PHYSICIAN-FOCUSED PAYMENT MODEL TECHNICAL ADVISORY COMMITTEE (PTAC)

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PUBLIC MEETING

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Virtual Meeting Via Webex

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MONDAY, SEPTEMBER 27, 2021

PTAC MEMBERS PRESENT

JEFFREY BAILET, MD, Chair
JAY S. FELDSTEIN, DO
JOSHUA M. LIAO, MD, MSc
KAVITA K. PATEL, MD, MSHS
ANGELO SINOPOLI, MD
BRUCE STEINWALD, MBA

PTAC MEMBERS IN PARTIAL ATTENDANCE

TERRY L. MILLS JR., MD, MMM
JENNIFER L. WILER, MD, MBA

PTAC MEMBERS NOT IN ATTENDANCE

PAUL N. CASALE, MD, MPH, Vice Chair
LAURAN HARDIN, MSN, FAAN

STAFF PRESENT

LISA SHATS, Designated Federal Officer (DFO), Office of the Assistant Secretary for Planning and Evaluation (ASPE)

VICTORIA AYSOLA, ASPE Staff

A-G-E-N-D-A

P-R-O-C-E-E-D-I-N-G-S

9:35 a.m.

* CHAIR BAILET: All right. Good morning and welcome to this meeting of the Physician-Focused Payment Model Technical Advisory Committee known as PTAC. I am Jeff Bailet, the Chair of PTAC.

Because of the coronavirus-continuing pandemic, we are gathering again virtually rather than in the Great Hall of the Humphrey Building.

Our goal is for a seamless virtual experience as close to an in-person PTAC meeting as possible.

That said, we appreciate your understanding in advance if any technical challenges arise such as sound delays and background noise.

If you have any technical questions, please email our contractor team at ptacregistration@norc.org. Again, that's ptacregistration@norc.org. If you've joined us by Webex, you can also message the meeting host with any questions.

I know that many stakeholders interested in PTAC are also directly involved in

the pandemic response. We're very thankful for your service to our communities.

We want to thank providers, support staff, caregivers, family members, and others who are supporting patients and families during the pandemic, and we're privileged that you've joined us today.

* **Welcome and Social Determinants of Health and Equity Session Overview**

As you may know, the Committee has received more than two dozen proposals for physician-focused payment models since its inception.

Over the years our reviewing them, common themes have surfaced across multiple proposals.

At our public meeting in June, we examined care coordination in the context of Alternative Payment Models, and our report to the Secretary from that meeting is forthcoming.

Today, we will explore a different theme from past proposals: how efforts to address social determinants of health, known as SDOH, and equity can be optimized in the context of physician-focused payment models and Alternative

Payment Models.

First, we are honored to be joined by some of the leadership team at the U.S. Department of Health and Human Services who will provide some updates on the Department's work in the SDOH and equity space.

Next, four Committee members who volunteered to assist in preparing for today's theme-based discussion will provide an overview for additional context.

They have done a lot of prep work for today, including working with staff on background materials available on the ASPE PTAC website. Then, a PTAC member will present on addressing equity through APMs[1].

After that, we have a listening session with six presenters, including previous submitters, who will describe innovative initiatives and approaches to addressing SDOH and equity.

Following the break, we'll reconvene for a panel discussion with experts representing a variety of perspectives. They will cover a variety of data and payment issues related to

1 Alternative Payment Models

SDOH and equity.

Then, we will have a public comment period to gather more input on SDOH and equity. Public comments will be limited to three minutes each to maximize the number of participants.

If you've not registered in advance to give an oral public comment, but would like to, please email ptacregistration@norc.org. Again, that's ptacregistration@norc.org.

Then, the Committee will discuss what we've learned today and shape our comments for the report to the Secretary of HHS on today's topic.

We'll adjourn after announcing a Request for Input and opportunity for stakeholders to provide written comments to the Committee on SDOH and equity.

*** Elizabeth Fowler, JD, PhD, Deputy Administrator,Centers for Medicare & Medicaid Services and Director, Center for Medicare and Medicaid Innovation Remarks**

To start off, I'm excited to introduce Dr. Liz Fowler, who serves as the CMS Deputy Administrator and the CMS Innovation Center

Director.

She gave remarks at our June public meeting. We have been eagerly waiting what more she can share on the strategy at the Innovation Center.

Before joining CMS, Dr. Fowler was the Executive Vice President of Programs at the Commonwealth Fund. She also served as Vice President for Global Health Policy at Johnson & Johnson, and as the Chief Health Counsel to former Senate Finance Committee Chair.

And now, it's my pleasure to welcome Dr. Fowler.

DR. FOWLER: Thank you so much, Dr. Bailet. I really appreciate it, and I'm so happy to be here.

As Dr. Bailet mentioned, I'm Liz Fowler, the CMS Deputy Administrator and Director of the CMS Innovation Center, or CMMI.

And if you tuned in to watch the PTAC meeting in June, you might recall that I was invited to give remarks at that time and share some early feature of CMMI's strategic refresh. Today, I'm excited to share more about our CMMI strategy with you.

In August, the CMS leadership published a blog in Health Affairs that describes the contours and goals of CMMI's strategy refresh.

Our Administrator, Chiquita Brooks-LaSure, and Center Directors, Meena Seshamani and Daniel Tsai, also joined in that blog, and they all agree with me that this new strategy will help drive our delivery system toward meaningful transformation.

The new strategy is also consistent with the Administrator's areas of focus and strategy, which she delivered and unveiled a couple of weeks ago on a public webinar.

"Meaningful transformation" means a delivery system that embraces the opportunity to advance health equity and address disparities and access and outcomes, payment structured around value and quality instead of the volume of services provided, and delivering person-centered care that meets people where they are.

The Innovation Center has been energetically working on this strategic refresh for the past several months to chart the course for value-based payment.

We examined the first 10 years of the Innovation Center's work and identified lessons learned.

Over the past decade, we launched over 50 models and learned something from every one of them. As a portfolio of models, we also have general lessons that will inform the next 10 years.

One of the crucial lessons we took away from the first decade is that models have been predominantly Medicare-oriented and not very representative of the population in terms of racial and ethnic makeup of the population.

Additionally, a limited number of models focused on Medicaid beneficiaries or included participation from Safety-Net and rural providers.

Going forward, equity will be centered in every model. Models will be designed to include meaningful representation of beneficiaries from racial, ethnic, and rural, and other underserved populations, as well as the providers who care for them.

The volume of models, the Innovation Center has planted a lot of seeds in our

innovation garden.

Many experts have said we ran too many models, and we created complexities for the Center and for model participants, particularly when models overlap.

In the future, the Center will focus on launching fewer models that are more harmonized and consistent with the Center's overarching strategy.

Models that work will be scaled to become a part of the core Medicare/Medicaid programs.

The success of the Innovation Center has been judged based on the number of models certified for expansion, but only four models have met this test, which is a high bar, and the successful models have not been the most transformative models.

We remain committed to our statutory mandate to identify and test approaches that can reduce spending and/or improve quality of care, but we will also focus on a new approach to defining successful models in terms of lasting transformation.

Models that meet the certification

standard can be expanded, but if we see innovation that has led to fundamental changes and improvements in the way care is delivered, even if they don't meet the high test of certification, we will look for opportunities to incorporate successful elements into other models, or into Medicare or Medicaid, and we will also consider whether legislation could be a path to greater adoption.

We will also endeavor to increase transparency. We commit to seeking diverse perspectives during model development, implementation, and evaluation, including patient and consumer feedback, utilizing the LAN, the Learning in Action Network, and other forums for engagement, and we will endeavor to share more data externally to gauge model progress and generate learnings.

These lessons have informed the five objectives of our strategy. They are, first, drive accountable care for beneficiaries.

We'd like to see all Medicare beneficiaries, starting with Medicare and moving into the rest of the populations, aligned into

advanced primary care, an ACO[2], or other forms of accountable care.

Second, advanced health equity in all our models, as I mentioned.

Third, support care innovations that drive person-centered care.

Fourth, address affordability for patients.

And fifth, partnerships to achieve transformation.

Especially critical to today's meeting is the second objective to advance health equity. CMS is committed to developing a health system that attains the highest level of health for all people and eliminates health disparities.

Achieving this goal requires centering equity in all stages of model design, operation, and evaluation and aligning these concepts with other CMS programs.

We are committed to understanding the current impact of Innovation Center models on all patients, such as the characteristics of beneficiaries attributed to our models.

This requires utilizing patient-level

2 Accountable Care Organization

demographic data and standardized social needs data, as well as tracking data on penetration of Innovation Center models in underserved communities.

I'm delighted to share that we recently brought on Dr. Dora Hughes to be our chief medical officer. As an expert in the field, she will lead the Center's work on health equity.

Dr. Hughes spent some time with the PTAC this morning, and we're looking forward to continuing these conversations.

We are especially interested in today's public meeting where the discussion themes are social determinants of health and health equity.

We look forward to the sharing of ideas, expertise, and experiences with social determinants of health and health equity.

In the coming weeks, we'll release more details on the new CMMI strategy, including ways we can measure progress on each of these objectives.

In closing, I'd like to take a moment to thank Dr. Jeff Bailet and Dr. Kavita Patel,

both of whom are among the longest serving PTAC members.

Thank you both for your hard work and dedication to the success of the PTAC. On behalf of CMMI, we are grateful for your tireless work over the last six years.

I also want to thank the Committee members more broadly for their time and dedication to furthering value-based care.

Have a great meeting, and thank you again for allowing me to share our work with you.

CHAIR BAILET: Thank you, Liz. Thank you for your comments. Much appreciated.

*** Andrea Palm, MSW, Deputy Secretary of the Department of Health and Human Services Remarks**

At this time, I'm thrilled to introduce Andrea Palm, who serves as the Deputy Secretary of HHS.

In that role, she serves as the Chief Operating Officer of the Department. She most recently served as a Secretary Designee of the Wisconsin Department of Health Services overseeing one of the largest government agencies in Wisconsin and its response to the COVID-19

pandemic.

She also held several policy and operational roles at HHS as part of the Obama/Biden Administration.

And with that, it is my pleasure to welcome Deputy Secretary Palm.

DEPUTY SECRETARY PALM: Thank you. I know that this is your last meeting and Kavita -- Dr. Patel's last meeting. So, thank you so much for six years of dedicated service to PTAC.

And I really do appreciate the work that you all have done, as well as the Committee as a whole.

So, Committee members, thank you for your invitation to join you today. On behalf of Secretary Becerra, I really want to extend our gratitude for your thoughtful reports and the work that you have delivered to the Department.

Finally, I also want to thank the community of health care clinicians and other crucial partners across the country for your ongoing efforts throughout this pandemic.

I know it has been a very challenging year and a half for you and for your families, and I really want to stress that your work has

been critical to our efforts to fight the pandemic, and it certainly has not gone unappreciated.

This Committee has come to serve as an important venue for stakeholder ideas as we work toward a value-based delivery system.

So, it makes me very happy that you've chosen social determinants of health and equity as the theme for your public meeting today.

As you know in America, the pandemic has been characterized by stark health inequities among racial and ethnic minorities, people with disabilities, and other vulnerable at-risk populations.

The question before us now is this: How do we incorporate the lessons from tackling COVID-19 and building a more resilient, inclusive, and healthy society as we move forward?

The answer starts with Building Back Better as President Biden has tasked us to do by centering equity as a core of all the work that we do.

Through Secretary Becerra on down, at HHS we want everyone to have the opportunity to

be as healthy as possible, to live long, happy lives, and to do so in a country that can provide access to health care for everyone.

That is why we extended access to health care to 2.8 million people who took advantage of the American Rescue Plan's lower health insurance premiums during this year's special enrollment period through the Marketplace.

That is why we've invested in telehealth, including $19 million that HHS distributed last month to strengthen telehealth services in rural and underserved communities so that no one gets left behind.

This Committee's telehealth report represented a thorough and careful deliberation on the important role telehealth plays in health care, its use in Alternative Payment Models, and considerations moving forward.

And that is why we want to ensure that we have the right data to be able to measure our progress on narrowing health disparities so that we have use of every tool in our toolbox to expand the data that we have of race, ethnicity, primary language, sexual orientation, gender

identity, geography, disabilities, and social determinants of health.

In addition to helping us gauge our progress, this information can help us strategically target our efforts such as communicating about opportunities to sign up for health insurance or to access care through a health center.

In general, we continue to examine how we can infuse health equity into each of our programs and processes and these efforts don't stop at the first "H" in HHS.

The human services aspects of our work are equally important. That is why I am especially eager to support linkages across the health and social service sectors at the federal, state, and local levels because we need clinicians on the ground making referrals to local community-based organizations in order to support patients who may need assistance in meeting their housing, food, or transportation needs.

We need to advocate for policies at the federal level to address housing affordability and homelessness, food security,

transportation, among other social determinants of health.

And we need to pursue opportunities, as we are currently doing, to work with other cabinet departments to see how we can use our collective strengths to build health equity and address social determinants of health.

Finally, in our pursuit of health equity, we also need to make health care delivery systems the best it can be, and this includes thoughtfully designed Alternative Payment Models and payment policy.

I know that our leadership team at the Centers for Medicare & Medicaid Services Innovation Center are sharing with you information on their strategic refresh to chart the course for value-based payments for the next decade.

The Center is committed to working with physicians and other health care leaders, patient groups, researchers, and other stakeholders, to drive meaningful change and make the health care system better for all people.

This will require a firm commitment to health equity, paying for value instead of volume

of care, and re-engineering care delivery to deliver person-centered care that meets patients where they are.

As you leave here today, know that your recommendations and your efforts do not go unheard or unheeded.

We are eager to learn about your findings from today's public meeting, and we're thankful for the time you have invested in exploring this topic, as well as your recent meetings on telehealth and care coordination.

I want to thank you again, and all of the members of the Committee, for your service to the nation.

I know that you take time out of your busy schedules to share your energy, your experience, and your expertise with us as volunteers, and I'm especially grateful to Dr. Bailet for his steadfast leadership as our inaugural chair.

Thank you for your service to our health care system. Have a great public meeting, and I look forward to continuing to work together.

Back to you, Dr. Bailet. Thank you.

CHAIR BAILET: Thank you, Deputy Secretary, for joining us and sharing those updates from the administration as the backdrop for today's conversation. We're eager to work with you and your team moving forward.

Now, before I ask my PTAC colleagues to introduce themselves, I want to remind our stakeholder community that PTAC accepts proposals on a rolling basis, and we remain ready to review proposals as they come in.

PTAC's proposal submission instructions are available online, as well as a reference guide we created on common APM approaches.

*** PTAC Member Introductions**

At this time, I would like PTAC members to please introduce themselves. Please share your name and your organization.

If you'd like, also feel free to share a brief word about any experiences you have with social determinants of health and equity, today's topic.

Because our meeting is virtual, I'll cue each of you, and I'll start with myself. I'm Jeff Bailet, the CEO of Altais and an ENT surgeon

by training.

I'd like Jay to introduce himself.

DR. FELDSTEIN: Hi. My name is Jay Feldstein. I'm the president and CEO of Philadelphia College of Osteopathic Medicine.

And prior to that, I was an emergency medicine physician and was also the vice president of five Medicaid health plans of which we attempted to address a lot of issues in social determinants of health.

Thanks, Jeff.

CHAIR BAILET: Thank you, Jay.

Josh.

DR. LIAO: Good morning, everyone. My name is Josh Liao. I'm a clinician practicing at the University of Washington in Seattle.

And outside of my clinical work, I am very focused and committed to work in equity in two other roles. One, is the medical director for payment strategy for our health system; and second, as someone who does research and evaluation on this topic, some of which I'll be fortunate to share with you later today.

CHAIR BAILET: Thank you, Josh.

Lee.

DR. MILLS: Good morning. I'm Lee Mills. I am senior vice president and chief medical officer of CommunityCare, which is a managed care provider-owned plan in Oklahoma.

I'm a family physician by training, and my career has been in leadership of full-discretion medical groups implementing payment models and then now in health benefit design and care management. Thank you.

CHAIR BAILET: Thanks, Lee.

Kavita.

DR. PATEL: Hi. Kavita Patel. I'm a primary care physician and also a fellow at the Brookings Institution, where I work on payment policy, and I'll just make a comment.

I'm glad that this topic is here today, and I couldn't echo more the need to think about meaningful models in Medicaid just because there are, as you heard from the previous PTAC members, so many overlap issues that really, I think, are challenges, but opportunities, with MCOs[3] and Medicaid beneficiaries.

And I practice in a primary and Medicaid setting, and I can tell you it's a world

3 Managed Care Organizations

of difference when we get a Medicare patient that's in an ACO and what feels like open, ample opportunities to coordinate their care; and then 10 minutes later find a Medicaid patient in an MCO, well-intentioned MCO with a lot of care coordination, kind of, tools, none of which can actually get to the patient for various reasons. So, thank you for tackling this today.

CHAIR BAILET: Thank you, Kavita.

Angelo.

DR. SINOPOLI: Yeah. Angelo Sinopoli. I'm a pulmonary critical care physician and have been the chief clinical officer for Prisma Health.

We have a large ACO with about 5,000 physicians and a lot of products and would echo Kavita's statements in that a lot of our success has been around focusing on social determinants of health and equity and particularly in the Medicaid populations, but surprisingly witnessing it to extend itself throughout all of our products. And so, it's a very important topic today.

CHAIR BAILET: Thank you, Angelo.

Bruce.

MR. STEINWALD: Hi. I'm Bruce Steinwald. I'm a health economist right here in Northwest Washington, and I have had various roles in health policy and health economics in and out of government over the past 50 years.

CHAIR BAILET: Thank you, Bruce.

Jen.

DR. WILER: Hi. I'm Jennifer Wiler. I'm a tenured professor and practice emergency medicine, but I'm also the chief quality officer for UC Health, which is the largest health care system in Colorado.

And I'm also the cofounder of the Care Innovation Center where we partner with digital health companies to grow and scale their solutions.

And I, too, as a practicing emergency physician, am very interested in this topic, but also in my role as a cofounder of our Innovation Center, where I think there's a lot of opportunity for technology to better enable us to address these disparities and inequities, so I look forward to the conversation today.

CHAIR BAILET: Thank you, Jennifer, and my thanks to the Committee. There are a few

Committee members -- Paul Casale, who is the Vice Chair of PTAC, and also Lauran Hardin, that unfortunately couldn't be with us today, but again thank the Committee for their service and unwavering support.

Now, let's move on to our first presentation. Four PTAC members served on the Preliminary Comments Development Team, or PCDT, that has worked closely with staff to prepare for this meeting today.

I'm thankful for the time and effort that they put in to organizing today's agenda. We will begin with a presentation of some of the findings from the background materials available on the ASPE PTAC website.

PTAC members, you'll have an opportunity to ask the PCDT team any follow-up questions afterward, and now I'll turn it over to the PCDT lead, Jay, and the rest of the team, Jen and Angelo, Lauran Hardin, again, who couldn't be with us today who also served. Jay?

*** Presentation: An Overview of Proposals Submitted to PTAC with Components Related to SDOH and Equity and Other Background Information**

DR. FELDSTEIN: Thank you, Jeff. Today, we're going to present an overview of proposals submitted to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) that included components related to social determinants of health (SDOH) and equity and other highlights from background information.

And I'd just like to thank my fellow team members, as well as NORC and ASPE staff, for the tremendous work they did on researching this topic.

Next slide. From 2016 to 2020, PTAC received 35 stakeholder-submitted proposed physician-focused payment models, or PFPMs.

Nine included components related to SDOH, and five of these also described strategies for advancing equity in access to care. Four did not explicitly focus on SDOH, but addressed equity in some way.

This presentation provides a summary of the characteristics of the nine proposed models that included components related to SDOH, with a focus on proposed activities and functions related to addressing SDOH and/or equity; performance measures for activities related to

addressing SDOH and/or equity; and payment approaches for accounting for and/or reimbursing for activities related to SDOH and/or equity.

This presentation also includes some additional background information on definitions and other issues related to SDOH and equity.

Next slide. So, let's all get a common background and define SDOH, social needs, and behavioral health as seen in these contexts.

SDOH, social determinants of health, are community-level barriers that patients can face to becoming and staying healthy. Although experienced by individuals, they exist at the community level.

Key areas are social context, economic context, education, physical infrastructure, and health care context.

Health-related social needs as related to, but different from SDOH, include nonmedical patient needs that impact health, such as housing instability, food insecurity, and exposure to interpersonal violence.

And behavioral health needs of patients within the context of addressing physical wellness, SDOH, and health-related

social needs, is an umbrella term that includes mental health and substance abuse conditions, life stressors and crises, stress-related physical symptoms, and health behaviors. Behavioral health conditions often affect medical illness and vice versa.

Next slide. Some of the key areas in AHRQ[4]'s definition include social context, demographics, social network and support, social cohesion; economic context, employment, income, poverty; education, quality of day care, schools and adult education, literacy and high school graduation rates, and English proficiency; physical infrastructure, housing, transportation, workplace safety, food availability; and health care context, access to high-quality, culturally and linguistically appropriate and health-literate care, access to insurance, health care laws, health promotion initiatives, supply side of service, and attitudes towards health care and use of services.

Next slide. From a background perspective, what really makes up health? What are the medical and nonmedical determinants of

health?

Forty percent of our health is determined by socioeconomic factors: education, job status, family support, income, community safety; 10 percent is the physical environment; and 30 percent is specialty towards chronic disease or health behaviors. Health care itself, as defined by access and quality, represents about 20 percent.

Now, this does not include genetic factors, but when you consider the $3.6 trillion health care spending we have in our country, how much and what services do we want to pay for to maximize health outcomes?

So, I leave that for everybody's consideration as we go throughout today's program.

Next slide. How do we define "health equity" and "health disparities"? Health equity is achieved when every person has the opportunity to attain his or her full health potential, and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.

Health disparities as related to, but different from equity, is a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.

Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.

Next slide. When we look at the relationship between health equity, social determinants of health, and health-related social needs, we really are talking about an integration and holistic view of health and health care not only at the individual level, the community level, state and federal, but at the systems level. This really takes a holistic perspective of health and health care.

Next slide. So, some of the examples of effective innovations for addressing SDOH

and/or equity are efforts to address SDOH can assist in improving equity and reducing health care disparities.

Examples of broad interventions that have been found to be effective are supportive community-based behavioral interventions; anti-poverty interventions; interventions targeting environmental conditions such as a smoke-free space.

Effective interventions for addressing SDOH that are relevant for health care providers include efforts to address patients' health care contexts and help them deal with unmet social needs.

For example, cultural and linguistically competent care and education have improved chronic disease outcomes, psychosocial outcomes, cardiovascular risk factors, and self-reported behavioral outcomes and patient and provider behaviors.

Transportation services embedded in multicomponent interventions involving patient navigation and chronic disease education have reduced unnecessary emergency department visits.

Next slide. Some health care

providers have collected data on patients' SDOH and health-related social needs and used this information to assist in referring patients to additional resources to address these needs.

During COVID-19, some health care providers with the ability to screen and refer individuals to community-based organizations were able to assist COVID-19 patients in isolating at home by providing resources such as food.

Several programs have been effective in addressing health-related social needs among Medicare populations.

Studies have shown that seniors participating in an affordable housing program experienced fewer hospitalizations and used the emergency department less frequently.

Studies have also shown that assistance primarily provided to alleviate food insecurity can result in reduced cost-related medication nonadherence, hospitalizations, emergency department visits, and overall health care costs.

Next slide. What's the impact of the COVID-19 health public emergency on the use of data related to SDOH and/or equity?

While telehealth use increased during COVID-19, research has highlighted disparities in access to telehealth.

Some state and local health departments started reporting COVID-19 outcomes data by race, ethnicity, and identifying disparities.

State and local health departments, health care organizations, and researchers used SDOH-related data to predict community risk for COVID-19, including UCSF[5]'s Health Atlas; Socially Determined's tool SocialScape helped Maryland plan for localized COVID-19 care; and MITRE's COVID-19 Healthcare Coalition Dashboard helped as well.

Health care organizations used SDOH-related data to improve care coordination. For example, early in the COVID-19 pandemic, Humana's use of SDOH-related data in its care coordination formed the impetus for its Basic Needs Food Program.

The Robert Wood Johnson Foundation launched a new collaboration between the Health Care Cost Institute, CareJourney, the Berkeley

5 University of California San Francisco

Research Group, and a network of health systems to create an open COVID-19 patient data registry network.

Next slide. With that background information, let's look at how SDOH and equity has been incorporated in proposals submitted to PTAC.

Next slide. Nine proposals that were submitted to PTAC included components related to SDOH.

Five of these proposed models also described strategies for advancing equity in access to care.

The nine PTAC proposals that were identified as having an SDOH and/or equity component varied by clinical focus, setting of care, and care coordination context.

Next slide. Key areas covered in the proposals submitted to PTAC included social context, health care context, and physical infrastructure.

Next slide. Each of the nine PTAC proposals that included SDOH and/or equity components addressed at least four SDOH-related functions.

The most common SDOH-related functions are summarized below with the leaders being monitoring progress and following up on identified health-related social needs; improving integration of health care and social services and supports; and providing referrals to address health-related social needs.

Next slide. Some additional background information is now going to be presented on CMMI models.

