House Energy & Commerce Committee, Subcommittee on Health
Summary: "Empowered by Data: Legislation to Advance Equity and Public Health"
June 24, 2021

The House Energy & Commerce Committee, Subcommittee on Health held a legislative hearing where Members considered 13 bills addressing health equity, public health data, and social determinants of health. In addition to the legislation before the Subcommittee, topics discussed included: addressing social determinants of health in Medicare Advantage supplementary benefits, improving public health data collection, the importance of cross-sector and public-private partnerships, health information exchanges, addressing structural factors impacting health, privacy in the collection of health and social needs data, modernizing data systems and public health infrastructure to identify and mitigate disparities, addressing maternal health, engaging the community in efforts to address social determinants, and more.

Members attending the hearing included: Chair Eshoo (D-CA), Ranking Member Guthrie (R-KY), Reps. Pallone (D-NJ), McMorris Rodgers (R-WA), Matsui (D-CA), Castor (D-FL), Sarbanes (D-MD), Welch (D-VT), Schrader (D-OR), Cardenas (D-CA), Ruiz (D-CA), Dingell (D-MI), Kuster (D-NH), Kelly (D-IL), Barragan (D-CA), Blunt Rochester (D-DE), Craig (D-MN), Schrier (D-WA), Trahan (D-MA), Fletcher (D-TX), Upton (R-MI), Griffith (R-VA), Bilirakis (R-FL), Bucshon (R-IN), Mullin (R-OK), Carter (R-GA), Dunn (R-FL), Curtis (R-UT), and Crenshaw (R-TX).

Witnesses

- **Romilla Batra,** MD, MBA, Chief Medical Officer, SCAN Health Plan
- **Beth Blauer**, Executive Director, Johns Hopkins University Centers for Civic Impact
- **Karen DeSalvo,** MD, MPH, MSc, Chief Health Office, Google Health
- **Faisel Syed**, MD, National Director of Primary Care, ChenMed
- **Kara Odom Walker**, MD, MPH, MSHS, Executive Vice President and Chief Population Health Officer, Nemours Children's Health System

Key Takeaways from Opening Remarks

Committee

Chair Anna Eshoo (D-CA), Subcommittee on Health

- Since 2010, spending for state public health departments dropped by 16 percent per capita and local public health departments by 18 percent. At least 38,000 public health jobs have disappeared since the 2008 recession.
- This country once had a globally respected public health system, and our disarrayed data system has broader consequences for so many Americans. It has allowed racial health disparities to persist without intervention, and we can't manage what we can't measure.
- Several of the bills considered today use data to help our health system improve the overall health and wellness of populations rather than treat individual sickness.
- I'm proud to co-lead the Health STATISTICS Act (H.R. 831). Put simply, public health data is a mess. A striking example is the incomplete and inconsistent COVID-19 case counts and death tallies.
- Beyond COVID, inconsistent public health data have been raised repeatedly as an issue before the Subcommittee in previous hearings. There is no specific example of how to determine a maternal death, for example.
- Robust and accessible public health data is a critical tool for state and local officials in their efforts to address the social determinants of health (SDOH) that perpetuate inequities in communities.

The [Improving Social Determinants of Health Act](#) (H.R. 379) builds and complements the [Health STATISTICS Act](#) by authorizing the Centers for Disease Control and Prevention (CDC) program to address SDOH.

- The remaining bills work together to address health disparities. I'm proud our Subcommittee is leading the charge in a bipartisan way to promote health equity and data-driven policy. These 13 bills will make real and lasting change to rebuild our public health system to address new and persisting emergencies like COVID and address ongoing systemic issues.

Ranking Member Brett Guthrie (R-KY), Subcommittee on Health

- We have several bills pertaining to SDOH and collecting health data before us today. Medicare Advantage (MA) can help address these social factors for seniors. MA plans continue to offer benefits to address SDOH. For example, 57 percent offer meal delivery services and 11 percent offer home modification.
- Nearly half of the eligible Medicare population is estimated to choose MA plans for 2022. Medicare for All would prevent beneficiaries from choosing such quality plans that offer services to address SDOH.
- The Subcommittee is considering several public health data bills. Some of the bills are too narrow in scope and duplicative of current efforts. There is no consensus of who needs to collect what data, how it will be used, and how to do it in a way that does not add more administrative expense.
- We must use lessons learned to prepare for future pandemics rather than focus on COVID-19-specific authorities for duplicative programs. The [Tracking COVID-19 Variants Act](#) (H.R. 791) includes provisions that would require the CDC to have collaborations in data sharing for COVID sequencing. Data sequencing has already been done on variants today. The [ETHIC Act](#) (H.R. 976) would retroactively require states to report COVID data – states are already required to report some of this data.
- I hope we can work at a bipartisan way to improve America's public health infrastructure to ensure we are better prepared for the next pandemic. We need to make sure taxpayer dollars are not used on duplicative programs and are used efficiently.

[*Chairman Frank Pallone (D-NJ)*](#)

- Public health departments have at timed lacked the information they need to understand the impact of disparities on communities.
- The slated bills being considered will make targeted improvements across three key areas: a unified federal strategic action plan on data standards and data sharing policies; collection of public health data that reveals drivers of health inequities; and discussion of proposals to create the public health data infrastructure necessary to create successful interventions.
- Public health data is essential for the health of the country. It allows us to understand health inequities and address them accordingly, and allows leaders to make upstream policy changes.
- Uniform data collection is imperative to better understanding inequities in our system and to guide real change. We need to be able to standardize and collect data related to social conditions. These interventions will also improve the health and wellbeing of the most vulnerable populations.
- Because of the resources Congress has provided through COVID relief packages, data modernization is underway and we must continue work to ensure public health departments are working with real-time data to better understand SDOH.
- Improving things like data collection infrastructure and public health will help us to be better prepared for future pandemics.

