Connecting Communities: HIEs and Social Determinants of Health

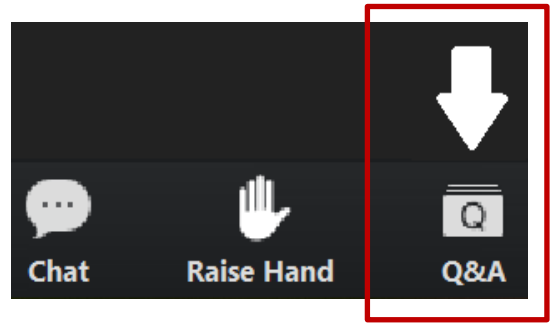
November 7, 2019

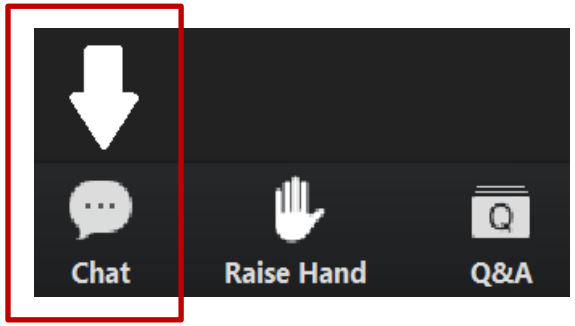
Agenda

- **Welcome**
  - **Jennifer Covich Bordenick,** CEO, eHealth Initiative
- **Presentation:**
  - **Lizzy Feliciano,** *Vice President Marketing, LexisNexis Health Care*
  - **Jordan Luke**, *Director, Program Alignment & Partner Engagement Group*, Office of Minority Health (OMH), Centers for Medicare and Medicaid Services (CMS)
  - **Chris Hobson, MD**, Chief Medical Officer, Orion Health
- **Q&A**
  - **Jennifer Covich Bordenick**, CEO, eHealth Initiative

Housekeeping

- **All participants are muted**
- **To ask a question to be answered by speakers:**
  - Use the “Q&A” box found on the bottom of your screen
  - We will address as many as possible after the presentations
- **For help with technical difficulties and non-speaker questions:**
  - Use the “chat” box and we will respond as soon as possible
- Slides and a recording of today’s presentation will be available for download on eHI’s Resource page: **www.ehidc.org/resources**





Our Mission

Convening executives from every stakeholder group in healthcare to discuss, identify and share best practices to transform the delivery of healthcare using technology and innovation.

Our Members

eHI
eHEALTH INITIATIVE

Current Areas of Focus

Value Based Care

- Cost Transparency
- Prior Authorization

Interoperability

- Understanding FHIR/ APIs/DaVinci
- Policy Issues/Burden, Workflow, Info Blocking

Privacy/Security

- Protection Vs Access
- HIPAA Part 2
- Cybersecurity Med Devices

Analytics/SDOH

- Non-Traditional Sources of Data for Health (SDOH, PGHD)
- EHR data for clinical trials (Doublejump)

eHealth Resource Center
www.ehidc.org/resources

- eHealth Resource Center available with best practices & findings identifying and disseminating best practices
- Online Resource Center: Over 600 new pieces of content, 125 best practices added this year

This webinar was made possible through the generosity and support of

SPEAKERS

Lizzy Feliciano
Vice President, Marketing
LexisNexis Health Care

Chris Hobson, MD
Chief Medical Officer
Orion Health

Jordan Luke
Director, Program Alignment &
Partner Engagement Group, *CMS*
OMH

SDOH Data & Insights that Fuel Connection

November 7, 2019

Lizzy Feliciano
VP, Market Insights
LexisNexis Risk Solutions
Health Care

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Social Determinants of Health made headlines in 2019

Why We Should Talk More About Social Care[1]
When the social conditions of people improve, their health does, too.

Social Determinants Screenings Cut Hospital Admissions by Nearly 30%[2]
Medicaid members who receive community-based services, particularly those that emphasize screening for and addressing the social determinants of health, experienced a 26.3 percent drop in inpatient hospital admission rates.

Employing Social Workers to Address Social Determinants of Health[4]
Many health plans previously saw addressing social determinants of health as something outside of their wheelhouse. More recently, payers are recognizing the importance of addressing these factors to better the health of their members.

MVP, Alliance Invest $800K to Address Social Determinants of Health[5]
The evidence is really irrefutable at this point that to improve someone's health, you have to look at more than just health.

Social Determinants Accelerator Act of 2019

1 https://www.forbes.com/sites/williamhaseltine/2019/10/25/why-we-should-talk-more-about-social-care/#5a0459d14a57
2 https://healthitanalytics.com/news/social-determinants-screenings-cut-hospital-admissions-by-nearly-30
3 https://healthitanalytics.com/news/5-ways-to-ethically-use-social-determinants-of-health-data
4 https://healthpayerintelligence.com/news/employing-social-workers-to-address-social-determinants-of-health
5 https://www.timesunion.com/news/article/MVP-Alliance-invest-800K-to-address-social-14282297.php