Next slide. Fifteen CMMI models were identified as including an SDOH and/or equity component.

All but one of the 15 CMMI models included Medicare beneficiaries as a target population, and half of these models targeted Medicare beneficiaries exclusively, as indicated in blue above.

Next slide. Each of the 15 CMMI Alternative Payment Models addressed at least two of the five SDOH domains identified in the AHRQ's definition.

The 15 CMMI models targeted a diverse range of health-related social needs, and the most common social needs addressed were

transportation problems, food insecurity, housing instability.

Nearly all of the CMMI models included a mental health component, and two-thirds of the models address substance use.

Six CMMI models also addressed needs related to physical wellness by empowering patients to lead a healthy lifestyle, for example, by engaging in physical activity and weight management.

Next slide. Twelve of the 15 CMMI models with SDOH and/or equity components have undergone evaluations.

Many evaluations reported an increase in screenings for health-related social needs and provider modifications to accommodate access to care issues resulting from nonmedical factors.

The IAH[6] Demonstration offering home-based primary care reported high satisfaction for both patients and caregivers regarding the model's effect on care accessibility.

Some participating hospitals used data from screening and population-level characteristics to open resource centers or

training programs to address SDOH.

A common evaluation finding was that participants in these models increased the number of social workers and other community service staff.

Common challenges identified by evaluators include lack of sufficient financial resources and personnel to provide patient-centered, value-based care on a large scale; and resource and financial challenges are intensified in rural settings and in historically disadvantaged communities.

Next slide. Five of the 15 selected CMMI models that included SDOH and equity components included performance measures related to SDOH and/or equity. Performance measures varied in scope. General performance measures, like those specified in the AHC[7] Model, looked for an increase in community capacity to respond to health-related social needs.

Models with specific measures, like the CPC+[8] Model, gathered data on the percentage of practices reporting after-hours services and

6 Independence at Home
7 Accountable Health Communities
8 Comprehensive Primary Care Plus

the use of telehealth to expand access to care.

Certain practices in some models included performance metrics in provider contracts to improve accountability and motivate physicians and other care providers. The MAPCP[9] Demonstration stratified health service utilization data by race, income, geographic location, and other socioeconomic factors underpinning SDOH and health-related disparities.

Next slide. So, what's the current state of evidence on the effectiveness of SDOH interventions relevant for APMs?

Successful patient-level interventions implemented by health care providers to address health-related social needs related to the patients' health care contexts often include provision of culturally and linguistically competent care and education; improved financial access to care; and improved communication, navigation, and self-management.

Health care providers are also well-positioned to assist their patients in accessing community-based benefits and support services. Many interventions addressing other health-

9 Multi-Payer Advanced Primary Care Practice

related social needs, such as transportation barriers, housing, and food needs, have also been shown to have a positive impact on health outcomes.

And health care providers can also engage with local community leaders to advocate for policies and intervention towards addressing social determinants of health. Examples of such policies and interventions include wage increases and improving environmental conditions.

Next slide. So, what are the trends in the use of SDOH and/or equity data for reimbursement?

At the federal level, CMMI has designed and implemented multiple APMs that address SDOH and/or equity.

As of 2019, Medicare Advantage plans are permitted to expand health-related supplemental benefits to include services such as meal delivery and transportation assistance.

However, Medicare's value-based purchasing programs do not currently include health equity measures to reduce beneficiary disparities.

At the state level, Section 1915

Medicaid waivers are designed to cover home-based care, and Section 1115 Medicaid demonstration waivers are in existence to cover nonmedical care such as North Carolina's Healthy Opportunities Pilots and California's CalAIM Program.

Medicaid managed care organizations engaging in these activities to address SDOH include AmeriHealth Caritas and CareSource to date.

From a commercial insurer perspective, Aetna has created SDOH indices, but, to date, there's been limited progress incorporating SDOH and/or equity into payment methodologies.

Next slide. So, where do we go from here? What additional information do we need? How has the COVID-19 public health emergency increased attention on efforts to address SDOH and advance health equity?

What activities can help to optimize efforts to address SDOH and/or equity in APMs and PFPMs to improve quality and reduce or control costs?

Which activities are particularly effective for Medicare beneficiaries? What kinds of data are needed to enhance health care

providers' ability to address SDOH and/or equity issues?

And how can APMs and PFPMs incentivize providers to screen for and make referrals to address SDOH issues?

How can APMs and PFPMs improve their measurement of the quality and effectiveness of SDOH and/or equity-related efforts, including assessing the impact of community partnerships related to addressing these issues?

And how can APMs and PFPMs move beyond individual interventions focused on health-related social needs to addressing community-wide interventions focused on SDOH and access to care?

And finally, how can APMs and PFPMs address the structural and systemic factors that cut across SDOH domains and contribute to health disparities?

So, again, I'd like to thank everyone for their participation and, Jeff, I'll turn it back to you.

(Pause.)

DR. FELDSTEIN: Jeff, you're on mute.

CHAIR BAILET: So, thank you, Jay. I'd like to just turn it over to Jennifer and Angelo

if they have any additional comments to add before we turn it over to the Committee.

(Pause.)

CHAIR BAILET: All right. Well, thank you, Jennifer and Angelo, and Lauran was also part of the team.

We now would like to move into our listening session, and the first listening session of the day we have one of our very own members presenting. That's Josh Liao. And Committee members will have time to ask Josh questions after his presentation, and I'd like to turn it over to Josh. Thank you.

*** PTAC Member Listening Session on Payment and Data Issues Related to SDOH and Equity**

DR. LIAO: Thanks, Jeff, thanks to all the Committee members, and thank you for all the attendees today. I'm grateful to be able to share on this topic addressing equity through Alternative Payment Models, or APMs.

Before we get going, I want to underscore something that I think we all know, that there are many APMs, many types of APMs that differ in scope, target area, design, et cetera.

It's certainly, in my perspective, impossible to cover all of that today. This presentation will focus specifically on my historical work in research and evaluation around episode-based bundled payment models.

And both in presentation and, I hope, through Q&A, we'll have a chance to kind of think about how we take these of some concepts to APMs more generally.

Next slide, please. So, the context for my work has been really threefold. The first is that APMs have played an important role in informing expectations and signaling direction towards value-based care.

It's certainly worth discussion about the differing magnitudes of the benefits that we see, the pluses and minuses, et cetera, again speaking to the diversity of APMs as a group; but I think it's fair to say it's really signaling the direction of where we're headed in health care; but, in my opinion, progress towards these delivery improvements haven't necessarily translated into progress in the critical area of health disparities.

And, third, I think there are reasons

to worry that APMs could perpetuate or even worsen existing disparities, particularly those facing historically marginalized groups, and I'll pause here and highlight two potential ones.

First, as you can imagine, the APMs and their incentives might create selective participation, which groups, hospitals, organizations, et cetera, might participate in certain regions and communities and those who might not.

The second, is that among organizations that participate, there could be selection or what some people term as "cherry picking," where there's a selection of which patients receive care under the APMs or even the types of care that they receive. And so, again, I think there are reasons to at least raise the question.

Next slide, please. So, I'd like to spend our time today really focused around three questions.

First, how have APMs engaged historically marginalized communities? And by that, I really mean the geographic element.

Second, how have APMs affected

disparities among individuals in those communities? This would be individuals receiving care under specific APMs.

And then stepping back a little bit and thinking about what are three ways, based on my research and work, to better advance equity through APMs going forward?

Next slide, please. So, just to bottom line my talk here, what I'm hoping when we're done today, I will leave you with these three takeaways. I wanted to give them to you now.

First, is some APMs, based on our work, my colleagues and I, have excluded historically marginalized communities from the geographic sense.

Second, despite encouraging early evidence, in my opinion and to my knowledge, there is an overall dearth of data about how APMs have impacted disparities among these communities.

And I think a few changes that can be potentially made to advance equity in APMs in the future include setting national intention and goals to prioritize equity as a priority; the

second is to incorporate equity into the evaluation of APMs; and the third would be to convene multistakeholder groups to do that work.

So, next slide, please. We'll go right into the first question, how have APMs engaged historically marginalized communities?

Next slide. I apologize about the animation here. What you're meant to see is a snapshot of a paper that colleagues and I recently published where we looked at the CJR Program, or the Comprehensive Care for Joint Replacement Program.

That is a mandatory joint replacement bundled payment program wherein hospitals in 67 urban areas around the country were required to accept bundled payment for joint replacement procedures.

We asked this question in this study, and I'll explain what you are seeing here in a second, what is the relationship between the -- kind of the number of dual-eligible beneficiaries in geographic communities around the country and selection for CJR for this APM?

And what you're looking at there on the top is -- I'll direct your attention to the

top right to where you see that chart with the point estimates and the bars. That's a forest plot.

And just to orient you on the x axis running along the bottom there, you have kind of the estimated probability of CJR participation.

In other words, the likelihood of being selected as a CJR market ranging from lower probability, negative 25 on the left, up to positive 25.

That vertical line of zero shows you kind of no difference, no greater or lower probability. And the point estimates, the boxes, and the lines, show you either less or more.

So, in this case, if the box -- if the points and the lines are on the left side of that zero line, we would say that it's a lower probability of CJR participation. To the right would be greater.

And so, in comparing these areas, CJR versus not, what we looked at was each community's dual share -- dual-eligibility share. In other words, the number of dual-eligible individuals in that community.

We picked that not because it's a

perfect measure. We picked it because based on work from ASPE and others, it is, unfortunately, a predictor of outcomes in value-based payment models.

And what you are looking at is that as you move from communities with the least, the fewest number of dual-eligible individuals, up to the highest, that would be quartile 1, up to quartile 2, 3, and 4, so quartile 4 has the highest, what you're seeing is an increasingly lower probability of being selected for a CJR market.

And so, we kind of, in text there, one of our conclusions is that markets that were more likely to have a higher burden of adverse outcomes through social risk factors, the study measured by dual-eligibility status, were less likely to be selected for CJR.

And I think if we take a step back, you know, CJR was a randomized policy that focused on regions with about average spending and adequate volume of these procedures.

In those criteria, there wasn't necessarily a direct consideration of social determinants or social risk factors, including

income or dual-eligibility status.

And so, I think one of the implications from this work that we found is that it's twofold.

The first is that to the extent that CJR required all the hospitals in a region to accept bundled payment and that CJR, as a program, yielded some benefits; stable quality and reduced spending, individuals, including duals, may not have access, geographic access to those programs.

And the second is that when we interpret the findings from CJR, positive as they may be, we have to be careful about generalizing that to communities and regions where there may be more, in this case, dual-eligible individuals.

Slide forward, please. So, my colleagues and I have also done work kind of asking that fundamental question about mandatory versus voluntary payment models.

This is not a new discussion. It's continuing forward -- advance slide, please -- but we've identified that, in general, mandatory APMs kind of from the concept have a potential for greater coverage to the extent that they are

covering larger geographic areas, can provide more generalizable estimates of APM impact in the sense of being less selective in participation; and, three, it may have less susceptibility to provider selection, that cherry-picking element I mentioned earlier.

However, the numbers I just showed you suggest that even mandatory programs, if perhaps not designed with the direct consideration of social risk factors, may not actually do that and, I think, is relevant for payment models and policy going forward.

Now, I'll just voice over here very quickly that in ongoing work that's unpublished at this time, my colleagues and I have asked this question: If we're going to raise this issue of mandatory versus voluntary, what happens if you compare them head to head?

In the space of joint replacement bundled payments, there's actually a comparator for this.

The BPCI program, which some of you may be familiar with, stands for Bundled Payments for Care Improvement Initiative, and it was a select -- it was a voluntary program where

organizations could choose to participate, but also encompassed joint replacement surgery.

And I mention this because in ongoing work, we have compared the two. We have said, if we take that framework I just described to you, but we look at mandatory bundled payments, CJR, and voluntary bundled payments, BPCI, and we compare them, what happens?

And just as a quick preview I'll say that you see these selection effects about who participates in both programs, and when you look at them head to head, you actually see differential changes.

In other words, depending on the dimension of SDOH you pick, as well as voluntary versus mandatory, there are actually different strengths of association there.

And so, it highlights the point we're making here which is that participation mechanism matters, but I'll also say that our findings are suggesting an interesting element which is that some of this selective participation may actually be a greater issue in mandatory versus voluntary programs. So, something to watch and to evaluate going forward.

Next slide, please. So, this is not my work, but it's work from colleagues at the University of Pennsylvania that looked at a pretty similar question around ACOs.

Again, this is where we're kind of moving a bit from my own work to say what are similar, kind of, findings from other areas in APMs -- advance slide, please -- and so they asked a similar question about geographic participation among ACOs. This was early after the beginning of the Medicare Savings Program.

And you can read there what they found was that physicians practicing in areas where higher percentages of the population were Black, living in poverty, uninsured or disabled, or had less than a high school education had lower rates of ACO participation than physicians practicing in other areas.

So, I won't spend a ton more time on this except just to highlight that this finding of inclusion geographically, or exclusion, is not limited to just bundled payments.

Next slide, please. So, just to quickly summarize what we just went through, I think what we're finding, and we have found in

our work, is that both voluntary and mandatory APMs, in this case bundled payments, which allows uniquely that comparison where other payment models do not allow that comparison, both of them may exclude historically marginalized communities from the geographic sense, unfortunately.

Second is that the mechanism actually can contribute to the dynamics that we don't see equal effects here, that voluntary versus mandatory could potentially matter.

And one of the implications of this, as I hinted at earlier, is that I think social determinants and participation mechanism could be directly considered as we think about designing and implementing APMs in the future.

Slide forward, please. So, on to the next question. So, if that's a kind of geographic region element, how have APMs affected disparities among individuals in these communities?

Next slide. So, this is a study that colleagues and I did looking at that second program I mentioned, the bundled payments for care improvement, the voluntary drug replacement program -- I'm sorry, the bundled payment

program.

It's not just joint replacement. It encompasses many different types of care episodes, and in this study, we looked at several common medical conditions -- so, pneumonia, congestive heart failure, acute myocardial infarction and COPD, chronic lung disease -- and we applied methods that are very similar to former evaluation methods used to understand the impact of these models, what we call quasi-experimental difference-in-differences, and we looked at long-term outcomes over three years.

Advance slide, please. So, this is what we found, and it's the same thing. You're looking at a forest plot again, and the difference, again, across that zero line is greater is to the right and less is to the left.

And so, advance slide, please. I'm going to draw your attention to two findings. So, the first is total episode spending, and what you see here is that compared to nonparticipating hospitals, those in this program, this bundled payment program for these medical conditions, there was episode savings, differentially less spending.

Advance slide. And when we unpacked where it came from, what we found was that one of the drivers was in skilled nursing facility length of stay, so not necessarily the proportion of people that went to those facilities, but the duration they stayed, the duration over which they needed those services.

And so, that was this -- those were kind of, at the time, to our knowledge, the first findings in this area.

So, relevant to the question I just flashed on the screen, we took this forward and asked the question around disparities.

And before I move on from here, I want to highlight that there's a difference between looking at how certain groups or individuals from different groups fare, in general, versus the disparities within an APM.

And I'll just harp on that for a second because it's, I think, critical for our conversation today.

Looking at how certain individuals are affected compared to those who don't receive care under APM is an important question, but it's a different question to ask how do individuals that

are in or not in certain groups fare under an APM, the disparities in how -- the differences in gaps in how they fare.

And so, this study I'm about to present to you, which is currently undergoing and is not yet published, focuses on the second.

So, slide forward, please. So, we took this study with these findings, and we asked the question, if we highlight certain groups that, based on literature and published studies, we know have particularly high clinical risk or a social risk, how did they fare under this BPCI model?

And, again, we didn't compare, for example, frail individuals in this APM versus frail individuals outside the APM necessarily. We asked the question, frail versus non-frail individuals within this APM, what is the gap, and did that gap change over time? Did it get bigger? Did it get smaller? Did it stay the same?

And it's relevant because you might find an APM has an overall effect, but it only comes from certain nonhistorically marginalized groups that may not be what we want in the

context of equity.

Or it may be that we find overall a program has no effect, but when you zoom in on it, it's because certain groups got the benefit, certain groups didn't get the benefit. It averages to kind of no effect. So, that is really the focus of this.

So, slide forward, please. So, we stuck with the same primary outcome -- and, again, these are unpublished studies, so it's a preview of what we're working on now -- where because we saw in that main study that length of stay was what really drove the episode spendings in the main study, we looked at that as an outcome and same forest plot here. Difference-in-differences approach.

What you're seeing is that across these seven groups, one takeaway is that the findings are variable, right? There's not one uniform finding here, but what you're seeing is that for certain groups, length of stay was differentially lower, for instance, for those of advanced age, which was defined as over 85, frail individuals, those that had previously used an inpatient rehabilitation or skilled nursing

facility.

You see for disabled patients, in fact, that length of stay was differentially greater for those receiving care through BPCI versus not.

And for those where the bar crosses that zero line, we would say there is no differential change based on our study design.

In addition to SNF[10] length of stay, we created a co-primary kind of counterbalancing measure -- so next slide, please -- which is 90-day readmissions.

The idea here being that if we saw people being discharged from SNFs earlier, was there that kind of countervailing effect of them being readmitted more frequently?

And based on what I just described to you, the takeaway from the slide is, no, in our data we did not see that, right, so that all the bars cross zero, and we did not find any statistical evidence that readmissions differentially changed for those in BPCI versus not and those in these groups versus not in these groups.

Okay. So, no adverse effects that we could observe with respect to 90-day readmissions.

Next slide, please. So, we did look at other outcomes in this study, and at the risk of drowning you in forest plots, I'll just summarize these verbally here.

The first is with respect to episode spending, we found that it was differentially lower for certain groups, those you see there: Frail, dual-eligible individuals and those of prior inpatient rehabilitation facility and skilled nursing facility utilization.

We actually observed that a 90-day mortality was differentially lower for patients in the disabled group.

And we found that actually in terms of the proportion of people, the likelihood of being discharged to SNF or IRF[11] was differentially greater for the frail patient group.

And so, pausing here for a second, I think there are a few things that I and colleagues are taking away from this.

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10 Skilled nursing facility
11 Inpatient rehabilitation facility

The first is that, again, when we looked around to say what is known in this space and, therefore, how can we do a study that would meaningfully provide some insight or would advance the discourse in this area, we found a remarkably -- just a remarkable absence of data in this area.

There had been one or two studies that have looked at how certain individuals in these groups fared, but, again, it's comparing them versus people outside of this payment model.

We really wanted to focus on this issue of the gap or the differences between them and whether they were greater or smaller, and we really couldn't find any. And so, we're hoping that this provides a unique contribution in that respect.

The second thing we take away from this is that the variation you see suggests that these groups are not being excluded from the benefit; but if we see impacts from APMs such as this program, that some of it's being driven by care redesign in these patient groups.

And third, as I highlighted earlier, at least from our data, we aren't able to see

untoward effects from individuals in this -- in these groups under this APM.

Now, of course, that doesn't mean there aren't any and that there are certain limitations that I'm happy to chat through and I think we're well aware of, but that helps allay, at least to some degree, some concerns.

So, next slide, please. So, just to summarize kind of what we just talked about, you know, I think under voluntary bundled payments for common medical conditions, our work has not revealed widened disparities observed for clinically or social high-risk patients as we just previously defined.

Strategies used in those bundled payments did not appear, based on our work, to be applied indiscriminately to high-risk patients.

You might think here that if frail or certainly more complex patients were being discharged from skilled nursing facilities more quickly, that that might, again, create some kind of negative effects.

We didn't see it indiscriminately used. It wasn't that all of these groups suddenly had lower SNF length of stays. As I

mentioned, the readmissions did not observe -- did not reveal any effects either.

And then this early evidence, we believe, may help allay some concerns, though more data are definitely needed.

My personal hope would be that going forward there would be more work studying disparities within APMs.

Next slide, please. So, the third question, what are three ways to better advance equity through APMs?

Next slide. So, this is taking a step back a little bit. It's taking that work that I just described, putting it together with some of the work that I have done in the realm of accountable care organizations thinking about, as I mentioned in my introduction, my clinical practice, my work working with decision-makers and understanding design, putting all that together, stepping back and saying, you know, how do we think about where do we go from here?

So, this is an article that I was privileged to pen with a few colleagues from the University of Pennsylvania addressing this issue -- advance slide, please -- and our takeaway

based on what I just described that there are reasons to worry about APMs and equity disparities and that there are certain gaps in how we understand historically, we identified a number of changes that we thought to be useful.

Just running across the rows here, the first we thought was to set national goals around prioritizing equity and health care payments.

And the real essence of that really is that we believe, and I believe, that policy intention precedes policy implementation.

And we often talk about equity and disparities as unintended consequences, you know, it's the unintended consequence, and I personally find that that is an intriguing way of describing it.

And that if we directly and explicitly intend to address equity, that we can really make progress in this away.

And so, that's really kind of our own idea of setting that goal and then kind of providing guidance about where we're headed with APMs and this issue of equity.

The second is to think about ways to incorporate equity in how we understand APMs. I

showed you a few slides ago some of the work that we've done. I know other work other groups are doing. We're trying to do similar work.

But if I was to step back and say if I pull up the evaluations of different APMs historically, I know from just those evaluations what happens to, perhaps, quality or spending or, in some cases, satisfaction or experience, but it's not clear to me what happened with equity.

And so, I think, you know, we provided a few examples on that right column, but, you know, really working in this idea of evaluating for equity, I think, is a real important one.

And it highlights a bigger question in my mind about APMs and, you know, I think it's incredibly important to try to get the biggest impact we can, the biggest proverbial bang for our buck in terms of seeing impacts on quality and spending experience, but I think all of this really underscores, to me, this idea of getting the most even bang for our buck that any improvements that we see would ideally be equal and even across different patient groups and not that we see a great average overall effect, but it's coming from certain groups and communities

and not others, right, and so that really -- the second point speaks to that.

And the third is that, you know, around convening multistakeholder groups of individuals and organizations you see there to achieve these goals, it's easy to say, it's hard to do.

I think we'll have some examples from our conversation today and a few have been alluded to before, you know. No payment changes happen in a vacuum, and we have existing systems.

So, thinking about how we take those elements that are useful that exist today and use them, I think, is really important.

That said, I think doing the same old thing is also not the best approach. And so, what are the new things we need to incorporate, also important consideration.

And no group's going to do that alone, so I really think it's critical to relay advancing health equity and how we pay for services.

Next slide, please. So, one of the last things I want to kind of mention here is just an initiative that colleagues and I are

fortunate to be kind of creating as we speak, actually now which we're calling Health Equity and Payment.

It's a new initiative to use payment to promote equity rather than perpetuate inequity, much of what I have presented on and much of what today's overall meeting is about.

The goals are as you see listed there and perhaps not surprising to you because colleagues and I have written about this space. It echoes a lot of what you heard on the last slide.

They're really saying, let's identify policy goals for different populations and what are the things we need to do to actually change measurement and evaluation.

And this last part is really important to me, which is that I think, you know, implementing and evaluating programs and being able to create programs and implement them and then study them is going to be the next thing ahead of us.

And so, you know, we are hopeful that this will pick up momentum in the coming months and the years, and I would love engagement from

anybody here on the Committee in the audience, but really this is a centerpiece of what I personally will be doing, I think, going forward. I'm excited about that and happy to share a little bit today.

So, next slide. So, I would be remiss if I didn't thank -- this is probably a partial list, but in terms of the study that you saw today, a list of individuals that have collaborated and made this work possible, and I'm hopeful this list will grow as we continue to work in the space as we do work outside of bundled payments and really think about how communities and health care organizations work together on that, but I'm indebted to this group of individuals for really potentiating and guiding the work.

Next slide. So, I will wrap up here by coming back to the takeaways, and hopefully I've provided some information and some insights to kind of underscore these, but that unfortunately some APMs, in particular, the bundled payment programs that I have studied, have excluded historically marginalized communities with respect to geographic

participation.

Second, despite encouraging early evidence such as the type that my colleagues and I are generating, to my knowledge there's an overall dearth of data about how APMs impact disparities. Again, the gaps, the differences in how individuals from these historically marginalized populations are impacted in these programs.

And, you know, mentioned it a few times now, but I think a few high-level changes could really help us advance equity using APMs going forward, including setting a national policy intention to do so and then kind of signposting goals to get there; incorporating equity in how we evaluate and understand the impact of APMs; and then really being thoughtful about convening multistakeholder groups to guide that agenda setting and that work.

And so, next slide, I will -- next slide, please. I will pause there. I appreciate everybody for giving me the chance to share here, and I'd be happy to answer any questions.

CHAIR BAILET: Thanks, Josh. I want to open it up to Committee members. Raise your

hand if you have any questions for Josh.

(Pause.)

CHAIR BAILET: Jennifer.

DR. WILER: Josh, thanks for an exceptional presentation. My question -- I love your comment about intention precedes implementation, so that's what my question will be regarding.

Can you talk a little bit more about the role risk adjustment plays and, as you described with the CJR bundle, how we may be able to eliminate this pilot selection bias, and are there any best practices regarding risk adjustment that are feasible, because some of these risk adjustment methodologies are quite complicated to implement. Thank you.