Ranking Member McMorris Rodgers (R-WA)

- Social and economic conditions have a powerful influence on health and wellbeing. These are all factors that make a difference in prevention and management of many conditions.
- We are only at the beginning of understanding the impact COVID lockdowns have had on mental health during the pandemic. We should be looking to how the private sector is leading the way to help communities.
- Meal delivery services are helping seniors access nutritional food, and MA plans offer coverage for these and similar services. About 60 percent of MA beneficiaries are enrolled in a plan that offers food assistance. The number of plans offering supplemental benefits tripled between 2020 and 2021.
- I look forward to listening to and learning more from witnesses on how MA flexibilities are helping to address SDOH for seniors and what more we can do to incentivize the private sector.
- In 2021, MA plans covered 26 million people, a little over 40 percent of the entire Medicare population. Seniors of all walks of life are choosing these private-run plans over government-run health plans. I am concerned about proposals that would ban MA plans and switch to a one-size-fits-all government run plan.
- As we look at data policies, we need to be clear about who is collecting what data and how it will be used. Some of the bills authorize an enormous sum of money. That approach does not drive results. I have concerns with continuing short-sighted COVID legislation. The big pandemic is yet to come, according to former CDC Director Robert Redfield.
- We need to be working on preparing data systems and public health for all threats, not just COVID, and take into account where these systems are after large investments made during COVID-19.
- Doctors, hospitals, state and local governments and health insurers are leading the way tackling SDOH. We need to encourage their continued leadership and success in tackling these roadblocks.

Witnesses

Karen DeSalvo, MD, MPH, MSc, Chief Health Office, Google Health

- Today's hearing takes place at a historic moment as we chart the road to recovery from the pandemic. The vision of this hearing recognizes how COVID-19 pulled back the curtain of the structural issues that exposed the disparities in the health system.
- Building resilient and equitable public health systems begins with cross-cutting solutions. Many of the proposed bills in today's hearings share this ethos. I offer the following recommendations to inform the Committee's vital work:
    - Legislation and policy making must focus on the systems that collect, exchange, and act on data, rather than the data itself. Recently proposed legislation for the public health infrastructure fund highlights the stable foundation of resources health departments will need, from infrastructure upgrades to workforce investments.
    - Public-private partnerships can maximize the value of data for governmental public health. To optimize these beyond the pandemic, we need to develop data infrastructure within public health focused on racial and rural disparities like the ones proposed in the bills today.
    - Achieving equity requires expanding our understanding of what data can be useful. Public health can leverage novel data signals in a privacy-preserving manner to inform research and public health decision making, such as where to dedicate more resources. Data systems aimed at addressing inequities should integrate data from the social and human services sectors.

- o Data systems need to be built to describe inequities at the individual and system level. Understanding where kids might not have access to sidewalks and playgrounds can help communities take action.
- o The CDC's data modernization effort would benefit from incorporating lessons learned from the Health Information Technology for Economic and Clinical Health (HITECH) Act. There needs to be opportunities to do more than require the current systems but to reimagine it. The 21st Century Cures Act articulated this vision by advocating for the use of open standards, and FHIR-based for APIs for the health system – which can also be used for public health. States and localities should not be rushed in spending the funds to ensure they can maximize impact.

Romilla Batra, MD, MBA, Chief Medical Officer, SCAN Health Plan

- The mission of SCAN Health Plan is to keep seniors healthy and independent. It was founded by seniors who wanted to age in place in the community, and were true pioneers who knew the importance of SDOH.
- SCAN is the only plan in California to offer a fully integrated dual eligible special needs plan.
- SCAN's approach to addressing SDOH is identifying what the social risks are across a population to match them with services and benefits, serving our members and clients, measuring the impact and scaling what works. We have consistently done health risk assessments to gather health and social needs data, as well as demographic data including race and language.
- SCAN offers different programs to stratify and serve members. We have a member-to-member program to interview members and engage them in programs to address their social needs and mental health. We have seen improvements in things like social isolation and physical activity.
- We have programs like connecting providers to homes, where we have a social worker and community health worker in the community that addresses the needs of the top one percent of the population with high social needs.
- We use our data to identify unmet needs and include supplemental benefits to address them. For example, the Return to Home benefit helps older adults get discharged to their home and includes caregiving support.
- We ask that Congress include SDOH such as food insecurity into supplemental benefits and that Congress specifically consider supporting the Ensuring Parity in MA and PACE for Audio-Only Telehealth Act (H.R. 2166), as telehealth and internet access became a SDOH during COVID.

Beth Blauer, Executive Director, Johns Hopkins University Centers for Civic Impact

- The bills that are the subject of today's hearing go a long way to realign resources with interventions that are proven, measurable and focused on ending multigenerational disparities.
- Governments have built data collection efforts to share data and make real-time decisions based on this data in the last 18 months. This has never been done at such scale. Local and state governments used every possible lever to stall the spread of this disease.
- Johns Hopkins became a trusted resource for millions of viewers worldwide. We created a methodology for scraping public data, and encouraged state and local governments to share their data in standardized way. We articulated standardized collection efforts under guidance of public health. By January 2021, we accrued more than a billion views.
- There are some lessons I can offer that have been helpful in my public sector career:
    - o We need data standards – one of the most important elements of a strong data practice is in the governance and alignment.

Key Takeaways from Q&A

Social Determinants Accelerator Act

- **Rep. Welch (D-VT):** I want to bring up the Social Determinants Accelerator Act. The Vermont housing needs assessment showed that over 19 percent of households in 2020 face housing quality issues. Dr. Walker, you mentioned this bill in your testimony. Are you aware of any cities or states that have developed any strong models to improve housing and health outcomes at the same time?
  - **Dr. Odom Walker**: There are a variety of examples that are critically important around housing, non-medical transportation, home delivered meals and more. Some states have incorporated waivers in their Medicaid programs, like in North Carolina where they incorporate this into their value-based payment. Minnesota has a waiver that looks at the provision of housing stabilization for individuals at risk for homelessness. Using these examples in innovation is helpful, and allows us to invest in families to address mental health and wellbeing for children and adolescents. Encouraging this across the nation could have a tremendous health impact.
- **Rep. Schrader (D-OR):** Oregon's Coordinated Care Organizations (CCOs) have worked well to deliver Medicaid benefits. They work from the ground up and have community organizations that know that community best help address SDOH. It should be about providing quality health care. Ms. Blauer, with the interagency council suggested in Rep. Bustos' Social Determinants Accelerator Act, how do you see best practices like in Oregon getting to folks across the country?
  - **Ms. Blauer**: Often when we talk about data and IT infrastructure, our gut is to put these folks on committees when we really need subject matter experts that are knowledgeable about the impact of program decision making and impact on the ground. They need to be staffed with people who have expertise and understand how to leverage tools and technology. We need leadership that can lead with prioritization to have clear goals that are articulated and measurable. Governance allows you to create prioritization with inputs of that subject matter expertise.
- **Rep. Bilirakis (R-FL):** Data drives decision making and the integrity of the decision is in the integrity of the data. Florida's COVID story is one of success driven by reliable data and following the science. Dr. Walker, Rep. Blunt Rochester and I introduced the CARING for Social Determinants of Health Act (H.R. 3894) to provide regularly update guidance to states to address SDOH under Medicaid and CHIP. Several members of the committee are championing the Social Determinants Accelerator Act (H.R. 2503), which would help states devise strategies to better leverage existing programs and authorities to improve health and wellbeing of those in Medicaid. How might HHS do more to coordinate SDOH efforts even without additional congressional authority? Can you explain how HHS can use its leadership in Medicaid to more broadly categorize efforts to better coordinate and measure impact of resources and initiatives to address SDOH?
  - **Dr. Odom Walker**: It is critical to think about how to refine ongoing guidance to states about how to address SDOH. It was extremely helpful to have updated guidance provided – it informs waivers and how to think about state plan amendments. This helps give clarity around where existing resources can be deployed and used most efficiently. I expect we will continue to learn from models like in North Carolina, but having evaluations and data available can be useful. Providing resources for technical assistance can be beneficial.

