NATIONAL QUALITY FORUM

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FOOD INSECURITY & HOUSING INSTABILITY PROJECT

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WEDNESDAY,
OCTOBER 18, 2017

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The Expert Panel met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, NW, Washington, DC, at 9:00 a.m., Romana Hasnain-Wynia, Chairs, presiding.

PRESENT:

ROMANA HASNAIN-WYNIA, PhD, MS, Chair; Denver Health
RON BIALECK, MPP, CQIA, Public Health Foundation
TRACI FERGUSON, MD, MBA, CPE, Clinical Services Management, WellCare Health Plans, Inc.
NANCY GARETT, PhD, Hennepin County Medical Center
LAURA GOTTLIEB, MD, MPH, University of California, San Francisco
NANCY LAWTON-KLUCK, Geisinger Health System
LYNN KNOX, Oregon Food Bank
AMANDA REDDY, MS, National Center for Healthy Housing*
SARAH HUDSON SCHOLLE, DrPH, MPH, National Committee for Quality Assurance
PRABHJOT SINGH, MD, PhD, Mount Sinai Health System
CLARE TANNER, PhD, MS, Center for Data Management and Translation Research, Michigan Public Health Institute

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer
ELISA MUNTHALI, MPH, Acting Senior Vice President
ANDREW ANDERSON, MHA, Senior Director
JOHN BERNOT, MD, Senior Director, Quality Measurement
VANESSA MOY, MPH, Project Analyst
JEAN-LUC TILLY, Senior Data Analytics Manager

ALSO PRESENT:

LISA DUBAY, PhD, ScM, Urban Institute
THOMAS NOVAK, Office of the National Coordinator for Health Information Technology
CHRISTAL RAMOS, PhD, MPH, Urban Institute
CORIANNE SCALLY, PhD, MSP, Urban Institute
BARRY STEFFEN, MS, Office of Policy Development and Research, Department of Housing and Urban Development
GINGER ZIELINSKIE, MBA, President and CEO, Benefits Data Trust

* present via teleconference

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

(9:07 a.m.)

MR. ANDERSON: Welcome, everyone, to the Food Insecurity and Housing Instability Expert Panel Meeting. We're really grateful for all of you coming out today, and we look forward to this conversation, and also special welcome and thanks for those who are joining us in public -- in the public area in person, and also over the phone.

Just a few, I guess, housekeeping items. For those of you who haven't participated in one of our panels before, we'll be raising our cards if you have comments, and then you'll be called on.

We have these mics here if you'd like to speak. We have a mute and then a speaking button, so when you're ready to speak, it's red, and if there are more than three mics on at a

time, then no one will be able to speak, so when you're finished speaking please remember to turn off your mic.

With that, I'll just introduce myself. My name is Andrew Anderson, I'm a director here at NQF in the Quality Measurement Department. You've recently -- you've heard me on the web calls and everything.

So, I'm going to turn it over to Romana to introduce herself. She's the Chair of the Panel, and then we'll -- I'll turn it over to Elisa, and we'll be doing some disclosures and introductions. Thank you.

CHAIR HASNAIN-WYNIA: Great. Good morning, everybody, and welcome. My name is Romana Hasnain-Wynia, and in my regular day job, I serve as the Chief Research Officer at Denver Health. And Denver Health is taking a very active role in trying to address the role of the healthcare system in terms of how to address social risk factors, social determinants, etc.,

so I'm really looking forward to the conversation here, and the expertise around the table. I'm really thrilled with the -- with the folks that NQF has been able to bring together for this important topic.

I'll be chairing the committee, but I'm hoping that I can participate and learn from all of you. The three aims -- we're going to be kind of embedded in the three aims of the National Quality Strategy around better care, healthy people, healthy communities, and affordable care, so that's kind of the overarching framework.

I've worked with NQF, I think, for the last -- I don't know, Helen -- forever on various committees. I serve with three of my colleagues here on the Disparities Standing Committee, and we just released our roadmap with the Committee's recommendations -- I think, last month, just a few weeks ago -- around achieving equity, a roadmap to achieving equity and reducing disparities. And we're hoping to really use that

as a foundation for our discussion in terms of some of the domains that were highlighted in that -- in that roadmap around the domains around data collection, and also around collaboration and partnership, because I think that one of the things that I imagine we're going to be hearing a lot about from all of you is, what is the role of the healthcare system in addressing food insecurity and housing instability, and recognizing that the healthcare system can't do it all.

So, and I think within the U.S. we're in a -- I'll just say -- unique position unlike other developed countries where there are stronger foundations around social safety nets and social programs, so within that context, what is the role of the healthcare system?

So, I will stop there, and let Drew guide us to our next step.

MR. ANDERSON: Sure. Elisa, did you want to take it over and do the disclosures?

MS. MUNTHALI: Absolutely. Good morning, and welcome, and thank you so much for being here. My name is Elisa Munthali. I'm the Acting Senior Vice President for Quality Measurement, so we really appreciate all the time you're spending on this panel.

So, what we're going to do is combine disclosures of interests with introductions. And I do have a couple of reminders for you. You received the disclosure of interest form when you were appointed to this panel, and we asked you to disclose any professional activities that were relevant to the work in front of you, and so what we're doing today is going to go through that process.

You're going to do that as matter of an oral disclosure for the purpose of being transparent and open. We don't want you to summarize your resumes. We just want you to disclose the activities that are most pertinent to the work that's in front of you.

I just wanted to remind you about a couple of additional things. That you sit on this panel as an individual. You're not representing the organizations or the people that may have nominated you for this panel. And just because you may disclose does not mean you have a conflict of interest.

As I mentioned before, we do this in the spirit of openness and transparency, and so we will start off, if you could tell us your name and your organization, and if you have any relevant disclosures.

And we'll start with your Chair, Romana.

CHAIR HASNAIN-WYNIA: Hi. I'm Romana Hasnain-Wynia. I already introduced myself as coming from Denver Health. I serve on the Disparities Standing Panel for NQF. I also serve on two separate panels for America's Essential Hospitals -- two expert panels -- and I think that's -- that's it. I don't have any conflicts.

MS. MUNTHALI: Nancy.

MEMBER LAWTON-KLUCK: Nancy Lawton, Geisinger Health System. I serve on a couple committees. One is Democracy Collaborative, which is something that looks at how a health institution can be a -- like a linchpin in a community.

I also serve on a continuum of care committee, which is looking at Scranton community and how funds can flow to the housing institutions. And I also have launched Fresh Food Pharmacy and the Springboard Healthy Initiative, which are two Scranton-based organizations that are looking at housing, opioids, fresh food, and different ways to attack social determinants of health. I have no conflicts.

MEMBER SINGH: Hi, how are you doing. Prabhjot Singh from Mount Sinai. I chair our Department on Health System Design and Global Health, and direct an institute there. I don't

have any conflicts. I think the three relevant things to mention are -- the other affiliation I have is that I'm a special advisor for design and strategy to the Peterson Center on Healthcare.

I work with a social enterprise called City Health Works, which trains and manages community health workers and pays them in a sustainable way. And in my role, I generally work on linking financing to data questions and information.

MEMBER GOTTLIEB: I'm Laura Gottlieb from the University of California, San Francisco. I direct the Social Interventions Research and Evaluation Network, SIREN, which is a research, translation, and an acceleration network working exclusively around social determinants and how to incorporate social determinants, identification, and interventions in healthcare delivery.

I don't have any relevant disclosures.

MEMBER FERGUSON: Good morning. Traci Ferguson. I'm the Chief Medical Director

of Medical Management at WellCare Health Plans, which is a national managed care organization focused on managed Medicare and Medicaid.

In terms of my affiliations, I stand on -- sit on the Disparities Standing Committee, and also on the expert panel for the Medicaid -- hospital-wide Medicaid readmission through Yale and CORE.

MEMBER GARETT: Good morning. I'm Nancy Garett. I lead our Analytics and IT Functions at Hennepin County Medical Center. We're a safety-net provider in Minneapolis. And I serve on the NQF Disparities Committee, and the Cost and Resources Committees.

And in my work, we're doing a lot around trying to understand better how to measure and address social determinants of health for our population, so I have a strong interest in the -- in the topic. I'm really excited to be here.

MEMBER TANNER: Hi. I'm Clare Tanner with Michigan Public Health Institute. I don't

have any conflicts of interest, but I am co-director of Data Across Sectors for Health, which is a national program funded by Robert Wood Johnson, and we seek to support communities that are integrating data for a variety of use cases, including both population health-type activities, as well as care coordination interventions.

I also serve as evaluator for a number of innovation projects in Michigan, including our recently completed patient-centered medical home demonstration, and currently evaluator for Michigan State -- State Innovation Model Implementation.

MEMBER SCHOLLE: Good morning. I'm Sarah Hudson Scholle. I'm Vice President for Research and Analysis at the National Committee for Quality Assurance, and I'm also a member of the Disparities Standing Committee.

I have no conflicts, but just some disclosures about work that we have under way.

We have a contract from the CMS Office on Minority Health that is a health equity innovation incubator, and so we have another -- a number of projects where we're looking at areas, issues related to social risk.

And NCQA does look at this topic in our patients in our medical home program, and we're looking at what else we should be doing with it.

MEMBER BIALECK: Good morning. I'm Ron Bialeck, President of the Public Health Foundation, and we focus on working with governmental public health agencies, hospitals and health systems, to improve performance and workforce to address community needs.

And I serve also on the NQF, renamed committee. I think it's called Prevention in Population Health. I got that right. Okay, good, good.

And at the time I submitted the form, I didn't have this, so I'm going to disclose it,

which is that the Public Health Foundation, we're working on a tool for hospitals and health systems to use that helps them take their community health needs assessment, potentially social needs assessments of individuals, and prioritize what types of social determinants of health they can address at the community level, and to finance those and move into action.

So, while I don't believe there's a conflict there, some of the learning that I do here from all of you may factor into what we ultimately do.

MEMBER KNOX: Good morning. My name is Lynn Knox. I'm the state healthcare liaison for the Oregon Food Bank. My role is to work with hospitals and clinics across the state, rural and urban, to implement food insecurity screening and interventions, and we have done that over 300 times in a wide range of settings.

I also lead a national learning community for Feeding America on the topic, and

have been the key technical assistant to the State of Oregon as they adopted a Medicaid performance improvement metric on food insecurity screening and intervention.

Prior to working for the Oregon Food Bank, I was involved in low-income housing for about 17 years, so familiar with both angles.

DR. BURSTIN: Hi. I'm Helen Burstin. I'm the Chief Scientific Officer here at NQF.

MS. MOY: Good morning, everyone. My name is Vanessa Moy, and I'm a project analyst here in NQF, and I look forward to hearing all your different perspectives, and I hope you'll have -- like I hope we'll learn from each other as well. Thank you.

MR. TILLY: I'm Jean-Luc Tilly, a Senior Project Manager here at NQF.

MR. ANDERSON: Oh, yes. Amanda, if you're on the phone, if you'd like to introduce yourself?

MEMBER REDDY: Sure. Good morning,

everyone. This is Amanda Reddy with the National Center for Healthy Housing. I don't have any conflicts to declare, and I guess some of the more recent initiatives we've been involved in that has relevance are, I served on the technical expert panel for the CMS core health-related social needs screening tool for the Accountable Health Communities. We are providing input as part of an expert convening for HUD working to redefine how they define the measure, housing insecurity, and we also, with our subsidiary, led the development of the Healthy Communities Index for HUD.

MS. MUNTHALI: Thanks, Amanda. So, one final reminder, if at any time during this meeting you believe you have a conflict, we want you to speak up. You may do so in real-time, or you may approach Romana or anyone on the team, and if you feel like one of your colleagues is acting in a biased manner, you may speak up as well, and you may approach Romana or any one of

us.

So, I wanted to thank you, and have a great meeting.

MR. ANDERSON: One more introduction. Ginger, would you like to introduce yourself?

MS. ZIELINSKIE: Thank you. Hi. I'm Ginger Zielinskie, President and CEO of Benefits Data Trust.

MR. ANDERSON: Do you have any disclosures?

MS. ZIELINSKIE: No.

MR. ANDERSON: Great. Okay. So, at this time, we're going to start by just giving a brief overview of the meeting and objectives and the project scope.

Vanessa, would you like to take it from here?

MS. MOY: Sure. Thank you, Drew. So, we have three meeting objectives today for this in-person meeting. The first is we'll be discussing the role of the healthcare system in

addressing food insecurity and housing instability, and we'll also be discussing current measurements of food insecurity and housing instability in healthcare as well, and then we're hoping that you'll have some -- create some recommendations for the framework in relation to food and housing as well.

Just to give a little bit of background about the project scope. We mentioned this in the orientation webinars. In collaboration with CMS, Centers for Medicare and Medicaid Services, we're hoping to develop a measurement framework to provide guidance on the healthcare system's role in addressing food insecurity and housing instability, and to support this effort, we are convening you as a panelist to provide us your expertise in the measurement area in disparities, food insecurity, and housing instability.

We also conducted an environmental scan of the measures on the literature review to

-- just to construct a strawman framework, which -- Drew will mention a couple of frameworks that will be used as existing framework to help us guide for this project, and also we'll identify gaps in measurement, and as well propose concepts that can be possibly translated into performance measures.

Just a quick overview brief of the project timeline for this project. The next steps after this in-person meeting is to have a key informant web meeting. As you can tell, the schedule of this timeline has been changed, because we would like to extend the time for the key informant meetings. That's why we're having that in early November, and that, that moves up a little bit of the timeline, so we're hoping to get more input and help us guide for the environmental scan, and the draft report, which will be submitted to CMS on November 15, and then from then, there'll be a public comment period on that draft framework from November 15 to 29th.

And then we're hoping to reschedule the webinar number two, which is the post-comment for the draft report. We're hoping to reschedule this on the week of early December.

And on your table there's a survey -- if you guys could fill that out -- for the webinar dates of your available dates and times, and just return it back to me. I would really appreciate it. It'll help us assist with scheduling the confirmation for that webinar.

Then, next, after that webinar, we'll have internal NQF meeting. It's called the CSAC, or Consensus Standards Approval Committee. It's just -- this time is where we provide the committee just an overview of the framework, what's been discussed, and the findings from the framework as well, and then, lastly, the final report will be published onto our site, and will also be distributed to you, as a panelist, on December 22.

And I'll hand it now to Drew. He'll

talk about the NQF health equity roadmap.

MR. ANDERSON: Great. Thanks, Vanessa.

So, as Romana mentioned, NQF released a roadmap for health equity just on September 28. You might have seen some of the press releases that we put out, so I wanted to just take a brief moment to talk about this roadmap, because it really can frame some of the discussions that we're having here today, and inform the measurement framework that we hope to develop from this work.

So, just a little bit of background. This project was funded by CMS back in September of 2016. It was a year-long project where we had a series of three reports that were released.

The first looked at disparities in five condition areas, which were cardiovascular disease, mental illness, cancer, diabetes, chronic kidney disease, infant mortality, and low birth weight. We used the National Academies'

report on identifying social risk factors and Medicare payment.

We looked at the social risk factors identified in their conceptual model, so this was socioeconomic position, you know, residential community context, social relationships, race, ethnicity, and several others. We also looked at disability.

So, we looked at the disparities across those five condition areas based on those social risk factors to see what the current state of disparities looks like, and that report was captured in -- earlier this year in a lit review.

From there, we looked at the interventions that are helpful in reducing disparities in those condition areas based on those social risk factors, and we published a second report highlighting those interventions.

In the third report, we did an environmental scan of measures to see what measures currently exist that can be used to

detect disparities within those condition areas based on those social risk factors, and also what measures are available that link the interventions to -- that are known to reduce disparities based on the current evidence, and those are what we would call health equity measures. It's the term that the committee settled on to kind of characterize what measures that assess health equity are.

And, then from there, we put together this comprehensive report, which documented the findings of the roadmap, which the committee came up with a series of recommendations.

And if you can go to the next slide, please?

So, the roadmap has four areas. The first is identify and prioritize reducing health disparities. So, this is -- the committee settled on a set of criteria for looking at disparity -- what we call disparity-sensitive measures. So these are measures that cannot only

detect differences in performance across providers or health plans, or whatever the level of analysis is, but also look at subgroups. So one of the main recommendations that came out within this area is the need to collect data on social needs and social risk factors.

The next area is implementing evidence-based interventions to reduce disparities. So, we found a number of interventions that were known, you know, like team-based care. Some of the interventions that kind of addressed disparities across social risk factors and can tackle multiple at once, the recommendation was to start implementing these more systematically.

And, then second -- the third area is looking at the investment in the development and use of health equity measures, because we found that many of the -- and I'll talk a little bit about the domains of measurement, or the areas of measurement that the committee identified, which

is quite relevant to this work, the development of measures in this area to begin assessing health equity.

And, then lastly, the incentivized domain is like, how do we get the healthcare system to begin doing this kind of work, and I'll go through a list of the relevant recommendations that came out of the work.

Next slide.

So, as I mentioned about the areas of measurement, the committee kind of fell into these five different areas. As Romana mentioned earlier, the one that's most applicable to this work when we are talking about community linkages and cross-sector collaboration in regards to food insecurity and housing instability, this first domain of collaboration and partnerships really captures that.

And in the environmental scan memo that we sent out on Monday, there's a proposed framework that kind of -- and we'll talk about

this a little bit later, about how we can create an overarch, use these five domains, or four -- this main domain of collaboration and partnerships, and these four sub-domains underneath, to kind of hang a number of different social needs, including housing instability and food insecurity.

And I won't go into the others as much, but the -- we also have a domain of a culture of equities, so, you know, making sure that equity is a high priority, a structure for equity, so these are more like the systemic things, the policies.

There's also equitable access to care, so these are some of the, you know, availability, accessibility, affordability, and then equitable high quality care, so this captures some of the interventions that we looked at through the third -- or the second report that I mentioned in reducing disparities.

Next slide.

So, I'm going to just quickly walk through some of the recommendations, because, again, these are quite applicable to some of the work here.

The first one, as I mentioned, is to collect data on social risk factors and social needs.

The second is to use and prioritize stratified health outcome -- health equity outcome measures, so these are measures that can capture data on certain social groups.

The third is to prioritize measures in the domain of -- so looking at access and high quality care as in -- for accountability purposes, but when we're talking about things like collaboration and partnerships, structure and culture, these may not be as suitable for accountability, and I think we'll get into that a little bit more when we talk about attribution later on today.

And then we also have this -- another

recommendation about investments in preventative and primary care for patients with social risk factors recognizing that these are, you know, really critical services to promoting health equity and reducing disparities in the groups that are most affected by these kinds of risk factors, such as, you know, food and housing insecurity.

And then the next is about payment models to support health equity.

Next slide, please.

The sixth recommendation -- and there are only ten -- is the -- is about linking health equity measures to accreditation programs, and so that is also quite relevant.

The next is around supporting outpatient and inpatient services with additional payment.

And then the eighth is about ensuring organizations that are disproportionately serving individuals with social risk factors have

the resources that they need to compete in value-based purchasing programs.

Then, the ninth is to fund delivery and payment reform demonstration projects, because there's still a lot that -- although there have been plenty done and are ongoing, there's still a lot more work to do.

And then, lastly, this issue around assessing the economic impact of disparities from multiple perspectives. We have a few studies out there about its impact, but there needs to be more research in this area.

And I imagine having some more economic studies around food and housing insecurity would also better make the case for some of these issues, and, I think, I'm going to talk a little bit about some of the research that's been done there as well.

All right.

CHAIR HASNAIN-WYNIA: So, I just want to pause for a minute. And, I think we have a

new person who just came, so if you could introduce?

DR. BERNOT: Thank you. I did -- I was able to meet most of you. My name is John Bernot. I am one of the senior directors at NQF working on the quality measurement team. I also have a slightly new role, as you may or may not have seen. We're rolling out an equity program across NQF. There's press releases that have come out just this week, so it's okay if you haven't heard it, you will, and I'll be doing a lot of work on that particular project also.

And, lastly, I still am a practicing family physician, so this topic is just really near and dear to my heart, and just seeing it in action, these upstream impacts on health, and what they can do to people is a real interest of mine going forward.

So, I'm not sure what all I missed, but I just want to thank everybody for coming, and it's probably been done, and I appreciate,

Romana, for you introducing me.

CHAIR HASNAIN-WYNIA: And I also want to make sure that we take a moment to see if there are any questions, questions about clarity about the objectives of the meeting, the work of the committee, and also any questions about the overview that Drew just gave?

And remember, if you do have comments or questions, please use your cards.

Sarah.

MEMBER SCHOLLE: So, I've read the goals of the meeting about three times trying to think practically what are -- who will use these recommendations, and are they targeted to specific -- specific implementation?

Because right now -- I mean, I understand the connections to the disparity report, but I wonder if you could just say some more about where -- you know, where is this coming from, and how might this report be used by -- and is there someone in particular at CMS or ONC that

wants to use this?

MR. ANDERSON: Yes. So, we actually -- we received this work through ONC, and they approached us a number of months ago to look at whether or not measures could be developed in this area, and that's why we're generally having this conversation about the role of the healthcare system, and, you know, what measurement could look like in the hopes that we could potentially do some kind of measure development in this area.

So, that's kind of the perspective that it's coming from, and that's the -- that's why we hope to get to some kind of measure concepts by the end of this meeting, or following this meeting, that could inform that development process.

CHAIR HASNAIN-WYNIA: Ron.

MEMBER BIALECK: I have a question similar to Sarah's just trying to get my head around the scope, because the measures that one

might have for a family physician or primary care practice might be quite different than a hospital or health system, and I just didn't know if we should be thinking about, or focusing on one or the other, and then there's FQHC. I mean, there's kind of whole variety, and the measures, again, would be quite different.

MR. ANDERSON: Yes, that's a good question. So, I think we've left that open for you all to decide. We have a conversation on what's the most appropriate areas of measurement. We will talk a little bit about the level of analysis, and what the current state of the evidence is, but I think it really is open to where the expert panel feels is most appropriate for measurement right now.

MEMBER SINGH: I think -- maybe just to build upon it. I think your theme is clear. Is -- you know, I think that I totally get if the customer, so to speak, is CMS or ONC. However, then CMS or ONC is then going to be taking kind

of essentially constraints and decisions based upon that that go into an implementation base or provider base. So it just strikes me that at this juncture that it's -- it would seem insufficient to be able to just provide high-level recommendations about some guidance on the current state of implementation play, what they're able to receive and then do, especially since the disconnect and action cycles around this, I think, often relates to that type of gap.

So, it's just really a question about scoping of work, and the answer could just be that like it is what it is, but I'd just be curious about the latitude on that metadata around vendors as it relates to implementation cycles or learning cycles.

MR. ANDERSON: And not to kind of kick it down the road a little bit, but the -- so Tom Novak is our main representative from ONC, and he'll be joining us at 10:30 -- or 10:15-ish -- and he plans to make a few remarks about the scope

and what they intend to take away with this work, so as we move forward, we'll be making some space for him to kind of give his perspective on it.

I don't know if you wanted to share anything else.

MS. MUNTHALI: No. I think that's right.

This is Elisa for those on the phone. And, I think, you know, going back to what Drew said, this, for us, is foundational work in this very important area. And, you know, there are going to be many steps before we get to the measures, but I think the guidance that you would provide would be helpful.

I'll just speak now, and Tom will tell us otherwise, but I think it will be helpful for ONC and CMS.

CHAIR HASNAIN-WYNIA: Sarah, did you have another comment?

(No audible response.)

CHAIR HASNAIN-WYNIA: No. Great.