DR. LIAO: Yeah. Thanks for those questions. Let me take them out of order a little bit, but I think, you know, what we learn from, for example, the work studying CJR and also comparing CJR to that BPCI program, is that we do observe potentially some selection there; but the other thing is that, I think, mandating participation focused on certain dimensions.

So, historical volume spending is

important, but if we don't directly consider other dimensions, then those programs may not yield those generalizable results.

So, I don't know that there's a best practice around that, but I do -- but to your question about how might we address that selection element, I do think one thing is at the beginning when we're designing programs and thinking about how to create programs voluntary, mandatory, or otherwise, what are those things we want to use in our selection criteria?

I think that could help, and it's something that I'm looking forward to seeing possible in the future.

You mentioned a challenging topic in risk adjustments and certainly I'm not the only one thinking about it. Many others have and there are also, I think, multiple ways of doing it, but I think I would just say two things to that.

The first is I think there's one -- there's one issue of adjusting quality measures, and there's one issue of adjusting payments.

And I think others have written thoughtfully about how we might adjust payments,

whether on the front end or the back end, to not just actually make sure we're not adversely impacting patients, but also the clinicians, right, and organizations taking care of them, so-called, quote, Safety-Net or other clinics, practices, hospitals.

So, I don't think it's a resolved issue. I think work needs to be done there. I think there are two or three candidate solutions others have identified. I personally think that would be a great thing to explore in future models.

CHAIR BAILET: Other questions for Josh?

(Pause.)

MR. STEINWALD: Yeah, I have one. It's Bruce. I did raise my hand, I think.

Josh, what do you think needs to happen on the reimbursement front to really advance social determinants of health and equity?

If we continue to rely to a large extent on a fee-for-service platform, are there limits to what can be accomplished, or how do you see that unfolding and coordinating reimbursement with the objectives that you've outlined?

DR. LIAO: Thanks, Bruce. I think there are -- I mean, in short, I think there need to be changes to that. I think people have mentioned different ways.

One would be prospective payment, which kind of changes, like, the timeline on how people get paid.

I think the other is care management fees, which may not be as relevant, perhaps, to the models we just described, but as you think about the overall universe of APMs, right, how did this specialty care which represents, has quality implications, cost implications, how does that connect to primary care? How do we think about that in the global sense of population-based models?

I do think we need to see changes there from where we are right now. I think the tough work ahead is how do we do that.

And the reason I say that is because in the models that we've studied, they are triggered by hospitalization, so they focus on a specific phase of care.

The population-based models are more broad, but if you talk to a lot of organizations

doing this work, a lot of them are focused on primary care, and the thing that I think is less clear to me is how that connects to the specialty care, end-of-life surgical subspecialty that we need.

So, I think in those ways things like coordination fees, things like prospective payments or some hybrid, I think, are really relevant to even the models I'm describing.

CHAIR BAILET: Kavita?

DR. PATEL: Josh, this is excellent. Just in thinking about kind of that earlier slide where you laid out, you know, the different forms of social determinants of health and payment and you -- I think Medicare Advantage has gotten, I would say, a lot savvier in a shorter amount of time because of freedom from what they're allowed to do.

Have you -- you may not have formally, or maybe you have, looked at, you know, do you see, like, shifts to Medicare Advantage, any sort of way to kind of think through a hypothesis that, like, if you're in an area where you're

seeing a larger penetration of MA[12] plans that somehow things are better?

And I -- that's fully loaded, I realize, but do you see any signals of that type of trend, or is it too early to tell something that others are interested in?

DR. LIAO: Yeah. Thanks, Kavita. Can I just clarify when you say "better," do you mean for how the fee-for-service APMs work, or do you mean overall?

DR. PATEL: Both. I mean, I'm just curious -- just my experience has been that once there's a certain percentage, like kind of a population in MA and so they've got incredible -- some of the plans have just used incredible kind of programs around, you know, many of the things that you mentioned.

And so, we can sometimes see a spillover effect just because, you know, these practices in communities.

So, I'm curious about that, but then also curious, like, is there kind of something to be said for should we have some of that apply?

And you allude to that, you know, in

12 Medicare Advantage

the fee-for-service market as well, that things that can facilitate that third option and social determinants of health, I'll call it, enablement services or some of the things that MA plans do.

DR. LIAO: Yeah, absolutely. So, a couple pieces here. The first is that we've begun not an MA space necessarily directly, but we've actually studied spillovers, so what happens in participation in the Medicare fee-for-service program.

The study I'll mention now is actually in the BPCI program where there's a spillover to MA patients and to actually other commercially insured patients.

And the short answer is it does, actually, and it's pretty sizeable, the spillover effect.

And so, I think it highlights what people have known for a while, but this issue of, you know, in some studies maybe a multi-payer approach, making sure that we do that because I think organizations, as many, if not all of us know, don't redesign care just for a certain segment only, and it never touches others. They often do it around service lines, around whole

units, et cetera.

So, yes, we see spillovers. I think it underscores the need to think about fee-for-service alongside MA and other populations.

The second thing I've been thinking a lot about, and maybe this is the basis for any future hypothesis, but would be kind of the ways in which we could still better engage beneficiaries in this.

One of the things that comes up in my work is, you know, degree to which people know and then choose to participate in these programs based on APMs.

And I think there, as you alluded to, I think MA has done -- some MA programs have done great work in that area.

So, I think provider, but also beneficiary engagement, is a critical piece of APMs going forward.

CHAIR BAILET: That's great, Josh. I have a question, you know, you're definitely talking about the impact of models on populations.

My question, did you study or did you see a difference in practice type, right,

university versus, you know, private practice, rural versus urban, especially in the backdrop of seeing mandated models coming down the road. Did you happen to look at that?

DR. LIAO: So, I'll answer in two ways. Thanks, Jeff, for that question. We, in published work, haven't looked directly at that, but in the CJR context, others have looked at that and have found that -- we have one study looking early on about who received savings, for example, in CJR, and we found that safety net hospitals are less likely to receive them, and I think others were -- kind of corroborated that. So, I think this issue of kind of practice type is critical.

We're actually undergoing work right now, which are not in my slides, but around BPCI, the voluntary program, in looking at safety in hospitals, and we're seeing actually that in some measures there are no differential effects and some there are, I think, again, speaking to the complexity of this.

And as we consider mandatory models in the future, I think this issue of provider type is going to be really important.

I want to highlight one other thing, which is that when we think about in practices and the, quote, analog to safety in hospitals, one of the things that I'm encountering personally is how we think about those practices.

And, for example, should we define practices as being Safety-Net based on the proportion of certain populations they take care of, should it be the practices that account for the majority of their care even if the practice-level kind of proportion is low?

And I'll just say that what we're seeing in some of our data is that it's actually not -- there's variation there, right?

So, how we consider practices in Safety-Net or serving a key need in SDOH is -- there are multiple ways to do it, and I think that's the policy challenge ahead of us because we may very well see similar dynamics there.

CHAIR BAILET: Well, I also think, and we're going to probably get into it as the conversation progresses this afternoon, you know, to hoist all of these requirements to ensure that determinants -- social determinants are delivered to the appropriate patients, it's untenable to

put all this on the backs of the practitioner specifically.

And so, how do we get the services, how do we identify them, how do we not only refer, but also ensure that that referral is carried out and that the services are delivered and the outcomes are driven forward?

I think that that's also a huge challenge and, again, you're looking at the end point, you know, did they get a bonus or did they not, but there's a lot of waterfront in between.

So, looking forward to that discussion and, again, Josh, great, great research that you're doing, you and your team. Super, super discussion and presentation and appreciate having you on the Committee and also your work presenting today. So, thank you very much.

DR. LIAO: Thanks for giving me the chance. Appreciate it.

CHAIR BAILET: So, now I'm very excited to move into the next listening session, and our presenters include previous submitters -- well, a previous submitter and other subject matter experts.

At this time, I'll ask our presenters

to go ahead and turn on their videos. Jay and the PCDT helped us level set with definitions and other helpful background materials on SDOH and equity, including how previous proposals submitted to PTAC included relevant elements.

Just some rules of the road here. Each presenter will give a 10- to 12-minute presentation, and then our Committee members will have roughly five minutes to ask each presenter questions. And you can find their full biographies on the ASPE PTAC website, along with other background materials.

And before -- maybe before we launch since we need a break, I think what we'll do is this is a great place to break for 15 minutes. And then what we'll do is we'll come back in 15 minutes, and then we'll hear from the previous submitter and our subject matter experts.

So, we're going to go ahead and take a 15-minute break. Appreciate your understanding. Thank you.

(Whereupon, the above-entitled matter went off the record at 10:59 a.m. and resumed at 11:15 a.m.)

*** Previous Submitter and Subject Matter Expert (SME) Listening Session on Payment and Data Issues Related to SDOH and Equity**

CHAIR BAILET: Great. Hope everyone enjoyed the break. As I was saying before the break, each presenter will have 10 to 12 minutes for the presentation, and the Committee members will have roughly five minutes to ask the presenter questions.

Their biographies, as I said, are on the ASPE PTAC website, along with other background materials.

So, presenting first we have our previous submitter representatives representing the CAPABLE provider-focused payment model.

We have Dr. Sarah Szanton, from Johns Hopkins School of Nursing, and Dr. Kendell Cannon, from the Stanford Clinical Excellence Research Center.

Sarah and Kendell, please go ahead.

DR. SZANTON: Thank you so much, and thanks for having us this morning. We've been asked to talk about the ways in which CAPABLE reduces disability, improves social determinants

of health, and saves cost.

Next slide. So, just a quick start with a CAPABLE participant who was 75 years old who had had a stroke and had diabetes. And before his stroke, he loved to bicycle, and that's how he stayed in shape and was told he couldn't bicycle anymore.

He also had a lot of difficulty bathing, and so didn't bathe except for just a little bit at the sink. He was a dually-eligible gentleman.

Next slide. And I could talk for an hour about him, but shortly we -- CAPABLE has a nurse, an occupational therapist, a handyworker, and the older adult, and the handyworker made a -- his bicycle into a stationary bicycle for him so that he can bike for an hour a day just in his house, and put up banisters, as you can see here, and situated the bathroom so that he could take a bath.

So, these several things, being able to get up and down his steps, being able to take a bath and being able to bike, puts this kind of a smile on his face and, of course, was good for his diabetes and not getting another stroke.

Next slide, please. So, CAPABLE, as mentioned, is a nurse, an occupational therapist, a handyworker, and the participant. And the innovation in terms of why we're here today is that it addresses social determinants of health that matter to the person.

So, what both the nurse and the occupational therapist do is assess the older adult and that person's environment around what would they like to be able to do. So, it's not primary care, it's kind of foundational to primary care.

And what they would like to be able to do is often circumscribed by social determinants of health like being food insecure or not being able to take a bath or not having, you know, having the boiler break or other things that matter for being able to have a meaningful life that keeps them out of the nursing home and the hospital.

Next slide, please. And so, CAPABLE is home-based. So, you see all of the challenges someone is up against, and it's convenient for the older adult.

It's built around their own goals and

building their self-efficacy. And that is, you know, decades of research about self-efficacy and how to improve it and how important that is for future challenges.

It's an integrated team and then, importantly, it generates data that advanced payment models can use to address social determinants of health and health equity.

Next slide, please. Sorry, the font is light on this, but the idea -- and I know you'll have the slides -- is that CAPABLE is really different in several ways, different compared to your typical disease management intervention.

So, it's not about a particular disease or risk factor like falls or congestive heart failure; it's designed to maximize independence around what the older adults care about, whatever it is to them -- if it's getting to their mailbox, if it's being able to get out their back stoop, if it's being able to bathe or get up and down their stairs -- and we've shown, with 10 years of evidence, it decreases hospitalization and nursing home admission.

Rather than being provider-driven,

rather than you should do this or you should not do this, it's completely around what matters to the client.

So, in the case example I gave, you -- you know, none of us, if we saw him in a clinic room or a hospital would say, oh, I bet you'd like to bicycle more, and let's brainstorm ways to do that. He said this is what matters to him, and we figured out how to make that happen.

And rather than being focused on narrow risk factors like just home safety, for example, it's focused on the fit between the person and the environment, and that's what's essential.

And the environment isn't just are there holes in the floor or are the cabinets too high to reach, it's also the social environment and the financial environment, and these are all layers of the social determinants of health.

And for most, kind of, disease management or risk management for patients, the benefit goes away once the program goes away, but CAPABLE is self-sustaining because of that building of self-efficacy, teaching someone how to brainstorm a new problem.

They often call us after the program is over with, oh, I had a new problem, and here's how I brainstormed about it.

And of course the changes to the home are sustainable as well because they are, you know, part of the walls and the floors.

Next slide, please. CMS evaluators show that CAPABLE reduces per-member/per-month cost by $918 over a two-year period, and it only costs $3,000.

So, it saves about seven times what it costs on average, and this is because disability is underassessed, but a big driver of cost of hospitalization and nursing home admission.

Next slide, please. So, modifiable disability, as I just said, it's highly predictive of the next year or two's cost. So, you're not catching people who are already high-cost spenders, you're catching kind of the rising risk, people who will reliably be costly.

They're identifiable with the right data such as asking people about if they have difficulty with bathing or dressing. It's underutilized questions that really pack a lot of punch in terms of being able to assess

addressable disability, and we've shown that it's treatable.

On average, people reduce their disability, cut it in half, and this has not just been in our research. This has been in multiple other sites in rural and in metropolitan areas.

There was recently a new paper published, a showing of all the studies of CAPABLE, the same findings that we have had, and CAPABLE is now in 45 places in 23 states, including in some advanced payment models.

Next slide, please. And so, you asked for suggestions about data and APMs and health equity, and I would just like to answer that the number of older adults with disabilities living at home is growing.

We've seen, through COVID, how important it is to be able to stay out of institutions for older adults and their families, and we know how to identify people, when to intervene and help payers get ahead of the curve on physical function.

Next slide, please. And just a little plug for physical function is mostly ignored, and it's the ultimate health equity indicator.

If you think about it, people, you know, whether at 80 someone is Speaker of the House or dead or has multiple chronic conditions, some of it has to do with genes, but a lot of it has to do with the life that they have been able to experience during those 80 years.

Were they food insecure? Did they get the education that they needed? What kind of jobs did they have? And we have a chance, as a nation, to address decreased physical function due to health inequities.

And just as one stark example, a 70-year-old who's food insecure, meaning that they don't have enough money for food or they have skipped a meal in the last month, has the physical function of an 84-year-old. So, there's a 14-year difference in if you're food insecure and your stability.

And with programs like CAPABLE, we can decrease the disability, and we can also treat their food insecurity. Only 50 percent of older adults who are eligible for SNAP, which is food stamps, are on it, and it's very simple to sign them up.

So, this kind of standardized

tailoring of assessing what matters to people and then not just referring them to programs the way some social determinants programs do, but actually enacting them with them and helping them, you know, to understand how to move forward with other problems is a really important way of addressing health equity.

I think that's our last slide and -- do you want to just click to the next one so we can see?

Yeah, so we've got some supplemental ones for questions and answers, but we'd be really honored to answer any questions that people have.

CHAIR BAILET: Great. Thank you for that presentation.

Committee members, questions?

DR. FELDSTEIN: Jeff?

CHAIR BAILET: Yes.

DR. FELDSTEIN: I have a question.

CHAIR BAILET: Sure, Jay.

DR. FELDSTEIN: So, what's the workflow for how people get into the program? Is it, you know, you do a data screen? Claims base? I'm just really curious as to the operational

workflow how people get into the program.

DR. SZANTON: Sure. So, claims are -- will underdocument physical function loss. It's often not assessed partly because it's not necessarily billable for. So, claims is one way, but you'll miss a lot of people that way.

So, the annual wellness visit has questions about functional disability like ADL, activities of daily living, instrumental activities of daily living.

So, asking someone is actually the simplest way and, you know, to get everyone that has an annual wellness visit to -- you can, you know, send them towards CAPABLE, but ideally, you know, one of my last slides was about the ways that the National Quality Forum and CMS are moving forward trying to put physical function as something that needs to be assessed, and ideally that would be in claims ultimately, but it's not currently.

CHAIR BAILET: Sarah, I have a question about, you know, a lot of the information you get to directionally focus your efforts is direct questions, surveys, that kind of instrument.

I'm wondering if you've had or have experience, or planning to get experience, with predictive analytic engines that can use a whole, you know, a variety, I guess, of data types and give you some better insights into which populations you want to proactively reach out to.

DR. SZANTON: Right. So, that's a great question, and some of the bigger partners that we're working with will be doing that.

So, I'm just a pointy-headed researcher at Johns Hopkins and the, you know, we're working with VillageMD, which, you know, is opening up two health clinics a week with Walgreens currently, and they've integrated CAPABLE into their home-based primary care.

They are exceptionally wonderful with this kind of predictive algorithm, so we're going to be learning a lot from them.

Some of the bigger and more regional MA plans are just starting to do CAPABLE, and so I think that will be the next phase what you're talking about, both in terms of predicting who would benefit, and maybe there should be some tiers of, like, full CAPABLE, which is 10 visits, or sort of a kind of CAPABLE light for people who

might need a little less.

CHAIR BAILET: Great. Thank you.

Angelo?

DR. SINOPOLI: Well, you asked the question I was going to ask, so I have another one. And I can't remember from the first time you presented to PTAC, the nurse that's involved in the program other than doing the CAPABLE functions, does she also do an assessment and work with other care managers or bring community-based organizations to the table to help with other identifiable issues?

DR. SZANTON: Yes. So, thank you for that great question. It's all very -- so, the assessment that the nurse does is about the person's pain, mood, strength and balance, connection with their primary care provider, do they have one, and medications and falls, but based on what the person is interested in.

So, they may say, I don't really know what my medications are, but my daughter fills up my pill box, and I don't want to work on that, but I do want to work on pain, or I do want to work on depression.

But in the course of working on those,

the nurse, she or he will often identify some of these other issues that they then refer back to kind of the care management of the primary care practice.

And we now at Johns Hopkins, since CAPABLE started at Johns Hopkins, Johns Hopkins' physicians using our all-payer hospital model, the hospital pays for CAPABLE out in the community to try to improve the health of the community and decrease preventable hospitalizations.

And we hear routinely from primary care teams, physicians, and nurse practitioners, how valuable it is for them to get that information back, that looping back from the visit in the home assessing those needs.

DR. CANNON: That's one of the things I find most interesting in terms of the CAPABLE model is twofold.

One, that the nurse is not just a typical skilled nurse that goes out and does, you know, medication management or refers to X, Y, Z, it is this incredible kind of assessing what is important to that person.

And by doing that, you end up with a

much different focus, and then the data that comes back to the clinicians is extremely valuable in terms of what can I do as a primary care clinician or as an internist to help improve their overall outcomes.

DR. SINOPOLI: Thank you for that.

CHAIR BAILET: Great. Any other questions?

DR. LIAO: This is Josh. I had a question. Thank you for that presentation. I really appreciated kind of how the self-management activation related to individuals engaging in these parts of their care, and I'm wondering -- you also presented a slide about the kind of cost reduction.

Where did you -- to the extent we know this, where have people found the cost savings? Is it related to, I think you mentioned, avoidable hospitalizations elsewhere? Is it multiple places? I'd be fascinated to learn more about that.

DR. SZANTON: Yeah. Absolutely. So, what we found, and this has been duplicated, is that the nursing home -- the reduction in nursing home admission is enough to break even for the

program, but it's the hospitalizations. Because in a typical year, an older adult is much more likely to be hospitalized than be in a nursing home; there's a lot more room to save there. It's also in specialty care savings.

The only place where the cost went up slightly was in home health care, and we think that's probably appropriate utilizations and probably home PT[13] and maybe some home OT[14].

Even though there's OT in the model, the OT is much more about this problem. It's not like so-called skilled OT.

So, we think that that's probably useful, you know, changing in resources, but it's mostly the hospitalizations and nursing home admissions.

DR. LIAO: Great. Thank you.

DR. SZANTON: Um-hmm.

MR. STEINWALD: I have a question, if I may. How commonplace is it, in your experience, that provider-based organizations support a program that results in less usage of their facilities?

DR. SZANTON: And when you say

13 Physical therapy
14 Occupational therapy

"provider groups," do you mean -- are you talking about, like, a hospital or --

MR. STEINWALD: Most likely a hospital, but it could be an organization that includes both hospital and nursing.

DR. SZANTON: I see. Right. And so, sometimes, you know, when I talk to a hospital, they'll say, unless you can help me shut down a whole unit, you're not really saving me money if you keep your bladder here because we still have the same staff and the same overhead and all.

So, it's really more a savings for Medicare than for the hospital usually except for if a, you know, if a hospital is on the brink of needing to build a new one, they do a lot to try to keep utilization down. So, I think it really varies.

CHAIR BAILET: All right. Sarah and Kendell, thank you so much for initially submitting your proposal for consideration and also coming back and presenting and speaking with us today. Really appreciate that.

DR. SZANTON: Thank you.

CHAIR BAILET: You bet.

DR. SZANTON: We're really hopeful

that we think this really fits in with what CMS is trying to do in terms of health equity and, you know, preventing disability and hopeful that it will spread more.

CHAIR BAILET: So do we.

DR. SZANTON: Um-hmm. Thank you.

CHAIR BAILET: So, now we have Dr. Jacob Reider who joins us from Huddle Health and the Healthy Alliance IPA[15].

Dr. Reider, please go ahead.

DR. REIDER: Thank you. I'm going to go off script a little bit and offer some context especially in the context of what we just heard and even carrying forward from a question that Bruce just asked, because I think it hits to the core of what our organization did and perhaps will continue to do.

So, when I speak of our organization, the core organization that I'm going to describe here is an organization called Healthy Alliance IPA, which is a daughter of Alliance for Better Health.

Alliance for Better Health is an organization that was created in 2015 as a

15 Independent Practice Association

product of the 1115 waiver that was granted to New York in 2014.

So, that was the so-called DSRIP Program, Delivery System Reform Incentive Payment Program, and that waiver was 2015 through 2020.

Alliance for Better Health and Healthy Alliance IPA persists even though that program is gone, and I think that, of course, is -- it is and/or was the intent was to initiate programs and then carry them forward at the end of the program.

So, for those who aren't familiar, that program was aimed at reducing preventable Medicaid utilization by 25 percent over the course of the program statewide, you know.

Our region, and I have a slide about our region, but in advance telegraphing my past, it's the capital region of New York, which is Albany and six counties around the city of Albany in the capital region of New York.

And so, I took over the organization after it was about two years into the five-year project, and much of what I'm going to describe is the evolution from its first two years, which, perhaps, through no fault of the leadership, were

following a model that looked to primary care to solve social problems and to look to primary care to reduce preventable Medicaid utilization.

Primarily, acute care facility utilization because of course that's where most of the cost is.

And so, I'm going to use my props now. So, I'm a family doctor and, in fact, the majority of the first two years of focus was, hey, let's get the primary care clinicians engaged, let's get the hospitals and emergency departments engaged and, to Bruce's point, let's cause them to participate in reducing their volume of work.

And the challenge here is that most of that work was, and today remains, fee-for-service work.

So, we're asking organizations to reduce their revenue for X amount of dollars in exchange for losing, you know, X times three amount of dollars. So, the economics, candidly, did not work.

They would, you know, when the CFOs got involved, they did the math and, again, you know, without throwing anybody under the bus, we

found that the care delivery organizations could not be sufficiently motivated to reduce their fee-for-service volume.

So, what we did is we took off the stethoscope -- my daughter is a social worker -- and I started to listen to the people around me and engage the community in working hard to address the needs of the community that were upstream.

And so, now we'll fly through the slide deck. Next slide. So, what's the secret to a healthy community?

Next slide. Well, obviously it's kombucha -- next slide -- or perhaps it's not. Is it a hospital? And what we learned is, sure, hospitals are important for managing illness, but, in causing health, hospitals are actually not all that useful.

Next slide. Is it these folks who you'll obviously recognize as physicians and nurses? And, again, in general, we, this group, are trained to be reactive. We are, in general, not trained to be proactive and think proactively about maintaining health. We are trained to respond to disease and treat illness.

Next slide. And so, our people, products, and processes, as they say, the three Ps, are all focused.

When you look at the workflow of a traditional primary care provider or a traditional hospital, that's what you'll see.

You'll see reactive and responsive -- and, again, this is not anybody's fault, you know. As they say, some of my best friends are doctors.

So, what we're going to talk about briefly today is that achieving better health is our shared commitment to the communities we serve.

Physicians are not the answer, right? We are part of managing the challenges that we face.

Hospitals are not the answer. Change is hard, and information technology is important. So, we'll go to the next slide, and I'll sort of power through most of these things.

So, we view health care as, first, just as the HHS style guide defines. It's two words, not one.

And we actually changed the name of

our organization from Alliance for Better Healthcare, one word, to Alliance for Better Health, for very obvious reasons to me, but perhaps those reasons were not obvious to those who initially named the organization, because we do not see "health" and "care" as synonyms, right?

We see them as very separate things, and if we focus on health, we think we've got things prioritized properly.

If we focus on care, then it's about us and our, you know, continuing to feel useful in the universe.

I'd love to put myself out of business. And if we can achieve that and accomplish health, then great work.

So, we view -- and this is obviously not a slide that most have never seen -- social health, behavioral health, and physical health, and they are in this order intentionally, right?