The Social Determinants of Health Accelerator Bill of 2019

Key Findings

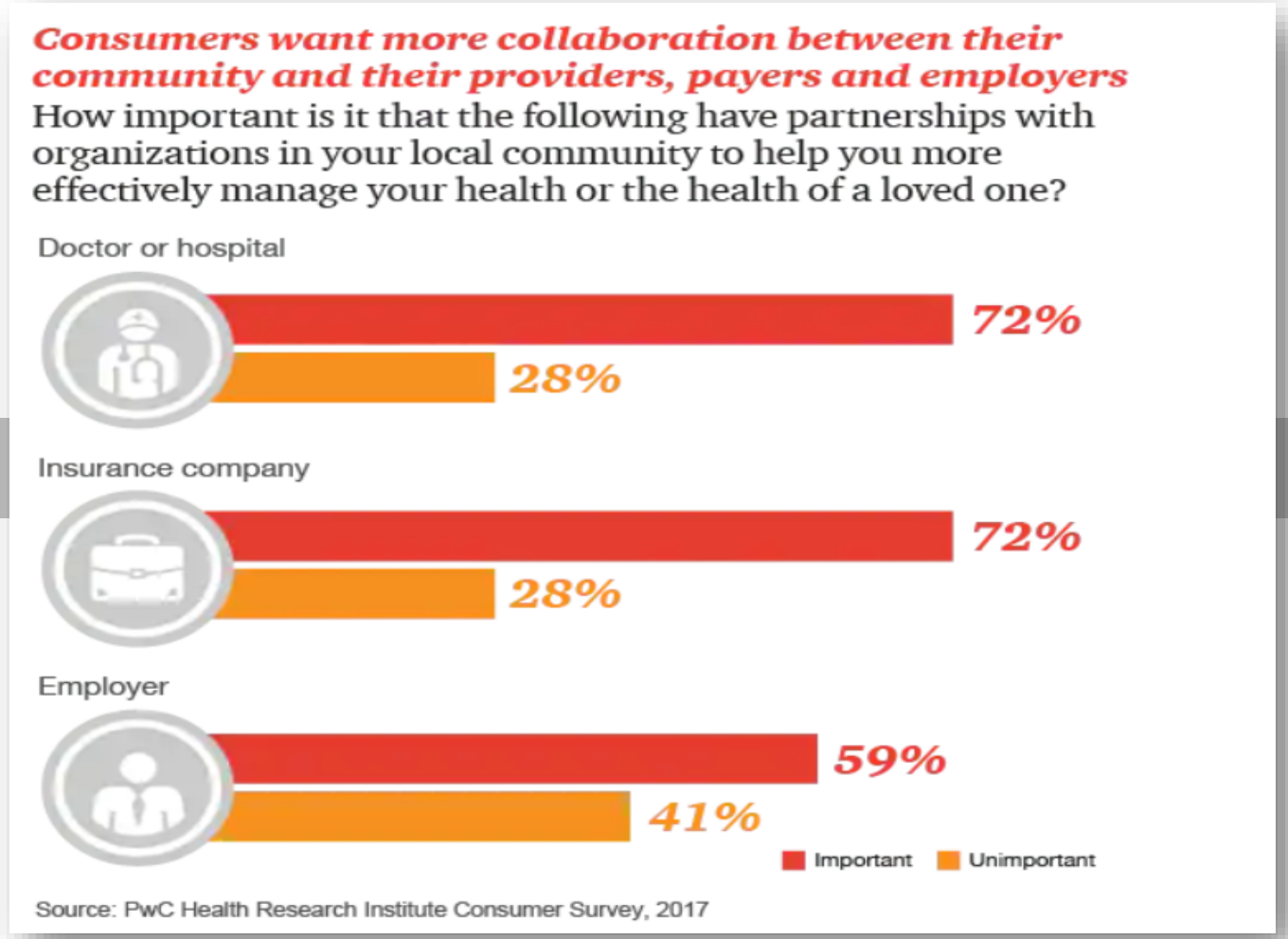
- There is evidence showing that economic and social conditions have a powerful impact on individual and population health outcomes and costs.
- State, local, and Tribal governments and the service delivery partners face significant challenges in coordinating benefits and services delivered through the Medicaid program and other social services programs.
- The Federal Government should prioritize and proactively assist State and local governments to improve health and social outcomes for individuals.

Purpose

1. Establish effective, coordinated Federal technical assistance to help State and local governments to improve outcomes and cost-effectiveness of, and return on investment from, health and social services programs.
2. To build a pipeline of State and locally designed, cross-sector interventions and strategies that generate rigorous evidence about how to improve health and social outcomes, and increase the cost-effectiveness of, and return on investment from, Federal, State, local, and Tribal health and social services programs.
3. To enlist State and local governments and the service providers of such governments as partners in identifying Federal statutory, regulatory, and administrative challenges in improving the health and social outcomes of, cost-effectiveness of, and return on investment from, Federal spending on individuals enrolled in Medicaid.
4. To develop strategies to improve health and social outcomes without denying services to, or restricting the eligibility of, vulnerable populations.

Souce: https://www.congress.gov/bill/116th-congress/house-bill/4004/text?r=5&s=1

Patients see value in addressing SDOH…even if they don't realize it



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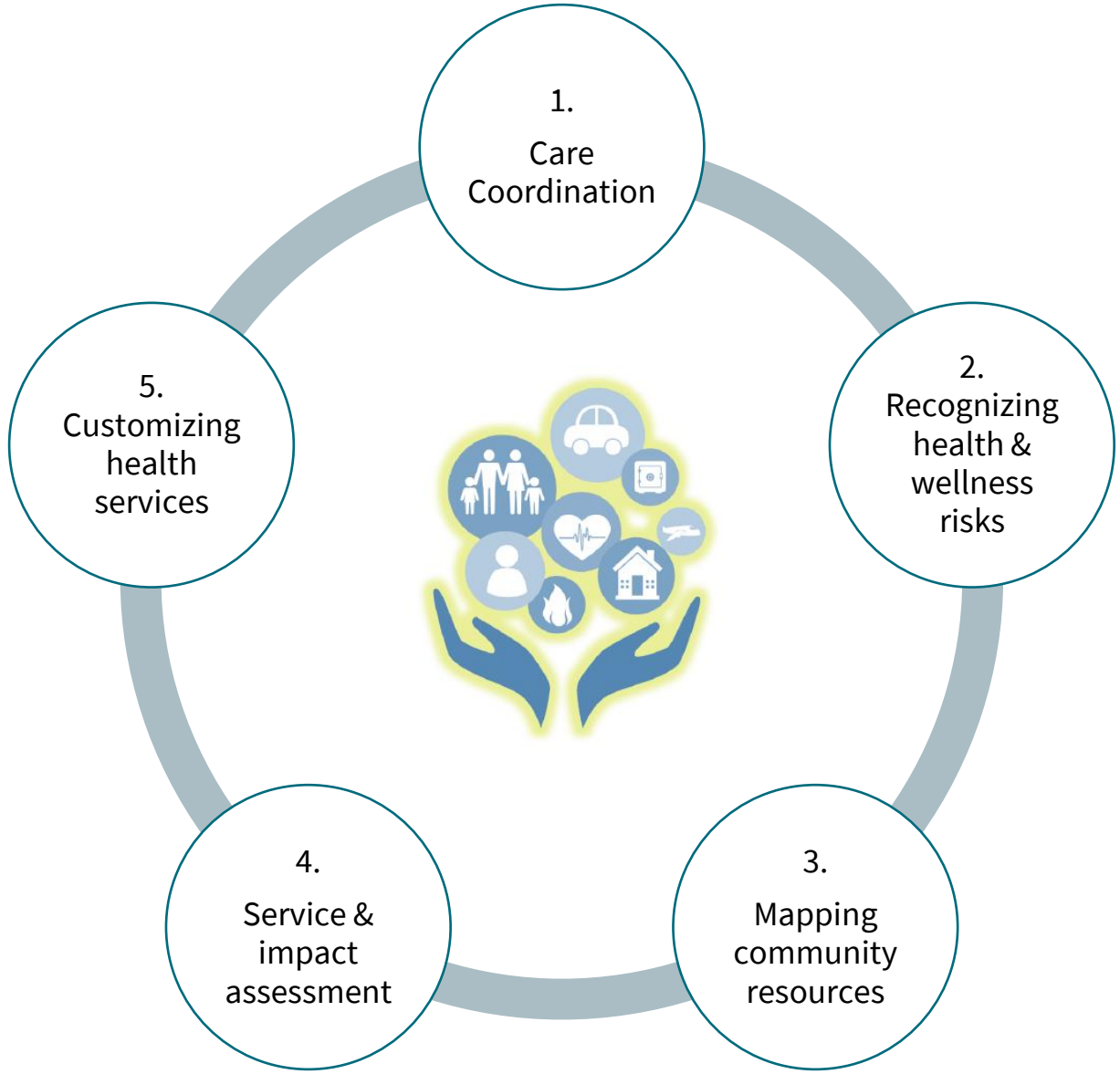
Addressing the elephant in the room – guidelines for the ETHICAL use of SDOH data