So, I just wanted to piggyback on the last comment related to potentially the committee's work being incomplete, or maybe insufficient, if we only provide high-level recommendations without understanding, excuse me, the current -- kind of the current state.

So, my question is related to the key informant interviews, and could you speak to how those might inform some of the current state work around implementation?

MR. ANDERSON: Right. So, we anticipated that this meeting might be -- you know, we might not get into the nitty-gritty of everything. We might still -- because there's so many conversations that need to be had before we get to a certain level of detail, so we've been beginning to schedule a key informant meeting based on some -- it's a web meeting that will happen a week or so -- probably two or three weeks after this -- where we'll bring together some other measurement experts in from like the

USDA and HUD, and several other areas, to kind of react to the higher level recommendations that come out of this meeting.

We'll be kind of circling that information back to you. But it really is an iterative process, so we want to give you all an opportunity to kind of have this higher level discussion, get down to, hopefully, recommendations that are able to be -- are actionable, but we do have this next step where we'll be bringing in some other folks, and then sharing that information with you to make it more -- or operationalize it, and make it more concrete for something that ONC or CMS can pick up.

CHAIR HASNAIN-WYNIA: Any other questions, comments?

(No audible response.)

CHAIR HASNAIN-WYNIA: Okay, Drew.

MR. ANDERSON: So, we thought that a good way to start this meeting would just be to

talk about the current state of the evidence, so we sent over -- this is going to be a high-level overview of both food insecurity and housing instability, and we sent over some of this information in the memo, but we just kind of wanted to walk through what the current state looks like.

So, I'm going to just give a brief overview on just some recent statistics from the USDA.

So, food insecurity, as you all know, about 12 percent of the population -- or households surveyed are food insecure during 2016. Among those, many households have children.

I actually inserted this graphic here just to kind of give a breakdown relating back to the roadmap and disparities kind of looking at the characteristics of people who are food insecure, so many of these are household headed by single women with children. You see a

disproportionate number of non-Hispanic blacks who are food insecure. Also, you can see an income gradient when it comes to food insecurity, and also there are several differences when it comes to Census region and place of residence.

Next slide.

Some measures of food insecurities, so we included a lot of these, again, in the memo. There were a number of screening tools that we found, but -- and we'll talk about those a little bit later, but one of the most common, as you know, is the 18-item instrument.

And I put in a definition here just to kind of -- the operational definition that we've been going on with this -- for this project is that food insecurity is a limited or uncertain availability of nutritionally adequate and safe foods, or a limited uncertain ability to acquire foods in an acceptable -- socially acceptable ways. And the main categories of food insecurity for this -- based on the USDA guidance is this

high, marginal, low, and very low food insecurity.

And I put this other image in here from the USDA just to kind of give some of the main measures that are used in this instrument about, you know, food, the food that was bought didn't last long enough, worries, so there's like anxiety, food insufficiency, and a number of other measures that are commonly used, and this instrument is adopted to the 18-item, the 10-item, 6-item, so it's commonly used throughout national surveys.

Next slide.

And then talking a little bit, we sent over -- along with the rest of the meeting materials -- this article by Gundersen at University of Illinois. It was published in Health Affairs back in 2015, and it really provides this nice overview of the effect of food insecurity on health outcomes, and so, you know, it documents that, you know, most of the studies

on health outcomes have used the current population survey that food insecurities supplement, and then we categorized these studies in these three different buckets. So the -- most of the studies have been done on children, and we found associations between food insecurity and birth defects, anemia, lower nutrition intakes, anxiety, aggression, you know, being hospitalized, asthma, behavior problems, all different kinds of health outcomes.

There's been fewer research -- fewer studies on non-senior adults, but we've seen -- the ones that have been done have found, you know, decreased nutrition intake, increased mental health problems, hypertension, and worse outcomes on health exams.

And while there's been a lot of research on -- among seniors on food insecurity, there have been fewer studies that specifically looked to link it to certain health outcomes, but those that have, have found that there is lower

nutrition intake, again, depression, and specifically some on limitations on activities of daily living.

Next slide. Oh, continue.

CHAIR HASNAIN-WYNIA: Have you explored the recent research by Seligman and Berkowitz that recently just came out? It was in JAMA in the past month.

MR. ANDERSON: Maybe. So, we have a whole list of sources. I just kind of pulled out -- we built mostly on this, this review, and in the memo, we did cite a number of more recent studies, but I can't remember off the top of my head which --

CHAIR HASNAIN-WYNIA: Okay, just because it just came out, and I think it adds to the research that would be important there.

MR. ANDERSON: Awesome. Okay. Yes, we'll take a look. If we don't have it in our listing, we'll reach out and make sure we include it.

Okay. So, we also put in a number of interventions. The ones that rose to the top, of course, SNAP is one of them, and I just put this image in here just to show how SNAP has been shown to reduce not only food insecurity, but also a number of other hardships related to housing and medical expenditures, utilities, that there are, you know, interventions that are helpful in reducing food insecurity. And this was published by Brookings and the Hamilton Project.

You want to --

MEMBER KNOX: Just, again, adding to recent research. Make sure that you noted the research on SNAP recipients by Hilary Seligman and Seth Berkowitz about the impact on health of SNAP.

MR. ANDERSON: And just to make sure, I don't know if you all wrote down the -- Ginger, if you want to -- could you mention the study that you --

MS. ZIELINSKIE: I think we're speaking of the same study.

MR. ANDERSON: Okay.

MS. ZIELINSKIE: There's also a recent --

MR. ANDERSON: Great.

MS. ZIELINSKIE: -- study out by Szanton --

MR. ANDERSON: That's what I thought, okay.

MS. ZIELINSKIE: -- Sara Szanton out of Johns Hopkins related to SNAP access and senior healthcare utilization and costs.

MR. ANDERSON: Okay, great. Yes, so we'll double-check that. Thank you.

Okay. And, so, this is -- this is just another image from the U.S. Census Bureau just linking -- again, food insecurity is highly, you know, associated with housing instability. This image just kind of shows, you know, the differences in homeowners versus renters, and

that you can see in the second bars here that homeowners -- or renters are far more likely to be -- or, I guess, have a higher prevalence of food insecurity than homeowners. So it goes back to that original slide that I showed with the income gradient and socioeconomic association.

So, next slide.

So, jumping into some quick stats on housing instability. So, this is just some of the recent statistics on homelessness in America in 2016 where there were over 22 percent of children, over 60 percent of homeless people are -- were over the age of 24, nine percent between ages 18 and 24 have experienced, or experienced homelessness at some point in 2016.

There was also a study in 2012 looking at, you know, over 40 million people -- U.S. households spent more than 30 percent of their pre-tax income for housing, which 30 percent is usually that marker that you want to keep your, you know, household expense -- or rent and

mortgage expenses below that.

And, then, also, just a quick stat on 8.3 million renters were classified as worse case needs or experiencing housing instability. And so, this is another -- worse case needs is a term from HUD.

Next slide.

All right. So, we also sent over in your packet of materials a document -- a review that was put together by the Urban Institute kind of giving the current state of measurement on housing insecurity, housing instability, and these are some of the main findings.

It also includes a number of the key measure concepts around -- within the larger construct of housing instability. So they found, you know, really large gaps in knowledge about the different components of housing instability, including duration, the relationship between housing instability and other forms of hardship.

There is also, you know, the research

is more focused on certain dimensions of housing instability than others rather than looking at this more continuum of bad options for poor renters, and then the other major finding here was that the field needs more -- better measures of housing instability, and would benefit from a more standardized set of measures, possibly some kind of standardized scale.

And we -- there is -- I think we also, we have some folks from HUD on the line, so we're going to be allowing them to kind of speak to some of the work that they're doing, and hopefully developing some kind of tool that's more standardized.

And I like this image here. I put this in. It's kind of, you know, showing that homelessness is the tip of the iceberg. We talk a lot about homelessness, but there's all these other dimensions of housing instability, like overcrowding, housing quality, all of the things that we listed in the memo, and also was

highlighted in the report.

Next slide.

And then just a quick overview of some of the research on housing instability and health outcomes. So, again, it's highly associated with food insecurity, so there was a number of studies kind of linking those together, and showing that, you know, it's very similar negative health outcomes as food insecurity.

There was also this study here that looked at housing instability being associated with child -- this is a study from the American Journal of Public Health, showing that it's linked to childhood food insecurity, poor health, developmental delays, lower weight amongst very young children.

There was also a study that was done a little time ago, it says 2011, I think it was through funding with the CDC in Washington State, that it found that it's associated with poor health, fair health status, delays, and doctor's

visits, because of costs.

And, then another review from the University of Michigan actually that looked at, you know, the stress associated -- well, they did a review that showed the stress associated with housing instability can also be linked to health, changes in health behaviors, and depression, cardiovascular disease, substance abuse, and unhealthy eating.

All right. And, so getting close to wrapping this up. And, so, the -- I just wanted to put this in here as just another example of, you know, interventions that have been shown to reduce, you know, housing instability, and have an impact on healthcare costs.

So, this study was published in Health Services Research, and it kind of shows that there's been -- when you address housing instability using supportive housing, you can see a lot of reductions and costs in both days in hospitals, emergency room visits, days in nursing

homes, and they showed like an average of over $6,000 a year per person in healthcare, so it has really real healthcare implications.

And there was actually a recently released report from the American Hospital Association highlighting a lot of the links between healthcare and, and housing.

Next slide.

Okay. So, that was just a brief overview. I guess, before we, we start the discussion, if anybody has any questions. I'm going to turn it over to Romana, but we wanted to pivot into this next section to talk about definitions, but before we do that, if you have any comments or other suggestions for research that we should be including in our scan.

CHAIR HASNAIN-WYNIA: I have a question. So, I'm curious in terms of the, the evidence synthesis that you just provided. Was there any -- did you look into any of the international work in this area, or was it

limited just within the U.S.?

MR. ANDERSON: Yes. So, we actually did -- we limited it to U.S. only sources, which I know that the vast majority of the research in this area has been done in other countries, so if there are particular studies that are highly relevant to this work that we should be including, we will -- we're definitely open to that.

CHAIR HASNAIN-WYNIA: So, I'm just going to ask members of the committee whether you have recommendations in this area. I will -- in terms of full disclosure say this is not my area of expertise, so, so I'm actually asking, because I think that there are individuals at this table that, that have this expertise, so particularly, international work that has been done looking at linkages between health systems, and other partners, I think, would be incredibly relevant to the work here.

And, I think, sometimes we forget to

look at our international partners for, for models and potential lessons, so I would recommend that we at least, you know, within certain parameters, open the, open our evidence search to the international community, so any guidance would be appreciated.

MEMBER GOTTLIEB: Drew, thank you so much for running through what I know probably took a lot of effort for many people, so thank you for that.

I want to take a step back, and then we'll try to answer to some degree your questions on it. So, I -- I'm a little bit -- I'm struggling a little bit with what the hope was with this scan, because what I -- what you just presented were the connections between food insecurity, housing instability, and health.

In the paper, there's a mix of connections to health, and ways you can screen, both inside and outside the healthcare system, and then the sort of review of the measures

themselves, sort of what we know about those measures.

And I think the question of -- or actually let me add. There was one other thing, which was what the healthcare, or what the role of the healthcare system could do about it, right, and those are three kind of different areas, what the healthcare system can do, are interventions effective, what's the connection to health, and what are measures that you can use to screen for it.

So, I sort of find, find that this, this scan, there's too much there, and it's not sort of separated into those three categories in a way that's as elegant as what you just did in terms of just connecting these, these topics to health.

So, Romana, I guess my question is, if the point of the scan was to connect it to health, I think there's tons of international literature that does that very beautifully. If the point

of the scan is to say, "These are measures that -- these are -- well, first, these are interventions that work in the healthcare delivery system to address these problems," then I would focus it on the U.S. healthcare system.

And if the point of this scan is, these are ways that you can screen for these determinants in the healthcare system, then I would limit it to the U.S. healthcare system, because I think our context is unique.

There may be some other contexts where the -- again, Australia, and, to some extent, in England, where there's some relevant literature about the healthcare delivery connection, but that -- I think it's more nuanced.

CHAIR HASNAIN-WYNIA: So, I think that's a really excellent articulation, kind of the three important buckets, and, you know, as I'm -- as I was listening to you, I think you're right in terms of the evidence linking food and housing instability insecurity to health

outcomes, there's a large body of literature.

And, you know, I guess, the question is, you know, do we get to a point of diminishing returns in terms of -- you know, once we get saturated, we know the evidence is there, so, you know, this is something I'm particularly attuned to, because I've, you know, been a disparities' researcher for many years, and I said for many years, "We know that disparities exist, so we don't have to keep saying that disparities exist," right, out we need to start looking at interventions, and really what works in terms of reducing disparities.

I think in some ways, that's what I'm hearing in your kind of first comment around the evidence. And my recommendation that we open up the, open up our evidence scan to include international, so I might take a step back in that, and I want to hear other people's comments related to that.

In terms of your comment related to,

you know, if one purpose of the scan is to really understand the interventions that have been implemented, and what works, we should focus on the U.S., but, you know, I would say that it might be relevant to a certain extent to look at some of the international literature in that area.

And, then the third -- oops. I know that you want to make a comment, so -- and then the third, in terms of the screening, I actually think that that is an important part of, I'm speculating, an important part of what ONC is looking for, some very tangible kind of movement forward, so it relates to the data collection piece, and within that context, is there a taxonomy that could potentially be implemented in terms of collecting data within the healthcare system around social needs, right?

And if that is the case, then I do think that there's probably a good reason for us to stay within the parameters of what we're doing within the U.S. for, for a variety of reasons.

So, I think, you did a really nice job of kind of articulating, you know, some of the questions, purpose of this committee to a certain extent, and, and, you know, how broadly do we want to kind of calf the evidence met if you will.

So, I'll stop there. I see that we have a number of people that have comments, so, Prabhjot, I think you -- oh, you, I'm sorry. Yes, you had a --

MEMBER GOTTLIEB: I'm getting used to it. I'm going to get there.

So, in the U.K., they've done some really interesting work with -- they call it, "social prescribing," which is a term we, you know, may want to elevate here in the United States, but specifically, the work that is being done at the clinical level to identify and help intervene around social determinants of health, they have kind of put it around, a line around saying that that's called social prescribing work.

And there's a recent review of the literature out, which I will send you shortly. They are saying that the evidence there is as crummy as it is here about what the healthcare sector can do, but just, just FYI.

CHAIR HASNAIN-WYNIA: Prabhjot, you're next, yes.

MEMBER SINGH: Yes, thanks. Thanks.

I think, I think part of why -- I think it's important to mention, you know, in the early part of the day to just make sure we're getting the scoping right is -- I don't want to make random comments that are not driving it forward.

I think if the, you know, if the clients are -- that may not be the way NQF thinks about it, but ONC or Medicare, which have, which have two different kind of like client requirements, I guess. You know, in some sense, if one question is, are we helping Medicare, or that group, CMS, like prepare something that can go through the CVO that states that there can be

changes to inclusion criteria for funding of Medicare disbursements, then there's kind of clear client-side requirements of what are the evidentiary standards, what are the gaps, and so forth, of which a lot of the literature does not, does not meet.

And over the last three years, this -- there's been a lot of modeling work that's been allowed for the first time to be included into this, into CBO analysis, and so I just like -- that may be like very specific, but it's worth clarifying if one of the purposes, like if one of the purposes -- I think it comes back to the early comments in the day is, does the purpose of this information help accelerate that process?

If the other purpose is to help ONC expand or clarify their taxonomy around this, then it makes the sharp shooting into broad literature basis just much more clear. If the purpose of this is to help NQF develop a foundational understanding that's a broader scan,

and one of its clients happens to be ONC and Medicare, but it could be other people over time, then that allows for just a broader discussion base.

And, so, I just, you know, just -- it would help clarify -- I know Tom, when he comes in, or is that the gentleman?

PARTICIPANT: Yes.

MEMBER SINGH: Might help clarify that a bit, but just want to get a sense from you in the day.

CHAIR HASNAIN-WYNIA: So, I would like to just -- I don't have an answer, but I, but I have some speculation just based on prior work. And given that this is funded by CMS/ONC, and kind of your, you know, splitting, kind of where, where the focus really is, and I'm going to ask my NQF colleagues to, to weigh in on this, but I think that if, you know, we're really kind of starting with the lens of, you know, really getting into the weeds where we're looking at CMS

potentially going to the CBO, it does, you know, touch on evidentiary standards, and whether, you know, the evidence is based on consensus panels, or, you know, actual hard evidence.

I almost think that we're jumping the gun in terms of going there first, and I do want to get a sense from, from, again, colleagues at NQF, and I know we'll be hearing from, from our colleague from, from ONC, but it almost feels to me that we are, in fact, the work in this committee is to lay the foundation.

And future work may get to the point that you're making, so that is my speculation. I don't know if I'm correct, so I'd like to get some clarity on that.

MR. ANDERSON: No, I was just going to agree with you, Romana, that that's exactly what this -- the purpose of this meeting is really to do foundation setting. That's why we have, you know, we didn't share the very detailed agenda, but it's really about having these higher

level discussions, so that we, we make sure that we, you know, we're very thoughtful about how we would approach measurement in this area before we kind of go down the road a little bit further, so -- but we'll see how -- I also meant to mention that we're very flexible with the agenda today.

We have a plan, but depending on where the conversation goes, we're willing to kind of go, you know, with where the committee thinks is --

DR. BURSTIN: Just wanted to -- again, I think we'll hear from Tom when he comes, but I think it's a fair assumption that I think on the CMS/ONC side, my guess would be this would be more closely tethered to healthcare delivery, and so I think if that's a helpful -- even if it's connectivity between healthcare and the community, healthcare and public health, healthcare and other -- I think that's -- my suspicion would be that would be the logical core of it as much as I love Europe too, but I suspect

that's not what they're on the table talking about.

MEMBER SINGH: What -- sorry. What part that they're not talking about?

DR. BURSTIN: I mean, the idea of thinking about how this changes Medicare payment for specific services, I'm not sure --

MEMBER SINGH: Oh, yes. No, no, no, I mean, just even constraining it into what you just said is, takes a lot of stuff off the table, which is great.

CHAIR HASNAIN-WYNIA: Okay? All right. Traci.

MEMBER FERGUSON: So, I did want to make a comment that when we're talking about food insecurity and housing instability, that looking on the international sort of arena to see -- in terms of national disasters, because coming from, you know, Florida, and even from Hurricane Harvey in Texas, that we may not have had in the U.S. a lot of experience of rebuilding a lot of areas

that have been affected by natural disasters, and so there might be some information on how, you know, on a more international basis how they've had to sort of rebuild the infrastructure of their healthcare, and, you know, the housing and the food resources.

So, you know, not to say that that's going to be -- we're going to expand to everything, but that if -- it does affect delivery of our members, and it does have a significant impact on, you know, Americans' ability to have food when you have the, the infrastructure is, is destroyed in a natural disaster, so I think we should include that.

It may not be, you know, an overarching, but that, that's something that we as, you know, healthcare payers and consumers have to deal with when we have that, and we may get additional evidence or possible interventions of how to rebuild the housing and food quickly from other, from other areas, so I just want to

add that in.

CHAIR HASNAIN-WYNIA: Thank you.

Sarah, and then Ron.

MEMBER SCHOLLE: Laura's organization of the literature just, you know, got me centered here, so thanks so much. It also helped me to think through like, how do we use this information to get to a performance measure for the healthcare delivery system?

Because the information about the relationship between food insecurity and housing instability for national surveys and how that's related to health outcomes, that's important. It helps us to identify a denominator population say, which is the population we care about.

It might also be relevant in all the discussions we have about how to address social risk when we are sharing information about performance measures. We're not adjusting for those measures, but we are accounting for it in how we present our data.

So, that's important information to help us guide where do we target our information, but if we're going to talk about a performance measure for the healthcare delivery system where we say, "We want you to identify people and do something for them, and we think it's going to work," then we need the kind of evidence that Seth Berkowitz, and others, are starting to develop from the health leads' work.

And, and I actually found that literature not to be very well represented in this review, because it felt like it was all high-level population health rather than what is the healthcare delivery system doing?

And it's important to do that, because we need to think about which of the populations for whom this really makes a difference. And the food -- I can't remember. What is it called? Food insecurity and housing instability. I can't remember which words are going where, but housing instability is a huge issue when we think about

re-admissions, and particularly for mental illness, right, because that, if you don't have a place -- if you don't have a home to discharge somebody to, then they're going to come back to the hospital, or you don't get discharged, right? That's a long -- so, there's going to be specific populations where this really makes a difference.

And food insecurity, you know, I've heard, and we've just done brief amount of work in this, and I said, "That really matters for people who are having surgery or some kind of procedure."

You've got to have people, you know, if they are malnourished, then they're not going to do well in surgery, so that's part of what you do there, but that, that kind of, that logic of what -- how do you identify people that are at high-risk where there's something the healthcare system can do, is important, and a lot of that -- what matters is, what's available in the community to support?

And, you know, Rebecca Onie at Health Leads said, you know, "We don't really try to ask about housing, because there's nothing to do about that." You know, it's a seven-year wait for Section 8 housing, so that's a hard thing for us to do something about, so there's where I think about what can the healthcare system do. Let's make sure bite off something that people, first of all, can do, and that they can do.

And, then the other piece is I see a lot of stuff that's called "measures" in here, but they're not performance measures. I'm not -- I don't think there's anything that's a performance measure, and I think it would really be helpful if we were really clear about that, because right now, we're saying measures, and we're NQF, and everybody kind of thinks we're talking about the same words, but I've had a lot of, and you guys know.

DR. BURSTIN: That's a really important point, Sarah. And I think what we're

really getting at today is really almost establishing a logic model of how, what this evidence-based could actually connects to healthcare, and really coming up with a set of ideas or measure concepts.

They're not performance measures yet. Some of them may never been performance measures. They may wind up being quality improvement strategies that you use between a community and the big healthcare system in town. Some of them may wind up being performance measures, and they can also be very different levels of analysis.

There's nothing that says this is a clinician level measure, or this is even a health plan level measure, it could be. This could be a state level Medicaid measure, so I think some of this is really kind of giving yourself a very broad sense of what you would use measures for, and recognizing that really what we're talking about here, I think, is establishing the logic model, and the ideas for what could be done at

what level of analysis.

CHAIR HASNAIN-WYNIA: Thank you.

Ron.

MEMBER BIALECK: Helen, you may -- you may have solved this for me, but I'm going to still ask. You know, John talked about upstream, and Laura mentioned social determinants of health, and we know that if we solely measure housing instability and food insecurity that moving the needle, maybe we'll move it a little bit, but if we don't look at the social needs associated with those, and the community infrastructure to support those needs, we're not going to really move the needle.

And I think about the Accountable Health Communities, the paper that, from National Academy, where a variety of social needs were taken into consideration, so my question really is, again, this is sort of back to scoping, but are we -- are measures that relate to whether it's social determinants or social correlates,

are those types of measures in play in this discussion, or is solely insecurity and housing instability?

CHAIR HASNAIN-WYNIA: Ron, can you clarify that question? I'm sorry. Just so -- distinguish again --

MEMBER BIALECK: So, there's measuring housing instability and food insecurity, then there's measuring the factors, the root causes --

CHAIR HASNAIN-WYNIA: Okay.

MEMBER BIALECK: -- behind that, and if you really want to move the needle, those root causes are what ultimately need to be addressed, otherwise, you're just measuring, and maybe occasionally moving things forward, but you're not getting to what ultimately will result in a more food secure individual and community and a housing stability.

