

Monogram Health treats patients with complex polychronic conditions, including advanced CKD, heart failure, COPD, diabetes, and more, through a multidisciplinary, in-home, value-based care model. We believe the care we deliver generates real-world evidence that the field needs but largely lacks. Through this partnership with Penn LDI, we want independent, academically rigorous research that evaluates whether and how our model of care actually improves outcomes (clinical, utilitarian, and experiential) for some of the most medically complex patients in the country. We're here as a learning organization: findings that challenge our assumptions are just as valuable to us as findings that validate them, and we're committed to giving researchers the access and operational support they need to do that work well.

Monogram SDoH Program: Data and Operational Detail

1. Data types

- SDoH data captured in structured fields across 10 domains: food/basic needs, housing insecurity, transportation, care and support gaps, medical need, pharmacy access, behavioral health, utility insecurity, financial strain, and health literacy
- Two-stage capture: (a) CMS-aligned primary screen embedded in our clinical assessments, and (b) a Monogram-developed secondary assessment triggered by a positive screen that stratifies severity and urgency by domain. This yields both prevalence data and clinically actionable severity data, not just a binary flag
- Referral data: full referral lifecycle across 50+ CBO types, tracked from identification through resolution
- Process/operational fields tied to each barrier and referral: date identified, date referred, days-to-referral, referral status, date closed, days-to-close, and closure-aging (e.g., open >30 days). These are the fields our payer partners monitor and are useful as process outcomes
- Behavioral health screening data (PHQ-9 and related instruments) captured alongside SDoH within the same assessment battery

- All of the above is collected by Monogram as a treating provider and is linkable at the patient level to our internal clinical, diagnosis, and utilization data

2. Completeness (% of population)

- Screening is universal, not sampled. Every engaged patient is screened as part of standard clinical workflow, across Medicare, Medicaid, ACO, and commercial. Current book of business is Medicare-heavy with a smaller Medicaid and ACO mix
- Data span mid-2020 to present
- 32,000+ patients identified with at least one SDoH barrier, approximately 53% of the enrolled panel
- 90,000+ total referral instances to date, with a referral-to-service conversion rate of approximately 46.5%
- Important completeness caveat: the barrier-positive rate reflects patients who both engaged and screened. Completeness is highest for engaged patients and thinner for patients with limited or telephonic-only contact. Coverage is also not uniform across markets or across the full time window (see caveats)

3. Number and types of assessments

- SDoH screening is embedded within three clinical assessments, so it is administered at multiple points in the patient journey rather than once:
 - Initial Evaluation (at onboarding)
 - Annual Evaluation
 - CCM Assessment (chronic care management)
 - Follow-up Assessment (recurring)
- Plus the Monogram-developed secondary severity/urgency assessment triggered by a positive primary screen
- Because screening recurs across assessment types, many patients have longitudinal, repeated SDoH data points rather than a single cross-sectional screen, which supports within-patient change analysis over time

4. Other useful operational context (screening, barriers, referrals)

- Delivery model: telephonic, social worker-delivered, with social workers embedded in Monogram's Pod structure. Referral and closure work is increasingly handled by a dedicated coordinator/navigator tier so that licensed social workers focus on higher-acuity clinical needs
- Referrals are logged and tracked operationally through a payer-facing portal with HEDIS-aligned expectations, which is why the referral and closure data are structured and reasonably complete for the post-standardization period
- Monogram maintains an internal financial impact model estimating the value of SDoH interventions. This is internal and not a validated research instrument, but the underlying intervention and outcome logic may be useful context for framing a value or cost-offset study
- Behavioral health is a meaningful overlap: BH is a captured SDoH domain and is also screened clinically, so proposals at the SDoH/BH intersection are well supported by our data

Caveats to flag for the researcher (methodological, important)

- Instrument change over time: the primary SDoH screen was reduced from 15 items to 10 in early 2026. Barriers captured before and after this change are not fully comparable at the item level. Any longitudinal analysis spanning that period needs to account for the instrument change.
- Evolving delivery model: the role delivering SDoH work is shifting (social worker to coordinator/navigator), and additional program changes are anticipated in late 2026 to early 2027. Go-forward data collection may differ from historical, which matters for any prospective or operationalized study
- Coverage is not uniform across markets or across the full mid-2020-to-present window
- External data-sharing scope: the data described here is Monogram provider-collected data. Claims, cost, and other payer-derived data are generally not shareable through this partnership under current contract terms. Internal linkage to claims/utilization exists but should not be assumed available for external research use

Hospitalization / Post-Hospitalization Data

Monogram holds hospitalization data from three distinct sources, which together give us both timely event detection and clinical depth beyond what claims alone provide.