American Health Information Management Association (AHIMA) ✱ America's Health Insurance Plans (AHIP) ✱ Allscripts ✱ Amazon Web Services (AWS) ✱ American Cancer Society ✱ American College of Cardiology ✱ American College of Physicians ✱ American College of Radiology ✱ athenahealth ✱ BDO ✱ Care Compass Network ✱ CareSource ✱ Cerner ✱ Change Healthcare ✱ CHRISTUS Health ✱ Cognizant ✱ CRISP ✱ eHealth Initiative ✱ EHNAC ✱ Epstein Becker & Green ✱ George Washington University—Milken Institute School of Public Health ✱ Google Cloud ✱ HealthCore ✱ HL7® International ✱ Hogan Lovells ✱ Inovalon ✱ InterSystems ✱ Johnson & Johnson ✱ LexisNexis Health Care ✱ LifeWIRE ✱ Manatt Health ✱ Marshfield Clinic ✱ Mayo Clinic ✱ Med Allies ✱ Medical Group Management Association (MGMA) ✱ National Alliance of Healthcare Purchaser Coalitions ✱ NextGen Healthcare ✱ Noridian Healthcare Solutions ✱ Ohio Health ✱ Orion Health ✱ Point-of-Care Partners ✱ PwC ✱ Providence St. Joseph Health ✱ Salesforce ✱ Solera Health ✱ Sonora Quest Laboratories ✱ Strategic Interests ✱ University of Chicago Medicine ✱ Updox ✱ Validic ✱ Verato ✱ Welldoc ✱ Wellmark ✱ Zipnosis ✱



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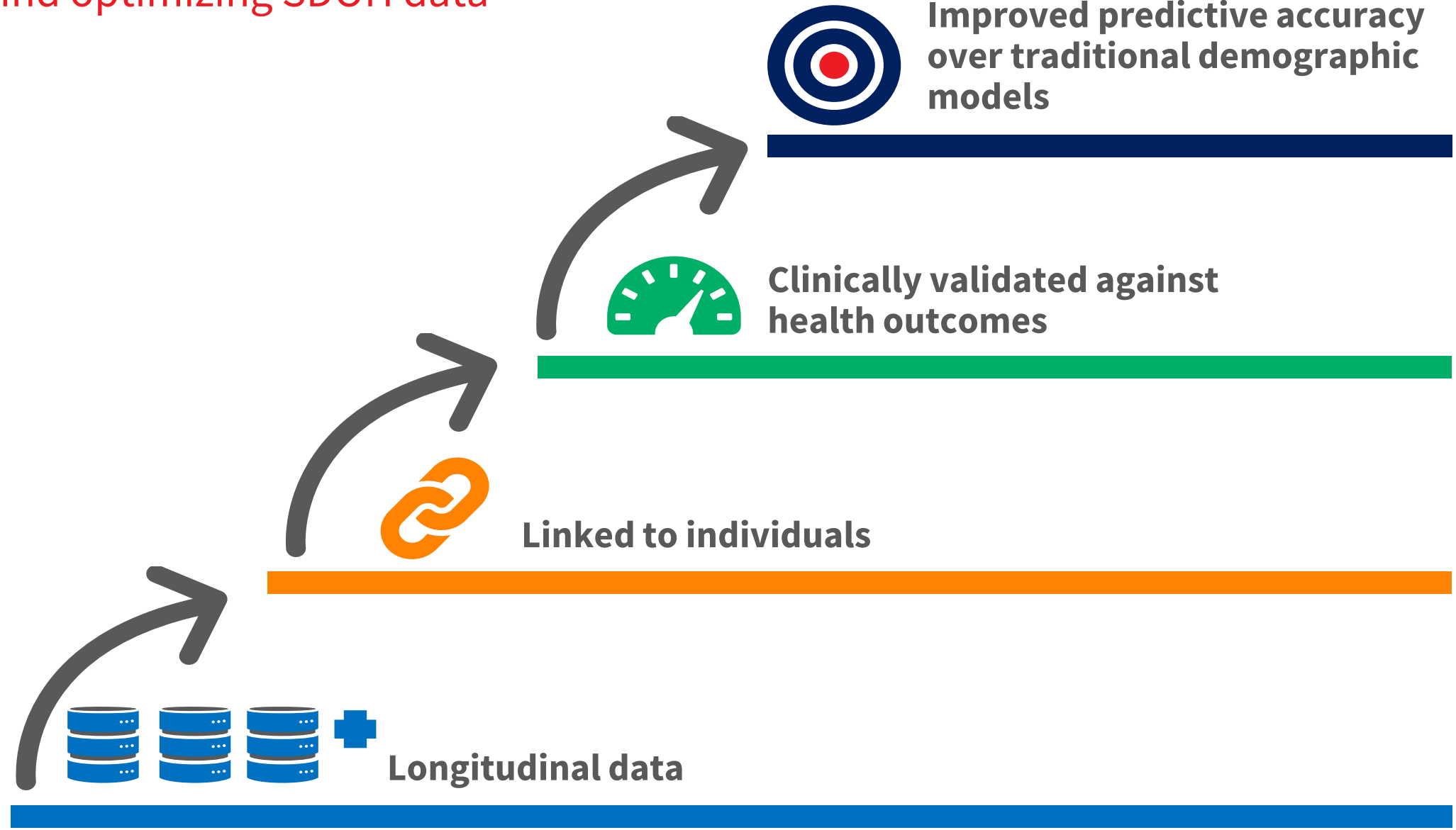
The logic behind optimizing SDOH data



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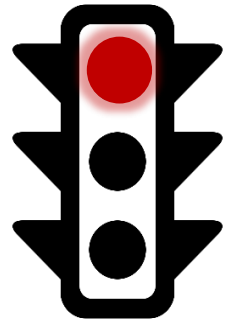
The evolution of SDOH approaches

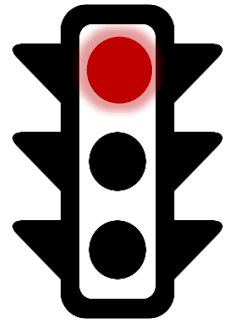
1st Generation

- **Effort:** County or zip code level “community” insights
- **Problem:** Wide variance in social factors at the community level



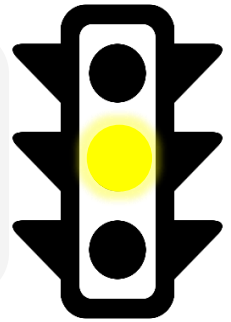
2nd Generation

- **Effort:** Patient-level data not specifically designed for healthcare from non-clinical vendors
- **Problem:** Data dumps that typically address only one category of SDOH, frequently with little correlation to health risk



Next Generation

A source of data that addresses multiple categories of SDOH and can deliver increased lift over existing models while decreasing time to value



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SDOH categories that correlate to outcomes

Social and Community Context

Accidents, Crimes, Weapons & Sporting Licenses, Voter Registration, Relatives/Associates

Economic Stability

Address Stability, Assets, Income, Professional Licenses, Liens, Bankruptcies

Neighborhood and Built Environment

Household Demographics, Housing Types, Crime and Income Indexes

Education

Level, Quality, Area of Study

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Delivering success with next generation SDOH