- **Rep. Kuster (D-NH):** One of my main focuses is addressing health access issues in rural communities, which are often underserved and under resourced. We need a comprehensive approach to tackling this problem. The existence of food deserts represents a challenge to rural communities and is linked to health outcomes. I'm pleased today's hearing includes the [Social Determinants Accelerator Act](). Ms. Walker, your testimony touches on this bipartisan legislation – can you expand on it to discuss how it will help rural communities address negative SDOH?
  - **Dr. Odom Walker**: There is an interconnection between how we look at health and social factors that influence health. Creating partnerships between state and local agencies is important – in light of the pandemic, those interconnections were even more important to address inequities. Having the ability to provide technical assistance and resources to ensure we are doing more of what works and focusing on communities of greatest need is important.
- **Rep. Craig (D-MN):** I appreciate the focus on the drivers of health disparities. Many folks living outside the major cities don't have reliable access to in-person appointments. I am a proud cosponsor on many of the bills discussed today, including the [Social Determinants Accelerator Act](). Dr. Walker, rural residents in my district face long drive times to the doctor and lack high speed internet. Many have limited to no broadband access which leads to worse health outcomes. How can this bill help rural communities fight factors leading to negative health outcomes?
  - **Dr. Odom Walker**: It is unique and one of the opportunities with this bill is that you invest in the local level and hear from communities about their particular needs. An example is that a telehealth kiosk can be developed at a local entity that is commonly available to provide broadband and telehealth access in a stable way. It needs scale to do more of it where it works, because just putting telehealth into place doesn't necessarily overcome challenges, nor does driving three hours to the doctor. Figuring out how to make it unique to the community and looking through the right lens at the right problem with the right data is important.

Cross-Sector Collaboration and Public-Private Partnerships

- **Rep. Mullin (R-OK):** What can Congress do to make it easier for the private sector and nonprofits to work together on funding streams to coordinate in this way?
  - **Dr. DeSalvo:** One of the calls that come from communities is that when they create collaborations, they want to share governance, data, and pool and share resources. There is more latitude than what communities realize – some have found ways to blend and braid funding to support low-income populations and address SDOH. On the other end, it's hard to blend and braid funds so some considerations in the bills like with the interagency councils can help understand the flexibilities communities can use to blend and braid public sector dollars, but also how the private sector can contribute in a way that is transparent, has shared governance, and accountability for outcomes.
- **Rep. Trahan (D-MA):** Can you speak to how cross-department sharing of information can be used to drive policy and combat public health crises like the opioid epidemic?
  - **Dr. DeSalvo:** When we are thinking about building public health data systems, the need to be useful for communicable disease and other conditions that effect communities like opioid use disorders is important. Multiple sources of data are needed to tell the story of someone's health or needs and take action in a multipronged way at the community level to see if we are making differences in outcomes, and be agile to address community needs at the front lines.

Addressing SDOH in Medicare Advantage Supplemental Benefits

- **Ranking Member Guthrie (R-KY):** One of the criticisms that is inaccurate about MA plans is that they cherry pick who is in the plan, but it's the opposite with flexibility incentives MA plans have. Could you address the criticism of cherry picking and how your plans are structured in a way that is better for people with chronic conditions?
  - o **Dr. Batra:** We serve about 15,000 duals. We also serve people who are low-income subsidy folks – from all swaths of the population. About 10-15 percent of our people have indicated they are food insecure, and some are also housing and transportation insecure. We address their needs with supplemental benefits such as in-home benefits for meals, benefits where we send occupational therapists to the home to help with safety and mobility in the home setting, and more. Transportation is a big issue – if you are an older adult and need access to the COVID vaccine, we brought that benefit to you.
  - o **Dr. Syed**: ChenMed goes where the need is. My biggest challenge has always been access. MA helps open the doors. I am able to give my patients my cell phone number. My team texts my patients daily about health with simple messages, like staying hydrated on a hot day. We call patients weekly with love calls, and I see my patients on a monthly basis to prevent little problems from becoming big ones.
- **Ranking Member McMorris Rodgers (R-WA)**: A number of Members on the Hill have been supporting the Medicare for All proposals, which would ban MA plans. The private sector is leading the way in addressing SDOH. Dr. Batra, are there specific programs you want to highlight that have been successful and could be implemented by employers and individual plans?
  - o **Dr. Batra:** Our Peer-to-Peer program is very important. Trust can be built with peers as well as physicians. We are utilizing our own members to engage with members in a way that they can understand barriers and ways to deal with things like social isolation. This program extends the reach of the physician team as well. The other program is our Community Health Worker Program – we need to recruit people from the community that have the trust of the community and can build on this to help navigate and connect members to community-based resources if they are not available within the MA plan. This program takes a physician's care plan and makes it happen in their home setting.
- **Rep. Cardenas (D-CA):** What kind of effort can Congress afford you in the community?
  - o **Dr. Batra**: The flexible benefits have been great to design benefits around addressing social needs. These are based on having medical needs and a qualifying diagnosis. If we believe social needs are the drivers of health, we should be allowed to design some benefits based on the social needs of the populations. During the pandemic, we were scrambling to do social outreach calls – we noticed there were zip codes with high social vulnerability index that didn't have access to iPads and technology for telehealth visits.
- **Rep. Carter (R-GA):** I serve a very rural community and many constituents have trouble getting to physicians for care. Many could not access vaccines for extended periods of time. Can you share what you did to get Medicare members access to vaccines that plans could duplicate?
  - o **Dr. Batra:** We follow the principle of leave no older adult behind. We figured out how to get the right people to the right places, and how to get people rides to get to appointments. We worked closely with an organization that deploys paramedics in people's homes that could carry the vaccine in a safe way. We were able to schedule visits in the comfort of their own home under watch of paramedic and oversight of nurses.
- **Rep. Bilirakis (R-FL):** I introduced H.R. 4074, which increases flexibility for MA plans to offer supplemental benefits that would help address SDOH. Can you discuss how supplemental benefits