So, if we can achieve social health, then most likely behavioral health will be built or maintained. And, of course, with those two, physical health is much easier to build and maintain.

Next slide. So, we sometimes talk about upstream and downstream, and I want to be explicit about what we mean.

We mean upstream, the social challenges are things that are upstream. And when people fall down the cascade and when their social challenges are not addressed, then it's very predictable that behavioral health challenges are going to occur and, perhaps, as a byproduct, physical challenges.

Now, this is not to say that people don't have physical challenges that are unrelated to these other issues, but it's very common that these other issues are, in fact, causal factors in physical challenges.

Next slide. So, I'm going to talk some about how we did what we did and, in fact, are still doing what we are doing.

Next slide. So, this is the laundry list, and you're not intended to take notes and read it all, but you can see that these are many of the issues that were presented to us as essentially a menu, like, what are we going to do?

And, as the saying goes, if you chase

two rabbits, you will catch none. And so, what we needed to do was focus.

Next slide. I'm a doctor, not a social worker -- next slide -- but we needed to learn some of those skills, as my eye-rolling daughter would remind me.

And so, working with social workers, working with public health researchers, working with community-based organizations after extensive work in needs analysis and deciding, you know, essentially what was best in our wheelhouse, these are the domains that we selected to initially fund and initially participate in.

So, food, housing, transportation and a CRPA[16] program, and I will describe each of them briefly.

In the food program, we partnered with Food Pantry Network, and we assisted them in participating in a closed-loop referral platform which we implemented throughout the community where we asked food providers to provide us with data on screening for other social determinants of health to the individuals that they were

serving, and then to assist us in identifying which were the needs that folks that they were serving wanted to also get assistance with.

With the -- and in so doing by screening for other problems, we addressed those other problems and then were more proactive in connecting people to services that they otherwise would not have been connected to.

We also did some food-as-medicine initiatives that probably time won't permit me to go into detail too much.

With housing and respite, we funded the creation of, and now maintenance of, a facility that partnered with regional hospitals and placed homeless individuals into the respite.

These were individuals who were not sick enough to be in the hospital, but not healthy enough to be homeless again.

And we found that this did an incredible job at preventing readmissions within 30, 60, and 90 days by getting these folks into sort of a middle ground position, and then they were actually placed into long-term housing when they more fully recovered.

16 Certified Recovery Peer Advocate

It's staffed with one nurse full-time, 16 beds, a fairly low-cost facility that had extraordinary ROI[17] both for the hospitals in preventing 30-day readmits, but also for the community as a whole.

With transportation, we provided transportation to individuals for nonmedical activities such as going to the pharmacy, going to the supermarket, going to the library to do job searches and so on, and we're reasonably sure that that also had ROI.

And in the CRPA program, we funded certification of certified recovery peer advocates who could assist people with substance use disorder -- primarily people who were having challenges with opiate addiction -- and, again, found significant reductions in preventable emergency department utilization.

Next slide. So, this is our region. I promised a slide with who we are, and so there you have it.

Next slide. And so, this is a brief summary of the closed-loop referral project. What we did was we empowered the community and

17 Return on investment

implemented a program that now over a hundred organizations, both medical community-based organizations, some faith-based organizations, are using.

And so, everybody has a common screening tool. Everybody has an ability to both identify and act on the results of that screening.

And I think it's the "acting upon" that's important, and we'll see a little bit later some of our thinking around how it is that we need to act on the work that we do.

But it's, you know, we've seen the studies that lament the paucity of screening for social determinants of health especially in medical facilities, and our observation was that, well, if you can't do anything about it, don't screen for it, right?

This is why we don't, you know, we teach medical students not to screen for brain cancer because the cost-benefit ratio isn't all that good.

And so, medical providers especially haven't had the ability to act on the results that they achieve when they provide social

determinant health screenings, so we think that this kind of resource is imperative to have before one implements a screening program.

Because if we screen and we can't do anything with those results, then our passion for that screening will be rather rapidly reduced.

Next slide. And so, what we did after implementing all of this -- next slide -- was to watch. And so, we watched very carefully.

In fact, we watched the screening initiatives, and then we watched the sort of bouncing ball of the referral as it passed through the community.

We actually have four individuals who are monitoring at all times. Every referral from any provider in the community to any other provider in the community, either social to social, social to behavioral health, behavioral health to medical and, you know, all of the above, and so we watch what happens when referrals are completed and/or not completed.

What's fascinating to me is that we started in many communities -- and we're actually working in other communities in both northern New York and now assisting providers in central New

York -- when we started initiatives, when we started ours, our, quote, success rate was somewhere on the order of 40 percent, and that's very similar to these other two communities that we've both been working with.

An A+ is actually more like 75 percent, so that means still 25 percent of referrals, for whatever reason, are not satisfied.

Now, sometimes that means that -- sometimes that means that we don't need to satisfy the referral because the needs have been met in some other way.

Next slide. So, the big question here is, do social interventions work?

Next slide. The way to do that is to look at the data.

Next slide. So, in order to do that, we acquire information. You've heard me describe that. We aggregate it into a data warehouse. We analyze it using nerds and some tools, and then we act on that data, and the actions actually cause another wave of acquisition, et cetera, et cetera.

Some of the data that we're looking at

is the acute care utilization. So, as we see that fall, we actually can adjust our -- fall or not fall, we can adjust our actions in so doing.

Next slide. So, what we've observed is that when initiatives occur in silos -- this is my attempt to portray that. So, that's a hospital and/or a health plan.

When a health plan tries to do something all by itself, we find that things don't work at all.

So, a community-based organization might be velcroed to a health plan, and then they need to either provide easy pass service to their members or not serve other members.

So, depending on your insurance card, and we've seen this, you may either get food or housing, but not both. We don't think that works at all. We've seen similar initiatives with hospitals.

So, next slide. And so, we view the way that this works as a set of social needs.

Next slide. I'm going to power through it to get -- we need to identify them, we need to understand them, and then we need to act on them.

Next slide. Our goal, of course, is to create the IPA that spans the community that's a horizontal resource -- next slide -- that addresses all of these things, right, social, behavioral, primary, specialty, acute, and medications.

Notice that the stuff at the bottom is explicitly at the bottom, and we want to focus first on the stuff that's at the top.

Next slide. And so, we view what we're doing as a public utility model. I have never seen a health plan lay claim to a fire station or a streetlight, nor have I seen a health system lay claim to a sidewalk.

And so, we view what we are doing as something that should be agnostic to where the funding comes from so that everybody can benefit.

Next slide. And so, we see this as roads or -- next slide -- telephone poles or -- and -- next slide -- in so doing we want to make the right thing to do -- next slide -- the easy thing to do -- last slide -- and that, we think, is the secret to a healthy community.

I will end there and take questions if there are any.

CHAIR BAILET: Great. Thank you, Dr. Reider, for that excellent presentation.

Do we have questions from the Committee?

MR. STEINWALD: I have one. This is Bruce. Before -- I do appreciate your data and IPA images. They didn't go unnoticed, at least not by me.

So, now, back to the hospital CFOs. Is there pushback from the provider organizations as you achieve a certain level of success in the communities?

DR. REIDER: No pushback. I would say the most significant response has been acquiescence, right?

They're interested in what we're doing, you know. These -- remember that physicians, in general, are benevolent human beings who want -- right, who want what's best for people, so they are not pushing back.

They are allowing this to go forward and, in some cases, embracing it where they see ROI for them.

So, the respite is an example where they're reducing 30-day readmits. And because of

the penalties from CMS, this is a good thing for them.

So, where there's aligned business incentive, this is a good thing. Where there's not aligned business incentive, it's been, I would say, an uphill activity to get them truly engaged.

Now, having said this, three of the five parent organizations of our entity are hospital systems, so, you know, they have supported this, and it's the individuals sitting on our board who, in their benevolence and in their fiduciary duty to help our organization succeed, have literally taken off their home team hats and have made decisions that align with what's best for the community rather than what's best for their financial perseverance.

CHAIR BAILET: Thank you.

Angelo.

DR. SINOPOLI: Yeah. Could you speak a little more about the actual screening tool itself?

Are you using a standard screening tool, or is it modified or come up with your own tool and talk about that a little bit?

DR. REIDER: No modification at all. The community agreed to use the PRAPARE[18] tool -- oh, no. Wait, I lied. It changed a few years ago. It's the Health Leads tool.

So, the Health Leads tool is what the community decided. We were agnostic and presented them with a series of options. And then we instantiated the questions in the Health Leads tool in our closed-loop referral platform.

DR. SINOPOLI: Thank you.

CHAIR BAILET: Any other questions before we wrap up and move on?

(Pause.)

CHAIR BAILET: Great. Dr. Reider, again, thank you for your time today. Really appreciated your presentation.

DR. REIDER: Thank you.

CHAIR BAILET: We're going to go ahead. Our next presenter is Dr. Robert Phillips from the Center for Professionalism and Value in Health Care and the American Board of Family Medicine Foundation.

Dr. Phillips.

DR. PHILLIPS: Thank you, Dr. Bailet.

18 Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

So, I want to talk about social risk and equity and how we use data to help funnel funding to the right places so that Dr. Reider's conundrum of not having resources as a problem up front for doing screening isn't there.

And this is based on a Health Affairs blog that we produced in June that came out of a workshop with federal stakeholders, and other stakeholders in January, and will be part of an ongoing effort with those federal stakeholders to get to a policy.

All of this is responsive to the 2014 IMPACT Act which directed HHS to answer the question whether and how we should adjust payments for social risk.

Next slide, please. So, right now, as Dr. Reider alluded to, we're not doing a very good job of capturing social determinants of health at the point of care in clinical care.

So, right now, it's less than four percent of Z-codes are being captured. Medicare Advantage programs -- or Medicaid Advantage programs are capturing, at best, at least in 38 states where it's a requirement, but only one of them has adjusted payments based on that, and, as

Dr. Reider said, practices are really not equipped or funded to manage social need.

So, we feel that we really need to lower the burden of screening, we need to put resources adequately to meet needs where they are most needed, and we need to reduce the capacity for gaming.

Next slide, please. So, the United Kingdom and New Zealand have figured this out on a big data scale. They measure social risk for all down to very small geographies, and they measure -- then they measure social need for each.

So, it's assessing risk, assigning payment, and then getting down to the individual patient needs or community needs and using those allocated funds to meet those needs.

Next slide, please. In the UK, it's the English Index of Multiple Deprivation where they adjust for social services payments and for clinical payments.

It is an index, so it's a handful of social determinants weighted based on their impact on outcomes, and then those are used to develop a payment scheme assigned to the index

and the geography.

So, you're getting down to the very small geographies where you're using that ecologic measure of risk and assigning it to people -- next, please -- because they've shown that the worst quintiles of deprivation, that's the Q5 bottom bars -- actually, I'm sorry, Q1 in the English Deprivation Index, the top one, have higher expenses despite having lower life expectancy. And so, there is a relationship between cost and utilization and deprivation.

Next, please. And they had a scheme of they wanted to have universally available, validated data at the base of the measure of risk.

They wanted to reflect the underlying social and medical needs in a locality. They wanted it to be independent of previous spending so it wasn't anchored in some history of cost.

They wanted it to be scientifically coherent and plausible, feasible so that there was low burden and low administrative cost.

They wanted to reduce the ability for manipulation or fraud or gaming, as we often call it.

They wanted to encourage the efficient delivery of services and keep it free from perverse incentives.

They wanted to be transparent, parsimonious so that there's a short list of social determinants driving it.

And they really wanted it to reflect their policy intentions, which is critical -- next slide -- because their initial criteria were to reallocate national health service budgets to secure equal opportunity for access for those at equal risk; but in 2001 they shifted -- if we could one more time -- advance one more time, yeah -- to contribute to the reduction in avoidable health inequities.

So, they really shifted to trying to reduce the equity gap in health outcomes and in mortality across the country, which was an important pivot for how they allocate their resources.

Next, please. So, the mechanism of delivering the funding is prescribed. How those funds are then distributed is a policy judgment. It's not evidence-driven, but it's trying to allocate the funding across the sectors that need

it in order to try and address inequities.

One of the things I wanted to emphasize is that there's almost a tenfold higher payment adjustment for areas with the worst mortality rates compared to those with the lowest. So, it's almost an exponential scale in terms of the payment adjustments made across the deprivation indices.

Next, please. New Zealand did something very similar with their socioeconomic deprivation indices or the New Zealand Deprivation Index.

Next, please. So, also on a five-quintile scale, theirs is reversed, quintile 1 is the least deprived, quintile 5 the most. And looking at the north island on the left, or the south island on the right, the mesh blocks that these are assigned to, again, are quite small trying to increase the correlation between risk and a person's experience.

Next, please. And, again, seeing also a significant shift in the funding so that, you know, for five- to nine-year-olds in quintile 1 compared to those above 80 in quintile 5, you see an almost tenfold difference in the per-person

funding.

Next, please. Now, we have something with similar capacity in the United States. We have the Area Deprivation Index that Amy Kind at University of Wisconsin developed -- next slide, please -- where you're measuring neighborhood disadvantage at varying -- at Census tract level.

We have it for every Census tract in the U.S. and Puerto Rico. They have been incorporated in predictive analytics and demonstrated to be related to a number of different health outcomes and costs and utilization.

It is privacy-compliant because you're dealing with geographic areas, and it has a very strong track record. It's had more than $50 million of NIH funding looking at everything from how this relates to mortality to dementia.

It's translatable because you can use it to drive action at the person level, or you can aggregate up to community and look at community interventions where it's needed, and yet this index is fairly underutilized even though it showed such great application.

Next, please. It was initially

developed by HRSA[19], but in the mid-2000s, she actually updated it using Census data and American Community Survey data to develop their indices and, again, adjusting the index and how each of the elements were weighted based on their predictive capacity for a number of outcomes.

And, again, Census tract looking down at areas that capture about 1,500 people on average.

Next, please. We did a similar thing in creating the Social Deprivation Index a few years before, and it's no coincidence that the SDI and ADI[20] are extremely highly correlated because they use the same impaired process of relating social determinants back to outcomes and then deriving an index from them.

Next, please. One of the things that we hope to accomplish with this is not only coming up with a policy for payment, but of being able to align that with what clinicians are using.

We also actually developed something we call PHATE, or the Population Health

19 Health Resources and Services Administration
20 Area Deprivation Index

Assessment Engine, that uses a similar process to help clinics identify patients as high risk based on where they live and also to be able to assess their communities for community-based interventions.

All of this in the hopes that if funds flow based on their patient population, they have a mechanism to use those more effectively.

Next, please. So, PHATE uses the clinic's EHR[21] data and the community data to map their service area. It tells them what geography they take care of.

Our own research shows us that most clinicians overestimate their service area by 100 percent, so it's important to really drill down and be able to understand who you're caring for.

We've labeled the Social Deprivation Index a Community Vital Sign and, like most vital signs, the idea is it identifies a patient with risk, and then you're supposed to use that as a way into asking them about their particular problems or needs and addressing them.

And the Oregon Community Health Information Network, or OCHIN, has implemented

this in a 27-state network and looked at different outcomes related to it, but we've used it in my own practice in the third wealthiest county in the country, Fairfax, Virginia, to demonstrate significant differences in quality across our patients based on the Community Vital Sign.

And, also, we've embedded Aunt Bertha so that you have the ability to find community-based organizations that might partner either for this patient on a particular need or this patient population who have a shared need.

And, again, we want to align any adjusted payment opportunities with tools to identify patients or communities with social needs.

Next, please. So, just to show you, you know, based on a clinic in Maryland, we can identify their service area outlined in red and then present to them underneath that the Social Deprivation Index, the score for the community that lives there.

When we break it down in the highlighted census tracts in purple, their

21 Electronic health record

Community Vital Sign is 68, kind of putting them in the top one-third of risk.

And then we show them the other social determinants that make up that risk so that they can start to assess, you know, what this person may be experiencing, but, again, not taking away from the need to ask the patient if they have social needs.

Next, please. Massachusetts is the only state that has used an ecologic measure of risk for adjusting Medicaid managed care payments. They use a neighborhood stress score.

We can go to the next slide, please. It is actually a hybrid measure, so it uses individual-level measures -- most heavily severe mental illness -- and then they use a neighborhood stress score that uses an array of social determinants that are aggregated into an index; and that combination of personal with neighborhood become the mechanism for adjusting the payments.

Next, please. So, again, our goal is to try and help this policy conundrum we're stuck in about whether and how we should adjust payments based on social risk.

We think we should be adjusting based on social determinants or an index constructed from them, and it should really aim to resolve the patient's specific social needs, as well as supporting community interventions.

We think the degree of adjustment should be proportional to the area of disadvantage and designed to address social needs not just reflective of usual, related health care costs.

We like the geographic opportunity and using as small geography as possible so that the association is very close to the person level, and it should be created based on patient and population outcomes so that the measure you're using you know is associated with things you would like to avoid or improve.

And it needs to be sustainable, and that's why we actually list Stanford University and the Census Bureau have forged a new relationship to try and improve on these indices and potentially create a steward within the government for producing the measure over time.

We think the policy should reduce the burden for providers and for payers and for

states and reduce inequities between the states in the current process, which is a self-nomination process, that I am concerned that some states will never enter into and will only widen the inequities that we see between states and health outcomes.

And we think funders should predefine the goals of reduced total cost and improved patient health outcomes at the outset and use those to not only titrate funding, but also to create accountability for how the funds are used and what they're producing.

We don't think they should be simply looking for cost offsets that don't align with accountability, but really should be looking to address the social needs that underlie the inequities, and I'll stop there. Thank you.

CHAIR BAILET: Thank you, Dr. Phillips.

Questions from the Committee?

DR. SINOPOLI: Yeah. This is Angelo again. I have a question. So, fascinating presentation. Just really enjoyed it and just love what you're doing.

Do you use some of that physician

practice area to assign community health workers? Do you use community health workers, and how do you use this data to assign those?

DR. PHILLIPS: Angelo, that's a fantastic question and absolutely that is the goal, is to be able to assign community health workers.

And, like I said, in our own practice, the clinicians overestimated their service area by a hundred percent, so we need more specificity in how we assign those community health workers to go out and work in the community.

We had a residency practice in Lawrence, Massachusetts, use the tool not only to define their service area, but they cut their data first looking at their patients who they already screened for food insecurity.

And so, the geography was not just their clinical service area, it was their clinical service area for the population with food insecurity, and they used that to create mobile food pantries, and they could direct them specifically where to go to try and meet that specific neighborhood need.

So, yes, the targeting, I think, is a

strong use for these.

CHAIR BAILET: Great. Any other questions for Dr. Phillips before we move on to the next presenter?

(Pause.)

CHAIR BAILET: All right. Thank you, Dr. Phillips, for your presentation. Very helpful.

We now have Toniann Richard, who joins us from the Health Care Collaborative of Rural Missouri.

Toniann?

MS. RICHARD: Good morning. It's been so great to listen to all of the presentations today. I feel honored to speak with you all.

My presentation is a little bit different as we are not a research organization and our -- while we do some research and development type of work with third parties, what I'm really going to talk with you about today is how we have implemented some of these programs within our organization.

So, a little bit about who we are and what we do. We are a vertically integrated rural health network, and we started in -- as an

organization in 2004 forming a board of directors. We then became a nonprofit in 2006. I've been with the organization since 2007.

I like to tell people that we were doing social care and social determinants of health before the cool kids were doing social determinants of health.

So, in this rural health network space, what we did was we brought together people in our service area which, at the time, was about, 35,000 was our population in one county, brought together people who wanted to solve some problems around provider recruitment, oral health care for those who do not have insurance or children with Medicaid.

We are located in west central Missouri, which is the desert for behavioral health, primary care, and oral health services.

And even though we're about 40 minutes outside of the Kansas City metropolitan area, we were not able to do -- we were not able to recruit and retain providers in the service area.

We were always rural-focused, and we've always been very culturally sensitive to do what makes rural communities different than our

urban counterparts.

So, you can go to the next slide, please. A little bit about our mission is to cultivate partnerships within our communities to meet the needs of underserved populations, and we don't -- we don't do this by building our organization stronger, but by building the partners that we work with stronger.

And so, we have some school-based work that we do that's been very instrumental in our social care, social determinants of health work.

We also have brought in -- we have a social service network of people that we bring together to meet on a monthly basis to help develop strategic planning for our organization to carry out to meet the needs that are unmet within those social service organizations.

We also have a larger network of membership that help drive our strategy and implementation around services at social -- social services, as well as our direct clinical services.

In 2013, we opened our first FQHC[22]. We are now -- we have five locations, three

mobile units, and several school-based and nursing home access points. And so, we've experienced extreme amounts of growth, but we were able to do a lot of that because of the drivers behind the social needs at our community.

Next slide, please. We knew that what was important around social determinants of health was making sure that we never compromised quality health care and focusing on wellness.

And so, I loved what Jacob mentioned earlier about putting doctors out of business. Those are conversations we've been having for a long time.

We are now getting our physicians to have that same conversation about what does that mean?

Does that turn physicians into more of a wellness seat in our communities, and what are we doing to make sure that people are raising their children and caring for the elderly in ways that help us to live longer and help us to live in more healthy ways?

Also, focusing on policy, making sure that we keep social issues at the top of our

policy initiatives.

And so, I'm going to talk here in a minute about how we've moved that into the development and implementation of community health workers within the clinical setting as well.

Next slide, please. So, we know that we are not large enough. We're an organization now of about 110 staff. Eighty percent of those employees are clinical. The other 20 percent of our staff are community-based staff.

Of those community-based staff, most of them are community health workers, and our community health worker program has soared and failed and soared and failed because of this kind of ever-moving target of what we want our social programs to look like and, more importantly, what our communities and what our hospital partners, what our clinic partners and what our community-based partners need for us to do around community health workers.

We use the social -- I'm sorry, the PRAPARE tool. Somebody mentioned the PRAPARE tool earlier. There's a love/hate relationship with PRAPARE.

Because we are a Federally Qualified Health Center, it's data that we use to capture within our electronic health record and then is used to tag our community health workers into making sure that those social issues are addressed within a specific time frame. And so, that is the tool that we use.

Our community health workers, we have some that are clinic-based, and we have some that are community-based.

We have tried several different models. We've tried a general community health worker that floats in and out of the clinic. That did not work well for us. It really did not work well for our licensed providers.

At the same time, we were also adding social workers into our care teams, and that was a new space for us.

And so, trying to define the work of a community health worker, making sure that they weren't crossing over into social worker space really, really became challenging, and so we split those roles. We looked for different ways on how to recruit and retain those individuals.

We're looking at a model now to drive

that down even one step further into finding content area expert community health workers.

So, it's really important for us that our community health workers look, feel, talk, and act like the patients that they serve. And so, looking at whether some community health workers are focused on transportation, some are focused on food access, some focused on housing, making sure that we have those specific content areas available to provide support to our staff.

One example of this area is -- or one of the examples of how we're utilizing these community health workers is through Community Health Worker ECHO[23] through the University of Missouri. Telemedicine network is excellent if you -- I'm sure you have ECHOs in your community within some of your partners.

I would really encourage you to look at the Community Health Worker ECHO bringing some major issues to light.

Getting community health workers together to solve larger, systematic problems has been really critical for us.

We recently had a 90-year-old patient

23 Extension for Community Health Outcomes

who has been a victim of fraud. And because of some other services within our community that have had to shut down due to the impact of COVID, our community health workers have had to get into this financial wellness space for some of our patients, and we were able to present this significant issue around elder fraud and what we can do to address it on this ECHO.

We were able to get expert help from law enforcement, some legal advice, and then some follow-up action as well. So, the Community Health Worker ECHO has been really critical for us.

Next slide, please. Taking a look at future models of care, I would -- some recommendations that I can make, based on our experience in this space, is bringing those CFOs in early.

I can't tell you how many times we, as a community health organization Federally Qualified Health Center, we get really excited about the important work that needs to be done at the community level, boots-on-the-ground work that we need to do, we're ready to implement, we bring the finance leader to the table and, you

know, they throw their hands up, hold up, wait a minute, we've got to talk about what does this cost, what are we going to bring in, and how are we evaluating costs based on the patients.

And it's not just about dollars and cents, you know. It's about livelihood, safety, security, those types of things as well.

And we think it's important to advocate with our health plans, with Medicaid about paying for what's right, paying for what's helping to keep people out of the hospital unnecessarily, out of overutilization of clinical space unnecessarily.

So, somebody mentioned earlier annual wellness visits for our aging population. That's a great capture place for us to be as an FQHC because 95 percent of our patients are experiencing some sort of vulnerability.

We really can maximize that PRAPARE tool one-on-one coaching with our community health workers, and then they follow that process as well.

I will also say that getting paid for enabling services kind of as a benchmark that we have used as an organization is that 10 percent

of all of our patients are assigned a community health worker to ensure that enabling services are offered for issues that are identified in that PRAPARE tool assessment.

Also, pairing a provider with a CHW, community health worker, or a social worker or some of our peer recovery coaches, which are working in the space of addiction and recovery, was really challenging identifying roles and responsibilities, expectations, boundaries, and communication.

So, how can we take those experiences and go to -- take a collective strategy and performance measures to our health plans, to our funders, development officers, et cetera, in order to develop payment strategies that make sense to help support these positions that are nonbillable within our space.