Sources:

- Daily direct ADT (admit/discharge/transfer) feeds: near-real-time notification of admission and discharge events, independent of claims lag
- Concurrent nurse review: a dedicated nurse team contacts the facility during the stay to obtain admit reason, clinical status, and discharge details. This produces structured and narrative clinical context that claims do not carry
- Payer claims: adjudicated utilization, used for reconciliation and completeness

Likely in scope (Monogram-generated):

- Grey area, but we may be able to share ADT-derived event timing (admission, discharge dates) as received through our feeds
- Nurse-collected clinical detail: reason for admission, clinical course, discharge disposition, and related notes
- Transitional care activity: post-discharge outreach, in-home and telephonic follow-up, medication reconciliation, follow-up scheduling
- Post-acute clinical documentation (assessments, vitals, care plan updates)

Out of scope / constrained (payer-derived):

- Adjudicated claims fields (DRG, billed length of stay, facility payment data). The event itself we often see via ADT, but the *claims record* of it is payer-sourced and out of scope

Key point for researchers: This is a differentiated asset. Because we run daily ADT plus active concurrent review, we can characterize hospitalizations with clinical specificity and timeliness that pure claims analyses cannot match, including admit reason and discharge context captured contemporaneously. Claims still lag and remain out of scope for sharing, but they are not our only or primary line of sight into utilization. Study designs built around timely, clinically-detailed admission and readmission data are feasible here in a way the original framing understated. One big

callout: much of the data (and interesting elements) are currently housed in notes and may not be discrete or easy to decipher.

Enrollment Procedures

In scope (Monogram-generated):

- The full engagement funnel: identified, outreach attempts, contact, consent, enrolled, active, disenrolled or graduated
- Outreach channel and attempt data, consent capture, enrollment and disenrollment dates and reasons
- Program and specialty assignment, pod assignment

Out of scope / constrained (payer-derived):

- The attribution and eligibility lists that seed the population, and the payer methodology behind attribution
- Payer eligibility files themselves

Key point for researchers: Patients enter through payer attribution under value-based arrangements, then Monogram runs its own consented enrollment process. We can fully describe the funnel and our operational definitions (what counts as enrolled, engaged, active). One consent caveat worth surfacing early: our consent framework covers treatment and care management, not research. Any patient-level data use for a study would likely require separate data-use agreement and appropriate approvals.

Reporting Standards and Practices

What we report and how:

- Operational scorecards and dashboards, quality measures (for example blood pressure control, screening completion), SLA and contractual compliance, engagement metrics, and NCQA accreditation evidence
- Standardized metric definitions with governance; cadence ranges from real-time dashboards to monthly scorecards to quarterly and regulatory reporting

- Source systems: the care management platform (currently transitioning from Salesforce to 360), the Athena EHR, and external lab feeds (Quest)

Key point for researchers: We are mid platform migration. Some historical metrics carry definitional discontinuities across the Salesforce-to-360 transition, so multi-year or longitudinal series may require reconciliation before they are analytically reliable. This is a genuine data-quality consideration, not a formality. Reporting content that embeds claims or payer submissions is out of scope for sharing.

Clinical Pathways

What we have:

- Standardized, condition-specific clinical protocols across our multispecialty model: cardiology, pulmonary, endocrine, palliative, and behavioral health, delivered in-home and telephonically to complex polychronic patients
- Structured elements: protocol-driven assessments (for example PHQ-9 and other validated instruments), vitals capture, labs, care plan templates, risk stratification, and visit cadence tied to acuity
- A pod-based care delivery model in which pathways define assessment cadence, intervention triggers, and escalation criteria

Key point for researchers: The pathway logic, assessment instruments, care-plan structure, and the resulting Monogram-generated clinical data are all in scope to describe. Data comes in both structured/coded form (assessments, problem lists, medications, labs) and unstructured form (clinical notes). This is a multispecialty polychronic model, not a single-condition program.