Data sources

- Multiple sources covering public records, credit and consumer data that can paint a comprehensive picture
- **Data elements that cover all 5 categories of SDOH data**
- Economic stability, Education, Health & Healthcare, Neighborhood and Built Environment, Social & Community Context

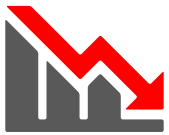
Member-level detail

- Each data element should be tied to the individual
- Every matched individual should come with associations, such as family, relatives and close associates

Correlation to health risk

- No data dumps
- Every element should already be proven to correlate to health risk
- Clients can reverse 80/20 rule on data prep/modeling

Increases lift



Decreases time to value

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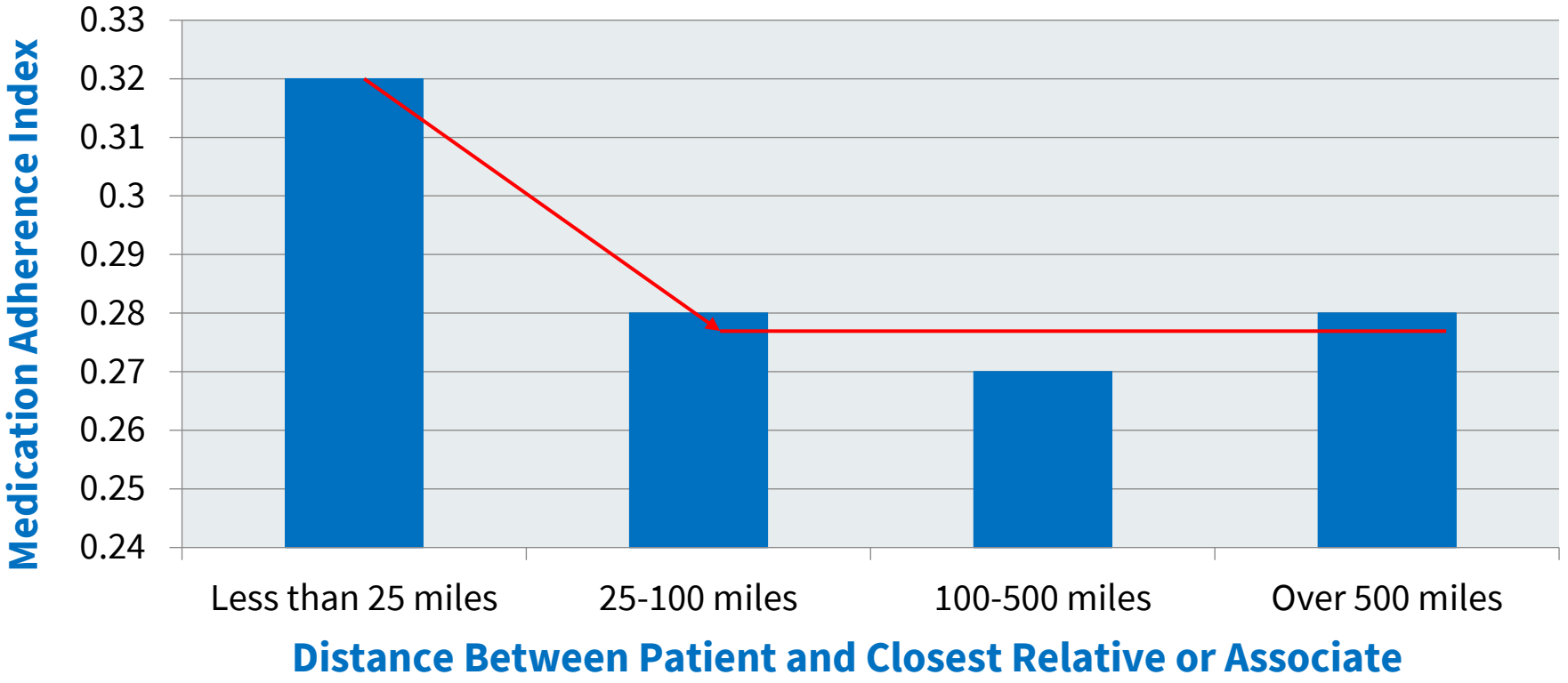
Social isolation example

Distance to nearest relative correlation with medication adherence



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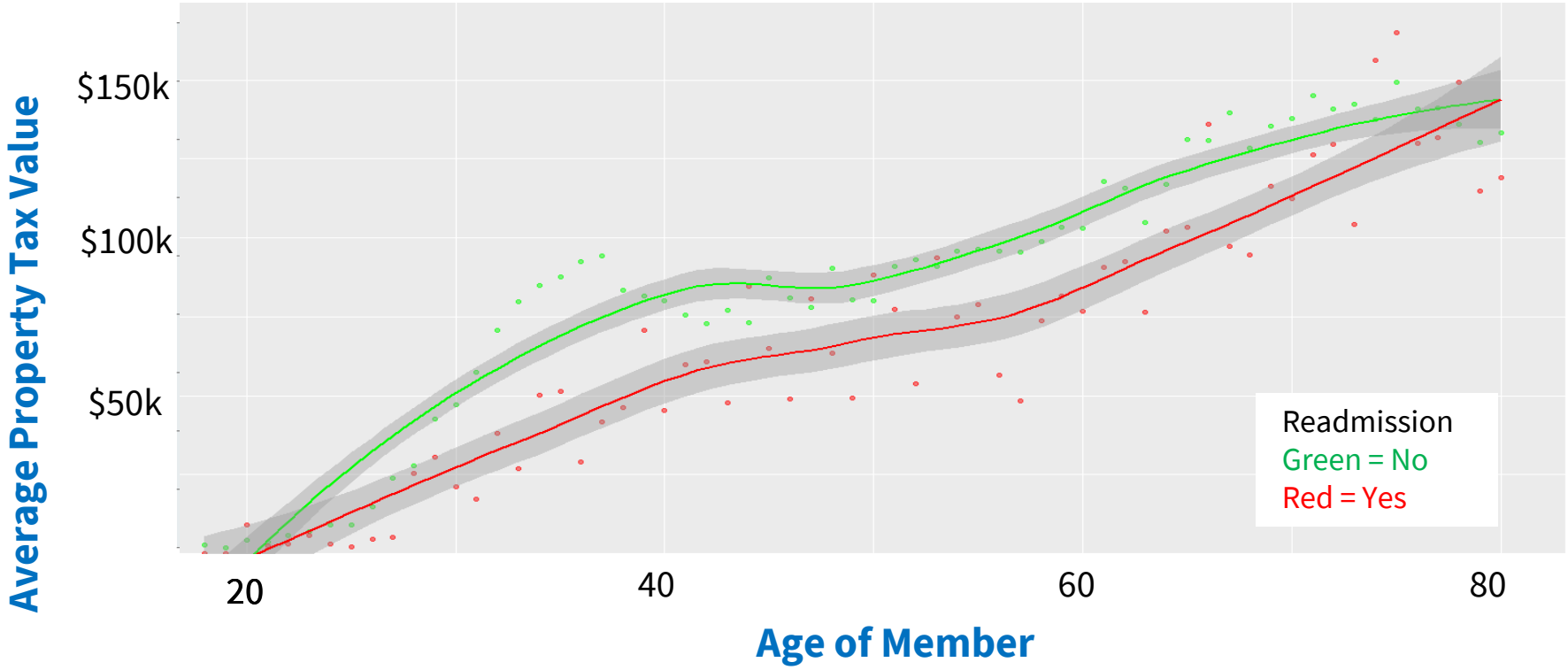
Economic health example

Owned property value correlation with readmission to the hospital



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How can ACOs harness the power of social determinants of health?