have improved the lives of your members, and how adding benefits to address SDOH in MA can mitigate social inequities and allow plans to assist even more members in need?

- o **Dr. Batra**: We appreciate getting the flexibility and have designed multiple new benefits. We introduce benefits like respite care for our populations who have caregivers. We extended our meal benefits to provide folks suffering from chronic conditions who need a meal for diabetes or end stage renal disease so they can have a better food lifestyle. We have seen based on utilization of adoption data and outcome data improvements in chronic conditions because of these benefits. We would love to have benefits based on social needs rather than just on medical conditions, as flexibilities now are still tied to chronic conditions. We have 20 percent of membership with food insecurity and we could do more if we could address social needs directly.
- **Rep. Curtis (R-UT):** My bipartisan legislation aims to give private health plans more flexibility to spend money focused on improving patient outcomes, specifically by allowing plans to count SDOH of health expenditures toward the MLR requirement. Could you explain how insurance plans are engage in providing SDOH services to beneficiaries?
  - o **Dr. Batra**: We design our benefits based on supplemental benefits made available based on chronic conditions they have. We look at qualitative data to look at opportunities to close gaps in care. We design and plan benefits is based on this approach.
- **Rep. Curtis (R-UT):** What can Congress be doing to offer incentives to help do your job better?
  - o **Dr. Batra**: Offering benefits in a more holistic manner would help.
- **Rep. Crenshaw (R-TX):** We have to make sure the government isn't putting barriers in place that would impede private plans from addressing SDOH. As we think through how to integrate SDOH into public health plans, I want to make sure we think of it as a piece of the puzzle and not a whole solution. Some of our most fundamental health care programs are in desperate need of real programmatic updates, and simply integrating SDOH won't get to root issues with FFS. Dr. Batra, what lessons can the federal government take from private plans to properly balance SDOH as they are integrated into the health system?
  - o **Dr. Batra:** Having a person-centered view with what matters to the patient can help. Medication is a big deal for them, so having affordable medications; access is huge with getting to the doctor.
  - o **Rep. Crenshaw (R-TX):** Can we get to that without reforming the FFS system? Would traditional Medicare have to create new benefit categories for Uber and other supports?
    - ▪ **Dr. Batra:** Dental and hearing aids are not covered by Medicare. There are other areas like vision that have to be given priority. Technology can play a role in some of these areas like with telehealth in rural areas. Addressing social needs would be another. There has to be a balance between social and medical on both sides.

Public Health Data Collection, Reporting, and Exchange

- **Chair Eshoo (D-CA)**: Dr. DeSalvo, your written testimony says that hospital data is some of the most reliable data. I was struck by your point that hospital records enabled health officials to sound the alarm about the Flint water crisis. Why is hospital data so reliable and how can we make this more available to health departments? I am assuming there isn't interoperability between the hospitals and public agencies.
  - o **Dr. DeSalvo:** In the HITECH Act, we invested resources to digitize health care. Now we have relatively reliable data in the health care system that have shown can be used for identifying public health crises like in Flint. There is a system in New York city that can identify chronic disease, and one in Massachusetts that can identify communicable

disease outbreaks. In HITECH, public health wasn't resourced to be able to receive that data, nor anonymize and make use of it in a way that can create dashboards that can be useful to the community. There are great examples – like in Oklahoma that has used electronic health record (HER) data to look for public health challenges – but it needs to be scaled and to ensure those systems are interoperable. Some of these bills think about designing systems with a standardized approach.

- **Rep. Upton (R-MI):** The 21st Century Cures Act included provisions to improve data sharing reform included by HITECH. This issue is bigger than ONC – how we use data is negatively impacted by a number of things including how we regulate data use and how agencies use the data. We released Cures 2.0 to help solve some of the issues we are discussing. Ms. Blauer, section 304 is about increasing use of real-world evidence (RWE). As we consider ways to improve data access and use, how important is patient participation and data access for health care operations?
    - o **Ms. Blauer**: We need to be comprehensive in how to reflect the realities of life in how we collect data, and patient engagement is at the center. We also need to include the privacy required to keep personal information safe when data is collected and ensure patients are informed and understand why it is important to have individual information as part of a consideration for data collection.
- **Rep. Bucshon (R-IN):** I worked on maternal mortality and maternal health – we have had testimony from physicians in Dallas that serve underserved communities, and their health outcomes were outstanding as it relates to maternal health, but other health systems didn't have as good data. We need to understand why. Innovation and better collected data help promote a more value-based system that helps lead to better outcomes because we are able to determine why the outcomes are poor in one area but outstanding in another area. I want to understand the provider's role of collecting and understanding data. Data is important and should be incentivized, but I don't want to put more of a burden on providers. There are existing ICD-10 codes for SDOH that most doctors aren't collecting. Someone will have to be responsible for reporting this data – who is responsible for collecting and reporting SDOH data?
    - o **Dr. Syed**: In the fee for service (FFS) system, I was forced to focus on sick care. I always felt I was two steps behind and reacting to problems. In MA, practice of preventive medicine keeps us steps ahead and we can notice small changes before they become the big ones. The primary care doctor should be at the center of the delivery system.
- **Rep. Dunn (R-FL):** Congress spent millions to support data collection and infrastructure modernization during the pandemic. We need to evaluate how the funds are being used. High quality health care starts with the doctor-patient relationship and should consider the individual needs of patients. The potential of more data being collected across other entities requires strong protections. Dr. Syed, you touched on coordination of care and strong doctor-patient relationships and matching resources to patient needs to drive improve outcomes. You seem to be an advocate for MA flexibilities that the system allows. From your perspective, is increased data collection in the primary care setting what is needed to improve health outcomes?
    - o **Dr. Syed**: With regard to data and collecting more data to improve patient health, when talking about improving health I think about If we know medications are critical we should not let them walk out the door without their medications. We should have cardiologists working hand in hand with primary care doctors if we know heart disease is a major killer. We should look at how care delivery is happening in the country. The care teams should take over the administrative work and let doctors be doctors.

