for Information on Health Care Reporting to the National Syndromic Surveillance Program

How can CMS further advance hospital and CAH participation in CDC's NSSP?

To further advance hospital and CAH participation in the CDC's National Syndromic Surveillance Program (NSSP), the EHR Association recommends clearly defining reporting requirements specific to applicable care settings, such as emergency or inpatient settings. By tailoring reporting triggers and requirements to the context of each care setting, we can facilitate broader adoption and ensure that reporting processes are relevant and feasible for all types of healthcare facilities.

What would be the potential burden for facilities in creating these connections in state and local public health jurisdictions that have not yet established syndromic programs and /or where state and local public health are not presently exchanging data with CDC's NSSP? Are there unique challenges in rural areas that CMS should take into consideration?

To address the potential burden for facilities in creating connections in state and local public health jurisdictions that have not yet established syndromic programs or where data exchange with CDC's NSSP is not currently happening, we suggest the following:

- **Standardized Formats and Vocabulary**: Adoption can be accelerated by using standardized formats and vocabulary across jurisdictions. This standardization simplifies implementation and configuration efforts for both IT developers and healthcare providers.

- **Single Submission Point**: Providing a single point for a provider to submit a report, which can then be distributed to the appropriate jurisdictions in either identified or de-identified formats, would improve efficiencies significantly. This approach does not necessarily require a single physical hub but could utilize a shared set of knowledge that enables any system (hub or endpoint) to consistently share information.
- **Leveraging TEFCA**: Enabling PHA reporting under TEFCA offers the opportunity to work under a single common agreement and trust framework. This can ease the establishment of connections and build on existing technologies, as demonstrated by the advances in electronic case reporting (eCR) under Carequality.

Additionally, we encourage CMS to consider the unique challenges in rural areas, including limited IT resources and staff, which can complicate the implementation of new reporting systems, and infrastructure constraints, such as limited internet connectivity, which can affect the ability to establish and maintain data exchange connections. Providing additional support and training for rural facilities can help overcome these challenges and ensure successful participation in syndromic surveillance programs.

Data reported as part of syndromic surveillance requirements could serve as an alternative source for the COVID-19, influenza, and RSV hospitalization reporting requirements proposed in this rule—and even support eventual evolution towards an all-hazards approach for monitoring inpatient hospitalizations for conditions of public health significance. Should CMS consider a future requirement or otherwise incentivize facilities to expand ADT-based reporting currently provided for emergency department visits to include data collected from inpatient settings as defined in the HHS COVID-19 reporting guidance, or a subset of these? If the latter, should a subset of inpatient locations be subject to such a requirement? What would be the potential value and burden trade-offs to facilities? And, should any requirement specify that reporting also be to CDC's NSSP (in addition to more general reporting to state/local syndromic surveillance systems? (noting that often the reporting to CDC's NSSP happens through a given state/local system and that applicable law may apply).

The EHR Association understands and supports the goal of identifying potential public health threats as early as possible. However, admission/registration event-driven notifications and reporting are typically based on symptoms and unconfirmed diagnoses, which may create unnecessary streams of data. We suggest that alternative means should be considered based on a federated research approach. This would involve combining data on confirmed diagnoses and certain tests ordered/performed with aggregate data on symptoms and problems. Such an approach would reduce the unnecessary sharing of individual patient data, thereby balancing the need for early threat identification with the burden on facilities.

How can CMS leverage its authorities and programs to improve the quality of data reported to CDC's NSSP, especially for key elements that are sometimes incomplete, including discharge diagnoses, discharge disposition, and patient class?

We recognize that certain key data elements, such as discharge diagnoses, discharge disposition, and patient class, are often incomplete at the time of admission or discharge, and in many cases, this timing cannot be accelerated. Instead of focusing solely on requiring completeness at these specific times, the

EHR Association suggests CMS explore a case reporting style approach. This would involve submitting data at set intervals from the start of reporting.

To match de-identified data, various methods can be used to link reports on the same patient. Additionally, follow-up queries based on report identifiers, without exposing patient identity, could be considered.

The EHR Association recommends re-aligning various public health reporting mechanisms to establish a common approach for trigger events, associated data submissions, follow-up reporting, and follow-up queries to augment data based on findings. This alignment should include a common format to simplify and increase efficiencies. For syndromic surveillance, this could mean focusing on early aggregate data reporting followed by patient-specific reporting to include early warning signals.