Next slide, please. Collaboration takes time. This is just a quick snippet of what our organization looked like before we implemented clinical services.

The clinical services, the FQHC model, is the economic engine of what we do. The network is the heartbeat of our organization. It

really drives the mission, vision, and values work that we're doing within our community and finding that right provider champion was really important.

We tried a couple different providers who thought that they wanted to take the lead on this initiative, and it became very clear that the risk assessment tools and then the risk to that licensed provider, by capturing some of these social issues within an electronic health record, just became too much.

The being able to address all of the red flags and the screening issue was just not a good use of the provider's time, not to mention the documentation, follow-up, and closing of the loop of all of those patients was really important.

We found that it was also time for us to find the right people to connect with others. And so, maximizing our community partners, that could be our social service agencies, that could be network members.

It could be a myriad of people that just volunteered and gotten involved with our organization.

Sometimes it's assigning patients or a patient population specifically to individuals within our network.

Migrant farm workers is a great example of that. We found some champions around the migrant farm worker space, and so directing patients to different teams within our organization has been very helpful.

Referral looping, I've heard mention of referral looping before. It used to be that nurses were really the only people that touched that referral looping from a quality metric perspective.

The physicians and nurse practitioners, dentists, hygienists, psychiatrists, et cetera, were involved in that, but it was a nurse-driven model.

It's still a nurse-driven model. Our nurses are ultimately responsible for it; however, our peer recovery coaches and community health workers are getting involved in those conversations.

They're actually working in tandem

with the EMR[24] through some platforms that we've used through integration to capture some of those additional conversations, especially when we have to go to bat for a patient for services that need to be covered.

I'm going to apologize right now. I do work in a rural area, and a train is getting ready to go by. So, in, you know, true fashion it's going by right now.

Next slide, please. So, how do we take our information and develop our areas of consideration?

So, we use the IHI[25] model PDSA[26] for health improvement. We use it a lot. We use it in our clinical performances. We use it in our community-based performances. We also use it in how we hire, how we do operational implementation.

And so, our return on investment strategies also went through the PDSA model, which is plan, do, study, act, which is a continual cycle of improvement, which is why the need to bring those financial leaders in early

24 Electronic medical record
25 Institute for Healthcare Improvement
26 Plan-Do-Study-Act

really helps you from going -- helps you continue to go through that model as opposed to hitting those financial roadblocks and having to start over.

A lot of our feedback in terms of what we're doing right now is anecdotal. It's conversations with emergency room physicians. It's conversations with nursing homes, partners that we work with in the clinical space and in the community health space.

We're working to move back into a more return on investment model looking at some of those indicators of how that can continue to improve.

Last slide, please. So, what's next? Some of the things that we're involving our community health staff in over the next 12 months is emergency room discharge planning with five of our hospitals that are within our service area or adjacent to our service area.

Also, I'm setting some new programs and resources out there for people experiencing homelessness.

We have a very small amount of shelters in our community. We have even less

short-term housing options for people, and so really taking a look at that special population to determine if we have moved the needle in terms of meeting their needs.

Also making the technology work for us, we have significant broadband issues. And also making our electronic health record work in a way that allows our community health workers and peer recovery coaches and support staff in ways of engaging in these conversations in the electronic health record space that doesn't push a liability over to our licensed providers and then taking these plans over to the health plans as well.

So, we have great support from Medicaid in Missouri around the work that we do with community health workers, social determinants of health.

A lot of that goes through our primary care association. Those contracts work through Missouri Medicaid through the primary care association down to the community health centers.

I feel like we've done a really good job of parlaying that into resources for our network members, which do include our hospitals,

clinics, and other social partners.

And I talked really quick to get through that and that is all.

CHAIR BAILET: Great, Toniann. Thank you very much, and we appreciate the train that was -- I don't know whether that was planned or not, but that was --

MS. RICHARD: Nope. No. I prayed it wouldn't come through, and here it is.

CHAIR BAILET: All right. They do try to stay on time.

MS. RICHARD: Yeah.

CHAIR BAILET: So, speaking of that, do we have questions from the Committee?

(Pause.)

CHAIR BAILET: All right. Toniann, again, thank you so much.

The last presenter for the listening session today is Dr. Michael Hochman. Dr. Hochman, the floor is yours.

DR. HOCHMAN: Hi, everyone. Thank you very much. It's a real honor to be able to present here today and especially after all those presentations we've heard, amazing, good work that people are doing in this space around the

country.

So, I'm a general internist, a primary care doctor. I'm going to tell you about a new medical group that we are developing to focus on care for patients experiencing homelessness initially in southern California, although potentially we hope to expand in the future. The group is called Healthcare in Action and we are funded by SCAN Health Plan.

Next slide, please. So, to give you a little bit of a background about the challenge and why we're jumping into the space, and tell you a little bit about our model of care, and then we'll talk a little bit about the payment implications, and feel free to jump in at any point if you do have questions.

Next slide, please. So, just a little background about SCAN, which is, again, funding this initiative, it is a nonprofit Medicare Advantage Plan.

It was founded in 1977 initially as a cooperative health care plan. It became a Medicare Advantage plan in the '90s.

SCAN is very proud of its 4.5 star rating with CMS the last several years. It is

the second largest nonprofit independent Medicare Advantage plan in California with 220,000 members, about 15,000 duals, and there, it's actually the third largest in the nation, as well, independent nonprofit plan.

Next slide, please. So, you all know this, but it is not easy to be a patient experiencing homelessness.

It's not easy -- anyone right now to be a patient in private care, it's cumbersome enough getting appointments and getting someone to respond to your phone calls, but let alone trying to be homeless.

And patients who are homeless report just very high rates of frustration getting to appointments, there's transportation barriers, there's access barriers, and so forth that really interfere.

And then on the provider side, it is not easy to care for patients experiencing homelessness who may not have telephones, who may have high no-show rates, you know.

I can speak from personal experience being at a county clinic and someone who's homeless comes in at 4 o'clock on a Friday and

you really want to help them, but in the back of your mind you're thinking, oh, gosh, here comes two hours, and I'm going to be out late, and everyone else is going to be running late today.

So, next slide. And just to acknowledge that there's also a big disparities angle here, I used to be the health deputy for Mark Ridley-Thomas, who is the LA County board supervisor member here in Los Angeles who has been really the local champion of this issue.

He got Measure H passed, which is a legislation to provide funding for supportive housing in Los Angeles.

And he always used to say, homelessness impacts every racial and ethnic group; it affects men, women, children, those of different sexual orientations, but it disproportionately affects those groups that have historically faced discrimination in the U.S. So, we really do think that there is an equity angle to this work that we're doing.

Next slide. So, I mentioned the challenges. Simply put, the existing medical infrastructure, doctors' offices, are not well-suited to care for patients experiencing

homelessness, and we've become very interested in the street medicine model of care.

I had some experience in working with the USC[27] street medicine team, and also there are a number of other groups that are doing this, community health centers like Venice Family Clinic; there's about half a dozen that I'm aware of in LA alone, and I know many others popping up around the nation.

The idea here is to do away with the standard doctor's office and to have clinicians go out to see patients where they are in the streets, in encampments, in shelters, under underpasses, follow them longitudinally in hospitals and other facilities where they may end up.

These programs have been associated with very high rates of patient experience, improved disease control for mental health and substance use disorders and, you know, basically a win all around.

The only problem with these programs is that they do rely on charitable funding. We certainly are not aware of any self-sustaining

27 University of Southern California

street medicine model, and you'll understand why as we talk about the model going forward.

Next slide, please. So, what our vision is is to take this street medicine model that works so well for patients and clinicians to put it in a managed care framework and to create a sustainable health care model for homeless adults, and we're going to be structured as a nonprofit, value-based, payer-agnostic medical group.

Although we're being funded by SCAN, we're going to see patients from any health plan, and we're actually looking for other health plan funders at the moment to help us with our start-up costs.

We are going to provide full-scope primary care services, which, in this case, is going to necessarily require mental health and substance use treatment and social work services, as I'll mention. And I should say we are targeting a launch of January 1st, 2022.

Next slide. So, the scope of services that we're providing are going to be full-scope primary care that would be expected of any other delegated primary care provider in a managed care

arrangement.

We'll also provide clinical care management services for chronic diseases and, in this case, mental health and substance use conditions will probably be the most common of those.

We're also going to provide ambulatory mental health and substance use services.

Our model is not to have psychiatrists be out there with our team, but rather to have psychiatrists consulting, providing case conferences to be able to do televisits in the field if necessary.

So, if our primary care clinicians need support -- because we know that if we refer a patient to a psychiatrist office, the chance that they're going to get there is low. So, we really want to empower our primary care clinicians to provide these services directly.

We're also going to provide the wraparound services, the care management, the social work, transportation so if a patient does need to go see a specialist, one of our community health workers or peer navigators would accompany

them maybe in a Lyft vehicle to that appointment, but the idea is to provide as much as possible point of care so that we don't need to transport patients unnecessarily.

And we're going to follow patients longitudinally. If they do get admitted to the hospital, because they are managed care members, we're going to give ADT[28] alerts and work closely with the health plan care management team so we can track them as they go to hospitals and other facilities and coordinate those transitions.

In the future, we do hope to move to professional risk, and this gets to some of the payment implications I'm going to talk about shortly.

Next slide. So, this is what the team would look like. We are hiring right now nurse practitioner and physician assistants who are going to really be the owners of these teams.

They are going to be the main primary care clinician. They're going to be coupled with three care navigators. We're hiring individuals with lived experience with homelessness.

Our lead navigator, for example, was

homeless for several years, was on skid row, had substance use challenges, overcame those, and for eight years he's been housed. He's doing great now, and he's been working on skid row as a care manager, and we're hiring him to impart the skills that he learned to others.

And, you know, needless to say, the patients just listen to him, and he has a resonance that just the rest of us don't have because of that personal experience that he's had.

And then we're also going to have a social worker be part of the team. We are not trying to recreate the housing systems in LA because there are very effective coordinated entry systems, but rather we're trying to understand those processes to be able to advocate for our patients and, frankly, hold our patient's hand as they go through the system because it is a very complex process.

But if we have someone to help them, we think the success rate's going to be a lot higher.

So, I mentioned before that the cost

28 Admission, discharge, and transfer

of the street medicine model is a lot more expensive than a standard primary care practice, and I think this number says it right here.

The panel size that we're targeting is about 125 patients per primary care clinician. The average private practice panel size is 2,300 patients or so.

So, this is going to be an order of magnitude more expensive than a standard primary care model. So, the question is, how do we make this work from a business perspective?

Next slide. And I'll get to the business model very shortly, just a little more details about what we're going to do.

So, first, you know, we're really aiming to get managed care prospective payments so we don't have to worry about day-to-day fee-for-service billing.

We want to provide all-inclusive primary care, as I mentioned, minimizing referrals.

We are partnering -- we'll publicly say this, but I'll just mention that American Well, the telehealth provider, is going to be working with us and may even be donating some

mental health and substance use televisits for our patients.

Again, the idea is that our care navigator would be with the patients in the streets, in the encampments, and the telehealth provider would come in and provide that guidance so we can do things like initiate long-acting, injectable antipsychotic medications, substance use treatments.

All our providers are going to be suboxone certified, but, of course, you know, sometimes complex issues come up where we do need a specialist perspective there.

24/7 access, how are we going to provide 24/7 access to our patients so that they actually call us?

We're planning to give cell phones with data plans to patients. And one of the biggest challenges patients do have in the field is charging those, so there's these solar chargers so that the patient can get their cell phones charged.

And so that if they have an issue at 7, 8 o'clock at night, 11 o'clock at night, they can actually -- we're going to really try to

encourage them to call us rather than going to the emergency room or even partnering with an organization that would be able to send EMTs out to the field at all hours to do a crisis response. So, really trying hard on the ER and hospital avoidance.

Our urgent care services on the streets are being set up so that we can provide IV fluids, IV diuretics, IV antibiotics to do wound care, drain abscesses, and so forth, medication management.

We're going to actually deliver medications to patients because I know in my county clinic if I prescribe a blood pressure medication, the chance the patient is going to go to CVS and get that is pretty low.

So, we'll actually pick up the medications for the patient, give it to them, and, in certain cases, we would even do directly observed therapy.

We know that preventing an ER visit depends on the patient taking their medications, whether those be cardiac medications or mental health medications.

We're actually going to observe them,

remind them, call them, and so forth. It's very high touch.

As I mentioned before, behavioral health is going to be built in. Social work is going to be built into the model, and longitudinally we're going to be following patients in various facilities.

So, the next slide. So, the business models to support this, to get an understanding, the average -- and this is the statistic for SCAN members. SCAN is a Medicare Advantage plan. So, we only have Medicare patients, including duals.

So, this wouldn't necessarily apply to a homeless patient who is just straight Medicaid. I would imagine it would be lower than this, but for the SCAN members, dually-eligible patients experiencing homelessness, the average cost of care is $60,000 per year.

We expect that the cost of the street medicine model is going to be about $10,000 per year per patient. A lot higher than a standard primary care capitation arrangement, but, again, so is the cost -- total cost of care for this population.

And I'll just mention that SCAN gets

about $10,000 -- I'm sorry, $24,000 per patient per year from CMS based on the HCC RAF[29] system. So, SCAN loses $35,000 per member per year on these patients.

Next slide. So, the first business model I mentioned that the average cost of care is about $60,000, based on some suggestive studies that we've seen we're hopeful that we're going to be able to reduce total cost of care by about $25,000 with ER and hospital avoidance.

So, if we're able to do that, it bumps down SCAN's cost from $60,000 to $45,000. That creates some shared savings.

If we could get 7-1/2 thousand of that – $7,500 of that, SCAN keeps $7,500, plus the standard capitation, that gets us to about the $10,000 that we need to sustain the model, and SCAN comes out, the health plan comes out ahead.

I will acknowledge that we're hopeful we can achieve this, the 25 percent reduction in ER and hospital utilization, but we're not aware of rigorous studies that have shown this, so we're applying for grant funding to see if we can demonstrate it.

29 Hierarchal Condition Category Risk Assessment Factor

There are some encouraging studies, but these have been pre-post studies. There may be regression to the mean and other challenges, so I don't want to in any way suggest that it's well-established that we're going to be able to actually achieve this, but that's what our goal is to do.

Next slide. The other potential business model that could work is if we were able to get an enhanced payment for the social determinants of health.

And I think it fits in very nicely with what Dr. Phillips was saying that if there could be an adjustment factor for the fact that patients who are homeless do cost more than the HCC RAF system suggests, again, for SCAN, $24,000 Medicare pays SCAN, but the actual cost is $60,000, we anticipate that the adjustment factor would need to be about 1.77.

We're going to get some reductions just from simply getting them into managed care arrangements, but, at the end of the day, it's still going to be more costly.

We also would need enhanced funding for health-related social services, so things

like paying for bridge housing services, care navigation that isn't part of standard scope of services that a health plan would provide, and then also some greater flexibility.

And one of the big ways that I think it's important to have flexibility, you know, all these star measures are based on how many mammograms, colonoscopies we can do, how good a job we do of getting hemoglobin A1cs under eight percent.

Well, these are lower-priority issues for patients experiencing homelessness, and I think we do need to have some flexibility too to reframe what the quality measures are.

Maybe it is control of mental health conditions and substance use, self-reported substance use rates, and maybe it's things like what percentage of our patients are successfully able to be enrolled in bridge housing that are not standardly part of the star measures.

So, next slide. So, let me stop there. That's a little bit about what we're doing and the business models that we're trying to negotiate to make it sustainable, and I'd love to take any questions you might have.

CHAIR BAILET: All right. Thanks, Dr. Hochman.

Jay?

DR. FELDSTEIN: Yeah. First, congratulations on a very noble effort, and I totally hope you're successful.

One question. How many SCAN members are actually homeless at this point in time?

DR. HOCHMAN: Yeah. SCAN has about 350 members who are homeless. That's part of the reason we are going to open it up to other health plan members. It's just not -- and that's 350 throughout California. It's about 200 in Los Angeles.

So, to achieve the economies of scale that we need, we're looking for -- and we're very close to getting some contracts with other local LA health plans to do this.

DR. FELDSTEIN: And do you make any attempt to enroll uninsured patients in any type of program, specifically Medicaid, while you're out on the street?

DR. HOCHMAN: Yeah. Absolutely. We're, you know, I worked at the USC street medicine program, and we come across patients who

aren't -- at the USC program those patients were empaneled to the county, but we all the time are going to come around friends and neighbors of people, and we encourage them to get enrolled in Medicaid.

For this to work, to be sustainable, we do need them to have a managed care program. Otherwise, you know, uninsured patients are not going to be able to be reimbursed, but we are prepared to deal with the acute issues that do just, you know, obviously if someone comes up and they have an acute crisis and they're not part of your insurance program, we have an ethical responsibility to deal with it and then to encourage them to get enrolled.

Now, I will say that some of the health plans are anxious about this because they -- if we take a contract from a health plan and a patient knows that they enroll in that health plan that we might be able to serve them, that could lead to some adverse selection, but I have to say that health plans have not prevented that from taking the leap, at least based on the discussions we've had that they're willing to still contract with us.

DR. FELDSTEIN: Thank you.

CHAIR BAILET: Any other questions from the Committee before we wrap this session?

(Pause.)

CHAIR BAILET: All right. I want to thank all of you for sharing your experiences with us today. We've covered a lot of ground during this session thanks to your input.

We are going to take a break. We reconvene at 1:30 Eastern, 10:30 Pacific, so we'll see you back for the subject matter expert panel at 1:30. Thank you.

(Whereupon, the above-entitled matter went off the record at 12:47 p.m. and resumed at 1:39 p.m.)

CHAIR BAILET: All right, so welcome back to this PTAC public meeting. I'm excited to kick off our afternoon panel. At this time, I've asked our panelists to go ahead and turn on their video, if they haven't already. They also know that they need to unmute themselves before they talk.

To further inform us about the issues related to the social determinants of health and equity, we've invited a variety of esteemed

experts from across the country. They represent several points of view, including providers, researchers, payers, and patient advocates. This morning, we learned about a handful of specific initiatives and some research findings. I think these panelists will offer some additional perspectives that will help us better understand the latest information emerging about social determinants of health and equity and Alternative Payment Models.

The full biographies of our panelists can be found on the ASPE PTAC website, along with other materials for today's meeting. I'll briefly introduce our guests and current organizations, and then I'll ask each panelist to please introduce themselves with their name and organization. Because this is virtual, I will prompt each of you alphabetically by last name.

First, we have Dr. Marshall Chin, who is the Richard Parrillo Family Professor of Healthcare Ethics in the Department of Medicine at the University of Chicago.

Next, we have Karen Dale. She's the Market President of AmeriHealth Caritas District of Columbia and the Chief Diversity Equity and

Inclusion Officer of the AmeriHealth Caritas family of companies.

Dr. Jen DeVoe is the John & Sherrie Saultz Professor and Chair of the Department of Family Medicine at Oregon Health & Science University. She also co-directs the BRIDGE-C2 Center.

Next, we have Kathleen Noonan, CEO of the Camden Coalition of Healthcare Providers.

LaQuana Palmer joins us from the Foundation for Health Leadership & Innovation in North Carolina, where she is the Program Director of NCCARE360.

Finally, we have Dr. Charlotte Yeh, who joins us from the AARP Services, Inc., where she is the Chief Medical Officer.

So, I am going to have folks introduce themselves and why don't we try that. Hopefully everybody is able to connect now. I'll start with Karen Dale first and then go down the list. Karen? (Pause.) Is she unmuted, Gabe?

MS. AYSOLA: I think we might need to start with Dr. Chin. I think Karen is still having some technical difficulties that our team is helping her with.

CHAIR BAILET: We can handle that. Let's start with Dr. Marshall Chin.

DR. CHIN: Hi, I'm Marshall Chin. I'm a general internist and a health services researcher at the University of Chicago. I co-direct a Robert Wood Johnson Foundation program called Advancing Health Equity, meaning care, payment, systems transformation. We work with seven teams of state Medicaid agencies, Medicaid managed care, organization health plans, and front-line health care delivery organizations on payment reform to advance health equity.

CHAIR BAILET: Thank you. Dr. Jen DeVoe?

DR. DeVOE: Hi, a pleasure being here. Thanks for having me. Jen DeVoe, I'm a practicing family physician. I've been out here in Portland, Oregon, for 20 years. I serve as the Chair of our Department of Family Medicine at Oregon Health & Science University, also working in implementation science and health services and health equity research here.

CHAIR BAILET: Great. Thanks, Jen. Kathleen Noonan?

MS. NOONAN: Hi, thanks for having me.

Kathleen Noonan, I'm the CEO of the Camden Coalition. We're based in Camden. We started with doing care management for very, very complex individuals in Camden. Since starting doing that, we've done a lot of clinical redesign projects. We do advocacy, policy, and work all around the country.

Before coming to Camden Coalition, I was at the Children's Hospital of Philadelphia for 10 years. I started the research center there and spent two and a half years in C-suites, so I have a good perspective on the hospital view of this and the community-based organization. Thanks for having me.

CHAIR BAILET: Great, thanks, Kathleen. Next, we have LaQuana Palmer.

MS. PALMER: Hi, good afternoon. I'm LaQuana Palmer. I am currently the Program Director of NCCARE360, which is North Carolina's electronic platform that we use with linking health and human services together. It was the first one that came across our nation, and it is just great to be able to share with you all today.

Prior to my role at the Foundation for

Health Leadership and Innovation, I served as the Healthy Opportunities Program Manager in the Office of the Secretary where they are currently working on the demonstration which they received an 1115 waiver to demonstrate how we can use the Medicaid dollars to pay for those unmet social needs services. So, excited to be able to share with you all today.

CHAIR BAILET: Great, LaQuana, and Dr. Charlotte Yeh?

DR. YEH: Thank you. Delighted to be here. I'm Charlotte Yeh, the Chief Medical Officer for AARP Services, Inc. I work predominantly in how to bring the strength of the consumer voice, the consumer lends to improvement of outcomes, affordability in the experience of health care. I'm an emergency physician for 20, 30-some years. I was also a former regional administrator for CMS, so I like to say I bring the perspective of a provider, payer, a bureaucrat, but most of all a consumer.

CHAIR BAILET: Great, thank you. I'm just going to check and see if Karen's been able to get her computer issues solved. Is she on? If she's not, we'll have her introduce herself

when she's able to join the group.

Thank you all for participating. I look forward to our discussion.

*** Panel Discussion on Payment and Data Issues Related to SDOH and Equity with Subject Matter Experts**

I have a series of questions that I will run through. Some will be directed to the entire panel, others will be directed to select members, and I'll call on them as we go through, but also panelists, if you're not called on, on a particular question, and have a point of view, feel free to jump in.

We're going to go ahead and start. Please tell us what you see as the role and the objectives of social determinants of health and equity in the context of value-based care. What specific activities related to addressing social determinants of health, health-related social needs and equity are most important for improving quality and reducing costs and Alternative Payment Models and physician-focused payment models? We'll start with Dr. Chin.

DR. CHIN: Thank you for the great question. So I'm going to start with three

simple principles. Of course, all to keep in mind over the next hour that the discussion is going to get very detailed, and I think it's easy to get lost in the weeds and to miss sight of the target goal of addressing social determinants of health and advanced health equity, so these are three principles I think we'll come back to as the North Star throughout the hour.

The first is to continually connect the dots. How does payment reform or a policy actually address social determinants of health and advanced health equity? I think overall in our field, we have too much actual thinking where someone will think about a policy intervention or a payment reform, and it becomes almost a payment reform for payment reform's sake, as opposed to payment reform that supports and incentivizes care transformations that address a person's medical and social needs to advance health equity. So again, payment reform that supports and incentivizes care transformation that addresses a person's medical and social needs and advances health equity.

The second general principle is that we truly need to keep the patient and community

central. We talk about patient-centered care. We talk about patients and communities in our mission statements, but frankly, this is one of the first things to go when organizations operationalize efforts. We tend to impose solutions on patients and communities as opposed to a true co-creation implementation process. One of the questions you asked, Jeff, was well, you know, like adapting to different contexts. There needs to be flexibility to adapt concepts to different contexts because patients and communities differ. When we do talk with patients and communities, there are a couple of common themes of what works.

One is holistically addressing medical and social needs, which sounds a lot like geriatrics, which is probably the least subscribed specialty in medicine and why, because our system is not well set up to do that, to holistically address medical and social needs. Patients also talk about then addressing the structural factors. We'll talk more about that, which is basically housing, education, et al.

The third principle, which is that we need to address both the structural and

technical, as well as the personal and cultural. We tend to focus on the structural and technical that alone isn't enough; we also need to address culture, implementation, volume, and the mission.

CHAIR BAILET: Great, thank you. LaQuana Palmer, please.

MS. PALMER: Yes, I can definitely just tie right into what Dr. Chin is saying. In North Carolina, we definitely were considering how do we connect those dots, and in many places we look at health and human services, and it is just very, very fragmented.

So before we can even begin to even think about volume-based care and Alternative Payment Models, we have to back up a little bit. It's almost like wait a minute, hold on before we can move forward with this, how are we talking to one another. In order to do that, we do have NCCARE360; again, it's that electronic network that we're using with linking health and human services together, but it actually even goes beyond that. We are looking at relationships that we have within, not only just at the community level, but also with our physicians and our providers as well.