ACO Commonality:

- ✓ Need to adapt in a new era of downside
- ✓ financial risk.
- ✓ Need to move beyond generating shared
- ✓ savings—to also about avoiding financial loss
- ✓ Expanding access to care

Typical Data Leveraged:

- ✓ **Health risk assessments**
- ✓ **Basic demographic information**
- ✓ **Survey results**
- ✓ **Other data within the**
- ✓ **EHR**

Challenges with this data:

- ✓ Demographic data becomes outdated quickly
- ✓ EHR data stored in unstructured format
- ✓ Survey data is not comprehensive

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SDOH data gives providers a well-rounded view of a patient

Situation 1:

1. An ACO notices an uptick in spending for patients with heart disease.

2. SDOH data (e.g., relatives, associates and zip code) helps the ACO identify patients who may be socially isolated.

3. So it can proactively connect these individuals with community resources to provide social support.

Situation 2:

1. An ACO sees an increase in its ED visits for diabetic patients.

2. SDOH data (e.g., income and education level) helps the ACO identify patients who may benefit from care coordinators who provide ongoing education and support to ensure these individuals take their insulin properly.

Situation 3:

1. An ACO decides to target obesity in an effort to improve health outcomes.

2. SDOH data (e.g., income, crime index and address) helps the ACO identify patients who may benefit from nutritional counseling and access to healthy food options.

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Ways to integrate socioeconomic data into new or existing clinical analytic models

Attributes

Vast amount of unique, patient-level, clinically-validated socioeconomic attributes that:

- Can be **combined in clinical analytics models to better assess risk** for patients with and without clinical or claims data
- **Correlate to specific health outcomes** including total cost, hospitalizations, Rx costs, medication adherence, emergency room visits, stress and motivation to care for one's own health

Scores

Health risk prediction scores provided at the patient level that leverage ONLY socioeconomic attributes to provide a picture of future risk:

- **Total Cost Risk Score:** Predicts an individual's health risk over the next 12 months based on cost
- **Readmission Risk Score:** Predicts potential for an individual to be readmitted to the hospital in the next 30 days

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Contact Information

Lizzy Feliciano
VP, Market Insights
Health Care
LexisNexis Risk Solutions
678.694.4923 Direct
Leonides.Feliciano@lexisnexisrisk.com

www.linkedin.com/showcase/lexisnexis-risk-solutions-health-care

Twitter.com/lexisnexisrisk

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Addressing Social Determinants of Health in CMS Programs & Policies

E-Health Webinar

Jordan Luke, CMS OMH
Director, Program Alignment & Partner Engagement Group

"Working to Achieve Health Equity"

CMS OMH Mission and Vision

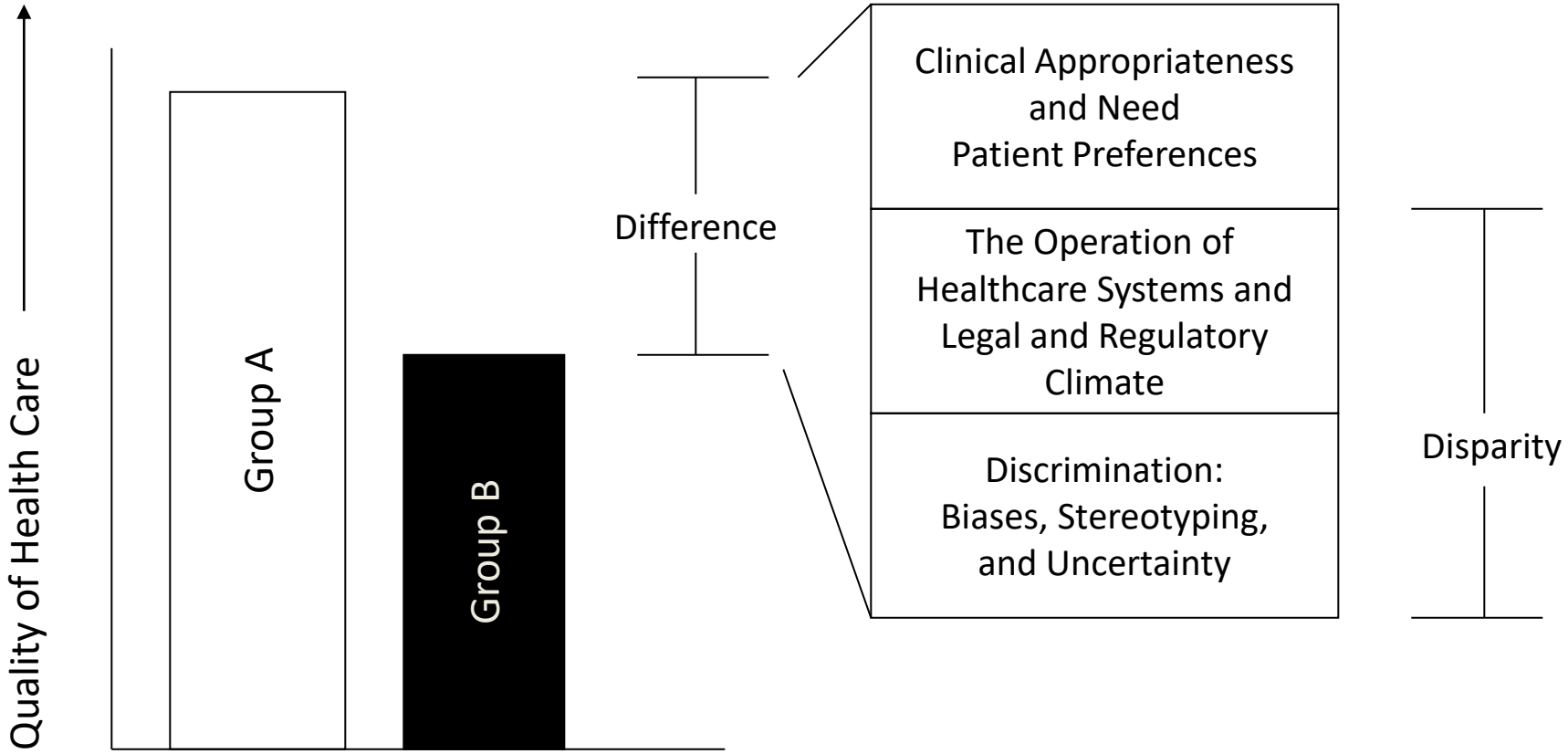
Mission

To ensure that the voices and the needs of the populations we represent (racial and ethnic minorities, sexual and gender minorities, rural populations, and people with disabilities) are present as the Agency is developing, implementing, and evaluating its programs and policies.