In addition to its value for public health, how could CDC's NSSP serve as a tool to directly improve clinical practice, patient safety, and overall situational awareness? What types of questions would you like the system to help answer?

The EHR Association suggests that the CDC's NSSP could serve as a valuable tool to directly improve clinical practice, patient safety, and overall situational awareness by leveraging aggregated data for early warning signals without necessitating extensive line-level data sharing. For example, regional warnings combined with aggregated counts of symptoms, conditions, and reasons for admission can provide critical situational awareness. Once a confirmed condition threshold is met, sharing individual patient data would enable targeted and efficient reporting and analysis, allowing for a scalable and flexible system that can expand or contract based on the needs during and after emergencies.

The Transforming Episode Accountability Model (TEAM)

The Transforming Episode Accountability Model (TEAM) proposes the creation and testing of a new mandatory alternative payment model. The intent of TEAM is to improve beneficiary care through financial accountability for episodes categories that begin with one of the following procedures: coronary artery bypass graft (CABG), lower extremity joint replacement (LEJR), major bowel procedure, surgical hip/femur fracture treatment (SHFFT), and spinal fusion.

The EHR Association generally supports CMS's ongoing efforts to test Alternative Payment Models (APMs). We recognize that while voluntary participation in these models is preferable, mandatory models are sometimes necessary to fully evaluate the effectiveness of a specific payment model. Such comprehensive testing is crucial for understanding how these models can save Medicare funds and enhance care efficiencies. By mandating participation, CMS can obtain a more accurate and representative assessment of the model's impact, which is essential for making informed decisions about broader implementation and policy development.

Other Considerations

We seek feedback from hospitals and health IT vendors for estimates on the potential upfront start-up costs of health IT investments for safety net hospitals, such as new health information exchange capabilities, solutions to provide patients with access to their health data (for instance, patient portals), capabilities to capture patient-reported outcomes, event notification

systems, and community referral capacity. Should we decide to provide such payments, we also expect the infrastructure improvement would require financial investment on the part of the participant, clinicians, and other payer partners, including those on the commercial side.

The EHR Association strongly supports CMS's consideration of providing financial support to safety net hospitals for health IT investments. We recognize that these investments are essential for improving healthcare delivery and patient outcomes. Beyond the cost of the health IT itself, upfront costs for these investments include software licenses and subscriptions, hardware such as servers and networking equipment, and fees for third-party integration and consulting services. Additionally, implementation and configuration expenses, data migration, system configuration, and ongoing maintenance and support are significant components of the total cost.

Social Determinants of Health

We also continue to be interested in receiving feedback on how we might otherwise foster the documentation and reporting of the diagnosis codes describing social and economic circumstances to more accurately reflect each health care encounter and improve the reliability and validity of the coded data including in support of efforts to advance health equity.

The EHR Association supports the inclusion of both patient-reported and organization-reported data to more accurately capture social and economic circumstances in healthcare encounters. We believe that flexibility in assessing health-related social needs is crucial to obtaining comprehensive and reliable data. By incorporating various assessment methods, we can better reflect the unique circumstances of each patient, thereby enhancing the reliability and validity of the coded data.

In this proposed rule, we are proposing to add four new items to be collected as standardized patient assessment data elements under the social determinants of health (SDOH) category under the LTCH QRP: Living Situation (one item); Food (two items); and Utilities (one item). We are also proposing to modify one of the current items collected as standardized patient assessment data under the SDOH category (the Transportation item), as described in section X.E.4.e. of the preamble of this proposed rule.

IPFs will also be required to report whether they have screened patients for the same set of SDOH categories.

The EHR Association strongly supports the standardization of SDOH requirements across all care settings. Implementing standardized requirements is essential for reducing practice variation, which can lead to inconsistencies in data collection and reporting. Standardization ensures that all healthcare providers are assessing and documenting SDOH in a uniform manner, thereby enhancing the quality and comparability of data across different settings.

Furthermore, standardized SDOH requirements are crucial for supporting interoperability. When data is collected and recorded in a consistent format, it can be more easily shared and integrated across various health information systems. This seamless exchange of information is vital for coordinating care, improving patient outcomes, and advancing health equity. By adopting a unified approach to SDOH, we can ensure that critical social and economic factors are accurately captured and utilized to inform care decisions, ultimately leading to a more effective and equitable healthcare system.