- **Rep. Sarbanes (D-MD):** Ms. Blauer, can you expand on the role data played in responding to the pandemic and what additional data and resources might have been helpful, particularly to better respond to challenges faced by communities of color?
  - o **Ms. Blauer:** It wasn't until several months into the pandemic response that the CDC released demographic data that was rich enough to validate the frontline anecdotal data we were getting,. It took a long time to get guidance around demographic data. We are still operating in an environment of confusion when it comes to disproportionality in the effects. Having some guidance and standardizing around demographic data is vital to think about how we look at SDOH and role data plays in deepening disparities and exacerbating bad outcomes.
- **Rep. Ruiz (D-CA):** I joined my colleagues in introducing the Treat and Reduce Obesity Act ([H.R. 1577](#)) to increase access to effective treatment for obesity. Bills like this and the ones under consideration will help address SDOH straight on. We need adequate, accurate and timely data that describes the social actors that impact health outcomes. This data has been challenging to get due to barriers ranging from inadequate designs in systems like EHRs and a lack of trust for those being asked about social risk factors. Can you speak to the importance of collecting quality data around SDOH and how to translate that into policy and public health programs?
  - o **Dr. DeSalvo**: The data collected does not always reflect the "now" on the minds of the community. Mixing qualitative and quantitative data is important. Fitness, obesity, and other factors are contributing to cancer and cardiovascular disease – and I realized the communities I served needed sidewalks, playgrounds, and school lunches. We worked with kids to design how kids wanted a salad that would drive them away from pizza. Once you have the data in front of you, local leaders and the community can bring people together to build interventions we know would work.
- **Rep. Dingell (D-MI):** How do other gaps in data affect your organization's ability to provide targeted interventions to seniors based on SDOH?
  - o **Dr. Batra**: We have an algorithm when we get data to see who can reach out and who has a program to connect members to services. We are trying to work with providers to see how to make data more comprehensive. How do you work with caregivers and community organizations to get data from that perspective? We are looking at all levels to make data complete.
- **Rep. Dingell (D-MI):** Missing and incomplete data is more common – particularly with long-term services and supports. How would uniform public health standards like in the [Health STATISTICS Act](#) (H.R. 831) as well as improved quality measures improve your organization's ability to meet needs of adults?
  - o **Dr. Batra:** We have a fully integrated dual eligible special needs plan and work with caregivers and community partners to fill in data gaps.
- **Rep. Fletcher (D-TX):** There is a need for data to address inefficiencies in our public health system, and more inclusive data that takes into account SDOH. Distrust among minority populations can be a barrier in people getting the help they need. How can we better use data to engage communities to address SDOH?
  - o **Dr. DeSalvo**: With respect to seeing the data and being able to act on it, I will give examples related to public-private coordination. Early in the pandemic it was clear there needed to be more understanding of how COVID disproportionately impacted communities of color. We worked with Morehouse to create a dashboard to report out on disparities. We have done work with Harvard Medical School to provide data insights and technical assistance, and partner with them so public health departments can see

where there are vaccine deserts. These are ways where everyone together can meet people where they are to get people the services they need.

Health Information Exchanges

- **Rep. Matsui (D-CA):** Public health involves the whole community. SDOH data exacerbates health disparities and the bills today can provide a range of solutions to capture the essential data that is important to ensure people do not fall through the cracks. I'm interested in exploring how we can strengthen public health reporting by leveraging both clinical and public health data. A lot of this data is in schools, education systems, and in listening to people. This kind of data is important to understand fully what is happening. Ms. Blauer, you highlighted the need for robust data collection and reporting systems at the local and state levels. As we build out our health data utility infrastructure, how can we coordinate state and local health information exchanges (HIEs) and other clinical data sources? How can we facilitate this even more so that we can capture data and understand what is happening throughout the region?
  - **Ms. Blauer:** There are some of the most important thinkers and subject matter experts in government, but we need to invest in the skills of subject matter experts to use data to solve our problems. We need to invest in the capacity of people charged with leading programs on how they can use data. HIEs are incredibly rich resources that exist that have great data and data skills, but there is a disconnect between the exchanges and people on the ground responsible for delivering programs. How do we build capacity to scope and think about problems that illicit the right data response and apply this to solutioning?
- **Rep. Blunt Rochester (D-DE):** Delaware was the first state to launch a statewide health information exchange. Can you speak about the opportunity to leverage clinical health information networks like the DEN to strengthen public health data and response to pandemics and SDOH?
  - **Dr. Odom Walker**: HIEs make It easier to exchange clinical information, treatment and more. We are fortunate to have a statewide health information exchange. This helps us leverage SDOH and clinical data, as they are interconnected and causal. We need physicians to think about wraparound indicators around health, not just what's happening with one-on-one patient encounters but at home and in communities. Integration across state lines is challenging, so sharing information in that way is helpful.

Addressing Structural Factors Impacting Health and Disparities

- **Rep. Matsui (D-CA)**: Dr. DeSalvo, we talk about structural racism as a public health crisis. This was a huge issue after Hurricane Katrina. What has the COVID pandemic revealed around the structural racism in the digital infrastructure?
  - **Dr. DeSalvo:** This is not a new conversation in many circles. Where people live is not just about a choice but structural factors that make a difference in access to food, education and economic opportunity. A recent NASEM report talked specifically about how equity and racism will have to be priorities for public health coming out of the pandemic and how data systems need to be capable to provide information about individuals and what the structural systems are that support them. It is a double layered system that looks at people and the context in which they live.
- **Rep. Sarbanes (D-MD):** Congress should use every available tool to have an equitable recovery and address root causes that have created health disparities for years. The federal government has failed to address structural racism for the public health threat it is. We need to treat this through a public health lens when we can. CDC declared racism as a public health threat and is

addressing it through the context of public health equity. One way to do that is by passing the bills we are discussing, including the Anti-Racism in Public Health Act (H.R. 666) and Social Determinants Accelerator Act (H.R. 2503). Dr. Walker, what is the significance of the CDC recognizing racism as a public health issue?