Vision

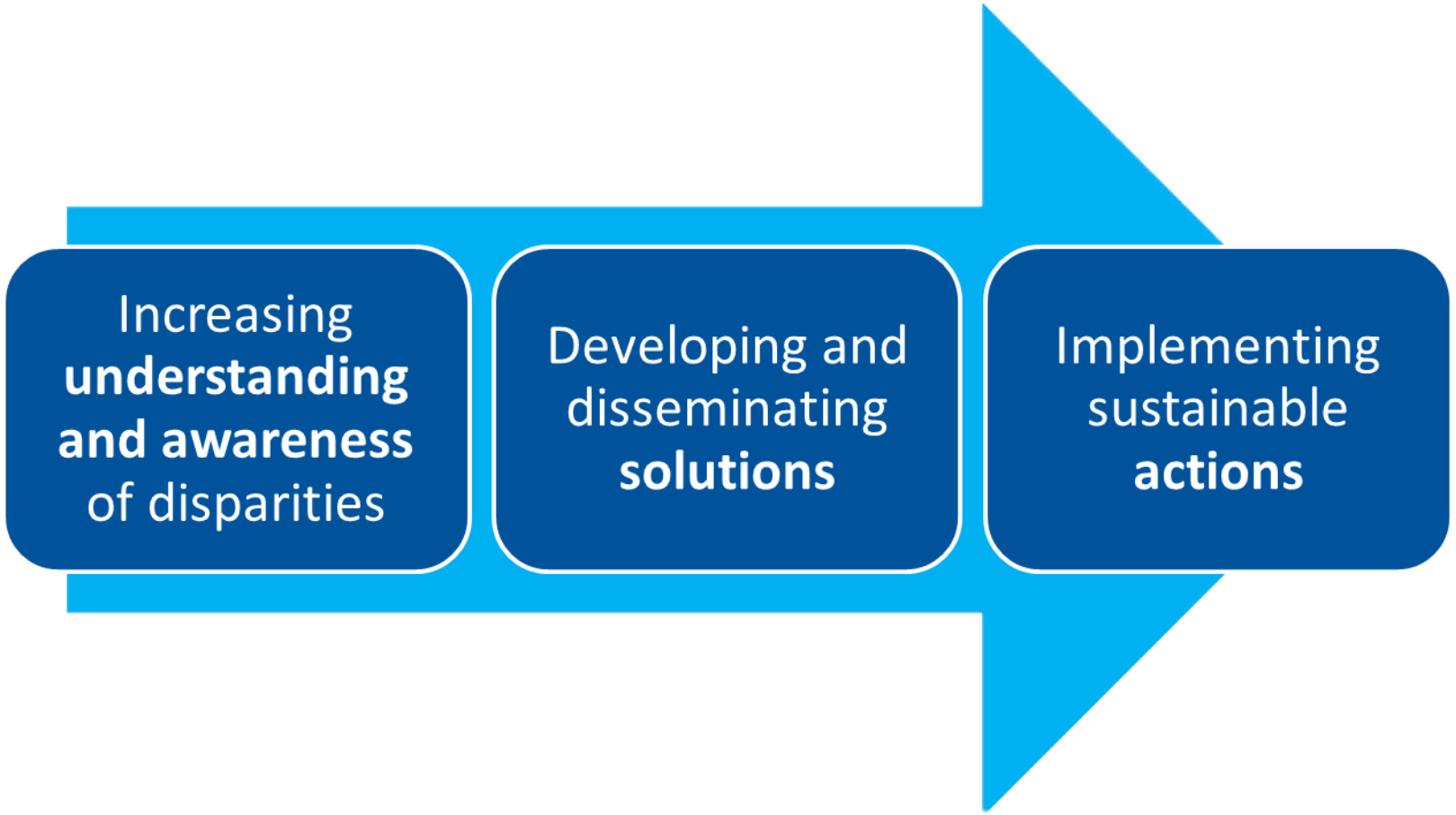
All CMS beneficiaries have achieved their highest level of health, and disparities in health care quality and access have been eliminated.

What is a Health Care Disparity?



SOURCE: Figure 1. Differences, Disparities, and Discrimination: Populations with Equal Access to Healthcare. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, Summary*. Brian Smedley, Adrianne Stith, and Alan Nelson, Eds. Washington, DC. Institute of Medicine, 2002.

CMS Path to Equity



Sources of Health Disparities

What Are Z Codes?

- Z-Codes are a subset of International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes.

- The full set of Z codes (Z00-Z99) cover an expansive set of "reasons" for health care encounters, ranging from contact with infections, inoculations and vaccinations, patient history, follow up care, reproductive services, and many others. ICD-10-CM Official Guidelines for Coding and Reporting FY 2019.
  https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf

- Apply to all health care settings.

Z Codes Related to Social Determinants of Health

- Within the Z code set, Z55-65 are used to identify individuals with potential hazards related to **socioeconomic and psychosocial circumstances**, capturing information on social determinants of health (SDOH).

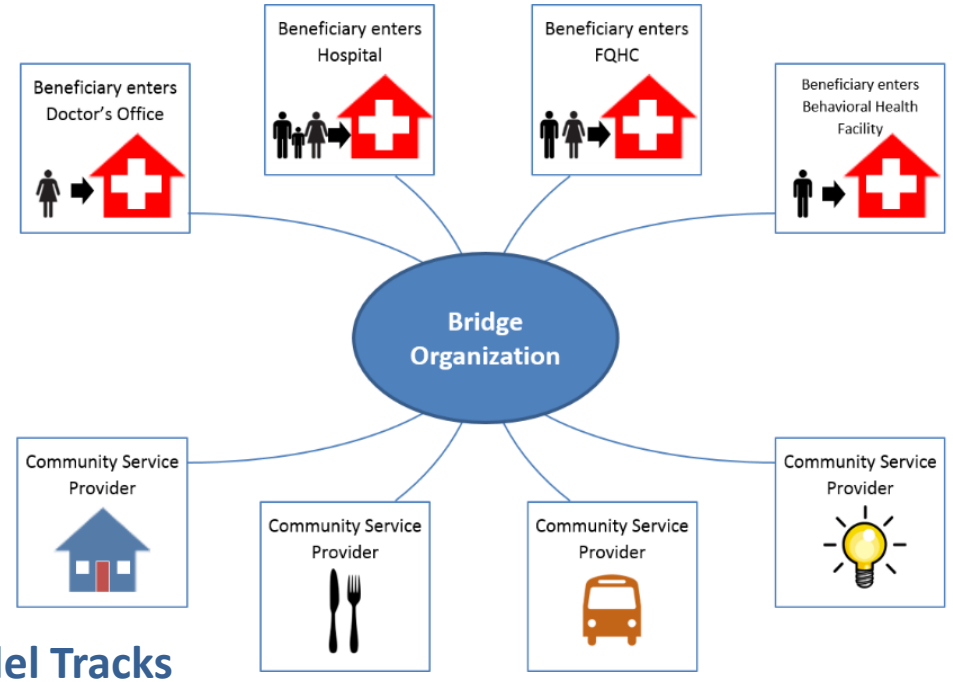
- There are 9 categories of Z codes related to SDOH, each code includes sub-codes resulting in a total of 97 more granular codes