With NCCARE360, we're not only just again looking on that community level as far as community-based organizations, we've actually backed up and looked at hey, what about our providers? What about our payers? What about all these individuals who are talking to one another to ensure that they have a mechanism that they are able to do that, so in order to really look at value-based care and those payment models, we had to build an infrastructure in order for that to happen.

So NCCARE360 is a part of that infrastructure that we are using specifically as we begin to, again, look at that demonstration that we have here in North Carolina. I'll touch on that and just a small bit on that. With that 1115 waiver that we received from CMS, and again this was a brainchild that we had from Dr. Cohen (Phonetic.) at the Secretary's level at the North Carolina Department of Human Services. This is a relationship that we have with FHLI[30] and the department to ensure that NCCARE360 can keep going to do a lot of that work, but with the 1115 waiver, we have that demonstration that will

allow us to be able to look at the work that we are doing, Medicaid, and again pay for those unmet social needs that so many individuals are in need of.

Later on in this discussion, hopefully on the panel, I can hopefully give some demonstrations as to how we were able to look at that even right now during COVID and looking at support services and linking them to a number of our COVID-related health care facilities that were able to provide services as well. So, again, when you're looking at that payment model, again, you have to look at connecting those dots and building an infrastructure for those things to actually happen.

CHAIR BAILET: Great, thank you. Dr. Jen DeVoe?

DR. DeVOE: Great, thanks. I would absolutely echo what's been said already about connecting the dots and keeping our patients and communities central. One of the areas that I've had the pleasure to work on this year with the National Academy is primary care, the foundation of our health care system. There's a lot of

great updates on the evidence on how to implement high-quality primary care in our country, rebuilding the foundation of health care, ensuring that we have strong primary care, and ensuring that it's not only the primary care teams that are addressing the social needs of our patients and identifying the social risks of their communities, but the entire health care system.

When we first started talking about this several decades ago, I was concerned about, you know, when we look at the pie, about five percent of our resources right now from health care go to primary care, the other 95 percent don't, yet everyone in our population needs primary care. I was concerned that much of the conversation was about let's take out of that sliver everything that we need to connect our systems with social service organizations to address social needs, to identify social risks. I guess I'm optimistic that we're beginning to look at the rest of the pie.

Some of the ways that I think we really want to hold our large health care systems

accountable and many of the places where those other 95 percent of dollars go downstream, and this is something I think CMS can do, other payers can do as well. Not so much saying, you know, if you have a readmission, we're going to penalize your system, but let's think about ways to incentivize your system to connect to the [NCCARE360][31] to have a chief community officer that knows your community, that's connected to your community. That person should also be working in your community. Maybe it's someone at the food bank or housing resource. A chief primary care medical officer knows every single primary care resource in your community, supports those resources, connects patients back to those resources when they do get discharged from the hospital, supports the comprehensive care by the team, continues to push the workforce training out into that community so that we can have a more robust workforce in our community. All of these things in addition to focusing on the individual patient, as best as possible addressing their social needs while they're in

31 Ms. Palmer stated "NC360" during the meeting but meant "NCCARE360"

the health care system. Most of our work needs to be investing in our communities, connecting those dots and building that infrastructure.

Tangible ways to do that, I think, are not only looking at how are the patients treated within the system; hopefully they spend very little time in the hospital or in the primary care setting; most of their lives are spent out in the community. What are we doing to improve our community? What types of dashboards do we have in the health care setting to follow? Is the third grade reading level of that community improving? Is the housing improving? Is the food insecurity eliminated? Do we have no further patients that are living in food deserts, et cetera? So, very uncomfortable for traditional C-suite leaders to think about those types of dashboards, but that's really where we need to move the needle. Thanks.

CHAIR BAILET: Thank you. Kathleen Noonan.

MS. NOONAN: Right, well, I'll just add something to the conversation that we haven't talked about yet. It's about flexibility of dollars.

Here's a story. We recently at the Camden Coalition put out an RFP for our health systems and FQHCs, and we now work broader than Camden. We're moving in South Jersey, to do a pilot with us where we would be redesigning standard of care and protocols in the emergency room because of so many pregnant women, who are coming into the emergency room, and, as you probably all know, it's not standard of care, but when that woman leaves the emergency room, anyone has checked to make sure she's connected to prenatal care and makes that appointment. So, we are booking with Health Systems in South Jersey to do that, and we only had $10,000 to offer them in flexible dollars. Every large health system applied to be part of our RFP, as did all the FQHCs, so much so that we had to go to a funder to get more $10,000 pots, and it just showed us again how not only are our clients in very inflexible positions, but our providers are. The idea that they could have $500 to work with a client to be able to help them that day was so important to them and so valuable, and so I just want to say that whatever we think about, we have to flex dollars. We have one hospital in our

area that every year gives us $25,000. It’s one of their main primary care practices so that we can then flex fund for them whatever a patient might need because they're not really allowed to do that, but they can do it through money to us. So I think this is a really important thing to think about when we're thinking about social needs, and I'll leave it there.

CHAIR BAILET: All right, thank you. Next, we have Karen Dale, and I'd like Karen to introduce herself as she wasn't able to do earlier and then provide her point of view. Thank you. (Pause.) Is Karen still having technical challenges? She might be. Let's go to Dr. Charlotte Yeh.

DR. YEH: Thank you. Ditto for all the comments of the other panelists before and Dr. Chin, I really appreciate your talk about making sure we stay person-centered.

So, building on the comments earlier by Dr. Joshua Liao that we have been underutilizing, undertapping the consumer engagement arm. I'd like to say that when we talk about SDOH and other factors, there are missing opportunity levels just by engaging the

patient and the family, and I'll give three key examples.

So, number one, we seem to think that only managed care of Medicare Advantage is the only route for creating value-based care. I'd like to say what happened to treat for service? So, I operate very much and we do a lot of our testing in the Medigap plan, which is the most perfect example of consumer engagement because there's no provider network. Your only touch point is through the consumer.

We did care coordination programs that included SDOH, like referring people to transportation, helping them with their financial payment for drugs, helping them with personal family issues, and we were able to demonstrate, talking only to the consumer, a reduction of hospitalizations, ED visits, reduction in falls and, my favorite, 44 percent less likely to move into a long-term care facility and being able to stay at home. Best of all, this was a boon to the physicians because they weren't having to track and capture all of this data and do all of this work themselves or through their teams; we were doing this through the multidisciplinary

teams through a Medigap plan. To me, we have an untapped opportunity in treat for service.

The second example I'd give is even if we solve all the structural and technical services that Dr. Chin mentioned, we have forgotten the person in the middle of this. You and I all know, you know, two 80-year-olds, and I'm an emergency doc, coming to the emergency department, they can look identical on paper, but we know one is going to walk out of the hospital, and the other is at the end of the rope. Why? Because we have failed to take into account personal skill sets, characteristics that I now call the personal determinants of health, and we should call those out. It's under this rubric of resiliency, the ability to adapt and cope. We found in our population that those who were long resilient, cost 24 percent more PMPM[32]. If you are low on purpose, you have no reason for living, you have 12 percent lower PMPM. If you are severely lonely, you cost 20 percent more PMPM. In fact, we looked at five protective factors from resilience, purpose, locus of control, optimism, and social connections, and we

found for every one of these positive protective, strength-building skills that you have, you have lower depression, lower reported anxiety, lower fair reported health, and more functionality. In fact, for every one of those personal factors that we helped build, the secret sauce in helping you live well, we dropped $1,356 per person.

And number three, when we talk about equity, I would ask that you include, in addition to the really, really important ways that most of these fluctuating things that you add to your discussion of equity and ageism. I just read on a study that came out of the UK that clinicians are less likely, they only prescribe digital health tools to people who over 65, four percent, much less than they do for the 18- to 35-year-olds because there is this inherent bias that the older adults don't know how to use technology. But we have AARP survey data that last year 72 percent of people 50 and older actually bought new technology in the midst of the COVID pandemic; 77 percent of 70-year-olds actually have a smart phone that they use on a daily basis. So it is time for us to think about the

32 Per member per month

change. Only five percent of marketing images actually show an older person using technology. So, if you have no vision or hope that you are capable, and you have no sense of purpose, why would you think you can change it? So I would like to have us talk about ageism as kind of a bid or effort as my third recommendation for adding to equity.

CHAIR BAILET: Great, thank you. One more time with feeling, and we're going to try and reach out to Karen Dale. Karen, are you with us? (Pause.) All right. I'm hoping, fingers crossed, that she will get her computer issues solved here quickly and can join the panel.

MS. DALE: Oh, am I now? Can you hear me?

CHAIR BAILET: I can hear you now.

MS. DALE: Oh my goodness. We've been working on getting me connected since 1:20. It's just…

CHAIR BAILET: Karen, that in and of itself is a major feat so you have the floor, please. We're anxious to hear about you and what you have to say for the first question. Thank you.

MS. DALE: Sure. Karen Dale, I'm the Market President and CEO for AmeriHealth Caritas District of Columbia. I am also the Chief Diversity Equity and Inclusion Officer for the AmeriHealth Caritas family of companies. So I thought wow, let's see the first question is about which activities are useful across diverse populations?

CHAIR BAILET: Yes.

MS. DALE: Okay, I'll be brief. A couple of thoughts. The highest on my list is member engagement. We often are working hard to design something for someone with whom we rarely have enough of a direct conversation about what we're planning to build for them. So much more inclusion which is in important part of equity is having those direct conversations and respecting, honoring, and celebrating their voices. If they disagree with us, right? That's awesome if they have thoughts of their own about something as personal as their health care and the delivery system which provides them with services.

We should focus more as well on health literacy. Just because it's what we do every day, sometimes some of what doesn't happen is

based on not knowing, and it's not not knowing because they're not smart and capable people, it is not knowing because we've designed such a complicated system, and so ensuring that we work to provide information in simple, clear terms that you don't have to be an insider to understand is useful as well.

The other piece is around really leaning in when we have conversations to understand barriers. I often, when I speak with our members, I start with a question. I say, what is it that we could've done differently, right, that would've helped you to utilize the full variety of all the services we have available to you? In the District, we have the richest benefits, we have the most people covered. So to me, I look in the mirror first, and I say what else could we have done and that very open-ended question has given us so much rich information to better understand where we can improve, though we're very well intentioned.

CHAIR BAILET: Thank you, Karen. It's great to have you with us today. I'm glad we got you sorted out.

MS. DALE: It's been a journey.

CHAIR BAILET: And for those of you who are looking at Karen's photograph, her last name is D-A-L-E, I think the K got flipped in there accidentally, so I'm not sure that can get corrected, but just want to make everyone aware.

The next question, COVID-19 public health emergency, it's elevated the importance and urgency of addressing social determinants of health, health-related social needs, and equity within the health care system. So, I'm asking, can you speak to the lessons learned related to COVID-19 that have informed or extended your ideas on how initiatives for addressing social determinants of health can be incorporated into Alternative Payment Models and physician-focused payment models? The second part of that question is are there any specific lessons connected to addressing equity? We'll start with Kathleen then go to LaQuana and Charlotte. Kathleen?

MS. NOONAN: Right, thank you for this. When COVID-19 first hit in Camden, Camden city developed a mega site, like everyone was doing. Our community advisory committee, which is a committee of our board, so two of my trustees are people who live in Camden, told us quite

loudly that it was a terrible site for the mega site in Camden. It was a site where the prison used to be. There was no public transportation, and I told all of my partners, and we have a coalition so I meet with them, that my community advisory committee did not think it was a good site. The horse was out of the barn, and the site went forward, and we did a lot of shots for people from the suburbs, a lot.

So because we are a coalition and we come together, I was able to tell my community advisory committee that we were patient and that, you know, we were not going to burn effigies. We were going to sort of have a conversation about what went right and what didn't. We did in the summer, about three months after the site went up. We decided that the next time we were going to do COVID sites, because that one came down, we were going to do committee embedded COVID sites, in places where there was high walking traffic and public transportation and all of that. Whoever sat on the panel, and I know a couple of you did, but you have to engage with community members is absolutely right, but then you have to have a forum for that, right? So it can't just

be a one-off. It's got to be some ongoing regular forum. We were lucky enough in New Jersey, February 2020, that the governor passed something called Regional Health Hub legislation, and the Camden Coalition is one of those. We receive Medicaid 50/50 match dollars to be a convener of multisector partners. So as this mega site was going up and then coming down, we were actually sort of getting our sea legs on being a regional health hub. Now, through the state and the county and the hospitals, we're really convening much more regularly than we used to about how to do this work, and that includes our community members.

I can't underscore how important that is, and I was at a health system for 10 years, and I can say that that was really not a regular part of our practice. It was very much a one-off kind of thing.

CHAIR BAILET: Thank you. LaQuana?

MS. PALMER: So for our COVID work, we had a number of different things that just really happened to work in our favor as we were preparing for response. I'll share with you all that prior to moving over to the Secretary's

office, where I was sitting when, you know, COVID first began to come across a lot of our screens. I had just transferred from the Division of Public Health, Public Health Preparedness and Response branch. I was very, very, very, very familiar with how response worked and just really looking at interoperability and ensuring that we were able to reach our communities that have access and functional needs. So you have that one element. You have the next element of having NCCARE360. When we looked at COVID, we were building the plane and flying it at the same time. That just means that we were in the process of actually rolling out NCCARE360 as an electronic platform statewide. So instead of rolling that out at the end of December, we actually rolled out NCCARE360 at the end of June, so we were able to expedite using NCCARE360 throughout the state and use that as our leverage for interoperability to link up to those community-based organizations, our health care systems and then also our other folks in public health, as well and DSS[33]. So you add that element.

33 Division of Social Services

We were also building a workforce of community health workers as well. When you take building a workforce of community health workers, you then develop a COVID support program that is then onboarded onto NCCARE360, and you use those two things together where you have your community health workers on the ground, who are using NCCARE360 along with those COVID support programs that has things such as income support, has a number of supplies that individuals may need, and these are things that individuals needed while they were living in isolation in quarantine. So if you put all of those things together, we had a great program where we were able to use this just throughout COVID to help with:

One, linking individuals to those support services, and at the time we were not under managed care yet, so we were using a fee-for-service model. Using that, we were able to help with paying for a number of those different services, using our CARES dollars to ensure that those that were living in isolation quarantine were connected to the resources that they needed as they were being tested for COVID and also looking for vaccine sites as well. Using that

NCCARE360, not only just the platform, but the whole network as a whole, whether we were sending messages through our website, using our listservs to get additional messages. We just used all of our different networks of NCCARE360 to ensure that each individual was connecting to one another. That just has really helped us with even growing a number of different programs across the state.

CHAIR BAILET: All right, thank you. Charlotte? You're on mute, Charlotte.

DR. YEH: Is that working now?

CHAIR BAILET: Yep.

DR. YEH: Great. Okay. Thank you. So I'd like to highlight some of the "aha"s that came out of the COVID experience. We all know about the vulnerabilities of older adults, marginalized communities that were all highlighted by COVID, but here's one I don't know you if you've been thinking about, is the impact of hearing loss. About two-thirds of people 70 and older have hearing loss that is clinically significant. About 40 percent of 60 and older. It turns out, and I learned this through my dad who is 92 with severe hearing loss, that as we

shifted to technology and telehealth, et cetera, you can't communicate if you can't hear. So think about something as simple as mask wearing, and I'll just show an example here. How many of the masks actually cover your mouth and you cannot read lips and if you cannot communicate, you cannot stay in motion.

On top of that, how many of you who are switched to telehealth during COVID actually made sure that you had captioning capability. It turns out there are three captioning services through the FCC that you can get on your telephone, that you can get on your computer, but it doesn't necessarily apply to telehealth. So we literally had to adapt and put a tablet next to my dad's computer so that he could actually have free captioning off of the tablet through the app so he could follow the conversation, and out of that we learned that if he took his tablet or phone to the physician's office when he got to the physician and use captioning, he could actually communicate and understand.

Why is this important? There is a recent study out at Johns Hopkins that showed that people with a lot of trouble hearing are 46

percent less likely to have a usual source of care. Think of what that means to getting a primary care physician. That you are 85 percent less likely to have a usual source of care, 60 percent even with a little trouble hearing, and it impacts your ability to fill prescriptions and communicate. Simply helping and testing for hearing and thinking about how we communicate for the older Medicare beneficiary with speech that is helpful.

The second is ageism, and I'm going to go back to that. As I mentioned earlier, 40 percent of our Medicare supplemental population has a negative perception of aging. It costs them 33 percent more PMPM. This is hugely impactful. There was one study that says it costs us $63 billion, and you have a 65 percent higher rate of hospitalization, just simply by your view of aging. And yet, did you notice during the COVID pandemic, everybody's mental stress and mental health burden went up? Absolutely correctable, but if you look at it by age, it's highest among the young and lowest among the old. (Audio interference) relax and have older adults learn to cope with stress and anxiety, and can we

teach that across the population.

Then finally, I don't need to speak about loneliness and social connection, but we identified them. Early on we found loneliness was the single biggest predictor of dissatisfaction in health care among our older adults, and yet we never talked about it, and now with COVID, we've highlighted the criticality of social connection, being in your community, staying connected, and not just staying in the home.

CHAIR BAILET: Great. Thank you. Are there any other panelists that wanted to add a point of view on this particular question?

DR. CHIN: Marshall here. I'll add two points. One is that COVID demonstrated that the public cares about equity, that for some of the public this was a greater awakening of the realities and existence of inequities, and the public is ahead of policy making. There was a hunger for action on equity.

The second is that the COVID pandemic led to disruptive innovation within health care that worked around things like reimbursement of telehealth or expansion of scope of practice.

Basically broke years of political and organizational roadblocks, sort of showed that transformational change can occur. It sounds ridiculous but the idea that having a health care system and payment system that enables providers to address medical and social needs is revolutionary, well you know, that sort of requires, and COVID demonstrates, that you can do disruptive change.

CHAIR BAILET: Thank you. I wanted to take a minute and ask for my PTAC colleagues if they have any questions about this particular section before we move onto the next question. Any of the PTAC members have a question, just raise your hand, jump in. (Pause.) All right. So, we're going to move onto the next question, which is to get the panelists' thoughts on opportunities and gaps related to the collection and use of social determinants of health and equity related data.

Within the context of optimizing value-based care and APMs and PFPMs, what would it take to ensure that health-related social needs and social risks are universally screened by all health care providers and in a standard

way? In your experience, what are the best or most promising approaches for facilitating this type of data collection and sharing and again, we'll start with LaQuana, move to Charlotte and then Karen. LaQuana?

MS. PALMER: I'll say that one of the greatest things that we've seen here in North Carolina is the actual use of screening questions within the health care setting. In North Carolina, we do SDOH screening questions that we have shared throughout the state, and we actually took those screening questions and imbedded them in NCCARE360 as well, so in order to, you know, have those screening questions and where we're talking about what are some of the barriers or gaps that we see even with collecting those screening questions, it is down to the patient level. So if you are sitting with a patient and you have a provider and in North Carolina with those screening questions, we're using them in a variety of different settings, not just our health care settings and whether it can be based on organization. We're using an approach where we're going through any door to be able to ask these questions.

So you have these questions that are available, and when you begin to ask them, sometimes there are barriers with that provider that is asking the question. So we have to start there with building a workforce that is more comfortable with asking these types of questions, whereas in the past, we have maybe been very focused on the medical needs, and now that we are addressing those non-medical, unmet social needs, that is something that has to be done concurrently, and we're seeing an issue and a gap with having a workforce that either has the time, because sometimes we're seeing time is an issue to be able to implement those questions, or even having the staff that is capable of asking those questions. So there's a number of a different things that have to be addressed before you even get to the point where you are taking the data from something like NCCARE360 and, yes, in NCCARE360 we're able to track outcomes. If a question is asked and a need is identified, if these assessments are happening, these things are in place, we can't get that information unless a person is very comfortable or gets more comfortable with asking for a person's race and

ethnicity, gets comfortable with asking questions about age, gets comfortable with asking questions about interpersonal safety and a number of other different determinants that we have, you know, that serve as indicators. So before we can even get to that point where we can even track and look at what those outcomes and those trends look like, we've got to go back to again, when I say patient and care level to ask those questions of the medical homes first.

CHAIR BAILET: Thank you. Charlotte?

DR. YEH: Thank you. Just building on Dr. Palmer's comments, totally agree that starting simple with the screening questions before you dive in to get the really deep questions when the screenings turn positive. We found that we can then go back to our members or patients to get a little deep dive, but what's important is not just the comfort of the person asking the questions, but we found and we learned in surveying on these very sensitive topics, nobody is going to raise their hand to say I'm lonely or I'm in financial distress or I'm depressed. You know, people, there's a huge stigma associated with it. We found using more

technology approaches were more effective because they were nonjudgmental. That is hugely important based on the use of IVRs[34], use of technology enabled screening questions, survey tools as opposed to using a live person, which probably is an assistant and people would answer because it was nonjudgmental. So I'd like you to, you know, as you do the data collection, is to really keep that in mind.

The second thing I wanted to add is also what's missing that I think is critically important going forward. It has to do with caregiving. So right now there's some 53 million adults who are caregiving for everything from children to adults, 42 million of them are for the 65 and older, the Medicare beneficiary. I don't know how many of you know that seven percent of caregivers are 75 and older, and three-quarters of them are caring for people that are 75 and older. We know that there's huge stress on the caregiver. They are spending anywhere from over $7,000 per person in out-of-pocket expenditures that we don't capture. The average caregiver spends 24 hours per week caring

34 Interactive Voice Response

for a loved one. That 24 hours, over half of it is involved in advocating in front of government agencies, community organizations, and provider health systems for the care that they need. (Audio interference) are actually medical services that they are providing, you know, catheter care, IV hydration, injections, et cetera, and nowhere in any of the metrics that I've seen have we captured the intensity of the caregiver burden. How much time are you spending? How much finances are spending out of pocket, 51 percent of that actually is for housing costs believe it not, so imagine the bills of housing and SDOH, and then thirdly about the stress on the caregiver themselves of being able to care for themselves. Nowhere do I see us measuring that, and if you want to demonstrate effectiveness in SDOH, if you want to demonstrate effectiveness in a shift to home care, if you want to demonstrate effectiveness in where you're spending their money, we should also be measuring that reduction on intensity and stress on the caregiver.

CHAIR BAILET: Thank you.

DR. YEH: That's my two cents.

CHAIR BAILET: Thank you. I think that's more than a couple of cents worth. I wondered if there were any other panelists that wanted to provide a point of view here? (Pause.)

MS. NOONAN: We run an accountable health communities grant, a large grant where we're social screening in so many sites in South Jersey, and I would say that the number one thing that we see as a problem is that the whole care team doesn't really see the resources connected to the screens. So if there isn't really a very visible connection between the screen and the resources that are available, you know, people from the receptionist--from the receptionist, right, from the med tech, the nurse, have some ethnical problems with the screen, and so I think we just need to do a better job of showing people that there are resources connected with the screens.

CHAIR BAILET: All right, thanks, Kathleen. Jen?

DR. DeVOE: Yeah, I agree. I think screening is all well and good. I think it's important to identify medical needs as well as

social needs, but I think we need to get moving in our country on looking at the social deprivation of the community. Kathleen, you mentioned that your advisory committee knew the communities that needed the COVID vaccination sites, the testing sites, the resources, and yet we continue to focus on where it's easiest, where we can get the biggest quantity of people through the door. Quantity does not equal equity. We saw that time and time again with COVID and the services we put out into communities in exactly the wrong places. We have sophisticated geographic information systems. We have sophisticated data. We know from other countries, like New Zealand and the United Kingdom and from the work in Massachusetts and other areas within our own country, that you can identify a community and a place where a patient or a consumer lives. You can understand the social deprivation in that community. It might not be that that individual has every single risk factor that people in their community do, but it's pretty likely that the situation in which they live is impacting their health.

So there's so much that we can be

doing in a very simple way. I say simple, it seems like it's taken us a really long time to identify service providers, whether they're health care service providers or housing providers, education providers, and say you are located in an incredibly deprived area. You deserve additional resources. Yes, we're going to hold you accountable for spending those resources, but we're going to be incredibly flexible in having you listen to your community and what they need and measuring your outcomes in very creative and sustainable ways.

Otherwise, we are going to continue to have misaligned incentives where health care providers and all the other providers are going to go places where it's easy to keep people healthy because those people have money and have resources, and if we don't begin to really understand what it takes to improve the health of all communities, we are not going to make it very far with screening every individual patient at every visit. Oh and by the way, the people that have the most social needs don't often walk into health care settings, so are screenings are missing them.

CHAIR BAILET: Thank you.

(Simultaneous speaking.)