CHAIR HASNAIN-WYNIA: Nancy, you're next, and Lynn, and -- Laura, do you still have

your card up?

MEMBER GOTTLIEB: Yes, I just want to respond to--

CHAIR HASNAIN-WYNIA: Okay. Say that again. You want to --

MEMBER GOTTLIEB: Just to respond to Sarah's point.

CHAIR HASNAIN-WYNIA: Okay.

I guess, my -- I just want to raise this question, and so I just want to --based on Ron's comment, that, you know, the one thing that I, as I read the materials, the one thing that, you know, kept coming back to me that was clear is, what's the role of the healthcare system, right? So, that's the thing that I was very clear about.

And, I guess, Ron, you know, the comment, or the question that I would raise is, if we do go back to the root causes, in some ways, are we moving away from what the role of the healthcare system would be within that context,

and I'm not saying that, that that is the case, but it raises the question.

It also raise the -- it raises to me the question of when we talk about the role of the healthcare system, and we think about root causes around food and housing insecurity, how proximal do we want our actions within this committee to be related to -- I'm thinking of our primary audience in this as being CMS and ONC for whatever purposes they use this for, and I hope that we get more clarity on that, so those are the comments that I just want to kind of put out there.

MEMBER BIALECK: And this is where it comes into, in some ways, the types of institutions. So, for instance, the American Hospital Association, their HRET, Health Research and Education Trust, has a couple of documents on the role of hospitals in addressing food insecurity, role of hospitals dealing with housing instability, and in those documents, they

do get into some of the causal factors and suggest that with, you know, value-based purchasing, and some other models out there, that indeed if hospitals are looking to reduce sick care that they do need to move upstream, so in that context, the field may be moving there. It's not there yet.

CHAIR HASNAIN-WYNIA: Thank you.

Nancy, Lynn, and then Laura.

MEMBER LAWTON-KLUCK: Just to align with what you just mentioned. I think we talked a lot about the measures, but I don't think the populations is something else we need to spend a lot of time talking about.

If you talk to a health system, or you talk to a payer, or you talk to different people, will have a different advantage point of what a population is, so sometimes we look at a healthcare institution, and it's easy to look at that patient population, but then with measures, you're looking at the entire health, or the

health population of the community, so then spending some time talking about what populations and what are the best interventions, and then to align with what you also had said.

I think that the health system has opportunity to do concentric circles of approach. So, for example, you've got things that you can do when people are right within your health system, you've got partnerships you can form that you might not have expertise in, but you have those partnerships that you can help build up.

And sometimes a lot of it is just building communications and building strategies, and then that third piece is just that one sense removed where you can build a family through access. So, you know, I just think spending a little bit of time on the population is going to be an important part of today.

CHAIR HASNAIN-WYNIA: Thank you.

Lynn.

MEMBER KNOX: So, our state spent nine

months with a committee of 50 health professionals designing and building our food insecurity and improvement and intervention metric. The most important and influential component of those nine months of discussion was the input of people in the field who are already in a hospital setting or a clinic setting implementing this work and doing something about it.

And, so, the work of this committee, it seems to me, is not building the evidence that something needs to be done, just like the work on disparities, that has pretty much been done. Where we need to go is looking at what to measure, how to measure, when to measure, who to measure, and then what to do, and proving to ourselves that there are things that we can do.

I totally agree that on the housing situation, the first blush is often to throw up your hands and say, "There is nothing we can do," but I can give you example after example of

communities that have grappled with that, and are moving forward, and certainly, the same with our 300-plus sites of food insecurity intervention in Oregon, and then others across the country.

So, it seems to me that we need to be moving forward and dealing what is really the, the brick in the road that prevents us from moving forward, and that is understanding what to do.

CHAIR HASNAIN-WYNIA: All right. Laura, I'm going to call on you next, but Amanda's been on the phone, and I just want to make sure that she has a chance to speak. She has her hand raised, but we can't see it, so, Amanda.

(No audible response.)

CHAIR HASNAIN-WYNIA: Amanda, are you on mute?

(No audible response.)

CHAIR HASNAIN-WYNIA: Okay. We're going to move on. Amanda, one more, one more, one more callout if you're listening. You've had your hand raised.

(No audible response.)

CHAIR HASNAIN-WYNIA: All right.

Laura.

MEMBER GOTTLIEB: Lynn, thank you for that. It's important.

I think -- this is in response to many really brilliant comments. I want to -- I want to just propose a framework. I think these are really different scans or reports. And one is sort of generally about what the healthcare sector can do, and another is, if the healthcare sector is going to do something, what, what are the different measures that we would propose for doing it, or for collecting information to inspire doing something about it.

And I just -- in each of those, there are sort of a different set of questions. And the framework that we've been using at SIREN for what the healthcare sector can do involves three different buckets of activities.

One bucket has to do with at the

direct patient care level, what we call, "social determinants of health informed care." And this is stuff we do every day in the healthcare sector.

We dose medication around work schedules, or the availability of refrigeration, we send out mobile vans to improve access, we open night clinics or Saturday morning clinics, so we do things that are informed by people's social circumstances, but we tweak the delivery of medical care.

The second bucket of activities is social determinants of health targeted care. And this is this new wave of interventions. People have mentioned health needs. There are a zillion other examples, but where we actually incorporate trying to change -- interventions that attempt to change people's social circumstances in some positive direction to decrease the impact on health, so we connect them with food services.

Like Lynn had mentioned, we try to identify housing instability, and intervene

around housing instability. And just as an aside, we have an RCT that we conducted where we actually showed that we decreased evictions in a very housing impacted market like San Francisco.

Even though we weren't able to house people, we decreased eviction, so there are lots of different ways to talk about the impact that we could have on housing.

The third bucket has to do, and Nancy, I hope you can talk about this more, but what the healthcare sector's role is as an anchor institution, and kind of influence in the availability of community resources.

So, those are three very different buckets. Each of them has difference evidence-based. It's really important if the committee wants to take this on to think about the challenges and the opportunities and building the evidence in each of those areas.

And I agree with Lynn. The committee's role is not to build the evidence.

The committee's role is to identify the evidence, identify the evidence gaps, and then use that information to think about what the potential is around measurement.

And just to go to the measurement report, to me it seems like -- Helen, your comments about the different levels of measures that could be, like there could be neighborhood level measures, there could be patient level measures, it would be super helpful to think about what the, again, the opportunities and the challenges are to measurement in each of those areas.

Because when I think about the patient level measures, I think about things like acceptability, feasibility, validity, all the psychometric properties, are we measuring what we think we're measuring. Those are not reflected right now in the environmental scan.

There is some literature. Again, it's not great literature, but we should know

exactly what that is in that category of work.

I'm done. Sorry.

CHAIR HASNAIN-WYNIA: That we might come back to you to help to restate kind of the buckets, but I want to move on to see if other comments kind of align as well, so Ginger was next, and then Prabhjot, and -- Helen, do you have your card up? Okay.

MS. ZIELINSKIE: In exploring -- what I'm hearing is that there's a lot of interesting kind of intervention strategy in the success or lack thereof. I strongly encourage us not to go just to the direct service provider or the healthcare provider, but what is the role of the state in terms of when we really think about upstream?

There are many ways in which we can indicate who these folks are. If you're on Medicaid, we know that you're a single mom. We know how old your kids are. We know that that's how we're identifying high likelihood of food

insecurity and housing instability.

So, if we really want to push the envelope, I agree that there is a need for in-person support, but we also need to be really thinking about how, especially from ONC and CMS perspective, how states are incented to be smarter about how they're building comprehensive service and support systems.

CHAIR HASNAIN-WYNIA: So, part of what I'm hearing in terms of what you just said, is I always think about, I think, it was Paul Schyve, who was at the Joint Commission for years, who talked about the inverted triangle, and the point being kind of the point of care.

So, in terms of thinking of the base at the top, we're almost thinking about state -- I would say federal/state policy level, then there's -- I'm just doing broad sweeps here, and then there's the organizational level potentially, and that would include communities and how health system interact, but then what I'm

hearing from the committee is at that point, the tip of that triangle, is really what's the role of the healthcare system?

And, then we have, you know, what Helen presented was, you know, measures at potentially different levels, but -- and correct me if I'm wrong, but in your comment, what I'm hearing is, you know, what is almost the federal/state level policy that could potentially provide the base for what comes further down that kind of inverted triangle diagram.

MS. ZIELINSKIE: Yes, absolutely. I think if states are doing their job and connecting people to health and human services supports in a way that is comprehensive, then there's less much of a need for the infrastructure, less people are falling through the cracks that aren't getting connected for the need to do the screen.

I believe that the screen is important as more of a downstream way to catch those that

weren't caught, but if we can use data smarter, then there should be less of a need for that comprehensive infrastructure to be established, and so I think how we, how we incent our state and county services and supports, how we pay for those services and supports to make sure that they're funded, really matters in thinking about how we can be most cost-effective.

Again, I think the vast majority of the folks that we're talking about are on Medicaid. That information is known at the state level down -- to a very specific -- you know, when that mom is getting pregnant, that should be triggering support for WIC.

CHAIR HASNAIN-WYNIA: Great. Thank you.

Prabhjot.

MEMBER SINGH: Just want to -- I just want to say that I think I really appreciated the sequence of comments that came here, you know, from Sarah, and then Ron, and then what Lynn had

clarified, and then building into a fairly tight framework that Laura provided.

Just in terms of like the day, how it proceeds, like I would I love if we weren't -- if we were able to like commit to things, and then not backslide, or not lose some of that, because I feel like we built into some depth during the course of the day.

I understand that you're kind of taking an exploratory view, but I feel like just mentally I get like disengaged and I get lost, and like I've just been given so much clarity, which I, which resonates deeply, so I just like want to say if we can have some like, I don't know, thumb up, something or the other.

It's like you commit to some element of that, because a lot of this could build in deeper and more like thoughtful comments along the way.

CHAIR HASNAIN-WYNIA: Yes, and, so, I'll just say that, you know, I think we were

hoping that, that Tom would be here from ONC to help anchor a little bit of our, kind of our scoping, and where we have the thumbs up in terms of our direction, so we'll keep this conversation moving.

And, and I think what will happen is when he comes and presents, we'll have some very targeted questions as well. I completely agree with you. I, you know, just by chairing, I also, if I start to feel like, you know, there's kind of scope creep. I'm not quite sure what the role is, so if we start to really hear themes, and we can get maybe, you know, the people who are going to be doing the hard work here are the NQF staff in terms of synthesizing, and really articulating what our next steps are.

So, as we hear kind of the comments, I would like some direction for all of us in terms of, yes, thumbs up, we're, we're going to move in this direction, so I heard Helen loud and clear in terms of a logic model, and then I heard some

elements of what needs to be in that logic model.

Of course, the question that I have when I think of logic model is, where do we want that logic model to go? And I still think that we're kind of ruminating and thinking, and I don't think that's been articulated yet, so we need to do that as well, so --

DR. BURSTIN: I one of those people who just needs a whiteboard, and I feel like we're ready to start --

CHAIR HASNAIN-WYNIA: Yes.

DR. BURSTIN: Bring in some newsprint and stuff, trying this out, because I think -- actually, the connection -- Nancy had said earlier, and the other comments, I mean, I think they're very much this idea of -- I guess, Nancy said patient informed care fits very nicely into SDOH informed care.

The patients within the healthcare system is the informed part. Patients within their communities and partnerships is the SDOH

targeted part. I think there's a logic model here you could really start to build, and maybe you can then have clarity and address each one of those separately rather than, I think, we're flying back-and-forth between the levels of analysis, as well as stream versus intervention, and so maybe there's a break coming up, we can try to just scribble some of this down, and put it in front of you just to target the discussion going forward.

And I'll just give one quick example. When I trained in Boston, the healthcare for the homeless did -- formed the respite for patients who were discharged from the public hospital, who clearly weren't ready to go back to a shelter, and needed a little bit more time.

And in some ways, it's that perfect model, because I think it was very much patients within the healthcare system, we could screen, we knew that they clearly had housing instability, and were too sick to go back to their prior level

of care, but it was really only because of the public health community partnership there that the respite was formed that allowed us to discharge those patients to the respite if the care they needed before they move forward, even if they weren't, in fact, getting housing, we could at least be that bridge.

And, then back to Sarah's point, I don't want to lose fact -- lose sight of the fact that sometimes it's also that the SDOH is informing measurement, and I think that's another piece of this, because, in fact, she's absolutely right, the literature supports the fact that housing instability, and particularly, there's a major driver of re-admissions.

In fact, a paper in Health Affairs a couple of years ago showed that vacancy rates in a community were one of the largest drivers of re-admissions to the hospitals, so there's such a logic approach here, but I don't want to lose sight of that informed measurement piece either.

CHAIR HASNAIN-WYNIA: John, did you have a direct comment?

And, Nancy, then we'll get to you.

DR. BERNOT: Yes. I was just going to reiterate what Helen said. Yes, we do -- we'll have a break coming up soon, and just want to make sure, you know, we're hearing the, the angst loud and clear, and realize the need to get this a little bit more focused here, so what we'll do is -- I do think this discussion is actually very helpful in hearing the words we're using, so we don't want to prolong it, but maybe continue it just a few more minutes to make sure there's nothing else left on the table.

We'll then come back with a nice statement of scope for the rest of the day for the group, and working it through, hopefully, very closely in line with what ONC wants. Either way, we'll come back right after the break and try to make sure we're going forward and jump -- that'll be the springboard for the rest of the

day for clarity, so just want to make sure that you know it's not lost on us, and we'll get this probably -- what do you think? Maybe ten more minutes of discussion, and then we'll take the break and come back with it. Okay.

CHAIR HASNAIN-WYNIA: Nancy.

MEMBER LAWTON-KLUCK: Yes, just two more comments. One going back to that institution being an anchor within a community. One thing to keep in mind, as a healthcare institution, many of them are growing larger by the day, so not only are you a healthcare provider, but you also are the largest employer, so where are you buying, where are you hiring, and where are you investing in the community, I think, is an important component, maybe not for this conversation, but definitely something to have an awareness about.

And, then part two -- because something I'd love to see is to explore a little bit as we're starting to do the identification of

the populations and the interventions, is there's different levels, so, for example, there's the clinical provision that we can have for the patients that come in the door.

There is partnerships from their formal partnerships. For example, we've done the Fresh Food Pharmacy, which is basically linking formally of a food bank with a clinical provider to help people get access to healthy food that we create the actual recipes for, and they provide the food for us, so it's an interesting mix, and then how we can help support those providers in the community that are helping our patients with social determinants of health, and helping the community as a whole.

So, I think maybe, as we look at that logic model and breaking things on a whiteboard, how we interact as an organization, how we interact within the community, and how we interact with our patients, and with the broader community, breaking that down into the

interventions and the population served.

CHAIR HASNAIN-WYNIA: Thank you.

Clare.

MEMBER TANNER: Yes. This is an idea that I'm still circling around, and I don't know how articulately I'll say this, but I feel like as we, you know, if the scope stays too narrow around purely measurement, we're going to lose some things, and potentially, lose the opportunity to think about unintended consequences, and so when we think about how, how information or measurement about food, or any social determinant, is then utilized -- I just think we need to, in our framework, to propose a way to think about unintended consequences about how things get done.

And just some quick examples. So, screening is a hot topic, and I've been seeing, you know, I've been concerned that it's going a little bit too far with this emphasis to do universal screening in multiple settings, and

automatically connected into health information exchanges, and shoot it out to, you know, some other entities.

And just because, you know, hopefully, we'll come up with a measurement framework, but some concerns and cautions about how to think about how this measurement is used going forward.

CHAIR HASNAIN-WYNIA: Thank you.

Other comments?

(No audible responses.)

CHAIR HASNAIN-WYNIA: I think we're actually at a place where if we can kind of get the, you know, get our buckets clarified start to kind of at least put a skeleton, if you will, around a logic model. I think it'll help the conversation here, and also the recommendations of the committee, so we start to kind of converge a bit, and we're clear about our scopes.

So, unless there are other questions about clarity or comments or recommendations related to the logic model, I'm going to

recommend that we break, and, and come back in -- how long do you think?

Okay, so 20 minutes, so we'll be back at 11.

(Whereupon, the above-entitled matter went off the record at 10:38 a.m. and resumed at 11:02 a.m.)

CHAIR HASNAIN-WYNIA: Okay, everyone, we are going to reconvene. And I'm going to start by asking Elisa to get us started.

MS. MUNTHALI: So we just wanted to recognize someone else who is at the table. This is Christal Ramos. She's over there. Christal, you can wave.

She's the contract manager with Urban Institute. This work that we're doing is part of a larger contract in which CMS and ONC and the Urban Institute are working on.

And so Christal will be here to join us until Tom joins us to help with some clarifying questions about the scope and direction of the

project.

Christal, I don't know if you wanted to say anything.

MS. RAMOS: Hello? Oh, yes, so Tom is in town. I think he had some meetings come up so that's why he couldn't come right now, but he plans to stop by.

But my name is Christal. And just to give some context, I guess, this task is part of a broader contract that is funded under Medicaid.

And so our bigger contract, it's Medicaid High TAC, the HR incentive program and health information exchange. Even though this panel doesn't need to focus on that specifically, but I think the bigger goal of what CMS is hoping for is something that state Medicaid agencies can use in terms of building systems, planning, you know, quality and payment efforts.

Some examples where this has started to show up in our work are, like, through health information exchanges. States are doing things

like building provider directories where they want to include human services providers linking them to the health system. Or there's also opportunity in data collection through EHR's to add measures.

I think these are the kinds of things that were first in mind as we were thinking of this task. But I think, as you guys are talking about it, it still needs to start with these foundational ideas of what the health system can do and what the evidence says worked, sort of promising practices.

In the end, I think it will help to focus it if we think of the scope as, what can state Medicaid agencies do and use to help consider social determinants of health as they work with their providers and others in the community? So does that help?

CHAIR HASNAIN-WYNIA: Thank you, Christal. So, I think, it does help. What it tells me, and I hope it tells others on the

committee, that our end user in terms of the report that will be released in December is, in fact, state Medicaid agencies. So that's what I'm hearing.

MS. RAMOS: I think, or, CMS first in thinking about how they can push -- ultimately, how they can push it out to CMS, so, yes.

CHAIR HASNAIN-WYNIA: Right. So okay, so the audience being CMS, but the accountable unit in terms of implementation potentially.

MS. RAMOS: Yes.

CHAIR HASNAIN-WYNIA: And I'll put in potentially being state Medicaid agencies.

MS. RAMOS: Right. That is who we worked with through our contract so.

CHAIR HASNAIN-WYNIA: Okay. All right. Thank you. So we are going to move on to kind of anchor us all in terms of a framework and a logic model in terms of how we think about our next steps and our deliberations and our

comments and recommendations. So, John, are you going to do this or you're -- okay.

DR. BERNOT: Sure. So, really, just working on what Laura has said to really anchor, again, with the audience in mind of the state Medicaid.

We thought it would be good to take and go through each of those three buckets, focusing only on that bucket for a while, for maybe about an hour each and at the end tie these together.

So we would probably -- we'll actually probably start in the reverse order. Looking at these health care organizations as anchor institutions, give them maybe a couple of examples.

I'll be relying on Nancy a little bit to talk about the projects they have and other ones that are working in the community and just go through each one of these.

What is working on these well? What

are the obstacles that we're finding? Where's the data needs?

And we can say measurement, but I don't want us to feel like you have to jump the whole way to an accountable performance measurement.

What are those things in there that allow us to assess the success of that going forward? Are there ways that we could assess the success?

Take that time and then we'll move on to the next one and really do the same thing for the FQH targeted care, talking about all those.

What do we know? What's working? What are some of these interventions in the EMR space, the data space? What is missing? What is working well? And then move down to the informed care, if that is okay.

So we'll have a focus for each discussion as to what that population is, again, the Medicaid and what the questions are around

the scope and move to the next.

At the end of the day then we'll try to tie this together and get at least the very basic preliminary concepts that might be hanging off of this framework or at least the right questions to get to those concepts.

I want to make sure though, since I know there was a lot of lack of clarity, does that sound reasonable and is it pretty clear? So I'll turn this over to see if there's any comments or questions.

MR. ANDERSON: I also wanted to add that we have another slide. If you could go to the next one.

Just on -- because we started talking about level of analysis. So we wanted to just kind of -- no, not that one. Actually, you can close that. Okay. Yes. Yes.

So just the level of analysis discussion, we just thought it might be helpful to think about it at these levels. Kind of just

keeping this in the back of your minds since this is essentially how we've been thinking about it.

But now that we're focusing a little bit more on Medicaid state agencies, the conversation might go more towards that. But feel free to kind of bucket your comments based on what level that we're speaking about as we move forward.

CHAIR HASNAIN-WYNIA: So can we go back to the first slide that we saw? I think, Nancy, you had mentioned the anchor institutions. And I think that's a really interesting framework.

It is a very specific framework. I can't remember the organization, but Tyler Norris and others have kind of worked on this and really laid out a framework for hospitals and health systems as anchor institutions and what the role in the community is and a notion of, you know, our health systems, health organizations out front. Are they supporting? Are they leading?

So my question is one, I'm trying not to see this as a continuum. You know, there's not like a necessary order here. So I think that wasn't the intent. Okay. All right. But my brain tends to work that way, so that's how I'm processing. So I just want clarity.

The second is, you know, are we all clear about what an anchor -- you know, when we talk about health care organizations as anchor institutions, is everybody clear by what we mean when we say that?

Because what I don't want is for us to be throwing out terms and, you know, potential frameworks within frameworks without a clear understanding, kind of a common base, that all of us share.

So I'm raising that question. Is everybody clear about what we're talking about when we say health care organizations as anchor institutions in the community? No or yes? We're not clear? Okay. I agree, okay. All right.

So I think maybe based on that, I don't know, Nancy, can I call on you to maybe just give us just a little bit of framing around anchor institutions so it's not just the terminology we're passing around without a core understanding of what we mean?

MEMBER LAWTON-KLUCK: Well, certainly. So how we're looking at anchor institutions is really how does an organization, potentially, drive a community because of the impact that it could possibly have?

So, I mean, like meds and eds, like sometimes a higher education institution can also be an anchor institution. So it's not limited just to health care.

But because health care does so much hiring because it does so much buying because it does so much investing in the community, especially if it covers quite a big footprint, it can really create an economic impact within the community that's above and beyond just the health

impact that it can create.

So it's really looking at how can you leverage not just the clinical expertise, but also the value of that organization within the footprint of the community. So that's where that comes from. I'm not sure if that's helpful.

CHAIR HASNAIN-WYNIA: Okay. And so, Nancy, your card is still up because you had other comments, so maybe we'll start with you and then we'll go to Laura.

MEMBER GARETT: So just following up on the institution concept, I'm just thinking through how and if that applies to lots of different types of health care systems.

It almost sounds like it's biased towards really big, you know, integrated care systems that are massive, but there's FQHCs, there's individual providers.

So I just want to be mindful of that and is there a way that we want that to be more inclusive or do we really just mean the mega

systems really do have a special role and we want to call that out. So that's kind of a question.

And then my other comment was when I look back at the meeting objectives on Page 10, I feel like this framework really helps a lot with the first bullet, which is discuss the role of the health care system in addressing food insecurity and housing instability. And I think it can help with the last one about recommendations for addressing these things.

I'm not sure it helps very much with the measurement of food insecurity and housing instability because you need measurement across all three of these.

And so I guess I would just call out, we need to make sure we pay attention to that one, too, because I think there's a lot that this committee could do to move measurement forward. And do we need a more standardized way in making some strong recommendations?

So I don't want to leave that part out

of our charge.