ICD-10	Description	Number of Sub-Codes
Z55	Problems related to education and literacy	7
Z56	Problems related to employment and unemployment	12
Z57	Occupational exposure to risk factors	12
Z59	Problems related to housing and economic circumstances	10
Z60	Problems related to social environment	7
Z62	Problems related to upbringing	24
Z63	Other problems related to primary support group, including family circumstances	14
Z64	Problems related to certain psychosocial circumstances	3
Z65	Problems related to other psychosocial circumstances	8

Accountable Health Communities (AHC)

Key Innovations

- **Systematic screening** of all Medicare and Medicaid beneficiaries to identify unmet health-related social needs
- Tests the **effectiveness of referrals and community services navigation** on total cost of care using a rigorous mixed method evaluative approach
- **Partner alignment** at the community level and implementation of a community-wide quality improvement approach to address beneficiary needs



Model Tracks

Assistance Track

- **Bridge Organizations** in this track provide community service navigation services to ***assist*** high-risk beneficiaries with accessing services to address health-related social needs

Alignment Track

- **Bridge Organizations** in this track encourage partner ***alignment*** to ensure that community services are available and responsive to the needs of beneficiaries

SDOH Domains & Indicators

Accountable Health Communities	National Academy of Medicine		Healthy People 2020	
Disabilities (Optional)	Acculturation	Sexual Orientation	Access to Foods that Support Healthy Eating	Housing Instability
Education (Optional)	Dual Eligibility	Social Support	Access to Health Care	Incarceration
Employment (Optional)	Education	Urbanicity/Rurality	Access to Primary Care	Language and Literacy
Family and Community Support (Optional)	Gender Identity	Wealth	Civic Participation	Poverty
Financial Strain (Optional)	Housing		Crime and Violence	Quality of Housing
Food Insecurity	Income		Discrimination	Social Cohesion
Housing Instability	Language		Early Childhood Education and Development	
Interpersonal Safety	Living Alone		Employment	
Mental Health (Optional)	Marital/Partnership Status		Enrollment in Higher Education	
Physical Activity (Optional)	Nativity		Environmental Conditions	
Substance Use (Optional)	Neighborhood Deprivation		Food Insecurity	
Transportation	Environmental Measures		Health Literacy	
Utilities	Race and Ethnicity		High School Graduation	

SDOH Domains & Indicators

ICD-10©	Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE©)	Health Leads©
Childhood	Access to Health Care	Behavioral/Mental Health
Education	Child Care	Childcare
Employment	Clothing	Education
Housing	Education	Employment
Income	Employment	Food Insecurity
Literacy	Family Living Situation	Health Behaviors
Occupational Exposure	Food Insecurity	Housing Instability
Other Psychosocial Needs	Health Insurance	Immigration Status
Psychosocial Needs	Housing Instability	Income
Social Environment	Incarceration History (optional)	Language
Social Support	Income	Race and Ethnicity
	Interpersonal Safety (optional)	Social Support and Social Isolation
	Language	Transportation
	Migrant and/or Seasonal Worker	Utilities
	Race and Ethnicity	Violence
	Refugee (optional)	
	Safe Environment (optional)	
	Social Support/Social Isolation	
	Stress	
	Transportation	
	Utilities (including phone)	
	Veteran Status	

Embedding SDOH into Data Elements through IMPACT Act

IMPACT Act of 2014 requires CMS to:

- Collect standardized data elements for use in the post-acute care (PAC) Prospective Payment System; and
- Assess appropriate adjustments to quality measures, resource measures, and other measures, and to assess and implement appropriate adjustments to payments.

Stakeholder Feedback (December 2018):

- Prioritize data elements under consideration;
- Customize assessment tools by local needs;
- Allow patients to self-identify;
- Broaden beyond medical care; and
- Provide best practices for question design.

Why Collect Standardized Patient Assessment Data Elements for SDOH?

- Facilitates coordinated care and care planning based on a broader view of the patient's circumstances;
- Improves quality of care & outcomes for beneficiaries by considering a larger set of factors affecting health;
- Provides data for analysis of disparities, development of equity solutions, improved measures, and more appropriate payment.

Post-Acute Care Prospective Payment System Regulation Revisions

- **Finalized Rulemaking for four sites of post-acute care (2019):**
  - IRF: Inpatient Rehabilitation Facility
  - SNF: Skilled Nursing Facility
  - LTCH: Long Term Care Hospital
  - HH: Home Health
- **CMS added SDOH Standardized Patient Assessment Data Elements (SPADE)**
  - Race and Ethnicity
  - Preferred Language/Interpreter Services
  - Health Literacy
  - Transportation
  - Social Isolation

Proposed Data Elements

(1) Race
- 2011 HHS Data Standards

(2) Ethnicity
- 2011 HHS Data Standards

(3) Preferred Language and Interpreter Services
- LTCH [Long Term Care Hospital] CARE [Continuity Assessment Record and Evaluation] Data Set (LCDS) and the Minimum Data Set (MDS)

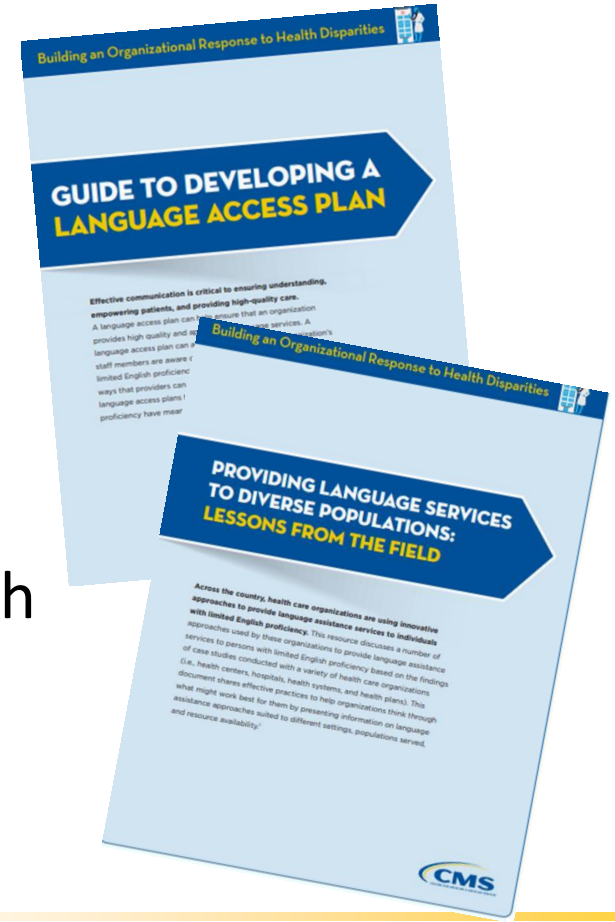
(4) Health Literacy
- based on Single Item Literacy Screener (SILS)

(6) Transportation
- Patient-Reported Outcomes Measurement Information System (PROMIS) and the Accountable Health Communities (AHC)