MS. PALMER: And if I could just add onto that a little bit more as well. I totally agree with you in saying that, you know, just identifying what the needs are is not enough, but something I'll tie onto that as well is when we're looking at our community-based organizations, who we are leaning on to provide a number of these services and resources. We're finding that a number of these, what I call grassroots homegrown, those individuals that will crawl under the bridge for you to pull those individuals out to find out exactly what is going on, those are the organizations who lack sometimes the infrastructure. They don't have the big boards that are available to help them with pulling in the number of dollars and things, so we're finding here in North Carolina where we are using capacity building dollars to help with those organizations who are doing work that's grassroots work to help them build up to the point where if we have a community health worker who is able to help them identify what the needs are, we have those other grassroots organizations

that are then able to work with those community health workers to ensure that we're linking to those individuals. I think it's important that as we are looking at value-based care, as we are looking at all these different models and you're building those resources for those individuals who are going to want to tap into those organizations, we're going to have to have those community investments into those smaller organizations to be able to help with doing this work. Because, again, I totally agree those individuals who have the greatest need, who have those access and functional needs, there are those individuals who typically, like you said, are not going to walk into this building. I come from a background where my jeans, my sneakers, and my T-shirt and I would go out there, and I will be the street walker looking for folks for those needs. Now using this as our opportunity to help, go back and make sure a lot of those organizations have the resources that they need to make sure they're linking folks in, so I totally agree with you.

CHAIR BAILET: Great. Thank you.

MS. DALE: I'd like to add just really

briefly just how much technology is an enabler to everything that we've been discussing. You know to reduce the stigma was already mentioned. Make it self-service. Also, leverage things like an HIE[35] that can house information for all the points of care. You can also build in many mechanisms to close the loop so that those smaller community-based organizations just have to get the information in, right? And it's a huge role that the managed care organizations can play, as well as aggregators and democratizers of data.

CHAIR BAILET: Thank you. All right, we have a couple of questions to get to before the last concluding question, so I'm going to motor on here. The next question is ways to properly account for all aspects of patient-centered care insuring health equity as a priority. In your experience, what types of care delivery, innovations, or practice transformations and Alternative Payment Models or PFPMs would have a direct impact on improving health equity? We've touched on some of these, but also what types of data have the most

35 Health information exchange

potential for measuring the equity-related impacts of these types of innovations? I'm going to ask Jen to start, then Kathleen and then Marshall. Go ahead, Jen.

DR. DeVOE: Yeah, I know there's several organizations based in communities doing incredible work with Accountable Care Organizations.

I do want to lift up one example from Hennepin Health Center in Minnesota and the work that they're doing. Going beyond using their hospital records, but also bringing in Department of Corrections, data from housing agencies, foster care, and identifying a very vulnerable population of patients that they're then able to address social needs as well as medical needs, dental needs, mental health care needs, and this has again linking back to some of the points that have been made. Flexible money to go to the community, identifying the community, linking them up with primary care, mental health care in very intensive ways, and then connecting all of the social services community organizations at the local level.

I think that's one example of

innovation. I know there's many others. You all represent some of them, but I was just really impressed. Beginning to look at metrics, I know it's certainly not all about saving money, it's about improving health. But very impressive that they have reduced medical expenditures by 11 percent annually for this population. Acute use and emergency department use decreasing by almost 10 percent, and then utilization of the outpatient care and primary care, mental health care services has increased. Continuing to look at overall metrics of population, health care quality improvement and equitable quality and improvement in health there as well.

One example where if you give an organization that's connecting communities to gather some dollars, hold them accountable, be flexible and comprehensive in the way that it gets spent across the different organizations. I think we're going to see some really great improvements if we continue to expand on those types of demonstration projects. Kudos to Hennepin, and I'm really impressed with what they're doing and what many of you are doing.

CHAIR BAILET: Thanks, Jen. Kathleen?

MS. NOONAN: Sure, the Camden Coalition has been running a regional health information exchange since 2010, and I think maybe the new parlance is community information exchange and that's probably what ours is. It's not focused just on the health systems. We also have shelter and food and other social services in that exchange. We have also been running an Aunt Bertha referral platform for about seven years so we have a lot of years of experience in these things. They are really important. They are like the foundation, right? You need those things in order to even create equilibrium between the health systems and everybody else and to be able to see patterns.

Also important on the practice level, you asked about data and what data you needed to collect around equity. You have to, have to, have to ask in your practice why are there are no-show rates? Why are people not showing up? To better understand your problems, you have to accept walk-ins. I mean these are just after years of doing this work, these should not be think about, these are have to do. Child and parent visits at the same time. Parent and elder

visits at the same time. Caretaker and elder visits at the same time. I take care of this person, treat them at the same time. Visits to the community.

These are things that have to be part of the standard of care and data points that we collect. That's sort of it, you need a regional data platform that connects to a statewide platform, but then you also need to really, really get at some practice changes and some qualitative data issues that are really important.

CHAIR BAILET: Thank you. Marshall?

DR. CHIN: So when you look at what works for improving care and addressing social determinants of health and advancing of equity, it's not rocket science. It's basically interventions that enable close relationships with patients, interventions in the systems that holistically address that person's medical and social needs and systems that allow close follow-up and monitoring of patients.

It's what many of the people have been talking about for the past hour, especially being able to spend time with the patient to understand

them and then address their medical and social needs. So it means team-based care, care coordination systems, seamless systems of care that integrate clinic setting, home setting, virtual care, inpatient care. It's care across the continuum so Jennifer has eloquently a couple of times talked about the partnership of health care system and the social service sector in addressing geographic-based social deprivation factors are all critical. It's primary care with aspects of specialty care.

Jennifer mentioned one of the two important NAM[36] reports that came up this year that are remarkably similar. It's a report on high-quality primary care and one on the future of nursing. Both have a very heavy social determinants of health, health equity emphasis talking about the types of systems performed, payment exchanges that need to occur to support these efforts.

I'd recommend that the panel looks at those particular recommendations and supporting community health workers, peer navigators regarding data. Data are critical for both

identifying a problem, designing interventions, eventually linking them to reimbursement and payment to support and incentivize these efforts. It may be doing things like stratifying clinical performance measures by social risk factors, such as race, ethnicity, socioeconomic status. It means that looking at, over time, is there improvement in performance? Is there retainment of appropriate levels of absolute performance? How do people against their peers, comparing apples to apples, for example.

Then I think it was either Kathleen or Jennifer, who also mentioned the importance of measures which may be new to health care, but are absolutely critical for population health. So metrics like high school graduation rates, housing rates, employment rates, measures of community and social cohesion, all critical, you know, for then improving community health outcomes.

Payment I'll talk about. I think we have a question coming up specifically payment, and I'll save my answers for that for later.

CHAIR BAILET: Thank you. Let's go

ahead and move on to our next question, and this is what are the most effective methods for collecting demographic data for equity? Again, Marshall just talked about many variables that could help assess equity from race and ethnicity, disability, primary language, sexual orientation, and gender identity.

So the question here is who would be best entity to collect this data and how? We'll start with Kathleen, then move to Karen and LaQuana. Kathleen?

MS. NOONAN: Yeah, I don't think there's one best entity just as my answer, you know. I think that we should all start collecting this data and then have a sort of embarrassment of riches with data and then figure out sort of, you know, how to make it as clean as we can make it. But I don't think there's one particular entity. I do know that at the Camden Coalition, we try very hard.

I know that community health workers are sort of the thing that we're all talking about, but the truth is, is that med techs and receptionists, they're all part of the care team. So getting them to actually be able to say, I saw

you didn't fill this out, why? Some people might say well, because I believe in a race blind world, right, which is what some people might say, and somebody that's able to say to them like well, here's why it's really helpful to fill that out, could be really useful. So thinking about training everybody to be sort of part of that discussion if you will, is really important.

CHAIR BAILET: Thank you. Karen?

MS. DALE: Sure, so I agree that we should all be helping to gather the information. My cautionary note is something our members say. They say to me, you all ask a lot of questions and then I go to the next person and they ask me the same questions, can't you all just talk to each other, right? So there's something in the human centeredness of our design that needs to account for that so we're not creating unnecessary abrasion.

The other component, which I don't believe, I know I was late getting on, I didn't hear us talk about is around trust. If, in fact, I believe that we are in relationship. If, in fact, I believe that in this relationship you truly care for me, you don't even have to ask me

the question, I'm going to reach out to you and say, can you help me with fill in the blank?

Somehow in our rush to do all the things and get all the information and all those things, we must determine the best way to establish an effective and trusting relationship early on because it pays so much dividends. I have members who we helped with something so many months ago or even years ago, when things go wrong they still have my number in their phone, right. So it's a matter of creating, because they know they're like--I usually don't tell them right off the bat I'm the CEO, right, because that would create this hierarchy in the relationship. So we talk and we talk and then they say well, what you do, and I tell them, they're like I've never talked to the CEO before. In doing so, we've created a dynamic where we're equals, right? So I would just encourage us to think about how to better establish relationships and lean in on that.

The other piece is to start where the other person is. So very often we start with, for example, some of my team, we have to work on this together all the time, we have pay for

performance measures, right. So, we're very acutely aware of those things that tend to impact that and then, of course, we all have our HEDIS[37] measures, so we tend to want to lean in on those. So, again, go back to something a lot more human-centered, which is to say I'm just going to ask a very open-ended question of this person, this other human being, and let's see what comes forward, because it's a much better way to build a relationship.

CHAIR BAILET: Great. Thank you. LaQuana, you're last up here.

MS. PALMER: I'll ditto what everyone has said so far. The thing that I would add along with that is when you're looking at your -- who I consider the frontline staff, those who were involved in that process of collecting the information, it's important to ensure that we have certain supportive trees to help them as well.

If you're looking at trauma-informed care, that approach to being able to ask those types of questions noted that when you're asking things related to race and ethnicity, if you have

37 Healthcare Effectiveness Data and Information Set

someone that is coming in and they identify as Latinx, there may be some real fear in sharing that information about exactly what their race or ethnicity is because they may feel there's no accommodation there.

They may block them from being able to receive certain types of services if they provide that information. To be able to have our staff go through things such as, in addition to the trauma care approach, comprehensive risk counseling services, which is a type of training that any of us can go through when they are on that front line to be able to ask these questions.

There's a number of different trainings that we can send our staff through so they can be prepared so that when those questions come, we are building that trust and we are able to build that connectiveness so that when they come in and the first time they ask the question, it's not the first time they've seen this person, so that's not the first time that they've been able to have that relationship with them. There's a certain level of trust and things that we have to build up with that frontline staff to

be able to help with building that relationship so when we do get to the back with their provider, whether it is our nurse practitioner or physicians or whoever it is, they are seeing our med tech, whoever it is, they are already building a level of comfort with them so they can get to the point where they can share that type of information.

Then we can be able to collect and be able to help them with different things. But we've also seen, and I'll speak specific to North Carolina, where folks are afraid to ask the question.

They go ahead and they fill out what they think that person is so we have very skewed data on a number of our different Native American individuals that live here in North Carolina because they never asked the question, just check the box that says white and Caucasian.

It's important to ensure that we are building that training and building that trust with our patients that are coming in to ensure that we are collecting that information correctly.

CHAIR BAILET: All right. Thank you.

This is the second to the last question. I'm hoping to allow enough time for concluding remarks around 10 minutes to the top of the hour because we're done at the top of the hour.

The next question is what are the best or most promising approaches for using payment mechanisms to incentivize efforts aimed at addressing social determinants of health and health-related social needs and advancing health equity? What services related to addressing health-related social needs in SDOH in advancing health equity could receive reimbursement under value-based payment models?

Two more parts. Can you tell us about existing performance or quality measures that could be used to meaningfully reflect improvements in addressing SDOH and health-related social inequity? Is there a need to develop a new measure to evaluate SDOH?

I'm going to go ahead and ask Karen, and then Marshall, and then Jen, please.

MS. DALE: There's a lot in there.

CHAIR BAILET: And we have a short amount of time so I'll ask you to laser in on the

most important elements here.

MS. DALE: All right. I'm going to jump in on the health-related social needs. Housing instability is high on the list of things that we know are predictors because it's the basis for our health and well-being.

Food insecurity. When you think about chronic diseases such as hypertension, cardiovascular disease, diabetes, healthier pregnancies, right? So those are my top ones in terms of social needs.

I also on the social determinants of health component, I put health literacy high up there because so many times when we label someone non-compliant, it is because there was somewhere in there a break in their understanding, so taking the time to ensure that people fully understand what it is that they need to know to support their health and resilience is important.

Then employment is also high on our list which we can do so much to become more in relationship in community by offering and supporting employment opportunities which really help as well in terms of mastery and greater independence.

Finally, I would just mention on social cohesion, there is more and more work happening with organizations such as Wider Circle, right? --- to figure out ways to make that social cohesion happen in a much more inviting, seamless. You know, it's not all health care ickiness that sometimes makes people want to step back. Those are the things I believe are important to focus on.

In terms of measures, since the health plans have to measure and gather information for HEDIS and whatever their pay-for-performance measures or focus areas for the state might be, I don't think we should try to immediately come up with something knew, right? We can build on what is there and what we need to do differently, though, is the lens through which we analyze -- which I believe has been said already, too -- we analyze the information.

Then finally in terms of how does this come together in a package; alternative payment methods really can work. They worked in a number of ways around value-based purchasing. It's a matter of helping to invest on the front end, especially for smaller practices, or even some

mid-size practices, that maybe we could be more -- "we" the managed care, or the state could be more matchmakers, right? -- to help create these cohorts of shared services.

So if we're talking about a four-block area, or a couple of zip codes where having a licensed dietician really be in that area, then can we figure out a way that the scheduling is shared, and then we are leveraging a resource for a great number of people.

CHAIR BAILET: Great. Thank you.

Marshall.

DR. CHIN: So I'm going to build upon Karen's excellent comments really focusing on the payment part. I want to focus upon three key levers to use. One is rewarding advancing health equity. This could be rewarding improvement in performance for less-advantaged populations, having the less-advantaged population achieving some threshold key target level of performance, and actually reducing a disparity in performance between more and less-advantaged populations.

In some ways that's the low-hanging fruit that a lot of people think, oh, payment reform, equity -- it’s actually pay for

performance. Helpful but not nearly enough and so critical. I would advise the panel to really sort of push organizations to also include the second component which, you know, building upon Karen's comments about Alternative Payment Models, which is the up-front payment for infrastructure. Again, like Kathleen mentioned this and Jennifer and all, the importance of flexible money, up-front money to basically fund the guts and infrastructure of interventions that are required to address SDOH and advancing health equity. Things like personnel and team-based care, need health workers. We talk a lot about information technology, social needs screening, referral. It can be organizations, bi-directional information sharing.

Then some of the most exciting work which, again, Kathleen, LaQuana, and Jennifer, among others, talked about were these community partnerships between the health care sector and social service agencies. These are things that requires up-front money for action.

I love the comments about geography based. I think it was Jennifer that talked about

that. It's critical to align efforts across payers. Ours was only one small payer. If you get the federal payers involved, of course, it can be incredibly powerful; Medicare, Medicaid, other privates. Think about how do you align other levers along these multi-stakeholders?

For example, including addressing social determinates of health in the medical loss ratio calculations and the contracting between payers in health plans is one example. Or the tax needs benefit that comes from the community needs benefit, how do you sort of tailor that to then address social determinants in geographic areas?

I will also mention too that, again, one of the frontier areas, how do you coordinate with social service sectors and then innovative ways to blend and braid funding streams. A couple examples are Rhode Island's health equity zones or some of the work Louisiana did after the hurricanes and some of their buildup that, you know, in some ways it would require these type of disruptive innovative changes regarding the finance schemes.

Then, third, and critical, and we

really haven't talked about it so far, is that for those providers, the safety net of the clinics, and hospitals and most providers that serve a lot of, particularly social and mental challenges, they can get killed if some of these plans that use value-based payments and Alternative Payment Models to address social determinants and the best equity, unless things were taken into account understanding their special circumstances.

They need more resources to level the playing field. Something like risk adjusting payment by medical and social risks, need to find a way so that we allow the safety net providers to succeed in these different systems that are designed to address social determinants of health and advance health equity.

CHAIR BAILET: Thank you.

Jen.

DR. DeVOE: Yeah, I was thinking about this at two levels. So building on what Marshall just said, at the patient-specific level, we are doing a lot with enhanced payments or adjustments for medical complexity. We can do the same thing for social vulnerability.

Again, we have that data at the geographic level. We can create social deprivation indices. The CDC has a vulnerability index that we can use so we are not putting the burden on our local providers to collect information and collect information that may or may not be accurate.

Flip the switch now. We are paying based on medical complexity, pay based on social vulnerability. Otherwise, the incentive is for hospitals and any health care providers to try to steer those patients away from their hospital to another hospital in order to have their performance look better.

The second level is at the community level. Again, communities matter. The place, the health of the community matters and the health of the individual. Are there systems that are making legitimate investments in their communities? This could be, are they using their data to not locate their primary care in the affluent communities, trying to lure those rich patients into their health care system or hospital? Are they using their data understanding where their sickest and most

socially vulnerable patients are coming from and locating their primary care in those places? Again, the incentives are not aligned with doing that right now. The incentive is to go to the rich neighborhoods. Let's change the incentives there. Let's identify systems that are doing the right thing.

Additionally, large health care systems, payers are anchor institutions. What are they doing to lift up their lowest-paid workers? Are those workers able to enhance their education? Are they able to become involved in training programs? Do their kids have access to college? Are they able to make a living wage?

These are the things that health care systems could be rewarded for as well with some type of Medicare bonus payment or some type of enhancement. Are you doing things in your community that are lifting up the health of your community above and beyond taking care of sick patients and billing Medicare for those patients' care?

CHAIR BAILET: All right. Thank you.

We have -- can the panelists stay on a couple minutes past 3:00, I hope? Okay. I do

want to give everyone an opportunity to provide any additional critical insights that they would like to share about social determinants and about inequity regarding APMs and PFPMs.

Anything around the relationship between them and their potential for optimizing outcomes for patients and anything around transforming value-based care? This is, you know, maybe a minute and a half or so for each of you. Let's begin with Charlotte.

DR. YEH: Thank you. Building on my comments earlier and from the rich conversation from the panelists, there are three things. One is on the payment issue. I want to follow up with Dr. Chin talking about payment and MLR, medical loss ratio, and social and personal vulnerabilities that were also mentioned. We should risk adjust for these.

More importantly, if you are spending effort on dealing with social and personal vulnerabilities, that counts as a medical expense. In the Medigap population, that counts as an administrative expense. It is not an even playing field between Medicare Advantage and Medigap and fee-for-service.

The second is, I would really caution people to not just measure all the things you are doing, but making sure as you are putting money into the health care system and the community that you are not shifting the burden onto the caregiver and onto the patient themselves. What is the time, money, and resource that they are now spending because we are failing to spend on it in the health care community?

Then the third is, and this is briefly transforming kind of the value base. Not only should we do going after risk reduction deficit model, but what are we doing to building the strengths, the personal strengths, the sense of resiliency, purpose, optimism, and changing how we can view how we age because that ageism costs us 33 percent more per member per month in health care cost. It could be as much as $63 billion in health care. I would love to see us remember the person in the midst of all of this as we address the health care and the community.

CHAIR BAILET: Thank you.

LaQuana.

MS. PALMER: I just wanted to share that our 1115 demonstration for healthy

opportunities is going to be going on until October 31st of 2024. I'm hoping that I'll be able to come back to this group to be able to discuss what are some of the things that we'll see in that demonstration because I do think it will be able to feed into a lot of the conversation that we're having today.

I'm really looking forward to sharing that as I begin to see the demonstration rollout. We are currently in a capacity building phase for building our network leads. We are building relationships with those payers. We are building relationships even with our human service organizations.

As we are doing that, we are documenting everything in every phase so that as we have that information available, we want to be a resource to the rest of you all to be able to share that information and the demonstration that we're doing here.

CHAIR BAILET: Thank you.

Kathleen.

MS. NOONAN: Sure. I want to share notes from a meeting I did with my community advisory committee after we received our null

findings on our RCT[38]. I met with -- I think most of you know what I'm talking about there.

So the 40 people, we explained to them that on readmission we showed no effect with our care model. Quote unquote, I have it right in my phone here what they said. This was January 23, 2020. When I'm feeling down, I just go back to it because it's what we need to do.

They said, "We were obviously asking the wrong question, readmissions. We need to ask better questions. How many people got housing and kept up with the program? I think you have to measure how people are involved with their community, their family. What are we helping them with? To go to regularly-scheduled doctor's visits? I had to learn those things and that is how I knew I was getting better."

So, anyway, I want to end on their voices, but we have to ask them what they need and then measure before doing that.

CHAIR BAILET: All right. Thank you.

Jen.

DR. DeVOE: I'm just reflecting on a couple weeks in the height of our COVID surge,

38 Randomized controlled trial

and our hospital packed to the gills, I spent seven days attending on our in-patient service. We had between 10 and 15 incredibly medically complex patients.

Most of them couldn't get into the ICU because our ICU was full of COVID patients, so they were on the floor with our family medicine in-patient team, many of the patients from our FQHCs and our family medicine clinics that we serve on the in-patient side.

It struck me -- I mean, I know this on the research and policy level but it struck me on the personal level. Every single one of those patients was below the age of 65 and would likely not make it to the age of 65 so they would never have access to Medicare.

It seems like an insurmountable challenge, but a small improvement for people, and a very important way to address their social needs, is health insurance. We've done a great job in expanding Medicaid. We have a lot of programs out there for socially vulnerable patients that are out there.

Certainly if we can't accomplish Medicare for All, maybe we need to think about

who gets Medicare and who doesn't. This may not be a very popular notion, but if you give people Medicare 25 years before their community's life expectancy, that means that a community with a life expectancy of 95 or 100 might not actually quality for Medicare until they are 70 or 75 years old.

Whereas another community whose life expectancy is 65, very close by as we've seen those maps that have been put out, might qualify for Medicare at 40. I know it's a very controversial notion there. Of course, all of us would like to see everyone with health insurance every day of their life, but it really struck me that these people are so socially vulnerable and so disadvantaged in so many ways.

These are primarily people in their 30s and 40s that were on an in-patient unit, whether it be COVID or other medical problems that were likely to end their lives incredibly early all due to in every single case of these 10 to 15 patients I cared for a couple weeks ago, social deprivation and social disadvantage.

Thinking about that and what we're going to do in our Medicare program, some of them

might qualify based on disability, but we know there's inequities in who gets access to Medicare before the age of 65. Most of them will not get any of these great transformative benefits that we are going to make for a Medicare program because they don't live to the age of 65. Something to really consider.

CHAIR BAILET: Thank you, Jen.

Karen.

MS. DALE: Sure. The first thing is around the fact that we need to advocate strenuously for the level of coverage that gives people that equal opportunity, or more than equal for those places where we see disparities in gaps, the opportunity to be healthy.

We chase the dollar after we've sometimes had a benefit design that doesn't support health and resilience. Right? So why not invest on the front end? I would say advocating for the types of benefits and the appropriate payment mechanisms to support them in terms of things like what's been said, including social determinants of health or how to pay for social risk factors and its mitigation in the payment structure.

The second thing is, I don't believe we've talked a lot about behavioral health, you know, carved in, carved out. Whatever we see oftentimes where someone hits a block, it is either a diagnosed behavioral health condition, or one that is not yet diagnosed.

Somehow we can get overly focused on all the medical things and forget that this human being is having a human experience in the ecosystem in which they exist. If we don't understand what is happening in terms of that experience. Are they becoming more depressed? Are they becoming more anxious? Right? And maybe not yet diagnosed. This is beyond social isolation.

If you think about what we've learned from the opioid epidemic, if you think about what we've learned where otherwise healthy, no risk factors, no major losses or things like that, what has happened with people during the pandemic, then we should take those lessons forward and invest more in the behavioral health components.

Finally, it's a focus on the provider experience. We often are designing and adding to

and not putting enough things on the chopping board in terms of our current model and expectations of providers. They can only do so much and take so much. We must vigorously review and be in relationship and conversation to identify what we can stop doing as well.

CHAIR BAILET: Thank you.

Marshall.

DR. CHIN: So we are in year 17 of running one of Robert Wood Johnson Foundation's measured health equity programs. I will share with you four aspects which we feel are cutting edge of equity now.

The first is aligning for measured stakeholders, the payers, the health plans, the health care liberalizations, and patients in communities. When you don't get everyone to the table, you rapidly reached a roadblock in how far you can go. Those intervention proposals that have been slowly co-created and co-implemented of these four stakeholders working together, they are more likely to have a major impact.

A second is that we're going to have increased focus on patients and communities. We've done that in our program, but we can do

better. My guess is that most organizations can also do better in true involvement of patients and communities.

Third, we talked a little bit about this today, but it's one of our major pillars of addressing structural racism and social justice moving forward and be really up front about the importance of addressing both the technical as well as the cultural. So having these discussions around racism and how that then sort of flows into the implementation process by actual technical intervention is critical.

Fourth, when it comes down to it, it's critical to integrate at least three different elements. One is payment reform. A second is that we just leave organizations in a lurch and, here, figure it out on your own. This coaching and technical assistance is provided to help organizations think about how they use payment and care transformation to advance health equity.

We are big, for example, on the whole learning collaborative idea whether it be shared learning and sharing best practices among peer organizations. But the third element is, again, this discussion around culture, racism, justice,

and ethics.

It's just like the overlay to everything. Unless that is actively discussed, this is not going to be the buy-in, the prioritization. What is really required is heart in conjunction with the technical and structural to advance health equity.

CHAIR BAILET: Thank you.