CHAIR HASNAIN-WYNIA: Mm-hmm. So I just want to piggyback on Nancy's comment. I'm almost wondering if, you know, the measurement piece is kind of sandwiched in between, right, the role of the health care system and then the recommendations and then we've got measurement.

And to me, I feel like the measurement piece needs to come later. I mean, it can be embedded in the discussion. But I almost feel like we're almost catapulting to talking about recommendations. And I'm still not completely anchored in the role of this committee around measurements.

So is the role of this committee to recommend a measurement framework? Or are we talking about recommendations related to the role of the health care system in addressing social needs?

So I think it would be important to -- I know that's kind of mincing words, but to me

that level of clarity is important when we're talking about the recommendations.

It is the recommendations around the measurement framework or is it recommendations around the role of the health care system?

DR. BURSTIN: I see them as integrally related. I'm not sure how you would separate them out.

I think the point is if you have a measurement framework, the questions would logically flow to say and then therefore, what could you measure?

And whether that's for accountability at the state level or whether that's for improvement at a community partnership level or a system level, it still measures. It's maybe not being quite so dogmatic in what a measure is.

CHAIR HASNAIN-WYNIA: Right.

DR. BURSTIN: But to Sarah's earlier point, it might help us.

CHAIR HASNAIN-WYNIA: Okay. All

right. Any other questions or comments. Laura?

MEMBER GOTTLIEB: Yes. At the break, we had a chance to talk briefly about the interplay between these three groups. And I just think -- I've just been fiddling with proper word.

But I think it's a circle -- you know, I think it's three circles. And I think each one of these is an entry point for any kind of health care system to think about what their roles are around identifying and addressing social determinants of health.

And so if we just imagine those boxes as there is no -- I really liked, Romana, your point that, you know, you're thinking of it linearly, but it shouldn't be linear.

And just to sort of highlight what Ginger was pointing out, that you can't do SDOH targeted care if it's a bridge to nowhere, right? If there is no -- or Ron, you, I think, said this eloquently, too.

If a community has no resources, then there's no point in bridging to those resources or it's informing you about them and strengthening those resources.

So, again, I think the interplay between them is also a really interesting place. You know, there's something else there about how you use information in each one of these areas to do better in the others.

MS. ZIELINSKIE: I'm going back to kind of a basic slide that we've all seen so many times, which is the body, and, you know, 90 percent of costs are in clinical care, but it's only 10 percent of the solution or 60 percent of the solution is outside of the clinical setting. I still feel like this is heavily focused on the clinical setting.

So if we're talking about the determinants of health, we have to get real about the network that is necessary to actually be part of the solution.

And I think if we only articulate in terms of what are health care institutions, we are only then perpetuating the problem.

So I just think that this model arrows no circles. No circles is really limited. And only is considering a piece of the necessary parties in order to be part of the solution.

CHAIR HASNAIN-WYNIA: Clare?

MEMBER TANNER: I think that's true. I think we also thought about limiting the scope in some way or other.

But I was just wondering if based on Nancy's comment a friendly amendment would be to change that third box to think more broadly about how different kinds of health care entities interact in partnerships, in communities or at other levels.

I don't know. We're seeing a lot of work around sort of collective impact and attempts to align and partner and, you know, join community coalitions and things like that so.

CHAIR HASNAIN-WYNIA: Right. And just as a reminder, you know, so this work is designed to be anchored within -- I keep using wording -- anchored within the work of the Disparities Standing Committee in terms of the roadmap, which one of the domains focuses on partnerships.

And I think that we should maybe kind of refer back to that as we start to think about there's the domain and then, you know, there are specific recommendations in terms of, you know, what does that mean?

Then you have the domain around collaboration and partnership with other organizations or agencies that influence the health of individuals. So within that, the examples include neighborhoods, transportation, housing, education.

Within the context and the parameters of this committee, you know, we're talking about in some ways broadly sometimes the social

determinants because they're so interlinked. But the charge of this committee is really to focus on housing and food insecurity.

So, I think, it's going to be important for us to kind come back and think about what are the specific recommendations around performance measures related to collaboration and partnership, whether we use, you know, anchor institutions as a framework to think about that.

So I think that's a really important point. Traci and then Nancy.

MEMBER FERGUSON: This is just adding to, again, that the health care organizations as anchor institutions, just looking in terms of Medicaid and what they will cover. And it depends on whether it's talking about fee-for-service or a managed Medicaid organization, what they'll do within the health care system but also the community based and social services.

So if we could -- and it seems like there's two sort of networks of organizations

that do care for the members. So it's within the health care system and then what I would consider, like, the community impact organizations.

So if we were to say health care or the community impact organizations so you can include both of those. Because both of those will influence and do have significant hiring pay, you know, in the community services so what we do that's inside the health care system and outside the health care system that impact the Medicaid population.

CHAIR HASNAIN-WYNIA: Nancy?

MEMBER LAWTON-KLUCK: No, I completely agree. And I think that one of the benefits of being an anchor institution is just that you have a lot more influence in the community. But it allows you to pull people together that are in disparate groups.

And what we found in working, especially with the food insecurity, is there is,

within the City of Scranton, which is only a 76,000 person population, there are 60 food banks. None of them talk with each other.

No one knew that there was no food bank hours on Sundays or Saturdays. No one knew that there was no after hours.

So a part of it is just being able to pull that group together and have those conversations and create an action plan that the health system doesn't necessarily control nor does it want to, but it empowers that group to do different work, maybe better work, and connect in a different way.

So I completely agree to add that other category, but also that convening power that the health institution has that it doesn't always utilize.

DR. BERNOT: Nancy, can I just ask a clarifying question? So one option would be based on the feedback that we're hearing is just to take the, where it says health care orgs

anchoring and change that to health care community linkages and focus that.

Or are we seeing the need for a fourth bucket on there? That's the question that's in my mind specifically when we were talking about it.

MEMBER LAWTON-KLUCK: Back to the group to weigh in, but I kind of see it as part of that anchor institution power.

So you have hiring. You've got investing. You've got how you purchase. But then you also have that convening power pulling the broader group together.

So maybe there's a subgroup under that of other organizations that already have coalitions surrounding them. But I do think that that is part of the power of health care institution that it can play into this pretty well.

CHAIR HASNAIN-WYNIA: So the comment that I want to make related to that, and then

we're going to go to Lynn and then to Ron. But, I think, Nancy, you raised this.

Are we talking about -- or Clare, I can't remember. But whoever raised it, it's an important point around when we're talking about anchor institutions, are we in fact only talking about kind of the large health care delivery, right?

So, I mean, I come from Denver Health. Denver Health is, you know, 7,000 employees. It's completely integrated. It is, in fact, an anchor institution based on the definition of an anchor institution within the Denver community.

But I worry that we will lose kind of, you know, what is the role of, let's say a private practice that works within the context of a community with, you know, very high social needs.

What is the role of a FQHC that is not affiliated with a large system but is, in fact, maybe, you know, part of a network of FQHCs?

Right. So I'm wondering whether

it's, you know, is it just anchor institutions or is it and? Is it anchor institutions and so?

MEMBER LAWTON-KLUCK: I would say, and it's again back to the group to respond, but I think it's anchor institutions and. I just think that anchor institutions have a unique opportunity that they don't always leverage. But it's the entire community working together that's going to make a difference.

So it doesn't by any stretch of the imagination limit the impact of the FQHCs and the other organizations about they are doing really good work.

But what happens too often is there's just silos that are created across a community, and nobody connects to talk about how they can collectively pull together to make a difference.

So the convening piece of it is likely an important role. But by no means from a clinical perspective is it the only, you know, piece that is important. All right.

CHAIR HASNAIN-WYNIA: All right. Lynn?

MEMBER KNOX: I think we're still challenged with talking about the 10,000 foot level and then the ground level and measurement and doing something about it versus systemic problems where these anchor institutions and state policy can have a role.

Somehow, I think we need to get to the point where we're clear about maybe even readiness of a community to screen on food insecurity and housing because they're all different and the issues are different.

You speak about, you know, the fragmentation of your food banks that you had to convene before you really could do good jobs of referrals. It's not that all the situation in our state where we're one unified system, but it is the case in many.

In housing, we've talked about that immediate compendium of referrals is pretty

difficult to find in most arenas. And until we can work as anchor institutions and state policy makers to develop those together, we may not be ready to do screening in the housing arena.

So it's the sense of how do we know when we're ready to screen? Then how do we screen and what do we do about it?

CHAIR HASNAIN-WYNIA: Yes. And, I mean, your comment is really important. I worry about what do we do about it?

So, you know, I, earlier in my career, did a lot of work on data collection. And so that's just one step. And we can collect data.

And particularly within the context of social needs if we're collecting data, and we know that there is housing and food insecurity, we, being a health care system, then why are we collecting it if there is no actionable next step, if there are no linkages? So it comes back to the partnerships.

And so, you're right, we're kind of,

you know, we're kind of jumping between kind of the, you know, 10,000 foot ground level doing something about it. And then kind of upstream, do we have enough of a foundation kind of at the systemic systematic level to connect the dots and make recommendations to do something about it?

What I worry about is the recommendation around data collection, you know, on social risks, social needs, et cetera, and, you know, the implementation side of that within the context of the health system.

So, you know, how is that data collected? Is it collected in a way that is, you know, not offensive from the people that we're collecting it from?

I worry about language. You know, as a disparities researcher, I worry about language like underserved and vulnerable and so on. Because it doesn't matter where you come from, people don't want to be viewed that way, right? People have a sense of empowerment and dignity.

And so when we talk about social needs, if we're collecting the data and then we don't have a way of linking in terms of a solution, I worry that, you know, we're kind of moving down a pathway that, to me, is a little bit questionable.

So I'm just kind of -- I think you make some really important points in terms of, you know, why we're jumping around.

I think that's part of the reason that, you know, we're talking about where are we upstream? And can we do something about it? And do we in fact have the systems in place to make those connections?

And then we're talking about kind of the proximal, what's the role of the health care system? One role is collecting data. But if we collect that data, how do we make the linkages? And we're back up to upstream.

So I think that's what we're really challenged with here right now. So, Ron?

MEMBER BIALECK: Well, I hope not to confuse matters, but I'm usually good at that. There's another concept related to the anchor institution that came out of the former Assistant Secretary for Health's office, which is out of the Public Health 3.0 initiative, which is the community chief health strategist, which is pretty similar to that.

And that was applying primarily initially to governmental public health serving as the organization to bring together the various ways to facilitate, to implement, et cetera.

And what I think is important is for the health care organization to be either an anchor or to participate with an anchor or a chief health strategist, something like that.

Because we've seen, and I think the literature supports this, that when there is not some entity or some individual in a smaller community serving that function, things tend to fall apart with that. And you really need the

conductor of the community orchestra.

And whatever we call it, again, I think it's important for that health care entity to be part of an anchor.

CHAIR HASNAIN-WYNIA: Laura.

MEMBER GOTTLIEB: Two comments. One is Lauren Taylor and Megan Sandel did a blog in health affairs about the hub versus the spoke model. And I think that's sort of -- we're all kind of referring to different versions of that, but it might be a helpful piece for people to just review.

And as this conversation has evolved, it's made me appreciate that there are lots of different ways to present this.

And I've been playing with another one, which may or may not be helpful. But I think what I'm hearing from you, Nancy, is -- and Nancy-Nancy, Nancy squared, is that it's -- the health care organizational piece maybe is -- or excuse me, the community role is broad.

There's like a lot of different ways in which, like, the health care sector can be involved in these community levels.

And the very small, you know, the much smaller circles of the two left boxes are just key roles in which the health care sector maybe plays a small role in identifying and addressing patient's social needs. But that there's really this much bigger circle.

And so maybe this different box is flawed, and I have to go back and rewrite my paper. It's like having a whole committee of expert reviewers. That's annoying. Okay.

CHAIR HASNAIN-WYNIA: So, Nancy, Ginger and then Prabhjot.

MEMBER GARETT: So I like that comment. And I wonder if a way to do this is to take, kind of like you did, what is the purpose of the anchor institutions? It's really around, I think, improving community resources.

And maybe if that's the broader

category, and then anchor institutions can be one way to do that. But there are others, lots of other ways to have partnerships.

There's a role for government. There's a role for policy. And so that might be a way to make that a little bit bigger so that it could be inclusive of all the different ways we need to attack those issues, which is, I think consistent with what you were saying.

MEMBER GOTTLIEB: Yes. I view health systems as partners in building community resilience and anchor institution is one. Other partner roles is another. And like there are probably many, many others that we could think about.

CHAIR HASNAIN-WYNIA: Ginger?

MS. ZIELINSKIE: I'm still having a hard time figuring out how this turns into a recommendation for a state Medicaid agency. That's it.

CHAIR HASNAIN-WYNIA: Helen, do you

want to comment?

DR. BURSTIN: I was having the same thought. And I think in many ways part of what's not here for me, and not even so much state Medicaid but also the specific IT focus here is data.

And somehow how data flows and the importance of data preceding being informed of the targeted, et cetera, and how that relates to what state Medicaid can do, what the insurance center programs can do at the clinician level somehow is missing stream for me.

MEMBER SINGH: I think maybe to build upon that a bit, I think one thing that's helpful to me when we're kind of in a broad -- there's so many different points of entry. And access is just starting to understand, like, where the highest points of constraint in the discussion are.

So, for example, in a set of data flows that might be helpful for the state

Medicaid agencies, like, where are the highest points of constraint?

If X actor does not participate or does not do something or does not engage in some manner, like, where do things start breaking down? And I think that just helps kind of scope down the problem at least, a little bit. That's a question because I don't know the answer that.

But people that are thinking about organization structure and information flow would probably be best able to start pointing us in that direction.

CHAIR HASNAIN-WYNIA: So I just -- I'm going to come back to you and just ask for a little bit more clarity.

MEMBER SINGH: Okay.

CHAIR HASNAIN-WYNIA: Because I'm trying to understand your comment.

MEMBER SINGH: So let's say, you know, like there's an assumption at least, you know, when I'm in the provider space that if we get

screening questions -- I think it came up over on this side -- screening questions into the EHR, like, something gets unplugged. Like something is enabled or some flows are enabled.

I don't know true that is, meaning that, like, are we in fact really focused currently on, like, the right pieces of information that will relieve a constraint for either action or being informed, one of the two?

And I think there is a lot of assumptions about what those things might be because people think, oh, wouldn't it be good to have that type of information so that somebody else can do something?

CHAIR HASNAIN-WYNIA: Mm-hmm.

MEMBER SINGH: And, you know, I don't know if those are true. My general assumption, actually, is that it's deeply unclear in my provider system what type of information is, in fact, the highest value, missing information or the highest value of available information to

drive the conversation forward.

CHAIR HASNAIN-WYNIA: So that's interesting because I just -- so I'm thinking about my earlier comment, which is, you know, so if health systems are screening and collecting information on social need and then what's the action related to that, right?

What are the linkages? And that's where the partnerships, community linkages working cross-sectorally, that's where that comes into play.

But I'm struck by your comment because I do think that data does have a role to play in just, you know, in the kind of two dimensions that you laid out, which is one, being informed to act and two then the actual action.

And sometimes the data play a really important role in providing information that says we must act, right?

So I guess what I'm struggling with is, you know, and I think, to me, that's a

recognizable framework. Like, we need to have data to know that we need -- you know, so if I am the -- let's say I either serve on the board of a health care delivery system or I am, you know, a CEO. And data are presented to me about social risks of our patient population, the community that we serve, it tells me that we need to act.

And having guidance on how to act is important, but I need that kind of being propelled to act. And so data plays an important role in that.

And so I don't have, you know, clarity about what the right pieces of information are that will, I think, to use your language, relieve constraint in terms of action and whether that action is, I'm learning I now know that there is a need to act.

And then, you know, do I have the right data then to actually undertake an action or an action step?

So, I mean, that's how I'm kind of

interpreting your comment. And I don't know if I'm completely off base, but that's what I'm hearing.

MEMBER SINGH: Yes. I think just -- unless, you know, that's too conceptual and kind move it a little bit on. But I think you represented it fairly.

You know, I think that there's just a huge set of both like screeners, assessments, methods, information sets that can come in. And at least for me it's extremely helpful to understand the minimal information required to move this forward because every question that's asked in any system, like, imparts an enormous cost, you know, across the implementation spectrum.

DR. BERNOT: Yes, I just want to see. Can we take a little bit of a dive on this? Because I actually feel that you may not -- I feel like everyone in this room.

But I just feel like we're on the cusp

of getting to that level where we need to go. And maybe just going around to answer that particular question around are two topics, the food insecurity and housing instability.

In our experiences here in this sector, whether it's health care organizations or it can expand a little beyond that, what are those top actionable pieces of data that we've seen so far on each one, or either one of those topics and what might that action be?

You can take either one of those questions. And if it's a gap in the data, that's fine, too. So if we had this data, we could take the action.

So identifying the high piece of data whether we have it or not and then try to figure out if that's a gap and then what the action would be.

And just if we can give it just 10 minutes, I feel like we're really getting to about where we can get to some concepts, but we're

just not quite there.

So is that fair to organize that -- and okay. It looks like we already -- go ahead, sir. Yes, go ahead.

MEMBER KNOX: Before we go there to look at, okay, what might we do with the data that we get. The whole conversation has been about what do we do with data that describes social determinants and then address that social determinants.

But in our experience of implementing this in so many settings, what we find is that at least the data on food insecurity is critically important to the provider in that visit that day to inform diagnosis and treatment. Because they often, not having that information, might see ADHD in a child or developmental problems that they don't know there is in food insecurity driving it. Or with seniors, they may see depression that's food insecurity induced that they would put them on medication for.

I mean, there are just myriads of situations and symptoms that if they don't have that information, just like you need a blood workup, you need that information about the food security to make sure you're proceeding appropriately with that patient.

And so we need to keep in mind that that's another critical role of this data and not just to address the patient's long-term social determinants.

CHAIR HASNAIN-WYNIA: I think you raised a really important point. So can we go to the slide with the concentric circles?

So I think there can be data collection and screening, but then it's applied at different levels. So I think about again the disparities work, right?

So a health care organization, let's think about language services. A health care organization can collect data on, you know, the need for language services so they can look at

their patient population, their community to see the number of people in the community who come into the system with limited English proficiency.

So, one, that could tell them information what about the patient and the need for a patient to have interpreter services or potential sign language services, right?

But it also tells the system about the need for potential partnerships at a population level because it may speak to patient education materials, their informed consent forms.

It could speak to the number of interpreters that need to be within a health system to provide face-to-face interpretation versus interpretation provided through, you know, video monitoring or telephonic.

So to me this is in some ways similar that you're absolutely right. We don't want to lose that yellow piece, which I think is acknowledged within this concentric circle.

So it's, you know, the data piece is

really important. But then, you know, how many pathways can those data be applied, right?

So is it useful at the actual -- you're talking about the individual, kind of where the rubber meets the road in some ways, the individual clinician patient encounter and diagnosis and treatment.

But it may also be very important at the organizational level and at the community level. So I think you make a really important point.

DR. BERNOT: I was just going to say, absolutely, 100 percent, especially as a primary care clinician.

But I was thinking, so when we get to that SDOH informed care, it is exactly whenever that temporality nature, I was wondering at this point is it at this community anchor institution level as our experience is?

And again, I keep looking to Nancy, knowing that she's been in the midst of these

projects, but what are those pieces at that level and then still having the same discussion as we think of the different levels of analysis, again, if that's okay with the group for this.

So that was just to respond to Lynn's comment. But thank you, highly important.

CHAIR HASNAIN-WYNIA: Laura, Nancy, Clare.

MEMBER GOTTLIEB: I was just going to suggest that instead of levels of analysis that we think about these as use cases, which I think makes use of, you know, just like a little bit of a frame shift that might be helpful.

And then I just want to caution us when we think about applying measures that are collected at one level to interventions at another level -- and I mentioned this to you folks at the break -- but the data fallacies involved in using patient level information for area level or neighborhood or community level interventions.

And I'm going to highlight one example

of that and it goes the other direction. So anytime you're crossing levels, right, you have these kind of epi data fallacies.

And the example that I would highlight is that I watched a presentation by Nirav Shah, who is now with Kaiser in Central California, about their health leads experiment and which, unfortunately, has gone up in flames.

But the example that he provided was, well, we have all this information now that connecting to this food bank for the patients that were -- the 400 patients in the study at the time, was not effective.

So we're going to actually use that information on a community benefits item and stop funding the food bank. And at the time that I watched the presentation, I was sitting next to somebody from the Alliance for Strong Families and Communities, and I could just watch her face just be, like, braawk.

So the idea that you could use data on

400 patients to inform -- that food bank is serving hundreds of thousands of people who have different issues and are benefitting from the, may be benefitting, I should put out, that may be benefitting from the food bank services.

So we have to be really careful when we use patient level data to inform the anchor institution or community level strategies, you know, and other partner strategies.

And you have to be very careful when you measure things at the area level and you then take them and assume that those are affecting our individual patients.

So I think it underscores Helen's point that for each of these different use cases, you have to think about the right level of data and measurement.

CHAIR HASNAIN-WYNIA: I completely agree with you. I think the challenge, and I think the use case kind of framework is a good way to go. So I completely agree with you, and

I will say this as a person who is a researcher who is also working very operationally within a health care delivery system.

And the earlier point about every time we, you know, from a delivery system perspective, we ask for data collection, we add a level of kind of resource and time burden.

So, I think, the challenge here is in not, you know, falling into the pitfalls of unintended consequences using data inappropriately or attributing, you know, data within, you know, with a certain denominator to a larger population.

But I guess I would say that we also need to be very cognizant of -- and again this is my researcher hat, where, you know, we want to make sure that we're not -- with all the caveats that you've laid out, I agree with you, but we're not letting the perfect be the enemy of the good.

Because I worry about what health systems will actually implement and the push back

at that level. So again, complete agreement, but I think it's a really important point that you raise, but we also need to think about those tensions in terms of the recommendations. Nancy?

MEMBER GARETT: So I thought I'd just share a little bit about what my organization is doing around screening just as a use case, an example, that might be helpful for people to hear.

So we, through our community health needs assessment, we identify social determinants of health as a key area we wanted to focus on. And specifically food insecurity and housing instability were the two biggest needs that came forward in our community that were important for us to look at.

And so we decided as an organization to begin screening all of our patients in our ambulatory settings for food insecurity. And we're using the two health leads questions, which there seems to kind of some emerging national

consensus around those questions. We wanted our data to be comparable to others. So that's why we started with those.

And so this decision was not without controversy because there's also an alternative point of view that some people feel that doing universal screening actually might not be respectful to patients. That some people might not want to answer these questions.

There's a lot of, you know, discussion back and forth about whether this is the right thing to do or not.

And I think a lot about the U.S. Preventative Services Task Force, which has really strong recommendations on screening for medical conditions.

And those recommendations are based on published literature about what screening will actually lead to an improvement in health outcomes. And we just don't have that level of evidence for screening for social risk factors.

So the Accountable Health Communities Project is underway. And so within a few years, there's going to be 3 million people or so screened on a set of social risk factors. And there is going to be an attempt to measure the effect of that.

And so I think the evidence is going to start to build, which is great. But right now, we're sort of in this dark period of not really knowing if this is the right thing to do or not.

So as we do this within our system, we're building this into the EHR. And we've built in a referral to a local food shelf that can help connect people to SNAP and other resources as an order in the EHR.

So there's actually an electronic process so it can be embedded in the workflow that we can use to get people referred to resources. And, however, some people who report food insecurity, that's not the intervention they

want.

