

Physician-Focused Payment Model Technical Advisory Committee

Questions/Topics to Guide Subject Matter Expert Panel Discussion

Subject Matter Expert (SME) Panel Discussion: To assist in grounding the Committee’s theme-based discussion, the first presentation of the day will describe which definitions PTAC is using: the Agency for Healthcare Research and Quality’s (AHRQ’s) definition of social determinants of health (SDOH), the Centers for Disease Control and Prevention’s (CDC’s) definition of health equity, AHRQ’s definition of behavioral health, and a definition of health-related social needs (HRSN) that is similar to what has been used by the Centers for Medicare & Medicaid Services (CMS) to create their social needs screening tool to support the [Accountable Health Communities Model](#) (see page 3 for definitions). At the beginning of the panel discussion, the facilitator will introduce each panelist, noting that full bios are available on the [ASPE PTAC website](#) (to be posted before the public meeting). The facilitator will then ask the italicized questions below. Unless otherwise specified, the facilitator will invite two to three SMEs to provide their particular expertise and perspectives for each topic. Other panelists will also have an opportunity to provide their perspectives on a given topic, time permitting. Some panelists may have expertise to share in more than one area. Panelists will also have an opportunity to respond to follow-up questions from PTAC Committee members.

NOTE: In the interest of ensuring balance across different perspectives and questions, the facilitator will encourage all panelists to keep each response to a few minutes.

A. The role and aims of addressing SDOH and advancing equity in the context of value-based care and alternative payment models (APMs) and physician-focused payment models (PFPMs):

Question 1. Based on your perspective and expertise, please tell us what you see as the role and the objectives of SDOH and equity in the context of value-based care. What specific activities related to addressing SDOH, health-related social needs, and equity are most important for improving quality and reducing costs in APMs and PFPMs? (All of the panelists will be asked to respond.)

- Which activities are useful across diverse populations? Are there any approaches that are particularly relevant to or successful for Medicare beneficiaries?
- Do these activities vary based on specialty, practice size, setting, geographic area, or discipline?
- What health-related social needs are most relevant for optimizing value-based care?

Question 2. The COVID-19 public health emergency has elevated the importance and urgency of addressing SDOH, health-related social needs, and equity within the health care system. Can you speak to the lessons learned related to COVID-19 that have informed or extended your ideas on how initiatives for addressing SDOH can be incorporated into APMs and PFPMs? Are there any specific lessons connected to addressing equity? (Three panelists will be asked to respond. Other panelists may also respond, time permitting.)

B. Optimizing value-based care delivery in APMs and PFPMs through the collection and use of SDOH- and equity-related data:

Question 3. Next, we’d like to get your thoughts on opportunities and gaps related to the collection and use of SDOH- and equity- related data. Within the context of optimizing value-based care in APMs and PFPMs, what would it take to ensure that health-related social needs and social risks are universally screened for 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? (Three panelists will be asked to respond. Other panelists may also respond, time permitting.)

- What are the challenges related to collecting data related to SDOH, health-related social needs, behavioral health needs, and equity faced by patients, providers, and others? What can be done to address those challenges? Are there any challenges unique to specific populations, such as for Medicare beneficiaries?
- How can the accuracy of this data be validated prior to sharing?
- How could the development of cross-sector partnerships that link health care and social service data be incentivized?

Question 4. As we think about ways to properly account for all aspects of patient-centered care, ensuring health equity is a priority. In your experience, what types of care delivery innovations or practice transformations in APMs and PFPMs would have a direct impact on improving health equity? What types of data have the most potential for measuring the equity-related impacts of these types of innovations? (Three panelists will be asked to respond. Other panelists may also respond, time permitting.)

- Are there innovations that have been implemented in specific populations, such as Medicare beneficiaries?

Question 5. What are the most effective methods for collecting demographic data for equity? There are many variables that could help assess equity, from race and ethnicity, to disability, primary language, sexual orientation, and gender identity. Who would be the best entity to collect this data and how? (Three panelists will be asked to respond. Other panelists may also respond, time permitting.)

- What are the types of healthcare data for which healthcare providers measure and report information relating to equity (e.g., utilization of healthcare and social services, patient health outcomes, patient satisfaction, etc.)?

C. Performance measurement and reimbursement of SDOH- and equity-related initiatives:

Question 6. In your experience, what are the best or most promising approaches for using payment mechanisms to incentivize efforts aimed at addressing SDOH and health-related social needs, and advancing health equity? What services related to addressing health-related social needs and SDOH, and advancing health equity could receive reimbursement under value-based payment models? Can you tell us about existing performance or quality measures that could be used to meaningfully reflect improvements in addressing SDOH, health-related social needs, and health equity? Is there a need to develop new measures to evaluate SDOH- and equity-related efforts? (Three panelists will be asked to respond. Other panelists may also respond, time permitting.)

- What types of measures can best reflect improvements in equity within the context of measuring overall population health?

D. Conclusion:

Question 7. Are there any additional critical insights you would like to share about SDOH and equity in APMs and PFPMs, the relationship between them, and their potential for optimizing outcomes for patients and transforming value-based care? (All of the panelists will be asked to respond.)

Attachment: Social Determinants of Health (SDOH) and Health Equity Definitions Being Used by PTAC

PTAC is using the Agency for Healthcare Research and Quality's (AHRQ's) working definition of the term social determinants of health (SDOH) and the Centers for Disease Control and Prevention's (CDC's) definition for the term health equity as a guide for focusing the discussion during the September 2021 Public Meeting:

Social Determinants of Health: *"SDOH, although experienced by individuals, exist at the community level. Healthcare systems that learn about the communities their patients live in, and the community-level barriers members can face to becoming and staying healthy, can better adapt their recommendations to people's lives. SDOH can be categorized into five key areas:*

- **Social context:** (e.g., demographics, social networks and supports; social cohesion; racial, ethnic, religious, and gender discrimination; community safety; criminal justice climate; civil participation).
- **Economic context** (e.g., employment, income, poverty).
- **Education** (e.g., quality of day care, schools, and adult education; literacy and high school graduation rates; English proficiency).
- **Physical infrastructure** (e.g., housing, transportation, workplace safety, food availability, parks and other recreational facilities, environmental conditions, sufficiency of social services).
- **Healthcare context** (e.g., access to high-quality, culturally and linguistically appropriate, and health literate care; access to insurance; healthcare laws; health promotion initiatives; supply side of services; attitudes towards healthcare; and use of services)."¹

Health Equity: *"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.'"*²

Behavioral Health: *"Behavioral health 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 illnesses."*³

PTAC is also defining **health-related social needs** as *"non-medical patient needs that impact health (such as housing instability, food insecurity, and exposure to interpersonal violence)."*⁴

¹ Agency for Healthcare Research and Quality. About SDOH in Healthcare. <https://www.ahrq.gov/sdoh/about.html>

² Centers for Disease Control and Prevention National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). Health Equity. <https://www.cdc.gov/chronicdisease/healthequity/>

³ Agency for Healthcare Research and Quality. What is Integrated Behavioral Health. <https://integrationacademy.ahrq.gov/about/integrated-behavioral-health>

⁴ Billioux A, Verlander K, Anthony S, and Alley D. (2017) Standardized Screening for Health-Related Social Needs in Clinical Settings: The Accountable Health Communities Screening Tool. <https://nam.edu/wp-content/uploads/2017/05/Standardized-Screening-for-Health-Related-Social-Needs-in-Clinical-Settings.pdf>