- o **Dr. Odom Walker**: There is clear evidence that racism is a public health threat. Many factors are social indications around housing, transportation, and getting access to care. For children and adolescents, one of those factors is having mental health access and resources in schools. We need to be able to incentivize health at the most local level.

- **Rep. Sarbanes (D-MD):** Gathering public health data to inform perspectives on this is a key undertaking. What significance would establishing a national center for anti-racism at CDC have?
    - o **Dr. Odom Walker**: The benefit is to make sure there is data standardization but also expertise that is not often accessible in state agencies. Having a national center to lend technical support and data standardization, but also collaboration with national partners with state and local data and having resources come together in a national center, could be beneficial.

- **Rep. Barragan (D-CA):** Addressing SDOH is crucial to reducing health disparities as we work to strengthen our public health infrastructure in the future. I introduced the Improving Social Determinants of Health Act (H.R. 379) to establish a program at the CDC focused on SDOH. Dr. Walker, how have SDOH contributed to minority health disparities, including worsening health outcomes in underserved communities?
    - o **Dr. Odom Walker**: Communities of color were most dramatically impacted because they were unable to follow my basic advice of staying home. Those are the challenges we are trying to navigate as we think about social factors. How do we bring them together when factors around poverty and food insecurity coalesce? Having data, linkages, and community health worker support would be tremendous to promote better health in local communities and to address inequities that have long existed so we can think about structural racism and multi-layered interventions needed.

- **Rep. Kelly (D-IL):** COVID provides an opportunity to better integrate and standardize data collection. Data on race and ethnicity continues to be incomplete across the public health system, which are critical to identify disparities. I applaud Congresswoman Bustos' work on the Social Determinants Accelerator Act and Rep. Pressley's Anti-Racism in Public Health Act. Dr. Walker, how does racism and other structural inequities drive SDOH? Specifically in your experience how does it affect the experience of pregnant individuals?
    - o **Dr. Odom Walker**: At Nemours, we were starting to figure out how to launch a SDOH screener to address all the needs of the child. We know these predictors happen during the pregnancy. If we can incorporate the same principles and strategies earlier on, we will have better opportunity to address these inequities.

Privacy in Collecting Public Health and SDOH Data

- **Rep. Curtis (R-UT):** Can you speak to privacy and how we put patients fully in charge of their own data while still meeting interoperability goals?
    - o **Dr. DeSalvo**: People need to understand how data is being used, have choice in how to get it, and control across the journey. This would fall under consent, so notions are there and systems are built, and the interoperability rule pushed this technologically to support an additional concept to see if data can be stored in one place and can be visited or borrowed when someone is critically ill, or longer term like with diabetes care.

- **Rep. Schrier (D-WA):** How do parents feel about data sharing between public health, social services, schools and doctors?
  - o **Dr. Odom Walker**: I often think of the context of families and how we are often limited by not having the entire picture as physicians. If I knew a student wasn't doing well in school, I could ask if they needed a hearing test or vision screening. The issue of trust in data sharing is a real one and one that we are always navigating. With the right support, we could ensure we have the right data analytics to ensure we are doing this right.
- **Rep. Schrier (D-WA):** Given your experience with public-private partnerships and privacy, when we talk about the relationship between schools, doctors, and social services, how do you address privacy issues related to that kind of data sharing to help patients?
  - o **Dr. DeSalvo**: We always want to know more about the home context. What I've learned from patients and what people tell you in focus groups and surveys, people want to know that they can have some sense of knowledge about who has access to their data and they want to share it with people they trust. They just need to know they have some control over how that happens. There has been a lot of work on how the system can be more inclusive of that data and give consumers more choice and control.

Modernizing Public Health Data Systems and Infrastructure

- **Chairman Pallone (D-NJ):** Robust public health data plays a critical role in improving public health. Dr. DeSalvo, you worked in the federal government and industry to improve sharing of public health data and know how this can improve health outcomes. Can you discuss what lessons learned from HITECH should be incorporated into policies to improve public health data collection?
  - o **Dr. DeSalvo:** It is an important opportunity to recognize we have to create a digital infrastructure for health care, and we are about to embark on this for public health. The specific areas I think the country learned lessons include data and standards – as we design the system going forward, rather than allowing each information technology system to create their own standards, we should create an open opportunity for shared standards. There are standards bodies already working with CDC and public health officials to identify and clarify which standards we should use as the foundation, and start with interoperability as a base case. We also need to think about uses and the end goal we have in mind. Equity has to be part of how we design the system, done in a way that allows us to know where resources need to be applied the most. What are the data systems that have to tell the story around equity or maternal mortality? Timing is important – we pushed out funding for HITECH and there was training for workforce, but it delayed when systems were up and running. It takes humans to work systems, interpret data for the public's health, and work with communities to put it to good use to make change on the ground. We need to think broadly about infrastructure on public health.
- **Chairman Pallone (D-NJ):** COVID investments were one-time investments and public health departments need stable resources. The LIFT America Act has a core public health infrastructure program to fund public health needs. Can you comment on this program and what further steps the federal government should take to improve public health data collection?
  - o **Dr. DeSalvo**: Data doesn't happen in isolation – it requires a system. We need strong data systems and upgrades initially, but they have to be durable and stable so health departments can update systems overtime. They also need workforce, partnerships, and basic infrastructure to keep the lights on. It would be hard to explain how under resourced and challenged many public health departments are. This is a learning moment that we

have a critical infrastructure that has struggled to meet the needs of the community's health and is ready to do more through partnerships.