And so we're also working on other alternatives, including having a list of community resources available and potentially embedded right into the after visit summary so we can have an electronic way of being able to scale this intervention. So it doesn't have to be just somebody who has a social worker assigned to them, but anyone who would report this could have these resources.

And then we've also done some convening work around trying to build a better database of local resources for social determinants of health. So we're kind of working on multiple fronts.

But it has been really important in our organization that as we do this that we have a way to help clinicians know, okay, if I do know that someone is food insecure, how do I change the clinical care that I'm giving them?

And there's been some good examples

already here, but that's not something that people are trained on. So there's a whole aspect of really understanding.

And again, the research isn't necessarily there even to support it. But how do you kind of build that into the workflow?

Then we're going to use that again to connect with resources and help address the social determinants. But one of the reason we did decide to do the screening in a standardized way across the organization is these larger purposes.

So we can look at our population then. We can identify where are the biggest needs? And then, you know, target resources in the community to help with that.

We can talk to others about resources we need. So we have a food bank in our facility, actually, that has lost funding. And so we are going to be using this data to go to the state legislature and ask for help.

So there are ways that we can use this then to try and get resources to people who need them the most. And having that standardized data, we feel is really important. So just an example for people to be aware of.

CHAIR HASNAIN-WYNIA: Clare? And then Lynn, did you have your card up again? Or was that from -- okay. So Clare, Ron and then Helen.

MEMBER TANNER: So I was just going to follow-up on, I think, John's comment, but it nicely ties into so many comments.

Because where my brain went was to start to think about those three buckets that we had up earlier as sort of categories of use cases. And what, if I were, you know, an actor in each one of those buckets, what data would I need? And I just started writing down some things.

So, you know, and Lynn, you very nicely articulated that, you know, for the SDOH informed care, there might be a base level of

information you need for everybody.

Maybe there's some diagnostic specific information you need on some populations. You know, like kids with asthma, you probably want to know more about the quality of their house in addition to housing insecurity.

And then if I move myself to be an actor in the SDOH targeted care, I believe, is what we called it. And so I'm attempting to coordinate with other community resources.

So the first data point I want is to know what is the availability of resources to meet this need in my community?

I want to understand outcomes, like, what happens if I try to refer somebody to a community resource? You know, what does it mean to get their needs met? I mean, outcomes not in the big sense, but in the most immediate sense. Like, what's the outcome of this referral?

And then I move my head down into the third bucket, which we were still, I think,

circulating around what that was.

And I started thinking, well, at this level, I want to understand population needs. I want to understand disparities. I want to understand the population resources again. I want a framework for understanding root causes and interrelationships between outcomes in my sector and other sectors.

So that's -- I started filling in those boxes. So I wanted to share that.

CHAIR HASNAIN-WYNIA: Okay. So, we're going to do, let's say, Ron, Helen and Nancy.

And then I just want to stop for a minute and do a time check. So I think we can keep this discussion going -- right. But can we keep the discussion going? Okay.

So we'll keep the discussion going. And then we're going to open it up for public comments? Okay.

And then we'll go to lunch. And I

think we need to come back, summarize and move into the afternoon.

And I also want to get a little bit of a time check with the agenda that we have laid out here and where we are with that. So, Ron?

MEMBER BIALECK: As I've been listening to the discussion and thinking about, you know, the charge again is a model for how do we develop measures or select measures. And it's difficult to think about selecting measures when we don't yet know what works.

So if we go back to our Medicaid as an audience, I'm wondering if there could be some sort of interim measures of some things that are recognized that are not the be all and end all, but a start.

So for instance, screening around food insecurity and knowing if an individual is eligible for and receiving SNAP and getting the individual SNAP, the program.

Well, that's a measure. It's

something that can be done. It's something that the evidence shows that SNAP impacts health.

And then at the same time, again, thinking about Medicaid. You know, Medicaid has done waivers before to experiment with long-term care.

They've done a lot there to try to keep people out of nursing homes. What can be done at the community level? Let's spend money there versus spending money in the nursing home. It saves money and improves quality of life.

So would it be inappropriate for this committee to suggest some potential waiver approach that Medicaid might adopt so that we learn more about what actually can work and does work?

So there can be very strict requirements for measurement. You know, with the Accountable Health Communities, they are doing some of that. But the measurement isn't necessarily -- I don't know if it's going to

contribute to the body of science ultimately here what works and doesn't with regard to food insecurity and housing.

So it's just a thought if that would be out of scope to say, okay, here's what we know. Let's do this short term. Here's what we don't know. And here's what we might suggest Medicaid do to find out.

CHAIR HASNAIN-WYNIA: So, Helen, I know that you're up next for comment. But can we just address that question in terms of scope? And so what I'm hearing, Ron, is, you know, you went to Medicaid waivers.

And so in some ways what I'm hearing is almost a request for, or a recommendation rather, and whether it's within the scope of this committee to do that, but a recommendation for a demonstration, which could then be within the context of a Medicaid waiver to implement a demonstration.

And I don't know if that's within the

scope of recommendations or not.

DR. BERNOT: I think at this point we definitely document it. I don't know how much time we want to put around it, double-checking with those. I hate to punt off. But I don't think we take anything that's been said here and completely discount it.

My instinct would be to say if there is some consensus that this could be a potentially topic for further discussion, I think, or, I'm sorry, for further research, it would be worthwhile, but probably sticking, wait until NC can weigh in before we have a real deep dive on that. But I want to see if others agree on that, Helen and others -- sorry.

MS. RAMOS: Yes. I don't think it's the -- I think it's maybe not the main priority, but I definitely think -- I mean, just thinking about what you guys have been talking about. I think, like, thinking about the role of the health system, the measures, the interventions

that Medicaid should focus on are definitely within the scope of prioritizing data.

But then I think if you were to say, oh, this seems really promising. We don't know if it really works, but it might be worth exploring further. That seems like something they would want to know.

CHAIR HASNAIN-WYNIA: Thank you. Helen?

DR. BURSTIN: I just want to pick up on two threads. One that Nancy Garett had mentioned about the level of evidence. I think some of the level of evidence is somewhat dependent on the use case.

And so when I used to oversee the U.S. Preventative Services Task Force when I was at ARHQ and that is an exquisite high, high bar level of evidence.

And actually I was just pulling up, and I can't get my hands on it immediately, but, you know, the better corollary here might be the

community guide that CDC does.

You know, what's the level of evidence for community-based interventions might be a way to reflect on this. Less so about what the individual clinician is doing and more about what the intervention's overall evidence is and how that then connects back to the health care system.

And that's also the nicer tie-in to the data piece. So what data has to flow to allow you to have sufficient evidence to get to that community-based intervention that connects back to the health care system?

CHAIR HASNAIN-WYNIA: So, Nancy and then Ginger. And then I think after Ginger's comment, we'll go to public comment? Okay.

MEMBER LAWTON-KLUCK: I'm not sure if it's inherent in the conversation, but just something to push out there. I love to build on frameworks that are already built.

So if there's an opportunity to use

the CHNA process and make that a recommendation that we use out of some sort of framework to start looking at the data collection and the measurement piece, it's something that's done continually across the country.

It's something that everybody is familiar with. So it might be an interesting way to use something.

I know for us, across our footprint, it's something we do every three years, and we've not moved the needle year after year after year.

So it's something that we definitely should be looking at anyways. And maybe this is an impetus to get that done.

CHAIR HASNAIN-WYNIA: Ginger?

MS. ZIELINSKIE: Using some of the new language of thinking about the use case as it relates to state policy and with our focus being state Medicaid directors or state Medicaid agencies, I would encourage us to think not only about data that's being collected at the

individual level, but data that already exists.

So if a performance measure is how many people are on Medicaid and on SNAP, what's that gap? That may be precursor to what you're talking about as it relates to a demonstration.

I would encourage us to look at that also in terms of how many moms on Medicaid are on WIC? WIC being another anti-hunger program that's another performance measure just to start to make the case.

How many people on Medicaid are on LIHEAP is another way that we can get to a piece of housing support. So I'm not saying that it's full housing insecurity, but it's a piece of it.

So as we think about our Medicaid plans, there are performance measures in terms of the data that they do have access to that are not being further utilized.

So when we want to then think about interventions, we can think about those state level interventions as well as community based or

more hub and spoke interventions.

CHAIR HASNAIN-WYNIA: Yes. That's an excellent recommendation in terms of actionable and the data that are available and so.

DR. BURSTIN: This gets back to what you had said earlier cogency and interest as well on the Medicaid piece or in health information exchanges. Because this is also the beauty of the interpretability of data within a given state as well, which is also hopefully on this measure with the state.

CHAIR HASNAIN-WYNIA: Right. Yes. Yes. Okay. Laura, last comment before public comment and lunch.

MEMBER GOTTLIEB: I just sent this brief. But the Center for Health Care Strategies, actually I worked with them on it. But we put out a brief called Measuring Social Determinants of Health Among Medicaid Beneficiaries, Early State Lessons.

And, Ginger, your comment just takes

it to a whole different level. So we highlighted state Medicaid programs that are doing both population and patient data, like health risk assessment data collection.

And none of them is doing that crosswalk kind of work that you're kind of work that you're suggesting. And so if you think about area level measures mixed with some of the patient level, that's just a beautiful example of where this panel could go.

CHAIR HASNAIN-WYNIA: I love that you make a recommendation. I feel like in some ways that it incorporated almost everybody's comments here, but it gave a very clear kind of action step that is doable and tangible and usable and therefore, actionable again. So thank you for that recommendation.

So shall we move on to public comment?

MR. ANDERSON: Hi, operator, could you please open the line for public comment for those on the phone?

OPERATOR: Yes, sir. At this time, if you would like to make a comment, please press star then the number one. And at this time, there are no public comments.

MR. ANDERSON: We also wanted to give those in the room an opportunity to comment. If you have any comments, raise your hand. Okay.

MS. SCALLY: Hi. I'm Corianne Scally with the Urban Institute. I'm very happy to be here observing your conversation.

And something that has struck me in terms of thinking about this scope of work and speaking to CMS and state Medicaid organizations is, from the housing perspective, you know, realizing that those systems don't match up very well at all.

There is no national state infrastructure for housing, so a nationalized state level infrastructure for housing assistance. And it's, you know, really concentrated at the federal level and the local

level.

And so I'm sure that you all in the field have experienced that, but I'm just wondering for those of you in the health care sector, you know, to just think about the consequences of that in terms of resource availability and in terms of how Medicaid can be mindful of housing needs, given the fact that the systems for assistance just simply don't align.

I'm sure that SNAP probably faces some similar issues as well, but probably not quite as out of sync as the housing assistance and health care programs are in the United States.

MR. STEFFEN: Hi. Barry Steffen from HUD. I'm in the Office of Policy Development and Research, and we're process of trying to develop a survey module to measure housing insecurity and to develop a scale based on such questions. We're finding it very challenging.

I do have a question about the scope of this meeting in terms of the housing

instability as in the label. But there seems to be a broader understanding of housing insecurity beyond instability that was exhibited in the slides.

So I just wanted to clarify are you looking at needs such as severe housing cost burdens that create shelter poverty, cause people to cut back on their health care or food purchases?

Are you looking at the quality of housing that they can procure with their incomes that may cause asthma, lead paint poisoning and a variety of other problems? Just a bit of clarity about the scope of housing instability.

MR. ANDERSON: Sure. So for the environmental scan, we were very broad in our definition of housing instability.

And we did include things like housing quality, overcrowdedness and all of those factors. So those are open for a conversation. We didn't limit it to any specific dimension of

housing instability.

CHAIR HASNAIN-WYNIA: So I don't -- no other comments? Okay. So timewise, so we're going to break for lunch. So I think lunch is right back there, okay, and we'll reconvene 12:35. Thank you.

(Whereupon, the above-entitled matter went off the record at 12:07 p.m. and resumed at 12:41 p.m.)

CHAIR HASNAIN-WYNIA: All right, so we are going to reconvene and move into the next stage.

Just in terms of what you see on the screen in front of you is just a very high-level summary of some of the discussion that we had earlier this morning. So we started with our very high-level framework which we've added to a little bit in terms of adding this notion of really thinking about our discussions around use cases.

So we had a discussion about social

determinants of health-informed care, about social determinants of health and then targeted care, connecting healthcare organizations to community resources. And one mechanism for that is within the framework of anchor institutions, but it's just one framework because we want to make sure that we are incorporating all providers including smaller clinics, health plans and community health centers.

We touched upon some measure -- potential measure concepts and themes around community readiness, identifying available resources. Ginger provided some really kind of nice, actionable, potentially aspirational, but actionable recommendations relating to connection of different data sources. So for example, mothers who are in Medicaid and how many of those individuals are also on the WIC program and same kind of intersection with SNAP; linking food insecurity and eligibility for SNAP, and looking at other broader community resources and

linking after-visit summaries with potential community resources.

So what we want to move into is a discussion of what data are important to collect. Is there an action associated with the data?

So we're going to move into a discussion about existing data, data that should be collected based on evidence, and then potential aspirational goals for data collection. But before we do that, before we launch into that discussion, I am going to hand the mic over to Tom Novak from ONC, and we're hoping that you can help anchor us a little bit more, maybe comment on the high-level summary, and if there are specific directions that you want to provide in terms of the work of our committee, coming from ONC, that would also be most welcome. So thank you for coming and we're looking forward to your comments.

MR. NOVAK: We know this is a broad task and that was by design. The support is --

so I work for the ONC. My name is Tom Novak from the Office of Policy where I focus on state interoperability. But I'm also detailed 50 percent to CMS. So it gets a little confusing. So on the CMS side, I work for the Medicaid Data and Systems group. So on both sides, I help states build interoperable systems.

And states more and more are looking at ways they can use system dollars which have a 90 percent federal match if you build it, and then a 75 percent federal match if you operationally sustain it. So they want to build systems that integrate social determinants of health.

They want to know -- and they're asking us -- what should we do? What are good paths forward? And we require them to do these things in a standard-based way, in a way that uses structured data, in a way that reuses existing federal investment we might have supported in the past.

So it's okay that this is a broad exercise because this work is going to be used 54 different ways. So don't feel compelled to find the one silver bullet for addressing food insecurity.

We're looking for something that will help a state with aspirations to build systems to address whatever the sort of the state HHS priorities are around certain social determinants of health, effectively, a standard-based way, an effective way that relies upon the evidence that you all are aware of, but also allows for experimentation if the state Medicaid agency wants to do a state plan for an 1115 waiver, or a 1332, or some sort of innovative experiments that sort of helps them lay the groundwork and not just sort of be just shooting in the dark with regards to creating an intervention or creating a data stream or a connecting system.

So these kinds of things are perfect. These are exactly what state Medicaid agencies

are asking us. They're asking us, okay, what can I do to connect Medicaid to the wavelength? What's the evidence there? Well, how will that help us? What can we do to -- you know, if we streamline staff enrollment and Medicaid enrollment that put people in these very programs, how will that help with Medicaid interventions?

So these are the things they're asking us and you're helping us come up with an answer. So we're forming a path forward for state Medicaid agencies because despite our current climate, health IT remains to be supported. It's something that leads to efficiencies, leverages existing federal investments. It's fairly apolitical, so there continues to be support for states to develop health IT systems. They can address these.

And now we are taking a broader view of what the Medicaid enterprise can support on various kinds of guidance related to the HITAC

acts under the Recovery Act as well as the 21st Century Cures Act. So again, you know, establish bipartisan support.

Things are moving forward, so we're looking for ideas and ways we can help states think sort of proactively about addressing social determinants of health.

So you're all on the right track. So I'm pleased to say that and again, I'm sorry I wasn't here earlier to give the spiel, but it sounds like everything is going in the right direction.

And I'll be here for a bit and honestly, just keep it up. And I'm here for questions and also accessible over email. If you think through some of these and you have more questions, more ideas, or you want to bounce off some hypotheticals, this is all very open ended.

I'm very much deferring to the experts -- or we are very much deferring to the experts on how to create something that is innovation

friendly and future proof for the states and that allows for future social determinants of health to be folded into the framework.

So we're sort of focusing on food insecurity and homelessness because that's what the states ask us about. So that's how that priority was set overall, so aware that you want a framework, you are going to incorporate domestic violence or transportation or other sort of future needs that may come up as states come to us, again, with questions on they want to design interventions or they want to design systems to support various things. We, again, want to have an answer.

We're sort of prioritizing. We also wanted sort of the future-proof approach that allows for folding in those other concerns that state Medicaid agencies might have if they're going to develop initiatives to support their agents and providers.

So that's it. Romana, thank you very

much. I'm going to sit down and stay out of your way.

CHAIR HASNAIN-WYNIA: I'm going to say I'm going to open it up for questions.

MR. NOVAK: Please, of course, yes.

CHAIR HASNAIN-WYNIA: If anybody has questions for Tom? Any questions? No. Helen?

DR. BURSTIN: Tom, that's actually very helpful. Just one thing that came up earlier was really how much is this initiative very much about thinking about what the data resources are and how that ties back to the HIT incentives and how much could it also be about measures that could be applicable to state Medicaid agencies and even the healthcare systems or health plans within that broader context?

MR. NOVAK: So I think a little of both. I think the states would very likely say I would like to connect this system to that system to connect my SNAP data, school data, CAHPS data, to connect some data stream to the Medicaid

enterprise to inform and enrich their data. I think that is probably the sort of thinking this -- perhaps cruder terms, that's the more expensive thing for a state to do. So you'll probably ask us about that first if we'd like to combine these two data sets.

And then the incentives for electronic health records, that's sort of less -- given less and less importance. That ends in 2021, but the states can still continue up until then to invest in health information exchange and then through other funding authorities, invest in health information exchange that meets other goals of the Medicaid enterprise. So that requires standards, but the standards don't necessarily exist.

So the language in Medicaid says you must use industry standards, which industry standards is obviously a very broad term. So it does point to an ONC regulation about industry standards and the ONC regulation points to really

just sort of limited to the meaningful use, so problem list, medication history, those sort of things. So it doesn't go anywhere near touching social determinants on health. So this will also sort of inform that work.

States are going to look to other resources to inform the best path forward. So we also have something called the ISA, which is our standards advisory that ONC publishes that we update every year. And social determinants of health are sort of covered in there a little bit, but every year we're sort of looking to enrich that data -- so I'll be taking off my CMS hat and putting on my ONC hat.

And we want to make more and more standards-based decisions for this -- we want the states to make more and more standards-based decisions as they build these systems. But that's sort of not something we can get too prescriptive about when the standards aren't really in a regulation. It's not like we're

saying you must follow this. So it's just sort of using the best advice, looking at what standard are they thinking of, what is the rate of adoption, what is the maturity of a standard. Does it even lend value, all these sort of considerations.

So I would say probably combining the data is a little more important. Standardizing data is, of course, important, but in terms of the carrots and sticks that Medicaid has, they are sort of a little less obvious with regards to SDOH standards.

DR. BURSTIN: Although they do have a fairly big stick around measures.

MR. NOVAK: Yes.

DR. BURSTIN: Which is why we wanted to make sure we understood from your lens what you were thinking in terms of how measures fit into this.

MR. NOVAK: Right, so that's a good point. So the state might want to do an 1115

waiver or something. So they say okay, we're going to measure ourselves against these things to get this sort of budget neutrality in this experiment we're going to do as a Medicaid agency. But the state will define their own measures. They'll say these are going to be our measures. We're going to do this. So again, there, we're trying to get them to use the best possible measures. There's no one who sort of reviews the waivers who is going to be pushing back and making them adhere to immature measures ideally.

DR. BURSTIN: That's incredibly helpful. But I think there's also a piece of this where there are, in fact, standardized measures and voluntary use by states. That's a big part of what NQF has done is actually identify the standards set at the CHIP and the adult Medicaid measures.

MR. NOVAK: Right.

DR. BURSTIN: Is there also through

your lens here, with your CMS hat on, an opportunity to think about, if we look at some of those potential measure concepts, would you actually want to be able to hold the state Medicaid or the Medicaid health plans, with Traci here, accountable for some of that connectivity back? Are there ways to think about how the data relates to measurement that could be used as a carrot or a stick, even within traditional Medicaid plans and Medicaid services?

MR. NOVAK: I think that's absolutely a possibility. I think it's sort of one of those things that are going to be 54 different possibilities there where how the state chooses to invest in innovation and you might even have within that 54 various Medicaid managed care contracts doing similar things, tying themselves to those measures as well become infinitely more important when there's money attached to them, right?

If you look at ways to do attribution

through those sort of incentive payments when you tie a measure to performance, then it gets to be much more important when you think of carrots and sticks in that manner. So it's absolutely possible, so we should sort of consider that.

Like I said, there's no way to know for sure exactly how states are going to pick this up. I would consider that states are going to think in those terms in some cases, but I also think there's probably a feedback loop where if the state came to CMS sort of proposing less mature measures or maybe sort of trying to get a round peg in a square hole, then we would push back. Hopefully, we would do that if they made such an approach to us.

DR. BURSTIN: We were talking earlier about there's a set of aspirational data and perhaps aspirational measures. So one thought might be is there a set of aspirational data linkages, forces, etcetera, as well as measures that could wind up being in the core set in the

future that Medicaid is required to report on to help drive some of this. So obviously aspirational, but I think it's potentially important.

MR. NOVAK: Yes, I can't actually speak to that. That's a different CMS hat. But I mean, I guess -- yeah, I'm not even going to comment. I think it would be a required statute though, so I think it's probably -- you're probably good with what we have right now.

CHAIR HASNAIN-WYNIA: Thank you. Any other questions?

So after we -- before we broke -- or right after we broke for lunch, I was talking to our CMS colleagues here in terms of what would be most useful in terms of next steps for discussion and recommendations from the committee. And so thinking about the framework -- and we all agreed that the framework that was laid out was not intended to be linear in any way, but it laid out important dimensions.

We broadened the anchor institutions to include a larger set of providers. And we started talking about the importance of maybe thinking about use cases in terms of our thinking.

If you jump down to the bottom of the slide, in terms of next steps, I think what would be most helpful is if we could hear from all of you in terms of potential existing data sources that tie back to some of these measure concepts that we have discussed related to community readiness, some of the data linkages that we have already talked about potentially for those data linkages.

So what we want to start with is what do we know and what can we recommend in terms of what already exists? And what may have already been used by organizations around the country or at the state level? So that's where we want to start the discussion and as Helen pointed out, we do want to get to this level of thinking around

potential aspirational data collection, but we want to know what's existing right now. And we may need to do some homework at the back end to get a more complete picture of that. But we'd like to get the discussion going with the committee.

And then also, what type of data collection is needed based on evidence? So we're tiering this with existing, what is needed based on evidence, and then aspirational.

Did I summarize that adequately? Anything else from the committee? Okay.

MEMBER GOTTLIEB: Just a clarification question, because I -- the framework and the themes, I don't feel like we're -- I don't think we've nailed them completely there. Are we just -- what's happening with that?

Like before we actually get to the existing data, data based on evidence and aspirational data, I feel like it would be maybe

helpful to just go clarify what works and what doesn't work about what is there so that we know which data we're targeting it to. Is that allowed?

CHAIR HASNAIN-WYNIA: Do you have a comment?

DR. BERNOT: Yes, I was going to say those were just some of the examples that we heard today. So I was only pointing those out to say that even though we hadn't actually said oh, here's a concept as we're hearing things, and again, with all the recording and stenographers of this, we're hearing the concepts. I just wanted to put those out there.

I don't want that to limit specific, I think, just -- but if you can think back to a concept in your mind and how that data would work or use case, I think that works. I only put these out there just to say that even though we've sat here and talked on sometimes unrelated, we're actually -- we're starting to get over the hump

and get to some of these concepts. So that was the point of that. Does that help?