(7) Social Isolation
- PROMIS and AHC

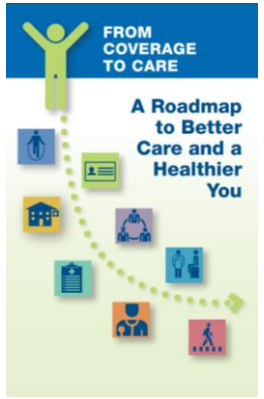
Providing Language Services

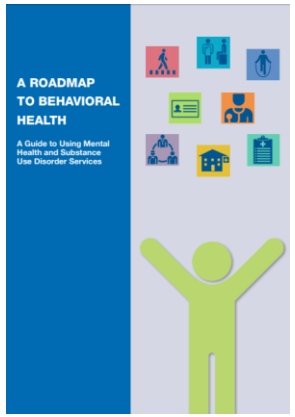
- Guide to Developing a Language Access Plan
  - Conducting a needs assessment
  - Offering language services
  - Notices
  - Training
  - Evaluation
- Lessons From the Field
  - Data collection and Electronic Health Records
  - Streamlining processes
  - Including interpreters on rounds



From Coverage to Care

- Roadmap to Better Care and a Healthier You
- 5 Ways to Make the Most of Your Health Coverage
- Roadmap to Behavioral Health
- Manage Your Health Care Costs
- Enrollment Toolkit
- Prevention Resources
- Partner Toolkit and Community Presentation





go.cms.gov/c2c

CoverageToCare@cms.hhs.gov

"Working t

2019 CMS Health Equity Award Winner: Centene Corporation

- Centene partnered with the National Council on Independent Living (NCIL) to increase the percentage of providers that meet disability access standards. 36,000 of Centene's members now have improved access to their providers.

- CMS is accepting nominations for the 2020 CMS Health Equity Award (10/9-11/15).

Health Equity Technical Assistance

ACT

Implement targeted interventions to reduce health disparities.

PRIORITIZE

Identify disparities, plan initiatives, and set SMART aims.

IMPROVE

Evaluate and improve your plan to reduce disparities.

HealthEquityTA@cms.hhs.gov

"Working t

Contact Us

Jordan Luke Director, CMS OMH,

Program Alignment and Partner Engagement

Health Equity Technical Assistance:

HealthEquityTA@cms.hhs.gov.

CMS OMH Homepage:

go.cms.gov/omh

Appendix

SDOH data elements used in Post Acute Care rulemaking

SDOH in the Rules: Race and Ethnicity

A1010. Race What is your race?	
↓ Check all that apply	
☐	A. White
☐	B. Black or African American
☐	C. American Indian or Alaska Native
☐	D. Asian Indian
☐	E. Chinese
☐	F. Filipino
☐	G. Japanese
☐	H. Korean
☐	I. Vietnamese
☐	J. Other Asian
☐	K. Native Hawaiian
☐	L. Guamanian or Chamorro
☐	M. Samoan
☐	N. Other Pacific Islander
☐	X. Patient unable to respond

A1005. Ethnicity Are you of Hispanic, Latino/a, or Spanish origin?	
↓ Check all that apply	
☐	A. No, not of Hispanic, Latino/a, or Spanish origin
☐	B. Yes, Mexican, Mexican American, Chicano/a
☐	C. Yes, Puerto Rican
☐	D. Yes, Cuban
☐	E. Yes, another Hispanic, Latino, or Spanish origin
☐	X. Patient unable to respond

SDOH in the Rules:
Preferred Language & Interpreter Services

A1110. Language

Enter Code ☐

A. What is your preferred language?

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

B. Do you need or want an interpreter to communicate with a doctor or health care staff?

0. No
1. Yes
9. Unable to determine

SDOH in the Rules: Health Literacy

B1300. Health Literacy

How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?

Enter Code ☐

0. **Never**
1. **Rarely**
2. **Sometimes**
3. **Often**
4. **Always**
8. **Patient unable to respond**

SDOH in the Rules: Transportation

A1250. Transportation Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?	
↓ Check all that apply	
☐	A. Yes, it has kept me from medical appointments or from getting my medications
☐	B. Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need
☐	C. No
☐	X. Patient unable to respond

SDOH in the Rules: Social Isolation

D0700. Social Isolation

How often do you feel lonely or isolated from those around you?

Enter Code	
☐	0. **Never** 1. **Rarely** 2. **Sometimes** 3. **Often** 4. **Always** 8. **Patient unable to respond**

Social Determinants of Health and HIEs

Dr Chris Hobson, Orion Health

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SDOH and HIE - Summary

- Privacy and security of sensitive data, managing patient consent
- Sourcing relevant data
- Normalizing standardizing, mapping and exchanging data
- **Combining clinical and SDOH data around specific uses is best practice**
- FHIR profiles and resources
- Data Governance

Challenges

- A new, evolving clinical domain, brings both new and familiar challenges
- Privacy in relation to sensitive data,
- Legal requirements with respect to financial data, the Gramm-Leach-Bliley Act
- Clinicians vs data brokers
- Integrating data so it doesn’t have to be captured repeatedly
- Informatics – mapping data standards for interoperability and understanding

Challenges

- Multitude of SDoH assessment tools and terminologies to capture relevant data
    - Legacy data stored in multiple proprietary formats
- Lack of agreed standards for data exchange
- Risks of too much low value data – every data element needs to be assessed
- Senior management support, including funding

Solutions

- Consent register with patient portal access to the data
- Role based and attribute - based access controls
- Informatics vision: collect once, use many
- Capturing structured data -
    - ICD 10 CM Z codes between Z55 and Z65, eg
        - Z59.0 Homelessness
        - Z59.1 Inadequate housing
- Every use case must be rigorously evaluated:
    - Care coordination / care transition management
    - Does SDOH help in understanding high risk pregnancy?
- Align with emerging FHIR standards

Data coding improvements

- **ICD 10 Z codes** for SDOH “Diagnoses”
  - Z59.6 Low Income
    - Proposed new Code Z59.61 Unable to pay for prescriptions
    - Proposed New Code Z59.62 Unable to pay for utilities
    - Proposed New Code Z59.63 Unable to pay for medical care
- **LOINC codes** for SDOH Assessments:
  - 76513-1 – How hard is it for you to pay for the very basics like food, housing, medical care and heating?
- **Snomed codes**
  - 11403006 | Financially poor (finding) |
  - 9629004 | Borderline poverty (economic status)

FHIR - Gravity Project4

- Develop semantically consistent FHIR profiles, resources and implementation guides
- Ensure the clinical relevance of terminology value sets and information models, and
- Vet information structures and analytic tools for bias
- Industry collaborators to pilot SDoH FHIR profiles in real-world settings
- Conduct research on the efficacy of their use

Data Governance

- Protecting patient rights, protecting clinicians and organizations
- HIEs should have well - established data governance processes and decision - making committees
  - SDOH then becomes just another data type
  - Agreed consent process
  - Who will collect the data? / Where does it originate?
  - Data dictionary / exactly what data do we want to capture / Can we get it in structured format?
  - Access controls
  - How do we handle financial data (with legal restrictions)
  - Fit to clinician workflow?
  - If used for predictive modelling / AI - can the clinician trust the recommendation?

Open Q&A

Q&Q

Lizzy Feliciano
Vice President, Marketing
LexisNexis Health Care

Chris Hobson, MD
Chief Medical Officer
Orion Health

Jordan Luke
Director, Program Alignment &
Partner Engagement Group, *CMS*
OMH

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