- **Rep. Upton (R-MI):** One provision in Cures 2.0 would begin the process of Congress working with HHS to update CMS and other computer systems to use data better. Do you think improving CMS data capabilities through modern computing approaches can help support our goals?
  - **Dr. Odom Walker**: From a state perspective, we would appreciate having additional support for CMS to update systems that allow for us to work together as states try to engage and leverage data that's available. As we learn more about the impact of SDOH, there are models to support payment strategies and innovations, like CMMI's maternal opioid use model and programs like Medicaid waivers help look at how we invest in the earliest years of life. The challenge is understanding what is working, and we need data to evaluate the programs and make assessments. We need opportunities to work with CMS to develop demonstration models to invest in data and implement value-based care.
  - **Dr. DeSalvo**: CMS data systems are in need of some upgrades and the opportunity has to do with making sure we can meet the needs of the population's health using data that can support value-based care or global health models. In 21st Century Cures, there was a push toward open API FHIR-based systems. Those same models can be applied to public health as we think about modernizing public health data infrastructure. Because of 21st Century Cures, there has been a movement to create that interoperable system to ensure we don't make mistakes with HITECH.
- **Rep. Castor (D-FL):** This committee has shined a light on lack of transparency of data during COVID. Many local communities and states did not have modern data reporting systems in place, there was a troubling pattern in a number of places in withholding COVID-19 data and centering of data, and we don't have the demographic data we need on health disparities. Communities and public health experts need consistent and transparent public health data to implement effective measures and keep families safe. Through the bipartisan emergency relief package, this committee helped direct huge new investments to update reporting at the CDC, but we need to provide additional direction. We need to do this through transparency in data reporting as well. We need to tap expertise of NASEM to review the current system and provide us with additional recommendations on public health data infrastructure and reporting. Ms. Blauer, consistency across states is important - can you talk about what we need to do to ensure dependable and transparent data for the public?
  - **Ms. Blauer**: There is a hunger at the state and local level for standards to guide how we collect and think about data across states and cities. We had daily calls with mayors, governors, and people from local communities seeking advice on how to collect data and express it to the public. While the systems that collected data were shoe string operations, the reality is that these organizations across the board were seeking that kind of high-level validation that what they were collecting and how they were using data was the right path forward. In the absence of standards and common language, it was difficult to do apples to apples comparisons. The role of government can be to create common language, provide standards, and provide support to state and local communities applying data to policy levers that have been critical to navigating the pandemic.
- **Rep. Welch (D-VT)**: How can investment in an updated health data system improve public health and prevent systemic inequalities?
  - **Dr. DeSalvo**: Vermont has done some great work for populations with substance use disorders (SUD) and understanding how to blend and braid resources to address SDOH, including housing. Housing is the most important SDOH. Data has to be timely, actionable

and granular. It has to be quantitative and has to have the voice of the community. Some of the bills include concepts to have community advisory voices, particularly the bill about maternal and child health, but that is true in every context. These bills speak to the idea of community collaboration and partnership – you will find threads throughout many successful projects in communities that it is about everyone coming together.

- **Rep. Barragan (D-CA):** Data from the CDC found African Americans and Latinos were more than three times more likely to be hospitalized and twice as likely to die from COVID. There is a lack of complete, accurate and standardized race and ethnicity data to paint a full picture of disparities. What existing health data infrastructure should be used to ensure health systems and plans that are implementing programs to address SDOH have accurate and comprehensive patient data? Where should government make additional investments?
  - o **Ms. Blauer**: We are still figuring this out and understanding where populations had major obstructions to accessing basic tools they needed to navigate the pandemic. The limitation on demographic data paired with release of COVID data has impacted this. There needs to be standardization and requirements for how data is collected and there needs to be optimization for how it is collected and broadly shared. This will help local policymaking to align to the needs and resources can be deployed to those disproportionately affected by disparities so they can navigate the pandemic and real health challenges associated with SDOH.
- **Rep. Fletcher (D-TX):** Many public and nonprofit safety net hospitals serve populations challenged by numerous social risk factors. They often lack data platforms that track both medical and social conditions to facilitate services to respond to the needs. Would you agree that investment in data platforms for safety net providers could drive progress in addressing health inequity?
  - o **Dr. Odom Walker**: Data helps inform strategy and without it we are often leaving people out and have an incomplete picture of where to deploy resources or make policy decisions. There is another benefit to have data available as a common good instead of having other organizations trying to piece this together.

Evaluating the Success of Existing Government Funds and Programs

- **Ranking Member McMorris Rodgers (R-WA)**: The CDC has received over $1 billion from COVID relief proposals. What are the metrics you would recommended we use to determine if those dollars are being spent wisely to drive results?
  - o **Dr. DeSalvo**: We can learn a lot from what is being learned on the ground. Communities like Spokane, WA have historically worked in partnership with the communities to address the public's health. As a country, if we want to address inequities on top public health issues, like maternal mortality for black women in particular, we can begin with a use case and work backwards to say we need data to inform actions at the community level to drive change. The importance of the data modernization initiative by Congress for CDC to develop a strategic plan will be essential to have clarity about what needs to happen by when and by whom. It must be done with intention of improving public health moving forward. Like with Rep. Burgess' (R-TX) bill (H.R. 4026), we need to think of what's already happening with HHS and what levers can be used, and act on challenges that need to be solved to address SDOH.
- **Rep. Mullin (R-OK):** Can you speak to the importance of federal programs to address SDOH?
  - o **Dr. DeSalvo**: In Oklahoma you have a great example of how primary care clinicians came together to create a data exchange and built a global health model to ensure doctors can care about communities and data helps tell the story of a community's health. It's a good

example of how federal action can spur innovation in models of primary care and health information exchanges can improve the care of patients and populations. The foundation of EHR information for use of individual data, when anonymized, can be useful to help understand the health of a community, and is the kind of innovation that can be scaled across the country.

- o **Rep. Mullin (R-OK):** Are there any examples to highlight how this has been working?
- o **Dr. DeSalvo:** There are a few states that have been leaders in this area of using existing data built on a foundation of a federal program that gets expanded. Macroscope was built in New York City by the public health department using data from their primary care clinics. They anonymized and used the data to understand rates of diabetes and high blood pressure in communities. Public health has used this to address inequities and SDOH. I would love for the Committee to know that innovation between public-private partnerships is happening across the US. We have a sense of what works from the data – we need to ensure we have strategy and prioritization and direction, and fill gaps in data layers and ensure the data layer is interoperable and helps us address inequities.