Does not have to be directly to that. Just for example, if there is something that links back to those, then that would be a way just to get your head wrapped around it.

DR. BURSTIN: And further work will be done on the framework. So staff will absorb all of this, send that back out to you for further review. It's hard to kind of do that on the fly. You've given us so much. These guys will do some great work and then we'll look.

CHAIR HASNAIN-WYNIA: In terms of this process being iterative -- so as we hear about data and we start to see themes, where it does tie into a potential kind of an alignment on another dimension of the framework, that I'm hoping that part of what will happen, as we see kind of the next iteration, is synthesis of that. So I don't think this is set in stone in any way, but these are the themes that definitely came

forward in the earlier discussion.

MEMBER GARETT: So I'm not quite sure if this is what you're looking for, but I can give a couple of examples of existing data sources that we're using. Is that kind of -- you want to get specific. Okay.

So one thing that we have done is developed an indicator of homelessness based on a patient's address in our EHR system. So if they reported that they lived in -- that their address matched the address of all the shelters in our geographic region, then they had a 1 on this indicator. And if they reported a general delivery mail address, that's another common indicator that may indicate somebody is in an unstable or homeless situation.

So we've calculated this indicator on our whole population and we're now putting it back into the EHR so that we can use it in clinical settings and also using it for kind of looking broader at risk stratification and that

kind of thing.

And we've done some validation against that -- that against a self-reported indicator of homelessness that we had on top of our calculation, and then we've worked with our state Medicaid agency and they've actually applied the same logic to the entire Medicaid population that's in the Medicaid ACO program in Minnesota. So they're serving that back to all the participating providers.

So the nice thing about it is that it's easy to scale because it's based on something that all health systems collect, which is address. And so that's something we've done that -- again, it's certainly not perfect and we call it an indicator because it's not the gold standard of a self-reported kind of thing, but it's something that is inexpensive and easy to do in the scale. And we still had some evidence of validity. So we've done that.

As I mentioned, for food insecurity,

we're using a screening question that we're collecting in the clinic setting based on those Children's HealthWatch questions which I think were in the lit review. And again, I think there's a lot of coalescing around those two questions. Just something about it people are using.

And then another instrument that we'd want to pay attention to is the Accountable Health Communities screening questions that are going to be used by all of the participants in that model. And I was on that committee that helped develop those, so that's something that we're going to have again three million people screen those questions pretty soon. So I think that the things on there are going to become kind of a standard that a lot of people are using.

CHAIR HASNAIN-WYNIA: A follow-up question on that. So the screening questions that are being used right now are different from the ones related to the accountable care

communities? They're not -- they don't --

MEMBER GARETT: The screening questions that we're using?

CHAIR HASNAIN-WYNIA: Yes.

MEMBER GARETT: So right now we're only screening on food insecurity at my system and raising the two Children's HealthWatch questions which also are the same as what's on that Accountable Heath Communities questionnaire.

CHAIR HASNAIN-WYNIA: Right.

MEMBER GARETT: So the food insecurity questions match.

CHAIR HASNAIN-WYNIA: Okay.

MEMBER GARETT: But then there's a bunch of other domains in the Accountable Health Communities questionnaire.

CHAIR HASNAIN-WYNIA: Okay. Ginger, Laura, did you --

MS. ZIELINSKIE: A couple of things. I totally agree that I don't think the framework

is just right yet. So just kind of my own personal asterisk there.

In terms of potential measures, I want to make sure that the distinction of the SNAP to Medicaid link is one that's articulated. And then thirdly, regarding existing data, there's also the potential -- I mean our healthcare partners on the clinical side are running discourse all the time about propensity of people to end up with X, diabetes, heart disease. We know, what someone looks like ten years before they're going to get this.

And so I think that there's also the opportunity to really think about how we can help states leverage their power and work with communities to really think about a social claim and what that means and how we can gather consent and explore how people and organizations can and should be sharing data to better define what the -- so there's data already available about communities and the risks associated with that

community and where people live. And then we can take it further to an individual level, so having the capacity to build almost like a sister to a health information exchange, like a social information exchange that better informs how that community and those individuals that live there can and should be served. There's a lot of existing data that can be pulled in to better inform healthcare delivery.

Who's going to the food bank? Are they all going to the food bank at the end of the month when their SNAP benefits run out? Things like that. So there's lots of, I think, environmental existing data that can and should be informing healthcare. But how we get the dollars flowing to build that really matters.

CHAIR HASNAIN-WYNIA: Other comments relating to existing data? Lynn?

MEMBER KNOX: I'm not quite sure what you're looking for here, but I've talked about that we're doing screening in over 300 settings

throughout the State of Oregon, both down to the real small community, FQHC or you know, family practice clinic to large Kaiser systems, Providence systems. And in almost all of those, we're using the Hunger Vital Signs similar to what Nancy was talking about that's in the Accountable Health Communities Survey. It's been somewhat adapted when we use it in a high school clinic, but not very much.

In most settings, administering those questions in writing because we have tested it and found that you get a 30 percent high rate of food insecurity when you ask in writing as opposed to in person. So that's significant.

There are many, many settings where a wide range of broader social determinants tools are being used and the two screening questions almost always are consistently the Vital Signs. But large numbers of organizations have implemented a wide range of tools. And that's the thing I hear from people most often is we

need to standardize these tools because too many people are using too many different tools and that's not helpful.

One of the approaches that I like the best that I was telling folks earlier is that some of our clinics take the two vital signs to screen the entire population and use those as a family distress signal, the red flag that they need a broader screen for other social determinants, thereby streamlining the process. You know, you're only doing the full social determinants screen with those who are already evidencing distress and then out of that you prioritize needs.

In every setting where I've had anything to do with it, we either have staff, trained community volunteers or interns that are on site following it up with connection to new resources. Oregon Food Bank provides a county-based one pager that fits into the electronic health records system that describes the full

compendium of food resources in an area and we provide it in 13 languages. So there are no excuses, as Ron was talking about, about oh well, we don't know what to do. Here it is.

So that level of work is happening in multi-sectors and then more such as VeggieRX programs and onsite produce distribution, anything you can think of that we can creatively do together is being done in other settings.

CHAIR HASNAIN-WYNIA: So this is being done in Oregon, and so I'm curious, in terms of -- because you mentioned Kaiser. So Kaiser is using the screening tool which is then potentially used to trigger maybe a deeper dive, right, around other social --

MEMBER KNOX: They're not doing it that way.

CHAIR HASNAIN-WYNIA: They're not doing it that way.

MEMBER KNOX: No. They first started using the two vital signs and then they decided

to go to a broader social determinant screen. So in Oregon, it's not national Kaiser, it's Oregon and Washington Kaiser are using a broader social determinant screen that they have developed and the two Hunger Vital Signs are part of that.

CHAIR HASNAIN-WYNIA: And then I'm just curious -- and so that's terrific in terms of Kaiser, where are other health systems within Oregon? Are they at the table?

MEMBER KNOX: Every major health system to some extent is engaged. Providence is the second largest and they are in all of their family practice clinics doing universal screening and their hospitals are including the food insecurity screening and discharge planning.

Legacy is the third biggest system. They are starting rolling it out clinic by clinic. Oregon Health Sciences University does it in most of their major outpatient clinics and some inpatient settings. Almost everybody is engaged in some way, shape, or form.

CHAIR HASNAIN-WYNIA: The reason I'm asking is because I'm trying to link this back to the discussion about potential 1115 -- I think Tom, you brought up 1115 waivers, you know, kind of -- I guess around the concept of community readiness or state readiness in this instance, around -- is there a potential. If this committee were to make a recommendation related to a potential demonstration, a waiver, could we provide potential examples of where some work is already being done within states such as Oregon?

MEMBER KNOX: Right.

CHAIR HASNAIN-WYNIA: Oregon seems to be down a pathway where you have multiple health systems at the table kind of beginning to really look at --

MEMBER KNOX: And I do believe it's because of the waiver and our incentive measures.

CHAIR HASNAIN-WYNIA: Yes.

MEMBER KNOX: I use that going in to talk to any institution. I look at their

performance on the measures before we meet, so that we can focus the conversation about what they need to do about A1Cs, what they need to do about blood pressures, and how this is part of the solution.

CHAIR HASNAIN-WYNIA: Thank you. Let's see, I think Laura, Traci, and Prabhjot.

MEMBER GOTTLIEB: Lynn, I think you highlight a really good point which is the ship sailed on the front end screening tools. So National Academy of Medicine, back when they were IoM, weighed in on these metrics, these instruments to use around social needs, but there were already dozens of other people who were collecting information about patients' social needs. And again, I'm just talking about patient-level data at this moment.

So you know, curiously, CMMI decided to develop its own screening tool separate from the National Academy of Medicine recommendations because they're actionable. Crazy.

So PRAPARE has a separate one. There's only one domain in social determinants that is common across those three tools. So the National Association for Community Health Centers, NACHC, put out PRAPARE with this multi-stakeholder process. National Academy of Medicine has theirs and whichever -- Accountable Health Communities has their own.

There are so many others. We Care, Kaiser's Your Current Life Survey, the YCLS, I mean all of these health risk assessments that are being used by Medicaid managed care organizations, everybody and their sister have another social screening tool. It's exhausting.

So one of the things that we are doing is saying okay, well, everybody maybe is being encouraged to put that into an electronic health record, but there's no standard for how to get that out of the electronic health record which is a potential avenue for data aggregation. If we collectively said okay, let's lump. Let's say -

- we were just talking about this, right?

So there are lumpers and there are splitters. Actually, Clare and I were talking about this at lunch, right? There are lumpers and there are splitters. There are people who say well, if you measure food insecurity in this way, it's completely different from if you measure food insecurity in this other way.

And I personally think maybe for the good of the order, it would be okay to lump them. So NQF could come out and say okay, we're going to suggest you lump them and these are the codes that you could use on the back end of the electronic health record that no matter how you measure food insecurity, this is the code that you would use.

So November 9th, in just a few weeks, we actually -- SIREN has convened a group of stakeholders from the major standards development organizations and from many other stakeholder groups to come together and say well at least we

need a process. We need some kind of process where you would do that, you would create a coherent strategy for developing new codes or for developing standards to use the existing codes. But nobody owns that. SIREN can't own that. Who is going to own that process? And maybe NQF should own that process.

CHAIR HASNAIN-WYNIA: I think that's a really important recommendation, because I can speak from my own experience in Denver where we have different healthcare organizations using different tools. Some are using screening questions, other questions within the health risk assessments for Medicaid managed care population, etcetera. They have come to the table and cannot come to an agreement, not only about data out, how you get the data out of the EHR, but also frankly, about data in.

So I think that any kind of practical recommendation around potential lumping -- and I don't know who would be the accountable body in

terms of sitting down and saying here are the codes. And I also don't know and so I'm pointing to NQF now is this the type of recommendation that this committee can make in terms of NQF's -- I don't know whether it's NQF owning or NQF actually making a recommendation around an accountable actor acting on data lumping in this case.

DR. BERNOT: Well, I can say we certainly can make a recommendation. The ownership part I don't think -- and correct me if I'm wrong, Helen -- I don't think we'd go there certainly at this point, but making a recommendation for standard output, I think, would be a more than reasonable and very effective.

One of these key points that comes out of this committee I personally very much like it, but it's not necessary what I like, it's really whether the committee thinks is this something that we want to bring forward.

So correct me if I'm wrong, but I think we would definitely want to recommend if that's the committee, but I think we would stop short of trying to say we own it.

DR. BURSTIN: I think so, but I think you could go further than that. I think that's kind of a first level. I think you could say there is an important opportunity there to standardize -- harmonize those tools, standardize the data that connects directly back to I think what Tom was talking about in terms of thinking about the data, how this relates to then the potential data standards that might be needed around some of these areas.

So I'd be curious, and Tom's got his card up, conveniently enough. So maybe he'll have some thoughts there.

CHAIR HASNAIN-WYNIA: So Traci, I'm just going to defer to Tom for a minute because I --- yes.

MR. NOVAK: It sounds like a lot of

conversation's happening about this, on the -- for medical EHRs about that, getting the data out. So in terms of the standards, that's -- that's sort of -- I'm going to speak to the data out, okay?

So the data out, there's a lot of conversations around open APIs. So -- and I don't want to get too technical here, but if you go to check your email and Amazon has shipped something, you go into your email and you click on the Amazon email and you click on the link in there, it takes you right to your Amazon account without reentering a user name and a password because you have an open API. They speak a common electronic language. They sort of have like a handshake or okay, I trust you, I trust you. And then you don't need to re-enter your password. And that is what we're trying to push more and more into healthcare, just open API functionality.

Now there's a lot of traction around

that in the ONC certification program and the meaningful use program. And for the 21st Century Cures Act, there are ongoing conversations around what is called the trusted exchange framework, which again, you look at an open API. And in many cases, it's FHIR-based, F-H-I-R, to get really technical, which is Fast Healthcare Internet Resources, which is even sort of a better way of viewing this.

And that -- the forces that be seem to be indicating they're moving towards a FHIR-based API as being the standard, which means the data comes out really decent. You don't need to build an expensive interface because you have this sort of spigot that is somewhat universal that one system can connect to and establish trust, hopefully using this eventual trust framework.

So when you're surfing the internet and you go to a website and it says the certificate to this website is out of date, do you still want to proceed, that's trust. That's

one device confirming it is who it says it is to a different device and if they're not using the same kind of system, then they don't trust each other. They're like oh, I'm not sure we should send data back and forth from this side to that side because we don't really have the certificate trust agreement. So that's one of the interoperability challenges that the ONC is trying to solve and it all links together. So if we sort of tackle all of these pieces on getting that data out, we'll have a good glide path for getting human service data, all of the data sets because we'll have outlined a trusted exchange framework where we say you know what, we're going to sort of take over some of the way this certificate system operates or we're going to get some guidance and say okay, it's okay for this group to talk to this group and we can encourage interoperability that way. So we have legislative authority to pursue that path forward.

CHAIR HASNAIN-WYNIA: Thank you. Traci?

MEMBER FERGUSON: So in terms of the existing data, I'm basically referring to more of the community level, the state level, looking at the referrals. I don't know if it exists, but I know that a lot of either referrals for housing at the VA system, looking at referrals for sort of the health departments or when you have a pregnant woman going to FQHC and how that information -- so more so if there is an existing sort of data or database that we can collect that would be sort of a marker indicator. If they're referring to the VA for housing, then that's probably -- if we can get those sort of wait-listed individuals that would be an indication at that -- more of that community level that shows that there is an indication, there is a sort of a community need for -- that demonstrates the housing instability.

So I think if -- again, not being so

close to that level in terms of the existence of how easy it is to get that information, but it's probably there since a lot of this is online, you know, referrals and application process.

CHAIR HASNAIN-WYNIA: Prabhjot.

MEMBER SINGH: A little bit of a different take, but I think it's inspired a little bit by Laura and Ginger's comments and actually Nancy's.

So one is -- I think to Ginger's point, there's just a huge amount of environmental and passive information that's out there that should be well considered. Even as we are thinking about purpose fit and the indicators of measures.

I think it's particularly important in this area because a lot of elements of food security or housing stability, our ancillary information sets are going to actually help us understand what to do, when is it really an issue, how is it changing over time. That's one.

Two is that I think Laura just made me think a little bit about the -- I think her comment was that the horse has left the barn on classic measure definitions. And I think in some sense you have to acknowledge that in this setting and then build based upon the role that this setting can contribute.

I feel like the conversation in some sense is like a little bit baroque about measure choice, what's there, what data sets are there, like in my world where we deal with like hoses of multi-data sets and have machine learning people in the background and so forth, if you ask like what data set are there, like their brains would explode. Because they'd be like I don't know, there's like thousands of them. And they're all fine.

The things that do matter is like what signal strength do they have, like do they have an effect in some combination or not and are they parsimonious, like will they come together, all

these different sets like do they add up to anything. That's like a discovery-based framework in some sense.

And you know, I think there are data engineering questions like what Tom had said about like how accessible are these things. Like in some sense, I feel like the questions are more about the fitting and piping and relations.

And then finally, recognizing that if you want to get into the business of interoperability of good VHRs, like you're just in a little tiny piece of a world that -- if you want to go there, like all your energy and resources will go into like clarifying those questions.

And so in our institution we're building new purpose build platforms like -- we call it Atlas, for instance. And it carries geospatial data. You can buy credit scores. You can get some access to Social Security information. I mean like there's huge amounts

of information that gives you pretty decent signal strength before you even get to purpose-fit measures.

And so I think in some sense I won't say don't look at purpose-built measures because they reflect the best, most precise thought of the expert community, so like they have a really important guiding role, but there's also just like at least another part of this discussion which is like passive, environmental, process oriented, parsimonious, like what's giving us good signal strength on any of these things?

And my guess is that a lot of times they'll outcompete purpose-built measures, you know. You just don't know for what and where. It's probably very different from what the NQF is used to putting out in terms of approach or report, but like I feel like of any areas like this requires like a little bit of a forward compatible, I think is what Thomas had said, a forward compatible view to how are we going to

handle the fact that these are just two domains. You know, there's transportation. There's all these other things.

It isn't going to get easier, you know. And the process isn't -- and EHRs can't contain the stuff anyway. And transacting with them may not even be the right fundamental question at the end of the day. So an editorial comment, but I guess the functional point is there's the expert set. I think it has a lot of value in guiding the discussion and purposeful history-informed and experience-informed ways. And then there's just a different side of this discussion which is process oriented, environmental passive, and gives us good signal strength about the conditions people are in over time.

CHAIR HASNAIN-WYNIA: Ginger, do you have your card up? Okay, so Sarah and then Ginger.

MS. ZIELINSKIE: I couldn't agree

more. And I think we have to be honest about where our state partners are, so while Mount Sinai is doing some extremely amazing powerful machine learning, our state partners are not. And so how can this space support them in getting there and how can we build the right parameters that allow dollars to be pushed in the direction to support those measures forward, I think is a great opportunity here. How do we encourage and guide and support and articulate how they can and should be using what pieces.

You know, I think in relation to food insecurity and housing instability specifically, what about connecting a trusted connection between housing authorities? Is that viable? Is that an option? We know who is getting Section 8 housing. HUD and Housing Authorities know who is on the wait list. I imagine if you're on a wait list for Section 8 housing, that's a pretty good indicator of housing instability. Is that a trusted connection that we should be

recommending that they explore and use the power of that data?

So I think how we talk about which connections can and should be strengthened and how for our state, again, if I'm focusing again on the states being the key primary receiver of this information, how do we help them get to even iota of where Mount Sinai is.

MEMBER SINGH: I just want to just kind of be in dialogue on that point is that you can sound hopelessly out of touch if you're talking about machine learning, etcetera in the conditions that we're talking about which are oftentimes poverty and settings that don't have like Excel databases, much less things beyond that. But I think it would just be, there's questions of like process and principles that allow for compatibility with people that have those resources or not. And like we're oftentimes choosing not, choosing not, and choosing not. And it's like why spend time

building these purpose-built architectures? They're going to cost a ton of money anyway, and make them inaccessible to like roads that people can be helpful with.

MS. ZIELINSKIE: And if I may just continue this dialogue and then Sarah, I promise I'll stop talking.

But I think what the permissions are, how states can share data, identified or de-identified is a huge opportunity again to provide further clarification and guidance because they sit behind HIPAA. They sit behind PAI and whatever it is -- name your acronym and our state partners -- those lawyers are there to mitigate risk, not to share data to improve outcomes.

And I think again, if we can find some common language to provide clarity about how different levels of data can and should be shared to improve outcomes, we have made some great progress.

CHAIR HASNAIN-WYNIA: So what I'm

hearing is -- you know, what I'm hearing in the dialogue that we just heard is that as a committee, we should be making a recommendation around those linkages, whether at the state level or --

MS. ZIELINSKIE: Across agency.

CHAIR HASNAIN-WYNIA: Across agency, however --

MS. ZIELINSKIE: Can we pull in USDA? Can we pull in the different agencies where the data sits.

CHAIR HASNAIN-WYNIA: But what I'm asking and maybe -- you know, I can just get a sense from the room in terms of support for a potential recommendation that is coming from this committee that really focuses on those kind of linkages and the -- and again, I don't have the language for that and that's something that I think we can develop, but that is something that at least in my mind and my past work with NQF that that is a recommendation that could be a

directed recommendation from this committee.

Yes? Am I -- is anybody in disagreement about that?

MEMBER GARETT: I would just offer a caution that goes along with that which is that you know that first part of our model about SDOH-informed care. So that's really based on a -- in a lot of cases a one-patient at a time, here I'm going to help you with this. And we struggle with this with our housing indicator which is not based on self-reported data. We have to be really careful about how we approach somebody and work with them, based on something that's not -- that's a secondary data source basically, right?

And so we just have to have caution about how other kinds of data would be used that may be more useful in the aggregate than on an individual level or you know, that kind of thing.

CHAIR HASNAIN-WYNIA: Just to build on that though, so I'm thinking about some of the conversations that I've been part of which kind

of gets to that point which is are there other data that we could get access to that are not based on a direct report, you know, reducing the data collection burden, if you will, but then the question always comes up that, you know, what are the cautionary notes that we want to put besides the data that we're saying we can get from other sources, either through linkages, other already existing data sources.

So I want to make sure that we're not saying this is the only path forward because there are data elements that have to be self-reported, right? Is that what you're getting at Nancy?

MEMBER GARETT: Not necessarily. I'm just saying we have to be really mindful of what we're using data for.

CHAIR HASNAIN-WYNIA: Right.

MEMBER GARETT: And --

CHAIR HASNAIN-WYNIA: Yes.

MEMBER GARETT: And if it's working

with a particular person and that person didn't give us that information, then to be really cautious about how we use it. So I'm not saying that you would never want to have, but in some cases you always have to have self-reported, but it just might change the way you approach the use of it. Does that make sense?

CHAIR HASNAIN-WYNIA: Yes, it does. Thank you. Let me just make sure. Sarah, I think you've been waiting.

MEMBER SCHOLLE: Actually, that was a point I was going to make because I do think this sounds really important in a state, community level and it can drive planning. It can drive your resource development. And then the issue is how does it get used at the point of care or in care planning for this individual. Because the health plan, it's useful to know that 75 percent of your members have food insecurity at some point in time, but which 75 percent or which 15 percent or who is it that really needs help at

this point in time?

So using those data, so it's two ways, right? So if it takes one more click for a clinician to go in and look something up on a database and find out that there's data coming in, they would just assume say how are you doing? Do you need help, right?

And so that's the question of how do we think about the functions and the uses of the data in the aggregate versus on the ground where people are interacting, where care teams are interacting with individuals, and then that follow-up step.

So I love the idea of taking advantage of the existing data to understand and I love the idea of trying to think through how do you make that more easily available so that when the Medicaid program sends over information about the members who were assigned that it can say and this is somebody who's got Section 8 housing or this is somebody who has done -- has these X, Y,

and Z, so you have that as part of the information.

Then the health planner has to figure out well how do I make that available to the care team that's responsible or how do I design my care planning around that? So I do think there are two pieces that are important and that level is important.

I have a question about kind of the coding systems and I understand the weeds of this, but is there any discussion of using the ICD-10 codes as a way to simplify our coding process? I was just looking, I just pulled it up. They don't get it through insecurity separate from housing. They're not -- I mean they don't work with the other things, but it's a coding system that's out there. Are there LOINC codes that are better, but something that lines up better?