So I'm going to ask if the panelists -- we have just a few more minutes since we don't have that many folks queued up for public comment. I just wanted to turn it over to my PTAC colleagues if there are any important questions you want to ask the panelists before we wrap. It's okay if you don't have any, but I thought we would take this opportunity for any of the Committee members to ask the panelists a question at this point. All right.

So on behalf of the Committee and our audience, I want to thank each of you for your insights today. We are extremely grateful that you've been generous in sharing your expertise and your time with us.

This is amazing information, and we will be sure to take your insights and

incorporate them into our final document that we'll share with the Secretary. Again, thank you all. It was a privilege to have you on the panel today. Take care. Thank you.

*** Public Comment Period**

So as we transition, we have the next section is for our public commenters, and there's just a handful of folks who have signed up. The way this works is I will call on the individual, and they'll have three minutes. Working through the operator, they will have three minutes starting with their name, title, and organization. Then we'll go on to the next person.

To ensure that I have everyone who has signed up or wants to speak, I'll work with the operator at the end just to see if there is anyone else. Right now I've got two individuals starting with Jennifer Gasperini, who is the Director of Regulatory Affairs from the National Association of ACOs.

Jennifer.

MS. GASPERINI: Great. Can you hear me?

CHAIR BAILET: Sure.

MS. GASPERINI: Wonderful. Like you mentioned, I'm Director of Regulatory and Quality Affairs with the National Association of ACOs, or NAACOS. I'm glad to be here today to give some public remarks.

We really feel that ACOs are uniquely positioned to do this type of work. We are actually just about to release two white papers on this topic in the coming weeks so stayed tuned for more information, but I wanted to highlight a few of the things that we'll be addressing in those papers here today.

I think in order for ACOs to do more work in this area, we really need to provide funding to support expanding social services to address health equity; adjust certain benchmarks like financial benchmarks appropriately to not punish ACOs who are treating vulnerable populations; provide grant money to support this work; flexibility and payment rules to allow ACOs to deliver supplemental benefits to patients to help address health equity; and improve ACOs' access to data needed for care coordination to improve equity.

Finally, as was discussed today, we do

believe you need to reward improvements in this area which will require more uniform data collection, among other things, so we can accurately evaluate this work that is being done.

But, again, really just feel that looking across the population, as ACOs do, they are really uniquely positioned to do this work, and we want to really see models that use ACOs to support this type of ongoing work. So thank you for the opportunity to comment, and we will also be responding to the request for information.

CHAIR BAILET: Great. Thank you for doing that, and thank you for your comments today.

We have one other person from overseas who is trying to get on but, with the time differences, I'm not sure that person has been able to join us. It doesn't look like that's the case. I'll just ask my staff if there's anyone else who signed up for public comment. Hearing none, that was a very brief public comment section.

*** Committee Discussion**

So we now roll into the last section of our meeting. We are a little ahead of

schedule, but it gives us an opportunity to refine our perspectives based on what we heard today. This is where the Committee members and I are going to discuss our perspectives based on the conversations today of the one public comment, our guests, and information that Jay and the PCDT presented this morning.

As with previous themes, we are going to take what we've learned and write a PTAC report to the Secretary about how efforts to address social determinants of health and equity can be optimized in APMs' value-based care and, more specifically, physician-focused payment models.

There's a lot of information to sift through, so I'm going to ask the team, our staff, to share a framework, put that up, that will help structure our conversation. Committee members received this document. It's in the binders tucked into a pouch in the binders. Please use the hand raise feature in Webex, and then Amy will keep me on track to make sure I get comments in the order.

Let's just talk about -- again, we don't have to cover all of the waterfront, but

let's talk about promising approaches for optimizing efforts to address social determinants of health and health-related social needs in value-based care to improve quality and reduce, or control, cost.

There's two subsections here. Important activities that should be included. The second section is the extent to which promising approaches are likely to vary based on population, specialty practice size, geographic area, discipline, et cetera. So that's the first section. I'll open it up to the Committee members. Anyone want to weigh in on important activities that we should include?

MR. STEINWALD: This is Bruce. Something struck me. A number of the panelists mentioned patient-level adjustments for geographically determined social vulnerability and something I hadn't heard before.

And I would only point out at this point that there's an infrastructure for doing that in Medicare. They have the geographic practice cost indexes. But they're only designed to adjust payments for differences in the cost of doing business. And I wonder if there's -- since

the infrastructure is already there, I wonder if there's a way of expanding those adjustments to get at the vulnerability factors that aren't typically built in to payment adjustments.

*** Public Comment Period**

CHAIR BAILET: That's a great point. So I'm going to just throw this back to the Committee. The professor from Europe did get on the line, and I know we're a little out of sequence.

But we have time. I'd love to hear his perspective since he's calling from the other side of the world. If you guys will indulge me, is it okay to have him share his comments?

DR. DE MAESENEER: Yes.

CHAIR BAILET: All right. So it's Dr. Jan De Maeseneer. He's a professor at Ghent University -- might've pronounced that wrong -- in Belgium. Please go ahead, Professor.

DR. DE MAESENEER: Thank you for having this opportunity. I have been working for 40 years as a family doctor and was also a professor in family medicine and actually leading

WHO[39] Collaborating Centre on Family Medicine and Primary Health Care at University of Ghent in Belgium. What we did to address social determinants of health is we started 40 years ago a system of payment because that's the topic of this meeting where we have created and integrated niche-based capitation system for interprofessional teams of family doctors, nurses, physiotherapists. And now it will be completed with psychologists and so on.

So the idea is that those groups, they work in a community. They have five to six thousand people that they take care of. Most are underserved communities. For these practices, we have 200 intervention work actively.

And they have the patients on their list, and they provide integrated care. What is very important is that the team has also a social worker that's paid by the regional government and that helps to look at social determinants directly. And what we have seen is in the assessment of this kind of practice is -- and I've worked myself and inspected for over 40 years -- is that, first of all, we have a very

39 World Health Organization

low threshold, the practice I worked in, and dealt with people from 93 different countries in this practice population.

So it was really accessible. At certain moments, we did a comparative study and we saw that it was -- that we were unable to create a control group that was as deprived as the group that we take care -- that we took care of in the Community Health Centre with this capitation system. Another important element was that we did not choose for disease-oriented bundled payment programs because those people, they have -- most of them have multi-morbidity.

So we needed really an integrated approach looking at all the different components that contributed to the situation. So housing was important. And what we also did, we implemented community-oriented primary care.

So we used the records in our practice to make a community diagnosis apart from the patient diagnosis where we looked at the upstream cost of ill health. So actions were done in order to, for instance, create green spaces when we saw the bad physical conditions of our youngsters, improve housing conditions when we

saw that there were problems in that field. And recently, of course, we organized care and early diagnosis for the people in this multicultural community when it comes to COVID-19.

So what we learned and what the assessment showed that, on one hand, we were very accessible. A lot of poor people that we know the level of poverty that were cared for. We also took care of undocumented people. Actually, we have more than 250 in our practice. And also when it comes to quality indicators also in prevention -- and that's remarkable for such a kind of population -- we saw that we really could reach also with preventive actions people from very vulnerable socioeconomic groups.

And so that was, for us, a very important thing. And also, of course, we used that for training in order to motivate other providers, nurses, social workers, family doctors to start working in these kind of communities. Actually, in Ghent where we have 250,000 people, we have 11 community health centers with more than 100 physicians taking care of those people.

And the target population is not only people living in poverty. It's people that live

in a certain geographical area. So we don't want to have service only for the poor because we think that if you have service only for the poor, that risks to become a poor service.

And so we try to look at the whole population. And the other thing is we do a lot of advocacy in order to improve the living conditions of our population. And we do that because all in Ghent, we have a primary care zone that brings all the primary care providers together. And we have a strong kind of advocacy mechanism to really try to put the needs of our population on the agenda of the local authorities.

And actually, it's 40 years that this mechanism of payment exists. What we are now going to do is we are going to refine and improve the variables that are used for defining the needs of the populations we serve so that we can better adjust for the risks and the needs of our people and organize a payment accordingly. And probably we will be inspired by the ACG, Adjusted Care Group's model that's been developed by Johns Hopkins where you use the International Classification for Primary Care codes of your

patients in order to characterize their needs and also then adjust the payment accordingly to that.

So that's more or less what we did. And the advantage of this model was that now last for 40 years is that it was comprehensive. It took the whole population in an inclusive way and tried to improve the care for that population.

Of course, the threshold was very low. There was zero financial threshold. Of course, in Belgium, we have collective public insurance for a health system. So people have access through this system to the fact that there's a public insurance system.

So that was, more or less, what came into my mind when I saw the difference. Very interesting. Thanks for that. I appreciate it very much, kind of projects that actually are developing in PTAC which I think we have to exchange experiences to learn from each other --

CHAIR BAILET: Right.

(Simultaneous speaking.)

DR. DE MAESENEER: -- the needs of those people.

CHAIR BAILET: Right. Well, thank you for your comments. Thank you for reaching out

from the other side of the world from Belgium. And again, thank you for participating today. Appreciate it.

*** Committee Discussion**

I'd like to go back to the framework now. Bruce had just talked about sort of an SDOH GPCI[40] adjustment kind of approach which I thought was a novel comment, Bruce. It's something that hopefully captures the eye of folks who have an opportunity to actually put something like that in motion. Any other comments from the Committee members on that first part about promising approaches for reducing or controlling costs or a driving quality?

DR. LIAO: This is Josh. Actually, I was struck by similar comments as Bruce was, perhaps a bit of a different angle which is that I think a few individuals mentioned the value of area-level measures. We heard that in the morning as well as in the afternoon or later on, afternoon for me.

But then at the same time, we asked a number of questions related to individual capture. And what I grapple with here and someone

40 Geographic Practice Cost Indexes

hinted at it is on the area level, not every individual will have those needs. On the other hand, the individual is incredibly hard to capture data on for many reasons we all know well. Actually, some studies show that the agreement between those two can be as low as 30 or 40 percent.

And so one of the things I think is really important is gathering more data. To me, I think area-level individual play a role. I think as we think about using area-level to adjust, though, that's a critical piece of that activity. An important activity is to think about how we braid together in the process of getting to where we want to be.

And in that final state, area-level and individual-level measures, they probably won't always agree. And it's not quite clear to me yet how they should be used in what kind of sequence to achieve the goals. But I do think that that type of adjustment can help improve quality in this -- under this first question.

CHAIR BAILET: Thanks, Josh. Any other comments before I roll into the next section which is really built on the same

framework? But this is to address equity and value-based care to reduce or eliminate disparities. Same framework, what should be included, to what extent should approaches vary based on population, specialty, practice size, et cetera? Any comments there?

DR. FELDSTEIN: Well, Jeff, I think what I heard from a lot of our panelists, especially in the afternoon, is whatever we capture, we really need to keep the focus on the patient, on the consumer, on the individual as it relates to their community. Not just capturing data for the sake of capturing data for the provider community, but really put the needs of the patient first to really have patient-centered care, so that we don't end up making the same mistakes we've made for 30 years in terms of making it easy for provider, easy to administrate, but really not getting to the root cause problem that we're trying to address. And it seems in this instance, it really is to be focused on the patient-centered need.

CHAIR BAILET: Thanks, Jay. Anyone else have a comment on this section?

DR. LIAO: Yeah, Josh again. I would

just build on Jay's comment. I don't think they're at odds. I would just complement that by saying I take -- I value the second bullet there about kind of how these approaches might vary. What I heard from multiple people is this idea of practices or organizations that could be harmed, right, under payment incentives, mentioning kind of urban versus rural size of the practice.

And so I think it's incredibly important to center on the individual and their communities. I think if we believe that some of that is mediated by the type of organizations, then that second bullet becomes very important. And that's one of the things that came out to me implicitly for many of the comments.

We have to be mindful of that. Looping that back to my first comment about area-level measures, right, of deprivation, imagine two very different organizations. One is large, regional, draws a big catchment area. People travel across areas to get care for certain conditions versus maybe more rural providers, right? And so I really want to co-highlight that point as we think about Issue No. 2 here.

CHAIR BAILET: Thanks, Josh. Kavita?

DR. PATEL: Something Josh said sparked. It makes me think that if we're going to try to end disparities and have appropriately bold goals that so much of our information gets kind of locked within our own system. And even some of the programs the gentleman this morning, Dr. Reider -- Jacob Reider -- I'm going to mispronounce his last name.

I thought it was fascinating because when he talked about almost everybody does this kind of work where food pantry, in his case in the afternoon, thinking about, like, other community-based organizations. We have always had a model of data kind of where we just take it and pull it in. And if you kind of flip it and think about what most consumer -- what most people probably spend a majority of their time with, it's around food and work.

And is there a way to actually draw kind of some level of those patient-oriented outcomes by capturing some of that data in these other settings? So it makes -- it can make things complicated and kind of messy. But it offers, I think, such an opportunity because who better knows. I find that in working with those

organizations, they know the community much better than I do and their patients much better than I do.

I'm never going to have the kind of time and interface or that unique interface where it feels less hierarchical, which is also a problem in medicine. But anyway, just it brings up for both PTAC as well as an opportunity if somebody is thinking about submitting a proposal. It just gives a -- it's a really provocative idea and one that the Accountable Health Communities, I think, started but you could build off of in CMMI.

CHAIR BAILET: Thanks, Kavita. I'm going to go ahead and roll into the challenges because I think there was a lot of comments made from our panelists earlier, subject matter experts around challenges. So we'll start with the challenges related to the beneficiary and the caregiver needs. Anyone want to comment?

(No audible response.)

CHAIR BAILET: While you guys are queuing up, the thing that struck me the most was actually ageism. And the sort of pigeonholing of older people, like, they can't use technology.

I've heard that so much, especially working in California, that the older population is not tech savvy. And there are statistics, greater than 70 percent of older folks are very savvy in the technology space. And that just sort of highlights the need to change our sort of way of thinking in asking these folks and be more open minded.

The other point, being an ear, nose, and throat physician, she talked about hearing loss. And I certainly in my practice really appreciated the isolation that people with hearing loss essentially default to because it's exhausting to have to be asked to repeat your -- to ask people to repeat themselves. And after a while, they just become closed off.

And it's just the fact that you can break through with having technology help these individuals better communicate, really was inspiring to me, particularly when I saw that 46 percent of them were less likely to pursue the kind of care that we just normally take for granted. So the ageism concept is something that I think should get more focus. Maybe one other comment around the caregiver burden.

We're very quick to quantify the dollars that are spent on Medicare and Medicaid. But I think it's really sort of the unknown significant burden that's placed on caregivers, is the amount of dollars that the caregivers have to spend supporting nursing care that is not covered by insurance, skilled nursing facilities, assisted living facilities. There's a tremendous burden on the caregiver community.

People might have to leave their jobs to care for a loved one. And that's not calculated. And I'm wondering if there's some way to get some directional sense of dollars that are spent and start figuring out a way to assist caregivers when in providing care structures or care dollars even for those folks because of the burden --

DR. LIAO: Okay. I'm connected. Can you reset?

CHAIR BAILET: Yeah. What's that? Was that Josh? Maybe that was -- all right.

DR. FELDSTEIN: Yeah. Jeff, I mean, one of my -- one of the challenges that I think covers all of these is how we build a sustainable revenue stream to finance this from an

infrastructure standpoint and keep it going on an ongoing operational basis. So we have the $3.6 trillion spend of which, let's just for argument's sake, 80 percent is for health care services, traditional medical services. Are we going to reallocate resources from that pool to fund this?

Or are we going to take from additional revenue streams? Is it going to be self-financing through the savings of the traditional cost reduction inpatient hospitalization, decreases in ER visits? I mean, what's the sustainable revenue stream so we can achieve this goal?

CHAIR BAILET: Well, I welcome others to jump in. I think there was a picture of the little stick figure where 20 percent of the acute care makes up the holistic care for an individual. That's where most of the dollars, Jay, are going right now.

And we're clearly missing the boat because we're not getting the lift. We all know when we embed behavioral health in our primary care practices, the overall sense of well-being for our patients increases dramatically when they

have access to behavioral health on almost a real-time basis when those folks are actually in the same clinic setting. So I think we have to find a way to sort of inculcate social determinants into the medical sort of lexicon, if you will.

And it's not something different. Because as long as it's something different, the ability to access those dollars are going to be more challenging. That's my perspective.

All right. I think the next topic was challenges related to the provider needs, including information about community-based organizations. There was a lot of discussion about this. Anyone have any comments on this section?

DR. LIAO: This is Josh again. I wanted to move back to something that I think Kavita mentioned earlier. I think the idea of -- actually, it was something I said and I think she said.

I think the idea of capturing individual-level data in a comprehensive, shareable way, I think is good. But it's incredibly hard in the context of how we deliver

health care in many settings to do that right now. So I think so long as this question is -- for example, using area-level measures to change how providers are compensated in these models versus having providers use things like Z codes or other things or capturing data to screen things, I think it's incredibly hard.

That, to me, is a challenge. The thing that kind of was interesting to me, I think to Kavita's comment, was, are there ways to work with community organizations to not only actually fashion new measures that we should use but also a broader way of capturing data so it's not all just on provider organizations or not? I think that's a really problematic thing going forward.

CHAIR BAILET: Yeah, I agree. What struck me are the physicians. A lot of this is being placed on the backs of docs to try and ensure that, A, they're aware of what's available in their communities; B, they can connect to the patients and determine what they need; and C, they can actually refer these people to make sure that they get referrals. And then D, follow up and make sure they actually availed themselves.

And that's just unrealistic with the

practice of medicine today to expect all of that to be shouldered by the doc. And it's almost -- physicians naturally feel they want to take it on. And it's not the best -- they're not the best individual or the best point in order to drive that.

And the more we provide the infrastructure for practices to ensure that all those activities happen without it falling on the backs of the clinicians I think would be a huge win. And I guess the other question that I've seen in different communities that have been faced with these challenges in different parts of the country, a lot of activities are very siloed. And there's a lot of reproducibility and expenditure of resources, financial and otherwise, that are duplicative.

And where I've seen it work is where health systems make contributions and leverage their expertise. Not every health system or not every provider or clinic does the same thing. They coordinate and collectively contribute in their own ways where they add the most value on behalf of the social determinant folks who need those resources more readily.

So I think it's misguided to build these models where it's the physician or clinician responsibility. It clearly has to be part of the care team. But I would even go farther. I think more the responsibility has to fall within the communities themselves.

DR. MILLS: Yeah, I was struck with that same point, Jeff. And just one step further, I mean, it's fairly obvious and yet it bears repeating that it's such a huge enmeshed system of care and that every step of that system, we have to have a patient present. And you have to have screening done reliably, then you have to have the data and the results available at the right place at the right time with the right people.

And you have to respond. And you have to track the effectiveness of the response, then you have to find your gaps. All of that has to work.

Any single step not working and the whole chain of events that leads to improvements, the community health falls apart. So I think your point about physician practice, that being the focus and the brain that runs all that

probably is misguided, not well trained for that, not resourced for that, definitely has to be part of the system. What that best model looks like I think is still up in the air.

MR. STEINWALD: Yeah, the irony of the situation is that as you push things upstream, which a number of our panelists said needs to be done and what Jeff just said needed to be done, you're pushing the spending beyond what's typically thought of spending for health care services, right? So how do we tap into that $3.6 billion to provide upstream services that aren't strictly speaking health care services and yet have an enormous influence on our health care system, both the outcomes of patients and the costs of care? I'm a believer that we must be able to tap into the -- there's got to be a few hundred billion here and there to support an initiative like this.

CHAIR BAILET: Well, and Bruce, to your point, people aren't going to make those kinds of investments recklessly. And they're not going to make them without some ability to monitor the results. And I think that's another challenge that's listed here around the measures

that we would need to track progress.

First of all, what are they? And two, who would be collecting them and reporting on them? Anybody have a point of view on that?

(No audible response.)

CHAIR BAILET: I think one of the panelists mentioned that we shouldn't come up with a whole new set of measures, that we should probably try to adjust the measures that are out there. And I'm certainly a disciple of limiting and standardizing measure sets because that's just another point of abrasion to the practice, is to try and hoist a whole other set of measures on them. So we need to be thoughtful about the burden that that might create.

I don't know. You can see the questions there related to referrals, screenings. I'll just open it up to you guys. You guys can see the framework. I don't need to drain each slide. But these comments that we're making now will be incorporated into our draft.

I think one interesting observation was flexible, up-front infrastructure investments. And to a large degree, it wasn't

that long ago if you remember that HIE[41], everybody was putting a lot of money into physician practices to help get them on an electronic health record. I'm wondering if there needs to be a similar movement, to your point, Bruce, about earmarking certain dollars to try and get the infrastructure not necessarily in individual practices, but certainly in individual communities to give them the resources that the practice and community can plug into to help secure the resources that these folks need. What do people think about that?

(No audible response.)

CHAIR BAILET: Well, I'll throw that question out there. And maybe as we wrap up, any other observations that you guys want to make before we wrap that the staff can capture to put into our report?

DR. LIAO: This is Josh. I'll just add one thing. The gears were turning, Jeff, while you were talking. But I think one thing I think is important, what I really appreciate from all the panelists is kind of the diversity, the different kind of facets of this thing we're

41 Health Information Exchange

trying to wrap our arms around.

And I think when it comes down to how we think about payment models goes back in one part to that issue of evaluation. I really want to understand that we know what works. And it doesn't mean having incredibly restrictive ways of doing things, and you can allow flexibility.

But I think it could be helpful to think about the other side as well, that if we provide up-front flexible things that's incredibly flexible, you may have some challenges at the other side. So understanding, so what exactly is it that we did and what do you get for it, upstream or downstream, some accounting for that couple hundred billion that Bruce is talking about. And so I don't know if that means, like, a quasi-type of flexibility, but just keeping evaluation in mind, within the context of payment models as one of many solutions to address equity I think is important.

CHAIR BAILET: Yeah. Look, I would say, Josh, your study, your research that you shared with us this morning, it's very complicated. If it was easy, we'd already be doing it. And I'm glad to see that people are

digging in and trying to strike a path to find solutions.

And as you said, it's not one-size-fits-all. It's going to be a multifaceted approach. It's very patient-centric on what their specific needs and circumstances are because not everyone is homeless. Not everyone has food insecurity. Not everyone has a compendium of all of those elements, but many do.

And it behooves us as we're spending $3.6 trillion on health care. Not to say what the caregivers are spending, it behooves all of us. This is a problem that has to be solved. And it's not a red or it's not a blue problem. It's a math problem.

And if we continue to care for patients tomorrow like we do today, there just isn't enough money in the system to make it happen to drive the outcomes that the patients deserve. So that's just food for thought. Any other closing comments before we move into the last section here?

DR. LIAO: Actually, Jeff, if I could just mention one more thing here. I think it's relatively closing. I think one of the things I

took away from this whole day which has been great I think is that SDOH is not a monolithic thing. It's like this thing we just adjust away.

It's a lot of complexity there. We all know that. On the other hand, no, it's not a laundry list of things. Here are the 25, 40 things. And the intersectionality of it, right, to your point about homelessness versus minoritized status versus something else and how they cross over.

The road in front of us, there's opportunity. But it gets more complex. So I think a lot of the things we're highlighting now and what the challenges are in picking a set of things that are flexible enough but that we can evaluate, that we can move forward, I think are important because I think if we defer them, it only gets more complex. So I think those are some of the things I took away from our session today.

*** Closing Remarks**

CHAIR BAILET: Thank you. Any other comments? All right. So I want to thank everyone for participating today, the guest presenters, our panelists, members of the public,

all of you folks on PTAC. We explored a lot of different facets of SDOH and equity, including the types of relationships needed to be able to better connect health care providers with their local community-based organizations, to address social needs, the data needed to measure progress, how payment approaches can incorporate equity as you all seek to drive improvement in health outcomes.

We know there's an enormous amount of energy. We heard that from Dr. Fowler this morning, an interest in this space. And we think the PTAC has an opportunity to make a contribution, and we're going to have a Request for Input that we are posting on the ASPE PTAC website. And we're sending that out through the PTAC listserv.

And then in closing on a personal note, this is my last public meeting as PTAC's Chair. I'm grateful for the opportunity to serve on PTAC and want to thank my PTAC colleagues and all of the ASPE leadership and staff for their support. It's been an exciting journey, and it's bittersweet to say farewell to my time on the Committee.

For the last year of my tenure on the Committee, I've had the honor to serve with Dr. Paul Casale as the Vice Chair. As I said earlier, unfortunately, Paul was not able to join the public meeting today. But I'm delighted to announce that he will be taking over as the Chair of PTAC. And I know I'm leaving the role in very capable hands.

Serving alongside Paul as Vice Chair will be Lauran Hardin. And she unfortunately also was called away for a family emergency today. But I know she will be wonderful in this role.

I'd also like to mention that this is the last public meeting for another one of the founding members of PTAC, Kavita Patel. Dr. Patel, she's been here since the start. And it's been a pleasure to work with her.

*** Adjourn**

And in closing, this has been really truly an honor. And I wish my colleagues on the Committee all of the best. Please take care. Be well. And the meeting is adjourned. Thank you.

(Whereupon, the above-entitled matter went off the record at 3:47 p.m.)

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Meeting

Before: PTAC Advisory Committee

Date: 09-27-21

Place: teleconference

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R Gross

Court Reporter