Addressing Maternal Health

- **Rep. Kuster (D-NH):** I appreciate you highlighting the intersectionality between children and maternal health. How can this committee advance legislation to tackle maternal health disparities?
  - o **Dr. Odom Walker**: Health starts at conception. The health of mothers is linked to the health of their children. Rural communities often don't have the same wraparound services, but could be supplemented by home visiting programs and other supports. We know factors like trauma and stress on the mother can impact the life course of the child through adulthood, and we need resources to ensure maternal supports for depression, even if local supports are not available. Other factors with how we create supports impact cognitive wellbeing and others. Figuring out legislation with telehealth resources and other resources could be a benefit.
- **Rep. Blunt Rochester (D-DE):** I'm pleased to see two bills from the Black Maternal Health Momnibus today. My bill, H.R. 909, would make community investments to support moms struggling with maternal mental health and SUD and grow the health care workforce in those sectors. Maternal mental health is deeply tied to SDOH. Dr. Walker, can you share how improving maternal mental health and health of mothers impacts lifelong health trajectory of their children?
  - o **Dr. Odom Walker**: Investing in maternal heath, particularly around mental health, has long-term impact. They are linked and factors early with trauma and stress risk their own lives and that of their child. It is a huge factor in how children develop. Maternal depression is linked to other factors that impact children. Even things around preconception diet have long-lasting impact. If we think about cognitive behavioral development and support of moms by looking at maternal depression it can impact a generation.
- **Rep. Kelly (D-IL):** What are the current gaps in maternal health data collection?
  - o **Dr. Odom Walker**: Some of those are around having accurate, reliable data – having data dashboards is critically important. We see differences by race and ethnicity and who reports their own information. It is an opportunity to drive guidance around technical assistance.
  - o **Rep. Kelly (D-IL):** Is it currently being collected by community organizations to integrate?
  - o **Dr. Odom Walker**: It is being collected but there are gaps in what we have – information in our health records may not be the same as what is in our HIEs. We need to use the best

data available and self-report race/ethnicity and sharing information with others trying to collaborate and address inequities. It takes everyone.

- **Rep. Craig (D-MN):** Dr. DeSalvo, I'm a proud original cosponsor of the Black Maternal Health Momnibus, including the Data to Save Moms Act (H.R. 925). Why is it important to gather a diverse range of perspectives in maternal health data collection and reporting processes, including elevation of voices and experiences of people most impacted by the maternal mortality crisis?
  - o **Dr. DeSalvo**: The work needs to be done with community, not to community. This part of the Momnibus package describes this so well. It's not just about experts looking at the data but needs to be done with the community to identify what is needed and a culturally and linguistically appropriate intervention. That suite of bills helps us understand, it's quantitative, it's the voice of the community, and a multipronged approach.

Misc.

- **Ranking Member McMorris Rodgers (R-WA)**: Based on your experience working at an FQHC and ChenMed, can you elaborate on the role of the doctor-patient relationship in addressing SDOH?
  - o **Dr. Syed**: It is so important for doctors to know about every emergency room visit. I was shocked that half of all medical care was delivered in the emergency setting in Tampa. Doctors must know about every emergency room visit and when a patient doesn't fulfill their prescription refill and every referral to a specialist. They also must understand the cost of health care.
- **Rep. Curtis (R-UT):** Can you talk to how Google partners with health systems or plans to gain a stronger understanding of health care trends within certain communities or populations?
  - o **Dr. DeSalvo:** One opportunity is how can data already available be more intuitive or accessible? How do we minimize and reduce the need for patients to repeat over and over what their medical conditions are, or social needs? Ascension asked if Google could be helpful to apply notion of making EHRs easier to find and be more intuitive for doctors.
- **Rep. Bucshon (R-IN):** I want to make sure whatever we do doesn't unnecessarily burden providers. Can you speak about your experience in MA – why do you think more federal and state governments are hesitant to embrace the existing approach that gives plans and providers a risk adjusted amount of money to let them decide which SDOH interventions need to take place without adding more reporting and box checking?
  - o **Dr. Syed**: All of us got into medicine to help people. I would like to see more education related to MA. Our current system is based on sick care. The MA model puts the primary care doctor at the center of the care delivery system, and they have time to look into the causes get to know patients better than a random doctor. Patients should be able to go to any doctor they want, wherever they want. When your health is on the line, you want a referral from a doctor who knows you the best. MA helps establish trust and make referrals that make sense for the patient.
- **Rep. Schrader (D-OR):** I appreciate the mention of value-based payments - what policy should we be pursuing to foster growth in that arena?
  - o **Dr. Odom Walker**: We need to incorporate incentives and expertise, and ensure they have bandwidth to move forward with value-based payment. It does take guidance and the CARING for Social Determinants of Health Act (H.R. 3894) includes a recommendation to include updated guidance to allow innovations like CCOs to flourish in other places, but it takes leadership, alignment and expertise.
- **Rep. Cardenas (D-CA):** Thank you for putting H.R. 3969 on the agenda – this bill would include spending on activities related to SDOH in private plans in the MLR. SDOH are all primary drivers

of health outcomes. To achieve health justice and equity for all, we need to be more intentional about how we address the impact on all parts of the system. Dr. Batra, you discussed a senior care action network – can you talk about the impact of your approach on members in your network?

- o **Dr. Batra**: We started off by making sure we collect data in ways members wanted their data to be reported. Having data around race and language is important. We have collected data around social needs, like transportation and loneliness. We use the data to identify member needs and connect them to the right benefits and programs. People wanted to get the COVID vaccine and didn't have caregivers, so we provided rides for them. We also had folks who were homebound, so we delivered vaccines to their homes for members and caregivers who were taking care of them. We have done studies that show if you experience transportation or food insecurity, you will have worse outcomes with diabetes. We are trying to engage our population with a program and benefit to ensure they have it and can go from there.

- **Rep. Dingell (D-MI):** The HITECH Act and funding have led to improvements in data collection that have led to better outcomes for patients in clinical settings. While we have seen additional resources at gathering and assembling actionable data, longer term reforms are needed to address gaps in public health data infrastructure. Doing so would allow us to better direct health care resources toward the areas of greatest need. Dr. Batra, it was good to see you highlight the Independence at Home program in your testimony. What barriers do you see in raising response rates for these assessments?

  - o **Dr. Batra**: These assessments are done over the phone or through mailings. We need to be ready to provide online assessments if that's how members want to engage in care. For folks who are homebound and have caregivers that don't have time to carry out assessments, we are thinking about going to their homes. We are also exploring building them out in different languages. Providers do a lot of assessments and we are looking at interoperability to see how to get that data into our system to have a more holistic understanding of the population.