MEMBER GOTTLIEB: Wouldn't it be great. I mean the ICD-10 took a step forward

when proposing Z codes from ICD-9, but there were actually social codes in ICD-9 under V codes that then got transitioned to Z codes. They capture their problems with them so the diagnostic codes that are in ICD, they lump things together, so like food insecurity is wrapped in with fresh water access or safe water access. That doesn't help me as I'm working on the back end and want to use that code.

Homelessness is a code, but it doesn't capture all the different forms of housing instability and maybe the code should be housing instability. And there are lots of different codes for different kinds of housing things.

So there are no codes for child care problems. There's some real gaps that are really relevant to this conversation. But there are also other activities that are not adequately captured with ICD.

And you started to mention that which is LOINC, SNOMED, CPT codes, all of which involve

different touch points within the clinical encounter. So if you're going to screen for social needs, should we have some kind of way of capturing, pulling up that information about I screened for some kind of social need.

Specifically or generally on the SNOMED side, LOINC and SNOMED talk to each other, but they don't talk to ICD, so there's like no mapping across the different systems, so you just put your finger on the major pain point in health information technology medical vocabulary for social determinants.

CHAIR HASNAIN-WYNIA: So I have Lynn and then -- Lynn, Traci, Helen, and Nancy.

MEMBER KNOX: I think the ideas is about capturing the big data and using that to guide some population health work is really important. But I think it is critical that we remember that part of what brings us here is the current volatility of our economy and the constant fluctuation of people's lives, both

personal and economic. And that will not be fully captured by big data. It's very time sensitive and somebody on SNAP is --- the average length of time on SNAP I think is about nine months. So we just need additional information from the source.

MEMBER FERGUSON: So just going back to what Sarah said in terms of the aggregate data with the state level, when you're talking about if we see that there is a prevalence of social determinants of health that is impacting an area, say in particular, let's say Georgia, and the health plan can overlay that with what they have at the individual basis in terms of the referrals to our community resources, then we can help prioritize where we want to do our interventions.

And at the state Medicaid plan, we have to put as part of our quality assurance improvement program identify areas of intervention and that this could give state agencies, we want the health plans to focus on

these areas and be able to have a little bit of information for us like this is what we as a community, because there's fee for service in their managed Medicaid plans, this is what we want to do so that we have a more coherent and collaborative approach to address this issue. And so I think that's how we can see the aggregate data. And then the states have the -- the health plans have their own individual data, so we can match that up so we're not getting those false positives out there and we can have more directed intervention.

DR. BURSTIN: I just want to reflect on the comments that have been made about the use of the data at the clinician level. And I guess as a clinician, I'm actually really struck by how useful that would be.

I frankly, very rarely, with the exception of what I practiced in a community health center, really know about the areas from which by patients come. So I would not discount

that up front. I agree with you. If I have to go somewhere else to look at it, that's kind of obviously not going to happen in clinical practice. But if there's a way to allow you to have that information streamed in so you know you're dealing with a diabetic who lives in a food desert or you're dealing with somebody who lives in a community that has a very, very high housing vacancy rate or a high rate of houses being foreclosed, that's potentially very useful information to me clinically. But I just don't want to lose sight of that.

I think it may be a really important feedback loop. Some of the clinical information could flow up. Some of the social determinants data could flow -- I don't mean up or down pejoratively, I just think it really is a cycle here that I just don't want to lose sight of because I think I would love to have those data. And frankly, my residents in clinic have no idea what part of D.C. their patients are from or what

kind of challenges they face that these data could be incredibly helpful for them.

MEMBER GARETT: I was just going to add to the coding question a little bit from kind of a provider perspective. So we do use the ICD-10 code for homelessness in some situations, mostly because we had a couple of physicians who really kind of mobilized around teaching other physicians how to document in the notes when they were addressing homelessness as part of the visit and then working with the coders actually to code that, a little bit of grassroots movement kind of going on. So we were surprised actually to find a bunch of these codes in our data.

The larger conversation we have had is, you know, just doing the basic screening does add costs, but now you talk about coding, that adds a lot more costs and now you have to make sure that that is documented as part of visit. So that influences the clinical interaction and then you have to have the coders be able to code

it which potentially adds time to every single coding interaction.

So really the value proposition from a provider perspective comes in if those codes are going to influence payments and it's a little bit circular because it's hard for them to influence payment if we don't have them in there, right? And so that's some of the conversation that is happening. But I do think that that's something we need to keep in mind. It's kind of on our road map as something to get to more systematically eventually as we do more of this work.

CHAIR HASNAIN-WYNIA: Ron?

MEMBER BIALECK: One set of data that are incredibly useful, or could be incredibly useful to clinicians, to healthcare institutions, to health departments and others, are data that come out of education. And that's one area where when we're talking about all of these different data sources, that's one where the sharing is

pretty much nonexistent. I don't know how to break that, but it strikes me that if schools, departments of education have federal funds and Medicaid is looking for a way to do something to help people and to save dollars that somehow, some incentive or some stick may be necessary to get those data out so they can actually be used for those who are dealing with health.

CHAIR HASNAIN-WYNIA: All right. So it seems to me that the conversation in terms of the next topics, we kind of merged a lot -- the three bullets into one big conversation which I think is absolutely fine. But I want to make sure that NQF staff were able to capture the information that's needed in terms of -- and is there anything specific that you need clarity on at this point from the committee?

DR. BERNOT: There's nothing of clarity for me. I just wanted to say if anybody felt that they were holding back because the topic had merged, we would still want to have that in the

next 15 minutes. But it's fine. Everything we've had so far is good in what we need to have right now.

CHAIR HASNAIN-WYNIA: And Drew, did you have something? Okay. Any other comments? Anybody holding back?

(Laughter.)

Okay. So I kind of feel like we were talking about aspirational, but we can move to aspirational as well, yes, additional points. I almost feel like we had a level of conversation, I mean in terms of even the last comment from Ron related to the educational system and lack of data sharing and what opportunities might be there -- might be within that context. But are there other aspirational sources, linkages, collection activities that anyone wants to raise at this point? Yes.

MS. RAMOS: I'm actually not sure which bullet this fits in, but as you guys are all talking I'm thinking of some state Medicaid

activity that we started to see around ADT alerts. I know like in terms of like we're working on evaluating SIM and like for their evaluated payment efforts, it's not like they're necessarily targeting social determinants of health directly, but they're targeting the admissions which is affected by social determinants of health. And then they're trying to do things like have built admissions, discharge, or transfer alert system where if a patient is discharged from the hospital, an alert would go to all the people on their care team, starting with primary care, but maybe also human services.

It kind of strikes me like there has been work on standards in terms of like what is included in that ADT alert because some providers will say oh, I got this huge list and I can't decide who to focus on. And I've heard you mention like risk stratification. If there were a way that in that information like meaningful

use specifies the care summary should include certain things like medication allergies, that something like homelessness seems pretty relevant if someone is being discharged from the hospital that they would want to know oh, this is someone I should flag who might be at extra risk for readmission because of homelessness.

I don't know how it all tracks. I'm just thinking that that might be an opportunity that I know states are starting to use more and more where this kind of information could be pretty practically set in.

CHAIR HASNAIN-WYNIA: Ginger, you had your card up.

MS. ZIELINSKIE: Yes. I just wanted to make sure that we heard loud and clear, what I heard from the two doctors was that there is some extremely valuable socio-environmental data that can better inform how we support the whole person. And that the guidance on how we could help state and Medicaid agencies build that into

the systems that they're sharing across their health delivery partners across the state is extremely valuable.

And then second, just thinking about aspirational data collection, I'm working with the county prison system and the homeless shelter in Philadelphia and 30 percent of all folks re-entering the community are self-identifying as homeless.

So if we can think about -- and I completely understand Nancy's point about confidentiality. I absolutely understand that. But if there are ways that we can think about how to connect those folks to the right services and supports including healthcare and getting them Medicaid and getting them connected to right housing, we can potentially avoid a lot of very costly health ramifications and other societal ramifications down the line. So when we think about aspirational connection points, I do want to just name folks reentering the community from

the prison system. That really matters.

We talked about WIC. I think that's it. Thanks.

CHAIR HASNAIN-WYNIA: Laura. So Nancy, let's start and then we'll see.

(Laughter.)

MEMBER LAWTON-KLUCK: But Ginger, to kind of lay in where you're talking as far as the aspirational piece, I think those bridges are really important, not just from the incarceration side, but there's so much on the addiction side. And it seems like when an addiction is on that road to recovery as well as some of who is now no longer incarcerated, it's a pat on the back and good luck. So there's so much that gets involved in that. So I just think that those are two elements that we should just take into consideration.

And the other piece I wanted to mention and I think inherent in the conversation, but we didn't verbalize it, so I just want to

make sure it's pointed in there. Mental health is such a big issue that ties so closely to the social determinants and I think that that's another firewall that we have to think through how we better integrate.

CHAIR HASNAIN-WYNIA: So Laura, you don't have anything?

MEMBER GOTTLIEB: He will respond.

CHAIR HASNAIN-WYNIA: He will. Okay, all right. Okay.

(Laughter.)

MEMBER GOTTLIEB: So I am also a clinician. I'm a family doctor by training. I work in the public hospital in San Francisco. And every patient has community-level needs, right? So what I want is actionable data about what their particular needs are and I want to be able to do something about it.

The jury is out about the difference between -- if you present clinicians, individual-level data and community-level data, and there's

any discrepancy or you know, even if there isn't, like are they more likely to act on a community level? Are they more likely to act on the individual level? We don't know. Is there a difference?

OCHIN in Oregon is doing a lot of -- well, now they're all over the country, 400 different healthcare centers that are on a single Epic platform. They're doing really great work around this. Although if you just present the social screening tools to different clinical settings, they're very unlikely to use them at all unless they're accompanied by training and other kind of incentives and supports.

Again, we'll learn a lot from the Accountable Health Communities' experiment around that. But one of the things that we have seen in a number of the studies, so this is a separate point, is that the people who identify a need like I am food insecure are -- there's incomplete overlap with the people who say they

have a desire for help with that need.

And this is -- I mean asking, as a researcher, if you ask me my aspirational data, like the sky is the limit, right? But I want to know both. For my research side, I want to be able to say they actually have this need. And for my clinician side, I want to know that they want help with that need and maybe from a researcher side, too. But there's no end on that question. I'm like I want all the connectivity between the different things. I want the surveys to be 7,000 questions long.

(Laughter.)

Like there's no -- I don't know how to answer that question, right? It's so hard. I want all of the ideas about integrating big data. I want all of it to be there. So it's really hard.

But I do think that if we're just going to talk about measurement we need to really think at the clinical level. I knew I'd get

them. I knew I'd get them.

If we're going to talk about collecting data at an individual level, we have to think super carefully about this parsimonious question, like how do we narrow it down so much that it is -- it's not cumbersome. It's acceptable to providers. It's acceptable to patients. And it is also useful.

CHAIR HASNAIN-WYNIA: Prabhjot, you're on.

MEMBER SINGH: I want to build on that. As a clinician. I just wanted to say that.

I think it's important, not that it's important that I'm a clinician, but I think if you're doing provider, if you're doing client-level interactions, you know, there's a very different type of parsimonious set of information that you need that if you're looking at information from different sources.

I just want to mention a principle

that we ended up using which I think actually honors Lynn's comments throughout the day which are -- is that we bring in a user-interaction designer to look at how our providers are thinking about the information that they're looking at. Are they responsive or are they not responsive? Are they motivated or are they not motivated? Did they find it actionable or did they not find it actionable? What is their instinct? Is that same information better in the hands of an MA who then hands it off to a TCP or an NP?

But I think the point is that we do look a lot at the big information sets and by the way, big data in social determinants of health is not big data. It's like medium-size data or medium-to-small data, actually. Like none of this stuff is big. I mean you can put all the stuff that -- all these sets that you mentioned on a hard drive. They are small sets. But I think the point is --

MEMBER GOTTLIEB: Other than Sinai hard drives.

(Laughter.)

MEMBER SINGH: On this hard drive, on your MacBook Air. But I think the point is that there's a process to be parsimonious about understanding that there's probably two very strong levels of information that we're interested in which is kind of understanding the scope of the problem and then what's doable about it.

There's methods and processes that are related to each layer. There's a very small number of linkages between the two, but those are really important because it allows people to speak in the same language across the two. And then if you go down to either one, then there's lots of things that people would like to know in the periphery that are not of interest otherwise.

And I feel like a group like this in terms of what are the useful quality measures or

rather not the quality measures, but what are the useful measures, there are also those that kind of concentrate a conversation, bring things together, allow for kind of repeated cycles of investment in the same common sets of sets and just clarify some element of like how do we move the communities' two views that you kind of pointed out really well.

So I mention that just in part because otherwise it sounds like one group of people is like flying off the handle and asking for all sorts of information and another group says look, I can't get the basic information I need to do my job. And there's a lot -- getting that sweet spot right is also like a huge contribution.

CHAIR HASNAIN-WYNIA: Ron.

MEMBER BIALECK: I am not a clinician and so I'm going to take this out of the clinic for a moment and think about -- Nancy talked about the community health needs assessments that are required of nonprofit hospitals. There are the

community assessments needs and assets also done by health departments. There are FQHCs that do needs and assets assessments. There are a variety of needs and assets assessments out there that could be utilized to identify the -- if we just talk about housing and food insecurity, to identify the needs with regard to those two areas and the gap. Those data do in many communities exist. It's not perfect because I'm not sure all of the CHNAs deal with the assets part of it. Often they do.

So I would suggest that the data that are really not, as far as I know, aggregated anywhere across the hospitals, across the health departments, across the FQHCs, they're even the United Ways who do that, that those are incredibly valuable for looking at what is it that the health system in the community could do now that it knows here's the need, here's the gap, what is its responsibility with regard to housing and food insecurity.

CHAIR HASNAIN-WYNIA: Nancy?

MEMBER LAWTON-KLUCK: Thanks for that, Ron, and one more add on to that because that's what we hadn't talked too much about today are the assets because that's something that not everybody knows where to find, how to access, what's really valid, what's not valid, and those are things that are also a little bit fluid. Sometimes they're there. Sometimes they go away. So an assessment of those are really important.

CHAIR HASNAIN-WYNIA: So we're almost at 2 o'clock and I'm actually going to take the opportunity to actually move forward with our break mostly because I have to leave at this point which the NQF staff are aware of, but I have to catch a flight. So NQF staff will facilitate the rest of the discussion. And 2:15. Okay.

Before I leave, I just want a little bit of clarity in terms of -- so we have this in-person meeting and then I think we have a webinar

scheduled. And then maybe I can circle back with you to find out where the rest of the meeting -- okay, perfect. Thank you very much. It's great to see you. Thank you.

DR. BERNOT: So yes, we can go to break, but first I'd like to thank Romana for her trying to rein us in and doing such a good job this morning of keeping everything on track and getting us to where we are. So we can reconvene at 2:15 p.m. then.

(Whereupon, the above-entitled matter went off the record at 1:56 p.m. and resumed at 2:15 p.m.)

DR. BERNOT: If everybody's ready, we can reconvene. We'll get everybody started back now, go over what we're going to hope to accomplish in the next hour to hour and a half, and give you a plan for the day and next steps.

MR. ANDERSON: So we've really gotten a lot of great information so far, and we really appreciate it. We have a lot to take back and

think about over the next few weeks.

But first we wanted to take what we've discussed over the last, well, throughout the whole day, and then bring it back to the original kind of framework that we were discussing earlier because some of you had some concerns that it might not be the right language or the right bucket, or we may be missing certain aspects.

And so we've kind of gone back and we've taken those, you know, those three boxes that we had before, and then put them into a similar framework to what Laura had suggested. So we kind of wanted to bring the conversation back to, you know, how can we get this more in line with your vision of how to categorize your recommendations, and if we need to probably spend a little bit more time discussing some of these areas that we may have missed in the earlier parts of the discussion.

So it's going to work the same way now. So John and I are going to be taking turns

kind of facilitating, and if you have a comment just raise your card. I'll try to keep track of you know who is -- go ahead Ginger.

MS. ZIELINSKIE: I can, maybe just a definition of who we're defining as healthcare.

MR. ANDERSON: Yes. I think this is going back to the conversation about anchor institutions. And so it's like larger healthcare systems, but then beyond that, we wanted to say anchor institutions and, so health plans, other types of -- it's broader, so it's not just focusing on that initial labeling.

MEMBER KNOX: Please don't let the small guys off the hook. If you talk about anchor institutions like that, it's both exclusive and it may let some people off the hook. So a broader definition that includes healthcare providers of all types and including the mental healthcare system and the dental care system.

I have major dental programs that are very engaged in social determinates. It's

possible.

MR. ANDERSON: Nancy? I don't think I --

MEMBER LAWTON-KLUCK: Yes, just a comment back to that. I completely agree, and it's not to let people off the hook. It's just as we're looking at this, who has the power to convene and move things forward in a way that provides some sense of empowerment and engagement behind it.

So it's really not saying, okay, the health system is the anchor so they're going to do it all. It's just that they have the opportunity to pull groups together to effect change in a different way than some of the smaller institutions can. But they should be part of the equation absolutely. And in some cases, they're the ones that should move specific initiatives forward.

So it's definitely not taking them off the hook or reducing the responsibility, but just

where's the best opportunity to move things forward.

MEMBER LAWTON-KLUCK: I've seen convening take place effectively by all types of agents, and I wouldn't assume that it has to be the anchor. And sometimes, I know in the city of Portland, competition is so strong between the anchor institutions that one will not come to the table pulled by another. It has to be an outside different force.

MEMBER KNOX: If I just might, prior conversation, but no, completely agree. It's just whose best position to effect change.

DR. BERNOT: So in that recommendation --

(Laughter)

MS. ZIELINSKIE: I'm sorry, I've got to keep going. If our recommendations are for states, are we talking about state Medicaid plans? Are we talking about payers? Are we talking about FQHCs, and I understand the local

variability. Are we talking about state Medicaid agencies? Are we talking about public health?

So we're taking the broadest definition of healthcare in which is possible? Traci's in. All right. Thank you, Traci.

MEMBER FERGUSON: Yes, and I think -- I was trying to find the words, but it's any organization that can impact the health of an individual as that individual's in a community. So it is that broad because it could be, you know, a coalition of the YMCAs who do provide food, and sometimes even shelter, but provide the food for the children with -- school-age children during the summertime. That they have breakfast and they provide breakfast and lunch. So it could be the YMCAs as part of this community that impacts these individuals.

So they're not -- they wouldn't consider themselves necessarily healthcare, but they do impact the health of that individual. So it's just that broad.

DR. BERNOT: Laura?

MEMBER GOTTLIEB: You had me at hello, and then I -- I think I disagree. But it's such an interesting concept. So I think the question that was initially laid out was what is the healthcare delivery sector's role in addressing social needs. And that could be totally wrong. That's how I envisioned that, right? That wasn't the word.

But does the healthcare system, in terms of healthcare delivery, have a role in helping to address patient -- identify and address patients' social needs?

Everybody. Everybody. There's no limit to the outer circle of everybody influences that, and whether they think of what they do is healthcare or not. But when we think about what the scope of this project is, I think we've got to limit it somewhere. I think. Maybe that's just like my own limited thinking.

But I would draw a line somewhere

around healthcare delivery systems. And to me that includes at local levels, community, you know, county, regional level, and then state level and federal level.

So, you know, I think about people who are involved in everything under the delivery systems, including the payers, including the people who set policy around what, you know, what we pay for in the healthcare delivery.

But I would say that you just named community agencies, community social service agencies, who also influence health but are not delivering healthcare. Don't hate me.

MEMBER FERGUSON: No, I don't. But the Medicaid agencies don't stop there. You know in terms of that state agencies, they, as part of what they're looking for in terms of managed care organizations, to have that what are your value-added benefits that are going to help address those issues.

So even though fee for service may not

do it and say we're just going to pay for this, they're looking for others to supplement and assist in that. So there should be some type of guidance and they're looking for those community outreaches and they want you to bring that in. So I don't think --

MEMBER GOTTLIEB: That's how healthcare, that's how Medicaid/Medicare organizations are strengthening communities is by building those bridges. But you're the healthcare entity there, right? Like the groups that you're partnering with are not the healthcare entity. They're strengthening health, but they're not the healthcare entity. Is that wrong?

MEMBER FERGUSON: No, that's correct. They're not the entity, but we can only do so much. We, as a health plan, we're not deliverers of care. We have to work with our partners whether they're providers, but also community agencies in order to do that.

But there is also those who don't even fall in that. So you have to qualify. For those individuals who don't qualify, you know, we're saying if you don't have insurance, where do you fall?

You know it's whether -- so some hospitals are able to catch all those individuals who don't have insurance, but we talking those entities uninsured. That they fall into the network of those social agencies that now become the health plan for them.

DR. BERNOT: And I definitely want to keep this discussion going because I think this is exactly -- Ginger brought up the right point. What are we defining is we're building a framework.

So a couple questions. Is there consensus on whether we're going to go with the broadest of health or healthcare? Or is this a place where we need to just pick a definition here? Or is there a fourth bucket that we need

to, a bigger circle around this, just so that we're all talking on the same page?

I completely agree with Ginger's point. So, I know Ron is next, and then we'll just keep the discussion going.

MEMBER BIALECK: I think with the, again the focus on healthcare, health systems, and I think that is the charge here. There is what it is that healthcare controls. There's what healthcare influences, and there's what healthcare has no influence over.

And I think the space that we're playing in is what it controls and what it has influence over. So it can have influence over social services that are provided. It can have influence and control for that matter over housing and other factors. But it is the, you know, what those healthcare entities are doing, or we think can be, should be doing, and have to measure that.

The one thing I'd like to amend,

Laura, in your language was, you talk about addressing patient needs, and I'd like to think of it as the healthcare entity addressing the individuals living in a community's needs; individuals who may never be a patient of that healthcare entity.

DR. BERNOT: Ginger?

MS. ZIELINSKIE: Yes, I mean I think this is a crux of a question, and I think it has real ramifications for how we think about how things get paid for in the future, right?

So if we want to talk about housing instability, we know that there are healthcare organizations paying for housing. And so is housing health? Is that housing unit a piece of healthcare? It's just the distinction really matters, and I don't have an answer.

But we know that there are pilots. We know what Camden Healthcare Coalition is doing. You know, we know that there have to be investments in housing instabilities

specifically. We know that there are returns from both the health outcome's perspective, and an economic perspective that makes sense. And that's all under a big frame of healthcare, but are Medicaid dollars going to start paying for it? I mean we know that there's a push there too, so it's a big circle.

DR. BERNOT: This is a follow up, but do you have a -- thinking specifically of these domains, if we want to call them that in the framework, do you have a specific recommendation of whether you would like to broaden the definitioner or the definition, or add another ring?

MS. ZIELINSKIE: So from our perspective, we've started thinking about it in terms of the health and human services ecosystem. That both of them are actually quite vital to delivering better economic, social, and health outcomes.

MEMBER GOTTLIEB: But you're thinking

of them as one? It's so unnatural.

MS. ZIELINSKIE: We think of the ecosystem as one comprehensive mechanism if we want to actually deliver better health. If we want to get from a sick-care model to a health-focus model, you have to integrate Health and Human Services programs, especially for low income, historically disadvantaged populations in people.

MEMBER GOTTLIEB: I totally agree with this. I think that the challenge that we have as an expert committee for NQF is that we're also trying to make a sale, right? So we're trying to say, look, the healthcare system has a role in what has historically been a different world, and we need to be able to say, clearly, that these -- maybe in like the discussion or whatever -- there's much more melding that needs to happen between Health and Human Services or Health and Social Services.

But if the -- I'm just trying to think

of like what the thesis is of this, whatever report comes out of it, and I do feel like there needs to be -- there's an audience. And the audience is a healthcare world, and I think we need to say to the healthcare world there are many different roles for you.

Even if our dream state, almost like the aspirational, is that these are -- this is -- of course, to like reach the dream state, these universes need to be collapsed. Does that make any sense?

MS. ZIELINSKIE: Yes, I think that we agree.

(Laughter)

MEMBER GOTTLIEB: Great. But then it's healthcare.

MS. ZIELINSKIE: But I just don't think that everything that you said, I don't read that in healthcare's role in strengthening communities. I read that as healthcare is coming to the table and delivering clinical care, but

now reaching down into the social services community and pulling in as opposed to an equal footing of how do we actually truly integrate Health and Human or Health and Social Services to deliver better outcomes?

MEMBER GOTTLIEB: Then I think this model's bad.

MS. ZIELINSKIE: Well I think it then gets back to what is the role of this entity. And if this entity's role is to help state Medicaid agencies plan and build systems that can address the determinates of health, then that level of integration has to be instrumental from the outset.

DR. BERNOT: Nancy?

MEMBER LAWTON-KLUCK: I don't think the model's bad. I think maybe the visuals need some, just more to it. It's almost as if, like if we go back to Ron's comment about the Community Health Needs Assessments and the FQHC's assessments, and all these different mechanisms

for gathering data, if we could collapse them into one standardized format. And then use that to start looking at what are the interventions necessary, and then whose best position to take care of that intervention.

One of the things that I always get a little bit concerned when I see this integration that's not directed, is that there -- we already have so much happening within our communities that's not connected.

So how do we have that galvanizing force that pulls everybody together to set some shared goals and metrics, and here's where we're going next has enough accountability standards that we don't have today. So I think the conversation has been really good. I just think that maybe that visual just needs to be -- yes, we just need to work on it. But conceptually, the way you were talking makes sense.

DR. BERNOT: And of course like this, everything is iterative here, and so the visual

-- I just was curious to come back to you and want to clarify. Do you have thoughts specifically on a visual? It's okay if you don't right now. It's something that we'll be synthesizing and getting feedback back-and-forth and back-and-forth many times. But I was curious right now if you have any thoughts?

MEMBER LAWTON-KLUCK: We've developed a logic model for another organizational group that we started with and are willing to share with everybody here. And it took a couple iterations to get there. It started with sticky notes all over a wall, so it's kind of cool to see it actually into something that's navigable.

But it starts with the data sources and it goes through the logic model and then the outcomes. And then it's an iterative process, because as you get to the outcomes, what did you find out from there that then forms the data, which then forms the next go-round.

But very willing to share so we can

use that to see if any of that makes sense for some of the work that we're doing here.

MEMBER SINGH: Thank you. You want to come back to the Ginger-Laura exchange? There is a significant difference in those points of views, and I'm not sure if I understand the implications of the difference as it relates to this discussion. So, you know, dig in a little bit further. What you represented as Laura's view, even if you don't like it anymore, I think reflects like the ground reality current state. And I think what you're speaking to like represents like an aspiration or a necessary environment to achieve the comprehensive change that we're looking at.

And so there's at least two differences. As it relates to measures that are practical and then aspirational. I'm not sure if that's the distinction between the two, but I think there's something deeper in the implication of what -- the premise upon which this discussion

rests, probably is informed a little bit about these points of view. And I think, as a last note, that you're referring back to the mandate about the state Medicaid organizations. The items through them in terms of measures, et cetera. That seems to take precedent but it also strikes me as aspirational somewhat.

I'm not able to reconcile the implications of that exchange, even though it's important.

DR. BERNOT: Traci?

MEMBER FERGUSON: So I was trying to see how the -- we can put the model together. And I think that if we have, in the blue were something like this, strengthening communities and then put the stakeholders or players all in that area. Like naming them -- saying that's not inclusive -- but naming them. And then, I don't know how you'd put it, but maybe there's five directional arrows in terms of if we see a means of how to strengthen a community is through the

social determinants of health, targeted care, and informed care.

So from there you go down by directional, somehow like that, and then ultimately to improve the health outcomes, and it could be for health, for food insecurity and for housing instability. I like the feedback loop, so as you get down there, you may see different things and you can feedback up, going back to still strengthening communities. And it just goes on and on with the loop.

I mean, so that we get -- so we don't say, we don't call out healthcare, but organization's role in strengthening communities and just listing the different types of organizations that we collectively agree to put in there. That may be something that, instead of just labeling it healthcare.

DR. BERNOT: Ron?

MEMBER BIALECK: Traci, I like the direction you're going, to just sort of

articulate some of the types of groups that might fit in.

I'd also suggest that maybe we want to have some examples of what we're talking about. Because models, we all interpret them a bit differently, and so maybe you know we could all nominate examples that we're familiar with.

And one that I would come off nominating would be the University of Vermont Medical Center where, in Burlington, Vermont, working with a coalition of I guess maybe 40 or 50 different organizations, some governmental, some not, address the issue of not having a place to discharge individuals who were homeless, or had housing instability.

And ultimately was able to find housing for individuals. Provide wrap-around services, social services, working with other organizations, and ultimately reduced chronic homelessness in Burlington, Vermont by 30 percent, and save $1.6 million for the hospital

and improve the health of the individuals who were part of this.

And I think that's what we're talking about is, how it is a health institution can take a role bigger than itself working within the community to have a sustainable way for people to remain healthy. And so attaching a few examples here and there might help us all see, and others see, well the customer ultimately -- you guys -- see what it is we're all talking about.

MR. ANDERSON: I think that was actually a really great segue because one of my next questions was, so we talked about having use cases to kind of describe what these different areas are. Are there other suggestions like Vermont?

And of course we can follow up after the meeting of making these areas more real so that, you know, state Medicaid agencies or whomever, you know, picks this up, will kind of really understand and how to apply the

committee's recommendations. And we've gotten some of that already throughout the day, so it might just be a matter of, you know, following up from this meeting.

MEMBER KNOX: I would think our time would be best spent by sending you examples, written rather than going through them here.

MR. ANDERSON: So, are there any other comments related to this direction that we're going in? So I see that we need to kind of play with the language about how we, you know, characterize this, and we can take, you know, what Traci has put forward and what you plan to share with your conceptual model to try to put together something a little bit more closer to what we've been discussing throughout the day.

But if there's -- do you have any other concerns or comments related to going in this direction and of categorizing the recommendations within these three buckets? Laura?

MEMBER GOTTLIEB: The only other thing that I would say is that, you know, I do think that the orange buckets -- I'm just going to transition to the orange which is sort of my universe. They're separate buckets and I think we need to think about them differently, but I don't think necessarily that the implications are that different for NQF.

So food for thought as you take this, and sort of think about how this informs the broader, our effort towards measures. You know, the evidence around informed care is all over the map and also non-existent. Like there's, it's very difficult to know. Yeah. I think that both of those rely on, mostly on patient-level data. Patient-reported data. And then the question is what are the activities that healthcare providers take? Like what the interventions are.

But if we're talking about measures, I think that the measures are very similar. Anyway, I just am not 100 percent sure it's worth

separating them out further in the model.

MR. ANDERSON: So, just to comment. So maybe not separating out the measures. Maybe the measures will overlap between the two. But is it helpful to separate for the recommendations, which there is also overlap there as well, but --

MEMBER GOTTLIEB: So to me it's helpful in thinking about the question that Romana put out there, which is what is the healthcare sector to do. And to me, those seem like, you know, people may be more comfortable as health care systems make decisions about investing in this work.

There may be some health systems that are more comfortable thinking about things that they're kind of already doing. Lots of people are already doing that without calling it social determinants of health informed care. We're providing interpreters, right? Like, it's just a thing that we do.

As a country, we're debating access, but we're debating it which is good, right, so we're trying -- probably trying to shape access for poor patients. I'm not going to go there because we're, I'm in D.C. I can only do that in San Francisco.

So, there are things that we're doing around social determinants of health-informed care all the time. It's a good entry point just saying, hey, all systems have a role in this.

But then, when you get to the other two categories, there's a lot more political complexity. So for that answer, yes. For the answer about measurement and recommendations, I just don't know. I'm having a hard time visualizing what this report does. Where it lands. So I don't know about the recommendations.

MR. ANDERSON: And that will be clarified after this meeting once we pull the information together for sure. Ron?

MEMBER BIALECK: Sorry, me again. Both of the orange circles have care, which suggests sort of a one-on-one individual approach, and I'm just wondering if the social determinants of health-targeted care might be targeting interventions which then would allow for things like food banks and housing, et cetera. Whereas, I don't see that as individual care, *per se*.

MR. ANDERSON: Sarah?

MEMBER SCHOLLE: So I'm seeing this as really functioning at a level of trying to understand the community and needs, and that's different from understanding the individual. And so what I'd really like to see in this model is an understanding of what's about responding to an individual's need and what is about responding to what the community needs.

And you need to do that because you won't be able to respond to the individual unless you understand the community and build what you

need in the community. So I'd like to see that, and I agree combining these because actually thinking about medications in terms of whether you have a refrigerator is something that may not happen as often as we might assume that people are thinking about that.

So I do think it's hopeful, because that is a specific thing you might do for your patient population, your panel, or an individual person. But that is a level of delivery of care, which could include delivery of healthcare, but also delivery of the social services that are needed to make the care work for an individual.

So that, maybe, I don't know if that helps you kind of think through your thing. The other piece in there, and Traci had it, is you've got to talk about where the data are and how the data are moving from these different places.

And we had a good discussion about that, and if you can somehow figure out how to get the data transfers in here because that's a

big, it's a big piece of being able to make this work.

MR. ANDERSON: Traci?

MEMBER FERGUSON: Yes, and I think building on that, if we had a similar model and you would just take it if you were sitting at the state level, or you're sitting at the community level, or at the administrative level. Whatever those data inputs come in, you may have as a healthcare system or as a provider, you have different inputs, different people who help you strengthen your community, you have a targeted intervention, and you have the outcome that's addressed. You're addressing that social determinant of health and you get outcome.

And you take that and you feed back in. So I think that a similar -- it depends like when you saw those concentric circles where you had the patient and you had the, you know, community organization and all that. Depending on where you are in that circle, you follow the

same, sort of the same process. But you may have different inputs of the data, or the inputs of your circle of influence which would be the blue. But it's the same process.

So whether you are an individual, you can take this report as an individual provider, if I get input in, this is how I can do to address this. If I am an organization, an integrated health system, I have much more input, data collection, and I have more, say more targeted intervention, but I would still be able to do it.

So it gives everyone sort of a mechanism of how they can use the information that's coming in and, you know, have an intervention. And then measurement is, depending on where we are, that's were measurement would come in. So at the community level, system level, and at the provider level.

MR. ANDERSON: Nancy?

MEMBER LAWTON-KLUCK: I think the question drives back to for me, what are we

measuring and how do we validate it? So there's so much information that already exists. So if I said I want to go into the treaty and see where the food deserts are, I can find them.

If I want to see where there's high incident rates of, you know, diabetes, I can find it. If I want to know what interventions are out there that have some sort of proven methodology behind them, I can find them. Though I think it's really hard, you know I'm not sure we're going to solve that in this session, definitely not today, is how do you prove that your interventions are actually moving the needle on a population health-based level.

I think that's where some of those, like we kind of touch on those conversations, but we don't actually jump into them. So I think part of this, for me, is how far do we go in that continuum? So is it looking at the stylization of the data elements, and maybe some opportunities for interventions. And then

looking at some basic elements that we're just trying to move the needle on.

But I think the bigger question that eventually we do have to answer is that how do we validate those treaty interventions on a population health basis.

MR. ANDERSON: Sarah, did you -- no, that's a really excellent point. I think when we were trying to kind of conceptualize this prior to the meeting, we did have some conversation about outcomes and how would we -- you know, we have all of these example interventions, and we have some promising information on, you know, their success. But, how do we, if we're recommending that these be used in some way, or there's some measure tied to some intervention, how are we making sure that they actually improve health outcomes? Or maybe it is some population level measure if it's tied to some state level measure.

But I think that's a really -- I don't

know if that should be a part of this framework in some way? That there needs to be some intervention, recommendation about assessment of outcomes, but that's a question that I would pose to the panel.

MS. ZIELINSKIE: In response to that, I think it's absolutely essential. If we look at where the gap in evidence exists, we know that there are social or human services interventions that have had maybe some anecdotal or retrospective, but I think we all agree -- and correct me if you think I'm wrong -- but that evidence still needs to be further brought to the surface around when we serve people the right way and help them meet their social needs.

If they get the right services at the right time, what is the potential to actually improve their economic social health outcomes? Right? So there has been fragmentation of both health and human services on both sides and together.

So we still have yet to know, when actually we deliver this aspiration. And which ones are a priority for us to meet? Which social needs are a priority in order to get better outcomes? So building the evidence base, I still believe as we connect those health outcomes with those human service interventions is absolutely essential. To protect them, to keep them funded, if nothing less.

DR. BERNOT: And Ron?

MEMBER BIALECK: When I look back at the objectives which is recommendations for addressing food insecurity and housing instability, we're looking at here on this model, outputs. And I'm not sure we've captured anywhere the necessary inputs, if you will, of the health system needing to know what the leads are with regard to housing insecurity, and housing instability and food insecurity, knowing what the assets again are in the community around that and the gaps.

Then you can move to, I guess, some of this here once you have that baseline. So if we -- in making recommendations, I think we need to describe both the inputs as well as the outputs.

DR. BERNOT: That's a really good point. Just to -- we'll get into next status. Vanessa will do that before we adjourn, but one of the steps is to really take of this the next key and form and interviews is going to being done by webinar, are largely folks outside of the healthcare system that are really in the community. Not exclusively, but that's where our target was to take this and bounce it off.

So I think you're point is just dead-on accurate. To get that litmus test, what do you have, what should be coming in, and make sure that connection exists. So I just want to make sure you know that was noted.

We also just -- if there's any more comments on this, do let us know, but we know that some folks have flights, and we wanted to be

sensitive to that. And as we -- I've never been on these within NQF or outside of NQF that's not a slugfest, and the magic happens afterwards. And I do hope that we've tried to allude to that in the, you know, the orientation. But I've just not been to one, I wouldn't forget, it had nothing to do with NQF, come out exhausted, beat up, bloodied, but then next steps, the iterations, I think is where things get hopefully really start to come together and crystalize.

But one thing we thought would be helpful, Drew and I were talking, would be just to go around before we conclude, and get just one to two key take-aways. Make sure you have that down. I mean, we know we have everything down, but just take this, synthesize one or two key thoughts. If we start with Ginger, it gets the easiest over on that end because everything often is already said, but if we could do that, then we'll go to public comment. And then Vanessa will give us the next steps for the project and

really outline where we're going over the next couple of months.

But I didn't want to cut off the discussion if there was anything else that people wanted to talk about on the framework. Hearing none, Ginger, would you be so kind as to give one or two just really key points to take away, that really resonated with you today, just after all these, a full day of discussions? You can pass if you need.

MS. ZIELINSKIE: Again, I would just focus on the fact that these recommendations are for how we can empower states to embed determinates of health work in their sphere. And so it's really a trickle-down, and I think states could really seek support in understanding how to get and unlock data that is available to better understand and better serve.

DR. BERNOT: Thank you.

MEMBER SCHOLLE: I think we have to think about what's actionable at the care

delivery side, and that is, could be informed by all that the state has available. But it needs to have that human interface that works for the care team.

MEMBER BIALECK: I would say there's a lot available already to understand the needs and the assets at the community level that needs to be built upon and built into this. And also, getting beyond care, and looking at the individual care as well as the population helping the veterans.

MEMBER KNOX: I think I would say if there are three things I'd want to come out of this meeting as recommendations is to work on a standardized set of questions, to provide strong guidance and funding for the population health data integration, and to provide case studies to states and local providers about how to address social determinates.

DR. BERNOT: Nancy?

MEMBER LAWTON-KLUCK: To echo some of

the comments, I think building on some of the framework that's already there I think's critical. And I think also building in some sort of incentive for the interventions to take place and for the collaborations to occur to incent those who that might not have it in their makeup to do so.

MEMBER SINGH: I think building upon the comments, just clarifying where NQF's kind of greatest point of impulse will be in the conversation is going to be helpful. And one thread that I think resonated was just clarifying how high-level information connects with people who are going to do the work.

MEMBER GOTTLIEB: I'm not 100 percent sure what I'm weighing in on, but I can make it up.

DR. BERNOT: It is just one to two key points that you really just want to hammer home before we -- then we'll go to public comment and then adjourn.

MEMBER GOTTLIEB: I would love to see NQF say that there is a role, some role, and ideally a multiplicity of roles for the healthcare system around tackling patients' social and economic context circumstances.

And I do believe that it's multi-fold -- there are many -- it's late, or it's early, I don't know. So I think that saying that out loud would be a wonderful statement from NQF. And then I think the question of, kind of weighing in on all the different ways in which the healthcare sector needs to develop standards, incentives, and formalize partnerships with other sectors to make those activities possible and normalize them, would be a phenomenal contribution.

DR. BERNOT: Traci?

MEMBER FERGUSON: I think the one thing I would stress is that Medicaid agencies are looking for ways to be innovative to address some of these. So that's where we can put in our aspirational either data collection or programs

that they want to push the envelope because they know that there is a need. So as part of a lot of these bids, they do want to say what are you doing to innovate. So as we can put that as part of these are some innovative things so that they'll not start from scratch.

MEMBER GARETT: So I think one thing that I don't know that came up explicitly today that was a recommendation of the disparities committee, was that we consider ways to actually try and get resources into the right places to help populations with the greatest needs.

And so if you think about the way payment works right now, most provider systems have kind of this cost off-set model where the money that they get for delivering the same services to commercial patients is a lot more. And so they use that money to kind of off-set the costs for treating Medicaid patients or uninsured patients, where you're actually getting paid less than it costs to give of the care.

And so for providers with a safety net mission, and with a model population, they don't have that cost offset. And so what happens is that we're actually giving fewer resources to the people who need it the most. And so I think that's a really important recommendation, and it's going to drive a lot of the work here.

So, in Minnesota, the Medicaid agency is working on a payment model within a Medicaid ACO that would actually have a payment add-on for populations with the greatest social needs within the ACO framework. And we're working with them right now on that methodology, and that's going to happen within the next year actually.

So, it's pretty innovative. They're kind of way out ahead of where the data and the methods support it. But that's the kind of thing that's really going to, I think, inspire action, get the resources to the right places, and then that's going to cause a lot more interest in standardized data collection because there's

actually resources to apply to these populations that come along with it. So I would say that's something I would want to make sure goes into our recommendations.

MEMBER TANNER: Well I like where we ended up. I liked the picture and the model. Maybe it was the way I was translating it is a way to sort of situate use cases and actors, and then think about the measurement that we need can be actionable for all actors within that are trying to accomplish things in those various circles.

And I liked the outside, the way the outside circle was worded healthcare. I'm not looking at it now, but healthcare, responsibility to strengthening communities, or something like that. And especially if we're saying that one part of healthcare is the payer, and a big part of that outside circle is the state Medicaid agency that it has an accountability to be strengthening communities and we're thinking

about how to measure that accountability.

And also as we think about that, it, you know, some sense of it not all being top-down, you know, so that it's not just Medicaid thinking of ways to push down measures onto providers and communities to say, hey now, you're accountable for this, but to actually engage with communities as an equal partner in their role and strengthening them.

MS. RAMOS: I think I really appreciated the discussion about how to define healthcare and implications for what Medicaid, state Medicaid is responsible for. It's hard because I think, well, like I hear you saying like the aspiration of looking at the whole person's needs. And thinking about like housing and health together are important. I think that like state Medicaid agencies are even feeling it's aspirational to think about population health.

I think a lot of the innovation around

this has been like how do we deal with the super utilizers? How do we address these high readmission population? I think like to think about just the boundary of that is waiting for the practical stuff you can give to state Medicaid agencies. That they won't be afraid of.

DR. BERNOT: Thank you. And that, to me, was just a fantastic summary of the whole day and just well put. So we have all of this down of course, plus everything else from the day. This is the beginning, and not by no means the end of the process.

So before we go, I will ask the operator to open the lines for any member or public comment. And then Vanessa will just give us a quick wrap-up and make sure, hopefully we can get everyone out for their flights on time. Operator, could you open the lines?

OPERATOR: My pleasure. If you would like to ask a public comment, please press star one. Press star one to ask a public comment.

There are no public comments.

DR. BERNOT: Is there any comments from anyone in the room?

MS. DUBAY: Lisa Dubay from the Urban Institute. And I think this has been a really interesting discussion. I'm glad to have listened to it. And I think there's a lot to be learned by having information on the social determinants of health at the individual level for clinicians.

And I think another place where it can be useful is for health plans and for the Medicaid agencies so they can see the picture of what their population looks like and what they're dealing with. And only then can they really think about developing innovations that would potentially work to address those issues.

And so I would very strongly suggest that you recommend greater flexibility in Medicaid waivers to try and do some real interesting and well-designed, well-evaluated

demonstrations on this. Because, you know, there's a little bit of this and a little bit of that. I think we heard a lot that we don't know how to do this.

And I also think we need to be extremely mindful that healthcare system, while it can help address these issues, cannot solve the problems that the USDA and HUD can do. And so, let's be realistic about what we can do, and what those partnerships can do.

But if you've got, you know, we're talking about housing insecurity, when Medicaid is an entitlement program; housing is not. There's no entitlement program for housing. 75 percent of the people eligible for federally subsidized housing have no housing available to them. It's not an entitlement.

And so the healthcare system can't fix that. And so that becomes a political discussion about what we want to do in society, and how we want to address housing insecurity. It's not

something that the healthcare system can fix. I'll just stop there. So I just think you need to be mindful about what we can and can't do.

DR. BERNOT: Thank you. Any other comments in the room? Great. Well I will turn it over then to Vanessa to go over just the next steps and what you'll hear from us and when.

MS. MOY: Okay, so just a little bit more about the next steps. We mentioned it earlier in the morning. As we all mentioned this framework project is an iterative process. So one of the next steps that we do is we're having a key informant web meeting to, so based upon this feedback from all of you, we're going to ask those participants additional questions to help us draft this framework along with your input from you guys, the expert panelists.

So we're planning to host that web meeting early November. And also the next step is we'll start drafting all the input that you have on the measure concepts, the domains, sub-

domains, and send that draft over, framework, to CMS on November 15. And then there'll be a public comment period on that draft and we'll ask for your input about it as well during that time period.

And then lastly, if you all have a chance to fill out that survey for that webinar, that would be great. And if you could hand it to me, we can start scheduling that second webinar which is about the comments received on the draft report. That's about it for the next steps.

One more thing is that I know it's been a very long day for all of you, and you might be leaving for your flights, but I really appreciate the rich discussion that we had and the meaningful conversations. But I don't know if you guys all have time for a dinner, an expert dinner, with us all. If you do, if you get a headcount of all who's interested. If not, it's totally fine.

Okay, that's great. That means this discussion was really great and I'm glad you guys are going to head back.

(Off-mic comment.)

MS. MOY: Yes, that too. Exactly. Well thank you so much for your feedback and all your discussions. If you have any further questions, you can email us to foodandhousing@qualityforum.org or just call us and thank you so much.

MR. ANDERSON: All right. Well, thank you everyone. We'll be in touch soon with next steps. And thanks for those who participated in the room and over the phone.

(Whereupon, the above-entitled matter went off the record at 3:17 p.m.)